THE EU ACTION PLAN ON DRUGS 2017-2020 AND THE NATIONAL DRUG POLICIES IN 8 EUROPEAN STATES

Divergences, convergences, gaps and areas for developments

OVERALL REPORT

By Susanna Ronconi and Antonella Camposeragna

Colophon

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Civil Society Forum on Drugs CSFD Project II – 2020-2021 - WP2

The EU Action Plan on Drugs 2017-2020 and the national drug policies in 8 European States

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Overall Report

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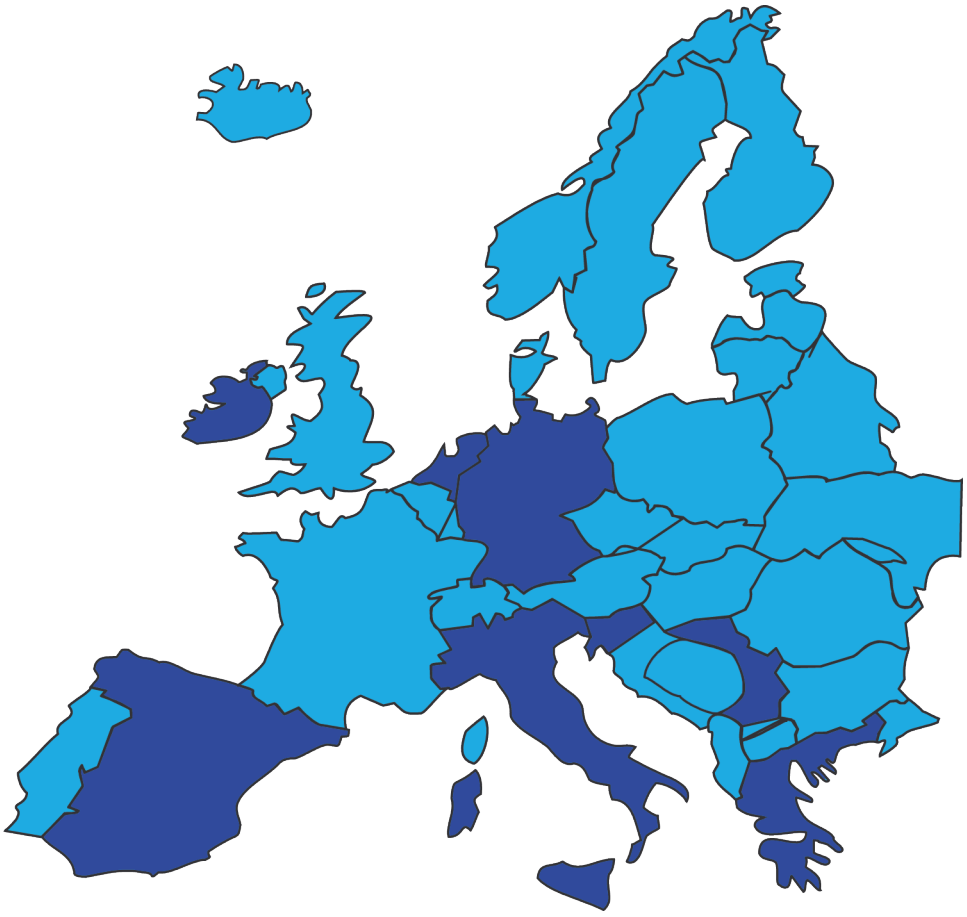

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INTRODUCTION

Background

The Civil Society Forum on Drugs (CSFD) is an expert group to the European Commission. Its membership comprises 45 civil society organizations from across Europe who represent a variety of fields within drug policy, and a variety of approaches on drug policies. Its aim is to provide a platform for a structured dialogue between the Commission and European civil society, which supports drug policy and its implementation through practical advice.

The CSFD contributes to an effective, evidence based and human rights-oriented European drug policy, in the civil society organizations (CSOs) perspective, which have expertise and are active in the drug field.

One of the four CSFD working groups (WG1) has the tasks to analyze and report – through periodic research activities involving CSOs all over Europe – each EU Strategy and Action Plan on drugs from the Civil Society perspective. It provides in-depth feedback to the European Commission, stressing strong and weak points as well as missed opportunities. It also suggests further innovations and areas for improvements[1].

Thanks to the participation of European Commission calls, the CSFD has the possibility to further develop its activities. In particular the WG1 can expand, through different quant-qualitative research methods, its evaluation action, looking at the content and the approaches adopted by the Strategy and Action Plans and their effective implementation by Member States (and also those who are candidates). This in-depth perspective is integrated with the routine activities of the WG1, providing the CSOs, the EC and the Member States the tools of understanding, knowledge and action aimed at having more coordinated, effective and adequate European and national policies on drugs.
The research actions included in this project update, complete and integrate at a distance of three years, the previous evaluation of the implementation of the Plan conducted by the WG1 of the CSFD in 2018, a year after its enactment.[2]

Objectives and expected results from the 8 national case studies

The project includes a work package (WP2) dedicated to the evaluation itself: how and in what way are the objectives and the key actions of the European Action Plan of Drugs 2017-2020[3] - approved by the Council of Europe on the basis of the EU Strategy 2013-2020[4] - included in the Plans and the national policies of the Member States and of candidate States.

As the above mentioned CSFD evaluation paper states: "*The current EU Drug Strategy was adopted for the years 2013-20, and its Action Plans for 2013-16 and 2017-20, respectively. […] With its vocal support for solutions that are evidence-based and strongly*

1 All materials and reports produced by the CSFD and in particular by the WG 1-EU Strategy and Action Plans are in http://www.civilsocietyforumondrugs.eu/projects/
2 Civil Society views on the implementation of the EU Action Plan on Drugs. Report by the Civil Society Forum on Drugs, by Iga Kender-Jeziorska and Péter Sárosi (2018) http://www.civilsocietyforumondrugs.eu/wp-content/uploads/2020/07/2018_CSF-report_final.pdf
3 European Action Plan of Drugs 2017-2020 https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52017XG0705(01)&from=EN
4 EU Strategy on Drugs 2013-2020 https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2012:402:0001:0010:en:PDF

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 recommendations and reflecting them in domestic policies and laws can vary significantly from country to country"***.

Considering the CSFD position on the Action Plan 2017-2020 as "*the most progressive EU document"* on drug policy so far, the ***general objective*** of this research is to contribute to promote and facilitate a wider implementation of the objectives and the actions of the Plan by Member States and candidate countries.

There are two different researches in the WP2 of the Project that combine with this objective:

- A quant-qualitative study, aimed in particular at evaluating the areas regarding services and harm reduction. This research was undertaken via an online questionnaire and interviews of privileged witnesses. The aim was to cover all of the MSs and the candidate countries through the European CSOs networks. This research – conducted by YODA - also allowed for a comparison to be made between the states.
- The present qualitative study - conducted by Forum Droghe - looks at convergences, divergences and gaps between the national action Plans of the 8 states (7 MSs and 1 candidate Country) and some of the most relevant objectives of the European Plan 2017-2020, in perspective of developing greater consistency between the European approach and the national policies on drugs.

Objectives and expected results from the 8 national case studies

The present research based on 8 national case studies shares the general aim cited above. The ***specific objectives*** are:

- The identification and in-depth inquiry into the existing gaps between some of the objectives and the actions envisaged by the European Plan 2017-2020 and the national policies in the 8 states, thanks to the observations on the ground and the experience of the CSOs;
- The identification of areas where it is necessary and possible to improve and develop the national policies, according to European Plan and in the CSOs perspective.

The ***expected outcomes*** of this research project are:

- To detect and elaborate- thanks to the methodology of qualitative research- not only the exploration of the gaps and the areas for potential improvement, but also the reasons for these variances, the contexts, the dynamics, the decisional processes that limit or block the implementation of the objectives and the actions suggested by the European Plan. The objective here is not to compare the findings from the 8 national researches, but rather to detect the most relevant, shared and common gaps and the reasons for these according to the CSOs, as well as the identification of common areas where innovation and change can be promoted.
- To have an evaluation not only regarding the variances between the European Plan and the national Plans, in terms of how they are formally elaborated, but also between the national Plans and their real implementation on the ground, in the policies and in

the systems of intervention. In this sense the research allows for a focus also on each national policy and gives the participants and all the actors an evaluation that is useful for advocacy actions within their own country.

- To extract recommendations and areas for intervention from the identification of areas for improvement, providing also the Commission with feedback concerning strenght points and weak areas in the European Plan implementation within a general profile of its efficacy in orienting national policies.

Methodology and research processes

Thematic areas. The action Plan is a complex text, covering 15 macro-objectives and 55 actions. A selection of the objectives and actions to explore was necessary, and it needed to be functional to the feasibility of the research and to the sustainability in terms of resources and time.
The selection of the 6 thematic areas, that are at the core of the research occurred on the basis of the priorities with which, over time, the actions of the CSFD became focused upon. These actions included CSFD internal debate; dialogue with the Commission; the points of major attention that emerged gradually from the evaluations and the inputs provided by the CSFD to the EC, all of which is contained in the reports and position papers produced by the Forum from 2016. The reference text in particular was the cited evaluation document of the Plan 2017-2020 elaborated by the CSFD in 2018.
Six macro themes were selected according these criteria, and they in turn were articulated into different points of attention by the participants at the national Focus Groups:

1. General approach
2. Availability, accessibility and quality of interventions and socially vulnerable groups
3. The inclusion of Harm Reduction in the national APs
4. Alternative Sanctions
5. Research and Evaluation
6. Civil society involvement in drug policy

(See Appendix II The core themes)

The selection of national case studies and of researchers
The selection of the countries where the research is to be conducted is integrated between, and a function of the selection process for the national researchers, and has as a first basic criteria that of including countries from diverse areas on the Union and at least one candidate country.
A public call was made for the selection of researchers, which was diffused thanks to the CSFD, the European networks of civil society and their websites and social media accounts.
The criteria for selection were established: for the researchers it was necessary to have competency and experience in the field of qualitative research, in the drugs field, in public policy and in participative processes; good and widespread relationships with the reality on the ground and the national networks of CSOs who deal with drug policy, with particular attention to the network of the CSFD and those correlated. For the countries, the cited criteria of the geographic differentiation for the EU area and the inclusion of at least one candidate country were important.

16 candidates from 12 countries answered the call. The evaluation process selected researchers from 8 countries: ***Germany, Greece, Ireland, Italy, Netherland, Serbia, Slovenia, Spain.***

Methodology

Summary of the national Action Plans (Part I)

The aim of this part of the research is to briefly illustrate the main content of national Action Plans (NAP) on drugs and drug strategies of the participating countries and facilitate comparison among them, highlighting how CSOs are involved.

Materials and methods. A researcher reviewed the national drug report of each country involved published by EMCDDA, extracting the main issue of each action plan. Consequently, a draft synthesis of each action plan was drawn up, taking into account the following issues: when and by whom the NAP has been formulated, its major priorities, whether and how an evaluation has been expected and how the coordination among the different stakeholders is working. This draft has been analyzed and integrated by each country expert; specifically, each expert explained how civil society involvement in drug strategy is developed in their country.

The main and common sources are the NAP published by EMCDDA and available on its website. Each researcher could add further references.

Overall analysis and report from 8 national case studies. (Part II)

The research is qualitative. The national studies were undertaken via focus groups that involved members of the national CSOs.

The focus groups were conducted by researchers on the basis of an agreed outline that looked at the 6 thematic areas and included some stimulus questions on aspects of interest to the research. The central themes of the focus groups were communicated to the participants a few days in advance of the meetings.

The focus groups were held online due to the limitations imposed by the Covid pandemic, in October and November 2020, and all were recorded.

The recordings were transcribed and the text was analyzed by the researchers adopting the Thematic Analysis methodology[5], within the Grounded Theory approach.

The researchers organized the content that emerged in accordance with the Thematic Analysis methodology, in the shape of categories, sub/categories and codes “trees”: in an analytic modality and non-redacted as a final report. This allowed for a second level analysis - elaborated by the researchers coordinators of the project- and included the results from the 8 national cases, resulting in an overall single vision. This second level analysis, illustrated in this report (Part II) was undertaken using the same Thematic Analysis methodology.

A final chapter including Conclusions and Recommendations was drawn up (Part III), on the basis of the most relevant findings from the case studies. This chapter include “8 areas for improvement” which have been formulated again through the Thematic Analysis methodology, that allowed to extract some “core categories”, the most relevant and transversal with respect to both the themes and the national contexts.

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5 Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), APA handbooks in psychology®. APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological (p. 57–71). American Psychological Association. https://psycnet.apa.org/record/2011-23864-004

Finally, the summaries of the most significant results of the single national researches were included (Appendix I) in order to not loose information focalized on specific contexts. Even though national reports were not the first aim of the research, but the basis for an overall analysis and reporting, nevertheless the work undertaken at a national level is significant and has its own purpose and usefulness, even at a local level in terms of promoting understanding, discussion and advocacy by the CSOs of each country.

The focus groups participants

The national researchers undertook the selection of participants for the focus groups. There was a shared set of guidelines based on certain criteria: plurality of intervention sectors (prevention, treatment, harm reduction, research, human rights); plurality of areas and interests represented (CSOs, Third sector service providers, policy advocacy and human rights, associations of sector workers, PWUDs organizations, associations and networks from the local communities); coming from different regions/cities in the country; balanced in terms of gender.

The participants were informed of the aims and the methods of the research, in person (vocally) and through the specific material sent to them for the presentation of the project. They also received in time an illustration of the themes at the center of the focus groups. They were informed of the privacy guarantees, with the adoption of the Chatham House protocols, according to which the affirmations contained in the report are anonymous and are not traceable to single participants, while the names of the participants are public (*included in the national summaries, Appendix I*).

With respect to the recording of the focus groups, the participants were informed of the video recordings and had the option of excluding the webcam. The focus group recordings are nonetheless private and will be kept for 6 months following the publication of the research and then cancelled.

The research team

Overall coordination/ Project manager: Susanna Ronconi (Forum Droghe)
Co-cordination and analysis of national action Plans: Antonella Camposeragna
Researchers: Thanasis Apostolou (Greece), Eva Devaney (Ireland), Antonio Jesús Molina Fernández (Spain), Irena Molnar (Serbia), Emanuele Perrone (Italy), Melissa Scharwey (Germany), Sanela Talić (Slovenia), Sara Woods (Netherland)
English version: Liz O'Neill (Forum Droghe)
(See the biographies of the researchers in Appendix III)

This report

The report contains:

- An Introduction that places the research in context with respect to its mission and to the activities of the SCFD; aims, objectives and expected outcomes from the research; the methodology adopted; the process of selection for countries, for national researchers and for participants in the research.
- Part I: a summary of the national action Plans and an update from the national researchers.
- Part II: a complete analysis of the results from the 8 national case studies. The analysis is articulated according to themes, eventual sub-themes and highlights the issues (the salient points) that emerged from all the case studies, in an integrated way. These were the most significant and/or the most reoccurring and/or the most promising in terms of change and innovation.
- Part III: The report concludes with "8 areas for change and development", extracted as "core categories" from an analysis of the salient findings. They provide the direction and the content for a discussion between CSOs, the EU institutions, and for an advocacy action towards a more coherent implementation of the European approach in drug policy in MSs and candidate countries.

Appendix

- Appendix I. A summary of the more relevant findings from the national reports, providing in brief the key points of the evaluations of national policies and their harmonizing or not with the EU Plan.
- Appendix II The research themes. A description of each issue, with references to the EU AP 2017-2020 and some questions and inputs
- Appendix III: The research team. Biographies of the researchers
- Appendix IV: References. A selection of documents, reports, guidelines regarding the 6 main themes of the research

Part I

THE CURRENT STATE OF THE ART OF DRUG ACTION PLANS[6]

On a yearly basis, each European country contributes to EMCDDA Drug Report by Reitox national focal points of the 27 EU Member States, plus Norway and Turkey. Moreover, EMCDDA cooperates with candidates and potential candidate countries to the EU.

The aim of this part is to briefly illustrate the main contents of Drug Action Plans and drug strategies of the participating countries and facilitate comparison among them, also highlighting if and how CSOs are involved in the decision-making processes.

Results

1.1 Structural data on Action Plans (APs)

All APs are drawn up during the period 2010-2017, and have been expected to be renewed but only a few has been revised. This paragraph illustrates the state of the art in each of the eight participating countries.

All the APs are aimed to reduce use of both licit and illicit substances (as well as addictive behaviors, when mentioned). Specifically:

Germany: the National Strategy on Drug and Addiction Policy was adopted in 2012 by the Federal Cabinet and it is an ongoing strategy with no specified end date. It aims to reduce the licit substances (alcohol, tobacco and psychotropic pharmaceuticals) and illicit substances consumption as well as addictive behaviors (e.g. pathological gambling)

Greece: the draft of Greek National Drug Strategy 2014-20 addresses illicit drugs and it has never been adopted. Since 2019 the National Drug Coordinator has been preparing a new text of a National strategy. There is not yet a draft. The Greek NGOs are expecting that the draft will be subject of public consultation and consequently will be submitted for approval to the Inter-Ministerial Committee and the Parliament.

Ireland: Irish national drug strategy was launched in July 2017 and it is intended to move towards an integrated approach to illicit drug and alcohol use. The strategy sets out an overarching vision for “a healthier and safer Ireland, where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life”.

Italy: Launched in 2010, the Italian National Action Plan on Drugs originally covered the period 2010-13, but it remains in force pending the development of a new strategy, that so far is not yet published. Primarily focused on illicit drug use, the Action Plan also covers licit substance use and addictive behaviors as elements that are addressed predominantly in the context of prevention.

The Netherlands: Drug policy is defined on a municipal level and through court decisions;

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there are many laws and acts, such as white paper 'A combined effort to combat ecstasy' (2001), the 'Cannabis policy document' (2004), the 'Medical prescription of heroin' (2009) and others. A National Action Plan has never been drawn up.

Slovenia: Adopted in 2014, the overarching goal of Slovenia's National Programme on Illicit Drugs 2014-20 is to reduce and contain the harm caused to individuals, families and society from illicit drug use.

Serbia: In 2014 the Government of the Republic of Serbia adopted the Strategy for Drug Abuse Suppression 2014-21 and its accompanying Action Plan 2014-17. The Strategy addresses individual and social harms caused by drug use, as well as drug-related crime and its consequences.

Spain: The current National Strategy on Addictions 2017-2024 [Estrategia Nacional sobre Adicciones, ENA 2017-2024] builds on and is informed by the two previous strategies (National Drugs Strategy 2000-2008 and the National Drugs Strategy 2009-2016), as well as by the three Action Plans developed under those two Strategies. It addresses illicit drugs, new psychoactive substances, the licit trade in alcohol, tobacco and medicines with addictive potential, and behavioural addiction.

1.2 Priorities and result achieved

We can distinguish between common issues and country specific ones. The common priorities are the following:

1. to promote and protect health;
2. to minimize/reduce harms caused by the substance use
3. To promote rehabilitation and recovery;
4. To promote support participation of individuals, families and communities as well as NGOs.

Although these priorities are comprehensive and reflecting different aspects of drug issue, the APs seem not to be evaluated systematically and, in some cases, they are not evaluated at all.

It has been noted that in some countries the strategy aims to avoid alcohol abuse and addiction, but not the reduction of its consumption, as it happens with illicit drugs. The explicit inclusion of harm reduction is not so common, as well as the explicit mention about therapeutic use of cannabis. In Serbia, for instance the scarce attention toward harm reduction programmes and the fact that harm reduction programmes exist because they are also part of the Strategy against AIDS. On the other hand, in Spain harm reduction is an explicit aim although it is part of a whole including also prevention and risk reduction, integrated and multidisciplinary care, social integration.

An interesting aim in the Spanish strategy focuses on delaying the age at first contact with dependence-producing substances and behaviours, reducing their availability and prevalence, and reducing associated harms.

In Germany since 2012 the AP has neither been evaluated nor updated (and there is no information about future plans to do so), providing in a sense of frustration. In Italy there is the same situation as well as in other countries. Some epidemiological data or studies are presented as evaluation but NGOs complain never being involved and that

epidemiological data themselves are necessary but not sufficient to evaluate policies.

In the Netherlands there is not one comprehensive drug policy document or national AP. National drug policy is defined through many different documents. Moreover, the national policy provides a loose and more general framework for municipalities. Municipalities have relatively a lot of freedom to design their own drug policies, especially concerning prevention, treatment and care. There is indeed a lot of monitoring and regular evaluations of specific health interventions, but there is no regular evaluation of the national drug policy. Anyway, some programmes are constantly evaluated, such as drug checking and heroin maintenance treatment. However, there is hardly any evaluation of the Dutch drug policy in general. The last overall drug policy evaluation was in 2009. This was an external evaluation of the 1995 White paper; it was carried out by the Trimbos Institute. Long-standing monitoring systems include the Drug Information and Monitoring System (drug composition), the tetrahydrocannabinol (THC) monitor (cannabis potency) and drug-related emergencies monitoring.

In Greece, the Law on Addictive Substances (Law 4139/2013), which is the main framework of drug policy, stipulates that the Interministerial Planning and Coordination Committee approves the national AP. This Ministerial Committee has never met up to date. Requests by NGOs and drug services and institutions to adopt the strategy and AP do not have a reply, so far. That means there is also no evaluation simply because there is no written and approved framework of the Strategy and AP for drugs.

In Serbia, the Evaluation of Action plan 2014-2017 was done by the Office for Combating Drugs with external help from EMCDDA. The results of the project are subject to a number of limitations. There was very little documentation and data on the implementation of the strategy and AP, so the evaluation was based on interviews, and there were not available progress reports. The EMCDDA report for Serbia from 2017 gave contextual information. In this regard, interviewing stakeholders was the most practical way to understand situations. However, not all significant entities were available during the interviews implementation period in June 2017, especially representatives of ministries, while the experts from health institutions and civil society representatives fully contributed. The project teams did not make any field visits.

The Spanish AP was also evaluated taking into account not only epidemiological indicators but using a mixed method approach. A final multi-criterion evaluation of the National Strategy on Drugs for 2009-16 was completed in 2017 by a mixed evaluation team in the context of the development of the new strategy. Indicators were developed and addressed the strategy's principles, objectives, processes and systems, degree of implementation and final results. As part of the consultation process, questionnaires addressing different aspects of the strategy were completed by representatives from the central, autonomous and municipal administrations, civil society and other stakeholders. Indicators related to the strategy's final results, its processes and outputs, the quality of the systems and transversal objectives as well as principles such as equality, equity, gender perspective, social participation and training. The degree of accomplishment of the 14 general objectives was analyzed, along with the objectives related to the guiding principles (evidence, social participation, an intersectoral approach, a comprehensive approach, equality and a gender focus). The findings of the Evaluation of the National Drugs Strategy 2009-16 show a positive development for the actions taken in the area of demand and supply reduction although there is still room for improvement.

Similarly, in Slovenia, the Ministry of Health commissioned two external evaluations of the Resolution on the National Programme in the Area of Drugs 2004-09. The evaluations

were completed by a research center in 2008 and a non-governmental organization in 2010 and considered the operation and implementation of the programme; the findings were used in the development of its successor for the period 2014-20. A mixed-methods process and outcome evaluation of the 2015-16 AP was undertaken by the Ministry of Health.

1.3 Coordination mechanism

In Italy and in Spain there is a specific coordination agency whose mandate is drawing up action plans; a similar situation should be operative in Greece.

In Italy, the Department for Anti-Drug Policies is responsible for the strategic and operational coordination of Italian drug policy. It is a department of the Presidency of the Council of Ministers and its responsibilities include ensuring coordination among the different ministries and functioning as a link between central, regional and local authorities through the mechanisms of the State-Regions Committee and the State-Regions-Autonomous Provinces-Municipalities Unified Committee. The Department's work also includes policy activities at the European and international levels, alongside reviewing scientific knowledge on different aspects of drug dependency. The director of the department is the national drug coordinator. The regions/autonomous provinces have a more strategic management role, which includes the planning and organization of the health regional systems, and programming and evaluation functions. The local health authorities are responsible for the activities of local public drug treatment centers (public services for addictions, which cover all drugs and addictions), while non-governmental organizations are supposed to be involved, working in cooperation with public centers in treatment, rehabilitation and harm reduction. Yet, in reality, the role of the Department for Anti-Drug Policies seems not to be effective from the perspective of CSOs: Italy has not a national AP on drugs since 2010, the National conference on drugs – required by law every 3 years – has not been held since 2009, the consultations with the Regions are not frequent. Also, CSOs involvement is unsatisfactory, clear procedures and transparency rules for participation have not been implemented.

In Spain, the Government Delegation for the National Plan on Drugs is the national drug policy coordinator. The Delegate's office is a directorate of the Ministry of Health, Social Services and Equality. It coordinates the institutions involved in delivering the drug strategy at central administrative, autonomous community and local levels. The Sectoral Conference on Drugs facilitates cooperation between central government and the administrations of the autonomous communities and cities. Chaired by the Minister for Health, Consumer Affairs and Wellbeing, it includes representatives of the central administration and the commissioners of the autonomous communities. The Communities Commission on Drugs, chaired by the Government Delegate for the National Plan on Drugs, reports to the sector conference, which is made up of all the deputy directors-general of the Government Delegation and those responsible for the regional drug plans. There is a drug commissioner in each of the 17 autonomous communities and two autonomous cities (Ceuta and Melilla). They communicate with the Government Delegation through their participation in the Inter-autonomic Commission and the sector conference, and each has an organization that is responsible for the autonomous community drug plan.

As established by National Law No 4139/13, Greek coordination system consists of three levels: Interministerial Committee on the Drugs Action Plan (chaired by the prime minister), the National Committee for the Coordination and Planning of Drugs Responses

(composed of representatives from 10 ministries) and National Drug Coordinator, who chairs the National Committee for the Coordination and Planning of Drugs Responses. The coordinator is appointed by the prime minister for a 5-year term, with a mandate to chair the National Committee for the Coordination and Planning of Drugs Responses, draft an action plan on drugs and represent the country on international bodies related to drug. Anyway, according to our expert, the law has not been applied at any of the three levels. Pressure to the government will not come from the state-approved agencies. The culture of state depended institutions in relation to the authorities is one of subordination to the leading political structures. Changes may come through pressure for Civil Society, PWUDs and clients' organizations and independent institutions. The participation of Civil Society in this respect is essential.

The expert from Serbia reported that on 2014 the Government of the Republic of Serbia established the multi-sectorial Committee for Psychoactive Controlled Substances, comprising a panel of experts and representatives of relevant authorities (but without civil society representatives), to coordinate actions in the field of drugs implemented by entities representing different sectors. The Office became partly operational in April 2016, almost two years after it was formally created. The Office is responsible for coordinating the work of public authorities; participating in the development of strategies and laws; monitoring the implementation of drug-related projects; analyzing the situation in the drugs field; establishing international cooperation; preparing annual reports for international organizations; and implementing the Strategy for Drug Abuse Suppression 2014-21. Its tasks should be implemented in close cooperation with ministries, health institutions, non-governmental organizations and other national and local entities involved in the implementation of the AP. However, to this day it is not yet clear why the National Observatory responding to EMCDDA still belongs to the Ministry of Health, although it is foreseen by the Article 2 of the Government regulation. The civil society organizations proposed this change during changes of the Law on Controlled Psychoactive Substances in 2017/18, but the Working group in the Ministry refused to support the proposal.

In Slovenia, the Commission on Narcotic Drugs of the Government of Slovenia is responsible for drug policy at the interministerial level. The Commission promotes and coordinates government policy and programmes, proposes measures and monitors implementation of the provisions of international conventions. It includes representatives from all ministries involved in implementing the programme. The Ministry of Health, which is the Commission's Secretariat, and the Ministry of the Interior are responsible for, respectively, the strategic and operational coordination of the programme in the areas of drug demand and supply reduction. Within the Ministry of Health, the Health Promotion and Healthy Lifestyles Division is responsible for the day-to-day coordination of drug policy.

In Netherlands, the responsibility for Dutch drug policy is shared among several ministries. The Ministry of Health, Welfare and Sport is tasked with coordination, while the Ministry of Justice and Security is responsible for law enforcement and matters relating to local government and the police. With regard to the dissemination of effective policies at the international level, including matters relating to human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and injecting drug use, the Ministry of Foreign Affairs is in charge. Regular coordination takes place through meetings between drug policy managers in these ministries. Moreover, a lot of practical decisions, for instance on what basic care is offered and to whom, are made on the municipal level. This leads to many local differences.

Similarly, in Germany, the federal government, Länder and municipalities share responsibility for drug and addiction policy**.** According to the German Constitution, the federal government has legislative competence for narcotic drugs law, penal law and social welfare law. The Office of the Federal Government Commissioner on Narcotic Drugs is attached to the German Federal Ministry of Health. The Commissioner on Narcotic Drugs coordinates the drug and addiction policy of the federal government. The enforcement of federal laws is mainly the responsibility of the Länder. The responsibility for the implementation of the drug and addiction policy, in particular its funding, rests with the Länder and municipalities, which may well set different priorities within the framework of statutory provisions and common goals. Coordination between the federal government and the Länder takes place in the interdepartmental conferences and working groups.

In Ireland, the Minister for Health has overall responsibility for Ireland's national drug strategy and is supported by a Minister of State with responsibility for Health Promotion and the National Drugs Strategy. The National Oversight Committee includes representatives from the statutory, community and voluntary sectors and benefits from the expertise of both a clinical and an academic representative. This group meets quarterly and is supported by a standing subcommittee chaired by a senior official at the Department of Health. The subcommittee meets monthly and supports the implementation of the strategy, as well as promoting coordination between national, regional and local levels.

1.4 CSO involvement

We can envisage two different scenarios, where CSO have a proactive role or where they simply undergo to decisions made elsewhere.

Spanish CSO were invited to be part of Spanish Council for Drug Addiction and Other Addictions. The formal structure of the Council allows the active participation of CSO as a useful tool to connect the Spanish policies with the commitment of CSO. Into the Strategic Objectives of national strategy, there is included to foster and encourage active and meaningful participation and engagement of civil society (scientific and professional associations, NGOs, social partners, neighborhood associations and others). There is an interest of CSO to be involved in drug (and other addictive behaviours) policies, expressed in national and international forums. In this context, CSO proposed the participation of PWUDs organizations in national forums same as happens in international committees. There is also a need of institutional channels of communication between CSO and administrations, at local and regional levels, especially for operational tasks as funding, design of programmes, development of the intervention structure and evaluation of the networks.

In the Netherlands, although CSOs are not included in a consistent or transparent way, some organizations, such as the Trimbos Institute and Mainline, have a monitoring role for the Ministry of health. On certain topics, the Ministry of Health holds open internet consultations, and the Ministry regularly facilitates expert meetings on specific policy topics with people from the field. In 2018 Correlation European Harm Reduction Network published a report on the national AP and CSI in the Netherlands. Following the conclusions of this report efforts have been made to set up an inclusive and transparent negotiation structure with the Ministry of Health. This first meeting was planned for 2020, but has been postponed due to COVID-19.

In Serbia the involvement of CSOs follows a regulatory process, prepared as established

by the Office for Cooperation with Civil Society and adopted by the Government of the Republic of Serbia in 2014, defining this type of involvement of organizations as a "partnership," recognizing it as the highest form of cooperation between the civil and public sectors. Following that, the former Office for Cooperation with Civil Society and the Office for Combating Drugs, on a basis of a public call and procedures for work and in open process with participation of civil society organizations, designed a Memorandum of Understanding between the Office for Combating Drugs and civil society organizations. After an open call, 11 CSOs signed the Memorandum and thus become partners in the fight against drug abuse in the Republic of Serbia. Based on this the CSOs were significantly involved in the process of Evaluation of Action plan 2014 - 2017, as well as drafting the Action plan 2018-2021. At the CSOs meeting called by the Office, the organizations agreed about their 4 representatives that were members of 18-members Committee that prepared the draft AP in a collaborative process in November 2018. Unfortunately, the Action plan was never adopted by the Government.

In the other ountries, there is no specific and explicit reference and/or documents to drive the involvement of civil society in drug policy issues.

In Germany, the national drug strategy does not mention civil society involvement, and there are no official documents mentioning it with regard to drug policy making. However, the annual report of the national focal points to the EMCDDA states the following about the role of non-governmental organizations when it comes to the implementation of drug policy: "Activities in the area of health care and in particular of social work in Germany are shaped by the principle of subsidiarity. Non-statutory welfare services organize a large part of socio-therapeutic measures and work with drug users." In brief, structural involvement of CSOs is only expected for intervention implementation and service providing.

We can find a similar situation in Italy, where CSOs involvement is mainly related to running services. Civil society and drug users are scarcely involved in decision making both at national and local level, even though in some regions the synergies between civil society and institutions exist and have proved to be productive; in other regions they are totally absent. This reflects also in running harm reduction programmes, performed differently along the country: in the southern Italy (with the exception of the city of Naples) harm reduction interventions are almost all absent, there are no specific projects or interventions for most vulnerable groups, as well as drug user association involvement.

The National Greek coordination mechanisms have not been operational since the adoption of the Law on addictive substances. The finding that the law has not been applied at any of the three levels should be thoroughly evaluated. Pressure to the government will not come from the state-approved agencies. Changes may come through pressure for Civil Society, clients organizations and independent institutions. The participation of Civil Society in this respect is essential. As an example, the platform of the MKOs on Psychoactive Substances has, in the past 5 years, worked in the field of advocacy activities. The platform must be strengthened as network of CSOs that are working in the field of drugs. The members of the platform have to decide whether they want to continue the current organizational form of a partnership without a legal status or be an organization with legal status. The partnership model stresses the autonomy of the member organizations; they share responsibility and contribute from their specialism to the work of the network. The legal status is favorable for the platform as such, because it will have a common statute that will make decision-making easier and can also apply for financial support for its activities.

1.5 Conclusion

This brief review of the APs of the countries participating in the project, despite its limitations, highlights some aspects that should be further explored. Some of them have been the subject of in-depth analysis in focus groups, as will be illustrated below.

In most APs, explicit reference is made only to illicit drugs, thus placing greater attention on law enforcement, rather than on aspects of well-being.

The lack of systematic evaluation, as well as a lack of clarity of policy evaluation indicators, should be further analyzed. Where the assessment is made, it is essentially based on epidemiological data, which, although fundamental, require other kind of data to better understand the phenomenon and the actions to be taken.

Another critical aspect concerns harm reduction (HR), which only in rare cases is an integral part of the APs. However, in all countries HR is an action that is considered fundamental and implemented, regardless of its mention in the plan.

What is clear is that reality is far from the regulatory action on a National Plan, as it reported by a focus group participant "*I don't know of any action plan other than on paper…. For me, AP does not exist at all, and no detail, nothing, nothing is working"*.

Last but not least, to fill the gap between theory and practice the involvement of CSOs should be mandatory and playing a proactive role in decision making, and not only a consultative role or, worse, as just service providers.

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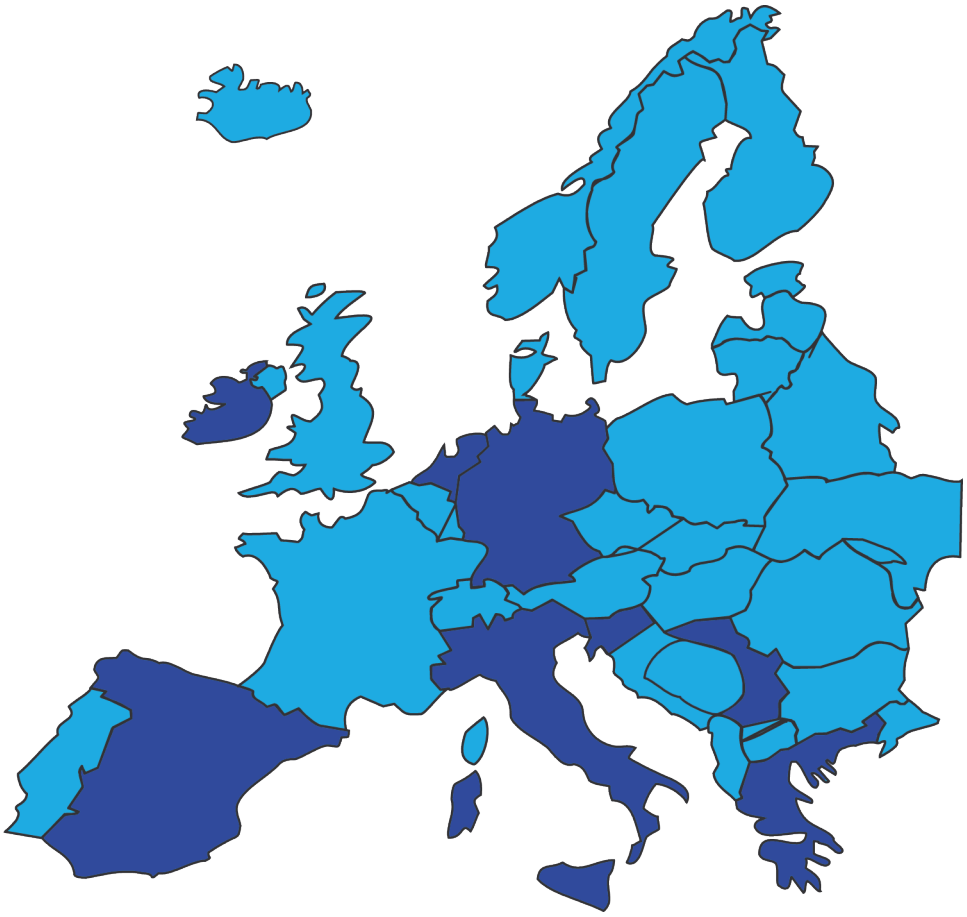
Part II

8 NATIONAL CASE STUDIES. OVERALL REPORT[7]



This part of the report analyses the findings from the 8 national case studies adopting an overall, integrated perspective. The reporting is based on the focus groups results about the 6 core themes of the EU Action Plan 2017-2020 identified as the most relevant ones, in the CSFD perspective.

7 By Susanna Ronconi

2.1 Drug policy general approach

The EU AP 2017-2020 is based on the European Strategy 2013-2020, according to which drug policy must be balanced (between reducing the demand and the supply, between socio-sanitary policy and repressive policies), *integrated and evidence based* and must respect *human rights* (*EU AP, Introduction*). To which extent these guiding principles are reflected in national APs?

This first area of inquiry is dedicated to if, and to what extent, national policy is inspired by the general principles that guide the EU policies on drugs, according to what is written in the European Plan and Strategy. The focus is the balanced approach between reducing the supply and the demand, the level of policy integration in diverse contexts, adopting an evidence- based criteria and respect for human rights.

Key Points

- **There are many barriers** to balanced, integrated, evidence and human rights-based drug policy. The reasons are multiple: decentralizations and local differences; opacity and opportunism by political bodies which are influenced by different variables; the difference between theory/proclamations and practice.
- **Balanced Approach**. There is a significant consensus between participants regarding the scarce balance between a repressive approach and a social-health approach, in favour of the former. There is ***a lack of evidence*** especially concerning law enforcement impact more so than social-health aspects and a difference in economic investments between these two areas.
- The trend is contradictory: on the one hand public debate seems to attenuate the importance of political ideologies but on the other hand in recent years ***a tendency to emphasize a law and order approach*** can be observed. This also occurs in countries traditionally viewed as more pragmatic and open. The context (populism and government orientations) is a significant variable.
- **Evidence based.** There are significant differences between countries regarding policies based on evidence. Nevertheless, even those with a better system show a decline in the trend of a positive science-policy dialogue and in crisis with respect to the years 1990-2000.
- Evidence appears to be in increasing difficulty, scarcely functional in producing change and reform. This is true in particular for controversial issues (such as the politics of cannabis) and with respect to repressive policies, which are insufficiently evaluated with regard to social-health policies.
- In the assessment of policies- that should guide innovative processes and reform- the evaluation of outcomes and impact is rarely present.
- **Integration.** Even if there are significant differences between countries with respect to formal systems of coordination and integration of policies, there is a common feeling of dissatisfaction regarding the gap between theory and practice of integration.

- The critical points are the scarce integration between the policies of demand and those of supply on the one hand, and, with respect to the former, the excessive self-referential nature of systems and services that often see integration as a threat to their autonomy and authority rather than a resource. There is a responsibility here that is not only political but also from workers and services providers.
- **Human rights.** There is wide-ranging consensus on this issue, notwithstanding the fact that some countries do have formal declarations with respect to the rights of PWUDs and all have an official rhetoric regarding this. The rhetorical risk is strongly felt in this field.
- Criminalization is indicated as the more influential variable and the places of criminalization (prisons and the relationship with the police force) are those with the majority of human rights violations. The claim for certain social rights is threatened and limited by criminalization.
- The right to health (care, access to services) is arbitrarily exposed by the selective rules of services and health professionals. There are no places or institutions where people can appeal to defend this right.
- There is the need for a specific approach for human rights for PWUDs. A specific action targeted at fundamental rights -which has occurred for other diverse social groups- in order to exit from a generalness that translates into a lack of accountability.

2.1.1 Is balance a mirage?

The balance between the policy of reducing the supply, which concerns the production and the supply of drugs, and the reduction in demand, is critically appraised by the majority of respondents, notwithstanding the differences in national contexts. It should be emphasized that when a balanced approach is being discussed, in reality this is not limited to just supply and demand as areas for intervention, but also refers more widely to a repressive approach versus a social, health and educational approach. Repression therefore is considered not only with respect to the market but also against consumption. It is where the intervention of law enforcement enters into the policy of reducing the demand and is seen as a potential deterrent for drug use.

Repressive policies and the reduction in supply have ***a greater weight in national policies***. It is one of the more homogeneous judgments among the diverse national realities.

> ***D*** *The approach is not balanced, because health aspects of drug policy remain subordinated to criminal justice aspects.*
>
> ***IT*** *National policies are absolutely not balanced between a repressive approach and a socio-health approach. (...) The repressive approach is absolutely predominant*
>
> ***SRB*** *Some 95% or 96% of the Action plan for this segment, and also the West Balkans Enlargement Country Reports published by the EU annually (including the one for Serbia), are oriented towards supply reduction, better said to repressive measures. Only in a small part in some countries appears to what is related to all other elements such as prevention treatment*
>
> ***SLO*** *When working with drug users, it is felt that repressive policies are still quite strong -*

drug users in their "career" of drug use are more likely to face repressive measures than treatment programs

ES *What I want to say is the weight is not in "No to drug problems", the weight is in "No to consumption of drugs."*

Ireland has diverged from this reasoning and their actual AP is considered balanced in favour of a health policy, even if, as will be seen later on, there is a significant gap registered between what is announced and the reality on the ground.

IRL *Very clearly, it's health-led, it's stated from the very beginning*

This ***overall imbalance*** is not always clearly visible in the APs or in the national strategies. Rather than the consequences of an explicit choice, it appears more as ***a result of a series of processes*** where different variables are at play. This makes the issue complicated to evaluate. As was described in the previous chapter, national policies are often disseminated in multiple and diverse official acts (laws, guidelines, regional or municipal norms) with the consequent difficulties both in identifying clear objectives and evaluating results and impact. It has been observed that this vagueness could be interpreted more as a political fact rather than inefficiency: a not ingenuous policy motivated from ***protecting the decision makers from excess exposure*** and criticism that a more transparent affirmation of the drug policy objectives would cause.

NL *Politicians are afraid to work on a visionary policy document. They don't want to become vulnerable for media critique.*

D *There is no overarching vision, no common thread or coherence.*

SRB *Our drug strategy is mostly in my head, representing the Ministry of the Interior as the most visible, and their repressive element, while these other institutions are more or less invisible.*

NL *It's hard to weigh up the balance, because it's not one policy. On the one hand we have the health policy from our ministry of health and on the other hand we have our so called 'undermining policy' from the ministry of justice and security.*

This ***undermining policy*** is therefore characterized by its complexity but also by the ***opacity of the objectives*** and the processes and from the perspective of the CSOs appear as a barrier for the promotion for change.
The lack of balance in policies has concrete negative effects (and at times paradoxical) with regards to reducing the demand. Firstly, it is to the detriment of the development of adequate policies and social health and educational interventions, which become ***ancillary in a hierarchical relationship***. The predominance of a repressive approach ends up being an obstacle for the development of better health and social policies:

D *Health interventions are only allowed up to the level where they do not contravene criminal justice policies.*

IT *Our system is a system that is centered on penalizing behaviors related to drug use and therefore paradoxically the health and social health system is experienced almost as "a servant" of this fundamental principle*

G *The criminalization of possession for personal use perpetuates the repressive behavior of the police (...) Furthermore it has negative consequences for the users who attend treatment programs.*

It has been further noted how paradoxically the prevalence of a repressive approach

does not only limit socio-medical approaches but is ***the origin of effects and correlated damages*** which must be remediated. Part of the CSO actions consist in trying to ***mitigate the negative impact of repressive policies***

> ***D*** *So I usually say that what we are trying to do, is simply to reduce the damages that the criminal justice system creates.*

2.1.2 The rhetoric and the practice of a balanced approach

Aside from what is written in the APs and the national policies, what the CSOs observe from their positions on the ground, is ***the gap between what is written and what is actually implemented***.

> ***ES*** *Politically it´s true, it´s a very well-designed plan, totally embedded with European strategic lines. Personally, I would like to put emphasis in the balance between papers and realities…because if not, there is no transfer to practice.*
>
> ***SLO*** *On paper, an integrated approach is very well taken into account, but again it is a big gap between what is written and the reality*

From this perspective, even countries that traditionally have a positive reputation regarding a balanced approach denounce **the risk of rhetorical discourse.** If this is compared to actual processes, this balancing appears to be critical in reality:

> ***NL*** *The Netherlands do well in their balanced approach, but other European countries do much better than us, e.g. Switzerland and Portugal. We are certainly not the pioneers that we used to be.*
>
> ***D*** *Internationally, people look at Germany and say that we in Germany listen to what the evidence says, but in reality, we are still locking people up, instead of treating their illness.*

The reasons for the theory-practice gap are also structural and economic, due to the lack of investment in services and structures. On top of this are the regional and local government delegations, which instead of following the written national laws follow their own local politics, often misrepresenting these norms

> ***IRL*** *On paper it's a very good one, by European standards, but we don't have the proper structures in place to make sure it's implemented'*
>
> ***SRB*** *A "special story" is practice. How it is implemented. (…) Practically, when it comes to prevention or cooperation at all, it all comes down to local self-government as it is lowered to the level of local authorities, public health institutes, regional and is simply only roughly regulated by law.*

Last but not least, the gap between theory and practice "seen from the street" appears decidedly wider: social and health policies aimed at people who use drugs are not adequate to their needs.

> ***G*** *The big disadvantage is that the situation of drug users in treatment and harm reduction programs as well as in the streets is not taken into account.*

2.1.3 Back and forth. The balanced approach swinging trend

The evolution over time of the balance between a repressive approach and a social-health approach appears contradictory and opinions are diverse between states and also within the same national situation.
On the one hand, positively, there seems to be an easing of an ideological vision regarding drugs in favour of a more pragmatic approach. It is interesting to note that even this attenuation however does not necessarily bring with it a better balance:

> ***D*** *It's less ideology and more pragmatism today, but that still doesn't mean that drug policy today is health-led.*

According to some there is less ideology around drug issues when the discussion is about adult users, who gain in visibility and status as protagonists, but this progress shows its limits when dealing with younger people. Here the culture of alarm remains and traditionally tilts the balance towards a law and order approach of governing the phenomena:

> ***D*** *Drug policy is less ideology-based when it comes to adult PWUD, but the same conversation from 25 years ago in relation to young users.*
>
> ***IRL*** *I think service users and the people who use drugs in this strategy are named an awful lot more. So again, they are definitely more visible'*

Critically, above all in the countries in northern Europe that are traditionally considered more balanced and pragmatic, a ***regression towards repressive tendencies*** is reported. This is the exact opposite of what is happening in other European countries.

> ***D*** *Overall, I see a societal shift towards more authoritarian and law-and-order ideology.*
>
> ***NL*** *In Amsterdam we see a shift away from public healthcare and more toward justice and security. While other countries seem to be moving forward, we are moving backwards.*

Here the dynamics of national politics evidently count, such as the changes in government majorities or the ***advance of populist agendas*** where the "order" approach regarding "sensitive" issues is ingrained. Faced with these political processes the EU guidelines appear clearly weak and hardly influential.

2.1.4 Variable geographies of balancing

The balance between the two diverse approaches also depends on the variable of the State organization with respect to policies and to social, health and educational interventions. This is especially true where there is ***regional or municipal autonomy*** and title. This autonomy, working on a social and political level, influences also the overall national balance between law enforcement and social policies.

> ***NL*** *We cannot really speak of one national drug policy. In our province there are seven central municipalities and each of them has defined their own policy. (...)There is no national policy, only local.*

Where there is greater autonomy, this translates into a constraint also for national policies. These can be hindered in the actual implementation processes when they are not adopted or not supported at a local level.

> ***D*** *In some cases, the federal government is willing to spend money and puts forward innovative ideas to the states, but usually that means the states have to contribute*

financially and don't agree to do that. Therefore, interesting and important interventions are not going ahead

The concrete fallout of these institutional dynamics is the ***generation of regional inequality***, both in the balancing of the two approaches and with respect to the rights of the recipients of these interventions.

IT *We have very, very fragmented situations in Italy, profound differences between regions as regards all interventions concerning drugs and drug addiction*

D *The government cannot implement something that the states do not agree with, do not want. That results in regional differences and inequalities, being it east-west or north-south.*

NL *If we strengthen our national policy, we could for instance decrease the influence of health insurances and municipalities on our healthcare for PWUD. It could contain the great variation between municipalities.*

2.1.5 No money, no balance

One indicator of the imbalance between repressive policies and social, health and educational policies, is that of ***the budget and of public investment.*** There are some cases where there is money for the former at the expense of the latter, which are subject to continual cuts; meanwhile there is also the problem of transparency and access to data.

IRL *But if you looked at the budgets that come through the task force actions and then compare that to budgets in the policing side which we wouldn't even be aware because they are not included anyway.*

IT *The investments in economic terms that are made in social and health services, in recent years have been subject to cuts and downsizing, and reduction of personnel.*

2.1.6 Scientific evidence. A thorn in the side of politics

Notwithstanding the fact that there are no national documents that, in line with European indications, do not introduce the principle of evidence in the adoption of adequate and efficacious policies and the evaluation of their interventions, this appears to be ***the area where the risk of rhetoric is great***, in the eyes of the CSOs. Basing policies on evidence appears to be ***a thorn in the side of policy makers rather than a resource,*** and the processes of "emptying" or "sterilizing" an evidence-based approach are numerous.
There are countries where an evidence-based approach in policy making has been historically lacking (for example where the descriptive evaluation process is confused with evidence). Others in the past have developed a good evidence-based system in the policy decision-making process, but today they are in standby at the best and regressing at worst. These dynamics are clearly correlated to the regressive national political dynamics mentioned above. A certain positive impetus registered in the '90s appears paradoxically to have suffered a setback, if the rapid changes in the drug scene are considered.

IT *In Italy our way "to evaluate" policies is only to describe the process data*

D *Important steps have been made during the 1990's and 2000's when important evidence-based measures were implemented. But little has happened since then, and in some cases, it seems there is a backwards going now and polarization, also on social media.*

NL *Although the Dutch government seems to be a strong proponent of evidence-based drug policy, we don't act on it. Our last national drug policy note stems from 1995, and our last evaluation was in 2009.*

One important point is the ***relationship between science/research and policy:*** this is a conversation that appears to be difficult and uncomfortable. The mediation between language and power is tested within the complex decision-making processes where strong variables are at play (ideologies, interest groups, alliances, the media, public opinion and consensus). There is the perception that politicians "don't know what to do or how to use" the research (apart from fearing it) and that ***evidence is not the actual engine for change***. This perception is frequently expressed by the participants and is translated into a lack of investment and limited development of competencies and resources.

IT *In Italy there is neither planning nor an assessment of the impact of drug policies*

SLO *This is an important aspect of the action plan – but on the other hand, no one is interested in the results and they are not used as a starting point for possible concrete steps in practice.*

The lack of evidence is even more noticeable when attempts are made to propose ***innovation regarding areas that are politically divisive,*** such as the policies around cannabis which continue to be ideologically governed notwithstanding the wide availability of evidence at various levels.

D *A similar trend can be seen in regard to cannabis debates, which are not evidence-based at all.*

The repercussions of the lack of real investment in evidence are very strong also in terms of ***services and interventions***. The absence of evidence and above all the incapacity of policy makers to put it to good use, runs ***the risk of perpetuating inefficient interventions*** at the cost of adequate and effective interventions, for example when dealing with standards of quality. This is a delicate and crucial aspect if this lack of dialogue between science and policy making is considered in terms of the direct repercussions on the rights of people to health and to access to high quality services.

ES *Is absolutely necessary to have all services evidence based, but then there aren´t budgets and grants for them. (…) There are things traditionally doing that haven´t shown never any evidence."*

SLO *Larger existing evidence-based models / interventions are not sufficiently funded - so in practice these models are introduced slowly / gradually (not comprehensively) (…) Huge discrepancy between what is written in the documents and the actual situation in practice is present - in practice it means that approaches that do not follow quality standards at any point are still present.*

There are cases where, with regards to policy or services that are still considered politically controversial, such as Harm Reduction in some countries, the request for evidence is utilised in an exaggerated way with respect to other sectors or systems of intervention. In such cases ***a political use of the evidence*** can be noted, when this same request is not required for other types of intervention.

SLO *The area of harm reduction is most often affected by the requirements for proving efficiency, while elsewhere (repression, police action) it is not necessary to prove approaches (…) Drug testing takes a huge amount of time to prove effectiveness - before you even put the model into practice. This necessary time is sometimes not available.*

Placing attention on a balanced approach, it is interesting to underline the observations around the imbalance in the evidence invoked (mostly) for social and health policies and those (much less) developed for law enforcement. Whether or not they are used well or otherwise, the evidence regarding services and social-health policies is nevertheless well articulated in indicators, evaluation processes and impact whereas ***evidence regarding repressive policy is lacking*** from the very beginning, not to mention the actual adoption of evidence as baseline criteria for instituting repressive policies in the first place. This aspect, which is a common limit among states and the EU, leaves the impact and the results of repressive actions in the dark, both in the area of supply and of demand.

> ***IT*** *Is there a global assessment that is able to combine, let's say the socio-health data with the data of the Justice system, with the data of the repression?*
>
> ***NL*** *Our ministry of health tries to operate in line with the monitoring indicators of the EMCDDA. They have a solid development of healthcare indicators, but in the field of security they have hardly been developed. This is the case on the national and on European level.*
>
> ***NL*** *The evidence base of our health policies is quite strong, but our security and supply reduction policies are hardly evidence based.*
>
> ***ES*** *If you check the Reports, the money for control of offer and the knowledge about how it´s working here… we haven´t got this information."*

As with other politically divisive themes, the ***entire area of law enforcement*** and of the criminalization of behaviours related to use ***remain completely extraneous to evidence criteria***. The lack of evaluation of this impact on people, families and communities means the outcome is perpetual inertia, ritualistic and a lack of innovation, even when the data illustrate their negative effects.

> ***D*** *It is very clear that the goals of repression have not been achieved, this is also acknowledged at official level. Still, nobody draws the conclusion that as a result, we need to change.*

This is the case also when statistics regarding crimes and incarceration- process data- are shown as indicators of success. If they were evaluated with respect to impact, for example on health or social conditions, there should be a push to decisively change such strategies

> ***IRL*** *Only recently we got the latest set of drug related offences, the most recent figures and again it was like close enough to 80% of those were for possession only. And this is presented as this is great, see how many people we are catching you know and you say hang on the strategy says its health, why are we 'catching' people who have an illness.'*

2.1.7 The difficult art of integration

Among the diverse national realities, there is also consensus regarding the integration between policies. As with a balanced approach, this is another area of concern.
In some cases, this integration is confirmed formally and on paper, for example between a national agency or a coordination between ministries. However, in reality this ***is more an interaction, and more or less occasional, rather than an actual system***. According to some CSOs in some cases it is totally absent.

> ***G*** *The integrated approach is expected to be realized through the tasks and responsibilities*

of the National Coordinator on drugs and the National Commission on the planning and co-ordination. (...) However in practice this structure has not functioned in the past years. In the everyday practice, there is no integrated approach.

IT *The repressive system and the socio-health system are two apparatuses that do not communicate*

IRL *'We don't have the kind of inter-departmental relationships that enable you to actually implement it, or measure it'*

SRB *There are no clear coordination mechanisms between different institutions*

SLO *In practice, there is a great disconnection between different sectors (health, courts, social). Everyone works on their own*

One aspect of this is the ***self-referential nature of the different systems*** in which policies are articulated (social, health, legal etc.) and within different systems that defend their competencies and prerogatives and regard integration more as a threat that reduces autonomy rather than a systemic resource. This resistance seems to be evident at all organizational levels.

IRL *It looks like we have the structures where everybody comes together, but …each agency says, this is our bit. Sometimes interagency approach is understood as "oh somebody is going to come and tell me how do my job".*

What works against integration, with respect to services, is also the prevalence of a certain operational model where there is emphasis on the "productive" performance of each single unit regardless of the context of the system.

NL *Due to spreadsheet management -keeping score of all your care activities- many of our services have become less integrated.*

2.1.8 Human Rights. Are PWUDs human beings?

G *There is a blatant violation of drug users' rights. Human rights are a key issue, the alpha and the omega of any policy that has to do with respect for human beings.*

The road for actual concrete respect for the human rights of people who use drugs - widely invoked in all official EU and international documents- is an uphill climb. According to some participants, there is above all a basic precondition that renders their claim rather weak and that is ***the statute of the illegal nature of conduct related to use***. With respect to the universality of fundamental human rights this statute should not in itself be translated into discrimination and violation of rights. However, the criminalization process, along with social stigmatization, has demonstrated the capacity of the formal system of rights to be often ineffective for PWUDs.

D *The discrimination and stigmatization that PWUD experience comes from criminalization.*

NL *If we really want to take into account the human rights of PWUD we would have to move more towards [legal] regulation.*

D *As soon as it touches something different, in this case the illegality, this governmental and financial support [to human rights] disappears and it becomes difficult to advocate for anti-discrimination at all*

There is also the formalized practice, correlated with criminalization, to ***exclude certain***

rights. An example of this is in the Netherlands with respect to housing: for a minor charge there is the risk the whole family will be evicted.

> ***NL*** *We offend human rights all the time (..) Another example is our Damocles law, which allows the mayor to evict people from their houses for possession of small quantities of drugs. Whole families can be evacuated this way*

In some countries the human rights of people who use drugs are not present on the drug policy agenda and therefore ***there is no place where this issue can be opened up*** for discussion.

> ***IRL*** *If we say it's got human rights approach what does that mean? Who is discussing that? we certainly aren't being involved in any discussion around that.*

Even when the issue of human rights is included in the national agenda for drug policy, it often results in being impromptu, vague and formulistic with its real implementation slowed down with this ***gap between rhetoric and practice.*** The lack of respect for rights is facilitated by ***the absence of actual accountability mechanisms*** with which public institutions should assume a specific responsibility and be accountable. According to some CSOs, a specific declination would be necessary ("human- rights -in- drug -policy"), via a circumscribed approach to an actual, not a rhetorical approach for a universality of rights that would also include PWUDs. This in actual fact is the path taken at an international level.[8]

> ***G*** *The Greek State approved in 2014 the Charter of the Rights of drug dependent people. This Charter (...) is important and allows drug users to invoke its provisions in cases of violation of their rights. In every day practice, many of the rights mentioned in the Charter are not respected.*
>
> ***D*** *There is no official strategy or campaign for human rights. If there are initiatives at all focusing on Human Rights, they are led at local level. (...) On the political level, the only time I hear about it is on the day of remembrance for overdose deaths.*
>
> ***NL*** *Our Ministry of foreign affairs and Ministry of health take human rights very serious in their policies and communication. It is an important theme, but the question is: how does this translate to practice?*
>
> ***SRB*** *Human rights in this country are reserved for national minorities, the Roma, and to some extent people with disabilities, and everyone else have nothing to do with it. And we can't break through that narrative. It would be good to have them (PWUD) included because the problem is sectorial.*
>
> ***SLO*** *The principle of human rights states that children and young people should be protected from such life circumstances that may lead to drug use and related problems - in practice this principle is not adhered to.*
>
> ***ES*** *We are stuck in the middle of consumers 'human rights, but a general consumer, not here that we can find people really in higher vulnerability.*

There are contexts where the violation of human rights appears to be more evident and frequent. In particular this occurs in ***total institutions and in the relationship with the police force***.

> ***G*** *Human rights in prisons do not exist when you have the label of a user.*

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8 UNHR, UNAIDS, WHO,UNDP, ICHRDP, International guidelines on human rights and drug policy, 2019 https://www.humanrights-drugpolicy.org/site/assets/files/1640/hrdp_guidelines_2020_english.pdf

G *The treatment of users by the police is to a great degree problematic. If we could record user testimonials, things would be shocking*

The violation of rights that occurs when there is coercion and force used by institutions is evident and unfortunately is something many people have been subjected to. However, another alarming aspect has emerged from the participants and that is ***the lack of respect for fundamental rights in the area of reducing the demand***, such as those concerning health and social matters. In particular the right to health appears threatened by discretional processes concerning access, care and treatment. This has to do with both ***procedures and regulations that services use to select clients*** and with the attitude of the health workers.

SLO *Regarding Drug Addiction Treatment Centres (DATC) – they have very rigid system. They have their own criteria for who to take into treatment. And sometimes when you refer someone to one of those centres, they don't accept him/her there because he/she doesn't meet their high.*

G *The degree of stigmatization by mental health professionals is enormous towards users of psychoactive substances and people who live with HIV.*

IRL *So it's kind of a bigger piece than just letting services be open. It's just thinking about what it means to a person that is being stigmatized by society that is being discriminated*

SLO *Human rights are violated many times by individual decisions about whether a person is eligible for help or no - to a very large extent this decision is subjective and not based on professionalism.*

ES *Drug users lot of times are out of other services, like gender violence social services.*

With respect to access to services, the difficulty or the impossibility of services themselves to be transparent and responsible regarding their decisions to exclude is lamented. There is a lack of designated ***places where a person can expect justice,*** where receive the protests and demands for respecting rights by individuals.

SRB *Everyone is talking about that local health council and when you look at what they do, we have very scant information about citizens' health advisers (…) The places where you can complain should be in place (…) These are places that should work, but unfortunately, we have big problems.*

2.2 Availability, accessibility and quality of interventions

The EU AP contains detailed objectives and actions aimed at guaranteeing access to services and treatments (AP 1.1 e 1.2) The AP dedicates particular attention to socially vulnerable groups (homeless people, migrants and asylum seekers, prisoners), to different age groups (children and the very young, older users) and to gender (AP 1.2, actions 6,7,8). Is availability, access and quality of interventions, services and treatments (in the areas of prevention, care and rehabilitation, harm reduction) provided for in the national AP sufficient and of a high standard? Are there policies aimed at vulnerable groups and encompassing diversity?

Key Points

- **Availability and access to services and treatments**. The 8 countries included in the research expressed an overall discreet satisfaction for the system of services and for access for the general population of PWUDs. However, they also note limits and negative trends with respect to the past.
- **A critical point is that of financing and the logic of the market**, which dominate over criteria of quality and coverage. This logic afflicts both municipal and regional policies as well as relationships with the Third sector, exposing the system to discontinuity and low standards.
- **Geographical inequalities characterize availability and access** with important differences between different cities, small and large centers, urban and rural areas. This creates differentiated levels of opportunities for users.
- **There are political mechanisms that are barriers to accessibility**: little transparency regarding decision-making; an excess of discretionary power; little relevance given to evidence in the decision-making process and a lack of clarity from decision-makers regarding interventions guidelines.
- **Prevention**. The same limits described for policies in general (financing, unequal geographies) are found here. Different exceptions also emerged regarding prevention (from safer use education to prevention of use).
- **Treatment and Rehabilitation**. The geographical inequalities of local autonomy are also noted. There is growing difficulty to access, for example the distance a person must travel to reach a service or due to the long waiting lists. This appears to be problematic above all for the OST programs, where timing is crucial, and exposes a person to the greater risk of resorting to the black market for medicine.
- **Critical areas in the integration of services**, with the consequent excessive compartmentalization that makes it difficult for clients to orientate themselves and navigate the system.
- **Positive trends in terms of innovation regarding options** has been observed, both with new services and with up-dating traditional services (such as rehabilitation centers for example), in line with the changes in modes of drug use and needs.

➲ **A negative trend** has been noted towards more **pathologizing** of behaviours of drug use and above all, more **psychiatrization**, at the cost of a wider social vision of the issues. This has repercussions for services and for health professionals.

In contrast to what occurred with the issues of a balanced policy, integrated, evidence/based and attentive to human rights, the 8 countries included in the research express ***a discreet or good level of satisfaction overall for the systems of service and for access*** with respect to the general population of PWUDs (less, as will be seen later, for certain social groups). The exception to this is Serbia, who declares their system to be below all of the European standards.

> ***IRL*** *We actually have a really, really good model of service delivery. So that you'd have obviously some very strong NGOs involved in different services and a there are brilliant, brilliant services.*
>
> ***D*** *For EU comparisons, Germany ticks most boxes because most programmes exist at least once, but often they do not cover all areas/needs/groups.*
>
> ***SRB*** *The health services targeted at these marginalized groups, including drug users and other related key populations, are underdeveloped in Serbia and incompatible with the EU*

Nevertheless, from the perspective of the participants-who have a concrete view of the operative processes and of the efficacy of services- ***a series of barriers can be listed that prevent greater accessibility***. These also make it more difficult to implement what national policies declare, at least formally. These barriers illustrate a range of critical areas that could be used as a road map for possible innovations.

2.2.1 Money and the right to health. "As a choice in a canteen"

A significant variable for a system of services that is accessible and of quality are ***the economic resources and financing*** for interventions. Whether this is a universal health care system, based on a national public health service, or a system based on private insurance, the crucial key point is ***the scarcity of resources or their dysfunctional distribution.*** The past few years have witnessed a ***negative trend*** in this area.

> ***NL*** *The insurance companies have too much power in the financing of drug treatment. It is now October; some clients cannot get any further treatment until January, because their insurance budget is finished.*
>
> ***G*** *The two state-approved organizations, OKANA and KETHEA, largely cover the needs of drug users in their centres in the big cities (...) The countrywide coverage of these organisations ensure availability for almost all aspects of the necessary interventions: prevention, treatment, care and rehabilitation, harm reduction.*

A specific aspect concerns the ***relationship between Governments and Ministries and the NGOs that provide services***. The ***lack and the discontinuity of public financing*** in the Third sector places the associations in great difficulty, and the quality and guarantee of the service systems that depend on them is affected as a consequence of this.

> ***ES*** *It is impossible to develop a project…especially it´s impossible with only a few euros they give to us. It´s impossible to develop a project with all the proper components."*
>
> ***SLO*** *Officials at the ministries should be dealing with coverage and not NGOs. This is the task of the government and it should take care of sustainability - by strengthening the*

knowledge and skills of the non-governmental sector (…) and of course regular funding.

The logic of the market in the services system, the question of costs, of containing spending and the fallout of this on quality, availability and accessibility to services, result in a problem that affects both the Third sector- which at times ends in conceding to purely economic and competitive logic- and local organizations and municipalities. These also care more about ***the economic convenience of the offer and not the quality or the priorities*** dictated by the needs of the context.

> ***SLO*** *The NGO sector sometimes behaves like a market entity (…) because we sometimes see each other as competitors - we do not want to lose "customers"*
>
> ***NL*** *Drug treatment providers are dependent on what the local government buys (...) the municipality treats their offer as a choice in a canteen: they only select a few of all the possible services on offer, even though that is much less effective*

2.2.2 Unequal geographies, unequal citizens

The research indicates that, aside from the differences in systems in the 8 states involved, there is a common question of "unequal geographies": ***the repercussions of autonomous regions and municipalities in terms of unequal opportunities*** for availability, quality and access to services. This unequal map undoubtedly raises the problem of how the national guidelines can, even with respect to these autonomous systems, guarantee that there are not important disparities regarding the right to health for everyone in the nation.

> ***IT*** *With regard to all interventions, on the socio-health level we have 21 different regional socio-health systems (...) There are profound differences between regions as regards all interventions concerning drugs and drug addiction*
>
> ***NL*** *There is no national policy; municipalities and organizations decide on the rules. For instance, whether or not people can use drugs in sheltered housing facilities is decided upon by the organizations themselves.*

A significant geographic difference is between ***big cities and small cities, or between regions,*** with rural areas being penalized.

> ***SLO*** *Poor coverage across the country (differences are even seen in individual towns). There are also differences between bigger and smaller cities.*
>
> ***D*** *In the cities where there is an obvious drug problem and need for services, a lot has been done. But the more rural you go, the less visible PWUD are, the less services are available*

2.2.3 The uncertainty of policy. "The 'wrong' individual can be a barrier"

Along with resources and geography, a number of barriers emerge which prevent the development of a better system of services. These can be defined as "hidden" or implicit. They belong first of all in the political sphere, and can be mostly described as ***a lack of transparency and the scarcity of verifiability in decision-making processes*** or that they oversee the implementation of policies:

> ***SLO*** *The state never defends written things in public and in the media*
>
> ***D*** *It depends a lot on the individual policy-maker and the "wrong" individual or party can*

be a barrier.

The ***dependency on a single person with power*** to significantly orientate policy emerges even when it comes down to the baseline, to an actual service. According to some, there is an ***excess of discretional judgement*** by the service and the workers, above all in interpreting the rules for access. This is an important question, as it has repercussions concerning the rights of everyone to a true ***free choice of treatment from a service***.

> ***D*** *But if you look at the conditions for accessing it, it's hard to say there is a free choice (...), So on a surface level, there is free choice of options, but the further you go into detail, the more you see it depends heavily on the institution or person that you are dealing with.*

There is of course a clear responsibility from political bodies regarding the system of verifying the ***quality of interventions***. This is an area with significant importance in the EU political arena and declared as such also in the APs of the member states. However even here there are areas where ***implementation and transparency is lacking,*** all of which results in some guidelines and good proposals regarding services remaining on paper only. The critical point- already cited- is the evaluation and the relationship between evidence -based evaluation and policy processes

> ***G*** *The issue of the effectiveness of the interventions is an open question due to lack of transparency*
>
> ***SRB*** *Standards (quality) do not yet exist. Regarding quality standards, we, as Re Generation, also participated in standardization, but we did not receive feedback on what happened to that document.*

Finally, when necessary innovation of services in accordance with the evolution of drug use modalities is discussed, politics can represent an explicit barrier: represented by rigid normative constraints and by the resistance from policy makers both to reform these and to interpret them in the most flexible manner possible. They also need to be as functional as possible with respect to changes in phenomena (an example of which is the obstruction regarding some intervention methodologies of Harm Reduction).

> ***D*** *Another barrier to increasing access and availability and introducing new options is that they may contravene with existing laws and criminal justice policies, and therefore it is so hard to progress.*

2.2.4 The different meanings of prevention

Those participants who specifically cited the area of prevention expressed positive evaluations regarding their national systems, underlining in particular the competencies and the experience developed over time by health workers. Only Serbia reported severe gaps in this area of intervention.

> ***D*** *Overall, I believe we have good quality prevention work, mainly due to very skilled staff.*
>
> ***SRB*** *We do not have direct program money in the Ministry of Health or Social Welfare for any kind of prevention.*
>
> ***G*** *There are 74 prevention Centres in all geographical departments of Greece*

As for interventions in general, even prevention suffers from the unequal geographies

mentioned previously, leaving entire territories without any kind of program.

> ***D*** *In some cities/regions, prevention works well and there are good initiatives, but in other regions, there is almost nothing.*

It is interesting to note that ***the meaning of prevention is not uniform.*** For some - the Dutch participants in particular - prevention has ***a wider significance*** than that more generalized, that alludes to the prevention of use *tout court*, and is connected to that of risk limitation, more commonly correlated with the Harm Reduction area (also in the answers provided in this research). Prevention in this instance is drug education or ***safer use education***, and indicates a set of objectives that concern the prevention of problematic use, avoiding the negative impact of drugs on the quality of the personal and social life and health of PWUDs. This is a significant position on this level for defining these same strategic objectives not only for prevention and more generally in terms of public policy.

> ***NL*** *We do a lot of prevention and drug education in the Netherlands. Dutch drug users have been defined as 'agenda hedonists' [people who use drugs during the weekend while fitting it into healthy, socially accepted and professionally productive lifestyles]. I consider this to be a successful result of years of good drug education.*

2.2.5 Treatments and rehabilitation. Not everywhere, not at the right time

Access to treatment is easier if a person lives in a city and better still if it is a medium to large sized city. The threshold for access rises also when people in therapy have to travel long distances. This applies to drug rehabilitation centers, clinics and methadone programmes (OST). Furthermore, ***an inadequate amount of services means long waiting times*** which can impede timely treatment offers, and often it is the timing that can make the difference.

> ***D*** *Substitution works well in bigger cities, people who want to be put on it, will get a spot relatively fast. But in the countryside, this looks very different and there are people travelling long distances every day for their substitution treatment.*
>
> ***NL*** *The availability and access of drug treatment services really needs to be improved. The waiting lists for drug treatment are enormous, and if you want instant treatment you need to go to a religious facility*
>
> ***SRB*** *Our state has reduced Methadone centres by 60% in the last two years (…) Who had then in smaller towns clinics where they received methadone, now have to go to bigger cities*

The differences in availability and access are also influenced by the ***system of financing the services***. For example, when a contribution from a local level is implied, this could make a difference in the investment and therefore the offer available.

> ***SLO*** *In general, there are about 20 DATC (substitution programs) in Slovenia - the state offers a certain share of money, but also requires co-financing from municipalities. (…) substitution therapy in one town/city is very different from substitution therapies in other places - the approaches of all DATC are therefore not the same in all cities.*

A disinvestment in services, specifically in the ***OST programmes,*** not only renders life more difficult for PWUDs, raises the threshold for services and reduces the numbers of

clients, but also contributes to multiplying potential harm, such as ***access to medicine from the illegal market***

> ***SRB*** *"Bup" (buprenorphine) and methadone are the main dealer products now, I know the prices, and out of my 30 protégés, 14 came and asked for help to treat bup*

There is a shared sense of dissatisfaction regarding ***the paucity of a system between services***, both in terms of integration between the public system and the Third sector/ community and an excessive compartmentalization between services. This means ***the client needs to "navigate" a complex system***, at times repeating the same steps, perhaps the same diagnosis plus having multiple files in their name.

> ***IRL*** *The vast majority of those opportunities are delivered through those community settings (...) But there is no, absolutely no formal connections between the two, there should be referrals and there should be interagency working between the clinical side and the broader side (...) At the moment everybody has to do everything because the facility isn't there to link up.*
>
> ***NL*** *The main problem with our care and rehab is that it is so compartmentalised. There are so many different institutes. People get sent to so many different professionals and need to share their story over and over*

On a positive note, treatments tend to be - more or less timely - adapted to the request of clients and to follow the changes in drug use and the needs that emerge bit by bit. This occurs in the rehabilitation centers, which must respond in an innovative way to diverse types of clients. It occurs in services traditionally centered on opiate users, which must look at new types of use.

> ***IRL*** *I think with the HSE services there's still a challenge with moving on from the very strong focus on methadone. They are still quite defined by that and it's a challenge for them to move past that.'*
>
> ***D*** *In-patient rehab, we do have a lot of different options, and they have also changed and adopted over the course of the years, and they have to do that because otherwise, their beds would remain empty.*

Finally, there is a question that should be considered more seriously and monitored, even if it should be researched more fully first, and this is ***a paradigm question more than an operative model***: the shift in the "drugs and dependency" area ***from social work and in some respects, public health, to psychiatric care***.

> ***NL*** *It used to fall under social work, but now it is the domain of psychiatrists. Just having a coffee and a chat together is no longer possible, because this is not supported by psychiatric theory.*

The ***psychiatrization of drug use***, and more generally the pathologizing of the same, is a process with serious consequences and one that contradicts the current approach based on social, educational and health dimensions. Given the implications of this, it should be a priority subject for critical analysis from civil society groups.

Vulnerable groups. From the mainstream to intersectionality

Key points

- **Vulnerable Groups.** Satisfaction for the services system drops when socially fragile groups are considered.
- **The specialization of services**, although functional and desirable, occurs nevertheless from a lack of inclusion and brings with them the risk of compartmentalizing, lower standards and stigmatization.
- The excess of specialization has left open **the question of intersectionality** and the complexity of the individual condition. This leads to a lack of integration in case management and often there is competition between sectors as to who is in charge of treatment.
- **People with psychiatric problems** (double diagnosis) are emblematic of these difficulties in case management. The system generally appears lacking and poorly integrated.
- **Prisoners.** The formal affirmation of equal rights to health comes up against the hierarchical relationship between the criminal justice system and the health system, where the later appears ancillary. The long delays in the justice system are an obstacle to alternatives to incarceration and to external treatments. OST treatments are more or less guaranteed, whereas harm reduction strategies are only evident in a few member states.
- **Migrants and Asylum seekers.** The regulations concerning immigration and the right to health are variable from country to country. Most include access to emergency and basic services but then they are much differentiated. Above all in Eastern Europe, drug use by migrants is invisible, and not on any drug policy agenda.
- In places where a better system of access exists, a negative trend is noted, encouraged by a hostile social climate and the intervention guidelines (national and European) aimed at limiting immigration. This results in a restrictive political agenda regarding the health of migrants and the perception from participants is pessimistic.
- This lack by the system results in provision made by services and health workers, in a process from the bottom-up, who try to accommodate the requests, often without resources or a specific mandate.
- The arrival of Covid-19 saw the constitution of new emergency services for migrants and asylum seekers but these were soon dismantled after the first wave and the “everyday selectivity” was restored.
- **Homeless people.** Notwithstanding the agreement at a European level for the Housing First approach and the good results attained, a reparative trend is apparent with the re-emergence of selective criteria based on drug use behaviour-which becomes a factor for exclusion.
- The lack of beds in emergency night structures is generalized, aggravated by the exclusion in many dormitories of people who use drugs. Another obstacle is the mobility of homeless people, who challenge the administrative and bureaucratic confines of the city.

- **Genders.** Undoubtedly the majority of services are based on a user who is "white, male and heterosexual". The attention paid to gender, above all to women, is judged to be lacking. There are however some exceptions.
- Even worse is the lack of consideration given to transgender and non-conforming genders Participants consider that a non-binary approach should be adopted.
- A correlation between the relative less frequent attendance of women at services and the fact that services are not designed for them is recognized. It is thought that the process of innovation in this area is too slow with respect to the need.
- Greater attention must be aimed at the correlation between prostitution and drug use. Today both interventions and Harm Reduction work is lacking.
- **Generations.** Interventions for youth are numerous. There is particular attention paid to creating more rapid access, even though here there are also important territorial inequalities that have been verified.
- At the moment there is a trend in innovations offered by services, although variable between the different national realities that take into account changes in styles of drug use and the lifestyle of younger people. They also aim to upgrade other operative models of intervention. The priorities are to increase the out-patient offer and increase caseloads for other dependencies such as gambling and alcohol.
- Older users do not appear to have acquired a place on the policy agenda. There are very few experiences/interventions recounted, even from the CSOs, even though on-going experiences have shown positive outcomes.

Under the title "socially vulnerable groups", also often used in official documents, ***very diverse social groups are included***. This practice merits a critical reflection on the use of this terminology. For example, often this definition groups together gender categories, whereas gender is a difference that involves multiple and complex dimensions that cannot be reduced to a definition of "social fragility". It is a category however used by participants- even though there are some issues as will be illustrated- and it is recognized as functional with respect to reality when compared to the mainstream category, **to overcome a double gap:** the first is that of social policies designed for everyone (or even for many vulnerable groups) but not for PWUDs. The second is that policies and interventions for drugs and dependency are based on a ***mainstream figure of a person who uses drugs: male, white and heterosexual.***

> ***D*** *Everything is guided by the needs of the „mainstream ". That is not the case everywhere, but that's how I explain the gaps we have in specific services for woman or other groups.*
>
> ***IT*** *On the website of the Ministry for social policies, let's see there are projects for inclusion but they are explicitly aimed at multi-problem families, prisoners, LGBT people, Roma, ... there is nothing for to do with job placement with PWUDs*

The classification of vulnerable groups is functional to promote their access to the system and to services, thanks to ***a needs assessment and specific measures*** that facilitate this access. This specific attention is at times promoted at an institutional level and included in formal guidelines aimed at overcoming inequality in health, at times from "lower levels" thanks to the work of operators. There is also a geographical variable amongst the 8 countries, in this effect between ***policies from the top down or bottom up:***

> ***SRB*** *Chapter 28, which deals with consumer and health protection, states that in the case*

of health inequalities in the field of health, access to health services should be improved for people with disabilities, people living with HIV, children, people who use drugs and so on.

IT *The few drop-ins that exist retain a sort of flexibility within which they then build from within, but not because there is an Italian program within this that takes into account the various targets*

The role of those who work on the ground is indicated however as crucial, notwithstanding diverse policies, because it is in the relationship established and the daily contact that the disadvantages and the barriers to access services become visible. This is true from the digital divide to the need for individual case planning and accompanying the person when necessary:

ES *You need a digital certificate to solicitate a grant, you need internet connection, a laptop…or a social worker ready to help you. A lot of people are going out of the system because these problems."*

IT *I think it would take some funding to encourage interventions in these areas. The first problem is to make these services stable and supported*

This ***functional specialization*** nevertheless presents some risks also, both with respect to social labelling, which is paradoxically caused/reinforced by services (***the risk of a "taxonomy" of fragile subjects*** which could result in further stigmatization and institutionalization), and with respect to the operative model of the services system. The term ***intersectional*** is strongly recommended. The fact that each person is a complex entity, both with respect to identity and to their social condition and, not least, to their fragility. Intersectionality and taxonomy of fragility are not well conjugated and what could emerge (and what has emerged if the term double diagnosis is considered) is a contention concerning ***the "ownership" by the person with respect to the services:*** homeless, woman, immigrant, with psychiatric problems, HIV+ …. Who *is this woman*? *To whom this woman "belongs"*? As often occurs, the best questions arrive from the margins not from the mainstream: how should a system of services and interventions be prepared when faced with this challenge of diversity and complexity? How better can we think in terms of ***flexibility, client -oriented approach, tailor-made solutions rather than in terms of sectional interests***?

IRL *A really important and interesting point back there about the intersectionality of the communities. That it looks like, oh if you are like a member of the traveller community you are just that. You are not a person from the LGBT+ community, you are not a person with a disability....*

2.2.6 People with psychiatric problems. "Harder to find something".

The question of a double diagnosis (psychiatric and dependency) is particularly emblematic in the difficulty to find an integrated approach. It could be due to ***a paradoxical hierarchy between fragility or pathology***, and the difficulty in identifying the primary service for referral, that makes it complicated for the person seeking assistance to have a linear pathway, not to mention the difficulties in accessing these services initially.

D *For people with dual diagnosis, it seems very hard to get different options at all, you can consider yourself lucky if there is something available at all for you to treat your mental health condition as well as your substance use*

D *In the case of dual diagnosis and psychiatric support alongside drug treatment, it becomes harder to find something.*

2.2.7 People in prisons. "Criminal justice sector is a black hole"

The barriers in place for people in prison to access services and treatment are correlated above all with an ***imbalance, the hierarchy that exists between the justice system and the health care system***, in favour of the former. The recognition of the rights of incarcerated people to access the same services and the same quality of services as people in the community is widely diffused, formally speaking. In reality, prisons are dominated by a security and control culture and ***the difficulty in conjugating the prison sentence and basic rights is enormous***. For some participants working with people in prison results in frustration mainly due to the multiplicity of agencies involved without any real integration and the fact that ***health remains a secondary concern*** with respect to that of control.

D *To actually tackle the needs is an extremely frustrating task because of the many systems that come together, it makes it hard to work with and we are usually unsuccessful.*

D *Indeed the criminal justice sector is a black hole for us, and there are so many systems colliding there and the health aspects simply remain sub-ordinate in criminal justice areas.*

The possibility of ***accessing alternative options to prison aimed at treatment, often remains restrained*** by the prolonged wait within the justice system. The outcome, to which the person has the right, is then not applicable. This is an imbalance that has repercussions in terms of fundamental rights - in this case the right to health care.

D *So many actors and conditions are tight to working with people in prison, and if our aim is to enable people to enter treatment instead of the prison sentence (...) people end up finishing their sentence in prison before they get a change to treatment.*

As far as treatments within prison are concerned, in particular OST (Opioid Substitution Therapy), what emerges is that even in cases where they are guaranteed, they are only likely to be so when there is continuity with a pre/existing therapy. It is more difficult to obtain prescription ex novo. ***The long delay to access treatment*** is a critical issue, especially considering that prison is a context that aggravates and produces suffering.

SLO If they are included in substitution therapy before serving their prison sentence, this continues in prison. If they are not, this is a problem because they have to wait a long time before a decision about therapies is accepted.

In some European countries ***Harm Reduction interventions*** have been introduced even in prisons. There are however just as many countries that are completely without these (*see also the following paragraph)*.

SLO *There is also no needle exchange program in prisons - because the use of drugs in prisons is prohibited and it is not supposed to happen.*

With respect to social rights, ***the right to work is not always guaranteed,*** for example if a person is HIV positive or HCV positive, which in particular regards PWUDs. Often this is not a formal negation, outside of the law, but it is precisely due to this informality and

opacity that it is even harder to contest.

> ***G*** *Imprisoned users with HIV or Hepatitis are often subject to an «unwritten law» that does not allow them to work in prison*

2.2.8 Migrants and asylum seekers. No services, no attraction!

The normative, political and social context within which drug use by migrants and asylum seekers are inserted is widely variable in accordance with national regulations on immigration, the right to asylum and humanitarian protection and not least of all, different health systems. The right to health care, and firstly access to the health system, often depends on the possession of a residency document and/or valid personal documents. In the case of illegal residency in a country, the right to health evaporates completely or remains only thanks to the eventual offers of NGOs. It remains nevertheless limited to emergency and basic services.

> ***G*** *Immigrant drug users are in a large percentage people without legal documents. That is why they face huge barriers to accessing health and social support services. Immigrant reception units have huge shortcomings.*
>
> ***IT*** *All the legislation that has existed in Italy regarding foreigners has generated a situation whereby there is a sort of impossibility to intervene if not to a lesser extent with respect to the needs*

With respect to health problems connected to drug and alcohol use, in some countries (above all in eastern Europe) there exists ***a sort of invisibility of drug and alcohol use by migrants*** and asylum seekers in the eyes of the institutions and politicians. The consequence of this is a lack of indicators and intervention programmes. The ***social climate furthermore is often hostile towards migrants*** and certainly does not help to put their rights on the agenda, not even when considered under the profile of public health: their health is a benefit to the health of everyone.

> ***SRB*** *The migrants issue is dealt by the State as a technical issue, without attention to other elements like drugs, social needs, health and their health needs or inter-cultural relations with local communities. It pays back in hostile attitude by the locals They are not interested in issues like migrants and drugs (…) I have never heard of any document or program that would in any way target substance abuse in them.*

When their drug use becomes visible on the other hand, they are dealt with by services, health workers and NGOs. At times there is some municipal or regional funding with the creation of specific services; at other times it is the good will of people working in that area who organize, often with few or zero resources, and include migrants and asylum seekers among their clients within their current services.

> ***IT*** *There are deficits in municipal policies (...) We have 30-40% of people who are migrants [in our service] despite not having any ad hoc funding*
>
> ***D*** *We are fighting again to keep the people who have been employed to increase support to migrants in particular.*

It is necessary to reflect on the institution of specific services for migrants only who use drugs: on the one hand ***this specialization is functional and guarantees a service,*** perhaps aiming for an offer that can facilitate access, acceptance and care. On the

other hand, ***the institution of separate services is the outcome of the politics of exclusion*** - normative or administrative- from the general system of services. This not only creates future problems for equal opportunities and rights but also contains the risks of constructing a circuit that differs with respect to standards and resources. The aspect of cultural mediation for example, which could be a positive factor in a specialized service, is not always guaranteed.

> ***NL*** *In Amsterdam there is a drop-in center especially for migrant PWUD. Usually they don't really have access to any other care*
>
> ***SLO*** *There is a centre in a particular town where asylum seekers are located. The police, who have a lot of control there, do not allow the entry of organizations that could start to address this issue.*
>
> ***G*** *Immigrants /refugees who have a residence permit face difficulty in communicating with service providers due to lack of good knowledge of the language. There are usually no translators who can help.*
>
> ***D*** *To put it very frankly, they say „as an institution, I do not want to have to change, the service user has to adopt to our way, not vice versa. And if it is not working, it is their own fault. "*

The event of ***Covid -19 provided an interesting observation point*** regarding this aspect: in part it ***has amplified the offer also for immigrants and asylum seekers***, especially during the first wave, but it did so ***from an emergency and temporary perspective***. This was such that in some cases the new services were dismantled after a few weeks, and then it was recognized that this situation was not going to end any time soon.

> ***NL*** *In my region European migrants are not allowed in night shelter. During the first corona wave they temporarily allowed European migrants into the shelter and the shelter filled up instantly*
>
> ***NL*** *The Netherlands was the first to stop methadone treatment once corona seemed to be under control in September. With the second wave in October everything had to be set up again. It shows how strict we operate*

Regarding the expectations, national and European situations do not invite optimism according to the participants. European ***policy towards immigration has become gradually more restrictive*** and centered on repatriation more than reception. It is also based on categorizing (political refugees or economic migrants for example) which, aside from a general critical reflection, does not stand up to the facts anyways, judging by the procedures that impede recognition for thousands of asylum seekers even if they are considered worthy of entry and protection. This social and political climate ***maintains the expectations for health rights and access to services at a minimum***: the trend that can be seen is negative, aimed at limiting the offer, also to avoid being perceived as ***a country that "attracts" immigrants***. The debate within countries is the conflict between integration and refusal to accept migrants at all. Health workers, services and NGOs find themselves operating within this tension.

> ***D*** *Every person in the country, no matter their status and if they are inside the (health insurance) system or not, should receive the health care they need. But they are trying to prevent that, out of fear that this will attract more people coming from abroad (...) And you could wonder, is this is also about, not wanting to have these people.*
>
> ***D*** *There is a clear conflict, of wanting to bring people to their home countries on one side, and integrating people and supporting them on the other side. And of course, this also*

impacts the work of drug services

2.2.9 Homeless people. Housing first or detox first?

Notwithstanding the evidence, at a European level the efficacy of a ***housing first approach***- start from the right to a home as a base, then slowly, progressively work to improve the other dimensions of life thus overcoming a reward approach that sees housing as the final objective of a pathway- it does not appear to participants that this model has in fact been adopted. Indicators that highlight these limits are both the still widely seen recourse towards first level structures (dormitories) and the perennially scarce numbers of places offered in these structures to PWUDs. A ***specific exclusion aimed at those who use drugs*** can be confirmed, not only with regards to the rights to a home but also that of emergency shelter.

> ***G*** *The living conditions of the homeless in the big cities of Athens and Thessaloniki are particularly problematic (...) There is a lack of dormitories. The NGO's and user organizations advocated for many years for such a facility.*
>
> ***IT*** *Reduction of night centers that welcome drug addicts, specifically in Rome we have many homeless drug addicts they cannot access services for the homeless, and as drug addicts continue to stay on the street*
>
> ***SLO*** *There are not enough beds for drug users either in shelters or elsewhere. In shelters, they often encounter violence and sexual abuse. (…) Another problem is that the use of drugs inside shelters is prohibited – drug users then go to other places - parks, streets, public toilets.*

Even where the housing first system has had a greater impact, such as in the Netherland, ***the imperative to detoxify beforehand is returning as new selective criteria***, which leaves workers disoriented and critical.

> ***NL*** *The group is increasing, and their care is decreasing. For instance, in housing first the principle is that you get a house and then you work on your problems, but in some situations, people first have to go into deter before they are allowed into housing first. That is not how it's supposed to work.*

This negative trend for housing first is surprising if the success of this strategy is considered. On the one hand it raises the question again of the difficulty of dialogue between evidence and policy, and on the other hand there is ***the changing social landscape of cities, producing many new excluded and new challenges for social policies.*** The social climate is also an incisive factor: policies aimed at the homeless who are visible on the streets are often ***governed by a security approach and centered around urban decorum*** more than on needs and objectives relating to inclusion.

> ***NL*** *We have successfully addressed this problem with a strong integrated approach, a network of shelters and social- and health services. In one city a population of 500 homeless PWUD has been reduced to a mere group of 30 people in the emergency shelter*
>
> ***NL*** *We have indeed had great successes in the past, but at the moment the group of homeless people seems to be growing again. For example, there are now camping places full of people who cannot be handled in the shelters.*
>
> ***IT*** *We move towards the interventions towards homeless which however are aimed at reducing the degrading impact on the city rather than supporting their ability to integrate*

A final but not secondary aspect is the corresponding ***lack of operative models*** from structures to the characteristics of the recipients, which lowers accessibility: their mobility, for example, between cities or between different zones of the same city-motivated by personal strategies of survival- comes up against the ***rigid system of admittance/entry***.

> ***SLO*** *Availability does not take into account the "mobility" of users. If a drug user becomes homeless overnight, the situation becomes difficult for him/her (…) unfortunately, the centres are not flexible enough and some do not take care of users coming from other places.*

2.2.10 Genders. "Male - white - hetero oriented policies"

The issues of gender in drug policy are focused on the female gender, even though as some have noted, in the plurality of non-binary genders, the most vulnerable and those not reached by services are others groups, such as transgender people.

> ***IRL*** *The gender is not only women and men, there's a bigger spectrum in that, and the fact that services are aimed towards women it doesn't mean that it's aimed towards sis women and trans women and gender nonconforming people. If a person is non-binary where do they go?'*

Considering Spain as the exception, with an Action Plan that is attentive specifically towards women and is evaluated as one of the more advanced in Europe (Spanish policies also do not neglect the theme of gender-based violence even when this is correlated with institutional and treatment contexts),

> ***ES*** *Spanish action plan talks about gender violence in treatment programmes and gender perspective and gender violence in addictive behaviours intervention, a topic not exactly included in Europe.*

in general, the level of ***dissatisfaction regarding the attention paid to gender*** is generalized among the participants, who underline how service systems are designed principally around a user who is ***male, white and heterosexual***. Any innovations that may have been initiated are considered still partial and late:

> ***D*** *It is clear that we have rather sketchy access and availability of gender specific services.*
>
> ***IT*** *Very recent is the beginning of a gender approach to the use of recreational substances, but by recent I mean the last year*
>
> ***IRL*** *We know that the average services cater towards male like Irish white sis hetro men. You know your default service user.'*
>
> ***NL*** *We used to have good women's shelters, but this has deteriorated over the years.*

The fact that the female population remains in general more hidden from services with respect to men, can be interpreted mainly in function of the limits of the system, that is not capable of being tailor-made or specific, rather than specific characteristics or resistance from women. There is increasing awareness that ***the limits here are not those of the women but those of the system***.

> ***IRL*** *A lot of organisations doing loads of work about engaging with women and why*

women are not turning up to services. Now I think we are all starting to like understand that it's not the women's fault if they don't turn up to services. That the services are not fit for purpose.'

One important area that is not paid sufficient attention to today is towards ***women who use drugs and are also sex workers***: there are problems relative both to access to services of Harm Reduction that safeguard women's health- and should be enhanced and organized in appropriate contexts- and housing security, when prostitution is exercised within a system of trafficking and organized exploitation.

IT *To the issue of trafficking and prostitution precisely where there is also a strong consumption of substances and it is intercepted, by the street prostitution units but certainly not by those of harm reduction, it is difficult to intervene in certain contexts*

SLO *The female population is much more hidden (…) and women are mostly forced into prostitution. Women get flats in return for prostitution – and there are not enough safe houses available for them.*

Finally, Greece in particular signals differences based on ***gender in the prison system***, where women are penalized above all regarding the difficulty in accessing OST programmes.

G *A major disadvantage for women is that there are no substitution programs in all women's prisons.*

2.2.11 Generations and drugs.

Young users. Innovating is necessary, and quickly. The social dimension of the condition of youth is correlated to use and to ways of using. Policies for young people cannot just be circumscribed, reparative and "afterthought". They need to have a strategic outlook with the aim of promoting the quality of life for younger people.

SLO *Younger drug users (who are at the beginning of their careers of using) are also a problem - some do not go to school, some are homeless - there are no programs and other capacities available for them. (…) Students who return to their local communities after graduation no longer have status, a job, they live with their parents, which is likely to increase the possibility for risky behaviours.*

This being said, for the younger generation there are territorial differences, already cited- the differences between bigger and smaller cities are noted- and operative differences, noted by the participants, that tend to facilitate access to interventions aimed at the young also through ***more rapid and less bureaucratic procedures.***

D *In terms of referral for treatment, it is much more straightforward as a young person,*

D *In many regions, there are no specific services for younger people, except of the big cities*

The main theme that emerges from the national focus groups is the need to ***rapidly update policies and interventions*** aimed at the younger generation. These should above all follow trends in drug use but also the emergence of new dependencies, such as gambling.

SRB *We have an Office for combating drugs, and nobody cares about alcohol and gambling? (…) They don't know that now our children are more into gambling than drugs. My centre, which once had 90% addicts to heroin and other psychoactive substances, now has 50-50. And they are all young children.*

The necessary changes that have been indicated regard the urgency to develop ***an out-patient system for the young*** as it is more adherent to their lifestyle and to the actual cultural orientation of the potential beneficiaries. The ***in-patient model such as rehabilitation centers, appear to be declining*** in favour of models that do not remove youth from their contexts and also know how to develop this work with families who remain attached to their origins, to their neighborhoods. This process of change is happening and it should be amplified and accelerated.

D *There is low availability of services for out-patient work with young people and also their families, trying to support them in the family setting and help with structures in their life, but high availability of in-patient services for young people. I see a change towards more out-patient services since the last few years.*

Municipal policies play a leading role with respect to youth, as has been discussed for other groups. Here the experience of the Dutch system is emblematic of the great risk of not accepting cases of young people with problematic drug use. This is due to mechanisms correlated with financing by the provider for the city. In some cases, these mechanisms - calibrated more on saving money on resources rather than on needs and on an understanding of individual pathways- weighs heavily on the rights to treatment access.

NL *The municipalities are responsible for the funding of treatment for youth. In one municipality they will only reimburse the treatment if the patient has no relapse. In practice this results in treatment facilities rejecting people with heavy additions, because the chance of relapse -and thus not getting paid- is bigger. Market forces are terrible for the accessibility of care*

Older users. An unexplored frontier. There are few references to older PWUDs elaborated by the focus groups. This group ***does not appear on the national policy agenda*** and is an area that is paid scarce attention to also by the CSOs.

NL *Older PWUD are hardly taken into account in our policies.*

SLO *Older drug users have additional (health) problems (...) There are no institutions to which they could be sent. (…) Almost nothing is done with the elderly in the field of prevention - loneliness, social exclusion, alcohol use are increasing.*

Where there has been the implementation of innovative services, the evaluation is positive and should be an incentive for the development of adequate policies.

NL *A study two years ago found Woodstock (a sheltered housing facility especially for elderly PWUD) to be one of the best practice examples in Europe.*

2.3 Harm reduction

The inclusion of Harm Reduction (HR) in drug policies and interventions. The EU AP 2017-2020 incorporated to a good extent the requests from SC for the full inclusion of HR and Risk Limitation (RL) for the fundamental areas of European drug policies (1.2. action 8). Are the policies and the interventions of HR and RL explicitly included in the national AP and are they adequately implemented?

Key points

- **Definitions of HR**. HR is not only the "fourth pillar" of drug policy but it is also an approach and a strategy that crosses and modifies other areas of intervention.
- In many national contexts the strategic scope of HR is weakened today due to the **scarce explicit support of policy makers**. It is still considered a divisive issue, notwithstanding the huge amount of evidence produced and the European guidelines.
- When HR is included, with very differentiated levels, in all national policies, difficulties still remain in integrating it as a fourth pillar. It exists as a kind of ancillary to the service systems, both with respect to policies that are abstinence-oriented and to the law and order approach of urban policies.
- A question of the system. As for other areas of intervention, the **unequal geographies** within national territories are notable.
- HR was promoted from the grassroots, the Third sector and NGOS. Even when it is an integral part of public policy the **relationship between public and private social services** remains problematic. There is a wide delegation to the NGOs, lack and uncertainty regarding funding and scarce integration with the system. The different models of outsourcing clearly affect the quality and continuity of services.
- **HR and an evidence-based approach**. HR was from the beginning accompanied by important evaluation processes, aimed at also reinforcing its own promotion.
- The evidence requested from HR is often more pressing than that required for other areas, even when international and European research projects have produced sufficient evidence and the services have been evaluated.
- **The innovation route is an impervious route**, above all for NGOs. Interventions such as drug checking, drug consumption rooms, and free access to naloxone, are implemented with a strong push and advocacy from the CSOs.
- Even though these interventions have been validated at an international and European level, they **still encounter distrust from policy makers**. One reason for this distrust is ideological and cultural, and makes the interventions even more divisive. The adopted approach is to mainly invest in a proactive manner in competencies, knowledge and choices of PWUDs, with the aim to promote safer use: this is can be a cultural challenge for policy makers.
- **HR is social and takes into account the context**. Although HR was developed mostly in health settings (the AIDS crisis onwards), and by urban governments, it cannot deny its strong social dimension. The social determinants that influence the life and patterns of use of PWUDs are crucial factors for intervention planning. This is a difficult issue with problems for integration between areas and systems of intervention.

➲ HR has to also take into account the **paradoxical damage produced by policies** and inadequate norms in reference to drugs. The mission of HR also includes working to create a social context that minimizes potential damage, for example stigmatization, criminalization and social exclusion.

Notwithstanding the fact that a HR approach and system of interventions has been in Europe since the mid-1980's, and are still today included in the EU Strategies and Plans, thanks to a vast production of scientific evidence- ***HR still suffers from political and ideological prejudice*** in some European countries. It is often placed in opposition to the strategic objective of abstinence, which threatens and slows its full adoption as an integral part of national strategies. It therefore becomes ***an ancillary area, less guaranteed with respect to financing and implementation*** and above all, ***lacking in clear and explicit political support.***

> ***G*** *Harm reduction has been for decades a controversial issue between the two big state-approved organisations OKANA and KETHEA.*
>
> ***D*** *Because harm reduction was not introduced out of conviction, but for other motivations, it was sometimes implemented half-heartedly or very slowly, because policy makers were not actually backing it up.*

2.3.1 The "fourth pillar" and beyond. "Harm reduction is a paradigm shift"

This political and ideological prejudice prevents HR from being developed and for its potential impact in diverse areas. The first is that of strategic capacity: HR is not limited to a collection of single and specific services, as the scientific literature and its own history clearly illustrate. It offers *an approach and a strategy* that aims to enable a coexistence with drug use and individual and social costs reduced as much as possible and as sustainable as possible, from a social, health and economic perspective. In its history and above all, in its European history, HR means a reduction in the health impact but also the social and criminal impact. It also means urban strategies aimed at containing the negative effects of certain drug use patterns with respect to social co-existence. In more recent developments HR has proposed strategies of prevention for problematic or at- risk ways of drug use, and not lastly, as an approach that better guarantees the rights of PWUDs. According to some of the research participants, faced with the potential of HR as a strategy, the slowness, "timidity" and scarce transparency of policy makers appear as critical issues and converge in creating a weakened representation, almost a "last chance" for residual users.

> ***IT*** *The reduction of harm is a paradigm shift, a way of rethinking interventions, rethinking services*
>
> ***NL*** *The opportunity to discuss the definition because it's a narrow definition. If you wanted to look at the harms, you know you have to look at a lot of stigma for example, it's the major probably drug related harm.*
>
> ***D*** *Harm reduction is still seen as an ultimatum: If nothing else is working, harm reduction measures are justified. It is a challenge to have it considered as an equally important pillar to the others ones in the strategy, and to accept that it is as important as abstinence-oriented work.*
>
> ***ES*** *They are trying to include as a perspective, not as intervention methodology. Because they are talking about to include it as an approach, aren´t they?*

Notwithstanding this political impasse, at a national level HR is already included in

intervention systems:

> ***IRL*** *I think again it's in terms of our strategy as it's written, it's quite strong on harm reduction. So, the overall harm reduction approach I think is generally accepted*
>
> ***IT*** *We have seen that where harm reduction is not only present but also has an institutional basis that recognizes even in this phase of the pandemic, we say that the interventions are adequate and effective*
>
> ***NL*** *Harm reduction is one of the four key pillars of the Dutch drug policy*

It is however revealed to be still weak and not well integrated as a "***fourth pillar"*** - according to the current EU definitions- regarding drug policy. This is a second level illustration of how it is weakened: it takes on a type of ***subordinate position to the system of services***, both with respect to the predominant policy of reducing demand and being abstinence oriented, and with respect to the law and order approach that it is often correlated with, especially in urban policy-making.

> ***SLO*** *The importance of harm reduction approaches is diminishing, which is reflected in the integration / concealment of this approach in the chapter on drug demand reduction.*
>
> ***D*** *Even today, the area of harm reduction is subordinated to public order and criminal justice policies. (...)The underlying motivation for financing harm reduction measures remains to improve public order, rather than the health and well-being of PWUD.*
>
> ***IT*** *It is considered secondary, outsourced and in any case not well integrated into the public system (…) the right to HR in general is not guaranteed*
>
> ***ES*** *Harm reduction network is subsidiary (…) at European level, with Covid topic, harm reduction approaches are suffering and I think in Spanish state it would be exactly the same.*

This absolutist rhetoric of abstinence-oriented objectives, the very same that limits HR strategies, also limits the integration between the "pillars" in the intervention system: at times objectives are spuriously contrasted when actually they should be seen as ***part of a continuum***, which they are when the reality of the life and careers of PWUDs are minimally considered.

> ***ES*** *They are still perceived as opposite teams even: drug-free versus harm reduction (...). In fact, it´s a continuum (...), there is a process of making decisions (...) from the person who is making decisions.*

It should be stated that in the debate on the strategic character of HR as described by the participants, this continuum is taken into account and is redesigning the confines of the definition of HR itself, according to a design that right now appears contradictory however. On the one hand the scope HR has as a "strategic policy" causes it to cross and change in doing so, all the traditional areas of intervention, according to a new culture and also a new paradigm perspective: ***all the "pillars" (prevention and treatment but also rehabilitation) assist in the deferment of the objectives, even semantically,*** of the same terms used. For example, "prevention" more often means prevent not only all use (the old primary prevention) but also rather risky behaviours or problematic use. "Treatment" includes and often means to conduct someone towards models that are more controlled and compatible with use (perhaps with the aid of methadone). Social rehabilitation (a job, a home, for example) exists also in the presence of conduct that is not abstinence. On the other hand, this reflection on the strategic scope of HR in other

areas could risk infringement, a weakening, or even a disappearance in the language and the objectives when the objectives are not clear and neither are the direction of policies and politics. Maintaining its own original "constitution" in its sector (pillar), could preserve this clarity, at the risk of a promising strategic process of growth.

> ***NL*** *It is not defined what this means in practice. In practice there is a lot of unclarity about the interpretation of harm reduction, and often it overlaps with recovery and prevention. Maybe recovery is the new harm reduction?*
>
> ***NL*** *Harm reduction is also part of our prevention work. When people use drugs, prevention is all about reducing harms, such as advising people on the xtc pill that they have tested.*
>
> ***SRB*** *We mainly work in the field of harm reduction, although, we can sometimes be classified as prevention, selective prevention, with people who are already using or already experimenting with drug use, means not universal, but with some people already at risk*

2.3.2 The 4 gaps in HR: geography, policy, system, money

As in other areas of intervention (see the above chapter), ***the geographic gap- the unequal distribution within a nation- of services and of systems of intervention***, greatly weakens HR, even in countries where it is more developed. The scarce interventions implemented in some areas or municipalities are also a function of their previously cited subordinate nature with respect to the "strong" pillars of the system (prevention and treatment), in terms of the lack of clear direction and unequivocal political support, which renders them a necessary and guaranteed part of the system.

> ***D*** *In terms of clean needles, at least in my city, every person who wants, can access clean injecting equipment relatively easy. But on the country side, that is almost impossible, unless you order online for a lot of money which most don't have. Therefore, there are big gaps in access, independent of the specific target group*
>
> ***IT*** *If we have harm reduction in northern and central Italy, certainly in the south this aspect is completely lacking absent, in some regions completely absent (…) People's access to these services is not homogeneous throughout the national territory*
>
> ***SRB*** *So, there are programs, there is OST in the 4 biggest cities in Serbia, there is (NSP) outreach in Belgrade, and needle exchange service in Novi Sad, but that's it. It is not provided throughout the country, but only in the largest cities*

The ***lack of political responsibility***, as has been mentioned, affects HR with vagueness in direction by policy makers when HR is considered a "divisive" policy. This lack of direction means a lack of incisiveness in policy even when it has been formally initiated. These policies become bogged down in implementation processes and in the latency of administrative acts that no one in the public sector either controls or complains about.

> ***IT*** *Since 2017 we have a national law that provides for the introduction of harm reduction in the LEA (essential services) which has not yet been implemented*
>
> ***SRB*** *Harm reduction in Serbia is not legally recognized. (…) According to Article 247 of the Criminal code, anyone who enables others to use drugs violates the law. Do our services that actually distribute sterile supplies actually allow the use of drugs? The Ministry of Justice said that they were not ... but that the Prosecution could assess that they were.*

The third gap refers to the system, in particular to ***the integration of the public-private social system*** and to the type of protagonism and title of both of the actors. HR was, in its rising moment, strongly delegated to the third sector and to the NGOs. This was

because of their greater flexibility and capacity for innovation and for the already cited lack of direction and support by political bodies, which effected its engagement with the public system. In some countries NGOs are not frequently supported by public money but by private donations and are therefore exposed to mechanisms that are not easily controlled. Where there do exist public national and regional health systems that allow for contracts with the Third sector, the ***resources are often inadequate and often not assured***. With the affirmation of HR as a public policy, this mandate did not improve. In some countries in particular it is connoted with shadows and light: the lights are those of an integrated system, capable of activating and valuing the resources of the social sector. These are resources that are actively applied, appropriate, flexible, innovative and close to the populations that they are intended to reach. The shadows are those of public abandon, where there is no system or worse, where the system is dominated only by outsourcing. All of this can lead to ***discontinuity, low investment, self-referentiality, isolation and separation***. ***An effective model of public-private integration could make the difference*** in terms of continuity of services, quality of services and the quality of work by health professionals.

> ***G*** *NGOs have been the initiators of Harm reduction programmes followed by initiatives of OKANA and KETHEA for Street work programmes. The discrepancy in the policy of the state towards NGOs is obvious. There is no funding from the state for the most dedicated workers in this area*
>
> ***D*** *NGOs focus their activities on street work and harm reduction programs in general. Their activities are not funded by the state, but by donations from charities. They often collaborate with the approved agencies in implementing programs.*
>
> ***IT*** *Among other things, the services are also built through tenders which obviously suffer from all the job insecurity and the absence of programming*

Connected to the issue of outsourcing but also more generally to the "political weakness" of HR, is that of ***financial coverage*** for services and interventions. This appears to be ***lower, less continuous, and more arbitrary*** than those for other sectors of intervention. Basically, if the budget must be cut, and often it must, the auxiliary position of HR is at risk, no matter what the evidence is of the efficacy and efficiency of its intervention system.

> ***NL*** *The heroin maintenance treatment is under pressure, because it is an expensive intervention for a small and shrinking client group. Consequently, some facilities now only open for clients twice a day, while heroin users need the facility to be open 3 times per day.*
>
> ***SLO*** *The quality of implementation depends on funding - the available resources are often only sufficient for the partial implementation of certain approaches - which is not enough in terms of quality assurance.*

2.3.3 Evidence based approach. Some nothing, some too much

With respect to proof of efficacy, HR has traditionally paid ***great attention to the aspect of evaluation***. This is in part due to its own history: in order to overcome numerous barriers and skepticism regarding its innovative approaches and to gain a role in national politics, it was crucial to demonstrate efficacy, efficiency and a good cost-benefit ratio. According to participants this is a point in its favour, both for the evaluation of services and for identifying necessary changes and updates and for the definition of standards and guidelines.

> ***NL*** *IVO is responsible for the development of the quality standards for opiate substitution*

treatment. This is well organized in the Netherlands. (...) The National Institute for Public Health and Environment provides general guidelines. (...) For the DIMS drug checking services there are many guidelines and protocols.

***G** Recently the law on psychoactive substances refers to harm reduction due to the approval of a change related to the establishment of supervised drug consumption rooms. (…) A ministerial decision of April 2020 defined the terms and conditions for operation*

Nevertheless, it can be observed that the evaluation of efficacy risks being, after more than 30 years, a kind of "***exam that never ends***". It is an obligation that appears less important for other areas of intervention (prevention for example) not to mention the area of law enforcement: here the best-case scenario is an evaluation of the process, rarely ever an outcome and practically never an evaluation of the impact. There are HR interventions that have been validated for decades now but it seems they must always start from zero, as if this was a newly discovered approach.

***SLO** Safe rooms have been present on paper for many years - the National Institute of Public Health has prepared a good document years ago justifying the importance and quality of safe rooms. (…) Unfortunately, all these years, responsibility has shifted from one institution to another and back.*

Faced with this continual need to demonstrate efficacy, even when these interventions are consolidated at an international level, HR paradoxically finds a ***political context that does not listen to evidence***. It often however privileges other variables in the decision/ making process, as stated above.

***SLO** Decisions to adopt (or not) methods / approaches that have been shown to be effective and useful in research are often the result of subjective decisions rather than decisions based on scientific knowledge.*

2.3.4 Unstoppable innovations. A slalom between good practices and political blocks

HR is constantly changing, as was stated previously. According to its statute and mission it renews along with the changes that occur in patterns and contexts of drug use. Innovation, based on an understanding of the phenomena, has bought with it over time, new services and approaches that have slowly been validated and adapted to different national and local contexts. In general, this means, and continues to mean, ***a process from the bottom up***, where NGOs have had a role as innovators and forerunners, and often at the cost of long advocacy battles.

***G** It was because of the strong advocacy of the NGOs and the public support for this initiative that the government and the parliament decided in favour of the drug consumption rooms*

***SLO** Drug testing has been in place for quite some time - but it took a long time for this approach to take its place. In the absence of NGOs, there is no doubt that these practices would be enforced at all.*

In some national contexts the greatest challenge continues to be that of innovating HR around ***models of use and of more recent settings for use***. This means overcoming the centrality of the use of opiates – mostly intravenous use- which characterized HR in the 80's and 90's last century. The intervention most cited is that of party settings and

other areas of entertainment that are mostly for young people. The approach is that of ***supporting safer use***, which gives PWUDs knowledge and instruments to regulate their use in the best way possible.

> ***SRB*** *That's traditional - there are some people who inject heroin, and that's all. For them we will give methadone, and some organizations will give sterile equipment and nothing else. (…) The national AP does not provide harm reduction services in recreational settings so these programs are not foreseen*
>
> ***IRL*** *It is something that we really feel that staff needs training around new drugs that are emerging, people need information into use when there are new drugs being identified and that are in the country. (…) But I think there's really the big gaps of service provision'*
>
> ***ES*** *Our harm reduction is what it is and none is going to increase it and not to go far beyond (…) The model we are using is the model of ending 80´s when we had an enormous opiates problem, now we have other problems. (…) It has been very difficult or it´s being very difficult to adapt to actual realities."*

The most emblematic service of HR in new contexts is ***drug checking***. It has been active for decades in informal contexts by users and peers and was then followed as a service provided also by professional workers. In some national contexts drug checking remains a difficult "frontier" to cross politically. Even with studies, evidence, good results and the work of advocacy by NGOs and PWUDs, it is still very difficult. It is credible that this "frontier" is due to the progressive growing central role - attributed to this and other HR interventions- of the ***competency of PWUDs and the recognition of their capacity to regulate their use.*** They "are given" the possibility to have greater information about drugs, and it is their choice what use to make of this. The political institutions more aligned with a law and order approach are those who express the most resistance.

> ***IRL*** *And there is no testing, drug testing and stuff there's a group looking at that.*
>
> ***IT*** *Drug checking in Piedmont is an essential level of assistance however more than a year has passed it is not that there has been a proliferation by the Local Health Authorities of implementation of this service indeed the directors are still very scared*
>
> ***D*** *In the case of drug checking we can see that if it was a matter of "only" the department of health, we would already have this measure implemented. But because it depends (…) on e.g. ministries of the Interior and Justice, it is not going ahead*

The same difficulty has been seen for interventions that regard the use of opiates, such as ***drug consumption rooms***. These have been active since the middle of the 1980's and have been well studied and evaluated. So, have measures specifically aimed at preventing opiate overdose, such as free ***access to naloxone***, which is still not fully available in many MSs, notwithstanding the fact that for some this has been available since the 1990's. Here again is the fatigue of research, which produces a great deal of literature, but comes up against very slow and very sceptical political processes. The map of national situations and reality is very unequal, despite the fact that the scientific literature is valid and should be valid for everyone, as should the international and European guidelines.

> ***IT*** *The distribution of naloxone in Italy is more brilliant than in other countries since the '90s*
>
> ***IRL*** *So like we are looking at the main gaps in service provision for Ireland was like no safe injection facility of any sorts, and like the availability of Naloxone and the distribution initiative for Naloxone.'*
>
> ***G*** *NGOs and organizations like OKANA advocate for a change of the legal framework to*

make possible that naloxone be broader available to users (…) The idea is supported by many and is expected that will be approved soon by the government.

In the discussion around HR, it was noted that while it is true that the evaluation of models of intervention do not know borders and therefore each local reality should not have to reinvent the wheel, but to make good use of what Europe and the world has already observed, studied and produced, it is also true that ***every innovation is a situated process***. The particulars of the local context are significant, and the lack of this aspect is likely to bring unsuccessful results.

SLO *The needle exchange approach is a good example of the "copy-paste" principle (…) which causes additional damage or problems. A copy-paste approach without thinking about needs and capacities within the country. Experience, research results from other countries are a good basis, but we can't just copy it*

2.3.5 Social determinants and HR. "The best harm reduction is giving people a home"

Last but not least, there are "social factors" in the HR processes that open up a range of questions that go beyond both a medical/health approach and that are also connected to order and the governing of cities. These are social factors with different meanings, all of which compete to further broaden the strategic scope of the HR approach. On the one hand is the knowledge that there are ***social determinants*** that are at the base of various issues and that HR intercepts and tries to manage. These influence how much and where drug use has consequences that can be more or less negative. This is the knowledge that not all of the issues concern the chemical molecule of a drug, but are a way more complex link between ***drug-set-setting***, as for example the reference to social and housing conditions (s*ee also the chapter on Vulnerable Groups*).

NL *Harm reduction begins with a roof over one's head. So many people need to wait too long before they can get shelter or housing. Housing problems relate strongly with drug use. (…) The best harm reduction is giving people a home.*

On the other hand, social factors are also the production of correlated harm caused by ***wrong, dysfunctional and paradoxical responses made by society and policies*** towards the phenomena of drug use. Should HR include these damages also in its mission? Should it widen the range of action to include the criticism- practical and political - of every factor that creates correlated risk and harm? The CSO's who promote and practice HR have already answered this question for a while now: in their concrete actions of advocacy around, for example, the correlated harm in processes of criminalization and stigmatization.

IRL *There's a whole load of other harms which are not actually caused at all by the drugs. They are caused by how our society responds to the drugs or the conditions that can lead to people being in the situation where that's their option. So again, it's back to depending on how you define harm reduction, you probably get two fairly different answers.*

2.4 Alternative Sanctions

The EU AP, along with the European Strategy, has not accepted the request from a wide network of Civil society organizations concerning the necessary decriminalization of conducts relating to personal drug use, in favor of an approach that is educational, social and sanitary. Nonetheless, the EU AP 2017-2020 includes the objective of reducing as much as possible the resort to coercive sanctions, limiting to a minimum the need for a prison sentence in favour of an alternative to prison (EU AP 2.5 action 22). Does the national AP include a similar strategy?

Key points

- **Criminalization affects above all the "small fry"**, small dealers - who are often also users- and users who fill up European prisons. Although in national legislations individual use is not sanctioned, or is, but with administrative or pecuniary penalties, or is not prosecuted at all thanks to diverse measures, nonetheless correlated behaviors, above all possession, means users end up behind bars.
- For this reason, according to the respondents, alternative sentencing to prison is important to reduce the impact of the penal law on users.
- **Alternative sentences are prescribed, with different modalities, in all the MSs.** For PWUDs there are specific types attached to dependency treatment programs, for which the objectives and the type of program are binding in terms of access. The ordinary alternative types, valid for all prisoners, are difficult to access for users, who are often excluded.
- **Alternatives based on treatment** result in an inferior application to what are necessary. The binary punishment-treatment, where the punishment should motivate the cure, appears to be insufficiently efficacious.
- There are diverse **obstacles to access the alternatives** based on treatment: the restrictive tendency of the magistrates; the lack of resources; the long waiting periods for trials- which often means a person has served their time before having an answer; the unequal geographical factors in the judiciary and prison systems.
- The treatment programs that are alternatives to prison do not present the same **freedom of choice** for the recipients with respect to those available to free users. Drug-free programs or abstinence as the main objective, or in-patient programs, are favored. In some instances, it is possible to access local, non-residential programs aimed at different objectives, such as stabilization. In either case the obligation to the judiciary or prison system ensures that treatments often result in being ancillary.
- Notwithstanding the fact that alternative sentencing is important to reduce the penal impact for the user, the participants underline that it is necessary to first deal with the crucial issue of the **process of criminalization** of behaviors correlated to drug use. Overcoming this- which most are pessimistic about- could also free up resources to invest in health and social protections. It would also reduce the amount of violence produced by the illegal market system.
- These considerations are particularly true with respect to cannabis. The **legal regulation of cannabis** could guarantee a better governance of the phenomena, such as occurs for other legal substances.

Within the European states legislative systems, individual use of drugs results in an administrative or pecuniary sanction, or it is not punished. Where there does not exist the obligation for penal action, there are various ways the police and the tribunals can moderate the persecution of the simple consumer, according to the different options available.

> ***NL*** *We stopped punishing drug use in the 1970s, since then their health is prioritised.*
>
> ***G*** *The perpetrator of the act of the previous paragraph may not be punished if the court, assessing the circumstances of the act and the personality of the perpetrator, deems that the criminal act was completely occasional and is unlikely to be repeated.*

Nonetheless, the participants are ***very critical with respect to the real impact of these norms,*** and that they do not manage to mitigate in an efficacious way the prevalence of criminalization even for simple users and their incarceration. For example, some behaviors connected to drug use - this starts with the possession for personal use - are sanctioned under the penal code, therefore send PWUDs to prison.

> ***D*** *The prosecution of PWUD remains, even if the police officially says that the individual consumer is not whom we are after, the reality looks different. The effects of criminalization, the stigma, criminal record, that all remains and the impact is underestimated.*

2.4.1 In prison the "small fry" mostly

In actual fact, ***prisons are populated*** not by the big criminals and narco-traffickers but ***by the "small fry"***: people who are involved in dealing small amounts and/or users who have been sanctioned for minor behaviors connected to their drug use. The majority of prisoners convicted for drugs are for ***minor crimes***, and the tendency of some countries is to increase the punishments and the prison sentences for these lesser behaviors

> ***D*** *We know that most of the recorded drug-related crimes are still low-level offences, often for individual drug use, and they continue to rise every year.*
>
> ***IT*** *30% of prisoners enter prison for violation of a single article of the law, let's say that it continues to be the major actor of the Italian penalty article 73 of drug law (309/1990). (…) 34% of inmates present in Italian prisons in 2019 by drug law. The presence of inmates defined as drug addicts is 27.87% of the total*
>
> ***ES*** *The 2016 Citizenship Security Law (La Ley de Seguridad Ciudadana de 2016) (…) it´s much more punitive than it was the law before, it seems to integrate sanctions for drug user; even they are still minor sanctions, now their severity has increased*
>
> ***IT*** *I would like to underline that they tell us how the data relating to reports are still increasing, even for drug possession alone*

PWUDs are also the targets for ***punitive detention related to unpaid pecuniary sanctions***, both for drug related crimes and for other reasons, sometimes banal, such as an unpaid tram ticket. The social and economic conditions that make it difficult to pay these fines increase their risk of ending up in prison, thus perpetuating a situation of social inequity.

> ***D*** *Most of the people who are in prison because they have not been paying their public transport ticket, are also dependent on drugs.*
>
> ***ES*** *In Spain, none goes to jail by consumption of drugs– unless you have got lot of no payments of administrative sanctions, because it would a moment in with (…) you can´t pay the sanctions and you have to pay the sanction with prison".*

2.4.2 Exempting punishment /criminal liability for personal use "Unfortunately people who use drugs also possess drugs"

Legislations that proclaim exemption for personal use, or the lesser charge resulting in an administrative sanction, do not in actual fact help PWUDs avoid prison. This is not only because there are users who also deal in small quantities, often only to guarantee their own supply, or who commit crimes such as theft, but above all because of the ***crime of drug possession***- which is a real Trojan horse and is correlated to personal use.

> ***NL*** *The quantities that a user is allowed to have on him/her are much too low. For instance, you are only allowed to have one drug on you, and for powders the maximum quantity is half a gram, while hardly any dealer sells in such small quantities.*
>
> ***SRB*** *These are all those who are related to (criminal) offenses related to drugs, i.e. all offenses related to drugs, both criminals and dealers, and unfortunately people who use but also possess drugs for personal use*
>
> ***G*** *Drug users complain that for small quantities of drugs the police easily decides to bring users to court, violating the provisions of the drug law. For this controversial point, it is needed to undertake an objective investigation with specific data (type and number of cases) for the correct application of the law.*

2.4.3 The alternatives to prison. Does the "treatment instead of punishment" approach work?

The alternatives to prison that PWUDs have access to are above all very specific and based on the willingness to follow a ***treatment programme for dependency.*** These are the conditions necessary to access this option and to avoid detention whereas the access to ordinary alternatives such as those prescribed for all types of crimes and all types of offenders, are less available for them, as can be seen.

> ***D*** *We have the system in place for a long time that prison sentences can be transformed into treatment for drug addiction ("Therapie statt Strafe"), and the success rate of this model varies a lot.*
>
> ***NL*** *Drug users can be sent to rehab or receive other drugs treatment through judicial measures. When they are trialled for other offences, drug addiction can be considered a mitigating circumstance.*
>
> ***SLO*** *Drug users are offered the option of opting for treatment in exchange for an extension of their suspended sentence or shorter prison sentence.*
>
> ***G*** *The Drug Law provides for special treatment of dependent detainees with the possibility of participating in treatment in some facilities. The time spent in these facilities is calculated as time of temporary detention or in case of a sentence of imprisonment as a time of serving the imprisonment sentence.*

The combination punishment-treatment that is the basis of multiple national legislations does not appear to be as efficacious in reality as perhaps the legislators hoped. This is also true for the ***administrative sanctions***, which are presented as good leverage for early treatment, but in reality have not been shown to be functional:

> ***IT*** *44,000 administrative sanctions report only 200 requests for a therapeutic program, we see how the administrative procedure on consumption is not constituting a possibility of connecting to therapeutic paths or in any case awareness in one's own behavior*
>
> ***SRB*** *The state will propose that you pay, let's say 200 Euros. So, they prefer that you pay 200 Euros not to go to prison, instead of "you have a problem and we recommend this*

institution, or this other therapeutic community, where you can try to solve your problem".

As an alternative to imprisonment, ***the treatment routes are not easily accessible,*** it seems and appear to be hardly encouraged with respect to their potential. There is in the first instance a question regarding the ***orientation of the relative judiciary,*** who tend to use this option in a restrictive way.

NL *Judges don't rule for ISD as often as they used to.*

SRB *(…) around 1.000 - 1.800 [inmates] related to drugs. In 2018, out of them only 25 were sent to curing addition and 40 to psychosocial treatment.*

Secondly, ***the justice system is often blocked***: the large number of requests and the length of the procedures for concession to alternative measures often mean that the person finishes their sentencing in prison before they receive a reply to their request, even though they formally have every right to access treatment.

D *However, once someone is in prison, it is incredibly hard to get them out of prison and into treatment. The duration of processing these requests are very long*

IT *Existing alternatives are a wide range but that fail to fulfil the big number of requests*

The risk of ending up in prison and remaining there also depends on a geographic variable, notwithstanding the fact that "the law is equal for everyone" within a nation. There is ***an unequal geography in terms of the direction of the judiciary***, which is disparate across the national territory with respect to concessions to alternatives, and that of the police, who are more or less likely to go after the "small fry".

D *I also observe a decline in application of "Treatment instead of sentence" overall here in the south (...) Even in cases that would have been a clear candidate before. I am not sure if it is because of our local government of the prosecutions office. The further you go south, the harder it gets.*

SLO *There are differences in the functioning and attitude of the police in relation to different cities. In some places they are more understanding, in others it seems that the main goal is to meet official quotas - in the form of written penalties.*

There is also ***a problem of resources and financial coverage*** for therapeutic alternatives to prison, which contribute to limiting the number of places (limits that already exist even for treatment in prison). The scarcity of resources also affects the quality of what is on offer, which in some cases has been found to be inadequate.

SRB *Every individual should enjoy this possibility (choice of alternative sanctions), but we cannot ask that he has a whole range of these possibilities, because it is already coupled with the financial moment*

ES *Istituciones Penitenciarias (Prison institutions) worked a lot with social organizations to design a framework of programmes for this topic, but then it has not ever been enough budgets for financing it."*

NL *The ISD trajectory, where repeat offenders who use drugs are imprisoned for two years with a focus on health, social and lifestyle recovery is great in theory, but doesn't work in practice. In practice there is very little support, and more often than not it is just a two-year sanction.*

SLO *The transfer of models that have proven to be effective (e.g. in Italy) would require a built-in system (comprehensive, integrated, systematic) – with the provision of housing, counselling and other services.*

2.4.4 Alternative sentencing and freedom of choice. Condemned to abstinence?

Treatment programs correlated with alternative sentencing are viewed mainly as ***treatments aimed at achieving and maintaining abstinence***. This "single objective" is the result of the procedures and practices put in place by the systems that are responsible for these: social-health systems and justice systems. If a health perspective is adopted and not the dominance of the penal system, this poses the problems of ***equal opportunities*** with respect to options available for people who are incarcerated and for those who are free. The later have a wide range of possibilities and therapeutic objectives open to them from the services they can access. The objectives are not limited to only abstinence but are tailor-made and individualized. This is much more difficult for those who are in an alternative to prison regime.

> ***G*** *The references of the courts to alternatives to imprisonment are in the rule references to KETHEA therapeutic community programs aiming at complete abstinence.*
>
> *SRB I think the system works so that the prosecutor proposes something (one or two options) and then s/he accepts or does not accept - not that s/he (the convict) has the right to choose from the whole range of opportunities.*

Greater flexibility rarely occurs with respect to alternatives to prison. The recourse to treatment in a residential structure prevails and it is rare to have local programs and stabilization objectives (methadone therapy).

> ***G*** *The person participating in such a programme will in the end abstain from drug use and will follow a rehabilitation Program*
>
> ***D*** *It is indeed quite possible and instead of in-patient treatment, other options like substitution and outpatient-psychosocial support is possible too.*

The treatment priority needs to take a step back with respect to the approach to sentencing, also in the case of the "chance" given to the person who uses: for those in an alternative to prison regime, aside from therapeutic needs and the trajectory of use and relative problems, ***the possibility of being accepted into a program can have limitations*** that can also be stringent. The difficulties encountered in continuing a therapeutic programme can be read as failure or that the therapeutic pact was not respected "under the conditions" dictated by the sentencing. A person could be therefore "judged" paradoxically, something that does not happen in a regime when one is free: in these circumstances success or otherwise of a therapy can be easily distinguished as well as transgressions or repetitions of the crime. In some cases, the number of therapeutic opportunities conceded is limited in advance and a priori, a clear illustration of the dominance of the punitive approach over that of a therapeutic approach.

> ***IRL*** *Your gonna allow people one opportunity, and maybe two, Justice is saying, that's as much as we are allowing' (...) 'Whereas on the health side, we should be saying, it doesn't matter how many times… if it is classified as a health issue, why does it matter how many times?*

Overall, between material limits and the limits in approaches, it most certainly ***cannot be said that therapeutic treatment as an alternative to prison offers the same opportunities and freedom of choice*** as it does for other people.

2.4.5 The other alternatives. Not for PWUDs

Aside from specific types of alternatives connected to therapeutic programs, the different national juridical systems provide for alternative options to jail - that all types of prisoners can adhere to - with different kinds of preconditions and selections. These other alternatives, such as socially useful job, which would potentially widen the range of opportunities also for PWUDs, are accessible to them only with great difficulty. ***Treatment is the option that is privileged***, placing the "drug problem" at the center.

> ***ES*** *At state level it´s included the theme of substitution; reduction, suspension and work in benefit of community. But even they are included in the law, it doesn´t mean they are going on.*
>
> ***SLO*** *An alternative sanctioning is possible in criminal law - judges can accept an alternative sanction, but in cases that involve drug users they do not decide to do so.*
>
> ***SLO*** *Socially useful work is intended for those who face up to 2 years in prison. Which sounds great. The problem arises, however, because in practice there is a very small proportion of organizations that involve drug users in these works - so they have to serve their sentences.*

Some of the participants reserved some comments in particular regarding ***the criminalization of minors and possible alternatives***. There are two aspects to this issue: on the one hand, an eventual alternative to prison cannot, anyway, really mitigate ***the huge impact for a minor when encountering the judiciary system***, at whatever level. And secondly, there is very little on offer of alternative options that are qualified and capable of working with young people.

> ***IT*** *In 2019, 1281 minors were reported for drug related offenses and 56 of these under the age of 14. The socio-sanitary approach is absolutely non-existent because we all know the very heavy repercussions that crossing the world of Justice and the prison can have above all on very young people.*
>
> ***SLO*** *Centres for social work (CSW), following court decisions, can take such cases of juveniles and work with them. However, a problem may arise due to the lack of capacity of the centres - when sending young people to other organizations; they often do not know who to turn to.*

2.4.5 Beyond alternatives. "Instead of repression, into an integrated approach"

All of the limits that have been highlighted regarding access to alternatives to prison and the conditions that apply for treatment options suggest that ***many things must change***: ***resources, waiting times for cases, the tendency of the magistrates, the possibilities of free choice between therapeutic options*** and objectives- in this way the alternatives to prison could be a most relevant measure of containing the negative impact of criminalization for people who use drugs. It is precisely this impact that concerns some of the participants. They reported on not only the alternatives but also observed the wider context and ***the processes of criminalization***: the alternatives to prison are seen as Harm Reduction measures.

There is much ***pessimism regarding the processes of decriminalization***, especially when looking at the trends seen in increasing sentencing and the internal divisions within the same institutional organs of the States.

D *We have been told that someone is looking at alternative models, similar to the Portuguese model. But the enthusiasm seems very little, and there is a lot of scepticism about the idea.*

D *In the department of health there are indeed some progressive approaches and attitudes, but as long as the other ministry does not take this on, no real progress can be made.*

It has also been observed that the criminalization of drugs causes the ***immense amount of violence*** that is created around drugs, thanks also to the illegal markets, to be lost from sight. Both of these issues are hardly affected by current strategies against supply.

NL *When it comes to supply reduction, we are so focused on the drugs that we hardly look for solutions to solve the increasing spiral of violence around drug supply.*

Criminalization also removes resources from other areas of intervention. Above all the areas of treatment and of alternatives to prison are affected.

SRB *The state would have the financial capacity to support treatment and rehabilitation to a greater extent, if part of the funds it used to criminalize drug users would be directed to treatment and preventive services. (…) but that's not the case in Serbia*

Finally, the existing schizophrenia between the social processes of normalizing drug use - with reference above all to ***marijuana, the most normalized of all drugs*** - and the persistent repressive approach needs to be underlined. An approach that not only costs- in social and economic terms- but could be better governed with a cultural and social strategy in a context that is capable of producing shared social norms, both formal and informal.

NL *It's rather special that the right to use drug is anchored so strongly in our society that our youth can have a conversation with a police officer while smoking a joint. That's definitely not the case in other countries.*

G *Taking into account the current drug law several civil society organisations are advocating for decriminalisation of cannabis production and use. The rapprochement of cannabis politics with that of tobacco smoking can help convince a wide public of the benefits of decriminalizing / legalizing cannabis.*

SLO *The police spend too much time writing penalties for cannabis possession - too much staff, time and energy is focused on this aspect of work, instead of focusing all capacity on transforming the prevailing mindset of police action - instead of repression into an integrated approach*

2.5 Research and Evaluation

The EU AP 2017-2020 has significantly developed the area of research, monitoring and evaluation, both for understanding models of use and for the evaluation of the policies and interventions in terms of innovation and efficacy (5.13-15). Does the national AP attribute a significant role to research and evaluation?

Key points

- **The evaluation of policies and of the APs.** This is the most critical area, cited many times in this research, that testifies to the diffidence of politics towards science (evidence) when dealing with the evaluation of policy choices undertaken.
- **The limitations in evaluating policies** bring with them a weakening of the capacity to promote innovation based on data, experience and evidence.
- When there are models and practices for evaluating policies, these are fragmentary, without vision and are just sectorial
- The area least evaluated is that of **law enforcement and reducing supply**. The success or otherwise in this area remains opaque, which is paradoxical if the huge investments and the social and institutional impacts are considered.
- **The EMCDDA**, with its questions to the national Focal Points, provide an important stimulus to the MSs to work with the data and the indicators, even if not all are competent in doing this.
- **The evaluation of services and interventions** is more widespread and present in each MS state. Nevertheless, among the participants there is a critical question regarding the concrete value of research and evaluation in terms of innovation. The CSOs have identified that notwithstanding the great amount of work involved, the data is often lost in the successive steps of the decision-making process and is not seen to be valued.
- There exists the problem of **scarce investment** of resources in research and evaluation.
- With respect to epidemiological research and also patterns of use, there is a recurring **lack of fresh data** concerning prevalence. Also, the prevalence of the biomedical model, which obscures applied and qualitative research on drug use models, and the little relevance and circulation of knowledge regarding the quality of drugs available on the illegal market- data which are fundamental for interventions aimed at safer use.
- As far as the CSOs are concerned-in particular in their role as a service provider- there is the problem of the **unsatisfactory involvement in the research processes**, monitoring and evaluation and, when this is requested, the lack of ad hoc resources.
- Furthermore, they are asked by the public sector and by the administrations, to produce evidence for their services. This entails an important work effort, which however results in the data and **the results not being valued and used for innovation**.
- Basically, there is a **potential of knowledge** and input for innovations that are not sufficiently exploited as they could be and should be. This potential is destined to be a paradox for the CSOs themselves who invest in monitoring and research activities and for governments and their policies that could derive very useful evidence-based indications.

Research, monitoring and evaluation are three areas that are strongly encouraged in the EU Strategies and Action Plans. They recommend that the CSOs are included in these processes, with their specific contribution, both as independent non-government researchers and as observers on the ground. The participants have contributed their observations and evaluations with respect to diverse areas: to those of ***national and local policies*** and to that of ***services***; analysis of ***models of drug use*** and their changes and ***trends***.

2.5.1 Evaluate the policies and the APs. "No-one is looking at that"

The area of evaluation of the APs and of the national policies appears overall the least satisfactory. The central question, which emerged in previous chapters, regards ***the difficult dialogue between science (evidence) and policies***: to monitor and evaluate the eventual limits or the failures of a national strategy appear more of a risk to politicians rather than an opportunity to improve, according to the participants. This attitude then poses the problem of the ***transparency of decisional processes***.

> ***D*** *The federal government has no plan to evaluate the strategy overall, as if they were afraid of the results, even though there might be many positives/lessons coming out of the evaluation as well.*
>
> ***G*** *Essential evaluation of the cost- effectiveness is actually absent (...) A real reason to avoid evaluation is the absence of transparency. You cannot evaluate if there are not common agreed transparency criteria that can be met in order to evaluate objectively. (…) Evaluation is a weak point of institutions either state-approved institutions or civil society organisations.*
>
> ***NL*** *We hardly evaluate our drug policy, the last evaluation was in 2009. In the Manifest for a realistic drug policy professionals advocate for more policy research and evaluation.*
>
> ***SRB*** *For the AP, even if it exists on paper, and only on paper, and a strategy on paper, there is no body that monitors implementation*

The lack of policy evaluation is translated into an elevated risk of conservatism and inertia and becomes a ***block for the capacity to innovate***, based on evidence, and the capacity to learn from experiences and results.

> ***D*** *No one is looking at that, and it is always stated that this is not planned, because it is too multi-dimensional. For that reason, it remains important to keep asking and demanding, what is the base for taking the decisions we are taking. That is the only way to achieve change.*
>
> ***SRB*** *As a rule, an independent consultant or person will evaluate the previously implemented action plan and based on the evaluation of what has not been done and what has been done will design a new one. We don't even do that, we write a new one again from the beginning, as if the previous one didn't exist.*

When they do exist, the evaluation models illustrate the incapacity to evaluate processes and outcomes of policy in a complete and integrated manner. Instead they often provide a ***sectorial, fragmented and non-correlated evaluation***, which is often limited to the processes themselves and does not provide any information regarding outcomes and impact. These limits often leave the concrete, real implementation data, foreseen by the Action Plans, in the dark. ***The gap between planning and programming and real implementation*** is an aspect that is very important to the CSOs, who see the critical results on the ground.

IRL *We are supposed to be engaged with the mid-term evaluation of the strategy and again it's back to the same point. Like all that's been proposed is that each agency that is responsible just reports on its own bit. Now that is not an evaluation of a strategy.'*

SLO *The report includes individual activities that give the appearance that a lot of work is being done, but in reality, it is completely different - services / operations are unrelated, fragmented and consequently do not achieve the desired effects*

SRB *There are a bunch of good things which are done, but the problem exists because there is no analysis or assessment of how much these activities have actually been implemented in practice and what the effect of that implementation is.*

Finally, there are also ***methodological problems***, that on the one hand are the product of the scarce attention paid to an integrated evaluation but at the same time are in part a concomitant cause, and therefore also become a question of policy choice: the research by different bodies, government and non-government, that contribute to the monitoring of data and indicators that are not, or hardly at all, comparable.

SLO *Individual ministries have different evaluation criteria - they also do not evaluate comparable things, which is then difficult to apply in practice.*

NL *When you evaluate something, it is all about what indicators you choose to look at. If you want to reduce drug use you can look at many different indicators. Our policy is very broad, so depending on what indicator you focus on we do well, or we don't.*

In the national policy area, the monitoring and evaluation of ***the policies of supply reduction***, and in general the area of ***law enforcement***, appear to be critical issues.

D *To start an evaluation of the pillar of repression in our strategy, seems impossible.*

G *The work of the supply reduction services is not evaluated in an open setting. This is perhaps because of the nature of their work.*

NL *There is a lot of research, but hardly any evaluation of our drug policy and also very little evaluation of the effects of our police enforcement policies.*

If the important impact of policies aimed at reducing supply is considered, the relevant national budget quota dedicated to these and also the fact that these are policies that are particularly controversial and divisive in the debate surrounding drug policy, then these limits appear to be very important.

NL *The scientific department of the Police (Police & Science) plays a major role in deciding what research is done in the field of supply reduction. But if you look at the bad substantiation of the publications (…) it gets me worried.*

Finally, there is a question to be considered that is not at all secondary: ***is the evaluation research independent?*** This is a complex question, but one which cannot be ignored. On the one hand the importance of an evaluation undertaken by ***an external authority*** must be underlined. On the other hand, aside from who evaluates, what is required is ***the clarity of objectives to evaluate***. Without this clarity (what exactly does this policy want to achieve?) any effort risks being in vain.

NL *There are a lot of scientific studies, but they aren't objective. It is financed from specific angles and by certain organizations. We need more independent research in all policy fields.*

NL *To do so you need a clear policy vision, but we don't have that. (…) What are the goals*

of our drug policy? It's hard to see that in our current fragmented policy. It lacks vision.

SLO *Evaluation often takes place within individual organizations working in different fields (prevention, harm reduction, social treatment) - it is difficult to avoid subjectivity. It would be important to activate an external, independent institution that would be more competent in this area.*

In this not exactly positive scenario, the task of monitoring and evaluating national policies requested of MSs from the ***EMCDDA and the EU AP indicators*** appear in some cases to be ***an important incentive*** for them to use more adequate objectives and models and also acts as concrete methodological inspiration.

G *A good overall report is the annual report of the Greek focal point of the EMCDDA on the drug situation in Greece. The report has also paragraphs of evaluation that contain suggestions for policy development.*

NL *We do well internationally. As a focal point for the EMCDDA we are always one of the better monitoring countries, and many other focal points come to us for advice, for instance on how we register our drug checking services.*

SRB *And only when IPA 7 started did the harmonization of data collection with the EMCDDA at the EU level begin.*

D *We could take EU AP as an example/inspiration, and pick a few of their indicators that are most relevant to Germany, and simply start evaluating according to those indicators.*

The national Focal Points produce reports nevertheless that the CSOs maintain are not always exhaustive. They do not, for example, include all of the sources, such as the ***data collected by operators and services***.

SLO *EMCDDA reports in certain segments do not reflect reality. Here we miss greater activity of the state and the provision of professional support.*

2.5.2 Services and interventions. Is research always useful to practice?

Monitoring and evaluation are practices that are widely diffused when talking not about policies but about ***services, interventions and projects on the ground***. A constant evaluation is crucial to sustain and improve services.

D *In the last report we see that 26 new projects were evaluated, that is not bad.*

NL *Despite having a few controversial services, such as heroin maintenance treatment, drug checking and drug consumption rooms, we were complimented for our monitoring and the fact that we constantly critically evaluate whether or not our approach is the right one.*

Nonetheless, there is an open question regarding the constant work of data collection, a job that falls on the workers and the organizations: ***if and how this data has a concrete finality***? Up to what point ***does it help to modify and improve practices***? Often those who collect data day after day of the activities undertaken are unable to follow the process or see the value in this.

D *We are champions in collecting all the data and provide it to them, but I am not clear what actually is happening with all this data. (...) In Berlin, we do have an evaluation of the drug consumption rooms. That is now in someone's drawer, but what will happen with it?*

NL *There is a lot of national research. Every year all relevant developments and publications*

are shared through the national drug monitor. There is a lot, but the question is: how is this translated to policy? What do the ministries do with this information?

The ***concrete application of research evaluation*** is an important issue for those, like associations and workers, who include it in their daily activities, often adding to the workload, and certainly do not aim for it to be academic research. Research therefore should aim to answer important questions, such as ***the efficacy and the adequacy of a service***, in order to help identify necessary changes and innovations.

ES *I miss in these academic research contexts (…) to be closer to application contexts and intervention contexts to make research a support for improvement of programmes and alternative developments (…).*

D *Drug research should always include the practice aspects and we are lacking in that. Doing research for the sake of research and only including academia, there is no point, it needs to have practical elements.*

NL *We monitor a lot of things, but I think we should spend more money on interventions. We should only do research if we know what we want to do with the results, what interventions will depend on it.*

This does not always happen. The coherence of the research with the objectives of improving services and projects can take another direction, thanks to the ***diversion of the objectives*** (which the workers and the CSOs do not control) or because of ***methodological limits*** - when for example process indicators are exchanged for indicators of results or outcome.

D *It is very resource intensive to collect all the data and we keep asking, what will happen to it? For years, the harm reduction services were not of interest, now we are because it is relevant from a law and order perspective, so now they want to see our numbers. That is a big failure.*

IT *It is taken for granted that the fact that there are a certain number of people in the community is a positive impact. But we need community follow-up research, and I haven't seen in years*

The ***economic factor*** also affects this: resources are scarce and are invested above all in some sectors at the cost of others. Resources are a political choice and so is their destination.

D *For the size of our countries, we do have very little research in this area and that is because of the lack of funding.*

NL *It is also very important to look at what studies are funded. Research is strongly influenced through funding.*

ES *I think they have done some advances, exactly with IRPF national grants (…) the problem is the limited number of resources you have access with this IRPF national grants."*

2.5.3 Drugs and drug use patterns. Which kind of research do we need?

In the field of research on drug use patterns and models, some participants have highlighted that often data, such as epidemiological data, is ***not sufficiently updated***, regarding the prevalence of drugs used and the types of users. An exception to this is for younger users, the data for which is encouraged by the research of ESPAD, and diffused

to all the MSs.

> ***G*** *A country wide epidemiological research is necessary. It is a significant omission that this research has not been carried out since 2004.*
>
> ***SRB*** *I was at the last 4 CNDs in Vienna and a spokeswoman on behalf of the country of Serbia at each of them starts her speeches with "According to the data from 2013 ..." It is a tragedy. I am ashamed that my country says something like that*
>
> ***G*** *Research on the use of addictive substances has focused on the school population (ESPAD survey) on a nationwide basis and in individual regions / prefectures of the country.*

Another aspect is that concerning the ***type of research that is privileged***. The prevalence of biomedical research over applied and qualitative research on models of drug use appears to be an issue. ***Qualitative research receives little support*** and remains in the shadows. It can be observed that the predominance of one paradigm for research produces a partial view of the phenomena, and this partiality has an effect also on policy given that it is deprived of comparison from different perspectives.

> ***ES*** *Only practitioners can talk about drugs, only medical researchers (…) And only researchers with sensitivity to the reality of the persons try to change these things, but they are a minority and it´s a pity.*
>
> ***ES*** *It has got the same logical framework the research in this topic, very limited applied research and very biased in negative effects of cannabis use, for me it´s very clear.*

One area that was specifically mentioned is that of ***knowledge of available drugs on the market,*** knowledge which is functional to HR interventions oriented towards safer use. It is important for people working in this area to know the composition and purity, but often a lack of basic information is recorded.

> ***IT*** *If we talk about purity you cannot quantify it because you do not have a reference standard*

2.5.4 Research and evaluation. The actors on the scene

CSOs, the Third sector professionals and universities are the non-governmental actors involved in the "research scene". As far as the CSOs are concerned and given their role as providers of services, the situation appears contradictory. On the one hand they are asked by the public sector and by administrations ***to produce evidence for their services, in terms of efficiency and effectiveness***. This often occurs while faced with ***insufficient resources***, which means they face the dilemma of working for their own clients or doing research. This in itself could bring a level of dissatisfaction to the quality of the research and in the evaluation.

> ***SLO*** *The quality of evaluation within individual organizations (…) is not at a high level. This may be due to the fact that the state otherwise anticipates and "requires" evaluation, but on the other hand, it cuts resources that could be used for better evaluation.(...) We prefer to allocate available (reduced) funds to specific work with users, although it would be wise to know whether we are successful or not.*
>
> ***ES*** *Usually it´s very difficult to sustain an intervention with the development of activities and to keep time and budget for the evaluation (…) there has been a limited support for the evaluative developments of programmes.*

Another critical area is the level of ***involvement of the CSOs in the research processes and the evaluation*** by government bodies, in clear discord with what is explicitly intended by the EU Strategy.

> ***SLO*** *Reports of action plans do not reflect the reality on the ground. We NGOs do not even have an influence on the report in terms of evaluation and validation.*
>
> ***ES*** *We are trying to develop more applied things from our research, but a lot of times the results and reports are not published and we don´t achieve the goal of visibility, and I think it´s a problem.*
>
> ***IRL*** *We won't be able to evaluate or give our view on how things are working (…) So we are being left out of that process.*
>
> ***G*** *There is no cooperation with and involvement of the workers in shaping the policy and use of the experience and knowledge of the employees is absent.*
>
> ***SRB*** *We do not know if there is a set of indicators for drug policies envisaged in the action plan, but we would be happy to participate in monitoring the AP if someone offered it to us.*

Notwithstanding the limits of this involvement at an institutional level, the CSOs and their workers produce a lot of research and information, often, as mentioned previously, with scarce or non-existent resources. All of this work could be destined to irrelevance and invisibility, which clearly causes it to have no impact on the work being done and to be a source of frustration. Above all it is an ***important loss of information and knowledge***, which the administrations and policy makers could well utilize.

> ***SLO*** *Evaluation can help improve the quality of our work, but why do it, because in the end it doesn't matter whether the evaluation is or is not there.*
>
> ***IRL*** *There's massive amounts of work and that progress report reflects practically none of it.*
>
> ***ES*** *It would be a must to have real participation and data from CSO*
>
> ***D*** *Positive example where an evaluation actually was helpful for our advocacy, in terms of young parents who use crystal meth (...) that is the only time I remember that an evaluation received attention.*

2.6 Participation of civil society in drug policies

The EU AP includes the participation of CSOs in all the phases of drug policy: definition, implementation, monitoring and evaluation (EU AP 3.9) Does the national AP foresee the participation of the CSOs? Does it clearly define areas, competencies and process?

Key points

- **The map of CSOs participation** in decision-making processes regarding drugs is much diversified, with some good practices but overall the level of satisfaction is low.
- There are many opportunities to participate, both at local and national levels. Anyway, the contribution of CSOs in the AP and in national policies is very limited
- Where participation is foreseen there is nevertheless **discontinuity and gaps** between what is written on paper and what actually occurs. It is a question of a lack of continuity and little definition regarding time, place and procedures.
- Criteria used for deciding the issues and the decisions when CSOs are involved or otherwise, are not clear. Overall there are problematic areas regarding the transparency of involvement, both for the **lack of clear guidelines** and for a more "political" type of selection based on the orientation of the CSOs and at times the institutional desire to avoid conflictual situations.
- **The quality of participatory processes** at times sees the scarce presence of institutional actors. An area that merits improvement is that of the completeness and the timeliness of communications and information.
- Regarding the efficacy of participatory processes, there are good practices where results are achieved. The processes however are more consultations rather than real active participation in a shared decision-making process. There is an open problem of recognizing the **negotiating power of the CSOs** and also, in cases of more stable and structured participation, the effort of maintaining their own independence.
- The CSOs need to respond to these problems in an active manner and activate strategic intelligence. Their strong points are their **competencies, knowledge and experience on the ground** that need to be recognized in the relationship with institutions and policy decision makers. The functionality of their knowledge risks sliding into exploitation at times, especially when involvement is sporadic, episodic and of a specific urgency. It is important to know how to govern this risk and strategically evaluate it.
- The CSOs know how t**o network well among themselves** and with other sections of civil society, which is important but not always continued because of competitive dynamics. The issue of **resources necessary for participation** is relevant and influences the quality of the contribution in the participatory processes. The institutions should take this into account.
- **The participation of PWUDs** and their organizations is a problematic area. Notwithstanding some positive experiences, their voice is still not well heard. It is the general context, more than the rules and procedures required for participation, which is a cultural influence, one that is the result of processes of criminalization and stigmatization.

➲ Nevertheless, beginning with positive experiences that are occurring, it is possible to work to transform PWUDs participatory occasions that are limited and sporadic today, into **more stable practices**. Alliances are crucial, and the CSOs can, and must, assume this responsibility of facilitation and support, but not as an authority to speak "in the name of". There is understanding that the road ahead is long and difficult, but the issue is one of the items on the agenda of necessary changes.

The map of participation by the CSOs in decision-making processes concerning drug policies is ***much diversified among the countries*** participating in the research, with a discreet level of involvement for some and total dissatisfaction for others. Very few realities have been able to ***fully participate in the process of defining the national AP*** or even as part of national policy making:

> ***ES*** *When it was designed last Action Plan into National Addiction Strategy that is actually working in Spain (..) it was open a giant process of consulting (…) all NGOs interested in participate could make comments and affords to the Action Plan (…)*
>
> ***D*** *We work a lot with governmental bodies in relation to infectious diseases, and are part of all working groups that CS can be part of.*
>
> ***NL*** *Following a publication of Correlation in 2018, efforts have been made to set up a similar CS dialogue on national level. Trimbos Institute will coordinate this. It was planned for 2020, but has been postponed due to corona.*

At the opposite extreme, other participants stated a ***total absence of involvement*** with regards to strategic decisions at a national level.

> ***IT*** *Despite the fact that the CSOs capture phenomena and are relevant observation poles within the territory, they are absolutely not taken into consideration in decision-making processes nor in political planning*
>
> ***SRB*** *The Strategy 2014-2021 was done without sufficient participation of the CSOs, (…) There are no CSOs in the National Commission for psychoactive substances, there are no CSOs in the Council of Office for combating drugs, there are any CSOs in many other places.*

In between these two extremes there is an articulated variety of diverse opportunities and occasions for participation. These are however ***partial,*** both for their ***infrequency,*** concerning only ***one limited area of drug policy*** and for being only ***local*** or additionally, for not having venues and stable and sanctioned ***procedures***.

2.6.1 The gap between theory and practice. "On paper but non in reality"

One first critical point underlined by the participants, even those who declared a discreet level of involvement, is ***the gap between what is provided for "on paper" and what actually happens*** in practice.

> ***IRL*** *Well it's as we said great on paper. It says on paper that we are all involved in the decision-making process, no we are not.'*
>
> ***SLO*** *The participation of civil society is provided only on paper. In reality, this cooperation is very selective and non-transparent. (…) The union has one vote in the Commission on Drugs. So formally things are set up, but the practice is different.*

Places, times and procedures are often uncertain and the practice of involvement is exposed to factors over which the CSOs have little control and of which they seem to

have little knowledge about: for example, ***on what basis are issues selected*** where they are then invited to be involved and those where they are not?

> ***D*** *Also another federal NGO is included sometimes, but it does not happen in any systematic way or on all levels, its rather someone that remembers, 'Ah we could invite these guys', and then it happens. But this is in no way continuous and depends on a lot of different factors*
>
> ***IRL*** *Structures can end up just being a façade (...) because you can say well look you are involved. but you are not, not really. You are involved in tiny bits of things that we are permitted to be involved in, basically.*

There also exists the problem of ***transparency***. For example, who and how among the CSOs ***should be involved in a certain process***? At times the problem is the lack of transparency or a **l*ack of defining the criteria*** and the procedure:

> ***D*** *I think a lot more CSO should be involved and it should be transparent, who is part of what and what exactly they are discussing.*
>
> ***ES*** *It depends again about personal contacts and casualties, doesn´t it? It depends of my good relation with X person*
>
> ***D*** *We experienced that it was very hard to become involved and get invited to a meeting with the minister (...) it is not an obviousness that CSO should be involved, especially not organizations that aren't part of the traditional and well-established ones.*

A more complex point - political - has been raised: selection on the basis of ***the orientation of the CSOs*** by those at an institutional level who have control over the participation process.

> ***D*** *Only being invited when they know you agree or cannot disagree, that is part of the problem. Which is why it would be so important to have a structural involvement of CSO, where there are organizations that agree and others that disagree. We do not want to be friends; we just want a seat at the table.*
>
> ***NL*** *The participation of civil society on policy development happens very selectively and non-transparent.*

2.6.2 The quality of participatory processes. "It's not clear what they do with our monitoring reports"

There are many variables that influence the ***quality of the participatory process***, both in terms of the ***participatory mechanism*** and that of the ***results.*** With respect to the real possibility of dialogue between CS and institutions, what matters is also the fact that ***the presence of institutional figures*** at the table is not constant. Aside from invalidating a real discussion, the CSOs often feel frustrated and it suggests to them that these meetings and their participation is not so relevant for the institutional representatives.

> ***IRL*** *The actions are actually very good, but most of them have just been given to the HSE, Department of Education or whatever, and I mean, half of the time the Department isn't even at the table*
>
> ***ES*** *Spanish Council of Drug Dependances it´s an assessor organ of National Plan about Drugs composed by NGOs, syndicates, other ministry workers (...) it was never ever more active and we ask continuously its activity*

There also exists, in the process, a problem of ***access to information and one of communication***, which is often not sufficient or timely.

SLO *The participation of civil society is planned, and it is also invited to meetings. But not always. (…) Even now we do not know what is the state of the art of the new AP. There is a lack of real dialogue (…) at all stages of preparation of various documents.*

With respect to the ***results*** of the participatory processes, there are critical areas above all relating to ***the function and the relevance that the contributions by the CSOs effectively have*** on decisions regarding drug policy. This is a central theme, one of the ***real negotiating powers*** of CSOs at institutional meetings. This is a question that evidently is not played out only within the formal rules of the participatory processes (even if this can influence them) but it is the outcome of a ***more generalized social and political dynamic***. Underneath this can be read the complexity of the variables that influence drug policy (see for example the already cited difficulty of basing policy on evidence and on competencies) and also the ***crisis of the so-called "social intermediate bodies",*** of civil society associations, that in times of populism and crisis of democracy models find themselves defending their role, their title and their credibility.

NL *We monitor the field on national and municipal level, but it's not clear what they do with our monitoring reports.*

IRL *You are going back to your networks and saying we are on these national networks but really, we have nothing to tell you. (...) it's supposed to be the bridging gap between policy and the ground and it's not working that way.'*

SLO *We are not present there for decision-making, many of our proposals are not taken into account.*

SRB *Ministry thinks that health services and access to them should be conducted exclusively by accredited health institutions - and not the non-governmental sector (...) MH does not consider them at all as an equal and reliable partner*

In apparent contradiction to what has just been stated, the CSOs that are regularly involved in participative and decisional processes know they run ***the risk of being "incorporated" by the institutional bodies***, at detriment to their own independence. Just as those who are excluded, those who are regularly included in the political processes can lose the capacity to carry the voice of civil society and of interest groups, of which they are the expression, if they do not ***hold and defend their own independent positioning***.

D *Being involved very closely does not make it easy to remain „independent ", and it is a challenge to not get influenced by politicians and PR people who are highly skilled at doing that, so it can also be a risk and we are constantly aware of that.*

2.6.3 A map of participation. Cities, parliaments, agencies

The geography of ***participation is articulated on a territorial basis and for areas of administration*** and competency. This research did not have the job of compiling a detailed overview. However, it is interesting to note how the places where drug policies are discussed and where decisions are made, are multiple. Within ***this multiplicity***, there can be ways where the CSOs ***can differentiate and increase opportunities*** for participation.
At a local level, the ***municipalities*** involve the CSOs, often not in regular processes but for single aspects, based on the agenda of local politics and also on the propensity of the mayor.

NL *CSI is very local. Municipalities will ask us for input on specific topics. But it really varies strongly between different municipalities; it even depends on the personal situation*

of the municipal councilor. (...) And it also matters what political party they belong to.

At a national level, the seats of participation are ***Parliament*** (Commissions and hearings), and national ***Ministries and Agencies on drugs***, that offer places for (often occasional) consultations and discussions rather that structural processes for participation. Notwithstanding the infrequency, at times the outcomes are appreciated.

> ***G*** *The CSOs, of the platform have claimed participation in parliamentary hearings on issues related to drug policy. The Greek parliament has a special sub-commission for drug policy, which is part of the standing parliamentary commission on Social Affairs.*

2.6.4 CSOs limits and challenges

The critical questions concerning the areas where an improvement in participatory processes could be made depends certainly on processes and institutional dynamics. They are however also a function of how ***the CSOs themselves have the necessary capacities and action strategies***.
One aspect regards ***the dialogue and the alliance that is made between CSOs***. It involves the capacity, notwithstanding the differences, even profound differences (and often the difficulty is here), to present a united front instead of proceeding in a random way and aiding the dynamics of competition.

> ***D*** *A positive example is during the first lock down, communication and cooperation was rather good, so it actually worked. Importantly, CSO amongst themselves communicated which each other more. Therefore, I think we also have to look at how we are organized and are we in a good and structural exchange amongst ourselves*
>
> ***NL*** *An all-inclusive dialogue is really complicated. Within CS you have strongly opposing standpoints. If you open it up you will get more lobby groups, and discussion with more extreme opposites. It makes it hard to filter the input. I understand that policy makers prefer to keep it practical.*
>
> ***G*** *Since 2013 NGOs (…) in the city of Athens created a partnership and operate together in advocacy issues. (…) Due to pressure of the platform several issues have been realized in the past 5 years*

The alliance also invests in ***civil society in every sense, other than the "drug sector"***, if one considers how drug policies are transversal across various areas. It happens at times between CSOs in general, that the issue of drugs is discriminated and removed or avoided. This is a problem both in terms of the risk of ***isolation for the CSOs of the drug field***, and for the further ***compartmentalization of the drug issue***. What is needed is a ***greater transversality*** (for issues of social inclusion, health promotion, rights to work and for a house, for example).

> ***SRB*** *Our colleagues from other segments of the civil sector, whenever we say something about drugs others ignore us, and put us aside*

A second challenge is how to promote ***the credibility of CSOs in the eyes of the institutions***, to support their participation and also ***their negotiating power.*** The first card to play is that of ***their competency and their role on the ground***. This renders the participation of CSOs useful and functional to politics. This functionality could be used at times, such as when there is an emergency or a critical situation where the institutions find themselves ill equipped. It is not easy to navigate between ***being functional in a positive sense and occasionally being used politically***. It depends a lot on the context

but also on the CSOs and on their capacity to relaunch their role in a more strategic way.

> ***SLO*** *Our focus must be on the role and importance of civil society and take advantage of this position in a greater role than it is now. It is necessary to set the mirror for politicians and look for and offer concrete solutions (which are not lacking).*
>
> ***D*** *When it is about issues with high time pressure or ones that can hardly be solved without CSO, e.g. problems of public drug use and public spaces, it is easier to be invited and asked for involvement.*
>
> ***NL*** *This year, Trimbos, MDHG and Mainline have been monitoring the impact of corona on harm reduction and marginalized PWUD for the Ministry of health. The Ministry was quick to come with this request and really appreciates this monitor.*

This aspect of professionalism, according to some, can also become a risk when a CSO, that is also ***a provider in the public-private system of services,*** could feel threatened by this profile in cases where they ***express dissent or conflict*** during round table participations. It is clear that greater transparency and more solid participative procedures could resolve this conflict of interest between being a provider and at the same time playing an active part in civil society. It is an important point given that the majority of CSOs involved in participatory processes have this double nature.

> ***SLO*** *The active role of non-governmental organizations also depends on funding - they often do not want to be exposed when they point out irregularities, as they are afraid that they will be left without funding*

Another aspect that has been identified, and is one of the aspects appreciated by the institutions, is the added value of the ***international relationships*** CSOs have.

> ***ES*** *We have got a very well connection with Plan Nacional de Drogas and networks, in national and international level (…) PNSD considers we are their label to international networks and I think it´s quite good*

A possible alliance to invest in for the CSOs are ***the media***, even though there are always positive and negative aspects. On the one hand they can assist in turning attention to a proposal or a change. On the other hand, playing ***a very influential role politically***, they can also represent a risk, if they assume an unfavorable position, for example. Either way, the media represent an area to cultivate with attention.

> ***NL*** *The media indeed have a lot of influence, but CS can also use that. I don't think it's a bad thing. We can use the media to put things on the political agenda. If I want something I'll go talk to a journalist.*
>
> ***G*** *There is quite a lot attention of the press for the initiatives of the platform. This helps essentially as a pressure instrument towards the decision-making bodies (the ministries, the parliament)*
>
> ***NL*** *The media have a lot of influence. Maybe too much. This is the problem with our political system.*

Last but not least, the CSOs encounter difficulties in the participation processes because of the ***very few resources available*** to them. This is not intended to mean defining participation as a "job" but to consider that in many cases participation means producing data, research, documents, and spending time in meetings. This is all time that members and workers of the associations have very little of and often entails ***taking time away from activities on the ground***. Serious participation should involve ***public investment to support*** it, also as an indicator of the relevance attributed to these processes.

SLO *Active involvement also requires human resources, which NGOs do not have - it all depends on individuals who are very active - it is often necessary to make a decision between working with our users or advocacy (BUT both areas are very important).*

2.6.5 The voices of PWUDs. A battle still to fight

The ***lack of participation of PWUDs*** in decisional processes or even in consultation processes is very much criticized. There are differences in national situations but none signal any real satisfaction regarding this aspect.

IT *Historically, especially in Italy, the protagonists don't have a voice.*

NL *The drug user union really needs to fight for it to be included in the policy process. We share signals, but what do they really do with that? We have to really make an effort to have some influence.*

ES *To make parallel lines with CSFD (…) there has been a big fight (and it´s still fighting) to make users groups in it (…) In the case of Spain there is participation of CSO, but only official NGOs*

There are ***cultural and ideological reasons*** at the base of this lack, above all the stereotypical image of the user and his/her ***criminalization***. The latter image is an obstacle that works in both directions: on the part of the institutions who do not see ***the drug user as a "citizen"*** who has the right to participate, and for the users who are ***not interested in institutions that criminalize them.***

D *Perspective and interests of PWUD are not included, which can be seen by the example that repression is still the goal, instead of safer use and access.*

D *Big gap between lived experiences of people and what drug policy says, therefore in many cases PWUD distance themselves from drug policy in general and do not want to become active.*

The ***CSOs can play a role*** here of facilitation and promotion for the participation of PWUDs. With the understanding that they are not a proxy for others or that active participation by users can then be said to have been achieved, nevertheless the responsibility and initiatives of the CSOs in this sense is important, at least to initiate the process. ***The associations who fight against AIDS*** for example, have, in their long history, made progress and often represent the voices of those who use drugs.

D *There was one very good example of involvement, (...) but simply because of people working in the bodies who involved a lot of CSO As always, there are good and bad examples but either way it is not a structural involvement.*

D *All of this works much better in the area of policy to prevent infectious diseases than in the area of drug policy, that is very clear.*

There are ***positive examples*** at national levels but they mostly demonstrate an impromptu and sporadic character that is not consolidated in a stable practice. It is clear that there is ***still a long way to go yet***.

D *Since two years, the national association of PWUD sits on one committee and attends regularly, but that is only one of many committees.*

G *The prime minister, (...), had a meeting with the Peer Network of Users of Psychoactive substances and other organizations of the platform in a neighborhood of Athens.*

Part III

CONCLUSIONS AND RECOMMENDATIONS

Beyond the gaps. 8 areas for improvements

The picture that the research offers reveals that some of the most relevant objectives and recommendations of the EU Action Plan 2017-2020 are not reflected in the national policies, or they are not enough; and, if and when they are, there is a deep gap between theory and practice.
The critical issues that have been described and analyzed in each chapter, have drawn a map of the most relevant points for each thematic area. These are the points where action must be taken in the future in order to ensure that the approach and the objectives of the European Action Plans are taken into greater consideration and implemented in the national Action plans and policies in accordance with the perspective of the CSOs.
In the final conclusion phase nonetheless, it is interesting and promising to see that under the profile of possible changes, in all, or at least a great part of, the six thematic dimensions analyzed, emerge as "core categories" some ***recurrent barriers***, common to different themes and dimensions and diverse national contexts. Overcoming these common barriers appears to be a priority, a necessary innovation, if we wish to proceed in the direction of better implementation of the spirit and the letter of the EU Strategy on drugs.
The following are the ***areas of development and improvement in national policies*** that have emerged from the research in light of the key themes regarding Strategy and European drug policy approach.

1. Greater clarification regarding decisions by policy makers

According to the CSOs, national policies are often not explicit in their approach and in their objectives. This makes it very difficult to evaluate them and to reformulate and innovate them. This happens above all in areas that can be considered to be still controversial, such as Harm Reduction, or other particularly sensitive areas with respect to the media or public opinion. Greater clarity of the objectives and a better definition of the interventions could bring with it stronger and explicit political support for drug policies. This in turn could lead to greater continuity, the guarantee of economic coverage for interventions, and greater attention to their quality.
Objectives, which are clearly declared, declined and motivated in an explicit manner, enable policy makers to be both responsible and to be guarantors. It would also enable all the actors involved (workers, CSOs, local organizations) to be able to work in a coherent and efficacious way for the quality and continuity of the interventions. This clarity would also allow for a more realistic and founded evaluation.

2. Greater coherence between the intent and the implementation of policies by the competent organizations

A recurring gap is that between intentions or guidelines (declared and written) and practice, their effective implementation. In part this is due to a political aspect, cited above, and

the weakness in clarifying policy choices. There is however also a barrier that has to do with administrative procedures, with the institutional devices that govern and should render the decisions and practices of different entities coherent (for example the diverse ministries that are involved in drug policies). It also regards the confrontation between political bodies and those who actuate programs, as well as between the public, private and private social spheres.

Greater care of the system setup in terms of competency and responsibility, of clarity for the agencies and the procedures that should govern the realization of policies, is highly desirable. Also, greater recognition of the CSOs and of their important role in being "observatories on the ground", able to give feedback regarding discrepancies in the actuation of policies, is a variable that would play a more significant role.

3. Greater transparency and care of the procedures

The question of transparency, connected to the issue cited above, also emerged. In institutional procedures, in any area of drug policy, transparency means certainty of the procedures, of the criteria upon which decisions and their implementation are based, the responsibilities, and their accountability. It also means access to data by the social, institutional and civil society groups, to information of all types on which political choices and intervention systems are based, and that they are at the same time useful and functional with respect to their verification and evaluation. This is important also for the involvement and participation of the CSOs in the decision-making processes, an area that specifically appears to be problematic and often opaque.

Greater care with respect to transparency in all of the areas concerning drug policy would ensure greater responsibility by all the actors involved and consequently better implementation of these same policies.

4. Inclusion of the criminalization of PWUDs in the political agenda

The processes of criminalizing PWUDs emerged in the research as a kind of mortgage on the development and the improvement of drug policy at many diverse levels: as a limitation of citizenship and of human and social rights; as a barrier to accessing services and treatment; as a motivating factor for exclusion and a source of stigmatization. The criminalization profile is a pervasive context factor that is capable of subjecting great stress on the eventual process of change in all of the other areas analyzed. The gap between the evaluations of actual policies of law enforcement, which has often been noted, does not help.

While a process of decriminalization is hoped for, what is required is to at least put the issue on the political agenda. It is necessary to overcome ideological blocks and have an open discussion concerning a possible process for the decriminalization of behaviours connected to personal use. This discussion must begin with the evaluations (of outcomes, of impact and of costs/ benefits) of actual policies of criminalization and facilitate the participation of all the competent and involved parties, PWUDs and CSOs included.

5. Overcoming the excessive inequality between regions and geographic areas

In all of the areas analyzed by the research, geographic inequality emerged as a very

critical issue, with profound and substantial differences noted between regions or states in every MS state. There were also differences between territorial areas, for example between small and larger urban centers or between the cities and rural areas. This results in the social and human rights of PWUDs being put in jeopardy. It is the inequality in the offer and the access to services and treatment that creates disparity in terms of rights to health and to the best possible social-health standards available. There are also problems with the application of alternatives to prison sentences with territories oriented in more restrictive ways or lacking the dedicated resources, all of which go against equality in the eyes of the law.

With respect to the constitutional architecture of each country, it is important that national policies provide a secure framework where the policies and the interventions guarantee equal opportunity and equal rights for PWUDs, families and social communities, notwithstanding specific local characteristics.

6. Invest in welfare. Good policies need the right resources

In all of the areas where drug policy is applied, there is a lack of resources and of investment: from prevention programs and services to treatment, alternatives to prison, social security, rehab programs and also support in CSOs participation. No policies, even those that are considered "good policies", manage to be efficacious without a proper level of funding. The trend in financial coverage for drug policies is generally negative, and this influences the quantity and the quality of the offer and is also the source of selectivity to the detriment of the client.

It is important to reinvest in a social and health welfare that is inclusive and of a high standard, one that PWUDs can also access without exclusion. It is also necessary to have greater financing for policies specific to drugs, and a new, more equal balance, between financing programs aimed at reducing supply and those aimed at reducing the demand.

7. Development of a dialogue between politics, science and research

Research, scientific evidence, monitoring and evaluation are the basis for policies that are more than ever capable of knowing and understanding the phenomena they must regulate and govern and for deciding and implementing the most coherent and efficacious intervention policies. The dialogue between policy and science however is too often difficult, auxiliary, or only formal and many decisions are made where ideological beliefs or economic factors prevail. The decisional processes undoubtedly concern the policy makers and not the scientists but, as the actual on-going Covid pandemic crisis 2020-2021 has well demonstrated, political decisions that disregard research results and scientific evaluations are destined to be unsuccessful. Greater dialogue between policy and evidence, that is produced according to all the diverse research, scientific and social approaches, is urgently needed. The role of EU bodies, such as EMCDDA, could and would play a stronger role and guidance towards MSs and their Focal Points.

This is necessary first of all in order to understand in real time a phenomenon that is continually and rapidly changing, and then to evaluate the necessary and coherent innovations in light of successful and unsuccessful actual policies. Research that is plural in both approach and orientation of actions is important. The participation of all the involved and competent parties, according to clear and transparent procedures, and the correct economic support for research activities, are the necessary preconditions.

8. Strengthen CSOs advocacy impact through grounding in communities and networking

Even if some important barriers are represented by the above-mentioned limits in procedures and transparency by institutions, nevertheless the CSOs have not hesitated to evaluate and criticize their own limits. It is not easy to deal with the crisis of associations in times of populism and of what goes under the heading of "the crisis of democracy", all of which tend to weaken and challenge the protagonist nature and the negotiating power of the CSOs in all areas. However, in the area of drug policy, the grounding in society, the acquired competencies and the social role played every day by CSOs, give them the possibility to have a voice in the political processes.

It is urgent to improve cohesion, while minimizing internal competitive dynamics, and to develop networking, also facilitating the involvement of PWUDs organizations and networks. Great attention must be paid both to a gender approach and to the participation of people and organizations from the so-called vulnerable groups, and to their involvement in the decisional processes regarding drug policies that concern them. It is also important to remember that placing value on and caring about the close relationships with local communities and the people who are involved in these, remain the strongest aspects and no "institutional engineering" or procedures can ever replace this.

APPENDIX

Appendix I

NATIONAL CASE STUDIES SUMMARIES

GERMANY

Researcher Melissa Scharwey
Focus group participants: Astrid Leicht, Fixpunkt e.V.,Dirk Schäffer, Deutsche Aidshilfe e.V., Nina Pritszens, Vista Berlin gGmbH, Olaf Ostermann, Condrobs e.V., Philine Edbauer, Mybrainmychoice Initiative, Rüdiger Schmolke, Chillout e.V.

General approach. The national drug strategy is in place since 2012 and has not been renewed or evaluated since. When compared with other countries, the participants agreed that drug policy in Germany is considered as progressive and evidence-based, and "doing well" overall. However, there was mixed agreement to what extend this is true. ● Federal structure. The federal government, Länder (states) and municipalities share responsibility for drug policy, including in the areas of enforcement and funding. This can result in regional differences in the services that are available and how (well-)funded different areas are. Generally, big differences were seen between the North-South and West-East of the country. Ideology-based vs. evidence-based: in some states, drug policy was described as less ideology-based than in others. Some participants noted that they see an overall shift in society towards more authoritarian and law-and-order ideology. The participants clearly acknowledged the important steps that have been made in the 1990s and early 2000 in regard to evidence-based drug policy, but agreed that there has been little progress since then. ● Repression. All agreed that drug policy remains largely in the area of criminal justice and public order, and that health policy is subordinated to those. Participants stated that health interventions can only go as far as they don't contravene existing criminal law. Therefore, drug policy was not necessarily considered as "balanced" by the participants. Participants reported that a large part of what drug services do is to try to reduce the collateral damages of repressionist policy, rather than the drug use itself. ● Human rights. There is no official strategy or campaign for HR and people who use drugs (PWUD), and no mention of it in the national strategy. However, civil society actors sometimes use the HR argument as a tool for advocacy. The participants mentioned that discrimination and stigmatisation are two crucial pieces to look at, and that it would be important to include this in the conversation of HR of PWUD.

Availability, access (AA) and quality of interventions. Overall, Germany ticks most boxes, also in EU comparison, because most programmes exist at least once in the country. However, they mostly do not cover all geographical areas/needs/groups ● Reported barriers to improving AA and introducing new options are either the existing legal structures, i.e. these interventions may contravene with existing laws and criminal justice policies ● The participants reported stark differences in availability and quality, in particular of low-threshold services (e.g. due to difference in funding) between north and south Germany and west and east Germany ● In the cities where there is an "obvious" drug problem and need for low threshold services, a lot has been done. In more rural areas, where PWUD and related problems are less visible, AA decreases. ●The availability of intervention depends on the federal structures, but also each of the states. In many cases, it depends on the individual policy-makers in the states/municipalities. Even though a lot of interventions exist, with varying AA, the rates of success of most programmes remain low ● AA prevention. Overall, the quality of prevention work was considered to be high,

mainly due to the highly-skilled staff. However, it seems that good prevention work is implemented only if there are political or other interests in it ● AA care and rehab in the case of substitution, participants reported that the AA varies a lot, depending on whether it is a big city or rural area. It was stated that in many big cities, everyone who wants to be put on substitution treatment, will receive it relatively fast. In the countryside, it becomes more challenging and some people travel long distances into the cities for their substitution treatment. On a surface level, there is free and broad choice of options, in some areas of treatment more than in others. But it was also discussed that the further you go into detail of different options and freedom to choose, the more evident it becomes that this depends heavily on the institution or individual professional that you are dealing with.

Vulnerable Groups ● Mental health. There was some discussion on how challenging it is to receive the support needed; in the case of a person in psychological treatment that is not about their drug use, they can experience stigmatisation and problems with the mental health professional. ● Woman. The gender-variable is briefly and vaguely mentioned in the national strategy, there is no mention whatsoever of LGBTQ+ issues. Part of the reason is that the management and leadership in the area of drug services is male-dominated (whereas the drug service delivery is mainly served by woman), and therefore the specific needs of women and other more vulnerable groups are not considered sufficiently ●Young people. The national strategy mentions the prevention of drug use among young people as one their nine goals for illicit drugs. The participants held mixed opinions about AA and quality of interventions for young people. It was reported that in some cases, it is easier for a young person to receive support i.e. in-patient rehab, but there are, for instance, much less drug support services specialised on working with young people, which can worsen the quality of the support. Low availability of out-patient services that work with the young person in their environment and e.g. with their family was reported. ● People in prison. Improving the situation of drug using people in prison is mentioned as goal 8 of the national strategy and there are many different actors working with people in the prison sector. More often than not, services working with people in prison fail in their mission to e.g. have their sentence suspended for a treatment plan, due to high bureaucracy and long-waiting times. ● Migrants. The national strategy recognise the specific needs of migrant communities and commits to considering these in their work, but there are no specific actions or approaches mentioned. A heavy conflict of interests was reported between the different political sectors which lead to poor support for migrants. E.g., the political sector of the interior and foreign affairs are leading with a policy that aims to lead people back to their country of origin. At the same time, the health sector aims to support all people who live here, and integrate them into society. The typical conservative attitude towards migration in general is very evident, e.g. “if you support migrants, they will not want to leave and it will attract even more people to come” ● People outside the public (health) system. In contrast to the previous group, the main challenge here is not necessarily political, but institutional. For service providers/ institutions/authorities, working with people outside the public health insurance system is complicated. There is a lack of flexibility and willingness to adopt to the circumstances of the service user.

The inclusion of harm reduction in drug policy and interventions. Harm reduction (HR) is one of the four pillars in the national drug strategy. However, a big gap between the official stand and the reality was reported: HR remains subordinated

to public order and criminal justice, in terms of finance and priorities. The underlying motivation for financing harm reduction work is not to improve the health and well-being of PWUD, but for public order issues. Participants agreed that harm reduction is still seen as an ultimatum, justified as an intervention "if nothing else works". ● Traditional. HR was introduced in Germany not out of a conviction that it was the right thing to do, but because it was seen as a solution to public order issues. Therefore, the implementation is rather half-hearted and slow, because most policy-makers are not actually standing behind the principles. ● Gaps strategy – implementation. Certain HR measures are not being implemented (e.g. drug checking), because the structures require the different actors and ministries to agree to it, it is often not a matter for the Department of Health to decide alone. In other cases, e.g. accessing clean injecting equipment, programmes are implemented but only in places where drug use is visible.

Alternative sanctions ●Treatment instead of prison sentence. Is a long-standing option in Germany, where the prison sentence can be substituted by treatment. It was reported that the success rate of this model varies. To apply this model when someone is already in prison has been reported as extremely challenging and frustrating for the services. ●Regional differences in application. Overall, it was reported that threshold levels for simple possession charges vary a lot, comparing e.g. the south of Germany to Berlin. In the south, the application of alternative sanctions has decreased over the last years. Contrary to this, participants reported that in Berlin, the prosecution of possession of minor amounts of drugs for personal use does not usually happen. ● Implementation. The prosecution of PWUD continues, even if in official terms, it is stated that it is not in the interest of law enforcement to do so. That also means that the effects of criminalisation, the stigma, criminal record etc. all remains and the impact is underestimated. Most recorded drug-related offences are still low-level offences and the number of offences continues to rise every year. Even though numbers and therefore effort increases in the area of law enforcement, the investment in drug support services is not being increased, drug policy remains in the criminal justice sector, and health aspects are subordinated. ● Progressing towards other alternatives There have been official statements that alternative sanctions and models are being considered, however large scepticism remains about alternatives to sanctions in general, and that this is the major barrier to progress.

Research and evaluation According to the national strategy, the promotion of research is one of the pillars of drug policy in Germany. However, the official statement in relation to evaluating drug policy as whole is that no evaluation of the strategy is planned or has even been conducted. Some participants contemplated that the government might suspect that the outcomes of the evaluation would not be very positive, and therefore have no interest in it. Participants discussed that this is unfortunate, also because there might be substantial learning to be taken from an overall evaluation, including about the aspects that are currently going well. There is no consistency or coherency in research and evaluation efforts on a national level. The overall approach to drugs is not being questioned, in particular regarding repression. ●Data collection. A lot of data is being collected, especially by HR services but there is no overarching evaluation of this data planned, and it is not transparent what the data is used for at all. Participants expressed frustration that the data collection process is very time-intensive, but the data collected is weak and attempts to improve what data is being collected and how it is used, have been unsuccessful/very slow. ● Project evaluation. On a project level, some evaluations being conducted, especially of new projects. However, participants noted the challenge

of transferring the knowledge from these evaluations to other areas, similar projects or to improve implementation. The federal structure requires that states (co-)finance the evaluation of projects and this was seen as a barrier to achieving the implementation of new programmes or evaluations. ● International The EU AP could be taken as an inspiration, a few of the indicators suggested in the EU document could simply be transferred for a national evaluation. ● Transfer of knowledge There is little work/intention to improve exchange of knowledge/best practices between states. There is a lack of funding and PWUD are not considered a "crucial" or "relatable" topic to most people. Some participants observed that input from practitioners was not considered, and therefore the gap grows between academic research and practical research/the reality of drug work. ● Funding. there was overall agreement that drug research receives little funding and therefore, very little independent research is being conducted. ● Positive examples. A very positive and impactful examples of drug research were mentioned: DRUCK Studie, conducted by Robert-Koch-Institut, Berlin, was conducted to learn about the state of and prevention of infectious diseases, which overlapped with drug-related issues, but it was not the main focus

Participation of Civil Society Organisations (CSO) Participants agreed that there is involvement of CSO sometimes, and in regard to specific issues, however most agreed that there is no structural, coherent involvement. It is not transparent which organisation is invited for what topic, and for which reason. One possible explanation which participants contemplated was that the government is aware that CSO might hold very different views and therefore want to avoid disagreement, and select actors that they know will not disagree. Others reported that in respect to specific topics or urgent topics, CSO are invited to participate. The explanation was that in those circumstances, CSO were "needed" and therefore involved ● A positive example is the CSO involvement on national level during the first wave of the COVID-19 pandemic: in that regard part of the answer might also be to foster stronger cooperation and mobilisation amongst the CSO themselves, as a means to achieve a voice and more relevant role in national drug policy ● Two negative examples were mentioned: 1) a campaign by CSO that asked for an independent commission of experts to be part of the drug policy making as well as an evaluation of the national drug policy. This has not been well-received by the minister 2) CSO involvement in drafting the national report to the EMCDDA was considered to be very weak, and the perspective of CSO was requested in very isolated cases only ● Difference in organisations: Established vs. non-established, federal vs. local a substantial gap was seen between the involvement of well-established CSO, compared to smaller or non-established organisations. It was also mentioned that it can be a challenge as a CSO to be very closely working with governmental bodies, as lines can get blurred between the national and CS perspectives. However, others clearly stated that for that exact reason, it is important to have strong involvement of diverse CSO which represent different viewpoints ● PWUD. Participants agreed either fully or partly that the perspective of PWUD is not included in national drug policy making, at least not in a structural, coherent way. In some cases, e.g. in relation to HIV/HepC work, the national association of PWUD is included. There were some good examples with quite constructive involvement of PWUD association, and other examples that were poor.

GREECE

Researcher Thanasis Apostolou
Focus Group participants: Giannis Kissas, Program Public Health of the NGO PRAKSIS; Natalia Lourantou, w Peer Network of Users of Psychoactive Substances; Marios Atzemis, coordinator "positive Voice", European Aids Network Drug Policy Network South East Europe (DPNSEE); Marianella Kloka, advocacy officer NGO PRAKSIS; Thanos Papagianopoulos, Association of the Greek Drug & Substitute User's Union", "PeNUPS-Peer Network of Users of Psychoactive Substances; Giorgos Kalamitsis, Hellenic Liver Patient Association "Prometheus", Committee Protecting the Rights of Recipients of Health Services

Several members of the focus group have been and some still are drug users. The participants' responses were to a great extent reflection from personal experiences and reactions of people that they meet in their daily work. The focus group members are well informed about the discussion on drug policy in Greece and the European Union. They have systematically emphasized in the discussion that policy on paper is not the reality they encounter in the everyday practice. They find that the voice of the people who use drugs and experience serious problems with their health and their social position is not heard and that they are not taken seriously. It is important that the beneficiaries of the institutions and organizations providing services participate in the formation of the programs and have a say in the evaluation of the services. Issues of particular concern to people using psychoactive substances are their health, their social status, social acceptance, their dignity and respect for human rights.
Important issues that emerged from the focus group are described in the National Report on the six (6) thematic areas. This synthesis is a summary of most of the features of the discussion in the focus group and a reference to some recommendations.

Despite of a non-approved Drug Strategy and action plan, important legislative changes have occurred. The fact that the Greek state does not have an approved drug strategy and action plan was a shortcoming for answering the themes and questions for the focus group. The lack of a formally approved Strategy and Action Plan does not mean that no drug policy has been pursued in Greece in the period 2017-2020. On the contrary, during this period important legislation was adopted on medical cannabis, alternatives to imprisonment, and the supervised drug consumption rooms. Further, the public discussion on drug policy has been supported by the Special Parliamentary Commission on drugs through the organisation of parliamentary hearings with active participation of Civil Society Organisations. Harm reduction and the relationship of the Greek state to the NGOs was an important issue. The European Union's Action Plan 2017-2020 has been used many times in the argumentation for the justification of these initiatives.

Balanced approach The State supports financially both demand and supply reduction. The financial support for demand reduction is published in the Annual report of the Greek Focal point of the EMCDDA. The financial support for supply reduction is unknown. This is a shortcoming that needs to be corrected.

Drug Users are not taken seriously. There is consensus that the drug users are not taken seriously. They are not co-determinants of the policy that concerns themselves. Their organisational structure is weak. If they want to exert influence, they need to

organize themselves better. The State and the state-approved agencies need to support the law 4139/2013 on psychoactive (addictive) substances which is not implemented by the state authorities.

The law 4139/2013 on psychoactive (addictive) substances is not implemented by the state authorities. The documents on strategy and action plans on drugs are needed, but have to be implemented first of all by the responsible bodies that draft them. The responsible authorities in Greece are not reliable since they do not operate according to the law on drugs which they adopted in 2013.

Evidence based policy. Drug policy must be evidence based. For a responsible drug policy, a general epidemiological survey on drug use must be conducted regularly. You cannot plan a policy on drugs with an epidemiological research from 2004. Moreover, research and evaluation of policy implementation will contribute to transparency and correction of misuses in every day practice. The National Drug Strategy must devote special chapters on the needs of vulnerable groups (homeless users, women, drug users in detention).

Respect for human rights of drug users is a key issue for a good drug policy. The Greek state (General Secretariat for Transparency and Human Rights, Ministry of Justice) adopted a charter on rights of Drug dependent people. This is a good policy document. In Practice, however, many of these rights are not implemented. It is needed to monitor the implementation of this Charter. There is a gap between policy and every day practice. Drug users face problems in particular with the attitude of the police and the situation in prisons. An open dialogue between police working in the streets and drugs users is necessary, in order to find solutions for an honest and respectful attitude. Also, research on the behaviour of mental health professionals towards drug users is needed in order to avoid stigma.

Civil society organisations and associations of drug users must be represented in decisions making institutions and agencies that provide services for drug dependent people. The Platform of NGOs in Greece must have a representative in the National Committee on Drugs.

Drug possession for personal use must be decriminalized The current Greek law is, although favourable for cannabis users and drug dependent users, not consistent. This makes the implementation of the law by the police problematic. Users possessing small quantities for personal use are brought to court while eventual convictions are not recorded in the criminal record sheets. The possession of drugs for personal use must not be an issue of the penal law.

Treatment of drug dependence and Harm reduction must be subject of free choice. The two big state- approved agencies OKANA and KETHEA are still representing two different options of addressing the drug issue. They have a history of contradiction and exclusion from each other. A new strategy should be structured on a model of more collaboration between the agencies through a provision of a possibility to examine which option fits best to the needs of a person that seeks professional help for problematic drug use.

IRELAND

Researcher Eva Devaney
Focus group participants: Anna Quigley, CityWide; Corinne Doyle, Pavee Point; Aoife Frances, Family Support Network; Maria Otero Vazques, UISCE

This focus group interview took place via a recorded video call in November 2020. At this time, Ireland had entered into a six-week phase of the most severe level of Covid-19 restrictions (Level 5), due to a second wave of infections. Civil society drug and alcohol projects and services were once again placed under the challenge of maintaining service provision; however, they had gathered significant learnings from the first lockdown (March – June) and were managing well. Albeit, it was difficult to find dates and times that suited potential participants during this time.

The recruitment process included purposive sampling, targeting representatives from civil society organisations that are active participants in the Irish drug policy setting. Six participants were recruited that were available at the chosen day/time for the focus group. Unfortunately, on the morning of the focus group, two representatives from voluntary agencies informed me that they were unable to participate. The resulting four participants included representatives from Citywide (an organisation representing the community sector), UISCE (a service that represents people who use drugs), National Family Support Network (an organisation that represents families living with substance use) and Pavee Point (an organisation that represents Irish Travellers). While the participants represent separate stakeholder groups, they also perceived that they held views that were common to the community and voluntary sectors broadly.

The general approach. It was agreed that Irish drug policy has recently moved towards an approach that contains a balance of criminal and health led approaches, highlighting the title of the strategy (Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025). In addition, the Irish Government approved the Health Diversion approach to the possession of drugs for personal use in August 2019 as an alternative to a criminal prosecution; however, it can only be used for the first, and possible the second time a person has been found with drugs in their possession. The participants highlighted the ambivalence inherent in this approach. Furthermore, there was a perception that this decision was a State led approach towards agreeing on the balance between criminal and health led approaches. For example, they pointed out that there had been limited representation and input from the CSOs into the Working Group that examined the issue of a Health Diversion approach. The programme has not yet been implemented, and the CSOs do not have representation on the group that is leading the roll-out of the programme. While the strategy clearly states that it is adopting a health-led approach, the participants noted a gap in the implementation of the 'health-led- approach. One participant noted, "Certainly, the overall way of policing the drugs issue hasn't changed…close enough to 80% of these [drug related offences] were for possession only. And this is presented as great…and you say, hang on, the strategy says its health, why are we 'catching people who have an illness". While discussing resource distribution towards the balanced approach, the participants agreed that it was difficult to judge how the State's resources were allocated. While health funding through the Department of Health was explicit, spending on policing drug related crime was included in mainstream policing budgets.

In terms of human rights, it was felt that People Who Use Drugs (PWUD) are better represented and visible in the strategy compared to previous versions. UISCE is also represented on national policy structures. An interesting discussion followed about the explicit meaning of a human rights-based drugs strategy, "…nobody is engaging us in a discussion about what that would mean." There has been a lack of meaningful discussion and the coming to a shared understanding of what a human rights approach actually looks like in practice. The participants spoke of their understating of a human rights approach, which included ideas of democracy – people having a voice and a say into decisions that impact on them. It also included notions of empathy, understanding and addressing stigma. In other words, human rights are more than having good access to a range of services.

Services and Interventions. It was felt that Irish drug policy contains a wide range of service provision, from low threshold and harm reduction services through to residential treatment, after care/relapse prevention and rehabilitation. It was felt that Ireland had a strong and effective model of service provision, with a mix of statutory, voluntary and community-based services. The participants perceived that statutory services were still focussing mainly on OST while patterns of drug use are rapidly changing towards an increase in crack cocaine and cocaine, street benzos, and other 'new' substances, with a reduction in the use of heroin. While there is a policy structure in place to track emerging trends, there was a view that there is a gap around harm reduction information, e.g. overdose prevention with the new/emerging drugs. The participants also noted some gaps in the delivery of 'rehabilitation services' and these primarily centred around the Community Employment schemes. Here participants felt that there could be a stronger relationships and links between the Department of Social Protection (that fund the schemes), the addiction services, and the community and voluntary organisations that deliver the schemes. In terms of interventions and different population groups, the discussion turned to gender. There was recognition that gender was a much more visible concept in the current drug strategy. It was also acknowledged that some excellent gender sensitive services are becoming more common in Ireland, albeit they are not the norm. The need for a continuing focus on gender specific services was discussed: "it's not the women's fault if they are not turning up to services…the services are not fit for purpose". A significant section of the focus group discussion under this theme was dedicated to the polarised nature of gender, and the gap in terms of services being friendly and accessible to men and women that are not 'gender-conforming'. One participant noted, "If a person is non-binary, where do they go?". They noted that the mainstream addiction service in Ireland "…caters towards male Irish white sis hetero men, you know, your default service user". There is one recommendation in the current drug strategy that groups 'vulnerable groups' under one action in the action plan. This was seen as problematic by the participants, where a number of groups with distinct and different needs, e.g. the LGBTQI community, 'new communities' (immigrants and asylum seekers), Irish Travellers, and sex workers are 'othered' in one sense but also not differentiated in terms of need in another sense. There was a feeling that there was a lack of a consistent national approach towards implementation of initiatives targeting 'vulnerable groups': "…localised funding in one and two areas. It's not a national approach". Another point of discussion emerged around a lack of an intersectionality approach in the action plan. A person using drugs is seen as a woman/man, or an Irish Traveller, or a LGBTIQ person; however, the intersections between these social categories are not considered in the strategy. One participant stated, "…you are like a member of the

Traveller community, you are just that. You are not a person from the LGBT+ community, you are not a person with a disability…people who use drugs as like just an individual without a family or they are not a carer of an older parent".

Integration of harm reduction. It was perceived that harm reduction is well accepted as a drug policy approach in Ireland and well-integrated into the action plan. Some gaps remain, for example the roll-out of a Supervised Injection Facility (included in the action plan and approved by Government; however delayed due to court actions and planning objections). There was also a perception that more actions can be implemented in the roll-out of availability of naloxone provision and its related legislation. There are also working groups examining options for drug testing. However, in the discussion on harm reduction an interesting topic emerged; this was the notion of defining harms in drug policy. It was perceived that the action plan on harm reduction measures, whilst welcome, takes a narrow, clinical definition of harm reduction in terms of physical harms. It is necessary because it is "…what protects people and keeps them alive". Other harms such as stigma, "the major drug related harm" and trauma. One participant commented, "there's a whole of harms not caused by drugs. They are caused by how society responds to the drugs or the conditions that can lead tom people being in the situation where's that's their option. So again, it's back to how you define harm reduction, you probably get two fairly different answers".

Alternative sanctions. Overall, the move towards a health-led drug and alcohol strategy was seen as a positive development. However, it was felt that the current 'health-diversion' approach approved by the Government in 2019 conflicts with the principle of a health-led approach to addressing drugs in society. One participant noted that "you are gonna allow people one opportunity, maybe two. Justice is saying, that is as much is, we are allowing." Another participant added, whereas on the health side, we should be saying it doesn't matter how many times…of it classified as a health issue, why does it matter how many times".

Research & Evaluation. The participants agreed that a lot of research has been conducted in the drug and alcohol field in Ireland, including significant contributions from CSOs. However, the participants questioned the accessibility of research and evidence to policy makers and other key stakeholders. It was felt that the research/policy link that had previously existed between the National Advisory Committee on Drugs (now dismantled) and national committees has now been weakened. In terms of evaluation of the action plan, a Mid Term Review of the strategy was due to take place early 2021. At the time of the interview, the participants were unsure about the process of the review and the level of consultation with stakeholders, especially with CSOs that are not named as actors in the action plan. The Department of Health issues an annual report on progress of the actions in the strategy. As most actions are led by statutory agencies, it tends to be reported from their perspective. It was noted that the CSOs had virtually no input into the reports. One participant stated, "…they are missing a massive amount of what's been happening in the report…there are massive amounts of work and that progress report reflects practically none of it." Another point that was raised in the discussion was the lack of clear indicators in how to measure progress, impact and outcomes of the strategy action plan.

CSO involvement. The final theme was a discussion about the level of CSO involvement in the development, implementation and evaluation of the strategy and action

plan. As Comiskey (2020)[1] points out "policy development by partnership is difficult", but a partnership approach was adopted in the development of the 2017 strategy and action plan. Partnership is one of the underpinning values of the strategy. However, as Comiskey again notes "success however depends on continuing support within the partnership and ongoing resourcing from the ministries". The findings from the focus group discussion indicate that there are challenges in implementing actions using a partnership approach. Most actions have the statutory agencies as lead actors, and the CSOs are listed as partners. However, in some instances the participants felt that they are not working in partnership to progress actions. For example, one participant stated, "we have actions [related to families] that say we are working in partnership with the community and voluntary sectors, but I don't find them reaching out and telling us what they are doing". The CSOs have representation on the national policy oversight and implementation structures, which was seen as positive; however, there are also challenges as the participants noted that the structures do not facilitate CSOs to share decision making in an equal manner. One participant stated, "it says on paper that we are all involved in the decision-making process, no we are not". It was felt that the statutory sector sets the agenda based on the relevant priorities at the time, and that the CSO sector is not involved in the discussions where the decision is being made. While the structures are interagency, the interagency working is not taking place. A related point that was made in the discussion was around the lack of an integrated and collective inter-departmental and inter-sectoral approach to decision making. "that collective thing is completely gone when we go to meetings, it is not about proposals, let's discuss them, let's bring everybody's expertise in…if we do this who will this effect, will there be an impact on other services…how will it impact on the people who use the services…we should have that discussion in advance. That's what's part of decision making". For the participants interagency working means a collective process, working in cooperation with others. The participants pointed out how a true interagency approach had taken place during the early Covid when CSOs and statutory agencies had collaborated in addressing the needs of people who are homeless, with addiction issues and health problems. There had been a shared purpose of that work – to protect this population from harm and to prevent Covid infections. Using this as an example, there was a wish from the CSOs to engage in collaborative processes and interagency working in the future as it has proven positive impacts for people in society.

1 Comiskey, C. (2020) 'Reducing Harm, Supporting Recovery: a partnership and evidence-informed approach to developing the new Irish health led, National Drugs Strategy', Harm Reduction Journal, 17, 3.

ITALY

Researcher: Emanuele Perrone
Focus group participants: Denise Amerini, CGIL (Trade Union), national coordinator Drugs, Prisons and Social inclusion Area; Stefano Bertoletti, C.A.T. (social cooperative) coordinator prevention and addiction area; Fiammetta Murgia, psychologist, Parsec cooperative, working in Treatment and harm reduction areas; Alessio Guidotti, president of Itanpud (Italian PWUDs network); Elia de Caro, president of Antigone Emilia Romagna (prisons sector), Stefano Vecchio, former director of the Public Drug Department of the City of Naples, now President of Forum Droghe.

This short report summarizes the areas of greatest interest that emerged during the focus group. Asking participants to assess whether the national action plan has incorporated the guidelines expressed by Europlan is a paradoxical task.
The last national action plan is in fact prior to the European formulation, which relates to the three-year period 2017-2020: it is therefore impossible to assess the implementation of policy. What can probably be assessed therefore is whether Italian policies on drug use have adhered – and to what extent – to the objectives, parameters and indicators expressed by the European strategic plan.

Drug policy. The first area discussed by the participants concerns drug policy. The participants came from different regions and therefore their contribution in this sense is highly qualified and varied. Four main topics of interest emerged: the perception of national drug policy and the balancing, integration and evidence-based evaluation of national policies ● All participants shared two main ideas: the profound regional differences that exist make it difficult to give an overall national assessment. Furthermore, the absence of an evaluation of active local policies based on data makes it difficult to assess compliance with the indicators and parameters proposed by the European Plan. The policies are poorly evaluated, the data of the judicial dimension with those of the socio-health dimension are not unified; and in general, these two central pillars of European politics are not in balance. The data describe the situation but are not used to evaluate efficacy ● In the second area, the absence of specific funding for groups considered vulnerable emerges. Consequently, there are no projects for these groups – to the knowledge of the participants – even though there are many situations of problematic substance use ● The possibilities of intervention are also over determined by excessive bureaucratic mechanisms and political visions that frame them within different observational focuses mainly related to the judicial and social control fields ● A partially different discourse concerns gender issues: there is a project, in which the city of Turin has been involved, and which also looks at national realities regarding the consumption of drugs.

Social determinants. The discussion also allowed us to describe the situation relating to two major social determinants: housing and work. It is known that these determinants have a notable impact on the emotional and behavioral regulation abilities of individuals, and their role in the structuring of disorders related to problematic substance use is increasingly clear. Despite this, the national plan does not provide for any integration path. There are no specific employability plans or active housing policies that can change the context for people who use drugs.

Harm reduction. Harm reduction interventions (HRI) are affected by the national

situation: ● they exist only in some regions and are totally absent in the south (except for the city of Naples). HRIs have become part of the rights guaranteed but are subordinated to budget decisions and this does not allow the accessibility that is guaranteed for many other social and health services ● The HRI are not considered from a scientific point of view by the public institutions, and is generally outsourced. There are regions where a partnership between the social private sector and the public sector has guaranteed good quality levels of implementation and others where the service simply does not exist. ● In the regions where the HRI are provided, the gold standard is represented by the distribution of naloxone and by socio-psychological counseling, as well as by the distribution of prevention materials. Some difficulties emerge relating to current legislation that does not allow for the purchase of materials from abroad. A drug checking service, a fundamental prevention tool, is not currently implemented in any Italian region except Piedmont.

Sanctions. A broad area of discussion focused on sanctions ● In Italy about 30% of prisoners are imprisoned for violating drug laws for minor crimes. The problem of overcrowding is therefore largely related to the criminalization of possession, use and consumption of drugs. Sanctions and alternative guarantees exist and are extensive, but are poorly supported by public policies capable of reducing recidivism ● Administrative sanctions for personal use do not seem to function as effective levers to identify situations of problematic consumption nor to facilitate treatments and rehabilitation pathways. There are also a high number of minors reported but not taken care of in the medium term by any service ● From the point of view of the interventions of social integration, PWUDs with minor legal problems who use drugs, do have access to educational paths at all levels. However, there are some critical issues related to work and concerning the lack of professionalism required by contemporary job market and there are no ICT paths that can then evolve into work or entrepreneurial jobs. There is therefore a lack of modernization relating to the type of professional training and opportunities.

Supply reduction. The evaluation of some indicators relating to the reduction in supply is very negative. The availability of drugs has not diminished and is indeed the only aspect of the discussion that is not affected by regional differences. The purity of NPS seems to have increased and the use of the web as a place of purchase is quite widespread. Criticisms emerged with respect to the European plan which envisages, among the various objectives, the reconversion of production crops in the various non-European countries: participants think that this approach is a return to a colonial mode of action in the international context and its pragmatic feasibility is strongly questioned.

Civil society participation. The involvement of civil society organizations is characterized by strong regional differences. In general, there are some well-functioning synergies, but organizations are not involved in the evaluation of policies and interventions or in the design of services. ● The contractual conditions of workers of the Third sector, in the existing synergies, are affected by a greater precariousness with respect to public services or services that do not concern consumers of drugs. ● The last aspect relates to the low involvement of people who use drugs in public debates and the absence of training courses concerning peers. PWUDs, who are the main recipients of policies, are absolutely not involved in their formulation.

THE NETHERLANDS

Researcher Sara Woods
Focus group participants Eberhard Schatz, Correlation European Harm Reduction Network; John Peter Kools, The Trimbos Institute; Leonie Brendel, MDHG drug user union Amsterdam; Alex van Dongen, Novadic Kentron addiction treatment services; Hans Dupont, Verslavingskunde Nederland; Tom Kiel, Changing Perspective foundation; Thomas Martinelli, IVO research institute; Ingrid Bakker, Mainline Foundation

The focus group discussion was a lively session, where all participants made an active contribution to the six main discussion themes. Each of the eight participants had their own specialty and viewpoint, which led to an interesting and stimulating synergy. Discussions flowed rather naturally and needed relatively little prompting. On a few occasions the participants needed to be steered towards the next topic, but this happened without a lot of effort. Only towards the very end, the focus and energy dropped a little bit, but this did not prevent us from having an informative discussion on theme 6. On all six themes the participants had consensus on the major themes. They disagreed on some details, but when the discussion continued, they often moved more towards each other in their stance. Whenever participants' viewpoints differed, both have been included in the quotations in the previous section. Below the most important shared conclusions and remarks are presented by theme

General approach. ● Compared to other countries we're not doing too bad. ● It's hard to really evaluate our drug policy, because it's not one comprehensive policy document. ● Scientific evidence is never really objective. ● Critical towards human rights for PWUD, especially due to our security and justice policies.

Services and intervention: ● Not really a national policy. A lot of differences on municipal level. Our national policy provides hardly any guidelines. ● Generally, rather positive about our drug prevention policies and more critical about treatment and rehab. ● The market forces of health insurance companies and municipal funding have a detrimental effect on the care for PWUD.

Vulnerable groups: ● older PWUD are hardly taken into account in our policies. ● We used to have good women's shelters, but this has deteriorated over the years ● Many cities in the Netherlands had huge homelessness, public nuisance and public health problems in the 1980s and 1990s. We have successfully addressed this problem with a strong integrated approach, a network of shelters and social- and health services. In one city a population of 500 homeless PWUD has been reduced to a mere group of 30 people in the emergency shelter. All others are housed and in care. However, in various cities we see an increase in homeless people, with long waiting lists for the shelters. We have indeed had great successes in the past, but at the moment the group of homeless people seems to be growing again. For example, there are now camping places full of people who cannot be housed in the shelters ● In some regions European migrants are not allowed in night shelter. During the first corona wave they temporarily allowed European migrants into the shelter. In Amsterdam there is a drop-in centre especially for migrant PWUD. Usually they don't really have access to any other care, but during corona

they had access to night shelter and methadone treatment. This also happened in other countries, but the Netherlands was the first to stop methadone treatment once corona seemed to be under control in September.

Harm reduction: ● Broad definition of harm reduction ● Possibly most important harm reduction is housing first ● The 'traditional' forms of harm reduction, such as OST, needle exchange and DCRs are all a core part of our national practice and interwoven with other services.

Alternative sanctions: ● In the Netherlands there are no sanctions on drug use, only on possession of drugs and supply. ● Critical towards our supply reduction policies: insufficient monitoring and insufficient evidence that they are effective ● We have a special rehabilitative sanction for repeat offenders who use drugs, which is great in theory but fails in practice.

Research and evaluation: ● We do relatively well on research and monitoring of drug use and specific health interventions, but less so on evaluation of our supply reduction interventions ● Dutch policy evaluation really is under par ● Research always is subjective.

Civil society involvement: ● There is quite a lot of CSI, especially on municipal/local level, but it is selective and on invitation. It is not transparent ● Not enough representation of PWUD in research or policy development. ● Currently a CS dialogue with various CS organizations and the three ministries is being set up on a national level. A similar dialogue already exists on international drug/harm reduction policy.

SERBIA

Researcher Irena Molnar
Focus group participants: Milutin Milošević, Executive Director of Drug Policy Network SEE based in Belgrade; Aleksandar Janić Jane, President of Treatment Center Duga; Goran Radisavljević, CEO Timok Youth Centar; Teodora Jovanović, researcher in NVO Re Generacija; Hajrija Mujović, Institute of Social Sciences and SUPRAM, Lawyers association; Saša Djordjević, Field coordinator for Serbia, Global Institute

Focus group participants have largely agreed views and opinions regarding the relationship between the European Action Plan 2017-2020, developed on the basis of the European Drug Strategy 2013-2020 and the Action Plan of Serbia 2013-2017, the last one which was adopted and implemented to some extent. The Action Plan for the period 2018-2021, after being drafted in November 2018, is still in the process of adoption (announced to be adopted in the last quarter of 2020). During the process of drafting, representatives of CSOs were present but their proposals were not accepted. All interlocutors believe that the adoption of strategies and action plans in Serbia in general, and in this particular case, is important only as a completion of formal fulfilment of conditions in the process of European integration, and not as a tool that will be applied in practice.

Balanced approach. ● The lack of balance between the social-health and repressive aspect of the attitude towards psycho-active substances and their users was stated, where the emphasis was placed on the repressive aspect. Most of the measures proposed by NGOs to join the AP were not accepted, as the institutions were not ready to go beyond the framework of the Strategy written in 2014, although the situation on the ground has changed significantly ● There was also a lack of coordination between different institutions. Participants observe the transfer of responsibilities from one to another Ministry, lack of financial resources for the implementation of Action Plan 2014-2017 as well as financial resources allocated for the work of specialized institutions such as Office for Combating Drugs, which shows that the state has no interest in deeper understanding and dealing with issues related to drugs. It is assumed that it would not have dealt at all with them if there was no obligation and responsibility regarding the prevention of HIV infection● However, even the prevention of HIV transmission has not affected the expansion of institutions and services, in terms of updating the understanding of the use and appearance of new psychoactive substances in the new socio-economic conditions. The system understands/ treats only the “classic” injection, i.e. what is funded from foreign grants and through projects such as Global Funds one.

Treatments. Focus group participants see a special problem in the health treatment of users of psychoactive substances: aside of OST and substitution therapy for heroin (buprenorphine, methadone - which is not legally defined), the prescribed medication (combination of antidepressant and benzodiazepines) are used as treatment regardless of the type and amount of substance that is being treated, and even in the treatment of behavioural disorders (gambling) only drug therapy is used. In addition, the consumption of alcohol and prescription drugs is not recognized as a problem, although it is very clearly visible in the field. Focus group participants unequivocally agree that evaluation and quality control of treatment programs is needed, given that the greatest stigmatization of users by doctors has been noticed as frequent.

Human rights The issue of human rights is generally not raised: although the legislation is relatively clear, in practice a large part of what is recognized in Europe as part of public health policies is not applied (because it is not regulated by special regulations, therefore is not possible).

Vulnerable groups Health services provided to vulnerable groups, including drug users, are underdeveloped in Serbia and do not comply with EU standards. A special issue is the attitude towards minority vulnerable groups (homeless people, migrants, sex workers, etc.), because there are no medical care programs for them, nor programs for prevention and harm reduction.

Harm reduction and criminalization At the same time, the repressive approach is very pronounced. In that sense, even harm reduction programs such as needle exchange and syringe programs are in the grey zone. There is no legal regulation of them, therefore prosecutors can interpret the distribution of the sterile equipment as "enabling drugs" and thus call activists and civil society organisations providing such services to criminal responsibility. For the same reason, it is not possible to organize drug checking services in recreational settings on the field ● In addition, there are serious differences between the European and national AP: the national AP does not provide harm reduction services in the recreational setting, while in the European AP these programs are foreseen. Thus, Civil Society organisations are providing harm reduction programs in those settings, but only because they believe that it should be done, and not in accordance with the AP. However, institutions do not understand the non-governmental sector that provides services to PAS (preventive, treatment and harm reduction) beneficiaries as an equal and reliable partner.

Alternative sanctions In that sense, there is no possibility of choosing a sentence as an alternative to imprisonment, but also the methods of treatment prescribed by the Criminal Code, although according to the current HR legislation (Law on Consumer Protection, Law on Health Care) this should be possible. A settlement is common. ● Recognition of criminal offense, that in the case of the first offense can result in the dropping the charges and acceptance of payment of the fine, called opportunity, in which only the offered alternative is accepted or rejected, but there is no possibility to choose from a different range of fines i.e. type of the treatment or place the money where goes (humanitarian or other type of the organisation). In practice, treatment is possible only in the "competent" health care institutions, although there the degree of cure is practically non-existent, because only one addiction changes to another (methadone, other medicines, without real rehabilitation), while treatment and rehabilitation at centres run by CSOs are excluded as an option. ● Going to jail, however, brings users back to an environment where there are many different psychoactive substances, so this is by no means a good way to rehabilitate, although users often choose it if they do not want to go to drug treatment, because that way they go to an environment with unhindered psychoactive substance flow. Cases when imprisonment can be avoided with a suspended sentence are when the therapy centre alone, privately initiates the process and the request before the court, as well as in rare cases for possession when the judge orders house arrest with leg bend due to overcrowded prison capacity, which is a more common case recently, meaning that our prisons are overcrowded.

Research and evaluation Institutional research at the national level is rarely conducted

(last ones were *Research within populations at increased risk of HIV and people living with HIV*, bio-behavioural research in the three largest cities in Serbia - Belgrade, Novi Sad and Nis from 2013[2] in *National survey on lifestyles of the population of Serbia in 2014. Basic results on the use of psychoactive substances and gambling*[3]), so it is difficult to talk about relevant data ● CSOs conduct smaller-scale research, in accordance with their scope of work, but based on them it is possible to make only assessments of the situation on the ground at the local level, which is insufficient to build a serious strategy and Action Plan on a National scale. Institutions take them with reserve because they do not trust the theoretical and methodological correctness of the research, often done way more often better quality and ethically better implemented. Thus, the results of the work of civil society organizations, even when they are invited to cooperate and formally be involved, are called into question ● An additional problem is that there are very few organizations that bring together people who have had or have a drug problem. The non-governmental sector is still not accepted as an equal partner to state institutions; it is considered insufficiently professional, and is often not accepted due to the critical attitude towards the work of institutions ● Most of the research conducted by the state is financed from EU funds, because Serbia does not allocate money for that purpose. Thus, the evaluation of the old Strategy was done thanks to IPA5 funding. There was an initiative of the Office for implementing the Evaluation, but funds were not allocated domestically. When IPA7[4] has started, we started to harmonize data collection with the EMCDDA at EU level. IPA is an instrument designed to help Serbia join the EU. There is a real possibility that the state, when IPA7 is completed, will not adopt protocols and procedures related to research and data collection that project is putting in place. The key fact is that all research is done exclusively with the support from EU funds. Other external funders (such as Global Fund) and that the state of Serbia doesn't support them financially ● In Serbia, the problem is the insistence on cooperation with state institutions when applying for new projects. This lead either to a change in the objectives of the projects, which are in line with the needs of the institutions, instead of being based only on the real situation on the ground, to a misinterpretation of research data, or to state institutions attributing good results to themselves. They even didn't do work ● All participants believe that, at this moment, instead of dealing with the old Strategy and the AP, for which it is not known whether and how it will be implemented to the end and if it will be evaluated, we should work on the preparation for the new Strategy. We should work on the analysis of the current situation at the local and national level. We should provide as much material as possible for writing a new strategy. Of course, the question arises as to how much the CSO sector will be involved in writing the new strategy, as well as how much the new EU Drugs Strategy will be respected and incorporated.

Overall opinion is that in the last couple of years the general situation in the field of Drug Policy and Public health degraded, in comparison to 2014 when the Strategy and accompanying Action plan were created, when according to the EU Accession process those areas should improve significantly. All of the participants are of the thought that things improve only on paper and not actually in the field, bringing us to the question of legitimacy of the whole EU Accession process as well as EU institutions, where in drug policy area Serbia is "guided" or followed by EMCDDA, which for the National Report 2019 didn't mention mid-term evaluation that they themselves facilitated.

2 http://prevent.org.rs/prevent/wp-content/uploads/2016/08/Istra%C5%BEivanja-me%C4%91u-populacijom-pod-pove%C4%87anim-rizikom-od-HIV-a-i-me%C4%91u-osobama-koje-%C5%BEive-sa-HIV-om-2013.pdf

3 http://www.batut.org.rs/download/publikacije/Izvestaj%20srpski%20web.pdf

4 IPA7 – Stepwise integration of the IPA beneficiaries in the activities of the EMCDDA and the Reitox network

SLOVENIA

Researcher Sanela Talic
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Gap between papers and practice. In the general aspect of the Action Plan (AP), focus group participants identify a significant gap between what is written and what is implemented in practice. In principle, different areas (prevention, risk and harm reduction, treatment, social integration and rehabilitation, and supply reduction) are balanced (at least in written form), but this is not the case. To a large extent, repressive policies are still in place (drug users are more likely to face repressive measures than treatment programs).

Evidence-based approaches. An important aspect of AP, which is also specifically mentioned, are evidence-based approaches, but what is written does not coincide with the real situation in practice. Such approaches require a support system (skills and knowledge), which does not exist, and the results of various evaluations are not used as a starting point for possible further concrete steps in practice ● Evaluation requirements vary from area to area, but despite concrete evidence of the effectiveness of some practices, there is no realization of these (e.g. safe rooms) ● It is difficult to ensure and maintain the quality of certain approaches / programs if there are no established training practices in this area (support system), the necessary funding - not only partial (NGOs are often left to themselves to seek additional funding), and sufficient time is not available to demonstrate the effectiveness of some approaches / programs ● Despite the important role that AP devotes to enforcing quality standards, subjective decision-making, which is not necessarily professional, is still present in practice. This is not in line with the principle of human rights (in prevention, quality standards are enforced too slowly, goals written in AP are too high; in the field of risk and harm reduction, treatment, social integration, and rehabilitation we often do not decide for the benefit of users due to a rigid system criterion for whom to take into consideration) ● The disconnection of different sectors (health, courts, and the social sector) is also noticeable, which affects the dispersion of services and the poor information of various stakeholders about their availability.

Services and interventions. The second thematic set concerned the availability, accessibility, and quality of interventions ● Participants note that the care for sustainability and coverage with quality or effective services / programs should be taken over by the government and not the non-governmental sector. Competitiveness between NGOs is also problematic, because of the way NGOs are funded (often funding is not conditioned by the quality of implementation). In terms of availability (services, programs) there is a big difference between smaller and larger places - e.g. user activity is not taken into account, mobile units are not the best possible solution because their presence is limited.

Vulnerable groups. Participants pointed to various vulnerable groups that could be dealt with in a more systematic way but are now excluded for various reasons - older

drug users, younger drug users (who are at the beginning of users' careers), the female population is much more hidden), student population, prisoners, migrants. In the field of prevention, there is still a lot of room for manoeuvre to work with the elderly, high school students and the student population (even after graduation). We touched on the quality of services in the first set.

Harm reduction. The third set was dedicated to the area of risk and harm reduction, which, according to some NGOs, is losing importance. ● In the public, this area has a negative connotation, on the political scene this area is often a "ground for gaining political points" - important political decisions consider the opinion of the public and not experts. Participants again highlighted safe rooms that have been in the plan for many years, but without concretization. ● They see the problem in the *unclear division of responsibilities in AP*. Some approaches have been partially established (due to partly funding), which only brings additional problems (e.g. needle exchange). Participants are of the opinion that many approaches are used only in the direction of meeting orders, provisions by the EU without deep consideration of the needs and capacities within the country. There is a wealth of experience and good research / practice in other countries that can be the basis for our decisions but cannot just be transferred.

Alternative sanctions. Participants agree that there is still room for improvement. ● Decisions on alternative penalties are in the hands of the courts and the police, and are often subjective decisions, as the specific possibilities are not specifically written in the documents. An alternative punishment is possible in criminal law, but in cases involving drug users, the courts do not decide to do so. ● The transfer of existing, efficient models would require a built-in system (comprehensive, integrated, systematic), thus considering the different needs of individual users. Socially useful works are intended for those who face up to 2 years in prison. The problem is that, in practice, there is a small proportion of organizations that involve drug users in these works - so they have to serve their sentences.

Research and evaluation. Participants see the greatest challenge in the subjectivity of evaluations, so they propose an external, independent institution that would be more competent in this field. ● The quality of existing evaluations within individual organizations is not at a high level. On the one hand, the state anticipates and "requires" evaluation, and on the other hand, it reduces financial resources. Given that the results of evaluations (regardless of quality) are not a criterion for further steps / improvements / funding, NGOs prefer to allocate existing small funds to their target users. Sometimes it is impossible to meet the demands of funders as they are unaware of the lengthy process required to achieve certain changes in users. Individual ministries also have different evaluation criteria - they do not evaluate comparable things, which is then difficult to apply in practice. Evaluation criteria are often at odds with the needs of users in the field ● Reports on the implementation of action plans do not reflect the reality on the ground. We NGOs do not even have an influence on the report in terms of evaluation and validation. The report includes individual activities that give the appearance that a lot of work is being done, but in reality, it is completely different - services/operations are unrelated, fragmented and consequently do not achieve the desired effects.

Involvement of civil society. The participants are of the opinion that the participation of civil society is envisaged only on paper. This cooperation is very selective and non-

transparent. Formally, things are set, but the practice is different. ● Active involvement also requires human resources, which non-governmental organizations do not have - everything then depends on individuals who are highly active, and unequal cooperation between non-governmental organizations is also noticeable. ● The participants also pointed out the problem in defining the tasks or roles of NGOs in AP. In the section where the organizations that will be active in achieving a certain goal are listed, all organizations are listed - the importance and role of the non-governmental sector is therefore lost. In the reports, this is reflected in the claims of all involved (ministries, NGOs, local communities) that things have been done and the realization never really happens. Many concrete steps have been taken because of the NGO sector, but the "profession" of non-governmental organizations is often underestimated, as they are often invited to associate with the professionals in public sector (representatives of the non-governmental sector are therefore not considered as experts). ● The active role of non-governmental organizations also depends on funding - they often do not want to be exposed when they point out irregularities, as they are afraid that they will be left without funding.

SPAIN

Researcher Antonio Molina Fernandez
Focus group participants: Lola Capdepòn, UNAD/ Unión de Asociaciones y Entidades de Atención al Drogodependiente; Immaculada Gòmez, RIOD/Red Iberoamericana de ONG que trabajan en Drogodependencias; Carlos Molina, Fundación Atenea; Gisela Hansen, Federación Catalana de Drogodependencias; Josep Rovira, ABD/Asociación Bienestar y Desarrollo; Antoni Tort, Asociación Dianova España; Mireia Ventura, Energy Control.

The focus group participants (and their organizations) are well informed about the discussion on drug policy in Spain and the European Union. A clear message they expressed during the focus group is the difference between laws and policies with daily practice. All of the participants indicated their focus in public health, human rights, dignity of every person, social integration and stigma of drug users in Spanish society. About these topics, a consensus emerged from the discussion, especially with the consideration about the voice and expression of drug users´ needs and expectations and the necessary participation of drug users 'representatives in forums and policies.

Spanish Drug Strategy and AP includes all the topics; reality is different than the policies. The perception about the Spanish Drug Strategy is that the plan is very well-designed, including the European Union's Action Plan 2017-2020 main strategic lines and well-connected with them. The differences start for the participants in how things are implemented in practice or how this Drug strategy and action plan become realities. There are several areas to improve for participants: the information about the development in practice of action plan; the (necessary) resources and the planning for those resources in the evolution of the action plan; the budget and the way the proposal in connected with the needs in the field; and the cooperation between administrations and the general administration and CSO.

Grants, funding and bureaucracy are limitations for the CSO activity. About these issues, the participants are not only expressing their senses about drug

problems and strategies, they are talking about a global situation for Spanish CSO● There are limited chances for funding, restricted to several topics, and most of the funding for drug intervention in specific topics such as gender violence and women drug users' health are not exclusive for the addictive behaviours sector CSO. So, the idea into CSO is the organizations are working in the sector, specifically, totally involved but without enough budget and with difficulties in grants 'searching. It was expressed the perception about to be impossible the proper development of several projects (with the right design, implementation and evaluation of the project) with the assigned budgets they receive● Other secondary problem but connected with this issue is the bureaucracy and the administrative limitations, a situation that has been more severe with the aftermaths of COVID19 crisis. In the voice of the participants, there are people now out of the system because of the demands of public administration such as digital certificate and Internet valid connection.

Criminalization of drug users. In Spain there are legal frameworks able to improve the situation of drugs users. It´s very well defined the line of understanding the depenalization, but the sense of decriminalization is consider as still not achieved in the perspective of Spanish CSO ● For the participants, in Spain there is not a penal model of drug consumption but there is a very administrative criminalization model. At state level they are included all the aspects about substitution of sanctions for persons with drug problems; reduction, suspension and work in benefits of community ● The perception of Spanish CSO is that even they are included in the law, it doesn´t mean they are going on. In the vision of the participants, sanctions and measures alternative to prison apart and the restorative justice topic is not totally worked in Spain. Even Instituciones Penitenciarias (Prison institutions) worked with social organizations to design a framework of programmes for this topic, last years it has not been enough budget for financing it● About the legal frameworks, one consideration: the participants 'opinion about the 2016 Citizenship Security Law (La Ley de Seguridad Ciudadana de 2016) is that this law is much more punitive for drug users than it was the previous legal framework.

Evidence-based practices and intervention network. The Spanish network integrates harm reduction programmes and recovery programmes into its intervention strategy. The perception of the participants about the actual situation of the network is that the intervention programmes are in weaker situation than 10 years ago, before the previous economic crisis, with the severe impact of COVID-19 crisis in programmes and centres. The global understanding of application of evidence-based practices, validated, evaluated and reported looks like an added effort for CSO in their daily intervention with people with drug problems and their families and social systems. The global expression is EBP are absolutely necessary but there aren´t enough grants and budget for these EBP implementation and Evaluation.

Treatment network and harm reduction programmes. In Spain there is still the idea of differences in orientation between harm reduction programmes and drug-free CSO. Even, the sensation is sometimes these organizations are still crashing because of the intervention strategy. There is a third line, more integrative, that consider both strategies as complementary, part of a continuum and both interventions absolutely necessary. Another expressed idea is the inexistence of harm reduction integral services and the decreasing in several harm reduction services (such as reduction in recovery programmes accessibility). In this sense, perception is that this harm reduction strategy

hasn´t done an evolution from the model of ending 80´s when Spain had an enormous opiates problem to the actual patterns of consumption or to the Spanish actual reality. So, the situation of harm reduction is that it´s being very difficult to adapt to actual realities. There is other very important idea about this issue: harm reduction network is subsidiary, especially with COVID19 topic. In this crisis, harm reduction approaches are suffering to maintain their activities and preserve the attendance to the people need them.

The participation of CSO in Spanish policies and the voice of drug users.

The opinion of CSO is they have got a very well connection with Plan Nacional de Drogas and networks, in national and international level. For CSO, PNSD considers them as a label to international networks. So, when it was designed last Action Plan into National Addiction Strategy (Estrategia Nacional de Adicciones del Plan de Acción) that is actually working in Spain, it was open a giant process of consulting and all NGOs interested in participate could make comments and affords to the Action Plan. There is an organ, the Spanish Council of Drug Dependances (Consejo Español de Drogodependencias), an assessor organ of PNSD, composed by NGOs, syndicates, other ministry workers. The problem with that organ is it has not been active since its foundation, and CSO are asking continuously its activity. In the voice of CSO, the capacity to participate with horizontal drugs group in Spain is very high but it seems to depend more about the person in the position than about institutional commitment. The idea of Spanish CSO would be a transfer from CSFD model to Spain, to make clearer the participation of NGOs in the official forums ● The last point about participation is a proposal about the involvement of former users and drug users in the forums. It exists indeed, but CSO have got the example of international experiences and forums with formal implication of drug users´ organizations and participants think it´s the right way to achieve spaces in which all the voices can be represented ● There are recurrent topics in the discussion group and in any kind of meeting with Spanish CSO: funding, coordination between public administrations and NGOs, the gap between the plans&strategies and the realities of organizations in daily work, the long distance between research and intervention, the need of higher efforts in gender perspective and other intersectional topics ● It was expressed several times the need of institutional channels of communication between CSO and administration The formal structure of the Council allows the active participation of CSO, but there has been (as it´s confirmed in the focus group) a gap between the proposal and real participation of NGO in this forum, that has not maintained the original frequency in meetings and products. There is one very clear vindication of Spanish Council for Drug Addiction and Other Addictions as a useful tool to connect the Spanish policies with the commitment of CSO. There is another fair proposal from CSO about the necessary inclusion of drug user organizations in formal forums, to hear the voice of the affected people.

Appendix II

THE FOCUS GROUP THEMES

The Focus Groups which have been held in the 8 countries adopted a common research form, based on EU Action Plan 2017-2020 six main themes, which were selected according to the CSFD perspective.

1. General approach

The EU AP is based on the European Strategy 2013-2020, according to which drug policy must be balanced (between reducing the demand and the supply, between socio-sanitary policy and repressive policies) *integrated and evidence based* and must respect *human rights* (EU AP, Introduction). ***How can you evaluate the national AP in the light of these guiding principles?***

2. Availability, accessibility and quality of interventions

The EU AP contains detailed objectives and actions aimed at guaranteeing access to services and treatments (AP 1.1 and 1.2) The AP dedicates particular attention to *socially vulnerable groups* (homeless people, migrants and asylum seekers, prisoners), to different *age groups* (children and the very young, older users) and to *gender* (AP 1.2, actions 6,7,8). ***Is availability, access and quality of interventions, services and treatments (in the areas of prevention, care and rehabilitation, harm reduction) provided for in the national AP sufficient and of a high standard? Are there policies aimed at vulnerable groups and encompassing diversity?***

3. The inclusion of Harm Reduction (HR) in drug policies and interventions

The EU AP 2017-2020 incorporated to a good extent the requests from Civil society for the full inclusion of HR and Risk Limitation (RL) for the fundamental areas of European drug policies (1.2. action 8). ***Are the policies and the interventions of HR and RL explicitly included in the national AP and are they adequately implemented?***

4. Alternative Sanctions

The EU AP, along with the European Strategy, has not accepted the request from Civil society concerning the decriminalization of conducts relating to personal drug use, in favour of an approach that is educational, social and sanitary. Nonetheless, the ***EU*** AP 2017-2020 includes ***the objective of reducing as much as possible the resort to coercive sanctions, limiting to a minimum the need for a prison sentence in favour of an alternative to prison (****EU AP 2.5 action 22****). Does the national AP include a similar strategy?***

5. Research and Evaluation

The EU AP 2017-2020 has significantly developed the area of research, monitoring and evaluation, both for understanding models of use and for the evaluation of the policies and interventions in terms of innovation and efficacy. (EU AP 5.13-15). ***Does the national AP attribute a significant role to research and evaluation? Are research and evaluation supported with resources and adequate competencies?***

6. Participation of civil society

The EU AP includes the participation of CSOs in all the phases of drug policy: definition, implementation, monitoring and evaluation (EU AP 3.9) ***Does the national AP foresee the participation of the CSOs? Does it clearly define areas, competencies and participation process?***

Appendix III

THE RESEARCH TEAM

Coordinators

Susanna Ronconi Susanna is a qualitative researcher and a trainer in the fields of drugs, prisons and social marginalization, with a specific gender and human rights approach. Since early 90s she has been working in Harm Reduction (HR) interventions, promoting and coordinating some of the first HR outreach programs in Italy; in 2000 she was a member of the national Committee for HR Guidelines, in 2008 participated at the National Board on Drugs and Drug Addiction (Welfare Ministry) and since 2019 she is a member of the Committee on HR in Regione Piemonte. She is one of the founders of ITARDD, Italian HR Network, and the President of the Scientific Board of Forum Droghe, an NGO working for drug policies reform and HR since 1995. On behalf of Forum Droghe she participates at the Civil Society Forum on Drugs. Among her publications: Città droghe sicurezza [*Cities, drugs, security*] (with M. Brandoli, Franco Angeli 2007); Droghe e autoregolazione. Note per consumatori e operatori [*Drugs and self regulation. Notes for PWUD and professionals*](with G. Zuffa, Ediesse 2017); Non solo molecole. Evidenze biografiche e stereotipi chimici [*Not only molecules. Biographic evidence and chemical stereotypes*] in G.Zuffa (edited by), Cocaina. Il consumo controllato, ed GruppoAbele, 2010; She has translated in Italian Harm Reduction, by Pat O'Hare (1994) and Drugs Set Setting, by Norman Zinberg (2019), published by Ed Gruppo Abele.

Antonella Camposeragna Antonella is a psychologist. She has been involved in drug addiction issues since 1994 as an outreach worker and field researcher in the experimental phase of harm reduction program in Italy, run by an NGO. According to her social health interests, she conducted many researches aimed to expand and to monitor harm reduction programs in Italy; she has been also involved in European projects aimed to encourage the exchange of good evidence-based practices among EU member countries. Since 2010 she is member of Forum Droghe Steering Committee and she is currently working for Local Health Authority as researcher with monitoring and data analysis tasks of Lazio Region informative system on drug addiction.

Researchers

Thanasis Apostolou Thanasis from 2004-2010 has been co-ordinator on the project "Informal drug policy Dialogue" a joint initiative of the "Andreas Papandreou Foundation" and the Transnational Institute. From 2010-2020 he was director of the Association "Diogenis, Drug Policy Dialogue" based in Athens, Greece. In the period 2010-2015 he was co-ordinator of the Informal Drug Policy Dialogue in South East Europe, (an initiative of NGO's from 10 countries of South East Europe working in the field of drugs). In 2015 this network became a formal organisation based in Belgrade. From 2015- 2016 he has been president of the "Drug Policy Network in South East Europe (DPNSEE) and from 2018-2020 vice-chair of the Civil Society Forum on Drugs (CSFD)

Eva Devaney Eva holds a PhD in sociology, and an MA in Health Promotion, from the University of Limerick (Ireland). She is currently the Policy & Communication Officer with the National Voluntary Drug and Alcohol Sector, an umbrella organisation for voluntary drug and alcohol treatment services in Ireland. She is a committed social researcher

with a strong personal belief in, and commitment to social justice. Her current research interests centre on policy making and implementation, drug treatment & prevention and its interaction with gender, and drug-related crime.

Antonio Jesús Molina Fernández Antonio, clinical & social psychologist and social anthropologist, is assistant professor of ·Social, clinical and epidemiological Aspects of Addictive Behaviours", "Evaluation of Social Programs", "Social Intervention", "Criminality & Urban gangs" and "Social Psychology of Health" in the Social, Work and Differential Psychology Department in Universidad Complutense de Madrid. He has worked for 20 years as practitioner (psychologist and director) in addictive behaviours programmes and as focal point/ manager, trainer, researcher, evaluator or coordinator in different national and international projects (with Dianova, Proyecto Hombre, RIOD, San Patrignano and in UNODC project GLO-H43/TREATNET). Member of National Hispanic Science Network on Drug Abuse/NHSN and European Society on Social Drug Research/ESSD. He has participated in more than 100 national and international conferences and published on issues related to the social psychology of addictive behaviours, especially psychosocial aspects of Recovery.

Irena Molnar Irena is graduated Ethnology and Anthropology at the University of Belgrade, interested in social aspects of substance use that led her professional career development to engagement in drug policy and its reform, on a national scale but as well internationally. She is an active advocate for sustainability of harm reduction programs, devoted educator and mentor, researcher focusing on new ways of education and sensibilization of society regarding psychoactive substances and substance use. She is co-founder of NGO Re Generation, youth led NGO from Serbia where she is elected Executive Directress, she is YODA foundation council member and a Steering committee member of EHRA, representing SEE.

Emanuele Perrone Emanuele is a psychologist with a degree from the University of Rome (cum laude). Student of medicine and surgery. He works as a psychologist in harm and risk reduction services, in different settings (Nautilus Project, mobile risk reduction unit in night entertainment contexts; UDS "fuoristrada", harm reduction project in urban contexts mainly aimed at PWUD, ethnic minorities, homeless; project by Cardias Latina aimed at pregnant women who consume substances; Parsec drug checking implementation project). He is the author of numerous publications dealing with the relationship between laws, organizations and health outcomes in the population (Perrone E, De Bei F, Cristofari G. Law and mental health: A bridge between individual neurobiology and the collective organization of behaviour. Med Hypotheses. 2020 Nov; 144: 110004. Doi: 10.1016 / j. mehy.2020.110004; Law and disease: a scoping review on population health prospective, in press; Law and mental health, the complex role of law in the distribution of mental outcomes in the population, in press). He also works as a psychologist in private clinical activity aimed mainly at adolescents.

Melissa Scharwey Melissa has varied experiences working in both drug policy research and advocacy. She holds a Masters in Public Policy and Human Development from Maastricht University. Her independent research focused on the factors contributing to drug policy change, specifically from repression towards harm reduction. Melissa has been working on research and advocacy, related to drug policy issues, across different contexts while working in the Ana Liffey Drug Project in Ireland. An important motivation for Melissa is to contribute to drug policy reform that is informed by evidence and knowledge,

including from those with lived experiences. This form of knowledge often highlights the intersectionality of drug policy issues with other policy areas. Melissa is now working in advocacy for Doctors without Borders/MSF Germany on the topic of access to essential medicines.

Sanela Talić Sanela is the Head of Prevention programmes at the Institute for Research and Development Utrip (UTRIP). She is a PhD in Prevention Science candidate at the Faculty of Education and Rehabilitation Sciences, University of Zagreb (Croatia). She is the Master Trainer for the school-based prevention programs Unplugged, EFFEKT, Good Behavior Game (GBG) and Boys & Girls Plus, and the national coordinator and the Master Trainer for the family-based prevention programme Strengthening Families Program (SFP) by Prof. Karol Kumpfer. For two consecutive terms, she was the Secretary of the European Society for Prevention Research (EUSPR). She is a co-author and co-developer of the European Prevention Curriculum (EPC), published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in September 2019 and the contributor to the second updated edition of the International Standards on Drug Use Prevention, issued in 2018 by the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO) in 2018. She has been awarded the ISSUP Early Career Award at the 4thInternational Society of Substance Use Professionals (ISSUP) conference in Nairobi (Kenya) in 2018. In 2020, the Society for Prevention Research (SPR) awarded her and her husband (Matej Košir) with International Collaborative Prevention Research Award.

Sara Woods Sara is a writer, coordinator, researcher, editor and networker; adept at switching between these diverse tasks. Sara holds a Master in Social Policy and Social Work in Urban Areas (graduated cum laude) and a Master degree in Eastern European Studies with a specialisation in Russia/USSR politics and modern history. Sara has worked in the drug policy and harm reduction field since 2007 in various roles and with several organisations, among which Amsterdam's Drug User Union (MDHG), before joining Mainline in 2016. As one of Mainlines key project managers and policy advisors, Sara has proven to be an analytical and critical researcher/evaluator in different cultural/ social contexts.

Appendix IV

RESOURCES

(by theme, from CSFD, EU and international institutions, European networks)

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