The Health Policy Partnership

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Opioid use disorder: The right to hope

Engaging policymakers around the need for urgent action on treatment and care for opioid use disorder (OUD) in Europe

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The following organisations endorse this report

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About this report

This report outlines the urgent need to improve access to best-practice treatment and care for people with opioid use disorder (OUD).

The findings and recommendations were developed based on a European-level literature review and interviews with leading national experts in OUD in six countries: Finland, France, Germany, Italy, Sweden and the UK. Insights from expert interviews are marked with “E” throughout the text.

We are grateful to the following national experts who provided valuable insights on the situation in their respective countries:

- Maurice Cabanis, Medical Director, Specialist in Psychiatry and Psychotherapy, Klinikum Stuttgart, Germany
- Albert Caporossi, Administrator, France Patients Experts Addictions, France
- Martin Degenhardt, Political Expert, Bavarian Association of Statutory Health Insurance Physicians (KVB), Germany
- Charlotte Gedeon, Specialist in psychiatry, Medical Director at Solstenen Addiction Centres (Solstenen), Sweden
- Benjamin Laub, Specialist for Strategic Supply Structures and Security, Bavarian Association of Statutory Health Insurance Physicians (KVB), Germany
- John Marsden, Professor of Addiction Psychology at the Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King’s College London, UK
- Cristina Meneguzzi, Medical Director, Department of Addictions and Mental Health (Azienda Sanitaria Friuli Occidentale, ASFO), Italy
- Petter Odmark, Business Area Manager, Health Reform Society, Sweden
- Dirk Schaeffer, Team leader, Advisor for Drugs, Prison, Junkie Ehemalige Substituierte (JES) (Deutsche Aidshilfe/JES), Germany
- Mirka Vainikka, Executive Director at Irti Huumeista Ry, Finland
- Annemarie Ward, Chief Executive Officer at Faces & Voices of Recovery UK (Favor UK), UK

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Foreword

There is still a lingering impression among many people that opioid addiction is a choice rather than an illness and, therefore, that those who seek treatment do not deserve it. In no other area of healthcare would we accept that patients should have to prove that they are worthy of treatment – so why should people with opioid use disorder accept this?

All people living with opioid use disorder have the right to good health. They have the right to receive care that is comprehensive and tailored to their needs, regardless of where they live. Because having the right to manage a debilitating, chronic and complex disease is a human right. High-quality, medically assisted treatment can be a pathway to recovery and a cause for celebration.

As such, it gives me great pleasure to introduce this report on treatment for people with opioid use disorder in Europe. It shows that although several European countries have achieved great strides in providing treatment, there is still much to be done to prevent overdose deaths and give people with opioid use disorder the help they need to lead stable lives.

To achieve this, policymakers need to be aware of the situation on the ground and prioritise filling the gaps in their own national, regional and local treatment provision networks. I hope this report will play a crucial role in informing and incentivising them to make the changes that are so urgently needed. I urge all organisations working in this area across Europe to use this report in advocating for change, and ensure comprehensive and tailored treatment and care are available to everyone with opioid use disorder.

Annemarie Ward, *Chief Executive Officer at Faces & Voices of Recovery UK*

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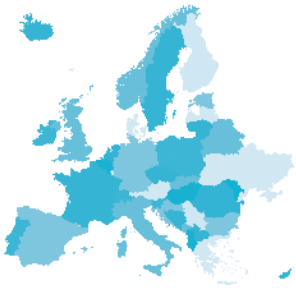
Executive summary

1 million people



4,300 deaths

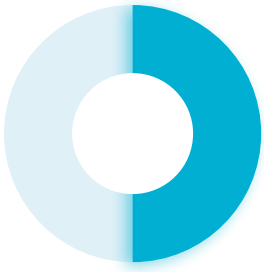
Thousands of people die each year due to opioid overdose and many more see their lives destroyed. In 2020 in Europe, there were approximately 1 million people reporting high-risk use of opioids, largely heroin.[1] While opioids are not the most widely used illicit substance, they are involved in the majority of drug overdose deaths, with 4,300 deaths in Europe attributable to opioids in 2020 alone.[1] People with opioid use disorder (OUD) have a much lower quality of life and poorer health outcomes than the general population.[2-4] The quality of life of their loved ones can also be affected by conflict, exhaustion and isolation that can be associated with OUD.[5 6]

Cost-effective

Comprehensive and individualised approaches to treatment and care can allow people with OUD to better manage their condition. A combination of medication and psychosocial care is recognised as a best-practice approach to reducing the risk of overdose among people with OUD, as well as improving their overall health, psychological and social outcomes.[7-9] People who receive medication for OUD are at an eight times lower risk of death from overdose than people with OUD who are not receiving medication.[10]

Effective treatment and care for OUD can be cost-effective and even cost-saving. People with OUD who are receiving treatment use healthcare services less and therefore incur lower healthcare costs than those who are not undergoing treatment.[11] In the UK, for example, it is estimated that for every £1 invested in drug treatment, there is a £4 return on investment, increasing to £21 over 10 years.[12] In Sweden, estimates found a return on investment of almost 18 kr for every 1 kr invested in a treatment programme for OUD.[13]

50% receive treatment



Despite the benefits, only half of people living with OUD in Europe are being treated.[1] At a national level the situation varies widely, with some countries, such as Italy reporting only 30% (or fewer) of people with OUD receiving medication, while in other countries, such as France, this percentage can be as high as 80%.[14 15]

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Even when, in theory, people with OUD could access treatment and care, unacceptable policy and systemic barriers can prevent them from doing so. These include the following:

- **Too few healthcare professionals and centres that provide treatment, limiting the number of people who can be treated**, leading to excessive waiting times[E16 E17] and increased distance a person may need to travel[E18 E19] as reported in interviews with OUD experts.

- **Eligibility criteria which represent high barriers to entry**[20] and make it too difficult for people with OUD to remain on treatment.

- **A lack of choice in the range of personalised treatment options available**, including a lack of psychosocial care and limited availability of innovative, patient-centred treatments.[E16 E18 21]

- **Services being insufficiently tailored** for the specific needs of groups such as older people, women and people in prison.[22-24]

- **Stigma at all levels of care**,[25 26] with slow progress in addressing the issue of stigma faced by people with OUD.

- **The lack of clear communication and effective implementation of guidelines** to tackle knowledge gaps among some healthcare professionals regarding the latest clinical guidelines and standards of care, as reported in an interview with an OUD expert.[E17]

Policymakers across Europe must recognise the urgent need to give people with OUD and their loved ones the right to hope for the treatment and care they need. Much remains to be done to ensure that national and local health systems can guarantee people with OUD are able to receive appropriate treatment and care. This call to action outlines key areas where action is needed, along with a set of targeted approaches for policymakers.

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1 Addressing equitable access to OUD treatment and care is an urgent policy priority in Europe

Opioid use disorder (OUD) is an urgent public health challenge in Europe. In 2020, around 1 million people in the European Union (EU) were reporting high-risk use of opioids, largely heroin; more than two thirds of them were in France, Germany, Italy and Spain.[1 27] The UK has 340,000 people with high-risk opioid use, higher than in any EU country.[28] Although opioids are not the most often used illicit substances in Europe, they are responsible for by far the greatest harm. In 2020, there were 4,300 opioid-related overdose deaths, which accounted for nearly three quarters of all fatal overdoses in the EU.[1] Worryingly, deaths from overdose among people aged 50–64 increased by 82% between 2012 and 2020.[1] This may indicate a trend of a growing proportion of people with OUD in the older age range.[1]

> ***'OUD can affect anyone in society. It is not restricted to certain socioeconomic conditions.'***
>
> **Charlotte Gedeon**, Sweden

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People with OUD may face chronic illness and poor quality of life. OUD is a chronic relapsing health condition (*Box 1*) and is often associated with multiple other conditions, including serious blood-borne infectious diseases such as HIV and hepatitis B and C.[3 4] People with OUD can also have a significantly lower quality of life than the general population,[2] including associated mental illness, unemployment and differential access to services, as well as strained relationships with their loved ones.[29] Many people with OUD may also have experienced a range of significant adverse life events, including childhood sexual and physical abuse.[E16 30]

Box 1. What is opioid use disorder (OUD)?

OUD is a chronic, relapsing health condition that involves compulsive opioid use. Opioids are both illicit substances (such as heroin or synthetic opioids) and prescription medicines for chronic pain. The compulsive use of opioids causes disruption to normal brain chemistry and function.[31] This creates a cycle of addiction through three stages: positive reinforcement (the 'high'); withdrawal, when the level of opioids begins to reduce in the body; and craving for more opioids.

> ***'OUD is a persistent and difficult-to-treat disorder. For a clinician, the task of helping people is complicated given the many physiological, psychological and social–economic comorbidities they may have.'***
>
> **John Marsden**, UK

OUD must be urgently addressed, not only to improve the lives of those directly affected, but also because of the wide-reaching impact it can have on families and communities. Families of people with OUD can experience conflict, exhaustion and isolation.[5 6] The consequences for children of a person with OUD can vary greatly. In extreme cases they can be at an increased risk of physical or emotional abuse, social isolation and housing difficulties.[32] For the broader community, in some cases, there may also be an increase in criminal activity associated with OUD.[1]

OUD places a significant financial burden on societies in Europe. Managing the impact of OUD is associated with a burden of costs for health and social care systems.[1 33] In France, in 2010 the annual healthcare and societal costs associated with illicit substance use, including heroin, amounted to almost €9 billion.[34] This included the costs of managing accompanying conditions such as HIV and hepatitis, overdoses, lower quality of life and productivity losses, among other issues.[34]

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2 Benefits of treatment and care: Comprehensive treatment and care for people with OUD can improve health, quality of life and societal outcomes

Comprehensive, multidisciplinary treatment and care are essential to improving outcomes for people with OUD. People who receive medication for OUD are at an eight times lower risk of death from overdose than people with OUD who are not receiving medication.[10] Medication for OUD has been linked to lower social costs and reduced risk of HIV infection among people who inject substances.[21] An overview of best-practice treatment and care for OUD, which include medication and psychosocial care, is provided in *Box 2*.

Medication for OUD can help reduce long-term healthcare costs. Evidence from Europe is limited, but data from the US suggest that people with OUD who receive medication use healthcare services less frequently and therefore incur lower costs than people with OUD

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who are not taking medication.[11] In the UK it is estimated that for every £1 invested in drug treatment, there is a £4 return on investment, increasing to £21 over 10 years.[12] In Sweden, a similar study found a return on investment of almost 18 kr for every 1 kr invested in an OUD treatment programme.[13]

Improving access to treatment and care for people with OUD has been recognised by the EU as a priority for Member States. The EU has produced drugs action plans, outlining actions for the EU and its Member States, since 1990. Its latest iteration (for 2021–2025) has a greater focus than ever on supporting people with OUD to reduce health and social risks and harms, including through increasing access to treatment and care.[36] The plan recommends the use of medication for OUD to reduce infectious diseases and overdoses related to opioid use.[37] It also recommends that policymakers support innovation in treatment delivery and new pharmacotherapies to increase access to treatment for all groups of people affected.[37] Addressing stigma is also recognised as an important element of the plan, with specific recommendations around creating training courses for decision-makers and healthcare professionals to increase awareness of the impact of stigma on people with OUD and the delivery of care.[37]

Box 2. What does best-practice treatment and care in OUD look like?

An integrated treatment plan for OUD involving medication and psychosocial care is recognised globally as best practice and has proven benefits for individuals and society more broadly.[7-9]

The aims of treatment include: reducing the risks associated with using illicit opioids; reducing the risk of death by overdose; preventing HIV and hepatitis B and C; and improving physical and mental health, and social outcomes.[7]

Integrated treatment plans should consider a person's individual needs and circumstances.[7] Factors such as ongoing physical and mental health conditions, side effects experienced for various medications, and their personal preferences should be taken into consideration when putting together a treatment plan.[7]

Innovative medicines for OUD, such as those which are long-acting, fast-dissolving and slow-release – combined with approaches such as allowing a person with OUD to take their medication home to reduce the need for frequent, sometimes daily visits to treatment centres – could be more appropriate for some people.[35] Evidence suggests that these innovative approaches may support greater adherence to treatment and sustained dosing at effective levels.[35]

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3 Barriers to accessing OUD treatment and care

Despite action at the EU level, policy barriers in many countries continue to hamper the ability of people with OUD to receive the treatment they need. Only around half of the people living with OUD in the EU receive medication for OUD.[14] At a national level the situation varies widely, with some countries, such as Italy, reporting only 30% (or fewer) of people receiving medication for OUD, while in France, it can be up to 80%.[14 15] A range of systemic and policy barriers prevent or limit access to medication for OUD, even where it is available in theory.[21]

> ***'Make it easier to get the treatment. It is currently too hard. People continue to die because of that.'***
>
> **Mirka Vainikka**, Finland

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3.1 The lack of accessible treatment centres and too few healthcare professionals who can provide medication can limit the ability of people with OUD to access treatment

In many countries, there are too few treatment centres, limiting the number of people who can be treated. National-level experts report that the number and distribution of centres are often insufficient to ensure all people with OUD can access treatment,[E18 E19] and legislative barriers can make opening new centres very difficult. In Sweden, for example, new centres have to get permission from a government agency to open, and treatment for OUD can only be initiated by doctors who are specialists in psychiatry, thus creating a significant bottleneck for the expansion of treatment facilities. Additional local requirements for new centres can include being open 365 days a year and having a combination of skilled personnel available including psychiatrists, nurses, social workers and psychologists.[E17] In countries such as Italy, geographical inequalities in access to treatment services have also been noted.[E38]

> ***'To make up for a shortage of doctors and centres, the government would like to allow hospitals to provide treatment. Yet some heads of hospitals say that they don't want "that kind of person" so doctors have to fight to be able to provide OUD outpatient treatment.'***
>
> **Maurice Cabanis**, Germany

The number of healthcare professionals who can provide medication for OUD seems to be decreasing, as indicated by some of the OUD experts interviewed for this report. This is a problem which may be getting worse in countries such as Germany, where older doctors are retiring and too few OUD specialist doctors are taking their place.[E39 E40]

> ***'In recent years, there has been an increase of people with OUD who need treatment and a decrease in the number of doctors who provide it.'***
>
> **Dirk Schaeffer**, Germany

When the number of clinics offering treatment is insufficient, waiting times can be very long. Expert interviews conducted for this report indicated that in Scotland, people with OUD could wait an average 14–16 weeks for treatment,[E16] whereas in some areas of Sweden this may stretch up to 6 months or more.[E17] In some countries, this is being addressed by increasing the number of clinics to support personal choice, which in turn is leading to greater uptake of treatment (*Case study 1*).

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Case study 1. Improving uptake of treatment for OUD with care choice reform, Skåne, Sweden

In 2014, the Skåne region in Sweden introduced a care choice reform for OUD treatment.[41] The aims were to increase access and give people more choice over their treatment.[41] People can now choose their provider, and any provider can access public funding as long as they meet basic organisational, competence and quality criteria.[E18 42]

Since the reform, there has been a sharp rise in the number of people with OUD receiving treatment, increasing by 53% between 2013 and 2017.[43] The number of clinics has also grown, from 8 in 2014 to 18 in 2018, and is now reported to have reached 27,[E17] with some set up in municipalities that did not previously have a clinic.[43] Even though the geographical spread of clinics in the region has improved, there is still room for improvement as some people with OUD still have limited access to treatment based on where they live.[43]

Waiting times to access treatment have dropped, while retention rates have increased since the start of the reform.[41 43] People with OUD can choose their treatment centre, which means that those who face challenges are more likely to change clinics rather than stop treatment.[41] Even people who are happy with their current clinic report the psychological value of knowing they can change clinics if they need to.[42] The competition that this invokes between clinics has helped to improve services and relationships between staff and people with OUD.[42]

A Swedish expert interviewed for this report noted that Skåne is seen as a benchmark for the rest of the country.[E18]

> ***'The capacity of the treatment system is shrinking. It is hard for people with OUD to receive continuing care that links to their wider social needs. More is needed to offer a complete treatment package.'***
>
> **John Marsden**, UK

Greater use of digital tools may help to address shortages in the availability of care and improve treatment retention for some people. Telemedicine can allow some people who would otherwise be unable to receive treatment and care – especially those in rural areas – to talk with a healthcare provider. Accessing treatment and care through telemedicine can also address internalised stigma and anxiety, which prevents some people with OUD from attending clinics in person.[44]

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> ***'Telemedicine can be an important tool to improve access to psychotherapists, but this is not a solution that fits everyone as some people would prefer to see their doctor face to face.'***
>
> **Albert Caporossi**, France

3.2 Overly restrictive eligibility criteria can exclude some people with OUD from accessing and remaining in treatment and care

Restrictions on who can access treatment for OUD and the criteria that must be fulfilled to continue treatment can exclude many people. Criteria to begin OUD treatment may include minimum age (e.g. in Spain) and the need to demonstrate unsuccessful prior treatment (e.g. in Finland).[20] Some restrictive criteria can also impact the ability of people with OUD to stay in treatment. In some regions of Finland, for access to unsupervised dosing, people must demonstrate they are 'stable and motivated' to continue their treatment.[20] In Germany, an OUD expert reports that requirements such as urine samples for illicit substances and alcohol tests can present a high threshold to accessing or remaining in treatment, especially if combined with an unstable social situation. This can lead to some people with OUD discontinuing their medication.[E19]

> ***'Doctors can face prosecution for criminal offence if they violate the very strict laws, for example by prescribing medication for OUD when the person with OUD is also consuming other substances. In 2017, the narcotics regulation changed, and regulations were relaxed, though barriers and fear of repercussions remain.'***
>
> **Martin Degenhardt and Benjamin Laub**, Germany

Many countries require treatment to be provided daily at specific facilities, effectively excluding people who may have family and work commitments, indicate experts interviewed for this report. National regulations in Sweden require new patients on oral medication to visit a centre every day for at least three months.[E17] This can be difficult to manage for people who have jobs or caring responsibilities, or for those who find it too complicated to attend a centre every day, and can lead to high rates of drop-out.[E17] In Germany, on the other hand, it is now possible for some people with OUD to take up to 30 days' worth of medication home, regardless of how long they have been in treatment.[E19] In some areas of Italy, a pilot project allowed retail pharmacies to provide some people with OUD treatment at better-suited locations and times (*Case study 2*).

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Case study 2. Supporting people with OUD to maintain social and work commitments by dispensing treatment in retail pharmacies, Italy

In 2012, the Department of Addictions and Mental Health in Pordenone, Western Friuli, highlighted the need to expand the range of locations and hours for access to OUD treatment to ensure continuity of care, improve autonomy for people with OUD, reduce costs and improve treatment adherence.[45] The department set up a small pilot initiative which allowed people with OUD to collect up to 30 days' worth of treatment from retail pharmacies.[E38 45]

Entry criteria for the pilot required people with OUD to have a job and good social and family integration. They needed to be clinically stable on treatment, with good compliance and no evidence of misuse or diversion of their treatment.[45]

At the end of the pilot in 2017, people with OUD highlighted the advantage of being able to collect treatment from a wider range of locations at a time that suited them, enabling them to manage work, family and social commitments.[45] People also emphasised that they felt less stigma and had a positive self-image.[45] No relapse of using illicit opioids was recorded during the pilot.[45] Pharmacists also benefited as they were able to upgrade their professional skills by completing training on addiction, the treatments offered, and counselling and support to help empower people with OUD.[45]

Healthcare organisations and healthcare professionals reported that this model of supplying treatment also optimised the costs and management of resources, and has the potential to ensure continuity of care, increased availability of access to treatment, better treatment monitoring, and better adherence to treatment.[45]

This model highlights the benefits of a more flexible service, especially for people who are stable on treatment and socially integrated indicated an expert in OUD interviewed for this report.[E38]

> ***'For no other disease area would service users be turned away. Users can be barred from a service or put to the back of the list for showing the symptoms of their condition – you are told you are not showing commitment. There is no policy to stop this happening.'***
>
> **Annemarie Ward**, UK

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3.3 Effective and comprehensive treatment and care may not always be available

The effectiveness of treatment relies on the person taking an appropriate dose of medication for OUD. Suboptimal dosing can affect a large proportion of people with OUD and have a significant impact on treatment success.[20 46 47] People who do not receive the correct dose may choose to stop taking their medication as directed or may relapse, leading to either discontinuing treatment completely, or in some cases using illicit opioids alongside their OUD medication.[48-52] On the other hand, higher initial doses of medication for OUD are associated with lower mortality for short-term treatments.[53]

> ***'Prescribing the correct dose for a person with OUD is essential for their continued treatment.'***
>
> **Maurice Cabanis**, Germany

Dependence on opioids is often accompanied by a dependence on other illicit substances, alcohol and prescription medicines. Estimates from 2020 indicate that, in Europe, the majority of overdose deaths result from the use of multiple substances including opioids, other illicit substances, medicines and alcohol.[1] While psychosocial interventions can reduce the use of multiple illicit substances, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) identifies the need for treatment models that take holistic approaches to a person's substance use.[54]

> ***'In the UK, many people with OUD are also addicted to cocaine. There are no substitution medications for cocaine, which makes it difficult to treat someone with these dual addictions. In fact, people with OUD and cocaine addiction are more likely to drop out of their OUD treatment than people receiving OUD treatment alone.'***
>
> **John Marsden**, UK

Psychosocial care is essential but can sometimes be neglected. While official medical guidelines often recommend that OUD treatment combine medication and psychosocial care, this comprehensive approach is often not available in practice. In Sweden, for example, there can be a need to differentiate these types of care, as people who find it difficult to continue treatment may need more support and closer contact.[55] In the UK, experts have noted the missed opportunity associated with a lack of focus on psychosocial interventions which can increase the chance of someone with OUD discontinuing their medication.[E16 E56]

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> ***'[People with OUD in Scotland] are only getting medication and are not receiving psychosocial support or being able to access group work. Services have been stripped back so much that, for people with OUD, the treatment being offered isn't worth showing up for.'***
>
> **Annemarie Ward**, UK

Healthcare providers may not always be familiar with current clinical evidence and standards of care, which can impact the quality of care available to people with OUD. The extent of training that care providers have received on OUD treatment can vary between European countries. Some treatment providers in primary care settings report feeling under-trained to deliver treatment.[57] Additional training is also required to make sure healthcare providers are up to date with the most recent clinical evidence. In Sweden, for example, an expert interviewed reported that although care guidelines are adequate, their implementation is sometimes insufficient owing to a lack of staff training.[E17] One example of how this might be addressed can be found in the UK, where the Best practice in Optimising Opioid Substitution Treatment (BOOST) e-learning programme provides healthcare professionals with guidance on how to implement current guidelines (*Case study 3*).

> ***'Many regions [in Sweden] still work according to old regulations which made treatment entry unnecessarily difficult, and even excluded some patients from treatment, so there is a great need for specific training of staff to be up to date with newer, more inclusive regulations.'***
>
> **Charlotte Gedeon**, Sweden

3.4 Innovative treatments for OUD exist but access is limited

Although a variety of medicines exist, people with OUD often do not have enough choice in what they receive. Sometimes, the most commonly available treatments do not meet the needs of a person with OUD. This can be because some medications need to be taken daily, which may not suit everyone's lifestyle.[35] Innovative, slow-release, or long-acting treatments have only been introduced in a handful of countries so far.[21] Although these may not be suitable for every person with OUD, they can provide a viable alternative.[E56 E63]

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Case study 3. Training for healthcare professionals to improve quality of care, England, UK

The Best practice in Optimising Opioid Substitution Treatment (BOOST) e-learning programme was developed by Public Health England in 2021.[58] It aims to improve the quality of OUD treatment by providing healthcare professionals with the appropriate training.[58]

The programme is mandatory for all addiction treatment and recovery professionals in the National Health Service (NHS), voluntary and private sectors.[58] It is also recommended for managers and other professionals working in substance addiction treatment services.[58] The programme comprises six sessions, including how to support someone to start treatment and get the most out of it, and optimising treatment (e.g. by switching medication).[58 59] The programme outlines how to implement current clinical guidance in a practical way, including through videos showcasing conversations between healthcare professionals and people with OUD to demonstrate typical clinical scenarios.[58]

BOOST is part of Public Health England's wider opioid treatment good practice programme,[60] which also includes a self-assessment tool for healthcare professionals. The tool contains guidance on assessing current OUD treatment practice and best practice.[61] The opioid treatment good practice programme also includes an OUD treatment guide for addiction treatment and recovery workers.[62]

> ***'In France, access to basic medication for OUD in general is good but we need to increase the number of medicines available.'***
>
> **Albert Caporossi**, France

3.5 Treatment and care services lack choice and are often not sufficiently tailored to the needs of specific groups

People with OUD in prisons often face restrictions and barriers to accessing treatment that meets their needs, as well as challenges in continuity of care once they are released. People with OUD in prison tend to have fewer treatment options available to them than in the general population, and can face legislative barriers and difficulties in ensuring continuity of care.[23] In Germany, even though people in prison may have good access to OUD treatment, one study identified the need for a diversification of the types of medication used, as well as a need for consistency and standardisation in treatment approaches.[64] In Finland, an expert commented that people in prison have limited access

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to treatment,[E65] while in Italy, an expert noted that the availability of medication for OUD in prison can depend on the institution.[E38] People with OUD in prison are at a high risk of death in the immediate period following their release, at least in part because of their reduced tolerance to opioids while in prison and their return to unstable social situations which can trigger a relapse.[66 67] Providing people with medication for OUD while they are in prison and, importantly, continuing this after their release can reduce their risk of overdose-related death in this critical post-release period by as much as 85%.[66 67]

> ***'Framing access to OUD treatment in prison as a human rights issue can help. After a prisoner went to the human rights court in Europe because they couldn't access medication, access in prisons improved dramatically.'***
>
> **Dirk Schaeffer**, Germany

Older people with OUD need programmes of care specifically tailored to their needs, but these are often not available. In Europe, a growing proportion of older people are living with OUD. If this trend continues, some commentators argue that older people could become the main group in OUD treatment.[22] Their needs are complex, often owing to many years of opioid use compounded by common health problems associated with ageing.[22] Despite this, specific treatment programmes are rare for this group, and health systems seem unprepared for their complex needs.[22] In some cases, older people with OUD have reported stigma at an institutional level, leading to a deep distrust in the health system and feelings of being 'dehumanised'.[68]

> ***'Older people can face humiliating practices within centres – younger members of staff would be asking to check under their tongue when they leave to check they aren't smuggling anything out.'***
>
> **Maurice Cabanis**, Germany

Women with OUD are a particularly vulnerable group requiring specially tailored approaches to treatment and care. Women with OUD face important gaps in the availability of comprehensive, coordinated and integrated services. They often experience coexisting psychiatric conditions and may also experience intimate partner violence, among other challenges, which require differentiated approaches to ensure good uptake of treatment and care.[24] Pregnant women with OUD are also an important group to consider; they experience six times the number of obstetric complications than women

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who do not use opioids and may give birth to low-weight babies, who may experience opioid withdrawal themselves.[69] Despite the importance of addressing the specific needs of women with OUD, there are important gaps in our understanding of OUD in women and, subsequently, of the most effective tailored treatment responses. There are also gaps in services that focus on particular subgroups, such as women who are older, women with OUD who also use other illicit substances, and women who misuse prescription medications.[70]

3.6 Stigma is pervasive at all levels of society, impacting policy and service delivery for people with OUD

Stigma is a multifaceted and ubiquitous barrier to adequate care. Personal histories or comorbidities associated with opioid use could further amplify the stigma faced by people with OUD. Some people report poor treatment from healthcare professionals, such as being considered untrustworthy or less valuable than other patients; this may lead them to hide details such as substance use history or OUD status, which could affect their treatment.[25] In the UK, an expert highlighted that some people with OUD view observed dosing of medication for OUD in retail pharmacies to be stigmatising and that this may motivate treatment discontinuation.[E56] Stigma associated with OUD is also a significant barrier to accessing treatment for people in the criminal justice system.[71]

> ***'In Finland, healthcare professionals do not view OUD as an illness… People with OUD are not trusted by healthcare professionals and this can impact the treatment and care they receive.'***
>
> **Mirka Vainikka**, Finland

While there are some signs of progress in addressing stigma, improvement in the perception of OUD is very slow. During the COVID-19 pandemic, members of the Network of Early Career Professionals working in the area of Addiction Medicine (NECPAM) representing ten countries globally identified a need to tackle stigma associated with OUD to improve care.[26] Several approaches were proposed to achieve this, starting with the decentralisation and integration of addiction services with other health services. As a next step they suggested a media campaign to tackle stigma, acknowledging and prioritising the physical and mental health of people with OUD, and recognising the role of loved ones in recovery.[26] Some advocacy organisations have already launched campaigns to tackle stigma (*Case study 4*).

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Case study 4. Using storytelling to tackle stigma, Scotland, UK

In 2019, Favor UK launched a campaign called 'You keep talking, we keep dying'. The aim was to tackle stigma by raising awareness among decision-makers of the high overdose-related death rate in Scotland and the lack of investment in harm reduction policies.[72 73]

The campaign involved a number of activities: a vigil of remembrance to mark the number of overdose-related deaths, an International Overdose Awareness Day meeting in Glasgow, and a report outlining the problems facing people who use illicit substances, with 23 recommendations for the government to address these issues.[72-74]

A key part of the campaign was communicating the personal stories of people with OUD and the challenges they face in getting access to care.[73 75] It highlighted that storytelling is an important way to tackle stigma.[E16] The publication of personal stories in the media may have helped to humanise people with OUD and challenge the stigma around the condition.[73]

As a result of the campaign, the Scottish government has openly stated that more needs to be done to address the issue and to take a person-centred approach to addictions policy.[73 76] The government also pledged £250 million to harm reduction policies over the next five years.[77]

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4 Call to action: European policymakers must take urgent action to ensure people with OUD receive the care and support they need

Policy and systemic barriers exclude too many people with OUD from receiving the comprehensive, multidisciplinary and tailored care that they need. Only around 50% of people with OUD in Europe are benefiting from treatment, with wide variations between countries.[1 27] There are significant gaps in access to both medical and psychosocial care. People with OUD may face a lack of choice in the range of treatment options available to them, an insufficient number of clinics, long waiting times, and unfair and restrictive eligibility criteria.

> ***'First, we need to build capacity for treatment. Second, we need low barriers for entry and high barriers for exit.'***
>
> **Petter Odmark**, Sweden

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Everyone should have a right to hope. While the recent EU Drugs Action Plan provides some clear guidance and concrete actions to Member States to ensure that people with OUD have this right, there is still much to be done.

> ***'There is fragmentation among national institutions regarding substance dependencies. Legal substances, like alcohol and tobacco, are under the tutelage of the Ministry of Health. Illegal substances, like many opioids, are under anti-drug departments and policies. A public health approach for OUD is needed to support better coordination.'***
>
> **Cristina Meneguzzi**, Italy

The authors and contributors to this report call on European policymakers to take the actions needed to ensure people with OUD can receive comprehensive and tailored treatment. Specifically, we call on policymakers to work with relevant stakeholders to ensure:

- ✔ all people with OUD have access to a variety of treatment and care options tailored to their needs
- ✔ national, regional and local regulations facilitate equitable access to treatment and care for OUD
- ✔ adequate numbers of healthcare professionals and facilities delivering care in line with the latest clinical evidence
- ✔ availability of specific guidance on tailoring care for specific groups of people with OUD, such as older people, women and people in prison
- ✔ adequate resources within the health systems to care for people with OUD, including innovative therapies and models of care
- ✔ developing and implementing strategies to address stigma in policy (recognising the right to treatment as a human right)
- ✔ progress monitoring within individual countries against indicators for access to treatment outlined in the EU Drugs Action Plan 2021–2025, and addressing any identified gaps.

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