CIVIL SOCIETY VIEWS ON THE IMPLEMENTATION OF THE EU ACTION PLAN ON DRUGS:

REPORT BY THE CIVIL SOCIETY FORUM ON DRUGS

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Colophon:

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1. INTRODUCTION

The involvement of non-state actors on various levels of policy-making has been one of the important issues of the European Union agenda for some time already. One of the manifestations of the EU efforts to include civil society representation in the work of various EU bodies has been creating Civil Society Fora – spaces where European non-governmental organisations can work together and sit at the round table with EU representatives.

The Civil Society Forum on Drugs (CSFD) is an expert group of the European Commission. Its members are selected by the Commission for a three-years mandate based on their competences, knowledge and expertise. One of its thematic working groups is concerned with the EU drug strategies and action plans.

EU Drug Strategy is a document "provid[ing] the overarching political framework and priorities for EU drugs policy identified by Member States and EU institutions" (European Council, 2012), thus setting the general directions of the field development. It is based on the EU values and principles on the one hand, and international agreements (e.g. United Nations conventions on psychoactive substances) on the other. The strategy constitutes a "base" to guide Action Plans on Drugs – documents encompassing 4-year periods and enlisting more specific actions and measures to be undertaken.

The current EU Drug Strategy was adopted for the years 2013-20, and its Action Plans for 2013-16 and 2017-20, respectively. The documents focus on few areas of drug policy: drug demand reduction, drug supply reduction, coordination, international cooperation, and information, research, monitoring and evaluation. With its vocal support for solutions that are evidence-based and strongly embedded in human rights and public health approach to the drug problem, they are by all means the most progressive EU documents of this type so far. However, EU strategy and action plans are documents of recommendation character only, i.e. they are not legally binding. Therefore, each and every EU member state has a full discretion over its drug policy (unless restricted by ratified international treaties), which means that the degree of following EU recommendation and reflecting them in domestic policies and laws can vary significantly from country to country.

For this reason, CSFD's Working Group on the EU Drug Strategy and Action plan has been involved in in the evaluation of the EU drug strategy (2013-20) and the previous Action Plan on Drugs (2013-16), as well as the preparation of the new Action Plan (2017-20). The Forum has also decided to contribute to the monitoring and evaluation of the current Action Plan (2017-20). To do so, we have conducted a research among European NGOs working in the field to assess their perspectives and views on how relevant actions of the document are implemented in their countries.

This report consists of five main parts. First, we will describe the methodology and data sources of this inquiry. Second, we will discuss the services accessibility and quality in general. Third, we will provide a comparative analysis of the European regions included in the study. Fourth, we will look more closely at services accessibility and quality in the context of few specific and vulnerable populations: youth, elderly, women, ethnic minorities/immigrants and inmates. Finally, we will present barriers to the effective implementation of the EU Action Plan and draw a set of recommendations for various stakeholders.

2. METHOD AND DATA

To conduct this exploratory inquiry, an online questionnaire was prepared by the working group in March 2018 and widely distributed among NGOs working in broadly understood drug policy field from 2nd April to 24th June 2018 via various channels of online communication. In addition to the organisations based in EU member states, the call invited also those NGOs that are based in some candidate and associated states (Macedonia, Serbia, Montenegro, Norway, Iceland and Switzerland) of the EU.

The first part of the questionnaire focused on the general assessment of accessibility and quality of the most important services/possibilities for people who use drugs included in the EU Drug Strategy and Action Plan on Drugs in respondents' respective countries. To ensure uniform understanding of services definitions, we referred survey respondents to the "Health and social responses to drug problems: a European guide" published by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) in 2017. Twelve services we asked about cover all relevant fields of demand reduction and harm reduction:

1) **Prevention** covers a wide spectrum of interventions aimed at preventing or delaying substance use and associated problems, ranging from those that target society as a whole (environmental prevention) to interventions focusing on at risk individuals (indicated prevention).

2) **Online prevention** in its substance is identical with 1); what is different is the form and channels of communication used: here we include online settings, e.g. social media, fora.

3) **Safer nightlife programs** are programs aiming to increase the level of safety and reduce levels of risk related to substance use in broadly understood nightlife (party) settings, e.g. distribution of condoms, distribution of free water, so-called psycare activities.

4) **Treatment** includes a range of interventions to treat drug problems in Europe, including psychosocial and medically assisted interventions and detoxification. Drug treatment services may be provided in a variety of outpatient and inpatient settings: specialist treatment units, primary healthcare and mental health clinics, low-threshold agencies, hospital-based residential units and specialist residential centres.

5) **Treating co-morbidities** refers to any treatment interventions, including community-based interventions, addressing the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder.

6) **Recovery/rehabilitation** involves programs where an individual temporarily lives

in a treatment facility and follows a structured, care-planned programme of medical, therapeutic and other activities.

7) **Needle and syringe exchange programs (NSP)** provide sterile injection equipment, information on safer injection and disposal, assistance to access treatment services and other health and welfare services. They usually constitute a part of some low-threshold services of broader scope.

8) **Opioid substitution treatment (OST)** is a type of service for people dependent on opioid-type substances (e.g. heroin, morphine) to replace illegal opiates with legal medicines. OST improves the health and social well-being of patients, as well as contributes to the prevention of blood-borne viruses' infections, crime and overdoses.

9) **Naloxone distribution** includes various form and channels of distributing naloxone, a medicine used to reverse opioid overdoses. Administration of naloxone immediately reverses the effect of a drug, restoring vital functions, e.g. breathing.

10) **Drug checking** refers to services where individuals can have their substance tested professionally, e.g. in the laboratory. Drug-checking services are effective in overdose prevention, they enable people who use drugs making informed decisions, and they significantly contribute to early warning systems and mechanisms: detecting especially dangerous substances is – as a rule – announced publicly and shared widely via various channels.

11) **Drug consumption rooms (DCR)** are services which provide safe, clean spaces for the administration of a substance. They are supervised by medical personnel (doctors, nurses) which contributes to decreasing the level of risk, e.g. of overdose.

12) **Alternatives to coercive sanctions (ACS)** refer to interventions/solutions that provide alternatives to coercive measures. For example, treatment, rehabilitation, social integration, aftercare and education can be applied instead of incarceration or administrative sanctions.

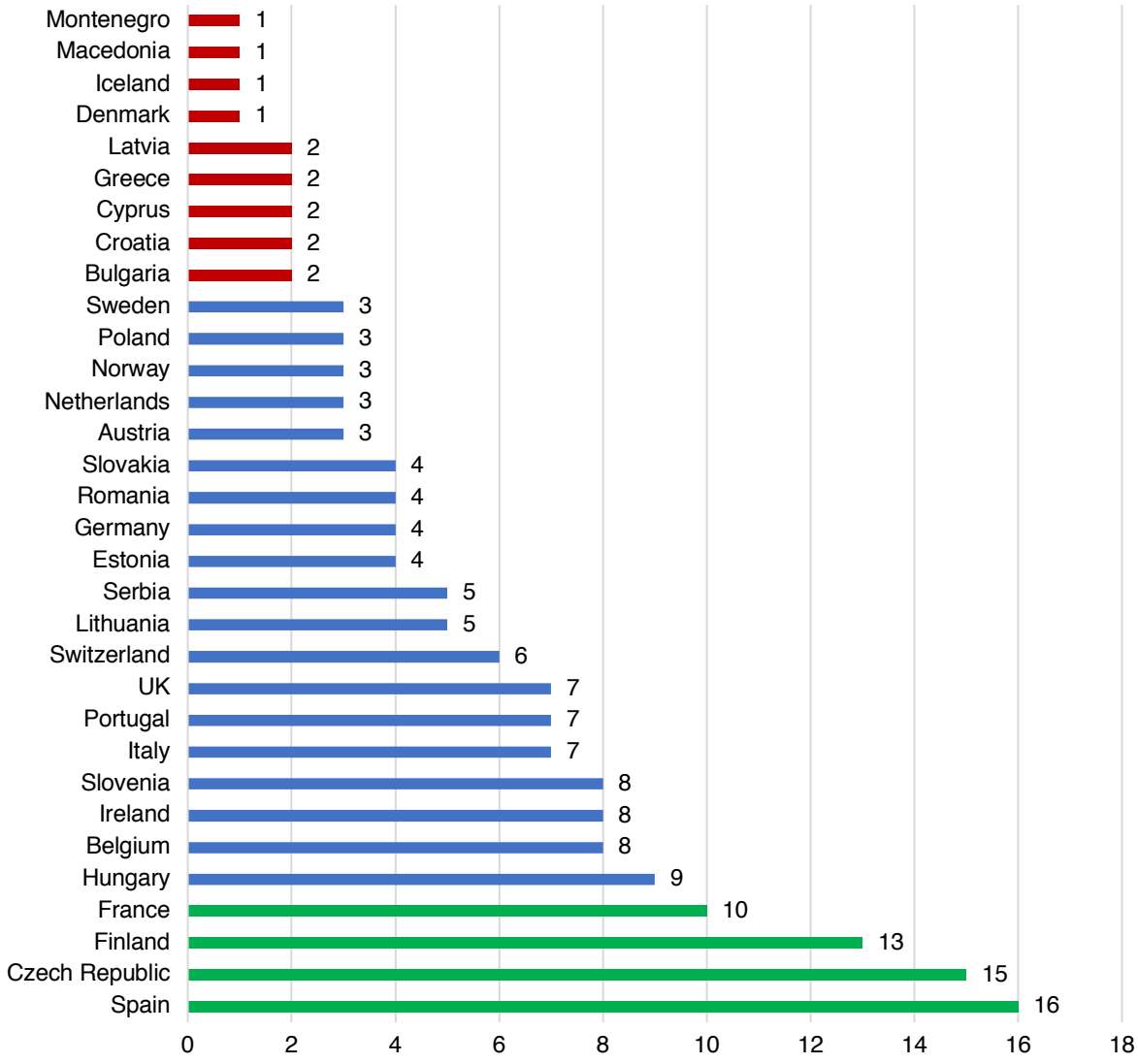
The scale included 11 points where "0" indicates no access/very low quality, while "10" indicates full access/excellent quality. The following levels of our variables (accessibility/quality) have been distinguished:

0 – no access/quality;
0.1-2.0 – very low access/quality;
2.1-3.9 – low access/quality;
4.0 – 5.9 – moderate access/quality;
6.0-6.9 – moderately high access/quality;
7.0-8.5 – high access/quality;
8.6 – 10.0 – very high access/quality.

2.1. Data and respondents' characteristics

The questionnaire was completed by 169 civil society organisations from 32 European countries. Among respondents representing individual countries we have identified 32 states: 26 EU member states (all except Malta and Luxembourg), 3 candidate states (Macedonia, Montenegro, Serbia) and three other European states (Iceland, Norway, Switzerland). The average response number per state was 5. We received a high number of responses (5 or more) from 15 countries and low (2 or less) from 9 countries (see Figure 1.). This means that the reliability of data collected from some countries is higher than in some others. Still, the overall data reliability is considered high due to selective sampling: our respondents were professionals and experts working in the field.

Figure 1. Geographical distribution of the respondents

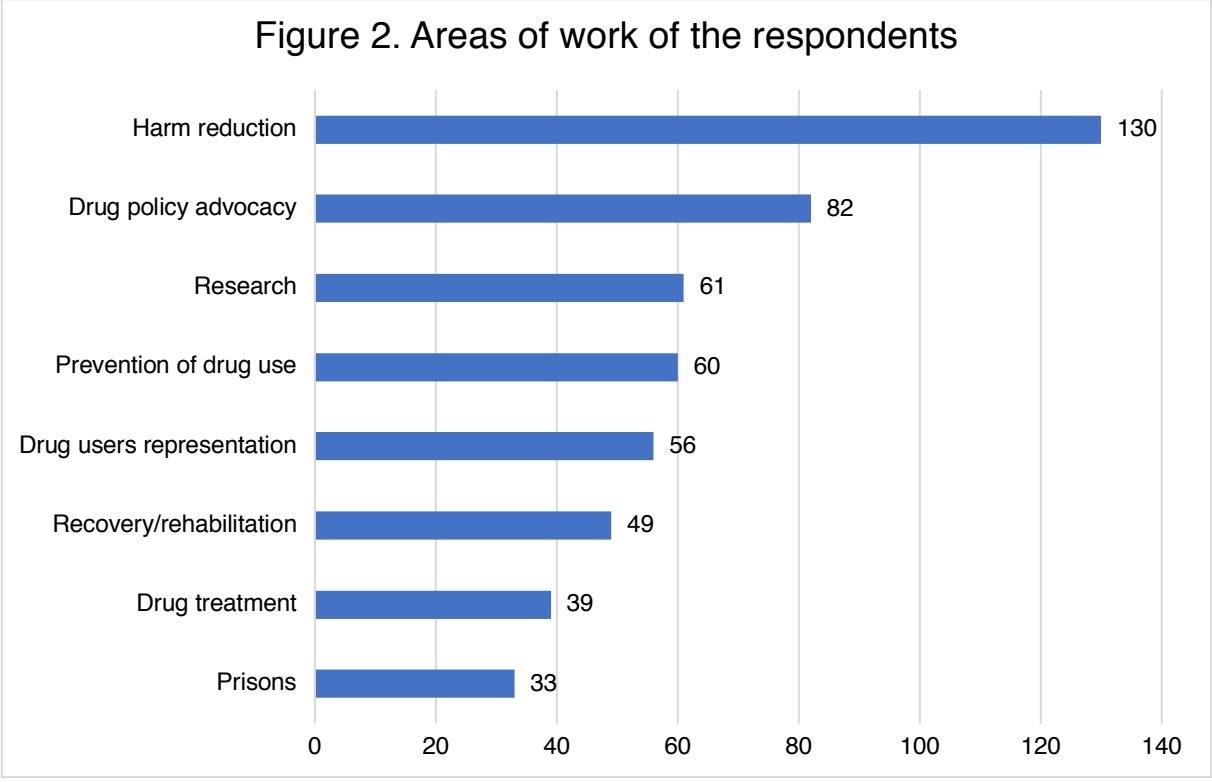


Regarding geographical scope of respondents' work, most of the examined NGOs work on local and national level. 18 respondents defined their focus as European while 21 as international (see Table 1.).

Table 1. Geography of NGOs' work and expertise

Scope	Local/city/regional	National	European	International
Number	69	61	18	21

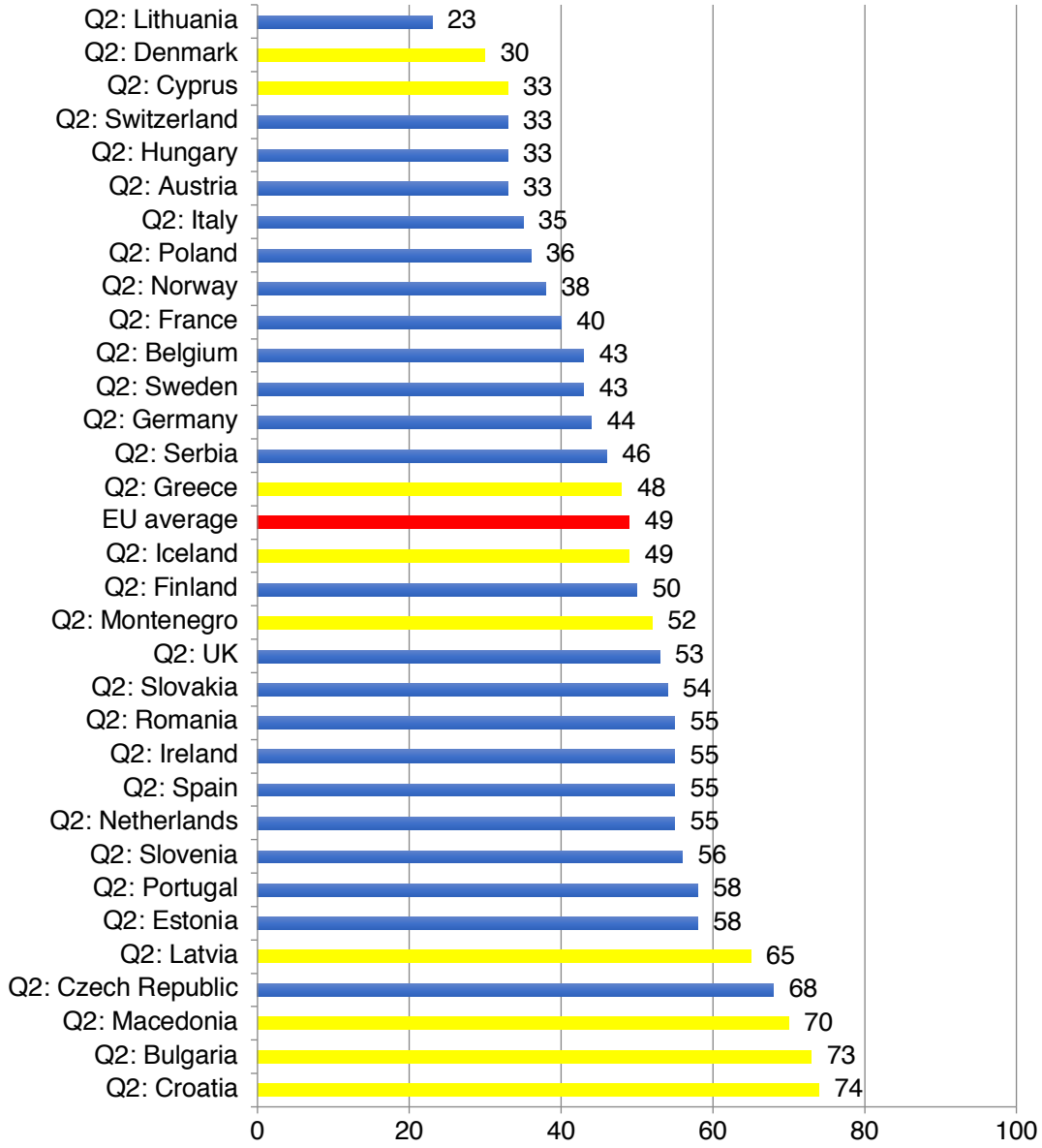
Respondents were asked to indicate the areas where they work and have expertise in (multiple answers were possible). The expertise of our respondents covers all relevant fields of drug policy (see Figure 2.). The majority of them indicated harm reduction and drug policy advocacy. Over one-third of our respondents have expertise in academic research and in drug prevention, nearly one-third in recovery/rehabilitation, and more than every fifth in drug treatment. There are 56 organisations that represent communities of people who use drugs, that is, the population most affected by drug policies. 33 organisations indicated that they also work on issues related to incarceration.



3. ASSESSING THE ROLE OF THE EU DRUG STRATEGY AND ACTION PLAN

We intended to assess what is the role of the EU Action Plan in policy-making processes and actual policies existing in examined countries. We asked respondents to rate this role on a 0-100 scale where "0" indicates no role at all, national policies are not in line with EU drug policies, while 100 is they play a great role and national policies are fully in line with EU drug policies. The average rate of impact assessed by respondents was 49. However, the results show a great diversity across Europe, ranging from 23 in Lithuania to 74 in Croatia. In the Figure 3 below, the countries with low number of responses (less than 3) are indicated by the yellow highlight.

Figure 3. The role of the EU drug strategy in policy-making on domestic (national) level (1-100)



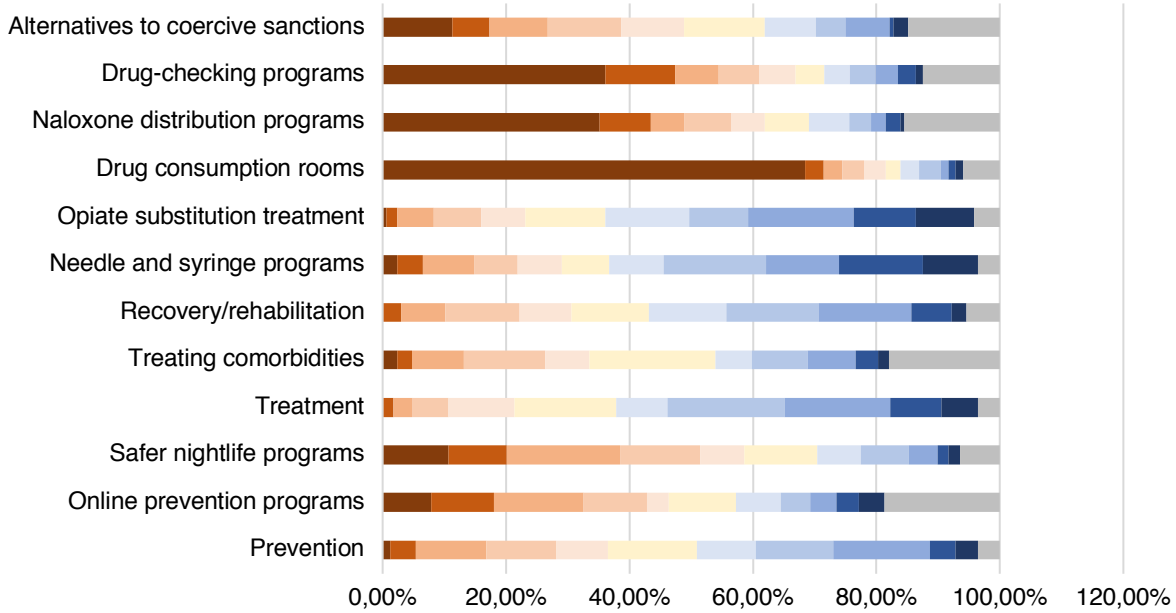
It is important to note that there is no correlation between high access to/quality of services in a country and the perception on how much the impact the EU drug strategy and action plan had on national/local drug policies. For example, in case of Switzerland, access to services is relatively high but the impact of EU drug policies is low: services development is completely independent from the EU recommendations. On the other hand, while national/local level strategic documents can follow the exact wording and structure of EU drug strategy in some countries, it does not mean that these documents are adequately implemented.

This can explain perceiving the EU strategy as having a significant impact on domestic policies in some Eastern-Central European countries, such as Bulgaria, where the national drug strategy is modelled after the EU drug strategy - yet these policies are not really implemented. In some other countries, such as Croatia, optimism and enthusiasm about the impact of EU documents can reflect real development of and investments in the drug policy field, driven by the EU accession process.

4. ACCESS TO AND QUALITY OF EXAMINED SERVICES

On the aggregate European level, two types of services were rated by the respondents as moderately highly accessible (6 or more points): OST (6.12) and treatment (6.03). Moderate accessibility was reported in case of NSP (5.73), prevention (5.13), recovery (5.10), and treating co-morbidities (4.62). Access to online prevention (3.53), alternatives to coercive sanctions (3.51), safer nightlife programs (3.00), naloxone distribution (2.21) and drug checking (2.05) were rated as low, and access to drug consumption rooms (1.21) was perceived as extremely low. Figure 4 below shows the ratings attributed to access to services: no access (0 points) is indicated by dark brown and full access (10 points) is indicated by dark blue, while other ratings, falling somewhere between the two extremes, are indicated by lighter shades of these two colours. Grey colour indicates the lack of data ("I don't know").

Figure 4. Perceived accessibility of services

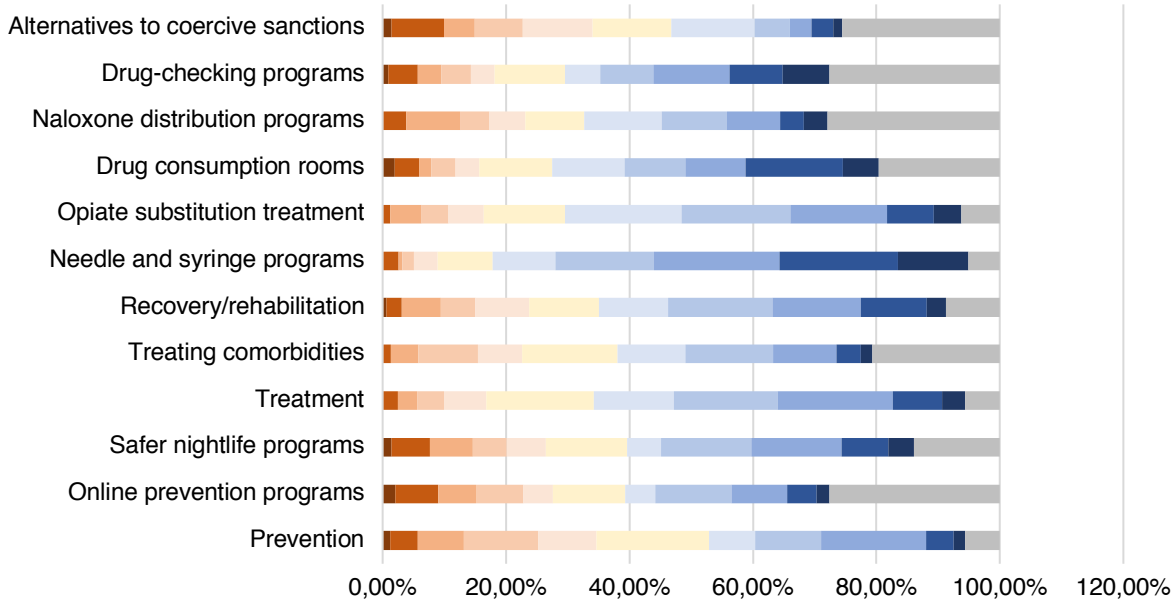


The results of the evaluation of the access to various services (Figure 4 and Figure 6) come without much surprise. Indeed, if we talk about harm reduction measures, OST and NSP have quite a long tradition in Europe and are widely accepted as health-oriented responses to tackle the drug use, though in some regions they are still more controversial than in others. On the other hand, drug checking services and drug consumption rooms are relatively novel ideas (if we take into consideration European scale) and are still highly contested (by public opinion and decision-makers alike).

Besides, their legal status can be dubious in the context where drug possession (and in some cases consumption) is criminalised, which is the majority of the examined countries. In sum, none of the services examined in this study are perceived as highly accessible by NGOs representatives which may suggest that drug policy does not constitute a priority area for the decision-makers in studied countries.

In the assessment of the services quality, we again used an 11-point scale. In the Figure 5, "0" (dark brown) indicates very low quality, while "10" (dark blue) indicates excellent quality. Similarly, lighter shades of these two colours indicate ratings falling between the two scale extremes.

Figure 5. Perceived quality of services

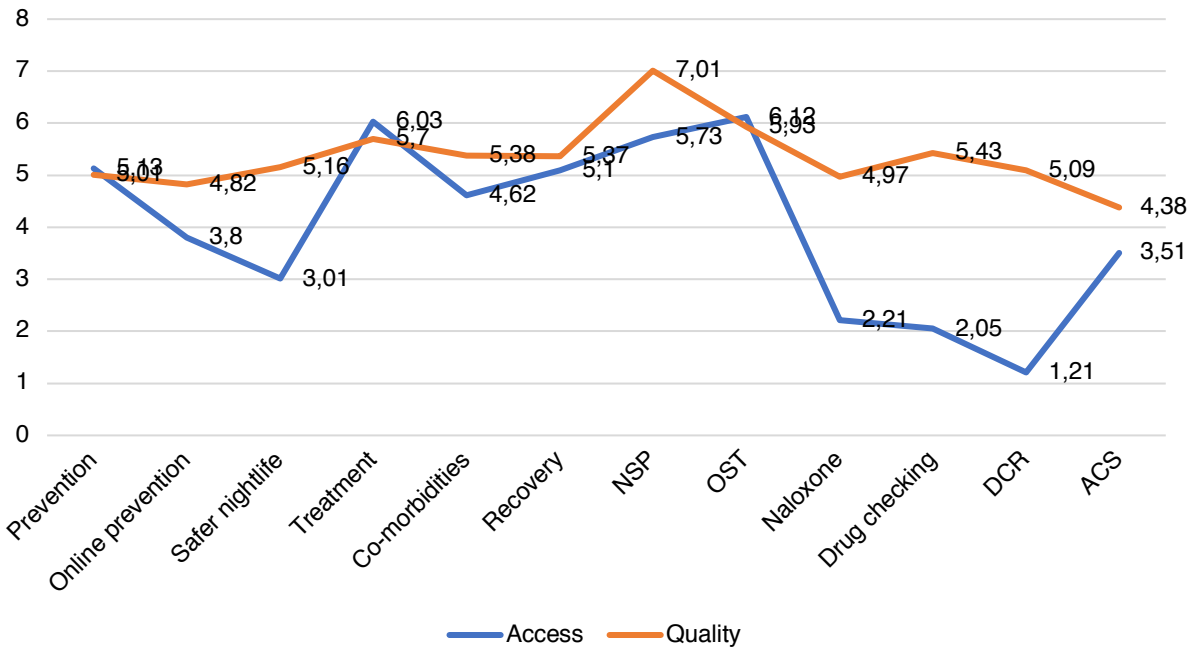


None of the examined services was evaluated as having low quality. The quality of NSPs was evaluated as high (7.10) and all the remaining services were rated as having moderate quality, with two of them being very close to "moderately high" threshold and further five crossing the rate of "5": OST (5.93), treatment (5.75), drug checking (5.43), treating comorbidities (5.38), recovery (5.37), safer nightlife programs (5.16), DCR (5.09), prevention (5.01), naloxone distribution (4.97), online prevention (4.82), alternatives to coercive sanctions (4.38).

If we compare how access to and quality of services was perceived by professionals in Europe, we will see that while in some types of services access and quality are evaluated at similar level (e.g. prevention, treatment, OST), while in case of some other services there is a large gap between perceived accessibility and quality (e.g. safer

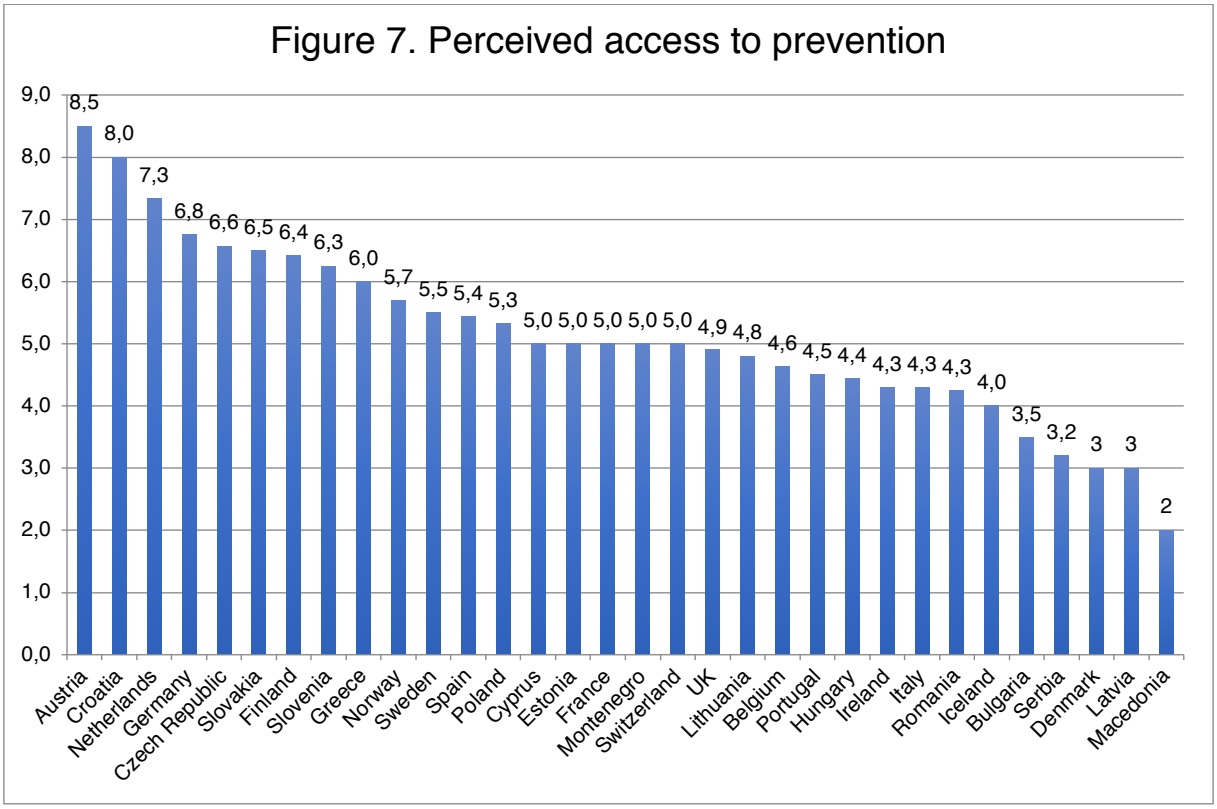
nightlife programs, drug-checking, DCR). Interestingly, instances where the access to services is significantly higher than their quality are not present in our data. The gaps always indicate higher rating of quality and lower of accessibility. Moreover, these instances are visible especially in cases of newer and more controversial types of services/responses. This may suggest that over time, given constant learning and aiming for improvement, the quality of these services will further increase, widening the gap even more, unless more favourable environment for establishing such responses will be created. We can also conclude that these services are highly professional yet not yet accepted by public opinion/policy makers (low accessibility suggests low political support and financing but on the other hand it may also suggest lack of professionals willing to deliver them).

Figure 6. Perception of access to and quality of services

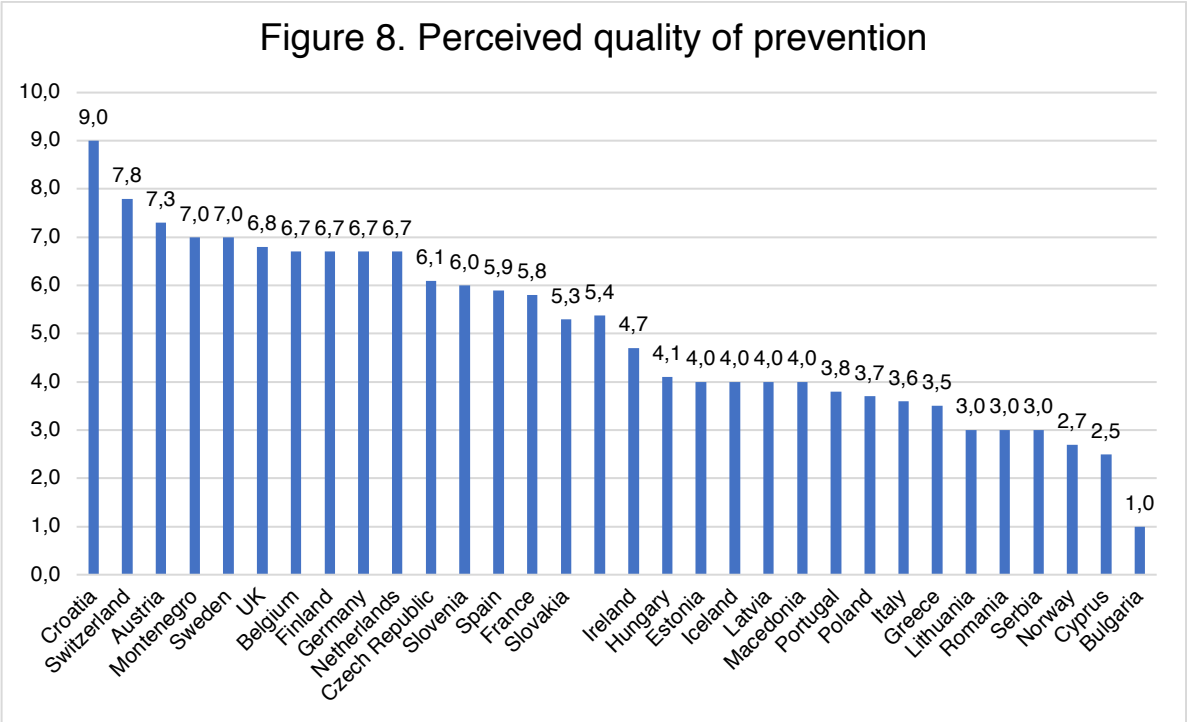


4.1. Prevention (Action Plan 1.1-5)

Drug prevention programs were rated by NGO professionals as the fourth most accessible type of intervention in the field of drug policy with an average rate of 5.13. Access to prevention was perceived rather high (5 or more) in 18 countries, with Croatia, Austria and the Netherlands having high ($x \geq 7$) perceived accessibility of prevention, and relatively high ($x \geq 6$) results of Germany, Czech Republic, Slovakia, Finland, Slovenia and Greece. Low accessibility was reported in Bulgaria, Serbia, Denmark and Latvia (between 3,5 and 3) and the lowest in Macedonia (2).



The quality of prevention was perceived very high or high (x≥7) in five countries: Croatia, Switzerland, Austria, Montenegro and Sweden. Relatively high (x≥6) results were reported in seven countries and moderate results (4≤x<6) in ten. Also, ten countries have low or very low perceived quality of prevention, with Norway, Cyprus and Bulgaria closing the list with ratings below 3[1].



1 The data on quality is not available for Denmark in case of all examined services.

If we look at the differences between perceived accessibility and quality of prevention, we can observe the largest differences in favour of quality in Switzerland (2.8) and Belgium (2.1). Further four counties are characterised by differences larger than 1 and smaller/equal 2 (Montenegro 2.0, Macedonia 2.0, UK 1.9, Sweden 1.5). In all but one abovementioned countries, we can observe moderate accessibility and high quality. In Macedonia, in turn, very low access and moderate quality were reported.

The largest differences and in favour of accessibility we can find in Norway (3.0), Greece (2.5), Cyprus (2.5) and Bulgaria (2.5), while the differences between 1 and 2 are features of Poland (1.6), Austria (1.2), Slovakia (1.2) and Romania (1.3). Among them, in Norway, Poland, Cyprus and Romania we can see moderate prevention accessibility and rather low quality. In Slovakia and Greece, we have moderately high accessibility and moderate or low quality, respectively. In Austria – despite the difference – both service aspects are rated as high, while in Bulgaria the access is low and the quality – very low. The smallest differences (x<0.5), i.e. situations where accessibility and quality of prevention are on the same level are observable in countries with moderately high ratings (Germany: 0.1, Finland: 0.3, Slovenia: 0.3), medium ratings (France: 0.1, Hungary 0.3, Ireland: 0.4) as well as rather low ones (Serbia: 0.3). Data analysis suggests the most developed prevention services operate in Croatia, Germany, the Netherlands and Austria (both aspect scores above 6.5) and the least developed in Bulgaria and Serbia (both aspects scores below 4).

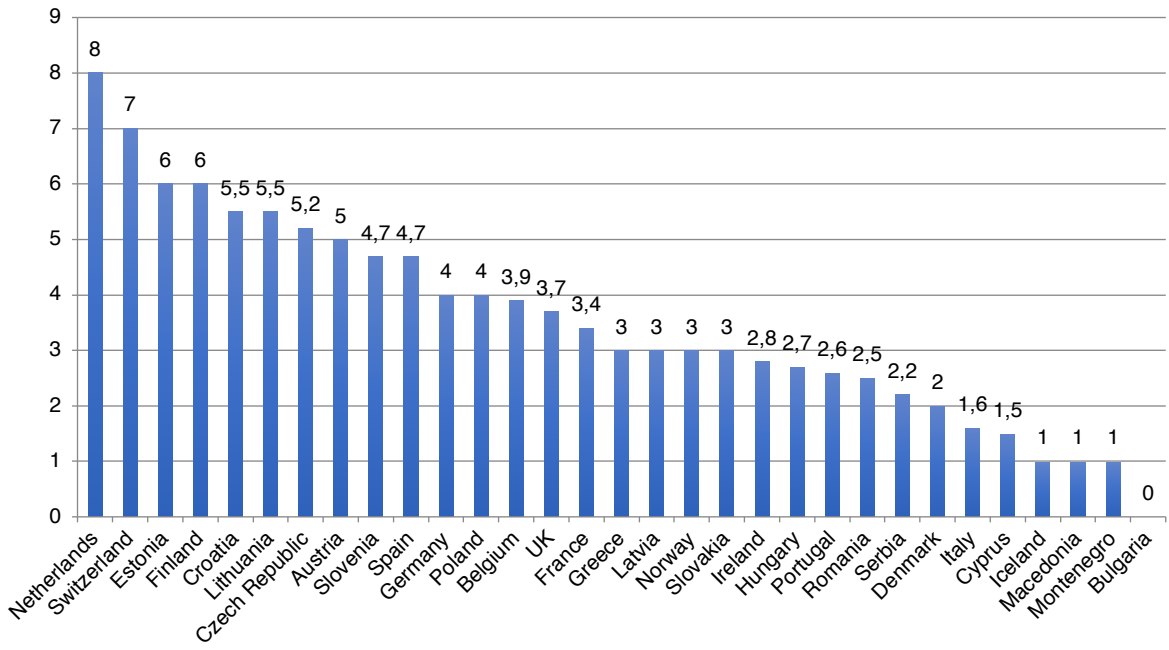
> *"There is a need for quality control for all interventions, school prevention programs are often based on outdated methods such as DARE-type policemen led prevention programs or programs run by the Church of Scientology."*
> *- Hungary*

4.2. Online prevention (Action Plan 1.3)

The internet and social media are playing increasingly important role in human life. This is also true for various activities and measures of educational character, especially in the context of youth. We therefore put special emphasis on online prevention services as one of the crucial platforms of prevention as highlighted by the EU Action Plan. Compared to offline forms of prevention, online drug prevention seems to be not really well-developed in most EU member and candidate states.

43 percent of informed respondents[2] reported equal or higher than 5 access to online prevention programs, as contrasted with over 62 percent in case of "traditional" prevention. Moreover, the ratio of "I don't know" answers was quite high – almost 19 percent (as opposed to over 3 percent in "traditional" prevention category). This suggests that online prevention activities are still in development stage. The highest perceived accessibility was reported in the Netherlands and Switzerland and the lowest in Italy, Cyprus, Iceland, Macedonia, and Montenegro. In Bulgaria complete lack of such services was reported[3].

Figure 9. Perceived access to online prevention

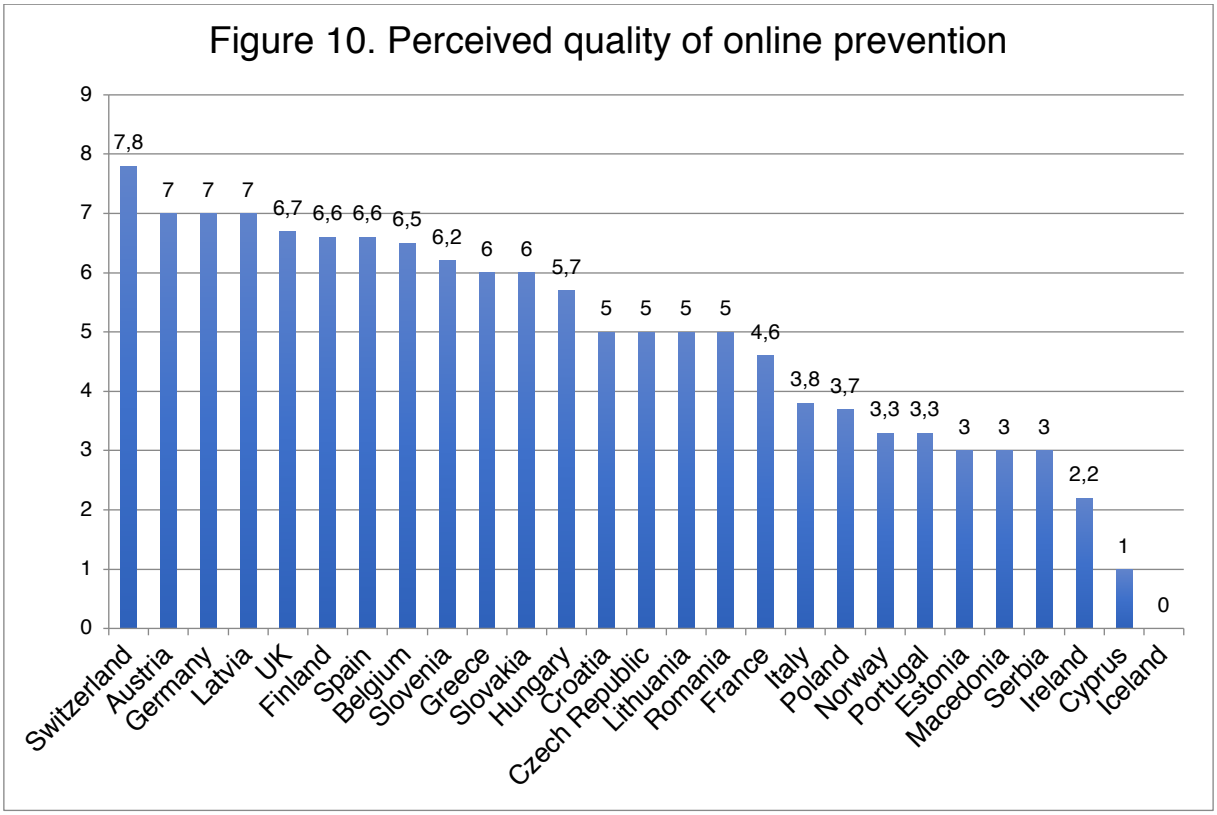


Regarding quality, the data includes 27 countries (data from Denmark, Montenegro, the Netherlands and Sweden are missing[4]. In general, perceived quality is higher than perceived access and was rated on moderate level (4.82) overall. Online prevention quality was rated 5 or above in sixteen countries, with the highest results of Switzerland, Austria, Germany and Latvia. Relatively low quality was reported in eight countries and extremely low in two (Cyprus and Iceland).

2 The ratio was calculated based only on rating responses – "I don't know" responses were not taken into consideration, i.e. the percentage of at least moderate rating = the number of responses 5-10 / the number of responses 0-10. This logic applies to all similar calculations in this report.

3 Data on Sweden is missing.

4 Bulgaria is also excluded from the list due to reported "0" access. In such case, quality category is not applicable. Such logic follows throughout the report. Moreover, in the data processing we have excluded answers regarding the quality in case of respondents who reported "0" access. The reason for that is simple: we want to examine the quality of existing services and including "0" ratings of quality from respondents who rated accessibility "0" would distort the picture.



A look at the differences in ratings between the accessibility and quality of online prevention services in examined countries reveals very large gaps between the two, although a large difference (x>1) in favour of accessibility can be identified only in Estonia (3.0), where the access is rated relatively high and the quality low. Cases where quality was evaluated significantly higher than accessibility include: with moderate accessibility and high quality Germany (3.0), UK (3.0), Belgium (2.6) and Austria (2.0); with low access and moderate or high quality Latvia (4.0), Greece (3.0), Slovakia (3.0), Hungary (3.0) and Romania (2.5), and with very low access and low quality Italy (2.2) and Macedonia (2.0).

The smallest differences were reported in Czech Republic (0.2), Norway (0.3), and Poland (0.3). The data shows that the overall best online prevention services can be found in Switzerland and Finland (both accessibility and quality equal or above 6) and the least developed in Cyprus, Iceland, Macedonia, and Bulgaria (accessibility below 2, quality below or equal 3)[5].

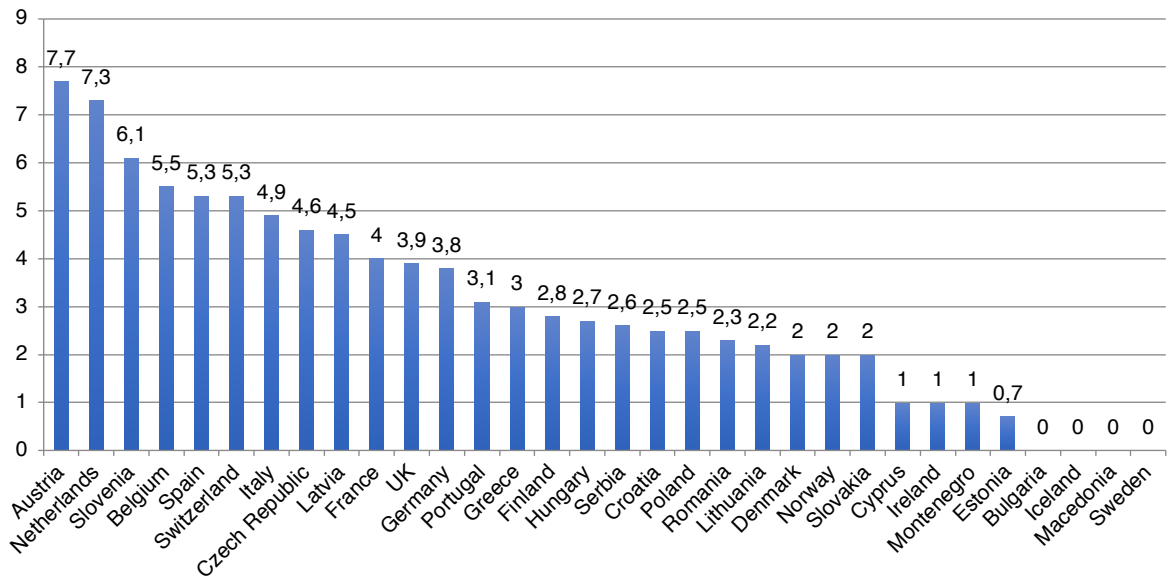
5 There is no data for the quality of online prevention for: Sweden, the Netherlands, Denmark and Montenegro.

4.3. Safer nightlife programs (Action Plan 1.1.b; 2.8)

Some pioneer safer nightlife strategies and programs, including mostly peer-driven interventions, have already been implemented in Europe in the 1990s. A thematic paper published by the EMCDDA - Responding to drug use and related problems in recreational settings (2012) - describes prevention, harm reduction and law enforcement interventions addressing specific risk factors in the nightlife scene. The Action Plan aims to "improve availability and effectiveness" of safer nightlife programs.

In our survey, 37 percent of respondents reported the access to nightlife services to be at the level of five or above. However, the access is perceived high only in Austria (7.7) and the Netherlands (7.3) and relatively high in Slovenia (6.1). On the other hand, there are eleven countries reporting low access (x<4), seven reporting very low access (x≤2), and four countries reporting no access at all (Bulgaria, Iceland, Macedonia, Sweden).

Figure 11. Perceived access to safer nightlife programs

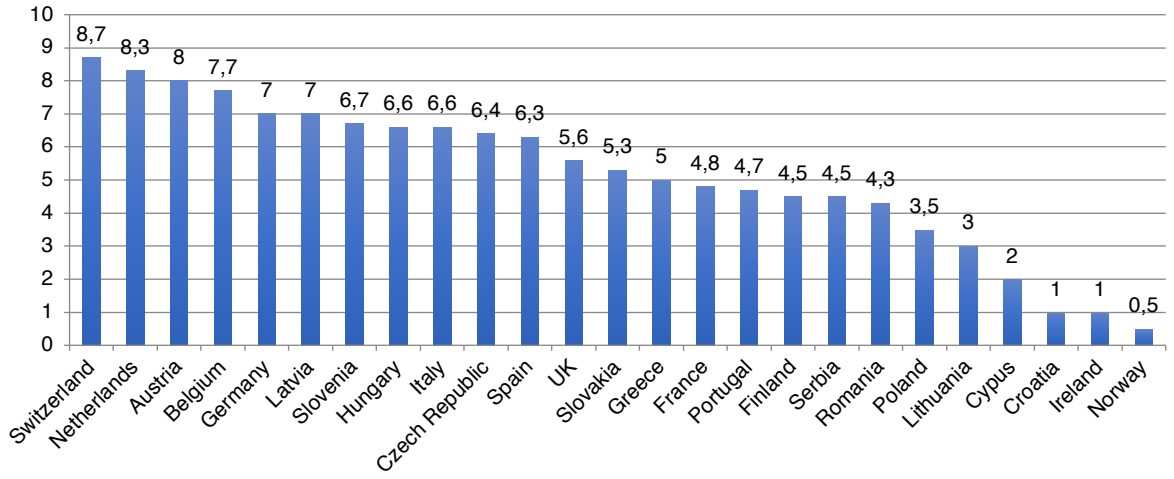


With the respect to quality, the situation looks much more promising[6]. We still have quite a few countries where the quality of nightlife services is perceived very low (x≤1, Croatia, Cyprus, Ireland, Norway) but on the other hand, there are eleven countries where it was rated from very to moderately high. Interestingly, all countries with low or very low scores on quality (Poland, Lithuania, Cyprus, Croatia, Ireland and Norway, scores from 0.5 to 3.5) have also low or very low perceived accessibility (from 1.0 to 2.5), which indicates embryonic stage of services development.

6 The data on quality for Montenegro, Estonia and Denmark is missing.

It may, however, also suggest somewhat problematic data reliability in these specific cases: it is certainly very challenging to assess the quality of services that are highly scarce. On the other hand, in both examined dimensions among five best rated countries we can find Austria, The Netherlands, Belgium and Switzerland, which indicates high level of development of safer nightlife services.

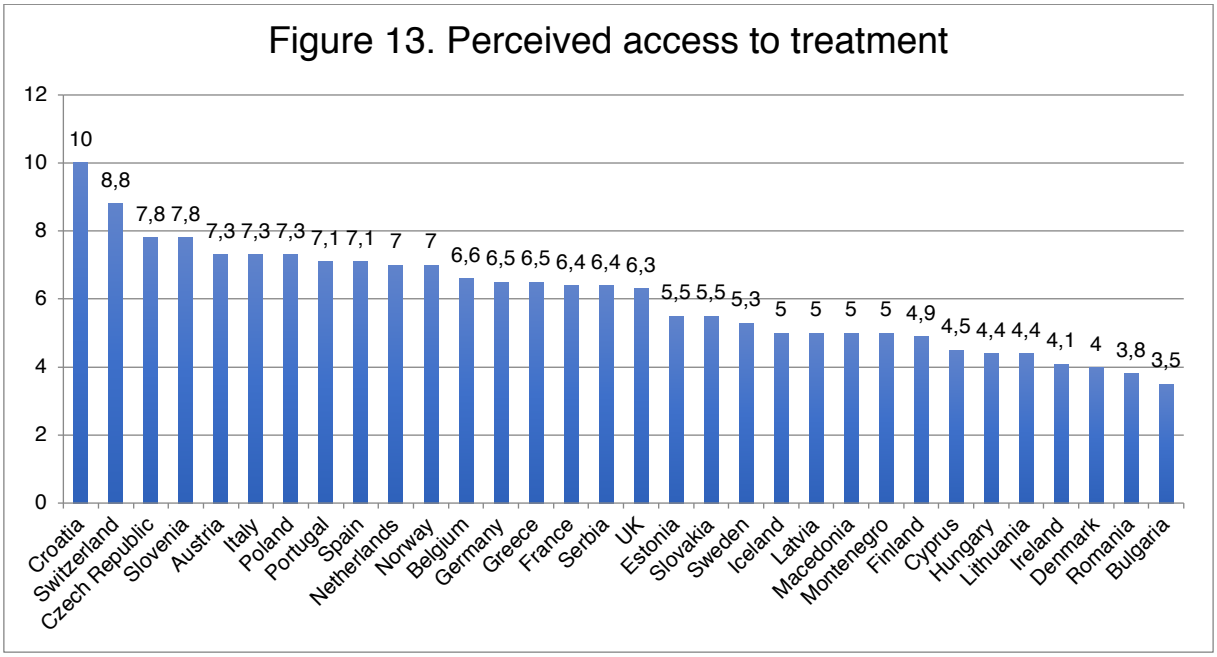
Figure 12. Perceived quality of safer nightlife programs



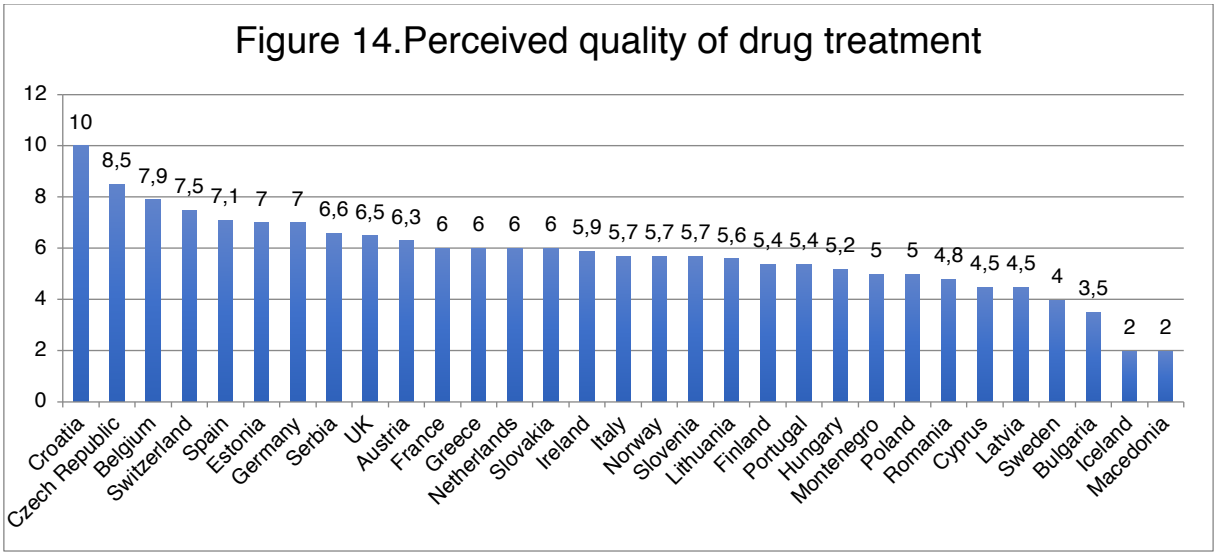
There are eight countries where nightlife services are perceived to be of better quality than accessibility by 2 or more points. The highest advantage of quality over access can be observed in Hungary (3.9 – low access and relatively high quality), Switzerland (3.4 – moderate access and high quality), Slovakia (3.3 – very low access and moderate quality), Germany (3.2), Latvia (2.5) and Belgium (2.2) – with the three latter having reported moderate access and high quality. The only differences in favour of accessibility occurs in Croatia (1.5) and Norway (1.5). In case of Ireland, in turn, there are equally low (1.0) results for both categories. Overall, the best services can be found in Austria, the Netherlands and Slovenia (both aspects rated above 6) and the least developed – but reported existing – in Norway, Cyprus, and Ireland (accessibility equal or lower than 2 but larger than 0 and quality equal or lower than 2).

4.4. Drug treatment (Action Plan 2.6-7)

In all but two (Bulgaria and Romania) examined countries, the access to drug treatment was perceived as at least moderate ($x \geq 4$). Over a half of our respondents rated the accessibility to this type of services as high ($x \geq 7$) in their countries, while further 37 percent as moderate ($6 \geq x \geq 4$). This translates to eleven countries having high or very high accessibility, six of moderately high, and thirteen countries reporting moderate access to treatment. In Bulgaria and Romania respondents evaluated the accessibility to treatment as low ($x < 4$).



With respect to the quality of drug treatment, 24 countries received scores 5 or higher. High (x≥7) quality of treatment can be observed in (in an ascending order): Germany, Estonia, Spain, Switzerland, Belgium, Czech Republic and Croatia. Moreover, low perceived quality was reported only in Bulgaria, Macedonia and Iceland. It is quite clear that in case of treatment the differences between countries are much smaller than in case of some other services (e.g. safer nightlife). Indeed, it comes without a surprise since treatment is one of the most widely accepted and recognised responses to drug problem globally and has a long tradition in most (if not all) examined countries.



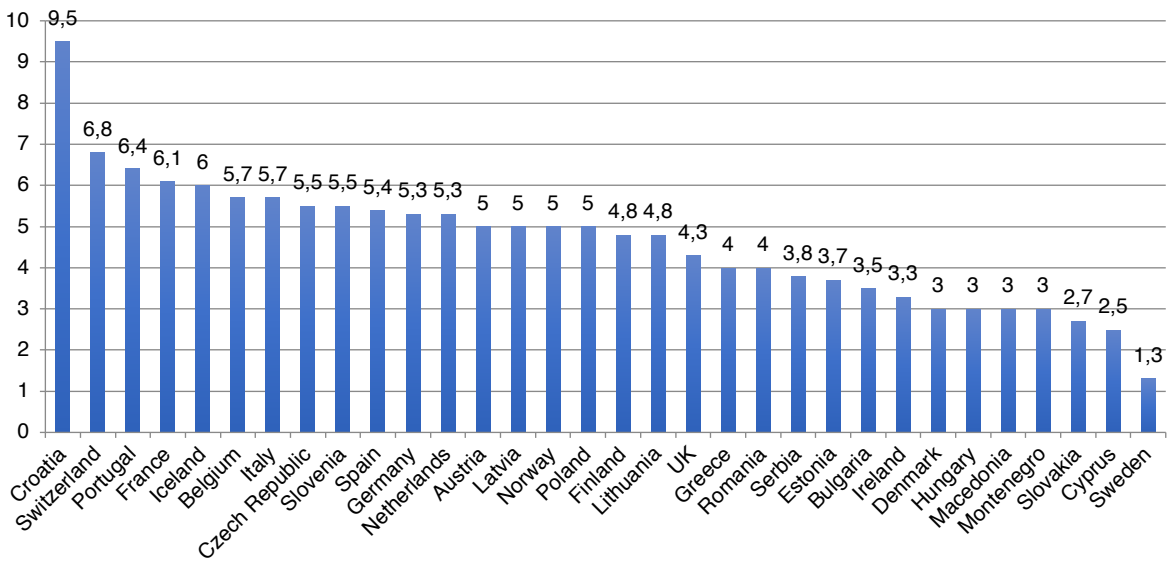
"Treatment, rehabilitation and prevention programs are not covered by the health insurance, patients have to pay. Only detoxification is free of charge in psychiatric clinics."
- Bulgaria

Comparing the two aspects, we can see that there are four countries where perceived access to treatment is significantly better than its quality: Macedonia (3.0), Iceland (3.0) Poland (2.3) and Slovenia (2.1). On the other hand, cases where quality of treatment was rated higher than accessibility include much smaller differences, with the largest ones in Ireland (1.8), Estonia (1.5), Belgium (1.3) and Lithuania (1.2). Overall, we can identify a group of countries where the treatment services are very well-developed (both examined aspects rated 7 or above): Croatia, Switzerland, Czech Republic and Spain. The only country where both accessibility and quality of treatment were rated low (below 4) is Bulgaria.

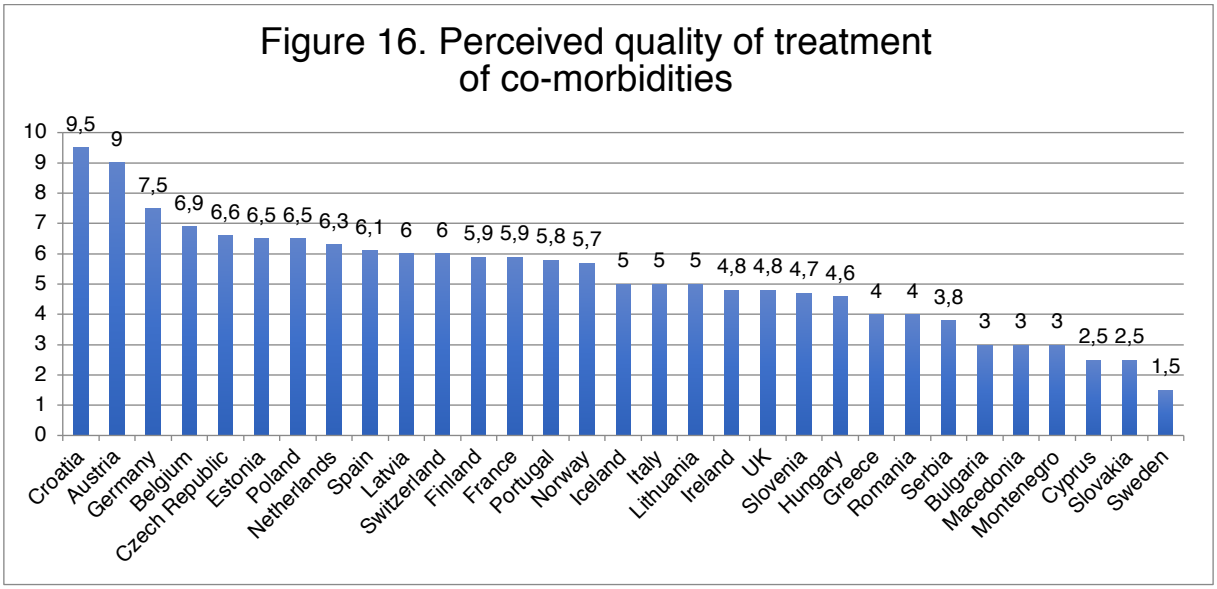
4.5. Treating co-morbidities (Action Plan 2.7.c)

A report published by the EMCDDA in 2015 - Comorbidity of substance use and mental disorders in Europe - points out that "the relevance of the comorbidity of mental disorders in substance users is related to its high prevalence, its clinical and social severity, its difficult management and its association with poor outcomes for the subjects affected." The EU Action Plan on Drugs, in line with earlier civil society recommendations, requests member states "to strengthen the diagnostic process and the treatment of psychiatric and physical co- morbidity involving drug use." In our survey, fifty-nine percent of respondents reported the access to treating comorbidities on the level 5 or more, which translates to sixteen countries. The access was rated as exceptionally high in Croatia, and the lowest in Sweden.

Figure 15. Perceived access to treatment of co-morbidities



If we talk about the other aspect, three countries (Croatia, Austria and Germany) were rated as having high (x≥7) quality of treating comorbidities, while in further ten countries it was perceived as moderately high (x≥6). Low quality (x<4) was reported in Serbia, Bulgaria, Macedonia, Montenegro, Cyprus and Slovakia, and very low quality was reported in Sweden (1.5).

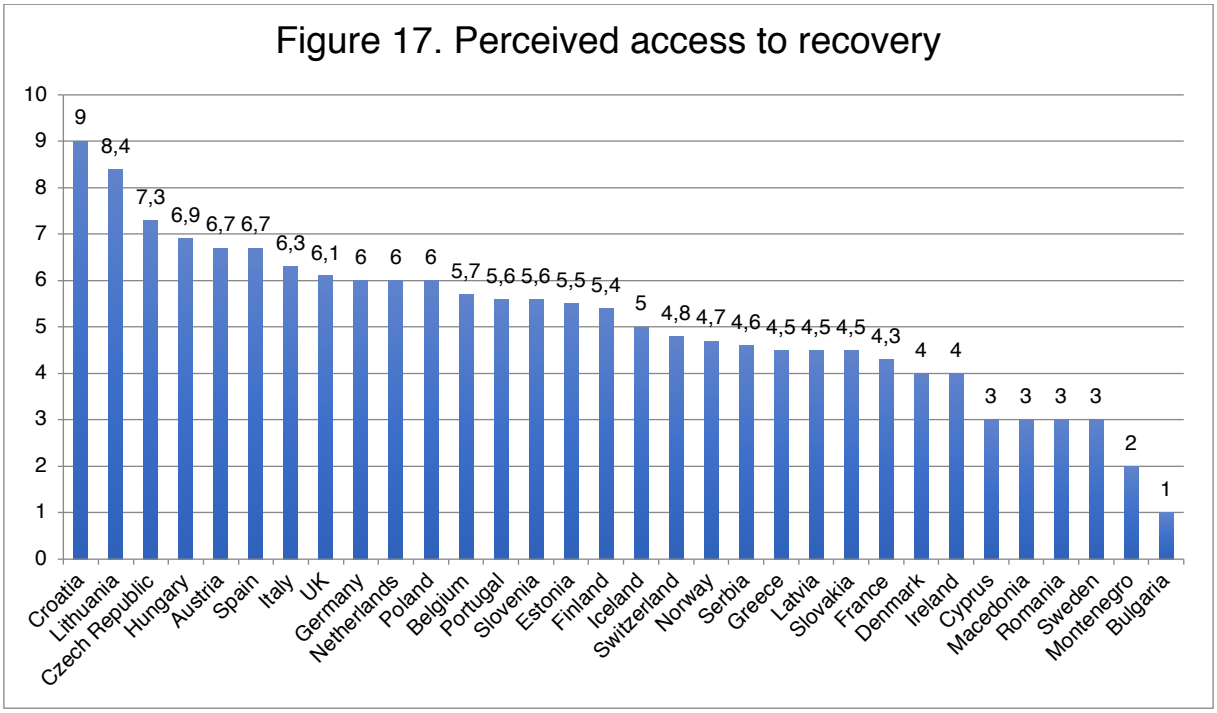


In this category, there are no countries where accessibility would be rated significantly higher (more than 1-point difference) than quality. On the other hand, quality of examined services was rated significantly higher (more than 2-point difference) than access in five countries: Austria (4.0), Estonia (2.8), Ireland (2.5), Slovakia (2.3) and Germany (2.2) and between 1 and 2 in eight more. Overall, the best treatment of comorbidities was reported in Croatia, Switzerland, Portugal, France and Iceland (accessibility of at least 6 and quality of at least 5). Cyprus and Sweden close the list with both services aspects rated below 3.

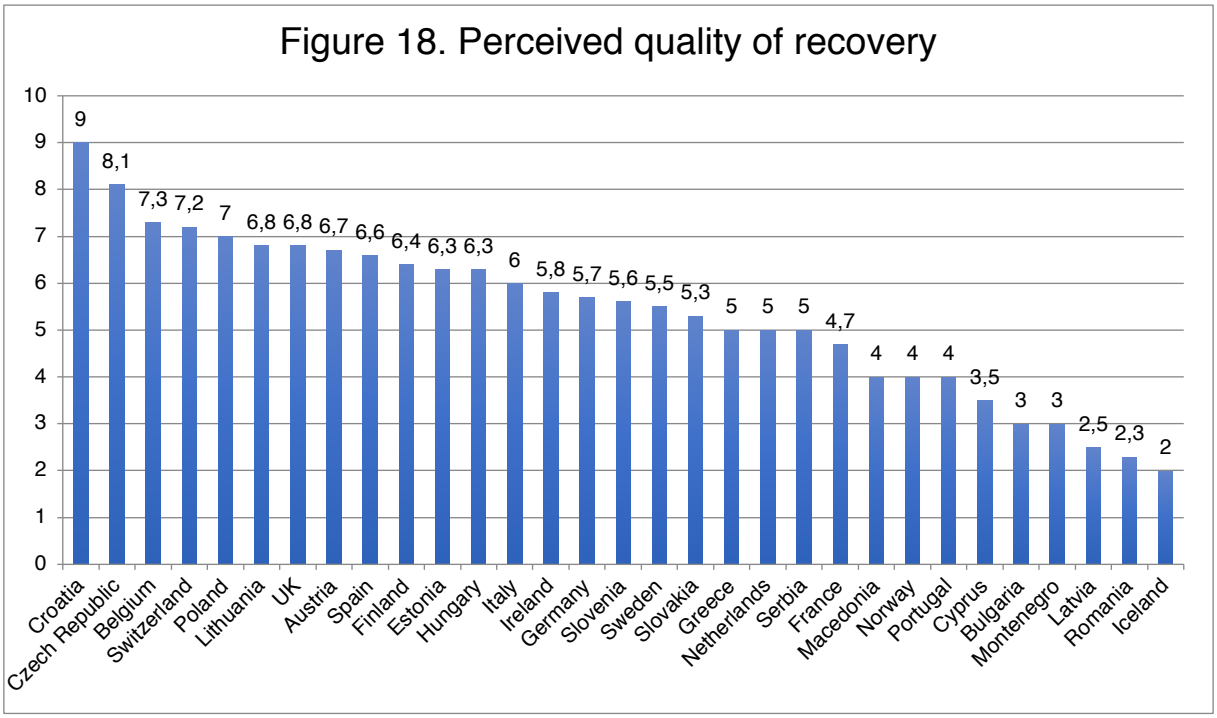
4.6. Recovery/Social rehabilitation (Action Plan 2.7)

The EU Action Plan on Drugs requests member states to expand the provision of rehabilitation/reintegration and recovery services. According to our data, recovery services are relatively common in almost all member states, with 54 percent of the respondents reporting moderately high or high (x≥6) coverage of these services. The mean rating is equal or higher than 5 in seventeen countries, while low or very low accessibility (x<4) is observable in six countries.

> *"There is a need to step up with the recovery plan and social responsibilities." - UK*



Quality of recovery services was rated even higher than the access to them, with 62 percent of respondents rating it 6 or higher, which translates to thirteen countries. In further twelve countries the quality is perceived as moderate (6>x≥4) and in 6 countries as low (x<4). The best quality was reported in Croatia, Czech Republic, Belgium, Switzerland and Poland, and the poorest in Latvia, Romania and Iceland.



The biggest differences in ratings of the two aspects in favour of accessibility occur in Iceland (3.0), Latvia (2.0), Lithuania (1.6) and Portugal (1.6). In turn, quality was rated significantly higher than accessibility Sweden (2.5), Switzerland (2.4), Bulgaria (2.0),

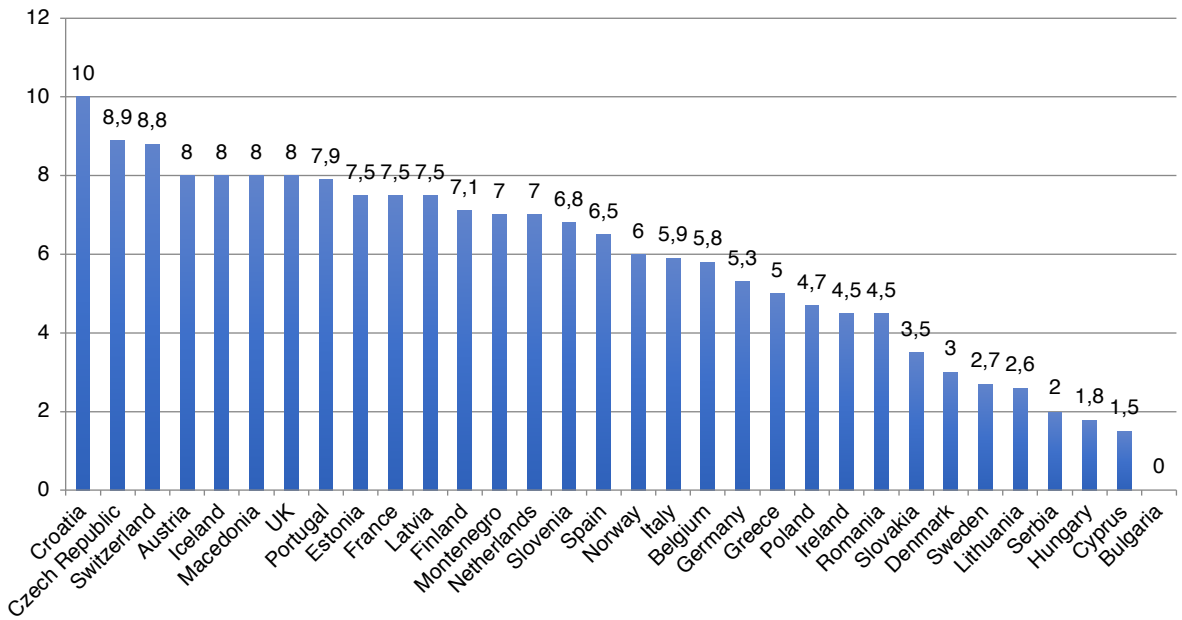
Ireland (1.8) and Belgium (1.6). The ratings for accessibility and quality are identical (0-point difference) in Croatia, Austria and Slovenia. In sum, the best perceived services (accessibility larger than 7 and quality larger than 6) are functioning in Croatia, Lithuania and Czech Republic, while the worst perceived situation (both aspects of 3 or lower) occurs in Romania, Montenegro and Bulgaria.

> *"Social reintegration has to be made more accessible, which presupposes a concentrated effort on the State's part to fight stigma, discrimination and ostracism around drug use and addiction." - Latvia*

4.7. Needle and syringe programs (8.a)

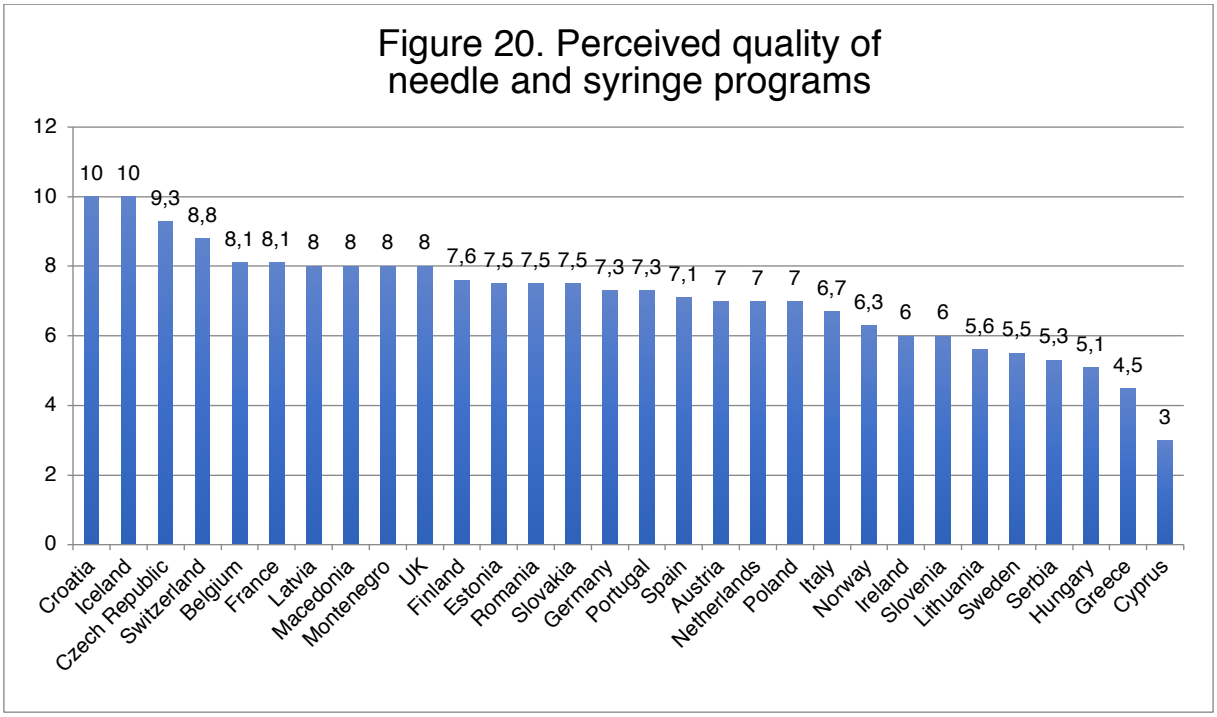
Scaling up availability, coverage and access to needle and syringe programs (NSPs) is part of the new EU Action Plan on Drugs, including indicators based on the WHO recommendations on the comprehensive package of health services for people who inject drugs (that is, member states are required to reach 200 sterile needles per injecting drug user per year coverage). NSPs are quite common services in Europe: respondents from seventeen countries reported relatively high or high accessibility (x≥6), while low rates (less than 4) were reported only from seven countries. No access to NSP was reported from Bulgaria and full access was reported from Croatia.

Figure 19. Perceived access to needle and syringe programs



"Indicators need to be highly specific, and not generalised. For example, there is arguably good coverage of NSP in Ireland; however, many NSP services do not carry the full range of equipment, meaning that PWID may not always be able to access the appropriate equipment for their needs." - Ireland

Quality of services is perceived as very high (x>8.5) in Croatia, Iceland, Czech Republic and Switzerland. Further sixteen counties scored 7 or more (high quality) and 4 countries have reported moderately high quality (7>x≥6). Only in Cyprus the quality is perceived as low.

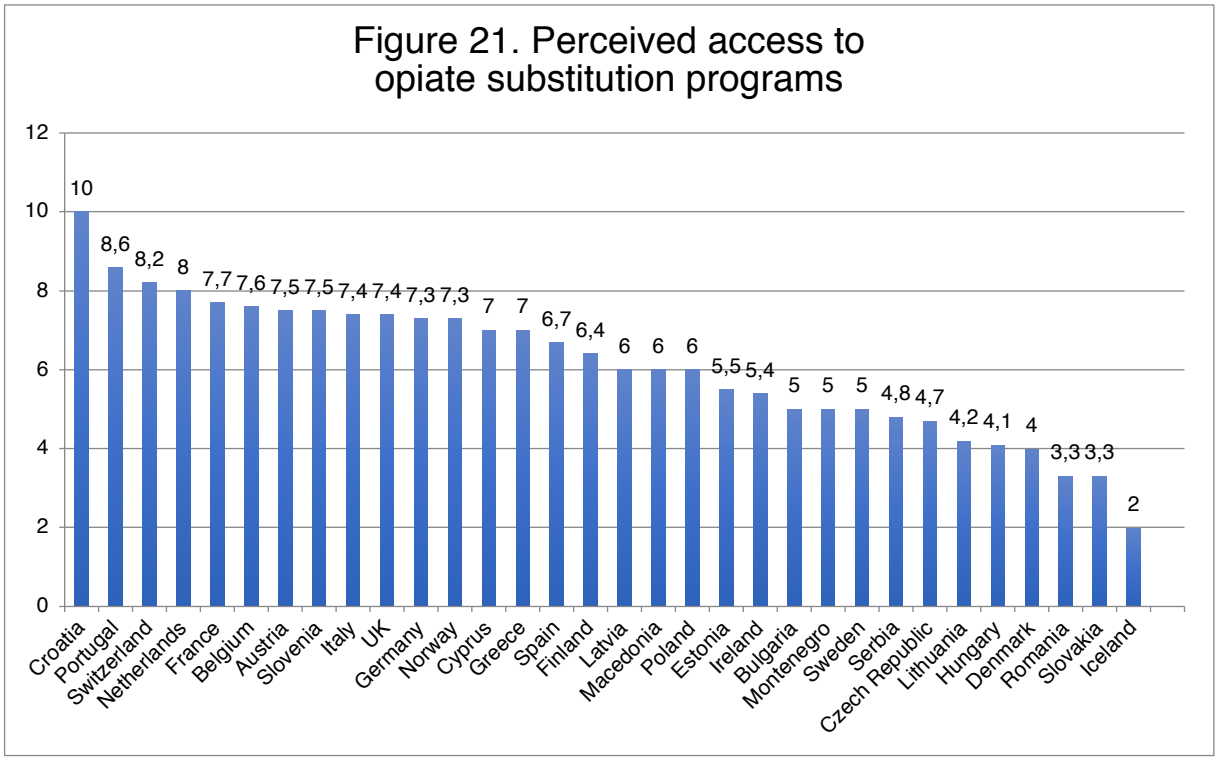


Only in four countries was NSP accessibility rated higher than its quality and the largest difference can be found in Austria (1.0). It is thus clear that overall, we have good quality services with insufficient coverage. Interestingly, with an exception of Cyprus, in all countries reporting low accessibility of NSP (x<4) their quality was rated significantly higher (x>5). This group consists of: Slovakia (difference of 4.0), Hungary (3.3), Serbia (3.3), Lithuania (3.0), and Sweden (2.8).

"The new EU action plan includes a much stronger focus on harm reduction, but more needs to be done to reflect this change at national level ... harm reduction is in crisis in a number of EU states including Romania, Bulgaria, Hungary, Greece and Poland, with government funding for harm reduction in these countries falling far short of what is needed." - international organisation

4.8. Opiate substitution treatment (Action Plan 8.a)

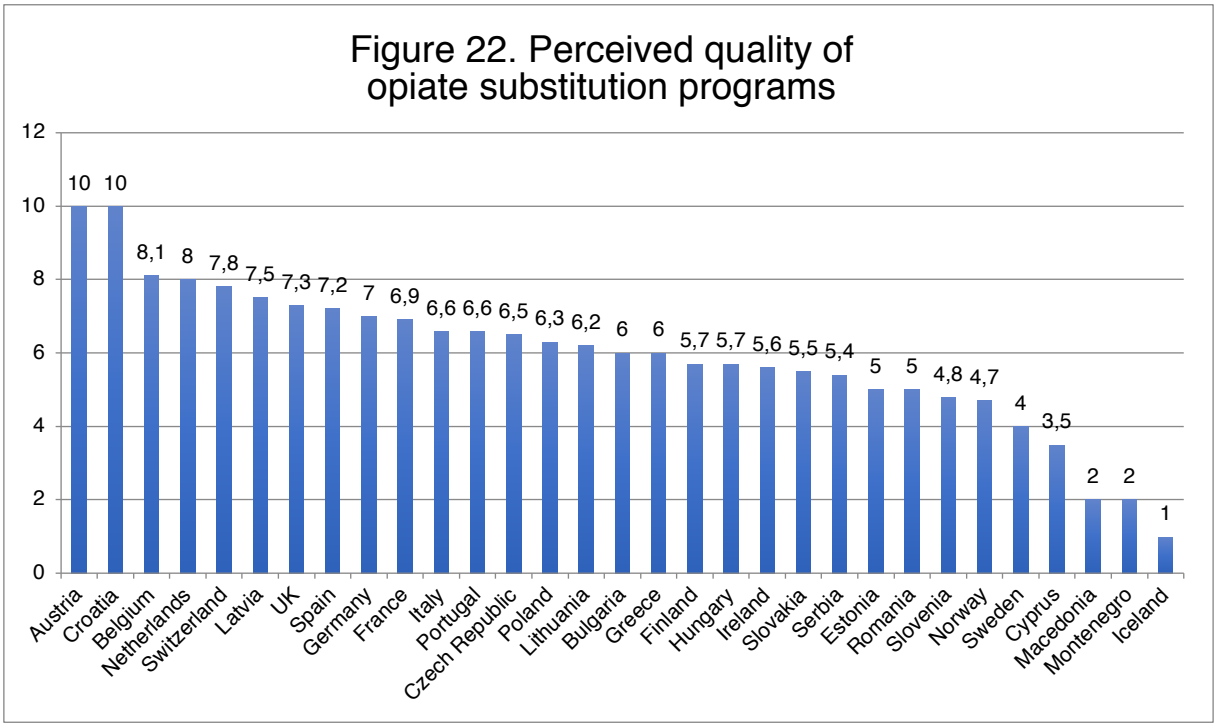
Opiate substitution treatment is one of the most common form of treating opioid dependence in Europe. The Action Plan calls member states to scale up access to these services, in accordance with the WHO recommendation on the comprehensive package of health services for people who inject drugs. According to our data, very high to moderately high access to OST occurs in nineteen countries (with the highest perceived accessibility in Croatia, Portugal, Switzerland and the Netherlands), while low accessibility (x<4) was reported only for Romania, Slovakia and Iceland.



Low quality of OST (x<4) was reported only in four countries: Cyprus, Macedonia, Montenegro and Iceland and in most of them it was actually assessed as very low (ratings 1 or 2). On the other hand, at least moderately high quality (x≥6) was reported in seventeen countries, with Austria and Croatia perceived as having excellent quality of OST (10).

"Civil society needs more state funding, for harm reduction too, more frequent calls for submission on specific grants and a tighter follow up with financed projects." - Austria

"Think more about the real needs and circumstances of the people. To involve the people into the design of strategies, projects and programs." - Slovenia

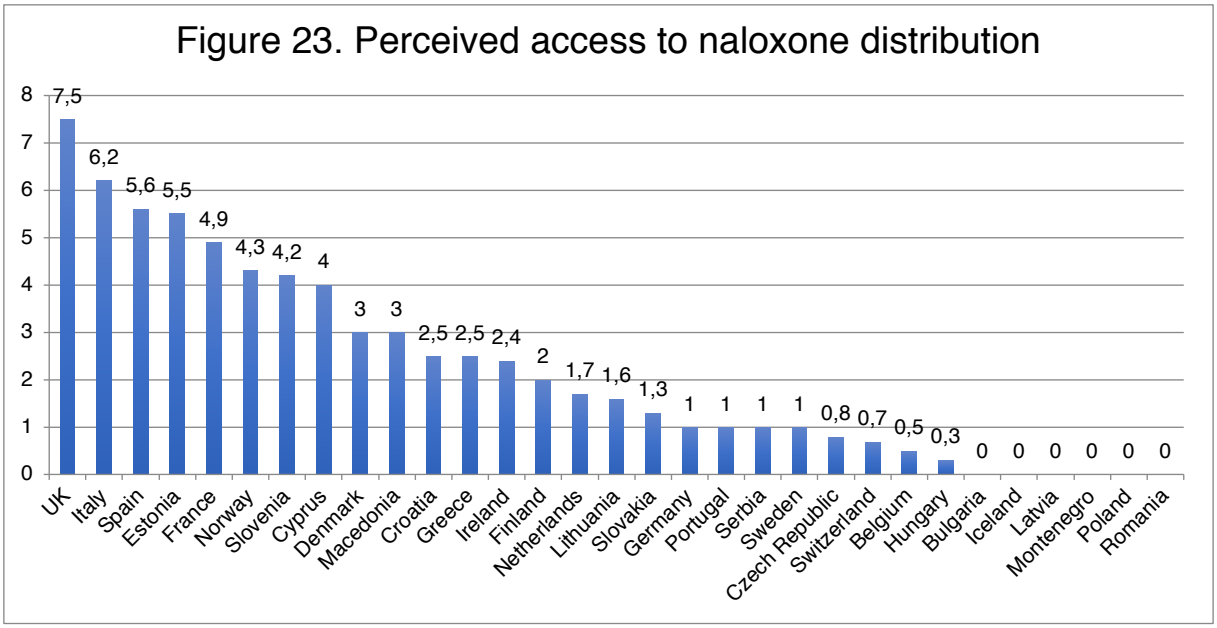


Here, contrary to NSPs, service accessibility was usually rated higher than its quality. The highest differences in favour of accessibility of OST can be found in Macedonia (4.0), Cyprus (3.5), Montenegro (3.0), Slovenia (2.7), Norway (2.6) and Portugal (2.0) – quite heterogeneous collection of countries. The highest differences in favour of quality were reported in Austria (2.5), Slovakia (2.2), Czech Republic (1.8), Romania (1.7) and Hungary (1.6). In sum, the perceived most well-developed OST services are functioning in Croatia, Switzerland and the Netherlands (accessibility equal or larger than 8, quality above 7) and the least developed in Iceland (both acpects rated less than or equal 2).

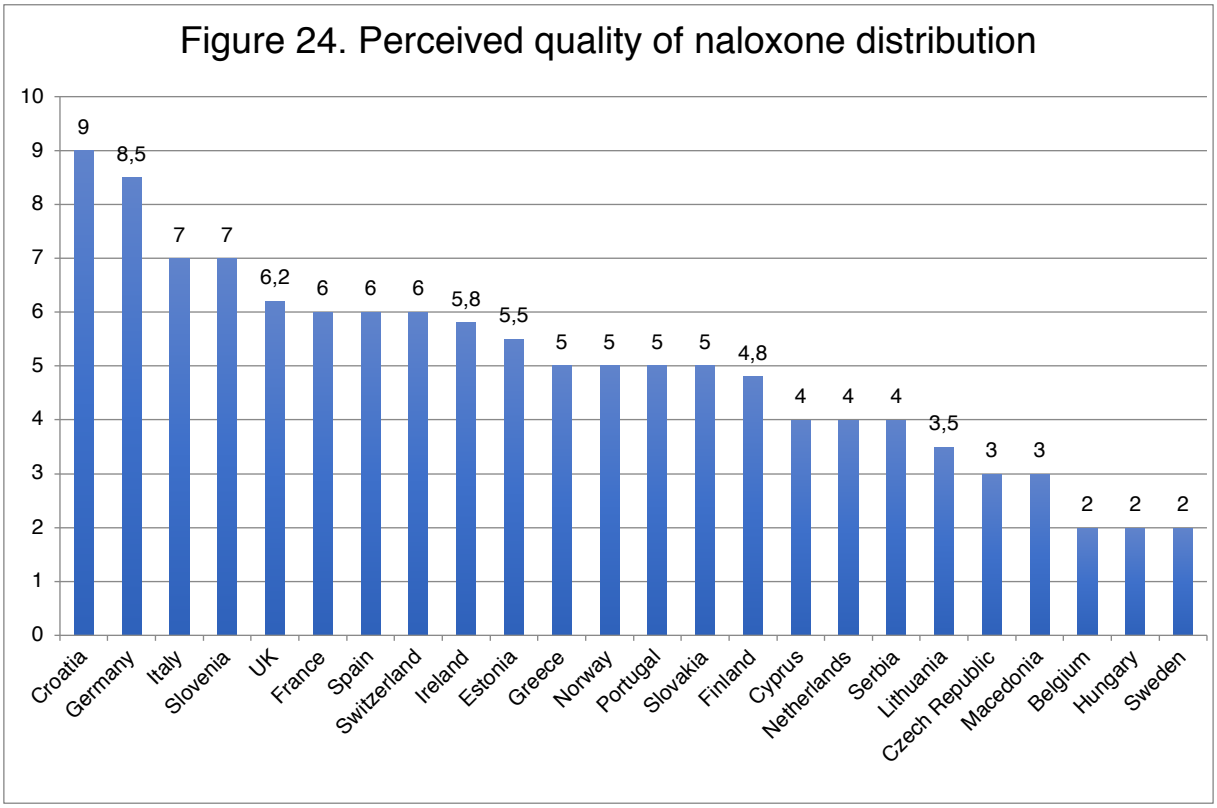
4.9. Naloxone distribution programs (Action Plan 8.b)

According to EMCDDA's report, an estimated 140.000 lives were lost to drug overdose in the past 20 years. Opioid overdose deaths are preventable with harm reduction measures, such as the distribution of take-home naloxone kits (an "antidote" to opioid overdose) among peers and their families. The EU Action Plan calls member states to "better prevent drug related deaths according to national circumstances as for example in the case of opiates, by providing access to authorised pharmaceutical dosage forms of medicinal products containing naloxone specifically certified to treat opioid overdose symptoms by trained laypersons in the absence of medical professionals." However, our data shows that this type of harm reduction service is extremely rare in Europe. High access was reported only in UK (7.5) and moderately high in Italy (6.2). Six further countries are perceived as having moderate access to naloxone $6>x\geq4$.

As many as seventeen countries report low or very low accessibility and six countries no access at all (Bulgaria, Iceland, Latvia, Montenegro, Poland and Romania)[7].



In contrary, the quality of naloxone distribution services is perceived to be significantly higher in many cases. Very high or high perceived quality (x≥7) can be found in Croatia, Germany and Italy and Slovenia and moderately high (x≥6) in UK, France, Spain and Switzerland. Moderate quality is a feature of ten countries and low or very low quality – six.



7 The data for Austria is missing.

"While naloxone is mentioned in the strategy, we know that currently at least 10% of local authorities are not supplying it to high-risk opioid users in their areas, and recent work by drug policy organisation Release showed that naloxone provision was inadequate in the majority of England." - UK

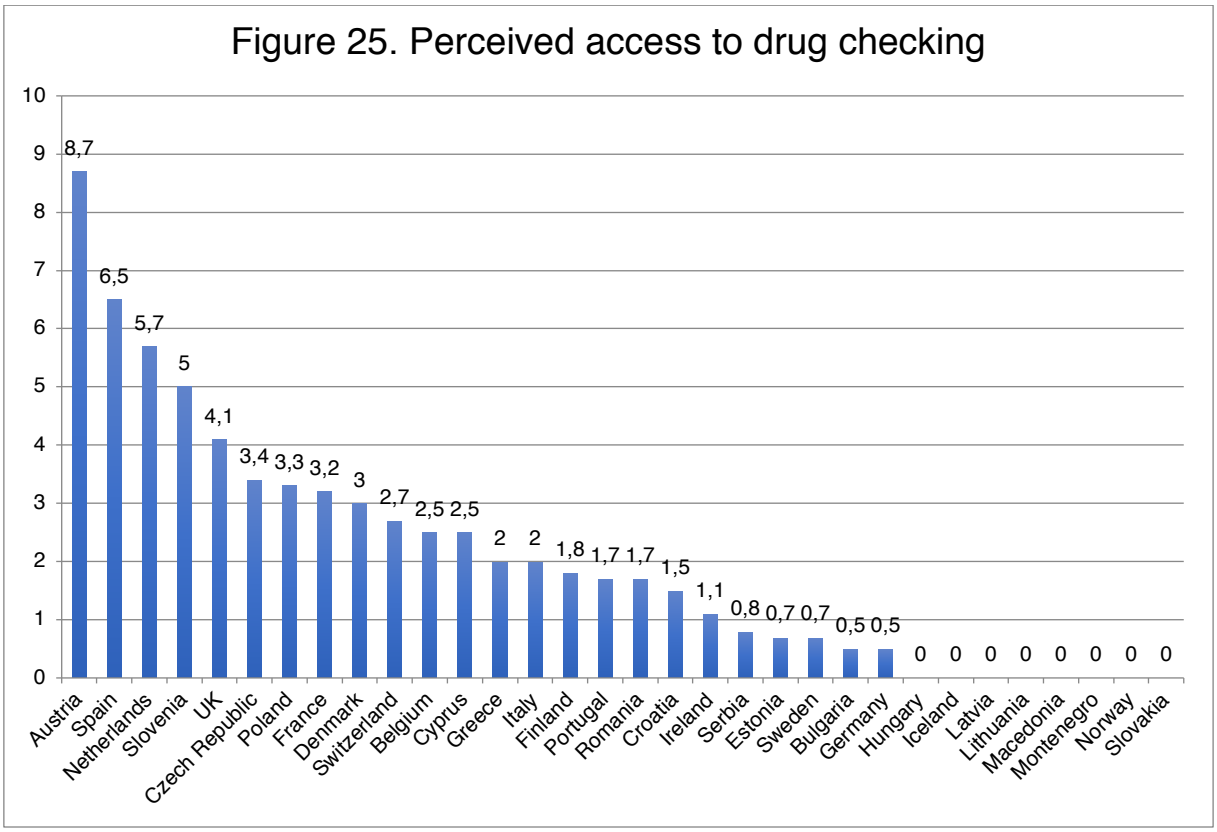
There is only one country where naloxone accessibility is rated higher than its quality: UK (1.3). On the other hand, the ratings favouring quality and exceeding one point of difference can be found in sixteen countries, with the largest differences in Germany (extreme 7.5 points), Croatia (6.5), Switzerland (5.3) and Portugal (4.0). Overall, we can distinguish a group of countries with relatively well-developed naloxone services where both aspects exceed „5" rate (UK, Italy, Spain and Estonia) and slightly larger group of countries, where they are in an embryonic phase with accessibility below 2 but larger than 0 and quality below 4 (Lithuania, Sweden, Czech Republic, Belgium and Hungary). Moreover, we can see quite a few countries with very low access but moderate or high service quality: the Netherlands, Slovakia, Germany, Portugal, Serbia, and Switzerland.

4.10. Drug checking (Action Plan 8.d)

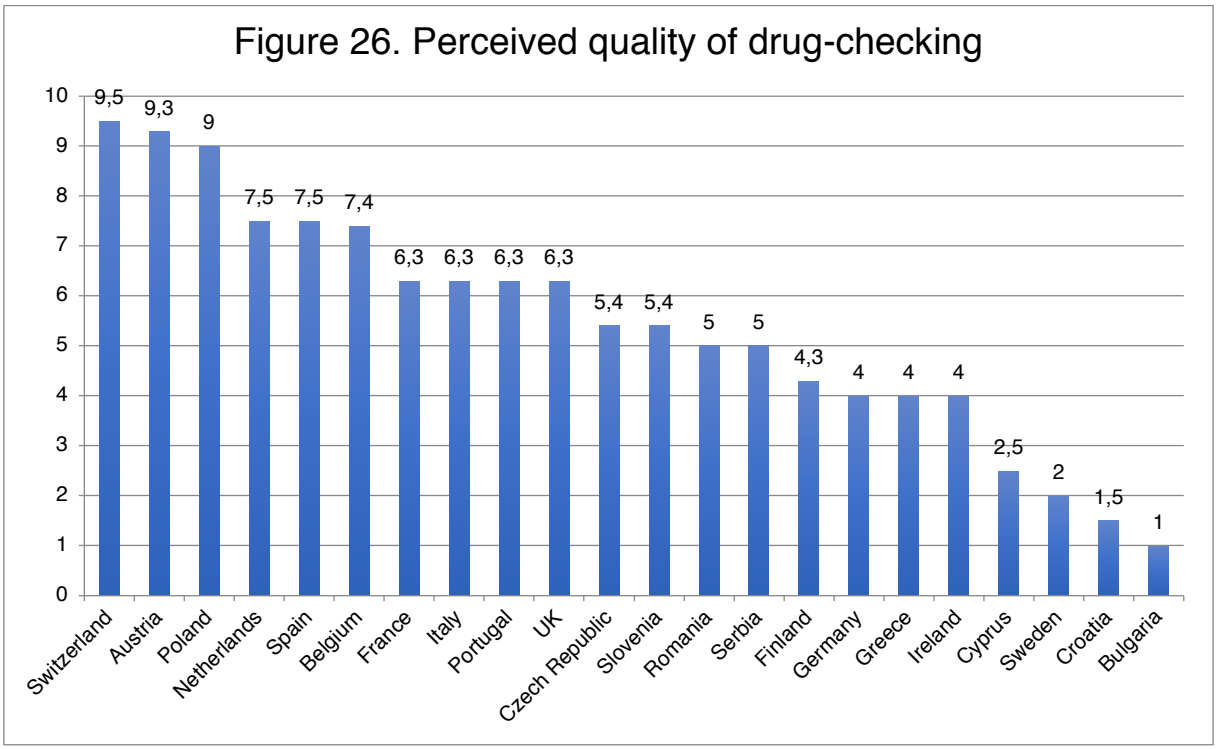
"Destigmatising drug use and lowering the threshold for seeking help for drug related problems is important. Better and quicker access to treatment, implementing harm reduction programmes such as drug checking services and drug consumption rooms [is needed]." - Finland

A number of European countries have implemented drug checking services with the aim of providing targeted preventive messages to recreational drug users. According to the EMCDDA, these interventions can possibly save lives. The Action Plan on Drugs calls member states to exchange information and – where applicable – best practices on pill-testing programs. According to our survey findings, access to drug-testing is very low in Europe, with eight countries reporting zero-access and further twelve very low (x≤2). Only four countries are perceived as having the access of 5 points or higher (Austria, Spain, the Netherlands and Slovenia).

"The government needs to do more harm reduction for MDMA and cannabis, and not only for heavy adult opiate users." - Norway



In contrast to low access, the quality of programs was perceived relatively high or high (x≥6) in ten countries. Low or very low perceived quality of drug-checking is a feature of only four countries (Cyprus, Sweden, Croatia, Bulgaria) and in eight countries drug-checking is perceived as having moderate quality.

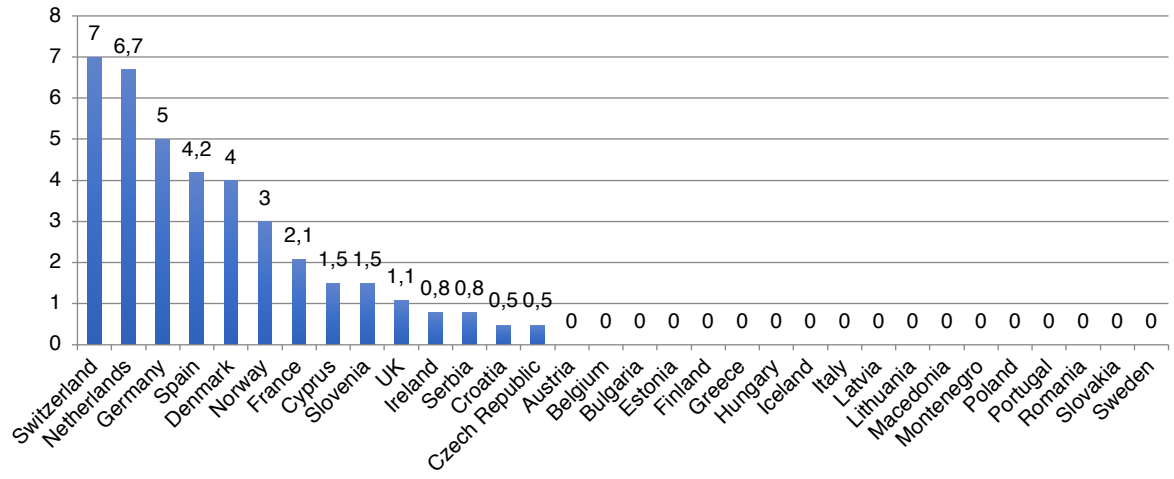


Even more extremely than in the case of NSPs, here we have no country perceived as having higher access to drug-checking than its quality. On the contrary, there are twenty-two countries where quality is perceived to be higher than accessibility, with the highest differences reported in Switzerland (6.8), Poland (5.7), Belgium (4.9), Portugal (4.6), Italy (4.3) and Serbia (4.2). We can thus again speak about good quality services of insufficient coverage. Overall, the situation looks the best in Austria, Spain and the Netherlands (both aspects rated above 5.5) and the worst (including only the countries with reported accessibility) in Croatia, Sweden and Bulgaria where both aspects were rated 2 or below.

4.11. Drug consumption rooms (Action Plan 8.d)

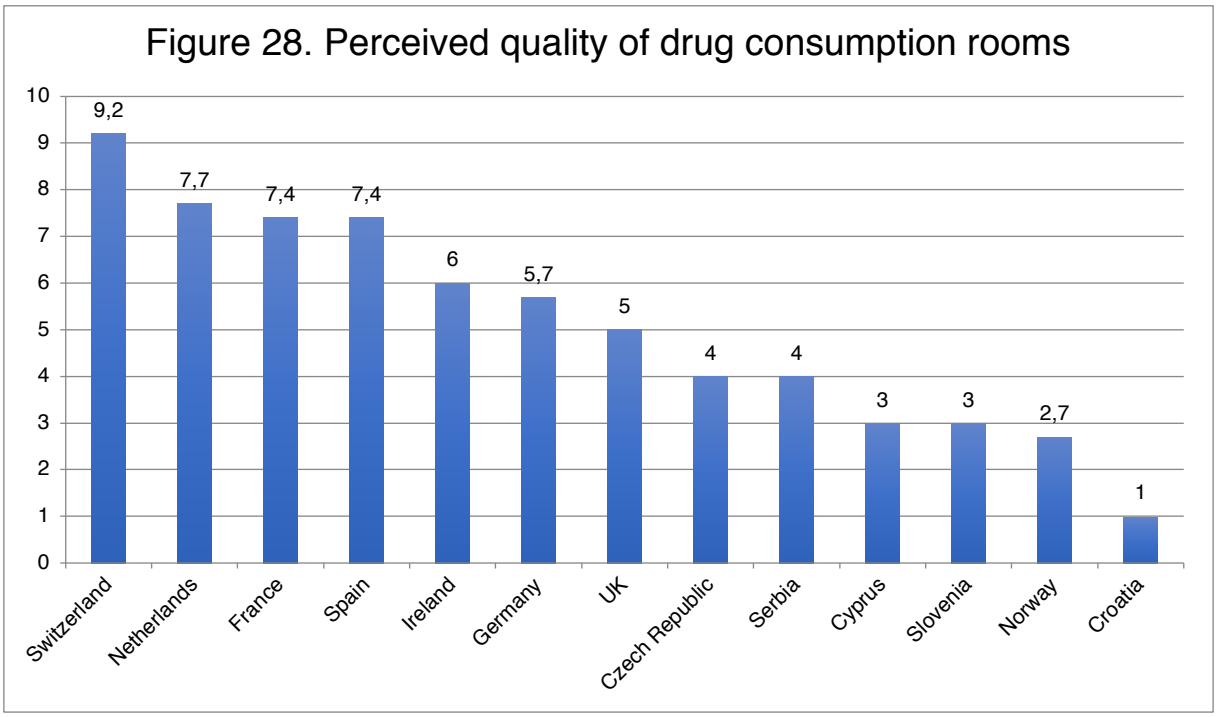
Supervised drug consumption facilities, where illicit drugs can be used under the supervision of trained staff, have been operating in Europe for the last three decades. According to EMCDDA, these facilities primarily aim to reduce the acute risks of disease transmission through unhygienic injecting, prevent drug-related overdose deaths and connect high-risk drug users with addiction treatment and other health and social services. The Action Plan on Drugs calls member states to exchange of information and where applicable best practice on drug consumption rooms. According to our data, this type of services is the least accessible among all examined services in Europe: any access was reported from fourteen states, but in seven of them it is perceived extremely low (rated less than 2).

Figure 27. Perceived access to drug consumption rooms



Reported quality was high in Switzerland, the Netherlands, France and Spain (x≥7) and relatively high in Ireland (x≥6). Moderate quality is a perceived feature of Germany, UK,

Czech Republic and Serbia, while in four remaining countries the perceived quality of DCR is low (x<4).

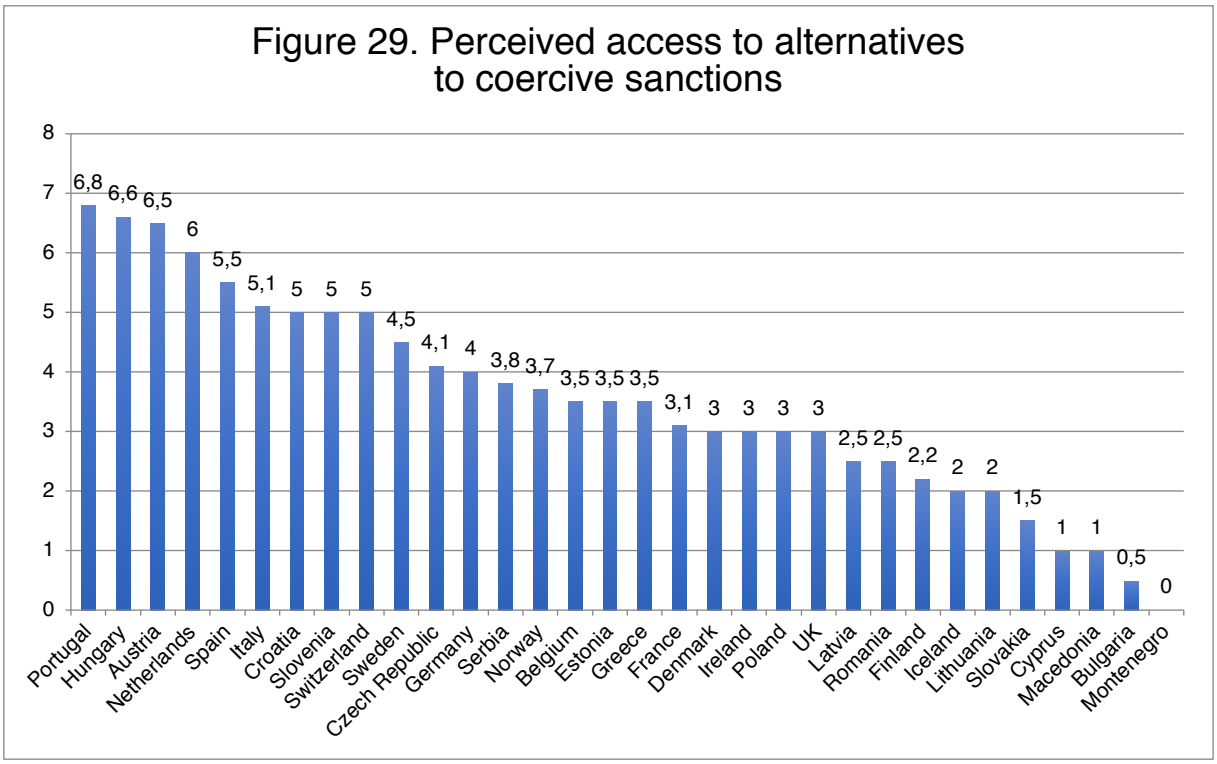


Perceived access to DCR is higher than perceived quality only in Norway (0.3). On the other hand, quality was rated higher than accessibility in twelve countries, with large differences found in France (5.3), Ireland (5.2), UK (3.9), Czech Republic (3.5) and Spain (3.2). In sum, DCRs are the best-developed in Switzerland, Germany and the Netherlands (both aspects equal or above 5).

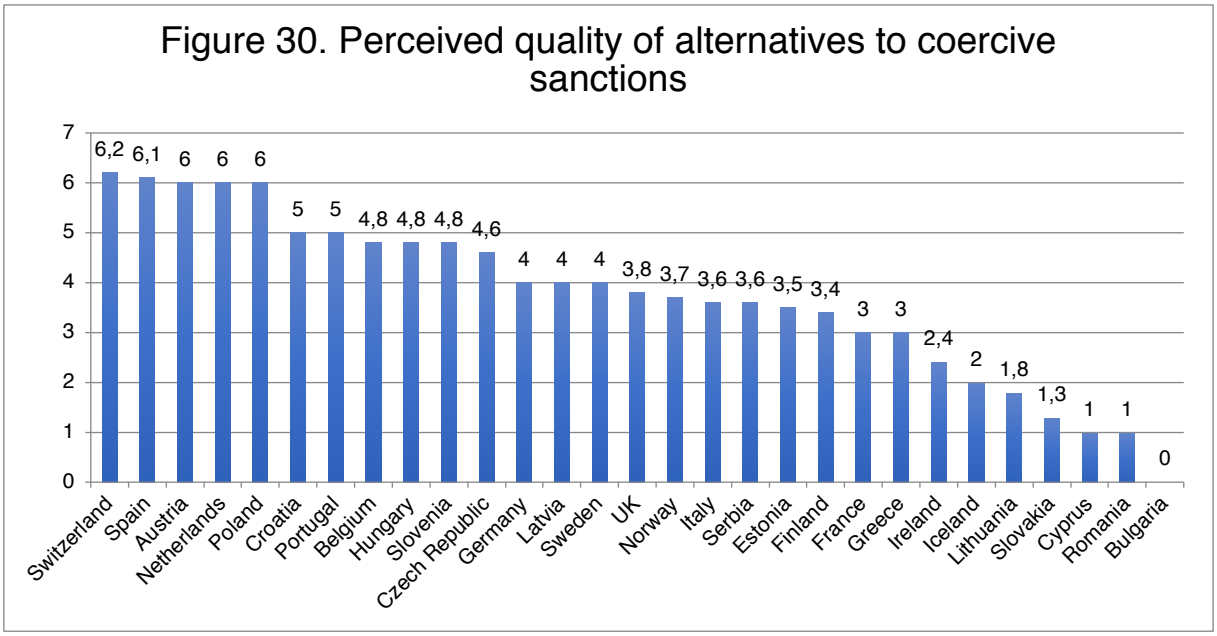
> *"We need to introduce needle and syringe programs for prisoners and open more than the only two drug consumption rooms." - France*

4.12. Alternatives to coercive sanctions (Action Plan 5.22)

Action 22 in the EU Action Plan on Drugs (2017-20) requires member states "to provide and apply, where appropriate and in accordance with their legal frameworks, alternatives to coercive sanctions for drug using offenders." As part of the implementation of this action, the European Council adopted its Conclusions on the alternatives to coercive sanctions (ACS) on 8 March 2018. All member states have at least one ACS and a study produced by RAND identified at least 108 ACS in the EU. Access to ACS is – according to our data – perceived equal or higher than 5 points in nine countries. The highest access was reported from Portugal, Hungary, Austria and the Netherlands (x≥6). Extremely low access (x≤2) was reported in six countries, with Montenegro reporting no access at all.



The quality of ACS is perceived relatively high (x≥6) in five countries: Switzerland, Spain, Austria, The Netherlands and Poland. Further nine countries are perceived as having ACS of moderate quality and nine as low, while very low rates were reported from Iceland, Lithuania, Slovakia, Cyprus, Romania and Bulgaria. In nine countries the access to ACS is perceived as higher than its quality, with the highest differences in Portugal (1.8), Hungary (1.8) and Romania (1.5). Countries with the largest large advantage of quality over accessibility include: Poland (3.0), Belgium (2.8), Greece (2.5) and UK (2.0). Overall, ACS seem to be the most well-developed in Portugal, Austria, the Netherlands and Spain (where at least one aspect is equal or higher than 5 and the other equal or higher than 6). On the other extreme we have Cyprus and Bulgaria where both aspects are rated equal or lower than 2.



Above analysis gives some hints regarding the accessibility and quality of various services in different countries. However, to make the picture clearer, we also developed a ranking of countries with respect to the examined services. We calculated an average of accessibility and quality for each country in each service category (if data on at least one aspect was not available, the country was not rated at all in given service category[8]). Based on overall averages, we ranked countries from 1 to maximum 32. In case of two countries having identical average, they were assigned the same rank; therefore, in some categories the ranking includes less positions. Countries having reported 0 access to services were ranked 32 regardless of the length of the scale for other services[9]. Subsequently, we calculated average of each country ranks across all categories.

This procedure resulted in following list:

Table 2. Countries Ranking

Country	Average rank	Country	Average rank
Switzerland	4,92	Poland	15,67
Croatia	5,67	Norway	15,75
Austria	5,73	Ireland	16,33
Spain	6,42	Serbia	17,17
Netherlands	6,64	Hungary	18,42
UK	8,25	Latvia	18,83
Czech Republic	8,75	Slovakia	18,83
Germany	9,00	Lithuania	19,00
Slovenia	9,00	Cyprus	19,83
France	10,25	Sweden	21,00
Belgium	10,50	Romania	21,58
Italy	12,83	Macedonia	23,18

8 Dania, due to unavailability of data on quality in each examined category, is excluded from the ranking.
9 For example, it is possible that countries with certain service access are ranked 1-20 and countries with no access are all ranked 32 in the same service category..

Finland	13,42	Montenegro	23,20
Portugal	13,42	Iceland	23,25
Estonia	14,60	Bulgaria	26,67
Greece	15,25		

As we can see, the five countries with overall best-perceives services are Switzerland, Croatia, Austria, Spain and the Netherlands. On the other extreme we have Sweden, Romania, Macedonia, Montenegro, Iceland and Bulgaria all of which ranked in the third ten on average. However interesting, it should be kept in mind that the results of some countries are less reliable than others due to limited number of responses.

Low number of responses from some countries may also slightly distort the picture. For that reason, in following chapter we will conduct a regional analysis, comparing the state of drug policy across European regions.

5. REGIONAL ANALYSIS

Not only overall European data and the data for individual countries are interesting, but also regional comparison is worth attention since it may reveal some additional trends or phenomena. To assign our examined countries into regions we have used Eurovoc classification with a small modification. We have distinguished a separate group – Western Balkans – from Central-Eastern European countries as defined by Eurovoc. The reason for such decision is that three countries classified as belonging to CEE region – Serbia, Montenegro and Macedonia – are EU candidate countries and their situation is somewhat different than those who are EU members.

Therefore, our regional classification looks as follows (last row in the table indicates the total number of responses collected from each region[10]):

Table 3. European regions

Western Europe	Central-Eastern Europe	Western Balkans	Southern Europe	Northern Europe
Austria	Bulgaria	Macedonia	Cyprus	Denmark
Belgium	Croatia	Montenegro	Greece	Estonia
France	Czechia	Serbia	Italy	Finland
Germany	Hungary		Portugal	Iceland
Ireland	Poland		Spain	Latvia
Netherlands	Romania			Lithuania
Switzerland	Slovakia			Norway
UK	Slovenia			Sweden
49	47	7	34	32

It is clear that not only we face the disproportions between the number of answers within the regions but also across them.

10 In some cases, there are large disproportions between the number of answers from each country. Thus: in Western Europe disproportions are the lowest, 20% of responses are from France and 52% altogether come from France, UK and Ireland combined; Central-Easter Europe is dominated by Czech Republic (32%) but also responses from Czech Republic, Hungary and Slovenia add up to 68% of the responses in the region; Western Balkans are dominated by Serbia (70% of all responses in the region); Southern Europe is dominated by Spain (47%); Northern Europe is dominated by Finland (41%).

Still, it is the largest amount of data on the civil society perceptions of EU Drug Action Plan implementation collected until this day.

Therefore, our report, though not without certain limitations, sheds some light on the current state of drug-related services in EU member states and beyond.

"More interaction is needed between the Health Ministry and civil society. The implementation of the EU Action Plan should be monitored by both sectors." - Netherlands

5.1. Countries' features

Before we move to the regional comparison, let us present short country characteristics. The table below contains all examined countries, the services rated as the best and the worst[11], as well as the most and least well-developed group of services[12] in the perception of our respondents. We also include the number of services that are not available at all in a country as well as standard deviation of the means of services categories ratings.

Table 4. Countries' features[13]

	Best service(s)	Worst service(s)	Best category	Worst category	Number of missing services	Standard deviation
Austria	OST	Online prevention	Recreational HR	Opioid/IV HR	1*	1.23
Belgium	OST	Naloxone	Treatment	Opioid/IV HR	1	1.10
Bulgaria	OST	ACS	Treatment	Recreational HR	5	1.06
Croatia	Treatment, NSP, OST	DCR	Treatment	Recreational HR	0	3.28
Cyprus	Prevention	Online prevention	Prevention	Recreational HR	0	1.18
Czech Republic	NSP	Naloxone	Treatment	Opioid/IV HR	0	1.18

11 The calculations include mean of both accessibility and quality; the table takes into consideration only services reported as available in a given country.

12 We distinguish between following groups of services: Prevention (prevention and online prevention), treatment (treatment, treatment of comorbidities, recovery), opioid/intravenous harm reduction (NSP, OST, DCR, Naloxone), recreational-settings harm reduction (safer nightlife, drug-checking).

13 Characters "*" indicate missing data regarding the accessibility of certain services. The number of "*" indicated the number of types of services where the data is missing. Therefore, in countries indicated by "*", the number of inaccessible services can be in reality higher (by maximum of the number of "*") than the number given in the table.

Denmark	Insufficient data	Insufficient data	Insufficient data	Insufficient data	0	Insufficient data
Estonia [14]	NSP	ACS	Treatment	Prevention	1**	0.71
Finland	NSP	ACS	Prevention	Recreational HR	1	1.35
France	NSP	ACS	Opioid/IV HR	Recreational HR	0	0.84
Germany	OST	Drug-checking	Treatment	Recreational HR	0	1.16
Greece	OST	Drug-checking	Treatment	Recreational HR	1	0.72
Hungary	Recovery	Naloxone	Treatment	Opioid/IV HR	2	1.36
Iceland	Treating co-morbidities	Online prevention	Treatment	Prevention	4	1.72
Ireland	OST	Safer nightlife	Treatment	Recreational HR	0	1.37
Italy	Naloxone	Online prevention	Treatment	Prevention	1	1.11
Latvia	NSP	ACS	Treatment	Recreational HR	3	0.75
Lithuania	Recovery	ACS	Treatment	Recreational HR	2	1.97
Macedonia	NSP	Online prevention	Opioid/IV HR	Prevention	3*	1.68
Montenegro	NSP	Recovery	Prevention	Opioid/IV HR	4**	2.47
Netherlands	OST	Naloxone	Recreational HR	Treatment	0*	0.60
Norway	Treatment	Safer nightlife	Treatment	Recreational HR	1	2.14
Poland	Recovery	Safer nightlife	Treatment	Opioid/IV HR	2	1.30
Portugal	NSP, OST	Naloxone, online prevention	Treatment	Prevention	1	0.94
Romania	Treatment	ACS	Prevention	Opioid/IV HR	2	0.53
Serbia	OST	DCR	Treatment	Prevention	0	0.88
Slovakia	Prevention	ACS	Prevention	Recreational HR	2	1.55
Slovenia	Treatment	DCR	Treatment	Opioid/IV HR	0	0.34
Spain	Treatment	Prevention, online prevention	Treatment	Prevention	0	0.37
Sweden	Prevention	Drug-checking, treating comorbidities	Prevention	Recreational HR	2*	2.34
Switzerland	NSP	Naloxone	Opioid/IV HR	Prevention	0	0.31
UK	OST	DCR	Opioid/IV HR	Recreational HR	0	0.59

Based on the table above we can see that if we think of groups/categories of services or so-called “pillars” of drug policy, in the vast majority of examined countries treatment services are the most developed – this is the case in nineteen out of 32 countries. On the other hand, it seems that harm reduction services are the least developed – they are the worst rated category of services in 22 countries altogether (opioid/IV harm reduction in 8 and recreational setting harm reduction in 14).

14 The data on safer nightlife programs and drug-checking is not available, hence, they were not taken into consideration.

What is also worth attention, however, are the values of standard deviation (SD). Using this statistical measure, we can have a look at the dispersion, hence we can see how balanced the policies of our examined countries are. In other words, the smaller the value, the closer were ratings of services categories to the average rating of all categories of services. Therefore, we can see that the most balanced policy is a feature of Switzerland (SD=0.31), Slovenia (SD=0.34), Spain (SD=0.37) and to a lesser extent Romania (SD=0.53), UK (SD=0.59) and the Netherlands (SD=0.60). Still, we should remember that in some of these countries this means balanced and effective drug policy (e.g. Switzerland) and sometimes it means balance on quite poor level (e.g. Romania).

On the other hand, we can also identify few countries where pillars (or services categories) ratings were more scattered: Croatia (SD=3.28), Montenegro (SD=2.47), Sweden (SD=2.34) or Norway (SD=2.14). Given the information included in the table, we can see what the focus of a country is, i.e. which services dominate, and which are underdeveloped

5.2. Regional analysis

> *"Barriers are based at local level - cities have resources but don't have knowledge how effectively allocate funding for drug policy." - Poland*

What strikes in the first place is the size of gaps between some regions. Western Europe has by all means the most-developed services among examined countries: it leads in ten out of twelve service types. In the remaining two (naloxone distribution and alternatives to coercive sanctions) it is overtaken by Southern Europe. Southern Europe has excellent results also in other categories, though sometimes it falls behind Central-Eastern Europe, which is especially visible in case of prevention and treatment. Northern European countries reach (and very slightly cross) the rating of 5 in only five services types. The most poorly accessibly services, however, are the feature of Western Balkans which clearly lag behind other examined regions, with the exception of NSP where they place on the 2nd position right after Western Europe. The table below presents the means of accessibility of each examined service across regions.

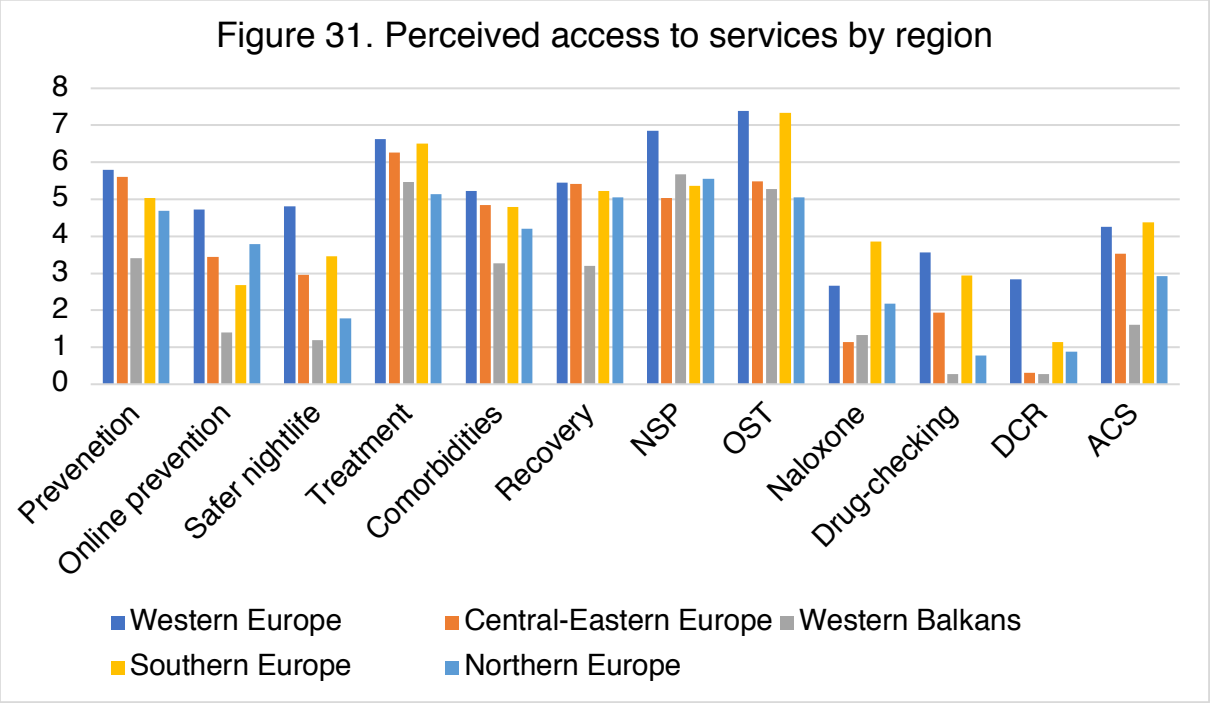
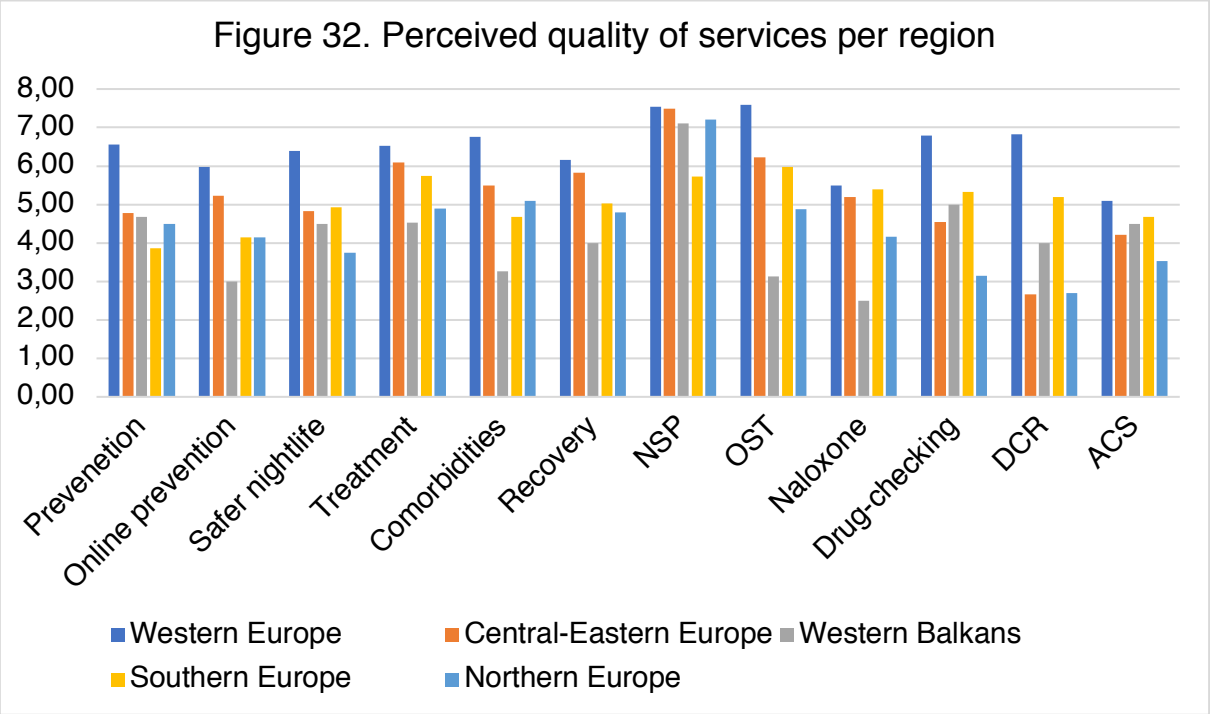


Table 5. Perceived services accessibility by region

	Western Europe	Central-East-ern Europe	Western Balkans	Southern Europe	Northern Europe
Prevention	5.8	5.61	3.4	5.04	4.68
Online prevention	4.73	3.45	1.4	2.68	3.79
Safer nightlife	4.81	2.96	1.2	3.46	1.78
Treatment	6.63	6.26	5.47	6.5	5.14
Comorbidities	5.23	4.84	3.27	4.8	4.2
Recovery	5.45	5.41	3.2	5.22	5.06
NSP	6.86	5.03	5.67	5.36	5.55
OST	7.39	5.49	5.27	7.34	5.05
Naloxone	2.67	1.14	1.33	3.86	2.18
Drug-checking	3.56	1.93	0.27	2.94	0.78
DCR	2.84	0.31	0.27	1.14	0.88
ACS	4.26	3.53	1.6	4.38	2.93
AVERAGE	5.02	3.83	2.70	4.39	3.50

We can see that indeed, Western Europe has overall highest level of services accessibility (though it is not really high in absolute terms, i.e. given that our scale included values 0-10). Second best access can be found in Southern Europe and third in CEE. As discussed above, Western Balkans are in significantly worse position, losing 0.8 point to Northern Europe and with services access almost twice as low as in Western European countries.



Already the first look at the data on perceived service quality allows for observation that the variance between regions is not as large as in the case of services accessibility. It is also clear that all the ratings of quality are overall significantly higher than those of accessibility. Here, however, Western Europe leads in all services types, followed by CEE and Southern Europe (depending on the service). Interestingly enough, in few services types Northern European countries overtake Southern Europe (i.e. NSP, prevention, treating comorbidities). Even more interestingly, Western Balkans overtake Northern Europe in five services types: prevention, safer nightlife, drug-checking, DCR and ACS. In prevention and NSP they are also ahead of Southern Europe. The table below presents the means of quality of each examined service across regions.

"After the Global Fund withdraw from Bulgaria, needle and syringe exchange in the country stopped, the so-called transition [to domestic resources] covered only a few HIV-testing programs." - Bulgaria

Table 6. Perceived services quality by region

	Western Europe	Central-Eastern Europe	Western Balkans	Southern Europe	Northern Europe
Prevention	6.56	4.78	4.67	3.86	4.49
Online prevention	5.97	5.23	3	4.14	4.15
Safer nightlife	6.39	4.83	4.5	4.92	3.75
Treatment	6.53	6.09	4.53	5.74	4.89
Comorbidities	6.76	5.49	3.27	4.68	5.09
Recovery	6.15	5.83	4	5.02	4.79
NSP	7.54	7.49	7.1	5.72	7.21
OST	7.59	6.23	3.13	5.98	4.87
Naloxone	5.5	5.2	2.5	5.4	4.16
Drug-checking	6.79	4.55	5	5.32	3.15
DCR	6.83	2.67	4	5.2	2.7
ACS	5.09	4.21	4.5	4.68	3.53
AVERAGE	6.48	5.22	4.18	5.06	4.40

"We do not only need financial support from the government but also political support." - Serbia

Again, Western Europe is clearly leading, followed by CEE and Southern Europe (with very similar results) and further by Northern European countries and Western Balkans. Interestingly, the difference between services quality perceptions in Western Balkans are this time only slightly behind Northern Europe and about only one-third worse of those of the Western countries. Here we can also talk about really "high" rates of services as in some categories regions reach the level of 6 or even 7 points on our 0-10 scale. To sum up, we can thus say that from the regional perspective, the accessibility of examined services is moderate (Western Europe, Southern Europe) or low (CEE, Northern Europe, Western Balkans), while their quality is perceived as relatively high (Western Europe) or moderate (all other regions).

To add another dimension to our analysis and make it – to the extent possible – comprehensive, in the next chapter we will examine the accessibility of studied services among specific vulnerable populations.

6. ACCESS TO SERVICES AMONG SPECIFIC POPULATIONS

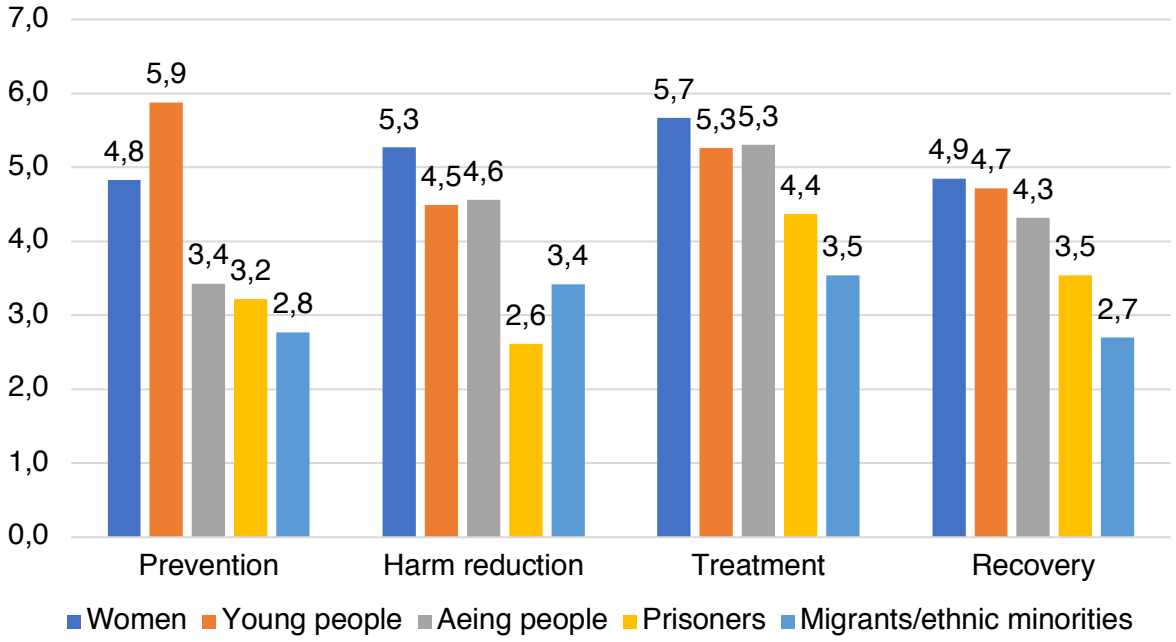
In this chapter we focus on four main types of services, namely, prevention, treatment, harm reduction and recovery/rehabilitation). We focus on these services accessibility among five specific target groups: (i) migrants/ethnic minorities, (ii) prisoners, (iii) ageing people, (iv) young people and (v) women. Similar to previously discussed issues, here we also used an 11-point scale (0-10).

"In general, there is a very poor support for prisoners in Iceland, there is no harm reduction in prisons, no OST and no drug treatment. This very much needs to change." - Iceland

The data shows that the mean access to services overall is perceived relatively moderate among all special populations taken together: its mean value equals 4.24. However, there are significant differences between examined populations. Migrants/ethnic minorities have perceived the lowest access to examined services, with mean access at 3.11. The most accessible service for them is treatment, and the least accessible – recovery. On the other hand, in all but one service categories women are the ones whose accessibility to services is the highest with the mean of accessibility equal 5.16. The only service where women's access is not the highest is prevention: here youth is perceived and having the best possibilities of accessing. Young people are overall in the 2nd position (right after women) Ageing people follow with the mean of perceived access 4.41, and prisoners fall further behind with the mean equal 3.44. In all examined groups except youth, treatment is the most available service from all services examined (mean 4.83). Overall accessibility of all other services is quite equal (means between 4.03 and 4.07). However, it is clear that availability of some types of services is especially problematic in certain groups. First and foremost, very low level of harm reduction accessibility for prisoners should be of concern, given their environment and the prevalence of risky behaviours, related to drugs and sex alike. Given that very often prison services are reluctant to accept any harm reduction interventions, special advocacy efforts should be considered to address his problem.

"There is a need for more labelled funding in both national and EU level on harm reduction, tailored to the needs of specific vulnerable populations, including Roma people who live in segregated settlements." - Hungary

Figure 33. Perceived accessibility among specific populations



"Language is a barrier to prevention and harm reduction services. Also, there is a lack of trust among ethnic minorities. Ageing populations do not tend to require prevention or harm reduction services. Although if this group require support there is excellent treatment and recovery services available."
- Czech Republic

7. BRIDGING THE GAPS: RECOMMENDATIONS FROM THE CIVIL SOCIETY FORUM

Based on the findings of the report and on consultations with European CSOs, the Civil Society Forum on Drugs is making the following recommendations to decision-makers and European institutions to contribute to bridging the gaps between the ambitious goals of the EU Action Plan on Drugs and the reality on the ground.

To the European Commission:

1. To strengthen the drug coordination system at the EU Commission by providing adequate staff and funding to the Drug Unit and keep its multidisciplinary approach.
2. To take the leadership in coordinating the implementation and evaluation of the current EU Drug Strategy and Action Plan on Drugs and the creation of the new EU Drug Strategy in 2019.
3. To initiate a dialogue with those member states that, according to this report, do not provide or provide low access to services required by the EU Action Plan and call them to implement it.
4. To promote and enhance the European approach to drug policies – in line with the EU Drug Strategy and Action Plan – in international contexts and settings.

To the EMCDDA:

1. To involve civil society in a meaningful way in the collection and analysis of national data to fill the gaps in our knowledge.
2. To conduct a comparative study in the European Union about the financial expenditures on drug policy in member states.
3. To promote and support studies, including all member states, on health, social and penal impact of current drug policies.
4. To monitor and evaluate innovative and experimental policies (at local, regional and national level) on legal regulation of cannabis.
5. To support more research on the access to and quality of services for vulnerable populations, such as migrants/ethnic minorities, women, prisoners, young and ageing people.
6. To support and/or conduct more qualitative research on patterns of drug use to serve as a basis for the development and adjustment of innovative interventions and policies.

To MEPs:

1. To support the budget plan of the European Commission to provide two sustainable funding mechanisms on drug policy interventions (European Social Fund + and Internal Security Fund).
2. To keep drug policies on the agenda of the EU Parliament and cooperate with the Civil Society Forum on Drugs in monitoring and evaluating the implementation of the EU Drug Strategy and Action Plan.

To Member States:

1. To adopt evidence-informed and human rights-based approach in developing national drug strategies and action plans, including through studies on health, social and penal consequences of current drug policies.
2. To fill the gaps in funding and political support for services that were perceived to have very low accessibility and availability according to the CSF report.
3. To improve the quality of services by implementing minimum quality standards for demand reduction in the national level and provide adequate support and training to service providers to meet the demands of these standards.
4. To improve the access to and quality of alternatives to coercive sanctions, as well as remove barriers to access by training law enforcement professionals and, where necessary, changing criminal laws.
5. To assess the needs for demand and harm reduction services in prisons and provide access to all needed services that are available in the community, as well as ensure the continuity of services when entering or leaving prisons.
6. To create formal mechanisms to involve civil society in drug policy decision making in a meaningful way in local and national level.
7. To recognise and take into consideration the voice of people who use drugs, including creating spaces and mechanisms for their involvement in policy-making at its various levels.
8. To improve the training of professionals in the field of demand and harm reduction.
9. To assess the needs of specific vulnerable populations and, where appropriate, provide funding for specific services to reach out these groups.