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POLICY BRIEF

The COVID-19 pandemic and the right to health of people who use drugs

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Abstract

Context: According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) people who inject drugs (PWID) make up a significant part of the population that needs to be looked after to eliminate infectious diseases such as those caused by HIV and HCV. This situation has been exacerbated by the COVID-19 pandemic. As COVID-19 rapidly spread across the globe, governments implemented various prevention measures which not only caused an increase in problem drug use (PDU) because of their negative impact on mental health and socioeconomic conditions but also prompted a decrease in drug services provided. Therefore, new challenges appeared, such as increased demand for drugs and diversification of clients, and new needs. Nevertheless, in clear contradiction to what was needed, the EMCDDA's initial reports suggested that there was a decline in European drug services both in providing treatment and harm reduction interventions. COVID-19 increased the need to access drug services, healthcare, and support services creating an increased demand for opioid substitution therapy and other medication. Thus, comprehensive, and sustainable policies are needed to combat the public health threats associated with these challenges and to ensure the continuity of care.

Policy Options: The challenging circumstances brought by the COVID-19 pandemic require policymakers need to take action to build capacity and resiliency for those facing drug-related health and social problems. These should include the adoption of integrated strategies that combine drug consumption rooms, substance-specific therapies, provision of free needles and naloxone, primary healthcare, and social support.

Recommendations: The creation of an integrated drug policy framework addressed to European Union member states is necessary to create robust drug services capable of surviving a crisis. This is guided by a relevant policy design and implementation framework, alongside tangible action principles in line with low-threshold service provision.

Keywords: High-risk drug use, integrated drug policy, harm reduction, drug treatment, healthcare, and social support

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List of Abbreviations

EMCDDA - European Monitoring Centre for Drugs and Drug Addiction

COVID-19 – SARS-CoV-2

EU – European Union

EEA – European Economic Area

MS – Member State(s)

PWID – People who inject drugs

HIV - Human immunodeficiency virus

HCV – Hepatitis C

HBV – Hepatitis B

PDU – problem drug use

OST – opioid substitution treatment

OAT – opioid agonist treatment

DCRs – Drug consumption rooms

EDPQS – European Drug Prevention Quality Standards,

NSP – Needle and Syringe Programmes

LTS – Low-Threshold Services

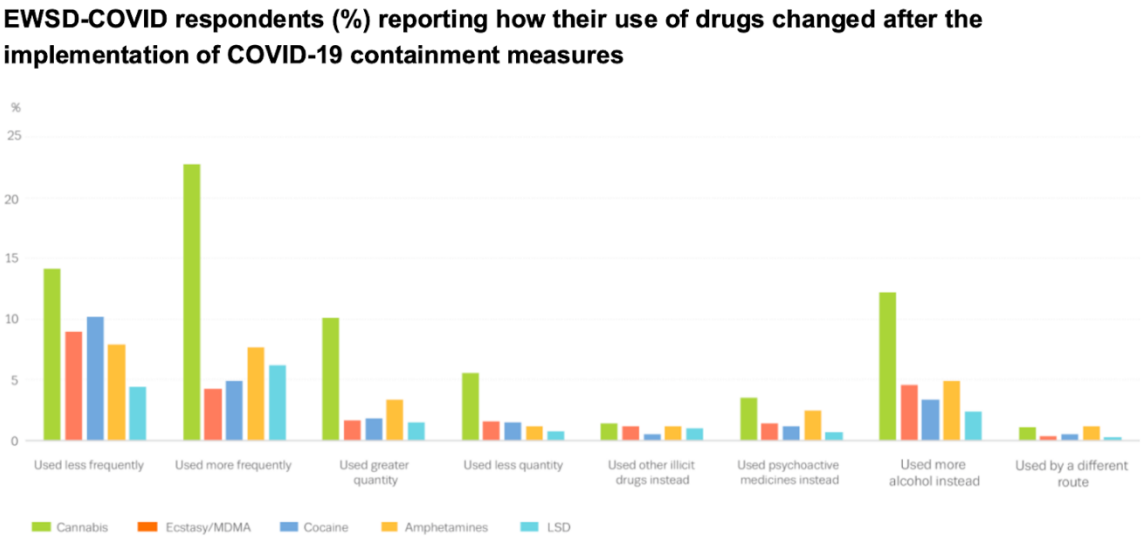
Introduction

As in any other realm of life, drug use has been impacted by the COVID-19 pandemic. Over two years, drugs typically prevalent in recreational settings like MDMA or cocaine decreased in popularity during lockdown periods, while a general increase in consumption of cannabis, crack cocaine, dissociative drugs as well as in non-medical use of some pharmaceutical drugs (ex. tramadol, benzodiazepines, barbiturates) has been observed (1)(2).

The COVID-19 pandemic's global impact has been particularly felt by vulnerable populations, such as high-risk drug users. The latter are more exposed to COVID-19 infection due to drug consumption practices such as the sharing of drug use equipment (pipes, syringes & needles) but also to their deteriorated health status (including comorbidities such as HIV/HCV infection and mental health problems) and often precarious living conditions (homelessness and unstable housing) (3). This has been reflected in an increasing number of visits to hospitals and calls to mental health services, alongside a rise in problem drug use (PDU) (4) with subsequent increases in demand for harm reduction and drug treatment options (5).

In particular, the COVID-19 pandemic saw a significant rise in high-risk drug use, alongside a convergence of homeless populations where drug services were offered, and increased demand for social support and low-threshold opioid substitution treatment during regional lockdowns (5), which was largely assumed to be due to disruptions in heroin supply in some countries (6).

Figure 1: The impact of COVID-19 on drug use in Europe. (6)



Note: The number of users per drug was as follows: cannabis, 7 006; MDMA, 3 637; cocaine, 2 928; amphetamines, 2 837; and LSD, 2 052 (only respondents who have used the substance in the last 12 months have been analysed).

Context

Marginalization of populations with PDU becomes increasingly prevalent in public health crises, yet adequate healthcare is often not provided accordingly (3)(6). Drug-related issues further exacerbated by the COVID-19 pandemic include changes in types and quality of drugs used; substance use relapse for individuals previously in recovery; and reuse of drug/medical materials which contributes to the spread of conditions such as HIV or viral hepatitis (2)(7).

Despite disparities between countries across Europe, reports from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) suggest an overall decline in drug treatment and harm reduction services provided during the first stages of the COVID-19 pandemic (5). Access to necessary harm reduction services was disrupted by the COVID-19 measures and has thus caused additional challenges for people who use drugs (PWUD) and the whole society (7). For example, HIV testing and treatment services have also significantly decreased globally throughout the COVID-19 pandemic, with estimates from the United Kingdom showing a 33% fall in new HIV diagnoses (8)(9). As a result of the disturbance of harm reduction services, people who inject drugs also face an increased spread of infectious diseases like HCV and HIV, contributing to a higher burden of disease in the population (5)(10). Those trends present new challenges for public health policy traditional harm reduction approaches.

With an estimated 10 million people living with chronic hepatitis in the European Union (EU) and European Economic Area (EEA) in 2016, improved disease prevention and treatment access are vital. To this aim, a key element is the strengthening of harm reduction systems, many of which were weakened during the COVID-19 pandemic (2).

Broadly, in the context of health or political crisis, it is necessary to protect marginalized communities and the whole society (10). In particular, the protection of harm reduction services is vital for both direct and indirect drug-use-related health problems. It is therefore imperative for drug services and

harm reduction facilities to be considered essential services and thus remain operational even under restricted or crisis conditions (5). Overall, harm reduction must be considered an essential service for it promotes respect for basic human rights (11).

Policy Options

Drug-related activities have been evolving since the outbreak of the COVID-19 pandemic. While no definitive patterns may be defined so far, some common trends in drug use emerged across the world with changing social circumstances (1)(3). Changes were also observed in the interventions addressed to people who use drugs, as countries had to alter their treatment services to new standards. Many started to prioritize outreach and home delivery services, and reduced opening hours of drop-in centers where social distancing measures were implemented. Concomitantly, a general increase in food, water, and hygienic supplies was reported, while the provision of opioid substitution treatment (OST) expanded in some places (12).

Considering the challenging circumstances brought by the COVID-19 pandemic, policymakers may promote capacity building and resiliency among those facing intertwined health and social problems.
As problem drug users are usually among the most vulnerable groups in society (13) resiliency and efficacity may be possible through the adoption of multisectoral approaches combining harm reduction strategies, primary and specialized health care - including drug services – as well as social support.
To this aim existing harm reduction services, including drug consumption rooms, substance-specific therapies, provision of naloxone and clean needles, and continuity in health care and social services must be strengthened and incorporated into a comprehensive, sustainable drug service provision. To promote such an initiative, we propose the introduction of an EU-wide integrated drug policy framework that reinforces existing innovative responses and linkage to care. We also provide some concrete actions aimed at facilitating the implementation of that public health-focused drug policy.

1. Safe Injection Sites: Drug Consumption Rooms (DCRs)

Drug consumption rooms (DCRs) are facilities that provide legally sanctioned, professional care to allow safe and hygienic drug consumption for people who inject drugs (PWID) in a supervised setting (12). The objectives for DCRs include overall reductions in overdose deaths and emergency service callouts, prevention of disease transmission from repeated needle usage, and a better connection with healthcare workers and social services (14)(15). In the EU, there are currently 17 countries that are in the process of implementing these facilities, with 11 countries where DCRs are already in active execution (14). DCRs are effective at not only reducing overdose deaths and risky behaviors in their service area but also in reaching the most vulnerable and problematic drug user populations – like those experiencing homelessness – to access appropriate social support, healthcare, and drug treatments (16)(17).
In addition to providing safe spaces for hygienic drug consumption, an important aspect of DCRs is the provision of healthcare, drug treatment, and linkage to social services. Around 60-70% of DCRs provide access to primary healthcare, breaking down the barriers to treatment often experienced by marginalized populations (15).
Moreover, essential services and goods such as food, water, shower, clean clothing, and the

use of a phone are also provided in many DCRs (15).

During the COVID-19 pandemic, the services provided at DCRs had to adapt to unprecedented situations. Although most of the DCRs were able to stay open in the EU, changes in service delivery such as opening hours, social distancing rules, limited client numbers, mandatory masking and hand washing, and client checks for entering DCRs were implemented to fit the changing conditions (18).

As DCRs can provide not only drug consumption safety but also a more comprehensive approach to drug use disorders, a continuation of services for vulnerable populations during these crisis times is crucial.

2. Substance-specific therapies (OST/OAT)

In 2017, there were over 1.3 million high-risk opioid users in the EU (19). Although the prevalence of opioid use varies by country, it is considered one of the most pressing issues of illicit drug use. Opioid substitution treatment (OST) / opioid agonist treatment (OAT) is the most common form of treatment approach for opioid dependence offered in outpatient settings (20). OST/OAT are pharmacological treatments that use substances similar to morphine, most commonly either methadone or buprenorphine, that mimic the effects of opioids to tackle opioid dependence (20). Currently, it is considered as best practice for opioid dependence to combat overdose risk, mortality, as well as other risky behaviors leading to the spread of blood-borne infections (notably HIV/HCV) (21). This treatment is crucial in tackling opioid dependence, overdose, and mortality as around 80% of all overdose deaths associated with illicit drugs in the EU involved opioids in 2017 (19).

However, difficulties in treatment approaches arose during the COVID-19 pandemic.

High-risk drug users were faced with disruptions to care during the pandemic, with over 91% experiencing some form of disruption such as cancellation of group activities, reduced opening hours, and complete closures of treatment facilities due to restriction measures (12). This is detrimental to the process of treatment as OST/OAT requires long-term outpatient care and pharmacological maintenance for better effectiveness (13). Vulnerable populations - such as people experiencing homelessness - were hit especially hard by these disruptions.

To confront these challenges, contingency strategies such as the outreach to enable take-home OST/OAT delivery, as well as increased flexibility in dispensing services, were strongly recommended (22). This aimed to increase the availability of and/or the maintenance of OST/OAT while addressing the societal barriers of stigmatization in accessing those services (12).

3. Provision of clean needles and naloxone

The sharing of previously used syringes is associated with the transmission of blood-borne viruses. Needle sharing causes PWID to be at higher risk for acquiring or transmitting various communicable diseases (23)(24). As recommended by the EMCDDA, Needle and Syringe Programmes (NSP) are key to preventing and controlling many harms associated with injecting drug use (25)(26). In addition to minimizing injecting-related risks, NSP also aims to decrease the presence of used equipment and associated wastes in public areas (27). Along with clean needles and syringes provision, a supply of naloxone administrable through an intranasal spray is an

essential part of the « take-home kit » needed for PWID to reduce harms associated with their consumption and to prevent fatal overdose.

Used in treating opioids overdoses, this medication is effectively used to reverse opioid-related mortality (28). The provision of such services also constitutes an appropriate time to facilitate education, counseling, and referral services (29).
During the COVID-19 pandemic, several countries reported problems with the provision and distribution of packs with sufficient supply (5). Also, as their effectiveness is coverage-dependent, lockdowns and social distancing have impacted their access and availability (30).
To be effective, those services need to be available in settings that are accessible to PWUD, either on fixed sites such as drug treatment services, community pharmacies, emergency departments, or even through mobile units (30)(31). The implantation of automatic dispensing machines (32), the encouragement of peer-to-peer distribution, and even the development of options for supplies delivery or posting (33) have proven to be successful in certain settings and may mitigate the barriers that some populations - especially women and LGBTQ+ people – sometimes encounter in accessing those services (34).

4. Primary healthcare & social support

PDU is more than a health-related concern, as populations who develop drug use disorders are often exposed to higher rates of poverty, unemployment, and homelessness while having a decreased access to vital resources (35)(36)(37)(38)(39). Therefore, essential services covering basic human needs such as housing, food, hygiene, education, and employment support for those in need must be provided (40). Social activities, as well as access to technologies, also contribute to the reintegration of the most isolated people into society. Access to legal support is also an essential aspect of a comprehensive service, considering the heavy burden of criminalization illicit drug users are faced with (41)
To comply with the right to the highest attainable standard of health described by the International Guidelines on Human Rights and Drug Policy Rights (42), general health considerations would also need to be integrated through the treatment of underlying chronic medical conditions, and the prevention of sexually transmitted infectious diseases through information campaigns on safe sex practices and screening. Moreover, the monitoring of the ongoing physical and mental health of drug service users would allow the arrangement of appropriate care where needed (43).

In this regard, service providers have identified several specific challenges related to the COVID-19 pandemic. This crisis has exacerbated the tensions that a large number of high-risk drug users were already facing (unstable economic status, precarious housing situation, etc.). Moreover, the health and social situation of the most precarious problem drug users has been degrading because of the stop or reduction of numerous services, only increasing the various vulnerabilities (44).

As an example, during the lockdown, the interruption of infectious disease testing and treatment among drug users with high-risk behavior could be, in a near future, associated with outbreaks of HIV, HCV, or HBV (6). The provision of continued health care and social services would help deal with all the aspects that are intertwined with the problem of drug use issue. This will not work unless those

services are implanted where populations are facing this problem and unless an effort of outreach to the most vulnerable and isolated individuals is made.

5. Designing and implementing an Integrated Drug Policy Framework

To tackle the issues amplified during the COVID-19 pandemic, there is an immediate need to develop and maintain a more holistic approach that does not only encompass the drug-specific health problem. For this purpose, the adoption of the inclusion health approach – a service, research, and policy agenda that aims to "*prevent and redress health and social inequities among the most vulnerable and excluded populations"* (45) – may be fruitful.

With this goal in mind, policymakers need to build strategies that would ensure access to drug-specific health services - with DCRs, OSTs/OATs, NSPs – while integrating primary healthcare & social support. This is only possible with the creation of an inclusive environment, implanted in areas that face those specific health and social problems. Given that such issues are multidimensional, a multidisciplinary team of professionals from complementary fields is required.

Thus, the establishment of cross-sectoral cooperation between healthcare professionals such as medical doctors, nurses, and psychologists along with social workers, educators, police officers, and local/governmental representatives is needed to enable the implementation of a comprehensive strategy that tackles all the intertwined issues associated with problem drug use. In parallel, such integrated services would also help reinforce the monitoring of trends in illicit drug markets, while providing a framework to understand the social determinants that influence problem drug use in a particular setting.

Ultimately, at a European policy level, we recommend the establishment and joint adoption of an integrated framework to guide drug policy decisions outlining the general and specific healthcare provisions and support needed by high-risk drug users. This framework should capitalize on well-established processes and principles while remaining flexible enough so that future policies can be adjusted to reflect the needs and characteristics of different geographical contexts and populations.

To aid in the creation of this integrated drug policy framework, we recommend reviewing and combining principles from the Six Harm Reduction Principles outlined by Hawk et al (46); the Alberta Health Service's Low-Threshold Service Model (47); and the EMCDDA's Five Factors of Drug Problem Response Implementation (48). Taken together, these principles and approaches can yield an innovative drug policy framework intended to promote cross-sectoral engagement within the EU and beyond.

In this section, we will explain the relevant principles and approaches guiding the proposed integrated drug policy framework. Subsequently, we will present a set of tangible actions intended to facilitate the implementation of the proposed policy framework. Evidenced-based policy frameworks supporting harm reduction approaches are already used to tackle high-risk drug use through a public health lens. Key elements from such frameworks can be examined and learned from to facilitate the creation of an innovative drug policy framework.

Successfully implemented harm reduction policies and programs can be quite sustainable and cost-effective, thus promoting lasting change among targeted populations (11). In a

public health crisis such as the COVID-19 pandemic, these policy orientations are crucial to protect already vulnerable populations.

5.1. General guiding principles

According to the six harm reduction principles outlined by Hawk et al (46), acting guided by the principle of humanism, we would ensure user-friendly services and responses that are focused on the patient's needs.
While taking pragmatism into account, we can provide a range of supportive approaches knowing that substance abstinence is neither prioritized nor assumed to be the goal of every drug treatment patient. Moreover, as every human being possess a unique skill set, their level of harm and receptivity to treatment should be seen as a spectrum to which proposed intervention options need to cater (individualism). Through the promotion of autonomy care negotiations will be based on the needs and wishes of the patient, thus strengthening the provider-patient relationship. Incrementalism encompasses the idea that any positive change is a step in the right direction towards improving the patients' health and stresses the importance of having a plan for dealing with backward movements. Finally, by recognizing the responsibility of the patient in their behavior without penalizing them for not achieving goals we can help them understand the impact of their choices.

Figure 2: Hawk et al. (2017) Harm reduction principles for healthcare settings (46)

5.2. Integrated drug policy framework: core components

The innovative policy framework we propose must include considerations for sustainable integrated services (including drug services, primary healthcare, and social support) considering a public health crisis such as the COVID-19 pandemic. Nevertheless, from a public health perspective, the implementation of integrated services for high-risk drug users must also be showcased in normal times. Regardless of the specific context, a successfully integrated drug policy framework must include the following core components presented in Table 1.

Table 1: The Four Core Components of an Integrated Drug Policy Framework

Recognition of drug services as essential healthcare services
Tools to protect a safe drug supply
Improved strategies to monitor drug composition and sale must be deployed to ensure a safe drug supply, thus reducing the likelihood of overdose and other related complications (49). Alongside this, protection of services like OST, at-home drug screening kits and naloxone provision must be guaranteed. This includes contingency plans to protect the production of such resources, and the ability for end-users to continually access them. This may include allowing end-users to create a personal "stockpile" of such tools to avoid the increased frequency of social interaction/infection exposure (50). Flexibility in access to such resources is critical.
Continuous end-user engagement and reflection
A variety of stakeholders must be engaged in the coordination of successfully integrated drug policies. Importantly, to ensure the pertinence and coherence of such policies, engagement with end-users and drug service workers must be prioritized and frequently evaluated (51). Policies and services must not simply be designed for PWUD but in close collaboration with them, along with other key stakeholders such as service providers.
Flexibility in the consideration of demographic, social, and structural issues
While the adoption of integrated drug policy allows for continuity and cohesion in the provision of drug services, primary healthcare, and social support, means to deal with demographic, social, and structural differences between countries and regions must be available. This will allow for some flexibility in how integrated drug services are designed and implemented.

5.4 Action principles for implementation

Alongside the four core components comprising our proposed integrated drug policy framework, several concrete actions will contribute to the implementation of services under such framework. In this regard, the Alberta Health Service proposes the “Low-Threshold Services” (LTS) model for the delivery of harm reduction services, which is focused on the patient and removal of barriers to improving access to care (Alberta Health Services, 2019). Based on the LTS model we describe in Table 2 action principles are intended to help successfully implement drug services under the guidance of an integrated drug policy framework.

Table 2: Action principles for the successful implementation of integrated drug policies and services, derived from Alberta Health Service's Low-Threshold Services

Action principles	Description
Accessible	To allow drug services facilities to operate at increased hours so support is available throughout the day
Accepting	To create a drug services training program geared towards recruiting, training, and maintaining skilled workers with lived experience of drug use (either personal or familial)
Affordable	To approve increased cross-national and supranational funding to offer integrated drug services for free under local/national/supranational health schemes
Accommodating	To create mobile OST/OAT delivery service to improve access and protect the continuity of OST/OAT provision during public health crises like pandemics
Removing barriers to care	Create a permanent coalition between other social support and healthcare services to ensure continuity of care from a holistic approach

5.4.1 Other Considerations for Implementation

To implement the proposed innovative policy framework and make the provision of integrated drug services feasible and sustainable over time, an effort must be made to consider the different stakeholders involved with the project. As their interest, power, and position on the issue may vary, their engagement in the design and implementation of the responses needs to be defined accordingly (Appendix 1). The main stakeholder which needs to be involved is the population directly faced with problem drug use.

To this end, this specific group needs to be consulted, as they can contribute by providing insights into the different practical dimensions that are associated with the implementation of integrated drug policies and services. Similarly, the implementation of integrated drug services might get drawbacks from the local communities living in the immediate surroundings, which is a substantial endeavor to effectively communicate with about services' main features (aims & components, target populations, opening hours, legal and institutional framework).

Addressing communities' concerns is a prerequisite to ensuring the sustainability of integrated drug services. Some local communities may be concerned that services will attract more high-risk drug users to the area, or that service user will openly engage in drug use and drug dealing. Thus, it is

important to address these concerns before the response can be implemented. Moreover, the successful implementation of integrated policy responses to drug-related health and social problems must also consider other factors as presented in Table 3 (48).

Table 3: Factors to consider for the successful implementation of integrated policy responses to drug-related health and social problems**.**

Enlisting policy and public support	By promoting the policymaker and the public recognition and comprehension of drug-related health and social problems, the need for a response can be better communicated and accepted by these stakeholders. Persuasion may be required in some cases to press the need for a public health approach.
Having well-prepared staff to deliver services	It may be necessary to hire and/or train additional personnel to provide the intended integrated drug response.
Finding appropriate facilities where the services can be delivered	Proper facilities are required to provide adequate treatment. Such facilities need to be geographically accessible through a variety of means, to limit barriers to access for various groups. Potential facilities must be able to adequately house necessary supplies, staff, and service users. Centrally located facilities will likely reduce many barriers to accessibility.
Inter- and Intra-coordination of health services	To ensure the efficient coordination of different agencies working on the proposed integrated response, management systems are needed. This may necessitate the constitution of an advisory board consisting of a range of key stakeholders. To incorporate socioeconomic factors and mental health issues into the services program, proper coordination between drug services and other healthcare provisions is also required. Importantly, these must be addressed simultaneously.
Ensure the use of quality standards for service supply	The EU has issued basic quality requirements (European Drug Prevention Quality Standards, EDPQS) in the areas of drug demand reduction, which also includes risk and harm reduction. The EDPQS emphasizes the importance of training, developing skills of staff, the reintegration into society of drug treatment patients, and the necessity to consider the readiness for change.

Conclusion

Protecting the right to health for people who use drugs is a complex issue, particularly in the context of the COVID-19 pandemic. Collaborative, sustainable, and robust integrated responses to drug-related problems are necessary to reduce health and social inequities, to ultimately improve health outcomes in vulnerable populations. The adoption and implementation of an EU-wide integrated drug policy framework is one crucial step in this pathway. These policy solutions are primarily geared toward injecting drug use of opioid-based substances, as there are known successful harm reduction options and users in this group are often the most vulnerable in public health crises. Strengthening services listed in this policy brief such as drug consumption rooms, substance-specific therapies, needles, and naloxone distribution, along with primary healthcare and social support plays an important role in mitigating structural barriers to health of high-risk drug users. However, this cannot, unfortunately, address all the drug-related problems that might have been yielded or exacerbated by the COVID-19 pandemic.

Addressing issues associated with cocaine use via harm reduction is challenging. There is no recognized alternative substance therapy for cocaine (like there is OST for opioids). Additionally, due to supply chain issues with substances like heroin, some individuals have turned to cocaine use (6).

Moreover, the adoption of an integrated drug policy framework across Europe may be very challenging as it requires a paradigm shift towards a more progressive human rights-centered approach to problem drug use. This involves the attainment of a broad political consensus at national and supranational levels, as well as the allocation of additional public funding to support the effective implementation of innovative responses to health and social responses associated with problem drug use. Nevertheless, we encourage national health authorities to take the time to rethink their approach to drug-related health and social problems through the lens of the integrated drug policy framework we propose.

Despite the financial and political costs such an endeavor may involve, available scientific evidence suggests that these changes need to be seen as an investment for a more effective and efficient national drug-related strategy in the future. An integrated drug policy framework such as the one we propose will significantly enhance the quality of drug-related services – including prevention, harm reduction, and drug treatment - which in turn will improve health outcomes for high-risk drug users (decrease in drug-related problems such as HIV/HCV transmission, poisoning, and fatal overdoses; higher rates of drug treatment maintenance, lower the risk of relapse).

As the EMCDDA's main objective is to combat drug-related health and social harms by informing EU and national drug policies, it may have a crucial role in providing specific guidelines together with evidence-based recommendations that facilitate the design and implementation of integrated drug policies and services. To this aim, one first action would be the creation of an EU task force with representation from all relevant stakeholders (see Appendix 1 & 2 for details) to ensure the provision of relevant responses.

Within this context, EU member states could be responsible for the appropriate provision of funding and practical support for local actors in the set-up of these responses. Additionally, local authorities would oversee capacity-building to achieve adequate coverage of the target population.

Finally, obtaining support from national authorities must rely on a common goal: finding a suitable balance between public health, social cohesion, and public security

Appendix 1: Stakeholder Mapping

NAME OF STAKEHOLDER	INFLUENCE/ POWER HIGH/MEDIUM/LOW	INTEREST/ STAKE IN THE ISSUE HIGH/MEDIUM/LOW	LIGHTLY POSITION IN RELATION TO THE ISSUE (i.e., positive, against)	ENGAGEMENT PRIORITY HIGH/MEDIUM/ LOW
EMCDDA	MEDIUM	HIGH	POSITIVE	MEDIUM
EU Member State Governments / Policymakers (Federal, Regional, Local)	HIGH	HIGH	POSITIVE / AGAINST	HIGH
Persons who use drugs	LOW	HIGH	POSITIVE	HIGH
Community members living in areas where harm reduction services are offered	LOW	MEDIUM	INITIALLY AGAINST	LOW
Harm reduction workers	HIGH	HIGH	POSITIVE	HIGH
Health care professionals	HIGH	HIGH	POSITIVE	HIGH

Law enforcement officials	MEDIUM	LOW	POSITIVE / AGAINST	MEDIUM

Appendix 2: Importance of stakeholders from a power and leadership perspective

Group 1: Influence & Interest High	Group 2: Influence or Interest Medium but other HIgh	Group 3: Engagement High
EU Member State Governments / Policymakers (Federal, Regional, Local)	EMCDDA	EU Member State Governments / Policymakers (Federal, Regional, Local)
Harm reduction workers		Persons who use drugs
Health care professionals		Harm reduction workers
		Health care professionals

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