ISSN 1609-6150

European Monitoring Centre
for Drugs and Drug Addiction

ANNUAL REPORT 2005

THE STATE OF THE DRUGS PROBLEM IN EUROPE

EN

European Monitoring Centre
for Drugs and Drug Addiction

ANNUAL REPORT 2005

THE STATE OF THE DRUGS PROBLEM IN EUROPE

Legal notice

This publication of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is protected by copyright. The EMCDDA accepts no responsibility or liability for any consequences arising from the use of the data contained in this document. The contents of this publication do not necessarily reflect the official opinions of the EMCDDA's partners, the EU Member States or any institution or agency of the European Union or European Communities.

A great deal of additional information on the European Union is available on the Internet. It can be accessed through the Europa server **(http://europa.eu.int)**.

Europe Direct is a service to help you find answers
to your questions about the European Union

Freephone number (*):
00 800 6 7 8 9 10 11

(*) Certain mobile telephone operators do not allow access to 00 800 numbers or these calls may be billed.

This report is available in Spanish, Czech, Danish, German, Estonian, Greek, English, French, Italian, Latvian, Lithuanian, Hungarian, Dutch, Polish, Portuguese, Slovak, Slovene, Finnish, Swedish, Bulgarian, Romanian and Norwegian. All translations were made by the Translation Centre for the Bodies of the European Union.

Cataloguing data can be found at the end of this publication.

Luxembourg: Office for Official Publications of the European Communities, 2005

ISBN 92-9168-227-6

© European Monitoring Centre for Drugs and Drug Addiction, 2005
Reproduction is authorised provided the source is acknowledged.

Printed in Belgium

PRINTED ON WHITE CHLORINE-FREE PAPER

European Monitoring Centre
for Drugs and Drug Addiction

Rua da Cruz de Santa Apolónia, 23–25, 1149-045 Lisbon, Portugal
Tel. (351) 218 11 30 00 • Fax (351) 218 13 17 11
info@emcdda.eu.int • http://www.emcdda.eu.int

Contents

Foreword

This year's annual report of the European Monitoring Centre for Drugs and Drug Addiction is accompanied by additional online elements including our new statistical bulletin, now in its second year, which has grown to include over 200 source tables of quantitative data detailing the European drug situation.

The EMCDDA has been working with the Member States of the European Union for more than 10 years to develop a comprehensive picture of the European drug phenomenon. The quantity and quality of the data now available to inform the analysis in this year's annual report reflect not only the technical achievements of the scientific working groups that provide the information, but also the commitment of policy-makers across Europe to invest in and support the data collection process. This is a concrete example of the benefits of working together at the European level. Member States differ not only in respect of the drug problems they face, but also in the ways in which they have responded to these challenges. Despite these differences, there has also now emerged what can be regarded as a European perspective on the drugs issue. A strong consensus now exists on the need to base actions on a sound understanding of the situation, to share experiences on what works and to act together whenever it is possible to achieve common benefits. These aspirations can be found in the new EU strategy and action plan on drugs and also form the key themes of our reporting here.

Our annual report highlights many important areas of concern about the way drug use is impacting on both citizens and the communities in which they live. We draw attention to emerging problems with which we are now confronted, such as the rising use in parts of Europe of stimulant drugs, and cocaine in particular, or the continued growth in the number of young Europeans who are experimenting with drugs. Clearly, there is still much to be done to improve the response to drug use in Europe. Nevertheless, in this report we are also able to point to a number of positive developments, not least the overall expansion of services for those with drug problems and signs of stabilisation or even a decline in some of the more damaging aspects of this phenomenon. Thus, this report not only highlights some of the key problems that we are facing, but also sheds light on what is likely to be the way forward in effectively addressing drug problems in Europe.

We are pleased to note that once again this year there has been an increase in the data available from the new Member States of the European Union. As well as reporting on the situation in the enlarged Union, when available, we also include data from Bulgaria, Romania and Turkey and some analysis on important international developments. The global nature of the drug problem means that we must locate our European analysis within a broader context. The trafficking and use of drugs are inextricably linked with many of today's most pressing concerns. Drug use impacts on global health and development, crime and personal safety, and international security. Our report is focused very much on the European picture, but we cannot afford to ignore the fact that we are addressing a problem with global dimensions.

Marcel Reimen
Chairman, EMCDDA Management Board

Wolfgang Götz
Director, EMCDDA

Acknowledgements

The EMCDDA would like to thank the following for their help in producing this report:

- the heads of the Reitox national focal points and their staff;
- the services within each Member State that collected the raw data for this report;
- the members of the Management Board and the Scientific Committee of the EMCDDA and the participants in the technical working groups of the EMCDDA/Reitox network;
- the European Parliament, the Council of the European Union — in particular its Horizontal Working Party on Drugs — and the European Commission;
- the Swedish Council for Information on Alcohol and other Drugs (CAN), the Pompidou Group of the Council of Europe, the United Nations Office on Drugs and Crime, the World Health Organisation, Europol, Interpol, and the European Centre for the Epidemiological Monitoring of AIDS;
- the Translation Centre for the Bodies of the European Union and the Office for Official Publications of the European Communities;
- Prepress Projects Ltd.

Reitox national focal points

Reitox is the European information network on drugs and drug addiction. The network is comprised of national focal points in the EU Member States, Norway, the candidate countries and at the European Commission. Under the responsibility of their governments, the focal points are the national authorities providing drug information to the EMCDDA.

The contact details of the national focal points may be found at:
http://www.emcdda.eu.int/?nnodeid=1596

Introductory note

This annual report is based on information provided to the EMCDDA by the EU Member States and candidate countries and Norway (participating in the work of the EMCDDA since 2001) in the form of a national report. The statistical data reported here relate to the year 2003 (or the last year available). Graphics and tables in this report may reflect a subset of EU countries: the selection is made on the basis of those countries from which data are available for the period of interest.

An online version of the annual report is available in 22 languages and may be found at http://annualreport.emcdda.eu.int

The 2005 statistical bulletin (http://stats05.emcdda.eu.int) presents the full set of source tables on which the statistical analysis in the annual report is based. It also provides further detail on the methodology used and over 100 additional statistical graphs.

Country data profiles (http://dataprofiles05.emcdda.eu.int) provide a top-level, graphical summary of key aspects of the drug situation for each country.

Three in-depth reviews accompany this report and explore the following issues:

- drug-related public nuisance: trends in policy and preventive measures;
- alternatives to imprisonment: targeting offending problem drug users in the EU; and,
- buprenorphine: treatment, misuse and prescription practices.

The selected issues are available in print and online (http://issues05.emcdda.eu.int) in English only.

The national reports of the Reitox focal points give a detailed description and analysis of the drugs problem in each country and are available on the EMCDDA website (http://www.emcdda.eu.int/?nnodeid=435).

Commentary — identifying drug trends in Europe

Piecing together the European picture

This section provides an overview of the main developments and trends in the European drug situation. This is arrived at by piecing together information derived from different sources and by taking into account both the strengths and weaknesses of the currently available evidence base. This year's commentary includes an assessment of how the new data available in 2005 contribute to our understanding of the medium- to long-term trends in the European drug situation.

Polydrug use problems complicate both our understanding of, and response to, drug use problems

Throughout much of this report, the analytical approach adopted is to focus on each of the main substances used. This substance-specific approach is conceptually easy to understand and has the additional advantage that most indicators of drug use are based on substance-specific behavioural measures. The disadvantage of this approach is that it does not reflect the fact that polydrug use is a major factor in drug problems in Europe. Analysis of the public health impact of drug use needs to take into account the complex picture of the interrelated consumption of psychoactive substances, which include both alcohol and tobacco. For example, in Europe cannabis is often smoked with tobacco, and this has implications both for the harms likely to be associated with this behaviour and for informing drug prevention activities. Toxicological analyses of drug deaths often reveal the presence of a number of substances, and the concurrent consumption of alcohol is known to increase the risks associated with both heroin and cocaine use. Furthermore, focusing on trends in one substance can be misleading if the interrelationship between different drug types is ignored; for example, in this report there is some evidence that the availability of synthetic opiates is increasing, an important consideration in any analysis of trends in heroin use. Similarly, it may be wise to consider the possible overlap in trends in the use of different stimulant drugs, and consider in any analysis the extent to which observed changes might be due to shifts in consumption patterns.

As most of those who present to treatment centres in Europe for a drug problem will have used multiple substances, there is a need to develop better methods of reporting this key aspect of drug use and to understand how polydrug use will impact on the effectiveness of interventions.

Young people and drug use — increasing use of cannabis, but different patterns emerging

Drug use in Europe remains largely a phenomenon of the young, and of young men in particular. Data from population and school surveys provide a useful insight into the way in which patterns of drug use in Europe have been developing since the mid-1990s. Available for inclusion in this year's annual report are data from the latest round of the European school survey project on alcohol and other drugs (ESPAD), which provides a valuable source of data for monitoring drug use in the school populations and for detecting trends over time.

Taking all the available data together, it is clear that the use of cannabis differs considerably between countries. Although the predominant European trend since the mid-1990s has been upward, some countries exhibit a more stable pattern. For example, although rates of cannabis use in the United Kingdom since the 1990s have been particularly high, they have remained stable over this period. In addition, there has been little change in the levels of cannabis use in several low-prevalence countries, including Finland and Sweden in the north of Europe and Greece and Malta in the south. Most of the increases in cannabis use recorded in ESPAD since 1999 have occurred in the new EU Member States. Analysis of school data and general population survey evidence suggests that, on most measures, the Czech Republic, Spain and France have now joined the United Kingdom to form a group of high-prevalence countries.

There is growing concern in Europe about the negative impact of cannabis use, although information on the extent to which the use of this drug is resulting in public health problems is scarce. Data available on drug treatment demands in Europe place cannabis second only to opiates, although cannabis still accounts for only 12 % of all treatment demands and the overall picture is greatly influenced by the situation in relatively few countries. Data on the regular and intensive use of cannabis are essential for developing an understanding of the likely connection between cannabis use and public health, but currently this information is limited. Although the available data suggest that as many as 3 million people, mostly young males,

may be using cannabis on a daily basis in Europe, the extent to which this group might be experiencing problems because of their use of the drug is not known.

What is happening to problem drug use — is recruitment into heroin use and drug injecting in decline?

Among the most methodologically challenging areas in monitoring drug use is the task of estimating the numbers of people using drugs in a chronic and particularly damaging fashion. The EMCDDA problem drug use indicator has been developed to estimate this type of drug use, and in the majority of EU countries, problem drug use indicators principally reflect the use of opiates and injecting use. Current estimates suggest there are probably between 1.2 and 2.1 million problem drug users in the EU, of whom 850 000 to 1.3 million are likely to be recent injectors. Problem drug use prevalence estimates over time are patchy, making it difficult to identify long-term trends. However, in the EU-15 Member States, indicators broadly suggest that the rapid recruitment into heroin use that most countries had been experiencing peaked at some time in the early 1990s and was followed by a more stable situation thereafter. Although several countries have continued to report increases since 1999, there are recent signs that this situation is not uniform, with prevalence estimates showing no consistent picture at EU level. In particular, the new Member States deserve special mention, as they appear to have experienced heroin problems later and to have a more fluid situation.

Additional sources of information for assessing problem drug use are the numbers of drug-related deaths and treatment demands. Analysis of drug-related deaths (most commonly due to opiate overdose) suggests that the victims constitute an ageing population, with recorded deaths among drug users younger than 25 having fallen since 1996. An important qualification is that data from the newer EU countries, although limited, show until recently an upwards trend in the proportion of deaths among those under 25, although a degree of stabilisation now appears to have occurred. Overall, although the number of drug-related deaths in the EU remains at a historically high level, it seems likely to have peaked.

In most countries, heroin remains the principal drug for which clients seek treatment. In some countries, trends in heroin use among new treatment clients can be tracked historically and show a small decrease in absolute numbers since 1996. Similarly, in some countries a trend suggesting an ageing population of opiate users is reported, although again this observation does not apply to all countries, and in some of the new Member States — again based on limited data — opiate users entering treatment for the first time appear to be relatively young. In some European countries, notably the EU-15 Member States, injecting among new opiate users requesting treatment has been in decline for some time, and across Europe less than half of new clients requesting treatment for opiate use now report injecting. Again, this trend generally does not hold among the new Member States, where injecting remains the predominant mode of administration among heroin users accessing services.

In summary, there is no simple answer to the question of whether heroin use or injecting across Europe is now in decline. In many respects, today's picture — in terms of recruitment into heroin use and injecting — looks more positive than it did in the early 1990s in the EU-15 Member States. There is evidence that the situation in many countries is now relatively stable, with signs even of an ageing population, perhaps reflecting reduced incidence. However, in some of the new Member States, where escalating heroin problems are a more recent occurrence, injecting continues to be the predominant mode of opiate administration, and from the data available current trends in heroin use are difficult to interpret.

The use of cocaine and other stimulants — no room for complacency

Europe remains a major market for stimulant drugs, and indicators suggest that for Europe as a whole the trend in amphetamine, ecstasy and cocaine use continues to be upwards. Ecstasy has, on many measures, overtaken amphetamines as Europe's second most used drug after cannabis. However, in the United Kingdom, which since the 1990s has on most measures had the highest prevalence rates of ecstasy and amphetamine use, both general and school population recent survey data suggest that rates of use of both drugs may be falling, quite dramatically for amphetamine and to a more limited extent for ecstasy. Nevertheless, prevalence rates in the United Kingdom remain relatively high in comparison with other countries, although the difference is now less marked, as a number of countries now report similar rates of use, resembling the picture described above for cannabis.

Prevalence of cocaine use varies considerably in Europe, but again the trend generally appears upwards. Survey data suggest that, in Spain and the United Kingdom in particular, cocaine use increased substantially during the late 1990s, and recently there have been further, albeit small, increases. In both of these countries, estimates for the recent use of cocaine among young adults now exceed those for ecstasy and amphetamine.

The public health impact of stimulant use in Europe is difficult to quantify, although the evidence suggests that we should not be complacent about current consumption patterns. Cocaine-related treatment demands are increasing. Although there is considerable variation between countries, cocaine accounts for about 10 % of all treatment demands across Europe. The use of crack cocaine, a form of the drug particularly associated with health and other problems, remains limited in Europe. Reports of crack cocaine use are generally restricted to a few major cities, but within the communities where this drug is used the resulting harm can be considerable. A number of practical and methodological issues make the assessment of the number of stimulant-related deaths in Europe difficult. Though small in comparison with reported opiate-related deaths, the number of stimulant-related deaths may be increasing and is probably under-reported. Although data are currently very limited, a number of countries indicate that cocaine plays a determining role in around 10 % of all drug-related deaths. Ecstasy-related deaths remain rare in most EU countries, although reporting procedures could be improved.

Bucking the global trend — no sign of significant methamphetamine problems in Europe

Methamphetamine is a drug known to be particularly associated with health and social problems. Globally, there is considerable concern about growing methamphetamine problems, and rates of use appear to be high or increasing in the USA, Australia, parts of Africa and much of south-east Asia. To date, the use of methamphetamine in Europe has largely been restricted to the Czech Republic, which has a long-established problem with this drug. Elsewhere in Europe, there are only sporadic reports that methamphetamine is available, with some reports of seizures and occasional mentions of importation from the Czech Republic to neighbouring countries. However, given that many European countries have strong links with parts of the world where methamphetamine problems exist, and considering the growing nature of the European market for stimulants, the potential for the spread of methamphetamine use cannot be ignored and thus this remains an important area for vigilance.

Expanding and developing services for those with drug problems

Services for those with drug problems can make a positive difference both to individual drug users and to the communities in which they live. This fact is recognised within many national drug policies, and a commitment to expanding services for those with drug problems is found within both the old and the new EU action plan on drugs. Although it is difficult to map comprehensively the scale of provision for those with drug problems in Europe, several indicators strongly suggest that both treatment services and some forms of harm reduction services have increased considerably. That said, the nature and scale of different types of services vary considerably between countries. One area of service provision that has clearly expanded during the last decade is that of opioid drug substitution treatment, especially in those countries with relatively high levels of injecting heroin use. Methadone accounts for just under 80 % of substitution treatment in Europe, and more than 90 % of substitution treatment in specialist services, but buprenorphine is becoming an increasingly popular pharmacological option and probably accounts for about 20 % of substitution treatment in Europe. (For more information on the use of this drug see 'Buprenorphine: treatment, misuse and prescription practices' in the selected issues section that accompanies this report.) It is currently estimated that the number of people in drug substitution treatment in Europe is in excess of 500 000, which would suggest that between one quarter and one half of those with opiate problems may be enrolled in substitution treatment.

Substitution treatment is not the only option for those with opiate problems, but there are insufficient data on other therapeutic approaches to make reliable estimates of the provision of these services at EU level. Considerable progress has been made in developing models of care for those with opiate problems, and the evidence base for judging effectiveness in this area is relatively robust. This is not the case with users of other types of drug, who are presenting in increasing numbers at European treatment services. The consensus is far weaker on the most appropriate therapeutic options for those seeking help for stimulant or cannabis problems, for example, and developing effective treatment options for these sorts of clients is likely to become an increasingly important challenge.

Drug use, HIV infection and AIDS — interventions are increasingly available and may be influencing overall trends

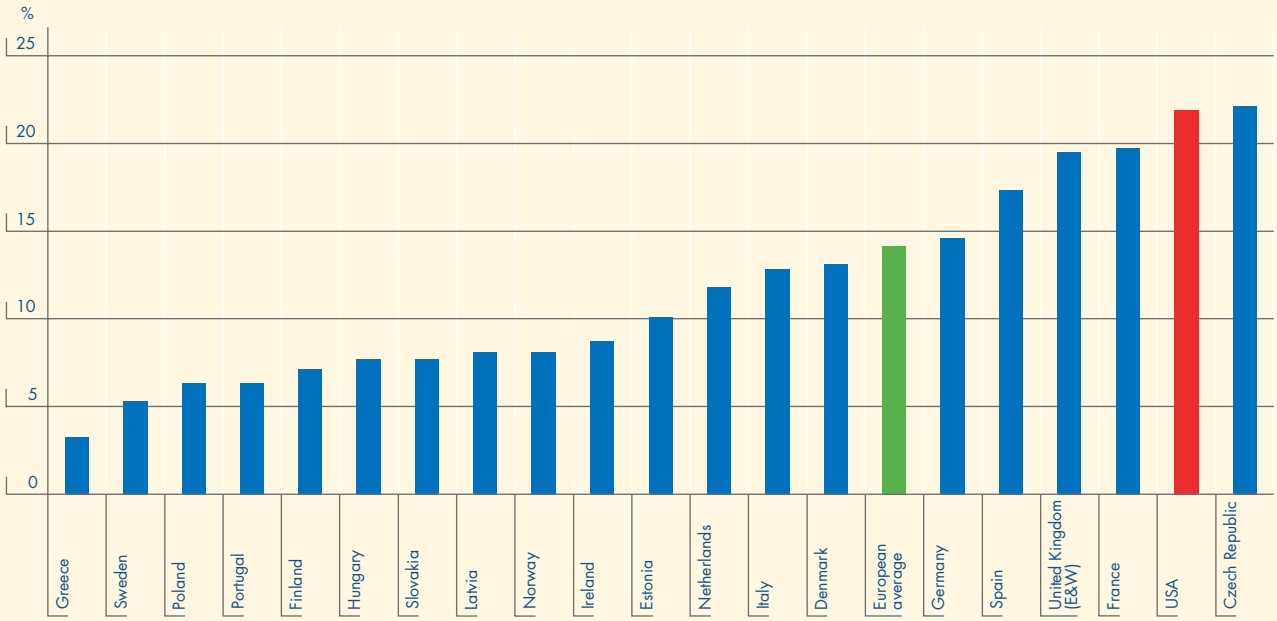
The expansion of treatment services is not the only area in which services for problem drug users have improved. Needle and syringe exchange programmes, which provide drug injectors with sterile equipment, are now found in virtually all EU Member States, and in most countries the medium-term trend has been for an increase in both the scale of activities and the geographical coverage. In some

Drug use in Europe is still lower than in the USA — but prevalence estimates are now similar in some areas

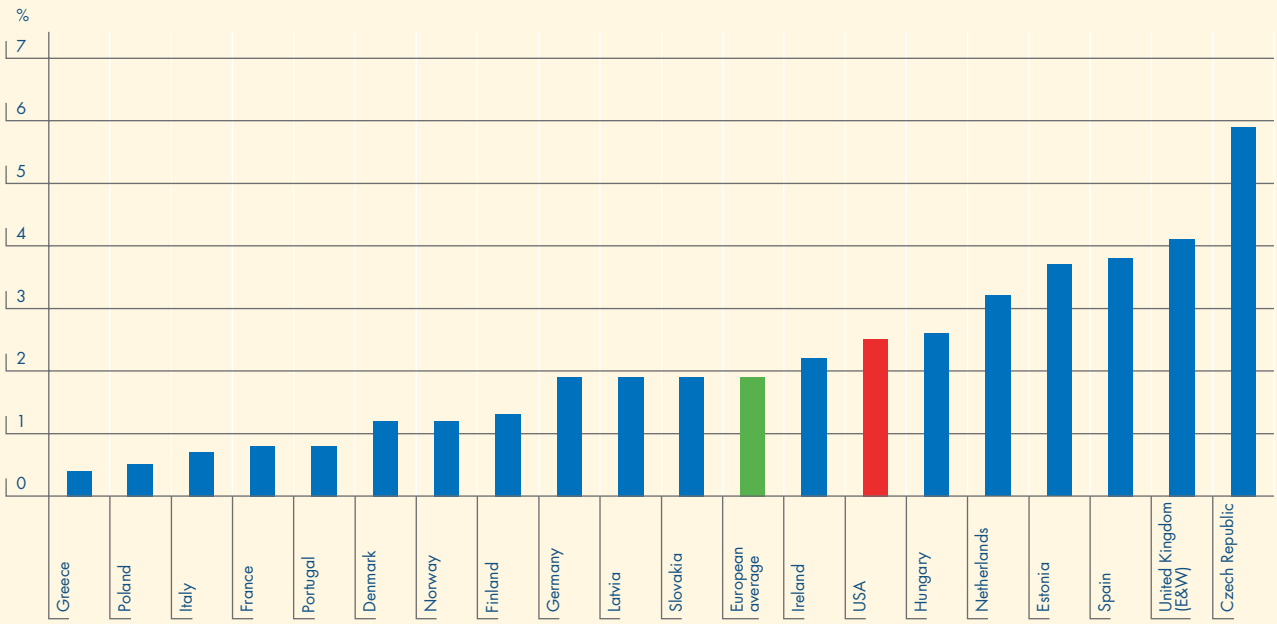
Levels of drug use in the USA have historically been considerably higher than those in European countries. To a large extent, this remains true today, but comparison of data on recent use (last year prevalence) suggests that in a few European countries levels of cannabis, ecstasy and cocaine use among young adults are now similar to those in the USA (see graphics below). And in the case of the recent use of ecstasy by young adults, US estimates are below those in several European countries, possibly reflecting the strong European link in the historical development of the use of this drug. However, overall, the European population average remains lower than the US average on all measures. In many European countries, widespread drug use occurred later than in the USA, and this may be reflected in the higher US lifetime prevalence estimates (see Figures 1, 2 and 3 in the 2005 statistical bulletin), which to some extent can be thought of as cumulative indicators of use levels over time.

Last year prevalence rates of cannabis, ecstasy and cocaine use among young adults (15–34 years) in Europe and the USA

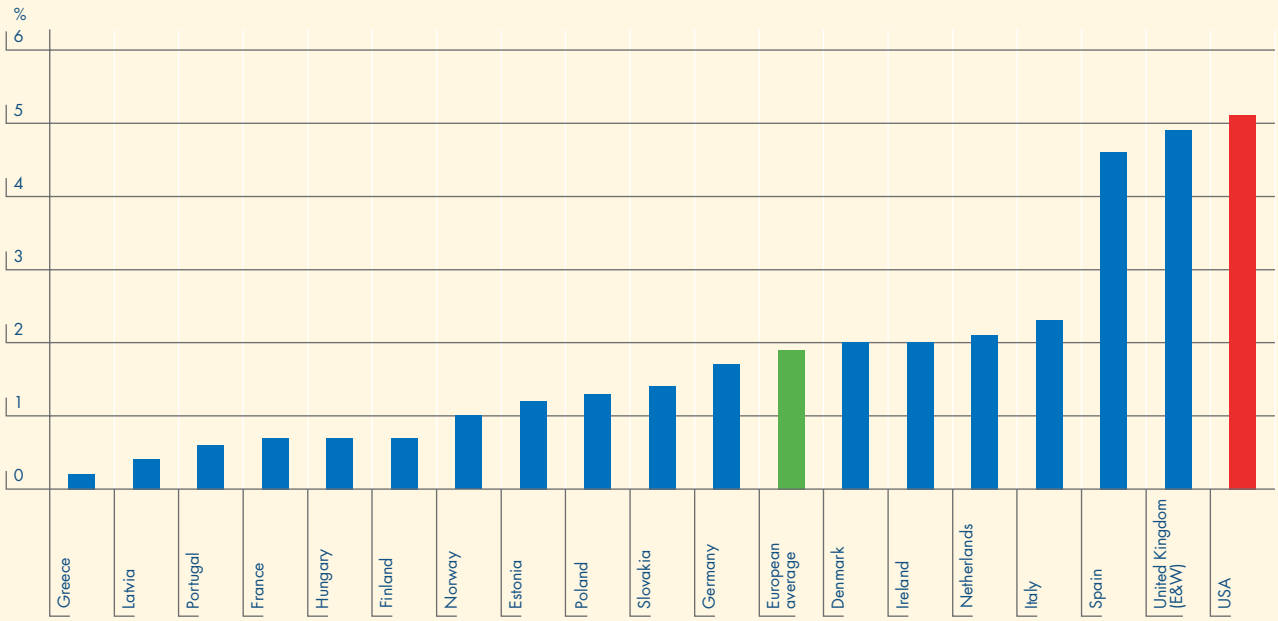
Recent (last year) use of cannabis among young adults (15–34 years)



Recent (last year) use of ecstasy among young adults (15–34 years)



Recent (last year) use of cocaine among young adults (15–34 years)



NB: In the USA, the survey was conducted in 2003, and the age range is 16–34 years (recalculated from original data).
In the European countries, most surveys (17 out of 19) were conducted between 2001 and 2004, and the standard age range is 15–34 (in some countries the lower end may be 16 or 18 years).
The European average prevalence rate was calculated as the average of the national prevalence rates weighted by national population of 15- to 34-year-olds (2001, taken from Eurostat).

Sources: USA: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2003 (www.samhsa.gov) and (http://oas.samhsa.gov/nhsda.htm#NHSDAinfo).
Europe: Table GPS-11 in the 2005 EMCDDA statistical bulletin. Based on Reitox national reports (2004).

Member States, pharmacies also play an important role in extending the coverage of these kinds of programmes. Specialist programmes are often integrated into broader services for those with drug problems, especially low-threshold agencies, and as such are often regarded as a way of making contact with active drug users and perhaps of providing a conduit to treatment and other services.

Overall, the incidence of AIDS due to drug injecting has been in decline for some time. Heterosexual contact has now overtaken injecting drug use as the highest risk factor for the development of AIDS in Europe. This may be attributable to the increasing availability of highly active antiretroviral therapy (HAART) since 1996, the increase in treatment and harm reduction services and declining numbers of drug injectors in most affected countries. Estimates from the WHO suggest that in most European countries over 75 % of those needing HAART have access to it. However, coverage is estimated to be poor in a number of Baltic countries, and this may be reflected in an increase in new AIDS cases among drug injectors in at least some countries in this area. At one time rates of new HIV infections were also increasing dramatically in some Baltic countries, but recent rates have declined equally dramatically, probably due to the saturation of the populations most at risk; moreover, arguably, an increase in service provision may be having an effect in some areas.

Among most of the other new EU Member States, HIV prevalence rates remain low, as they do in many of the EU-15 Member States. Of those EU countries where HIV prevalence rates were historically high among drug injectors, most have seen a significant decrease and then stabilisation. This is not to say that these problems have disappeared: despite methodological difficulties that make trends difficult to interpret at the national level, some recent studies report new transmissions among certain subpopulations of drug injectors, emphasising the need for continuing vigilance.

Overall reports of legal sanctions for the possession or use of drugs

Comparable data at the European level on most aspects of the relationship between drugs and crime are largely lacking. The main exception is drug law offences, which are recorded crimes against drug control legislation. Although comparisons between countries must be made with caution, it seems that between the late 1990s and

2003 drug law offences increased in many EU countries. Increases were particularly marked in some of the new Member States. In most countries, the majority of reports are for the possession or use of drugs. In most Member States, the majority of offences involve cannabis, and since 1998 in most countries the proportion of cannabis offences has either increased or remained stable. In contrast, the proportion of offences that are heroin related has fallen in many countries.

In many European countries, there is a growing concern about the wider impact of drug use on the communities in which it occurs. Issues related to public safety and the exposure of young people to drugs are among the more commonly cited concerns that can be grouped under the title of 'Drug-related public nuisance' — this issue is explored in detail in the selected issues section accompanying the annual report, and continuing the criminal justice theme is a selected issue devoted to a review of strategies to divert those with drug problems away from custodial sentences and towards treatment ('Alternatives to imprisonment: targeting offending problem drug users in the EU').

Developments in drug policies — some common elements are apparent, but within the context of respecting national differences

As a reading of this report will clearly demonstrate, across Europe there are considerable differences between Member States in terms of both the drug problems they face and the policies and the scale and nature of interventions. Despite this, there are some common elements in the drug situation facing most countries. At a policy level, Member States express a general political commitment to develop a balanced and evidence-based response, in line with international commitments and, while acknowledging that drug policies remain a national responsibility, also look to the benefits that can accrue from improved cooperation at the European level. These aspirations are expressed in the EU drug strategy and action plans. The EU drug strategy and action plan 2000–04, while it has not achieved all of the ambitious targets set, is evidence of an important development in the way Member States, EU institutions and specialist agencies can work together to coordinate and measure progress in the drug field. The new EU drug strategy 2005–12 seeks to take forward this process.

Chapter 1

New developments in policies and laws

Introduction

Policy developments in the field of drugs among EU Member States are inevitably heterogeneous, reflecting the variety of approaches at national and European level. However, this does not preclude the existence of common features that merit analysis.

During the reporting period, foremost among these features is the way in which drug strategies are evaluated in different Member States. The implementation of national drug strategies is evaluated in several EU countries. Although the effects of evaluation on drug policy as a whole cannot yet be determined, evaluation has already yielded some promising results: we now have a greater understanding of successes and failures, and in some cases a result of evaluation has been that more resources have been allocated to enable unrealised strategy objectives to be achieved. Moreover, the evaluation of the EU strategy and action plan 2000–04 represents the first outcome of an important process in which Member States, EU institutions and specialised agencies are working together to measure progress in the field of drugs.
Other policy developments taking place over the reporting period include reduction in some countries in penalties for drug use and an increase in the severity of penalties for drug trafficking and drug-related offences threatening minors.

A strategic approach to drug policy in the European Union

The EU drug strategy 2005–12, adopted by the European Council in December 2004, takes into account the results of the final evaluation of progress made during the previous period (2000–04). It aims to add value to the national strategies while respecting the principles of subsidiarity and proportionality set out in the treaties. It sets out two general goals for the EU with regard to drugs:

- to achieve a high level of health protection, well-being and social cohesion by complementing the Member States' action in preventing and reducing drug use and dependence and drug-related harm to health and the fabric of society;
- to ensure a high level of security for the general public by taking action against drug production and supply and cross-border trafficking, and intensifying preventive action against drug-related crime through effective cooperation between Member States.

These two goals cover the six priorities identified in the 2000–04 EU strategy on drugs. The new strategy reiterates the integrated, multidisciplinary and balanced approach of combining measures to reduce both demand and supply. It concentrates on these two policy areas and on two cross-cutting themes — 'international cooperation' and 'information, research and evaluation' — and on 'coordination'.

In February 2005, the European Commission presented the European Parliament and the European Council with a communication on an EU drug action plan for the period 2005–08. The EMCDDA and Europol were consulted in the drafting of this action plan. The Commission also consulted civil society. The action plan, which takes account of the results of the evaluation of the previous plan, is designed in such a way that, for each action, the actors involved are clearly identified and assessment tools, indicators and dates for achievement are specified. This should facilitate follow-up monitoring of the actions as well as providing more effective guidance regarding the implementation of the plan. The Commission will carry out annual progress reviews of the action plan, as well as an impact assessment, before proposing a plan for 2009–12.

Following the lead of the EU, national drug strategies have been adopted in most Member States. Of the 29 countries considered in this report, 26 operate their national drug policy according to a national plan, strategy or similar document. As far as the rest of the countries are concerned, in Italy the national plan was approved by the National Committee for the Co-ordination of Anti-drug Activities in March 2003 and is under consideration by regions and autonomous provinces; Malta and Austria indicated that procedures for drafting and adopting a

national drug strategy were under way at the time of writing ([1]).

New national drug strategies have been adopted in seven EU countries (see Table 1). The principle that drug policies should be global and multidisciplinary seems to be accepted in all the national drug strategies of Member States, in accordance with the EU approach on drugs. However, there can be fundamental differences in the content of different countries' national strategies, for example in the implementation of interventions, which may vary despite use of the same terminology; in the role of evaluation in the strategies, which can range from important to marginal; and even in the adoption or otherwise of important policy approaches such as harm reduction. Indeed, among the 26 policy or strategy documents examined ([2]), harm reduction appears to be the issue over which there is most difference of opinion: it features prominently in 12, is included among the discussion of other subjects in nine, and is not mentioned in five.

Evaluation of drug strategies provides first results

The EU drug strategy (2000–04) was evaluated during the reporting period. The Justice and Home Affairs Council of 25–26 October 2004 examined the Commission report on this final evaluation ([3]). It aimed to assess the extent to which the action plan attained the objectives of the drug strategy and the impact of both the drug strategy and the action plan on the drug situation in the EU. It also contributed to the debate leading to the endorsement ([4]) of a new drug strategy. The Commission was assisted in its evaluation task by a steering committee (drawn from the Commission, the four Member States holding the presidency during 2003–04, the EMCDDA and Europol). The lack of precise and quantifiable operational objectives represented a serious constraint in this exercise.

The communication on the final evaluation and its annexes ([5]) highlighted the main achievements in the drug field at national and EU level and the areas where further

Table 1: New national drug strategies

Country	Title	Timetable or date of adoption	Objectives	Quantifiable targets	Performance indicators	Responsibility for execution	Budget for execution
Estonia	National strategy on the prevention of drug dependence	2004–12	✓	✓	✓	n.a.	n.a.
Estonia	Goal-oriented action plan of the strategy	2004–08	✓	✓	✓	✓	✓
France	Action plan against illicit drugs, tobacco and alcohol	2004–08	✓	✓	✓	n.a.	✓
Cyprus	National drug strategy	2004–08	✓	n.a.	n.a.	n.a.	✓ ([3])
Lithuania ([1])	Strategy on national programme on prevention of drug addiction	2004–08	✓	n.a.	✓	✓	✓
Luxembourg	Strategy and action plan on drugs and drug addiction	2005–09	✓	✓ ([2])	✓	✓	✓
Slovenia ([1])	Resolution on the national programme in the field of drugs	2004–09	✓	n.a.	n.a.	✓	✓
Finland	Drug policy action programme	2004–07	✓	n.a.	n.a.	✓	n.a.

NB: n.a., data not available.
([1]) Data supplied by staff of national focal points.
([2]) Quantifiable targets in the Luxembourg strategy not available for supply reduction.
([3]) The Cyprus strategy notes that, in order to meet the objective of the strategy, financial and human resources will be made available — no specification of figures in the text.

([1]) For further information and definitions, see the EMCDDA website (http://www.emcdda.eu.int/?nnodeid=1360).
([2]) No information on this subject is available for Malta, Slovakia and Turkey.
([3]) COM(2004) 707 final.
([4]) European Council (16–17 December 2004) — Conclusions.
([5]) Among which is the EMCDDA–Europol statistical snapshot (1999–2004) (http://snapshot.emcdda.eu.int).

progress is needed. It emphasised that progress had been made towards reducing the incidence of drug-related health problems (including HIV infection and hepatitis) and the number of drug-related deaths (target 2 of the EU drug strategy), and, in particular, in improving the availability of treatment (target 3). Regarding target 1, reducing drug use, no significant progress was observed. Similarly, no decrease in the availability of drugs was found (target 4). Nevertheless, targets 4 and 5, taken together, appeared to be a catalyst for several EU-level initiatives that have strengthened law enforcement measures against drug trafficking and supply. During the period of the plan, several major initiatives emerged to combat money laundering (target 6.1) and to prevent the diversion of precursors (target 6.2), in particular through the amendment of Community legislation on the control of trade in precursors.

The communication also underlined the need for further research, for instance on the biomedical, psychosocial and other factors underlying drug use and addiction, especially in areas where information is still scarce (e.g. the long-term use of cannabis or synthetic drugs). The need for regular consultation of civil society in the formulation of EU drug policy was highlighted. The Commission also recommended extending the EU strategy from five to eight years, covering the implementation of two consecutive EU action plans over the period, to allow full implementation and fine-tuning of initiatives to match the strategy objectives.

A number of evaluation exercises conducted at national level during this reporting period are worthy of comment. Of particular interest are evaluations carried out by countries that adopted a more 'structured' approach to their national drug strategy, the elements of which can be summarised as the formal documenting of objectives, defining and quantifying targets, identifying the authority responsible for implementation and specifying the date for the achievement of objectives. This approach makes it easier for countries to report on the tasks that have been accomplished and to identify problematic issues, therefore enabling action to be taken where needed.

Examples of such an approach can be found in the strategies of the Czech Republic, Ireland, Luxembourg, Poland and Portugal, where evaluation of the national drug strategies revealed, or has the potential to reveal, actions that have been achieved and unaccomplished tasks that still have to be acted on. An example of how a structured approach can help an evaluation of progress made can be found in the 2004 evaluation of the Portuguese national drug strategy. External evaluators concluded that progress had been made in achieving some of the 30 main objectives of the Portuguese action plan, with eight objectives fully achieved and 10 partially achieved; however, a lack of information meant that other objectives were difficult to evaluate, and five objectives were judged not to have been achieved. In Germany, a steering committee (National Council for Drug Addiction) has been established to guide the 2003 action plan towards implementation and monitor the outcome.

The adoption of a national drug strategy, or the evaluation of the success of a previous one, has resulted in an increase in the drug-related budget in some countries. For example, in Greece there has been a steady increase in expenditure on healthcare-related services; in Hungary funds have been mobilised to fund the as yet unimplemented elements of the strategy; and in Luxembourg the drug-related budget of the Ministry of Health increased from about EUR 1 million in 1999 to almost EUR 6 million in 2004. However, in all Member States, public expenditure on the drug issue represents only a small part of total public expenditure (between 0.1 % and 0.3 %). This may partly explain the observation that, across the EU, there is no direct link between economic growth and associated changes in general budget and changes in the level of public expenditure on the drug issue.

In several EU countries, spending on supply reduction continued to account for the bulk of public expenditure (an estimated 68–75 % of the total drug-related expenditure) ([6]). However, in a few countries, including Malta and Luxembourg, spending on demand reduction was apparently higher than expenditure on supply reduction (demand reduction expenditure accounting for 66 % and 59 % of total drug expenditure respectively). However, it is not clear whether the reported differences in budgetary allocations represent a fundamental difference in policy priorities or reflect a bias in data collection.

The lack of availability of information on direct public expenditure on the drug issue continues to be a problem. However, there are signs that, alongside growing academic interest in this area ([7]), there is growing political commitment to the identification and description of drug-related public expenditure so that national expenditure on drugs can be included as a key element in cost–benefit evaluations. Together with the Reitox network and the European Commission, the EMCDDA is now developing

([6]) See the selected issue, 'Public expenditure in the area of drug-demand reduction' in the EMCDDA annual report 2003 (http://ar2003.emcdda.eu.int/en/page077-en.html).

([7]) In Belgium, Spain, France, Luxembourg, the Netherlands, Finland, Sweden and the United Kingdom — for detailed references, see the EMCDDA website (http://www.emcdda.eu.int/?nnodeid=1357).

methodology that will allow consistent and credible estimates of drug-related public expenditure within the EU, as requested by the EU action plan of 2005.

This first evaluation process at national and European level represents a valuable feedback mechanism, informing decision-makers of the extent to which their decisions have been implemented, and at what cost, and enabling them to increase efforts in those areas where problems have been recorded or assessment has produced unfavourable findings. Although clear evidence of the impact of national drug strategies on the overall drug phenomenon is not yet available (EMCDDA, 2004a), the approach of 'counting the score' is a positive sign and, hopefully, will trigger a general trend in Europe towards the detailed assessment of each national drug strategy.

Debates in national parliaments and media

Societal concerns about the drug phenomenon are reflected both in the media and in parliamentary debates. During the reporting period, among the data on parliamentary debates provided in the Reitox national reports, the most reported subjects were 'harm reduction' or interventions that fall under this category, 'cannabis use' and 'drug-related crime and related modifications of drug laws'.

The advantages and disadvantages of substitution therapies and harm reduction measures compared with drug-free approaches stimulated animated parliamentary debates in the Czech Republic, Estonia, France, Ireland and Norway. Subjects of heated political debate included the proposal to make the syringe exchange programme permanent in Sweden, even though it would be under strictly controlled conditions, and the temporary establishment of injecting rooms in Norway (see the selected issue on national laws and public nuisance).

Cannabis remained an important topic of debate, particularly in Germany, where the main focus was on cannabis use by young people, and in Luxembourg and Portugal, where it has been proposed that it should be made available on medical prescription. The use of cannabis, or more generally drug use in school and by young people, was widely reported by the media in Belgium, the Czech Republic, Germany, Cyprus, Luxembourg and Austria. In the Netherlands, media attention was attracted by the reported increase in the tetrahydrocannabinol (THC) concentration of cannabis cultivations (*nederwiet*) and the possible health consequences of highly potent cannabis. In Poland, cannabis was the most reported substance in the media, accounting for 865 of a total of about 2 500 references to drugs. Bills advocating its legalisation were presented in Belgium, Denmark and in some city councils in the Netherlands, with the aim of solving the 'back door problem' ([8]), provoking strong and public opposition from most members of parliament and government ministers.

The prospect of changes in the drug laws has attracted media attention and generated political debate in France and Italy. In France, a proposal to replace prison sentences for drug use with fines was abandoned because of concerns that such a change would be 'interpreted as a sign that drugs are not very dangerous' and lead to 'a new increase in use and use at an earlier age' ([9]). In Italy the media echoed the vigorous parliamentary debate on changes to the 1990 law and a differentiation in sanctions for possession of drugs attracted media and political attention in the Czech Republic.

Ad hoc research to analyse media messages has been undertaken in the Czech Republic, Greece, Luxembourg, Poland and Portugal, and national media campaigns targeted at young people in particular have been developed in Belgium ([10]), Poland and the United Kingdom ([11]).

New developments in EU programmes and legislation

Important EU initiatives relating to drugs that were identified during the reporting period took place in the fields of public health, drug trafficking and the control of precursors and synthetic drugs.

Public health

At the European level, drug prevention is included in the health determinants strand of the public health programme ([12]). The 2004 work plan of this programme focused on the Council recommendation of 18 June 2003 and the development, with the involvement of the EMCDDA, of an appropriate base for an inventory of activities in the EU. The Commission encouraged stakeholders to submit proposals involving a lifestyle

([8]) Coffee shops can hold stock of up to 500 g of cannabis for sale but they can only acquire it through illegal markets. This is the so-called 'back door problem'.

([9]) MILDT (2004), p. 43, cited in the French national report.

([10]) www.partywise.be

([11]) The 'Talk to Frank' campaign on the risks of cannabis use (http://www.talktofrank.com/).

([12]) Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002, adopting a programme of Community action in the field of public health (2003–08) — Commission Statements (OJ L 271, 09.10.2002, pp. 1–12).

Setting up a sustainable health monitoring system

The establishment and operation of a sustainable health monitoring system is among the key objectives of the public health programme (2003–08). The Commission has pursued consultations with Member States and international bodies with a view to consolidating a set of European Community health indicators. In this context, 'drug-related deaths' and 'consumption of psychotropic drugs' were included in the draft core indicators list, thereby reinforcing structural links with the EMCDDA as a potential data producer.

approach to addressing the abuse of all substances with addictive potential, especially in recreational places (e.g. nightclubs) and prisons. It was particularly interested in the development of best practice and improvements in communications and the dissemination of information involving modern techniques. The Commission selected four projects in 2004, which aimed to prevent risk-taking behaviour, to harmonise international knowledge on the biomedical side-effects of doping, to reinforce the transfer of knowledge on responses to drug consumption and to extend to the new Member States an existing web resource of information on licit and illicit drugs.

Drug trafficking

In 2004, a number of instruments were adopted at EU level to counter drug trafficking. The Council framework decision 2004/757/JHA of 25 October 2004 laid down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking ([13]) and is a key instrument in tackling drug trafficking through the establishment of minimum penalties for such offences in Member States.

Agreement on a Council decision on information exchange, risk assessment and control of new psychoactive substances was reached by the Council in December 2004. This decision provides a framework for effective information exchange on new psychotropic substances as well as a mechanism for bringing them under control at EU level.

The Council adopted on 30 March 2004 a recommendation regarding guidelines for taking samples of seized drugs. It recommends that, where this is not already done, Member States introduce a system of taking samples in accordance with internationally accepted guidelines. The Council also adopted a resolution on cannabis and a progress report in relation to the implementation plans on demand and supply reduction of drugs and the supply of synthetic drugs.

On 11 February 2004, the European Parliament and the Council adopted Regulation (EC) No 273/2004 on drug precursors ([14]). This establishes harmonised measures for the intra-Community control and monitoring of certain substances frequently used in the illicit manufacture of narcotic drugs or psychotropic substances, with a view to preventing the diversion of such substances. In particular, it provides guidelines for Member States to adopt the measures necessary to enable their competent authorities to perform their control and monitoring duties and information on how to recognise and notify suspect transactions. On 22 December 2004, the Council adopted Regulation (EC) No 111/2005, laying down rules for monitoring the trade in drug precursors between the Community and third countries.

Following on from a Council resolution from November 2002, the European Commission presented a study on a generic and emergency list approach to the control of synthetic drugs at the Council's horizontal working party on drugs (HDG) in November 2004. It also presented suggestions for possible further improvements in the methods of mapping distribution networks of synthetic drugs in the EU to the HDG in April 2004.

New national laws

Young people

Changes in the national legislation of several Member States during the reporting period included measures to protect young people from offenders or to respond to the possibility that they might wish to take drugs.

Protection may be delivered by direct or more general approaches. In Hungary, the March 2003 law aims to protect persons under the age of 18 against misuse of narcotic drugs, and punishments for adults will be more severe for offences involving minors. In Estonia, amendments at the beginning of 2004 provide stricter penalties with respect to most drug-related crimes, including inducing minors to consume drugs illegally.

In Denmark the Euphoriants Act was amended in July 2004; the distribution of drugs in restaurants, discotheques or similar places frequented by children or young people is now deemed to be a significantly aggravating circumstance. Such offences should always be punished with a prison sentence, and it is intended that the average prison sentence for such offences will be increased by one

([13]) OJ L 335, 11.11.2004, p. 8; see also EMCDDA annual report 2004 (http://ar2004.emcdda.eu.int).
([14]) OJ L 47, 18.2.2004, p. 1.

third. Similarly, in Spain, since October 2004 trafficking near schools is an aggravating circumstance, and, in addition, the age limit for a 'young person' enlisted to commit trafficking offences has been increased from 16 to 18. Direction on the new legislation in England and Wales has been issued through the *Cannabis enforcement guidance* (ACPO, 2003), which gives advice on how to deal with people found in possession of cannabis in or near premises such as schools, youth clubs and play areas.

Measures in response to young people taking drugs included two cabinet regulations adopted in Latvia in December 2003. One outlined procedures for the obligatory institutional treatment (with parental consent) of children caught misusing drugs and the other specified actions to be taken when drugs or other intoxicants are found in a school. In England and Wales people under 18 years old arrested for cannabis offences continue to receive a reprimand or final warning or are charged by the police, depending on the seriousness of the offence. After a final warning, the young offender will be referred to a youth offending team (YOT), which will make arrangements for treatment or other support.

In the Czech Republic, the Act on Juvenile Justice, which took effect in 2004, modifies the conditions governing young people involved in penal code offences, which take precedence over general laws. Penal measures should be imposed only when necessary, and educational measures may include prohibition of substance use or an obligation to undergo treatment. The maximum limits for non-custodial sentences also are now half those applying to adults. In Poland, a ministerial regulation of January 2003 establishes specific forms of educational and preventive activities among drug-endangered children and youths. Schools must put in place educational and preventive strategies.

In October 2003, the European Legal Database on Drugs (ELDD) published a comparative study on the laws regarding drugs and young people ([15]), which formed the basis for a paper assisting the Commission's evaluation of the EU action plan 2000–04, published in October 2004 ([16]). The latter found that a total of 22 laws, passed by 11 Member States (out of 15), addressed the issues in the action plan concerning young people. The majority of the laws aimed to provide alternatives to imprisonment, though six countries passed laws intended to reduce the prevalence of drug use, particularly among young people. Overall, however, comparatively little original legislative attention seems to have been given to those points of the action plan over the five-year period. For an in-depth analysis of measures targeting young drug-using offenders, see the selected issue on alternatives to imprisonment.

Harm reduction

During 2003 and 2004, several laws touching on the issue of harm reduction were passed.

In France, a law passed in August 2004 adopting the five-year public health policy plan incorporates the policy on harm reduction for drug users into the public health regulations, giving harm reduction an official definition and bringing it within the jurisdiction of the state.

In Finland, a government decree amended the Communicable Disease Act to state that communicable disease specialists in health centres should undertake prevention work, including the provision of health counselling for intravenous drug users and the implementation of needle and syringe exchanges as necessary. In Luxembourg, the Grand-Ducal decree of December 2003 regulates the national syringe distribution programme by defining facilities and professionals authorised to provide syringes to drug users. This continues a trend towards permitting possession and supply of sterile syringes via explicit legislation ([17]) supported by the outgoing EU action plan 2000–04, which requested the development of provision of prophylactics. Further legal information can be found in the ELDD topic overview 'Legal framework of needle and syringe programmes' ([18]).

The Misuse of Drugs Act in the United Kingdom was amended in August 2003 to allow doctors, pharmacists and drug workers to legally supply swabs, sterile water, certain mixing utensils (including spoons, bowls, cups and dishes) and citric acid to drug users who obtained controlled drugs without a prescription. In June 2004, the Norwegian parliament adopted, for three years, the Temporary Act Relating to a Trial Scheme of Drug Injection Rooms. This exempts users of an injection room from punishment for the possession and use of a single dose of drugs and allowed a designated injection room to open in February 2005.

In the Czech Republic, several non-governmental organisations (NGOs) provide tablet testing services, which aim to reduce the risk of an unknown or unexpected substance being consumed, although the legality of such schemes is hotly debated. There were no criminal prosecutions in 2003, and the only case brought so far by the police (a case from 2002) was rejected by the public

([15]) *Young people and drugs: a legal overview* (http://eldd.emcdda.eu.int/?nnodeid=5620).
([16]) *Drug law and young people 2000–2004* (http://eldd.emcdda.eu.int/?nnodeid=9937).
([17]) Seven countries have legislated since 1999: Belgium, France, Luxembourg, Poland, Portugal, Slovenia and Finland.
([18]) http://eldd.emcdda.eu.int/?nnodeid=5036

prosecutor. The office of the supreme prosecutor has since issued guidance on the subject.

In line with these legislative developments, harm reduction services are generally recognised by the new EU strategy and action plan as a valid response to the demand for increased access to needle exchanges to reduce the drug-related risks to individual health and society as a whole.

Penalties

During the reporting period several countries also made changes in their drug legislation to the penalties that can be imposed for various offences, besides those reviewed above and that specifically involve young people.
For example, it was reported last year that Belgium and the United Kingdom effectively lowered the penalty for non-problematic cannabis possession. In Belgium, a new directive issued in February 2005 clarified the exceptions to this reduced penalty, calling for full prosecution in cases involving 'disturbance of public order'. This includes possession of cannabis in or near places where schoolchildren might gather (schools, parks, bus stops) and also 'blatant' possession in a public place or building.
In Denmark, a May 2004 amendment to the Euphoriant Substances Act, together with a public prosecutor's circular, stated that the possession of drugs for own use will now normally be punishable by a fine rather than the warnings issued previously.

These follow the pattern of changes to possible penalties for users and traffickers that has emerged over the last few years, as reported by the EMCDDA ([19]). For example, in 2003 Belgium created a new category of offence that allows non-problematic cannabis users not to be prosecuted, Greece reduced the maximum penalty for drug use from five years to one year, and Hungary removed the offence of drug use from its penal code. In 2002, Estonia removed the offence of repeated use or possession of a small amount of illicit drugs for personal use (with its associated maximum three-year prison sentence), although Lithuania added the offence of possession to its penal code, with a potential punishment of imprisonment for up to two years. In 2001, Luxembourg decriminalised cannabis use and removed the associated prison sentence for simple cannabis use not associated with aggravating circumstances, and Finland enacted the drug user offence, with a lower maximum sentence of imprisonment and summary penal proceedings by the prosecutor. In 2000, Portugal enacted administrative sanctions for drug use, though in the same year Poland removed the exemption from punishment previously possible for the offence of possession. This pattern does not, however, reflect a lessening of control over the effects of drug use on society, as can be seen in the selected issue on public nuisance and the restrictions on possession near young people, above.

For those suspected of trafficking, the trend is to increase the possible penalty. In Denmark, the maximum penalties for trafficking offences were raised by over 50 % in March 2004. At the beginning of 2004, Estonia enacted stricter penalties with respect to most drug-related crimes, particularly in the presence of aggravating circumstances. In the United Kingdom, the maximum penalty for trafficking class C drugs has increased from five to 14 years' imprisonment. In addition, recent years have seen an increased emphasis on sentences for the specific offences of distributing to young people (above) and for trafficking offences in Greece in 2001, in Lithuania in 2000 and in Ireland in 1999. This unanimous growth in the severity of penalties for drug trafficking is reflected in the European framework decision of October 2004, laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking.

Drugs in the workplace

Two countries reported moves to legislate on drugs in the workplace. In Finland, the Act on Protection of Privacy in Working Life (759/2004) aims at regulating and enhancing the privacy of the employee in relation to drug testing in working life. The Act states that the employer and personnel must draw up an anti-drug programme for the workplace, including prevention plans and treatment options and listing those jobs that require a drug test certificate. During the recruitment process, an employer can ask only the successful candidate for a drug test certificate. The employer has the right to use the information on the certificate if the job calls for precision, reliability, independent consideration or alertness, and if performance under the influence of, or dependent on, drugs could endanger life or health or result in considerable damage. During employment, the employee must provide a certificate only if there is just cause to suspect that he or she is addicted to or working under the influence of drugs.

In Ireland, the Safety, Health and Welfare at Work Bill was published in June 2004. One section requires that employees ensure that they are not under the influence of any intoxicant(s) while at work to the extent that they would endanger their own safety, health or welfare at work, or that of any other person. It also requires employees, if reasonably required by their employer, to submit to any appropriate, reasonable and proportionate tests by a competent person.

([19]) For further details see EMCDDA thematic paper, *Illicit drug use in the EU: legislative approaches* (http://www.emcdda.eu.int/?nnodeid=7079).

Prevention in specific settings, such as in the workplace, is highlighted in the new EU action plan. The increased emphasis on targeted prevention may be a counterweight to the general trend towards the reduction in the severity of penalties for drug users, perhaps as a result of concern about the prevalence and frequency of drug use in the EU. However, there are no clear figures on the true size of this perceived phenomenon, and drug testing for anything other than actual influence may raise complicated legal issues of privacy under certain national and international laws. Meanwhile, private investment continues with the aim of improving the accuracy and user-friendliness of the testing kits.

Drug-related public nuisance: trends in policy and measures, in *EMCDDA 2005 annual report: selected issues*

Public nuisance is an emerging concern within drug policy debate, at both national and European level. Behaviours and activities usually covered by the term 'drug-related public nuisance' have long existed in most of the Member States, candidate countries and Norway. Hence, we are looking not at new phenomena, but rather at a new tendency in drug policy, apparent in at least some Member States, to categorise and collate these phenomena under an umbrella concept, and to set the reduction in their occurrence as an objective of national drug strategy.

To what extent is this tendency shared by European countries? Is there a consensual definition for this concept? How are the nature and the extent of the phenomena to be assessed? What are the policies aiming to achieve and what types of interventions are being implemented, regardless of whether or not they are specifically and explicitly designed to reduce drug-related public nuisance? Are any evaluation results already available and are quality standards for intervention established? All these are among the core questions that this selected issue aims to address.

By presenting a timely review of the development of drug-related public nuisance in the policy debate in Europe, the EMCDDA aims to inform policy-makers and the public at large about the nature of the phenomenon and the trends and measures in this area of drug policy.

This selected issue is available in print and on the Internet in English only (http://issues05.emcdda.eu.int).

Chapter 2
Schools, youth and drugs

Comparable data on young people's use of alcohol and drugs come largely from surveys of 15- to 16-year-old school students. The European school survey project on alcohol and other drugs (ESPAD) conducted surveys in 1995, 1999 and, most recently, 2003. The 2003 survey (Hibell et al., 2004) provides comparable data from 22 EU Member States as well as Norway and three candidate countries (Bulgaria, Romania and Turkey). Other school surveys (e.g. in the Netherlands, Sweden and Norway) and 'health behaviour in school-aged children' (HBSC) surveys also provide data on drug use among school students, and generally the findings are very similar.

Prevalence and patterns of drug use

Cannabis

The latest ESPAD survey data, from 2003, reveal that the highest lifetime prevalence of cannabis use among 15- and 16-year-old school students is in the Czech Republic (44 %) (Figure 1). The lowest lifetime prevalence estimates (less than 10 %) occur in Greece, Cyprus, Sweden, Norway, Romania and Turkey. Countries where the rate is higher than 25 % include Germany, Italy, the Netherlands, Slovakia and Slovenia (27 % and 28 %), while the highest

The European school survey project on alcohol and other drugs (ESPAD): a growing resource for understanding trends in drug and alcohol use in young people

ESPAD is an important source of information on drug and alcohol use among European school students and is invaluable for recording trends over time. ESPAD surveys were conducted in 1995, 1999 and 2003. The use of standardised methods and instruments among nationally representative samples of school students aged 15 to 16 years provides a high-quality and comparable data set. Participation in ESPAD has grown with each survey, and both EU Member States and non-EU countries participate. In 1995, a total of 26 European countries participated (including 10 countries that joined the EU in May 2004). This figure increased to 30 in 1999, while the 2003 survey involved an impressive 35 countries including 23 EU Member States (including the 10 countries that joined the EU in 2004) and three candidate countries (Bulgaria, Romania and Turkey) and Norway. Spain did not participate in the study, but the 2003 ESPAD report presents national data from the Spanish school survey (PNSD).

The comparability of the ESPAD school survey is based on standardisation of target age group and method and timing of data collection, use of random sampling, the robustness of questionnaire design and assurance of anonymity.

The survey questions focus on alcohol consumption (lifetime, 12-month and 30-day prevalence, average consumption, binge drinking) and use of illicit drugs (lifetime, 12-month and 30-day prevalence including measures of how frequently drug use occurred during these time windows).

Some of the main findings of the 2003 survey in the EU Member States, candidate countries and Norway were:

- Cannabis is by far the most commonly used illicit drug;
- Ecstasy is the second most used illegal drug, but experience is relatively low;
- Experience of amphetamines and LSD and other hallucinogens is low;
- Although prevalence of use is relatively low, magic mushrooms are the most commonly used hallucinogens in 12 EU Member States;
- Other substances used by school students include tranquillisers and sedatives without a doctor's prescription (with a highest reported national level of 17 %), and inhalants (national maximum 18 %);
- The 30-day prevalence of binge drinking (defined as consuming at least five drinks in a row) varies considerably between countries.

Information on ESPAD and the availability of the new report can be found on the ESPAD website (www.espad.org).

lifetime prevalence estimates, ranging from 32 % to 40 %, are reported in Belgium, France, Ireland and the United Kingdom. In most countries, since 1995, there has been a consistent increase in the number of school students who have ever tried cannabis ([20]). However, country variations are marked.

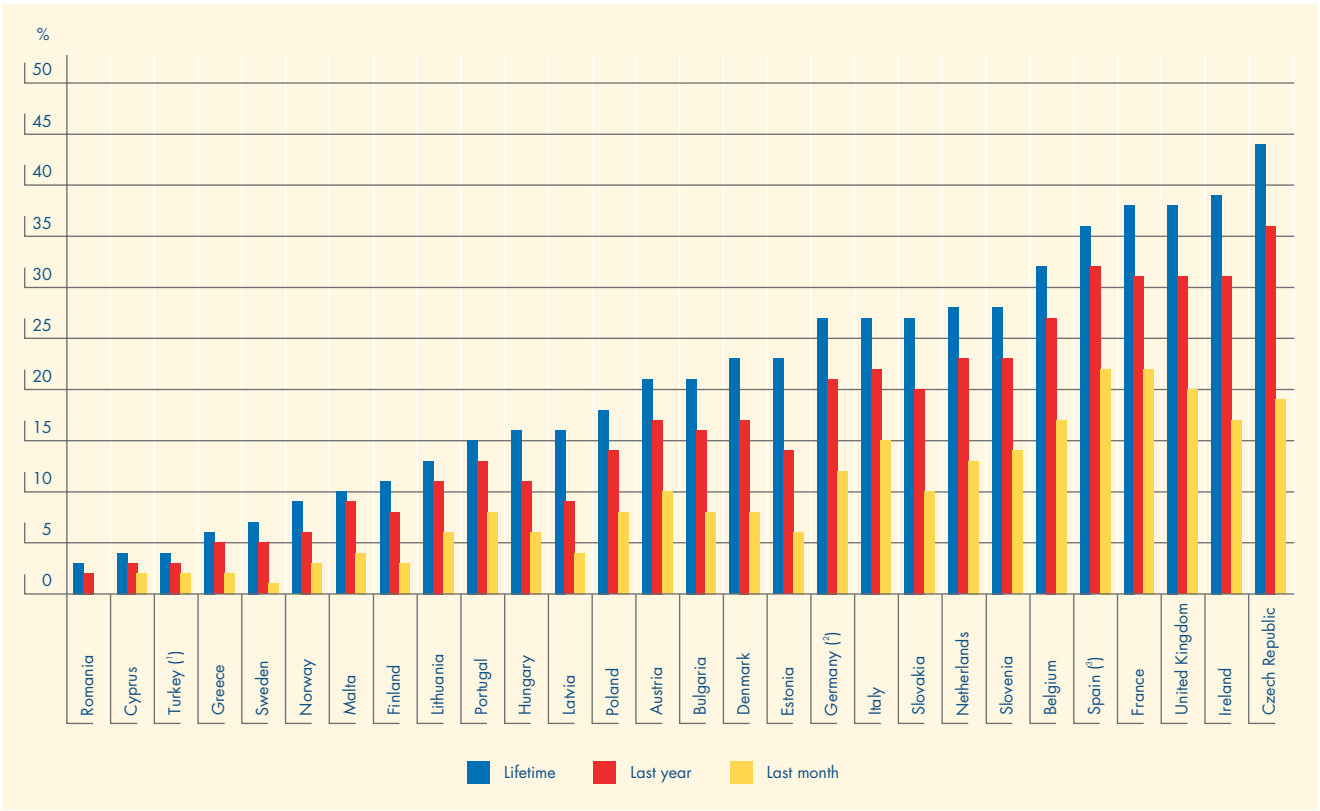
New data from 2003 ESPAD surveys of 15- to 16-year-old school students show that lifetime prevalence of cannabis use ranges from 3 % to 44 %. Between 2 % and 36 % of school students report having used the drug in the last 12 months, while use in the last month ranged from 0 % in some countries to 19 % in others ([21]) (Figure 1). There are relative variations in the different prevalence rates. For example, lifetime prevalence is highest in the Czech Republic, but current (last month) use is highest in Spain and France (22 %).

In nearly all countries, prevalence of cannabis use is higher among males than in females. Gender differences are more marked for students who report having used cannabis 40 or more times in their life ([22]).

Older students (17–18 years) were included in national school surveys conducted in 11 Member States and Bulgaria. Lifetime prevalence of cannabis use in this age range varied from less than 2 % in Cyprus to 56 % in the Czech Republic, while current (last month) cannabis use ranged from less than 1 % in Cyprus to nearly 30 % in France. In all countries that conducted surveys, except Cyprus, prevalence estimates among older students were higher than those for 15- to 16-year olds ([23]).

Between 1999 and 2003, in the Czech Republic there was an increase of 5 % in the number of school students who reported having tried cannabis at the age of 13 or younger. Thirteen other EU countries reported small increases (1–3 %) ([24]). A decrease (of 1 %) was reported only in the Netherlands and the United Kingdom.

Figure 1: Lifetime, last year and last month prevalence of cannabis use among 15- to 16-year-old school students in 2003



(1) Turkish figures are based on one major city in each of six different regions (Adana, Ankara, Diyarbakir, Istanbul, Izmir and Samsun).
(2) German data are based on six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia).
(3) Spain did not participate in the ESPAD survey. The data included here are based on a Spanish survey conducted in November–December 2002. Drug prevalence questions may be considered comparable to the ESPAD questions, but other aspects of the method mean that the Spanish data are not strictly comparable.
Source: Hibell et al., 2004.

([20]) See Figures EYE-1 (part ii) and EYE-1 (part ix) in the 2005 statistical bulletin.
([21]) See Chapter 3 for a more detailed account of cannabis use among school students.
([22]) See Figure EYE-1 (part iii) in the 2005 statistical bulletin.
([23]) See Tables EYE-1 and EYE-3 in the 2005 statistical bulletin.
([24]) See Figure EYE-1 (part vii) in the 2005 statistical bulletin.

According to a recent Eurobarometer (2004) study ([25]), the number of young people aged 15–24 years who declared that they had been offered cannabis rose from 46 % in 2002 to 50 % in 2004. In the same period, the number of young people who reported that they knew people who had used cannabis also rose from 65 % to 68 %.

ESPAD surveys show that school students' perceptions of cannabis, both of the risks associated with use and of the availability of the drug, are strongly correlated with lifetime prevalence of cannabis use. The relationship between risk and prevalence is an inverse one ([26]), i.e. high perceptions of risk are associated with low prevalence of use and vice versa, but the perception of availability is directly correlated with lifetime prevalence of use ([27]).

Young people in countries with higher than average prevalence estimates for cannabis use may be increasingly disposed to regarding cannabis use as 'normal'. Most countries that report relatively high estimates of lifetime use of cannabis also report relatively high estimates for 'binge' drinking (defined as drinking five or more drinks in a row) during the last 30 days ([28]), suggesting that the two behaviours may be part of a common lifestyle. Exceptions to this pattern are displayed by France, Italy and Bulgaria, where cannabis use is relatively high but binge drinking is relatively low.

Other drugs

Prevalence of ecstasy use was higher than that of amphetamine use in 14 of the EU and candidate countries reported in the 2003 ESPAD survey ([29]). The lowest levels of lifetime use of ecstasy (2 % and under) were found in Denmark, Greece, Cyprus, Lithuania, Malta, Finland, Sweden, Norway, Romania and Turkey. Higher prevalence rates, ranging from 3 % to 4 %, were reported in Belgium, Germany, France, Italy, Latvia, Austria, Poland, Portugal, Slovenia, Slovakia and Bulgaria. The countries with highest lifetime prevalence rates for ecstasy use were the Czech Republic (8 %); and Estonia, Spain, Ireland, the Netherlands and the United Kingdom (all 5 %).

Regarding prevalence rates over different periods, the highest rate of lifetime prevalence of ecstasy use in 2003 was 8 %, compared with 5 % for use during the last 12 months (recent use) and 2 % for use during the last month (current use).

Consecutive surveys show that, generally, lifetime prevalence of ecstasy use among 15- and 16-year-old school students increased over the period 1995 to 2003, with the greatest increases occurring in the Czech Republic and most of the new Member States ([30]). However, lifetime prevalence figures from the 1999 ESPAD surveys reveal fluctuations in some countries. The decreases in ecstasy use that occurred in the United Kingdom took place before 1999, and may be partly attributable to extensive media coverage of ecstasy-related deaths during the late 1990s.

Psilocin and psilocybin — magic mushrooms

Psilocin and psilocybin, the psychoactive ingredients of so-called 'magic mushrooms', are included in Schedule 1 of the 1971 UN Convention and thus are controlled in all Member States. However, the legal status of magic mushrooms, as well as the extent to which any legal restrictions on their growth and consumption are enforced, varies between Member States, i.e. mushrooms may be controlled, uncontrolled or controlled if 'processed', a status that is not entirely legally clear.

The ESPAD survey reported on the use of 'magic mushrooms' for the first time in 2003. Prevalence estimates for use of 'magic mushrooms' among 15- to 16-year-old school students exceeded or equalled those for LSD or other hallucinogenic drugs in most of the countries that participated ([31]). In addition, compared with lifetime experience of ecstasy use, lifetime prevalence of magic mushrooms use was higher in Belgium, Germany and France and the same in the Czech Republic, Denmark, Italy, the Netherlands and Poland. Lifetime prevalence of magic mushrooms use was zero in Cyprus, Finland and Romania, rising to 4 % in Germany, Ireland and the United Kingdom, and to 5 % in Belgium, France and the Netherlands. Prevalence is highest in the Czech Republic (8 %). Trend data for the use of magic mushrooms are not available.

New developments in prevention

Individuals' values and behaviours are influenced by what they perceive to be the normality in their social environment, and this is especially true of young people. If they perceive experimental cannabis use as 'normal' and socially acceptable (associating it with low levels of risk and easy availability), this may be a key influence on their values and behaviour regarding cannabis use (Botvin, 2000).

([25]) A second Eurobarometer survey (Eurobarometer, 2004), 'Young people and drugs', was conducted in 2004. This non-probability sample survey comprised 7 659 young people aged 15 to 24 in the 15 Member States included in the previous 2002 survey.
([26]) See Figure EYE-1 (part v) in the 2005 statistical bulletin.
([27]) See Figure EYE-1 (part vi) in the 2005 statistical bulletin.
([28]) See Figure EYE-1 (part viii) in the 2005 statistical bulletin.
([29]) See Figure EYE-2 (part iv) in the 2005 statistical bulletin.
([30]) See Figure EYE-2 (part i) in the 2005 statistical bulletin.
([31]) See Figure EYE-2 (part v) in the 2005 statistical bulletin.

The challenge for prevention is to provide young people with social and cognitive strategies to manage these influences. It is therefore not realistic to assess the effectiveness of prevention policies using data on drug use by young people, particularly not estimates of experimental use, as they reflect societal norms and not genuine problem behaviour.

Instead, prevention should be evaluated against a number of clear criteria: well-defined objectives, target groups and actions set out in national strategies and based on the international knowledge base; quality control measures; the development of selective prevention measures and of family-based prevention; and regulatory measures on legal drugs aimed at influencing the social norms that imply condonation of or consent to particular consumption behaviours.

As far as evaluation of prevention strategies is concerned, the new national strategies in France and Italy exhibit important advances over their previous policies in that the role of prevention is now better defined, as is the importance of structured programmes and priority areas for taking action. In almost all Member States, a tendency towards more strategic approaches is apparent, and vulnerable groups are increasingly being envisaged in the overall planning.

Normative and structural measures

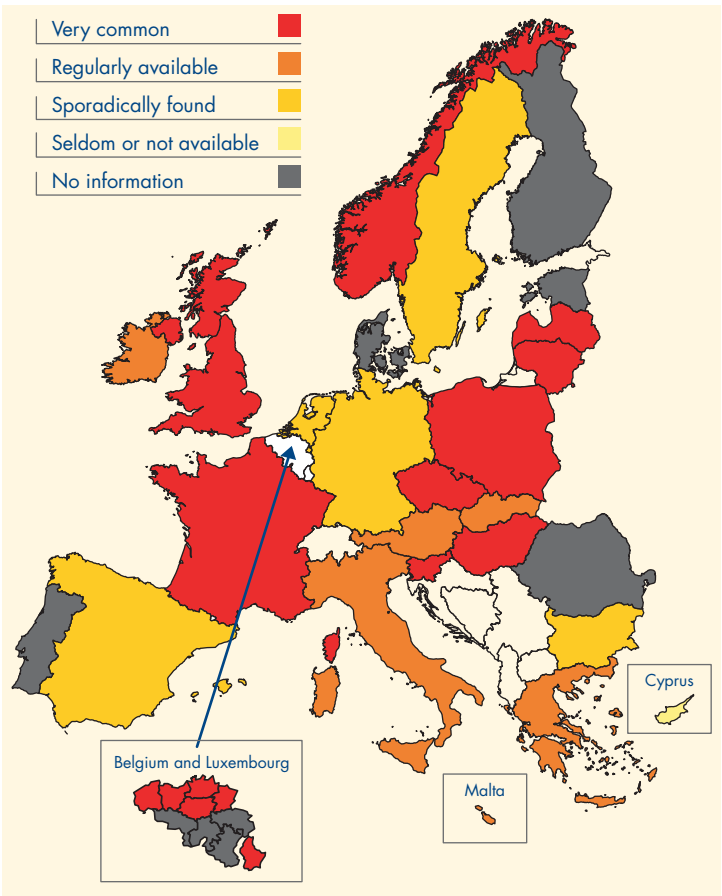
Control measures on legal drugs help to establish the normative foundations on which other prevention measures can be built. Societal norms that support tobacco and alcohol use and tolerate their influence on behaviour are well-known risk factors for a sympathetic attitude to and use of illicit drugs (Becoña, 2002). Contrary to popular belief, societal norms are influenced more by control policies than by mass media campaigns or educational approaches (Hawks et al., 2002; Canning et al., 2004). Eurostat (2002) compared tobacco control measures and smoking indicators in children/adolescents in EU Member States and found a relationship between the rigidity of tobacco control policies (advertising ban, age limits on purchasing, restrictions, etc.) and smoking habits. Smoking rates among adolescents were found to be higher in countries with relatively lenient policies (e.g. Denmark, Germany and the United Kingdom) than in countries with stricter controls (e.g. France, Sweden and Norway). It is known that the impact of prevention interventions is limited if they are counteracted, or at least not supported, by societal norms and policies. EU and WHO initiatives (Aspect Consortium, 2004) in this field have gained ground, and Member States are now increasingly linking tobacco control policies with drug prevention.

School-based prevention

In all Member States, schools are considered the most important setting for universal prevention, and there has been a noticeable increase in the emphasis placed on school-based prevention in national strategies and in the structured implementation of this approach. This is reflected in the expansion of school drug policies (Figure 2) and the development of specific modular drug prevention programmes for schools as well as improved teacher training.

More countries than before have introduced (Denmark has its first school-based life skills programme), expanded (Germany) or are planning (France and Italy, in their national strategies) more structured prevention programmes. For example, in 2003, prevention programmes were being implemented in 60 % of Polish schools.

Figure 2: Development of school policies



NB: German-speaking Belgium = sporadically found.
Sources: Reitox national focal points.

Greece provides a particularly good example of moving prevention policies away from traditional information-based and individualistic (counselling) approaches towards the implementation of a true public health strategy that can maximise coverage through programme-based approaches. The number of school-based prevention programmes in Greece more than doubled between 2000 and 2003, and family-based programmes increased threefold over the same period. Malta and the United Kingdom also increased the role of programme-based approaches in their prevention policies: the 'Blueprint programme' seeks to determine how international research on effective drug prevention can be adapted within the English school system, and is based upon evidence suggesting that combining school-based education on drugs with parental involvement, media campaigns, local health initiatives and community partnerships is more effective than school interventions alone. Six million pounds (EUR 8.5 million) has been allocated to this programme over five years ([32]).

Monitoring and quality control

Controlling and improving the quality of prevention is highly dependent on first having a meaningful overview of existing activities and their contents. Accordingly, Member States are giving increasing importance to monitoring prevention programmes, as exemplified by new schemes in Germany ([33]) and Norway ([34]) and by the Hungarian research project 'Lights and shadows', which collected information on the content, objectives, methodology, target groups and coverage of school-based prevention programmes. Monitoring is also implemented in the Czech Republic as well as through 'Ginger' in Flanders. Unfortunately, Spain has abandoned 'IDEA prevención', which for many years was the best-developed monitoring and quality system on prevention in Europe.

Information systems on prevention also help to track the occurrence of ineffective practices and programme components. For instance, one-off information sessions or lectures by experts or police officers are still common in several Member States, despite the unanimous conclusions from research that these interventions are at best ineffective, if not harmful (Canning et al., 2004).

Only by systematically recording prevention activities can the content of prevention programmes be reviewed and, as a result, based on existing knowledge regarding effectiveness, targeted to specific populations. Guidelines or standards for the implementation of prevention programmes are essential, particularly in countries where prevention is strongly decentralised.

Contents of programmes and activities

An increase in programme-based approaches and improved standardised information collection have enabled the contents of, and trends in, prevention policies to be reviewed and compared across the EU. The information usually comes from national experts or expert groups who have a reliable overview of their country's situation that allows them to come up with standardised ratings or from quantitative data on monitored, programme-based interventions that is available in some Member States, e.g. Greece and Hungary.

For instance, most Member States have implemented personal and social skills training in schools as a prevention approach. Topics covered include decision-making, coping, goal-setting and assertiveness, communicating and showing empathy. This evidence-based technique, which is derived from social learning theories ([35]), seems now to be an important methodology in most Member States, even in countries where programme-based approaches do not exist (France, Luxembourg and Sweden) (Table 2). Estonia reports the widespread use of a book that teaches social skills.

Information provision continues to play a central role in drug prevention in many Member States (see Table 2). The limited value of information provision in the prevention of drug use is only slowly being acknowledged (see, for example, the Swedish national report). Approaches based solely on health education are also limited to influencing cognitive processes and often lack concrete components of behavioural and social interaction training. However, these approaches are still widespread in some countries despite our present understanding of effective drug prevention.

There are two explanations for the continuance of such approaches to drug prevention. One is the instinctive and traditional presumption that providing information on drugs and the risks associated with drug use will act as a deterrent. The second explanation reflects a very recent trend inspired by harm reduction movements and is based on the belief that cognitive skills are more important than behavioural approaches in teaching young people to make informed decisions and choices in life. Advocates of this technique believe that behavioural approaches to drug prevention, such as improving life skills, are patronising and demonise drug use (Ashton, 2003; Quensel, 2004)

([32]) www.drugs.gov.uk/NationalStrategy/YoungPeople/Blueprint

([33]) PrevNet (www.prevnet.de).

([34]) www.forebyggingstiltak.no

([35]) Behaviour is seen as a result of social learning by role models, norms, attitudes of 'important others' (Bandura, 1977). Negative attitudes to drug use and protective self-efficacy can be learned or conditioned. This concept is the basis for peer models and the specific life skill model.

and that giving young people the cognitive tools they need, by providing information, is the best method. Despite their different traditions, both approaches view health behaviour, and specifically drug use, as a matter of personal rational choice, whereas the broad consensus in the health sciences is that social factors (neighbourhood, peer group, norms) and personal factors (temperament, academic and emotional skills) are more influential in shaping health and drug use behaviour than is mere cognition.

Table 2: School-based prevention in Europe

	Quality standards/guidelines (')			Personal social skills	Objectives	
	In place	Mandatory for funding	Prerequisite		Primary	Secondary
Belgium fl	Yes	Yes	Yes	Very common	Life skills	Information
Belgium fr	Yes	Yes	Yes	n.a.	Protective environment	Educational relationship
Czech Republic	Planned		Yes	Very common	Self-esteem	Protective environment
Denmark	No			No	Information	
Germany	No			Very common	Life skills	Information
Estonia	No			Sporadically	n.a.	
Greece	Yes	Yes	Yes	Very common	Life skills	Educational relationship
Spain	Planned	Yes	Yes	Very common	Life skills	Self-esteem
France	Yes			Seldom	Information	Life skills
Ireland	Yes	Yes		Very common	Life skills	Self-esteem
Italy	Yes			Regular	Information	Life skills
Cyprus	Planned	Yes	Yes	Sporadically	Protective environment	Life skills
Latvia	Planned			Sporadically	Information	Life skills
Lithuania	No			Regular	Information	
Luxembourg	Yes		Yes	Regular	Educational relationship	Life skills
Hungary	Planned			Regular	Information	Life skills
Malta	No			Very common	Information	Life skills
Netherlands	Yes			No	Information	
Austria	Yes		No	Sporadically	Life skills	Protective environment
Poland	No			Regular	Life skills	Information
Portugal	Yes	Yes	Yes	Sporadically	Information	Life skills
Slovenia	Planned			Sporadically	Information	Life skills
Slovakia	No			Seldom		
Finland	n.a.			n.a.	Provision of welfare services	Information
Sweden	No			Regular	Protective environment	Social inclusion
United Kingdom	Yes			Very common	Information	Life skills
Norway	No			Regular	Information	Self-esteem
Bulgaria	n.a.			Sporadically	Information	Protective environment
Romania	n.a.			Sporadically		

NB: n.a., no information available.
(') It should be remembered that no common European definition of 'quality standards and guidelines' exists, and that the level of detail may vary, which influences comparability.

The erroneous perception of drug use as normal and socially acceptable among the peer population is the most important cognitive element that can be influenced by prevention. In fact, a lifetime prevalence of cannabis use among young adults of 30 % means that more than two-thirds of this population have never used cannabis, and that is the true 'normality'. However, despite the proven benefit of techniques that address young people's normative beliefs (Reis et al., 2000; Taylor, 2000; Cunningham, 2001; Cuijpers et al., 2002), they are rarely used in Europe.

Selective prevention

National drug strategies and action plans are increasingly and explicitly mentioning vulnerable groups to be particularly targeted by prevention measures. This focus is even stronger in the new Member States: Estonia (street children, special schools), Cyprus, Hungary, Malta, Poland (neglected children and young people from dysfunctional families) and Slovenia.

Because the vulnerable groups targeted by selective prevention often have considerable experience with legal and illegal drugs, most selective prevention interventions are restricted to the provision of tailor-made information, individual counselling and creative or sports alternatives. However, it should be remembered that the techniques used in the comprehensive social influence programmes of universal prevention are equally as effective, if not more effective, in selective prevention. Normative restructuring (e.g. learning that most peers disapprove of use), assertiveness training, motivation and goal-setting, as well as myth correction, have proved to be very effective methods among vulnerable young people (Sussman et al., 2004) but are rarely used in selective prevention in the EU. However, intervention techniques in recreational settings (see 'Prevention in recreational settings', p. 48) mostly take the form of the provision of targeted information.

Selective prevention in schools

The main focus of selective prevention in schools is crisis intervention and early identification of pupils with problems. The aim is to find solutions at school level in order to avoid at-risk pupils dropping out or being expelled and thereby aggravating their situation. Programme-based approaches are offered in Germany, Ireland, Luxembourg and Austria (Leppin, 2004), while Poland and Finland provide teacher training courses or guidelines on how to recognise pupils with problems, including drug use, and take appropriate action. Traditional individualistic approaches include educational psychology services (as in France and Cyprus), which depend on (self)-referrals. Ireland has a new intensive educational welfare service to work with schools and families in educationally disadvantaged areas in order to ensure that children attend school regularly.

Selective community-based approaches

Selective community-based approaches mostly target vulnerable young people on the streets. In the Nordic countries, the 'Nightwalkers' approach engages parent groups in patrolling the streets. Austria has invested heavily in improving the balance between drug prevention, social education and social work structures through courses, quality guidelines and joint seminars, e.g. for youth social workers in recreational settings. The aim is also to use youth social work structures for professional drug prevention interventions. Along the same lines, Norway boosts cooperation and strengthens interdisciplinary efforts between school, child protection services and social services. RAR (rapid assessment and response) methods ([36]) — the speedy gathering of information (statistical material) combined with interviews (questionnaires, focus groups) and/or observations of the problem area — are used in these projects in Norway, but also in Germany and the Netherlands.

Interventions focusing on high-risk neighbourhoods have a tradition in Ireland, the United Kingdom and, to a small extent, the Netherlands and Portugal. However, Germany (Stöver and Kolte, 2003, cited in the German national report) and France have now also proposed action in this area. It is new for these countries to target drug prevention to particular geographical areas according to social criteria.

Member States are also increasingly targeting specific ethnic groups in their selective prevention policies (e.g. Ireland, Luxembourg, Hungary). For example, the focus on ethnicity is an important aspect in Hungary, where the Roma population is at high risk of drug-related problems owing to its social and cultural characteristics and disadvantageous living conditions. There, peer training, self-help groups, supervision, various prevention programmes and low-threshold services for Roma are operated by non-governmental organisations (NGOs).

Vulnerable families

Universal family-based prevention, mostly evening events, lectures, seminars and workshops for parents, is still popular in many Member States (Germany, France, Cyprus and Finland) despite the lack of evidence for its effectiveness (Mendes et al., 2001). However, in Greece, Spain, Ireland and Norway there have been interesting

([36]) World Health Organisation, *The rapid assessment and response guide on psychoactive substance use and especially vulnerable young people* (http://www.who.int/docstore/hiv/Core/acknowledgements.html).

developments in selective prevention with families through the introduction of innovative concepts that go beyond families/parents with drug problems and recognise the role of social, economic and cultural factors in drug use. In the Netherlands, the evaluation of drug prevention projects for immigrant parents concluded that a standardised intervention offered via immigrant networks, with women and men addressed separately, would be a feasible new direction (Terweij and Van Wamel, 2004). In Norway, 'parent management training' (PMTO, the Oregon model), originally a training method for families with children with serious behavioural disorders, has been implemented and evaluated in three municipalities. In another two countries, the 'Iowa strengthening families programme' (ISFP) has been implemented. This intensive family intervention programme for families at risk combines teaching methods for students (10–14 years) with an educational programme for their parents, aiming at drug prevention through strengthened family competence and family ties (Kumpfer et al., 2003).

The need for indicated prevention

Indicated prevention focuses on individuals identified as having risk factors for drug problems, for instance attention deficit/hyperactivity disorder (ADHD). However, drug prevention measures aimed at young people with ADHD are reported only from Germany and Sweden. In Germany, current estimates of the prevalence of ADHD suggest that 2 % to 6 % of people between the ages of 6 and 18 years are affected, making it one of the most common chronic clinical pictures among children and young people. In Sweden, the preventive strategy for these children includes cognitive and social training, and methodologies are disseminated through training of prevention professionals. As almost all pre-school children are reached by primary healthcare and most children go to primary school, the majority of children at risk could be identified through systematic screening and subsequent individualised interventions.

The Italian action plan places a strong focus on psychopathological conditions and serious behavioural problems in children and adolescents which are predictive of drug use and misuse if ignored at an early stage. The problems identified include behavioural problems; hyperactivity and attention deficit; anxiety accompanied by mood disorders; bulimia and psychogenic obesity; personality disturbances; interpersonal communication problems; post-traumatic stress disorders; and panic attacks. Both universal and selective prevention approaches are foreseen as responses.

Chapter 3
Cannabis

Prevalence and patterns

Cannabis is by far the most commonly used illegal substance in Europe. Recent population surveys indicate that between 3 % and 31 % of adults (aged 15 to 64 years) have tried the substance at least once (lifetime use). The lowest prevalence rates of lifetime use are found in Malta (3.5 %), Portugal (7.6 %) and Poland (7.7 %) and the highest in France (26.2 %), the United Kingdom (30.8 %) and Denmark (31.3 %). In most countries (15 of 23 countries with information) lifetime prevalence lies between 10 % and 25 %.

Between 1 % and 11 % of adults report having used cannabis in the last 12 months, with Malta, Greece and Sweden presenting the lowest prevalence rates and the Czech Republic, France, Spain and the United Kingdom the highest. Most countries (14) reported prevalence rates of recent use of between 3 % and 7 %.

An estimate of the total number of adults (15 to 64 years) using cannabis in the EU as a whole can be constructed from the available national estimates. This exercise suggests that around 20 % of the total population, or over 62 million people, have ever tried cannabis. This figure falls to around 6 % of adults, or in excess of 20 million people, when the more recent use of cannabis is considered (last year prevalence). For comparison, in the 2003 United States national survey on drug use and health (SAMHSA, 2003), 40.6 % of adults (defined as 12 years and older) reported having tried cannabis or marijuana at least once and 10.6 % reported having used it during the previous 12 months. Among 18- to 25-year-olds, the figures were 53.9 % (lifetime), 28.5 % (last 12 months) and 17 % (last month) ([37]).

As is the case with other drugs, young adults consistently report higher rates of use. Between 11 % and 44 % of young Europeans aged 15 to 34 years report that they have ever tried cannabis, with the lowest prevalence rates being found in Greece, Portugal and Poland and the highest in France (39.9 %), the United Kingdom (43.4 %) and Denmark (44.6 %). Recent use was reported by 3–22 % of young adults, with the lowest figures in Greece, Sweden, Poland and Portugal, and the highest in the United Kingdom (19.5 %), France (19.7 %), and the Czech Republic (22.1 %) and 11 countries reporting recent use prevalence rates of between 7 % and 15 %.

Among 15- to 24-year-old Europeans, 9–45 % claim to have tried cannabis, with rates in most countries falling in the range 20–35 %. Recent use (in the last 12 months) was reported by 4–32 %, with rates in most countries being in the range 9–21 % ([38]).

Estimating drug use in the population

Drug use in the general population is assessed through surveys, which provide estimates of the proportion of the population that has used drugs over defined periods of time: lifetime use (experimentation), last 12 months' use (recent use) or last 30 days' use (current use) ([1]).

The EMCDDA has developed a set of common core items ('European model questionnaire', EMQ) that is implemented in, or compatible with, most surveys in the EU Member States. The EMQ is included in a report available on the EMCDDA website ([2]). 'Lifetime use' may be of limited value as an indicator of the current situation among adults (although it could be a reasonable indicator among school children), but in conjunction with other measures it can give insight into aspects of patterns of use (continuation or discontinuation of use) and the generational dynamics of the spread of drug use. 'Last 12 months' use' gives an indication of recent drug use, although often this use will be occasional, and 'last 30 days' use' gives an indication of more current use, which will include people using the drug frequently.

([1]) For more about the methodology of population surveys, and the methodology used in each national survey, see the 2005 statistical bulletin.
([2]) Handbook for surveys about drug use among the general population (http://www.emcdda.eu.int/?nnodeid=1380).

([37]) Note that the age range in the US survey (12 years and over) is wider than the age range reported by the EMCDDA for EU surveys (15–64 years). On the other hand, the age range for young adults (18–25 years) is narrower than the range used in most EU surveys (15–24 years).
([38]) See Figure GPS-2 in the 2005 statistical bulletin.

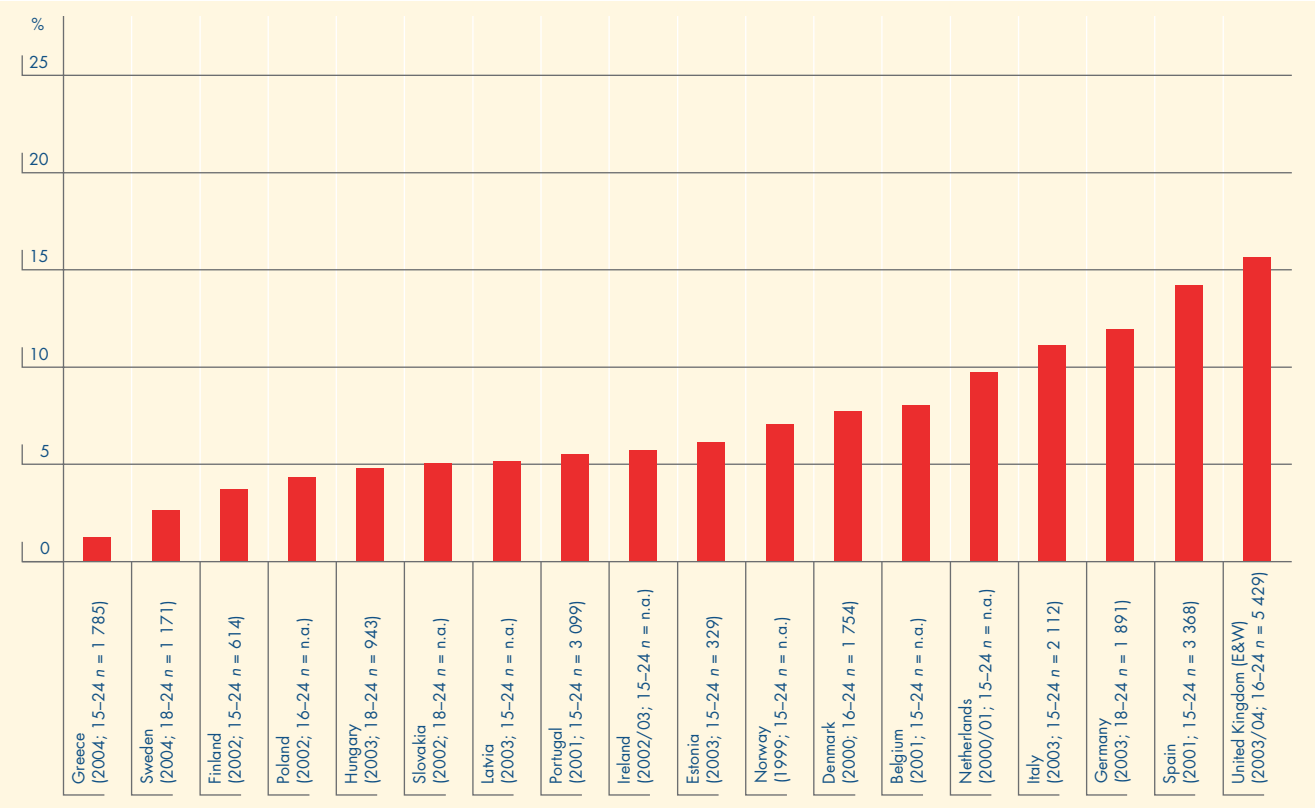
As with other illicit drugs, rates of cannabis use are notably higher among males than among females, although the extent of this difference varies between countries. The male–female ratio for lifetime experience varies from 1.25:1 to 4:1 (1.25 to 4 men for each woman) and for current use from approximately 2:1 to 6:1. Surveys also indicate that cannabis use is more common in urban areas or in areas with high population density. Thus, national differences noted might, in part, reflect differences in levels of urbanisation, although it has been suggested that recreational drug use is spreading from urban areas towards rural areas.

The fact that rates of recent use and current use are substantially lower than lifetime experience rates indicates that cannabis use tends to be occasional, or to be discontinued after some time. In most EU countries, 20–40 % of those adults who have ever tried cannabis report having used it during the previous 12 months, and about 10–20 % report having used it during the last 30 days ('continuation rates').

In recent surveys, rates of use in the last month were reported by 0.5–9 % of all adults (with many countries in the range 2–4 %), by 1.5–13 % of young adults (with many countries in the range 3–8 %) and by 1.2–16 % of 15- to 24-year-olds (with many countries in the range 5–10 %) (Figure 3). A very rough estimation will be that 1 in 10 to 20 young Europeans is a current user of cannabis. The countries with the lowest current prevalence rates included Malta, Greece, Sweden, Poland and Finland, while the United Kingdom and Spain had the highest.

In the 2004 annual report (EMCDDA, 2004a), data presented on frequency of cannabis use in the last 30 days suggested that approximately one quarter (19–33 %) of those who had used cannabis in the last month were doing so on a daily or almost daily basis ([39]), most of them young males. It was estimated that among 15- to 34-year-old Europeans, 0.9–3.7 % were daily cannabis users, and that roughly 3 million people in Europe could be using the substance daily or almost daily.

Figure 3: Current use (last month) of cannabis among young adults (aged 15–24), measured by national surveys



NB: Data are from the most recent national surveys available in each country.
Some countries use a slightly different age range to the EMCDDA standard age range for young adults. Variations in age ranges may to a small extent account for disparities between countries.

Sources: Reitox national reports (2004), taken from population surveys, reports or scientific articles. See also Table GPS-0 in the 2005 statistical bulletin.

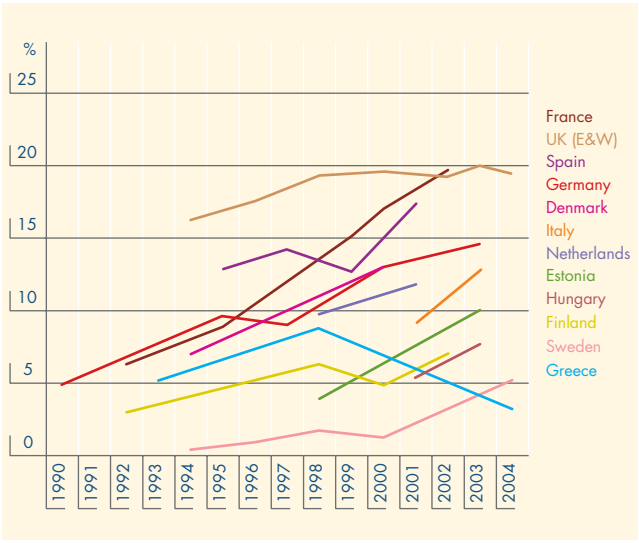
([39]) See the 2004 annual report (http://ar2004.emcdda.eu.int). The information refers to 'use on 20 days or more during the past 30 days', expressed also as 'daily or almost daily use'.

Trends

The lack of a long-term series of consistent surveys in most EU countries presents a limit to the reliable identification of drug trends. Many countries carry out consecutive surveys, but these are not series in the strict sense — despite progress in harmonisation, methods and sample sizes differ between surveys and frequency may be irregular. In addition, surveys are conducted in different years in different countries, making it difficult to identify European trends. Ideally, national population surveys would be carried out in all Member States at the same time; this would make it much easier to compare results at a national level (over time) and at a European level (between countries), facilitating evaluation of the achievement of the European action plan on drugs.

What the available findings, obtained from different types of surveys (national or local household surveys, conscript and school surveys), reveal is that cannabis use increased markedly during the 1990s in almost all EU countries, particularly among young people, and that cannabis use has continued to increase in recent years in some countries (Figure 4). In the United Kingdom, which until 2000 exhibited the highest figures, cannabis use among young adults remained relatively stable between 1998 and 2003/04, with other countries (France and Spain ([40])) catching up. In Greece there was a reported decrease between 1998 and 2004.

Figure 4: Trends in recent use (last year) of cannabis among young adults (aged 15–34), measured by national surveys (')



(') Sample sizes (respondents) for the 15–34 age group for each country and year are presented in Table GPS-4 in the 2005 statistical bulletin.

NB: Data taken from national surveys available in each country. Figures and methodology for each survey can be consulted in Table GPS-4 in the 2005 statistical bulletin.
For young adults, the EMCDDA uses the range 15–34 years (Denmark and UK from 16, Germany, Estonia (1998) and Hungary from 18). In France the age range was 25–34 in 1992 and 18–39 in 1995.

Sources: Reitox national reports (2004), taken from population surveys, reports or scientific articles. See also Table GPS-0 in the 2005 statistical bulletin.

Among new Member States, the available evidence, mainly from school surveys, suggests that there has been a substantial increase in cannabis use in recent years in many of them. This has mostly occurred since the mid-1990s, and has been concentrated in urban areas and among males and young adults. In Estonia and Hungary, consecutive surveys among adults have allowed the identification of recent trends (Figure 4).

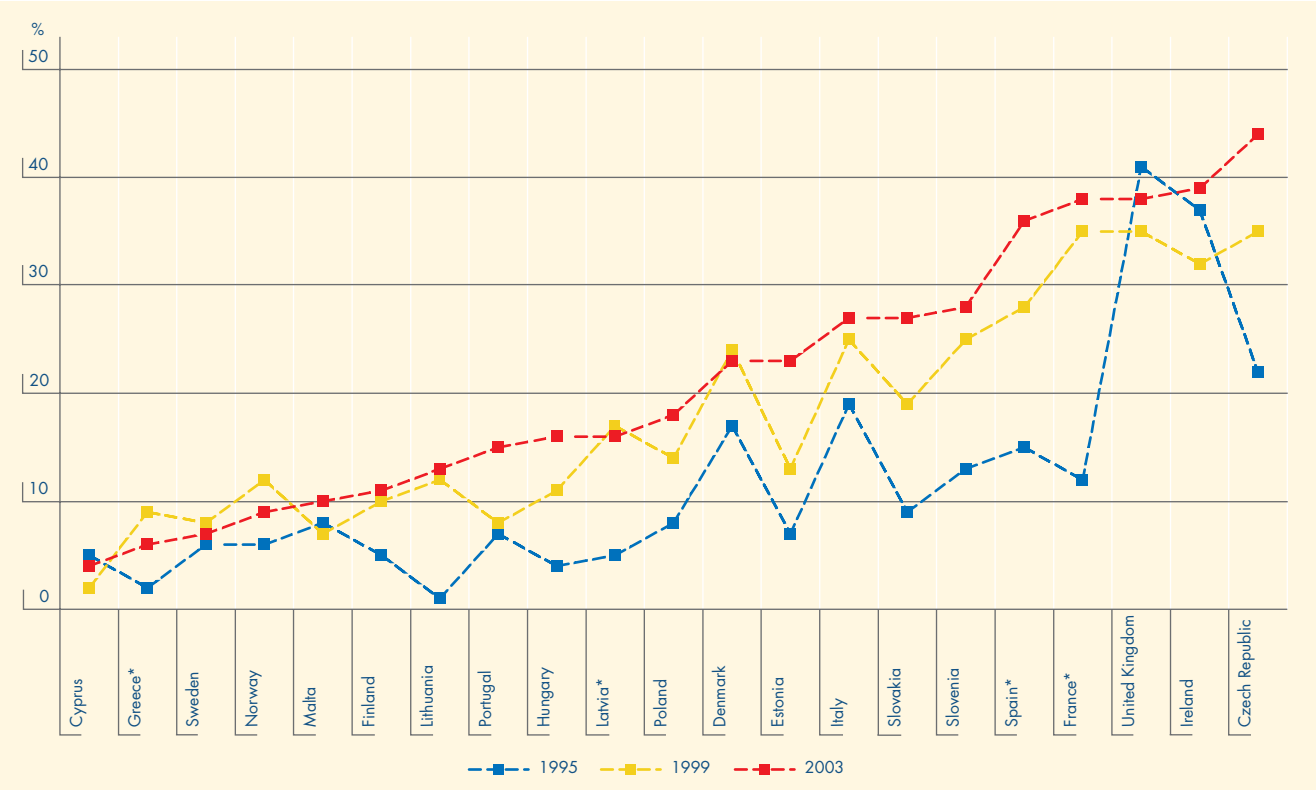
A comparison of the results of the 1995, 1999 and 2003 ESPAD school surveys (Hibell et al., 2004) shows that, in almost all Member States and candidate countries that participated in the survey, the prevalence of lifetime use of cannabis among 15- to 16-year-old school students increased by 2 % or more (Figure 5). In more than half of these countries, prevalence estimates have doubled or trebled since 1995. The highest relative increases occurred mainly in eastern European Member States that had reported lifetime cannabis prevalence rates of less than 10 % in 1995. In none of the countries surveyed by ESPAD was there a continuous and noticeable decrease in lifetime use of cannabis across the three surveys.

School surveys reveal that EU Member States can be categorised into three distinct groups regarding trends in the recreational and occasional use of cannabis. In the first group (which includes Ireland and the United Kingdom), lifetime prevalence is high (around 38–39 %) but has remained stable over the past eight years. These countries have long histories of cannabis use and high prevalence rates of cannabis use developed during the 1980s and 1990s. In a second group of countries, lifetime prevalence of cannabis use among school students has increased substantially over the period (by up to 26 percentage points). This group comprises all the new eastern European Member States together with Denmark, Spain, France, Italy and Portugal. In the third group, estimates of lifetime prevalence among school students have remained at relatively low levels (around 10 % and below). This group includes Member States from both the north and south of Europe (Finland, Sweden and Norway as well as Greece, Cyprus and Malta).

Among adults, the picture is less clear because less information is available, and what is available is more heterogeneous, but a similar pattern emerges, with recent cannabis use (last year use) high but stable in the United Kingdom, some countries (e.g. Denmark, Germany, Estonia, Spain and France) showing substantial increases

([40]) Information that arrived too late to be included in the report gave an LYP among young adults in Spain of 20.1 % in the 2003 survey.

Figure 5: Lifetime prevalence of cannabis use among 15- to 16-year-old school students reported in the 1995, 1999 and 2003 rounds of the ESPAD survey



NB: In 1995, surveys in countries marked with an asterisk were not strictly comparable with the ESPAD surveys. Spain did not participate in the ESPAD survey. The data included here are based on a Spanish survey series in 1996, 1998 and 2002. Drug prevalence questions may be considered comparable to the ESPAD questions, but other aspects of the method mean that the Spanish data are not strictly comparable.

Source: Hibell et al., 2004.

in recent years and other countries exhibiting lower prevalence estimates and less clear trends (e.g. Greece, Finland and Sweden). New school and adult surveys in the next two to three years will help to throw more light on the complex issue of the development of drug trends.

Prevention of cannabis use

Concern in some countries about increasing cannabis consumption among young people has resulted in discussions about whether drug testing would be a useful control measure. Some countries have taken steps in this direction, although drug testing measures remain uncommon. In the Czech Republic, there have been reports in the media of the use of urine testing and drug detection sniffer dogs in schools. While there is some support for these measures, an expert panel concluded that such methods should not form any part of an effective primary prevention strategy. In the United Kingdom, newly launched guidelines for schools note a number of important issues that need to be considered before implementing a drug testing programme. These include ensuring that appropriate consent is obtained from parents (and pupils if they are deemed competent), considering whether testing is consistent with the school's pastoral duty of care and taking into account the availability or otherwise of appropriate support services. Any decision to subject pupils to drug testing must be included in the school's drug policy. The EMCDDA website includes a short report on drug testing in schools in the EU ([41]).

Cannabis is almost always included in universal (non-targeted) drug prevention programmes. Attention given in the media to the increasing use of cannabis among young people, with the insinuation that cannabis use is increasingly 'normal', emphasises the need to address normative beliefs among young people. Unease about the growing acceptance of cannabis use among young people has resulted in the introduction of prevention programmes that aim to address their beliefs about what constitutes normal or acceptable behaviour. This issue is discussed in more detail in Chapter 2. Many interventions consist principally of providing information on cannabis through media campaigns, leaflets or websites. However, some

([41]) http://www.emcdda.eu.int/?nnodeid=7022

interesting examples of selective prevention do exist, and these can be found in the EMCDDA's database of evaluated prevention projects, EDDRA ([42]). These schemes mostly target young cannabis users who have committed drug offences and offer counselling, personal competence training and multiagency support. Examples of these schemes include 'FRED' (Germany), 'MSF-Solidarité Jeunes' (Luxembourg), 'Ausweg' (Austria) and 'youth offending teams' (YOTs) in the United Kingdom.

The high prevalence of cannabis use among young people means that the use of the drug is often a central issue for those working with school-aged children. One potentially promising selective school-based prevention approach is the 'Step by step' programme, which has been implemented in Germany and Austria. This programme helps teachers to identify and deal with drug consumption and problem behaviours among their pupils ([43]).

A difficult issue for those engaging in the responses to cannabis is where to draw the line between a prevention perspective and a treatment perspective. Cannabis use is influenced by social, peer and personal factors, and these factors play an important part in an individual's risk of developing a long-term drug problem; thus, prevention work often focuses on these areas rather than on the drug itself (Morral et al., 2002). For example, an evaluation of the 'Ausweg project', in Austria, found that young people notified for first-time cannabis offences were less likely than expected to exhibit personality deficits, illustrating the importance of situational, social and peer influences, rather than individual psychological problems, on drug use (Rhodes et al., 2003; Butters, 2004). A number of projects do focus, however, on cannabis and advise young people on reducing their drug use. An example from Germany is the 'Quit the shit' website (www.drugcom.de), which is an innovative website-based counselling programme for cannabis users.

Treatment demand data

Among the approximately 480 000 treatment demands reported in total, cannabis is reported as the primary drug in about 12 % of cases, making it the second drug after heroin. Over the eight-year period 1996–2003, the proportion of cannabis clients among new clients seeking treatment for all drugs increased by at least two-fold in many countries ([44]), with a similar rise in numbers of clients. However, this analysis should be treated with caution as it is based on a restricted number of countries that can provide the data necessary for a time–trend comparison.

Treatment demand indicator

Information on the number of people seeking treatment for a drug problem provides a useful insight into general trends in problem drug use and also offers a perspective on the organisation and uptake of treatment facilities in Europe. The EMCDDA's treatment demand indicator (TDI) ([1]) ([2]) provides a uniform structure for reporting the number and characteristics of clients referred to drug treatment facilities. Although TDI data can be regarded as providing a reasonably robust and useful representation of the characteristics of clients referred to specialised drug services, for a number of technical reasons caution should be exercised in extrapolating findings to the clientele across the overall provision of services. In particular, the number of countries reporting each year varies and therefore trends identified at the European level need to be interpreted with caution. In addition, it should be considered that data coverage may change by country (data on units covered are reported in the statistical bulletin) and treatment demand data partly reflect the availability of drug treatment in the countries.

To facilitate interpretation and comparison of treatment demand data, the following points should be borne in mind:

- Clients starting treatment for drug use for the first time are referred to as 'new clients'. This group is considered analytically more important as an indicator of trends in drug use. Analyses are also reported for all clients. This group includes new clients as well as those who, having interrupted or ended treatment in a previous year, resumed it in the reporting year. Data on clients who during the reporting period continued, without interruption, treatment that had been begun in previous years are not recorded.

- Two types of data are collected: summary data on all types of treatment centres and detailed data by centre type (outpatient treatment centres, inpatient treatment centres, low-threshold agencies, general practitioners, treatment units in prison, other types of centres). However, for most countries, data are sparse for centre types other than outpatient and inpatient treatment centres. For this reason, analysis is often restricted to outpatient treatment centres, for which data coverage is best.

- Qualitative and contextual information extracted from the 2004 Reitox national reports is also included to aid in the interpretation of TDI data.

([1]) For further details, see the EMCDDA's web page on treatment demand (http://www.emcdda.eu.int/?nnodeid=1420) and link to the joint Pompidou Group–EMCDDA treatment demand indicator protocol version 2.0.

([2]) For details on data sources by country, see Table TDI-1 in the 2005 statistical bulletin.

([42]) http://eddra.emcdda.eu.int/

([43]) See the EDDRA website for further information on 'Step by step' (http://eddra.emcdda.eu.int/eddra/plsql/showQuest?Prog_ID=36) and 'Early detection and intervention with regard to problematic drug use and addiction' (http://eddra.emcdda.eu.int/eddra/plsql/showQuest?Prog_ID=2088).

([44]) See Tables TDI-2 (part i) and TDI-3 (part iii) in the 2005 statistical bulletin.

Overall, after heroin, cannabis is also the second most frequently cited drug in reports on clients entering treatment for the first time ([45]). There are considerable variations between countries, with cannabis being cited by 2–3 % of all clients in Bulgaria and Poland but by more than 20 % of all clients in Denmark, Germany, Hungary and Finland ([46]). In all countries from which data are available, the proportion of clients seeking treatment for cannabis use is higher among new clients than among all clients, with only a few exceptions, where the proportions are roughly equal ([47]). Nonetheless, over the eight-year period 1996–2003, the proportion of cannabis clients among clients seeking treatment for all drugs increased from 9.4 % to 21.9 % ([48]). However, this analysis should be treated with caution as it is based on a restricted number of countries that can provide the data necessary for a time–trend comparison.

Among drug users in treatment, males far outnumber females. The highest male to female ratios are found among new clients demanding treatment for cannabis use (4.8 to 1). Higher male to female ratios are found in Germany, Cyprus, Hungary and Slovakia and lower ratios in the Czech Republic, Slovenia, Finland and Sweden. These differences between countries may reflect cultural factors or possibly differences in the organisation of treatment services ([49]).

Those being treated for cannabis problems tend to be relatively young; virtually all cannabis clients new to treatment are under 30 years old. Teenagers in specialised drug treatment are more likely to be recorded as having a primary cannabis problem than are clients in other age groups, with cannabis accounting for 65 % of treatment demands among those younger than 15 years and 59 % among those aged 15–19 years ([50]).

There are marked differences between countries in the frequency of cannabis use among new clients. The highest proportions of daily cannabis users are in Denmark and the Netherlands among new cannabis clients, and the highest proportions of occasional users or persons who have not used cannabis in the last month prior to treatment are found in Germany and Greece ([51]), probably reflecting differences in referral to treatment. In Germany, about one third of new cannabis clients use the drug occasionally or have not used it in the month prior to treatment, but elsewhere this group is about 11 % of clients, and about 60 % use it daily.

Seizures and market information

Production and trafficking

In 2003, cannabis continued to be the most widely produced and trafficked illicit drug worldwide. However, the global spread of cannabis production and the difficulty of monitoring it make the estimation of how much is produced problematic (UNODC, 2003a).

Large-scale production of cannabis resin is concentrated in a few countries, in particular in Morocco, while trafficking is widespread across a large number of countries (CND, 2004, 2005). Based on a survey of cannabis production in Morocco carried out by the UNODC and the Government of Morocco (2003), it is estimated that the Rif region accounted for about 40 % of the global production of cannabis resin in 2003 (INCB, 2005). Most cannabis resin consumed in the EU originates in Morocco and enters Europe mainly through the Iberian Peninsula, although the Netherlands represents an important secondary

Interpreting seizures and market data

The number of drug seizures in a country is usually considered to be an indirect indicator of the supply and availability of drugs, although it also reflects law enforcement resources, priorities and strategies, as well as vulnerability of traffickers to national and international supply reduction strategies. Quantities seized may fluctuate widely from one year to the next, for example if in one year a few of the seizures are very large. For this reason, the number of seizures is considered by several countries to be a better indicator of trends. In all countries, the number of seizures contains a high proportion of small seizures at the retail level. The origin and destination of drugs seized may indicate trafficking routes and producing areas, but this information is not always known. The purity and price of drugs sold at retail level are reported by most of the Member States. However, data come from a range of different sources, which are not always comparable or reliable, making accurate comparisons between countries difficult.

([45]) See also the selected issue on cannabis treatment demand in the EMCDDA 2004 annual report (http://ar2004.emcdda.eu.int). Data analysis is based on clients demanding treatment in all treatment centres for the general distribution and the trends, and on outpatient treatment centres for profile of clients and patterns of use.

([46]) See Tables TDI-2 (part ii) and TDI-5 (part ii) in the 2005 statistical bulletin.

([47]) See Tables TDI-4 (part ii) and TDI-5 (part ii) in the 2005 statistical bulletin.

([48]) See Table TDI-3 (part iii) in the 2005 statistical bulletin.

([49]) See Table TDI-22 in the 2005 statistical bulletin.

([50]) See Table TDI-10 (part ii) in the 2005 statistical bulletin.

([51]) See Table TDI-18 (part iv) in the 2005 statistical bulletin.

distribution centre for further transportation to EU countries (Bovenkerk and Hogewind, 2002). Other countries mentioned in 2003 as source countries for the cannabis resin seized in the EU include Albania, Afghanistan, Iran, Pakistan, Nepal and India (Reitox national reports, 2004; INCB, 2005).

Global herbal cannabis production continues to be spread across the world and potential production was estimated as being at least 40 000 tonnes (CND, 2005). Herbal cannabis seized in the EU in 2003 is reported to have originated from a variety of countries including the Netherlands and Albania, but also African countries (Malawi, South Africa, Nigeria) and the USA (Reitox national reports, 2004). In addition, some local (indoor or outdoor) cultivation and production of cannabis products takes place in most of the EU Member States (Reitox national reports, 2004).

Seizures

Worldwide, a total of 1 347 tonnes of cannabis resin and 5 821 tonnes of herbal cannabis were seized in 2003. Western and central Europe (70 %) and south-west Asia and the Near and Middle East (21 %) accounted for most cannabis resin seized, whereas quantities of herbal cannabis seized were concentrated in the Americas (68 %) and Africa (26 %) (CND, 2005). In terms of number of seizures, cannabis is the most seized drug in all countries of the EU except Estonia and Latvia, where in 2003 the number of amphetamine seizures was higher. In terms of quantities, cannabis is also usually the most seized drug in the EU, although in 2003 quantities of other drugs seized were reported to be higher in a few countries — amphetamines in Estonia and Luxembourg, heroin in Hungary and cocaine in Poland. Historically, most cannabis seizures in the EU have been made by the United Kingdom, followed by Spain and France, and this is probably still the case ([52]). However, for the past five years, in terms of quantities, Spain has accounted for more than half the total amount seized in the EU. At the EU level, the number of cannabis seizures ([53]) has shown a more or less upward trend since 1998, though partial reporting of data from a few countries makes this uncertain, while quantities ([54]) seized appear to have risen since 2000.

Price and potency

In 2003, the average retail price of cannabis resin in the European Union varied from EUR 1.40 per gram in Spain to EUR 21.50 per gram in Norway, while the price of herbal cannabis ranged from EUR 1.10 per gram in Spain to EUR 12 per gram in Latvia ([55]).

The potency of cannabis products is determined by their content of tetrahydrocannabinol (THC), the primary active constituent. In 2003, in countries from which data are available, cannabis resin at retail level was reported to have an average THC content that varied from less than 1 % (Poland) to 25 % (Slovakia), while herbal cannabis potency ranged from 1 % (Hungary, Finland) to 20 % (home-grown produced in the Netherlands) ([56]).

([52]) This should be checked against missing 2003 data when available. Data on numbers of cannabis seizures in 2003 were not available for Italy, Cyprus, the Netherlands and Romania; data on both number of cannabis seizures and quantities of cannabis seized in 2003 were not available for Ireland and the United Kingdom.

([53]) See Table SZR-1 (part i) in the 2005 statistical bulletin.

([54]) See Table SZR-2 (part i) in the 2005 statistical bulletin.

([55]) See Table PPP-1 (part i) in the 2005 statistical bulletin.

([56]) See Table PPP-5 (part i) in the 2005 statistical bulletin.

Chapter 4

Amphetamine-type stimulants, LSD and other synthetic drugs

In terms of prevalence of use, in almost all countries some form of synthetic drug is the second most commonly reported substance used. Overall rates of use of these substances in the general population are typically low, but prevalence rates among younger age groups are significantly higher, and the use of these drugs may be particularly high in some social settings and/or among some subcultural groups.

Among the synthetic drugs used in Europe are both stimulants and hallucinogenic substances. Of the latter, lysergic acid diethylamide (LSD) is by far the most well known, but overall consumption levels have been low and somewhat stable for a considerable time. Some evidence is emerging of increasing interest in naturally occurring hallucinogens, and this topic is covered elsewhere in this report.

The term amphetamine-type stimulants (ATS) is used to refer to both the amphetamines and the ecstasy group of drugs. Amphetamines is a generic term used to describe a number of chemically related drugs which stimulate the central nervous system, the two most important of which, in terms of the European illicit drug market, are amphetamine and methamphetamine. Of these, amphetamine is by far the most commonly available, although, globally, levels of methamphetamine use are increasing. To date, significant methamphetamine use in Europe appears to be restricted to the Czech Republic, although sporadic reports from elsewhere underline the importance of monitoring as this is a drug known to be associated with a range of severe health problems.

The best-known member of the ecstasy group of drugs is 3,4-methylenedioxy-methamphetamine (MDMA), but other related analogues are also sometimes found in ecstasy tablets. These drugs are sometimes known as entactogens, meaning to 'touch within', and comprise synthetic substances that are chemically related to amphetamines but which differ to some extent in their effect, as they combine some of the effects more typically found in hallucinogenic substances.

Prevalence and patterns of use

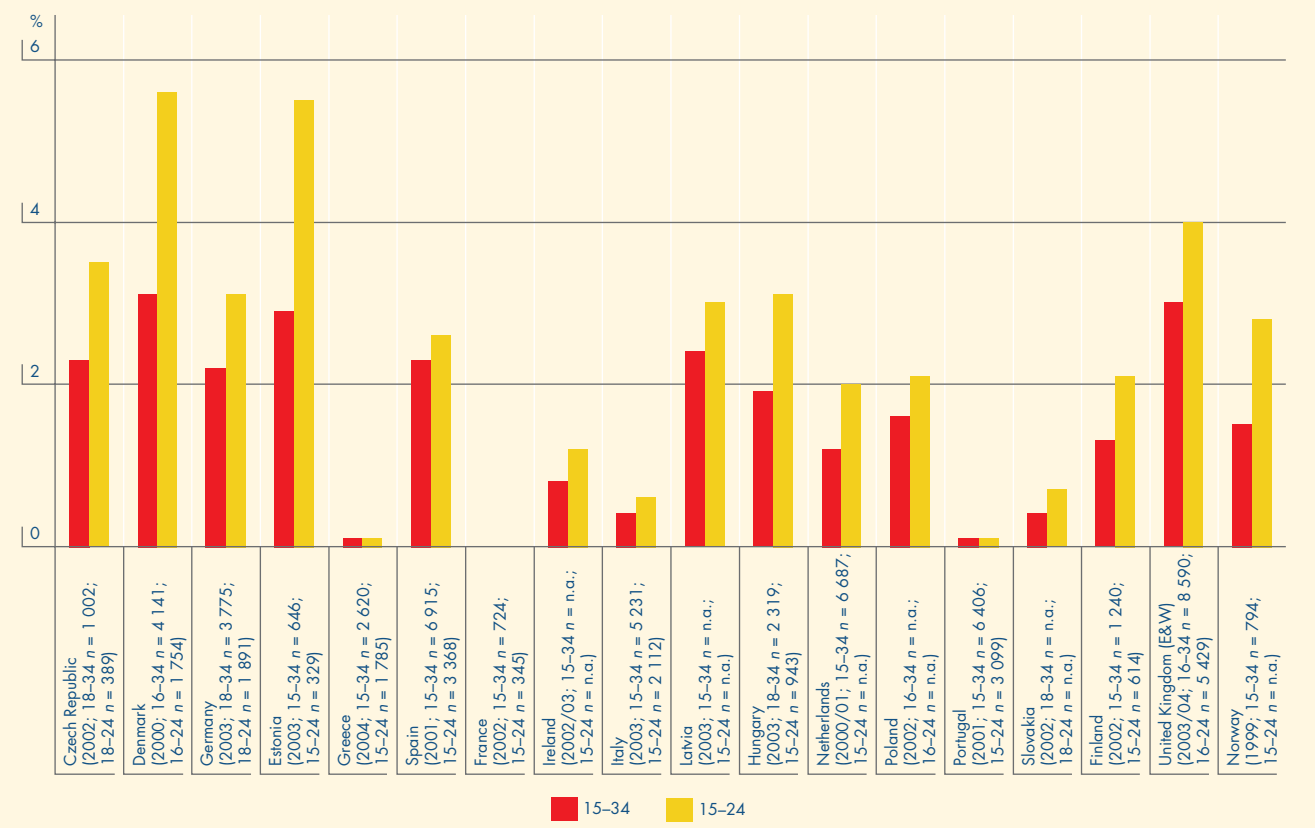
Traditionally, population surveys have shown that, after cannabis, amphetamines are the most commonly used illegal substance, albeit overall prevalence of amphetamine use is clearly lower than that of cannabis. This pattern now appears to be changing in many countries, with ecstasy overtaking amphetamines and taking second place after cannabis in both recent general population surveys and school surveys. For example, the 2003 ESPAD school surveys (Hibell et al., 2004) found that lifetime prevalence estimates for ecstasy use exceeded those for amphetamine in 14 of the EU, Norway and candidate countries ([57]). However, it is worth remembering that ecstasy became popular only during the 1990s, whereas amphetamine use has a longer history. This is reflected in recent adult surveys, which have revealed higher figures for lifetime experience of amphetamine use in 11 countries and for ecstasy use in 10 countries, but higher recent (last 12 months) use of ecstasy in 15 countries and of amphetamines in only five countries (in two countries the reported figures were equal).

According to recent surveys, among all adults (15–64 years), lifetime experience of amphetamine use in EU Member States ranges from 0.1 % to 6 %, except in the United Kingdom, where the figure is as high as 12 %. Recent use is clearly lower, ranging from 0 % to 1.5 %, with Denmark, Estonia and the United Kingdom at the higher end of the scale.

A similar picture emerges among the young adults group (15–34 years) in population surveys, among which group lifetime experience of amphetamine use ranges from 0.1 % to 10 %, with the United Kingdom reporting an exceptionally high rate of 18.4 %. Recent use ranges from 0 % to 3 %, with Denmark, Estonia and the United Kingdom again at the top end of the scale (Figure 6). Although lifetime use figures for the United Kingdom are considerably higher than those found in other countries, the prevalence of recent amphetamine use (use in the last 12 months) is very similar to rates reported in other countries and overall is continuing to fall.

([57]) See Figure EYE-2 (part iv) in the 2005 statistical bulletin.

Figure 6: Recent use (last year) of amphetamines among young adults at selected ages, 15–34 and 15–24, measured by population surveys



NB: Data are from the most recent national surveys available in each country (see Table GPS-4 for the 15–34 age group).
Some countries use a slightly different age range to the EMCDDA standard age range for young adults. Variations in age ranges may to a small extent account for disparities between countries.

Sources: Reitox national reports (2004), taken from population surveys, reports or scientific articles. See also Table GPS-0 in the 2005 statistical bulletin.

New data on the use of amphetamines among 15- to 16-year-old school students are reported in the 2003 ESPAD surveys ([58]). Lifetime prevalence of amphetamine use ranges from less than 1 % to 7 %; the highest national estimates for recent use and current (last 30 days) use of the drug are 4 % and 3 % respectively.

Ecstasy has been tried by about 0.2–6.5 % of the adult population, with figures for most countries lying in the range 1–4 %. Recent use is reported by 0–2.5 % of adults, with the Czech Republic, Spain and the United Kingdom presenting the highest prevalence figures.

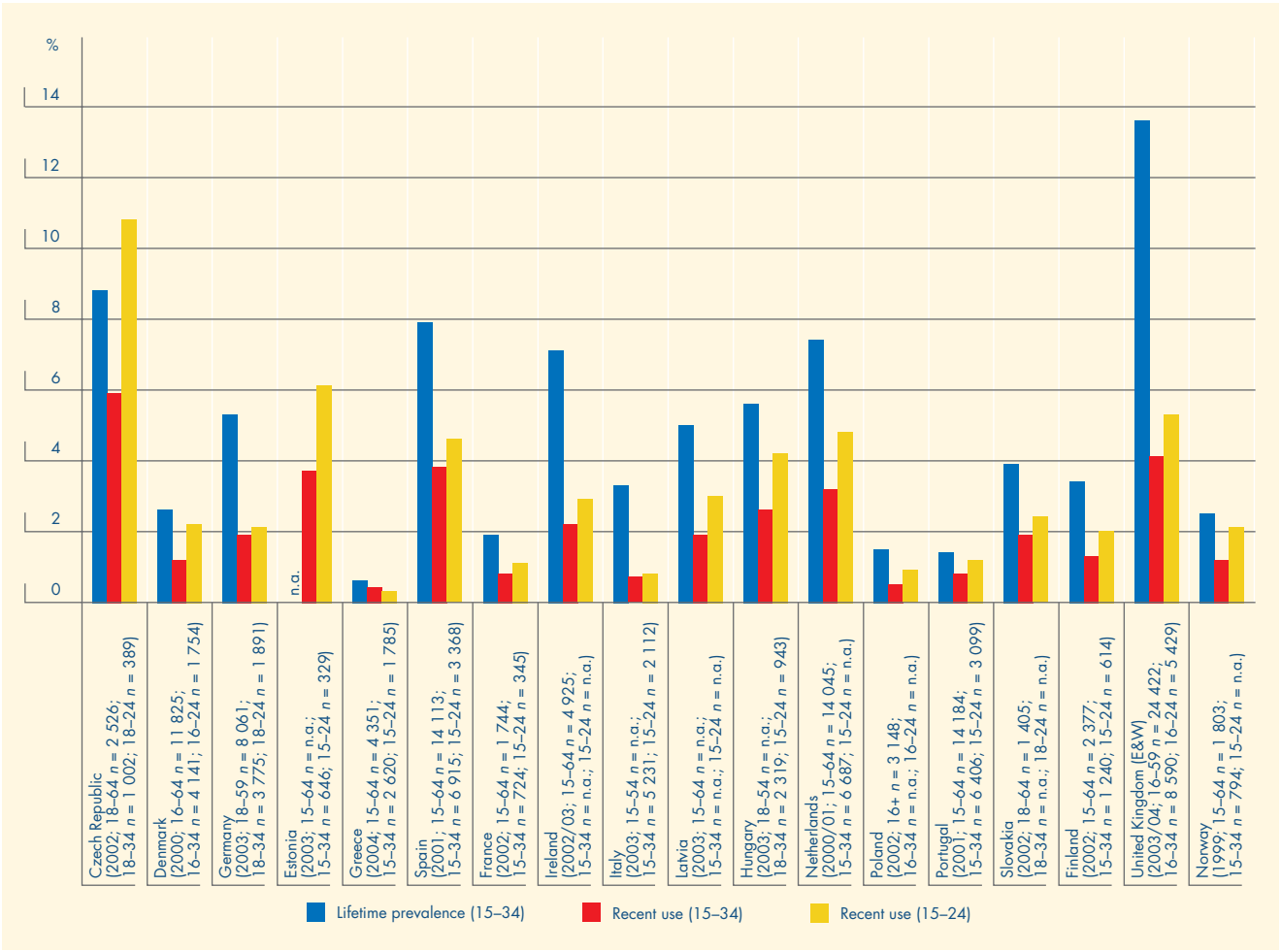
Among young adults (15–34 years), 0.6–13.6 % report experience of ecstasy use. Recent use (last 12 months' prevalence) is reported by 0.4–6 %, with the Czech Republic, Estonia, Spain and the United Kingdom presenting the highest prevalence rates (Figure 7).

As ecstasy use is predominantly a youth phenomenon, it is useful to analyse prevalence rates among rates 15- to 24-year olds and 15- to 16-year-old school students. Among the 15–24 age group, lifetime experience rates range from 0.4 % to 13 %, while recent use figures range from 0.3 % to 11 %. Furthermore, as rates of drug use in this age group are higher in males than in females, most countries report lifetime experience rates among 15- to 24-year-old males in the range 4–16 % and recent use rates among males of 2–8 %. Finally, figures for current use (use in the last 30 days), which would include regular use, were reported by seven countries and ranged from 2 % to 5 %, suggesting that 1 in 20–50 males aged 15–24 years use ecstasy regularly. These figures are likely to be higher in urban areas and, in particular, in people frequenting discos, clubs or dance events (Butler and Montgomery, 2004).

Estimates of prevalence of ecstasy use are considerably lower for 15- to 16-year-old school students than for 15- to 24-year-olds. Lifetime ecstasy prevalence among the school students surveyed ranges from 0 % to 8 %, with even lower rates of recent use (0–4 %) and current use (0–3 %). In most countries, estimates of current use lie between 1 % and 2 %, with little difference between the sexes (Hibell et al., 2004).

([58]) See Chapter 2 for a detailed analysis of the results of the 2003 ESPAD schools survey.

Figure 7: Lifetime prevalence and recent (last year) use of ecstasy among young adults at selected ages, 15–34 and 15–24, measured by population surveys



NB: Data are from the most recent national surveys available in each country (see the 2005 statistical bulletin Tables GPS-2 for lifetime prevalence and GPS-4 for recent use among the 15–34 age group).
Some countries use a slightly different age range to the EMCDDA standard age range for young adults. Variations in age ranges may to a small extent account for disparities between countries.
Sources: Reitox national reports (2004), taken from population surveys, reports or scientific articles. See also Table GPS-0 in the 2005 statistical bulletin.

For comparison, in the 2003 United States national survey on drug use and health (SAMHSA, 2003), 4.6 % of adults (considered to be those aged 12 years and older) reported lifetime experience with ecstasy and 0.9 % reported recent use. Among 18- to 25-year-olds in the same survey, 14.8 % reported lifetime experience, 3.7 % recent use and 0.7 % current use (last month) ([59]).

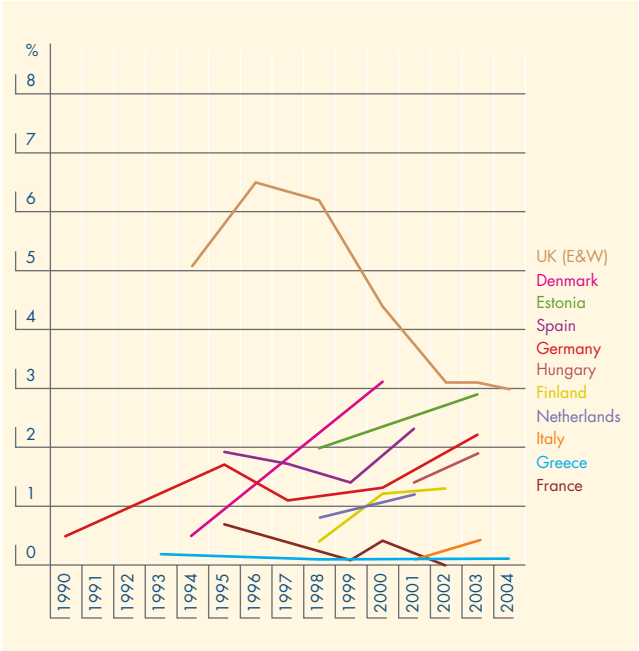
Trends

Population surveys show an increase in recent use of amphetamine (Figure 8) and ecstasy (Figure 9) among young adults in most countries with information for consecutive surveys. For ecstasy, the exceptions are Germany and Greece, where levels have not increased, and the United Kingdom, where use of these drugs has recently stabilised (2002/03), albeit at relatively high levels (Figure 9).

As mentioned above, ecstasy use now exceeds amphetamine use in many countries; however, this is far from representing a decline in amphetamine use. In most countries able to provide information from consecutive surveys, amphetamine use (recent use among young adults) has, in fact, increased. A notable exception is the United Kingdom, where a substantial decrease in amphetamine use has been observed since 1998. This may explain why, in the United Kingdom, lifetime experience prevalence is high compared with the more moderate levels of recent use recorded. It can be speculated that the decrease in amphetamine use has to some extent been compensated by increases in cocaine and ecstasy use (see Figures 8 and 9).

([59]) Note that the age range in the US survey (12 years and over) is wider than the age range reported by the EMCDDA for EU surveys (15–64 years). On the other hand, the age range of young adults (18–25 years) is narrower than the range used in most EU surveys (15–24 years).

Figure 8: Trends in recent use (last year) of amphetamines among young adults (aged 15–34), measured by population surveys ([1])

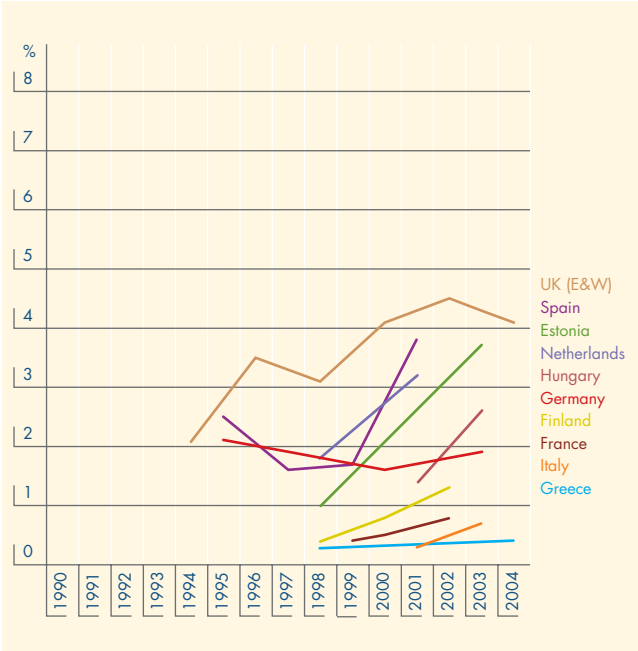


([1]) Sample sizes (respondents) for the 15–34 age group for each country and year are presented in Table GPS-4 in the 2005 statistical bulletin.

NB: Data taken from national surveys available in each country. Figures and methodology for each survey can be consulted in the Table GPS-4 in the 2005 statistical bulletin.
For young adults, the EMCDDA uses the range 15–34 years (Denmark and UK from 16, Germany, Estonia (1998) and Hungary from 18). In France the age range was 18–39 in 1995.

Sources: Reitox national reports (2004), taken from population surveys, reports or scientific articles. See also Table GPS-0 in the 2005 statistical bulletin.

Figure 9: Trends in recent use (last year) of ecstasy among young adults (aged 15–34), measured by population surveys ([1])



([1]) Sample sizes (respondents) for the 15–34 age group for each country and year are presented in Table GPS-4 in the 2005 statistical bulletin.

NB: Data taken from national surveys available in each country. Figures and methodology for each survey can be consulted in Table GPS-4 in the 2005 statistical bulletin.
For young adults, the EMCDDA uses the range 15–34 years (Denmark and UK from 16, Germany, Estonia (1998) and Hungary from 18).

Sources: Reitox national reports (2004), taken from population surveys, reports or scientific articles. See also Table GPS-0 in the 2005 statistical bulletin.

Treatment demand data

Use of ATS is rarely the primary reason for attending drug treatment. However, there are some exceptions: in the Czech Republic, Finland and Sweden, ATS, specifically amphetamines rather than ecstasy, account for anything between 18 % and more than 50 % of all primary treatment demands. In the Czech Republic, more than 50 % of reported treatment demands relate to a primary methamphetamine problem. This is reflected too in new treatment demands, with the addition of Slovakia ([60]). Moreover, 11 % of new European clients demanding treatment and reporting data cite ATS as a secondary drug ([61]).

Comparison of data from 2002 and 2003 reveals that the upward trend in the number of ATS users continued (+3.5 %); between 1996 and 2003, the number of clients seeking treatment for ATS increased from 2 204 to 5 070 in 12 EU countries.

Among new clients seeking treatment at outpatient centres for ATS use, 78.5 % are using amphetamines and 21.4 % MDMA (ecstasy) ([62]). The highest proportion of ecstasy clients are found in Hungary, the Netherlands and the United Kingdom.

Almost one third of ATS users seeking treatment are aged 15–19 years and another third are between 20 and 24 years ([63]). The large majority of ATS clients first use the drug between 15 and 19 years of age ([64]).

Among ATS clients in treatment, there are equal numbers of occasional and daily users. In the countries where the proportion of amphetamine clients is higher, most clients use the drug 2 to 6 times a week ([65]).

The main route of administration of amphetamines and ecstasy is oral (58.2 %); however, around 15 % of clients inject the drug; in some countries, more than 60 % of ATS clients are current injectors of amphetamines (Czech Republic and Finland) ([66]).

([60]) See Tables TDI-4 (part ii) and TDI-5 (part ii) in the 2005 statistical bulletin.
([61]) See Table TDI-24 in the 2005 statistical bulletin.
([62]) See Table TDI-23 in the 2005 statistical bulletin.
([63]) See Tables TDI-11 (part i) and TDI-11 (part v) in the 2005 statistical bulletin.
([64]) See Tables TDI-10 (part i) and TDI-10 (part v) in the 2005 statistical bulletin.
([65]) See Table TDI-18 (part iii) in the 2005 statistical bulletin.
([66]) See Table TDI-17 (part iii) in the 2005 statistical bulletin.

Deaths related to ecstasy

Compared with opiate-related deaths, deaths involving ecstasy are relatively unusual but, in some countries, not negligible, and monitoring of these deaths could be improved. The description 'ecstasy-related death' could mean that ecstasy was mentioned on the death certificate or that it was found in the toxicological analysis (often along with other drugs) ([67]).

Although reporting is not harmonised, data from the 2004 Reitox national reports suggest that deaths involving ecstasy are rare in most EU countries, especially deaths involving ecstasy alone. In 2003, several countries reported ecstasy-associated deaths: Austria (one death involving ecstasy only), Czech Republic (one death probably due to an MDMA overdose), France (eight cases associated with ecstasy), Germany (two cases associated with ecstasy alone and eight involving ecstasy in combination with other drugs — with corresponding figures of 8 and 11 in 2002), Portugal (detected in 2 % of drug-related deaths) and the United Kingdom (ecstasy 'mentioned' on 49 death certificates in 2000, 76 in 2001 and 75 in 2002). The Netherlands reported seven deaths due to acute psychostimulant intoxication, although the substance involved was not reported.

Few countries report data on hospital emergencies involving ecstasy. In Amsterdam, the number of non-fatal emergencies (Dutch national report) attributable to ecstasy use remained stable between 1995 and 2003 (as did those associated with amphetamines), whereas emergencies caused by hallucinogenic mushrooms and gamma-hydroxybutyrate (GHB) increased. In Denmark (national report), the number of hospital contacts attributable to intoxication with stimulants increased from 112 cases in 1999 to 292 cases in 2003; of these hospital contacts, the number associated with ecstasy use increased markedly from 1999 to 2000 but with no clear trend subsequently, whereas the number of contacts associated with amphetamine use increased steadily over the period.

Prevention

Mobile prevention projects are adapting to fragmentation of the 'rave' culture, so that the target group of young recreational drug users may still be reached, for instance through contact points for every 'scene'. Among the countries where pill testing existed, the practice has been discontinued in Germany and Portugal. In the Netherlands, pill testing is carried out only in laboratories, and in France the abandonment of on-site pill testing has been proposed. Among the reasons for these changes are the reduced frequency of adulterated pills in western Europe and continuing concerns over the legality of the practice. In the Czech Republic, however, pill testing projects continued and were, in fact, the subject of media debate.

Prevention in recreational settings

Selective prevention projects in recreational settings are increasingly reported by the new Member States, especially the Czech Republic, Cyprus (mobile information unit in nightlife venues), Hungary (three organisations), Poland and Slovenia.

Typically, the content of interventions remains unchanged and is similar in most Member States, taking the form of anti-drug discos, art performances, theatre, media support (films, cartoons, etc.), seminars, mobile exhibitions and travel experiences (Luxembourg national report).

Structural approaches remain important. In Italy, the Netherlands and Scandinavia, networking is considered a prerequisite for drug prevention, the aim being to influence nightlife culture. To this end, prevention professionals liaise with the owners of premises typically used for recreational drug use (including coffee shops in the Netherlands) and others involved in the nightlife scene, such as doorkeepers and bar staff. In Sweden, such interventions are being rolled out to large cities other than Stockholm. A study of similar schemes in the Netherlands concluded, 'visitors and organisers of parties behave considerably more responsibly on illegal drugs than expected' (Pijlman et al., 2003). Integrated approaches such as these also have the advantage of deflecting public attention away from incidents and medical emergencies involving illegal drugs at large parties and focusing awareness on the overall risks of the club setting. Safer nightlife guidelines fall into this category but are not yet widespread in Europe (Calafat et al., 2003).

Individual online counselling through websites is a relatively new approach adopted in Austria and Germany (www.drugcom.de). Along the same lines, in Austria, e-mail counselling is available at the new Vienna Drug Assistance call centre, and quality standards have been developed (FSW, 2004). However, most drug prevention websites simply provide expert advice and do not include discussion forums, as robust evidence of the effectiveness of such consumer-led peer-to-peer communities does not exist (Eysenbach et al., 2004).

Seizures and market information ([68])

As the United Nations Office on Drugs and Crime (UNODC, 2003a) reports, the production of ATS — 'synthetic drugs including the chemically related amphetamine,

([67]) See EMCDDA annual report 2004 (http://ar2004.emcdda.eu.int/en/page038-en.html) for a more detailed discussion of ecstasy-related deaths.
([68]) See 'Interpreting seizures and market data', p. 41.

methamphetamine and ecstasy' — is difficult to quantify because 'it starts with readily available chemicals, in easily concealed laboratories'. However, the annual global production of ATS is estimated at about 520 tonnes (UNODC, 2003b). Global seizures of ATS peaked in 2000 at 46 tonnes and, following a subsequent decline, increased again, to 34 tonnes, in 2003 (CND, 2004, 2005).

Amphetamine

Based upon the number of laboratories dismantled, worldwide amphetamine production remains concentrated in Europe. In 2003, amphetamine laboratories were uncovered in eight EU countries (Belgium, Germany, Estonia, Lithuania, Luxembourg, the Netherlands, Poland, the United Kingdom). Most of the amphetamine seized in the EU in 2003 originated from the Netherlands, followed by Poland and Belgium. In addition, there are reports of amphetamine being produced in Estonia and Lithuania and then targeted at Nordic countries. Trafficking in amphetamine remains mainly intraregional (Reitox national reports, 2004; CND, 2005).

Similarly, most amphetamine seizures are made in Europe. Western and central Europe accounted for 82 % of the total amount of amphetamine seized worldwide in 2003, with eastern and south-eastern Europe accounting for 13 % and countries in the Near and Middle East for 3 % (CND, 2005). Over the last five years, the main amphetamine-seizing country in the EU has been the United Kingdom ([69]). In the EU as a whole, the number of amphetamine seizures ([70]), which had previously shown an increasing trend, peaked in 1998, while quantities of amphetamine seized ([71]) peaked in 1997. Numbers of amphetamine seizures increased again in 2001 and 2002 but, based on trends in countries from which data are available, they may have stabilised or decreased in 2003. Quantities seized have been fluctuating also, but seem to be on the increase since 2002 ([72]).

In 2003, average amphetamine prices at user level varied from less than EUR 10 per gram in Belgium, Estonia, Greece, Latvia, Hungary, the Netherlands and Slovakia to EUR 37.5 per gram in Norway ([73]). The average retail purity of amphetamine in 2003 ranged from 7.5 % (Germany) to 50 % (Norway) ([74]).

Methamphetamine

At a global level, the most important ATS in terms of quantities manufactured and trafficked is methamphetamine. In 2003 the greatest quantities continued to be produced and seized in east and south-east Asia (China, Myanmar, the Philippines, Thailand), followed by North America (United States) (CND, 2005). Methamphetamine production in Europe is on a much smaller scale. In 2003, clandestine methamphetamine laboratories were detected and reported by the Czech Republic, Germany, Lithuania and Slovakia (Reitox national reports, 2004; CND, 2005). In the Czech Republic, production of methamphetamine has been reported since the early 1980s (UNODC, 2003a); most is destined for local consumption, although some of it is smuggled to Germany and Austria (Czech national report, 2004). In 2003, the Czech authorities reported an increase in the production of 'pervitin' (local methamphetamine) from branded pharmaceutical products as a result of a lack of ephedrine (the precursor of methamphetamine) on the local black market. Although data on methamphetamine seizures are not systematically collected by the EMCDDA, the Czech Republic, Germany, Lithuania and Norway report having made such seizures in 2003. In addition, Denmark reported that methamphetamine is increasingly common in the illicit drug market, and Latvia reported an increased quantity (0.8 tonnes) of ephedrine seized in 2003 (compared with 2002) (Reitox national reports, 2004).

In 2003, the retail price of 'pervitin' in the Czech Republic was reported to range from EUR 16 to EUR 63 per gram ([75]), while purity varied between 50 % and 75 % ([76]).

Ecstasy

Globally, Europe remains the main centre of ecstasy production, although its relative importance appears to be declining as ecstasy manufacture has spread to other parts of the world in recent years, notably to North America and east and south-east Asia (CND, 2005; INCB, 2005). In 2003, the number of ecstasy laboratories detected worldwide decreased (CND, 2005); in the EU, such laboratories were reported to have been uncovered in Belgium, Estonia, Lithuania and the Netherlands (Reitox

([69]) This situation should be checked against 2003 UK data when available. Data on numbers of amphetamine seizures in 2003 were not available for Italy, Cyprus, the Netherlands and Romania; data on both number of amphetamine seizures and quantities of amphetamines seized in 2003 were not available for Ireland and the United Kingdom.
([70]) See Table SZR-7 (part i) in the 2005 statistical bulletin.
([71]) See Table SZR-8 (part i) in the 2005 statistical bulletin.
([72]) This should be checked against missing 2003 data — in particular for the United Kingdom — when available.
([73]) See Table PPP-4 (part i) in the 2005 statistical bulletin.
([74]) See Table PPP-8 (part i) in the 2005 statistical bulletin.
([75]) See Table PPP-4 (part i) in the 2005 statistical bulletin.
([76]) See Table PPP-8 (part i) in the 2005 statistical bulletin.

national reports, 2004; CND, 2005). Ecstasy seized in the EU is reported to originate mainly from the Netherlands, followed by Belgium, although Estonia and the United Kingdom are also mentioned as source countries (Reitox national reports, 2003).

Ecstasy trafficking is still strongly concentrated in western Europe, although, like production, trafficking has spread throughout the world in recent years (UNODC, 2003a). In terms of quantities seized, in 2003 western and central Europe accounted for 58 %, followed by Oceania with 23 % (CND, 2005). In 2002, the Netherlands, for the first time, overtook the United Kingdom as the EU country seizing most ecstasy ([77]).

The number of ecstasy seizures ([78]) at EU level increased rapidly over the period 1998–2001. However, since 2002 numbers of seizures have decreased and, based upon trends in countries from which data are available, this decline seems likely to have continued in 2003. Quantities of ecstasy intercepted ([79]) increased steeply from 1998 to 2000 and since then at a slower pace. In 2003, however, quantities seized decreased in most of the countries reporting data. However, the apparent decline in EU ecstasy seizures (both numbers and quantities) in 2003 has to be confirmed against missing 2003 data — in particular from the United Kingdom — once they are available.

In 2003, the average cost of an ecstasy tablet at street level varied from less than EUR 5 (Hungary, the Netherlands) to EUR 20–30 (Greece, Italy) ([80]).

In 2003, most tablets sold as illicit drugs were found, when analysed, to contain only ecstasy (MDMA, the active substance) and ecstasy-like substances (MDEA, MDA) as the psychoactive ingredients. This was the case in Denmark, Spain, Hungary, the Netherlands, Slovakia and Norway, where more than 95 % of tablets analysed contained these substances. However, two countries, Estonia and Lithuania, reported that a high percentage (94 % and 76 % respectively) of tablets analysed contained amphetamine and/or methamphetamine as the only psychoactive substances. The MDMA content of ecstasy tablets varies greatly from batch to batch (even among those with the same logo) both between and within countries. In 2003, the average MDMA content of ecstasy tablets ranged from 54 to 78 mg ([81]). Other psychoactive substances found in tablets sold as ecstasy in 2003 included MDA, MDE, PMA, PMMA, DOB, 5-MeO-DIPT, 4-MTA and 1-PEA (Reitox national reports, 2004).

LSD

LSD is manufactured and trafficked to a much smaller extent than ATS. Until 2000, most EU seizures of LSD occurred in the United Kingdom, but since then Germany ([82]) has accounted for the highest number of seizures ([83]). Over the period 1998–2002, at EU level, both the number of LSD seizures ([84]) and the quantities ([85]) seized decreased steadily — except for a plateau in 2000. However, in 2003, for the first time in nine years, both the number of LSD seizures and amounts intercepted increased. Exceptionally high quantities were seized in Spain, France and Poland. This might point to a revival of LSD trafficking (and possibly use) in the EU. In 2003, the average cost to users of a unit of LSD ranged from EUR 4 in the United Kingdom to EUR 25 in Italy ([86]).

Early-warning system information

The principal aim of the European early-warning system (EWS) in the framework of the EU 1997 joint action on new synthetic drugs ([87]) is the rapid collection, analysis and exchange of information on new synthetic drugs as soon as they appear on the European drug scene. The EWS comes under the auspices of the EMCDDA through the Reitox network, and operates in close cooperation with

([77]) This should be checked against missing 2003 data when available. Data on numbers of ecstasy seizures in 2003 were not available for Italy, Cyprus, the Netherlands and Romania; data on neither number of ecstasy seizures nor quantities of ecstasy seized in 2003 were available for Ireland and the United Kingdom.

([78]) See Table SZR-9 (part iv) in the 2005 statistical bulletin.

([79]) See Table SZR-10 (part i) in the 2005 statistical bulletin.

([80]) See Table PPP-4 (part i) in the 2005 statistical bulletin.

([81]) This range is based on data from a few countries only, namely Denmark, Germany, France, Luxembourg and the Netherlands.

([82]) The small number of LSD seizures should be noted in order to avoid overinterpreting variations from one year to another.

([83]) This should be checked against missing 2003 data when available. Data on numbers of LSD seizures in 2003 were not available for Italy, Cyprus, the Netherlands and Poland; data on both number of LSD seizures and quantities of LSD seized in 2003 were not available for Ireland, Malta, Slovenia, the United Kingdom, Bulgaria and Romania.

([84]) See Table SZR-11 (part i) in the 2005 statistical bulletin.

([85]) See Table SZR-12 (part i) in the 2005 statistical bulletin.

([86]) See Table PPP-4 (part i) in the 2005 statistical bulletin.

([87]) The 1997 joint action concerning the information exchange, risk assessment and the control of new synthetic drugs (OJ L 167, 25.6.1997) defines new synthetic drugs as 'synthetic drugs that are not currently listed in any of the Schedules to the 1971 United Nations Convention on Psychotropic Substances, which pose a comparable serious threat to public health as the substances listed in Schedules I or II thereto, and which have a limited therapeutic value'. It relates to end products as distinct from precursors.

Europol, which provides relevant law enforcement information through its network of national units (ENUs).

In 2004, the EMCDDA was notified by Member States of six new synthetic drugs, bringing the total number of monitored substances to more than 25. These include ring-substituted phenethylamines (mostly from the 2C group as well as TMA-2, 4-MTA, PMMA, etc.), tryptamines (such as DMT, AMT, DIPT and various derivatives) and piperazines (including BZP, mCPP). Information on various other substances, including some cathinones (such as substituted pyrrolidines), was also collected and exchanged. However, the European Commission and the European Council were not asked to sanction a risk assessment of any new substance because there was insufficient evidence of individual/public health or social risks.

Ketamine and GHB, both of which underwent risk assessment in 2000, continue to be monitored through the EWS. Although there are indications that use of these two substances in recreational settings could spread significantly, the available evidence is not yet sufficient to quantify prevalence or identify trends at EU level.

Ketamine identifications were reported from Belgium, Denmark, Greece, France, Hungary, the Netherlands, Sweden, the United Kingdom and Norway. Most of the seizures were of white powder, but France and the United Kingdom also reported seizures/acquisitions of ketamine in liquid form. The highest numbers of detections in body fluids and specimens were reported by Sweden and Norway (51 and 30 respectively), but neither country distinguished between medical and illegal use.

GHB identifications, including seizures of its precursors GBL and 1,4-BD (chemicals that are commercially widely available), were reported from Belgium, the Czech Republic, Denmark, Estonia, France, the Netherlands, Sweden, Finland, the United Kingdom and Norway. GHB has been seized in both powder and liquid form.

In the last two months of 2004, several cases of intoxication due to consumption of cocaine adulterated with relatively high doses of atropine ([88]) were reported in Belgium, France, Italy, and the Netherlands. As soon as the risk of combined cocaine/atropine intoxication became apparent, the EMCDDA issued an alert to the EWS partners, advising them to inform their networks and, in particular, the relevant health authorities on the signs of cocaine/atropine intoxication so that it can be diagnosed at an early stage. As a result, several Member States also chose to release early warnings to their networks or public health authorities.

In May 2005, the EWS was further strengthened through a Council Decision (2005/387/JHA) that replaced the 1997 joint action. The Council decision extends the scope of action to all new psychoactive substances (both narcotic drugs and synthetic drugs). In addition, the mechanism allows for the inclusion of medicinal products in the exchange of information on new psychoactive substances.

International action against production and trafficking of synthetic drugs

Increasingly, EU and international cooperation has recognised the importance of monitoring and control of the precursor chemicals necessary for the production of controlled substances. By increasing the vigilance on chemicals necessary for the production of drugs like heroin, cocaine and ecstasy, measures can be implemented to disrupt or inhibit supply. Currently, there are three major international programmes in this area: Operation Purple, concerned with potassium permanganate, used in the production of cocaine; Operation Topaz monitoring international trade in acetic anhydride, a precursor used in the production of heroin; and Project Prism, which is focused on backtracking investigations into seizures of precursors of amphetamine-type stimulants at ports of entry or illicit drug laboratory sites. A total of 20 227 transactions have been notified to the INCB and examined under these operations during the past two years and some evidence exists that these actions have impacted on drug production.

Project Prism is particularly important in consideration of the production of synthetic drugs within the EU. This is a challenging area in which to work because among the large number of chemicals that can be used for the production of ATS are many substances that are required for or are by-products of legitimate commercial activities. Areas of interest to the Prism project include the monitoring of international trade in safrole, used in the production of ecstasy; preventing diversion of pharmaceutical preparations containing pseudoephedrine; and locating laboratories involved in the illicit manufacture of 1-phenyl-2-propanone. Despite the difficulties of working in this area, Project Prism appears to have facilitated better international cooperation, resulting in successful interdiction activities. An example of which, noted by the INCB (2005) in their recent report, was the cooperation between China and Poland that led to the identification of a major case of smuggling of 1-phenyl-2-propanone into Poland.

([88]) Atropine, an anticholinergic agent, is a naturally occurring alkaloid of *Atropa belladonna*. Severe intoxication may be fatal.

Measures against production and trafficking of synthetic drugs in Europe

In accordance with the implementation plan on actions to be taken in regard to the supply of synthetic drugs, the Commission, in cooperation with Europol, prepared a report in December 2003 describing the current status of major multilateral projects on the mapping of distribution networks and of experiences gained in this field at EU level, in the Member States and in candidate countries. The report pointed out the key elements in such projects that appear to be essential to the achievement of operational benefits. It also concluded that there is 'potential benefit of combining information and intelligence from a variety of synthetic drug related areas within an inclusive and integrated strategy.'

In December 2004, Europol merged Projects CASE and Genesis to form project Synergy, comprising an analytical work file (AWF) supported by 20 Member States and some third states, the Europol Illicit Laboratory Comparison System (EILCS) and the Europol Ecstasy Logo System (EELS). The project continues to support the Comprehensive Action against Synthetic Drugs in Europe (CASE), a Swedish initiative on amphetamine profiling, plus the European Joint Unit on Precursors (EJUP), comprising experts from six Member States.

The AWF component provides for the collection and analysis of high-level synthetic drug- and precursor-related criminal intelligence. Priority is given to investigating criminal groups and/or significant modi operandi.

The EILCS collates photographic and technical information from synthetic drug production sites and related chemical waste dumps, enabling the investigation of links between seized equipment, materials and chemicals, initiating information exchange, back-tracking investigations, forensic examination for evidential purposes plus the identification and targeting of facilitators and associated criminal groups. Europol, via the EILCS, is the European focal point for 'Project Prism — Equipment', the United Nations INCB global back-tracking programme on tableting machines and other synthetic drug production equipment.

The EELS collates modus operandi, photographic and basic forensic information on significant seizures, enabling the identification of matches between seizures, and with seized punches, initiating law enforcement information exchange, further investigation and forensic profiling for evidential purposes and the targeting of criminal groups.

The *Europol synthetic drug production equipment catalogue* and *Europol ecstasy logo catalogue* are updated and published on a regular basis.

Chapter 5

Cocaine and crack cocaine

Prevalence and patterns of cocaine use

According to recent national population surveys, between 0.5 % and 6 % of the adult population report having tried cocaine at least once (i.e. lifetime prevalence), with Italy (4.6 %), Spain (4.9 %) and the United Kingdom (6.8 %) being at the upper end of this range. Recent cocaine use (last 12 months) is, in general, reported by less than 1 % of adults; in most countries, the range is between 0.3 % and 1 %. In Spain and the United Kingdom, recent prevalence rates are higher than 2 %.

Although cocaine prevalence figures are much lower than comparable figures for cannabis, levels of use among younger adults can be higher than the population average. Lifetime experience among 15- to 34-year-olds ranges from 1 % to 11.6 %, with the highest levels again being found in Spain (7.7 %) and the United Kingdom (11.6 %). Recent use ranges between 0.2 % and 4.6 %, with Denmark, Ireland, Italy and the Netherlands all having rates of about 2 %; in Spain and the United Kingdom the figure is over 4 %.

Cocaine use is higher among males. For instance, surveys from Denmark, Germany, Spain, Italy, the Netherlands and the United Kingdom found that, among males aged 15–34 years, lifetime experience was between 5 % and 13 %. In six countries, recent use was higher than 3 %, with Spain and the United Kingdom reporting rates of 6–7 % (Figure 10).

Among the general population, cocaine use either is discontinued after a period of experimentation during young adulthood or is occasional, occurring mainly at weekends and in recreational settings (bars and discos). But, in some countries, some forms of regular use may be not negligible. Current use (in the last 30 days) is reported by 1.5–4 % of young males (15–34 years old) in Spain, Italy, the Netherlands and the United Kingdom. In urban areas, rates of cocaine use are likely to be substantially higher.

In a recent multicity study, the vast majority (95 %) of what were defined as socially integrated users (recruited in discos, clubs or private contacts) snorted cocaine; only a small fraction had ever smoked or injected the substance (Prinzleve et al., 2004).

A very rough estimate of recent use (last year prevalence) of cocaine, assuming an average prevalence of about 1 % of all adults, will give a figure of between 3 and 3.5 million people in Europe. Rates of current use result in a rough estimate of about 1.5 million users ([89]).

As a point of comparison from outside Europe, in the 2003 United States national survey on health and drug use (SAMHSA, 2003), 14.7 % of adults (12 years or older) reported lifetime experience of cocaine use and 2.5 % reported having used cocaine during the previous 12 months ([90]). Among 18- to 25-year-olds, the figures were 15 % (lifetime), 6.6 % (last 12 months) and 2.2 % (last month). For males aged 18–25 years, the figures were 17.4 %, 8.2 % and 2.9 % respectively. Overall, the lifetime prevalence of cocaine use is greater among the general population in the USA than in the higher prevalence countries in Europe. However, this difference is not as apparent for more recent use measures, with some European countries now reporting estimates in excess of the American figures.

Trends in cocaine use

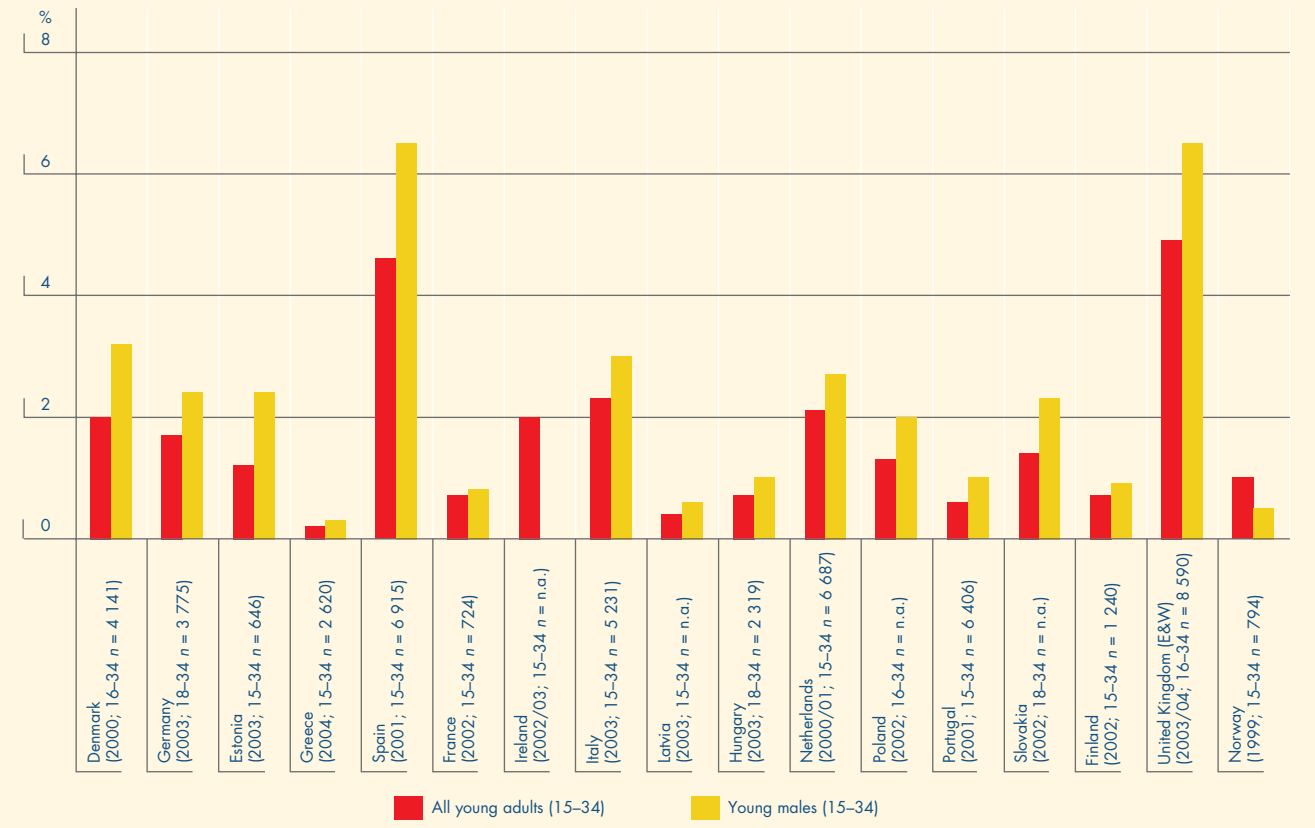
Clear-cut European trends in cocaine use, based on population studies, are still difficult to identify (see section on cannabis trends). However, warnings about increases in cocaine use in Europe have come from several sources, including local reports, focused studies conducted in dance settings, reports of increases in seizures indicators and some increases in indicators related to problems (deaths, emergencies).

Recent cocaine use among young people increased substantially in the United Kingdom from 1996 until 2000,

([89]) These very rough estimates are simply based on taking prevalence values in the middle of the range of national prevalence rates (see Table GPS-1 in the 2005 statistical bulletin). Note that several countries with large populations (Germany, Spain, Italy, the Netherlands and the United Kingdom) have comparatively high prevalence rates, in several cases higher than the range used for the computation.

([90]) Note that the age range in the US survey (12 years and over) is wider than the age range reported by the EMCDDA for EU surveys (15–64 years). On the other hand, the range 18–25 years is narrower than the range used in most EU surveys (15–24 years).

Figure 10: Recent use (last year) of cocaine among all young adults and among young males, measured by national surveys



NB: Data are from the most recent national surveys available in each country (see Table GPS-4 in the 2005 statistical bulletin). Some countries use a slightly different age range to the EMCDDA standard age range for young adults. Variations in age ranges may to a small extent account for disparities between countries.

Sources: Reitox national reports (2004), taken from population surveys, reports or scientific articles. See also Table GPS-0 in the 2005 statistical bulletin.

but has remained relatively stable since then, although moderate increases have been observed in recent years, and in Spain ([91]) from 1999 to 2001. Less marked increases were observed in Denmark, Italy, Hungary, the Netherlands and Austria (in local surveys) and, with oscillations over the 1990s, in Germany (Figure 11).

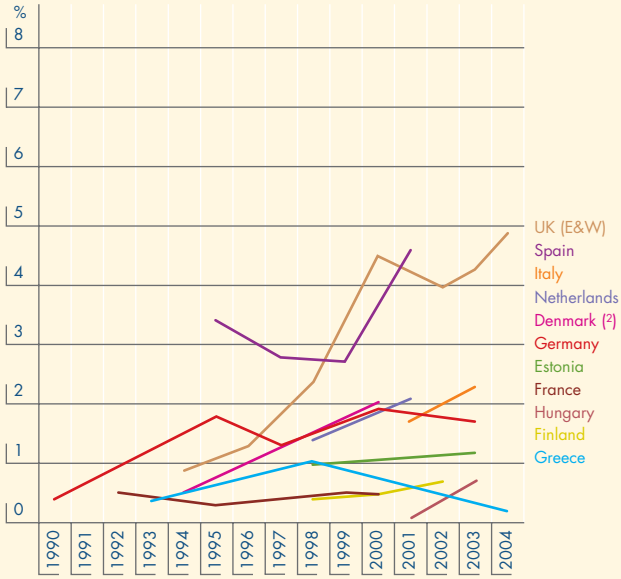
Deaths related to cocaine

There have been growing concerns about the health risks of cocaine use, particularly because of the trend of increasing recreational use observed in some countries, especially in settings (discos, clubs) frequented by youth groups. Despite the difficulties in estimating the number of cocaine-related deaths, this measure may act as a valuable indicator of increased risk or help to identify risky patterns of use. Although acute deaths in which cocaine is present without opiates seem to be infrequent in Europe, it is likely that current statistics are inadequate in recording cocaine-related deaths. The information that is available about cocaine deaths at the European level is limited and is reported in different forms. Cocaine use is frequent among opiate users, and it is common to find cocaine in toxicological analyses of cases of opiate overdoses, in addition to other substances such as alcohol and benzodiazepines.

Several countries reported information about cocaine deaths in 2003 (Reitox national reports): Germany (25 cases involving cocaine alone and 93 involving cocaine in combination with other drugs; in 2002, the corresponding figures were 47 and 84), France (10 deaths due to cocaine alone and one associated with a medicine), Greece (two cases due to cocaine), Hungary (four deaths due to cocaine overdose), the Netherlands (17 deaths due to cocaine in 2003, with an increasing trend between 1994, two cases, and 2002, 37 cases), Austria (cocaine was found in 30 % of drug-related deaths, but alone in only three cases and in one case in association with gas), Portugal (cocaine was found in 37 % of drug-related deaths) and the United Kingdom ('mentions' of cocaine in death certificates increased from 85 in 2000, to 115 in 2001 and 171 in 2002, with an eightfold increase over the period 1993–2001). In its 2003 Reitox national report,

([91]) Information that arrived too late to be included in the report suggests a stabilisation in 2003 surveys (last-year prevalence among young adults 4.8 % compared with 4.6 % in 2001).

Figure 11: Trends in recent use (last year) of cocaine among young adults (aged 15–34), measured by population surveys ([1])



([1]) Sample sizes (respondents) for the 15–34 age group for each country and year are presented in Table GPS-4 in the 2005 statistical bulletin.
([2]) In Denmark, the value for 1994 corresponds to 'hard drugs'.
NB: Data taken from national surveys available in each country. Figures and methodology for each survey can be consulted in Table GPS-4 in the 2005 statistical bulletin.
For young adults, the EMCDDA uses the range 15–34 years (Denmark and UK from 16, Germany, Estonia (1998) and Hungary from 18). In France the age range was 25–34 in 1992 and 18–39 in 1995.
Sources: Reitox national reports (2004), taken from population surveys, reports or scientific articles. See also Table GPS-0 in the 2005 statistical bulletin.

Spain reported that, in 2001, cocaine was present in 54 % of all drug-related deaths; in 39 cases (8 % of all drug-related deaths) death occurred in the absence of opiates, of which 21 were caused by cocaine only and five were caused by cocaine and alcohol.

Despite the limitations of the available information, cocaine seems to have played a determinant role in between 1 % and 15 % of drug-related deaths in countries that were able to make the differentiation between drug types causing death, with several countries (Germany, Spain, France and Hungary) reporting figures of around 8–12 % of drug-related deaths. Although it is very difficult to extrapolate these results to the whole of Europe, this could mean several hundreds of cocaine-related deaths per year at EU level. Although the numbers are much lower than deaths caused by opiates, cocaine-related death is a serious and possibly increasing problem; in the few countries where trends can be estimated, they tend to show an increase.

In addition, cocaine may be a contributing factor in deaths due to cardiovascular problems (arrhythmias, myocardial infarction and cerebral haemorrhages; see Ghuran and Nolan, 2000), particularly in users with predisposing conditions, and many of these deaths may pass unreported.

Treatment demand data ([92])

After opiates and cannabis, cocaine is the most common drug reported as the principal drug used by those entering drug treatment and accounts for about 10 % of all treatment demands across the EU. However, this overall figure reflects a wide variation between countries: in most countries treatment demands related to cocaine use are quite low, but in Spain and the Netherlands the proportion of all clients who ask for treatment for cocaine use is 26 % and 38 % respectively ([93]). In most countries, the percentages of new clients demanding treatment for primary cocaine use are higher than for all clients overall ([94]). Cocaine is also reported as a secondary drug by 13 % of new clients seeking treatment in outpatient treatment centres ([95]).

Many countries report increases in cocaine use among clients seeking treatment; from 1996 to 2003, the proportion of new clients demanding treatment for cocaine use grew from 4.8 % to 9.3 %, and the number of new clients asking for treatment for primary cocaine use rose from 2 535 to 6 123. In the Netherlands, in 2003, for the first time, new clients demanding treatment for cocaine use exceeded those demanding treatment for opiate use. From an analysis of treatment data produced in London, during the period 1995/96 to 2000/01, the number of clients using cocaine more than doubled (GLADA, 2004), albeit from a low baseline (735 to 1 917).

These data are probably influenced by a small but growing crack cocaine (smokable cocaine base) problem, of which there have been indications from both the Netherlands and the United Kingdom, where the number of crack cocaine clients has increased in recent years. Although the numbers of problematic users are low, they tend to be concentrated in a few major urban areas and therefore are most visible in reports from city-based monitoring.

Crack cocaine users tend to have a different social background from users of cocaine powder. Crack cocaine users are more likely to be socially disadvantaged, and

([92]) Data analysis is based on clients demanding treatment in all treatment centres for the general distribution and the trends, and on outpatient treatment centres for profiles of clients and patterns of use.
([93]) See Table TDI-5 (part ii) in the 2005 statistical bulletin. Data for Spain refer to 2002.
([94]) See Table TDI-4 (part ii) in the 2005 statistical bulletin.
([95]) See Table TDI-24 in the 2005 statistical bulletin.

there is some evidence to suggest that ethnic minority populations may be particularly vulnerable to crack cocaine problems: two thirds of black people requesting drug treatment in London are primary crack cocaine users (GLADA, 2004) and 30 % of crack cocaine clients in the Netherlands have a non-Dutch background. Despite worries about crack cocaine, it should be remembered that, although the drug is associated with particular damage to both the individuals who use it and the communities in which they live, this problem remains highly localised in Europe. It should be noted that crack cocaine clients are mainly reported by two countries (the Netherlands and the United Kingdom).

Overall, most cocaine treatment demands in Europe are not related to crack cocaine. Around 70 % of new cocaine clients are using cocaine hydrochloride (cocaine powder) (most sniffing the drug) and the remaining 30 % are using crack cocaine. Around 5 % of new cocaine clients report injecting cocaine.

New clients asking for treatment for primary cocaine use are predominantly males (3.7:1 male to female ratio). Differences between countries are found in the gender distribution ([96]). A qualitative research study carried out in Italy on clients requesting treatment for use of stimulants, mainly cocaine, reports that women almost equal men among consumers, but among people demanding treatment for cocaine and other stimulants the male to female ratio is strongly biased towards males (Macchia et al., 2004).

New clients using cocaine as the primary drug are on average older than other drug consumers (mean age of 30 years, with most in the 20–34 year age group); a smaller, although important, proportion of clients is reported to be between 35 and 39 years ([97]).

Cocaine is often used in combination with another subsidiary drug, often cannabis (40 %) or alcohol (37 %). Local studies of drug injectors suggest that, in some areas, the combination of heroin and cocaine within an injection is becoming more popular (sometimes referred to by drug injectors as 'speedballing'). If this is the case, it is not evident in the overall treatment demand data from most countries, in which only a small proportion of clients report the combined use of heroin and cocaine. However, this is not true for all countries; for example, in the Netherlands, an analysis of treatment demand data for cocaine users suggests that many cocaine clients are polydrug consumers and that the largest group is composed of those using both cocaine and heroin (Mol et al., 2002).

Treatment of problem cocaine use

There is no well-established and widespread pharmacological treatment available for users with cocaine problems as there is for those suffering from opiate drug problems. Medicines for systematic relief may sometimes be prescribed to cocaine users, but they are usually short-lived and targeted at reducing problems related to cocaine use, for example anxiety or sleep disturbances. Longer-term treatment options for cocaine users are generally carried out within generic drug services. However, overall treatment options for those with cocaine problems appear to be poorly developed (Haasen, 2003). This may be starting to change as some countries begin to develop new treatment responses targeting those with cocaine problems, an example being the development of specific services for crack cocaine use being developed in England (NTA, 2003).

Most of the scientific literature on treating cocaine problems is from American studies and therefore may not reflect the European context. Unfortunately, evaluation of treatment for problem cocaine use remains scarce in the EU, in part simply reflecting the fact that, historically, cocaine problems were encountered relatively rarely by treatment services. One European systematic review of literature on cocaine treatment (Rigter et al., 2004) noted that treatment compliance by problem cocaine users is generally low and relapse rates are high. Some evidence exists that psychotherapy could help to reduce consumption, and no strong evidence was found for the effectiveness of acupuncture for treating cocaine problems. However, overall, these findings should be viewed in the context of simply an absence of a strong European evidence base to guide therapeutic interventions in this area. For example, it is not even clearly known whether specific cocaine-targeted interventions are more effective than enrolling those with cocaine problems in more generic non-drug-specific treatment programmes. Furthermore, it remains an open question whether it is possible to develop a pharmacological treatment for problem cocaine users that can become the 'standard treatment option' in the way that methadone and buprenorphine have become standard approaches in the treatment of problem opiate use. It should be noted that there are important differences in the mechanisms by which opiate drugs and stimulants such as cocaine act on the body, which means that therapeutic options to treat drug problems are likely to differ. Some interesting work is currently being conducted in the USA to develop interventions that would temporarily block the effect of

([96]) See Table TDI-22 in the 2005 statistical bulletin and *Differences in patterns of drug use between women and men* (http://www.emcdda.eu.int/?nnodeid=7293).

([97]) See Table TDI-10 (part i) in the 2005 statistical bulletin.

cocaine use on the user, and it will be interesting to see whether new treatment options become available from this work in the future.

Reducing health-related harm

Over the past few years, measures aimed at the prevention and reduction of health-related harm associated with the use of cocaine and crack cocaine have increased rapidly, and new cocaine and crack-specific information has been produced, especially on the Internet. Telephone helplines in Belgium, France and Portugal have received more information requests about cocaine and crack cocaine use than ever before, although the percentage of these calls still remains far lower than those concerning legal drugs and cannabis. More training on how to respond adequately to problems arising from cocaine and crack cocaine use in a number of settings where this is a recent phenomenon (the weekend scene in Dublin or the techno-scene in Vienna) is available for staff working at drug services.

Specialised counselling and offers of treatment for cocaine and crack cocaine users exist in big urban centres, for example in Frankfurt (Suchthilfezentrum Bleichstrasse: www.drogenberatung-jj.de), Barcelona (Hospital Vall d'Hebron: www.vhebron.es), Vienna (ChEck iT!: www.checkyourdrugs.at) and London (www.cracklondon.org.uk).

Seizures and market information ([98])

Production and trafficking

Colombia is by far the largest source of illicit coca in the world, followed by Peru and Bolivia. Global production of cocaine in 2003 has been estimated at 655 tonnes, to which Colombia contributed 67 %, Peru 24 % and Bolivia 9 % (CND, 2005). Most of the cocaine seized in Europe comes directly from South America (Colombia) or via Central America and the Caribbean. In 2003, Brazil and Venezuela, in particular, were reported as transit countries for cocaine imported into the EU, alongside Argentina, Costa Rica and Curaçao (Reitox national reports, 2004; CND, 2005). Other transit areas were southern and western Africa (INCB, 2005). The main points of entry into the EU remained Spain, the Netherlands and Portugal (Reitox national reports, 2004; CND, 2005; INCB, 2005).

Seizures

Seizures data indicate that cocaine is the third most trafficked drug in the world after herbal cannabis and cannabis resin. In terms of volume seized — 490.5 tonnes worldwide in 2003 — most trafficking in cocaine continued in 2003 to be in the Americas (82 %) and Europe. The latter accounted for 17 % of total cocaine quantities seized worldwide, an increase compared with the previous year (CND, 2005). Within Europe, most quantities of cocaine seized are recovered in the western states. In the last five years, Spain has consistently been the EU country with the highest level of cocaine seizures. In 2003, it accounted for more than half the EU total of both number of seizures and quantities seized ([99]).

Over the period 1998–2002, the number of cocaine seizures ([100]) increased in all countries except Germany and Portugal. Over the same period, quantities of cocaine seized in the EU ([101]) fluctuated, although the trend has been upward. However, based upon trends in countries from which data are available, numbers of cocaine seizures at the EU level seem to have decreased in 2003 (notably in Spain), whereas amounts of cocaine seized rose substantially (especially in Spain and the Netherlands). Seizures of particularly large amounts of cocaine appear to have been made in 2003 in the EU.

Although seizures of crack cocaine have been reported by some EU countries, they are sometimes not distinguishable from cocaine seizures. Thus, the trends in cocaine seizures reported above might include crack cocaine.

Price and purity

The average price ([102]) of cocaine at retail level varied widely across the EU in 2003, from EUR 34 per gram in Spain to EUR 175 per gram in Norway.

Compared with heroin, the average purity of cocaine at user level is high, varying in 2003 from 32 % in the Czech Republic and Germany to 83 % in Poland ([103]).

([98]) See 'Interpreting seizures and market data', p. 41.

([99]) This should be checked against missing 2003 data when available. Data on numbers of cocaine seizures in 2003 were not available for Italy, Cyprus, the Netherlands and Romania; data on both number of cocaine seizures and quantities of cocaine seized in 2003 were not available for Ireland and the United Kingdom.

([100]) See Table SZR-5 (part i) in the 2005 statistical bulletin.

([101]) See Table SZR-6 (part i) in the 2005 statistical bulletin.

([102]) See Table PPP-3 (part i) in the 2005 statistical bulletin.

([103]) See Table PPP-7 (part i) in the 2005 statistical bulletin. Note that the average purity estimates of cocaine in the Czech Republic and Poland in 2003 are based on small numbers of samples (n = 5 and 6 respectively).

Chapter 6
Heroin and injecting drug use

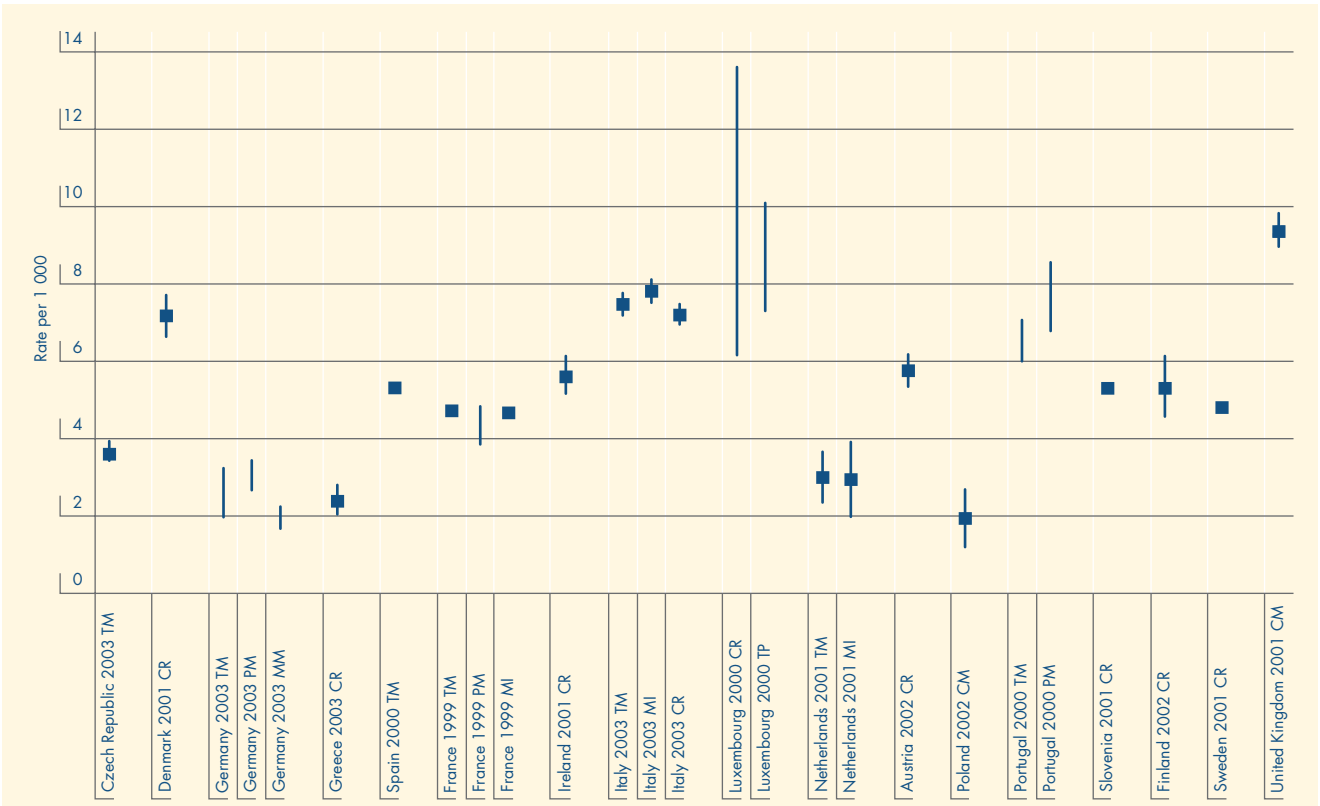
The regular and sustained use of heroin, drug injecting and, in some countries, the intensive use of stimulants account for a substantial proportion of drug-related health and social problems in Europe. The number of individuals exhibiting this kind of behaviour is low relative to the population overall, but the impact of problem drug use is considerable. To help understand the scale of this problem and to allow trends to be monitored over time, the EMCDDA is working with the Member States to redefine the concept of 'problem drug use' and to develop strategies to measure both its scale and its impact.

Problem drug use

Problem drug use (PDU) is defined operationally as 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines' ([104]). Variations in definitions and methodological uncertainties mean that obtaining reliable estimates in this area is difficult, and caution should be used when interpreting differences between countries or over time.

Problem drug use can be subdivided into important groupings. A general distinction can be made between

Figure 12: Estimates of the prevalence of problem drug use, 1999–2003 (rate per 1 000 population aged 15–64)



NB: CR, capture–recapture; TM, treatment multiplier; PM, police multiplier; MI, multivariate indicator; TP, truncated Poisson; CM, combined methods. For more details see Tables PDU-1, PDU-2 and PDU-3 in the 2005 statistical bulletin. The symbol indicates a point estimate and a bar indicates an uncertainty interval, which can be either a 95 % confidence interval or an interval based on sensitivity analysis (see Table PDU-3). Target groups may vary slightly owing to different methods and data sources; therefore comparisons should be made with caution. The Spanish estimate does not include problem cocaine use; a higher estimate is available in Tables PDU-2 and PDU-3, which takes this group into account but which may not be as reliable.

Sources: National focal points. See also EMCDDA (2003).

([104]) For more detail, see the methodological notes on problem drug use in the 2005 statistical bulletin.

heroin use, which has historically accounted for most PDU in the majority of EU countries, and problem use of stimulants, which predominates in Finland and Sweden, where the majority of problem drug users are primary amphetamine users. Similarly, in the Czech Republic, methamphetamine users have traditionally formed a significant proportion of problem drug users.

Problem drug use is becoming more diverse. For example, polydrug use problems have become progressively more important in most countries, whereas some countries where opiate problems have historically predominated now report changes towards other drugs. In Spain, estimates of problem opiate users are declining, and an increase has been observed in cocaine-related drug problems; however, reliable time trends of PDU that include problematic cocaine use are not available. Germany and the Netherlands report an increasing proportion of crack cocaine users among their problem drug populations, although the overall estimate of problem drug users in the Netherlands remains unchanged.

Prevalence

Estimates of the prevalence of problem drug use at national level over the period 1999–2003 range between two and ten cases per 1 000 population aged 15–64 (based on midpoints of estimates) or up to 1 % of the adult population ([105]). Prevalence appears to differ greatly between countries, although when different methods have been used within one country the results are largely consistent. Higher estimates are reported by Denmark, Spain, Ireland, Italy, Luxembourg, Austria, Portugal and the United Kingdom (6–10 cases per 1 000 inhabitants aged 15–64 years), and lower rates are reported by Germany, Greece, the Netherlands and Poland (fewer than four cases per 1 000 inhabitants aged 15–64 years) (Figure 12). Among the new countries of the EU and the candidate countries, well-documented estimates are available from only the Czech Republic, Poland and Slovenia, where figures are in the low to middle range at 3.6, 1.9 and 5.3 per 1 000 population aged 15–64 respectively. The weighted average rate of PDU in the EU is probably between four and seven cases per 1 000 population aged 15–64 years, which works out at 1.2–2.1 million problem drug users in the EU, of whom some 850 000 to 1.3 million are active injectors. However, these estimates are far from robust and will need to be refined as more data become available from the new Member States.

Local and regional estimates suggest that the prevalence of PDU can vary greatly between cities and regions. The highest local prevalence estimates in the period 1999–2003 are reported from Ireland, Portugal and the United Kingdom, with rates per 1 000 reaching 16 (Dublin), 17 (Beja), 24 (Aveiro) and 25 (parts of London), up to 29 (Dundee) and 34 (Glasgow) (Figure 13). Geographic variability is, however, marked at the local level, with prevalence in another part of London being estimated at 6 per 1 000. This suggests the need to increase the availability of reliable local prevalence estimates in many other countries, where particularly high (or low) local or regional prevalence rates may exist but are not being measured.

Although there have been considerable improvements in estimation techniques, a lack of reliable and consistent historical data complicates the assessment of trends in problem drug use. Reports from some countries of changes in estimates that are supported by other indicator data suggest that there has been an increase in PDU since the mid-1990s (EMCDDA, 2004a); however, in some countries, this appears to have stabilised in more recent years. Repeated estimates are available for 1999 to 2003 from 16 countries (counting Denmark and Sweden, both with data from 1998–2001, and the United Kingdom, where data are for 1996–2001). Of these 16 countries, six reported an increase in PDU estimates (Denmark, Austria, Finland, Sweden, United Kingdom and Norway), five reported a stable prevalence or a decrease (Czech Republic, Germany, Greece, Ireland and Slovenia) and five (Spain, Italy, Luxembourg, the Netherlands and Portugal) reported different trends depending on the estimation method used, which may partly refer to different target groups among problem drug users ([106]).

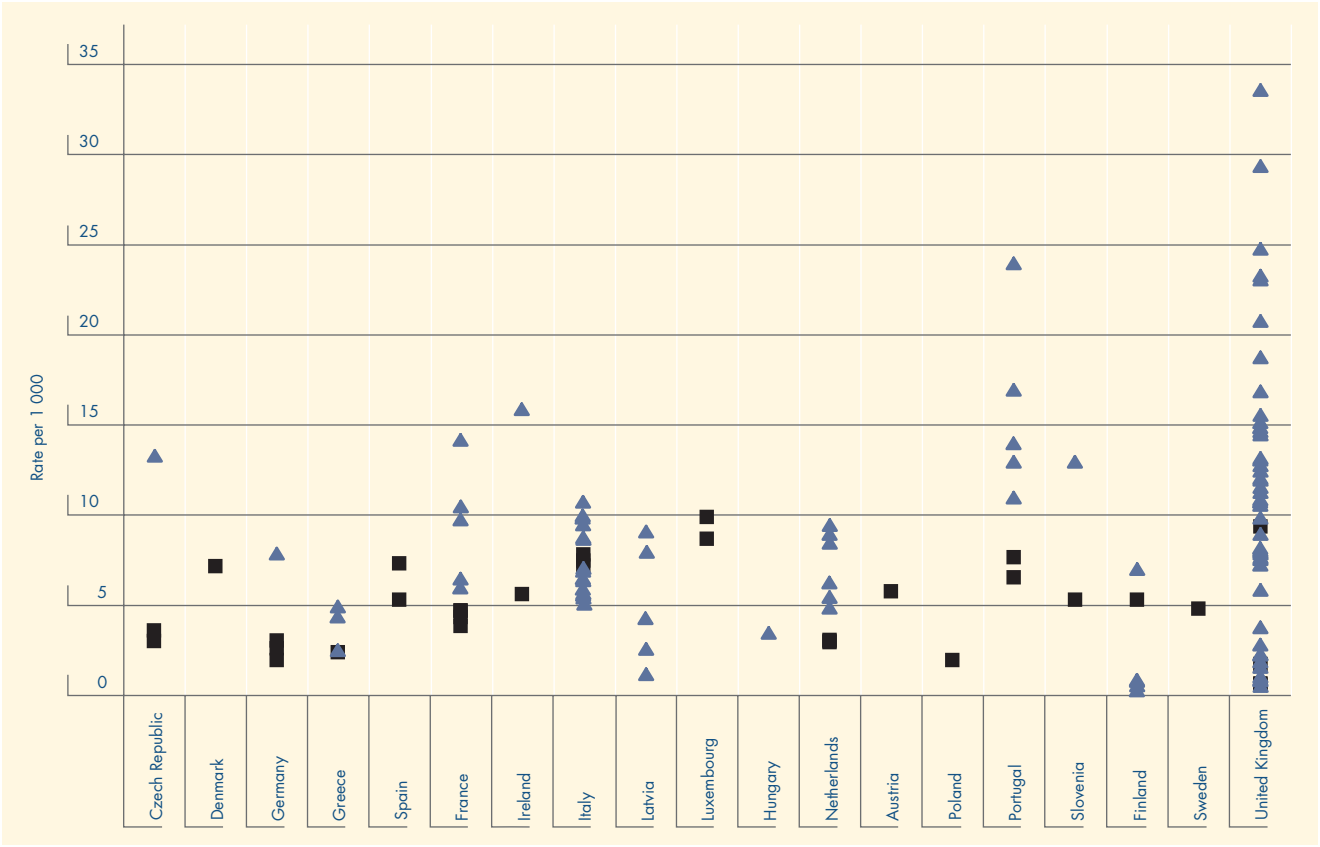
Drug injecting

Injecting drug users (IDUs) are at very high risk of experiencing adverse consequences. It is therefore important to consider drug injection separately, as a core category of PDU.

Despite its importance for public health, few countries provide national or local estimates of injecting drug use. Available national-level estimates range between one and six cases per 1 000 population aged 15–64, suggesting important differences between countries in the prevalence of IDU ([107]). Luxembourg reports the highest national estimates of IDU, with rates of about six cases per 1 000 population aged 15–64, whereas Greece reports the lowest IDU estimate, with just over one case per 1 000. Although prevalence estimates for injecting drug use are scarce, there is evidence of increasing prevalence after

([105]) See Table PDU-1 in the 2005 statistical bulletin.
([106]) See Figure PDU-4 in the 2005 statistical bulletin.
([107]) See Figure PDU-2 in the 2005 statistical bulletin.

Figure 13: National and local estimates of the prevalence of problem drug use, 1999–2003 (rate per 1 000 population aged 15–64)



NB: Black square = samples with national coverage; blue triangle = samples with local/regional coverage.
Target groups may vary slightly owing to different methods and data sources; therefore comparisons should be made with caution. For more details see Tables PDU-1, PDU-2 and PDU-3 in the 2005 statistical bulletin. The pattern of local prevalence estimates depends much on availability and location of studies; however, if available, local estimates can suggest that prevalence is different from the national average in specific cities or regions.
Sources: National focal points. See also EMCDDA (2003).

1999 in Norway, while in Portugal different estimation methods suggest different trends ([108]).

Analysis of injecting rates among heroin users in treatment suggests marked differences in rates between countries as well as varying trends over time ([109]). In some countries (Spain, the Netherlands and Portugal), a relatively small proportion of heroin users inject, whereas in most other countries injection of heroin is still the norm. In some long-standing EU countries from which data are available (Denmark, Greece, Spain, France, Italy and the United Kingdom), rates of injecting among heroin users in treatment have declined. However, in most of the new Member States, at least where data exist, almost all heroin users in treatment are injectors.

Treatment demand data

Of the total treatment requests made, 60 % are known to be for opiate treatment, although in many cases the primary drug is not recorded — and over half (54 %) of these opiate clients are known injectors, with 10 % being of unknown injecting status. Opiates are also reported to be the secondary drug for around 10 % of new clients ([110]).

In many countries, opiates (largely heroin) remain the principal drug for which clients seek treatment, but relevant differences are found between countries. Dividing the EU countries broadly into three groups, depending on the extent to which the treatment population is characterised by those with heroin problems, shows the following:

- below 40 % — Czech Republic, the Netherlands, Poland, Finland, Sweden;
- 50–70 % — Denmark, Germany, Spain, Ireland, Cyprus, Latvia, Slovakia, Romania;
- over 70 % — Greece, France, Italy, Lithuania, Luxembourg, Malta, Slovenia, United Kingdom, Bulgaria ([111]).

([108]) See Figure PDU-5 in the 2005 statistical bulletin.
([109]) See Figure PDU-3 in the 2005 statistical bulletin.
([110]) See Table TDI-24 in the 2005 statistical bulletin.
([111]) See Table TDI-5 (part ii) in the 2005 statistical bulletin.

The prevalence of opiate clients who continue in treatment for many years is reported to be increasing, while the incidence of new opiate treatment demands is decreasing (Reitox national reports, 2004; Drug Misuse Research Division, 2004). For some countries, trends in heroin use among new clients in treatment can be tracked from 1996 to 2003, and these show an overall decline in absolute numbers seeking treatment.

The relative contribution of opiate treatment to the size of the new-to-treatment population has decreased more markedly, owing to an increase in the number of reported clients with problems primarily related to other drugs. This, in turn, may be due to a switch from heroin to cocaine use by some opiate clients (Ouwehand et al., 2004), differentiation of the treatment system, which has become more accessible for other problematic drug users, or the reduced recruitment of new problem users (Dutch national report).

Differences in this trend in the last decade are found between countries, with a strong decrease in heroin clients in Denmark, Germany, the Netherlands, Slovakia and Finland and some increase in the United Kingdom and Bulgaria ([112]).

Data analysis on new clients attending outpatient treatment centres allows a more detailed description of the profile of opiate users. There are 2.8 men for every woman asking for new treatment for primary opiate use; however, gender ratios vary considerably by country, from 5:1 to 2:1, with the exceptions of Cyprus, where the male to female ratio is very high (11:1), and Sweden, where it is very low (0.9:1) and women outnumber men among opiate users ([113]).

Most opiate users are aged between 20 and 34 years, and in the age group 30–39 years more than half the clients seek treatment for opiate use. The reported trend is towards an ageing opiate clientele; for example, in the Netherlands around 40 % of new opiates clients are over 40 years old. The exceptions are Slovenia and Romania, where a very young population (15–19 years) of opiate clients is found ([114]).

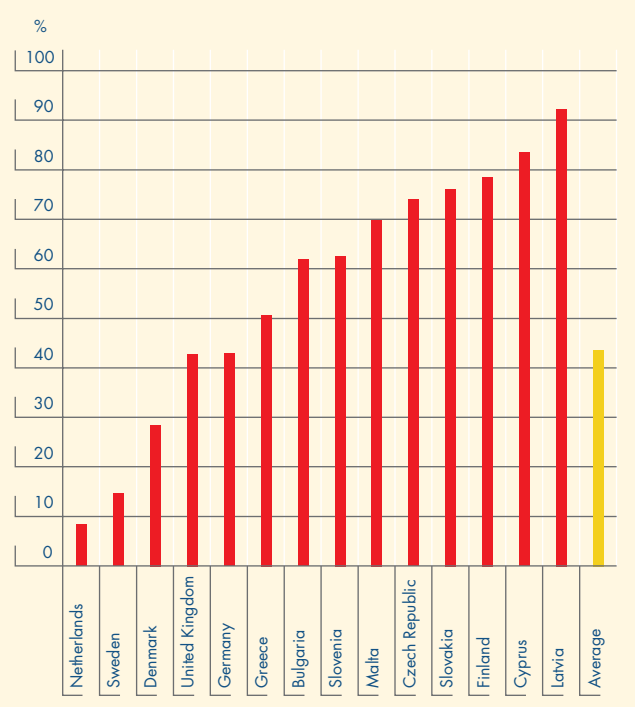
Most opiate clients report having used opiates for the first time when they were between 15 and 24 years old, with around 50 % of clients first using the drug before the age of 20 ([115]). Comparing the age at first use with the age at first treatment, the time lag between first use and first demand for treatment is generally between 5 and 10 years. An early age at onset of opiate use is often associated with a range of behavioural problems and social deprivation (United Kingdom national report).

In most countries, between 60 % and 90 % of opiate clients use the drug daily, whereas some clients have not used opiates in the last month or used them only occasionally; this is probably explained by clients stopping use of the drug before entering treatment ([116]).

Forty per cent of clients inject the drug and another 40 % smoke or inhale it. Differences in the method of use are reported between old and new Member States ([117]) (Figure 14), with the proportion of opiate injectors being higher than 60 % in the new Member States and lower than 60 % in the old Member States (with the exception of Finland, where the proportion of opiate injectors among clients is 78.4 %). The proportion of injectors among opiate clients is lowest in the Netherlands (8.3 %) ([118]).

Many new clients use opiates as well as another drug, often cannabis (47 %) or alcohol (24 %). However,

Figure 14: New outpatient clients injecting opiates as a proportion of the total number of new opiates clients by country, 2003



NB: Only countries where there are clients with opiates as primary drug and/or countries supplying data are reported.
Source: Reitox national reports (2004).

([112]) See Table TDI-3 (part i) in the 2005 statistical bulletin.
([113]) See Table TDI-22 in the 2005 statistical bulletin.
([114]) See Table TDI-10 (part iii) in the 2005 statistical bulletin.
([115]) See Table TDI-11 (part ii) in the 2005 statistical bulletin.
([116]) See Table TDI-18 (part i) in the 2005 statistical bulletin. Only Germany reports 70 % of new clients using opiates occasionally or not having used them in the last month.
([117]) Only countries for which data were available.
([118]) See Table TDI-17 (part i) in the 2005 statistical bulletin.

marked differences are found between countries: in the Czech Republic and Slovakia, almost half the clients use opiates together with stimulants other than cocaine; in Greece and Malta, 18 % and 29 % of clients, respectively, use opiates with cocaine as a secondary drug; in Finland, among opiate users (mainly users of buprenorphine) 37 % report the use of hypnotics and sedatives (mainly benzodiazepines) as secondary drugs ([119]).

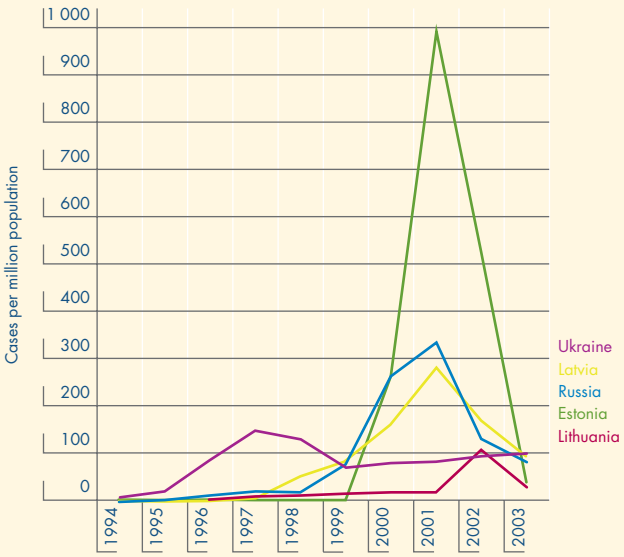
Drug-related infectious diseases

HIV and AIDS in eastern Europe

Human immunodeficiency virus (HIV) has shown massive and recent epidemic spread among IDUs in Russia and the Ukraine, as it has in the EU Member States of the Baltic region. In 2001, the rate of newly diagnosed infections related to intravenous drug use peaked in Estonia and in the Russian Federation, at 991 and 333 cases per million population respectively. However, in the Ukraine, the peak was reached earlier in 1997, at 146 cases per million, as a result of widespread IDU-related transmission, after which rates of new IDU-related HIV diagnoses declined but more recently have increased again.

The incidence of AIDS among IDUs is increasing rapidly in Latvia and the Ukraine, suggesting that access to and coverage of antiviral treatment is probably insufficient (see 'Highly active antiretroviral therapy in the WHO European region', p. 65).

HIV infections newly diagnosed in injecting drug users in selected EU countries, Russia and Ukraine, by year of report



Source: European Centre for the Epidemiological Monitoring of AIDS (EuroHIV) (2004).

HIV and AIDS

Recent trends in reported HIV cases

HIV has shown strong epidemic spread among IDUs in the new EU Member States of the Baltic region, following massive epidemics in eastern Europe (EuroHIV, 2004) (see box 'HIV and AIDS in eastern Europe'). Rates of newly diagnosed cases peaked in Estonia and Latvia in 2001, and in Lithuania in 2002, but more recently rates have fallen dramatically. This pattern is typical of HIV epidemics among IDUs. It arises because the core group of IDUs at highest risk all become infected in a short period of time, following which incidence falls because of a lack of susceptible IDUs and then stabilises at a level that depends on the rate of recruitment of new IDUs at high risk. However, an additional effect of behaviour change cannot be excluded and, if true, this could in part be the result of specific interventions (see 'Prevention of drug-related infectious diseases', p. 66).

In the EU-15 countries, rates of newly diagnosed HIV cases have remained low in recent years, with the exception of Portugal. However, comparisons at the EU level are incomplete as HIV case reporting data remain unavailable (Spain and Italy) or are only starting to become available (France) for some of the countries most affected by AIDS. Portugal showed a very high rate of 88 per million in 2003, but also a large decrease since 2000 (when the rate was 245 per million). This decrease has to be interpreted with caution as European data reporting was only implemented in Portugal in 2000.

HIV seroprevalence

Seroprevalence data from IDUs (per cent infected in samples of IDUs) are an important complement to HIV case reporting data. Repeated seroprevalence studies and routine monitoring of data from diagnostic tests can validate trends in case reporting and can also provide more detailed information on specific regions and settings. However, the prevalence data are from a variety of sources that, in some cases, may be difficult to compare, and they should therefore be interpreted with caution.

The recent increases recorded in the HIV case reporting are mostly confirmed by the available seroprevalence data; for example, in Latvia, prevalence in national treatment samples of tested IDUs rose from 1.5 % (5/336) in 1997 to 14 % (302/2 203) in 2001 and then fell to 7 % (65/987) in 2003. In Austria, where HIV case reporting data for IDUs are not available, HIV prevalence among national samples of (direct) drug-related deaths suggests some increase, to 7 % (11/163) in 2003 from

([119]) See Table TDI-25 (part ii) in the 2005 statistical bulletin. See also the selected issue on buprenorphine. Each client may report the use of up to four secondary drugs.

1 % (1/117) in 1998, but numbers are small and the trend is not statistically significant.

In 2002 and 2003, HIV prevalence among IDUs, mostly those in drug treatment, showed wide variation within and between countries, ranging from 0 % in Bulgaria, Hungary, Slovenia and Slovakia to a maximum of 37.5 % (54/144) in one city in Italy (2003, Bolzano — users in treatment and prisons) ([120]). The highest prevalence rates in national samples (over 10 % in 2002–03) were found in Italy, Latvia and Portugal ([121]); in Spain, data for 2001 suggest a very high prevalence, but more recent data are lacking ([122]). The highest prevalence rates in regional and local samples (over 20 % in 2002–03) were reported from Spain, Italy, Latvia and Poland ([123]), although recent data have not been provided from some countries and areas with high prevalence in previous years. In Latvia and Poland, local studies suggest recent transmission of HIV, based on the very high prevalence among young IDUs ([124]). In the case of the Polish study, this recent transmission is confirmed by a prevalence of 23 % among a sample of 127 new injectors ([125]).

Time trends in prevalence also differ between countries. Although there have been recent outbreaks in the Baltic region, HIV seroprevalence data from samples of IDUs suggest a decrease since the mid-1990s in some of the most affected countries (Spain, France and Italy), followed by a stabilisation in recent years ([126]). However, if seroprevalence is high and stable, transmission is likely to continue. Data for new IDUs strongly suggest ongoing, and even increased, transmission in Spain between 1999 and 2000. In some other countries (France 2001–03, Portugal 1999–2000) local and regional data on new and young IDUs suggested some (increased) transmission, but sample sizes are too small for the trends to be statistically significant ([127]). On the other hand, it should be noted that in several countries HIV prevalence among IDUs remained very low during 2002–03. HIV prevalence was less than 1 % in the Czech Republic, Greece (national data), Hungary, Slovenia, Slovakia, Finland, Romania (data for only 2001), Bulgaria and Norway (data for Oslo). In some of these countries (e.g. Hungary), both HIV prevalence and hepatitis C virus (HCV) prevalence are among the lowest in the EU, suggesting low levels of injecting risk (see section 'Hepatitis B and C' below).

Highly active antiretroviral therapy in the WHO European region

WHO estimates of the coverage of highly active antiretroviral therapy (HAART) suggest that, in the EU and most of central Europe, over 75 % of persons in need of treatment have access to HAART.

However, among the Baltic states, coverage is estimated to be 'poor' in Estonia and Lithuania (25–50 %) and 'very poor' in Latvia (under 25 %). Coverage is estimated to be 'very poor' in most countries of eastern Europe.

Coverage estimates specific for IDUs are not available, but studies have shown that IDUs are often at higher risk of inadequate access to HAART than people infected by other routes.

Source: WHO Regional Office for Europe, Health for All Database (www.euro.who.int/hfadb) (accessed 8 March 2005).

AIDS incidence

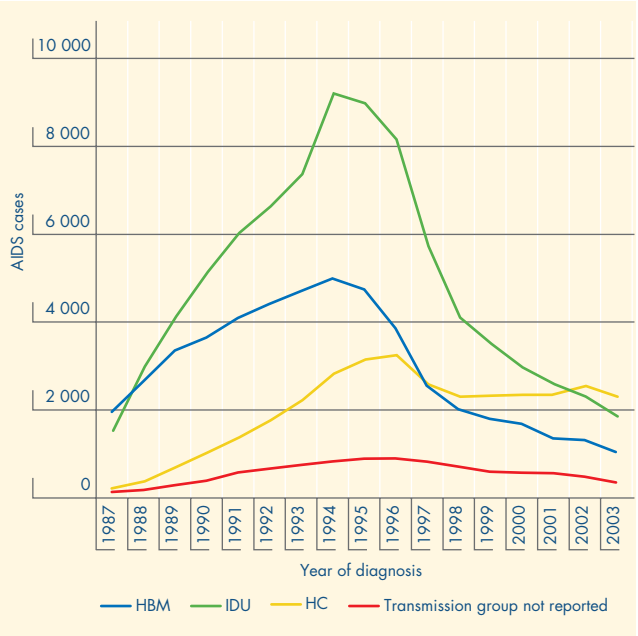
In Latvia, the incidence of AIDS related to IDU increased from zero cases in 1997 to an estimated 19 cases per million population in both 2002 and 2003 ([128]). However, the EU country with the highest incidence remains Portugal, with 33 cases per million, although this figure has been decreasing since 1999. AIDS incidence due to IDU in the EU peaked in the early 1990s and declined thereafter. The most affected country used to be Spain, where incidence peaked at 124 cases per million in 1994, but by 2003 this figure had declined to an estimated 16 per million.

The decline in AIDS incidence in the late 1990s is the result of the introduction in 1996 of highly active antiretroviral therapy (HAART), which prevents the development of AIDS in people infected with HIV (see box on HAART). In the case of IDUs, HIV prevention measures may also have played an important role and, in some countries, a decrease in the number of injectors may have been a factor (see 'Drug injecting', p. 61).

Annual incidence data show that, until 2002, the greatest number of new cases of AIDS in the EU could be attributed to intravenous drug use; subsequently, this mode of

([120]) See Figure INF-3 in the 2005 statistical bulletin.
([121]) The data for Italy and Portugal are not limited to IDUs and may thus underestimate prevalence among IDUs.
([122]) See Tables INF-1 and INF-8 in the 2005 statistical bulletin.
([123]) See Table INF-8 in the 2005 statistical bulletin.
([124]) IDUs aged under 25: 33 % infected among 55 young IDUs in Poland and 20 % among 107 young IDUs in Latvia.
([125]) See Table INF-10 and Figures INF-4 and INF-5 in the 2005 statistical bulletin.
([126]) See Figure INF-16 in the 2005 statistical bulletin.
([127]) See Figures INF-26 and INF-27 in the 2005 statistical bulletin.
([128]) See Figure INF-1 in the 2005 statistical bulletin.

Figure 15: AIDS cases by transmission group and year of diagnosis (1987–2003) adjusted for reporting delays, EU



NB: Data shown for the three main transmission groups and for cases with no transmission group reported.
HBM, homosexual and bisexual men; IDU, injecting drug users; HC, heterosexual contact.
Countries not included are France, the Netherlands (data not available for the whole period) and Cyprus (no data available).
Source: EuroHIV; data reported by 31 December 2003.

transmission was overtaken by heterosexual sex, reflecting changes in the epidemiology of HIV in the preceding years (Figure 15). It should be noted, however, that infection patterns can differ greatly between individual countries ([129]).

Hepatitis B and C

The prevalence of antibodies against hepatitis C virus (HCV) among IDUs is, in general, extremely high, although there is wide variation both within and between countries ([130]). Among samples of IDUs, prevalence rates of over 60 % in 2002–03 are reported from Belgium, Estonia, Greece, Italy, Poland, Portugal and Norway, while samples with prevalence under 40 % are reported from Belgium, the Czech Republic, Greece, Hungary, Austria, Slovenia, Slovakia, Finland and the United Kingdom (Figure 16) ([131]).

Prevalence data from young IDUs (aged under 25) are available from only a few countries and, in some cases, sample sizes are small. Where available, the highest prevalence among young IDUs in 2002–03 (over 40 %) is found in samples from Greece, Austria and Poland and the lowest prevalence (under 20 %) in samples from Hungary, Slovenia, Finland and the United Kingdom ([132]). Data on HCV prevalence among new injectors (injecting for less than two years) are even more limited but what information is available for 2002–03 shows that the highest prevalence (over 40 %) is in samples from Belgium and Poland and the lowest prevalence (under 20 %) in samples from the Czech Republic, Greece and Slovenia ([133]). Hepatitis C notification data for the period 1992–2003 suggest that, in those countries providing data, IDUs account for the large majority of notified cases of hepatitis C (notifications are mostly limited to diagnosed cases of acute infection) (Figure 17).

The prevalence of hepatitis B virus (HBV) markers also varies greatly both within and between countries ([134]). The most complete data are for anti-HBc, which indicates a history of infection and, among those testing negative, the potential for vaccination. In 2002–03, IDU samples with prevalence over 60 % were reported from Belgium, Estonia and Italy, while samples with prevalence under 30 % were reported from Belgium, Spain, Italy, Austria, Portugal, Slovenia, Slovakia and the United Kingdom ([135]). Hepatitis B notification data for the period 1992–2003, for those countries from which data are available, suggest that the proportion of IDUs has been increasing ([136]). In the Nordic region, the great majority of notified acute cases of hepatitis B occur among IDUs, and hepatitis B outbreaks have coincided with increases in drug injecting in several countries (Blystad et al., 2005).

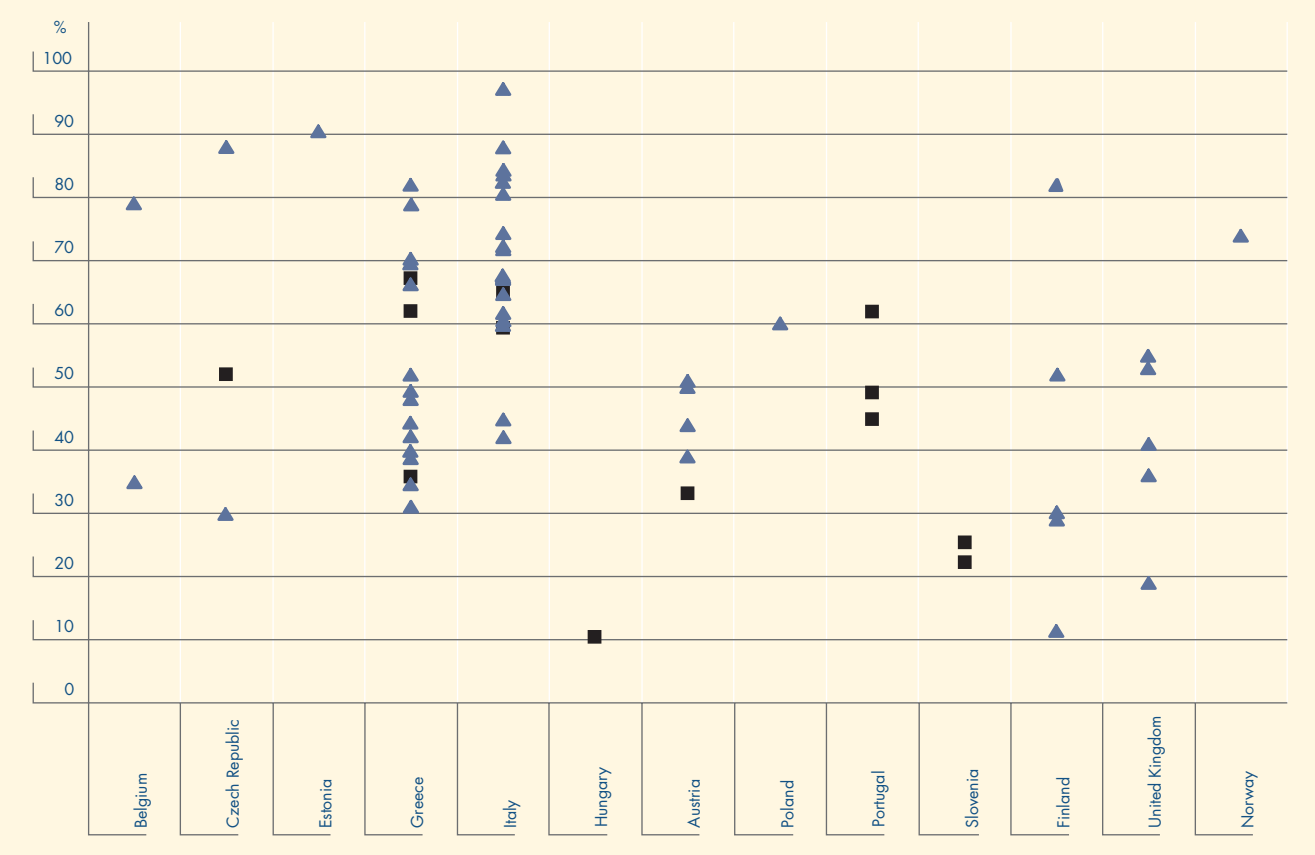
For a brief overview of other drug-related infectious diseases, see the 2004 annual report (http://ar2004.emcdda.eu.int/en/page074-en.html).

Prevention of drug-related infectious diseases

Although the national policies of Member States vary, reflecting their individual drug situation and political context, there is also increasing evidence of a consensus emerging at the European level on the key elements necessary for an effective response to combating HIV and other infectious

([129]) See Figure INF-2 in the 2005 statistical bulletin.
([130]) See Tables INF-2 and INF-11 in the 2005 statistical bulletin.
([131]) See also Figure INF-21 in the 2005 statistical bulletin and Matheï et al., 2005.
([132]) See Table INF-12 in the 2005 statistical bulletin.
([133]) See Table INF-13 and Figures INF-7 and INF-8 in the 2005 statistical bulletin.
([134]) See Tables INF-3, INF-14 and INF-15 in the 2005 statistical bulletin.
([135]) See Figures INF-9, INF-10, INF-22 and INF-23 in the 2005 statistical bulletin.
([136]) See Figure INF-14 in the 2005 statistical bulletin.

Figure 16: National and local estimates of HCV prevalence among injecting drug users, 2002–2003



NB: Black square, samples with national coverage; blue triangle, samples with local/regional coverage.
Differences between countries have to be interpreted with caution owing to different types of settings and/or study methods; national sampling strategies vary.
Data for Spain and Portugal and some of the data for Czech Republic include non-IDUs and therefore may underestimate prevalence among IDUs (proportion of non-IDUs in the samples not known).
Data for Portugal, Slovenia and Slovakia are limited to prevalence among IDUs in treatment and may not be representative of prevalence among IDUs who are not in treatment.

Sources: Reitox national focal points (2004). For primary sources, study details and data before 2002, see Table INF-11 in the 2005 statistical bulletin.

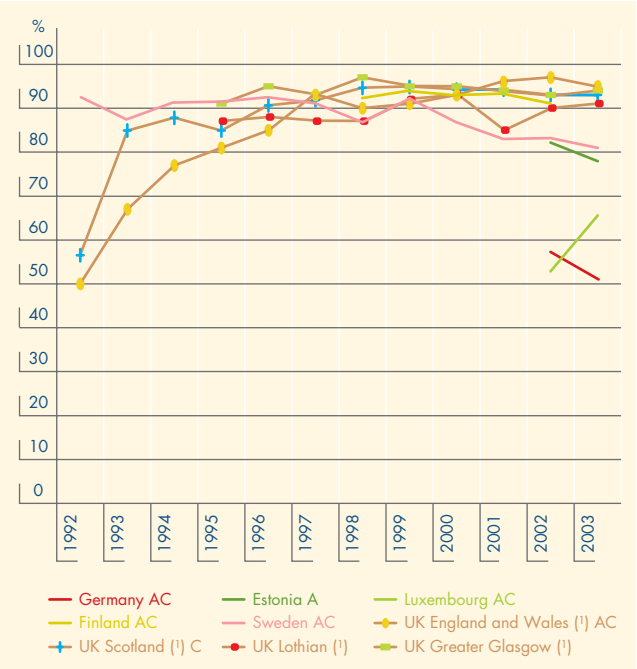
diseases among IDUs ([137]). Appropriate responses include enhanced access to drug treatment (WHO, 2005), the development of low-threshold services and the provision of sterile equipment and education programmes, although it should be noted that there are differences between countries with respect to the emphasis placed on these different service elements. Of particular importance is that there should be sufficient availability of oral substitution treatment for injecting opioid users, as this significantly reduces drug-related behaviour with a high risk of HIV transmission (Gowing et al., 2005; Sullivan et al., 2005).

Needle and syringe availability

Needle and syringe programmes (NSPs) started in the European Union in the mid-1980s as an immediate response to the threat of an HIV epidemic among drug injectors and expanded rapidly over the course of the 1990s (Figure 18). In 1993, publicly funded programmes already existed in more than half of the current 25 EU Member States and in Norway. Today, NSPs are available in Bulgaria, Romania and Norway as well as in all EU countries, except Cyprus, where sterile equipment is, however, freely obtainable at pharmacies and an official NSP is under consideration ([138]). Once such programmes have been introduced to a country, the geographical coverage of outlets for NSPs generally increases continually. Many countries have now achieved full geographical coverage, with pharmacies being a crucial partner in several Member States. However, in Sweden, the two programmes started in 1986 in the south of the country remain the only ones; and in Greece, the number of NSPs is limited and they are only available in Athens ([139]).

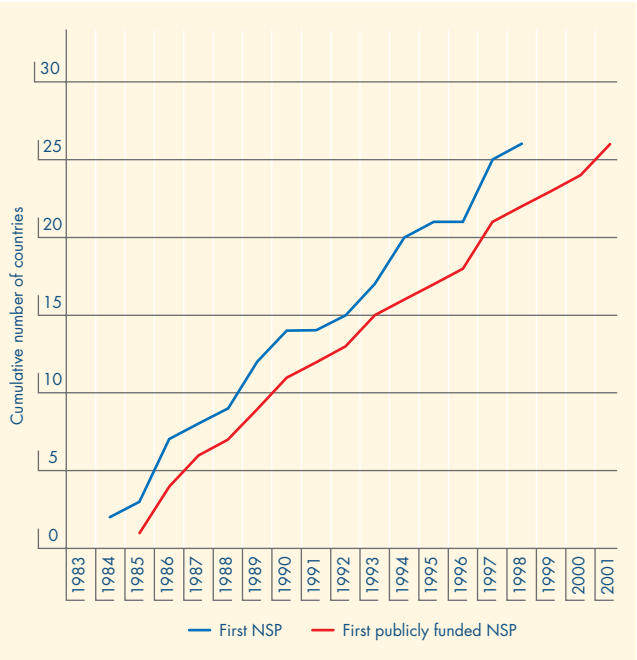
([137]) In two recent conferences, European government representatives have confirmed their partnership in the fight against HIV/AIDS and defined measures to strengthen their responses in this area (Dublin Declaration, February 2004, and Vilnius Declaration, September 2004). All key EU documents on HIV/AIDS can be found on the European Commission's public health website (http://europa.eu.int/comm/health/ph_threats/com/aids/keydocs_aids_en.htm).
([138]) See Table NSP-2 in the 2005 statistical bulletin.
([139]) See 'Needle and syringe availability' in the 2005 statistical bulletin.

Figure 17: Notified cases of hepatitis C, percentage of cases reported as IDU, 1992–2003



(1) The data are not for the national level.
NB: A, acute cases; AC, acute and chronic cases; C, chronic cases.
Source: Reitox national focal points.

Figure 18: Introduction of needle and syringe programmes in 23 EU countries, Norway and Bulgaria



Source: Reitox national reports, 2004.

Making services more accessible

The term 'low-threshold' describes an implementation setting that aims to make it easier for drug users to get access to social and health services. To lower their threshold of access, agencies are placed in specific locations and have opening hours that are adapted to their clients' needs, including late evening or night-time opening. Low-threshold agencies often also deliver their services through outreach workers. The use of the agencies' services requires little bureaucracy and often no payment and is not linked to an obligation on the clients' part to be or to become drug-free. Such agencies target current users who have never been in contact with other drugs and health services and those who have lost this contact. Their services are targeted towards the 'hard-to-reach' groups and specific high-risk groups of users and also experimental users (for example, through delivering their services in clubs and discos or other party settings). The low-threshold setting can apply to street agencies, drop-in day centres and field healthcare stations and also to emergency shelters. Within a comprehensive system of care, these agencies, because of their easy accessibility, have an important role in reaching out to the more 'hidden' or 'difficult-to-reach' populations of drug users. Besides motivating users to seek treatment and making referrals, they often deliver 'survival-oriented' services, including food, clothes, shelter, sterile injecting equipment and medical care. They are core settings for disseminating health promotion messages and increasing knowledge and skills regarding safe use among those who use drugs either experimentally or in a dependent or problematic way. Increasingly, they deliver treatment services too.

NSPs are usually integrated firmly into the work of low-threshold drug counselling agencies (see box 'Making services more accessible'), outreach work and the care for the homeless in the EU countries and Norway. As agencies that have a low threshold of access are successful in reaching hidden populations of active drug users, they can be an important starting point for contact, prevention, education and advice, as well as for referrals to treatment. It is also increasingly recognised that low-threshold services can be a vital platform for offering basic medical care, infectious disease screening and vaccination and antiviral treatment to members of the community who, for a variety of reasons, may find it difficult to access more formal healthcare services.

Needle and syringe programmes are described as a predominant approach to the prevention of infectious diseases among drug users in 16 EU Member States and Norway and a common approach in a further six; and it is

considered a priority policy response to infectious diseases among drug users in two thirds of EU countries ([140]).

Evidence on effectiveness of needle and syringe programmes

Scientific research into the effectiveness of NSPs in reducing HIV/AIDS among IDUs dates back to the 1980s ([141]). A review of the literature, published by the WHO in 2004, concludes that there is compelling evidence that increasing the availability and utilisation of sterile injecting equipment by IDUs reduces HIV infection substantially and that there is no evidence of any major unintended negative consequences (WHO, 2004). However, the review concluded that, by themselves, NSPs are not enough to control HIV infection among IDUs, and that these programmes must be supported by a range of complementary measures in order to control HIV infection among and from IDUs. Reviewing the cost-effectiveness of NSPs, de Wit and Bos (2004) conclude that NSPs seem to be cost-effective in preventing the spread of HIV and have additional and worthwhile benefits apart from reducing HIV, such as bringing a difficult-to-reach population of drug users into contact with health and social services.

Hepatitis prevention

Those who inject drugs are at very high risk of acquiring HBV and HCV infection, and 50–80 % of drug users become infected within five years of starting to inject, which can result in chronic infections that can damage and ultimately destroy the liver (EMCDDA, 2004b). While no vaccine is currently available against hepatitis C, hepatitis B can be effectively prevented by vaccination ([142]).

Several EU countries have introduced or reintroduced hepatitis B into national immunisation programmes in the past decade, and the vaccination is now part of the routine vaccination schedules for children in most EU countries. So far, only Denmark, the Netherlands, Sweden, the United Kingdom and Norway have not followed the WHO recommendation ([143]).

Although it will be some decades until no substantial at-risk populations are left, targeted vaccination programmes for drug users are currently implemented in most EU countries and Norway. To reach their target populations, vaccination is made available to drug users at easily accessible contact points and also increasingly in prisons ([144]).

Hepatitis B immunisation campaigns are often combined with hepatitis A vaccinations and hepatitis C virus counselling, testing and referral. Even though hepatitis C treatment is offered in all countries, access can in practice be difficult for drug users. As official medical guidelines are considered an important tool in steering the provision of hepatitis C treatment, in 2003–04 they were the subject of an analysis by the EMCDDA ([145]). Most guidelines recommend that drug users be treated after they have come off drugs or have been stable on an oral substitution treatment for a period of time that can vary from three months to two years. The more recent the guidance documents are, the more likely they are to take into account research showing the benefits for drug users of a multidisciplinary approach to treatment by teams of hepatologists and drug use specialists. The recent increase in national guidance is likely to improve treatment options and enhance outcomes for drug users.

Drug-related deaths

Heroin deaths

In this section, the term 'drug-related deaths' is used to refer to deaths caused directly by the consumption of one or more drugs and generally occurring shortly after the consumption of the substance or substances. These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths' ([146]).

Opiates are present in most cases of 'drug-related deaths' caused by illegal substances reported in the EU, although in many cases other substances are also identified during the toxicological examination, in particular alcohol, benzodiazepines and, in some countries, cocaine ([147]).

Between 1990 and 2002, EU countries reported 7 000–9 000 deaths due to overdoses each year ([148]), adding up

([140]) See the EMCDDA website for an overview of national responses to infectious diseases (http://www.emcdda.eu.int/?nnodeid=10212).
([141]) See the EMCDDA website for a list of key reviews (http://www.emcdda.eu.int/?nnodeid=5777).
([142]) For more information on hepatitis, see the EMCDDA website (http://www.emcdda.eu.int/?nnodeid=10192).
([143]) Report on the 14th global advisory group: expanded programme on immunisation, 14–18 October 1991, Antalya, Turkey, endorsed by the World Health Assembly in 1992.
([144]) See Hepatitis B vaccination table (http://www.emcdda.eu.int/?nnodeid=10192).
([145]) Consultant study on hepatitis C treatment guidelines for injecting drug users (http://www.emcdda.eu.int/?nnodeid=5826).
([146]) This is the definition agreed by the EMCDDA group of national experts: see methodological notes 'Drug-related death EMCDDA definition' in the 2005 statistical bulletin and DRD standard protocol, version 3.0 (http://www.emcdda.eu.int/?nnodeid=1419). Most countries have national case definitions that at present are the same as the EMCDDA or relatively similar, although some countries include cases due to psychoactive medicines or non-overdose deaths, generally as a limited proportion (see 'National definitions of drug-related deaths' in the 2005 statistical bulletin).
([147]) See Table DRD-1 in the 2005 statistical bulletin.
([148]) See Tables DRD-2 and DRD-3 in the 2005 statistical bulletin.

to more than 100 000 deaths during this period. These figures can be considered a minimum estimate because under-reporting is likely to occur in many countries.

Overdosing with opiates is one of the leading causes of death among young people in Europe, particularly among males in urban areas (EMCDDA, 2004c). At present, overdose is also the main cause of death among opiate users in the EU as a whole; for instance, in 2001, the EU-15 Member States reported 8 347 drug-related deaths, compared with 1 633 deaths from AIDS among IDUs (EuroHIV, 2004) ([149]), although the costs and possible longer-term problems of HIV infection should not be overlooked.

The majority of drug users who overdose are men, accounting for 60–100 % of cases, and in most countries the proportion ranges between 75 and 90 %. Most overdose victims are in their 20s or 30s, with a mean age in the mid-30s (range 22–45 years). The mean age is lowest in several of the new Member States (Estonia, Latvia and Lithuania) and Romania, in many of which the proportion of overdose victims younger than 25 years is relatively high, which may reflect a younger heroin-using population in these countries ([150]).

Methadone deaths

Several countries reported the presence of methadone in a substantial proportion of drug-related deaths in the 2004 Reitox national reports. The information is provided in accordance with national terminology and, in some cases, it is difficult to assess exactly what role methadone played in the death; some cases are genuine methadone intoxications, but in others the presence of the substance is merely noted. Denmark reported that methadone was present in 49 % of deaths from intoxication (97 out of 198 cases, of which 64 cases involved methadone alone). Germany reported that 23 % of cases were attributed to 'substitution substances', of which 3 % were such substances alone (55 cases) and 20 % in combination with alcohol and narcotic drugs (354 cases), while in 2002 these figures were 30 % overall (7 % alone and 23 % in combination). The United Kingdom reported 418 cases with 'mention' of methadone, although this does not mean a causal relationship. Other countries reported the presence of methadone in drug-related deaths less frequently: France (eight cases alone or in association), Austria (found in 10 % of fatalities), Portugal (detected in 3 % of cases) and Slovenia (four deaths due to methadone). In the 2003 Reitox national reports, Ireland and Norway also reported significant numbers of cases associated with the presence of methadone.

As is the case with all opiates, methadone is a potentially toxic substance, but research has shown that substitution treatment reduces the risk of overdose mortality among programme participants. Several studies have indicated that deaths in which methadone is implicated are more likely to be the result of illicit rather than prescribed use, and others have found a higher risk during the initial phases of methadone maintenance treatment. These findings suggest the need to ensure good quality standards in substitution programmes.

Fentanyl and buprenorphine deaths

In recent years, the Baltic countries have reported some deaths in which fentanyl was found in the toxicological investigation, frequently concomitantly with heroin. In its national report, Sweden reported 13 deaths related to fentanyl among IDUs in 2003, compared with only occasional cases in previous years. For information about the role of buprenorphine in drug-related deaths, see the selected issue on buprenorphine.

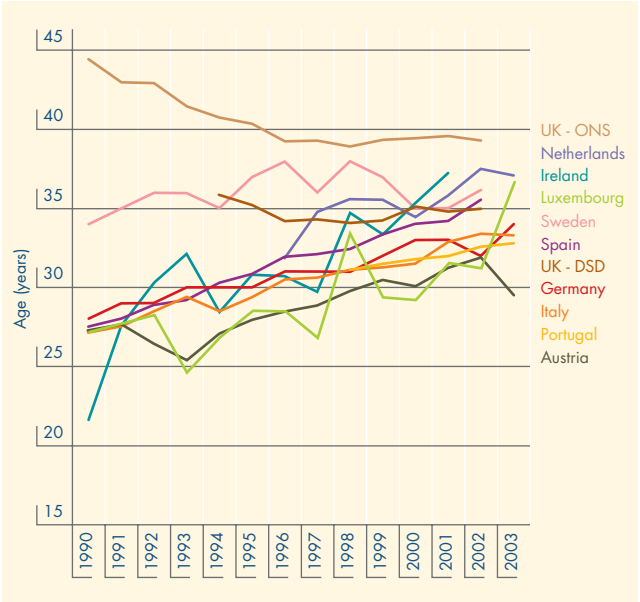
Trends in acute drug-related deaths

Trends in drug-related deaths vary from country to country ([151]), and even from region to region, as a result of differences in the course of the heroin epidemic, in the prevalence of its use, in risk behaviours (e.g. proportion of injectors, polydrug use), in provision of treatment and support services for drug users and, perhaps, in the availability and characteristics of heroin. Differences in the organisation and policies of the medical emergency services can also play an important role.

With these limits in mind, some general trends can be identified for the EU, in particular for the EU-15 Member States, where longer and more systematic series of data are available. Overall, a marked increase in drug-related deaths was observed during the 1980s and early 1990s. During the period 1990–2000, and despite decreases in some countries, the overall increasing trend continued in Europe, although at a lower rate. In 2000, 8 930 deaths were reported, compared with 6 426 in 1990 (a 40 % increase) ([152]). In most of the longer-standing Member States, an ageing trend can be observed among overdose victims, suggesting an 'ageing cohort effect', which could be related to a decline in the recruitment of young addicts (Figure 19).

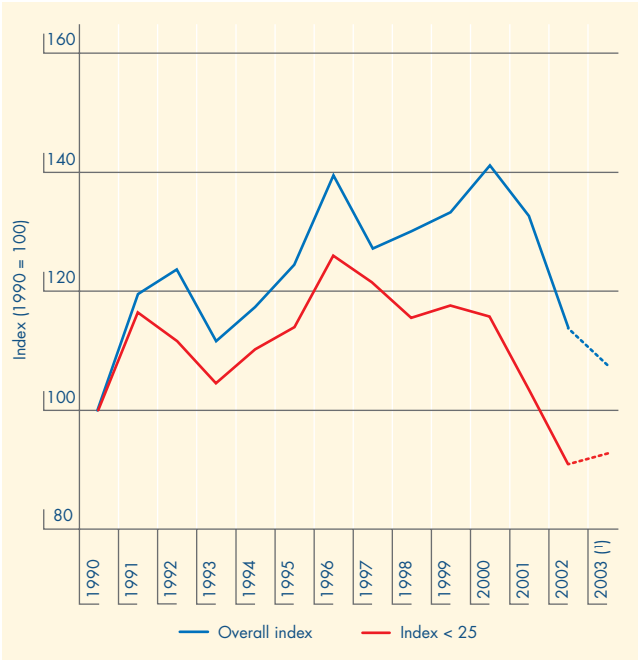
([149]) The figure for AIDS deaths refers to the western area of WHO Europe and includes deaths in several non-EU countries, e.g. Switzerland, Iceland and Israel.
([150]) See Figure DRD-2 in the 2005 statistical bulletin.
([151]) See Figure DRD-7 in the 2005 statistical bulletin.
([152]) See Figure DRD-8 in the 2005 statistical bulletin.

Figure 19: Trends in mean age of acute drug-related deaths victims in some of the EU-15 Member States, 1990–2001/03



NB: The figure represents data from countries that reported mean age of victims in most years during the reporting period.
Information based on 'national definitions' as presented in Table DRD-6 in the 2005 statistical bulletin. In England and Wales, the 'drug strategy definition' is used.
Sources: Reitox national reports (2004), taken from national mortality registries or special registries (forensic or police).

Figure 20: Overall trend in acute drug-related deaths in the EU-15 Member States and trend in the proportion of drug-related death victims under 25 years old, 1990–2003



(1) The figure for 2003 is provisional, since only 10 countries provided data for 2003. The figure for 2003 is based on those countries which provided data for both 2002 and 2003.
NB: Index: 1990 = 100. Numbers of cases per country per year are presented in Table DRD-2 (parts i and v) in the 2005 statistical bulletin.
Belgium did not provide data for 1998–2001 and Ireland for 2002. A computation method, defined in EMCDDA (2001), has been used to make corrections for this situation.
Sources: Reitox national reports (2004), taken from general mortality registries or special registries (forensic or police), based on national definitions as presented in Table DRD-6 in the 2005 statistical bulletin.

Since 2000, however, many EU countries have reported a decline in the numbers of drug-related deaths. Among the EU-15 Member States and Norway, the total number fell from 8 930 in 2000 to 8 394 in 2001 (a 6 % decrease) and 7 122 cases in 2002 ([153]) (a further 15 % decrease). Only 10 countries reported information for 2003, and so inferences for trends in the EU should be made with caution. However, on the basis of those 10 countries, a 5 % decrease was observed in 2003, or only one-third of the decrease that occurred in 2002. Of the 10 countries supplying information for 2003, three reported increases, one reported no change, and six reported decreases, of which those in Greece (22 %) and Italy (17 %) could be considered significant ([154]). These developments should raise serious concerns, as it is possible that the factors responsible for the decline in drug-related deaths between 2000 and 2002 (a reduction of almost 20 %) were abrogated in 2003; this is particularly important as drug-related deaths are still at historically high levels — approximately the same as in the early 1990s (Figure 20).

Overall, drug-related deaths among people younger than 25 years old have been decreasing relatively steadily since 1996, indicating a possible decrease in the number of young injectors (Figures 19 and 20), the result of a decreasing or stable trend in most of the EU-15 Member States, except France, Sweden and Norway. However, in several new Member States, a clear increase in the proportion of victims younger than 25 years was observed between the mid-1990s and 2000–02, suggesting increasing recruitment of young users ([155]). In addition, the decrease observed at EU-15 level since 2000 has taken place mainly among men (a 21.9 % decrease). Women have exhibited a much smaller decrease (14.5 %), and in 2003, in contrast to men, the decreasing trend among women appears to have been reversed ([156]).

Identification of trends in the new Member States is difficult because of the limited information available. Although there are differences from country to country, the available information suggests that drug-related deaths started to increase more clearly in the early to mid-1990s. This is

([153]) Figures for Belgium and Ireland in 2002 are not included (there were 88 cases in Ireland in 2001).
([154]) On the basis of a simple statistical Poisson model. Police data from Norway also suggest a clear decrease in 2003.
([155]) See Figure DRD-9 in the 2005 statistical bulletin.
([156]) See Figure DRD-6 in the 2005 statistical bulletin.

also supported by the increase in the proportion of victims younger than 25 years old that occurred between the mid-1990s and 1999–2000 in most of the countries supplying information ([157]). In the new Member States from which data are available, the number of victims younger than 25 increased substantially more than the total number from 1996 until very recently (Figure 21), supporting the view of a more recent epidemic. Since 2000, deaths due to illegal substances have stabilised or decreased in Bulgaria, the Czech Republic ([158]), Latvia (in 2003) and Hungary. Overall, a degree of stabilisation appears to have occurred in recent years, but this finding has to be considered with caution as the quality and coverage of reporting are still limited in many countries. The probable increase in heroin use that took place during the 1990s in many of the new Member States might have been compensated for by increases in the provision of treatment services in more recent years, or other factors, but it is difficult to predict the future trend (Figure 21).

It can be concluded that, despite positive developments from 2000 until 2002, possibly related to factors such as a shift away from injection among opiate users in a number of countries and increased treatment provision, and the possible stabilisation or decline in the number of opiate users, the current figures remain high from a longer-term perspective, and there are indications that the improvement may not continue.

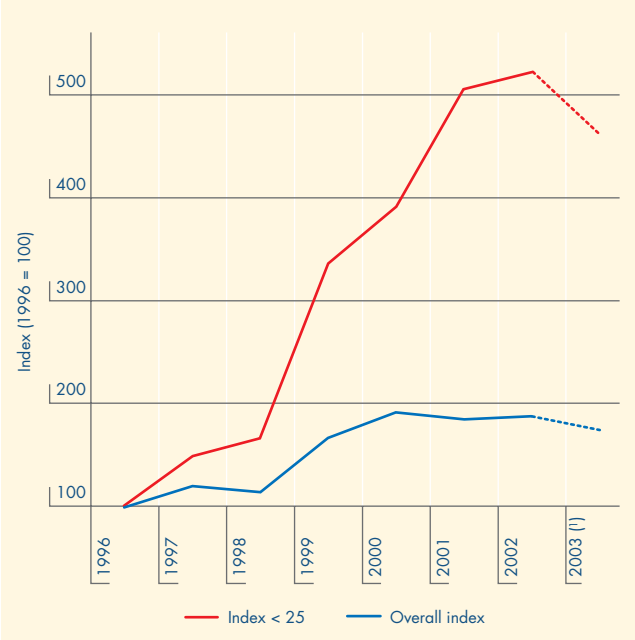
Overall mortality among opiate users

Opiate users have an overall mortality that is up to 20 times or more higher than that of the general population of the same age. This increased mortality is particularly high among injectors. Despite the low prevalence of opiate addiction, this condition has a significant impact on the mortality of young adults in Europe (Bargagli et al., 2004).

Causes of mortality among opiate users include not only overdoses, but also AIDS and other infectious diseases, and external causes of death (accidents, violence, suicides, etc.). The main cause of death among cohorts with a low prevalence of HIV infection is overdose. AIDS deaths have decreased substantially in recent years, even among cohorts with a high prevalence of HIV infection, due to increased availability of HAART treatment after 1995 (see above for the overall figures in Europe) ([159]).

As opiate users age, mortality progressively increases as deaths from chronic conditions (such as cirrhosis, cancer, respiratory diseases, endocarditis, AIDS) are added to deaths from overdose and external causes such as suicide and violence (Dutch national report).

Figure 21: Overall trend in acute drug-related deaths in new Member States and candidate countries and trend in proportion of victims under 25 years old, 1996–2003



(1) The figure for 2003 is provisional.
NB: The countries included are Czech Republic, Estonia, Latvia, Lithuania, Hungary, Malta, Slovenia and Bulgaria.
Index: 1996 = 100. Numbers of cases per country per year are presented in Table DRD-2 (part ii) in the 2005 statistical bulletin.
It is important to remember that the index has been computed using data from a limited number of countries. Also note that the Czech Republic and Estonia account for a substantial proportion of victims younger than 25. Estonia did not provide data for 1996 and 2003, Hungary for 2002 and Czech Republic for 1996 to 2000. The computation method is detailed in EMCDDA (2001).
Sources: Reitox national reports (2004), taken from general mortality registries or special registries (forensic or police), based on national definitions as presented in Table DRD-6 in the 2005 statistical bulletin.

In addition, living conditions and factors other than drug use per se (homelessness, mental illness, violence, poor nutrition, etc.) may contribute substantially to the high mortality among drug users. Studies have shown that mortality among psychiatric patients is four times higher than that of the general population (Korkeila, 2000) and that mortality among homeless people is also three to four times higher than in the general population (Hwang, 2001).

Reduction in drug-related deaths

Response policies

The 2000–04 EU policy target of a substantial reduction in drug-related deaths found a considerable level of

([157]) See Figure DRD-9 in the 2005 statistical bulletin.
([158]) Considering only cases under EMCDDA 'Selection D', which includes illegal drugs. The national definition includes many cases resulting from psychoactive medicines (75 %).
([159]) Mortality of drug users in the EU: coordination of implementation of new cohort studies, follow-up and analysis of existing cohorts and development of new methods and outputs. EMCDDA report CT.00.EP.13, 2002 (http://www.emcdda.eu.int/?nnodeid=1419).

acceptance among Member States. Eight of the EU-15 Member States (Germany, Greece, Spain, Ireland, Luxembourg, Portugal, Finland and the United Kingdom) plus four new EU countries (Cyprus, Latvia, Lithuania and Poland) have included a reduction in drug-related deaths in their national strategy documents ([160]). The fact that several new Member States still lack reliable information on the number of drug-related deaths is, however, an important obstacle to the establishment of an adequate response policy.

The new EU drug strategy (2005–12) places a high priority on improving access to a range of services that can reduce the morbidity and mortality associated with drug dependence, and the number of drug-related deaths has been chosen as one of the main indicators of progress towards this aim in the first four-year action plan (2005–08) ([161]).

Interventions

A major intervention in terms of its impact on drug-related deaths is adequate provision of treatment, especially substitution treatment (WHO, 1998; ACMD, 2000; Brugal et al., 2005). During the 1980s, and to an even greater extent in the 1990s, substitution treatment underwent a rapid expansion in Europe, especially in EU Member States with a high prevalence of heroin injecting. Currently, more than half a million heroin users in the EU — which is between one quarter and half of the estimated target group of heroin users — are enrolled in substitution treatment programmes.

In countries where more than half the problem drug-using population is in substitution treatment, reductions in the levels of drug injecting and related risk behaviours are likely, with a consequent reduction in overdose deaths.

In 2003, the European Council recommended to EU Member States a number of measures to reduce the number of drug-related deaths ([162]). Besides the provision of treatment for drug addiction, these include the improvement of education and the dissemination of information on overdose risk and management among drug users and their peers and families; and proactive strategies to reach those who are out of contact with services through outreach work and easily accessible, attractive drug services. The level of implementation of the recommendation and the effects thereof are under close assessment by the Commission with a report expected in 2006.

The demographic profile of overdose victims shows that untreated older heroin users are at the greatest risk of dying from a drug overdose. A specific measure that is effective in reaching this priority group is the establishment of supervised drug consumption facilities ([163]). Such services currently operate in 15 German and 15 Dutch cities as well as in Madrid, Barcelona and Bilbao (Spain) and Oslo (Norway).

Opiate treatment

In simple terms, the options available for the treatment of problem opiate use can be divided into three general categories: medically assisted treatment (MAT), drug-free treatment and withdrawal treatment (the last mentioned will not be explored here). However, addressing issues of dependence and withdrawal is only one aspect of successfully treating opiate problems. Helping the individual re-enter society through social integration, i.e. finding work and secure housing, and developing the necessary social and coping skills to avoid relapse, are likely to be equally important in ensuring a positive outcome in the longer term. Numerous studies have noted that those with opiate drug problems often have multiple treatment contacts and that therapeutic goals, especially abstinence, may not necessarily be achieved in an individual's first treatment contact, but may be gained through repeated therapeutic interventions.

Medically assisted treatment

Medically assisted treatment (MAT) includes both substitution treatment with agonists (methadone, buprenorphine, dihydrocodeine, heroin, slow-release morphine) and, although much less widely used, treatment with antagonists (for example, naltrexone).

Methadone is available in almost all Member States (see Table 3) and continues to be the most commonly prescribed substitution treatment in Europe. However, in recent years, treatment options have widened. Buprenorphine is now available in 18 of the 26 countries for which information is available. Treatment with other agonists, as well as treatment with antagonists (naltrexone, naloxone or clonidine), is less frequently used across the EU. A study on the introduction of controlled heroin prescriptions is currently under way in Belgium, and Austria has received an expert opinion on heroin-assisted treatment of chronic opiate addicts, based on the results of existing international programmes.

([160]) See the overview table: Strategies and selected measures to reduce drug-related deaths (http://www.emcdda.eu.int/?nnodeid=10697).
([161]) See the EU drug strategy 2005–2012 (http://www.emcdda.eu.int/?nnodeid=6790).
([162]) http://eldd.emcdda.eu.int/?nnodeid=5173&pluginMethod=eldd.showlegaltextdetail&id=2603&lang=en&T=2
([163]) European report on drug consumption rooms (http://www.emcdda.eu.int/?nnodeid=1327).

Table 3: Applied substances in medically assisted treatment in Europe (including trials)

Country	Methadone	Buprenorphine	Dihydrocodeine	Slow-release morphine	Heroin	Naltrexone/ naloxone	Clonidine
Belgium	X	X	X			X	X
Czech Republic	X	X					
Denmark	X	X					
Germany	X	X	X		X	X	
Estonia	X	X					
Greece	X	X				X	
Spain	X	X			X		
France	X	X		X			
Ireland	X						
Italy	X	X				X	X
Cyprus							
Latvia	X						
Lithuania	X	X				X	
Luxembourg	X	X		X			
Hungary	X						
Malta	X		X			X	X
Netherlands	X	X			X	X	X
Austria	X	X	X	X			
Poland	X						
Portugal	X	X				X	X
Slovenia	X						
Finland	X	X					
Sweden	X	X					
United Kingdom	X	X	X		X	X	X
Bulgaria	X			X			
Romania	X						
Norway	X	X					

NB: No information is available for Slovakia or Turkey.
Source: Standard table on drug-related treatment availability.

The latest figures show that in 2003 there were more than 450 000 clients in substitution treatment in specialised units in the EU (Table 4), of whom more than 90 % were receiving methadone. In addition to these were clients receiving other kinds of substitution treatment (such as dihydrocodeine, slow-release morphine or heroin) and those who received substitution treatment in settings such as at their general practitioner. Unfortunately, reliable data on these aspects of substitution treatment are not currently available in many Member States and consequently it is not possible to determine aggregate figures for the EU as a whole.

However, some countries do have reliable data or estimates on the number of clients receiving substitution treatment from general practitioners, thereby adding important information to the overall estimates of clients in substitution treatment in the EU. Clients receiving methadone treatment through their general practitioner in 2003 numbered 8 500 in France, 2 682 in Ireland,

Table 4: Estimates of clients in substitution treatment in Europe in 2003

Country	Clients in methadone treatment in specialised units	Clients in buprenorphine treatment in specialised units	Total of clients in substitution treatment in specialised units
Belgium	1 922	48	1 970
Czech Republic	368	204	572
Denmark	4 971	484	5 455
Germany	65 000	9 000	74 000
Estonia	60	13	73
Greece	2 018	275	2 293
Spain	88 678	36	88 714
France	15 000	13 000	28 000
Ireland (1)	5 561	0	5 561
Italy	79 065	7 113	86 178
Cyprus	0	0	0
Latvia	67	0	67
Lithuania	332	n.a.	332
Luxembourg	133	10	143
Hungary	750	0	750
Malta	698	0	698
Netherlands	12 000	n.a.	12 000
Austria (2)	1 796	1 667	6 413 (3)
Poland	865	0	865
Portugal	9 765	2 743	12 508
Slovenia	1 909	0	1 909
Finland	170	430	600
Sweden	800	1 300	2 100
United Kingdom	128 000	n.a.	128 000
Bulgaria	380	0	380
Romania	400	0	400
Norway	1 947	484	2 431
Total (4)	422 655	36 807	462 412 (3)

(1) This is the number of cases rather than individuals treated in the year.
(2) In Austria, around 46 % of clients are receiving substitution treatment other than methadone and buprenorphine, which have been added to give the correct total. The proportional breakdown is based on first treatments.
(3) The higher aggregated total is due to an estimated 2 950 clients in substitution treatment with drugs other than methadone and buprenorphine in Austria (predominantly slow-release morphine).
(4) n.a. = no information. In calculating totals, 'no information' has been given the value of 0, and hence the numbers presented are minimum values.
NB: No information is available for Slovakia or Turkey.
Source: Standard table on drug-related treatment availability.

851 in Luxembourg and 930 in the Netherlands. In addition, in the Czech Republic and France, 1 200 and 70 000 clients, respectively, were receiving buprenorphine treatment through their general practitioner. It is estimated that a total of 81 743 clients were receiving substitution treatment at their general practitioner in these five countries. Bearing in mind that there are more than 450 000 clients in substitution treatment in specialised units, the total number of clients receiving substitution treatment has now passed the half million mark at around

530 000. Again, as the information is incomplete, the figure of 530 000 represents a minimum estimate of the number of drug users in substitution treatment.

The level of availability of substitution treatment differs markedly between the EU-15 and the new Member States and candidate countries. Although they account for more than 20 % of the total population, the new Member States and candidate countries account for only 1.3 % of clients in substitution treatment (not including Turkey, where no data regarding substitution treatment are available). Of the new Member States, only two, the Czech Republic and Slovenia, provide estimates of the prevalence of problem drug use, and in both these countries substitution treatment is available for a smaller proportion of problem drug users (16 % and 26 % respectively) than is average for the EU-15 (35 %). Despite the lack of estimates of the prevalence of problem drug use in other new Member States and candidate countries, the level of substitution treatment is far behind that in the EU-15 Member States. Considering the high risk of spread of infectious diseases in some countries and the preventive role that MAT can play in limiting this (see, for instance, UNODC, 2002), the situation is a cause for concern.

Two distinct trends in MAT have emerged in recent years. The first is a continuation of the trend of increasing availability of substitution treatment, although the increase is becoming less pronounced. In addition, there has been a diversification in substances provided; for example, the number of countries reporting use of buprenorphine has risen to 14 in 2003, compared with six in 1999/2000.

A third, although less distinct, trend is that of increasing involvement of general practitioners in the provision of MAT. Involvement of general practitioners was reported in only three of the 15 Member States (Belgium, France, the United Kingdom) in 2000/2001 (Solberg et al., 2002) but is now found in 10 of the EU-15 Member States (Belgium, Germany, France, Ireland, Italy, Luxembourg, Netherlands, Austria, Sweden and the United Kingdom) as well as three of the new Member States (Czech Republic, Malta and Slovenia).

Drug-free treatment

Drug-free treatment involves the application of psychosocial and educational techniques to achieve long-term abstinence from drugs. Traditionally, drug-free treatment has been residential and long term, e.g. in therapeutic communities. Today, it is often also offered in community-based settings.

Unlike MAT, for which centralised national registers exist in many Member States, registers of drug-free treatment are rare, and reliable, clear, quantitative data for this method of treatment are scarce. Although it is not possible to make an accurate comparison with MAT, reports from Member States indicate that MAT is the principal form of treatment for problem opiate users in the majority of EU Member States and at an aggregated EU level. However, some countries report a general preference for drug-free treatment rather than MAT (Estonia, Cyprus, Lithuania, Poland and Finland). In a number of countries, notably Greece, Spain and Norway, levels of MAT and drug-free treatment appear to be similar.

New developments in quality assurance

Several countries (Germany, Austria and Portugal) have issued manuals for medical staff involved in drug-related treatment. Efforts in the framework of the United Kingdom government's drug strategy have shown that, by investing in budget, organisation, monitoring and staff, waiting lists can be reduced and more problem drug users can gain access to and remain in treatment. In England, 41 % more problem drug users were in contact with drug treatment services in 2003–04 than in 1998–99, and waiting times have been cut by two thirds since 2001. In 2003–04, 72 % of clients had either successfully completed structured treatment or were retained in treatment, compared with 57 % in 2002–03 (NTA, 2004).

The setting in which drug-free treatment is provided varies considerably. In one group of countries (Germany, Greece, Spain, France, Cyprus, Luxembourg, Netherlands, Poland, Slovenia, the United Kingdom) drug-free treatment of problem opiate users takes place predominantly in outpatient settings, whereas a smaller group of countries report predominant use of inpatient settings (Ireland, Italy, Austria) and others show no clear predominance (Sweden, Norway).

Social reintegration

Social reintegration is defined as 'any social intervention with the aim of integrating former or current problem drug users into the community'. The three 'pillars' of social reintegration are (1) housing; (2) education; and (3) employment (including vocational training). Other measures, such as counselling and leisure activities, may also be used.

Social reintegration is a less well-established response to problem drug use than is treatment and, consequently, monitoring and reporting in this field are more patchy. Some countries report qualitative assessments of their efforts in the field of social reintegration; however, none

reports good coverage. The countries reporting (Estonia, Ireland, Malta, the Netherlands, Sweden, Romania and Norway) all identify deficiencies in their social reintegration services and/or programmes. One exception to the rule is Greece, where there is both a relatively wide fan of social reintegration programmes and reliable data on the number of clients they reach.

Seizures and market information ([164])

Production, trafficking and seizures of opiates

Afghanistan has become by far the world leader in the supply of illicit opium, especially as the total area under cultivation increased again in 2004. Global production of illicit opium in 2004 was estimated to be about 4 850 tonnes (4 766 tonnes in 2003), to which Afghanistan contributed 87 % and Myanmar 8 %. Global opium production has remained stable over the last five years, except in 2001, when a ban on opium poppy cultivation in Afghanistan, enforced by the Taliban regime, resulted in a dramatic but short-lived decline. Global potential manufacture of heroin was estimated at 485 tonnes in 2004 (477 tonnes in 2003) (CND, 2005).

Heroin consumed in the EU is predominantly manufactured in Afghanistan (increasingly) or along trafficking routes for opium, notably in Turkey (UNODC, 2003a; INCB, 2005), and enters Europe by two major trafficking routes. The historically important Balkan route continues to play a crucial role in heroin smuggling. Following transit through Pakistan, Iran and Turkey, the route then diverges into a southern branch, through Greece, the former Yugoslav republic of Macedonia (FYROM), Albania, part of Italy, Serbia, Montenegro and Bosnia–Herzegovina; and a northern branch, through Bulgaria, Romania, Hungary and Austria. The INCB (2005) reports that, in 2003, the northern branch of the Balkan route became the dominant one for heroin trafficking. Since the mid-1990s, heroin has increasingly been smuggled to Europe through the 'silk route' via central Asia, the Caspian Sea and the Russian Federation, Belarus or Ukraine (Reitox national reports, 2004; UNODC, 2003a; CND, 2005; INCB, 2005). Although these routes are the most important, several countries in eastern and western Africa and the Americas have made seizures of heroin destined for Europe in 2003 (CND, 2005; INCB, 2005).

In addition to imported heroin, some opiate drugs are produced within the EU. This is mainly confined to the limited production of home-made poppy products (e.g. poppy straw, poppy concentrate from crushed poppy stalks or heads) in a number of eastern EU countries such as Estonia, Latvia and Lithuania (Reitox national reports, 2004). In particular, such products seem to have regained popularity in 2003 in Estonia.

In volume terms, in 2003, Asia (56 %) and Europe (34 %) continued to account for most of the heroin seized worldwide. Europe's share is on the increase, in particular because of increased heroin seizures in eastern and south-eastern European countries (CND, 2005). Since 1998, the EU country accounting for the greatest number of seizures and quantity of heroin seized has been the United Kingdom, followed by Spain in terms of number of seizures and Italy in terms of quantities intercepted ([165]). In 2002, the United Kingdom was responsible for about 30 % of both heroin seizures and the total amount of heroin seized in the EU.

Quantities of heroin seized ([166]) in the EU have generally been on the increase over the last five years, with a plateau in 2000–02, while, overall, numbers of seizures have been declining during the same period. Based upon trends in countries from which data are available, both seizures and quantities of heroin intercepted in the EU seem to have decreased in 2003 ([167]).

Seizures of fentanyl and methylfentanyl — synthetic opiates that are up to 100 times more potent than heroin — were reported again in 2003 in Estonia, while Latvia reported its first seizure of 3-methylfentanyl in 2003 and Austria its first seizure of fentanyl in January 2004. In Estonia, the poor quality of the heroin available on the local market has been compensated for since 2002 by the introduction of these two synthetic opiates, under the names 'white Chinese', 'white Persian' or 'synthetic heroin' (Reitox national reports, 2004).

Although data on seizures of benzodiazepines — usually used as substitutes by heroin users — are not systematically collected by the EMCDDA, Spain, Lithuania, Sweden and Norway reported having made such seizures (in particular of Rohypnol) in 2003.

([164]) See 'Interpreting seizures and market data', p. 41.

([165]) Although this should be checked against missing 2003 data when available. Data on numbers of heroin seizures in 2003 were not available for Italy, Cyprus, the Netherlands and Romania; data on both number of heroin seizures and quantities of heroin seized in 2003 were not available for Ireland and the United Kingdom.

([166]) See Table SZR-4 (part i) in the 2005 statistical bulletin.

([167]) See Table SZR-3 (part i) in the 2005 statistical bulletin.

Price and purity of heroin

In Europe, heroin occurs in two forms: the commonly available brown heroin (its chemical base form) and the less common and more expensive white heroin (a salt form), which typically originates from south-east Asia. In 2003, in the EU the average street price of brown heroin was reported to vary between EUR 27 per gram in Belgium and EUR 144 per gram in Sweden, while the price of white heroin ranged from EUR 25 (Slovakia) to EUR 216 (Sweden) per gram ([168]). This price differential is likely to reflect the purity of the drug being sold.

In 2003, the average purity of brown heroin at street level in the EU varied from 6 % in Austria to 40 % in Malta. Data on purity of white heroin were reported by only a few countries ([169]); it ranged on average from 6 % in Finland to 70 % in Norway ([170]).

Buprenorphine: treatment, misuse and prescription practices, in *EMCDDA annual report 2005: selected issues*

In the past 10 years, buprenorphine has increasingly become available in Europe as an alternative to methadone for the treatment of opiate dependence. First developed as an analgesic, buprenorphine was suggested for use in the treatment of opiate dependency in the late 1970s. Buprenorphine's introduction for opiate treatment in the EU-15 Member States and its expansion in these countries and into the new Member States is described.

Comparisons are made between buprenorphine and methadone in terms of efficacy and costs. The provision of buprenorphine treatment in Europe is described, and comparisons are made between Member States in which buprenorphine is the principal substance used in the treatment of opiate dependency and those where medically assisted treatment (MAT) is mainly carried out with methadone. Among the findings is that around 20 % of clients in MAT in the EU today receive buprenorphine, although most of these clients are in one country (France). Overall, buprenorphine has spread to many countries, but the actual number of clients is still limited in the majority of Member States.

Buprenorphine is looked at from the perspective of potential misuse. The first indications are that misuse of buprenorphine is prevalent in only a few countries, and is uncommon elsewhere. Some evidence is reported that relates misuse of buprenorphine to specific populations or age groups, or attempts to identify distinct groups of buprenorphine misusers. Although deaths due to buprenorphine misuse are very rare, some deaths are reported by scientific literature and by some European countries. Reports of deaths related to buprenorphine misuse are compared with those related to methadone misuse.

The selected issue draws conclusions about the relative merits of buprenorphine and methadone in the treatment of opiate dependency. Buprenorphine is identified as representing an opportunity to make MAT more widely available and more easily accessible.

This selected issue is available in print and on the Internet in English only (http://issues05.emcdda.eu.int).

([168]) See Table PPP-2 (part i) in the 2005 statistical bulletin.
([169]) See Table PPP-6 (part i) in the 2005 statistical bulletin.
([170]) Small sample number for Norway (n = 8).

Chapter 7
Crime and prison issues

Drug-related crime

Drug-related crime is taken as referring to crimes committed under the influence of drugs; those committed in order to finance drug use; those occurring in the context of the functioning of illicit drug markets; and those against drug legislation. Routine data are available in the EU only on the last type of crime — drug law offences.

'Reports' ([171]) of drug law offences reflected differences in national legislation, in the ways in which the laws are applied and enforced and in the priorities and resources allocated by criminal justice agencies to specific crimes. In addition, information systems on drug law offences vary considerably between countries, especially in relation to reporting and recording practices, i.e. what is recorded and when and how. These differences make comparisons between EU countries difficult.

Between 1998 and 2003, the number of 'reports' of drug law offences increased in most EU countries. Increases were particularly marked (twofold or more) in Estonia and Poland. However, the number of 'reports' decreased in 2003 in Belgium, Spain, Italy (since 2001), Hungary, Malta, Austria and Slovenia (since 2002) ([172]).

In most EU Member States, the majority of reported drug law offences continued to be related to drug use or possession for use ([173]), ranging from 39 % of all drug law offences in Poland to 87 % in Austria and the United Kingdom. In the Czech Republic and Luxembourg, 91 % and 46 %, respectively, of reported drug law offences were related to dealing or trafficking, whereas in Italy and Spain — where drug use and possession for use are not criminal offences — all drug offences were related to dealing or trafficking. Finally, in Portugal ([174]) and Norway ([175]), 59 % of offences were related to drug use and trafficking together.

Drug use and crime: some data

In a survey carried out in 2004 in the Czech Republic, police officers working in regional headquarters estimated that approximately 40 % of ordinary thefts and approximately 30 % of burglaries had been committed in order to buy drugs. In the same country, routine data on recorded crime showed that, in 2003, 0.7 % of all offences were committed while the offenders were under the influence of narcotic or psychotropic substances, alcohol excluded (Czech national report).

In Finland, during 2000–03, the proportion of homicides and assaults committed by offenders under the influence of illicit drugs was much lower than the proportion committed by offenders under the influence of alcohol (6 % compared with 64 % of homicides and 2 % compared with 71 % of assaults) (Lehti and Kivivuori; cited in the Finnish national report). Although the presence of drugs in robbery offences seems to have increased in the last decade, the presence of alcohol in robbery offences is still more common (43 % of robbery offences involve alcohol compared with 9 % that involve drugs).

In Germany, 'direct economic compulsive crimes' — criminal offences committed in order to obtain narcotic drugs or substitute or alternative drugs — decreased in 2003 to 2 568 cases, of which over 70 % were related to forgery of prescriptions or theft of prescription forms (BKA, 2004).

In Latvia, routine data from the Ministry of the Interior showed that 2.8 % of all detected crimes in 2003 (3.1 % in 2002) were committed by offenders who were under the influence of narcotic substances (Latvian national report).

([171]) The term 'reports' for drug law offences is in quotation marks because it describes different concepts in different countries (police reports of suspected drug law offenders, charges for drug law offences, etc.). For an exact definition for each country, refer to the methodological notes on definitions of 'reports' for drug law offences in the 2005 statistical bulletin. (NB: The term 'arrests' was used in annual reports until 2001.)

([172]) See Table DLO-1 (part i) in the 2005 statistical bulletin. Data on 'reports' for drug law offences in 2003 were not available for Denmark, Germany, Ireland, Latvia, Slovakia and the United Kingdom.

([173]) See Table DLO-2 in the 2005 statistical bulletin.

([174]) In Portugal, remaining drug law offences are related to 'drug dealing/trafficking', as offences of drug use/possession for use were decriminalised in July 2001.

([175]) In Norway, no distinction is drawn between 'drug dealing/trafficking' alone and 'drug use/dealing and trafficking'. Therefore, remaining drug law offences are related to 'drug use' alone.

In all countries from which data are available, except Portugal, the proportion of all drug law offences accounted for by those related to drug use or possession for use increased over the five-year period 1998–2003 ([176]). The rate of increase was generally slow, but more marked upward trends were evident in Belgium, Luxembourg and Slovenia, and in Ireland until 2001. In Portugal, the proportion of use-related offences started to decrease in 2000, one year before drug use and possession for use were decriminalised in July 2001 ([177]). In 2003, decreases were reported in the Czech Republic, Luxembourg, Austria and Slovenia.

In most of the Member States, cannabis continued to be the illicit drug most often involved in reported drug law offences ([178]). In the countries where this was the case, cannabis-related offences in 2003 accounted for 39 % (Italy) to 87 % (France) of all drug law offences. In the Netherlands, offences involving 'hard drugs' ([179]) were predominant (58 %), whereas in the Czech Republic the majority of drug law offences related to amphetamines (48 %). The relative proportion of drug law offences related to any specific drug is influenced by a number of factors, including the operational priorities of law enforcement agencies and explicit or implicit strategic decisions to target different types of drug law offences differentially.

Since 1998, the proportion of drug offences involving cannabis ([180]) has been increasing in Germany, Spain, France, Ireland, Lithuania, Luxembourg, Malta and Portugal, whereas it has remained stable overall in Belgium, the Czech Republic, the Netherlands, Slovenia, Sweden and the United Kingdom, and has been decreasing in Italy and Austria ([181]).

Over the same period, the proportion of heroin-related offences decreased in all EU countries from which data are available, except Austria and the United Kingdom, where it increased ([182]). In contrast, cocaine-related offences have increased as a proportion of all drug offences since 1998 in all countries providing data except Germany, which reported downward trends ([183]).

Drug users and prison

Drug users in prison

National routine information on type and pattern of drug use among prisoners is scarce and patchy. Much of the data available in the EU comes from ad hoc studies based on samples of varying size, the results of which (and trends) are very difficult to extrapolate.

Drug users are strongly overrepresented among the prison population compared with the general population. In most studies in the EU, lifetime prevalence of drug use among prisoners is reported to be over 50 %; however, it varies widely, from 22 % to 86 %, between prison populations, detention centres and countries ([184]). In the EU, the prevalence of regular drug use or dependence prior to imprisonment ranges from 8 % to 73 % ([185]).

The majority of drug users reduce or stop their drug use on admission to prison. However, many prisoners continue to use drugs after incarceration, and some start using drugs (and/or injecting drugs) in prison. Available studies show that between 8 % and 60 % of inmates report having used drugs while in prison, and 10–42 % report regular drug use ([186]).

Lifetime prevalence of injecting drug use among prisoners is generally reported to be between 15 % and 50 %; however, some studies have reported values as low as 1 % or as high as 69 %. Where comparable data are available (Austria 1999, England and Wales 1997–98), they show that young offenders are less likely to inject than adults and that, among the prison population, women are more likely to inject than men ([187]). Based on several studies in the EU, Bird and Rotily (2002) have shown that around one third of adult male prisoners are drug injectors. Data provided by the Reitox focal points show that between 0.2 % and 34 % of inmates ([188]) have injected drugs while in prison. This raises issues of access to sterile injection equipment and hygienic sharing practices among the prison population and the potential spread of infectious diseases.

([176]) See Table DLO-4 in the 2005 statistical bulletin.
([177]) The law to decriminalise drug use and possession for use was passed in November 2000 and came into effect in July 2001.
([178]) See Table DLO-3 in the 2005 statistical bulletin.
([179]) In the Netherlands, 'hard drugs' are defined as drugs that pose unacceptable public health risks, such as heroin, cocaine, ecstasy and LSD.
([180]) The following countries provided a breakdown by drug or drug offences over time: Belgium, the Czech Republic, Germany, Spain, France, Ireland, Italy, Lithuania, Luxembourg, Malta, the Netherlands (only 'soft drugs'/cannabis and 'hard drugs'), Austria, Portugal, Slovenia, Sweden and the United Kingdom.
([181]) See Table DLO-5 in the 2005 statistical bulletin.
([182]) See Table DLO-6 in the 2005 statistical bulletin.
([183]) See Table DLO-7 in the 2005 statistical bulletin.
([184]) See Table DUP-1 in the 2005 statistical bulletin.
([185]) See Table DUP-5 (annex) in the 2005 statistical bulletin.
([186]) See Table DUP-3 in the 2005 statistical bulletin.
([187]) See Table DUP-2 in the 2005 statistical bulletin.
([188]) See Table DUP-4 in the 2005 statistical bulletin.

Assistance and treatment for drug users in prison

In all Member States and candidate countries, there are systems of one kind or another in place to ensure that assistance for drug users in prison is available, although the variety of services and their availability differs considerably. A notable trend is the increasing acknowledgement of the fact that prisoners have the same rights as the rest of the population concerning access to healthcare, including assistance and treatment for drug users (WHO Regional Office for Europe, 2002; Irish, Lithuanian and Finnish national reports). Among the services that should be made available to prisoners are strategies for prevention, including drug-free programmes, detoxification treatments, methadone and other substances treatments, counselling and education.

However, countries report various problems with the provision of adequate assistance. For instance, the availability of services is precarious in Estonia; no specific services are available for drug users in Latvia; Poland has long waiting lists for treatment; Sweden reports overcrowded prisons and reduced prison staff levels; and, in Romania, appropriate legislation is lacking. In Cyprus, even though there is no integrated support programme for imprisoned drug users, some prevention measures are taken.

Education and training activities represent general prevention strategies. In most EU and candidate countries, such activities have been carried out for both drug users in prisons and prison staff. Among the countries reporting such activities are Estonia, Spain, Cyprus, Hungary, Slovenia and Romania (Reitox national reports).

Another preventive element is the establishment of drug-free units within prisons. Participation is on a voluntary basis, generally after written declarations to accept certain conditions, for example periodic urine testing, have been signed by imprisoned drug users. Such units exist in all EU-15 Member States. In the 'new' Member States, drug-free units have been established in most countries. An

Alternatives to imprisonment: targeting offending problem drug users in the EU, in *EMCDDA annual report 2005: selected issues*

Prison is a particularly detrimental environment for problem drug users and there is a broad political consensus on the principle of treatment as an alternative to prison. The alternatives to prison that may be offered to drug-using offenders cover a range of sanctions that may delay, avoid, replace or complement prison sentences for those drug users who have committed an offence normally sanctioned with imprisonment by national law. The selected issue focuses on those measures that have a drug-related treatment component.

Since the 1960s, UN and EU agreements, strategies and action plans have several times reaffirmed and strengthened the principle of providing treatment, education and rehabilitation as an alternative to conviction and punishment for drug-related offences. This has been translated into national legislation in EU Member States, and the criminal justice systems as well as health and social services systems have been adapted accordingly. Young drug users are especially vulnerable to getting into a vicious circle of drugs and crime, and there is a particular determination to avoid imprisonment for young offenders.

The implementation of alternative measures to imprisonment, however, faces certain difficulties due to the different administrative systems involved and their different underlying principles. Efforts are made to bridge the gap between the judicial and the health and social services systems through coordination structures and initiatives, i.e. between police, courts and prisons and drug treatment services. Often, informal cooperation mechanisms at local level have been forerunners to more stable institutionalised forms.

Recourse to alternatives to prison increased during the last decades in the EU-15 Member States and has recently even stagnated in some, whereas legislation and implementation of alternatives began later in the new Member States. Usually, the mainstream treatment system is called on to ensure the treatment of offenders with problematic drug use. In most countries, treatment is usually provided in residential settings, but the possibility also exists to follow outpatient treatment programmes.

European evaluation studies of treatment as an alternative to prison are rare and partly inconclusive. However, consistent with other treatment research, retention in treatment proves to be a key indicator of success and drop-out rates are one of the biggest problems for alternatives to prison. Evidence suggests that it is the quality of treatment provided and not the route of the client into treatment that is important for treatment success. Treatment as an alternative to prison seems to work best if the addicts are motivated for treatment and if care facilities follow good clinical standards and have enough and qualified staff.

This selected issue is available in print and on the Internet in English only (http://issues05.emcdda.eu.int).

evaluation of the drug-free zone in one Austrian prison showed that prisoners released from the drug-free zone were sentenced again significantly less often than prisoners released from normal units in the prison (35 % compared with 62 %).

The most common treatment modality in prisons is drug-free treatment, which exists in all Member States (except Cyprus and Latvia), although availability varies. Treatment centres within the community provide support and treatment as well as aftercare in many countries, e.g. Belgium, the Czech Republic, Greece, Luxembourg and the United Kingdom.

In most countries, the availability of substitution maintenance treatment inside prison is not the same as its availability outside prison. Only in Spain is maintenance treatment widespread, with 18 % of all prisoners, or 82 % of problem drug users in prison, receiving this treatment. Luxembourg also has high coverage. Countries reporting considerable increases in the availability of medically assisted treatment include France, mainly with buprenorphine, and Ireland (Reitox national reports). In the Netherlands, medically assisted treatment is available only for short-term detainees who used methadone before imprisonment, whereas in Poland the first programme of methadone treatment with 14 clients was introduced in a remand prison.

New developments in combating the spread of infectious diseases in prison

In Estonia, the situation regarding the prevention of the spread of HIV improved in 2003. The number of primary HIV tests increased 2.6-fold compared with 2002, although the number of positive tests increased only slightly. Pre- and post-test counselling services also improved in terms of quantity as well as quality. In Romania, programmes aimed at preventing the spread of HIV/AIDS in penitentiaries and among prisoners were developed in cooperation with some international non-governmental organisations (NGOs).

Spain is the only country systematically implementing needle and syringe exchange programmes in prisons. In 2003, these programmes distributed a total of 18 260 syringes. Implementation of similar programmes is not foreseen in other Member States and candidate countries.

References

ACMD (2000), *Reducing drug-related deaths: A report by The Advisory Council on the Misuse of Drugs,* The Stationery Office, London.

ACPO (2003), *Cannabis enforcement guidance*, ACPO, London.

Ashton, M. (2003), 'The American STAR comes to England', *Drug and alcohol findings* 8, pp. 21–6.

ASPECT Consortium (2004), *Tobacco or health in the European Union*, Office for Official Publications of the European Communities, Luxembourg (http://europa.eu.int/comm/health/ph_determinants/life_style/Tobacco/Documents/tobacco_fr_en.pdf).

Bandura, A. (1977), *Social learning theory*, Prentice Hall, Englewood Cliffs, NJ.

Bargagli, A. M. et al. (2004), *Drug-related mortality and its impact on adult mortality in eight European countries*, 6th Europad Conference, Paris.

Becoña, E. (2002), *Bases científicas de la prevención de las drogodependencias*, Delegación del Gobierno para el Plan Nacional sobre Drogas, Madrid.

Bird, S. and Rotily, M. (2002), 'Inside methodologies for counting blood-borne viruses and injector-inmates' behavioural risks — results from European prisons', *Howard journal* 41(2).

BKA (Bundeskriminalamt) (2004), *Polizeiliche Kriminalstatistik 2003 Bundesrepublik Deutschland*. BKA, Wiesbaden.

Blystad, H., Blad, L., Tulisov, A. and Aavitsland, P. (2005), 'Hepatitis B in northwest Russia and the Nordic and Baltic countries: recent trends and prevention activities', *Eurosurveillance weekly* 10: 050310 (http://www.eurosurveillance.org/ew/2005/050310.asp).

Botvin, G. J. (2000), 'Preventing drug abuse in schools: social and competence enhancement approaches targeting individual-level etiological factors', *Addictive behaviours* 25, pp. 887–97.

Bovenkerk, F. and Hogewind, W. I. M. (2002), *Hennepteelt in Nederland: het probleem van criminaliteit en haar bestrijding*, Willem Pompe Instituut voor Strafrechtswetenschappen, Utrecht.

Brugal, M. T., Domingo-Salvany, A., Puig, R., et al. (2005), 'Evaluating the impact of methadone maintenance programmes on mortality due to overdose and AIDS in a cohort of heroin users in Spain', *Addiction*, in press.

Butler, G. K. L. and Montgomery, A. M. J. (2004), 'Impulsivity, risk taking and recreational 'ecstasy' (MDMA) use', *Drug and alcohol dependence* 76, pp. 55–62.

Butters, J. E. (2004), 'The impact of peers and social disapproval on high-risk cannabis use: gender differences and implications for drug education', *Drugs: education, prevention and policy* 11, pp. 381–90.

Calafat, A., Fernández, C., Juan, M., et al. (2003), *Enjoying the nightlife in Europe: the role of moderation,* IREFREA España, Palma de Mallorca (www.irefrea.org).

Canning, U., Millward, L., Raj, T. and Warm, D. (2004), *Drug use prevention among young people: a review of reviews*, Health Development Agency, London.

CND (2004), *World drug situation with regard to drug trafficking: report to the secretariat,* Commission on Narcotic Drugs, United Nations Economic and Social Council, Vienna.

CND (2005), *World drug situation with regard to drug trafficking: report to the secretariat,* Commission on Narcotic Drugs, United Nations Economic and Social Council, Vienna.

Cuijpers, P., et al. (2002), 'The effects of drug abuse prevention at school: the healthy school and drugs project', *Addiction* 97, pp. 67–73.

Cunningham, J. A. (2001), 'Impact of normative feedback on problem drinkers: a small-area population study', *Journal of studies on alcohol* 62, pp. 228–33.

De Wit, A. and Bos, J. (2004), 'Cost-effectiveness of needle and syringe exchange programmes: a review of the literature', In *Hepatitis C and injecting drug use: impact, costs and policy options, EMCDDA Monographs 7*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, pp. 329–43.

Drug Misuse Research Division (2004), 'Trends in treated problem opiates use in the seven health board areas outside the Eastern Regional Health Authority, 1998 to 2002', *Occasional paper No 13/2004,* Drug Misuse Research Division, Dublin.

EMCDDA (2001), 'Co-ordination of the implementation of the EMCDDA standard guidelines on the drug-related deaths in the EU Member States, and the collection and analysis of information on drug-related deaths', project CT.99.RTX.04, coordinated by the Trimbos Institute, European Monitoring Centre on Drugs and Drug Addiction, Lisbon.

EMCDDA (2003), 'National prevalence estimates of problem drug use in the European Union, 1995–2000', CT.00.RTX.23, coordinated by the Institut für Therapieforschung, Munich European Monitoring Centre on Drugs and Drug Addiction, Lisbon (http://www.emcdda.eu.int/?nnodeid=1372).

EMCDDA (2004a), *Annual report 2004: the state of the drugs problem in the European Union and Norway*, European Monitoring Centre on Drugs and Drug Addiction, Lisbon.

EMCDDA (2004b), 'Hepatitis C and injecting drug use: impact, costs and policy options', *EMCDDA monographs 7*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon (http://www.emcdda.eu.int/?nnodeid=428).

EMCDDA (2004c), *Drugs in focus 13. Overdose — a major cause of avoidable death among young people*, European Monitoring Centre on Drugs and Drug Addiction, Lisbon.

Eurobarometer (2004), 'Young people and drugs', *Flash Eurobarometer 158*, Taylor Nelson Sofres, Directorate General Press and Communication, European Commission, Brussels.

EuroHIV (European Centre for the Epidemiological Monitoring of AIDS) (2004), *HIV/AIDS surveillance in Europe, end-year report, 2003, No 70*, Institut de Veille Sanitaire, Saint-Maurice.

Eurostat (2002), *Health statistics: Key data on health 2002*, Office for Official Publications of the European Communities, Luxembourg, p. 58.

Eysenbach, G., Powell, J., Englesakis, M., et al. (2004), 'Health related virtual communities and electronic support groups: systematic review of the effects of online peer to peer interactions', *BMJ* 328, p. 1166.

FSW (Fonds Soziales Wien) (2004), *Jahresbericht 2003*, Fonds Soziales Wien, Vienna.

Ghuran, A. and Nolan, J. (2000), 'Recreational drug misuse: issues for the cardiologist', *Heart* 83, pp. 627–33.

GLADA (Greater London Alcohol and Drug Allliance) (2004), *An evidence base for London crack cocaine strategy*, Greater London Alcohol and Drug Alliance, London (http://www.london.gov.uk/mayor/health/drugs_and_alcohol/docs/coc_strategy_evidence.pdf).

Gowing, L., Farrell, M., Bornemann, R. and Ali, R. (2005), 'Substitution treatment of injecting opioid users for prevention of HIV infection' (review), *The Cochrane library*, 2005, Issue 2 (www.thecochranelibrary.com).

Haasen, C. (2003), Speech at 'Conference on treatment monitoring in the EU and the EU action plan on drugs 2000–04' at the EMCDDA, November 2003.

Hawks, D., Scott, K., McBride, N., et al. (2002), *Prevention of psychoactive substance use: a selected review of what works in the area of prevention*, World Health Organisation, Geneva.

Hibell, B., Andersson, B., Bjarnasson, T., et al. (2004), *The ESPAD report 2003: alcohol and other drug use among students in 35 European countries*, The Swedish Council for Information on Alcohol and Other Drugs (CAN) and Council of Europe Pompidou Group.

Hwang, S. (2001), 'Mental illness and mortality among homeless people', *Acta psychiatrica scandinavica* 103, pp. 81–2.

INCB (2005), *Report of the International Narcotics Control Board 2004*, United Nations International Narcotics Control Board, New York.

Korkeila, J. (2000), *Measuring aspects of mental health*, Themes 6/2000, STAKES, Helsinki.

Kumpfer, K. L., Alvarado, R. and Whiteside, H. O. (2003), 'Family-based interventions for substance use and misuse prevention', *Substance use and misuse* 38, pp. 1759–87.

Leppin, A. (2004), Vortrag zur schulischen Suchtprävention im Rahmen der Fachtagung 'Qualität schulischer Suchtprävention' am 20.04.04 in Kärnten (http://www.schule.at/community).

Macchia, T., Giannotti, F. C. and Taggi, F. (2004), *I servizi e le sostanze ricreazionali: una rilevazione clinica in Italia*, FrancoAngeli, Milan.

Matheï, C., Robaeys, G., van Damme, P., et al. (2005), 'Prevalence of hepatitis C in drug users in Flanders: determinants and geographic differences', *Epidemiology and infection* 133, pp. 127–36.

Mendes, F., Relvas, A. P., Olaio, A., et al. (2001), *The challenge of prevention of drug use*, IREFREA España, Palma de Mallorca (www.irefrea.org).

Mol, A., Van Vlaanderen, J. L. and De Vos, A. (2002), *Ontwikkeling van de cocaïne hulpvraag in de ambulante verslavingszorg 1994–2000*, IVZ, Houten.

Morral, A. R., McCaffrey, D. F. and Paddock, S. M. (2002), 'Reassessing the marijuana gateway effect', *Addiction* 97, pp. 1493–504.

National Treatment Agency (NTA) (2003), 'New guidance on injectable heroin and injectable methadone treatment for opiate misusers', press statement 13 June 2003 (http://www.nta.nhs.uk).

National Treatment Agency (NTA) (2004), '54 per cent more drug misusers get treatment in England', press statement 30 September 2004 (http://www.nta.nhs.uk).

Ouwehand, A., Van Alem, V., Mol, A. and Boonzajer Flaes, S. (2004), *Key figures addiction care 2003*, IVZ, Houten (http://www.sivz.nl).

Pijlman, F. T. A., Krul, J. and Niesink, R. J. M. (2003), *Uitgaan en veiligheid: feiten en fictie over alcohol, drugs en gezondheidsverstoringen*, Trimbos-instituut, Utrecht.

Prinzleve M., Haasen C., Zurhold H., et al. (2004), 'Cocaine use in Europe — a multi-centre study: patterns of use in different groups', *European addiction research* 10, pp. 147–55.

Quensel, S. (2004), *Das Elend der Suchtprävention*, Verlag für Sozialwissenschaften (VS), Wiesbaden.

Reis, J., Riley, W., Lokman, L. and Baer, J. (2000), 'Interactive multimedia preventive alcohol education: a technology application in higher education', *Journal of drug education* 30, pp. 399–421.

Reitox national reports (2004) (http://www.emcdda.eu.int/?nnodeid=435).

Rhodes, T., Lilly, R., Fernández, C., et al. (2003), 'Risk factors associated with drug use: the importance of "risk environment"', *Drugs: education, prevention and policy* 10, pp. 303–29.

Rigter, H., Van Gageldonk, A., Ketelaars, T. and Van Laar, M. (2004), 'Hulp bij probleemgebruik van drugs: stand van wetenschap voor behandelingen en andere interventies, 2004', Trimbos Institute/National Drug Monitor (NDM), Utrecht.

SAMHSA, Office of Applied Studies 2003 National Survey on Drug Use and Health (http://oas.samhsa.gov/nhsda.htm#NHSDAinfo).

Solberg, U., Burkhart, G. and Nilson, M. (2002), 'An overview of opiate substitution treatment in the European Union and Norway', *International journal of drug policy* 13, pp. 477–84.

Sullivan, L. E., Metzger, D. S., Fudala, P. J. and Fiellin, D. A. (2005), 'Decreasing international HIV transmission: the role of expanding access to opioid agonist therapies for injection drug users', *Addiction* 100, pp. 150–8.

Sussman, S., Earleywine, M., Wills, T., et al. (2004), 'The motivation, skills and decision-making model of "drug abuse" prevention', *Substance use and misuse* 39, pp. 1971–2016.

Taylor, B. J. (2000), 'Modeling prevention program effects on growth in substance use: analysis of five years of data from the Adolescent Alcohol Prevention Trial', *Prevention science* 1, pp. 183–97.

Terweij, M. and Van Wamel, A. (2004), *Ouders aan zet: opvoedingsondersteuning en verslavingspreventie voor allochtonen: succes- en faalfactoren*, GGZ Nederland, Utrecht.

UNODC (2002), *Contemporary drug abuse treatment: a review of the evidence base*, United Nations Office on Drugs and Crime, Vienna.

UNODC (2003a), *Global illicit drug trends 2003*, United Nations Office on Drugs and Crime, Vienna.

UNODC (2003b), *Ecstasy and amphetamines: global survey 2003*, United Nations Office on Drugs and Crime, Vienna.

UNODC and Government of Morocco (2003), *Morocco cannabis survey 2003,* United Nations Office on Drugs and Crime, Vienna.

WHO (1998), *Opioid overdose: trends, risk factors, interventions and priorities for action*, World Health Organisation, Programme on Substance Abuse, Division of Mental Health and Prevention of Substance Abuse, Geneva.

WHO (2004), 'Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users', *Evidence for action technical papers*, WHO, Geneva.

WHO (2005), 'Effectiveness of drug dependence treatment in preventing HIV among injecting drug users', *Evidence for action technical papers*, final draft, March 2005, WHO, Geneva.

WHO regional office for Europe (2002), 'Prisons, drugs and society: a consensus statement on principles, policies and practices', WHO regional office for Europe, Geneva.

European Monitoring Centre for Drugs and Drug Addiction

Annual report 2005: the state of the drugs problem in Europe

Luxembourg: Office for Official Publications of the European Communities
2005 — 87 pp. — 21 x 29.7 cm
ISBN 92-9168-227-6

SALES AND SUBSCRIPTIONS

Publications for sale produced by the Office for Official Publications of the European Communities are available from our sales agents throughout the world.

You can find the list of sales agents on the Publications Office website (http://publications.eu.int) or you can apply for it by fax (352) 29 29-42758.

Contact the sales agent of your choice and place your order.

TD-AC-05-001-EN-C

About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of the European Union's decentralised agencies. Established in 1993 and based in Lisbon, it is the central source of comprehensive information on drugs and drug addiction in Europe.

The EMCDDA collects, analyses and disseminates objective, reliable and comparable information on drugs and drug addiction. In doing so, it provides its audiences with an evidence-based picture of the drug phenomenon at European level.

The Centre's publications are a prime source of information for a wide range of audiences including policy-makers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public.

The annual report presents the EMCDDA's yearly overview of the drug phenomenon in the EU and is an essential reference book for those seeking the latest findings on drugs in Europe.

Publications Office
Publications.eu.int

ISBN 92-9168-227-6
9 789291 682270