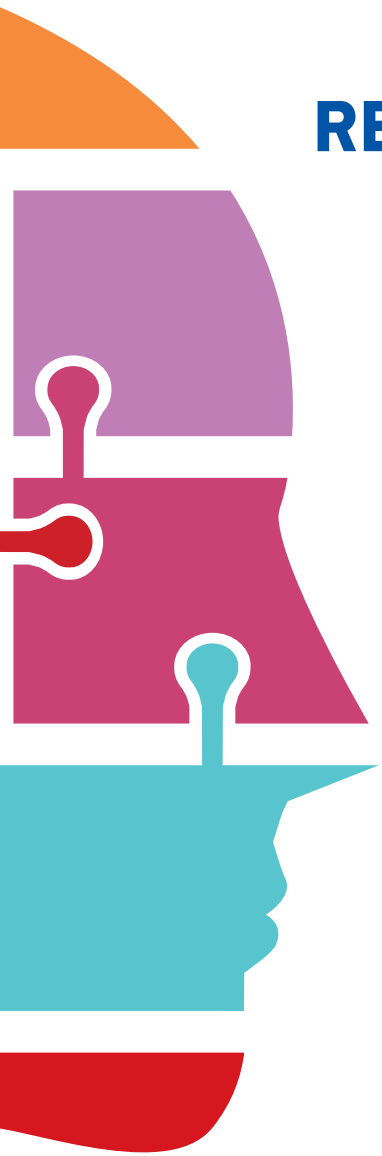
POLICY PAPER ON REDUCTION OF DRUG RELATED HARM IN MONTENEGRO



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Juventas

POLICY PAPER ON REDUCTION OF DRUG RELATED HARM IN MONTENEGRO

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LIST OF ACRONYMS USED IN THE DOCUMENT

AIDS – Acquired Imuno Deficiency Syndrome;

EMCDDA – European Monitoring Center for Drugs and Drug Adiction;

ECDC – European Center for Disease Control;

HIF – Health Insurance Fund;

HIV – Human Imunodeficiency Virus;

HBV – Hepatitis B Virus;

HCV – Hepatitis C Virus;

HAT – Heroin assisted Treatment;

HEP – Health Education and Health Promotion;

INF/EDU – Measures of information and education;

MSM – Men who have sex with men;

NGO – Non governmental organization;

NSP – Needles and Syringes Provison programs;

OST – Opioid Supstitution Treatment;

OUT/MOT – Outreach and motivational activities;

PWID – Persons Who Inject Drugs;

PUD – Persons Who Use Drugs

STI – Sexually Transmitted InfectionsPolno prenosive infekcije;

UNODC – United Nations Office for Drugs and Crime;

UNAIDS – United Nations joint program for HIV/AIDS;

WHO – World Health Organization;

1 Introduction

Evaluation of a century of international efforts invested in controlling drugs, done by UNODC, showed that the system of drugs controlling and its application had some sideffects. One of these is *lack of investments solving the question of harmfull consequences for public health caused by drug use.* [1]. With global acceptance of the fact that drug dependence is a chronical, but preventable disease, but also a disease that one can be cured or recovered from, a widely accepted standing point is that *measures and interventions directed towards achieving apstinence and recovery have to be accompanied by measures that can significantly contribute to decrease of risks and harmfull consequences of drug use.* Today, interventions in the area of risk prevention and harm reduction are considered fundamental and necessary, due to the fact that there is a wide scope of evidences that can prevent disease, save lives and protect the community. On a global level we have a highly present tendency that the practice of drug use harmful consequences' reduction is being spread and finds its application in the area of illegal, but also legal psychoactive substances use, as well as in the work of the law enforcement services. In the same time the concept of harm reduction became a mean to achieving golas of the public health policies, policies in the area of community security, policies of social protection aiming to decrease social, legal and economic problems related to psychoactive substances use.[2].

Harm reduction approach and interventions derived from it have been introduced on a larger basis, principally as a response to a high number of overdose cases as well as fast spread of HIV®AIDS and other STIs due to intrevenous drug use. From the perspective of public health, subpopulations with a high infections burden have direct and indirect onerous effect on the society, and prevention can substantially limit these effects. The first effect is direct morbidity due to heavy forms of chronical infections, having high treatment expenses as a result. The second is reflected in the lost of human productivity, which increases social expenses. The third is high prevalence of diseases among persons who use drugs, which, especially if sustained a long period of time, can increase the risk in the wider population. Practice shows that harm reduction measures represent a noteworthy input to the conventional public health approach, can have a strong effect on spreading blood-borne and other infections among people who inject drugs, therefore the society in general. Prevention is feasible and effective if populations most at risk of acquiring infection have been provided with adequate services, in an adequate manner, in their own surrounding and in the adequate time.

Harm reduction measures, i.e. *prevention and reduction of mortality,*

reduction of health and social risks and harms, as well as general feeling of insecurity of the community due to drug use,in most countries of Europe and world represent an integral part of national strategies and policies of fight against drugs, applied in different scope and combinations, dependant to drug policies' goals. All European and international refferent organizations and bodies strongly support harm reduction as an efficient, evidence based approach to prevention of infective diseases transmition and treatment of persons who use drugs [3].

Harm reduction approach has been supported by the "Strategy of Montenegro for prevention of drug abuse 2013 – 2020 [4]", but there is no unique national doctrine, i.e bylaws that regulates this particular area. Although there are the most important harm reduction services set in place, which proved their worth and necessity on multiple occasions, ending of a nine year long donation program of the Global Fund for Fight against AIDS, Tuberculosis and Malaria in July 2015, brought the sustainability of certain services into question and the same are facing closure. This is especially related to service functioning within the NGO sector, **without which the harm reduction approach in a certain country can not be neither complete nor efficient**, daily centers i.e. drop in centers for people who inject drugs and outreach work with most at risk populations in respect to HIV, Hepatitis C and B. In order to make services mentioned mentainable and developed according to growing needs, **it is necessary to permanently secure their functioning and sustainability.**

Due to all things mentioned it is necessary to adopt this document as a referent conceptual and practical framework for further development and improvement of the national policy in the domain of reduction of harm caused by drug use in Montenegro, according to strategic goals set. Drug users' access to adequate treatment must not be a priviledge, but a right coming from the fundamental right to health, as well as an obligation of every responsible system. Likewise, the possibility of access to programs and measures of decreasing drug related harm represents the right of every individual, which must be recognized as such.

2 Goal of the publication

General goal of this document is to support the creators of the policy in Montenegro in planning adequate and evidence based, rationally conceived responses of the public health and civil sector to decreasing drug related harm, i.e. according to generally accepted principles and recommendations of relevant international bodies and organizations with national strategic orientation. This document provides guidelines and counseling to decision and policy makers, based on the insight into the international and national situation, experience and practice, science based research and conslusions of perennial debates on the underlying subject.

Furthermore, this document gives a starting impulse and necessarz framework for a productive dialogue between decision makers and civil society on general policy on drugs as well as dialogue on the role of reduction of drug related harm, based on experience and existing practical evidence rather than ideological positions.

3 Context

A more widespread notion that addiction should be treated as a chronical, preventable disease, that one can cure or be recovered from contributed to accepting of harm reduction measures' significance. Although there are differences in political acceptance, interpretation and variations in the type of measure to be applied, as well as their accessibility and availability, a general consensus is that measures directed towards achieving apstinence and recovery must be complemented with measures that can significantly decrease psychoactive substances induced harm.

3.1. The definition of the harm reduction concept

Harm reduction is a term that implies ***interventions, programs and policies aiming to prevent, decrease and relieve health, social and economic harmful consequences of drug use on individuals, communities and society in whole.*** This term also indicates a movement that advocates for social justice based on drugs users' human rights respect.[5].

Different definitions of the harm reduction concept in documents and instruments on public policy illustrate existence of differences in understanding this concept. Most often the term "harm" is accompanied by the term "risk"-the probability that a certain event causing harmful consequences will happen, having in mind that harm isn't always directly and easily measured. According to consensus, harm reduction became a usual term which is used in this document, which implies risk prevention and reduction of drug related harm. The thing which specifically defines harm reduction measures is the fact that their focus is on prevention of drug related harm rather than prevention of drug use itself. Widely accepted concept of harm reduction differs harmful consequences on different levels-individual, community and social level which is in the same time an indicator how wide is the focus of this approach. The concept of harm reduction incorporates wide specter of strategies-from safer drug use, through controlled application to complete abstinence, which have a goal to reach persons who use drugs in their "natural surrounding", recognizing not only drug use, but also the terms under which it happens. Concept of harm reduction is closely connected with health promotion and concept

of public health in general, because public health in its core contains the idea of individuals' and populations' health protection through supervision, identification and managing health risks, which is in fact the model of harm reduction.

3.2. History of harm reduction concept

Harm reduction in the area of drug use has a long history, starting from the practice of prescribing heroin and morphine via prescriptions to persons addicted to opiates in Great Britain in the twenties of the last century, through introduction of methadone maintenance in the USA in the sixties, so that by the end of seventies WHO recommended policies of harm reduction aiming to "prevent and reduce the severity of problems connected to use of drugs causing addiction for non medical purpose"[2]. In 2003 Council of Europe recommended seting up of adequate sufficient, aligned with the needs and accessible services in the area of prevention and reduction of drug related harmin all EU countries. The recommendations were seeking for the decrease in numbers of drug use related death cases, but also the level of harmful consequences for health, including the ones related to HIV, Hepatitis B and C [6]. These goals have been confirmed in the EU Strategy for drugs 2005-2012 [7] and EU Strategy for drugs 2013-2020 [8] through the goal set: "measurable decrease in drug use, addiction, health and social risks on drug use throughout an intervention package which combines harm reduction, treatment and rehabilitation". Drug related harm reduction became a goal of public health policies in the EU member states, and the general trend implies broadening the scope and additional development of these measures.[9].

WHO, UNODC and UNAIDS jointly developed a *comprehensive package*-technical guidelines for the universal approach to HIV prevention, treatment and care for persons who inject drugs. A specific recommendation of the guidelines implies that, aiming to successfully fight HIV in the context of injecting drug use, *the states should give priority to programs of needles and syringes exchange as well as evidence based drug addiction treatment, especially opioid supstitution treatment* [10]. According to WHO recommendations, pharmacological treatment should consist of **methadone** and **buprenorphine** for the symptoms of withdrawal and abstinence, alpha-2 adrenergic agonists for symptoms of abstinence crisis, naltrexone for relapse prevention, and naloxone for overdose treatment [11].

EMCDDA and ECDC drawn up joint guidelines for the prevention and control of infectious diseases among persons who inject drugs. They recommended seven key interventions to achieve this goal, including: *ensuring free and legal access to sterile injection equipment* in the framework of multi-component approach implemented through harm reduction programs,

counseling and treatment; *opioid substitution treatment* and other effective forms of treatment; *health promotion* focused on safe injecting, sexual health - including the use of condoms, infections' prevention, testing and treatment; *targeted provision of services through mobile outreach work and fixed outreach locations* that offer treatment, harm reduction, counseling and testing, and referral to general and specialist health services [12].

3.3. Key principles of harm reduction concept

There is no universal definition or formula for the implementation of harm reduction measures, given that their effective implementation requires that they reflect specific needs of individual users as well as community needs. However, certain **principles** are seen as crucial for the implementation of practical interventions:

- accept the fact that drug use is part of the world in which we live, do not ignore or judge, but work on reducing the harmful consequences,
- understand drug use as a complex and multifaceted phenomenon that encompasses a continuum of behavior patterns from severe abuse to total abstinence, and accept the fact that certain methods of drug use are safer than others,
- putting a stop to use of all drugs is an unrealistic goal, so one should use the quality of life of an individual and the community as criteria for the success of interventions undertaken,
- provide services to persons who use drugs in the community in which they live and approach them in a non-judgmental and non-violent way,
- include persons who are or were using drugs in the creation of programs that are designed for them,
- accept the fact that the real circumstances such as poverty, exposure to religious and national intolerance, social isolation, suffered trauma, gender discrimination and other social inequalities affect the vulnerability of the individual and the ability to effectively fight the harmful consequences of drug use,
- refrain from all attempts to minimize or ignore the actual harmful effects and dangers associated with the use of legal and illegal drugs. [5]

3.4. Goals of harm reduction

Short-term goal of harm reduction is to prevent and reduce the drug related harms on the user, his/her family, community and society as a whole.

A long-term goal of harm reduction implies that, wherever possible and as early as possible, persons using drugs are directed towards rehabilitation and reintegration treatment, with the ultimate aim of achieving abstinence. At the community level long-term goals are the following: reducing morbidity and comorbidity, improving public safety, reducing the number of crimes against property as well as number and severity of prison sentences. Harm reduction policies have their own significance in the area of human rights with regard to their effect on the overall well-being and quality of life of the individual, and can have a significant impact on overcoming prejudice and discrimination that are often present in the field of drug use and addiction.

3.5. Harm reduction measures

Measures to reduce harmful effects are complementary and integrated with existing health policy measures of prevention, treatment and rehabilitation. Within them we have intertwined policies of decreasing demand and supply. Availability and implementation of various measures to reduce the harm depends on the national policy and legal framework in each individual country. Some measures, such as opioid substitution treatment and needles and syringes provision, are present in almost all countries. In opioid substitution programs for heroin addiction it is very important to recognize the specific aspect of the treatment, although the application of these forms of treatment also reduces the risks and adverse consequences of drug use.

The most common and most strongly evidence based harm reduction measures include:

- Needles and syringes programs;
- Provision of sterile injection equipment;
- Providing condoms;
- Opioid substitutional low threshold programs.

Some countries also apply other harm reduction measures, which are still the subject of controversy:

- Rooms for safer drug use;

- Pharmacological testing of psychoactive substances;
- Providing sterile equipment for consumption of crack;
- Providing foil;
- Providing medical first aid and overdose kits, including the program of naloxone assistance;
- Heroin Assisted Treatment (HAT).

To achieve the full effects of harm reduction measures, it is necessary to connect them with the following interventions:

- Outreach work and motivational activities,
- Accessibility and availability of services with a low threshold of access,
- Detox in cases of acute and chronic intoxication,
- Referral to appropriate psychological, social and health services,
- Support self-help groups [3].

3.6. Principles of harm reduction policy impplementation

Principles of good policy in the field of harm reduction include the following:

- harm reduction measures appropriately applied to be accessible and affordable,
- to establish a connection with the services to which users are referred and continuity of refferrals,
- to carry out monitoring and evaluation of effects, effectiveness and impact of these measures.

Measures to be applied in practice must be focused on the effects of the substance, specific type of use, specific risks and harm coming from the use. In order to ensure the long-term impact of these measures and realistic prospect for people to accept the treatment, with the ultimate aim to achieve abstinence where possible, harm reduction measures must be closely related to prevention, treatment and rehabilitation. However, abstinence should not be a condition for access to harm reduction services.

In order to achieve effective and efficient implementation of harm reduction programs, the general set of interventions and services must be added the following:

- Informing and counseling PUDs and their families;
- Information about available addiction treatment options;

- Sensitizing the public in order to avoid stigma and discrimination;
- Enabling outreach work in the local community aiming at specific user groups;
- Encouraging the involvement of the beneficiaries themselves and volunteers;
- Promoting professional networking and cooperation between services;
- Ensuring the efficiency of the system of users' referral, between services and institutions.

Experience has shown that significant measures of assistance also include: providing accommodation, seeking employment, education as well as general use of free time, as well as providing legal aid.

Harm reduction programs and measures must be consistent with other policies, and must take into account the interaction of these policies with other areas: police, judicial system, economic policy, employment policy, family policy, youth policy, etc. Failure to observe these interactions can lead to mutual opposition of objectives of various policies and thus cause counterproductive effects. It is important to identify which goals are potentially conflicting with each other and establish a mediation mechanism to ensure that the harm reduction measures reach their full potential, thereby not neutralizing the effects or exert a negative impact on other policies. The right of access to adequate harm reduction services refers to prisons to the same extent as the community, which is the reason why some countries introduced needles and syringes exchange programs in penal institutions along with substitution treatment [3].

4 Examples of harm reduction policy measures

This review specifies the most commonly applied, experience based, illegal drug related harm reduction policy measures, which are currently applied in European countries, with special emphasis on programs providing needles and syringes and methadone substitution therapy, as the most common programs administered. Comprehensiveness and exhaustive list of all existing measures is not the aim, but rather, a review of key harm reduction measures, in relation to the type of substance that caused the addiction.[1]

4.1. Opiates

4.1.1. Risk and harmful consequences

Individual negative effects of illegal opiates include: decreased willing dynamisms and capacity to perform complex tasks, respiratory inhibition, serious consequences for the cardiovascular system in the case of high doses, gastro-intestinal inhibition, paralysis of muscle function. The symptoms of apstinential crysis are very disabling and represent a strong incentive for continued use. Physical dependence on substances from the group of opiates is extremely strong, and the price on the black market high, which leads most users to financial instability to poverty and social marginalization as a final outcome, encouraging involvement in criminal activities aimed at the acquisition of funds for the procurement of the necessary daily dose. Beside addiction, uncontrolled use of opiates has other direct health effects, such as risk of overdose and death, but also indirect adverse consequences for other people (as when driving or performing other complex tasks in a state of intoxication). In addition, injecting use of opiates, sharing and reuse of needles, syringes and other equipment for preparation of the injecting substance among PUDs puts them at an increased risk of rapid transmission of blood-borne infections such as HIV, hepatitis B and C. This is the main source of adverse consequences not only for the individual,

1 It should be noted that the principle of harm reduction is also used for so called legal drugs-tobaco and alchocol, but the description of these measures exceeds the purpose of this document.

but also for the society as a whole, given that many of the diseases that are transmitted among persons who inject drugs are chronic and infectious, and carry a high degree of morbidity and mortality. Widespread epidemic of chronic blood-borne diseases among people who inject drugs produces a very heavy disease burden in the general population, causing long-term high costs of health care.

4.1.2. Harm reduction measures

The most commonly applied opiate use related harm reduction measures are: opioid substitution treatment (OST) needles and syringes provision program for persons who inject drugs (NSP) in combination with measures of information and education (INF / EDU), health promotion (HEP), outreach work and motivational activities (OUT / MOT). There is a big number of evidences that these measures are effective when applied appropriately. **The strongest evidence shows that OST and NSP are the key elements of opiate use related harm reduction measures, and can not be omitted or replaced without loosing the effectiveness of harm reduction program. Evidences also show that the best results are achieved by the synergistic effect of the combination of these measures.**

4.1.2.1. Needles and syringes exchange programs

These programs imply provision of free and legal access to clean equipment for injecting drugs, including a sufficient amount of sterile needles and syringes. The importance of these programs comes from the fact that the main risk factor for acquiring blood-borne disease is sharing needles, syringes and other equipment for preparing and injecting drugs. Even among PUDs who report that they have never shared needles and syringes is a common thing to share drug preparation equipment such as drug mixing bowl, dissolving water or filters, which also can lead to the transmission of hepatitis C or bacterial infections. Also, there are evidence that persons who inject drugs are troubled by skin, vein and blood infections due to non-sterile injection practices. There are reports on increasing injection of drugs that are on prescription, where these drugs' pills are crushed into powder, which increases the risk of pulmonary embolism and endocarditis. It turned out that some homemade acidifiers, used to dissolve certain drugs, contained fungus that, when injected, can cause a heart infection endocarditis or infection of the eyes that can lead to blindness called fungal endophthalmitis.

Based on the existing evidence, expert opinion and safe injection practices, the way to make the spread of HIV and HCV among people who inject drugs minimal is to provide sterile needles and syringes as well as other clean equipment (spoons/ cookers, filters, water for injection,

acidifiers, and dry and alcohol cotton wool swabs) for each injection and in sufficient quantities. The ideal would be to make such services free and organized in an acceptable and easily accessible way for PUDs.

There are evidences provided from the systematic review of various literatures that providing needles and syringes leads to significant reductions in self-reported risky behavior during injection. Also, there is evidence that these programs can reduce the prevalence of HIV, while due to methodological limitations it is difficult to make final conclusions about the link between the provision of equipment for the preparation of drugs, such as containers for mixing drugs, sterile water and cotton wool filters and reduction of HCV or HIV. However, HCV could be isolated from 67% of cotton sticks, 40% filter 33% of water samples and 25% of spoons that were used by HIV positive individuals to prepare drugs for injection. All of this clearly speaks in favor of the justification and the need to apply this harm reduction measure. There is also evidence that the distribution of such equipment reduces injecting risky behavior and acts as an incentive to attract and retain clients to services. Sterile needles and syringes, as well as clean injection equipment should be provided along with health promotional messages on services for drug addiction treatment and pieces of information about the warning signs of infection in the soft tissue or skin [2, 3].

4.1.2.2. Opiates substitution therapy

Pharmacological maintenance therapy for opiate dependence is consisted of prolonged use of prescribed opiate drugs, which relieves withdrawal symptoms and reduces the craving, which enables the user to lead a more stable life, to reduce illegal heroin use, risky behavior and criminal activity, but also improve the health, well-being and quality of life. Opiate agonists may also be used for detoxification treatment, which should, however, be integrated with other treatment options, and not to be provided as a standalone service in order to avoid high rates of recurrence.

Methadone maintenance treatment has been developed in the United States in the sixties of the 20th century, but its introduction into clinical practice in Europe increased only since the mid-80s. Today, in European countries are using: methadone and buprenorphine, dihydrocodeine, slow release morphine and diacetylmorphine. Following the adoption of comprehensive drug policies in the EU, the provision of opioid substitution treatment from the mid-90s accelerated and now reaches more than half of the estimated target population. The share of buprenorphine use in the opioid substitution treatment in Europe is lower than the share of methadone use, but is on the rise, partly due to its better safety profile. Buprenorphine is a partial agonist, has weaker opioid effects and causes a lower level of physical

dependence, and is less likely to result in an overdose.

There is a significant amount of evidence regarding the effectiveness of OST in the treatment of addiction to heroin and other opioids, reducing infection rates and self-reported prevalence and frequency of injecting and injecting risky behavior. The evidence shows that OST is effective in reducing HIV seroconversion, especially among those who are on continuous treatment and when administered in adequate doses. Recent data, including cohort studies of hepatitis C incidence among clients in the OST which were carried out in the community, together with meta-analysis of studies conducted in the UK, indicate a strong positive impact of OST on HCV infection prevention. These studies indicate a greater benefit among those on continuous OST compared to those with interrupted OST; protective effect of methadone maintenance treatment in respect to the primary and secondary infection by HIV and HCV; and "dose-response" effect of OST, where those who are longer in treatment have lower rates of incidence of HCV. The effectiveness of OST-a can be improved when they are psychosocial intervention sprovided [2].

Based on consistent evidence from multiple robust studies and articles, as well as expert opinions, opioid substitution therapy for the treatment of opiate addiction should be available and easily accessible.

Findings of experimental and observational studies on OST in prison show that benefits of maintenance therapy in prison are similar to those achieved in the community. The availability of such treatment in prisons is an opportunity to reduce illegal opioid use and risky behaviors in prisons. Good links between programs in prisons and community programs is important to enable the continuity of the treatment (after the encarceration / upon-release) in order to achieve long-term benefits and prevent high risk of harm, including death, in the period immediately after release.

4.2. Cocaine, crack and amphetamines

Cocaine, crack and amphetamines (such as methamphetamine and other amphetamine derivatives) are stimulant drugs that are used in a variety of ways, including injection, inhalation, sniffing and swallowing.

4.2.1. Risk and harmful consequences

The use of these substances can lead to addiction and serious mental and physical problems: overdose, infectious diseases (associated with injecting), cardiovascular, pulmonary, neurological and psychiatric disorders (depression, paranoia, panic attacks). In addition to health

consequences, problematic use of cocaine and amphetamines is often associated with rapid worsening of a social situation, poverty, job loss, lack of regular income, etc. Frequent use of amphetamines, also causes loss of memory abilities, attention and generally reduced ability to function. The use of stimulant drug increases sexual libido and as a result of increased sexual activity and unprotected sex with different partners can cause an increased number of sexually transmitted infections in the population of PUDs, unplanned pregnancies and abortions, as well as increased rate of contracting HIV infection. The existence of STIs, such as genital herpes or syphilis, significantly increases the risk of HIV transmission through sexual intercourse.

4.2.2. Harm reduction measures

For persons who use cocaine and amphetamine there are no pharmacological approaches based on the substitution of the substance, as it is the case in persons who use opiates, since there is no safe and efficient substitution substance. Since cocaine, particularly amphetamines, are also injectied, the risk of transmission of infectious diseases is similar to the one found in persons who use opiates and can be reduced by providing check points for syringes and needles distribution. For persons who inject, both opiates and stimulant drugs, it is necessary to ensure that services are following a low-threshold approach, that detoxification and treatment of pathologies associated with drug addiction is being provided, to have access to adequate accompanying psychological assistance and that the functioning of services offering emergency medical assistance is being provided in case of overdose.

However, injecting is not the only way of taking the drug which carries the risk of infectious diseases. Common use of equipment for sniffing (slug, etc.) represents a risk for transmission of hepatitis C among PUDs, given the fact that the walls of the nasal cavity or lips are often cracked with regular PUDs, and hepatitis C is highly virulent in contact with the air. For persons who use crack, in some countries, there are programs of consumating equipment distribution. However, it is necessary to continue to design specific harm reduction programs for persons who use stimulant drugs and evaluation of existing measures, such as mobile teams for risk reduction, pharmacological testing of drugs (known as “testing the pill”), etc. The most likely starting point for reaching the target population are the needles and syringes exchange points, outreach work and mobile teams to provide emergency medical assistance.

In order to reduce the adverse neurological consequences, the most commonly applied strategy is to reduce the frequency of consumption and dose, thus decreasing the risk of cardiovascular disorders. The approach

of supplementing the use of these substances with food, vitamins, and antidepressants for which there are medical indications is often applied. It is very difficult to find adequate measures to reduce the effects on the respiratory system and lungs, due to specific effects of these substances on the lung tissue. Measures related to the problem of mental health are mainly focused on the provision of services with a low threshold access, including secured facilities that provide a peaceful environment i.e. rooms for daily rest. Often these services are the first point of contact and the first step towards programs aimed at achieving abstinence [2, 3].

4.3. Ecstasy and other synthetic stimulants

Ecstasy is a stimulant drug which is mainly used recreationally by young people, often in conjunction with specific lifestyle.

4.3.1. Risks and harmful consequences

The use of ecstasy is associated with a high risk of dehydration, loss of consciousness, accidental injuries due to behavior caused by the influence of drug, and even death.

4.3.2. Harm reduction measures

In all European countries guidelines for safer nightlife are distributed in order to reduce the risk associated with the use of ecstasy. They are propagating provision of free water in clubs in order to prevent dehydration, the availability of first aid service in places where the drug is consumed, interventions conducted by outreach workers and volunteers, dissemination of information materials specific to the target group and the context of use of these substances. Furthermore, useful is the education of nightclubs' owners and staff on measures of safe nightlife. In addition, one of the measures to reduce the risk and harm that implies that at rave parties there is a cooling provided in the room or special space designated for this purpose. Brief interventions based on the method of motivational interviews carried out by outreach workers and trained volunteers can contribute to responsible behavior of ecstasy users The Measure of pharmacological analysis of the substance, which includes a complete analysis of the ecstasy ingredients, is expensive and time consuming and represents a harm reduction measure which can distract the attention from the final consequences like overdose, coma and collapse. On the other hand, there is a partial analysis, which is faster and more targeted to confirm the presence of MDMA in a pill, but without identifying the other present and potentially hazardous products.

However, this intervention is banned in some European countries because it is seen as encouraging to the use of illegal drugs.The use of ecstasy has been largely associated with certain lifestyles, night outs and visits to clubs, parties, etc. that follow this way of life. In order to reach the target population, it is essential that appropriate harm reduction measures are provided in a specific context, time and place of the events and adapted to the activities of people who consume this drug [2, 3].

4.4. Canabis

4.4.1. Risks and harmful consequences

The use of cannabis carries an increased risk of respiratory diseases, which is even enhanced when smoking cannabis with tobacco. Driving under the influence of cannabis increases the risk of traffic accidents. A correlation of cannabis and alcohol while driving significantly increases the risk. Scientific evidences show that cannabis impairs cognitive and behavioral capacities of PUDs, hence the ability to drive as well as motivation and concentration and the level of damage depends on the dose. In addition, it was found that regular use can cause addiction to cannabis, and that has a negative effect on psychological development, while some studies show that it can even pose a trigger for psychosis in predisposed individuals [2, 3].

4.4.2. Harm reduction measures

For persons who use cocaine and amphetamine there are no pharmacological approaches based on the substitution of the substance, as it is the case in persons who use opiates, since there is no safe and efficient substitution substance. Since cocaine, particularly amphetamines, are also injectied, the risk of transmission of infectious diseases is similar to the one found in persons who use opiates and can be reduced by providing check points for syringes and needles distribution. For persons who inject, both opiates and stimulant drugs, it is necessary to ensure that services are following a low-threshold approach, that detoxification and treatment of pathologies associated with drug addiction is being provided, to have access to adequate accompanying psychological assistance and that the functioning of services offering emergency medical assistance is being provided in case of overdose.

However, injecting is not the only way of taking the drug which carries the risk of infectious diseases. Common use of equipment for sniffing (slug, etc.) represents a risk for transmission of hepatitis C among PUDs, given the fact that

the walls of the nasal cavity or lips are often cracked with regular PUDs, and hepatitis C is highly virulent in contact with the air. For persons who use crack, in some countries, there are programs of consumating equipment distribution. However, it is necessary to continue to design specific harm reduction programs for persons who use stimulant drugs and evaluation of existing measures, such as mobile teams for risk reduction, pharmacological testing of drugs (known as "testing the pill"), etc. The most likely starting point for reaching the target population are the needles and syringes exchange points, outreach work and mobile teams to provide emergency medical assistance.

In order to reduce the adverse neurological consequences, the most commonly applied strategy is to reduce the frequency of consumption and dose, thus decreasing the risk of cardiovascular disorders. The approach of supplementing the use of these substances with food, vitamins, and antidepressants for which there are medical indications is often applied. It is very difficult to find adequate measures to reduce the effects on the respiratory system and lungs, due to specific effects of these substances on the lung tissue. Measures related to the problem of mental health are mainly focused on the provision of services with a low threshold access, including secured facilities that provide a peaceful environment i.e. rooms for daily rest. Often these services are the first point of contact and the first step towards programs aimed at achieving abstinence [2, 3].

5 The background of the problem and reasons for harm reduction existence

According to the joint assessment of UNODC / WHO / UNAIDS / World Bank, the world contains about 246 million people, or 1 in 20 people aged 15 to 64, that used illegal drugs in 2013. Among them there is about 27 million, or more than one out of 10 "problematic drug user" - who suffers from addictions or disorders associated with drug use. Almost half of the "problematic" drug users (12.19 million) injects drugs, which makes the 0,26% of the world's population aged 15 to 64 years [13]. Consumers who use opiates, mainly heroin as the primary drug, make up 41% of all drug consumers' population who in 2013 entered the specialized treatment programs in Europe (175 000 users) and approximately 20% of first-timers in starting treatment (31 000 beneficiaries) [14].

People who inject drugs are under increased risk of contracting the following infections: HIV, Hepatitis A, Hepatitis B, Hepatitis C, Hepatitis D, tuberculosis infections, skin and soft tissue infections caused by staphylococcus aureus and streptococcus infections (e.g., endocarditis, necrotizing fasciitis), heavy systemic sepsis, other sexually transmitted infections (eg, chlamydia, syphilis and gonorrhea), respiratory infections such as pneumonia, diphtheria and influenza, wound botulism, tetanus, infection of human T-cell lymphotropic virus [12].

According to WHO data, on a global level and since the beginning of the HIV epidemic, almost 78 million people were infected with the HIV virus, while 39 million have died. At the end of 2014 there was approximately 36.9 million people living with HIV in the world, and about 2 million new cases of infection, which is an estimated 0.8% of people aged 15 to 49 years. In the period between 2000 and 2015, the number of new HIV infections cases has declined by 35% thanks to the establishment of a variety of evidence-based services for population groups that are most at risk of acquiring the infection. There are approximately 130-150 million people in the world infected with chronic hepatitis C virus, while on an annual basis, around half a million of infected die from diseases caused by this virus. According to estimates, 240 million people are chronically infected with hepatitis B, while more than 780,000 of infected dies every year due to complications of this disease, including cirrhosis and liver cancer [15].

The main mechanism of transmission of these infections is injection equipment sharing among persons who use drugs, but there is also the sexual intercourse transmission within the population of persons who inject drugs as well as from current or former persons who inject drugs to their sexual partners

or clients. Although all three viral infections are easily transmitted through sharing of the equipment used for injecting drugs, the risks of transmission vary. Compared with HIV, hepatitis C is characterized by a relatively high concentration of virus in the blood, not only during the primary phase of infection, but also in those who become chronically infected. It is believed that this leads to high rates of transmission after exposure to HCV when infected and uninfected individuals share needles, syringes and other equipment for drugs preparation. Greater risk of transmission, could also explain why hepatitis C is more difficult to limit by applying only one of the interventions in the field of harm reduction, and why would we need greater interventions' coverage for decreasing Hepatitis C rates on a population's level. [12]. According to the joint assessment of UNODC / WHO / UNAIDS / World Bank injecting drug use are responsible for 30 percent of new HIV cases. In 2013 among persons who inject drugs there was an estimated 1.65 million living with HIV / AIDS, which would correspond to the assessment that 13.5 percent of people who inject drugs are actually HIV positive. Moreover, in the Eastern and Southeastern Europe estimated prevalence of HIV among PWID is 23%, while it is projected that more than a half of these persons is living with hepatitis C [16]. This represents an enormous burden on the public health systems in terms of prevention and treatment of disorders associated with the use of drugs and their health consequences. 2011 brought the Political Declaration on HIV / AIDS, which has set a goal of reducing HIV transmission among persons who inject drugs by 50% by 2015 [17].

Transmission of infectious diseases and overdose related deaths are just some of the risk factors that make the mortality rate among people who inject drugs almost 15 times higher than it would be expected among people of the same age and gender in the general population. Globally, the annual death rate due to drug use is an estimated 187,100 cases in 2013, mainly among young people aged between 20 and 30 years who were taking opiates by injecting. In addition, frequent and simultaneous is the use of several drugs, especially heroin in combination with other central nervous system depressants. It is estimated that in Europe each year about 2% of people who inject heroin dies, which is 6 to 20 times higher rate when compared to the same age persons who do not inject drugs. In people who regularly injected heroin, half of these deaths were overdose related. On average, a heroin user who overdosed had previously experienced overdose at least three times. Immediate death occurs in about 15% of cases of overdose. 80% of those who have survived a heroin overdose in the previous six months are not considered to be at an increased risk of repeated overdose [18, 19, 20]. The risk of death from opiates overdose is significantly reduced among users of methadone maintenance program, and more interventions are being implemented that actively involve persons who use drugs themselves in overdose prevention which enable them to provide assistance in overdose attended [21].

6 Review of the situation in Montenegro

6.1. Epidemiological data

According to data from the register for HIV / AIDS since the beginning of the epidemic in 1989 until the end of 2014, total of 175 persons infected with HIV have been registered in Montenegro, while during the same period, 41 person died of AIDS. The largest number of HIV infections has been diagnosed between 20 and 39 years of age (77%). The largest number of infections (91%) was discovered at the lifetime belonging to the working and reproductive age from 15 to 49 years. There are registered HIV / AIDS cases in 15 out of 21 municipality in Montenegro. The highest numbers were registered in the coastal region (40%) and Podgorica (41%). The leading way of transmission is through sexual intercourse (85%). This is the most common way of transmission since the beginning of the epidemic and the trend keeps growing. Unlike sexual intercourse transmission, blood transmitted HIV infection, whether it regards persons who inject drugs or people who received infected blood transfusion in health care institutions, remains fairly rare. 4% of people registered with HIV got infected via blood. 1% out of these cases occurred throughout infected blood or its derivatives in medical institutions (outside of Montenegro) *while 3% were a result of intravenous drug use.*

Bio-behavioral survey among persons who inject drugs[2] (conducted in 2008, 2011 and 2013) provided the ability to determine the behavior of adult PWIDs in Montenegro, following changes in risky behavior and prevalence of HIV, Hepatitis B and C in this population. The prevalence of HIV in PWIDss tested sample amounted 1.1% in a reserach implemented in 2013, while in 2011 amounted to 0.3% and 0.4% in 2008. The prevalence of hepatitis B i.e. HBsAg is very low - 1.4%, as in previous studies, while the prevalence of hepatitis C is very high - 53%, and slightly changed compared to 2011 and 2008 when it amounted to 53.6% and 55% . The high prevalence of HCV infection indicates that, at least in the past, there was a significant degree of risky behavior in the population of persons who inject drugs. The level of information among PWIDs about the ways of HIV transmission and prevention of HIV infection has improved, but is still insufficient, and along with the identified risky behavior, makes this population vulnerable to the spread of HIV infection. The research showed that targeted prevention programs have a definite positive impact on the prevention of blood-borne infections' spread in the population but further

2 *Hereinafter PWIDs*

progress needs more investment. The research confirmed the importance of harm reduction services that operate within the NGO sector, ie. drop-in centers and outreach work. According to the findings, in the last 12 months, 99.9% of adults who inject drugs had access to sterile equipment for injecting drugs, 61.5% through NGOs, 1.1% got it in pharmacies, 17.9% in health centers and 11.7% from friends. Furthermore, PWIDs reported to receive pieces of information about HIV/AIDS in the NGOs drop in centers (43.3%) on the Internet (32.5%) through outreach workers of NGOs (2.6%), VCT centers, primary health centers (6.2%) and pharmacies (1.1%). Free condoms are available in NGO's drop in centers (50.6%), in outreach work of NGOs (6%), in health centers and VCT centers (5.3%) and pharmacies (14.5%).

The research among prisoners confirmed that the HIV epidemic in this population in Montenegro belongs to the low level of the epidemics (among respondents a single case of HIV infection hasn't been detected), Hepatitis B virus infection was found in 3 participants, and the presence of HCV has been determined in 20.1% of respondents. The study confirmed that prisoners have a significant degree of behavior which is associated with the risk of HIV infection, hepatitis B and C, as well as that the knowledge on the HIV infection is not sufficient.

In 2014, another research has been conducted among the population of men who have sex with men. The result of this study showed HIV infection detected in 12.5% of the respondents (the study conducted in 2011 showed HIV infection detected in 4.5% of respondents). Such HIV prevalence is consistent with the fact that over the past few years most people registered with HIV belong to this population which crossed the border of concentrated epidemics. However, the results of this study, which is based on the "snowball" sampling method, must be taken with a grain of salt, due to the fact that this method can not provide a fully representative sample of respondents based on which one could obtain information that would be representative of the entire population of men who have sex with men. However, these studies provided baseline information for understanding the situation in relation to HIV infection in MSM population (it was confirmed that the knowledge about the ways of transmission and prevention of HIV infection is not sufficient, that the prevalence of risky sexual behavior is noteworthy and that there is a significant need for a greater use of anonymous testing and counseling in relation to HIV and other STIs). The results of the study conducted in 2013 among *sailors* indicate that the prevalence of HIV in this population is at a low level and amounting 0.06% (in the research conducted in 2008, HIV prevalence among sailors stood at 1.5%).

In 2013, the first bio-behavioral research was conducted in the population of *young Roma and Ashkali (RA)*. The survey obtained socio-demographic and behavioral characteristics, based on which targeted programs of prevention and infection control in this population could be

developed. Among respondents not a single case of HIV infection was detected.

Maintaining low HIV prevalence among registered sex workers (HIV prevalence stood at 0.8% in a survey conducted in 2008, 1.1% in the 2010 survey and 0% in the study from 2012), but the HIV epidemic among sex workers in Montenegro corresponds to the type of epidemic of a low intensity. The study found that the prevalence of drug use, as well as the prevalence of risky sexual behavior in that population, is still significantly high [22].

As far as estimates of the size of the population that uses drugs is concerned, it takes a lot of investment and research in order to reach an objective, science-based assessment. The data on the number and characteristics of persons who use drugs that seek treatment in health institutions are not yet complete and reliable, although the registry of demand for treatment was established in 2013. Even though the reporting is obligated by the law, in practice this is not enforced. As an institution in charge of contorling the register, Institute of Public Health took up intensive work on educating health workers on the need and purpose of reporting the data in the register, with the aim of fixing the dynamics and quality of reporting. It is expected that health care institutions will submit all requests for 2013 by the end of the current year. However, it should be clarified that this register contains "only" the data on PUDs that appear for assistance in the health system institutions, with the exception of private institutions and institutions of social protection. It is, therefore, necessary to conduct further research and methodologicaly demanding analysis to arrive at a valid and scientifically based estimate of the total number of PUDs in the country, starting from the research indicating the level of drug use in the general population. Until then, the available data come from the health care information system, according to which in 2014 Montenegrin health facilities treated 675 PUDs (not taking into account the so-called "legal drugs" - tobacco and alcohol). About 86% of them turned to the institutions due to being in need for opiate addiction treatment, while other drugs are significantly less represented in demand for treatment in medical institutions. These data can not provide the percentage of users who take drugs by injecting. The only information on the estimated number of PWIDs in Montenegro were obtained within the study on the assessment of population of persons who inject drugs size in Montenegro carried out by the Institute of Public Health in collaboration with Dr. Ivana Božičević from the School of Public Health "Andrija Štampar" in Zagreb in 2012, according to which the number of PWIDs in Podgorica is 1282 (0.7% of the total population) [23].

6.2. Programs and activities in the domain of harm reduction in Montenegro

Harm reduction approach is supported by the "Strategy of Montenegro for the Prevention of Drug Abuse 2013 - 2020 [4], but there exists no unique national doctrine, or protocol that regulates this area [23]. The most important harm reduction services have been established in the state- centers for opiate substitutive therapy and daily (drop in) centers for PWIDs as well as outreach work in populations that are most at risk of contracting and transmiting infectious diseases such as HIV, Hepatitis B and C. However, although the established services on multiple occasions justified and confirmed the necessity of their existence throughout high coverage level as well as the level and type of services they offer, ending the nine-year grant program of the Global Fund for Fight against AIDS, Tuberculosis and Malaria in July 2015, put a big question mark on their sustainability and at this point the services are facing closure. This especially applies to drop in centers that function within the NGO sector. To be exact, for the two drop in centers opened by NGO Cazas in Podgorica and Bar there was no support from the state budget, while the NGO Juventas' Drop in Center in Podgorica has its costs partially covered from the state budget through the Ministry of finances' Fund for the distribution of revenues from games on chance while the largest part of the support was provided from the donation of the Global Fund.

It is necessary to point out that without these services, access to harm reduction in the state can not be complete or effective. In order for the established services to be sustained and developed according to the growing needs, *it is necessary to permanently ensure their viability and sustainability.* Comparing the data on the costs of prevention services for most at risk populations in terms of HIV and other infectious diseases leads to the conclusion that these services are highly needed. Preventive services cost 6 to 8 euros per person per month, while for the treatment of HIV infection it is required to single out from 1200 to 1500 €, and for the Hepatitis C treatment from 1500 to 2000 € per person per month.

The existing harm reduction programs in Montenegro include programs of opiate substitution with methadone, sterile injection equipment exchange programs within the drop-in centers, and other risk prevention programs that include the distribution of condoms and lubricants.

6.2.1. Opioid supstitution therapy program (OST)

The program of methadone detoxification, substitution and maintenance was introduced in 2005 in Montenegro, when the first methadone center was opened in the primary health care center in Podgorica. This was followed by opening of these centers in the primary health care centers in Kotor, Berane, Bar, Niksic and Pljevlja (which is not yet operational). By the end of 2014, the total of 548 patients underwent the methadone program. In order to better understand the dynamics of work and monthly capacities required, we emphasize the information that for example in November 2014, the methadone centers had 155 patients. Since April 2013, methadone has been provided by the Health Insurance Fund. The criteria for admission into the program vary depending on the type of treatment (detoxification or maintenance), as well as on the availability of methadone centers. Centers with no waiting lists could adopt more lenient criteria, in comparison to places where the demand for the treatment possibilities is higher than their offer. In order to achieve a unified working practice of methadone centers in Montenegro, Podgorica Primary Health Care center produced a Guide for the application of methadone for opiate addicts.

Although there are centers for opiate substitution treatment in Montenegro, there is still no official legal framework for the implementation of this type of treatment [23]

Methadone program patient that were sent to prison have the possibility to continue methadone therapy while serving a prison sentence in the Institute for the Execution of Criminal Sanctions in Podgorica and Bijelo Polje (17 users at the end of 2014 in Bijelo Polje and 12 users in Podgorica).

Buprenorphine substitution has not yet been introduced into regular practice in all centers for substitution therapy. Given that the introduction of this type of substitution is unquestionably necessary and supported by the strategic documents, it is necessary to develop and adopt protocol of the substitution therapy with buprenorphine, which will include penal institutions.

6.2.2. Needles and syringes exchange programs (NSP)

The first needles and syringes exchange program was introduced in 2004 as a part of the Primary Health Care Center in Podgorica, having 13 injection points. The program included needles and syringes exchange, i.e. users were encouraged to return used needles and syringes in order to get new ones. Later on, these programs have been extended to the NGO sector, now conducted through outreach work and the work of daily

(drop in) centers run by NGOs Cazas (in Podgorica and Bar), and Juventas (Podgorica). In addition to the replacement of sterile injection equipment, these centers also provide other services - preventive education, information and counseliing on a variety of topics (STI, HIV / AIDS, hepatitis B and C, condom use, drug use, treatment of addiction, safe injection, methadone maintenance, overdose, stigma, social support), basic medical care, distribution of condoms, psychosocial support, referral to health and social protection institutions with an emphasis on institutions for treatment and rehabilitation. *Annual coverage is about 1500 people.*

Preventive program for sex workers, coordinated by the NGO Juventas consist of outreach work and work of the daily (drop in) center. In addition to the outreach work and the exchange of sterile injecting equipment, clients are provided with condoms and lubricants, medical counselling and treatment of injuries caused by injection (abscesses, failures, wounds), referrals to services of health and social care in the community, assistance in undergoing addiction treatment or treatment of sexually transmitted or blood born infections, individual, group and family counseling with a psychologist / psychiatrist, counseling with a social worker, legal aid, education and information. *Annual coverage is about 200 persons.*

There are still no programs of needles and syringes exchange outside the territory of the capital city. In addition, although the national strategy for drugs recognized harm reduction services provided by NGOs, they are not yet legalized in Montenegro and the very operation of these services requires a special permit from the police and the state prosecutor. This is a very difficult circumstance for the service providers, given that all activities must be announced to the police and the state prosecutor some time in advance. On the other hand, despite these announcements an often encountered situation implies mobile teams on the ground being watched by the local police units. Frequent changes in governmental structures at the national and local level make the process of outreach work more difficult [23].

6.2.3. Prevention programs for decreasing the risk of HIV and other STIs transmission in specific populations

Several preventive programs implemented within the NGO sector are aiming at reducing the risk of HIV and other infectious diseases transmission in specific populations. Prevention programs targeting MSM (men who have sex with men) is coordinated by the NGO Juventas. The program is implemented through the provision of services in the field, but also in the Counseling center for LGBT people. Services include individual counseling about STIs, protection, testing for HIV and other STI, distribution

of condoms and lubricants, distribution of informational and educational materials, referrals to health services, implementation of field researches, advisory, consultative and educational services of a doctor/ psychologist/ peers. Annual coverage is about 450 people.

Preventive-educational programs among the RE population are coordinated by the NGO Cazas.

The program is consisted of outreach work, peer counseling, condoms, lubricants and informational materials distribution. *Annual coverage is about 1500 people.*

The program of prevention of HIV/AIDS and other sexually transmitted infections among sailors has been implemented in Montenegro since 2003 by the NGO Protection from Bar, when the Counseling center for seamen was founded. Activities incorporate providing information on HIV/ AIDS and other sexually transmitted diseases, distribution of informational and educational materials and condoms. *Annual coverage is about 900 people.*

The program of prevention of blood boorne infections and harm reduction promotion in the population of prisoners and young people in conflict with the law has been executed since 2004, by the NGO Juventas. The program is based on a free will and consisted of intensive group trainings and individual counseling sessions, which are held at least once a week and more often if necessary. Consultations are mostly related to the following topics: HIV / AIDS, Hepatitis A, B and C, condom use, drug use, addiction treatment, safe injecting, overdose, stigma and discrimination, as well as social support. This program instigated campaigns for the improvement of prisoners' rights, particularly in relation to health care. *Annual coverage is about 250 people* [23].

There are no specific national or local overdose prevention programs in Montenegro, with the exception of existing methadone maintenance programs which can be viewed in this context, as the risk of mortality due to opiates overdose is significantly reduced among users of the afore mentioned program. There is no adequate data on mortality due to overdose, because in most of these cases the cause of death reported is the condition or the cause associated with overdose, but not the overdose itself. Overdose, as such, can be classified only after the identification through an autopsy. This significantly underestimates the problem of overdose in the population of people who inject drugs, and therefore its importance remains neglected for future policy and public-health interventions in the area of reducing the harmful consequences of drug use. [23]

7 Conslusions and reccommendations

A whole set of measures based on scientific evidence and designed to reduce the risk of damage caused by the use of psychoactive substances has been implemented in Europe and the world for a long time now. Such interventions exist even in the domain of so-called "legal drugs" - alcohol and tobacco. There is a general trend in force that this concept is applied to all psychoactive substances and in respect to any given addictive behavior, so that the increasing importance is being given to the development of measures to reduce the risks and damages due to dependence on the Internet, video games and gambling. In addition, after initial skepticism and resentment, the concept of harm reduction is becoming increasingly more important in the strategies and activities of the law enforcement to reduce the supply of drugs, which deserves significant attention, research and evaluation, and recognition on a wider scale.

Patterns of psychoactive substances use that are rapidly changing, new psychoactive substances that appear, as well as changing behaviour patterns, determine to a large extent if any adverse effects occur. Only an objective approach that looks to the future, uses the human rights perspective and recognizes the dynamics of changes in the psychoactive substances use, will be able to face the problem in an efficient, cost-effective and sustainable way.

The current practice of risky behavior in relation to ways of drug use in Montenegro is relatively favorable. Such a situation can be attributed to the fact that sterile injecting equipment is available to the largest number of adult PWID through the services of drop in centers ran by NGOs, outreach activities, and liberalization of sterile equipment purchase in pharmacies. However, in a situation of the ongoing financial crisis, and the end of support from the Global Fund to Fight AIDS, Tuberculosis and Malaria the issue of sustainability of these programs is a major challenge. Results obtained through three surveys in the population of PWID in Montenegro clearly demonstrated that the existence of such programs has a very favorable impact on the prevention of blood-borne infections spread, therefore significant savings in the health sector and the country in general. All of this points to the necessity to, despite the crisis, come up with ways to keep needles and syringes exchange programs alive and continue to develop [24].

The same conclusion is imposed for the centers for methadone substitution therapy that have been established in 5 municipalities in Montenegro a decade after the opening of the first one. However, most

of these centers have long waiting lists for admission of new patients, indicating the need for the expansion of this program i.e. harm reduction. The introduction of buprenorphine use as substitution opioid treatment will represent a new challenge for the health care institutions, as well as devising interventions in the prevention of risk and harms caused by the use of other drugs - cannabis, cocaine, crack cocaine, amphetamines, ecstasy and other synthetic stimulants.

Note: Part of the recommendations is taken from an unpublished report of NGOs Juventas and SOS Phone for Women and Children Victims of Violence - Analysis of the National Strategic Response to HIV implementation effects.

7.1. General recommendations

Recommendation: *It is necessary to provide a stable source of funding for programs and activities arising from strategic documents dealing with drug related harm reduction and prevention of HIV and other infections.*

Recommendation: *Develop and adopt bylaws regulating the programs and activities in the field of harm reduction, due to the fact that this area is not clearly regulated by the existing legislation in Montenegro.*

Recommendation: *Establish and provide adequate and continuous work of the National Commission on Drugs, which will be made up of professionals in the field of prevention, treatment and rehabilitation of persons who use drugs, and professionals in the field of data collection and research in the field of drug use.*

Recommendation: *Expand the coverage of existing harm reduction programs, both at local and national level (national geographical coverage).*

Recommendation: *Encourage and facilitate the design and implementation of evidence-based measures to reduce the harm related to use of other drugs, or drugs that are not injected, which are increasingly present among young people, such as cannabis, cocaine, crack and amphetamines, ecstasy and other synthetic stimulants, as well as "legal drugs", alcohol (eg. the program of a "designated driver" for young people who go out to places where alcohol is consumed, guidelines for safer nightlife for young people at risk of using synthetic drugs, etc.).*

Recommendation: *Introduce a program of detox for people who use drugs upon arrival to serving of a sentence in the Institute for the execution of criminal sanctions.*

Recommendation: *Introduce the program of treatment for people who use drugs and who are located in the Institute for Execution of Criminal Sanctions, medical therapy, which is in line with national guidelines on the treatment of addiction.*

7.2. Opioid supstitution treatment

Recommendation: Define a unique position on the use and mode of the implementation of substitution therapy with buprenorphine (Ministry of Health, Mental Health Commission, the Commission on Drugs, once established, Section of psychiatrists of Montenegro etc.) and make a protocol and application guide in order to create conditions for initiation of this type of substitution, in accordance with the national strategic documents.

Recommendation: Develop a specific protocol and application guidelines for opioid substitution treatment with methadone and buprenorphine in pregnant women and women that gave birth.

Recommendation: *Develop and adopt a bylaws which defines the cooperation between the Ministry of Health and the Institute for the Execution of Criminal Sanctions, regarding the opioid substitution treatment for persons who use drugs.*

Recommendation: Provide timely and adequate planning of needs and continuous supply of methadone and buprenorphine.

Recommendation: Urgently expand the existing capacities for opioid substitution treatment in Podgorica in accordance with the number and needs of PUDs, while keeping in mind that in Podgorica, lives more than a third of the total population of Montenegro.

Recommendation: Encourage cooperation and communication between the centers for substitution therapy with continuous strengthening of capacities of professional staff throughout formal and informal education.

Recommendation: Enable the establishment of methadone substitution treatment in prison conditions and unhindered continuation/ initiation of treatment for all prisoners in accordance with the indications, including the persons who prior to serving the prison sentence were not in possession of health insurance.(Note: Currently, OST is available only for prisoners who have started treatmen in community, prior to entering prison.)

Recommendation: Given the fact that minors who use drugs in the current situation can not use the services of harm reduction, whilst there is an evident growing need for increasing the availability of appropriate HR services to this population, it is necessary to:

- *define the lower age limits for certain types of treatment (detox, substitution with buprenorphine), in preparing the legal and technical framework for the implementation of OST programs, with regard to the current legal age which is applied in practice of the existing methadone programs.*

7.3. NSP

Recommendation: It is necessary that the relevant bodies immediately take responsibility for meeting the objectives of strategic documents that recognized harm reduction services as an integral part of providing services to PUDs and groups that are at increased risk of transmission of infectious diseases such as HIV / AIDS, Hepatitis C and B, and so on. To this end, current urgent priority is achieving lasting sustainability of drop in centers and outreach work with PUDs. Some possible solutions are the following:

- *provision of free space or spaces that will be rented at a symbolic monthly sum for the work of drop in centers from the municipalities where the centers are located;*
- *introducing amendments into the legal framework concerning health care, with solutions that would introduce licenced non-institutional services into the national social and/or health system and make them its full members with the possibility of funding from the state budget;*
- *consider the possibility of licensing services in the context of the social protection system after the adoption of secondary legislation regulating the field of non-institutional provision of social services;*
- *introducing the occupation "outreach worker in the harm reduction programs" into the system of social and/or health care;*
- *introducing the exemption from fuel taxes and car registration for NGOs engaged in the outreach work with PUDs;*
- *release or subsidize the payment of taxes and contributions for outreach workers and professionals working in the harm reduction programs;*
- *provision of free needles and syringes and other materials for NGOs*

dealing NSP (eg. as a donation by the health institutions);

- *provision of a special fund within the Health Insurance Fund that would finance the cost of the program of NGOs delivering harm reduction services*

Recommendation:

- *When creating legal framework for the implementation of the program providing sterile injecting equipment, define the lower age limit in relation to the legal age for use of these services.*

7.4. Programs of overdose prevention and treatment

Recommendation: Develop and adopt a protocol on the ways of handling cases of drug overdose in:

- *health institutions,*
- *social welfare institutions,*
- *the Institute for the Execution of Criminal Sanctions and prisons,*
- *units for retention and detention.*

Recommendation: Develop and implement targeted overdose prevention programs in Montenegro, including the programs of mutual aid provided by PUDs to one another.

Recommendation: Significantly improve the system of registration of drug related deaths, in accordance with standard indicators in this area.

7.5. Research

In order to realistically consider and evaluate national needs for harm reduction services, it is necessary to have valid data on key indicators in the area of drug use and especially injecting drug use in the population. Therefore, it is necessary to continuously improve the system of collecting data on key indicators in the field of drug use, while respecting the following recommendations:

Recommendation: Improve the functioning of registry of PUDs seeking treatment in medical institutions, or practice of reporting users by health care institutions.

Recommendation: Enable data collection of PUDs within social care and community based harm reduction programs, with bylaws developed.

Recommendation: Ensure implementation of the research on drug use in the general population.

Recommendation: Enable the implementation of the new study related to the estimation of the number of people who inject drugs.

Recommendation: Provide continuous surveys in the population of PWID and sex workers, in order to secure the supervision of HIV and other sexually transmitted and blood borne infections spread, as well as frequency of risky behaviour, monitoring of new drugs and trends in drug consumption.

7.6. Social and health protection

Recommendation: Improve the availability of the counselling and testing on HIV and other sexually transmitted and blood borne infections for persons using drugs and sex workers, especially by introducing these services into the drop in centers and in the field.

Recommendation: Organize targeted immunization campaigns against hepatitis B and hepatitis A for PWIDs and sex workers.

Recommendation: Ensure conditions for the provision of free health care and preventive services in the field of infection prevention and drug related harm reduction for people who are not citizens of Montenegro.

Recommendation: Develop medical guidelines on the prevention of vertical transmission of Hepatitis C.

Recommendation: Increase the coverage of people who are being treated for viral infection with hepatitis C.

7.7. Improving the capacities for the imeplementation of harm reduction program

In the current situation, implementation of harm reduction activities can be punishable by the Criminal Code as an act of enabling the use of PAS, while outreach workers who provide services to PUDs and sex workers can be found in the role of witnesses during the misdemeanor or criminal proceedings against their clients, which is contrary to the ethics of the outreach work.

Recommendation: Provide legal protection for the occupation of an outreach worker.

Recommendation: Create conditions for continuous training of harm reduction service providers from NGOs in the field of social and health care.

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Authors' biographies

Tatjana Djurisic was born in 1975. She finished primary and secondary school in Podgorica. She acquired the title of a graduate psychologist at the Faculty of Philosophy in Novi Sad, Department of Psychology (REBT psychotherapist).

Since 2000 she was involved in various organizations such as:

Since 2000 she was involved in various organizations such as:

- NGO Anima where she worked in the context of refugee and IDP camps to protect and improve the mental health of refugees and displaced persons;
- INTERSOS as a field assistant on the implementation of humanitarian and infrastructural projects in the camp Konik;
- MAPA - Montenegro Advertising and Production Agency, on the planning and implementation of marketing campaigns.

In 2004 she was the Country Project Manager for Montenegro within the "Stability Pact for South-eastern Europe" Mental Health Programme in Sarajevo, Bosnia and Herzegovina. In the same time, she worked as a psychologist at the Centre for Mental Health in Podgorica, as well as the coordinator of the project "Harm reduction among injecting drug users," UNDP SCG.

Since 2007 Ms Djurisic has been working at the Institute of Public Health of Montenegro as a psychologist at the Center for Health Promotion and the national coordinator of the ESPAD survey (Europian School Survey on Tobacco, Alcohol and Drugs).

Tijana Žegura was born in 1979 in Podgorica.Since 2000 she was involved in various organizations such as: She finished primary and secondary school, in Danilovgrad and received a Luca diploma. Ms Zegura completed her basic studies at the Faculty of Political Sciences in Podgorica, study program Social Policy and Social Work.

Tijana is the mother of Jovana, Darija, Hana and Relja.

Since 2004, she is the activists of the civil sector in Montenegro, when began her involvement in Juventas' activities. Tijana is one of the founders of the program for reducing health, social and criminogenic harm in people who have a history of substance abuse in Montenegro. In this program, which includes direct work with persons using drugs, prisoners and sex workers, she still works as a program director. She participated in numerous national strategic documents, and has a certificate for voluntary counselling and testing on HIV, issued by the Institute of Public Health of Montenegro. As a coordinator of one part of the research Ms Zegura participated in the implementation of 4 national bio-behavioral studies with sex workers, and 4 with persons who inject drugs. She is the co-author of numerous informational materials concerning risky behaviors of people who use drugs, issued by Juventas, but also the first report to the international community regarding the situation of human rights, social and health protection of vulnerable groups with whom she works. Tijana is volunteering in the association "Parents", where she also preforms the role of a member of the Steering Board. In addition, she is a member of the Steering Board of the Network for the treatment of opioid dependence Southeastern Europe and vice president of the Steering Board of the Network for drug policy in Southeastern Europe.

She won the first prize for professionals younger than 35 years at the 4th Summit of the Adriatic region on the addiction treatment and 1st Montenegrin psychiatric days, with international participation, October, 2009.

Tijana lives and works in Podgorica.

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