Public health: Union strategy on drugs 2000-2004, prevention and reduction of risks of drug dependence

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The 2003 Recommendation on the prevention and reduction of health related harm associated with drug dependence requires the Member States to report back on the implementation of the Recommendation within two years of its adoption. Based on the data forwarded to it by the Member States the Commission is expected to prepare a report. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) publishes annual reports on the state of the drugs problem in the EU which includes information on drug related deaths (DRDs) and drug-related infectious diseases such as HIV/AIDS and hepatitis. The EMCDDA's finding can be found in Annex to this report.

To recall, the aim of the Recommendation is to reduce the number of DRDs and drug-related health damage by encouraging Member States to set up and develop responses and strategies to prevent and reduce drug-related harm. The Recommendation is support by an EU Drugs Strategy (2005-2012) and EU Drugs Action Plan (2005-2008).

The report itself, is based on two main sources – the Member States and an independent processing of the data by the Trimbos Institute, which is an independent research centre acting in the field of mental health and addiction.

In summary, the report makes the following findings:

Recommendation 1: Harm reduction as a public health objective: In all of the EU Member States the prevention and reduction of drug-related harm is a defined public health objective. The Recommendation played an important role in national public health policy – particularly so in many of the Member States that joined the EU in 2004.

Recommendation 2: Harm reduction services and facilities in the Member States: All Member States have established harm reduction services and facilities – some to a greater extent than others. Thus, all Member States have a policy of providing information and counselling to drug users. Twenty two countries use websites and some have on-line counselling tools. The communities and families of drug users are widely involved in harm reduction activities in the Member States. In the United Kingdom, for example, families are involved in overdose prevention training in a bid to reduce DRDs. Peers and volunteers are systematically involved in outreach work in the majority of the EU Member States. In Belgium, drug users are trained to disseminate HIV prevention and overdose prevention messages. Other measures include:

- networking and co-operating between outreach work agencies;
- providing drug treatment (such as opioid substitution treatment which is used in 24 EU Member States);
- preventing the diversion of substitution substances (used in 22 Member States);
- testing/screening of infection diseases; vaccination campaigns for hepatitis B (in use in 15 Member States);

- offering needle and syringe exchange progress to drug users (available in 24 Member States);

- training and equipping the emergency services to deal with overdoses. In 20 of the EU Member States ambulances routinely carry the opiate antagonist naloxone;

- offering support for training activities leading to a recognised qualification for professions who work in the field of drug dependence. This policy exists in 22 Member States.

As far as prisons are concerned, the EMCDDA reports that the lifetime prevalence of injecting drug use among prisoners in European is between 7% and 38%. A policy to provide drug users in prisons with services that are similar to those available to drug users outside prisons exists in 20 Member States and is about to be introduced in four countries. As far as DRDs in the mental health sector is concerned the report notes that harm reduction is considered at policy level and deemed to be part of an integral part of mental health and social care. Twenty three countries have a policy aimed at promoting integration between health services and social care. The Commission does point out, however, that the implementation of this policy at Member State level, still needs to be developed further since it appears that providing a fully integrated system of care for drug users remains a challenge.

Recommendation 3: Quality assurance, monitoring and evaluation: Not all Member States see quality assurance, monitoring and evaluation as the task of national government – although they do subscribe to the need for an emphasis on, and the use of scientific evidence, in harm reduction practice. The majority of Member States (19) report that policy decisions are based specifically on scientific evidence. In general, the Member States do agree with the need for assessments at the initial stage of programmes but often do not make it a condition in the selection of programmes and interventions. In Ireland, however, a baseline assessment determined the hepatitis B vaccination coverage among drug users in order to design a pilot project to improve infectious disease preventative care for IDUs. The development of evaluation protocols, for the evaluation of interventions is a task often considered to be one for scientific institutions dealing with quality evaluation - although some Member States, such as the Czech Republic and Denmark have developed protocols and guidelines as part of their drug policy. Fourteen Member States have a policy in place the aim of which is to support the development of evaluation quality criteria, whilst 23 Member States report compliance with the five key EMCDDA indicators. The evaluation training programmes for different levels and target groups have been implemented in 14 Member States and 14 Member States report having a policy in placed to enable all actors and stakeholders to be involved in the evaluation process. On a final point, bi- and multi-lateral programmes involving several Member States have been developed. 21 countries report that they have a policy to encourage exchange and collaboration with other Member States. The Member States are also collaborating with the Commission through initiatives such as the “Community Programme on Public Health”.

Follow-up: Reporting on the implementation of this programme covers a period of 1.5 to 2 years. Given that this period is still quite limited and given that the EU has absorbed new Member States since the adoption of the Recommendations, the Commission warns that this report is primarily a “baseline” overview of the Recommendation’s implementation. The Commission, therefore, intends to repeat this exercise within the framework of the new EU Action Plan on Drugs (2009-2012) at which point the Commission will be better placed to consider, together with the Member States, whether there is a need, or not, for further recommendations.