Overdose in Europe:
Results from the 2019 Monitoring Report

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Correlation - European Harm Reduction Network is co-funded by the European Union
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Introduction:

Drug-related deaths account for a significant burden of preventative and premature deaths within the European region and are on the rise in many European countries.\textsuperscript{1} Policy makers looking to reduce these deaths must look to evidence-based interventions to prevent opioid-related overdose (OD). These interventions can occur at three levels 1) Reducing fatal OD’s by providing Drug Consumption Rooms (DCR) and Take Home Naloxone (THN) programs; 2) Reducing OD risk, by improving retention in Opioid Substitution Therapy (OST) and promoting OD awareness and 3) Reducing vulnerability by providing a broad set of low-barrier services such as harm reduction and outreach by empowering PWID.\textsuperscript{1} Civil society has a crucial role to play not only in policymaking and implementing these activities but in collecting data on OD-related context and local interventions at the community level. Civil society also provides valuable information on the miss-match between official guidelines and strategies and the real-life situation as experienced at the local and regional levels. The 2019 C-EHRN monitoring survey collected information on OD prevention as seen by the C-EHRN focal points from 34 European countries (Scotland was treated separately).\textsuperscript{2} Although the monitoring tool focuses on opioids, a brief section was included on OD prevention for other substances.

Countries included in the survey:
Albania, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czechia, Denmark, Finland, France, Georgia, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Montenegro, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Russian Federation, Scotland, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom, Ukraine.
Main findings

OD prevention at a policy level
Strategic planning and programming on a national level to combat ODs are essential for effective action. C-EHRN monitoring asked participants whether drug-related overdose deaths, and ways to prevent them, are mentioned in the respective national drugs strategy or action plan. Twenty out of 34 countries reported having OD prevention mentioned in their national drug strategy or action plan. Respondents in Belgium, Bosnia & Herzegovina, Croatia, Finland, Germany, Montenegro, Poland, Portugal, Russia and Slovenia (n=9) did not report having either a national strategy, protocol or separate strategy in their respective countries.

Take-Home Naloxone (THN)
Take-home naloxone (THN) programmes are an evidence-based opioid overdose prevention initiative that is increasingly implemented in Europe. The idea behind THN programmes is to expand the availability of naloxone from medical emergency staff to people who use opioids, their peers, family members, and other trained laypeople to reverse overdoses. In the C-EHRN monitoring survey, 13 countries reported having THN available (though availability in some countries might be restricted to a few regions or cities). In addition, Slovenia and Switzerland have plans to make THN available soon (see below).

Figure 1:
OD Prevention in National Strategies and Protocols

Figure 2:
THN programs in Countries Surveyed by C-EHRN
For respondents in countries without THN programmes, the main reason given (or guessed) is that legislation in these countries allows naloxone to be handled only by medical staff. This is the case in Belgium, Bosnia and Herzegovina, Croatia, Greece, Hungary, Luxembourg, Poland, and Russia (n=7). Other reasons given included a ban on the use of naloxone (Slovenia); the prevalent use of street buprenorphine (Finland); and the unwillingness of medical doctors to prescribe naloxone (Slovakia).

From the 14 countries reporting to have THN programmes, only four (Georgia, Italy, Norway, and Spain) affirmed that THN is available and used as it should be. Issues reported included THN being project-based (not widely distributed), requiring a medical prescription, lack of widespread availability or unnecessary barriers in place. Naloxone is predominantly available in its injectable form, although nine countries have nasal spray available though significant cost variation was reported. Other countries without THN programs reported ad-hoc access to naloxone (Belgium, Slovakia and Russia). In most countries where THN programmes are available, naloxone can be provided by harm reduction services without a medical prescription.

<table>
<thead>
<tr>
<th>Country</th>
<th>Only with prescription (doctor)</th>
<th>With prescription (paid by health insurance)</th>
<th>Over the counter status (without prescription in pharmacies)</th>
<th>By harm reduction providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norway</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ukraine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 3: Countries with THN programs, how is THN accessible?**
Of the countries above with THN available, there is significant variability as to where and how naloxone can be obtained and by whom. Naloxone training also varies by country, only Italy, Slovakia and the UK do not require mandatory training in order to carry naloxone. Training allowed ranges from only medical doctors in Sweden to harm reduction staff and peer users in countries like Georgia, France, Norway and Spain. The only countries with no THN available, and which reported to not have plans for increasing access to naloxone, were Bulgaria, Croatia, North Macedonia, and Greece. In Poland, Portugal, Russia, and Serbia initiatives taken have not achieved any success to-date. Initiatives and strategic plans to increase naloxone availability were reported in Albania, Belgium, France, Germany, Italy, Luxembourg, Norway, Scotland, Spain, and the United Kingdom (either government or NGO-driven).

**Drug Consumption Rooms (DCRs)**

Drug consumption rooms (DCR’s) play an important role in overdose prevention. These facilities where illicit drugs can be used under the supervision of trained staff have been operating in Europe for the last three decades. These facilities primarily aim to reduce the acute risks of disease transmission through unhygienic injecting, prevent drug-related overdose deaths and connect high-risk drug users with addiction treatment and other health and social services. They also seek to contribute to a reduction in drug use in public places and the presence of discarded needles and other related public order problems linked with open drug scenes.4

Respondents were asked if they were aware of any new initiatives for DCR’s. 17 countries reported ongoing discussions, or new initiatives, on starting new DCRs. The map below shows the different stages in which these discussions are per country.

In 5 countries there is advocacy reported but no results yet (Hungary, Slovenia, Italy, Scotland and Czech Republic). New regulations have been proposed or set into place in Germany, Finland and Ireland to allow for new DCR’s. In Germany Akzept and DAH have advocated for DCR’s to be implemented in all German states (currently they are only operating in 7 of the 16 states). More concrete initiatives have been reported in 7 countries (Belgium, Denmark, Luxembourg, Portugal, Switzerland, Ukraine, France and Greece) whereas in the Netherlands DCR’s have been changing to adapt to new drug consumption patterns. These changes include supervised alcohol consumption rooms and sheltered housing facilities.

So far 14 countries (Belgium, Denmark, France, Germany, Greece, Ireland, Luxembourg, Netherlands, Norway, Portugal, Scotland, Slovenia, Spain, Switzerland and Ukraine) report having a legal framework in place for DCR’s.
Overdose prevention in Prison
The immediate period after release from incarceration is when overdose risk is highest, due to relapse and reduced opioid tolerance. WHO has estimated that 20% of drug-related deaths (DRDs) appear in connection to prison release or treatment relapse. Thus it is a crucial opportunity for overdose prevention both in the form of naloxone and OST. According to the C-EHRN monitoring survey, OST is available in prisons in all participant countries other than Georgia, Hungary, Russia, Slovakia, and Ukraine.

Participants were asked whether their country has OD prevention responses linked to prison release. Slightly less than half of the countries (15 out of 33) reported having such measures. In most cases, however, these actions are not systematic and are carried out by CSOs with lower support from the prison authorities or the government. Exceptions to this are France, the Netherlands, Norway, and the United Kingdom (including Scotland), where a more systematic approach to OD prevention on release is undertaken by prison staff. The map below details whether or not OST is available upon release from prison.

Figure 5: Countries with Naloxone in Prisons

<table>
<thead>
<tr>
<th>Country</th>
<th>Naloxone available in prisons</th>
<th>Who can access it</th>
<th>Pre-release naloxone available</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>✓</td>
<td>Inmates, staff and medical staff</td>
<td>✓</td>
</tr>
<tr>
<td>Italy</td>
<td>✓</td>
<td>Medical staff</td>
<td>✓</td>
</tr>
<tr>
<td>Norway</td>
<td>✓</td>
<td>Staff</td>
<td>(in some prisons)</td>
</tr>
<tr>
<td>Scotland</td>
<td>✓</td>
<td>Staff and medical staff</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>✓</td>
<td>Medical staff</td>
<td>Do not know</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>✓</td>
<td>Don’t know</td>
<td></td>
</tr>
</tbody>
</table>

(At least in 58 of 109 prisons surveyed in England)
Other OD prevention measures
C-EHRN Focal Points were asked to evaluate the training and capabilities of first responders (ambulance, fire brigade, police) for handling overdose situations in their country, region or city. These are given in the map below:

Some reasons given for positive evaluations were the good performance and speed of first responders, good knowledge about OD; being equipped with naloxone and having good collaboration with harm reduction services. Another important issue is for first responders to not report to the police. Another third of respondents mentioned that the preparedness of first responders varies considerably. The other third of respondents considered the preparedness of first responders as not good. Reasons for a negative assessment included not having naloxone having limited knowledge and training about OD, not cooperating to help PWUD and calling the police when there is an OD case.
OD prevention training
Providing naloxone to people most likely to witness an opioid overdose, in combination with training on the use of naloxone can substantially reduce the deaths resulting from opioid overdose.  C-EHRN Focal Points were asked if there is information and/or education/training available for PWUD (and their friends and family members) on overdose prevention measures. From the 34 respondents, seven reported not having any education and training for PWUD, their friends or family members. In 26 countries, there is education and training for PWUD. This is shown the map below. In all these cases, however, CSOs were primarily responsible for delivering OD prevention education to this population.

Figure 8: OD Prevention Training in Countries Surveyed by C-EHRN

Fentanyl and synthetic opioids (SO’s)
While heroin remains the most commonly used illicit opioid, a number of sources suggest that licit synthetic opioids (such as methadone, buprenorphine, fentanyl) are increasingly used and fentanyl involvement in fatal OD’s has been on the rise in many countries.  Respondents were asked whether fentanyl and other Synthetic Opioids (SO) are available in their country/region/cities and if they have perceived of any changes in the situation regarding these drugs. They were also asked about prevention campaigns around fentanyl and other SOs and if fentanyl test strips are being used. Almost two-thirds of participants (21 out of 34) mentioned having noticed the presence of fentanyl and other SOs in their country, region or city. One perceived change is the increased availability of these substances, which sometimes comes with a few cases of OD and doubts from professionals on how to deal with the public using such drugs. This was mentioned with regards to the Czech Republic, Denmark, France, Italy, Greece, Norway, and the Netherlands.
Figure 9: Fentanyl and SO’s in Countries Surveyed by C-EHRN

= no fentanyl or SO’s reported
= fentanyl or SO’s present, no test strips or awareness campaigns reported
= fentanyl or SO’s present, test strips or awareness campaigns enacted

OD prevention for other substances

Respondents were asked if there are overdoses and related responses to other drugs than opioids, such as new psychoactives, GHB, MDMA, cocaine, or others. More than half of participants (19 out of 34) answered positively. At least 11 of these mentioned stimulant drugs as a cause of ODs. They referred mostly to cocaine but also MDMA and, to a lesser extent, GHB and synthetic cathinone. Cocaine has been mentioned in France, the Netherlands, Montenegro, Romania, Serbia, Slovenia, and the United Kingdom. In the Netherlands, for instance, overdoses related to the use of stimulant drugs are reported and are much more common than opiate overdoses, especially in combination with alcohol. MDMA was mentioned by respondents from Denmark, Belgium, France, the Netherlands, Serbia and the United Kingdom. GHB was mentioned by Focal Points in Serbia, France, the Netherlands and the United Kingdom. In the Netherlands, there is information for professionals and for PWUD on how to respond to a GHB overdose. Synthetic cathinones were mentioned by Focal Points in France, Poland, Georgia, and Spain. In Georgia, many non-injectable new stimulants are purchased online and, since most users do not know about the dosages and contents of these materials, OD happens quite often.

The responses to these other drugs, besides the ones mentioned above, include information campaigns, drug checking, OD training, and DCRs. In the Netherlands, MDMA and other stimulant ODs are not uncommon and there is a lot of information distributed among users on how to prevent OD and the risks of overdosing as well as access to drug-checking to obtain information on the content of their pills and contamination although, in practice, many marginalised PWUD do not make use of this service. In addition, professionals have guidelines, training, and information on how to respond to stimulant ODs, such as Excited Delirium Syndrome, psychotic episodes and, in the case of MDMA, serotonin syndrome. In Spain, DCR’s, naloxone programmes and robust consumer health education has been noted to significantly decrease fatal reactions to drugs.
Conclusions

With the rise in fatal overdoses in many European countries it is vital for policy makers to consider the solid scientific evidence for measures that reduce opioid and other drug related OD deaths. National overdose prevention plans, DCR’s, widespread naloxone distribution, focus on the vulnerable period following release from prison and OD education for PWUD and their friends/families are all demonstrated to reduce fatal overdose. Despite this evidence, the C-EHRN report shows a completely mixed picture of policies and measures across Europe.

The political authorities are called upon to take appropriate legal initiatives to ensure that naloxone is available free of charge and without prescription in pharmacies for people who use drugs. In order to obtain a real overview of the number of doses of naloxone administered, and data on the successful use of naloxone, a national reference point should be established to collect and analyse this and other data related to OD.

Despite the uneven situation regarding policies and measures to prevent drug-related overdose, positive developments have been taking shape in the form of new initiatives for DCR’s and THN programs. In many places national harm reduction networks are the driving force behind these ongoing discussions about establishing these lifesaving policies and play a key role in decreasing fatal overdose rates in Europe.


