European Monitoring Centre
for Drugs and Drug Addiction

Final Meeting Report

EU expert meeting on the EMCDDA key epidemiological indicator
Drug Related Infectious Diseases (DRID)

EMCDDA, 16-17 October 2013

EMCDDA, 24 June 2013

(Draft report circulated on 29 November 2013)

European Monitoring Centre for Drugs and Drug Addiction

EMCDDA annual expert meeting on Drug-related infectious diseases (DRID) 16-18 October 2013 – EMCDDA (Lisbon)

Authors and acknowledgements

This report was prepared by Anastasios Fotiou (Greek National Focal Point) and Lucas Wiessing (EMCDDA). Isabelle Giraudon (EMCDDA) contributed to the parts on the joint DRID and DRD sessions. The ideas and discussions provided by participants during the expert meeting which are summarised in this report are highly appreciated.

Summary of key findings

1. The DRID expert meeting was held on 16-18 October 2013 at EMCDDA. For the first time, the DRID meeting was organised in combination with the DRD meeting, having both separate sessions and combined plenary sessions covering common themes[1]. The last day of the DRID meeting was dedicated to the HIV risk assessment with a focus on economic indicators (the report for the HIV risk assessment day is provided in a separate document).

2. The objectives of the 2013 DRID meeting were to assess and discuss recent developments on DRID in Europe, including: (a) Progress, new developments and future strategy review of DRID, (b) Results from recent work (international collaborative projects, national studies, analyses, etc) related to drug-related infectious diseases and (c) assessment of HIV outbreak risks. The meeting also aimed at bringing together expertise from multiple domains and enhance cross-indicator collaboration and networking. As such, the DRID meeting revolved around the following themes:

   - Progress with DRID and achievements
   - DRID strategy review
   - New insights from European studies on epidemiology and interventions
   - HIV outbreaks and countries at risk

3. Progress achieved in DRID concerns the following areas: conclusion of three modules of DRID Toolkit (guidance on bio-behavioural studies, behavioural indicators, and example questionnaire); analysis of the behavioural pilot data set collected since 2006; risk assessments and outbreaks management (HIV outbreak in Romania and Greece and anthrax outbreak in mainly UK); new results from the DRID modelling group; HCV systematic review of the literature, and other projects (including relative infection risks of drug injecting and stimulant use).

4. Results of a DRID strategy review meeting were discussed in plenary and further developed in 8 workshops covering: Monitoring HBV vaccination; Burden of HCV disease; Capacity building and feedback to service providers; networking of experts; Diagnostic testing prevalence data; Reporting and use of subnational data; categorising and grading data; reporting burden; Monitoring other infections (TB; HAV; STIs; spore-forming bacteria; MRSA); Using TDI data for DRID / DRID study in treatment centres; Non-IDUs; other groups (steroid users; and MSM who use drugs)

   4.1. Following expert contribution, the key conclusions of the DRID strategy review workshops were:

      4.1.1. Additional consideration is needed regarding the monitoring of HBV vaccination coverage, also taking into account the burden involved with data collection and reporting;

      4.1.2. More attention should be given to communicating effectively DRID data with data providers and other key stakeholders at the national level, while more attention should be given to the national working groups;

      4.1.3. In addition to HIV, HCV and HBV markers, EMCDDA should consider only collating available data on tuberculosis among IDUs;

      4.1.4. For monitoring emerging trends and risks a communication platform is needed with the national DRID experts playing a major role in disseminating information published in the platform;

      4.1.5. The possibility of implementing a cross-European prevalence study on infectious diseases in the treatment system should be considered (keeping in mind the burden involved with data collection and reporting) although the opportunity offered for DRID by the existing TDI system should also be looked at;

      4.1.6. Drug use among MSM and sex-and IDU related HIV transmission risk are topical issues that may deserve ad hoc, but not routine, EU analyses.

[1] The minutes of the DRD meeting, including its plenary and parallel sessions are available from the DRD restricted access area - for participants in the expert meeting and national focal points (http://projects.emcdda.europa.eu/alias.cfm/areaDRD - username: area3, password: DRD2012)

5. New insight from European studies on DRID epidemiology and interventions:

HIV

5.1. An EMCDDA study on estimating HIV mortality related to IDU and how these estimates are reflected in the different European countries

5.2. An University of Tartu/EMCDDA collaborative project analysing differences in injecting risks and HIV infection between PWID in Eastern and Western Europe

5.3. The ARISTOTLE research and prevention intervention implemented in Athens with the aim to, inter alia, contain the HIV outbreak among PWID in the city and link HIV positives to treatment

5.4. The Spanish component of the European MSM Internet Survey (EMIS) indicating that monitoring of drug use and determinants among MSM should continue in order to inform effective prevention strategies

5.5. An evaluation of the state-of-the-art in HIV and service provision in Europe, ten years after the 2003 European Council Recommendation on prevention and reduction of health related harms associated with drug dependence.

HCV

5.6. A Europe-wide research, practice and policy initiative on Hepatitis C with the aim to improve the knowledge, capacity and policy advocacy in this area, specifically also targeting drug users

5.7. A Finish initiative to measure HCV burden of disease in drug users

5.8. A study on UK data looking at the incidence of hepatitis C infection among people who inject drugs indicating frequent imprisonment, female gender and hepatitis B ever-infection as potential determinants of recent HCV infection.

Other infections

5.9. The background and key aspects of the ECDC/EMCDDA Joint anthrax prevention guidance for PWID in response to the recent anthrax outbreaks in some European countries

Next steps

- DRID diagnostic testing data: there is an urgent need to better understand these data, this may lead to future guidance (as part of DRID toolkit)
- DRID Behavioural data: EMCDDA aims to publish, beginning of 2014, the results from the analysis of the pilot behavioural data collection.
- DRID data: EMCDDA will further expand the exercise of reviewing and grading of DRID studies, methods, sites, and indicators with the aim to improve comparability and reduce data analysis burden.
- Strategy review: EMCDDA and the DRID Advisory Group will elaborate on the conclusions drawn in the context of the strategy review workshops and develop a plan for further actions.
- Rapid risk assessments to continue in the framework of DRID meetings and a platform on emergent risks to be established
- Next meeting: in the week of 15-17 October 2014, likely to be held again in combined form with DRD—exact dates and format to be confirmed

Abbreviations

FP	Focal points
DRD	Drug related deaths
DRID	Drug related infectious diseases
HIV	Human immunodeficiency virus
NGO	Non-governmental organisations
ECDC	European Centre for Disease Control and Prevention
NSP	Needle and syringe programs
OST	Opioid substitution treatment
PLHIV	People who live with HIV/AIDS
STIs	Sexually transmitted infections
SMR	Standardised mortality ratio

Chairs of DRID Day 1 and of the Joint DRD/DRID on Day 2

Julian Vicente & *Alexis Goosdeel*, **Welcome**
Julian Vicente & *Lucas Wiessing*, **DRID plenary sessions**
Marica Ferri & *Viktor Mravcik*, **Mortality cohort studies among drug users**
María José Bravo & *Vivian Hope*, **Mortality related to infection HIV, anthrax: service provision & guidelines**
Magdalena Rosinska & Mika Salminen, **Hepatitis C infection in PWID**
Isabelle Giraudon & Gergely Horvath, **Harm related to new psychoactive drugs and methamphetamine**
Dagmar Hedrich & *Teodora Groshkova*, **Prevention of overdose and infection**
Isabelle Giraudon & Lucas Wiessing, **Closure**

Moderators in DRID workshops on Day 1

Mario Cruciani **Workshop 1**
Mika Salminen **Workshop 2**
Anastasios Fotiou and Frederic Denecker **Workshop 3**
Catherina Matheï & Magdalena Rosinska **Workshop 4**
Eleni Kalamara, Sandrine Sleiman & Andre Noor **Workshop 5**
Hans Blystad **Workshop 6**
María José Bravo & Julián Vicente **Workshop 7**
Vivian Hope **Workshop 8**

Meeting Report[2]

EU expert meeting on the EMCDDA key epidemiological indicator
Drug related Deaths (DRD) and Drug Related Infectious Diseases (DRID) EMCDDA
16-17 October 2013

Background of the 2013 DRID meeting

1. Since 1996 the EMCDDA is annually monitoring 'Drug related infectious diseases' (DRID, mainly HIV and viral hepatitis prevalence) among injecting drug users (IDUs) in the EU, as one of its five 'key epidemiological indicators' of drug use and consequences. This is done using a standard form for the collection of existing data (Standard Table 9 or ST9) through an online data collection system (Fonte). Data can come from seroprevalence surveys among IDUs or from diagnostic testing of IDUs in services. The first guidance (ST9 and overview DRID guidance document) were developed in 2000 with help of SCIEH, Scotland.
2. In 2006, a draft protocol was developed in collaboration with the Greek national focal point, giving more detailed guidance to improve the comparability of primary DRID data collection (sero-behavioural studies) among IDUs in Europe. From this protocol, which included an extended 'example questionnaire', a shortlist of behavioural indicators was proposed for inclusion in ST9, with the purpose of monitoring key behavioural factors and risks for infectious diseases in IDUs (see ST9 part 3). Given the state of low comparability of behavioural indicators between countries, it was decided to keep the 2006 draft protocol draft for a few years in order to pilot and further develop the EMCDDA behavioural indicators, before the protocol would be finalised.
3. At the 2009 annual DRID expert meeting the finalisation process of these draft tools was started, with a first focus on the behavioural indicators in ST9 part 3, resulting in a list of suggestions for change of these indicators (see 2009 meeting report). These suggestions were fed back during 2010 in an EU-wide consultation of national experts on which they could 'vote' (for results see the expert consultation report, meeting document 3 at the 2011 expert meeting). In 2009 it was also decided not to finalise the original draft protocol, but to convert it into a Modular 'Toolkit' consisting of multiple more specialised documents ('modules') that could be developed more flexibly and according to need.
4. In the 2011 meeting the final version of the behavioural indicators ST9 part 3 were reviewed and presented in a first DRID toolkit module 'Behavioural Indicators'. A second module 'Example Questionnaire' was also presented suggesting example formats for actual data collection at national level.
5. In the 2012 DRID meeting the third (draft) module 'Methods for Serobehavioural studies' was presented for designing and implementing seroprevalence surveys at the national level.
6. In 2013, following initial discussions at the 2012 expert meeting, a small expert strategy meeting was convened of members of the DRID advisory group and EMCDDA staff, to discuss the future needs of DRID. This resulted in a number of recommendations that were further discussed with the DRID experts in eight workshops during the 2013 DRID meeting (see this report). The recommendations range from "improving the communication infrastructure to help the DRID network to interact rapidly" to "improve our understanding of the strengths and limitations of the prevalence data collected".
7. The 2013 DRID was organised back-to-back with the DRD meeting with the aim to increase cross-indicator collaboration and exchange of intelligence and at the same time to reduce costs. The meeting had plenary sessions that were common for DRD and DRID as well as parallel sessions devoted to each indicator. Central in the DRID component of the 2013 meeting had been working on the review strategy. To that end, eight (8) workshops were implemented around the following topics (moderators in brackets): *Monitoring HBV vaccination through the existing EMCDDA data system* (Mario Cruciani), *Burden of HCV disease* (Mika Salminen), *Capacity building and feedback to service providers, networking of experts* (Anastasios Fotiou), *Diagnostic testing prevalence data* (Cathy Matheï & Magdalena Rosinska), *Reporting and use of subnational data, categorising and grading data, reporting burden* (Sandrine Sleiman, Eleni Kalamara, Andre Noor), *Monitoring other infections* (TB, HAV, STIs, spore-forming bacteria, MRSA) (Hans Blystad),*Using TDI data for DRID / DRID study in treatment centres* (Maria Jose Bravo, Julian Vicente)
8. All presentations and meeting documents for both days of the meeting are available from the restricted DRID website of EMCDDA http://projects.emcdda.europa.eu/areaDRID (username: area16, Password: DRID2012). The main points of these presentations are reviewed in this report.

[2] This report covers the DRID sessions of Day 1, as well as the joint DRD/DRID sessions on Day 2 and the HIV risk assessment sessions on Day 3. For the minutes of the DRD sessions, see footnote 1.

Objectives of the 2013 DRID meeting and joint DRID/DRD day

1. To assess and discuss recent developments on DRD and DRID in Europe, including:
    a. Recent findings of European mortality cohort studies and monitoring of drug-induced deaths
    b. DRID strategy review and HIV outbreak risk assessment follow-up
2. To convene the DRID and DRD expert networks for information exchange and stimulating new initiatives

DAY ONE

Welcome speeches

Chair: Julian Vicente & Alexis Goosdeel, EMCDDA

Julian Vicente (JV), EMCDDA
Welcome speech

JV introduced the meeting welcoming the focal point (FP) representatives, the nominated and invited national experts, EMCDDA colleagues, ECDC and other organisations. He highlighted that the annual expert meetings of the EMCDDA serve several purposes and that the EMCDDA's main aim is to enhance the utility and relevance of the key epidemiological indicators including cross-indicator work. The new format of the present meeting (combining the DRID and DRD meetings) aims at reinforcing cross-area cooperation and work inside and outside EMCDDA. It offers greater opportunity of synergy between the two areas which is hopefully reflected in the presentations and discussions that will take place. More than 20 plenary and parallel sessions as well as technical workshops will be held over three days. This will maximise the opportunities for the participating epidemiologists and other experts to discuss some technical issues related to monitoring drug-related harms, and to present and discuss the new developments in their countries as well as their implications for public health.

Alexis Goosdeel (AG), Head of Reitox coordination Unit, EMCDDA
Welcome speech

AG stressed some important points of the background on which this combined meeting takes place: the collaboration with the national focal points and their nominated experts constitute the basis of the EMCDDA work, enabling it to provide Europe with relevant data on monitoring the drug situation in Europe. After more than 15 years of building and consolidating the key epidemiological indicators in particular, the Reitox network and EMCDDA ensure that sound, robust and comparable data are more and more available to inform policy making. AG referred to the evaluation and revision process for the annual key indicator expert meetings resulting in the introduction of this new format, in line with the recommendations of the evaluation conducted by Alan Lodwick. This DRD/DRID joint meeting is special because of its 3 days duration, its complementary themes, and the involvement of many experts and organisations. AG stressed that the continuous challenge is to produce information which meet a purpose, to allow evidence based decisions to be made and to link decisions with the responses that have an added value. This is particularly important these days, with the economic pressure for organisations to deliver cost-effective outputs with evident European added-value. Another challenge is to feed-back and communicate effectively information to policy makers and to other stakeholders. Added-value and effective communication will help much towards the sustainability of the European and national monitoring systems. AG also referred to upcoming (EMCDDA and ECDC) expert meetings in Serajevo, Talinn and Bucharest which will follow on the present meeting in Lisbon, in particular on the issue of HIV outbreaks.

Open speeches

Luis Mendão (LM), Civil Society Forum on HIV/AIDS
Brief civil society address

LM thanked EMCDDA and ECDC for putting attention to the issues of infections, economic crisis and responses. He stressed the importance of discussing the adverse health effects of the economic and social crisis in Europe and the increasing socio-economic disparities in many member states that affect mainly the most vulnerable groups. He commented on a Europe that concentrates on an ageing population and the general well-being of its population, but does not give much attention to transmissible diseases or those population groups most affected by poverty and social exclusion. LM stressed the need to put these issues higher on the agenda. This is not an easy task as the vast majority of the population is less affected by the phenomenon of drug use and transmissible diseases related to sex and drug use. The situation requires close collaboration between all actors in this area. The challenge is to deliver the right information at the right level. According to LM, apart from the key responses related to needle and syringe programs (NSP) and opioid substitution treatment (OST), the drivers of drug use and infection related risks in many countries are rather social determinants that are not directly addressed by these interventions. Finally, LM urged to look more often from the viewpoint of the drug users, in order to understand these phenomena better.

DRID plenary contributions

Chair: Julian Vicente & Lucas Wiessing, EMCDDA

Lucas Wiessing (LW), EMCDDA
Introduction, meeting objectives and overview of DRID activities

LW provided a brief overview of DRID activities and projects. These are summarised in the following areas: (1) the DRID Toolkit – the first 3 modules providing basic DRID guidance will be published by the end of the year. One of them is about how to set up bio-behavioural studies among PWID at the national/local level. Another module is about defining behavioural indicators. A third one is an example questionnaire that can be used as a collection of individual example questions or sections that can be used in studies in this area. Routine diagnostic testing data may be the theme of a future module (see workshop). (2) Analysis of the behavioural data in a report planned to be published beginning next year. This data collection has been introduced and implemented by a number of countries since 2006 (in ST9/Fonte) providing a pilot data set available for analysis. At the same time we have been revising the indicators and for some of them there is going to be a change in format (see Toolkit). The report shows that there are difficulties with the comparability as well as the availability of the data, but the situation is improving. There is also an issue about how many data can be handled by EMCDDA and in some countries there is a need for evaluation of the amount of DRID data being provided. One of the key difficulties is the aggregate nature of the data and the inability to assess associations between the variables at the individual level. (3) A DRID strategy review meeting was held in July with a limited number of DRID advisory group members, which has produced some interesting ideas (see next sections). (4) The DRID modelling group is an ongoing project with an open invitation of those interested to join the group. It has resulted in a number of publications, one piece of work being presented at the meeting (Mait Raag etal). Other key activities have been the risk assessments (since 2010 intensive work has been done on outbreak management regarding HIV and anthrax), in the last 2 years the HCV systematic review was carried covering 7 sub-areas, assessing and compiling data that are related and useful for guiding HCV treatment in the EU, and a systematic literature review regarding the risks for infection between IDU and non-IDU populations and between stimulant and non-stimulant users, both foreseen to be published in 2014.

Vana Sypsa (VS), Greece
HIV outbreak in Greece, results of the ARISTOTLE study

VS presented data on a research and prevention programme which was set up in response to the ongoing outbreak of HIV infection among IDUs in Athens, Greece. Its aims have been to screen IDUs in Athens Metropolitan Area for anti-HIV and provide the WHO/UNODC/UNAIDS and ECDC/EMCDDA prevention, treatment and care packages. Recruitment is performed in 5 sampling rounds in a period of approximately 16 months (August 2012-December 2013). Respondent driven sampling (RDS) is employed to recruit approximately 1400 IDUs in each sampling round. Participants are interviewed and provide a blood sample for HIV testing. In the first 4 rounds, 5700 questionnaires and blood samples were collected and 3,007 unique persons participated to the programme. Out of 3007 participants, 17% tested anti-HIV(+). The weighted HIV prevalence per round - accounting for RDS design - ranged between 13.7%-17.5%. Approximately half of the seropositive participants were diagnosed for the first time through Aristotle. Homelessness, using cocaine as the main substance of injecting drug use, injecting once per day or more and sharing syringes were found to be independently associated with increased risk of HIV infection. Depending on the sampling round, 54%-62% of IDUs reported having received free syringes through health prevention activities carried out in Athens within the past year with a median number of 20 syringes. A low, but increasing from round to round, proportion of participants were current OST participants (10.4%, 15.5% and 20.2% in rounds A, B and C, respectively). The results of the programme so far indicate that there is high HIV prevalence among IDUs in Athens, and on-going high-risk behaviour, including frequent drug injection, syringe sharing, and low reported access to needle and syringe distribution services. In addition to scaling up prevention services, addressing homelessness is a priority in order to reduce HIV transmission and improve linkage and retention to care.

In the follow-up discussion: **Cruciani** asked whether, based on the phylogenetic analyses and genotyping, there have been new subtypes from countries other than those before the outbreak. *VS* responded that new subtypes have emerged, subtypes that were not present in blood samples collected in the previous years (example: CRF subtypes). **Another** question concerned the possible reasons for the outbreak (e.g. change to service provision in relation also to the economic crisis) and the current level of coverage especially of OST. *VS* highlighted the complexity of the issue but she referred to the recently published paper in PloS One where it is argued that the economic recession may have played a role in this outbreak. *VS* also mentioned the significant increases in OST coverage but at the same time long waiting lists for entering OST in Athens. *VS* finally referred to the possible role

of behavioural changes (e.g. frequency of injection, sharing) in the recent years. **Mendão (LM)** stressed the importance of monitoring antibodies for HCV for having a more complete picture of the antibodies present. LM commented that the reasons why NSP and OST are still below standards are not comprehensible. *VS* agreed that the problem insists for OST, but that there has also been some good progress with the involvement of the public hospitals. As for HCV, tests have been collected and analysed for only a sub-sample of the ARISTOTLE's population. **Bravo** (MJB) asked about the percentage of the new injectors in this population (onset in the last 1-2 years). *VS* responded that the study used a measure about years of injection and based on data from that item, ARISTOTLE estimated an incidence of about 20 new cases per 100 new injectors per year. **Blystad** (HB) raised the issue of homelessness and wondered whether there are other infections among these people (e.g., TB or bacterial infections). *VS* replied that no data are available on other infections. **Salminen** (MS) asked about the real linkage of people who get referred and whether there is a follow-up for this population regarding retention, adherence to treatment for HIV. MS also asked what is the cost of the study and, especially, the breakdown between the study and services provided including any possible follow up studies. VS was not aware about the costs of the study. As for linkage VS commented that this is the most challenging part of the project and that there is staff in the programme dedicated to help with linkage. However, not much info is available about whether that person retained in care. Some monitoring is being taking place by the Hellenic Centres for Disease Control (KEELPNO), but it hasn't been easy. **Wiessing** (LW) commented on the low service coverage observed for many years in Greece and the fact that countries simply cannot afford to wait until an outbreak emerges in order to start doing something about this. LW noted also the important progress in Greece following the outbreak both in terms of collaborations and responses.

Mait Raag (MR), Estonia
Important differences in injecting risks between people who inject drugs in Eastern and Western Europe

Presented data from a collaborative project initiated by the EMCDDA and run by the department of Public Health of the University of Tartu. The aim of the study was to explore differences in injecting risks between Eastern and Western European samples of injecting drug users. Studies considered for the analysis had to include current IDUs, be conducted between 2001 and 2009 in European countries with high HIV prevalence among IDUs, and include HIV status (blood samples) and behavioural data (e.g., self-reports on number of sex partners, condom use, syringe sharing, and injecting frequency). Individual studies were cross-sectional, mostly based on convenience samples (Netherlands, Portugal, Poland, Spain, (Catalonia) or chain-referral (Estonia, Russia, Latvia, Spain (Barcelona, Madrid)). Data from 7 countries (12 sites in total) and n=5328 IDUs were analysed. Different data collection years and therefore meta-analysis was used synthesize the data and explain heterogeneity. Heterogeneity in associations between risk behaviour and HIV-status was best explained by study region (i.e., western or eastern Europe) (n=1971 IDUs in Western Europe were different from n=3537 IDUs in Eastern Europe. Analyses of the socio-demographic and risk behaviour characteristics showed statistically significant differences with the most notable ones the proportion of sharing syringes which is much higher in the eastern part (32%) that the western part of Europe (13%). In the eastern part also IDUs are more sexually active and report higher risk behaviour, while they also get tested for HIV less frequently. MR concluded that there are significant differences between old (West) and new (East) epidemics. In Eastern Europe, HIV prevalence and risk behaviour are higher. They also explored whether the HIV infected IDUs were different from HIV negatives in terms of these characteristics (associations between HIV serostatus and risk behaviour). MR compared HIV infected and not infected IDUs regarding different behaviours (being sexually active, having more than one sex partner, not always using condoms, being ever tested for HIV, sharing syringes etc) while adjusting for age, gender, and length of injecting drug use. He found significant differences in Eastern Europe: HIV+ IDUs engage less in sexual transmission behaviour, but more in injection-related transmission behaviour than HIV- IDUs. In Western Europe, the only difference between HIV-pos and HIV-neg was in sexual activity. MR concluded that interventions to decrease injecting risk continue to be very necessary.

In the follow-up discussion: **Hope** (VH) questioned why the focus was only on countries with high HIV prevalence and wondered whether analyses were adjusted for age (as much of sexual behaviour is age related). *MR* responded that age was included in adjustements. High prevalence countries were preferred because of the important public health implications (risks) from observed risk behaviours for these countries. **Wiessing** (LW) asked what could be the reason that HIV infected IDUs report more sexual risk behaviour in the western part of Europe than in the east and wondered whether it is treatment that it is more available in the west and perhaps make positives feel safer to take risks (no data are available nonetheless on treatment in the database). *MR* responded that one cannot say that they risk less because they are HIV+. He used the example of Estonia where treatment is also high, at least comparable to countries in the west. MR went on to stress that this type of studies are cross-sectional and cannot tell

about the direction of the association. **Mendão** (LM) argued that part of these findings could be explained by the assumption that IDUs in the eastern part have lower access to condoms and needles whereas these have been available in western countries. *MR* responded that the study year may also be important in understanding the associations and the observed differences. **Salminen** (MS) raised a concern about the analytical approach: HIV positives are the high-risk groups and that is exactly why they are positives (used the 'chicken-or-egg' metaphor). *MR* reminded the cross-sectional nature of the study which cannot tell much about the causations. **Wiessing** (LW) agreed that this kind of data are hard to understand but he also stressed that it is interesting that, except from the differences between east and west, there are differences between sexual and injecting variables. There are possible explanations for that, such as that sexual behaviours may be easier to change, but not the injecting ones. LW welcomed other people interested in this analysis to contribute if they wish.

Mika Salminen (MS), Finland
Burden of HCV disease in Finland

MS presented the rationale of a descriptive study which is in progress in Finland on the burden of disease of HCV. He described the process and motivation for developing this project. MS stated that the concept (burden of disease) is by no means clear. It is not simply about prevalence, incidence or mortality. It includes aspects that involve both the individual and society. MS stated that it is important to measure the burden especially nowadays that questions about the cost-effectiveness of interventions are becoming more important. There are different types of measures that could account for or be components of the construct of burden of disease: mortality (death), disabilities (effect on quality of life , productivity, cost for society etc), life of years lost, costs from health care (doctor visits, medicines), loss of productivity or earnings (direct as well as indirect). Treatment is effective but it is costly not so much due to the drug but rather the support that it is built around it (follow-up and the management of the patients). Modelling studies have suggested some promising results about the effectiveness of new hepatitis C drugs. MS then focused on Finland: active drug users are not treated (drug and alcohol use is a contra-indication for hepatitis C treatment - one has to be abstinent for 2 years before entering treatment). The sources of data to be used are records/databases (register based studies) providing a good quality cohort of HCV infected drug users (national infectious diseases registry, the main tool for disease surveillance in Finland covering all notifiable diseases, with the use of a national identifier (national security number). Then they will link these data with mortality data (reasonably good data) and consider cause of death (primary/secondary). Cancer registry and hospital discharge records are other data sources (with some delay) that will be used. There are about 1,000 hepatitis C cases reported annually in Finland most of these based on anti-HCV detection but there is little information about what happens with these people after being diagnosed. There are some studies which are not that positive compared to the treatment recommendations currently available internationally (the hepatitis C treatment approach in Finland is specialist-driven, not based on a national protocol for treatment). Data are available already since 1995 and therefore a cohort of about 19,000 individuals exists which can be followed. There are notification data and data from prevalence studies of various quality and breadth, including the prison settings. Other data include maternal health, blood donor data (with biases), immigrant health data from studies etc. It is important to try to triangulate the data from the different sources. HIV prevalence has been historically low in Finland, with no outbreaks. Currently they are looking at causes of death: a challenge is to determine whether HCV infected drug users survive long enough. The study shows that 17% of the cohort have died (between 1995 and 2011). MS then presented some of causes of death e.g., liver-cancer (multifactorial), this is not very high (but still corroborates existing evidence in the literature), other cancers are higher, alcohol and accidental harm from alcohol is also higher (16%), and poisonings due to intoxication. MS then presented data by age groups (at the time of diagnosis) of the cohort showing that the survival rate varies by age group. In the future it is important to compare the real outcomes with the predictions. DALY measures for population health will be used (as used by ECDC and WHO).

Follow-up discussion: **Croes** (EC) made a remark that a similar study was conducted in the Netherlands in 2008. That study estimated disability rates according to ICD10 and DSMIV for drugs and alcohol, plus depression and infectious diseases. Used the same methodology as the Global Burden of disease and another Dutch study. It found that the disability rate for heroin dependence was 0.57 and when combined with chronic hepatitis C it was 0.41. *MS* acknowledged that the ECDC work has been based on former Dutch work and the Global Burden of Disease. **Wiessing** (LW) noticed that no data were presented on numbers based on incidence and/or prevalence estimates and asked whether there was a plan to do so. Mentioned also a monograph which is available at the EMCDDA about the cost aspects of HCV. That monograph includes a Dutch contribution about the importance of the perspective of cost (who pays the costs). LW highlighted that this is issue is complicated and cost cannot simply be a sum-up.

Cinta Folch (CF), Spain
EMIS results on MSM in Spain – new drugs and sexual risks of HIV

CF set the background by stating that a high use of non-injected drugs is observed among men who have sex with men (MSM), often for recreational purposes (parties and sex). In recent years, an increase in the prevalence of new psychoactive drugs (injected and non-injected) has been reported among MSM in Europe. In Spain, the use of injected drugs has not been explored in this group. In order to describe the patterns of injecting and non-injecting drug use among Spanish MSM, data from the European MSM Internet Survey (EMIS) was used. This online survey was implemented in 2010 in 38 European countries. The final sample of subjects living in Spain for analysis was 13,111. The most consumed drugs within the previous 12 months were poppers (28.4%), cocaine (18.7%), ecstasy/MDMA (10.1%) and amphetamine (7.7%). The use of injecting drugs among Spanish MSM was low (2.5% had ever injected and 1.4% in the last 12 months). In comparison with non-IDU MSM, MSM who injected drugs reported a higher level of sexual risk behaviours (the prevalence of unprotected anal sex in the last 12 months with non-steady partners was 53.4%, vs. 45.9% in non-IDU). The prevalence of self-reported HIV, hepatitis C and sexually transmitted infections in the last 12 months was also higher among IDU-MSM (23%, 8.2% and 15.8% in IDUs vs. 8.6%, 1.7% and 11.3% in non-IDUs). Although the use of injecting drugs is low, this group shows a higher prevalence of blood-borne and sexually transmitted infections and associated risk behaviours. The monitoring of drugs and its determinants among MSM should inform early prevention strategies highlighting the party drugs issue and its use for sex. In this sense, closer working between drug services, HIV and sexual health clinics will be necessary. Directed the audience to EMIS website (http://www.emis-project.eu/)

Follow-up discussion: **Wiessing** raised the importance of looking also at non-injectors among MSM, a large population with high sexual risks. **Mounteney** (EMCDDA) asked whether there was any information as to which drugs were being injected. *CF* responded that there is no data about drugs injected. **Hope** asked whether there are any recent indications about shifting drug use patterns among injecting MSM, at least from Spain. *CF* responded no recent data are available. Data are collected currently in Catalonia. **Matheï** wondered whether Spanish data are comparable to those from other countries. *CF* mentioned that the situation is very different among countries in Europe. **Blystad** referred to the phenomenon of repression and stigma regarding the discussion of these issues in the MSM community and asked whether there is any interest in repeating the survey, at least in Spain. *CF* responded that there are some positive indications that the study may be repeated in Spain. **Wiessing** noticed the differences in the characteristics of the IDU-MSM in this sample with IDU in harm reduction settings and wondered whether there are data about MSM who also are in drug treatment, as this is important (also for routine monitoring). *CF* responded that there is no data and referred to some recently published London data.

Maria Jose Bravo (MJB), Spain
Incidence of drug injection: systematic review and meta-analysis of cohort studies among at-risk populations

Published cohort studies show a wide variation on the rate of drug injection initiation. Nevertheless no systematic reviews have been published in this area and the reasons for heterogeneity have not been explored yet. A meta-analysis of cohort studies on initiation into drug injection was conducted to obtain an overall pooled incidence of drug injection (IDI) and to explore potential sources of heterogeneity and bias. All relevant bibliographic databases were searched between 1980 and 2012 for prospective cohort studies on initiation into drug injection among vulnerable populations. Two investigators independently reviewed studies for inclusion, retrieved information on baseline population characteristics and follow-up features, and assessed study quality. Random-effects models were used to estimate the overall pooled IDI, as well as to identify determinants of heterogeneity and trends in IDI across studies. The results showed that IDI varied widely from 2.1 to 24.2 cases per 100 person-years across the 9 meta-analysed cohorts. The overall pooled IDI was 7.8 new injectors per 100 person-years (95% CI 5.0–12.3), with strong between-study heterogeneity (I^2=90%, P<0.001). However, this heterogeneity disappeared after accounting for the different follow-up lengths (I^2=17%, P=0.30), with a 57% decrease in pooled IDI (95% CI 46–66%, P<0.001) per 1-year increase in average follow-up. MJB concluded that there is a strong progressive decline in IDI as increasing follow-up is highly consistent with a severe differential selection bias involving a greater loss to follow-up among individuals at higher risk of initiating injection. Other bias/factors might contribute in the same direction. Strategies to maximize retention and proper analytical methods to correct for follow-up bias are required in cohort studies on initiation into drug injection.

Follow-up discussion: **Wiessing** commented on the importance for DRID of understanding initiation of injecting. **Sypsa** (VS) commented that the study is very useful for people who try to model the impact of interventions in treatment because we need to have an estimate of new injectors each year. VS asked what population this incidence

refers to. MJB mentioned that a mix of populations are referred to in this study, e.g., street youth, aboriginals, methadone programs .

Lucas Wiessing (LW), EMCDDA
DRID Strategy Review, presentation of expert meeting results

LW presented the outcomes of the small DRID strategy review meeting held in July 2013. The background for the meeting was that although DRID has successfully established a monitoring system for infections among PWID in Europe, the environment is rapidly changing, both epidemiologically and institutionally and therefore there was a need for DRID to reflect upon these changes. Fourteen people in total have been involved in this process: seven experts invited from the DRID advisory group, representing a broad range of epidemiological realities and expertise; another seven were EMCDDA staff from EPI and other units related with DRID. The conclusions revolve around the following four domains: a) the enhancement of communication channels and facilitation of experts´ information rapid exchange (perhaps by developing a rapid reporting platform to informally link up experts and by continuing work on outbreaks and risk assessments, also maintaining the rather successful annual HIV risk assessment session/day at the DRID meeting); b) building the capacity and reducing the reporting burden (by assessing the burden of current reporting, both within countries and at the EMCDDA level, before looking at ways in which this could be reduced, and by developing the capacity and the mechanisms for feeding back information to those service providers who gather/provide the data to DRID); c) consolidate and improve the information collected by DRID (e.g., consider developing a DRID study in treatment centres using a comparable and simple tool, assessing issues with the comparability of prevalence data obtained from the routine diagnostic testing at the drug treatment centre level with that obtained from studies, to modify HBV monitoring to make it useful also as vaccination indicator, to categorise and to grade the data collected on DRID indicators); d) direct attention on and explore other areas (e.g., switch the main focus from HIV to HCV and assess the burden of HCV disease, and to non-injectors and the use of stimulants). LW referred also to the future steps which are: first, to discuss these issues with the network during the workshops and get input from country experts, and explore ideas further; and second, EMCDDA to assess what is feasible to prioritise, given budget and other constraints. LW final mentioned that some key themes may be developed earlier than others.

PANEL DISCUSSION
on the strategy review expert meeting results followed by introduction to the workshops

A/N. Moderators provided brief overviews of the workshop rationales. These are not reproduced here but can be found in Annex 2. Only issues raised in plenary discussion are presented below.

On the enhancement of communication channels and facilitation of experts´ information rapid exchange: **Salminen** (MS) mentioned that as example of a platform for rapid communication and information exchange is that of ECDC (EPIs system), there should be one on HIV and STIs. Discussed also the possibility of open access to these platforms; other platforms (e.g., European Commission's) are less likely to be accessible. **Wiessing** supported the idea that DRID is somehow linked to EPIs system or even develop something additional. **Vicente** (JV) referred to a former UK presentation (on changing injection patterns in London sub-populations that increasingly inject methamphetamines or mephedrone) as an example of how one could envisage this platform, i.e., not a classical rapid reporting risk assessment system of e.g., reporting outbreaks but rather a platform for communicating information on emerging patterns of use and new developments including both quantitative and qualitative information. **Wiessing** commented on the possible expansion of the scope of such an exercise to issues that go beyond the narrow sense of infections but to behaviours that increase infection risks; need to see if it fits in ECDC's platform; **Salminen** commented that this is possible as this is also the idea behind ECDC EPIs. **Schatz** referred in this context to similar work to be undertaken by the European initiative he is involved in and includes in its activities, among other issues, information exchange, events, conference, information campaigns, communication with Parliament.

On risk assessments: **Wiessing** suggested an annual publication on HIV risk assessment in PWID in collaboration with other international organisations (ECDC, WHO) and that a structured/systematic way is established to collect up-to-date data on situation and risks. **Mendão** commented on the importance to use risk assessments not only where there are outbreaks but also where only risks for outbreaks are present. Another important issue is sex risks and their close association with drug use and the HIV infection risks. The latter is important to consider as it is critical in the early stages of an outbreak. **Wiessing** acknowledged the importance but also the necessity to use a limited number of

indicators e.g., hepatitis C infection as an indicator for high risk behaviour, or intervention coverage, as for other indicators there are not always strong data.

On building the capacity and reducing the reporting burden: Wiessing connected this issue with the sexual risks discussed above (see *On risk assessments*) and the fact that although there is for DRID a strong interest in measuring as many risks as possible, the burden for handling the data collected is very high for those involved in the process.

DRID Workshops - Parallel sessions

Mario Cruciani
DRID workshop 1: Monitoring HBV vaccination through the existing EMCDDA data system
See Annex 2

Mika Salminen
DRID workshop 2: Burden of HCV disease
Not available

Anastasios Fotiou
DRID workshop 3: Capacity building and feedback to service providers, networking of experts
See Annex 2

Cathy Matheï & Magdalena Rosinska
DRID workshop 4: Diagnostic testing prevalence data
Not available

Sandrine Sleiman, Eleni Kalamara, Andre Noor
DRID workshop 5: Reporting and use of subnational data, categorising and grading data, reporting burden
Not available

Hans Blystad
DRID workshop 6: Monitoring other infections (TB, HAV, STIs, spore-forming bacteria, MRSA)
See Annex 2

Maria Jose Bravo, Julian Vicente
DRID workshop 7: Using TDI data for DRID / DRID study in treatment centres
See Annex 2

Vivian Hope
DRID workshop 8: Non-IDUs, other groups (steroid users, MSM who use drugs)
See Annex 2

DAY TWO

Mortality cohort studies among drug users (Joint Plenary DRD-DRID)

Chair: Marica Ferri and Viktor Mravcik

Tim Millar (TM), United Kingdom
Mortality cohort study NIQUAD

[**Pre-publication: presentation not for further circulation or dissemination**] Excess mortality has long been observed among users of opiates, crack cocaine and those who inject drugs, but few cohorts have sufficient power to detect cause and subgroup specific mortality. NIQUAD is a major cohort study in the UK, using five different sources of data on drug users (more than 800 000 persons) and linking them with mortality registries to identify all deaths occurring between April 2005 and March 2009 (as registered by Sept. 2011). It is the largest cohort is of opiate and/or crack cocaine users to date. The study presented observed excess mortality across many avoidable causes, in particular overdoses, liver disease, suicide and homicide. It also demonstrated that an increased risk for many causes of death persists, and for some causes widens with increasing age. This is a first demonstration of a clear, highly significant, age-related increase in users' drug related poisoning (DRP) rate beyond 45 years of age. Women had a lesser DRP risk than men at younger age; with increasing age this difference is not sustained when taking account of behavioural risks. The study highlighted the importance of managing the complex health needs of older opiate users to reduce their mortality risk and health inequalities.

Follow-up discussion: The data will be made public soon. **Lyons** questioned why alcohol related poisonings are excluded from the drug related deaths category considering especially those older problem drug users who have also or mainly alcohol related problems. *TM* responded that it is included as a risk factor but not in the death category.

Anne-Claire Brisacier, France (ACB)
French study: preliminary findings of the 2013 record linkage

ACB presented the results from a mortality cohort study among drug users in France. The settings of enrolment were treatment centres and harm reduction / low-threshold centres. The inclusion criteria were to be born in France or born abroad but covered by social security, and have used substance other than cannabis in the last 30 days or used BZD excluding therapeutic use in the last 30 days or used substitution substance prescribed or not by a physician in the last 30 days. A comprehensive questionnaire was filled at enrolment, prospectively, and included social and demographic items, use of substances and health items. Enrolment and data linkage with mortality registries: 1,134 individuals were included between 09/2009 and12/2011; 970 vital status could be checked (86 %) through linkage: three quarters of the cohort (77%) were males; 37 deaths were identified (the first linkage exercise was completed in 07/2013 and a second one will be carried out in 12/2015); the causes of death was retrieved for 8 individuals only. Preliminary results on the total of 970 persons were shown (person years of follow-up=2949). Crude mortality rate (per 1000 PYs)=12.55 overall, 16.7 in females and 11.35 in males. Standardized mortality ratio= 6.72 overall (P<0.001, 4.73 - 9.26), 20.8 in females and 5.2 in males. Some of the study difficulties were the overall difficulty with inclusion (due to the non-anonymous data collection), the relatively high cost (10 € were paid to the centres per individual included = 11 500 € plus cost for logistical and data entry = 6000 €). One limitation is the lack of data on the substances consumed at the time of death (as data on drug use are collected at enrolment and drug use might have changed over time). Next steps: include multivariate models for the analysis of cohort studies (as many risk and protective factors are collected at enrolment; repeat in 12/2015 the data linkage with the national general mortality register (second point to find the vital status and cause of death).

Follow-up discussion: **Wiessing** noted that injecting drug use as a risk factor for death is missing in the data presented (given that there is large heterogeneity in Europe) and asked whether there is any plan for specific analyses in this area, as injecting drug use is linked with mortality. *ACB* responded that this could be one of the issues to be further explored in the future multivariate analyses.

Isabelle Giraudon (IG), EMCDDA

Overview and main findings of the pooled EU cohorts
The present pooled study was conducted together with the EMCDDA and the NFPs and national experts on mortality. It is the 2nd European coordinated study on mortality among drug users, building on the experience of the COSMO study. The rationale of this new exercise is that many studies have been carried out in Europe, in many countries, but that most of them are not published, and their results are not available for a wider international audience. The other purpose of the exercise was to increase the statistical power of the analysis, in particular with regard to the causes of death, and to involve more Eastern-Europe countries, which were underrepresented in COSMO. The objectives of the pooled studies are to describe: the overall and cause specific mortality, gender and age differences, trends, and social inequalities and mortality. Cohorts of opiate users entering treatment in 9 countries/sites were included: Spain (Barcelona), Netherlands (Amsterdam), Slovenia, Croatia (Zagreb), Romania (Bucharest), Norway (Oslo), Malta, Poland. A similar methodology was used for all, following the EMCDDA protocol http://www.emcdda.europa.eu/scientific-studies/2012/mortallity-cohorts: common core dataset, data linking (Population register, Mortality Register), baseline measure at intake and standardized mortality ratio with European population. 31000 persons were enrolled (all cohorts were dynamic), representing more than 200000 person-years (PY) of follow-up. There were 2885 deaths, 2043 of which with known cause. The CMR was 14.2/1000 PY ranging from 3.5 to 22 between countries. The SMR was 8.8 ranging from 3.5 to 18.8 between countries. Causes of death, where known were mainly overdose (34.9%), HIV-AIDS (14.4%), circulatory diseases (9.2%), hepatic disease (viral 2.3% or unspecified 4%), traumatic causes (9.6%), respiratory diseases (5.4%), suicide (5.2%) and neoplasm (4.9%). The findings confirm the current high mortality of opioid addicts in Europe and a considerable excess risk of death compared to the European population. Too many years of life are lost, with most causes being preventable (external causes). The share due to overdose might be underestimated in some countries (e.g. coded as diseases of the circulatory system).

Marcis Trapencieris (MT), Latvia
Pooled EU cohorts – implications of age differences in mortality

MT presented a preliminary analysis of age differences in mortality in the above described pooled EU cohort. Background: in the 9 pooled studies, the year of entry, length of follow-up, year of birth, and age at entry vary from country to country. The oldest drug users were in the NL, NO, and SP and the youngest in RO, MT and LV. Overall, mortality rates are considerably higher among opioid users as compared to the general population but this varies by country and cohort. Four of the younger cohorts (HR, MT, RO, SI) had significantly lower mortality rates (CMR or SMR); two of the younger cohorts (LV, PL) had as high mortality rates as three oldest cohorts. The number of deaths in some cohorts was relatively small. Other limitations include: the patients are not necessarily enrolled in their first treatment and few countries have this information available, few countries have data on the 'current drug-use status' (it is not sure whether or not people are still active drug users) and current treatment status. Health status at entry is not known in most participating cohorts. Further plans: explore the use of ACP (age-period cohort) analysis further in the pooled EU cohort.

Follow-up discussion: **Giraudon** acknowledged the difficulties with this kind of pooled analysis and the observed heterogeneity in the results; also proposed that together with the participating national experts, a methodological paper is published encapsulating this experience. **Mravcik**, commented that it is a very interesting study especially when trying to explain differences between countries; noticed possible differences in service provision, OST in particular and in the characteristics (e.g., injecting) of the drug users between the countries; these can be included in the discussion rather than as correlates. He noted as well that there was a constant risk of deaths over time, whereas a decrease could have been expected as some patients may stop using drugs. This might be due to the continuous enrolment of new patients as all cohorts are dynamic. Finally the possibility was discussed to use national populations as reference populations to compute the SMRs.

Mortality related to infection: HIV, anthrax: service provision & guidelines (Joint Plenary DRD-DRID)

Chair: Maria J Bravo & Vivian Hope

Isabelle Giraudon (IG), EMCDDA
Estimation of HIV mortality related to IDU

HIV/AIDS is one of the common causes of deaths reported in cohorts and the reduction of HIV-mortality is achievable in EU. This is why reducing mortality should be among the key priorities of HIV/AIDS policies. Mortality is an indicator of HAART coverage and access to HAART should be equitable for all groups. Study questions: how many HIV-AIDS deaths in Europe are accounted for by IDUs and what are the trends? Methods: EUROSTAT and HIV/AIDS surveillance database (ECDC) over time were the two European level sources used in the analysis (as is the case for the EMCDDA Statistical bulletin). Results: the 2010 standardised HIV/AIDS death rate per 100,000 inhabitants (Eurostat HIV-AIDS; ICD 10 B20-B24) where the highest in Portugal, France, Spain and Italy (West) and Estonia and Latvia (East). Trends in Italy and Spain clearly decreased after 1996 (because of HAART treatment) and decreased in Portugal but with several years of delay. In Estonia and Latvia there is an increase since 2003. The estimated proportion accounted for by IDUs varies from country to country. Based on surveillance data (ECDC data on deaths among AIDS patients with known risk group), the IDU risk group accounts from 64% (Spain) to less than 5% (HU, CY, the NL, MT, GR) of the reported AIDS patients. The estimated heaviest burden in numbers of HIV deaths related to IDUs were in Spain, Italy, Portugal, France, Poland, Germany, Latvia and Estonia; Most of the estimated deaths related to IDUs 1413/1663 (2010) of the estimated deaths are in Spain, Italy, Portugal and France (85%). IG went on discussing the increasing discrepancy between mortality statistics (Eurostat, based on death certificates in national mortality registries) and surveillance data (deaths among reported AIDS cases). Possible reasons (beyond reporting delays) include increasing non-AIDS mortality among PLHIV, possible underreporting of AIDS cases and deaths, differences between countries coding of the cause of death for the general mortality register, and likely different combinations of these factors in different countries. There is a need for surveillance of deaths among all HIV cases (not only AIDS cases), inclusion of information on cause of death in surveillance, assess underreporting of death among AIDS cases in national surveillance, compare coding practices and the development of national level linkage studies between mortality statistics and AIDS surveillance. This is particularly important in the current context of increased concern with HIV in some Baltic and south-east European countries.

Follow-up discussion: **Corkery** commented on the fact that within the UK, about 8% of HIV/AIDS deaths were attributed to IDUs in England in 2012, but about 46% in Scotland. Thus, regional characteristics and (to a certain extent may be) coding practices should be taken into account.

Anda Karnite and Marcis Trapencieris, Latvia
Mortality trends in PLHIV in Latvia and insight from cohort studies

Anda Karnite
Background: thanks to treatments, mortality decreased among PLHIV, and the causes of death tend to become similar to the causes existing in the general population (in EU and the USA). Objective of the study: to explore whether the mortality trends among PLHIV in Latvia are similar to the situation in the EU, and identify factors associated with higher death rates (socio-demographic, risk, and clinical or health care factors). Methods and sources: HIV cases register and mortality databases. The data sources and the population involve 4888 PLHIV and 31,192.6 py of follow-up since 1987. Analysis included indirect standardization (standard – age specific mortality rates of the general population), time trends-log transformation and linear regression, survival analysis - Cox regression, and cause-specific MRR - Poisson regression. Results: There was a peak in 2001 with around 650 newly diagnosed HIV in PWID (more than half, were known (for ~ half of the cases), in 2010). There is a high and increasing proportion of late diagnoses among PWID and poor treatment coverage. 30% of HIV positive PWID have not received care, 46% no ART, and only 6% received ART with no interruption. The crude mortality rate among PLHIV / PWID, in the period 2001-2010, increased annually (8.4%). The underlying cause of death is HIV for half (48%) of the PLHIV / PWID, and external causes (mainly overdose or suicide) for a quarter (26%). HIV specific proportional mortality increases (63% of the deaths in 2010). PLHIV who became HIV infected via drug injection have a two times higher death hazard (vs. MSM), two times higher HIV specific mortality and six times higher mortality from external causes of death. Limitations were discussed (underestimation of the PLHIV (half could be missed), underestimation of late diagnosis, unspecific definition of interruption of treatment, and ART duration, combination of treatments not taken into account). Conclusions were that mortality rates among PLHIV / PWID in Latvia increase annually and HIV has

been established as the underlying cause of death for half of the PLHIV / PWID; the HIV specific proportional mortality increases annually.

Marcis Trapencieris
The objective was to provide a complementary approach and describe HIV-related mortality among treated drug users in Latvia. Sources were a cohort of treated amphetamine users and a cohort of opioid users (described earlier as component of the EU pooled study). Automatic record linkage was carried out of PREDA (treatment database) and the mortality register. Results: 1) 1709 amphetamine users entered in treatment from 2000 to 2012, representing 8055 PY of observation; 61 died (including 51 males). The median age was 29. The CMR was 7.6/1000 PY and the SMR 4.3. 15 out of 61 died of HIV, with a median age of 34 years. 2) 3599 opioid using clients entered treatment from 2000 to 2011 representing 25775 PY of follow-up and of whom 417 died. The CMR was 16.2 (17.2 for males and 12.4 for females); 68 of 417 (16%) died of HIV and the proportion is increasing (40% in the last years). The mean age at death was 31 years.

Martin Busch (MB), Austria

Ten year trends in HIV and service provision in Europe
MB presented results from a report on the state of play of the 2003 Council Recommendation (CR) on prevention and reduction of health related harms associated with drug dependence. He summed up the key components of the CR (prevention of drug dependence and reduction of related risks, and development/implementing comprehensive strategies; reduction of incidence of drug-related health damage - e.g. including HIV and drug-related deaths; develop a range of different services and facilities, aiming at risk reduction). He listed the different purposes of the project: describe developments in epidemiology (in particular based on the EMCDDA Key Indicators DRID and DRD), availability of harm reduction measures, carry out a statistical analysis of changes in the epidemiological situation and the supply of harm reduction, collate existing evidence in effectiveness of harm reduction interventions based on literature review; produce conclusions and recommendations. He presented briefly the findings from the 3rd Work Package on which his team worked: country profiles (based on EMCDDA data mainly, Statistical Bulletin, Best Practice Portal, country overviews, survey among the Reitox network); stakeholder consultation and statistical analysis (using trends in DRD numbers, HIV diagnosis in PWID, OST and NSP from 2003-04 to 2009-10 or 2011). MB highlighted that some harm reduction measures (drug consumption rooms (5 countries), peer naloxone programs (8), heroin assisted treatment (6), NPS in prison (5) in particular) are poorly available in the EU. Conclusions and Recommendations included: need for political strengthening of harm reduction; increase of the availability and coverage of NSP and OST through specialised programmes; introduction of harm reduction interventions in prison (where non available); naloxone “take-home” programmes; use of emergency services; drug consumption rooms; counselling, outreach and peer involvement; access to HCV treatment; HBV vaccination; housing; integration of services; and research. Three priorities were identified: a) reduction of drug-induced deaths; b) improvement of harm reduction coverage in prison settings; and c) reduction of harm caused by drug-related infections.

Follow-up discussion: Some updates were reported from Germany (Although Germany has NSP in prisons ‘available’, NSP is provided in only one prison among about 240 prisons in Germany, this is significantly less than in former times due to a political reaction) and the UK.

Cornelius Bartels, ECDC (CB)

ECDC/EMCDDA Joint anthrax prevention guidance for PWID
CB provided an overview on the characteristics and the history of anthrax. Then he focused on injection anthrax and referred to the outbreak among heroin users following the injection of heroin contaminated with B. anthracis spores; it became a new clinical entity in 2009. As main symptoms one expects to see serious soft tissue infection (SSTI), coupled with extensive oedema, developing at the injection site several days after heroin injection; in some cases there are signs of systemic infection, including signs of fever, raised white cell count, cardiovascular compromise, blood coagulation disorder and multi-organ dysfunction syndrome. The outbreak has re-emerged in 2012, continuing in 2013, involving likely all single cases, not linked with each other. All cases are associated with heroin use/injection - heroin is the likely contaminated agent. CB presented recent results from genotyping and also possible geographical routes of trafficking contaminated heroin from Asia to central and Western Europe. A rapid response was requested by the Commission and ECDC and EMCDDA worked to produce a joint evidence based guidance. The process focused on primary and secondary prevention, systematic review of existing literature and grading of documents. An

expert panel for formulation of recommendations was also consulted. Interventions targeted behavioural changes (e.g., adherence to OST and adherence to heroin assisted treatment, adherence to NSP, modifications in the preparation of heroin, alternative routes of administration) as well as prophylactic approaches (e.g., vaccination, antibiotics). The role of the expert panel was deemed crucial in the process (its rich composition in expertise was presented). Recommendations in the area of public health action & identification were: a) Appropriately-dosed opiate substitution treatment (OST), including a wide-range of OST options, should be provided to reduce or eliminate illicit heroin use in a context of anthrax outbreak among drug users or suspected circulation of drugs contaminated with anthrax. In countries where heroin-assisted treatment is legally possible, it should be seen as an intervention among an extended range of OST options for the prevention of anthrax in people who use heroin; and b) as early as possible diagnosis and referral of the case is essential to prevent further harm and death. Therefore, a wide range of professionals in contact with PWUH, but also PWUH themselves and peers should be made familiar with possible symptoms of infection with B. anthracis. These include localised soft tissue oedema near to the injection site and generalised symptoms like systemic illness, gastrointestinal, respiratory or CNS-disorders. All symptoms may appear separately or in combination with each other. Other key recommendations focused on risk communication. CM concluded that the anthrax outbreak is most likely on-going at least since 2000; contamination occurs most likely repeatedly in single production site(s) depending on environmental factors; early diagnosis and early treatment are crucial; there is an important role of aggressive surgical debridement; integration of clinics, public health, harm reduction and drug control for effective management are crucial; there is a potential for use of monoclonal antibodies; a positive heroin sample is still the missing link to identify and eventually control the source.

Follow-up discussion: (A*/N. The discussion following this presentation has been extensive. Work on this guidance is ongoing and likely to be finalised in 2014. Only some points are reproduced below*) **Blystad** asked about the role of vaccines. *CB* reported that the panel considered this matter but did not include it among its recommendations for, among other things, it was not clear how this would work with heroin users (health status). **Wiessing** acknowledged the important initiative of the ECDC on this project. More research is needed for getting more evidence. Discussion followed over the process of forming the recommendations on the basis on existing evidence. **Strang**: Some commented that some of the recommendations are not pragmatic (e.g., HAT is very costly) while others (e.g., OST) are inadequate. **Wiessing**: acknowledged the complications of HAT but also noted that the aim of prevention was to reduce all illicit heroin use and not so much to change of the route of administration as anthrax infection is not specifically related to injecting. A short discussion about heroin profiling followed.

Hepatitis C infection in PWID (Parallel session–Conference Centre)

Chair Magdalena Rosinska & Mika Salminen

Katelyn Cullen & Vivian Hope, United Kingdom

Incidence of hepatitis C infection among people who injecting drugs in the EU (with a focus on the UK)

KC stated that sero-behavioural monitoring of PWID is important to informing public health responses. In 2011, a novel hepatitis C antibody (anti-HCV) avidity testing algorithm to detect recent infections was introduced in the national survey of PWID to estimate HCV incidence. Method: PWID are recruited annually, through >60 needle & syringe programmes and prescribing services across England, Wales and Northern Ireland. Participants complete a short questionnaire and provide a dried blood spot sample. Samples containing anti-HCV antibodies that were found to be of weak avidity and also contained HCV RNA were classed as probable recent infections (those anti-HIV positive N=35 (1.23%) were excluded). Factors associated with recent infections were explored. Results: Overall anti-HCV prevalence among those who had injected during the preceding year was 45% (N=1,718). Of the 980 that had been at risk of infection (mean age 35), 960 were anti-HCV negative and 20 (1.2%) had been recently infected. Incidence was between four to 12 infections per 100-person-years of exposure (assuming an avidity window period of 60 to 180 days). In multivariable analysis, recent infections were more common among: those imprisoned on >5 occasions (3.8%, 8/213; adjusted odds ratio [adj-OR]=8.7, 95%CI 2.04-37.03); women (3.5%, 8/230; adj-OR=3.8, 95%CI 1.41-10.38); and those ever-infected with hepatitis B (8.9%, 5/56; adj-OR=6.25, 95%CI 2.12-18.43). The conclusions were that this study, one of the first in the UK to examine the risk factors associated with recently acquired HCV infection among PWIDs, found that recent infection was associated with frequent imprisonment, and was also more common among women and those ever-infected with hepatitis B. These associations are probably markers for underlying risks, and require further investigation. The findings also suggest a need for targeted interventions in prisons and post-custodial support services.

Knut Kielland (KK), Norway
All-cause and liver-related mortality in hepatitis C infected drug users followed for 33 years

KK started by stating that the course of chronic hepatitis C virus (HCV) in injecting drug users (IDUs) has not been well described. The aim of this study was to compare long term all-cause and liver-related mortality among anti-HCV positive IDUs with and without persisting HCV infection. Methods: A retrospective-prospective controlled cohort design was applied. A cohort of 864 drug users admitted for resident drug abuse treatment in a Norwegian drug abuse clinic 1970-1984 was established in 1991. At that time-point causes of death were included retrospectively through register linkage. The cohort was then followed up prospectively by new register linkages to national registers. The 635 individuals with available stored sera were screened for anti-HCV antibody. Anti-HCV positive individuals were further tested for the presence of HCV Ribonucleic Acid (RNA). All-cause and liver-related mortality was compared between HCV RNA positive (n=328) and HCV RNA negative individuals (n=195). Mean observation time from time-point of admission to 2008 was 33 years. Results: All-cause mortality rate among the 523 anti-HCV positive subjects was 1.9 (95% CI 1.6-2.1) per 100 person-years, males 2.1 (95% CI 1.8-2.5), females 1.4 (95% CI 1.1-1.8). All-cause mortality rates were not influenced by persisting HCV infection. Main causes of death were substance use related (49%), suicide (9%), and accidents (8%). Liver disease was cause of death in 7.5% of deaths among HCV RNA positive subjects. Five of 17 deaths among IDUs with persisting HCV infection occurring after age 50 were caused by liver disease. The conclusions were that the all-cause mortality in IDUs is high and with no difference between HCV RNA positive and HCV RNA negative individuals the first three decades after HCV transmission. However, among IDUs with chronic HCV infection who have survived until they reach the age of 50 years, HCV infection emerges as a main cause of death.

Eberhard Schatz, Netherlands
Hep C initiative
Summary project outline: Viral hepatitis affects more than half a billion people worldwide and is a major public health problem in Europe, where it disproportionately affects injecting drug users. On average, 60% of injecting drug users (IDUs) are estimated to have hepatitis C, and in several countries the vast majority, over 90% of people who inject drugs (PWID), are believed to be living with hepatitis C.

The current situation regarding viral hepatitis and drug use indicates a clear need for action on various levels: a) Need for action on the practical level: Evidence shows, that testing for HCV and referral to HCV treatment are - among others - key interventions for the prevention of hepatitis. There is a need to improve a pragmatic prevention approach in services frequented by active drug users and to analyse barriers and obstacles to treatment uptake. b) Need to review and summarise current evidence and knowledge: The literature on HCV issues, including epidemiology, diagnosis, treatment, prevention programmes, screening programmes and societal attitudes varies considerably and is not always easily accessible for stakeholders in the field. c) Need for peer involvement and peer training: Peer involvement at an early stage has the potential to prevent new infections, promote testing for those who have been exposed to risks, and support and inform people for whom treatment is an option. Capacity building and training is a crucial pre-requisite for effective peer involvement activities. d) Need for political leadership: Although the great majority of governments in Europe is aware of the alarming data in regard to hepatitis C, policy responses to the epidemic and to the needs for interventions in the field of prevention, diagnosis, care and treatment, are insufficient.

The project will address the priority 'Review opportunities for developing and implementing (innovative) interventions, including training activities, to prevent hepatitis C in drug users'. Overall aims: to improve the knowledge regarding hepatitis C policies and practice; to improve the capacities of target group representatives and professionals in the field of HCV prevention, counselling, testing and treatment, specifically targeting drug users; to influence HCV policies at the national and European level. Specific objectives are: to assess obstacles and barriers to the implementation of effective strategies in the field of HCV prevention, counselling, testing and treatment; to compile up-to-date information regarding theory and practice in the field of HCV and drug use and to identify emerging issues; to organise peer-to-peer training and capacity building among injecting drug users in Europe, targeting HCV prevention, counselling, testing and treatment; to influence policies and advocate for the development and implementation of evidence-based HCV strategies at the European and national levels; Methods: The project will focus on three main areas: research, practice and policy.The following methods have been selected to cover these areas and to achieve the objectives of the project: intervention analysis; literature review; training; advocacy; multidisciplinary cooperation. Results:Inventory of effective interventions: Documentation of factors of success and

failure, including recommendations; Literature review: up-to-date literature, research reports and project documentations will be analysed and reviewed; A peer-to-peer training course for drug users; Policy and advocacy activities, comitted to better access to high quality and effective HCV prevention, counselling, treatment and care; the project will organise 3 expert meetings, a peer to peer training seminar, four national policy dialogue meetings and an international policy seminar; a web-based resource centre will be set up, including all project outcomes and results.

Harm related to new psychoactive drugs and methamphetamine

Chairs: Isabelle Giraudon and Gergely Horvath

David Wood, UK

Establishing the acute harm associated with the use of NPS: what is available, deficiencies in current datasets, potential for poison centre data, Euro-DEN data collection

Background: recreational drugs and NPS use are common; systematic data is available on prevalence of use, drug seizures, use of treatment agencies (TDI), drug-related fatalities. But, there is no systematic data collection on acute recreational drug toxicity. There is a need for data triangulation on NPS toxicity. The sources of information are in vitro pharmacological studies, animal studies, users' reports and subpopulation surveys, case reports (series), pre hospital emergency data, emergency department presentations, poison information services, data collection through specialist sentinel surveys. Scope, strengths and limitations of all of these are presented and discussed. The conclusions were that there is no pan European data collection systems on the acute harms related to novel psychoactive substances; data triangulation from multiple sources allows patterns of acute toxicity to be determined; poison centres and information services can provide useful information (there is some potential to link international centres to provide more robust data); Euro-DEN project is a novel pan-European coordinated approach to collecting Emergency department data.

John Corkery, UK

Trends in recreational drug-related deaths including new psychoactive substances

General trends in np-SAD deaths, related to 'traditional' and to NPS drugs were described. UK legislative changes are summarised (e.g MDPV controlled in April 2010; Methoxetamine Temporary Class Drug Order in April 2012 and controlled Class B in April 2013; 25I-NBOMe Temporary Class Drug Order in June 2013). The sources, design, cases definition used by np-SAD were presented. In 2012, there were about 1700 deaths reported, of which about 500 were related to heroin morphine, 150 to cocaine and 50 to amphetamines, prices, and 35 to ecstasy type drugs. For each drug, the context of purity, seizures, convictions, persons in treatment are discussed. The conclusions of the presentation were that there was a fall in price, use and purity of some 'traditional' stimulants - cocaine, amphetamines, and ecstasy type drugs accompanied by fall in deaths. There was appearance of new stimulants in the mid-2000, GHB, Ketamine and slow emergence of piperazines, and then methcathinones especially mephedrone. Both of these had associated deaths. New drugs can also cause deaths in their own right. Important to note that in many cases polydrug use is the typical scenario for these deaths. Effect of control legislation on deaths clear for GHB/GBL where the control of both these substances was followed by initial fall. For mephedrone there was a sharp fall but then levelling off. The picture is not so clear between ketamine and methoxetamine. Finally, control appear to create displacement.

Jane Mounteney, EMCDDA

2013 trendspotter meeting on methamphetamines: main findings, main concerns

The 'trend spotter concept' includes in depth information gathering, on subject of concern and uncertainty, one off and ad hoc with rapid reporting. It is a multi-source, multi-methods, multi-disciplinary triangulation: literature review, routine data collection, electronic survey, meeting with experts' presentations, focus groups and analysis. Harms, traffic, seisures, production, populations of users, responses were covered. The cmine in Europe is onclusions were that there were multiple different situations in Europe, and that there were many information gaps. Methamphetamine in Europe is not a mass phenomenon (but even a low prevalence can cause harm); the situation is stable in countries with history of methamphetamineor which already had a marked amphetamine problem; there are new IV trends amongst small MSM groupps in large cities (requiring close monitoring); in some countries like Latvia and Germany, the use of methamphetamine is increasing. In others like Greece, Cyprus, Turkey, methamphetamine (smoking) is an emerging threat).

Prevention of overdose and infection (Joint Plenary DRD-DRID)

Chair: Dagmar Hedrich & Teodora Groshkova

Paul Dargan (PD), United Kingdom
Improvement in the recognition and assessment of acute drug toxicity in the pre-hospital environment

The clinical classification of drugs are: Stimulants (e.g., amphetamines, MDMA, cocaine and NPS such as piperazines, cathinones, synthetic cocaine, pipradrols, indanes, benzofurans); Depressants (heroin, opioids, benzodiazepines, GHB and NPS such as GBL, 1,4-BD, novel opioids and metabolites); and Hallucinogens (e.g., LSD, Psilocybin, Ketamine and NPS such as glaucine, ketamine analogues, tryptamines, synthetic cannabinoids, salvia). Clinicians are familiar with the patterns of toxicity associated with classical drugs and become increasingly more familiar with the NPS. NPS have additional characteristics in their toxicity. The presentation focused on pre-hospital environment and what can be done to improve the management of the cases and in particular the identification of those at risk and the adequate referral to A&E and ambulance. The backdrop are large festivals; night clubs; recreational settings and the recreational drug toxicity and in particular the presentations in first aid facilities. In pre-hospital acute drug toxicity has different patterns compared to hospital cases and different drugs are in cause (e.g. more GHB and ketamine, than cocaine and XTC, contrary to hospital cases). Pre-hospital cases may just need reassurance in a calm environment but there is a potential for severe toxicity and life-threatening clinical features as well (e.g. coma with aspiration, sympathomimetic toxicity). These cases should be fast-tracked to hospital. Delayed transit of patients to hospital can be critical. Hence, an initiative towards the early identification and simple clinical assessment of those at risk in a London pre-hospital environment started in 2006. This included guidelines on responding, equipment, training etc. These guidelines were adapted to a European context accounting for the different models of pre-hospital care across Europe (EMCDDA funded project in 2011). An Internet-based review was done of the UK guidelines (guideline components and facilities needed for initial assessment and care). 17 countries responded to the survey and there was an overall acceptance of the guidelines. The next step (through one workstream of the Euro-DEN project, funded by the EC DPIP project 2013-2015)[3] is to provide training and guidelines to staff in recreational settings to respond to drug-related incidents. The objective is to develop and finalise an interactive training package and updated guidelines for pre-hospital assessment, recognition of drug-toxicity and referral. A feasibility study will be conducted in London, Mallorca, Oslo and Brno.

Follow-up discussion: **Georgiadis** asked whether alcohol was considered when developing the guidelines. The response was that these guidelines were focused on drugs but they could be considered to be appropriate also for alcohol in pre-hospital environments. **Another** question was about a possible 24-hour telephone line with specialist advice. The response was that this kind of service may be anyway available in many places in Europe (poison centres).

John Strang (JS), United Kingdom
Pre-provision of naloxone to prevent heroin overdose deaths: evidence, myths and UK experience

JS noted several reasons why take-home naloxone is an important intervention to consider: first, overdose is the major cause of death among drug users–mainly opiates; second, most heroin overdoses are witnessed (often by family members in home contexts) and therefore invite for active reaction by bystanders; except that often this reaction is often wrong. In all, overdoses are common hazards in this population and in addition they are frequently witnessed: this is where there is room for intervention that can make a difference. Naloxone is critical in settings and times of high risk. There are: Post-detox and post-rehabilitation phases, during methadone early treatment, and upon prison release (high excess drug-related mortality ratio). The value of naloxone interventions was supported and possible concerns (e.g., encouraging risk taking) acknowledged.

Follow-up discussion: **Mendão** called for gathering all necessary evidence; in order to achieve this, any possible (ethical, bureaucratic, legal) barriers for carrying out scientific research on the effectiveness of use of naloxone in community settings, incuding trials around Europe. *JS* commented that that there should not be any controversy on this issue, except perhaps when we don't know who the recipient is. **Wiessing**: liked the idea of the clinical trial and but wondered whether it could be ethically possible to set up a clinical trial if the comparison is going to be with not providing naloxone. *JS* thought that there is a need for well-designed trials in this area. **Another** concern is the

[3] See presentation given by David Wood on day 2, and minutes of the DRD sessions of the joint expert meeting.

restrictions for use (safety) JS doesn't know the national regulations but everywhere the context of use for naloxone is the reversal of overdose, except that it allows someone other than the drug user to do it. **Trapencieris** believes that naloxone interventions are important for countries that report high numbers of overdoses. He wondered however whether, considering precarious living conditions of many drug users they would have the medication readily at hand when required. JS responded that current tests address only whether naloxone peer distribution is effective: deaths among those exposed to the intervention compared to those not exposed.

Fabio Patruno, Italy

Prevention of overdose and infection. Experience from Villa Maraini Foundation/Italian Red Cross/International Federation Red Cross Red Crescent (IFRC)

Already in 1980, a Red Cross (RC) expert meeting on drugs held in Strasbourg recommended to include the antagonist medicine naloxone in RC first aid kits. This should be done after emergency professionals and RC volunteers have been formally trained on how to use this product. The medication does not present any risk and possibly saves the live of those who suffer an opioid overdose. Villa Mariani, a facility in Rome, managed by the Red Cross offers a wide range of services suited to individual needs and capacities. The services are defined as 'very low theshold' and include street units, emergency units and prison projects. Over the course of the past 20 years, more than one . million contacts with POUs took place, and 13000 naloxone vials were given out.Of11000 interventions for emergencies including overdoses, 9000 led to referals to drop in centres. In 2012 alone, over 600 OST patientsare followed up in the RC outpatient clinic per month.Furthermore, the RC conducts harm reduction trainings in many countries, including in Belarus, Cambodia, Kazakhstan, Ukraine and Latvia.

Charlotte Klein, Austria

Report on the EU consultant project: "Current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm": focus on evidence on the prevention DRD

The Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence was briefly presented and the scope of the Follow-up project, which involved the documentation of trends and developments in harm reduction responses in Europe since 2003, was described. . As part of the analytical work, a review of the DRID and DRD situation as carried out. Overall, incidence of HIV infection among injecting drug users has been decreasing over years in many countries, a change that coincided with a broader availability of treatment and harm reduction responses. However, similar improvements were not yet evidenced with regard to drug-induced deaths. Countries were grouped according to their trend in the number of reported drug-induced deaths into those where an increase and those where a decrease was noted from the 2003/04 to 2009/10. These changes were analysed against the current estimated coverage in various harm reduction measures. The greatest reductions between the two periods, in the numbers of reported deaths were observed in countries with high coverage of harm reduction measures. Literature supports these results. The available evidence was discussed for some of the measures, including OST, supervised drug consumption rooms and, peer naloxone provision in particular. A special emphasis was given to measures targeting prisoners and ex-prisoners. It was noted that pre-release councelling and through care are essential to reduce DRD but are hardly available in European countries. Prison release without adequate throughcare is one of the main risk factors for drug-induced deaths. Consultants recommended that measures targeting reduction of DRD should become a priority if the Council Recommendation were to be renewed. Proposed measures included: improving the coverage of interventions, providing low threshold access to OST, improved provision of OST to avoid interruptions, especially upon prison release and to avoid waiting lists; comprehensive health insurance covering OST; as well as measures to facilitate the use of emergency services in cases of overdose; peer involvement and family support, including through naloxone distribution programmes.

End of the regular DRID – DRD meetings, closure

Annex 1 – DRID Strategy Workshop guidance and reports

Workshop 1: Monitoring HBV vaccination through the existing EMCDDA data system.

Moderator: Mario Cruciani, Italy

Workshop guidance

Mario Cruciani, Italy

Background

Drug users are at high risk of HBV infection, both through parenteral/percutaneous and sexual transmission. Among notified acute cases of hepatitis B where transmission route is documented, one in five has been infected by injecting drugs. Prevention of primary infection by vaccination is an important strategy to decrease the risk of chronic HBV infection and its subsequent complications. Hepatitis B serologic testing involves measurement of several HBV specific antigens and antibodies. Different serologic "markers" or combinations of markers are used to identify different phases of HBV infection and to determine whether a patient has acute or chronic HBV infection, is immune to HBV or is susceptible to infection.

Problems

In ST9, data are requested on HIV, HCV and HBV. For HBV, the following tests should be performed:
• hepatitis B surface antigen (HBsAg); • hepatitis B surface antibody (anti-HBs); • hepatitis B core antibody (anti-HBc , IgG and IgM); moreover, If only one HBV marker can be provided, priority is given to HBsAg. However, while HBsAg is an indicator of acute/chronic liver disease and infectivity, its absence does not provide any information on immunization status. By contrast, testing antiHBs and antiHBc" provides information on immunization status as a result of prior infection (antiHBc +, antiHbs +) or vaccination ((antiHBc -neg, antiHbs +), or on susceptibility to infection. Individuals testing negative to antiHBs and antiHBc are candidates to HBV vaccine.

The implemention of mass HBV immunization programs is recommended by the WHO since 1991, and this practice has dramatically decreased the prevalence of HBV infection and its complications in many countries. Ideally, HBV vaccine should be offered to all PWID, to people at risk of progression to injecting (e.g., people who are currently smoking heroin and/or crack cocaine, and heavily dependent amphetamine users) as well as non-injecting users who are living with current injectors. Nonetheless, HBV vaccination coverage in drug users is still low in many countries.

Other problems that may arise are related to the acceptance of the test, acceptance and compliance with the vaccine schedule, and need to test antibody response after vaccination

Aims of the workshop

- To discuss ways to improve the reliability and comparability of diagnostic testing data for DRID monitoring
- Discuss ways to promote and offer testing to people at increased risk of HBV infection

What do we expect from participants?

- To prepare a short country report (e.g. less than one page) about the use of HBV diagnostic testing data for DRID monitoring in their country, what are the difficulties using this data and how these problems are dealt with.
- To participate in the discussion
- To think about cost-effectiveness of testing
- To appoint someone to make a report (1-2 pages in Word)

Workshop report

Participants: Mario Cruciani, Italy (Chair); Violeta Bogdanova, Bulgaria; Silvia Slezakova, Slovakia; Hans Blystad, Norway; Nasia Fotsiou, Cyprus (Rapporteur)

Drug users are at high risk of HBV infection, both through parenteral/percutaneous and sexual transmission. Among notified acute cases of hepatitis B, where transmission route is documented, one in five has been infected by injecting drugs. Prevention of primary infection by vaccination is an important strategy to decrease the risk of chronic HBV infection and its subsequent complications. Hepatitis B serologic testing involves measurement of several HBV specific antigens and antibodies. Different serologic "markers" or combinations of markers are used to identify different phases of HBV infection and to determine whether a patient has acute or chronic HBV infection, is immune to HBV or is susceptible to infection.

The countries participating the workshop referred to the situation and to some problems that the monitoring of HBV vaccination presents. The aims of the discussion were to improve the reliability and comparability of diagnostic testing data for DRID monitoring, and to find ways to promote and offer testing to people at increased risk of HBV infection.

During the discussion some problems erased concerning basically the information requested in ST9 on HIV, HCV and HBV and the number of tests that should be performed in order to have the results requested. As a result, a new approach to reporting HBV data has been proposed during the workshop, supporting that it should be simpler and less expensive.

The implementation of mass HBV immunization programs is recommended by the WHO since 1991, and this practice has dramatically decreased the prevalence of HBV infection and its complications in many countries. Ideally, HBV vaccine should be offered to all PWID, to people at risk of progression to injecting (e.g. people who are currently smoking heroin and/or crack cocaine, and heavily dependent amphetamine users), as well as non-injecting users, who are living with current injectors. Nonetheless, HBV vaccination coverage in drug users is still low in many countries.

The aims of the workshop were difficult to accomplish as there was substantial heterogeneity of the countries represented at the workshop. There were small and big countries, with different prevalence/incidence of HBV infection in general and selected populations. Moreover, the cost of testing may be an issue in certain countries, while some others suggested that the burden of reporting HBV data is quite big. Another point raised in the workshop, is the "Preemptive vaccination" (a first shot or complete cycle given before knowledge of results of screening test) that is adopted in certain countries (e.g., Norway, Cyprus).

The group discussed the usefulness and added European value in collating hepatitis B markers in prevalence studies that who would indicate vaccination coverage of hepatitis B in IDUs. The group did not agree on any recommendations. All participants agreed that monitoring vaccination coverage can be useful on a national level if the resources and capacity to perform such tests are available, but the view differed in the question of added value on a European level. Member states have different vaccination policies. Some countries, like Italy, have had hepatitis B in their vaccination policy for a long time and soon most young IDUs will have received the vaccination in childhood. "

The participants suggested that the issues raised in the workshop should be discussed with the other European countries. This can be accomplished through the preparation of a questionnaire by the EMCDDA and sent to all the focal points, in an attempt to share their opinions on the key issues raised (e.g. cost issues, vaccination coverage, burden of reporting, etc).

Workshop 2: Burden of HCV disease

Moderator: Mika Salminen, Finland

Workshop guidance
n.a.

Workshop report
n.a.

(see presentation at
http://projects.emcdda.europa.eu/areaDRID
Username: area16
Password: DRID2012)

Workshop 3: Capacity building and feedback to service providers, networking of experts

Moderator: Anastasios Fotiou, Greece

Workshop guidance

The role of the DRID towards stakeholders

Anastasios Fotiou, Greece

Background

DRID is a unique indictor. DRID evolves in different settings (routine testing /community surveys, European/national/local), and deals with a wide range of stakeholders and audiences: drug users, health professionals (pathologists, biologists, nurses, and treatment personnel), social researchers, health economists and policy makers, NGOs and human rights advocacy groups, ethical committees, funders, etc. With the new format of the European Drugs Report (EDR) and the novel approach with its reporting system overall, the EMCDDA shows that stakeholders lie right at the centre of its operations. Annual DRID meetings held at EMCDDA also increasingly include participants from a wide array of actors across Europe (experts, Focal Points[FP], professionals, NGOs and policy makers, only to name few) thereby creating the basis for stakeholders' involvement into DRID processed.

Problem

Despite improvements, the annual EMCDDA indicator assessments consistently show that, still in several countries DRID data are not readily collected, while where DRID data are available these are not always readily shared. These findings show that more attention needs to be placed on stakeholders, especially at the national level. In some countries DRID stakeholders, especially primary data providers, may feel not enough involved and not getting sufficient in return for their data provision to the FP and the EMCDDA. The FPs and national experts have a significant role to play in this: to present the situation, raise awareness, involve experts and set up expert groups, produce and disseminate DRID data and other information, help build up the capacity through trainings and seminars.

Aims of the workshop

- Identify stakeholders and weigh up their relevance to DRID's effective implementation
- Identify stakeholders' needs and prioritise them taking into account the threats and opportunities presented in the currently dull economic climate in many countries
- Exchange national experiences of best practice and discuss ways to improve the cohesion of the EMCDDA and FP networks by creating effective mechanisms of e.g., 'translating' DRID information in formats that satisfy different audiences (drug users, professionals, policy-makers, and the media)

What do we expect from participants?

- To think and discuss previously about the issue
- Participate in the discussion providing national experiences
- One participant to do the reporting (one or two pages in Word)

Workshop report

Participants: EU experts: Jan Fouchard, Denmark (JF), Anna Tarjan, Hungary (AT), Sofia Lopes da Costa, Luxembourg (SLC), Iva Pejnović Franelić, Croatia (IPF), Eberhard Schatz, Netherland (ES), Dolores Sesma, Spain (DS), Anastasios Fotiou, Greece (AF). EMCDDA staff: Rosemary Martin de Sousa, EMCDDA (RMS), Sandrine Sleiman, EMCDDA (SSL), Alexis Goosdeel, EMCDDA (AG), Ilze Jekabsone, EMCDDA (IJ), Frederic Denecker, EMCDDA (FD), Kasia Natoniewska, EMCDDA (KN)

Experts representing seven countries (Greece, Denmark, Hungary, Luxembourg, Croatia, Netherlands and Spain) and six EMCDDA staff members (Communication and Reitox units) attended the workshop.
AF, in the capacity of a moderator, introduced the workshop giving a short presentation. He highlighted contextual challenges related to data collection for DRID indicator; on how data collection system is perceived at various levels (individual; local; national and international) and who are main actors involved in the DRID data collection, analysis and dissemination system. Further, to set-up the scene for discussion, he defined **DRID stakeholders as any person, organisation or group, who has an interest in DRID or could be potentially affected by its delivery or outputs**, noting that for the purpose of the workshop one should assume that these stakeholders play several important roles: they may be data providers, partners, decision makers, advocates or funders, they affect how well DRID indicator data are collected and their management is regarded as a central part of DRID effectiveness. AF also acknowledged EMCDDA efforts to increasingly address needs of various stakeholder groups through the improved European Drug Report package and the new format of expert meetings. Although NFPs have also scaled up their national networks and stakeholder engagement significantly over the years, he highlighted challenges some countries may still face:

- DRID data are not readily collected or are not always shared;
- lack of funding available for studies;
- lack of co-operation between key persons or organizations;
- no national DRID working groups in some countries, however for this issue one should distinguish between *formal* and *informal* cooperation at the national level.

These challenges suggest that NFPs should pay more attention to their stakeholders, engage them appropriately and efficiently, and also sustain two-way communication on data collected, analysed and reported. Following the introduction, AF introduced aims for the workshop:

- to identify stakeholders;
- weight their relevance to effective DRID implementation;
- pin-down and prioritise stakeholders needs taking into account the current economic climate;
- share national experiences and best practices.

A discussion was opened by ES from Netherlands, who proposed considering **drug users as stakeholders** of DRID. He shared experience on using **peer involvement**, e.g. involvement of drug users or their associations, in various training projects on hepatitis C and stressed unique knowledge drug users possess about DRID. This idea was further elaborated also by JF, however he argued that smaller countries may not have drug user associations and other platforms needs to be consulted – such as organisations working on HIV issues in general. While AF noted, that in Greece there was no practice engaging any peer organisations in the past, but that recent HIV/AIDS outbreaks have changed perception and added value for such cooperation is now more visible; however he noted that drug users are involved already indirectly through harm reduction services. While AT from Hungary shared her personal volunteering experience in a harm reduction organisation parallel to her duties in the NFP, which gives her additional insights into drug scene and allows better interpret the situation. In Croatia the NFP closely collaborates with six harm reduction NGOs.
Further participants discussed how **different experts are involved in DRID** data collection system. IPF from Croatia highlighted that involvement of experts at national level depends a lot on personal relationships and the NFP has a unique role to put all the experts around one table. Further to that AG referred that management of relationships with national experts is one of the main tasks of the NFP.
To advance the discussion, AF encouraged the experts to give examples what a NFP could **feed back to drug users/their associations, data collecting agencies and experts involved in the DRID system** (in theory and practice). Following elements were noted by the workshop participants:

- better services, which would match the needs of users;
- appropriate information for service users;
- counselling;
- training to NGOs;
- feedback to data providers on the use of data (publications, reports etc);
- validation of data analysis and interpretation (‘*did we understood situation correctly?’*);
- provide more information on what is EMCDDA, its role and what is the role/obligation of the NFP.

Further participants exchanged views on some practices implemented at the country level to **engage health professionals/social workers/ programme managers**, which are also stakeholders of DRID data collection system. In Hungary, as example, the NFP created a data collection page on the NFP website for needle and syringe programmes where NSPs report on their syringe turnover and client data for national data collection needs. To motivate NSPs the page was further developed and was extended by service provider level statistics so now service providers can use this page to analyse their own data and utilise output tables and figures for their own needs. IPF from Croatia noted that for a practitioner, perception that he/she is contributing to the work of an international organisation is also very important and may be motivating; while AF indicated possibility to involve data providers more in commenting of documents produced at the national level. It was also noted that there are different working cultures between treatment and harm reduction service providers which may influence their attitude towards data collection, while some changes in these cultures can be observed also over time.
Further the participants discussed what would be the role of **a national working group** in the context of DRID data collection system. In general, there is a feeling that working groups are currently considered as research bodies for data analysis which helps the NFP with the reporting function rather than a forum to exchange opinions at the national level. Interpersonal relationships among different experts may influence the composition, quality and outcomes of its work. However, it was also noted that formalistic approach would not help to improve cooperation among experts, and that each NFP should find their own triggers for a meaningful cooperation with them in that way making the NFPs work more relevant to the national partners. It was noted also, that for a small country, such as Luxembourg, a national working group is more manageable than for a larger country with complex structures. Some options were indicated for enhancing cooperation at national level:

- a big event with all data providers;
- webinars;
- collection of data/information at regional levels (NUTS3);
- modernising websites;
- making working groups more flexible (mixing formal and informal; changing the meeting patterns based on the need) but maintaining the sense of 'belonging' to the group;
- combining working groups for various indicators;
- avoiding 'politicising' working groups;
- changing the topics a working group focuses every year.

RMS noted a move towards more dynamic expert meetings in the EMCDDA with better dissemination of meeting content and results via the website, which could also be used by the NFPs to enhance relationships with the national partners. Further AF indicated that the NFP should invest more in dissemination of the EMCDDA information to the national partners/audiences. As such a proposal was given to train the NFP staff on how to communicate data to national audiences. Or when resending EMCDDA information/emails to a network of national experts, the NFPs should try always to introduce the email with a short text in their national language/-s. This might increase the interest and attention of the national experts.

Main conclusions:

— The workshop participants discussed three groups of DRID stakeholders at national level: drug users, experts and health professionals. All these groups may have different perceived needs and motivations to cooperate with NFPs. One of the tasks of the NFPs is to define what these needs are and what could trigger or enhance the cooperation at the national level. At the same time, good informal relationships, feedback on data and providing opportunities for additional analysis on data were noted as important aspects to ensure cooperation with the stakeholders.

— A national working group was acknowledged as a resource to initiate national cooperation, while in most cases it is regarded as a scientific advisory body for data analysis and interpretations. It was suggested to consider adaptation of working group tasks and objectives to national needs and to consider transforming it into a forum for information exchange and analysis.

— Communication with data providers is additional skill which sometimes is not present among NFP staff, therefore it was suggested that EMCDDA train NFPs staff on how to communicate with data providers and national expert networks.

Workshop 4: Diagnostic testing prevalence data

Moderators: Catharina Matheï, Belgium & Magdalena Rosińska, Poland

Workshop guidance

Catharina Matheï, Belgium

Background

"The protocol for the implementation of the EMCDDA key indicator Drug Related Infectious Diseases (DRID)" (European Monitoring Centre for Drugs and Drug Addiction 2006) advocates the use of two complementary approaches to monitor drug-related infectious diseases: (a) sero-behavioral surveys and (b) routine diagnostic testing. Sero-behavioral studies are more informative as they are specifically designed to study IDU populations. However, as a result of being time- and resource intensive, the sero-behavioral studies often have a limited geographical coverage and a poor continuity over time. Data from routine diagnostic testing also provide useful insights in case annual routine testing is widely offered. Compared to sero-behavioral studies, it is less resource intensive to collect data from routine diagnostic testing and they can be more easily collected on a continuous basis with good geographical coverage..

Problem

As the generation of routine diagnostic testing data is not specifically designed for DRID monitoring, some methodological concerns exists regarding the validity of their use for DRID monitoring (European Monitoring Centre for Drugs and Drug Addiction 2006)

Case study: Belgium
Belgium reports yearly to the EMCDDA prevalence rates of HCV, HBV and HIV among IDUs based on routine diagnostic testing data provided by 2 drug treatment services. However, the prevalence rates reported by both services differ substantially, especially with respect to the HCV-prevalence rates, which were in 2011 42 and 81% respectively. These differences are partly the result of differences in patient population. However other factors were identified that might contribute to the important differences in the observed prevalence rates. Adherence to testing policy is suboptimal in both centres but the way testing practice deviates from testing policy differs considerably. There are also substantial differences in the way the prevalence rates as provided by both centers are calculated.

Aims of the workshop

- To identify the barriers/facilitators to the use of diagnostic testing data for DRID monitoring
- To discuss ways to improve the reliability and comparability of diagnostic testing data for DRID monitoring

What do we expect from participants

- To prepare a short country report (less than one page) about the use of diagnostic testing data for DRID monitoring, what are the difficulties using this data and how these problems are dealt with.
- To participate in the discussion
- To appoint someone to make a report (1-2 pages in Word)

European Monitoring Centre for Drugs and Drug Addiction 2006, Protocol for the implementation of the EMCDDA key indicator Drug Related Infectious Diseases (DRID), EMCDDA, Lisbon.

Workshop report

Problem: Routine diagnostic testing is one of the approaches to monitor drug – related infectious diseases. As the generation of routine diagnostic testing data is not specifically designed for DRID monitoring, some methodological concerns exists regarding the validity of their use for DRID monitoring (EMCDDA 2006).

The aims of the workshop:
1. to identify the barriers/facilitators to the use of diagnostic testing data for DRID monitoring,
2. to discuss ways to improve the reliability and comparability of diagnostic testing data for DRID monitoring.

Participants:
Chair: Catharina Matheï, Belgium and Magdalena Rosińska, Poland

Andrei Botescu, Romania
Domingos Duran, Portugal
Cinta Folch, Spain
María Jose Bravo, Spain
Anda Karnīte, Latvia
Viktor Mravčík, Czech Republic
Christophe Palle, France
Silvia Slezáková, Slovakia
Marta Struzik, Poland (raporteur)
Julián Vicente (EMCDDA)
André Noor (EMCDDA)

Summary
The workshop revealed many different sources of data on infectious diseases among injecting drug users. Moreover diagnostic testing data are defined differently among countries and different type of data are reported then to the EMCDDA. Data collected are in general based on biological testing but a significant part are also self-reported data. It is worth noting that self-reported data were quite an important predictor of an outbreak in Romania. There are some countries where rapid test are commonly used (e.g. Czech Republic, Slovakia).
The link between DRID and TDI could be a possible source of better information. In many instances the link occurs, testing being completed on the basis of the treatment centres. One problem with TDI data itself is that it is self-reported. In parallel to this discussion is the suggestion of a protocol or survey to harmonise the collection of data from treatment centres (ES).
There is a need to make an in-depth analysis what type of data are reported to the EMCDDA as diagnostic testing data.

The participants presented short country reports about the use of diagnostic testing data for DRID monitoring and discussed the difficulties using this data. The situation in each country is briefly described below.

Belgium
Diagnostic testing data reported to the EMCDDA come from two treatment services (abstinence oriented and low threshold). Of the estimated 50 – 100 centres, two provide data. The protocol on data collection was prepared and working groups are being organized to monitor data collection. The problem identified is that hepatitis C prevalence and risky behaviours among populations of both centers are different. Differences in testing policy in those two centers result in different prevalence rates. Hepatitis C prevalence estimated in 2011 Antwerp 81.5% (340) and Flemish community 41.3% (52) with setting and method defined the same (INF 111). The reality is that different methods were used to calculate the prevalence levels. Centre A used newly diagnosed Hepatitis C cases as the numerator and new clients as the denominator. Centre B used all known Hepatitis C cases as the numerator and all patients attending the clinic in a given year as the denominator.

Poland
Diagnostic testing is implemented only for HIV and covers laboratories offering screening tests for HIV. These laboratories operate within the general HIV surveillance system, not only for drug users. Data received refer to the number of tests, not individuals and only aggregated data are reported. The decreasing number of laboratories participating in the screening is due to the fact that they are not allowed to collect any information that is not

necessary to give the test result. Data are tend to be interpreted as undiagnosed cases because people with positive test result are not tested again.
The link between DRID and TDI has not been fully implemented as the TDI system is still in pilot phase. DRID questions are included in the new TDI protocol but some problematic issues may occur as either the clients do not respond or the centres do not implement or report the results. TDI data would be self-reported mostly.

Spain
Data on prevalence come from TDI monitoring system. There is a time lag between test result and reporting data on national level and then to the EMCDDA. In Spain the coverage of centers reporting data is very high but more problematic is the coverage of testing. Data in different centers are collected in a very various manner.
In Catalonia high level of missing data is identified. Prevalence data come from treatment centers and local studies. Data are aggregated by age and sex.

Slovakia
Prevalence data come from different sources:
1. 5-6 specialized centers for treatment of drug dependencies. The tests are performed at every new treatment admission (first time ever or after a very long time) for injecting drug users and problem drug users for HIV, HCV, HBV. About 300 patients are tested every year and some repeat tests may occur.
2. from opioid substitution treatment – 2 methadone maintenance clinics have contract on testing (every client tested every year). Data are being provided systematically.
3. in low threshold services testing is not implemented for a very large scale. The number of tests (not clients) is reported but data are not collected on systematic basis. Projects on HIV testing for e.g. 3-month-period are performed. The question was raised as to how to deal with the new rapid testing.

Czech Republic
There is a range of sources for diagnostic testing data. The first one are laboratories (available data refer only to the number of tested; HIV below 1% in the IDU population). Second – data from TDI monitoring system (partly self-reported data; for HCV 30%, HIV below 1%). The next source is the online questionnaire survey conducted among around 100 low threshold programs (the coverage is not full, partly rapid testing, HIV and HCV). Another source of data is the substitution treatment system that overlap with TDI monitoring system (based on testing, not all clients tested and not all tests reported). The different sources each possess particular characteristics and biases, including selective testing, self-reporting, the tested group being new clients and the range of diagnostic methods.

Portugal
Data come from treatment centers and low threshold methadone maintenance programs. Clients in treatment are tested for HCV, HIV. If the test result for HCV is negative the test is repeated after
6 months.
In methadone maintenance programs, HIV testing is mandatory. If negative – repeated every
6 months. The main reason for this is to take care of people that are not admitted to treatment centers and to secure public health.
In Portugal there were changes in public health system. Currently it is only possible to provide data from treatment centers. The next challenge is to receive data also from low threshold services.

Latvia
Two sources for HIV prevalence data are available: the first one – network of needles and syringes exchange programs (18 centers in the country; full coverage; rapid tests only; medical staff needed). An internet based system of reporting funded by UNODC was initiated last year. Rapid test results are reported in ST9. The second – cross sectional studies, RDS studies for Riga and surroundings (2007, 2012). HIV prevalence rates differ in both sources.

Romania
The problem is located primarily in Bucharest. Main source of data is TDI monitoring system and RDS studies (one in three years mainly in Bucharest). Institute for Infectious Diseases collect some additional data randomly around the country.
Data from TDI (partly self-reported) were a good predictor of the outbreak. HIV testing is not compulsory in treatment facilities. Usually clients are tested at the beginning of treatment.

France

The following sources of data on infectious diseases among IDUs are available:

1. cross sectional multicity survey with testing (2004, 2011) - as yet no results are available,
2. self – reported status from TDI monitoring system,
3. study in low threshold centers (2 weeks or 1 month - period - survey).

In general available data are mainly self-reported and testing is not mandatory in treatment centers.

Workshop 5: Reporting and use of sub-national data, categorising and grading data, and the reporting burden.

Moderators: Eleni Kalamara, Sandrine Sleiman, Andre Noor; EMCDDA

Workshop guidance

Eleni Kalamara, Sandrine Sleiman, Andre Noor, Lucas Wiessing; EMCDDA

Background

EMCDDA Drug Related Infectious Diseases (DRID) key indicator (KI) collects information from targeted studies of injecting drug users. The number and diversity of the studies presents a specific set of challenges in the collection, interpretation and presentation of the data. The indicator is subject to review this year a meeting was held in mid-July with a group of DRID experts. The following are amongst the issues raised as part of the general review of the indicator and it is hoped to further investigate these during the workshop.

Problems

As a collection of studies, DRID represents the largest number of reports submitted of any indicator, though many of these are sub-national reports submitted by a limited number of countries. In addition, few countries are not reporting national studies but only sub-national data sets. Are there ways in which the reporting could be more harmonised?

Assessing the comparability and quality of the data is complicated, and requires the evaluation of a range of characteristics of the studies. Consequently, are there a set of characteristics that are collected that could be used to determine the comparability of studies, and more generally would it be useful to adopt a grading scheme that provided some notion of the confidence in a study.

With regard to grading of data, a method of grading studies has been suggested within systematic reviews of infection amongst injecting drug users based on the number of sites and methods of diagnosis.[4] The information collected in the DRID provides the opportunity of extending the characteristics used to grade data, and may also be used to assess comparability.

The data suggests the following possible characteristics:

- Coverage: national, regional, capitals, other cities, …
- Type of diagnosis used in the study: seroprevalence, diagnostic testing, seroprevalence with unlinked anonymous testing, self-reported
- Type of injectors: current, ever, unknown
- Setting: drug treatment centre, needle and syringe programme, ... , open vs. closed settings, and one vs. many settings
- Number of sites: one vs. more than one.
- Periodicity of the study: continuous or ad hoc

Aims of the workshop

To explore:

- Areas in which the burden of reporting and of processing could be alleviated.
- Is it a "real" burden of reporting or is it useful at national level, for other analysis, networking purposes,…? Is there a need to report all variables in the case of the reporting of sub-national data?
- The possibility of establishing a grading system for DRID data on the basis of the methodological information collected.
- The characteristics that determine the comparability of data.

What do we expect from participants?

[4] Mathers, B. et al (2008) "Global epidemiology of injecting drug use and HIV amongst people who inject drugs: results of systematic reviews" , The Lancet, published on line September 24th 2008. Accessed October 2013.
Nelson, P. et al (2011) "Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews" , The Lancet, published on line July 28 2011. Accessed October 2013.

- To briefly describe the methodology used to collect the data submitted by your country for the DRID
- With regard to the estimates submitted by your country to DRID:
  - Are they comparable across years? If so, on what basis.
  - If more than one estimate is submitted for a given year, are these estimates comparable?
  - What characteristics of the methodology would you consider necessary to compare estimates across countries?
- To consider the characteristics suggested for grading data listed above and to participate in a general discussion of the utility and possible methods of grading received data.

Workshop report

Note on workshop related to grading (Workshop 2), 16th October 2013.
André Noor.

General Themes:

The data collected for DRID was useful information and of importance, but the complexity of the studies made it difficult to interpret and to present. The way in which the information is constructed is not always similar, and can influence the possible interpretation.
In understanding the data delivered for DRID, given the particular nature of the information received, some combination of the following could be useful and would merit further investigation.
Grading of the data according to an agreed set of characteristics and weights.
A narrative describing the method of the data collection within each country. The National Reports provide this and could be developed as a summary.
A contextual description of the perceived need for testing within a country. NL pointed out that the developed information system, the historical provision of testing and care, and the relatively few new injectors made it less relevant to have a large testing procedure. This was important contextual information which should be used when understanding the data.
In presentation, a breakdown of the information received according to distinguishing factors, such as continuous studies, ad hoc studies, national studies, sub-national studies. The characteristics would overlap or mirror those of the grading.
Additional topics raised were a question as to what conditions were necessary to describe the data submitted as prevalence, and the comparability of data across time where there was no repeat testing.

Descriptions of country circumstances.

Netherlands: Raised the issues of information being in the National reports but seemingly not used, the importance of context in understanding the available data particularly in the Dutch case, the overemphasis on single studies with high prevalence (Dutch study of 2008 reporting 100% positive for hepatitis C on the basis of 27 individuals was cited) and the importance of determining whether the reported information could be referenced as an estimate of prevalence. Little data is available in the Netherlands, primarily sub-national studies, that should not be used to determine prevalence. All important is the context, which is available from the National reports.
Testing is completed amongst those on methadone treatment at the beginning, it is not compulsory, and re-testing occurs only when there is a self-report of risk behaviour.
Further issues raised in general discussion was whether the calculation changed over time as those IDU were tested and brought into treatment, definitions of the numerator and denominator changing. Also whether this could be described as prevalence.
Belgium: As above, with additional information that there are about 20 000 IDUs.
Hungary: Again pointed to the National report as the best description of testing procedures and the importance of contextual information. Data is collected and reported for Budapest and outside of Budapest. They report good coverage of treatment centres.
Romania: As above, with the additional information that they do have a survey using respondent driven sampling every three years, which should be repeated, and had a seroprevalence study repeated every year for the past 5 years, but this has now stopped.

Workshop 6: Monitoring other infections

Moderator: Hans Blystad, Norway

Workshop guidance

Monitoring other infections

Hans Blystad, Norway

Background

Drug-related infections diseases are one of the key epidemiological indicators used by EMCDDA to monitor drug use and its health consequences. Since 1992, data on chronic viral infections like HIV, HCV and HBV infections among IDUs have gradually been collected from all the member states (MS). These infections have till now been regarded as the main causes of infectious diseases burden related to drug use. The data is collected from IDUs each calendar year using two main methods.

- the monitoring of routine diagnostic testing for HIV, hepatitis C and hepatitis B infection among IDUs (notification data)
- surveys of IDUs that include serological testing (prevalence data)

Data have since 2008 been submitted electronically through a special template within Fonte. EMCDDA work in close collaboration with the MS and the ECDC and WHO in collecting such data.

Problem

The chronic viral infections currently monitored have over the years given a good overview on the burden the disease burden related to drug use in Member states and to a lesser degree been able to identify outbreaks within MS or across border outbreaks and acute public health problems related to IDUs. In addition, IDUs are vulnerable to a range of other infections which are currently not monitored by EMCDDA. These are mainly bacterial infections like:

- skin and soft tissue infections caused by the staphylococcus and streptococcus bacteria (including infections caused by antibiotic resistant bacteria, like MRSA)
- spore forming bacterial infections (f.inst. anthrax)
- respiratory infections (like tuberculosis, pneumonia and influenza)
- wound botulism
- tetanus

Common for some of these infections are that they may spread across borders through contaminated drugs. In addition, sexually transmitted diseases (STIs) are more common among IDUs in many MS as well as hepatitis A.

Aims of the workshop

- Identify which infections among IDUs (besides HIV,HCV and HBV) are monitored in the individual MS.
- Identify infections (other than HIV,HBV and HCV infections) that could be monitored by EMCDDA
- Discuss feasibility and added value of monitoring these infections on a European level
- Discuss monitoring national and cross border outbreaks among IDUs

What do we expect from participants?

- To have some knowledge of surveillance of infectious diseases among IDUs in own country
- Participate in the discussion providing national experiences and thoughts on feasibility of data collection
- One participant to do the reporting (one or two pages in Word)

Workshop report

Participants: Hans Blystad, chair (NO), Jan Foucher, rapporteur (DK), Katelyn Cullen (UK), Luís Mendão (PT), Knut Boe Kielland (NO), Mait Raag (EE), George Grech (MT), Anda Karnite (LV), Mario Cruciani (IT) and Cornelius Bartels (ECDC)

Background

Since 1992, data on chronic viral infections like HIV, HCV and HBV infections among PWID have gradually been collected from all the member states. PWID are vulnerable to a range of other infections which are currently not monitored by EMCDDA. These are mainly bacterial infections like skin and soft tissue infections (including antibiotic resistant bacteria like MRSA), spore forming bacterial infections (like anthrax, wound botulism, tetanus), sexually transmitted infections and respiratory infections (like tuberculosis, pneumonia and influenza). In addition, other viral infections like hepatitis A are not uncommon among PWID. Should EMCDDA monitor any of these infections, and is there an added European value? How should EMCDDA monitor and communicate outbreaks of infectious diseases among PWID?

Discussions

Feasibility and added European value of collecting PWID notification data for additional disease: The majority of participating countries at the workshop have presently difficulty in identifying IDUs in their surveillance system for the majority of the diseases, with exception of UK and NO. Most of the countries will probably be able to report notification data on tuberculosis, including IDU as a risk factor, but many countries have separate system for TB and this possibility will have to be explored. In some countries (f.inst. PT), a number of HIV positive IDUs are co-infected with TB and this gives it an added value in monitoring TB among IDUs at a European level. The participants agreed that although antibiotic resistance may be an increasing problem among IDUs, it is not feasible to collate data on this at the present time. Outbreaks of hepatitis A among IDUs is a problem in some of the countries (NO and LV) , but the participants agreed that monitoring hepatitis A among IDUs in Europe by notification data or prevalence data is not necessary if a good communication platform monitoring outbreaks and trends is in place.
ECDC and EMCDDA informed that notification data for HIV, hep C and hep B among IDUs will soon be provided by ECDCs Tessy database which means that notification data on these disease will not have to be entered in Fonte ST9.

Outbreaks and communication platform

The participants agreed that the present form of communication of outbreaks and infectious disease events among IDUs through e-mail from EMCDDA is not good enough, and a better communication platform is needed. ECDC presented the Epidemic Intelligence Information System (EPIS) which has been in operation for some years at ECDC. EPIS allows exchange of non-structured and semi-structured information regarding current or emerging public health treats with a potential impact in the EU. At present ECDC there is 3-4 different EPIS platforms (f.inst for food and waterborne and vaccine preventable infections). EPIS has shown to be a very useful tool as an addition the more formal Early Warning and Response System (EWRS). The participants agreed that it is probably not feasible for EMCDDA DRID to develop a similar communication platform from scratch. Close cooperation with ECDC is therefore essential in creating such a new platform (called EPIS PWID??).
If such a communication platform should be a reality, further discussion is need in relation to who should have access to the platform. National DRID experts will have an important role in disseminating information posted on the platform.

Recommendations

The participating countries and institutions in the workshop recommend that:

- At present, EMCDDA should only consider to collate data on tuberculosis among IDUs in addition to the present three disease; HIV infection, hep B and hep C. The TB data could probably be provided by ECDCs Tessy database. For monitoring other infections on a European level, monitoring trends and outbreaks through a communication platform is considered sufficient.
- A new communication platform run and developed by EMCDDA in close cooperation with ECDC is urgently needed. National DRID experts would play a major role in disseminating information published at such a platform.

Workshop 7: Strengthening behavioural DRID indicators through TDI–DRID collaboration

Moderators: María Jose Bravo, Spain, Julián Vicente, EMCDDA

Workshop guidance

María Jose Bravo, Spain, Julián Vicente, EMCDDA

Background

DRID draws upon many data sources. Behavioural indicators (BI) are basically collected through "ad hoc" bio-behavioural studies in the community or care centres. Community bio-behavioural studies are necessary but expensive and they would likely be affected by economic crisis in some countries.

TDI is highly consolidated. Recently TDI added 4 variables relevant to DRID. Enhancement of TDI-DRID collaboration at national and EU level might contribute to DRID BI reinforcing and hopefully increase the number and sustainability of BI time series, which is crucial for surveillance.

➔ Exploring the possibilities of TDI-DRID collaboration is essential and a challenge. The collaboration between TDI and DRID might bring benefits at national and EU level.

Issues

A closer link between TDI and DRID is still to be defined on their possible main lines of action. A few examples are following in order of complexity:

- To use TDI data (related to DRID) as they are, analysed together with other TDI variables (primary drug, sociodemographics...). Currently some countries have not yet reported these new variables but hopefully this will improve progressively.

- To design a protocol to implement cross-sectional behavioural surveys at drug treatment centres/others centres. This is ambitious and clearly has important drawbacks on their definition and implementation. But it also has potential relevant benefits and its design and application could be tailored (i.e. one page questionnaire, computer assisted ..., sentinel centres) to suit the possibilities and needs at both country and EU levels.
  More simple could be to design a short questionnaire/module to be used voluntarily in treatment centres, and the information collected periodically also on a voluntary basis. There is the risk that this enters in competition with the more in-depth behavioural studies conducted at present.

- More challenging would be to collect information on prevalences. This is done at present in specific sampling studies. Nevertheless collecting routinely presents considerable challenges about what is really measured (who is testing, when, how results are recorded). One possibility could be to map what is done and whether in some countries the information could be useful.

Other options of collaborations might as well be possible based mainly on national data availability and report feasibility.

Aims of the workshop

- To discuss the benefits and drawbacks of an enhanced collaboration between TDI and DRID at national and EU level.
- To identify a feasible line of collaboration between TDI and DRID, and discuss the above alternatives, among others.
- To review pros and cons of the lines of work identified, at both national and EU level.

What do we expect from participants?

1. To reflect and discuss with his/her colleagues at national level previously to meeting attendance
2. Participate in the discussion based on his/her experience
3. One participant to do the reporting (one or two pages in word)

Workshop report

Participants: Maria Jose Bravo (ISCIII, Spain, Moderator); Julián Vicente (EMCDDA Co-chair); Magdalena Rosinska (Poland, raporteur); Zuzana Alexandercikova (Slovakia); Sofia Lopes da Costa (Luxemburg); Anastasios Fotiou (Greece); Elif Mutlu (Turkey); Nasia Fotsiou (Cyprus); Christophe Palle (France); Iva Pejnovic Franelic (Croatia); Tanja Kustec (Slovenia), Maris Salekesin (Estonia), Marta Struzik (Poland)

Three general ideas proposed to improve the collaboration between the two indicators at the country level were:

- To analyse together DRID related data with other TDI data - available through already existing system
- To work towards simple instrument to implement at voluntary but regular basis at treatment centres to do cross-sectional study linking directly TDI with behavioural variables
- To connect the prevalence data collected through TDI system to behavioural variables

The participants were asked to provide a synthetic review of their preferred approach for the collaboration between DRID and TDI. The views and expectations of each participating country related to collecting and using behavioural and prevalence data within the existing TDI systems were discussed. Current practices were described by the country representatives including the organisation of the system, data collected at each level and data reported to the EMCDDA. Participants were supportive of the idea of closer collaboration between DRID and TDI. The situation is each country is summarized below.

1. Slovakia: interested in the 3rd option. The prevalence data mostly come from centres (routine, reported based on test) and behavioural data could largely enhance the prevalence data. Behavioural information already gathered routinely at the level of treatment centre. However it is locally different between centres and harmonizing the variables between centres and integrating the whole network or some of the centres (sentinel) would be needed. Behavioural data are not at the moment provided to the national level.
2. Luxemburg: DRID data is based on TDI protocol, but data are still poor since only the self-reported sero-status is recorded. Testing is not on drug treatment protocol/ guidelines in out-patient centres (only in in-patient and prisons) – staff is social workers, not trained to perform infectious diseases testing, so only some institutions perform testing, but still the results are not on the TDI protocol. Some behavioural variables are already collected. Serological studies are performed sporadically.
3. Estonia: Drug treatment database is maintained with socio-demographic and behavioural data including risk behaviours connected with injecting. Treatment centres don't test for infectious diseases, so these data are not included, self-reported status is not collected. Testing is conducted in the network of testing centres. Possibly sero-behavioral surveys could include TDI variables – then these two datasets could be combined and used together.
4. France: self-declared prevalence of infectious diseases is collected in the TDI system. Two contradictory ideas emerge: increasing the number of variables in TDI – logical since making use of existing system but necessitates adding variables to the software – centres use different software products, in consequence takes time and effort. More reliable data could be achieved by conducting a survey – even a survey among treatment centre clients – which requires a limited time effort and allows to avoid the effect of tiredness in the centres associated with routine monitoring (increase quality of data). In addition to what is already reported in TDI information on needle exchange participation and serostatus is collected.
5. Slovenia: TDI collection tool is basic. The prevalence of HIV, HCV and HBV infections is monitored by collecting data about voluntary diagnostic HIV, HCV and HBV testing within the national network of 18 Centres for the Prevention and Treatment of Illicit Drug Addiction whose coverage is natiowide. DRID indicators are avaiblable and reported to the EMCDDA without behavioral part (ST9 Part 3). . At national level behavioural and prevalence data are available through already existing system and can be analysed together –.

6. Cyprus: TDI protocol is implemented, both self-report or test results are used for providing serostatus. Testing takes place at public or private laboratories. The IDUs coming to treatment are tested in most of the centres, but this is not a requirement. At this point the protocol is still being developed.
7. Poland: TDI is separate from DRID, and at a developmental stage. Restrictive data protection regulations see these data not as medical documentation but statistical system, only self-reported data are possible to include. DRID data rely on surveys from laboratories, sero-behavioural studies and anonymous HIV VCT sites. Behavioural survey between clients of harm reduction services is performed with self-reported prevalence of infectious diseases.
8. Greece: TDI has high coverage at the level of treatment units and at the level of clients. Prisons and private services are not included. 103 centres provide service for all kinds of demands, including ~88 that provide for IDUs - 78 are included in TDI. Greece was involved in discussions on TDI variables and all the variables (even the newest ones) were implemented in TDI (initial interview) similarly, but on a separate from, the DRID data were collected. The DRID data relied on a report from a clinician, which caused incomplete reporting. Revision of DRID and TDI at the EMCDDA stimulated to create a single form combining TDI and DRID for injectors (implemented in 2013) – reducing the overlapping part. If the client takes drugs by administration routes other than injection –not all the questions will be asked. The physicians only have to fill the information on the infectious diseases (or train somebody to do it). Forms scanned to a single database. Greece showed interest on the possibility of applying a very simple cross sectional survey at country level that might be carried at a given periodicity. These could be implemented during a given short period of the year. Other approach could also be contemplated. Nevertheless an increased burden to the centres should also be considered as a negative consequence of this approach.
9. Croatia: DRID relies on the data from seroprevalence studies, VCT network (HIV,HCV, syphilis). TDI – self-report, tests are done for those indicating recent risk injecting or sexual (~30% of clients). Possibility to merge HIV register and other infectious diseases notifications using the common identifier that is used. Behavioural data are already gathered routinely – but may be locally different.
10. Turkey: 22 in-patient centres, TDI and DRID information included in the questionnaire. Each person is tested. 1280 IDUs in treatment. No other data providers, not reported out-patient treatment, no harm reduction.

Conclusions:

- Great heterogeneity of the TDI system
- Treatment data often used to inform both TDI and DRID (prevalence data)
- The new TDI protocol (version 3.0) includes several behavioural variables. The data will be collected at European level from 2014. The analysis of results and quality of these variables will give further insight on the use of TDI data for DRID.
- Mapping might be of value to really understand how the prevalence data (and behavioural data) are collected in and to more accurately assess whether prevalence data can be connected with behavioural data (TDI variables) at national level, or subnational level
- Adding or collecting additional variables from TDI does not seem feasible at this stage given the great heterogeneity in the system functioning and what is being collected in terms of behavioural data.
- Is it possible to agree on a common study in a high number of countries, collecting data on treated population and collect blood samples (sero-behavioral survey among treated population)? Given the great heterogeneity of the systems between countries, further assessment at country level is still needed.

Workshop 8: Non IDUs, other groups (steroid users, MSM who use drugs)

Moderator: Vivian Hope, United Kingdom

Workshop guidance

Sex and image related drug use and infections

Vivian Hope, UK

Background.

EMCDDA Drug Related Infectious Diseases (DRID) key indicator (KI) has so far focused its data collection on blood-borne viral infections – specifically HIV, hepatitis B and C - among people who injecting psychoactive drugs. This focus reflects long standing concerns about the transmission of these infections through injecting drug use and the resulting burden of disease.
Psychoactive drugs, such as heroin, cocaine and amphetamine, are not the only type of illicit substances that can be injected. Drugs to alter image and performance, such as anabolic steroids, melanotan, and growth hormone, can also be injected. People who use and inject these drugs are also at risk of infections.
To varying extents HIV, hepatitis B and C can also be transmitted through sexual activity. Drug use (both non-injecting and injecting) before or during sex is not uncommon, and such drug use may increase the sexual risks that can lead to the transmission of blood-borne viral infections and bacterial STIs.

Issue

DRID KI current focus on blood-borne viral infections among people who inject psychoactive drugs does not capture the full extent infection transmission related to drug use. Neither does it fully elucidate the foci of risk. For example, DRID does not necessarily capture, or identify data on:

- Infections associated with risk among people who inject/use image and performance enhancing drugs.
- Infections associated to increased sexual transmission from psychoactive drug use (injecting and non-injecting) before or during sex among heterosexuals, MSM, sex workers, etc..

Aims of the workshop

To explore:

- which sub-groups/groups of people who use/inject drugs – beyond the broad category of “people who inject psychoactive drugs” - should be considered in relation DRID data/information collection.
- for these groups whether either routine on-going monitoring at an EU level or periodic focused data/information collection (every two or three years) would be useful.
- what form any such data collection might take.

What do we expect from participants?

- To think and discuss this issue with colleagues in their country.
- To establish what is already known about these issues in their country.
- Participate in the discussion providing national experiences.
- One participant to do the reporting (one or two A4 pages in Word).

Workshop report

Chair: Vivian Hope; *Participants***:** Vivan Hope, UK; Ruth Zimmerman, Germany; Viktor Mravcik, Czech Republic; Cinta Folch, Spain; Violeta Bogdaivova, Bulgaria;Silvia Slezakova, Slovakia; Henrikki Brummer-Korvenkontio, Finland; Carrie Garavan, Ireland

The chair informed group that workshop was to be unstructured and aimed to explore ideas with a focus on non IDUs and other groups who inject drugs such as MSM, body builders, sex workers. Group was asked to think about these groups and the workshop be used to throw up ideas.

Spain stated that MSM are now the group most affected HIV epidemic and this mainly due to sexual relationships. The MSM population uses a wide selection of drugs which are associated with high risk sexual behaviour. Recreational drug users are also a group who are not frequently captured via harm reduction centres. Several years ago, sex workers were targeted but their drug use via injection has decreased and cocaine is the main drug used on but of course this can also increase risk taking behaviour.

Germany said that similar behaviour amongst MSM that makes them susceptible to acquiring infection. One case control study among HIV-HCV-coinfected MSM in Germany recently found that sex-associated rectal bleeding, receptive fisting and snorting cocaine/amphetamines, combined with group sex, were independently associated with hepatitis C positive status. HIV positive MSMs are now screened regularly so acute infections of HCV are seen more often.

Czech Republic said that the primary focus has been IDUs, but now there is more information on infectious diseases in other populations but this is anecdotal. Not common for MSM to inject drugs, sex workers are of concern but there is no routine data collected only once off studies.

Bulgaria has no data on MSM and IDU and the main problem is IDUs injecting prescription methadone.

Slovakia has data on HIV and greatest number positive are among MSM.

Finland has surveys on HIV status of MSM, this is 20 times greater than overall. No data on sex workers.

Ireland has new cases data, data from prison study on steroid injectors, data from maternity hospitals on pregnant mothers and data from various studies on IDUs and tattoos.

UK said historically most MSM-IDU was thought to be related to sale of sex, but recently injecting among HIV positive MSM (methamphetamine and mephedrone) has caused concern. This is mostly is around sexual activity and men are often being injected by another at a party. While there is concern, the numbers are thought to be relatively small, but this drug use might move in to the wider population. Considering the mobility of MSM and so spread to other cities is of concern. In addition many steroid using body builders use also using cocaine and amphetamine and this is associated with risk behaviour.

Germany said that it is very important to work with the clinicians as an outbreak of meningitis was linked to MSM group when investigated but had been reported by a clinician.

Czech Republic said had an outbreak of Hep A among IDUs who were homeless and most likely due to poor or difficult hygiene practices.

STIs were discussed and felt to be an important neglected area due to a decrease in awareness to HIV and decrease in budgets. Condoms need more attention to decrease social transmission.

Smoking and snorting of drugs was discussed from risk perspective. It was pointed out that alcohol is also a drug and associated risk behaviour.

<u>Conclusions were:</u>

- Dearth of prevalence data in this area.
- Generally agreement that MSM and drug use is a current issue and it needs more attention and focus.
- Working closely with clinicians can identify clusters or outbreaks early.
- STIs related to drug use are also a neglected area and needs more attention.
- HIV increase and sexual transmission (among IDUs as well) requires renewed focus and attention.

Annex 2 – Participants List

European Monitoring Centre
for Drugs and Drug Addiction

Expert meetings on the EMCDDA Key Indicators
Drug-related deaths and mortality among drug users (DRD)
& Drug Related Infectious Diseases (DRID)
EMCDDA (Lisbon) - 16-18 October 2013

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Annex 3 – Meeting Programme

Annual expert meeting on Drug-related deaths (DRD) and Drug-related infectious diseases (DRID)

Objectives

- To assess and discuss recent developments on DRD and DRID in Europe, including:
  - Recent findings of European mortality cohort studies and monitoring of drug-induced deaths;
  - DRID strategy review and HIV outbreak risk assessment follow-up;
- To convene the DRID and DRD expert networks for information exchange and stimulating new initiatives.

Day 1 – Wednesday, 16 October 2013		
Conference Centre		
09.00	**Welcome** — Chairs: Julián Vicente and Alexis Goosdeel, EMCDDA **Brief civil society address** — Luis Mendão, Civil Society Forum on HIV/AIDS	
	Conference Centre	Room CdS 106
09.30	**DRID Plenary** — Chair: Julián Vicente, EMCDDA • Introduction, meeting objectives and overview of DRID activities — Lucas Wiessing, EMCDDA • HIV outbreak in Greece, results of the Aristotle study — Vana Sypsa, Greece • Important differences in injecting risks between people who inject drugs in eastern and western Europe — Mait Raag, Estonia • Burden of HCV disease in Finland — Mika Salminen, Finland	**DRD Workshop 1**: Mortality cohort studies: EU pooled analyses and other longitudinal studies — Chair: Janusz Sierosławski, Poland • Discussion of the main findings of the nine pooled cohort studies – way forward — Marko Markus, Croatia, Marcis Trapencieris, Latvia, Roberto Debono, Malta, Guus Cruts, Netherlands, Thomas Clausen, Norway, Janusz Sierosławski, Poland, Carmelia Matache, Romania, Jozica Selb, Slovenia, Noelia Lloren, Spain, EMCDDA • Amphetamine users study: overall and cause specific mortality — Marcis Trapencieris, Latvia
		Room CdS 107
		DRD Workshop 2: Medicine-related deaths: a focus on tramadol and fentanyls — Chairs: Klaudia Palczak and João Matias, EMCDDA • Fentanyl: trendspotting overview and focus on deaths — Jane Mounteney, EMCDDA • Update on fentanyl national trends — John Corkery, United Kingdom, Gleb Denissov, Estonia, Erkki Vuori, Finland and Joakim Stranberg, Sweden • Medicines in the context of the Early warning system (EWS): legal requirements under the Council Decision and Pharmacovigilance — Michael Evans-Brown, EMCDDA • Tramadol-related deaths: Situation in the United Kingdom — Jonh Corkery, United Kingdom Results of the 2013 survey — João Matias, EMCDDA
11.00	Coffee break	

Day 1 – Wednesday, 16 October 2013		
	Conference Centre	Room CdS 107
11.30	**DRID Plenary** — Chair: Lucas Wiessing, EMCDDA • EMIS results on MSM in Spain – new drugs and sexual risks of HIV — Cinta Folch, Spain • Incidence of drug injection: systematic review and meta-analysis of cohort studies among at-risk populations — María José Bravo and Blanca Iciar Indave, Spain • DRID strategy review, presentation of expert meeting results — Lucas Wiessing, EMCDDA • Panel discussion on the strategy review expert meeting results followed by introduction to the workshops (30–40 min)	**DRD Workshop 3:** Enhanced monitoring of acute emergencies: focus on cannabis/cannabinoids — Chair: Isabelle Giraudon, EMCDDA • Update on national cannabis-related emergencies: continuous increase — Noelia Llorens, Spain • National Trends: Eva Januševičienė, Lithuania, Henrik Saelen, Denmark, Viktor Mravčík, Czech Republic, Esther Croes, The Netherlands • Barcelona: experience of acute drug-related poisoning monitoring — Antonia Domingo-Salvany, Spain
		Room CdS 106
		DRD Workshop 4: Underestimation and cross-validation of drug-induced deaths data — Chair: Danica Thanki, EMCDDA • Monitoring drug-induced deaths in Turkey — Bulent Sam, Turkey • DRD underestimation, overestimation, biases in reporting? — Anne-Claire Brisacier, France • Monitoring drug-induced deaths in Slovakia — Jozef Sidlo, Slovakia
13.00	Lunch	
	Different rooms	Conference Centre
14.00	**DRID workshop 1:** Monitoring HBV vaccination through the existing EMCDDA data system — Mario Cruciani, Italy (Room CdS 106) **DRID workshop 2:** Burden of HCV disease — Mika Salminen, Finland (Room CdS 107) **DRID workshop 3:** Capacity building and feedback to service providers, networking of experts — Anastasios Fotiou, Greece and Frédéric Denecker, EMCDDA (Room CdS 012) **DRID workshop 4:** Diagnostic testing prevalence data — Catharina Matheï, Belgium and Magdalena Rosińska, Poland (Room PAL 102)	**DRD Plenary: Overview of 2013 activities and discussion of new developments at national level** Chairs: Julián Vicente, EMCDDA and Erkki Vuori, Finland • Objectives of the 2013 meeting: Key indicators progress and work in progress — Isabelle Giraudon, EMCDDA • Drug-induced deaths reported in 2013: preliminary results for discussion — João Matias, EMCDDA • What is causing the increase in DRDs in Ireland? — Suzi Lyons, Ireland • Enhancing toxicovigilance of new drugs (including reporting of deaths) — Michael Evans-Brown, EMCDDA • NPS-related deaths – a tool for prospective monitoring? 4-MA and 5-IT exemples — Isabelle Giraudon, EMCDDA Feedback received from countries and discussion • Feedback and discussion on cohorts workshop (1 national expert rapporteur)
15.30	Coffee break	

Day 1 – Wednesday, 16 October 2013		
	Different rooms	Conference Centre
16.00	**DRID workshop 5:** Reporting and use of subnational data, categorising and grading data, reporting burden — Eleni Kalamara, Sandrine Sleiman and André Noor, EMCDDA (Room CdS 012) **DRID workshop 6:** Monitoring other infections (TB, HAV, STIs, spore-forming bacteria, MRSA) — Hans Blystad, Norway (Room CdS 106) **DRID workshop 7:** Using TDI data for DRID/DRID study in treatment centres — María Jose Bravo, Spain and Julián Vicente, EMCDDA (Room CdS 107) **DRID workshop 8:** Non-IDUs, other groups (steroid users, MSM who use drugs) — Vivian Hope, United Kingdom (Room PAL 102)	**DRD Plenary: Overview of 2013 activities and discussion of new developments at national level** (continued) — Chairs: Isabelle Giraudon, EMCDDA and John Corkery, United Kingdom • Feedback and discussion on DRD cross-validation studies, acute emergencies and medicine-related deaths workshops (3 national experts rapporteurs) • Follow-up study: Adherence rate to OST — Charlotte Klein, Austria • Developments in the Norwegian overdose situation — Thomas Clausen, Norway
17.30	Cocktail	

Day 2 – Thursday, 17 October 2013		
Conference Centre: **Joint Plenary DRD–DRID**		
09.00	**Mortality cohort studies among drug users** — Chairs: Marica Ferri, EMCDDA and Viktor Mravčík, Czech Republic • Mortality cohort study NIQUAD — Tim Millar, United Kingdom • French study: preliminary findings of the 2013 record linkage — Anne-Claire Brisacier, France • Overview and main findings of the pooled EU cohorts — Isabelle Giraudon, EMCDDA • Pooled EU cohorts – implications of age differences in mortality — Marcis Trapencieris, Latvia	
10.30	Coffee break	
11.00	**Mortality related to infection – HIV, anthrax: service provision and guidelines** — Chairs: María José Bravo, Spain and Vivian Hope, United Kingdom • Estimation of HIV mortality related to IDU — Isabelle Giraudon, EMCDDA • Mortality trends in PLHIV in Latvia and insight from cohort studies — Anda Karnīte and Marcis Trapencieris, Latvia • Ten year trends in HIV and service provision in Europe — Martin Busch, Austria Anthrax prevention • ECDC/EMCDDA Joint anthrax prevention guidance for PWID — Cornelius Bartels, ECDC	
13.00	Lunch	
	Conference Centre	Room CdS 107
14.00	**Parallel session:** Hepatitis C infection in PWID — Chairs: Magdalena Rosińska, Poland and Mika Salminen, Finland • Incidence of hepatitis C infection among people injecting drugs in the EU (with a focus on the UK) — Katelyn Cullen and Vivian Hope, United Kingdom • All-cause and liver-related mortality in hepatitis C infected drug users followed for 33 years — Knut Kielland, Norway • Hep C initiative — Eberhard Schatz, Netherlands • EMCDDA HCV treatment for prevention project in Scandinavia and Belgim – short activities update — Teodora Groshkova, EMCDDA	**Parallel session:** Harm related to new psychoactive drugs and methamphetamine — Chairs: Isabelle Giraudon, EMCDDA and Gergely Horvath, Hungary • Establishing the Acute Harms associated with the use of new psychoactive substances: what is available, deficiencies in current datasets, potential for poisons centre data, Euro-DEN data collection — David Wood, United Kingdom • Trends in recreational drug-related deaths, including new psychoactive substances — John Corkery, United Kingdom • 2013 Trendspotter meeting on methampheta-mines: main findings, main concerns — Jane Mounteney, EMCDDA
15.30	Coffee break	
Conference Centre: **Joint Plenary DRD–DRID**		
16.00	**Prevention of overdose and infection** — Chairs: Dagmar Hedrich and Teodora Groshkova, EMCDDA • Improvement in the recognition and assessment of acute drug toxicity in the pre-hospital environment — Paul Dargan, United Kingdom • Pre-provision of naloxone to prevent heroin overdose deaths: evidence, myths and UK experience — John Strang, United Kingdom • Prevention of overdose and infection. Experience from Villa Maraini Foundation/Italian Red Cross/International Federation Red Cross Red Crescent (IFRC) — Fabio Patruno, Italy • State of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm: focus on trends in DRD and responses — Charlotte Klein, Austria	
17.30	End of the regular DRD–DRID meeting, closure — Chairs: Isabelle Giraudon and Lucas Wiessing, EMCDDA	