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Harm reduction services in the Netherlands: recent developments and future challenges

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1 Introduction

Harm reduction (HR) has been a pillar of drug policy in the Netherlands for many decades (VWS, 2015). In fact, the Netherlands was a pioneer in the field of HR. Like many other Western countries, the Netherlands was hit by a wave of heroin use in the 1970s. The Dutch adopted HR programs early on at the height of their heroin crisis in the 1980s, and implemented the first needle and syringe exchange program worldwide (Van Santen et al. 2021). HR seeks to reduce the health and social harms of drug use to individuals and the wider community, without requiring people to stop using drugs (EMCDDA, 2010). It is a client-centered and low-threshold approach that allows users to engage with medical and social services in a non-judgmental way and provides opportunities for referral to further care.

In the Netherlands, the first HR initiatives were initiated by civil society and user advocates, and were later adopted by care providers and the government (De Gee & Van der Gouwe, 2020). HR initiatives focused on people with problematic use of heroin and/or (base) cocaine. In the late 1970s and 1980s, regular addiction care was mainly aimed at abstinence with little or no services for people who could not or did not want to stop using drugs. HR services emerged as a response to this lack of alternatives. It included needle and syringe exchange programs, opioid substitution treatment, drug consumption rooms, and other facilities such as walk-in centers (De Gee & Van der Gouwe, 2020). These interventions are now proven to be effective and cost-effective approaches that contribute to the health and wellbeing of people who use drugs (PWUD) and decrease public nuisance and drug-related crime (EMCDDA, 2010; Wilson et al. 2015).

The Dutch Harm Reduction Network (HRN) monitors the state of affairs of HR services in the Netherlands, and provides regular updates. It is part of the department of Drugs at the Trimbos Institute and funded by the Dutch Ministry of Health, Welfare and Sports (VWS). In addition to being the center of expertise at a national level, the HRN also regularly receives requests for information from the wider international HR community. Moreover, as Reitox National Focal Point, the Trimbos Institute (including the HRN) annually shares information on HR with international bodies, such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the United Nations Office on Drugs and Crime (UNODC).

In 2021, the HRN conducted an investigation of HR services in the Netherlands. Four main types of HR services were examined: drug consumption rooms (DCRs), opioid substitution treatment (OST), heroin-assisted treatment (HAT), and needle and syringe exchange programs (NSP). The aim of this report is to provide a brief overview of the current state of affairs of HR services in the Netherlands and to present recent developments and future challenges.

2 Methods

This report is based on an investigation conducted among employees of four types of HR services in the Netherlands in 2021. Qualitative data was collected by means of interviews and questionnaires from employees from 17 DCRs, 53 OST centers, 17 HAT units, and 29 NSP. Quantitative data was collected where possible, but should be regarded as merely an indication rather than nationally representative numbers. That is because many HR services do not keep a systematic record of the number of clients they serve or items they provide. Data is compared to two previous assessments of HR services in the Netherlands, which were published in 2018/2019 (De Gee et al. 2018; De Gee et al. 2019; Laghaei et al. 2013).
The main topics of interest in the present study were:

- The current state of affairs of HR services (e.g. provision of services, daily work practices, number and type of clients, capacity)
- Recent developments at the HR services (e.g. changes in target groups in the past 5 years)
- Challenges that HR services are facing in the (near) future

HR facilities were identified using the databases from previous assessments in 2018 and 2013. All addiction care organizations and their HR facilities were contacted and additional HR facilities were identified through snowballing technique. There was some non-response. Moreover, some HR facilities had to be excluded from the study because they recently changed their work practices (e.g. some DCRs changed their status from public to private) and therefore no longer fit the inclusion criteria of the present study. The changes in HR facilities further complicate the comparison with previous assessments.

Due to the lack of a comprehensive registration system of HR services in the Netherlands, the number of HR facilities identified in the present study may not be complete. However, based on the methodological approach of this study and the fact that most HR services are linked to an overarching addiction care provider in the Netherlands, the present study provides a fairly comprehensive estimate.

It should be noted that this report does not provide an exhaustive description of the current state of affairs of HR services in the Netherlands. It aims to highlight some interesting pieces of information and focuses on developments and challenges that have been observed at HR services in recent years.

3 Findings

3.1 Drug consumption rooms

A drug consumption room (DCR) is a professionally supervised facility where people can consume their drugs in a safe environment and under the supervision of trained staff (EMCDDA, 2018). The present study includes public DCRs and not private DCRs. Public DCRs are basically accessible to any PWUD and just require a simple registration. Private DCRs are only accessible to PWUD who also make use of other care or services provided at the facility, such as DCRs at half-way houses ('Regionale Instellingen voor Beschermende Woonvormen' (RIBW's)) or the drug consumption areas for HAT.

General information

Number of DCRs: A total of 17 public DCRs were identified in the study. The number of DCRs has been declining for over a decade. However, the previously recorded decline between 2013 and 2018 appears to have slowed down between 2018 and 2021. A few public DCRs have become private DCRs in recent years and were therefore not included in the study.

Number of clients: DCRs do not systematically record the number of clients that make use of their services each day. Employees estimate that a DCR is used by around 5 to 30 clients per day depending on the DCR. The total number of unique individuals who made use of DCRs in 2020 is estimated to be around 600.

Capacity: While there is no limit to the number of people who can be registered at a DCR, there is a limit to the number of people who can use a DCR at the same time. DCRs determine their own limits.

Average client: DCR clients are typically older Dutch men who use heroin and/or crack (cocaine base) and who have received treatment and other care for their drug use disorder for many years.

Daily work practices

Goal: DCRs in the Netherlands are often multi-purpose facilities. They do not only provide a safe space to consume drugs, but also provide basic necessities such as meals and clothing, and offer opportunities for referral to further care.

Intake: More than half of the DCRs require an intake interview in which type, frequency and duration of substance use is assessed. Also potentially negative consequences are assessed, such as whether the individual is expected to increase their drug use as a result of having access to a DCR.

Autonomous or integrated: More than a third of the facilities that provide a DCR also provide other services, such as night shelters. Some clients make use of all services at one facility.

Injection and smoking rooms: In all DCRs smoking of drugs is allowed. Most facilities have separate rooms for smoking and for injection, some have a room for both smoking and injection, and a few facilities do not allow the injection of drugs at all. The fact that there are more facilities for smoking than injection reflects the decreasing trend of injection drug use in the Netherlands. However, some DCRs, which do not allow injection of drugs, have seen signs that PWUD are injecting in public areas and are therefore considering re-installing a space for injection.

Minimum age: The minimum age to use a DCR is on average 21-25 years of age.
Rules: Rules regarding the use of DCRs vary. Some implement a maximum duration or a maximum amount of times that a client can visit a DCR in a day to avoid that they stay in the facility indefinitely. Others do not set any limits, claiming that it enables them to establish better personal contact with the clients.
Drug use: All DCRs allow the use of heroin and (base) cocaine; some also allow the use of amphetamines and cannabis. Alcohol is prohibited in most DCRs and clients can be denied access if they are excessively under the influence of alcohol. Use of other substances such as benzodiazepines is permitted to some extent in DCRs. The use of GHB is usually not allowed.

Developments

Ageing population: A large proportion of the DCR clients represent an ageing population that is increasingly developing somatic health problems. Particularly injection drug use is associated with increased health problems. As these individuals are generally long-term clients who are well-known at the facilities, employees can provide adequate care in a timely manner.
Young clients: Some DCRs report an increase in young clients (younger than 35 years of age). It usually -but not exclusively- concerns young individuals with a migration background who consume soft drugs such as cannabis. Some of these clients use amphetamine; few if any use heroin.
(Labor-)migrants from Central and Eastern Europe: Many DCRs have observed a significant increase in (labor-) migrants from Central and Eastern Europe. These individuals are often not allowed to use DCRs due to due to restrictions set by the DCR and/or because they are not eligible for medical care. Some municipalities work in close cooperation with DCRs and other care institutions to ensure that these individuals can receive the necessary care nevertheless.
Refugees from the Middle East and North Africa: DCRs which are located near asylum seeker centers have observed an increase in PWUD from the Middle East and North Africa. At present, this only concerns a small group of individuals.
GHB: Many DCRs report an increase in the use of GHB, both among existing clients and new clients. The use of GHB is currently prohibited in almost all DCRs. Only few DCRs permit the use of GHB, stating that it allows users to consume the drug in a safer environment. GHB causes a significant amount of problems in DCRs because of the high risk of overdose. Moreover, employees report that they often do not know how to care for individuals who use GHB.
Pain medication: Another new development is the slight increase in the use of pain medication among clients of DCRs.

3.2 Opioid substitution treatment

Opioid substitution treatment (OST) is an evidence-based intervention to treat opioid use disorders. It involves replacing the use of illicit opioids with medically prescribed opioid medication (EMCDDA, 2021a). In the Netherlands, the majority of OST patients receive methadone and a much smaller percentage receives buprenorphine.

General information

Number of OST centers: A total of 70 centers that provide OST were identified in the study, which is a reduction compared to the 82 OST centers in 2013. Of the 70 OST centers, 53 were included in the present study; the rest was non-response.

Number of patients: Employees of OST centers have observed a reduction in the number of OST patients for many years. Official data on the number of patients in OST is expected at the end of 2022 from the National Alcohol and Drugs Information System (LADIS). The latest available data is from 2015.

Capacity: OST centers in the Netherlands do not have a maximum capacity and there are no waiting lists.

Average patient: The average OST patient is male and older than 40 years of age. Very few individuals stop OST and even fewer enter OST. The average age of the OST patient population is therefore increasing and the total number of patients is slowly decreasing.

Daily work practices

Goal: The main goal of OST is the stabilization of patients' lives and the reduction of illicit opioid use. Abstinence is nowadays no longer a primary goal. While patients often wish to work towards abstinence, either from illicit drugs or also from OST medication, few achieve this goal. Most receive long-term treatment with OST and are able to minimize and regulate their illicit drug use.

OST medication: Different OST medications are available. Methadone is available at every OST center and is by far the most prescribed OST medication in the Netherlands. In addition to methadone, many OST centers also offer Suboxone (buprenorphine with naloxone) and to a lesser extent buprenorphine. Of the 53 OST centers, 24 also offer Suboxone, 8 offer buprenorphine, and 19 offer both Suboxone and buprenorphine. At least four OST centers also offer oxycodone and fentanyl to individuals who are dependent on pain medication.

Treatment regimen: Compared to methadone, buprenorphine is less sedating but also suppresses cravings less. In the Netherlands, methadone is typically prescribed with the primary goal of stabilizing a patient. Buprenorphine is prescribed for a number of reasons. It may be prescribed if a patient has had an opioid use disorder for a relatively short period of time, or if a patient does not want to use heavily sedating medication because of work or other reasons. Moreover, when a patient wishes to work towards abstinence, they may switch from methadone to buprenorphine or Suboxone. The choice of medication is made in consultation with the patient.

Mode of obtaining the medication: OST medications are usually dispensed at the OST center. Frequency of dispensing can vary from daily to fortnightly or even longer periods of time. Since the start of the Covid-19 pandemic, most OST centers have switched to home delivery of OST medication or dispensing through general practitioners or pharmacies. This change in work practice appears to be here to stay.

Developments

Ageing population: While the average age of the population of OST patients was steadily increasing for many years, it seems to have somewhat slowed down due to the recent influx of younger patients. However, the older group of OST patients is increasingly experiencing somatic health problems due to their long-term drug use and age.

Young patients: Employees of OST clinics report an increase in younger patients, albeit at low levels thus far. This includes homeless Dutch who are younger than 35 years of age, young (labor-)migrants from Central and Eastern Europe, and young asylum seekers.

(Labor-)migrants and refugees: Some OST centers have seen an increase in new registrations from (mostly) male labor migrants from Central and Eastern Europe (mainly from Poland,

Greece, Romania and Bulgaria). In addition, OST centers that are located near an asylum seeker center report an increase in male refugees from North Africa among their patients. These individuals are generally younger than the average Dutch OST patient who has been in OST for many years.

Chemsex: Another group which enters OST somewhat more frequently in recent years concerns people who engage in chemsex. This group is currently very small but also seen is also seen at other HR services, such as needle and syringe exchange outlets.

Pain medication: Employees indicate that the number of people entering OST due to a dependence on pain medications has been increasing in recent years. A number of OST centers report a notable increase in patients who developed a dependence on for example oxycodone or fentanyl, because they received these as prescription medication for a long time. These individuals typically reach out to OST centers when they stop receiving their prescription medication from their health care professional and experience symptoms of dependence.

Increase in buprenorphine prescriptions: A number of OST centers have been observing an increase in prescriptions of buprenorphine or Suboxone as compared to methadone. This may be due to the recent intake of patients with a relatively short medical history of opioid use disorder.

3.3 Heroin-assisted treatment

Heroin-assisted treatment (HAT) is a treatment option which may be useful for people who have not responded well to other forms of OST (EMCDDA, 2021b). Medically prescribed pharmaceutical-grade heroin (diacetylmorphine) is taken by patients under clinical supervision in a safe medical setting, so-called HAT units. In the Netherlands, medical heroin is typically prescribed in combination with methadone and psychosocial counseling.

General information

Number of HAT units: A total of 17 HAT units were identified in the Netherlands and included in the study; one unit less than identified in 2013.

Number of patients: The total number of patients on HAT has been decreasing slightly in recent years. On 1 January 2021, there were 534 HAT patients in the Netherlands (VWS, 2021).

Capacity: Most HAT units are able to treat 20 to 45 individuals. Some have more available treatment spaces, with one center having a capacity of 100 spaces.

Average patient: The average HAT patient is male, Dutch, of older age, and has made several attempts with other forms of OST.

Daily work practices

Goal: HAT seeks to provide an alternative treatment option to those who do not respond well to other forms of treatment.

Fixed appointments or flexibility: HAT is highly standardized and follows strict protocols. Nevertheless, HAT units differ in their daily work practices. At some HAT units, the medication must be taken at fixed times; this is intended to promote structure in a patient's life. Other HAT units are flexible in this regard and place the focus on the patient's own responsibility and wishes.

Group setting or individual: At some HAT units, patients take their medication individually (usually one-on-one with a health care professional). This is done to give patients a sense of rest. At other HAT units, multiple people take the HAT medication together simultaneously to reduce work load or costs. While some HAT units let patients take their medication within a specific time slot, other units prefer to focus on patient responsibility.

Developments

Ageing population: The average age of HAT patients has been increasing steadily. HAT patients are usually older than clients at other HR services and report an increasing number of somatic health problems. HAT units respond to this by providing more geriatric and palliative care. HR services also try to collaborate with external care providers in order to provide more comprehensive care (i.e. for non-addiction specific, age-related health problems).

Reduced number of patients: While most HAT units had a waiting list in 2013, this remains the case for only a few HAT units in 2021. Heroin use has been decreasing in the Netherlands for a long time and there is little influx of young people at HAT. More than a third of HAT units report a decrease in patients. The main reasons for this are increased mortality (due to old age), switching to OST with (only) methadone or buprenorphine, and increasingly poor health which hinders patients' mobility and makes it more difficult for them to attend HAT units.

Young patients: Although the number of HAT patients is generally decreasing, there is (at least) one HAT unit that reports an increase in patients due to (mostly) younger Dutch individuals.

3.4 Needle and syringe exchange programs

Needle and syringe exchange programs (NSP) provide PWUD with sterile needles and syringes to reduce transmission of bloodborne viruses as a result of sharing injecting equipment. It also allows PWUD to drop off their old injecting equipment to ensure safe disposal and that no syringes are left on the streets. In addition, NSP offer a range of other HR items, including paraphernalia for smoking drugs (e.g. base pipes), condoms and educational materials.

In the Netherlands, NSP are no longer considered 'programs' but rather an activity that is carried out as part of the day-to-day business of HR services. The present study includes any NSP that was reported by HR services in the interview or questionnaire. It is possible that some HR facilities provide clean needles on a small scale and did not report this in the study. Moreover, other facilities in the Netherlands, such as pharmacies, sometimes provide clean needles and these locations were not included in the study.

General information

Number of NSP: A total of 29 NSP were identified and included in the present study. This is an underestimation, as there are other locations in the Netherlands that provide clean needles on a small scale and are not included in the study.

Number of clients and syringes: The number of needles and syringes exchanged on an annual basis is unknown, as most NSP do not (systematically) register this. Employees of NSP estimate that the number has remained stable or decreased slightly over the past five years. Also, the number of people making use of NSP is unknown and varies widely, from a few to several dozens of clients per NSP.

Capacity: NSP in the Netherlands do not have problems with capacity. Needle and syringe exchange is not a time-consuming activity and facilities have sufficient equipment available.
Average client: The average NSP client is male, Dutch, without a migration background, and above the age of 35 with a long history of opioid use. They have usually been in addiction care for many years.

Daily work practices

Goal: NSP do not only provide sterile needles and syringes, but also a low-threshold setting to get into contact with PWUD and offer opportunities for referral to further care.
Organization: NSP are usually found at facilities that also provide other HR services, such as DCR and OST. Needle and syringe exchange is often done by an employee who also keeps an eye on the clients' health.
Intake: Most NSP require an intake interview before an individual can use the NSP. Questions may include the number of syringes needed or the type of drugs that will be used.
Monitoring of behavioral patterns: Although it is not common to keep track of the number of syringes exchanged by each client, employees of NSP do pay attention to changes in clients' need for syringes. Changes in behavioral patterns, such as more frequent or less frequent visits to the NSP, can be a reason for NSP employees to engage in a conversation with the client and offer them referral to further care.
One-for-one rule: Most NSP have the one-for-one rule, in which a client receives a clean syringe for every used syringe they return. In practice, this rule is not followed strictly as the primary aim is to prevent infectious diseases. However, the one-for-one rule is applied more strictly to new clients than to known or homeless clients. That is because new clients sometimes sell the paraphernalia that they receive. On the other hand, the one-for-one rule is applied less strictly to homeless individuals as they are less able to store their used syringes in a safe and hygienic manner. Besides exchanging paraphernalia, some locations also provide the option to purchase materials for a small fee.
Available materials: The range of materials available at NSP varies considerably. While NSP focus on providing paraphernalia for safe injection drug use, most NPS also provide materials for smoking drugs. Other materials for HR include condoms, pregnancy tests, adhesive bandages, and educational material.
Drop-off containers: Some NSP do not provide containers to drop off used syringes, stating that it helps them keep an eye on clients by engaging with them on a regular basis. Other NSP provide containers due to hygienic and safety reasons and because it gives PWUD the flexibility to not have to visit the NSP on a daily basis.
Personal use: It is only permitted to exchange needles and syringes for personal use. This enables NSP employees to be in contact with all clients.
Number of syringes: NSP differ in the number of syringes that they provide per person per day, ranging from a few to a maximum of 15 syringes. Some NSP exchange containers of 100 syringes. One NSP does not have a limit to the number of exchanged syringes. Setting a daily limit is intended to prevent PWUD from using more than usual or from overdosing.

Developments

Reduction in number of clients: The number of NSP clients is decreasing. That is mainly because injection drug use has been declining for many years among the 'traditional' ageing population of PWUD. A large proportion has switched to smoking of drugs and some have

stopped injecting when they entered OST. Nevertheless, employees of HR services do not expect NSP to cease existing in the Netherlands. Needle and syringe exchange is not a time consuming activity and it has great benefits to the health of PWUD.

Diversifying population including labor migrants: Some NSP mainly serve the 'traditional' population of older Dutch men who have been in addiction care for a long time. They only serve clients who also attend the health care service that the NSP is a part of. Other NSP are low-threshold and serve a broader population. In recent years, some NSP have occasionally had new clients, such as tourists, people who use anabolic steroids, and sex workers (although sex workers may come primarily for birth control pills and less for needle and syringe exchange). More than half of the NSP report an increase in labor migrants from Central and Eastern Europe. Due to language barriers and the relatively closed communities that they live in, contact with this group is limited.

4 Future challenges for HR services

Reduction in the number of patients and clients

Overall, the number of patients and clients at all four HR services is declining. As a result, funding for HR services may be reduced or insufficient, which could put services at risk of having to close down. About a quarter of all HAT units have concerns about their future existence due to the decreasing number of patients. Funding is based on the number of patients in treatment, and if the number of patients becomes too low, funding can no longer cover the fixed costs. HAT units that are dealing with a stark reduction in the number of patients are exploring (cheaper) alternatives, such as home-delivery of HAT, to ensure continuity of care. Moreover, in some places in the Netherlands, the decline in DCR clients has led some policy makers to question whether DCRs need to remain open. It is proving to be increasingly difficult to convince policy makers of the necessity of DCRs, and at least one DCR was recently closed because of this. Keeping HR services available and maintaining good coverage of HR is important to stay in contact with the population of PWUD and provide low-threshold care, which in turn serves public health and safety.

Increase in new target groups, including (labor) migrants from Central and Eastern Europe

The emergence of new target groups among HR services, although still limited, is a key development. Lagging communication with these target groups is a challenge and can hinder treatment uptake. There has been a notable increase in clients who are (labor) migrants from Central and Eastern Europe. These individuals often live in rather closed communities with other (labor) migrants who use drugs, making them difficult to reach. Moreover, they often have little to no knowledge of the Dutch addiction care system, and language barriers hinder communication. In addition, these individuals often do not qualify for healthcare because they do not have proper or valid documentation. Language barriers and lack of proper documentation also applies to the group of refugees (e.g. from North Africa) that is increasingly seen at HR services. Language barriers hinder effective treatment and can also lead to people foregoing treatment. Employees at HR services differ in how responsible they feel for providing care for non-citizens. This leads to regional differences in the extent to which these target groups are being reached. Also, an increase is seen in numbers of young PWUD (with and without a migration background) who attend HR services. These young clients pose a challenge as they often do not want to be referred to further care or treatment. Furthermore, there are increasingly more homeless Dutch PWUD under the age of 35 who sign up for OST. According to employees, they regularly have a mild intellectual disability, which can complicate communication. HR services may need to evolve to better reach and engage with these new populations. Enhancing communication strategies and more outreach work may be key in this regard.

Ageing population and increasing somatic health problems

A major challenge is the increasing amount of somatic health problems which older PWUD suffer from. They require additional (geriatric) care, which HR services attempt to address

through more health screenings and additional health and social care. However, the required care often exceeds what can be offered within addiction care. HR services seek to cooperate with external care providers to offer geriatric and palliative care. Unfortunately, the cooperation does not always run smoothly due to prejudices that some health care professionals continue to have towards PWUD. These prejudices and stigma can hinder the provision of adequate care to PWUD. Addressing the needs of the ageing population of PWUD is not only a challenge in the Netherlands, but across Europe. Strategies need to be developed to ensure proper care to aging PWUD.

Decreased mobility

As a result of the increasing somatic health problems, many older patients also suffer from decreased mobility. This in turn hinders their ability to attend HR services. For example, it makes it difficult for them to go to DCRs or to pick up their OST medication. Two solutions have so far been developed to this problem. Care and OST medication is sometimes delivered to patients' homes. Although it is not a part of their normal day-to-day care activities, employees of HR services often feel responsible for the overall health and wellbeing of their clients and go the extra mile to provide good care. They seek collaborations with external care providers to be able to deliver the appropriate care, also to people's home. Home care is time intensive and costly, so not every HR facility has the opportunity to arrange this. Instead, some OST clinics arrange for public transportation to be reimbursed for patients with limited mobility. However, this is not a viable option for all patients. Given that the issue of the ageing population will become an even more prominent issue in the near future, it is imperative that effective solutions are found and implemented.

Stigma among healthcare professionals

According to employees of HR services, PWUD often experience prejudice from their general practitioner or (non-addiction specific) health care professionals. This is particularly an issue among older PWUD who require more care due to their increasing somatic health problems. Prejudice towards PWUD creates problems for both the patients and the HR services. Diseases can progress for too long before they are diagnosed or treated due to prejudices by health care professionals. Employees of HR services often make additional efforts to ensure that their patients and clients receive the appropriate medical care. Furthermore, some OST centers experience resistance from pharmacies and general practitioners when asked to take over the treatment with OST. According to the employees of OST centers, this is due to the stigma and prejudice associated with PWUD. This resistance hinders the opportunity for OST centers to invest their time and money in patients who require more intensive care. Stigma and prejudice towards PWUD among health care professionals continues to be an issue in the Netherlands as well as the rest of Europe. Efforts need to be made to tackle prejudice, as it can undermine good and timely care.

Increase in use of GHB

There has been an increase among (existing and new) clients of DCRs in the use of GHB. Yet the use of GHB is not allowed in almost any DCR in the Netherlands; only some DCRs permit the use nonetheless to enable safer consumption. GHB use is associated with a high risk of overdose. The restrictive policies of DCRs often place users in the situation of having to use the drug alone or in public spaces. Moreover, employees often do not know how to care for

individuals who use GHB and vary in their opinion on whether GHB should be permitted in DCRs. Given the high risk of overdose with GHB, DCRs should consider how they can extend their services to these users. Moreover, training should be offered to staff on how to care for this target group.

Increase in the use of pain medication

Across HR services, there is some increase in patients who are using or are dependent on pain medication. This is not limited to the 'traditional' group of people with opioid use disorders, but also includes an increasing number of people who became dependent on prescription opioids that they received from their health care professional.

Restrictive policies

Many HR services have restrictive policies that either exclude PWUD or make it difficult for PWUD to receive adequate care. For example, many DCRs are restricted in whom they can provide care to. Some DCRs do not admit people who have an independent living space, they set strict minimum age limits, or set restrictions for the admission of (labor) migrants. Moreover, many DCRs don't permit the use of GHB despite an increasing number of problematic users and high risk of overdose. As a result, many PWUD are placed in risky situations of having to use alone and/or in public spaces. As DCRs are intended to be low-threshold facilities to prevent overdoses, restrictions should be minimized with the aim of ensuring the safety of PWUD as well as public safety. Expanding access to DCRs could prevent overdoses and provide a safe space for new target groups. The increasing number of new clients would further reinforce the need for DCRs.

Also, HAT units are facing challenges due to restrictive policies. Funding of HAT units in the Netherlands runs via municipalities and is subject to strict inclusion criteria. An example is patients having to have lived in the municipality for at least three years before being eligible to take up HAT. This can hinder the delivery of care for certain PWUD. Furthermore, the minimum age limit of 35 can be an obstacle to treatment. Individuals who are younger than 35 years old but who may have been living with an opioid use disorder for many years are excluded from HAT. The minimum age criterion also contributes to the image of HAT being a 'last resort' in treatment. As a result, external care providers as well as PWUD not always view HAT as a serious treatment option, which can have a negative effect on the effectiveness of treatment. It also makes it more difficult to convince patients that HAT may be an appropriate treatment option. HAT is an evidence-based treatment that can provide substantial benefits to patients. Access to HAT should not be restricted unnecessarily.

5 Conclusion

HR services may need to evolve and adapt to new developments in the national drug situation. While the Netherlands has seen a decline in the 'traditional' group of PWUD for many years, there appear to be new emerging target groups and new types of drugs that post novel challenges to HR services. The continuous reduction in the number of older patients and clients is causing concerns that HR services will be reduced or closed down in the future. However, given the recent developments in e.g. new user groups, it is important to reevaluate the form and format in which these HR services are provided. HR services may need to evolve to better meet the needs of current users and not exclude potential clients. Particularly the restrictive policies may pose significant barriers that are often not in line with the philosophy and objectives of harm reduction – namely to provide care in a non-judgmental way and to respect the human right to good health care. Advocacy for HR towards policy makers, then, will remain necessary, as will efforts of de-stigmatization of PWUD among healthcare providers.

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