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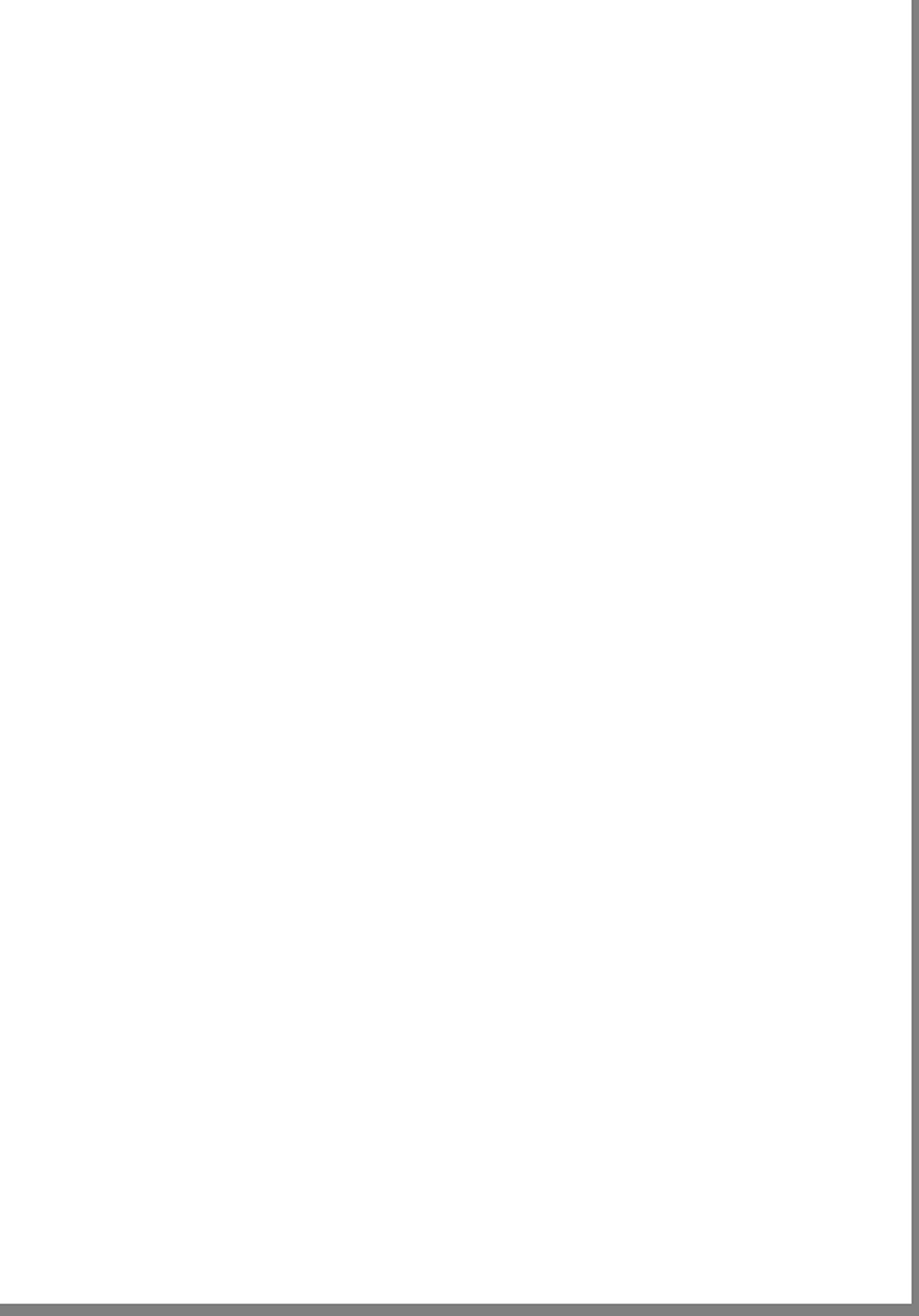
Annual Report on the State of the Drugs Problem in the European Union

FOR DRUGS

1997

AND DRUG

ADDICTION



E.M.C.D.D.A.

European Monitoring Centre for Drugs and Drug Addiction

Annual Report on the State of the Drugs Problem in the European Union

1997

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Preface

The *Annual Report on the State of the Drugs Problem in the European Union 1997* is important not just for what it says about drug problems in Europe (summarised in this document), but also for its revelation of major advances in our *ability to make* such statements. Increasingly the nations of Europe speak the same language on drugs and drug policy – a prerequisite for profiting from each other's experiences and cooperating to safeguard Europe's populations. In this process the EMCDDA can claim a major role as instigator and midwife. The fruits of these advances are seen in the enhanced policy relevance of this year's report, most obviously where it branches into new areas:

- A new chapter (chapter 3) on abuse of drugs such as ecstasy shows how systems and networks have developed to the point where information can rapidly be disseminated in response to an emerging concern – and how important this is when drug use itself disseminates with alarming rapidity.
- Last year's discussion of the relationships between the EMCDDA and its international partners is supplemented (in chapter 6) by a practical demonstration of those relationships in action, providing the perspectives and the data to define Europe's place in international drug trafficking patterns.
- This year's analysis of demand reduction activities (chapter 2) breaks new ground through a special study of interventions in Europe's criminal justice systems, giving Member States pointers to where they can learn from each other in this key sector.
- Last year we admitted that funding was a major gap in our knowledge of national strategies. It remains so, but now the new section in chapter 4 clearly defines the gap, analyses the issues involved in filling it, and draws on new data from the EU and elsewhere which shows the way forward.
- Chapter 1 now documents the worrying extent of hepatitis (especially hepatitis C) infection among injecting drug users, and data has improved to the extent that we can present meaningful figures on problem drug use – key inputs for Europe's policymakers and planners.

Other advances are less apparent but still solidify the platform for policy making at national and EU levels. These are just a few examples:

- For chapter 1 new surveys have enabled us to cover more drugs and to document the extent of relatively *current* drug use in the general population, a major advance in policy-relevant information.
- An EMCDDA study of the language of demand reduction sharpened the categories in this sector and led (in chapter 2) to a more diversified description and analysis of such activities.

In chapter 4 we see clear evidence of a spiralling process where increased scope for meaningful debate between EU nations produces benefits which encourage more of the same. Information from the EMCDDA (and the Europol Drugs Unit) was commended as "particularly helpful" by the Conference on Drugs Policy in Europe held in 1995–96 and by the subsequent European summits. Such events stimulate national developments which in turn improve the information available to the EMCDDA.

Last year I said the results presented in our first report justified the efforts required. That is even more so for this report. Investing relatively small sums in comparability improvements clearly has the ability to maximise the targeting, effectiveness and quality of national anti-drug expenditures. It is also clear that achieving this benefit demands deepened cooperation between data providers and those charged with producing EU-level information for policy makers. At the heart of this system is the EMCDDA's REITOX network and its focal points in each Member State. Focal points must have the resources and the freedom to work with their data providers on the one hand, and with the EMCDDA on the other, to create the scope for even more useful analyses. Progress entails being in a position to adopt common standards for best practice from wherever these derive, even if this means amending national data collections systems.

A companion technical report based on this year's findings is being disseminated to Europe's leaders, administrators and experts in the drug information field. As empowered under the EMCDDA's founding regulation, in that report we will make our recommendations with the force justified by the ultimate aim – to safeguard Europe's people, and especially our children, from the risks of drug misuse.

But there is one very basic objective, to which the coming millennium attaches an obvious time scale: by the year 2000, to have promoted a survey of the extent and nature of drug use across the European Union, with each country adopting compatible methodologies to enable us to define the scale of the problem with unprecedented confidence. The Treaty on European Union created the necessary framework for taking this decisive step forward. If we enter the new era without having grasped this opportunity, we will have failed even to approach the sophistication our people deserve.

I hope you find this summary useful, will be stimulated to obtain the full report, and will support our work for those affected by drug problems in Europe.

Georges Estievenart
DIRECTOR, EMCDDA

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For their commitment to making REITOX an active and essential part of the Centre's work by collecting the information and improving its quality and comparability

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For the daily efforts behind the scenes of many people in ministries, departments and services across the EU's 15 Member States who collected the raw data for their own national centres and for sending the books, reports, leaflets – and T-shirts – which help enliven this report

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THE EUROPEAN COMMISSION

For the quality and significance of its contribution – as we have come to expect, a thorough and complete view of European Union action against drugs

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THE POMPIDOU GROUP, UNDCP, WHO, EUROPOL, INTERPOL AND WCO

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- REITOX FOCAL POINTS
- THE EMCDDA'S PRIORITY INTERNATIONAL PARTNERS

THE READER'S CONTRIBUTION

HELP CREATE NEXT YEAR'S REPORT BY RETURNING THE SHORT QUESTIONNAIRE AT THE END OF THIS PUBLICATION

A NOTE TO READERS

Most of the succeeding chapters provide three levels of reading, enabling readers to quickly assimilate only the main points or new developments, or to delve into detailed findings.

Level ❶ KEY POINTS

Towards the beginning of each chapter is a KEY POINTS panel extracting the main findings, conclusions and any recommendations from throughout that chapter.

Level ❷ NEW DEVELOPMENTS

Again towards the beginning of most chapters is a panel extracting the main developments since the last report, enabling readers to directly key into recent trends. This panel will be particularly useful to readers familiar with last year's report who want a quick update to its findings.

Level ❸ MAIN TEXT

The main text of each chapter incorporates and expands on its key points and new developments, placing these in the context of a more detailed and complete account of the topic.

RELATIONSHIP TO 1995 REPORT

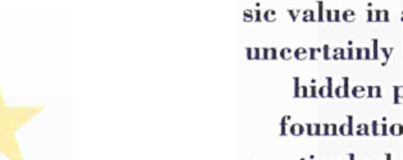
As the first in the series, last year's report included background information which for the sake of brevity is omitted from or abbreviated in this year's report; sufficient has been retained to avoid the need for readers to refer back to the previous report. In particular, last year's parts III and IV detailing how the information for these reports is collected are now published in a separate volume. Contact the EMCDDA for details.

Last year the report was dated according to the year reviewed in the text (1995). This year it is dated according to its year of publication (1997) but the data relates to the year 1996.

CHAPTER 1

Prevalence and patterns of use

How many Europeans take drugs, what sorts of drugs, what sorts of people, and what problems do we see as a result? Are these increasing, changing, and in what ways? And how do drug use and drug problems differ between the countries of the European Union? Answers to such questions have an intrinsic value in allowing us to grasp – even if uncertainly – the dimensions of a largely hidden problem. They also provide a foundation for developing responses – particularly the demand reduction policies and practices described in the next chapter.



All the questions posed in the introduction to this chapter are the province of epidemiology. Though its results are largely couched in numbers ('quantitative' data), understanding what these mean often demands more descriptive ('qualitative') information. Both are drawn on here to give a state-of-the-art picture of drug use in Europe. But readers should be aware that here the 'art', though advancing, remains far from advanced. The numbers are deceptively precise but their relationships to the realities at issue are usually distant and complex. Nevertheless, the data is sufficiently robust to hazard national-level answers to the following questions:

- How many people use different drugs ('prevalence') within a given time period? How many addicts are there? What are the characteristics of those involved? How are the drugs taken? What are the trends over time? And what new drugs or new patterns of use are emerging?
- What are the consequences, such as drug-related deaths, infectious diseases like AIDS, or crime related to different patterns of drug consumption?
- What are the patterns and trends in the supply and availability of different drugs?

Answers to such questions are essentially descriptive. However, they lead to questions which begin 'Why' and 'How'. How and why do people become involved with drugs? Why do some develop problematic patterns of use and others not? Why does drug use change over time and can future trends be anticipated? Why do nations differ or show similarities in drug use and trends? How does the broader national context affect drug use? Following from these are the 'What works' questions which most interest policymakers – which policies and interventions impact on drug trends and in what ways.

The EMCDDA is starting to address these questions but this cannot be done satisfactorily until basic descriptive data is improved. For example, it is fruitless to puzzle over the reasons for what seem different trends in different countries if we cannot be confident that the trends really do differ. Thankfully, progress is being made, clearly seen in the data available for this year's report compared to last year's.

• Ways to count the hidden •

As applied to illicit drug use, epidemiology is relatively young and faces unusual challenges. Illegality and social disapproval make the populations involved difficult to reach and raise questions about the degree to which they will be candid. These obstacles, together with the complexity of the drug phenomenon, demand creativity and the integration of knowledge and research technologies from a variety of social and health sciences. The basic tools available fall into three categories.

- Surveys are the main way to assess the extent of drug use in the general population. Those questioned may be a representative sample of the whole population or (often) just of the younger sectors.
- Assessing the prevalence of heavier, more problematic and less common patterns of drug use usually means resorting to alternative methods to study hidden populations. Often this entails following trails from known users to those not in contact with services, or extrapolating from data on known users to estimate the total population.
- Repeats of these studies or surveys are valuable ways to track trends over time, but such trends are more frequently tracked by indirect indicators based on routine statistics from services.

The contexts in which these methodologies are applied need to be taken into account when interpreting their output. Cultural differences and diverse health, social, legal and administrative structures influence results to such a degree that they become meaningless unless seen in the light of the systems from which they were derived.

While studies and indicator statistics are the ultimate sources (referenced at the end of the chapter), these have been sifted and supplied to the EMCDDA mainly by the National Focal Points of European Union (EU) Member States, supplemented by sources such as the international bodies described in chapter 6. For the first time Focal Points were asked to provide information using a standard framework and guidelines, improving coverage and facilitating information extraction and synthesis.

Limitations of the data

In many countries epidemiological research on illegal drug use is restricted to descriptive studies and reliant on data drawn from systems not geared to epidemiological needs. Often objective and reliable information is simply not available at national level. At European level the complexities are multiplied by national differences which would render even perfect national data incompatible. As a result, national differences seen in the tables which follow may reflect real differences in drug use and problems but may also (or instead) reflect differences in definitions, in how information is collected and in the treatment or enforcement systems from which much data emanates.

KEY POINTS

▶ Usually only a small minority of people who have tried a drug have done so recently or repeatedly, yet 'ever used' figures are often the only ones available.

▶ Throughout the European Union cannabis is the most commonly used illegal drug; depending on the country, from 5–8% to 20–30% of the population have at least tried it. However, use is commonly occasional or intermittent rather than frequent and the drug rarely appears as the primary drug in health and social care indicators.

▶ In most countries amphetamines are the second most frequently used illegal drug, generally tried by up to 3% of adults. From the late 1980s many countries reported that amphetamines, ecstasy and in some cases LSD had become more popular among young people, linked to a youth culture based around discotheques and large 'house' parties.

▶ Among young adolescents prevalence of solvent misuse may be higher than of any other drug apart from cannabis.

▶ European populations usually have less experience of heroin than of almost any other drug. Typically under 1% of adults have ever tried the drug, but among younger adults in major cities heroin addiction can be much more prevalent than the national average. Heroin continues to dominate among populations identified as having problems related to drug use and remains a major threat to public health and public safety.

▶ Combinations of drugs, including medicines and alcohol, play a continuing and increasingly important part in drug problems. Some countries in northern Europe have significant numbers of amphetamine injectors; in a few these form the majority of problem drug users.

▶ More people may have tried cocaine than have tried heroin, ranging from 1 to 4% of adults. Users tend to be socially integrated young adults who use intermittently, but cocaine also has more marginalised adherents. Crack smoking has been reported in several countries in groups similar to heroin users and in other marginalised groups, but it remains a limited phenomenon. Cocaine is rarely the main problem drug in treatment clients.

▶ Although there are exceptions, capital cities tend to have problem use rates higher than those of provincial cities and higher than the national rate.

▶ Injection seems to be less common among younger drug users and probably also among those who started drug use most recently. Compared to existing clients, a higher proportion of new, younger clients have problems involving cocaine and/or cannabis and fewer (but still the majority) have problems with opiates. Clients tend to be in their early 20s to early 30s; 70–85% are men.

▶ Addicted heroin injectors face a risk of death which may be 20 or 30 times higher than in the general population of the same age. Other forms of drug use pose a far lower risk. Many EU countries witnessed a marked rise in drug-related deaths in the second half of the 1980s and the early 1990s. Since then trends have diverged.

▶ Among drug users, sharing contaminated injecting equipment is the main transmission route for HIV and hepatitis. In many countries injectors have reduced such sharing. This and other infection control measures appear to have impacted on HIV transmission but not on hepatitis C. Generally, the rate of new cases of AIDS is decreasing.

▶ Hepatitis C is 50 to 100 times more infectious than HIV and can lead to extensive liver damage and cancer. The potential burden on society could be comparable to that of the HIV epidemic. There may be half a million drug users infected with hepatitis C in the European Union.

▶ High rates of hepatitis C infection imply that the risk behaviours which transmit viruses such as HIV are continuing, if at a lower level.

▶ Since the 1980s all but a few countries have reported increasing numbers of drug offences; in some, cannabis accounts for the large majority; in others, it is heroin. Everywhere the proportion of offences involving cocaine is low. Drug users constitute a significant proportion of the prison population in several, probably many, countries.

▶ The number of ecstasy seizures is increasing in all countries where these are reported. In many northern countries they remain well below those for amphetamines; in others the reverse is the case.

▶ In general, retail prices for cannabis are stable or slightly increasing, and for heroin and cocaine are either stable or falling. All other things being equal, stable or falling prices imply that supply is *not* being reduced relative to demand.

In some charts on the following pages these abbreviations and colours are used to refer to EU Member States

A Austria
B Belgium
D Denmark
FIN Finland
F France
D Germany
GR Greece
IRL Ireland
I Italy
L Luxembourg
NL The Netherlands
P Portugal
E Spain
S Sweden
UK United Kingdom

For these reasons this review confines itself to broad features and trends over time. Except in those rare cases where the data can support this, it does not attempt precise comparisons between countries or to sum national data into an EU total. With these caveats in mind, the next section synthesises the different types of data to present an overview of drug use and drug problems in Europe, picking out some major drugs or drug groups for special attention. Later sections detail what we know about drug use, drug problems and the availability and supply of drugs in the European Union.

An overview of drug use in Europe

Each source and type of data affords a partial and potentially distorted window on drug use in Europe, but the biases of one can be checked against those of another to achieve a more valid assessment. Convergent implications from several sources lend confidence to conclusions; differences suggest that the implications may be mistaken or that the picture is more complex. This triangulation process permits some general observations to be made.

A fundamental observation is that indicators of prevalence, of problems arising from a drug's use, and public awareness of either or both, may be at very different levels for the same drug. Among those singled out in this overview is the most widely used illegal drug in the EU (cannabis), one of the least used (heroin), and an intermediate example (cocaine). They model three very different relationships between prevalence of use measured in surveys and indicators of problems arising from that use recorded in health statistics.

	USE	PROBLEMS
Cannabis	⇑ High	⇓ Low
Heroin	⇓ Low	⇑ High
Cocaine	⇓ Fairly low	⇒ Intermediate

• Cannabis •

Throughout the European Union cannabis remains the most commonly used illegal drug, common enough to make survey results an appropriate measure. Partly because intensive use of cannabis is relatively unusual, partly because risks of dependence and other problems are relatively low, and partly because treatment is often oriented towards heroin addicts, cannabis rarely appears as the primary drug in health and social care indicators.

Reported prevalence rates vary substantially, depending (among other things) on the survey method used, the age range sampled, when the sample was questioned and the study's geographical scope; an urban study may report higher rates than a national study incorporating rural areas.

Except for countries (such as Ireland, Portugal or Greece) which started with low baseline levels, available trend data suggests that cannabis use was either relatively stable over the 1980s or dropped below levels reported in the early 1970s. In the 1990s this trend appears to have reversed and almost all countries report increased use. Use patterns are commonly occasional or intermittent rather than frequent. For example, although 40% of the Danish population aged 16 to 44 have ever tried cannabis, just 6–7% admitted use in the past 12 months and only 2% in the last month. Similar (but mostly less steep) gradients between lifetime use and more recent use are seen in every country where there is data. Gradients reported in school surveys will generally be much flatter since (by definition) any drug use is likely to have been recent.

• Cocaine and crack •

In the 1980s cocaine aroused concern in several European countries. More recently cocaine smoked (or less often injected) as crack has been seen in EU Member States. Despite high levels of concern, reliable data on cocaine and crack consumption is still lacking in many countries. Limited data suggests that more people have tried cocaine than have tried heroin. However, heroin accounts for a much higher proportion of cases recorded in indicators of drug-related problems. To the extent that trend data is available, this suggests modest increases in the prevalence of cocaine use in most countries, but less steep than increases in indicators of supply, such as quantities of cocaine seized.

Some national surveys have looked into cocaine use, though survey methodology is stretched to pick up such a rare form of drug use and the results may be underestimates. The proportion of adults who admit they have tried cocaine varies from 1% or less in countries such as Finland, Belgium and France,

New developments

▶ Improved information from population surveys allows it to be stated with confidence that other illegal drugs are reported much less commonly than cannabis in all EU countries, and that for all illegal substances recent use is much more widespread than lifetime experience.

▶ Trend data from surveys is available from a limited number of countries but the main trend is an increase of cannabis use in the last few years.

▶ In recent years, amphetamines, ecstasy and in some cases LSD have gained popularity among young people, linked to youth culture based around discotheques and large 'house' parties.

▶ Information on prevalence of problem drug use has improved substantially. We can, for example, more reliably conclude that capital cities tend to have higher rates than provincial cities and also higher than the national average.

▶ A number of indicators suggest a trend away from injecting. Compared to last year's report, there was a decrease in the proportion of clients entering treatment who were injecting, and among clients treated for the first time the proportion of injectors was significantly lower than for former clients.

▶ The downward trend in drug-related deaths observed in several countries over the last few years has reversed or stabilised. In others an upward trend continued.

▶ Data on HIV infection is substantially improved. In most countries the prevalence of HIV infection seems stable or decreasing, suggesting that injectors have reduced their risk behaviours, especially the sharing of injecting equipment. In most countries AIDS incidence is decreasing.

▶ New data enables us to conclude that the prevalence of hepatitis C in injecting drug users is substantially higher than for hepatitis B, implying that the risk behaviours which transmit other viruses such as HIV are continuing, if at a lower level.

to about 2% in Denmark and the UK and 3% in Spain. Among younger adults rates are usually about twice as high. In most EU Member States, school surveys suggest that around 1% of 15–16-year-olds have tried cocaine, but 2% in the Netherlands and Spain. In some larger cities cocaine use is probably more common than national figures suggest.

For insights into how the drug is used and with what consequences we must turn to alternative methods to study hidden populations. Several such studies have been carried out in different cities, often using the 'snowball' technique to interview cocaine users traced through their social networks. These show that cocaine consumers tend to be socially integrated 20–40-year-olds with above average educational and/or occupational status. Commonly they use cocaine intermittently, consuming relatively low doses in social contexts; a minority develop more intensive and problematic patterns of use.

Cocaine also has its more marginalised adherents. Heroin addicts who also take cocaine constitute a distinct cocaine using group with a social profile typical of heroin addicts rather than of cocaine users. Crack smoking has emerged as a significant problem in certain cities in France, the Netherlands and the UK, and has also been reported in countries such as Germany and Spain. Again the social profile of consumers appears partly to overlap with that of heroin addicts, but also to match that of other marginalised groups.

• Heroin and other opiates •

Although 'new' problem drugs such as cocaine or ecstasy sometimes attract more attention, in most EU countries heroin still dominates indicators which reflect problems arising from drug use, such as demand for treatment, drug-related deaths, and HIV and hepatitis infection. In some parts of Europe heroin markets are thriving, creating the potential for more widespread extension of heroin use to new groups in the population. Heroin remains a major threat to public health and public safety – one we would do well not to underestimate.

The prevalence of heroin use reported in surveys is usually among the lowest of the drugs surveyed. Typically about 1% or less of adults admit to ever having tried heroin, 1–2% among younger adults. These are likely to be underestimates but it would be surprising if prevalence was much higher. In contrast, heroin is often the main problem drug seen as driving drug-related crime or implicated in hospital admissions, physical complications and drug-related deaths. In all these regular users account for most

of the damage, making the number of heroin addicts a key statistic. Estimates suggest that typically between 0.2–0.3% of the general population in the EU are addicted to heroin, with national estimates varying from under 0.1% to about 0.5%. A tentative extrapolation to the EU as a whole suggests somewhere between 750,000 and one million heroin addicts – a figure in need of more scientific confirmation and one on which the EMCDDA is working. If proved roughly correct, this suggests a prevalence rate about half that of the USA.

Among younger adults in major cities heroin addiction can be much more prevalent than national figures suggest – and higher still if narrowed down further to men and deprived neighbourhoods.

Recent trends

Recent trends in heroin addiction present a mixed picture between countries and sometimes between different regions within a country. Most countries saw an increase in the 1980s. In some, recruitment of new addicts (incidence) has since dropped off and the prevalence of heroin addiction has stabilised or perhaps fallen slightly. In others prevalence seems to be increasing, in some cases after an apparent pause in the late 1980s. Often there may have been stabilisation or decline in heroin addiction in the major cities but an increase elsewhere.

Where the average age of known addicts has been steadily rising – the case in many countries – some observers have optimistically concluded that addicts are an ageing generation with few younger recruits joining in. Were this true, then the average would step up by nearly a year as each year passes; in most countries the rate of ageing is much slower and consistent with continued recruitment of younger addicts. Several countries also consistently report increases in heroin smoking by new groups of young people, among them Belgium (French community), Denmark, Ireland, Sweden and the UK.

• Amphetamines, ecstasy and LSD •

Chapter 3 details trends in 'synthetic drugs' of which amphetamines, ecstasy and LSD are the main concerns in the context of youth culture. This is a brief summary of the main features. Amphetamines have been for many years and remain important drugs of choice in several northern European countries (including the Nordic countries and the UK). During the 1980s they were uncommon in other parts of Europe. LSD became a feature of the 'alternative' culture of the late 1960s and the 1970s but in the 1980s consumption of LSD and other hallucinogens became relatively rare.

In the late 1980s and the 1990s many countries reported that amphetamines, ecstasy, and in some cases LSD, had become more popular among young people, linked to a youth culture based around discotheques and large 'house' parties. Where studies have been conducted there is little doubt that the trends are real. There is clear evidence of a broadening of the range of drugs used in a wider variety of recreational and social contexts, including use of the other main illegal stimulant, cocaine. Increases in the consumption of amphetamines, ecstasy and LSD have occurred among adolescents as well as younger adults, whereas increased cocaine use appears mainly to involve those over 20 years of age.

Where survey data is available, generally about 2–4% of schoolchildren aged 15–16 years have tried amphetamines (less in Finland and Sweden and up to 10% in the UK). By 18 to 20 years of age the proportion increases to 3–4% in some countries and 9–10% in others. Similar ranges are reported for ecstasy and LSD, with Belgium, the Netherlands, Spain and the UK tending to report the higher rates.

• Legal and semi-legal •

The drugs itemised above are illegal in the sense that they are controlled by laws designed to prevent drug misuse, and also in the sense that many countries permit no legitimate medical uses. There remains a mixed bag of drugs used as medicines or which are not controlled under drug laws but are nevertheless used as intoxicants. Perhaps top of the list among adolescents are volatile inhalants based on solvents, use of which attracted attention in some European countries during the 1970s and 1980s. As table 4 indicates, experience of these substances in the early teens is often higher than for any drug apart from cannabis, typically about 6% by 15–16 years of age. Though concentrated among relatively young adolescents, solvent misuse sometimes persists into later adolescence or young adulthood.

Many countries note increased misuse of medicines such as tranquillisers like flunitrazepam and temazepam, or painkillers such as buprenorphine, though systematic information at national level is scarce. Similarly several countries note increasing problems arising from use of several drugs in combination, including alcohol. For some (the UK, Sweden) use of anabolic steroids in sports clubs has become an issue and experience of 'poppers' (amyl or butyl nitrite) is not uncommon; in both cases too

few countries provided information for these drugs to be covered in this report.

In contrast with the more strictly illegal drugs, some countries note rural or small-town prevalence levels for misuse of solvents and medicines (with or without alcohol) which match those of cities. Behind this may lie the concentration of illegal drug markets in cities. For at least some drugs and some countries, the urban-rural differential may diminish as illegal drugtaking diffuses from major cities. Set against this is the possibility that cities act as a magnet attracting young people from smaller communities who have become involved in illegal activities.

Prevalence: how many users?

The most direct way to measure the extent of drug use in a country is to ask a representative cross-section of the population whether they have used drugs – the familiar survey. As applied to drug use the method suffers important limitations, but for more common and less stigmatised drug use patterns, such as cannabis use, surveys are feasible and potentially reliable. For rare and stigmatised forms of drug use, surveys need to be supplemented or replaced by other methods.

At international level comparison between countries is hampered by different sampling and data collection methods and by analyses which employ incompatible categories or measures. This makes it difficult to compare trends over time in the same country as well as between countries. The situation is slowly improving, as more countries recognise the value of a consistent series of surveys repeated every few years as a trend indicator, and as projects to improve comparability, initiated by the EMCDDA amongst others, start to bear fruit. Such improvements are likely to be incremental rather than dramatic.

Figures given in this chapter should be treated as approximations of the dimensions of drug use among the populations sampled, especially where the sample is less than 1000. If national data is lacking, the tables in this chapter occasionally resort to regional surveys, but not to city surveys as these can report prevalence rates orders of magnitude greater than regional or national surveys.

• General population surveys •

Since 1990 over half the 15 EU Member States have mounted nationwide surveys of illegal drug use in the general population – no more than last year, but some report more recent surveys and others provide more complete information. Tables 1 and 2 on page 16 summarise the results in terms of the percentage of people who reported use of certain drugs at some point in their lives, and whether they

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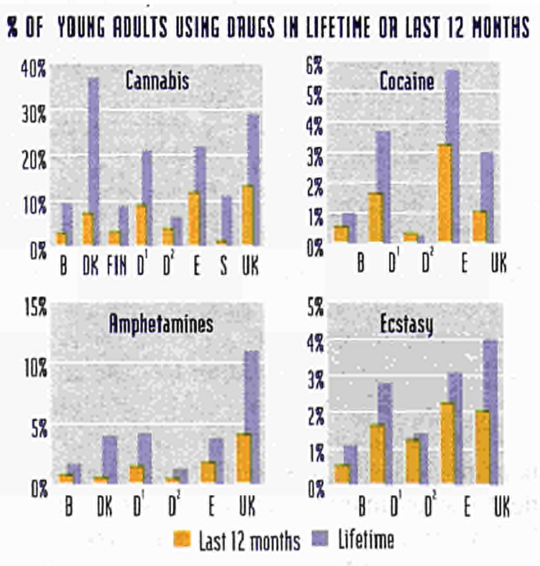
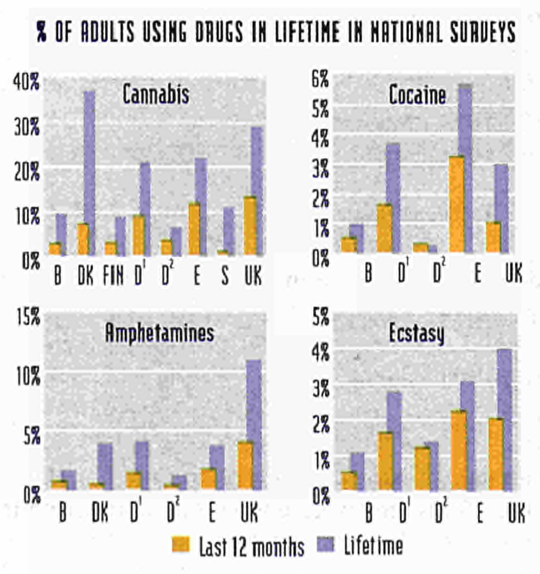




Drug use is primarily seen among younger adults and cannabis is the drug used most. Only a proportion of younger adults who have ever tried drugs will have done so in the past 12 months and the range across countries is much narrower

Based on tables 1 and 2.

1. West Germany.

2. East Germany.

See tables 1 and 2 for further notes.

Table 1 • Lifetime prevalence of drug use in recent nationwide general population surveys in some EU countries

COUNTRY	Year	Method	Sample size	ALL ADULTS %					YOUNGER ADULTS %				
				Age range	Cannabis	Cocaine	Amphetamines	Ecstasy	Age range	Cannabis	Cocaine	Amphetamines	Ecstasy
BELGIUM FLEMISH	1995	Phone	1142	18–65	5.5	0.5	0.9	0.5	18–39	9.5	1.0	1.7	1.1
DENMARK	1994	Interview	2521						16–44	37.0		4.0[1]	
	1994	Mail	2000	18–69	31.3	2.0	4.0		16–44	43.0			
FINLAND	1992	Mail	4892	18–74	4.8	0.6[1]			18–34	8.8	1.1[1]		
FRANCE	1995	Phone	1993	18–75	15.2	1.1	0.7[4]		18–39	25.7	1.8	1.4[4]	
GERMANY WEST	1995	Phone	6292	18–59	13.9	2.2	2.8	1.6	18–39	21.0	3.7	4.2	2.8
GERMANY EAST	1995	Phone	1541	18–59	3.6	0.2	0.7	0.7	18–39	6.4	0.3	1.3	1.4
SPAIN	1995	Interview	9984	15-70	13.0	3.3[2]	2.3	1.8[3]	15–39	21.9	5.7[2]	3.8	3.1[3]
SWEDEN	1996	Interview	1500	15–75	8.0	1.0	2.0	0.0	15–39	11.0	1.0	3.0	1.0
UNITED KINGDOM	1994	Interview	10,000	16–59	21.0	2.0	8.0	2.0	16–39	29.0	3.0	11.0	4.0

Sources: see notes at end of chapter. Empty cells indicate data not available.
1. Hard drugs.
2. Cocaine or crack.
3. Designer drugs.
4. Amphetamine and ecstasy.

Table 2 • Last 12 months prevalence of drug use in recent nationwide general population surveys in some EU countries

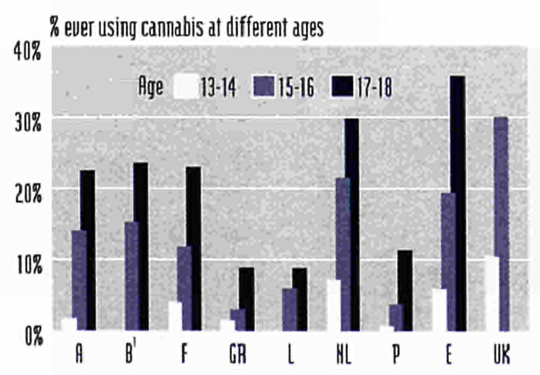
COUNTRY	Year	Method	Sample size	ALL ADULTS %					YOUNGER ADULTS %				
				Age range	Cannabis	Cocaine	Amphetamines	Ecstasy	Age range	Cannabis	Cocaine	Amphetamines	Ecstasy
BELGIUM FLEMISH	1995	Phone	1142	18–65					18–39	2.7	0.5	0.7	0.5
DENMARK	1994	Interview	2521						16–44	7.0		0.5[1]	
	1994	Mail	2000	18–69	3.3				16–44	6.0		0.5[1]	
FINLAND	1992	Mail	4892	18–74	1.2				18–34	3.0			
FRANCE	1995	Phone	1993	18–75	4.4	0.1	0.3[5]		18–39	8.9	0.3	0.6[5]	
GERMANY WEST	1995	Phone	6292	18–59	5.0	0.9	0.8	0.9	18–39	8.8	1.6	1.4	1.6
GERMANY EAST	1995	Phone	1541	18–59	1.9	0.2	0.2	0.6	18–39	3.5	0.3	0.4	1.2
SPAIN	1995	Interview	9984	15-70	6.6	1.7[2]	1.0	1.2[3]	15–39	11.6	3.2[2]	1.7	2.2[3]
SWEDEN	1996	Interview	1500	15–75	<0.5[4]				15–39	1.0[4]			
UNITED KINGDOM	1994	Interview	10,000	16–59	8.0	1.0	2.0	1.0	16–39	13.0	1.0	4.0	2.0

Sources: see notes at end of chapter. Empty cells indicate data not available.
1. Hard drugs.
2. Cocaine or crack.
3. Designer drugs.
4. All illegal drugs.
5. Amphetamines and ecstasy.

Table 3 • Lifetime prevalence of cannabis use in recent nationwide school surveys in some EU countries and among teenagers in recent general population surveys

COUNTRY	Year	SCHOOLS Age range	Total %	13–14 years %	15–16 years %	17–18 years %	GENERAL Age range	Teenagers %
AUSTRIA	1994	13–18	8.7	1.8[1]	14.0[1]	22.5[1]		
BELGIUM FLEMISH	1994	15–18	18.6		15.3[1]	20.5[1]	18–24	11.2
DENMARK	1995	15–16	18.0		18.0		16–19	28.0
FINLAND	1995	15	5.0[1]		5.0[1]		18–24	11.5[1]
FRANCE	1993	11–19	11.8	4.0	11.9	23.0	18–24	30.0
GERMANY	1994						18–20	22.6
GREECE	1993	13–18	4.6	1.5	3.0	8.9	12–17	1.1
IRELAND	1995	16	37.0		37.0			
LUXEMBOURG	1992	16–20	10.1		6.0[1]	8.8[1]		
The NETHERLANDS	1992	12–18+	14.6	7.2[1]	21.6	29.8	16–19	30.2
PORTUGAL	1995	14–17	3.2	0.7[3]	3.8	11.4[5]		
SPAIN	1994	14–18	20.8	5.9[4]	19.4[1]	35.8[1]	15–19	16.4
SWEDEN	1995	15	5.0[1]		5.0[1]		15–19	3.0
	1996	15	7.2		7.2			
UNITED KINGDOM	1994	11–16		10.5[1]	30.0[1]		16–19	36.0
	1995	11–16			37.0[1,2]			

Sources: see notes at end of chapter.
Empty cells indicate data not available.
In all the surveys the method of data collection was written questionnaires, but due to other differences in methodology the results cannot be directly compared. Due to the differences in reporting of results, in some cases it was necessary to do some reasonable estimations (eg, average of results from girls and boys).
1. Estimated.
2. "All illegal drugs" as an aproximation.
3. Under 14 years of age.
4. 14 years of age.
5. 17 years of age and over.



In the teenage years experience of drugs is highly related to age

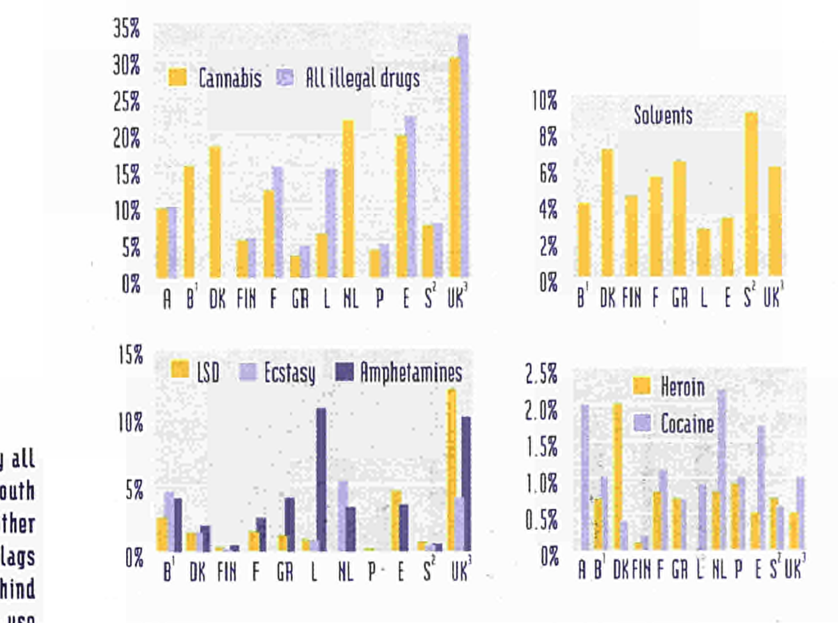
Based on table 3.
Only countries/studies where at least two sets of data are available.
1. Flemish community.

Table 4 • Lifetime prevalence of use of different illegal drugs among 15-16 year old students in recent nationwide school surveys in some EU countries

COUNTRY	Year	Sample size	% EVER USING DRUGS: All illegal	Cannabis	Solvents	Amphetamines	Ecstasy	LSD	Cocaine	Heroin
AUSTRIA	1994	2250	9.9[1]	9.5[1]					2.0[2]	
BELGIUM FLEMISH	1994	10414		15.3[1]	4.0[1]	4.0[1]	4–5[1]	2–3[1]	1.0[1]	0.7[1]
DENMARK	1995	2571		18.0	7.0	2.0	1.5	1.4	0.4	2.0
FINLAND	1995	2300	5.5[1]	5.2[1]	4.4[1]	0.5[1]	0.2[1]	0.3[1,7]	0.2[1]	0.1[1]
FRANCE	1993	12391	15.3	11.9	5.5	2.5[6]		1.5[7]	1.1	0.8
GREECE	1993	10543	4.5	3.0	6.3	4.0		1.2	0.7	0.7
LUXEMBOURG	1992	1341	15.0	6.0	2.6	10.6	0.9	0.9	0.9	0.0
The NETHERLANDS	1992	7591		21.6[1]		3.3[1]	5.2[1]		2.2[1]	0.8[1]
PORTUGAL	1995	4767	4.7	3.8				0.2	1.0	0.9
SPAIN	1994	21094	22.1[1]	19.4[1]	3.2[1]	3.5[1]	2.9[1,3]	4.5[1,7]	1.7[1]	0.5[1]
SWEDEN	1995		5.8	5.0	9.2	0.4	0.4	0.5	0.3	0.2
	1996	6027	7.5[1]	7.2	9.0[1]	0.6	0.5	0.7	0.6[4]	0.7[5]
UNITED KINGDOM	1994	20218	33.3[1]	30.0[1]	6.0[1]	10.0[1]	4.0[1]	12.0[1]	1.0[1]	<1.0[1]
	1995	18000	37.0[1]	37.0[1,2]						

Sources: see notes at end of chapter.
Empty cells indicate data not available.
In all the surveys the method of data collection was written questionnaires, but due to other differences in methodology the results cannot be directly compared. Due to the differences in reporting of results, in some cases it was necessary to do some reasonable estimations (e.g. average of results from girls and boys).
1. Estimated.
2. Hard drugs.
3. Plus other synthetic drugs.
4. Cocaine and crack.
5. Opiates.
6. Plus ecstasy and stimulants.
7. Hallucinogens.

In nearly all countries youth use of any other illegal drug lags far behind cannabis use



Based on table 4.
Missing bars or countries indicate data not available.
1. Flemish community.
2. 1996 survey.
3. 1994 survey.

Table 5 • National prevalence estimates of problem drug use in EU countries

COUNTRY	Year	Data[1]	Methods[2]	Definition[3]	Prevalence estimate (thousands)	Popul-ation (millions)	Rate /1000
BELGIUM	1996	Treatment surveys, estimates from various indicators	Case-finding, multiplier	**Heavy drug abusers**	**16–70**	10.1	**1.6–6.9**
DENMARK	1996	Mortality data	Multiplier	**Heavy drug abusers[4]**	**12.5**	5.25	**2.4**
FINLAND	1991	Drug deaths	Multiplier	**Opiate addicts**	**<1**	5.1	**<0.2**
FRANCE	1993	Treatment surveys (November census)	Demographic model	**Heroin addicts[5]** (mostly IDUs)	**160**	58.2	**2.7**
GERMANY	1996	Arrests, treatment, deaths, surveys, GPs	Multiplier, other methods	**IDUs or frequent hard drug users[6]**	**150**	81.5	**1.8**
ITALY	1992	Treatment, police, prison, deaths, AIDS, cohort study	C-RC, multiplier	**Opiate addicts** (mostly IDUs)	**190–313**	57.7	**3.3–5.4**
LUXEMBOURG	1994	Treatment, drug offences, prison	Multi-indicator	**High-risk drug consumers[6]**	**2**	0.42	**4.8**
The NETHERLANDS	1993	Treatment, police, experts municipalities	Multiplier, extrapolation	**Opiate addicts** (including IDUs)	**25–28**	15.2	**1.6–1.8**
SWEDEN	1992	Social services, treatment, correctional system	Case-finding, C-RC	**Severe drug abusers[7]**	**14–20**	8.7	**1.6–2.3**

Sources: see notes at end of chapter.
Countries omitted indicates data not available.
1. GPs=general practitioners
2. C-RC=capture recapture.
3. IDUs=injecting drug users.
4. Opiate addicts (IDUs as well as smokers), amphetamine addicts, cocaine addicts, and patients undergoing methadone treatment.
5. This estimate assumes opiate addicts present to health or social systems at least once in their career; those who do not are excluded.
6. Almost all are opiate misusers or injecting drug users.
7. Injected at least once in last year or daily/almost daily use of any illegal drug (including cannabis and ecstasy). Of these, 34% were opiate users and 93% injected in the last year (mostly amphetamines).

had done so in the last 12 months. There are no major changes compared to last year.

Lifetime experience

These surveys reveal that the proportion of adults who say they have tried cannabis (which in most cases approximates to experience of any illegal drug) at some point in their lives ranges from about 5–8% in Belgium, Finland, Sweden and the former East Germany, to 13–15% in France, the former West Germany and Spain, to about 20% in the UK and 30% in Denmark. More younger adults admit experience of cannabis, varying from about 10% in Flemish Belgium, Finland, Sweden and former East Germany, to around 20% in the former West Germany, Spain and France and over 30–40% in the UK and Denmark.

This year the data was sufficient to support tabulating use of drugs other than cannabis. However, caution is required because of low prevalence figures and because higher levels of social disapproval may affect people's readiness to admit use of these drugs to different degrees in different countries. The most obvious finding is that other illegal drugs are used much less commonly than cannabis. In most countries, amphetamines are second to cannabis, ever used by under 3% of adults and 2–4% of younger adults. The exception is the UK with 8% and 11% respectively. Except for Spain and France, cocaine is less common than amphetamines, ever used by under 2% of adults and less than 4% of younger adults (but 3% and nearly 6% in Spain). Among adults in general, experience of ecstasy is less than of cocaine, but among younger adults it may be the same or higher, reaching around 3% in the former West Germany and Spain and 4% in the UK. Heroin use (data not presented) is rarely admitted in population surveys.

Table 6 • Local prevalence estimates of problem drug use in some EU countries

COUNTRY	Region or city	Year	Data sources	Methods[1]	Definition[2]	Prevalence estimate	Population Age range	Rate /1000
AUSTRIA	Vienna	1995	Treatment, deaths, police	Consistency checks, case-finding	**Opiate addicts**	5000–6000	1,601,630 all ages	3.1–3.7
FRANCE	Toulouse	1994	Treatment, hospital, prison drug unit	3 sample C-RC	**Opiate addicts**	1156	332,654 15–44	3.5
GERMANY	Berlin	1995–96	GPs	C-RC, monitor GPs	**IDUs**	6,500–8,000	3,466,000 all ages	1.9–2.3
ITALY	Lazio region	1992	Public treatment, therapeutic community, police	3 sample C-RC	**Opiate addicts**	24,060	2,313,755 15–44	10.4
ITALY	Rome	1987–88	Treatment, AIDS registration	2 sample C-RC	**IDUs**	9946	848,211 15–34	11.7
The NETHERLANDS	Alkmaar	1991	Field study	Case-finding, nomination, snowball	**Opiate users**	98	120,000 all ages	0.8
The NETHERLANDS	Amsterdam	1995	Treatment registration, methadone in police cell	2 sample C-RC	**Opiate addicts**	3758–6317[8]	725,000 all ages	5.2–8.7
The NETHERLANDS	Rotterdam[3]	1988–90	Treatment registration, arrested heroin addicts	2 sample C-RC	**Opiate addicts**	4000–4600	600,000 all ages	6.7–7.6
The NETHERLANDS	Rotterdam[4]	1994	Treatment, street survey	Treatment multiplier	**Opiate addicts**	2400–3500	600,000 all ages	4.0–5.8
The NETHERLANDS	Utrecht	1993	Police, methadone, field study	C-RC, nomination, network analysis	**Opiate users**	950	234,000 all ages	4.1
SPAIN	Barcelona	1989	Emergencies, treatment, deaths	3 sample C-RC	**Opiate addicts**	6324–7414	747,000 15–44	8.5–9.9
SPAIN	Madrid	1992	Deaths, treatment, AIDS registration, prison	3 sample C-RC and multipliers	**Heroin addicts**	41,000	2,330,973 15–44	17.6
SPAIN	Navarra	1990	Health and social systems	Case-finding	**Heroin users in treatment**	1231	513,000 all ages	2.4
SWEDEN	Malmö	1992	Needle exchange, treatment, social services, detention	Case-finding, C-RC	**Severe drug abusers[6]**	1100–1300	236,684 all ages	4.6–5.5
SWEDEN	Stockholm	1995	Treatment, social services	Case-finding	**Drug users at services[5]**	1656	711,119 all ages	2.3
UNITED KINGDOM	Dundee	1990–94	Treatment, police, HIV test, GPs	4 sample C-RC	**Misusers of opiates or benzodiazepines**	1974–3458	88,785 15–55	22.3–39.0
UNITED KINGDOM	Glasgow	1989	Treatment, police, HIV test	3 sample C-RC	**IDUs**	6964–11,884	630,000 15–55	11.1–18.9
UNITED KINGDOM	Glasgow	1990	Treatment, police, HIV test, needle exchange	4 sample C-RC	**IDUs**	7491–9721	630,000 15–55	11.9–15.4
UNITED KINGDOM	Liverpool	1991	Treatment, police, infectious diseases unit	3 sample C-RC	**Users of opiates or cocaine**	2344	451,000 all ages	5.2
UNITED KINGDOM	Wales	1994	Treatment, probation, police, needle exchange	C-RC	**Serious drug users[7]**	8357	1,565,000 15–55	5.3

Sources: see notes at end of chapter.

1. C-RC=capture-recapture. GPs=General Practitioners. 2. IDUs=injecting drug users. 3. One-year period prevalence.

4. Three-month period prevalence of 2400, extrapolated to a one-year prevalence of 3500.

5. Includes cannabis and ecstasy users in contact with social services.

6. Injected at least once in last year or daily/almost daily use of any illegal drug (including cannabis and ecstasy). Of these 44% were opiate users and 95% injected in the last year (mostly amphetamines).

7. Includes IDUs. Arrests data may be confined to problem users of opiates and amphetamines. Because this estimate is not truly local C-RC is difficult to apply due to spatial heterogeneity.

8. Dutch=3758, Foreign=2559, Total=6317. The estimate for foreigners could be too high as these form an 'open' population.

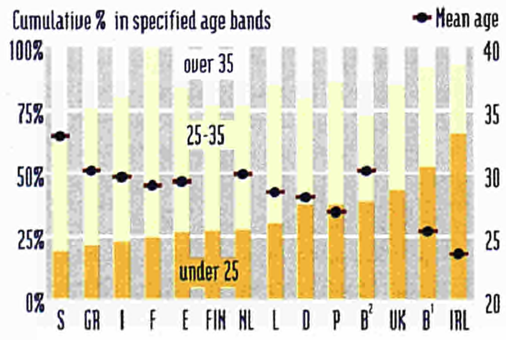
Table 7 • Some characteristics of clients treated for drug problems in different EU countries

COUNTRY	Year	CLIENT CHARACTERISTICS: Mean age	% under 25 years	% over 35 years	% male	% injecting main drug	MAIN DRUGS USED AND % INJECTING MAIN DRUG: Opiates % of total	Opiates % injecting	Cocaine % of total	Cocaine % injecting	Amphetamines % of total	Amphetamines % injecting	Hallucinogens % of total	Cannabis % of total	Other % of total
BELGIUM															
BRUSSELS	1996		22.0	25.0	71		79.0		6.0					5.1	10.2[5]
FLEMISH[1]	1995	25.4	52.2	8.4	82		62.1		11.7		18.6		1.4	4.4	1.9
FRENCH[2]	1995	30.2	38.4	27.2	76	18.6	59.0	31.0	2.0		0.3		0.1	4.7	34.1[6]
DENMARK	1995				68	30.0	88.0		0.1		0.2		0	4.6	5.3
FINLAND	1995		27.0	22.8	69		33.6		0.8		42.1		2.4	21.1	
FRANCE[3]	1995	28.9	24.2		73		68.1		2.2		0.8		0.4	8.1	20.4[7]
GERMANY	1995	28.0	37.2	20.4	76		72.6		6.7		1.8		5.4	12.9	0.8
GREECE	1995	30.1	21.1	24.4	85	84.3	89.0	94.0	0.6	14.0	0.0		0.3	4.9	5.2
IRELAND	1995	23.6	65.3	7.2	79	45.6	74.6	61.0	0.5		0.3		1.3	13.1	10.2[8]
ITALY	1996	29.7	22.4	19.8	85		88.7		1.8		0.4		0.2	5.8	3.1
LUXEMBOURG	1996	28.4	30.0	15.0	82	65.0	76.0		13.0		0.0		0.0	5.0	6.0
The NETHERLANDS	1996	29.9	27.3	22.9	80		68.0	14.0	14.5		2.6		<1	10.5	3.4
PORTUGAL	1995	26.9	37.2	13.6	81	41.0	95.7		1.5					0.4	2.4
SPAIN	1996	29.2	26.5	16.3	84	32.2	89.8	35.0	5.6	8.0	0.6	1.4	0.1	3.0	0.9
SWEDEN	1995	32.8	18.7	34.0	70		29.2		0.1		22.2		0.1	7.9	40.5[9]
UNITED KINGDOM	1995/6		43.0	15.0	75	36.0[4]	70.0	42.0	4.0	7.0	9.0	42.0	0.0	7.0	10.0[10]

Sources: see notes at end of chapter.
Empty cells indicate data not available.
1. Specialised residential treatment only.
2. First treatments only.
3. Specialised centres only.
4. Based on heroin users.
5. 3.5% hypnotics/ sedatives.
6. Polyaddicts: alcohol plus illegal drugs.
7. 13.5% substitution treatments. Remaining cases: solvents, alcohol and others.
8. Including stimulants and hypnotics/ sedatives.
9. Multiple abuse.
10. 5% benzodiazepines of whom 2% inject.

Use in the last 12 months

Ever having used a drug could mean a single episode dating back to the 1960s of little relevance to today's policy decisions. A better indication of current use is the proportion who report use in the past 12 months, though if drug use is subject to serious social disapproval or legal sanctions people may tend to under-report recent drug use, even in confidential surveys. Availability of such data from all countries to have recently conducted national surveys of the general population (see table 2 on page 16) is one of the major advances since the previous report. The consistent picture was that just a small minority of adults who had ever used drugs admitted doing so in the past 12 months.



Across EU nations the average ('mean') ages of problem drug users in treatment vary by nearly 10 years

Based on table 7.
1. Flemish community.
2. French community.
See table 7 for further notes.

Table 8 • Definitions of drug-related death in EU countries used in table 9[1]

	CASE DEFINITION	SOURCE OF INFORMATION
AUSTRIA	Direct and indirect drug-related deaths (overdose, suicide of drug addicts, AIDS related to drug use, accidents). In EMCDDA Annual Reports only cases of overdoses for morphine-type substances are included.	Cases are reported by the police and hospitals to the Federal Ministry of Health and Consumer Protection which orders forensic examination.
BELGIUM	Statistics on general mortality are registered by the Belgian Communities and officially published by the National Institute of Statistics, classified in accordance with ICD 9[5]. The Justice Department separately registers certain causes of death, amongst which are drug-related deaths known to the police.	Cases are reported by police and transmitted for recording to the police central office (Service Général d'Appui Policier).
DENMARK[2]	Deaths caused by accident or suicide due to: misuse of illegal drugs; misuse of other drugs if the deceased was a known drug addict; or misuse of intoxicating but not illegal drugs.	Cases are reported by police districts to the National Commissioner of Police.
FINLAND	Sudden and unexpected deaths in which drugs are found in samples investigated by forensic toxicologists (medical examiners).	Cases are reported by hospitals and police to medical examiners at the Dept. of Forensic Medicine, University of Helsinki, which analyses and records the data.
FRANCE	Overdose in the strictest sense of the term and accidents directly or indirectly linked to the conditions in which the substance was administered.	Cases are reported by police and gendarmerie departments to a special police department (OCRTIS, National File of Perpetrators of Narcotic-related Legislative Infractions) for recording.
GERMANY	• Deaths following overdose. • Deaths as a result of a long-term abuse. • Suicide resulting from despair about the circumstances of life or the effects of withdrawal symptoms. • Fatal accidents under the influence of drugs.	Cases are reported by local police units, working jointly with forensic physicians, to the Federal Criminal Police Office (BKA) which records the information.
GREECE	Direct drug-related deaths (overdoses).	Cases must be notified to the police who refer sudden deaths to the forensic department for autopsy and toxicology, which notifies police of the results. Records are sent to the police central office for registration and publication.
IRELAND	Death certificate indicates the underlying cause of death as ICD[5] 9 codes 304 (drug dependence) or 965 (poisoning). Information on the drug-related aspect of deaths is frequently available in the data collection process but lack of a methodology to capture this means it can be lost, limiting the data.	Data is collected by regional registrars of births and deaths from a number of sources (doctors, police, coroners) and returned centrally to the Office of the Registrar General. The Central Statistics Office reports on the deaths annually to the Minister of Health.
ITALY	Cases of death caused by acute intoxication (overdoses), broken down by type of substance.	Cases are reported by local and special police units to the Central Office of Anti-drug Services (DCSA) for recording.
LUXEMBOURG	Lethal intoxication, voluntary or accidental, caused directly by: abuse of illicit drugs or; by any other drug in if the victim is considered a regular consumer of illicit drugs.	Information is reported by police to the Drug Unit of the Criminal Investigation Department.

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Where drug addiction is the underlying or contributory cause of death or where accidental poisoning (almost always overdose) by opiates or related narcotics is the underlying cause of death, according to codes 304 and E850 respectively of ICD 9.[5] Only persons named in the Dutch population register are included.	Data is collected from death certificates submitted by physicians and coroners. Information is recorded by the Central Bureau of Statistics (CBS) in its Statistics of Death Causes.	**The NETHERLANDS[3]**
Direct drug-related deaths (overdoses).	The information is recorded and reported by the institutes of legal medicine in Lisbon, Porto and Coimbra.	**PORTUGAL**
Deaths due to acute reactions following opiate or cocaine consumption. From 1996 onwards, deaths due to acute reactions following consumption of any psychoactive substances are included.	Data is extracted by a specific reporting system (SEIT) from the files of medical pathologists, mostly working at institutes of pathology in larger cities and at the National Institute of Toxicology or other institutes in six major cities.	**SPAIN**
Cases in which drug dependence or poisoning are an underlying or contributory cause of death, according to ICD 9[5] codes 304 (drug dependence) and 965.0, 968.5, 969.6 and 969.7 (poisoning).	Information is reported by the physician who issued the death certificate. In some cases complementary information is collected from the issuing institution. Cases are recorded by Statistics Sweden and reported and published by the National Board of Health and Welfare.	**SWEDEN**
Deaths due to drug dependence or non-dependent abuse; accidental, suicidal or undetermined poisonings.	Information for the whole population is recorded and reported by the Office of Population Censuses and Surveys (OPCS).	**UNITED KINGDOM[4]**

Notes to table 8

1. In some cases rephrased as a case definition or to avoid overly general statements.

2. The National Register of Causes of Death may produce statistics on cases in which drug abuse or poisoning are the underlying or contributory cause of death, according to ICD-8 (see note 5).

3. In Amsterdam and Rotterdam specific methods are used to monitor overdose deaths. In Amsterdam other causes related to drug use (such as AIDS) are also included. Data are collected from several sources, and deaths of illegal foreigners are also included.

4. Also available are statistics of deaths among those recorded in the Home Office Addiction Index.

5. International Classification of Diseases, identifed by edition number.

Cannabis use in the past 12 months ranges from 1–2% in Finland, Sweden and former East Germany, to 3–5% in Denmark, former West Germany and France and about 6–8% in Spain and the UK. As with lifetime prevalence, rates are higher in younger adults but still much lower than ever use figures, ranging from 3% or less in Flemish Belgium, Finland and Sweden to 6–13% in Denmark, France, Germany, Spain and the UK. On this measure the range across countries is condensed, suggesting that the wider variation in lifetime prevalences is partly a historical residue rather than a current reality.

For drugs other than cannabis, reported use in the past 12 months is generally very low even among younger adults, at under 2% for amphetamines, cocaine and ecstasy. Exceptions are the 4% of 16–39-year-olds in the United Kingdom recently to have used amphetamines and over 3% of 15–39-year-olds in Spain who admitted recent cocaine use.

Trends over time

Few countries conduct regular surveys using comparable methods so it is difficult to draw conclusions about trends over time. Also, for important methodological reasons, lifetime prevalence figures should not be used to assess such trends. It is much more valid to look at recent use. On the basis of information from a limited number of countries, the main trend seems an increase in cannabis use in the past few years. In some countries at least, there has also been an increase in use by younger adults of amphetamines or related substances such as ecstasy. Cocaine use remains relatively uncommon across the general populations of all Member States; heroin even more so.

However, general population surveys are not sensitive to new trends in drug use, especially when these develop in subgroups or in specific areas such as major cities. Neither do such surveys always produce reliable information on the high-risk age range, from adolescence to the mid-20s. It is important to improve sampling and data collection in this age range and to carry out more detailed and comparable analyses enabling us to disentangle the effects of age from those of year-by-year trends.

• School surveys •

With concern over drug use focused on the young, surveys also tend to focus on the same group, espe-

cially secondary school pupils. Almost all EU Member States (more than for general population surveys) have recent national surveys to draw on (tables 3 and 4 on p. 17 and 18). Here lifetime prevalence is more relevant; by definition, any drug use is likely to be recent. However, in these maturing years the exact age of the sample is a key variable which must be taken into account; from 12 to 18 years of age prevalence can multiply by a factor of ten or more. Results are also influenced by methodology. General population surveys which include younger age groups usually report lower levels of drug use than school surveys. Classroom surveys use anonymous self-completion questionnaires; population surveys contact people at home. It could be that young people more readily admit drug use when anonymity is assured and parents at a safe distance.

Cannabis

Cannabis (see table 3 on page 17) provides a useful starting point which maximises comparability. The proportion of 15–16-year-old schoolchildren who (in anonymous surveys) admit to having tried cannabis ranges from 3–7% in Finland, Sweden, Greece, Luxembourg and Portugal, to 15–22% in Belgium, Denmark, the Netherlands, France and Spain and 37% in Ireland and a non-random UK sample. Where data is available, the proportion of 15–16-year-olds who report having used cannabis is the last 12 months ranges from 2.5% in Greece and Portugal to 17–18% in the Netherlands and Spain.

Though fewer countries provided this data, by 18 years of age the proportion of pupils admitting experience with cannabis is always higher than at 16, ranging from around 10% to over 35%. Surveys in cities often give higher rates than the national average, including some of over 50% for lifetime experience of cannabis.

Notes to chart based on table 9. In the chart on the right data for each country has been plotted as % of the average for all the years for which data is available for that country. In the chart on the left the same data has been replotted within each year in order of the magnitude of national changes. The result is to show for each year the range of national trends (width of all bands) and (darkest band) the trend most typical of EU nations. See table 9 for further notes.

Other illegal drugs

Moving away from cannabis, we also move on to less secure ground. Table 4 on page 18 details findings for 15–16-year-old school pupils. Figures for experience of all illegal drugs should be treated with special caution; solvent misuse and the non-medical use of tranquillisers may be included, excluded, or not covered by the survey. This explains why Greece and Sweden report lifetime experience of solvents (6% and 9% respectively) higher than for all illegal drugs. In those countries solvents are the most commonly used drugs among 15–16-year-olds; elsewhere, cannabis is most common. Apart from Sweden, solvent use is reported by around 4–6% of 15–16-year-olds in most countries.

Typically 2–4% of 15–16-year-olds admit having tried amphetamines, ecstasy or LSD. In Finland and Sweden use is lower (under 1%) while 1 in 10 youngsters in Luxembourg and the UK have tried amphetamines, and in the UK 12% have tried LSD. Reported levels of lifetime experience with cocaine or heroin are generally below 1% but occasionally around 2%.

Trends over time

Though comparability remains a problem, more trend information is available for young people than for adults in general. Illegal drug use has increased among schoolchildren and young people in Belgium, Finland, Germany, Greece, Ireland, the Netherlands, Sweden, the UK and perhaps Portugal, but seems relatively stable in Denmark. Elsewhere trend data was either unclear or unavailable.

Where there have been increases, cannabis accounts for much of them, but in several countries (Flemish Belgium, Luxembourg, the Netherlands, Spain and the UK) use of amphetamines, ecstasy and/or LSD has also increased. There is no evidence of increased school-age use of cocaine or heroin, though surveys would be relatively insensitive to such changes.

Despite recent increases some countries still report lower levels of drug use among their young than was the case in the early 1970s, though this largely refers to cannabis and in a few cases to amphetamines. In others current levels of reported drug use are unprecedented.

In 1995 a European comparative study was carried out by the Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group, deploying the same methodology in secondary schools in 25 countries. The results, to be published later in 1997, should provide a more reliable basis for comparison than the existing mixture of different studies.

• Problem drug use and addiction •

In information submitted to EMCDDA for this report some countries synthesised existing sources of information to tentatively estimate the rate of more problematic drug use or 'addiction' within their borders. Table 5 (p. 19) presents these estimates and outlines how they were arrived at. Estimates were only tabulated if there was an attributable source and at least a basic scientific method to justify them. Although all countries were asked to provide such estimates, not all were able to do so.

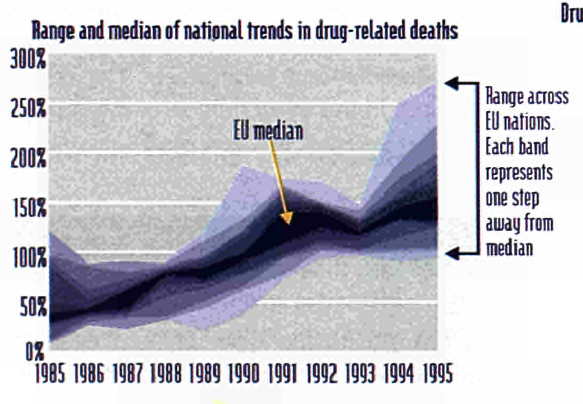
Table 9 • Drug-related deaths[1] in EU countries 1986–1995

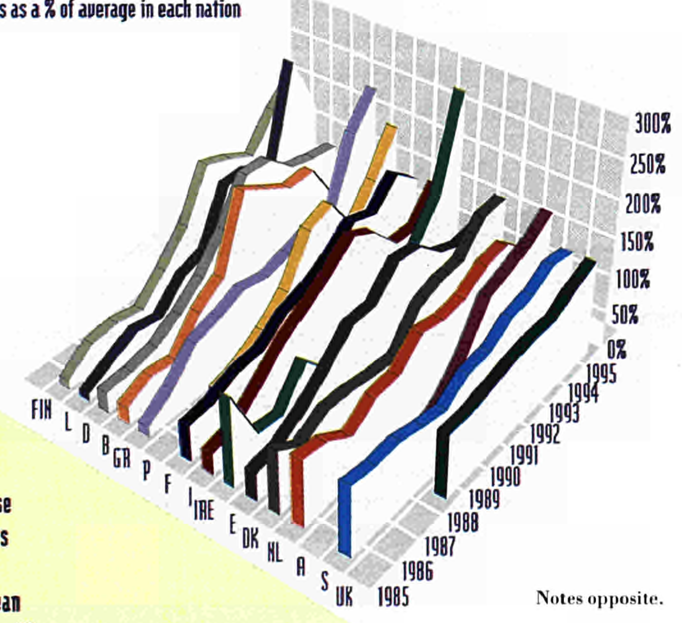
COUNTRY	Pop (mill)	At risk[2] (mill)	NUMBER OF DEATHS 1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
AUSTRIA[5]	7.9	7.9				20	36	70	121	130	140	160
BELGIUM	10.1	10.1	20	17	37	49	96	85	75	76	46	48
DENMARK[6]	5.2	5.2	109	140	135	123	115	188	208	210	271	274
FINLAND	5.1	5.1	14	15	12	24	38	62	57	50	66	76
FRANCE	58.2	58.2	185	228	236	318	350	411	499	454	564	465
GERMANY	81.1	81.1	348	442	670	991	1491	2125	2099	1738	1624	1565
GREECE	10.4	10.4	28	56	62	72	66	71	79	78	146	176
IRELAND[7]	3.5	1.8[3]	8	7	15	8	11	14	17	20	28	49
ITALY	57.1	57.1	292	543	809	974	1161	1383	1217	888	867	1195
LUXEMBOURG	0.4	0.4	3	5	4	8	9	17	17	14	29	20
The NETHERLANDS[8]	15.4	15.4	55	40	54	55	74	68	70	82	84	65
PORTUGAL	9.8	9.8	18	23	33	52	82	143	155	100	142	196
SPAIN	39.0	14.5[4]	163	234	337	455	455	579	556	442	388	394
SWEDEN	8.8	8.8	138	141	125	113	143	147	175	181	205	194
UNITED KINGDOM	58.0	58.0			1212	1191	1284	1369	1428	1382	1627	1778

Sources: see notes at end of chapter.

Empty cells indicate data not available or not comparable with remaining years. In some countries, these figures could be an underestimation.

1. See table 8 for definitions of drug-related deaths used in this table. Data from different countries are not directly comparable due to differences in case definition and methods of data collection.
2. Considered different from the total population only when the cases of death are confined to a clearly defined subgroup of the population.
3. Population aged 15–49.
4. Population and cases refer to six major cities.
5. For comparability reasons only overdoses were taken from national data on drug-related deaths.
6. Last year only poisoning cases included.
7. Differences from last year are due to a change in the age range considered and to the improvement of the case definition.
8. Differences from last year are due to a change in case definition.





Though in the long-term the trend is clearly upwards, in the 1990s trends in drug overdose deaths have been mixed. The chart right plots these trends for each nation. The same data replotted left reveals the typical pan-European trend (darkest band) and the range across the EU

Notes opposite.

The rates per 1000 are based on the total population of all ages. Rates are considerably higher in younger adults, though countries with a history of addiction stretching back to the 1960s (such as Denmark, the Netherlands, Sweden and the UK) have significant minorities of addicts in their 40s and even 50s. To take account of this pattern, the EMCDDA plans to standardise the age range for addiction estimates and subdivide it to allow for examination of prevalence and trends in different age groups.

The temptation to construct a league table of addiction from these figures should be resisted, as they were generated using different definitions and methods. Differences in definition are not arbitrary and cannot be resolved by imposing a standard definition. Rather, they reflect how each society perceives, and therefore defines, their drug problem. So most the estimates refer to opiate addicts because they dominate all the various problem indicators. Other estimates are based on broader definitions; for example, Sweden includes amphetamine injectors (more common there than heroin addicts) as well as a small proportion of daily cannabis users. Conversely, the estimate for Finland is confined to opiate addicts, though there too problem drug use is dominated by amphetamines, and to a lesser extent cannabis and misuse of various medicines. On the Swedish definition the Finnish estimate would be several times higher.

Estimates may also be strongly affected by specific local circumstances, such as policy shifts which change the extent to which drug users are likely to seek help, or even by apparently minor administrative factors such as how treatment records are kept. Methodological variation can also be important; for example, estimates extrapolated from drug-related deaths are likely to be biased towards injecting drug users. The wider and more diverse are the data sources, the higher are the estimates likely to be because they encompass a larger range of drug-related problems.

Local estimates more reliable

Given the margin of uncertainty, the only safe conclusion is that national estimates suggest levels of problem drug use of a similar order of magnitude (around 2 per 1000) in most countries. Higher estimates are seen in Belgium, Italy and Luxembourg. Luxembourg's includes an important proportion of foreigners (as does that for the Netherlands), which may spuriously increase the rate if they are not also included in the total population. The wide range in Belgium reflects uncertainty over the figure. Several other countries (France, the Netherlands and Finland) might also report higher estimates if non-opiate users were included.

Especially in large countries, reliable estimates are more achievable for smaller areas such as cities. Such estimates can also be used to target demand reduction efforts to areas whose problems exceed the national average. Table 6 on page 20 provides some examples; though these vary in scientific rigour, definitions, methods and sources, most are more reliable than national estimates. They refer predominantly to frequent opiate use and/or injection. The potential for variation within a country is illustrated by the eight-fold difference between Dutch cities. Although there are exceptions, capital cities tend to have rates that are higher than provincial cities and also higher than the national rate.

The EMCDDA is currently working to improve the clarity, reliability and comparability of estimates of problem drug use and to extend the number of Member States for which scientific estimates are available at national and local levels. The results will be reflected in the 1998 edition of this report.

Drug problems: health and welfare

Drug use is directly measured by surveys but problems arising from this use cannot be so readily surveyed. They can, however, be indirectly tracked by the volume and types of drug-related problems seen by health and welfare services. Caution is needed because the underlying data collection systems were created to meet service rather than epidemiological needs. Also the problems registered by services are not only related to the extent and nature of drug problems, but also to the types of services available, their resources, and the degree to which they are accessible and attractive to different groups of drug users. Key indicators are: the demand for treatment for drug problems; drug-related deaths; and drug-related infectious diseases – indicators which largely reflect the consequences of heroin use or heavy multiple drug use, especially when these involve injecting.

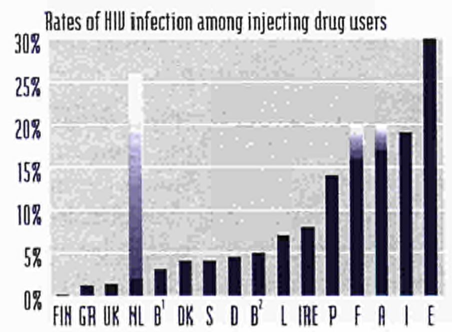
Table 10 • Prevalence of HIV infection among injecting drug users in EU countries

COUNTRY	Year	Data	Number tested	% infected	Prevalence trend
AUSTRIA	1990–91	Vienna: prisoners/drug deaths	86	17–20[1, 5]	decrease[2, 5]
BELGIUM					
French	1995	First treatment	236	3	increase[2, 3]
Flemish	1993	Antwerp: study treatment/streets	217	5[5]	increase[2, 3]
DENMARK	1995	Estimate from HIV notification		4[1]	stable[2, 5]
FINLAND	1995	IDUs[4] with hepatitis A in hospitals	714	0.1	stable
FRANCE	1995	Survey treatment centres, self-reports	6429	16–20	decrease
GERMANY	1996	Drug users in treatment	2074	4.5[1]	decrease[2, 5]
GREECE	1994	Treatment reporting system, self-reports	587	1.2	stable[2, 5]
IRELAND	1993	Dublin: study treatment/streets	185	8[5]	decrease[5]
ITALY	1995	Treatment in public services	65,685	3–32 (19)	decrease
LUXEMBOURG	1996	Treatment reporting system	354	7	decrease
The NETHERLANDS	1996	Repeated treatment/street studies	581	2–26	stable
PORTUGAL	1995	Survey treatment centres, self-reports	394	14	increase
SPAIN	1996	Survey treatment centres	871	30	decrease
SWEDEN	1996	Estimate from 1996 HIV notification and 1992 case-finding study		4	decrease[2, 5]
UNITED KINGDOM England & Wales	1995	Unlinked anonymous	2843	1.4	stable

Sources: see notes at end of chapter.
1. All problem drug users; % in injecting drug users not known but almost certainly higher.
2. Trend estimate is based on data other than the prevalence estimate.
3. National HIV notification for 1995 indicates a strong increase in the age group 15–24.
4. Injecting drug users.
5. Local data.

• Demand for treatment •

Trends in the numbers in treatment for drug problems (treatment demand) can be an indicator of wider trends in problem drug use, but only if we take into account the potential bias arising from changes in treatment or reporting systems. From chapter 2 we learn that treatment services are indeed changing; in many countries methadone programmes are expanding and new low threshold services make entry into treatment easier, both likely to increase treatment demand figures. Another confounding factor is that in many countries monitoring systems are improving so the number of cases they pick up is likely to increase.



Based on table 10.
1. Flemish community.
2. French community.
See table 10 for further notes.

There are large differences between countries in the prevalence of HIV infection among injectors but also between different areas or samples of drug users within the same country

Describing people who seek help for drug problems is a more modest epidemiological objective which avoids the problems involved in extrapolating to the wider population of problem drug users. Here treatment centres are clearly the most valuable sources, one drawn on by nearly all Member States, though the variables recorded differ. Cross-country comparisons remain risky due to different data collection structures.

Clients entering treatment for the first time are the ones whose drug use is most likely to reflect recent trends in drug problems. However, not all countries were yet in a position distinguish this group from clients previously in treatment. As a result here we report data for all clients starting a new treatment episode, regardless of how many times (if at all) they had previously been in treatment.

Clients entering treatment

The characteristics of clients entering treatment are summarised in table 7 on page 21, which concentrates on the national level. Though improved over last year, national data remains incomplete and derives from widely varying ranges of treatment centres – from hospital units only, as in Sweden, to a range of services, as in Ireland.

In almost all countries, heroin is the main drug for which most clients (generally 70–95%) seek help, though methadone is increasingly mentioned in some countries. Amphetamines are more important in Finland and also account for a significant minority of cases in Sweden and Flemish Belgium, and to a lesser degree in the UK. Cocaine remains relatively rare as the main drug clients seek help for, accounting in most countries for under 5% but a little higher in Germany and more prominent (10–14%) in the Netherlands, Luxembourg and Flemish Belgium. In several countries cocaine is commonly used by the same people who use heroin, but generally heroin is recorded as the main drug and cocaine (if at all) as a secondary drug.

Typically about 5–10% of clients report cannabis as their main problem drug, though the figure in Portugal is close to zero, over 10% in France, Germany, Ireland and the Netherlands, and over 20% in Finland. The proportion for Sweden would be higher if non-hospital services were included. In all countries LSD or ecstasy rarely feature as the main drug, with Germany topping the range at 5% of all clients. What table 7 does not show is that combinations of different drugs – including alcohol and medicines such as tranquillisers as well as various amalgams of illegal drugs – are an important feature of drug use patterns seen among the treatment clients of many countries.

Eight countries provided information on whether clients were injecting; the differences were striking. Focusing on heroin users, the proportion injecting when they started treatment ranges from 14% in the Netherlands, through around 30–40% in Spain and the UK, to 60% in Ireland and 94% in Greece.

National averages for the ages of people entering treatment are confined to the early 20s to early 30s with most around 27 or 29 years. Countries such as Denmark, the Netherlands and Sweden, are towards the top end with averages of over 30 years, Ireland at the bottom end with an average of under 24 years. Similarly, though men dominate the statistics everywhere, there are differences in degree. Typically between 20 and 25%, the proportion of women ranges from about 15% in southern Europe to over 30% in Scandinavia.

Trends stable or increasing

Trends over time are most meaningful in countries with established treatment reporting systems or relatively consistent sources of information. In several of these (Finland, France, Germany, Ireland, Italy, the Netherlands, Portugal, the United Kingdom) the number of clients asking for or starting treatment has for several years been steadily increasing. Increases are probably partly due to the expansion of treatment services or to improved monitoring, though in some countries they also signal increases in problem drugtaking, for example in Ireland and the UK. In Luxembourg, Spain and Sweden the trend appears relatively flat.

In most of the countries for which this data was available, the average age of clients starting treatment has for several years been slowly increasing. Exceptions are Ireland and the UK where ages seem stable. Treatment reporting systems in most countries are not yet reliable or stable enough in terms of coverage of treatment centres to assess changes from last year, though generally there is a slight continued increase in age.

Compared to last year the proportion of injectors among clients entering treatment fell. In several countries (eg, Spain) this continued a trend seen for several years. Confirming this trend is the fact that the proportion of injectors among first time clients is significantly lower than among older clients with previous experience of treatment, implying that drug injecting is less common among younger and probably more recent drug users.

Notes to chart based on table 11.

In the chart on the left national data (chart on right) has been replotted within each year in order of the magnitude of national incidences. The result is to show for each year the range of national figures (width of all bands) and (darkest band) the figure most typical of EU nations.

See table 11 for further notes.

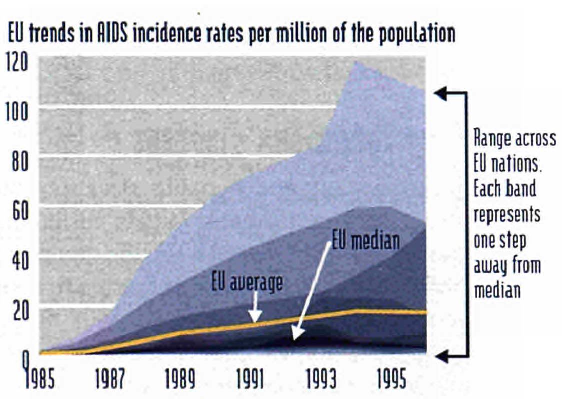
Table 11 • Incidence of AIDS cases related to injecting drug use in EU countries and cumulative % of AIDS cases related to injecting

COUNTRY	ANNUAL INCIDENCE RATES PER MILLION OF THE POPULATION											% all AIDS cases related to injecting
	1986	1987	1988	1989	1990	1991	1992	1993	1994[1]	1995[1]	1996[1]	
AUSTRIA	0.4	3.6	4.3	5.5	5.8	7.0	7.2	7.4	5.3	4.6	2.9	26.2
BELGIUM	0.1	0.5	0.7	1.0	1.3	2.0	2.1	2.2	2.1	1.3	0.9	6.5
DENMARK	0.2	0.6	1.2	1.6	3.1	3.1	3.5	4.1	4.6	5.4	3.1	8.1
FINLAND	0.0	0.2	0.0	0.0	0.0	0.0	0.6	0.2	0.4	0.2	0.4	4.0
FRANCE	2.7	6.0	11.1	15.6	18.5	20.8	22.8	25.1	23.0	22.2	16.6	24.0
GERMANY	0.6	1.6	2.2	2.9	2.8	2.9	3.2	3.2	3.4	3.3	2.8	14.0
GREECE	0.1	0.1	0.2	0.5	0.6	1.2	0.6	0.8	0.5	0.4	1.0	3.8
IRELAND	0.3	2.8	3.1	6.8	8.3	9.4	10.3	10.8	6.8	6.8	9.0	43.8
ITALY	4.8	12.0	21.3	29.1	36.2	43.4	48.4	53.0	59.2	59.5	53.1	63.5
LUXEMBOURG	2.7	0.0	2.7	8.0	0.0	2.6	7.7	12.7	5.0	0.0	4.9	15.5
The NETHERLANDS	0.4	1.1	2.3	2.3	2.7	2.9	3.7	3.9	3.8	4.8	2.7	10.6
PORTUGAL	0.3	0.7	1.0	3.0	4.2	7.2	12.9	23.0	32.2	39.8	51.0	40.4
SPAIN	7.1	17.0	38.9	51.9	64.1	72.9	78.4	84.8	118.6	111.4	105.9	65.8
SWEDEN	0.0	0.1	0.6	0.5	1.3	2.3	2.5	3.8	3.0	2.7	2.6	11.6
UNITED KINGDOM	0.1	0.3	0.5	1.1	1.4	1.5	1.4	2.6	2.2	2.4	2.0	6.4

Sources: see notes at end of chapter.

Cases as reported by 31 March 1997. In some countries there may be small differences between national figures and incidence rates reported by the source due to reporting delays.

1. Adjusted for reporting delays.



AIDS incidence rates per million of the population

Notes opposite.

AIDS incidence rates among drug injectors vary greatly across the EU. High rates in a few countries raise the EU average (left hand chart) but in a typical country (median band) levels have remained low

Trends in injecting may be related to the main drugs used by new clients. In several countries (Germany, Italy, Spain, the UK, Luxembourg, the Netherlands, and especially Flemish Belgium) there continue to be modest increases in the numbers seeking treatment for cocaine, though these remain a relatively small minority. Some countries have also recorded modest increases for cannabis, a trend difficult to interpret without knowing more about changes in the types of services covered by reporting systems.

• Drug-related deaths •

Drug deaths are widely reported and sometimes taken to reflect the prevalence of problem drug use, an assumption which cannot be justified. The number of recorded deaths reflects not only the number of problem users but also the degree of risk to which their drug use and lifestyles expose them and the definitions and procedures by which deaths are recorded.

Addicted heroin injectors face a risk of death which may be 20 or 30 times higher than non-drug users of the same age. On average, 1–2% die each year from overdoses, accidents, suicides or drug-related diseases; where HIV infection is rife among injectors the rate may be 3 or 4%. In contrast, risk of death is considerably lower if drugs are not injected and if cocktails involving high doses of different drugs (especially those including alcohol or sedatives) are avoided. There is no evidence that in itself the use of cannabis increases risk of death (though the relationship with road traffic accidents is unclear). Risk of death per dose taken is also far lower for ecstasy than for injected heroin, though still of concern given the youth of the users and the volume of use.

The definitions and sources of information used in recording deaths (table 8, p. 22) have a crucial impact on the figures in table 9 (p. 25). These are also based on different recording systems, reinforcing the message that absolute numbers cannot be compared between countries. However, within each country drug-related deaths can be a useful indicator of trends in the most severe patterns of drugtaking.

Trends mixed

Assuming that definitions and data collection procedures have remained consistent, trends in the numbers within each country may be a valid reflection of trends in deaths as defined by that nation. It then starts to become possible to make international comparisons of trends in deaths as opposed to absolute levels. This is why the charts with table 9 relate trends to each nation's own average, effectively ironing out potentially misleading differences in absolute numbers.

However, even trend comparisons can be misleading if factors such as HIV infection change death rates in some countries but not others and are not recorded similarly across those countries. Partly for this reason, table 9 primarily refers to deaths directly related to drug misuse (such as overdoses) and in almost all cases excludes AIDS. In most EU countries reported cases are usually heroin addicts who died suddenly and shortly after taking their last dose. Overdose is the main cause and often a mixture of drugs was involved.

Many European Union countries witnessed a marked rise in the number of drug-related deaths in the last half of the 1980s through into the early 1990s. Denmark and Sweden were exceptions but there the decreases have been reversed and the number of deaths have increased steadily over the past five years. The upward trend which started in the 1980s has continued in Austria (overdoses only – other drug-related deaths are decreasing), Greece and Ireland and, with some fluctuations, in Finland, France, Luxembourg, Portugal and the UK. In other countries, the 1990s trend has been downwards, for example in Belgium, Germany, Italy and Spain, though (especially in Italy) this may no longer be the case. In the Netherlands, drug deaths increased sharply in 1990 and since then have fluctuated.

No single factor seems to account for these trends. In several countries it appears that the risk of addicts dying has really increased, possibly because chronic addicts form an ageing and increasingly debilitated population. In others the risk of death may not have changed but increases or decreases in the prevalence of addiction may be a factor.

• Infectious diseases •

In Europe excess HIV and hepatitis infection rates among drug users are probably largely attributable to viral transmission via shared injecting equipment rather than sexual contact. In most European countries injecting is closely associated with heroin, whose users commonly inject other drugs. These links make injecting and/or heroin use to an extent necessary conditions for excess viral infection in drug users, but other factors will determine whether this potential is realised in actual infections. Among these are: whether the virus is in circulation; sharing traditions; awareness of the risks; and the practical options available for avoiding these risks.

Table 12 • Prevalence of antibodies against hepatitis B and C among injecting drug users in EU countries

COUNTRY	HEPATITIS B Year	Data	% infected	HEPATITIS C Year	Data	% infected	Number infected[2]
AUSTRIA							7500
BELGIUM							7500–10,000
DENMARK	1995	Estimate	21[1]	1995	Estimate	50[1]	7500
FINLAND				1994	Drug-positive traffic controls (IDUs[5])	65	3000
FRANCE				1995	Survey treatment centres, self-reports	53–70	70,000–100,000
GERMANY	1993	Drug deaths/emergencies	37[1]	1993	Drug deaths/emergencies	44[1]	35,000–75,000
GREECE	1995–96	Athens: methadone treatment	9[4]	1995–96	Athens: methadone treatment	87[4]	24,000–32,000
IRELAND				1995	Dublin: treatment	84[4]	
ITALY	1996	Treatment	44	1996	Treatment serosurveys	>50	140,000
LUXEMBOURG							500
The NETHERLANDS	1994	Rotterdam: treatment serosurvey	61[4]	1994	Rotterdam: treatment serosurvey	84[4]	6000
PORTUGAL	1995	Treatment	56	1995	Treatment	85	35,000–58,000
SPAIN	1996	Treatment	59	1996	Treatment	83	
SWEDEN	1992	Estimate	2	1992	Estimate	32	6000–36,000[3]
UNITED KINGDOM	1995	Unlinked anonymous, England & Wales	22	1994	Survey treatment centres, UK	48–77	75,000

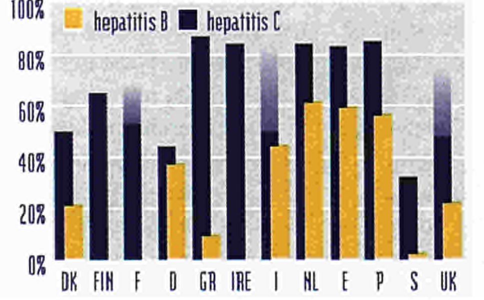
Sources: see notes at end of chapter.
Empty cells indicate data not available.
1. In all problem drug users; % in injecting drug users not known but almost certainly higher.
2. Due to lack of data these estimates are necessarily very global. Source estimates a total of 417,000 to 550,500 infected "drug addicts" in the EU. Almost all will be injecting drug users.
3. The upper limit of this estimate is probably too high – compare with table 5.
4. Not national.
5. Injecting drug users.

HIV infection

Table 10 on page 27 reveals quite large differences between countries in the prevalence of HIV infection among drug users (in particular injectors) and sometimes even larger differences between different areas or samples of drug users within the same country. For example, rates from Dutch cities vary from 2% to 26% and for different Italian samples from 3% to 32%. Prevalence often tends to be higher if based on studies in larger cities or on drug users who have died or been hospitalised.

The proportion of HIV positive drug users seems very low (under 2%) in Finland, Greece and England and Wales; relatively low (3–8%) in Belgium, Denmark, Germany, Ireland's capital, Luxembourg, the

Prevalence of antibodies against hepatitis B and C among injectors



Based on table 12.
See table 12 for notes.

Even where other drug-related infectious diseases are rare, generally half or more of injectors have been infected with hepatitis C – worrying in itself and because it means HIV risk behaviour is continuing

Notes to table 13
Empty cells indicate data not available.
1. Details:
Austria Violations of NDA.
Belgium Concerned in cases of illicit drugs.
Denmark Charges for violations of drug laws.
Finland Reports of narcotics offences.
France Arrests for drug use and trafficking.
Germany Drug offences.
Greece Arrests.
Ireland Charges for all drug offences.
Italy Arrests.
Luxembourg Presumed offences.
The Netherlands Offences against the Opium Act.
Portugal Presumed offences.
Spain Arrests.
Sweden Persons suspected of drug offences.
2. Possession and small-scale purchase/trafficking.
3. Large-scale trafficking.

Notes to chart based on table 13.
In the chart on the right data for each country has been plotted as % of the average for the years for which data is available for that country.
In the chart on the left the same data has been replotted within each year in order of the magnitude of national changes. The result is to show for each year the range of national trends (width of all bands) and (darkest band) the trend most typical of EU nations.
See table 13 for further notes.

Netherlands (apart from the largest cities) and Sweden; and relatively high (10–35%) in Austria's capital, France, Italy, Portugal, Spain, and Amsterdam and Rotterdam in the Netherlands.

In recent years national rates of HIV infection among drug injectors (last column of table 10) seem either to be falling (especially where rates were high to begin with) or stable (especially where rates were low). Only in Belgium and especially in Portugal is the rate increasing. Declines elsewhere suggests injectors have curbed their risk behaviours, especially sharing injecting equipment, a suggestion supported by indicators and converging findings from studies.

AIDS diagnoses

Table 11 (p. 29) displays the rate of new cases of AIDS reported each year among drug injectors in relation to national populations. On average over ten years elapse between HIV infection and recorded AIDS, so even if the rate of new infections is no longer increasing, the number of drug-related cases of AIDS may continue to rise. Development of more effective therapies may play an increasingly important role in reducing new cases of AIDS in the future.

As with rates of HIV infection, differences between EU nations are more striking than the similarities. The latest year's incidence rate is low (under 5 per million) and either stable or declining in ten states. The Irish rate fluctuates between 7 and 10 per million. In France new cases fell from a high of 25 per million in 1993 to under 17 in 1996. Recent falls from much higher rates of over 50 and 100 per million were seen in Italy and Spain and may herald a stabilisation and perhaps a decrease from the peak levels of 1994 and 1995. Exceptionally, rates are increasing rapidly in Portugal, a trend consistent with HIV prevalence in drug users.

Low figures for Finland and Greece may reflect low levels of drug injecting in the mid-1980s, but differences of 100 times or more cannot be explained by differences in the extent of injecting. For example, it is inconceivable that in the 1980s injecting was 50 times more common in Spain than in the United Kingdom – yet this is the factor by which Spain now exceeds the UK in its AIDS incidence rate among injectors. A more likely explanation is differences in the other factors which affected HIV spread in the 1980s – risk behaviours, the degree of social contact between groups of drug injectors and when the virus became common in the respective national populations of injectors. Prevention measures taken more vigorously or earlier in one country than another may also have played their part.

The last column in table 11 reveals that there are also large differences in the proportion of all AIDS cases identified as drug injectors. These may reflect the balance between injection-related risks and other risk factors such as sexual transmission. Most AIDS cases in Spain and Italy are linked to drug injecting, though significant proportions are also reported in Ireland, Portugal, Austria and France.

Hepatitis and other diseases

Several types of hepatitis and other infectious diseases can be transmitted in the same way as HIV and present a serious threat to the health of drug injectors and those close to them. For many years hepatitis B was the main form found in drug injectors. Over the 1980s hepatitis B incidence fell in many countries, only to be supplemented in recent years by a newly identified and potentially more serious form, hepatitis C, now found in a high proportion of the injectors in several countries. Some countries have also reported increases in endocarditis among injectors.

Table 12 on page 31 provides information on the prevalence of antibodies to hepatitis B and C virus among injecting drug users. Presence of these antibodies indicates that the person tested has been infected, but not necessarily in the recent past. Notwithstanding very different samples and data collection methods, there seem considerable differences between countries in terms of hepatitis B. For example, in Sweden and Greece prevalence is under 10% but 50–60% in countries such as Italy, the Netherlands, Portugal and Spain. Hepatitis C infection rates are substantially higher than for hepatitis B, even in countries where hepatitis B and/or HIV are uncommon; in most countries over half of injectors are infected, in several, over 80%.

High levels of hepatitis C infection imply that the relevant risk behaviours continue at levels sufficient to transmit the much more (in blood, 50 to 100 times more) infectious hepatitis C virus, even if HIV transmission has been reduced. They are also of deep concern in their own right. Much more often than hepatitis B, the C variant leads to chronic hepatitis and to extensive liver damage and/or cancer. Spread to partners, health care and other staff, and to a wider circle of drug users who occasionally inject, could impose a burden on society comparable to that of HIV. Already an estimated half a million drug users are infected with hepatitis C in the European Union. With mobility between EU countries set to increase, the need to improve infectious disease data systems take on fresh importance.

Table 13 • Arrests for drug use and trafficking in EU countries 1986–1996

Notes opposite.

Study unit: C=Reported cases P=Persons O=Offences A=Arrests

Offences: MF=Misdemeanours[2] and Felonies[3] UT=Use/traffic T=Traffic

COUNTRY	Study unit	Offences	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
AUSTRIA	C	MF	4739	4778	4963	4474	4829	5392	7805	10,915	12,636	13,093	16,196
BELGIUM	P	UT	4646	6393	7000	6093	7051	10,720	18,179	19,482	19,467	18,376	
DENMARK	P	UT		7862	7031	7566	8915	9535	10,290	12,421	9536	9008	8678
FINLAND	O	UT	1194	1203	1024	741	1346	1969	2399	3063	3175	3944	6059
FRANCE	A	UT	30,493	31,105	31,213	33,510	34,213	45,063	54,468	51,657	59,697	69,432	77,640
GERMANY	O	UT	67,844	74,111	83,889	93,095	102,571	115,947	122,572	120,614	130,322	156,117	
GREECE	P	T	1734	2257	2471	2660	3081	3197	2966	2636	3340	4400	
IRELAND	O	UT	1163	1196	1081	1073	1530	2314	3494	3833	4053	4021	
ITALY	P	UT	14,851	19,373	23,320	20,582	18,343	22,966	27,677	23,500	25,951	21,904	22,020
LUXEMBOURG	O	UT	623	689	1136	1001	1071	1249	1504	890		1265	1368
The NETHERLANDS	O	T	5400	5420	4820	4700	5900	4430	3380	3010	4040	3470	
PORTUGAL	O	UT	2047	2192	1845	2534	3586	4667	6280	5197	4708	6380	9054
SPAIN	P	T	19,203	25,545	27,911	27,407	24,812	28,581	27,713	30,161	31,703	44,318	48,529
SWEDEN	P	UT	6426	6533	6697	6625	7676	8123	7974	7394	8604		
UNITED KINGDOM Engand & Wales		UT	6200	6500	9100	14,000	16,000	17,500	18,095	19,401	25,446	30,693	

National trends in drug arrests as a % of average in each nation

Range and median of national trends in drug arrests

EU median

Range across EU nations. Each band represents one step away from median

300% 250% 200% 150% 100% 50% 0%

1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996

FIN A P F B IRE E UK I DK D GR L S NL

Over the 1980s and 1990s almost all countries saw rising drug arrests. The chart right plots these trends for each nation. The same data is replotted left to show the typical trend (darkest band) and range of trends across the EU

Notes opposite.

With demand reduction the EMCDDA's priority for its first three years, for now our comments will be less extensive in relation to law enforcement indicators. Diversity in the framing and implementation of drug laws in EU Member States render some direct comparisons difficult or impractical. A fundamental obstacle is the fact that offences concerning drug use, possession, production and trafficking are defined and distinguished in different ways (outlined in chapter 4). Another is that police and prosecution procedures vary considerably, as do the ways in which the police record their statistics.

Police arrests for drug offences

Data on arrests made by police depend on their resources and priorities and the extent to which they actively seek out drug users or drug suppliers. As with other indicators, perhaps the most secure comparison point is trends in arrests rather than absolute levels. Table 13 on page 33 shows that over the 1980s and into the 1990s almost all countries saw increasing arrests for drug offences. In some, for example Belgium and Denmark, the trend stabilised in the 1990s; in the Netherlands it actually fell, and in Italy and Portugal it fluctuated, probably because of changes in the law in the former and police reorganisation in the latter.

The proportion of arrests involving particular drugs differs considerably from one country to another. In some, for example Austria, Ireland and the United Kingdom, cannabis accounts for the large majority; in others, such as Portugal, a minority. Conversely, heroin is the drug most often involved in recorded drug law offences in Portugal and Spain, but accounts for rather low proportions in Finland, Sweden and the UK. In all countries, the proportion of offences involving cocaine is low. Where cannabis is in the minority among offences, surveys reveal that this reflects laws and policing priorities rather than prevalence of use, but in most countries the low level of cocaine offences is unlikely to be due to official tolerance. Here, relatively low prevalence is a more likely explanation.

The Netherlands and Spain accounted for three-quarters of the cannabis seized in the EU in 1995

Based on table 14. 1996 omitted as data incomplete. See table 14 for further notes.

Drug-related crime

'Drug-related crime' is ill-defined but nevertheless important. Often it subsumes offences committed to obtain money for drugs and offences committed under the influence of drugs. Sometimes it extends to public order offences related to the nuisance caused by open drug markets and to drug-related illegal activities such as organised crime, corruption or (where illegal) prostitution.

In all these respects drug use or supply impact on public safety, an impact which has recently become an increasingly salient policy issue in many Member States. This makes it important to collect and analyse relevant information, but data collection systems have yet to catch up with the policy need. Several countries provided some relevant information, but it is not possible to make comparisons since this was presented in different ways.

Drug users in prison

About half the EU countries provided some information about the proportion of drug users in prison, but definitions and data collection methods were not always comparable.

Even from this limited information, it is clear that in several, probably many, countries, drug users constitute a significant proportion of the prison population. About 12% of new inmates in Finland, 30% in Denmark, Italy and Spain, 40% in Sweden, and 50% in Luxembourg are described as 'drug users'. It is not always clear whether this refers to the use of any drug or to heavier patterns of use, though in Denmark about half of imprisoned drug users are defined as habitually using drugs. About a third of prisoners in both Germany and Austria are addicts (in Austria, about a quarter of these are injectors).

We are grateful to the Europol Drugs Unit for an overview of drug trafficking in the EU. Here we draw attention to some of the most important points from an epidemiological perspective.

• Seizures •

The amount of drugs seized by enforcement agencies is sometimes considered an indirect indicator of drug supply and availability and therefore, possibly, of drug consumption. However, amounts seized also depend on the resources and priorities of enforcement agencies and figures for a particular year can be seriously affected by a single large seizure. The limitations of this indicator are seen in the fact that seizure data sometimes clash with indicators of drug-related problems, such as treatment or deaths. This is the case for cocaine in some European countries, where supply indicators such as seizures are quite high but demand indicators, though increasing, are much lower than for heroin. Like drug-related deaths, this indicator may be useful if its limits are understood and other sources of information are taken into account. Bearing these cautions in mind, tables 14 to 17 show the quantities of cannabis, heroin, cocaine and amphetamines seized

TEXT CONTINUES ON PAGE 38 ►

Table 14 • Quantities of cannabis seized in EU countries 1986-1996

	kg seized										
COUNTRY	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
AUSTRIA	300	175	205	192	320	12,166	248	546	394	697	517
BELGIUM	3791	6562	13,008	9844	7918	6021	9504	35,217	59,903	38,104	106,690
DENMARK	472	1243	1369	729	1250	1703	2152	1273	10,665	2414	1772
FINLAND	10	25	24	164	71	107	48	118	69	148	99
FRANCE	13,777	12,613	24,425	17,852	21,754	33,121	42,070	45,784	58,015	42,270	66,861
GERMANY	2675	2998	11,350	12,073	13,641	12,344	12,166	11,353	25,693	14,245	
GREECE[1]	638	136	170	683	726	1782	618	464	461	923	
IRELAND	43	110	251	194	132	1174	549	4239	1537	15,616	
ITALY	16,039	13,043	7168	23,232	7893	9722	23,232	12,019	8931	5399	11,639
LUXEMBOURG	15	21	190	11	33	24	35	403	317	12	21
The NETHERLANDS	47,855	48,617	68,238	42,305	109,762	96,292	94,593	138,222	238,258	332,086	
PORTUGAL	5502	4933	354	4628	9606	7753	11,720	52,527	40,425	7493	5362
SPAIN	47,900	59,200	90,900	64,200	70,100	104,800	121,400	160,200	219,200	197,000	247,745
SWEDEN	326	579	423	470	601	639	376	563	457	527	287
UNITED KINGDOM	25,136	16,936	45,476	59,369	30,889	33,204	51,103	53,574	63,021	58,000	
TOTAL	164,479	167,191	263,551	235,946	274,696	320,852	369,814	516,502	727,346	714,934	n/a[2]

Empty cells indicate data not available.

1. From 1986 to 1990 only police seizures are included. From 1991 all seizures are included (police, coastguard and customs).

2. Data too incomplete to total.

Table 15 • Quantities of heroin seized in EU countries 1986-1996

COUNTRY	kg seized										
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
AUSTRIA	43	33	51	101	72	103	78	105	80	47	81
BELGIUM	78	141	116	89	291	186	107	76	137	129	133
DENMARK	17	13	29	37	27	31	39	28	29	37	61
FINLAND	0	0	0.2	0.2	0	0.7	1.9	0.7	1.6	16	6.5
FRANCE	220	213	221	295	405	561	328	386	661	499	617
GERMANY	157	320	537	727	847	1595	1438	1095	1591	933	
GREECE[1]	22	65	53	34	51	279	165	148	283	173	
IRELAND	1.9	0.1	0.4	0.4	0.6	0.2	0.8	1.3	4.7	6.4	
ITALY	333	322	574	685	901	1155	1357	630	1150	952	1251
LUXEMBOURG	7.8	0.3	15	0.5	0.5	10	6.7	11	0.9	13	2.9
The NETHERLANDS	542	517	510	492	532	406	570	916	246	351	
PORTUGAL	19	30	33	61	36	62	41	92	89	66	
SPAIN	407	413	480	713	886	741	672	604	824	546	537
SWEDEN	3.6	4.6	9.4	8.9	12	11	25	22	21	31	26
UNITED KINGDOM	223	236	237	351	603	493	547	656	744	1390	
TOTAL	2074	2308	2866	3595	4664	5634	5376	4771	5862	5189	n/a[2]

Empty cells indicate data not available.

Figures given in grams have been rounded to the nearest 100gm. Totals subject to rounding errors.

1. From 1986 to 1990 only police seizures are included. From 1991 all seizures are included (police, coastguard and customs).

2. Data too incomplete to total.

Over the longer term there seems no downturn in heroin availability or use in the EU and in some cities the heroin market is clearly thriving. Illegal use of the drug remains a major threat to public health

Based on table 15.

1996 omitted as data incomplete.

See table 15 for further notes.

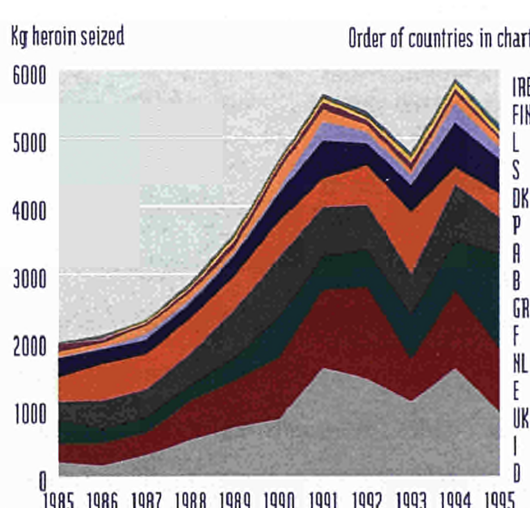


Table 16 • Quantities of cocaine seized in EU countries 1986-1996

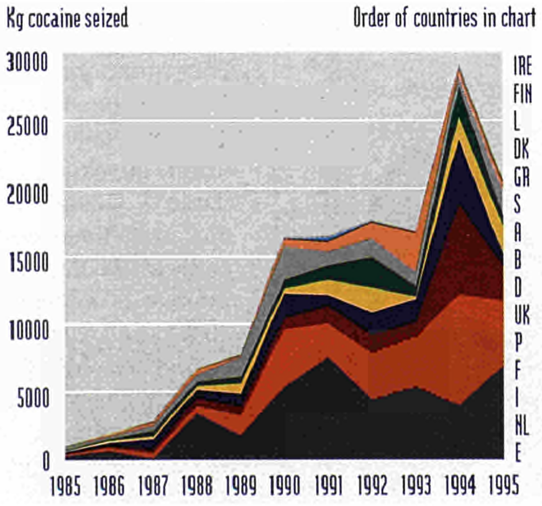
	kg seized										
COUNTRY	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
AUSTRIA	7.4	27	14	21	41	84	58	84	53	55	73
BELGIUM	116	270	404	89	537	756	1222	2892	479	576	838
DENMARK	7.1	26	10	55	28	40	21	11	30	110	32
FINLAND	0	0	0.1	11	0	38	0.1	0	0	0.1	0.1
FRANCE	258	754	593	939	1845	831	1625	1715	4743	865	1742
GERMANY	186	296	496	1406	2474	964	1332	1051	767	1846	
GREECE[1]	2.9	24	2.2	2.3	34	13	9	5	176	9	
IRELAND	0.2	0	0	3	1	0	10	0.4	0.1	22	
ITALY	127	321	616	668	805	1300	1366	1101	6636	2600	2336
LUXEMBOURG	6.5	18	4.6	21	23	14	12	16	16	0.5	13
The NETHERLANDS	274	406	517	1425	4288	2492	3433	3720	8200	4851	
PORTUGAL	165	222	302	793	360	1094	1860	216	1719	2116	812
SPAIN	669	113	3461	1852	5382	7574	4454	5350	4016	6897	13,742
SWEDEN	3	1.4	6.5	4.6	8.8	226	61	14	29	3.7	18
UNITED KINGDOM	103	407	323	499	611	1078	2248	717	2261	672	
TOTAL	1925	2885	6749	7789	16,438	16,504	17,711	16,892	29,125	20,623	n/a[2]

Empty cells indicate data not available.

Figures given in grams have been rounded to the nearest 100gm. Totals subject to rounding errors.

1. From 1986 to 1990 only police seizures are included. From 1991 all seizures are included (police, coastguard and customs).

2. Data too incomplete to total.



EU cocaine seizures fell by almost half in 1995 but there were contrasting trends in different countries: seizures rose significantly in Belgium, Portugal and especially in Germany; large falls were seen in France, Italy, Spain and the Netherlands

Based on table 16.
1996 omitted as data incomplete.
See table 16 for further notes.

in the Member States of the European Union from 1986 to 1996, the latest year for which data was available. Much of this analysis and the accompanying charts omit the last year because incomplete data might give a false impression of EU trends.

Cannabis

Weights of cannabis seized (table 14, page 35) increased from the mid-1980s, and especially from 1992 to 1994. In 1995, however, the EU total fell slightly. As in the previous year, over half the EU total in 1995 was seized in the Netherlands and Spain, though substantial amounts were found in the UK, Belgium and France, and Irish seizures increased sharply. International sources are outlined in chapter 6, but illicit cultivation, mainly for local consumption, has also increased within the EU.

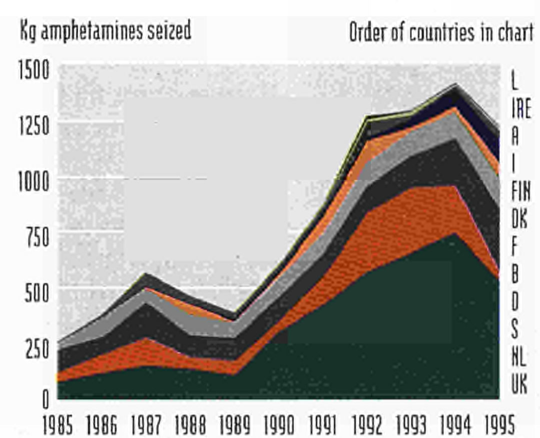
Heroin and cocaine

Heroin seizures (table 15, page 36) steadily increased over the second half of the 1980s, decreased somewhat in the early 1990s, and increased again in 1994 only to fall in 1995 (except in the United Kingdom). In 1994, the largest amounts were seized in Germany and Italy followed by Spain, the UK and France.

Seizures of cocaine (table 16, page 37) clearly increased in 1990 and again in 1994 but fell by almost a third in 1995. This overall fall conceals contrasting trends: in 1995 seizures rose significantly in Belgium, Portugal, Spain and especially in Germany, whereas large falls were seen in France, Italy and the Netherlands. Nearly 80% of 1995's total was seized in Italy, the Netherlands, Spain and Portugal, though significant quantities were also seized in Germany, Belgium, France and the UK.

Almost all the increase in amphetamines seizures in the early 1990s was accounted for by the United Kingdom

Based on table 17.
1996 omitted as data incomplete.
Only nations where data available.
Omissions have a negligible impact on EU total.
See table 17 for further notes.



Amphetamines, ecstasy and LSD

Trends in use of these drugs are dealt with more comprehensively in chapter 3. As noted there, almost all the dramatic increase in quantities of amphetamines seized in the 1990s (table 17, page 39) and most of the seizures were accounted for by the United Kingdom. Significant quantities were also reported by the Netherlands, Sweden, Germany and, in 1995, Belgium.

Variations in units of measurement between countries make it difficult to present information on the quantities of ecstasy and LSD seized. Instead table 18 (page 40) tabulates numbers of seizures, with amphetamines included for comparison. Numbers of ecstasy seizures are increasing in every country where these are recorded. The year when the first seizure was recorded reflects when different countries identified ecstasy in the statistics as well as when ecstasy was first seized. In some, such as France and the United Kingdom, this was in the 1980s; in others, such as Denmark or Finland, it was not until 1995 or later. In many northern countries (Denmark, Finland, Sweden, the UK) ecstasy seizures lag well behind those for amphetamines; in others (Belgium, France, Ireland) the situation is the reverse and amphetamines seizures are relatively rare.

Where data is available, seizures of LSD, although usually fewer than for amphetamines or ecstasy, have nonetheless been increasing in the 1990s.

• Price and purity •

Information on seizures should be interpreted in the context of the retail or street prices of the drugs concerned and their purity (percentage of pure drug in the sample). As a general rule, increasing seizures with falling prices and/or rising purity imply increased availability. Conversely, rising prices and falling purity imply decreased availability.

Price and purity data are not always available and are of unknown reliability. Subject to this caveat, in general retail prices of cannabis seem stable or slightly increasing, and of heroin and cocaine either stable or falling. Purity levels vary between countries, sometimes perhaps because these are based partly on wholesale quantities rather than solely on street-level amounts. Heroin is reported to be up to 20% pure in France and Spain, around 40% in Ireland and the UK and over 60% in Denmark (this includes larger seizures). Cocaine powder is usually purer than heroin, reaching over 70% in Denmark and the Netherlands but under 50% in Spain and the United Kingdom.

The first of these annual reports dealt with the methodological issue of how we know about drug use patterns and prevalence under three main headings:

- **Availability** What types of information on drug use are available, from what sources, and how accessible are they?
- **Quality** What confidence can we have that these types and sources of information are comprehensive and reliable?
- **Compatibility** Is this information collected and analysed in such a way that it makes sense at a European level, enabling a meaningful aggregate to be computed for the EU as a whole?

To answer these questions, in 1995 the EMCDDA asked National Focal Points in each Member State to map sources of information in their countries according to a common format. Their responses formed a benchmark against which to measure

Table 17 • Quantities of amphetamines seized in EU countries 1986-1996

COUNTRY	kg seized										
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
AUSTRIA		0.3	0.1	0.1	0.2	0.3	0.4	0.3	0.7	1.6	3.7
BELGIUM	2.4	9	47	4.2	15	77	96	19.2	23	68	24
DENMARK	10	52.2	29.8	23.9	26	23.6	73.6	11.7	12.6	40	27
FINLAND	1.1	1.2	2.1	1	1.3	6.3	11.6	18.7	9	20	22
FRANCE	1.6	6.8	4	12.8	16.1	19.7	13.2	43.3	79.6	104	128
GERMANY	85	61.7	91	66.7	86	88.3	105.4	108.6	120	138	
GREECE[1]	0	[2]	[2]	[2]	0			0.6[2]	0[2]		
IRELAND	0	0.1	0	0.1	0.3	0.1	0.1	0.7	0.4	1.5	
ITALY	0.3	2.9	1	0.7	0.6	0.6	15.4	0.5	3.4	1.1	
LUXEMBOURG	0	0.3	0.4	0	0	0.1	0.3	0.4	0.1	0	0
The NETHERLANDS	86	125	53	65	47	128	267	293	215	45	
PORTUGAL					39[3]						
SPAIN											541
SWEDEN	78	157	98	103.9	107.8	103.7	120.6	141.9	210.2	279	127
UNITED KINGDOM	116	152.4	137.1	108.2	303.8	420.7	568.9	656	744	530	
TOTAL	380.4	568.6	463.6	387.1	643.4	869.4	1272.8	1295.5	1418.6	1228.2	n/a[4]

Empty cells indicate data not available.

Figures given in grams have been rounded to the nearest 100gm. Totals subject to rounding errors.

1. From 1986 to 1990 only police seizures are included. From 1991 all seizures are included (police, coastguard and customs).

2. A small number of items were also seized.

3. Number of pills.

4. Data too incomplete to total.

Table18 • Number of seizures in EU countries of amphetamines, ecstasy and LSD 1986–1996

COUNTRY	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
	NUMBERS OF SEIZURES										
AUSTRIA											
Amphetamines	3	5	4	4	2	4	14	26	103	43	136
Ecstasy	0	0	0	0	0	0	0	0	51	153	254
LSD	23	15	30	21	31	30	51	58	50	80	102
BELGIUM											
Amphetamines	54	92	151	81	66	85	92	124	104	102	
Ecstasy	0	0	0	0	18	196	267	560	872	1002	
LSD	7	32	22	22	36	88	233	254	301	281	
DENMARK											
Amphetamines										1167	1386
Ecstasy										9	84
LSD											16
FINLAND											
Amphetamines								381	415	696	972
Ecstasy								0		0	52
LSD										0	14
FRANCE											
Amphetamines	31	19	26	40	63	58	73	86	98	104	91
Ecstasy	0	1	1	22	26	60	73	186	358	587	644
LSD	62	61	42	67	71	95	119	121	160	158	190
GERMANY											
Amphetamines	0	0	1131	1299	1193	1414	1675	1856	2319	4315	
Ecstasy	0	0	0	0	0	0	0	0	0	0	
LSD	284	278	255	255	197	237	228	257	391	656	
IRELAND											
Amphetamines	8	12	5	4	14	4	49	82	391	89	
Ecstasy	0	0	0	0	0	41	65	135	261	571	
LSD	7	11	2	4	6	34	48	129	116	62	
LUXEMBOURG											
Amphetamines	0	6	7	0	0	2	9	11	7	9	11
Ecstasy	0	0	0	0	0	0	0	0	8	25	26
LSD	0	2	1	0	1	3	8	2	0	8	15
PORTUGAL											
Amphetamines				2	39	1					
Ecstasy										77	3982
LSD			3	8							704
SWEDEN											
Amphetamines	1509	1900	1965	2572	2889	2851	3538	4288	4359	4386	4199
Ecstasy						2	2	6	0	26	163
LSD						9	15	46	23	28	69
UNITED KINGDOM											
Amphetamines	3047	2852	3277	3322	4629	6821	10,570	11,719	12,970	15,443	
Ecstasy	0	0	0	768	399	1735	2399	2336	3574	5513	
LSD	329	302	361	967	1859	1636	2474	2529	2289	1155	
TOTAL											
Amphetamines	4652	4886	6566	7324	8895	11,240	16,020	18,573	20,766	26,354	n/a[1]
Ecstasy	0	1	1	790	443	2034	2806	3223	5124	7963	n/a[1]
LSD	712	701	716	1344	2201	2132	3176	3396	3330	2428	n/a[1]

Empty cells or omitted countries indicate data not available.

1. Data too incomplete to total.

progress in improving epidemiological information. This exercise was repeated in 1996. A separate technical report will detail the progress made and the gaps that need to be addressed. Here we summarise some of the key points.

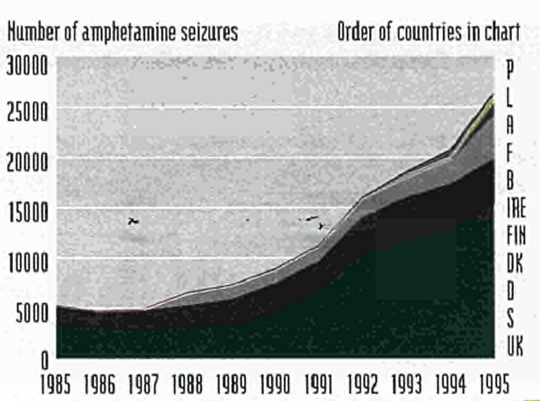
Since the first report the availability and quality of information improved for a number of important indicators:

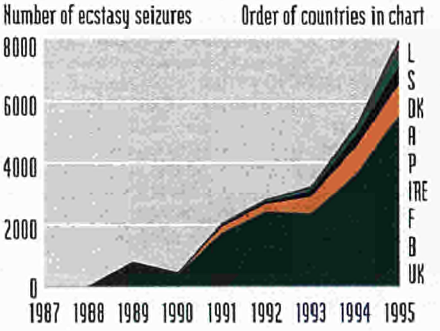
- prevalence figures from general population surveys;
- the prevalence of problem drug use at both national and local level, enabling two new tables to be included in this year's report;
- drug-related deaths, supporting a new table on the definitions used in each Member State;
- infectious diseases, enabling new tables on HIV and hepatitis;
- law enforcement information, permitting new tables on drug arrests and on seizures of amphetamines, ecstasy and LSD.

For the other indicators (school surveys, treatment demand, AIDS cases, quantities of drugs seized) there was less room for improvement, but more recent data has become available.

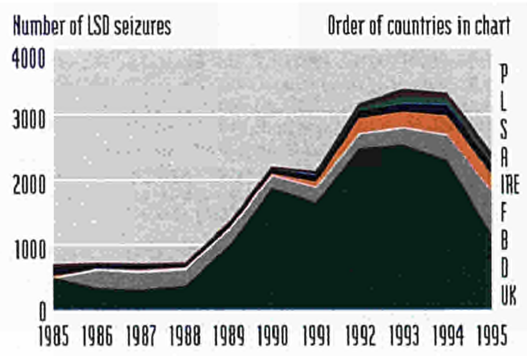
Modest improvements in comparability were seen in general population surveys and data on drug-related deaths. The EMCDDA is involved in a range of projects with Focal Points and other scientific institutes to improve the comparability and quality of several key indicators, including treatment demand, drug-related and other deaths in drug users, general population surveys, prevalence estimates of problem drug use and hepatitis in drug users. The results should have a progressive impact on the quality and comparability of data in future reports.

Beyond the technical and scientific aspects, administrative and political measures will be needed at both national and EU level to help support the adoption and implementation of standards. The EMCDDA will initiate moves in this direction during the current year, starting with the first priority indicator on treatment demand, followed by four others on drug-related deaths; mortality rates and causes of death among drug users; core data and guidelines for general population surveys; and guidelines for prevalence estimation methods. The EMCDDA is also working to improve methods for analysing the information so that future reports and publications will progressively become more relevant to the questions posed by policy makers and others, not only in terms of 'How many?' but also in terms of 'Why?' 'How?' and 'What works?'





Seizures of the main trio of 'dance drugs'. Where records are available, the increase in ecstasy seizures has been universal, but in many northern countries amphetamines seizures still far exceed those of ecstasy. Despite recent falls, seizures of LSD in the 1990s remain much higher than in the mid-80s



All charts based on table 18.

Only nations where some data is available for the years charted. are included. 1996 omitted as data incomplete.

Table 1 • **BELGIUM Flemish Community** CATI, COOV, IHE. 1995 • **DENMARK** DIKE *Health and morbidity in Denmark*. 1994 • CFR. *Nordic alcohol and drug use survey* • **FINLAND** Kontula O., Kostela K. *Drug use and opinions on drugs* • **FRANCE** CFES. *Baromètre santé*. 1995 • **GERMANY** BUND. *Representative survey on the use and abuse of alcohol, medicines, tobacco products and illegal drugs* • **SPAIN** National Plan on Drugs • **SWEDEN** Council for Information on Alcohol and other Drugs (CAN) • **UNITED KINGDOM** Home Office. *British Crime Survey*. 1994.

Table2 • As table 1.

Table 3 • **AUSTRIA** Boltzmann L. *Schuller Suchtmittelstudie*. Institute for Addiction Research • **BELGIUM Flemish Community** Peeters R., Maes L., Van De Mieroop E. *Youngsters and health in Flanders*. 1995 • **DENMARK** ESPAD, 1995. Sabroe S. *et al* 1996 • **FINLAND** Ahlstrom S. *et al*, 1996. ESPAD. Finland Social Research Institute of Alcohol Studies • **FRANCE** Enquête Santé des Adolescents, 1993. INSERM-U169 • **GERMANY** Federal Centre for Health Education. *Study of the drug affinity of youths and young adults* • **GREECE** Kokkevi A., Stefanis K. University Mental Health Research Institute, 1994 • **IRELAND** ESPAD, 1995. Morgan, in press • **LUXEMBOURG** *Shüler an drogen*. IEES, 1995 • **The NETHERLANDS** Kuipers H. *et al*. *National youth health survey*. NIAD, 1993 • **PORTUGAL** Machado Rodrigues L. *et al*. *Estudos em meio escolar – 3° ciclo*. GPCCD, 1996 • **SPAIN** *School survey on drugs*. 1994. Plan Nacional Sobre Drogas • **SWEDEN** *School survey – Sweden*. 1995 and 1996 • **UNITED KINGDOM** Balding J. *Young people in 1994*. Balding J. *Young people in 1995*. Schools Health Education Unit, University of Exeter.

Table 4 • As table 3 except no sources for Germany and Ireland.

Table 5 • **BELGIUM** Professor I. Pelc, personal communication. National Focal Point, 1997 • **DENMARK** National Focal Point, 1997. (epidemiological study supported by estimates of the total number of addicts made by each of the 16 Danish counties) • **FINLAND** Meretniemi K. 1992, unpublished. National Focal Point, 1997 • **FRANCE** National Focal Point, 1995 • **GERMANY** National Focal Point, in press, 1997 (consensus estimate taking account of: Kirschner W., Kunert M., EFB Berlin, 1997) • **ITALY** Mariani F., Guaiana R., Di Fiandra T. *Journal of Drug Issues*: 1994, **24**, p. 579–595. Perucci C.A. *Prevalence seminar*. EMCDDA/Pompidou Group, 1996 • **LUXEMBOURG** National Focal Point, 1997 • **The NETHERLANDS** Ministry of Health, Welfare and Sports, 1995. Bieleman B., Snippe J., De Bie E. Intraval, 1995 (the authors state "a minimum of 28,000") • **SWEDEN** National Focal Point, 1997. Olsson O. *et al*. *National case-finding study 1992*. CAN Report 28, 1993.

Table 6 • **AUSTRIA** Vienna drug coordinators, 1997 • **FRANCE** Bello P.Y., Chéne G. In: *Scientific Monograph 1*. EMCDDA/Pompidou Group. In press, 1997 • **GERMANY** Kirschner W., Kunert M. EFB, 1996 • **ITALY** • **Rome** Perucci C.A., Forastiere F., *et al*. *British Journal of Addiction*: 1992, **87**, p. 1637–1641 • **Lazio region** Lazio Region Department of Epidemiology, 1997 • **The NETHERLANDS** • **Alkmaar** Korf D.J., Hes J., Van Aalderen H. *Brijder stichting*. 1991 • **Amsterdam** Van Brussel G. *et al*. Municipal Health Services, 1996 • **Rotterdam 1988–90** Korf D.J., Reijneveld S.A., Toet J. *International Journal of the Addictions*: 1994, **29**, p. 1393–1417 • **Rotterdam 1994** Wiessing L.G., Toet J. *et al*. National Institute of Public Health and the Environment, 1995 • **Utrecht** Ten Den C., Bieleman B. *et al*. Intraval, 1995 • **SPAIN** • **Barcelona** Domingo-Salvany A., Hartnoll R. *et al*. *American Journal of Epidemiology*: 1995, **141**, p. 567–574 • **Madrid** Paredes D., del Llano J. *et al*. *Comunidad de Madrid, Plan Regional sobre Drogas*. 1994 • **Navarra** Moreno Iribas C., Urtiaga Dominguez M. *Gaceta Sanitaria*: 1993, **7**, p. 55–62 • **SWEDEN** • **Malmö** Swedish Council for Information on Alcohol and other Drugs (CAN). *UNO-92 report 34*. 1993. Department of Social Welfare and Public Health, City Office, Malmö • **Stockholm** Social Services Research and Development, Stockholm. *Research and development report*. 1996/12. 1996 • **UNITED KINGDOM** • **Dundee** Hay G., McKeganey N. *Journal of Epidemiology and Community Health*: 1996, **50**, p. 469–472 • **Glasgow 1989** Frischer M. *British Journal of Addiction*: 1992, **87**, p. 235–243 • **Glasgow 1990** Frischer M., Leyland A. *et al*. *American Journal of Epidemiology*: 1993, **138**, p. 170–181 • **Liverpool** Squires N.F., Beeching N.J. *et al*. *Journal of Public Health Medicine*: 1995, **17**, p. 103–109 • **Wales** Bloor M., Wood F. *et al*. University of Wales, 1997.

Table 7 • **BELGIUM** • **Brussels** Reporting System, all treatments • **Flemish Community** Reporting System, only specialised residential treatment • **French Community** Reporting System, only first treatments • **DENMARK** Reporting System, Copenhagen • **FINLAND** National Hospital Register • **FRANCE** SESI. (Enquête toxicomanie de Novembre), specialised centres only • **GERMANY** EBIS. Reporting System, nationwide • **GREECE** Reporting System, nationwide • **IRELAND** Reporting System, nationwide • **ITALY** Health Ministry • **LUXEMBOURG** RELIS/LINDDA Reporting System, nationwide • **The NETHERLANDS** IVV/LADIS Reporting System, nationwide • **PORTUGAL** SPTT cross-sectional study, two-day survey, nationwide • **SPAIN** SEIT Reporting System, nationwide • **SWEDEN** National Hospital Discharge Registry • **UNITED KINGDOM** RDMD Reporting System, England, Wales and Scotland.

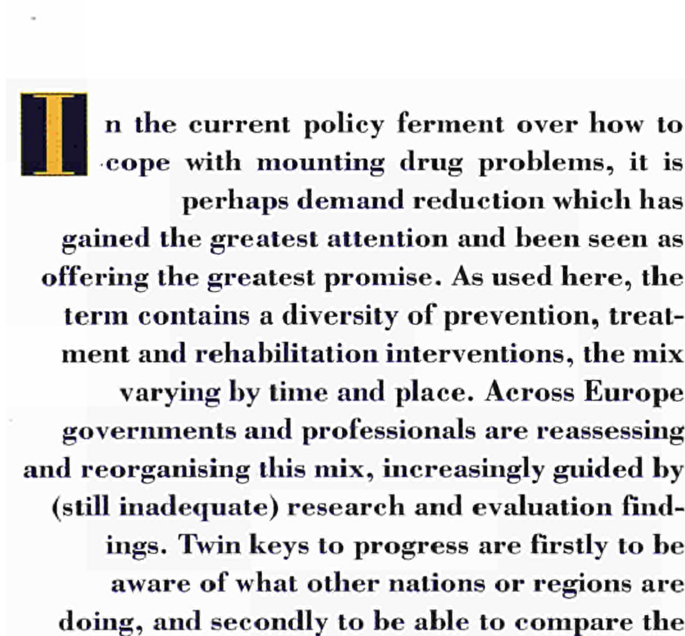
Table 10 • **AUSTRIAN** National Focal Point, 1997. Prevalence trend from low-threshold service in Viennna (n=360; 1992, 5.4%; 1994, 1.6%) • **BELGIUM** • **French Community** French Community Sub-Focal Point, CCDA 1997 • **Flemish Community** Papaevangelou G., Richardson S.C. "HIV prevalence and risk factors among injecting drug users in EC and COST countries." In: Baert A.E., Koch M.A. *et al*. *AIDS research at EC level*. Amsterdam: IOS Press, 1995, p. 73–82 • **DENMARK** National Focal Point, 1997. Prevalence trend, Papaevangelou G., op cit (study conducted in treatment services and at street-level in Copenhagen: 1989, n=200, 19%; 1993, n=203, 22%) • **FINLAND** European Centre for the Epidemiological Monitoring of AIDS, 1996 • **FRANCE** *Survey for November 1995*. SESI, 1997 • **GERMANY** EBIS. National Monitoring System for Outpatient Advisory and Treatment Facilities, 1996. Prevalence trend, Papaevangelou G., op cit (study conducted in treatment services and at street-level in Berlin: 1989, n=197, 18%; 1993, n=251, 14%) • **GREECE** National Focal Point. Prevalence trend, Papaevangelou G., op cit (study conducted in treatment services and at street-level in Athens: 1989, n=201, 2%; 1993, n=200, 3%) • **IRELAND** Papaevangelou G., op cit • **ITALY** National Focal Point, 1997. *Prevalence of HIV antibodies in SER.T users by region 1990-95*. Ministry of Health • **LUXEMBOURG** National Institutional Contact Reporting System RELIS-LINDDA, 1996 • **The NETHERLANDS** Wiessing L.G., Houweling H. *et al*. *Report series*. RIVM, 1997 (1996 data refers to Amsterdam, Arnhem and Utrecht) • **PORTUGAL** Félix da Costa N., Correia J. *et al*. *Estudo Sagital*. SPTT, 1996 • **SPAIN** National Plan on Drugs. ECHT, 1996 • **SWEDEN** Swedish Institute for Infectious Disease Control, 1997. Prevalence trend, Papaevangelou G., op cit (study conducted in treatment services and at street-level in Stockholm: 1989, n=213, 22%; 1993, n=205, 16%) • **UNITED KINGDOM** Public Health Laboratory Service, 1997.

Table 11 • European Centre for the Epidemiological Monitoring of AIDS.

Table 12 • **DENMARK** National Focal Point, 1997 (estimates from HIV notifications and study on national prevalence of drug use, Stalens Serums Institut) • **FINLAND** National Focal Point, 1997 (5500 drug tests, 1005 positive of which 628 IDUs; 37 tested for HCV) • **FRANCE** *Survey for November 1995*. SESI, 1997 • **GERMANY** Heckman W., Püschel K. *et al*. Bundesministeriums für Gesundheit, 1993 • **GREECE** National Focal Point, 1997 (500 tested) • **IRELAND** Smyth R., Keenan E.A. *et al*. *Irish Journal of Medical Science*: 1995, **164**, p. 267–268. 229 tested • **ITALY** Hepatitis B: Ministry of Health. Hepatitis C: Centro Operativo AIDS, Instituto Superiore di Sanità, 1997 • **The NETHERLANDS** Wiessing L.G., Houweling H. *et al*. RIVM, 1995 (343 tested) • **PORTUGAL** Hepatitis B: Félix da Costa N., Correia J. et al. *Estudo Sagital*. SPTT, 1996. Hepatitis C: Godinho J., Costa H. *et al*. SPTT, 1996 • **SPAIN** National Plan on Drugs. *Survey of heroin users in treatment*. 1996 (heroin injectors only) • **SWEDEN** National Focal Point, 1997 (estimates from notifications and national drug use study, 1992) • **UNITED KINGDOM** Hepatitis B: Public Health Laboratory Service, 1997. Hepatitis C: Waller T., Holmes R. *Druglink*: 1995, **10**, p. 8–11 (2081 tested, results reported by treatment centres) • **NUMBER INFECTED** Nalpas B., Delarocques-Astagneau E. *et al*. *European survey on hepatitis C*. Report to the European Commission, DG V, Paris, December 1996.

CHAPTER

Demand reduction



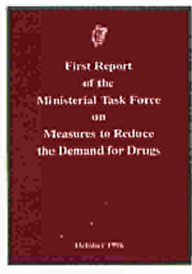
In the current policy ferment over how to cope with mounting drug problems, it is perhaps demand reduction which has gained the greatest attention and been seen as offering the greatest promise. As used here, the term contains a diversity of prevention, treatment and rehabilitation interventions, the mix varying by time and place. Across Europe governments and professionals are reassessing and reorganising this mix, increasingly guided by (still inadequate) research and evaluation findings. Twin keys to progress are firstly to be aware of what other nations or regions are doing, and secondly to be able to compare the effectiveness of their projects and policies. This chapter takes both processes as far as the data allows.

The working definition of 'demand reduction' used by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is inclusive, encompassing interventions aimed at decreasing the demand for drugs or the harmful consequences of drug use at an individual or collective level, from work with children to prevent the onset of demand for drugs to programmes which prescribe drugs to established drug users. However, some would, for example exclude harm reduction interventions because these accept continuing drug use and drug users' lifestyles while seeking to modify both to reduce drug-related social and health problems. At European level, another layer of complexity arises from the fact that 'demand reduction' is an English term with no direct equivalent in most other European languages. In 1996 an EMCDDA study sought to clarify these issues by mapping how the term is used in practice in Europe.[1] It found it was used to describe at least three levels of reality:

- the political level of drug policy;
- the administrative level;
- the operational level of activities and projects.

At each level experts may differ over what to include. Others see demand reduction not as a collection of activities but as a comprehensive approach including prevention, treatment, harm reduction, criminal justice responses, and sometimes supply reduction. The implications for the current report were that the structure adopted in the previous report remained a pragmatic and acceptable solution, but that the categories could be more sharply drawn and some new categories (eg, the criminal justice system) should be added.

The context: political, administrative and cultural



Across Europe states are reconsidering drug policies. Demand reduction is high on the agenda. This Irish report concentrated on heroin misuse in the capital

Demand reduction activities in Europe take place within diverse national, regional and local structures, increasingly linked at European level. Alongside these is a shifting set of cultural understandings about drug use, addiction and the role of demand reduction, trends which in some ways can be seen as European in scope. This section sketches these structures and trends as a context for the main business of the chapter – detailing the activities themselves.

• Organisation and structures •

There is no single European model for organising demand reduction, but some observations are generally if not universally applicable.

Locally responsive

The overwhelming majority of demand reduction work is locally based, focused on units such as the neighbourhood, the family, schools or local associations. A few countries have regional centres to initiate programmes and/or to encourage or advise in the implementation of local activities. These may adapt guides and material to local needs and train professionals, including those who will go on to train and advise others – the 'multiplier' effect. Examples include the provincial addiction prevention units recently established in Austria. Based on health promotion principles and focusing on local activities, these have enhanced coordination and networking, accelerating the development of good practice. In Sweden, the model programme Municipalities Against Drugs launched in 1996 involves 11 municipalities, sufficiently diverse for other communities to find at least one of the models relevant. Italy and Greece acknowledge the importance of local involvement and reinforcing the knowledge and skills of local professionals, enabling initiatives to be geared to the specific community rather than imposed top-down. The UK's 100+ drug action teams are encouraged to collate local indicators of drug problems, to share information between the various local agencies and to develop suitable strategies.

National framework

National level responsibility for demand reduction is commonly placed in ministries of health, the interior, education, justice and defence. These disseminate guidelines and methodologies, usually to be implemented at local level. As well as initiating certain activities (such as mass media campaigns), national bodies also help coordinate local administrations and groups.

Many countries have developed national anti-drug policies accompanied by increased funding for demand reduction. A documented policy framework allows for more structured services and regional networking, and appears to improve cooperation between specialist and non-specialist services.

KEY POINTS

- **Drug demand reduction interventions aim to decrease the demand for drugs or reduce the harmful consequences of drug use.**
- **Health, social, educational and criminal justice systems, and voluntary organisations are implementing a broad range of demand reduction activities; approaches vary according to the accessibility and lifestyles of the target populations.**
- **Many EU countries have new or revised anti-drug policies which give greater priority to and increased funding for demand reduction.**
- **Prevention is thought most effective when organised locally, close to its targets. While potentially effective, comprehensive community programmes are demanding. School programmes are at the heart of prevention in all EU countries.**
- **Harm reduction approaches have expanded due to fears over HIV infection and public concern about the growing drug problem, and have reduced HIV spread in many countries.**
- **Community-based outreach services set out to reach and maintain contact with high-risk groups in their own settings; many rely on (ex)-drug users for a peer-to-peer approach. Low threshold services help the most deprived addicts with daily survival, preventing further deterioration.**
- **Substitution treatment is available in all EU countries, but to a widely varying degree. Most have expanded methadone treatment; in the three years to 1996 patients may have doubled. Eventual abstinence is usually the goal but treatment may be designed to continue indefinitely.**
- **Outpatient treatment aims to improve the quality of life of substance users and safeguard their health while if possible motivating them to seek addiction treatment.**
- **Inpatient facilities range from detoxification to comprehensive therapy programmes and may also include services for special groups such as very young drug users, women or parents with children.**
- **Aftercare to reinsert ex-drug users into social networks and employment constitute the last phase of long-term treatment and offers job training, half-way housing, family care, etc.**
- **More drug users may have contact with the criminal justice system than with treatment services. Demand reduction interventions in this system commonly involve criminal justice agencies referring drug users to health and social services.**
- **Despite growing demand for evaluations of demand reduction activities, such research is inadequate.**

Also common are inter-ministerial or inter-sectoral working groups which may develop national policies and attempt to ensure the effectiveness and quality of demand reduction work.

The UK provides one example of a demand reduction policy in which local initiatives are encouraged and guided by a new national framework (see National framework; local action, p. 47), but such policy development is seen across Europe. In Sweden, a national steering group established in 1994 by the National Institute of Public Health with representatives from several central agencies formulated a National Plan of Action for prevention. In Ireland, the first report of the recently established Ministerial Task Force on Measures to Reduce the Demand for Drugs concentrated on heroin misuse in the Dublin area. The Danish Government's proposals to enhance and reorganise the treatment sector led to significant changes. A report from the Luxembourg parliament's Special Commission on Drugs proposed a reorientation of national policy. In the Netherlands, the agenda for 1996 was dominated by the policy paper Continuity and Change. In Spain The Drug Problem report with its demand reduction strategy was approved in 1995 by the Congressional-Senate Commission for the Study of the Drug Problem.

European cooperation

EU countries cooperate with the EMCDDA in monitoring the drugs problem and participate in programmes arising from the EU's Third Action Plan on drugs (see chapter 5). Among these is the Community Action Programme on the Prevention of Drug Dependence and the COST A-6 programme evaluating action against drug abuse in Europe. EU and other European countries cooperate in the Council of Europe's Pompidou Group and with WHO's Regional Office for Europe (see chapter 6), for example in the Healthy City and Health Promoting Schools networks, the latter with the

European Commission as the main funder. Inter-regional cooperation has a long history in Nordic countries, where the Nordic Council for Alcohol and Drug Research publishes studies and organises meetings for the exchange of information and experience. The 'Euregio' (Belgium, Germany, and the Netherlands) and 'Mondorf' (Luxembourg, Germany, France, Belgium) groups are developing regional, cross-border cooperation models in the fields of prevention, treatment and research through common projects and conferences, part-funded by the European Commission.

Table 1 • Objectives of drug demand activities

▲ = Major objective
▴ = Additional objective(s)

Type of activities	NO USE		CONTROLLED USE	
	No onset of use	Abstinence	Harm reduction unrelated to use period	Harm reduction during harmful use
Childhood interventions	▲			
School programmes	▲		▴	
Youth programmes outside schools	▲		▴	
Mass media campaigns	▲		▴	
Telephone helplines	▴	▴	▲	▲
Community programmes	▲		▴	▴
Outreach work		▴	▲	▲
Low threshold services			▴	▲
Preventing HIV infection			▲	▲
Substitution programmes		▴		▲
Detoxification		▲		
Outpatient treatment		▴	▴	▲
Inpatient treatment		▲		
Aftercare		▲		
Self-help groups		▲		
General health care		▲		▲
Gender-specific issues	▴	▴	▲	▲
Parenthood & drug use: children of drug users	▲		▲	▲
parents of drug users		▴		▴
Prison programmes		▲	▴	▴
Workplace programmes	▲	▲		

• Understandings of drug use •

Across Europe consensus is growing over the priority to be given to demand reduction, one facet of the evolution of drug policy described in chapter 4. In both the prevention of drug use and in treatment, some broad trends are apparent.

Generally a health promotion approach characterises attempts to prevent drug use. Where previously prevention featured fear arousal, punishment and prohibition, now the focus is less on dysfunction and deficiency, more on empowerment – providing enriching alternatives to drug use and enhancing the individual's ability to manage their life and take responsible decisions on drug use ('lifeskills').

In most European countries treatment is founded on an understanding of addiction as an illness and a social problem. Since about the mid-80s, the AIDS epidemic led to abstinence-oriented strategies being complemented by risk-reduction approaches. Like their clients, treatment approaches are now varied and multifaceted, a spectrum more widely extended by substitute prescribing of methadone or related substances. In some countries harm reduction is now a major goal, though in others it is all but rejected. Across this policy divide debate remains heated both within and between countries, but in practice the emphasis is now on helping (re)integrate problem drug users into society – the process of 'normalisation'.

While this compassionate vision has at least theoretical public support, in practice public and media associate drug users with crime, public nuisance and other social problems, and favour more repressive responses. This ambivalence is replicated at administrative level where the sometimes conflicting involvements of therapeutic and judicial systems often lead to problems. Nowhere is this seen more sharply than in treatment responses to imprisoned addicts, where the ambivalence is patent in the juxtaposition of punishment based on a view of the addict as criminal, and treatment based on a view of addiction as an illness.

National framework: local action

As in several other countries, the UK's drug policy aims to create a national framework for predominantly local demand reduction activities. Its underlying principles are:

- An emphasis on decisions being made locally by the people involved, within national and local strategic frameworks. In turn this creates an emphasis on meeting local needs in locally appropriate ways and allows for the variety and dynamism needed to rapidly respond to new needs.
- Ensuring quality through national guidance on best practice and evaluations of effectiveness, often incorporated in service contracts.
- A strong emphasis on multidisciplinary cooperation between services in different sectors.

Building on these underlying principles, recent policy documents have set explicit drug policy objectives and implementation mechanisms in some respects common to the strategies of England, Scotland, Wales and Northern Ireland. The intention is not to suppress local initiative but to provide a framework within which local decision-making will contribute to national priorities. These are exemplified in the core statement of purpose in England's *Tackling Drugs Together*:

Clarity of purpose

A clear definition of the priorities of drug control policy:

- increase the safety of communities from drug-related crime;
- reduce the acceptability and availability of drugs to young people;
- reduce the health risks and other damage related to drug misuse.

Clarity of roles

Styles of intervention are stipulated for each of the main sectors:

- enforcement should be *vigorous*;
- treatment should be *accessible*;
- education and prevention should have a *new emphasis*.

Coordination of effort

New organisational structures for implementing the strategy were defined at national level (where a coordination unit already existed), regional level (to a limited extent only, given UK structures) and local level (strong emphasis). Local drug action teams have been set up across the UK to strengthen coordination.

The dimensions of demand reduction

'Dimensions' here has a double meaning: the variables along which demand reduction activities can be located or categorised; and the extent of these activities. The sections which follow deal with the extent of activity under headings related to each major category.[2] The task here is to reveal how those categories relate to each other. At first sight the complexity is daunting. In 1996 EU Member States reported demand reduction activities under over 20 headings according to their objectives (table 1) and target populations (table 2). However, these headings can more simply be grasped as different locations on five major dimensions:

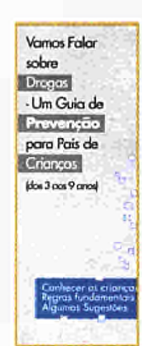
1 Basic strategy An activity's basic strategy relates to the main changes it seeks to achieve (see diagram overleaf). There is a broad distinction between measures to avoid the onset of drug demand and helping drug users reduce an existing drug demand or the harmful consequences of that demand. At a more detailed level, methods can be categorised as: disseminating information; education; influencing the circumstances which affect drug use; control measures; offering alternatives; and various forms of help. Approaches may be explicitly drug-related or aim to achieve long-term prevention of substance abuse through general health promotion. Key concepts here are 'risk factors' (events and traits frequently seen in the life histories of drug users and thought to create a predisposition to use drugs) and 'protective factors' (those which lead most young people to reject drug use). Other approaches aim to disrupt or encourage social structures thought to affect the probability of drug use. Measures may be drug-specific, such as closing down a public ('open') drug scene, or involve improving general social

BASIC STRATEGY		MODALITY Prevention	Treatment
OBJECTIVES	No use	Avoid onset of drug use.	Achieve abstinence from harmful use of drugs.
	Harm reduction	Support controlled drug use with low harmful consequences.	Support change from harmful drug use to use with low harmful consequences.

conditions, such as through community or employment programmes. In between lie campaigns to influence the social and policy climate by raising awareness of drug problems.

2 **Objectives** Traditionally demand reduction interventions aim for drug-free lives by avoiding onset of drug use (prevention) or moving problem drug users towards abstinence (treatment). Most countries have extended this remit to harm reduction in the form of information about controlled drug use with a low level of risk (as a type of prevention), or supporting the change from more to less harmful use patterns.

3 **Target group** Demand reduction activities may target individuals using or at risk of using drugs, relevant others like parents or youth leaders, groups, communities or whole societies (see table 2 opposite). Another way to categorise target groups is in terms of their degree of involvement with drugs. The target may be the general population, regardless of whether they have ever tried any drug or are likely to do so; a level up are groups at risk of drug use, and a level up from that are those identified as having a drug problem.



Portugal's Projecto VIDA recognises the importance of early influences in this leaflet for parents of children aged 3–9

4 **Type of drug** Some prevention programmes target specific drugs such as cannabis or ecstasy but most aim to prevent use of all licit and illicit substances. In contrast, treatment programmes target the main drug currently used by the client, in most cases heroin, or, especially in northern Europe, amphetamines – drugs which are often injected and, partly as a result, cause the most severe health and social problems.

5 **Setting** Several of the categories used below relate to the setting for the intervention (school, youth venue, etc). This in turn will depend on the target group's lifestyles, where they can most easily be reached and the setting's relation to their drug use patterns – ecstasy information campaigns at youth nightlife venues are an obvious example of a programme which exploits all three factors.

• First childhood intervention •

Preschool experiences in family and nursery are widely agreed to play a key role in cultivating lifestyles which promote social, physical and emotional health in general, and in relation to later decisions about drug use. Yet activities targeted at these years play a relatively minor part in European demand reduction strategies. There are programmes – and the attention now being given to this field means others are likely to emerge – but most are still in development and have not been evaluated.

Health education programmes for this age group target not only children but also their parents, who

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Parents of drug using children

Treatment outcomes benefit from the involvement of drug users' families, particularly parents, siblings and partners. Parents often seek treatment for their drug using offspring long before the user themselves. With this in mind, treatment facilities in many countries, especially in southern Europe, attempt to mobilise parental support for the treatment of their child as well as to help and encourage parents. In some countries treatment centres involve parents in treatment through weekend courses, family days and other services.

Parents often organise themselves in self-help groups and form the core of community action groups. The Parents Against Drugs Association in Sweden has branches across the country, providing counselling, self-help groups and education for parents. It cooperates with similar organisations at Nordic, European and international levels. In the Netherlands the National Foundation of Parents of Drug Addicts runs a helpline for parents. Families Anonymous groups in Portugal and the UK provide counselling and support for the parents of addicts. Italy's state addiction clinics and some NGOs have set up programmes to advise parents of drug users.

receive drug information at parents' meetings or as booklets given to them after the birth or when their children enter nursery school. Parenting programmes go beyond information in an attempt to educate parents and develop their parental skills. Topics covered in Spanish programmes include: the family as a prevention agent; basic drug information; key prevention concepts such as risk and protective factors, setting rules and parent-child communication; and the stages of childhood and adolescence. In Belgium, a general objective of drug prevention is to promote communication between young people and adults. Programmes in Sweden focus on young women and expectant mothers, aiming to ensure a drug-free pregnancy and childhood, objectives supported by education for child care workers. Some countries incorporate drug prevention in basic nursery teacher training.

Germany has several years' experience of addiction prevention projects in nurseries and primary schools. Originated in Bavaria, the 'toy-free nursery' project has spread internationally. Encouraging children and nursery staff to invent new forms of activity by temporarily banning conventional toys is thought to foster creativity, imagination, and greater contact between children, while avoiding early reliance on objects is seen as a foundation for later drug prevention. The project requires training for nursery staff and parental involvement.

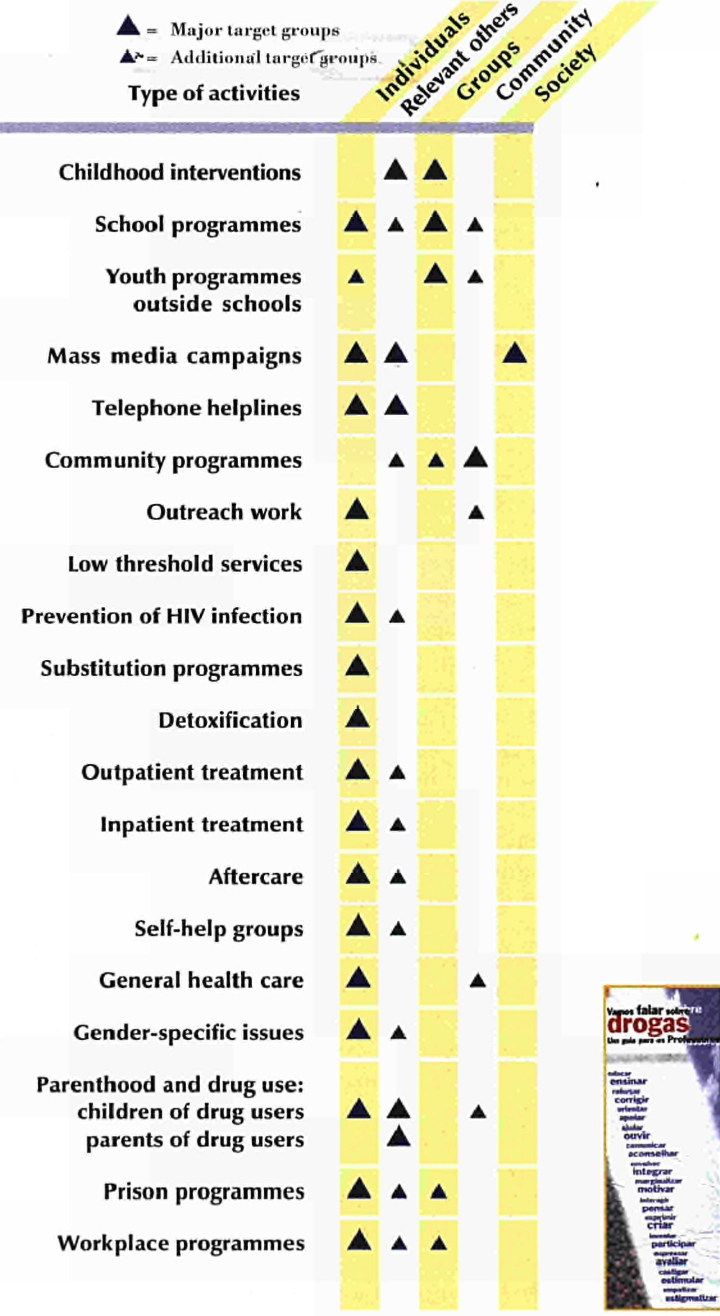
• School programmes •

Across Europe school programmes are the major primary prevention measure. Most European Union Member States legally require drug education lessons in secondary schools; several also require or recommend this in primary schools. Typical objectives are:

- ▶ to enhance pupils' personal development and self-esteem;
- ▶ to develop personal and social skills in handling conflict situations and peer pressure and in resisting or controlling substance use;
- ▶ to foster a critical attitude and decision-making skills in relation to one's own and others' health.

Most programmes are designed for the years spanning the transition from primary to secondary schooling, though the tendency is to start younger. Drug prevention is often seen as an educational priority to be integrated across the curriculum, though the core locus is usually the general health promotion syllabus. Major elements are special syllabi, teaching packs and materials, teacher training, and reorganising school life to stimulate participation of pupils and parents. Initiatives range from an ad-hoc two or three hours of lessons to comprehensive multimedia programmes with lifeskills training and different educational modules tailored for pupils, parents and teachers.

Table 2 • Target groups for drug demand reduction



▲ = Major target groups
▴ = Additional target groups

Type of activities	Individuals	Relevant others	Groups	Community	Society
Childhood interventions		▲	▲		
School programmes	▲	▴	▲	▴	
Youth programmes outside schools	▴		▲	▴	
Mass media campaigns	▲	▲			▲
Telephone helplines	▲	▲			
Community programmes		▴	▴	▲	
Outreach work	▲			▴	
Low threshold services	▲				
Prevention of HIV infection	▲	▴			
Substitution programmes	▲				
Detoxification	▲				
Outpatient treatment	▲	▴			
Inpatient treatment	▲	▴			
Aftercare	▲	▴			
Self-help groups	▲	▴			
General health care	▲			▴	
Gender-specific issues	▲	▴			
Parenthood and drug use: children of drug users	▲	▲		▴	
parents of drug users		▲			
Prison programmes	▲	▴	▴		
Workplace programmes	▲	▴	▴		

In the same Talking about Drugs series as the parents' leaflet opposite is this one addressed to teachers

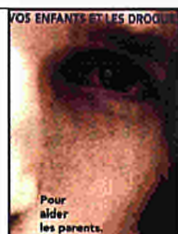
Central support, local initiative

In many countries guidelines, teaching materials, and teacher training courses are provided centrally by education ministries. A teaching pack available on request to schools in Belgium aims to raise teachers' awareness of how drug prevention can be conducted, encourages its integration in the daily life of the classroom and provides ready-made materials teachers can turn to. The school drug prevention manual published in 1996 by Spain's National Plan on Drugs aimed to improve teaching methods, facilitate evaluation, and suggested ways to integrate and reinforce programmes.

New trends

- Most EU countries now have or are formulating **national drug policy** or demand reduction frameworks which facilitate inter-regional and inter-sector cooperation while encouraging local initiative.
- Increasing **professionalisation** of prevention workers is seen in training and in jobs.
- A more **accepting attitude** is seen in the prevention strategies of some countries (and rejected in others), where the aim is not necessarily or solely no drug use, but health promotion and education enabling well-informed and more sensible use.
- In the treatment sector community approaches, low-threshold services and outreach work have expanded, and reoriented to **harm reduction** in response to the spread of HIV. The same threat has stimulated expansion of substitution treatments.
- **The differentiation of approaches** for helping drug users is seen both in treatment services and in a finer categorisation of client groups.
- **Economic stringencies** have driven some aspects of treatment reorganisation in some countries.
- In conjunction with the criminal justice system, treatment services are increasingly playing their part in reducing the **public nuisance** caused by open dealing and drug use sites, a rising policy priority.
- **Evaluation** structures and requirements are being upgraded from a low base.
- There is more widespread recognition of the role of demand reduction interventions in the **criminal justice** system.

Across the EU parents are an important target for drug education and information. These booklets are from France, Greece and the UK



Local activities are important, widespread, and varied, ranging from one-off drug information lessons to comprehensive, year-round programmes. Some Austrian schools have opted for a peer education approach: weekend workshops prepare older pupils to act as tutors and trusted advisers, helping younger pupils settle into school and supporting those with problems. In 1994/1995 Funen's campaign in Denmark was distinctive for its ambitious scope and for its scientific evaluation (see opposite, Comprehensive, local and effective: Funen's schools campaign)

Not just the teacher

Class teachers both control and perform at the sharp end of most school prevention programmes, but do not do so unsupported. Italy, Germany, Sweden, Portugal, all provide specially trained teachers to implement drug education or as a resource for front-line teachers. In Luxembourg primary and secondary teachers are educated in drug prevention and all schools have psychologists trained to detect drug problems at an early stage. From April 1995 funds to train teachers and support innovative drug education and prevention projects were made available by England's education department. In Ireland the Department of Education's psychological service provides nationwide programmes for secondary teachers.

Schools commonly also draw in other groups and other institutions, in some cases building what amounts to a comprehensive school-based local programme. In many countries governmental and non-governmental agencies cooperate to support educational initiatives; health promotion professionals, agencies specialising in pupil support and external professionals may all play their part.

An example is the programme developed by the Netherlands Institute of Mental Health and Addiction for the last two years of primary schooling. This entails an initial four lessons from a drug expert before the teacher takes over. The same body provides three years' support helping secondary schools develop cohesive health policies, while school boards are helped to establish rules for responding to drug use at school. The educational programme includes modules on alcohol, tobacco, gambling, cannabis and ecstasy, and peer pressure, while teachers and parents learn to recognise problem behaviour. Appointed counsellors are on hand to advise pupils who develop drug problems. The programme reached a third of all secondary schools, meeting with a generally positive response from

pupils, who said it meant they felt freer to reject drug offers.

Portugal's CRISTAL project aimed at 10–15-year-olds extends out from the school to join parents and teachers in a global community programme based on special school committees. The programme's workshops engage health and rehabilitation professionals and the police, who often play an important role in such initiatives. In the UK, SPIDER is a police training pack for teachers with an associated manual for parents and governors, while DARE is a prevention programme delivered by police officers in the classroom, focusing on decision-making skills and how to resist peer pressure and drug offers.

Most countries see involving parents as important to school-based prevention. Fundamental to Italy's prevention effort in 1994/95 was the participation of 852,768 parents in 'Parents' projects'. Their objectives are to inform and increase parents' knowledge, competence and educational awareness, and to create a stable relationship between parents, teachers and social workers.

Sweden's National Institute of Public Health helps funds projects to develop educational approaches for pupils, teachers and parents. An example is Mia's Diary – a Work Material about Life, Love and Alcohol developed by a Nordic collaboration project and oriented towards basic facts, dialogue, role play, self-awareness and training for decision-making. Translated versions have been disseminated in Russia and Lithuania. Also in Sweden, the Super Parents publication on alcohol was produced in 1996 for use at parents' meetings and each year The Hashish Book is mailed to all families with children in grade eight.

Comprehensive, local, effective: Funen's schools campaign

In 1994/1995 the county of Funen in Denmark mounted an ambitious regional campaign under the slogan 'Drugs – don't fool yourself', aimed all the county's school pupils aged 10–16 and their parents. Evaluation showed the campaign substantially improved pupils' knowledge, had gained parental support and had adopted an effective organisational structure. The campaign has been revised and launched again in school year 1996/97. Based on cross-sector and inter-disciplinary co-operation, it operated at four levels:

- 10,000 posters were distributed using a common logo and slogan while a campaign newspaper for all pupils sought to stimulate discussion and highlight the problem.
- Pupils in grades seven and eight and their teachers were invited to meet an ex-user, a police officer and a drug use expert in a 'drugs bus' which visited schools over a five-month period. Activities included a simulated arrest and visit to a 'drugs den'.
- Older pupils were invited to see a musical by young people for young people about a girl's life as a drug abuser.
- A leaflet mailed to all parents with children in grades four to six aimed to raise their awareness of drug abuse and encouraged them take a stand on it. A specially produced film about a group of young people's thoughts on cannabis was shown at parents' evenings.

DON'T FOOL YOURSELF was the message of the Danish county of Funen's anti-drug campaign

• Youth programmes outside school •

Programmes for young people in settings other than schools take place in venues such as church youth clubs, youth centres or sports clubs. The aim is to increase the appeal of a drug-free life and promote alternatives to drug use. Active participation in locally organised leisure events is usually the dominant approach: there are anti-drug discos, rock concerts, plays and mobile exhibitions. Minds are broadened and non-drug interests stimulated via media workshops, seminars, discussion groups and travel. In several countries such initiatives are underpinned by training for youth club leaders, leisure venue staff and social care workers.

Such programmes are gaining in popularity, as in Portugal where nearly 600 voluntary sector youth projects were organised in 1996 encompassing a full range of activities. Recently some Member States have paid special attention to the use of drugs such as ecstasy (see chapter 3). Despite this growth, evaluation has been patchy; a few studies have shown positive results but generally the impact on drug use can only be guessed at.

Germany provides an example of a comprehensive programme based on sport, organised jointly by the Federal Centre for Health Education and the national associations for athletics, football and gymnastics. Youth coaches in sport clubs are trained to be aware both of drug problems and of their preventive influence as role models. Another

Striking images produced by Italy's schoolchildren were used as the basis for a mass media campaign against drugs

element of this programme was the Join-in-Action drug prevention competition which involved 152 youth teams in Lower Saxony's football association, a project which has been evaluated; the generally positive results showed widespread acceptance of the initiative, resulting in a variety of activities.

While Germany's programme aims at youth in general, others target those at risk or in special need of diverting activities. In France projects offer alternative after-school and holiday leisure and sports activities to the young residents of marginalised neighbourhoods. A new Danish project focused on risk groups among the young involves all the country's continuation schools (age group 14–18) in an initiative to combat heroin smoking. Another example is Youthreach in Ireland, which targets 15–18-years-olds who leave school without qualifications; about a third of this group have been involved in substance use or crime.

• Mass media campaigns •

With their broad targets, generally mass media campaigns do not aim directly to prevent drug use, but rather to raise public interest in and awareness of the drug problem, or to provide information on drugs and how to respond to drug use. The core vehicles are television, radio, the press, cinema, and advertising, supplemented by Internet sites, posters, leaflets, stickers, T-shirts and other materials. Several EU countries run such campaigns, either nationally (as in Germany, Italy and Spain) and/or regionally (as in Austria and Italy), or plan to do so in 1997 (Portugal and the UK province of Northern Ireland). Others countries are profoundly sceptical about their value, arguing that drug information should be provided in a situation which allows for dialogue and preferably face to face (eg, Denmark, Finland). Sweden too is moving away from national campaigns towards community programmes.

Rather than mounting prevention campaigns, in some countries the preference is to inform the media or to use it to promote anti-drug work. In Greece the national drugs coordinating body OKANA and the treatment agency KETHEA provide experts for TV interviews and disseminate drug messages on TV and radio. Occasionally the media themselves effectively mount a campaign as part of their normal output. In the UK TV 'soap operas' have portrayed the heroin entanglements of key characters.

As in the Netherlands, mass media campaigns may be seen as just one element of a broader strategy encompassing regional and local initiatives. Media output is often supplemented by information materials and by activities such as workshops, seminars, youth rallies and local projects. Recent examples include a campaign in Ireland which provided a free telephone information line to back up media advertisements aimed at parents and young people.

A campaign run in 1995/96 by the German Federal Centre for Health Education scheduled several series of television and radio spots, complemented by numerous activities at regional and local level and in associations or institutions, tied together by the slogan Make Children Strong (Kinder stark machen). An evaluation demonstrated overwhelmingly positive results, including attracting the attention and interest of three million people. The same slogan headed a media campaign in Vorarlberg in Austria in 1995/96 run by the NGO SUPRO, intended to attract public attendance at face-to-face events such as seminars and workshops.

With media time and space at a premium, often the message is quite specific. Spain's CONTROL campaign sought to counter the idea that drug use can be controlled. In some countries campaigns target specific forms of drug use such as synthetic drugs (Luxembourg and the UK) or cannabis (the Netherlands). The Dutch campaign launched in 1996 aimed to help parents discuss cannabis with their young children; over 175,000 campaign brochures were picked up from post offices and public libraries.

• Telephone helplines •

Offering anonymous and easy access, telephone helplines are important both as referral points leading to more intensive help and for the direct provision of information and advice to parents, teachers, young people, drug users and professionals. Several countries say calls to such services have increased; in France in 1995 they were up by 30%. Helpline development in the EU is aided by FESAT, the European Foundation of Drug Help Lines. Supported by the European Commission, FESAT facilitates the exchange of experiences between professionals and volunteers across the European Union, provides training and seeks to improve service quality.

Taking gender into account

All the national reports to the EMCDDA from Member States related gender issues solely to female drug users. Most information is available on gender-specific services for drug users (see below). With respect to prevention, school-based programmes have recently adopted girl-specific approaches, particularly in Sweden. Sometimes these take the form of 'girls' groups' with education and discussion not only on drugs but also sexuality, self-esteem and healthy lifestyles. Sweden's Women's Organisation Committee on Alcohol and Drugs developed and disseminates the *Rubbles and Roses* drama materials for girls and offers writing courses for women with drug problems.

Helping addicted women

Help for women drug users tends to target addicted prostitutes, victims of sexual abuse, actual or expectant mothers, and those infected by HIV. The rationale is that treatment and care programmes are tailored to the needs of the majority of male clients, so in mixed programmes women cannot properly come to terms with experiences such as sexual assault. Special wards or counselling facilities for drug addicted women are found in most countries; services exist in nearly all Germany's cities while British community drug agencies commonly offer women-specific services or times and spaces for female clients only.

Sexual abuse is a common factor in the histories of addicted women. Projects in the Netherlands alert professionals to this possibility and try to help the victims. Low threshold services offer drug using prostitutes psychosocial services, practical help (needle exchange, condoms, etc) and a safe place to sleep or relax, often at times adapted to their late-night working hours. In Denmark, drug service staff noted that a group of women drug users had been exposed to incest in childhood and suffered from a number of potentially related problems. However, their drug use obstructed therapies addressing this underlying issue. Individually tailored treatments often lasting several years were developed to address both drug abuse and incest.

Special services for pregnant drug users counter concern that this group's fear of rejection by general services has led to inadequate care. Most countries now have services which seek to secure close cooperation between drug treatment and HIV units and those concerned with pregnancy and neonatal care. They aim to help women succeed in what for many is an event which provides the opportunity and the motivation for a fresh start. Priority tasks are medical and psychosocial surveillance of mother and child, establishing a support network for the mother embracing health, social welfare and rehabilitation services, and protecting children whose mothers reject treatment.

Published in 1996, the proceedings of an international conference held in in Lisbon on women and drug abuse

A leaflet from the national helpline run by the Trimbos Institute in the Netherlands illustrates the range of people who phone and the types of questions received

Often national administrations (as in France, Italy, the Netherlands) provide nationwide, anonymous, toll-free 24-hour services. Italy's municipalities also provide local services. In other countries helplines are integral to counselling or treatment services; counselling is anonymous and either free or inexpensive, but services are generally limited to weekday working hours and directed at drug users and their relatives. Frequently volunteers or private associations set up local helplines. Sweden has a tradition of providing temporary helplines linked to television programmes which may raise queries or concerns.

Helping services are what most callers tend to ask about. An evaluation of the Italian national telephone helpline showed that 34% of calls were about counselling and psychological support and

27% about treatment and other services, a pattern replicated elsewhere. Most (57%) callers were family members of drug users, mainly mothers; next came drug users themselves (26%).

• Community programmes •

Community programmes are based on an understanding of drug use as embedded in social norms and networks. In this vision it follows that prevention involves generating a social environment supportive of healthy lifestyles or specifically resistant to drug incursions. The distinctive ambition of community programmes is to achieve this by gaining the active participation of all relevant social institutions and groups in a community (the catchment area of a school or youth centre, a neighbourhood, a borough or a whole city) employing varied methodologies and targeting several sectors, advances in one sector supporting advances in the others.

This ambition is often tempered by the scale of the task and only partially realised. Comprehensive programmes are demanding in terms of funding and in terms of the range of groups whose acceptance or involvement must be gained – municipalities, parents, schools, businesses, young people, youth centres, police, leisure outlets, shops and multiple administrative bodies. In many countries the attempt is mainly confined to metropolitan areas (Lisbon in Portugal, Amsterdam in the Netherlands, Vienna in Austria or Paris in France). Programmes in such areas may be related to preventing public nuisance from open dealing and drug use and drug-related crime, an increasing policy priority in several countries.

A patchwork of examples from EU nations, all impacting on the drug problem but not all explicitly drug related, will help give a flavour of an activity which by its nature is hard to circumscribe. In Germany, Bremen's Obervieland model project, initially promoted by the Council of Europe, provides an example of a comprehensive programme. Schools, social administrations, the local public health department, civic centre, teachers, parents, children and young people work together to improve the quality of life in the community and to promote health education among young people, via a range of activities under headings such as AIDS, health education, and school or social environment. A qualitative evaluation reported excellent outcomes founded on active participation.

Another example, this time from Ireland, is ICON, the Inner City Organisations Network. ICON aims to develop integrated, local responses to drugs spanning treatment, education, prevention and rehabilitation by promoting partnership between state, voluntary, community and business groups operating in Dublin's inner city. Ongoing projects in 1996 included a Drugs Crisis Campaign and an Integrated Education and Family Support Initiative. In the UK the voluntary Community Development Foundation is working with local networks and government-run drugs prevention teams. One of the first tasks was to bolster the community through neighbourhood-based practitioners, using and creating networks, and by initiating training. Also in the UK, 'community safety' initiatives aim to reduce crime and the fear of crime – in which drug-related crime is thought a major factor – by community groups working closely with police.

With its alternative lifestyles, the 'free city' of Christiana in Denmark is unique in many ways, among which is its comprehensive community initiative, engaging almost all its citizens in an attempt to keep the city free of 'hard' drugs. Across Denmark a liaison scheme has formalised cooperation between schools, social administrations and the police through special regional and local committees. Street workers become known to local youngsters, encourage participation in leisure time activities, spot the early signs of problems, and offer counselling and referral. Sweden too has its distinctive approaches. A common local prevention measure known as the 'Parents Walking Tour' or 'Mamas and Papas in the City' involves parents of teenagers walking the areas where young people congregate. Their presence helps deter drunkenness, violence and other problems among younger teenagers and enhances informal social controls. In larger cities young people experimenting with drugs are a particular target.

Germany's KINDER STARK MACHEN (Make Children Strong) campaign recently used TV and radio spots aimed at parents. The message: how we bring up our children can protect them from or make them vulnerable to drug misuse. A recent evaluation was overwhelmingly positive

In 1995 the Austrian NGO SUPRO mounted a media campaign with associated events under the KINDER STARK MACHEN banner also used in Germany

Workers regularly in contact with young people in Vienna's 15th district are being joined in a network involving youth workers in parks, police and the immigrants' integration service. Amsterdam's Jellinek Centre emphasises the 'multi-actor' approach drawing in coffee shop owners, police and local minority organisations. In its first year (1995/96), the Educational Centre for the Promotion of Health and the Prevention of Drug Abuse trained 46 agents from 20 municipalities all over Greece to implement prevention programmes in their areas. In the next three years 300 agents will been trained.

• Outreach •

Outreach comprises community-based activities to contact people not effectively reached by office- or clinic-based services, typically reaching out to and maintaining contact with high-risk groups in settings familiar to them and where they feel comfortable. Services range from prevention to health care and advice for untreated drug users, delivered with acceptance and understanding of drug users' lifestyles. Targets range from youthful experimenters to established addicts. Though the profile of outreach work is fluid in response to needs, there are three main models:

- the 'classic' model operates in streets and other public spaces where drug users gather, such as station concourses and pubs;
- other workers visit the institutions where drug users may be found – hostels, syringe exchange schemes, youth clubs, schools and prisons;
- home visits.

Such approaches have generally grown in importance, especially in metropolitan areas with severe drug problems. In northern Europe the emphasis is on actively addressing drug users and outreach services are well structured and mature. In the south (Italy is an exception) outreach is less developed and may amount only to short pilot projects or unstructured initiatives.

Greece and Austria provide examples of projects that depart from the norm. The mobile information unit run since 1989 by KETHEA in Greece aims to counsel and motivate addicts and their families to seek help, and to publicise KETHEA's prevention strategies and treatment approaches. A novel outreach service was created in Vienna in 1995 in response to mounting overdoses. Called CONTACT, it involves hospitals informing the patient's drug worker when they are admitted so that the worker can contact them immediately. Most clients agree to see the worker. Referral to other drug services may be offered, but clients are also free to return to CONTACT.

SPECIAL ISSUE 3

Curbing public nuisance

Open dealing scenes, gathering sites for addicts, drug-related criminality, and the detritus of drug use in the form of discarded syringes and other paraphernalia, can constitute a significant annoyance – and source of fear – for local residents. Cohesive policies for reducing this 'public nuisance' share four elements:

- **improving the accessibility of treatment and care facilities and extending suitable options;**
- **social rehabilitation of offenders;**
- **making better use of the options already available in the judicial system;**
- **efforts to 'design out' nuisance through such things as architectural adjustments to eliminate gathering places or improved street lighting.**

For the Netherlands reducing drug-related public nuisance has been a priority since 1993, entailing close collaboration between addiction and social care services and police and judicial systems. Easy-access 'report and regulate' points enable the public to report nuisance cases to professionals who generally call on police, health services, outpatient facilities or other bodies to intervene.

• Low threshold services •

Low threshold services are easy-access help points demanding little from clients in terms of motivation to change. They can contact otherwise hidden populations of drug users and help them establish contact with mainstream society. Harm reduction interventions including basics such as shelter, hygiene and food, help addicts with daily survival and stem further deterioration – increasingly important as clients accumulate the wear and tear of an extended drug using career. Facilities may extend to rooms where users can take drugs under hygienic circum-

stances. A few services also offer general health care for those unable or unwilling to access normal primary care services. In other countries low threshold services are rare (Sweden) but a few are run by voluntary organisations in metropolitan areas.

Even where harm reduction is or was controversial, low threshold approaches have become more widespread in response to the threat of HIV. Mostly they are carried out by office-based centres or by mobile and outreach services. With fewer constraints on accepting drug use, and perhaps greater trust from drug users, voluntary organisations and other non-governmental organisations (NGOs) are the dominant providers. A result is that official sources may underestimate the extent of such efforts.

Spain illustrates the profiling of services in response to need. The high prevalence of infectious disease among addicts recently led to an expansion in harm reduction interventions delivered by low threshold services in major cities such as Madrid, Barcelona and Valencia. In France too, where traditionally services have emphasised overcoming addiction, 25 'boutiques' set up since 1993 help the most marginalised addicts with the everyday needs of a lifestyle they are unwilling to abandon, but one which renders them less able to preserve their own health. Services offering similar help, but also night-time shelter and low-cost meals, are found in big city centres, often run by voluntary organisations. Coverage ranges from three emergency shelters in France and eight in Italy to the large number reported in the Netherlands

Low threshold services verge into outreach in the form of mobile units, such as Austria's 'Big Elephant'. Commonly these deliver counselling, crisis intervention, HIV information and free condoms, as well as exchanging needles and syringes or selling new sets at low cost. In Ireland's capital, Dublin, a methadone bus is being piloted in two areas, a form of mobile prescribing service well established in other countries such as the Netherlands and the UK.

In Austria the BIG ELEPHANT delivers clean injecting equipment and health services to drug users' doorsteps

HIV and hepatitis prevention

Preventing infectious diseases is less a type of service than a common objective of many services, especially those with a harm reduction brief. This aim is pursued mainly through low threshold, outreach or crisis intervention services, or by specialist projects. Non drug-specific HIV/AIDS services also care for and counsel addicts and their families. Preventing transmission of HIV and other infections among drug users commonly involves:

- health education promoting non-injecting and safer injecting/safer sex practices;
- providing the means to practise these, often as all-in-one 'kits' with clean needles and syringes, condoms, disinfectant pads, sterile water, prevention advice and helpline numbers;
- hepatitis and HIV screening for drug users and their sex partners, and measures to prevent sexually transmitted diseases;
- substitution with methadone or other drugs to obviate the need to inject heroin (see below).

Peer education is an important methodology. The Boule de Neige project operating in the cross-border region between Belgium, the Netherlands and Germany attempts to sidestep drug users' rejection of official information sources by educating opinion leaders within the drug scene so they can inform their peers about HIV and AIDS. Similar projects exists in many other countries.

Syringe exchange is a core modality. Typically injectors collect free clean syringes and needles from the service and return used ones for safe disposal, reducing the circulation of potentially contaminated equipment. The number of syringe exchange programmes varies widely. In the UK over 300 specific schemes and 2000 pharmacies share provision of safer drug use equipment, and HIV prevention is high on the agenda of treatment services and outreach teams. A similar scale of activity is seen in the Netherlands. However, France has just 51 syringe exchange programmes and in Italy too such interventions are not widespread, limited by funding and continuing controversy. In some countries pharmacies are involved in HIV prevention among drug users, distributing free needles and syringes free or at low cost. Occasionally free needles are also available from slot machines or via automated distribution systems.

Sweden has two needle exchange programmes in the south which started in 1986/1987. This exception was made because the local drug markets are outposts of a market focused on Copenhagen in Denmark, a short ferry trip away, raising the spectre of HIV also crossing the straits. Clients are also tested for HIV and offered hepatitis B vaccination. No more exchanges are planned and these two are continually under scrutiny. In Finland too syringe

This unique harm reduction guide to crack use emerged from a peer education project in Manchester in England

exchange is sparse and in some towns banned on moral grounds and for fear of inciting drug use. However, until recently pharmacies sold syringes and needles fairly freely until public reaction forced a stricter line.

• Substitution treatments •

Substitution treatments prescribe addicts a legal alternative to the drug to which they are addicted in order to reduce or eliminate illegal use. The aims are social stabilisation and health gains, either leading in the longer term to abstinence or (in maintenance programmes) as objectives in their own right. Such programmes are found in all EU countries, but to a widely varying extent. Substituting for heroin, oral methadone is the most widely prescribed drug in addiction treatment in Europe. Other heroin substitutes are codeine, buprenorphine and leva acetylmethadol (LAAM), a methadone variant which need only be taken every two to three days.

Services range from slowly tapering withdrawal to indefinite maintenance. Many countries have no central register of patients in such treatments; here information from REITOX focal points has been supplemented with information from a special EC-funded study of programmes in the early 1990s.[3]

Services expanding

In recent years many countries have reported expansions in methadone treatment (see table 3); across the EU treatment slots may have more than doubled in the three years to 1996, when over 200,000 people were in treatment.

Belgium's programme moved beyond its experimental phase in 1995 on the basis of a consensus about the treatment sponsored by the federal Minister of Public Health; in 1995/96 GPs (general practitioners), GP networks and specialised centres treated an estimated 10,400 patients, nearly five times the figure in 1993. Luxembourg's methadone programme is partly aimed at long-term abstinence and partly harm reduction. In 1996, 100 places were available, double the 1994 total and up from 30 in 1993; 150 places are planned for 1997. For the first time in 1995 methadone treatments were more widely practised in Italy than drug-free psychosocial and rehabilitation regimes, accounting for 43% (18% short term, 25% longer term) of clients at state treatment centres. A dramatic increase is also reported for Germany, from 5500 places in 1992 to 28,000 in 1995; many patients are also prescribed codeine and an unknown proportion receive multiple methadone prescriptions.

In 1987 a legal framework for substitution treatment was established in Austria in the form of a decree issued by the Ministry of Health and Consumer Protection. To cope with recently rising demand, more GPs are being encouraged to play a role. With this aim a meeting organised in 1995 by Vienna's Psychiatric University Hospital and Drug Coordination Centre armed GPs with a sound information base and further training. In January 1996 a law came into force in Denmark making county councils responsible for methadone treatment. While the drug may still be prescribed at a treatment centre or by

Table 3 • Number of people in methadone treatment

Country	1993[1]	1995/96[2]
Austria	2,731	3,820
Belgium	2,200	10,400
Denmark[3]	3,100	2,692
Finland	0	<10
France	500	5,000 30,000[4]
Germany	5,500	28,000
Greece	0	300
Ireland	1000	1861
Italy	12,382	50,000
Luxembourg	30	100
The Netherlands	13,581	11,000
Portugal	1100	1100
Spain	12,000	37,263
Sweden	500	480
United Kingdom	18,785	25,024
EU TOTAL[5]	73,409	207,050

1. Except Austria, Denmark, Finland, Germany, Sweden and UK, figures sourced from: Michael Farrell *et al. A review of the legislation, regulation and delivery of methadone in 12 Member States of the European Union*. Luxembourg: Office for Official Publications of the European Communities, 1995. Figures used here are estimates for the number of methadone treatment slots in terms of patient years and may not be comparable to the remaining figures.

2. Based on reports from Member States.

3. Numbers in treatment for over five months.

4. Subutex (buprenorphine).

5. Approximate and indicative only due to inadequacies and incompatibilities in data.

GPs, one objective was to ensure that patients' needs are comprehensively assessed before prescribing starts and alternative treatments offered. At the same time Spain modified its legislation to replace previously strict admission criteria for opiate substitution programmes with more flexible ones demanding only a diagnosis of opiate dependence.

Only since 1995 has France permitted methadone substitution, either in special centres or through GPs chosen by the client in conjunction with the centre. Since 1996 any doctor can prescribe buprenorphine as an opiate substitute. In both cases patients must first have been medically assessed and the drug should form part of a more comprehensive therapeutic programme; clients must be voluntary, motivated and aware of the drug's effects and associated regulations. The objective is abstinence, not maintenance.

Portugal hosts several substitution programmes using methadone and/or LAAM. Since May 1994 an addiction clinic in Lisbon[4] has tried LAAM with some long-term addicts whose previous treatments have failed. In 1996 a study found that the vast majority of patients who stayed in the programme were helped to stop or reduce illegal drug use. Greece's first two pilot substitution programmes started in 1995 in Athens and Thessaloniki and have since accepted 300 chronic injectors over 22 years of age for treatment. Four Swedish hospital wards provide methadone substitution to about 480 patients at any one time. One treatment facility in Finland regularly provides substitution treatment, in 1996 for less than ten patients.

The UK has specialist hospital treatment clinics offering substitution treatment following their own regimes, but is now prioritising a 'shared care' model in which specialist drug services support GPs, helping overcome their resistance to taking on drug using patients and making more treatment slots available than would be feasible through dedicated clinics.

Maintenance programmes

Maintenance programmes are a subset of substitution treatments in which drugs (mainly methadone for heroin addicts) are prescribed indefinitely to enable patients to be productive and to function physically and socially. Stabilisation is the goal rather than progression to abstinence, though in practice services may have mixed goals. While 'on-

Treatment in flux

A trend by its nature not fitting into any one category is the differentiation and fine-tuning of approaches for helping drug users. This can be seen in the expansion of specialist organisations, in the new options opened up by improved cooperation between addiction and health care services, in refinements in the classification of client groups and in the tendency to treat each case on an individual basis.

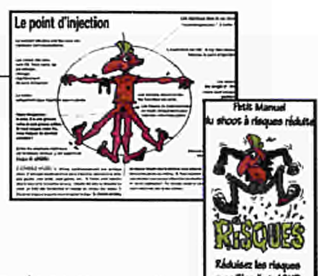
In Denmark, Ireland and Italy, treatment systems are being reorganised to make them more efficient and able to respond to emerging needs. Increasingly prominent in the UK is the recognition of the differing service requirements of various client groups: ethnic minorities, women, and non-opiate users. Particularly in the Dublin area, services in Ireland have expanded in response to the needs of injectors and other special groups such as young heroin smokers and ecstasy users.

In the Netherlands current treatment plans include:

- **a greater variety of inpatient facilities;**
- **more emphasis on prevention, social rehabilitation and resettlement;**
- **experimental provision of heroin on medical grounds to treatment-resistant addicts;**
- **expansion in the number of projects to coerce addicts into treatment.**

Treatment system reorganisation often has an economic background. In Germany, cost-cutting policies have forced treatment clinics to accept higher intake quotas and sometimes to reduce staff, and there have been the first closures of drug-free treatment centres. Professionals in some countries fear that the more expensive residential treatment centres may suffer from the expansion of 'cheaper' substitution programmes. Cost limits on residential care in the UK have led to shorter regimes and forced centres to seek a broader client base.

In its magazine ("planned and made by drug users and ex-users for drug users") and in its irreverent harm reduction materials, ASUD in France clearly identifies itself as working with and representing drug users



site' consumption at the clinic or pharmacy is sometimes required, securely stabilised patients are often thought capable of taking their medication at home and (especially at weekends) may be given several days' doses at once.

In the Netherlands methadone has long been considered a key element in assistance for addicts. Supply is mainly from outpatient addiction clinics either at their clinics or from buses parked at designated spots. Methadone is also supplied by municipal health services and by GPs, as well as in prisons, detention centres and police stations. 11,000 patients receive methadone, 90% on a maintenance basis. Maintenance treatments in the UK have traditionally been delivered in hospital drug dependency units and clinics (DDUs) usually in the form of oral methadone, occasionally injectable methadone, rarely heroin; under 100 patients (compared to over 25,000 on methadone) now receive heroin from specialist doctors licensed to prescribe it for addiction. This treatment, once common in the UK, may be revived elsewhere. In 1996 a pilot heroin maintenance study was being considered in Denmark and one is being prepared in the Netherlands, where since 1995 the opiate-type drug dextromoramide has gained acceptance for older, long-term addicts, supplying the 'buzz' missing from oral methadone.

Long established in Dublin, from the late 1980s methadone maintenance was decentralised and made available on a more widespread basis in Irish cities, a response to the HIV epidemic. Each new contact is individually assessed for suitable treatment options including short-term methadone prescribing with a view to detoxification and longer-term maintenance. In all cases the ultimate aim is a return to a drug-free life.

• Detoxification •

Detoxification regimes aim to achieve a drug-free state while containing withdrawal symptoms and drug cravings. Widely seen as an essential component of drug services, at least four countries report increased demand for this intervention. Regimes are commonly medically supervised, often involving a prescription of a substitute drug which tails off to zero within a limited time. Non-drug regimes based on acupuncture or other methods to alleviate craving are also seen, especially in relation to drugs such as cocaine with no accepted drug substitute. Detoxification is often a preparation for longer-term treatment aimed at maintaining abstinence.

The setting may be a drug treatment centre, a special ward, or a general or psychiatric hospital; therapy may be outpatient (the rule in southern Europe) or inpatient. While medical settings are common, in some cases drug-free therapeutic communities detoxify residents before entry. Danish treatment centres sometimes take groups away to be detoxified in geographic isolation.

Detoxification periods are 8–10 days in Portugal, at least 11–14 days in Germany, three weeks in the Netherlands and up to six weeks in Ireland. During detoxification counselling and social support are universally considered essential adjuncts; afterwards patients are generally referred into other therapies. For several years services in Germany have practised a three-week 'qualified withdrawal', supplementing medical treatment with early psychotherapy and social support thought to facilitate HIV prevention, help prevent relapse, and prepare and motivate the client for follow-up therapy.

In the last two years 'ultra-rapid' detoxification using drugs which counter the effects of opiates (opiate antagonists) has been tried in Italy and is planned in the Netherlands in 1997. The Italian Ministry of Health part-funded a controlled trial; preliminary results do not suggest the technique is more effective than traditional methods.

• Non-residential treatment •

On a European scale non-residential or (in a medical setting) outpatient services comprise a diverse range of community-based 'care and cure' services for drug users and their families while they remain in their home environments, providing individually tailored support, crisis intervention and referral into wider treatment networks. Some are public services, others run by charities or voluntary groups, the latter often community-based and offering care in an environment which the carers share with their clients. Depending on whether the primary goal is supportive counselling or addiction treatment, case workers may be doctors, psychotherapists, psychologists or social workers, sometimes working as a team adapting their inputs to the varied needs of a varied patient group.

Facilities may provide one-stop access to a range of treatments sufficient for some clients to see out their treatment careers on an outpatient basis. Others see one of their key roles as motivating and preparing

clients for follow-on treatment, a role which may lead to more formal links or mergers between outpatient facilities, and between these and inpatient services. For example, since 1994 hospital drug dependency departments in French cities have forged strong links between GPs, hospital doctors and other professionals to foster cooperation and continuity of care. Such continuity can suffer from bottlenecks, sometimes resulting from the relative expense of residential options. In Finland, outpatient facilities for drug users are readily available but admission to residential care is hampered by municipal economies and the low priority afforded drug use by social and health services. Similar bottlenecks have been seen in the United Kingdom where the community care system for funding residential care sometimes sees boroughs quickly exhaust their drug allocations.

In Ireland community drug centres are an important local resource for parents, community groups and schools, as well as drug users and their associates. The Eastern Health Board around Dublin plans a significant expansion of community-based services (more drug centres, greater involvement of GPs and community pharmacists in methadone treatment and dispensing, and a mobile clinic), but often residents resist the siting of drug services in their neighbourhoods. Decentralisation efforts drawing on general primary health care services as well as specialist services aim to dissipate the concentration of users in small areas.

Gaps in the network

While across Europe the scale and diversity of activity is impressive, between and even within countries there are glaring disparities in the density of provision, with services concentrated in metropolitan areas suffering severe drug problems. In some countries the number of outpatient facilities is known:

- Austria has 80 facilities distributed unevenly over the country.
- Belgium's French-speaking community has at least 28 outpatient centres and five day centres.
- The 1100 outpatient centres for alcohol and drug problems in Germany average one to every 72,000 inhabitants; each treats an average of 250 people.
- Spain's 500 outpatient centres contacted 86,027 drug users in 1995 and 75 day centres provided continuous, intensive treatment for 6150.
- France's 184 addiction treatment centres have a global approach which makes it hard to distinguish between outpatient and inpatient treatment; each offers medical, psychological, social, educational and family services.

SPECIAL ISSUE 4

Ethnic minorities

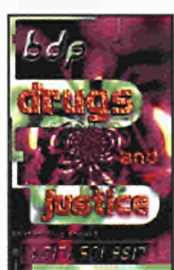
Several countries are aware of the problem of providing culturally sensitive services for immigrants and drug users from ethnic minorities (Sweden, the Netherlands, UK). The most extensive work in this area has been carried out at City University in London, where the EC-funded Race and Drugs Project has examined service provision in cities in England, France, the Netherlands and Portugal. The first fieldwork phase was completed in November 1996 and volume one of their report was published the following year.[11]

The report identifies an overlapping pattern of disadvantage and discrimination affecting both problem drug users and 'visible minorities' – groups whose minority status is apparent in skin colour or other physical features. National drug policies rarely address their needs which feeds down into funding requirements which do not specify these needs be met. What the needs may be are largely unexplored as epidemiological data is lacking and services rarely assess the needs of minorities in their catchment populations.

Drug services may deter attendance by failing to take steps to ensure their accessibility to and suitability for visible minorities. Together with discriminatory criminal justice systems, this creates the perverse tendency for black and other minority drug users to be diverted from treatment to prison – the reverse of the desired direction.

However, isolated examples of good practice and promising innovation could be identified, including the forging of links which enable minority community groups to act as gateways to drug services, potentially improving accessibility and helping to profile responses to their members' specific cultures and needs.

Sensitive to the fact that black youngsters are disproportionately involved with the criminal justice system, a project for black drug users in London stresses its role in achieving justice for clients



Old and new technologies are being adapted to prevention. In 1996 Portugal developed the CD-ROM game Jack and the Drugs for teenagers while a new adaptation of a successful story by Portuguese writer makes the same point in print

▶ The Netherlands has 17 specialised outpatient services with some 100 branches providing group and individual therapy and counselling, methadone treatments, and often also residential and aftercare services. Another 15 services provide low-threshold care. In 1996 outpatient services saw over 23,000 clients with a primary drug problem.

• Residential treatment •

Residential or inpatient treatment occurs in a setting where patients live 24 hours a day, usually receiving multidisciplinary treatment in special departments of (general or psychiatric) hospitals, special drug wards or therapeutic communities; the latter predominate in southern Europe. Approaches range from unadorned detoxification to comprehensive addiction therapy, plus special centres for groups such as very young drug users or women. Programmes are often extended but may also include brief respite care, crisis intervention, and assessment. Patients with additional psychiatric problems are usually treated in the psychiatric system.

Many centres follow a set therapeutic model, such as the 'Minnesota' model,[5] the therapeutic community or Phoenix House model,[6] or structure everyday life on a group basis as in the US Daytop programme. But most are pragmatic and eclectic, embracing elements from different traditions and tailoring treatment to the patient. Some facilities, as in Finland, treat those dependent on illegal drugs and on alcohol together, arguing that all substance abuse results from deeper problems susceptible to similar approaches. The Netherlands is setting up inpatient 'motivation centres' to help drug users stabilise their drugtaking and prepare them for more far-reaching inpatient treatment.

Depending on the individual, clients in Denmark and Sweden may be referred not to institutional care but to live with and as part of a family, whose adults often have specialist knowledge of drug abuse and are paid for the care given. Relapse is a feature of addiction careers and one recognised in Sweden, where it is considered important to offer treatment actively and frequently, even if relapse is probable. The thinking is, for example, that three drug-free months in a therapeutic community will prevent perhaps 400 injections and the associated health risks and social harm, regardless of what happens afterwards. Repeated interventions – mostly voluntary but sometimes compulsory – will also, it is thought, cumulate into the motivation for further treatment leading to a life free from drugs.

Extent of provision

As with non-residential services, countries report varying levels of service provision, probably related as much to the prevailing treatment philosophy as to the need for residential care:

▶ France's 54 residential centres offer psychological stabilisation, social rehabilitation and re-entry into the job market.

▶ Austria reports 25 facilities catering for about 600 patients, with great regional and inter-centre differences in structure and method.

▶ Belgium's French-speaking community has at least 18 specialised inpatient centres.

▶ In 1996 Spain's 95 recognised public or private therapeutic communities treated 7235 drug users.

▶ Three general hospitals, one state neuropsychiatric hospital, and one therapeutic community offer inpatient treatment to Luxembourg's addicts.

▶ 19 clinics in the Netherlands offer either detoxification (three weeks), short-term treatment (up to three months), or longer-term treatment (up to one year). There are also abstinence-oriented therapeutic communities with longer treatment periods.

▶ Germany has about 5230 places for long-term residential therapy (fixed duration of up to 12 months), 1450 for inpatient detoxification and 1050 special care housing places. Residential therapy is almost exclusively drug free. Most centres provide group therapy, work therapy, occupational therapy and individual psychotherapy.

• Self-help groups •

In self-help groups people affected by drug use organise themselves for mutual support or to influence drug-related policies and practices. In countries such as Austria and Greece they play a marginal role, in others they form an important resource in the care system for drug users and their families. Examples of the latter are Sweden, whose network is large and increasing, and Denmark, where former and present drug users as well as parents and others are involved in several hundred groups, a response to the perceived lack of support for families of drug users and to long waiting lists for treatment. Denmark's groups aim to influence public opinion and local government decision-makers, and to provide counselling and treatment for abusers and their relatives.

Treatment facilities often encourage clients to establish or join self-help groups as part of their programmes. Italian NGOs and state addiction clinics have cooperated in establishing such groups. In French-speaking Belgium groups are usually located in psychiatric hospitals or specialised outpatient

centres and generally adopt the 12-step model. In several countries parents of drug users have set up mutual support groups which may also be involved in service provision and prevention.

Quite different are groups set up by drug users to promote their welfare and defend what they see as their rights. Since 1984 Amsterdam's Junkiebond has been active in HIV prevention, organising the world's first syringe exchange. Brugerforeningen in Copenhagen aims to advance drug user welfare by influencing political decision-makers and involving treatment clients in setting their own programmes. Such groups may receive official support. 'Junklife asbl' in Luxembourg was created in 1996 by ex-drug addicts aided by the Ministry of Health as a mutual support group and to defend addicts' rights.

• General health care •

Covered here are medical efforts to treat the physical complications of drug use over and above the health care expected for that age group of the general population. In almost all European countries such care is provided by general medical facilities, though access is hampered where drug users feel stigmatised by health professionals who they see (often correctly) as lacking expertise in drug use. Partly for this reason, health care is provided in some countries by medical staff in drug counselling centres in liaison with the drug client's GP or by specialist hospital departments.

Generally, however, training generic health professionals is seen as the main way forward. In the Netherlands, one project trains nurses to detect signs of drug use and to react appropriately while another aims to improve collaboration between family doctors and addiction treatment services. As in Spain, training may go beyond information provision to counter reluctance on the part of health workers to get involved with what many see as troublesome and undeserving patients.

In the United Kingdom GPs are the main providers of health care to drug users, including referral to other services. Many addiction treatment centres have set up liaison schemes to support GPs, especially in Scotland where specialist services provide GPs with support and advice on prescribing. But in France a survey revealed that in 1995 32% of GPs had not seen a drug user in the past year compared to 12% in 1992; just 6% had seen over 20 compared

SPECIAL ISSUE 5

Children of drug using parents

Risk of physical and mental violence, neglect, isolation, and of being stigmatised and disadvantaged, make the children of drug users – and their parents – groups in need of special care. Programmes aim to support parents while at the same time safeguarding their children. Many countries provide drug treatment facilities where women can live with their children, but, in relation to need, special programmes are relatively few; examples are outlined below.

▶ Belgium's Midrash project includes an outpatient counselling centre for pregnant drug users and young drug using parents. Services are comprehensive – medical, psychological, social, practical and psychotherapeutic – and contact is maintained through pregnancy and early childhood. The project helps clients access hospital care, creches and health insurance authorities.

▶ The National Board of Health in Denmark publishes guides on working with the children of drug users for doctors, health visitors, social workers, teachers and other professionals. Copenhagen's Dag and Dogn Centret has 20 mother and child places where the mother can detoxify and possibly later arrange family care for herself and the child.

▶ Preventive efforts in the Netherlands focus on children below the age of six, based on collaboration between addiction treatment and general social, health or youth care services. Workers at child welfare councils, guardianship boards and youth care agencies are offered training on addicted parents and their children.

▶ In Portugal at least one addiction clinic offers paediatric psychiatry services for children of drug users and projects for pregnant drug users monitor the mother-infant relationship. One voluntary organisation works with high-risk families in an intensive six-week child protection programme.

▶ In Spain, where over a third of drug users in treatment have children, regional governments responsible for child welfare provide multidisciplinary family support and specialised counselling.

In this resource for professionals the Italian NGO CEIS emphasises that, with support, drug dependents can succeed as parents

to 15% three years before.[7] However, there did seem to be greater continuity of treatment and, as elsewhere, relations between GPs and specialist treatment agencies are said to have improved.

• Aftercare •

Aftercare programmes aim to reinsert treated ex-drug users into social networks and employment, helping to maintain psychological stability and abstinence; in some countries this is called 'rehabilitation'. In all European countries aftercare forms the last link of the treatment chain, though the intensity and structure of programmes varies. Ireland has just one, an inner-city rehabilitation and training programme for addicts 'in recovery' or stabilised on methadone, while in countries such as Germany and the Netherlands rehabilitation covers the range of activities for (former) drug users – housing, education, leisure-time activities and securing income and employment.

Models also vary depending on the patient's situation and status, mainly consisting of psychosocial and psychotherapeutic support, sometimes for several years after treatment. There are also temporary therapeutic homes and housing communities supporting integration into a drug-free environment, and specific services offering job opportunities. Where there are specialist aftercare or halfway houses, these usually liaise with in-patient centres to secure a smooth transition from their closed environments to a more normal life. Denmark reports four models for phased reintegration: reintegration houses linked to a residential treatment institution, providing post-treatment training or job programmes in living conditions as normal as possible; reintegration houses in the ex-user's own area; weekly or daily contact with the treatment organisation while the ex-user lives in their own flat; ex-user support networks.

The importance of work

Finding employment is widely seen as a priority. Noting that many clients are willing and able to work but cannot find suitable employment, a project in Austria aims to move addicts into the regular labour market via relatively undemanding postal despatch work, screen printing and building renovation, allied to on-the-job instruction and psychosocial counselling. In many of Germany's larger cities non-profit job clubs are conducting or planning projects to reintegrate addicts into working life. Initial experiences supports a phased extension of working hours, easing addicts into full-time employment after about six months. In Spain vocational training programmes (which in 1995 had over 12,000 clients) also focus on the reacquisition of social skills and provide support in establishing relationship with non-users and in looking for a job. A national programme in the Netherlands aims to find employment for addicts in order to support local initiatives to reduce drug-related public nuisance.

Work can also be itself a form of therapy. In Germany, the innovative 'Treatment on the Farm' project originated in Bavaria from 1992 caters for addicts who do not want long-term inpatient treatment. Shortly after detoxification they are placed with farming families to live and work together. Compared to inpatient treatments, there were far fewer relapses and dropouts and much improved social stabilisation, overwhelmingly positive results

Sample prison interventions

In 1996 the German regions of Berlin, Hamburg and Lower Saxony introduced a pilot automated syringe exchange scheme in trial prisons, an infection control measure which goes considerably beyond that seen in most other countries. Prisoners receive a booklet about the risks of HIV and other blood-borne viruses, the dangers of sharing needles and syringes, and the rationale for the project. A used syringe must be returned before a clean one is dispensed. An evaluation will assess the impact on levels of infection, on drug using behaviour in the prisons and on prison staff. In pilot prisons drug users are also offered advice and information from community-based helping agencies and access to a methadone programme.

Recently the UK introduced drug testing regimes into all its prisons, testing at random and if drug use is suspected. Allied with this is a dramatic expansion of treatment, partly funded through a £5.1 million grant supporting 22 pilot programmes now being evaluated. Contrary to fears expressed before the experiment, testing has not led to widespread unrest but there are concerns over a possible switch from cannabis (the metabolites of which linger in the bloodstream) to the less detectable heroin.

Delightfuly, a leaflet from OKANA in Greece tells youngsters that life is better "with friends and if you are in love" – and without drugs.

Exploiting the images and idioms of the target audience is exemplified in a drug information magazine from ISDD in the UK

As in this cannabis booklet from Spain's Basque country, some materials concentrate on drugs of particular concern either due to their effects or to their widespread use

which led two other German regions to replicate the approach.

Often drug users lack the basic education needed to compete in the job market; attending school, particularly for young ex-drug users, can be important to rehabilitation. In Germany, Frankfurt's Hermann Hesse Educational Centre offers 140 school places for young people with drug problems to enable them to work towards the university entrance examination, courses preceded by several months of social and educational preparation. This unique project has been operating since the 1970s.

• Criminal justice interventions •

Drug users are often involved in criminal activity which brings them into contact with the criminal justice system. Recently increasing attention has been paid to demand reduction at the different stages of this system. As outlined in chapter 4, every EU nation makes some legal provision for demand reduction activities (usually treatment) as at least a partial alternative to prosecuting or imprisoning drug users. Here we are concerned with the extent to which such options are implemented.

Drug users are found at all four key stages of the criminal justice system – arrest, court proceedings, imprisonment, and release – in numbers many believe significantly greater than those in treatment. For drug users, legal crises are a major stimulant to seeking help. These factors sum to suggest considerable potential for demand reduction interventions in the criminal justice system.

With this in mind the EMCDDA commissioned research to assess how far and in what ways this potential is being realised.[8] Data from this study presented here is provisional, in some cases partial, and in others suffers from conflicting reports – sometimes attributable to differing localities and occupational perspectives, but often because official sources reported activities not apparent to frontline workers. Before considering each stage in turn, some general observations can be made:

- no single country appears to have a comprehensive nationwide approach to demand reduction at every stage (see table 4);
- many more activities occur in prison than at any other stage; activities for those released from prison are least common;
- a common role for criminal justice workers is to act as a conduit between drug users and health and social services, though increasingly these workers are themselves delivering demand reduction interventions.

Table 4 • Extent of demand reduction activities in the criminal justice system

Country	Arrest	Court	Prison	Release
Austria	Few areas	Few areas	Few areas	Few areas
Belgium	Few areas	Few areas	Most areas	Few areas
Denmark	Most areas	Few areas	Most areas	
Finland	Few areas	Few areas	Most areas	
France			Most areas	Few areas
Germany	Few areas	Few areas	Few areas	Few areas
Greece	None		Most areas	
Ireland	Most areas	Few areas	Few areas	
Italy	Most areas	Most areas	Most areas	Few areas
Luxembourg	None	Few areas	All areas	All areas
The Netherlands	All areas	All areas	Most areas	Most areas
Portugal	None		Few areas	Few areas
Spain	Few areas	Few areas	Most areas	Most areas
Sweden	All areas		All areas	Most areas
United Kingdom	All areas	Most areas	Most areas	Few areas

▲ = All areas
▲ = Most areas
△ = Few areas
= None

Empty cells indicate data not available.

Arrest

Three countries reported no activities at arrest and in most of the remainder they were concentrated in a few localities.[9] Table 5 shows that information provision interventions were most commonly performed by police and that their content is varied but most often relates to helping services. Information is primarily given in both written and spoken form to arrestees known or thought to be drug users, but in the UK typically to all arrestees.

Most countries also aimed to put drug users in contact with helping services ('arrest referral'). Notable for its systematic approach is Sweden,

where a 1993 law enabled police to take blood or urine samples from arrestees whom they had a reasonable cause to suspect of being under the influence of drugs. Sixty police stations across Sweden have urine screening facilities and to date nearly 30,000 people have been screened. Of those who tested positive, 95% were fined and referred to helping services, the vast majority on a voluntary basis. Police credit this intervention with an average decrease in dishonesty offences of 24%. Elsewhere interventions are focused on a few localities. Police officers are the commonest referral agents followed by drug workers. Referral is always to advice and counselling services and in about half the countries also to detoxification and substitute prescribing. In a few countries contact may be reinforced by legal sanctions, though even here contact is usually voluntary.

Court

There are fewer demand reduction activities at court stage than at either arrest or imprisonment. Where activity occurs it is usually concentrated in a few localities and commonly involves probation workers putting drug users in contact with helping services, though in four countries the judiciary were also involved.

All countries have laws permitting treatment as an alternative to a legal sanction, but in many this power is rarely used, often because the legislation is very recent. Usually treatment can be an alternative to prosecution or imprisonment, or a condition imposed by the court; in some countries not all these options are available. The work of Altox, a Belgian advice and treatment service working with Antwerp's Justice Department, provides a rare example of court-based intervention reliant on an external agency. In its brief intervention and assessment service, drug users before the courts are normally seen three times before Altox workers recommend treatment options. The programme started in 1997 and has yet to be evaluated.

Prison

In all EU countries drug use in prison has received considerable attention. It is generally recognised that both drugs and drug users are present in prisons at significant levels, and that prisoners who use drugs tend to do so in ways which heighten the risk of infection. About a third of prisoners in both Germany and Austria are addicts (in Austria, about quarter of these are injectors) while in Luxembourg the proportion is 50%. Many drug dependent inmates are HIV positive – in Spain, 60%.

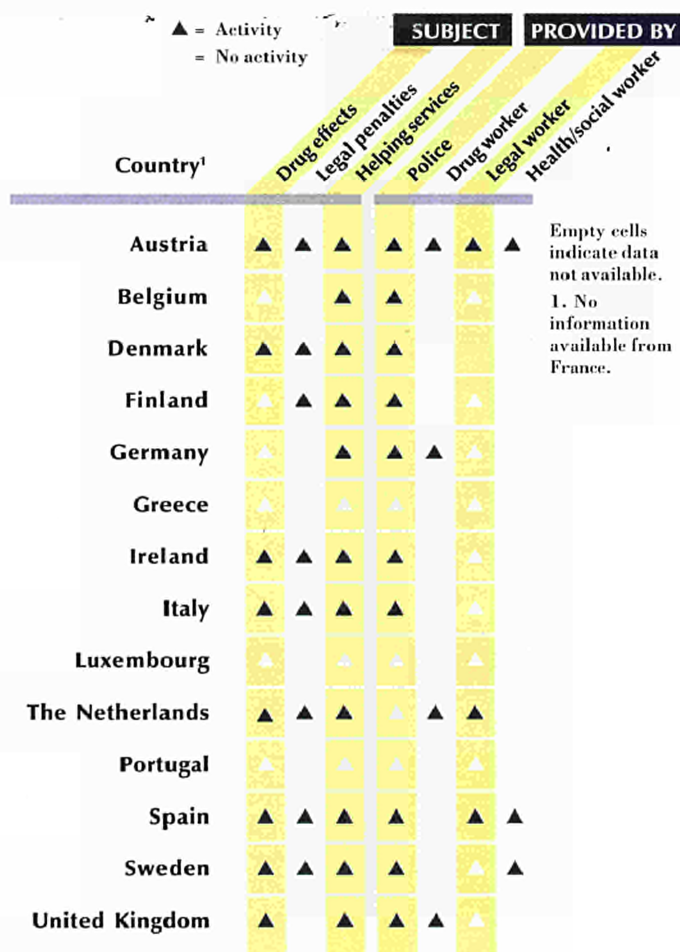


Table 5 • Criminal justice system: what information is provided and by whom?

▲ = Activity
= No activity

Country[1]	SUBJECT: Drug effects	Legal penalties	Helping services	PROVIDED BY: Police	Drug worker	Legal worker	Health/social worker
Austria	▲	▲	▲	▲	▲	▲	▲
Belgium			▲	▲			
Denmark	▲	▲	▲	▲			
Finland		▲	▲	▲			
Germany			▲	▲	▲		
Greece							
Ireland	▲	▲	▲	▲			
Italy	▲	▲	▲	▲			
Luxembourg							
The Netherlands	▲	▲	▲		▲	▲	
Portugal							
Spain	▲	▲	▲	▲		▲	▲
Sweden	▲	▲	▲	▲			▲
United Kingdom	▲		▲	▲	▲		

Empty cells indicate data not available.
1. No information available from France.

As table 4 shows, every country has made some demand reduction response to the problem and the range and number of activities seem considerable. All countries provide information to prisoners in at least most of their prisons, covering drug effects, legal penalties, helping services, HIV/AIDS, harm reduction and safer injecting, provided by a range of personnel including prison officers and health workers, probation officers, and external drug, health or social workers.

Treatment too is widespread and may substitute for part of the sentence, as in a Danish pilot scheme initiated in 1995 which allows prisoners to spend 6–12 months of their sentence in treatment. Detoxification (often on admission) and counselling are

The high-tech mobile SEHNSUCHT exhibition in Germany makes the point that unfulfilled needs can be one reason why the young turn to drugs, reinforcing the KINDER STARK MACHEN campaign

offered in most prisons in all the countries where information was available. Abstinence-based programmes have expanded in many countries but to widely varying degrees. About half the EU nations have introduced drug testing regimes (normally both on a voluntary and a compulsory basis) to curb use in prison. Many prisons also have 'drug-free' zones whose volunteer inmates accept tight controls to help them stop or avoid using drugs (checked by urine tests). In return they may receive individual and group counselling with specialist staff, occupational facilities, special privileges and fewer restrictions. An example is the UK. As part of a recent initiative, 16 programmes now treat prisoners in a 'drug-free' wing, generally adopting a 12-step approach and requiring their voluntary clients to submit to drug testing. Other interventions include self-help groups and, in at least four countries, relapse prevention. Methadone maintenance is commonly available in Spanish and Luxembourg prisons and occasionally in Germany.

On release

Eleven countries provide demand reduction information to released prisoners, often supplied by probation and prison services and generally applicable rather than drug-specific. Seamless transfer to a therapeutic community or other forms of treatment is attempted, but, for example, in the United Kingdom, liaison and funding difficulties, and differences between prison regimes and those outside, have been acknowledged to impede ideal arrangements.

Other activities include help in social reintegration, establishing or maintaining contact with helping services and, rarely, relapse prevention. For example, in France the care of drug using prisoners is primarily undertaken by Antenne Toxicomanie – teams of workers attached to particular prisons and managed by the health ministry. Since March 1992 Antenne Toxicomanie and other organisations have been facilitating an intensive pre-release programme during the last few months of custody, aimed at persistent reoffenders.

Ensuring quality: research, evaluation, training

Ensuring that demand reduction activities meet quality standards and are effective is part of the everyday role of those delivering the interventions, but increasingly planners and funders look for objective evidence, and services themselves are linking with research teams or adopting research techniques to guide their work. Formal quality assurance methodologies take the form of:

- research, which may or may not take the form of an evaluation of effectiveness;
- evaluation, which may involve special research projects or more routine data collection;
- staff training.

• Research •

Some countries' administrations support a significant body of research on drug addiction (UK, the Netherlands, Sweden, Germany) but in others the absence of national policies and coordinated funding mechanisms mean research is mainly confined to a few universities and government institutions. In several countries where research is relatively abundant, little is relevant to demand reduction. For example, of 155 addiction research projects in Sweden over the last decade, only three were related to prevention, while neurobiology is the topic of the most prominent projects in Germany. However, across Europe the drive from policymakers and professionals seeking a scientific basis for their work is tending to upgrade the still low priority afforded demand reduction research.

In most countries such demand reduction research as there is focuses on drug abuse among young people – their attitudes, norms and behaviours, and the prevention implications. Other topics are mass media campaigns and treatment modalities, particularly treatment in prisons, and (eg, in Italy) the development of children born to addicted mothers. An analysis of demand reduction research in the Netherlands (see panel) may well represent the upper end of what tends to be available in other countries.

• Evaluation •

Evaluations of demand reduction activities are scarce in Europe, but there are signs that more data will become available. A priority for the EMCDDA is to foster an 'evaluation culture' across Europe, and many Member States have set up structures and

strategies to underpin progress in this area (see The drive to know what works). The following (not comprehensive) list – illustrates the range of activities recently evaluated in Europe.

▶ The Healthy School programme for secondary schools, developed by the Netherlands Institute of Mental Health and Addiction, has been evaluated in a before-and-after design with a control group. Use of alcohol and tobacco was lower in the group that had followed the programme.

▶ Ireland's On My Own Two Feet programme for post-primary schools aims to prevent substance abuse and promote healthy living. Schools piloting the programme were compared with matched controls. The results suggested that appropriate educational efforts have an important role to play in coping with the problem of drug misuse.

▶ The Nordic teaching material Mia's Diary has been evaluated by teachers' assessments and by before-and-after questionnaires completed by pupils. The course clearly improved pupils' knowledge of substance use, but not their attitudes to alcohol or to the self-control of substance use.

▶ Aarhus county in Denmark has assessed its pilot outpatient programme for young cannabis abusers, who often suffer social and psychological problems. Cannabis abuse was significantly reduced and psychosocial status improved, results which led to the project being made permanent and inspired replication in other areas.

▶ A follow-up study of injectors using syringe exchange programmes in Amsterdam compared them to injectors not using syringe exchange; unsafe sexual and injecting behaviour fell in both to a similar degree. Such findings in other countries have been attributed to the percolation of anti-HIV initiatives through drug using networks rather than to the ineffectiveness of syringe exchange.

▶ England's National Treatment Outcome Research Study covering community prescribing and residential programmes was commissioned by an official effectiveness review task force and funded by the health ministry. Interviews with clients six months after treatment started confirmed that early gains had largely been maintained in the form of reduced and less risky drug use, less crime, and improved health and social functioning.[10]

▶ As well as assessing outcomes, evaluation may also be used to fine-tune the implementation of new projects and services, as in an Austrian short-term treatment service established in 1995. Monitoring showed that clients were significantly older than expected, a finding which influenced the later stages of the project.

Research in the Netherlands

An analysis of demand reduction research in the Netherlands concluded that:

▶ many studies focused on distinct and sometimes hard to reach subgroups, such as drug injecting adolescents, body-builders and addicts not in treatment;

▶ several projects have addressed the risk factors leading to drug use, addiction or drug-related harm such as HIV infection;

▶ how professionals decide what treatment clients should receive has been an important research topic and considerable attention has been given to client/staff satisfaction;

▶ few studies researched clinical effectiveness and treatment centres tend not to evaluate their own clinical approaches;

▶ rigorous assessment of outcomes is rare but developing; randomised clinical trials have recently started, directed at pharmacological and psychotherapeutic interventions.

• Training •

Training and professional education in demand reduction are increasingly available across Europe. All EU countries train key personnel such as GPs and other doctors, psychologists, social workers, teachers and police, either at prevention centres, in one-off events or in the further education curricula of universities and other institutions. With funding from the European Commission, the European Addiction Training Institute in the Netherlands offers international training programmes.

Upgraded and specific training is part of a trend towards the increasing professionalisation of prevention, seen also in the increased number of posts for specialist staff. Further education and training courses may be systematically constructed to lead to qualification in an aspect of demand reduction, sometimes at postgraduate level. Greece's new Educational Centre for the Promotion of Health and the Prevention of Drug Abuse teaches community workers how to organise and evaluate local primary prevention programmes and develop resources. For several years Spanish universities have organised postgraduate courses in drug dependency for social workers, nurses, teachers, physicians, psychologists, lawyers and other professionals,

References/notes

1. *Concepts and terminology in the field of demand reduction* was carried out in 1996 by ISDD, the operational focal point of the UK.

2. Unless indicated otherwise, deficiencies in documentation mean countries cited as featuring or not featuring a particular characteristic are examples only rather than an exhaustive list. Unfilled cells in tables referring to activities in each country indicate data not available.

3. Michael Farrell *et al. A review of the legislation, regulation and delivery of methadone in 12 Member States of the European Union*. Luxembourg: Office for Official Publications of the European Communities, 1995.

4. CAT das Taipas.

5. Typically a short but highly structured therapy which focuses on the development of a 'recovery plan' based on self-help, the resident's responsibility for making the decisions needed to achieve and sustain abstinence, and the '12-step' treatment model derived from Alcoholics Anonymous which sees addiction as an illness that can only be controlled by lifelong abstinence. Aftercare usually takes the form of attending a Narcotics Anonymous (or similar) self-help group.

lasting from 250 hours (expert level) to 500 hours (masters level). In the Netherlands, a national drug prevention 'help-desk' is to be established to help prevention workers improve the effectiveness and efficiency of programmes. Belgium's University of Liège provides an addictions option in its two-year public health course which can lead to a master's degree or doctorate.

Not only professionals benefit from training. In Denmark Esbjerg's School of Social Work is creating a qualification training programme for a new group of therapists – ex-addicts employed by private and state treatment institutions.

The way forward

What is clear is that demand reduction is generally moving in a direction which most expert observers would assess as forward and positive and that the volume of activity is increasing, but the gaps are many and in some cases extensive.

▶ More regional cross-sector (drug, health, social and criminal justice system) cooperation is needed along with community planning and constructive social policy.

▶ EU countries do not have reliable, well-developed and differentiated national monitoring systems, yielding comparable data at least on a nationwide basis. Such a system is a prerequisite for planning and implementing any action programmes on drugs. Here, the work of the EMCDDA and its REITOX partners serves as a framework for managing national and European information.

▶ Urgently needed is further research to evaluate the effectiveness of demand reduction interventions, but common measures, definitions and outcome criteria are also required before different projects can be compared.

▶ National and international cooperation is required not only to conduct in-depth studies in special areas but also to ensure comparability of results. At the European level this requires the support of an effective organisation to disseminate information and coordinate action, plus new communication channels which facilitate information dissemination and dialogue, such as the Internet.

The drive to know what works

Across Europe evaluation is being integrated into demand reduction funding and activities, illustrated by these six examples.

▶ Italy now has an Evaluation Task Force created within the Presidency of the Council of Ministers' Department of Social Affairs to monitor the effectiveness and progress of interventions.

▶ Demand reduction programmes funded by the French government must submit evaluation reports as a basis for planning further funding.

▶ Sweden's National Institute of Public Health insists on evaluations of the yearly total of about 150 demand reduction projects it funds.

▶ In Greece, OKANA, the coordinating body for drug services, is devising means to make continuous evaluation and scientific supervision preconditions for supporting programmes.

▶ Monitoring has been strengthened in Denmark by the collating of nationwide client statistics. Under consideration is follow-up monitoring of clients entering treatment, documenting their progress and status on discharge.

▶ The UK's local drugs prevention teams seek to stimulate prevention activity. Their work is being evaluated by several groups of researchers, each focusing on one key issue, including the success of community involvement approaches. Other research includes large scale evaluations of criminal justice and school-based projects, plus many smaller local evaluations.

6. Classically involving group living in a hierarchical structure through which residents move from one stage to another under the tutelage of more senior residents and staff. Techniques which are often openly confrontational are designed to break down the psychological patterns underlying addiction and rebuild these in a non-addictive mode using the power of peer interaction.

7. Populations surveyed were not identical; the first survey concentrated on areas with high levels of drug use.

8. The study was conducted in 1997 by the Centre for Research on Drugs and Health Behaviour in London. The full report is available from the EMCDDA.

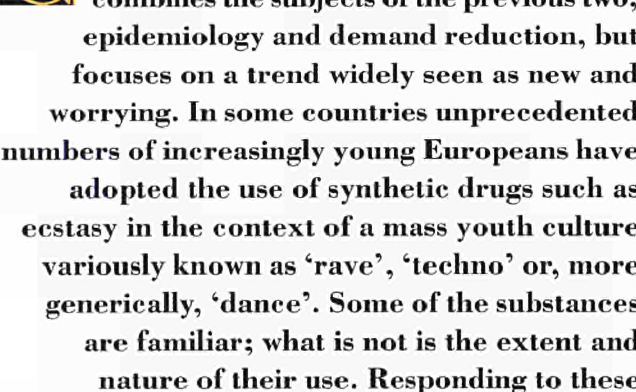
9. Throughout numbers and proportions of countries are based on those which provided relevant data as indicated in the tables.

10. National Treatment Outcome Research Study. *Improvements in substance use problems at six months follow-up*. 1997.

11. Race and Drugs Project. *Race · drugs · Europe: Volume 1*. London: City University, 1997

CHAPTER 3

New trends in synthetic drugs



Chapter three is a special review which combines the subjects of the previous two, epidemiology and demand reduction, but focuses on a trend widely seen as new and worrying. In some countries unprecedented numbers of increasingly young Europeans have adopted the use of synthetic drugs such as ecstasy in the context of a mass youth culture variously known as 'rave', 'techno' or, more generically, 'dance'. Some of the substances are familiar; what is not is the extent and nature of their use. Responding to these concerns, the EMCDDA commissioned major reviews soon to be published in their own right; this chapter is both a preview and a distillation.

Across the European Union (EU) increasing unease has been expressed about the rising popularity of 'synthetic' drugs (see Definitions). Concern is based partly on the rapidly emerging and novel patterns of use of these drugs. Unlike drugs such as heroin, users are not concentrated among the marginalised or deprived but are mostly young, employed or students and relatively affluent. Use takes place in social and recreational settings, often at large dance events. These patterns of use were established rapidly across the European Community. Where the trend arrived earlier it became more pronounced and responses emerged which in places developed into quite sophisticated demand reduction activities. Elsewhere, decisions are still being made about how to respond to a new trend. In this situation much can be gained from sharing information and experiences. The speed with which synthetic drug use transcends national boundaries makes such communication especially relevant. Where responses are more developed there remains a need to audit what is known.

Its profile is such that the meaning of the character e has been transformed, instantly identified as the symbol for Europe's most talked about drug, ecstasy

Definitions

▶ **Synthetic drugs** are produced in laboratories from chemicals rather than from natural products. Though this applies, for example, to barbiturates, benzodiazepines and methadone, in this chapter the term is used more narrowly to refer to the ecstasy family, amphetamines and lysergic acid diethylamide (LSD). Along with other substances linked with dance events, these substances are sometimes colloquially referred to as **'dance drugs'**.

▶ **Designer drugs** are synthetic drugs similar to controlled substances but chemically constructed to avoid legal controls. This means the substances embraced by the term may differ in different legislatures.

▶ **Amphetamine-type stimulants** (ATS) is a term sometimes used for the different amphetamines, including methamphetamine, and other drugs with similar actions. Unlike in some other areas, in the European Union, amphetamines are indeed almost always amphetamine itself, so the broader term ATS is not used in this chapter. Other amphetamine-type drugs are referred to by name.

▶ **Ecstasy** is strictly the compound methylenedioxymethamphetamine (MDMA) but is used also to cover the family of drugs of which MDMA is a member. These share a core molecular structure which may be modified to produce many related drugs, often collectively referred to as 'ecstasy'; unless indicated otherwise, the term is used here in this collective sense. Because of the term's strong symbolic associations with rave and allied lifestyles, it is sometimes used to refer to any product marketed as a 'dance drug'.[35]

To inform this process, the study on which this chapter is based sought to collate available information and identify gaps, under three main headings:

▶ What do we know about the extent and patterns of use in the EU?

▶ What do we know about the problems this may give rise to?

▶ How are these being addressed by demand reduction activities?

After describing the youth culture within which synthetic drug use has flourished, each of these topics is addressed in turn. The usual disclaimers that information on drug use is partial and potentially misleading here carry extra weight. The difficulties of assessing and addressing problems arising from use patterns so new and unfamiliar are obvious, but even assessing use levels is far from straightforward; indicators are not geared to this form of drug use.

This chapter concentrates on ecstasy (MDMA), LSD and the amphetamines – not because of pharmacological similarities, but because they form the pillars of the culture at the heart of current concerns. However, the drugs do share a degree of pharmacological compatibility with the values of rave/dance culture. The stimulant properties of amphetamines and ecstasy have an obvious attraction for club-goers attending an all-night venue where energetic dancing is the norm. The 'empathic' effects of ecstasy and the hallucinogenic nature of LSD fit a crowd situation where psychedelic lighting, strobe effects and insistent rhythms suggest mood alteration is high on the agenda. Most young people enjoy their nights out without illegal pharmacological aids, but for many who attend rave-type events these substances are integral to the experience – the term 'dance drugs' signifies the closeness of the link.

Rave culture and the emergence of ecstasy

Among the trio of drugs considered in this chapter, ecstasy is the most novel, most closely identified with rave culture, and the one which has attracted most

KEY POINTS

▶ In some EU countries unprecedented numbers of young Europeans have adopted the use of synthetic drugs such as ecstasy, LSD and amphetamines in the context of the mass youth culture known as 'rave', 'techno' or 'dance'. Users are mostly young, employed or students and relatively affluent.

▶ The ease with which synthetic drug use transcends national boundaries and the common cultural context of dance music mean that much can be gained by sharing experiences.

▶ Ecstasy and amphetamines share stimulant effects while LSD's effects are primarily emotional and perceptual. The effects of all three share an affinity with the energetic, mind-altering context of all-night, rave-type dance events.

▶ The numbers who have tried these drugs and the frequency of use have increased since the advent of rave culture in the late 1980s but usually well below 10% of all young people have tried them and regular use is uncommon. Generally fewer people have tried ecstasy than LSD and amphetamines, but recent ecstasy use is often highest.

▶ Fatalities and other serious harm from amphetamines, ecstasy or LSD seem relatively rare. Annual recorded national death totals for each drug are often zero and rarely exceed ten. However, the context of some deaths – 'normal' young people enjoying a night out – heightens their impact, and problems may be hidden by the inadequacy of the data or develop if use patterns become chronic.

▶ Adverse physical effects of amphetamines and ecstasy are largely related to their stimulant properties, which can stress the circulatory and other systems, and to their use during prolonged bouts of energetic dancing in hot venues, which can lead to heatstroke. LSD's physical effects are relatively mild. Lasting neural impairment has yet to be demonstrated in human beings though animal experiments suggest this could arise from ecstasy use.

▶ Stimulant-induced anxiety and paranoia followed by depression can occur with amphetamines and ecstasy, and LSD can cause distressing temporary symptoms similar to psychosis. Though rarely seen, heavy amphetamine use can cause a transient drug–induced psychotic episode.

▶ Dependent patterns of use are not uncommon with amphetamines, but usually not in the context of dance events. Dependence is not a recognised feature of LSD or ecstasy use. Social and health problems can arise from excessive or particularly ill-advised use; impaired driving has received increasing attention.

▶ Localities, municipalities and national bodies have recognised the importance of harm reduction strategies. These have usually been instigated by non-governmental bodies. Often they seek to persuade club owners and event organisers to provide safety features such as improved ventilation, drinking water and first aid. Increasingly clubs are taking on these responsibilities.

▶ Prevention tactics often involve adopting the language and images of rave culture and using this culture – sometimes through peer education – to promote drug-free events or safer drug use.

▶ The widespread but illegal nature of drug use at many dance events means authorities oscillate between repression and the view that on occasions this might cause more harm than good, eg, by encouraging illegal events at remote venues.

▶ Synthetic drug use is poorly understood compared to opiate use or the problems of drug injection. There is a need for studies both of patterns of use and of the consequences, including those which follow up users to monitor possible harmful effects.

A scene from the early days of the rave scene, the youth dance culture now closely associated with new trends in use of synthetic drugs

media attention. Understanding how ecstasy emerged from relative obscurity to become the most 'talked about' drug in Europe is also to go a long way towards understanding the subculture it symbolises. This subculture was foreshadowed by the confluence of ecstasy use with house and soul music in a few black, gay and exclusive discos and clubs in US cities in the late 1970s and early 1980s. The music that emerged was influenced by European experimentation with computers and black American dance music. Europe's music and fashion industry élites visited and imported what they saw, initiating ecstasy use in a few London clubs. 1985/86 saw the first ecstasy parties in London. Shortly after, Londoners holidaying on Ibiza discovered an emerging 'Balearic sound' which, with its associated drug experiences, soon began to influence musical fashions across many European countries.

Young people are warned of the dubious contents of pills sold as ecstasy in these leaflets from Andalucia's regional council, and from the Portuguese NGO GATo funded by the national drugs prevention service, Projecto VIDA. Both include advice for those who ignore 'Don't use' messages

From the late 1980s ecstasy and its dance culture spread from fashionable trendsetters to become a mass dance/drug phenomenon, a transition (far more rapid in some countries than others) encouraged by the popularity of the music, the ease with which it could be 'mixed' and developed, and the promotion of legal and illegal mass social events. As with its US beginnings, ecstasy's rise was linked to a new style of music known as 'acid house', 'rave' or 'techno'. Ecstasy's stimulant and 'entactogenic' (empathy-promoting) properties contributed to the inclusive, bonding atmosphere of the environment and to the drive to dance.

Rapid spread

The new drug trend rapidly transcended Europe's previously less pervious national borders. Advances in communications technology meant young people across the Community increasingly had access to the same information sources. Rapidly they became directly aware of rave culture and indirectly aware of ecstasy use, aided by astute marketing. Advertisers responsive to young and relatively affluent consumer markets adopted dance culture's sounds and images and now use these to market products from soft drinks to sportswear across Europe. Much of this marketing is implicitly or explicitly drug related; international corporations appear to have become increasing blasé about ads with explicit drug imagery. With spin-off fashions, music and other products, the dimensions of the European dance economy are considerable. In such an arena, health education faces formidable competition.

During the 1990s countries first affected by dance drugs saw a fragmentation of rave culture and many clubs and events became increasingly mainstream and commercial. In these countries ecstasy is no longer linked to a musical fashion, but rather to nightclubs and dance parties in general; for many youngsters, ecstasy and recreational drug use have become everyday and barely worthy of comment.[1]

Young people at dance events is not the only context for ecstasy use, especially where nightclubs have become an important leisure venue across the age range. For example, many gay men and women use nightclubs as key social centres; in this context, drug use is less associated with age and more with leisure preferences. In some countries ecstasy has also been associated with attending football matches.

The way drugs such as ecstasy rapidly established themselves may influence and be the model for future European drug problems. Recently ketamine, 2CB (4-bromo-2,5-dimethoxyphenethylamine), and 'ice' (crystalline methamphetamine) have attracted attention; accounts of new forms of 'ecstasy' suggest their use is increasing.

The prevalence of synthetic drug use in Europe

In most European countries indicators of drug use focus on heroin and similar drugs mainly taken by injection and associated with physical dependence for which treatment is more or less widely available. In contrast, the drugs at issue here are rarely injected and are taken in ways which usually do not result in dependence; the result is that their use is poorly reflected in treatment statistics. Nevertheless, information is sufficient to support an overall sketch of synthetic drug use in the EU (see Synthetic drug trends: the main features on page 74) and some details which may prove helpful to policymakers.

• Survey data •

Given the limitations of treatment or enforcement sources, surveys provide the best data on the prevalence of synthetic drug use, but these also have their limitations (see chapter 1). Especially with respect to synthetic drugs, the numbers using regularly are likely to be far lower than the numbers who have ever tried the drugs ('ever-use' or 'lifetime use'), the figures most commonly reported. This disparity may vary across drugs. For example, more people may have tried LSD than ecstasy, but the number of repeat, long-term consumers may still be lower.

Provincial surveys in **Austria** suggest that about 3% of 18–20-year-olds have tried ecstasy, more in cities, such as Vienna where 6% of 15–18-year-olds reported ever using the drug. A representative study of the school population in the **Belgian** capital Brussels in 1996 reported male ecstasy use ranging from 2% for those aged under 14 to 10% for 15–16-year-olds. Figures for girls were far lower – 1% and 2% respectively. Two years earlier, a survey in the

'Dance drugs': what they are and what they do

Annexe 1 gives basic information about ecstasy, LSD and the amphetamines, which is supplemented rather than repeated here.

Amphetamines

Most illicit amphetamine in Europe is sold as a mixture of amphetamine sulphate and dexamphetamine sulphate. Non-medical use of amphetamines has been a feature of the licit and illicit drug scene in Europe since at least the end of World War II.[36] Users divide into three distinct populations.

- **Chronic users** Often socially marginalised and in some respects comparable to chronic opiate users, in countries such as Sweden this group represents the major drug problem. Dependence, injection and the attendant risks of disease and other physical damage are common.
- **Instrumental users** Historically and globally, probably most often amphetamines have been used as a means to an end – for example, by drivers, students or night workers to improve concentration and ward off fatigue, and (particularly by women) to assist with weight loss.
- **Social/recreational users** In some ways this is a subset of instrumental use, but the 'end' here is 'fun' rather than improved performance. Consumption often takes place in social/recreational settings, such as parties or dance events, where the drug enables the user to remain active for longer. As befits its social nature, users may identify with a subcultural group identity characterised by music, fashion and a shared value system.

Social/recreational use is the focus of this report, while acknowledging that globally it may be the use of amphetamines by drivers and its association with road accidents that causes the greatest concern.

Ecstasy

Ecstasy is methylenedioxymethamphetamine (MDMA) but tablets sold as 'ecstasy' may contain MDMA, a related substance, a combination of related substances, or substances outside the ecstasy family, usually a stimulant and a hallucinogenic, such as LSD-amphetamine mixtures.

There was little interest in ecstasy until the mid-1970s when it was revived by the chemist Alexander Shulgin and used in psychotherapy. In this setting its effects were thought to be moderate, principally feelings of empathic understanding for others.

Effect are noticeable after about 30–60 minutes, peak after about 1° hours and then fall away slightly to a plateau maintained for another three hours, followed by a 'come-down'. Typically users experience an increased sense of empathy with and positive feelings towards other people and diminished aggression. The unpredictable content of 'ecstasy' tablets results in similarly unpredictable effects, and the context in which the drug is taken and the consumer's mood further vary the outcome.

LSD

Despite its history in psychotherapy and as a personal tool for 'mind expansion', the major use of LSD in Europe at present is for recreational purposes in the context of dance or similar events.

Noticeable after 30 minutes to two hours, LSD's effects come in waves, each more intense than the last, peaking at four to six hours and fading out after 12. Initially the user experiences stimulation of the autonomic nervous system, often in the form of mild tremors, some anxiety and mild nausea. There follows a gradual change in perception, frequently involving a dramatic intensification of colour, swirling patterns, movement of stationary objects, illusions and pseudo-hallucinations. Genuine hallucinations, when the person believes what they are seeing is real and is unaware that this is a drug effect, are uncommon. Higher doses can produce synaesthesia, where one sense is perceived as another; eg, music may be seen as colour. LSD does not generally produce auditory hallucinations or persistent delusions. Profound time distortion may occur, usually as brief periods being perceived as very lengthy; perception of time may cease all together. Loss of boundaries may occur, resulting in perceived merging with the environment and other persons present.

A key feature is a sense of intense meaningfulness which may develop into a mystical or religious experience. An overblown sense of personal power is common, sometimes in the potentially dangerous form of a belief that one has superhuman abilities. Feelings of insight into the self and others may be enhanced. The prevailing mood is fluid and may vary from ecstatic bliss to deep depression or extremely unpleasant panic attacks ('a bad trip'). Opposite effects may be experienced by different people, by the same individual on different occasions or even within a session.

Flemish region of Belgium reported that about 4% of 15–16-year-olds had used either amphetamines or ecstasy in 1994 and 2–3% LSD.

As elsewhere in northern Europe, in **Denmark** amphetamine use is second only to cannabis and has a long history. In 1971 over 1 in 10 military conscripts aged 18–22 had tried amphetamines and 5% had tried LSD. Use of both fell until in the early 1980s amphetamine was restricted to small subcultural groups. During the 1980s recreational use of amphetamines spread; now 4% of the general population have ever used it though only about 1% have used in the past year. Usage is highest in densely populated areas, most so among the socially marginalised. Fewer have tried either LSD or ecstasy. In 1995, about 2.5% of 15–16-year-old schoolboys and 1.5% of girls had tried amphetamines, but less than 0.5% had tried either ecstasy or LSD.

Although in **Finland** amphetamines are second only to cannabis, compared to other EU countries synthetic drug use is low. In 1992, 0.2% of adults had tried amphetamines, rising to 0.7% in 1996 when just 0.3% or less of the population had tried LSD or ecstasy. Among schoolchildren in 1995, lifetime use of amphetamine was 0.5%, of ecstasy 0.2%, and of LSD 0.3% – very low figures. Unlike some of its neighbours, amphetamines are not widely used in **France**. LSD and ecstasy are mainly used in the dance scene. By 1995 1.5% of the general population had tried hallucinogens and 0.7% ecstasy. Two years earlier a survey of schoolchildren aged 11–19 found that 2.8% of boys and 1.3% of girls had tried amphetamines, 2.7% and 0.9% hallucinogens.

Municipalities such as Bremen in Germany have adopted unconventional methods to counter the risks of dance drug use, including this selection from a set of posters for the inside of toilet doors – where ravers have "a lot of time to read"

Amphetamine use in **Germany** has a long history but has never been extensive. Emergence of dance culture in the 1990s saw a steady spread of ecstasy, amphetamines and LSD; people are now trying them at an earlier age and using more often. Usage seems far lower in the East, reflecting the former political divide, but the gap may be narrowing. In the West in 1995 2.8% of adults had experienced amphetamines, 2.1% LSD and 1.6% ecstasy, peaking among men aged 25–29. But in the past year more (0.9%) had taken ecstasy than amphetamines (0.8%) or LSD (0.6%), illustrating that ever-use is not always a guide to recent use. Use in the past year peaked among 18–20-year-olds, the age group in which there was also the steepest increase in use levels; in 1990 2% had tried amphetamines, rising to 7% in 1995, when 7% had tried ecstasy and 4.5% LSD. In 1995 in the East just 0.7% of the adult population had tried amphetamines, 0.7% ecstasy and 0.3% LSD.

Synthetic drug trends: the main features

First seen in restricted circles from the early 1980s and to a significant degree around 1986/87, ecstasy use has now been reported in virtually all EU countries. Some, such as the UK, Spain and the Netherlands, have relatively long-established populations of ecstasy users and prevalence is comparatively high. In others (for example, the Nordic countries and Greece) ecstasy is relatively new and prevalence is correspondingly lower. Lifetime prevalence of ecstasy use is generally lower than that of amphetamines and LSD. This may be because ecstasy emerged more recently.

Popular in some countries during the 1970s (UK, Ireland, the Netherlands), LSD use appears to have declined in the early to mid-1980s, only to be revived from the late 1980s and spread to countries where exposure was previously limited. This resurgence reflected the increased popularity of a range of drugs, including ecstasy and amphetamines, used by a new group of young consumers, usually in dance-related settings.

A broadly similar trend can be found with regard to amphetamines, with some important differences. Among these is the existence of some older, long-term, injecting populations (in Nordic countries and, to some extent, the UK) and the fact that throughout the 1980s and 1990s amphetamines have been consistently used by some subcultural groups, such as biker gangs.

A 1993 survey found that 1% of **Greece**'s general adult population had tried amphetamines. This included a higher proportion of women than men (1.2% versus 0.7%) and was highest at 2.2% among women aged 25–35. In another survey, 4.4% of school students said they had used amphetamines. In this younger group more boys (5%) than girls (3.8%) had tried the drug and use peaked among those aged 17 and over (5.3%). In Greece in 1993 1.2% of 15–16-year-old school pupils had ever tried LSD. **Ireland**'s growing dance scene has seen increased use of ecstasy and cannabis and some resurgence in LSD use. In 1984 3.3% of secondary school pupils had tried amphetamines falling to 2.9% in 1991; the corresponding figures for hallucinogens (including LSD) were 2.7% rising to 5.9%.

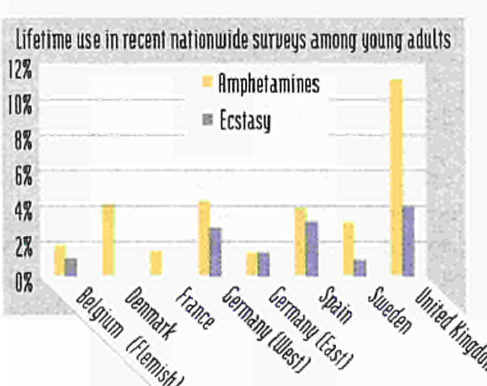
Methamphetamine, amphetamine and prescribed amphetamine-like drugs such as phendimetrazine are all available on the illicit market in **Italy**. As elsewhere, the ecstasy family and LSD have become more widely used by nightclub goers, recently alongside other hallucinogenic substances such as 2CB and DMT (dimethyltryptamine). Perhaps 50,000 to 85,000 take ecstasy on a typical Saturday night, mainly in nightclubs. In different studies, from 9% up to 65% of nightclub attenders in the northeast reported using ecstasy, usually with other drugs. It may also be taken at football games and private parties.

In 1988 drug use in **Luxembourg** began to diversify from cannabis and a few drug injectors to embrace amphetamines and polydrug (several substances) use. Indicators for 1995 suggest that polydrug use had increased, but that LSD use had dropped to negligible levels. Falling amphetamine treatment data may not reflect the trend in the general population; from 1983 to 1992 experience of amphetamine among schoolchildren rose from 2.5% to 9.9%; ecstasy use rose from negligible levels to 1.2%, while LSD use fell from 3.7% to 2.1%.

Data from Amsterdam, while useful, is unlikely to be typical of **the Netherlands**. In Amsterdam lifetime prevalence of ecstasy use increased from 1.2% (1990) to 3.4% (1994) whilst experience of amphetamines or hallucinogens remained at about 4%. Increased use of ecstasy may partly be explained by its continuing spread following a relatively recent introduction, meaning use levels have yet to stabilise. In contrast to ever-use figures, more Amsterdammers seem currently to be using ecstasy than either of the other drugs; at 1.4%, use of ecstasy in the last year was nearly three times that of amphetamines or hallucinogens (each 0.5%). By 1993, 3% of Amsterdam's schoolchildren had tried amphetamines, 2% LSD, and 5% ecstasy; again, ecstasy was the most commonly used in the last year (4%). For the Netherlands as a whole, in 1992 2.1% of schoolchildren over 12 years of age had tried amphetamines and 3.3% ecstasy. Studies of 'at risk' groups report far higher rates. A 1995 study of 462 disco-goers found 52% had tried ecstasy and 41% had done so in the past year; for LSD the figures were 23% and 9%; for amphetamines, 34% and 20%.

In **Spain**, since the late 1980s there has been a rise in the social/recreational use of ecstasy, LSD and amphetamines among young people, linked to dance events. Use is also common in other social settings. In the 1990s use of ecstasy rose more than any other drug, peaking in those aged 18–25 at 5–10%, though prevalence is high across the 14–30 years age band. LSD use also has risen sharply, but regular or sustained use remains rare. Chronic and instrumental (see Dance drugs: what they are and what they do, p. 73) use of amphetamines was relatively common until the 1980s, but since the 1990s these have also become 'dance' drugs. In 1995, 1.6% of those aged 15 or over had tried ecstasy, 2% amphetamines and 1.8% LSD; use in the last 12 months was 1.1%, 0.9% and 0.7% respectively. At roughly 5% for each, the same study found that experience of these drugs peaked among those aged 19–24. Another study in 1994 found that in the past year 3.3% of school students aged 14–18 had used amphetamines, 3% ecstasy and 4% hallucinogens. As many older pupils had left school these figures may be more indicative of use among 14–16-year-olds.

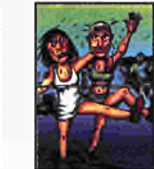
Unlike most Western countries, amphetamines dominate **Sweden**'s drug problem. As early as 1943, a third of adults had used amphetamines in the past year. In the early 1950s injecting amphetamines became popular; today 81% of "severe drug abusers" (injecting or/and daily use, estimated at 17,000 in 1992) use amphetamines and nearly all inject them. Nevertheless, estimates suggest that just 2% of the adult population in 1996 had tried the drug. Ecstasy use, introduced around 1992, seems mainly limited to affluent young people at dance events; only 1% of young adults have experienced the drug. LSD has virtually vacated the Swedish drug scene since its limited use among 'hippies' in the 1960s and early 1970s. Of 18-year-old male conscripts in 1995, 2.4% had tried amphetamines, up from below 1% in the late 1980s; in 1995 0.9% admitted ecstasy use rising to 1.4% in 1996. LSD use in the same group fell from 1% in the 1970s to around 0.3% in the 1980s, rising to 1.1% in 1995. In 1996 under 1% of 15–16-year-old school pupils had ever used each of amphetamines, LSD or ecstasy.



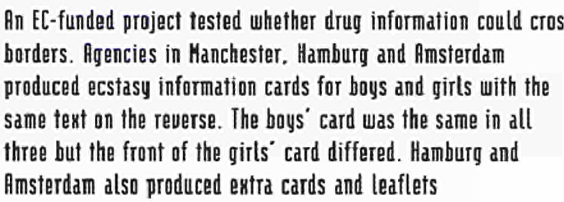
More young people have experienced amphetamines than ecstasy but that may be because ecstasy appeared on the scene later

See table 1 chapter 1 for sources and notes. For Denmark and France ecstasy data unavailable.

Boys' card

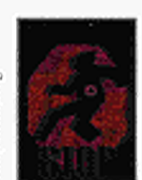


Girls' cards



An EC-funded project tested whether drug information could cross borders. Agencies in Manchester, Hamburg and Amsterdam produced ecstasy information cards for boys and girls with the same text on the reverse. The boys' card was the same in all three but the front of the girls' card differed. Hamburg and Amsterdam also produced extra cards and leaflets

from Hamburg



Additional cards

Leaflets from Amsterdam

During the 1990s, use of amphetamines, LSD and ecstasy rose steadily in the **United Kingdom**. Amphetamines have been a long-standing feature of the UK dance and drug scene, but during the 1980s LSD use fell only to revive in the 1990s, accompanied by the emergence of ecstasy use. Ecstasy, amphetamines and LSD are now commonly used socially and recreationally by young people, usually at nightclubs and dance events, but also at other social events. The UK also has a smaller and older chronic amphetamine using population, who often inject. A national survey conducted in 1994 suggested that drug use rose throughout the 1990s.[2] Among those aged 16–59, 8% had tried amphetamines (1% in the past month), 4% LSD and 2% ecstasy (both at negligible levels in the past month). Of those aged 16–29 (the peak age band for these drugs), 14% had ever used amphetamine (3% in the last month), 9% LSD and 6% ecstasy (both 1% in past month). A survey in 1995 of 11–35-year-olds details where these drugs were used.[3] Of those who had used them, 52% had taken amphetamines in clubs, 47% at parties, 36% at friends' homes and 33% in pubs. Ecstasy was used at clubs by 65%, raves by 51%, and parties by 43%. School surveys indicate that ever use of drugs has spread, though regular use is far lower. A 1996 survey of 15–16-year-olds found that 12.2% of girls and 17% of boys had ever used LSD, 12.3% and 14.5% amphetamines, 7.3% and 9.2% ecstasy.[4]

• Seizures •

Though on their own a poor guide to use levels (see chapter 1), across Europe trends in numbers of seizures by police and Customs and the amounts seized generally support the findings of the surveys reported above.

Five countries (Spain, UK, the Netherlands, Germany, France) account for most of Europe's ecstasy seizures, each seizing 100,000s of doses a year while others rarely exceed 1000. Wherever these are reported, the trend in numbers of ecstasy seizures over the 1990s has been uniformly upwards, sometimes dramatically so, though the levels vary from a high of over 5500 in the UK in 1995 to several countries where the figures do not yet warrant separate reporting (see table 18 in chapter 1). The increase in amphetamine seizures in Europe between 1993 and 1994 was almost entirely due to the UK; elsewhere the trend is mixed or relatively stable, though Germany's total for 1995 was both high in comparison to other countries and a steep increase on the year before.

LSD seizures generally peaked in the 1970s and then fell before increasing again in the late 1980s and early 1990s. In the 1990s so far the picture is less clear, perhaps influenced by the potential for a few large seizures to dramatically skew the figures. What is clear is the vast range in quantities seized across the EU. In 1995, 100 LSD tablets were seized in Luxembourg and 500 in Finland, but 70,217 in France and 382,000 in the UK.

Data available from the United Kingdom illustrates how trends in availability can be illuminated by retail market data. The price of a unit of ecstasy has fallen from about 24 ECUs in 1993 to 12–18 ECUs in 1995 and LSD from 4–6 ECUs to 2°–4 ECUs. Amphetamine's purity increased from 6% to 10% in 1995 while per-gram prices fell slightly to 10–12 ECUs in 1995. All these trends are consistent with increased availability.

• Drug problems •

In most countries synthetic drugs are rarely the 'primary' drugs used by treatment clients (ie, the ones which caused them to seek help). However, many clients will also be recorded as using other 'secondary' drugs before entering treatment. Though it may bear little relation to youth recreational use, the presence of synthetic drugs in these figures is some indication of their availability in drug using circles.

Especially in the north of Europe, populations of dependent amphetamine users, many injectors, can make a substantial demand on treatment and other services. This is not the case for ecstasy or LSD. For example, in Finland in 1995 amphetamine offences represented 42% of all drug offences, involving 1579 arrests. In contrast there were just 32 ecstasy arrests in 1995 and 25 for LSD. Since 1993 amphetamine has accounted for about half of all Finnish drug treatment episodes. Over half of all drug-related arrests in 1994 in Sweden involved amphetamines, illus-

Edinburgh's CREW 2000 peer education project deploys distinctive Scottish humour in its leaflet advising that 'ecstasy' is not always MDMA. The lower postcard gives ravers safer driving advice

trating the drug's importance in the Swedish illicit drug market. In 1994, 36% of clients starting hospital treatment for drug-related problems were primary amphetamine users; under 1% had hallucinogens recorded as their main problem drug.

In the Netherlands amphetamine use is quite low although it has been reported among polydrug users and dance goers. In 1996, only 2.6% of all drug clients registered at outpatient services reported amphetamines as their primary drug (though this represented an increase since 1991). For 1.5% ecstasy was their primary drug problem. Under 1 per cent of all client registrations involved LSD as a primary drug. The UK records the primary drug and secondary drugs (in brackets below) used in the month before starting treatment. In a six-month period in 1994/95, 20,733 people started drug treatment in England. Of these, 8.7% had a primary amphetamine problem (18% had used it), 0.8% hallucinogens (5%) and 1.2% ecstasy (6%). However, it is widely recognised that Britain's treatment system is geared more to the needs of opiate addicts than to those with stimulant problems, so the proportions for amphetamine may underestimate addiction to this drug.

At the other end of the scale are countries such as Greece where in 1995 just 0.4% out of 1130 drug users seeking treatment had used amphetamines, 0.4% ecstasy and 1.1% LSD. These minimal figures were confirmed in 1996 when just 1.1% of heroin users also used amphetamines, 0.7% ecstasy and 2.7% LSD. Similarly in Ireland and Italy, amphetamines or ecstasy are primary drugs for less than 1% of treatment attenders. However, amphetamines are the main concern among teenagers in Italy supervised by social services.

• Deaths from synthetic drug use •

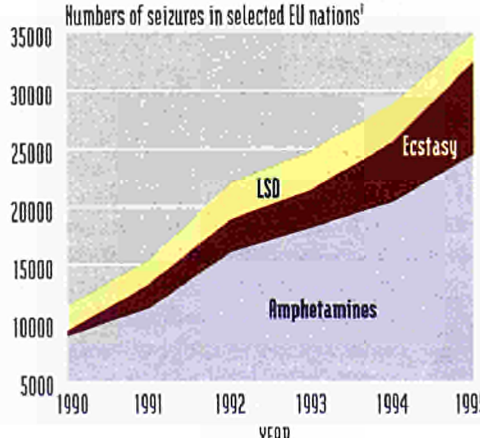
Though serious over- or under-reporting cannot be ruled out, the evidence suggests that relatively few users die from synthetic drugs. Ecstasy-related deaths may be rising, but so too has usage, meaning that the death rate per use episode may not have increased. Chronic amphetamine injectors are more likely to die from their drug use due to the drug's effects and to health problems from injecting.

In Finland evidence of amphetamine use was found in half the 16 drug-related deaths in men aged 16–34 in Helsinki in 1995. Just 0.8% (13 cases) of the 1565 drug-related deaths in Germany in 1995 were related to amphetamines, 0.6% (9 cases) to ecstasy.

Over the last five years in Italy toxicological investigations have linked two deaths to ecstasy but at least four others may also be ecstasy-related. In the first half of 1996 neither amphetamines, ecstasy nor LSD featured among 572 fatal overdoses. Neither have these drugs ever been cited as the cause of drug deaths in Luxembourg. The same is true of ecstasy and LSD in Sweden, but there studies suggest an annual death rate of 1–2% among amphetamine addicts.

From 1989 to 1995 ecstasy-type drugs were found in the post-mortems of 14 drug users in Spain. In most cases other drugs were present, clouding the issue of what caused the death. The Spanish scientific literature records one confirmed death due to ecstasy and one case of severe liver failure. Research implicates amphetamines in a small but increasing number of road accident deaths. However, other substances (including alcohol) have commonly been consumed.

In the UK drug-related deaths may be recorded as a death 'with an underlying cause of drug abuse' and/or as a death from poisoning. In 1994, 24 of the 489 drug abuse deaths were related to amphetamines (including ecstasy) and none to LSD. Since 1979 60 drug abuse deaths have been related to amphetamines (including ecstasy) and five to LSD. Out of 575 poisoning deaths in 1994, 14 were related to amphetamines, 19 to ecstasy, two to LSD. From 1980 to 1994, 91 poisoning deaths were related to amphetamines, 39 to ecstasy, six to LSD.



Where records are available there is no doubt about the increase in ecstasy seizures. amphetamines figures are skewed by a few high-seizure countries

Based on table 18 chapter 1.

1. Includes countries where all or most figures were available: Austria, Belgium, France, Germany, Ireland, Luxembourg, Sweden, UK.

Thankfully – given escalating use – both fatalities (see Deaths from synthetic drug use, page 77) and severe harm from amphetamines, ecstasy or LSD seem relatively rare. This may be partly due to the dominance of occasional, non-injecting and time-limited use patterns, and to the youth and vitality of the users. More extensive problems may be hidden by the inadequacy of the data or develop if use patterns become chronic – we already know this can be the case with amphetamines. It is also true that the unpredictability of the incidents, the youth of the users and their maintream social status, heighten the public sense of shock at each tragedy. The role of this section is to place such problems in the perspective provided by the evidence.

A typical safer dancing service

Analysis of project protocols suggests that the following elements are typical of services to safeguard the health of young dance-goers:

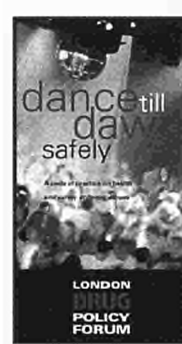
- information and advice about drugs (effects and risks) and about safer sex, often as information leaflets as well as personally;
- supply of condoms;
- support to those experiencing mental or physical health problems;
- liaison with organisers and licensing authorities over health and safety.

Some also provide:

- a total chill-out environment with appropriate decor, lighting and music;
- free massage;
- free chilled fruit, ice lollies and water at free parties/festivals;
- on-site testing and pill identification;
- collection of information on the current availability of drugs within the scene.

Most safer dancing projects engage in other activities and some are part of larger agencies. These have more on offer including shop-front premises with drop-in times and facilities for counselling. The range of advice can be quite extensive, incorporating legal advice.

In the UK, London and Scotland are among the regions to have produced 'safer dancing' guidelines for event organisers, often accompanied by advice for rave-goers themselves



• Physical problems •

Adverse physical effects of amphetamines may include: anorexia and malnutrition; mouth ulcers; dental damage from grinding teeth; raised blood pressure and heart rate; increased blood sugar and use of energy. High doses may result in headache, nausea, vomiting, blurred vision, lack of response to pain and repetitive movements. Very high doses can cause abnormal heart rhythms, salivation, convulsions, strokes, overheating, coma and death. 'Snorting' amphetamines up the nose may impair the sense of smell and cause nasal damage and inflammation. Injecting carries the familiar risks of infections, vascular damage, endocarditis, abscesses and damage from adulterants.

Many of the adverse physical effects linked to ecstasy result from an interaction of its effects with its use at events where dancing is strenuous and prolonged. Acute reactions have usually been related to exhaustion, overheating and dehydration, aggravated by ecstasy-induced stimulation and its effects on body temperature control. In extreme cases this leads to breakdown of muscle tissue causing kidney failure, widespread blood clotting, convulsions and death. Deaths have also been caused by abnormal heart rhythms leading to heart failure. Other rare complications have included liver inflammation with jaundice, severe strokes leading to paralysis and bone marrow problems.[5] Ecstasy also produces the stimulant effects typical of an amphetamine (see above).

In comparison, LSD's physical impact is unremarkable and adverse consequences are extremely rare. LSD increases heart rate and blood pressure and can cause blurred vision. There may be sweating and chills, gooseflesh, headaches, nausea, vomiting, weakness, tremors, numbness and twitching of the muscles, and sometimes impaired muscular coordination, abnormal skin sensations, convulsions and hypepyrexia (high body temperature). The few injuries or fatal accidents were generally linked to the context in which the drug was consumed rather than directly to its effects.

Neurotoxicity

As drugs which can profoundly affect brain functioning, there is concern that the drugs used at dance events may also cause lasting damage which impairs

Perhaps the most widely known 'safer dancing' publications are from the English drug agency, Lifeline, featuring the cartoon adventures of 'Peanut Pete' and 'Claire and Josie'

mental health or performance. There is no evidence that LSD has the potential to cause such damage. For amphetamines and ecstasy, so far there is little evidence that such damage has occurred, but some that it could do.

Amphetamines elevate levels of the neurotransmitter (chemical messenger between brain cells or 'neurones') dopamine, thought to account for their stimulant effects. To a lesser extent, they also affect serotonin-producing neurones. Following use, levels of these chemicals may be depleted and the brain's ability to use them reduced.

Animals given ecstasy have suffered damage to serotonin-producing neurone terminals, but neurotoxicity in humans has yet to be shown.[6] Research on a small sample[7] has revealed some depression a few days after taking ecstasy which might reflect depleted serotonin levels, but the significance of these results is contested.[8] Given these tentative findings, an increasing body of informed opinion argues that the possible danger of high doses of ecstasy should be widely publicised.

• Psychiatric & psychological problems •

Adverse psychological effects of amphetamines include: mood swings, irritability and aggression with possible violence;[9] guilt and low self-esteem;[10] sleep disturbances; severe depression which may result in suicide; anxiety disorders including panic attacks, paranoid ideas and paranoid psychoses involving compulsive, repetitive behaviours, delirium, and vivid hallucinations. The less extreme of these are quite common and become more common and more serious with high, repeated doses and if the drug is injected.[11]

During ecstasy use people sometimes experience impaired judgement, confusion, disorientation, flashbacks, anxiety, panic attacks, depression, insomnia, paranoia, and (more rarely) psychotic phenomena. Some effects may continue for a period after use.[12] The 'down period' in the days after use can descend into a moderately serious depression, perhaps due to a biochemical 'pendulum' effect, or perhaps because the user confronts the relative tedium of everyday life after the rave.[13]

Impaired judgement and mental health during use are the main psychological harms from LSD, often in the form of confusion, disorientation, anxiety, panic, depression, paranoia and feelings of overblown personal power. Serious persisting disturbance is rare but has been seen, especially after repeated use and in those with pre-existing or latent mental illness.

The possibility of a 'drug-induced psychosis' in previously normal individuals is hotly debated.[14] Even when drug use and mental illness coexist, which led to the other (if at all) is often unclear. For example, those in distress may try to 'self-medicate' with illicit drugs. Though rare, there is evidence for a short-lived amphetamine psychosis, but the evidence for ecstasy or LSD is relatively weak. Flashbacks and chronic hallucinations after ecstasy or LSD use has stopped appear rare and psychological in origin.

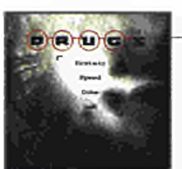
• Tolerance, dependence, withdrawal •

Amphetamine use can lead to tolerance (the need to take more of the drug to maintain the effect) and a dependence syndrome (a compulsive need to continue taking the drug). Withdrawal symptoms starting several hours after repeated high doses include a sharp drop in energy and mood; then perhaps 24 hours of sleep may be followed by days of depression. Tolerance also develops to ecstasy and LSD (for the latter, meaning that closely repeated doses are ineffective) but there is no recognised withdrawal syndrome, nor are these drugs considered addictive. However, practically any behaviour can become compulsive and excessive in some individuals; a few have taken LSD or ecstasy daily for prolonged periods, despite tolerance effects.

• Other problems •

Problems may be linked not so much to the effects of drugs but to where and how they are used in the overall context of the person's life situation. Particularly negligent or excessive use of synthetic drugs may result in unemployment, economic and work difficulties, child care and marital problems, social marginalisation, homelessness, crime and criminalisation, susceptibility to illness and accidents. Addictive drugs such as temazepam, opiates, barbiturates and alcohol may be used to 'come down', sometimes resulting in fatal overdoses.

'Dance drug' culture often entails frequent, long-distance travel between venues, when the driver may be under the influence of amphetamine, ecstasy or LSD – a special concern where (as in Italy, Portugal and Spain) venues are often in rural areas. Drugs may also be taken on the way to out-of-town



In Denmark a dance event promoters' forum enlisted the assistance of the National Board of Health to produce harm-reduction information materials, including a SafeRave leaflet. In Austria too club owners have cooperated to safeguard the health of their customers

dances to evade security searches or to ensure the desired state of mind on arrival. Drugs taken during an event or to 'chill out' after it has finished may still be affecting the user's judgement when they leave. There are similar concerns over drug use (particularly amphetamines) by long-distance lorry drivers or employees operating dangerous machinery.[15]

Dance events have often been poorly regulated or illegally organised with inadequate fire safety and crowd control measures. Risk of death from overheating after ecstasy use is potentiated by unventilated conditions, lack of access to water, failure to ensure chill-out periods and areas, and inadequate first-aid provision.

Demand reduction and other responses

Almost all Member States either have or are planning demand reduction activities related to synthetic drugs. With the largest dance scenes, the Netherlands, Germany and the United Kingdom also have most initiatives. There are some in Spain, Denmark and Sweden and Portugal is encouraging their development. Existing Finnish services handle a limited amount of work in this area. Greece and Ireland are not currently developing specific activities, though there is some informal activity in Ireland.

With treatment responses mostly ruled out (dance drug users generally do not see themselves as having a drug problem), debate over how to respond has featured calls to clamp down on events and make mass arrests, counterbalanced by demands for measures to minimise the harm to actual or potential drug users and to the wider society.[16]

Regulation or repression?

In many countries the argument that police are targeting dealers rather than their 'victims' – the users – maximises public acceptance of anti-drug operations. This strategy fits a pattern of use based on homes and small private parties, yet much synthetic drug use is at large, very public, events and clubs. At first most countries or regions reacted with repressive responses; some still do, while others oscillate between tolerance and repression.

Some police forces see repressing raves as a more cost-effective way to disrupt drug dealing and use than targeting individual dealers;[17] strict enforcement of public order and drug laws often leads to closing the event. Other forces, faced by a difficult and sometimes impossible task, opt for pragmatic responses such as informal rules on how many ecstasy pills trigger an arrest as opposed to less costly non-criminal sanctions. Other interventions involve police collaborating with local institutions, health and social care professionals, self-help groups and rave promoters in the interests of safety – even allowing on-site testing of illegal drugs.

Further tempering outright repression is the fear that this could increase the risks. This could happen if regulated legal events are replaced by uncontrolled illegal events at remote and unsuitable venues without medical or welfare cover.[18] Some believe clubs should be punished if drugs are used on their premises, others argue this would make it difficult for services to gain access, or that facilities such as chill-out rooms would be withdrawn as owners became wary of any association with drug use. Police action to stop raves in progress risks sending people home or elsewhere while still high and/or in distress.[19] There is also the argument that if synthetic drug use is largely contained to music and dance events (where one study found that 93% of users had first taken ecstasy[20]), then demand reduction has a clearer and more accessible target than if repression or over-regulation led events to take place illegally, or users to use elsewhere.

• Repressive strategies •

Policies aiming to curb raves or drug use at raves may dominate in a country or feature even in those which also have well-developed regulatory and harm-reduction policies. In 1997 the United Kingdom enacted legislation to make it easier for local authorities and the courts to close an establishment at or near which there is a serious drug problem, without having to await the outcome of a lengthy appeal. New measures in the Netherlands strengthened control of nightclubs and raised penalties. For instance, if drug dealing is discovered a club can be closed down for six months; a second incident may entail permanent closure. Some Dutch city councils have simply banned raves and house parties.[21]

The French authorities usually attempt to forbid raves by cancelling their authorisation. Event organisers are held responsible for possession or use of drugs at their events and some have already been imprisoned.[22] Police also intervene during raves, a tactic which other countries avoid due to fears over safety. This tactic is also employed systematically in Sweden, which sees law enforcement as integral to demand reduction. The Rave Commission set up by police in Stockholm in 1996 entails officers attending dance venues. The aims are to prevent synthetic drug use by identifying users early and to reduce the risk of a move to more addictive drugs rather than primarily to target dealers. Its work is aided by the fact that in Sweden users can be penalised if testing detects that drugs have been taken. Three-quarters of the many young people detected have never been involved with the authorities and most are not from socially deprived backgrounds. While the Commission wants to shut down illegal parties (many occur in large disused buildings and in woods), it also aims to cooperate with event organisers so that it can influence event planning.

• The attempt to regulate •

Several Member States have sponsored guidelines to help in the licensing and regulation of events. Examples here are from the Netherlands and the UK, but the approach extends to countries such as France where a government charter project guides event organisers and to one region in Italy where the Nuove Droghe project in Emilia-Romagna has also developed guidelines.

In the Netherlands the Ministry of Health, Welfare and Sports advised local authorities on regulations for large events such as 'house parties', following recommendations from a working group with representation from government, the Netherlands Institute of Mental Health and Addiction, umbrella organisations and experts. Event organisers should provide: checks for weapons and drugs at entry; access for emergency services; free drinking water; experienced first-aiders; adequate ventilation and chill-out rooms; and accessible transport links. These conditions can be imposed on licensees.[23]

In the United Kingdom, safer dancing guidelines were first developed in Manchester in the early 1990s. In 1993 a government working group published a safety guide for music events which proved valuable to licensing authorities and event planners. In 1995 the Scottish Drugs Forum's (drug service coordinating body for Scotland) Guidelines for Good Practice at Dance Events included this statement from the commissioning minister: "We must be realistic about the lives led by young people and alert organisers of dance events, and those who attend them, to the dangers of drugtaking and how to reduce the risks. We do not want to deprive young people of a source of entertainment but we want them to enjoy themselves safely."[24] Also focusing on clubs rather than full-scale raves, the following year the London Drug Policy Forum produced dance safety guidelines[25] covering: security (attempting to stop drugs being available at events); ventilation, drinking water, chill-out and drug advice spaces; training staff to recognise the signs of drug use and drug problems (especially heatstroke); multi-agency cooperation to provide an enjoyable, safe environment; and the provision of information and advice by drug agency staff.

The origins of 'safer dancing'

The idea of 'safer dancing' was brought to fruition in the UK in the early 1990s as a regulatory alternative to repression through withholding licenses or raiding events in progress.[37] The strategy had five components.

1 **Develop detailed guidelines for the regulation of raves, involving all relevant authorities (police, fire, health) and interested parties (such as promoters, club managers, community groups).**

2 **Reconsider the routine revocation of entertainment and liquor licenses on the grounds of drug use or other problems on condition that rave managers and promoters agree to cooperate with the police and local authorities in attempting to resolve or reduce problems.**

3 **Develop a system for regulating security staff, involving registration, training and monitoring, with the police playing a central role.**

4 **Police resources are most cost-effectively utilised if focused on drug dealing gangs.**

5 **The harmful effects of dance drugs can be substantially reduced by properly tailored health care interventions.**

Clubs themselves are increasingly taking responsibility for safer dancing services – essential, as no external service can cover all the clubs in a busy locality. Barna Occio, an association of clubs and discos in Barcelona, is one example of this encouraging development.

Pill testing

Government-sponsored laboratory analysis is used systematically in the Netherlands to alert participating agencies to the contents of products being sold as ecstasy. Discovery of a dangerous pill swiftly triggers a warning campaign aimed at potential users. In other countries laboratory testing is more ad hoc, connected with police or medical investigation, university research,[26] or instigated by non-governmental organisations (NGOs)[27] and private individuals.[28]

Flyer introducing Austrian dance-goers to a research project involving on-site testing of pills sold at raves. The project also warns ravers of dangerous pills

On-site testing actually at raves and clubs is far less common. This tactic is much more formalised in the Netherlands than elsewhere. The Safe House campaign of the Amsterdam Drugs Advisory Bureau cooperates closely with laboratory analysts. As well as testing they distribute information about drugs and warning leaflets at most large events. German groups have also been enthusiastic about testing and interest has been expressed by groups in Austria, the United Kingdom and France.

• Prevention programmes and projects •

Beyond curbing or regulating rave-type events, the more familiar prevention strategies applied to drug use in general have also been adapted to synthetic drugs, in four main areas.

- ▶ Information and advice for a general audience, sometimes via mass media.
- ▶ Drug education programmes in schools and more informal youth contexts. Lessons may be integrated into the school curriculum and/or use outside visitors or experts. For example, the Mixmusic group in Italy conducts school sessions on dance drugs and rave culture.
- ▶ Interventions targeted at young people who have tried dance drugs or are at risk of doing so. These may be conducted by generic services or by drug services specialising in the dance scene (often developed by individuals and networks with personal experience). Alternative activities may include the 'drug-free raves' seen in Germany and Sweden.
- ▶ Support, advice, information and counselling provided on site at large rave events, often in chill-out rooms; as in some Italian towns, workers may conduct sessions in several clubs in an evening.

Often these elements are linked in an overall approach. Advice personnel and facilities are increasingly stipulated in safer dancing guidelines, and usually form part of a wider, locally agreed harm-minimisation policy featuring 'safer drug use' materials distributed in clubs, youth venues, record shops and other outlets frequented by people who may be, become or be the friends of drug users.

Prevention services are delivered using a number of methods, some quite distinctive to the dance scene whose mass appeal to socially integrated youngsters demands approaches (often based on marketing techniques) which go beyond clinic- or service-based interventions. Below are some of the main features of current approaches.

Harm reduction predominates

Most projects specific to synthetic drugs adopt a non-judgemental, harm reduction approach. They argue that, while drug use can never be entirely safe, in this sphere ever larger numbers are using and the most practical response is to shift consumption toward less risky modes. A common tactic is to translate key messages into a few 'Golden Rules' which users can constantly keep in mind. Projects tend to see themselves as providing unbiased information so individuals can make their own decisions.[29] Some emphasise that there can be fun without drugs and organise drug-free events to prove the point.

Self-help common

Many interventions (as in the Netherlands, Germany, France, Italy and the United Kingdom) were initiated by dance drug users, promoting self-mobilisation and formal and informal peer education. Such groups are also now increasingly being consulted and heeded by health and social planners in various cities and regions. They build on informal policing mechanisms which evolve among groups of friends who monitor each others' behaviour and provide reassurance and support if and when difficulties emerge.

Peer education supplements outreach

It has been argued that traditional outreach is inappropriate in noisy clubs where the target group is seeking pleasure, not counselling.[30, 31] This is not a universal view but may have contributed to the perceived failure of many established drug services to understand and respond more rapidly to rave culture. Notable exceptions include the Lifeline Project

in Manchester, the Drugs Information Monitoring System (DIMS) in the Netherlands, and the public sector (Ser.T) treatment services in Padova, which has become an Italian centre of expertise.

Many projects supplement or replace outreach work with peer education, trading on dance scene participants' credibility and ability to deliver messages tailored to the culture.[32] For example, Association Techno Plus (in Paris and Lille) consists of ravers who seek to inform other ravers about the risks of use and to prevent harm. Rather different is the Youth Awareness Project in London which implements a peer education approach in school and youth work locations addressing youth drug use in general.

A project funded by the European Commission tested the cross-national applicability of harm reduction materials largely devised and distributed by dance scene devotees. Starting in June 1996, the Büro für Suchtprevention in Hamburg, Lifeline in Manchester and the Jellinek Centre in Amsterdam collaborated in the production of a core set of two postcards (one for boys, one for girls) with similar text and designs, plus other local variants. Initial evaluation suggests the approach reached and was accepted by the target audiences and helped develop a peer education infrastructure in the cities concerned.[33]

Working with the scene

Peer education is a variation on 'working with' the dance scene – using rave culture itself to promote anti-drug or harm reduction messages. An example is Mindzone, a youth project trying to promote a healthy, drug-free culture in Bavarian dance events, building on an identified non-drug using group of ravers. In the UK, Natural High is a group of young people in Edinburgh who run rave music road shows for youth clubs and venues, exploiting publicity materials, DJ skills, song lyrics, discussion sessions and drug information displays. In a monthly German techno magazine (Mushroom), DROBS in Hannover has space to warn about dangerous substances and to answer reader's letters. The Lookout project in Northern Ireland employs similar tactics.

Accessible information points

Taking the information to the audience is being tried by Hannover's DROBS project in the form of a bus with drug information and a drug-free chill-out room. In Belgium, two drug-free buses are used. One provides drug information and advice and in the other club-goers and ravers are invited to experience a simulation of driving under the influence of drink or drugs. Visitors can also talk on a one-to-one basis with a worker. Recognising their reluctance to visit drug agencies, Edinburgh's Crew 2000 peer education project has a city-centre shop where young people can go for information about drugs, sex and the dance scene, and be referred to other helping services if necessary. The shop has also become a resource for the media, parents, teachers, club managers and security staff.

In Hannover in Germany the DROBS project's tactics to reduce ecstasy-related accidents include promoting five key rules:[38]

1. No drug makes you happy if you are unhappy
2. Less is more
3. Mixing is crap
4. Don't push yourself into continuous drugtaking
5. Don't take anything about which you know nothing or have anxieties.

Some of the many faces of the peer education project Drobs in Hannover – answering readers' letters as 'Dr Obs' in the techno magazine Mushroom and advertising its chill-out and information bus in the heartland of the rave scene, an events listing booklet

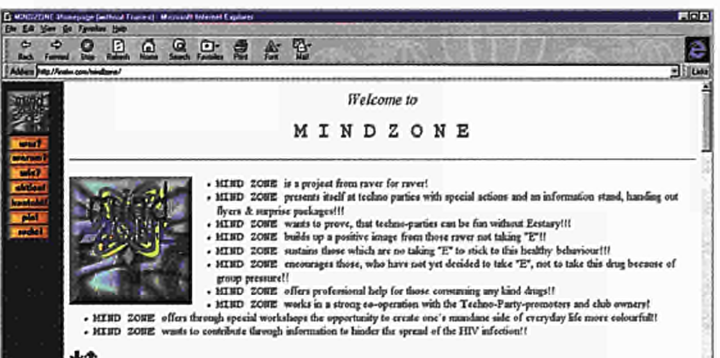
Broadcasting the message

Where dance drug use is widespread national mass media campaigns may seem an appropriate option. In 1996/97 England's Health Education Authority focused on the health risks of ecstasy, amphetamines and LSD and the added dangers of mixing drugs. Advertisements ran over the Christmas and new-year party season in the youth and 'style' press, women's magazines and on the radio. The German Federal Centre for Health Education (BZgA) has received funding for a national campaign, currently under development. The Netherlands Institute of Mental Health and Addiction plans an ecstasy campaign in 1998 to encourage educators and young people to seek information.

The written (and illustrated) word

Many of the projects and approaches already cited incorporate printed materials in their work, often as a bridge to personal contact with workers or peer educators. Materials are mainly either posters, leaflets, booklets or postcards, though there are videos, T-shirts and logos. They are developed by NGOs and central, regional and local government, often in collaboration with dance promoters and organisers. There is widespread agreement that the look and content of materials must appeal to the culture they are trying to inform,[34] hence the distinctive colour schemes, sophisticated graphics and dance scene imagery. The more extended productions dwell on the potential medium- and long-term problems of synthetic drug use, while snappier ones transmit 'Golden Rules' to follow immediately after drug use.

Mindzone (a youth project "from raver for raver") aims to promote a drug-free rave and techno culture at Bavarian dance events. A distinctive logo and web presence are among its tools



Perhaps the most widely known publications are from an English NGO, the drug agency Lifeline, and feature the cartoon adventures of 'Peanut Pete' and 'Claire and Josie'. Also in the UK, the Scottish Drugs Forum's full-colour The Survivor's Guide to Drugs and Clubbing aims to dispel myths around drugs and to enable informed choices by identifying the risks. Edinburgh's Crew 2000 has developed a set of postcards housed in racks in targeted bars and clubs, and distributed in records and clothes shops to reach people who do not go to clubs.

Barcelona's city council organised materials on synthetic drugs for distribution at discos and music bars. A dance event promoters' organisation volunteered suggestions for design and distribution and a business association is helping extend the campaign. Readers are told no drug use is risk free but recommendations are made should they decide to use. Objective information encouraging informed choice is the aim: "You are the only one responsible for your life; value it and decide." A positive reception encouraged wider distribution in an area dense with nightclubs. Also in Spain, Andalucia's regional council produced two leaflets with a similar approach and target audience, as did Portugal's Projecto VIDA.

In Denmark a dance event promoters' forum enlisted the assistance of the National Board of Health to produce harm-reduction information materials, including a SafeRave leaflet, T-shirts for bouncers, and a logo for event flyers. Individual promoters decide how to use the materials locally. In Austria, a leaflet on the long-term consequences of taking ecstasy has resulted from collaboration between the Federal Ministry of Health and Consumer Protection, the City of Vienna and rave promoters. In Germany, Bremen's cultural department has produced posters for entrances to events, chill-out areas and the insides of toilet doors, linked by the slogan: "Enjoy the Rave, but Rave Safe." The Berlin-based NGO Eve and Rave has developed a full-colour booklet called Partydrogen: Safer-use-info zu: Ecstasy, Speed, LSD, Kokain.

• A learning experience •

Europe's encounter with raves and drugs has been a learning experience in two senses: over time, and across regions at different phases of the dance drugs trend. Most official drug services were slow to re-

The research agenda

The research bank on synthetic drug use in Europe is not entirely empty but its resources are few and inadequate. Studies of ecstasy consumers are being conducted or planned in some countries, such as France, Spain, the UK, Ireland, Italy, the Netherlands and Germany. However, many of the studies are relatively modest in their aims and overall the area is poorly understood compared to the consumption of the opiate drugs or the problems of drug injection.

A number of areas appear particularly salient topics for research activity.

- **Across the EU we lack methodological systems capable of rapidly reporting on the development of new drug trends, an area in which resource investment is likely to pay dividends.**
- **There is a need for follow-up studies of samples of synthetic drug users to assess and understand the adverse consequences associated with this kind of drug consumption. In particular, the issue of long-term neurotoxic effects needs to be resolved.**
- **Patterns of synthetic drug use have been poorly explored. There is much of value to be learnt about how these patterns are initiated and why some individuals become long-term users while others only experiment.**
- **The needs of chronic amphetamine users are poorly understood.**
- **In some countries, particularly where synthetic drug use is a new phenomenon, virtually nothing is known about this pattern of drug consumption and there is an urgent need to collect information to inform the development of prevention, demand reduction and legislation.**
- **Badly needed are process (how the work was done) and outcome (its results) evaluations of prevention and other demand reduction responses, assessing what works and why in order to guide planning and implementation of such responses.**

spond and saw working with ecstasy users as irrelevant to their main mission of stabilising and treating heroin addicts. However, countries first affected on a mass scale, such as Britain, the Netherlands and Germany, also had forward-looking NGOs in touch with consumer trends, which could implement harm-reduction programmes found acceptable by local government, event organisers and drug users. Their alacrity has meant that models are available for neighbouring regions as yet unaffected by the trend or which have begun to realise a response is needed. What seems remarkable is the ease with which programmes have been adopted and customised in other countries, perhaps reflecting the international nature of the dance scene and advances in networks linking drugs field professionals across Europe. There have been complaints about the explicitness and irreverent tone of some materials, but many policymakers have been pleased at the imaginative responses to a newly identified need.

Despite this cross-national sharing, strong differences remain between those who condemn rave and similar events as condoning or promoting drug use and those who see the repression of such events as causing more harm than drug use itself. Quality research and evaluation might help sharpen the issues but it is difficult for research to keep pace with developments. There is an increasing awareness that no intervention should be allowed to continue indefinitely without rigorous testing of its effectiveness and encouraging evidence that this is becoming a requirement in major prevention projects.

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T-shirts – the ultimate in using the young to take rave safety and anti-drug messages into the heart of youth culture

From the German Federal Centre for Health Education: "I AM: genial; not alone; special. I WILL: talk and listen to others; have fun; decide for myself. I CAN: say no; be effective; dream."

From Mindzone in Munich: "Just be yourself today."

From the Greater Glasgow Health Board: "Using any drug involves risks. Chill Out. Taking more or mixing drugs increases the risk."

From the Greater Glasgow Health Board: "Don't dance with drugs."

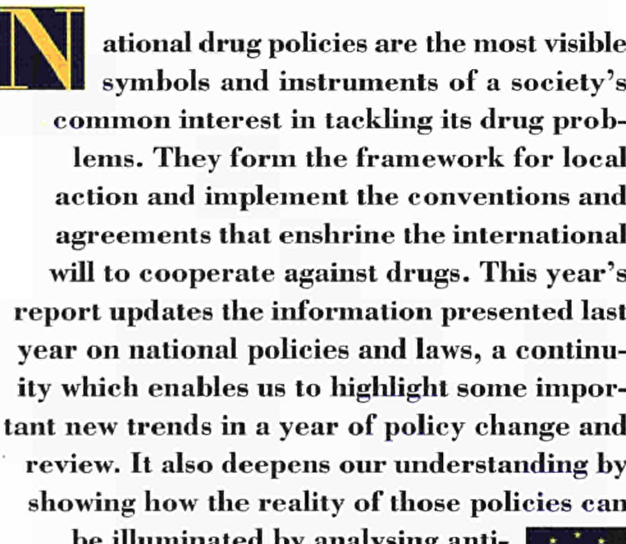
From the German Federal Centre for Health Education: "Kinder stark machen (*Make Children Strong*)."

From the Danish National Board of Health and a dance event promoters' forum: "SafeRave."

An early example from the Merseyside Drugs Council in the UK: "Stay Kickin'! ... Chill out! Safer sex makes sense."

CHAPTER 4

National strategies



National drug policies are the most visible symbols and instruments of a society's common interest in tackling its drug problems. They form the framework for local action and implement the conventions and agreements that enshrine the international will to cooperate against drugs. This year's report updates the information presented last year on national policies and laws, a continuity which enables us to highlight some important new trends in a year of policy change and review. It also deepens our understanding by showing how the reality of those policies can be illuminated by analysing anti-drug expenditures and the social costs of drug misuse.

The development of national drug policies since the late 1980s has two main roots: firstly, the emergence of drug use and drug problems from small marginal groups to affect the lives of a broad cross-section of national populations; secondly, the fact that the multidisciplinary nature of these problems demands a nationally coordinated response incorporating education, health, enforcement and foreign relations among other elements. Despite the recent policy ferment analysed below, the commonalities in EU (European Union) Member States' approaches can still be summarised in six broad features.

- The fundamental objective is to create a policy which embraces and then strikes an appropriate balance between all the relevant national elements and integrates these with the regional level. Within this, perhaps the key is maintaining a balance between policies aimed at reducing the demand for drugs and those aimed at reducing supply.
- The fundamental administrative task is to create structures capable of coordinating policy across national ministries (table 1) and coordinating national with regional administrations (table 2).
- Typically there is concern to generate public participation in the definition and implementation of the national strategy, with voluntary organisations and community groups seen as important partners.
- Generally European nations recognise addiction as an illness and implement this recognition in both health and penal systems (though to widely varying degrees).
- Policies are constantly under review. The evolution of drug use, increased scientific knowledge, the stimulus provided by developments in other countries and international geopolitics in relation to drugs constantly provoke changes and reorientation.
- National policies are increasingly defined by supranational policies derived from membership of the European Union or the Council of Europe, or by the nation's obligations under United Nations conventions.

Building on this platform, the following sections show that while the fundamentals remained unchanged, developments in laws and coordination structures in 1996 reveal some clear tendencies with important implications.

The national level

In 1996 most EU countries reviewed their national strategies through a plethora of parliamentary commissions, committees and expert groups. The Netherlands encapsulated the process in the title of its policy paper Continuity and Change; effective elements are to be consolidated, while opening the door to new ways to tackle persistent or emerging problems. This rethinking is a response to several factors.

1 Successive meetings were held at the European Union level during 1996 to analyse the drug policy divergences and convergences between EU nations. In particular, the Conference on Drugs Policy in Europe held in 1995 and the follow-up seminar in 1996 on the enforcement of national laws fuelled this process.[1] Discussions sponsored by other international bodies contributed to national debates.

2 In most states many of the competencies involved in the drugs issue are being devolved from central to regional or local government, drawing a wider range of actors into the policymaking process who bring with them new policy ideas.

3 Several governments are formalising community participation by involving voluntary organisations in the design of national strategies. Again this can open the process up to fresh concepts and new possibilities, often reflecting community concerns and the experiences of those directly or indirectly affected by drug misuse.

4 Perhaps most influential has been the availability of increasingly sound, well-documented, rigorous and comparable information allowing for a degree of policy evaluation and evidence-based debate. As a result the pragmatic assessment of options against evidence has become more prominent in policy debates and the more ideological components have diminished.

The Conference on Drugs Policy in Europe, held in 1995, stimulated analysis of the drug policy divergences and convergences between EU nations

1996: year of change

Across the EU these policy trends were expressed in reports, meetings, structures, and laws.

- Coordination structures were consolidated across **Austria**'s nine provinces and between these and the federal government, stimulating regional-level debate.

KEY POINTS

▶ National drug policies emerged in European Union Member States as drug use increased, demanding a nationally coordinated interdepartmental response. Key tasks are to balance supply and demand reduction and to achieve coordination across national bodies and between national and regional or local levels.

▶ National laws are increasingly confined by supranational policies deriving from the United Nations and the European Community; differences relate mainly to the severity of punishments and enforcement practices.

▶ European nations generally recognise addiction as an illness but the extent to which this perception pervades penal policy and practice differs.

▶ Although coordination structures and drug laws changed little in 1996, analysis reveals some important policy trends. While radical change is not on the mainstream political agenda, in most European Union countries drug policies are under review, a response to:
- EU-level analyses of drug policy divergences and convergences between Member States;
- participation of a wider range of people and viewpoints due to decentralisation and increasing community involvement;
- increasingly sound and comparable information enabling a degree of scientific evaluation of policies, in turn encouraging a less ideological and more pragmatic perspective.

▶ New decentralising measures place a premium on coordination; where this fails to keep pace, intra-national policy divergence is apparent.

▶ No EU nation can claim a comprehensive and reliable accounting of its anti-drug expenditures or the costs imposed by drug misuse. The core problems are defining boundaries and accounting for sub-national expenditure.

▶ A relatively small drug budget does not necessarily mean less, or less effective, social action against drug problems. For example, a more relaxed (and less expensive) legal approach can foster social action, and some anti-drug expenditures can aggravate problems arising from the drug use they fail to prevent.

▶ Because it is more centralised, spending on supply reduction is more easily accounted for, so may seem larger relative to demand reduction than is actually the case.

▶ Though in theory it may seem attractive to move resources between demand and supply reduction, when resources on both sides are stretched, in practice the required increases are made by raising the global budget or reallocating within sectors.

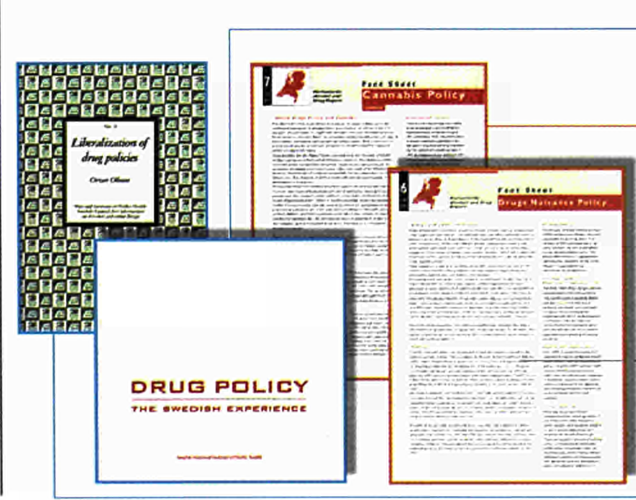
▶ A critical issue in assessing the costs imposed on society by drug use is placing a monetary value on human life. However, such an accounting is needed to gain a perspective on the appropriate level and mix of investments devoted to curbing these costs.

▶ Through **Greece**'s national drugs coordinating body, OKANA, relevant experts and groups were encouraged to form committees to place their views in the national policymaking arena.

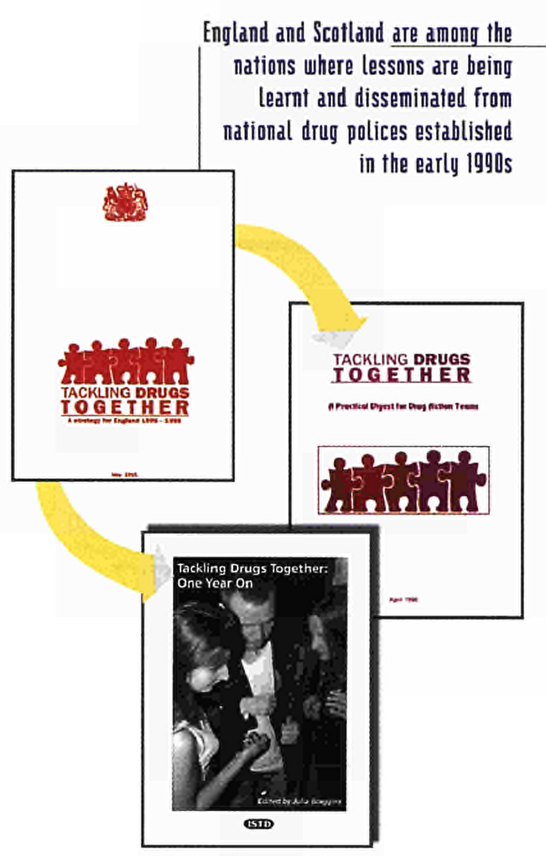
▶ A report from the **Luxembourg** parliament's Special Commission on Drugs proposed a reorientation of national policy, questioning the present drug classification and making novel proposals on both supply and demand reduction.

▶ In **the Netherlands** the inter-ministerial policy paper Continuity and Change discussed how to adjust the country's drug strategies to new situations.

▶ A new law in **Portugal** restructured the National Drug Prevention Programme, encouraging community participation and reinforcing coordination between government and voluntary sectors.



European debate is aided by the fact that Sweden's explanation of its policy and policy factsheets from the Netherlands are available in several European languages. Concern over the legalisation movement led Sweden to publish a summary of the evidence and arguments



England and Scotland are among the nations where lessons are being learnt and disseminated from national drug polices established in the early 1990s

New developments

▶ In 1996 most European Union countries engaged in reviews of their national strategies.

▶ Several European-level meetings analysed drug policy divergences and convergences between EU nations, encouraging national debate.

▶ In most states many of the competencies involved in the drugs issue are being devolved from central to regional or local government and several governments are formalising community participation in the design of national strategies.

▶ Increasingly sound and comparable information has allowed for a degree of policy evaluation and evidence-based debate resulting in a more pragmatic tone to policy debates.

▶ Laws have changed fastest in those areas subject to international and EU law such as combating money laundering or the control of chemical precursors.

▶ Criminal groups and their financial activities were targeted with further tough penal measures.

▶ A few EU countries have published assessments of the cost to society of their drug problems and the expenditures involved in tackling those problems. Increasing attention is being paid to cost-effectiveness.

▶ Drug action teams or similar bodies across the **United Kingdom** coordinated local strategies, drawing in high-level officials from general health, social and enforcement sectors as well as broadening community and voluntary involvement.

▶ In recent years **German** social groups, political parties and Länder (federal states) have engaged in extensive discussions, broaching issues such as distinguishing further between prosecution of addicts and dealers, decriminalising cannabis use, differentiating between substances according to consumer risk or establishing standards for methadone maintenance services. The Bundesrat, the council of the 16 Länder, has initiated proposals to reform drug laws to allow for controlled trials of heroin maintenance treatment. Some Länder are taking steps to allow addicts to take their drugs (including those illegally acquired) in hygienic circumstances in designated care centres.

▶ **Ireland**'s new Ministerial Task Force on Measures to Reduce the Demand for Drugs proposed minor legal reforms to enhance the coordination of drug services. Its first report called for local drugs task forces in the 13 areas with most acute drug problems, working under the direction of the National Drugs Strategy Team.

▶ In **Denmark**, the Act on Detention of Drug Abusers in Treatment passed in 1992 was reviewed and more competencies devolved to the counties.

▶ **Finland**'s Council of State has discussed drugs issues and in 1996 the Ministry of Social Affairs and Health appointed a committee to prepare a proposal for a national drug strategy.

▶ In **Belgium**'s Flemish community the drug policy paper Drugnota documented initiatives to be taken in the next three years. Parliament set up a working group to review the drug phenomenon in Belgium and to make drug policy recommendations.

▶ New priorities outlined for **Spain**'s national plan on drugs maintained the overall policy direction but placed a greater emphasis on prevention.

▶ Four important reports drafted in **France** in 1996 (the Masson, Ghysel, Gentilini and the Court Services General Inspection reports) each proposed new measures to address different aspects of the drug problem.

Though many of the measures proposed may never be implemented, such widespread policy reviews signify a notable acceleration in the speed and dynamism of the evolution of drug policy in the search for pragmatic and feasible solutions.

Table 1 • National coordination: ministries and coordination structures

	MINISTRIES INVOLVED[1]	NATIONAL COORDINATION STRUCTURES[2]
AUSTRIA	• **Labour Health & Social Affairs** • Interior • Finance • Foreign Affairs • Youth/Family • Education/Cultural Affairs • Justice	The Ministry of Health and Consumer Protection leads interministerial coordination and is responsible for coordinating political strategy.
BELGIUM	FEDERAL LEVEL • Justice • Public Health • Social Affairs • Interior COMMUNITY OR REGIONAL LEVEL • health ministries	At national level coordination is through the Interministerial Conference on Drugs led by the Minister for Social Affairs. At community level coordination takes place through the responsible ministries.
DENMARK	• **Health** • Social Affairs • Justice • Taxation	The Ministry of Health leads interministerial coordination and coordinates political strategy. The **National Drug Council** advises government and parliament.
FINLAND	• **Social Affairs and Health** • Interior • Justice • Finance • Education • Foreign Affairs	The **Advisory Committee for Intoxicant and Temperance Issues** under the Ministry of Social Affairs and Health is appointed by government. National voluntary organisations are represented.
FRANCE	• Prime Minister • Finance • Education • Youth & Sports • Social Affairs • Health • Affaires Etrangères • Action Humanitaire • Justice • Interior • Overseas Devpt.	The **Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie** (MILDT) coordinates action across government and supports the **Commission Interministérielle**, a committte chaired by the Prime Minister with ministers from the main ministries involved in the problem.
GERMANY	• Health • Interior	**Interministerial Working Group for Drug Abuse**
GREECE	• **Health** • Justice • Public Order • Mercantile Marine • Finance • Education	**Greek Organisation for Combating Drugs** (OKANA)
IRELAND	• Prime Minister • Environment • Education • Justice • Enterprise & Employment • Health	**Cabinet Sub-committee** and a cross-departmental **National Drugs Strategy Team**
ITALY	• Prime Minister • Health • Defence • Interior • Justice • Finance • Education • Labour • Social Affairs • Foreign Affairs	**National Coordinating Committee for Anti-Drug Action**
LUXEMBOURG	• Health • Justice • Family • Youth/ Education	**Interministerial Commission on Drugs**
The NETHERLANDS	• **Health, Welfare & Sports** • Justice • Internal Affairs	**Minister of Health, Welfare & Sports**
PORTUGAL	• Prime Minister • Defence • Justice • Home Affairs • Health • Education • Welfare • Professional Qualification and Employment	**Interministerial Commission** sets policy guidelines implemented by the **Interministerial Technical Group**, chaired by the High Commissioner for Projecto VIDA.
SPAIN	• Presidency • Health & Consumer Affairs • **Justice** • **Interior** • Economy & Finance • Labour and Social Affairs • Education & Culture • Foreign Affairs	**Interministerial Group for the National Plan on Drugs** sets policy guidelines implemented by the **Government's Delegation for the National Plan on Drugs.**
SWEDEN	• **Social Affairs** • SAMNARK (see opposite)	The **Interministerial Committee on Drug Issues** (SAMNARK); the **National Institute of Public Health.**
UNITED KINGDOM	• **Privy Council** • Home Office • Health • Education & Employment • Prison Service • International Devpt. • Customs & Excise • Foreign & Commonwealth Office • Treasury • Scottish, Welsh, and N. Ireland Offices • Culture, Media and Sport • Defence	The **Cabinet Ministerial Sub-committee on the Misuse of Drugs** decides policy, supported by the **Central Drugs Coordination Unit.**

1. Bold text = lead ministry.
2. Bold text = identified specific coordinating body.

Table 2 • National-regional coordination and coordination with NGOs

	NATIONAL–REGIONAL COORDINATION	COORDINATION WITH NGOS
AUSTRIA	Each of the nine Austrian Provinces has a drug coordinator or/and a Drogenbeauftragter (representative in charge of drug issues) who monitor drug problems and coordinate prevention, treatment and health care. In a newly established communication forum they meet periodically with representatives of the federal ministries involved to discuss drugs and drug addiction generally and particularly topical issues.	Prevention, health care and treatment are mainly carried out by NGOs, and only in some cases by state institutions. NGOs do not have a national umbrella organisation but cooperate with provincial and federal drug coordinators.
BELGIUM	The national level retains responsibility for coordination and law enforcement. Demand reduction is carried out independently under the leadership of the respective ministers of health.	Umbrella organisations in each national community play an important role in coordination and implementation of prevention and treatment policies.
DENMARK	Municipal social, health and welfare systems are responsible for treatment and other services. The Association of County Councils and the National Association of Local Authorities represent county and local authorities to central government.	NGOs play a minor part in Danish drug policy. Coordination with NGOs is mainly in relation to treatment.
FINLAND	At county level, county Social Welfare and Health Departments handle drug issues. Municipal social, welfare and health care systems are responsible for treatment.	The few NGOs with a special interest in drugs provide a significant proportion of welfare services for those engaging in harmful use of alcohol and drugs.
FRANCE	The Prefect (a state representative in each region or 'département') heads a system which coordinates the work of official agencies in liaison with the judicial authorities and assures coordination with local groups and associations.	
GERMANY	Coordination is handled by a permanent working group of federal and Länder (regions) drug commissioners and welfare organisations and by the Committee on Addiction Treatment of the Health Ministers Conference of the Länder.	Cooperation is organised through the German Association against Addiction, an umbrella body with 21 members, primarily NGOs.
GREECE	OKANA, the national coordinating body, subsidises programmes implemented by local authorities.	OKANA's major role is coordinating ministerial, public and private sector actions.
IRELAND	Regional coordinating committees in the eight health boards, with representation from the health boards, education, the police and relevant voluntary and community agencies. Local drugs task forces in priority areas with representation from the health hoards, education, probation and welfare services, police and community organisations.	NGOs play a key role in prevention and treatment programmes and now participate in local drugs task forces set up in priority areas with very serious drug problems.
ITALY	National coordination is handled through the National Coordinating Committee for Anti-Drug Action.	The state treatment service is provided by public institutions and NGOs recognised by regional boards, which receive state funding and are supervised by the Ministry of Health.
LUXEMBOURG	Coordination is achieved through the Interministerial Commission on Drugs.	Coordination with NGOs is handled through the Service d'Action Socio-Thérapeutique of the Ministry of Health.

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The Netherlands has 23 regions, each with a municipality which receives central funding for outpatient addiction care. Inpatient care is coordinated by the National Health Insurance Board	The Trimbos Institute (Netherlands Institute of Mental Health and Addiction) advises government and consults organisations in the drugs field. GGZ Nederland coordinates mental health and addiction activities.	**The NETHERLANDS**
Regional centres have a coordinator nominated by the regions's civil governor whose activities are coordinated through the High Commissioner of Projecto VIDA.	Projecto VIDA is responsible for mobilising community action by supporting and coordinating NGOs.	**PORTUGAL**
The Sectorial Conference and the Interautonomic Commission handle coordination between the central administration and the 17 autonomous regions and two autonomous cities.	Priorities and programmes are set by the Advisory Joint Commission composed of representatives of the Government Delegation for the National Plan on Drugs and the Standing NGO Council.	**SPAIN**
Locally based prevention activities are empowered by the National Institute of Public Health. Treatment is mainly organised by regional and local authorities and coordinated and supervised by the National Board of Health and Social Welfare. All counties and half of all municipalities have bodies to coordinate prevention and treatment activities.	Coordination is through the National Institute of Public Health and the Swedish Council for Information on Alcohol and other Drugs (CAN) and the regional and local coordination bodies.	**SWEDEN**
Funds provided by ministries in England, Scotland, Wales and N. Ireland are generally devolved to local level. Local inter-agency coordination is achieved through the 105 drug action teams in England and similar bodies elsewhere. The Home Office funds 12 regional drug prevention teams in England.	In England and Wales the Standing Conference on Drug Abuse (SCODA) is the main umbrella body for drug services including NGOs. In Scotland a similar role is played by the Scottish Drugs Forum. Both receive central funding.	**UNITED KINGDOM**

National-regional coordination

Last year's report classified policymaking structures in EU nations as either centralised, regionalised or mixed. In the last two categories sub-national administrations may exercise considerable discretion over demand reduction in their regions. Here is where movement was greatest in 1996 as further competencies were devolved to authorities closest to the public, and in some cases to the public itself in the form of community organisations.

This process has important implications, injecting a new dynamism into policymaking, but also giving coordination structures (table 2) an increasingly key role in containing divergence between regions, and between regions and the centre. In some states such divergence is already apparent. In 1996, for example, coordination of anti-drug action between regional and federal government in Belgium was seen as suffering from regional autonomy. Coordination also demands information systems capable of keeping all the agencies involved abreast of changes in the situation and in each other's activities.

Decentralising measures taken or continued in 1996 included the following eight examples.

- ▶ The roles of **Austria**'s nine provincial drug coordinators were substantially strengthened and provincial conferences coordinated their activities.
- ▶ Each **French** department appointed a coordinator for prevention and treatment, accountable to the government's local representative, the prefect.
- ▶ Some of **Spain**'s autonomous regions exercised their authority to enact their own drug legislation.
- ▶ In **Germany** drug laws are set at federal level but the Länder can exercise some discretion over how these are implemented, allowing local influences to create inter-regional differences over issues such as the amount of cannabis legally considered to be for personal use. The Federal Constitutional Court has urged the Länder to harmonise these differences.
- ▶ The **United Kingdom**'s four major regions established their own coordinating bodies and implemented policies which differed in some important respects, while the more local drug action teams enhanced the localisation of anti-drug strategies.

In its title the Dutch drug policy paper Continuity and Change symbolised the rethinking taking place across Europe

Table 3 • Drug classifications in European national laws

	CLASSES OF DRUGS	RELATION TO PENALTIES
AUSTRIA	**NO FORMAL LEGAL CLASSES.** Drugs subject to control are those listed in the UN Conventions on narcotics and on psychotropic substances.	No relation between different drugs and penalties or offences, but penalties vary with the quantities of drugs involved.
BELGIUM	**NO FORMAL LEGAL CLASSES.** Drugs subject to control are established by royal decree and include narcotic substances (opium, heroin, cocaine, morphine, methadone, cannabis, etc) and some psychotropic substances (some amphetamines, hallucinogens, MDMA, etc).	No relation between different kinds of drugs and penalties or offences.
DENMARK	**FIVE CLASSES** **A** Cannabis, heroin, prepared-opium **B** Cocaine, MDMA, amphetamines, methadone **C** Codeine **D** Barbiturates **E** Tranquillisers	No relation between classes and penalties or offences. Possession of and dealing in cannabis is punished less severely than for drugs such as heroin, amphetamines or cocaine.
FINLAND	**TEN CLASSES** based on the UN Conventions on narcotics and on psychotropic substances. **Narcotics** **I** Heroin, cannabis, methadone, morphine, etc **II** Propiram, codeine, etc **III** Preparations containing drugs **IV** Drugs in class I with no medical uses **Psychotropic substances** **I** MDA, LSD, MDMA, etc **II** Amphetamines, THC, etc **III** Barbiturates **IV** Benzodiazepines, etc **Precursors** **I** Ephedrine, lysergic acid **II** Acetone, piperidine	No relation between classes and penalties or offences.
FRANCE	**FOUR CLASSES** **I** Hallucinogens **II** Amphetamines **III** Barbiturates and buprenorphine **IV** Benzodiazepines and phenobarbital	No relation between classes and penalties or offences.
GERMANY	**THREE CLASSES** **I** Not for medical or industrial use: heroin, cannabis, LSD **II** For industrial use but not available on prescription: coca leaves **III** For industrial and medical use on special prescription: morphine, methadone	No relation between classes and penalties.
GREECE	**FOUR CLASSES** **I** Cannabis, heroin, LSD and other hallucinogens **II** Cocaine, methadone, opium **III** Amphetamines **IV** Barbiturates, tranquillisers	No relation between classes and penalties or offences.
IRELAND	**FIVE CLASSES** **I** Cannabis, LSD, mescaline, opium **II** Cocaine, heroin, methadone, morphine **III & IV** Other psychotropic substances **V** Specific preparations of drugs	No relation between classes and penalties or offences.
ITALY	**SIX CLASSES** **I** Opium, cocaine, hallucinogens, some amphetamines **II** Cannabis **III** Barbiturates **IV** Medicinal substances **V** Preparations of substances mentioned listed in I to III **VI** Antidepressants, stimulants	Criminal penalties and administrative sanctions vary according to the classification of substances.

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Classification	Penalties	Country
NO FORMAL LEGAL CLASSES Grand Ducal decrees control narcotic drugs, psychotropic substances and toxic substances	No direct relation between penalties and schedules.	**LUXEMBOURG**
TWO MAIN CLASSES **I Drugs which pose unacceptable risks** opiates, coca derivatives, cannabis oil, codeine, ecstasy, amphetamine, LSD, etc **II Other drugs** cannabis, barbiturates, tranquillisers	Penalties differ for the two classes of drugs.	**The NETHERLANDS**
SIX MAIN CLASSES **I** Opiates, coca and derivatives, cannabis and derivatives **II** Hallucinogens, amphetamines, barbiturates **III** Specific preparations **IV** Tranquillisers and analgesics **V & VI** Precursors	For some offences penalties vary according to the classification of substances.	**PORTUGAL**
Narcotic drugs and psychotropic substances are placed under control by Spanish legislation through different orders as in UN Conventions.	Law distinguishes between substances which do or do not cause serious damage to health.	**SPAIN**
FIVE CLASSES **I** Narcotics with no medical uses **II** Narcotics with medical uses **III** Codeine **IV** Barbiturates, benzodiazepines **V** Narcotics as defined under Swedish law but not restricted by international Conventions	No relation between classes and penalties or offences.	**SWEDEN**
THREE CLASSES AND FIVE SCHEDULES **Classes** **A** Opiates and opioids, MDMA, LSD, cocaine, amphetamines for injection **B** Codeine, cannabis, other amphetamines **C** Anabolic steroids, benzodiazepines **Schedules** **1** No medical uses: cannabis, hallucinogens **2** Only available as a prescription medicine with some restrictions: most opiates, cocaine **3** Only available as a prescription medicine: most barbiturates, some stimulants **4** As above but possession not an offence: benzodiazepines **5** Available without prescription: certain preparations	For certain offences, the classification in three classes determines maximum penalties. Drugs in class A are considered most dangerous, class C least dangerous. Schedules define the degree of control applied to each substance but bear no relation to penalties.	**UNITED KINGDOM**

▶ Implementation of **Portugal**'s national programme was decentralised into 18 districts.

▶ Three-quarters of **Italy**'s anti-drug budget was transferred to the regions, vesting them with much greater political importance in the implementation of drug programmes.

▶ From 1 January 1996 in **Denmark** addiction treatment became the responsibility of the counties.

THE LEGAL FRAMEWORK

EU states made no major changes to their legal frameworks in 1996 (see table 3) but did progress in certain areas. Laws have changed fastest in those areas subject to UN conventions and EC regulations. Here also national laws converge most because international influences have led to parallel initiatives on issues such as combating money laundering or control of chemicals needed to produce drugs. In 1996, France, for example, legislated on both issues by incorporating Community directives. Ireland also made a number of significant changes including a new law which provides a powerful mechanism for freezing and forfeiture of the proceeds of crime, supported by a Bureau to identify and seize assets.

Generally the major differences between national statutes relate to the severity of punishments allowed for a given crime, precisely where international

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Table 4 • Laws prohibiting the possession of drugs and associated penalties

	LAWS AND PENALTIES
AUSTRIA	Small quantity for personal use: prosecution is obliged to discontinue proceedings for a probation period of 2 years. Small quantity not for personal use: up to 6 months' imprisonment or fine. Possession with aggravating circumstances (involving minors, etc): up to 3 years' imprisonment. Large quantities for distribution: up to 3 years' imprisonment.
BELGIUM	3 months to 5 years' imprisonment and/or fine. Aggravating circumstances (offences involving minors, etc): up to 20 years' imprisonment. For personal use: suspension or deferral of sentence available.
DENMARK	Up to 2 years' imprisonment and/or fine; up to 6 years in certain cases and 10 for serious offences.
FINLAND	Up to 2 years' imprisonment and/or fine. Very dangerous drugs, up to 10 years' imprisonment. Sentence may be waived if the offender is undergoing treatment.
FRANCE	No specific penalty. Up 10 years' imprisonment and/or fine for possession and other offences.
GERMANY	Up to 5 years' imprisonment and/or fine. Large quantities: minimum 1 year's imprisonment.
GREECE	Small quantity for personal use: penalties as for drug use (see table 5). Large quantity for distribution by addict: 5–20 years' imprisonment and fine (sentence can be spent in a therapeutic institution). Large quantity for distribution by non-addict: 10–20 years' imprisonment or in some cases lifetime imprisonment plus fine.
IRELAND	Cannabis or cannabis resin for personal use: fine only on first or second conviction then fine and/ or up to 1 year's (summary[1]) or 3 years' (indictment[2]) imprisonment. All other controlled drugs: fine and/or up to 1 year's (summary[1]) or 7 years' (indictment[2]) imprisonment.
ITALY	For personal use: administrative sanctions, (suspension of driving licence, gun licence, passport, etc) lasting 2–4 months (classes I and III) or 1–3 months (classes II and IV). First time offenders or minors, offences involving classes II or IV: the Prefect can discontinue the case and issue a simple warning. Suspension of sanctions for personal use is possible if the offender is willing to undergo treatment.
LUXEMBOURG	For personal use: 3 months to 3 years' imprisonment and/or fine. Not for personal use: 1–5 years' imprisonment. Very serious cases: up to lifetime imprisonment.
The NETHERLANDS	Less than 30g cannabis for personal use: up to 1 month's imprisonment and/or fine. Cannabis other than above and other class II drugs: up to 2 years' imprisonment and/or fine. Class I drugs (unacceptable risk), small quantities for personal use: up to 1 year's imprisonment and/or fine. Class I drugs, not for personal use: up to 4 years' imprisonment and/or fine.
PORTUGAL	For personal use: up to 1 year's imprisonment or fine 'up to 120 days' (fines are expressed as days in prison). Three daily doses or less: up to 3 months' imprisonment or fine up to 30 days. Possession by user-dealers: up to 3 years' imprisonment or fine (classes I or III), or up to 1 year's imprisonment or fine (class IV). If the quantity exceeds five daily doses the crime is not treated as possession.
SPAIN	For personal use: administrative sanctions. Not for personal use: fine and 1–3 years' imprisonment (substances causing less serious damage to health) or up to 9 years' imprisonment (substances causing a serious health hazard).
SWEDEN	Minor offences: up to 6 months' imprisonment or fine. Ordinary offences: up to 3 years' imprisonment. Serious offences: 2–10 years' imprisonment.

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UNITED KINGDOM

With intent to supply to another:
- class A, up to lifetime imprisonment and/or an unlimited fine;
- class B, up to 14 years' imprisonment and/or unlimited fine;
- class C, up to 5 years' imprisonment and/or unlimited fine.

No intent to supply to another:
- class A, up to 7 years' imprisonment and/or unlimited fine;
- class B, up to 5 years' imprisonment and/or unlimited fine;
- class C, up to 2 years' imprisonment and/or unlimited fine.

These are penalties available on indictment.[2] Maximum terms of imprisonment and fines are less for summary[1] trial.

Notes to tables 4 and 5

1. Enables proceedings to be completed more quickly in less serious cases. Hearings are before a judge or magistrate, procedures are simplified and sentences moderate.
2. For serious cases. The judge is assisted by a jury which records a verdict after a detailed hearing. Sentences can be more severe including unlimited fine.

Table 5 • Laws on drug use: restrictions and penalties

	RESTRICTIONS	PENALTIES
AUSTRIA	Not an offence.	Indirectly prevented by prohibiting possession and acquisition.
BELGIUM	Only group use is prohibited.	3 months to 5 years' imprisonment and/or fine. Courts may suspend or defer sentence if addicts agree to undergo treatment.
DENMARK	Not an offence.	Indirectly prevented by prohibiting possession and acquisition.
FINLAND	Prohibited.	Imprisonment up to 2 years or fine; aggravating circumstances 1–10 years. Sentencing can be waived for addicts undergoing treatment.
FRANCE	Prohibited.	Up to 1 year's imprisonment and/or fine. Proceedings can be waived for addicts undergoing treatment; treatment may be made compulsory.
GERMANY	Not an offence.	Indirectly prevented by prohibiting possession and acquisition.
GREECE	Prohibited.	Non-addicts may be imprisoned for 10 days to 5 years and/or fined. Addicts are sentenced to compulsory treatment. Sentence can be waived for a first-time offender.
IRELAND	Only opium use is prohibited.	Imprisonment and/or fine: summary[1] trial, up to 1 year; on indictment,[2] up to 14 years.
ITALY	Not an offence.	See table 4.
LUXEMBOURG	Prohibited.	3 months to 3 years' imprisonment and/or fine. With aggravating circumstances, 1–5 years (use in a group) or at least 2 years (use in prison, school, etc).
The NETHERLANDS	Not an offence.	Indirectly prevented by prohibiting possession.
PORTUGAL	Prohibited.	Up to 3 months' imprisonment or fine. If the quantity exceeds three daily doses, up to 1 year or fine. For occasional users sentence can be suspended.
SPAIN	Not an offence.	Administrative sanctions for use in public.
SWEDEN	Prohibited.	Fines and up to 6 months' imprisonment. In practice fines only. Personal use of narcotics is not punished if the offender agrees to seek counselling or treatment.
UNITED KINGDOM	Only opium use is prohibited.	Imprisonment and/or fine: summary[1] trial, up to 6 months; on indictment,[2] up to 14 years. Otherwise indirectly prevented by prohibiting possession.

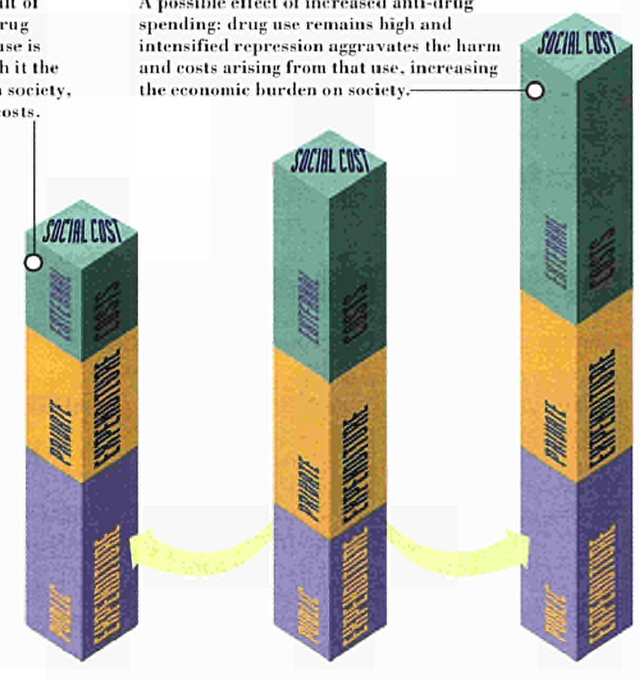
Table 6 • Penalties for trafficking in drugs

	PRISON SENTENCES
AUSTRIA	Basic offence: up to 5 years. Professional trafficker or member of a trafficking group: 1–10 years; 1–15 years with aggravating circumstances. Leader of a trafficking group: 10–20 years.
BELGIUM	Addict-dealers:[1] 3 months to 5 years. With aggravating circumstances: 10–20 years.
DENMARK	Addict-dealers:[1] up to 2 years. Other offenders: up to 10 years.
FINLAND	Addict-dealers:[1] up to 2 years or fine.
FRANCE	Addict-dealers:[1] up to 5 years. Basic offences: up to 10 years. Member of a trafficking group: up to 30 years. Leader of a trafficking group: life.
GERMANY	Severe cases (large quantities, etc): up to 15 years. Other cases: up to 5 years. Minimum sentences set according to 1988 UN Convention: • trafficking, etc; minimum 1 year; • money laundering, etc; minimum 2 years; • receiving proceeds of trafficking, possessing equipment for illicit production, etc; minimum 3 years.
GREECE	5–20 years or life.
IRELAND	Addict-dealers:[1] up to 1 year and/or fine. Other offenders: up to life.
ITALY	Minor offences: classes I & III, 1–6 years; classes II & IV, 6 months to 4 years. Basic offences: classes I & III, 8–20 years; classes II & IV, 2–6 years. Member of a trafficking group: minimum 10 years. Leader of a trafficking group: minimum 20 years.
LUXEMBOURG	1–5 years or life.
The NETHERLANDS	Within the country: class I, up to 8 years; other drugs, up to 2 years. International: class I, up to 12 years; other drugs, up to 4 years. Penalties may be increased for members of organised crime groups.
PORTUGAL	1–25 years depending on the drug, the quantity involved and the circumstances
SPAIN	Addict-dealers:[1] substances causing less serious damage to health, 1–3 years; substances causing a serious health hazard, 3–9 years. Aggravating circumstances: substances causing less serious damage to health, 3–4° years; substances causing a serious health hazard, 9–13° years. Severe circumstances: substances causing less serious damage to health, 4° years to 6 years 9 months; substances causing a serious health hazard, 13°–20 years.
SWEDEN	Minor offences: up to 6 months' imprisonment or fine. Ordinary offences: up to 3 years' imprisonment. Serious offences: 2–10 years' imprisonment.
UNITED KINGDOM	Class A: up to life. Class B: up to 14 years. Class C: up to 5 years. These are penalties available on indictment.[2] Maximum terms of imprisonment and fines are less for summary[3] trial.

1. Drug users supplying drugs to other users to finance their own consumption.
2. For serious cases. The judge is assisted by a jury which records a verdict after a detailed hearing. Sentences can be more severe including unlimited fine.
3. Enables proceedings to be completed more quickly in less serious cases. Hearings are before a judge or magistrate, procedures are simplified and sentences moderate.

Table 7 • Legally specified alternatives to prosecution and imprisonment

ALTERNATIVES TO IMPRISONMENT OR PROSECUTION	
If a drug user acquired, imported, exported, offered or supplied drugs in small quantities and is ready to undergo treatment or guidance, the prosecutor may suspend proceedings. Courts may suspend sentence for up 2 years if the offender voluntarily undergoes treatment.	**AUSTRIA**
Prosecutors have discretion on whether to proceed and can propose that an offender who admits to addiction should undergo treatment; cases can then be dropped and declared closed. Courts can order probation and defer or suspend sentence. Treatment is commonly a condition of probation.	**BELGIUM**
Prosecutors have discretion on whether to proceed. General alternatives to prison include suspended sentences and conditional discharge. Prosecutors may order treatment as an alternative to imprisonment.	**DENMARK**
Prosecutors and courts can withdraw from prosecution or waive punishment when the offender voluntarily undergoes treatment.	**FINLAND**
Prosecutors can oblige addicts to follow a treatment regime instead of going to prison.	**FRANCE**
Prosecution may be waived for offences involving small quantities for personal use. Sentences of less than 2 years' imprisonment can be suspended if an addicted offender is undergoing or intends to undergo treatment.	**GERMANY**
Drug addicts may be declared irresponsible and incapable of being morally liable for their offences. Prosecution of drug offenders can be postponed if they agree to treatment and permanently suspended if they successfully complete the programme. Addicts can be ordered into compulsory therapeutic treatment in a closed establishment. Time spent in treatment can be deducted from the sentence.	**GREECE**
Sentence may be deferred if the offender volunteers to undergo treatment. Offenders are offered treatment while in custody.	**IRELAND**
Courts can arrange a broad range of therapies for drug users or addicts who volunteer for treatment. Sentences of up to 4 years are suspended for a probation period of 5 years. If treatment is successful the case is closed.	**ITALY**
On application from the prosecutor or the accused, for certain offences examining magistrates may order detoxification. If treatment is successful the offender will not be prosecuted. Offenders who volunteer for treatment may have sentence suspended for a probation period of 2 years. Courts can compel addicts to undergo treatment.	**LUXEMBOURG**
Prosecutors may drop proceedings if addicts volunteer for treatment. Courts can give a provisional judgement if a drug user attends a treatment centre or order a drug addict to be treated in a psychiatric institution (very rarely used).	**The NETHERLANDS**
Prosecutors may propose voluntary treatment. Sentence may be suspended if the offender volunteers for treatment. Suspended sentences may be accompanied by a probation order.	**PORTUGAL**
Courts may encourage addicts to seek treatment. Sentence may be conditionally suspended for addicts sentenced to less than 3 years who opt for treatment.	**SPAIN**
Courts may substitute treatment for imprisonment. Imprisoned drug users may serve the last part of their sentence in a treatment programme.	**SWEDEN**
In addition to a range of general non-custodial alternatives to prison (probation, community service, or both), treatment may be made a condition for granting probation to problem drug users.	**UNITED KINGDOM**



The SOCIAL COST imposed on society by drug misuse is the sum of PUBLIC EXPENDITURES to curb drug use and trafficking, PRIVATE EXPENDITURES by drug consumers such as to buy drugs, and EXTERNAL COSTS incurred by society due to drug-related criminality and illness

agreements allow the greatest leeway. But there are differences too – less visible but not less important – in how major provisions are implemented and in how they are enforced. Such is the case, for instance, with possession (see table 4, page 96). Though universally prohibited, countries differ over whether they subdivide this into personal use, in how they define this and in enforcement practices – to the extent that in practice the approach varies from effective non-enforcement to the explicitly penal.

There is greater statutory variation with respect to prohibiting drug use itself (see table 5). All states seek to prevent use by prohibiting possession and in some cases purchase, but just six ban all use and two prohibit only opium use. UN conventions permit prohibited drugs to be used for medical purposes, but this term has no universal definition, particularly in respect of which drugs may be prescribed to addicts and in what circumstances. Here (as noted in chapter 2) the trend in several countries has been to open up the legal options to curb the spread of infections.

Unauthorised supply or trafficking in drugs is universally prohibited and subject to penal sanctions (see table 6), though, especially with respect to cannabis, regulations and enforcement practices create divergence. The tendency to target severe penal measures against criminal groups and their financial activities continued in 1996 when some countries regulated on undercover agents and 'controlled delivery' of illegal drugs under police surveillance.

Table 7 shows that every EU nation makes some legal provision for demand reduction activities (usually treatment) as at least a partial alternative to prosecuting and imprisoning drug users.

PUBLIC EXPENDITURE, SOCIAL COSTS

At this point the current report enters territory not explored in the previous report – the cost to society of its drug problems and of tackling those problems. Much of the discussion will be setting the contexts and raising the issues needed to understand such data as there is and to guide the generation of more useful information.

The ultimate in policy-relevant information would be an accounting of the cost-effectiveness of different activities or policies: how great is the benefit to society in terms of cost savings from extra expenditure on policy A as opposed to policy B? Less ambitiously, a reliable accounting of anti-drug spending would enable us to assess the priority afforded the drugs issue, and knowing the costs imposed by drug misuse would provide a guide to how much public investment is warranted to reduce those costs.

The steps to such an ideal are many and difficult. They start with an accounting of anti-drug expenditures on the one hand, and on the other of the costs incurred by society as a result of drug use or traffic. Examples of such expenses are the loss to society from the premature death of some of its citizens, treatment of illnesses such as overdoses and AIDS, and the value of goods stolen in order to purchase drugs. Additional to these social expenditures and costs are the private expenditures of drug consumers. Together (see diagram above) these sum to the social cost of drug misuse – the burden on society expressed in economic terms. The presumption is that varying the quantity or mix of anti-drug expenditures can affect costs and thereby reduce (or at least curb the growth of) the burden on society.

If the theory is simple, the application is not. The most straightforward task ought to be accounting for public expenditures, yet no EU nation can claim to know how much it spends to counter drug misuse. But there have been a few important breakthroughs, among which are the recent report on France's anti-drug expenditures[2] and a German book assessing the social cost of heroin use.[3] For a more systematic approach we have to look across the Atlantic to the USA which has documented its federal anti-drug expenditures since the 1970s and from 1985 has planned its budgets in detail. Even here the figures might not withstand probing audit.

• Public expenditure •

The first task in assessing expenditures is to define for each administrative sector where anti-drug activity begins and ends. These questions are of practical relevance in each of three major policy domains: law enforcement; health/treatment; and prevention.

Clearly, expenses related to enforcing *anti-drug* laws must be in the expenditure equation. Less clear is how far this should embrace expenses related to the other types of offences by drug users, such as theft. To the extent that such offences are caused by drug use, and would not otherwise have occurred, then the answer is yes. But how far is this the case? The notion of a direct link between crime and addiction stems from the stereotypical image of an addict suffering withdrawal and, it is assumed, willing to do anything to get the drug needed to end their distress. But this image relates only to certain drugs, such as heroin. Even then there are degrees of dependency; some consumers can and do adapt their consumption to the market. Substitution treatments also add a non-crime option for maintaining drug use. Even assuming a causal relationship between addiction and criminality, it is not necessarily one way, and it could be that both are caused by underlying social and psychological factors.[4]

Similar problems arise with respect to health expenditure. For example, a significant proportion of HIV infections are due to activities involved in drug use. So should HIV prevention among drug users and the treatment of those infected be counted as anti-drug expenditures or as health expenditures?

With respect to prevention the problems are even more acute. A major aim is to prevent *onset* of drug use, so the target cannot be circumscribed in terms of drug use; potentially it is the entire population – or at least that part thought of as at risk of drug use. An alternative is to include only activities aimed directly at drug use. But (see chapter 2) this would be to enshrine a much reduced and outdated view of prevention. Practically any activity which promotes the maturation and welfare of the young can be seen as contributing to drug prevention. Though in line with latest prevention thinking, adopting this view as a basis for accounting would make it impossible to isolate and assess anti-drug expenditure in a way which can inform policymaking. The more relevant route seems to be to include only explicitly anti-drug activities, accepting that this will underestimate the funds which support prevention.

Table 8 • Anti-drug expenditures in France in 1995

Source: see reference 2.

1. Based on mid-1995 exchange rate of 1ECU = 6.55 francs.

MILLION ECUS[1]

	Internal budget	Inter-ministry credits	Total
Justice	**231.99**	**2.53**	**234.51**
Judiciary	30.52		
Prisons	201.46		
Police	**188.60**	**3.79**	**192.39**
Gendarmerie	**70.08**	**1.58**	**71.66**
Customs	**65.63**	**3.09**	**68.72**
Health	**96.18**	**3.98**	**100.17**
Social affairs	**2.14**	**2.23**	**4.36**
DIV	**3.36**	**1.44**	**4.80**
MILDT		**6.92**	**6.92**
Education	**0.31**	**1.51**	**1.82**
Young people and sports	**2.70**	**1.26**	**3.97**
Research	**6.41**	**0.37**	**6.78**
Foreign affairs	**2.14**	**1.10**	**3.24**
Cooperation	**2.75**	**0.27**	**3.02**
Work, employment, professional education		**0.12**	**0.12**
Contribution to EU drug budget		**4.58**	**4.58**
TOTAL	**676.85**	**30.20**	**707.06**
AIDS	**150.03**		
HIV prevention	6.10		
Health treatment	141.02		
Health costs	2.90		

The French example

This conservative approach was adopted in the French study previously cited, which demonstrates the limits of current accounting possibilities, and the perspective this can nevertheless provide on the balance of public policy. Table 8 shows that in 1995 France's national government dedicated over 700

Table 9 • Public expenditures in USA and the Netherlands

Source: see reference 2.
1. Original data in US $. ECU conversion based on mid-1991 exchange rate of 1ECU = $1.14 US.
2. USA 1991, Netherlands 1992.
3. USA 1988.
4. Federal, state and local.

ECUs[1]

	USA		NETHERLANDS	
	millions ECUs	per capita	millions ECUs	per capita
ENFORCEMENT				
Federal/central[2]	6277	25.43	201.72	13.16
State and local[3]	4596	18.42	0	0
TREATMENT[4]	788	3.51	78.93	5.26

million ECUs, then equivalent to 4700 million francs, to its anti-drug policies. At the equivalent of over 230 million and nearly 200 million ECUs respectively, justice and police accounted for 60% of the total, overshadowing health and education. (All these figures exclude sub-national expenditure.)

Some of the major findings involved in reaching such conclusions are itemised below.

▶ Jailing people is expensive. On 1 May 1995, French prisons held 11,816 people for drug offences, at an estimated annual cost of over 200 million ECUs. This underestimates drug-related prison costs as it takes no account of addicts jailed for property and other crimes committed as a result of drug use.

▶ Estimating police expenditure to combat drugs is difficult. Only 2000 officers are dedicated to this work; most have other duties. Specific drug policing expenditure totalled nearly 200 million ECUs, including 77 million on drug squads, 90 million on public security forces and 16 million on prevention.

▶ In 1995, 100 million ECUs were spent on health care specifically for addicts, of which 1.65 million funded treatment alternatives to prison. This can only be a fraction of all health expenditure attributable to the consequences of drug use.

▶ Around 6.1 million ECUs were dedicated to preventing HIV infection among drug users and nearly three million to housing and daily help for HIV-infected addicts. Add in hospital and medical expenses for treating those with HIV disease and the cost of responding to HIV infection among drug users would exceed 150 million ECUs.

• Budgets and policymaking •

What makes it worth struggling with the complexities outlined above is that knowing expenditures should help assess how policy has been translated into action, and then help develop budget plans to implement new policies. Nevertheless, these results must be cautiously interpreted. Most state agencies are not devoted to drugs; their budgets must be allocated to the issue according to a formula which reflects its share in their workload. The risk is that the allocation does not change even though the agency's priorities have. It also becomes possible to give the politically desired impression of spending trends by adjusting the allocation method year on year. External audit might be a safeguard, but the derivations of these formulae are so complicated and opaque that they are impossible to verify.

Less can be more

Even if studies on public expenditure were comprehensive and reliable, the issue of interpretation would remain. On the face of it a higher per capita expenditure on combating drugs implies intensified activity and greater benefits. But some anti-drug activities can obstruct other activities. For example, a regime which pulled back from prosecuting known

Table 10 • Some tentative comparisons

Table 10
Source: see reference 2.
1. 1 billion = 1000 million. Original data in French francs. Conversion based on mid-1995 exchange rate of 1ECU = 6.55 French francs.

BILLIONS ECUs[1]

Notes opposite	USA	Nether-lands	France
All state expenditures	868.39	80.52	233.45
GDP	5619.05	283.22	1203.17
State expenditure as % GDP	15.4%	28.4%	19.4%
ANTI-DRUG EXPENDITURE	11.14	0.26	0.69
Enforcement	10.38	0.18	–
Treatment	0.76	0.08	0.69
As % of GDP	0.2%	0.06%	0.06%
As % of state expenditures	1.3%	0.32%	0.3%

addicts is likely to permit the formation of open and active addict self-help groups. Conceivably its anti-drug expenditure may be less than in a stricter regime, but the level of social action may be higher.

Also it is widely accepted that the benefits from suppressing drug use can be offset by aggravating the damage from such drug use as does occur. So a policy of preventing access to syringes by pursuing pharmacists who supply them and addicts found with them may curb injecting, but at the cost of greater HIV spread as addicts share equipment more. Similarly, investment in seizing drugs may drive up prices, deterring entrants to the market, but also induce addicts to commit more crimes or switch to more dangerous substitutes. The confusing upshot is that a relatively small drug budget does not necessarily mean less, or less effective, social action against drugs or drug problems. Each nation's spending must be seen in the light of its legal system and social priorities.

Aiming for balance?

Earlier it was observed that balancing demand and supply reduction was a key objective of European national strategies. Here surely expenditure estimates come into their own as a guide to policy. Yet prudence is called for.

First there is the technical issue of comparing the two. Administrations responsible for supply reduction are generally centralised, treatment and prevention localised. Centralised expenditures are more easily accounted for, so supply reduction spending may seem larger relative to demand reduction than is actually the case. Deterrence is a major enforcement goal meaning expenses may be high and action effective even if arrests and seizures are few. In contrast, many treatment costs (eg, for methadone treatment or residential care) occur only if someone is being treated. Assessing both solely on a case-by-case basis is bound to lead to the conclusion that enforcement is more expensive than treatment.

For many, the reason for comparing supply and demand reduction expenditures is to assess the scope for transferring funds between the two – usually from enforcement to treatment or prevention. But in practice a substantial part of public expenditure cannot be reallocated within normal political time frames. For example, in the short to medium term, administrative complications often rule out cutting police numbers in order to augment health workers (or vice versa). It would be more feasible to redeploy anti-drug officers to other police duties, but this limited action would not reduce police costs overall.

Table 11 • Social cost of heroin abuse in Germany in 1992

SOURCE OF COST	MILLION ECUs[1] Amount
Police costs, drug offences	234.33
Police costs, drug-related crime	628.41
Losses suffered by victims of crime	1572.23
Justice costs	251.55
Prison	403.50
Treatment	293.84
Prevention and research	12.19
Substitution programmes	22.05
Productivity loss	3288.21
TOTAL	6706.32

Source: see reference 3.

1. Based on mid-1992 exchange rate of 1ECU = 2.05 German marks.

With stretched resources on all sides, the decision to reduce in one sector – especially one with public support – is politically difficult to sustain. Experience shows that when one sector needs to be reinforced, this does not occur at the expense of another but through a global budget increase. Such reallocations as do occur are usually negotiated within rather than between sectors. Attractive as it may seem, the idea that expenditure estimates could underpin inter-sector resource reallocation seems unrealistic.

The conclusion is that while policies determine expenditure, the scope for using knowledge about expenditure to determine policy is limited. Budgets are driven by laws and programmes; we should debate those and not the budgets that flow from them.

• International comparisons •

Gaining a perspective on your own country by comparing it with another is in theory an important function of budgetary data, one in this case hampered by inadequacies in that data. No EU nation has conducted a detailed survey of its anti-drug expenditure, let alone one that ensures the international compatibility of the figures. Comparisons must rely

Table 12 • Social costs of alcohol and drug addiction in the Netherlands in 1995

	MILLIONS ECUs[1]	
	Alcohol	Drugs
Addiction care and treatment	67	77
General health care	48	
Productivity loss	957	72
Judicial costs		177
Property crimes	low	311
Traffic accidents	144	low
Social welfare expenditures	1292	144
Debts of addicts	180	239
Devaluation of immovable property	low	479
TOTAL[2]	2688	1499

Source: see reference 6.

Empty cells indicates data unavailable.

1. Based on mid-1995 exchange rate of 1ECU = 2.09 Dutch guilders.

2. In source rounded to 6 billion and 3 billion guilders.

on the partial data available, deriving from disparate sources and methodologies. Tables 9 and 10 on page 102 illustrate the potential for illumination from such comparisons rather than shining the light.

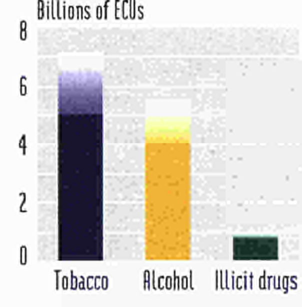
• The social cost of drug use •

To public expenditures must be added the costs imposed by the consequences of drug use and drug trafficking ('external costs') to reach an accounting of the total burden on society. In theory, attention would then be drawn to those problems that drain society most and to responses which promise to most cost-effectively reduce that drain. Across the range of substance legal and illegal, in any country where this has been studied the costs imposed by tobacco exceed those of alcohol and illicit drugs.

The chart below gives the example of Canada;[5] similar findings are available from other nations. But here too the obvious policy implication – divert resources to legal substances – must be tempered by concern that this might allow the scale of illegal drug use to approach closer to that of alcohol and tobacco, and with it also the scale of social costs.

Table 11 (page 103) illustrates with respect to an illegal drug how such cost estimates might be constructed while table 12 is an attempt to estimate expenditures and costs for drug addiction as a whole for the Netherlands. The latter data was estimated as part of a cost-benefit study carried out in 1995 by the Dutch Bureau voor Economische Argumentatie for the Jellinek Centre in Amsterdam.[6]

Again the precision of numbers gives a misleading impression of objectivity. The most serious source of subjectivity is that cost estimates must place a value on human life and welfare , or, more precisely, the loss of them. Here value judgements are inevitable and profoundly affect the numbers. To transcribe, say, the number of drug-related deaths into monetary units means treating each death as a loss of 'human capital' which would otherwise have generated an output with a market value. The uncomfortable consequence is that children or the elderly retired are afforded little value, and that what value they and others have will fluctuate with the market; conceivably a greater value will be placed on human life in a booming economy than in one where labour requirements were depressed. Despite these fundamental difficulties, social cost estimates are essential to a dispassionate discussion of public policies which aim to reduce such costs.



The social cost of substance abuse in Canada in 1992 – as elsewhere, illicit drugs come well below tobacco and alcohol

Source: see reference 5.

1. Based on mid-1992 exchange rate of 1ECU = $1.55 Canadian.

References/notes

1. European Parliament, European Commission, Spanish Government. *Conference on Drugs Policy in Europe: summary of discussion and conclusions*. 1996.

2. Kopp P., Palle C. *Le coût de la politique publique de la drogue. Essai de mesure des dépenses des administrations d'Etat*. Paris: OFDT, 1997.

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5. Single E., Robson L. *et al*. *Les coûts de l'abus des substances au Canada*. Toronto: CCLAT, 1995

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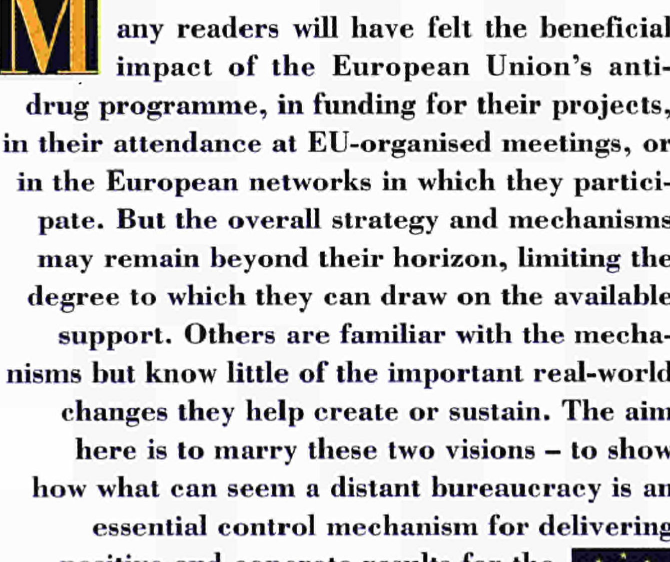
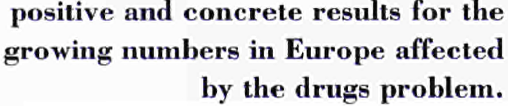
CHAPTER 5

Action taken by the European Union



Many readers will have felt the beneficial impact of the European Union's anti-drug programme, in funding for their projects, in their attendance at EU-organised meetings, or in the European networks in which they participate. But the overall strategy and mechanisms may remain beyond their horizon, limiting the degree to which they can draw on the available support. Others are familiar with the mechanisms but know little of the important real-world changes they help create or sustain. The aim here is to marry these two visions – to show how what can seem a distant bureaucracy is an essential control mechanism for delivering positive and concrete results for the growing numbers in Europe affected by the drugs problem.



As the first in the series, last year's report dealt extensively with the history of the European Union's (EU) involvement in the drugs issue and detailed the administrative and legal mechanisms through which that involvement is delivered and controlled. As those mechanisms remain essentially unchanged, only a minimum of that framework is retained to enable readers to contextualise the core content of this year's report – progress made in 1996, when the EU's spending on drugs doubled to over 61 million ECUs, fuelled largely by a tripling of expenditure on cooperative ventures with non-EU nations critical to the development of policy within the Union.

Legal and Political Framework

Joint European action against drugs dates back at least to the setting up in 1972 of the Customs Mutual Assistance Group to combat drug trafficking. A turning point came in the 1980s when concerns voiced by the European Parliament led European Community (EC) ministers of health, meeting as the European Council, to implement a drug control strategy shifting the focus from supply to demand reduction. From then, the Community as such became a party to the international community's fight against drugs, complementing the work of Member States (see chapter 4) within a global context (see chapter 6). In the 1990s the European Council adopted three European Action Plans on drugs, intended to integrate activities at regional, national and European levels. The third and current plan is the first within the framework of the Treaty on European Union.

• 3rd European Action Plan to Combat Drugs •

Entry into force of the Treaty on European Union in 1993 offered the potential for widened and more integrated action against drugs, leading the European Council to adopt a third action plan for 1995–1999. With the associated detailed plans, this constitutes the present legal and institutional framework for anti-drug action in the European Union, emphasising coherence and coordination of demand and supply reduction policies both in EU Member States and in their articulation at international level.

The two major ways for the European Union to deal with drugs are:

- 'community competence' – policy areas under the 'first pillar' of the Treaty on European Union where Community institutions are empowered to act, subject to the principle of subsidiarity;
- cooperation between Member States in the framework of the Treaty on European Union's second and third pillars, often in the form of 'joint actions' and 'common positions' agreed by heads of state or of government.

1 Community competence

The topic of drugs is found in only one article of the Treaty of Rome as modified by the Treaty on European Union, but other provisions provide a basis for the Community's actions in this field:

- article 100A on harmonisation is the basis for preventing money laundering;
- article 113 on a common commercial policy allows the Community to act against the diversion of precursor chemicals;
- article 129 on public health; drug misuse is the only itemised topic, with prevention as the priority;
- article 130 W allows the EU to cooperate with non-EU nations in the field of drugs in the context of development aid and cooperation, giving priority to developing countries.
- article 235, the basis on which the EMCDDA was established.

2 Foreign and Security Policy

Member States realised they could more effectively promote European positions internationally if they coordinated their diplomatic efforts, a process underpinned by greater internal political dialogue and encouraged by positive outcomes. Formal recognition came in 1992 when the European Council identified drugs as a suitable topic for common action under the Common Foreign and Security Policy.

3 Justice and Home Affairs

The Treaty on European Union identifies combating drug addiction and police cooperation against trafficking as matters of "common interest" to Member States. Here Member States have exclusive competence: ministers meeting within the Council may agree to certain actions on their own initiative, but the Commission cannot take the initiative. Competence and right of initiative for the remaining aspects of the fight against drugs under this pillar are shared between Member States and the Commission.

KEY POINTS

- Joint European action against drugs dates back at least to 1972 and accelerated in the 1990s when the European Council adopted three European Action Plans on drugs.
- In 1996 the high profile of the drugs problem was confirmed when both European Council meetings addressed the issue in depth.
- Within a stable framework, EU action progressed rapidly, especially in the second half of the year in relation to home affairs and justice cooperation.
- The co-decision procedure between Parliament and the Council of Ministers produced important public health decisions, including the Community Action Programme on the Prevention of Drug Dependence, allocated 27m ECUs over five years.
- Anti-money laundering measures continued to be seen as crucial. Progress was made on implementing the anti-laundering directive and Parliament called for the legislation to be extended.
- Available information was greatly enhanced when the EMCDDA and the Europol Drugs Unit both produced their first annual reports.
- Action in 1996 was marked by mounting concern with synthetic drugs and with how to ensure rapid updating of information about their spread, the problems, and responses to these problems.
- There may be a case for rationalising EU drug budgets to reinforce synergies and cost-effectiveness and to reduce duplication.
- Compared to the previous year, in 1996 the global spend more than doubled to over 61m ECUs. Nearly all budget lines at least maintained last year's spend and most increased.
- Whereas last year's funding was evenly split between internal and external programmes, in 1996 75% was allocated for external action, representing a tripling of the external budget.
- Helping Latin American countries eradicate illicit drug production and trafficking is a foreign policy priority for the EU. In 1996 political dialogue with the region was enriched and a new budget line allocated 30m ECUs to Bolivia.
- There was a decisive increase in internal funding for monitoring and demand reduction.

INSTITUTIONAL AND ORGANISATIONAL CONTEXT

The roles of the four major EU institutions actively involved in the drugs issue are outlined below.

European Parliament

The Parliament has some legislative power concerning drugs, particularly in the approval of the General Budget. Most directly involved are its committees on Civil Liberties and Internal Affairs (coordination and supply reduction) and on Environment, Public Health and Consumers (demand reduction). Together with the Council (the 'co-decision' procedure), the Parliament decides on proposals from the Commission under article 129 of the Treaty on European Union.

European Council

The European Council defines the Union's general policies and guidelines. Meetings held at least twice a year consist of heads of state or of government plus the Commission President. Given this membership, such meetings are also termed 'summits'.

Council of the European Union

The Council of the European Union is a meeting of ministers of EU Member States from departments relevant to the issues under discussion. They are assisted by Coreper, a committee of ambassadors from Member States which the European Council also made responsible for guaranteeing consistency of action in the drugs field; in this they are assisted by the Horizontal Drugs Group of the Council. Reflecting its membership, this body is also known as 'the Council of Ministers' or simply 'the Council'.

European Commission

The EU Treaty gives the European Commission powers to initiate and implement policies. Within the Commission, coordination on the drugs issue is ensured by the Secretariat General.

DG V (Employment, Industrial Relations and Social Affairs) is the most important directorate dealing with demand reduction. Its Directorate F (Public Health and Safety at Work) implements drug-related

Table 1 • Legal framework for European action on drugs

	1ST PILLAR	2ND PILLAR	3RD PILLAR
FIELDS COVERED	**Public health • Trade cooperation** Money laundering and precursors' trade **Development cooperation** Assistance to developing countries **Global information on drugs** EMCDDA	**Common Foreign and Security Policy**	**Cooperation in the fields of Justice and Home Affairs**
PRIORITY OBJECTIVES	• Preventing addiction • Including drug misuse as a priority in development aid • Monitoring the drug situation, drug policies and the legal drugs trade	• Fight against drug production and trafficking in and from other countries and related activities	• Judicial, police and customs cooperation to combat drug trafficking
LEGAL BASIS	**EC Treaty** • Title V article 100A • Title VII, article 113 (235) • Title X, article 129 • Title XVII, article 130W • article 235	**Treaty on European Union** • Title V, article J	**Treaty on European Union** • Title VI, article K.1
INSTRUMENTS	• Regulations • Decisions • Directives • Recommendations • Incentives	• Joint actions (J.3) • Common positions (J.2) • Cooperation/coordination between Member States (J.2)	• Joint positions • Joint actions • Conventions
INITIATIVE	• Commission	• Member States • Commission	• Member States • Commission (not criminal justice & policing)
DECISION-MAKING	**Qualified majority**, articles 113, 100A **Qualified majority** and **co-decision**, article 129	**Unanimity** unless decided to the contrary	**Unanimity** unless decided to the contrary

programmes on health monitoring, prevention of drug dependence and AIDS, and health promotion.

DG XII (Science, Research and Development) heads the drive to improve the fight against drugs through scientific and technological research.

DG XV manages Community legislation aiming to prevent use of the financial system for money laundering. On drug precursors a similar role is played by DG XXI (external aspects) and DG III (internal). The Secretariat General's Task Force on Title VI of the EU Treaty (Justice and Home Affairs) handles all drug-related issues under its third pillar. Eurostat conducts statistical work on drug-related issues under its work programme for 1993–1997 and is preparing to develop this activity in its next work plan.

Four Directorates-General handle international co-operation. Accountable for the largest drug-related responsibilities are DG IA (coordinates aid to 11 Central and Eastern European countries via the Phare Multi-Country Programme on Drugs) and DG IB (coordinates external anti-drug actions; deals with the southern Mediterranean, Latin America, SE Asia, and North–South Cooperation).

Other bodies

In the EU, the **Economic and Social Committee** can provide advice on its own initiative and is consulted before the adoption of legal instruments and documents. The **Committee of the Regions** may be consulted when regional interests are involved. The **European Monitoring Centre for Drugs and Drug Addiction** is a decentralised Community agency providing Member States and EU institutions with information on drugs and drug addiction in the European Union (see Annexe 2).

Among non-EU bodies, the **European Police Office** (Europol) is an inter-governmental body aiming to enhance police cooperation among EU Member States against drug trafficking and other serious international crime. The **Europol Drugs Unit** (EDU), the first arm of Europol to be set up, operates within the framework of a Ministerial Agreement.

As in 1995, in 1996 both European Council summits addressed the drugs issue, maintaining the policy impetus and confirming its high profile among the Union's political concerns. The shape of that profile is explored here through an analysis of the actions funded and of trends in EU funding policy.

• General measures & political context •

Major decisions at the two 1996 summits (in Florence and Dublin) and at the last summit in 1995 (in Madrid) are summarised in table 2 overleaf. Several decisions taken at the Madrid summit flowed into 1996. Among these were translating the Third European Action Plan on Drugs into a detailed, coordinated programme, plus requests for two reports, one on drugs in Latin America and the Caribbean (with an eye to intensifying cooperation) and another on how legislative and law enforcement harmonisation might aid the fight against drugs.

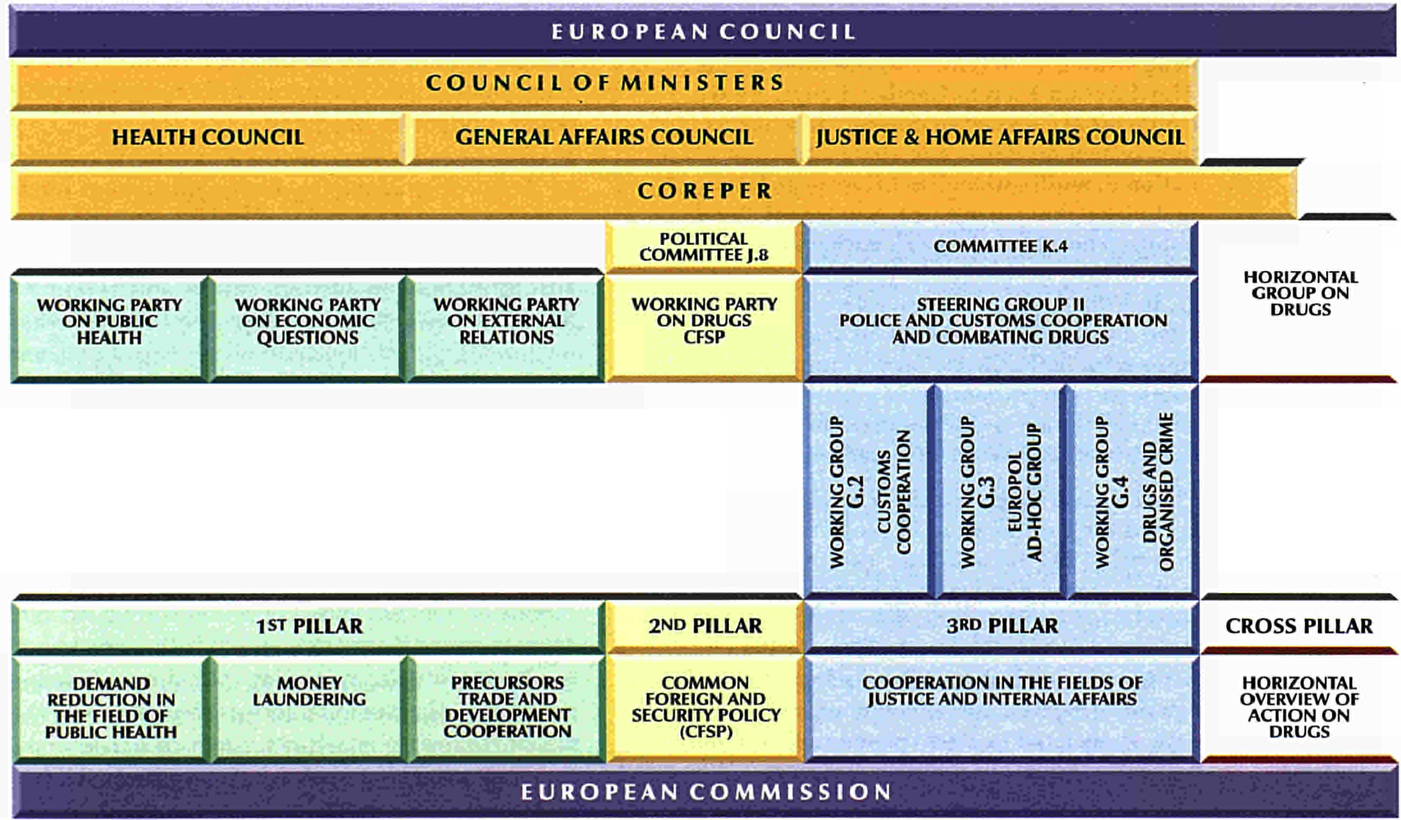
The first summit in 1996, held in Florence, underlined the importance of an integrated approach through reinforced cooperation between Member States. The last summit held in Dublin noted the significant advances made in the second half of the year and endorsed proposals for action in three sections of a report from the Council of the European Union, dealing with:

- the aims and states of play of the anti-drug measures agreed or proposed in 1996;
- drug-related laws in the EU, the differences, implementation, and how far harmonisation might help;
- the main problems in the Latin America/Caribbean region and possible cooperation mechanisms.

Several Commission directorates are involved in the implementation of EU anti-drug policy

Coordination of anti-drug actions advanced in 1996, symbolised when the Expert Group on Drugs set up within the Council of the EU was renamed the 'Horizontal Drugs Group' to stress its cross-sector brief. In 12 meetings this sought to establish links between specialised groups of the Council addressing drug issues.

Information EU institutions and Member States increasingly turn for information to the EMCDDA and EDU. In addition to their regular annual reports, initiated in 1996, the Council of Ministers asked these bodies to



Relationships between EU institutions concerned with action on drugs

Concern expressed by the European Parliament led to the creation of an EU anti-drug programme

address specific subjects; both showed they could quickly supply information on topical issues such as synthetic drugs and urban petty crime. A node of the EMCDDA's REITOX database collated information from several internal services on demand, demand reduction, legislation and policies including EU-funded projects, general literature and the EC's human network of those working in the field.

Synthetic drugs A report from the Horizontal Drugs Group to the Dublin summit stressed the need to tackle synthetic drugs through legislation, cooperation against production and trafficking (including improved cooperation between national authorities and the chemical industry), and through international cooperation. At the same time the Council of the Ministers adopted a joint action to encourage national early warning systems to identify and enable action against such drugs as soon as they appear, a system being implemented in 1997.

Research The Commission and Member States initiated several activities to explore the research contribution in the fight against drugs, mainly in biomedicine, drug profiling, detection methods, social and socioeconomic impact, and epidemiology. Part of this programme was an academic seminar on drug research in Member States and related EU initiatives, organised by the Commission and the EMCDDA and held at the European University Institute in Florence.

Phare • Preparing for EU expansion

As well as protecting the EU by strengthening the anti-drug capacities of its neighbours in Central and Eastern Europe and the Baltic (CEEC), the Phare Multi-Country Programme for the Fight Against Drugs is also preparing future Member States from those regions to play their part in the EU's anti-drug strategy, currently represented by the Third Action Plan to Combat Drugs. Phare countries are helped to develop an information system on drugs and drug addiction at national, multinational and European levels, including the setting up of national focal points. The CEEC's network mirrors the EU's REITOX drug information system (see Annexe 2). In 1996 developments accelerated, stimulated by the EU's delivery of training and equipment in the CEEC. Networking improvements in 1996 (expansion of a network of experts and the electronic linking of focal points) significantly enhanced information exchange.

Phare's 1996 budget of 5m ECUs mainly supported the continuation of projects initiated in 1993–1994 focusing on establishing: a multi-country information system; money-laundering legislation in line with international standards; the introduction of EU-compatible precursors control legislation; and a regional drug demand reduction strategy. New actions initiated in 1996 related to licit drug control and multidisciplinary training.

The 11 Phare countries are:
Albania
Bulgaria
Czech Republic
Estonia
Hungary
Latvia
Lithuania
Poland
Romania
Slovakia
Slovenia.
Phare can be accessed on the Internet at:
http://www.fad.phare.org

• Demand reduction •

The EU's most important demand reduction initiative in 1996 was the Parliament's and the Council's endorsement of the Community Action Programme on the Prevention of Drug Dependence within the public health plan for 1996–2000. With an overall budget of 27m ECUs, its main goal is to encourage coordination and cooperation between Member States, under two headings:

- data, research, evaluation – improving knowledge of drugs, drug problems and of prevention methods, drawing on information from the EMCDDA and on experience from existing initiatives;
- information, health education and training – aimed at preventing drug dependence and reducing the risks, in particular among young people and vulnerable groups such as former drug users.

Other public health Community action programmes adopted in 1996 included those on health promotion, information, education and training, and the prevention of AIDS and other communicable diseases. A fourth, on health monitoring, completed its legal stages in 1996.

Through the Commission, the EU also encouraged cooperation between Member States over prevention. Support continued for projects on risk factors leading to HIV infection in female drug injectors and on training health and social workers in counselling and the prevention of drug abuse and AIDS.

Table 2 • Main decisions taken and action requested at recent European Council meetings

MADRID • December 1995	FLORENCE • June 1996	DUBLIN II • December 1996
▶ Approved a report of the Expert Group on Drugs with guidelines following the adoption of the Third European Action Plan on Drugs in Cannes. ▶ Requested the Italian Presidency, the Council and the Commission to prepare, in concert with the Member States, the EDU and the EMCDDA, a report for the Dublin summit with a precise programme of activities which takes account of the guidelines in the report of the Expert Group on Drugs. ▶ Requested the Council and the Commission to prepare a report and the requisite proposal for action in the area of cooperation with Latin America and the Caribbean, setting up for that purpose an ad hoc working party. ▶ Called upon the Council and the Commission to consider the extent to which harmonisation of laws could contribute to a reduction in the consumption of drugs and unlawful trafficking in the EU.	▶ Stressed the vital importance of reinforced cooperation between Member States to fight against drugs and organised crime. ▶ Reiterated the importance of speedily completing the study about harmonisation of Member States' laws and the the potential for this to reduce use of and illicit trafficking in drugs. ▶ Invited the Council and the Commmission to rapidly complete the report requested in Madrid for action in the area of cooperation with Latin America and the Caribbean, by identifying any remaining gaps.	▶ Confirmed the priority it attaches to sustained and coordinated action in the fight against drugs, making full and coherent use of all EU instruments. ▶ Examined and adopted the draft report from the Council on the substantial progress made since the last meeting in Florence and endorsed the proposals for action contained in it: • measures to tackle the drug problem in 1996; • harmonisation of legislation; • Latin America/Caribbean initiative. ▶ Encouraged examination of further harmonisation of laws where an agreed need is identified, complemented by reinforced cooperation between EU institutions and Member States.

• Supply reduction •

With respect to money laundering and the precursor chemicals needed to manufacture drugs, the Community itself has the authority ('competence') to act. In the fields of Justice and Home Affairs governments cooperate under the third pillar of the Treaty on European Union.

Money laundering and precursors

Anti-money laundering measures continue to be seen as crucial. The main advance during 1996 was the Parliament's adoption of its report and resolution on the Commission's implementation report. Parliament called for legislation to encompass new forms of laundering, non-financial professions and a wider range of related actions. It also asked the Commission to report on the effectiveness of the anti-laundering effort, on new laundering methods and on laundering's potential economic impact.

The Commission monitors intra-Community trade in chemicals used in the illicit manufacture of drugs. During 1996 it enhanced existing electronic mail networks and the specialised databank, continued to train Member States' officials and formed closer cooperative links with representatives of chemical traders and manufacturers. Implementation of the relevant Council directive moved forward through a Commission regulation detailing the declaration of use to be provided by a purchaser supplied with substances listed in the directive.

Cooperation in Justice and Home Affairs

The Irish Presidency in the second half of 1996 prioritised drugs, evidenced by the 18 initiatives taken by the Council of Ministers from September, most involving cooperation over Justice and Home Affairs (see table 3 overleaf). Of these, two stand out:

▶ In the joint action on the 'approximation' of laws and procedures to combat addiction and trafficking,

Table 3 • Most important EU actions and meetings in 1996 impacting on the drugs problem

Parliament = European Parliament
Summit = European Council
Council = Council of the European Union
Co-decision = Decisions made jointly by the European Parliament and the Council
Commission = European Commission

Month	Parliament	Summit	Council	Co-decision	Commission	Other	Action
MARCH				▲			**Decision** n.645/96 adopting a Community action programme on health promotion, information, education and training within the framework for action in the field of public health, 1996–2000.
				▲			**Decision** n.647/96 adopting a programme of Community action on the prevention of AIDS and certain other communicable diseases.
					▲		**First report** on the implementation of the money laundering directive.
					▲		**Elaboration** of an aide-memoire of Commission services working on drugs.
APRIL			▲				**Directive** 96/23/EC on measures to monitor certain substances and residues thereof in live animals and animal products, an anti-trafficking measure.
			▲				**Resolution** to implement the outlines of an industrial policy in the pharmaceutical sector in the EU.
			▲				**Joint action** concerning a framework for the exchange of liaison magistrates to improve judicial cooperation between Member States, based on article K3 of the Treaty on European Union.
JUNE	▲						**Report** on the Commission's first report on the implementation of the money laundering directive.
		▲					**Meeting** in Florence.
			▲				**Cooperation agreement** between the EC and the Socialist Republic of Vietnam.
			▲				**Cooperation agreement** between the EC and the Kingdom of Nepal.
					▲		**Regulation** laying down detailed rules for the application of Council Directive 92/109/EEC requiring purchasers to declare the specific uses they intend for certain substances used in the illicit manufacture of drugs.
JULY			▲				**Regulation** n.1488/96 on financial and technical structures in the framework of the Euro-Mediterranean partnership.
AUGUST			▲				**Framework cooperation agreement** leading ultimately to the establishment of a political and economic association between the EC and its Member States and the Republic of Chile.
SEPTEMBER						▲	**Europol Drugs Unit** publishes the European Union Situation Report on Drug Production and Trafficking.
OCTOBER			▲				**Decision** on measures implementing Article K1 of the Treaty on European Union.
			▲				**Resolution** laying down priorities for cooperation in the field of Justice and Home Affairs for the period 1 July 1996 to 30 June 1998.
			▲				**Joint action** providing for a common framework for Member States' initiatives concerning liaison officers, based on article K3 of the Treaty on European Union.
			▲				**Joint action** on a programme (known as Grotius) of incentives and exchanges for legal practitioners, based on article K3 of the Treaty on European Union.
			▲				**Joint action** introducing a programme of training, exchange and cooperation regarding identity documents, based on article K3 of the Treaty on European Union.
					▲		**Directive** amending Council Directive 91/414/EEC concerning the marketing of plant protection products, an anti-trafficking measure.
						▲	**EMCDDA** publishes the first Annual Report on the State of the Drugs Problem in the European Union.
NOVEMBER			▲				**Resolution** on the drawing up of police/customs agreements in the fight against drugs.
			▲				**Resolution** on measures to address 'drug tourism' within the EU.
			▲				**Joint action** concerning a directory of specialised competence, skills and expertise in the fight against international crime, based on article K3 of the Treaty on European Union.
			▲				**Joint action** concerning exchange of information on the chemical profiling of drugs, aiming to improve cooperation between Member States in combating illicit drug trafficking; based on article K3 of the Treaty on European Union.
			▲				**Common position** with a view to adopting a Council resolution on North-South cooperation in the campaign against drugs and drug addiction.

continued ▶

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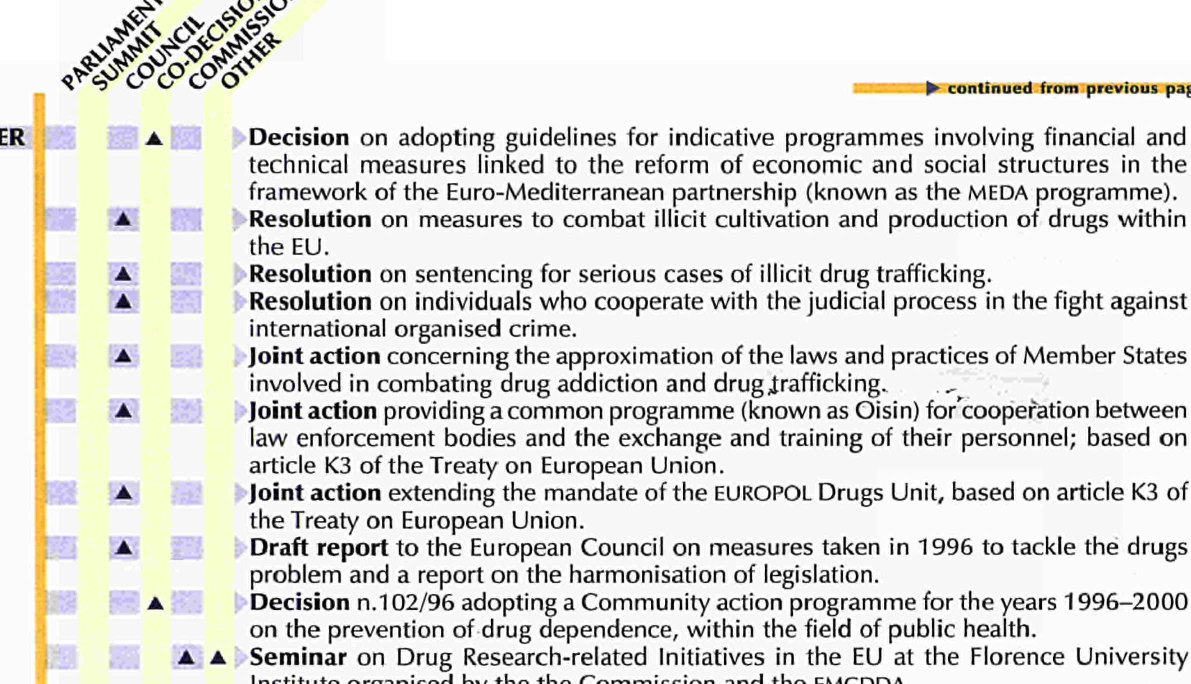


	PARLIAMENT	SUMMIT	COUNCIL	CO-DECISION	COMMISSION	OTHER	
DECEMBER				▲			**Decision** on adopting guidelines for indicative programmes involving financial and technical measures linked to the reform of economic and social structures in the framework of the Euro-Mediterranean partnership (known as the MEDA programme).
			▲				**Resolution** on measures to combat illicit cultivation and production of drugs within the EU.
			▲				**Resolution** on sentencing for serious cases of illicit drug trafficking.
			▲				**Resolution** on individuals who cooperate with the judicial process in the fight against international organised crime.
			▲				**Joint action** concerning the approximation of the laws and practices of Member States involved in combating drug addiction and drug trafficking.
			▲				**Joint action** providing a common programme (known as Oisin) for cooperation between law enforcement bodies and the exchange and training of their personnel; based on article K3 of the Treaty on European Union.
			▲				**Joint action** extending the mandate of the EUROPOL Drugs Unit, based on article K3 of the Treaty on European Union.
			▲				**Draft report** to the European Council on measures taken in 1996 to tackle the drugs problem and a report on the harmonisation of legislation.
				▲			**Decision** n.102/96 adopting a Community action programme for the years 1996–2000 on the prevention of drug dependence, within the field of public health.
					▲	▲	**Seminar** on Drug Research-related Initiatives in the EU at the Florence University Institute organised by the the Commission and the EMCDDA.

Member States committed themselves to cooperate and, where appropriate, to achieve greater coherence between their legal regimes.

▶ The resolution asking Member States to apply among their most severe penal sanctions to serious illicit drug trafficking.

• International action •

Cooperating under the Common Foreign and Security Policy, Member States have increasingly pooled their diplomatic efforts, using the weight of the Union to reinforce their positions in international forums. The aim is to combat production in and trafficking from non-EU countries. EU agreements with these countries now commonly incorporate a standard anti-trafficking clause.

Coordination

In 1996 cooperation with a range of international organisations intensified. The Commission participated:

▶ in the annual session of the United Nations' Commission on Narcotic Drugs, which resolved to prevent diversion of chemical precursors and to prepare for an extraordinary session of the UN General Assembly 1998 on the drugs problem;

▶ in the two regular meetings of the Dublin Group, an informal forum for exchanging information on international anti-drug initiatives;

▶ in the Pompidou Group's preparations for the Inter-ministerial Pan-European Conference in 1997;

▶ as an observer in a meeting of the Inter-American Drug Abuse Control Commission.

Agreements with non-EU countries

The Florence summit designated three regions as priorities for common action through bilateral and multilateral agreements: Latin America/Caribbean; Central and Eastern Europe; and Russia. Dialogue and consultation with the USA and Canada on matters of common interest were also priorities.

Countries bordering the EU territory in Central and Eastern Europe and the Baltic (CEEC) are an obvious priority for international action – partly as buffer to drug incursions from outside the EU, and partly to prepare those nations for future EU membership (see Phare • Preparing for EU expansion, page 110).

Also in Florence, the European Council agreed that TACIS, a programme of technical assistance to nations of the former Soviet Union, should be oriented to fight organised crime and strengthen economic cooperation and regional development. To help guide this work the Commission approved funding for a study in 1997 to identify the potential for cooperation in Justice and Home Affairs between the EC and individual countries or the region as a whole.

The first Asia-Europe Meeting in March saw the fight against drugs as a serious challenge to be addressed through cooperation between Asian and European administrations. Japan and China were delegated to take the lead on customs cooperation and procedures. Both sides at the EU-Japan summit in September reaffirmed their intention to work together against international organised (including drug-related) crime and to enhance customs cooperation. An agreement for trade and cooperation between

the EC and South Korea included commitments to counter illicit drug production and supply, diversion of precursor chemicals and money laundering, and to promote demand reduction.

In July the European Council adopted a regulation on financial and technical measures to accompany reform of economic and social structures in the framework of the Euro-Mediterranean partnership. Support can be provided for cooperation and technical assistance to reduce drug trafficking.

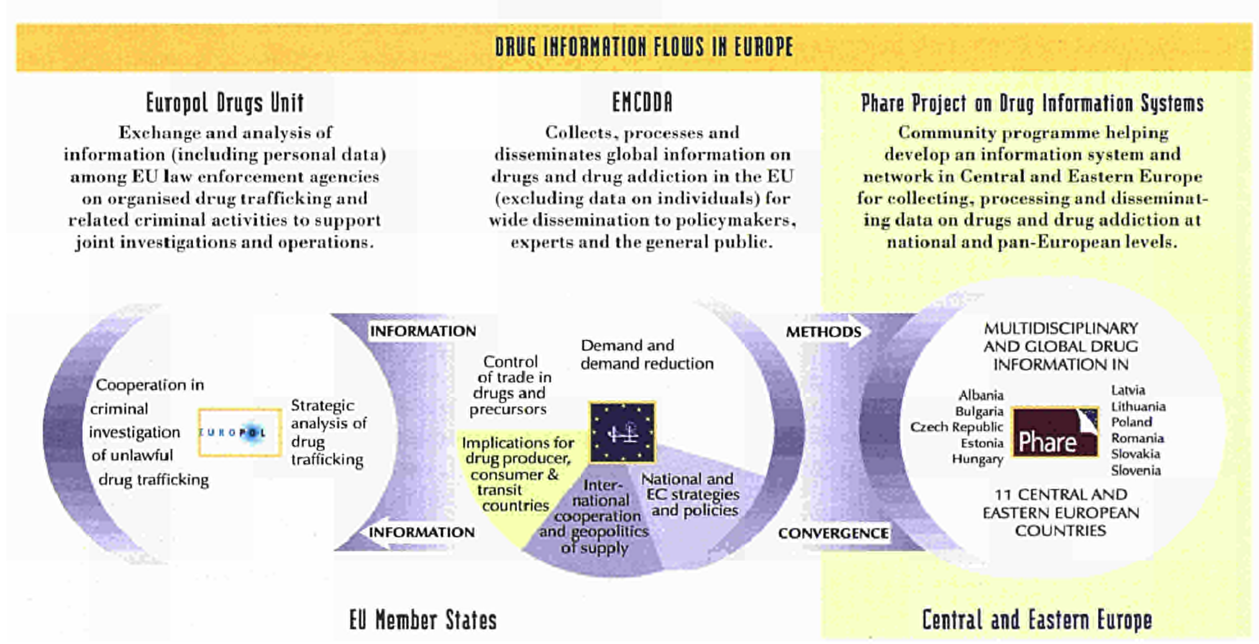
A priority of the EU's Common Foreign and Security Policy is to help countries in Latin America eradicate illicit drug production and trafficking. Political dialogue was enriched when the EU/Rio Group meeting underlined the shared responsibility of EU and South American states in the fight against drugs, a position reiterated during the Florence summit. After that meeting a global cooperation strategy was established, split into six areas: reinforcing relevant institutions; prevention; supply reduction; enforcement; combating trafficking and money laundering; regional cooperation.

The first EC-US working group meeting on drugs control cooperation in the African, Caribbean and Pacific (ACP) countries party to the Lomé Convention took place in December. The Commission also decided to offer technical assistance to the South African Development Community for a regional action plan against drugs and is implementing a five-year programme in line with the European Council's recommendations related to the Regional Plan of Action on Drugs Control Cooperation in the Caribbean. Similarly, a four-year regional drugs control programme supporting the 16 West African nations was approved in December and is now being launched.

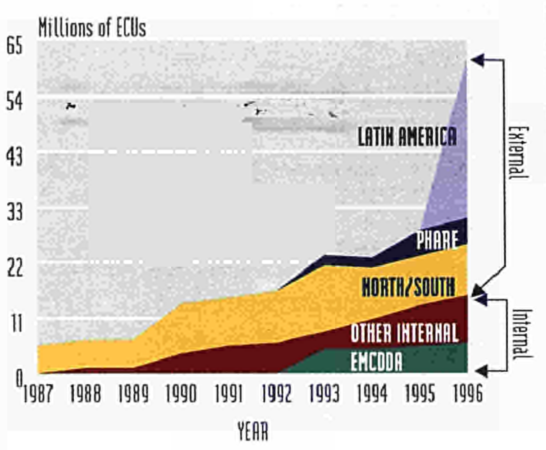
A joint report to the EU-US summit noted significant advances in anti-drugs cooperation. The EU and the USA are working together in the Caribbean on reinforcing law enforcement and institutional capabilities, marine interdiction, training and information sharing. Cooperation increased over money laundering and police and customs issues, and an agreement on precursor control is imminent. The EU-US summit also agreed to address synthetic drugs and to strengthen the Dublin Group. An EU-Canada action plan committed the parties to enhancing the effectiveness of the Dublin Group, to seek agreement in 1997 on combating the diversion of precursors and to coordinate their counter-narcotics assistance programmes in the Caribbean.

Special topics

To extend control over precursors and other chemicals, the Commission reinforced its international profile through organising conferences and seminars with other countries and international organisations. An agreement with Mexico was signed and one with the USA was near conclusion. The Commission continued to include anti-laundering clauses in agreements with non-EU countries, in line with recommendations from the Financial Action Task Force.



In 1996 ten budget lines supported EU action to combat drugs, five on projects within the Union and five externally (see table 5). Of the total of over 61 million ECUs, 75% was spent outside the EU. The relatively high number of budget lines, each corresponding to relatively small amounts, suggests that a rationalisation of the EU drug budget might be promoted to reinforce synergies and cost-effectiveness and to reduce existing and/or potential duplication in the light of the political priorities set by the EU.



EU anti-drug spending since 1987 has totalled nearly 200 million ECUs

Based on table 4

• Internal funding •

Internal spending totalled over 15 million ECUs, under the following headings.

Health aspects related to drug abuse

Funding related to the public health aspects of the drugs problem absorbed 6.5m ECUs. Of the 33 projects funded, at least 10 involved organisations from all 15 Member States; nearly half involved more than ten. They focused mainly on joint activities and cooperation, including:

- prevention tools targeting ethnic minorities;
- exchange of experience on peer support;
- training for professionals in contact with young people (teachers, social workers) and addicts (including law enforcement sector);
- evaluation of methadone programmes;
- regional cross-border exchanges concerning local initiatives (eg, health aspects of drug tourism) and between cities (eg, responses to synthetic drugs).

Priority was given to projects aiming to reinforce transnational cooperation through joint activities and exchange of experiences and information – 52% of all projects – and to those implemented by European networks of professionals. The latter together involved at least ten states and constituted 47% of all projects. Fostering well-organised European professional networks is seen as creating potentially important partners for next year's implementation of the prevention programme agreed in 1996.

In mid-1996 one ECU was equivalent to:
13.47 Austrian schilling
39.35 Belgian francs
7.39 Danish kroner
5.90 Finnish markka
6.48 French francs
1.91 German marks
302.25 Greek drachmas
0.79 Irish pounds
1937 Italian lire
39.35 Luxembourg francs
2.14 Dutch guilders
197.24 Portuguese escudos
161.06 Spanish pesetas
8.43 Swedish kronor
0.88 UK pounds

Table 4 • A decade of European Community/European Union funding in the drugs field

	TYPE OF ACTION	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	TOTAL
		Millions of ECUs										
INTERNAL	EMCDDA						p.m.	4.800	4.800	5.350	6.008	20.958
INTERNAL	Other internal		1.125	1.125	3.900	5.418	5.973	3.300	5.800	7.999	9.291	43.931
EXTERNAL	North/South programme	5.500	5.500	5.500	9.800	9.450	10.100	13.000	10.000	9.590	10.000	88.440
EXTERNAL	Phare programme							2.000	2.000	5.000	5.000	14.000
EXTERNAL	Latin America cooperation										30.000	30.000
EXTERNAL	Other external										0.980	0.980
	TOTAL	5.500	6.625	6.625	13.700	14.868	16.073	23.100	22.600	27.939	61.279	198.309

Table 5 • EU budget lines supporting action on drugs in 1996

	SUBJECT	BUDGET LINE	ECUs
1	**INTERNAL**		
1,1	**Health aspects related to drug abuse**	B3-4302	**6,500,000**
	Tools and methods for specific target groups		1,170,000
	Guidelines on prevention focusing on youth		845,000
	Reduction of risks associated with drug use		845,000
	Identification of data		650,000
	Risk factors associated with drug use		585,000
	Training		585,000
	Research strategy		455,000
	Public awareness-raising		325,000
	Exchange on local initiatives		325,000
	Relapse prevention		260,000
	Coordination of actors in the field of education		260,000
	Distribution of data		195,000
1,2	**Measures to combat drug abuse**	B3-440	**2,000,000**
1,3	**EMCDDA**[1]	B3-441	**6,008,000**
1,4	**Cooperation in the fields of Justice and Home Affairs**[2]	B5-800	**41,198**
1,5	**IDA (drug network) – telecommunications programme**	B5-7210	**750,000**
	TOTAL INTERNAL		**15,299,198**
2	**EXTERNAL**		
2,1	**North–South cooperation in the field of drugs and drug addiction**	B7-6210	**10,000,000**
2,2	**Financial and technical cooperation with Latin American countries**	B7-310	**30,000,000**
2,3	**Europol Drugs Unit**[3]	B5-801	**3,750,000**
2,4	**Phare multi-country programme**	B7-5000	**5,000,000**
2,5	**EDF Development cooperation – Lomé Convention**	EDF	**980,000**
	TOTAL EXTERNAL		**45,980,000**
	TOTAL SPENDING		**61,279,198**

1. Of which 2,688,000 ECUs is the operational budget.
2. Amount spent from budgeted 5,500,000 ECUs.
3. Community funding only. Held in reserve in 1996 so excluded from total.

Measures to combat drug abuse

A budget line of 2m ECUs supported implementation of the EU's Third Action Plan to Combat Drugs. The plan encompasses supply and demand reduction, international cooperation and cross-sector ('horizontal') coordination involving multidisciplinary issues. However, other Community resources fund demand reduction and international cooperation so the budget focused on supply reduction (69%) and horizontal issues (31%).

Supply reduction projects extended implementation of Community law on precursor control (1,320,000 ECUs), for example, by training officials, organising international meetings, and developing networks and databases to underpin rapid information exchange. 60,000 ECUs were allocated to combat money laundering including 25,000 ECUs for the Financial Action Task Force which provides technical aid in implementing the relevant directive.

The horizontal funding (620,000 ECUs) advanced research, training and information. Examples included the Irish Presidency's Conference on EC Drugs Policy and the joint EC-EMCDDA academic seminar on drugs research.

EMCDDA

The EMCDDA is mandated to provide the EU and its Member States with information on drugs and drug addiction. Its budget of about 6m ECUs in 1996 supported the studies, surveys, consultations, training and meetings which facilitate data analysis and exchange of information between officials, researchers and experts, the results of which are then disseminated to policymakers, professionals and the general public (see Annexe 2).

High point of the year was the publication of the first Annual Report on the State of the Drugs Problem in the European Union which will become a major feature of the Centre's work and its main institutional product. Experience gained in the compilation of this report led to new reporting structures for 1997 to ensure greater reliability and comparability of information. Considerable effort went into identifying and implementing relevant indicators and methodologies ready for this, the current report. The Centre also produced scientific and technical studies as well as its 1995 Report of Activities and the bi-monthly newsletter, DrugNet Europe.

The EMCDDA is carrying out scientific work allowing it to clarify the issues involved in the spread of new synthetic drugs and the harmonisation of

legislation, facilitating decision-making at the level of Member States and the institutional bodies of the European Union.

Justice and Home Affairs cooperation

To rationalise expenditure under this heading (which is not exclusively devoted to drugs), in 1996 the European Council adopted four multi-annual programmes mainly intended to foster cooperation between Member States' law enforcement bodies and practitioners. Due to late transfer of the budgeted 5,500,000 ECUs, spending in 1996 was just 41,198 ECUs.

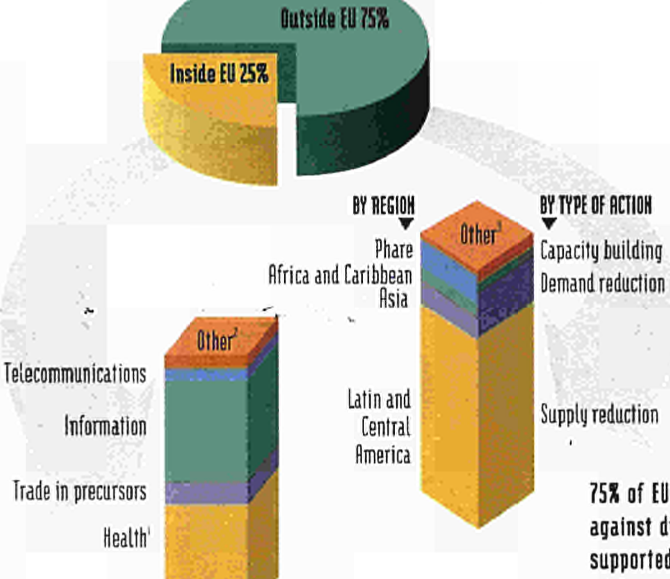
IDA drug network (telecommunications)

The IDA-Drug Network Project aims to upgrade the EMCDDA-REITOX computer network to facilitate transfer of data on drugs between Member States and the EMCDDA. In 1996 750,000 ECUs were allocated to implement the project during 1997. This network is one of several IDA (Interchange of Data between Administrations) programmes in various areas, each with a three-year life span.

Analysis of internal spending

At just over 15 million ECUs, the EU's internal anti-drug budgets are a modest investment but one capable of exerting leverage in upgrading its Member States' anti-drug capacities. Networking and mutual learning underpinned by the funding extend the impact of the much greater total spending of EU nations, making the most of their experiences. In 1996 the key development was a decisive increase in funding for demand reduction, reflecting the EU's policy priorities, which themselves reflect the ambitions of populations affected by drug problems. Of over 15 million ECUs, 42% were allocated to health-related programmes, 70% up on 1995 when health spending amounted to just 29% of all internal spending. In contrast, supply reduction spending was 29% down on 1995 and just 13% of the internal budget.

Though slightly up in amount, in both 1995 and 1996 spending on information in the form of EMCDDA represented about 40% all internal spending – recognition that without a steady investment in good information, other more directly anti-drug programmes risk being misdirected and ineffective. However, in 1996 the operational element (2.688m ECUs) was just 18% of the total. Spending in 1996 on the drug-related telecommunications network was less than 60% of the year before and just under 5% of all internal spending.



75% of EU funding against drugs in 1996 supported cooperation with non-EU nations

Based partly on table 5

1. Includes cross-sector projects, anti-money laundering and cooperation in the fields of Justice and Home Affairs.

2. Includes identification and dissemination of data

3. By region: includes Mediterranean and multi-region or coordinating projects.
By type of action: includes cross-sector projects and information.

• External funding •

North-South cooperation

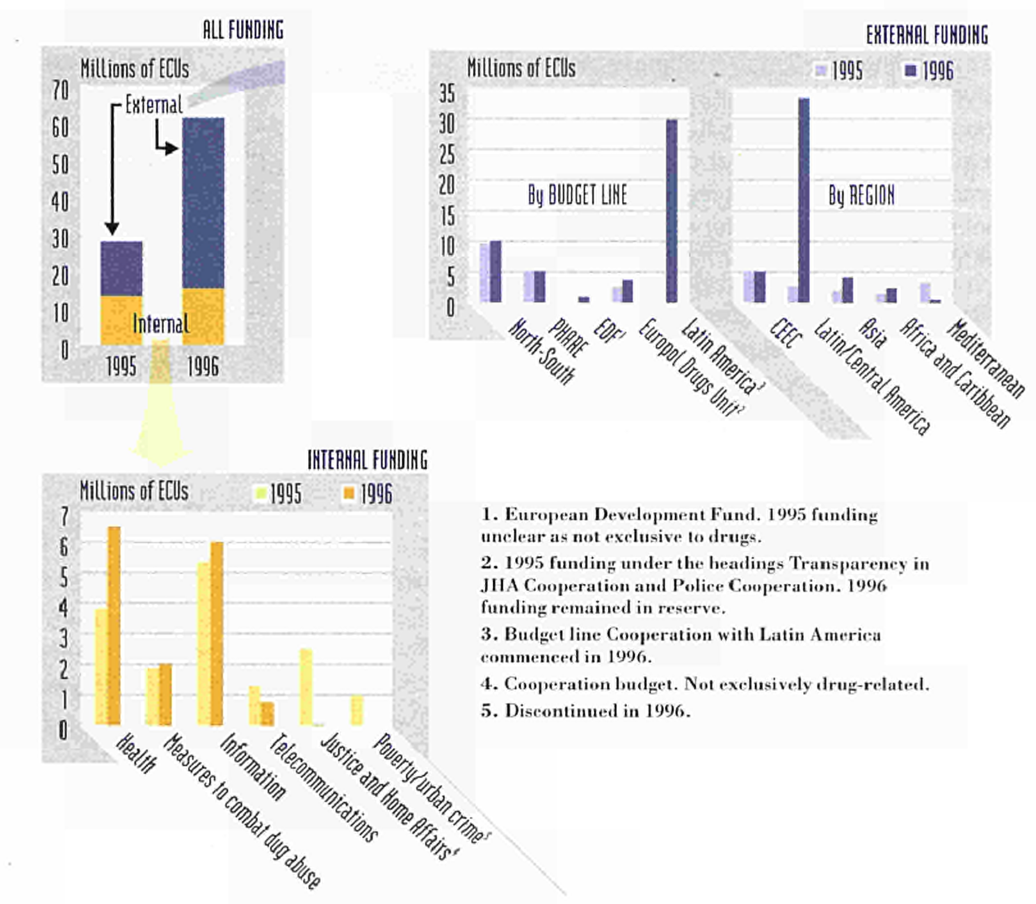
Under this heading the European Community directly funds anti-drug activities in the developing world and supports international bodies with similar objectives. With the advent of a separate budget for this region (see below), at 34% of the 10m ECU budget line, Latin/Central America is no longer the top region, being exceeded by projects in Asia (42% of budget line). As with spending inside the EU, demand reduction in the form of prevention, treatment and rehabilitation absorbed most of the funding (61%). Supply reduction projects took another quarter to fund crop substitution and precursor controls; a further 13% bolstered institutional capacity in Africa and the Caribbean. Non-governmental organisations were the recipients of nearly half the budget, mainly for their demand reduction work. About a third went to official bodies and 18% to the United Nations Drug Control Programme (down from 25% between 1987 and 1995); another 4% went to UNESCO and the Council of Europe.

Lomé Convention and Latin America

Also concerned with aid to developing nations, from the Lomé Convention budget the European Development Fund allocated 980,000 ECUs for drug-related projects in Africa and the Caribbean. UNDCP was the main partner responsible for the implementation of capacity building (54% of the budget) and drug demand reduction projects (46%).

The budget supporting cooperation with Latin America allows funding of macroeconomic and sec-

Between 1995 and 1996 EU anti-drug spending doubled to over 60m ECUs, largely due to new spending in Latin America. Some budget lines were discontinued though ongoing expenditure was generally maintained or increased



1. European Development Fund. 1995 funding unclear as not exclusive to drugs.
2. 1995 funding under the headings Transparency in JHA Cooperation and Police Cooperation. 1996 funding remained in reserve.
3. Budget line Cooperation with Latin America commenced in 1996.
4. Cooperation budget. Not exclusively drug-related.
5. Discontinued in 1996.

torial development projects, including those against drug trafficking. In 1996 the entire budget, 30m ECUs, was pledged to Bolivia for crop eradication and substitution programmes.

Europol Drugs Unit

The EDU budget line was created in 1996 to encourage agreements with the countries of Central and Eastern Europe. The aim was to evaluate problems at the EU's external borders and then address these within the available resources. The budgeted 3.75m ECUs of Community funding remained in reserve so no actions were funded.

Phare

The main objective of the Phare Multi-Country Programme on Drugs is to prepare associated countries to be in line with the EU Action Plan to Combat Drugs (1995–1999) and with Member States' drugs policies. The methods and proportions of this key programme are dealt with in the panel Phare • Preparing for EU expansion on page 110.

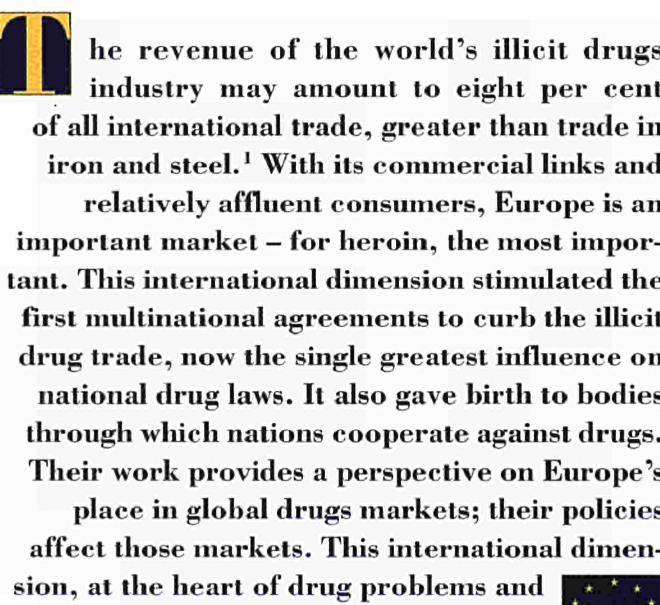
Analysis of external spending

In 1996 European Community support for drug-related projects outside the EU totalled nearly 46m ECUs, over three times the 1995 external spend and 65% more than the total spend in 1995. Of this, 65% was allocated to crop substitution in Bolivia, reflecting European concern over cocaine and crack; the remainder supported demand reduction, reinforced states' institutional infrastructure, helped finance UNDCP's programme of national master plans to combat drugs, addressed precursor diversion, and upgraded the drug control systems of countries bordering the EU in Central and Eastern Europe.

CHAPTER 6

The international environment

The revenue of the world's illicit drugs industry may amount to eight per cent of all international trade, greater than trade in iron and steel.[1] With its commercial links and relatively affluent consumers, Europe is an important market – for heroin, the most important. This international dimension stimulated the first multinational agreements to curb the illicit drug trade, now the single greatest influence on national drug laws. It also gave birth to bodies through which nations cooperate against drugs. Their work provides a perspective on Europe's place in global drugs markets; their policies affect those markets. This international dimension, at the heart of drug problems and of responses to those problems, is explored in the following pages.



In one sense the control of drug misuse is, in national terms, an intensely individual endeavour, tied closely to a culture's traditions and national lifestyle. Today, even within the European family, one nation may be proud of its tolerance to certain forms of drug misuse and another equally proud of its refusal to compromise. What nearly all have shared over the last century is a primary reliance on penal measures and attempts to curb supply. Especially with respect to the latter, the limits of a national approach became apparent in the early years of this century and nations began to make agreements to support each others' efforts. In the post-World War II era the most important of these have been United Nations conventions, international legal instruments which bind participating nations to adapt their national policies and legislation to form a common international approach to an international phenomenon.

Sometimes linked to these agreements, but often independently organised, other international agreements and organisations have sought to take or stimulate action against drugs. Among these is the European Union, whose work is taken forward partly by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). In turn that centre has six priority international partners, which include the key bodies involved in European or global anti-drug cooperation.

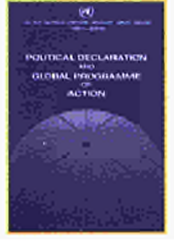
These two international dimensions – the legal and the operational – are the subjects of the major sections of this chapter. With respect to the first, the aim is to outline the international legal framework which now so heavily influences national laws and policies (see chapter 4). With respect to the second, the main aim is to gain a global perspective on Europe's position in world illegal drug markets.

The framework of international law

Today's international legal framework for drug control is largely composed of three major United Nations conventions. Essentially these codify the efforts of the international community to contain use of certain drugs to medical and scientific purposes. Nations may agree to these treaties but are not considered to have ratified them until the provisions are incorporated into and implemented in their national laws. The main treaties are:

- the Single Convention on Narcotic Drugs agreed in 1961 and amended in 1972;
- the Convention on Psychotropic Substances adopted in 1971;
- the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances adopted in 1988.

Deeply alarmed at mounting drug misuse, in 1990 the UN General Assembly declared 1991–2000 the Decade Against Drug Abuse. Demand reduction was a priority in its global programme



The Single Convention on Narcotic Drugs

As its name implies, the 'Single' Convention of 1961 aimed to incorporate and simplify existing international agreements. Its other objectives were to streamline the international drug control machinery and to extend controls to cultivation of the raw plant material for drug production.

All 15 European Union Member States are among the 158 countries to have ratified the convention (see table 1). The drugs it controls (mainly opiate-type drugs and coca and cannabis derivatives) were divided into four schedules subject to varying degrees of control. Common to all four is that supply and possession of these drugs is to be regulated to confine their use to authorised medical and scientific purposes. Penal provisions are foreseen if the laws are contravened, balanced by demand reduction measures in the prevention, education, treatment and rehabilitation sectors.

The treaty created the International Narcotics Control Board (INCB) to collate the parties' legal drug requirements and to monitor legitimate trade. An amending protocol agreed in 1972 called for increased efforts to prevent illicit drug production, trafficking and use, and highlighted the need to provide treatment and rehabilitation, including using these as an alternative to imprisonment.

The Convention on Psychotropic Substances

In the 1960s pharmaceutical technology and youth culture combined to create concern over the non-medical use of substances not covered by the 1961 convention, most with legitimate medical uses. In 1971 the international response came in the form of the Convention on Psychotropic Substances. By

KEY POINTS

▶ Since the beginning of this century nations have set up international instruments binding them to adapt their own national policies and laws relating to drug misuse in order to create a common legal approach, combating an international phenomenon with international measures.

▶ The current international legal framework mainly derives from three United Nations drug control treaties:
- the Single Convention on Narcotic Drugs of 1961 (amended in 1972);
- the Convention on Psychotropic Substances of 1971;
- the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

▶ The core objective of the first two of these treaties was to confine use of listed drugs to approved medical and scientific purposes. The third sought to strengthen international cooperation to combat illicit trafficking. All 15 EU nations have ratified the first two of the conventions and all plus the European Community itself have at least signed the anti-trafficking convention.

▶ The need for international cooperation in information provision was recognised by the European Community when it stipulated six priority international partners for the EMCDDA:
- the United Nations International Drug Control Programme (UNDCP);
- the World Health Organisation (WHO);
- the International Criminal Police Organisation (ICPO or Interpol);
- the European Police Office (Europol);
- the Pompidou Group of the Council of Europe;
- the World Customs Organisation (WCO).

A synthesis of some of their latest reports provides a perspective on Europe's position in global illegal drug markets.

▶ EU Members States are primarily recipient countries for drugs. However, most are also transit countries, some are now significant producers of synthetic drugs and a few act as secondary distribution points.

▶ Highly developed international trade and transportation systems combined with geographical, cultural, historic and economic factors affect the role of individual Member States as entry points and transit zones. Large seaports in Germany, the Netherlands, the UK and Belgium make these countries vulnerable to the smuggling of major consignments in legitimate container-transported freight. Linguistic and historic ties influence the role of Spain and Portugal as entry points for South American cocaine.

▶ The vast majority of heroin seized in the EU originates from South West Asia before being transported mainly by lorries starting in Turkey and traversing neighbouring Balkan states. The creation of depots in Central and Eastern European countries has led to a shift to a two-stage smuggling pattern with lorries transferring their loads to private cars at these depots for delivery mainly to Turkish networks in EU Member States.

▶ The proliferation of road frontier crossing points, diversification of trafficking gangs and networks, the use of air transport and the increasing involvement of traffickers and couriers of different nationalities make enforcement increasingly difficult.

▶ The European Union remains in 1996 a major market for cocaine, second only to the USA. Morocco and Colombia remain the main providers of cannabis derivatives for the EU markets, the first of resin (hashish), the second of herbal cannabis (marijuana). Indoor cultivation within the EU is now important in European cannabis markets.

▶ The European Union has become one of the world's major illicit production regions for amphetamine-type stimulants. Increasingly these and other synthetic drugs are being exported by Central and Eastern European countries and Baltic States.

Published in 1996, UNDCP's analysis of trends in the illicit trafficking and use of stimulants such as amphetamine and ecstasy confirms Europe's role as a manufacturing region

1996 146 countries had ratified the treaty, including 14 EU Member States. Austria is ratifying this year. The convention adopted the objectives and framework introduced in 1961. Its schedules classified substances such as amphetamine-type stimulants, hallucinogens, barbiturates and tranquillisers depending on whether they were judged: very harmful with no medical uses; harmful but with medical uses; and less harmful with substantial medical uses. As before, INCB is mandated to monitor licit trade.

• The Convention against Illicit Traffic •

In 1988 the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances targeted the growing threat of international trafficking by strengthening cooperation between customs, police and judicial authorities. Enforcement agencies were encouraged to establish and maintain channels of communication enabling exchange of information on suspected traffickers, backed by measures (such as extradition and mutual legal assistance) to ensure that offenders cannot shelter behind national borders. The convention also provides for new legal powers and enforcement tools to enable the monitoring and control of precursor chemicals used to produce drugs, to combat money laundering and to confiscate the proceeds of drug trafficking. Parties are called on to implement modern enforcement techniques, such as 'controlled delivery' of illegal drug shipments under police surveillance.

Among the 140 countries to have ratified the convention up to 1996 were 13 EU Member States. Unusually, the European Community is itself a party to the convention because measures to control precursors affect the European Union's (EU) internal market policy. On 8 June 1989 the European Economic Community signed the treaty and the EEC Council ratified it on 22 October 1990.

EUROPE IN WORLD ILLEGAL DRUG MARKETS

Here we draw on the work of the EMCDDA's international partners (see panel on page 127) and other bodies to gain a perspective on the role played by Europe in global illicit drug markets. Europol's contribution summarises international trends in drug smuggling to EU consumers. Selected texts from the World Customs Organisation (WCO) and Interpol analyse the supply of heroin into the EU. INCB's 1996 report outlined the main features of drug use trends on the continent of Europe. Also of value is the USA's International Narcotics Control Strategy Report which identifies (from the US perspective) nations seen as major drug production or transit countries. Where appropriate the main policy concerns of these bodies are described in so far as they relate to European concerns.

Cocaine growing and trafficking routes in 1995 centred on the Caribbean, with Europe a major target

UNDCP. *World Drug Report*. 1997

The Caribbean problem

At the request of the European Commission, in April 1996 a group of experts produced their report on *The Caribbean and the Drugs Problem*.[10] It underlines the Commission's awareness of the region's vulnerability to the drug phenomenon, in particular the potential for powerful drug cartels to corrupt democratic institutions. Recommendations include better coordination at all levels and the report makes proposals in the fields of law enforcement, information and intelligence, the harmonisation of legislations, networking of judicial systems, measures against money laundering, control of precursors, and demand reduction activities.

• EUROPOL •
New openings for traffickers

Europol's contribution for this report reminds us that EU Members States are primarily recipient/consumer countries for drugs. However, most are also transit countries, some are now producers and a few act as staging posts for drugs originating elsewhere ('secondary distribution'). The roles of different states as points of entry and transit routes depend largely on their place in Europe's highly developed international trade and transportation systems and on geographical, cultural, historic and economic factors which may facilitate trading links with drug producing nations. Many EU countries also legally

produce and export chemicals which may be diverted to serve as precursors in the manufacture of illicit drugs outside the EU's borders.

Europol stresses that the criminal organisations which dominate drug trafficking find in Europe a developing market, as flexible smuggling routes and methods take advantage of the abolition of internal border controls and the expansion of consumer demand for certain types of drugs. In this respect Europol's Drugs Unit concentrates on heroin, cocaine, synthetic drugs, and cannabis.

New heroin depots

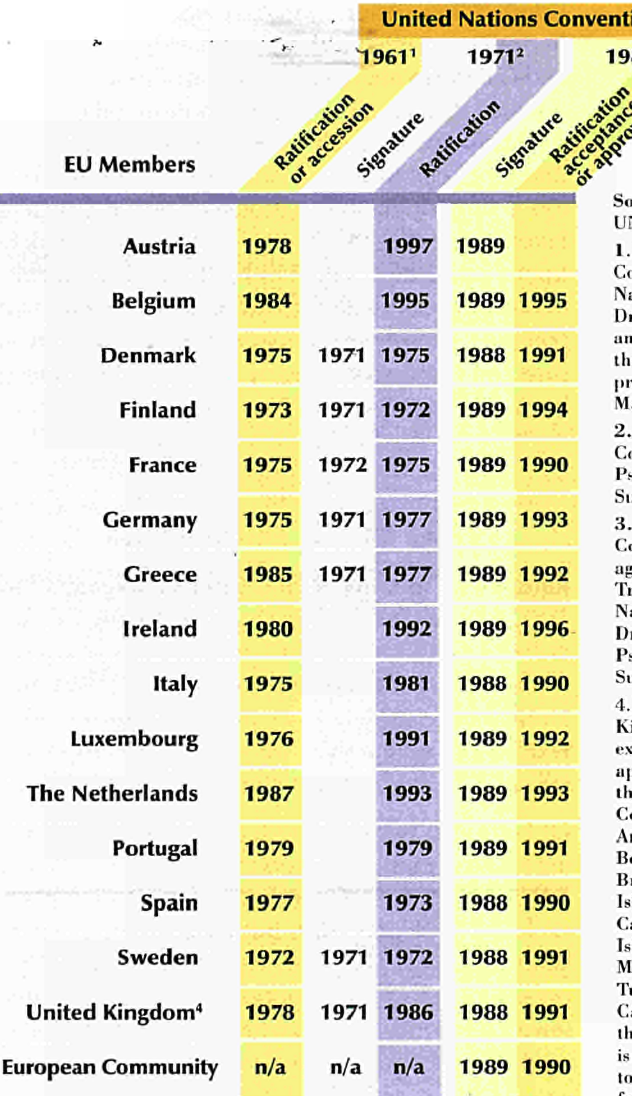
The vast majority of heroin seized in the EU originates from South West Asia before being transported to Member States mainly by TIR[2] lorries traversing the various Balkan routes. Classically these involve entry points in Bulgaria, Romania and Hungary, but (see WCO section below) there has been diversification. However, EDU experts say new depots in Central and Eastern Europe have led to a shift in smuggling patterns.

Starting in Turkey, TIR lorries deposit large consignments of heroin at these depots which European nationals relay in private cars mainly to Turkish networks in EU Member States. Intelligence suggests these networks are linked in a partnership covering almost the entire territory of the Union. In addition, drug smuggling networks consisting of Kosovo Albanians and emigrants from the former Yugoslav Republic of Macedonia have settled in Denmark, Sweden, Austria, Italy and Germany.

Cocaine routes from South America

The European Union's cocaine market is second only to that of the United States. Coca cultivated in Latin America transits through Venezuela, Brazil, Panama, Argentina, Ecuador and Surinam. Located between these and European cocaine markets, the Caribbean has become an important staging post (see The Caribbean problem). Importation into the EU is dominated by Colombian criminals groups. Large seaports in Germany, the Netherlands, the UK and Belgium render these vulnerable to major consignments smuggled in legitimate container-transported sea freight. Linguistic and historic ties to South America influence the role of Spain and Portugal as points of entry. Limited consumer markets in Denmark, Sweden and Finland make these less attractive to Colombian networks, but consumer markets are growing in Central and Eastern Europe.

Table 1 • Adherence to UN Conventions by EU Member States



	United Nations Conventions				
	1961[1]	1971[2]		1988[3]	
EU Members	Ratification or accession	Signature	Ratification	Signature	Ratification acceptance or approval
Austria	1978		1997	1989	
Belgium	1984		1995	1989	1995
Denmark	1975	1971	1975	1988	1991
Finland	1973	1971	1972	1989	1994
France	1975	1972	1975	1989	1990
Germany	1975	1971	1977	1989	1993
Greece	1985	1971	1977	1989	1992
Ireland	1980		1992	1989	1996
Italy	1975		1981	1988	1990
Luxembourg	1976		1991	1989	1992
The Netherlands	1987		1993	1989	1993
Portugal	1979		1979	1989	1991
Spain	1977		1973	1988	1990
Sweden	1972	1971	1972	1988	1991
United Kingdom[4]	1978	1971	1986	1988	1991
European Community	n/a	n/a	n/a	1989	1990

Source: UNDCP

1. The Single Convention on Narcotic Drugs as amended by the 1972 protocol of 25 March 1972.
2. The Convention on Psychotropic Substances.
3. The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.
4. The United Kingdom has extended the application of the 1988 Convention to Anguilla, Bermuda, the British Virgin Islands, the Cayman Islands, Monserrat, Turks and Caicos Island; the convention is also applied to Hong Kong from 1997.

Synthetic drugs from the East

The European Union has become one of the world's major production regions for amphetamines and ecstasy-type stimulants. Privatisation of the chemical and pharmaceutical industries of Central and Eastern Europe and the Baltic states has led to unemployment or salary cuts for those nations' chemists, some of whom have diversified into illicit drug production. Increasingly exports from these regions are entering the EU, in particular, Germany, Denmark, Sweden and Finland (see chapter 3).

Cannabis production diversifies

Massive seizures confirm that cannabis is still the prime illicit drug of abuse in the European Union. Morocco is the main source. Another important region is the Golden Crescent (Afghanistan, Iran and Pakistan), from whence large consignments are transported by sea or overland via Balkan routes. Nigeria and Colombia are major suppliers of herbal cannabis, the latter mainly in containers destined for large container ports such as Rotterdam, Hamburg, Bremen, Felixstowe and Antwerp. Southern Africa too is developing into a producer region targeting European markets. Major cannabis traffickers mainly from the UK, the Netherlands, Italy and Spain control transport through EU states into their respective countries, delivering cannabis overland in lorries, vans and private cars, and by sea in trawlers, sailing boats and yachts.

• WCO •
Focus on the 'Balkan routes'

Information from the World Customs Organisation (WCO) focused on heroin smuggling along the so-called Balkan routes from Turkey via neighbouring states in South-eastern Europe. Between 1991 and 1995 WCO recorded 7541 heroin seizures worldwide; more than a third were made in Europe, totalling 2751 seizures netting 29,562 kg of heroin.

Of European seizures, 1065 (see table 2) accounting for nearly three-quarters by weight were classed as traversing Balkan routes, a classification which excluded secondary distribution from the Netherlands. The chart opposite illustrates the persisting pre-eminence of these routes but the routes themselves, the personnel and what happens along them are becoming increasingly diversified. The prolifera-

tion of road frontier crossing points and of trafficking gangs and networks, the use of air transport and the increasingly varied nationalities of traffickers and couriers make control more difficult, placing a premium on cooperation between authorities in Western and Eastern Europe.

For Western Europe, Turkey is the key to the Balkan routes, and here heroin seizures increased in 1995. Out of 3625 kg seized in 207 seizures, 1187 kg was intercepted in Turkey.[3] In 1995 a fourfold increase in the quantity of heroin seized (to 956 kg) placed the United Kingdom at the top of the European heroin seizure table, but Germany (516 kg) and the Netherlands (212 kg) remain the main hubs for trafficking to Western Europe from the Balkans. Increasingly Southern Europe is also becoming affected by Balkan-route heroin: seizures increased in Italy, Greece and Spain.

Since the break up of the Soviet Union in 1991 Eastern and Central Europe have become favoured transit routes for drugs on their way to Western Europe. As with the Balkan routes, their role is not confined to transit but extends to drug storage warehouses and illicit laboratories, particularly for the production of synthetic drugs. These nations now also offer a potential market for the products routed through them.

• INTERPOL•
Europe is world heroin target

Interpol records unprecedented production of illicit drugs in 1996: "The drug trade remained as lucrative as ever and traffickers continued to diversify their products and develop new markets." Four major reports from Interpol were drawn on for this chapter,[4] which focuses on the extra information they provide about heroin supply to EU countries.

Interpol identifies three phases in sourcing of morphine then heroin for consumption in Europe:

- in the early 1970s Turkey was the main source;
- Laos, Burma, Thailand (the Golden Triangle) dominate the ten years from 1975–1985;
- since then the Golden Crescent region of South West Asia has been and remains the major source.

Within this last phase, from 1987 heroin trafficking patterns altered radically to multi-kilogram quantities moving west from the producing areas of Afghanistan and Pakistan via Iran and then Turkey.

Heroin found in a lorry exiting Turkey via a Balkan route

WCO. *Customs and drugs 1995*. 1996

Traversing the overland route, opium, morphine and heroin enter eastern Turkey to be picked up from collection centres controlled by Turkish criminal groups and transported in vehicles to Istanbul for shipment to Western Europe.

Afghanistan remains the world's major producer of illicit opium, accounting for 2500 to 3000 metric tons[5] in 1995. Torn by civil strife, its agricultural economy in ruins, opium continues to be a valuable cash crop for farmers in eight of Afghanistan's 21 provinces. Iranian authorities reported to Interpol that an estimated 100,000 kg of morphine (equivalent 10,000 kg of heroin) are produced yearly in the Helmand/Nimroz provinces. In Pakistan, the North-West Frontier province bordering Afghanistan and the roads into Iran continue to evade drug enforcement efforts, while Karachi's harbour and the airports of Lahore and Islamabad remain active relay points for smuggling into Europe and Africa.

• UNITED NATIONS •
The Narcotics Control Board report

Annually the UN's International Narcotics Control Board reports on the drug control situation across the world. Its 1996 report[6] underlined the importance of international cooperation against drug trafficking based on the mutual legal assistance and extradition provisions of the 1988 Convention. Anti-money laundering measures are seen as a key weapon in the fight against trafficking organisations. The board called on governments to upgrade the efficiency of their criminal justice systems, pointing out that the special session of the UN General Assembly on drug control planned for 1998 will be an opportunity to determine good practice in this sector. To provide a sounder basis for drug policies, INCB asked the governments of EU Member States "to harmonise data collection and evaluation at the European level within the framework of the European Monitoring Centre for Drugs and Drug Addiction".

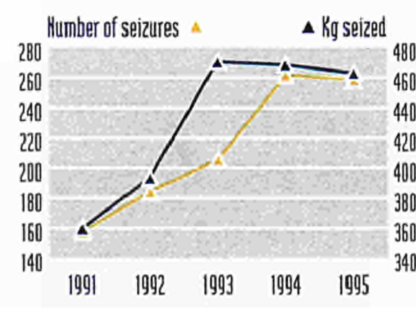
Though primarily a drug consumer, Europe also has its illicit production centres. INCB notes a clear, steady increase in illicit traffic in, and abuse of, synthetic drugs manufactured in clandestine laboratories in Europe. These supply drug markets inside and outside Europe with amphetamines and, above all, with hallucinogenic amphetamines such as ecstasy. Illicit indoor cannabis cultivation in Europe using hydroponics to produce potent varieties is now an important element in Europe's drug markets. Although chemicals used in the illicit manufacture of narcotic drugs are manufactured in many European countries, the INCB notes that only certain of these precursors have been seized and only in a limited number of countries in Western Europe.

Table 2 • Departure point of European heroin seizures 1991-1995

Departure point	Number	kg
Balkan route	1065	21553.91
India	69	235.44
Pakistan	178	761.91
Thailand	88	337.71
Lebanon	41	127.49
West Africa	197	302.37
East Africa	62	68.41
Hong Kong region	32	144.67
South America	2	3.98
Secondary from the Netherlands[1]	334	1398.56
Unknown	683	4627.94
TOTAL	2751	29562.39

Source: WCO Database, 1996

1. An ambiguous category since it does not pinpoint the point of departure of the heroin, which transits mainly through Germany before being despatched to bordering countries (Netherlands, Belgium, France, Denmark, Luxembourg).



Balkan route heroin seizures

Balkan routes have proved of lasting importance as the main way heroin enters Europe

Source: WCO Database, 1996

In the former republics of the Soviet Union forming the Commonwealth of Independent States and, to some extent, in the Baltic states of Estonia, Latvia and Lithuania and in some Central and Eastern European countries, INCB says new socio-economic frameworks demand rapid development of administrative and legal structures to prevent drug-related crime and to ensure more effective border controls. In this respect the EU's Phare programme (see chapter 5) plays an important role.

• UNDCP's first World Drug Report •

In 1997 The United Nations International Drug Control Programme (UNDCP) launched its first World Drug Report.[7] UNDCP identified Asia's Golden Crescent and Golden Triangle regions as the two main opium production areas, stressing that Afghanistan is the main heroin source for Europe, which itself is the world's premier heroin market. The report estimates world opium production in 1996 at 5000 tons, of which a third of is consumed as opium. The remainder is converted to an annual total in the 1990s of roughly 300 tons of heroin, mostly for export.

Globally, UNDCP estimate that around 220,000 hectares[8] were devoted to coca cultivation in 1996, half in Peru and nearly a quarter each in Colombia and Bolivia. The resulting crop of 300,000 tons of coca leaves was sufficient for 1000 tons of cocaine hydrochloride.

The report confirms that Europe's recent experience of a wave of synthetic stimulant use (see chapter 3) is a worldwide phenomenon, seizures increasing ninefold from 1978 to 1993. Ephedrine and pseudoephedrine extracted from the Ephedra plant are precursors for the powerful stimulants methamphetamine and methcathinone. Ephedrine used in illicit laboratories is largely diverted from licit sources feeding the pharmaceutical industry. Between 1990 and 1994 ephedrine's share in global seizures of precursors grew from 13 to 46%. In the 1990s 55% of laboratories detected worldwide as manufacturing ecstasy were located in Europe.

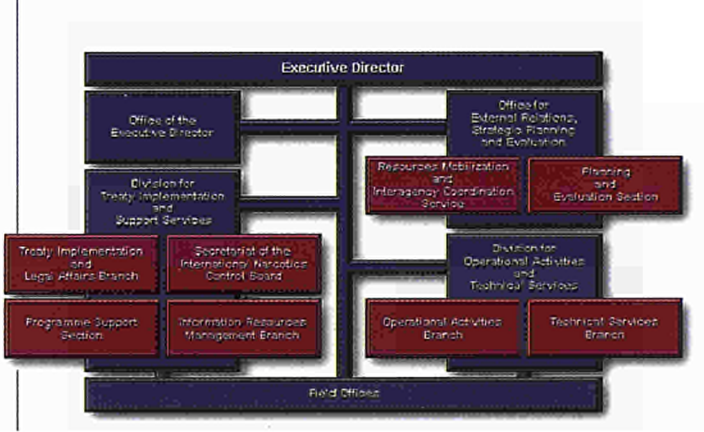
• The USA's INCS report •

Unlike the INCB report, which is an amalgam of perspectives from UN member states, the USA's distinctive national drugs policy agenda shapes its annual report of the Bureau for International Narcotics and Law Enforcement Affairs at the US Department of State.[9] It presents the results of the annual process of assessing ('certifying') the anti-drug performance of drug producing and transit countries in terms of whether they have cooperated with US efforts and/or attempted to comply with the 1988 UN anti-trafficking convention. Denial of certification results in the withdrawal of aid and commercial privileges and commits the US to oppose loans to those counties from multilateral development banks.

In 1996 President Clinton certified the following "major drug producing and/or major drug transit countries or dependent territories": Aruba, the Bahamas, Bolivia, Brazil, Cambodia, China, Dominican Republic, Ecuador, Guatemala, Haiti, Hong Kong, India, Jamaica, Laos, Malaysia, Mexico, Panama, Paraguay, Peru, Taiwan, Thailand, Venezuela and Vietnam. Another six were denied certification: Afghanistan, Burma, Colombia, Iran, Nigeria and Syria.

The USA's prime foreign policy objective in the drugs field is to curb trafficking from Latin America, though South East and Central Asia remain its main sources of heroin. In pursuit of this objective, in 1996 a Peruvian drug syndicate was successfully disrupted and collaboration with the Mexican authorities led to the arrest of the head of the Mexican Gulf cartel. Bolivia signed an extradition treaty with the United States and work started on a treaty with Argentina. For the USA, as for Europe, the Caribbean is a seen as a key staging post and organisational centre for drug trafficking. In 1996 the USA signed eight new extradition treaties with Caribbean nations and also one with France for its Caribbean Départements.

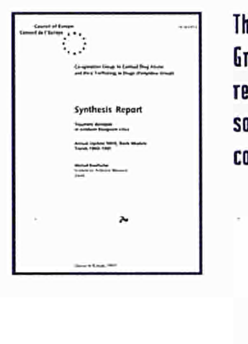
Though the USA remains the world's largest cocaine market, the INCS report emphasises American drug users' growing taste for high purity heroin. The report also bears witness to the international nature of drug trends seen in Europe, noting increasing use



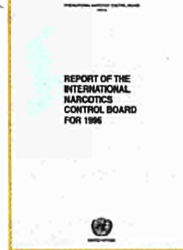
Opposite, UNDCP's structure as displayed on its World Wide Web site

of crack in many countries in Central and South America and the Caribbean. Similarly the report points out that demand for amphetamines generally and for ecstasy in particular has increased in most countries of the developing world as well as in industrialised nations; Mexico is the USA's principal supplier but Poland is among the lesser sources.

Intervening in source regions and combating the first three links of the drug supply chain– cultivation, processing and trafficking – are seen as the most promising anti-trafficking strategies, but ones which, the report comments, demand political will on the part of governments in producer countries and success in the struggle against corruption.



The Pompidou Groups's epidemiological reports are an important source of internationally comparable data



Each year INCB provides a résumé of drug use and trafficking trends across the world

The EMCDDA's international partners

The EMCDDA's founding regulation stipulated six international bodies with which it was to cooperate most closely. Each has its own information collection mechanisms which form the basis for the analyses described in this chapter.

1 **The United Nations International Drug Control Programme** (UNDCP) coordinates all the UN's anti-drug activities. UN drug Conventions oblige signatories to supply information on drug misuse primarily through an annual questionnaire. Replies feed into a database on epidemiology and demand reduction and provide the basis for reports including an annual global report on drug abuse.

2 The Regional Office for Europe of the **World Health Organisation** (WHO-Europe) collects and analyses health data from its member states and has a drug-specific data collection system which extends to legal as well as illegal drugs. Based on this system WHO publishes reports on drugs, tobacco and alcohol in Europe.

3 The **Pompidou Group** is an inter-governmental structure within the Council of Europe which aims to support national policies and programmes on drug misuse and to strengthen European cooperation. Members include (but go well beyond) all 15 EU Member States. Its main information activities are in the field of epidemiology and feature a network of researchers which annually produce a standardised report on drug trends in 15 Western European cities.

4 **Europol's Drugs Unit** (EDU) started work in 1994 as the first phase of Europol, which will provide the European Union with a common body of intelligence on criminal activities and support for joint policing operations. Europol National Units set up in each Member State process requests made to Europol for information or assistance. The EDU is a non-operational body with a remit limited to the exchange of information and the preparation of general situation reports and analyses of criminal activities.

5 **Interpol** aims to encourage cooperation worldwide between police services combating international crime but cannot conduct its own policing operations. In the 1970s it set up a Drugs Subdivision to centralise and analyse data from its member states on drug trafficking. This information is entered in Interpol's database and distributed back to members, mainly in the form of reports providing general analyses of the problem. Regular reports are published on drug trafficking and related statistics and on each major drug.

6 The **World Customs Organisation**'s (WCO) main published information output is an annual global overview of seizures of drugs made by the world's enforcement services. WCO's sophisticated information system includes a database on drug seizures which enables member customs services to target high-risk travellers or routes. It is also the basis for analyses of trafficking trends. The database, accessible electronically and updated monthly, is seen as one of the best global information resources on illicit drug trafficking.

References/notes

1. United Nations International Drug Control Programme. *World drug report*. Oxford: OUP, 1997.

2. The TIR badge signifies that Customs services in a country party to the relevant international agreement have inspected and cleared the contents of a transport vehicle and then sealed it to prevent tampering. Unless there is suspicion of wrongdoing, other nations party to the agreement (including those on the Balkan routes) accept the badge as indicating the vehicle's contents are legal.

3. WCO. *The Balkan route and heroin*. April 1997.

4. These are:
European heroin scene, Balkans: the focus, 1996–1997.
Cannabis trends in Europe.
The 1996 *European situation report on cocaine.*
Psychotropic substances: the European scene – 1996.

5. One metric ton is 1000 kg. All references to tons are metric quantities.

6. International Narcotics Control Board. *Report of the International Narcotics Control Board for 1996*. New York: United Nations, 1997.

7. United Nations International Drug Control Programme, op cit.

8. 10,000 square metres or 2.471 acres.

9. US Department of State Bureau for International Narcotics and Law Enforcement Affairs. *International narcotics control strategy report*. March 1997.

10. EU Expert Group on Drugs. *The Caribbean and the drugs problem*. April 1996.

The drugs described

What follows is a brief description of the main drugs or drug groups misused in the European Union. The intention is to orient readers unfamiliar with some of these substances and to provide a reference point for the findings presented in the main report. This account is neither exhaustive in the substances it covers nor encyclopaedic in the information it gives about each substance – and some of the most important facts are not yet established, disputed, or both. We have attempted to encapsulate the most widely accepted views about the sources, methods of use and effects of the drugs most commonly misused in the European Union. But first the deceptively simple term 'effect' needs to be explored.

• Less an effect, more an interaction •

'Effect' suggests a change reliably imposed by one object on another, with the second object playing the passive role of recipient of the effect – like a moving ball striking a stationary one. This impression could hardly be further from the reality of how drugs and human beings interact. Despite the slang use of the term, people are not 'hit' by drugs but take them to achieve an effect – with an aim in mind which itself will mediate the impact of taking the substance. Once in the body, drugs are chemicals which interact with – rather than dominate – the body's existing biochemical state and the feelings, expectations and emotions already present. For example, the arousal caused by stimulants may in some situations contribute to feelings of extreme anger, in others to elation, depending partly on the user's expectations, emotional state and social environment. So in talking of a drug's 'effects', we are really using the term as shorthand for the typical outcomes of this interaction in (mainly) Western twentieth century culture. Only at the extremes, when so much of the substance is used that it dominates the system is the impact predictable regardless of personal and social factors; overdose may be the result.

Complicating the picture is the fact that illegal drugs are under-researched compared to medicines; even when the substances are the same (eg, benzodiazepines), how they are used may differ so much that the outcomes also differ significantly. Among these may be dependence, categorised here as physical (the user is driven to take the drug in order to maintain normal physical functioning) and/or psychological (the user feels they cannot cope without the drug). Physical dependence is associated with an unpleasant withdrawal syndrome when the drug is stopped, but people can and often do experience withdrawal without becoming dependent.

• Cannabis •

Obtained from the cannabis plant (which grows readily in many parts of the world, including Europe), cannabis is available in three main forms.

- Herbal cannabis (also known as marijuana, grass, ganja, etc) is the dried leaves and flowering tops of the plant.
- Cannabis resin (hashish, hash, etc) is resin scraped or rubbed from the plant; for the illicit market it is usually compressed into blocks.
- Least commonly found is cannabis oil, a sticky liquid prepared from the resin.

The psychoactive chemicals are typically most concentrated in oil and least in herbal cannabis, though some forms of herbal cannabis come from plants specially bred and grown to match the impact of resin.

Cannabis in all its forms is usually smoked (often with tobacco) in handmade cigarettes ('joints') and sometimes through a pipe. It can also be eaten, for example in cakes, or brewed into drinks.

Generally cannabis is used as an aid to relaxation and to enhance sensory experiences. Used more intensely it can cause noticeable intoxication and 'psychedelic' effects. While effects last, intellectual and physical performance will be impaired and (especially inexperienced) users may feel anxious or distressed. There is virtually no risk of fatal overdose.

Smoking cannabis frequently over a long period is likely to lead to diseases similar to those linked to tobacco such as bronchitis and cancer. Physical withdrawal and dependence are not a problem but users can become psychologically dependent.

• Steroids •

Anabolic steroids are usually synthetic compounds derived from the male hormone testosterone, but designed to emphasise the muscle building properties of that hormone as opposed to its 'masculinising' effects.

They may be illicitly produced or diverted from licitly manufactured supplies, and taken by mouth or injected.

Such substances can increase muscle strength but only if taken over a period of time and combined with intensive training and an appropriate diet. Side-effects of repeated use can include:

- liver, kidney and heart problems;
- masculinisation in women;
- steroid-induced aggression leading to violence is also concern.

Dependence can occur.

• Alkyl nitrites •
('poppers')

Amyl, butyl and isobutyl nitrite (known as the 'alkyl nitrites') are liquids referred to by misusers as 'poppers'. They may be sold in small bottles or vials and the fumes inhaled to produce a 'rush' sensation which lasts just a few minutes.

The effects are associated with their ability to dilate blood vessels and accelerate the heart rate. A side-effect is reduced blood pressure which can cause fainting. Use among those with existing cardiovascular problems or anaemia is particularly risky. Dependence is uncommon.

• Amphetamines •

Amphetamines are synthetic drugs produced from chemicals rather than extracted from plants. Production is well within the capacity of a crudely equipped home laboratory. The many derivatives of amphetamine include amphetamine sulphate, dexamphetamine, methamphetamine and drugs such as ecstasy in the MDA family of substances (see *Ecstasy and family*). All these drugs may be taken by mouth. Amphetamines may also be injected or, in powder form, sniffed up the nose ('snorting') like cocaine.

Amphetamines stimulate the body much as the body's natural adrenaline does to prepare for bouts of exertion. The experience is commonly one of increased energy and confidence lasting several hours, during which the desires for food and sleep are suppressed. These effects have led to amphetamines being used to aid weight-loss and to prolong or temporarily improve athletic or work performance. However, irritability, anxiety and fear to the point of panic or paranoia can also occur, and accepted medical uses are now limited. After the effects have worn off the user will feel tired and perhaps depressed; full recovery can take days.

With frequent, regular use unpleasant effects become more common and more severe and the user's health suffers from lack of food and sleep. Dependence can result from the user's need for the lift given by the drugs and from the depression and other unpleasant effects which occur during withdrawal from regular high-dose use.

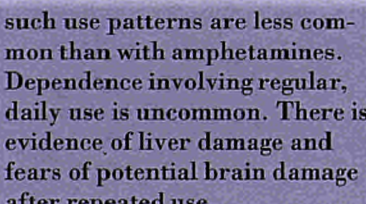
All photographs courtesy of ISDD, London, UK

• Ecstasy and family •

Ecstasy (methylenedioxymethamphetamine or MDMA for short) is one of the MDA (methylenedioxyamphetamine) family of drugs, itself a branch of the amphetamine family. Though derived from the oils of natural products such as nutmeg, these substances are either entirely or largely synthesised in laboratories. Commonly they are taken by mouth in tablets or capsules.

Their effects include those of amphetamine itself – increased energy lasting several hours followed by fatigue and perhaps depression. But there is an added ingredient reminiscent of LSD consisting of heightened perceptions, though rarely full-blown hallucinations, leading these substances to be termed 'hallucinogenic amphetamines'.

Interaction between the situations in which ecstasy is used – prolonged energetic dancing in hot dance venues – and the physical effects of the drug have led to deaths from heatstroke. Prolonged, regular use may lead to the ill-effects noted with amphetamine, but



such use patterns are less common than with amphetamines. Dependence involving regular, daily use is uncommon. There is evidence of liver damage and fears of potential brain damage after repeated use.

• LSD and other hallucinogens •

LSD (lysergic acid diethylamide) is produced in laboratories from raw materials derived from the fungus 'ergot'. Minute quantities of the pure liquid are commonly soaked into small squares of paper or bulked out into tablets for illicit distribution.

Some naturally growing fungi such as psilocybin mushrooms have similar hallucinogenic properties and are simply harvested and eaten raw, cooked or preserved by drying. All these drugs are taken by mouth.

Physical effects are slight compared to the sometimes overwhelming impact on perceptions and feelings. A 'trip' lasting several hours often features:

- perceptual distortions, which the user may find entrancing or frightening;
- feelings of being outside one's body ('dissociation').

The experience depends largely on the user's state of mind and surroundings; inexperienced, anxious users in environments which are less than reassuring face the greatest risk of a distressing 'bad trip', which may recur as 'flashbacks'. There is virtually no risk of fatal overdose but there have been a few injuries and deaths due to the perceptual and emotional effects.

Adverse psychological effects are more common after regular use. Physical dependence does not occur and regular daily use is highly unusual as such closely repeated doses are ineffective.

• Other synthetic drugs •

This 'remainder' category of drugs includes substances associated (like ecstasy) with the youth dance scene and a variety of hallucinogenic amphetamines and opiate-type drugs. Often known as 'designer drugs', these substances sometimes have been 'designed' anew to avoid current legal restrictions, but may also be existing substances not (or not yet) subject to those restrictions.

- In several countries these substances include gammahydroxybutyrate (GHB) and ketamine. Both have featured in the youth dance scene and been used medically as anaesthetics. They can produce profound and potentially dangerous sedation.
- Phencyclidine (PCP), a compound rarely seen in Europe, has effects reminiscent of GHB and ketamine.
- Fentanyl is a very potent drug with effects similar to heroin.
- Synthetic hallucinogenic amphetamines include rarely seen compounds such as PMA and DOM, with effects like ecstasy but more extreme.

• Solvents •

A variety of household and other products based on organic solvents and gases can be used to produce intoxication by inhaling the gas directly or by inhaling the fumes given off by the solvent. Among these are glues, paints, petrol, cigarette lighter fuel, butane gas canisters, certain aerosols, nail varnish remover, some fire extinguishers, and so on.

The experience is like being very intoxicated after excessive alcohol use but lasts only 15–45 minutes unless the inhalation is repeated. The main danger appears to be death or injury due to accidents, unconsciousness, suffocation or heart failure. Long-term, frequent use may cause a degree of brain damage and some substances can damage the liver and kidneys, though such cases seem rare.

Psychological dependence can occur.

• Heroin and other opiates •

Heroin is a more potent derivative of morphine, a drug extracted from opium which itself comes from the opium poppy. These and other painkillers derived from the opium poppy (such as codeine) are known as 'opiates'. Synthetic opiate-type drugs are termed 'opioids'; methadone is an opioid often used to treat heroin addiction; buprenorphine is a painkiller also used in addiction treatment.

Most of the heroin found in Europe comes from poppies grown in South West Asia, mainly Afghanistan or Pakistan, though some comes from South East Asia, mainly Myanmar. Traditionally heroin is injected, but it can also be sniffed up the nose or – and this is becoming more common – smoked. Smoking involves heating heroin and inhaling the fumes, graphically described by the phrase 'chasing the dragon'.

A powerful painkiller, heroin is valued by addicts for its ability to distance them from emotional as well as physical distress – the property which contributes to its high addiction potential. Sedation is not as marked as with sedatives and users can function well if they do not take excessive doses. Death from overdose is an ever-present risk due to the variability of illicit products, loss of tolerance to the drug's effects after a period of abstinence, and if other sedating drugs are taken along with opiates.

Respiratory complaints and constipation are among the long-term physical effects of opiates but these are mild compared to the impact of an addicted life-style and the risks associated with injecting. Physical and psychological dependence are significant risks as users can come to rely on the effects, and withdrawal from regular high dose use can be very unpleasant, though only rarely dangerous.

• Benzodiazepines •
('tranquillisers')

Benzodiazepines are a class of drugs which are used in medicine to reduce anxiety (ie, as 'tranquillisers') and/or to promote sleep (ie, as 'hypnotics'). One of the main differences between different benzodiazepines is how long the effects last:

- in long-acting variants such as flunitrazepam (trade name Rohypnol) and diazepam, effects last up to 24 hours;
- effects of medium-duration drugs such as temazepam and lorazepam last 6–8 hours.

There is virtually no illicit manufacture of these substances; the illicit market is fed by supplies diverted from the medical market. The tablets and capsules are made to be taken by mouth but addicts also commonly inject them.

In medical use benzodiazepines are valued for reducing anxiety without the sedation and overdose risk seen with older drugs. But misusers often take these drugs and at very high doses, by injection, and in combination with other drugs such as opiates and alcohol. Taken in these ways intoxication does occur and users run the risk of death from overdose and of injecting-related damage, which can be severe.

Physical and psychological dependence are significant risks as users can come to rely on the effects and withdrawal from regular high dose use can be very unpleasant and occasionally dangerous.

• Cocaine and crack •

Cocaine is derived from the coca plant of South America where its leaves were (and still are) chewed to deliver the drug little by little over a long period. In Europe (and the United States) it is used in much more potent forms.

- Cocaine hydrochloride is a white powder usually sniffed up the nose but which may also be dissolved and injected. It is rarely smoked or swallowed as these methods are relatively ineffective.
- Crack is small, crystalline 'rocks' of cocaine 'base' (cocaine split from the hydro chloride part) which, unlike the hydrochloride powder, are effective when smoked. Crack is usually smoked in containers formed into pipes.

Cocaine is a stimulant with effects similar to amphetamine, but lasting only about half an hour. Particularly when injected or smoked, the effects are practically immediate and may be felt as intensely pleasurable, though anxiety and panic can happen.

Negative effects build up if the user frequently repeats the dose. Restlessness and irritability can end in paranoia and a psychotic state. After-effects include fatigue, weight loss and depression. Physical damage is related to how the drug is taken: nasal damage from sniffing; respiratory problems with smoking; abscesses, etc from injecting.

The more rapid and intense effects from injecting or (as crack) smoking cocaine lead to a higher risk of compulsive use. Dependence can result from the user's need for the lift given by the drug and from depression and other unpleasant effects after regular, high dose use. Occasional use is also common, especially when the drug is sniffed.

The EMCDDA and REITOX

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a European Community information agency charged by its founding regulation to provide "objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences". The strands which make up this remit are wide-ranging and interconnected; the Centre's mission has is correspondingly wide – to furnish the Member States of the European Union (EU) and the European Community with an overall statistical, documentary and technical picture of the drug problems they are seeking to tackle.

• Major tasks •

On 8 February 1993 the European Council regulation which founded the Centre divided its tasks (diagram overleaf) into four categories.

1 Data collection and analysis

First was collecting, documenting and analysing information from a range of sources including EU Member States, international bodies and non-governmental organisations. Means to this end include surveys, studies and pilot projects, expert group meetings, and information exchanges between all those involved in combating drugs at governmental and non-governmental level whether as decision-makers, researchers or specialists. Particularly important is the Information Map questionnaire completed each year by the national Focal Points in each EU Member State.

The Centre also seeks to promote scientifically valid information provision and can help supply the resources needed. This work provides the platform for the second major task.

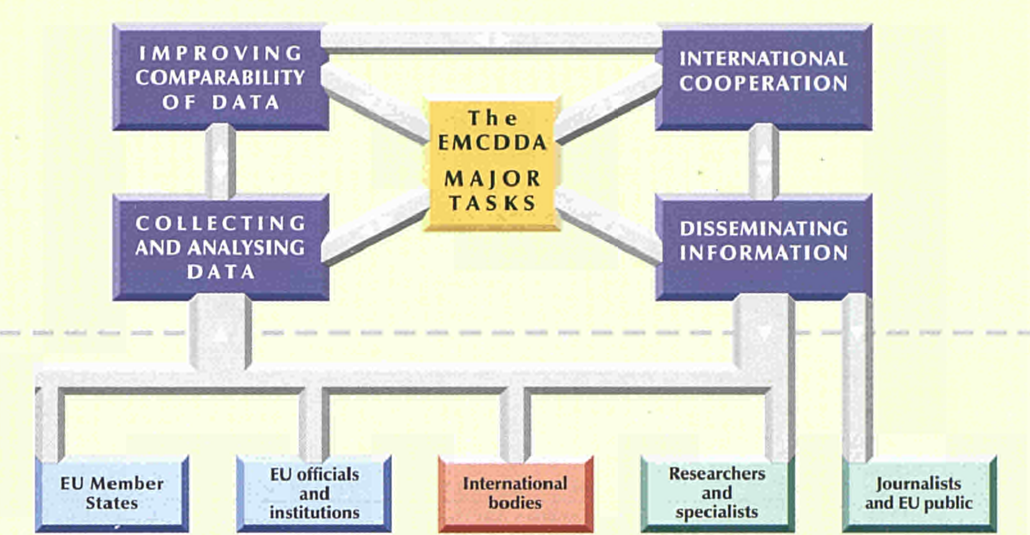
2 Improving comparability

Next was "improvement of data-comparison methods" – not just collating existing data, but improving it by upgrading its cross-EU comparability, objectivity and reliability. To achieve this the Centre recommends that each Member State establish a common set of *key indicators* and adopt a *core dataset*. Deploying these across the states will improve the coherence of their approach to drug problems and create the basis for an EU-wide vision of the nature and extent of drug use and drug problems.

3 Disseminating information

"Dissemination of data" was the third area of work stipulated by the regulation – dissemination not only to Community institutions, Member States and organisations working in the drugs field, but also to researchers, academics, policymakers, journalists and to the public at large.

This report is itself perhaps the key vehicle for achieving this task, in the process establishing the Centre's reputation for quality in information provision *vis-à-vis* the European scientific community and policymakers at national and Community levels. As will be clear from chapter 6, international organisations working in the drugs field provide valuable input to this work – an example of the fruits of the fourth of the Centre's major tasks.



In 1993 a European Council regulation set the EMCDDA four major tasks in the effort to create a truly European drug information system

4 International cooperation

"Cooperation with European and international bodies and organisations and with non-Community countries" was the fourth of the Centre's original mandates.

The key objectives are to share information and skills, avoid duplication, and build on the synergies in the work of the EMCDDA and other cross-national bodies. In the longer term the aim is to incorporate data from the EMCDDA into international monitoring and drug control programmes, particularly those established by the United Nations.

The founding regulation named six priority partners: the United Nations International Drug Control Programme; the World Health Organisation; the Pompidou Group of the Council of Europe; the World Customs Organisation; the International Criminal Police Organisation (Interpol); and the European Police Office (Europol).

• Priorities •

Within this broad remit of tasks were set five priority areas for information gathering and dissemination:

- the demand for drugs and programmes/ policies for reducing this demand (the focus for the first three years);
- national and European Community strategies and policies (with special emphasis on international, bilateral and European Community policies, action plans, legislation, activities and agreements);
- international cooperation and the geopolitics of the supply of drugs (with special emphasis on cooperation programmes and information on producer and transit countries);
- control of trade in narcotic drugs, psychotropic substances and precursors, as provided for in the relevant present or future international conventions and Community acts;
- implications of the drugs phenomenon for drug producer, consumer and transit countries, within areas covered by the Treaty on European Union, including money laundering, as laid down by the relevant present or future Community acts.

• Decision-making and management •

Community law established a tripartite structure (see diagram opposite) for the Centre, headed by a Management Board which deliberates on and decides policy, a Director who proposes actions to the Management Board and implements those agreed by the Board, and an advisory Scientific Committee. The Centre's staff and computerised REITOX system for collecting and exchanging information and documentation (further details below) complete its resources.

Legal status

The EMCDDA is an entity with a legal basis in European Community law. In the words of its founding regulation, the Centre has a "legal personality" and "shall enjoy, in each Member State, the most extensive legal status granted to legal persons under their laws". Among other things, this enables the Centre in its own right to own and dispose of property and take legal proceedings. Although the EMCDDA is separate from the institutions of the European Union, it can rely on stable funding provided under a specific heading in the general budget of the European Commission.

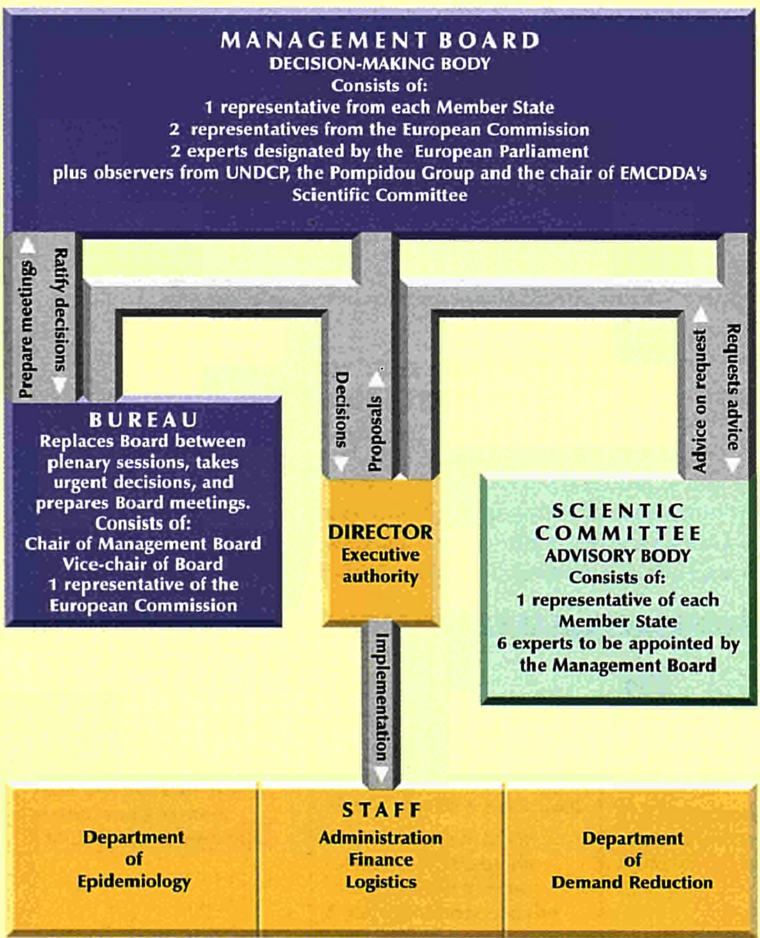
The Management Board

At the head of the structure is the Centre's Management Board, consisting of representatives from each EU Member State, from the Commission, and scientists chosen by the European Parliament for their special qualifications in the field of drugs.

The Board's chair is elected for a three-year period. Each member has one vote in meetings held at least once a year; between meetings a smaller committee (the Bureau) can take urgent decisions on the Board's behalf, subject to the Board's ratification. Every three years the Board adopts the Centre's three-year work programme; annually it adopts a work programme for the coming year based on a draft submitted by the Director, after consulting the Scientific Committee and having sought the prior opinion of the European Commission.

The Director

The Centre is managed by a Director who is responsible for the preparation and implementation of the decisions and programmes adopted by the Management Board, for the preparation of documents to be submitted to the Board, and for day-to-day administration. The Director is also legally the Centre's representative.



Community law established a tripartite structure for the EMCDDA headed by a Management Board drawn from all the nations of the European Union

The Scientific Committee

Both Management Board and Director can seek advice from the Scientific Committee on any scientific matter concerning the Centre's activities. The Committee consists of representatives of each of the EU Member States, and the Management Board may elect up to six other members. Members serve for a three-year period and the Committee is convened by its chair at least once a year.

The staff

The Centre's highly qualified and competent scientific and administrative staff are recruited according to the procedures laid down for Community institutions; by 1997, they totalled 36.

• The key network: REITOX •

REITOX is the European Information Network on Drugs and Drug Addiction. Set up at the end of 1993, and since 1995 coordinated by the Centre, REITOX is the human and computer network at the heart of the collection and exchange of data on drugs in Europe, linking the information systems of the 16 Focal Points in the 15 Member States and the European Commission (illustrated opposite). REITOX carries data to and from these Focal Points to the Centre and to national monitoring bodies devoted to the Centre's main areas of concern, as well as governmental and non-governmental specialised centres likely to make a useful contribution to the Centre's work.

The Focal Points play a fundamental role in the production of this report by submitting reports on drug use and demand reduction in their countries, or on the work of the European Community. Each year they also complete the *Information Map* questionnaire detailing information sources and the availability of different kinds of data in their countries, a key tool for working towards comprehensive and compatible cross-EU data collection systems.

Overleaf – contact details for the EMCDDA's Management Board, Scientific Committee and for its partners in REITOX

Austria

Austrian Federal Institute for Public Health

ÖBIG is a non-governmental institute sponsored by the Ministry of Health.

B Belgium

Scientific Institute of Public Health Louis Pasteur

A government institute sponsored by the Ministry of Social Affairs, Public Health and Environment.

Denmark

National Board of Health

NBH is an expert unit within the Ministry of Health.

Finland

National Research & Development Centre for Welfare & Health

The Centre is an expert institution under the Ministry of Social Affairs and Health, which also coordinates national drugs policy.

France

French Observatory for Drugs and Drug Addiction

An independent body sponsored by the government's Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie.

EMCDDA European Monitoring Centre for Drugs and Drug Addiction

European Commission

United Kingdom

Institute for the Study of Drug Dependence

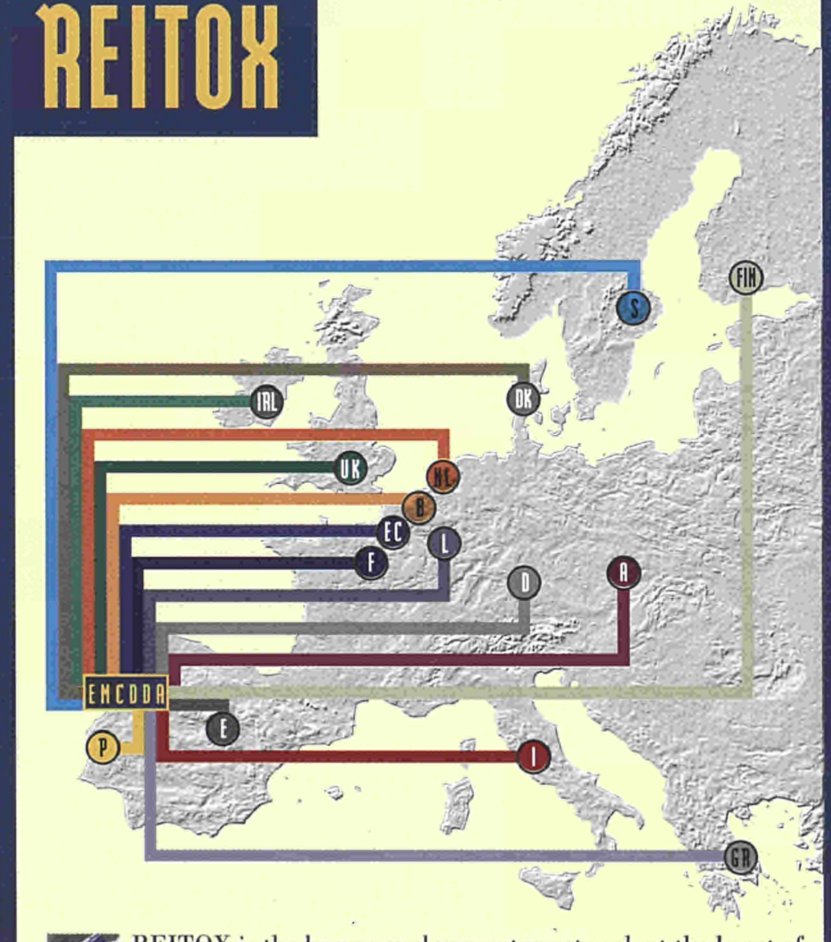
ISDD is a non-governmental organisation.

isdd

Sweden

National Institute of Public Health

A government agency under the Ministry of Health and Social Affairs.



REITOX is the human and computer network at the heart of the collection and exchange of data on drugs in Europe. It links the information systems of the Focal Points in all 15 EU Member States and the European Commission. REITOX carries data to and from these Focal Points to the Centre and to national bodies devoted to its main areas of concern, as well as to specialist governmental and non-governmental centres likely to make a contribution to the Centre's work.

Germany

Institute for Therapy Research

IFT is a non-governmental organisation sponsored by the Ministry of Health.

Greece

University Mental Health Research Institute

A non-governmental body sponsored by the Ministry of Health.

Ireland

Health Research Board

A government unit within the Ministry of Health.

Spain

Government Delegation to the National Plan on Drugs

Pre-existing department responsible to the Ministry of Justice and Interior.

Portugal

Observatory VIDA

New unit set up within government to meet EMCDDA requirements.

The Netherlands

Trimbos Institute

(Netherlands Institute of Mental Health & Addiction)

An independent body formed in 1996 by the merger of the former Focal Point host and the Dutch Centre of Mental Public Health.

Luxembourg

Department for Socio-therapeutic Action

The department is a pre-existing unit within the Ministry of Health.

Italy

Standing Monitoring Centre on Drug Addiction

The Standing Monitoring Centre on Drug Addiction is a unit within the Ministry of the Interior.

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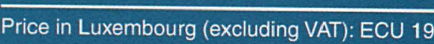

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