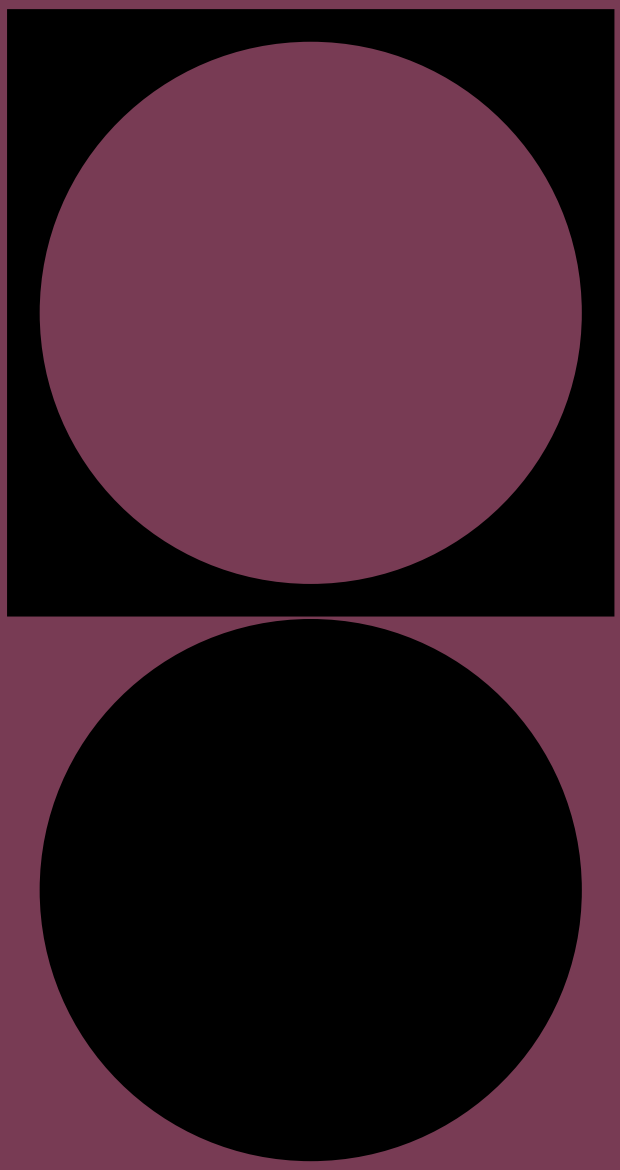
REGIONAL OVERVIEW: WESTERN EUROPE



THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION INTERNATIONAL

AUTHOR OF WESTERN EUROPE REGIONAL OVERVIEW: **Robert Csák**

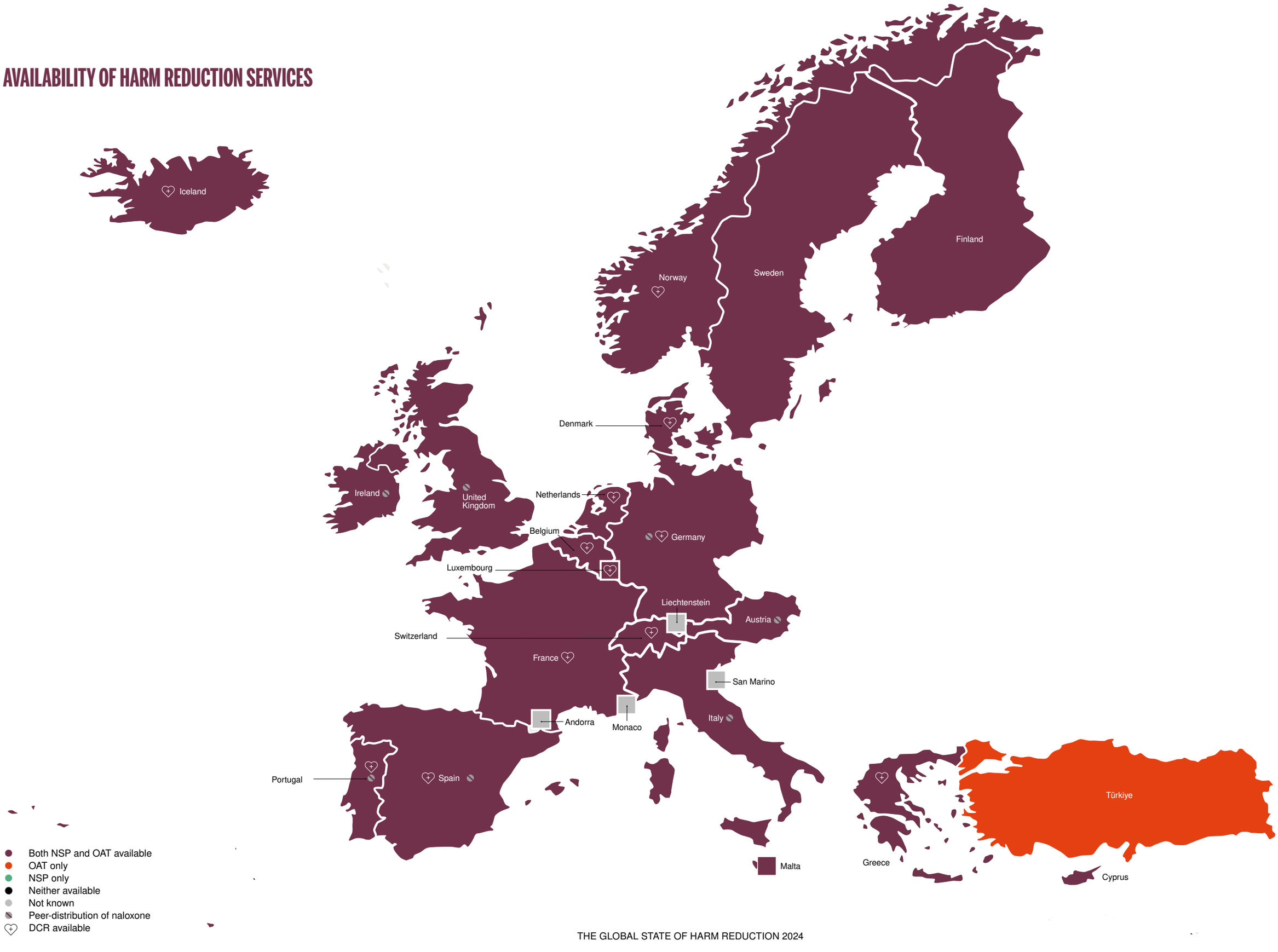
Robert Csák is a sociologist and researcher. His research has focused on various aspects of harm reduction. He has worked in needle and syringe programmes, community outreach, HIV and HCV testing and counselling for over 10 years. He has worked on the *Global State of Harm Reduction 2020 and 2022* and is the author of the Harm Reduction International report on Low Dead Space Syringes.

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN WESTERN EUROPE

Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Andorra	nd[f]	nd	nd	nd	nd	nd	nd	nd	nd
Austria	15,000	12.3	16.7	4.4	✓ 55	✓ B M	✓	×	✓
Belgium	7,000	4.5	48.8	2	✓ 243	✓ B H M	×	✓ 2	✓
Cyprus	710	3.5-7.1	42.4	4.7	✓ 33	✓ B M	×	×	nd
Denmark	nd	1.3	65.6	1.3	✓ 5	✓ B H M	×	✓ 5	nd
Finland	25,000	1.2	73.7	nd	✓ 84	✓ B M	×	×	nd
France	125,500	6	41.7	0.8	✓ 1,220	✓ B M	×	✓ 2	✓
Germany	nd	4.1	62.9	0.9	✓ 475	✓ B H M	✓	✓ 25	✓
Greece	3,287	7.3	53.7- 69.6	2.1	✓ 18	✓ B M	×	✓ 1	✓
Iceland	500	5	10	nd	✓	✓	nd	✓ 1	nd
Ireland	688	8.3	77.2	nd	✓ 140	✓ B M	✓	×	✓
Italy	105,652	28.3	63.8	nd	✓ 152	✓ B M	✓	×	✓
Liechtenstein	nd	nd	nd	nd	nd	nd	nd	nd	nd
Luxembourg	822	1.9	71.1	nd	✓ 10	✓ B M	×	✓ 2	nd
Malta	805	0.2	43.8	0	✓ 10	✓ B M	×	×	nd
Monaco	nd	nd	nd	nd	nd	nd	nd	nd	nd
Netherlands	840	2.6	61	0	✓	✓ B H M	×	✓ 25	✓
Norway	7,878	1.3	38.8	1.5	✓	✓ B H M	×	✓ 2	nd
Portugal	28,287	13	71.9	5.7	✓ 1997	✓ B M	✓	✓ 3	✓
San Marino	nd	nd	nd	nd	nd	nd	nd	nd	nd
Spain	6,762	32	45.9	5.3	✓ 866	✓ B M	✓	✓ 16	✓
Sweden	nd	5.1	65.2	1.5	✓ 30	✓ B M	×	×	nd
Switzerland	42,000	1.4	74.6	nd	✓	✓ B H M	×	✓ 14	✓
Türkiye	nd	0.8	37.5	3.9	×	✓ B M	×	×	nd
United Kingdom[g]	341,032	1.5	57	5.9	✓	✓ B H M	✓	×	✓ [h]

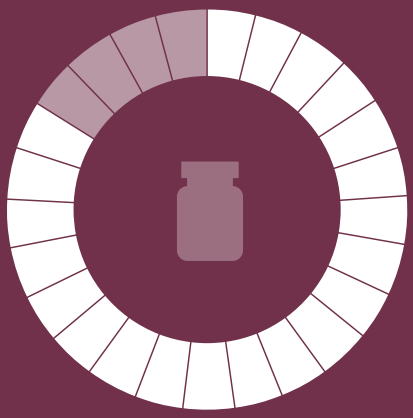
a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data
g The United Kingdom population size estimate for people who inject drugs refers to subnational data from England and Scotland only. The data on HIV and viral hepatitis refers to England, Northern Ireland and Wales only.
h Pilot programme

AVAILABILITY OF HARM REDUCTION SERVICES

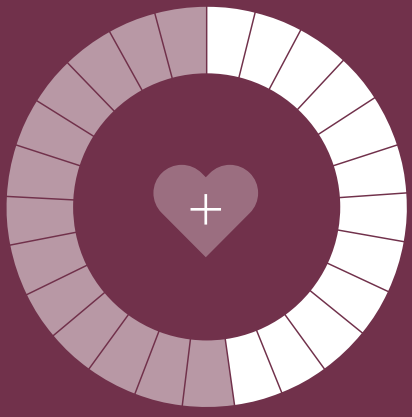


NSP, OAT, DCRs AND SAFER SMOKING KITS

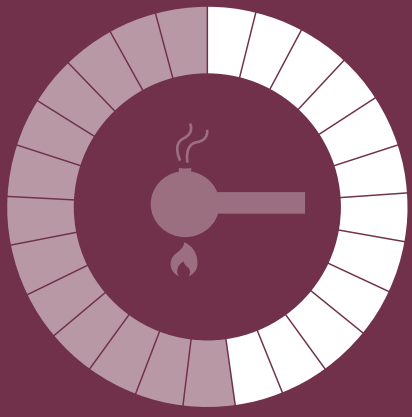
20 countries (80%) in Western Europe provide **needle and syringe programmes** (no change from 2022)



21 countries (84%) in Western Europe provide **opioid agonist therapy** (no change from 2022)



12 countries in Western Europe provide **drug consumptions rooms** (no change from 2022)



12 countries in Western Europe provide **safer smoking kits** (+2 countries from 2022, Greece and Ireland)

KEY ISSUE

SERVICES FOR MARGINALISED GROUPS OF PEOPLE WHO USE DRUGS

Western Europe is one of the regions where core harm reduction services like needle and syringe programmes (NSP) and opioid agonist therapy (OAT) are available in almost every country[1] and harm reduction has been explicitly included in national drug strategies and action plans for years. Western Europe has the most countries of any region in which drug consumption rooms (DCRs) and drug checking services are available. Despite harm reduction being an established public health intervention in the region, marginalised groups such as women, LGBTQI+ people, migrants and people in prison and other closed settings, are underserved and face barriers in accessing harm reduction services.[2,3,4] Marginalised groups of people who use drugs should have access to harm reduction services tailored to their needs to ensure appropriate coverage, not only to achieve public health goals but to realise the right to health and human rights for all.

According to the Correlation-European Harm Reduction Network's recent report, which summarises responses from 35 European cities in 30 countries, harm reduction services are delivered to the greatest extent to people who inject opiates, while the least served population in Europe are young people under the age of 18 who use drugs.[5,6] Despite adolescence being a common time for starting substance use, harm reduction for under 18s, particularly in school settings, is still controversial.[7,8,9,10] Age restrictions prevent adolescents who use drugs from getting vital services. For example, DCR, NSP and drug checking services are for adults-only in many countries as under 18s are not formally permitted to use these services (e.g. in Belgium, Germany, Sweden, Switzerland).[11,12,13,14]

Being at the intersection of different vulnerabilities can make access to services difficult. It can be a precarious situation if you are someone who does not identify as belonging to the groups that are targeted by harm reduction programmes.

For example, people who engage in chemsex can be at the intersection of other marginalised groups and their needs may not be appropriately met either by programmes focusing on gay men and other men who have sex with men or by programmes for people who use drugs – and stigma stops many from engaging with harm reduction services.[15,16] Despite suitable harm reduction services having been developed across the region, people engaging in chemsex are still the second least-served population in Europe.[17,18] The services that are available focus on men, while heterosexual couples in the swingers scene or lesbians and other women who have sex with women are rarely mentioned in the chemsex context. But that does not mean people who use drugs during sex who are outside of the chemsex scene do not need services. O'Yes in Belgium, which offers lesbians and other women who have sex with

women consultations with health professionals to discuss issues related to sexualised drug use, is an example of a service that does cater to underserved populations. But such services are not widespread, and without adequate support these important subpopulations are likely to be missed.[19]

Migrants are also inadequately served by harm reduction services in the region. They face significant barriers to accessing health services; the most prominent relate to their legal status, the discrimination they experience and cultural differences.[20,21,22,23] Migrants who use drugs face many barriers, on top of being stigmatised for using drugs, such as xenophobia and racism. Administrative barriers including language, can hinder access to health and ham reduction services.[24,25,26,27] For example, in Berlin, Russian-speaking migrants, West African migrants and migrants from Maghreb Arab countries are present, all with unique characteristics and needs, speaking different languages.[28] Integrated services involving professionals such as interpreters, multicultural mediators and peer navigators are crucial in this setting.[29,30]

Gaps in the range of available harm reduction services still exist in the region. For example, harm reduction for people who use opioids is the most common type of intervention, but people who use opiates intranasally (through the nose) are greatly underserved and can only receive heroin-assisted treatment in Switzerland.[31,32]

There is a need to bridge these gaps by implementing appropriate services for all, especially in a region where harm reduction is an established intervention supported in national strategies. People who use drugs are a heterogenous group made up of different populations with diverse needs. To ensure appropriate access for everyone, peers from different drug-use groups should be involved in providing support, from designing an intervention to evaluating it, so services and materials are informed by and centred around the specific and diverse needs, circumstances and priorities of all people who use drugs.[33]

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KEY ISSUE

EXPANSION OF DRUG CHECKING SERVICES

Drug checking services analyse drug samples that people who use drugs submit. These services provide feedback to clients and offer counselling based on the results to help people reduce the risks associated with drugs containing unknown components, unknown quantities of components and unwanted substance interactions.[34] Drug checking services can also be used as a tool to monitor drug markets, and in Western Europe the data they provide is making a substantial contribution to regional knowledge on the substances available and emerging trends.[35,36,37,38] For example, drug checking services were instrumental in detecting synthetic cannabinoid receptor agonists in herbal cannabis in Zurich, Switzerland.[39] Drug checking services are currently available in 13 of 25 countries in the region (Austria, Belgium, France, Germany, Greece, Italy, Ireland, Luxembourg, Netherlands, Portugal, Spain, Switzerland and the UK).[40,41] In Ireland and Greece, these services are only available at some music festivals.[42,43]

A systematic review of drug checking services since 1990 found that people who used them consistently reported having a greater intention not to use drugs if the result of a drug-checking test was unexpected, questionable or suspicious.[44] Evidence included in the review also demonstrates the capacity of drug checking services to detect new psychoactive substances and drugs of concern that are available on the ground, while providing information on both expected and detected content.[45]

Despite mounting evidence about the benefits of drug checking services, legal barriers – along with a lack of political will to change the policy environment – prevent the implementation or scale up of existing drug checking services in the region.[46]

Other studies also show that drug checking services can influence people's behaviour, and unexpected results can stop people taking the drug being checked, using less and applying harm reduction practices, such as not mixing substances.[47,48] Enacted behaviour over the longer term is less researched.[49] However, a recent study in Portugal followed people who had used a drug checking service at a festival for six months to check their behaviour compared to their intentions after getting unexpected test results.[50] They found that, after six months, 71% of clients reported enacting behaviour that matched the intention they expressed when they got the test result (for example, not taking an ecstasy pill when it did not contain MDMA).[51] Six months after using the drug checking services at the festival, there was an increase in most harm reduction practices among respondents.[52]

Drug checking might be useful outside of nightlife settings too. For example, an organisation in Belgium made drug checking services part of its programme for people engaged in chemsex.[53] Research on heroin and cocaine used in DCRs in Luxembourg compared clients' expectations and

the level of active compound measured, and found that most people had very limited information on the active compound content of the substance they were about to use.[54] In the Netherlands, an intermediate testing project is being piloted until the end of 2024. Here, field workers can test drugs that belong to people who they meet during street outreach, thus providing information on the drugs available in more marginalised communities.[55]

The public health benefits of implementing drug checking services are evident, and may be particularly useful given the emergence of synthetic opioids across the globe, including in Western Europe (for example, nitazenes in the UK, or fentanyl derivatives in Sweden and Austria).[56,57]

Decision makers should be aware that a drug checking service is a simple tool that increases people's safety and helps them to make informed decisions about the drugs they use.[58]

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