

# HARM REDUCTION IN PRACTICE

FRANCE / GERMANY / UK /  
NETHERLANDS / ITALY / SPAIN /  
PORTUGAL / SWITZERLAND

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## PREFACE



# European Drug Wars

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Changes in drug policy forced their way into almost every European country in the '80s under threat of the AIDS epidemic. The virus-induced crisis, the rise in mortality rates among people who use drugs ("heroin dependents," one of the "4H" populations particularly affected by AIDS in the '80s), and the obvious incapacity of past policy — based on "detoxifying" people who use drugs — all made it necessary to develop new public health approaches that could protect users' health while curbing transmission risks (whether sexual or injection-related).

These new measures directly contradicted existing drug policy, whose stated objectives were to prohibit and eradicate drugs. In the UK, harm reduction first emerged in 1987. Starting in 1990, Switzerland adopted a new approach that combined prevention, repression, health-care, and harm reduction. Harm reduction policies were largely successful, especially against HIV transmitted through injection — in fact, much more successful than they were against HCV.

In France, change came both later and more progressively. In 1987, Health Minister Michèle Barzach imposed the liberalization of syringe sales. For a long time, the struggle against HIV rested on this political measure alone. France waited until 1994 to authorize opioid substitution treatments, and until 2017 to authorize the opening of its first drug consumption room (DCR). The first DCR had opened in Berne in 1986 (see *Swaps* n°38).

By 2003, 62 DCRs operated in 36 cities in Switzerland, the Netherlands, Germany and Spain.

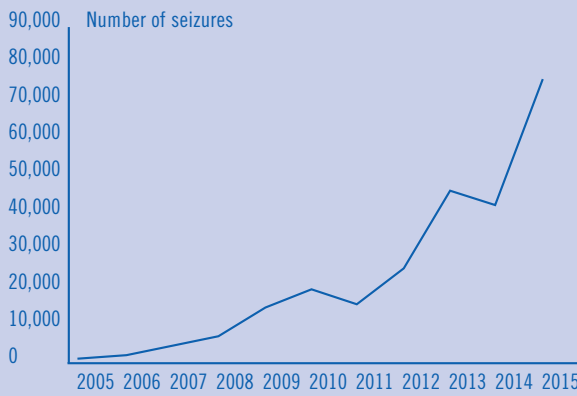
The HIV/AIDS epidemic has dismantled some dogmas surrounding drug use, and today no one in Europe can reasonably refute the benefits of harm reduction policies. What remains to be seen is whether we can mark out the political boundaries of this concept. Although the crisis appears to have subsided — states are funding harm reduction organizations and interventions, and there seems to be a solid consensus within the European Union — we still get a sense of routine and institutionalization, which seems logical as both PWUD and harm reduction professionals become older. This is why we think innovative experiments in Europe could inspire creativity in neighboring countries. In this first European issue of the French harm reduction journal *Swaps*, we have decided to promote the visibility of such experiments.

The free circulation of individuals, the ease with which designer drugs can be obtained, and the issues's shifting epicenter towards Eastern Europe make exchanges of information, data, practices, and innovative experiments more important than ever. The European Monitoring Center for Drugs and Drug Addictions (EMCDDA), in its 2017 drug report, highlighted major European trends. Among these was the rise in deadly overdoses. Instances of death by overdose, estimated at 8,441 in 2015, are mostly related to heroin and other opioid use in the



**Figure 1. Number of new psychoactive drug (NPS) seizures recorded by the European Early Warning System (EWS) declined into categories**

Source: <https://eurotox.org/2017/06/06/rapport-europeen-sur-les-drogues-2017-de-lemcdda>



Cathinones	33%
Cannabinoids	29%
Benzodiazepines	11%
Phenethylamines	6%
Piperazines	6%
Other substances	5%
Arylalkylamines	4%
Arylcyclohexylamines	2%
Tryptamines	1%
Piperidines & pyrrolidines	1%
Opioids	1%

28 European member states, Turkey, and Norway (see figure 1), a 6% increase since 2014. Other trends include ubiquitous access to synthetic drugs and the growing health risks of high-content synthetic opioids.

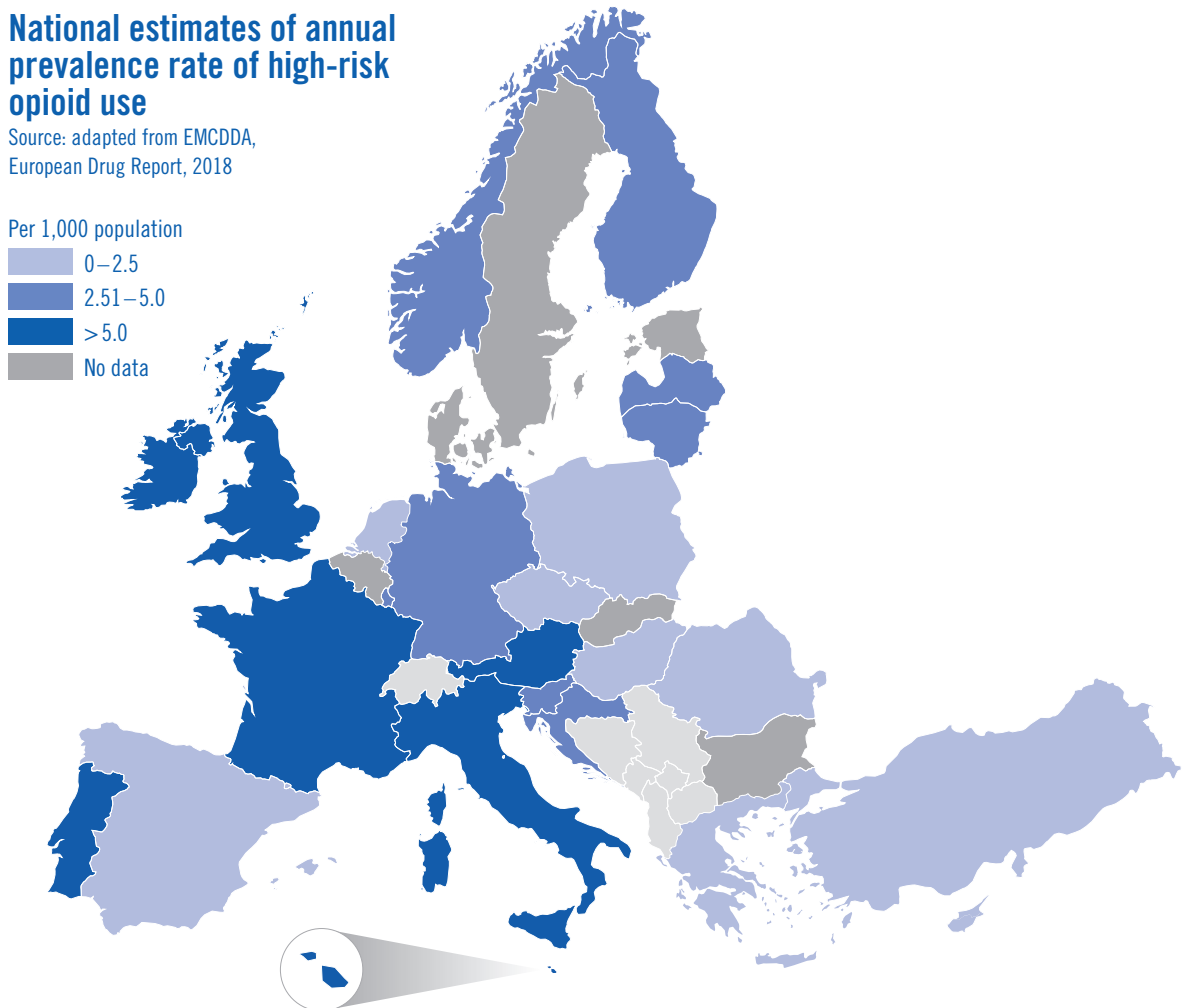
We acknowledge this situation by offering leads, as a way to create dialogue around the focus for this issue (“Harm Reduction in Practice”), which will center on substitution treatments. We decided to examine eight countries:

**National estimates of annual prevalence rate of high-risk opioid use**

Source: adapted from EMCDDA, European Drug Report, 2018

Per 1,000 population

- 0–2.5
- 2.51–5.0
- > 5.0
- No data



France, Germany, the UK, the Netherlands, Italy, Spain, Portugal, and Switzerland. For each country, local professionals will present an overview of substitution treatments, as well as innovative experiments in harm reduction. We also provide tables of the most recent available data from the EMCDDA, with a review on the latest trends in overdoses by Isabelle Giraudon.

This *Swaps* issue was able to lend an independent voice to those who work at the heart of harm reduction throughout Europe thanks to a grant from Indivior Ltd (London) and from Gilead Sciences (Paris). All the articles are available for download in English and French at [vih.org](http://vih.org). We hope to publish more English-language issues and to

explore further areas of harm reduction as it responds to evolving modes of drug use and new substances that can and should prompt innovative approaches.

We are not losing sight of the fact that the front line for the advancement harm reduction has shifted. While there have been remarkable political advances in Western Europe and in Switzerland, everything remains to be done in Eastern Europe. As Michel Kazatchkine points out in his editorial: “reducing harm is also fighting poor policies; it is about advocating for decriminalization of use and low-level non-violent actors in the drug trade and for changing the roles and behavior of law enforcement.”

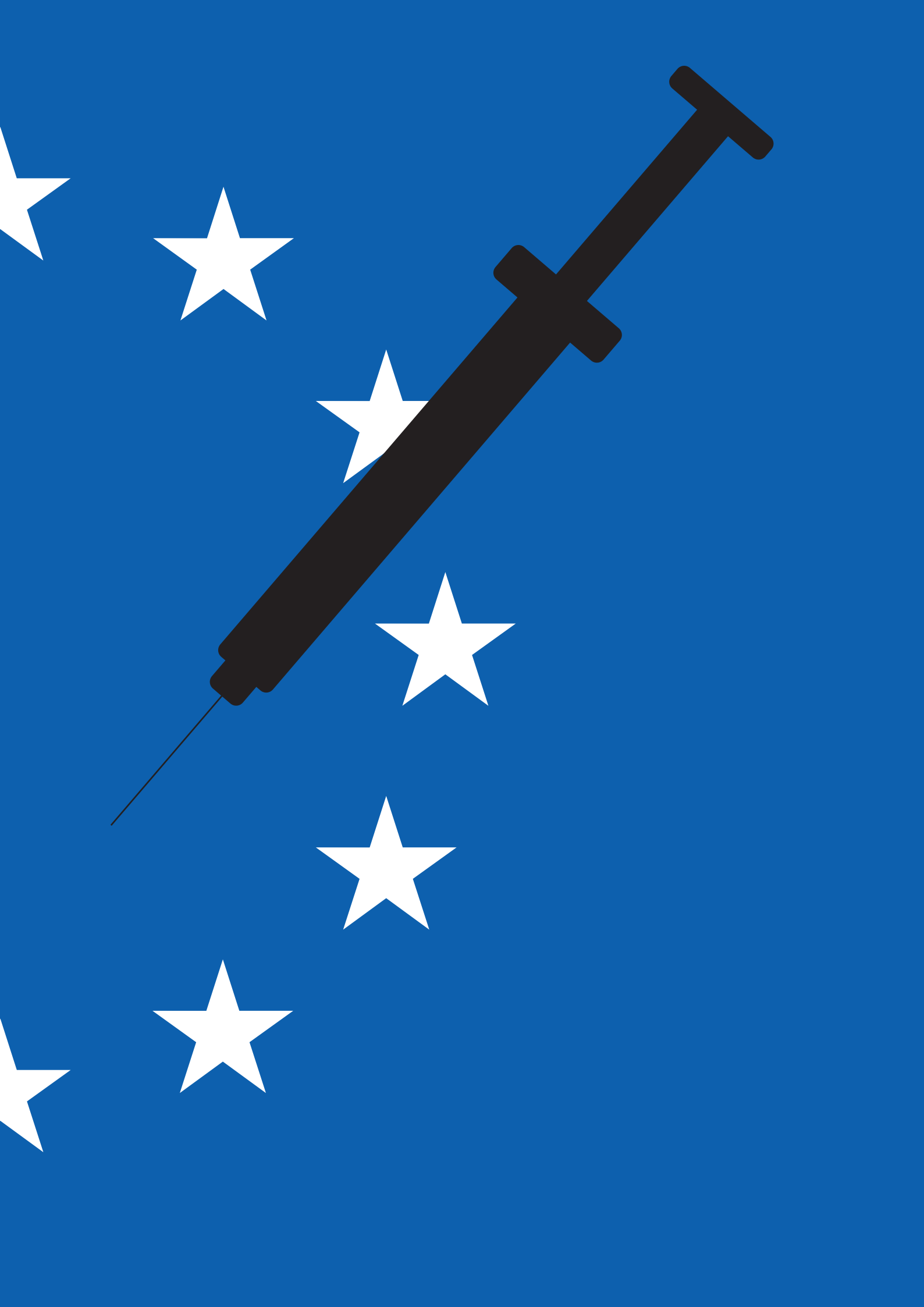
## Interventions in place in European countries that can reduce opioid-related deaths

Source: adapted from EMCDDA, Health and social response to drug problems, 2017

NB: Year of data, 2016

	Take-home naloxone programmes	Drug consumption rooms	Heroin-assisted treatment	Opioid substitution treatment
Austria				•
Belgium				•
Bulgaria				•
Croatia				•
Cyprus				•
Czech Republic				•
Denmark	•	•	•	•
Estonia	•			•
Finland				•
<b>France</b>	•	•		•
<b>Germany</b>	•	•	•	•
Greece				•
Hungary				•
Ireland	•			•
<b>Italy</b>	•			•
Latvia				•
Lithuania	•			•
Luxembourg		•		•
Malta				•
<b>Netherlands</b>		•	•	•
Norway	•	•		•
Poland				•
<b>Portugal</b>				•
Pomania				•
Slovakia				•
Slovenia				•
<b>Spain</b>	•	•		•
Sweden				•
Turkey				•
<b>United Kingdom</b>	•		•	•







# Substitution in France: the emergence of a modern harm reduction system

**Didier Jayle** / MD, *Swaps* editor and former president of the French Mission against Drug and Behavioral Dependence (MILDT)  
**William Lowenstein** / President of “SOS addiction” and drug dependence specialist

*France has evolved significantly since the days of psychoanalytical approaches to drug use. The shift toward harm reduction has led to a system that works — though it needs to be defended and improved.*

## HIV and the emergence of harm reduction

When passing a cornerstone drug law in 1970, French legislators opted for a public health policy that included little medicalization, no options for substitution treatment, and a psychological rather than social approach to drug dependence. With the advent of HIV/AIDS, harm reduction emerged in France largely thanks to the efforts of associations, and then very slowly made its way into public policy.

In 1994, under pressure from associations and doctors treating HIV, who teamed up with a small group of general practitioners, Bernard Kouchner (health minister at the time) and Simone Weil (former health minister) endorsed a brand new approach to dependence based on substitution treatment and harm reduction. This revolution happened despite the opposition of a number of addiction professionals who had not measured the gravity of the HIV/AIDS epidemic. These professionals swore by the sanctity of abstinence as the only path towards real recovery. For them, prescribing and distributing drugs to addicts amounted to “handing out drugs to drug addicts.”

At first methadone, which had proved itself internationally in the US, the UK, and the Netherlands, was officially recommended in 1994 (and approved for distribution in 1995). Initially, methadone was meant to be distributed in specialized centers (CSST, or Centers for Drug Addiction Treatment). As it faced continued opposition, methadone treatment would not become widespread for another while.

General practitioners were then allowed to prescribe methadone to stable patients. One year later, noting the slow propagation of methadone treatment, public officials allowed to high-dose buprenorphine (known in France as BHD or Subutex®), which was approved for distribution in 1996. Since, in theory, buprenorphine presented no risk of overdose, general practitioners were allowed to prescribe it directly to their patients (“primo-prescription”).

## New healthcare for drug dependence

This extremely flexible setup gave general practitioners a lot of leeway, and revolutionized medical care for people who use drugs. For the first time, doctors had an effective



tool to wean patients off heroin, while responding to users' need. Beyond treatment, the relationship between doctor and patient evolved: the doctor's role went from simply treating the most dramatic consequences of intravenous use (abscess, septic shock, endocarditis, viral infections...) to actually treating drug dependence.

This new relationship played an important role when the HIV epidemic reached its apex. As the first effective antiretroviral treatments became available (first AZT, followed by antiprotease and later triple therapy), people who used drugs were deemed too unstable to receive such treatments. Substitution, by giving users greater stability, also granted them access to triple therapy, and, later, to hepatitis C treatment. In the minds of doctors, users acquired the status of patients (as opposed to "defective and sick users") from the moment they opted into substitution medication. Substitution treatment came to represent a kind of key or passport into other forms of treatment.

### France: the buprenorphine exception

France is the only country where high-dosage buprenorphine had become so widespread. By the early 2000s, 90,000 patients were receiving buprenorphine treatment for 10,000 patients on methadone. About 10,000 doctors prescribe substitution medication, or one in 10. Between 2002 and 2017, the number of methadone prescriptions rose steadily to include 50,000 patients. In the same period, the number of people receiving buprenorphine treatment remained stable at around 100,000-120,000. The benefits of substitution were massive. Most drug dependence specialists, originally opposed to substitution for ideological reasons (because it failed to "free" users from dependence and instead "substituted one addiction for another"), are now convinced of its effectiveness and prescribe it without hesitation. As for public authorities, they have continued to urge addiction centers (renamed CSAPA, center for care, support and prevention

of drug addictions, since 2005) to meet their responsibilities as prescribers of substitution treatments and advocates of harm reduction practices.

### Positive effects of substitution

Substitution had three positive consequences. First, widespread prescription of substitution medication made it possible to treat and prevent viral infections. The number of HIV infections collapsed among people who inject drugs (PWID). Today, PWID make up only 1% of new HIV infections (70 out of 7000). HIV prevalence among PWID fell from 40-50% to less than 10%. The collapse of HIV prevalence is due in part to the massive death counts among the first generations of patients, who were unable to access effective treatment. If harm reduction strategies (access to "Stéribox" sterile syringes and syringe exchange programs) played an important role in lowering the incidence of HIV infections, substitution treatment also certainly had a significant impact. It was only after it became widely available that the number of HIV infections fell drastically.

Second, substitution treatment led to a collapse in the incidence of overdose, from 450 a year (an underestimated official figure) to fewer than 200 in 1996. Since 2003, the number of overdoses has risen again and reach 350 in 2015, in part because of an uptick in heroin use, which users consume at higher dosages, and in part because of the increasingly unsafe uses of methadone and morphine sulfates (especially when mixed with other psychoactive substances: alcohol, benzodiazepin, cocaine, and designer drugs).

Third, substitution partially updated a once-chaotic course of treatment for people who are dependent on heroin. We have also observed a lower incarceration rate and a decrease in petty crime associated with opioid trafficking. Today, pharmacists fear controls by the Social Security Fund more than they do potential heists by people in need of fix. Substitution, which was designed to protect individuals against HIV, also turned out to benefit society at large. Public health and public safety, which are usually opposed, find common ground in substitution treatment.

### Undesirable side effects: injection and trafficking

Patients misuse medication mostly by injecting products designed specifically to avoid injection. This phenomenon has been reported among 15-40% of patients, according to various studies. In most cases, patients inject high-dosage buprenorphine and Skenan®. They crush and filter the pills for injection. In cases where

### France: introduction dates

Methadone	1995
Buprenorphine	1996
Buprenorphine + naloxone	2012
Heroin-assisted treatment	N/A
OST in prison	1995

Source: EMCDDA, Statistical Bulletin, 2018, [www.emcdda.europa.eu/data/stats2018/hsr](http://www.emcdda.europa.eu/data/stats2018/hsr)

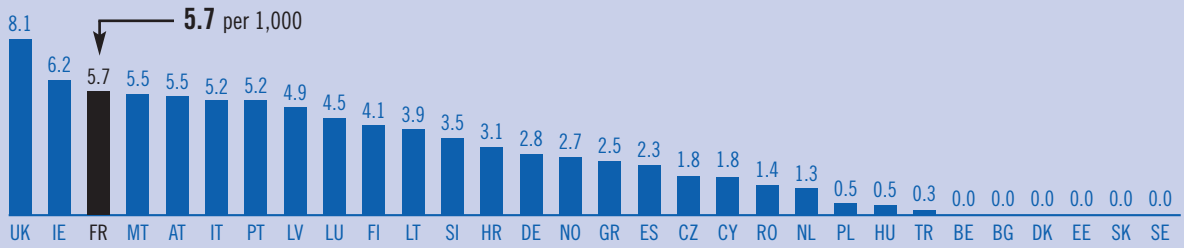


### France at a glance

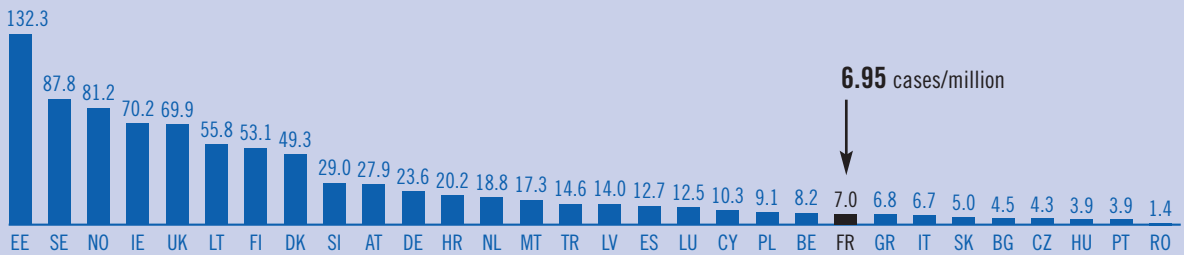
**230,000** (180,000 – 280,000) **High-risk opioid users**

**169,750** **Opioid substitution treatment clients**

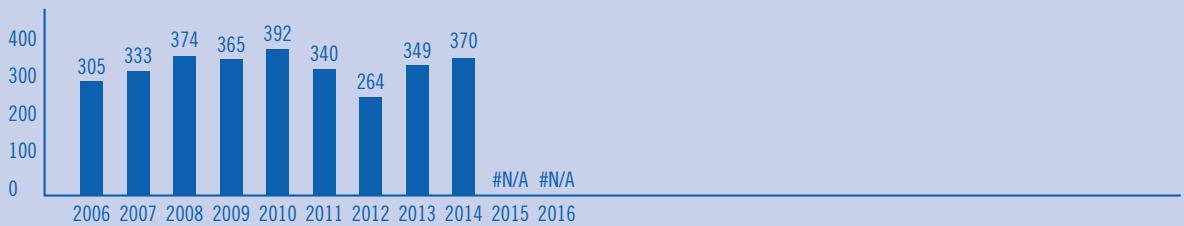
#### Opioids / High-risk opioid use (rate/1,000)



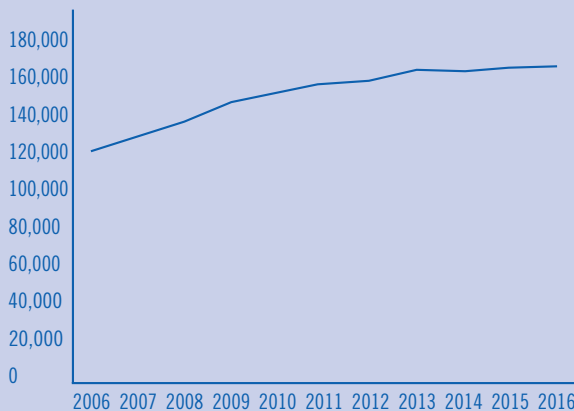
#### Drug-induced mortality rates / National estimates among adults (15–64)



#### Trends in the number of drug-related deaths



#### Trends in the number of clients in OST



#### Which substitution?

Methadone	67,216
Buprenorphine	106,387



Source: adapted from EMCDDA, Country Drug Report, 2018, [www.emcdda.europa.eu/edr2018](http://www.emcdda.europa.eu/edr2018)

patients are known to inject substitution medication, providers usually recommend prescribing syrup-form methadone, which is much harder to inject. Although users who inject methadone sometimes end up in drug consumption rooms, it occurs very rarely. When that does happen, they use trocars rather than insulin syringes, which have disastrous consequences for the veins.

High-dosage buprenorphine trafficking has also emerged, especially in the three regions of the greater Paris area, Alsace, and Provence Alpes Côte d'Azur. Most often, patients have their doctors prescribe excessive doses, and sell the excess amount, which supplements their revenues. Sometimes, people who are not dependent get unscrupulous doctors to prescribe them substitution medication and unobservant pharmacists to provide it to them. They then sell all of their prescribed pills. One person can consult multiple doctors and get prescriptions for 64 or 128 mg of high-dosage buprenorphine (four to eight times the recommended amount for 28 days).

A significant traffic network has emerged between France and countries that do not offer access to high-dosage buprenorphine such as Georgia, Finland, or Mauritius. The misappropriation of substitution medication reached a peak in the early 2000s, when it involved a few hundred individuals (out of 90,000 patients receiving treatment). At that time, 40% of buprenorphine refunded through social security was not used as recommended.

In an effort to contain misappropriation, the MILDT (a branch of the French government responsible for dependence and drug use disorder) attempted to add high-dosage buprenorphine to the category of narcotics (like methadone). However, several HIV associations worked to block this decision, judging it regressive.

The social security fund mobilized to pinpoint the doctors and pharmacists who did not follow good practices, which involve a three-pronged relationship between doctor, pharmacist, and patient. The name of the pharmacist must be written out on the prescription, and the pharmacist and doctor must maintain open contact. Currently, misappropriation makes up 10% of prescribed buprenorphine, and the trend is stable at 2.4% of those who receive treatment.

Some will say that buprenorphine is an easy way to find substitution in cases of emergency, others that buprenorphine is a gateway to opioid addiction. A study conducted by Priminject shows that heroin remains far and away the most important gateway drug.

In general, this system works fluidly and allows 150,000 patients to follow substitution treatment (60–70% of people who are dependent on opioids). This figure is satisfactory from a public health point of view, but it also

stresses the need to increase treatment access and options, especially by developing new natural products, injectable medication, and setting up drug consumption rooms (as of now, two rooms have opened, in Paris and Strasbourg).

Patients receive substitution treatment in 93% of prisons. In these institutions, Suboxone® (a mixture of buprenorphine and naloxone) is most often prescribed, contrary to the community, where Suboxone® use has not spread.

## Evolutions in the last twenty years

Methadone, originally available only as a syrup, has been available in pill form since 2008. Pharmacists can provide them for 28-day spans since 2014. These pills are available only to stable patients who have received syrup methadone for one year.

Buprenorphine (usually Subutex®) remains the first-choice substance and the most prescribed substitution medication. Generic brand medication makes up less than 20% of prescriptions. Prescription of morphine sulfates (Skenan®, Moscontin®) is still marginal (2,000 patients). A letter written by the General Director of Health in 1996 clumsily regulates its use. Today, the Social Security Fund supervises its use and authorizes its prescription.

Misuse of Skenan® through injection continues to expose the reticence of French authorities towards injectable substitution medication, as well as towards medically assisted heroin programs. No time-release model of these treatments is currently available.

Injection seems less frequent than in the 1990s. Education and harm reduction programs are progressively developing (see chart).

Following recommendations by the substitution treatment group of the General Director of Health in 2009, as well as recommendations by the WHO in 2014, limited access to OD antidote (naloxone — Nalscue®) emerged in 2017. We are still waiting for the development of adequate programs (take home naloxone) for this product.

## Hopes and concerns

Though less serious than that of North America, the epidemic of overdoses following unsupervised distribution of opioid medication could threaten French populations. Health authorities have been especially vigilant since 2017. The death of two teenagers after they ingested codeine cocktails brought about the requirement that any codeine-based painkiller or cough medication be prescribed.

Under pressure of the HIV epidemic, the French model of drug dependence treatment medicalized its procedures, and developed harm reduction strategies to respond to



rising opioid consumption. It was also partially able to leave behind the dogma of abstinence and criminalization. We hope that this model will last, and that it will inspire other fields in dependence healthcare: tobacco, alcohol, cannabis, cocaine, designer drugs and behavioral addictions.

We are concerned about three issues:

– Many general practitioners who are deeply engaged in the struggle for harm reduction are now reaching retirement age. These are the same doctors who fought for the development of networks of general practitioners and hospitals, and for access to HIV and HCV treatment through general practitioners. Most of them will not be replaced. The shortage of general practitioners in France will become a more serious issue in the coming years. New generations of doctors have known neither the AIDS crisis nor the activist efforts that were necessary to prescribe substitution treatments. Without specific outreach and education about treatment of addiction, the French model of substitution will come under threat.

– The state of disarray in drug use disorder research and the low budget dedicated to it cannot deliver the kind of advances this issue requires. We need to conduct research on a potential “vaccine against cocaine,” or about designer drug addictions (mephedrone, amphetamines, designer cannabinoids...)?

– The reaction of detractors to the opening of the only drug consumption room in France goes to show that there is still vigorous disagreement and that the indifference of public authorities can endanger what we have already accomplished.

But we are still hopeful. The victory over AIDS and the important progress made in hepatitis C treatment show that moving forward is possible. The development of exchanges between European actors could be a new motor for dynamic research and faith in innovation.

## FRANCE



# An example of postal syringe exchange program

Florence Arnold-Richez / Journalist

*The Postal Syringe Exchange Program (“Programme d’échange de seringues,” or PES) was launched in 2011 by the harm reduction association SAFE. PES currently supplies 140 drug users, who receive injection or sniffing equipment... by mail.*

Whut? “No, of course we do not automatically distribute new injection kits in exchange for used ones by mail,” warns Catherine Duplessy, SAFE’s director. Our program is called “PES postal” because people who use drugs understand the “PES” terminology. In reality, we provide injection kits with all necessary equipment for injections, sniffing, and smoking crack to those who express a need for it.

The program started based on this simple observation: a population of drug users (more integrated, younger, and made up of more women than the average) lives far from treatment and care centers. This population fears interactions in small town pharmacies, where private information always runs the risk of becoming public. They are sometimes unwelcome at the doctor’s office.

All in all, this is a different crowd than SAFE is used to in our syringe exchange program in the Paris area — whether we are talking about the people we meet on the streets when refurbishing automatic dispensers, or those we welcome at the association’s headquarters on Avenue Porte-de-la-Plaine, near the Parc des Expositions. How could we empower this other population to take advantage of harm reduction programs and equipment?

## A daring experiment

The solution was simple: to meet these people where they lived, via electronic and snail mail. Catherine Duplessy

did this with conviction, passion, and above all with great professionalism in her management of contacts and supplies.

The experiment started on private funds at the end of May 2011, and it persevered without institutional backing in 2011 and 2012. It was made possible by donations from laboratories and suppliers. The National Institute for Health Prevention and Education also donated kits in which water was the only expired component. We were able to recycle much of the rest of the equipment.

The program also survived and expanded thanks to the SAFE team, who displayed great motivation. This team of six manages 61 dispensers in the Paris area, which provide prevention kits (Kit+) containing all the equipment needed to perform two injections, 24h/day and 7 days/week. They also perform fieldwork, and manage the postal PES program. All in all, they provide close to 500,000 syringes every day.

## Not simply a matter of stamps

The process starts with SAFE’s phone and email hotline, an essential tool in the “path” of any drug user who wishes to enter the postal PES program. Through attentive listening, SAFE staff have to get a sense of the users’ practices, at-risk behaviors, and expectations as well as their need for information, equipment, or even orientation towards more standard structures of harm reduction and



treatment. They must do all this without imposing a solution, and without expressing any judgment whatsoever.

“Many users tell us that they prefer to talk to us on the phone or by email so that they don’t have to answer questions in their local addiction centers. On the phone or on the screen, users frequently reveal risky practices they haven’t disclosed to their local addiction specialist yet. For example, users systematically underestimate their needs in equipment, as they do in their local drug addiction center. When this happens, we understand that they are reusing their equipment, and we revise their needs upwards. On the contrary, they overestimate their needs because they are evidently trying to provide for their friends. We attempt to initiate a conversation about these practices, so that we can adapt the equipment to their specific needs. We are attempting to popularize the rule that for every new injection, you need a new injection kit,” Catherine Duplessy explains.

“When users ask for 5mm needles (large caliber), which pharmacies can’t easily provide, SAFE staff understand that these users usually inject medication, and try to communicate about those risks. 60% of our active participants in 2012 were injecting at least one medical substance (including substitution medication), and 25% of them were injection at least two.”

Next, SAFE staff process order forms, supplies, and mailing. These homemade logistical undertakings happen in a basement very much like those of standard pharmacies. On shelves, cardboard boxes hold the various pieces of available equipment: syringes, with or without integrated needle, of 1, 2, and 5 ml in volume; needles (G23, G25, G26, G27, G30), syringe filters, disinfecting wipes, doses of sterile water for injection, ascorbic acid, saline, cups, kits, sterile drapes, chlorhexidine wipes (standard or specifically for hepatitis C prevention), male and female condoms, doses of lubricant, and instruction manuals. Other boxes contain flyers and various brochures on hepatitis C, AIDS, and harm reduction.

In a corner stands a small desk, on which SAFE staff sort and process order forms. These are never digitalized; they are given anonymous IDs. The team prepares the orders so that users have enough equipment for a month, so as to save on shipping costs (averaging €7). Packages contain about €75 worth of equipment (175 syringes, enough for three injections a day, as well as other equipment for two users). On the first floor, they take care of administrative and evaluative tasks for the program. They manage their partnerships with socio-medical organizations of the areas where users live and — only with the user’s consent — create points of contact between users and professionals in their area

(addiction centers, doctors, and others). One third of active beneficiaries follow simultaneous treatments. “We sometimes can work as a substitute for the addiction center during breaks or when the center is closed. On our side, we try to direct users towards structures they may not have been aware of. We have a good working partnership with addiction centers.”

So everything is good? No, not really: today, SAFE is quite concerned about the longevity of this program, because it continues to be underfunded.

– Orders came from 17 regions (out of 22) and from 51 departments. Half of users live in rural townships of fewer than 10,000 inhabitants. The great majority of them live in towns of fewer than 5,000 inhabitants.

– Users follow the program because of: geographic distance and commuting times towards special treatment centers, difficulty of accessing necessary equipment in local addiction centers (lack of supplies, insufficient quantities, incompatible opening times), and fear of being identified as drug users in pharmacies or at automatic dispensers.

– The program benefits people ages 20 to 50 (average age: 33). 36% are women and 64% are men. Among them, 84% live in stable housing and 8% in mobile housing (caravans) as part of an intentional lifestyle. Only 4% live in squats, and another 4% live in structures that cannot guarantee them housing in the long term. More than half of them work.

– About one third of PES beneficiaries are on OSTs. In 2012, they reported injecting Skenan® (38%), buprenorphine (23%), methadone (11%), and other medicine (14%), as well as heroin (29%), cocaine (19%), and designer drugs (4%).

## FRANCE

# *Médecins du Monde* in Georgia: a project for harm reduction advocacy



Elizabeth Avril / Director of Gaïa-Paris

Véronique Miollany / General Coordinator for MmM Georgia

*Faced with increasing numbers of drug users from Georgia, a French NGO decided to conduct a diagnostic mission abroad. Two members relate their efforts to establish harm reduction measures in the East European capital.*

Since the early 2000s, harm reduction (HR) programs in Paris, Lyon, and, to a lesser extent in Marseille, Nice, and Metz, have seen increasing numbers of people who use drugs from ex-Soviet states, particularly from Georgia. The Gaïa association in Paris, founded and supported by Médecins du Monde (MmM), has taken in 455 Georgian patients since 2000, and has designed a specific health path for this population in the following years. These users are predominantly males who inject opioids. Their health needs revolve around substitution treatment, and hepatitis C treatment.

Encountering these Georgian users significantly impacted the Gaïa team and the way we operate. This led us to organize an exploratory mission in Georgia in June of 2007, in the context of the East European Thematic Group run by MmM. Our mission aimed to establish a health diagnosis and to assess the relevance of an intervention

among people who use drugs, as well as to specify the nature of such an intervention.

The mission confirmed the need for an intervention, and MmM chose to work primarily in Georgia's capital, Tbilisi, where the majority<sup>1</sup>

of people who inject drugs (PWID) live. MmM partnered with New Vector, the first local self-support group for users in the Caucasus region.

The 2008 conflict between Russia and Georgia, which displaced hundreds of thousands of people from South Ossetia, delayed the launch of the program. We also faced difficulties when attempting to secure funds outside of MmM's own resources. At the end of 2010, a general coordinator and a harm reduction project leader travelled to Georgia to implement the project with the support of the MmM board and of the mission director.

## Our partnership with New Vector

Our mission was twofold. We wanted to help lower transmission risks of HIV/hepatitis C/hepatitis B and other STIs. We also wanted to reduce harm related to drug use, all the while improving the quality and visibility of harm reduction interventions. MmM was new to the concept of partnering with an existing organization, which proved challenging in this complex environment. New Vector consists of current or former PWUD who have been organizing harm reduction interventions financed by the Global Fund

<sup>1</sup> 27,000 in Tbilisi out of a total of about 40,000 in Georgia – "Estimating the prevalence of injecting drug use in 5 cities of Georgia", 2009. According to the latest study in 2012 by the Curatio International Foundation – "Behavioral surveillance on injecting drug users" – the number of PWUD in Georgia is 45,000.



since 2008. These interventions were rare and uncoordinated, and the organization lacked resources, visibility, and support.

In close collaboration with New Vector, we opened a care center in a central neighborhood of Tbilisi. We set up in a large, three-story, publicly visible building. Police repression is particularly severe in Georgia, and we were quite worried that PWUD would not venture into the center.

We reinforced New Vector's team of users and ex-users and trained their members. We opened a dental care center and recruited a local nurse, doctor, and psychologist. The dental care service brought more patients into the active file at the drop-in location, which attracted new users. In 2013, at the international conference for harm reduction in Vilnius, we presented a poster outlining strategies for attracting users to a drop-in location in repressive environments.

Social workers (the term used for peer educators in Georgia) carry out significant outreach interventions in Georgia. They travel to users' homes, bring injecting equipment, and pick up used equipment for disposal. They also distribute Narcan® (Naloxone) and teach users how to use it.

### Drugs in Georgia: from “narcostate” to repression

In Georgia, users historically inject opioids. There was a drug epidemic in the 90s, which locals dubbed the “black years.” For 10 years, the country's economy and infrastructure were in ruin. Criminal behavior was ubiquitous and drug use (especially heroin use) grew exponentially. Georgians say that using drugs was in vogue at the time, and that to be in on the moment, or to be a “real man,” one had to inject drugs. The epidemic affected all social spheres, particularly the elite. Through rampant corruption, drug use spread into law enforcement, but also in business, academic, and medical communities. Drug-themed humor has a lot of currency nationally, and families often laugh at well-known stories of drugs and drug users. Georgia was set to become a “narcostate;” some even attempted to grow coca plantations on the coast, where they could find a suitable subtropical climate. The situation changed when Mikheil Sakaashvili came to power. Following the example of the US, the new leader engaged a fierce fight against corruption and drug use. There were numerous dismissals from police forces, universities, and medical bodies. Every year, the police conduct 60,000 forced, arbitrary urine tests among common citizens. A positive opioid test results in heavy fines, especially relative to the population's earning standards. A second offence soon leads to long prison sentences.

For a long time, Georgian PWUD, like Russian ones, mostly consumed opium and heroin. They prepared opium solutions for injection. As repression made heroin harder to come by and costlier, an illegal buprenorphine trade emerged between France and Georgia. In Tbilisi, in 2007, one Subutex® (buprenorphine) pill would go for \$120-240.

### The emergence of homemade drugs

Since 2008, users have fallen back on homemade drugs, whose effects are less suppressed than those of illegal drugs. These drugs (Krokodil, Vinte, and Jeff, for the most part) are widespread and make up most of drug use in Georgia. Only very recently have designer drugs — informally referred to as “bio” drugs, a miscellaneous group of substances purchased online that includes bath salts — started to replace homemade drugs.

Krokodil can be made with a base of codeine (from which desomorphine is extracted). Preparation takes about 45 minutes. Labor and costs are usually split among four or five users. One acquires the codeine, another the sulfur, another the remaining ingredients (hydrochloric acid, bleach, iodine). Another member will cook (which requires specific skills), and another yet can be the “stinger.” The preparation work is convenient to divide up, and users can inject up to six or seven times a day.

Vinte and Jeff are psychostimulants. They are made out of a base of pseudoephedrine contained in Actifed® pills and in other flu medication. Vinte has a similar effect to cocaine, though it lasts longer. Jeff involves a particularly hazardous preparation process as it contains manganese. It soon causes irreversible neurological damage similar to Pseudoparkinsonism. Users need to hide, have little access to information, and incur high levels of risk. Syringes have always been legally available in pharmacies, but they are practically inaccessible due to fear of police harassment and of being apprehended with injecting equipment. Therefore, users often reuse or exchange syringes after boiling them for a few minutes.

Socially, the situation is rather paradoxical. Georgian PWUD are neither stigmatized nor condemned. There is a strong family structure. Georgians marry and have children at a young age. PWUD remain in those family structures and few people become homeless. The unemployment rate is very high and many Georgians either migrate or remain within families, in which they have found a way to make out with the resources of the rural branches of their family.

Saakashvili entirely privatized the healthcare system; treatment is now at the patient's charge. A basic safety net has recently been implemented for the poorest Georgians, but it only covers primary care. Until just last



1. Installation of hurdles indicating costs of treatment
2. Demonstration at the Merck and Roche laboratories on July 24<sup>th</sup>
3. Concert in Batumi
4. Street happening in Zougdidi
5. Signing up on a waitlist

1  
23  
4

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5

year, standard treatment for hepatitis C (pegylated interferon, ribavirin) cost \$12,000, not including additional follow-up exams. Few people can afford these costs.

### A tougher political context

The elections for parliament held in October 2012 resulted in the victory of a coalition of opposition parties. The leader of the coalition, multibillionaire Bidzina Ivanishvili, became prime minister of the ruling administration. In October 2013, the presidential elections confirmed the coalition's victory. As Ivanishvili retired from politics, it was the minister of internal affairs who became prime minister, and reinforced the new administration's "strong" position on drug policy. These political shifts had three major consequences on our program:

1. There was a freeze on all ongoing conversations and considerations of policy changes. As the new government came in, we had to take time to forge relationships with the incoming administration.

2. There was an unprecedented release of prisoners (from 24,000 in January of 2012 to 10,500 in January of 2013), which increased the number of users participating in the syringe exchange program, particularly at the drop-in center.

3. Contrary to what was initially announced, the legislative context of drug policy did not become more flexible. We therefore had to increase our advocacy efforts in that domain.

One of the project's goals is to advocate for access to treatment for HCV, which has turned into a national emergency with a prevalence of 7–13% in the general population.

Since the launch of the program in June 2011, MdM and New Vector have worked together to improve users' access to harm reduction services and to raise the quality of these services. A major objective of the program is to train field staff and educators who can spread good practices to regions that MdM and New Vector cannot directly impact.



We also sought to involve PWUD because they are the program's key actors. With the support of MdM, New Vector has created a group for patients who live with hepatitis C (Hépa +). MdM is actively involved in advocacy operations in civil society and with the government, and participates in coordination committees on HIV/hepatitis C/hepatitis B prevention. These new committees are the result of these associations' advocacy and activism (public protests, TV interventions, witness accounts, and more).

PWUDs' capacity to advocate for their rights at the local, national, and international levels has improved. New Vector's director is a member of the Georgian harm reduction network, and has created "Georgian Network of People Using Drugs" (Genpud), based on the British model of Inpud. This group ensures better visibility for harm reduction operations at the international level, as well as financial support (from Soros, among others).

These collaborative efforts led to the installation of a publicly visible drop-in center in Tbilisi. It also enabled face-to-face work with the program's beneficiaries, as well as harm reduction training for educators, in cooperation with the Georgian harm reduction network (of which MdM is a member).

These steps led to a significant increase in the active file at the drop-in center over four years (from 600 to over 3,000 direct beneficiaries, not including beneficiaries outside Tbilisi — our conservative estimate is 100 people). Attendance at the center continues to increase steadily, from 200 visits a month when the center opened to 1,000 now.

At the drop-in center and through outreach efforts, beneficiaries have access to sterile equipment and condoms. The Global Fund distributes syringes and alcohol pads very irregularly and in short quantities. MdM complements these supplies, and, together with beneficiaries, decided to widen the selection of accessible sterile equipment so as to reduce risks related to injection: sterile water, cotton wads, disinfecting wipes, tourniquets, face masks, and gloves (used for product preparation). Thus, 690,308 injection syringes (1 to 5 cc) were distributed over the project's duration (averaging 227 syringes per beneficiary every year<sup>2</sup>), as well as 115,416 condoms.

## Our advocacy initiatives

We have led advocacy efforts on two fronts: free access to HCV diagnosis and treatment and strengthening of harm reduction practices (decriminalization).

<sup>2</sup> This figure matches international standards.

<sup>3</sup> "Hepatitis C among People who inject drugs in Tbilisi, Georgia: an urgent need for prevention and treatment." June, 2013 for the *International Journal of Drug Policy (IJDP)*.

In order to escalate our advocacy, MdM has set up a FibroScan® intervention since September

2012. We started with a study, the only one focusing on Georgian PWUD to this day. We analyzed the treatment needs of users in Tbilisi from October 15<sup>th</sup> to November 2<sup>nd</sup> of 2012. We published the results in 2013<sup>3</sup>. Out of 217 diagnosed participants, 90% were HCV-positive and 22% were developing severe liver fibrosis that requires immediate treatment.

July 28<sup>th</sup>, World Hepatitis Day, has become a pretext to talk about this issue, through a series of events throughout the country. Along with Soros and the Georgian Harm Reduction Network, MdM chose to focus its advocacy work on:

- Providing access to HCV diagnosis and treatment.
- Shifting the legislative context towards decriminalizing harm reduction practices, particularly syringe disposal and access to naxolone in case of overdose.

Our main advocacy efforts concerning HCV take place on World Hepatitis Day every year. In 2012, our teams organized a press conference on HCV and a street happening where activists installed fences in front of the parliament building.

HCV-positive patients (or their representative) who wish to do so can sign up on a waiting list for treatment. On July 26<sup>th</sup>, we organized a roundtable with the European Union representative and the vice-ministers of probation and health.

Since 2013, the new government has launched a program for HCV treatment in prisons. 10,000 treatments (pegylated interferon, ribavirin) are now accessible for around €3,500 per treatment (48 weeks). But this is still too steep a price for a large part of the population. In March of 2014, for financial reasons, only 700 applications were sent.

In 2015, MdM is looking to set up a treatment program for hepatitis C. Since 2012, the actions of MdM in Georgia have ensured the growth and visibility of harm reduction efforts at the national level. New Vector has become a major, visible, and recognized actor of harm reduction through activism and advocacy efforts. The drop-in center is now central to harm reduction efforts in this country.

We will have to continue to fight for access to treatment, which, despite rising awareness, is not always effective in Georgia because of financial limitations.



# Supervised injections: challenging the principle of non-judgment

**Marie Jauffret-Roustide** / Researchers at Cermes 3 (Inserm U988/CNRS UMR 8211/EHESS/Université Paris Descartes)

**Marie Debrus, Yaelle Dauriol** / Harm reduction advisors at Médecins du Monde

**Aude Wyart** / Researchers at Cermes 3 (Inserm U988/CNRS UMR 8211/EHESS/Université Paris Descartes)

*The ERLI program, which started as a rogue harm reduction project in large social events, has turned into a long-term program to assist people who inject drugs while they inject. This new type of intervention questions the very relationship between harm reduction professionals and people who inject drugs.*

Médecins du Monde's ERLI program ("Education to Injection-Related Risks") makes quite a daring proposition: to address the risks involved in injecting drug use during the injections. ERLI offers educational sessions led by teams of two harm reduction facilitators. During these sessions, the user prepares and injects his or her substance. Together, the user and the facilitators can discuss infection and overdose risks and work to preserve the user's venous system.

The ERLI approach is rooted in early experiments of injection assistance during large social events in the early 2000s. In the beginning, a few harm reduction workers from various associations spontaneously took the radical initiative to assist and educate people as they inject. The actions of these pioneers ended up convincing their peers; especially those of Médecins du Monde's "Mission Rave" (which plans health and safety interventions in large social or entertainment events). Mission Rave

decided to structure these covert interventions by clarifying their framework and mode of operation.

This was the beginning of the ERLI program, which continued until 2016. When the

program ended, a report of best practices was created for those who might seek to develop similar types of interventions.<sup>1</sup>

Today, various addiction centers (CAARUD) continue to offer live injection assistance services. The AIDES association offers harm reduction staff training in AERLI — AIDES added an A to their training program to signify "accompaniment," stressing AERLI's community aspect and departing from Médecins du Monde's approach, which always required that a harm reduction professional be present at injection sessions. ERLI emerged in an ambiguous context, since new healthcare reforms allow for different interpretations: according to some associations, the law now authorizes injection education sessions, while a more conservative reading only allows for training on simulation mannequins' arms.

In this article, we will describe Médecins du Monde's ERLI experiments and the way they contributed to the field of harm reduction. We will also discuss the difficulties they met when implementing the program, as these might come up when trying to develop similar approaches.

<sup>1</sup> Cheyron, "ERLI: Les veines du savoir. Capitalisation du programme ERLI (éducation aux risques liés à l'injection)", 2016; Cheyron, "Référentiel pour les dispositifs d'éducation aux risques liés à l'injection", 2016.



## New relationships, new conversations

ERLI gives professionals a brand new role by making them direct witnesses of injection practices. The presence of substances in this kind of approach can be seen as a benefit, because the substance no longer has to be imagined. This new proximity deeply transforms the relationship between users and harm reduction professionals. The opportunity to watch injection practices from up close allows professionals and users to work together to design a set of harm reduction strategies that are most adapted to the user's needs.

During injection sessions, the relationship between harm reduction workers and the person who injects drugs (PWID) is unique, and contradicts the usual roles these stakeholders have in situations of counseling. The face-to-face leads each party to deconstruct his or her own knowledge base. Harm reduction professionals may struggle to see their skills challenged when these skills have been acquired through lengthy training and experience. Likewise, it is not obvious for the PWID to reveal their own difficulties and acknowledge their limitations. Harm reduction workers cannot identify these obstacles beforehand without making the relationship between facilitator and PWID asymmetric, which would damage the exchange. A session in which workers witness a user "butchering" themselves without managing to inject their substance is delicate for everyone involved: the user will struggle to keep face while facilitators will have a hard time intervening and acknowledging their own limitations. During injection sessions, PWID will be unable to conceal their practices, which can disturb both the user and the professionals. The principle of absence of judgment, which supposedly determines the professional stance of harm reduction workers, is often challenged — especially when workers witness practices considered risky or extreme. They can struggle to accept or tolerate this kind of relationship to one's body and to health risks.

Beyond injection techniques, ERLI sessions present an opportunity to listen attentively and learn about users' needs. When they agree to being watched by facilitators, users reveal an intimate and private routine. In the wake of this act of trust, they will often open up and make important requests related to their needs. Facilitators do not always know how to respond to these demands in the context of sessions that focus on injection technique.

## Adapting approaches to users and professionals alike

As ERLI has shifted from social events to urban contexts, we have had to adapt our approaches and assist our teams in the transition. ERLI is not a set of rules that one

can simply apply as is. Setting up assisted injection sessions calls for advance definition of guidelines and modes of operation. This preliminary work must take into account the specific characteristic of the program's target population, but also of the involved professionals. Working to incorporate workers' apprehensions, reluctance, and personal limitations allows us to set up a system that works for them and that they will be better able to operate.

Indeed, witnessing an injection is quite an unfamiliar experience, and harm reduction workers are not always prepared for it. Intervening during an injection session creates a unique proximity with the substances injected. Users' pursuit of particular sensations and pleasures, and their relationship to their body and to the risks they incur, can destabilize facilitators. That is why it is fundamental to adapt the program's mode of operation to the context, and to involve harm reduction workers in this effort by allowing them to express their own fears and limitations.

Beyond the public health and technical issues of injection, defining and questioning ERLI's approach challenges our teams' practices. ERLI can create tensions that destabilize the global framework of all harm reduction practices. ERLI questions harm reduction staff's capacity to define a collective behavioral standard that all harm reduction workers can adhere to when interacting with users, but also with professionals. This implies that the team will remain united and coherent in their decision-making process.

## Creating meaningful guidelines

Defining guidelines for our practices is not only preliminary work — it is a dynamic process that constantly undergoes transformation. For some users, the main value of the ERLI program is that it provides a calm, safe, and clean environment for injection. This primary motivation does not prevent users from later engaging in educational interactions. ERLI also makes it possible to gather information on practices that professionals do not fully understand or accept, such as methadone injection. Observing these practices forces professionals to adapt their predefined frame of reference, as users' actual practices come to shake up that frame.

It is also necessary to create a space for negotiation, so that workers can tell a PWID that they cannot inject this time around, considering that they are on the verge of becoming unconscious or visibly intoxicated with alcohol, all the while asking what they think and allowing them to express their opinions. Harm reduction professionals have a duty to remind PWIDs of ERLI's guidelines, and to

explain the rationale behind these principles. Justifying guidelines takes time and resources, but it is necessary if we want PWID to eventually accept them. Above all, the guidelines must make sense: we cannot hide behind our self-made regulations. Sometimes, we have to question our own rules if our experience shows that they are not the best adapted. We must also listen to our visitors when they question these rules.

Sometimes, harm reduction workers themselves can break the rules. For example, when users become frustrated with their own inability to inject after numerous attempts, workers can be tempted to directly perform the injection on the user to alleviate their own discomfort. When responding to users' sense of emergency, workers have to remind themselves of ERLI's ultimate aspirations in order to remain steadfast and to question their own practices without losing sight of our goal to assist PWID towards autonomy.

**Réduction  
des risques  
Schadens-  
minimierung  
Harm reduction  
Schadebeperking  
Riduzione dei  
danni Reducción  
del daño Redução  
de danos**

# In Germany, a new ordinance opens up opioid substitution treatments

Virgil Blanc, based on a presentation by **Kenan Maric-Horstmeyer, MD** at the European Conference on Addictive Behaviours and Dependences, October 2017

*In an effort to widen access to substitution, Germany has passed a new ordinance that affects the very definition of substitution — and therefore redefines who has the right to provide it, for how long, in what form, in what places, for what purposes, and much more.*

## The legal basis of substitution in Germany

The regulatory approach to the legal treatment of opioid dependence is mainly based on the provisions contained in the German Narcotic Drugs Act. This legislation came into effect in 1992 and allowed the first legal substitution treatment for people who depend on opioids under section 13, subsection 3. In the same year, the Fourth Narcotic Drugs Prescription Ordinance (*Betäubungsmittelverschreibungsverordnung, BtMVV*) put detailed rules in place for the management of opioid dependence with physician-prescribed substitution medication.

Thus, the principle of “assisting instead of punishing” people who use or depend on drugs, now so central to German public health approaches to drug use, was established twenty-five years ago. For the past 25 years, OST has been legal in Germany.

Since 2002, substitution is generally paid for by the mandatory health insurance or, if necessary, by the social welfare system. This means that people who are dependent on heroin have free access to treatment, with no additional expense on their part.

In 2009, legalized substitution was extended to Diamorphine-assisted treatment of people who depend on drugs. With 77,500 patients (of an estimated 150,000 to 200,000 people who depend on opioids) receiving opioid substitution treatment, this regime has proven to be quite successful.

## Recent transformations

After 25 years of existence, however, it was felt in medical and political circles that the system should be updated. A directive issued by the German Medical Association would now manage medical-therapeutic aspects originally regulated by the BtMVV.

The legal definition of opioid substitution needed to be updated to reflect a transition away from abstinence. Abstinence became an overall idealistic goal to be achieved through motivational interviewing rather than a condition of success. New priorities included: ensuring survival, improving and stabilizing health conditions, abstaining from illegally acquired or obtained opioids, providing support in the treatment of addiction-related



## Germany: introduction dates

Methodone	1992
Buprenorphine	2000
Buprenorphine + naloxone	N/A
Heroin-assisted treatment	2003
OST in prison	1992

Source: EMCDDA, Statistical Bulletin, 2018, [www.emcdda.europa.eu/data/stats2018/hsr](http://www.emcdda.europa.eu/data/stats2018/hsr)

diseases, and reducing pregnancy- and birth-related risks. The new ordinance follows the prescriptions by the most recent evidence-based research.

The legal context under which general practitioners could provide substitution needed to be updated as well. Physicians who have qualifications in drug use disorders (and who are approved by medical associations of the Länder) can provide substitution treatment. Identifications of the physician and patient involved are encrypted onto the substitution registry to prevent multiple substitutions. In the event that a physician lacks the necessary qualifications, the patient will receive counselling by a qualified physician on a trimonthly basis. A nonspecialist physician can have a maximum of 10 OST patients at a time, and cannot prescribe diamorphine-assisted treatment. With this new framework, we aimed to expand OST to Germany's rural region with the assistance of general practitioners.

The legal rules for patients taking home substitution medication had to be modified. Patients can now take home their substitution prescription according to a three-tiered scheme: if a patient matches certain conditions defined by the GMA, including concomitant use of psychotropic drugs, they will receive a supervised OST prescription (S-prescription). This is the basic principle. Some patients under the basic principle can be exempted if they seem suitable candidates in the short term for self-administered treatment. In cases where treatment might otherwise be interrupted (weekends, vacations), patients could be allowed to take home medication supplies for up to five days (Z-prescription).

Some patients can self-administer take-home doses for up to seven days (T-prescription) based on patient stability (as defined by the GMA directive). A new regulation states that patients can also self-administer take home doses for up to 30 days according to treatment progress and extraordinary social and medical circumstances. Such extraordinary circumstances can include distant place of work, participation in social life, medical rea-

sons, and others. This last type of prescription has further prerequisites: patients must be in a stable condition and must not present a risk profile for narcotics consumption, diversion, or endangerment of others (e. g. children).

Opioid substitution treatment and administration will be available from a wider range of institutions and persons. Previous rules stated that substitution medication had to be ingested under the supervision of the physician or his/her medical substitute at the doctor's office. The physician could also delegate this responsibility to medical staff at the doctor's office or medical or pharmaceutical staff of a hospital or pharmacy or staff specially trained for this task in state-approved facilities for the treatment of people who are dependent on drugs (§ 35 BtMG).

New rules state that in addition to these persons, nursing staff of hospitals, pharmacies, rehab hospitals, public health departments, homes for the elderly, nursing homes, or any other facility authorised by a state authority; or staff of nursing services for outpatients carrying out home visits can now provide substitution treatments. This change was specifically intended to respond to changing demographic trends in people who depend on opioids.

Diamorphine-assisted treatment will be allowed for any relevant use. The main relevant novelty is that diamorphine treatment is now authorized in all forms available for other substitutive treatments rather than restricted to intravenous use. This was designed specifically to assist very sick patients with disastrous venous conditions. This only concerns a small group of patients (0.5% of OST).

## Expected results

Legal Opioid Substitution Therapy is now based on three complementary pillars. The first is federal law, which defines the legal framework of oral substitution therapy. The second is the German Medical Association (GMA)'s guidelines, which regulate the medicinal-therapeutic aspects of the most recent ordinance, and have increased the therapeutic responsibility of physicians specialized in opioid substitution treatment (and thereby removed medicinal-therapeutic aspects of OST from the purview of directly enforceable criminal law). The third is mandatory health insurance (or social welfare), which reimburses all substitution treatment.

As a result, substitution treatment management now more closely resembles "conventional" narcotic prescription. We hope that these revisions will increase the number of physicians qualified to manage substitution treatment. We hope to meet requirements imposed by future demographic challenges, to strengthen the application of harm reduction, and thereby to improve the situation of OST patients overall and particularly in rural regions.

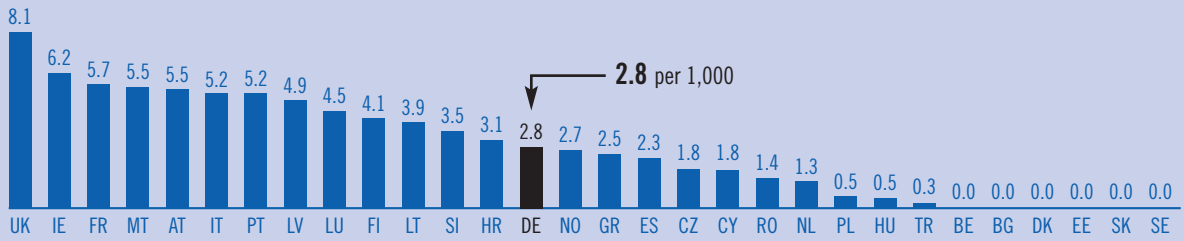


### Germany at a glance

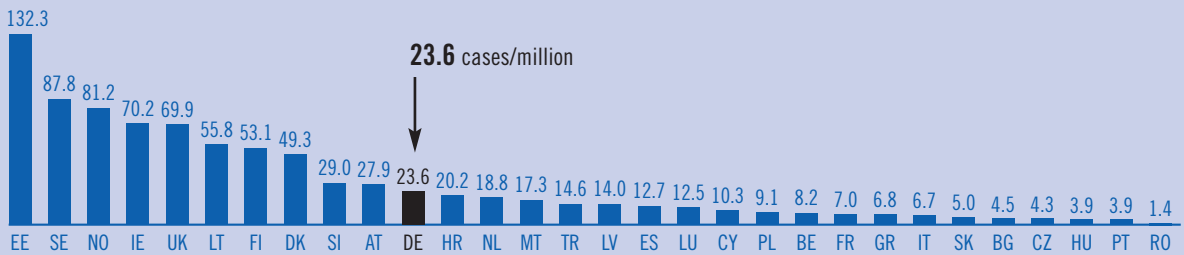
**150,943** (138,005 – 163,881) **High-risk opioid users**

**78,500** **Opioid substitution treatment clients**

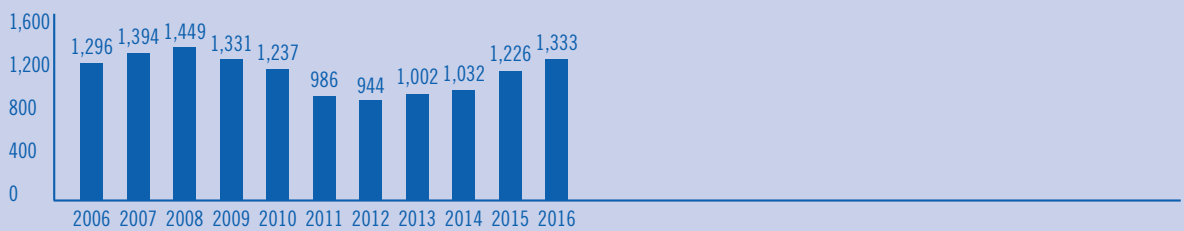
#### Opioids / High-risk opioid use (rate/1,000)



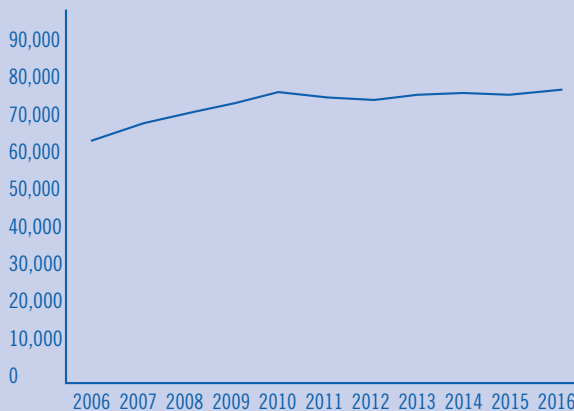
#### Drug-induced mortality rates / National estimates among adults (15–64)



#### Trends in the number of drug-related deaths

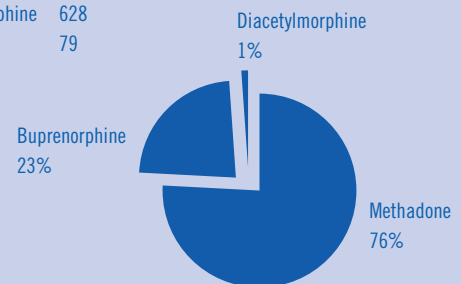


#### Trends in the number of clients in OST



#### Which substitution?

Methadone	59,267
Buprenorphine	18,133
SROM	236
DHC	157
Diacetylmorphine	628
Other	79



Source: adapted from EMCDDA, Country Drug Report, 2018, [www.emcdda.europa.eu/edr2018](http://www.emcdda.europa.eu/edr2018)



# Syringe vending machines in North Rhine-Westphalia

**Daniel Deimel** / Professor at the Catholic University of Applied Sciences, Northrhine-Westphalia, Germany;  
German Institute on Addiction Prevention and Treatment (DISuP)

*People who inject drugs are some of the most vulnerable to HIV and HCV. An automatic syringe vending machine program in Germany has attempted to remedy this situation since 1989.*

In this article, we will describe the syringe vending machine program implemented in North Rhine-Westphalia (NRW), Germany's most populated state. We will also present factors for successful practice for this program. Out of the 170 automatic drug distributors that can be found in Germany's public spaces, 110 are in the NRW region.

## Risks for people who inject drugs

When the AIDS epidemic spread in the 1980s, there was a paradigm shift in the treatment of intravenous drug consumption in Germany: drug abstinence, which had been the main therapeutic aim, was complemented with harm reduction measures. Alongside traditional treatments based on cessation and abstinence, syringe distribution programs, substitution treatments for people who depend on opioids, low-threshold drug consumption and consultation rooms, psychosocial resources and street outreach all became a part of drug healthcare in Germany (Deimel, 2013; Michels & Stöver, 2012; Stöver et al., 2017).

The efficiency of harm reduction programs is now considered empirically proven. People who inject drugs (PWID) are one of the groups most exposed to HIV and HCV in Germany (RKI, 2015, 2016a & 2016b). This was proven by the results of the DRUCK study at the Robert Koch Institute (RKI 2016a):

- Up to 55% of injecting participants were affected by HCV, an infectious and transmissible virus that requires treatment.
  - Five to 22% of participants claimed that they had shared syringes or needles with other users when they consumed drugs in the last month.
  - Between 32% and 44% of injecting drug users claimed that they shared other consumption equipment such as water, filters, and small pots.
  - Between 36% and 48% of injecting drug users engaged in at least one “unsafe practice” in the last month.
  - There is a lack of awareness specifically concerning risks of HIV infection in groups of PWID. Risks of HIV infection through sniffing or water sharing practices are also not well understood among participants.
- Current data indicates that improving access to harm reduction resources and circulating harm reduction strategies are still fundamental objectives for drug addiction healthcare. Automatic distribution programs are implemented with this aim.

## The syringe distributor program

The automatic syringe vending machine program has existed in the NRW region since 1989 (Meyer & Schmidt, 2011). For now, there are 110 vending machines available in public spaces. These are managed by 61 local

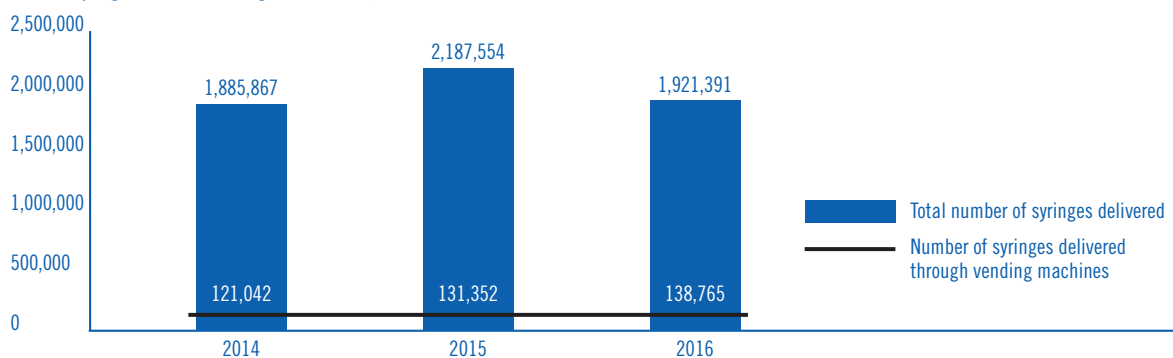


Two automatic syringe distributors in NRW

**Figure 1. Needles and syringes delivered to drug users in NRW, Germany.**

Data from Aidshilfe NRW, 2017.

Needles/syringes delivered to drug users in NRW, 2014-2016



associations. Every year, around 130,000 syringes are made available to injecting drug users. This represents 7% of the total number of syringes used by injecting drug users (see figure 1).

The program exists on three levels: the health department for the NRW region is the political decision maker, and enables funding for the coordination of the program and the purchase of new machines. The NGO Aidshilfe NRW coordinates the program. They assist local actors in requesting and maintaining vending machines, organize the dispatch of harm reduction supplies to local associations, and coordinate maintenance of the machines. At the local level, associations against drug addiction and HIV manage the distributors. They file for a placement permit and organize the machine's supplies in harm reduction equipment. They also manage the disposal of used syringes collected in the distributors.

Alongside syringes of all sizes, the vending machines offer care kits (care packs), sterile paper for smoking drugs (smoke it packs), sterile spoons, condoms and lubricant in boxes of various sizes. The price for a box is €0.50. Currently, two types of distributors are in circulation. The machines are used cigarette distributors refurbished for this purpose. They are also collection sites where users can safely dispose of used syringes and needles. The price of a machine is around €850.

### Best practices and some issues

The vending machines in the NRW region are a good example of successful cooperation between elected officials, NGOs, and local associations fighting addiction and AIDS. The vending machines present in public spaces are a good addition to already existing drop-off sites for harm reduction supplies. Thanks to this program, PWID have uninterrupted access to supplies of syringes and needles.

Anonymous use of the machines can also attract users who do not use existing care services. In some areas of NRW, particularly in rural areas, distributors are the only source of sterile equipment for drug consumption. Vending machines can also be used as a medium of communication by supplying information material for harm reduction practices.

We have to try to offer equipment that caters to more varied drug uses, such as equipment for nasal consumption or chemsex paquets (kits designed specifically for the practice of sex under the influence of drugs) for men who have sex with men, so as to attract a wider group of users.

We are experiencing frequent vandalism on the machines, which therefore require constant upkeep. This complicates the work of local institutions. What's more, the distributors' managers are reporting that users rarely take advantage of the distributors' syringe drop-off function. To this date, despite the program's growth, we have not been able to fully cover the region with 24/7 access to harm reduction equipment. Besides, injecting users in prison settings have no access to sterile consumption equipment. Therefore, developing the program further remains necessary.

## GERMANY



# Prison-based needle exchange: a lingering controversy

**Heino Stöver** / Professor of Social Scientific Addiction Research at the Frankfurt University of Applied Sciences

*Without harm reduction interventions, people in prisons have little choice but to share and re-use injection supplies. Syringe exchange programs are an effective solution to this problem, but they are expanding too slowly.*

No prison system has yet succeeded in remaining drug-free. In German prisons, 30-40% of inmates are drug users, and a significant proportion continues to inject drugs during their incarceration (Stöver, 2012). Although injecting in prisons may be less frequent, in most situations prisoners have to use and share unsterile injecting equipment (Stöver, 2016). Incarceration is therefore associated with various risk factors and forms of risky behavior. These are primarily related to injecting drug use, unsafe needle-use practices (like injecting, tattooing, and piercing), and unprotected sexual contact.

## HIV and HCV in prisons

In most countries, the spread of HIV and hepatitis C virus (HCV) in prisons is clearly driven by injecting drug use. Many people in prisons remain unaware of their HIV status. In many prisons worldwide, HIV testing is offered to prisoners immediately after admission. Pre- and post-test counseling is not available everywhere.

For the most part, specialized centers operating outside the medical units of prisons provide diagnosis and treatment by antiretroviral therapy (ART) for HIV-positive patients. Most prisons worldwide allow for the continuation of ART. However, the modalities of treatment and the

support offered to help patients stay on treatment vary considerably. After release, a substantial number of ex-prisoners drop ART for various reasons, such as inadequate health insurance, lack of personal financial resources, homelessness, or relapse.

Although many studies have confirmed that prison settings encourage inmates to maintain or pick up risky behavior, little progress has been made to implement effective and efficient prophylaxis against infection through prison-based needle and syringe programs or targeted communication (Stöver & Hariga, 2016). The question is: why are effective and proven prevention models applied in local communities but only very rarely implemented in prison settings?

## Communicating is not enough

Worldwide, only approximately 60 out of more than 10,000 prisons provide needle exchange programs. Thus, HIV and HCV prevention is almost exclusively limited to verbal advice, leaflets, and other measures directed at cognitive behavioral change (Arain, Robaey, & Stöver, 2014).

Raising awareness through information, education and communication programs (IEC) about HIV, sexually trans-



mitted infections (STIs), viral hepatitis and tuberculosis is a necessity in all closed settings. However, IEC strategies are only one of 15 possible types of intervention within a comprehensive package suggested by the United Nations Office on Drugs & Crime (UNODC), the United Nations Development Program (UNDP), the International Labour Organization, the WHO, and the UNAIDS (2013) to combat the spread of HIV and other infectious diseases. As standalone IEC measures continue to fall short, other types of intervention should come to complement them. The UNODC has published and updated a handbook on the implementation of prison-based needle exchange programs to better inform and guide officials in the Ministries of Justice and Health and prison healthcare staff. The handbook integrates the views and experiences of many experts throughout the world (UNODC, 2016).

### Needle exchange in prison

Prison needle exchange programs have been successfully implemented in both men's and women's prisons in Germany. They now exist in institutions of various sizes; in both civilian and military systems; in individual-cell prisons and in barrack-style prisons; in institutions with different security levels; and in different forms of custody (remand and sentenced, open and closed).

Needle exchange typically started out as pilot programs, and later expanded based on information acquired during the pilot phase. Several different methods of syringe distribution are employed, based on the specific needs and the environment of the given institution. These methods include automatic dispensing machines; hand distribution by prison physicians and healthcare staff or by external community health workers; and programs involving inmates previously trained as peer outreach workers (Lines et al., 2006).

The results of a meta-analysis of 11 prisons scientifically evaluated to assess feasibility and efficacy did not support fears that commonly arise at the implementation of prison-based needle and syringe programs (PNSP; Stöver & Nelles, 2003). There is no increase in drug use or injecting drug use following the implementation of exchange programs. Inmates do not misuse syringes or make syringe disposal challenging. The exchange program lowered instances of syringe sharing among inmates who inject drugs.

The authors concluded that in these settings, harm reduction measures, including syringe exchange, were not only feasible but effective in prison settings (Stöver & Nelles, 2003). One important lesson learned from this meta-analysis is that PNSPs are part of a broader health approach and should therefore be embedded in a global,

comprehensive, prison-based drug and health-promotion strategy. Looking at PNSPs in an integrated way was part of the success of PNSPs in penal institutions.

Evidence from countries where prison needle-exchange programs exist clearly demonstrates that:

- PNSPs are feasible and affordable in a wide range of prison settings.
  - PNSPs have been effective in decreasing syringe sharing among injecting drug users in prison, thereby reducing the risk of disease transmission (HIV, HCV) among both prisoners and prison staff.
  - PNSPs encourage prisoners to readily accept and use sterile syringes provided through PNSPs, as has been found in previous studies.
  - PNSPs have not been associated with increased attacks on prison staff or other prisoners.
  - PNSPs have not led to an increase in new drug consumption or injection.
  - PNSPs contribute to workplace safety. When prisoners are not forced to conceal injection equipment, guards conducting searches of prisoners or cells are less likely to be stung by a contaminated needle.
  - PNSPs can lead to lower overdose risks and a decrease in abscesses. They also facilitate referral to drug dependence treatment programs (where available).
  - PNSPs can successfully employ any of several methods for needle distribution based on staff and inmate needs.
  - PNSPs can successfully coexist with other drug prevention and treatment programs (Lines et al., 2006).
- For PNSPs to be successful in prisons, prisoners need to have easy, confidential access to syringes and equipment. Both prisoners and staff should be involved in the design and implementation of the program. Successful PNSPs also feature a rigorous procedure for safe disposal of syringes as well as evaluation and quality control.

### Obstacles for expansion

A key issue, beside political barriers in implementing and legitimizing PNSPs, is that they do not guarantee confidentiality for prisoners. This hinders prisoners from participating in the programs.

A second issue is that HIV and opioid consumption are no longer the center of debates around drugs and infectious diseases in prisons. Instead, new psychoactive substances (NPS) and steroids have become a priority. In many countries, the HIV rate among prisoners who use drugs is lower compared to 20 years ago (for example, in Western Europe). While hepatitis C is by far the most prevalent infectious disease, policy-makers have neglected its impact. It has been difficult to develop momentum to legitimize concerted action against the

spread of infectious diseases (Arain, Robaeys, & Stöver 2016). However, in Germany, social workers, along with user groups, medical doctors and lawyers, have managed to put together a nationwide handbook to tackling threats of HCV in closed settings. This initiative received funds from the Federal Ministry of Health (Aktionsbündnis Hepatitis und Drogengebrauch, 2013).

In Germany, activists and social workers working inside and outside prisons have now made a number of concerted attempts to introduce prison-based needle and syringe exchange programs. However, for political reasons, six out of seven prisons shut down their needle and syringe programs and only one out of more than 180 custodial institutions in Germany provides needles and syringes via dispensing machines to female prisoners (at the women's prison in Berlin Lichtenberg). This model has been running for approximately 20 years without any problems (Stöver & Knorr, 2014). However, the discrepancy around the success of PNSPs in prisons on the one hand, and their low acceptance and adoption, on the other hand, is striking.

Activists and social workers are completely dependent on the decisions and goodwill of the 16 different state departments of justice in Germany (prisons are entirely the responsibility of the *Länder*). Apart from throwing needles and syringes over the prison wall as a mode of public action, they are not in a practical position to start a PNSP, as was successfully done in the community!



# The British government's dwindling support

Virgil Blanc speaking with

**Alex Stevens** / Member of the UK Advisory Council on the Misuse of Drugs and professor in Criminal Justice at the University of Kent

*The UK features a long history of substitution dating back to 1926. Today, a government that does not believe in substitution or harm reduction threatens this tradition and prevents it from expanding.*

## The “British System”

The UK has a very long tradition of providing substitution treatment for people who are dependent on opioids, dating back to 1926, when it was decided that people who are dependent on opioids should be provided heroin. This view of people who use drugs as patients was known as the “British System,” and it lasted until the 1960s.

The “British System” was challenged on the basis that there were a few doctors providing far too much heroin, which then leaked into the illicit market. Since that time, substitution treatment in the UK has largely involved methadone — at first provided through NHS clinics (National Health Service, the UK’s national healthcare system) and then more recently through charitable treatment providers.

A lot of the treatment is now provided by large charities like Addaction, CGL, and Turning Point. Opioid substitution treatment, and specifically the provision of methadone to people who have problems with heroin dependence, is a very well established part of the British system.

In the ‘60s, opioid dependence was a relatively small problem involving a few hundred people, most of whom were being prescribed heroin. Since then, the scale of the problem has massively expanded. We have 300,000 people experiencing problems with heroin and crack. Most of

those receiving treatment are receiving methadone substitution treatment.

Buprenorphine is also used by some clinics. The clinical guidelines (known as the “Orange Book”) advise the use of buprenorphine as a frontline treatment for heroin dependence. Methadone remains the main product, however, as doctors are more familiar with it and it is cheaper.

The expansion of methadone in the ‘80s and ‘90s was a response to the HIV crisis. In 1988, the Advisory Council on the Misuse of Drugs advised that it was more important to prevent the spread of HIV than it was to get people off drugs. Harm reduction became the official policy of the British government. This led to the emergence of a whole range of policies that have been in place since then, which include substitution treatment, but also a network of needle exchange services (either in pharmacies or in specialized treatment services). Drug treatment services are now routinely testing and vaccinating hepatitis B and hepatitis C.

## Shared care and supervised consumption

Traditionally, we function with a clinic model, which has developed since the ‘60s. People who have dependence problems would be referred to a drug treatment unit or a



drug treatment service, which all used to be part of the NHS. As the years have gone by, more and more treatments have been provided by charities.

Normally, people are first referred to a specialist treatment service and start their prescription under supervision of that service. Once they become stable, they can be referred to shared care (arrangements made largely in the British healthcare system, in which patients take responsibility for part of their own treatment). In the context of shared care, general practitioners largely oversee treatment and prescriptions.

Since the late '90s and early 2000s, more charities became involved in the delivery of drug services, including prescribing services. These large charities would employ their own doctors, who could prescribe methadone or other substitution treatments. This happened when funding shifted from a top-down, centralized system in the NHS to a system where local counsels buy services for their local communities. Quite often they will buy those from charities rather than from the NHS.

Many regular community pharmacies have contracts to fill methadone and buprenorphine prescriptions. In the last few years, there have been spreading practices of supervised consumption, based on concerns about diversion of methadone from pharmacies. Especially in the early days of their prescriptions, people are increasingly expected to consume their methadone under the supervision of a pharmacist. Though this is not a legal requirement, it is a spreading clinical practice.

The clinical guidelines state that optimal treatment duration should be established between doctors and their patients. The government asked a group of experts to look into the possibility of time limiting the substitution treatments, but it was decided that this would be a dangerous and counter-productive measure, because it would push people off methadone and buprenorphine treatment before they are ready to do so. Given that there is a much higher death rate and indeed HIV incidence rate outside treatment than in, this practice would lead to a much higher level of risk. There is no formal limit, and indeed the guidelines state that in some cases OSTs may be "lifelong" and that such situations do not represent "failures of treatment."<sup>1</sup> Patients often want to stop using, and their clinical team and their doctor will help them do that if it is their decision.

The way that treatment contracts have been constructed since 2010 has focused on "treatment completion", and this has sometimes put pressure on people to finish their treatment early, before they are ready to do so. Nevertheless, this is a spreading practice.

<sup>1</sup> "Drug Misuse and Dependence: UK guidelines on clinical management". UK Department of Health, 2017.

<sup>2</sup> Farrell, M and Marsden, J. "Drug related mortality among newly released offenders 1998 to 2000" in the Home Office Online Report 40/05.

## The prison system

In 2008, the government introduced the "integrated drug treatment system" (IDTS). The IDTS was based on research showing that people leaving prison with heroin problems without receiving substitution treatment have very high mortality rates, especially in the first two weeks.<sup>2</sup>

The integrated drug treatment system was established in order that methadone treatment that was equivalent to that available in the community should be provided in prisons. This system was expanded over the next few years, and research has come out showing that it is successful in reducing deaths among people living in prison. People can continue their prescription in prison; sometimes, people start their prescription in prison. In some prisons, the practice is to help people reduce off methadone if they are going to be in prison for more than six months.

In some cases people are "retoxified" before they leave if they are considered to be at high risk of relapse. In that case, they will be put back on a methadone prescription before they leave and then they will be referred straight to a methadone program once they rejoin the community.

## Failing government support

In a report called "Reducing Opioid Related Deaths in the UK," we expressed our concern that the government is cutting funding for substitution treatments. This will heighten the risk of people dying, given the evidence that substitution treatment is highly protective against drug-related deaths.

There is some evidence that waiting times to enter substitution treatment have increased, but there is even more evidence that the quality of service people receive when they are in treatment has reduced. There is less group work and less support for recovery. Health staff have to cut back to just the minimum of filling a prescription.

There are also some concerns nationally that while some people have been on methadone for years, there are also a lot of people who are not on methadone long enough. They come into treatment and leave quite quickly. Cycling in and out of methadone treatment is a dangerous pattern of treatment. We should be aiming to retain people longer in methadone treatment.

There are also concerns about sub-optimal dosing. The recommended range of methadone prescription is 60-120mg/day, but lots of people are prescribed less than that, and there is evidence to suggest that this leads to a greater likelihood of using heroin on top of the prescription. This obviously still exposes people to the risks of illicit heroin use in the illegal market.

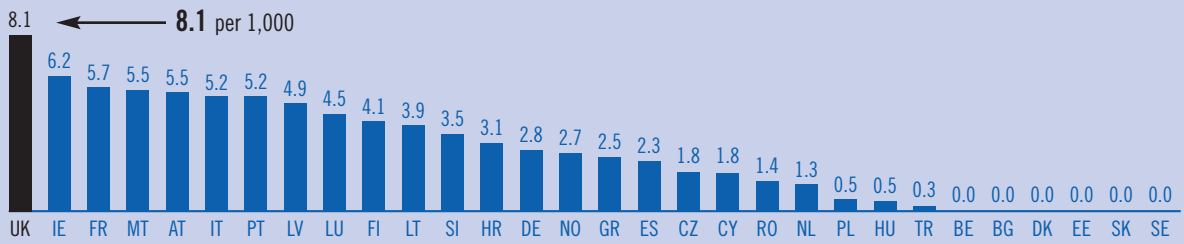


### UK at a glance

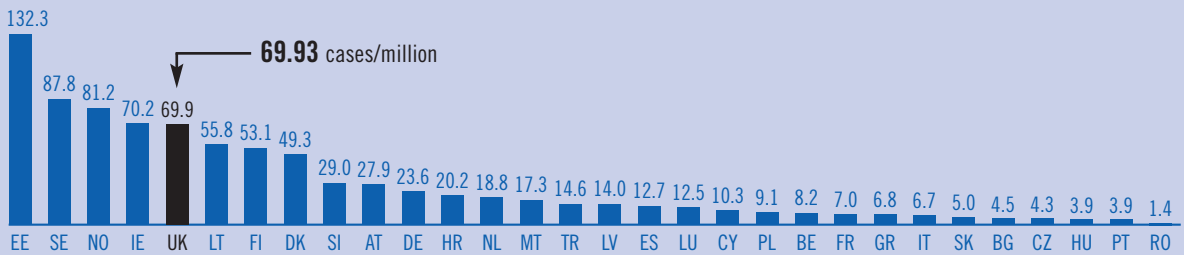
**330,445** (324,048 – 342,569) **High-risk opioid users**

**138,422** **Opioid substitution treatment clients**

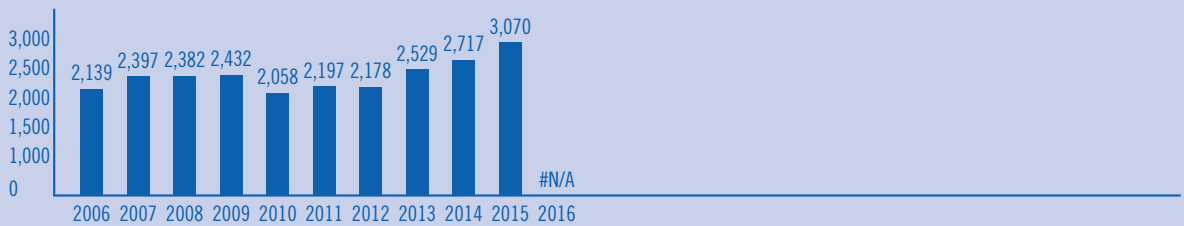
#### Opioids / High-risk opioid use (rate/1,000)



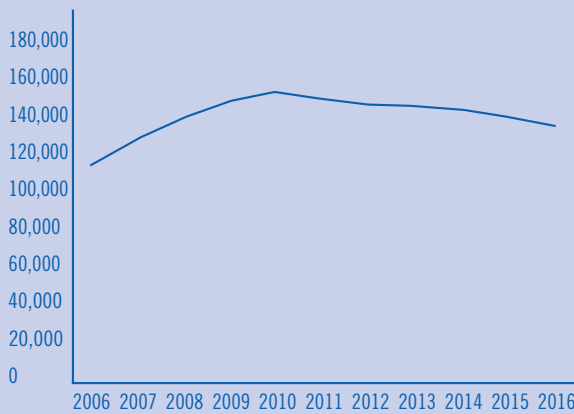
#### Drug-induced mortality rates / National estimates among adults (15–64)



#### Trends in the number of drug-related deaths

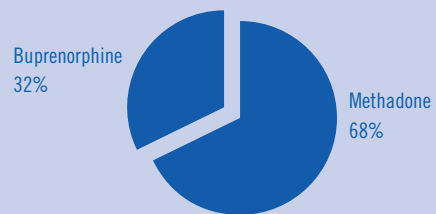


#### Trends in the number of clients in OST



#### Which substitution?

Methadone 1,164  
Buprenorphine 557



Source: adapted from EMCDDA, Country Drug Report, 2018, [www.emcdda.europa.eu/edr2018](http://www.emcdda.europa.eu/edr2018)

## UK: introduction dates

Methadone	1968
Buprenorphine	1999
Buprenorphine + naloxone	2006
Heroin-assisted treatment	1920s
OST in prison	2006

Source: EMCDDA, Statistical Bulletin, 2018, [www.emcdda.europa.eu/data/stats2018/hsr](http://www.emcdda.europa.eu/data/stats2018/hsr)

There are still a few doctors licensed to prescribe diamorphine heroin to patients. Between the late 2000s and 2015, there were also three clinics providing heroin-assisted treatment, which was developed in Switzerland. People who have not been able to stabilize their heroin use with methadone or buprenorphine and therefore still make risky use of street heroin attend a clinic, which provides heroin to be injected on site. Although the legal framework exists for these practices, these clinics closed down in 2015 because the government withdrew funding and local funders did not replace that funding. A few people are still prescribed diamorphine by their doctors.

## Political barriers

We have seen a very concerning increase in drug-related death since 2012. The Advisory Council on the Misuse of Drugs produced a report in 2016 on reducing drug related deaths in the UK. However, the government is not doing enough to implement that report.

Our main recommendation is to at least maintain investment in OST, and the government is not doing that. In fact, it is cutting funding for substitution. We also recommended a rapid expansion of naloxone, which is not being delivered enough, especially in England, which has a different health system to Scotland, Northern Ireland, or Wales. Scotland, Northern Ireland and Wales have been quicker in upscaling the delivery of naloxone. Research shows that provision of naloxone is still very patchy and inadequate across England.

We also recommended that the government consider opening medically supervised drug consumption rooms in places where there are high concentrations of injecting drug use. A special concern is Glasgow, where there was both an outbreak of deaths and a very concerning increase in the number of HIV transmissions among injecting drug users since 2012. They have a local plan in place, and a lot of critical backing behind it to open a drug consumption room. They also intended to implement heroin-assisted treatment.

But the government at the national level decided that it would not consent to the opening of a drug consumption room because it considers it to involve committing an illegal act. There is some legal debate on whether we need to change the legal framework. Some lawyers have argued that you could open DCRs under the existing system on the basis of local compacts between drug treatment services, the police, and prosecutors. It would be clearer if we could change the law.

The Scottish parliament last week passed a motion that it wanted the law to be changed and the powers to be devolved to Scotland so that it could change the law to allow the opening of a drug consumption room. But the national UK government has refused to consider changing the law to enable that to happen. The conservative party and their leader Theresa May are morally opposed to liberalization of drug laws in any direction, including the opening of drug consumption rooms.



# From evidence to policy: Scotland's National Naloxone Programme

Andrew McAuley / PhD, Senior Research Fellow, Glasgow Caledonian University

*After five years, Scotland's groundbreaking National Naloxone Programme has achieved its original aims regarding adoption, reach, and impact. Despite this, gaps remain in its ability to achieve optimum effectiveness.*

Opioid overdose is a major cause of premature mortality globally. Scotland has the highest rate of drug-related deaths (DRDs) in the United Kingdom and is amongst the highest in Europe. Between 2006 and 2010, Scotland averaged 500 DRDs per year, nearly 80% of them opioid-related deaths (ORDs), that is: DRDs involving heroin, methadone, or buprenorphine. The supply of naloxone, an opioid antagonist, for peer administration has been promoted as a harm reduction measure to prevent ORDs for over 20 years.

## Implementation

In 2011, Scotland became the first country in the world to implement a centrally funded and coordinated National Naloxone Programme (NNP). Take-home naloxone (THN) is available to any individual at risk of opioid overdose and is supplied following successful completion of a brief 10-15 minute training session incorporating basic life support and naloxone administration. Training and supply of THN to individuals in Scotland takes place in a range of community settings (including pharmacies) and across the entire prison estate.

Between 2011 and 2017, over 35,000 THN kits were issued by the NNP in Scotland. In total, almost 90% of THN kits were distributed to persons at risk of opioid overdose, the remainder

to family/friends and service workers. Supplies of THN kits to those most at risk of opioid-related overdose appear to be increasing over time, with community and prison settings equally efficient at targeting people who inject drugs. Although uptake of the programme has increased overall, some sub-groups appear to have experienced lower rates of access, notably older drug users who are at increased risk of mortality (see figure 1).

## Impact

The evaluation of the NNP has primarily focused on its impact on ORDs following prison release, a known high risk period for DRD. It was designed to have statistical power to discern a reduction in this primary outcome of 30%. Five years after the NNP had been implemented, the percentage of ORDs within four weeks of prison release was substantially lower (5.2%) than in the five-year period prior to its introduction (9.8%). This represented an almost a 50% reduction in ORDs in the four weeks following prison release and provided evidence that Scotland's NNP had achieved its aims as intended.<sup>1</sup> An earlier analysis of this data concluded that the decrease in Scotland's ORDs in the four weeks following prison release could be directly attributed to the NNP itself and that it was a highly cost-effective public health intervention<sup>2</sup> (see figure 2).

<sup>1</sup> Bird S., McAuley A., Munro A., Hutchinson S.J., & Taylor A. (2017). Prison-based prescriptions aid Scotland's National Naloxone Programme. *The Lancet*, Vol. 389 (10073), 1005 – 1006.

<sup>2</sup> Bird S., McAuley A., Perry S., & Hunter S. (2015). Effectiveness of Scotland's National Naloxone Programme for reducing opioid-related deaths: a before (2006-10) versus after (2011-13) comparison. *Addiction*, Vol. 111, 883–891.

In contrast, THN has had no discernible impact on ORDs following hospital discharge, another known high-risk period for DRD. It is unclear whether this is related to factors associated with the setting, the individual, or both. Unlike Scotland's prisons, and despite a communication from Scotland's Chief Medical Officer in January 2011, hospitals were not specifically targeted to prescribe THN to at-risk clients resulting in only limited supplies from this setting across the country.

Less successful has been the roll out of THN supplies in general practice, with few primary care doctors engaging with the programme. In addition, police officers in Scotland do not carry naloxone despite being first responders at many overdose incidents. We hope that availability of a new non-injectable naloxone product in the near future will encourage the police service to adopt naloxone as part of their basic first aid kit.

### Next steps

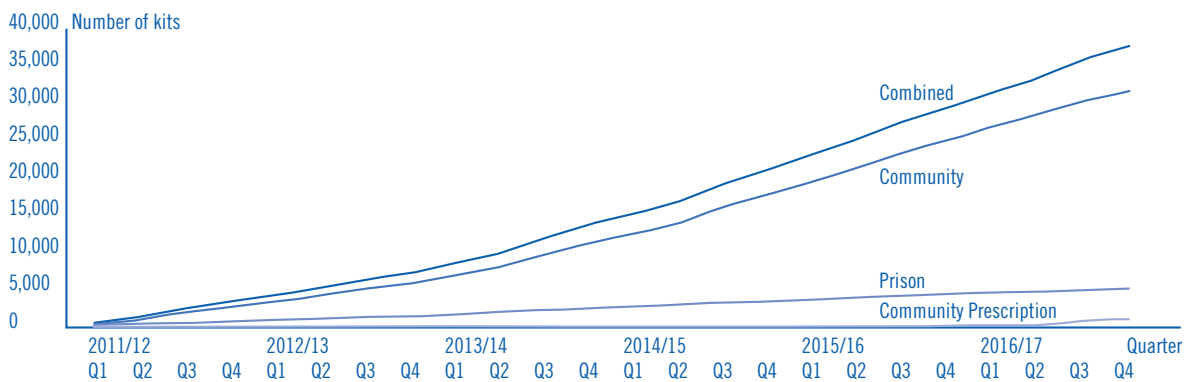
Over time, the NNP in Scotland has developed and is now available in many different community settings including services for those experiencing homelessness and mental health issues. More recently, It has expanded to incorporate peer-to-peer training and supply. Such steps are important in normalizing THN within communities as part of basic first aid.

### Summary

After five years, Scotland's groundbreaking NNP has achieved its original aims regarding adoption, reach, and impact. Despite this, gaps remain in its ability to achieve optimum effectiveness, in particular in the lack of impact on ORDs following hospital discharge and access to naloxone supplies among particular sub-groups, such as older drug users who are amongst the most at-risk of drug-related mortality.

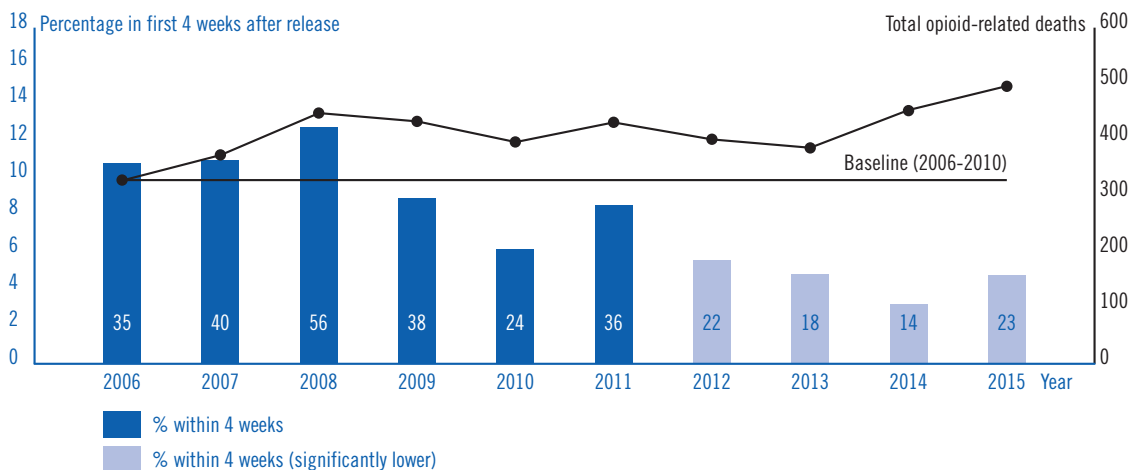
**Figure 1. Cumulative number of THN kits supplied, by source, financial year and quarter (Scotland; 2011/12 to 2016/17)**

Source: NHS National Services Scotland (2017)



**Figure 2. Number of opioid-related deaths and percentage within four weeks of prison release, by calendar year (Scotland; 2006 to 2010 (baseline) & 2011 to 2015)**

Source: NHS National Services Scotland (2016)





# Substitution in the Netherlands: aging patient populations

**John-Peter Kools** / Senior drug policy advisor at the Trimbos Instituut

*The Netherlands has been able to create a highly effective, institutionalized system of opioid substitution treatments since the 1960s. Today, populations of people who use opioids are aging and the country prepares to meet new challenges.*

There is a long tradition of substitution treatment in the Netherlands. Methadone substitution began in the 1960s, initially as a high-threshold, abstinence-oriented, second-choice medical treatment. The system evolved due partly to the HIV crisis, but also to transformations in the program's funding and administration.

Initially, funding for OST came from the federal budget, and substitution treatments were managed nationally. This changed in the 1980s, when there was a drastic change in the regulation. Treatment and funding became decentralized. The modalities of treatment changed as well. The threshold was lowered, which signaled another change in addiction healthcare: abstinence objectives were gradually fading away.

## From abstinence- to stability-oriented

The pressures of the HIV epidemic pushed the government to set new priorities. They needed to reduce the number of people using illegal and unknown street substances. With this aim, the government started promoting addiction treatments so that they could become more easily accessible. Dosages increased. The purpose of substitution programs was no longer for patients to abstain from drug use, but rather to stabilize them so they could function and reintegrate their lives and communities.

Since then, there have been two other major transformations. Options for medication have widened. In 1996, a highly regulated and thoroughly assessed research pilot for heroin-assisted treatment was conducted. After a couple of years, the experiment showed that there were significant individual, social, and health benefits outcomes to this form of treatment. It was also related to reductions in public health and public order issues. Since then, heroin-assisted treatment has become a standard option for patients who experience better outcomes with heroin than with methadone. Of the estimated total of around 14,000 people who are dependent on opioids (2013), 9,700 follow substitution treatments. 750 of these are heroin-assisted treatments.

The second evolution happened in 2011: funding for substitution treatments was merged into regular health insurance. Substitution medication is now covered by basic individual health insurance, which is mandatory for all citizens in the Netherlands.

## Shifting demographics

Although the Netherlands authorized buprenorphine in 1999, in the vast majority of cases, doctors and patients prefer to stick to methadone. For doctors, it might be a pricing concern. But another reason is that there are hardly

any new people using opioids. Over the years, the average age of the patient population for substitutive treatments has gone up by twenty or thirty years and is now around 51. Patients have been receiving their methadone treatments for 20, 30, sometimes 40 years, and they rarely decide to change their drug consumption practices.

There used to be a substantial group of problematic opioid users who used additional stimulants like cocaine. But in the Netherlands, the group of problematic opioid users has decreased significantly and public health and order issues have been somewhat contained. People who currently still use are now starting to live in retirement homes. There is no influx of younger people experimenting with opioids and the Netherlands scores among the lowest prevalence rates in Europe. Opioids are currently out of fashion in the Netherlands.

### Addiction clinics: the Netherlands' methadone providers

Technically, there are two ways to procure methadone. The majority of people who want treatment receive their treatment in specialized addiction treatment clinics. Patients can go to their general practitioner for a prescription, which OST patients rarely do.

These public addiction clinics are organized geographically in the Netherlands. There are seven of them spread across the country. The clinics are huge institutions that often provide comprehensive mental health and addiction services. Treatment of opioid addiction and provision of substitution medication is one branch of their services. Private addiction clinics are also widespread in the Netherlands, but they are more abstinence-oriented and tend to serve other client populations.

Since these clinics have 30 to 40 years of experience, their addiction healthcare delivery system is well developed. They have evolved from emergency clinics to established healthcare centers: they feature electronic dosing systems, and most clinics offer additional medical and harm reduction services in their treatment facilities. Patients can receive regular medical check-ups. They can also get support for infectious diseases monitoring, like HIV checkups and medication, or, more frequently nowadays, hepatitis C screening and referral to hepatitis C treatment. The clinics use an efficient client monitoring system that allows patients to take home methadone dosages for a few days or a week, depending on their condition, but also on their needs and on whether they comply with regulations. The system also applies sanctions in cases where patients do not comply.

Through this system, patients can actually move towards more flexibility in their dosages or, by complying with reg-

ulations, in the requirements they must meet to take their medication home. It has been important to move towards this more flexible model, especially considering that opioid addiction patients are aging patients, and thus experience aging health issues.

OSTs are available in Dutch prisons since the 1980s. Methadone treatment in prisons is the responsibility of the Ministry of Justice. They have developed guidelines that allow for continuation of methadone treatment in prison (according to the protocol they developed, detainees' treatment can be adjusted after six weeks of incarceration). In principle, then, prisons in the Netherlands strive for continuation of care.

A key principle of the Dutch healthcare system is that they combine closely with the Ministry of Justice. The Ministry of Justice hires general practitioners independently. They are not prison staff; they work outside the prison system. This all goes to ensure that as far as substitution is concerned, treatment in prison settings looks very similar to treatment in the community.

### Black markets?

There is a grey market of opioids in the Netherlands, although it used to be way more significant than it is today.

We have to remember that we are dealing with treatments of chronic diseases; people have lived with their syndromes for 30 years. There is certainly a level of diversion to the black market, although it has decreased dramatically over time.

It used to be an issue in the 80s and 90s, at the beginning of the OST system, which was still immature. Neighboring countries like Belgium, France, or Germany didn't provide or allow OSTs, which created a market vacuum. Now that almost every European country has made OST and harm reduction programs available, the exportation market has faded out. By the early 2000s the problem had already all but disappeared.

It's technically impossible that everyone always use chronic medication according to prescriptions, but the grey market is not an issue at all anymore.

The overall rate of overdoses for all illicit substances in the Netherlands has been very low in the last ten years, though it has increased in the last two years. We are still looking for the exact causes of this phenomenon. It might be a matter of registration and evolving data collection practices, or there might be other explanations like aging populations, with fed up older patients who have lived with 20 or 30 years of addiction problems. These new overdoses may or may not be intentional on the part of the users. We do not know that yet.

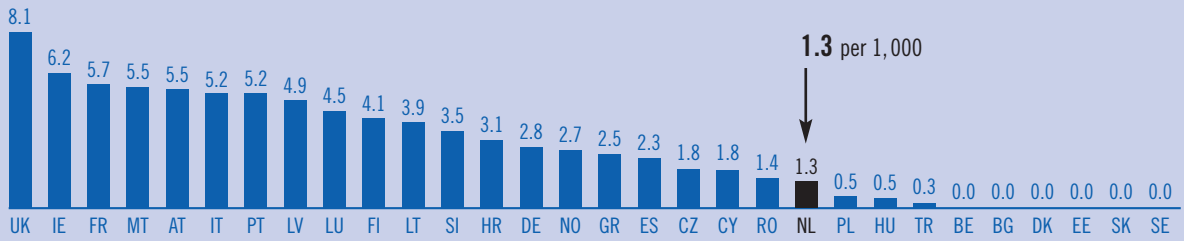


### Netherlands at a glance

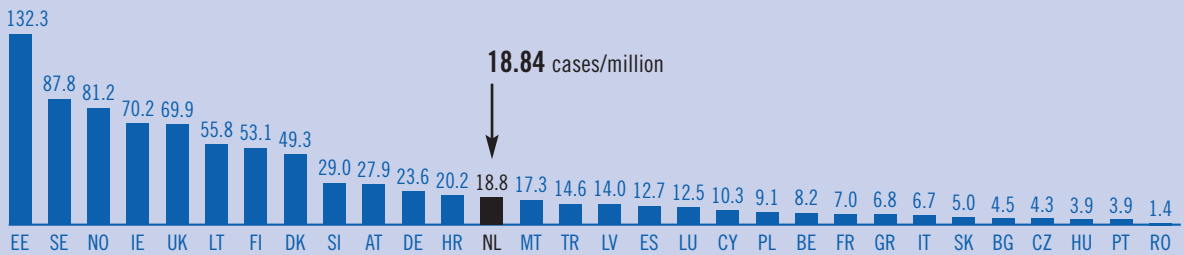
14,000 (12,700 – 16,300) High-risk opioid users

7,421 Opioid substitution treatment clients

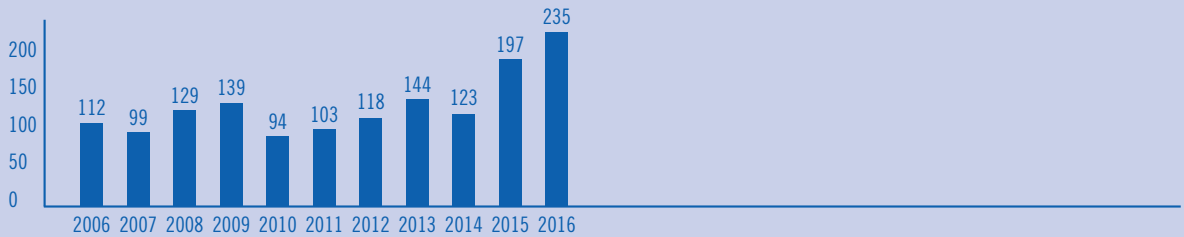
#### Opioids / High-risk opioid use (rate/1,000)



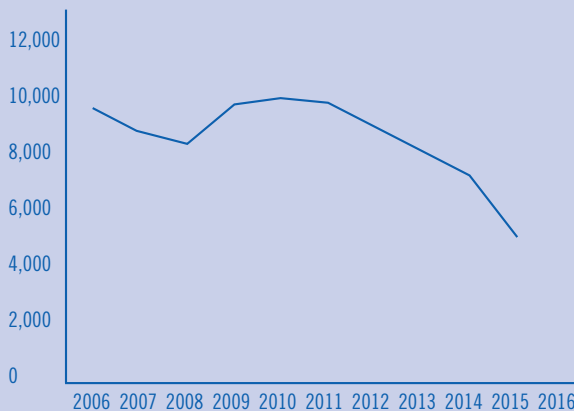
#### Drug-induced mortality rates / National estimates among adults (15–64)



#### Trends in the number of drug-related deaths

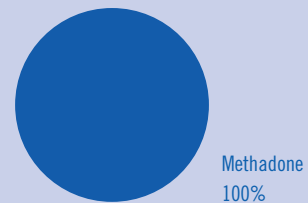


#### Trends in the number of clients in OST



#### Which substitution?

Methadone 5,214



Source: adapted from EMCDDA, Country Drug Report, 2018, [www.emcdda.europa.eu/edr2018](http://www.emcdda.europa.eu/edr2018)



## Netherlands: introduction dates

Methadone	1968
Buprenorphine	1999
Heroin-assisted treatment	1998
OST in prison	1985

Source: EMCDDA, Statistical Bulletin, 2018, [www.emcdda.europa.eu/data/stats2018/hsr](http://www.emcdda.europa.eu/data/stats2018/hsr)

### What now?

OST in the Netherlands is a well-functioning system that is fit for its purpose, as indicated by regular client satisfaction surveys. If you are not able to develop a decent system in 40 years, it's never going to happen.

If you look at developments in the world, if you look at New Psychoactive Substances (NPS) and synthetic opioids like Fentanyl in North America, which are increasingly reported in Europe, you might have cause to worry. But it is much too early to report on this in the Netherlands at this time. If you look at the Netherlands, the system has worked very well in the past, particularly as a response to the heroin epidemic of the '70s and '80s, and it works very well at the moment with people who are chronically dependent on opioids.

There are two things we need to remain cautious about: first, we have to stay alert to the evolving market for synthetic opioids, and to make sure we are prepared for unpredictable developments as new products become available. We are witnessing massive issues with increased availability, consumption, and especially health risks like overdose, of these synthetic opioids in North American countries. Although our country is different in many ways (think of the drug consumption culture and of our healthcare systems, for instance), we should not consider ourselves protected against the harms and risks of changing drug trends.

Second, we have to make sure that there is continued funding for programs that have proved to be effective but are actually less visible. As it turns out, the OST program survived a huge funding crisis following austerity measures in Europe during the economic recession ten years ago. Health insurance companies, which are usually really keen on cutting costs, did not put any pressure to reduce OST funding because they have found that the cost benefits are so obvious.

We have to make sure governments continue to realize that we are dealing with a chronic disease that needs constant attention, funding, and regulation.

# Integrating Hepatitis C treatment into addiction care



**Esther Croes / MD, PhD, Drug Monitoring expert at the Trimbos Instituut**

*After noting a “treatment gap” for hepatitis C (HCV), an ambitious implementation program got teams from different health institutions to work together on a solution.*

As an EMCDDA expert for the Netherlands, my work was to monitor the prevalence of HCV. I realized that although we are lucky to have a low incidence of HCV, we do have a high prevalence, and no program existed to remedy the situation. We knew that some patients were getting screened, but after the screening process patients received no continued healthcare or treatment. Our ministry funded a project to find out why.

We found out that the staff at addiction care centers, where screening happens, are not familiar with the hospital system: they do not know who to contact or what treatment options exist. As a result, patients can receive positive results for HCV at an addiction facility and then never receive HCV treatment. This is called the treatment gap.

We decided to try to bridge that gap by using the breakthrough method, an American, short-term (one and a half years, from 2014-2015) method to implement change in practices. Following this method, we brought together local teams, in this case addiction care personnel and hospital personnel. We had them sit around a table and say, “well, we have an unpleasant situation, because we have patients who need treatment, but they are not getting into hospitals. How are we going to solve that?”

Over the course of the project, team members had to figure out who would be responsible for which step of the

process. At the end, we had them write out and sign a care compact. They had to agree to adopt this practice in the future, to test it in practice to see if it worked, and to improve it if it did not. The initial step of the project worked very well. There are 11 major healthcare organizations in the Netherlands, and we tried to involve one local team from each organisation. This team would then have to figure out how the new practices could work in their region. Our hope was that best practices would spread fluidly among the rest of the addiction care organizations.

## Simple Answers on the Ground

All the answers were simple, organizational, and locally specific. In one of the healthcare organizations, for example, addiction care receives funding allocated for mental health. Since HCV is a somatic problem, HCV treatment could not be funded in the addiction care department. The company would not pay addiction doctors for providing HCV healthcare or orientation. The solution was very simple.

Addiction specialists have to organize and supervise substitution treatment, and as part of that work, they monitor the health and mental health status of patients. They have to complete a number of tasks to prepare the patient for treatment. What we decided to do was to include HCV prevention and treatment as part of that routine, without

declaring it as somatic care. That way, addiction staff could get paid for HCV prevention and patients could receive treatment.

What we found were mostly simple, organizational obstacles like these. You can only see these obstacles if you gather all participants and have them state the problem and find the solutions together.

### Top-down, Bottom-up

At the beginning it was clear to us that in order to succeed, we needed to do two things: convince people higher up, and convince people on the ground.

We needed to get management to see this as a major problem. In order to start the implementation process, the organizations' management had to agree to put in extra energy and to grant extra working hours and extra personnel. The hardest part was to convince management that for the period of this project they had to allow for these extra resources. They needed to understand that it was worth investing in. Once the program is implemented and running, you do not need extra resources anymore. New practices become part of the regular work and they do not require any additional involvement.

We set up a regular meeting of the directors of all addiction care institutes, which was very high level. I was able to give a short presentation there, and I also gave a handout of one page to sum up all the essential information. We made a short, clear, and convincing presentation. The directors realized they had to take our advice, because the issue is very important and because it is part of the European agreement. They decided they had to go for it.

But if you know how management works, you will know that they often forget to implement the ideas they agree to. It was therefore important to inform lower level management, staff, and health workers that we had convinced management to implement the project.

### Spreading the idea

The breakthrough method works very well in local teams that express their concern, recognize the issue, and commit to fixing the situation. We hoped that the implementation process would spread to all health organizations fluidly, but it did not do so. Some remote institutions decided the process was too complex, required too much work, was not adequate for their specific situation, or simply was not a priority.

Our response to this, which is planned to begin soon (three months), is to send a doctor with a Fiberscan and a testkit to any addiction center that has not adhered to the program so that the doctor can perform hepatitis C

screening and prevention directly in the addiction center. These doctors would also travel to the homes of patients with drug use disorders in cases where patients receive treatment at home.

### Lessons learned

All local places were different: what works for one does not work for the other, and each team had to solve their own specific problems. But part of the implementation method was that local teams came together every now and then and discussed the solutions they had found. They exchanged best practices, which worked very well and was very stimulating.

If you sit at a desk in an office, you will never realize what the problems are in practice. So you have to go out and talk to many people and hear what their problems are. You will realize that these problems are often extremely easy to solve.

For example, I heard that people who use drugs who tested positive for HCV would not go into hospitals because they were afraid of what they would see and of the specialist they would meet. The solution was again very simple: we printed a flier with pictures of the treating hepatologist, and we said: "see? It's just a person and if you go to the hospital you will meet this person." Now, when patients go to the hospital, they can say to their doctor: "oh I know you, I've seen your picture." They feel reassured and can continue receiving treatment.



# A history of consumption rooms activism in the Netherlands

Daan van der Gouwe / Researcher at the Trimbos Instituut

*The introduction of official drug consumption rooms in the Netherlands was the result of efforts of communication and transparency between drug users, associations, consultants, and local officials.*

I started working in drug policy and advocacy about 25 years ago. I worked in interest promotion for drug users, which meant that I sought to empower drug users to fight for their rights. At that time, we became involved in the setup of several consumption rooms (DCRs) in the Netherlands. Consultants who were designing the rooms asked us to weigh in. As they were creating these spaces, they wanted to know what features would be essential from the point of view of the DCRs' most important visitors: drug users.

## Listening to drug users

They called us with very broad questions. One guy asked me, "Daan, how bright should our light bulbs be in the consumption room? How do we make sure it is neither too bright nor too dark in there?" This was the end of the '90s and early 2000s, and stakeholders started to involve drug users in these processes.

Drug users cared about things like low threshold entry and location, but not so much about opening hours. We conducted a client survey in a city where a DCR was scheduled to open, and I remember thinking that it should be open 24 hours a day because drug users should be able to use drugs whenever they need. The result of the survey contradicted me: drug users preferred to use DCRs during the day (and maybe a little bit in the evening) and preferred to rest at night. It was important to talk to drug users because they can be surprising in their choices and preferences, and our preconceived notions could always be wrong. In the discussion about whether or not alcohol should be forbidden in the consumption rooms, for exam-

ple, we discovered that alcohol consumption was mainly a concern for staff, and that the rooms' visitors did not particularly care about it.

## Starting a conversation

As consultants, we came up against fairly straightforward issues. They needed to make sure that DCRs and their visitors would not interfere with residential areas. They were soon confronted with the NIMBY effect ("Not In My BackYard," a phenomenon in which local residents oppose the construction of a facility in their neighborhood even though they believe it is beneficial for society): even if people were not afraid or even supported DCRs, they were reluctant to accept them near their home.

We sought to gather all different stakeholders in this field (including drug users) and engage them in conversation. Our goal really was to start a dialogue. We were effective because we decided to be visible and transparent about DCRs and what happened inside of them. We almost literally used glass windows for people to look inside and see that there were no shady things going on, and in fact that what happens inside DCRs is quite simple.

We organized meetings and public forums, along with neighborhood communities. Because there was still a lot to fight for back then, there were a lot of interest groups: (groups of people promoting drug users' interests). As a result, some of the drug users were already organized, which made it easy for us to set up these meetings. Our role was to facilitate conversation between local user groups and those who were proposing to set up consumption rooms. We constantly intervened to say 'please, take

into account the interests of drug users and listen to what they want, because if you set up something they do not want and do not use, it will fail. For example, if you set up a DCR 10 miles out of the city, nobody will show up.’

With some user groups, we received state funding to organize “study visits.” Thanks to this state partnership, we came to be seen as a serious partner of drug users, and we managed to have groups of local authorities from cities that did not yet offer a DCR visit another city’s DCR for one day. We wanted to show them what a DCR actually looks like and how it works. On paper, these officials may have had all kinds of ideas, but seeing a DCR firsthand often came to contradict those ideas. This experience was beneficial in more than one way: one was that decision makers changed their opinions about drug consumption rooms. Another was that because they rode the bus from one town to another together, they actually created a conversation at the local level. For these reasons, this was a very effective strategy at the time.

We needed to make DCRs look as neutral and practical as possible, and to deconstruct all the myths surrounding DCRs. I think we were mostly successful: in many cities where we worked, people in the neighborhood first protested or demonstrated against DCRs. But maybe two weeks or a couple of months after the rooms opened their doors, the protests would die out because residents would see the benefits of DCRs, in particular for themselves. They would see improvements in public peace on the streets. They could also use DCRs as a trusted point of reference. If someone found a syringe on the street they could just call a DCR and ask them to pick up the syringe. If they witnessed something drug-related on the street, they could also easily contact the DCR, which ensured that these issues would be resolved much quicker and more efficiently than before. The bottom line of the DCRs’ success was cooperation between all parties.

## DCRs in the Netherlands, then and now

The first formal DCR (there were several informal DCRs in the Netherlands) was actually set up by police officers in the small town of Apeldoorn. These officers wanted to remedy a situation in which they kept catching drug users hanging around the central train station. So they decided to set up a room in which drug users might be able to inject or smoke without causing public nuisance. It became the first official DCR and was very successful. After about a year, the city’s regular drug services took on the coordination of the room, and similar services expanded throughout the country. Our institute is currently conducting a survey to get an exact number of DCRs in the country and of the people they serve. We esti-

mate that we currently have around 30 DCRs in the Netherlands.

In the past 15 years, DCRs have become institutionalized and have become an integral part of the regular drug services in the Netherlands. We have about 12-13 large drug addiction services. These provide all different kinds of treatments (like methadone treatment). As DCRs became a part of that comprehensive service, they also became better accepted by the public. In the ‘90s, DCRs were still a controversial issue (and in many countries they still are), but in this country, they have become very normal. Nobody ever talks about it, you never hear anything about them on the news. Of course, if you ask a random person on the street what their opinion is about DCRs, they would probably reject it. They might still refer to the same myths that people used in the ‘90s. But nothing comes of these fears, and we still have 30-35 DCRs in the country. There rarely are any incidents.

The choice to open DCRs always belonged to local authorities in the Netherlands. Our goal was to get the movement started, to make DCRs a common facility. Now that this has happened, it has to be up to local authorities and drug services whether they think they need one or more.

The surprising thing now is that the number of DCRs is stabilizing or maybe even decreasing. I noticed that a number of DCRs that were active a few years ago have closed or will close soon. I’m not sure whether this is a bad thing. In the Netherlands, we now have a large number of pensions — houses where drug users over 55 live together and are allowed to use drugs. These drug users are supervised by drug treatment services, but they have a roof over their head so they do not need to use in the streets or in a DCR anymore. This may be one reason that there is less need for DCRs, and that there are very slightly fewer of them around.

The history of argumentation for DCRs in the Netherlands differs from that of most countries. The primary reason for DCRs originally was to get rid of public nuisance on the street (as opposed to the health and safety of drug users). People care about street safety, which is why DCRs have been accepted and is also probably why they still exist.

I am not sure whether DCRs are here to stay in the Netherlands. Right now, people see them as a necessary evil: they separate drug users from everyday life and have them gather to use drugs among themselves. But without DCRs, drug users have no safe place to go to inject drugs, and they will continue to use on the streets. There is no talk about closing down DCRs currently, but as pensions become more common, the need for them certainly seems to be decreasing.

# A brief history of substitution in Italy



**Paolo Jarre** / Head of the addiction department (Ser.T) at ASL To3 in Piedmont

*Italy has featured varying substitution practices depending on the politics of its individual regions, and Italian drug policy has been sensitive to alternating political parties at the national level. Despite significant advances, old stances and opinions continue to shape the discourse on drugs in Italy today.*

## The beginnings of substitution

Methadone use in Italy goes back to the second half of the '70s, which saw the first experimental use of intravenous medication. This happened mostly in private clinics (for the offspring of well-to-do families) or in civil society institutions like the Villa Maraini in Rome (for other patients).

Public services were still in their infancy. These had been created in the '70s, when medical and social care centers first opened in a few major Italian cities. Following a 1975 regulation (Legge n°685 dicembre 1975), services proliferated throughout the '80s in less central institutions of Northern and Central Italy. Almost all of Southern Italy had to wait until the 1990 law was passed (Legge n°162) for similar services.

In the '70s, even in Italy, the works of Vincent Dole received increasing attention. They demonstrated the positive effects of methadone, especially in the context of maintenance treatments for heroin dependence: decreased recourse to street drugs would lead to a decrease in linked pathologies, as well as a decline in petty criminality and improved capacity for academic or professional tasks among patients.

## Political obstacles

Meanwhile, at the level of government, an intense correspondence emerged between the Direzione Generale in

charge (Social Medicine), the Health Ministry, the High Health Council, and the High Health Institute. These documents reveal profound hesitation regarding the implementation of methadone treatment, especially when it came to prolonged uses rather than “progressive” treatments aimed at quick cessation (within 21 days according to the law). For longer treatments, various actors tended to use divisive terms, often with negative connotations. For example, they wondered if it wouldn't be more appropriate to talk about “prolonged detoxification” rather than “maintenance treatment” so as to “avoid the idea that the addiction syndrome is irreversible.” Health authorities appeared powerless in their attempt to manage the heterogeneity of interventions performed in various care centers across Italy (for example, injectable methadone — Physeptone® — in Genoa and Milan; ingestible pills in Florence and Rome). They were also unable to respond to the emergence of a “grey market,” which received frequent and dramatic media attention. In their correspondence, they discussed limitations and regulations instead. Using a moralizing rather than scientific perspective, they emphasized that substituting illegal addictions for legal ones could never represent “a real cure.”

For a long time, attempts at straightening out this chaotic situation were unsuccessful, and even turned out to be counterproductive. In particular, the June 1978 Decreto

Anselmi (a Christian Democrat health minister in the Andreotti administration), restricted methadone use to hospital settings in an attempt to curb “improper uses.” There was strong backlash against this measure, and the minister soon issued a second decree (in August of 1978), extending methadone use to services that complied with the recent Law 685 of 1975. Still, he did not authorize methadone in pharmacies, and therefore made methadone prescription impossible. This 40 year old decision still weighs on Italy’s current drug policy: as described in the latest EMCDDA report (2017), experiments with pharmacy distribution of opioid agonists are minimal and limited to only a few institutions.

### “State drug”

In the first years, treatments varied greatly. As a rule of thumb, however, doctors selected doses with the aim of reaching receptor saturation (so as to prevent overdoses). They also followed the demands of patients, who had more or less therapeutic goals.

The year after the Anselmi Decree (1979) was marked by an unprecedented proposal by liberal health minister Altissimo, Anselmi’s successor. He wanted to make heroin-assisted treatment available. This proposal led the country into heated debate. It is worth noting here the various political stances of that time, which had repercussions on current approaches to “legal” substitution medication like methadone, morphine (sometimes), as well as buprenorphine in the last 20 years. To this day, although numerous studies (concluded or ongoing) have proven its efficacy in various European countries, heroin-assisted treatment remains taboo.

On one side were the critics, who adhered to the principle that one “cannot cure drugs with drugs.” On the other side, stances varied greatly. Even among those who did not oppose, or even explicitly supported the use of opioid agonists, there were notable differences. Franco Basaglia, a psychiatrist who had striven to end the use of insane asylums as a place of treatment for mentally ill patients, emphasized the risk of creating a new type of institutionalized treatment based on the power of medicine and doctors. Such an institution would risk resembling that which had penalized mentally ill patients (a late ‘70s law in Piedmont specifically prohibited assigning workers and services exclusively to heroin addiction treatment for this exact reason).

Among those who opposed the “state drug,” there were also different shades of disagreement. From the Communist Party came two disagreeing voices: one was psychotherapist Luigi Cancrini, one of the first theorists of drug dependence, who penned the legendary 1982 essay

“Those Magnificent Men in their Flying Machines,” and maintained in the next decades his stubborn opposition to substitution therapy, even as evidence had overcome most doctors’ doubts. Another was doctor Laura Conti, who had founded modern Italian environmentalism.

### Methadone in pharmacies

In August 1980, the legislative controversy over substitutive substances continued with the signing of the Aniasi Decree (Altissimo’s socialist successor). The decree extended distribution of methadone to pharmacies, even when general practitioners prescribed it. The decree caused some issues: among other things, by postponing the approval of other substitution medication, it delegitimized intravenous morphine treatments. A limited number of private doctors and public services in some Italian cities (particularly Naples and Florence) relied on this form of treatment. Doctors prescribed morphine treatments not only because methadone was unavailable in pharmacies (in accordance with the previous year’s measures), but also because they believed that in the most difficult cases morphine was more efficient than methadone in discouraging street drug use. One anecdote that circulated just before the turn of the millenium credited intravenous morphine treatment with the low incidence of HIV among Neapolitan drug users in comparison with the rest of the country.

Thus, the Aniasi decree prompted many in Italy to choose sides. Some opposed the measure because it promoted the wider availability of a “state drug;” others opposed it for the opposite reason that it delegitimized morphine use; others still supported it because it represented a “lesser evil.” Advocates often based their arguments on the idea that better access to methadone would curb morphine use, and often reiterated their staunch opposition to the use of morphine when treating drug addicts.

In this tense political climate, difficult negotiations began to amend or block the decree, or even to propose regressive measures. Francesco Pocchiari, director of the Superior Health Institute, offered a resolution. The Institute’s Commission for Pharmacopoeia issued a favorable opinion on “experimental use” of morphine in October 1980 — i.e., restricted to specific conditions and subject to evaluations and assessments meant to inform future measures. Thus, in October 1980, Aniasi signed a second decree legalizing experimental uses of morphine (such use persisted exclusively in the urban institutions cited above throughout the 1980s).

Discord did not abate, however. Immediately after the decrees were signed, protests emerged because appropriate methadone packs could not be found in pharmacies.



## Italy: introduction dates

Methadone	1975
Buprenorphine	1999
Buprenorphine + naloxone	2007
Heroin-assisted treatment	N/A
OST in prison	1990

Source: EMCDDA, Statistical Bulletin, 2018, [www.emcdda.europa.eu/data/stats2018/hsr](http://www.emcdda.europa.eu/data/stats2018/hsr)

On top of this, depending on the situation, the measures were either too strict — as was the case, for example, in the historically communist region of Tuscany, particularly in Florence, where public services had significant experience in the use of substitutive substances, including morphine — or too lenient, as in the heavily Catholic region of Veneto, where regional authorities continued to prohibit morphine and introduced stringent restrictions on methadone. In early '80s Piedmont, a regional memo set the maximum daily dose of methadone at 40mg, well under the doses prescribed in previous years, and well under what scientific research would eventually prove to be effective.

One odd fact is worth mentioning here. In the brand new addiction department of the San Giovanni Hospital in Rome, doctors used Ketamine to treat patients addicted to street heroin (this experiment was taken up in other parts of the world decades later). Someone had suggested it might work as a valid alternative to methadone when doctors could no longer use opioid agonists.

### Early signs of harm reduction

At the end of the 1980s, the High Health Institute entered the fray when they issued a statement on substitution treatments. Given the climate, the document could not afford to mention prolonged opioid treatment as an appropriate response to dependence. In fact, it began with a warning that such treatments were “outside the frame of established medical treatments in the strict sense of the term,” and instead “were predicated upon a situation of emergency,” in which a patient who is not ready to give up street drugs faces high risks of disease and death. Still, they affirmed that while “those who provide treatment must always aim to progressively reduce administered doses,” the cessation process “cannot be established according to a codified formula.” The document went on to clarify that when a patient refuses to reduce doses, health professionals, especially in public services, should not impute motives for this decision. In a

way, we can see in these statements an unintentional anticipation of one of the founding principles of harm reduction.

As patients' subjective experience and right to self-determination gained importance, the document also called attention to the ambiguity of a term like “maintenance treatment” when talking about treatments without a pre-determined end-date. At best, the term would “hold semantic value only, and at worst (and more frequently) it will work to significantly damage the application of best practices.” Here, the document criticized (largely to placate the government commissioner) Dole's philosophy, whose proposal to use methadone indefinitely was based on a minimalist, organicist, and indivisible interpretation of drug dependence.

We should point out that in these early years, no one in Italy thought of methadone as an overdose prevention measure. Still, in practice, high dosages and widespread trust, along with few administrative barriers, created the necessary conditions to protect a majority of heroin addicts attending dependence treatment centers.

### Craxi's “war on drugs”

Starting in the mid-'80s and into the first half of the '90s (in the midst of the HIV crisis!), a widespread and stubborn “treatment prohibitionism” took hold in Italy. On one front there was a political attack against “friends of small doses,” a famous phrase coined by Prime Minister Bettino Craxi when he returned from the US infatuated with Reagan's war on drug. (After meeting Rudolph Giuliani in New York, Craxi — forgoing the socialist party's libertarian vocations — suddenly convinced himself that cracking down on drug traffickers and small dealers was insufficient, and that it was necessary to punish consumers. This contradicted the law in effect at that time, which considered possession of small doses not punishable by law.) On another front, various powerful members of the therapeutic community (Catholics, for the most part) began to demonize methadone as a “state drug.”

In various Italian regions, legal limitations on methadone doses began to spring up, like the Piedmont measure mentioned above. The official death count for overdoses, which had lingered at less than 100/year since 1985, began to rise to reach its all-time high of almost 500 in 1999.

The Craxi administration's initiative culminated in the Jervolino-Vassalli law (n°162, 1990). It replaced a socially inspired law from 1975, and continues to be enforced today with only slight modifications. The penalizing streak reached a peak first with this law, which defined consumption as a punishable offence (this was later

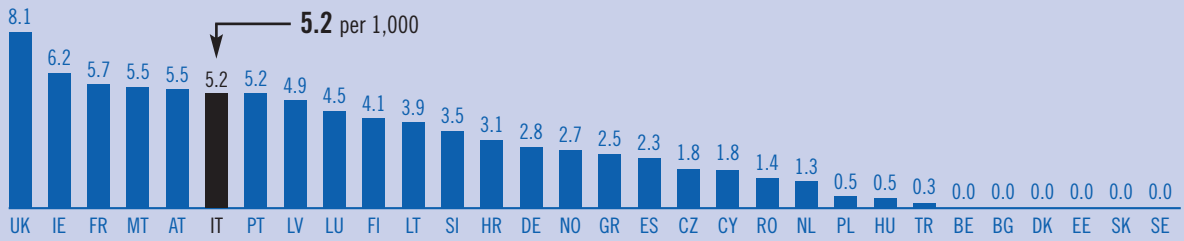


### Italy at a glance

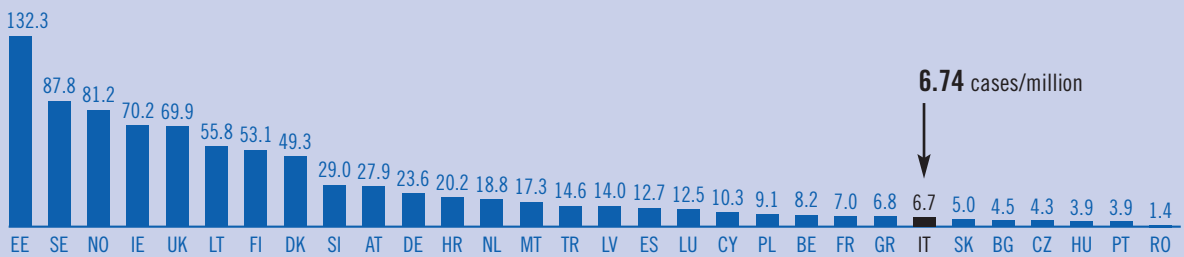
**205,200** (180,000 – 230,000) **High-risk opioid users**

**62,868** **Opioid substitution treatment clients**

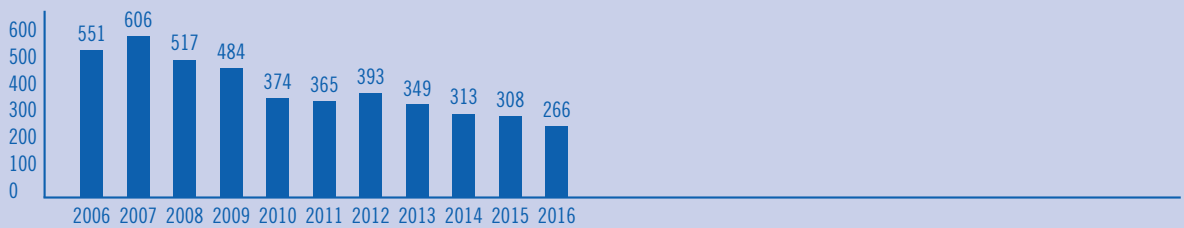
#### Opioids / High-risk opioid use (rate/1,000)



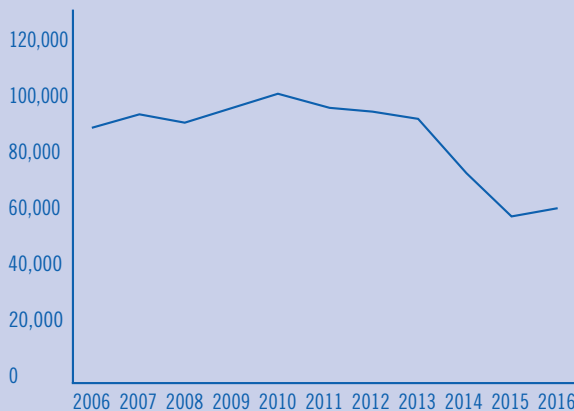
#### Drug-induced mortality rates / National estimates among adults (15–64)



#### Trends in the number of drug-related deaths

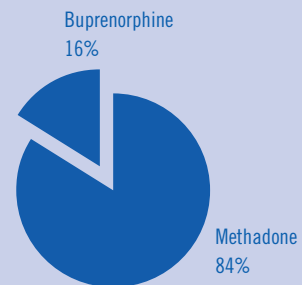


#### Trends in the number of clients in OST



#### Which substitution?

Methadone 53,070  
Buprenorphine 9,798



Source: adapted from EMCDDA, Country Drug Report, 2018, [www.emcdda.europa.eu/edr2018](http://www.emcdda.europa.eu/edr2018)

rescinded in a 1993 referendum), and second with Decree 445 from the health ministry, which restricts methadone to progressive, short-term treatments.

The possibility of morphine treatments was buried there and then: “only methadone in syrup form, used as substitution medication in treatment programs for opioid dependence, is authorized.” The law made it compulsory to integrate pharmacological treatment into psycho-social ones: “Substitution treatment programs must always be part of a larger, integrated plan that must include regular consultations, whether to monitor the drug addict’s health status, or to provide him with psychological, social, or rehabilitative counsel.” It also designated methadone as a second choice treatment: “methadone programs are intended for patients for whom other types of treatment have not led to cessation of heroin or opioid use.” The possibility of entrusting medication to patients was revoked: “the administration of substitution medication will take place in the presence of the doctor, or of health staff officially designated by the doctor, on the institution’s premises. Where this is impossible on the part of the patient in treatment, administration can happen at home. Health staff trained in substitution must personally engage their own responsibility to ascertain that the patient has taken the substitution medication. External programs are prohibited.” And, to cap it all, the law discarded Vincent Dole’s findings, as well as all scientific evidence gathered between 1964 and 1990 on the efficiency of methadone maintenance. “Substitution treatment will be administered for a predetermined length of time suited to one patient. Health staff will provide it with the lowest dosages that can ensure detoxification.”

### The birth of harm reduction services

The popular referendum of 1993, by revoking the health ministry’s authority to sign decrees on pharmacological treatments for drug addiction, made the most stringent legislative measures of “treatment prohibitionism” of the last 50 years obsolete.

At the turn of the ‘90s, the term “harm reduction” did not yet have currency in Italy. Doctors described and treated overdose as an unavoidable fact that followed from drug addiction (if not as a more or less suicidal act), and almost no one wondered whether it might be rationally avoided through timely use of adequate doses of opioid agonists. Change occurred mainly due to rising awareness of the importance of preventing and reducing harm after the HIV epidemic struck injecting drug users. In the first half of the ‘90s, the first single-use syringe distributors and exchange programs emerged, and in 1994 the first *Unità di Strada* (Street Unit), an intervention group for people

who actively use drugs, was created. In 1993 and 1994, fewer than half of those receiving treatment (more than 90% of whom were heroin addicts) in addiction services received pharmacological treatment.

Things began to change in the second half of the ‘90s, based on the more rational and scientifically grounded approach of the Ser.T. (Servizio Tossicodipendenze) staff. These changes were also due to the progressive propagation of early harm reduction practices like Take Home Naloxone, and to the tenacity of a few health staff members who tirelessly read scientific literature and updated their practices accordingly (“with science and conscientiousness”).

Studies backed by regional Epidemiological Observatories for Addictions also contributed to this enlightenment. Little by little, these studies made their way into Italian awareness and revealed in very clear terms the inadequacy of many Ser.T institutions compared to the recommendations of contemporary scientific literature.

The proportion of patients treated with medication rose to reach 73.8% in 2001. Dosages, however, took a longer time to reach adequate levels. In Piedmont, as late as 2000, the average dose remained around 40mg/day, and some institutions still refused to make any use of methadone whatsoever. What’s more, many Ser.T services still impose complex obstacle courses, sending patients from staff to staff for days or weeks before providing treatment. In the first decade of the century, countrywide dosages slowly increased from an average of just under 40mg/day to almost 60mg/day.

Overdose prevention emerged as a point of interest, especially after this discovery (obvious in hindsight): methadone, and after 1999 buprenorphine (although it is harder to maintain at higher doses, which can lead to a diminished protective effect), when used in dosages between 40 and 80mg, leads to such a level of receptor saturation that it makes heroin overdose extremely unlikely.

Methadone dosages in Italy have increased again in the last 15 years, and ultimately became those prescribed by scientific literature (the average in Italy is currently above 60mg). We still lack a good understanding of short-term preventative methadone treatment, which should be used as soon as possible in informal healthcare contexts like street interventions and drop-in centers.

A very simple framework still informally guides methadone use with the three following objectives:

- From 20 to 40mg: suppression of major withdrawal symptoms only.
- From 60 to 80mg: receptor saturation prevents overdose and completely suppresses withdrawal symptoms.

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– Above 80mg: anti-craving effect, along with the two previously mentioned effects.

This is mostly the way methadone is used in Italy today. However, health staff are not familiar enough with treatments, and are therefore unable to share information appropriately with their patients. Instead, doctors engage a struggle to raise doses to prescribed standards in order to comply with entirely theoretical best practices, when patients really only aim for withdrawal relief rather than receptor saturation — the opposite of “treatment prohibitionism,” when doctors pressed for lower doses. Instead of a path to abstinence, health staff seek to set up a legitimate, safer, and more controlled use of heroin (from a clinical perspective).

## Current opioid use in Italy

To get an idea of opioid use in Italy, available resources include substance confiscation data, which only informs us about what quantities are available on the market. There are also estimations of problematic drug use (PDU), one of the “five key indicators” used by the EMCDDA to provide comparable and scientifically rooted estimates of PDU trends. Estimates indicate a recent decrease in opioid consumers in Italy, with prevalence dropping from 7.7/1,000 (range 7.4-8.0, about 299,000 users) in 1996 to 8.1/1,000 (range 7.8-8.3, about 312,000 users) in 2004, to 5.2 (range 4.5-5.7, about 203,000 users) in 2014, the most recent available estimate (data published in the EMCDDA Statistical Bulletin, 2004-2015). Italy is in the top five countries with the most PDU, as reported in the last European Drug Report published by the EMCDDA. Official data for opioid users receiving treatment, provided by the Health Department’s National Information System for Addictions (Sistema Informativo Nazionale per le Dipendenze, SIND), still show a consistent decrease, since 2010, in the number of users receiving treatment for opioid addiction. 2015 saw a trend inversion, when, after decreasing consistently from 130,000 in 2012 to

less than 100,000 in 2014, the figure rose above 100,000. Opioid addicts made up 70,1% of addiction patients. In 2015, among the roughly 50,000 new cases at the SerT service for PDU, 53% were treated for opioid use (that figure had fallen under 50% in 2010 and was still above 60% in 2007).

The latest National Report available from the EMCDDA website displays the trend for opioid substitution treatment in Italy from 2006 to 2015. In 2006, 91,503 patients were in treatment. That number grew beyond 100,000 for the first time in 2010. The figure lingered between 90,000 and 100,000 until 2013. The next figures, as the Report notes, suffer from serious underestimations following the change in data collection (changed over to SIND, mentioned above). This new system made it impossible to collect adequate data for the first two to three years of its implementation. In 2015, the number of patients undergoing opioid substitution treatment supposedly fell to a little above 60,000, but even when taking into account the decrease in OST patients, that figure is not realistic. Overall, the number of cases of death by overdose for all substances is clearly decreasing. This trend is confirmed by various models and data collection entities.

In Italy, overdose episodes are recorded by a branch of the department of internal affairs: the Registro Speciale (RS) for mortality attached to the Central Management for Anti-drug Services (Direzione Centrale per i Servizi Antidroga, DCSA). This group records events in which police forces were notified, on the basis of circumstantial evidence (for unmistakable signs of intoxication by psychoactive substances). Based on the DCSA’s numbers, from 1999, when 1,002 cases of death by OD from all psychoactive substances were recorded, the phenomenon has waned until 2003, when it reached 517 deaths/year. From 2004 to 2007, the figure stabilized, although it fluctuated between 551 and 653.

In the next years, the figure decreased again until it reached its lowest point in 2011 with a death count of 365. 2012 saw a slight increase (393 deaths), until it reached its lowest recorded point in 2015 with 305 deaths.

Cases of death by OD from opioids are also decreasing in accordance with the general trend. Since 1999, when 470 deaths were attributed to heroin use, the phenomenon has decreased, although not linearly, reaching 280 cases in 2005 (the only year with a drastic trend inversion), and 154 cases in 2010 (a 34,7% decrease from the previous year), and finally 101 cases in 2015.



# Take Home Naloxone: a pioneering movement from Italy

Susanna Ronconi / Representative for Forum Droghe

*In Italy, Take Home Naloxone (THN) was among the first harm reduction interventions to emerge in the 1990s. THN radically transformed the status of PWUDs and the role of their families and communities in preventing opioid overdose.*

Take Home Naloxone (THN) is not a recent harm reduction initiative; we created this program in Italy in the mid-

'90s. We wanted to start distributing naloxone — a lifesaving drug in situations of opioid overdoses — to users and to members of the community. Today, THN comes up again after more than twenty years in the context of a global campaign to spread the practice. There

have been renewed debates and initiatives surrounding THN, particularly to make naloxone accessible to professionals (including non-health professionals) and to users themselves in the context of harm reduction services and operations. At this moment, networks of drug users, professionals, and members of civil society<sup>1</sup> are organizing campaigns and setting up projects to make naloxone more widely accessible throughout Europe and beyond. Even the EMCDDA has conducted a preliminary study to this effect,<sup>2</sup> and the WHO has issued guidelines for naloxone distribution.<sup>3</sup> Further, the accessibility of naloxone for intranasal administration increases chances that the drug will become more commonly available and

accessible. Advocacy for naloxone diffusion is clearly urgent and necessary. As of today, only a few countries have made naloxone an over-the-counter medication. As result, it has been difficult to set up a detailed and widespread prevention plan among consumers based on their specific skills, relationships, and responsibilities.

## Italy's pioneering movement

Italy has carried out this harm reduction practice for the longest time and in the most widespread and sustained manner, which has yielded positive results. Thus, starting in 2016, we have decided to spread our model (along with lessons learned) to inspire others in different contexts. After we conducted a national qualitative survey to determine the program's strengths and efficacy, we were able to issue guidelines for best practices.<sup>4</sup> We also wanted to fill a gap: weak political support for harm reduction in Italy has led to an irregular development of harm reduction services. The magnitude of THN programs is unequal across the 20 Italian regions. Some areas offer good or optimal services while others have not developed the program at all. Likewise, the Italian government has not invested in monitoring and research on the application of THN programs. This means that paradoxically, until 2016,

<sup>1</sup> [www.eurohrn.eu/index.php/overdose-campaign](http://www.eurohrn.eu/index.php/overdose-campaign);

[www.eurohrn.eu/images/stories/pdf/publications/models\\_of\\_community\\_report.pdf](http://www.eurohrn.eu/images/stories/pdf/publications/models_of_community_report.pdf);

[www.eurohrn.eu/images/stories/pdf/publications/study\\_report\\_euroHRN\\_II.pdf](http://www.eurohrn.eu/images/stories/pdf/publications/study_report_euroHRN_II.pdf);

[www.opensocietyfoundations.org/publications/stopping-overdose](http://www.opensocietyfoundations.org/publications/stopping-overdose); [www.naloxoneinfo.org/](http://www.naloxoneinfo.org/)

<sup>2</sup> [www.emcdda.europa.eu/publications/emcdda-papers/naloxone-effectiveness](http://www.emcdda.europa.eu/publications/emcdda-papers/naloxone-effectiveness)

<sup>3</sup> WHO (2014) Community management of opioid overdose, in [www.who.int](http://www.who.int)

<sup>4</sup> Preventing Opioid Overdose deaths - An investigation on the Italian model of Naloxone distribution [www.fuoriluogo.it/ricerca/naloxone/](http://www.fuoriluogo.it/ricerca/naloxone/).  
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Research was coordinated by the Forum Droghe association and conducted in partnership with Etelectica, Dipartimento Patologia delle Dipendenze ASL ex Torino 2, Dipartimento Patologia delle Dipendenze ASL Torino 3, Dipartimento Dipendenze ASL Napoli 1, Franca Beccaria, Antonella Camposeragna, Paolo Jarre, Sara Rolando, Susanna Ronconi, Angelo Giglio, Stefano Vecchio and Grazia Zuffa constituted the research team. Report compiled by Susanna Ronconi, with contributions by Paolo Nencini. We received partial support from the Public Health Program of the Open Society Foundation and the unconditional support of Indivior Italia Srl.

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the country with most experience in this field was also the country that had produced the least research about it, and appeared least often in international publications.

THN in Italy started in the early '90s. At that time, Italy faced a deadly epidemic: opioid overdoses and the spread of HIV among injecting users decimated the consumer population. Just to get a sense: in 1999, there were 470 fatal overdoses from opioids; in 2015, only 101 users died in similar circumstances, a trend that has consistently decreased since. In the '90s, hyper-prohibitionist national policies privileged the single objective of abstinence. These policies left active drug users who refused abstinence-oriented treatment to their own device. In 1990, a new punitive drug law imitating the American war on drugs was passed. However, a large movement made up of professionals, associations, legal experts, and drug users protested the measure. In the span of three to four years, this coalition achieved three important goals: a popular referendum repealed the most repressive aspects of the 1990 law; methadone substitution treatment became widely accessible and addiction services were generally expanded; and we saw the first experimental harm reduction initiatives, such as syringe exchange programs, outreach interventions, and drop-in centers.

Thanks to this innovative movement, we began distributing naloxone to drug users through low-threshold interventions and outreach. The first experiences, from '92 to '95 in the regions of Piedmont and Lazio, pioneered the movement. Naloxone was not yet an over-the-counter medication then, and could not be distributed or acquired without a personalized prescription. Nevertheless, some doctors in public addiction services who witnessed the high risk incurred by drug users took on the responsibility to authorize distribution, and went so far as to engage their personal liability. This proves yet again that innovation requires courage and integrity, and that we cannot afford to lag behind norms when such norms are inadequate. From there on, thanks to the efforts of many drug users, associations, and professionals, the Health Department finally issued a decree authorizing two important measures: naloxone became an over-the-counter drug and anyone could acquire and carry it for cases of emergency; and since it is a lifesaving drug, all pharmacies had to have it in stock. From 1996 on, this practice spread to many Italian regions through harm reduction interventions.

## Empowering users and their communities

Naloxone availability, and harm reduction approaches more generally, represented a radical paradigm shift. The concept of safer use — introduced by harm reduction

and applied concretely through a number of specific actions intended to make drug use less risky and more controlled — is proof that harm and drug-related risks are not "intrinsic characteristics" of the substances. Instead, they are potential, relative, contextual, and progressive risks. This idea toppled a double paradigm that motivated and still motivates all prohibitionist policies, including Italian legislation: the moral paradigm (drug users are deviants who cannot escape their tragic destiny if they do not put an end to their practices) and the "disease" paradigm (users are in a state of chronic illness and have little or no power to exercise control over their own use).

Little by little, this latter paradigm had translated into a desperate form of medication-centrism, an approach in which the substance's chemical properties govern everything, and which minimizes both the "set" (the characteristics and capacities of the individual) and the "setting" (the context, culture, and rituals that underlie self-regulated drug use). Harm reduction and THN, on the other hand, understand users as social actors who have the power to know, to learn, and to modify their own behavior. This idea follows an approach proposed by Norman Zinberg, in which drug, set, and setting are inseparable variables. For Zinberg, the concept of "social learning" acknowledges what other paradigms conceal: consumers can learn to know and manage drugs. They can self-regulate and reduce risk to a point of sustainability where drugs are compatible with their daily lives. The success of harm reduction cannot be separated from this change in perspectives: THN would not be effective if drug users were not (or were not perceived as) active subjects capable of learning, cooperating, and transforming their behavior.

This concept of empowerment also applies to users' networks of friends, family, and social relations. Administering a lifesaving drug as a common citizen enters into the WHO's definition of health promotion: a social community can take charge of its own wellness and health by normalizing and diffusing basic skills like non-professional intervention in situations of emergency. This position has existed for several decades, and if we have struggled to apply it in the context of drug use, that is only because of moral preconceptions and stigma: users are seen as lacking skills and knowledge, and are not expected to be able to "do it on their own," at least not without professional assistance. On the contrary: drug users have demonstrated evident skills and knowledge (as shown in our research and in extensive international literature), and they can engage in processes of learning and skill acquisition.



In this project, the most important principle of harm reduction we applied was its order of priorities: it is most important to protect the life and health of drug users. Second, we applied the idea that there can never be a set of objectives preordained and hierarchized by professionals (less so by a legal framework), but that each objective depends on the wishes of the consumers for themselves, their well being, and their health. We should accept and contextualize users' decisions in terms of their chosen lifestyle. The objective of safer use is entirely within the bounds of this set of priorities. This means reimagining the relationship between client and health practitioners by moving away from the traditional context of drug-free treatment: in a harm reduction context, this relationship is less asymmetrical and features stronger social ties. Clients can manage their own path to their given objectives, and the consumers are considered through the lens of their resourcefulness rather than that of their shortcomings.

This is very clear in the THN program. We accept the user's decision to live with drugs and potentially dangerous substances. We invest in the knowledge and capacities of individuals (to prevent risks of overdose, to intervene when others are in situations of emergency, and to avert fatal overdoses), and in the possibility to expand these skills for self-protection. At the same time that harm reduction workers distribute naloxone, they provide information and training sessions on its proper uses.

We also value the relationship between consumers and the horizontal form of communication they establish among themselves (peer support). We recognize their social network and facilitate these bonds in social contexts and in situations of drug use. This involves supporting and reinforcing solidarity practices, communicating informally on things like the quality of substances currently offered on the market, and whistleblowing substances known to cause overdoses. Finally, we try to transform social environments to make them into "settings" that encourage intervention and reduce harm instead of increasing it. This involves informing and training other relevant services and workers, police forces, and families.

## Naloxone Distribution in Practice

The Italian model for opioid overdose prevention is based on two types of large-scale intervention: for prevention, it is based on widespread and guaranteed access to methadone substitution treatment (OST) which, when prescribed by public services with an objective of harm reduction, plays its own role in overdose prevention. In terms of emer-

gencies, fatal overdose prevention is based on the territorial network of emergency rooms, harm reduction services, outreach programs, drop in centers, and on THN itself. In the Italian model, the role of pharmacies is rather residual and secondary, partly due to the confrontational relationship between pharmacists and drug users. Low-threshold services, on the other hand, are very efficient.

At the same time, in harm reduction contexts, the approach of "combined intervention" — where multiple services or interventions obtain better results when combining their efforts with respects to a stated objective — is not developed enough. In Italy, for example, we have not yet been able to set up drug consumption rooms, for purely ideological reasons. Practices of drug checking exist but remain infrequent. As a result, the crucial task of limiting fatal overdoses falls on the THN program alone.

In 2016, out of 104 harm reduction facilities accounted for as part of a national investigation, 57 distributed naloxone to consumers.<sup>5</sup> Between 2014 and 2015, there was a 6% increase in facilities making naloxone available. The total number of naloxone vials distributed every year is 15,000, an average of 272 per providing facility. Estimates from the same investigation say that one in five patients attending a harm reduction facility has received a vial of naloxone, and that one in 39 visits (which include counseling and guidance on multiple public health issues, referral to other services, distribution of sterile equipment and dropping off of used supplies, distribution of condoms, screenings, treatment, etc.) consists in handing out naloxone. Every 2.4 naloxone distributions, patients receive informational training on its proper use — a high figure if you consider that many clients have received and used naloxone for years, if not decades, and do not require training.

The number of distributed vials is decreasing: in 2005, 80 out of 100 clients received naloxone, while only 20 in 100 clients received naloxone in 2015. Health staff cite various reasons for this. Some are objective, like the decreasing number of opioid consumers, especially of injecting opioid users, among their facility's clients. They also cite the growing portion of long-time users who already have naloxone in their possession compared to the small percentage of new clients who use opioids. Other factors have more to do with shifting perceptions of risk: on the one hand, the clear decrease in deaths from opioid overdoses in Italy means that politicians and health administrations have paid less attention to this issue as compared to the '90s. On the other hand, new generations of poly-consumers, who make use of opioids (although not as their primary substance and not via

<sup>5</sup> Forum Droghe - CNCA (2016) *Harm reduction and limiting risk*, in DPA - Dipartimento Politiche Antidroga (2016), *Communication to the parliament on data related to drug addictions in Italy (2015 and first semester of 2016)*, in [www.politicheantidroga.gov.it](http://www.politicheantidroga.gov.it)

injections), perceive lower risks of overdose (rightly so in part, but only in part!). In any case — and on this point health staff and drug users agree — new trends in drug consumption and poly-consumption have brought new challenges to the THN model. Today, we are experimenting new modes of intervention that could adequately face risks resulting from new modes and cultures of drug consumption, such as the promotion of intranasal naloxone, along with adequate modes of communication and information.

## Strengths and setbacks

The factors of success of the Italian THN model reside in the capacity of healthcare professionals and harm reduction networks to intervene. They have been able to couple naloxone distribution with information and training sessions (whether individual or in groups) on proper uses, thereby setting up an effective system of both social networking and social learning: according to research, for example, THN has clearly led to more saved lives through the intervention of fellow users, but also to a higher awareness of risks and better prevention skills among populations that received training and information. This is interesting because it rebuts criticisms of THN in the literature,<sup>6</sup> according to which possession of self-regulated lifesaving medication might lead users to incur higher risk. This is incorrect: on the contrary, the most savvy users, who carry naloxone with them and have used it most often, are also those who pay closest attention to harm and risk reduction behaviors — and not only with respect to overdose.

A second factor of success is that THN intrinsically builds up empowerment: it values and particularly invests in drug users' social networks, skills, and capacities. This creates strong alliances between health workers and drug users as they work towards a common goal. Research states that in 75% of cases, successful rescue happens at the hands of a fellow drug user. This figures shows the crucial importance of drug user networks. The majority of interviewed health professionals confirm that the close presence of another user in possession of naloxone is a predictor of positive outcomes, more so than the close presence of an efficient service of emergency professional intervention.

A third factor is naloxone availability over the counter. Evidently, free access to a medication is a fundamental prerequisite for its diffusion and for extending its use to drug users, regular citizens, and close relations. Along with this norm, which makes it possible for anyone to administer naloxone whenever they witness a life-threat-

ening situation, the Italian legal system does not penalize interventions in situations of emergency, and in fact sanctions whoever fails to intervene to save a life when they have the possibility to do so.

The fourth factor is the drug itself: it is a safe product, with no adverse side effects. Following simple application instructions when using naloxone prevents risks of opioid relapse — and the resulting risk of another overdose — after an intervention. 70% of interviewed users have shown that they are familiar with these instructions.

Last but not least is the cost: in Italy, naloxone is relatively inexpensive. For regular clients, the medication costs an average of €4.2. At hospital pharmacies — which supply harm reduction services — it costs around €2. Economic arguments have no traction whatsoever in limiting or ruling out this type of intervention. A remarkable advantage of the Italian model is that it distributes naloxone to drug users free of charge.

Since THN depends on the Italian system of harm reduction services, these programs also display the same kinds of limitations. Harm reduction services are unevenly distributed throughout the national territory, because political support for harm reduction has been and remains weak today (for ideological reasons). The national drug plan does not involve harm reduction as a major tenet of national policy, and as a result there are no guidelines in this area. Therefore, until 2017, all drug addiction has been the purview of regional administrations, which can make independent decisions and regulate all matters of public health (save for a few binding national regulations). This has resulted in a highly uneven geographical distribution of services: four out of 20 regions offer no harm reduction programs or services; two regions have never disclosed data on this topic; only six regions feature stable harm reduction systems; and the other regions have intermittent and erratic systems of harm reduction (according to data from 2015<sup>7</sup>). Further, less than a third of facilities have secured their continued existence, while most facilities have secured funding for only one to two years (22% for two years and 11% for less than one year). Starting in 2017, however, we are looking at some changes: some harm reduction programs have entered the Livelli Essenziali di Assistenza (LEA), which means that all regions are required to offer these services. This represents a great step forward for the harm reduction movement. In the coming months, we have to implement this political measure more concretely. THN will be included among basic harm reduction services that should be available to all Italian citizens in all regions. This should lead to a significant improvement in prevention policies against fatal overdoses.

<sup>6</sup> Bazazi A.R., Zaller N.D., Fu J.J., Rich J.D. (2010). Preventing Opioid Overdose Deaths: Examining Objections to Take-Home Naloxone in <http://muse.jhu.edu/article/400754>

<sup>7</sup> Forum Droghe - CNCA (2016), cit



## THN abroad?

Our THN program could be developed in any context. We are circulating information and expertise concerning our model precisely so that we can lend concrete aid to the global campaign for THN. I think that in some situations it will be necessary to reclassify the drug: there is now ample evidence justifying an over-the-counter status for naloxone.

It is important to look at regions' cultural context, paradigm of drug use, and local perspective on drug users. We must adopt harm reduction approaches as a way to "learn to see" and to value various social skills, and to focus on drug users as resources to promote public health. Finally, we must integrate drug policy into the paradigm of health promotion and extract it from the defunct dichotomy of the deviance paradigm and of the mainstream literature of drug use as a brain disease, which would only confine us to an ossified version of biological determinism.

In the concluding chapter of our investigation on THN in Italy, using the perspectives of both health workers and drug users, we draw useful conclusions on the strengths and weaknesses of our mode of operation. From these observations, we issued recommendations for good THN practices in three different areas: concrete application, research, and politics.

The gist of it is: we must invest in skills and in networks of drug users; we must invest in the harm reduction apparatus and in the skills of health workers; and we must aim for a profitable alliance between them. We must trust in drug users' capacity to self-regulate and to learn. We must build an environment (in terms of social norms and in terms of public health welfare) that recognizes and values drug users. We must set up services and programs that facilitate users' growth and responsibility. No one adopts responsible behaviors if they are not free to do so or if they do not feel recognized as a citizen of their community. That is why excessive formal and external regulations (punitive measures, repression, stigma) weaken and actively hinder self-regulation practices. In a world where, whether we like it or not, drug use has been normalized to the point where it is compatible — in most cases — with social life, self-regulation and drug education are the most concrete, plausible, and sustainable ways to manage the phenomenon. Without the skills and involvement of drug users, there is no future.





# Progressive harm reduction initiatives in Catalonia

**Joan Colom Farran** / MD, director of the program for prevention, control and treatment of HIV, STIs and Viral Hepatitis and director of the substance abuse program at the public health agency of Catalonia

*In comparison with other Spanish regions, Catalonia became a leader in harm reduction initiatives by radically widening access to substitution treatment and implementing initiatives like naloxone, DCRs, and syringe exchange programs.*

## Catalonia and methadone: “a system that works”

Spain — Catalonia in particular — has a long tradition of substitution treatments. At the end of the 1970s, legislation in Spain provided a framework for substitution treatments. Patients needed special documentation approved by a health inspector in order to access methadone medication.

In 1985, Catalonia introduced new legislation to transform the context of access to methadone. In the mid-’80s, Spain passed very restrictive legislation that limited access to methadone substitution treatment. However, Catalonia managed to open up these policies. Methadone treatment became free, public, and very easy to access. With no other explanation than an addiction to opioid, patients can enter into a substitution program and access methadone. All they have to say to their physician is: “I’m interested in entering a program of substance abuse treatment.” If such a program is not incompatible with the patient’s health status, the doctor will immediately initiate the patient’s substitution program. This has been the case since the 1980s.

In the beginning, security was a major concern. As a result, in the early 1980s, the majority of centers that played a role in methadone distribution featured heavy

security systems, and came to resemble banks rather than health centers. After the ’80s these centers tried to foster a more welcoming environment and to feature more friendly access to the centers for its visitors.

Methadone is distributed in outpatient centers, hospitals, pharmacies and prisons. In Catalonia, we also have mobile units, or buses that work as distribution centers for substitution treatment. Depending on the patient, they can be entrusted with multiple days’ worth of medication — up to one month.

Methadone treatment is also available in prisons. In Catalonia, we adhere to the principle of equal access in prison settings. For obvious reasons, prison inmates must take their substitution medication in front of professionals to avoid smuggling or the creation of a black market. There is no black market in free society because access to methadone is easy and free. Obviously, some patients acquire products for other people, but in general, access to free methadone really makes a black market meaningless.

In the last decade, treatment substitution in Spain has also included buprenorphine, and in some cases, patients have started to include buprenorphine in substitution treatments. The majority of patients, however, still use methadone. In this way, Spain is quite different from

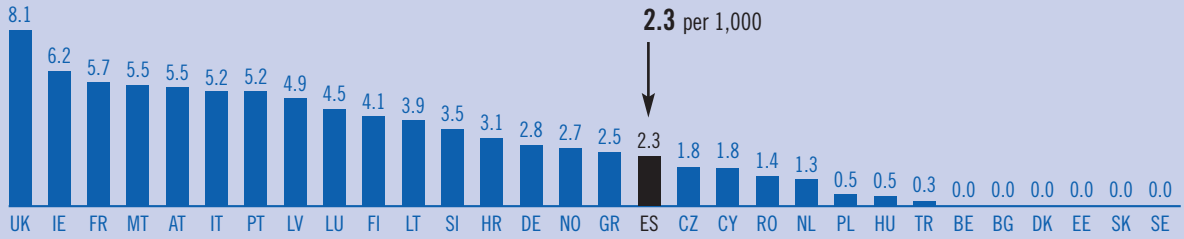


### Spain at a glance

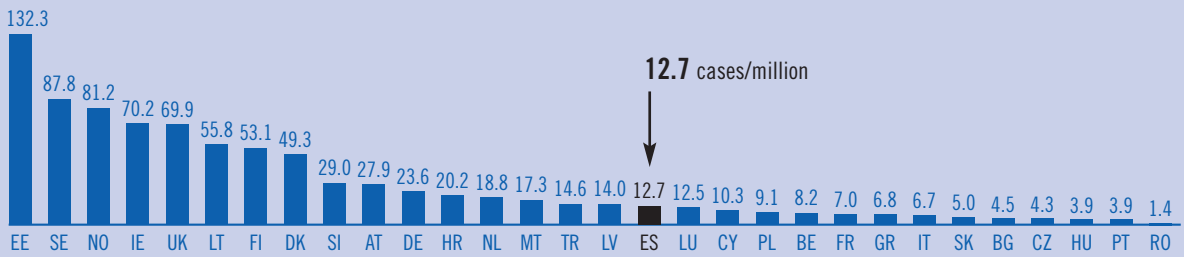
70,471 (48,102 – 92,840) High-risk opioid users

59,264 Opioid substitution treatment clients

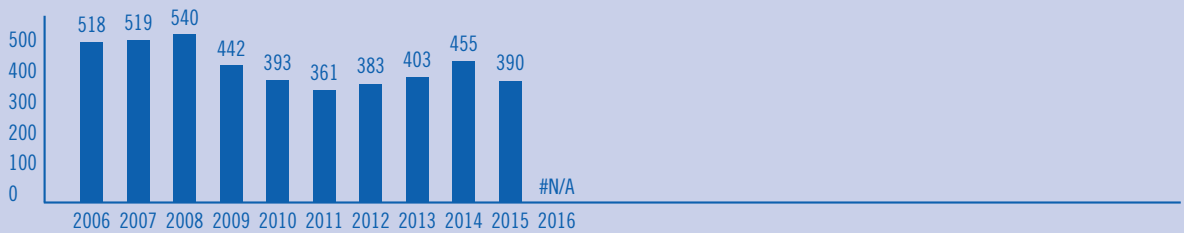
#### Opioids / High-risk opioid use (rate/1,000)



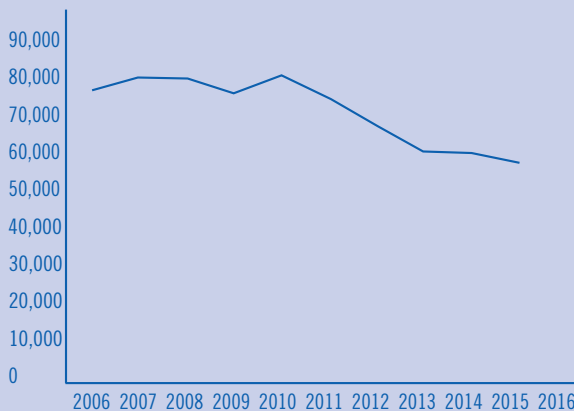
#### Drug-induced mortality rates / National estimates among adults (15–64)



#### Trends in the number of drug-related deaths

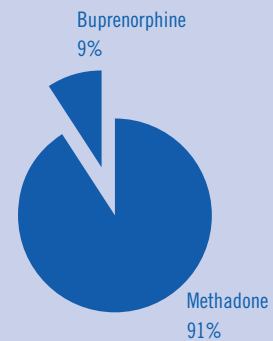


#### Trends in the number of clients in OST



#### Which substitution?

Methadone 54,110  
Buprenorphine 5,154



Source: adapted from EMCDDA, Country Drug Report, 2018, [www.emcdda.europa.eu/edr2018](http://www.emcdda.europa.eu/edr2018)

## Spain: introduction dates

Methadone	1990
Buprenorphine	1996
Heroin-assisted treatment	2003
OST in prison	1998

Source: EMCDDA, Statistical Bulletin, 2018, [www.emcdda.europa.eu/data/stats2018/hsr](http://www.emcdda.europa.eu/data/stats2018/hsr)

France. Substitution treatment became available in Spain quite a bit earlier than in France (1990). In its early days, only oral methadone was available. Because methadone was introduced earlier, it became part of the way a lot of structures (clinics, hospitals, health centers, pharmacies, and others) function. Doctors and patients were already used to methadone. This has made methadone difficult to replace. It is part of a system that works and therefore resists change.

The main obstacle to buprenorphine, though, is price. Buprenorphine is expensive, and it is not fully covered by social security. It is only reimbursed for patients who have very little economic resources. Other patients pay for parts of their treatment as they would for treatment of other chronic diseases like diabetes or hypertension. Methadone, on the other hand, is always free.

There are no legal limits on the duration of substitution treatment — it depends on the evolution of the patient. Some patients continue treatment for five years, others for 10 years; others stop after just one year. There is no rule. In the previous treatment model, outpatient centers aimed for abstinence. Now, patients have a choice to continue or drop their treatment at whatever point. A lot of people in old age have received treatment for a significant portion of their lifetime, much like diabetic patients have taken insulin for most of their life.

### Harm reduction in Catalonia

People predicted that methadone treatments would increase the incidence of overdose, but this has not happened. We have seen a significant decrease in deaths from overdoses in Catalonia for the last 30 to 40 years. In 1992, 160 people died from overdoses. Last year, only 48 did. This is probably also due to Catalonia's important harm reduction initiatives like naloxone distribution and overdose training programs. In 2017, we reversed 119 overdoses in drug consumption rooms.

Our other harm reduction initiatives include low-threshold centers, drop-in centers, social care, counseling,

access to HIV and HCV treatments, needle exchange programs, and training in more hygienic consumption and safer sex, among other programs. We have expanded access to all treatments as widely as we can. We are the only region where people have access to healthcare very easily without needing documentation or a home address. We recognize the importance of drug user organizations and support groups as well in providing assistance to fellow drug users.

We also have an action plan in trafficking and consumption areas. We know of 14 areas where people inject drugs very actively.

The first drug consumption room opened in Spain in 2001. This was a difficult task, because there is a lot of hypocrisy around programs like these. We had to fight against a deeply stigmatized view of people who take drugs. We were also confronted with instances of the NIMBY effect, where people think DCRs are great and have witnessed their positive outcome, but refuse to host one in their neighborhood. Today, however, we count up to 100,000 uses/year in all of our drug consumption rooms.

### Curbing overdose incidence

There are two situations in which we use naloxone in Catalonia: in conjunction with buprenorphine and as a treatment for opioid overdose. Catalonia features a unique program of overdose prevention through naloxone. We have trained a lot of people in the prevention of overdose. As of now, 7,000 users and 1,500 professionals have received training in overdose prevention.

Someone who is trained in overdose prevention will have learned to easily recognize behavior that increases risks of overdose. In this case, we train people to say “be careful, you are in a critical situation; if you take some drugs now, you will potentially have an overdose.” This is the initial prevention.

Trainees also learn to take care of someone who shows symptoms of overdose. For example, they know to safely position their body and to call emergency services.

Finally, trainees can use the naloxone kits we distribute. These contain a dose of naloxone, water, syringes, gloves, wipes, and a mask for mouth-to-mouth intervention. They also include lots of informational and educational material. We have distributed 8,700 naloxone kits in the last seven years. This is an unusual program that does not exist in the rest of Spain.

### Looking ahead

Although we do not currently offer slow-release medication, there are ongoing studies looking into different options, such as slow-release forms of methadone or



buprenorphine like patches. Some are also working on slow-release diacetylmorphine. We also would like to use oral forms of heroin for patients who are not receptive to methadone or buprenorphine.

We provide over 750,000 syringes every year to injecting drug users through our syringe exchange program, but we are hoping to distribute a lot more in the future. We would like to grow our already successful naloxone program.

In the case of methadone, we have been successful in creating a system that works, in which patients have easy access to the treatment they need. There is not even a waitlist for methadone treatment. What we need to do is to provide people who used drugs with a viable path towards reintegrating their communities, organizing their spare time, and finding work. We need reintegration programs for these patients.

We continue to remain vigilant about new drug forms. We have workers monitoring what kinds of drugs circulate on the street. We obtain samples of each new drug that hits the streets, like synthetic drugs, opioid and cannabinoids. We analyze them in laboratories and if they are new, we declare them to the EMCDDA.

At this point, we have to worry not only about drug dealers, but also about new modes of distribution. Today, bath salts labeled “dangerous for human consumption” can arrive in an envelope at your house, but this does not prevent people from using them as drugs.

Our most important work in the future is to place the people (rather than substances) at the center of our concerns. We have to keep communicating to the general population, to politicians, and to decision makers the idea that drug addiction is a chronic disease much like diabetes, and that it requires a similar long-term health-care response.



# An overview of harm reduction services in Portugal

Luis Patricio / Psychiatrist

*Recent changes have occurred in Portugal in the fields of drug demand reduction as well as addiction treatment and recovery. As a clinician and long-time actor in the field of health and medicine, I share my views of these transformations here in the most honest and objective way possible.*

## The slow birth of treatment centers

*Luis Patricio, MD, is a consultant psychiatrist at the Health Ministry. He is responsible for the clinical application of LAAM, naltrexone pills, buprenorphine, and buprenorphine + naloxone in Portugal, and proposed the resolutions for the Harm Reduction Law of 2001. He directs the Addiction and Dual Diagnostic Clinic at Casa de Saúde de Carmaxide in Portugal.*

Since the seventies, the so-called “contemporary” drug issue has been a visible and a growing social reality in Portugal. People who depend on illegal drugs have not been well integrated in the general health system or in more standard mental health facilities.

The first addiction treatment in Portugal came about in 1973. Cordeiro, a psychiatrist travelling from Switzerland, created the Consultation for Adolescents & Addiction, which was implemented at the psychiatric service of the Lisbon Medical School at the Hospital Santa Maria.

Only in 1977 did the government respond with actions for drug prevention and treatment. Under the leadership of the justice ministry, three facilities opened in Portugal’s three largest cities. Before 1986, three NGOs had emerged offering three models of treatment in residential settings.

In 1987, there was significant change in government. An inter-ministerial project was created to respond to the issue of drugs. This project included the Health Ministry’s commitment to conducting interviews in the field of drug addiction therapy. Lisbon’s Taipas Center, with its eight branches, became the first and largest pilot center. Initially, the center received a hundred new patients monthly, for the most part heroin addicts requiring treatment. The Health Ministry continued to open treatment centers throughout the country.

In 1992, at the International Taipas Meeting, health professionals from 20 countries officially recognized people who depend on drugs as patients. In 1993, social workers operating in the streets of Coimbra began a new syringe and needle exchange initiative, in collaboration with local actors and politicians.

From 1994 to 2000, the Health Ministry continued to create services for people who depend on drugs, covering the main cities and towns of mainland Portugal and increasing access to high-threshold opioid maintenance treatment. Methadone was also made available in pharmacies and from NGOs that registered with the Ministry of Health. In 1999, another significant change occurred in the drug quarters of several cities, starting with Lisbon’s largest drug market. These neighborhoods drastically increased pragmatic social and public health interventions. Since then, local politicians have increased low-threshold programs throughout the country.

In 2000, the Health Ministry’s public healthcare network covered all districts of continental Portugal, and added up to 40 centers, plus hundreds of beds managed by NGO communities. Thousands of heroin addicts, mostly from major cities, received treatment.

Portugal approached the issue of drugs from the point of view of demand reduction. It increased access to treating facilities for people who depend on drugs and facilitated



## Portugal: introduction dates

Methadone	1977
Buprenorphine	1999
Heroin-assisted treatment	N/A
OST in prison	1999

Source: EMCDDA, Statistical Bulletin, 2018, [www.emcdda.europa.eu/data/stats2018/hsr](http://www.emcdda.europa.eu/data/stats2018/hsr)

interventions, especially for problematic uses of heroin. It is important to note that heroin addiction was the main cause of referral to drug services in Portugal.

In 2000, Portugal's socio-political climate became supportive enough to carry the harm reduction law and the law of decriminalization of consumption. Both laws were passed in 2001. From 2000 to 2005 (after a period of stagnation in the area of harm reduction), harm reduction and treatment programs, including increased opportunities to enter into methadone treatments and additional spots in therapeutic communities, have continued to expand throughout the country.

This phenomenon led to positive outcomes: it significantly decreased HIV prevalence among addicts and lowered mortality from heroin overdose. We have also observed a stabilizing trend in heroin consumption. This was a positive consequence of several years of hard work and intensive investment in health and social projects for patients living with drug use disorders.

In any event, alcohol misuse was and still is the most significant and harmful addiction in Portuguese society, with alarming increases in abusive consumption in this century among adolescents and young adults. The rising consumption of cannabis, alcohol, cocaine, and synthetic drugs are quite worrisome.

From 1977 to 2007 several important pharmacological treatments have been made available in Portugal for heroin addiction:

- 1977- Methadone
- 1986 - Clonidine (withdrawal medication)
- 1987- Guanfacine (withdrawal medication)
- 1988 - Naltrexone (opioid inhibitor)
- 1989 - Tramadol (opioid painkiller)
- 1994/2000 - LAAM (Levo alfa acetyl methadol)
- 1995/1996 - Naltrexone pills
- 1999 - Buprenorphine
- 2007 - Buprenorphine + Naloxone.

## Drug demand, 2007-2017

In the field of drug demand, the idea that the 2001 Decriminalization Law had legalized personal consumption of illicit drugs has become relatively widespread. This is not true. For many, decriminalizing consumption amounted to legalizing it, and consumers were surprised when authorities confiscated their illegal substances. Nowadays, in reality, when the police catch an individual with illicit drugs, it is common for them to seize the drug; order consumers to destroy it; or turn a blind eye and allow consumption. Legally, in such cases, the consumer should be formally sent to one of eighteen nationwide commissions for dissuasion. This only happens quite rarely, however.

Consumption in public has markedly increased in the recreational context. In larger cities, we have observed adults' open scene (when people who use drugs do so in public spaces) drug abuse in the context of bars, where people used cocaine, freebase, alcohols, and synthetics. Public use is also evident in urban settings, from major cities to many villages. In open scenes on the street, young people and adolescents abuse alcohol, cannabis, and synthetics.

In some larger cities it's possible to observe drug spaces with open scene abusive behavior, where users consume heroin, cocaine, freebase, cannabis, synthetics, benzodiazepine (bzip), methadone, buprenorphine, and alcohol. These substances can be ordered in several places or even delivered at home.

In some high schools, as well as in university settings, there is evident misuse of legal and illegal substances by students in open scene settings. In some schools and their surrounding areas, students frequently use cannabis. Consumption by teachers is not uncommon.

In small or large music festivals and events, whether indoors or outdoors, legal substance abuse and so-called recreational consumption of illegal drugs are a reality throughout the year. In those places, harm reduction intervention teams are rarely present.

Evident consumption of illegal drugs is also present in prison settings.

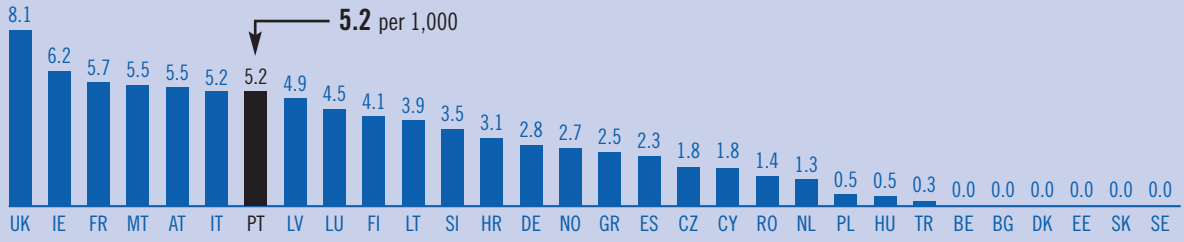
The presence of "Smart Shop" retail establishments has legally increased offers of synthetic drugs in Portugal since 2010, despite the EMCDDA's May 2010 announcement in Lisbon of a ban or control of various substances in several EU countries. In Portugal, some drugs were outlawed in 2013, but it is possible to purchase them in the "right" places in cities or online. Damages from smart drugs often come as a surprise to unprepared professionals.

### Portugal at a glance

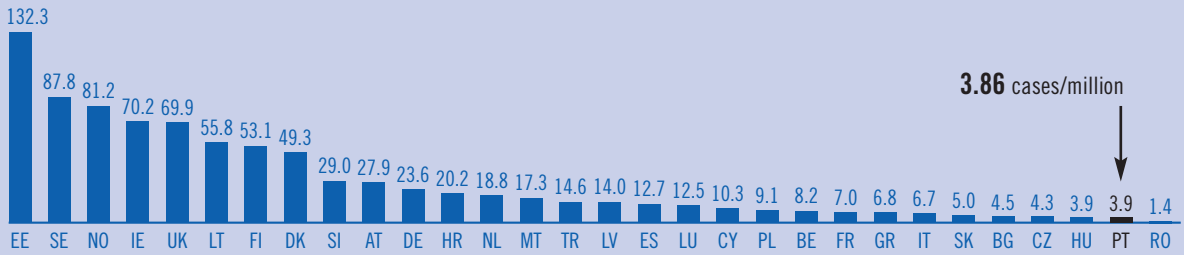
**33,290** (24,070 – 48,565) **High-risk opioid users**

**16,368** **Opioid substitution treatment clients**

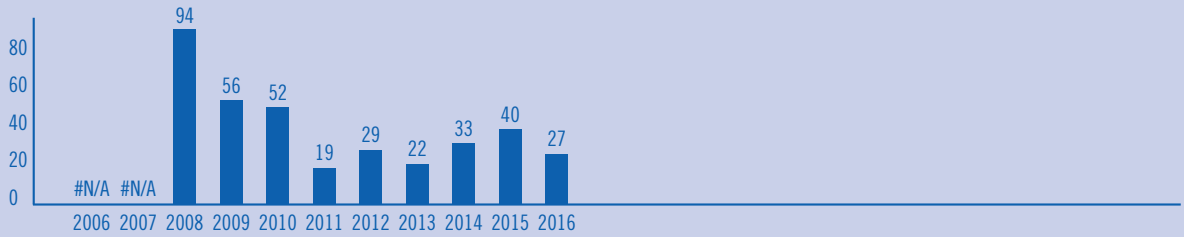
#### Opioids / High-risk opioid use (rate/1,000)



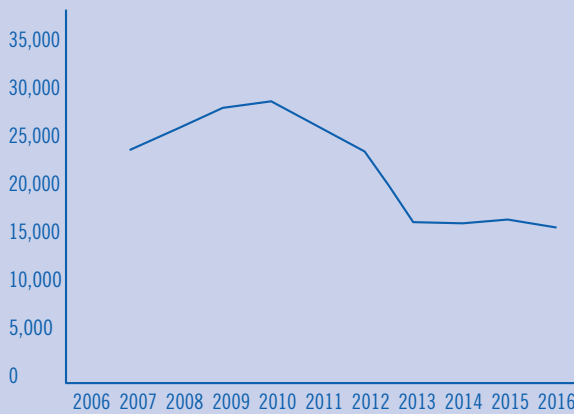
#### Drug-induced mortality rates / National estimates among adults (15–64)



#### Trends in the number of drug-related deaths

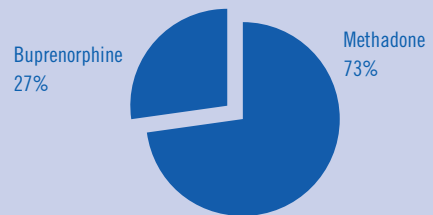


#### Trends in the number of clients in OST



#### Which substitution?

Methadone 11,371  
Buprenorphine 4,127



Source: adapted from EMCDDA, Country Drug Report, 2018, [www.emcdda.europa.eu/edr2018](http://www.emcdda.europa.eu/edr2018)

## Outcomes and varying qualities of response

We have observed a disparity in the quality of outpatient treatment facilities, which is a consequence of the large-scale and quickly evolving nature of the Health Ministry's network — comprising both harm reduction programs and NGO therapeutic facilities.

It is necessary to solve the issue of unprepared, insufficiently knowledgeable treatment teams that fail to connect and communicate with local health structures. We must bridge the gaps in medical treatment in therapeutic communities. It is necessary to reinforce knowledge in harm reduction teams that are insufficiently trained or unprepared to motivate patients.

The well-known context of the economic crisis, together with the lesser-known context of the technical crisis, allows us to understand the decreased relationship of treatment between patient and general practitioner or psychiatrist, and the important reduction in the number of MDs who are qualified to treat addictive pathologies. It is necessary to overcome the following difficulties in harm reduction policies:

- Existing syringe exchange programs have been reduced; there are no existing syringe exchange programs that function every day in consumer districts; in some neighborhoods of consumption, there has never been a syringe exchange program; syringe distributors that function 24hrs/day do not exist in Portugal. In Portuguese prisons, there are no needle exchange programs and syringes for single use have never been implemented.
- Injectable naloxone kits have not been distributed anywhere.
- Shooting galleries, open scenes for injectable drugs (traditional heroin, cocaine, midazolam in the form of crushed tablets either for heroin and freebase/crack cocaine smoking) have become commonplace again.
- Although the 2001 Law on Harm Reduction allowed for the existence of drug consumption rooms, not a single room has opened in Portugal as of 2018.
- Harm reduction programs must not be funded according to a financial model based on the number of patients taken in, but rather based on outcomes of treatment programs.
- Harm reduction programs must be improved to avoid simultaneous poly-consumption, double interventions in various programs, lack of integration of information systems, and misuse or misappropriation of prescribed medication.
- There is also a rise in risky behavior, particularly associated with alcohol (including regular occurrences of alcohol-induced comas in adolescents) and consumption of unknown substances.

- Saliva alcohol testing was never implemented.
- Programs to test drugs in recreational contexts are very scarce, despite an evident, widespread, and generalized consumption increase.

It is necessary to overcome the following difficulties in opioid treatments:

- The existence of unequal therapeutic responses, especially for opioid treatments, and the frequent practice of prescribing sub-therapeutic doses as well as engaging in other specific medical practices without prior training, is confirmed in the low rate of successful treatment.
- Many patients who are prescribed too little methadone engage in significant abuse of alcohol and cocaine.
- There is an increased misuse and diversion of prescribed medication and simultaneous consumption of other drugs.
- For far too long, take-home doses without safety guarantees have increased risk, including lack of quality of methadone bottles with significant drug losses.
- Long waiting lists for high-threshold methadone treatment cause patients to access methadone from low-threshold harm reduction programs.
- And again, waiting lists for high-threshold methadone treatment, including in prisons, have emerged.

## Other characteristics

Methadone requires mandatory prescription from a Health Ministry Centre. Initially, it is delivered to the patient in face-to-face encounters, which can evolve into Take Home supplies for one or two weeks. Methadone must be provided in addiction services of the Health Ministry, in pharmacies or NGOs registered with the Health Ministry's services. There is no methadone in private and public hospitals, where methadone treatments cannot be initiated. If a patient requires methadone in an emergency context at a hospital, the substance will hopefully be provided by the addiction service in that area. For obvious reasons, this is not at all a convenient setup. Buprenorphine and buprenorphine + naloxone require medical prescriptions. Any MD can prescribe this medication, which patients then purchase in pharmacies at a cost partially subsidized by the national health service. Injectable naloxone continues to be restricted to health services. Naloxone spray is not yet available. Naltrexone and Tramadol require prescriptions. Any MD can prescribe them, and they can be purchased from pharmacies at a cost partially subsidized by the National Health Service.

In Portugal's continental districts, asymmetries in responses to treatment are greatest between coastal and inland regions. In the Autonomous Region of Madeira



there is also a lack of doctors intervening in addictive services. In the Autonomous Region of the Azores there are also asymmetries in therapeutic responses and harm reduction services between the nine islands.

professionals who accepted training have shared their knowledge of updated best practices.

We need to increase skills to assist patients in achieving health and managing their autonomy.

## Comorbidity

Many addiction services are still lacking the expertise to treat comorbid conditions, seeking to focus solely on treating the prevailing addiction. Some addiction teams face significant difficulties when taking in cocaine- and alcohol-dependent patients, as well as consumers of synthetics and social addictions.

In addition to underprepared human resources, there are difficult circumstances that have not improved, such as unequal access to treatment facilities, stigma, distance, mobility, economic difficulties for transportation and access to medication, unequal quality of treatment, and lack of funds to implement reintegration projects.

Paradoxically, some of the most obviously alarming situations of alcohol abuse as well as heroin and cocaine consumption or open scene drug use have occurred in Lisbon, less than four kilometers from the headquarters of the Ministry of Health and EMCDDA, for more than ten years. We have undergone a lot of important developments, especially in our understanding of the conditions of dependence, as well as in the pharmacological and social treatment of people who depend on drugs. Despite heavy investment in Portugal, some strategies have not been fruitful. Inadequate practices in methadone maintenance programs have remained the same, and some residential programs go on without adequate technical support.

The 2001 Portuguese harm reduction law has not been fully implemented: for example, until now, no drug consumption rooms (whether fixed or mobile) have opened. We have also noticed that testing practices are only now emerging despite the massive rise in consumption. Regarding the quality of opioid treatment in Portugal, it is unacceptable that there are waiting lists for admission to high-threshold methadone treatment programs, with some patients receiving methadone from low-threshold programs for years.

Sub-optimal dosing in methadone or buprenorphine treatments is also noteworthy, considering the training provided to the entire country, continent and islands, by the international Quality Patient Care Network program. This QPCN program provided training to 25 MD Portuguese trainers, for all 18 districts of Portugal (mainland and islands). In the islands all educators passed along their acquired knowledge. In the continent, only half of the educators shared their training. Perhaps the stigma that still plagues opioid treatments helps to understand that not all



# Leaders in heroin-assisted treatment

**Frank Zobel** / Assistant director of Addiction Suisse

**Barbara Broers** / Chief of the Addiction Unit at the Hôpitaux Universitaires de Genève

Both are members of the Federal Commission for Addiction Issues (CFLA)

*Switzerland has been a leader in the accessibility and range of its opioid substitution treatment program, particularly in the scale of heroin-assisted treatments. As the generation of doctors prescribing these treatments retires, it is more important than ever to normalize heroin-assisted treatments.*

## A progressive stance

In Switzerland, federal regulations on narcotics (LStup) constitute the legislative basis for Opioid Substitution Treatments (OST). The third article of LStup specifies that OSTs must be authorized by individual cantons. One exception is the prescription of heroin, which requires federal authorization, as well as specific conditions of access and distribution (it can only be distributed in specialized clinics). The government directive on narcotics addiction (OASup) defines — rather broadly — the objectives of OST.

Nationwide recommendations, published and periodically updated by the Swiss Society of Addiction Doctors (SSAM), provide the framework for OST distribution. Treatments (including heroin prescriptions) are covered by basic mandatory social security plans.

OST has been available in Switzerland since the mid-1970s. In the beginning, OSTs were made available with an objective of abstinence and with a high threshold of accessibility. After the heroin crisis and the spread of HIV/AIDS, the government reviewed its directives. At the end of the 1980s, OSTs became the first choice treatment for drug use disorders, with an aim towards harm reduction. In 1987,

1,800 drug users had received OSTs. Four years later, that figure was nearly 11,000. The number of beneficiaries continued to rise before stabilizing at the end of the 1990s. In the course of 2016, some 17,700 patients received standard forms of OST and 1,750 more had access to heroin prescriptions. Switzerland is the only country that has developed heroin-assisted treatment on such a large scale. In the international as well as European contexts, we can say that Switzerland largely encourages OST with a primary concern of harm reduction. Some professionals complain about certain restrictions that limit treatment programs, but by and large the system seems to function rather well.

Switzerland is engaged in a wide variety of practices in the field of OST. These range from methadone (prescribed by general practitioners and distributed in pharmacies) to more complete treatments offered in specialized addiction centers, which prescribe and provide diacetylmorphine on site. In prison settings, inmates can enter or continue standard OST programs. One Swiss prison features a special medical unit that can prescribe diacetylmorphine.

## General practitioners at the forefront

General practitioners have always played a central role in the configuration of OST. Doctors set up the majority of treatments. Typically, GPs take a limited number of patients in need of OST (10 at most, depending on recommendations). Some doctors in large cities have specialized in drug addiction treatment and see numerous patients, but it is difficult to estimate what portion of these patients receives OSTs.

Doctors must disclose all OST prescriptions (such as long-term benzodiazepine prescriptions) to the public health official of their canton (médecin cantonal) so as to avoid repeat prescriptions. Some cantons train doctors specifically for addiction treatment, but for now such training is not mandatory for the prescription of OSTs.

Addiction centers and clinics, both public and private, encourage general practitioners to prescribe OST. These centers usually take in the most difficult patients, or patients who are going through OST for the first time. However, such centers do not exist in all regions, and networks of addiction doctors (COROMA, FOSUMOS, FOSUMIS) can complement them or replace them altogether. These networks were created in various Swiss regions to offer assistance to doctors prescribing OST. The Swiss Society of Addiction Doctors (SSAM) also issues recommendations regarding OST and develops training programs and continuing education for doctors in that domain.

The practice of OST has also spread to centers for residential treatment that had traditionally focused on abstinence. There are still exceptions to this trend.

Methadone was first authorized for OST in the 1970s. Today, it remains the most used substance. In 2012, we estimated that about 85% of OSTs (outside of heroin) mostly made use of methadone. High dosage buprenorphine is authorized and covered by social security since 2001. However, it has failed to replace methadone, never reaching 10% of prescriptions. Other substances, such as codeine and oxycodone, have also been used. A few years ago, authorities approved a new form of delayed morphine (Sevrelong®) for OST. Doctors often prescribe this substance when they find contraindications to methadone. Suboxone (buprenorphine + naloxone) was only very recently authorized.

As we already mentioned, diacetylmorphine (heroin) involves specific regulations. Specialists intend it for patients for whom other OSTs have not had the desired effects. It was introduced for the first time in 1994 and fully institutionalized in 2011. Heroin prescriptions represent about 9% of OSTs.

popular sentiment that methadone yields better results. Both doctors and patients seem to prefer methadone.

## Distribution and duration

Most general practitioners work in partnership with pharmacies for OST distribution. Prescriptions are delivered on special forms (voucher pads). The pharmacy supplying the substitution substance must be registered with the canton's public health official. In clinics and specialized practices, doctors can supply the substance on site — though patients who live or work far away can still get the substance from a pharmacy. The frequency of refills depends on the medico-psycho-social condition of the patient, and most often varies between once a day (especially at the beginning of the treatment) and once a week. Sometimes patients can get a special refill for three to four weeks for vacation.

In general, doctors act according to the patient's wishes, but there is no imposed minimal or maximal treatment duration. The SSAM's recommendations show that Swiss doctors usually think of OST as a long-term treatment. Most OST patients in Switzerland have received their treatment for a significant amount of time. There are relatively few requests for new treatments.

Sometimes, patients ask for a progressive cessation of their treatment. The SSAM recommends taking such requests seriously and seeking to find out the patient's motives in making that request — especially considering risks of relapse and overdose. The SSAM advises great caution, and if needed, a very slow tapering of the prescribed substance. Doctors should regularly discuss advantages and disadvantages of OST with their patients.

## OST Misuses and Challenges in Switzerland

A recent study on opioid markets in the Vaud Canton<sup>1</sup> showed that there exists a small market among drug users for substitution substances, but that it looks nothing like an organized traffic network. The issue of substance misappropriation has been discussed, notably in the media, but it has not been a pressing issue for the last several years. Since there is no waitlist for OSTs in Switzerland and treatment is covered by social security, there is little demand for these substances on the black market.

The misappropriation of benzodiazepine, and particularly of midazolam (Dormicum®), which is mixed with heroin, is a recurring issue, especially in French-speaking areas of the country. Cantons have taken prevention measures to limit mis-prescriptions.

Due to Switzerland's federal structure, and to the fact that each canton uses its own investigation and record-

<sup>1</sup> [www.addictionsuisse.ch/fileadmin/user\\_upload/Rapport\\_MARSTUP\\_1.pdf](http://www.addictionsuisse.ch/fileadmin/user_upload/Rapport_MARSTUP_1.pdf) As for other European countries, the limited use of buprenorphine for OSTs is probably due to a



ing practices, we have poor visibility on overdoses and their causes. The number of drug-related deaths, the majority of which we think are caused by opioids, has remained stable from 2010 to 2015 at about 130/year. This figure is often compared to the 300-350 deaths/year recorded in the mid-1990s.

Switzerland has a lot of experience with OSTs and harm reduction in general. In the international context, it is one of the countries — perhaps the country — that has developed the most important line of treatment offered in that domain. That does not mean that some constraints, notably regarding heroin prescriptions, could not be reduced. The exceptional status of heroin treatment does not have the same justification it had 20 years ago. A sort of “normalization” of OST, through lower constraints and softer regulations, can still be undertaken.

One of the future challenges of OSTs in Switzerland could be the renewal of doctors who prescribe them. Indeed, the generation of doctors who take care of most OST patients is in the course of retiring. The social and sanitary importance of this issue is largely inferior than it was 30 years ago, and as the issue has ebbed, so has doctors’ interest for OSTs.

## SWITZERLAND



# Trampoline: reimagining a relationship to beer and alcohol consumption

Cédric Fazan / Director of the Tremplin Foundation

*A low threshold drop-in center in Switzerland works to change the way its visitors, often polydependent users, consume beer — first by changing its own regulations on alcohol consumption, and then by involving visitors in creating a brew that resembles them.*

Can we offer innovative services that reflect the realities of psychotropic drug use, while reducing harm and encouraging civic engagement from those most socially at risk? For a long time now, this challenge has driven our work. In response, we have attempted to engage in an original and disruptive course of action.

For two years now, people who depend on drugs in situations of social and economic poverty have been able to purchase beer at the Seuil, our low-threshold drop-in center. Better yet (or worse, depending on opinions), our beer is tailored specifically to the center's visitors, who have brewed it themselves since May of 2017 at a local brewery.

<sup>1</sup> We counted three outraged reactions in the local press: two because we produced a toxic substance and one decriing our use of public funds.

<sup>2</sup> [www.tremplin.ch](http://www.tremplin.ch)

<sup>3</sup> For all these steps, a team of the Chaire de Travail Social of the Freiburg University provided assessments. The project has developed over three years.

<sup>4</sup> Federal regulations on narcotics allow, among other things, the use of safe consumption spaces. Implementation of such spaces is usually subject to cantonal approval. Thus, Freiburg is one of the cantons that does not allow this practice. Our project has therefore focused on social harm reduction.

As this harm reduction and civic engagement project circulated in the media, it attracted quite a bit of attention. The reactions of detractors (in the minority, thankfully<sup>1</sup>) were as violent as those of advocates were enthusiastic and encouraging. The Tremplin Foundation<sup>2</sup> seeks rehabilitation and socio-professional reintegration for people who depend on drugs in situation of economic and social distress. One may wonder, then, why Tremplin started to produce the very substance that marginalizes its beneficiaries. Better still, how did Tremplin

justify encouraging poly-drug users to brew their own beer?

In an attempt to answer this question, which seems legitimate at first sight, and in order to grasp the issues behind what some have called a “red line,” we have to go back to the project's genesis.<sup>3</sup>

## The problem of alcohol at the “Seuil”

It all began in 2013. Our Foundation includes six units, all dedicated to rehabilitation and socio-professional reintegration. One of these is the low-threshold drop-in center “Au Seuil,” which seeks to create and strengthen social networks and harm reduction for legal and illegal narcotic use.<sup>4</sup> For thirty years, the norm had been to ban drinking and allow smoking inside the drop-in center. And yet, the Center is a public institution that should follow cantonal legislation. If banning tobacco is no longer a matter of public debate in Switzerland, drop-in centers continue to be an exception, a kind of privileged space where the law does not apply. This state of affairs was probably due in part to our express wish to welcome polydependent visitors (our most at-risk beneficiaries), the majority of whom smoke.

But there is another reason that remained unexamined: our desire to keep peace in the center by avoiding brawls,



which were triggered, according to our calculations, mostly by alcohol. Things always went as expected: users who brought alcohol were temporarily excluded from the center (before they could cause any trouble), brawls regularly took place outside, and heroin smokers occupied the rare bathrooms... all of which triggered scuffles inside the center among users who had already had several pints of beer outside. A deliciously puzzling situation. Stuck between our non-exclusionary values and the tough realities of our visitors' conditions, the new administration opted to reverse the rules.

It is true that our visitors are poly-users, sometimes in situations of great social and economic distress, and that some of them have developed rough defense mechanisms; but their substance use does not deprive them of their human and civic rights. On what grounds do we professionals decide for them what they should or should not be able to do? Our visitors rarely claim their rights, and when they do, they do so clumsily. Citizens also have duties, which we had decided not to ask visitors to perform.

As such, the Seuil's visitors had become "second-class citizens" and we only perpetuated that image through our professional practices. Worse even, our institution's beneficiaries had integrated this status, and proceeded to exclude themselves. We were and still are determined to transform their self-perception and relations with others, and to flip their preconceived notions. With this in mind, we imagined a project in 4 steps: prohibiting smoking, authorizing alcohol inside the Center, producing a standardized beer for visitors, and having the users brew their own beer.

## 1. Prohibit smoking (January 2014)

We wanted users to accept their role as citizens, which they justifiably claim, by asserting their rights and performing their civic duties, including respecting the center as a space where smoking is prohibited. The drop-in center and the Foundation's other units aimed to assist them in this objective. Social workers would be available for counseling three times a week to answer questions and offer social and administrative support on top of the assistance already provided.<sup>5</sup>

The leadership announced the decision at a roundtable in December 2013, in the presence of some thirty users, with mixed reactions. The majority of users recognized the benefit of this process. Some even acknowledged our effort and thanked us for it wholeheartedly. Others, however, felt left out. Could it be, they thought, that the new leadership, which was only a

month old, despised them? Some decided right then that they would no longer attend the Center.

The reality of the process, however, contradicted their intuitions. The average number of distributed meals per day rose from 70 to more than 110. Supply exchanges remained stable, and through a peer support group, a wider selection of consumption equipment became available: straws, aluminium sheets, and others. The atmosphere at the center became more wholesome and serene. However, we also started to see the negative effects of our decision: the space's visitors, though they appreciated site's new interior, tended to linger in front of the center... to drink even more alcohol. We were experiencing the "balloon effect": by prohibiting smoking, we had restrained access to the space and removed our problems outside the Center. The magnitude of alcohol intake seemed enormous to us. Some users drank between a few beers (cans go for half a Swiss Franc<sup>6</sup> each) and several pints a day (30 pints between 7am and 3pm for the heaviest drinkers!), and we began to worry about their physiological, psychological, and social condition. The beer they drank, on top of being dangerously cheap (1 Franc/liter), had very high alcohol contents.<sup>7</sup> The great majority of our visitors took medication and/or received substitution treatment, and they often made excessive use of black market narcotics. All this continued to alarm us, and encouraged us to find innovative solutions.

## 2. Tolerate alcohol inside the Center (March 2015)

We sought to strengthen the social fabric among our visitors and to offer a safe space, to avoid brawls outside the center, to lower stress, to help users take responsibility and improve their image in the eyes of the general population and of the neighborhood.

Once again, we announced our decision at a Seuil roundtable. Our beneficiaries' reactions were lively: they said they would not be able to "hold themselves back" and announced an Armageddon — a striking instance of preemptive self-exclusion! A minority of users thanked us for trusting them and told us they felt ready for this reversal of practices. In hindsight, we noticed only one thing: that tolerating alcohol inside the Seuil was a "non-event." Nothing happened, not even a small scrap, nothing!

We had prepared our educational team for this paradigm shift, and the reality of the field confirmed our intuitions: users were entirely capable of consuming their alcoholic drinks inside the center without causing utter chaos. They no longer downed their cans in one swig to enter the premises. Since they could drink inside, they drank more slowly. The brawls outside the center grew smaller, fewer,

<sup>5</sup> The "Seuil" offers basic harm reduction services: unconditional and anonymous reception, showers and laundry services, affordable meals, bio-psycho-social counseling, cultural and sporting activities, and others: [www.tremplin.ch/seuil](http://www.tremplin.ch/seuil)

<sup>6</sup> 1 Swiss Franc ≈ € 0.845

<sup>7</sup> One department store beer sells for CHF 0.75/50cl. Alcohol content is 13,6%



BIÈRE ARTISANALE BRASSÉE À FRIBOURG  
LA BIÈRE DU TREMPLIN DEPUIS 2016

*La*  
**Trampoline**  
LA BLONDE

FONDATION LE TREMPLIN

and farther between. Some users even played the role of “moderators” inside and outside the center. Educators and users created closer and more peaceful relationships, as we had more time to assist them in issues other than coping with consumption and violence.

### 3. Sell our first homemade Bock (August 2015)

We hoped to standardize a product that many of our visitors consume heavily, to guarantee low alcohol contents, and to offer a homemade beer with taste and character. We wished to cultivate our visitors’ sense of belonging at Tremplin and to reinvest in the concept of pleasure.

After asking our colleagues to shift from discipline and control to tolerance, we had to ask them to provide and sell alcohol inside the Center! A local brewer took up the challenge, and agreed to craft a beer exclusively for the Seuil Center according to our criterias. When a first draft was ready, we asked the center’s users to taste it. They liked it, but thought it was too liquid and ended up “not feeling it.” We kept the beer’s taste and decided to cap alcohol content at 4.5%. We sold it at cost price: 1 Swiss Franc for a 25cl bottle, four times department store prices. We put a lot of work into the packaging and presentation: an imposing name, “Trampoline,” a printed snifter, a display stand advertising the Center’s cultural and sporting events, latest releases, and prices.

Many users transformed their drinking style. We were aiming to strengthen their civic engagement, normalize their relationship with the space, and improve their image for themselves and their environment. Our first assessments were positive. We never thought we could “cure” polydependent users with the “Trampoline,” and yet, some users reported critical changes. Early feedback shows that users improved their self-perception and managed their alcohol intake by alternating between the Trampoline and other, stronger beers. The experiment also worked to foster conversations about drinking that took into account the concept of pleasure. Finally, users reported that our vision of them had improved.

### 4. Seuil visitors brew their own beer

We aimed to create part-time jobs that would be demanding in terms of hours (6am morning shift), skills, and hygiene. We hoped to transform users’ relationship to the product they consume and to have them engage differently with the Seuil community.

There was an unforeseen step: other drop-in centers and socio-cultural spaces asked to sell the Trampoline, citing its original concept and appealing flavor. We took up this challenge, and bottles of Trampoline are now available in

partner spaces. Consumers have become “consum’actors,” and therefore real producers in the free economy. But we also came upon an issue: what was to be done with the profits? We invested part of it to fund the project, but some of it remains (not a lot, of course, but some). The project’s assessors proposed a solution that the Seuil’s members loved: whatever profits remained were deposited, and from time to time, the brewers made a donation to an association or a social, cultural, or educational project. Way to be civically engaged!

Based on the numerous visits and requests we receive for the project, we can tell it is interesting to our colleagues in Switzerland and abroad. Though Trampoline triggered sometimes anxious reactions, it was also successful in questioning our values on the very important issues of civic and ethical engagement, exclusion and inclusion, human rights, penalization, consumption and market regulation (whether legal or illegal), harm reduction, and social education.

Considering the rising number of visitors in our centers, we had to acknowledge that our services, though successful with the majority of users, left others in situations of social and economic poverty feeling left behind. We could either hold on to our convictions and be content with the status quo, or we could try to solve the problem from scratch once again.

We owe it to ourselves to be creative, and to disrupt what seems evident, even when we risk disrupting ourselves. This project forced us to justify our practices to public authorities, institutional partners, and to the public by going beyond false beliefs and moralizing certainties. Who knows: perhaps this approach will inspire similar projects for other substances, to guarantee safe products and encourage users to perform their civic responsibilities.





# Drug-related harms in Europe: old and new challenges to tackling premature and avoidable deaths

Isabelle Giraudon, Dagmar Hedrich, Alessandro Pirona, André Noor, Jane Mounteney  
European Monitoring Centre for Drugs and Drug Addiction

*Highlights from the European Drug Report 2018: Trends and Developments*

With at least 9,100 overdoses or drug-induced deaths reported in Europe in 2016 — a 4% increase since 2015 — illicit drug use represents a major public health challenge (EMCDDA *European Drug Report 2018: Trends and Developments*). Males accounted for the majority (79%) of fatalities in 2016. Heroin and other opioids are associated with most deaths, and the highest toll is reported among middle-aged adults ages 35-39. These preventable and premature deaths (hundreds of people also die in their late teens or early twenties) mean that we are losing thousands of years of life in Europe every year.

Although the European mortality and overdose rates are not close to those reported in the USA (68,000 deaths in 12 months, more than 45,000 related to opioids) (Ahmad, 2018), tackling fatal drug overdose and identifying health threats related to the evolving drug situation have rightly become European public health priorities.

## Data collection

Mortality statistics in the European Union, Norway, and Turkey are reported to and collated by the EMCDDA. For this purpose, we use a common European definition of drug-related death: 'death happening shortly after consumption of one or more illicit psychoactive drugs, and directly related to this consumption.' A European protocol indicates which codes of the World Health Organization International Statistical Classification of Diseases (ICD) should be selected to extract relevant underlying causes

of deaths from the national mortality statistics. The codes provide information on both the intentionality of the drug poisoning (accident, suicide, or undetermined intent) and the substances involved. The protocol also defines which cases should be considered when using complementary sources such as special mortality registers of drug-induced deaths maintained by police or forensic services (EMCDDA, 2010).

Although data quality has improved over the last years and most countries comply with common reporting guidelines, we still have a limited understanding of the drugs involved. Toxicological investigations are not conducted systematically or to the same extent across European countries. There are also reporting issues and only 15 out of 30 countries reported standardised data, based on their mortality register for the last year (EMCDDA Statistical Bulletin 2018). There are also differences in the use of the toxicological evidence that inform the final coding of the cause of death, and differences in coding practices across Europe. In some countries, this makes it difficult to flag and extract overdose cases from general mortality registers. Thus, the numbers in some countries are likely to be underestimated and simple comparisons should be avoided (England, 2017; Millar, 2017; Leifman, 2017).

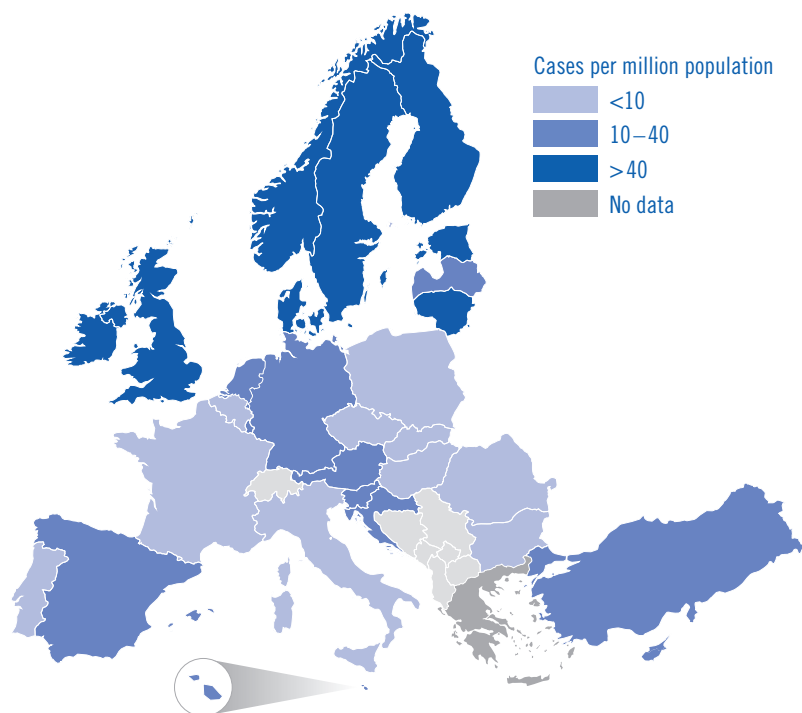
## Different victim populations

Bearing in mind these differences in recording, we can point out some demographic contrasts among various



## Figure 1. Drug-induced mortality rates among adults (15-64): selected trends and most recent data (cases per million population)

Source: adapted from EMCDDA, European Drug Report, 2018



European countries' populations who have died from drug-related deaths. The proportion of males is markedly above average in South East Europe: males accounted for 95% of deaths in Turkey, 93% in Portugal, 90% in Hungary and Italy and 88% in Slovenia. Age varies as well: reported victims are much younger in some South European countries including Turkey (mean age: 31) and Romania (32), as well as in some Baltic countries, such as Latvia and Estonia (34), compared to the European average age of 43.

The presumed intentionality of the deaths (accident or suicide) also varies. In many cases, the intentionality was undetermined or not reported. Where information was available, however, a code for suicidal intent was twice to five times more frequent among females than among males. Suicidal intent is more commonly reported in Northern European countries such as Poland, the Netherlands, Belgium, Denmark, Sweden and Norway, where these cases could represent 15% or more of overdoses with available information. This probably reflects differences in the case ascertainment, coding practices, and completeness of the data; but also, to a certain extent, differences in the populations at risk and in the pattern of high-risk drug use across countries. This diversity in terms of age, gender and intentionality reveals the

complexity of the drug-related public health problems that Europe is facing, and it suggests that no simple, unique response will be able to address them all.

Finally, there are differences in the overdose mortality rates across Europe. Overdose-related mortality is the highest in Northern Europe, compared to the European average (estimated at 21.8 drug-related deaths per million population ages 15-64 in 2016) (see figure 1). Analyses of possible reasons for these differences in mortality rates should be cautious as the proportion of drug-related deaths in the general population is influenced by factors such as prevalence and patterns of drug use, which determine, respectively, the size of the population at risk in a country or region and the level of risk among this population. An enhanced analysis of the drug-related data in 2017 concluded that simple comparisons should be avoided, and that no single contextual element or driver could explain the numbers and trends of drug-induced deaths. It also advised that no single response would be effective everywhere (Millar and Mc Auley, 2017).

### Some common trends

Despite significant differences across Europe, there are also commonalities; the first of which is the overwhelming involvement of opioids in drug-induced deaths.

Heroin and other opioids are identified in more than 80% of reported deaths. Heroin-related deaths have increased in Europe, in particular in the United Kingdom, where nine in 10 cases (87%) involved opioids. There was a rebound of heroin/morphine-related deaths in England and Wales (an 18% increase in one year and a 44% increase in two years). This was mirrored in Scotland with 473 heroin or morphine deaths recorded in 2016 (+37% since 2015).

In France, according to the special mortality register, heroin was implicated in a third (30%) of cases in 2015, twice the proportion observed in 2012. In France and other countries, other opioids are often found in post mortem examinations as well. Methadone is the most commonly reported, but others are identified such as buprenorphine (Finland), fentanyl derivatives (particularly in Estonia) and tramadol.

Although opioids are responsible for most drug-related deaths, stimulants (in particular cocaine, amphetamines, MDMA, and cathinones) are also implicated in many deaths.

With respect to cocaine, and particularly crack, several western countries of the European Union signal increases in fatal and non-fatal intoxications which may be related to increased availability and purity (EMCDDA 2018).

Apart from the important impact of opioids in most countries, another common trait is the ageing phenomenon

among cohorts of drug users. Between 2012 and 2016, overdose deaths in the European Union increased in all age groups above 30 years (see figure 2) and more than doubled among those aged 50 or older (+55% overall). The increased opioid risk among the elderly mirrors and reveals the aging phenomenon among Europe's opioid-using populations. Overall, there were an estimated 1.3 million high-risk opioid users in the European Union in 2016. Ageing in these populations is particularly pronounced in Western and Northern Europe, which reflects the earlier onset of the heroin epidemics in these parts of Europe between the 1970s and the 1990s, compared to Eastern European regions.

### Synthetic drugs and the challenges ahead

Against this backdrop of ageing populations of drug users and upticks in heroin and cocaine-related harm in some countries, new psychoactive substances cause concerns and challenge current drug policy (Pirona, 2017). Synthetic cannabinoids and opioids cause particular concern: a Europe-wide investigation conducted in 2017 to assess the risks of synthetic cannabinoids found that four of them were involved in more than 80 deaths in Europe (EMCDDA, EDR 2018).

Among opioids, fentanyl has long been flagged as the most problematic substance (Mounteney, 2015). However, new evidence has emerged on the scale of the problem. Five fentanyl derivatives were jointly investigated by Europol and the EMCDDA in 2017, and the risk assessment revealed that they have been involved in more than 160 deaths. Despite development and scaling up of forensic toxicology laboratory capacities across Europe,

not all laboratories have the adequate procedures in place or the capacity to detect these drugs in post mortem examinations. This likely led to an underestimation of the number of deaths involving these NPS (Leifman 2017, Heinemann 2017).

### Preventing overdoses and saving lives: what works

Public health responses to drug-related deaths aim to reduce vulnerability among people who use drugs by making services available and accessible (EMCDDA *Health and social responses to drug problems: a European guide*, 2017).

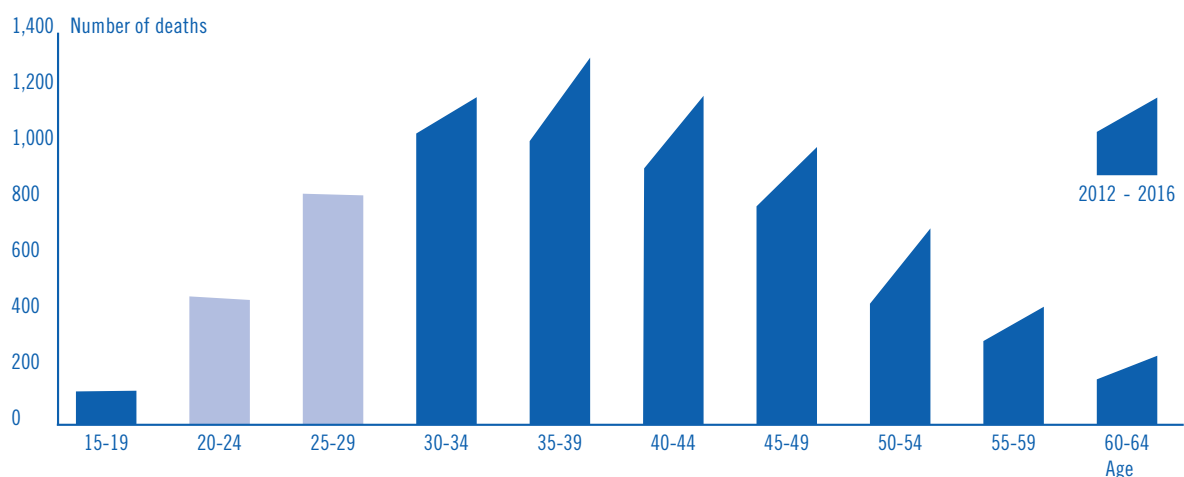
European countries have implemented a variety of approaches, including overdose risk assessments and continued care between community and prison settings. Ideally, professionals in healthcare, drug treatment, and primary care settings should routinely provide overdose prevention, education, and counselling. Overdose risk-assessment interventions could promote early identification of high-risk drug users.

Twenty-eight of the 30 countries (the 28 EU countries, Norway, and Turkey) now report distributing overdose risk information. Several prevention measures target prisons, including pre-release education, continuation and initiation of oral opioid substitution treatment (OST), and improved referral to aftercare and community treatment services (EMCDDA *Preventing overdose deaths in Europe*, 2017).

More generally, OST, often combined with psychosocial interventions, is the most common treatment approach for opioid dependence in Europe. This approach is widely

**Figure 2. Number of drug-induced deaths in the European Union in 2012 and 2016, or most recent year, by age-band**

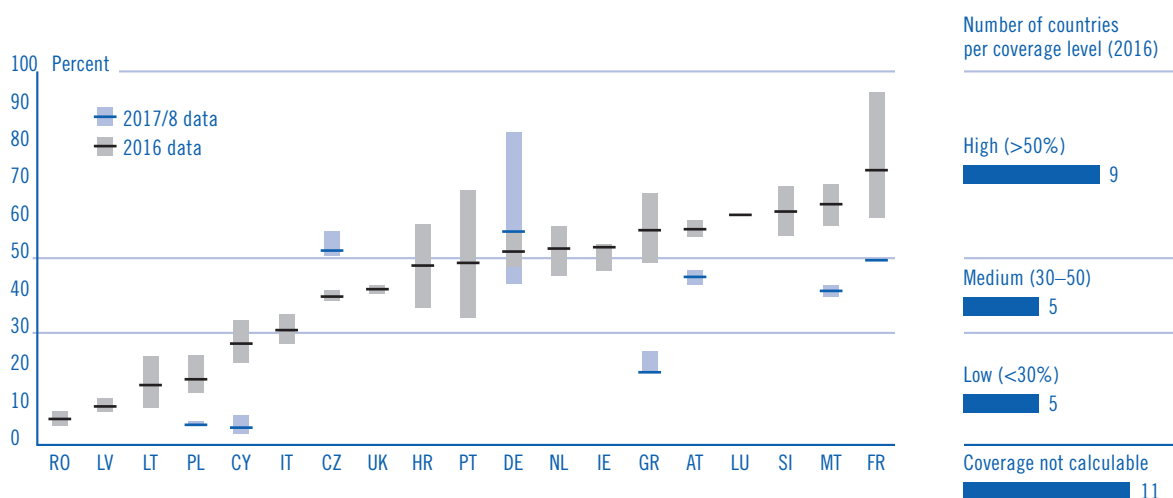
Source: adapted from EMCDDA, European Drug Report, 2018



**Figure 3. Coverage of opioid substitution treatment (percentage of estimated high-risk opioid users receiving the intervention) in 2016 or most recent year and in 2007/8**

Source: adapted from EMCDDA, European Drug Report, 2018

NB: data displayed as point estimates and uncertainty intervals



supported by available evidence of positive outcomes in terms of treatment retention, injecting risk behaviour, illicit opioid use, and drug-related deaths (Sordo, 2017). In Europe, around half of opioid-dependent people are enrolled in OST — an estimated 636,000 patients received OST in Europe in 2016 (see figure 3). The majority of opioid users in substitution treatment in Europe are middle-aged to old males who have been enrolled in long-term treatment for some years. Methadone is the most commonly prescribed opioid for maintenance treatment (for 63% of patients), followed by medication based on buprenorphine (for 33% of patients). The former medicine is the preferred option in eight out of the 30 countries.

### Expanding the range of available responses

To complement this treatment approach, interventions such as supervised drug consumption facilities (DCRs) and take-home naloxone programmes have been introduced in Europe. In the former, drug users can consume drugs in hygienic and safer conditions, with immediate support from professionals in cases of overdose. DCRs contribute to reductions in injecting risk behaviour and overdose mortality, and help improve highly marginalised drug users' access to medical care, drug treatment, and other health and social services. There are now 78 facilities operating in 56 cities in six EU countries and Norway (EMCDDA *European Drug Report 2018: Trends and Developments*).

Naloxone is an opioid antagonist that reverses opioid overdoses. Professionals have used it for decades in worldwide hospital and pre-hospital emergency situations. For some years, there has been an expansion of 'take-home' nalox-

one programmes targeting opioid users, their peers, and their families. The programmes consist of giving out naloxone kits to people trained in recognising and responding to overdose.

In 2017, such programmes were in place in 10 out of 30 European countries. There is evidence that naloxone is effective when provided in combination with educational and training interventions (EMCDDA, 2015). Some populations with an elevated risk of overdose, such as recently released prisoners and people withdrawing from drug treatment, could particularly benefit from naloxone. In Estonia, France, the United Kingdom (and Norway in 2018), prisoners already benefit from these initiatives. Although naloxone is traditionally an injectable medication, new formulas for nasal application have just been introduced in Europe and may facilitate bystander intervention in the future.

### The way forward

Thousands of premature and avoidable drug-related deaths occur every year in Europe. The scale, urgency, and multifaceted nature of the problem call for further assessments of overdose risks and improvements in responses at the levels of systems, services, and individuals. It also justifies reinforced surveillance and alert systems to better understand, monitor, and tackle the epidemiology of fatal overdoses.

The changing drug market is challenging our responses, which have to address the needs of aging, long-term opioid users; but also younger users and users choosing new substances. While opioids (primarily heroin) remain the cornerstone of poly drug use patterns that cause deaths,

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the recent rebound of heroin- and cocaine-related harms is cause for renewed concern. Together with the — again, likely underestimated — harm caused by new psychoactive substances including synthetic opioids, this evolving landscape calls for continuous adjustments and evaluation of responses. There is already solid evidence to back best practices in prevention, harm reduction, and treatment. Innovative initiatives are implemented across Europe, and should contribute to consolidate further this evidence base and to support the spread of responses in Europe.

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In its first ever European issue, *Swaps* reports on the state of harm reduction across the Europe Union and offers multi-country European perspectives from experts in the field. Despite having been a pioneer in harm reduction and in promoting evidence-based policies, Europe and many of its member states remain ambiguous with regard to drug policy, the dogma of prohibition, criminalization of drug use, priority for health and the role of law enforcement.

Better understanding the history and the current state of harm reduction in Europe and exchanging on best practices is thus a helpful and salutary initiative, as we also need to remain vigilant together. Conservatism and populism across the continent translate into direct threats on the gains we have made with harm reduction.

It is Europe's experience that has established the comprehensive and undisputable body of evidence of the effectiveness of harm reduction interventions in preventing HIV infection and hepatitis; HIV infections among people who inject drugs is no longer an issue in Western Europe.

However, significant shifts have been taking place in recent years in the European and global drug scene and the global debate on drug policy in terms of public discourse and policy implementation. I believe it is time to revisit some of our terminology and have methadone be acknowledged and named as the most effective treatment for opioid dependence, rather than seeing it as a “substitute” (something many countries would not accept) and/or “just” a harm reduction tool.

When reading this collection of reports, I also wonder whether it is not time for the harm reduction movement to distance itself somehow from medicine and HIV and take a more political stance. Reducing harm is also fighting poor policies; it is about advocating for decriminalization of use and low-level non-violent actors in the drug trade and for changing the roles and behavior of law enforcement. Finally, reducing harms is also increasing our efforts to prevent overdoses as it appears so needed in the US and Canada with the growing availability of fentanyl and moving faster to test the insufficiently explored ways of preventing harm from other new synthetic drugs.

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