Harm Reduction

Policy paper on preventing risks and reducing harm linked to the use of psychoactive substances

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Co-operation Group to Combat Drug Abuse and Illicit trafficking in Drugs

Foreword

Long perceived as an offense or a deviant behaviour, drug addiction is now widely acknowledged as a medical condition. As such, access to appropriate treatment for those who suffer from addictive behaviour is no privilege, it is a right. The right to equitable access to health care services derives from the fundamental right to health which is enshrined in international law, and especially in the International Covenant on Economic, Social and Cultural Rights.

Access to risk prevention and harm reduction measures thus constitutes a human right and needs to be recognised as such. In compliance with the United Nations conventions on drugs, risk prevention is an integral part of a balanced addiction policy and aims in particular to reduce harm associated with addictive behaviours.

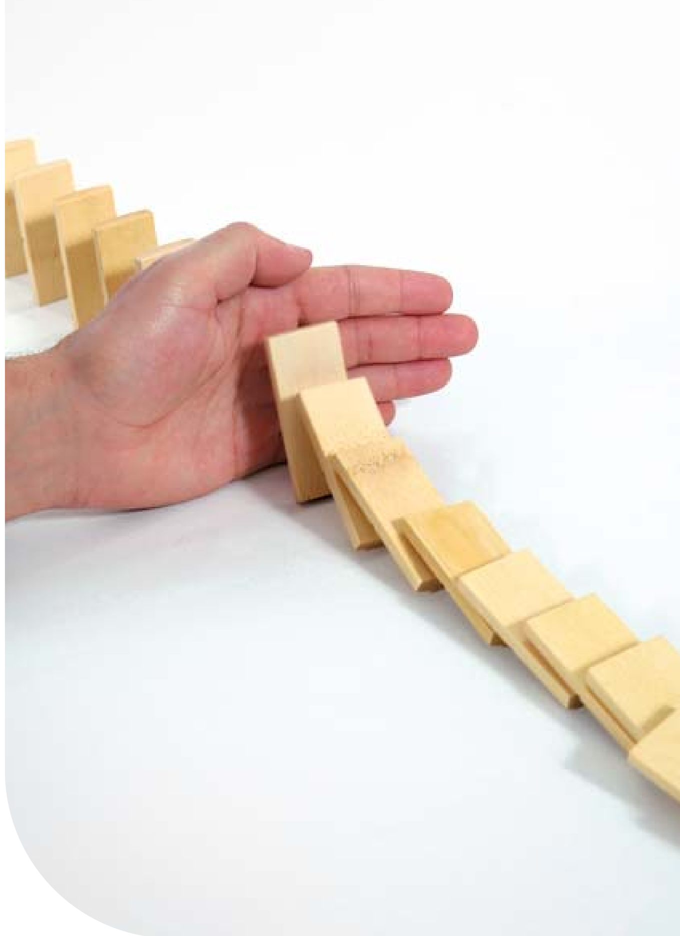
If many States worldwide have made risk prevention and harm reduction an important part of their drug and addiction policies, it is not only because it should be a right, but because it has proved its worth in reducing the social and health consequences of psychoactive substance use. Indeed, the efficiency of risk prevention and harm reduction having been scientifically validated, its measures have now become reality.

However, the debate over concept and definition of 'harm reduction' continues at European and international levels. Risk prevention and harm reduction measures have been and still are the subject of much controversy, while some understand them as an insidious form of encouraging the use of psychoactive substances.

Within this context, the French Presidency of the Pompidou Group initiated work on a consensual definition of the terms, in order to provide policy makers with practical tools and guidance for the implementation of harm reduction measures, based on evidence. After more than two years of negotiation, this policy paper was adopted by the Permanent Correspondents of the Pompidou Group in November 2013.

I am proud to present this policy paper which, though non-binding, constitutes a major achievement in our bid to promote a balanced approach to the problem of drugs and addictive behaviours at European and international levels. I hope it will significantly contribute to reach those who suffer from addiction and to provide them with effective care, treatment and rehabilitation, in order to change their lives for the better.

Danièle JOURDAIN-MENNINGER
President of the Pompidou Group
President of the French Interministerial Mission for the Fight Against Drugs and Addiction (MILDT)



Harm reduction

Policy paper on preventing risks and reducing harm linked to the use of psychoactive substances [1]

At their 73rd meeting on 26-27 November 2013 in Athens the Permanent Correspondents of the Pompidou Group,

- *In recalling that all countries have the aim of reducing the use of psychoactive substances at the heart of their policies;*
- *and in recognising that differences in substances used, patterns of use and risk behaviour, lead to variations in legislation, policy implementation and services provided;*
- *as well as being conscious of the fact that regardless of existing supra-national drug strategies and action plans, there continues to be variation as to how and which risk prevention and harm reduction measures are implemented in countries across Europe;*
- *and in recalling that European drugs strategies and action plans are based on integrated approach including different and complementary measures, that are early prevention, treatment, care, rehabilitation, recovery and risk prevention and harm reduction, as well as law enforcement.*

adopt this policy paper as a conceptual and practical reference tool for policy development and implementation within the objectives of national drug policies and legislation.

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1 *The Russian Federation dissented on the content of the policy paper and did not support the adoption.*

Introduction

1. Measures to prevent and reduce drug-related deaths, minimise health and social consequences and risks associated with psychoactive substance use, as well as to mitigate public nuisance, are an integral part of many national drug strategies and mark part of national drug policies in a majority of countries in Europe and the world. They are commonly referred to as harm reduction measures and acknowledge drug use as a health and social problem. The term and concept encompass both the aim to prevent risks and the aim to reduce harms.

2. Such interventions were introduced on a broad scale primarily as a response to a high number of overdoses and the rapid spread of HIV/AIDS, Hepatitis and sexually transmitted diseases as a result of injecting drug use. Today risk prevention and harm reduction interventions are considered fundamental and indispensable as they can be disease preventive, life-saving and a protection to the community. They proved to be an important contribution to mainstream public health approaches, inter alia in the area of blood borne and sexually transmitted diseases.

3. In some countries harm reduction constitutes a set of measures that are part of an overall policy aim to reach full recovery and abstinence. In other countries harm reduction constitutes a health policy objective per se that is also used to reach differentiated sets of drug policy goals, including aspects of public nuisance, safety and even supply reduction. Depending on their drug policy aims and objectives, as well as the evolving situation, countries apply harm reduction measures in different combination and to different extents.

4. Risk and harm reduction interventions are inter alia endorsed globally by the United Nations and in the HIV/AIDS and drugs strategies and action plans in the EU and other countries. International and European policy instruments promote their provision together with prevention, treatment, care as well as rehabilitation and reintegration services for drug users. At the same time European drug strategies have stipulated that risk prevention and harm reduction should not be considered as an alternative to drug dependence treatments, but as complementary and part of integrated, rehabilitation and reintegration efforts and part of a balanced approach to the drug phenomenon.

Scope and purpose of the policy paper

5. The main purpose of this policy paper is to clarify and provide a practical and widely applicable definition of risk and harm reduction, which encompasses different psychoactive substances and behaviours related to substance use or drug dependence. It aims to provide an overview and conceptualisation of policy areas and goals under which risk and harm reduction measures are presently implemented in Europe, as well as an inventory of existing types of measures presently implemented and in the course of experimentation. Risk and harm reduction mean different things to different people. This is illustrated by the variety of definitions in national and international drug policy instruments.

6. Furthermore, the policy paper sets out a conceptualisation of risk and harm reduction that are complementary to prevention, treatment and rehabilitation concepts. Most existing definitions of risk and harm reduction overlap with these or lead to unclear differentiation. The policy paper sets out to clarify the systematic attribution of risk and harm reduction measures.

7. Risk and harm reduction measures impact different policy areas, in particular health care, social welfare, law enforcement, criminal justice, international relations and human rights. In this policy paper it is sought to provide inspiration and guidance to mediate and reconcile the influence of risk and harm reduction measures on associated policy fields and goals.

8. Moreover, the policy paper provides much needed input for dialogue between policy makers and civil society on drug policy in general and the role of risk and harm reduction more specifically. Like any strategy that arouses deep political controversy over a long period of time, moving forward is inconceivable without open debate. It need simply be recognised how divisive and sometimes ideological the debate about risk and harm reduction continues to be in Europe in order to understand the fundamental importance of engaging in this debate all stakeholders from the public service/government sector to civil society. The policy paper intends to provide starting points for productive debates on risk and harm reduction, based on experience and existing evidence rather than on ideological positions, and is aimed at reconciling and bridging diverging positions.

9. The policy paper is not binding for governments but rather provides guidance and advice to policy makers and drug policy managers based on insights from national policies, experiences and practice, evidence-based research and conclusions from debates on the subject.

Context

10. A growing recognition that drug dependence must be understood and treated as a chronic, preventable, treatable and recoverable disease has contributed to a broad agreement on the need for value of the risk and harm reduction measures. At the same time national differences in political acceptance, interpretation and variance in the type of feasible measures, as well as access to them and their availability, persist. Despite these differences in opinion and experience, there is a general prevailing consensus that abstinence and recovery-oriented policies need to be supplemented by measures that can demonstrably reduce the harms and risks of psychoactive substance use.

11. The tendency today is to broaden the application of the risk and harm reduction concept in health, practice and research, as well as in policy development. It is increasingly put to use for other substance use problems and addictions on the one hand, and in law enforcement practice on the other hand. In other words, the practice of risk and harm reduction experiences a net widening effect and finds its application nowadays for licit and illicit psychoactive substances and more generally in the field of addictions. At the same time the risk and harm reduction concept has become a mean to achieve policy goals in public health, safety and order, as well as social welfare with a broader aim to alleviate social, legal and economic problems related to the use of psychoactive substances and to addictive behaviour.

Concept of preventing risks and reducing harm

Definition

12. Risk and harm reduction is the umbrella term for interventions, programmes and policies that seek to prevent, reduce and relieve the

health, social and economic harms to individuals, communities and societies, resulting from the use of psychoactive substances and addictive behaviour. In drug policy, risk and harm reduction measures are well integrated together with prevention, treatment and rehabilitation offers and are cross cutting demand and supply reduction policies.

Aims

13. Risk and harm reduction measures can be applied in the pursuit of different policy goals, inter alia: reducing morbidity and co-morbidities, improvement of health status, referral into care, treatment and rehabilitation, social stabilisation, reduction of public nuisance, increase of public safety, reduction in acquisitive crime and imprisonment.

14. The short-term aim of risk and harm reduction is to prevent and relieve the harms and risks associated with the use of psychoactive substances which affect the user, his or her family and the community, as well as society at large. The more long-term aim is, where possible, to channel drug users at the earliest possible moment into care, treatment, rehabilitation and reintegration, the final objective being to achieve abstinence where possible, or long-term treatment to limit any further use of psychoactive substances.

15. Risk and harm reduction policies have significant human rights relevance to the extent that they affect the well-being and quality of life of individuals. Risk and harm reduction measures can play an important role in overcoming prejudice and discrimination that may result from drug use and addiction. The case law of the European Court of Human Rights illustrates numerous drug use related cases which violate rights such as: the right to life, the prohibition of inhuman or degrading treatment, the right of timely and equitable access to health care, and the prohibition of discrimination.

Categorisation

16. The risk and harm reduction approach has found its way into various fields of action, not only in demand reduction but also in supply reduction. This may be attributed to the fact that the concept emerged from practice and is consequently pragmatic, open and intended to be as adaptable as is necessary to the evolution of uses, of substances used and of their associations.

17. Because of the varying definition and understandings of risk and harm reduction, various interventions types are often categorised differently. Most notably in this context are substitution treatment and heroin-assisted treatment programmes which, already by definition, would rather fall into the category of treatment. Other examples are outreach work and motivational interviewing, which are primarily social work interventions, used in many fields including prevention. Notwithstanding this, such treatment offers and socio-psychological interventions constitute important complementary provisions to reach successful results in risk and harm reduction programmes. Risk and harm reduction measures therefore need to be embedded in an overall care concept and linked to prevention and treatment programmes.

Measures

18. Different measures are applied under existing risk and harm reduction programmes. Their availability and implementation depends on the respective legislation in each country.[2] Among the most widespread and recognized evidence-based measures are:

- Needle and syringe programmes,
- Provision of clean injection equipment,
- Provision of condoms,
- Low threshold substitution treatment.

19. In addition to the above measures, other measures, the use of which remains controversial, are applied in some countries, among these are :[3]

- Consumption rooms,
- Pharmacological testing of psychoactive substances,
- Provision of clean crack smoking pipes,
- Provision of folios,
- Provision of first aid self- medication to treat overdoses, including peer naloxone programmes
- Heroin assisted treatment.

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[2] *Legislation of the Russian Federation prohibits treatment of drug addiction with narcotic drugs and psychotropic substances included in the "List of Narcotic Drugs and Psychotropic Substances under International Control"*

[3] *ibid*

20. In Appendix I, a non-exhaustive overview with examples of currently applied risk and harm reduction measures for licit and illicit psychoactive substances can be found. The application and availability of these measures depends on national policies and legislation, Appendix II provides guidance and recommendations for implementation adopted by international organisations.

21. The most important measures and interventions that require to be linked to risk prevention and harm reduction measures, in order to reach their full beneficial effects include:

- Access and availability of low threshold services,
- Outreach work and motivational actions,
- Provision of emergency services to deal with overdoses,
- Detoxification services for acute and chronic intoxication,
- Adequate accompanying psychological, social and health care,
- Low threshold substitution treatment,
- Referral services,
- Support of self-help.

It is important that early access to such services is offered to those in need.

Principles for implementation of risk and harm reduction measures

22. The principles related to governing policies that incorporate concepts of risk and harm reduction include: adequate implementation including early access and availability, ensuring referral links and continuity, as well as monitoring and evaluation arrangements of effectiveness, efficiency and impact.

23. The measure applied in practice needs to address the effects of the substance, the specific types of use as well as its specific harms and risks. To ensure a long-term effect, and to provide a realistic prospect for the user to accept treatment, with the goal of eventually achieving

abstinence where possible, risk and harm reduction measures must be closely connected to prevention, treatment, care and reintegration services. Abstinence though should not be a prerequisite for access to risk and harm reduction services. Harm reduction measures are also important in reaching the goal of voluntary recovery.

24. Provision of integrated services and referral to psychological counselling, treatment, rehabilitation and self-help offers will afford the necessary continuum of prevention, risk and harm reduction, care and reintegration, provided it takes into account users' specific individual needs.

25. In order to ensure the effective and efficient implementation of risk and harm reduction programmes, the following must be connected to a set of general interventions and services:

- Informing and counselling users and their families,
- Informing about treatment offers,
- Sensitising the general public to avoid stigma and discrimination,
- Facilitating local outreach work targeting specific user groups,
- Encouraging the involvement of peers and volunteers,
- Promoting professional networking and inter-agency cooperation,
- Ensuring effective referral services between different agencies and services concerned.

Experience shows that measures of assistance in providing housing, employment, training and leisure activities are as important as the provision of legal services and debt counselling.

26. Risk and harm reduction programmes and measures need to be mutually consistent with other policies. In order to be effective, they must take into account the interaction of these policies with other areas: law enforcement, criminal justice, economic policy, labour policy, family policy, youth policy etc. Non-observance of such related policy areas will create risks that well-planned policies in one field may clash with policy aims in other fields, which may cause misunderstandings or counterproductive effects.

27. Early access to structured treatment programmes for stabilisation or abstinence should be effectively offered and made available to recipients of risk and harm reduction measures. A comprehensive care and support continuum should include easily accessible services that meet the immediate needs of users, as well as incentives and support that motivate them to abandon lifestyles centred on the use of psychoactive substances. Available services should be geared to the needs of different patient groups.

28. Risk and harm reduction measures aimed at the reduction of public nuisances, or those requiring the setting up of centres to provide specific services and interventions, should be carried out in consultation with the residents of neighbourhoods, local councils and their political representatives. It is highly expedient to inform them of the guiding principles behind the risk and harm reduction actions, their methods, and their outcomes, to help them become embedded. Thus risk and harm reduction is founded both on interventions directly benefiting not only users but also everyone living in the residential areas concerned by the actions while at the same time taking into consideration their concerns.

29. The right to have access to adequate health care also applies to prisons at the same level as outside prisons; this includes that early help should be available to those in need. Accordingly needle and syringe exchange programmes together with substitution treatment have been introduced in the penitentiary system of some countries. To achieve effectiveness, a continuum of care must be ensured as far as possible by creating links with prison health services and similar programmes provided outside the incarceration settings.

30. In implementing risk and harm reduction programmes by following the above principles it is paramount to co-ordinate the goals that are derived from the different policy sectors involved, as well as from the mission statements of stakeholders involved. It is of paramount importance to identify which policy goals are potentially conflicting and establish mediation mechanisms. This is indispensable for ensuring that risk and harm reduction efforts reach their full beneficial effect and do not counteract or negatively impact other policies.

Outlook

31. There is already a range of measures geared towards risk and harm reduction and based on scientific evidence that target use of psychoactive substances, including alcohol and tobacco. The trend is to apply the concept for all psychoactive substances and addictive behaviour. After a period of experimentation, models may be adapted, if they have shown to be effective, efficient and sustainable, for wider implementation. Experimentation is recommended in cases where no specific measures exist yet or where evidence is not yet available. Increased importance is given to the development of risk and harm reduction measures addressing the harms and risks of internet, gaming and gambling addictions. It is important to facilitate and continue experimentation in order to meet the challenges of this evolution and mitigate emerging risks and harm.

32. After initial scepticism and reluctance, the concept of risk and harm reduction becomes more relevant in law enforcement strategies and actions aimed at reducing drug supply. The increasing prevalence of such strategies in the field of law enforcement dealing with supply reduction merits closer attention, research and evaluation, as well as recognition on a wider scale.

33. Rapidly evolving patterns of use, new emerging psychoactive substances, and changing behaviour patterns determine, to a great extent, incurring harms and risks. Closely observing cultural trends in society on enhancing performance, or altering mind and behaviour by means of psychoactive substances, will be crucial to predict emerging new harms and risks or an increasing spread of existing harms and risks. Only an objective approach that looks to the future, uses a human rights perspective, and recognises the dynamic of developments in the use of psychoactive substances and addictive behaviour will be able to target resources in an efficient, cost-effective and sustainable way.

Appendix I

Examples of existing risk and harm reduction measures

The following are examples of measures under existing risk and harm reduction programmes in Europe that currently target licit and illicit psychoactive substances. This overview includes the most frequently applied evidence based measures, as well as other examples. It does not aim to be comprehensive, but includes the key risk and harm reduction measures. There are several recent in-depth systematic analytical reviews that comprehensively cover all existing interventions, both those for which ample evidence of effectiveness exist, but also those that are still controversial.[4]

Injecting use of substances

Today the most widespread and evidence based risk and harm reduction measures targeting injecting users of psychoactive substances are needle and syringe programmes (NSP) and opiate substitution treatment (OST). It is important to recognise the strong treatment aspect of opiate substitution for heroin dependence, although its implementation also reduces both harm and risks related to drug use.

In some countries heroin-assisted treatment (HAT) is, for some patients who are unable to successfully undergo substitution treatment, an integral part of health services for several years. In other countries, pilot projects in this area are on-going.

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[4] *EMCDDA monograph on Harm reduction: evidence, impacts and challenges. Lisbon, 2010. doi: 10.2810/29497. This monograph is comprehensive and covers all existing interventions, including those that are still controversial. It also addresses new challenges for a harm reduction approach, such as alcohol and tobacco use and stimulant drugs*

ECDC and EMCDDA. Guidance: Prevention and control of infectious diseases among people who inject drugs. Stockholm; 2011. doi 10.2900/58565

ECDC and EMCDDA. Technical Report(s): Evidence for the effectiveness of interventions to prevent infections among people who inject drugs. Part 1: Needle and syringe programmes and other interventions for preventing hepatitis C, HIV and injecting risk behaviour. Part 2: Drug treatment for preventing hepatitis C, HIV and injecting risk behaviour. Stockholm; 2011. doi 10.2900/58996 and doi 10.2900/58978

EMCDDA Insights: New heroin-assisted treatment (2012)

Besides these programmes, in some countries safe injecting spaces or drug consumption rooms (DCR) are available. However, this measure is still controversial.

Opiates

Harms and risks
Uncontrolled use of illicit opiates results in multiple forms of harm to society and the individual. Negative effects of use include drowsiness and decreased capacity to perform complex tasks, respiratory inhibition along with serious cardiac consequences in high doses and gastro-intestinal inhibition or paralysis of muscular function. Withdrawal symptoms are severely incapacitating and a strong incentive to continued use. As physical addiction is strong and the non-medical use of the substances of this class is generally banned, prices of the substances are high on the illicit market. The combination leads most users to financial instability and eventually leads to poverty, social marginalisation and drives criminal activity to obtain the means to purchase the daily required doses. This leads to harm both to society and the individual user.

Uncontrolled opiate use also has other direct health effects in addition to the addiction (such as the risk of overdose and death) and indirect harm to others (such as risks associated with driving or performing other complicated tasks intoxicated). Furthermore, opiate injection use (as opposed to smoking) and specifically sharing and re-use of needles, syringes and other tools used to prepare doses between users exposes to the risk of rapid transmission of blood borne diseases, such as HIV-, Hepatitis B and C and even Hepatitis A infection.

This is a major source of harm not only to the individual but also to society, as many of the diseases are chronic and infectious and carry a high morbidity and mortality level. Consequently, large epidemics of chronic blood-borne infections among persons who inject drugs can lead to a very high population disease burden and also long-term high healthcare costs as well as avoidable suffering.

Measures
The risk and harm reduction measures most frequently applied today to help users of opiates are opiate substitution treatment (OST) and needle and syringe programmes (NSP; for people who inject drugs) combined with information and education (INF/EDU) measures, health promotion

(HEP), outreach work and motivational actions (OUT/MOT). There is ample evidence of the effectiveness of these measures when properly implemented. The strongest evidence shows that OST and NSP are the key elements of the measures, and cannot be omitted or substituted without losing the effectiveness of risk and harm reduction programs. Recent evidence strongly supports synergistic effects of a combination of the measures (see also Appendix 2 containing selected policy instruments and reports on harm reduction).

In practice, and at the level of service provision, these measures are connected to treatment and prevention programmes including integrated services or referral systems in different areas: vaccinations, HIV/AIDS, TBC, sexually transmitted diseases, condom distribution, hepatitis treatment, services handling referral to psychological support, therapies and rehabilitation, group training, self-help, etc. Likewise, the measures must also take into consideration and adapt to life situations, such as pregnancies and motivation to behavioural change.

The availability of these measures and the possibility of combining them still vary between European countries, as do coverage, access, and application criteria. More and more, OST and NSP type care programmes are offered in prisons and other detention facilities although NSP programmes are not considered feasible in these facilities by some countries.

Cocaine, crack and amphetamines

Harms and risks
Cocaine, crack and amphetamines (as well as methamphetamine and other amphetamine derivatives) are stimulant drugs that are used in various ways, including injecting, inhaling, ingesting and snorting. Their use has serious health effects: overdosing, infectious diseases (in relation to injection use; see above section for opiates and injection for details), as well as cardiovascular, pulmonary neurological and psychiatric illnesses and risks to pregnancy.

The use of these stimulant drugs can result in dependence and serious mental and physical health problems, such as depression, paranoia, panic attacks and heart and respiratory problems. Besides the effects on health, problem use of cocaine and amphetamines is often associated with a rapidly deteriorating social situation: poverty, no fixed abode, loss of employment, deviance etc. Heavy amphetamine use also leads to

memory loss, attention deficits and reduced ability to function. Stimulant use increases sexual libido and can contribute to an increased STI burden and increase the rate of unintended pregnancies and abortions. The use of stimulants (e.g. methamphetamines) is associated with increased sexual activity, including unprotected sex and number of partners, unintended pregnancies and abortions, as well as increased rates of HIV and other STDs. In turn, STD's (e.g. genital herpes or syphilis) substantially increase the risk of HIV sexual transmission.

Measures

Drug substitution based pharmacological approaches (as available for opiate users) do not exist for cocaine and amphetamine users as safe and effective substitution drugs have not been developed.

As cocaine and especially amphetamines are also used by injection, the risk of passing on infectious diseases is similar to that of injecting opiate users and can be reduced through NSP provision. For crack users, programmes for distributing crack-smoking pipes exist in some countries.

Consequently, specific harm reduction programmes for stimulant users need to be further defined. Such programmes are under development, e.g. mobile risk reduction teams, drug checking (formerly referred to as 'pill testing') etc.. Actual instances of association with other measures are rare and mainly limited to local level in specific contexts. The monitoring and evaluation of these approaches should thus be taken further, although some examples of apparently successful combination programmes have been described. [5]

The most promising starting points in order to reach this target group are NSP (where applicable) and outreach work, building peer group competence for awareness counselling, as well as mobile responses in cases of medical urgency, together with professional emergency personnel, cardiologists especially.

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[5] *Arponen, A., Brummer-Korvenkontio, H., Liitsola, K and Salminen, M. Trust and free will as the keys to success for the Low Threshold Health Service Centers (LTHSC): An interdisciplinary evaluation study of the effectiveness of health promotion services for infectious disease prevention and control among injecting drug users. KTL (2008). 15; 164p. http://urn.fi/URN:NBN:fi-fe201204193408 (permanent archive access). Also available in Finnish, Swedish and Russian (published by the Pompidou Group of CoE; http://urn.fi/URN:NBN:fi-fe201205085477)*

In reducing the neurological effects, the most commonly applied strategy is to reduce the frequency of consumption. Supplementing use with food, vitamins and anti-depressant medication, where medically indicated, is another frequently applied approach.

Reducing frequency and dosage of stimulants helps to reduce the risk of cardiovascular disorders. As with the general population, control of high blood pressure, cholesterol levels and reduction of tobacco and especially alcohol use also can also have a profoundly positive impact on this target group. Consequently, prescribing a proper diet and exercise plays an important role.

The respiratory and pulmonary effects are difficult to tackle due to the specific effects of the substances on the lung tissue. In some countries, projects have been initiated to provide filters and other equipment, in particular to crack users to reduce the immediate effects on the respiratory system.

Measures to address mental health problems mainly focus on providing low-threshold services including safe spaces that offer calm and tranquil environments (daytime rest rooms for example). Often such offers are a first point of contact and can constitute a first step towards programmes for cessation of inhaled or injected cocaine and amphetamines.

For injecting (opiate and stimulant alike) users, the following should be ensured in conjunction with risk and harm reduction services:

- Low threshold service concepts;
- detoxification services and therapy for drug dependency connected pathologies ;
- adequate accompanying psychological care;
- provision of emergency services to deal with overdoses.

And for opiate user OST services:

- preventing diversion of substitution substances;

However, injection is not the only mode of consumption bearing risks of infectious diseases. Sniffing can contribute to the spread of HCV among users. Nasal walls are frequently injured among regular users, and HCV is highly virulent in contact with air. The sharing of sniffing materials e.g. crack pipes and their use via oral sores and cracked lips have been identified as HCV transmission risks.

Ecstasy and other synthetic stimulants

Harms and risks
Ecstasy is a stimulant that is mainly recreationally used by young people, often related to a specific lifestyle. Ecstasy use carries the high risk of dehydration, loss of consciousness; behaviour induced accidental injuries, coma, hepatic neurosis and even death.

Measures
Safer night life guidelines are widely disseminated across Europe to reduce ecstasy-related risks. They promote the provision of free water to combat dehydration, the availability of first aid services in settings of consumption, the intervention of outreach workers and peer group workers, as well as the dissemination of target group specific and contextualised information material. Training of proprietors and staff of entertainment venues on safer night life measures, similar to the training programmes aimed at safer alcohol consumption in bars (see RBS below in the section on Alcohol), can constitute an additional contribution to reducing risks related to ecstasy use. Also, at rave parties and free parties, provision for chill-out with an area or room equipped to let participants rest is classed as a risk and harm reduction measure.

Brief one-on-one interventions based on the method of motivational interviewing conducted by outreach workers and trained peer-group volunteers can yield good results in developing increased awareness behaviour of ecstasy users. With this type of intervention, it must be observed that a settings-based approach needs to be adopted.

Drug checking with full analysis of the ingredients in ecstasy pills, though expensive and time-consuming is a harm reduction measure that can help to avert the worst dangers such as overdosing, coma and collapse, or the risk of inadvertently using very harmful and dangerous psychoactive substances. Partial analysis however, which is quicker and purely intended to confirm the presence of MDMA in pills without indicating the other products present and potentially dangerous. In some European countries this intervention is perceived, and not suggested by evidence, as facilitating the consumption of an illegal drug and is therefore prohibited.

Unlike cannabis use (see section below on Cannabis), ecstasy consumption is to a great extent connected with certain lifestyles and related night-life activities (going out to nightclubs, parties etc.). In order to reach consumers,

it is indispensable that the appropriate prevention and harm reduction interventions are delivered in the specific context, time frame and venue of the recreational activities. When this proximity in terms of lifestyle, setting and timing is observed, it is also feasible to deliver healthy lifestyle messages, focused campaigns adapted to the activities of the persons concerned. The messages need to be directly delivered on the scene and tested on focus groups in order to be effective.

Cannabis

Harms and risks
Driving under the influence of cannabis increases the risk of road traffic accidents. Scientific evidence shows that cannabis impairs cognitive and behavioural capabilities, hence ability to drive, as well as motivation and concentration both in the middle and long-term. The degree of impairment depends on the dosage. Association of cannabis and alcohol when driving significantly increases the accident risk.

Furthermore, it is established that regular use can lead to cannabis dependence and may impact adversely on adolescent psychological development. Some studies indicate that it may trigger psychosis among predisposed people. The evidence suggests that cannabis is associated with an increased risk of psychosis when it is used frequently. Whether cannabis can trigger a primary psychotic disorder that would not have otherwise occurred is unclear. However, in most individuals who use cannabis, psychosis does not develop, which suggests that the increased risk must be related to other vulnerability factors (genetics, frequency, or age of onset of cannabis misuse). Another important factor is the varying levels of THC/CBD found in street cannabis. The fact that these constituents have divergent properties may explain the manifestation of different psychological symptoms among users. In fact, CBD may actually attenuate some of the unwanted psychopharmacological effects of THC, because it may have anxiolytic and antipsychotic properties. Furthermore, CBD has been shown to have neutral or even procognitive effects. In summary, the link between cannabis and psychosis (especially schizophrenia) is not straightforward.

In addition, there is an increased risk of respiratory disease when cannabis is smoked; this risk is further elevated when cannabis is smoked together with tobacco.

Measures
The following set of measures and harm reduction strategies for cannabis have been adopted by several European countries to combat cannabis use. Their implementation varies according to the country, and some measures are still at the experimental stage. Most are adapted from existing measures and strategies introduced to prevent risks and reduce harm resulting from the consumption of alcohol and tobacco and other psychoactive substances. Most of the measures and strategies adopted are still undergoing evaluation, and to date limited evidence is available as to their effectiveness.

To reduce the number of road traffic accidents, several countries have introduced random roadside testing. In some countries, blood sampling to measure THC content has been introduced into road traffic legislation. These measures are normally accompanied by awareness raising campaigns.

The risk of cannabis dependence can be addressed by targeted campaigns to inform the public that the risk of dependence increases with regular use and is greatest when used daily for weeks or months. In the context of treatment of respiratory diseases or depression and psychosis, integrated provision may be contemplated, based on a regular offer of appropriate therapies, screening in clinical, outpatient and other care settings. Tailor-made and context-related brief interventions in high-risk settings, aimed at factually presenting the dangers of cannabis, are among other promising options.

The risk of respiratory diseases can be reduced by not inhaling cannabis or smoking without added tobacco. Deep inhalation should be avoided to reduce the health damage from by-products, in particular tar and other particulate matter. Vaporisers may help to reduce the cancer risk, since in this way the active substance in cannabis, THC, is inhaled without carcinogens and toxins.

Alcohol

Harms and risks
Whilst drinking alcoholic beverages is, for the most part, an experience perceived as pleasurable and often associated with meals, relaxation and celebrations, there are several societal and health harms associated with its consumption. Excessive alcohol use can result in physical and psychological dependence.

Alcohol is the fifth most important risk factor for diseases worldwide [6]. The European Union (EU) is the heaviest drinking region of the world and alcohol is linked to multiple health and social problems. The estimated social cost attached to alcohol in the European Union is 125 billion € in 2003. The main costs are related to premature mortality, healthcare, crime (police, courts, and prisons) and unemployment [7].

Negative long term health effects of problem alcohol use include increased risk of cancer, neurological injury, liver cirrhosis and cardiovascular disease; at a global level, it is estimated that 3.7 % of all deaths and 4.4 % of disability-adjusted life years are attributable to alcohol. 1 in 7 deaths among men, and 1 in 13 deaths among women in the EU are attributable to alcohol use[8]. There is also a broad range of direct and indirect societal harms associated with excessive alcohol consumption including crimes, violence, traffic accidents, unemployment and absenteeism, which place a significant burden on societies and economies[9]. Alcohol use during pregnancy is an important cause of congenital birth defects.

Measures
In dealing with alcohol use and dependence, a number of risk and harm reduction measures have been developed and extensively tested. The following are the most frequently applied measures. Drink-driving policies (DDP) aim to prevent risks and reduce the harm associated with drink-driving and include direct measures for reducing the likelihood of drink-driving and indirect DDP measures, such as police alcohol testing and campaigns promoting responsible and moderate consumption of alcohol. DDP measures that create a safer driving environment aim at reducing the consequences and level of severity of crashes involving drunken drivers.

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6 *Lim, S. Et.al., (2012), A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factors clusters in 21 regions, 1990-2012: a systematic analysis for the Global Burden of Disease Study 2010, Lancet, 380, pp. 2224-60.*

7 *Anderson P. & B. Baumberg, (2006), Alcohol in Europe. A public health perspective, European Commission, DG Sanco*

8 *Rehm, J., Shield, K.D., Gmel, G., Rehm M.X., Frick, U. (2013), Modeling the impact of alcohol dependence on mortality burden and the effect of available treatment interventions in the European Union, European Neuropsychopharmacology, 23, 89-97.*

9 *WHO (2008a), Strategies to reduce the harmful use of alcohol: report by the Secretariat to the 61st World Health Assembly, 20 March 2008, A61/13, World Health Organization, Geneva. Available at http://apps.who.int/gb/ ebwha/pdf_files/A61/A61_13-en.pdf*

Restricting the availability of alcohol and introducing pricing policies through taxation, as well as regulating production and distribution of alcoholic beverages, is an effective strategy to protect young people and other vulnerable groups. It is also applied as a supply reduction strategy.

Regulating the marketing of alcoholic beverages by controls or partial bans on volume, placement and content of alcohol advertising are important parts of an alcohol strategy, and research results underline the need for such controls or bans, not only to protect adolescents and young people from pressure to start drinking, but also to prevent particularly harmful consumption patterns such as 'binge drinking' and excessive consumption generally.

Moderation management (MM) measures do not aim at abstinence but at reducing consumption levels, and lead to fewer alcohol-related problems, as well as fewer symptoms of dependence. Furthermore, many who choose a moderation goal are likely to opt for abstinence later on. MM measures include behavioural self-control training (BSCT) and guided self-change (GSC), which are increasingly available as computerised self-administered tools. Moderation orientated cue exposure (MOCE), behavioural couple's therapy (BCT) and mindfulness-based relapse prevention (MBRP) are methods designed for delivery in the context of counselling and treatment services.

Pharmacological agents (PA) are available to reduce harmful drinking and to improve the success rate of controlled drinking attempts. Naltrexone is used to reduce the sense of power reinforced by alcohol and thus reduce the behavioural response encouraging a drinker to consume greater amounts more frequently. Acamprosite depresses neurological receptor activation and suppresses the alcohol withdrawal symptoms. There are also other medicines some of which used to reduce the ill-effects of alcohol on the cognitive functions, such as vitamin B1 supplements.

Further measures aimed at preventing risks and reducing harm connected with alcohol consumption seek to improve the safety of drinking environments in bars and other licensed premises. Existing measures in Europe include staff training for responsible beverage service (RBS), which aims to reduce over-serving and avoid alcohol sale to minors, as well as to reduce violence resulting from excessive consumption. A reduction in the use of glassware is an important component of RBS that can have a significant effect on reducing violence involving glassware and the serious

bodily harm created by it. Such measures achieve most significant results when all glassware is banned from the premises. Awards for best managed "premises for 'safe' drinking" can help to reduce to reduce alcohol-induced crime, disturbances and public nuisance. The system of a "captain for the evening" is also a possible measure. Experiments with breathalysers that immobilise car starters are also under way in some countries. Lastly, information on the labels of bottles about risks to pregnancy and generally about the alcohol content of each container served is another risk reduction measure.

Tobacco

Harms and risks

Tobacco smoking is the leading cause of preventable premature mortality and disability in European and other developed countries. Tobacco can be smoked or used via non-smoked products such as chewing tobacco or snuff. Nicotine is the main substance responsible for tobacco dependence and is highly addictive.

Most of the health damage (harm) caused by tobacco use is not from nicotine but from the by-products of smoked tobacco (e.g. fine particulates, carcinogens and noxious gases including carbon monoxide. The long-term expose to these directly lead to various circulatory and respiratory conditions with a high morbidity and mortality; among the most serious are heart disease and lung- as well as several other forms of cancer.

The harm that is caused by tobacco smoking does not limit itself to smokers. Non-smokers who are exposed to second-hand smoke (the emissions from lit cigarettes and the exhaled smoke) are also at increased risk of many of the same diseases that affect smokers.

Measures

It is widely acknowledged that discontinuation of the use of all tobacco products would be the most effective way to lower risk and harms to individuals and society. Consequently, tobacco control policies aim to deter people from starting to smoke and to reduce or end tobacco consumption. While media campaigns, advertising bans, higher taxation and cessation support services have on the whole helped reduce tobacco consumption, there remains a considerable population of smokers who are unable or unwilling to stop smoking, mainly because of nicotine addiction.

In terms of preventing risks and reducing harm, effective alternatives need to be considered that allow smokers to obtain nicotine without being subjected to the risks of tobacco smoke. Tobacco harm reduction measures are also termed nicotine replacement therapy (NRT). Nicotine replacement therapies can also lead to prevention and reduction of risks caused by tobacco.

Tobacco harm reduction efforts can constitute important interim steps towards the ultimate cessation of smoking.

Pure nicotine products (PNP) are substitutes available in the form of chewing gums, patches, tablets, lozenges, spays and inhalants. They contain only nicotine and no tobacco products. Currently available pure nicotine substitutes are for short-term and low dose use and feasible for smokers who are trying to quit. The use of PNP is seen as considerably safer than smoked and smokeless tobacco products. These solutions are particularly relevant in pregnancy.

Smokeless tobacco products (STP) are available in a variety of forms. These include moist snuff, dry snuff and chewing tobacco. The health risks of using these smokeless tobacco products are considered to be lower than smoked tobacco, essentially because of the toxins in the tobacco. However, none of these products is without health risks, and they continue to be banned in most countries.

Appendix II

Selected policy instruments and reports relating to harm reduction

European Commission (2007), Report from the Commission to the European Parliament and the Council on the implementation of the Council Recommendation of 18 June 2003 on the prevention and reduction of health related harm associated with drug dependence, COM (2007) 199 final
- *Available at*
http://eur-ex.europa.eu/LexUriServ/site/en/com/2007/com2007_0199en01.pdf

Council of the European Union (2003), *Recommendation on prevention and reduction of health-related harm associated with drug dependence*, 2003/488/EC
- *Available at*
http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:165:0031:0033:en:PDF

EMCDDA (2004), *European report on drug consumption rooms*
http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf

EMCDDA (2010), *Harm Reduction: evidence, impact and challenges.*
- *Available at*
http://www.emcdda.europa.eu/publications/monographs/harm-reduction

ECDC- EMCDDA (2011), *ECDC and EMCDDA guidance: Prevention and control of infectious diseases among people who inject drugs.*
- *Available at*
http://www.emcdda.europa.eu/publications/ecdc-emcdda-guidance

EMCDDA (2012), Insights: *New heroin-assisted treatment.*
- *Available at*
http://www.emcdda.europa.eu/publications/insights/heroin-assisted-treatment

CND (2002), *Preventing the transmission of HIV among drug abusers: a position paper of the United Nations system, endorsed by the High-Level Committee on Programme (HLCP)*, document E/CN.7/2002/CRP.5.
- *Available at*
http://www.cicad.oas.org/en/Resources/UNHIVaids.pdf

ECOSOC (2009), *Economic and Social Council resolution E/2009/L.23 adopted by the Council on 24 July 2009: Joint United Nations Programme on Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (UNAIDS).*
- *Available at*
http://www.un.org/Docs/journal/asp/ws.asp?m=E/2009/L.23

United Nations General Assembly Sixtieth Special Session (2006), *Political declaration on HIV/AIDS*, Resolution 60/262
- *Available at*
http://data.unaids.org/pub/report/2006/20060615_hlm_politicaldeclaration_ares60262_en.pdf

UNAIDS (Joint United Nations Programme on HIV/AIDS) (2005), *Intensifying HIV prevention: UNAIDS Policy Position Paper*
- *Available at*
http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hivnewstyle_en.pdf

UNODC (2011), Reducing the Harm of Drug Use and Dependence and HIV Risk Reduction, in: Treatnet Training Package, Vol. 3
- *Available at*
http://www.unodc.org/ddt-training/treatment/VOLUME%20D/Topic%204/1.VolD_Topic4_Harm_Reduction.pdf

UNODC (2008), *Reducing Adverse Health and Social Consequences of Drug Abuse: A Comprehensive Approach.* Discussion Paper.
- *Available at*
http://www.unodc.org/documents/prevention/Reducing-adverse-consequences-drug-abuse.pdf

UNODC (2004), *HIV Prevention among Young Injecting Drug Users.* Publication No. E.04.XI.20.
- *Available at*
http://www.unodc.org/pdf/youthnet/handbook_hiv_english.pdf

WHO Europe (2002), *Resolution to scale up the response to HIV/AIDS in its European Region,* Committee for Europe resolution EUR/RC52/R9, 2002
- *Available at*
http://www.euro.who.int/en/what-we-do/health-topics/communicable-diseases/hivaids/policy/scaling-up-the-response-to-hivaids-in-the-who-european-region

WHO, UNODC and UNAIDS (2009), *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.*
- *Available at*
http://www.who.int/hiv/pub/idu/targetsetting/en/index.html

WHO, UNODC and UNAIDS (2008), *Policy guidelines for collaborative HIV and TB services for injecting and other drug users,* WHO, Geneva.
- *Available at*
http://www.who.int/tb/publications/2008/en/index.html

WHO, UNAIDS and UNODC (2007), *Effectiveness of interventions to manage HIV in prisons: opioid substitution therapies and other drug dependence treatment,* WHO, Geneva.
- *Available at*
http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf

WHO, UNAIDS and UNODC (2004), *Policy brief: provision of sterile injecting equipment to reduce HIV transmission,* General Assembly of the United Nations
- *Available at*
http://www.unodc.org/documents/hiv-aids/provision%20of%20sterile%20injecting%20equipment.pdf

Human Rights

Council of Europe (1951) Convention for the Protection of Human Rights and Fundamental Freedoms ETS no. 5
- *Article 2 sets out the right to life*
- *Article 14 prohibits discrimination*
- *Available at*
http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=005&CL=ENG

United Nations Convention on the Rights of the Child (adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49.) in particular *article 33 protecting children from the use of harmful drugs and from being used in the drug trade.*
- *Available at*
http://www.unicef.org/crc/

Criminal Justice

Pompidou Group (2008), *Quasi coerced treatment: findings from a survey conducted in PG member States*, P-PG/CJ (2008) 15
- *Available at*
http://ebookbrowse.com/p-pg-cj-2008-15rev1-en-pdf-d137090255

Pompidou Group (2007), *Guidelines on the application of quasi coerced treatment,* P-PG/CJ (2007) 21

In prison settings

Pompidou Group and WHO Europe (2005), *Status Paper on Prisons, Drugs and Harm Reduction*
- *Available at*
http://www.euro.who.int/__data/assets/pdf_file/0006/78549/E85877.pdf

Pompidou Group and WHO Europe (2001), *Prison, drugs and society – consensus statement on principles, policies and practices*
- *Available at*
https://wcd.coe.int/com.instranet.InstraServlet?command=com.instranet.CmdBlobGet&InstranetImage=1288 615&SecMode=1&DocId=1433204&Usage=2

European Commission (2008), *Final report on prevention, treatment, and harm reduction services in prison, on reintegration services on release from prison and methods to monitor/analyse drug use among prisoners,* SANCO/2006/C4/02.
- *Available at*
http://ec.europa.eu/health/ph_determinants/life_style/drug/documents/drug_frep1.pdf

Committee of Ministers (2006), *European Prison Rules*, Council of Europe.
https://wcd.coe.int/ViewDoc.jsp?id=9557

Murdoch, J. (2006), The treatment of prisoners - European standards. Council of Europe publications.
- *Available at*
https://book.coe.int/eur/en/penal-law-and-criminology/3559-the-treatment-of-prisoners-european-standards.html

Public safety

Pompidou Group (2006), *Responding to open drug scenes, drug related crime and public nuisance: towards a partnership approach*, document P-PG/Coop (2006) 3
- *Available at*
https://wcd.coe.int/ViewDoc.jsp?id=1210441&Site=DG3-Pompidou

Pompidou Group (2010), *Prevention interventions in recreational settings*, document P-PG/Prev (2010) 7
- *Available at*
https://wcd.coe.int/ViewDoc.jsp?id=1705481&Site=COE

Tobacco

European Commission Health and Consumer Protection Directorate-General (2008), *Orientation note: electronic cigarettes and the EC legislation*, European Commission, Brussels.
- *Available at*
http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/orientation_0508_en.pdf

European Commission SCENIHR (2008), *Health effects of smokeless tobacco products,* Scientific Committee on Emerging and Newly Identified Health Risks.
- *Available at*
http://ec.europa.eu/health/ph_risk/committees/04_scenihr/docs/scenihr_o_013.pdf

Alcohol

Pompidou Group (2009), *Drugs and alcohol: violence and insecurity*, document P-PG/CJ (2004) 7
- *Available at*
https://wcd.coe.int/ViewDoc.jsp?id=1210927&Site=COE

European Commission (2006), *Report by the Institute of Alcohol Studies, London, on Alcohol in Europe: a public health perspective.*
- *Available at*
http://ec.europa.eu/health-eu/doc/alcoholineu_content_en.pdf