



European Monitoring Centre
for Drugs and Drug Addiction

ANNUAL REPORT 2003

THE STATE OF THE DRUGS PROBLEM IN THE
EUROPEAN UNION AND NORWAY



European Monitoring Centre
for Drugs and Drug Addiction

ARTS UDROOS NPE2 AR

THE STATE OF THE DRUGS PROBLEM IN THE
EUROPEAN UNION AND NORWAY

Legal notice

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

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

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

New freephone number:

00 800 6 7 8 9 10 11

This report is available in Spanish, Danish, German, Greek, English, French, Italian, Dutch, Portuguese, Finnish, Swedish and Norwegian. All translations were made by the Translation Centre for Bodies of the European Union.

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

Luxembourg: Office for Official Publications of the European Communities, 2003

ISBN 92-9168-159-8

© European Monitoring Centre for Drugs and Drug Addiction, 2003

Reproduction is authorised provided the source is acknowledged.

Printed in Belgium

PRINTED ON WHITE CHLORINE-FREE PAPER



European Monitoring Centre
for Drugs and Drug Addiction

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

Contents

Foreword	5
Acknowledgements and introductory note	7
Overall trends and developments	9
Trends in the drug situation	9
Developments in responses to drug use	11
<hr/>	
Chapter 1: Drug situation	
Drug use in the general population	15
Problem drug use	18
Demand for treatment	20
Drug-related infectious diseases	24
Drug-related deaths and mortality among drug users	28
Drug-related crime	33
Drug markets and availability	36
<hr/>	
Chapter 2: Responses to drug use	
National drug policy developments	41
Legal developments	42
Developments at EU level	43
Prevention	45
Harm-reduction responses	46
Treatment	49
Responses targeting drug users in criminal justice settings	51
Supply reduction	53
<hr/>	
Chapter 3: Selected issues	
Drug and alcohol use among young people	57
Social exclusion and reintegration	65
Public expenditure in the area of drug-demand reduction	69
<hr/>	
References	75
Reitox focal points	81



Foreword

With this 2003 annual report, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) presents to the EU and its Member States an overview of the drug phenomenon in Europe. The publication of the report coincides with the 10th birthday of the EMCDDA (1993 founding regulation). This is also the last time that we will focus only on the 16 countries that constitute our current membership (the 15 Member States and Norway). It therefore seems appropriate to reflect briefly on both the changes that have occurred in the drug phenomenon during this initial period and the progress made by the Monitoring Centre in our mission to provide policy-makers with a sound, up-to-date and insightful commentary on the evolving European drug problem.

A key feature of the drug phenomenon is its dynamic nature. It is a sobering thought that, even if we restrict our attention to the short time that the EMCDDA has been in existence, the differences in the developments that have occurred in both the nature of the drug problem and the way in which Member States respond are profound. Patterns of drug consumption have always varied between European countries, especially in respect of scale. This remains true, but the data in this report show that, increasingly, trends are observable that illustrate the global and European nature of the issue. At one time, any comparison of drug use in Europe would be marked more by differences than by similarities; this is no longer the case. While the overall situation is complex and considerable local variation exists, more general and common patterns in drug use are also apparent. Increasingly, we can conclude that in many ways we share as Europeans a common drug problem and also, we believe, a common responsibility to learn from our shared experiences. We are not alone in this conclusion. The EU action plan on drugs demonstrates the political commitment given to this issue, and there is now a near universal recognition that policy in this area must be based on a clear understanding of the situation.

If drug problems have evolved during the last 10 years then, equally, so has our ability to report on them. Credit for this rests not with the EMCDDA alone, but also with the many dedicated professionals throughout the EU who have

worked to understand the nature of the problem, to develop effective responses and to critically assess the impact of their work. We do believe, however, that the EMCDDA has played a vital role both in acting as a catalyst for the development of a sound evidence base and by providing the forum necessary for collaboration and progress at the European level. Ten years ago, no one could have talked with confidence or authority on the nature of the European drug situation. Today, this report demonstrates that this is ever more possible. We are now both better prepared and better informed to deal not only with the drug problem we face at present, but also with any potential threats that we may be confronted with in the future. We would like to acknowledge the considerable investment that has been made both within Member States and at European level to develop the tools and infrastructure to provide this evidence base, and to express our thanks, in particular, to the focal points of the Reitox network.

We hope you will find this report a comprehensive overview of the European drug situation — further and more detailed data can also be found in the extended online version of this document. For the EMCDDA, this report also successfully marks the end of the first phase of development of the organisation's work, and we must now look to the challenges that the future will bring. Among these will be the need to continue to improve the availability, quality and comparability of the European data set, and we will need to develop our systems and capacity to manage efficiently a growing knowledge base on the drug situation across an enlarged European Union. We are in no doubt that we will increasingly be faced with a larger, more diverse and complex picture on which to report. A central challenge for the organisation will remain the need to exploit fully the information available to us to provide an informed, timely and policy-relevant analysis that reflects the value of an EU perspective and a harmonised approach.

Marcel Reimen

Chairman, EMCDDA Management Board

Georges Estievenart

Executive Director, EMCDDA



Acknowledgements

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

- the heads of the Reitox national focal points and their staff;
- the services within each Member State that collected the raw data for this report;
- the Members of the Management Board and the Scientific Committee of the EMCDDA;
- the European Parliament, the Council of the European Union — in particular its Horizontal Working Party on Drugs — and the European Commission;
- the Pompidou Group of the Council of Europe, the United Nations Office on Drugs and Crime, the World Health Organisation, Europol, Interpol, the World Customs Organisation and the Centre for the Epidemiological Monitoring of AIDS;
- the Translation Centre for Bodies of the European Union and the Office for Official Publications of the European Communities;
- Prepress Projects Ltd;
- eLg Language Integration and Kaligram.

Introductory note

This annual report is based on information provided to the EMCDDA by the EU Member States and Norway (participating in the work of the EMCDDA since 2001) in the form of a national report. The statistical data reported here relate to the year 2001 (or the last year available) for Chapter 1, 'Drug situation', but may refer to 2002 or later for developments in the area of responses to drug use and for the selected issues.

The national reports of the Reitox focal points are available at:
http://www.emcdda.eu.int/infopoint/publications/national_reports.shtml.

An expanded online version of the annual report is available in 12 languages and may be found at:
<http://annualreport.emcdda.eu.int>. This online version comprises a wealth of additional material and statistics in the form of tables, graphics and boxes. It also provides further detail on the methodology used as well as links to the data sources, reports and background documents used in assembling the report.

All elements — included in both the printed and online version of the report — are listed thematically online (<http://annualreport.emcdda.eu.int>).



Overall trends and developments

Trends in the drug situation

Cannabis

Cannabis remains the most commonly used drug in the EU, with many countries reporting lifetime prevalence rates in excess of 20 % of the general population. A conservative estimate would suggest that at least one in every five adults in the EU has tried the drug.

Indicators suggest that cannabis use has been increasing across the EU, although this increase appears to have stabilised in some countries, albeit at what can generally be considered to be historically high levels. Some evidence of a convergence in patterns of use is also found, although rates still vary considerably, with France, Spain and the United Kingdom, in particular, reporting relatively high levels of use, and Finland, Sweden and Portugal reporting comparatively low figures. In all countries, estimates of the prevalence of recent use (last-year prevalence) among the adult population remain below 10 %. When young adults are considered, rates of use rise considerably. In all countries, recent use (last-year) prevalence peaks in the 15- to 25-year age group, with France, Germany, Ireland, Spain and the United Kingdom all reporting that over 20 % of this age group have used cannabis in the last 12 months. Lifetime use estimates are higher, with most countries reporting lifetime prevalence estimates of between 20 % and 35 % among young people. The number of people using cannabis on a regular basis is small in overall population terms (generally less than 1 %), although higher rates of regular use may be found among young people, and in particular among young men.

A worrying trend is the increasing frequency with which cannabis is mentioned in the context of the treatment demand indicator (TDI). In many countries, cannabis is now the drug most frequently reported after heroin, and a steady increase in cannabis-related demand for treatment can be observed. Caution is needed in interpreting these data as a number of factors are likely to be important here. This issue is currently being explored by an EMCDDA technical working group and will be the focus of a publication in 2004.

In most EU countries, the majority of reports for drug law offences are related to cannabis. Cannabis seizures have exhibited an increasing trend over the last decade, although there are signs that seizures have stabilised.

Europe remains the world's biggest market for cannabis resin, with as much as three quarters of the world total of cannabis resin being seized within the borders of the EU. Many countries also now report that herbal cannabis is being grown within the EU. The content of THC (tetrahydrocannabinol), the main active chemical in cannabis, varies greatly in street-level samples. On average, the THC content of resin and herbal cannabis is similar (5–14 % and 5–11 % respectively), although some samples of both forms of the drug are found to have a very high THC content.

Amphetamines and ecstasy (MDMA)

Europe remains an important area for the production and use of amphetamines and ecstasy but not methamphetamine. After cannabis, the most commonly used drug in EU countries is usually either ecstasy or amphetamine, with rates of lifetime experience among the adult population generally ranging between 0.5 % and 5 %. In the past, prevalence of amphetamine use was generally higher than prevalence of ecstasy use, but this difference is now less apparent. Among school populations, lifetime experience of inhalants is second only to that of cannabis and in general is considerably higher than experience of either ecstasy or amphetamines.

As with cannabis, the highest rates of lifetime and recent use are found among young adults. A number of indicators suggest that ecstasy use has continued to spread among some sections of urban youth in Europe. Some studies have found extremely high prevalence rates among such groups, although a pronounced increase in use of the drug is not generally observable in the wider population.

The numbers of people treated for an amphetamine problem in Europe vary widely: just under a third of drug users in treatment in Sweden and Finland are amphetamine users, compared with around 9 % in Germany and 3 % or less in all other countries. In almost all countries, rates of treatment demand related to ecstasy are very low. A small number of deaths in Europe can be directly attributed to the use of ecstasy, but overall the numbers remain low in comparison with deaths related to opioids.

Although there have been some fluctuations in recent years, and possibly signs of stabilisation in some areas, both amphetamine and ecstasy seizures (numbers and quantities) have increased substantially in the EU over the last decade.

In Finland, Sweden and Norway, amphetamines are the second most commonly seized drug (after cannabis).

Cocaine and crack cocaine

Survey data suggest an increase in cocaine use in the United Kingdom and, to a lesser extent, in Denmark, Germany, Spain and the Netherlands. Cocaine use and increases in use appear to be more common among young people living in urban areas. National figures may therefore reflect local trends in some major European cities to only a limited extent.

A number of indicators suggest that concern about levels of cocaine use and related problems is justified. Such indicators include treatment demand, toxicological findings in victims of overdose deaths, drug seizures and studies of at-risk populations. Apart from a decrease in 2000, the number of cocaine seizures has increased steadily since 1985. Similarly, the quantity of cocaine seized has generally exhibited an upward trend over the same period, although figures tend to fluctuate from year to year. Relatively high rates of drug-treatment attendance for cocaine use are reported from the Netherlands and Spain (30 % and 19 % respectively) and to a lesser extent from Germany, Italy, Luxembourg and the United Kingdom (between 6 % and 7 %). With the exception of the Netherlands and the United Kingdom, most cocaine treatment demand appears to be related to the use of cocaine powder (cocaine hydrochloride) as opposed to crack cocaine (cocaine base).

The prevalence of use of crack cocaine in Europe appears to be relatively low, although sporadic local reports suggest a problem among marginal groups in some cities. As crack cocaine is particularly associated with negative health and social consequences, even when prevalence rates are low, more detailed attention needs to be paid to any emerging trends in this area as the public health impact of even a moderate increase in use could be considerable.

Heroin and injecting drug use

Problem drug use is defined as 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines'. Although small in terms of overall numbers, problem drug users are responsible for a disproportionate share of the health and social problems resulting from drug consumption. In most countries in the EU, with the exception of Sweden and Finland, where amphetamine use is more prevalent, problem drug use remains characterised by the use of heroin, often in

combination with other drugs. As estimation in this area is difficult, and the precision and reliability of estimates vary considerably, caution is required both in interpreting trends and in making comparisons between countries.

National estimates of problem drug use vary between two and 10 cases per 1 000 of the adult population (that is between 0.2 % and 1 %). No common trend in the number of problematic drug users in the EU can be observed, although studies suggest that in at least half of EU countries some increase has occurred since the mid-1990s.

Probably around half of 'problem drug users' in the EU are drug injectors, i.e. around 500 000–750 000 of the EU's estimated 1–1.5 million problem drug users. The proportion of injectors varies considerably between countries and has changed over time, with levels of injection falling in almost all countries during the 1990s, although there is some evidence of more recent increases. National estimates of injecting drug use vary between two and five cases per 1 000 of the adult population (or 0.2–0.5 %).

Despite a dramatic decrease in opium production in Afghanistan in 2001, there does not seem to be any evidence that this had a direct impact on the availability of heroin on the European illicit market. This can probably be explained by the existence of stocks of the drug.

Human immunodeficiency virus (HIV), hepatitis C (HCV) and hepatitis B (HBV)

Of particular concern in the EU is the drug-related spread of HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV), usually through behaviours associated with drug injection. Available data suggest that the prevalence of HIV infection among drug injectors (IDUs) varies greatly between, as well as within, European countries, from about 1 % in the United Kingdom to over 30 % in Spain. In some countries and regions, HIV prevalence among IDUs has remained very high (over 25 %) since the mid-1990s. Although these data may reflect well-established epidemics, in these areas special prevention efforts remain important to prevent further infections.

It may be misleading to rely completely on national data sets, which in general have suggested a fairly stable situation across the EU, as trends may differ widely within regions and cities. Increases in HIV prevalence among subgroups of IDUs have recently been reported from regions or cities in Spain, Ireland, Italy, the Netherlands, Austria, Portugal, Finland and the United Kingdom. This picture remains diverse, as in some of these countries decreases were also recorded in other subgroups, and in

other countries prevalence has remained stable or decreased.

Data on HIV infection in young and in new IDUs may be a better indicator of recent infections and again indicate that new infections are continuing to occur in some regions. AIDS incidence has fallen across the EU since the introduction of more effective treatments.

Hepatitis C infection can cause severe chronic health problems, and the treatment of conditions related to HCV infections is likely to become a major cost to European healthcare systems. The prevalence of hepatitis C is extremely high among drug injectors in all countries, with infection rates varying between 40 % and 90 %. Among notification data where a risk category is known, 90 % of cases of hepatitis C and 40–80 % of cases of hepatitis B are related to injecting drug use. Trends over time show a mixed picture, with increases and decreases being observed in different regions. The prevalence of HCV infection among young IDUs and new IDUs is high in general (40 % or more), confirming a high incidence of new infections, with injectors continuing to acquire the disease after relatively short periods of injecting. Throughout the EU, approximately 20–60 % of IDUs have antibodies against hepatitis B, suggesting a large potential for vaccination programmes directed at this disease in IDUs.

Overdoses

Each year, 7 000–9 000 acute drug-related deaths are reported in the EU. The overall EU trend has continued to increase in recent years, although less dramatically than was the case in the 1980s and early 1990s, and with a more complex and divergent picture appearing at the national level. Most of the victims are young people in their 20s or 30s, representing a considerable cost to society and loss of life.

In most cases (typically over 80 %), opioids are present in the toxicological analyses, often in combination with other substances (such as alcohol, benzodiazepines or cocaine). Cocaine or ecstasy alone is found in a smaller number of cases. Some of the factors that appear to be associated with increased risk of opioid-related deaths are drug injecting, polydrug use and, in particular, the concurrent use of alcohol or depressants, loss of tolerance and not being in contact with treatment services. It is known that proper and timely interventions can help to prevent many fatal overdoses, supporting the need for interventions in this area that encourage those witnessing a drug-related overdose to take appropriate action.

Developments in responses to drug use

EU policy

The mid-term evaluation of the EU action plan on drugs 2000–04, undertaken by the European Commission, observes that Member States give priority to demand reduction and follow the lines set out in the action plan. However, it perceives a need for the EU to make an even stronger effort to develop innovative prevention programmes. While acknowledging achievements, it stresses that much work remains to be done, including the development of systems of evaluation of national and EU activities.

The presidencies of the Council in 2002, Spain and Denmark, introduced resolutions in order to improve the commitment of Member States to further invest in drug-prevention programmes in school curricula, to intensify efforts aimed at the prevention of the recreational use of drugs and to improve the treatment of drug users in prisons. In May 2002, the Commission presented a proposal prepared in consultation with the EMCDDA for a Council recommendation on the prevention and reduction of risks associated with drug dependence, addressing the target of the EU drugs strategy to reduce substantially the incidence of drug-related health damage using risk-reduction measures that have been shown to be successful.

Member States' policies

The trend observed in recent years of organising national drug policy through national action plans and coordinated systems continued in 2002. Sweden and Norway and some Austrian provinces joined other EU partners in adopting a coherent drugs plan, programme or strategy. At the same time, members of the public are becoming increasingly aware of drug abuse and its consequences and are taking an interest in national policy. Surveys show that the clear majority of the public remains opposed to legalisation of cannabis. The low level of support for legalisation probably reflects the belief that cannabis is a gateway drug. However, varying levels of support were given to the idea of modifying punishments for the use of cannabis in certain circumstances.

An overview of developments of drug use and responses to it in the educational, health, social and criminal justice systems shows that both problems and problematic groups are often not clear-cut. National and local policies increasingly reflect an awareness of the insidious character of the phenomenon by making boundaries between the systems more permeable and flexible through increasing cooperation and diversification.

Healthcare, educational and social policies are becoming more important in reducing drug-related problems in the widest sense, and it is increasingly recognised that the criminal justice system alone is not always capable of handling the problem of drug use. The link between social exclusion policy and drug issues is stronger in some countries, such as Ireland and the United Kingdom, than in others. Several countries in the EU have introduced legislative changes to facilitate the treatment and rehabilitation of addicts and other legal changes have opened up possibilities for early interventions among young experimental drug users. Denmark, Germany, the United Kingdom and Norway have increased healthcare investment in an attempt to reduce the number of drug-related deaths. In line with the EU action plan's commitment to provide a variety of wide and easily accessible treatment options, some countries, for example Finland and Greece, have changed their financing schemes as well as regulations regarding substitution treatment.

Against a background of increased security, a number of countries report legal changes to improve the monitoring of traffickers and users, including telecommunications monitoring, body searching and drug testing. Other legal changes have aimed at minimising the social impact of drug use by providing stricter control of public order and public nuisance.

Interventions

School-based prevention remains at the core of activities directed towards all young people, usually from the pre-teens upwards. Although a broad evidence base exists identifying effective approaches, such as interactive teaching with a focus on personal and social life skills, only a few countries, such as Spain, Greece and Ireland, systematically implement such programmes in the school curriculum. Of the other countries, Sweden and France concede that school drug-prevention practice is not state of the art but often rather eclectic, non-professionalised action.

However, a growing concern that the most vulnerable young people will not be reached in schools has triggered the development of specific preventions aimed at groups experimenting with drugs in recreational settings, such as discos, clubs and music events. Peer and on-the-spot counselling seem to be the most promising approaches. Prevention initiatives and early interventions directed at socially excluded youths and young offenders similarly seem to be most effective when implemented using a personalised methodology. Good results have been reported from projects in Germany, Austria, Portugal and the United Kingdom. Although vulnerable families, possibly

with drug-using parents, are considered to be at high risk, supportive services for such families are rare.

Syringe exchange is now an established method to prevent the spread of infectious disease through injecting drug use, although the availability and coverage of such programmes is variable and accessing sterile equipment can still be a problem. Only in Spain are syringe-exchange services being implemented systematically in prisons. Specific measures to prevent hepatitis C transmission as well as hepatitis B vaccination are increasingly considered as important complements to HIV prevention. First aid training and risk education have become more prominent as particular interventions to prevent fatal overdoses. Another important development is that medical care is increasingly becoming available at low-threshold level, integrated in local drug services.

Drug-related treatment still very much equals treatment for opiate use, or polydrug use including opiates, with the exception of Sweden and Finland, where injecting amphetamine use is still important. More recent developments in problem drug use, partly away from opiates and injecting drug use, have triggered the emergence of new kinds of early interventions, as described above, rather than reform of existing drug-treatment structures. Substitution treatment is prominent and has further expanded and diversified in recent years. Over the EU as a whole, the expansion in the last five years is estimated to be 34 %, the largest increases being reported from countries with a low initial provision, such as Greece, Ireland, Portugal, Finland and Norway. Care for long-term, ageing, deprived drug users, often with psychiatric comorbidity, is a serious challenge to drug policy, which has not found adequate solutions. The EMCDDA will look into this issue further in the coming year.

Innovations in penal policy have introduced alternatives to prison, diverting drug users to quasi-compulsory treatment or community service on the assumption that their needs are better met by such interventions. Alternatives to prison specifically prevent young drug users coming into contact with the criminal subculture in prisons. The need for alternatives to prison has also arisen from acute overcrowding in prisons. Drug use and drug users in prisons are an increasingly important problem, calling for flexible responses. Health and welfare authorities are increasingly involved and taking responsibilities for service provision for drug users in prisons, although there is still room for improved cooperation. Often, treatment that is standard in the community is not available or accessible in prison. In most countries, harm-reduction measures in prisons are relatively limited.

Quality assurance

A number of recent studies focus on innovative and controversial interventions such as consumption rooms, heroin prescription or pill testing. While these types of intervention remain controversial, decision-makers are in need of information on the effects of such strategies in order to provide the basis for a more informed debate.

European research on psychosocial interventions in prevention and treatment is lacking. In the area of prevention, evidence from North American research has been widely used. However, both the objectives and the settings of prevention differ from the European situation. Nevertheless, it has been possible to replicate some successful approaches, and this evidence is increasingly taken into consideration in policy-making. Although a substantial body of research and evidence-based knowledge exists regarding medically assisted treatment,

partly funded by the pharmaceutical industry, large national evaluation studies provide little direction as to best practice of other treatment modalities.

The transfer of scientific evidence to policy and practice can be improved. Closer cooperation and greater mutual understanding between research and decision-makers are urgently needed. Only a few countries are reviewing their school-based prevention practice on the basis of scientific evidence. While scientific evidence is increasingly acknowledged in the area of prevention of infectious diseases, it seems that in many cases quality of care is not taken into sufficient consideration in the areas of drug-related treatment and services for drug users in prisons. Scientific evidence is largely lacking in the area of alternatives to prison. However, more formalised quality assurance is gaining ground in Member States with the establishment of guidelines, quality standards and accreditation systems.

Light blue horizontal bar

Dark blue horizontal bar

Light blue horizontal bar

Dark blue horizontal bar

Light blue horizontal bar

Dark blue horizontal bar

Chapter 1

Drug situation

This chapter provides an overview of the situation of drug use and supply in the EU and Norway and highlights recent developments and emerging trends.

Drug use in the general population ⁽¹⁾ ⁽²⁾

Reliable information on the extent and patterns of drug use and age at first use among the general population and young people, as well as on the characteristics of users and risk perceptions, is important when formulating and evaluating drug policies and prevention initiatives. Drug use in the general population is measured by surveys, which provide estimates of the proportion of the population who have used drugs at any time. The most common measures are:

- any use during a person's life (lifetime prevalence), often called 'lifetime experience';
- any use during the previous year (last 12 months prevalence), often called 'recent use'; and
- any use during the previous month (last 30 days prevalence), often called 'current use'.

The figures for 'lifetime experience' are always higher than for the other two groups, as this group includes everyone who has ever tried drugs, no matter how long ago this was. 'Recent use' figures are generally lower but better reflect the prevailing situation. 'Current use' may be an indicator of the number of people who use drugs regularly, but figures are generally low. A combination of lifetime experience and recent or current use can provide insight into drug-use patterns (e.g. continuation rates).

Many surveys also investigate age at first drug use and frequency of use, data which allow estimations of incidence and reveal differences in patterns of use, such as higher doses or more frequent use (which imply increased risk). In addition, correlations between drug use and sociodemographic factors, opinions and risk perceptions, lifestyles, health problems, etc. can be established.

A number of factors need to be taken into account when considering differences in the overall national figures.

The relative sizes of the urban and rural populations in each country may partly account for the differences. Other sources of variation include factors to do with generation (for example, the birth cohort in which drug use became widespread) and the extent of convergence of the lifestyles of young men and women. Social and cultural context can also influence self-reporting of drug use. Finally, methodological questions such as sampling errors and non-response can influence results. Comparative analysis across countries should be made with caution, in particular where differences are small, and formulation and evaluation of drug policy should take into consideration, among other criteria, specific age groups, birth cohorts, gender and place of residence (i.e. urban versus rural) of the studied population.

Prevalence and patterns of drug use in the general population

Despite methodological limitations to the comparison of survey results across countries, some common patterns of drug use throughout the EU can be identified. These basic patterns have remained relatively unchanged since the last annual report.

Cannabis continues to be the illegal substance most commonly used in all EU countries. Lifetime experience is much higher than recent or current use, suggesting that cannabis use tends to be occasional or to be discontinued after some time ⁽³⁾. Current drug use is unusual in people over 40 years of age. Some countries report a small proportion of adults (0.5–1 %) who consume the substance almost daily, and particular attention should be paid to this group.

Illegal substances other than cannabis are used by much smaller proportions of the population, although there are considerable differences between countries ⁽⁴⁾. Again, regular or sustained use of drugs is uncommon — for most

⁽¹⁾ For further explanation, see Box 1 OL: Methods used to estimate drug use in the general population (online version).

⁽²⁾ See the EMCDDA guidelines for the key indicator 'prevalence and patterns of drug use among the general population — population surveys' (http://www.emcdda.eu.int/multimedia/project_reports/situation/population_survey_handbook.pdf).

⁽³⁾ Figure 1 OL: Patterns of cannabis use among the general population — lifetime experience versus current use (last 30 days), national (drug use) prevalence survey 2001 (the Netherlands) (online version).

⁽⁴⁾ Figure 2 OL: Recent use (last 12 months) of cannabis, amphetamines, ecstasy and cocaine among young adults (15–34 years) in European countries, measured by national population surveys (online version).

people their drug use is relatively short-lived (i.e. lifetime experience is clearly higher than recent use) ⁽⁵⁾.

The use of illegal substances is highest in young adults (e.g. 15–34 years), among whom prevalence rates are approximately twice those among adults as a whole. In all countries and all age groups, men are more likely than women to have ever used drugs. Drug use is more prevalent in urban areas, although some spread to smaller towns and rural areas may be taking place.

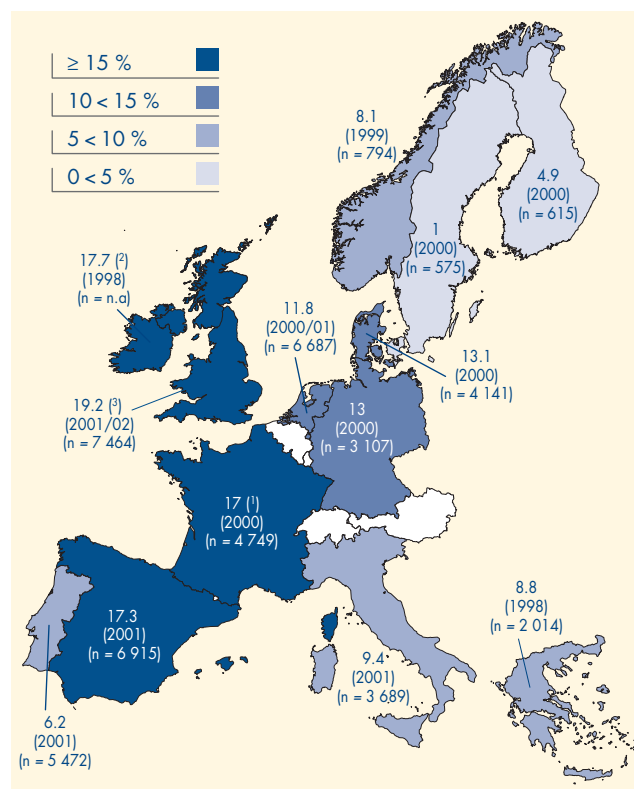
Lifetime experience of cannabis use is reported to range from about 7–10 % (Portugal and Finland) to around 30 % (Denmark and the United Kingdom) of the whole adult population, with most other countries reporting figures in the range 20–25 %. Reported rates of drug use other than cannabis are 0.5–6 % for amphetamines (except in the United Kingdom, where the figure is 11 %) and 0.5–5 % for cocaine and ecstasy ⁽⁶⁾. Generally, heroin has been tried by less than 1 % of the population, although in some countries up to 2–3 % of young men report having experimented with the drug.

Recent use of cannabis is reported by 1–10 % of all adults, although in most countries (10) prevalence varies between 5 % and 10 %. Recent use of amphetamines, cocaine or ecstasy is in general reported by less than 1 % of adults. In Spain, Ireland and the United Kingdom, the rates of use of all of these drugs are somewhat higher, while in Denmark and Norway the use of amphetamines is relatively higher, and in the Netherlands ecstasy use is more common ⁽⁷⁾.

Drug use (in terms of both lifetime experience and recent use) is higher among young adults than among the population as a whole. Recent cannabis use is reported by 5–20 % of young adults (Sweden 1–2 %), with a substantial number of countries (seven) reporting rates between 10 % and 20 % (Figure 1). Recent amphetamine use is generally reported by 0.6 %, cocaine use by 0.5–4.5 % and ecstasy use by 0.5–5 % (Figure 2).

For comparison, in the 2001 United States national household survey on drug abuse, 36.9 % of adults (12 years and older) reported lifetime experience of cannabis, 12.3 % lifetime experience of cocaine and 3.6 % lifetime experience of ecstasy. Recent (last 12 months) cannabis use was reported by 9.3 %, cocaine use by 1.9 %

Figure 1: Recent use (last 12 months) of cannabis among young adults (15–34 years) in European countries, measured by national population surveys



NB: Data are from the most recent national surveys available in each country. Sample sizes (n) refer to the number of respondents for the 15–34 age group. For details regarding number of respondents for the whole survey, see Statistical Table 2: Last-12-months prevalence (LTP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway (online version). The standard EMCDDA definition of young adults is age 15–34 years. In Denmark and the United Kingdom, young adults are aged 16–34 years and in Germany and Ireland 18–34 years. Variations in age ranges may, to a small extent, account for some national differences. In some countries, the figures were recalculated at national level to adapt as far as possible to the standard EMCDDA age groups.

(1) France conducted a new survey in 2002 but with a substantially smaller sample (2 009 respondents). See Statistical Table 1: Lifetime prevalence (LTP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway (online version).

(2) In Ireland, the sample for the whole survey (18–64 years) is 6 539.

(3) England and Wales.

Sources: Reitox national reports 2002, taken from surveys, reports or scientific articles. See also Statistical Table 1: Lifetime prevalence (LTP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway (online version).

and ecstasy use by 1.4 % ⁽⁸⁾. Cannabis lifetime experience and recent use are higher in the United States than in any EU country. Cocaine lifetime experience is also higher in

⁽⁵⁾ This is expressed as 'continuation rate', i.e. the proportion of people who, having used a substance during their lifetime, have also used it during the last 12 months or last 30 days.

⁽⁶⁾ See Statistical Table 1: Lifetime prevalence (LTP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway (online version).

⁽⁷⁾ See Statistical Table 2: Last-12-months prevalence (LTP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway (online version).

⁽⁸⁾ Source: SAMHSA, Office of Applied Studies, national household survey on drug abuse, 2001 (www.samhsa.gov/oas/nhsda.htm). Note that the age range in the US survey (12 years and over) is wider than the age range reported by the EMCDDA for EU surveys (15–64 years). This means that the reported figures in the US survey will tend to be somewhat lower than if the EU range had been used because of the low level of drug use among 12- to 15-year-olds and, in particular, among people over 65 years.

the United States than in any EU country, and recent use is higher than in most countries, except Spain (2.6 %) and the United Kingdom (2.0 %). Ecstasy use is higher than in all EU countries except Spain, Ireland, the Netherlands and the United Kingdom.

Trends in drug use among the general population

It is difficult to define clear-cut trends that apply to the EU as a whole. A consistent series of surveys has been carried out in only a very few countries and, even then, generally for only a few years. In addition, social/cultural context varies widely among EU countries. Lifetime experience is of limited value in analysing trends as it is a cumulative measure that may increase as a result of a generational effect even if current drug use is stable or falling.

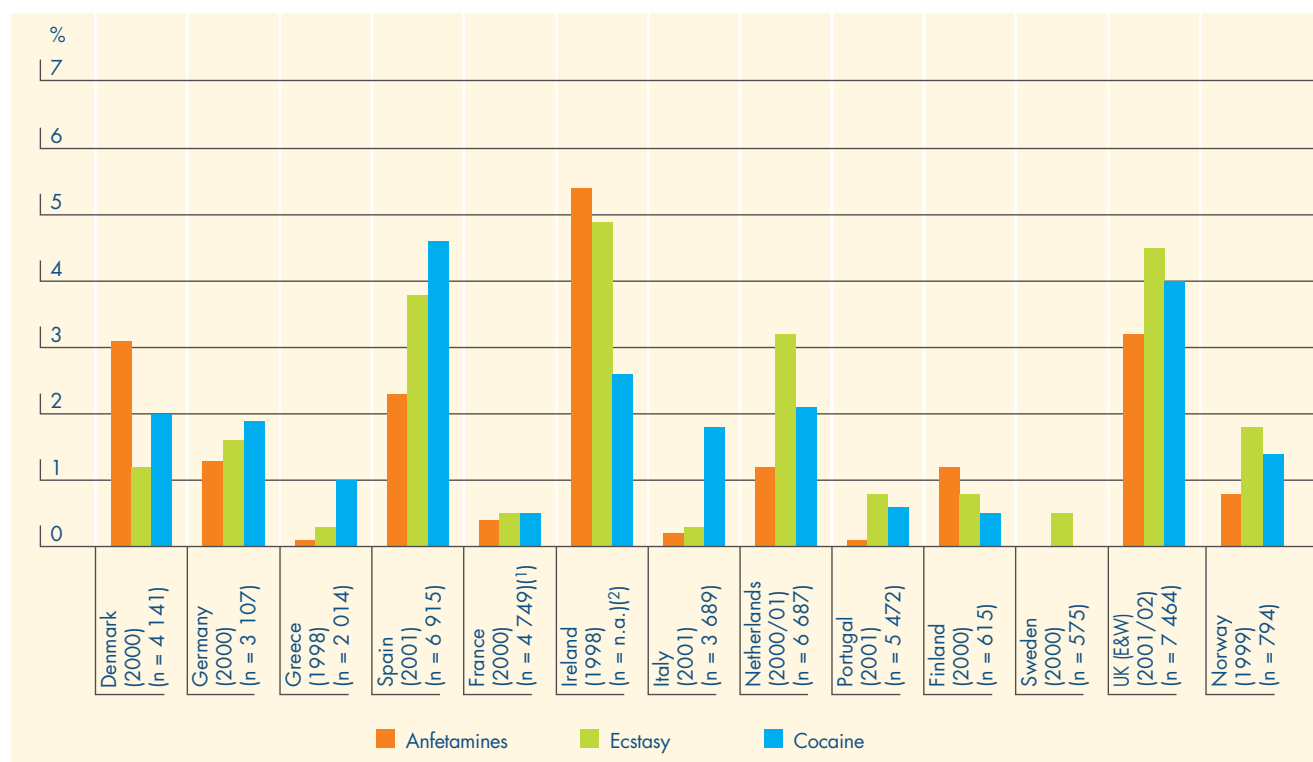
On the other hand, in the case of very young people (aged 13–15 years), lifetime experience will tend to reflect recent use.

Different types of surveys (national or local or surveys of military conscripts or schoolchildren) show that cannabis use, particularly among young people, increased markedly during the 1990s in almost all the EU countries. At the same time, cannabis use in different countries tended to converge, with a significant number of countries reporting rates of around 20–25 % lifetime experience and 5–10 % recent use.

Although many countries report a continued increasing trend in cannabis use, it is worth noting that a number of countries (Ireland, Italy, the Netherlands, Finland, Sweden and Norway) report that use may be levelling off based on studies among school students, military conscripts and teenagers.

European trends in the use of other substances (e.g. cocaine, ecstasy and amphetamines) are more difficult to track, partly because in many cases survey samples are

Figure 2: Recent use (last 12 months) of amphetamines, ecstasy and cocaine among young adults (15–34 years) in European countries, measured by national population surveys



NB: E&W, England and Wales.

Data are from the most recent national survey available in each country. Sample sizes (n) refer to the number of respondents for the 15–34 age group. For details regarding number of respondents for the whole survey, see Statistical Table 2: Last-12-months prevalence (LYP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway (online version). The standard EMCDDA definition of young adults is age 15–34 years. In Denmark and the United Kingdom, young adults are aged 16–34 years and in Germany and Ireland 18–34 years. Variations in age ranges may, to a small extent, account for some national differences. In some countries, the figures were recalculated at national level to adapt as far as possible to the standard EMCDDA age groups.

⁽¹⁾ France conducted a new survey in 2002 but with a substantially smaller sample (2 009 respondents). See also Statistical Table 2: Last-12-months prevalence (LYP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway (online version).

⁽²⁾ In Ireland, the sample for the whole survey (18–64 years) is 6 539.

Sources: Reitox national reports 2002, taken from surveys, reports or scientific articles. See also Statistical Table 2: Last-12-months prevalence (LYP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway (online version).

small and partly because of the much lower prevalence of use of these drugs overall. In addition, new trends tend to concentrate in selected groups, and a focused analysis (e.g. of drug use by young men in urban areas) would be necessary to determine such trends and assess their true extent. Ideally, surveys should be complemented by targeted anthropological studies.

Ecstasy use clearly increased during the 1990s (and seems to be still diffusing) among certain youth groups, but only four countries (Spain, Ireland, the Netherlands and the United Kingdom) report a rate of recent use (last 12 months) among young adults of more than 3 %.

Worryingly, indicators of drug use (treatment demand, seizures, post-mortem toxicological findings) suggest that the use of cocaine is increasing in some countries. Although cocaine use among the population as a whole remains low, increases in recent cocaine use (last 12 months) among young people seems to be a consistent finding (1994–2000) in the United Kingdom^(?) and possibly, to a lesser extent, in Denmark, Germany, Spain and the Netherlands. Other countries have reported (2001 or 2002 Reitox national reports) increases based on local or qualitative information (Greece, Ireland, Italy and Austria). This phenomenon should be closely monitored, in particular among young people in urban areas (Figure 3).

See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

Statistical Table 1: Lifetime prevalence (LTP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway

Statistical Table 2: Last-12-months prevalence (LYP) of drug use in recent nationwide surveys among the general population in the EU countries and Norway

Statistical Table 3: School surveys — lifetime prevalence among students, 15–16 years of age

Problem drug use

Problem drug use is defined as ‘injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines’⁽¹⁰⁾.

Given the dependability of current estimation methods, data quality and data availability, it is not always possible to interpret trends reliably. In addition, there is no estimation method that can be used in all countries in a comparable

Figure 3: Evolution of recent (last 12 months) cannabis (A) and cocaine (B) use among young adults (15–34 years) in some EU countries

Figure 3 (A): Evolution of cannabis use

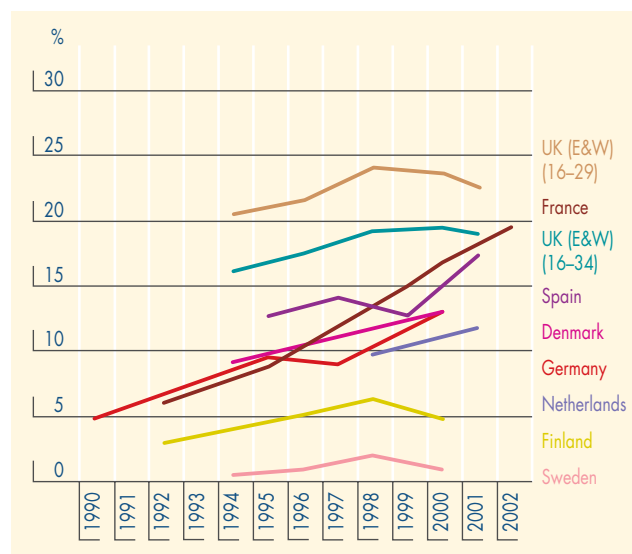
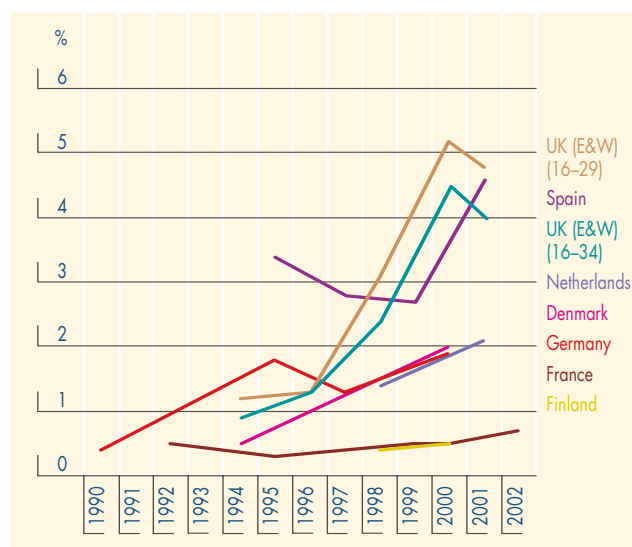


Figure 3 (B): Evolution of cocaine use

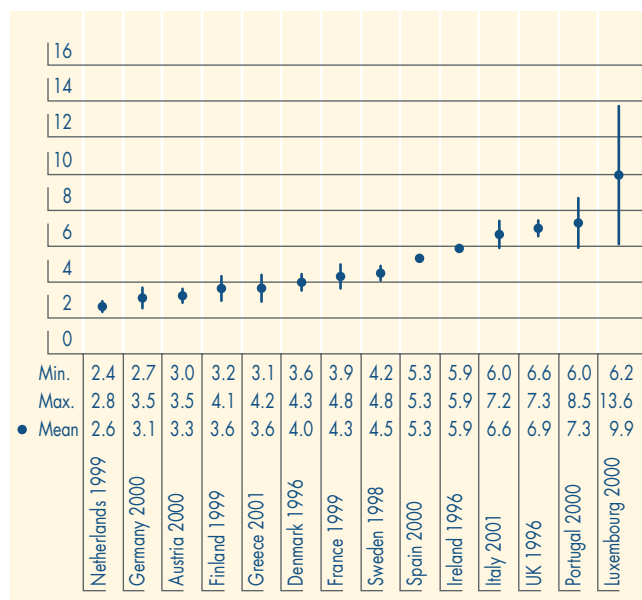


NB: E&W, England and Wales.
Data are from the most recent national survey available in each country. The figures and methodology for each survey can be obtained from Statistical Table 2 (online version).
The standard EMCDDA definition of young adults is age 15–34 years. In Denmark and the United Kingdom, young adults are aged 16–34 years and in Germany and Ireland 18–34 years. In France, the age range is 25–34 (1992), 18–39 (1995) but 15–34 for the other years.
Sample sizes (respondents) for each survey can be obtained in Statistical Table 2 (online version).
In Denmark, the figure for 1994 is for use of ‘hard drugs’.
Sources: Reitox national reports 2002, taken from surveys, reports or scientific articles. See individual sources in Statistical Table 2 (online version).

^(?) Although, according to the Home Office, it seems to be levelling off (see Figure 3). Studies among people in England and Wales age 16–29 years found significant changes (at the 5 % level) between 1996 and 1998 and between 1998 and 2000. However, differences between 2000 and 2001/2 were not significant.

⁽¹⁰⁾ For more detail see Box 2 OL: Definition of and methods used to estimate problem drug use (online version).

Figure 4: Estimates of problem drug use in different EU Member States (most recent one-year prevalence per 1 000 inhabitants aged 15–64)



NB: Figures show the combined country range of different estimates. They may be based on different methods and data sources and should be interpreted with caution (see online statistical tables for specific estimates and full details). The dot shows the midpoint of the range, while the line represents the uncertainty range or 95 % confidence interval. The longer this line, the wider the range of the prevalence estimates is (not available for Spain or Ireland). All estimates are compatible with the EMCDDA definition of problem drug use. The Swedish estimate has been adjusted to fit this definition.

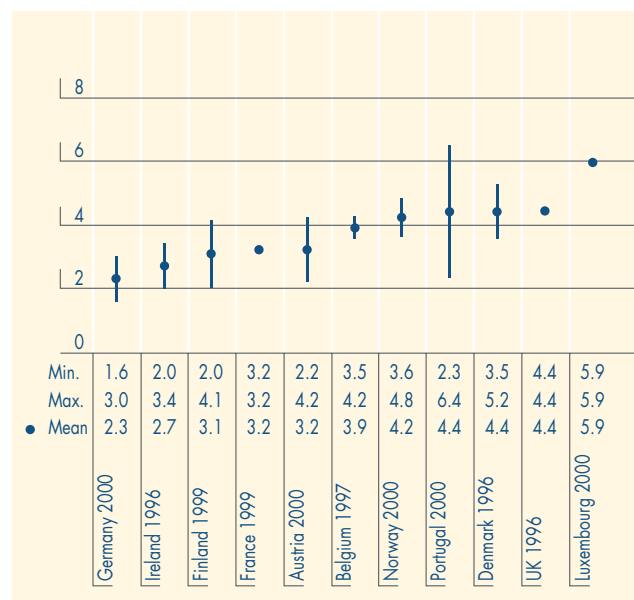
Sources: National focal points through the EMCDDA project: 'National prevalence estimates of problem drug use in the European Union, 1995–2000', CT.00.RTX.23, Lisbon, EMCDDA, 2003. Coordinated by the Institut für Therapieforschung, Munich.

way, therefore between-country comparisons should be carried out with caution.

Several countries report changes in estimates, suggesting increases in problem use since the mid-1990s. Out of 16 countries, eight report higher estimates of problem drug use (Germany, Spain, Italy, Luxembourg, Finland, Sweden) or injecting drug use (Belgium and Norway) during the 1990s, although the increase reported in Sweden at national level does not seem to be confirmed in two local studies) ⁽¹¹⁾.

The prevalence estimates of problem drug use are all between two and 10 cases per 1 000 of the population aged 15–64 (using the midpoints of the estimates). The highest rates are reported in Italy, Luxembourg, Portugal and the United Kingdom (6–10 per 1 000 inhabitants aged 15–64). Rates are lowest in Germany, the Netherlands and Austria, each with about three problem drug users per 1 000 inhabitants aged 15–64. Data for Belgium and Norway are not available (Figure 4).

Figure 5: Estimates of injecting drug use in EU Member States (most recent one-year prevalence per 1 000 inhabitants aged 15–64)



NB: Figures show the combined country range of different estimates. They may be based on different methods and data sources and should be interpreted with caution (see online statistical tables for specific estimates and full details). The dot shows the midpoint of the range, while the line represents the uncertainty range or 95 % confidence interval. The longer this line, the wider the range of the prevalence estimates is (not available for France, Luxembourg or the United Kingdom).

Sources: National focal points through EMCDDA project: 'National prevalence estimates of problem drug use in the European Union, 1995–2000', CT.00.RTX.23, Lisbon, EMCDDA, 2003. Coordinated by the Institut für Therapieforschung, Munich.

In Finland and Sweden, the majority of problem drug users are primary amphetamine users (an estimated 70–80 % in Finland in 1999). This is in contrast to the situation in other countries, where problem drug users are mostly primary opiate users (and often polydrug users). In Spain, cocaine has become an important factor in recorded drug problems (treatment and emergency data), and this is confirmed by recent prevalence estimates. Some countries (Germany, the Netherlands) report a high prevalence of crack cocaine use among problem drug users, although mainly in large cities and principally among primary opiate users.

Separate estimates are given for injecting drug use, a subcategory of all problem drug use. These estimates are based on multiplier methods using mortality data and rates of human immunodeficiency (HIV) or hepatic C virus (HCV) infection. As it is difficult to distinguish rates of current injection (probably best represented by mortality-based estimates) and lifetime injection (from the HIV/HCV estimates), the estimates are difficult to compare. Estimates of injecting drug use are in general between two and five

⁽¹¹⁾ See Box 3 OL: Trends and patterns of problem drug use by country (online version).

cases per 1 000 of the population aged 15–64 (data are not available for five Member States). The estimate for Luxembourg is higher, at almost 6 per 1 000. Estimates of injecting drug use indicate the population at risk for serious health consequences or drug-related death (Figure 5).

Analysis of the proportions of injectors among heroin users in treatment suggest marked differences in prevalence of injecting drug use between countries and varying trends over time (Figure 6). In some countries, injecting drug use appears to be low (Portugal, the Netherlands), whereas in other countries levels of injection among heroin users in treatment are high (Greece, Luxembourg). In almost all countries, injecting drug use among treated heroin users seems to have fallen during the 1990s, although data for some countries suggest increases since 1996 and more recently (Ireland, Finland), which, if confirmed, are worrying and should be acted upon. In the United Kingdom, the proportion of injectors fell until 1996, but it increased the next year and since then has remained stable.

The same data on the percentage of current injecting among opiate users in treatment, weighted by the estimated absolute numbers of problem drug users (see Statistical Table 4), suggest that roughly 60 % of problem drug users in the EU are injectors, but with large variation between countries (not shown). If the rate of problem drug use in the EU as a whole is between four and six cases per 1 000 population aged 15–64, this translates into between 1 and 1.5 million problem drug users, of whom 600 000–900 000 are injectors.

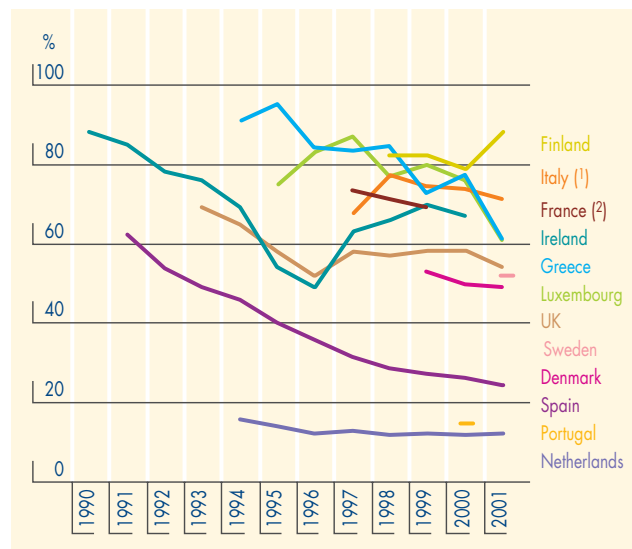
Demand for treatment

The characteristics (e.g. social characteristics) of clients entering treatment as well as their consumption behaviour (e.g. the proportion of injectors or opiate users) are potential indicators of wider trends in problem drug use. Treatment demand data also offer a view of the organisation of treatment centres in Europe. However, biases may arise owing to different methods of information collection and variation in the type of treatment services on offer in different countries. Data collection was based for the second time on a common European protocol (treatment demand indicator, TDI), including information on around 150 000 patients ⁽¹²⁾.

Substances

Despite differences in treatment policies and recording practices, it is possible to identify both common and divergent trends across Europe.

Figure 6: Trends in injecting drug use in EU Member States, 1990–2001 (percentage of current injectors among heroin users in treatment)



(1) Italy: data from Standard Table 4 (2002).

(2) Data are not available for France 1998; figure is based on interpolation. Data represent several thousands of cases per country per year and in most countries include almost all treated cases at national level.

Sources: National focal points through EMCDDA project: 'Treatment demand indicator' (http://www.emcdda.eu.int/situation/themes/demand_treatment.shtml).

See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

Statistical Table 4: Estimated number of problem drug users in EU Member States, 1995–2001

Statistical Table 5: Estimated rate of problem drug users in EU Member States, 1995–2001 (rate per 1 000 aged 15–64)

Information sources

In 2002, as in 2001, two information sources were used: the extended TDI protocol in treatment centres where data were available and a concise form of the TDI protocol, which is included in the tables collected since 1993. In order to be consistent with previous years and see trends over time, in some cases the second information source has been used. The number of covered cases for each country by data source is reported in the online version ⁽¹⁾.

(1) Table 1 OL: Number of covered cases by data source (online version).

⁽¹²⁾ A full report on the treatment demand indicator is available online (http://www.emcdda.eu.int/multimedia/project_reports/situation/treatment_indicator_report.pdf).

As in previous years, for 2001, all countries report an increase in the overall number of people treated for drug problems. According to the national reports, there are several reasons for this: improved methods of registration (more persons treated are reported), increased availability of treatment facilities (especially substitution treatments and low-threshold services), differentiation of programmes (there are now specialised services for specific target groups and different substances used in substitution programmes, such as buprenorphine as well as methadone), increasing treatment duration of existing clients and an increase in the number of persons being treated in rural/non-urban areas (National reports, 2002).

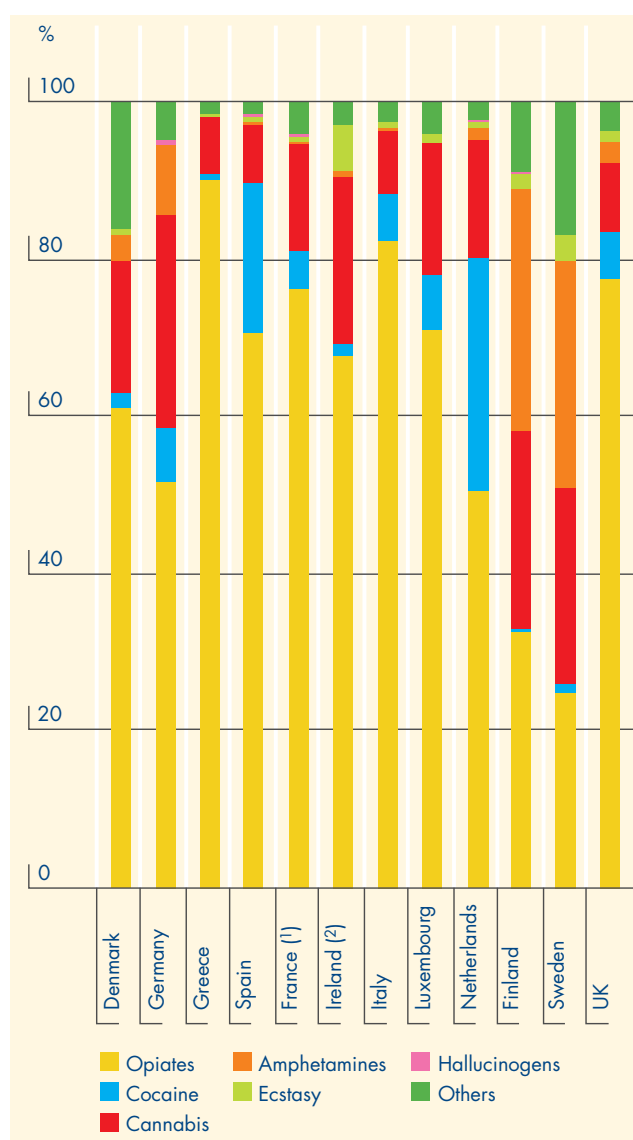
Drug users mainly demand treatment spontaneously or because family members exert pressure on them to do so; other sources account for only a small proportion of referrals⁽¹³⁾. Referrals to drug-treatment centres vary from country to country, for several reasons: differences in distribution of use of abused substances; differences in the national organisation of health, social and judicial services; and social or cultural differences. For example, the proportion of clients referred by the courts, police or other judicial services is highest in Germany, possibly because of the high proportion of cannabis users there⁽¹⁴⁾. In contrast, in Sweden, which has a highly structured welfare system, social services play an important role in referring drug users to specialised services. In Greece, the family is a central institution in society and plays an important role as a source of referral (National report, 2002)⁽¹⁵⁾.

Opiates (especially heroin) remain the main substances of abuse among all clients seeking treatment in most countries (Figure 7). In most EU countries, between 50 % and 70 % of clients requesting treatment are heroin users, but the figure varies widely. It is possible to categorise EU Member States into four groups depending on the extent to which opiates abuse accounts for referrals to drug-treatment centres:

- below 50 % (Finland, Sweden);
- 50–70 % (Denmark, Germany, France, Ireland, the Netherlands);
- 70–80 % (Spain, Luxembourg, the United Kingdom); and
- over 80 % (Greece, Italy, Portugal)⁽¹⁶⁾.

It seems that attendees of outpatient treatment centres tend to be more differentiated than users of other treatment services⁽¹⁷⁾ either because outpatient clinics specialise in

Figure 7: All clients admitted to treatment — presented by main drug



NB: n = 300 414.

(1) 1999 data.

(2) 2000 data.

Sources: Reitox national reports (2002). See also Statistical Table 6: Characteristics of persons treated for drug problems in the EU (online version).

specific drug-related problems or because such clinics have developed in response to demand for treatment of different types of drug abuse (such as cannabis or cocaine abuse) (Molinae et al., 2002).

In many countries, heroin is followed by cannabis in terms of the number of users seeking treatment, and the figure is highest among new clients (24.7 % of the total number of

⁽¹³⁾ Figure 3 OL: New clients admitted to treatment by source of referral (online version).

⁽¹⁴⁾ For various reasons (including, for example, the imposition of administrative sanctions such as a driving ban), the proportion of users referred by the criminal justice system does not necessarily correspond to the proportion of offenders.

⁽¹⁵⁾ Figure 4 OL: Source of referral among new clients in some countries (online version).

⁽¹⁶⁾ See Statistical Table 6: Characteristics of persons treated for drug problems in the EU (online version); and Statistical Table 7: Characteristics of persons treated for drug problems in the EU for the first time (online version).

⁽¹⁷⁾ Figure 5 OL: Primary drug among all clients by centre type (online version).

new admissions are cannabis users) ⁽¹⁸⁾; clients requesting treatment for cannabis use mainly attend outpatient and inpatient clinics ⁽¹⁹⁾. Often, cannabis is used in association with other substances and is used as a secondary drug ⁽²⁰⁾. The proportion of people seeking treatment for cannabis use varies greatly between countries: from 7.3 % in Greece to 27.2 % in Germany (Figure 7).

Spain (19 %) and the Netherlands (29.9 %) remain the countries with the highest percentages of clients seeking treatment for cocaine as their main drug. Rates in other countries are lower — from 0.8 % in Greece to 7 % in Luxembourg. A specific study of treatment data conducted in the Netherlands found that the two largest groups of people requesting treatment for cocaine use in the last years were cocaine base/crack users and those using cocaine in combination with heroin or methadone. Base/crack users may be particularly challenging for treatment services as crack cocaine is associated with high levels of dependence and problems and those who use it, either alone or in combination with heroin, are often poorly integrated socially (Mol and van Vlaanderen, 2002).

The drug group for which demand for treatment shows the widest disparity between countries is amphetamines, with the proportion of demand accounted for by amphetamine users being 3 % in Denmark, 8.7 % in Germany, 1.5 % in the Netherlands, 31.1 % in Finland, 29 % in Sweden, 2.7 % in the United Kingdom and less than 1 % in the other countries.

Polydrug use is increasingly apparent in treatment data. In all countries, over 50 % of all clients use at least one other drug in addition to their first drug, mainly cannabis (18.4 %) or cocaine (19 %). The most frequently reported combinations of substances are heroin with cocaine or cannabis, and cocaine with alcohol or cannabis (National reports, 2002).

Trends

Common trends across European countries are reported for treatment demand for heroin and cannabis use; heroin use appears to be stable or decreasing in all countries, whereas cannabis use is increasing almost everywhere, especially among new clients (Figure 8).

Possible reasons for the apparent decrease in the numbers of heroin users could include the end of the heroin epidemic that occurred in the late 1980s and early 1990s and the consequent decrease in requests for treatment; saturation of treatment services for heroin users; and increased differentiation of treatment programmes, with more facilities now available for users of other drugs (including cannabis).

Figure 8: New clients admitted to treatment for (A) heroin/opiates use or (B) cannabis use

Figure 8 (A): Heroin/opiates use

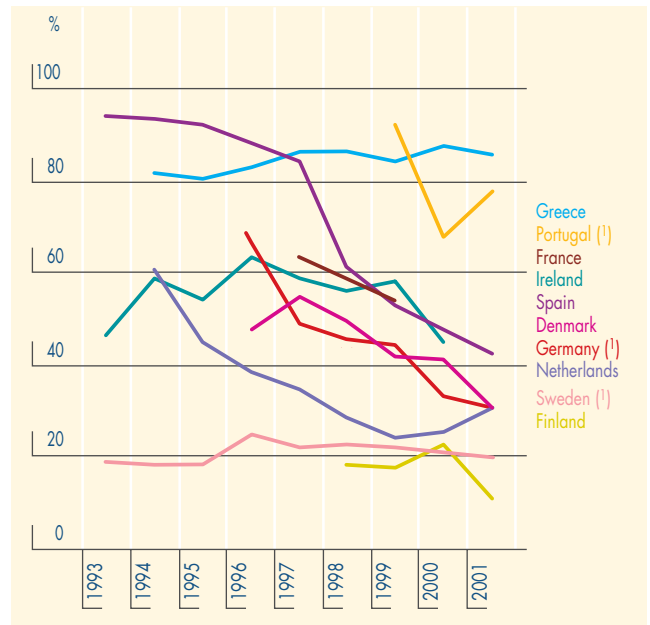
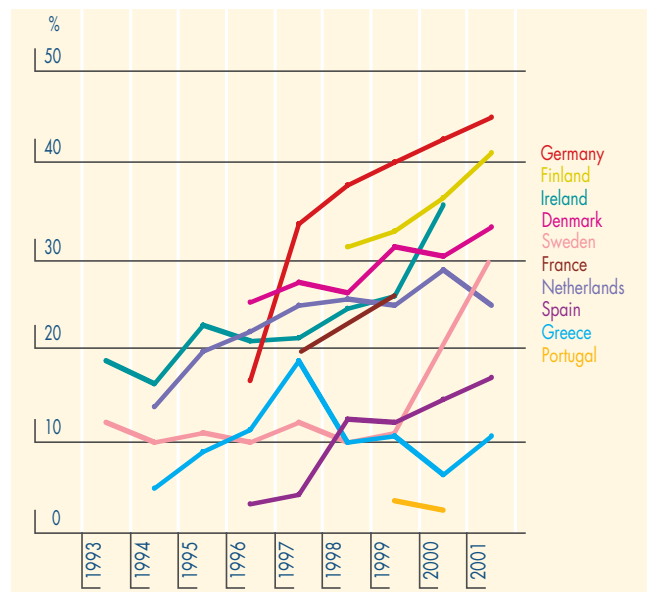


Figure 8 (B): Cannabis use



NB: Data were not available for Belgium, Italy, Luxembourg, Austria and the United Kingdom. See Statistical Table 7 for the number of cases (online version).
 (1) Heroin includes all opiates.
 Sources: Reitox national reports (2002). See also Statistical Table 7: Characteristics of persons treated for drug problems in the EU for the first time.

The trend towards an increase in demand for treatment for cannabis use (Figure 9) could have several reasons: increasing prevalence of regular cannabis use, an increase

⁽¹⁸⁾ Figure 6 OL: Distribution of new and all clients by primary drug (online version).

⁽¹⁹⁾ Figure 5 OL: Primary drug among all clients by centre type (online version).

⁽²⁰⁾ Figure 7 OL: Most used secondary drugs among all clients (online version).

in the number of cases reported by the criminal justice system, market factors (such as greater availability or lower prices) and an increase in the number of adolescents with social or psychological problems unable to find other suitable services. The increase in the number of new clients demanding treatment for cannabis appears to be particularly marked in some countries where prevalence data, seizures of cannabis, cannabis offences and demands for treatment for cannabis use are following parallel trajectories (National reports, 2002). Ongoing research in Germany is focusing on those groups referred to the treatment services by the justice system and/or social services for cannabis use; first results seem to indicate that some young cannabis users meet the criteria for dependence according to ICD-10 codes (R. Simon, personal communication, 2002).

Trends in the use of cocaine ⁽²¹⁾ and other substances are less homogeneous among countries: in Spain and the Netherlands, the sharp increase seen in previous years seems to have slowed down, with demand for treatment now stable or increasing only slightly, mainly among first-time clients.

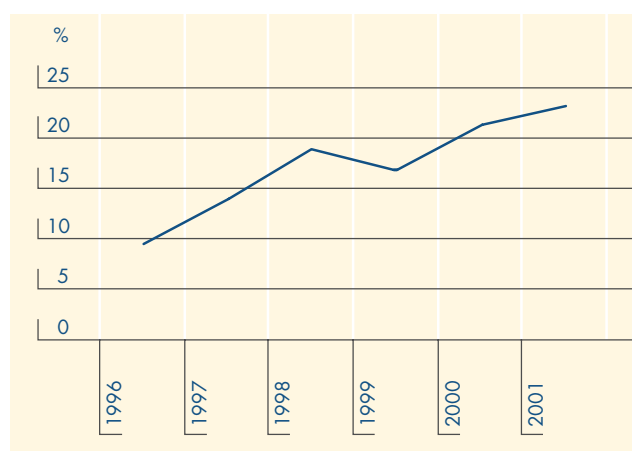
Patterns of use and routes of administration

Mostly, users take drugs for the first time during adolescence (between 15 and 29 years and in particular from ages 15 to 19). However, age at first use differs by substance: 33.6 % of clients start to use cannabis before the age of 15 and 56.3 % when aged between 15 and 19 years, and 63.3 % use stimulants for the first time at the same age (15 to 19). In contrast, the age at first use of heroin and cocaine appears to be higher (more than 40 % of clients first use heroin and cocaine when aged between 20 and 29 years, and a group even after this age) ⁽²²⁾.

Heroin, cocaine and cannabis users demanding treatment, if they have used drugs in the last 30 days, have usually taken them on a daily basis, while stimulants are typically used two to six times a week ⁽²³⁾.

The routes of administration of the primary drugs most frequently reported are injection and smoking for heroin, snorting or smoking/inhaling for cocaine and ingestion/drinking for stimulants (Figure 10). Taking into account the methodological limitations (the sample was not exactly the same as in the previous year (2001) and there were fewer unknown data in 2001), a change in patterns of use has been reported in 2001: fewer clients inject

Figure 9: Trend in demand for treatment for cannabis use, 1996–2001



NB: Valid percentage weighted on the number of clients per country. New clients only. 'N' value varies by year from 31 143 – 56 394. More details are available in Table 1 OL.

Sources: Reitox national reports (1996 to 2001).

heroin and more sniff or smoke cocaine. Possible reasons could be related to market factors, especially price and availability of smokable heroin and crack/cocaine, and the impact of prevention and harm-reduction programmes (EMCDDA, 2002a; National reports, 2002).

Social characteristics

Clients entering treatment tend to be men in their 20s or 30s. The mean age is 29.8 years overall, and 26.9 years among first-time clients. Germany, Ireland and Finland have the youngest treated population, while the oldest clients seeking treatment are to be found in Spain, Italy and the Netherlands ⁽²⁴⁾. The age distribution of clients seeking treatment seems to be correlated with the type of substance consumed — in general, cannabis consumers are younger, whereas heroin and cocaine users are older. The highest proportion of cannabis users is in Germany, while the greatest proportions of cocaine and heroin users are found in Spain and Italy respectively. The high proportion of young drug users in Finland might be partly explained by the relatively late development of drug culture in that country. The gender distribution varies from a male–female ratio of 2:1 to 6:1 ⁽²⁵⁾. The higher proportion of men may reflect generally higher levels of drug use among males or may be influenced by differential access to services (EMCDDA, 2002a). Gender distribution patterns tend to be similar among southern countries or northern countries (e.g. the proportions of male users are higher in southern countries).

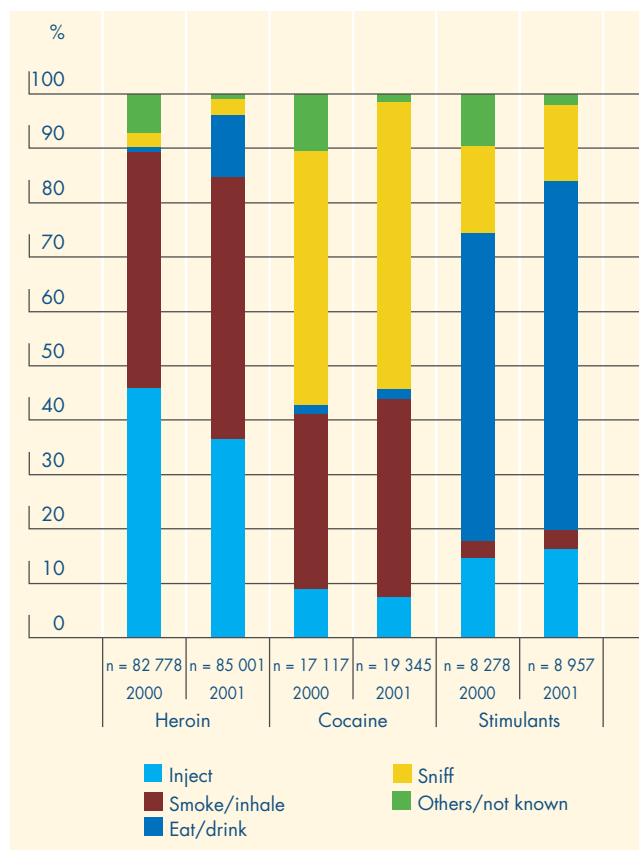
⁽²¹⁾ Figure 8 OL: New clients admitted to treatment for cocaine use (online version).

⁽²²⁾ Figure 10 OL: Age at first use of main drug among all clients (online version).

⁽²³⁾ Figure 9 OL: Frequency of use of main drug among all clients (last 30 days before starting treatment) (online version).

⁽²⁴⁾ Table 2 OL: Mean age of clients in treatment (online version).

⁽²⁵⁾ See Statistical Table 8: Characteristics of women treated for drug problems in the EU; and Statistical Table 9: Characteristics of men treated for drug problems in the EU (online version).

Figure 10: Route of administration among all clients at EU level

NB: Valid percentage.
Data were not available for France, Ireland, Austria and Portugal for 2000 or for Belgium, France, Italy and Portugal for 2001.
Sources: Reitox national reports (2001, 2002). TDI data (2000, 2001) from out-patient treatment centres.

This is attributable to a difference in the pattern of substances use between northern and southern countries (the southern countries have a higher proportion of heroin users, who are mainly men) and to cultural and social differences.

See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

Statistical Table 6: Characteristics of persons treated for drug problems in the EU

Statistical Table 7: Characteristics of persons treated for drug problems in the EU for the first time

Statistical Table 8: Characteristics of women treated for drug problems in the EU

Statistical Table 9: Characteristics of men treated for drug problems in the EU

In general, the social conditions of clients demanding treatment, for example education, living and labour status, are deteriorating compared with the general population ⁽²⁶⁾.

Drug-related infectious diseases ⁽²⁷⁾

Prevalence and trends in HIV and AIDS

Infectious diseases related to injecting drug use have a major impact on the economic and social costs of drug use, even in countries where HIV prevalence is low (Postma et al., 2001; Godfrey et al., 2002). They can be prevented by providing injecting drug users (IDUs) with information about disease transmission, clean needles (Hurley et al., 1997; Commonwealth of Australia, 2002) and vaccination against hepatitis A and B viruses. Effective treatment for HIV and HCV infections is now available and, as the prevalence of infections is often very high among IDUs, policies aimed at prevention and treatment of infections are highly cost-effective.

The EMCDDA is systematically monitoring the prevalence of HIV infection and hepatitis B and C among IDUs in the European Union. Information on aggregate prevalence (overall and within subgroups) is collected from different routine settings (e.g. drug-treatment or needle-exchange programmes, prisons) as well as from special studies ⁽²⁸⁾. Although the data are difficult to compare because they come from a variety of sources, they provide an overall impression of differences between countries, regions and settings. More importantly, following trends over time, especially prevalence in young and in new injectors, provides crucial information on the spread of infections among IDUs and the success of preventative policy measures. The longer-term aim is to improve data quality and comparability from existing routine sources and to set up truly comparable local European seroprevalence studies among IDUs.

The data that are available suggest that the prevalence of HIV infection among IDUs varies greatly between, as well as within, countries. The levels of infection reported by different sources vary from about 1 % in the United Kingdom (surveys and unlinked anonymous screening) to over 30 % in Spain (routine diagnostic tests in drug treatment), but they are, in general, stable ⁽²⁹⁾. This overall picture has not changed in recent years (Figure 11).

In some countries and regions, HIV prevalence has remained extremely high among IDUs since 1995. Although in most cases this reflects old epidemics, special prevention

⁽²⁶⁾ See 'Social exclusion and reintegration', p. 65.

⁽²⁷⁾ A more detailed insight into this issue is provided in the 2001 Annual report, Chapter 3, Selected issues — Drug-related infectious diseases. Available online (<http://ar2001.emcdda.eu.int>).

⁽²⁸⁾ See the EMCDDA web site (http://www.emcdda.eu.int/situation/themes/infectious_diseases.shtml) for more detail on methods and guidelines.

⁽²⁹⁾ For more detail on these data and for original sources, see Statistical Table 10: Summary table of prevalence of HIV infection among injecting drug users in the EU; and Statistical Table 12: Prevalence of HIV infection (per cent infected) among injecting drug users in the EU and Norway (online version).

efforts are very important (e.g. efforts to prevent transmission to new IDUs, to sexual partners of IDUs and from mother to child). Prevalence was over 25 % in some regions and cities ⁽³⁰⁾.

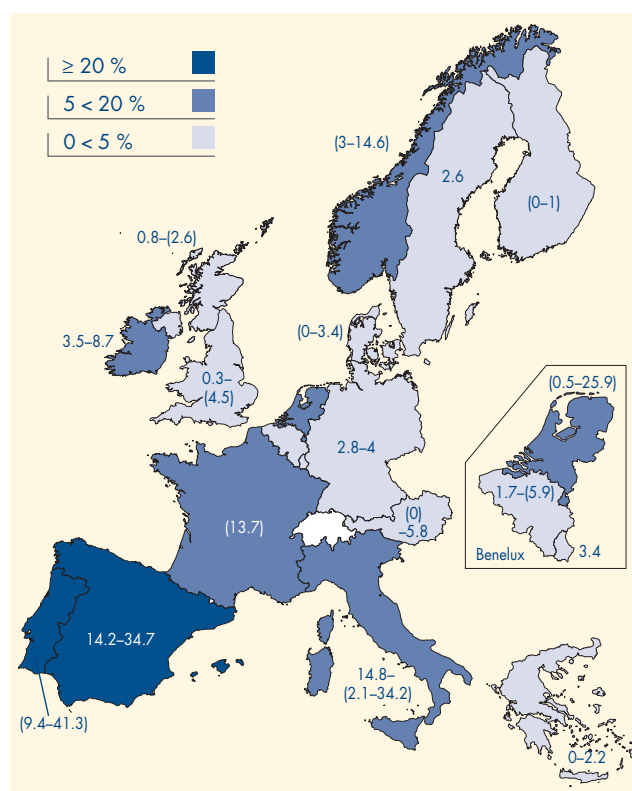
Trends in HIV prevalence provide important information for making and evaluating policy. More action is needed if trends suggest that levels of infection are increasing but may be unnecessary if infection levels appear to be declining. However, even in areas where prevalence is stable or decreasing, new infections may still occur. In recent years, increases in HIV transmission in (subgroups of) IDUs may have occurred in regions or cities in Spain, Ireland, Italy, the Netherlands, Austria, Portugal, Finland and the United Kingdom, although in some of these countries large decreases were also recorded ⁽³¹⁾. The Italian data demonstrate that in countries with significant numbers of infections national averages are of limited value, and breakdowns by smaller regions or cities are important to evaluate the success of prevention ⁽³²⁾. However, few countries can yet provide national data broken down by region. To facilitate the detection of trends over time, prevalence data should, ideally, be supplemented by notifications of newly diagnosed cases. Although not yet available for the countries with the highest prevalences, and still highly dependent on testing patterns, in Finland, notification data have helped reveal new increases in transmission rates. Recently, Portugal has started to provide HIV notification data, revealing much higher rates per million population than the other reporting countries ⁽³³⁾.

HIV prevalence among young IDUs may provide further feedback on the effectiveness of prevention measures, as infection in young people will typically be more recent than in the IDU population as a whole. Although sample sizes are small, these data suggest that infections have occurred in young IDUs in several regions in recent years ⁽³⁴⁾.

For some countries, information is available on HIV prevalence among new injectors. This is a much better indicator of recent HIV infections and may reflect incidence of HIV infection, thus providing stronger evidence for the effectiveness of prevention measures. Assuming that injectors who have been injecting for less than two years have, on average, been injecting for one year, prevalence in that group may provide an estimate of incidence. The available data suggest that incidence per 100 person-years of exposure among new injectors (95 % confidence

intervals) may vary from 0–3.7 in England and Wales (0/122, 1998), through 0.8–11.4 in the Belgian Flemish Community (3/77, 1998–99) and 4.4–14.5 in Coimbra, Portugal (12/127, 1999–2000), to 4.4–15.5 in France

Figure 11: Prevalence of HIV infection among IDUs in the EU Member States and Norway



NB: Figures in brackets are local data. Differences between countries should be interpreted with caution because of the different source types and use, in some cases, of local or self-reported data. The colour for each country indicates the midpoint of the range of prevalence estimates obtained from different data sources.

This summary map is meant to give a global overview of HIV prevalence among IDUs in the EU. In this map, data are reported for the most recent year available. Data from samples with no information on IDU status were excluded. If this led to exclusion of sources that clearly improve generalisability (e.g. national data, out-of-treatment data) data from more than one year were combined. Data for Italy, Portugal and Norway are limited to HIV prevalence among IDUs in treatment and are not representative of HIV prevalence among IDUs who are not in treatment. Having health problems is one selection criterion for admission to drug treatment in some countries or cities (Greece, Portugal, Rome); because of long waiting lists or special programmes for infected IDUs, this may result in upward bias of prevalence. Prevalence in this map should not be compared with previous versions to follow changes over time, as inclusion of sources may vary according to data availability. For time trends, methodological detail and for sources see Statistical Table 12: Prevalence of HIV infection (percentage infected) among injecting drug users in the EU and Norway; and Box 6 OL: Data sources — prevalence (online version).

Sources: Reitox national focal points. For full details and primary sources, see Statistical Table 10: Summary table of prevalence of HIV infection among injecting drug users in the EU; and Statistical Table 12 (online version).

⁽³⁰⁾ See Box 4 OL: Areas with high HIV prevalence, increases and decreases in HIV transmission among IDUs in some EU countries, HIV prevalence among young IDUs (online version).

⁽³¹⁾ See Box 4 OL: Areas with high HIV prevalence, increases and decreases in HIV transmission among IDUs in some EU countries, HIV prevalence among young IDUs (online version).

⁽³²⁾ See Figure 11 OL: Prevalence of HIV infection in Italian IDUs in treatment, by region (online version).

⁽³³⁾ See Statistical Table 15: HIV infections newly diagnosed among injecting drug users in the EU and Norway (online version).

⁽³⁴⁾ See Box 4 OL: Areas with high HIV prevalence, increases and decreases in HIV transmission among IDUs in some EU countries, HIV prevalence among young IDUs (online version).

(11/111, self-reported serostatus in needle-exchange scheme attendees, 1998) ⁽³⁵⁾. However, the data from Belgium, France and Portugal are from routine testing and may be affected by selection bias. (The data for Portugal may be an overestimation because of the selection criteria of detoxification units, which give priority to problematic and/or seropositive drug users).

AIDS data provide little information for following trends in new HIV infections because of the long incubation time of HIV before onset of symptoms of AIDS and the major improvements in HIV treatment that delay the onset of AIDS. However, AIDS incidence does reflect trends in the burden of disease from HIV infection in the different countries. The incidence of AIDS has fallen in most countries since about 1996 as a result of improved treatment of HIV infection and possibly lower infection rates in the 1990s. In Portugal, the latest data show that the incidence of AIDS among IDUs has been decreasing since 1999 ⁽³⁶⁾. This may indicate increased uptake of HIV treatment consistent with reports from the drug-treatment system.

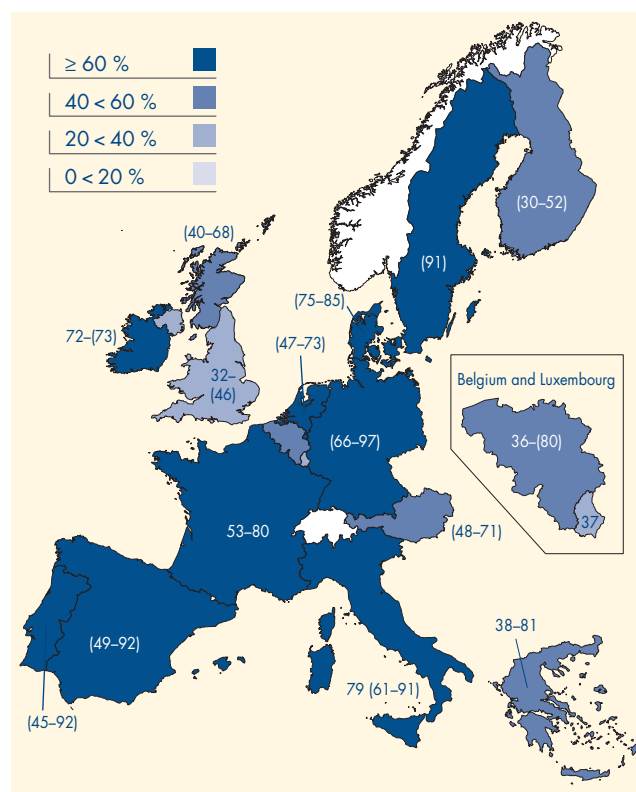
Prevalence of and trends in hepatitis C virus infection

Data on prevalence of infection with HCV are less readily available and, where provided, are subject to the same limitations as the HIV data. However, the overall picture is clear — HCV prevalence is extremely high in all countries and settings, with infection levels of between 40 % and 90 % among different countries and subgroups of IDUs (Figure 12).

Although all prevalence figures show very high levels of infection, the range is still wide. As for HIV, this may partly reflect different selection mechanisms in the different data sources, and comparisons should be made with caution. In 2000 and 2001, levels over 75 % were reported for Antwerp, Belgium (80 % of IDUs in drug-treatment and low-threshold services, 2001), Frankfurt and Berlin, Germany (82–90 % in a low-threshold service and two prisons), northern Greece and Greece at national level (83 % of IDUs in methadone-treatment programmes), the Italian regions of Piedmont, Trentino, Friuli-Venezia Giulia, Liguria, Emilia-Romagna, Basilicata and Sardinia and the cities of Trento and Bolzano (drug treatment), and in Lisbon and some smaller Portuguese cities (drug-treatment clients) ⁽³⁷⁾.

As an indicator of high-risk injecting behaviour (e.g. sharing needles or other equipment) and the effectiveness of prevention programmes, trends in HCV prevalence may be much more sensitive than trends in HIV. HCV is more

Figure 12: Prevalence of hepatitis C virus infection among IDUs in the EU Member States



NB: Figures in brackets are local data. Differences between countries should be interpreted with caution because of different source types and use, in some cases, of local data or saliva tests, which underestimate prevalence. The colour for a country indicates the mid-point of the prevalence estimates obtained from different data sources.

This summary map is meant to give a global overview of HCV prevalence among IDUs in the EU. In this map, data are reported for the most recent year available. Data from samples with no information on IDU status as well as self-reported test results were excluded. If this led to exclusion of sources that clearly improve generalisability (e.g. national data, out-of-treatment data) data from more than one year were combined. Data for Ireland and Luxembourg are limited to IDUs in prisons, while data for Italy are limited to HCV prevalence among IDUs in treatment and are not representative of HCV prevalence among IDUs who are not in treatment. Having health problems is one selection criterion for admission to drug treatment in some countries or cities (Greece, Portugal, Rome); because of long waiting lists or special programmes for infected IDUs, this may result in upward bias of prevalence. Prevalence in this map should not be compared with previous versions to follow changes over time, as inclusion of sources may vary according to data availability. For time trends, more methodological detail and for sources see Statistical Table 16 and Box 6 OL.

Source: Reitox national focal points. For primary sources, see Statistical Table 16: Prevalence of hepatitis C infection among injecting drug users in the EU (online version).

infectious than HIV and can be transmitted more easily through injecting materials other than syringes, such as cotton, spoons and water (but is very much less readily transmitted sexually). Both increases and decreases are found in different regions ⁽³⁸⁾.

⁽³⁵⁾ See Statistical Table 15: HIV infections newly diagnosed among injecting drug users in the EU and Norway (online version).

⁽³⁶⁾ Figure 12 OL: Incidence of AIDS related to injecting drug use in EU Member States (online version).

⁽³⁷⁾ Box 5 OL: Trends in prevalence of hepatitis C (online version).

⁽³⁸⁾ See Box 5 OL: Trends in prevalence of hepatitis C (online version).

As far as they are available, data from treatment programmes indicate that the prevalence of HCV infection in IDUs aged under 25 varies from 12 % in Tampere, Finland (2001), to around 60 % in Dublin, Ireland (1997), and Italy (1999). Prevalence in young IDUs seems to be decreasing in Belgium and Greece but increasing in England and Wales (1998–2001).

Information regarding the prevalence of HCV infection in new injectors (those who have been injecting for less than two years) is still not available from most sources. Where data are available, they generally suggest that the prevalence is very high — 40 % or more — although lower figures have been reported from Belgium and the United Kingdom (Figure 13).

Prevalence of and trends in hepatitis B virus infection

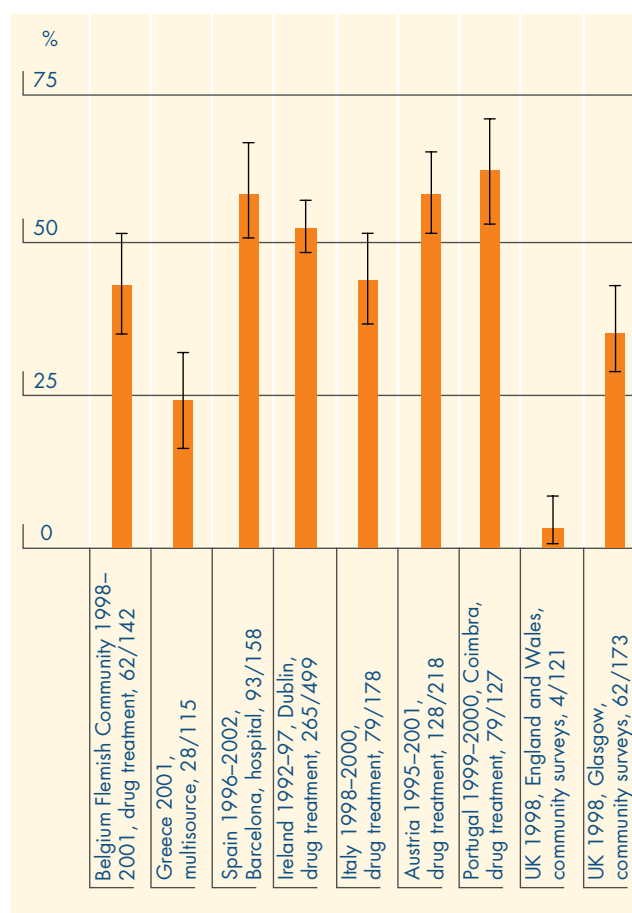
The presence in the blood of antibodies to a virus indicates that someone has at one time been infected with or vaccinated against the virus. In contrast to HIV and HCV, there is an effective vaccine against hepatitis B virus (HBV). Thus, in the case of HBV, the proportion of IDUs who do not have antibodies (aHBs or aHBc) against the virus constitutes the potential vaccination population and is an important indicator of the need for a vaccination programme. In the EU, there is greater variation in the proportion of drug users who have (any type of) antibodies against HBV than in those with antibodies to HCV. Throughout the EU, approximately 20–60 % of IDUs have antibodies against hepatitis B, suggesting a large potential for vaccination programmes directed at IDUs (40–80 %).

Current hepatitis B infection, as indicated by the presence in the blood of a serological marker called HbsAg, can be either recent or chronic. High levels of current infection suggest a risk of a high future level of severe, long-term complications and of widespread transmission to others through high-risk injecting behaviour or unsafe sex. The prevalence of current HBV infection is recorded in only a few countries, but appears to differ widely and in some cases is high.

Notified cases of hepatitis B and C

Notification data for HBV and HCV are available for some countries. Although definitions differ and do not allow direct comparisons to be made, trends over time may provide useful information. Reported cases of hepatitis C seem to have decreased over time in Denmark, Finland and Sweden, whereas numbers have increased in the Netherlands and the United Kingdom. In the case of hepatitis B, decreases have also occurred in Denmark and Finland, whereas the numbers of cases have increased in Norway and the United Kingdom. Increased testing may

Figure 13: Prevalence of hepatitis C virus infection among IDUs who have been injecting for less than two years



NB: Brackets indicate the 95 % confidence interval.

Source: Reitox national focal points. For primary sources, see Statistical Table 18: Prevalence of hepatitis C infection among new injecting drug users in the EU (online version).

partly account for increasing trends. The proportion of all cases accounted for by IDUs is very high (about 90 % in the case of HCV and 40–70 % in the case of HBV) in most countries, suggesting that the majority of HBV and almost all cases of HCV infection in the EU are due to injecting drug use⁽³⁹⁾.

See <http://annualreport.emcdda.eu.int> for further information related to this section:

Box 6 OL: Data sources — prevalence (for Statistical Tables 10–14, 16–20)

Box 7 OL: Data sources — notifications (for Statistical Tables 21 and 22)

Statistical Table 10: Summary table of prevalence of HIV infection among injecting drug users in the EU

Statistical Table 11: Summary table of prevalence of HCV infection among injecting drug users in the EU

⁽³⁹⁾ See Statistical Table 21: Notified cases of hepatitis C infection among injecting drug users in the EU and Statistical Table 22: Notified cases of hepatitis B infection among injecting drug users in the EU and Norway (online version).

Statistical Table 12: Prevalence of HIV infection (percentage infected) among injecting drug users in the EU and Norway

Statistical Table 13: Prevalence of HIV infection among injecting drug users under age 25 in the EU

Statistical Table 14: Prevalence of HIV infection among new injecting drug users in the EU

Statistical Table 15: HIV infections newly diagnosed among injecting drug users in the EU and Norway

Statistical Table 16: Prevalence of hepatitis C infection among injecting drug users in the EU

Statistical Table 17: Prevalence of hepatitis C infection among injecting drug users under age 25 in the EU

Statistical Table 18: Prevalence of hepatitis C infection among new injecting drug users in the EU

Statistical Table 19: Prevalence of current hepatitis B infection (HbsAg) among injecting drug users in the EU

Statistical Table 20: Prevalence of antibodies against hepatitis B virus among injecting drug users in the EU

Statistical Table 21: Notified cases of hepatitis C infection among injecting drug users in the EU

Statistical Table 22: Notified cases of hepatitis B infection among injecting drug users in the EU and Norway

Statistical Table 23: Incidence of hepatitis C infection among injecting drug users in the EU

Drug-related deaths and mortality among drug users ⁽⁴⁰⁾

National statistics on 'drug deaths' usually refer to acute deaths directly related to drug consumption or 'overdoses', although differences between countries exist ⁽⁴¹⁾. The EMCDDA key indicator 'Drug-related deaths' is also defined in this way ⁽⁴²⁾. The development of the key indicator has prompted work in different Member States to improve reporting procedures on drug-related deaths.

Direct comparisons of national statistics should still be made with caution owing to differences in definitions, reporting quality and coverage. However, if consistent recording methods are maintained over time within a country, the

number of drug-related deaths can be a useful indicator of trends in severe forms of drug use, especially when analysed together with other indicators.

Drug overdose is an important cause of death among young people, particularly young men, in most EU countries. Deaths from AIDS and other causes (violence, accidents, etc.) account for additional drug-related mortality, with important differences between countries and cities. Generally, these deaths are reported from different data sources.

Drug-related deaths among injectors and opiate users are much higher than in the general population, and problem drug use is a major cause of death among young adults in most EU countries. Studies in the 1990s in some EU cities (Glasgow, Madrid, Rome) found that a significant proportion of deaths among young adults could be attributed to problem drug use (in particular injection of opiates). Although deaths from AIDS are declining, overdose deaths are stable or continuing to increase, and new studies are needed to provide more recent information on drug-related mortality in other cities.

Impact of drug-related deaths

For the last 10 years, the annual number of acute drug deaths reported by EU countries in total has varied between 7 000 and 9 000 ⁽⁴³⁾. These figures can be considered as minimum estimates as it is likely that in most countries there is some level of under-reporting (which could sometimes be substantial). Most of the victims are young people and, in addition, many of these deaths are preventable.

Despite some encouraging findings of a stabilisation or decrease in the number of drug-related deaths in some EU countries, in many other EU countries (and in other parts of the world) overdose deaths continue to increase.

Risk factors

Opiates are present in the blood of most victims of overdose death due to illegal substances, although concentrations found in toxicology vary widely, and other substances are very frequently present ⁽⁴⁴⁾.

Several risk factors for opiate overdose are known: administration by injection; concomitant use of other

⁽⁴⁰⁾ Box 8 OL: The methodology and definitions used to estimate drug-related deaths and mortality (online version).

⁽⁴¹⁾ Box 9 OL: Definitions of 'acute drug-related death' in EU Member States, as used in the EMCDDA annual report and reported in national reports (online version).

⁽⁴²⁾ Box 10 OL: Drug-related deaths — EMCDDA definition (online version). See also the EMCDDA protocol for drug-related death (http://www.emcdda.eu.int/multimedia/project_reports/situation/drd_standard_3.pdf).

⁽⁴³⁾ See Statistical Table 24: Number of 'acute drug-related deaths' recorded in EU countries (according to national definitions used to report cases to the EMCDDA), 1985–2001 (online version).

⁽⁴⁴⁾ Figure 13 OL: Proportion of drug-related deaths with or without the presence of opiates in the EU countries in 2000–01; and Statistical Table 25: Summary of characteristics of victims of acute drug-related death in the EU countries (online version).

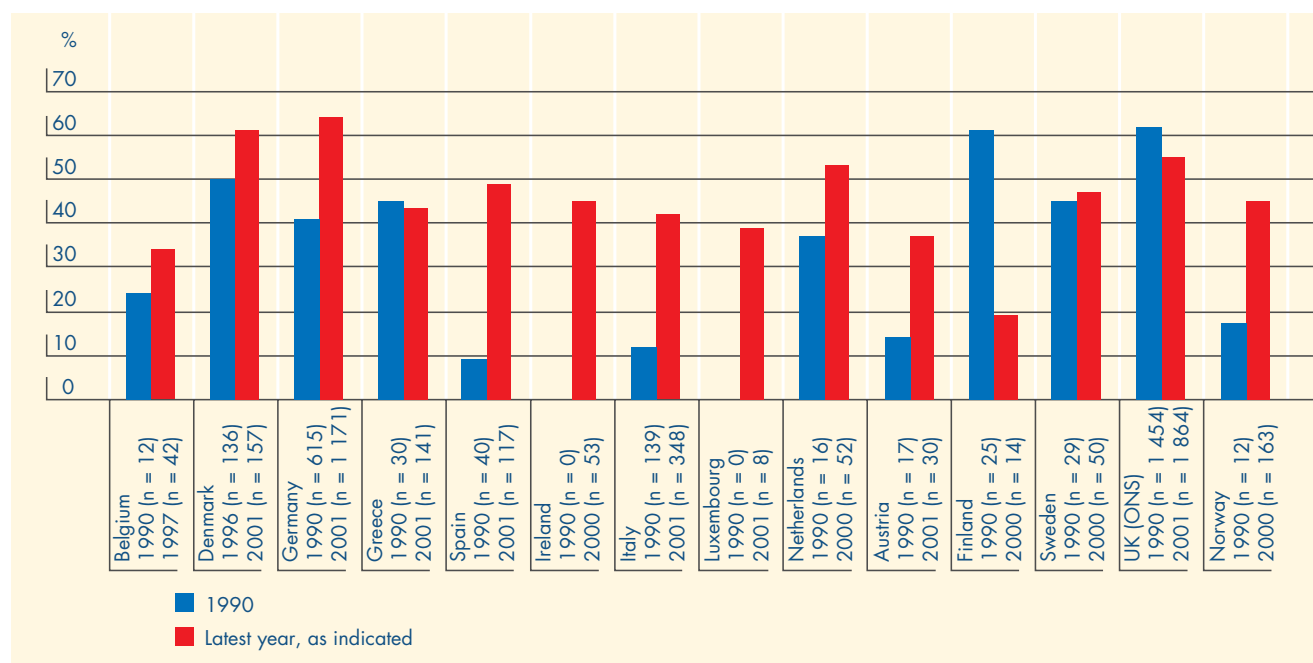
depressant drugs (e.g. alcohol or benzodiazepines); loss of tolerance after a period of abstinence (e.g. on release from prison or discharge from a treatment programme); injecting in public places (which may be associated with the use of untested drugs); a long history of opiate dependence; older age (perhaps as a result of concomitant liver or respiratory diseases); and possibly unexpected changes in purity (although studies present divergent results). In addition, most opiate overdoses take place in the presence of other users and, as death is usually not immediate, there is time for intervention. Unfortunately, however, bystanders are often unable or unwilling to assist because of either lack of knowledge or fear of police intervention.

The fact that risk factors are well known and that death is not immediate should mean that it is possible to prevent a significant proportion of drug overdoses, or at least to prevent a fatal outcome in many cases, and stresses the need to implement appropriate interventions, especially for older injectors and those who have lost tolerance after a period of relative abstinence.

Characteristics of victims

The majority (80–90 %) of overdose victims in most EU countries are men (range 69–90 %) ⁽⁴⁵⁾. This may reflect the high proportion of men among opiate addicts, as some studies suggest that the risk of overdose is similar among men and women. However, in many cases, the proportion of overdose victims who are men is higher than the proportion of men among clients admitted to treatment. Most victims are in their late 20s or 30s and have been using opiates for several years. Among EU countries, the mean age of drug-related death victims ranges from 30.2 to 40 years, and in most countries the age of victims is tending to increase (Figure 14). This trend has also been reported from countries outside Europe. However, in Finland and, to a lesser extent, the United Kingdom, there was an increase in the proportion of younger victims, a finding that deserves particular attention as it might indicate an increased incidence of injection or opiate use in recent years, and in Greece and Sweden no such trend towards an increase in the age of victims was apparent.

Figure 14: Changes in the proportion of victims of drug-related deaths over 35 years among EU countries from 1990 ⁽¹⁾ until 2000–01



⁽¹⁾ Denmark 1996. Years presented are those with the necessary breakdown or those for which a comparative analysis was possible (same age distribution). For some countries, ages ranges differ between years (Greece: 1990, ≥ 31 ; and 2001, ≥ 30 ; Germany: 1990 and 2001, ≥ 30). In Ireland and Luxembourg the proportion of victims over 35 in 1990 was 0 %.

Sources: Reitox national reports 2002, taken from general mortality registries or special registries (forensic or police). Based on national definitions as presented Box 9 OL: Definitions of 'acute drug-related death' in EU Member States, as used in the EMCDDA annual report and reported in national reports (online versions). See also Statistical Table 25: Summary of characteristics of victims of acute drug-related death in the EU countries (online version).

⁽⁴⁵⁾ Figure 14 OL: Proportion of males and females among victims of drug-related death in the EU countries in 2000–01.

Deaths due to substances other than opiates

Deaths due to overdose of cocaine, amphetamine or ecstasy in the absence of opiates are infrequent in Europe. However, several countries (Spain, France, Italy, the Netherlands and the United Kingdom) have reported national or local increases in the number of victims in whom cocaine was found, generally in addition to other substances, although information is reported in heterogeneous ways. Some countries (e.g. Spain and Portugal) reported the frequent presence of cocaine in the victims of opiate overdose. In addition, cocaine may contribute to death from cardiovascular disease and such deaths may pass unnoticed.

Although deaths associated with ecstasy use arouse considerable public concern, they are relatively rare compared with deaths associated with opiates use, despite the fact that ecstasy use is far more common. The number of cases in which toxicology findings for ecstasy are positive has increased as ecstasy use has become more popular, but, frequently, other substances are also present, and it is not clear whether death can be attributed solely to ecstasy. Short- and long-term risks associated with ecstasy use need to be assessed more accurately. Although adverse reactions to ecstasy appear to be unpredictable, some deaths could be prevented by the adoption of relatively simple measures (e.g. supply of water) in dance clubs, as well as by improved health education.

Although deaths associated with abuse of volatile substances generally attract less attention, in countries where information is available, the numbers of such deaths are far from negligible. For instance, in the United Kingdom over the period 1992–2000, such deaths amounted to 64–85 cases per year, with most victims being very young (Field-Smith et al., 2002). The collection of information about such deaths should be improved in other countries.

Research clearly shows that substitution treatment reduces the risk of overdose mortality among programme participants. However, in several EU countries and cities, methadone has been detected in a significant number of victims of drug-related deaths. Several studies have found that death is more likely to be associated with use of illicit rather than prescribed methadone, while other studies have found a higher risk during the initial phases of methadone substitution. These findings suggest that there is a need to assure quality standards of substitution programmes.

Trends in acute drug-related deaths

Trends in drug-related deaths vary from country to country, and even between regions or cities within a country. With these limitations in mind, some general trends can be outlined for the EU countries. A marked increase in the number of drug-related deaths was observed during the 1980s and early 1990s (Figure 15 A). During the period 1990–2000, the overall increasing trend continued, albeit at a lower rate. In 2000, 8 731 acute drug deaths were reported throughout the EU, compared with 6 394 in 1990 (an increase of 36.5 %) (Figure 15 B) ⁽⁴⁶⁾.

This overall trend may reflect the rapid expansion of heroin injection in many European countries during the 1980s and early 1990s. Recent trends might be related to the apparent stabilisation of the prevalence of problem drug use in some countries, a decrease in injection in others and, probably, the increase of treatment availability — including substitution programmes. On the other hand, the increasing age of problem drug users and polydrug use may contribute to an increase in the number of fatalities.

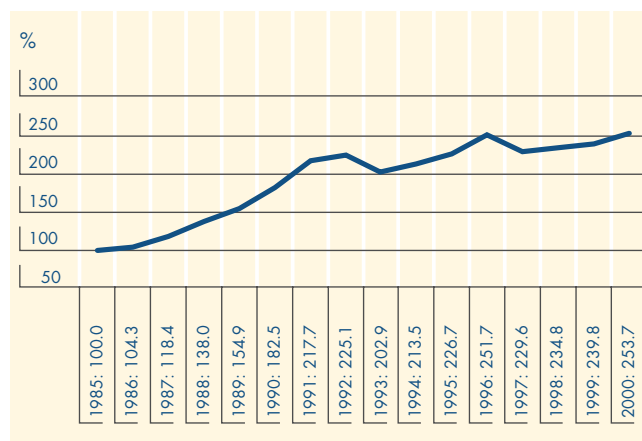
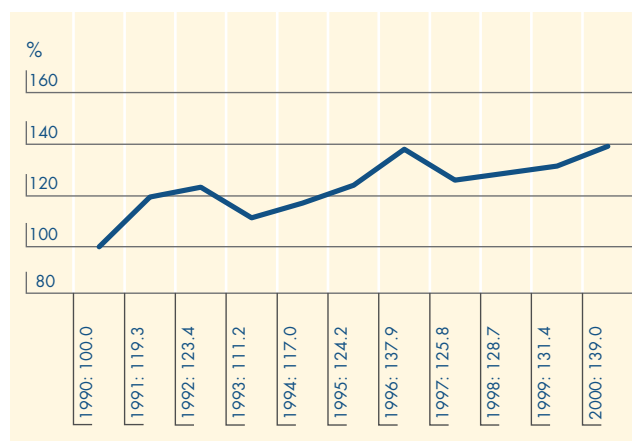
It should be emphasised that within the EU different, and sometimes divergent, national trends exist ⁽⁴⁷⁾. Many EU countries continue to report increases in drug deaths up to the present or very recently, while some report stabilisations or decreases. Changes in reporting procedures and reporting quality should always be taken into account when interpreting national or local trends.

Several countries reported a stabilisation or a downward trend in the number of acute drug deaths during the second half of the 1990s. France and Spain showed an apparently consistent decreasing trend. Although these findings may be subject to the limitations of under-reporting (in the case of France) or limited coverage (only five big cities in Spain), it is important to investigate further the reasons for these trends. Changes in the route of heroin administration and a substantial expansion of treatment programmes (especially substitution treatment) might be influencing these trends ⁽⁴⁸⁾. In other countries (Germany, Italy and Austria), the number of drug deaths has fluctuated in recent years and, thus, although the number of drug deaths appears to have stabilised, albeit at a high level, there is no guarantee that a decrease for two or three years will not be followed by an increase.

⁽⁴⁶⁾ Note that numbers of and trends in drug-related deaths for the EU as a whole are available only up to 2000. Nine countries reported 2001 data, but for seven countries only 2000 data were available at the time of data collection (autumn 2002). Whenever possible, 2001 information was used for countries that reported it.

⁽⁴⁷⁾ Figure 15 OL: Trends in acute drug-related deaths among EU countries, 1985–2001 (online version).

⁽⁴⁸⁾ See EMCDDA annual report (2002a, p. 17), Figure 10, 'Route of administration of heroin in Spain, first treatments 1991–2000' and the section 'Availability of treatment facilities' (p. 49) and Table 3 of this report: Development of substitution treatment in the 15 EU Member States and Norway.

Figure 15: Trends in acute drug-related deaths in the EU, 1985–2000 ⁽¹⁾**Figure 15 (A):** Overall long-term trend in acute drug-related deaths in the EU, 1985–2000 (indexed: 1985 = 100 %)**Figure 15 (B):** Overall recent trend in acute drug-related deaths in the EU, 1990–2000 (indexed: 1990 = 100 %)

⁽¹⁾ A few countries did not provide data for some years (see Statistical Table 24: Number of 'acute drug-related deaths' recorded in EU countries (according to national definitions used to report cases to the EMCDDA), 1985–2001 (online version)). To correct this situation, the computation method defined in Project CT99.RTX.04, EMCDDA (2001) (http://www.emcdda.eu.int/multimedia/project_reports/situation/guidelines_deaths_report.pdf) was used. In all, 10 countries provided information for 2001 and six did not. The index for 2001 has not been computed. The trends for those countries that provided information can be seen in Figure 15 OL: Trends in acute drug-related deaths among EU countries, 1985–2001 (online version). Numbers of cases per country per year are presented in Statistical Table 24.

Sources: Reitox national reports 2002, taken from general mortality registries or special registries (forensic or police). Based on national definitions as presented in Box 9 OL: Definitions of 'acute drug-related death' in EU Member States, as used in the EMCDDA annual report and reported in national reports (online version).

Still other countries have reported substantial upward trends in the second half of the 1990s (e.g. Greece, Ireland, Portugal, Finland and Norway); in some cases these may be partly due to improved reporting. In Portugal, this trend was reversed in 2000, and the same appears to have occurred in Finland in 2001. These increases might be related to the later expansion of heroin use in these countries, although improved reporting systems may have played a role in some cases.

The United Kingdom exhibited a steady, although moderate, increasing trend in acute drug deaths until 2000 according to the traditional definition (which includes some medicine-related cases; Office for National Statistics), but if heroin–morphine cases are considered independently a

much steeper upward trend is evident: a fivefold increase in 2000 compared with 1993 in England and Wales (Griffiths, 2003) ⁽⁴⁹⁾.

Finally, in some countries, trends are less clearly defined, or changes are difficult to interpret because of the switch between ICD classifications (from 9th to 10th edition), changes in national definitions or the small number of cases involved.

The fact that there are no indications of an overall decrease at EU level emphasises the fact that drug-related health damage is far from being overcome, and stresses the need for further investigation of risk factors for drug-related deaths as well as appropriate targeted interventions.

⁽⁴⁹⁾ The recently developed 'Drug strategy definition' focuses on drugs of abuse (drugs controlled under the Misuse of Drugs Act of 1971 but not indirectly related deaths such as deaths from AIDS) and is relatively similar to the EMCDDA definition. Using the drug strategy definition, the number of reported cases almost doubled in England and Wales between 1993 (864) and 2001 (1 623). The application of the EMCDDA definition produces 1 606 cases in England and Wales in 2000 and 1 443 in 2001.

Overall mortality among problem drug users

Problem drug users account for less than 1 % of the adult population of the EU, but significant health and social problems are concentrated within this small group.

Mortality cohort studies show that mortality among problem drug users is up to 20 times higher than among the general population of the same age. Much of this high mortality can be attributed to death from accidental overdose, but other causes include deaths from AIDS and other infectious diseases, accidents and suicides. Overdoses and accidental deaths account for an important part of this mortality in areas where HIV prevalence among drug users is low, whereas AIDS plays a significant role in countries with high injection-related HIV prevalence.

Mortality among injectors is two to four times higher than in non-injecting problem drug users, and (until recently) mortality among HIV-infected drug users was two to six times higher than in non-infected users. With recent improvements in HIV treatment, this difference appears to be declining.

Trends in mortality among problem drug users

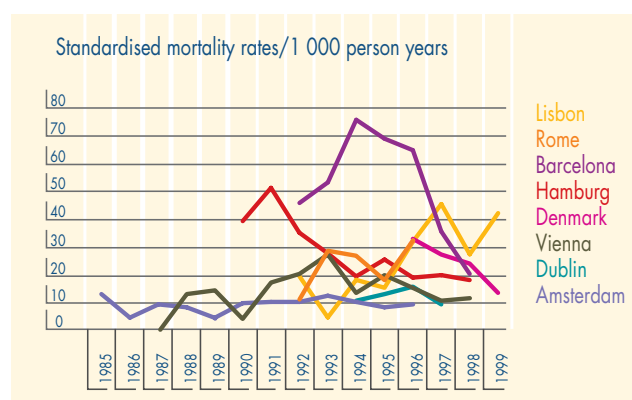
The multi-site study coordinated by the EMCDDA⁽⁵⁰⁾ shows differences in overall mortality rates and distribution of causes of death between participating sites. The study also reveals relevant changes over time in overall and cause-specific mortality⁽⁵¹⁾.

Barcelona presented the highest mortality rates and Vienna and Dublin the lowest. In several locations, mortality rates have decreased since the early or mid-1990s. In Barcelona, rates were particularly high between 1992 and 1996 but have decreased sharply in recent years, mainly because of a decrease in deaths due to AIDS. In Lisbon, mortality rates were increasing until recently (Figure 16).

Direct comparisons across sites should be made with caution, as there are differences in the typology of treatment centres where cohorts are recruited, although they would tend to represent the common types of treatment available. However, age- and gender-standardised mortality rates among drug users can provide a useful measure of the impact of problem drug use on mortality in different countries.

Analysis of the standardised mortality ratios (SMRs)⁽⁵²⁾ from cohorts enrolled within the multi-site study showed that in Barcelona the risk of death among male and female

Figure 16: Overall mortality among problem drug users in several EU cities or countries



NB: Standardised mortality rates, men and women. Mortality from all causes in cohorts of opiate users recruited in treatment centres. There are some differences in typology of recruitment settings (treatment centres) and treatment modalities across sites, although treatment setting and modalities tend to represent the common types of treatment available in each site and therefore the cohorts will tend to be representative of the treatment using population per site. The EMCDDA multi-site study also included a Swedish cohort (see characteristics of participants in Statistical Table 26 and Bargagli et al., 2002). Presentation of further results from this cohort has been postponed to allow for Swedish review of the cohort and additional data analysis. For more detailed information see Statistical Table 26: Mortality cohorts participating in EMCDDA multi-site project — characteristics of participants and results (online version).

Sources: EMCDDA projects CT.99.EP.07 and CT.00.EP.13, 'Mortality of drug users in the EU', coordinated by Department of Epidemiology, Rome E Health Authority.

problem drug users was, respectively, 24 and 64 times higher than in individuals of the same age and gender in the general Spanish population. In Lisbon, Hamburg and Rome, the risk of death among female problem drug users was 30- to 40-fold higher than in the general population. The high SMRs among female problem drug users can be explained, to some extent, by the low baseline mortality among young women in the general population.

See <http://annualreport.emcdda.eu.int> for further information related to this section:

Box 9 OL: Definitions of 'acute drug-related death' in EU Member States, as used in the EMCDDA annual report and reported in national reports

Box 10 OL: Drug-related deaths — EMCDDA definition

Statistical Table 24: Number of 'acute drug-related deaths' recorded in EU countries (according to national definitions used to report cases to the EMCDDA), 1985–2001

⁽⁵⁰⁾ EMCDDA projects CT.99.EP and CT.00.EP.13, Mortality of drug users in the EU, coordinated by the Department of Epidemiology, Rome E Health Authority (http://www.emcdda.eu.int/situation/themes/death_mortality.shtml).

⁽⁵¹⁾ See Statistical Table 26: Mortality cohorts participating in EMCDDA multi site project — characteristics of participants and results (online version).

⁽⁵²⁾ SMR estimates the mortality excess (number of times) of problem drug users compared with people of the same age and gender in the general population.

Statistical Table 25: Summary of characteristics of victims of acute drug-related death in the EU countries

Statistical Table 26: Mortality cohorts participating in EMCDDA multi-site project — characteristics of participants and results:

- Characteristics of opiate users enrolled in the cohorts by site
- Standardised mortality ratios (SMRs) by gender and study site
- Distribution of causes of death of cohort participants

Drug use and crime: some data ⁽¹⁾

Several sources show that a majority of drug users in treatment have been in contact with the criminal justice system. Among individuals charged with crimes and convicted prisoners, studies in Greece (Aristotelian University of Thessaloniki, 2000) and England and Wales (Bennett, 2000) show that drug users are more likely than non-drug users to have committed several types of crimes. Property crimes are generally identified as the main type of crime committed by drug users (Aristotelian University of Thessaloniki, 2000; Bennett, 2000; Meijer et al., 2002).

As regards the link between drug use and crime, a study of the Irish prison population (Hannon et al., 2000) found that 51 % of men and 69 % of women claimed to be under the influence of drugs when they committed the crime for which they were incarcerated. Another study (Millar et al., 1998) of juvenile suspected offenders in Ireland estimated that 42 % of cases were related to alcohol use, 17 % to drug use and 4 % to both, alcohol being most likely to be associated with public order offences, while drugs were most often associated with robberies.

Though interesting, these results should be seen as an example rather than as representative of the link between drug use and crime: first, because they come from studies carried out in specific populations; second, because they might vary considerably according to the drug used; and, third, because a link — especially a causal one — between drug use and crime is particularly difficult to determine.

⁽¹⁾ The results shown in the box were provided by Greece, Ireland, the Netherlands and the United Kingdom in their 2002 national reports to the EMCDDA.

Drug-related crime

Drug-related crime can be considered to include criminal offences in breach of drug legislation, crimes committed under the influence of illicit drugs, crimes committed by users to support their drug habit (mainly acquisitive crime and drug dealing) and systemic crimes committed as part of the functioning of illicit markets (fight for territories, bribing of officials, etc.). Except for drug law offences, routinely available data do not provide information on these categories and, when available, they come from ad hoc local studies and are not suitable for extrapolation.

Drug law offences

'Reports' ⁽⁵³⁾ of offences against national drug legislation (use, possession, trafficking, etc.) reflect differences in law but also the different ways in which the law is enforced and applied, and the priorities and resources allocated to specific problems by criminal justice agencies. In addition, information systems on drug law offences/offenders vary considerably between countries, especially as regards recording procedures, definitions and statistical units. These differences lead to major difficulties when comparing data from several EU countries. For this reason, whenever possible, trends, rather than absolute figures, are compared.

The majority of reported drug offences are related to drug use or possession for use ⁽⁵⁴⁾ — ranging from 39 % of all drug law offences in Portugal ⁽⁵⁵⁾ to 89 % in Austria. In Spain, Italy and the Netherlands, where drug use is not a criminal offence, all drug offences relate to dealing or trafficking. Finally, Luxembourg and Norway ⁽⁵⁶⁾ report a majority of offences for both drug use/dealing and drug trafficking.

In 2001, cannabis remained the drug most often involved in drug law offences — accounting for 34 % of drug-related reports in Portugal and Sweden and as many as 86 % in France. In Luxembourg, heroin is the most commonly involved drug, while in the Netherlands most drug offences are related to 'hard drugs' (drugs other than cannabis and its derivatives) ⁽⁵⁷⁾.

Trends

In the EU as a whole, 'reports' for drug law offences steadily increased over the 15 years from 1985 to 2001 ⁽⁵⁸⁾, increasing fourfold in the EU as a whole and from less than

⁽⁵³⁾ The term 'reports' for drug law offences covers different concepts, varying between countries (police reports of suspected drug law offenders, charges for drug law offences, etc.). For an exact definition for each country, refer to Box 11 OL: Definitions of 'reports for drug law offences' in the EU countries and Norway (online version). (The term 'arrests' was used in previous annual reports.)

⁽⁵⁴⁾ Statistical Table 27: Offence type most involved in 'reports' for drug offences in the EU countries and Norway (online version).

⁽⁵⁵⁾ In Portugal, drug use has been decriminalised since July 2001. As a result, the proportion of drug offences that were drug use related was lower in 2001 than in 2000, when it was 55 %.

⁽⁵⁶⁾ Norway is not able to distinguish between 'drug dealing/trafficking' alone and 'drug use/dealing and trafficking'. The remaining drug law offences are related to 'drug use' alone.

⁽⁵⁷⁾ Statistical Table 28: Drug most involved in 'reports' for drug offences in the EU countries and Norway (online version).

⁽⁵⁸⁾ Statistical Table 29: Number of 'reports' for drug law offences in the EU countries and Norway, 1985–2001 (online version).

twofold in Denmark, Luxembourg and the Netherlands to more than sixfold in Ireland and Finland.

Over the last three years for which data are available, the number of drug-related 'reports' increased in most EU countries. The highest increases were reported by Ireland, Finland and Norway. However, in 2001, Denmark, France, Italy, Luxembourg and Portugal⁽⁵⁹⁾ reported a fall in the number of drug-related 'reports'⁽⁶⁰⁾ (Figure 17).

In all countries for which information was available, the proportion of all drug law offences accounted for by offences related to drug use/possession for use generally increased between 1996 and 1999–2000⁽⁶¹⁾. Since then, trends have diverged, with a continuous upward trend in France, Germany and Norway, a decrease in Luxembourg, Austria, Portugal and Sweden and stabilisation in the United Kingdom⁽⁶²⁾.

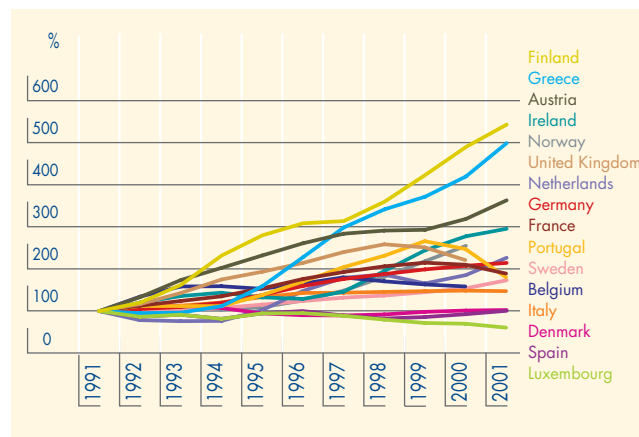
In 10 EU Member States, available data enable trends in the drugs involved in reports of drug law offences to be determined for the period 1996–2001. Over this period, the proportion of all drug offences that were cannabis related generally increased in France, Germany, Italy, Luxembourg, Portugal and Spain, remained stable in Sweden and decreased in Ireland, Austria and the United Kingdom⁽⁶³⁾. In 2001, marked increases were reported in Spain, Luxembourg and Portugal⁽⁶⁴⁾.

Over the same five-year period, the proportion of reports of heroin-related offences decreased in all Member States for which data are available, except in the United Kingdom, where heroin-related offences have increased year on year since 1996⁽⁶⁵⁾. The opposite trend is apparent for cocaine-related offences, with the proportion increasing in all countries except Germany and Portugal⁽⁶⁶⁾.

Drug users in the criminal justice system: prisoners

National routine information on type and patterns of drug use as well as its consequences among prisoners is rare. Most of the data available in the EU come from ad hoc studies carried out at local level using samples of prisoners that vary considerably in size but are generally small. In addition, prisons studied are often not representative of the prison system as a whole and a lack of repeat surveys prevents analysis of trends in most countries. These factors make extrapolation of results very difficult.

Figure 17: 'Reports' for drug law offences in the EU countries and Norway, 1991–2001 — three-year moving averages indexed (1991 = 100)



NB: For definitions of reports for drug law offences, please refer to Statistical Table 29: Number of 'reports' for drug law offences in the EU countries and Norway, 1985–2001 (online version). Real values have been input for all countries in 2001, for Belgium in 1995 and 1997, for Spain in 1996 and for the United Kingdom and Norway in 2000, as available data do not allow calculation of moving averages in these cases. The series is discontinued for Belgium in 1996 (data not available).

Sources: Reitox national focal points.

However, studies show that, compared with the wider community, drug users are over-represented among the prison population⁽⁶⁷⁾. The proportion of inmates in the EU reporting ever having used any illicit drug varies between 29 % and 86 % depending on the prisons and countries (more than 50 % in most studies) (Figure 18). As in the wider community, cannabis is the most frequently used drug, but several studies also show high levels of a history of heroin use (50 % of inmates or more in some cases).

According to several studies, prisoners reporting more regular and/or harmful use, such as injecting drug use, regular use or dependence, represent 6–69 % of the prison population. In particular, several studies in the EU show that around one-third of adult male prisoners are drug injectors (Bird and Rotily, 2002).

Most drug users stop or reduce their drug use after imprisonment. However, some continue to use drugs, and others only start on incarceration. Drug use within prison is reported by 12–60 % of inmates and regular drug use by 10–42 %. Between 3 % and 34 % of the prison population have ever injected drugs while incarcerated⁽⁶⁸⁾.

⁽⁵⁹⁾ The decrease in Portugal is mainly due to the decriminalisation of drug use since July 2001.

⁽⁶⁰⁾ At the time of writing, 2001 data were not available for Belgium, Norway and the United Kingdom.

⁽⁶¹⁾ See Figure 16 OL: Proportion of 'reports' for use/possession offences out of the total of drug law offences, 1996–2001 (online version).

⁽⁶²⁾ Up to 2000, as at the time of writing 2001 data were not available for the United Kingdom.

⁽⁶³⁾ Up to 2000, as at the time of writing 2001 data were not available for the United Kingdom.

⁽⁶⁴⁾ See Figure 17 OL: Proportion of reports for cannabis-related offences out of the total of drug law offences, 1996–2001 (online version).

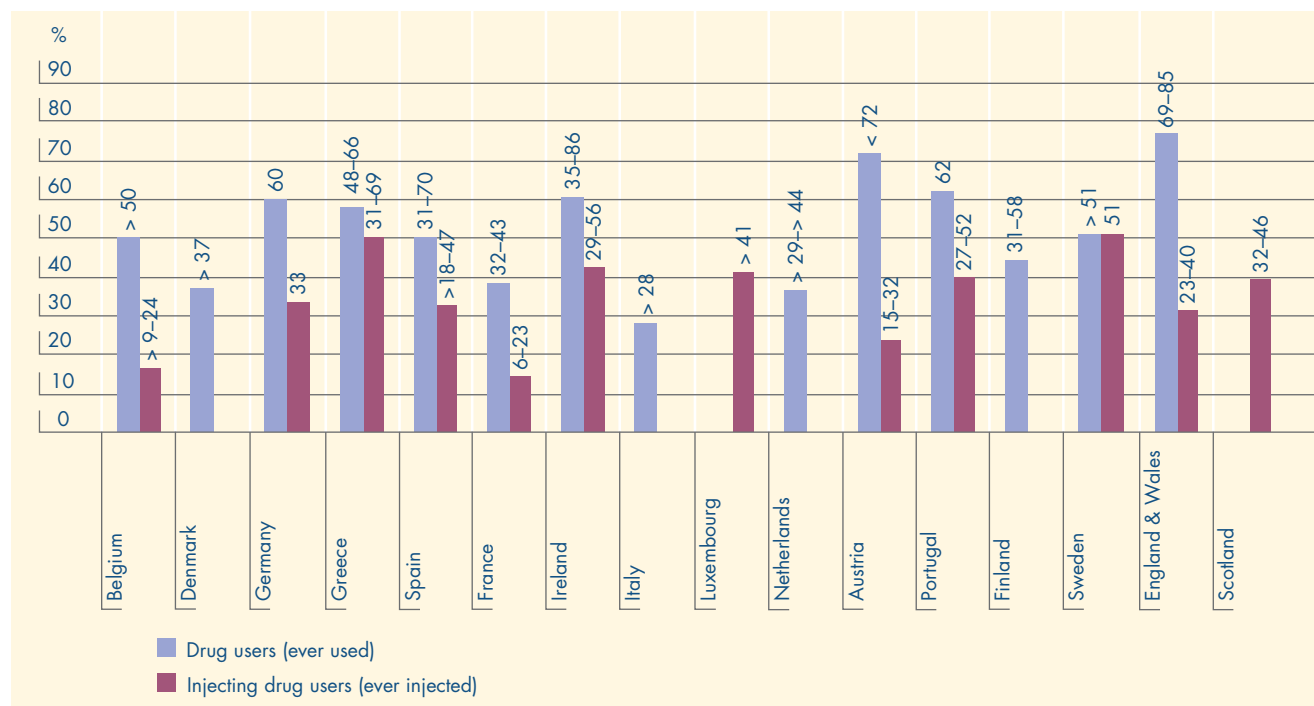
⁽⁶⁵⁾ See Figure 18 OL: Proportion of reports for heroin-related offences out of the total of drug law offences, 1996–2001 (online version).

⁽⁶⁶⁾ See Figure 19 OL: Proportion of reports for cocaine-related offences out of the total of drug law offences, 1996–2001 (online version).

⁽⁶⁷⁾ See Statistical Table 30: Proportion of drug users among prisoners in the EU countries and Norway (online version).

⁽⁶⁸⁾ See Figure 20 OL: Estimates of levels of drug use within prison in the EU countries and Norway (online version).

Figure 18: Estimates of lifetime prevalence of drug users in prison in the EU



NB: Whenever possible, data refer to adult prisoners, although some figures might also include young offenders. Values shown in the figure were derived from the following data. Caution in drawing comparisons is necessary as definitions, periods of reference and methodologies vary widely between surveys and countries. Most data come from local ad hoc studies (not comparable). For additional information on each survey, see Statistical Table 30: Proportion of drug users among prisoners in the EU countries and Norway.

Belgium

- 50 % last month drug use before prison, 1999 (n = 246).
- 9 % regular drug injecting before prison, 1999 (n = 246); 24 % drug injecting before prison, 1997 (n = 115).

Denmark

- 37 % last six months repeated drug use before prison, 2001 (n = 3 445).

Germany

- 60 % drug users, 1996 (n = 16).
- 33 % drug injecting before prison, 1997 (n = 437).

Greece

- 48 % lifetime drug use before prison (n = 136), 2000; 66 % lifetime heroin use before prison, 1995 (n = 544).
- 34 % lifetime drug injecting, 1996 (n = 861); 31 % injecting drug users, 1995 (n = 1 183); 69 % drug injecting before prison, 1995 (n = 544).

Spain

- 43 % last month cannabis use before prison, 2000 (n = 5 028); 31 % last month cocaine use before prison, 1998 (n = 2 223); 70 % (women) lifetime drug use (alcohol included), 1998 (n = 356); 35 % (women) regular drug use (alcohol included), 1998 (n = 356); 56 % drug users, 1998 (n = 10 111).
- 18 % last month heroin injecting before prison, 1998 (n = 2 223); 47 % drug injecting before prison, 1997 (n = 101).

France

- 43 % last year drug use before prison, 1998 (n = 1 212); 32 % last year regular drug use before prison, 1997 (n = 8 728); 35 % last year cannabis use before prison, 1997 (n = 960).
- 12 % lifetime drug injecting before prison, 1998 (n = 1 212); 9 % last year drug injecting before prison, 1998 (n = 1 212); 6 % last year drug injecting before prison, 1997 (n = 8 728); 14 % drug injecting before prison, 1997 (n = 960); 23 % lifetime drug injecting before prison, 1996 (n = 574).

Ireland

- 35 % lifetime heroin use, 1999 (n = 607); 52 % lifetime heroin use, 1998 (n = 1 205); 70 % lifetime heroin use, 1997 (n = n.a.); 86 % (men) lifetime drug use, 1996 (n = 108).
- 29 % lifetime drug injecting, 1999 (n = 607); 43 % lifetime drug injecting, 1998 (n = 1 205); 56 % (men) lifetime drug injecting, 1996 (n = 108).

Italy

- 28 % lifetime drug dependence before prison, 2001 (n = 55 275).

Luxembourg

- 41 % regular drug injectors, 1998 (n = 362); 32 % regular drug injecting before prison, 1998 (n = 362).

Netherlands

- 29 % with drug addiction problems, 1997 (n = 528); 44 % drug addicts, 1997 (n = 319).

Austria

- 72 % lifetime drug use (in one prison specialising in drug-related offences), 1994 (n = 307).
- 26 % (men) and 32 % (women) drug injecting before prison, 1999 (n = 143 and 69 respectively); 15 % intravenous drug users, 1996 (estimated by experts).

Portugal

- 62 % lifetime drug use, 2001 (n = 2 057).
- 27 % lifetime injecting drug use before prison, 2001 (n = 2 057); 52 % drug injecting before prison, 1997 (n = 535).

Finland

- 58 % lifetime drug use, 2001 (n = 825); 31 % lifetime drug use, 1995 (n = n.a.).

Sweden

- 51 % last year injecting or daily drug use before prison, 2000 (n = 3 352).
- 51 % last year injecting or daily drug use before prison, 2000 (n = 3 352).

England and Wales

- 84 % (women) lifetime drug use before prison, 2001 (n = 301); 69-85 % lifetime drug use before prison, 1997 (n = 3 140).
- 38 % (women) lifetime drug injecting before prison, 2001 (n = 301); 24 % (men) and 29 % (women) lifetime drug injecting, 1997-98 (n = 2 769 and 407 respectively); 23-40 % lifetime drug injecting, 1997 (n = 3 139).

Scotland

- 32 % (men) and 46 % (women) lifetime drug injecting, 1991-96 (n = 2 286 and 132 respectively).

Sources: Reitox national focal points; see also Statistical Table 30: Proportion of drug users among prisoners in the EU countries and Norway (online version).

See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

Statistical Table 27: Offence type most involved in 'reports' for drug offences in the EU countries and Norway

Statistical Table 28: Drug most involved in 'reports' for drug offences in the EU countries and Norway

Statistical Table 29: Number of 'reports' for drug law offences in the EU countries and Norway, 1985–2001

Statistical Table 30: Proportion of drug users among prisoners in the EU countries and Norway

Drug markets and availability

The number of drug seizures in a country is usually considered to be an indirect indicator of the supply and availability of drugs, although it also reflects law-enforcement resources, priorities and strategies, as well as vulnerability of traffickers to enforcement. Quantities seized⁽⁶⁹⁾ may fluctuate more widely from one year to the next, for example if in one year a few of the seizures are very large. For this reason, the number of seizures⁽⁷⁰⁾ is considered by several countries to be a better indicator of trends⁽⁷¹⁾. In all countries, the number of seizures includes a major proportion of small seizures at the retail level⁽⁷²⁾. Where known, origin and destination of drugs seized may indicate trafficking routes and producing areas. The price and purity of drugs at retail level are reported by most of the Member States. However, data come from a range of different sources which are not always comparable or reliable, making accurate comparisons between countries difficult.

As a result of a lack, at the time of writing, of data on 2001 seizures⁽⁷³⁾ from Belgium, Italy, the Netherlands and the United Kingdom, analyses of the 2001 situation and of trends up to 2001 are incomplete. Data on drug seizures in the EU and Norway in 2001 are detailed in Table 1. In the text below, trends between 2000 and 2001 have been inferred from the evolution of the EU totals calculated from figures from the only countries for which data were available for both years.

According to Europol, global statistics show a concentration of drug seizures, with some 75 % of worldwide seizures of

Drug availability in 15- to 24-year-olds

The Eurobarometer (EORG, 2002) survey carried out in 2002 on the attitudes to drugs and opinions of young people in the EU Member States provides data on exposure to cannabis as well as perceived availability of illicit drugs. In the EU as a whole, 65 % of respondents claim to know people who use cannabis, and 46 % have already been offered cannabis. Depending on the country, 34–69 % (55 %)⁽¹⁾ consider it easy to obtain drugs near their school/college, 39–71 % (62 %) near where they live, 46–90 % (72 %) in pubs/clubs and 49–90 % (76 %) at parties.

(1) Figures in brackets relate to the EU average.

all types of illicit drugs occurring in just a few countries. These include Spain, the Netherlands and the United Kingdom in the trafficking of cannabis resin, in addition to Morocco and Pakistan; Spain in cocaine trafficking, along with the United States, Colombia, Mexico and Panama; and the Netherlands and the United Kingdom in the trafficking of synthetic drugs, together with the United States, Thailand and China⁽⁷⁴⁾.

Cannabis

Cannabis is the most seized drug in every Member State except Portugal, where heroin seizures predominate. Since 1996, Spain has been seizing the largest quantities of cannabis, more than half the total amount seized in the EU. Up to 2000, the United Kingdom reported a higher number of cannabis seizures than Spain, but on average involving smaller quantities⁽⁷⁵⁾.

In 2001, Morocco remained the major producing country of cannabis resin seized in the EU. Cannabis can be smuggled directly from Morocco but, in many cases, it comes via the Iberian Peninsula. Cannabis resin is also smuggled from the Nordic and Baltic countries to Finland and from Albania to Italy and Greece. Most cannabis herb seized in Belgium, Germany, France, Luxembourg and the Netherlands originates in the Netherlands⁽⁷⁶⁾. In addition,

⁽⁶⁹⁾ See Figure 21 OL: Quantities of drugs seized in the EU countries and Norway (indexes, 1996 = 100), 1996–2000; and Figure 22 OL: Quantities of cannabis, cocaine, heroin and amphetamines seized in the EU countries and Norway, 1985–2000 (online version).

⁽⁷⁰⁾ See Figure 23 OL: Number of drug seizures in the EU countries and Norway (indexes, 1996 = 100), 1996–2000; and Figure 24 OL: Number of cannabis, heroin, cocaine, amphetamine, ecstasy and LSD seizures in the EU countries and Norway, 1985–2000 (online version).

⁽⁷¹⁾ Caution is required when analysing trends at EU level, as series start at different years in different countries. For more information, see Statistical Tables 31–43 (online version).

⁽⁷²⁾ See Figure 25 OL: Quantities and numbers of drug seizures in EU countries (indexes 1996 = 100), 1996–2000 (online version).

⁽⁷³⁾ For Italy and the Netherlands: 2001 data on numbers of seizures are missing. For Belgium and the United Kingdom, 2001 data on numbers of seizures and quantities seized are missing.

⁽⁷⁴⁾ Further information from Europol can be found in Box 12 OL: Drugs trafficking in the EU.

⁽⁷⁵⁾ This should be checked against United Kingdom data when available.

⁽⁷⁶⁾ As reported in the national reports from these countries.

Table 1: Drug seizures in the EU countries and Norway, 2001

Country	Amphetamines		Cocaine		Cannabis		Heroin		LSD		Ecstasy	
	Number	Quantity (kg)	Number	Quantity (kg)	Number	Quantity (kg)	Number	Quantity (kg)	Number	Quantity (doses)	Number	Quantity (tablets)
Belgium	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Denmark	954	161	815	26	5 788	1 763	1 304	25	29	159	331	150 080
Germany ⁽¹⁾	3 459	263	4 044	1 288	29 824	8 942	7 538	836	289	11 441	4 290	4 576 504
Greece ⁽²⁾ ⁽³⁾	n.a.	0.078	n.a.	297	n.a.	11 926	n.a.	330	n.a.	577	n.a.	58 845
Spain ⁽⁴⁾	4 574	18	26 127	33 681	74 391	518 620	11 800	631	n.a.	26 535	11 947	860 164
France	111	57	1 583	2 094	45 789	62 121	2 652	351	115	6 718	1 589	1 503 773
Ireland ⁽⁵⁾ ⁽⁶⁾	162	18	300	5	6 233	10 157	802	30	6	323	1 485	469 862
Italy	n.a.	0.6	n.a.	1 808	n.a.	53 078	n.a.	2 005	n.a.	1 139	n.a.	n.a.
Luxembourg	7	0	58	8	490	16	211	1	1	1	17	8 359
Netherlands ⁽⁷⁾ ⁽⁸⁾ ⁽⁹⁾	n.a.	579	n.a.	8 389	n.a.	33 419	n.a.	739	n.a.	28 731	n.a.	3 684 505
Austria	161	3	768	108	5 249	456	895	288	32	572	352	256 299
Portugal ⁽¹⁰⁾ ⁽¹¹⁾ ⁽¹²⁾	4	0	1 100	5 575	2 411	6 707	2 430	316	6	3 588	160	126 451
Finland ⁽¹³⁾	3 778	137	55	7	5 846	622	557	8	14	1 026	465	81 228
Sweden	5 513	231	328	39	6 935	739	1 271	32	28	629	595	86 336
UK	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Norway	4 214	93	477	21	10 254	861	2 501	68	52	417	829	61 575
Total	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

n.a., data not available.

⁽¹⁾ Amphetamines data also include metamphetamines.
⁽²⁾ A small number of amphetamine tablets were also seized in 2001.
⁽³⁾ One tablet of LSD was also seized in 2001.
⁽⁴⁾ 11 026 tablets of amphetamines were also seized in 2001.
⁽⁵⁾ 23 seizures and 0.975 kg of methylamphetamines were also seized in 2001.
⁽⁶⁾ 10 tablets of LSD were also seized in 2001.
⁽⁷⁾ 20 592 tablets of amphetamines were also seized in 2001.
⁽⁸⁾ 884 609 'nederwiet plants' were also seized in 2001 (cannabis).
⁽⁹⁾ 113 grams of ecstasy was also seized in 2001.
⁽¹⁰⁾ 25 tablets of amphetamines were also seized in 2001.
⁽¹¹⁾ The number of heroin seizures also includes seizures of liquid heroin.
⁽¹²⁾ 100 grams of ecstasy was also seized in 2001.
⁽¹³⁾ The number of cannabis seizures includes hashish only.
Sources: Reitox national focal points.

France mentions its own national territory, Italy and Belgium as other sources of supply for cannabis herb. Cannabis herb also reaches Greece and Italy from Albania and Portugal from Angola. Local production of cannabis is reported in most Member States.

In 2001, the retail price of cannabis resin was reported to vary, on average, between EUR 2.3 (United Kingdom) and 26.6 (Norway) per gram, and that of cannabis leaves between EUR 1.9 (Spain) and 8 (Belgium, Sweden) on average per gram. The content of the active ingredient, tetrahydrocannabinol (THC), in cannabis resin is usually between 5 % and 14 %, although samples with a THC content

of 0.15–39 % were reported in the EU in 2001. The average THC content of cannabis leaves is similar, around 5–11 %, although in Norway it is typically lower (1–3 %) and it was reported to reach 34 % in some samples in Germany.

Trends

The number of cannabis seizures ⁽⁷⁷⁾ increased steadily in the EU from 1985 but seems to have stabilised since 1999. In 2001, cannabis seizures increased in Denmark, Spain, Ireland, Luxembourg, Austria, Finland, Sweden and Norway. Quantities seized ⁽⁷⁸⁾ also increased from 1985, but have stabilised since 1995.

⁽⁷⁷⁾ See Figure 26 OL: Number of cannabis seizures, 1996–2001 (indexes) (online version).

⁽⁷⁸⁾ See Figure 27 OL: Quantities of cannabis seized, 1996–2001 (indexes) (online version).

The retail price of cannabis has generally been stable in the EU, except in the United Kingdom, which reports a downward trend in the last four years. In 2001, the price increased in Belgium, France, Luxembourg, the Netherlands (leaves) and Norway (resin). In 2001, Portugal and the United Kingdom reported an increase in the purity of cannabis resin and leaves at street level. Cannabis resin purity also rose in Belgium and Italy.

Heroin

In 2000, almost nine tonnes of heroin was seized in the EU, of which over one-third was seized in the United Kingdom. Heroin seized in the EU comes mainly from Afghanistan (and Pakistan), followed by South-East Asian countries, via Iran, Turkey and the Balkan route. However, increased trafficking via eastern Europe (Russia, Estonia, Byelorussia, Bosnia) and central Asian countries from the former USSR is reported.

At street level, heroin prices in 2001, on average, varied from EUR 31 to 194 per gram across the EU. The highest prices are reported in the Nordic countries and Ireland. Heroin (white or brown) average purity ranges from 14 % to 48 %, but in 2001 Norway reported a higher average purity of white heroin.

Trends

At EU level, heroin seizures ⁽⁷⁹⁾ increased up until 1991–92 and then stabilised. In 2001, they decreased in Denmark, Germany, France, Luxembourg and Portugal. Compared with the situation in 1985, quantities seized ⁽⁸⁰⁾ at EU level have been increasing. They stabilised during the period 1991–98, but have been increasing again since then. In 2001, a majority of countries reported increases in the amount of heroin seized. According to Europol, the spectacular decrease in Afghan opium production in 2001 was not reflected to the same extent in the availability of heroin in the EU drugs market, probably because of the vast opium and heroin stocks that built up after the record harvests of 1999 and 2000.

Heroin street prices are generally stable or decreasing, though in 2001 an increase was reported in Belgium (brown heroin) and Denmark. Heroin purity is generally reported to be stable or decreasing in all countries, although recently the purity of brown heroin has increased in Belgium, Denmark, Ireland and the United Kingdom.

Cocaine

Spain remains the EU country with the highest level of cocaine seizures, in 2001 accounting for more than half ⁽⁸¹⁾ of the EU total for both number of seizures and quantities seized. The cocaine seized in Europe comes from Latin America (mainly from Andean countries such as Peru and Colombia, but also from Ecuador), directly or via Central America, Spain and/or the Netherlands. Although Spain has been reported by some EU countries to be a transit country for cocaine into the EU, the Spanish authorities report that there was no evidence of big shipments of cocaine in Spain corresponding to international trafficking. According to Europol, some 200 tonnes of cocaine enters the EU each year via maritime shipments and air couriers, facilitated by the presence of large ports and airports ⁽⁸²⁾.

The retail price of cocaine in 2001 varied from EUR 47 to 187 per gram on average. The lowest prices were found in Spain, and the highest in Finland and Norway. Cocaine purity is generally high, between 45 % and 80 % in most countries, except in Ireland, where it was on average lower (23 %) in 2001.

Trends

The total number of cocaine seizures ⁽⁸³⁾ in the EU has risen steadily since the mid-1980s — apart from a decrease in 2000 — and seems to have continued to rise in 2001 ⁽⁸⁴⁾. The quantities of cocaine seized ⁽⁸⁵⁾ also fluctuated within the context of an overall upward trend between 1985 and 2001. In 2001, a marked increase was reported — mainly due to a large increase in the total amount of cocaine seized by Spain.

Cocaine street prices have stabilised or decreased in all countries in recent years, but increased in 2001 in Norway. Cocaine purity remains generally stable or is decreasing in every Member State, though increases were reported in 2001 by Denmark, Germany, Portugal and the United Kingdom.

Synthetic drugs: amphetamines, ecstasy and LSD

In Finland, Sweden and Norway, amphetamines are the second most commonly seized drug (after cannabis). Ecstasy is the second most seized drug in Ireland. In the last five years, the largest quantities of amphetamines and ecstasy seizures have been in the United Kingdom ⁽⁸⁶⁾.

⁽⁷⁹⁾ Figure 28 OL: Number of heroin seizures, 1996–2001 (indexes) (online version).

⁽⁸⁰⁾ Figure 29 OL: Quantities of heroin seized, 1996–2001 (indexes) (online version).

⁽⁸¹⁾ Although this should be checked against missing 2001 data when available.

⁽⁸²⁾ Further information from Europol is given in Box 13 OL: Cocaine trafficking (online version).

⁽⁸³⁾ See Figure 30 OL: Number of cocaine seizures, 1996–2001 (indexes) (online version).

⁽⁸⁴⁾ This should be checked against 2001 missing data when available.

⁽⁸⁵⁾ See Figure 31 OL: Quantities of cocaine seized, 1996–2001 (indexes) (online version).

⁽⁸⁶⁾ This situation should be checked against 2001 United Kingdom data when available.

According to Europol⁽⁸⁷⁾, the number of production sites for synthetic drugs discovered each year in the EU is consistent at around 50–70. However, although the number of production facilities is relatively stable, advances in methodology, increased sophistication of manufacturing equipment and increasing involvement of specialists is resulting in ever-increasing production efficiency and capacity. For the time being, the Netherlands, and to a lesser extent Belgium, are major sites for the production of ecstasy, amphetamines and related drugs, but production in other Member States (Spain, France, the United Kingdom) and in central and east European countries (the Czech Republic, Estonia, Lithuania, Poland), as well as in Thailand, is also reported. According to Europol, while the European Union remains the primary source of ecstasy, production is spreading worldwide, with facilities discovered in South-East Asia, China, North America, South Africa and South America.

The price of amphetamines is reported to be, on average, between EUR 12 and 40 per gram, while ecstasy tablets cost between EUR 6 and 20 each on average. Data for 2001 show that synthetic drugs are cheapest in Belgium and the United Kingdom. Amphetamine purity is very variable, from 2 % in Ireland to 52 % in Norway. Most tablets sold as ecstasy do in fact contain ecstasy or ecstasy-like substances (MDMA, MDEA, MDA), varying from 58 % of the tablets analysed in Finland to 99 % in Germany, Spain, the United Kingdom and Norway and 100 % in Portugal.

Amphetamines (or metamphetamines) are found in 2–20 % of tablets, but various other psychoactive substances (2-CB, 2-CT7, 4-MTA, MDE, PMA and PMMA) may also be found.

Trends

Amphetamine seizures — both numbers⁽⁸⁸⁾ and quantities⁽⁸⁹⁾ — increased throughout the EU between 1985 and 1998 or 1999. The number of amphetamine seizures fell in 1999 and 2000, mostly because of a decrease in the United Kingdom, but apparently increased again in 2001 at EU level⁽⁹⁰⁾. Quantities seized decreased between 1998 and 2000, but rose again in 2001 in a majority of countries⁽⁹¹⁾.

Ecstasy seizures⁽⁹²⁾ have been increasing in most of the EU since 1985 — except in 1997 and 1998 — with marked increases in 2001, especially in Spain, which reported 11 947 ecstasy seizures in 2001 (compared with 3 750 in

2000). The amounts of ecstasy seized⁽⁹³⁾ followed the same upward trend from 1985 until 1993, when they stabilised. However, this was followed by a peak in 1996, and quantities seized have, since 1999, again been increasing. At EU level, the number of ecstasy tablets seized seems to have stabilised in 2001, but this trend should be further confirmed by the United Kingdom data, as the United Kingdom is the main ecstasy-seizing country in the EU. LSD seizures are less common. At EU level, both numbers⁽⁹⁴⁾ and quantities⁽⁹⁵⁾ increased until 1993, and decreased from then on⁽⁹⁶⁾, except for a slight increase in 2000.

Following significant decreases in the 1990s, amphetamine and ecstasy prices have stabilised in the EU. However, in 2001, Norway reported a significant decrease in the price of amphetamines sold at street level. The average price of ecstasy tablets decreased in 2001 in most countries. In 2001, the proportion of tablets containing ecstasy or ecstasy-like substances increased in Belgium, Denmark, Portugal and Spain, while those containing amphetamines (and metamphetamines) decreased. Finland reported the opposite, as well as a high proportion of tablets containing buprenorphine (23 %).

See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

Statistical Table 31: Number of seizures and quantities seized (all drugs), 2001

Statistical Table 32: Number of amphetamine seizures, 1985–2001

Statistical Table 33: Number of cannabis seizures, 1985–2001

Statistical Table 34: Number of cocaine seizures, 1985–2001

Statistical Table 35: Number of ecstasy seizures, 1985–2001

Statistical Table 36: Number of heroin seizures, 1985–2001

Statistical Table 37: Number of LSD seizures, 1985–2001

Statistical Table 38: Quantities of amphetamine seized, 1985–2001 (kg)

Statistical Table 39: Quantities of cannabis seized, 1985–2001 (kg)

Statistical Table 40: Quantities of cocaine seized, 1985–2001 (kg)

Statistical Table 41: Quantities of ecstasy seized, 1985–2001 (tablets)

Statistical Table 42: Quantities of heroin seized, 1985–2001 (kg)

Statistical Table 43: Quantities of LSD seized, 1985–2001 (doses)

⁽⁸⁷⁾ Further information from Europol is given in Box 14 OL: Synthetic drugs trafficking (online version).

⁽⁸⁸⁾ See Figure 32 OL: Number of amphetamine seizures, 1996–2001 (indexes) (online version).

⁽⁸⁹⁾ See Figure 33 OL: Quantities of amphetamine seized, 1996–2001 (indexes) (online version).

⁽⁹⁰⁾ This trend should be checked against 2001 missing data (especially from the United Kingdom) when available.

⁽⁹¹⁾ This trend should be checked against 2001 missing data (especially from the United Kingdom) when available.

⁽⁹²⁾ See Figure 34 OL: Number of ecstasy seizures, 1996–2001 (indexes) (online version).

⁽⁹³⁾ See Figure 35 OL: Quantities of ecstasy seized, 1996–2001 (indexes) (online version).

⁽⁹⁴⁾ See Figure 36 OL: Number of LSD seizures, 1996–2001 (indexes) (online version).

⁽⁹⁵⁾ See Figure 37 OL: Quantities of LSD seized, 1996–2001 (indexes) (online version).

⁽⁹⁶⁾ This trend should be checked against 2001 missing data when available.

Light blue bar

Dark blue bar

Light blue bar

Dark blue bar

Light blue bar

Dark blue bar

Chapter 2

Responses to drug use

This chapter presents an overview of developments in national and EU drug policies and strategies. Responses to the drugs problem in the fields of education, healthcare, social care, criminal justice and supply reduction are also covered.

National drug policy developments

Reorganisation in drug coordination systems

The trend observed in recent years to organise national drug policy through national action plans and coordinated systems continued in 2002⁽⁹⁷⁾. Germany, Italy, some Austrian provinces, Sweden and Norway joined other EU partners in adopting a coherent drugs plan, programme or strategy. However, it is interesting to note how this area is subject to frequent changes. Often, changes in government result in a change in drugs strategy or the organisation of drugs agencies.

In Portugal, the new government that took office in 2002 merged the Portuguese Institute for Drugs and Drug Addiction (IPDT) and the Service for the Prevention and Treatment of Drug Abuse (SPTT) into the IDT (Instituto da Droga e da Toxicodependência), and transferred responsibility for the new agency from the Presidency of the Council to the Ministry of Health. In the United Kingdom, following its re-election in 2001, the government presented an updated drug strategy in December 2002 for England and also instituted some restructuring within its local crime reduction partnership. Drug action teams were restructured in 2000 to conform to the boundaries of local authorities. In Norway, the Central Health and Social Administration was reorganised to place more emphasis on knowledge and experience as a basis for strategic planning and development of drug policy, while in Ireland the new government (2002) assigned responsibility for the national drugs strategy 2001–08 to the newly created Department of Community, Rural and Gaeltacht Affairs. A Minister of State was appointed with responsibility for the national drugs strategy and community affairs, and for housing and urban renewal — areas which in Ireland are considered to be interlinked. In addition, the government highlighted initiatives to tackle drug abuse and crime and to regenerate disadvantaged communities aimed at ‘building a caring society’. In Austria, the Federal Criminal Agency was created within the Ministry of the Interior to ensure greater

coordination in combating crime. Moreover, and for the first time in Austria, staff resources have been allocated to the Federal Drug Coordination, which is in charge of coordination of drug policy at federal level.

The EMCDDA constantly monitors these trends, patterns and changes, and in December 2002 published an online comparative study of drug strategies and coordination in the field of drugs⁽⁹⁸⁾.

Public perception of drugs and drug policy

Members of the public are becoming increasingly aware of drug abuse and its consequences and are taking an interest in national drug policy. However, the results of several surveys and opinion polls show that attitudes to drugs are not uniform throughout the EU.

A survey conducted in Voralberg, Austria, found that 63 % of students and 40–45 % of adults are opposed to punishment for cannabis use by persons over 18. In Vienna, 78 % of people surveyed expressed the opinion that cannabis should be prohibited but favoured decriminalisation for drug addicts, constituting a large proportion of the 86 % who agreed that drug addicts should receive therapy rather than punishment. Another survey, conducted in Spain in 2002 by the Centro de Investigaciones Sociológicas, found that drugs and alcohol are perceived as an important social problem, behind unemployment and terrorism, but ahead of delinquency and civic insecurity. In France, the percentage of people in favour of cannabis being sold openly rose from 17 % in 1999 to 24 % in 2002, and almost three quarters of French people (Beck et al., 2002) think that it is not possible to achieve a world without drugs. However, half of respondents believed that experimentation with cannabis is dangerous, two thirds of people questioned believed in the ‘gateway effect’⁽⁹⁹⁾ and 65 % opposed decriminalisation of cannabis even under certain conditions (while 88 % opposed decriminalisation of heroin use). In Ireland, a survey of attitudes to cannabis use conducted by Lansdowne Market Research (involving face-to-face

⁽⁹⁷⁾ This report focuses on new developments. A full picture of national strategies and coordination in the field of drugs is provided at: http://www.emcdda.eu.int/policy_law/national/strategies/strategies.shtml.

⁽⁹⁸⁾ Available at http://www.emcdda.eu.int/policy_law/national/strategies/strategies.shtml.

⁽⁹⁹⁾ The ‘gateway effect or theory’ implies the existence of a sequential stage of progression in the use of drugs. For further information, see ODCCP (2000).

interviews of a national representative sample of 1 159 adults aged 15 years and older), indicated that opinion is highly variable. While almost two thirds of those eligible to vote (18 years and over) felt that cannabis should be allowed for medical reasons (provided medical benefit had been proven), only a minority (one in seven) were in favour of outright legalisation. The low level of support for legalisation probably reflects the fact that cannabis is believed to be a gateway drug. In the United Kingdom, the reclassification of cannabis from a class B to a class C drug stimulated a widespread debate, with some people for and others against the reclassification.

Legal developments

Legal developments over the reporting period have occurred in the areas of improved treatment and rehabilitation conditions for addicts, State monitoring of traffickers and users and stronger action against breaches of public order and nuisance caused by drugs at street level.

Treatment and rehabilitation

Last year, several countries in the EU introduced legislative changes to facilitate the treatment and rehabilitation of addicts. In Luxembourg, a national decree established the legal framework for drug substitution treatment at the national level, with a licensing system for doctors, admission criteria for patients and a committee for surveillance of the programme. In Greece, a pilot scheme authorising buprenorphine substitution was implemented in the public general hospital in Rhodes. In Finland, opiate addicts are entitled to receive detoxification and substitution treatment, complemented by maintenance treatment, and as a result there has been an increase in the number of units assessing the need for and providing pharmaceutical treatment of drug addicts. And in Germany, since the ninth book of the German Social Security Code came into effect in July last year, addicts have benefited from improved rights and legislation that defines more clearly how and when health insurance schemes should pay for detoxification and pension insurance schemes should pay for rehabilitation.

In April 2002, the Danish Parliament decided to abolish legal provisions which, although they had never been implemented, had previously allowed county authorities to retain drug addicts in treatment. And in June last year, a ministerial decree in Italy, in line with the national drugs plan and aiming to improve abstinence-focused treatment, gave private treatment services the authority to certify drug

dependency. As a result, drug-treatment centres were able to admit residents directly from anywhere in the country and, with the authority of a certificate of dependence, require a drug user's local SerT (drug addiction service) to pay for the treatment provided. However, following an amendment to the Italian Constitution, transferring competence for healthcare and social care from the central to regional administrations, the Constitutional Court determined that the decree was unconstitutional as it concerned a matter that was the responsibility of the regions. In Norway, the State assumed ownership and operational responsibility for hospitals in 2002, and responsibility for low-threshold health services and medically assisted rehabilitation of drug abusers resides with the Ministry of Health. County responsibility for specialist health services for drug abusers should be transferred to the State in 2004, and the Ministry of Social Affairs has proposed that county responsibility for specialist social services and care of drug abusers should be transferred to the municipalities as of 2004. This aims to provide drug abusers with a more comprehensive and coherent system of care and treatment measures.

In Austria, there is a problem providing the health-related measures required by Article 11 of the Narcotic Substances Act. Officially, effort should focus on the elimination of (organised) drug trafficking, but despite this a large proportion of offences concern cannabis use, for which district health authorities usually, under Article 11, prescribe health-related measures. As a result, drug-treatment centres do not have sufficient resources to meet demand and are unable to fulfil their responsibilities.

Monitoring of traffickers

Against a background of increased security, a number of countries report legal changes to improve monitoring of traffickers and users. In Denmark, a law that came into force in June 2002 requires providers of telecommunications services to record and store for one year any telecommunications and Internet communication data that may prove relevant to police investigations. Provided they have a court warrant, police may now, using computer programs or other equipment, read non-public data held on computers. Similarly, in Portugal, a law introduced in January 2002 established special measures (in the areas of evidence collection, information confidentiality and confiscation of assets) to help fight organised financial crime and other serious crimes, including drug trafficking. In Finland, an amendment to the Police Act extended the rights of the police to acquire telecommunications information (e.g. in cases of suspected

drug-related crime) and to engage in technical surveillance. In 2002, the government also put forward the Coercive Means Act. This will extend the means for telesurveillance and monitoring communications although the details are still to be specified.

In January 2002, the Code of Criminal Procedure of the Netherlands was changed to allow, in addition to body cavity searching, the use of X-rays and ultrasound scans in anyone suspected of having swallowed small packages of drugs, provided these procedures are carried out by a physician. User detection techniques also increased, and last summer the United Kingdom's drug-testing pilot programme in England and Wales was extended. This scheme allows samples to be taken from adults in police detention who are charged with a 'trigger offence' (mainly acquisitive crimes and drug offences) in order to test for heroin and cocaine. Those who test positive are offered the opportunity to see an arrest referral worker for an assessment for treatment, and the drug test results are made available to the courts to assist with bail and sentencing decisions. Early pilot findings were published in March 2003. Drug testing on charge is being extended during 2003 to 30 high-crime police basic command units (police divisions within a police area) in the United Kingdom.

Measures to reduce public order/nuisance offences

Over the last year, legislative provisions in some Member States have aimed at minimising the social impact of drug use by providing stricter control of public order and public nuisance.

In Ireland, the Criminal Justice (Public Order) Bill, 2002, was introduced to strengthen the 1994 Act relating to public order. Persons convicted under the 1994 Act for a public order offence, including intoxication (by drug use) in public, and who could endanger themselves or others, may be issued with an exclusion order prohibiting them from entering or being in certain premises, including licensed premises, dance halls or premises that serve food.

In the United Kingdom, Section 8 of the Misuse of Drugs Act, which applies to individual occupiers and managers of certain types of premises, was amended to cover the unlawful consumption of any controlled drug (previously it applied only to smoking of cannabis or opium) in order to deal with crack houses. However, these powers are wide in scope, and the government has subsequently decided that the Section 8 proposals may not be sufficiently effective in dealing with this problem. Consequently, it is seeking to introduce new legislation in the form of the Anti-Social Behaviour Bill, which is targeted at premises rather than

individuals, which will enable the police, in consultation with local authorities, to shut crack houses within 48 hours. Consequently, the UK is not intending to implement the amendment to Section 8(d) for the time being, although this may yet be the case if the sanctions incorporated in the Anti-Social Behaviour Bill are found to be less than completely effective over the next two years.

In the Netherlands, the 1997 Victoria Act gave town mayors the power to close down premises where drug use or trafficking was causing a public nuisance. However, as the closure of buildings may adversely affect the appearance and social structure of a neighbourhood, the new Victor Act of May 2002 allowed municipalities to reassign closed premises, for example by permitting new tenants to move in. In the city of Venlo, a four-year pilot project involving police, prosecutors and the government is aimed at reducing the nuisance caused by the many drug tourists who buy cannabis at unlicensed coffee shops. And in July 2002, the mayor of Rotterdam, exercising powers provided under the Municipality Act, personally imposed a six-month ban on about 50 drug addicts who were troubling the residents of a local borough. However, the regional court decided that, although the mayor was entitled to combat nuisance, a six-month ban was too long and not justified; despite this, the city of Rotterdam intends to continue with its banning policy.

In Denmark, an act prohibiting visiting in certain premises became effective in June 2001. The objective of the act is to provide more effective intervention in relation to cannabis clubs and other types of organised crime being perpetrated on premises and causing concern to neighbours. It allows the police, after advance warning, to issue a three-month injunction against the owner of such premises, prohibiting visitors from arriving or staying there. Violation of a injunction is punishable by a fine, with repeated violations attracting a prison sentence of up to four months.

Developments at EU level

In November 2002, the European Commission issued a communication regarding the mid-term evaluation of the EU action plan on drugs (2000–04) ⁽¹⁰⁰⁾. The aim of this mid-term evaluation was to assess the level of achievement of the activities set out in the action plan. As the EU action plan comprises actions to be undertaken by the Member States, the European Commission, the EMCDDA and Europol, the mid-term evaluation was based on complementary tools, including the replies of the Member States to a questionnaire and a follow-up table of the achievements of the Commission, the EMCDDA and

⁽¹⁰⁰⁾ COM(2002) 599 final.

Europol. These were supplemented by the results of the peer evaluation of law-enforcement systems in the Member States and information on drug-related initiatives at the EU level. The communication summarised achievements in each area covered by the action plan and highlighted the areas where progress is needed at each level.

While acknowledging achievements, the Commission stressed that much work remains to be done, including the development of systems of evaluation of national and EU activities. It also stressed the need to cooperate closely with the candidate countries to ensure their future contribution to the European Union drugs strategy. The document sets out methodological bases for the final evaluation. In particular, the Commission proposed to pursue the evaluation process with the support of a steering group including representatives from the Commission, the European Parliament, the Council Presidency, Europol and the EMCDDA. This group will help to create the final evaluation setting. As part of the final evaluation, the EMCDDA will compare data available in 2004 in the field of drugs with the 1999 baseline it produced in association with Europol. The EMCDDA will also assist the Commission in implementing the second Eurobarometer study on youth attitudes and drugs and update the follow-up table on activities of the EMCDDA. It should be noted that, according to a special Eurobarometer survey entitled 'Attitudes and opinions of young people in the European Union on drugs' (2002) ⁽¹⁰¹⁾, the two most effective ways of tackling drug-related problems in Europe are tougher measures against drug dealers and traffickers (supported by 59.1 % of the sample, EU-15) and improved treatment and rehabilitation services for drug users (favoured by 53.2 %, EU-15) ⁽¹⁰²⁾.

The Council of the European Union has also adopted an implementation plan on actions to be taken on synthetic drugs, which sets out a number of issues with regard to the supply of synthetic drugs that should be further addressed by the European Union over the coming years. The plan proposes actions to address the problems identified and defines appropriate bodies to take the work forward within specified timeframes.

On 28 February 2002, the European Council adopted a decision concerning control measures and criminal sanctions in respect of a new synthetic drug, PMMA. PMMA is not currently listed in any of the schedules to the 1971 United Nations Convention on Psychotropic Substances, but, as a result of this decision, PMMA is now subject to control measures and criminal provisions within the Member States ⁽¹⁰³⁾.

Another important development is Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002, which instigates a programme of Community action in the field of public health (2003–08) ⁽¹⁰⁴⁾. The aims of the programme are:

- to improve information and knowledge to further the development of public health;
- to enhance capability to respond rapidly and in a coordinated fashion to threats to health;
- to promote health and prevent disease by addressing health determinants across all policies and activities.

This programme will, among other things, support implementation of monitoring and rapid reaction systems and actions in the field of health determinants. Both areas should allow follow-up of initiatives launched by stakeholders in Member States in the context of the programme of Community action on the prevention of drug dependence within the framework for action in the field of public health (1996–2000 and extended to 2002).

In 2002, the European Commission also made some proposals, discussed by the Council during the reporting period (March 2003), that concern the drugs field: one is related to reduction of risks associated with drug dependence and the other to drug precursors ⁽¹⁰⁵⁾. In December, the European Community concluded an agreement with the Republic of Turkey on precursors and chemical substances frequently used for the illicit manufacture of narcotic drugs and psychotropic substances ⁽¹⁰⁶⁾.

⁽¹⁰¹⁾ See http://europa.eu.int/comm/public_opinion/archives/eb/ebs_172_en.pdf.

⁽¹⁰²⁾ Attitudes and opinions of young people aged 15–24 in a sampling which is representative of the EU.

⁽¹⁰³⁾ 2002/188/JHA: Council decision of 28 February 2002 concerning control measures and criminal sanctions in respect of the new synthetic drug PMMA (OJ L 063, 6.3.2000, p. 14). Proposal for a Council decision defining PMMA as a new synthetic drug which is to be made subject to control measures and criminal provisions ((COM)2001 734 final).

⁽¹⁰⁴⁾ Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003–08) (OJ L 271, 9.10.2002, pp. 1–12).

⁽¹⁰⁵⁾ Proposal for a Council recommendation on the prevention and reduction of risks associated with drug dependence ((COM)2002 201 final). Proposal for a regulation of the European Parliament and of the Council on drug precursors ((COM)2002 494 final, OJ C 20 E, 28.1.2003, pp. 160–170).

⁽¹⁰⁶⁾ Agreement between the European Community and the Turkish Republic on precursors and chemical substances frequently used in the illicit manufacture of narcotic drugs or psychotropic substances (OJ L 64, 7.3.2003, pp. 30–35).

Prevention

Prevention is often divided into ‘universal’ prevention (targeting children and young people in general and implying a no-use objective) and ‘targeted’ or ‘indicated’ prevention (aimed at particular high-risk groups). The latter is discussed in Chapter 3 (p. 63). School is the preferred setting for universal prevention interventions as this environment guarantees long-term and continuous access to large populations of young people. A recent research project on good practices in school-based prevention, funded by the European Commission ⁽¹⁰⁷⁾, drafted recommendations for school-based prevention programmes as well as for necessary frameworks: school policy and school environment. There is a broad evidence base from the international literature identifying approaches that are potentially promising or confirmed to be effective ⁽¹⁰⁸⁾.

In all Member States, prevention is included in school curricula, in the sense that the topic ‘drugs’ has to be dealt with in one way or other, but this might simply mean that teachers or police officers provide information about drugs and risks. Purely informative and unstructured approaches have been found to be ineffective (Hansen, 1992; Tobler, 2001). Only a few Member States have national plans for school-based prevention that detail the scope of actions to be carried out (and to be avoided) and by whom ⁽¹⁰⁹⁾. Other countries, however, prefer to develop municipal or departmental plans into which school-based prevention is integrated ⁽¹¹⁰⁾. Even fewer Member States have clear standards for the content of school-based prevention (mandatory only in Ireland and the United Kingdom) ⁽¹¹¹⁾. However, EU countries are beginning to recognise the need to provide high-quality prevention measures rather than just reiterating the importance of prevention in their national strategies. Sweden is one of the few countries to admit that its school-based prevention ‘was very often arranged with methods that research has shown have little or no result, while effective methods were seldom in use’ (Skolverket, 2000) and that lack of quality control led to a situation ‘where any school principal was able to decide how drug education should be accomplished’. Now, the whole strategy is being refocused towards ‘regular programmes based on evaluated, effective methods’. Similarly, in France

‘the relative silence [...] in the legislative and statutory texts and the early implication of associations [...] has resulted in a multiplicity of active participants in prevention, [...] without any model or action theory being imposed or particularly encouraged’ (French national report). In reality, this description could be applied to many more Member States. In contrast, Spain, Ireland and the United Kingdom have developed a clear quality control and evidence-based orientation in their prevention policies and intend to further strengthen this focus ⁽¹¹²⁾. In addition, stricter quality requirements are now being introduced in Portugal.

Systematic mapping and documentation of programmes as the cornerstones of quality improvement ⁽¹¹³⁾ are gaining in importance: recently, Denmark, Germany and Portugal have set up pilot projects to develop monitoring systems similar to those already existing in Belgium, Greece, Spain, France, the Netherlands and the United Kingdom.

Curricular interventions (i.e. formal prevention programmes with detailed contents and outline for sessions) are, according to existing knowledge (Tobler, 2001), the most useful way to deliver effective prevention in a controlled manner that also allows evaluation of both process (good delivery) and outcome (positive results). The proportion of schools covered by such curricular programmes is relatively low in some Member States, either because the necessary information systems are missing (Germany, Italy) or because a non-programme-based treatment of prevention in daily school life is preferred (Austria and Finland ⁽¹¹⁴⁾ ⁽¹¹⁵⁾).

Because it is a relatively well-defined concept, school-based prevention is the most accessible area for the mapping and quantification of prevention coverage; in this respect, the information systems within the EU are beginning to yield results, whereas information on other important fields still needs to be structured and improved ⁽¹¹⁶⁾.

Community-based prevention, on the other hand, is a very heterogeneous concept partly because it is, by definition, decentralised. The only common feature across Europe is the setting itself: ‘community’. Interventions include general activities (such as staff training and training of trainers), structural measures (development of local policies and networks as well as involvement of decision-makers) and

⁽¹⁰⁷⁾ See www.school-and-drugs.org.

⁽¹⁰⁸⁾ See *Drugs in focus* No 5 at http://www.emcdda.eu.int/multimedia/publications/Policy_briefings/pb4_6/pb_05_EN.pdf.

⁽¹⁰⁹⁾ See Figure 38 OL: National plans for school-based prevention (online version).

⁽¹¹⁰⁾ See Figure 39 OL: Organisation of prevention (online version).

⁽¹¹¹⁾ See Table 3 OL: Overview on policies and frameworks for prevention (online version).

⁽¹¹²⁾ See *Drugs in focus* No 5 at http://www.emcdda.eu.int/multimedia/publications/Policy_briefings/pb4_6/pb_05_EN.pdf.

⁽¹¹³⁾ See *Drugs in focus* No 5 at http://www.emcdda.eu.int/multimedia/publications/Policy_briefings/pb4_6/pb_05_EN.pdf.

⁽¹¹⁴⁾ See *Drugs in focus* No 5 at http://www.emcdda.eu.int/multimedia/publications/Policy_briefings/pb4_6/pb_05_EN.pdf.

⁽¹¹⁵⁾ See Table 4 OL: Main quantitative parameters of school-based prevention programmes (online version).

⁽¹¹⁶⁾ See Table 5 OL: Prevention programmes in schools and kindergarten (online version).

specific actions such as the provision of local centres for the prevention of addiction and marginalisation (France) or parent patrols/‘night ravens’ (Denmark, Sweden and Norway) ⁽¹¹⁷⁾. Interventions are not necessarily organised by community groups, but — as, for example, in Luxembourg — may be managed top-down by a national agency responsible for initiating projects, including drug awareness programmes. Often, there is a lack of a solid foundation and of any clear goal; only in Greece are the aims and structure of community projects subject to any monitoring process. Except in Luxembourg and Ireland, no significant evaluations have been reported.

Family-based prevention, despite being frequently mentioned as a key element in national strategies, seems to be developed on a disparate, intuitive and impromptu basis, without any notable experience or evidence base. A frequent feature is the training of parents in parenting skills and/or dissemination of information (Belgium, Denmark, Germany, France, Italy, Portugal and Norway). Only Ireland, the Netherlands and the United Kingdom have focused projects in place, which target families at risk and concentrate on socially deprived neighbourhoods. Spain, however, has issued a systematic and exhaustive overview on family-based prevention practices ⁽¹¹⁸⁾, while Greece has also developed well-organised and well-documented family projects nationwide.

Until now, it has been impossible to compare the amounts spent on prevention in the different Member States, even if focusing only on resources for school-based prevention plans.

Mass media campaigns, despite the weak evidence base for their impact on consumption behaviour when used alone (Paglia and Room, 1999), as well as their considerable cost, often remain important pillars of prevention strategies.

Harm-reduction responses

Measures to minimise drug-related health damage, reduce deaths and mitigate public nuisance ⁽¹¹⁹⁾ have become an integral part of many national drugs strategies and a clear policy priority in a majority of countries ⁽¹²⁰⁾. Implementation of harm-reduction activities is described by the national focal points as ‘very important’, ‘of key significance’, ‘fundamental’, ‘a priority’ or ‘a pivotal aspect of our national drug strategy’.

Syringe-exchange programmes, outreach initiatives and low-threshold services have continued to expand and in various countries have diversified to include basic medical care, vaccinations, safer use education, overdose emergency care, first aid courses for drug users or supervised consumption rooms. Table 2 provides an overview of selected harm-reduction initiatives in the EU Member States and Norway. Increased geographical coverage of syringe-exchange programmes is among the most important measures to reduce injection-related infections. Other interventions are generally less widespread and are presented here as ‘indicators’ of the orientation of drugs services responses towards the basic health needs of marginalised drug users. In all countries, drug-treatment initiatives, especially substitution programmes, also make an important contribution to reducing drug-related health damage.

⁽¹¹⁷⁾ More information on the ‘night ravens’ is provided on page 63.

⁽¹¹⁸⁾ http://www.mir.es/pnd/publica/pdf/intervencion_familiar.pdf.

⁽¹¹⁹⁾ See EMCDDA annual report 2002; EMCDDA *Drugs in focus* No 4; Council recommendation on the prevention and reduction of health-related harm associated with drug dependence (Cordroque 32).

⁽¹²⁰⁾ See Table 6 OL: Role of harm reduction (online version).

Table 2: Geographical coverage of syringe-exchange schemes and the availability of other selected health services for drug users in the EU Member States and Norway

Country	Geographical coverage of syringe-exchange programmes ⁽¹⁾	Low-threshold medical care ⁽²⁾	Safer use education ⁽³⁾	First aid courses for drug users ⁽⁴⁾	Supervised drug consumption rooms	Heroin prescription
Belgium	> 40 sites, major cities		Yes	Yes		Trials under discussion
Denmark	10 of 14 counties		Yes	Yes		
Germany	Almost all cities	Yes	Yes	Yes	20 facilities in 11 cities	Three-year medical study started in 2002
Greece	Athens	Yes	Yes	Yes		
Spain	18 of 19 regions, prisons	Yes	Yes	Yes	2 facilities	Trial in Andalusia and Cataluña
France	87 of 100 <i>départements</i>	Yes	Yes	Yes		
Ireland	20 sites and outreach, mainly Dublin area		Yes			
Italy	SerT and non-government organisations in 'many cities'; machines in smaller urban settings	Yes		Yes		
Luxembourg	Specialised services in three main cities; machines in five cities	Yes	Yes	Yes	1 (planned)	Legal framework created
Netherlands	> 95 % of bigger cities	Yes	Yes	Yes	21 rooms in 11 cities	Randomised clinical trial completed; 300 clients continue treatment
Austria	13 towns across most provinces	Yes	Yes	Yes		
Portugal	National coverage through pharmacy-based programme; SEP/outreach network under construction	Yes	Yes	Yes	Legally possible, not foreseen	
Finland	Over 70 % of cities > 50 000 inhabitants, plus five smaller cities	Yes	Yes	Yes		
Sweden	Malmö and Lund			Yes (at SEP)		
UK	Major programmes in most English and Scottish cities; SEPs introduced in N. Ireland in 2001		Yes	Yes	Recommendation by Home Affairs Select Committee not supported by Home Secretary	Limited, ongoing heroin prescription. Expansion recommended by Select Committee (and agreed in principle by government)
Norway	Oslo since 1988 and most major municipalities	Yes		Yes		

⁽¹⁾ See Table 7 OL: Provision and types of syringe-exchange programmes (SEPs), pharmacy involvement, numbers of syringes distributed/sold (online version).

⁽²⁾ At least one low-threshold medical care service.

⁽³⁾ At least one service regularly provides safer use training courses.

⁽⁴⁾ Regular first aid courses for drug users in at least in one city. See Table 11 OL: Strategies and selected measures to reduce drug-related deaths in the EU Member States and Norway.

Prevention of infectious diseases

Syringe-exchange programmes are available in all countries, but coverage is very limited in Sweden and Greece. A proposal to continue the two existing programmes and to expand needle-exchange programmes nationwide has recently been made in Sweden. In many other countries, accessibility of sterile injecting equipment has further improved, and better coverage of rural areas has been achieved through installation of vending machines and involvement of pharmacists ⁽¹²¹⁾.

HIV

Voluntary counselling and testing (VCT) for HIV is commonly available in all EU countries, and is mostly free ⁽¹²²⁾. Efforts to access 'hard-to-reach' drug users and encourage them to make use of VCT through new low-threshold services and outreach work have increased, though in several countries availability of free testing with full anonymity is limited.

Combination antiretroviral therapy (HAART ⁽¹²³⁾) is provided by healthcare systems in all EU countries, but serious problems of both access and compliance by HIV-infected drug users are observed. Active drug users are not well covered by HIV treatment, especially those who are homeless or leading unstable lives. Further obstacles include the attitudes of treatment providers and a lack of information among drug users about dramatic reductions in morbidity and mortality achievable through treatment. Some countries (e.g. Belgium, Germany, Austria, Portugal and Finland) have implemented innovative approaches, such as providing HIV treatment at drugs services and low-threshold centres or changing medicine-dispensing modalities to match clients' lifestyles, but improving treatment uptake and success remains a challenge.

Hepatitis B

Free vaccination campaigns against hepatitis B are currently implemented in some countries ⁽¹²⁴⁾. More proactive offers of vaccination by drug services and efforts by drug services to make vaccination available to drug users through contact points for high-risk populations can be noted. Pilot programmes in Germany, the Netherlands and Austria are proving successful in increasing

immunisation rates. Combined vaccination against hepatitis virus A and B is recommended for drug users (BAG, 1997).

Although vaccination is available and covered by health systems in most countries, reported immunisation rates are low.

Drug users may not remain long enough in contact with one treatment service to complete the course of vaccinations and achieve full immunisation. Solutions that are tried include vaccine administration at different services, rapid dose schedules and specialised easy access programmes.

Hepatitis C

Treatment for hepatitis C is offered in all countries, but in practice access is difficult for drug users (Wiessing, 2001). Current guidelines suggest that drug users should not be treated until they are off drugs or have been stable on oral substitution for at least one year because of the risk of reinfection among active users. Limited access to treatment or low treatment compliance is reported by many countries ⁽¹²⁵⁾. New possibilities to improve uptake and compliance by drug users include pegylated interferon, which involves a less demanding regime, and development of evidence-based treatment guidelines.

There are few national action plans to reduce hepatitis C virus infection. Safer use training and information and awareness campaigns for drug users have been implemented in several countries. Prison programmes to raise awareness about infectious diseases are reported in some countries, as are efforts to improve knowledge of hepatitis C prevention among professionals working with drug users.

Reducing drug-related deaths

Around 8 000 acute drug-related deaths are recorded each year throughout the EU and Norway, mostly involving young people. The burden of drug-related deaths for society becomes even more apparent if represented in terms of 'years of life lost' ⁽¹²⁶⁾. Thus, the burden due to drug-related deaths in England and Wales in 1995 was 70 % of that due to deaths in road traffic accidents (ACMD, 2000).

⁽¹²¹⁾ See Table 7 OL: Provision and types of syringe-exchange programmes (SEPs), pharmacy involvement, numbers of syringes distributed/sold (2001 data are presented in Table 8 OL of the 2002 annual report at: <http://ar2002.emcdda.eu.int/en/popups/oltab08-en.html>).

⁽¹²²⁾ See Table 8 OL: Provision of HIV voluntary counselling and testing (VCT) and treatment (online version).

⁽¹²³⁾ Highly active anti-retroviral treatment.

⁽¹²⁴⁾ See Table 9 OL: Provision of hepatitis B virus (HBV) vaccination for injecting drug users (IDUs) in some European countries (online version).

⁽¹²⁵⁾ See Table 10 OL: Treatment for hepatitis C-infected injecting drug users (IDUs) (online version).

⁽¹²⁶⁾ Years of life lost: based on the age to which any individual would be expected to live if he or she had not died as a result of drug use (ACMD, 2000, p. 56).

Findings indicate a considerable potential to reduce the number of deaths through medical and educational approaches ⁽¹²⁷⁾. Increased availability of substitution treatment, which has a substantial protective effect on mortality (WHO, 1998), has been found to be correlated with reductions in overdose deaths in France and Spain, though decreasing rates of drug injecting in Spain may also have made an important contribution (EMCDDA, 2002a). Educational programmes for drug users to identify risks, recognise overdose signs and respond correctly have yielded positive effects by increasing drug users' competence to help when witnessing an overdose.

Local strategies to reduce overdose deaths in Oslo, Copenhagen, Amsterdam and Frankfurt have been the topic of a study that found that, although existing levels and patterns of drug use set limits on what can be achieved, local policies on responses can help reduce the number of deaths (Reinås et al., 2002).

A reduction in drug-related deaths, which is a key objective in target 2 of the EU drugs strategy (2000–04), is increasingly being taken seriously as an achievable goal. It is identified as a priority in the new national drug strategies of Germany, Greece, Ireland, Luxembourg, Portugal, Finland and the United Kingdom. Local strategies to reduce overdose deaths are also reported ⁽¹²⁸⁾.

Information resources on overdose prevention are available in most countries. Training in basic resuscitation methods for drug users is offered by drugs and health services, though geographical coverage of these first aid courses is often limited to major urban centres ⁽¹²⁹⁾.

Distribution of an opiate antagonist, naloxone, is one measure taken in some countries with the aim of reducing heroin overdoses (Sporer, 2003). In Italy, a significant number of *Unità de Strada* (street drugs services) provide drug users with naloxone, which can be administered as an interim emergency measure while awaiting medical help. A pilot study in Berlin of combined first aid training and naloxone distribution found increased competence to react adequately in drug emergencies and medically justified use of the antagonist in the large majority of cases (93 %) (Dettmer, 2002). The same study also pointed to the relevance of naloxone for emergencies occurring in domestic settings.

Overdose deaths in public places have been of particular concern in European cities with large open drugs scenes. In

some German and Spanish cities, supervised consumption facilities have been introduced, targeting the often marginalised populations of open drug scenes. Supervised consumption rooms are also to be found in the Netherlands. Among other services, they provide immediate emergency care in cases of overdose. A study of consumption rooms in Germany (Poschadel et al., 2003) found that they contributed significantly to a reduction in drug-related deaths at city level and improved access to further health and treatment services for problem drug users who are not reached by other services.

Treatment

Medically assisted treatment and drug-free treatment are the two main modalities of treatment related to illegal drug use. Medically assisted treatment is almost exclusively provided in an outpatient setting, whereas drug-free treatment can be given in residential or outpatient settings. In the EU, in practice, only agonists (e.g. methadone) or combined antagonists/agonists (e.g. buprenorphine) are used for long-term treatment, whereas antagonists (e.g. naloxone) may be used in withdrawal treatment.

Medically assisted treatment

Methadone is by far the most used substitution substance. Buprenorphine, the most used substitution substance in France for years, is also prescribed by private doctors in Portugal and Luxembourg. Sweden is preparing restrictions on the prescription of buprenorphine, and in Finland illicit misuse of buprenorphine has caused demand for treatment, with a few deaths reported related to misuse of buprenorphine and depressants. Currently, buprenorphine is used to a much lesser extent than methadone in Belgium, Denmark, Germany, Greece, Spain, Austria and the United Kingdom.

Information on the number of persons receiving substitution treatment has been available for some years (Farell et al., 1996, 2000) and it is now possible to follow development in this area. Table 3 compares information on substitution treatment as reported in 1997/98 with the latest information from Member States. Table 3 shows that there has been a substantial increase in the overall availability of medically assisted treatment. The aggregate increase at EU level is about 34 % in approximately five years.

⁽¹²⁷⁾ Toxicological aspects, social and personal correlates and risks, and the circumstances under which deaths and non-fatal overdoses occur and prevention strategies have been researched, e.g. Varescon-Pousson et al. (1997), Hariga et al. (1998), Seaman et al. (1998), Villalbi and Brugal (1999), ACMD (2000), Ferrari et al. (2001), Lepère et al. (2001), Brugal et al. (2002), Buster (2002), Kraus and Püschel (2002), Origer and Delucci (2002) and Pant and Dettmer (2002).

⁽¹²⁸⁾ Table 11 OL: Strategies and selected measures to reduce drug-related deaths in EU Member States and Norway (online version).

⁽¹²⁹⁾ Table 11 OL: Strategies and selected measures to reduce drug-related deaths in EU Member States and Norway (online version).

Table 3: Development of substitution treatment in the 15 EU Member States and Norway

	Estimated number of persons in substitution treatment reported (1)		Change (%)
	1997/1998	2001/2002	
Belgium	6 617	7 000	5.8
Denmark	4 298	4 937	14.9
Germany (2)	45 300	49 300	8.8
Greece	400	1 060	165.0
Spain	51 000	78 806	54.5
France	53 281	85 757	61.0
Ireland	2 859	5 865	105.1
Italy	77 537	86 778	11.9
Luxembourg (3)	931	1 007	8.2
Netherlands	13 500	13 500	0
Austria	2 966	5 364	80.8
Portugal	2 324	12 863	453.5
Finland	200	400	100.0
Sweden	600	621	3.5
UK (4)	28 776	35 500	23.4
Norway	204	1 853	808.3
Total	290 793	390 611	34.3

(1) For some countries numbers refer to clients, for other countries they refer to estimated slots.
(2) In the case of Germany, figures also include patients receiving dihydrocodeine, which was estimated to be around 8 800 patients in 1998 and 3 700 patients in 2000.
(3) 186 and 156 clients were registered in the State-run methadone project in 1998 and 2001 respectively, whereas 745 and 849 received substitution treatment through general practitioners.
(4) England and Wales only.
Sources: EMCDDA annual report 1998 (with data from 1997 or earlier national reports) and national reports 2001 and 2002.

Co-prescription of heroin

The Netherlands has already conducted a trial with medical co-prescription of heroin and presented its findings in February 2002 (<http://www.ccbh.nl>; Central Committee on the Treatment of Heroin Addicts, 2002). Clients admitted to the trial received both methadone and heroin. The evaluation showed that the clients in the experimental group experienced considerable health benefits compared with the control group, which received methadone treatment only.

Between March 2002 and February 2003, the German cities of Bonn, Cologne, Frankfurt, Hamburg, Hannover,

Karlsruhe and Munich launched a heroin-assisted treatment programme in the framework of a scientific randomised controlled trial. A total of 1 120 clients were admitted to the heroin trial, which will be closely monitored and evaluated by the Centre for Interdisciplinary Addiction Research, Hamburg (Zentrum für Interdisziplinäre Suchtforschung), for two study periods each of 12 months (<http://www.heroinstudie.de/>).

In Spain, the autonomous regions of Cataluña and Andalucía are preparing trials of co-prescription of heroin. In Barcelona (Cataluña), the total cohort of the study will be 180 male clients aged 18–45. The heroin prescribed will be for oral administration.

In Luxembourg, a decree of 30 January 2002 allows for a trial of heroin prescription to be conducted in the framework of a pilot project managed by the Directorate of Health.

In the United Kingdom, heroin is prescribed through general practitioners to an estimated 500 clients.

Drug-free treatment

Drug-free treatment involves the application of psychosocial and educational techniques to achieve long-term abstinence from drugs.

Available data on drug-free treatment do not allow a quantitative comparison, partly because they come from both centres targeted exclusively at illegal drug users and those aimed at addiction treatment in general, i.e. treatment of alcoholism and other kinds of abuse, and partly because 'treatment' is not readily defined (e.g. as a minimum number of sessions) and cannot be measured in quantifiable units, such as registered prescriptions, as is the case with medically assisted treatment.

There is a trend towards a north-south divide in treatment provision, with treatment predominantly supplied through specialised services for illegal drug use in the southern part of Europe and through generic addiction services in the north (with the exception of Denmark). One explanation could be that northern countries (except Denmark) have a longer history of drug-free treatment of alcoholics than southern countries. Perhaps once illegal drug use began to develop, the already existing treatment facilities were adapted to deal with this particular group within the facilities. Conversely, the other countries did not have the same network of treatment facilities and additional specialised services were created for illegal drug users (130).

Standards and quality of treatment

Setting up accreditation systems, establishing quality standards, developing guidelines, training staff and

(130) See Figure 40 OL: Problem drug users in drug-free treatment (online version).

monitoring and evaluation are all examples of measures aiming at assuring a certain standard and quality level of treatment related to illegal drugs.

Accreditation or certification systems are reported from Germany, France, Luxembourg, Austria and Portugal and imply that an authorised independent external body monitors services to ensure that they meet pre-established specific requirements. In some countries, for example France and Luxembourg, treatment providers must be certified or accredited in order to receive funding for treatment. In other countries, national certification is possible but optional, although the opportunity to become certified according to international standards, such as ISO, is available throughout Europe.

Guidelines on treatment implementation in order to assure quality are reported from many Member States, such as Greece, Italy, the Netherlands, Austria and Finland. However, their extent of use and implementation as well as their nature vary. Guidelines can be non-binding advice that is widely available or semi-binding principles that have to be adhered to for funding to be considered. At EU level, non-binding guidelines for the provision of methadone treatment have been developed and are available in German, English, French and Spanish ⁽¹³¹⁾.

Staff training is available in all Member States, although no Member State reports nationwide systematic training of treatment staff. The availability, diversity and level of training vary widely across the EU, as does the involvement of treatment-related authorities in setting up such activities.

Treatment evaluation and research

Evaluation of and research into drug treatment, which takes various forms, is reported from all countries. However, the vast majority of studies are small scale and conducted at institutional or local level. In the United Kingdom, a nationwide treatment outcome survey was conducted in England and Wales with results over five years ⁽¹³²⁾. Italy's VEdette study, which involves almost 12 000 clients in 118 outpatient treatment centres (SerT), is still ongoing, and so far only initial results are available. The preliminary results show that the daily average dose of methadone was 40 mg and only 10 % of clients received 60 mg or more, the required dose according to the scientific literature. Annual treatment drop-out rates for drug-free treatment and for methadone maintenance treatment were 52 % and 35 %

respectively. It also appears that higher doses of methadone reduce the risk of drop-out. The study also confirmed that psychosocial intervention is effective ⁽¹³³⁾. The Danish DANRIS study ⁽¹³⁴⁾, which started in May 2000, aims to monitor treatment and its efficiency at roughly 40 inpatient treatment centres. At European level, the Treat 2000 project, partly financed by the fifth research framework programme, aims to analyse and compare healthcare systems and their efficiency in dealing with opioid addicts in six European regions.

Responses targeting drug users in criminal justice settings

Policy framework

Drug addiction plays a central role in violation of drug laws as well as petty acquisitive crime. A high proportion of drug users are arrested, and many are incarcerated. In addition, some prisoners start taking drugs while in prison. These observations are taken into consideration in the criminal justice systems of all the EU Member States and Norway. The majority of EU countries have included in their drug strategies a focus on the improvement of psychosocial and health services addressing drug addicts in prisons.

A need for flexible penal justice systems has emerged because of the growing number of imprisoned drug users and the consequent overcrowding of prisons. The notion that drug users might not be best accommodated in prison settings has resulted in the expansion of alternative measures to sentence proceedings and to incarceration. Cooperation between the criminal justice structures, namely prison and probation, and between these and health structures, is generally considered to be in need of improvement, and appropriate measures are developing ⁽¹³⁵⁾.

Prison-based psychosocial and health interventions

In prisons, services targeting drug-using inmates are expanding. Most of the countries where addiction treatment is generally available in prisons also provide harm-reduction measures (Table 4). However, an analysis of prison-based programmes contained in EDDRA (Exchange on European Drug Demand Reduction Action) ⁽¹³⁶⁾ found that the dominating objective of the interventions is not health related but the reduction of drug-related crime ⁽¹³⁷⁾.

⁽¹³¹⁾ See guidelines at Euromethwork web site at <http://www.q4q.nl/methwork/home2.htm>.

⁽¹³²⁾ <http://www.ntors.org.uk>.

⁽¹³³⁾ www.studio-vedette.it/pubblicazioni.htm.

⁽¹³⁴⁾ <http://www.crf-au.dk/danrisenglish/default2.asp>.

⁽¹³⁵⁾ See Table 12 OL: Recent prison drug strategies, ministerial directives and service standards in the EU and Norway (online version).

⁽¹³⁶⁾ <http://eddra.emcdda.eu.int>.

⁽¹³⁷⁾ EMCDDA criminal justice based drug demand and harm-reduction interventions in the EU — an analysis of police station, court and prison-based programmes (http://eddrapdf.emcdda.eu.int/eddra_cjs.pdf).

Table 4: Availability of socio-health services targeting drug users in EU prisons ⁽¹⁾ ⁽²⁾

Percentage of prisons offering the services	Abstinence-oriented			Substitution treatment	Harm-reduction-oriented				
	Detoxification	Drug-free units	Therapeutic communities in prison		Blood screening	Vaccination programmes	Provision of disinfectants	Needle exchange	Provision of condoms
All	Belgium, Denmark, Spain, France, Luxembourg, Netherlands, Austria, Portugal, Sweden			Belgium, Denmark, Spain, France, Austria, Portugal	Belgium, Greece, Spain, France, Ireland, Luxembourg, Netherlands, Austria, Portugal, Sweden	Denmark, Greece, Spain, France, Ireland, Luxembourg, Austria, Portugal	Belgium, Denmark, France, Austria, Portugal, Norway		Belgium, Denmark, Spain, France, Austria, Portugal, Sweden, Norway
More than half	Ireland, Finland, UK	Finland, UK		Luxembourg	Finland	Finland, UK	Finland		Luxembourg, Finland, UK
Less than half	Greece, Italy, Norway	Denmark, Netherlands, Belgium, Greece, Spain, Ireland, Austria, Portugal, Sweden, Norway	Belgium, Denmark, Spain, Greece, Austria, Portugal, Finland, Norway	Ireland, Italy, Finland, UK			UK	Germany, Spain	
None		Italy, France, Luxembourg	France, Ireland, Italy, Luxembourg, Netherlands, Sweden, UK	Greece, Netherlands, Sweden	Denmark, UK, Norway	Belgium, Netherlands, Sweden	Greece, Ireland, Italy, Luxembourg, Netherlands, Sweden	Belgium, Denmark, Greece, France, Ireland, Italy, Luxembourg, Netherlands, Austria, Portugal, Finland, Sweden, UK, Norway	Greece, Ireland, Italy, Netherlands

(¹) Data from Germany are missing owing to the federal structure of the justice system.

(²) An extended version of this table is available as Table 1.3 OL: Prison-based interventions for drug users (online version).

Source: Reitox national reports (2002).

Generally, in any particular country, specific services exist either in almost all prisons or in almost none. This is especially true for harm-reduction measures, as shown in Table 4. Blood-screening and vaccination programmes are available and disinfectants provided in almost all prison establishments in approximately two thirds of the countries, but are completely lacking in approximately one third of Member States. This reflects the crucial role of national

policies in determining the availability of prison services. However, pilot projects at the level of individual prisons are usually tried before any policy is rolled out nationwide.

Detoxification is the measure most universally provided. It is available in almost all prisons in nine countries and less widely in only three countries, Greece (2001 data), Italy and Norway. Needle exchange is the most uncommon of the investigated interventions: needle-exchange

programmes are available only in Spain (11 of 68 prisons) and in Germany (four of 222 prisons). The accessibility of substitution treatment follows the pattern of availability in community settings (except in the Netherlands) and is available in almost all prisons in six Member States. Other countries offer it in very few of their prison establishments or not at all ⁽¹³⁸⁾.

Alternatives to incarceration

Community-based alternatives to incarceration ⁽¹³⁹⁾ targeting drug-using offenders have expanded in EU Member States since the late 1990s ⁽¹⁴⁰⁾. They have been developed within an extensive framework of innovations in penal policy, the other main components of which are mediation and reparation (i.e. a trend towards community service). Basically, the alternatives consist in the provision of drug treatment. There is evidence that treatment is effective in reducing drug use and crime (Stevens et al., 2003). Treatment could be especially effective in reducing crime if it is targeted towards long-term drug users, who are responsible for the majority of minor offences. In addition, prison sentences have been found to be ineffective as a deterrent against petty crime (Brochu, 1999).

There is no clear evidence that quasi-compulsory treatment approaches are successful. European research tends to be more sceptical in this regard than American research, which since the 1970s has reported positive findings. More research is needed on the process and outcomes, and this research should include both quantitative and qualitative studies. However, the evaluation of a Danish scheme that allows offenders to serve their sentence in a special in-prison treatment department found that the crime rate decreased, especially when the alternative to incarceration was offered to criminals of long standing (Danish national report, 2002). The Triple Ex project in The Hague, a coercive type of treatment, found that longer duration in treatment was associated with a reduced relapse rate (Vermeulen et al., 1999).

Many of the factors identified as leading to lack of success of alternatives to punishment are linked with the lack of coordination across the different sectors involved, namely justice, health and social welfare. Typically, evaluations reveal gaps in funding for treatment ⁽¹⁴¹⁾, a lack of any clear demarcation between the roles of judges and treatment staff regarding who should determine the best

type of treatment, and inadequate community treatment services ⁽¹⁴²⁾ (EMCDDA, 2003a). An evaluation of the Community Service Order, one of the tools available to the Irish legal establishment to redirect drug users from prisons to an alternative forms of punishment, shows that formal and/or informal collaboration across the justice, social and health services is crucial for success (Expert Group on The Probation and Welfare Services, 1999).

The justice systems in Member States have designed special measures targeting young drug users, including early interventions and alternatives to prosecution. Early interventions aim to prevent criminality by acting at the early stages of criminal careers. One of the measures most commonly applied across Member States is to avoid or to delay the first prison sentence by diverting young people from the criminal justice system to an alternative socio-health programme. In Portugal, the commissions for the dissuasion of drug abuse are an example of a structure created to implement alternatives to prosecution. They were established when the possession of drugs for personal use was decriminalised in 2001. An evaluation after one year shows positive results in preventing development of a drug problem and diminishing the time period between initiation of problematic drug use and the contact with treatment institutions (Portuguese annual report, 2002).

Supply reduction

Interdiction measures

According to 'Europol's organised crime report', production and trafficking of drugs remain prime activities among criminal groups in the EU. No other field of organised crime delivers such an enormous profit ⁽¹⁴³⁾.

'Interpol at work 2001' reports that increased international cooperation has resulted in a number of relevant law-enforcement operations. For instance, Project Exit, based on shared intelligence, resulted in large-scale ecstasy seizures in Europe. In addition, important shipments smuggled from European airports to North America were detected. The drug data sharing programme, in which Interpol, UNDCP (now the United Nations Office on Drugs and Crime, UNODC) and WCO (World Customs Organisation) participate, exchanging intelligence, continued to play a key role in the fight against smuggling of synthetic drugs.

⁽¹³⁸⁾ See Table 13 OL: Prison-based interventions for drug users (online version).

⁽¹³⁹⁾ Figure 41 OL: Alternatives to prison — conceptual framework (online version).

⁽¹⁴⁰⁾ See Table 14 OL: Alternatives to prison targeting drug-using offenders — a comparative EU description (online version).

⁽¹⁴¹⁾ The evaluation of a Swedish alternative to prison project showed lack of financial sources to pay the treatment at the end of the sentence period (Swedish national report, 2003).

⁽¹⁴²⁾ http://www.emcdda.eu.int/multimedia/project_reports/responses/alternatives_prison_expert.pdf.

⁽¹⁴³⁾ More details are given in Box 15 OL: Interdiction measures (online version).

Anti-money laundering measures

Europol estimates that the cocaine trade generates billions of euro within the EU. Laundering methods involve both physical and electronic cash movements. It remains difficult to link cash movements and related drugs business transactions. Interpol has developed important tools to counter specific money laundering systems. In 2001, specialised studies were made available to allow investigators to become better acquainted with these ⁽¹⁴⁴⁾ ⁽¹⁴⁵⁾.

According to the Financial Action Task Force (FATF) 2001–02 annual report ⁽¹⁴⁶⁾, seven EU Member States fully comply with 28 out of its 40 recommendations requiring specific national action; the other countries do not comply fully ⁽¹⁴⁷⁾.

Measures against diversion of chemicals under control

The International Narcotics Control Board (INCB) 2002 report on 'chemicals under control' notes that most exporting countries now provide export data, but that, unfortunately, France, which previously provided comprehensive data on its exports of controlled substances, did not supply such data for 2001. Most exporter countries submitted data on precursors used for manufacturing amphetamine-type stimulants. Data on the export of norephedrine, which for the first time in 2000 was included in Table I of the INCB report (imposing pre-export notifications), were provided by Denmark, Spain, Germany and the United Kingdom. In addition, most of the P-2-P and safrole EU producer countries submitted data ⁽¹⁴⁸⁾. Governments continued to achieve successes in preventing diversion of potassium permanganate ⁽¹⁴⁹⁾, used for the illegal manufacturing of cocaine, in particular through Operation Purple. In 2001, the number of shipments and the volume of trade monitored decreased ⁽¹⁵⁰⁾.

Seven illicit laboratories manufacturing potassium permanganate were dismantled in Colombia under Operation Purple, from April to September 2002. As potassium permanganate becomes more difficult to divert from licit trade, cocaine producers attempt to manufacture this chemical themselves.

The international operation, Operation Topaz, which monitors traffic of acetic anhydride ⁽¹⁵¹⁾, continues to function well in terms of both international tracking of licit shipments and law-enforcement investigations to trace the origin of seized, or intercepted, chemical shipments. Between January and November 2002, 2 800 export shipments were reported, involving nearly 300 000 tonnes of acetic anhydride. Belgium and the Netherlands, where the majority of consignments originated, were particularly helpful in ensuring that the international tracking programme functioned smoothly. The majority of the transactions take place between EU Member States, and a total of 92 % of the monitored shipments were reported by EU Member States. The concentration of licit trade within the EU and the success of the control procedures of Operation Topaz have led to a review to find a viable alternative to the shipment-by-shipment tracking within the EU.

Europol believes that up to 90 % of heroin seized on the EU markets originates from south-west Asia (Afghanistan). Despite efforts to eradicate opium cultivation, production in 2002 is believed to have amounted to 3 400 metric tonnes. Taking into account the fact that some of the acetic anhydride diverted from licit supply channels is smuggled into Afghanistan, an international task force from Germany, the United Kingdom and the United States was established to provide technical assistance in combating trafficking in this region.

During 2001, over 200 tonnes of acetic anhydride was seized. This is the largest amount ever reported for a single year. The largest single seizure was reported by the United Kingdom, when an attempted diversion of 70 tonnes to Yugoslavia was uncovered. Other European countries reporting seizures of acetic anhydride were Belgium, Germany, Italy and Slovenia.

To help prevent diversion of chemical precursors used in manufacturing amphetamine-type stimulants, such as ephedrine, norephedrine and 3,4-MDP-2-P, INCB, in cooperation with the European Commission and the United States, agreed to initiate a voluntary international project, Project Prism, to assist governments in achieving this goal ⁽¹⁵²⁾ ⁽¹⁵³⁾.

⁽¹⁴⁴⁾ <http://www.interpol.int/Public/FinancialCrime/MoneyLaundering/EthnicMoney/default.asp>.

⁽¹⁴⁵⁾ Further details in Box 16 OL: Anti-money laundering measures (online version).

⁽¹⁴⁶⁾ http://www.fatf-gafi.org/pdf/AR2002_en.pdf.

⁽¹⁴⁷⁾ Box 17 OL: Level of compliance (FATF) (online version).

⁽¹⁴⁸⁾ Box 18 OL: Measures against diversion of chemicals under control (INCB) (online version).

⁽¹⁴⁹⁾ Potassium permanganate is a licit compound that is an important reagent in analytical and synthetic organic chemistry; it is used in bleaching applications, disinfectants and antibacterial and antifungal agents. It is also used in water purification processes.

⁽¹⁵⁰⁾ Box 19 OL: Operation Purple (online version).

⁽¹⁵¹⁾ Acetic anhydride is an acetylating and dehydrating agent used in the chemical and pharmaceutical industries for the manufacture of cellulose acetate, in textile sizing agents and cold bleaching activators, for polishing metals and in the production of brake fluids, dyes and explosives.

⁽¹⁵²⁾ http://www.incb.org/e/ind_ar.htm.

⁽¹⁵³⁾ Box 20 OL: INCB (online version).



Light blue bar

Dark blue bar

Light blue bar

Dark blue bar

Light blue bar

Dark blue bar

Chapter 3

Selected issues

This chapter highlights three specific issues relating to the drug problem in Europe: drug and alcohol use among young people; social exclusion and reintegration; and public expenditure in the area of drug-demand reduction.

Drug and alcohol use among young people

Young people are often at the leading edge of social change, and upward trends in alcohol and illicit drug use by young people constitute an important social development in the EU. The inclusion of alcohol in this section of the report is new and arose out of concerns about complex patterns of substance use and associated dependency, health damage and criminal behaviour. These patterns of psychoactive substance use present a particular challenge for policy-makers to develop an appropriately wide and timely range of responses for effective action.

The EU has set itself a target to reduce significantly, over a period of five years, the prevalence of illicit drug use, as well as recruitment to it, particularly among young people under 18 years of age, and to develop innovative approaches to prevention (COR 32).

Material consulted in the writing of this chapter includes the Reitox national reports and population survey data. Comparable data on young people are largely based on the European school survey project (ESPAD) reports from 1995 and 1999 (ESPAD, 1999), which covered 15- to 16-year-old school students and in which nine Member States participated. The data from the Netherlands in ESPAD surveys are not strictly comparable with those from other participating Member States. Published research, grey literature⁽¹⁵⁴⁾ and government publications on drugs and alcohol use by young people (particularly from France and the United Kingdom) have also been used for reference.

Prevalence, attitudes and trends

Prevalence

Excluding tobacco and caffeine, alcohol is the psychoactive substance used most by young people across the EU. The proportion of 15- to 16-year-old students who have been

drunk at some time in their lives ranges from 36 % in Portugal to 89 % in Denmark⁽¹⁵⁵⁾ (Figure 19)⁽¹⁵⁶⁾. The majority of young people in the EU have never used illicit drugs but, among those who have, cannabis is the most commonly used drug, followed by inhalants/solvents⁽¹⁵⁷⁾. According to the 1999 ESPAD survey in Greece and Sweden, lifetime experience of inhalants/solvent use is as high as or higher than lifetime experience of cannabis use among 15- to 16-year-old students⁽¹⁵⁸⁾.

National school surveys do not measure problem substance use among young people, but they are a very useful source for assessing experimental drug use and attitudes among young people. On the basis of Reitox reports and 1999 ESPAD data, lifetime prevalence of cannabis use was lowest in Portugal (8 %), Sweden (8 %), Greece (9 %) and Finland (10 %). Lifetime prevalence was highest in France (35 %), the United Kingdom (35 %) and Ireland (32 %), followed by Spain (30 %). School survey sample sizes may be found in Statistical Table 3⁽¹⁵⁹⁾. Strict comparability of data in this table is limited as not all Member States used the same school survey methods.

Among 15- to 16-year-old students, in general, lifetime prevalence of use of cannabis, inhalants, tranquillisers and sedatives (without a doctor's prescription) is higher than use of stimulant and hallucinogenic drugs. School students experimenting with cocaine and heroin are relatively rare throughout the EU, with lifetime use of these drugs ranging from 0 % to 4 % (Statistical Table 3).

Most young people who have tried cannabis will have some experience of alcohol and tobacco. Young people who use ecstasy, amphetamines, cocaine and hallucinogens tend to form a separate cluster and belong to specific social groups. Relationships in consumption of different drugs are shown in Table 15 OL (online version) based on Spanish school survey data (Observatorio Español sobre Drogas, 2002)⁽¹⁶⁰⁾. A major challenge is to respond to the

⁽¹⁵⁴⁾ Defined as 'a document which has not been published in a peer-reviewed journal'. For more information see QED Network Journal (<http://qed.emcdda.eu.int/journal/bulletin27.shtml>).

⁽¹⁵⁵⁾ Based on responses to having been 'drunk from drinking alcoholic beverages'.

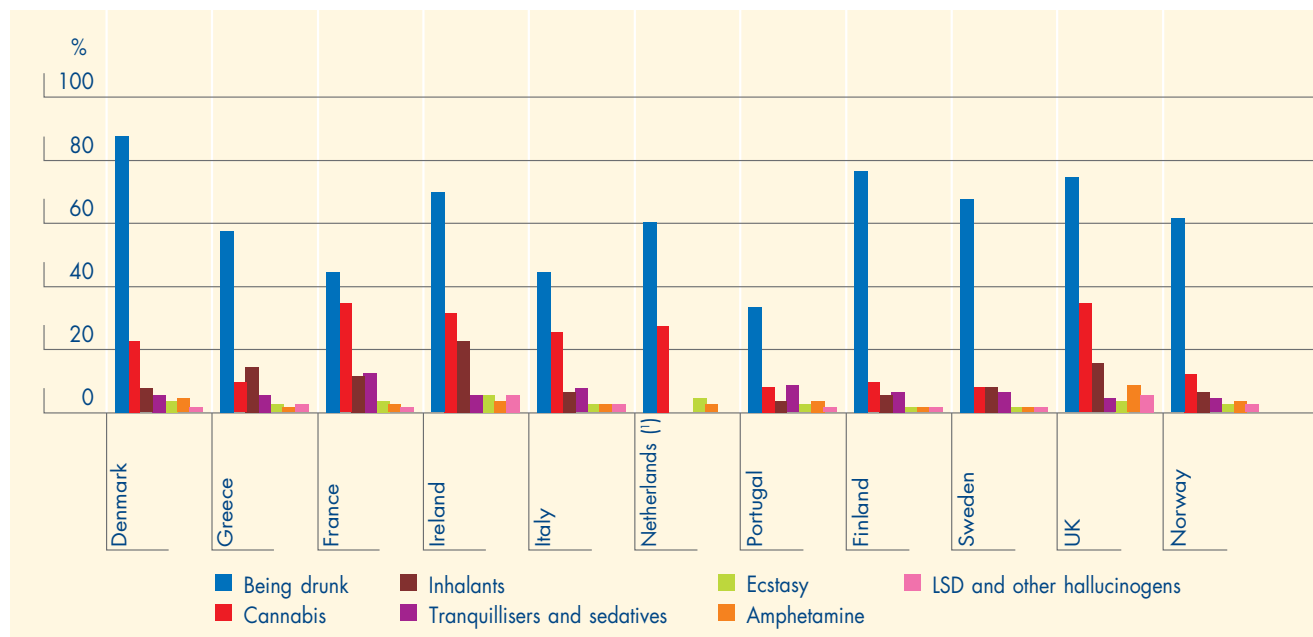
⁽¹⁵⁶⁾ Figure 42 OL: Comparison of 'binge' drinking with cannabis use in last 30 days.

⁽¹⁵⁷⁾ Based on responses to 'sniffed a substance (glue, aerosols, etc.) to get high'.

⁽¹⁵⁸⁾ Statistical Table 3: School surveys — lifetime prevalence among students, 15–16 years of age (online version).

⁽¹⁵⁹⁾ Statistical Table 3: School surveys — lifetime prevalence among students, 15–16 years of age (online version).

⁽¹⁶⁰⁾ See Table 15 OL: Relationship of consumption of different substances among Spanish school students (14–18 years) (online version).

Figure 19: Lifetime prevalence of being drunk and illicit substance use (15- to 16-year-old students)

(1) Limited comparability.
Source: ESPAD school survey project (1999).

complexities and idiosyncrasies of different patterns of drug use (Calafat et al., 1999; Parker and Eggington, 2002; Smit et al., 2002).

A higher level of drug use among males than among females is more marked in adult populations than in school students. However, among school students, gender differences are greatest in Greece, France, Italy and Portugal. One exception is that the use of tranquillisers and sedatives without a doctor's prescription and of alcohol together with 'pills' is generally higher among girls.

Variations in prevalence also occur between regions within Member States. In Germany, the gap between east and west is closing faster in students than in adults. Other aspects of drug prevalence, such as the spread of cannabis into rural areas, are the same as those observed in older populations.

Attitudes

Attitudes towards different drugs can help predict future prevalence of drug use. In 1999, disapproval of getting drunk once a week varied widely, from relatively low in Denmark (32 %) to high in Italy (80 %). Disapproval of cannabis experimentation was less variable and was lowest in France (42 %) and highest in Portugal (79 %) and Sweden (78 %) (161). Attitudes help to predict trends, but other factors are also involved. In all Member States, disapproval and perceptions about 'great risks' attached to

experimenting with drugs such as ecstasy, cocaine and heroin were generally very high among 15- to 16-year-old school students. Disapproval of trying ecstasy ranged from 71 % in Greece to 90 % in Denmark.

Trends

Concern is growing about increased levels of drunkenness and 'binge' use of alcohol for recreational purposes (162). Between 1995 and 1999, marked increases in lifetime experience of being drunk occurred in Greece and Norway (Figure 20). Strictly comparable data for alcohol use are not available for Member States that do not participate in the ESPAD surveys, but trend data from both Germany (1973–2001) and Spain (1994–2000) show recent decreases in alcohol consumption by young people (Bundeszentrale für Gesundheitliche Aufklärung, 2002; Observatorio Español sobre Drogas, 2002). However, it is possible for overall consumption to decrease while patterns of 'binge' drinking increase.

During the 1990s, lifetime prevalence of cannabis use increased to such a level that it could be described as widespread in a number of Member States. However, by 1999, the use of cannabis among young people in Ireland, the Netherlands and the United Kingdom had decreased. This may indicate that prevalence has reached saturation in these countries, with a trend towards stabilisation at levels of around 30 %.

(161) See Figure 43 OL: Percentage of 15- to 16-year-old students who disapprove of getting drunk compared with trying cannabis and ecstasy (online version).

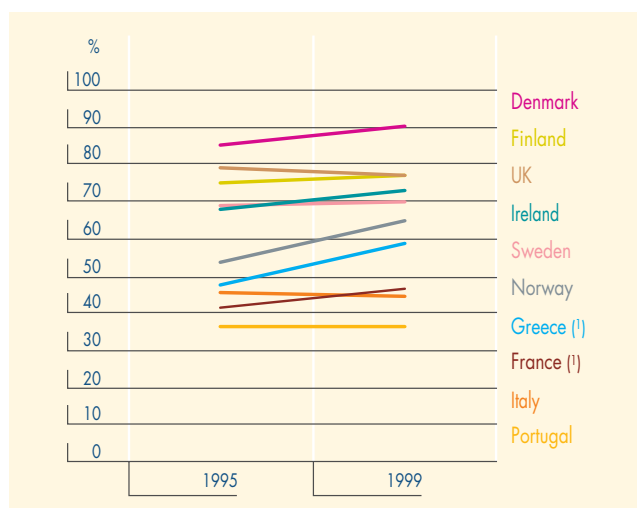
(162) Figure 44 OL: Changes in drinking five or more drinks in a row during past 30 days.

There are also indications of stabilisation of lifetime use of ecstasy at very much lower levels than for cannabis. In the case of the United Kingdom, decreased lifetime prevalence of both cannabis and ecstasy was accompanied by a decrease in perceived availability⁽¹⁶³⁾ ⁽¹⁶⁴⁾ and an increase in disapproval⁽¹⁶⁵⁾. In 1999, the proportion of students who perceived that the risk associated with trying ecstasy once or twice was great was highest in the two Member States (Ireland and the United Kingdom) in which lifetime prevalence of ecstasy was also highest⁽¹⁶⁶⁾ and where much media coverage was given to a relatively small number of ecstasy-related deaths. Media coverage, together with an increasingly negative image, appears to have influenced the downward prevalence of ecstasy use in these two Member States.

Young people judge each other on the basis of image, style and possession of status symbols. Such symbols, which may include drugs, change constantly. Currently held negative images of heroin users and the ready accessibility of other drugs are important factors in current drug choices (FitzGerald et al., 2003). A recent analysis of drug lyrics in English-language popular music since the 1960s has shown that musicians today are more likely than in the past to decry the harm that cannabis does⁽¹⁶⁷⁾ (Markert, 2001).

Figure 20: Lifetime prevalence for (A) being drunk, (B) taking cannabis and (C) taking ecstasy (15- to 16-year-old students)

Figure 20 (A): Being drunk



(1) The data for France and Greece for 1995 are based on surveys in 1993.
Source: ESPAD school survey project (1995 and 1999).

The results of a recent survey of 878 young people up to the age of 19 conducted in 10 EU cities signal a possible tendency in urban mainstream culture towards decreasing amphetamine and ecstasy use and increasing cocaine use. This sample was not sufficiently representative or large enough to draw definitive conclusions. This study also found that respondents spend more money on alcohol than on drugs or any other single category of recreational consumption, such as admission to discos, clubs or cinemas, mobile phones and tobacco (Calafat et al., 2003)⁽¹⁶⁸⁾.

Figure 20 (B): Taking cannabis

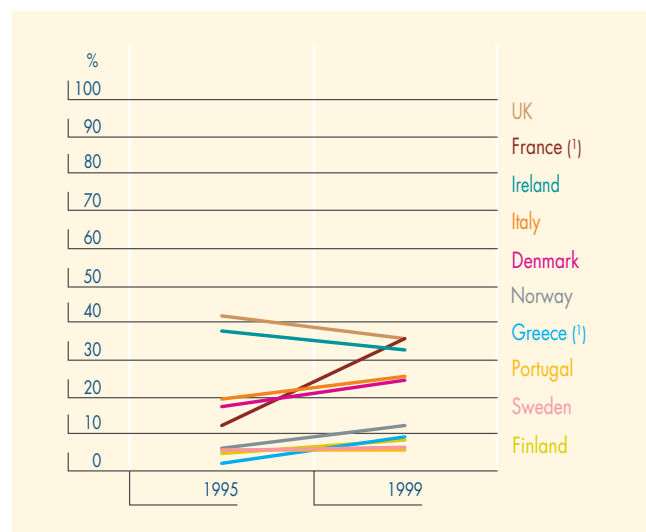
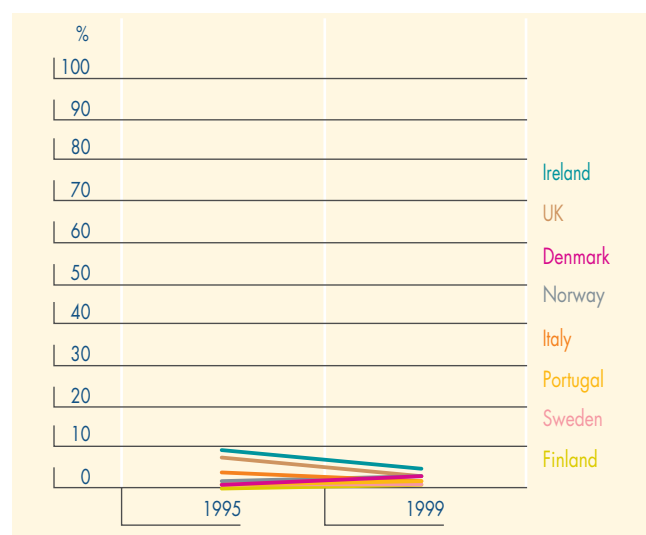


Figure 20 (C): Taking ecstasy



⁽¹⁶³⁾ Based on responses that the drug would be 'very easy' or 'fairly easy' to obtain if wanted.

⁽¹⁶⁴⁾ Figure 45 OL: Changes in the perceived availability of (A) cannabis and (B) ecstasy (online version).

⁽¹⁶⁵⁾ Figure 46 OL: Change in the percentage of 15- to 16-year-olds who disapprove of (A) getting drunk once a week or (B) trying cannabis once or twice or (C) trying ecstasy once or twice (online version).

⁽¹⁶⁶⁾ Figure 47 OL: Percentage of 15- to 16-year-old students who perceive a 'great risk' associated with using ecstasy once or twice and lifetime prevalence of ecstasy use (online version).

⁽¹⁶⁷⁾ Figure 48 OL: Percentage of positive images in contemporary popular music, 1960s to 1990s (online version).

⁽¹⁶⁸⁾ Figure 49 OL: Euro spent each weekend by 13- to 19-year-olds in 10 EU cities in 2001–02 (online version).

Almost all of the EU Member States (Belgium, Denmark, Germany, Spain, France, Luxembourg, Italy, the Netherlands, Austria, Portugal and the United Kingdom) report rising concerns about a possible increased cocaine and base/crack market for young problem drug users. Further information about trends in availability can be found on p. 36.

Initiation, patterns and risk factors

In general, the likelihood of young people aged 12–18 years getting drunk or being offered cannabis, or any other illegal drug, as well as their willingness to try drugs, increases sharply with age. This is illustrated here by data from the French Escapad survey (Beck, 2001). Figure 21 A shows that, among boys aged 13 and 14, the proportion who had lifetime experience of being drunk was 15.9 % and the proportion who had experimented with cannabis was 13.8 %. Among 17- to 18-year-olds it had increased to 64.5 % and 55.7 % respectively.

In a recent EU young population survey, ‘curiosity’ was given as the main reason for trying drugs (EORG, 2002). Of those who experiment with drugs, the majority do not continue to use them on a regular basis. In a small but significant minority, use escalates to intensive levels. This is illustrated in Figure 21 B, which shows the distribution of cannabis use among the general population of 18-year-olds in France. General population surveys show that lifetime experience of illicit drug use is significantly higher than recent or current use (169). Comparable information on patterns of use among regular drug users is less developed than in the field of alcohol research. This limits understanding about the patterns of drug use and, consequently, the development of effective responses. Definitions of ‘problem cannabis use’ are being explored in some Member States, and it has been suggested that people who have used cannabis on 20 or more occasions during the past month are most at risk of developing a problematic pattern of use (Beck, 2001; Dutch national report). By this definition, one out of every five people in the Netherlands who have used cannabis during the past month can be classified as ‘at risk’. According to Figure 21 B, in France 13.3 % of 18-year-old men, compared with only 3.6 % of 18-year-old women, fall into the ‘at-risk’ category.

One major concern about experimental use of cannabis is related to the ‘gateway effect’ (170). However, the association between cannabis use and other illegal substances is complex and not reducible to a simple causal model. An alternative ‘common factor’ model demonstrates how correlations between the use of cannabis and hard drugs

Figure 21: Cannabis use among 17- to 18-year-olds in 2001. (A) Age at initiation of use. (B) Level of use.

Figure 21 (A): Age of initiation to being drunk and cannabis use among 17- to 18-year-old boys in France in 2001

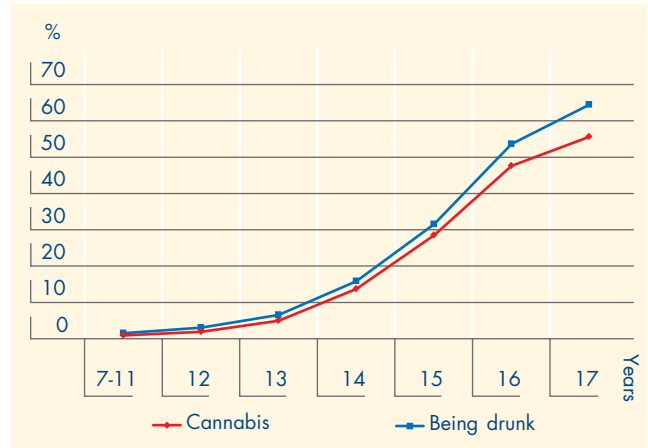
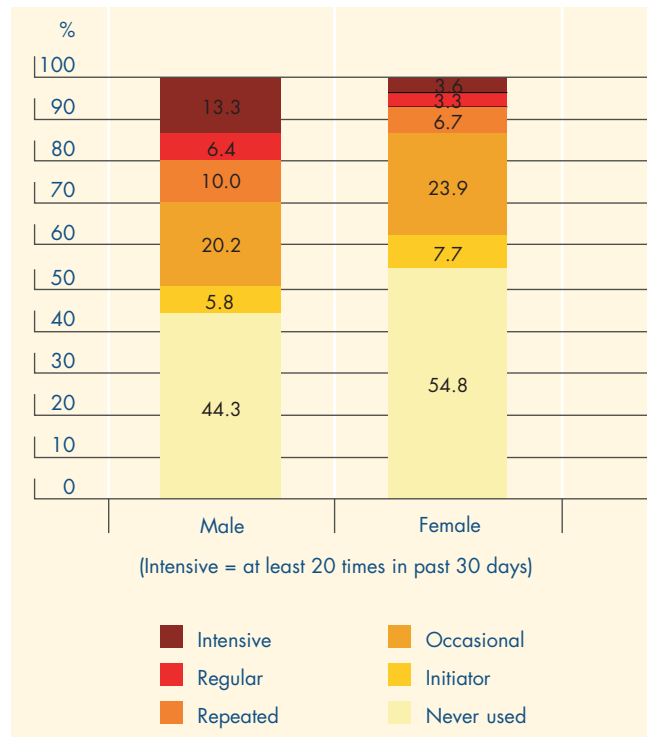


Figure 21 (B): Level of cannabis use at the age of 17-18 in France in 2001



Sources: Escapad (2001), OFDT. National representative sample.

are due to a range of common risk factors, including vulnerability and access to drugs and propensity to use drugs. Findings from cohort studies show that illicit drug use is rarely the first sign of trouble for adolescents. Alcohol use, antisocial behaviour, truancy and crime often occur at

(169) See Figure 1 OL: Patterns of cannabis use among the general population — lifetime experience versus current use (last 30 days), National (drug use) prevalence survey 2001 (the Netherlands).

(170) This is based on the hypothesis that use of cannabis per se increases risk of initiating hard drugs.

a younger age than cannabis use ⁽¹⁷¹⁾. Adolescents rarely use illicit substances without concomitant exposure to other illicit users and believe that the potential benefits of use outweigh the potential costs (Engineer et al., 2003). Evidence for the ‘gateway effect’ may be explained by cannabis bringing users into contact with an illicit market, increasing access to other illegal drugs and providing a platform of acceptability for using other illicit drugs (Grant and Dawson, 1997; Petraitis et al., 1998; Adalbjarnardottir and Rafnsson, 2002; Brook et al., 2002; Morral et al., 2002; Parker and Eggington, 2002; Pudney, 2002; Shillington and Clapp, 2002).

In the Netherlands, a youth survey conducted in 1999 found that the majority of young cannabis users purchased cannabis from friends (46 %) and from coffee shops (37 %) (De Zwart et al., 2000).

Identifying a range of risk factors that influence both the initiation and escalation of drug use in an extremely heterogeneous adolescent population is an approach that has begun to gain currency. These factors span a continuum from individual to community to macroenvironmental factors and are probably different for recreational and problem drug use.

Risk factors

Targeted surveys have shown that particular groups of young people have much higher levels of drug use than those found in the general national population. These are often young people who have been excluded from school or truanted, committed a crime, been homeless or run away from home, and those whose siblings are drug users (Lloyd, 1998; Swadi, 1999; Goulden and Sondhi, 2001; Hammersley et al., 2003). The United Kingdom youth lifestyles survey 1998/1999 found that prevalence of drug use was significantly higher among these vulnerable groups ⁽¹⁷²⁾. The size of these vulnerable groups at national level suggests that current school-based surveys are underestimating drug prevalence by failing to identify the populations of high-risk adolescents not found in the school environment. Comparable EU data on ‘vulnerable groups’ of young people at present are scarce. Young people who go out at night to particular dance music settings constitute another vulnerable group. The links between specific youth cultures and drugs are well documented, most recently in relation to the diffusion of ecstasy (MDMA) use (Griffiths et al., 1997; Springer et al., 1999). In techno dance settings, lifetime prevalence of ecstasy use ranges from 12.5 % (Athens) to 85 % (London), compared with a lifetime prevalence of 1 % (Greece) and 8 % (United Kingdom)

among the general young adult populations (EMCDDA, 2002a).

Community

In recent years, increased attention has been given to social, economic and cultural determinants including physical environment (Spooner et al. 2001; Lupton et al., 2002). Drug problems are often concentrated in particular geographical areas and housing locations. For example, the Irish national report cites that children in focus groups recounted routine encounters with drug users and made casual reference to the presence of drug paraphernalia on stairs and balconies. Parents living there expressed extreme anxiety about their children’s high level of exposure to drugs (O’Higgins, 1999).

Deaths and hospital emergencies

Drug- and alcohol-related deaths among the under-20s are relatively rare. However, during the 1990s, the number of drug-related deaths among young people in the EU overall rose steadily. A total of 3 103 deaths among young people were recorded in the EU between 1990 and 2000 ⁽¹⁷³⁾. The comparable loss of years for the death of a young person is higher than for an older person when years of life expectancy lost ⁽¹⁷⁴⁾ are calculated. Detailed information on drug-related deaths can be found on pp. 28–32. The United Kingdom is the only Member State that reports on deaths specifically related to inhalation of volatile substances. Over a period of 18 years, there were 1 707 deaths specifically related to this phenomenon. The majority of these deaths occurred in people between the ages of 15 and 19 (Field-Smith et al., 2002). Despite the media attention given to ecstasy-related deaths, inhalants probably constitute a greater health risk to adolescents than other forms of drug use.

There are no routinely collected EU data on drug-related hospital emergencies because of the hidden nature of illicit drug use, combined use of alcohol and other drugs and lack of toxicological analyses (Tait et al., 2002). The limited data that are available suggest that alcohol is a greater burden on the health services in some Member States than illicit drug use. WHO estimates that in developed countries alcohol accounts for 10–11 % of all illness and death each year (Rehn et al., 2001). For example, a Danish survey of young people in 2001 found that fewer 17-year-olds had reported hospital attendance for drug-related problems than for alcohol-related problems (Danish national report). In Ireland, a regional study of hospital case notes over a three-month period found that almost all of the 55 hospital

⁽¹⁷¹⁾ Figure 50 OL: Percentage of 15- to 16-year-old students who have been drunk or tried cannabis aged 13 or younger (online version).

⁽¹⁷²⁾ Figure 51 OL: Comparison of drug use by vulnerable group (online version).

⁽¹⁷³⁾ Figure 52 OL: Acute drug-related deaths reported in the EU among young people up to the age of 19 (online version).

⁽¹⁷⁴⁾ The current EU average life expectancy is 75 years for men and 80 for women.

admissions among young people aged 10–18 were related to alcohol alone or deliberate self-poisonings (Mid-Western Health Board, 2002; reported in the Irish national report).

Legal responses and recommendations

In almost all Member States, availability of alcohol is controlled by means of State monopoly or a licensing system. Attempts to control the availability of alcohol to young people have been made in most EU Member States by applying age restrictions (usually either 16 or 18 years) to off-premises and on-premises sales of alcohol. Portugal introduced its age restrictions relatively recently, in January 2002. Alcohol advertising restrictions vary from complete bans to voluntary advertising codes or no restrictions (Rehn et al., 2001; Bye, 2002). In the United Kingdom, the sale of cigarette lighter refills to under-18s was restricted by the 1999 Cigarette Lighter Refill (Safety) Regulations (Field-Smith et al., 2002). A decrease in deaths is thought to have been achieved as a result of this legislation together with information campaigns targeted at parents. There are some variations in legislation, and little is known about practice. An example of a new initiative to address issues of practice is to be found in Germany, which has recently introduced the 'Apple juice' law, which requires bars to offer at least one non-alcoholic drink cheaper than the cheapest alcohol (German and Dutch national reports). In the United Kingdom, a new scheme is being launched by retailers, with the support of government, to provide a special 'pass' for young customers to help enforce age restrictions on the purchase of alcohol and volatile substances (BBC News).

In recent years, the Netherlands has increased controls over coffee shops and coffee shops selling cannabis near schools have been closed. Under-18s are not permitted to purchase cannabis. Advertising of cannabis products is prohibited, and in recent years the tighter control of coffee shops has significantly reduced the number of customers under 18 years old (Dutch national report). In Copenhagen, Denmark, police have closed down approximately 50 cannabis clubs since an act to prohibit visitors in certain premises came into effect (Danish national report).

In Ireland and the United Kingdom, initiatives have been taken recently to reduce problems linked with drugs and alcohol in young people. For example, the Children's Bill (1999) in Ireland places responsibility on parents to control children. Penalties for parents include treatment for their own substance abuse and training in parenting skills. Children considered to be out of control may be subject to

night-time curfews. Also, in Ireland, two national public order initiatives are operated by the police. Operation Oíche focuses on under-age drinking, illicit drug use and under-age alcohol sales and Operation Encounter concentrates on antisocial conduct on the streets as well as in licensed premises, nightclubs and fast food outlets. For further details about legal responses, see p. 42.

A broad continuum of needs and responses

A major EU objective for addressing drugs and alcohol misuse is to make appropriate interventions in order to have the most effective impact. The main focus is on five broad, sometimes overlapping, target groups for intervention strategies: (1) school-age young people; (2) young experimental and recreational drug users; (3) young people in socially deprived areas; (4) young offenders; and (5) young people with a need for drug treatment⁽¹⁷⁵⁾.

School-age young people

Prevention in schools is a widely used response for this target. Details can be found on p. 45.

At a school policy level, several Member States have issued recommendations on how to react to drug incidents and drug-using students. In France, there is a strong focus on 'Reference points for the prevention of at-risk behaviour in schools' and the resolution of problems through targeted counselling. There is a major focus on professional training for school staff in order to handle deviant youth behaviour. In Austria and Germany, the STEP-by-STEP programmes⁽¹⁷⁶⁾ help schoolteachers to identify and intervene with drug-using pupils. In Norway, a handbook for this purpose has been launched.

The United Kingdom Drug Prevention Advisory Service evaluated a drug-prevention programme aimed at young people excluded from school and concluded that drugs programmes are clearly needed, but that brief periods of drugs education are inadequate. Many young people targeted by the programme were already taking drugs, implying that programmes should be implemented at a younger age, and should clearly identify and deal with problems. The new Portuguese national framework for prevention anticipates allocating EUR 400 000 for alternative school curricula and early professional training for school drop-outs. Almost all Spanish autonomous communities have such programmes in place. In Greece, early interventions are aimed at adolescent drug users and their families (family therapy), as well as at adolescents who have problems with the law.

⁽¹⁷⁵⁾ Figure 53 OL: Selective prevention — targets of intervention (online version).

⁽¹⁷⁶⁾ See EDDRA http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=36.

Young experimental and recreational drug users in the community

The potential harm caused by alcohol and illicit drug use in the lives of a small but significant proportion of the young population is increasingly recognised. A major target for more effective action are vulnerable groups of young people who consume alcohol and experiment with drugs for recreational purposes while being unaware of, or unable to control, the risks associated with their patterns of substance use (overdosing, accidents, criminal behaviours, violence, loss of capacity to study or work, sexually transmitted infections and longer-term health damage to liver/brain, etc.) (Boys et al., 1999; Parker and Egginton, 2002).

Concern about changing patterns of use of alcohol and drugs for recreational purposes is growing in the EU, and particularly about the health risks for women. Recreational facilities such as bars, discos, sport clubs and youth clubs would seem to be suitable settings for drug prevention as they guarantee contact with a large number of young people, many of whom use drugs or are at risk of doing so⁽¹⁷⁷⁾. There is an urgent need for methodological documentation and thorough evaluation of interventions in this setting.

In France, by 2001, at least 30 % of *départements* were taking preventative actions or providing first aid at dance events. In one regional health board area in Ireland, nightclub staff and clubbers are targeted by 'The sound decisions' project⁽¹⁷⁸⁾. However, in Luxembourg, no legal framework exists for drug agencies' interventions in nightclubs.

Train-the-trainer courses in first aid for drugs incidents in recreational settings are organised in the Netherlands.

The Dutch 'Going out and drugs' initiative includes interventions for different settings outside school where youngsters use drugs, such as coffee shops, discos, parties and clubs, and places where major musical events are organised.

Several projects approach drug users within the music scene to minimise the risks of consuming legal and illegal drugs. Sometimes, project staff drive to different events in a mobile home, providing a quiet atmosphere for informal counselling. Special hotlines or web sites⁽¹⁷⁹⁾ can be additional features.

An overview and analysis of examples of prevention in party settings has been carried out on the projects in

EDDRA⁽¹⁸⁰⁾. An overview of current projects and policies is provided in a series of online tables⁽¹⁸¹⁾.

Specific on-the-spot counselling services and on-site pill testing at rave events are — according to a recent Commission-funded study — effective in reaching those young people who, although they take drugs regularly, do not think of themselves as drug users and would not contact established drug help services. The study also found that pill testing does not counteract abstinence-oriented prevention interventions⁽¹⁸²⁾. In Austria and Spain, these services have now expanded, while in the Netherlands they are restricted to services with high standards of methodological accuracy.

Another set of interventions involves peers, self-help groups and alternatives to drugs use such as information and psychosocial support as well as involvement in cultural or sports activities (e.g. in summer camps in Greece). In Spain, alternative leisure programmes have for some years been available throughout the country.

In Norway, Sweden and Denmark, 'The night ravens' are volunteer adults who patrol the city centre streets during weekend evenings and nights. Their mission is to be visible and available to young people. The idea is that their presence will reduce the likelihood of violence and harm.

Young people in socially deprived neighbourhoods

In Sweden, the Drugs Commission conducted a review of the research literature on preventative responses (Narkotikakommissionen, 2000), and concluded that three types of initiative are needed: specific initiatives targeting the poorest people; general initiatives to improve public health; and initiatives aimed at helping vulnerable families.

Ireland, Portugal and the United Kingdom are the only Member States that identify particular areas with a view to providing special programmes in these areas. Ireland's Young People's Facilities and Services Fund (YPFSF) aims to attract 'at-risk' young people in disadvantaged areas into facilities and activities that divert them from the dangers of substance abuse. In the United Kingdom, Positive Futures is operating in 57 deprived areas to divert vulnerable young people from drugs and crime through involvement in sport. The initial results are encouraging, showing reductions in criminal activity and truancy and improved community awareness. Health action zones (HAZs) are multi-agency partnerships located in some of the most deprived areas in England, and their aim is to tackle health inequalities through healthcare and social care modernisation

⁽¹⁷⁷⁾ Figure 54 OL: Target group prevention in recreational settings (online version).

⁽¹⁷⁸⁾ See http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=356.

⁽¹⁷⁹⁾ See <http://www.emcdda.eu.int/responses/infosites.shtml>.

⁽¹⁸⁰⁾ See http://eddra.emcdda.eu.int:8008/FurtherReading/eddra_party_settings.pdf.

⁽¹⁸¹⁾ Table 16 OL: Main quantitative parameters of prevention in recreational settings; Table 17 OL: Outreach work/prevention in recreational settings; and Table 18 OL: Overview of policies and frameworks for outreach work/prevention in recreational settings (online version).

⁽¹⁸²⁾ See http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2828.

programmes to cover a wide spectrum of vulnerable young people thought to be a risk of misusing drugs (130 projects and initiatives in the 26 HAZs). Connexions is a United Kingdom support and advice service for young people aged 13–19 that incorporates the identification of young people at risk and makes referrals to specialist drug services. Twenty-seven partnerships were operational in 2002, with another 20 expected to be introduced by 2003.

In the United Kingdom, all drug action teams (DATs) conducted a young people's needs assessment in 2001 and are required, through young people substance misuse plans (YPSMPs), to plan services for young people from universal prevention services through to substance misuse treatment services, which are based on local need.

In Austria, mobile centres targeting young people in the streets are working in close cooperation with other relevant help organisations to provide assistance to drug-using adolescents and young adults at an early stage. It is anticipated that the geographical coverage of these centres will increase in future ⁽¹⁸³⁾.

In Finland, Walkers youth cafés ⁽¹⁸⁴⁾ provide early intervention and currently operate in 24 localities. An important role is played by trained adult volunteers supported by youth work professionals. An effort has been made to develop the youth cafés into safe meeting places. Similarly, in one regional health board area in Ireland a health advice café, which aims to provide a combined prevention and direct access health service for young people, is in place.

In Norway, most large municipalities have outreach services. Their objectives include various preventative interventions aimed at older children and young people as well as counselling and referral to the support and treatment services.

Young offenders

Some Member States provide targeted support, training and outreach programmes for at-risk young people such as young offenders. A major impact of some of these initiatives has been to reduce the number of young people receiving criminal sentences.

Interventions provide alternatives to law-enforcement and punishment strategies, with the aim of reducing or preventing young people falling into a life of crime, with irreversible consequences. In the United Kingdom, youth offending teams (YOTs) include drug workers who assess young offenders for drug abuse and, where appropriate, offer interventions to prevent further abuse. The

Luxembourg MSF Youth Solidarity project operates on a similar basis in direct collaboration with youth magistrates and competent law-enforcement actors.

The FRED project in Germany aims at early interventions with first notified drug users ⁽¹⁸⁵⁾. Finnish law-enforcement projects operate under the same principles.

Young people with a need for treatment services

Demand for drug treatment is a significant indicator of drug dependency and severe need. In 2001 in the EU, young people up to the age of 19 accounted for just under 10 % of the total reported specialist drug-treatment demand. Over half of these young people were receiving treatment for cannabis as their main drug of use. Nearly a quarter were being treated for opiate problems, and the remainder were evenly divided between treatment for use of cocaine and other stimulant drugs. However, there are national variations; for example, Ireland treats a larger proportion of young people than any other country in the EU. Treatment for under-18s is complicated by issues of parental consent and concerns about prescribing substitution drugs in the absence of adequate research into the effects of such drugs in this age group. Most young people in treatment with severe drug problems attend ordinary treatment settings.

Specialised treatment services have been developed in some countries. For example, in the Netherlands, there is a small-scale clinic targeting 13- to 18-year-olds. In Finland, special emphasis is on a sustained and intensive psychosocial treatment continuum, with necessary institutional treatment. Based on 1999 information, there were six treatment units for young substance abusers, with a total of 40 beds. In addition, reform schools had three units specialising in drug treatment, with a total of 23 beds. In Luxembourg, there is one specialist centre, 43 % of whose clients are under the age of 16 years. In Greece, early interventions are aimed at adolescent drug users and their families (family therapy), as well as at adolescents who have problems with the law.

In Sweden, young people aged between 12 and 21 who have serious psychosocial problems, often in association with elements of criminal behaviour and psychoactive substance use, can be placed in institutional care without their consent. Methods of treatment include environmental therapy, functional family therapy, cognitive behavioural therapy and, for substance abuse, the 12-step method. Young offenders will, as an alternative to prison, be taken care of according to the Care of Young Persons (Special Provisions) Act in closed institutional youth care

⁽¹⁸³⁾ See Auftrieb in http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2086.

⁽¹⁸⁴⁾ See <http://www.aseanlapset.fi/walkers-nuorisokahvilat/walkers-kahvilat-suomessa/>.

⁽¹⁸⁵⁾ See EDDRA http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2091.

treatment ⁽¹⁸⁶⁾. For further information about treatment responses see p. 49.

Social exclusion and reintegration

Definitions and concepts

According to the last survey on 'social precarity and integration' ⁽¹⁸⁷⁾, the proportion of the European population at risk of poverty and social exclusion in Europe varies from 9 % to 22 % (European Council, 2001). People are considered to be socially excluded if they 'are prevented from participating fully in economic, social and civil life and/or when their access to income and other resources (personal, family and cultural) is so inadequate as to exclude them from enjoying a standard of living that is regarded as acceptable by the society in which they live' (Gallie and Paugam, 2002).

Social exclusion can thus be defined as a combination of lack of economic resources, social isolation, and limited access to social and civil rights; it is a relative concept within any particular society (CEIES, 1999) and represents a progressive accumulation of social and economic factors over time. Factors that could contribute to social exclusion are problems related to labour, educational and living standards, health, nationality, drug abuse, gender difference and violence (European Council, 2001; National reports, 2002).

Drug use could be viewed as either a consequence or a cause of social exclusion (Carpentier, 2002): drug use can cause a deterioration of living conditions, but, on the other hand, processes of social marginalisation can be a reason for starting drug use. Nevertheless, the relation between drug abuse and social exclusion is not necessarily a causal one, because social exclusion 'does not apply to all drug consumers' (Tomas, 2001).

Taking into account this complexity, it is possible both to analyse drug use among socially excluded populations and study social exclusion among drug addicts (Figure 22).

Drug-use patterns and consequences observed among socially excluded populations

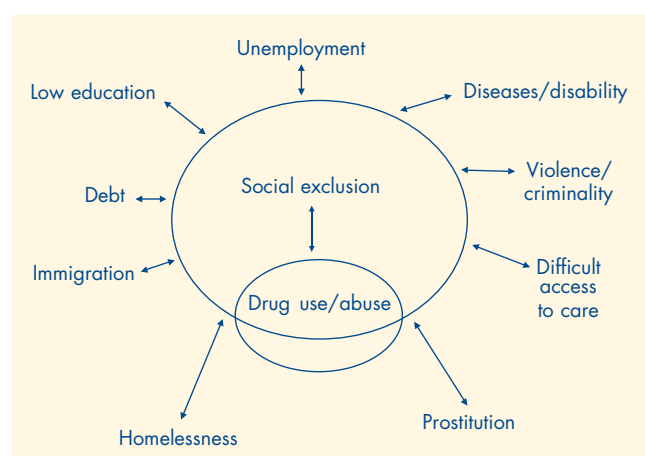
In the literature and research, the following populations are usually considered to be at risk for social exclusion: prisoners, immigrants ⁽¹⁸⁸⁾, the homeless, sex workers and vulnerable young people. Bias and methodological

limitations in the presented information on drug use and patterns of use among socially excluded groups have to be considered, because of the lack of information sources and comparable data across Europe.

The association between being prisoner and using drugs has been shown to be quite strong (see also p. 34). A large proportion of prisoners are drug users before being imprisoned, and the reason for their incarceration is often associated with drug use. However, some people follow the opposite course, becoming drug users only after being incarcerated for committing crimes. Studies suggest that between 3 % and 26 % of drug users in European prisons start taking drugs in prison and between 0.4 % and 21 % of incarcerated IDUs first inject while in prison. Drug use within prison is very common: up to 54 % of inmates report using drugs while incarcerated, and up to 34 % report injecting in prison (Stoever, 2001; EMCDDA, 2002a).

The relation between 'black and minority ethnic groups' and drug use is less clear, as little information is available. There is no scientific evidence to suggest that drug use is higher among immigrants than in the general population. However, some studies in specific ethnic minority groups have found a higher proportion of problematic drug users among those groups than among the general population, such as among the Ingrian in Finland (1–2 % of whom are estimated to be drug users, especially heroin users), Kurds in Germany, Gypsies in Spain and several ethnic groups in the Netherlands (Vrieling et al., 2000) ⁽¹⁸⁹⁾. The reasons for this could be a combination of socially disadvantageous factors, such as poor command of the local language,

Figure 22: Relationship between social exclusion and drug use



⁽¹⁸⁶⁾ See <http://www.stat-inst.se/article.asp?articleID=87>.

⁽¹⁸⁷⁾ Eurobarometer survey 56.1 (http://europa.eu.int/comm/employment_social/soc-prot/soc-incl/eurobarometer_en.pdf).

⁽¹⁸⁸⁾ According to the EMCDDA (2002b), immigrants are defined as 'black and minority ethnic groups' and include immigrant populations from diverse communities living in EU countries.

⁽¹⁸⁹⁾ Table 19 OL: Distribution of primary addiction problems (alcohol, heroin, cocaine, cannabis and gambling) in the Netherlands among immigrants and native Dutch (online version).

unemployment and housing problems, poor living conditions and lack of economic resources (National reports, 2002).

As regards patterns of drug use, differences are found among ethnic groups. Use of qat is reported only by Somali populations and black Africans while heroin is smoked by immigrants from Surinam and from Bangladesh. And drug use among Gypsies in Spain appears to start at a younger age (by two to three years) than in the native population (Eland and Rigter, 2001; Reinking et al., 2001; Fundación Secretariado General Gitano, 2002).

Homeless people are also reported to be at risk for drug use. Although comparable data across Europe on the relation between homelessness and drug use are not available, specific studies have been conducted in many countries, and drug use is reported as a frequent problem among the homeless (National reports, 2002). Denmark, France, the Netherlands and the United Kingdom report that up to 80 % of homeless people living in shelters are drug dependent; and prevalence rates are even higher among people living on the streets or among homeless people with other social problems. For example, according to a small study carried out in Ireland, 67 % of homeless ex-prisoners are drug dependent (Hickey, 2002). Among the homeless, heroin is the most commonly used drug, followed by cocaine and polydrug use. Other high-risk behaviours, such as injecting drug use and needle sharing, are also reported to be high among homeless people ⁽¹⁹⁰⁾.

Among vulnerable young people, the use of drugs is reported to be frequent; high prevalence is found among children who have experienced family and social problems or problems at school. High prevalence of drug use has been found among the children of drug addicts: rates of lifetime drug use among children whose parents have used drugs in the past year are significantly higher than those found in the 'non-vulnerable' group (lifetime prevalence of 37–49 % compared with 29–39 % among children of non-user parents) ⁽¹⁹¹⁾. Several studies report that children who have suffered sexual or physical abuse within the family have a higher risk of using drugs when adults (Liebschutz et al., 2002). In Portugal, young victims of family abuse and violence are reported to be seven times more likely to use heroin than young people in the general population (Lourenço and Carvalho, 2002). In the United Kingdom,

'young runaways' ⁽¹⁹²⁾ appear to be more likely to misuse drugs. Rates of lifetime drug use are two to eight times higher than in young people who have never run away. The drugs most used are crack, heroin and solvents. Problems at school are another risk factor for taking drugs: a high prevalence of drug use is reported in children not attending school (Amossé et al., 2001), among those attending reform schools (40 % of reform school students in Finland were reported to have had an addiction problem at some time, in 16 % of whom this was related to drugs) (Lehto-Salo et al., 2002) and in those with poor educational grades (13.5 % in Norway) (Vestel et al., 1997).

Among sex workers, drug use is often a motive for prostitution, but could also be a consequence (as is the case for other factors associated with drug use). Drug-use patterns vary depending on whether prostitution comes before or after drug addiction. An Italian qualitative study among street prostitutes found that, when sex workers start to use drugs in order to deal with problems related to prostitution, they mainly use alcohol, tranquillisers or other psychoactive medicines; in contrast, when drug addiction is the main reason for prostitution, heroin is the primary drug used (Calderone et al., 2001).

Research findings or data on other socially excluded groups are less readily available; Denmark reports that among patients of psychiatric services 50–60 % are drug addicts, probably because of the widespread availability of drugs and the fact that such patients are familiar with taking psychoactive medicines (National report, 2002).

Relationship between social exclusion and drug use

More data are available on social conditions among the treated population. Socioeconomic factors related to drug use include low educational levels, early school leaving and drop-out; unemployment, low salaries and difficult jobs; low income and debt; insecurity of accommodation and homelessness; mortality and drug-related diseases; poor access to care; and social stigma (Table 5).

Relevant differences in the social conditions of drug use are found by substance used and drug-use patterns; the worst conditions are found among heroin and opiates users and chronic drug addicts.

⁽¹⁹⁰⁾ The British Home Office reports that in the United Kingdom over one-third of homeless people have injected heroin, and one-fifth have injected crack. In the last month, over 10 % are likely to have used someone else's syringe or passed on their own syringe (Carlen, 1996; Goulden and Sondhi, 2001).

⁽¹⁹¹⁾ According to a survey conducted in England and Wales in 1998–99 among 4 848 young people (Goulden and Sondhi, 2001).

⁽¹⁹²⁾ The Social Exclusion Unit of the British Office of the Deputy Prime Minister defines a 'young person running away' as 'a child or young person under the age of 18 who spends one night or more away from the family home or care without permission, or has been forced to leave by their parents or carers' (Social Exclusion Unit, 2002).

Some 47 % of all clients in treatment in 2001 never went to school or only completed primary school; high rates of early school leaving and drop-out are also frequent among drugs users. Differences are found according to main drug used and by country ⁽¹⁹³⁾: opiates users (in particular heroin users) have the lowest educational level (National reports, 2002).

Because of their precarious social conditions, drug users also have problems related to labour status; unemployment rates are very high compared with the general population (47.4 % among drug clients compared with 8.2 % ⁽¹⁹⁴⁾ in the general population); finding a job is difficult and it is rare for drug addicts to keep a job for long or to progress in a career (DrugScope, 2000) ⁽¹⁹⁵⁾. A precarious labour status can lead to financial problems; drug addicts frequently have low income or no financial resources (32–77 % of clients in treatment survive on social benefits). Debts are also common.

Table 5: Social conditions (education, labour status, housing) of clients in treatment in EU Member States in 2001

Social conditions		Drug users in treatment (valid %) ⁽¹⁾
Education (n = 98 688)	Never went to school/never completed primary school	8.0
	Primary level of education	43.6
Labour status (n = 100 000)	Unemployed	47.4
	Economically inactive	9.6
Housing (n = 41 299)	Unstable accommodation	10.4
	Institutions	7.5

⁽¹⁾ Percentages are calculated on the total number of cases reported under each single item; the total does not sum to 100 % as only the values of interest for this chapter are reported (never went to school, unemployed, etc.); for the complete figures, see Figure 55 OL: Level of education among all clients by country; Figure 56 OL: Labour status among all clients by country; and Figure 57 OL: Living conditions among all clients by country (online version).

Source: Reitox national reports — TDI data 2001.

The living conditions of drug users are often reported to be very poor: 10.4 % of clients live in unstable accommodation and 7.5 % live in an institution. Furthermore, many countries report high homelessness rates (up to 29 %) among drug addicts ⁽¹⁹⁶⁾.

With regard to nationality, characteristics resemble the general population structure ⁽¹⁹⁷⁾; clients are mainly nationals of the country where they request treatment, and the number of clients from other countries (European or non-European) is consistent with the proportion of foreigners in the general population. However, it should be remembered that in some countries registration of clients' nationality/ethnicity is not allowed and consequently such information is not consistently available.

Apart from direct health consequences (see pp. 24 and 28), drug users can find it difficult to access care because of a reluctance to deal with services or poor education, a low degree of acceptance by mainstream medical services and unique health problems for which appropriate services are not available.

Finally, drug users suffer from a negative social image and may face hostility from the general population and public authorities. Research conducted in a prison in Vienna found that drug users may experience violence and abuse from police officers or other public officials (Waidner, 1999).

Social reintegration

Measures to deal with social exclusion among groups with or without drug addiction problems and with the social consequences of drug use/abuse are set out in the European countries and Norway.

On the basis of the European Union drugs strategy (2000–04) (Council of European Union, 2000) and a specific study on social reintegration in the EU and Norway (EMCDDA, 2003b), social reintegration could be defined as 'any integrative efforts for drug users in the community'.

Social reintegration interventions target both current and former problem drug users, ranging from well-functioning 'clean' former addicts and long-term methadone clients to very deprived street addicts. A treatment component, whether medical or psychosocial, is not necessarily required. This also implies that social reintegration does not necessarily take place after treatment but can take place

⁽¹⁹³⁾ Figure 55 OL: Level of education among all clients by country (online version).

⁽¹⁹⁴⁾ Average unemployment rate among the 15 Member States (Eurostat, 2002).

⁽¹⁹⁵⁾ Figure 56 OL: Labour status among all clients by country (online version).

⁽¹⁹⁶⁾ Figure 57 OL: Living conditions among all clients by country (online version).

⁽¹⁹⁷⁾ Figure 58 OL: Clients' nationality by country (online version).

irrespective of prior treatment, being either the final step in a treatment process or a separate and independent post-treatment intervention carried out by non-treatment services with their own goals and means. Social reintegration services do not target problem drug users exclusively but may target all kinds of addicts (including those addicted to alcohol and legal drugs) or even all socially excluded groups (e.g. homeless people and rough sleepers).

A quantitative overview of social reintegration measures in EU Member States is impossible to achieve, as the term 'social reintegration' is not used consistently. Although different services may exist alongside each other, at country level, there are typically general 'provision modes' for social integration:

- targeting all excluded groups with or without addiction problems;
- targeting persons with addiction problems in general;
- targeting explicitly and exclusively problem drug users of illegal drugs (Figure 23) ⁽¹⁹⁸⁾.

It is difficult to quantify the availability of social reintegration services and assess the adequacy of service provision although the evidence would suggest that the number of facilities is probably inadequate. For example, Germany estimates that it needs around 25 000 social reintegration places, whereas the actual number available is roughly 4 000. An employment project in Austria registered twice as many applications as places and had to turn down an average of 15 persons a day.

Social reintegration can be broken down into three main types of interventions: education (which includes training), housing and employment.

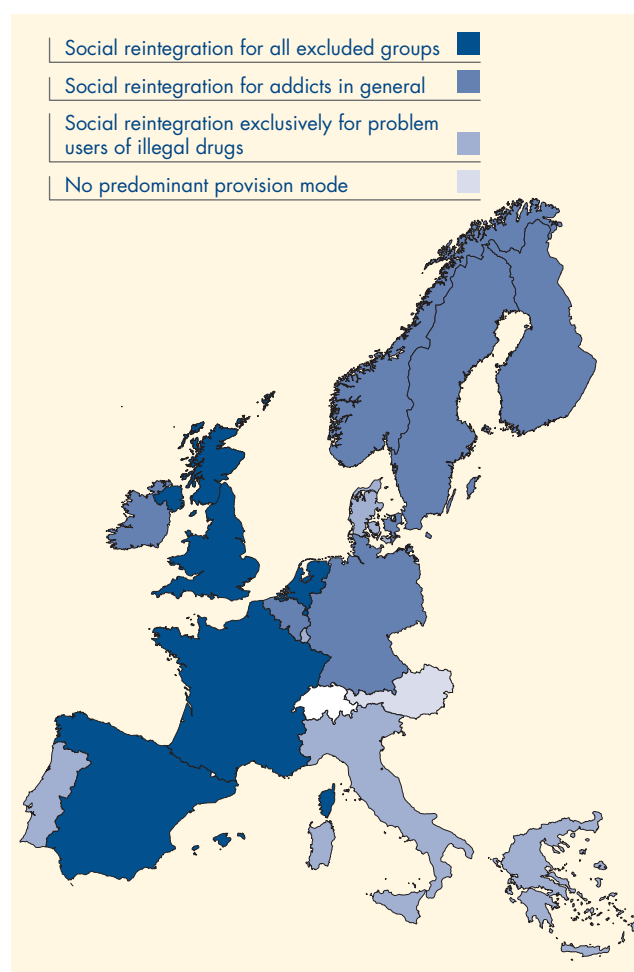
Many drug users have a poor level of education, and many national reports describe a poor relationship between problem drug users and the labour market (Greece (Kavounidi, 1996), Denmark (Stauffacher, 1998), the Netherlands (Uunk and Vrooman, 2001)). Hence, interventions aimed at upgrading academic, technical or practical skills would improve clients' chances in the labour market.

Employment measures can take many different forms, for example providing financial support to companies which employ a drug user in a competitive job, as is reported from Greece. Other measures include setting up employment services, such as the Vienna Job Exchange in Austria, or helping clients to establish their own businesses, as also occurs in Greece as well in Spain under the

auspices of the employment programme 'Self-employment promotion' (this kind of intervention overlaps with education/training).

Finally, providing housing or assistance to find housing aims at bringing some stability into clients' lives. Offering housing can be an intervention in itself but will often be accompanied by psychosocial assistance and some degree of supervision. An example of parallel psychosocial care is Haus am Seespitz in the Tyrol, which runs an open after-care group for clients that meets in housing facilities. In Belgium, 'Habitations protégées' provides both housing and psychiatric care. Research performed in Ireland (Irish national report (Hickey, 2002)) showed that 79 % of female and 76 % of male ex-prisoners indicated that finding suitable housing was their main problem and reason for their social exclusion, suggesting that housing is an important social reintegration intervention.

Figure 23: Main provision modes for social reintegration for problem drug users in the EU and Norway



Source: Reitox national reports.

⁽¹⁹⁸⁾ For more in-depth information and country overviews, see the study 'Social reintegration in the European Union and Norway' (http://www.emcdda.eu.int/multimedia/project_reports/responses/social_reintegration_eu.pdf).

Public expenditure in the area of drug-demand reduction ⁽¹⁹⁹⁾

The European Union drugs strategy (2000–04) specifies that the Council and the EU Commission should, based on work by the EMCDDA and the Pompidou Group, attempt to itemise a list of all public expenditure in the field of drugs.

In its efforts to respond to the European Union drugs strategy, the EMCDDA, with the valuable contribution of the Reitox national focal points, is investigating in this report direct public expenditure in the field of drug-demand reduction incurred in 1999 ⁽²⁰⁰⁾. It concentrates on expenditure at national and regional level, on drug-use prevention, treatment of addiction (in- and outpatient, substitution and drug-free), rehabilitation and reintegration, outreach work, harm reduction and education, and research and coordination when related to demand reduction. To better delineate our research, we have excluded direct expenditure sustained by private health organisations (therapy centres, clinics, etc.) and indirect expenditure sustained by general services such as general hospitals and emergency rooms. Finally, the broader and much more complex question of the social costs of illegal drugs has not been considered.

In addressing the question of public expenditure in the field of drugs (albeit in a restricted domain), this report aims primarily to increase awareness in the EU countries of the relevance of a drug policy indicator, rather than to produce empirical evidence.

Limitation and reliability of data

Nevertheless, although we have restricted our scope, the results that emerge confirm the difficulties caused by limited data availability and data collection in a field that is relatively undeveloped in the EU. In fact, other than the 'ad hoc' research undertaken during the preparation of this report ⁽²⁰¹⁾, only a few studies have been conducted with the aim of quantifying public resources allocated to drug issues in the EU ⁽²⁰²⁾. As matter of record, the majority of countries in the EU cannot say precisely how much they spend on combating drugs and drug addiction.

Most of the participants in this research, therefore, could not provide comprehensive data. In fact, some figures are missing, and often calculations have been based on estimation and extrapolation methodologies ⁽²⁰³⁾.

As reported by a large number of focal points, and confirmed by literature in the field, at least five factors can limit such research: (1) the lack of data for some areas and some countries; (2) the difficulty in isolating data on illicit drugs from data covering both illicit drugs and alcohol; (3) the variety of actors and organisations at central, regional and local level accountable for spending; (4) the difficulty of precisely dividing public expenditure among theoretical categories, such as demand and supply reduction; and (5) the complexity of breaking down expenditure, within these two categories, by area of intervention (treatment, primary prevention, rehabilitation, cooperation, coordination, etc.).

It is, however, interesting to note that, although studies of this kind are obviously complicated by methodological problems, decision-makers are showing growing interest in public spending reviews ⁽²⁰⁴⁾ both as a basis upon which to make decisions and as a means of measuring performance.

Expenditure in drug-demand reduction

In the process of calculating 'a list' of all direct public expenditure in drug-demand reduction in the EU Member States, and on the basis of the data received from national focal points, a comparison of similar expenditure has been attempted.

Although all possible statistical precautions have been taken, it is not possible to avoid the problem that the reported figures may sometimes correspond to different categories in different countries and the fact that in some countries figures are just not available. Indeed, for Belgium, Denmark, Italy and especially Germany and Sweden, some relevant information on demand-reduction expenditure is missing and, thus, the total figure is certainly grossly underestimated. In the case of other countries (Greece, Spain, France, Luxembourg, Austria and Portugal), data can be considered to be more comprehensive despite some residual uncertainty regarding the categories of spending

⁽¹⁹⁹⁾ The differences in the data available limited the possibility of drawing cross-country comparisons. For a more complete picture of expenditure in the field of drugs in the individual EU Member States, see http://www.emcdda.eu.int/policy_law/national/strategies/public_expenditure.shtml.

⁽²⁰⁰⁾ Year of reference for the European Union drugs strategy (2000–04) 'snapshot' reporting exercise.

⁽²⁰¹⁾ The EMCDDA is particularly grateful to the Greek, Austrian and Portuguese focal points for undertaking specific research and investigations in this field, increasing the value of this annual report. Acknowledgement should also be given to Professor Pierre Kopp for peer review of the research.

⁽²⁰²⁾ Belgium (2003), Luxembourg (2002), the United Kingdom (2002); for more references see http://www.emcdda.eu.int/policy_law/national/strategies/public_expenditure.shtml.

⁽²⁰³⁾ Our desire to include as many countries as possible in order to provide a complete European picture conflicts with the scarcity of data in some of the countries considered. Consequently, while a broad scope has been maintained, the capacity for analysis and comparison has been very much diminished by the uncertainty of the final figures.

⁽²⁰⁴⁾ Belgium (2003), Luxembourg (2002), the United Kingdom (2002); for more references see http://www.emcdda.eu.int/policy_law/national/strategies/public_expenditure.shtml.

included. In the Netherlands and Norway, in particular, the reported estimates concern both illicit drugs and alcohol, making the final figures for those two countries, in comparison with others, rather high. Finally, most data refer to 1999 as baseline figures for the EU action plan evaluation process, but there are some exceptions. For Ireland, the figures reported are planned State expenditure in the area of demand reduction for the year 2000, for France, the data date back to 1995; and for the United Kingdom, the data refer to the financial year 2000–01. The reading of the amounts shown in Table 6 must therefore take into account the above-mentioned constraints.

The total amounts spent by EU countries in the field of drug-demand reduction in 1999 basically seem to reflect the size and wealth of each country (Kopp and Fenoglio, 2003). Unsurprisingly, the largest and richest countries (Germany, France, Italy and the United Kingdom) appear to allocate, in absolute terms, more financial resources than the small countries, although spending is also relatively high in the Netherlands and Norway (possibly because alcohol addiction interventions are included in the figures).

Research shows (Godfrey et al., 2002; Origer, 2002; Kopp and Fenoglio, 2003) that estimates of this kind could be a valuable source of information at national level. Comparisons over time within a country can reveal an increase or decrease in drugs-related budgets. Comparison across sectors (demand, supply, international cooperation, etc.) might reveal, in addition to formal strategies, the concrete financial effort expended in tackling the drugs phenomenon.

At EU level, 'cross-country' comparisons (the most complex) can determine common patterns, or differences, in the amounts allocated to drug policy and allow expenditure to be compared against a European average or across world regions.

In addition, the use of macroeconomic indicators (such as gross domestic product (GDP), total population, total government expenditure or number of problem drug users) at national and European level can help to measure the extent of the expenditure and to give a more informative interpretation of data that, taken alone, would be of little value.

Indeed, the comparison of expenditure on drug-demand reduction and, for example, the GDP of each country could reveal how much of its wealth a country is likely to spend to prevent drug use and combat the consequences of drugs. According to the data collected in this research, it appears that in 1999 Norway allocated approximately 0.1 % of its

economic wealth (GDP), followed by the Netherlands (0.078 %) (although both countries included in their estimation drugs and alcohol). Portugal (0.074 %), Finland (0.073 %) and Ireland (0.070 %) spent the greatest proportion of GDP on drug demand-reduction activities; in comparison, the largest and apparently richest countries seem to lag behind. However, the known incompleteness of the data for the latter may bias the comparison.

The interpretation of this information is not straightforward, and not only because of the lack of data. The proportion of wealth that is dedicated to drug addiction control in the EU Member States can be interpreted as reflecting the extent of the drug problem or the size of the response to it (or both), or the level of the social and health interventions in the population. Exploring such questions can contribute to a better understanding of the phenomenon and deeper comprehension in the field of cost estimates.

Another way of analysing public expenditure is to look at it in the context of the area it is intended to deal with, in this case problem drug users⁽²⁰⁵⁾. Using as an indicator the estimated number of problem drug users, expenditure per individual most in need of assistance can be calculated. Unfortunately, this calculation is beset by two problems: first, the figures do not necessarily relate directly to problem drug users — drug addicts — as prevention, education and coordination can also be targeted at individuals who are not classified as problem drug users; and, second, calculation of the number of problem drug users is, for obvious reasons, rather uncertain.

Again, according to our data, the value of services consumed by each drug addict in need is considerably higher in some countries (Finland, Luxembourg, Austria) than in others (Greece, Portugal, France, United Kingdom). This could be interpreted as the result of a stronger commitment to drug services in the former group; however, it is more likely that the figures depend on the quality and type of intervention. Indeed, differences in the levels of expenditure do not automatically translate into the level of commitment, but rather represent a different level of reaction, which is determined by the specificity of the situation.

Together with the expenditure per problem drug user, it is useful to calculate the burden of drug demand-reduction policy on society as a whole. Considering the expenditure on drug-demand reduction in the 16 countries studied (15 Member States and Norway), and from the limited data available (Table 6), the total (minimum) amount spent in the EU in 1999 on prevention of drug use and the care of drug addicts amounted to around EUR 2.3 billion. This means

⁽²⁰⁵⁾ Injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines. To calculate expenditure per problem drug user, the estimates of numbers of problem drug users as reported by the national focal points using average rates were used. For more information, see Statistical Table 4: Estimated number of problem drug users in EU Member States, 1995–2001 (online version).

Table 6: Breakdown of direct public expenditure figures in millions of euro as reported in the Reitox national reports 2002

Country	EUR million	Categories of expenditure in 1999
Belgium	139	Treatment (100); rehabilitation (22.5); methadone (8.9); communities and regions: prevention, care, training, coordination (8.3) (not included: EUR 7 million allocated to the prevention of criminality by the Ministry of Internal Affairs)
Denmark	67	Expenditures on 'drug addiction' by counties and municipalities DKK 495.5 (66.5); prevention at central level DKK 6.2 (0.8), in counties and municipalities not known
Germany	343.2	Emergency accommodation (3.0); psychosocial accompanying (13.3); 951 outpatient counselling facilities (57.9); inpatient rehabilitation (25 % of EUR 434 million (99.7)); integration in work (4.3); cared housing (8.0); treatment in addiction departments in hospitals (97.0); substitution treatment (not known but estimated minimum of 30.0), Länder budget 'addiction' 23.9 % (drugs share) of EUR 127 million (30.0) (not included: prosecution and enforcement expenditure)
Greece	16.2	39 prevention centres (OKANA), salaries and staff (KETHEA), housing and operational costs (2.4); treatment: drug-free, substitution and low threshold (11.9); social rehabilitation (0.3); research (0.3) OKANA, data not included; education (0.8), some central administration costs (0.5)
Spain	181.5	Central level: Ministries of the Interior (GDNPD), Defence (prevention), Health and Consumption, Education and Culture; Foreign Affairs, Work and Social Matters (19.8); fund of confiscated goods allocated to demand reduction 66 % (2.8); autonomous communities (158.7, of which 22.3 from the GDNPD)
France (1995)	205.8	Subutex (91.4); Social Health and Urban Affairs (101.9); Education (Research) (6.6); Youth and Sport (1.3); Work, Employment and Training (0.12); MILDT (66 % of EUR 6.9 million (4.5) (not included: international cooperation and subsidies to international organisations)
Ireland (2000) Estimated State exp.	57.1	Department of Health and Children (treatment, prevention, research) (32.0); Department of Enterprise, Trade and Employment (reintegration) (6.0); Department of Education and Science (prevention) (7.5); Department of Tourism, Sport and Recreation (prevention, research, evaluation, coordination) (11.6)
Italy	278.5	Outpatient treatment (99.1); residential and semi-residential treatment (88.8); National Drug Fund projects promoted at the local/regional level (67.6); National Drug Fund projects sponsored by ministries (23.0). No data were available from eight regions and only partial data were available from most other regions
Luxembourg	13.7	Ministry of Health (5.7); Family, Social Solidarity and Youth (2.3); Education, Professional Training and Sport (0.5); other ministries (0.3); Social security reimbursement (4.9)
Netherlands	287.9	General Act on Special Disease Management (to regional care offices and addiction clinics) (76.0); Ministry of Health, Welfare and Sport (outpatient addiction care) (74.2); funds for homeless addicted, neglected drug addiction (about two thirds of EUR 150 million (112.5)); drug-related nuisance (24.1); drug-prevention activities (1.1) (most of the figures concern both drugs and alcohol)
Austria	52.3	Federal, provincial and municipal sources including health insurance funds, public employment services and the Healthy Austria Fund: primary prevention (2.4); outreach work and harm reduction (3.3); counselling, care and treatment (40.7); reintegration (4.2); quality assurance (0.6); other expenditures/not assignable (0.8)
Portugal	71.7	Presidency of the Council of Ministers (16.2); Ministries of Health (41.6); of Education (3.1); of Employment and Social Affairs (9.5); of Defence 1.2
Finland	76.2	Healthcare (inpatient) (15.1); healthcare (outpatient) (7.9); drug-related pensions (4.3); drug-related sickness benefits (0.5); compensation (insurance companies) (0.9); substance abuse services (in/outpatient) (26.5); living allowances (4.8); child welfare (10.9); research and prevention (5.2)
Sweden	62.5	Very rough estimate on costs for demand-reduction expenditures on alcohol and drugs (Tullverket, 2000). Municipalities SEK 300 (EUR 30), Counties SEK 250 (EUR 25) and State SEK 50 (EUR 5). Non-governmental organisations, foundations and companies SEK 25 (EUR 2.5)
UK 2000-01	466.3	Estimation for the financial year 2000-01 (12 months to 31 March 2001). 'Drug treatment' GBP 234 million (EUR 367.4); 'Protecting young people' (Prevention), GBP 63 million (EUR 98.9)
Norway	224.9	Estimation of costs at central, county and municipal level for drugs and alcohol-related services prevention, treatment and healthcare (in-/outpatient, drug free, substitution), social services for drug addicts outreach work, harm/risk reduction, rehabilitation and reintegration

Sources: Reitox national reports, 2002.

that each EU citizen contributed between EUR 5 and 10. Of course, it is likely that this amount may be considerably higher.

Finally, as emphasised by several participants in the research, a common methodology would be crucial to cross-country research, assuming that this type of information, and its subsequent analysis, turns out to be relevant for decision-making.

Repatriation of expenditure

With current data collection systems, it is very difficult to obtain a reliable breakdown of figures on spending by category. Nationally, areas such as treatment, harm reduction and prevention often merge into each other, and not all countries apply the same system of categorising expenditure. Consequently, international comparisons are hampered by the use of different data collection and classification methods, making it very difficult to compare expenditure in specific areas.

However, the methodological constraints aside, one rather solid conclusion can be drawn on the basis of the best data provided in this report: the area of healthcare and treatment seems to attract the lion's share of the money, accounting for 50–80 % of all direct government drug demand-reduction expenditure.

In Austria, 'counselling, care and treatment' for drug addicts in 1999 accounted for 78 % of federal demand-reduction expenditure. In Greece, the data show that almost 73 % of known expenditure was allocated to treatment (and secondary expenditure), while in Spain, in 1999, expenditure on treatment in the communities and autonomous cities accounted for 74 % of the total. In Portugal, 49 % of total drug expenditure in 1999 went on treatment, but with 25 % of the total expenditure allocated to drug-use prevention this is one of the highest rates (of the known data) in this area in the EU.

Direct expenditure on 'prevention' is, in fact, very difficult to identify, and as a result the data are more uncertain. Known rates range from 4 % in Austria, which provided data only on primary prevention, to 20 % in Greece (again only primary prevention) and are 15 % in the Spanish communities and autonomous cities and 10 % in Luxembourg.

The share of total drug-demand reduction expenditure allocated to rehabilitation and reintegration, and to outreach

and harm-reduction activities, seems to be lower, most likely because of the different scale of expenditure in comparison with treatment or because partially included in it.

Final considerations

As far as analysis of drug-related expenditure is concerned, a distinction must be made between research on expenditure at national level and cross-country comparisons of this research.

Recent studies in some countries⁽²⁰⁶⁾ have shown the possibilities of achieving satisfactory results even without applying an 'internationally agreed methodology'. Of course, on such a basis, the comparability among countries is certainly limited, but still at national level this research can increase knowledge of the responses to the drug phenomenon and can be a useful instrument for decision-makers, allowing them to assess the level of expenditure in their own countries over time (if repeated) and across sectors (if detailed enough). Moreover, when cost estimates are compared with other indicators, as seen earlier, it is possible to estimate how much is spent per drug addict or how much the drug-demand reduction policy costs compared with other policies, or how much citizens must contribute to drug-demand reduction.

These ratios and comparisons raise very relevant questions and hypotheses, the answers to which may be obtained through more in-depth studies.

Comparison 'across countries' (the scope of this study) is another dimension of drug-related cost estimates research. As shown in this report, such studies are highly dependent on different data sources and are therefore hampered by the lack of uniformity among the different countries' methodology, statistics and figures. To overcome these (and other) difficulties, common data collection standards should be implemented. However, such an approach would require investments without yet being certain of the quality and usefulness of the final results. Prior to such investment, further research is needed, together with a deeper reflection on the relevance and utility of such studies at European level.

In the meantime, and while reflection on further development is undertaken among European partners, it is the role of the EMCDDA to continue promoting the improvement of the statistical systems in the field and to disseminate information on the methodologies in use and the research undertaken.

⁽²⁰⁶⁾ Uhl (2001), ONDCP (2001); Godfrey et al. (2002) and Origer (2002), Kopp and Fenoglio (2003). See also the national focal points from Austria, Portugal, Spain and Greece, in the framework of the 2002 Reitox national reports.





References

- ACMD (Advisory Council on the Misuse of Drugs) (2000), *Reducing drug-related deaths*, report by the Advisory Council on the Misuse of Drugs, The Stationery Office, London.
- Adalbjarnardottir, S. and Rafnsson, F. D. (2002), 'Adolescent antisocial behaviour and substance use: longitudinal analyses', *Addictive Behaviours* 27, pp. 227–40.
- Amossé, T., Doussin, A., Fizardon, J.-M., et al. (2001), *Vie et santé des jeunes sans domicile ou en situation précaire*, Enquête INED, Paris et petite couronne, février–mars 1999, série resultants, Biblio no. 1355. CREDES, Paris.
- Aristotelian University of Thessaloniki (2000), 'Evaluation report of the Leonardo da Vinci programme: needs and methods assessment for vocational training in juvenile delinquents and adolescents at risk — ORESTIS', Aristotelian University of Thessaloniki, Thessaloniki.
- BAG (Bundesamt für Gesundheit) (1997), 'Empfehlungen zur kombinierten Hepatitis-A- und Hepatitis-B-Impfung', *Bulletin No 3*, 27 January 1997.
- Bargagli et al. (2002), 'Mortality among problem drug users in Europe: a project of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)', *Heroin Addiction and Related Clinical Problems* 4 (1), pp. 5–12.
- BBC News World Edition (2003), 'ID cards for teenagers launched', Wednesday 22 January 2003.
- Beck, F., Perreti-Wattel, P., Choquet, M., et al. (2000), 'Consommation de substances psychoactives chez les 14–18 ans scolarisés: premiers résultats de l'enquête ESPAD 1999; évolutions 1993–1999', *Tendances* 6, p. 6.
- Beck, F. (2001), *Santé, mode de vie et usages de drogues à 18 ans*, Escapad, OFDT, Paris.
- Beck, F., Legleye, S. and Perreti-Wattel, P. (2002), 'Enquête sur les représentations, opinions et perceptions sur les psychotropes' (EORPP) (available at <http://www.drogues.gouv.fr>), OFDT (Observatoire français des drogues et des toxicomanies), Paris.
- Bennett, T. (2000), 'Drugs and crime: the results of the second stage of the NEW-ADAM programme', *Research Study 205*, Home Office, London.
- Bird, S. M. and Rotily, M. (2002), 'Inside methodologies: for counting blood-borne viruses and injector-inmates' behavioural risks — results from European prisons', *The Howard Journal*, 41, No 2.
- Boys, A., Marsden, J., Fountain, J., et al. (1999), 'What influences young people's use of drugs? a qualitative study of decision-making', *Drugs: Education, Prevention and Policy* 6 (3).
- Brochu, S. (1999), *Drogue et criminalité une relation complexe*, Les Presses de l'Université, Montréal.
- Brook, D. W. et al. (2002), 'Drug use and the risk of major depressive disorder, alcohol dependence, and substance use disorders', *Archives of General Psychiatry* 59, pp. 1039–44.
- Brugal, M. T., Barrio, G., de la Fuente, L., et al. (2002), 'Factors associated with non-fatal overdose: assessing the effect of frequency and route of heroin administration', *Addiction* 97, pp. 319–27.
- Bundeszentrale für Gesundheitliche Aufklärung (2002), *Drug affinity among young people in the Federal Republic of Germany 2001*, Bundeszentrale für Gesundheitliche Aufklärung, Cologne.
- Buster, M. (2002), 'What can we learn from literature?', in Reinås, K. T., Waal, H., Buster, M. C. A., et al. (eds), *Strategic choices for reducing overdose deaths in four European cities*, a joint project of the cities of Oslo, Amsterdam, Copenhagen and Frankfurt am Main, Part II: Appendix, pp. 97–107, Alcohol and Drug Addiction Service, Oslo.
- Bye, E. K. (2002), *Alcohol and drugs in Norway*, *Statistikk '02*, Norwegian Institute for Alcohol and Drug Research, Oslo.
- Calafat, A., Bohrn, K., Juan, M., et al. (1999), *Night life in Europe and recreative drug use*, IREFREA and the European Commission, Valencia.
- Calafat, A., et al. (2003), *Enjoying the nightlife in Europe. The role of moderation*.
- Calderone, B., Fornasiero, A., Lolli, S. and Montanari, L. (2001), *Prostituzione tra dinamiche di mercato e percorsi individuali. Una ricerca qualitative sulla prostituzione femminile di strada in Emilia-Romagna*, Rapporto di ricerca, Bologna.
- Carlen, P. (1996), *Jigsaw: a political criminology of youth homelessness*, Open University Press, Milton Keynes, UK.
- Carpentier, C. (2002), *Drug-related social exclusion, in the context of socio-demographic and economic indicators*, Working paper, EMCDDA, Lisbon.
- CEIES (Statistics Users Council) (1999), *Social exclusion statistics*, Conference Proceedings, Joint Conference, 22 November 1999, Imac Research, Esher, UK.
- Central Committee on the Treatment of Heroin Addicts (2002), *Medical co-prescription of heroin, two randomized controlled trials*, report by van den Brink, W., Hendriks, V. M., Blanken, P., et al. Central Committee on the Treatment of Heroin Addicts, Utrecht.
- Commonwealth of Australia (2002), *Return on investment in needle and syringe programmes in Australia*, Canberra, Commonwealth Department of Health and Ageing, Commonwealth of Australia.
- Council of European Union (2000), 'European action plan on drugs (2000–04)' (http://www.emcdda.eu.int/policy_low/eu/eu_actionplan.shtml).
- De Zwart, W. M., Monshouwer, K., and Smit, F. (2000), *Jeugd en riskant gedrag. Kernegevens 1999. Roken, drinken, drugsgebruik en gokken onder scholieren vanaf tien jaar*, Trimbo-instituut, Utrecht.
- Dettmer, K. (2002), 'First-aid training for drug users and (in emergency) naloxone. Report on a pilot study by Fixpunkt e.V., Berlin', paper presented at the EMCDDA expert meeting 'Overdose prevention and management', Lisbon, 24 and 25 October 2002.
- DrugScope (2000), *Vulnerable young people and drugs: opportunities to tackle inequalities*, DrugScope, London.
- Eland, A. and Rigter, H. (2001), *Immigrants and drug treatment*, background study, Bureau National Drug Monitor, Utrecht.

- EMCDDA (2002a), *Annual report on the state of the drugs problem in the European Union and Norway*, EMCDDA, Lisbon.
- EMCDDA (2002b), *Update and complete the analysis of drug use, Consequences and correlates amongst minorities*, EMCDDA Scientific Report, EMCDDA, Lisbon.
- EMCDDA (2002c), 'Strategies and coordination in the field of drugs in the European Union, a descriptive review', November 2002 (http://www.emcdda.eu.int/multimedia/project_reports/policy_law/strategies_report/national_strategies.pdf).
- EMCDDA (2003a), *Alternatives to prison for drug dependent offenders*, Expert Meeting Report 2003, EMCDDA, Lisbon.
- EMCDDA (2003b), 'Social reintegration in the EU and Norway' (http://www.emcdda.eu.int/multimedia/project_reports/responses/drugtreatment_socialreintegration.pdf).
- Engineer, R., Phillips, A., Thompson, J. and Nicholls, J. (2003), *Drunk and disorderly: a qualitative study of binge drinking among 18–24 year olds*, Home Office Research Study No 262, Home Office, London.
- EORG (European Opinion Research Group) (2002), *Attitudes and opinions of young people in the EU on drugs*, Eurobarometer 57.2/Special Eurobarometer 172, report to the Directorate-General for Justice and Home Affairs, EORG, Brussels.
- ESPAD (European School Surveys Project) (2001), *Alcohol and other drug use among students in 30 European countries* (B. Hibbell, B. Andersson, S. Ahlström, O. Balakireva, et al., the Swedish Council for Information on Alcohol and Other Drugs (CAN), the Pempidou Group of the Council of Europe, December 2000).
- European Council (2001), 'Communication from the Commission to the Council, the European parliament, the Economic and Social Committee and the Committee of the Regions', *Draft joint report on social inclusion* (COM(2001) 565 final), available on the Internet (http://europa.int/comm/employment_social/soc-prot/soc-incl/joint_rep_en.htm).
- Expert Group on The Probation and Welfare Services (1999).
- Farrell, M., Neeleman, J., Gossop, M., et al. (1996), *A Review of the legislation, regulation and delivery of methadone in 12 Member States in the European Union*, Brussels, European Commission.
- Farrell, M., Verster, A., Davoli, M., et al. (2000), *Reviewing current practice in drug-substitution treatment in the European Union*, EMCDDA, Lisbon.
- Ferrari, A., Manaresi, S., Castellini, P., et al. (2001), 'Overdose da oppiacei: analisi dei soccorsi effettuati dal Servizio Emergenze Sanitarie '118' Modena Soccorso, nel 1997', *Bollettino per le Farmacodipendenze e l'Alcoolismo*, Anno XXIV 2001, No 2.
- Field-Smith, M., Bland, J., Taylor, J., et al. (2002), *Trends in death associated with abuse of volatile substances 1971–2000*, Report No 15, Department of Public Health Sciences and Department of Cardiological Sciences, Toxicology Unit, St. George's Hospital Medical School, London (www.shms.ac.uk/depts/phs/vsa2000/vsa2000s.htm).
- FitzGerald, M., Stockdale, J. and Hale, C. (2003), *Young people and street crime*, Youth Justice Board for England and Wales, London.
- Fundación Secretariado General Gitano (2002), *Grupos étnicos minoritarios y consumo de drogas*, Fundación Secretariado General Gitano, Madrid.
- Gallie, D. and Paugam, S. (2002), *Social precarity and social integration*, Eurobarometer 56.1, report to the European Commission, Directorate-General for Employment and Social Affairs, EORG, Brussels.
- Godfrey, C., Eaton, G., McDougall, C. and Culyer, A. (2002), 'The economic and social costs of Class A drug use in England and Wales, 2000', Home Office Research Study 249, Home Office Research, Development and Statistics Directorate, London.
- Goulden C. and Sondhi, A. (2001), *At the margins: drug use by vulnerable young people in the 1998/99 youth lifestyles survey*, Home Office Research Study 228, London.
- Grant, B. F. and Dawson, D. A. (1997), 'Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: results from the national longitudinal alcohol epidemiologic survey', *Journal of Substance Abuse* 9, pp. 103–10.
- Griffiths, C. (2003), 'Deaths related to drug poisoning: results for England and Wales, 1997–2001', *Health Statistics Quarterly*, 17 (Spring 2003), pp. 65–71.
- Griffiths, P., Vingoe, L., Jansen, K., et al. (1997), *Insights: new trends in synthetic drugs*, EMCDDA, Lisbon.
- Hammersley, R., Marsland, L. and Reid, M. (2003), *Substance use by young offenders: the impact of the normalisation of drug use in the early years of the 21st century*, Home Office Research Study 261, Home Office, London.
- Hannon, F., Kelleher, C. and Friel, S. (2000), *General healthcare study of the Irish prisoner population*, Government Publications, Dublin.
- Hansen, W. (1992), 'School-based substance abuse prevention: a review of the state of the art in curriculum, 1980–90', *Health Education Research*, 7, pp. 403–30.
- Hariga, F., Goosdeel, A. and Raedemaker, A. F. (1998), 'Opération boule-de-neige sida, hépatites, overdoses', *Carnets du Risque* 15, Modus Vivendi, Brussels.
- Hickey, C. (2002), *Crime and homelessness*, Focus Ireland and PACE, Dublin.
- Hurley, S. F., Jolley, D. J. and Kaldor, J. M. (1997), 'Effectiveness of needle-exchange programmes for prevention of HIV infection', *Lancet* 349, pp. 1797–800.
- Kavounidi, T. (1996), 'Social exclusion: concept, community initiatives, the Greek experience and policy dilemmas', in *Dimensions of social exclusion in Greece* (edited by D. Karantinos, L. Maratou-Alibranti and E. Fronimou), pp. 47–96, Athens, EKKE.
- Kopp, P. and Fenoglio, P. (2003), *Public spending on drugs in the European Union during the 1990s — Retrospective research*, EMCDDA, Lisbon.
- Kraus, L. and Püschel, K. (eds) (2002), *Prävention von drogenbedingten Not- und Todesfällen*. Lambertus, Freiburg, Germany.
- Lehto-Salo, P., Kuuri, A., Mattunen, M., et al. (2002), 'POLKU-tutkimus. Tutkimus nuorista kolmessa koulukodissa — Psykiatrinen ja neuropsykiatrinen näkökulma', *Aiheita* 16, STAKES, Helsinki.
- Lepère, B., Gourarier, L., Sanchez, M., et al. (2001), 'Diminution du nombre de surdoses mortelles à l'héroïne en France, depuis 1994. A propos du rôle des traitements de substitution', *Annales de Médecine Interne* 152 (suppl. au No 3), IS5–12.
- Liebschutz, J., Savetsky J. B., Saitz R., et al. (2002), 'The relationship between sexual and physical abuse and substance abuse consequences', *Journal of Substance Abuse Treatment* 22, pp. 121–8.

- Lloyd, C. (1998), 'Risk factors for problem drug use: Identifying vulnerable groups', *Drugs, Education, Prevention and Policy* 5(3).
- Lourenço, N. and Carvalho, M. (2002), *Jovens delinquentes e drogas: Espaços e trajetórias*, Lisbon (unpublished report).
- Lupton, R., Wilson, A., May, T., et al. (2002), 'A rock and a hard place: drug markets in deprived neighbourhoods', Home Office Research Study 240, Home Office, London.
- Markert, J. (2001), 'Sing a song of drug use—abuse: four decades of drug lyrics in popular music — from the sixties through the nineties', *Sociological Inquiry* 71, pp. 194–220.
- Meijer, R. F., Grapendaal, M., Van Ooyen, M. M. J., et al. (2002), *Geregistreerde drugcriminaliteit in cijfers — Achtergrondstudie bij het Justitie onderdeel van de Nationale Drugmonitor — Jaarbericht 2002*, WODC, The Hague.
- Millar, D., O'Dwyer, K. and Finnegan, M. (1998), *Alcohol and drugs as factors in offending behaviour: garda survey*, Research Report No 7/98, Garda Research Unit, Tipperary, Ireland.
- Mol, A. and van Vlaanderen, J. L. (2002), *Ontwikkeling van de Cocaine hulpvraag; Periode 1994–2000; Het lijntje doorgetrokken*, Stichting Informatievoorziening Zorg (IVZ), Houten.
- Molinae, M., Pecsteen, D., Hariga, F., et al. (2002), 'L'usage de drogues en communauté française', Rapport Communauté française 1999–2000, Ministère de la Communauté Française, Brussels.
- Morral, A. R., McCaffrey, D. F. and Paddock, S. M. (2002), 'Reassessing the marijuana gateway effect', *Addiction* 97, pp. 1493–504.
- Narkotikakommissionen (2000), *En strategi för lokalt narkotikaförebyggande arbete. Diskussionspromemoria nr 12*, Narkotikakommissionen, Socialdepartementet, Stockholm.
- National reports (2002), Reitox national reports.
- ODCPP (2000), *Demand reduction, a glossary of terms*, ODCPP, New York.
- Observatorio Español Sobre Drogas (2002), *Informe No 5*, Ministerio de Interior, Delegación del Gobierno para el Plan Nacional sobre Drogas.
- O'Higgins, K. (1999), 'Social order problems', in *Social housing in Ireland: A study of success, failure and lessons learned* (edited by Fahey, T.), The Katherine Howard Foundation and Combat Poverty Agency, Dublin (Reported in Irish national report).
- Origer, A. (1999), *Comparative study on the drug population of Portugal and a representative sample of Portuguese drug addict residents of the Grand Duchy of Luxembourg*, Point Focal OEDT — CRP-Santé, Luxembourg.
- Origer, A. (2002), *Le coût économique direct de la politique et des interventions publiques en matière d'usage illicite de drogues au Grand-Duché de Luxembourg*, Séries de recherche No 4. Point focal OEDT Luxembourg — CRP-Santé, Luxembourg.
- Origer, A. and Delucci, H. (2002), *Etude épidémiologique et méthodologique des cas de décès liés à l'usage illicite de substances psychoactives. Analyse comparative (1992–2000)*, Series de recherche No 3, Point Focal OEDT Luxembourg — CRP Santé, Luxembourg.
- Paglia, A. and Room, R. (1999), 'Preventing substance use problems among youth: a literature review and recommendations', *Journal of Primary Prevention* 20, pp. 3–50.
- Pant, A. and Dettmer, K. (2002), *Videoprojekt: Erste Hilfe im Drogennotfall, Abschlussbericht*, Institut für Prävention und psychosoziale Gesundheitsforschung, Freie Universität, Berlin.
- Parker, H. and Egginton, R. (2002), 'Adolescent recreational alcohol and drugs careers gone wrong: developing a strategy for reducing risks and harms', *International Journal of Drug Policy* 13, pp. 419–32.
- Petratis, J., Flay, B., Miller, T., et al. (1998), 'Illicit substance use among adolescents: a matrix of prospective predictors', *Substance Use & Misuse* 33, pp. 2561–604.
- Poschadel, S., Höger, R., Schnitzler, J. and Schreckenberger, D. (2003), *Evaluation der Arbeit der Drogenkonsumräume in der Bundesrepublik Deutschland. Endbericht im Auftrag des Bundesministeriums für Gesundheit. Schriftenreihe des Bundesministeriums für Gesundheit und Soziale Sicherung Bd. 149*, Nomos-Verlagsgesellschaft, Baden-Baden.
- Postma, M. J., Wiessing, L. G. and Jager, J. C. (2001), 'Pharmacoeconomics of drug addiction; estimating the costs of hepatitis C virus, hepatitis B virus and human immunodeficiency virus infection among injecting drug users in Member States of the European Union', *UN Bulletin on Narcotics* 53, pp. 79–89.
- Pudney, S. (2002), 'The road to ruin? Sequences of initiation into drug use and offending by young people in Britain', Home Office Research Study 253, Home Office, London.
- Rehn, N., Room, R. and Edwards, G. (2001), 'Alcohol in the European Region — consumption, harm and policies', WHO — Regional Office for Europe, Copenhagen.
- Reinås, K., Waal, H., Buster, M. C. A., et al. (2002), *Strategic choices for reducing overdose deaths in four European cities. A joint project of the cities of Oslo, Amsterdam, Copenhagen, and Frankfurt am Main*, Drug and Alcohol Addiction Services of the Municipality of Oslo, Oslo.
- Reinking, D., Nicholas, S., Van Leiden, I., et al. (2001), *Daklozen in Den Haag; Onderzoek naar omvang en kenmerken van de daklozenpopulatie*, Trimbos-instituut, Utrecht.
- Seaman, S., Brettle, R. and Gore, S. (1998), 'Mortality from overdose among drug users recently released from prison: database linkage study', *British Medical Journal* 316, pp. 426–8.
- Shillington, A. M. and Clapp, J. D. (2002), 'Beer and bongs: differential problems experienced by older adolescents using alcohol only compared to combined alcohol and marijuana use', *American Journal Drug Alcohol Abuse* 28, pp. 379–97.
- Single, E., et al. (2001), *International guidelines for estimating the costs of substance Abuse*, second edition.
- Skolverket (2000), *Nationella kvalitetsgranskningar 1999*, Skolverket, Stockholm.
- Social Exclusion Unit (2002), *Young runaways*, British Office of the Deputy Prime Minister, London (<http://www.jrf.org.uk/home.asp>).
- Spooner, C., Hall, W. and Lynskey, M. (2001), *Structural determinants of youth drug use*, Australian National Council on Drugs, Woden, Australia.
- Sporer, A. (2003), 'Strategies for preventing heroin overdose', *British Medical Journal* 326, pp. 442–4.
- Springer, A., Uhl, A., et al. (1999), 'Bedeutung und Konsum von psychoaktiven Substanzen bei österreichischen Jugendlichen', Ludwig

- Boltzmann-Institut für Suchtforschung und Österreichisches Jugendforschungsinstitut, Unveröffentlichte Studie im Auftrag des Bundesministeriums für soziale Sicherheit und Generationen, Vienna (reported in Austrian national report).
- Stauffacher, M. (1998), *Treated drug users in 22 European cities. Annual update: 1996 Trends 1992–96*, Pampidou Group, Council of Europe, Strasbourg.
- Stephenson, J. (2001), 'Former addicts face barriers to treatment for HCV', *Journal of the American Medical Association* 285, pp. 1003–5.
- Stevens, A., Berto, D., Kersch, V., et al. (2003), *QCT Europe: literature review summary*. University of Kent, Canterbury, UK.
- Stoeber, H. (2001), *Assistance to drug users in European Union prisons: an overview study*, EMCDDA scientific report, EMCDDA, Lisbon and London.
- Swadi, H. (1999), 'Individual risk factors for adolescent substance use', *Drug and Alcohol Dependence* 55, pp. 209–24.
- Tait, R. J., Hulse, G. K., Robertson, S. I. and Sprivilis, P. (2002), 'Multiple hospital presentations by adolescents who use alcohol or other drugs', *Addiction* 97, pp. 1269–75.
- Tobler, N. (2001), 'Prevention is a two-way process', *Drug and Alcohol Findings* No 5, pp. 25–7, The Findings Partnership, London.
- Tomas, B. (2001), 'Möglichkeiten und Grenzen sozialer Integration von SuchtmittelkonsumentInnen — Erfahrungen aus der Praxis', *Tagungsband der Enquete Wirkungskreise — Was wirkt in der ambulanten Suchttherapie? Was braucht ambulante Suchttherapie um zu wirken?*, pp. 56–64, Verein Dialog, Vienna.
- Uunk, W. J. G. and Vrooman, J. C. (2001), 'Sociale uitsluiting', in *Armoedemonitor 2001*, pp. 139–62, SCP/CBS, The Hague.
- Varescon-Pousson, I., Boissonnas, A. and Ionescu, S. (1997), 'La surdose non mortelle: étude descriptive d'une population de toxicomanes', *Psychologie Française* 3, pp. 255–60.
- Vermeulen, K. T., Hendriks, V. M. and Zomerveld, R. (1999), *Drangbehandeling in Den Haag: Evaluatieonderzoek naar de effectiviteit van het behandelprogramma Triple-Ex voor justitiabele verslaafden*, Parnassia Addiction Research Centre (PARC), The Hague.
- Vestel, V., Bakken, A., Geir, H. and Moshuus Tormod, Ø. (1997), 'Ungdomskultur og narkotikabruk', *NOVA Temahäfte* 1/97.
- Villalbi, J. R. and Brugal, M. T. (1999), 'Sobre la epidemia de heroína, su impacto, su contexto y las políticas sanitarias', *Medicina Clinica (Barcelona)* 112, pp. 736–7.
- Vrieling, I., Van Alem, V. C. M. and Van de Mheen, H. (2000), *Drop-out onder allochtonen in de ambulante verslavingszorg 1994–98*. IVV/IVO, Houten/Rotterdam.
- Waidner, G. (1999), *Die Viktimisierungserfahrungen drogenabhängiger Personen. Eine Untersuchung mit qualitativen Verfahren*, Unveröffentlichte Diplomarbeit an der Grund- und Integrativwissenschaftlichen Fakultät der Universität Wien, Vienna.
- Warner-Smith, M., Lynskey, M., Darke, S. and Hall, W. (2001), 'Heroin overdose: prevalence, correlates, consequences and interventions', report prepared by the National Drug and Alcohol Research Centre, University of New South Wales. Australian National Council on Drugs, Woden, Australia.
- WHO (1998), 'Opioid overdose: trends, risk factors, interventions and priorities for action', World Health Organisation, Programme on Substance Abuse, Division of Mental Health and Prevention of Substance Abuse, Geneva.
- Wiessing, L. (2001), 'The access of injecting drug users to hepatitis C treatment is low and should be improved', *Eurosurveillance Weekly*, Issue 31 (www.eurosurv.org/2001/010802.htm).





Reitox focal points

Belgique/België

Institut scientifique de la santé publique/Wetenschappelijk Instituut Volksgezondheid
Rue Juliette Wytsman 14
B-1050 Bruxelles/Brussel
Denise WALCKIERS
Tel. (32-2) 642 50 35
Fax (32-2) 642 54 10
E-mail: BIRN@iph.fgov.be

Danmark

Sundhedsstyrelsen

Islands Brygge, 67 — Postbox 1881
DK-2300 København S
Ole Kopp CHRISTENSEN/Kari GRASAASEN
Tel. (45) 72 22 77 60
Fax (45) 72 22 74 11
E-mail: okc@sst.dk, kag@sst.dk

Deutschland

Deutsche Referenzstelle für die Europäische Beobachtungsstelle für Drogen und Drogensucht
Parzivalstraße 25
D-80804 München
Roland SIMON
Tel. (49-89) 36 08 04 40
Fax (49-89) 36 08 04 49
E-mail: Simon@ift.de

Elláda

University of Mental Health Research Institute
Argirokastrou & Ionias Street
Papagou
GR-15601 — Athens
Manina TERZIDOU
Tel. (302-10) 653 69 02
Fax (302-10) 653 72 73
E-mail: ektepn@ektepn.gr

España

Delegación del Gobierno para el Plan nacional sobre Drogas
C/Recoletos, 22
E-28001 Madrid
Elena GARZÓN/ Ana Andrés BALLESTEROS
Tel. (34-91) 537 27 25/2686
Fax (34-91) 537 26 95
E-mail: egarzon@pnd.mir.es, anaab@pnd.mir.es

France

Observatoire français des drogues et des toxicomanies
105, rue Lafayette
F-75110 Paris
Jean-Michel COSTES
Tel. (33) 153 20 16 16
Fax (33) 153 20 16 00
E-mail: jecos@ofdt.fr

Ireland

Drug Misuse Research Division
Health Research Board
73, Lower Baggot Street
Dublin 2
Ireland
Hamish SINCLAIR
Tel. (353-1) 676 11 76 ext 160
Fax (353-1) 661 18 56
E-mail: Hsinclair@hrb.ie

Italia

Ministero del Lavoro e degli Affari sociali, dipartimento delle politiche sociali e Previdenziali, direzione generale per le tossicodipendenze e l'osservatorio nazionale
Via Fornovo 8 — Pal. B
I-00187 Roma
Mariano MARTONE/Silvia ZANONE
Tel. (39) 06 36 75 48 01/06
Fax (39) 06 36 75 48 11
E-mail: mmartone@welfare.gov.it, szanone@welfare.gov.it

Luxembourg

Direction de la santé, point focal OEDT, Luxembourg
Allée Marconi — Villa Louvigny
L-2120 Luxembourg
Alain ORIGER
Tel. (352) 47 85 625
Fax (352) 46 79 65
E-mail: alain.origer@ms.etat.lu

Nederland

Trimbos Instituut
Netherlands Institute of Mental Health and Addiction
Da Costakade, 45 — P.O. BOX 725
3500 AS Utrecht
Nederland
Franz TRAUTMANN
Tel. (31-30) 297 11 86
Fax (31-30) 297 11 87
E-mail: ftrautmann@trimbos.nl

Österreich

Österreichisches Bundesinstitut
für Gesundheitswesen

Stubenring 6

A-1010 Wien

Sabine HAAS

Tel. (43-1) 515 61 60

Fax (43-1) 513 84 72

E-mail: HAAS@oebig.at

Portugal

Instituto da Droga e da Toxicoddependência

Av. João Crisostomo, 14

P-1000 — 179 Lisboa

Fernando NEGRÃO/Maria MOREIRA

Tel. (351) 213 10 41 00/41 26

Fax (351) 21 310 41 90

E-mail: Fernando.Negrão@ipdt.pt, Maria.Moreira@ipdt.pt

Suomi/Finland

Sosiaali ja terveystieteiden tutkimus ja kehittämiskeskus

PO BOX 220

(Office: Lintulahdenkuja, 4 — 00530 Helsinki)

FIN-00531 Helsinki

Ari VIRTANEN

Tel. (358-9) 3967 2378

Fax (358-9) 3967 2497

E-mail: ari.virtanen@stakes.fi

Sverige

Statens folkhälsoinstitut

(Office: Olof Palmes gata, 17)

S-103 52 Stockholm

Bertil PETERSSON

Tel. (46-8) 56 61 35 13

Fax (46-8) 56 61 35 05

E-mail: Bertil.Pettersson@fhi.se

United Kingdom

Sexual Health and Substance Misuse Policy

Department of Health, Skipton House

80 London Road

London SE1 6LH

United Kingdom

Alan LODWICK

Tel. (44-20) 79 72 51 21

Fax (44-20) 79 72 16 15

E-mail: Alan.Lodwick@doh.gsi.gov.uk

European Commission/Commission européenne

Directorate-General for Justice and Home Affairs — Drugs
Coordination Unit/Direction générale de la justice et des
affaires intérieures — Unité de coordination de la lutte
antidrogue

Rue de la Loi/Wetstraat 200 (Lx-46 3/186)

B-1049 Brussels/Bruxelles

Timo JETSU

Tel. (32-2) 299 5784

Fax (32-2) 295 3205

E-mail: Timo.Jetsu@cec.eu.int

Norge

Statens institutt for rusmiddelforskning

PB 565 Sentrum

NO-0105 Oslo

(Office: Øvre Slottsgate 2B)

NO-0157 Oslo

Knut BROFOSS/Odd HORDVIN

Tel. (47) 22 34 04 00

Fax (47) 22 34 04 01

E-mail: odd@sirus.no

Acceding and candidate countries' focal points:

http://www.emcdda.eu.int/partners/candidates_focalpoints.shtml

European Monitoring Centre for Drugs and Drug Addiction, 2003

Annual report 2003: the state of the drugs problem in the European Union and Norway

Luxembourg: Office for Official Publications of the European Communities

2003 — 82 pp. — 21 x 29.7 cm

ISBN 92-9168-159-8

BELGIQUE/BELGIË

Jean De Lannoy

Avenue du Roi 202/Koningslaan 202
B-1190 Bruxelles/Brussel
Tél. (32-2) 538 43 08
Fax (32-2) 538 08 41
E-mail: jean.de.lannoy@infoboard.be
URL: http://www.jean-de-lannoy.be

**La librairie européenne/
De Europese Boekhandel**

Rue de la Loi 244/Wetstraat 244
B-1040 Bruxelles/Brussel
Tél. (32-2) 295 26 39
Fax (32-2) 735 08 60
E-mail: mail@libeurop.be
URL: http://www.libeurop.be

Moniteur belge/Belgisch Staatsblad

Rue de Louvain 40-42/Leuvenseweg 40-42
B-1000 Bruxelles/Brussel
Tél. (32-2) 552 22 11
Fax (32-2) 511 01 84
E-mail: eusales@just.fgov.be

DANMARK

J. H. Schultz Information A/S

Herstedvang 12
DK-2620 Albertslund
Tlf. (45) 43 63 23 00
Fax (45) 43 63 19 69
E-mail: schultz@schultz.dk
URL: http://www.schultz.dk

DEUTSCHLAND

Bundesanzeiger Verlag GmbH

Vertriebsabteilung
Amsterdamer Straße 192
D-50735 Köln
Tel. (49-221) 97 66 80
Fax (49-221) 97 66 82 78
E-Mail: vertrieb@bundesanzeiger.de
URL: http://www.bundesanzeiger.de

ΕΛΛΑΔΑ/GREECE

G. C. Eleftheroudakis SA

International Bookstore
Panepistimiou 17
GR-10564 Athina
Tel. (30-1) 331 41 80/1/2/3/4/5
Fax (30-1) 325 84 99
E-mail: elebooks@netor.gr
URL: elebooks@hellasnet.gr

ESPAÑA

Boletín Oficial del Estado

Trafalgar, 27
E-28071 Madrid
Tel. (34) 915 38 21 11 (libros)
913 84 17 15 (suscripción)
Fax (34) 915 38 21 21 (libros),
913 84 17 14 (suscripción)
E-mail: clientes@com.boe.es
URL: http://www.boe.es

Mundi Prensa Libros, SA

Castelló, 37
E-28001 Madrid
Tel. (34) 914 36 37 00
Fax (34) 915 75 39 98
E-mail: libreria@mundiprensa.es
URL: http://www.mundiprensa.com

FRANCE

Journal officiel

Service des publications des CE
26, rue Desaix
F-75727 Paris Cedex 15
Tél. (33) 140 58 77 31
Fax (33) 140 58 77 00
E-mail: europublications@journal-officiel.gouv.fr
URL: http://www.journal-officiel.gouv.fr

IRELAND

Alan Hanna's Bookshop

270 Lower Rathmines Road
Dublin 6
Tel. (353-1) 496 73 98
Fax (353-1) 496 02 28
E-mail: hanna@iol.ie

ITALIA

Licosa SpA

Via Duca di Calabria, 1/1
Casella postale 552
I-50125 Firenze
Tel. (39) 055 64 83 1
Fax (39) 055 64 12 57
E-mail: licosa@licosa.com
URL: http://www.licosa.com

LUXEMBOURG

Messageries du livre SARL

5, rue Raiffeisen
L-2411 Luxembourg
Tél. (352) 40 10 20
Fax (352) 49 06 61
E-mail: mail@mdl.lu
URL: http://www.mdl.lu

NEDERLAND

SDU Servicecentrum Uitgevers

Christoffel Plantijnstraat 2
Postbus 20014
2500 EA Den Haag
Tel. (31-70) 378 98 80
Fax (31-70) 378 97 83
E-mail: sdu@sdu.nl
URL: http://www.sdu.nl

PORTUGAL

Distribuidora de Livros Bertrand Ld.ª

Grupo Bertrand, SA
Rua das Terras dos Vales, 4-A
Apartado 60037
P-2700 Amadora
Tel. (351) 214 95 87 87
Fax (351) 214 96 02 55
E-mail: dlb@ip.pt

Imprensa Nacional-Casa da Moeda, SA

Sector de Publicações Oficiais
Rua da Escola Politécnica, 135
P-1250-100 Lisboa Codex
Tel. (351) 213 94 57 00
Fax (351) 213 94 57 50
E-mail: spoce@incm.pt
URL: http://www.incm.pt

SUOMI/FINLAND

**Akateeminen Kirjakauppa/
Akademiska Bokhandeln**

Keskuskatu 1/Centralgatan 1
P/L/PB 128
FIN-00101 Helsinki/Helsingfors
P./tfn (358-9) 121 44 18
F./fax (358-9) 121 44 35
Sähköposti: sps@akateeminen.com
URL: http://www.akateeminen.com

SVERIGE

BTJ AB

Traktorvägen 11-13
S-221 82 Lund
Tlf. (46-46) 18 00 00
Fax (46-46) 30 79 47
E-post: btjeu-pub@btj.se
URL: http://www.btj.se

UNITED KINGDOM

The Stationery Office Ltd

Customer Services
PO Box 29
Norwich NR3 1GN
Tel. (44) 870 60 05-522
Fax (44) 870 60 05-533
E-mail: book.orders@theso.co.uk
URL: http://www.itsofficial.net

ISLAND

Bokabud Larusar Blöndal

Skólavörðustíg, 2
IS-101 Reykjavík
Tel. (354) 552 55 40
Fax (354) 552 55 60
E-mail: bokabud@simnet.is

SCHWEIZ/SUISSE/SVIZZERA

Euro Info Center Schweiz

c/o OSEC Business Network Switzerland
Stampfenbachstraße 85
PF 492
CH-8035 Zürich
Tel. (41-1) 365 53 15
Fax (41-1) 365 54 11
E-mail: eics@osec.ch
URL: http://www.osec.ch/eics

BĂLGARIJA

Europress Euromedia Ltd

59, blvd Vitosha
BG-1000 Sofia
Tel. (359-2) 980 37 66
Fax (359-2) 980 42 30
E-mail: Milena@mbox.cit.bg
URL: http://www.europress.bg

CYPRUS

Cyprus Chamber of Commerce and Industry

PO Box 21455
CY-1509 Nicosia
Tel. (357-2) 88 97 52
Fax (357-2) 66 10 44
E-mail: demetrap@ccci.org.cy

EESTI

Eesti Kaubandus-Tööstuskoda

(Estonian Chamber of Commerce and Industry)
Toom-Kooli 17
EE-10130 Tallinn
Tel. (372) 646 02 44
Fax (372) 646 02 45
E-mail: einfo@koda.ee
URL: http://www.koda.ee

HRVATSKA

Mediatrade Ltd

Pavla Hatza 1
HR-10000 Zagreb
Tel. (385-1) 481 94 11
Fax (385-1) 481 94 11

MAGYARORSZÁG

Euro Info Service

Szt. István krt.12
III emelet 1/A
PO Box 1039
H-1137 Budapest
Tel. (36-1) 329 21 70
Fax (36-1) 349 20 53
E-mail: euroinfo@euroinfo.hu
URL: http://www.euroinfo.hu

MALTA

Miller Distributors Ltd

Malta International Airport
PO Box 25
Luqa LQA 05
Tel. (356) 66 44 88
Fax (356) 67 67 99
E-mail: gwirth@usa.net

NORGE

Swets Blackwell AS

Hans Nielsen Hauges gt. 39
Boks 4901 Nydalen
N-0423 Oslo
Tel. (47) 23 40 00 00
Fax (47) 23 40 00 01
E-mail: info@no.swetsblackwell.com
URL: http://www.swetsblackwell.com.no

POLSKA

Ars Polona

Krakowskie Przedmiescie 7
Skr. pocztowa 1001
PL-00-950 Warszawa
Tel. (48-22) 826 12 01
Fax (48-22) 826 62 40
E-mail: books119@arspolona.com.pl

ROMÂNIA

Euromedia

Str.Dionisie Lupu nr. 65, sector 1
RO-70184 Bucuresti
Tel. (40-1) 315 44 03
Fax (40-1) 312 96 46
E-mail: euromedia@mailcity.com

SLOVAKIA

Centrum VTI SR

Nám. Slobody, 19
SK-81223 Bratislava
Tel. (421-7) 54 41 83 64
Fax (421-7) 54 41 83 64
E-mail: europ@ttb1.sltk.stuba.sk
URL: http://www.sltk.stuba.sk

SLOVENIJA

GV Zalozba

Dunajska cesta 5
SLO-1000 Ljubljana
Tel. (386) 613 09 1804
Fax (386) 613 09 1805
E-mail: europ@gvestnik.si
URL: http://www.gvzalozba.si

TÜRKIYE

Dünya Infotel AS

100. Yil Mahallesi 34440
TR-80050 Bagcilar-Istanbul
Tel. (90-212) 629 46 89
Fax (90-212) 629 46 27
E-mail: aktuel.info@dunya.com

ARGENTINA

World Publications SA

Av. Cordoba 1877
C1120 AAA Buenos Aires
Tel. (54-11) 48 15 81 56
Fax (54-11) 48 15 81 56
E-mail: wpbooks@infovia.com.ar
URL: http://www.wpbooks.com.ar

AUSTRALIA

Hunter Publications

PO Box 404
Abbotsford, Victoria 3067
Tel. (61-3) 94 17 53 61
Fax (61-3) 94 19 71 54
E-mail: jpdavies@ozemail.com.au

BRESIL

Livraria Camões

Rua Bittencourt da Silva, 12 C
CEP
20043-900 Rio de Janeiro
Tel. (55-21) 262 47 76
Fax (55-21) 262 47 76
E-mail: livraria.camoes@incm.com.br
URL: http://www.inc.com.br

CANADA

Les éditions La Liberté Inc.

3020, chemin Sainte-Foy
Sainte-Foy, Québec G1X 3V6
Tel. (1-418) 658 37 63
Fax (1-800) 567 54 49
E-mail: liberte@mediom.qc.ca

Renouf Publishing Co. Ltd

5369 Chemin Canotek Road, Unit 1
Ottawa, Ontario K1J 9J3
Tel. (1-613) 745 26 65
Fax (1-613) 745 76 60
E-mail: order.dept@renoufbooks.com
URL: http://www.renoufbooks.com

EGYPT

The Middle East Observer

41 Sherif Street
Cairo
Tel. (20-2) 392 69 19
Fax (20-2) 393 97 32
E-mail: inquiry@meobserver.com
URL: http://www.meobserver.com.eg

MALAYSIA

EBIC Malaysia

Suite 45.02, Level 45
Plaza MBf (Letter Box 45)
8 Jalan Yap Kwan Seng
50450 Kuala Lumpur
Tel. (60-3) 21 62 92 98
Fax (60-3) 21 62 61 98
E-mail: ebic@tm.net.my

MÉXICO

Mundi Prensa México, SA de CV

Río Pánuco, 141
Colonia Cuauhtémoc
MX-06500 México, DF
Tel. (52-5) 533 56 58
Fax (52-5) 514 67 99
E-mail: 101545.2361@compuserve.com

SOUTH AFRICA

Eurochamber of Commerce in South Africa

PO Box 781738
2146 Sandton
Tel. (27-11) 884 39 52
Fax (27-11) 883 55 73
E-mail: info@eurochamber.co.za

SOUTH KOREA

**The European Union Chamber of
Commerce in Korea**

5th Fl. The Shilla Hotel
202, Jangchung-dong 2 Ga, Chung-ku
Seoul 100-392
Tel. (82-2) 22 53-5631/4
Fax (82-2) 22 53-5635/6
E-mail: eucock@eucock.org
URL: http://www.eucock.org

SRI LANKA

EBIC Sri Lanka

Trans Asia Hotel
115 Sir Chittampalam
A. Gardiner Mawatha
Colombo 2
Tel. (94-1) 074 71 50 78
Fax (94-1) 44 87 79
E-mail: ebicsl@slnet.lk

T'AI-WAN

Tycoon Information Inc

PO Box 81-466
105 Taipei
Tel. (886-2) 87 12 88 86
Fax (886-2) 87 12 47 47
E-mail: euitupe@ms21.hinet.net

UNITED STATES OF AMERICA

Bernan Associates

4611-F Assembly Drive
Lanham MD 20706-4391
Tel. (1-800) 274 44 47 (toll free telephone)
Fax (1-800) 865 34 50 (toll free fax)
E-mail: query@bernan.com
URL: http://www.bernan.com

ANDERE LÄNDER
OTHER COUNTRIES
AUTRES PAYS

**Bitte wenden Sie sich an ein Büro Ihrer
Wahl/Please contact the sales office of
your choice/Veuillez vous adresser au
bureau de vente de votre choix**

Office for Official Publications of the European
Communities
2, rue Mercier
L-2985 Luxembourg
Tel. (352) 29 29-42455
Fax (352) 29 29-42758
E-mail: info-info-opoce@cec.eu.int
URL: publications.eu.int

About the EMCDDA

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

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

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

The annual report presents the EMCDDA's yearly overview of the drug phenomenon in the EU Member States and Norway and is an essential reference book for those seeking the latest findings on drugs in Europe. The printed publication is complemented by an expanded online version available at: <http://annualreport.emcdda.eu.int>.



Publications Office
Publications.eu.int

ISBN 92-9168-159-8



9 789291 681594