

IMPLEMENTATION OF THE EU ACTION PLAN ON DRUGS 2017-2020: THE CIVIL SOCIETY PERSPECTIVE

**REPORT OF THE CIVIL
SOCIETY FORUM ON DRUGS**

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Colophon



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1. Introduction

This report is produced on behalf of the Civil Society Forum on Drugs (CSFD), an expert group of the European Commission, created in 2007 based on the Commission Green Paper on the role of civil society in drugs policy in the EU. The Forum's membership consists of approximately 45 civil society organizations from across Europe. CSFD members represent a broad range of areas within drug policy field and diverse approaches to addressing drug use and drug policy. The primary aim of the Forum is to provide a platform for a structured dialogue between the European Commission and civil society which supports drug policy formulation and implementation through practical advice.

One of the CSFD's focus areas is the European drug policy. Over the years, a dedicated Working Group on the EU Drug Policy has been contributing to the promotion of effective, evidence-informed, and human rights-based policies through providing recommendations for the European Commission and through reporting on the drug policy situation in Europe. This report is a continuation of the CSFD's efforts to assess the implementation of the EU Action Plan 2017-2020 and builds on a similar study published by the CSFD in 2018, providing new information, complementing, and deepening the previous analysis.

1.1. The objective of the study

The EU Drug Strategy provides an 'overarching political framework and priorities for EU drugs policy identified by Member States and EU institutions' (European Council, 2012). The Strategy is strongly embedded in the values of the EU as well as in international agreements. It is complemented by Action Plans on Drugs, which – building on the general framework provided by the Strategy – enlist and describe specific actions to be implemented, along with responsible actors and monitoring indicators.

The EU Drug Strategy and Action Plans require a relative consensus among the Member States regarding the content of the document. However, there is no legal obligation for the Member States to adhere to these documents while formulating national drug policies. The EU drug policy documents are merely recommendations. Hence, the national-level policies in the

Member States and Candidate States reflect them to a varying extent, creating a mosaic of diverse responses to drug use.

To assess the extent of the implementation of the EU Action Plan on Drugs 2017-2020, the CSFD surveyed civil society experts for the first time in 2018, at the very beginning of the Action Plan implementation period. Focusing on the demand and harm reduction parts of the Action Plan, the present analysis aims to provide information on the civil society's perceptions of the availability and quality of thirteen key services in 2021, as well as account for the possible changes that took place over the period 2018-2021. Like the previous assessment, we also explore the accessibility of several services among selected vulnerable populations. The novelty of the present study compared to the earlier one lies in the inclusion of qualitative data to provide a more in-depth information on how services function in selected countries. Besides the main explorative ambition, this study also aims to contribute to further improvement of drug policymaking practice, highlighting the shortcomings existing in the field.

2. Method and data

This exploratory inquiry includes data collected through an online questionnaire and semi-structured interviews with 22 key informants from 20 European countries¹.

The data collection through the questionnaire took place in April-July 2021.

To maximise the comparability of the results with the previous assessment, we disseminated the survey the same way as we did it in 2018: through the mailing list of the Civil Society Forum on Drugs (asking experts to fill in the questionnaire and disseminate it among their networks), as well as through social media channels and newsletters of the organisations engaged in the Project. We used the same questionnaire with one exception: the treatment

¹ The interviewed experts represented the following countries: Austria, Belgium, Bosnia and Herzegovina, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Lithuania, the Netherlands, Portugal, Serbia, Slovakia, Slovenia, Spain.

of HIV and HCV was added as the 13th service to evaluate. The first part of the survey asked the respondents to assess the 13 key services for people who use drugs in their countries:

1. **Prevention:** a range of interventions aimed at preventing or delaying substance use and associated problems, ranging from activities targeting the broad society (universal prevention) to interventions focusing on at risk individuals (indicated prevention).
2. **Online prevention:** interventions sharing aims and content with 'traditional' prevention, but using online channels of communications, e.g., social media, fora.
3. **Safer nightlife programmes:** programs delivered in nightlife settings and aiming to reduce risks characteristic for nightlife (substance use, sex, etc.).
4. **Treatment:** a spectrum of services aiming for a person to stop use of substances. It includes including psychosocial interventions and detoxification in a variety of inpatient and ambulatory setting, e.g., specialised treatment institutions, primary healthcare and mental health clinics, hospital-based residential units, specialist residential centres.
5. **Treating co-morbidities:** treatment services addressing the co-occurrence of a psychiatric disorder next to use of psychoactive substances.
6. **Recovery/rehabilitation:** programmes including a structured, planned care programme of medical, therapeutic, and other activities, e.g., housing support, job support, legal support.
7. **Needle and syringe exchange programs (NSP):** low-threshold services distributing and/or exchanging sterile injection equipment, and a variety of information and referral services.
8. **Opioid substitution treatment (OST):** a service dedicated for people with opioid-type substances (e.g., heroin, morphine) dependency to replace illegal opiates with legal medicines.
9. **Naloxone distribution programmes:** services using various ways to provide individuals with a medicine reversing opioid overdoses.
10. **Drug-checking:** services enabling individuals to have their drugs tested in a professional manner, normally in a laboratory.

- 11. Drug consumption rooms (DCR):** units providing spaces supervised by medical personnel and sterile equipment for the administration of a drug to decrease the health risks and risk of overdose.
- 12. Alternatives to coercive sanctions (ACS):** mechanisms, stipulated by the law, that provide an opportunity for PWUD arrested for some specific offences to avoid incarceration conditional upon fulfilling specific requirements, e.g., completing a treatment programme.
- 13. HIV and HCV treatment:** antiretroviral (for HIV) and antiviral (for HCV) medications within public health care system scheme.

The aspects of services respondents were asked to evaluate were accessibility and quality, understood as:

Accessibility - the equitable distribution of services taking into account the demographic composition, rural-urban mix and under-served areas or populations.

Quality - services employees' competencies, skills, knowledge, and behaviour, as assessed according to professional norms and as perceived by users.

The questionnaire used 11-point scale where '0' indicated no access/extremely low quality, and '10' indicated full accessibility/excellent quality. The following levels of our variables (accessibility/ quality) have been distinguished:

0 – no access/extremely low quality.

0.1-2.0 – very low access/quality.

2.1-3.9 – low access/quality.

4.0 – 5.9 – moderate access/quality.

6.0-6.9 – moderately high access/quality.

7.0-8.5 – high access/quality.

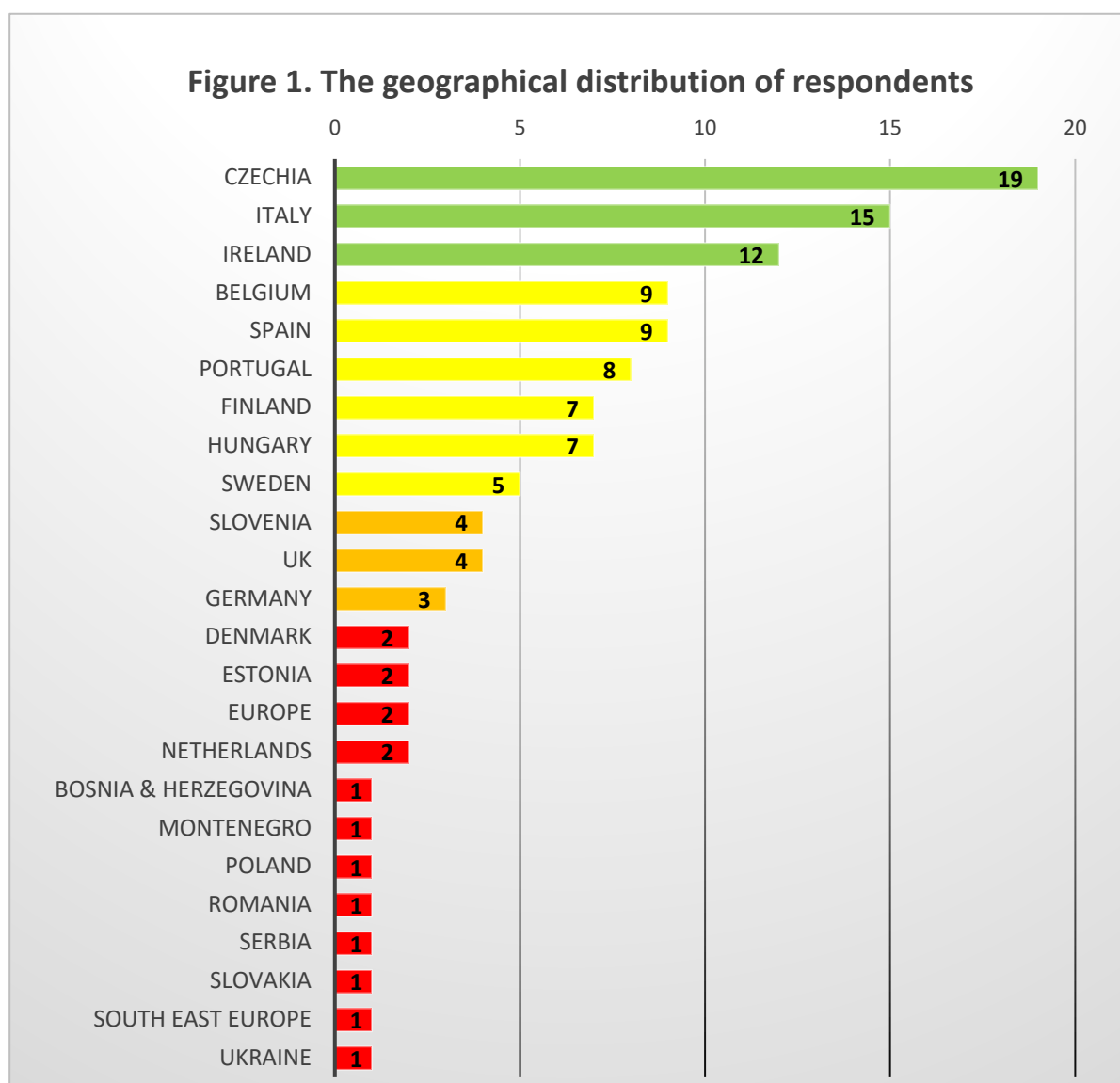
8.6 – 10.0 – very high access/quality.

The expert interviews were conducted in June 2021 using online channels of communication. Interviewees were asked about availability, accessibility, and quality of the 13 services mentioned above in their countries currently and any significant changes in the area over the last decade. The interviewed experts were asked to apply a practical perspective, that is, to describe how certain levels of availability, accessibility and quality of services affect the reality of people who use drugs. The interviews lasted 80 minutes on average (the shortest one 44 minutes and the longest one 113 minutes).

2.1 Data and respondents' characteristics

The questionnaire was completed by 118 representatives of civil society organisations from 22 European countries. 17 countries were EU Member States, two were Candidate Countries (Serbia and Montenegro), and three were other European countries (Bosnia and Herzegovina, Ukraine, and United Kingdom). Additionally, there were two responses for the entire Europe and one for South-East Europe. The median of the number of responses per country was 2.5, and high variance of the number of responses per country could be seen. We have received a high number of responses (≥ 5) from nine countries and low number of responses (≤ 2) from twelve countries. Given the low number of responses collected from a significant number of states, the data analysis – contrary to the 2018 report – does not include individual countries but regions or entire Europe. For 2018-2021 comparison, the same countries were included in each regional category. Figure 1 below shows the exact number of responses collected per country.

Figure 1. The geographical distribution of respondents.



Concerning the scope of work, the majority of the respondents' organisations work at local level, followed by national level. Only 22 organisations characterised their level of work as European or international.

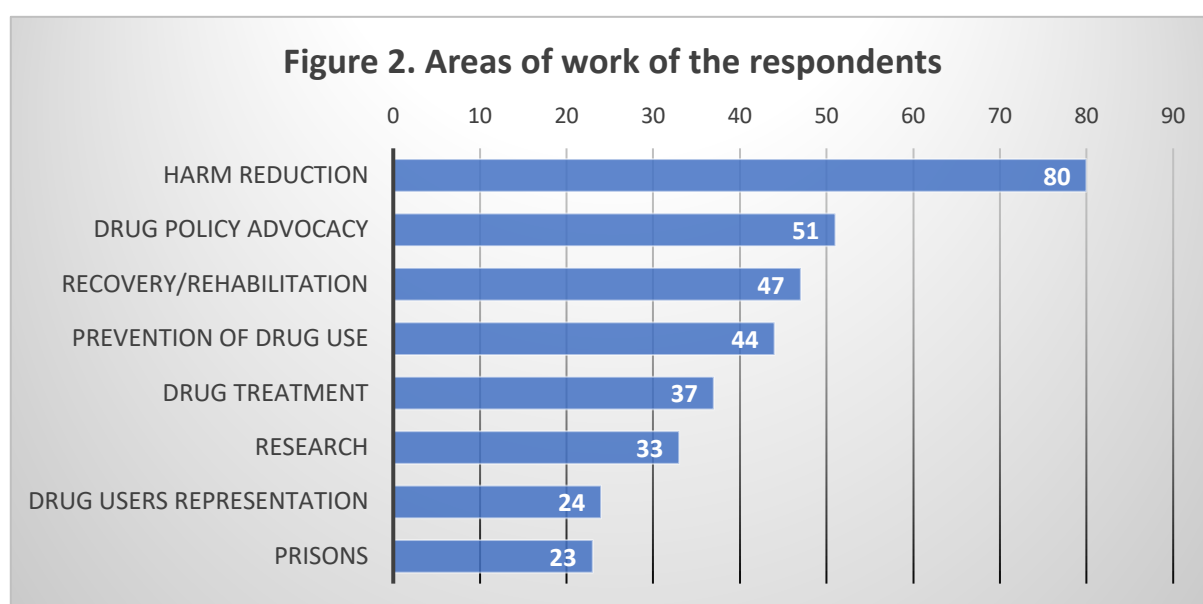
Table 1. The geographical scope of respondents' organisations work.

Scope of work	Local/city/regional	National	European	International
Number of organisations	65	31	13	9

We have also asked the respondents to characterise their organisations concerning the drug policy area(s) they are mostly active in (multiple answers were allowed). Figure 2 below shows the distribution of different aspects of drug policy organisations operate in. The mean of areas per organisation equalled 2.87, while the middle value was 2.0. There were 31 organisations reporting one area of expertise, 43 organisations reporting two or three, 34 organisations working in four or five areas and nine organisations working in six or more areas.

The distribution of surveyed organisations across the different drug policy areas was relatively balanced, with a slight domination of harm reduction. More specifically, there were 29 organisations representing demand reduction (working in prevention and/or treatment and/or recovery and possibly in other neutral areas but not harm reduction) and 37 organisations focused on harm reduction (but not working in either prevention, treatment, or recovery). The remaining organisations provide a mix of services from both demand and harm reduction areas.

Figure 2. The respondents' organisations areas of work.

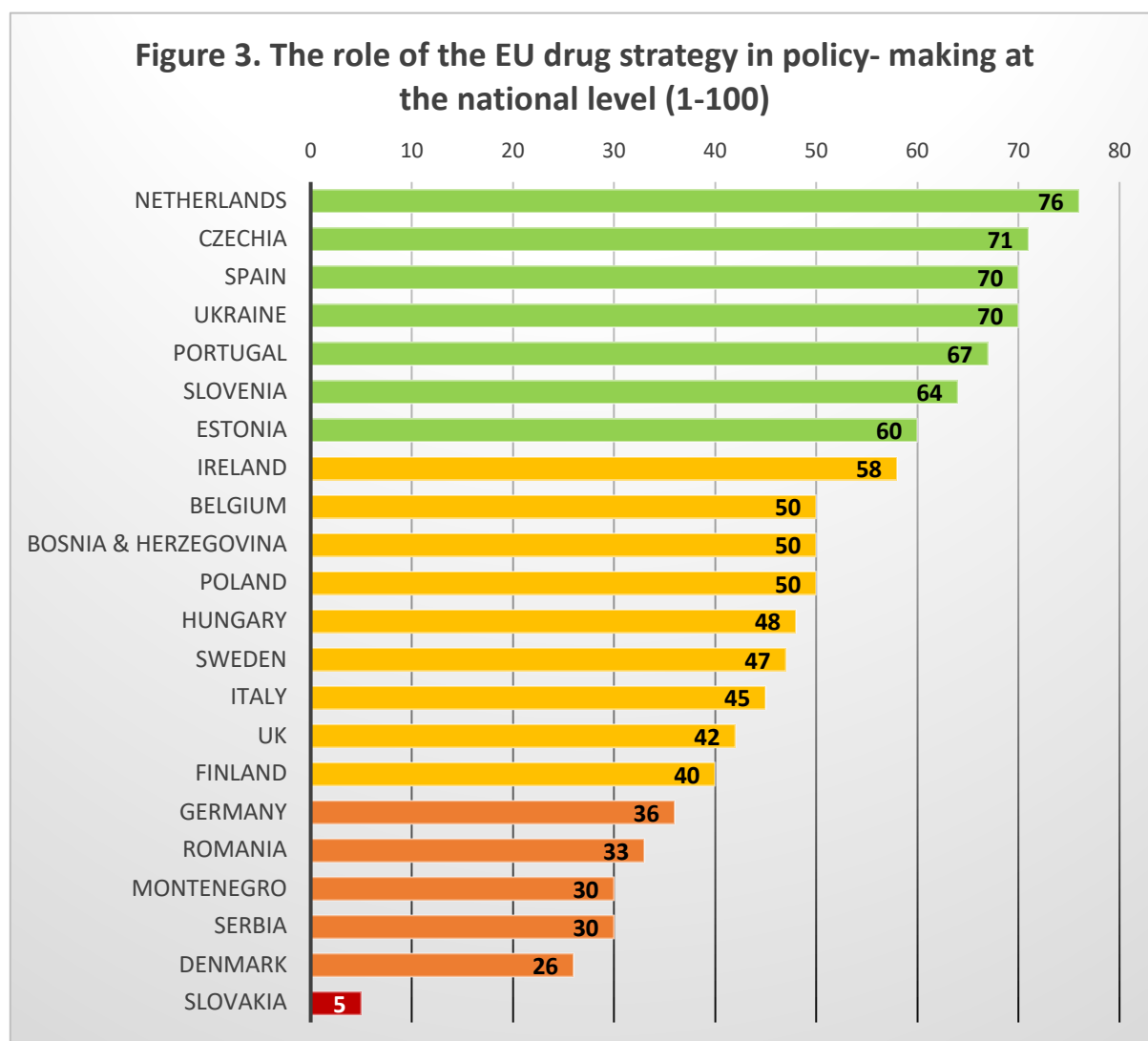


3 The role of the EU drug policy in shaping national responses

The first aspect we intended to study was the role of the EU Drug Strategy and Action Plan in shaping the national-level drug policies in European countries. The respondents were asked to rate it on a 0-100 scale where '0' indicated complete lack of significance and '100' indicated

a great influence of the EU drug policy on the national policies. The average expert rating equalled 49 points, with great differences between countries, ranging from 5 points in Slovakia to 74 points in the Netherlands.

Figure 3. The role of the EU drug strategy in policy- making at the national level.

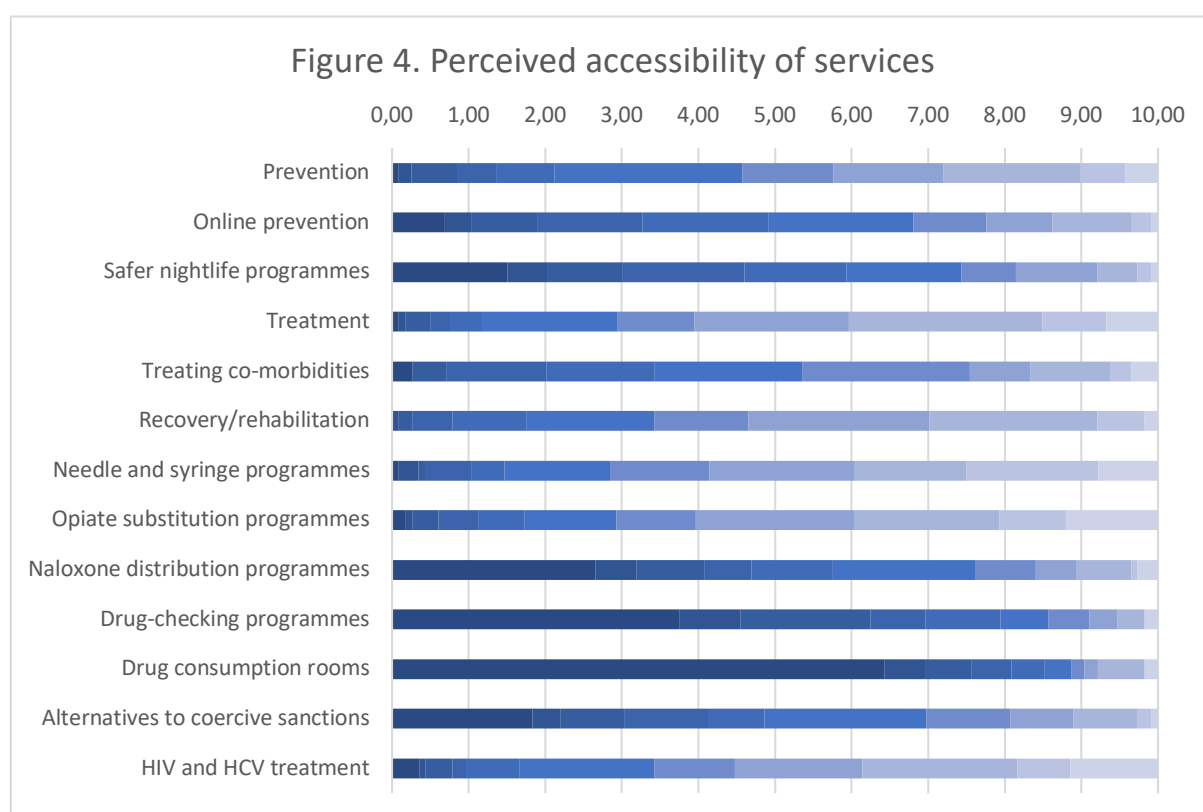


4 The accessibility and quality of drug services

Five types of services were perceived by the experts as moderately highly accessible across Europe: needle and syringe programmes (6.69), opioid substitution treatment (6.65), treatment (6.65), HIV and HCV treatment, and recovery/rehabilitation (6.30). Moderate accessibility was reported in case of prevention (5.91), treatment of co-morbidities (5.31), online prevention (4.54), and alternatives to coercive sanctions (4.04). Low accessibility was

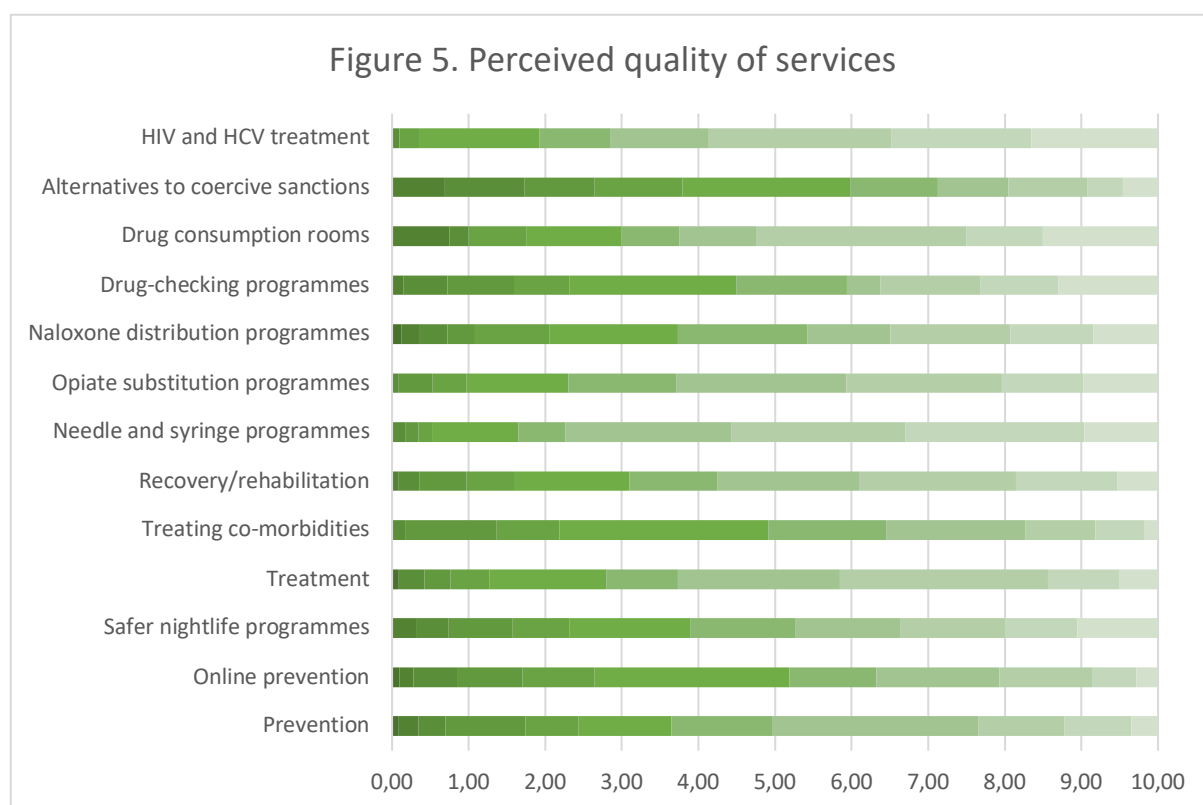
characteristic for safer nightlife programmes (3.85), naloxone distribution programmes (3.53) and drug-checking programmes, while very low accessibility for drug consumption rooms (1.57). Figure 4 below shows the perceived accessibility of the 13 services. Lack of accessibility is indicated by very dark blue and full accessibility by very light blue colour. The other levels fall between the two extremes. In other words, the lighter the line, the more accessible a given service is.

Figure 4. The perceived accessibility of services.



With respect to services' quality, the picture is significantly better. The lowest rating here was moderate quality and only three services were assessed as such: alternatives to coercive sanctions (5.14), online prevention (5.61) and treatment of co-morbidities (5.76). Moderately high quality was dominant, with the following services exhibiting this level: prevention (6.0), drug-checking (6.20), safer nightlife programmes (6.23), naloxone distribution (6.28), recovery/rehabilitation (6.59), treatment (6.74) and drug consumption rooms (6.80). High quality of services was the case for opioid substitution treatment (6.95), needle and syringe programme (7.49) and HIV ad HCV treatment (7.57).

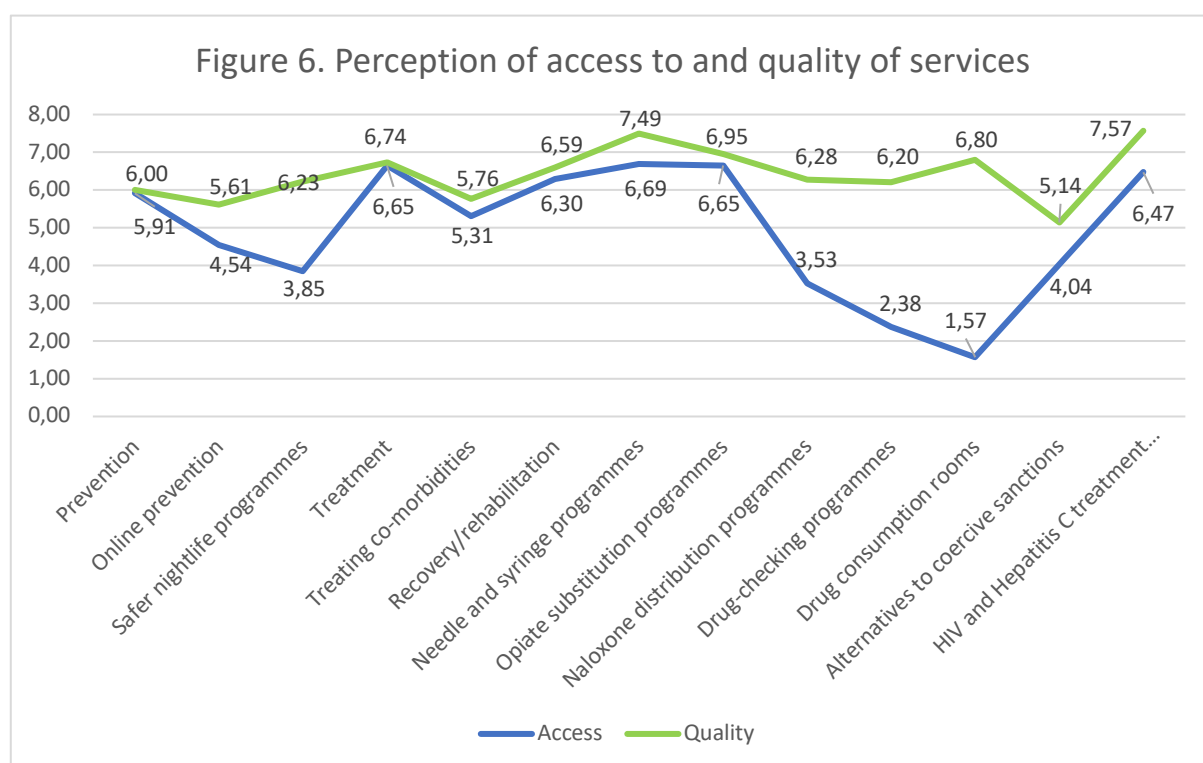
Figure 5. The perceived quality of services.



Interesting picture emerges when comparing the accessibility and quality of the drug services. The accessibility of all services together was rated at 4.91 points and quality at 6.41 points. However, in case of well-established and widely accepted services, the gaps between their two aspects are relatively small (though quality is always higher). For example, only 0.09 points in case of prevention and treatment, 0.29 for recovery, 0.3 for opioid substitution treatment, and 0.45 for treating co-morbidities. On the contrary, gaps between the perceived accessibility and quality are wide in case of more innovative harm reduction interventions, like safer nightlife programmes (gap of 2.38 points), naloxone distribution (2.75), drug-checking (3.82) and drug consumption rooms (huge 5.23 points). Interestingly, the discrepancy between accessibility and quality is not very high for innovative and very recent online prevention services (1.07). It may suggest that the dominant paradigm of drug policy in Europe is still that of abstinence and prohibition – establishment of new types of services is hindered (low accessibility) only if these services focus on harm, rather than demand reduction.

In our 2018 report, we hypothesised that, given that the political environment of these innovative harm reduction intervention does not change to more favourable, the gaps between accessibility and quality will further widen. This – we supposed – would be due to constant organisational learning and striving for improvement, which will likely result in increasing quality. Indeed, our prediction seems to have been fulfilled, to some extent, already merely three years later. Compared to 2018, the gap between accessibility and quality increased by 0.23 points for safer nightlife services, by 0.44 points for drug-checking services and by striking 1.35 points for drug consumption rooms. The accessibility of each of these services has increased since 2018, however, their quality rose more quickly. On the other hand, the gap has decreased by 0.48 points in case of needle and syringe programmes as a result of only a slight increase in quality and a significant improvement of accessibility.

Figure 6. The perception of access to and quality of services.



In the following sections, we discuss the current accessibility and quality of drug services in different regions of Europe. The table below shows the countries belonging to the analysed regions and number of responses from each of them.

Table 2. The list of countries in analysed regions.

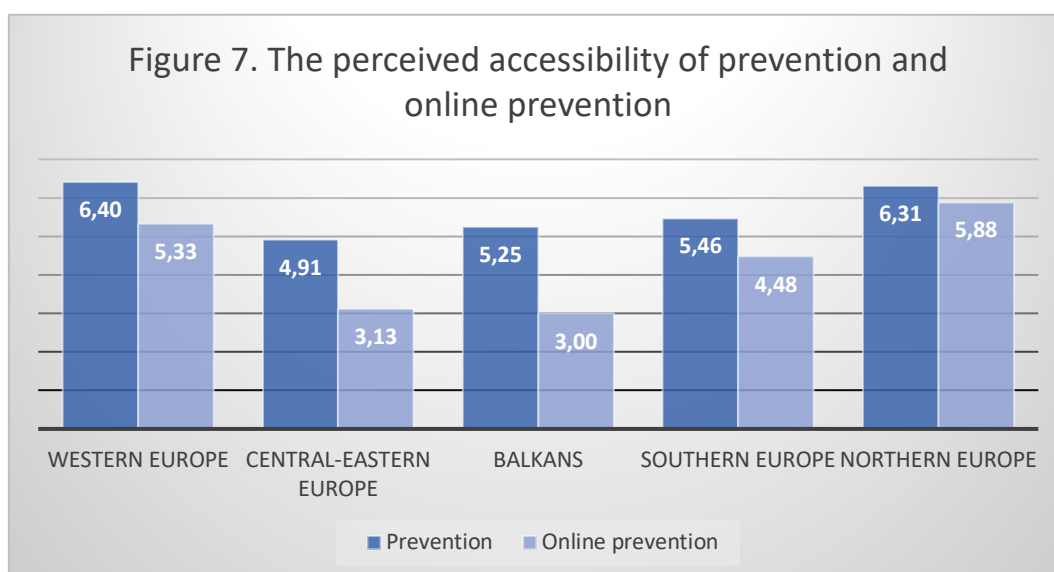
Western Europe	Central-Eastern Europe	Balkans	Southern Europe	Northern Europe
Belgium	Czechia	Bosnia & Herzegovina	Italy	Denmark
Germany	Hungary	Montenegro	Portugal	Estonia
Ireland	Poland	Serbia	Spain	Finland
The Netherlands	Slovakia	Slovenia		Sweden
UK	Romania			
	Ukraine			
29	30	7	32	16

4.1 Prevention

Prevention is seen by the responding professionals as the fifth most accessible services from our list, averaging at 5.91 points. Relatively high accessibility of prevention can be seen in Western European (WE) and Northern European (NE) countries, while moderate accessibility in Southern Europe (SE), the Balkans and Central-Eastern Europe (CEE).

The situation is less favourable in case of online prevention, which rated as the seventh in Europe in terms of accessibility (4.54 points). Like in case of traditional prevention, here also NE and WE were rated the highest, together with SE exhibiting moderate level of accessibility. In CEE and the Balkans, in turn, the level of online prevention's accessibility was perceived as low.

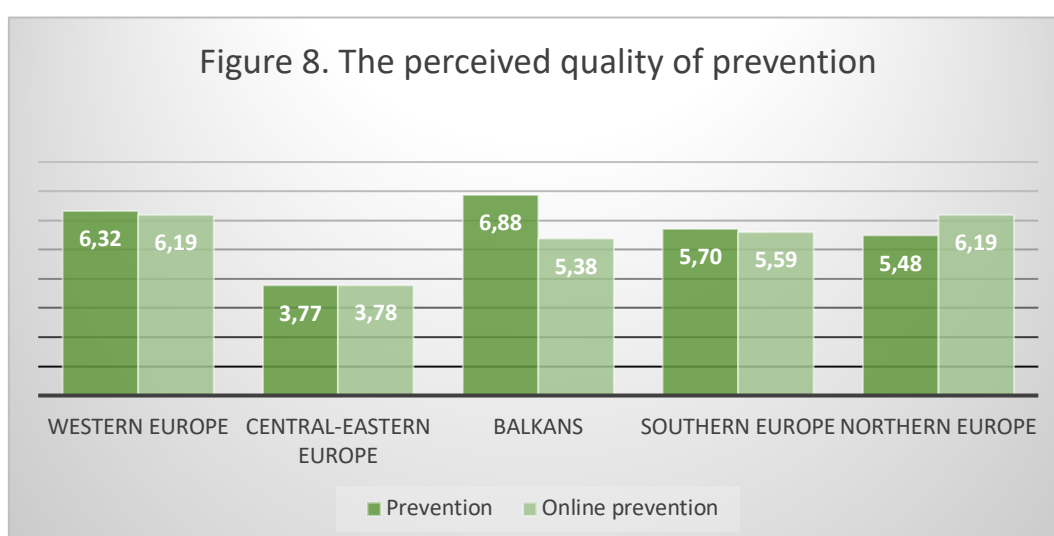
Figure 7. The perceived accessibility of prevention and online prevention.



With respect to quality, prevention places at 10th position out of 13 services, with 6.0 points. The professionals perceived the Balkans and WE regions as implementing moderately high-quality prevention. Moderate quality was characteristic for SE and NE, while in CEE prevention was rated at low quality level.

Online interventions aiming at preventing drug use was, in turn, seen as exhibiting moderately high quality in WE and NE, and moderate in SE and the Balkans. In CEE, experts perceived the quality of online prevention as low. Overall, it was the second poorest type of service in terms of quality, with 5.61 points.

Figure 8. The perceived quality of prevention.



4.2 Treatment and recovery

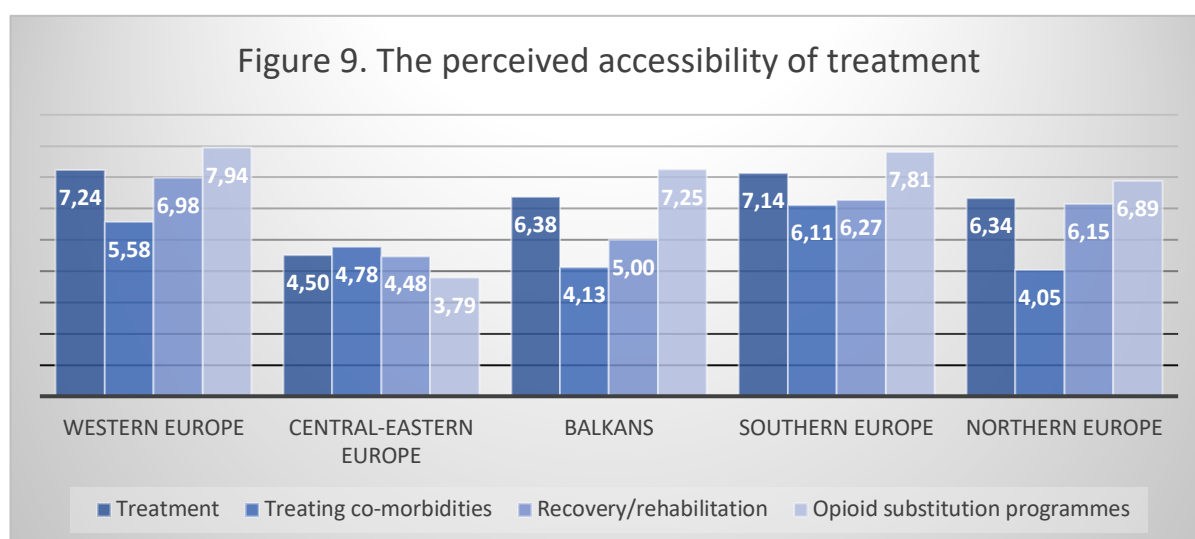
Abstinence-oriented treatment, along with OST, were perceived by professionals as the second most accessible types of services with average accessibility at 6.65 points. Abstinence-oriented treatment was seen as highly accessible in Western Europe and Southern Europe. Moderately high level of accessibility can be seen in the Balkans and Northern Europe, while Central-Eastern Europe is seen as having moderate level of treatment accessibility.

Opioid substitution treatment seems to be highly accessible in Southern Europe, Western Europe, and the Balkans. Meanwhile, in Northern European countries its accessibility was rated as moderately high. Finally, low level of OST accessibility was reported for Central-Eastern Europe.

Another service we analysed is concerned with the treatment of co-morbidities, which was rated as the sixth most accessible at the level of 5.31 points. The accessibility of treating co-morbidities was perceived as moderately high in only one region – Southern Europe, while all other regions fell into the ‘moderate’ category.

Finally, recovery/rehabilitation was the fourth most accessible service with 6.30-points average. Like in the other services, here also the highest level of accessibility was reported for WE, SE, and NE (all falling into the ‘moderately high’ category). On the other hand, in the Balkans and CEE the accessibility of recovery/rehabilitation was seen as moderate.

Figure 9. The perceived accessibility of treatment



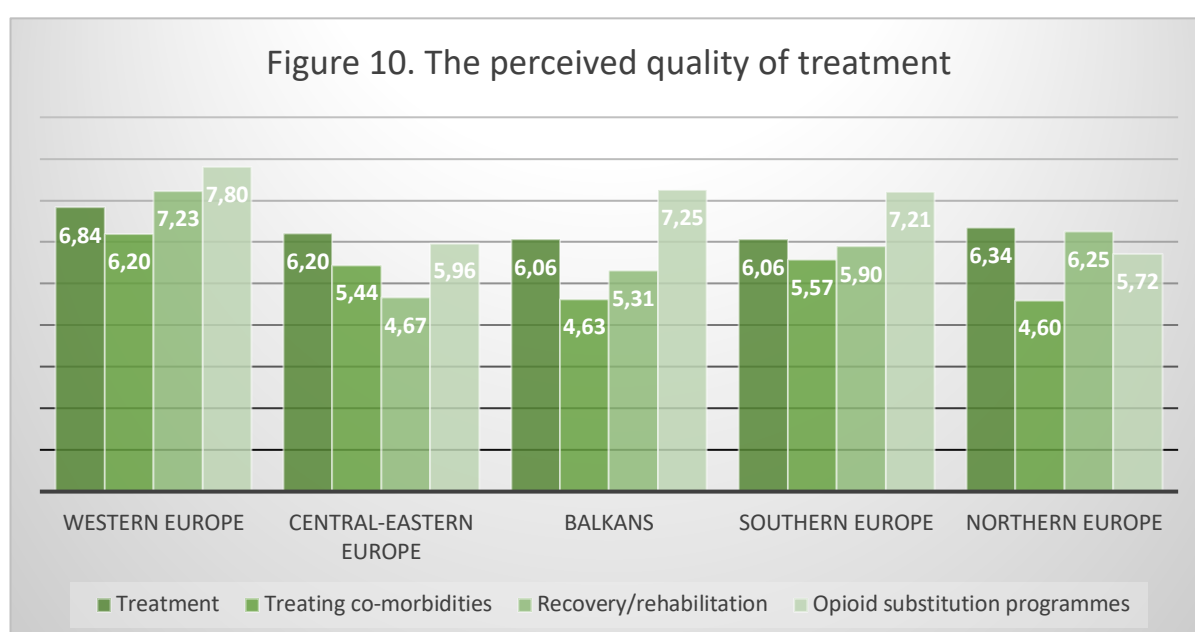
Among treatment and recovery interventions, the quality of opioid substitution treatment was seen as the highest – 3rd best among all examined services, with 6.95 points. OST quality was rated as high in WE, the Balkans, and SE. Meanwhile, CEE countries were perceived as having moderately high-quality OST, and NE countries – moderate.

Abstinence-oriented treatment was rated as 5th best type of service in terms of quality, averaging at 6,74 points. The quality of this kind of treatment was seen as moderately high in all examined regions.

Recovery and rehabilitation interventions occupy the 6th position among 13 services, with 6.59 points on average. Quality of recovery/rehabilitation was seen as high only in WE countries. Moderately high level of quality can be seen in NE, while in the three remaining regions the professionals perceived the quality of recovery/rehabilitation as moderate.

Finally, the lowest result was characteristic for treatment of co-morbidities, which was rated as the third poorest service with average of 5.76 points. It was one of three types of services (next to online prevention and alternatives to coercive sanctions), which overall quality was seen as moderate. The quality of treating co-morbidities was perceived as moderately high only in WE. In all other regions, the professionals assessed the quality level of this type of intervention as moderate.

Figure 10. The perceived quality of treatment.



4.3 Harm reduction and overdose prevention

The next group of analysed services is concerned with reducing harms that can potentially result from drug use, including drug overdoses.

Clearly, the service type perceived by professionals as the most accessible both in this category and among all services we study was needle and syringe exchange (NSP), with average accessibility at 6.69 points. High accessibility of NSPs can be seen in NE, WE and – quite surprisingly – the Balkans. Professionals saw the NSPs accessibility as moderately high in SE, and moderate in CEE.

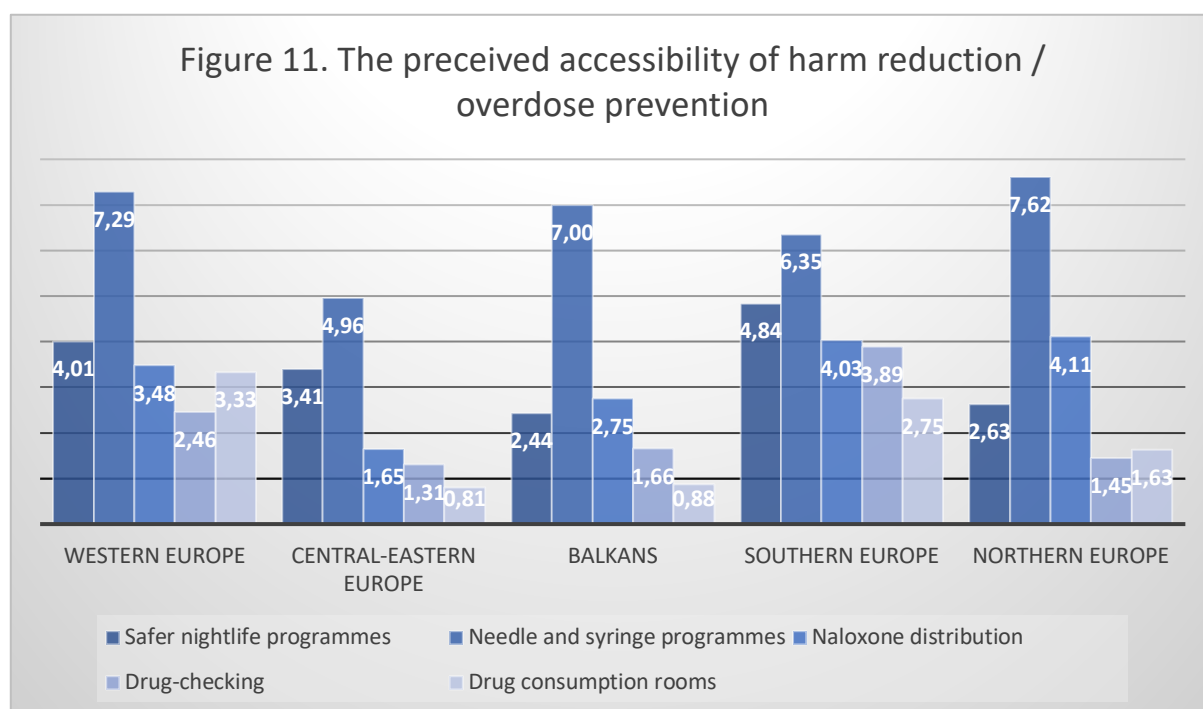
The remaining harm reduction services occupy the last four positions on the list. The fourth least accessible service among all we analyse were safer nightlife programmes, with an average of 3.85. The professionals rated their accessibility as moderate (the highest existing rating) only in Southern European and Western European countries. In other regions, the accessibility of this type of services was perceived as low, with CEE being somewhat closer to the top threshold of this category, and the Balkans leaning towards its bottom threshold.

The accessibility of naloxone distribution programmes was perceived yet lower, with 3.53 points. Moderate accessibility of naloxone was reported in NE and SE. In WE and the Balkans the naloxone distribution programmes were seen as poorly accessible, while the level of their accessibility CEE was rated as very low.

Drug-checking programmes were last but one type of service in terms of their accessibility, rated at an average of 2.38 points. Drug-checking seems to be most accessible in SE countries, which nevertheless fell into the ‘low’ category, along Western Europe. The professionals rated the accessibility in the Balkans, NE, and CEE as low.

Drug consumption rooms are least accessible type of drug services in Europe. It is the only type of service which accessibility was perceived by the respondents as poor, with only 1.57 points. The highest perceived accessibility (‘low’ category) was the case in WE and SE. In NE the accessibility of DCRs is very low, and they are virtually absent in the Balkans and CEE.

Figure 11. The perceived accessibility of harm reduction / overdose prevention.



Overall quality of harm reduction services is significantly higher than their accessibility. Needle exchange programmes were perceived by professionals as the second best-quality type of intervention, with 7.49 average (one of three types of services, along OST and HIV/HCV treatment rated at high level of quality). The quality of NSPs was seen as high in all examined regions.

The fourth best-quality type of service was drug consumption rooms, with an average of 6.80. The quality of DCRs was seen as high in NE2, WE and SE countries. In the Balkans, the professionals rated the quality of DCRs as moderately high³, and in CEE as moderate.

² The data on the quality of DCRs in NE comes only from Denmark as this type of service is not accessible in other countries in the region.

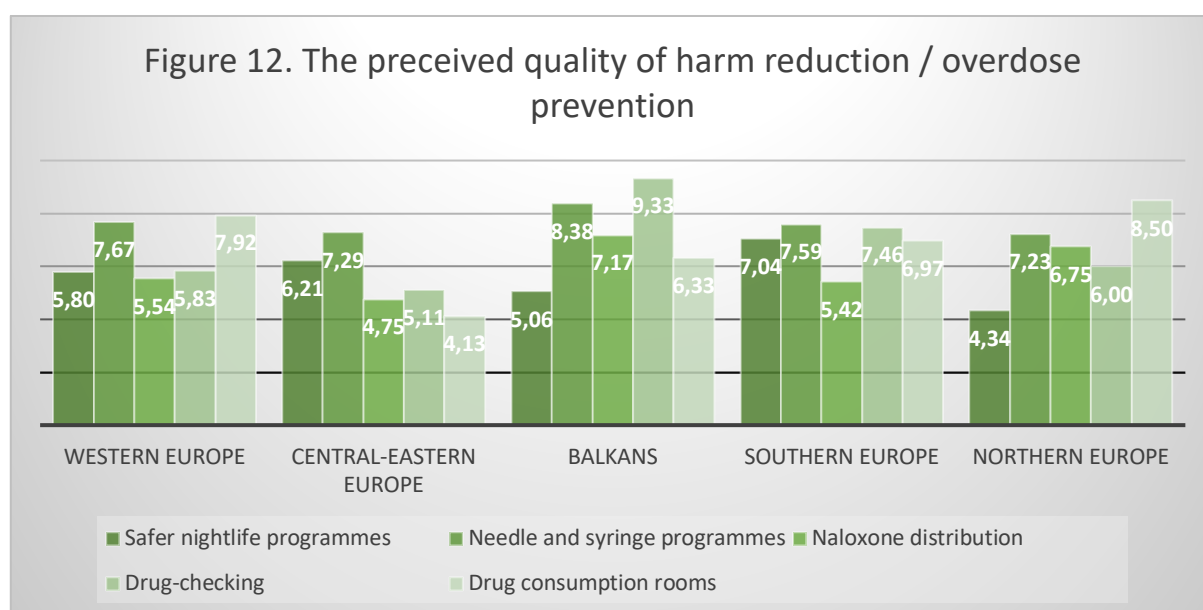
³ For DCRs and drug-checking services, the quality data comes only from Slovenia, as the service is not accessible in other countries in the region.

Naloxone distribution programmes placed as 7th in terms of quality, with average of 6.28. The quality of naloxone distribution was seen as high in the Balkans and moderately high in NE. In the remaining regions, the experts perceived the quality of this service as moderate.

Safer nightlife programmes are the 8th best-quality type of intervention, averaging at 6.23 points. Their quality was perceived as high in SE countries, and moderately high in CEE. In WE, the Balkans, and NE the quality of safer nightlife programmes was rated as moderate.

The quality of drug-checking was seen by professionals as 9th best with 6.20 points on average. The best quality of drug-checking can be seen in the Balkans (very high quality). In SE, drug-checking were seen as exhibiting high quality, an in NE – moderately high. WE and CEE fell into the ‘moderate’ category.

Figure 12. The perceived quality of harm reduction / overdose prevention.



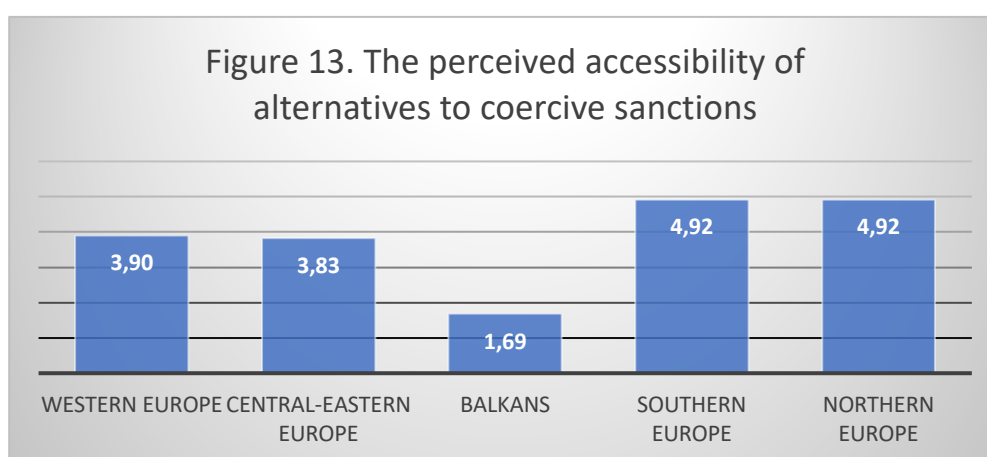
4.4 Alternatives to coercive sanctions

According to the Justice and Home Affairs Council (2018), alternatives to coercive sanctions (ACSs) include, for example, social reintegration and aftercare, recovery and rehabilitation, education, suspension of sentence with treatment, and suspension of investigation or prosecution.

Compared to other drug policy measures, ACSs are moderately accessible across Europe, being rated at 4.04 points, which makes them the fifth least accessible instrument.

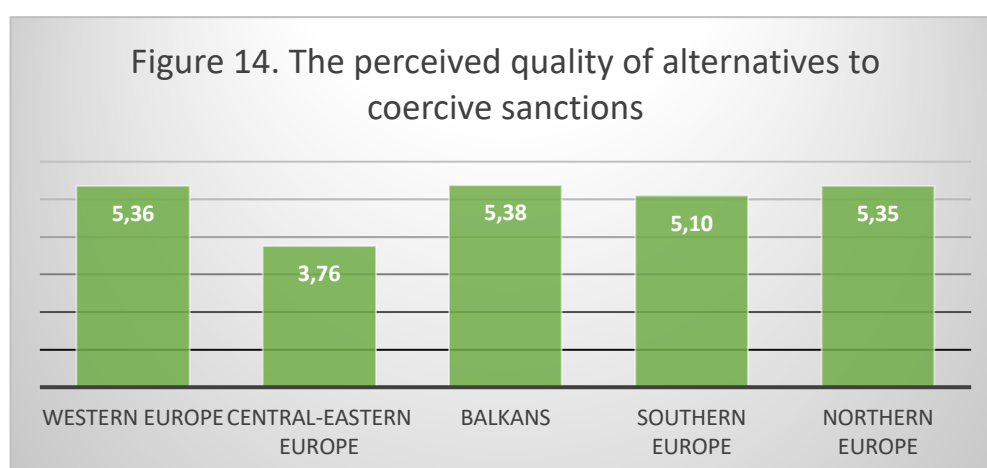
The accessibility of ACSs was seen as moderate in SE and NE. WE and CEE, with very similar ratings, fell into the 'low' category of accessibility, while in the Balkans the accessibility of ACSs was rated as very low.

Figure 13. The perceived accessibility of alternatives to coercive sanctions.



Alternatives to coercive sanctions seem to be the poorest type of intervention in terms of quality, rated at 5.14 points on average. The quality of ACSs was seen as moderate in all regions but CEE, which was rated by experts as exhibiting low level of quality.

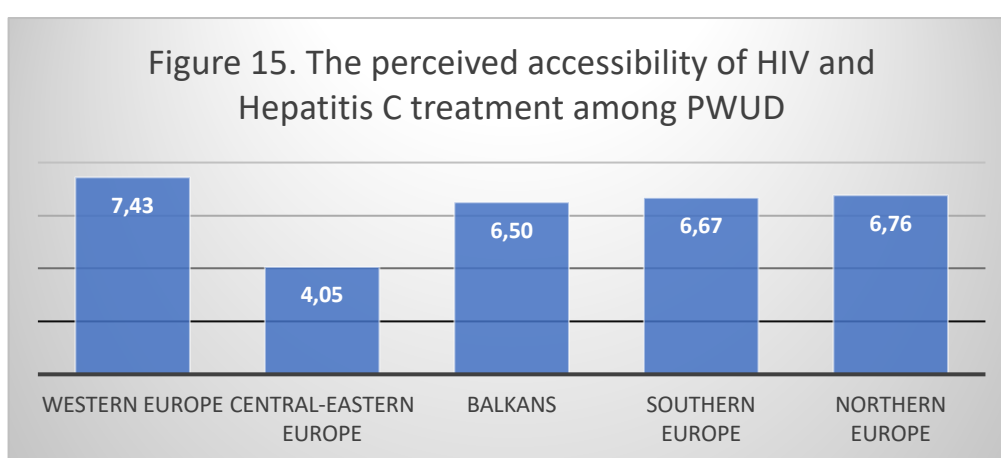
Figure 14. The perceived quality of alternatives to coercive sanctions.



4.5 HIV and HCV treatment

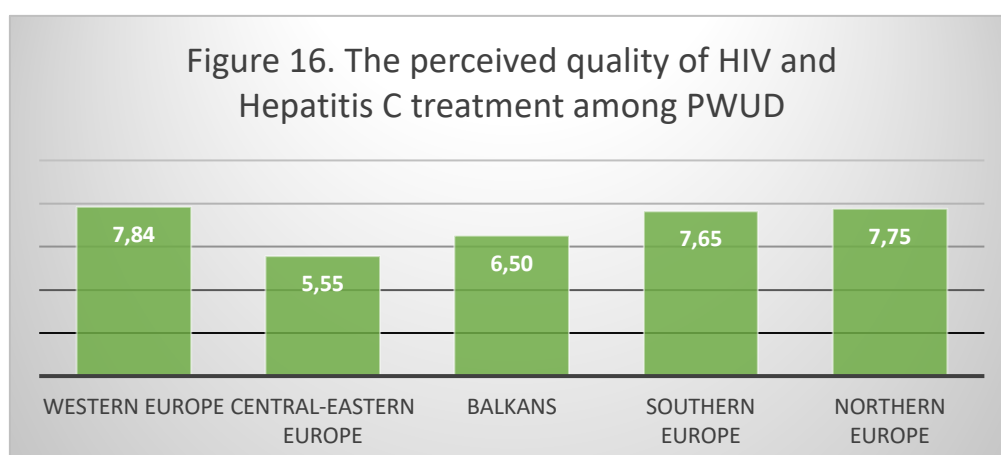
Finally, the last type of services we analyse is the treatment of HIV and HCV. It is the third most accessible service in Europe, rated at 6.47 points. The accessibility to HIV and HCV treatment was seen as high in the Western European countries. In NE, SE and the Balkans, the accessibility of this service was perceived as moderately high, with all three regions receiving very similar scores. CEE region placed last, with moderate perceived accessibility of HIV and HCV treatment among PWUD.

Figure 15. The perceived accessibility of HIV and Hepatitis C treatment among PWUD.



HIV and HCV treatment services for PWUD were rated as having the best quality among all examined services, with 7.57 points. In three regions: WE, NE and SE, the quality of HIV and HCV treatment was perceived as high. Meanwhile, the Balkans fell into the 'moderately high' quality category, and CEE into 'moderate'.

Figure 16. The perceived quality of HIV and Hepatitis C treatment among PWUD.



In this section, we have discussed the accessibility and quality of 13 key services for people who use drugs, as perceived by professionals responding to our survey. The overall picture shows that all examined services together are moderately accessible and characterised by moderately high quality. The most accessible group of interventions (among prevention, treatment, and harm reduction) is treatment. On the other hand, harm reduction services are the group with highest perceived quality. We have already discussed the high discrepancies between the quality and accessibility of more innovative harm reduction services. Interestingly, although indeed the average quality differs across services (ranging from 5.14 for ACSs to 7.57 for HIV and HCV treatment; 2.43-point difference), a much higher variance can be seen in the accessibility: from 1.57 for drug consumption rooms to 6.69 for needle and syringe programmes (5.12-point difference). This data suggests that the more innovative harm reduction services, where accessible, do not stand out from the others in terms of their quality.

The table below shows the professionals' ratings for the accessibility and quality of each examined services, as well as the European average. In bold red, we have indicated the services that differ from the average by more than two points. There are no services that would be perceived as more accessible or of better quality (by more than 2 points) in any of the regions. On the other hand, there are several services that were rated in specific regions by 2 or more points below the European average. The largest number of such types of services can be found in Central-Eastern European countries. The accessibility of services was seen as lower by more than 2 points than the European average in case of treatment (2.16 points difference), OST (2.86) and HIV and HCV treatment (2.42). One such case can be also found in the Balkans – there, alternatives to coercive sanctions were rated as much less accessible than the average (2.35 points difference). With respect to quality of services, again, the largest number of those rated significantly lower than the average can be found in CEE: prevention (2.23 points difference), online prevention (2.59), naloxone distribution (3.43), drug-checking (3.13), DCRs (5.15) and HIV and HCV treatment (2.02). The second position in this context is occupied by the Balkans where the significantly lower than average quality was the case for safer nightlife programmes (3.61 points difference), naloxone distribution (2.70), drug-checking (3.87), DCRs (5.22) and ACSs (2.45). DCRs were perceived as having significantly lower than average quality also in Northern European countries (4.68 points difference)

	Prevention	Online prevention	Safer nightlife	Treatment	Treating co-morbidities	Recovery/rehabilitation	NSPs	OST	Naloxone distribution	Drug-checking	DCRs	ACS	HIV and Hepatitis C
Accessibility of services													
Western Europe	6,4	5,3	4,0	7,2	5,6	7,0	7,3	7,9	3,5	2,5	3,3	3,9	7,4
Central-Eastern Europe	4,9	3,1	3,4	4,5	4,8	4,5	5,0	3,8	1,6	1,3	0,8	3,8	4,0
Balkans	5,3	3,0	2,4	6,4	4,1	5,0	7,0	7,3	2,8	1,7	0,9	1,7	6,5
Southern Europe	5,5	4,5	4,8	7,1	6,1	6,3	6,4	7,8	4,0	3,9	2,8	4,9	6,7
Northern Europe	6,3	5,9	2,6	6,3	4,0	6,1	7,6	6,9	4,1	1,4	1,6	4,9	6,8
<i>European average</i>	5,9	4,5	3,9	6,7	5,3	6,3	6,7	6,7	3,5	2,4	1,6	4,0	6,5
Quality of services													
Western Europe	6,3	6,2	5,8	6,8	6,2	7,2	7,7	7,8	5,5	4,7	6,3	5,4	7,8
Central-Eastern Europe	3,8	3,0	6,2	6,2	5,4	4,7	7,3	6,0	2,9	3,1	1,7	3,8	5,5
Balkans	6,9	3,9	2,6	6,1	4,6	5,3	8,4	7,3	3,6	2,3	1,6	2,7	6,5
Southern Europe	5,7	5,6	7,0	6,1	5,6	5,9	7,6	7,2	5,4	7,5	7,0	5,1	7,6
Northern Europe	5,5	6,2	4,3	6,3	4,6	6,3	7,2	5,7	6,8	4,5	2,1	5,4	7,8
<i>European average</i>	6,0	5,6	6,2	6,8	5,8	6,6	7,5	7,0	6,3	6,2	6,8	5,1	7,6

Table 3. The summary of ratings for the accessibility and quality of examined services.

5 Comparative analysis 2018-2020

To make the comparison possible, we have selected only those countries, for which the data were available in both 2018 and 2021 survey and only those services that appeared in both surveys (HIV and HCV treatment was not included in 2018). The table below shows the list of countries belonging to each region.

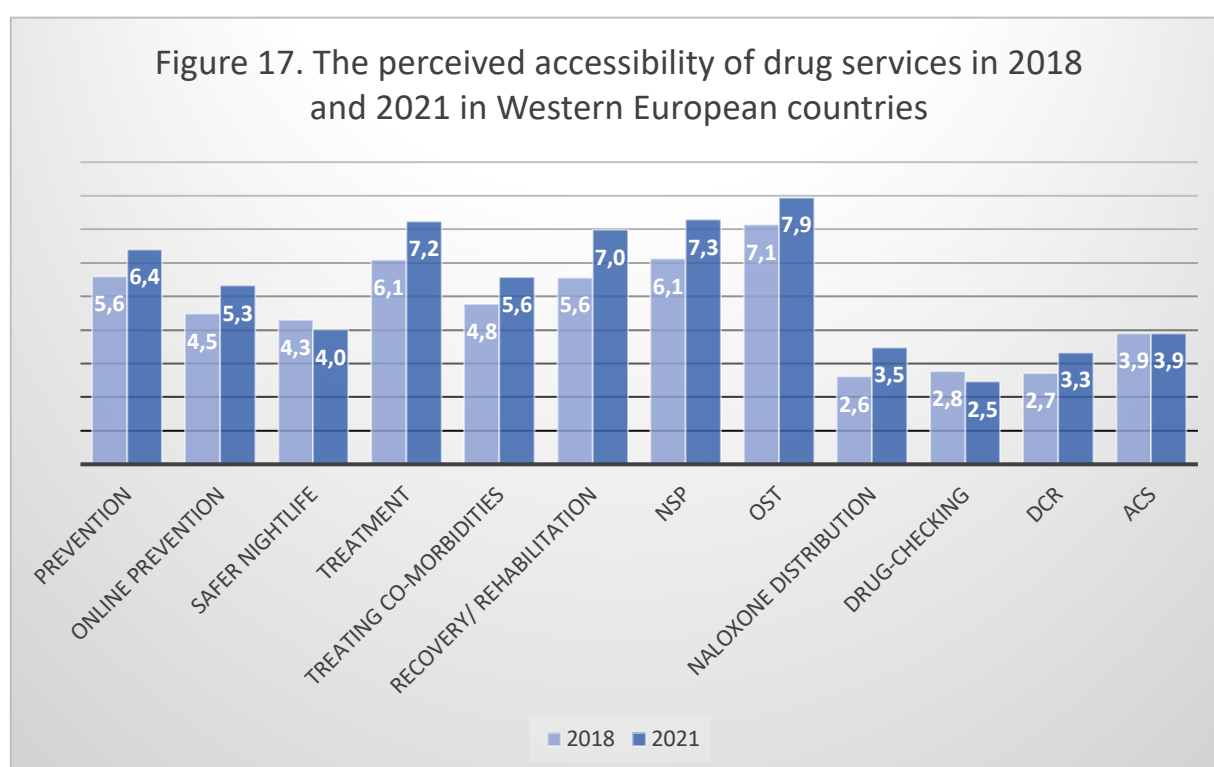
Table 4. The list of countries in regions for comparative analysis.

Western Europe	Central-Eastern Europe	Western Balkans	Southern Europe	Northern Europe
Belgium	Czechia	Montenegro	Italy	Denmark
Germany	Hungary	Serbia	Portugal	Estonia
Ireland	Poland		Spain	Finland
The Netherlands	Slovakia			Sweden
UK	Romania			

5.1 Western Europe

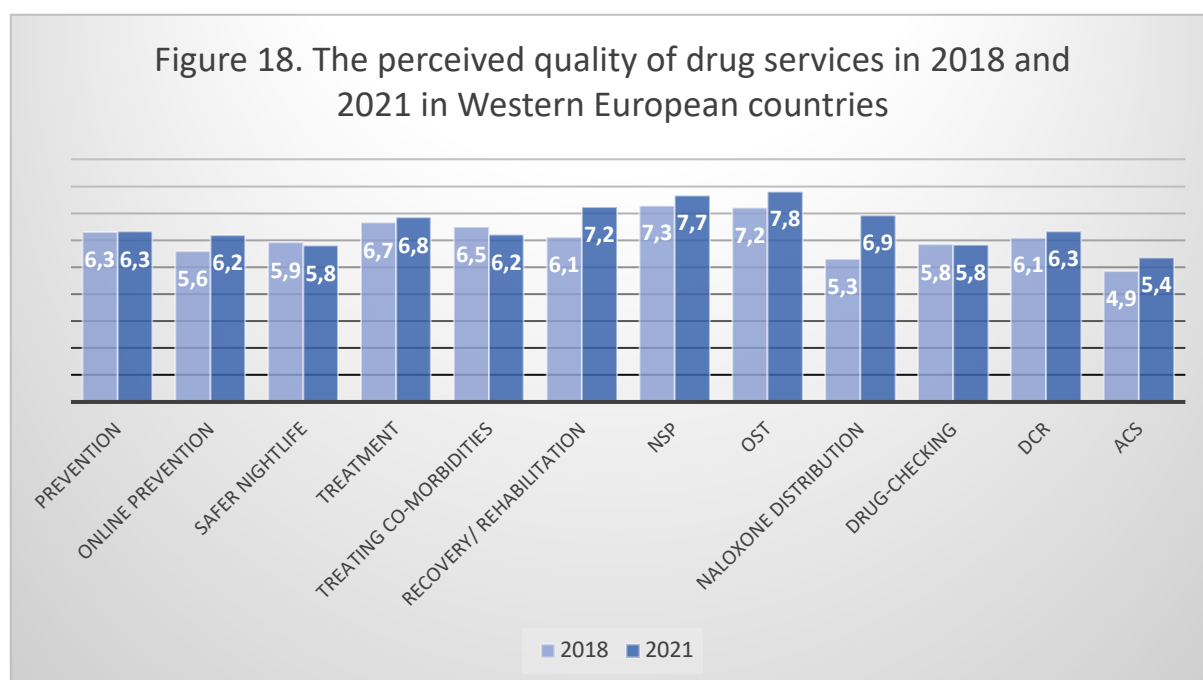
First, we take a closer look at the situation in Western Europe. As shown in the figure below, the vast majority of examined services were perceived as more accessible in 2021 than in 2018, with the overall increase by 0.6 points. The most significant increase of perceived accessibility can be seen in recovery/rehabilitation (1.4 points), followed by NSPs (1.2) and treatment (1.1). The increase in accessibility in other services does not exceed one point. Two types of services were perceived as slightly less accessible in 2021: safer nightlife programmes and drug-checking.

Figure 17. The perceived accessibility of drug services in 2018 and 2021 in Western European countries.



The overall quality of drug services in Western Europe was perceived as 0.4 points higher in 2021 than in 2018. The highest improvement in quality can be seen in naloxone distribution programmes (1.6 points) and recovery/rehabilitation (1.1). On the other hand, a minimal deterioration of quality was reported for treating co-morbidities and safer nightlife interventions. The quality of other examined services was seen as unchanged or improved by less than one point.

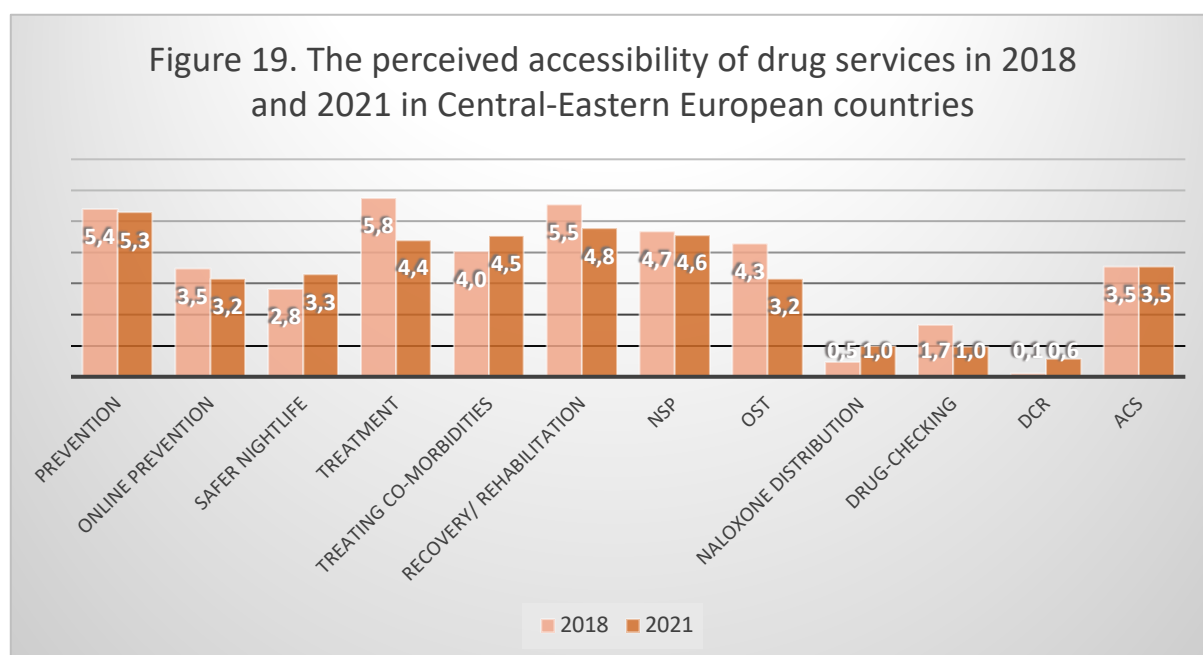
Figure 18. The perceived quality of drug services in 2018 and 2021 in Western European countries.



5.2 Central-Eastern Europe

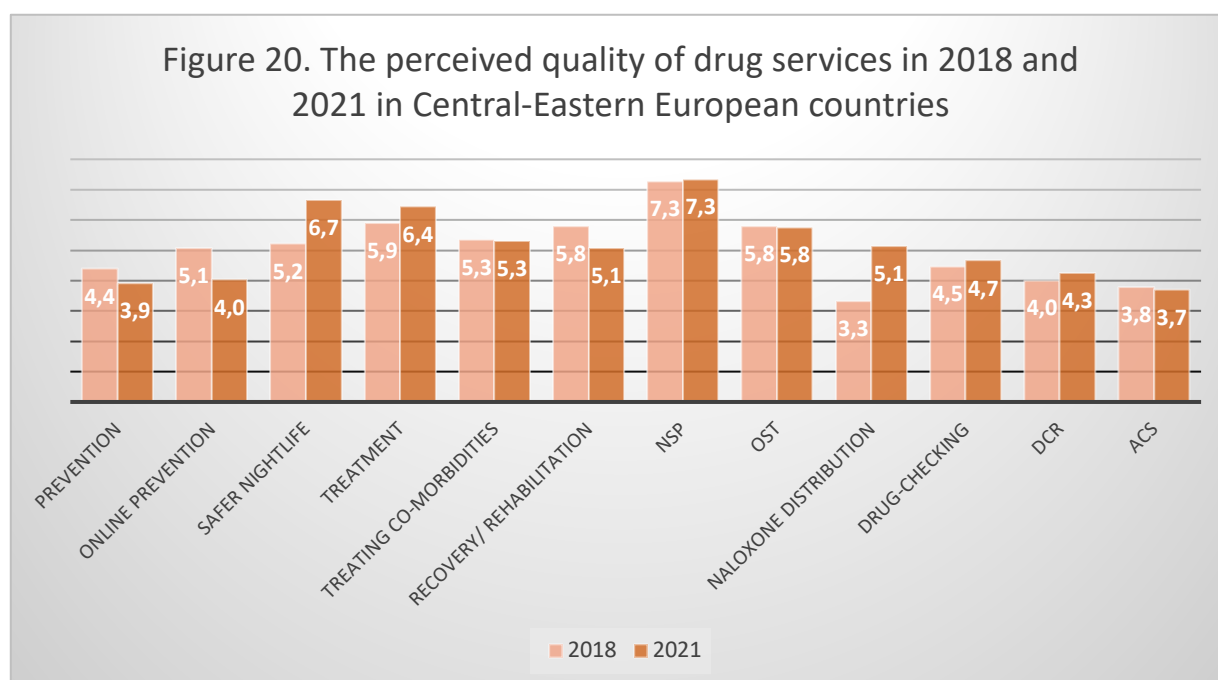
The overall perceived accessibility of examined drug services was seen as slightly lower in 2021 than in 2018 (3.27 and 3.5 points, respectively). There were only four types of services rated as more accessible in 2021: DCRs (0.5 points), naloxone distribution (0.5), treating co-morbidities (0.5) and safer nightlife programmes (also 0.5 points). The accessibility of ACSs was rated as unchanged, and all other types of services exhibited a perceived decrease in accessibility. The most notable deterioration can be seen in case of treatment (1.4-point decrease) and recovery/rehabilitation with 0.7 points fall since 2018.

Figure 19. The perceived accessibility of drug services in 2018 and 2021 in Central-Eastern European countries.



The picture emerging from the data on quality is slightly more optimistic. Overall, the quality of services in CEE was seen as slightly higher in 2021 than in 2018 (0.2-points difference). There were two types of services rated as significantly higher-quality in 2021: naloxone distribution (1.8-points improvement) and safer nightlife programmes (1.5 points). On the other hand, visible deterioration of quality was reported for online prevention (1.1 points). Among remaining services, where the 2018-2021 difference has not exceed one point, five were perceived as having their quality poorer in 2021, and four as higher.

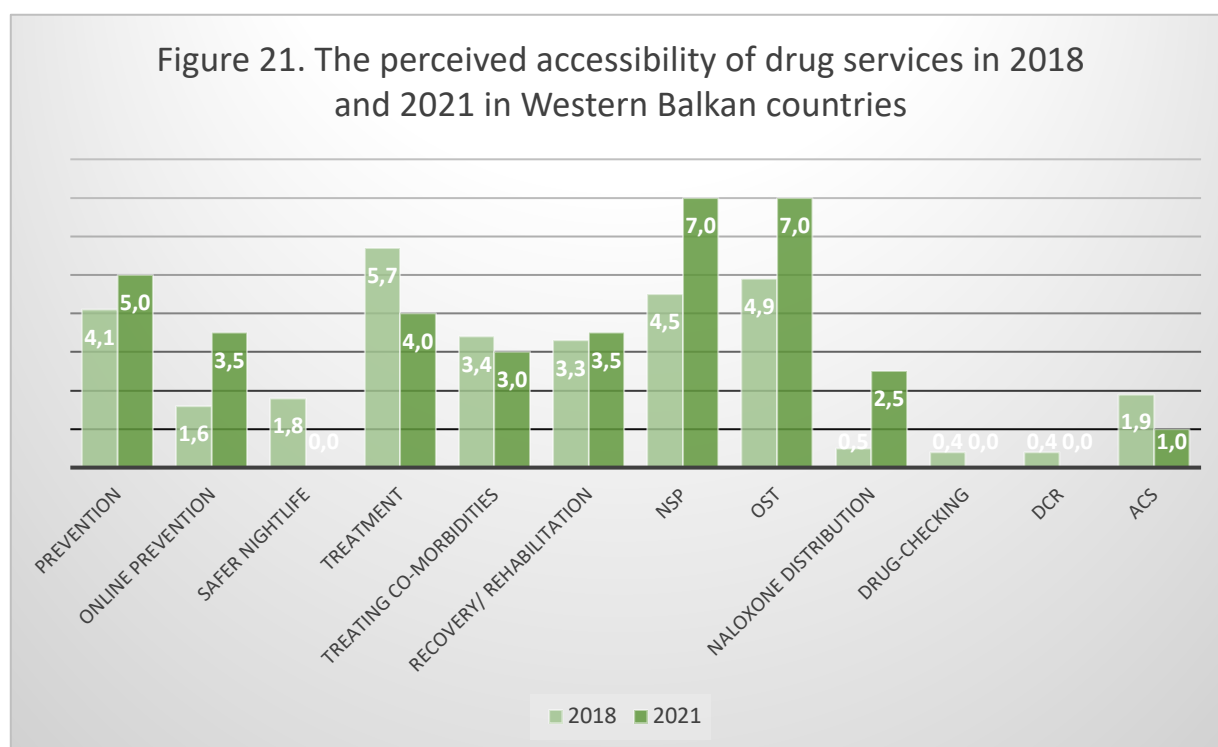
Figure 20. The perceived quality of drug services in 2018 and 2021 in Central-Eastern European countries.



5.3 Western Balkans

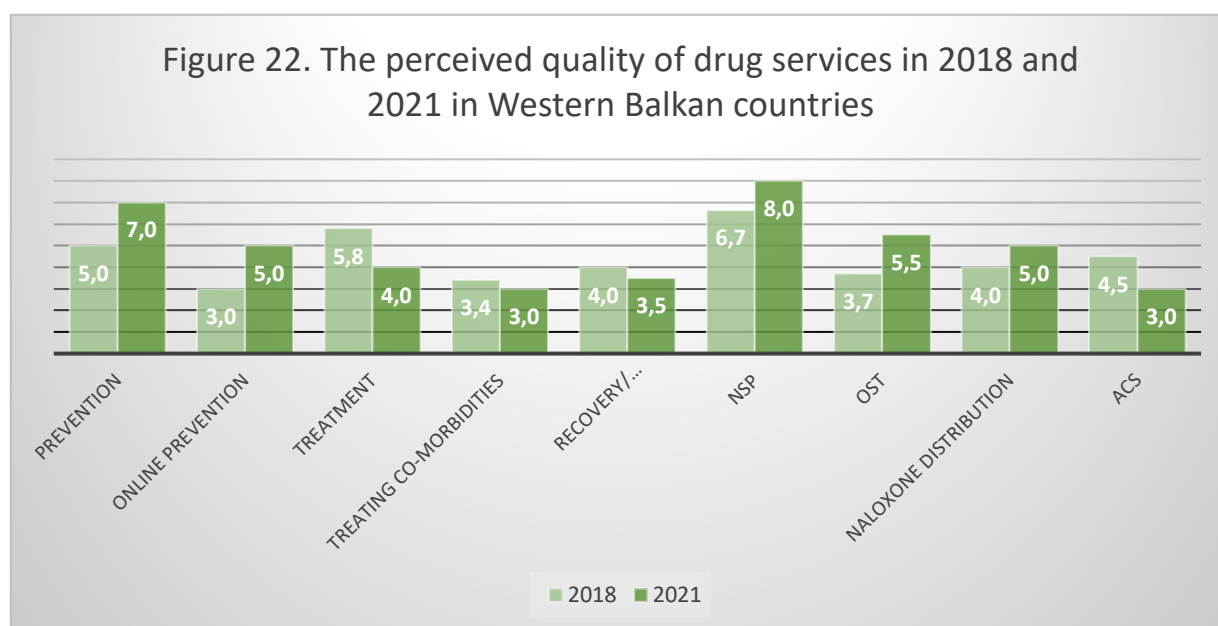
The perceived accessibility of examined drug services slightly increased in Western Balkans (2.7 in 2018 and 3.0 in 2021). The most notable increase in perceived accessibility can be seen in NSPs (2.5 points), OST (2.1), naloxone distribution (2.0) and online prevention (1.9). On the other hand, a significant decrease in perceived accessibility was reported for safer nightlife services (1.8 points) and treatment (1.7). Among services where the difference between 2018 and 2021 did not exceed one point, accessibility was rated higher in 2021 for two of them and lower for four.

Figure 21. The perceived accessibility of drug services in 2018 and 2021 in Western Balkan countries.



The overall quality of drug services was seen by professionals as stable (0.4-points higher in 2021 than in 2018). The service types which exhibited significant improvement of perceived quality include prevention (2.0 points), online prevention (2.0), OST (1.8), needle and syringe programmes (1.3) and naloxone distribution (1.0). On the other hand, the types of services where quality was seen as significantly lower in 2021 include treatment (1.8 points) and ACS (1.5 points). Treatment of co-morbidities and recovery/rehabilitation were perceived as slightly deteriorating. Other services were not included in the analysis as they were reported as not accessible by the respondents.

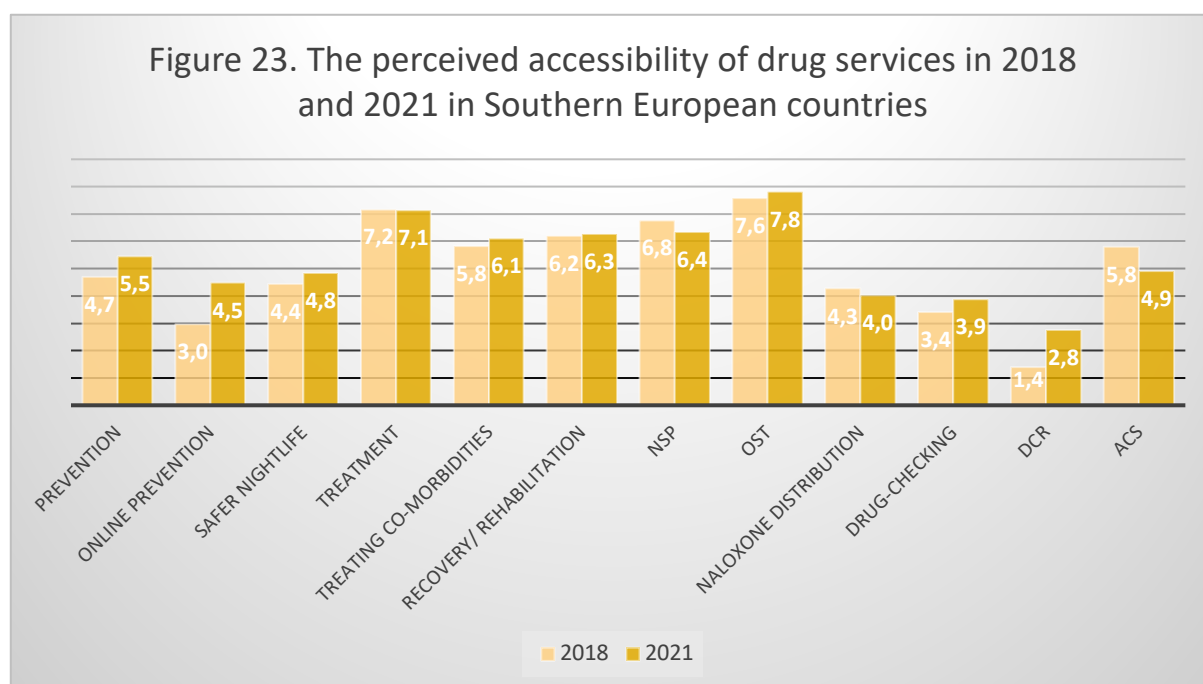
Figure 22. The perceived quality of drug services in 2018 and 2021 in Western Balkan countries.



5.4 Southern Europe

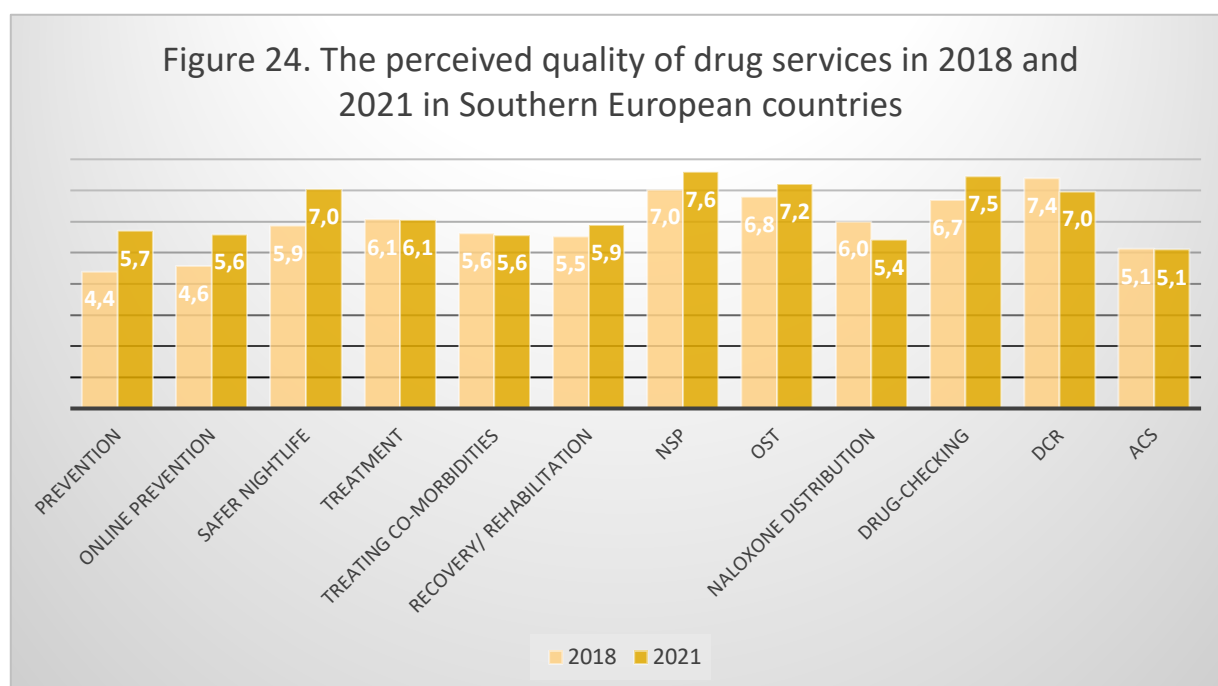
In Southern European countries, the aggregate accessibility was seen as 0.34 points higher in 2021 than in 2018. There were two types of services which experts perceived as becoming significantly more accessible: online prevention (1.5-points difference) and drug consumption rooms (1.4 points). Among other services, there were four with slight decrease in perceived accessibility and five interventions exhibiting some improvement.

Figure 23. The perceived accessibility of drug services in 2018 and 2021 in Southern European countries.



With respect to quality, we can see a slightly higher aggregate improvement of 0.4 points. Three services noted a significant improvement of perceived quality: prevention (1.3 points), safer nightlife programmes (1.1) and online prevention (1.0). Naloxone distribution was the only type of service where the perceived quality deteriorated during 2018-2021 period (0.6 points), and in case of treatment, treating co-morbidities and ACS it remained unchanged.

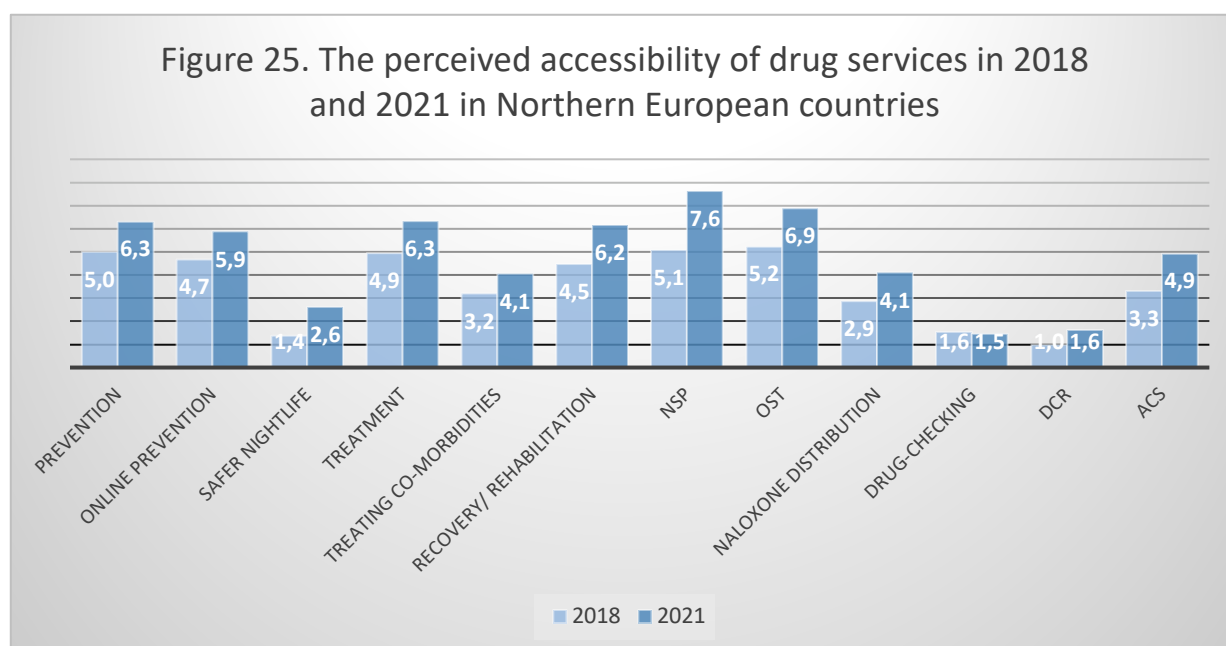
Figure 24. The perceived quality of drug services in 2018 and 2021 in Southern European countries.



5.5 Northern European countries

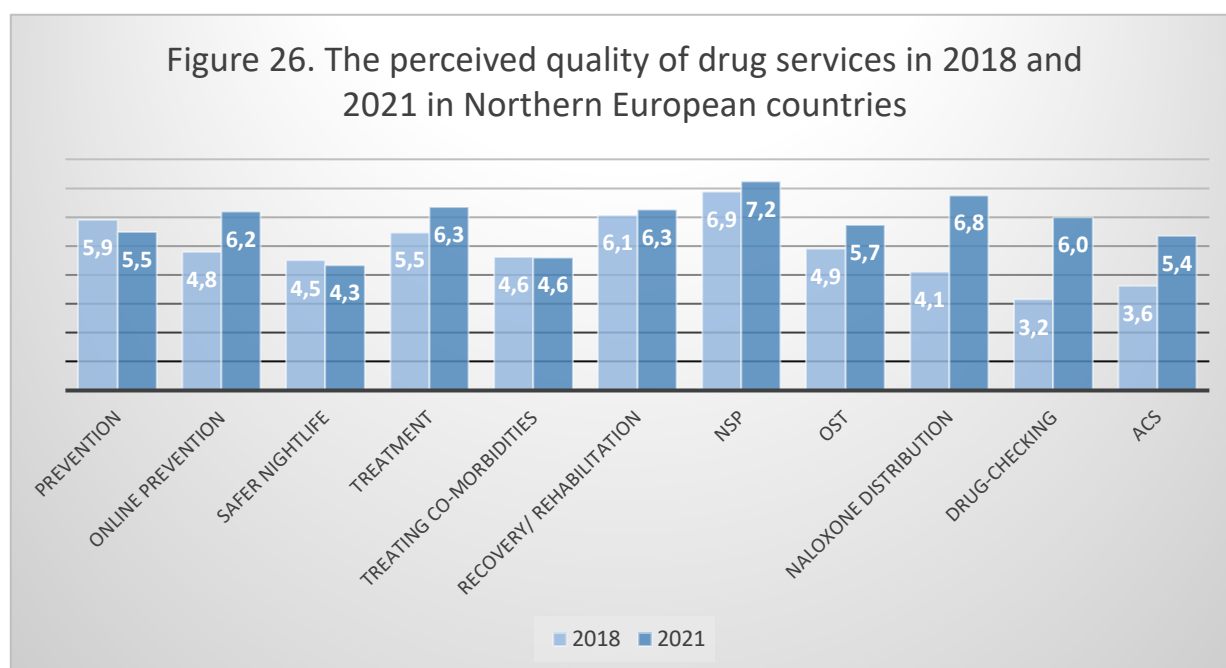
The most notable increase in the perceived accessibility of examined drug services took place in Northern Europe, with a difference of 1.4 points overall. There was only one type of services rated slightly lower in 2021 than 2021 – drug-checking (0.1-point difference). Meanwhile, nine types of interventions were reported to have their accessibility increased by more than one point: NSPs (huge, 2.5-points increase), recovery/rehabilitation (1.7), OST (1.7), ACS (1.6), treatment (1.4), prevention (1.3), online prevention (1.2), naloxone distribution (1.2) and safer nightlife programmes (1.2).

Figure 25. The perceived accessibility of drug services in 2018 and 2021 in Northern European countries.



Northern Europe also noted a rather spectacular, compared to other regions, improvement of the perceived quality of the examined drug services, averaging at 0.9 points-increase. Safer nightlife interventions and prevention were the only two services rated slightly lower in 2021 (0.2 and 0.4 points, respectively). On the other hand, the services exhibiting great improvements in perceived quality include drug-checking (2.8 points), naloxone distribution (2.7) and alternatives to coercive sanctions (1.8).

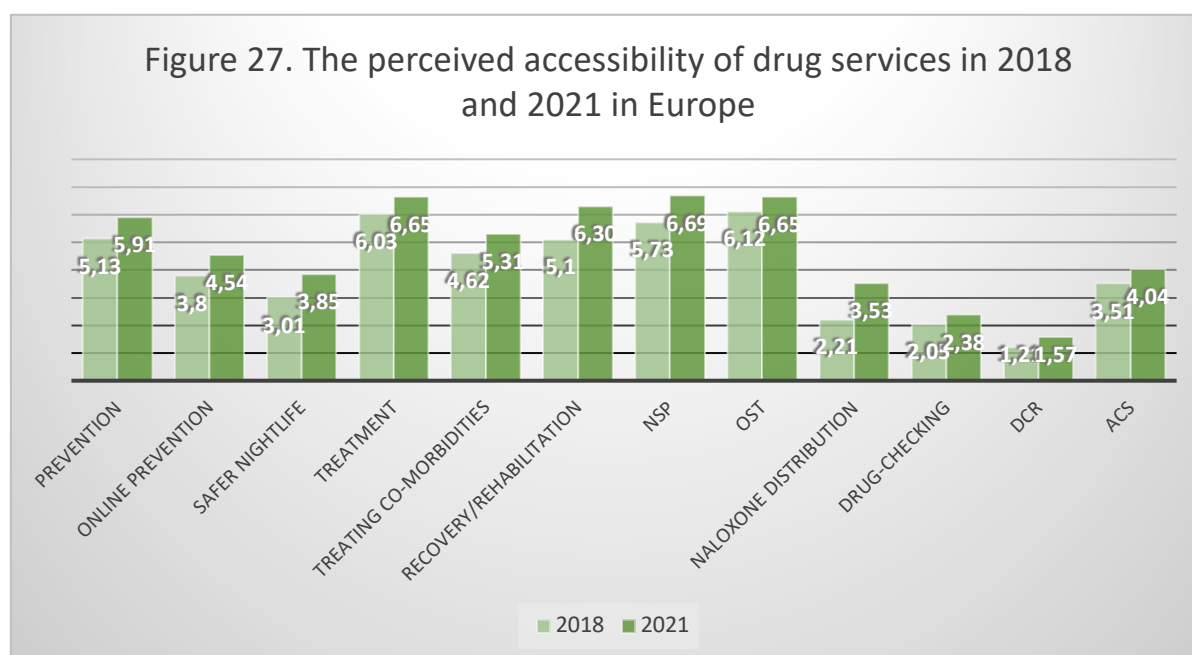
Figure 26. The perceived quality of drug services in 2018 and 2021 in Northern European countries.



5.6 Europe

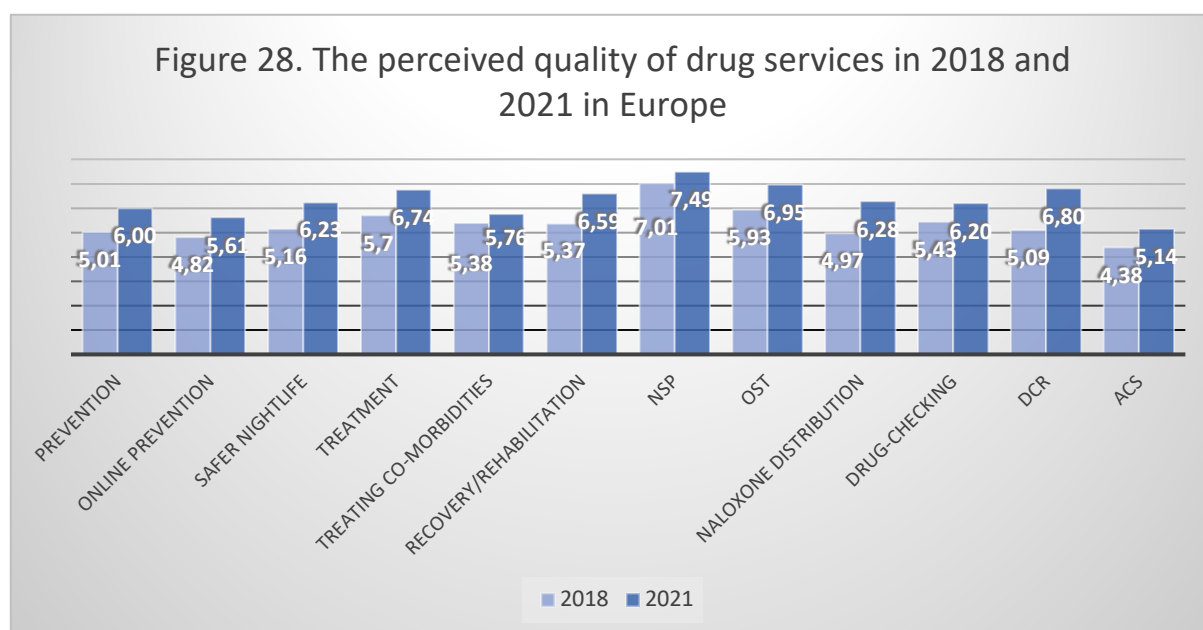
At the aggregate European level, the accessibility of examined services increased by 0.74 points during 2018-2021 period. Interestingly, not a single type of intervention was rated as less accessible in 2021 than in 2018. The highest increase in perceived accessibility can be seen for naloxone distribution (1.32 points) and recovery/rehabilitation (1.20), followed by slightly less impressive increase for NSPs (0.96) and safer nightlife services (0.84). The smallest increase in perceived accessibility can be seen, not surprisingly, in case of drug-checking and drug consumption rooms (0.33 and 0.36 points, respectively).

Figure 27. The perceived accessibility of drug services in 2018 and 2021 in Europe.



With respect to perceived quality, the aggregate average improvement was 0.96 points. Like accessibility dimension of services implementation, no service type was seen as exhibiting poorer quality in 2021 than in 2018. Six types of interventions were rated one or more points higher in 2021: drug consumption rooms (1.71 points), naloxone distribution (1.31), recovery/rehabilitation (1.22), safer nightlife programmes (1.07), treatment (1.04) and OST (1.02). The most modest improvement of perceived quality was reported for NSPs (0.48 points) and treatment of co-morbidities (0.38). It needs to be noted, however, that the quality of NSPs was rated as the highest among all services both in 2018 and 2021. Meanwhile, the quality of treating co-morbidities is nearly 1.75 points lower than the quality of NSPs. Therefore, the room for improvement is much broader in this case.

Figure 28. The perceived quality of drug services in 2018 and 2021 in Europe.



So far, we have discussed the accessibility and quality aspects of services for PWUD in general. In the next chapter, we will take a closer look at accessibility of several basic services among selected special populations.

6 Access to services among special populations

In this section, we focus on four basic types of services: prevention, treatment, harm reduction and recovery/rehabilitation. The specific groups taken into consideration are women, youth, ageing people who use drugs, prisoners, and migrants/ethnic minorities.

The average of perceived accessibility of all services together was the highest among women (6.08), followed by youth (5.69), ageing PWUD (5.27), prisoners (4.61) and migrants/ethnic minorities (3.92). Women enjoyed the best-rated accessibility in case of harm reduction, treatment, and recovery/rehabilitation. For all types of services, the accessibility among women was seen as moderate or moderately high.

The perceived accessibility of prevention was the highest among youth ('moderately high' score), and moderate among prisoners, women and ageing PWUD. Low accessibility of prevention was reported among migrants and ethnic minorities.

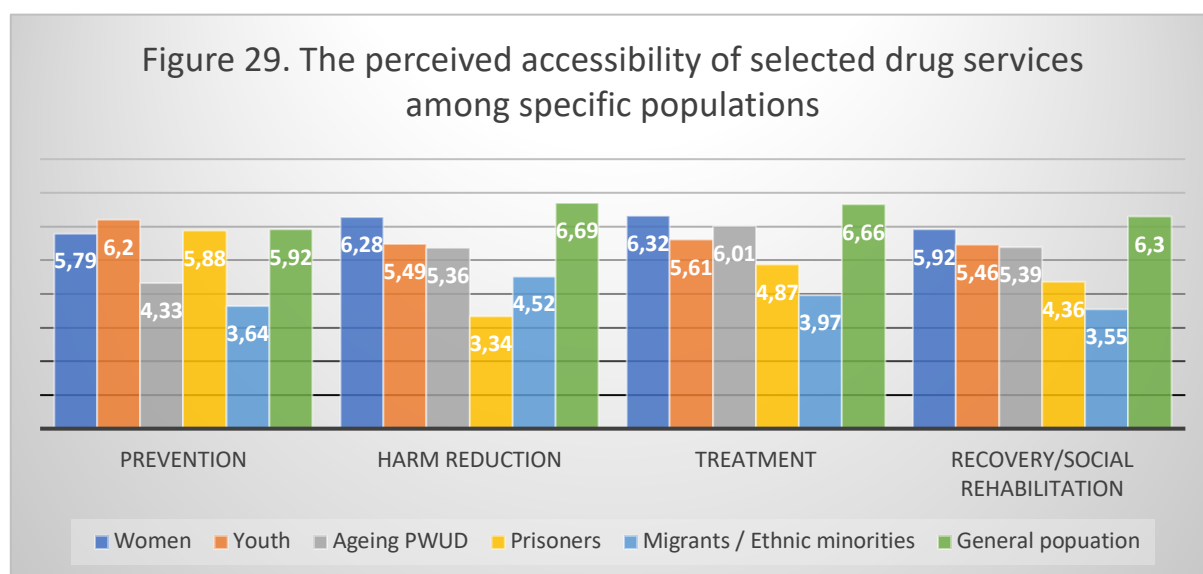
Prisoners are the population with the most limited access to harm reduction ('low' category). Moderate accessibility was reported for migrants/ethnic minorities, ageing PWUD and youth.

Treatment was the most accessible type of service among special populations (5.4 points), with moderately high perceived accessibility among two groups: women and ageing PWUD. Perceived access to treatment was seen as moderate among youth, prisoners, and migrants/ethnic minorities.

Finally, recovery/rehabilitation was rated as most accessible for women, followed by youth, ageing PWUD, prisoners and migrants.

As shown in the figure below, for all special populations, the access to different types of services is more restricted than for the general population. The differences are especially striking when comparing groups of prisoners and migrants with general population.

Figure 29. The perceived accessibility of selected drug services among specific populations.



As shown in the table below, however, the accessibility of examined services increased notably over the period 2018-2021. The most significant improvement of perceived accessibility can be seen among prisoners – 1.19 points, translating to 37%-increase. Prevention services are responsible for a large portion of the improvement, increasing by 84% during 2018-2021. The accessibility of harm reduction in treatment also improved in this group notably, reaching 29% and 25% increase, respectively.

The second-best group in terms of proportional increase of perceived accessibility of services were migrants and ethnic minorities, with 27% improvement (0.82 points). Here, the highest improvement can be seen in harm reduction (33%) and treatment (32%), followed closely by prevention (30%).

The third group on the list is ageing people who use drugs, with 21% (0.87 points) improvement in perceived accessibility of services. The perceived accessibility of recovery/rehabilitation was the highest in terms of points (1.09 points, 25%). Proportionally, the highest increase can be seen in prevention (27%, 0.93 points).

The improvement of services' accessibility equalled .0.9 points, translating to 18%. Here, prevention and recovery/rehabilitation scored 21%-increase each, followed by harm reduction (19%) and treatment (11%).

Finally, youth was the group experiencing the lowest increase of perceived access to services, with only 0.59 points of difference, or 12%. The perceived accessibility of prevention and treatment among youth improved only by 0.3 and 0.31 points (5% and 6%), respectively. The most notable improvement can be seen for harm reduction services, with 0.99 points translating to 22%.

Table 5. The changes in perceived accessibility to services among specific populations between 2018 and 2021.

		Prevention	Harm reduction	Treatment	Recovery/ rehabilitation
Women	2018	4,8	5,3	5,7	4,9
	2021	5,8	6,3	6,3	5,9
	Change	0,99	0,98	0,62	1,02
Youth	2018	5,9	4,5	5,3	4,7
	2021	6,2	5,5	5,6	5,5
	Change	0,3	0,99	0,31	0,76
Ageing PWUD	2018	3,4	4,6	5,3	4,3
	2021	4,3	5,4	6,0	5,4
	Change	0,93	0,76	0,71	1,09
Prisoners	2018	3,2	2,6	4,4	3,5
	2021	5,9	3,3	4,9	4,4
	Change	2,68	0,74	0,47	0,86
Migrants/ethnic minorities	2018	2,8	3,4	3,5	2,7
	2021	3,6	4,5	4,0	3,6
	Change	0,84	1,12	0,47	0,85

7 Qualitative assessment

7.1 Austria

Traditionally, Austria has been a good example of drug policy, and the national policy is strongly related to the EU Drug Strategy. As drug policy in Austria is to a large extent the responsibility of the districts, regional differences in drug services can be seen. Vienna is seen as the best example, with many available services, pioneering in innovation, and leaning towards decriminalisation of drugs over the last several years.

In Austria, besides the general national drug strategy, each district has their own strategy or action plan as well, own system of services. The level of development of different services in different districts is rather a question of funding than ideology, i.e., a question of how much to invest in specific services. National-level drug coordination in Austria does not have much impact on the regional services and their funding. Still, it is the level that is in connection with the EU Drug Strategy, and it is responsible for ensuring that certain measures are available in Austria. In some areas, it seems, Austrian drug policy is developed more than the EU one.

Over the last years, the approach to prevention has changed. Nowadays, instead of operating with fear, the approach is more evidence-based, focusing on strengthening self-esteem, raise awareness about risks of drug consumption. It also addresses alcohol, which is considered as the most serious danger. Prevention programmes are operated mostly by CSOs, and there are many good quality programmes in the field. There is no consistent system, however. Prevention is not a part of the school curriculum, hence, the way it is delivered depends to a large extent on the school and organisation a school invites to implement the intervention.

Minimum quality standards in the existing prevention programmes are met to a large extent. Still, there is no one global strategy, but several smaller initiatives with narrow focus (e.g., prevention of tobacco smoking). This results in lack of consistency and significant differences between programmes, schools, or regions. Another problem is the instability of funding. In consequence, there are no comprehensive programmes that would extend for several years.

The situation of residential, long-term treatment is seen as good, with some room for improvement. Namely, it seems that there is not enough flexibility and freedom in adjusting

the services to needs of individual clients, e.g., in terms of negotiating the treatment plan. For example, various lengths of treatment should be available, based on the individual assessment; adjusting the treatment to the situation and factors that emerge during the treatment, etc. One of major problems is that residential treatment centres normally only accept clients after detoxification. At the same time, the accessibility of detoxification in hospitals is very limited. Hence, it is often too difficult for PWUD to access it.

There is also residential treatment for clients on OST, which is more accessible.

One of the main criticisms is regarding the complete lack of treatment of relapse, which results in people getting back to steady consumption again.

Most people dependent on opiates are in the substitution treatment. OST is operated through pharmacies. In addition to methadone and buprenorphine, retard morphine is also prescribed. There is no heroin maintenance treatment. OST can be prescribed by medical doctors who have further education in substitution treatment. There are not many doctors interested in prescribing OST, however, as PWUD are considered difficult clients. Still, the extent of OST provision it seems sufficient for the needs. Having an appointment for initiation of substitution is seen as relatively easily. The practice is to prescribe the medicine for; subsequently, the prescription must be evaluated and approved by a local GP. There are different regimes in place. Some clients must go to pharmacy every day, others once a week, depending on the individual situation (e.g., clients with stable work get the medicine for entire week). The regimes were relaxed during the Covid-19 pandemic: it was not necessary to see a doctor, and pharmacies gave away the medicine for a longer period. OST is available in prisons.

In general, there are significant differences between cities and the countryside. In cities with large drug scenes more services operate. Normally, all towns around 15,000-20,000 population do have drug services.

Austria has the tradition of residential treatment combined with very good reintegration programme through halfway houses, communities, etc. Such services were sometimes delivered by separate organisations, but they were mainly integrated in treatment centres. Programmes were comprehensive, including creative shops, employment, possibilities for

leisure activities, sport, etc. In the past, a person could stay in the reintegration programme for even up to three years. In the first half of 2010s, reintegration programmes were scaled down due to cost-effectiveness concerns. The cuts resulted in both disappearance of some programmes altogether and in restricting the scope of activities in programmes that remained. This is seen as a negative development, especially given the high success rate of such long-term programmes. Social reintegration still exists but marginally.

The accessibility of services for vulnerable populations (including dual diagnosis) is seen as insufficient and pushed to the background, compared to the past. There is a need for more specialised support for women with children, especially in the context of children support and parental rights. The situation is relatively difficult also in case of youth, where the main danger comes from the high THC-concentration cannabis. Many adolescents with drug-induced psychosis cannot access treatment because there are too few places, and the facilities are not qualified enough to address such problems. There are very few residential programmes for adolescents. Quality standards are not met in this area, there is a deterioration observable compared to the past.

NSPs in Austria follow the changes and developments on the drug scene. The services are following the users. NSPs are easily accessible, needle distribution is done through pharmacies, drop-in centres, outpatient clinics. There are big city-countryside differences with respect to programmes specialising in needles distribution. However, in the countryside needles are available locally in pharmacies, which are anyway highly involved in drug policy implementation because of the substitution treatment.

NSPs are normally delivered by CSOs, and sometimes also by public entities. Normally, if an CSO delivers harm reduction services, it is within a broader offer, with counselling, shelters, etc. NSPs are also available in prisons.

Naloxone is a regulated drug available for emergency services. It also can be used in drug services which employ medical doctors and be purchased with a prescription as well. There are no take-home naloxone programmes, and it does not seem to be an issue of interest now.

DCRs are not available, yet not for ideological, but pragmatic reasons. The arguments against this kind of service include the problems with localisation (to avoid drug scene emerging around it), geographical dispersion of PWUD and not much drug use visible on the streets.

Drug-checking has been available in Vienna for more than 20 years. It is considered a very good prevention tool (having a direct impact on the consumption of drugs) and very helpful instrument for the party scene. It seems that in Austria the introduction of drug-checking was not preceded by any ideological debate, but only pragmatic considerations. The situation of drug checking is excellent in Vienna and mixed in other parts of the country. There are more services in the far West. During Covid-19 pandemic, parties and festivals were cancelled. Some organisations moved their services online, providing online consultations, etc. Notwithstanding this interruption, drug-checking has been a continuously developing system, adapting to the developments on the drug scene. With respect to safer nightlife, it is a standard for organisers of big parties that harm reduction services are present with water and other services.

HIV and HCV treatment is evaluated positively. Since the beginning of the HIV epidemic, special units in hospital were created. Nowadays, HIV does not seem to be a problem of PWID communities due to the effective work of NSPs. The treatment is accessible.

HCV treatment, due to the cost and length of the therapy, sometimes is connected to drug treatment measure. In other words, receiving HCV treatment by PWUD is sometimes conditional upon at least attending drug counselling. Treatment is covered by health insurance. Additionally, there are CSOs who support treatment for people without insurance (e.g., undocumented migrants). Still, the access can be difficult for people who are not insured.

Overall, the Austrian system of drug services has been developing consistently, works well and meets the quality standards for drug services to a large extent. There has been some reduction (mostly financial) in services, but there are no major problems.

7.2 Belgium

Drug policy in Belgium is perceived as involving contradictions in the system. Namely, there are many top-down policies that are and not consulted. At the same time, there are some bottom-up projects, e.g., drug-testing at festivals, which get funding and are appreciated, but they do not make their way to the general national policy framework. It seems that there is no systematic, general strategy and holistic implementation. This results in a situation where there are bottom-up projects funded, operating well, and evaluated positively for years, and then suddenly disappearing due to the cuts in funding (e.g., DCRs and heroin-assisted treatment 10-15 years ago). Still, Belgian drug policy is seen as relatively good compared to other countries and offering a wide range of interventions. Arguably, drug policy NGO exist as a sector and, despite some differences between how things are organised in different parts of the country, numerous services often work together, there is complementarity, joints actions and co-existence.

Prevention in Belgium is seen as quite insufficient and inadequate. There are no proper drug prevention programmes in schools unless teachers are involved with local networks of drug organisations. This results in significant differences between individual schools in how prevention is delivered. Over the last decade, the expenses for drug prevention and education have been very low. Still, there is a mix of different types of interventions available, e.g., some NGOs are outsourced to help in prevention and health promotion activities in different institutions. The police implement some prevention activities as well, however, this practice is criticised by a number of professional organisations as counterproductive. Neither of these activities are systematic, however. According to the experts, some schools do not implement prevention at all, some do only reactively (when some of the pupils are caught possessing drugs). The programmes in schools which implement prevention at all can vary a lot.

Treatment in Belgium is seen as well-developed and offering a range of services for different target populations. There is still some room for improvement in facilitating access to some specific populations (e.g., in some services there are still many more men than women). If a person is a client of a low-threshold service already, they can access treatment very quickly. If someone wants to start a long-term therapy in a consultation centre, with psychologist and a full therapeutic package organised for them, it may be up to two-months waiting time for

the first set-up meeting. In case of residential treatment, it is necessary to wait several months more. However, 'in-between' places offering crisis intervention do exist. They are accessible within one week, and they provide support for people waiting for a place in treatment. There are big differences in geographical distribution of services – many more possibilities are available in big cities.

In Brussels, services for people with dual diagnosis have been available for a very long time. There are also residential services in place that specifically focus on dual diagnosis treatment. However, the complexity of people's problems in the Belgian drug services system is perceived as much higher than it was a decade years ago, cumulating mental health, precarity and drug use problems. It is seen as a big challenge because such clients require more time, more staff, and higher competencies from professionals.

There are very few specialised NGOs providing reintegration and recovery work, significant gaps exist in this area of care. However, all treatment services employ social workers who support clients in getting their basic situation in order, e.g., obtain social security documents, IDs, help manage their debts, find housing, etc. According to the experts, the most difficult part of reintegration is the link with employment support sector. This is because the clients in drug services are often outside the job support system, they do not have necessary documents to join a training, etc. Still, it seems that the situation has been improving recently, and a new way of thinking has been developing, involving not specifically employment support but voluntary or community work. Some services developed relationships with, for example, agricultural enterprises, and they offer new possibilities of work. Such participative projects are, according to the experts, a kind of new activism related to the environmental movement and are based on social ethics not oriented for profit.

According to the experts, employees in various services know one another. They know where they can refer the clients to receive support that respond to their needs. However, arguably, no real case management exists; if a person is referred to and taken over by another organisation or institution, the relationship stops, there is no continuity of informing about the person's situation between services. Still, many organisations are connected in a network, and work on common issues together. What is seen as more difficult is building relationships

with professionals outside of the drug policy sector, e.g., with GPs who work with PWUD, doctors from the mental health institutions and other sectors where PWUD also appear.

Opioid substitution treatment is seen as well-established and stable for years. There are specialised, state-funded, low-threshold services with social focus and medicalised services within the health care system. All general practitioners can prescribe OST for purchase in a pharmacy. GPs are required to undergo a special OST training only if the number of their OST patients exceeds certain threshold. Hence, the OST is seen as relatively highly accessible. Some barriers can be identified, however, as not all GPs are willing to accept PWUD as their patients. With respect to the regime of treatment, there is a variety of possibilities within OST: different medications, different doses, different terms of prescriptions.

The regime and control of OST clients depends on the individual centre. Urine tests are done in some centres, but they are not seen by the experts as an integral part of the treatment process. A lot depends on the person's relationship with their OST provider and trust between them.

As a rule, OST centres also employ psychologists and social workers. According to the experts, the OST system works well, and opioid use has been decreasing for some time. The difficulties arise elsewhere, e.g., in treating pregabalin or benzodiazepines dependency, which is an especially severe problem among migrants. Another challenge is the treatment of crack and methamphetamine addictions, which are a new, increasing trend in Belgium, that health professionals are not used to work with.

Needle and syringe programmes are seen as working well, too. Low-threshold services, operated mostly by NGOs funded from the regional budget, have access to needles. NSPs are available in many cities where there is a demand and need for them. Low-threshold services are the only type of services accessible for people without legal status in the country.

The situation of needle exchange is perceived as better today than several years ago. The funding system for supporting NGOs providing needle exchange is working well. The accessibility, according to the experts, could be improved in the countryside. Even there, however, sterile needles and syringes can be obtained in some local pharmacies, although not of them (there is a lack of systemic approach). The one element that is seen as missing is

the vending machines with injecting kits available for free at any time. Interestingly, it seems that the lack of this solution in Belgium is not a result of the lack of political will or funding (of which both were in place), but a technicality: the water for injections is considered a medication under the EU law, and as such it cannot be freely accessible.

One of the most difficult challenges within harm reduction area is the establishment of drug consumption rooms. The hundred-years old federal drug law does not allow for providing a space for people for drug consumption because of fear of opium-smoking places back in the day. Since this provision is still in the law today, drug consumption room cannot legally operate. DCRs are a topic of a heated political debate, with significant differences in approaches visible in different regions (e.g., in the French part there is political will for implementing DCRs, but it is lacking in Flanders), which results in blocking the initiative at the federal level.

Naloxone is available in Belgium in injecting form. It can be prescribed by doctors and purchased in pharmacy only by the prescription recipient. Moreover, it is included in the equipment of ambulances. It is not available for drug services' staff (e.g., social workers), PWUD and their families and friends. Naloxone administration is an act that can only be performed by doctors. Nasal spray is not available in Belgium because of several reasons. First, the pharmaceutical industry is not willing to deliver it to such a small market. Second, there is no overdose prevention plan in the country that could support importing the medicine. Third, the official number of overdoses is small. However, the experts argue that the official numbers can be underestimating the prevalence of overdoses, as often other death reasons (like heart failure) are reported by the doctors if a PWUD dies.

There are projects working in party scene, festivals, and clubs in Flemish and French part of the country. Over the last ten years, there has been more and more places labelled by Quality Nights project. According to the experts, it is not easy to assess whether the nightlife scene got better or worse, however. Most likely the situation has been stable, improving in some areas but deteriorating in others. This area seems to still be very fragile, however. The presence of services is seen as a result of the presence of strong willingness of activists and NGOs to provide the services. They need to continuously fight and convince party organisers and venues that their work is useful.

Drug-checking has been available in Belgium for 15 years, but it is perceived as not well-developed. It is a part of an official project funded by the state, although the level of funding is low. The organisation implementing the project is based in Brussels, and it also works at one or two music festivals per year. The situation, however, has been improving due to the linking to the European network of drug-checking services. Due to this cooperation, there is a possibility of mailing substances to get them tested in a partner organisation from Spain. There has been a proposition of implementing drug-checking not only in nightlife settings but also in low-threshold services, during limited hours. Now, the scale of service provision is very small. Opposition from local politicians against establishing drug-checking is also possible in some smaller towns in the future.

Drug services in prisons are perceived as inadequate. It is argued that one of the major problems in this context is the management of health care services in prisons by the justice system and not health care system. Harm reduction is not available in prisons. It is possible to access drug-free treatment and OST through doctors, however, the system is not well-organised. It depends on the individual GP's willingness whether an inmate can receive drug treatment or not. The absolute minimum of services is available, but there is not enough information exchange with the services outside. The continuity of care after releasing from prison is not ensured. It is difficult for ex-inmates to find a place where they can go to receive health care.

The treatment HCV is universally accessible free of charge. In Brussels, there are mobile testing services offering free testing and treatment with doctors specialising in this area. Still, it seems like there is not enough systematic detection in other drug-related services or in prison. Once diagnosed, a person received a high-quality treatment, with personalized follow-up. The universal accessibility of HCV treatment is a recent development linked to the availability of the new-generation medicine in the market. Before, the treatment was not reimbursed from social or health insurance, and it was often not available for PWUD at all. Now, the doctors who earlier did not believe that PWUD can follow the long treatment, prescribe the new generation medicines for them.

HIV treatment is available. The situation is seen as improving but early detection is perceived as insufficient, not systematic, especially in prisons. According to the experts, the prevalence

of testing should be also improved in low-threshold services which, at the moment, offer only a very limited possibilities in this area.

7.3 Bosnia & Herzegovina

Arguably, there is only one organisation in Bosnia & Herzegovina providing evidence-based primary prevention, based on the assessment of the needs of the population. The special focus of the organisation is on primary and secondary school and the methods of work are based on the European Minimum Quality Standards. It seems that the prevention is not a priority for Bosnian government, and good quality work is not sufficiently recognized and appreciated by the government. As a result, the funding for prevention is extremely low. There are also prevention programmes available that work in the abstinence paradigm, which are implemented by various sport and religious organisations. This latter approach is seen as obsolete and ineffective for the new generation, which is proficient in internet use and has the knowledge exceeding the level of knowledge of many organisations providing prevention with old methods.

With respect to treatment, there are four therapeutic communities operating in the country. More communities worked in the past, however, six of them ceased to exist due to low demand for such kind of treatment and due to COVID pandemic. Two of the therapeutic communities are funded by the government, and two are funded by the church.

With respect to abstinence-based treatment, here are four addiction centres, which recently have been accepting increasing numbers of clients. Three of them provide inpatient and outpatient care, and one only outpatient one. Recently, these centres built new facilities, which are seen as very modern and of a very high standard.

The inpatient care involves the process of detoxification, and individually adjusted plans for one month-long treatment, including psycho-social therapy and art therapy. The treatment is free of charge for people with health insurance. There is a possibility of entering one of the therapeutic communities straight from the treatment centres.

All the above-mentioned centres also provide OST, which is – in principle – free of charge for both methadone and buprenorphine. Clients normally need to visit the treatment centre

every day to pick up their medicine. There is a practice of urine testing in OST in Bosnia. However, the results of the tests are used to adjust the dose of the medicine and the frequency of work with addiction and mental health professionals.

Only public health care institutions and medical staff have the right to provide the methadone treatment in Bosnia. OST is seen as accessible, there are no waiting lists to enter the treatment. Before entering the therapy, basic medical check-up is also done (e.g., blood tests). Availability of the services is seen as sufficient in the context of the current drug use patterns. Services are decentralised, they also operate in the centres for mental health within primary health care units in smaller towns. The professionals in these local units are in constant contact with supervision teams from the regional centres. OST is available in prisons since 2016.

There is, apparently, only one organisation working in recovery and reintegration area. The legal framework for such work is seen as very poor, and – arguably – there are no high-quality recovery services in the country. However, there is professional willingness and political will to develop innovative social integration services, including small social enterprises, vocational training, etc.

In the field of harm reduction, it is argued that the period 2006-2018 was the Golden Age in Bosnia, primarily due to the presence of the Global Fund in the region and related financial support. During this period, needle and syringe programmes were operating in all parts of the country. After the Global Fund withdrawal in 2018, only one organisation survived, thanks to the unpaid work of its professional staff. Although any organisation willing to provide harm reduction services needs to acquire the accreditation in Bosnia, it seems that the government is not willing to fund harm reduction services at all. Professionals in the field advocate for contracting-out relationship between the government and harm reduction services. There are plans in the professional environment to advocate for funding for accredited organisations exclusively to incrementally change the negative picture of harm reduction NGOs in the Bosnian society.

Naloxone is not available in Bosnia & Herzegovina at all. Some professionals bring it from Western European countries. There are plans to advocate for drug regulations reform to allow naloxone in ambulance units.

According to the expert, the debate about drug consumption rooms will not start in Bosnia for the next decade or so. Arguably, politicians do not have knowledge about this type of services, and they are also too controversial for the traditional Bosnian society.

HIV treatment is free of charge for all residents of Bosnia and Herzegovina, also non-citizens, and people without health insurance. There are four HIV treatment centres in the country.

HCV treatment is seen as more problematic, as it is not free of charge. However, PWUD, with the help of drug services professionals, can often access it for free using loopholes in the system. Namely, HCV treatment is provided for free for war veterans and their families; since almost all PWUD have a relative who is a veteran of the Yugoslavian war, they can benefit from free HCV treatment as well. The new generation HCV treatment became available in Bosnia several years ago, and addiction professionals advocate to include PWUD among the beneficiaries of the programme.

7.4 Czechia

Drug prevention in Czechia falls under the authority of the Ministry of Education. Schools have the discretion regarding what prevention activities are implemented and how. Over the last several years there is a certification system in place (a programme needs to be certified to get funding and access schools), and this kind of control improves the quality of programmes. Still, prevention is seen as one of the poorest fields of drug policy in Czechia. Arguably, the decisionmakers do not perceive this area as important, which results in chronic underfunding and low accessibility.

With respect to treatment, it seems that its coverage is satisfactory. Geographical gaps do exist, but they are not striking. There is a large network of services, and they are accessible all over the country. Waiting lists for inpatient treatment in some busier facilities can be up to three months. However, the Czech system works in a way that some other solution (e.g., ambulatory care) is normally offered temporarily, to support PWUD during the waiting period.

The clients are not left alone. Meeting the standards and obtaining a certification is a precondition for a treatment centre to be funded by the state. This quality control system verifies the services' quality every few years. There are several services dedicated to populations with special needs in Czechia, for example, mothers with children or ageing PWUD.

According to the expert, Czech decisionmakers understood quite early that recovery services are necessary for successful reintegration after treatment. As a result, there are around 20 services working in this area in Czechia today, and aftercare programmes are recommended after each treatment in psychiatric clinics. Over the last several years, a trend can be seen to move drug services towards recovery and case management. This is seen as a significant change – such services are more costly, include work in the community and following the clients, reaching out to them instead of waiting for them in a fixed facility. Still, the number of services addressing reintegration has increased over the last 2-3 years. They support clients on the labour market, in housing, etc., for example, through establishing social enterprises where PWUD can work. Like in the case of treatment, the quality control system is in place, with certification renewal required every few years. Recovery/reintegration services normally target the general population and are not tailored to specific needs of some populations.

Substitution treatment is seen as a 'sad story' in Czech drug policy. Although the accessibility (understood here as geographical coverage) of the services is relatively good, only a small proportion of high-risk drug users are enrolled in the programmes, even considering that most high-risk users in Czechia use methamphetamine. Non-governmental organisations push for reforms in the prison system as currently, the OST is available only in several facilities in the country. Moreover, substitution treatment cannot be initiated in prisons, only continued. One of the reasons behind this situation, according to the expert, is that the prison service claims that there are no drugs in Czech prisons.

Needle and syringe programmes cover a high proportion of the target population, approximately 65%. The main problem in Prague is the low number of services and lack of their capacity. The organisations offered high-quality services since their establishment, and clients are returning to them. The staff feels morally responsible to keep the facilities working every day of the year from the morning until the evening, which requires a lot of capacity.

Naloxone distribution programmes are a very recent development in Czechia. There are currently around a dozen organisations implementing pilot interventions. The relevance of wide naloxone distribution is, however, questionable, in a country where Pervitin and suboxone are the main injected substances.

Drug-checking is legally prohibited, it is not supported by either central or local government. There are some agreements with toxicological services in place, on the basis of which CSOs can send suspicious substances for testing. There is no advocacy for drug-checking because of few drug overdoses in the country.

Drug consumption rooms are on the political agenda and significant advocacy efforts are undertaken to introduce them. In 2021, there was a discussion in the Parliament on the matter, however, but the legalisation of DCRs did not pass. Low number of overdoses in Czechia stirs discussion on the relevance and necessity of DCRs, which are also opposed by The Ministry of Health and the police as violating international treaties. According to legal analyses, CSOs could implement DCRs in the existing legal framework, however, they do not want to trigger a conflict with the public institutions.

There are a few organisations implementing safer nightlife programmes in Czechia. However, it seems that there is no state funding for such interventions, unless organisations deliver them within the framework of general outreach. There is also opposition from festival organisers who see safer nightlife services in a negative light.

7.5 Denmark

In mid-2010s, the regional-level system of care was dismantled and the responsibility for the implementation of drug services was transferred to local governments. As a result of this change, inpatient, long-term drug-free treatment disappeared almost completely. Such facilities were earlier funded by regional centres, which were not in place anymore. Drug-free treatment is still possible, including in local centres, but the number of residential centres is about 10% of what it was 20 years ago. This is seen as a problem especially in the context of homeless people who use drugs.

The change in the responsibility had also consequences in terms of capacity. In some communities (mostly in the largest cities) the services seem to become better, with adequate methods of work and staff. On the other hand, communities with smaller populations tend to have problems with staffing their centres. PWUD are sometimes sent from their community to neighbouring centres due to lack of capacity. A salary of a GP is higher than of a nurse or a social worker, so poorer communities try to keep the number of doctors working in services at minimum. In consequence, there are communities where doctor can be available only twice a month. The differences between richer, urban areas and smaller, poorer communities are significant in terms of access to services.

It is argued that the EU drug policy documents do not influence policymaking at the national level. Moreover, it seems that there is no continuous interest in harm reduction and drug treatment at political level. The funding for services decreases from one year to another, so the field is underfunded.

There is a huge difference between the services' accessibility in cities versus in rural areas. Some communities have a very low number of professionals working with addiction, which is seen as a serious problem.

Opioid substitution treatment is the main opportunity for getting treatment in Denmark. It is available with methadone, buprenorphine, and diamorphine. OST is seen as relatively easily accessible, normally within two weeks. The first choice is always buprenorphine, but for older PWUD with long-term use of methadone or heroin these two are also an option. Diamorphine treatment is more restrictive as it must be taken on-site. This results in people having to visit the treatment centre every day and wait for their medicine. It is nearly impossible to live a normal life next to this kind of treatment. The main problem in smaller towns is lack of access to medical doctors who can prescribe OST. Rules around methadone treatment are rather restrictive – people need to start from a lower dose, and gradually their dose is increased to reach the final dose.

OST seems to be less accessible in the rural areas, some of which may have only one city where OST is available. The restrictions on the frequency of visits were relaxed during the

COVID-19 pandemic. Normally, it should be possible to acquire methadone in the local pharmacy and visit treatment facility once every two weeks only.

Drug services are not integrated at the institutional level. However, the Danish system was developed in the bottom-up manner and professionals know one another well. For example, in Copenhagen, staff from the local drug treatment facilities cooperate with drug consumption rooms and do street outreach from DCRs. Sometimes organisations cooperate in a way that they exchange or borrow their staff in order to ensure the provision of a broader range of services in their facilities. Still, sometimes dramatic situations occur when clients die in low-threshold services because they were evicted from shelters and could not access hospital despite their very poor physical and mental condition. The lack of institutional integration of services results in frequent interruption of intra-organisational relationships and the necessity of -re-building them due to employee's turnover.

One of general is the access to services for vulnerable populations. For example, the national laws stipulates that if a person is an undocumented migrant, they do not have the access to treatment and health care except acute medical care. This was especially problematic during the Covid-19 pandemic. In the beginning, social services were not allowed to accept undocumented migrants (however, this regulation was changed after a few months). Moreover, many people accepted into the isolation facility needed substitution treatment, and its delivery was formally impossible. Nevertheless, sometimes services disregarded the ineligibility of clients and decided to continue adequate treatment for as long as was needed.

Harm reduction services are low-threshold and universal. There are no formal restrictions regarding the acceptance of clients (e.g., insurance).

With respect to needle and syringe programmes, there is no central coordination of what the communities do. There are guidelines for services, but there is no monitoring or control over it. In some communities, injecting paraphernalia are distributed for free at homeless services, drug treatment centres, etc. The availability of needle exchange is perceived as relatively good, although black spots do exist, especially in the countryside. In such rural areas where NSPs are not operating, people normally should be able to obtain syringes in local pharmacies relatively easily.

First drug consumption room was launched in Denmark in 2013, and there are DCRs functioning in five cities today. It is argued that after the initial development and expansion of services in mid-2010s, the progress stopped, in part due to opposition from local politicians.

There is no public system of services for recreational settings. There is one small NGO working at festivals and offering drug-checking as well. Drug-checking is also available in the local open drug scene in Copenhagen since mid-2010s.

Naloxone training for local community services has been in place for ten years. However, it stopped in 2018 because of lack of local funding. The professionals are trained, but PWUD and their families are not. This is seen as one of the main problems with naloxone distribution.

There is no public strategy or funding mechanisms to identify PWUD with HCV and refer them to treatment. Some local organisations implement HCV testing. There are new-generation medications available, but the treatment is not free of charge. There are local systems of treatment and care developed in some communities (e.g., Copenhagen), where everybody entering such a system is assessed and can be referred to appropriate institution to receive treatment. However, the access to treatment is poorer for people who are not inside the treatment system, for example, they only are in contact with a DCR.

7.6 Estonia

EU drug policy documents are considered important and needed in Estonia. According to the expert, the EU drug policy documents play an important role in shaping drug policy in Estonia – sometimes even to the extent that certain solutions included in the national drug policy do not take into consideration the societal opposition against them (e.g., drug consumption rooms). It is argued that the public opinion, in general, strongly opposes harm reduction interventions, and extensive education activities are seen as necessary. This results in a situation where although existing harm reduction centres operate effectively, it is challenging to open new facilities due to the widespread NIMBY attitudes and stigmatisation. It is argued, however, that such attitudes are not characteristic for young people, the new generation is considered open-minded, tolerant, and eager to work with drug policy NGOs.

Most of the prevention work is done among young people. There is a variety of programmes available in different settings and for different target groups. During the last ten years, the situation has changed drastically, especially with respect to the approach to discussing mental health, with much less stigmatisation in the area. There are several NGOs implementing prevention activities, however, the main responsible institution for it is the public Institute of Health Development. Some prevention interventions are also implemented by the police. It seems that prevention is evidence-based. Contrary to many other countries, it is argued that the police also provide reliable, non-judgmental information on the consequences of drug use, and on where to get help if necessary. Moreover, the background of young people and their families is being increasingly taken into consideration in planning prevention programmes.

There are many online programmes about mental health, risks, how to cope with problems, how to take care of oneself, etc. Especially thanks to the pandemic, a broad variety of counselling forms became available online. Several websites exist that provide information about drug use and support services. What is available in Estonia is seen as having good quality, but the accessibility is insufficient, especially compared to services that are in place for people who already use drugs.

The quality of existing treatment services is perceived as high, and PWUD share positive experiences with them. Still, the accessibility of these services is much poorer. There are currently two government-funded treatment centres in Estonia. They are placed far away from the two cities with the most severe drug use problem, resulting in difficulties accessing them. There are several church-based centres as well (also evaluated positively), although neither of them is based in the aforementioned cities. This is a result of the NIMBY attitudes and difficulties to find premises for drug services in the city.

There is one detoxication centre in Tallin (with a few state-funded places). The waiting time for a state-funded place there normally does not exceed two weeks. In government-funded treatment centres, detoxication is usually the first step, after which a person can decide if they want to continue the treatment. Treatment can be accessed also without prior detoxication, and – depending on the current situation – the entry can be possible

immediately or after up to four weeks of waiting time. Services do their best to take new patients regularly.

One government-funded centre in Tallin is dedicated to people with co-morbidities. Ambulatory care is also available for such people, but the number of places there is very limited. It is argued that the offer for people with co-morbidities is insufficient. Lack of adequately skilled is one of the problems behind it. The situation is exacerbated by the changes in drug use patterns. Following the closing of a big fentanyl operation by the police in 2018, bath salts (mostly alpha-PVP) became more popular. It is a new phenomenon for the professionals who do not have sufficient knowledge and skills to work with such clients. Hence, there are no adequate services for these needs.

Government-funded rehabilitation centres in the countryside operate aftercare services for patients who finish treatment. There is also aftercare available in Tallin. Social reintegration is also done by harm reduction centres that have social workers who help to find a job, housing, etc. Housing services are seen as well-developed, with many shelters and more permanent places. Homelessness does not seem to be a problem in Estonia, including among PWUD.

Around 2018, a project developed by the Institute of National Health in cooperation with the police started in Tallin and has ever since expanded to other cities due to its popularity. The project provides a support person for the clients to talk about the problems with. The support involves also finding different services a person may need, getting in contact with them, etc. People willing to participate in the programme are not incarcerated or fined, they instead enter the programme and receive necessary support. The programme is extremely popular among PWUD and has a good reception among drug professionals, who appreciate its quality and acknowledge its effectiveness in terms of social reintegration of clients. Social workers working in prisons sometimes cooperate with social reintegration programmes to ensure the continuity of care for people who are released.

OST in Estonia is available only through specialised centres operating in bigger cities and funded by the public health care system. There are services available in hospitals, but mostly it is delivered in harm reduction centres. Hospitals-based OST does not have the best

reputation regarding the quality of services. PWUD report that OST staff are mostly older people, and it is difficult to feel the connection with them. Stigmatisation and overly strict rules also seem to be a problem. OST is high threshold in Estonia, use of psychoactive substances is prohibited, and there are random urine tests conducted. In case of a positive test, officially clients should be removed for the programme temporarily. In practice, however, it seems that the OST staff does not apply such sanctions. To the contrary, a positive test seems to be a sigh for the OST staff that the dose of medicine should be adjusted (increased). The overall accessibility is perceived as relatively good. The number of places is seen as adequate for the needs of people using opioids. OST is also available in prisons as a continuation of treatment initiated in the community.

Harm reduction, and especially needle and syringe programmes, are perceived as very effective in Estonia, and their accessibility is seen as high. There are various centres all over the country and several mobile harm reduction buses operating in different cities. There are, however, several small towns that do not have fix-location harm reduction services and would need them.

The NSPs have changed their focus over the last years, moving away from only distributing the equipment towards providing more counselling and serving as the first contact point for PWUD with the care system. Since the beginning of 2021, new equipment has become available besides needles and syringes, e.g., smoking pipes, smoking foil, vitamin C. As a result, since the beginning of 2021, new groups of clients (non-injecting) started visiting low-threshold services. The professionals are happy with this development, as the lack of services for people who do not inject is seen as a major problem in Estonia.

Take-home naloxone programmes operate all harm reduction services and are perceived as very effective. Naloxone is also available in hospitals. a Naloxone programme which is perceived as very good by the professionals. It is a requirement for drug services to employ a nurse to be allowed to provide naloxone to their clients. The accessibility is seen as high and improving. Naloxone programme has been in place for several years. Before its introduction, the number of overdose deaths was very high and it's likely that this situation has triggered the launch of the naloxone programme by the government. At first, only injecting naloxone was introduced, and its accessibility was low, mainly due to the requirement of completing a

training. It was not available for clients, only for harm reduction workers. The introduction of the nasal spray programme is seen as a result of the advocacy efforts of harm reduction NGOs. Naloxone is also available in prisons.

Drug consumption rooms are not available in Estonia. They are included in the current Estonian drug policy documents; however, drug policy professionals do not see it as a feasible option soon. Still, they believe this service is very much needed.

Drug checking is seen as urgently needed. It is not available in Estonia due to legal barriers and lack of political will to change the law. It is against the law to handle and test drugs by harm reduction services' employees.

There are no safer nightlife services in Estonia, either. Around 2019, some festivals-based initiatives were undertaken, focusing on providing information and various materials (condoms, water), and counselling. Due to the COVID-19 pandemic and lack of mass events, the activity has stopped. According to the expert, there is a big need for such services in Estonia as there are a lot of different drugs used in party settings. Information-provision part of the service is seen as the most crucial. It is argued that the awareness/knowledge level of people using drugs in party settings is low, as they gather information mostly from friends or unreliable internet sources, which often can be incorrect or misleading. Various NGOs in different cities have tried to work together with different club owners; however, this work is challenging as the owners claim that there is no drug use in their premises. The expert highlights the need to work more with the society regarding drug education and awareness-raising.

Overall, the situation in Estonia is seen as quite positive, with many changes happening over the last several years, including changes in societal attitudes. There are increasing numbers of medical institutions interested in the work of drug services and reach out to find out more about how they help their clients.

HIV treatment is perceived as very good, with high accessibility, and being free of charge for everyone (including people without health insurance). Quick testing is available in harm reduction services which also refer clients tested positively to appropriate doctors. HCV treatment is seen as much poorer. There is no quick testing in harm reduction services. Some

NGOs work with medical companies to acquire training and quick tests for their clients. Still, HCV testing is not a regular service in harm reduction organisations. Free treatment is only available for people with health insurance. It is argued that a lot of stigmatisation takes place in the context of HCV treatment. Many medical professionals do not see the need to provide such an expensive treatment for PWUD. Many of low-threshold services' clients are denied the services unless they stop using drugs. HIV and HCV testing is available in prisons, but its coverage is not exactly known. While HIV treatment is available, HCV treatment is much more difficult to access in prison settings.

7.7 Finland

Prevention in Finland is a part of the compulsory school curriculum on health education; hence its accessibility is very high. Still, there is no official system or methodology of how drugs are discussed in schools. In some places, there are police officers delivering prevention lectures which objectivity is seen as very questionable. On the other hand, there are also NGOs delivering prevention applying dialogue-based methods, which are seen as a much more effective way to speak to children or youth. The system seems to be somewhat 'stuck in the old-fashioned ways', where the focus is on negative aspects of drugs and drug use and demonization, which makes such interventions not trustworthy. According to the expert, there is very little evidence-based drug education.

In Finland, a major part of problematic drug use is related to mixed use of buprenorphine, benzodiazepines, and alcohol. There are several elements of treatment in Finland, including detoxification, inpatient, and outpatient treatment. These services, however, are not available instantly: the waiting time for detox is normally around 2-4 weeks. The accessibility of treatment services was especially low during the COVID pandemic due to the low accessibility of drugs on the market. The waiting lines were even up to six weeks. At the same time, there is a 3-months guarantee for treatment in Finland, which means that anyone reporting a need for such service must receive it within this time frame. The costs of treatment are covered by the Social and Health Ministry for Finnish citizens and residents (but not for undocumented migrants). There is a big urban-rural divide; especially in the northern part of the country, there are very few services. Still, it does not affect the accessibility greatly - if a person knows a place, municipality will organise their admission there. In the context of the

needs of the target population, the treatment system provides the necessary minimum. It is argued that facilities should have more places and offer more interventions (social counselling, psychological services, mental health services). This is seen as a more pressing problem than actual geographical placement of the services.

Arguably, there is a very good care system for pregnant women who use substances. The services exhibit supportive attitudes, and they are seen as working very well. However, it seems there are no services for people with small children or ageing PWUD. Even more, if a person with small children enrolls to the treatment, child services are automatically involved. As a result, women with children, don't really seek treatment.

There is a very strict policy making mental health services and drug addiction services mutually exclusive. There is no possibility of using mental health services by people who use drugs. This is seen as a major problem, as many PWUD suffer from trauma and depression, and they self-medicate with drugs. On the other hand, in addiction clinics there are professionals (mostly nurses) who have only basic knowledge in mental health. There are no psychologists or proper mental health care professionals. The services are only focused on drug use and issues that evolve around it. The approach is to treat drug use as the core problem and not symptom of something else.

With respect to recovery and reintegration, there is a housing first system operating in Finland. Social workers in this system very often arrange treatment services for the clients. Reintegration services are mostly delivered by NGOs, and their work in this area is evaluated positively. Funding for these programmes comes mainly from gambling income, as the government has the monopoly on gambling in Finland. There are interventions in place that provide labour market support and help people to get used to activities that are related to living in freedom. There are also homes for elderly PWUD, including a range of support needed among this population. The Third Sector Social and Health Care Donation Centre is operated by the Ministry of Social and Health Care, which puts some political pressure on NGOs.

Harm reduction services are seen as having their golden age in the late 1990s and not progressing much since. There are no minimum requirements or standards for harm

reduction, except for that it must be available in each municipality. In practice, this means that a harm reduction facility could be open only one day a month, for example. This results in a situation where there are considerable geographical differences between the accessibility of services.

Needle and syringe programmes are often (especially in big cities) operated by municipalities, and sometimes outsourced to NGOs. The operation of NSPs by municipalities is seen as positive, as municipalities are not affected by price competition. On the other hand, NGOs, being more cost-effective, have been involved in the process of such price competition, resulting in funding decreasing over the years. Interestingly, it seems that there are official and unofficial NSPs – some organisations which officially do not operate such services, in fact do it (e.g., housing first programmes), and they receive the sterile materials from municipalities for free, based on personal relationships. The effectiveness of NSPs in terms of needles distributed per year is seen as very good. What is seen as problematic is the insufficient offer of services around needle exchange, e.g., doctors, counselling. Moreover, NSPs are not able to issue direct referrals to specific services (e.g., detox or treatment) but can only refer clients to an addiction clinic where they can get referred further.

The abovementioned problem with referrals seems to be also characteristic for OST. This type of service is mostly implemented by NGOs; hence, there is no straight way from OST to detox or rehabilitation (which are health care system). There are, however, also OSTs operating within the public health care system and the connection to other services is much better there. As in the case of NSPs, because of price competition between NGOs and decreasing funding, the offer in OST is basically limited to giving away the medicine, without any accompanying services.

OST is a high-threshold one in Finland. A person must go through the official procedure lasting two months. First the health care provider: before getting OST, a person needs to see several medical professionals on multiple occasions over several months. They are interviewed many times to assess their attitude and motivation to get the treatment. After the procedure is finished, there is up to 6-months waiting list for OST. Once enrolled, for the first two months, people must come to a clinic every day, with some possibility of having days off after this period. Urine tests are not frequent, but they are performed. If someone is caught using, for

example, illegal benzodiazepines, the likely punishment will be the lowering of the methadone dose and taking away benzodiazepines they received from the clinic. 'There's no logic, there's only control'. Nowadays, with the buprenorphine injection available, the system became slightly more flexible.

With respect to more innovative harm reduction interventions, the situation is poor. Professionals have been advocating for the introduction of take-home naloxone for the last two decades, without success. Naloxone nasal spray is available for prescription in pharmacies, but it is very expensive. Additional problem is that doctors are not willing to prescribe it to anyone but PWUD. PWUD, in turn, are reluctant to disclosing their opioid use to their doctors. As a result, the access to this life-saving medicine is significantly limited. Besides, naloxone is available in health emergency services only.

Similar situation can be seen with respect to drug-checking and drug consumption rooms. Despite advocacy efforts, they are not available in Finland. Recently, however, a fentanyl testing pilot project was launched, which can be a step in a good direction.

Harm reduction interventions are not available in prisons. OST, on the other hand, can be both continued and initiated in prison settings.

With respect to alternatives to coercive sanctions, over the last year or so there seems to be an increase in the number of diversions (ordering treatment instead of fine). Officially diversion is available also for people who arrested for drug use several times. What is seen as problematic is that people who do not use substances problematically are ordered treatment as well. This, in turn, arguably distorts the data on the reasons why people seek help: now, cannabis is the most prevalent substance in this context. Another problematic issue is related to the records kept by the police. The authorities claim there is no data kept on the cases of diversion, however, it seems that NGOs working in the field have evidence to the contrary. This raises the important question of criminalisation and life and legal consequences for young people using drugs recreationally.

The HIV prevalence among PWUD is very low, and the response time in cases of detection is seen as 'amazing'. With respect to HCV, there has been a long tradition of not treating people for HCV until they were two years sober. This changed with the development of the new

medication. Nowadays, drug use is officially not a barrier to receive HCV treatment but in practice, people are sent to a specialist (who can only treat a small number of people per year) and not local health care unit. In some municipalities, there are doctors treating everyone, who quickly eradicated HCV from their areas. In roughly the same municipalities, the threshold for OST was also lower (i.e., 2-weeks 'pre-waiting' period instead of two months). Anti-virus testing is easily available in every drug treatment facility. It is more difficult to get the activity of the virus tested.

Overall, in the context of the decisionmakers, drug policy and support for PWUD are seen as 'political suicide'. The stagnation and lack of introduction of new services is seen as resulting from the lack of political will. According to the expert, the political life is largely influenced by the law enforcement professionals and conservatives, resulting in opposition towards more bold solutions. Indeed, it is argued that during the last decade, there was a backwards movement in the evidence-based policymaking.

The perceived major positive changes in the field include the responsibility for harm reduction services in Helsinki transferred from NGOs to municipality, and the development and introduction of the new-generation HCV treatment.

7.8 France

In France, most of drug-related services are seen as quite obsolete, not addressing the new challenges and phenomena, e.g., chemsex. Arguably, the drug services system is based on the characteristics of PWUD back in 1980s or 1990s. Meanwhile, injecting drug use has been decreasing and it is not a major problem anymore. Professionals see the government as rather reactive (than proactive), that is, a crisis is needed for the actions to be undertaken. 'Now we have chemsex crisis and migrant crisis, so we have some actions taken on the subject'.

Prevention in France is not seen as a priority, it is not advanced, the focus seems to be more on treatment. It seems that the government has transferred a large part responsibility for this area to NGOs and is only funding the programmes. School prevention interventions are perceived as providing the necessary minimum of education. They are usually implemented by NGOs. A decade ago, prevention was based on scaring the youth off and on testimonies of various individuals. Nowadays, it seems to be slightly improving.

Treatment is free within the public health care system for people with insurance. The accessibility of it is limited, however. The waiting time for a place in residential treatment (that is provided in public hospitals) is normally one to two months. There are also private, for-profit addiction treatment centres, where admission is much quicker. Regarding ambulatory care, people in emergency situations are accepted immediately. In non-emergency situations, the admission is also quicker than in the case of residential treatment. Ambulatory services are delivered by public clinics and community health centres.

The services are concentrated in cities, in the countryside they are virtually non-existent, which is seen as a big problem. The offer has been shrinking, with many hospitals and other facilities closing over the last 15 years. In Paris, demand for treatment is very high and the waiting time is long. The situation is often better in smaller major cities.

There are some special units for women with children available. The access is more difficult, the waiting lines are longer than in the case of mixed, not-specific services. Women drug use is a taboo, especially if they are pregnant. There is a very strict social control in place.

One of the main problems is the fragmentation of the health care system and health professions. Entities specialise in one thing and there is lack of a global vision. Mental health issues are addressed by the psychiatric wards or psychiatric hospitals and there is no guarantee that drug use will be addressed there as well. Mental health conditions tend to have priority over drug use. The chances to address all the problems simultaneously (drug dependency and co-morbidities) are the highest in the ambulatory system.

According to the expert, some forms of social reintegration are available, e.g., housing support, but the services are insufficient, their accessibility is low. Moreover, it seems that there is lack of awareness among PWUD regarding the potential gains from such services. Instead, after the treatment they seem to come back to their environments. There is a need for developing a more innovative approaches, as the system has not changed a lot over the last 10 years. Some changes started to happen very recently, especially in the area of chemsex.

Arguably, the main problem here is low accessibility. Moreover, reintegration services tend to be high threshold, e.g., they require abstinence from clients to be eligible for housing. Even

in case of one relapse, people are removed from the programme. There is no recognition that relapses are a natural part of the recovery process.

Case management approach, trying to connect various services around a patient is new in France. However, several organisations have been implementing this approach over the last 5-10 years. One of the main problems in this context is that professionals are reluctant to share the patient information with others (even given client's consent), making case management difficult. Since the system for case management interventions has not developed yet, a lot depends on individuals and personal-level or institution-level (e.g., hospital) relationships and connections.

OST is seen as working well. It is not only available in hospitals, but also many NGO-operated specialised centres. It seems to be relatively easy to start OST, there are no waiting lists. There are several NGO-operated centres in every city, next to hospitals. There are no OST centres in the countryside. Nevertheless, it is possible to get OST prescribed by a person's GP, which makes it more accessible for people from outside urban areas. In principle, the treatment is free or very cheap. The system of OST delivery is stricter in hospitals than in NGOs. In NGO-based programmes, the treatment is more person-centred and adequate. Normally, OST is not available in prisons.

Needle and syringe programmes are mostly operated by NGOs. Vending machines on the streets in the cities are also available. Some pharmacies operate needle exchange programmes as well, for charge. There are programmes operating mail-based needle exchange, and they send injecting paraphernalia to clients living in the countryside who otherwise would not have the access to services. Needle exchange has been in place for over 30 years, so it is well-developed and well accepted in the society.

Naloxone was introduced in France around mid-2010s. It is only available in the injecting form. PWUD can obtain it in hospitals and harm reduction centres. Interestingly, it seems that the demand for naloxone is not very high. It is believed that one of the reasons behind it is insufficient communication with clients. Also, the programme is relatively new. The general picture is, however, that the opioid use is decreasing, and use of other drugs is increasing, so naloxone becomes less and less relevant in the country.

There are three DCRs operating in France and their work is perceived as very good. Another several DCRs are due to be opened in near future. The current offer does not seem to meet the needs of the target population. According to the expert, there are 2-3 additional DCRs needed in Paris next to the one currently operating. Some harm reduction centres plan to create spaces in their premises (not separate DCRs) where people can be accompanied and take their drugs.

The framework for drug-checking services is not yet completely set up. There are several methods service providers can use for the purpose of drug checking: samples can be sent to official laboratories (with results coming after several weeks), and there are services using spectrometry launched recently by NGOs in Paris and a few other big cities. For a long time, spectrometry drug checking has been available only in Paris. Because the unclear status of the services, it is not common to use these services, however. The problem is also that the results are not available immediately. Clients need to think about testing beforehand and plan it, as it is never available at festivals or party venues.

Party services are very welcome by party organisers and people who use drugs. Still, there are not enough services offered on site. The available services are focused mostly on prevention. There are chill-out spaces available since recently; before it was focused on water distribution, information provision, etc. Sometimes, HIV or HCV testing is available, which is seen as a good way to start a conversation. In general, party services are widely present, but their offer is limited. The cooperation with party organisers is working well. The problems often arise when someone dies, since then festival/party organisers apply very strict measures towards party attendees, like detailed searches, etc.

HIV and HCV treatment is free, and the level of coverage is sufficient. The access is universal, there is public health approach to it, health insurance is not necessary. HIV and HCV treatment is also available in prisons. The access to HIV treatment for PWUD is seen as very good. For HCV, it tends to be slightly more difficult. For example, doctors may delay the start of the treatment to treat other (non-PWUD) patients first, or some of them may demand abstinence before providing the treatment. Importantly, such situations are seen as exceptional, and are not allowed by the official policy.

7.9 Germany

In Germany, prevention work has been specified over the last ten years, to focus on specific groups and develop more detailed strategies, for example, cannabis and amphetamine prevention for youth, HIV/HCV prevention for older people, etc. Prevention programmes are evidence-based; it is characteristic for German policymaking in general that scientific evidence is necessary for adopting any policy. Interestingly, this also means that best-practice examples are not simply transferred from elsewhere, but own scientific evidence is required and produced to implement any new services. Minimum quality standards are also implemented in prevention activities.

Arguably, there were significant changes in school prevention over time. The authority over how prevention is delivered and by whom is in the hands of individual schools. Today, it is implemented mostly by NGOs. There are some interventions implemented by the police as well, but they are seen as sporadic. Many organisations working in the drugs and HIV field provide school preventions using their own curricula. There is no certification or permission system for NGOs offering prevention programmes, but normally it is done by very well-known organisations who are asked by directors or teachers to come to schools.

There has been no significant development in the area of long-term abstinence-based treatment over the last decade. Such residential treatment is seen as highly accessible, with people without special needs able to enter the facility normally within a week, but in maximum up to 30 days. This is, among others, due to their low popularity among PWUD.

Services for people with special needs (e.g., mothers with children, ageing people) are available, but limited in number, which results in longer waiting lines and lower accessibility.

Services are perceived as well-integrated, and the continuity of care is ensured. Transferring between different services also seems to be smooth and unproblematic. Importantly, however, residential treatment is normally not accessible for people on OST, with only a few facilities accepting them. As a rule, minimum quality standards are implemented in all treatment and recovery programmes.

Opioid substitution treatment is available through a GP prescription or in NGO-operated drug services, which have specialised programmes. While 'traditional' OST is not delivered in hospitals as a separate service, the diamorphine programmes are operated there due to the availability of adequate staff. OST is available in prison, but the coverage of the target population is much lower than in the general society (15-20% versus 50%).

There have been some developments in OST over the last years regarding what medications are used. In 2017, because of a change in the law, it became possible to prescribe the substitution medications for a longer period (30 days instead of previously seven). Moreover, the law specified more clearly the tasks and responsibilities of the GPs in the context of OST. This was motivated by the fact that there are not enough doctors willing to prescribe OST. They were reluctant to do this because some of doctors were prosecuted and incarcerated due to mistakes made while prescribing the medications. As a result of the changes in the legal framework, the number of GPs willing to prescribe OST has arguably increased.

Since 2017, OST provided through specialised programmes is low threshold, i.e., there is no requirement of abstinence from other substances. The earlier goal of the abstinence from all psychoactive substances, the illegal use of opioids became the main aim of OST. This change is perceived as very important for daily operation of services; there is much less pressure on doctors and patients to control the substance use. A lot of burden was also taken off as random urine testing is not done anymore for all drugs.

Until 2017, there was a law in place preventing OST clients and from accessing mental health treatment (although they could access social support services). Although this is not the case anymore, psychiatrists and other mental health professionals are reluctant to accept people who use drugs. In practice, then, it is normally impossible for PWUD to receive mental health treatment, although rare exceptions do exist. Rehabilitation centres do not address mental health of their clients, they only focus on the treatment of drug addiction. There are not many psychotherapists in treatment facilities. It is big problem for OST clients, who are often stuck in the same place for years due to the lack of treatment of their other conditions, which cannot be handled by their GPs.

The situation of social reintegration services is perceived as poor. There are some adaptation centres available where people can enter after a long-term residential treatment. During their 4-8 weeks stay, they receive job and housing support. These services, however, are not well connected to other facilities and their availability is limited.

With respect to needle and syringe programmes, there are some white spots in the east and south of the country. Nevertheless, in principle, if a person wants to access sterile injecting equipment, they can (in the worst-case scenario, paying for it in a pharmacy or a vending machine). There are more choices in bigger cities, where low-threshold needle exchange programmes are operated by NGOs. Normally, however, these facilities provide many other services as well, e.g., social work, access to showers, food. There are also several mobile units providing needle exchange only. In the countryside, pharmacies are the most accessible option.

Over the last decade, the drug administration patterns have changed significantly, with intravenous drug use decreasing significantly. There are projects being launched to distribute smoking foils, pipes, etc. in low-threshold services as well. It is seen as working well, with a broad variety of drug use equipment available. Services also encourage their clients to change their drug administration form to less risky.

Nasal naloxone spray is available in Germany since 2018. It can be bought in pharmacies for prescription. According to the expert, there are many PWUD in the country trained to use naloxone, but their GPs refuse to prescribe it, arguing that it is only dedicated to ambulances and doctors. As a result, naloxone is available, but it is not in the field due to limited accessibility. To address this problem, a new federal project funded by the government and implemented by NGOs was launched in 2021 to educate and train the doctors and, consequently, increase the number of naloxone prescriptions.

First drug consumption rooms were launched in mid-1990s. They are exclusively operated by NGOs and funded by the state or local authorities. The quality of DCRs is perceived as excellent. There are geographical differences in service provisions (i.e., urban-rural divide and North-South divide) also affects this area. DCRs are available on only nine out of 16 states in Germany. There are states where there are none and there are states where there are ten or

more DCRs. The geographical distribution is very uneven. The existence of DCRs depends on the politicians in charge in each state. Where DCRs are available, they are a very popular service. There have been some changes regarding the accessibility of DCRs. Until mid-2010s, it was forbidden for people on OST to access the DCRs. As a result of the professional NGOs advocacy, it is now for people on OST to use DCRs. Today, approximately half of the clients of DCRs are people on OST.

There is no federal legal framework for the implementation of drug checking services. Some safer nightlife projects in clubs and festivals are implemented (though only in major cities) but they are perceived as not working very well due to the lack of the most important element – drug-checking. This is especially important since there has been a significant increase of amphetamine, cocaine, and amphetamine use. People using these drugs are arguably well socialised active on the labour market, but there are no services for them available. In some states, preparatory work has been done, everything around drug-checking has been organised and now organisations waiting for the legal change to be able to launch the services. The opposition to the change of federal-level law stems from the politicians' belief that with such services in place, and the green-yellow-red system working in Germany, people would believe that certain drugs are not risky, and they have 'green light' to use them. According to the expert, the drug commission sees the positive sides of drug checking and it is argued that this kind of service may be available in the country within the next several years.

With respect to HIV and HCV treatment, there have been many changes in this field over the last years. With respect to HIV, all people who want to receive the treatment can get it quite easily. There are many HIV specialists administering the treatment. The medical guidelines for HCV treatment have changed significantly; now, being on OST is considered the best condition for a person who uses drugs to receive HCV treatment. The treatment is free if a person has the health insurance (and normally people have insurance if they have an apartment or an address in their drug service centre). According to the medical guidelines, one can access the treatment if they want, but the problem is to find a doctor, especially in smaller towns or countryside.

Some changes were implemented in the testing area. Until 2020, it was only possible for medical professionals to do PCR and antibody testing. Since March 2020, non-medical staff

like social workers or peers are allowed to perform antibody testing. As a result, testing was introduced in the offer of low-threshold services. The cooperation with doctors is seen as working well. Still, the coverage of treatment is not sufficient yet to reach the 2030 goals of ending Hepatitis C. It is argued that there are only 2000 PWUD per year in treatment in the last several years. One of the reasons behind it is that only HCV specialists implement the treatment, it is not done by many OST doctors. This is not something that is characteristic only for PWUD, however, but a more general phenomenon, 'it's more that many doctors are not familiar with Hepatitis C and that's the problem'.

The treatment is not accessible for refugees and migrants without legal status and health insurance. HIV treatment is easily accessible in prisons, while HCV treatment is more limited due to significant costs that are not covered by the health insurance. Testing is not universal in prisons (e.g., during admission), but it is done upon request. Arguably, not many people request it, however.

7.10 Greece

Major changes in Greek drug policy in the last decade are connected to two interrelated main events. After the 2008 economic crisis, the field experienced significant cuts in funding for first-line services (especially in NSPs and street work), the direct result of which was a major HIV outbreak among PWUD in Athens in 2011-2013. As a response, funding became available again for a whole package of harm reduction. Additional investments were done in humanitarian services area as a result of 2015 refugee crisis. The funding then was cut again, to return recently because of the Covid-19 pandemic. The mobilisation in times of crisis seems to be characteristic not only in the context of funds in Greece, but also in terms of the extent of stakeholders' cooperation and unity, too.

Prevention is seen as not working due to the corruption of the system. Although a drug prevention centre exists in each municipality, it is argued that the activities of these centres are not transparent. Activities include visiting schools to discuss the hazards of drug use, however, the quality of these interventions is seen as questionable. The programmes are perceived as being far from international standards of drug prevention and delivered by staff

without necessary skills and expertise. The quality of prevention depends a lot on the area – it seems that it is much higher in rich municipalities.

Both residential and ambulatory treatment is available in Greece. The field is dominated by one non-governmental organisations, which is funded entirely by the state and receives most addiction treatment funds. The organisation offers a range of services but focuses on therapeutic community model. It is argued that a decade ago, methods used by this organisation included extremely strict, army-like rules, strict hierarchy, work exploitation, humiliation, and worship of the leaders. Since then, some reforms were introduced some modest progress can be seen with respect to methods used. Services offered by this organisation are the only choice of people living in the countryside or on an island, as it has facilities all over the country, even in remote areas.

Another possibility of abstinence-based treatment (both residential and ambulatory) is offered in psychiatric hospitals. This kind of treatment combines psychotherapy with art therapy and social support. People working there are seen as good specialists in medicine, social work, psychology, etc. It is argued that treatment units in hospitals implement gender-sensitive approach and are the only ones accepting pregnant women or women with little children. Hospital units are also the only ones treating co-morbidities. Hospital-based services are perceived as much better in terms of quality; however, they are available only in the two biggest cities: Athens and Thessaloniki. There is very little demand for abstinence-based treatment, hence, there are no waiting lists, and the treatment is accessible immediately.

The accessibility of detoxification seems to be extremely low. It is argued that there were only two facilities operating detoxification before the Covid-19 pandemic, and it became virtually inaccessible during the crisis. In practice, if a person from Athens wants to go through detoxification in a public health care system, they must register, wait for their turn (they are put on a waiting list), and then travel by train for seven hours. The waiting time depends on several factors, it is normally several weeks (up to two months).

Adolescents can use day-care, drug-free treatment services in OST clinics and treatment centres in psychiatric hospitals. The accessibility is seen as high, with no waiting lists in place.

In contrast, there are no specialised services for ageing PWUD. It seems that support services consider ageing PWUD 'lost cases' and focus on the age group 25-35.

Services for refugees, migrants and ethnic minorities are seen as 'the most chaotic area'. There are only two small facilities accepting refugees and migrants in Athens, both of them drug-free. It is highly insufficient compared to the needs. It seems that some refugees join the twelve-steps self-support groups (in the face of lack of other possibilities and because such groups function in their mother tongues). This kind of therapy, however, is not officially recognized in Greece.

OST is delivered exclusively by the state. Significant changes took place in OST over the last decade. Namely, until mid-2010s, it was virtually impossible to enter OST. The waiting lists reached 5-7 years at the peak, and people often died before accessing the treatment. In mid-2010s, the list was abolished, and a huge influx of clients to OST units followed. OST also became decentralised, with units opening in hospitals all over the country. The quality of service in hospitals is not seen as very good, yet, better than in specialised centres before the reform. It is argued that discriminative and hostile attitudes towards PWUD in OST are, at least in part, due to the general increase in aggression and xenophobia resulting from the refugee crisis.

The default medicine of OST is buprenorphine, as PWUD cannot use heroin next to it. Exceptions are possible, but extremely rare, e.g., in case of allergy to buprenorphine). The idea of mandating buprenorphine therapy to prevent people from using heroin is seen as counterproductive as it seemingly encourages people (who would use anyway) to use potentially more dangerous drugs.

Since there is no country-level framework for OST operation, the directors decide on the rules and methods of service delivery. The regime of OST varies from one service to another, although using any drugs is prohibited everywhere. Still, in some facilities a positive urine test may result in removal from the programme, and in others it will be a cause for adjusting the medicine dose. One of the main problems in OST is insufficient psycho-social support. It is argued that OST clients in Greece are considered second-class clients (opposed to first-class clients choosing drug-free treatment). People in substitution are seemingly perceived as lost

cases, and not much attention is devoted to them. Although many professionals are available (doctors, dentists, psychiatrists, psychologists, social workers), most of the OST clients seem to be abandoned by the care system. It is argued that clients are stuck on OST for years, without participating in a therapy session ever in their life.

The regime of receiving the medicine depends on the assessment of a client done by the service. Clients with good assessments are awarded with several-days doses, others must visit the facility every day. One major problem related to this is the low accessibility of services, which are only open for a few hours in the morning. As a result, OST clients cannot work and live a normal life. For many people, substitution is the most essential thing in their life, and they have completely withdrawn socially, professionally. This is arguably one of the aspects that deters some people from enrolling to OST.

OST is also available for refugees and undocumented migrants; however, the awareness of services is very low in these communities. Language barrier is also an obstacle.

Social reintegration programmes are available in the dominant treatment CSO and in psychiatric hospitals' treatment centres. A person can enter such programme after completing a drug-free treatment. A person can stay in a guest house for round one year (in case of hospital-based programmes) or 2-3 months (in case of a CSO-based programme). Besides these programmes, there is no housing or systematic support. There are small-scale projects in the Employment Office to subsidise employers hiring people who completed drug treatment. This part of support was much more developed before the economic crisis, with vocational training and instant employment after training graduation. Nowadays, the scale of the programme is not sufficient for the needs of the target population, and services are concentrated in the cities. Aftercare programmes are more easily accessible for people completing abstinence-based treatment, as OST clients rarely reach the reintegration stage.

Heroin use and injecting drug use has been decreasing in Greece, but not that much in Athens. Needle and syringe programmes are operated by both state institutions and CSOs. One major problem with the state-operated NSPs is that they are strictly exchange-based. In practice, if a person is unable to bring used syringes, they may be denied access to sterile ones. Two such centres operate in Athens, but they are not widely known in the PWUD community.

CSOs operate programmes of needles and syringes distribution, so the accessibility is higher. However, a general problem is that CSO-operated NSPs also work only in specific areas in Athens and Thessaloniki. Large areas in suburbs, with open drug scenes, are not covered by services at all due to fear and, sometimes, hostility of local authorities towards services. Moreover, it is argued that organisations often compete instead of cooperating, which results in a situation that teams from different organisations cover the same areas during the same time slots, leaving other areas/time slots unserved.

Needles and syringes can be also purchased in pharmacies. However, while it is relatively easy in the countryside or suburbs, pharmacies around open drug scenes in the centre of Athens do not sell needles and syringes to PWUD. The available offer is seen as critically inadequate and insufficient in the context of the target population's needs.

There are no take-home naloxone programmes in Greece. Injection naloxone is only available in hospital for emergency use, including ambulances and life-rescue motorbikes. Administering naloxone is legally a medical act and only doctors have the right to use it. It is illegal to have naloxone in harm reduction services or in the community.

There are no drug consumption rooms in Greece. There was one operating for several months a decade ago, however, it was closed because of conservative government's opposition. In 2019, a national-level law authorizing DCRs was passed in the parliament, but the implementation of these services has not started yet. Drug-checking and safer nightlife services are not available either, and not on the political agenda.

HIV treatment is free, also for undocumented persons. However, HIV clinics (Special Infections Units) were significantly scaled down after the 2008 economic crisis, and they are severely understaffed. The major problem, however, is the accessibility of treatment for PWUD. It is argued that nowadays, doctors from HIV clinics make the treatment conditional upon completing drug-free treatment and stopping using drugs. Active PWUD are often denied treatment, which is seen by the expert as a human rights violation. Organisations providing low-threshold services cooperate with non-discriminating doctors and link their clients to these doctors in an unofficial way.

With respect to HCV, DAA is available for free in public health care clinics for people with social security number. Hence, the treatment is less accessible for undocumented persons. PWUD are not discriminated here because of the short duration of treatment and different units implementing it. It is argued that it is much easier to receive HCV treatment than HIV treatment.

HIV and HCV treatment is also available in prisons, and testing projects are also implemented. OST is extremely limited in prison settings and accessing it is very difficult. Moreover, it is argued that treatment is discontinued for OST clients entering prison as a form of punishment. Harm reduction in prison is non-existent.

One of the main problems of the last decade in Greece is the inflow of migrants and refugees who do not use drugs when they come but they become PWUD in Greece due to desperation and social exclusion. This seems to be a problem especially among adolescents who live in refugee camps who experienced serious trauma. It is argued that these young people, trying to earn money through petty drug dealing, often become addicted themselves (mainly to crystal meth, benzodiazepines, and heroin). There are no services for this population, and staff in camps does not have necessary expertise to work with it.

7.11 Hungary

One of the general problems in Hungarian drug policy is chaos and lack of transparency of public decision-making, as well as lack of political leadership in the drug policy area.

Hungarian national drug strategy 2013--2020 follows the European Union Drug Strategy in its structure. However, the essence of the policies and the actual policies implemented in practice make it clear that the Hungarian government opposes all kinds of harm reduction. It is argued that the government includes harm reduction and references to the European Union drug policy documents in the national strategy to maintain the impression that the country is still a proper EU member state.

Most of the prevention interventions in schools are implemented by the police. These interventions use outdated methodologies, they are based on deterrence, and one way communication, which is against international standards. Only a few prevention programs are

based on interactive methods involving young people in the process. Another problem in the prevention field is the lack of well-trained professionals. Insufficient funding and delays in payments also have negative impact on the accessibility and quality of prevention. Over the last several years, significant amount of the EU funding was spent on prevention programs in Hungarian countryside. Prevention programs were developed and implemented by consortia of local CSOs and local governments. However, based on the curricula of these programs, it seems that none of these interventions reached out to the most vulnerable young people (e.g., Roma youth, youth living in foster care). Several initiatives of perceived good quality are also implemented, especially in the northern part of Hungary.

In general, the situation is not sustainable. There is a need for coordination of the drug policy, training of new professionals. After the National Drug Prevention Institute was abolished in 2013, there is no research and methodological support for professionals, there are no trainings for teachers, drug prevention professionals, and school social workers. Another problem is that there is no quality control. Although a system of certification exists for school prevention programmes, it is applicable only to CSOs and not to the police. It is also uncertain to what extent schools verify the certification of the organisations they invite.

Several years ago, Hungary introduced school police, justifying it with school violence and school drug use prevention. Uniformed policemen go to schools with gas spray, often in vulnerable communities, and their only goal is to keep the order. Instead of investment in the school psychologists and social workers system, the government hired retired policeman who have no expertise or skills in solving social conflicts, providing support, etc.

In the treatment system, one of the main problems is the lack of integration of services and lack of case management approach. It is argued that clients feel lost in the system, and they are not really supported in accessing other services than the one they enter.

The access is especially difficult in case of detoxification and outpatient treatment, and it was further exacerbated because of the Covid-19 crisis. The lack of accessibility and waiting lists often result in situations when by the time there is a place for a person, they lose motivation and disappear from the system.

Inpatient rehabilitation centres are seen as the best part of the Hungarian treatment system, with are rehabilitation centres across Hungary and significant public investments over the last several years. Two treatment centres for youth were established as well, to separate severely dependent 13-14 years-old adolescents from adults. What is problematic is that evaluation and monitoring of residential treatment programmes is missing. There are self-evaluations conducted, but their reliability is questionable due to the use of flawed methods. There is no interest in evaluating these facilities from the side of the government, unlike in the case of harm reduction, which is perceived as disturbing.

Women are still underrepresented in the system. There are very few treatment centres for women and many treatment services are not really responding to women's needs.

There are very few addiction professionals, i.e., psychiatrists who are trained in treating addiction. Most psychiatrists refuse to treat PWUD and refer them to addiction departments. There are only very few specific addiction departments, however, and there are long waiting lists to get there.

The situation is similar for OST, it is difficult to access it and there are still regions without OST programmes at all. It was reported that during the Covid-19 pandemic, due to a change in the leadership in one OST programme, patients were required overnight to visit the centre every day. The medicine was not given for the entire week anymore, as it used to be before. As a result, dozens of clients lost their job and returned to using heroin. Others quit the programme. This is seen as completely opposite of what OST should be about.

The threshold is seen as too high. There are only a few hundred people in OST. There are also very few centres accepting people with co-morbidities. The situation has been stagnating for years. Arguably, the OST programmes became even higher-threshold recently, and there is more pressure on the abstinence-based treatment. This is seen as an indirect consequence of the national drug strategy: there was no specific government instruction on the issue, however, the entire conceptual framework of Hungarian drug policy supports this kind of approach, focused on recovery and abstinence.

Social reintegration programmes do exist, but their number is insufficient. There are virtually no supported places or homes for PWUD. There is only one housing first program in Budapest,

and many more is needed. Drug use has been increasing very rapidly among homeless people (especially young ones), and lack of housing is a large part of this problem. The government does not support social reintegration services much. There are also problems experienced at local level. For example, building houses within the existing housing first project was blocked by the local authorities and local community.

In 2014, two of the country's largest NSPs were closed because of government's political fight against harm reduction. According to the expert, it sent the message to all other programs. Now, there are only a few very low-profile programs remaining in Budapest and many PWUD disappeared from organisations' sight.

Quality control and evaluation does not exist in NPSs now, organisations are busy trying to survive. Sometimes organisations do not have resources even for the staff.

Naloxone can be only administered by a professional doctor; it is only available in ambulances and emergency services. There are no naloxone distribution programmes available.

DCRs are not a priority at the moment. The drug market changed, and there is not much open injecting drug use anymore.

There are several safer nightlife services in bigger cities and some of the bigger festivals. However, the quality of these services is questionable, e.g., in terms of lack of adequate staff training on drug issues. There are services available also on the underground scene, yet some of them are criticised because of their approach, which is professional (i.e., involving psychology and social work students) instead of peer based. Overall, the services are seen as much better than a decade ago, mainly due to the emergence of peer-based organisations, which are nevertheless very small.

The access to HIV and HCV treatment is, in theory, universal. The treatment is covered by a separate budget so even persons without health insurance can access it (although they must pay for the medicine). Still, many PWUD cannot access it for several reasons. Namely, PWUD are not reached out to with treatment, they are not motivated, they do not have the knowledge about the existence of the treatment, they do not have identification papers, their lifestyle is not appropriate for longer commitment, etc. This is connected to the issue of the

general low coverage of harm reduction programmes. The coverage HIV testing and counselling is very low.

7.12 Ireland

School prevention is the compulsory element of the curriculum for secondary school pupils in Ireland. As a rule, the teachers deliver the prevention. The prevention programmes are seen as extremely weak, low-quality, patronising and based on the idea of scaring youth off drugs, not taking into consideration the level of knowledge the youth have about drugs. Moreover, it seems that many teachers covering drug prevention do not receive adequate training, which is seen as especially problematic in of areas where there are significant drug problems, in more disadvantaged communities. Some innovative approaches could be seen where the schools partner up with the local drugs organisations to provide the education, but such partnerships are rare nowadays. The practical authority over how prevention activities are delivered belongs to schools, which have autonomy in deciding on that matter. There is no monitoring or quality control of the implemented programmes. There are examples of good practices, but the structure of the system results in lack of consistency in the area.

According to the expert, the schools reflect the kind of the culture of their local surroundings. Hence, for example, schools in larger urban areas where there are serious drug problems are more likely to engage with local organisations for support in the prevention work, and they are likely to be a more realistic in their approach (no ‘drug-free world’). Despite of the lack of coherent, consistent system of country-level support, relationships built by eager individuals work towards ensuring that the local needs are met.

Treatment in Ireland is mostly based on outpatient services that are delivered by the primary health care entities, while residential treatment is operated by NGOs. The one type of service that seems to be universally available across the country, is counselling. However, the access to counselling is perceived as very limited. The public health system is underfunded, and the waiting lists to professionals in the public institutions are very long. There are huge geographical differences in accessibility of counselling as well, with even several months waiting time in less-well served areas of the country. This is seen as a big problem in the country. However, there are no difficulties in accessing residential treatment, counselling,

therapies, etc., for people with a private health insurance. Regarding the residential services, there has always been a problem of insufficient number of beds in the public system. Moreover, some of the available places were closed during COVID pandemic.

Patterns of drug use have changed a lot over the last years, with decreasing heroin use and many young people using crack cocaine. Arguably, the public system and its institutions are not keeping up with these changes. There are positive local initiatives aiming for analysis of the situation and development of the responses needed, but the problem was ignored at the national level. In theory, there is access to services for any kind of drug use, but that does not seem to be a reality.

With respect to recovery and social reintegration, there is a range of community drug projects, which offer nearly all the interventions: housing support and social welfare, income support, education, training, family issues, legal help, childcare, etc. There is no requirement of abstinence, and the approach is person-centred, with the main idea being about progression, helping people be where they want to be. There are many independent organisations providing such services, however, they are underfunded because of unrestored budget cuts following the 2008 recession. Despite underfunding, the quality of these services' work is seen as high, with innovative approaches and ability to respond to the changing circumstances. However, the coverage is very low, there are about a thousand places available country-wise (for comparison, there are 11.000 people on OST alone).

There are numerous pilot programmes around case management operated, using various models and approaches. However, it is argued that such projects lack intersectionality and holistic approach, focusing on clinical issues only instead. There is a big divide between addiction and mental health services. The policy has recently changed, requiring that a person should have access to both services together. In practice, however, still, there is no cooperation between the two areas. The division between drug services and mental health services in practice means that PWUD do not have the access to specialist mental health services. There is a very limited dual diagnosis service, which only deals with people who have a specific diagnosis of some relatively serious mental health condition. The staff of the addiction services is not trained to assess people's mental health condition. In some cases, the skills and training of addiction services' staff is sufficient to help a client but sometimes it

is not. In the latter case, clients' condition often worsens to the point they need hospitalisation. It seems that the main cause of this situation is that psychiatrists and mental health professionals do not want to accept PWUD as clients due to stigmatisation, and state institutions are too weak to enforce the official policy. It is argued that the main consequence of this problem is that the capacity that could be there to prevent problems escalating is not used.

PWUD report that case management is not available for everybody and that PWUD themselves are not being involved in their own care planning and decision making on their reintegration. This is seen as a class divide with public drug services discriminating people from more disadvantaged areas.

One of the phenomena seen as problematic in Ireland is the obsolete approach used by the national-level health services delivering OST. Namely, it is argued that the number of clients on OST is used as an indicator of the severity of drug problem in the country. Meanwhile, drug use patterns have changed significantly over the last several years. Long-term OST clients report abusive environment where their treatment is used as a control tool, as a form of sanction.

OST is available in a few different ways. During the emergence of OST in Ireland, it was planned that the OST services should be delivered through the local general practitioners. However, the treatment is still dominated by big clinics. Although there are general practitioners who prescribe methadone, there are not many of them. Prescribing OST is not mandatory for medical practitioners, but it is based on a separate contract. One of the main problems related to that is that the areas most affected by heroin use, the poorest ones, also have the lowest coverage of GPs.

Other problems in this area are the lack of standardisation and high-threshold nature of the services. Arguably, the waiting time for entering OST has improved a lot over the years, but the enrolment and continuation of treatment is a subject to a strict set of criteria. As a rule, clients need to go to their clinic every day, the right to get the medicine for several days needs to be earned. OST clients are required full abstinence, and urine testing is a norm in all OST services. In practice, the focus is on the opiate use and not on other substances. Until recently,

urine testing was in fact supervised, which raises the question of patients' rights. According to the expert, in many of OST clinics the medication is treated as a sanction tool for controlling people's behaviour. Another problem is the practice of removing people from their local services and sending them to other places as a punishment for alleged misbehaviour. These strict rules were justified by safety and well-being concerns. However, during the COVID-19 pandemic, the rules were relaxed, and services still worked well. In this instance, 'the health service broke their own rules to do this, which raised the question, why were they using those rules in the first place'.

OST is generally available in prisons, including initiation of treatment.

In relative terms, Irish services are seen as focused on harm reduction, which is a consequence of treating them as a public health response since the mid-1980s' HIV/AIDS crisis. According to the expert, at a policy level, there is no real questioning of the need for harm reduction. Harm reduction is not available in prisons, however.

Needle and syringe programmes are seen as very well-established, although regional variations exist, particularly outside of the major urban areas. Pharmacy-based needle exchange is limited.

Naloxone became available in Ireland in the second half of the 2010s. Ever since, its distribution significantly expanded, which was a result of the high number of drug-related deaths in the country. The geographical coverage of the services is perceived as uneven, but there has been a significant increase in availability. There are distribution programmes of injecting form of Naloxone among PWUD, their families and spouses. Training is required to be able to obtain the medicine, and it is argued that a considerable number of trainings were provided over the last several years. This development is seen as very positive.

Drug consumption rooms are not available in Ireland. There is one pilot safe injection facility approved by the government. However, its launching was blocked by the local community. The case is currently reviewed by the court, with the government fighting in favour of it. According to the expert, the health authorities have done all they could on the case.

Drug-checking is seen as extremely limited. There were a limited number of pilot interventions at festivals, however, it seems that there is no urgency to implement this type of service among the decisionmakers.

HIV and HCV testing is free, there are several NGOs that provide testing and link clients in with public services. There are rural areas where it is less accessible, but overall, the situation is perceived as satisfactory. HIV treatment is seen as generally good and stable. It is free and the access is universal. If a person is detected as HIV positive, they are automatically entitled to the treatment. Regarding HCV treatment, initially the government's approach was to make the new-generation medicines only available to people who are very sick. In the end, however, it was made available to everybody. In the expert's opinion, there is an interesting dynamic applicable to both HIV and HCV, and to Covid pandemic as well. It is argued that when the decision-makers recognise the advantages of giving everybody access to the best possible treatment, PWUD are being taken care of. For example, at the start of COVID, the population of homeless PWUD received a very good service instantly, because they were seen as a threat to public health.

7.13 Italy

Decisionmakers are not very well-informed about the EU drug policy documents in Italy, except for the national drugs agency. Over the last several years, drug issues were not on the political agenda. For more than ten years, there was no politician delegated to drug policy.

The last public campaign on drugs was implemented in Italy a decade ago. It used fear-based approach and its results are unknown, as it was not evaluated.

A great part of prevention activities is implemented in schools as universal prevention aimed at discouraging youth from using drugs altogether. It is very difficult to include risk reduction-based prevention in programmes for schools. CSOs trying to implement pragmatic, harm reduction-focused prevention faced great opposition from teachers, parents, etc. School prevention works using traditional approach. In many cases in the last several years, the responsibility for delivering school prevention is delegated to the police. The approach used by the police is seen as questionable. Many CSOs offer programmes based on skills development, but recently, the law enforcement approach became dominant, also in

prevention. The problem with insufficient CSOs engagement in prevention is related to lack of resources, as well as the general paradigm – schools are not very open to pragmatic, neutral approach to drug education. It is argued that in contrast to the general normalisation of drug use, in case of young people, moralistic approach is more dominant, and this moralistic approach is in many cases connected to law enforcement approach. It is also usually combined with alarmistic discourse regarding drug use among young people.

Online prevention interventions were not really developed before the Covid-19 pandemic. During the lockdown, however, programmes were developed aimed for young people who already use drugs (risk reduction), which is seen as a positive development.

Treatment system is perceived as sufficiently good, with a very strong national framework establishing a basic level of services and assistance that must be met by each region. Being responsible for drug policy implementation, regions can do more, too, but the minimum guidelines need to be met. Treatment is delivered by the national and regional public health care system (approximately 600 units in the country), it is free, and access is guaranteed for everyone. The system is seen as effective in the context of traditional patterns of use (injecting use of opiates). The situation is different with respect to other kinds of use, e.g., stimulants; There are very few regions offering specific treatment for such dependencies. There are also more inequalities between regions in case of non-traditional use.

Drug-free treatment works in a mixed system with non-state actors. CSOs operate residential care, while the ambulatory services of all kinds are delivered within the public health care system. There are no waiting lists in the public system. In some regions, however, there are some problems with undocumented migrants. The national guidelines ensure the right to services also for undocumented migrants, however, in some regions, it seems that the national guidelines are sometimes not respected. It is likely due to the lack of resources for accepting undocumented migrants, whose treatment is not covered by the insurance. Although the law stipulates that all public units must cover these costs, the treatment access for undocumented persons is more difficult than for the Italian citizens.

One of the main problems in this area is lack of evaluation of services. Anecdotal evidence shows that dropout rates are high, services are becoming obsolete. The demand for

residential treatment them has been low for several years. This is partly because of decreasing number of opiate users and partly because people are usually not willing to withdraw from their daily lives for months, and prefer programmes allowing to continue their lives and not lose social contacts etc. As a result of this trend, therapeutic communities changed their programmes to much shorter than in the past, and they also offer semi-residential programmes, with activities during the day but without living in the community/facility.

There are very few specialised services for women, unless they have children – then the offer is broader. Usually, these are residential services with support in raising children and professionals with expertise in this area. There are also communities for minors, however not focused on drugs specifically, but with broader scope. There are no innovative services for ageing PWUD. It is a new issue in Italy and there is no experience with that.

OST is highly accessible, without significant barriers and quick admission. In theory, GPs can prescribe methadone. In practice, it is very rare because of the centralisation of the system in public drug units. Most of the public drug units have their own OST centres. With respect to the regime, the most common treatment plan is the every-day pick-up. In some centres, the take-home regime is possible based on the assessment of a client's progress, skills to manage the therapy, etc. There is not much control in OST for long-term clients, although they need to visit their doctor sometimes. A range of services (e.g., counselling) are available if needed, but people are not obliged to see the professionals very often.

The level of control is one of the fields where there are significant regional differences in OST. In some services, moral approach dominates in OST, and clients may be punished by non-compliance through, for example, being removed from the programme. In the vast majority of regions, however, a great proportion of drug units accept use of substances during the therapy. A positive opiate drug test is a trigger for a discussion with a client regarding their treatment plan and adopted approach, possibilities of adjusting, improving the treatment plan to serve their needs. It is treated as a harm reduction tool and not a treatment ultimately leading to abstinence. These regional differences are seen as problematic in the context of clients' rights.

Every public drug unit in Italy has a social assistant who takes care of the overall social situation of a client and supports them in the contact with other services. What is problematic is that it often happens that the professionals cannot find the resources. With respect to social reintegration, there are some good experiences in the field of employment, although in general it is not easy, and depends a lot on the general situation on the labour market. There is a good system of social cooperatives and a system of incentives for social cooperatives employing people with different social problems (e.g., drug use). Still, many people complete treatment without being sure that they will have employment, without no real alternative. The situation in the housing area is perceived as very bad. Due to the lack of good housing policy in Italy, many people and poor families are squatting in Italian cities. In this context, PWUD are the last ones to benefit from any support, which is seen as the most serious problem.

Opiates use and injecting drug use have been decreasing in Italy. The patterns of use are quite different, so the numbers of NSPs have been decreasing. Changing patterns of use also the reason why NSPs change their offer, e.g., including paraphernalia for snorting and other ways of drug administration. There are still many NSPs in Italy, however. Every low-threshold service offers syringes and other equipment.

With respect to harm reduction system, there was a legislative innovation towards the end of 2010s when harm reduction interventions were included in the category of basic and essential services. This innovation is seen as very positive. Still, there are significant regional differences between the operation of harm reduction. Half of the regions in Italy have rather good and effective harm reduction system, some regions have only a few services in a few cities, and yet some other regions have no services at all. The most common services are drop-in centres and mobile units, and interventions in party settings.

NSPs are not sufficient for the needs of the target population. The coverage is about 30%. Besides NSPs, needles are also available for purchase in pharmacies. However, pharmacies are not eager to serve PWUD, the relationship is not easy. Moreover, pharmacies sometimes decide to sell needles only in bulks, which can be a price barrier for PWUD.

Naloxone distribution has been historically good in Italy as naloxone is an over-the-counter drug since the 1990s. Naloxone distribution is connected to the harm reduction system. The regions where harm reduction does not work, naloxone distribution does not work either. Public drug units have injecting naloxone due to its low costs. Nasal spray can be bought in pharmacy, but it is not a frequent practice among PWUD. More experienced PWUD are used to have naloxone in their pockets, but there is a big problem with younger ones who do not inject, see the risk of overdose as very low, and are not comfortable with syringes. As long as there is no spray naloxone available for distribution from public services, it will be very difficult to promote it among young users. However, as the number overdoses is low, it is not an emergency.

Drug-checking was introduced several years ago informally by a peer organisation, and in 2019 made its way to the regional guidelines on harm reduction. Now, drug-checking services are being developed in two regions. There is also a working group established in The Ministry of Health, developing a protocol on drug-checking. It is planned to launch drug-checking services all over the country within a year or two.

There are different safer nightlife programmes working at regional level. Sometimes, organisations cooperate at national level for bigger event. There is an informal, bottom-up network in place that works well. Safer nightlife services exist in Italy for two decades and there is continuous development visible due to excellent exchange of knowledge and information. The services are mainly delivered by CSOs but supported and funded by the state. Still, there is a problem with resources. For example, many services receive funding only for one year, which makes them unsustainable, forcing the staff to constantly look for resources to continue their work. There is also a problem with coverage as not enough organisations exist. A large part of the southern Italy is not covered, which is related to the general underdevelopment of harm reduction in these regions.

There is a rather good system of HIV and HCV care, every citizen diagnosed with HIV or HCV has free access to basic treatment. In case of undocumented persons, the problems with HCV treatment are like those mentioned in the discussion on addiction treatment. HIV, however, is treated as a public health issue, so the access to treatment is universal.

7.14 Lithuania

In Lithuania, the government recently took a decision to create a global comprehensive strategy including all kind of issues: social, health, etc., instead of focusing on more narrow areas, like drug policy, separately. The new Lithuanian framework is seen as largely guided by the EU Drug Strategy as the main source used in drafting the national policy. The objectives, actions, indicators, etc., follow the EU agenda. This is seen as a broader phenomenon not limited to drug policy – arguably, in Lithuania most policies and solutions try to follow the EU recommendations, especially in case of more sensitive areas like drugs.

According to the expert, one of the main problems in Lithuania is that the majority of service providers employ relatively older staff who do not speak English, hence cannot access many international events (conferences, trainings, seminars). Funding is also seen as a problem here, as many organisations struggle to fund their day-to-day operation, and they do not have the money for employees' travels and trainings. Organisations and professionals who are active members of the international drug policy community try to transfer the knowledge they acquire abroad via organising trainings and seminars for their colleagues at the national level. Arguably, there is a high interest in such events. There seems to be a general problem with implementation, too. The policymaking process ends on policy adoption, and no funding is secured for services' operation.

With respect to prevention, it is mostly concentrated in schools where different programmes are implemented. There are seven-eight prevention programmes available in the country, however, they do not seem to cover many schools. It seems that no studies were conducted on the effectiveness of these programmes.

Based on the information gathered from pupils, it seems that the available prevention programmes are not really evidence based. To the contrary, they seem judgemental and based on scaring youth off, and include promotion of healthy lifestyle as one of their main messages. There are also prevention activities implemented by the police, that focus mainly on the criminal consequences of drug possession. Apparently, there is a law in Lithuania which forbids educating minors about drugs and drug use, in practice also about harm reduction. The law is seen as being strictly applied in school settings but not elsewhere, e.g., at festivals.

Detoxification programmes and 12 steps programmes exist only in several biggest cities. Treatment is available through public and private treatment facilities. The former ones are underfunded, which makes their accessibility low, and waiting time long.

With respect to OST, methadone funded by the government and non-refundable buprenorphine are available. The coverage is very low (less than 20% of the high-risk opioid users) because of lack of funding from the government. OSTs operate only in bigger cities, which makes them inaccessible for people living in smaller towns, who often do not have money to travel frequently to pick up their medicine. The programmes are high-threshold, with random urine tests and every-day medicine pick-up as the default mode. Use of psychoactive substances is prohibited and testing positive for any drug results in sanctions, although usually not removal from the programme. Since 2018, OST has been available in prisons, first only as a continuation, and since summer 2021 it is also possible to initiate the treatment in prison.

All treatment programmes, including OST, are difficult to access because of the long waiting lines. However, apparently, people diagnosed with HIV or HCV, and those referred to treatment by the law enforcement, can access OST almost immediately. This resulted in a paradoxical and dangerous situation where people were intentionally sharing injecting equipment with their HIV-positive friends to get infected and get into the treatment more quickly.

Case management exists, also in OST – it is included in the package of services and many positive stories can be heard. Social reintegration works relatively well, but it largely depends on the skills, motivations and knowledge of social workers and other professionals working with PWUD. Shelters normally do not accept PWUD because of their drug use. Some shelters of church-based organisations do not accept people on OST either, suggesting them to quit the treatment to be allowed to stay in the shelter. Such church-run organisations are virtually the only provider of shelters in the country.

The situation of needle and syringe programmes is seen as slightly improving over the last several years, in terms of number of paraphernalia distributed. On the other hand, the number of NSPs has been decreasing – from 13-14 several years ago to nine now. NSPs are

concentrated in big cities. According to the expert, this is a question of funding. There is demand for the programmes and capacity of professionals willing to operate them, but the funding is insufficient. This also affects the range of services offered in NSPs, which is limited to distribution of needles and syringes, and injecting water, without any other paraphernalia.

Naloxone is available in Lithuania, but very limited. It is possible for PWUD and their family members to buy it with prescription. Limited quantity is also available in several drug treatment centres (three or four out of eleven). For example, if a person receives OST, they can attend a short training about naloxone administration and get the medicine for free. The level of awareness about naloxone among PWUD is seen as low, especially among people who are not in contact with any treatment services. Very recently, a pilot programme for nasal spray was launched; a group of police officers in Vilnius were trained on how to use it. Overall, the prevalence of naloxone in the field is seen as very low. Still, it is possible to access it relatively easily if someone asks for a prescription and can afford it. Peer distribution programmes do not exist because of the lack of funding.

Drug consumption rooms are not available. There is a discussion around it, working groups developing the new national drug strategy push for their introduction, however, but the final decision is uncertain. There is a lot of opposition against DCRs in the society.

With respect to safer nightlife programmes, there is no official legal framework regulating them or funding framework for such work. There are, however, two initiatives implementing safer nightlife interventions in the country. One of them is a public-private partnership focusing on prevention activities at music festivals, employing only middle-aged professionals (and youth or peers) and using methods perceived as obsolete. The second one is operated by NGO and not financially supported by the state and focused on the distribution of harm reduction tools and information.

Drug checking is not legally forbidden in Lithuania. However, since drug possession is a criminal offence, proper drug-checking programmes cannot be launched due to the questions arising around handling of psychoactive substances by services' staff or volunteers. Reagent test kits are available in Lithuania, although they are politically controversial; the decisionmakers are reluctant to introduce their widespread distribution. Safer nightlife and

drug-checking are perceived as most poorly functioning area of Lithuanian drug policy. It is seen as a positive change that safer nightlife services exist at all (which was not the case in mid-2010s), that they are expanding, covering more festivals, reaching out to more different types of clients. Still, lack of funding and lack of political will (distribution of harm reduction materials in party settings are considered promotion of drug use) seem to be great challenges for further development in this area.

HIV treatment is available to everyone, and the costs are covered by the insurance. For people without health insurance, support programmes exist, which they can access with help of the social workers in treatment or low-threshold programmes. HIV testing among PWUD is limited due to the legal regulations and underfunding. More specifically, only medical staff is allowed to perform testing, and some of the low-threshold services do not have the money to pay for the medical staff. According to the expert, there is a big urban-rural divide in the accessibility of services, as both testing and treatment can be accessed only in big cities. A significant change happened in the 2nd half of 2010s: contrary to the situation before, when only people most affected by the virus were allowed to receive treatment, now it is covered by insurance for everyone diagnosed with HIV. In practice, however, one of the main problems is that many PWUD drop out from treatment, arguably, due to stigma and discrimination in the health care settings, high threshold of the services, social-economic reasons, and inadequate geographical coverage.

7.15 The Netherlands

In The Netherlands, drug services seem to work well, compared to other European countries.

Prevention in The Netherlands delivered by well known, big, widely recognised organisations. It is seen as relatively good, adopting progressive and evidence-based approach. It is likely that only evidence-based interventions are implemented at a large level, for example, in schools. There is no certification system, but there is a best practice portal available, where all health and social interventions delivered in schools are listed and described.

OST can be obtained from a local general practitioner or in one of the municipal health centres. The system is seen as relatively well-integrated, and the medicine is free of charge. While there can be some disproportions in the context of urban-rural areas, in the countryside

it is also to receive OST conditional upon finding a GP willing to prescribe it. Importantly, in the Netherlands both heroin use and injecting drug use has been decreasing over the years. Hence, the existing system of OST seems to be adequate to the needs of PWUD. The main problem with respect to the access seems to be for people who are not residents of the country – EU and other migrants, who do not have the access to any kind of social or health services, except for life-saving interventions. Access to OST was provided for these populations during the first wave of the COVID pandemic. However, it was withdrawn as soon as the first-wave lockdown measures were relaxed, against medical knowledge and quality standards, and to the disappointment of the professionals working in the field.

Accessibility of NSPs is also seen as sufficient. There are different facilities where sterile needles can be accessed, it is also possible to buy them in pharmacies, which is especially relevant for rural areas.

Naloxone is available only in hospitals and ambulances. There are no take-home naloxone programmes or medicine available for peer-to-peer support interventions. It is seen as an odd element of the Dutch drug policy. It seems that there have been no real advocacy efforts undertaken to change this situation, ‘because there are no numbers that would support it’, as the injecting drug use and overdoses are rare.

The low prevalence of injecting drug use and overdoses is related to the next interesting phenomenon in the Netherlands. Namely, the authorities are considering closing drug consumption rooms. It is claimed that increasingly more PWUD do not live on the streets anymore, but in the housing first facilities or in their own apartments instead. According to the expert, the problem here is that the decisionmakers forget that DCRs are much more than a clean place to consume drugs, preventing overdoses and blood-borne infections. Apparently, it is difficult for professionals to explain to the decisionmakers that DCRs are places of social integration where people make and sustain their relationships with others. Furthermore, in the Netherlands, many DCRs were established next to already existing drop-in centres, which makes them surrounded by a range of other services that people using DCRs can be offered. Indeed, it seems that there is also a growing trend in case of DCRs not to limit the offer to space for drug consumption only but to build an integrated care around it, including work support and integration, social activities, etc.

Drug-checking has been available in the Netherlands for decades, both on-site and in the community (at festivals and parties). Sometime around the first half of the 2010s, however, the activities at festivals and parties were cancelled because of political pressure claiming that they exceedingly facilitate drug use. Nowadays, therefore, substances must be delivered to one of several centres operating drug-checking. This is seen as insufficient, as the lack of services available at festivals and parties limits the access and utilisation of them, and in consequence, their overall effectiveness. Party services are still accessible at festivals and parties and are seen as working very well.

With respect to HIV and HCV treatment, it is accessible, and in principle guaranteed for Dutch citizens and residents, covered by the insurance or municipal health service. Interestingly, however, during a testing project implemented several years ago, it turned out that there is a considerable group of people who are infected but have not been tested ever before. The main problem that is being raised here is not the lack of access but rather the need for ensuring that people are supported in getting the treatment.

Overall, there are several main issues perceived as problems by the expert. First, the division between social harm reduction services and the health care system. Apparently, it is no longer the case in the Netherlands that medical personnel (doctors) work in harm reduction centres. There is no integrated approach, which is seen as a major shortcoming of the system. 'It is not enough to have facilities, but you also need to make sure that people are being supported and that the knowledge is there on both workers side and users' side, and that the services cooperate'.

Second, there is a large group of people without access to any services – people without legal status in the country and without insurance. Recently, however, there has been a new programme launched targeting undocumented people or non-residents who are homeless, use substances etc. The focus of this programme is on the integration through finding a job, providing a shelter, etc.

Finally, it seems that medicalisation and professionalisation of harm reduction contributed to the problem of detaching harm reduction as a range of services from its political meaning. 'Workers in harm reduction are no longer aware of what harm reduction is'. Harm reduction

organisations, it seems, are not political actors anymore. Instead, they have become a part of the system, the implementers who do not do advocacy anymore and who do not show any political commitment. Drug use is seen as one of many social problems, hence the organisations do not feel the need to get involved politically in drug policy.

7.16 Portugal

In Portugal, significant changes in drug policy took place after the global economic crisis of 2008, when the authority over the implementation of drug-related services was put in the hands of the regional authorities. This, according to the expert, this is one of the reasons why regional differences in services' accessibility and quality became more visible in the country. State institutions providing services as seen as 'frozen in time' and using obsolete methods of work. Arguably, any push for innovations comes from the civil society organisations.

In Portugal, project-based (and not service-based) funding of drug services is seen as one of the major problems in the drug policy field. Such a framework, where organisations can acquire funding only for three to five years, and only 80% of a project is funded, is perceived as 'very precarious'. Moreover, the budget available for NGOs-operated services has remained the same for the last ten years. The underfunding seems to be true for all the pillars of drug policy, but especially true for prevention, which likely loses funding for the advantage of harm reduction.

Prevention programmes in Portugal are arguably severely underfunded, and the funding has been decreasing over the years. The accessibility of prevention highly varies geographically, mainly in terms of urban-rural divide. There are numerous universal prevention programmes available, but their quality is assessed critically. Although there are good-quality interventions available, they are seen as exceptions. According to the expert, most prevention programmes are not evidence-based, and they do not respond to the needs of people already using drugs, for example, though the inclusion of harm reduction elements in the curriculum.

In the area of treatment, some therapeutic communities are run by NGOs, but most of the treatment is within public health care system. The public treatment services are seen as underfunded, lacking many professionals, having elder staff, and experiencing outflow of more skilled workers. The outpatient centres that are operated almost exclusively by the state

are seen as having a rather low quality, but they are available in any medium or large city. The accessibility of these services, however, is rather low. For example, in Lisbon, it is very difficult to book an appointment for treatment in one of these centres, even if low-threshold services' employees help. According to the expert, the reason for that is bureaucracy and obsolete methods of work (only in-person requests, not using phone or email). There are waiting lists, and there is no alternative in the form of a low-threshold treatment service. The length of the waiting period varies across the country and depends also on whether a client is helped by a worker from a low-threshold service. During the COVID pandemic, the waiting time for detoxification was more than six months in Lisbon. Moreover, it seems that treatment services handpick their clients, e.g., they are reluctant to accept people for OST programmes and accept those willing to enter therapeutic communities. They are also claimed to be especially reluctant to accept people who have many problems, e.g., those living on the street. Treatment services are seen as not adjusted to specific needs of special groups like women, migrants, people living in poverty. There have been some recent improvements in the area (e.g., drug agency organising trainings on gender, chemsex, MSM), but services are still not adequate.

Although there are many psychiatrists and psychologists in Portuguese drug treatment centres, the system is seen as divided into two separate parts: addiction services and mental health services. According to the experts, people with dual diagnosis are sent back and forth between the institutions from each side, as mental health facilities do not want to accept people who use drugs, and treatment services are only willing to address dependency, and refuse to accept people with mental health problems. There also seems to be insufficient integration between treatment and harm reduction services. Any instances of cooperation are based on good personal contacts between services' employees, 'it's not structural aspects of the system'.

With respect to OST, a quick access is possible in NGOs. According to the expert, the availability of OST in NGOs may be one of the reasons why the state-run treatment centres refuse to accept such clients. There are two types of programmes in the country. The high-threshold programmes require abstinence and adherence to strict rules, but people can get their medicines for a longer period. In low-threshold programmes (mostly methadone) abstinence is not required, people can use any drugs, but they are required to take their

methadone daily, they must visit the treatment centre in person every day. Buprenorphine is available in pharmacies; it can be prescribed even for several months. It is also cheap, which makes it highly accessible. However, there are significant barriers in access among specific population, for example, people living in the streets. Methadone can be acquired for a few weeks or a month. OST is available in majority of Portuguese prisons as a continuation of treatment and can be initiated in four facilities in the country. NGOs see this as a violation of human rights of prisoners.

With respect to recovery and reintegration, it seems that the COVID-19 pandemic helped expanding housing first programmes in Lisbon. Still, social reintegration programmes are perceived to be very weak. There is little investment in this area, although the situation has improved recently, compared to the years after the global financial crisis. Available reintegration programmes are not specific for people who use drugs but for vulnerable populations in general. As a result, PWUD are left out of these programmes because of the stigma. Organisations advocate for specific programmes for people who use drugs. Still, some social reintegration projects are implemented by NGOs. Moreover, it is also a last phase of treatment in therapeutic communities. Housing serving social reintegration is difficult to access, and they are only accessible for people in long-term treatment programmes, not for clients of low-threshold services.

Over the last 10 years, there were some positive developments in harm reduction.

For example, two drug consumption rooms were open in Lisbon, including one mobile unit and one fixed location room. This is seen as a result of the 20 years of work of professionals and advocacy organisations.

A drug checking service in Lisbon was also established in 2019, which is the first permanent service in the country. Before that, drug checking was available only at festivals and other events.

In 2020, for the first time, the nasal Naloxone became available for harm reduction organisations. However, it was only for a short period of time as the medicine was received in January 2020, and its expiration date was only four or five months later. There is a news stock expected to arrive at the time of the research. There is no national programme for

Naloxone distribution, however. NGOs distribute it to clients on their own initiative and monitor the activities on their own. There is no central system for that. Injecting form of Naloxone is normally reserves for medical personnel. However, the good Samaritan law enforced in Portugal makes it possible to use by any individual to prevent someone's death.

Another development in the past several years was the acknowledgement of the importance of the peer input and peer work, which was pushed for by some organisations. Now, it seems to become more normal to employ peers as regular staff, which is seen as very important. This has not been achieved easily, however. First, the recognition of peers' importance in programmes had to be achieved. Second, since peer work is not a recognised professional category in Portugal, there were bureaucratic barriers to overcome. Namely, funding grants did not include this type of professional category. Still, the cooperation of NGOs and their wide agreement on the issue resulted in submitting numerous grant proposal involving peers, and as a result, the bureaucracy was 'not in a position to refuse that anymore'. Even more, in Lisbon city, organisations receive additional points for a grant application if the project includes peers, which is seen as a step in a good direction.

With respect to needle and syringe programmes, it seems that one of the main programs is the urban-rural divide, resulting in significant variance in accessibility. A significant change in the accessibility of sterile needles dates to the economic crisis when pharmacies (which earlier were the main facilities for needles distribution) opted out from the agreement with the state. As a result, the geographical coverage of needle distribution programmes deteriorated drastically. The situation has improved several years later with some pharmacies re-launching their programmes. Still, many needle and syringe programmes are operated by NGOs, which are based mostly in urban areas. They distribute increasingly more syringes, however, because of poor monitoring, it is difficult to estimate the changes of specific indicators (e.g., needles distributed per person per year, coverage of the target population). Over the last several years, some improvement could be seen around the NSPs' offer, e.g., inclusion of other drug use equipment (crack pipes, snorting kits, different kinds of needles).

HIV and HCV treatment is treated in Portugal as a public health issue; hence, it is free for everybody, including people without legal status in the country. The treatment is operated by public health care system institutions. There may be some bureaucratic barriers to access it,

sometimes help of low-threshold services is necessary, but everyone has the right to access treatment. If there are some cases of discrimination, it is seen as an exception. Now, people actively using drugs can receive HCV treatment in Portugal. 'From the medical point of view, there is no excuse to not treat someone who is using drugs'. In general, the access is universal. The barriers, that people face, are more related to their social situation (e.g., living in the street) or place of living. There is a need for more efforts to make the HCV treatment more available at GPs, to decentralise it from the hospital. However, the accessibility of the treatment has increased in prisons several years ago, because of a responsibility transfer from the Ministry of Justice to the Ministry of Health.

7.17 Serbia

The situation in Serbia changed significantly in 2013, when the country progressed in the EU accession process, and the EU policies started to affect Serbian policies to a larger extent. Still, although CSOs tried to advocate EU-inspired solutions during the drafting process of the Serbian national Action Plan 2018-2021, state authorities were not willing to allow too much influence of the EU. It is argued that the EU drug policy documents are too progressive for Serbian government. At the same time, some Serbian CSOs see them as not progressive enough. It is believed that the Serbian government accepts the parts of the EU drug policy that address repression and law enforcement but is not willing to accept the parts that refer to people-centred approach, human rights, harm reduction and civil society involvement.

Prevention in Serbia is usually limited to universal prevention. It is focused on activities delivered in school settings and campaigns in public spaces. The quality of prevention is perceived as rather low. The accessibility of prevention is higher in bigger cities, while in small cities and rural areas it is virtually absent. In 2019-2020, an inter-ministerial body developed a prevention programme covering more than 40,000 pupils and 12,000 teachers in primary and secondary schools. However, no curriculum, manual, evaluation, or impact assessment of this programme was shared or published. It is also unknown who was responsible for the implementation of the programme.

In theory, certification is necessary for a CSO to implement any activities in schools. Still, the content of prevention programmes is 'different from school to school, from region to region,

from organisation to organisation'. There are no national quality standards in Serbia, however, organisations can use the EU MQSs as the document is available in Serbian. Next to lack of quality standards, lack of evaluation is also one of the main problems in the field. Online prevention is limited and mostly uses fear-based approaches.

The situation of treatment in Serbia is seen as poor. Most of the treatment facilities are run by hospitals, but there are also several places operated by CSOs. The quality of public treatment facilities is questionable. It is reported that people using cannabis, stimulants or other non-opiate substances, treatment, in essence, is limited to receiving 'a cocktail of medicines; different types of medicines that are sedatives, narcoleptics, a variety of subscription medicines'. There are cases reported of young people who seek help from CSOs after six months of the hospital treatment. It is argued that the kind of treatment people receive in hospitals is, in fact, exacerbating their state instead of improving it. Reports from clients draw a completely counterproductive picture of public treatment facilities, where a person goes through detoxification process to subsequently be admitted to a treatment programme where they receive a range of medications and see a psychiatrist once every week or two weeks. Clients are also tested for drugs once a month and the urine tests results form a basis of progress assessment.

Inpatient treatment is largely limited to detoxification. The access to it is limited. In both CSOs-operated and hospital-based facilities, waiting lists are long due to low capacity. Waiting period normally extends to several months (from two months to even one year), and the services are only operated by psychiatric clinics in hospitals. There is no abstinence-based treatment available in the countryside.

There are many private clinics offering detoxification, treatment, and other services. However, these facilities operate entirely beyond any control, the government has no information about the situation there. It is widely known that some of the private clinics offer very innovative treatment using, for example, ibogaine, which is a controlled substance in Serbia. There is no possibility of implementing any mechanisms of control or evaluation in private clinics.

Overall, except urban-rural disproportion, there is a great disbalance in accessibility of treatment depending on the socio-economic situation of a person, their place of living, etc.

OST is available with buprenorphine (prescribed by a psychiatrist) and methadone (available only in specialised centres). In the former case, a monthly visit at psychiatrist's, accompanied by urine testing, is necessary, and a monthly prescription is issued, however, it is only possible to buy a maximum of 2-weeks supply of the medicine at once. In the latter case, the medicine must be picked up every day, and. The treatment is not free of charge. In case of buprenorphine, a person must cover the entire cost, while in case of methadone, there is a limited number of state funded places (where a person only pays a proportion of the treatment, approx. 60 Euro per month, as opposed to 200 Euro per month in case of non-state funded therapy).

Monthly urine tests target mostly opiates as there is no funding to test regularly for all controlled substances. If a person tests positive, the problem is discussed with a psychiatrist and normally some additional measures are applied (more psychiatrist visits, more family support). It is argued that the extent of discrimination in treatment is high. Still, there are exceptional doctors who understand that relapse is a normal part of treatment.

The psycho-social support in OST is based on treating a person and their environment. A family member supporting a person needs to be involved in the treatment.

With respect to accessibility, there are only four OST centres operating in big cities. These specialized centres are the only possibility to get OST, there is no possibility of getting it for a GP prescription from pharmacy. OST programmes in countryside used to be available until 2014 due to funding from the Global Fund. The transition from Global Funding to other sources of funding failed to work ('was not done correctly'). Nowadays, the situation is especially difficult in the rural areas. It was especially challenging during the Covid-related travel restrictions when people living in the countryside couldn't go to a hospital to pick up their medication. The regulations of OST were relaxed after CSOs' intervention. Overall, the ability and accessibility of treatment is seen as very low.

OST is available in prisons only as continuation of treatment started in the community. The quality of drug services in prisons, however, is perceived as low. There is no data regarding whether and OST is implemented in prisons at all, how it is implemented, etc.

The most severe problem with respect to OST is that it is common that people stay in treatment for many years without a chance of progressing. There are many clients who wish to quit OST but are not able to as there is no adequate psycho-social support available. Moreover, being severely medicated prevents people from finding job and function normally.

The quality assessment of treatment is missing, there are no data on the number of people completing the hospital treatment.

Except one church-operated treatment centre, there are no services adjusted to the needs of women who use drugs. There is no offer for other vulnerable populations.

There is no state aftercare available. The existing social reintegration programmes (in three cities in southern Serbia) are operated by CSOs established by PWUD who felt the need for such support. There is no state support for these programmes, they acquire funding from churches, humanitarian organisations, private and corporate donations. They also often operate social enterprises employing PWUD. The organisations offer community support centres, psychotherapy, work support, legal support, etc. One organisation provides housing support, and in one of the centres there are programmes for women with children.

The effectiveness of these services is seen as likely low because of the stigma and discrimination of people who used to have a problem with substance use. This stigma is especially strong in rural areas, where also the proportion of people using drugs problematically is higher than in large cities. It is argued that it is very difficult, if not impossible, to recover in 'in that setup of the society'.

Needle and syringe programmes almost disappeared from the map of Serbia after 2014, when the Global Fund withdrew from the region. The only organisation that managed to survive could do it because of injecting materials saved from previous years. The accessibility of services slightly improved after 2019 when Global Fund started to fund HIV programmes again, including NSPs. Still, the funding is lower than before 2014. The government does not

fund harm reduction. Organisations have problems in reaching out to target populations, which suggests that they did not build communities, relationships with the clients. The quality of services is questionable, there are also some ethical considerations regarding the complete lack of peer involvement in service delivery.

Naloxone is available exclusively in emergency units of hospitals in bigger cities. CSOs are not allowed to have naloxone in their drop-in centres. Drug-checking is blocked by the police. Moreover, there is no legal framework for such a service; Because drug possession is illegal, organisations' staff is not allowed to handle substances. There is some process starting, however, with CSOs involved, regarding if and how drug-checking can be introduced in the country.

There is one organisation delivering safer nightlife interventions in Serbia. The organisation operates services on major festivals and parties, and outreach in the downtown Belgrade. Progress was made in 2019 as the organisation worked on the biggest festivals that were organised in the country. Still, there is a huge stigma around talking openly about drugs in nightlife setting. The accessibility of harm reduction in nightlife settings is seen as insufficient, and there is no public funding for such activities. Although, cooperation with state actors is improving each year, there are still many limitations. There is a thin line between what kind of services are legal and what not, e.g., due to being interpreted as facilitating drug use.

Access to HIV and HCV treatment is seen as difficult, but possible. Treatment is implemented in hospitals and partly covered by insurance. Organisations working with people living with HIV focus on the MSM community, as PWUD is not a recognised community in Serbia.

7.18 Slovakia

According to the expert, the EU Drug Strategy does not play an important role in shaping the drug policy in Slovakia. It seems that one of the reasons behind it can be the poor connection between the staff working in the focal point of the EMCDDA and staff of the Ministry of Health. There is no oversight regarding to what extent the Slovak drug strategy is in compliance with the EU Strategy. There is no monitoring of meeting the goals, no impact assessment of the national strategy. It is argued that drug policy is not important at all for the parliament, government, and political parties. Slovak CSOs were invited to provide input in

the process of preparing the drug strategy for 2021-2025, but their recommendations were not accepted. According to the expert, the Ministry of Health (responsible for drafting of the national drug strategy) claims to copy the EU Drug Strategy solutions in the national strategy of Slovakia, while it is seen that problems in Slovakia are different from those emerging at the EU level. The main problem in the country is the access to services, especially for people without insurance. Another set of problems concerns civil society involvement in policymaking and funding for harm reduction services-operating NGOs. The last Slovak drug strategy included provisions on the support for harm reduction programmes, but this was – according to the expert, not realised.

The overall state of prevention in Slovakia is seen as ‘not good at all’, and this has been stable for years. Drug prevention is not a part of the compulsory school curriculum. How it is delivered is mostly decided at the level of school. There are no rules, no guidelines, there is no institution responsible for overseeing the activities. Prevention is mostly a responsibility of schools, and each of them should have a drug coordinator (normally, a school psychologist). There are several NGOs that maintain relationships with some schools and implement drug-related educational activities when invited. However, the one organisation with the strongest presence in the field is the Scientology church, active all over the country. This is an alarming situation as it is widely known, and confirmed by materials produced by this organisation, that it disseminates misleading, factually incorrect information. Except interventions in schools, the church also operates a website “Slovakia without drugs” and install many billboards in public spaces. Some prevention activities are also delivered by the police.

It seems that there is no specific funding for prevention activities in Slovakia. However, schools can request a grant for prevention and similar activities from a modest budget managed by the

With respect to online space, there are two informational websites about drugs available, one of them operated by the Ministry of Health. There is also a widely known campaign “Grab a ball, not drugs”, managed by a basketball club in Košice. The expert’s organisation moved some prevention activities online because of the COVID-19 lockdown measures. They organised workshops with students at the school they had been already cooperating with before. Arguably, there are no more initiatives visible in the online space.

Detoxification units are available in some of the hospitals in Slovakia. Treatment centres are operated as separate entities or units in hospitals under the Ministry of Health. Psychiatric facilities also provide drug treatment. The availability and accessibility of treatment services depends on many factors, mainly, the health insurance status and place of residence of a person. In one facility Bratislava, it is possible to access treatment even without health insurance or with debt on health insurance. In other parts of the country, it is very difficult to access detoxification.

In Slovakia, there are three insurance companies: one public, and two private ones. Each health insurance company has contracts with different health care facilities. The state-owned insurance company is seen as the best one for PWUD as it has more treatment places available for their clients. Overall, the availability and accessibility of treatment varies a lot depending on the person's situation. The waiting period can take anywhere between two weeks and one year (as reported by expert's clients). In some of the cases of court-mandated treatment (next to prison sentence), the waiting time can be even up to two years. Cases of court-mandated treatment contribute to the increase of the waiting time.

Theoretically, ambulatory treatment should be available at any psychiatrist specializing in drug dependency. However, it seems that psychiatrists are reluctant to accept patients with drug dependency. The accessibility of ambulatory treatment also depends on a range of factors. This kind of treatment is likely most accessible in the capital of the country.

There is a big diversity of services providing reintegration, and they are operated by different actors: churches, private companies, NGOs, the state. There are no standards regarding what support such programmes should provide. There are only few public reintegration programmes, which makes them difficult to access due to overcrowding. Private programmes have more available places, but the need to pay for them makes them inaccessible for many PWUD.

There are two methadone programmes in two major cities in Slovakia, and a buprenorphine therapy in the third one. There are no more programmes in the country. Psychiatrists can also

prescribe buprenorphine. However, the problem is that psychiatrists are reluctant to accept patients with drug dependency and in practice, they don't really prescribe OST.

Methadone treatment is covered by health insurance. In Bratislava, there is a change of accessing it in the abovementioned treatment centre accepting people without insurance as well. Buprenorphine can be bought in pharmacy for prescription and is partly reimbursed for insured individuals.

OST in Bratislava provide a basic dose of methadone for each client. If a person wishes to have their dose increased, they need to give up using other drugs. People on higher doses are subject to random urine testing and testing positive for non-opioid substances is followed by sanctions (e.g., decrease of the methadone dose). There is a system of sanctions, awards and control mechanisms present. For example, testing positive for other drugs on several occasions may result in being removed from the programme; failing to pick up a dose continuously may result in regressing in the process (which is important from the point of view of the regime of picking up the medicine).

In 2009, there a significant change took place when the drug fund under the government was reduced and moved to the Ministry of Health. Ever since, organisations providing drug services have been closing. In 2021, the Ministry of Health closed the only remaining programme harm reduction organisations could apply for. Currently, there is virtually no state-level funding for harm reduction organisations. They acquire funds from municipalities and regions. This results in a significant change in the focus of some organisations, which now try to register as social organisations (like those working with homeless, youth at risk, people with disabilities, etc.), providing also social services to people who use drugs. According to the expert, however, harm reduction organisations need much more funds for materials to distribute. Even before the funding withdrawal, the situation with materials was challenging – organisations had to introduce limits of the numbers of materials given away due to the shortages they experienced. After the change, operating needle and syringe programmes is likely to be even more difficult.

NSPs are available only in the western part of the country. There are two organisations in Bratislava and one organisation operating in a few smaller cities. Officially, needles and syringes are available for purchase in pharmacies as well, but – according to the expert – many pharmacies refuse to sell injecting equipment to PWUD. It is also possible to order needles from a pharmacy online, however, it may not be easy for many PWUD as to do so, one needs internet access, bank account and card, posting address, etc.

The coverage of NSPs in the country is perceived as insufficient, however, the situation is better in Bratislava. There are problems with needles supply in the country, especially in the period towards the end of a year and beginning of the next one. Even if organisations do have funds for purchasing more equipment, it is not always possible due to the shortages of this specific type of needles in the market.

Naloxone is available only in hospitals. Since only the injecting form is registered in the country, only health personnel and ambulances can use it. Theoretically, it is also possible to buy naloxone with a prescription, but it is very difficult to obtain one even for a harm reduction organisation's staff. It also seems that the level of awareness about naloxone is very low among PWUD. Nasal spray is not registered in Slovakia. Despite advocacy efforts of some professionals, inclusion of naloxone distribution programmes in the new Slovak drug strategy was not supported. There is stigma around PWUD and reluctance to equip them in a medicine in a form of injection. There is also argument raised against the naloxone programmes, claiming that there is no problem with overdoses in Slovakia.

There are no DCRs available in Slovakia, which is related to the criminalisation of drug possession. Introduction of DCRs is not on political agenda either. For the same reason, drug-checking is not available either. Organisations can only buy reagent tests and distribute them among clients. There are no organisations specialising in safer nightlife activities in Slovakia. One organisation tries to implement some activities, but they are very limited due to lack of capacity. It is argued that this area regressed over the last ten years, for example, the possibility of low-threshold testing for infectious diseases is not available anymore within safer nightlife programmes.

The situation around HIV and HCV testing and treatment is seen as ‘completely horrible’. It is argued that the prevalence of testing is insufficient, and it decreased a lot during the COVID-19 pandemic because of the lack of staff and need to focus on other issues. It is not possible to get free, anonymous testing for the general population, while PWUD can be tested in low-threshold services. It is not possible to get the confirmatory HCV test without insurance (after quick-testing positive).

HIV treatment is covered by the insurance. People with no health insurance or debt on the insurance cannot access HIV treatment if their life is not in danger. Therefore, for many PWUD, ARV is available only when their condition is already bad. The information NGOs received in summer 2021 from the decisionmakers was that free of charge HIV treatment for PWUD without insurance will not be included in the new country’s drug strategy as discriminatory against non-drug users.

Theoretically, HIV treatment is available in prisons as well. However, there is no official information about the situation, it only can be acquired through a special procedure based on the law on public information. In practice, very few people receive HIV treatment in prisons (two persons in 2019, according to the expert).

HCV treatment is not available without insurance, either. For insured PWUD, there is an additional requirement of proved one-year abstinence. Active drug users are not eligible for the treatment. There are no exceptions made for one-time relapses, so for many PWUD accessing the HCV is very difficult.

7.19 Slovenia

Drug policy in Slovenia uses the framework of the EU drug policy. Slovenian drug strategy follows the structure of the EU Drug Strategy. However, the biggest challenge in Slovenia is the extent to which these documents are implemented in practice, how much effort different responsible ministries put on the implementation of those documents. This is seen as a big problem in the country.

Prevention is mostly the responsibility of the Ministry of Health, and to some extent (with respect to school setting) the Ministry of Education. The two ministries usually do not

collaborate with one another in development and funding of prevention programs. Funding is usually provided by the Ministry of Health through a call for applications announced every three years. The eligibility criteria are seen as very vague and general, and the evaluation and selection of applications as not very strict. As a result, many organisations receive the money without showing any evaluations beyond process data. It is argued that civil servants in the Ministry are not skilled and educated enough to be able to evaluate these applications well. Currently, there is no requirement of planning and conducting an evaluation in the call for applications. Organisations use mostly quantitative and process-focused indicators. There is nothing about the outcome, impact of those interventions.

There is one organization in the country providing education and training of prevention professionals, based on quality standards. There is a network of organizations trained by this organization which provide evidence-based prevention all over the country. There is a small number of other organizations which also have evidence-based components in their prevention programs. There is lack of needs assessment, as well.

The coverage and quality of prevention interventions is better in the western and southwestern parts of the country. It is argued that the change of mindset is necessary in Slovenia in order to implement more evidence-based prevention interventions, because the quality control system is lacking, and organisations are funded even without increasing quality of interventions.

Some online campaigns were implemented during the Covid-19 pandemic that focused mostly on the mental health and helping parents to deal with difficult emotional and mental state of their children during the lockdown. Before the lockdown, there were no prevention interventions implemented online in Slovenia. Organizations plan to continue with online prevention activities after the pandemic. They consider this way of reaching out to youth and their parents very effective and allowing for more coverage.

Abstinence-based ambulatory and residential treatment is a responsibility of the state, and services are funded from the health insurance. The accessibility is high. There are no waiting lists, and a person must wait for maximum one to two days to enter the treatment, depending on their location. This applies also to detox. It is argued that residential treatment offer is

sufficient given the needs of the target population. There is one big hospital in Ljubljana that has departments for different special populations, e.g., women with children, ageing PWUD. Its quality is perceived as very high.

There is a hospital in the countryside outside of Ljubljana specialising in treating comorbidities. The accessibility of this service is seen as high. Normally, people access treatment services in regular treatment centre, and when they are diagnosed with double diagnosis, they are referred directly to the specialised centre.

OST is provided by rather a large network of public health services and covered by health insurance. It is only accessible in specialized centres and cannot be prescribed by a general practitioner. There are close to twenty of such centres spread across Slovenia offering methadone and buprenorphine treatment. The accessibility is seen as relatively good: everyone in need of this kind of service can access it relatively close to their home, and there are no waiting lines. Normally people do not need to travel more than 30 km from their place of living to receive treatment. Heroin treatment is not available yet but there are plans to introduce it.

OST is rather high threshold. Clients need to pick up their medicine every day in the beginning of their treatment. After a certain amount of time, if a person is considered a stable patient, they can take their medicine home for weekends or holidays. OST includes development of individual plans of treatment agreed between doctors and clients to meet clients' needs. Substance use is not permitted for OST clients. Random urine testing is practiced during visits in the centre. A positive test results in regress in the treatment process and likely withdrawal of any existing privileges.

OST is also available in inpatient form, starting with detoxification, following to OST and treatment (including music therapy, zoo therapy, different kinds of activities). Whenever a person is stabilised and ready to function on their own, they leave the facility and continue the treatment in ambulatory mode, with regular visits at psychiatrist or psychologist.

OST is available in prisons both as a continuation and can be also initiated there.

Recovery and social reintegration services are the responsibility of Ministry of Social Affairs, but they are operated almost exclusively by CSOs. There is high level of funding available for recovery and social reintegration services, and there are many of them working in Slovenia. However, since they are not covered by health insurance, their situation is not very stable and depends on the views of the current government in power.

Most of social reintegration services are associated in larger international networks. Hence, they implement interventions according to some evidence-based methodologies. Still, one of the main problems is lack of integration of services. There are relationships based on private connections, but the institutional collaboration is missing. Any cooperation is based on goodwill, motivation, and eagerness of individuals working in different services. It is not a system approach, which should be in place. There should be one system created where professionals can follow a person from medical treatment to reintegration.

There is a network of state-funded harm reduction services operated by seven CSOs. Their financial situation is relatively good. They are incorporated into the drug policy system of Slovenia and deliver public services recommended and funded by the state, like needle exchange programmes, outreach work, mobile units covering rural areas. Hence, there are some services which are well-organized and well-funded, but there are no new developments.

In case of needle exchange programmes, there is some room for improvement. The accessibility of NSPs is not sufficient. The needs of the target populations are bigger than the capacity of the existing network. During the Covid-19 pandemic, the number of open drug scenes increased, especially in some bigger cities. In some areas, especially in Ljubljana, it is visible that services are not able to cover the needs of the target population. The main problem is human resources capacity – understaffing. Organisations can only provide basic services, which were developed based on the needs assessment conducted a decade ago. The needs have been increasing but the number of staff in the network has remained unchanged. The funding of the network is not in line with the needs of the situation anymore.

Naloxone is registered as a medicine, but its use is limited to those professionals who are responsible for medical treatment.

HIV services and treatment are seen as one of the best in Europe. There is a very low prevalence of HIV infections especially among the community of PWUD. HIV and HCV treatment are both public health services funded by the health insurance. They are integrated in a systemic way into the health care system. Due to the status as a public health priority, HIV and HCV treatment are also available, to a large extent, to undocumented persons, as well as in prisons.

7.20 Spain

In Spain, many service types are available, mainly in Basque country and Catalonia which are considered the top regions in the country in terms of number of services, a variety of different facilities, implementing innovations, etc. The situation in other autonomous regions is poorer. Moreover, due to the high level of independence of the Autonomous Regions which are responsible for drug policy implementation, significant between-regions differences can be seen in drug services' availability, accessibility, quality, and coverage. The situation in Spain is seen as similar to Portugal. Namely, drug policy was very effective compared to other European countries already 20 years ago, yet little progress has been made ever since. Opening new services is possible, however, there has been no significant changes in terms of drug policy at large. Many policy-level innovative initiatives are blocked at the level of the Supreme Court (e.g., CSOs' initiative to introduce heroin maintenance treatment instead of methadone). It is argued that during the last ten years, there has been no significant changes in drug policy in Spain.

According to the expert, the impact of the EU Drug Strategy on Spanish national policy is low. This is, in part, because of the government's perception that Spain had already have an impressive range of services available long before they made it to the European level. However, from the point of view of civil society, there is a big problem with resources. The distribution of the resources between the supply reduction on the one side, and demand and harm reduction on the other, is clearly unbalanced. The innovative drug services, like drug-checking, drug consumption rooms, are always implemented by CSOs, and the state financial support is seen as insufficient. Moreover, some services are contracted out to CSOs as public services, which restricts their flexibility in operating the facilities.

In Spain, schools can freely choose the organisation they want for the delivery of prevention intervention. Hence, the quality of prevention varies from one school to another, and on specific organisations invited to conduct the activities. In many regions, prevention is still delivered mostly by the police, using an outdated approach based on fear, without harm reduction considerations or applying gender perspective. Hence, the interventions conducted by the police are criticised in terms of quality and evidence base.

Sometimes, prevention is delivered by teachers, and in some regions, also CSOs. Contrary to the police, CSOs are seen as striving for quality and developing evidence-based interventions. There is no governmental control over the quality of prevention and minimum quality standards are not used, however, CSOs implementing prevention programmes apply exchange of experiences and best practices.

Other perceived problems relate to universal prevention. It is argued that there is still a lot of advertising in public spaces that is based on fear. The specific content of these messages became more modern, but the essence is still the same.

Overall, it seems that prevention has been always underfunded, which results in lack of evaluation and evidence in this area. There is interest in the Best Practices Portal of the EMCDDA, however, it seems that the organisations find it challenging to translate programmes included there to the specific Spanish conditions. This is seen as a big problem. Prevention is focused on public spaces and schools and there are no community prevention programmes addressing at-risk populations, which are perceived by the expert as the most important.

There is no culture of online prevention in Spain. Before 2020, there were hardly any online prevention activities available in Spain. The situation changed with the pandemic and related lockdown measures, when many CSOs developed interventions in this area. These activities were not funded, however. According to the experts, the situation remained challenging during the pandemic, schools were not prepared for receiving online prevention (e.g., children's access to necessary devices). Still, for many months it was the only possible method of communication between organizations and their target populations. It is believed that

online contact with clients is not as effective as honest, face to face conversation with a drug expert.

Drug treatment services are operated within public health care system, which means they are free of charged and covered by their health insurance (hence, not accessible for undocumented migrants or refugees). The network of treatment services is seen as generally good, as every person in need of treatment can access it. Treatment services, in principle, are available throughout the country in most of the cities, including smaller ones. However, there are significant regional differences in terms of quality, range of services, etc., as the Autonomous Regions have authority over these services. For example, in Murcia there are a lot of therapeutic communities but no other kind of services.

Many treatment centres are managed by CSOs. Treatment is also offered in some hospitals and local state health care system facilities, however, treatment there is limited to detoxification and mental health care, without addressing the social aspect. The quality and methods of work depend a lot on the staff the treatment facilities hire. Numerous treatment centres work with therapeutic community model. Some of these communities are seen as high-quality, and some as using methods based on stigma and discrimination.

It seems that the waiting lists for abstinence-based treatment are very short if the goal is only to address substance dependency. However, many people do not want to go to a general facility due to their specific situation (e.g., women with children, victims of gender-based violence). In such cases, accessing treatment is more difficult. Private treatment services are available instantly and there is a wide range of them, however, they are expensive.

In Spain, there has been some effort to include gender perspective in treatment, harm reduction, prevention, and other services. There are a couple of centres (in Catalonia and Andalusia) for women with children who are victims of violence, where both professionals with expertise in gender violence and addiction work. All such projects and other small initiatives applying a gender perspective that were recently established come from CSOs, there are arguably no such initiatives from the side of the government. There is also still a lot of stigma around being a woman and using drugs.

There are specific treatment services addressed to young people, which are described by the expert, as 'the most terrible [places]'. It is argued that they are not effective, using methods rooted in strict control and abusive.

In Spain, drug treatment centres employ psychiatrists and other mental health professionals who can treat mental health problems next to addiction. There are no specialised centres for treating co-morbidities, but they are addressed in treatment facilities. It is also argued that the level of cooperation between different services and actors (e.g., CSOs-government) is higher than in other countries, except for prisons. CSOs are in contact with public health centres and other facilities, and integrated interventions are available. Information-sharing between services is done to the extent it is possible within the legal frameworks (e.g., limits for GPs to share patients' clinical history). The network of services is institutionalised at the national and local levels.

With respect to social reintegration, it is perceived as the least developed area in Spain, with very little progress over the last years. It is seen as a question of funding and political and policy priorities. It is believed that contrary to the picture of Spain as a poor country, money is available where the priorities lie. And currently, most of the funding is dedicated to the police and border control near Gibraltar because of the migrant crisis. There are no public aftercare programmes or social reintegration services. It is argued that in public services and among decision-makers, the dominant paradigm of thinking treats drug use as an isolated problem. In consequence, as soon as a person finishes drug-free treatment and quits using drugs, the problem is seen as solved and a person is considered as being able to function well. It seems that there is no understanding that drug use is usually only a symptom or one of many problems a person may have. The continuity of care seems to be ensured only in CSOs providing a range of services from low-threshold harm reduction to social reintegration. Still, it is argued that the most vulnerable populations have the lowest access to any kind of services in Spain, which is seen as a crucial problem.

Opioid substitution treatment is offered in all public health care centres. The regime in OST is very strict, the medicine can be picked up only during a few hours during a day. The facilities are accessible, but the mindset is seen as conservative in facilities belonging to the public health care system. CSOs can operate OST if they employ a doctor. OST operated by CSOs are

seen as more flexible. Still, OST remains a high-threshold service. The main problems are strict timetables, strict control, and insufficient psychological support. The services are, again, limited to addressing drug use, and integrated perspective is not really applied.

Needle and syringe programs are seen as working well. There are several options to choose from, e.g., NSPs operated by CSOs, exchange in pharmacies. In Catalonia, many NSPs opened during the last five years because of an extensive community work, cooperation with local communities, etc. In the same region, most of the hospitals also have a specific department for harm reduction services with DCRs and NSPs closely linked to treatment, giving a possibility of easy access to treatment if needed, in less than 24 hours. This, is, however, not representative for the entire country.

One of the problems reported with DCRs, however, is that they work with obsolete mindset and methods. They do not adjust to the changing needs and patterns of drug use. For example, the majority of DCRs have big spaces for clients to meet and talk. It is argued that while this worked for people using heroin back when the DCRs were established, it does not work with the current users of methamphetamine (clients argue and fight with one another). There is a need for an update of the approach regarding how harm reduction services are organised and what methods are used, taking into consideration the changes in the drug use trends. DCRs are integrated in the public health care system in Catalonia but the situation in other parts of the country is seen as much worse.

Drug-checking is not developed well. There are two services in the Basque country and one organisation in Barcelona. Safe party services are more widespread but still limited. It seems that no major developments can be seen over the last decade. The main problem is the lack of resources and lack of capacity. In Catalonia, the administration responsible for drug policy developed quality label system for clubs and festivals, and they became more open for accepting safer nightlife services. However, the change is seen as very modest.

HIV treatment is available for PWUD for free (with insurance), and the collaboration of CSOs with hospitals and medical centres is perceived as very good. Testing is very extensive. There is also an HIV network established, which works closely with the drug addiction network.

One of the biggest challenges of the recent times, especially in Madrid and Barcelona, was the spread of chemsex practices. Clients engaging in chemsex are completely different compared to clients the services were used to. Professionals were challenged to develop new methods of work and their attitudes to be able to work with this population where self-stigma, engaging in different sexual practices, and different mental health issues, often related to methamphetamine use, had to be addressed. In some organisations providing treatment, there are special programs addressed to people engaging in chemsex, with professionals with adequate expertise.

Overall, among the positive developments of the last decade, the experts mention increasing recognition of CSOs as experts in the policy field (resulting in more meaningful involvement in policymaking processes and numerous collaborations) and striving for the integration of gender perspective in services.

Still, the mainstream of drug policy in Spain is seen as conservative. It is argued that harm reduction does not have the importance it enjoyed several years ago, and that the situation is far less favourable for more progressive harm reduction and human rights-oriented organisations. Drug policy is not a political priority in Spain today. A lot of funds were available in 1980s and 1990s during the high prevalence of heroin use, and later in the beginning of 2000 during the problem with NSPs. Nowadays, the area is highly underfunded. An exception is the situation with chemsex, where apparently changes can be seen in terms of development of and innovation in services. Such initiatives, it is argued, are always grassroots, bottom-up actions. The visible changes are a result of the eagerness and good work of CSOs and supportive people in the positions of power. Innovations come from civil society and are later adopted by the government. Government does not lead the innovation.

8 Conclusions

This report presents the results of a research conducted among CSO experts in the field of drug policy about the implementation of key drug demand and harm reduction services in European countries.

The overall picture of the situation is not very optimistic. Out of twelve examined services, none are seen as highly accessible to people who use drugs. Clear differences can be seen at

several levels: within Europe, West versus East-Centre; within countries, urban versus rural, and regional gaps. Moreover, there is also very clear imbalance between the accessibility of demand reduction (OST, abstinence-based treatment, recovery) and BBV prevention-related services (NSPs, HIV/HCV treatment) and more innovative harm reduction services (safer nightlife programmes, naloxone distribution, drug checking and drug consumption rooms).

The quality of examined services is significantly higher than their overall accessibility. Three out of twelve types of services were rated with high quality level (OST, NSP, HIV/HCV treatment). Interestingly, great discrepancies were identified between the accessibility and quality of more innovative harm reduction services: drug-checking, safer nightlife programmes, naloxone distribution and drug consumption rooms. These gaps were larger in 2021 than in 2018, although both accessibility and quality of these services increased.

With respect to the between-regions differences, the overall picture suggests – not surprisingly – the most advanced service provision in Western Europe, followed by Southern and Northern European countries, and backwardness of the Central-Eastern European region and Balkans.

In temporal comparison, it seems that the situation in Europe improves. In Western Europe, only two types of services were assessed as (slightly) less accessible in 2022 than in 2018 (safer nightlife programmes and drug checking); at the same time, the accessibility of treatment, recovery, and NSPs was seen as largely improved. Significant improvements in accessibility can be seen also in Northern Europe, with nine out of twelve services seen as much more accessible (more than 1 point increase). In Southern Europe, the accessibility of services was stable between 2018 and 2021, with significant improvement in the access to online prevention and DCRs. In Western Balkans, significant improvement of accessibility was seen in online prevention, NSPs, OSTs and naloxone distribution. The only exception here is Central-Eastern Europe where no significant improvements were reported, and seven out of twelve types of services were assessed as less accessible than three years before.

The qualitative analysis allowed for a more in-depth insight into how demand and harm reduction services work. Although the situation varies significantly for one country to another, some common problems and challenges can be seen across Europe. Insufficient and often unstable, unsustainable funding is one of the problems appearing almost universally across countries. Lack of political will to put drug policy high on the policy agenda is another

challenge. In many countries, there are significant differences in the access to care between people depending on their place of living and socio-economic status; more wealthy citizens living in urban areas are in a much better position to receive care they need than the most vulnerable individuals, like young undocumented migrants or refugees. Moreover, significant shortcomings can be seen with respect to the availability of services tailored to specific needs of women, youth, ageing PWUD, and other special populations.

The differences between how services are delivered in different countries are striking. What seems similar, however, is the way how services – especially harm reduction ones – function. The picture emerging is the one of motivated, eager activist-spirited individuals working in a bottom-up way to establish services, develop and implement innovations, and adjust to the dynamically changing needs of the populations they serve (e.g., chemsex, migrants and refugees, ageing PWUD, Covid-19). On the other hand, we can see rather uninterested and passive states, which provide framework for CSOs' work (varying from supportive to hostile) but are generally not interested in pioneering in the field. In addition, it seems that in most situations the relationships between service delivering CSOs and governments, and the resulting level of support, depend to a large extent on individuals occupying positions of power. In consequence, also the cooperation between drug CSOs and other health care and social services is not institutionalised but relies on individual connections between services' employees.

In sum, although the situation of demand and harm reduction services in Europe seems to be improving over the years, there are numerous voices concerned about the regress in the politics of drug policy (e.g., Ireland, Italy, Spain, Hungary). This regress can take different forms, from pushing CSOs to the margins of governance, to general lack of interest in the policy field, to outright hostility of the government towards CSOs implementing harm reduction services. This is a worrying phenomenon, especially given the emerging challenges that require extensive, meaningful cooperation between governments and CSOs in the field: from Covid-19 pandemic and the consequences of lockdown measures to increasing mental health challenges, to the threat of synthetic opioids crisis in Europe.

In the face of these considerations, the following recommendations are formulated:

To the European Commission:

- To take the leadership in coordinating the implementation and evaluation of the new EU Drug Strategy and Action Plan on Drugs 2021-2025.
- To initiate a dialogue with those Member States that, according to the available data, do not provide or provide inadequately low access to services and call them to improve the implementation of services.
- To continue to promote and enhance the European approach to drug policies – in line with the EU Drug Strategy and Action Plan – in international contexts and settings.

To the EMCDDA:

- To involve civil society in a meaningful way in the collection and analysis of national data to fill the gaps in our knowledge.
- To promote and support studies, including in all member states, on health, social and criminal justice impact of current drug policies.
- To monitor and evaluate innovative and experimental policies (at local, regional, and national level) on legal regulation of cannabis.
- To support more research on the access to and quality of services for vulnerable populations, such as migrants/ethnic minorities, women, prisoners, young and ageing people.
- To monitor the implementation of the EU Drug Strategy in the Member States, including the collection of qualitative data.

To Member States:

- To adopt evidence-informed and human rights-based approach in national drug policies.
- To support and conduct studies on health, social and criminal justice impacts of current drug policies.
- To ensure funding and political support for underdeveloped services.
- To improve the quality of services by implementing minimum quality standards for demand reduction at the national level and provide adequate support and training to service providers to meet the demands of these standards.
- To assess the possibilities and potential impact of decriminalization of drug use and minor possession for personal use.

- To provide adequate access to all needed services in prisons and ensure the continuity of care when entering or leaving prisons.
- To develop institutional mechanisms to meaningfully involve civil society in drug policy making at the local and national levels.
- To acknowledge the expertise of people with lived experience and create mechanisms for their involvement in policy making.
- To assess the needs of specific populations and ensure funding for adequate, tailored services for these groups.