E.M.C.D.D.A.
European Monitoring Centre for Drugs and Drug Addiction

Extended annual report on the state of the drugs problem in the European Union

1999

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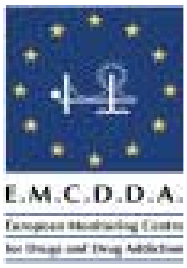

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Preface

It gives me great pleasure to introduce the EMCDDA's annual report for 1999. This is the fourth annual report that the Centre has produced. It has undergone some minor changes in form and content since the last report. These have been made so that the report can reflect more clearly the rapidly evolving trends and patterns in drug use in Europe, as well as make it more accessible to its varied readership. Our aim is to provide up-to-date, quality information as a basis for sound decision-making. The collection and collation of comparable, reliable and useful information takes a great deal of time and effort, as does the creation of the local, national and European networks through which such information is gathered.

Action on drugs and problems related to drugs has been high on the agenda, both in Europe and elsewhere. Significant progress was made during 1998. At the special session on drugs of the United Nations General Assembly (8-10 June 1998), the world community strengthened its commitment to confronting the world drug problem in a collaborative, balanced way. The adoption of a political declaration on the guiding principles of drug demand reduction by 185 participating countries constituted a considerable advance in the international 'drugs debate'. It was the first time at this level that demand reduction was recognised as an indispensable component of any global approach to the world drug problem. The General Assembly requested the Commission on Narcotic Drugs to explore a proposed action plan based on this declaration. The United Nations International Drug Control Programme (UNDCP) prepared a preliminary draft that was discussed and amended by an intergovernmental working group with specialised agencies, that included the EMCDDA, in December 1998.

The 42nd session of the Commission on Narcotic Drugs [1] ended with the adoption of a resolution on the first United Nations action plan on drug demand reduction. The plan focused on identifying, assessing and communicating information on the causes and consequences of substance use; coordination mechanisms and the participation of all relevant authorities and sectors of society; the implementation of research and the dissemination of results; the development of customised programmes ranging from the discouragement of initial use to reduction of the negative health and social consequences of drug use; the enhancement of information and services offered to the public and to drug users in particular; and the development of evaluation strategies.

Action against drug trafficking and drug misuse was also a major priority at European Union level. The Europol Convention entered into force on 1 October, following its ratification in June 1998 by all Member States, providing the EU with a complementary tool to prevent and combat unlawful drug trafficking. The coordination and implementation of a third European Drug Prevention Week during the Austrian Presidency was an important step in the implementation of the first Community action programme for the prevention of drug dependence.

The United Kingdom and Austrian Presidencies played a central role in developing a wide range of initiatives. In early 1998 the United Kingdom Presidency invited Horizontal Drug Group (HDG) members to outline their likely priorities for inclusion in a post-1999 European drugs strategy. The HDG [2] coordinated the European Union input for the UN General Assembly session on drugs. The Cardiff European Council [3] endorsed a set of key elements for a European Union strategy to tackle all aspects of the problem in 2000–04 [4]. The Austrian Presidency pursued the task and the Vienna European Council [5], having examined the report on drugs and drug-related issues of the Presidency period, invited European institutions to develop an integrated and balanced post-1999 drugs strategy further, in line with the new opportunities offered by the Amsterdam Treaty. The Council specified that full use should be made of the expertise of the European Monitoring Centre for Drugs and Drug Addiction.

[1] Vienna, 16 to 25 March 1999.
[2] This Horizontal Drugs Group was created by the Permanent Representatives Committee (Coreper) in February 1997 as a forum to coordinate the drugs activities of the Union, especially when they are of a trans-pillar nature. The HDG met 11 times in 1998.
[3] 15 and 16 June 1998 — Presidency conclusions.
[4] Based on the Council report to the European Council on activities on drugs and drug-related issues under the UK Presidency, including key elements of a post-1999 EU drugs strategy (7930/2/98 REV 2).
[5] 11 and 12 December 1998.

The European Parliament examined and commented on the Council report (6). It especially emphasised the need to ensure maximum synergy between all Community efforts, and called upon the Commission and the Council to record all initiatives on drugs in one single document. The requirement for reliable and comparable information on drugs was stressed through the adoption by the European Parliament, of the document on the EMCDDA's annual report (7).

The post-1999 EU drug strategy is envisaged as multidisciplinary, balanced and integrated, covering a range of actions on demand and supply reduction involving international cooperation across the three pillars of the EU. Both the European Parliament and Council stated the importance of focusing upon the improvement of cooperation with EU accession countries, and in assistance for facilitating the taking of the Community drug *acquis*.

The Commission took advantage of the work already completed by the Centre between 1995 and 1999 and the inputs of both the European Parliament and Council in the preparation of its proposal for an EU action plan to combat drugs (2000–04). The action plan foresees an important role for the EMCDDA in providing the European institutions and Member States with relevant information, observing that 'the extent and magnitude of the drugs phenomenon is now better known thanks to the valuable work carried out by the European Monitoring Centre for Drugs and Drug Addiction'.

The launching in 1998 of the fifth framework programme for research for 1998–2002 should also be noted. It includes support for research activities into the psychological and socioeconomic factors involved in drug use in order to develop a better understanding of long-term health and social consequences and the pursuit of more effective treatment strategies.

Efforts have been made with the Phare programme to develop information systems for collecting, processing and distributing data on drug use, and to achieve convergence between the central and east European countries (CEECs) and the tasks and data currently being pursued by the EMCDDA Reitox national focal point network. Much remains to be done and the Centre and its partners are aware that they are standing at the threshold of a major, new venture.

The EMCDDA, in close collaboration with the Reitox national focal points, will continue to concentrate its efforts on the regular collection, analysis and dissemination of data at European level; the improvement of data comparison methods; the implementation of key harmonised epidemiological indicators; the systematic and scientific evaluation of demand reduction initiatives; and cooperation with European and international bodies and organisations.

The Centre's core tasks include, in epidemiology, the implementation of five harmonised key indicators (demand for treatment by drug users; drug-related deaths, mortality and causes of death among drug users; the incidence of drug-related infectious diseases; the comparability of surveys of drug use, behaviour and attitudes in the general population; and the comparability of prevalence estimates of problem drug use). Enhancement of the European database on demand reduction activities (EDDRA) is the leading project in the identification, assessment and promotion of routine, scientific evaluation in the demand reduction field. Scientific investigation and collaboration with institutional partners continue in the implementation of the joint action on new synthetic drugs, as does the annual preparation and publication of this report and a series of research monographs and other studies.

I believe that this report demonstrates the real progress made by the Centre since its foundation. This has been achieved through the commitment and hard work of those involved in the process at all levels throughout the European Union. I am confident that the EMCDDA is now well placed to respond to the challenges that the next millennium is bound to present.

Georges Estievenart
Executive Director
EMCDDA

(6) EP resolution on the report, including key elements of a post-1999 EU drugs strategy, from the Council to the European Council on activities on drugs and drug-related issues under the UK Presidency (7930/2/98 – C4-0409/98).
(7) Report on the 1997 annual report of the European Monitoring Centre for Drugs and Drug Addiction on the state of the drugs problem in the European Union (C4-0552/97).

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Chapter 1

Developments in drug use, problems and responses

Throughout the European Union (EU), national, regional and local policies for the prevention of drug use and addiction, as well as assistance to and treatment of drug users, are changing. More efforts are being made at all levels and by all sectors to ensure that cooperation and coordination between the educational, health, social and criminal justice systems become more effective and efficient.

Despite the considerable differences between EU countries, and between drug users and patterns of use, some clear trends in, and consequences of drug use are emerging throughout the Union. More details about patterns and consequences of drug use are provided in Chapter 2.

Prevalence and patterns of problem drug use

In most Member States, the main substance recorded by indicators of problem drug use has been heroin. In some northern States, amphetamines are significant in admissions to treatment, although overdoses and drug-related infectious diseases often also involve heroin. Estimates of the prevalence of the overall number of problem drug users thus largely refer to problem opiate use.

Out of a total EU population of about 375 million, an estimated 1 to 1.5 million are problem users (mainly of heroin). This estimate is based on a 12-month period prevalence rate of 2.7 to 4.0 per 1 000. The range reflects the margin of uncertainty around any estimate and the fundamental issue of definition. The lower figure can be taken as indicating the extent of dependence — 'addiction' in common parlance — while the higher figure represents a somewhat broader population which, while not dependent in the strict sense, are nonetheless using opiates or other drugs in a sufficiently intense or risky fashion (for example, by injection) to be at significant risk of experiencing serious consequences such as dependence, overdose, and infectious diseases.

This estimate also excludes occasional use of opiates. Surveys, although usually unreliable regarding the assessment of problem drug use, suggest that up to 1 % of the

Defining problem drug use

'Problem drug use' is defined as the use of drugs in a way that significantly increases the risk of serious, adverse physical, psychological or social consequences for the user. This definition includes dependence (addiction), but also covers patterns of non-dependent use that may lead the user to seek help or that are associated with increased mortality or morbidity, such as overdoses or infectious diseases.

The operational definition used by the EMCDDA to compare estimates of the prevalence of problem drug use is limited to intravenous drug use or long duration/regular use of opiates, cocaine or amphetamines. For practical reasons, ecstasy and cannabis are not included when comparing estimates for different countries, even though, as shown elsewhere in this report, the use of these drugs may sometimes be associated with personal or social problems.

general population and 1 to 2 % of the school or youth population have tried heroin or other illicit opiates. This implies that the total number of people with some experience of these drugs could be in the order of a few million. It is unclear to what extent this figure includes users who smoke heroin on a more than experimental basis.

Since most indicators used to generate prevalence estimates are more likely to detect injecting drug users (IDUs), heroin smokers may be under-represented. It is also not clear to what extent estimates of problem drug use cover heavy users of drugs such as cocaine, amphetamines or combinations of legal and illegal drugs (such as medicines and alcohol) if they are not using heroin.

The overall prevalence of problem drug use as defined in this context, and in particular of heroin, appears to have been largely stable in most EU States in recent years. However, there is a continuing incidence of new cases balanced by others who become abstinent or die. The estimate for the EU as a whole is a little higher than in previous reports, due to new or improved estimates from a larger number of countries.

The known/treated population is predominantly male with an average age between 24 and 33. This figure is slowly increasing in most Member States, perhaps partly as a result of increased substitution treatment which tends to be offered or taken up by older clients. This population is also associated with serious health and social problems linked to multiple drug use, psychiatric co-morbidity, infectious diseases, crime, imprisonment and social exclusion (see also Chapter 2).

Social distribution and diffusion

Problem drug use is unequally distributed between and within countries, with large differences between cities and within specific areas. The more socially deprived areas tend to have higher prevalence, although the relationship between prevalence and socioeconomic factors is complex. Not all socially deprived areas have high levels of problem drug use, and high-prevalence pockets are also found in some of the richest cities or regions.

This picture of heroin and urban deprivation should not be oversimplified. Although, in general, heroin is more prevalent in urban areas, diffusion to smaller towns and rural areas is increasingly apparent.

Furthermore, there have been repeated reports over recent years of heroin use, mostly smoking by new groups. For example, young people from socially integrated backgrounds, heavy recreational users of ecstasy, amphetamines and other drugs, individuals from some minority groups and older people with problematic heavy consumption of alcohol and/or medicines are also smoking heroin. Initiation into heroin use, including injecting, also continues in areas of established heroin use.

Insight into diffusion processes, both geographical and social, is a valuable field for further study (see Chapter 2 for examples). The steady rise in the availability and use of amphetamines and cocaine, plus the wide variety of combinations of legal substances such as medicines and alcohol used with illegal drugs, need to be taken into account in the future development of treatment responses.

Treatment responses to problem drug use

Challenges for treatment services

Poly-drug use, co-morbidity (both psychiatric and organic) and an ageing population challenge treatment services in many countries. This development is crucial when determining the best approach to delivering high-quality treatment and ensuring its provision in all settings.

One response to this trend, evident in some countries, is that as patterns of drug use change the number of multiple patterns increases. Treatment centres, which generally define themselves by the substances used by their clients, are also changing. There are signs that care centres for drug addicts are merging with those for alcoholics, addicts of prescribed drugs and illegal drug users.

Greece offers new service

The non-residential, drug-free unit Diavasi in Greece meets the needs of adults who, despite their drug habit, are nevertheless able to lead a relatively stable life and to maintain fairly good relationships with their families who support their efforts to become abstinent.

Diavasi offers both day and evening treatment programmes, as well as services targeted at the user's family to help strengthen family relations and consolidate a new attitude.

Treatment is also supplemented by many other activities and the Diavasi cultural centre hosts exhibitions, films, concerts and plays in cooperation with the local community.

Primary healthcare involvement

In parallel with the developments observed in specialised treatment centres, the primary healthcare system throughout the EU is increasing its involvement in the care of drug users, probably due to the expansion of substitution treatment and financial cutbacks in the social sector in many countries. At the same time, there has been a move away from residential treatment towards out-patient treatment.

For example, general practitioners (GPs) in the UK are increasingly involved in seeing drug users and are currently the main providers of generic healthcare services to them. As a result, a new edition of clinical guidelines on treating drug users has been revised and is being distributed to all GPs in England in 1999.

In France, the proportion of GPs (39 %) who see at least one drug user has not increased since 1995. However, GPs are seeing more users, usually as regular patients. This indicates, as in other countries, a move towards long-term, ongoing care relationships, although many GPs are reluctant to see drug users who are considered troublesome. Doctors may also feel incompetent in treating such cases or believe only specialised people can help drug users.

Substitution treatment

Substitution treatment for opiate dependence is rapidly expanding in Europe and GPs are largely involved in this. Since many countries do not have national registration formalities (which in some cases they had before, as in the UK), it is not possible to give an exact number of patients undergoing substitution treatment. An educated guess is that about 300 000 persons in the EU are receiving substitution treatment. There are also great variations between Member States. It is estimated that per 100 000 population aged 16 to 60, about 200 receive substitution treatment in Spain compared with six or less in Greece or Finland.

Setting the estimate of patients in substitution treatment against the total prevalence estimate implies that within the EU 20 % of all problem opiate users and perhaps 30 % of dependent opiate users receive substitution treatment. In 1999, the EMCDDA is publishing an in-depth study on substitution treatment in the EU.

Questions and assessment

This issue raises a series of questions:

- What is the impact of the growth of substitution treatment on public health consequences such as drug-related deaths and infectious diseases, as well as on social consequences such as drug-related crime and the illicit market?
- Are substitute drugs such as methadone involved in overdoses?
- What is the long-term outcome of substitution treatment?
- What are the expansion limits of substitution treatment (in terms of capturing a higher proportion of the dependent population)?
- What is the relationship between substitution treatment and other services such as psychosocial support or drug-free treatment?
- What are the consequences of different modalities for delivering substitution treatment (the increasing role of GPs, the involvement of pharmacists, the impact of 'take-home' drugs)?
- What are the needs of target groups who are not reached by existing substitution programmes?
- To what extent can other substitution programmes, such as heroin prescription, meet needs that cannot be achieved through extending and improving methadone and associated services?
- How can the broader social, economic and environmental correlates of problematic opiate use be addressed?
- What responses are needed for younger users, those who are not yet dependent or who are smoking heroin?

Some possible answers?

Given the scale of substitution services across Europe, there are only limited data on research and evaluation of treatment processes, its benefits and the factors associated with good treatment. These include the quality of the management and organisation of services, and of the staff, and the level of multidisciplinary and interagency work to ensure good relations and links across a range of community institutions. Alongside drug-free treatment, there is now a substantial consensus on the benefits of methadone maintenance. Systematic reviews of this area indicate that treatment can improve psychological and social well-being, and reduce illicit heroin use, criminality and HIV transmission. However, further research is needed to determine the role of such treatment in reducing hepatitis C transmission.

French alternative

In France, the prescription of buprenorphine has increased rapidly since its introduction in 1996. French GPs prescribe buprenorphine to about one third of heroin users who consult them. According to the 1998 Inserm evaluation study, 'Evaluer la mise à disposition du Subutex pour la prise en charge des usagers de drogue', ('Evalution of the use Subutex for the treatment of drug users') the social background of such clients is usually poor and clients are generally older users (45 % are over 30 years of age).

After one year, the progress of around 69 % of these clients is still monitored by their GP. Of this group, 9 out of 10 are still taking buprenorphine. Although overall heroin consumption has fallen by 43 %, just over one fifth of users are still injecting, but in many cases buprenorphine is also injected. It is thought that users continue to inject because they are dependent on the ritual itself and its social context (injecting with others), and because the effect of the drug is insufficient if taken orally.

Deaths seem to have occurred from mixing buprenorphine and benzodiazepines, particularly in countries with a high level of substitution medication where combining it with benzodiazepines is also frequent.

Training for both generalists and specialists and good models for working together are necessary if services are to continue expanding and high standards maintained. Models of delivery range from the purely specialist to predominantly primary care, but better integration between these approaches is needed. Pharmacists are also taking an increasingly active role in substitution treatment.

Diversion- and methadone-related deaths continue to be substantial problems in some countries. Countries with lower levels of supervision are more likely to report higher rates of diversion. Overall, countries with high levels of control tend to reduce them in order to improve access while countries with low levels of supervision tend to increase control.

Methadone is by far the most common opiate substitute in the EU, although in France the prescription of buprenorphine by GPs has risen steadily since 1996. In Portugal, treatment with LAAM, a substitution medication with a longer effect than methadone, has been established over the last six years, while Denmark and Spain have recently begun experiments with this medicine.

Over the past five years, there has been a substantial growth in the evaluation of treatment. The science and treatment evaluation culture continues to expand and has been promoted through research and training networks across the EU. Large-scale national treatment evaluation projects, such as the 'National treatment outcome research study' (NTORS — www.ntors.org.uk) in the UK, and several smaller-scale outcome evaluation studies have been carried out.

Heroin prescription

In 1998, an experiment to supply heroin on strictly medical grounds began in the Netherlands, following an earlier study carried out in Switzerland. The selection criteria the addicts have to meet before entering the programme are strict and only problematic addicts with a long history of unsuccessful treatment are admitted. Although first reports describe the challenges faced in the first six months, results show that it is possible to organise and carry out this complex experiment.

Medical heroin prescription was also under discussion in 1998 in Denmark, Germany and Spain, and continues at a low level in the UK. In 1999, the German federal government plans rapidly to implement former initiatives of the *Bundesrat* (the federal chamber of the German *Länder*), in particular to carry out a scientific trial on heroin maintenance treatment with long-term addicts who failed with other treatments.

In Luxembourg, the Prime Minister has confirmed the government's will to implement a small-scale heroin distribution programme. The pertinent bill still has to be voted on in Parliament.

Community responses to problem drug use

A broad, although ill-defined, range of drug-use patterns in the EU involves more than experimental or intermittent recreational use but is not usually reflected in problem indicators such as treatment demand and not covered by the prevalence estimates of problem drug use. These

patterns include the use of amphetamines, ecstasy and other drugs by young people, multiple use of medicines, alcohol and illicit drugs by various age groups, and increased heroin smoking by different groups in different populations.

Responses to drug use by younger people mainly focus on synthetic drug use (see Chapter 3). However, some initiatives for experimental users of different drugs have been reported from Belgium, Denmark, Greece, Spain, France and Austria. Often, these try to involve the young people in alternative activities within and outside the educational system, increase the awareness of drug behaviour and other life choices, and involve peers, parents and teachers in activities.

Danish help for the young

The Danish project Tjek-Punkt ('Checkpoint') aims to (re)establish a constructive relationship among teenagers from the most deprived backgrounds. These young people can go to the Tjek-Punkt without an appointment and can receive a meal, use the telephone or simply talk to the staff. The Tjek-Punkt works because visitors come of their own free will and are guaranteed anonymity. The help offered can extend to both fieldwork and case work. The project aims to motivate these youngsters to ask for and receive treatment — even to be rehoused — to seek other kinds of help and to encourage them to become involved in their own future.

Such initiatives frequently focus on general social and health issues, as well as on illegal drug use. For example, the committees on social environment in France are active in 20 % of secondary schools. These committees are instrumental in changing the relationship between pupils and adults and promote participation and the assumption of responsibility by all players.

Problem drug use, and in particular chronic drug dependence, is linked not only to individual difficulties requiring specific interventions such as treatment, but also to more structural, social factors requiring responses at community level.

Social exclusion

Social exclusion and drug problems are closely related to marginalised communities and individuals. Many drug services report that the health and social conditions of their (often ageing) clients are deteriorating. This suggests that both structural responses and more specific interventions are needed. Some community development programmes, together with outreach work and low-threshold services, take this into account.

Although some publicity has been given to the increasing use of drugs by relatively affluent 'rich kids', drug services are aware that problems mainly arise in socially marginalised groups and areas. There is a growing focus on the need for community work in disadvantaged areas, involving cooperation between the education, health, social and criminal justice systems, employers and non-governmental organisations (NGOs). Activities related to these groups centre on raising awareness and training.

In the Netherlands, the fundamental premise underlying most policies is that drug use should be contained and curbed, but not at the expense of stigmatising and isolating drug users socially. This approach is also seen in demand reduction strategies where the emphasis is on informing and convincing people of the hazards of drug use rather than on moral premises. Another goal of prevention strategies is to protect society itself from what the general public perceives as the danger and social nuisance caused by drug use.

In Sweden, drug policy is closely linked to alcohol measures. These two areas are in turn part of the total social policy. For the Swedes, drug schemes should be based on the fact that all citizens have the right to live their lives in dignity and no group no matter what their actions or lifestyle should be excluded from the community. An ongoing government investigation is focusing on drug use and social exclusion, and aims to explore drug use in marginalised groups as well as studying how marginalisation may lead to drug use.

North-West London Drug Prevention Team

A project was developed by the North-West London Drug Prevention Team to target young people expelled from their schools. The project developed an assessment process which helps teachers to work with these youngsters as well as a drug education programme relevant to their specific needs, including helping drug users to modify their behaviour. The scheme helps young people to address their drug-using behaviour, and at the same time ties them into a process through which they can win a youth achievement award. This is important for regaining self-respect and for pursuing further education and gainful employment in the future.

Roma and drugs

In Spain, drug addiction affects specific groups of Roma, leading to increased social, family and cultural fragmentation and alienation in a community already vulnerable. The sale of drugs by some members of the community reinforces the stereotype of Roma as drug dealers.

Generally Roma addicts do not benefit adequately from treatment and harm-reduction services. This leads to a higher rate of HIV infection among the community, although methadone-maintenance programmes have been accepted and may be a solution to this problem.

The connection between social exclusion and drugs is a main feature of the UK programme 'Tackling drugs to build a better Britain'. This scheme targets six high-risk groups on which services and activities should focus: those expelled from school; truants; children in care; young offenders; young homeless; and children of drug-using parents.

Ethnic minorities are sometimes particularly vulnerable to drug use, partly because of social exclusion. Some countries deal with drug problems in an ethnic group through specific prevention or treatment interventions. For example, following a comparative study on Luxembourgish and Portuguese drug addicts living in Luxembourg, actions targeted specifically at the Portuguese community are about to be implemented. Drug use has also been reported particularly to affect the Roma population in Spain, Portugal and Sweden.

Outreach work and early intervention

A pilot study undertaken for the EMCDDA analyses how long heroin users who undergo treatment had used the drug before first entering treatment (see Chapter 2). The study found that the younger the age of first heroin use, the longer the time lag before treatment. Heroin users undergoing treatment for the first time did so, on average, five years after first use. Younger users, however, took seven to eight years or even longer to seek treatment.

This means that treatment-demand indicators miss new epidemics among younger people and that treatment services have little contact with them. This factor raises issues of the availability, accessibility and attractiveness of treatment, and the need to investigate obstacles to obtaining treatment, especially for younger users. However, the results also suggest that latency is more importantly a function of the natural history of addiction once a certain level of treatment availability exists. If so, then treatment services do not appear to provide an appropriate basis for early interventions, especially among younger users, and alternative strategies should be considered.

The grey zone between prevention and treatment generally widens and becomes more prominent as a result of both budget cuts and the reluctance of drug users themselves to recognise the need to seek treatment. Drug services thus need to go out onto the streets where young people meet in order to make contact and offer help, including referrals to treatment centres.

Children at risk

Drug-using children are perhaps the most vulnerable of all risk groups. Specific projects aim to protect these children and help them find a way out of the drug trap, but one of the major problems they face is getting the children to seek treatment.

In Rome, children under the age of 16 when they first use heroin usually take an average of eight to nine years to enter treatment. This compares unfavourably with over-21-year-olds who generally seek treatment within three to four years of first use. Similar patterns are found in other Italian cities.

In Lisbon, a pilot project has been introduced to respond to the specific needs of children and groups of high-risk young people such as school drop-outs, children of drug users and children from broken homes or criminal backgrounds.

The project team identified areas where such youths congregated and then began promoting various activities designed to draw the children into a wider social setting. Artistic and socio-educational pastimes designed to stimulate acceptable social behaviour and to gain trust helped workers to approach the target group and in some cases allowed them to refer children to other services.

Outreach work may have different objectives. Street workers may be seen as local resources who pick up signals and encourage young people to integrate into the community. Such workers may give advice on safer sex and drug use to help prevent infectious diseases, as well as counsel and help drug users to contact support services. Some outreach initiatives also provide help within drug-user groups.

Public nuisance and community safety

Public order and nuisance issues are a high priority in many Member States. In the Netherlands in 1998, the public prosecutor introduced guidelines for 'coffee shops' stating that those causing a public nuisance can be closed. In Belgium, a new law passed in November 1998 allows the authorities to close public places where drug offences are committed.

Challenges for healthcare systems

Mortality and morbidity

In recent years, 6 000 to 7 000 acute drug-related deaths (overdoses) have been officially recorded each year in the EU. This figure has remained relatively stable, although differences may be observed within individual countries.

The large majority of such deaths involve opiates, mainly heroin, but other substances such as benzodiazepines and alcohol are also often present. The actual number of acute deaths directly attributed to intoxication with heroin or other opiates is likely to be somewhat higher due to under-recording, but by how much is hard to assess. Acute deaths from other illegal drugs are much less commonly recorded.

If indirect deaths were also included, such as those arising from drug-related infectious diseases, accidents or suicides, and if under-reporting of acute deaths were taken into account, then the total figure would be considerably higher — perhaps by a factor of three or more.

The incidence of new cases of AIDS related to injecting drugs is decreasing, partly because of improved treatment. However, hepatitis B and especially C prevalence is high. Despite behavioural changes and a reduction in the proportion of injectors in most countries, the incidence of new infections of HIV (and probably of hepatitis) among the younger-age group and new injectors appears to be continuing. This indicates that transmission of infectious diseases is not under control and continued and expanded preventive efforts are needed.

Low-threshold services and harm reduction

Low-threshold services have existed for some time in a few Member States, and have been reluctantly introduced in others throughout the 1990s. They now exist in all EU countries, but differ in availability and type of service. Generally, they provide individual assistance, and medical, psychological and social care to mainly very deprived users, mostly older users with a long history of addiction. They offer basic services such as washing facilities, meals, needle and syringe exchanges and basic medical attention.

Day-centre care in Austria

An Austrian project known as Wald ('Forest') provides low-threshold services through a day centre where clients may find temporary work. Every day, at least eight people — drug users or homeless persons — can work for up to four hours on the basis of a daily employment contract.

The jobs include tending forests, reforestation and other similar employment. The short-term goals of the project are psychological and social stabilisation, developing the ability to work and the capacity to complete tasks. The long-term aim is to help reintegrate people into the regular job market.

Needle exchanges

Needle exchanges exist in all countries, although to a different extent. In some countries, they are less relevant as pharmacies provide free or cheap needles. Needle exchanges were introduced early in the Netherlands, Sweden and the UK, but relatively late in Spain, France and Italy, the countries most affected by HIV. However, in recent years the number of programmes in these countries has been rising rapidly. Often the rule is 'one-for-one' exchange, but in some countries, such as the Netherlands, there are exceptions to this practice at local level.

In Belgium, the supply, sale and delivery free of charge of syringes to prevent infectious diseases were made possible by a law passed in November 1998. This law states that the distribution or exchange of syringes can no longer be considered as supporting or facilitating illicit drug use and those engaging in these activities cannot be prosecuted.

Injecting rooms

The desirability, availability and status of injecting or 'fixing' rooms have been raised as issues in many parts of the EU.

In Germany, 'fixing' rooms have existed for several years in some large cities. The main purpose is to prevent fatal incidents by providing a hygenic setting and medical supervision. The new federal government is committed to providing a legal basis for these rooms which have until now operated on a precarious basis.

In Luxembourg, a parliamentary bill has been introduced which proposes setting up injecting rooms which will provide addicts with hygienic conditions and medical control.

The Netherlands has increased the number of gebruiksruimten (literally 'using spaces') available for opiate users, the majority of whom are not injecting, in both major and smaller cities. The rooms are seen as a way of reducing the nuisance level to the public of drug users.

Discussions on injecting rooms have also taken place in Denmark.

Drug users and the criminal justice system

Between 15 and 50 % of prisoners in the EU have or have had problems with substance use. The concentration of drug users within the penal system is clearly a challenge, but also presents an opportunity to confront the problem and to increase efforts where they are most needed.

Three strategies have been identified regarding demand and harm reduction in prisons:

- drug-free prison wings;
- methadone treatment; and
- involvement of local community drug services.

Syringe exchange exists in a few prisons in Germany and Spain and in the latter a memorandum to all prisons from the prison institutions' directorate recommends that syringe exchange be available in all prisons. In the UK, inmates who inject have recently been allowed sterilising tablets.

Several Member States report that overcrowding in prisons often hinders progress in this area. Lack of training of prison personnel is another problem. Consistency of treatment is also often lacking between prisons and between the prison and the community. This can lead to a lack of continuity for drug users who pass from the penal system into the community or for users from the community who are committed to prisons.

Treatment in prison yields results

Little evaluation of treatment in prison has been carried out with sufficiently representative samples. Nevertheless, information from evaluations of methadone-treatment programmes in prisons in Spain gives some indication of the positive benefits accruing to prisoners undergoing treatment. The key findings are that:

- subjects under treatment display less aggressive behaviour;
- patient participation in treatment activities is increasing;
- inmates in treatment exhibit greater self-control;
- treatment programmes are retaining more subjects; and
- the habit of sharing hypodermic syringes is decreasing.

Alternatives to prison

An EMCDDA study, 'Alternatives to prison in cases of drug addiction', gives an overview of the various options available in the Member States studied. The following alternative measures are used throughout the EU:

- postponement of legal proceedings or of a sentence;
- parole;
- exemption from prison term;
- suspension of application of the sentence;
- replacement of prison term;
- exemption from criminal responsibility; and
- other special formulas for applying a prison sentence, such as partial liberty, charging the custody of the offender to a third party or integrating the jailed drug addict into a daytime detoxification programme (with the obligation to return to prison at night) and other variations.

The application of such alternatives, however, is limited in practice and some existing legal alternatives are not sufficiently used.

Hope offered to convicted addicts

A forensic addiction clinic for drug users resisting regular care and treatment opened in 1998 in the Netherlands. This is a new, experimental facility to treat criminal addicts who are admitted for compulsory care on remand under a suspended detention order. The clinic's programme has three stages: intramural, semi-mural, and re-socialisation. In the final stage, clients are supported while learning to live independently again.

Those attending the clinic must complete a long-term programme whose main elements are work-related projects. The aim is to offer the most appropriate mix of treatment, practical and social skills, and labour and educational projects to each individual.

Long-term addicts who have committed a series of criminal offences and who require intensive care are eligible to join the scheme. Admission to a regular clinic would not be appropriate because of the severity of the addiction and/or of the criminal activities of the addicts, or because of repeated failure to complete treatment.

In its first four years, the clinic will operate as a scientific experiment. The first evaluation results will be published in 2000.

Compulsory care

Only the Netherlands and Sweden report compulsory care, although the choice of terminology might very well hide the fact that there is more or less compulsory care in most EU countries when addicts have to or can choose between imprisonment or treatment alternatives.

In Sweden, the use of compulsory care has declined sharply. Some form of specialised treatment has been interchanged with regular treatment and out-patient contacts in recent years. Although the costs of substance use treatment may be unaffected, the services are not.

Policy changes regarding drug offenders

The principle of therapy instead of punishment has been adopted as extended in the general guidelines of the drug policies in a growing number of countries. For example, in Germany the federal strategy affirms priority of treatment and also emphasises the importance of harm reduction, in Ireland where a project for a drug-court system is being developed and in Austria under the revised Narcotic Substance Act (1 January 1998).

Some Member States have consolidated social and medical support towards drug-addicted offenders using the first contact with enforcement authorities as a door to treatment or counselling facilities. Behind the general principles, insufficient resources are, in practice, allocated for treatment and care. In some countries, for example Austria, the principle of legality makes it mandatory for police to report and prosecute drug offences such as possession, thus creating a contradiction between medical and psychosocial approaches to the problem and law-enforcement activities.

To reduce this contradiction, the judicial systems in most EU countries are moving towards legal instruments and facilities allowing small-scale offenders with drug problems to avoid prison. This trend, which is more evident in some countries than in others, is prevalent enough to be defined as a pan-European phenomenon.

In addition, prosecution for minor drug-related offences relating to cannabis (possession of small amounts for personal use) seems increasingly deferred or social measures such as counselling preferred to legal recourse.

Prevention and health promotion

Family, parents and schools all have a role to play in preventing drug use. School is still the main setting for prevention activities and more countries now believe that these should start as early as possible. School is possibly one of the best ways of reaching the majority of children and as teachers generally take their job seriously, programmes introduced through the education system can have a real impact. Substantial evidence shows that school programmes can at least postpone drug use among young people. Preventive activities do not stop in the compulsory educational system and more countries now extend such work into universities.

Teacher training and parental involvement are crucial and are promoted throughout the EU, although the role of the family, and especially parents, varies. In southern Europe, the family is seen more as a support, while in northern Europe the responsibility of the parent is stressed.

Schools lead the way

In 1998, in Belgium, a new tool was designed for use in secondary schools. It was based on materials previously developed as part of the national drug policy towards schools and introduced to allow school drug policies to be evaluated.

By providing all pupils with questionnaires and focusing on their attitudes towards a variety of activities including smoking, drinking and illegal drugs, actual drug use, as well as the pupils' opinion of the drug policy at school, can be estimated.

The questionnaire results can give the school authorities an indication of the atmosphere in the school and can demonstrate what pupils would like to see change. The school receives the results together with recommendations for prevention activities, how to work with parents on the issue and suggestions for adopting and optimising drug policies.

A school programme, 'Walk Tall', was developed in Ireland in 1996 and introduced into urban primary schools throughout the country. It forms part of a new subject — social, personal and health education — being introduced into the primary school syllabus from September 1999.

'Walk Tall', which adopts a whole-school approach, focuses on active learning and the development of self-esteem, assertiveness and decision-making skills to help children withstand pressures to use drugs. It emphasises self-respect, emotions, influences, decision-making and drug awareness and is based on the premise that self-confidence and its association with substance misuse have an important role to play in preventing abuse. The programme will be extended to all primary schools over the next two years.

An evaluation (Morgan, 1998) concludes that the approaches adopted by the programme are most effective in preventing substance abuse and reports a high rate of satisfaction among participating teachers. A full evaluation of the programme is expected at a later date.

Policy developments

Towards a balanced approach

Striking a balance between demand and supply reduction is a major political consideration. From a global point of view, political approaches to the drug problem in Europe show a gradual progression from the repressive positions prevalent in the past decade to strategies that focus more on prevention and treatment and the need to reduce the risks caused by drug use.

Overall, drug policy in Europe takes the middle way between repression and tolerance. There exist both pragmatic policies reflecting the fact that illicit drugs are available and require a range of responses (including socio-medical) to limit their use and harmful consequences, and strong law-enforcement approaches to drug-related crime to protect public order and reduce the supply and availability of illicit drugs. The evolution of drug laws and strategies reflecting governmental concerns to adopt alternative approaches to pure repression is a barometer of these new trends.

In Austria, a new law, the Narcotic Substance Act, replaced the Narcotic Drugs Act in January 1998. Under the new law, alternatives to criminal prosecution and the therapy instead of punishment model — principle first introduced in 1980 — now apply to petty offences involving the acquisition of illegal substances. Rules pertaining to withdrawal of the police report on first-time consumers of cannabis have been eased. In health policy, pain therapy, withdrawal and substitution treatments were given a firmer legal basis and the range of health-related measures provided by the law was extended. In addition to medical treatment and supervision, health-related measures now also include substitution treatment, psychotherapy, psycho-medical and socio-therapeutic treatment and care.

Important practical changes to Germany's narcotic law came into effect on 1 February 1998. These include facilitating the regulation of prescribing narcotics (BtMVV) for pain treatment and for methadone maintenance treatment. Current drugs policy strengthens harm reduction and treatment prior to punishment, clarifying the legal position of injecting rooms and introducing experimental projects on medical prescription of heroin.

In Greece, special treatment can now be provided for addicted drug users who kick the habit on their own without entering a detoxification programme.

In Ireland, a pilot project to set up a drug-court programme is being developed. In addition, a new regulation lays down rules for prescribing methadone.

In Italy, the suspension of the detention order for drug addicts has been extended to a four-year penalty from its normal three years.

In 1998, in Portugal, a national strategy committee was created and aimed to establish new orientations and priorities in the national drug policies. Modifications of drug laws were recorded in the field of treatment and rehabilitation.

One of the aims of the UK's strategy 'Tackling drugs to build a better Britain' is to reduce the number of young people abusing drugs. The Crime and Disorder Act 1998 created parenting orders that hold parents responsible for the behaviour of their children. The Drug Treatment and Testing Order, a key component of the UK strategy, aims to strengthen treatment options for drug users and offenders.

Harm reduction

After years of semi-marginal status in many countries, harm reduction is increasingly recognised as an important tool in national and local drug policies. Debate now focuses mostly on the scientific evidence. Projects aim to give legal, professional or political recognition to a range of activities described above, such as needle exchange, injecting rooms or substitution treatment, which attempt to reduce the health and social damage caused by drug addiction.

Discussions are still intense on the interpretation of the precept establishing the use of scheduled drugs only for medical and scientific purposes as laid down in UN conventions, and laws prohibiting the delivery of narcotic substances and instruments for drug use (Article 4 of the 1961 UN Single Convention on Narcotic Drugs, and Article 5 of the 1971 UN Convention on Psychotropic Substances). This still leaves some fine-tuning to be achieved between prohibiting use and possessing narcotics and the more pragmatic philosophical approach behind harm reduction measures.

Decriminalisation

Prohibition of possession and/or use of drugs is the general concept followed by all 15 EU drug control systems. Legalisation is not considered an option in any national drug policy. Nevertheless, Member States are aware that the prosecution and imprisonment of individuals with drug problems cause even greater problems.

At the same time, the thin grey line of the past years between users and traffickers has widened in Europe under new drug strategies that focus on issues such as prevention, help and treatment for drug users even if they are convicted offenders, and punishment for drug traffickers even if they are users.

Drug consumption, in general, seems not to be prosecuted in most EU countries. However, debate continues on how to deal with consumers in possession of small quantities of drugs for personal use, or who commit petty crimes because of their drug dependence.

Developments in European drug policies and new legal approaches towards illicit drugs show a shift towards decriminalising some behaviour linked to consuming and possessing drugs for personal use, notably when this is related to drug dependence. Most Member States reject extreme solutions — such as full legalisation or harsh repression — but continue to prohibit drug consumption while modifying the penalties and measures applied to it.

In Belgium, a directive issued in 1998 harmonises the action of judicial authorities. For the first time, a distinction has been established between possession of cannabis for personal use and other illegal drugs with non-acceptable risks for health. The possession of cannabis for personal use remains an offence, but attracts the lowest prosecution priority if pursued. In the case of a one-time or occasional user of cannabis, a simplified police report is filed and, as with all other drug offences, the drug is seized.

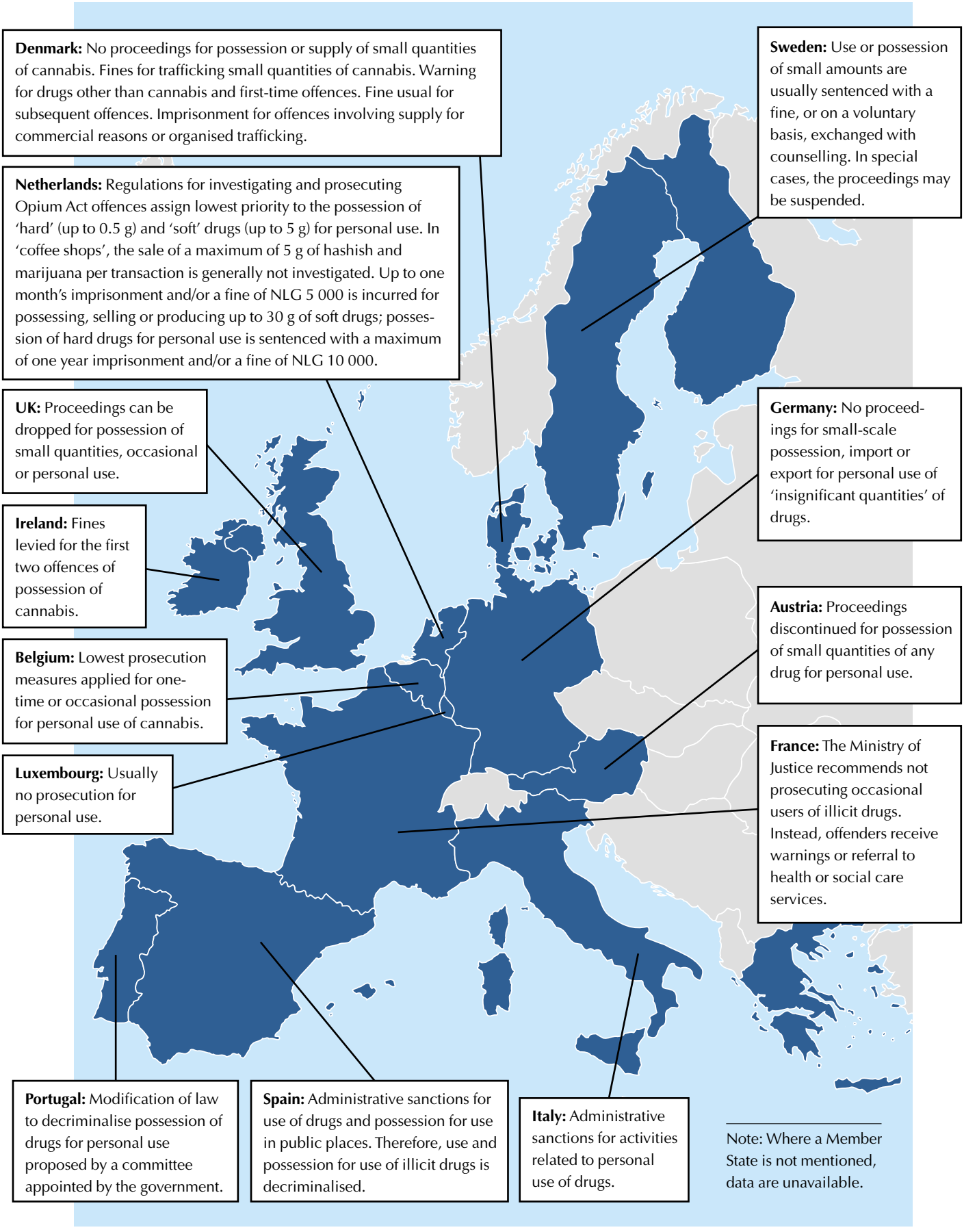
In Luxembourg, a new law proposes decriminalising reduced-risk substances (like cannabis) and re-scaling penalties.

Decriminalisation of illicit consumption and possession for personal use in Portugal is being considered. This, together with other measures, forms the government's strategy and represents an overall modification of the country's drug law.

Theory and practice

Although the trend in many Member States, as seen in policy statements, is to reduce the emphasis on prosecuting and imprisoning drug users, the other side of the coin reveals increased enforcement activity. For example, police arrests and indicators of drug use in prison suggest some need for fine-tuning theory and practice within some areas of the criminal justice system. The number of police arrests, apparently more for use-related offences than trafficking (see Chapter 2), is increasing in most Member States with cannabis being the main drug involved.

Summary of EU responses to minor drug-related offences



Denmark: No proceedings for possession or supply of small quantities of cannabis. Fines for trafficking small quantities of cannabis. Warning for drugs other than cannabis and first-time offences. Fine usual for subsequent offences. Imprisonment for offences involving supply for commercial reasons or organised trafficking.

Sweden: Use or possession of small amounts are usually sentenced with a fine, or on a voluntary basis, exchanged with counselling. In special cases, the proceedings may be suspended.

Netherlands: Regulations for investigating and prosecuting Opium Act offences assign lowest priority to the possession of 'hard' (up to 0.5 g) and 'soft' drugs (up to 5 g) for personal use. In 'coffee shops', the sale of a maximum of 5 g of hashish and marijuana per transaction is generally not investigated. Up to one month's imprisonment and/or a fine of NLG 5 000 is incurred for possessing, selling or producing up to 30 g of soft drugs; possession of hard drugs for personal use is sentenced with a maximum of one year imprisonment and/or a fine of NLG 10 000.

UK: Proceedings can be dropped for possession of small quantities, occasional or personal use.

Germany: No proceedings for small-scale possession, import or export for personal use of 'insignificant quantities' of drugs.

Ireland: Fines levied for the first two offences of possession of cannabis.

Austria: Proceedings discontinued for possession of small quantities of any drug for personal use.

Belgium: Lowest prosecution measures applied for one-time or occasional possession for personal use of cannabis.

Luxembourg: Usually no prosecution for personal use.

France: The Ministry of Justice recommends not prosecuting occasional users of illicit drugs. Instead, offenders receive warnings or referral to health or social care services.

Portugal: Modification of law to decriminalise possession of drugs for personal use proposed by a committee appointed by the government.

Spain: Administrative sanctions for use of drugs and possession for use in public places. Therefore, use and possession for use of illicit drugs is decriminalised.

Italy: Administrative sanctions for activities related to personal use of drugs.

Note: Where a Member State is not mentioned, data are unavailable.

At the same time, the number of drug users and problem drug users in prison is high in most Member States for which data are available. While some are imprisoned for dealing or trafficking, many appear to be users imprisoned for other offences.

The blurred line between licit and illicit drugs

A growing issue in drug policy concerns the extent to which it is useful to maintain the traditional distinctions between illicit drugs such as cannabis and cocaine, licit recreational substances such as alcohol and tobacco, and licit psychoactive medicines such as tranquillisers and analgesics. The status of other substances such as solvents and steroids adds a further dimension to this debate.

It is clear from a variety of epidemiological indicators that illicit drug-use patterns frequently also involve licit substances, notably alcohol, tobacco and tranquillisers (taken for non-medical purposes). The more problematic patterns of drug use, in particular, are characterised by multiple use of licit and illicit substances, while treatment centres are reporting more poly-drug use. It is not clear if this represents a change in perception or a real change. Experts suggest it is probably both.

This reality has long been recognised in the prevention field and prevention initiatives are generally geared to preventing the use of any drug, whether illicit or licit. Increasingly, this trend is also being recognised in the treatment field and, as noted earlier, there is a tendency towards merging care for those experiencing problems with illegal drugs, alcohol or prescription drugs.

The trend towards a more unified approach to licit and illicit drug use is also reflected in developments in some Member States.

The French Government recently decided that the authority formerly dealing with illegal drugs only, the Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT), and the French National Focal Point, the French Observatory for Drugs and Drug Addiction (OFDT), would in future be responsible for issues involving legal drugs, including alcohol and tobacco. In Germany, the Netherlands and Austria, this policy has been followed for some time.

In the German language, the term 'addiction prevention' rather than 'drug prevention' is used.

These developments have important implications not only in the fields of prevention, harm reduction and treatment, but also for the legal bases of an integrated approach. It is not clear how this will evolve in the future.

Cooperation between sectors

In an area where so many factors are interrelated and so many authorities and organisations participate, positive results will only be achieved if all parties cooperate. Across Europe, cooperation between the health, social, education and criminal justice systems appears to be improving, and there is less rivalry than before. Cooperation occurs both at national level between ministries and at local level where the police work with social workers and teachers. The primary health sector is also becoming more involved.

At the same time, the borders between prevention and treatment are blurring. Drug users at different stages depend on varying structures for help. The nature of drug use is characterised by ups and downs and this affects the way prevention and treatment are implemented and used. In most countries, outreach work and low-threshold facilities are developing quickly. More traditional structures do not cater for all needs while these newer facilities are seen as providing a valuable service. Cooperation between the criminal justice system and the health and social sectors is also developing with diversion schemes for drug-using offenders and projects for imprisoned drug users, although much remains to be done in these areas.

Developments in national coordination

A clear trend in recent years has been the development of horizontal drug coordination bodies within national administrations. These groups coordinate national drug strategies and reinforce local authorities which implement national political and legal guidelines. In 1998, coordination between these two levels strengthened, underlining the importance and effectiveness of national coordination mechanisms.

In Austria, competence in the field of drugs is held at federal level by the Labour, Health and Social Affairs Ministry (FMLHSA), with two departments primarily responsible for drug-related issues. One department deals with treatment and addiction prevention, the drug casualties register and, since summer 1998, legal matters connected with drugs and drug addiction. Also in summer 1998, responsibility for the coordination of drug-related issues was transferred to the head of the pharmaceuticals group. This group includes the Austrian Narcotic Drugs Monitoring Agency (ANDMA), which is responsible for maintaining the register of personal drug-related data and for monitoring activities concerning substitution treatment.

In Germany, the office of the commissioner for drug issues of the federal government transferred in 1998 from the Interior Ministry to the Health Ministry, illustrating the growing emphasis on the social and health aspects of drug dependency. The national advisory board on drug issues will be chaired by the Health Ministry's drug commissioner. Drug-related regulations require the approval of the *Bundesrat* (federal chamber of *Länder*) and the *Bundestag* (federal parliament). Drug and addiction representatives of health ministers in the 16 *Bundesländer* have regular meetings in the Committee for Addiction Services. A third coordination body is the Standing Working Group of Drug Commissioners, traditionally chaired by the Federal Health Ministry.

In Ireland, coordination has been allocated a high priority with the institution of a Cabinet Committee on Social Inclusion and Drugs which is chaired by the Taoiseach (Prime Minister). This committee is serviced by a high-level interdepartmental group. A Minister of State at the Department for Tourism, Sport and Recreation is responsible for coordinating the national drug strategy through, *inter alia,* the National Drug Strategy Team. This team includes representatives from relevant government departments and agencies, along with representatives from the voluntary and community sectors. Integration is also a feature of the integrated services process and the work of the local drug task forces.

In 1999, the post of national drug monitor (NDM) was created in the Netherlands.

In 1998, the Portuguese Government restructured the coordinating structure known as 'Projecto vida'. The national coordinator was given the tasks of promoting interdepartmental coordination in developing the activities of the various services involved in drug addiction prevention, representing Portugal at international level in drug-addiction prevention matters, and setting up the Technical Monitoring Commission composed of delegates from the competent ministries to support and assist him in his work.

In Spain, an order of 24 November 1998 issued by the Ministry of the Interior establishes the functions, composition and structure of the advisory council of the Spanish Observatory on Drugs and Drug Addiction. The observatory is the official body providing support and advice to the government members of the national plan on drugs (PNSD).

In the UK, the first anti-drugs coordinator has been appointed, along with a deputy — both acting as governmental expert advisers on action against drugs, and on ways to increase the profile of drug policies and improve coordination of local and national strategies. The anti-drugs coordinator chairs a new body, the Anti-drugs Strategic Steering Group, which meets regularly to help assess overall progress in implementing the strategy. The deputy coordinator addresses the four main areas of the strategy — young people, communities, treatment and availability — through four newly formed strategy support groups which report to the steering group. Under the strategy, drug action teams (DATs) operate as strategic planners at local level and are the main mechanism for pooling resources. They also work together on a regional basis to ensure county-wide coherence in strategic plans.

Similar organisational changes to improve coordination have also been introduced in Ireland and Portugal.

Finnish initiative

Since 1996, Finland has had an ombudsman for substance abusers. Working throughout the country, the ombudsman gives counselling in legal matters relating to services and safeguards the clients' legal rights in issues concerning municipal financial obligations, sickness pay and other financial matters, as well as data protection. The first report on the ombudsman's activities was published in 1998.

Developments in European cooperation

European Drug Prevention Week (see Chapter 3) was the main action funded by the programme of Community action on the prevention of drug dependence in the year 1998. The three other priorities for this programme for 1998 were 'Young people and synthetic drugs', 'Particularly vulnerable groups and preventive and health actions linked to drug tourism' and 'Support for exchange of information and experiences' through 'Improving practices in Europe'. The budget allocated to these four actions in 1998 was ECU 5 million. Community funding was also provided for projects focusing on the reintegration of marginalised groups, including addicts, into the workplace. The estimated annual budget for these projects within the Employment-Integra initiative was ECU 15 to ECU 20 million. A further ECU 11 million was provided for candidate countries in central and eastern Europe within the Phare multi-country programme for the fight against drugs.

These are just a few examples of European cooperation. But Europe is also improving its cooperation in other

areas. For example, the Euregio cross-border partnership between Belgium, Germany and the Netherlands uses outreach workers from all three countries. Similarly, the treatment of drug addicts at the Centro Italiano di Solidarietá in Rome was an essential source of inspiration for the Danish project 'Human being'. By the end of a three-year trial period, an external evaluation found that the project had succeeded in obtaining and adapting the treatment model, but that it had also become very much like treatment in other Danish socio-educational treatment centres.

Nordic cooperation and exchange of experiences have a long history. A common research centre, the Nordic Council for Alcohol and Drug Research, is financed by the Nordic Council of Ministers.

The Mondorf Group coordinates activities in Luxembourg and the border regions of Belgium, Germany and France.

Information, evaluation and research

Progressive harmonisation of epidemiological indicators

Improving comparability is a central task for the EMCDDA. The Centre has been working with scientific experts and partners from various national focal points (NFPs) to develop five key epidemiological indicators on the prevalence and health consequences of drug use. At an October 1998 meeting, the Centre's Management Board adopted a key paper on the role and financing of the NFPs. From 1999, the focal points are committed to ensuring that use of these indicators is implemented to a set timetable.

The five indicators concern:

- surveys of drug use, behaviour and attitudes in the general population;
- prevalence estimates of problematic drug use;
- demand for treatment by drug users;
- drug-related deaths, mortality and causes of death in drug users; and
- drug-related infectious diseases (HIV, AIDS, hepatitis B and C).

Although the nature of the standards to be implemented varies according to the indicator, each will include a core data set, definitions and methodological guidelines for data collection, analysis and reporting.

Since structures for collecting data on each indicator differ between Member States, and the NFPs themselves vary considerably in terms of their expertise and potential to influence the implementation of standards, the first task will be for each focal point to identify realistic targets and implement concrete work plans for progressively achieving these targets. It is important that the NFPs establish national reference groups made up of key partners and experts to carry out work on each indicator. They must also ensure that national authorities are committed to this task and offer both political and institutional support.

Although the EMCDDA is optimistic about progress, comparability across the EU will not be achieved quickly or without difficulties. Improved comparability of statistics must be accompanied by measures ensuring the quality (including training), interpretation and understanding of data in a national and local context.

Improving evaluation

Evaluation practice has improved in the EU, although many gaps still remain in terms of scientific and financial support and in the awareness of relevant professionals of the necessity and benefits of evaluation. This can result in assessments that are not scientifically sound or in total resistance to evaluation. The EMCDDA's 'Guidelines for the evaluation of drug prevention' and the promotion of its exchange on drug demand reduction action (EDDRA) information system by the NFPs put evaluation on the agenda of national administrations and professionals alike. Several countries, such as France and Italy, have developed their own evaluation guidelines on the basis of the EMCDDA's guidelines. Other countries, such as Luxembourg and Portugal, are developing evaluation systems based on EDDRA.

Research

For the first time, drugs are specifically included in the EU's research programme. European Commission Directorate-General XII (Science, Research and Development) has implemented its fifth framework programme (1998–2002) which refers to drugs in the context of public health research. This provides an excellent opportunity to strengthen the scientific knowledge base needed to improve the understanding of drug-related problems and to develop evidence of the impact and effectiveness of public health responses.

Overall trends

Trends in drug use

Cannabis

• Considerable differences remain between countries in the extent of cannabis use. However, there are indications of a convergence in prevalence levels (higher-prevalence countries: stable or some decrease after increases over the 1990s; lower-prevalence countries: increase in recent years).

• A tentative, conservative extrapolation from recent surveys suggest that over 40 million people in the EU have used cannabis (about 16 % of the population aged 15 to 64) and that at least 12 million have used it in the last 12 months (about 5 % of people aged 15 to 64).

• These proportions are higher among young people. On average, about one in five adolescents aged 15 to 16 report that they have used cannabis, and by the time they reach their mid-20s, the proportion approaches one in three.

• Some increase in treatment demand for cannabis is noted in several countries especially in younger clients.

• In most countries, cannabis is the main drug involved in arrests for drug offences, mostly related to use rather than trafficking.

• The quantities of cannabis seized per year are stable, although the number of seizures is steadily increasing. Availability remains high across most of the EU and the cannabis market appears entrenched with mostly stable prices.

• In much of the EU, cannabis use is not associated with any specific social or recreational context nor with any particular group.

Amphetamines, ecstasy, LSD

• Public concern about 'synthetic drugs' rose in the 1990s in response to the adoption of ecstasy and related drugs within a mass recreational and music culture known as 'rave', 'techno' or 'dance' that mostly involved mainstream youth. The most recent development is one of diversification regarding the drugs that are used and the contexts and manner in which they are used.

• The dominant trend, confirming last year's annual report, is a long-term, and continuing, rise in the availability and use of amphetamines. Within the broader recreational youth culture, amphetamines are mostly taken by sniffing (powder) or orally (as pills or added to drinks).

• Ecstasy continues to be available and used not only within recreational dance and party settings, but also in more private situations, although there are considerable differences between countries. Recent evidence from several countries suggests a stabilisation or decline in the level of use (seizures also show an overall decrease) and some disenchantment with pills sold as ecstasy. Analyses of ecstasy pills show wide variations and, periodically, high levels of amphetamine content.

• The patterns of diversification in use are hard to define precisely. Various reports point to increased interest in stimulant-type drugs such as amphetamines and/or cocaine in some situations and in hallucinogens such as LSD or mushrooms in others. The use of drugs with sedative effects, such as heroin or benzodiazepines, is also reported, especially in heavy consumers of ecstasy or amphetamines.

• Other patterns reported in this context, and in particular reflected on the Internet, include the use of, or experimentation with, different substances, including for enhancing sexuality, developing physical or mental capacities, or self-medication of psychological states.

• In more northern countries, amphetamines have been, and continue to be, used (often injected) by chronic, problematic drug users in more socially marginalised situations that are not usually linked to the mainstream youth drug scene.

• Apart from this more traditional, problematic pattern of amphetamine use, the increases in amphetamines and ecstasy are barely reflected in indicators such as treatment demand.

Trends in drug use

Opiates

• The level of heavy opiate use or dependence (mainly heroin) appears relatively stable across the EU. The average age of known users continues to rise slowly, although this may also reflect the expansion of substitution treatments.

• The total number of problematic opiate users is estimated to be up to 1.5 million people (4.0 per 1 000 population) in the EU, of whom about 1 million (2.7 per 1 000 population) probably meet the criteria for dependence (addiction).

• Although there are differences in prevalence between countries, differences within countries are greater and appear associated with a range of factors including social exclusion. Geographical spread outside major cities is also reported.

• There continue to be reports from several countries of increased heroin use, especially by smoking, amongst different groups. Recent studies suggest that young users take longer than average to enter treatment, so most existing indicators would not confirm this trend.

Cocaine

• The prevalence of cocaine use is lower than for amphetamines or ecstasy but higher than for heroin.

• Increased seizures and supply indicators suggest continuing steady growth in the cocaine market across the EU.

• Increases in treatment demand involving cocaine are reported from some countries and cocaine is commonly recorded as a secondary drug by heroin addicts.

• The situation regarding crack is not clear, although some growth beyond the previously limited number of localities is reported from some countries.

Multiple drug use

• The use of various medicines and/or alcohol is increasingly reported, both among problematic drug users and in recreational drug scenes.

Health consequences

• Trends in reported drug-related deaths (mainly overdoses) are stable overall, although a few countries note increases or decreases.

• AIDS incidence is decreasing in almost every country, partly reflecting improved treatment.

• HIV prevalence is stable or decreasing in general, although increases are reported in a few local studies and the continued reporting of new cases in younger age groups indicates that transmission continues.

• Prevalence of hepatitis B and C is still high (especially C) and not decreasing.

• There are reports of increasing co-morbidity (other psychiatric or organic diseases in combination with drug dependence) amongst injecting and other problematic drug users.

Law-enforcement indicators

• Police arrest mostly for use, and the proportion of arrests for trafficking is not generally increasing.

• Fairly high proportions of prison population are drug users, although they are not necessarily imprisoned for drug offences.

Trends in demand reduction responses to drug use

• Both in treatment and prevention, the borders between licit and illicit drugs are blurring.

• Between prevention and treatment, the classical interventions, many initiatives are emerging that might be termed 'outreach work', but which may have very different objectives and approaches.

• Problematic drug use is clearly linked to social exclusion and prevention and treatment options must be more comprehensive and not only deal with drugs.

• Community work is considered more and more important in preventing and managing drug use.

• Especially in southern Europe, the family as a source of support is a major factor in prevention and treatment. In northern Europe, the responsibility of parents as educators is increasingly stressed.

• Substitution treatment is expanding fast. However, psychosocial treatment, accompanying substitution treatment, is not always given the same priority.

• Primary healthcare is becoming more and more involved in treating drug users.

• Drug use is a major problem within the criminal justice system. Different options of alternatives to prison, care within prisons and compulsory treatment are developing.

• Evaluation of demand reduction activities is improving, but most activities are still not evaluated. The impact of the EMCDDA in enhancing evaluation practice is considered important.

Trends in drug policies

• Drug strategies show the still growing importance of prevention and treatment over punishment in cases of drug use.

• The aim of reducing the risks caused by drug use is emphasised by some Member States, providing a legal basis for 'harm reduction activities'.

• Political responses to minor drug-related offences aim to reduce the emphasis on prosecuting and imprisoning drug users. However, data shows that use-related offences are not decreasing in relation to overall drug-related offences.

• Some countries put new emphasis on the danger of addictive substances regardless of their legal status.

• The need to coordinate the multilateral efforts in tackling the drug phenomenon, meant that some Member States developed national horizontal bodies to oversee the design and implementation of the national drug policy.

Chapter 2

Prevalence, patterns and consequences of drug use

This chapter presents updated information on a range of indicators of different aspects of the drug phenomenon in the EU. This will help to ensure that information may be compared, where possible, between the Member States, to highlight broad similarities and differences and to comment on methodological limitations and developments.

The information is largely based on national reports provided by the national focal points, supplemented by results of published research or scientific studies carried out by the EMCDDA.

The broad areas covered are:

- the prevalence of drug use;
- health consequences;
- law-enforcement indicators; and
- illicit drug market indicators.

Although the emphasis is on national data, local or regional information is included to illustrate some of the richness and variation within countries. (See Chapter 1 for details of the five key epidemiological indicators in the EU Member States.)

Prevalence of drug use

Drug use in the general population

The extent and pattern of consumption of different illegal drugs in the mainstream population can be estimated through general population surveys. These surveys also highlight characteristics and behaviour of users, and attitudes towards drugs of different sections of the population. Information is based on self-reporting by participants and data are collected by personal or telephone interviews or by posted questionnaires.

Generally, surveys provide information on whether a person has ever tried a drug (lifetime prevalence) or has taken one recently (last 12 months or last 30 days prevalence, sometimes called 'current use'), along with socio-demographic characteristics and attitudes towards drugs.

This methodology is useful for substances whose use is relatively common and not socially stigmatised. It has more limited use for studying more marginalised forms of drug use. Such a study would require large samples, and surveys may exclude those in institutions or without a permanent address or telephone contact. New emerging trends appearing among local or closed, trend-setting groups are also difficult to identify.

National population surveys

National population surveys on drug use have been conducted in 11 Member States over recent years (the Flemish Community in Belgium, Denmark, Germany, Greece, Spain, France, Ireland, the Netherlands, Finland, Sweden and the UK). Information on Greece and the Netherlands has not been included in previous EMCDDA annual reports because only cities were surveyed or because national information was too outdated. Results from Ireland are not yet available.

Cross-national comparative analysis of survey results can help to identify and understand drug-use patterns, show international similarities and differences, and help in formulating drug policies. Differences in prevalence of

use between countries do exist, but direct comparisons should be made with caution. Such differences may result from methodological factors, such as data-collection methods, the sampling frame used or the age ranges chosen in reporting results. Social and cultural differences regarding drug use between countries may also influence the willingness to report drug use. Illegal drug use appears to be concentrated in urban areas, and the relative proportion of a country's rural and urban populations may influence its overall prevalence figures.

The EMCDDA has been working to develop common European guidelines for population surveys on drugs. These guidelines will include a set of basic common core items, which may be incorporated into broader surveys, common reporting formats and methodological guidelines. A preliminary joint analysis of several recent national surveys is also being done. This will allow exploration of the actual compliance of existing national questionnaires with the set of common core items, and will explore the possibilities of conducting research at European level on such issues as patterns of drug use or drug-using careers with existing survey databases.

Similarities and differences

Despite the differences between countries regarding the level of drug use, there are also similarities across the EU. Cannabis is the illegal substance most frequently used in all countries, whereas other drugs have much lower prevalence rates. In all cases, recent use (last 12 months) is much less common than lifetime experience. This seems to indicate that for most people drug use is an occasional experience or is discontinued after a time. Only a limited proportion of cases evolve into continuous use.

Lifetime experience with drugs

Recent surveys show that in the EU lifetime experience of cannabis in the general adult population ranges from 10 % in Finland to 20 to 30 % in Denmark, Spain and the UK. Young adults report consistently higher rates of lifetime experience with cannabis, ranging from 16 to 17 % in Finland and Sweden to 35 to 40 % in Denmark, Spain and the UK. Figures from the former East Germany and the Flemish Community in Belgium are lower, but the figures are taken from a particular social situation or from relatively outdated surveys.

Amphetamines are generally the second most prevalent substance, with about 1 to 4 % of the general EU adult population and about 1 to 5 % of young adults in Europe having experimented with them. Ecstasy has been tried by 0.5 to 3 % of the general adult population in Europe and between 1 and 5 % of young adults. Experience with ecstasy seems to be relatively more concentrated among young adults in the EU than other substances, with prevalence higher among people in their 20s. Experience with amphetamines and ecstasy among the general population seems to be significantly higher in the UK than in other countries.

Cocaine has been tried by 1 to 3 % of the whole adult population in Europe, and by 1 to 5 % of young adults. In Spain and France, cocaine has been tried by a higher proportion of the population than amphetamines.

Recent drug use

People who admit to having used drugs may include those who experimented with them long ago and never used them again. Data on recent drug use would thus give additional insight into the present situation. In this report, last 12 months prevalence is used as an indicator of recent drug use as last 30 days' prevalence figures are in many cases too low to be able to draw meaningful conclusions.

Recent cannabis use is reported by 1 to 9 % of the adult population in Europe, depending on the country: Sweden presents the lowest rates, and Spain and the UK the highest. As with lifetime experience, recent use is higher among young adults, ranging from 2 to 20 %, although in most countries figures are between 6 and 10 %.

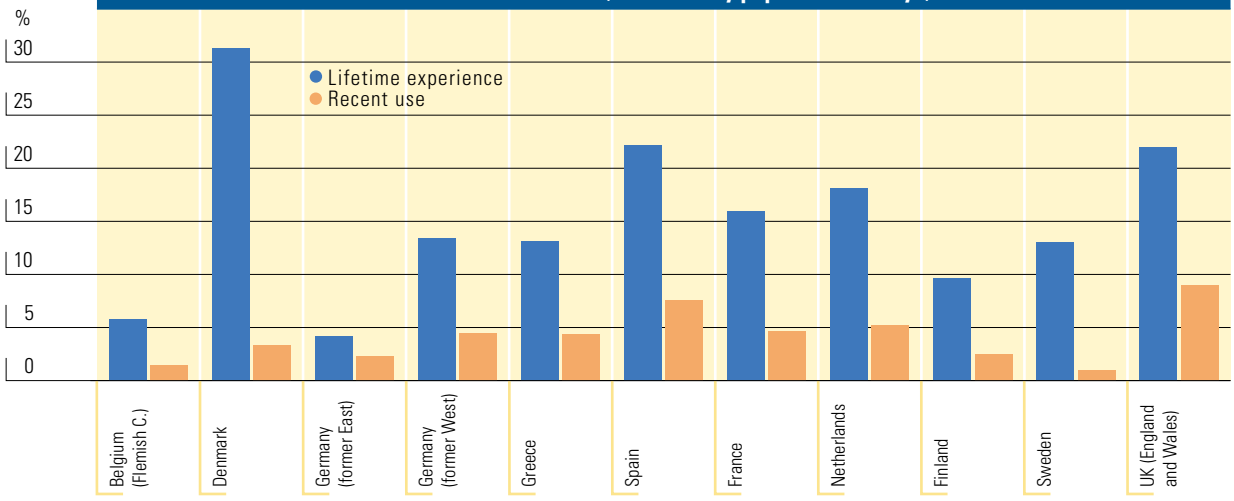
Recent use of substances other than cannabis in the EU is generally very low, rarely exceeding 1 % among the general adult population and generally below 2 % among young adults. Higher levels are reported for cocaine in Spain, and for amphetamines and ecstasy in the UK.

Trends

Consistent information on trends is limited at present as few EU countries have undertaken series of surveys using the same methods. With information presented in this report and other data contained in national reports (including local surveys or older surveys), it can be concluded that cannabis use (in terms of cannabis experience) has increased during the 1990s in most EU countries. The level of drug use in EU countries also appears to have converged, at least for cannabis experience. According with information presented in the national reports, in countries with high- or medium-level prevalence figures (Denmark, Germany and the UK), the increase seems to have levelled off over recent years. Countries with low initial prevalence figures (Greece, Finland and Sweden) show an increasing trend.

Figure 1

Lifetime experience and recent use of cannabis among adults in some EU countries (measured by population surveys)



Notes: Lifetime experience = lifetime prevalence (LTP); recent use = last 12 months prevalence (LYP). Results of the most recent surveys were used here.
For more detailed information on each survey, see Tables 1 and 2. Some Member States were unable to supply data.

Information on trends for substances other than cannabis is more limited and difficult to interpret. Figures are much lower and more easily affected by random changes (wider confidence intervals) and by methodological problems. No major changes in prevalence figures have been observed over recent years among the general population.

Cocaine seems to produce divergent trends in different countries, and amphetamine use, especially ecstasy, has increased moderately in several countries, especially among young adults.

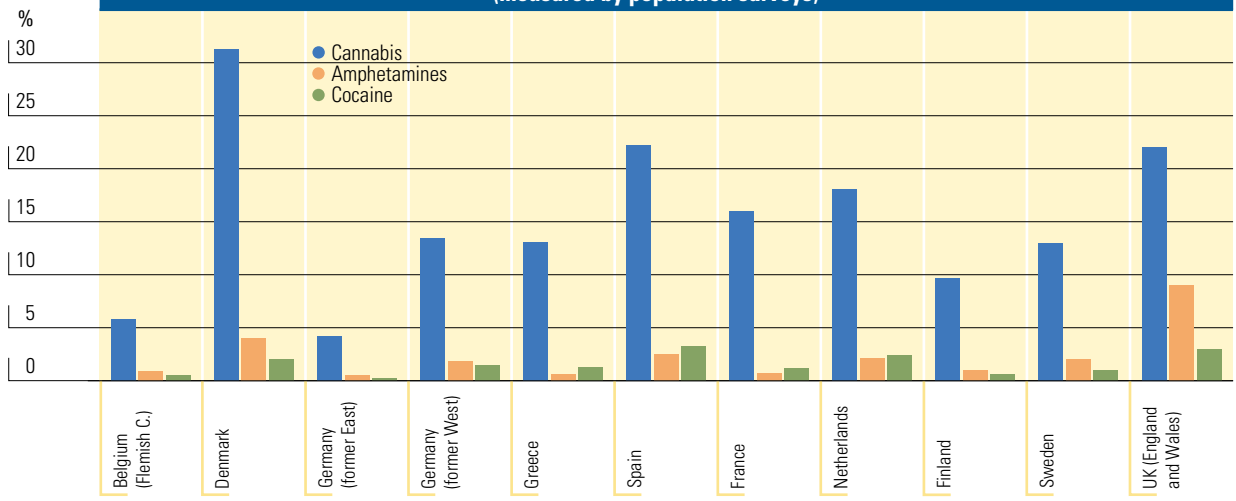
Identifying trends in use of these substances would be facilitated if the analysis concentrated on more selected subgroups of the population surveyed, such as people in their 20s living in urban areas. A good case in point is the 1994 British crime survey which reported 3 % last 12 months prevalence of ecstasy use among 20- to 24-year-olds (4 % in males and 3 % in females). The figure in the 1996 British crime survey for the same group was 6 % (11 % for males and 3 % for females).

Drug use among schoolchildren

Information on drug use among schoolchildren may be useful for assessing future trends among the general population and for planning and evaluating prevention strategies. School surveys are relatively less expensive than general population surveys because information is usually collected with anonymous self-administered questionnaires answered in the classroom.

Figure 2

Lifetime experience of cannabis, amphetamine and cocaine use in some EU countries (measured by population surveys)



Notes: Results of the most recent surveys were used. For more detailed information on each survey, see Table 1. Some Member States were unable to supply data.

School surveys generally focus on 12- to 18-year-olds, especially the 15 to 16 age range. Some new trends in drug use may not be well represented in this age group, however, and use among trendy club-goers may be better represented by adults in their early 20s.

Most EU countries have conducted national school surveys over recent years, some as part of the 'European school survey project on alcohol and other drugs' (ESPAD). This project coordinates school surveys in both EU and non-EU countries using similar questionnaires and methodology. It is coordinated by the Swedish Council for Information on Alcohol and other Drugs (CAN) with support from the Pompidou Group of the Council of Europe, an intergovernmental structure which aims to promote and support the establishment of national policies and programmes and strengthen international cooperation on drugs. In 1995, 25 European countries participated in the project. The study is being repeated in 1999 using the same questionnaire and methodology.

Methodological factors must be taken into account when comparing prevalence figures of drug use among schoolchildren between countries. Factors such as the type of schools selected and the context in which the questionnaire is administered may influence reported prevalence. The exact age of the students is important because given the limited range, one or two years' difference may double prevalence rates. The social context, such as living in an urban or rural area, may also significantly influence the onset of drug use in this age range. For example, in Finland the 1995 national school survey reported a lifetime prevalence of 5.5 % for cannabis among 15- to 16-year-olds, but in the same year, 17- to 18-year-olds in Helsinki reported a 30 % lifetime prevalence rate for cannabis.

Experimentation with drugs among schoolchildren is generally a recent experience and lifetime prevalence and last 12 months prevalence figures are far more similar than they are among adults. In this report, the age group 15 to 16 has been selected to present the results because the ESPAD project concentrates on this group. Almost all other national surveys include this age group in their studies.

Cannabis use by schoolchildren

In most EU countries, cannabis is the most widely used illegal substance. The proportion of 15- to 16-year-olds who report cannabis use ranges from about 5 to 40 %, depending on the country. The lowest rates are reported in Finland and Portugal, and the highest in Ireland and the UK. Some countries that report a low prevalence of cannabis experience report higher levels of solvent use.

Solvent use by schoolchildren

Figures on solvent use should be interpreted with caution because different questionnaires may ask for them in different ways, making comparisons difficult.

In general, solvents are the second most commonly used substance among 15- to 16-year-olds, ranging from about 3 to 4 % in the Flemish Community in Belgium, Spain and Luxembourg to 20 % in the 1995 survey in the UK. In some countries (Greece and Sweden), experience with solvents is reported more frequently than experience with cannabis, although methodological problems may influence the figures.

Other drugs used by schoolchildren

Use of amphetamines is reported by 1 to 13 % of 15- to 16-year-olds, although in most cases figures are between 2 and 8 %. Ecstasy experience is reported by 1 to 9 % of schoolchildren, and use of LSD and hallucinogens by 1 % to over 10 %, although in most cases the figures are between 2 and 5 %. Ireland, the Netherlands and the UK report comparatively higher figures for amphetamines, hallucinogens and ecstasy experience than other countries.

Cocaine and heroin present the lowest lifetime prevalence figures. Cocaine has been tried by an average of 1 to 3 % of schoolchildren. Heroin has been experienced by less than 1 % of those surveyed, although this rises to 2 % in Denmark, Ireland, Italy and the UK.

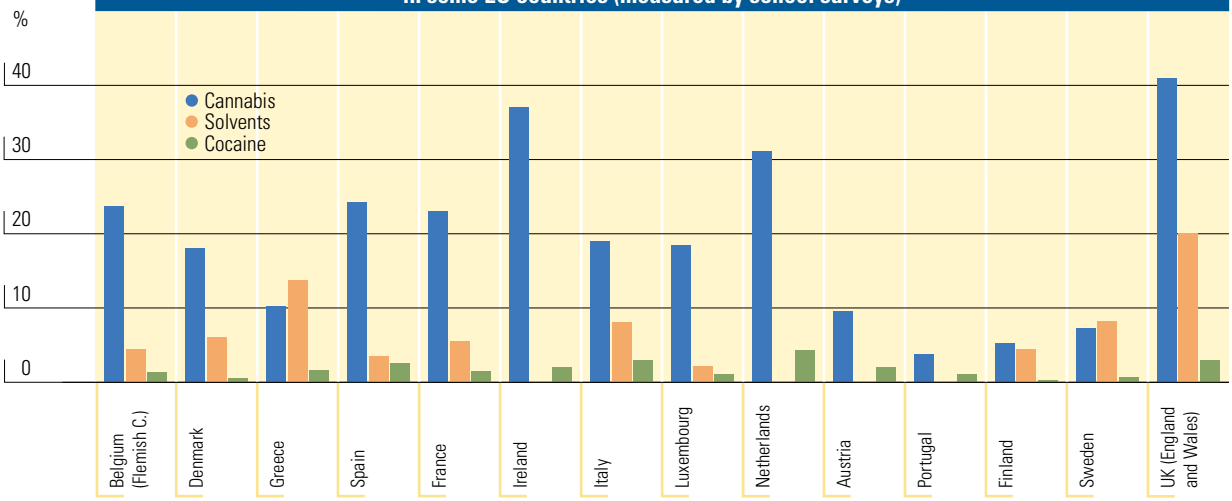
Trends among schoolchildren and young people

Several countries report information on trends in drug use among young people or schoolchildren from different sources including national school, local school, youth and conscript surveys. Most countries that have access to this information report that cannabis use has increased clearly during the 1990s, in some cases to a remarkable extent.

In general, the upward trend has continued in recent years. However, Finland and the UK reported in their 1998 national reports that after several years of increases, cannabis use among young people has stabilised or even decreased in recent years. Information on trends about other substances is more limited.

Amphetamine and ecstasy use seem to have increased in the 1990s among schoolchildren, although at lower levels than cannabis.

Figure 3 **Lifetime experience of cannabis, solvent and cocaine use among 15- to 16-year-old schoolchildren in some EU countries (measured by school surveys)**



Notes: Results of the most recent surveys were used except in the UK as the 1995 survey was more comparable with other European ESPAD surveys. For more detailed information on each survey, see Table 3. Some Member States were unable to supply data.

Estimating problem drug use

Problem drug use, such as addiction to opiates or stimulants, injecting or drug use associated with criminal behaviour, poses the highest risks to the individual drug user and to society. Consequences of problematic use include:

• extreme mortality (injectors may be at 20 times higher risk than non-drug-using peers);

• risk of infectious diseases (rates of HIV or hepatitis infection may be 10 to 100 times higher); and

• loss of educational opportunities, employment, social support, partner, family and friends.

For society, besides health, social care and law-enforcement costs, problem drug use often incurs costs related to property damage as well as, more subjectively, nuisance and feelings of insecurity.

Despite the large impact on society made by problematic drug users, their numbers are relatively small. Opiate addiction or injecting drug use is generally low in the adult population and almost absent at school age. Use of hard drugs such as opiates is usually hidden and users are unwilling to admit to it for fear of stigmatisation. It is thus not possible to obtain reliable prevalence figures through general population or school surveys.

Estimating prevalence requires indirect methods, such as multiplier techniques or advanced statistical models, such as three-sample capture—recapture. These methods extrapolate prevalence from known numbers in drug registries (treatment, arrests, deaths). However, statistical uncertainty is always present in estimations which are therefore expressed as a confidence interval (which, with 95 % certainty, contains the real prevalence rate) or, if this is not possible, as a 'plausibility range'. In addition, prevalence estimates at national level are difficult to obtain because of within-country heterogeneity and lack of data.

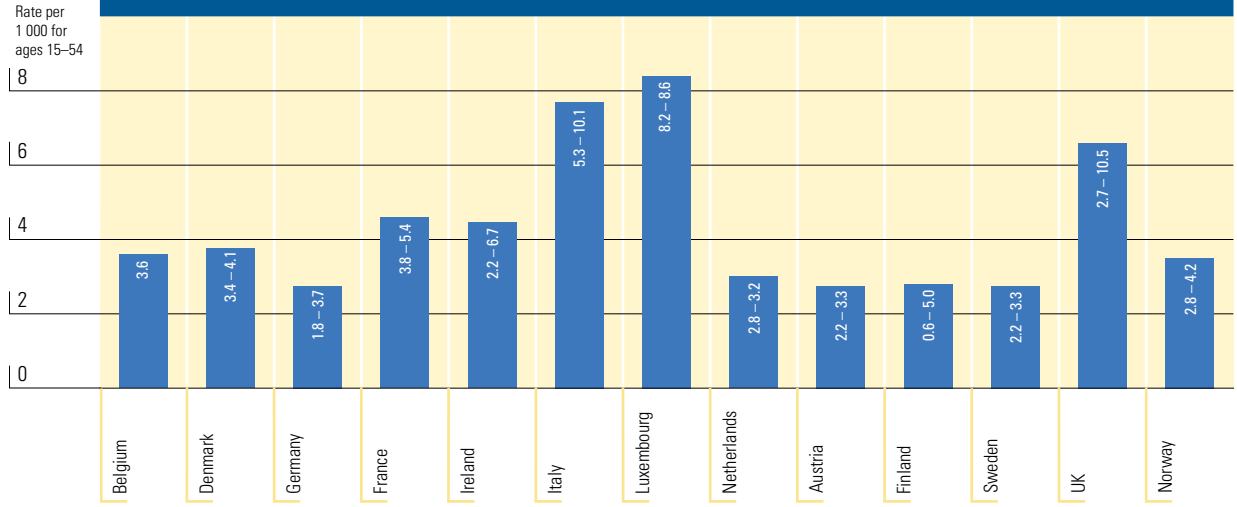
All this means that prevalence figures should be interpreted as only a crude indication of prevalence, or as a 'best estimate' of the number of problem drug users in a given area.

National estimates of problem drug use

Updated national estimates are presented for the countries that participated in an EMCDDA study to improve prevalence estimates at national level (see Figure 4 and Tables 4 and 5). Until recently, methods and definitions varied significantly — the terms 'opiate addicts' or 'heroin addicts' were used in some countries, while a wider definition of 'heavy/severe drug abusers' or 'high-risk drug consumers' was used in others. For example, in Sweden, frequent users of cannabis and ecstasy were included, although over 90 % of the total estimate are amphetamine injectors.

In the EMCDDA study, all participating countries provided figures using the same definition of problem drug use: 'intravenous drug use (IDU) or long-duration/regular use of opiates, cocaine and/or amphetamines'. This definition excludes ecstasy and cannabis users and those who do not use, or at least not regularly, opiates, cocaine or amphetamines. The study applied methods already used in some countries to all participating countries.

Figure 4 **National prevalence estimates of problem drug use in some EU countries and Norway**



Notes: The estimate for Belgium only includes IDUs and thus underestimates problem drug use.
For more detailed information, see Tables 4 and 5. Some Member States were unable to provide data.

Six basic methods were used, mainly based on statistical models incorporating drug indicators (see Table 4):

- multivariate indicator or synthetic estimation;
- capture—recapture;
- three multiplier methods based on contact rates with treatment or police, or on mortality rates; and
- a multiplier method using back-calculated numbers of IDUs with HIV/AIDS in combination with HIV/AIDS rates among IDUs.

In general, prevalence of problem drug use seems lowest in Germany, Austria, Finland and Sweden and highest in Italy, Luxembourg and the UK. In the countries with intermediate prevalence, the estimates typically range between three and five problem drug users per 1 000 population aged 15 to 54.

Given the methodological caveats already mentioned, estimates based on multiple methods giving comparable results should be regarded as more reliable. The EMCDDA study is now investigating social indicators to estimate prevalence of problem drug use using statistical modelling techniques. Possible social indicators include unemployment, property crimes, migration, housing density and socioeconomic status. As these data are more widely available than drug-specific data, estimates might be easier to obtain even at regional level or where there are few reliable drug data. The Netherlands based its study on social indicators and confirmed previous estimates obtained using other methods.

Incidence

Another EMCDDA study recently examined ways of using observed incidence — defined as the rate of new cases a year — of new drug users in treatment to estimate real incidence of problem drug use and, more importantly, the direction of trends in incidence which could be used for future projections. This was done using a back-calculation model and estimates of the latency time between onset of drug use and first treatment (Box 1 shows the results for Italy using different models). The results indicate a generally stable incidence of problem drug use with two peaks in 1986 and 1991 (the initial zero value is an artefact of the method and should be disregarded).

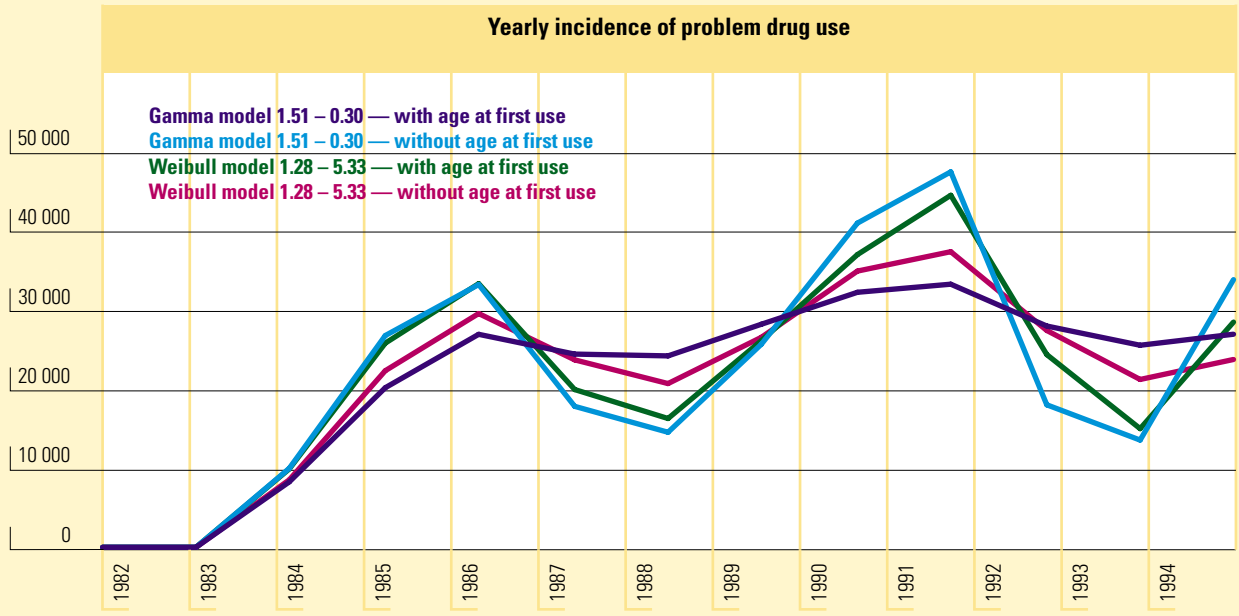
As incidence is directly related to prevalence (the rate of all existing cases in a certain year), this work will lead to improved prevalence estimates. It may also give more insight into the changes in prevalence over time and determining factors. The long-term aim is to be able to relate changes in drug policies and interventions to changes in incidence and prevalence of problem drug use.

Geographical spread of drug use

A third EMCDDA project evaluated the possible use of geographic information systems (GIS) to map drug-use data and estimates and to develop models of geographic spread between cities and towns. The example for Glasgow shows how peak incidence gradually moved from the city centre (1984) to the outskirts (1988) and then on to neighbouring towns (1990). This pattern of spread from larger cities to surrounding towns has been

Box 1

Incidence of new cases of problem drug use in Italy

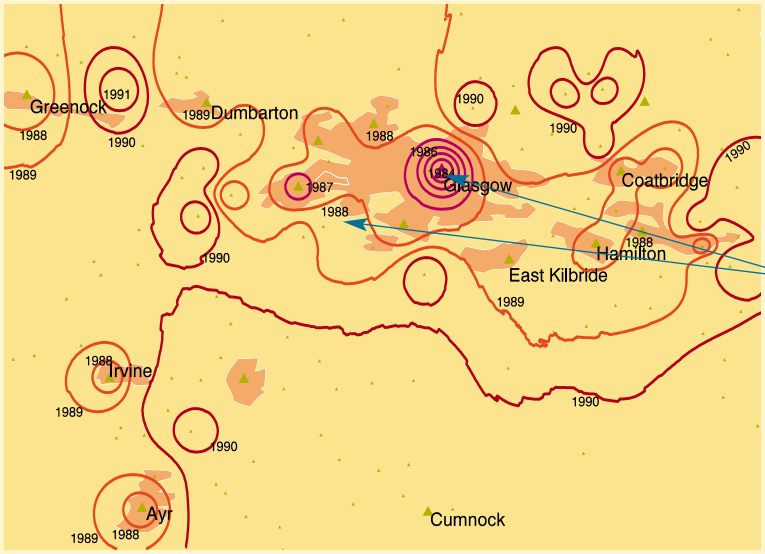


Here, estimates have been back-calculated from the observed incidence of new cases in treatment. The incidence curves of new problem drug users provided by the back-calculation model depend greatly on the latency period model chosen (two models were used, both with and without adjustment for 'age at first use'). However, the location of the peaks of the epidemic and the qualitative trends seem to have been estimated robustly. The initial low incidence (1982–84) is a spurious result of the method and should be disregarded.

Source: 'Pilot project to estimate time trends and incidence of problem drug use in the European Union', EMCDDA, 1999.

Box 2

Estimated peak incidence of new cases of problem drug use in the west of Scotland (1984–91)



Note: Incidence was estimated using an 'infectiousness' model of macro-geographic spread.

Source: 'Pilot project to develop a model of geographic spread of drug use in the European Union', EMCDDA, 1999.

This map illustrates the estimated peak incidence of new cases of problem drug use in the west of Scotland from 1984–91. Each 'isoline' represents the location of the highest incidence of new drug users in a given year, thus showing where and when drug use spread most rapidly.

For example, these isolines show drug misuse starting in the centre of Glasgow in 1984, before spreading more rapidly to the suburbs in 1988.

By combining this type of information with other data such as social indicators (trends in unemployment, socioeconomic status) or drug trafficking routes, it may be possible to make predictions about the spread of drug use within and between countries.

observed previously. It may, therefore, be possible to predict the future spread of problem drug use at macro level using this type of model. A follow-up to these projects is expected gradually to improve knowledge on prevalence and the dynamics of the spread of problem drug use in Europe.

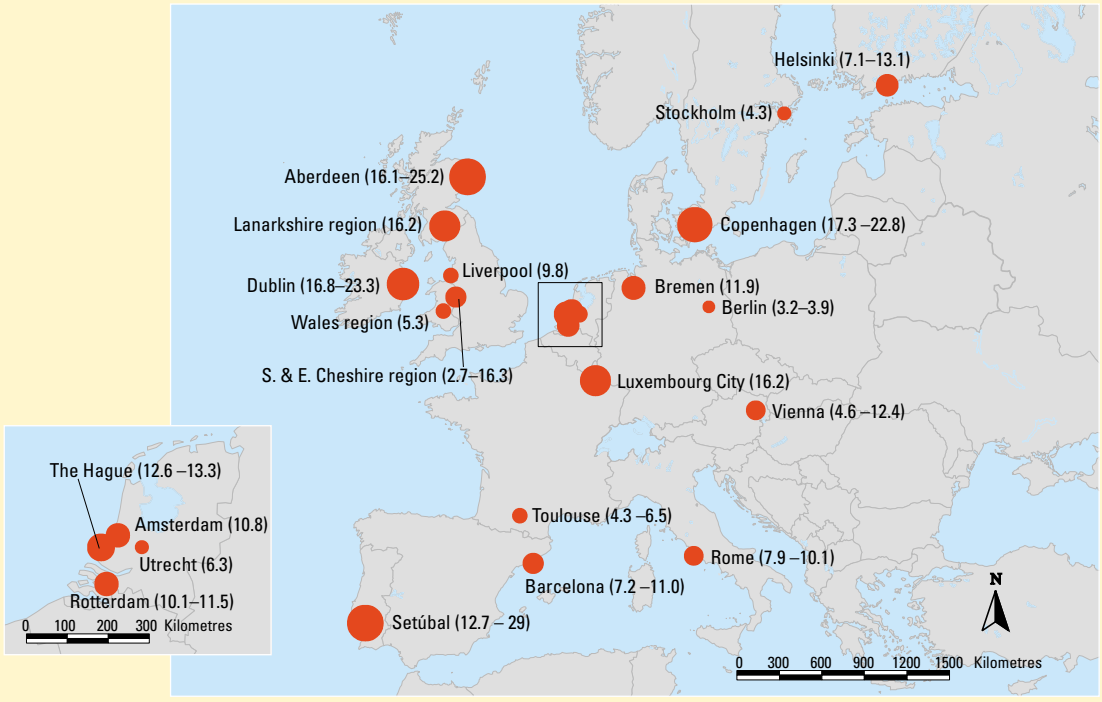
Local prevalence estimates

Prevalence estimates of problem drug use were first developed, and are more easily applied, at local level. An overview of local prevalence estimates since 1993 suggests that even when techniques vary and definitions are not always compatible, important differences may exist between cities and towns in Europe (see Figure 5).

For example, estimates in the age range 15 to 54 vary from 3.2 to 3.9 per 1 000 for Berlin to 16.1 to 25.2 for Aberdeen, and possibly even 44 to 124 per 1 000 in the region of Setúbal, Portugal (not shown). Less dramatic, but still important, differences in prevalence are observed between major cities. However, variability within a country may be just as pronounced, as illustrated by the Netherlands (from 6.3 to 12.6 – 13.3 per 1 000 aged 15 to 54) and the UK (from 5.3 to 16.1 – 25.2 per 1 000 aged 15 to 54).

In 1997, a study commissioned by the EMCDDA produced estimates for opiate use in six cities using comparable methods and definitions. Estimated prevalence for ages 15 to 54 ranged from 4.2 to 8.1 per 1 000 in Helsinki (not shown) to 12.7 to 29 per 1 000 in the city of Setúbal. This suggests that the wide range of prevalence found in other studies cannot be attributed only to methodological issues, but partly reflects real differences.

Figure 5 Local prevalence estimates of problem drug use in the EU (rate per 1 000 population aged 15 to 54)



Notes:

1. The surface of the symbol is proportional to the estimated prevalence rate.

2. This map shows available local estimates of the prevalence of problem drug use, not the prevalence of problem drug use throughout the EU. Countries and cities not indicated have not provided an estimate, but may also have high rates of problem drug use. For national-level estimates, see Table 4.

3. Prevalence estimates of problem drug use are not directly comparable because of differing methods and definitions. However, despite these differences a global impression can be given. Estimates of problem drug use in Stockholm and Helsinki include amphetamine injectors. Estimates of use in Copenhagen and studies in the UK used a wider definition than opiate use. The Berlin estimate is limited to injecting drug users. Most other estimates refer to opiate addicts or problematic opiate users.

4. For estimates prior to 1993, see the EMCDDA's 1997 and 1998 annual reports.

5. For sources, see end of chapter.

Indicators of health consequences

Demand for treatment

The number of admissions to drug treatment is a useful indirect indicator of trends in prevalence of problematic drug use, although changes in service availability, treatment modalities or reporting procedures must be taken into account. Treatment information may be especially useful in describing characteristics and patterns of drug use (injection, multiple drug use) among problematic users, and in identifying patterns of service uptake, so helping to assess service needs.

The EMCDDA is also working to improve quality and comparability of treatment demand information at European level. Building on previous work undertaken by the Pompidou Group, a new common European protocol on a treatment demand indicator has been drawn up by the EMCDDA. This protocol will be adopted and promoted by both organisations.

At present, almost all EU countries provide information on drug treatment. Methods of data collection and coverage of various types of treatment centres (in-patient, out-patient and others) vary. This may explain some of the cross-national differences in substances reported by treated clients and other characteristics. New services (such as substitution, low-threshold) may attract new users, increase the number of treatment admissions or change profiles like age, sex and route of administration.

Characteristics of clients entering treatment

With these limits in mind, some common features can be identified consistently among clients entering treatment in EU countries. These are, for example, the predominance of opiate clients and of young males. Other characteristics, especially the proportion of injectors among treated clients, differ from country to country. These differences may give important insight into the extent and nature of public health problems related to drug abuse.

The majority of clients (70 to 95 %) required treatment for opiate (mainly heroin) use (see Figure 6 and Table 6). The Flemish Community in Belgium, Finland and Sweden were the exceptions, with under 40 % of opiate cases. However, in these countries, treatment information was based only on hospital discharges or specialised in-patient treatment centres, which may bias the type of population covered. In some countries, methadone is increasingly mentioned as the primary drug. This may result from clients in methadone-maintenance programmes willing to switch to drug-free programmes, or to data-collection methods where clients already enrolled in a methadone programme are signed up in another clinic as new methadone cases.

In most countries, cocaine is reported as the main drug by less than 10 % of treatment admissions. In Luxembourg (15 %) and the Netherlands (18 %) the proportion is higher. Heroin users frequently report cocaine as a second drug.

Cannabis is generally reported as a main drug by about 10 % or less of treatment admissions in the EU. In some countries, this proportion is higher: Belgium (22 % in the Flemish Community and 13.2 % in the French Community), Germany (16.2 %) and Finland (17.9 %).

Amphetamines, amphetamine derivatives (such as ecstasy) and hallucinogens are primary drugs for generally less than 1 or 2 % of treatment cases. However, the proportion is higher in Finland (48 %), Sweden (20 %), the Flemish Community in Belgium (19 %), and Great Britain (9 %). However, as mentioned before, data from the Flemish Community in Belgium, Finland and Sweden come from different types of treatment centres than in most other countries.

Prevalence of injecting among drug users in treatment varies widely between countries, although important differences also exist within countries. Opiates are the substances most commonly injected, ranging from about 14 % (the Netherlands) to over 80 % (Greece and Luxembourg), although in most countries that provide this information, 30 to 60 % of opiate clients admitted to treatment inject their drug.

Injection of amphetamines is reported frequently in the Scandinavian countries and the UK, although this is not a common pattern in most countries. In some, a significant proportion of clients admitted to treatment for cocaine use injected the substance. This pattern of use does not seem to be common among cocaine users in general in the EU.

In all EU countries, young males make up the largest group admitted to treatment for drug use. Depending on the country, males represent 70 to 85 % of clients admitted to treatment. This high proportion has remained relatively stable in recent years.

The mean age of clients admitted to treatment ranges from 24.3 (Ireland) to 33 (Sweden). In most cases, it is 25 to 35. In Ireland, the general population is much

younger than in any other EU country which could explain the younger age of drug users entering treatment. Some countries report an increase in the mean age, which can be interpreted as the possible existence of an ageing cohort of drug users, with fewer new cases. However, the ageing of the treated population is difficult to interpret because the expansion of substitution programmes has attracted older clients, some of whom were not previously in contact with treatment services.

Trends in the treated population

Some interesting trends in the characteristics of the treated population have been identified in recent years, and these changes may highlight variations among the whole population of problem drug users. New trends can be identified by monitoring all treatment admissions, but also by comparing the characteristics of clients seeking treatment for the first time with those of old clients.

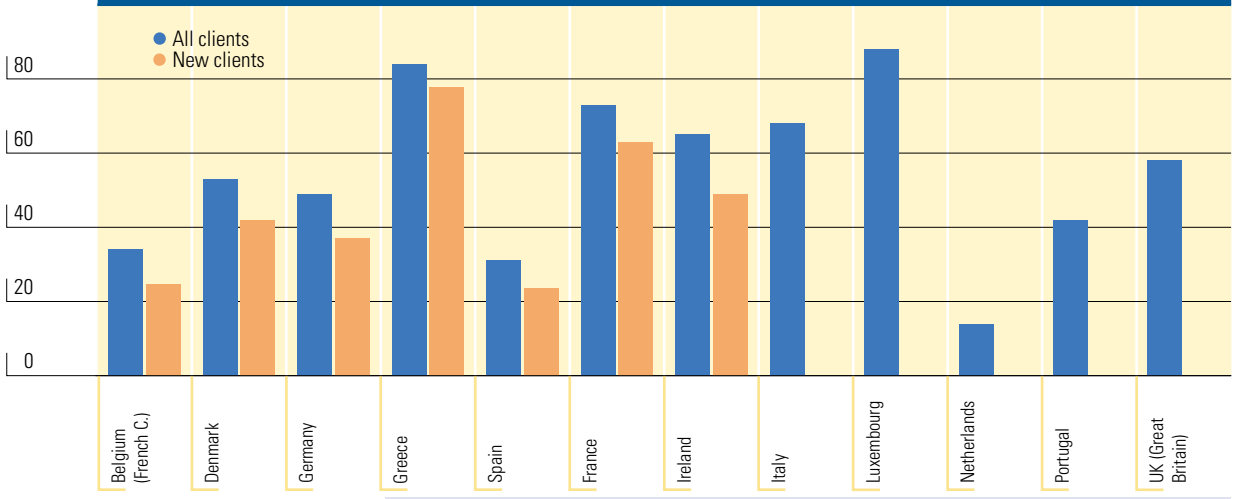
Available treatment information indicates that in general the proportion of treatment admissions for opiates is decreasing, while cases of treatment for cocaine and cannabis are increasing, although they remain at lower levels than for opiates. Recently, some countries reported the increase in cannabis cases, especially among clients treated for the first time.

This result requires more detailed examination, as other factors should also be considered. These include the type of reporting centres, the sources of referral and other characteristics of the client such as simultaneous use of other drugs as well as whether treatment is an alternative to administrative sanctions. Attention should also be paid

Figure 6 **Proportion of clients admitted to drug treatment whose main drugs were opiates in some EU countries**

Notes: For more detailed information on the characteristics of clients admitted to drug treatment, see Table 6. Some Member States were unable to provide data.

Figure 7 **Proportion of clients admitted to treatment for opiate use who injected the drug in some EU countries**



Notes: For more detailed information, see Table 6 which presents information on 'all clients' but on 'new clients' admitted to treatment for the first time. Some Member States were unable to provide data.

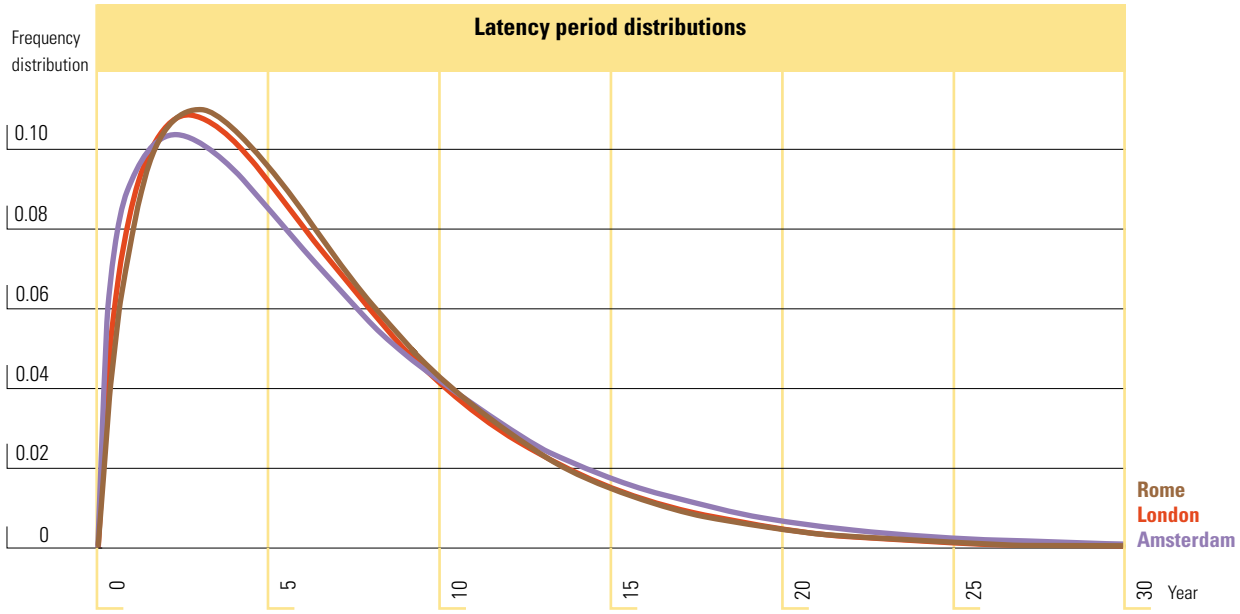
Box 3

Analysis of treatment data using statistical and mathematical models

An EMCDDA project analysed the 'latency time' between first use of opiates (mainly heroin) and first demand for treatment in Amsterdam, Lisbon, London and Rome.

The graph shows a similar pattern in Amsterdam, London and Rome. The main factor determining latency time in all three sites was age at first use. Other influential determinants were route of administration, gender, ethnicity and year of first treatment. Lisbon also participated in the study, but latency time was not plotted as the treatment services had existed for only a short time, resulting in a biased (longer) latency period. A different (shorter) latency time has more recently been found in Dublin, possibly because the heroin epidemic is much newer there.

However, in cities with long-established and stable treatment capacity, and not too recent heroin epidemics, latency time before treatment, as well as its determinants (mainly age at first use), appear similar.



Latency time between first use of opiates and first demand for treatment in Rome (years)

Age at first use	Sample size	Mean	25 %	Median (50 %)	75 %
Under 16	555	9.2	6	8	13
16–21	2 675	7.0	3	6	10
Over 21	1 426	4.7	1	3	7

The table above, giving the results for Rome, shows that the mean latency time differs greatly according to age, being much longer in those who started using drugs at a young age. There is also much variability within each age group — of those who started using drugs under 16 years of age, 25 % enter treatment within six years, 50 % (including the first group) within eight years and 75 % (including both previous groups) within 13 years. This information is important for treatment services as it may partly reflect 'treatment attraction'.

It is now clear that treatment services do not attract young drug users. This may be either because these users do not feel the need for treatment, or because the services are less well suited to treat them. This should be studied further at local level, for example by interviewing users on the streets and in treatment about their reasons for attending or not.

The statistical analysis of treatment data can generate hypotheses that lead to further research and potentially important information for treatment services.

Source: 'Pilot project to estimate time trends and incidence of problem drug use in the European Union', EMCDDA, 1999.

to the increase in clients admitted to treatment for cocaine use in some countries (Spain and the Netherlands).

Most EU countries report a decrease in the proportion of injectors among treated opiate users. This shift is detected among all clients, and more clearly with new clients, with some countries having experienced this trend for several years. Changes in the route of administration of drugs may have a major impact on public health consequences of problem drug use (fatal and non-fatal overdoses and infectious diseases), and close monitoring of this pattern of use is important.

Drug-related deaths and mortality of drug users

Drug-related deaths

Death is a possible consequence of some forms of drug use, although the risk varies depending on the substance and the pattern of use. Drug-related deaths are a cause of grave social concern, especially acute forms ('overdoses') among young people. Their number is often simplistically used as a marker of a country's drug situation.

In the EU, statistics on drug-related deaths generally refer to deaths occurring shortly after drug use (sometimes known as acute intoxication, overdose, poisoning or drug-induced deaths). Other types of deaths (from infectious diseases, accidents or suicides) should be taken into account when assessing the overall impact of drug use in society. However, their causal relationship to drug use and the methods of recording such cases are less clear.

Direct comparisons between national statistics cannot be made because these depend not only on the prevalence of drug use, but also on the methods and definitions used to record cases. Some countries use rather restrictive definitions, while others use broader criteria. The detection rates of reporting systems also vary substantially between countries. Bearing in mind these limits, if recording methods are maintained consistently within a country, drug-related deaths can be a useful indicator of trends for severe forms of drug use.

Improving the quality and comparability of death statistics is difficult, however, because countries rely on different types of registries (general mortality or forensic/police) which use different recording and reporting procedures. The EMCDDA has been working in collaboration with Eurostat and the World Health Organisation to produce standard guidelines for reporting results from both types of registries. The feasibility of implementing these standards is being tested in all EU countries during 1999.

Trends in drug-related deaths

Trends in drug-related deaths differ from country to country, perhaps as a result of changes in recording procedures. Despite these limitations, some general trends in drug-related deaths can be outlined (see Figure 8 and Table 7). In most EU countries, acute drug-related deaths increased markedly during the late 1980s and early 1990s. Since then, the number of drug-related deaths in many countries has stabilised or even decreased, although in some it has continued to increase until recently. In a few Member States, the trend is still upwards, specially in those where opiate use appears to have spread more recently as in Greece, Ireland and Portugal, although in the last the number decreased in 1997 partly due to under-notification.

The reasons for this changing trend are not clear. Variations in recording practices may play a role, but it may also be related to a stabilisation in problematic drug-use prevalence, to changes in the patterns of use (such as a decrease in injecting) or to the effects of interventions (like the spread of opiate substitution programmes).

Although other substances are often present, opiates are found in most cases of deaths by acute intoxication recorded in the national statistics. Alcohol and benzodiazepines are frequently found and may be risk factors for fatality in cases of opiate intoxication. Acute deaths relating solely to cocaine or amphetamines are unusual.

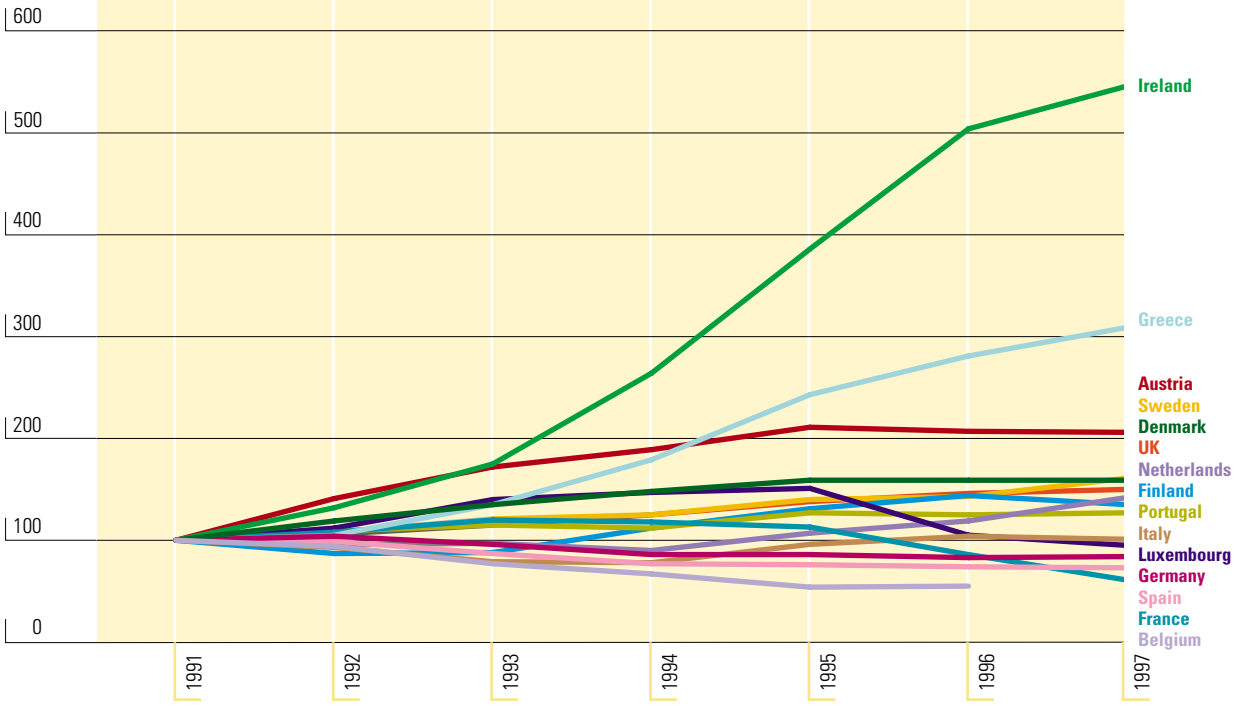
Deaths related to ecstasy or similar substances, although widely publicised, are few in number. For instance, in England and Wales the number of deaths where positive toxicology to ecstasy was recorded in the death certificate peaked in 1994 with 23 cases falling to 10 in 1995 and rising to 12 in 1996. These figures may underestimate the number of deaths where ecstasy is present but, on the other hand, the presence of a substance in the toxicological examination does not necessarily imply a causal relationship with the death. This may change if chronic use develops, or if use in combination with other substances increases.

Mortality of drug users

In addition to national statistics on drug-related deaths, mortality risk associated with some forms of drug use may be assessed by following groups of drug users and monitoring their mortality (known as longitudinal or cohort studies). Problematic drug users have a much higher risk of death than the general population, from a wide range of causes and not just acute intoxication. Longitudinal studies indicate that opiate injectors have a 20

Figure 8

Trends in the number of drug-related deaths in the EU (1991–97)
Three-year moving averages indexed (1991 = 100)



Notes: Trends and not numbers are presented here as absolute numbers cannot be directly compared between countries.
The markedly increasing trend during recent years in Ireland may be partly related to under-reporting in previous years.
For more details, see Table 7.

to 30 times higher risk of death by overdose, HIV infection, accident or suicide than non-drug users of the same age.

Mortality among injectors has increased with the spread of HIV infection, while non-injectors or users of other psychoactive substances have a much lower risk of death, especially from acute intoxication. The EMCDDA has developed a standard protocol to conduct mortality cohort studies among drug users recruited in treatment centres. This protocol will improve comparability between the results of mortality studies conducted in different localities in the EU.

Drug-related infectious diseases

Infectious diseases, such as HIV and hepatitis B and C, have reached high prevalence among IDUs in most countries. By their very nature, infectious diseases pose a threat to others, to partners and children of IDUs, and to clients of prostitutes. The rise of heterosexually acquired AIDS in Spain is largely driven by the large epidemic among IDUs.

There is still no cure for HIV, which requires lifelong use of strong medication with many side effects. In many countries, HIV/AIDS is still the major health threat to IDUs, but in others hepatitis B and, especially, hepatitis C — both of which are difficult to treat — may pose a heavier burden to IDUs and public health resources. Other infection-related problems in IDUs are tuberculosis, sexually transmitted diseases (STDs), abscesses and endocarditis.

The spread of infectious diseases is difficult to measure. Antibody levels in blood or saliva reflect the prevalence of those who have ever been infected and recent infections cannot be distinguished. In some cases, such as for HIV or hepatitis C, most of these people have a chronic infection, sometimes with severe long-term implications such as AIDS (in the case of HIV) or severe liver problems (hepatitis B and C), and long-term transmissibility to others.

Prevalence can vary greatly between areas and subgroups, so that a national average prevalence rate may be difficult to derive or interpret. Trends in prevalence are also hard to interpret, often because of a lack of repeated data and because the total number of prevalent infections reacts only slowly to changes in the rate of new infections. In order to assess the effects of interventions and factors related to infection, it is important to know the incidence rates of new infections.

These data can only be obtained in settings that permit repeated testing of the same individual, such as cohort studies or surveillance of person-based test results in reference laboratories. Cohort studies can give data of good quality, which allow clear scientific conclusions to

be drawn about changes over time or interventions. But these studies are expensive, often only local and over time they become no longer representative of the population of IDUs in general. Laboratory surveillance can cover large areas, but it depends on the strongly biased sample of IDUs who are being tested for different reasons, while background information on risk behaviour is poor. A possible 'surrogate' incidence might be derived from prevalence data in young IDUs or from IDUs with a short injecting history, as this necessarily reflects more recent infections.

The EMCDDA has been collecting data from the different available data sources, such as screening of IDUs in treatment, needle exchanges, notification of self-reported or 'known' test results (the quality of which may be unknown) by services, results of studies or rates of infection in opiate overdose deaths. Although these data are difficult to compare, many sources have a large coverage and the data do provide a rough impression of the spread of these diseases in IDUs in the EU.

A current EMCDDA project is investigating how to improve these data and to develop a valid and comparable European surveillance system of infectious diseases in IDUs. The aim is to give public health authorities a rapid insight into increases in transmission among IDUs, at present the largest risk group for HIV and hepatitis C infection. Another EMCDDA project is studying the public health costs of infectious diseases in IDUs and the cost-effectiveness of interventions.

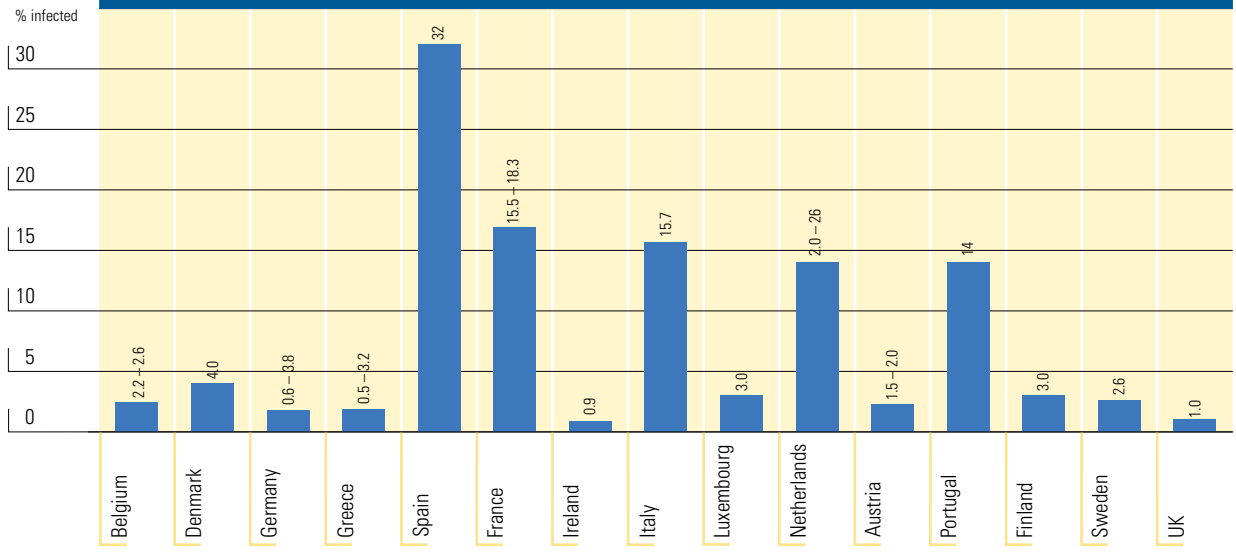
HIV

There are major differences between countries in prevalence rates for HIV infection among IDUs, ranging from 1 % in England, Wales and Ireland to 32 % in Spain (see Figure 9 and Table 8). Similar differences in prevalence also exist within countries, between regions and cities. Prevalence is declining slowly in some countries (France and Italy), but apparently not in other countries (Spain and Portugal). In Finland, an increase (statistically not significant) from 0 % to 3 % has been reported this year, possibly indicating an increase in transmission. Even in countries where prevalence remains stable, transmission most probably continues among IDUs. This stable state is called an endemic situation, meaning that the new infections balance the numbers of deaths and migrations of infected IDUs. The HIV epidemic has now entered the stable endemic phase in most west European countries.

Modelling studies, based on estimates of HIV incidence from reported AIDS cases, have shown that new generations of users have continued to become infected in the 1990s. This ongoing transmission in young IDUs, however, has been hidden by the general decline in incidence after the first epidemic phase (see the EMCDDA's 1998 annual report).

HIV prevalence rates often differ between subgroups of IDUs. Female IDUs sometimes have higher infection rates, possibly because they more often have a sexual partner with whom they share injecting materials. IDUs who have been imprisoned also have higher rates of infection.

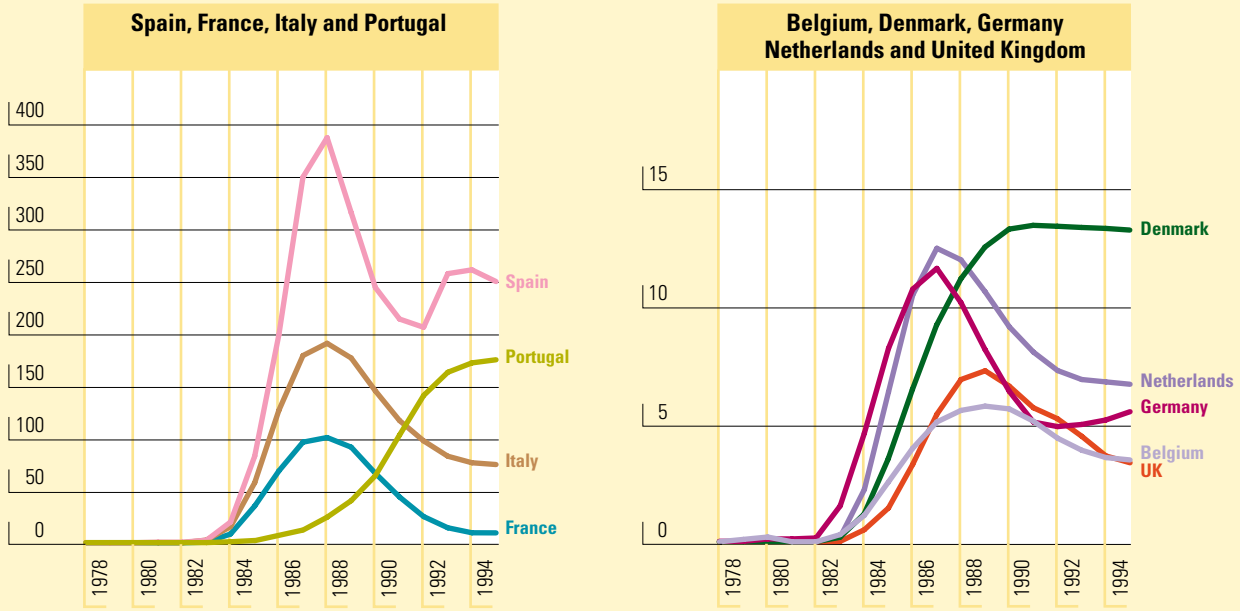
Figure 9 **Prevalence of HIV infection among injecting drug users in the EU**



Note: For more detailed information, see Table 8.

Box 4

HIV incidence in injecting drug users (cases per million total population, back-calculation by country)



Back-calculation estimates of HIV incidence show large differences between countries. Countries with low incidence are shown in the right-hand figure while those with high incidence are shown in the left-hand figure (note the different scales). In the above figures, the estimated peak incidence of HIV occurred between 1986 and 1988 in most countries. The shape of the HIV incidence curves is also different from that of the AIDS incidence curves, illustrating delayed and less peaked incidence because of the long and variable incubation time between HIV infection and AIDS. The curve for Portugal began to rise later than in other countries and continued rising until 1994, possibly because the heroin epidemic also started later.

Source: Jager and Ruitenberg (1997), unpublished results.

Differences in prevalence are often found between ethnic groups. Prevalence rates differ strongly by age or length of injecting career, as the risk of infection cumulates with use. However, incidence studies show that young and new IDUs often take the highest risks, presumably because they have not yet learned how to protect themselves. Therefore, it is important that prevention measures target these young and new IDUs, or, if possible, prevent them from starting to inject.

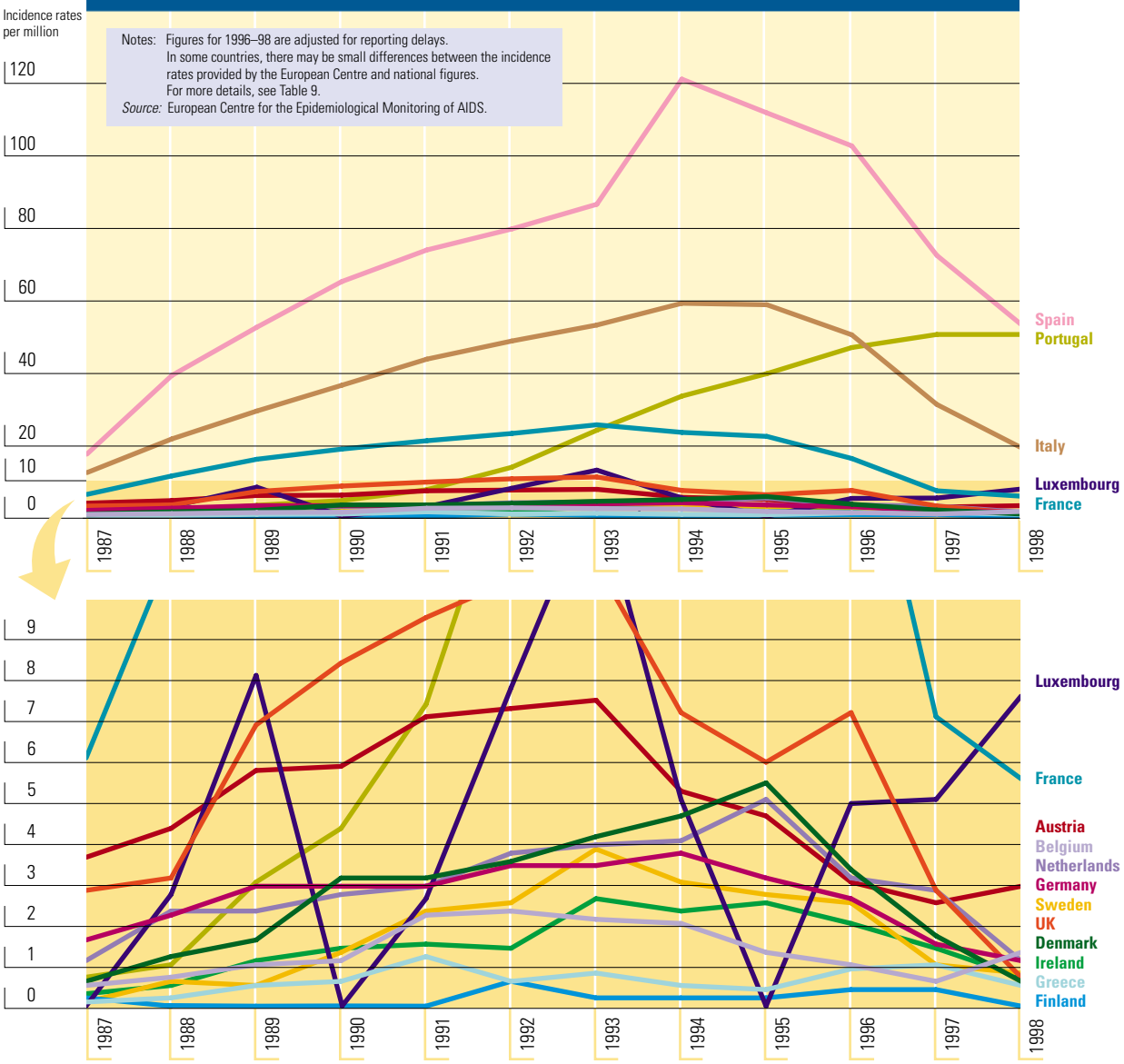
The data given currently provide the best available information on HIV among IDUs in the EU (Table 8). Where possible, data are presented from sources with national coverage. In some cases, these are not available and local prevalence is presented instead.

The Netherlands illustrates geographical variation in prevalence within a country, with prevalence ranging between 2 % in Arnhem and 26 % in Amsterdam. As only local studies exist, a national average cannot be given. In other countries, data collection is so extensive that a national average becomes meaningful. For example, in Italy 16 % of 73 784 tested drug users (mostly IDUs) were HIV positive, while prevalence differed markedly by region (1 to 28 %). In France, the national average is estimated to be between 16 and 18 % according to a national survey of treatment centres. As this figure is based on self-reported or 'known' test results notified by the drug services, it may be less reliable than data based on other sources such as screening.

AIDS

Incidence rates for AIDS also vary greatly between countries and in general continue to decline (see Figure 10 and Table 9). This is probably the effect of a steady increase in uptake of new combination treatments among IDUs which delay the onset of AIDS. The only country that has still not shown a decrease is Portugal. This may be because the rate of new infections has been increasing until recently or possibly because pre-AIDS treatment is not being offered to IDUs to a significant extent. The

Figure 10 **AIDS incidence in injecting drug users in the EU (1987–98)**



proportion of IDUs among all cumulative AIDS cases differs significantly between countries, illustrating variations in the relative importance of IDUs in the AIDS epidemic.

AIDS monitoring is becoming less useful as an indicator of the extent of HIV infection. Instead, AIDS is becoming more an indicator of treatment uptake. New, highly effective treatments are further increasing the time lag between HIV infection and AIDS, which was already about 10 years. Centralised reporting of known HIV cases is now being considered in Europe to complement existing AIDS reporting.

Hepatitis B

The prevalence of antibodies against hepatitis B infection (anti-HBc, indicating past infection) differs markedly among EU countries — from 19 % in the UK to 68 % in Greece and a high, but local, prevalence of 80 % in Germany (see Figure 11 and Table 10). Some lower rates may be less reliable, such as those based on self-reports. Although the hepatitis B virus (HBV) is probably more transmissible than the hepatitis C virus (HCV), prevalence levels of anti-HBc are lower. This is because only about 10 % of those infected with HBV become chronically infected (carriers) and thus remain infective for others. Hepatitis B is less of a public health problem for IDUs than hepatitis C. As HBV is much more sexually transmissible, it poses a potentially greater problem for the sexual partners of IDUs and for the general population.

Vaccination for hepatitis B

Since 1996, hepatitis B vaccinations have increasingly been offered to IDUs. This makes antibody levels for

hepatitis B less reliable as an indicator for past infection. Surveillance might need to focus more on those testing positive for hepatitis B antigen (HBsAg), which is a marker of current or chronic infection. The proportion with no antibodies remains important as an indicator of the population of IDUs still at risk of infection, and to show the potential for vaccination.

As those infected by both hepatitis B and C may be most at risk of developing long-term liver problems, the hepatitis B vaccine may be a cost-effective method of preventing liver disease in those infected with HCV. Improving coverage of hepatitis B vaccination among injecting drug users is, therefore, important. One problem in offering vaccinations to IDUs is the need for three injections over a period of six months or more. Shorter time periods that might be more appropriate for vaccination of IDUs in prison are currently being evaluated.

Efforts to develop vaccines for HIV and hepatitis C have so far been largely unsuccessful, although clinical trials are evaluating some experimental HIV vaccines that might give partial protection.

Hepatitis C

Hepatitis C infection shows higher and more similar prevalence rates across the EU than hepatitis B, generally between about 50 and just over 90 %, even in countries with low rates of HIV infection like Greece (see Figure 11 and Table 10). For years, HCV prevalence seemed not to follow the decline observed in HIV infections. More recently, HCV prevalence may be declining in the UK and Switzerland, suggesting that harm reduction measures might have affected HCV transmission. On the other hand, a local rise from 89 % to 95 % is reported by the drugs emergency service in Frankfurt, Germany.

About 80 % of HCV infections in IDUs become chronic. This implies continuous risk of infection for others, as with HIV, and risk of severe liver damage in the long term. A French study by Nalpas et al. (1998) estimated that around 500 000 injecting drug users are infected with hepatitis C in the EU. Taking infections among ex-IDUs in the general population into account, the number is probably much higher. These infections may lead to significant disease and healthcare costs, possibly comparable to those of HIV. It is thus important to increase measures that reduce transmission (for example needle exchanges) and disease progression in those infected (such as treatment and information regarding alcohol use).

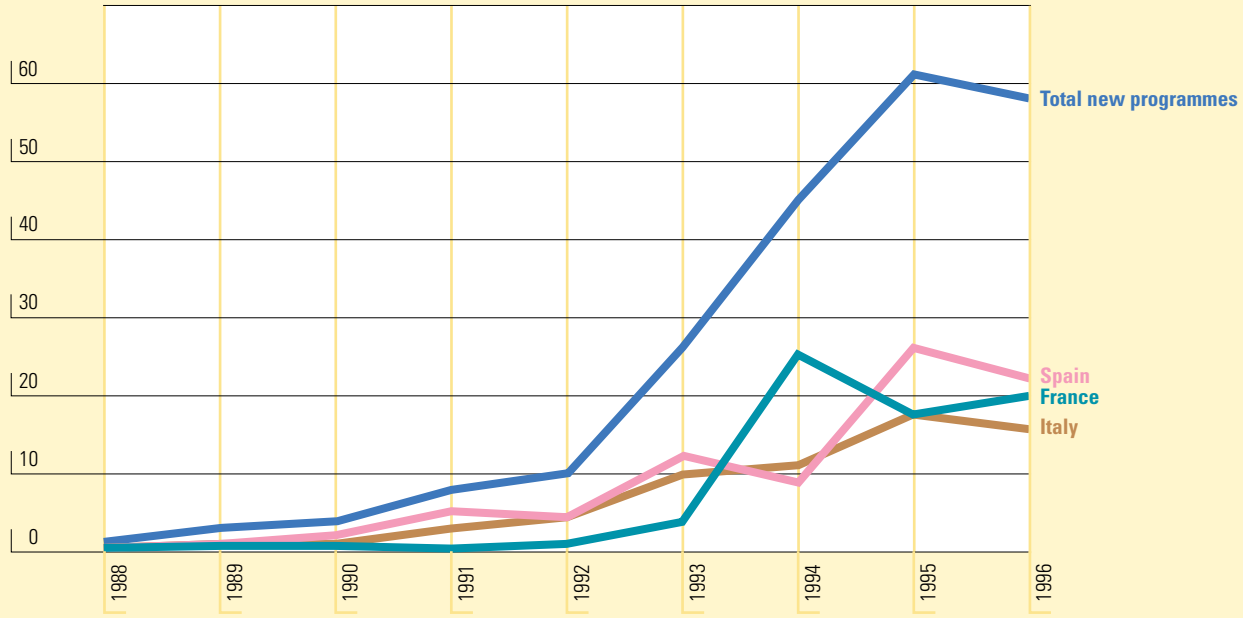
Saliva tests for HCV are now becoming available thus making it easier to test IDUs in epidemiological studies. These tests may underestimate the percentage of IDUs that ever become infected, but they do give a positive test result in almost all cases of chronic infection. Using saliva implies higher safety for the drug user as well as the interviewer or service provider.

Risk behaviour

The high rates of hepatitis infection suggest that risky injecting practices are still prevalent. Because of the higher transmissibility of HCV, these levels of risk behaviour might be sufficient to transmit HCV, but not HIV. The transmission of hepatitis B and C may continue in inject-

Box 5

Growth in syringe-exchange programmes in Spain, France and Italy (number of new programmes each year)



The graph shows that syringe-exchange programmes were mainly established after 1992 in Spain, France and Italy. In France, however, syringes have been readily available from pharmacies since 1987. The number of programmes has increased in recent years.

Source: Programas Échange Seringues Europa Sud (Pesesud) (1998).

quantities which are insufficient to transmit HIV. HCV and HBV may also be transmissible by 'environmental contamination' — through fingertips and contaminated surfaces. IDUs should thus be made aware of the dangers of sharing materials other than needles and syringes, and of the importance of washing hands and general hygiene.

Risk behaviour is also difficult to measure because it is based on self-reports of socially undesirable behaviour. Such reports can be affected by recall bias and intentional under-reporting. Other factors, such as 'mixing patterns' — who shares with whom — may have become more important than risk behaviour. For instance, an epidemic among IDUs is less likely when most share injecting materials with a steady sexual partner rather than with strangers. The decline in levels of HCV in the UK may not be attributable to low levels of sharing, but could possibly be due to sharing shifting to within close relationships so reducing transmission of the virus.

Harm reduction measures

In recent years, more countries are introducing syringe-exchange programmes and pharmacies often actively distribute clean needles and syringes to IDUs. Syringe-exchange programmes were set up in Spain, France and Italy mainly after 1992, but syringes were sold through pharmacies before then (see Box 5). Although syringe-exchange programmes in these countries were introduced too late to prevent massive transmission of HIV, the increase in such projects has been extensive and the effects on HIV transmission should become visible in the coming years.

Although harm reduction measures are now being implemented in almost all EU Member States, the fact that transmission of HIV and hepatitis B and C continues in many countries (for example, among the young and new IDUs and in prisons), suggests that harm reduction measures such as syringe-exchange programmes should be intensified. It is clear that in practice harm reduction has become the standard in most EU countries (see Table 11). This is interesting in itself, given the different impressions arising from some recent political controversies over national drug policies.

Syringes are available in all countries, and condoms and HIV counselling and testing also seem to be widely available. Substitution treatment exists in all countries as well,

Box 6

HIV, hepatitis C and injecting risk behaviour among intravenous drug users in prison (%)

Prison location	IDUs infected with HIV	IDUs infected with HCV	IDUs who shared materials during last injection outside prison in previous four weeks	IDUs who inject in prison	IDUs who began injecting in prison
Belgium (one site)	0	38.5	47	35 (10*)	15
Germany (one site)	1.4	14.4	n.a.	36 (18*)	9
Spain (one site)	23.4	n.a.	32	79	10
France (three sites)	13.3	53.2	34	37 (29*)	7
Italy (three sites)	16.1	64.2	32	25	6
Portugal (three sites)	28.1	61.9	49	57	5
Sweden (nine sites)	2.6	57.6	30	64	5

n.a. = not available
(*) Figures in parentheses refer to the percentage of the total who have injected in the past four weeks.
Source: European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', May 1998.

mostly in the form of oral methadone, and heroin trials have now started in the Netherlands, following Switzerland's example (see Chapter 1).

However, the coverage and intensity of harm reduction measures vary considerably. From the national reports, it appears that syringe availability is not always nationwide and may depend greatly on local or regional initiatives which may be more frequent in high-risk areas. Finland and Sweden have only limited syringe-exchange programmes and the former recently restricted the sale of syringes by pharmacies.

In France, substitution treatment, although increasing, mostly involves buprenorphine, which is sometimes injected. Methadone programmes are also developing. In Germany, wide differences appear to exist between regions and cities in their implementation of harm reduction measures.

Prisons

Awareness of the role of prisons in the HIV and hepatitis epidemics has increased rapidly in recent years. Many studies among IDUs show higher prevalence rates among those who had been imprisoned. This may be the result of selecting more problematic and risk-taking IDUs, as well as of possible transmission of HIV and hepatitis B and C in prisons. It may also be that infections occur immediately after release because of the temporary social disruption leading to a lack of self-protection (no steady dealer, no own injecting material).

An EU study brought together data on infections among IDUs in prison in Europe (the Swedish figures from this study have been used in Tables 8 and 10). However, prison populations are in general expected to have higher prevalence rates and the figures are, therefore, an upper limit of prevalence in IDUs in general.

The study showed that injecting is highly prevalent in prisons and that an important proportion of imprisoned IDUs first injected in prison. Even if this is a selected population, the results may indicate that sharing injecting material is still prevalent in subgroups of IDUs in many countries.

Treatment of HIV and hepatitis

Major improvements have recently been made in treating both HIV and hepatitis infections, although treatment of these viral infections is still far from perfect. In the case of HIV, the virus is merely suppressed and AIDS is delayed. In the case of hepatitis B and C, about 60 to 80 % of patients are still infected after being treated for one year.

The side effects of HIV and HCV treatment are severe, and in the case of HIV treatment lifelong. The side effects of HIV include nausea, diarrhoea, diabetes, bleeding and body fat changes and those of HCV include fatigue, malaise, depression, fever, joint and muscle aches and blood and autoimmune problems. These effects represent a serious burden to the patient which, in turn, has consequences for treatment compliance.

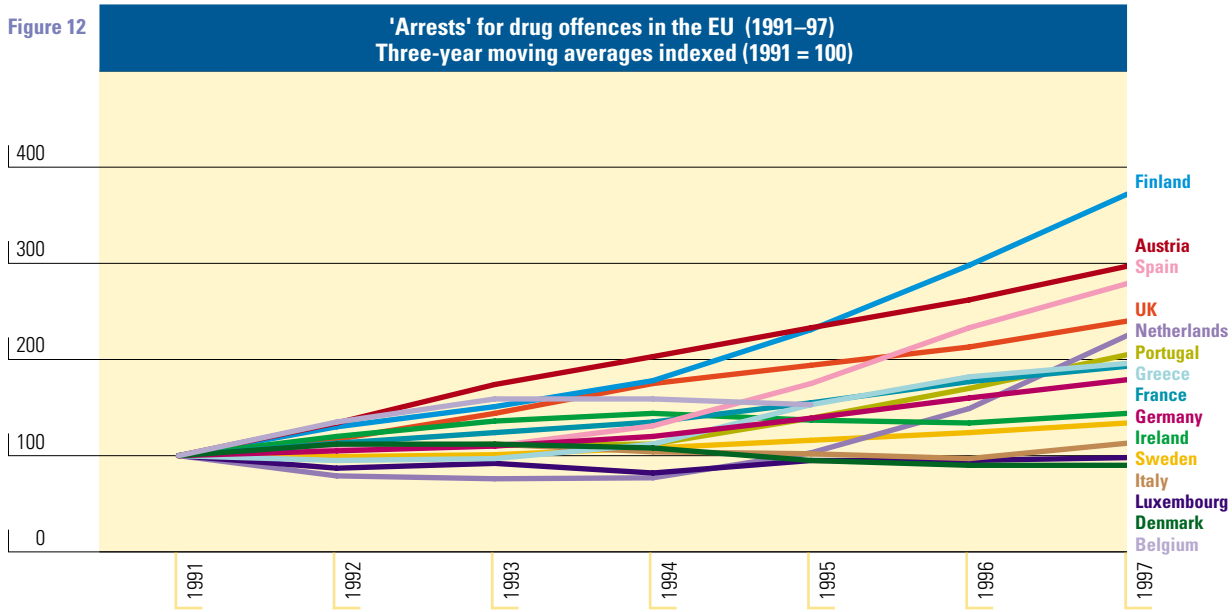
Discontinued treatment increases the risk of resistant virus strains, thus posing high risks for the patient and others. Treatment is expensive. HIV treatment is estimated to cost around EUR 8 000 to EUR 12 000 per person per year.

Law-enforcement indicators

Police 'arrests' for drug offences

The only data systematically available on law-enforcement interventions refer to offences against drug laws (such as

Figure 12



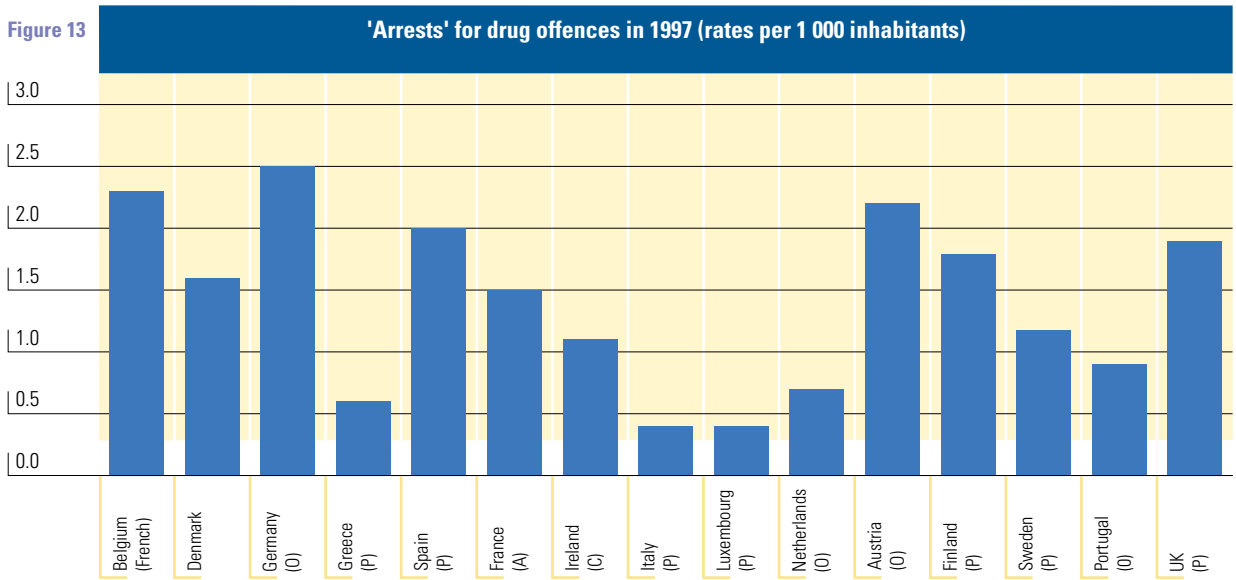
Note: For definitions of 'arrests' for drug offences, see Figure 13.

trafficking, possession, and use). These reflect Member State legislation, administrative recording procedures and police resources and priorities. Data are affected by differences in definition and statistical units (persons, offences, and arrests). Given the difficulty in comparing them directly, emphasis is placed on time trends.

The number of arrests for drug-related offences has been steadily increasing since the mid-1980s in the EU as a whole (see Figure 12). It rose up to twofold in Denmark, Italy, Luxembourg and Sweden and over six times in Belgium, Greece, Spain, Portugal and Finland. In these latter countries, and in Italy and the Netherlands, this rising trend has accelerated in recent years. However, in Denmark, Ireland and Luxembourg, the number of drug-related arrests has been stabilising.

In 10 Member States, cannabis is the main drug involved in arrests, accounting for nearly half of all cases in Germany, Italy and Finland and of over 70 % of cases in Greece, France and the UK. In Luxembourg and Portugal, heroin is the predominant drug involved, in the

Figure 13



Notes: P = person; O = offence; C = charge; A = arrest Where the statistical unit is O, C or A, more than one event may relate to the same person in one year. For Belgium, the number of arrests used to calculate the rate refers to 1998 (1997 data not available). For the Netherlands, the number of arrests used to calculate the rate is a provisional figure.
The Member States define 'arrests' for drug offences as follows (the definitions are presented as submitted by the country concerned): Belgium: illicit drug activity registered by the police; Denmark: charges for violations of drug laws; Germany: drug offences (including directly supply-related crimes); Greece: arrests (caught by the police) of suspects of drug law offences; Spain: arrests related to illicit drug trafficking; France: arrests for violation of drug laws; Ireland: charges for drug offences; Italy: arrests; Luxembourg: arrests for violation of the modified 1973 drug law; Netherlands: offences against the Opium Act; Austria: reported violations of the Narcotic Drugs Act; Portugal: presumed offences against the drug law; Finland: suspected drug offenders; Sweden: suspected of offences against the Narcotic Drugs Act or the Goods Smuggling Act; UK: persons found guilty for drug law offences
Sources: Reitox national focal points; Eurostat.

Netherlands it is 'hard drugs', while in Sweden amphetamines are most common.

Nearly all the EU countries provide data that distinguish use-related from trafficking-related offences. Use-related offences remain predominant, ranging from 61 % in Portugal to over 85 % in Austria and Sweden. In all the countries, except Belgium and Ireland where it is decreasing, the proportion of use-related drug offences is increasing or stable.

To take into account the population size to which they refer, arrests have been reported for the total population of each country (see Figure 13). In the nine countries that count persons as the statistical unit, the rates of drug-related arrests per 1 000 inhabitants range from 0.4 in Italy and Luxembourg to 2.3 in Belgium. Where the statistical unit is the offence (one person can be arrested for more than one offence), the rates vary from 0.7 per 1 000 in the Netherlands to 2.5 per 1 000 in Germany. However, these rates should not be compared. It is still

Box 7

'Arrests' for drug offences in the EU

Drug most frequently involved	Proportion of 'arrests'(%)	% trend over previous three years
	Cannabis	**Cannabis**
France (1998)	85	↑
United Kingdom (1997)	74	↓
Greece (1998)	73	n.a.
Belgium (1997)	65	n.a.
Ireland (1997)	64	→
Spain (1998)	61	↑
Austria (1) (1997)	60	↑
Finland (1997)	47	↓
Italy (1998)	46	n.a.
Germany (1997)	46	↓
	Heroin	**Heroin**
Luxembourg (1998)	60	↑
Portugal (1997)	48	↓
	Stimulants (mainly amphetamines)	**Stimulants (mainly amphetamines)**
Sweden (1) (1997)	55	↑
	'Hard' drugs (2)	**'Hard' drugs (2)**
Netherlands (1996)	81	↑

For definitions of 'arrests' for drug offences, see Figure 13.
↑ = proportion increasing; ↓ = proportion decreasing; → = proportion stable n.a. = data not available
(1) Among all drugs mentioned, whether alone or not; Sweden reports convictions not arrests.
(2) In the Netherlands, all illicit drugs except hashish and marijuana are considered 'hard' drugs.

Offence most frequently involved	Proportion of 'arrests' (%)	% trend over previous three years
	Use/possession for use	**Use/possession for use**
Sweden (1997)	88	→
Austria (1) (1997)	85	↑
France (2) (1998)	82	↑
United Kingdom (2) (1997)	80	→
Finland (1998)	77	↑
Greece (1998)	75	n.a.
Ireland (1997)	74	↓
Belgium (1997)	71	↓
Germany (1997)	64	→
Portugal (2) (1998)	61	↑
	Dealing/trafficking	**Dealing/trafficking**
Spain (1998)	100	not applicable
Netherlands (1998)	100	not applicable
	Use and trafficking	**Use and trafficking**
Luxembourg (1998)	67	n.a.

For definitions of 'arrests' for drug offences, see Figure 13.
↑ = proportion increasing; ↓ = proportion decreasing; → = proportion stable n.a. = data not available
(1) Also includes small-scale trafficking (the law differentiates between small and large quantities).
(2) Cases of use plus trafficking are excluded here.
(3) Possession for personal use is normally not prosecuted in the Netherlands; drug use and possession for use are not criminalised in Spain.

Source: Reitox national focal points.

difficult to assess which aspect of the variation in the figures between Member States is attributable to differences in the people committing the offences, in law-enforcement strategies or in law-enforcement information systems, such as variations in definitions and recording procedures.

Prison data

Information at national level on drug use in prison remains very limited and reliable data are rare. The type of information varies widely, from people imprisoned for drug offences to drug users identified on entry to prison, to levels of use revealed by surveys or tests in prison.

Drug offenders in EU prisons range from 15 to 50 % of the total prison population. Data provided by some countries show that in over 75 % of these cases the main drug offence is related to dealing/trafficking. The proportion of drug offenders among prisoners in Belgium and Finland is increasing, is stable in the Netherlands and is decreasing in Luxembourg. Figures are not available for other countries.

Box 8

European survey of drug users in prison

A survey was carried out at local level in seven European countries in 1997 using a common methodology. It showed proportions of 'active intravenous drug users' — defined as intravenous drug users who have taken drugs within the 12 months prior to imprisonment — among prisoners in 21 prisons ranging from 9 % in France to 59 % in Sweden, and 16 to 46 % in Belgium, Germany, Spain, Italy and Portugal. However, the prisons examined are not representative of the whole prison system, which makes it impossible to extrapolate results to the whole country.

Source: European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', May 1998.

Twelve Member States provide information on drug users among prisoners. However, the data refer in most cases to different definitions and cannot be directly compared. Drug use is reported for 30 to 90 % of prisoners, while problematic drug use appears to concern 10 to 45 % of prisoners. These figures generally relate to the local level. Since the local context varies widely, it cannot be taken as representative of each country.

Drug market indicators

Seizures, price and purity of illicit drugs

The quantities of drugs seized by law-enforcement agencies are indirect indicators of the supply and availability of drugs. Seizures reflect a range of factors other than the quantities of drugs imported and distributed, including law-enforcement resources, priorities, strategies and the vulnerability of traffickers to enforcement efforts.

Although only a proportion of the supply is seized, there is no factual basis for the common assumption that seizures represent 10 % of the total supply. This figure varies over time, between countries and between drugs, and one exceptionally large seizure can seriously distort the figures for a given year or country. In general, consistent changes are a surer guide to trends than year-on-year fluctuations.

Variations in seizures among the Member States do not always reflect differences in availability or consumption in these countries. This applies particularly to those that, for geographical or historical reasons, are first destinations for imported cannabis, heroin and cocaine, or that produce synthetic drugs. The number of seizures of different drugs, which in many countries includes an important proportion of small seizures from the retail and consumer levels of the market, should be taken into account. This may be a better indirect indicator of availability than total quantities, which are skewed by small numbers of large seizures.

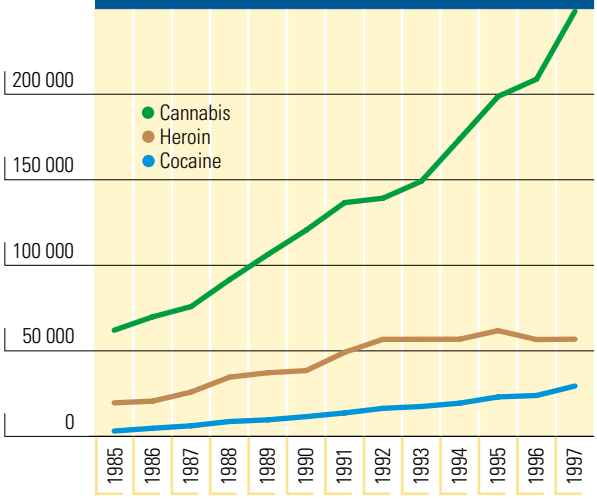
In any event, seizure data should be treated with caution and interpreted together with other indicators, such as price and purity, availability at consumer level, information on the structure of drug markets and the actors involved.

Price and purity are usually considered as indicators of drug availability at user level. Drug prices vary between and within Member States according to factors such as purity of substances, level of drug availability, trafficking routes, law-enforcement interventions, time and place where the price and purity are measured and other drug market indicators.

Some countries provide data on price and purity, but as it is difficult to analyse these without any additional information on contextual factors, it is impossible to compare them directly.

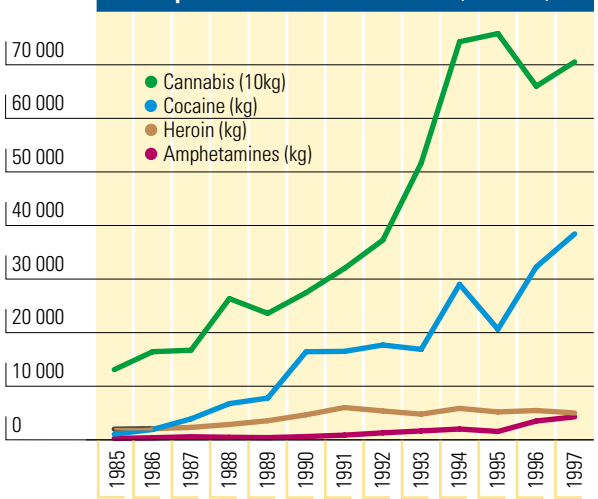
For this annual report, all Member States provided details of the quantities seized up to 1997 (1998 data were not available for Ireland and the UK) and all except Greece and the Netherlands gave the number of seizures made (see

Figure 14 **Number of cannabis, heroin and cocaine seizures in the EU (1985–97)**



Notes: Data are not available for Greece and the Netherlands.
The number of seizures for 1996 and 1997 is underestimated as data for Belgium are missing.
For more details, see Table 14.

Figure 15 **Quantities of cannabis, cocaine, heroin and amphetamines seized in the EU (1985–97)**



Notes: The quantity of amphetamines seized in 1997 is underestimated as data for Belgium and the Netherlands are not available.
For more details, see Table 15.

Figures 14 and 15 and Tables 14 and 15). Data on price and purity were available for some countries, although they were of uncertain quality and comparability.

Cannabis

The total quantity of cannabis seized increased rapidly in the early 1990s from 236 tonnes in 1989 to a peak of 758 tonnes in 1995. This indicator has been relatively stable for three years at about five times the level recorded in the mid-1980s. The largest quantities of cannabis were seized in Spain in 1998.

In all Member States that provided data, except Portugal, cannabis accounted for the greatest number of seizures. Like data on quantities, the number of seizures showed an increase from the mid-1980s, but at a steadier rate. Between 1985 and 1997, the number of cannabis seizures was multiplied by a factor of eight. In all countries where 1998 data were available except Austria, a rising trend was observed.

Generally, cannabis prices appear to be stable, although Germany and Sweden report a decreasing trend. The cannabis market is entrenched in most of the EU and, depending on the country, availability is high and stable or is increasing.

Heroin

The quantities of heroin seized increased threefold in the late 1980s and early 1990s, from under 2 tonnes in 1985 to over 6 tonnes in 1991. Since then, the quantities have fluctuated at a slightly lower level within a range of 5 to 6 tonnes. Fluctuating patterns can be observed in most Member States. Until 1994, the largest amounts of heroin were seized in Germany and Italy. Since 1995, the UK has been in first place, with nearly half of the total amount seized in the EU in 1997. In 1998, Germany, Spain, France and Italy, the main seizing countries after the UK (the UK did not provide data for 1998), show a decrease in the quantities of heroin seized.

The number of seizures illustrates a clearer pattern. Overall, the numbers rose steadily from 1985 to 1992 and have since stabilised. There are clear decreases over the past three years in Denmark, France, Italy, Luxembourg and Austria and marked increases in Ireland, Finland, Sweden and the UK. In most Member States, heroin is the second most commonly seized drug after cannabis, while in Portugal it is the most common.

The average quantity of heroin per seizure at EU level has remained stable since the mid-1980s at about 60 to 80 g. France and the UK are currently seizing a higher quantity of heroin on average. These results should, however, be taken with some degree of caution since this measure is global and only a rough indicator of the average quantity of a substance seized.

Following a decrease in previous years, the street price of heroin seems to be stable in most EU countries, although the trend in Belgium and Germany is falling while Italy reported an increase in 1997. Heroin purity is reported to range from 10 to 25 % in Germany, Greece and Luxembourg and from 30 to 50 % in Spain, Finland and the UK.

Overall, there are no major indications of change in the heroin market. While heroin is less widely available than

cannabis, there appear to be few difficulties in obtaining supplies for users in most Member States, especially in large cities. There are reports of increased availability in smaller cities and towns, too.

Cocaine

The quantities of cocaine seized increased from 1 tonne in 1985 to over 16 tonnes in 1990. Following four years of stability, the amounts seized rose sharply to 29 tonnes in 1994, and 38 tonnes in 1997. Spain remained the country where the largest quantities of cocaine were seized in 1998. Although data are missing for some Member States, the amount of cocaine seized in 1998 in the EU appears to have decreased, especially in Spain which reported a fall of over one third.

The number of seizures shows a steadier increase from 1985–97, without any of the sharp peaks and troughs seen in the data on quantities. This increase is reflected in almost every Member State, but has been especially marked in recent years in Spain, Ireland and Austria.

The quantities of cocaine seized have increasingly exceeded those for heroin since 1987. In recent years, they have been six to seven times higher. In contrast, the number of seizures is half that for heroin.

The average quantity of drugs seized at EU level is much lower for heroin than for cocaine, which has been increasing slightly since 1985 from about 250 g per seizure to over 1 kg in 1997. This contrast between heroin and cocaine seizures may reflect a tendency for cocaine to be trafficked in larger quantities than heroin, as well as a lower vulnerability of cocaine retail suppliers and consumers to law-enforcement interventions compared with heroin.

After decreases in previous years, the street price of cocaine is relatively stable in most reporting countries, although a downward trend is reported in Belgium and Germany. Limited data suggest that retail purity ranges between 50 and 70 %, except in Greece which reports 5 to 10 % purity at user level.

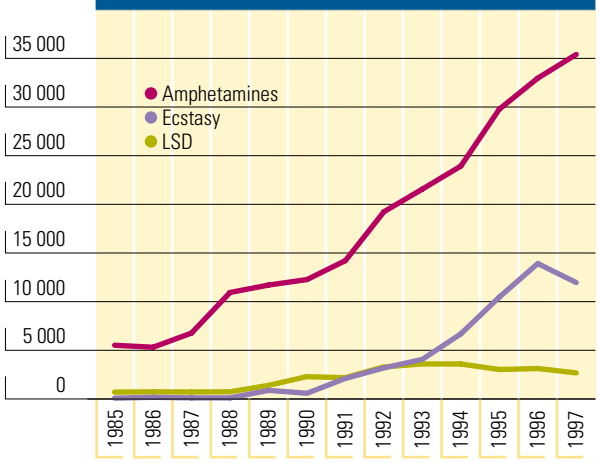
The overall picture is of an expanding market with increased availability in recent years, especially in metropolitan areas. Although the situation is unclear, there are anecdotal reports of increased availability of crack in EU countries, apart from those established locally in areas of France, the Netherlands and the UK.

Synthetic drugs: amphetamines, ecstasy and LSD

The quantities of amphetamines seized in the EU increased slowly in the late 1980s from a relatively low level in 1985 to over 1 tonne in 1992. Since then, the upward trend has accelerated and the total amount rose to over 4 tonnes in 1997. More than 75 % of this is accounted for by seizures in the UK, although there have been significant seizures in Germany, France, the Netherlands and Sweden.

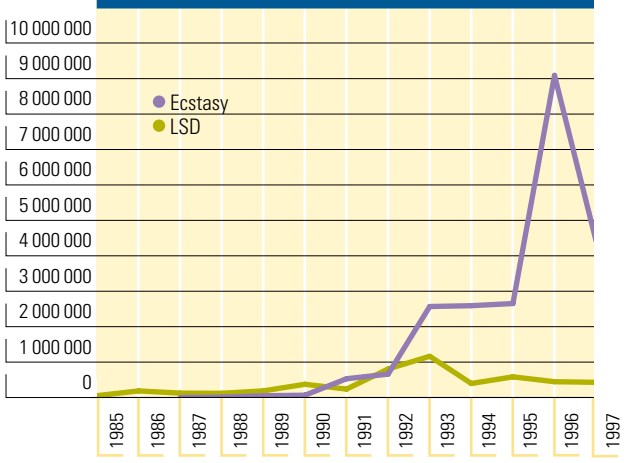
The number of amphetamine seizures in the EU has increased steadily sevenfold since 1985, but has accelerated in recent years in Germany, France, Ireland, Austria and Finland. In Sweden and the UK, amphetamines are the second most common drug seized.

Figure 16 **Number of amphetamine, ecstasy and LSD seizures in the EU (1985–97)**



Notes: Data are not available for Greece and the Netherlands.
The number of seizures for 1996 and 1997 is underestimated as data for Belgium are missing.
The number of ecstasy seizures for 1985–94 is overestimated as LSD seizures are also included for Spain. For more details, see Table 14.

Figure 17 **Quantities of ecstasy and LSD seized in the EU (1985–97)**



The quantities of ecstasy seized have increased sharply from 1 000 pills in 1987 to 2.5 million in 1993. Following stabilisation, they rose to a peak of 9 million in 1996 before decreasing to 4.5 million in 1997. Larger amounts were seized in Germany, the Netherlands and the UK.

Following a steady upward trend, the number of ecstasy seizures declined or stabilised in most countries in 1997 and 1998. Only in Denmark has the number of seizures continued to increase over the last three years.

The quantities of LSD rose from low levels in the 1980s to over one million units in 1993. They have fallen substantially since and remain relatively stable at around less than half a million.

As for amphetamines and ecstasy, LSD seizures increased in the late 1980s and early 1990s, but since 1993–94 have levelled or fallen in all the Member States except Austria which saw a continuous rise up to 1997.

Apart from trends over time, there are differences between Member States. In most countries, amphetamines predominate, but in Belgium, France, Italy and Luxembourg ecstasy is more frequently seized. Seizures of LSD are less common.

As with other drugs, the data available make comparisons of price and purity difficult. The recent general trend has been a decrease in the price of both amphetamines and ecstasy, although some countries report price stability. Reported purity ranges for amphetamines are between 10 and 100 %.

The purity and composition of pills sold as ecstasy vary considerably and are unknown. In contrast with the 1997 trend, in 1998 the Netherlands (thanks to its surveillance system on drugs) reported an increase in the presence of MDMA and a decrease in that of amphetamines in pill contents. Other synthetic drugs have been reported from Member States in recent years, including analogues of MDMA sold as ecstasy (such as MDA, MDEA, MBDB) as well as ketamine, DOB, 2-CB and, more rarely, 4-MTA. This may reflect market testing by illicit manufacturers, but so far there has been no indication that any of these alternatives is achieving a significant market share.

Data on 1998 seizures appear to confirm that, despite rising concern about ecstasy in recent years, amphetamines are actually increasingly dominating the market in synthetic drugs.

Tables

Table 1

Lifetime prevalence of drug use in recent nationwide surveys among the general population in some EU countries

	Method			All adults					Younger adults				
	Year	Data collection	Sample	Age range	Cannabis (%)	Cocaine (%)	Amphetamines (%)	Ecstasy (%)	Age range	Cannabis (%)	Cocaine (%)	Amphetamines (%)	Ecstasy (%)
Belgium (Flemish C.)	1994	Phone	2 259	(18–65)	5.8	0.5	0.9	0.5	(18–35)	9.2	1.2	2.0	1.3
Denmark (1)	1994	Interview	2 521	n.a.	n.a.	n.a.	n.a.	n.a.	(16–44)	37.0	n.a.	5.0[a]	n.a.
Denmark (2)	1994	Mail	1 390	(18–69)	31.3	2.0	4.0	n.a.	(16–44)	43.0	n.a.	n.a.	n.a.
Germany (former East) (1)	1995	Mail	1 541	(18–59)	3.6	0.2	0.7	0.7	(18–39)	6.4	0.3	1.3	1.4
Germany (former West) (1)	1995	Mail	6 292	(18–59)	13.9	2.2	2.8	1.6	(18–39)	21.0	3.7	4.1	2.8
Germany (former East) (2)	1997	Mail	1 682	(18–59)	4.2	0.2	0.5	0.7	(18–39)	7.8	0.4	1.0	1.3
Germany (former West) (2)	1997	Mail	6 338	(18–59)	13.4	1.5	1.8	1.7	(18–39)	20.1	2.2	2.4	3.2
Greece	1998	Interview	3 752	(15–64)	13.1	1.3	0.6	0.3	(15–34)	19.7	2.2	0.7	0.6
Spain (1)	1995	Interview	9 984	(15–64)	14.2	3.7 [b]	2.5	2.0 [c]	(15–34)	22.9	5.9 [b]	4.0	3.5 [c]
Spain (2)	1997	Interview	12 445	(15–64)	22.2	3.3 [b]	2.5	2.5 [c]	(15–34)	31.8	5.2 [b]	4.1	4.7 [c]
France	1995	Phone	1 993	(18–69)	16.0	1.2	0.7 [d]	n.a.	(18–39)	25.7	1.8	1.4 [d]	n.a.
Netherlands	1997–98	Interview	22 000	(15–69)	18.1	2.4	2.1	2.2	(15–34)	27.3	3.7	3.0	4.4
Finland (1)	1996	Mail	3 009	(16–74)	7.3	n.a.	0.7 [a]	n.a.	(16–34)	15.0	n.a.	n.a.	n.a.
Finland (2)	1998	Mail $	2 568	(15–69)	9.7	0.6 [b]	1.0	0.5	(15–34)	17.5	1.2 [b]	2.0	1.3
Sweden (1)	1996	Interview	1 500	(15–69)	9.0	1.0	2.0	0.0	(15–34)	12.0	1.0	3.0	1.0
Sweden (2)	1998	Interview	1 500	(15–69)	13.0	1.0	2.0	0.0	(15–34)	16.0	1.0	3.0	1.0
UK (England and Wales) (1)	1994	Interview	9 646	(16–59)	21.0	2.0	8.0	2.0	(16–29)	34.0	3.0	14.0	6
UK (England and Wales) (2)	1996	Interview	10 940	(16–59)	22.0	3.0	9.0	3.0	(16–29)	36.0	4.0	16.0	9

Data collection = data-collection method; interview = face-to-face interview; phone = telephone interview; mail = mailed questionnaire; $ = combined sample: mail (n = 2 143) and phone (n = 425); n.a. = data not available
(1) See list of sources. (2)See list of sources. [a] Hard drugs. [b] Cocaine or crack. [c] Ecstasy and other designer drugs. [d] Amphetamines and ecstasy.
Notes: 1. In countries with information on more than two national surveys, only the last two are presented.
2. In some countries (e.g. UK), the age range for young adults is more restricted than in other countries, which tends to produce higher prevalence figures.
3. In Spain, methodological differences in the 1995 and 1997 surveys (questionnaire and sampling method) limit their comparability.
4. UK figures for Ecstasy have been rounded.

Table 2

Last 12 months prevalence of drug use in recent nationwide surveys among the general population in some EU countries

	Method			All adults					Younger adults				
	Year	Data collection	Sample	Age range	Cannabis (%)	Cocaine (%)	Amphetamines (%)	Ecstasy (%)	Age range	Cannabis (%)	Cocaine (%)	Amphetamines (%)	Ecstasy (%)
Belgium (Flemish C.)	1994	Phone	2 259	(18–65)	1.5	0.2	0.3	0.1	(18–35)	3.6	n.a.	n.a.	n.a.
Denmark (1)	1994	Interview	2 521	n.a.	n.a.	n.a.	n.a.	n.a.	(16–44)	7.0	n.a.	0.5 [a]	n.a.
Denmark (2)	1994	Mail	1 390	(18–69)	3.3	n.a.	n.a.	n.a.	(16–44)	6.0	n.a.	n.a.	n.a.
Germany (former East) (1)	1995	Mail	1 541	(18–59)	1.9	0.2	0.2	0.6	(18–39)	3.5	0.3	0.4	1.2
Germany (former West) (1)	1995	Mail	6 292	(18–59)	5.0	0.9	0.8	0.9	(18–39)	8.8	1.6	1.5	1.6
Germany (former East) (2)	1997	Mail	1 682	(18–59)	2.3	0.1	0.3	0.4	(18–39)	4.5	0.2	0.6	0.7
Germany (former West) (2)	1997	Mail	6 338	(18–59)	4.5	0.7	0.5	0.9	(18–39)	7.8	1.2	0.9	1.7
Greece	1998	Interview	3 752	(15–64)	4.4	0.5	0.1	0.1	(15–34)	8.8	1.0	0.1	0.3
Spain (1)	1995	Interview	9 984	(15–64)	7.3	1.9 [b]	1.1	1.3 [c]	(15–34)	12.8	3.4 [b]	1.9	2.5 [c]
Spain (2)	1997	Interview	12 445	(15–64)	7.6	1.6 [b]	0.9	0.9 [c]	(15–34)	14.2	2.7 [b]	1.7	1.7 [c]
France	1995	Phone	1 993	(18–69)	4.7	0.2	0.3 [d]	n.a.	(18–39)	8.9	0.3	0.6 [d]	n.a.
Netherlands	1997–98	Interview	22 000	(15–69)	5.2	0.7	0.4	0.8	(15–34)	9.8	1.4	0.8	1.8
Finland (1)	1996	Mail	3 009	(16–74)	1.9	n.a.	n.a.	n.a.	(16–34)	5.2	n.a.	n.a.	n.a.
Finland (2)	1998	Mail $	2 568	(15–69)	2.5	0.2 [b]	0.2	0.2	(15–34)	6.3	0.4 [b]	0.4	0.4
Sweden (1)	1996	Interview	1 500	(15–69)	1[e]	n.a.	n.a.	n.a.	(15–34)	1.0 [e]	n.a.	n.a.	n.a.
Sweden (2)	1998	Interview	1 500	(15–69)	1.0	n.a.	n.a.	n.a.	(15–34)	2.0	n.a.	n.a.	n.a.
UK (England and Wales) (1)	1994	Interview	10 000	(16–59)	8.0	<0.5	2.0	1.0	(16–29)	20.0	1.0	7.0	3
UK (England and Wales) (2)	1996	Interview	10 940	(16–59)	9.0	<0.5	3.0	1.0	(16–29)	21.0	1.0	8.0	4

Data collection = data-collection method; interview = face-to-face interview; phone = telephone interview; mail = mailed questionnaire; $ = combined sample: mail (n = 2 143) and phone (n = 425); n.a. = data not available
(1) See list of sources. (2) See list of sources. [a] Hard drugs. [b] Cocaine or crack. [c] Ecstasy and other designer drugs. [d] Amphetamines and ecstasy. [e] All illegal drugs.
Notes: 1. In countries with information on more than two national surveys, only the last two are presented
2. In some countries (e.g. UK), the age range for young adults is more restricted than in other countries, which tends to produce higher prevalence figures.
3. In Spain, methodological differences in the 1995 and 1997 surveys (questionnaire and sampling method) limit their comparability.
4. UK figures for ecstasy have been rounded.

Table 3

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

	Year	Sample	All illegal drugs (%)	Cannabis (%)	Solvents (%)	Amphetamines (%)	Ecstasy (%)	LSD (%)	Cocaine (%)	Heroin (%)
Belgium (Flemish C.) (1)	1996	2 391	n.a.	19.6	2.9	3.2	5.6	2.0	0.6	0.6
Belgium (Flemish C.) (2)	1998	9 211	n.a.	23.7	4.4	3.8	6.2	2.1	1.3	0.7
Denmark	1995	2 571	n.a.	18.0	6.0	1.9	0.5	0.4	0.5	2.0
Greece (1)	1993	10 543	4.5	3.0	6.3	4.0	n.a.	1.1	0.9	0.6
Greece (2)	1998	8 557	11.4	10.2	13.7	3.6	1.8	2.6	1.6	0.8
Spain (1)	1994	21 094	22.1	19.4	3.2	3.5	2.9 (a)	4.5	1.7	0.5
Spain (2)	1996	19 191	29.6	24.3	3.5	4.1	4.6 (a)	5.6	2.5	0.8
France (1)	1993	12 391	15.3	11.9	5.5	2.5 (b)	n.a.	1.5	1.1	0.8
France (2)	1997	9 919	27.5	23.0	5.5	1.9	2.5 (c)	n.a.	1.5	1.4
Ireland	1995	1 849	37.0	37.0	n.a.	3.0	9.0	13.0	2.0	2.0
Italy	1995	1 641	21.0	19.0	8.0	3.0	4.0	5.0	3.0	2.0
Luxembourg	1998	660	n.a.	18.5	2.1	1.0	1.5	0.0	1.0	0.5
Netherlands	1996	10 455	31.7	31.1	n.a.	7.8	8.1	n.a.	4.3	1.3
Austria	1994	2 250	9.9	9.5	n.a.	n.a.	n.a.	n.a.	— 2.0 (d) —	
Portugal	1995	4 767	4.7	3.8	n.a.	n.a.	n.a.	0.2	1.0	0.9
Finland	1995	2 300	5.5	5.2	4.4	0.5	0.2	0.3	0.2	0.1
Sweden (1)	1997	5 683	7.6	6.8	8.7	0.9	0.8	0.5	0.5	0.5
Sweden (2)	1998	5 455	7.7	7.2	8.2	1.1	1.0	1.0	0.6	0.6
UK (1)	1995	7 722	42.0	41.0	20.0	13.0	8.0	14.0	3.0	2.0
UK (2)	1997	28 756	39.8	37.5	4.0	7.3	3.0	3.2	1.5	0.7

n.a. = data not available
(1) See list of sources. (2) See list of sources.
(a) Ecstasy and other synthetic or designer drugs. (b) Amphetamines, ecstasy and stimulants. (c) LSD and ecstasy. (d) Hard drugs.
Notes: LSD = 'LSD and other hallucinogens' in Spain, Ireland, Italy and the UK. 1. In countries with information on more than two national surveys, only the last two are presented. 2. In all the surveys, the method for data collection was written questionnaires. 3. Crack use has been reported independently of cocaine in Ireland (3 %), Italy (2 %) and the UK (survey 1 to 3 %). 4. The 1997 French survey gives information on last year's prevalence of drug use, not lifetime prevalence. 5. In Germany, a youth survey (12- to 25-year-olds) has been conducted every three to four years since 1970 instead of the school survey. In the 1997 survey, the total sample was 3 010. Lifetime prevalence for any illegal drug among 14- to 17-year-olds was 11 % (former West Germany) and 10 % (former East Germany). 6. In the Greek surveys, amphetamines are not included in the category 'all illegal drugs'. 7. In Luxembourg, the age group selected is 15 to 17. The sample size of this survey is very small and results should be interpreted with caution. 8. Results of the UK surveys of 1995 and 1997 are not comparable due to differences in methodology (sample and questionnaire).

Table 4

National prevalence estimates of problem drug use in the EU and Norway (absolute numbers of problem drug users aged 15 to 54)

	Extrapolation from police date	Extrapolation from treatment data	Mortality multiplier	Capture–recapture	Multivariate indicator	Back calculation (BC) – HIV/AIDS multiplier
Belgium	n.a.	n.a.	n.a.	n.a.	n.a.	20 200 (a)
Denmark	n.a.	n.a.	12 500	n.a.	n.a.	10 200
Germany	140 843–165 424	94 350–140 600	80 000–112 000	n.a.	n.a.	n.a.
Greece	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
France	164 000	156 000–176 000	n.a.	n.a.	n.a.	124 000–155 000
Ireland	n.a.	n.a.	4 600–7 726	6 304–13 735 (b)	n.a.	8 600
Italy	172 000	240 000–299 000	n.a.	293 814	248 672	326 000
Luxembourg	1 800	1 900	n.a.	n.a.	n.a.	n.a.
Netherlands	n.a.	25 145–29 014	n.a.	n.a.	26 984 (c)	n.a.
Austria (1) (d)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	n.a.	1 600–2 400 (e)	4 000–8 500 (e)	8 700–14 500 (e)	n.a.	n.a.
Sweden	n.a.	n.a.	n.a.	10 600–15 800 (f)	n.a.	n.a.
UK	n.a.	262 633–341 423	88 900–177 800	n.a.	273 923–288 675	n.a.
Norway	n.a.	n.a.	7 200–10 300	n.a.	n.a.	n.a.

n.a. = data not available
(1) See list of sources.
(a) Estimate using HIV/AIDS register instead of back calculation; definition includes only IDUs and thus underestimates all problem drug use. (b) Problematic opiate use. Police data include 7 % non-opiate users; 10 % were identified because of possession (not necessarily users) and 5 % were identified by other means. Three-sample capture–recapture: police data cover 1 September 1995 to 30 August 1996, other sources the 1996 calendar year. (c) Heroin addicts or hard drug users. (d) In Austria an estimate of 10 000 to 15 000 opiate addicts exists (rate 2.2 to 3.3 per 1 000 population aged 15 to 54) based on 'consistency checks' between data sources. This estimate was not derived within the EMCDDA project. (e) Problematic opiate and amphetamine users (1997). The lower estimate refers mainly to drug users with medical problems while the higher also includes drug users with potential legal problems such as driving under the influence. (f) 1992: 1 700 to 3 350 heroin addicts; 8 900 to 12 450 other addicts, mostly amphetamine injectors (excluding cannabis addicts). The official Swedish estimate which was presented last year includes cannabis addicts and is thus higher.

Table 5

National prevalence estimates of problem drug use in the EU and Norway (prevalence rates of problem drug use per 1 000 inhabitants aged 15 to 54)

	Total population size (age 15 to 54)	Extrapolation from police data (%)	Extrapolation from treatment data (%)	Mortality multiplier (%)	Capture – recapture (%)	Multivariate indicator (%)	Back calculation (BC) – HIV/AIDS multiplier (%)
Belgium	5 602 499	n.a.	n.a.	n.a.	n.a.	n.a.	3.6 [a]
Denmark	3 014 995	n.a.	n.a.	4.1	n.a.	n.a.	3.4
Germany	45 207 736	3.1–3.7	2.1–3.1	1.8–2.5	n.a.	n.a.	n.a.
Greece	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
France	32 431 857	5.1	4.8–5.4	n.a.	n.a.	n.a.	3.8–4.8
Ireland	2 061 028	n.a.	n.a.	2.2–3.7	3.1–6.7 [b]	n.a.	4.2
Italy	32 315 499	5.3	7.4–9.3	n.a.	9.1	7.7	10.1
Luxembourg	220 572	8.2	8.6	n.a.	n.a.	n.a.	n.a.
Netherlands	9 117 319	n.a.	2.8–3.2	n.a.	n.a.	3.0 [c]	n.a.
Austria (1) [d]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	2 895 000	n.a.	0.6–0.8 [e]	1.4–2.9 [e]	3.0–5.0 [e]	n.a.	n.a.
Sweden	4 765 656	n.a.	n.a.	n.a.	2.2–3.3 [f]	n.a.	n.a.
UK	32 481 100	n.a.	8.1–10.5	2.7–5.5	n.a.	8.4–8.9	n.a.
Norway	2 462 300	n.a.	n.a.	2.8–4.2	n.a.	n.a.	n.a.

n.a. = data not available
(1) See list of sources.
[a] Estimate using HIV/AIDS register instead of back calculation; definition includes only IDUs and thus underestimates all problem drug use. [b] Problematic opiate use. Police data include 7 % non-opiate users; 10 % were identified because of possession (not necessarily users) and 5 % were identified by other means. Three-sample capture—recapture: police data cover 1 September 1995 to 30 August 1996, other sources the 1996 calendar year. [c] Heroin addicts or hard drug users. [d] In Austria an estimate of 10 000 to 15 000 opiate addicts exists (rate 2.2 to 3.3 per 1 000 population aged 15 to 54) based on 'consistency checks' between data sources. This estimate was not derived within the EMCDDA project. [e] Problematic opiate and amphetamine users (1997). See Table 4. [f] 1992: 1 700 to 3 350 heroin addicts; 8 900 to 12 450 other addicts, mostly amphetamine injectors (excluding cannabis addicts). The official Swedish estimate which was presented last year includes cannabis addicts and is thus higher.

Table 6

Some characteristics of persons treated for drug problems in the EU

	Year	Mean age	Age distribution		Gender distribution male/female	IV route of administration of main drug (%)	% distribution of main drug (% IV route of administration)						
			< 25	> 35			Opiates [a]	Cocaine	Amphetamines [b]	Ecstasy	Hallucinogens	Cannabis	Others [c]
Belgium (Brussels)	1997	30	21	17	78/22	n.a.	77.1(n.a.)	7.2(n.a.) [d]	n.a.	n.a.	0.1	6.6	8.6
Belgium (Flemish C.)	1996	26.6	52	18.5	75/25	n.a.	39.5(n.a.)	7.1(n.a.)	18.7(n.a.)	1.2	4.9	22	5.5
Belgium (French C.)	1997	27.4	37.4	14.1	74/26	24	67.7(34)	3.8(35)	0.7(0)	2.5	0.1	13.2	11.9
Denmark	1997	32.5	20	40	73/27	27	84.6 (53)	0.7(n.a.)	2(n.a.)	n.a.	n.a.	10.5	0.6
Germany [e]	1998	28.1	41	22	77/23	37.1	64.6(49)	7.1(38)	3.2(13)	n.a.	1.2	18	5.9
Greece	1998	31.6	21	35.1	84/16	77.5	91.9(84)	0.7(0)	0(n.a.)	0	0	5.7	1.7
Spain	1997	29.6	24.8	18.9	84/16	27.3	84.9(31)	8.9(6)	0.6(2)	0.5	0.2	4.2	0.7
France [f]	1997	29.8	21	21.5	76/24	63	78.6(73)	3.1(47)	0.5(56)	0.7	0.4	11	5.7
Ireland	1997	24.3	60.5	8.2	69/31	49.2	79.8 (65)	0.9(10)	1(0)	5	0.5	10.6	2.1
Italy	1998	30.5	19.5	25	86/14	n.a.	86.4 (74)	3.2 (23.6)	0.2 (6.8)	0.7	0.2	67.6	1.7
Luxembourg	1997	28.5	27	15	81/19	79	81(88)	15(80)	1(n.a.)	1	n.a.	4	n.a.
Netherlands [g]	1998	30.8	23.2	30.4	81/19	9.8	65.1(13.6)	17.5(2.6)	3(8.7)	1.1	0.2	10.9	2.0
Austria	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.
Portugal [h]	1997	28.2	29.1	16	80/20	41.9	96.9 (n.a.)	1.2(n.a.)	n.a.	n.a.	n.a.	1.9	1.5
Finland	1997	n.a.	37.2	22.7	72/28	n.a.	27.2(n.a.)	0.6(n.a.)	47.9(n.a.)	n.a.	6.4	17.9	n.a.
Sweden	1996	33	17	42	72/28	n.a.	39(n.a.)	< 1(n.a.)	20(n.a.)	n.a.	<1	7	33
UK (Great Britain) [i]	1997	n.a.	42	15	74/26	40	71(58)	4(5)	9(44)	n.a.	0	8	7

IV = intravenous; n.a. = data not available
[a] In some countries (Germany, Italy and Luxembourg), information about IV route of admission of opiates refers to heroin. [b] In some countries, 'amphetamines' include ecstasy. [c] 'Others' include: Belgium (Brussels – hypnotics, sedatives, others); Belgium (Flemish Community – hypnotics, sedatives); Belgium (French Community – hypnotics, sedatives, solvents, others); France (solvents, hypnotics, sedatives); Sweden (multiple abuse); UK (hypnotics, sedatives, solvents, others). [d] Cocaine = stimulants including cocaine and amphetamines. [e] IV = currently injecting the drug. [f]Data refer to specialised centres only. IV refers to currently or previously injecting. Data are collected on a census basis, and injection status is assessed at time of data collection. Presentation of results in this table may overestimate the proportion of injectors, but using only 'currently injecting' would underestimate the injection behaviour to a much larger extent. [g] Data refer to specialised out-patient centres. [h] IV = currently injecting any drug.
[i] UK data correspond to the period 1 April 1997 to 30 September 1997. Data are for persons presenting for treatment, not persons treated.

Table 7 Number of acute drug-related deaths recorded in the EU (1985–97)

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	Population at risk (million)
Belgium	12	20	17	37	49	96	90	75	80	46	48	n.a.	n.a.	10.1
Denmark	150	109	140	135	123	115	188	208	210	271	274	266	275	5.2
Germany (a)	324	348	442	670	991	1 491	2 125	2 099	1 738	1 624	1 565	1 699	1 486	81.8
Greece	10	28	56	62	72	66	79	79	78	146	176	222	232	10.4
Spain (b)	143	163	234	337	455	455	579	556	442	388	394	415	347	14.5
France	172	185	228	236	318	350	411	499	454	564	465	393	228	58.2
Ireland	19	6	4	7	5	7	7	14	16	19	39	50	52	3.6
Italy	242	292	543	809	974	1 161	1 383	1 217	888	867	1 195	1 566	1 160	57.1
Luxembourg	1	3	5	4	8	9	17	17	14	29	20	16	9	0.23
Netherlands	40	42	23	33	30	43	49	43	38	50	33	61	67	15.6
Austria (c)	d.a.	d.a.	d.a.	d.a.	20	36	70	121	130	140	160	179	132	7.9
Portugal (d)	n.a.	18	22	33	52	82	121	156	115	143	145	169	135	9.8
Finland	n.a.	n.a.	n.a.	11	23	41	34	27	26	35	51	45	n.a.	5.1
Sweden	150	138	141	125	113	143	147	175	181	205	194	250	n.a.	8.8
UK (England and Wales)	1 254	1 362	1 332	1 348	1 321	1 339	1 411	1 533	1 615	1 796	1 956	2 150	2 144	58

d.a. = data available, but not comparable with the other years; n.a. = data not available
(a) Cases from the former West Germany. Former East Germany: 1996 (13 cases); 1997 (15 cases).
(b) Only cases related to opiates or cocaine, although from 1996 other psychoactive substances have been included. Cases for 1997 from Seville are estimated (36).
(c) Only overdoses are presented for greater comparability with other countries.
(d) Only overdoses are reported. In 1997, there may have been an under-notification of cases.
Notes: 1. Data from different countries are not directly comparable, as there are differences in the ways cases are defined (see Table 8 of the EMCDDA's 1997 annual report).
2. In some countries, the case definitions used for this table have been modified from those described in Table 8 of the EMCDDA's 1997 annual report. Finland: set of International Classification of Diseases, ninth edition (ICD-9) codes (1988–95) and ICD-10 codes (1996) related to harmful use, dependence syndrome, substance-induced brain syndrome, poisoning and other drug-related syndromes. Netherlands: cases whose underlying cause of death were ICD-9 codes 292, 304, 305.2–9, E850.0, E854.1 or E854.2 (1985–95) and cases whose underlying cause of death were ICD-10 codes F11–F19 (excluding F17) or X42 (from 1996). United Kingdom: cases whose underlying cause of death were ICD-9 codes 1304, 305.2–9, 965.0, 967, 968.5, 969 and 977.8–9.
3. The population at risk is different from the total population only when cases of death are recorded from a defined subgroup of the population (Ireland and Luxembourg — population aged 15 to 49; Spain — population of six major cities).

Table 8 Prevalence of HIV infection among injecting drug users in the EU

	Year	Data	Number tested	Percentage infected (a)	Prevalence trend (a) (b)
Belgium (Flemish C.) (1)	1996–97	Treatment/street studies	225	2.2	Stable
Belgium (French C.) (2)	1997	First treatments, self-reports (c)	270	2.6	Stable
Denmark	1995	Estimate from HIV notification	n.a.	4	Stable
Germany	1997	Drug users in treatment, self-reports (c)(d)	1 605	0.6–3.8	Stable
Greece	1997–98	Treatment reporting system, self-reports, screening (c)	1 119	0.5–3.2	Stable
Spain	1996	Survey of treatment centres, self-reports confirmed by medical records	2 025	32	n.a.
France	1997	Survey of specialised treatment centres, notifications/ self-reports of lifetime IDUs (c); data from GPs	8 511	15.5–18.3	Stable
Ireland	1995–97	Dublin: study in treatment	333	(0.9)	(Decrease)
Italy	1997	Treatment in public services, screening (d)	76 096	15.7/1–28	Decrease
Luxembourg	1998	Treatment reporting systems, self-reports (c)	274	3	Stable
Netherlands	1995–97	Repeated treatment/street studies	1 333	2–26	Stable
Austria	1997–98	Opiate overdose deaths; Vienna: low-threshold treatment	232	1.5–(2)	Stable
Portugal	1996	Survey of treatment centres, self-reports (c)	379	14	Stable
Finland	1998	Helsinki: syringe exchange, saliva tests	135	(3)	(Increase)
Sweden	1997	Study of nine prisons	196	2.6	Stable
UK (England and Wales)	1997	Unlinked Anonymous	2 678	1	Stable

n.a. = not available
(1) See list of sources.
(2) See list of sources.
(a) Information based on local data is given between parentheses.
(b) Trend in prevalence is not always based on same data source as prevalence, see list of sources.
(c) Data based on self-reports may be unreliable.
(d) Data are based on all opiate users entering treatment and thus represent a lower limit of prevalence for IDUs.

Table 9 Incidence of AIDS cases related to injecting drug use in the EU (by 31 December 1998)

	Annual incidence rates per million population														% of AIDS cases related to injecting drug use
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1985–98
Belgium	0.0	0.1	0.5	0.7	1.0	1.1	2.2	2.3	2.1	2.0	1.3	1.0	0.6	1.3	6.5
Denmark	0.0	0.2	0.6	1.2	1.6	3.1	3.1	3.5	4.1	4.6	5.4	3.3	1.7	0.6	7.9
Germany	0.2	0.6	1.6	2.2	2.9	2.9	2.9	3.4	3.4	3.7	3.1	2.6	1.5	1.1	14.2
Greece	0.0	0.1	0.1	0.2	0.5	0.6	1.2	0.6	0.8	0.5	0.4	0.9	1.0	0.5	3.9
Spain	2.4	7.1	17.1	38.8	52.1	64.7	73.4	79.2	86.0	120.5	111.2	102.1	71.9	52.7	65.1
France	0.8	2.7	6.0	11.1	15.7	18.5	20.8	22.8	25.2	23.1	22.0	15.9	7.0	5.5	23.6
Ireland	0.6	0.3	2.8	3.1	6.8	8.3	9.4	10.3	10.8	7.1	5.9	7.1	2.8	0.7	42.5
Italy	1.7	4.8	12.0	21.3	29.0	36.1	43.3	48.3	52.7	58.7	58.3	50.0	30.8	18.8	61.7
Luxembourg	0.0	2.7	0.0	2.7	8.0	0.0	2.6	7.7	12.7	5.0	0.0	4.9	5.0	7.5	16.9
Netherlands	0.1	0.4	1.1	2.3	2.3	2.7	2.9	3.7	3.9	4.0	5.0	3.1	2.8	1.1	10.9
Austria	0.8	0.4	3.6	4.3	5.7	5.8	7.0	7.2	7.4	5.2	4.6	3.0	2.5	2.9	25.4
Portugal	0.1	0.3	0.7	1.0	3.0	4.3	7.3	13.5	23.7	33.1	39.3	46.5	50.1	50.1	45.7
Finland	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.6	0.2	0.2	0.2	0.4	0.4	0.0	3.8
Sweden	0.0	0.0	0.1	0.6	0.5	1.3	2.3	2.5	3.8	3.0	2.7	2.5	1.0	0.8	11.5
UK	0.0	0.1	0.3	0.5	1.1	1.4	1.5	1.4	2.6	2.3	2.5	2.0	1.4	0.7	6.5

Notes: 1. Figures for the years 1996–98 are adjusted for reporting delays.
2. In some countries, there may be small differences between incidence rates provided by the European Centre for the Epidemiological Monitoring of AIDS and national figures due to reporting delays.

Table 10 Prevalence of antibodies against hepatitis B and C among injecting drug users in the EU

	Hepatitis B			Hepatitis C		
	Year	Data [a]	% infected [b]	Year	Data	% infected [b]
Belgium (Flemish C.)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Belgium (French C.)	1997	Treatment demands, self-reports [c]	22	1997	Treatment demands, self-reports [c]	47
Denmark	1995	Estimate	21	1995	Estimate	50
Germany	1996–97	Dortmund: treatment; Frankfurt: emergencies	(48–80)	1996–97	Dortmund: treatment; Frankfurt: emergencies	(63–95)
Greece	1998	Methadone treatment	65	1996–98	Methadone treatment	50–80
Spain	1996	Survey of treatment centres	59	1996	Survey of treatment centres	83
France	1996 (1)	Survey of specialised treatment centres	15–30	1997 (2)	Survey of treatment centres, notifications/ self-reports [c]	62–70
Ireland	n.a.	n.a.	n.a.	1997	Dublin: study in treatment	(62)
Italy	1997	Treatment	40	1997	Treatment	67
Luxembourg	1998	Treatment, self-reports [c]	23	1998	Treatment, self-reports [c]	18
Netherlands	1994–96	Rotterdam/Heerlen/Maastricht: treatment	(59–63)	1994–96	Rotterdam/Heerlen/Maastricht: treatment	(74–84)
Austria	1996	Vienna/Vorarlberg: hospital, low-threshold treatment	(50–56)	1996	Vienna/Vorarlberg: hospital, low-threshold treatment	(72–79)
Portugal	n.a.	n.a.	n.a.	1996	Treatment, self-reports [c]	74
Finland	1997	Helsinki: needle exchange, self-reports [c]	(34)	1997	Helsinki: needle exchange, self-reports [c], treated addicts	(63–85)
Sweden	1997 (1)	Study in nine prisons, saliva	55	1994 (2)	Stockholm: study in prison/treatment	(92)
UK	1997 (1)	Unlinked Anonymous, England and Wales	19	1998 (2)	Community and treatment agencies, England, saliva tests	38

n.a. = data not available
(1) See list of sources.
(2) See list of sources.
[a] Hepatitis B data partly reflects vaccination levels. The proportion not positive is still at risk for infection and indicates the vaccination potential.
[b] Information based on local data is given between parentheses.
[c] Self-reports of hepatitis infection may be unreliable.

Table 11

Harm reduction measures for IDUs in the EU

	Syringe-exchange programmes	Unrestricted access to syringes in pharmacies	Availability/ distribution of condoms	HIV counselling and testing	HIV treatment	Hepatitis B vaccination	Hepatitis C action	Substitution therapy	Measures available to prisoners
Belgium	Some	Yes	Yes	Via NGOs	Yes	Yes	Some measures	Since 1990	HIV testing
Denmark	Yes	Yes	Yes	Yes	n.a.	n.a.	Testing	Yes	Information
Germany	In most cities, via low-threshold and outreach services	Yes, cheap	Yes, including in prostitution projects	Yes	n.a.	n.a.	n.a.	Increase since 1992	Methadone
Greece	Yes, and via low-threshold and outreach services	Yes	Yes	Yes	Yes	Yes	Testing	Since 1996	Information plus testing
Spain	Yes, via low-threshold services	Yes	Yes	Yes	Yes	In prisons	Testing	Yes	Information and testing, vaccinations, methadone
France	86 programmes	Yes	Yes	Yes	Since 1996	Experimental in prisons	Testing	Since 1993	Testing, vaccinations
Ireland	Yes	No	Yes	Yes	Yes	Yes	Information and screening	Yes	Information
Italy	All regions, mostly from machines	Yes	Yes	Yes	Yes, free	Yes (5–6 % vaccinated)	Screening (60 % tested)	Yes	Information plus testing, methadone, bleach for cleaning needles
Luxembourg	Yes, via low-threshold services	Yes, but expensive	Yes, via outreach services	Yes, via outreach services	Yes	n.a.	n.a.	Yes	Information plus methadone
Netherlands	Yes	Yes	Yes	Yes	Yes	Pilot	Experimental treatment	Yes	Information
Austria	Many, via low-threshold services	Yes, sold nationally	Via low-threshold services	Via low-threshold and other services	Yes	Yes	Information and testing	Yes	Information and condoms
Portugal	1 mobile unit, rest via pharmacies	Yes, but some problems	Yes	Yes	Yes, but very limited	Yes	n.a.	Yes, but very limited	Information and testing, condoms, methadone, vaccination
Finland	Few, Helsinki	Recently restricted	Rare	Rare	n.a.	Experimental	Information	Limited	HIV testing
Sweden	2 programmes	No	Yes	Yes	Yes	Yes	n.a.	Yes	Information and HIV testing
UK	Yes > 300 programmes	Yes > 2 000 pharmacies	Yes	Yes	Yes	Information and testing	Information for pregnant women	Yes	n.a.

n.a. = data not available

Notes: These data are derived from qualitative descriptions in national reports provided by the Focal Points and were validated by the Focal Points and other experts. However, the data provide little or no information on coverage of the measures, quality or utilization. In many instances these may still be on average very low.

Table 12

Number of 'arrests' [a] for drug offences in the EU (1997 and 1998)

	Population as at 1 January 1997 [b] (1 000)	Number of 'arrests' for drug offences, 1997	Number of 'arrests' for drug offences, 1998
Belgium (P)	10 170.2	n.a.	23 184
Denmark (P)	5 275.1	8 234	8 900
Germany (O)	82 012.2	205 099	n.a.
Greece (P)	10 486.6	6 040	n.a.
Spain (P)	39 298.6	78 847	81 644
France (A)	58 491.6	89 285	91 048
Ireland (C)	3 652.2	4 156	n.a.
Italy (P)	57 461.0	22 705	33 179
Luxembourg (P)	418.3	154	143
Netherlands (O)	15 567.1	10 300 [c]	n.a.
Austria (O)	8 067.8	17 868	16 624
Portugal (O)	9 934.1	9 333	11 333
Finland (P)	5 132.3	7 015	8 173
Sweden (P)	8 844.5	10 625	n.a.
UK (P)	58 901.8	113 154	n.a.
Total EU	**373 713.4**	**628 582**	**n.a.**

(P) = person; (O) = offence; (C) = charge; (A) =arrest;
n.a. = data not available
[a] For precise definitions of 'arrests' for drug offences, see Figure 13.
[b] Figure from Eurostat.
[c] Provisional figure.

Table 13

Drug users among prisoners in the EU

	Definition	Percentage of drug users among prison population	Year	Methodological comments
Belgium	People reporting having used illicit drugs (1)	42	1993	Survey in one prison (n = 1 627)
Denmark	Drug abusers: those having used euphoriants regularly in the six months prior to imprisonment (2)	36	1997	Nationwide survey
	Heavy drug abusers: those who habitually use substances other than cannabis (2)	19	1997	Nationwide survey
Germany	Drug users in prison (based on positive urine samples) (3)	5–26	1995	Survey in one German *Länd* (n = 5 771)
	Drug users in prison (based on information given by key persons) (4)	60	1996	Survey in one prison based on reports of pre-selected prisoners (n = 16), doctor, pastor(s)
	Hard drug users (based on information given by key persons) (4)	10	1996	Survey in one prison based on reports of pre-selected key prisoners (n = 16), doctor, pastor(s)
	Soft drug users (based on information given by key persons) (4)	50	1996	Survey in one prison based on reports of pre-selected key prisoners (n = 16), doctor, pastor(s)
Greece	Injecting drug users (5)	31	1995	Survey in one prison (n = 1 183)
Spain	Women reporting lifetime drug use (alcohol included) (6)	70	1998	Survey in 18 prisons (n = 356)
	Women reporting having used drugs several times a day (alcohol included) (7)	35	1998	Survey in 18 prisons (n = 356)
	People reporting to be drug users (8)	56	1998	Survey in 62 prisons (n = 1 011)
	People whose frequency of heroin and/or cocaine use in the past two years is at least once a week for a minimum of one month (9)	54	1994	Nationwide survey in 25 % of all prisons among people entering prison (n = 1 541)
France	People reporting regular use of all illicit drugs in the 12 months prior to imprisonment (10)	33 (Cannabis: 25; Heroin: 14)	1997	Nationwide survey among 86 % of those entering prison (n = 8 728)
	People reporting illicit drug use within the 12 months prior to imprisonment (11)	43	1997	Survey in four prisons (n = 1 212)
	People reporting lifetime intravenous drug use (11)	23	1996	Survey in one prison (n = 574)
Ireland	Regular heroin users (12)	35	1997	Estimated in one prison
	People with a history of heroin abuse (12)	70	1997	Estimated in one prison
	People reporting heroin use while in prison (13)	42	1996	Survey in one male prison (n = 108)
	People reporting ever having used heroin or cannabis (13)	Heroin: 66; Cannabis: 86	1996	Survey in one male prison (n = 108)
Netherlands	People judged by a clinical psychologist to have drug-addiction problems (14)	29	1997	Survey in one prison (n = 528)
	People reporting drug abuse or drug dependence within the last month (14)	14	1997	Survey in one prison (n = 135)
	People judged to be drug addicts according to two criteria (at least two months of regular use within the past two years; and a severity score of over three in the EuropASI drug section) (15)	44	1997	Survey in one prison (n = 319)
Austria	Intravenous drug users (16) People reporting having used illicit drugs (17)	15 72	1996 1994	Estimated by experts Survey in one prison focusing on those convicted under the Narcotic Drug Act (n = 307)
Finland	People reporting having used drugs (18)	31	1995	Survey in four prisons
Sweden	People having used drugs intravenously or on a daily (or almost daily) basis within the 12 months prior to imprisonment (19)	44	1997	Nationwide survey (n = 3 616)
UK	Prisoners testing positive for drugs during random mandatory drug testing (20)	19	1998	Nationwide survey among 10 % of prisoners (n = 10 340)
England and Wales	People reporting use of drugs in the 12 months prior to imprisonment (21)	68	1994	Nationwide survey (n = 1 000)
	Men entering prison reporting a history of injecting drug use (22)	29	1996	Survey in one prison
	Men entering prison reporting a history of injecting drug use (23)	15	1995	Survey in three prisons
Scotland	Men reporting a history of injecting drug use (24)	32	1991–96	Survey in six male prisons (n = 2 256)
	Women reporting a history of injecting drug use (24)	43	1991–96	Survey in one female prison (n = 127)
	Young offenders reporting a history of injecting drug use (24)	18	1991–96	Survey in two young offenders' institutions (n = 556)

Note: The note numbers in the table reflect those given in the list of sources.

Table 14 Number of drug seizures in the EU (1997 and 1998)

	Cannabis		Cocaine		Heroin		Amphetamines		Ecstasy		LSD	
	1997	1998	1997	1998	1997	1998	1997	1998	1997	1998	1997	1998
Belgium [a]	n.a.	13 020	n.a.	799	n.a.	1 112	n.a.	n.a.	n.a.	2 675	n.a.	75
Denmark	4 886	5 904	723	885	2 509	2 199	1 324	1 609	110	143	15	24
Germany	29 826	31 241	5 482	5 532	9 509	8 387	3 571	4 079	2 368	1 986	727	561
Greece	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	44 227	48 363	12 276	13 567	15 399	13 393	5 040	4 083	1 999	1 358	475	289
France	34 266	40 115	1 471	1 688	3 924	31 113	163	158	628	608	171	154
Ireland	4 102	n.a.	157	n.a.	599	n.a.	475	n.a.	347	n.a.	48	n.a.
Italy	11 423	12 406	3 163	3 867	6 851	6 360	53	41	847	729	173	120
Luxembourg	190	237	54	22	237	189	3	5	12	22	3	0
Netherlands [b]	n.a.	2 681	n.a.	1 168	n.a.	797	n.a.	n.a.	n.a.	583	n.a.	15
Austria	4 957	4 683	651	531	861	654	221	n.a.	253	135	113	61
Portugal	1 604	2 003	1 234	1 373	3 476	3 696	n.a.	n.a.	34	33	n.a.	n.a.
Finland	1 686	1 997	16	24	153	210	1 339	1 641	74	57	14	n.a.
Sweden	4 545	5 061	116	172	833	1 285	4 639	4 859	203	104	86	61
UK	106 753	n.a.	4 093	n.a.	12 474	n.a.	18 575	n.a.	5 087	n.a.	851	n.a.
Total EU	**248 465**	**n.a.**	**29 436**	**n.a.**	**56 825**	**n.a.**	**35 403**	**n.a.**	**138 173**	**n.a.**	**2 676**	**n.a.**

n.a. = data not available
[a] The number of ecstasy seizures also includes amphetamines.
[b] Provisional figures; the number of ecstasy seizures also includes other synthetic drugs.

Table 15 Quantities of drugs seized in the EU (1997 and 1998)

	Cannabis (kg)		Cocaine (kg)		Heroin (kg)		Amphetamines (kg)		Ecstasy (pill)		LSD (dose)	
	1997	1998	1997	1998	1997	1998	1997	1998	1997	1998	1997	1998
Belgium	48 705 [a]	n.a.	3 329	2 028	55	76	n.a.	n.a.	126 211 [b]	271 080	621	2 050
Denmark	467	1 572	58	44	38	55	119	25	5 803	27 038	381	105
Germany	11 498 [c]	21 007 [c]	1 721	1 133	722	686	234	310	694 281	419 329	78 430	32 250
Greece	19 237	48 321	17	283	146	185	0.05	0.003 [d]	179	101	166	44
Spain	315 328	428 234	18 419	11 687	479	444	120	202	184 950	194 493	25 357	9 063
France	55 122	55 698	844	1 051	415	344	194	165	198 941	1 142 226	5 983	18 681
Ireland	1 347	n.a.	11	n.a.	8	n.a.	102.9	n.a.	17 516	n.a.	1 851	n.a.
Italy	60 613	54 199	1 650	2 144	537	307	0.4	0.5	161 631	129 773	7 973	9 752
Luxembourg	35 [a]	7 [a]	9	6	3	4	0.01	0.07	367	145	4	0
Netherlands	31 513 [e]	118 122	6 744	11 437	194	2 043	n.a.	n.a.	1 054 218	1 673 592	137 218	35 964
Austria	912	1 336	87	99	102	118	8	n.a.	23 522	114 677	5 243	2 494
Portugal	9 693	5 550	3 163	621	57	97	0	0	525	1 127	84	261
Finland	210	161	0.1	2	2	2	22	25	3 062	3 320	323	301
Sweden	660	496	34	19	12	71	186	135	20 254	21 273	1 397	2 704
UK	149 969	n.a.	2 350	n.a.	2 235	n.a.	3 296	n.a.	1 925 500	n.a.	164 000	n.a.
Total EU	**705 309**	**n.a.**	**38 436**	**n.a.**	**5 005**	**n.a.**	**4 282**	**n.a.**	**4 416 960**	**n.a.**	**429 031**	**n.a.**

n.a. = data not available
[a] Cannabis leaves plus resin plus plants.
[b] Ecstasy plus amphetamines.
[c] Cannabis leaves plus resin plus concentrate; 67 065 additional plants in 1997 and 81 097 in 1998.
[d] Small number of items also seized.
[e] 1 479 821 additional 'nederwiet plants'.
Note: For the Netherlands: 1998 figures are provisional. The quantities of ecstasy seized also include other synthetic drugs. The 1997 ecstasy figure is also provisional.

Table 1

All sources are presented as submitted by the Reitox national focal points.

Belgium (Flemish C.): Quataert, P. and Van Oyen, H., *Gegeveninzamzeling in verband met middelengebruik door middel van CATI,* IHE/Episeries No 6, CCOV (Brussels: IHE, 1995).

Denmark:(1) 'Health and morbidity in Denmark 1994', DIKE, 1994 (unpublished report).

Denmark:(2) Laursen, L., 'Nordic alcohol and drug use survey', Centre of Alcohol and Drug Research, 1996.

Germany:(1) Herbst, K., Kraus, L. and Scherer, K., *Representative survey on the consumption of psychoactive substances in the German adult population 1995,* Bonn: Bundesministerium für Gesundheit, 1996.

Germany:(2) Kraus, L. and Bauernfeind, R., *Representative survey on the consumption of psychoactive substances in the German adult population 1997,* Bonn: Bundesministerium für Gesundheit, 1998.

Greece: Kokkevi, A., Loukadakis, M., Plagianakou, S., Politikou, K. and Stefanis, C., *Outburst of illicit drug use in Greece: Trends from a general population survey on illicit drug use* (Athens: University Mental Health Research Institute, in press).

Spain:(1) 'Household Survey on Drugs 1995', National Plan on Drugs (unpublished report).

Spain:(2) 'Household Survey on Drugs 1997', National Plan on Drugs (unpublished report).

France: Baudier, F. and Arenes, J., *Baromètre Santé adultes 1995* (CFES, 1997).

Netherlands: Abraham, M., Cohen, P. and De Winter, M., *Licit and illicit drug use in the Netherlands,* UvA/CBS (Amsterdam: CEDRO, 1999).

Finland: (1) Kontula, O., *Drugs in Finland in the 1990s* (Helsinki: Ministry of Social Affairs and Health, 1997) Monisteita 27.

Finland: (2) Partanen, J. and Metso, L., 'The second drug wave in Finland', *Yhteiskuntapolitiikka-lenti,* 2, 1999.

Sweden: (1) *Drogutvecklingen i Sverige. Rapport 99* (Stockholm: National Institute of Public Health and Swedish Council for Information on Alcohol and Other Drugs, 1999).

UK (England and Wales): (1) Ramsay, M. and Percy, A., 'Drug Misuse Declared: Results of the 1994 British Crime Survey', Research Study 151 (London: Home Office, 1996).

UK (England and Wales): (2) Ramsay, M. and Percy, A., 'Drug Misuse Declared: Results of the 1996 British Crime Survey', Research Study 172 (London: Home Office, 1997).

Table 2

Sources as for Table 1.

Table 3

All sources are presented as submitted by the Reitox national focal points.

Belgium (Flemish C.): (1) Maes, L. and Vereecken, C., 'Jongeren en gezondheid 1996' database, Department of Public Health, University of Ghent, 1999.

Belgium (Flemish C.): (2) Maes, L. and Vereecken, C., 'Jongeren en gezondheid 1998' database, Department of Public Health, University of Ghent, 1999.

Denmark: Sabroe, S. and Fonager, K., 'Young people, alcohol and drugs', ESPAD study 1995 (Arhus: FADL, 1996).

Germany: Christiansen, G. and Töppich, J., *Die Drogenaffinittät Jugendlicher in der Bundesrepublik Deutschland. Wiederholungsbefragung 1997* Bundeszentrale für gesundheitliche Aufklärung (Köln, 1998).

Greece: (1) Kokkevi, A. and Stefanis, C., *Licit and Illicit Drug Use in Greece: Trends in the General and in the School Population* (Athens: University Mental Health Research Institute, 1994).

Greece: (2) Kokkevi, A., Terzidou, M., Politikou, K. and Stefanis, C., *Substance Use among High School Students in Greece: Outburst of Illicit Drug Use in a Society Under Change* (Athens: University Mental Health Research Institute, in press).

Spain: (1) 'School Survey on Drugs 1994', Plan Nacional Sobre Drogas (unpublished report).

Spain: (2) 'School Survey on Drugs 1996', Plan Nacional Sobre Drogas (unpublished report).

France: (1) Choquet, M. and Ledoux, S., *Enquête santé des adolescents 1993* (Paris: Inserm, 1994).

France: (2) Ballion, R., *Enquête sur les conduites déviantes des lycéens 1997,* Rapport OFDT (Paris: CADIS–OFDT, 1998).

Ireland: Hibell, B. et al., 'Alcohol and other drug use among students in 26 European countries', ESPAD study 1995 (Stockhom: Swedish Council for Information on Alcohol and Other Drugs, 1997).

Italy: Mariani, F., di Fiandra, T., Schiallero, L. and Rico, G., ESPAD study 1995.

Luxembourg: *Les drogues de type ecstasy au Grand-Duché de Luxembourg* (Luxembourg: Centre de Prévention des Toxicomanies, 1998).

Netherlands: De Zwart, W. et al., *Key data: smoking, drinking, drug use and gambling among pupils aged 10 years and older* (Utrecht: Trimbos Institute, 1997).

Austria: Springer, A., Uhl, A. and Widensky, K., 'Schüler und Drogen in Österreich: Wissen, Erfahrungen, Einstellungen', *Wiener Zeitschrift für Suchtforschung,* 1–2, 1996, pp. 3–21.

Portugal: Machado Rodrigues, L. et al., *Estudos em Meio Escolar – 3° ciclo* (Lisbon: GPCCD, 1996).

Finland: Salrue, A. et al., ESPAD study 1995 (Finland Social Research Institute of Alcohol Studies, 1996).

Sweden: (1) Andersson, B. et al., *Skolelevers drogvanor 1997,* Report 53 (Stockholm: Swedish Council for Information on Alcohol and Other Drugs, 1998).

Sweden: (2) 'School Survey 1998' (Stockholm: Swedish Council for Information on Alcohol and Other Drugs) (unpublished report).

UK: (1) Miller, P. and Plant, M., 'Drinking, smoking and illicit drug use among 15 and 16-year-olds in the United Kingdom', *British Medical Journal,* 313, 1996, pp. 394–397.

UK: (2) Balding, J., 'Young people in 1997: The health-related behaviour questionnaire results for 37 538 pupils (9 to 16)', Schools Health Education Unit, University of Exeter, 1998.

Table 4

'Study to obtain comparable national estimates of problem drug use prevalence for all EU Member States', EMCDDA, 1999.

Austria: (1) National Focal Point.

Table 5

'Study to obtain comparable national estimates of problem drug use prevalence for all EU Member States', EMCDDA, 1999.

Table 6

All sources are presented as submitted by the Reitox national focal points.

Belgium (Brussels): Vanderveken, M., *Rapport epidemiologique 1997* (Brussels: CTB–ODB, 1998).

Belgium (Flemish C.): Van Baelen, L. and Wydoodt, J. P., *Vlaamse Registratie Middelengebruik (VRM),* Jaarrapport 1996 (VAD, 1998).

Belgium (French C.): Preumont, C. and Bills, L., Fiche commune, '1ere demandes et demandes de traitement, Communauté Francaise', CCAD, 1997.

Denmark: Register of Drug Abusers in Treatment. New Figures from the National Board of Health No 6, National Board of Health, 1998.

Germany: Simon, R. et al., 'Erweiterte Jahresstatistik 1998 de ambulanten Beratungs und B. fur S.' in der Bundesrepublik D (Tabellenband) (Berichtszeitraum 1,1,98–31,12,98 1999).

Greece: Greek Reitox Focal Point 1999.

Spain: Delegacion del Gbobierno para el Plan Nacional sobre Drogas, 'Sistema Estatal de Informacion sobre Toxicomanias (SEIT)' (unpublished report, 1998).

France: Tellier, S., Unpublished results from the 'Enquete sur les toxicomanies suivis dans les structures sanitaires et sociales en novembre 1997', Direction de la recherche, des études, de l'évaluation et de la statistique (DREES).

Ireland: Moran, R., O'Brian, M. and Duff, P., *Treated Drug Misuse in Ireland* (Dublin: Health Research Board, 1997).

Italy: SER.T Monitoring System Annual Report (Rome: Health Ministry).

Luxembourg: Origer, A., *RELIS/LINDDA Annual Report 1998* (Luxembourg: Service d'action socio–therapeutique, Ministère de la Santé, 1999).

Netherlands: LADIS Reporting System. IVV, 1997.

Portugal: Félix da Costa, N., 'Toxicodependentes em tratamento: estudo sagital de 1997', *Toxicodepêndencias,* 5(1), pp. 35–48, 1999.

Finland: National Hospital Patient Discharge Register Stakes.

Sweden: National Hospital Discharge Registry, National Board of Health and Welfare.

UK (England, Scotland and Wales): 'Drug misuse statistics for the six months ending 30 September 1997', *Statistical Bulletin* 1998/29, Department of Health, London, 1998.

Table 7

Reitox national focal points, based on the following information sources:

Belgium: Service général d'appui policier.

Denmark: National Commissioner of Police.

Germany: Federal Criminal Police Office (BKA).

Greece: Forensic Department for Autopsy and Toxicology, and the police central office for registration and publication.

Spain: SEIT, based on information of institutes of pathology and the National Institute of Toxicology.

France: OCRTIS, National File of Perpetrators of Narcotic-related Legislative Infractions.

Ireland: Office of the Registrar General and Central Statistics Office.

Italy: Central Office of Anti-drug Services (DCSA).

Luxembourg: Drug Unit of the Criminal Investigation Department.

Netherlands: Central Bureau of Statistics (CBS) in its *Cause of death statistics.*

Austria: Federal Ministry of Health and Consumer Protection.

Portugal: Institutes of legal medicine in Lisbon, Oporto and Coimbra.

Finland: Stakes.

Sweden: Cases are recorded by Statistics Sweden and reported and published by the National Board of Health and Welfare.

UK: Office of Population Censuses and Surveys (OPCS).

Table 8

All sources are presented as submitted by the Reitox national focal points.

Belgium (Flemish C.): (1) Todts, S., 'Risicogedrag bij injecterende druggebruikers in Vlaanderen', GIG project, VAD and Free Clinic, 1997.

Belgium (French C.): (2) Belgium French Community Sub-Focal Point, CCAD, 1998 (prevalence trend based on last three years: 3 %, 1.4 %, 2.6 %).

Denmark: Smith, E., 'Status of the HIV/AIDS epidemic in Denmark by the end of 1995', *Ugeskr Læger* 159, pp. 585–590, 1997 (prevalence trend based on notifications of HIV among IDUs).

Germany: German National Focal Point, 1999.

Greece: Greek National Focal Point 1999 (screening drug-free treatment: n = 409, 0.48 %; Athens methadone treatment reporting system n = 710, confirmed tests 3.2 %.Trend in prevalence from treatment reporting system: 1996 1.6%, 1997 2.0%, 1998 3.2%; trend non-significant).

Spain: Encuesta sobre Consumidores de Heroína en Tratamiento — ECHT— 1996, reported in DGPNSD, *Observatorio Español sobre Drogas,* Informe no 1 (Madrid: Ministerio de Justicia e Interior, 1998).

France: Gadel, G. and Nunes, C. 'Les toxicomanes suivis dans les structures sanitaires et sociales en novembre 1996', *Études et résultats No 1* (Paris: Direction de la recherche, des études, de l'évaluation et de la statistique (DREES), 1998.) (The range is not geographical; the upper limit gives the seropositives among all known test results while the lower limit assumes that those who do not know their test result are seronegative.)

Ireland: Smyth, B. P., Keenan, E. and O'Connor, J. J., 'Bloodborne viral infection in Irish injecting drug users', *Addiction* 93, pp.1649–1656, 1998.

Italy: 'Prevalence of HIV antibodies in SER.T users by region 1990–97', Ministry of Health (national average and range of seroprevalence by region).

Luxembourg: RELIS–LINDDA, 1998 (2 % assumes that all with unknown test results are seronegative; 3 % is prevalence in all those with known test result; 4 % if also corrected for 79 % IDUs and assuming all seropositives are IDUs).

Netherlands: 'National surveillance of HIV in IDUs', *Report* series (Bilthoven: RIVM, 1998) (1995: Arnhem 2 %; 1996: Amsterdam 26 %, Utrecht 5 %; 1997: Heerlen 16 %, Maastricht 3 %, Rotterdam 9 %).

Austria: Data on overdose deaths provided by the Ministry of Labour, Health and Social Affairs; treatment data from *Jahresbericht 1998 des Ambulatoriums Ganslwirt,* Vienna.

Portugal: Portuguese National Focal Point 1998.

Finland: Finnish National Focal Point 1999.

Sweden: Käll, K. and Thorstensson, R., 12th World AIDS Conference, Geneva, 28 June to 3 July 1998 (abstract 23552) (trend in prevalence based on notifications of IDUs).

UK: Unlinked Anonymous Surveys Steering Group (1998), 'Prevalence of HIV in England and Wales in 1997', Department of Health, Public Health Laboratory Service, Institute of Child Health, London.

Table 9

European Centre for the Epidemiological Monitoring of AIDS.

Table 10

All sources are presented as submitted by the Reitox national focal points.

Belgium: Belgium French Community Sub-Focal Point, CCAD 1999.

Denmark: Estimates from HIV notification and study on national prevalence of drug use, Stalens Serums Institute.

Germany: Bätz, B. and Reymann, G., *Sucht* 1997; 43, pp. 264–266. Jugendberatung und Jugendhilfe e.V., Frankfurt, 1998.

Greece: Greek National Focal Point 1999 (previously only % HbsAg+ was reported. Anti-HCV — Athens 68 %, Thessaloniki 80.47 %, other 49.6 %).

Spain: Encuesta sobre Consumidores de Heroina en Tratamiento — ECHT — 1996 (approx. n = 1 000 heroin users who ever injected).

France: (1) Six, C., Hamers, F. and Brunet, J. B., 'Enquête semestrielle sur les infections à VIH, VHC et VHB chez les résidents des centres de soins spécialisés pour toxicomanes avec hébergement. Rapport global sur les 10 semestres d'enquete juillet 1993 à juin 1998', CESES, 1999.

France: (2) Gadel, G. and Nunes, C., 'Les toxicomanes suivis dans les structures sanitaires et sociales en novembre 1996', *Études et résultats No 1* (Paris: Direction de la recherche, des études, de l'évaluation et de la statistique (DREES), 1998).

Ireland: Smyth, B. P., Keenan, E. and O'Connor, J. J., 'Bloodborne viral infection in Irish injecting drug users', *Addiction* 1998, 93, pp. 1649–1656 (prevalence of hepatitis B antibodies n.a. as vaccination is being offered. In 1997 (n = 116 tested).

Italy: Ministerio della Sanità – Sistema Informativo Sanitario — Dipartimento della Prevenzione — Ufficio Dipendenze da Farmaci e Sostanze d'abuso e AIDS (n = 66 623 tested).

Luxembourg: RELIS–LINDDA, 1998.

Netherlands: 'National surveillance of HIV in IDUs', *Report* series (Bilthoven: RIVM, 1998).

Austria: *Drogenambulanz Jahresbericht 1996; Jahresbericht 1996/1997 des Ambulatoriums Ganslwirt;* HIOB.

Portugal: Portuguese National Focal Point 1998.

Finland: Ovaska, A., Holopainen, A. and Annala, T., Information Service Vinkki: Final report on activities in the health information service experiment on 4 April–31 December 1997 (Turkia, Mika 1998); 'Private practitioner and heroin addicts: a case study on the impact of medical outpatient care on criminal activities', *Aiheita* 51/1998.

Sweden: (1) Kall, K. and Thorstensson, R., 12th World AIDS Conference, Geneva, 28 June to 3 July 1998 (abstract 23552).

Sweden: (2) Krook, A., Albert, J. and Andersson, S. et al. in *Journal of Acquired Immune Deficiency Syndrome Human Retrovirol 1997;*15, pp. 381–386.

UK: (1) Unlinked Anonymous Surveys Steering Group (1998), 'Prevalence of HIV in England and Wales in 1997', Department of Health, Public Health Laboratory Service, Institute of Child Health, London.

UK: (2) CRDHB and PHLS CDSC, unpublished data (prevalence of 30.4 % (895/2943) corrected for test sensitivity of 80 %).

Table 11

Reitox national focal points.

Table 12

Reitox national focal points; Eurostat.

Table 13

(1) Todts, S., Fonck, K., Colebunders, R., Vercauteren, G., Driesen, K., Uydebreouck, M., Vranckx, R. and Van Mol, F., 'Tuberculosis, HIV, hepatitis B and risk behaviour in a Belgian prison', *Archives of Public Health,* 55, 1997, pp. 87–98.

(2) The Probation and After-Care Service, 1997.

(3) Kern, 1997 (Justizministerium Baden-Württemberg).

(4) Kern, J., 'Zum Ausmaß des Drogenmißbrauchs in den Justizvollzugsanstalten und den Möglichkeiten seiner Eindämmung', *Zeitschrift für Strafvollzug und Straffälligenhilfe,* 1997(2), pp. 90–92.

(5) Malliori, M., 'Greece', in European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', 1998, pp. 114–118.

(6) Informe de la Comparecencia del Director General de Instituciones Penitenciarias en el Parlamento, 1999.

(7) Miranda, M. J., Barberet, R., Canteras, A. and Romero, E., 'Analisis de la eficacia y adecuation de la politica penitenciaria las necesidades y demandas de las mujeres presas', 1998.

(8) Rios, J. C. and Cabrera, P., Mil voces Presas, Universidad Pontificia de Comillas, 1998.

(9) Delegacion del Gobierno para el Plan Nacional sobre Drogas/Direccion General de Instituciones Penitenciarias, 'Evolucion Terapeutica previa del drogodependiente que ingresa en prison', 1994.

(10) Mouquet, M-C., Dumont, M. and Bonnevie, M-C., 'La santé à l'entrée en prison: un cumul des facteurs de risque', *Études et résultats No 4* (Paris: Direction de la recherche, des études, de l'évaluation et de la statistique, Ministère de l'emploi et de la solidarité, 1999).

(11) Rotily, M. and Delorme, C., *L'usage de drogues en milieu carcéral — Drogues et toxicomanies: indicateurs et tendances* (Paris: OFDT, forthcoming 1999).

(12) Mountjoy Prison Visiting Committee, 1997.

(13) O'Mahony, P., 'Mountjoy prisoners: A sociological and criminological profile', Department of Justice, 1997.

(14) Schoemaker, C. and van Zessen, G., *Psychische stoornissen bij gedetineerden; Een verkennend onderzoek in Penitentiair Complex, Scheveningen* (Utrecht: Trimbos Institute, 1997).

(15) Koeter, M. W. J. and Luhrman, G. C., *Verslavingsproblematiek bij justitiabele drugverslaafden* (Amsterdam: Amsterdam Institute for Addiction Research (AIAR), 1998).

(16) Pont, J., 'Auswertung des Fragebogens zu GZ 52201/2–V.4/1996', Bundesministerium für Justiz, 1996 (taken from the European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', 1998).

(17) 'Drogenfreie Zone im Strafvollzug', unofficial report on one-year experience with a drug-free zone in Hirtenberg prison.

(18) National Public Health Institute.

(19) Kriminalvårdens officiella statistik 1997, Kriminalvårdstyrelsen, 1998.

(20) 'Prisoners: drug tests results', Written Answers, *Hansard,* 1 February 1999, col. WA 184.

(21) Bridgwood, A. and Malbon, G., 'Survey of the physical health of prisoners' (taken from the European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', 1998).

(22) Bellis, M. A., Weild, A. R., Beeching, N. J., Mutton, K. J. and Syed, Q., 'Prevalence of HIV and injecting drug use in men entering Liverpool prison', *British Medical Journal,* 1997, 315, pp. 30–31 (taken from the European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', 1998).

(23) 'Prevalence of HIV in England and Wales in 1995', Annual report of the Unlinked Anonymous Seroprevalence Monitoring Programme in England and Wales (London: Department of Health, Public Health Laboratory Service, Institute of Child Health, 1996) (taken from the European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', 1998).

(24) Gore, S. M., 'Scotland: First WASH (Willing Anonymous Salivary HIV) surveillance studies', in European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', 1998, pp. 149–150.

Table 14

Reitox national focal points.

Table 15

Reitox national focal points.

Figure 5

Copenhagen: Saelen, H. 1999 (unpublished)

Berlin: Kirsschner, W. and Kunert, M. Berlin, EFB, 1996.

Bremen: Zenker, C., Greiser, E. *Erprobungsvorhaben zur Prävalenzsschätzung des regionalen illegalen Drogenmißbrauchs und seiner Folgen,* Bremer Institut für Präventionsforschung und Sozialmedizin (BIPS), Bremen, 1998.

Barcelona: Domingo-Salvany, A., Hartnoll, R.L., Maguire, A., Brugal, T., Albertin, P., Caylà, J.A., Casabona, J. and Suelves, J.M., 'Analytical considerations in the use of capture–recapture to estimate prevalence: case studies of the estimation of opiate use in the metropolitan area of Barcelona', *Am. J. Epidemiol.,* 1998, 148 pp. 732–40.

Toulouse: Bello, P.–Y. and Chéne, G., in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 'Methodological pilot study of local level prevalence estimates', EMCDDA, Lisbon, December 1997.

Dublin: Comiskey, C. in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 'Methodological pilot study of local level prevalence estimates', EMCDDA, Lisbon, December 1997.

Rome: D'Ippoliti, D. in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 'Methodological pilot study of local level prevalence estimates', EMCDDA, Lisbon, December 1997.

Luxembourg City: Origer, A., Luxembourg National Focal Point, 1998.

Amsterdam: van Brussel, G.H.A. and Buster, M.C.A., *Zorg voor de toekomst, opiaatverslaafden in Amsterdam,* GG&GD, Amsterdam, 1999.

Rotterdam: Netherlands Focal Point, 1998 (Smit, E., Toet, J. and van der Heijden, P., in preparation).

The Hague: *Haagse drugsgebruikers en het bereik van politie en verslavingszorg,* Onderzoekscommissie MORE, The Hague, 1997.

Utrecht: Ten Den, C., Bieleman, B., de Bie, E. and Snippe, J., Intraval, Groningen, 1995.

Vienna: Seidler, D., Uhl, A. in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 'Methodological pilot study of local level prevalence estimates', EMCDDA, Lisbon, December 1997.

Setúbal: Freire, S. and Moreira, M., in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 'Methodological pilot study of local prevalence estimates', EMCDDA, Lisbon, 1997.

Helsinki: Partanen, P., Kinnunen, A., Leinikki, P., Nylander, O., Seppälä, T., Simpura, J., Virtanen, A., Välkki, J., 'Selvitys amfetamiinin ja opiaattien käyttäjien määrästä pääkaupunkiseudulla ja koko maassa vuonna 1997', Stakes, Helsinki, *Aiheita* 19/1999.

Stockholm: Finn, E. (1998), 'Socialtjänstens kontakter med missbrukare, psykiskt störda och hemlösa 1997'.

Aberdeen: Centre for Drug Misuse Research (1998), 'Estimating the prevalence of opiate and benzodiazepine misuse in Grampian: A report to Grampian Health Board', Centre for Drug Misuse Research.

Lanarkshire Health Board Region: Centre for Drug Misuse Research (1997), 'Estimating the prevalence of drug misuse in Lanarkshire: A report for the Lanarkshire Drug Action Team', CDMR, Glasgow.

South and East Cheshire Region: Brugha, R.F.H., Swan, A.V., Hayhurst, G.K., Fallon, M.P. (1998), 'A drug misuser prevalence study in a rural English district', *European Journal of Public Health,* 8, pp. 1101–1262.

Wales Region: Bloor, M., Wood, F. and Palmer, S., University of Wales, Cardiff, 1997.

Chapter 3

Established responses to drug misuse in the EU

European Drug Prevention Week
Cannabis: trends and responses
Synthetic drugs: developments and responses

European Drug Prevention Week

Drug prevention is high on the EU agenda. In the second half of 1998, during the Austrian Presidency of the Council of the European Union, the issue was given a boost with the launch of the third European Drug Prevention Week (EDPW) from 16 to 22 November. The event highlighted a variety of initiatives and projects throughout the EU, as well as in participating non-member countries, such as Norway.

The main objective of the EDPW is to reinforce cooperation at European level on health aspects of the drugs phenomenon, highlight long-term prevention activities in the Member States and raise public awareness at EU level.

Since the first EDPW in 1992, the Week has helped to strengthen cooperation between professionals involved in drug-prevention work, particularly those in the health, education and social services, youth work and law-enforcement agencies within and among the Member States.

Building on experience gained from the previous weeks (held in 1992 and 1994), the Commission opted to retain a similar organisational structure for the 1998 event. In addition to providing financial support to EU initiatives and national programmes, this included setting up a coordination group of highly qualified representatives from the Member States and 15 ad hoc national coordination agencies.

Although conducted on the same basis as previously, the 1998 EDPW was the first to be organised and held in the context of the EU's action programme for the prevention of drug dependency (1996–2000). For the first time, the new Member States, Austria, Finland and Sweden, participated, along with Norway.

Young people and youth workers, families, professionals in the field, politicians and representatives of the media were all targeted by activities developed during the EDPW. Some Member States also identified other groups, such as ethnic minorities, drug-users and very young children.

The Week's theme was multidisciplinary — to raise awareness in society and to increase working partnerships — and in this context an EU-wide campaign, 'Talking is the first step', was launched. The Week also promoted the evaluation of drug-prevention activities using EMCDDA tools such as its guidelines for the evaluation of drug-prevention activities. The exchange on drug demand reduction action (EDDRA) questionnaire was used to report back on the Week's activities. The results are being examined by the Commission and a report on the EDPW is expected by the end of 1999.

Lessons from the European Drug Prevention Week

• Although the European Commission's final evaluation of European Drug Prevention Week events throughout the participating countries is still to be finalised, some observations can already be made about the 1998 event. Information from the national reports of the Reitox national focal points has helped to highlight some of the Week's key elements.

• The European Drug Prevention Weeks are efficient tools for promoting both EU and national prevention activities. The events help to encourage and promote the exchange of information on best practice in prevention at European level.

• The organisation of the 1998 Week itself highlighted the benefits of coordination at EU level, as well as helping national agencies to collaborate in a wider European context.

• The European media campaign did have an impact, but would have benefited from addressing a specific and common drug prevention message — similar to the Europe Against Cancer Weeks.

• Taking into account the difficulties encountered by some project leaders to develop the European component of their initiatives, support at an early stage should be envisaged for the next EDPW to facilitate the development of projects with a Europe-wide dimension that focus on a common European-defined theme.

• The use of EMCDDA reporting tools will allow for a standardised presentation of the Weeks' activities. Nevertheless, the evaluation procedure was not begun early enough and it will therefore take some time until reporting is completed.

'Drug prevention and drug policy', opening event of the Week

As the EDPW was held during the Austrian Presidency of the Council of the European Union, the event opened in Vienna. A conference entitled 'Drug prevention and drug policy' was held on 5 and 6 November involving 300 experts and politicians from all 15 Member States as well as representatives from Liechtenstein, Norway and central and eastern Europe. The conference, conceived as a forum for exchanging information and good practice, discussed pragmatic ways of cooperating and coordinating drug-prevention strategies at local, national and European level, and examined health and social policy, education and youth issues, security policies, regional and local politics, and public relations.

Delegates concluded that more work was needed to improve the quality and comparability of data on the drug phenomenon in the EU. Such information would help substantially in drawing up current and new strategies.

During the conference, an exhibition was held to highlight all projects supported by the EU's action programme for the prevention of drug dependency (1996–2000).

The event was organised by representatives of the City of Vienna, the European Commission, the EMCDDA, the Pompidou Group of the Council of Europe, the World Health Organisation and the United Nations International Drug Control Programme.

Talking is the first step

During the first two EDPWs, the Commission supported pan-European radio campaigns created and implemented by the European Foundation of Drug Helplines. The aims were to inform European citizens about helpline services, strengthen links between preventive structures and media targeted at young people and to publicise the Week itself.

The 1994 campaign covered 19 helplines in 11 Member States and involved 400 radio stations. The helplines involved dealt with over 51 000 calls during the campaign — for some, this represented an increase of 300 % in their normal workload over the same time period.

The 1998 communication campaign concentrated on a common slogan, 'Talking is the first step', highlighting the importance of dialogue in drug prevention. The campaign itself was directed mainly at adults in permanent contact with young people, including parents, teachers, youth workers, instructors and sports trainers. Despite differences in prevention approaches, constructive dialogue is seen as the common denominator in the field of prevention at all levels.

The media campaign, carried out by a professional public-relations agency, consisted of: a television commercial in 18 languages; a radio commercial in six languages; a poster produced in 19 language versions; a leaflet in 13 languages; a press advertisement in 12 languages; and a press release in 18 languages. To reach

as wide an audience as possible, the European Commission produced material not only in the 11 official EU languages, but also in Luxembourgish and others.

At a meeting of national coordinators, the Commission outlined the preliminary results of the campaign. It revealed that 28 television channels in 10 Member States used the commercial, 23 radio stations in seven Member States broadcast the radio commercial and 76 magazines and newspapers in 10 Member States published 93 inserts on the EDPW. This coverage represented free publicity worth over EUR 1.6 million, excluding the free media space obtained directly by the national coordinators. In addition, over 1 300 articles published in all EU Member States and Norway mentioned the event.

The 1994 campaign reached an estimated 100 million, far more than in 1992, with 90 % contacted through television, press and radio. The 1998 event reached an even wider audience.

Member State overview

The adoption of the 1994 structure —16 national coordinators from all 15 EU Member States plus Norway and ad hoc national agencies co-financed by the Commission — resulted in over 1 000 initiatives launched at national, regional and local level during the Week (see http://europa.eu.int/comm/dg05/phealth/index_ph.htm).

The Commission contributed about EUR 950 000 to activities implemented in the Member States that included a transnational component. These activities are still being evaluated in the Member States. An EU evaluation report based on contributions from the Association of Schools of Public Health in the European Region (Aspher), which evaluates the Commission's public health programmes, is expected to be published by the end of 1999. From information already available from the Commission and the Reitox national focal points, some preliminary elements can be identified.

Drug-prevention strategies

Generally, the Member States incorporated the EDPW into their national annual drug-prevention strategies and used it to draw public attention to long-term projects. In some States, the Week coincided with debates on existing national prevention strategies and new approaches to prevention.

In Austria, in addition to the opening conference, the overall programme was tailored to inform the public about national prevention policies and activities developed over recent years.

Drug policy was also one of the themes of a symposium in Tyrol organised by the Tyrolean drug coordinators in cooperation with the Faculty of Law of the University of Innsbruck. Austria also initiated a broad debate on the theoretical and organisational basis for preventive measures. For example, one project, 'Theoretical basis and structure of primary prevention — analysis and development', organised by the nine Austrian drug units in cooperation with a research institute, aimed at contributing to the further development of drug prevention in Austria. Cooperation with experts from Germany, Luxembourg, the Netherlands, Spain and Switzerland allowed the project to contribute to a wider, European discussion of models of addiction prevention.

As a major aspect of the Dutch EDPW programme, the Trimbos Institute organised a national working conference in Arnhem which targeted professionals and policy-makers working in the field of drug prevention. The conference consisted of presentations on community approaches, the efficiency of drug prevention, new trends in Dutch drug-prevention policy and financing of prevention work. Workshops allowed for an exchange of information and experiences. Five EDPW projects were presented during five workshops, while in five others participants discussed major issues of prevention in the Netherlands, including effectiveness of measures, prevention aimed at migrants and prevention in small communities, at parties and in schools. Representatives from Denmark, Germany and Sweden presented their experiences of drug prevention in schools and in the party scene.

In Sweden, 10 press seminars were held to support and educate the media in writing on new synthetic drugs, as well as on other drug-related topics.

The UK programme reflected the objectives set out in its drugs strategy, 'Tackling drugs to build a better Britain'. It used the EDPW to help local professionals and planners in the field increase the profile of drug prevention and education on the local agenda and to ensure that both national and European level activities during the Week actually helped local drug prevention and education initiatives.

Young people

All the Member States targeted young people and those in close contact with them during the EDPW.

Activities dealing with childhood intervention played an important role in Austria's EDPW projects. During

'Summer Talks '98', Austrian, German and Hungarian experts discussed a variety of drug-prevention options and strategies for children aged three to six. A conference on drug prevention in kindergartens was organised by the Vienna Information Centre on Addiction Prevention.

In Finland, activities were mainly directed at young people and their parents. An international meeting for nurses specialised in treating drug addiction also took place.

In France, out of 46 projects, 39 targeted the young reaching 18 000 people — 70 % aged 15 to 25 and 13 % aged less than 15 years.

In Greece, the drug and alcohol dependency unit of the Psychiatric Hospital of Thessaloniki, in cooperation with Centro Italiano di Solidarietà, organised prevention activities for students from minority populations such as Roma, and those from the former Soviet republics. The main aims were to promote the cultural identity of minority groups and the concept of prevention through the active involvement of students in planning and implementing preventive activities.

In Sweden, the Week's programme included 15 local projects in cooperation with other Member States targeting young women's groups, refugees, peer-support schemes in schools, community programmes, prevention in the dance scene and parental empowerment in rural areas.

Dialogue, creativity and arts

In addition to traditional activities such as conferences, seminars and training courses, all Member States organised activities that encouraged a dialogue with young people, raised awareness of the issue and reinforced self-esteem. 'Establishing self-esteem and pleasure' was the underlying theme of projects in France.

A large number of artistic and cultural activities were held throughout the EU during the Week. In Austria, a project on theatre and addiction prevention was organised by the addiction prevention coordinating body of the provincial government of Carinthia. This idea was based on the concepts of creativity, pleasure and sensation and addressed young people aged 15 to 17 using drama as a means of motivating them to deal with addiction.

The German Week's programme focused on enhancing self-respect in children and young people using artistic means of expression such as music, theatre, dance, drawing, plastic arts, games, photography, films and video. Activities were also designed to promote intercultural understanding.

Ireland launched its EDPW with a 'fun day' for families offering a variety of activities including music groups, magicians, face painting, games and treasure hunts.

The municipal health service of Groningen in the Netherlands, in cooperation with a drug-prevention agency in the UK, organised interactive theatre performances with a prevention message aimed at young people aged 14 to 20 who experimented with party drugs. The performances, on stages in schools and community centres, provided the youngsters with information and education.

Peer-to-peer approaches

Peer-to-peer approaches were highlighted during the EDPW in most Member States. For example, Belgium's EDPW programme included a 'Prevention through peers' project. Denmark's National Board of Health, YAP-Denmark and the county of Funen organised an international seminar on peer-group communication focusing on young people, alcohol, drugs and quality of life. Participants included young people as well as drug-prevention professionals from all over Europe and ended with an anti-drug party.

In the Netherlands, CAD Limburg in Maastricht ran a project involving drug users as peer workers in the Limburg, Liège and Aachen area, on the border between Belgium, Germany and the Netherlands. This scheme produced and disseminated information on party and soft drugs using bilingual leaflets distributed to drug users, drug-prevention professionals and drug sales points such as coffee shops. The leaflets contained information about drugs, safer drug use, Dutch drug laws, nuisance-reduction measures and national behavioural codes.

New technologies

Jellinek Prevention of Amsterdam launched the 'Tune in, tune on' scheme using new media such as CD-ROMs, the Internet, chat-boxes and video performances. This project provided young people in the party circuit with harm reduction messages on party drugs. Activities were implemented in two clubs — one in Amsterdam and one in Liverpool. Prevention workers, generally peer workers, were present to provide support to visitors to the clubs, mainly young people aged 16 to 25.

The Irish National Television and Radio Broadcasting Agency RTE broadcast a series of programmes focusing on drug problems during the EDPW.

In Portugal, the Internet was used to undertake a national investigation in schools of pupils' and teachers' knowl-

edge and attitudes to drugs. In Spain, the 'Play prevention' project included computer games designed to prevent drug dependence. The project also included the use of various games (role-playing and table) as well as a video forum to provide adolescents from 60 schools with prevention information.

Partnership and interdisciplinary approaches

The reinforcement of partnership and interdisciplinary approaches also characterised a number of activities of EDPW. Each Member State responded to the challenge of the Week in a different way. Some Member States, such as the Netherlands, created a national steering committee made up of representatives from government and non-governmental organisations (NGOs) responsible for drug prevention. This group produced and implemented national programmes following the Commission's guidelines.

In Denmark, a prevention initiative, 'Know your cooperation partner', was launched by the National Health Board. The aim was to make contact with key agents working in and around the drugs field and to encourage them to establish multidisciplinary cooperation at local level. The initiative targeted adults who work indirectly with youngsters with abuse problems, such as teachers, policemen, social workers, sports trainers and staff in fast-food restaurants. The project began in early 1998 and peaked in November during the EDPW with a series of meetings for the target group.

In Greece, the national drug coordinating body, OKANA, in collaboration with local television channels produced a television commercial presenting the goals and activities of local prevention centres. This initiative aimed to enhance the visibility of these centres at local level and to promote their cooperation with local communities.

The EDPW programme in Luxembourg concentrated on cooperation between different structures active in drug prevention.

In Norway, families, schools, businesses and public institutions participated in a debate, 'Time out', that examined ways and means of countering the drug problem.

In the UK, 106 drug-action team coordinators in England and their equivalents in Scotland, Wales and Northern Ireland, were involved in the Week's activities.

Follow-up

The European Commission is currently evaluating the EDPW, as well as the other activities implemented as part of the EU action programme for the prevention of drug dependence (1996–2000). This global evaluation of the action programme is carried out with the support of the Association of Schools of Public Health in the European Region (Aspher).

Concerning the evaluation methodology, in an attempt to ensure standardised information from Member States on the Week, the Commission provided all national coordinators with a reporting questionnaire produced by the EMCDDA as part of its exchange on drug demand reduction action (EDDRA) information system. At the time of writing, the completed questionnaires were not yet available, but should provide a more complete picture of the Week in the different Member States.

The EMCDDA also provided the Commission and the national coordinators with its 'Guidelines for the evaluation of drug prevention' for distribution to project leaders of the Week. The main purpose of this tool was to promote the evaluation of preventive activities and to provide guidance to project leaders when conceiving new activities and related evaluation.

A selection of the initiatives developed in the context of the 1998 EDPW will be included in the EDDRA information system.

Cannabis: trends and responses

Cannabis is the most common illicit drug in Europe, as it is in the rest of the world. During the 1990s, the extent and patterns of cannabis use and availability have been changing, health and social issues related to cannabis and appropriate responses are being re-examined, and debates have intensified over the legal status and possible medical uses of cannabis.

Historical context

The cannabis plant has been used for around 6 000 years, partly because the fibres from the plant's stem, called hemp, were used for making clothes, ropes, nets, paper and other items. Around 4 000 years ago, the Chinese used cannabis for medical purposes, in treating malaria, rheumatism, cramps and lack of appetite.

In modern Europe, cannabis made its primary entrance as a recreational drug in the 1950s via the jazz scene. In the 1960s and early 1970s, the use of cannabis as a euphoric substance boomed with the rise of the hippie culture. Use then stabilised and in some countries declined until a fresh resurgence in the late 1980s which resulted in the spread of cannabis use across a broad social and geographic spectrum. Cannabis and its consumption are now more widespread than ever before in Europe.

Legal status

Cannabis extracts — marijuana, hashish and oil — are classified as narcotic drugs under Schedule I of the 1961 United Nations Single Convention on Narcotic Drugs, which provides for strong control measures. The Convention prohibits the production, trade, possession or use of narcotic drugs, except for amounts necessary for medical or scientific research (see Table 1).

The Single Convention obliges each party to adopt measures ensuring that a wide range of activities, including the cultivation, manufacture, possession and distribution of narcotic drugs, are punishable. However, 'when abusers of drugs have committed such offences', the Convention permits recourse to therapeutic measures 'either as an alternative to conviction or punishment, or in addition to conviction or punishment'.

The general obligations under the Single Convention to limit the use and possession of these drugs exclusively to medical and scientific purposes are reinforced by the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which invites each party, according to their respective constitutions and basic legal concepts, to establish as a criminal offence the possession, purchase or cultivation of narcotic drugs – including cannabis — for personal consumption.

The EU Member States have transposed the UN precepts concerning the penal or administrative control of cannabis, and have applied them according to their own local or regional circumstances. This has resulted in an heterogeneous 'legal map' regarding cannabis offences: some countries or regions tolerate certain forms of possession and consumption; other countries apply administrative sanctions or fines; while still others apply penal sanctions.

Table 1 **Classification of cannabis in the 1961 UN Single Convention on Narcotic Drugs (as amended by the 1972 protocol)**

Schedule I Opiates and derivatives, coca and derivates, **cannabis** and derivatives and many other substances • High-risk abuse • Dangerous drugs • Low therapeutic value • Strict control	**Schedule II** Codeine, propriram and others • High-risk abuse • Dangerous drugs • High therapeutic value • Medium control
Schedule III Preparations of cocaine, codeine morphine, opium and several others • Low-risk abuse • Medium dangerous drugs • High therapeutic value • Low control	**Schedule IV** Heroin, **cannabis** and its resin and others • High-risk abuse • Dangerous drugs • No therapeutic value • Maximum control

Table 2

Legal status of cannabis in the EU Member States

	Legislation	Prosecution level	Notes
Belgium	Drug-related offences (including cannabis) are punishable by imprisonment for between three months and five years and/or a fine.	Possession and cultivation for personal use are less likely to be punished according to the directive of 17 April 1998.	
Denmark	Cannabis-related offences (possession) are punishable by a fine or imprisonment for up two years.	For possession of small quantities of cannabis, the Chief Public Prosecutor recommends that the police should settle cases by dismissing the offender with a caution.	
Germany	Drug-related offences (including cannabis) are punishable by up to five years' imprisonment or a fine; punishment can be remitted in case of 'insignificant quantities' for personal use.	The Constitutional Court stated that even if penal provisions for the possession of cannabis are in line with the Constitution, the *Länder* should waive prosecution in minor cases when possession of cannabis is for personal use. The *Länder* have determined the following amounts as 'insignificant quantities' of cannabis: up to three consumer units or up to 6 g (four *Länder*), up to 10 g (three *Länder*), up to 15 g (two *Länder*), up to 30 g (two *Länder*), up to the 'size of a matchbox' (one *Land*).	Possession of a small quantity of all drugs is a criminal offence, but is not prosecuted/ punished when: • there is no harm to third persons; • minors are not involved; • it is for personal use; • it involves an 'insignificant quantity'.
Greece	Drug-related offences (including cannabis) are punishable by up to five years' imprisonment, which the offender can exchange for compulsory treatment.		
Spain	Drug-related offences, such as possession and use in public places, are punished by administrative sanctions.		
France	Cannabis-related offences, such as use, are punishable by a fine or imprisonment for up to one year.	Warnings are given for first cannabis use, if use is occasional and the circumstances justify not prosecuting.	
Ireland	Cannabis-related offences (possession for personal use) are punishable by a fine on the first or second conviction. From the third offence onwards, the offender incurs prison sentences of up to one year (summary) or up to three years (on indictment).		
Italy	Cannabis-related offences (such as possession for personal use) are punishable by administrative sanctions (such as suspension of driving licence) from the second offence onwards. Only a warning is given for first offences for possession of cannabis for personal use.		
Luxembourg	Drug-related offences (including cannabis) are punishable by imprisonment for between three months and three years and/or a fine.	First offences of simple consumption usually incur only a warning.	The distinction between lower-risk and higher-risk drugs is proposed as a modification of the drug law.
Netherlands	Sale, production and possession of up to 30 g of cannabis are punishable by one month's imprisonment and/or a fine (NLG 5 000); for possession of more than 30 g of cannabis, the maximum penalties are four years' imprisonment for import or export, and two years for manufacture including cultivation of hemp for non-agricultural purposes, transportation, sale or possession/storage.	Investigation and prosecution of possession of cannabis for personal use (up to 5 g) carry the lowest priority; the sale of cannabis in coffee shops of up to 5 g per transaction is generally not investigated.	AHOJ-G guidelines specify the terms and conditions for sale of cannabis in coffee shops. AHOJ-G criteria = 'A' stands for no advertising of any drug; 'H' for no hard drug sale; 'J' for not selling cannabis to young persons (under 18); 'O' for no public nuisance; 'G' for no large quantities (more than 5 g of cannabis) per transaction. The maximum stock allowed at any one time is 500 g per coffee shop.
Austria	Drug-related offences (including cannabis) are punishable by up to six months' imprisonment. If the defined conditions are fulfilled, reports have to be withdrawn in cases involving small quantities. The conditions for withdrawal of reports in connection with 'first consumers' of cannabis are easier to fulfil.		
Portugal	Cannabis-related offences, such as use, incur up to three months' imprisonment or a fine if the quantity does not exceed three daily doses, and up to one year's imprisonment if the quantity exceeds this limit (1).	Offences involving very small quantities are usually exempt from punishment.	The new strategy proposes to distinguish penalties and administrative sanctions taking into account the varying risks of illicit substances.
Finland	Cannabis-related offences, such as use, possession, and cultivation, are punishable by a fine or up to two years' imprisonment.		Finnish law recognises the concept of a 'very dangerous drug', which refers to a narcotic drug that may cause death by overdose or serious damage to health. This definition is not normally applied to cannabis.
Sweden	Drug-related offences, such as use of cannabis, if judged minor, are punished with imprisonment for up to six months or a fine.	Users are usually fined, which may be exchanged on a voluntary basis for counselling.	
UK	Cannabis-related offences, such as possession, are punishable by up to five years' imprisonment; police may caution instead of prosecuting; courts may apply fines, probation or community service.	Where only small amounts are involved for personal use, the offence is often met by a fine.	

(1) Law No 73 of 26 March 1996 establishes the following daily average doses: marijuana: 2.5 g; hashish: 0.5 g.

Cannabis, marijuana and hashish

In 1753, Carl von Linnaeus first named the cannabis plant 'cannabis sativa'. This plant is found widely throughout the world and contains the psychoactive substance delta9-tetrahydro cannabinol (THC), the principal active ingredient of the drug cannabis. 'Marijuana' is another name for the same plant and is used most often to refer to its dried leaves and flowering tops. The resin extracted from the buds and flower heads of the cannabis plant is known as hashish, and hash oil can be extracted from the resin.

Today, the terms 'cannabis', 'marijuana' and 'hashish' are all commonly used, sometimes without any differentiation. The word 'cannabis' comes from the Greek word 'kannabas', while 'marijuana' has more uncertain and indistinct origins. It is most likely derived from the Mexican-Spanish word 'Mariguana' (meaning 'Mary's leaf') or from the names Maria and Juan — or from a combination of both. Americans often use this term instead of cannabis, but spell it 'marihuana'. The name 'hashish' is alleged to have derived from a tribe of Arabs known as the 'ashishin' who supposedly consumed the substance (in the 12th century) before ambushing or raiding opponents, although there is little historical evidence for this. A fourth term, 'Indica', is a variety of cannabis characterised by its appearance, odour and high THC content.

However, despite the different legal approaches towards cannabis, a common trend can be seen across the Member States in the development of alternative therapeutic measures to criminal prosecution for cases of use and possession of small quantities of cannabis for personal use without aggravating circumstances. Fines, cautions, probation, exemption from punishment and counselling are favoured by most European justice systems. However, as noted in Chapter 2, police arrests for drug offences, mainly for cannabis and mostly for use-related offences, are increasing in several countries.

Imprisonment seems to play a major role above all when cannabis is linked to trafficking. However, a more accurate understanding of how drug policy is applied in practice in relation to cannabis can only be achieved through specific studies that analyse data from police forces and prosecutors in more detail.

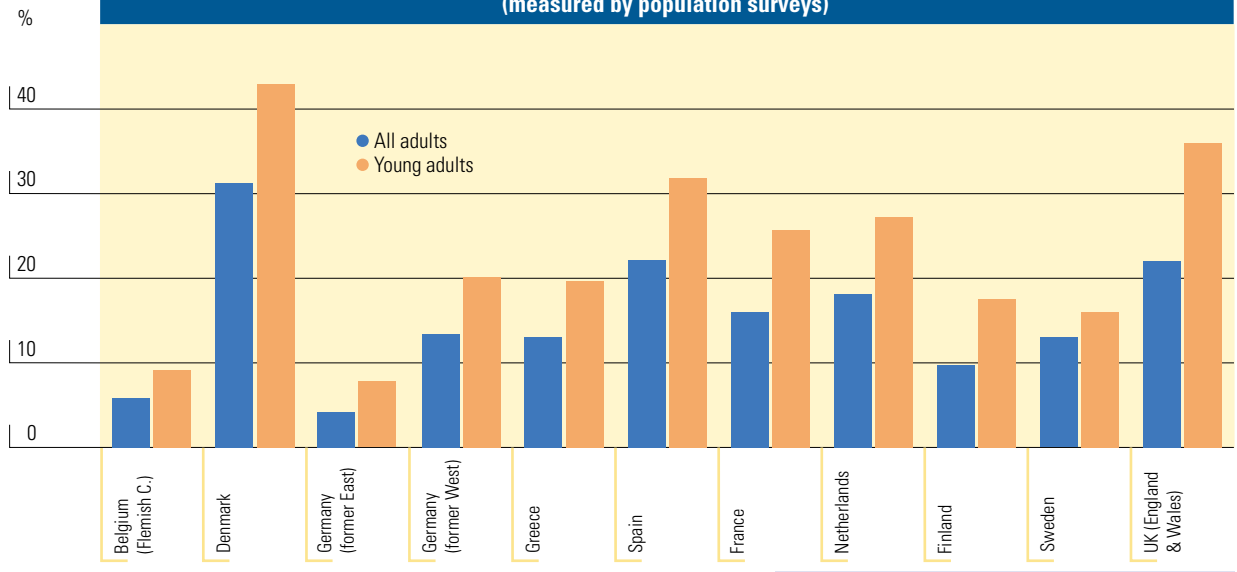
Extent and patterns of use

Prevalence

As stated in Chapter 1, a tentative, conservative extrapolation from recent surveys suggests that over 40 million people in the EU (about 16 % of the population aged 15 to 64) have used cannabis and at least 12 million (about 5 % of those aged 15 to 64) have used it in the last 12 months.

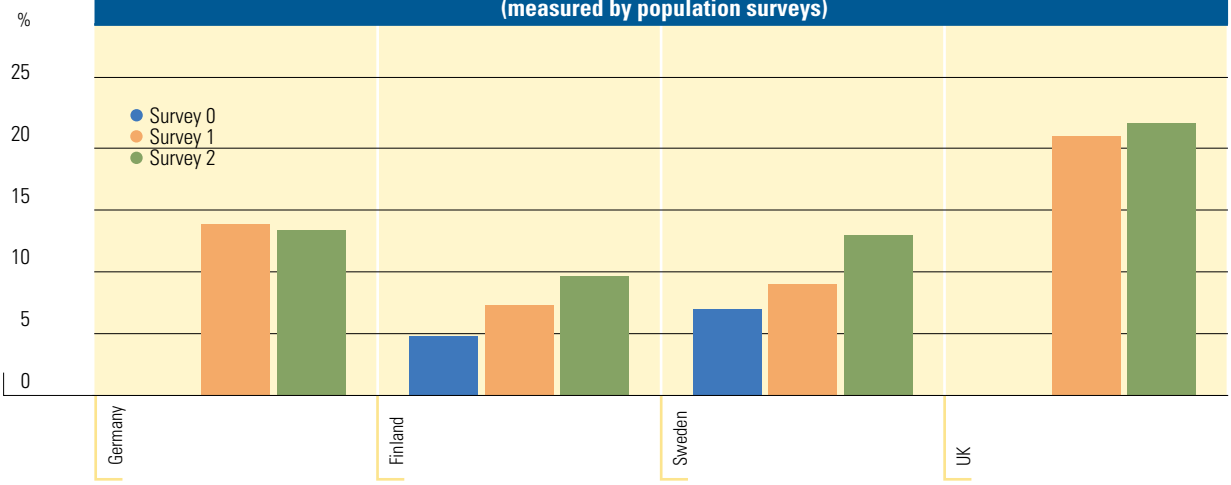
Levels of use are higher among young people, with on average about one in five adolescents aged 15 to 16, and at least one in four adults aged 15 to 34, admitting to having used cannabis.

Figure 1 **Lifetime prevalence of cannabis use among all adults and young adults in some EU countries (measured by population surveys)**



Note: For more detailed information on each survey, see Chapter 2, Table 1.

Figure 2 **Evolution of lifetime prevalence of cannabis use in some EU countries during the 1990s (measured by population surveys)**



Note: For more detailed information on each survey, see Chapter 2, Table 1 (survey results are not presented in Table 1).

Considerable differences remain between countries in the extent of cannabis use (see Chapter 2), but there are indications of a convergence in prevalence levels. In higher-prevalence countries, the trend appears to be stable or decreasing following increases in the 1990s. In lower-prevalence countries, however, use is increasing.

The stabilisation or decrease in cannabis use in some higher-prevalence countries should be examined more closely. For example, surveys in the UK show a fall in drug use (mainly cannabis) among some young people. Balding suggests that this may be due to the fact that the young people surveyed in 1997 were younger, on average, than those surveyed in 1996. Another explanation is that drug use is decreasing because alcohol use is rising, a 'fashionable renaissance' encouraged by marketing efforts by the industry to reclaim the lucrative youth market. Furthermore, it has been suggested in the UK that a crossover between problematic drug and alcohol use has been better observed by alcohol agencies than by drug agencies (*Druglink,* May–June 1998). Some other countries also note indications of increased alcohol use among young people.

Patterns of use

In much of the EU, cannabis use is not associated with any specific social or recreational context or group. In much of the EU, there appears to be a trend towards perceiving cannabis use as normal or mundane rather than as deviant. However, cannabis users cannot be considered as a homogeneous group and different patterns of use are reported.

For example, in the Netherlands, Cohen and Sas (1997) re-analysed data from the Amsterdam population surveys on use of drugs among residents of 12 years or over (1987, 1990, 1994). They first tested the hypothesis that cannabis consumption leads to regular use of other drugs. In general, cannabis use indeed preceded experience with other drugs. However, the large majority of persons who had ever used cannabis had never experimented with other drugs. About 22 % had used cocaine, about 10 % ecstasy and only 4 % heroin. In the previous month, non-use of other drugs was almost universal among people taking cannabis. Some eight other variants of the so-called 'stepping stone' hypothesis were tested, but none of these was confirmed under the criterion that at least 75 % of the cannabis consumers behaved in accordance with the hypothesis. Some support was found only in the small group of people using cannabis heavily (20 times or more in the last month). In this sample, about half had taken cocaine, 28 % ecstasy and 17 % heroin. However, only very few became current or regular users of hard drugs. This group, with heavy recreational poly-drug histories, may now be represented among those seeking help for cannabis problems.

Similarly in Germany, cannabis users frequently live inconspicuously and without great problems, although in the last few years there has been a marked increase in the number of clients starting treatment for cannabis problems in out-patient centres. Most are young people, some of them with multiple drug use patterns whose primary drug may be reported as cannabis, but who are frequently also using ecstasy and other drugs. This group is partly associated with the 'rave' scene, where other drugs are also found. In particular there is evidence of an increase in LSD and cocaine.

Drugs, cannabis and driving

A review of the scientific literature on drugs and driving commissioned by the EMCDDA found that evidence as to whether cannabis impairs driving and increases the risk of road accidents was inconclusive.

Experimental studies are not entirely consistent, with some finding no significant effects on perception, and others pointing to some impairment of attention and short-term memory, although these effects are typically observed at higher doses.

In some field studies which tested the bodily fluids of drivers involved in accidents, cannabis has been found to be quite prevalent, but since these tests may give positive results up to one month after the cannabis has been used, they may not be a reliable measure in this case.

Interpretation of the causal contribution of cannabis to road accidents is further complicated by the concurrent presence of other drugs, especially alcohol. Some studies suggest that cannabis does not appear to pose a high risk for drivers since it was found that drivers under the influence of cannabis actually drive more carefully.

Chait and Perry's 1994 UK study shows that the combination of alcohol and cannabis produces a greater level of impairment than either drug alone.

Cannabis market in the EU

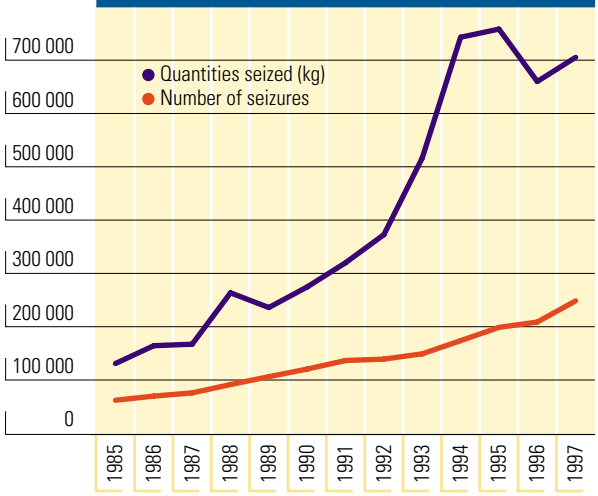
Seizures and sources

The quantities of cannabis seized each year in the EU have remained stable since 1994, although the number of seizures is steadily increasing (see Figure 3). Availability remains high across most of the Union and the market for cannabis appears entrenched with relatively stable prices.

The cannabis seized in the EU comes mainly from Morocco, which is the first producer of hashish for the European market, although smaller seizures originate in Afghanistan, Lebanon and Pakistan. Spain and the Netherlands are often reported as transit countries for cannabis imported into the EU.

Herbal marijuana seized in the EU largely comes from Colombia, Nigeria, South Africa and Thailand. Cannabis is also grown domestically in almost every Member State, although there is little evidence of large-scale trafficking.

Figure 3 **Cannabis quantities seized and number of seizures in the EU (1985–97)**



Notes: Numbers of seizures are not available for Greece and the Netherlands.
Numbers of seizures are underestimated in 1996 and 1997 as data for Belgium are missing.
For more information, see Chapter 2, Tables 14 and 15.

The potency of cannabis on the European market

In some countries, a variety of 'pedigree' cannabis seeds ('indica') are bred specifically for indoor cultivation, giving bushy plants and high-quality flowering tops. Many of the newer strains appear to have been developed from Himalayan plants, whereas domestically produced cannabis had previously used seeds that give taller plants from Africa, the Caribbean and the Far East.

Some countries report an increase in the potency of cannabis, in particular of herbal cannabis (marijuana), over recent years, and concern over this has been expressed by law-enforcement agencies amongst others. The limited data available give the content of delta9-tetrahydro cannabinol or THC (the main active ingredient of cannabis) as predominantly 5 to 11 % in Germany (German national report, 1998), 6 to 9 % in the Netherlands (Dutch national report, 1997) and 2 to 14 % in the UK (UK national report, 1998), although in a few cases higher potency is reported. However, it is not always specified if this is for hashish, marijuana or oil. Others suggest that marijuana contains 0.5 to 5.0 % THC, hashish 2 to 20 % and hash oil 15 to 50 %.

The available evidence in the EU is rather haphazard and difficult to interpret. Neither the typical content of different forms of cannabis on the market nor to what extent the potency has actually increased is clear. Furthermore,

Commercial use of hemp

'Hemp' is the name given to the fibres produced in the stem of the cannabis plant and to the variety of cannabis which is cultivated for the commercial production of its fibres and seeds which are valued for the oil they contain. Two varieties of cannabis are recognised: the drug type in which THC predominates and the fibre type in which another cannabinoid, cannabidiol (CBD), predominates. The second does not posses the euphoriant properties of THC, but tends instead to be a depressant. The EU provides subsidies for the cultivation of hemp with a THC content of less than 0.3 % by weight under Article 1 of Council Regulation (EEC) No 2059/84. Hemp is used in industry for various products

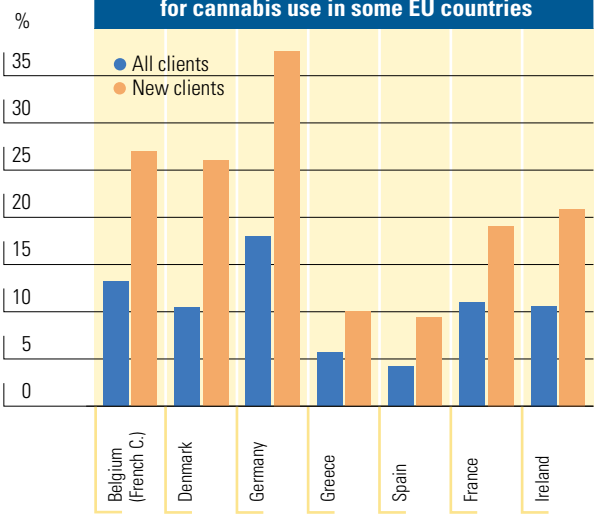
consumer behaviours and preferences are not known; for example, is higher-potency cannabis preferred or not, and if so are smaller quantities used to take account of this? Detailed, systematic studies would help to establish a more informed basis for discussion.

Treatment of cannabis-related problems

Trends and patterns of treatment demand

Cannabis is considered the main drug in only a minority of clients starting treatment, typically around 10 % or less (see Figure 2), but is more commonly reported as a secondary drug for those entering treatment for other substances. Some increase is noted in several countries, and the proportion is higher in new clients entering treatment for the first time (see Figure 1). Most treatment demands for cannabis involve clients who are much younger than those whose main drug is heroin or other drugs. This difference is also found in similar data from the United States. More detailed information is needed to ascertain if cannabis clients differ in other ways too.

Figure 4 **Proportion of clients admitted to treatment for cannabis use in some EU countries**



Notes: 1. For more detailed information on the characteristics of clients admitted to drug treatment, see Chapter 2, Table 6, which presents information on 'all clients' but not on 'new clients'.
2. For Denmark it is 'new clients' versus 'old clients'.

The data come from treatment-monitoring systems that mostly cover specialised treatment centres and often exclude other services such as youth advisory services or general practitioners (GPs) who may see cases involving cannabis. This makes it difficult to be certain about the extent and characteristics of cannabis-related problems and the exact demand for treatment.

What the demand for treatment for cannabis and the observed increase mean in terms of needs and possible responses depends on a better understanding of the types of problems linked to cannabis.

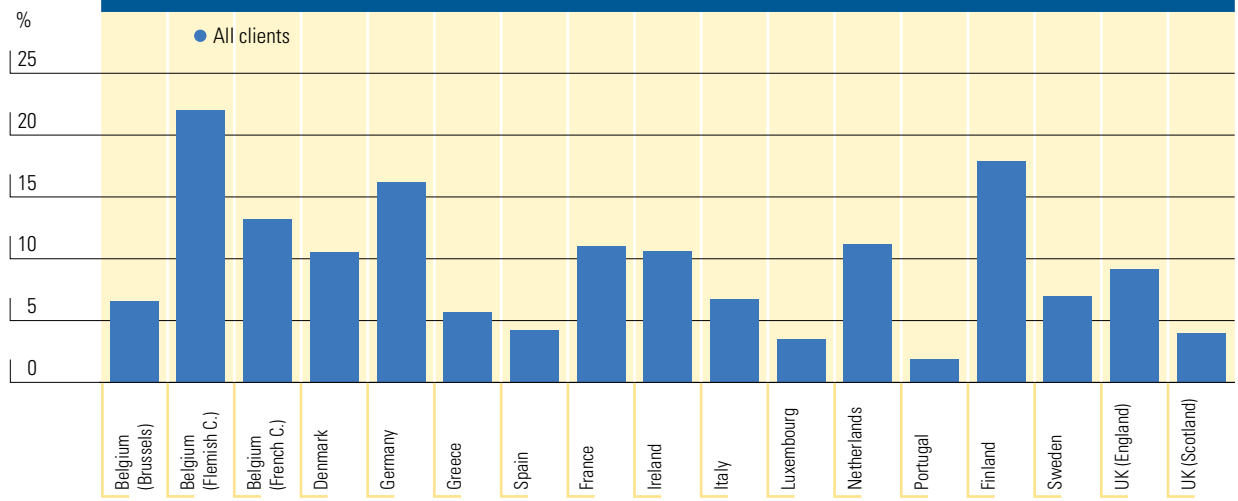
- Are these problems primarily caused by cannabis or are other drugs, including alcohol, involved?
- Is cannabis a convenient label for a wider cluster of problems? For example, in some countries, mental-health problems in general, including suicides, are increasing amongst adolescents and young people.
- How far does the increase in treatment demand reflect increased prevalence, frequency of use or changes in the potency of cannabis?
- Have there been changes in treatment services, for example new services oriented towards young users or non-opiate users?
- Has the use of therapeutic or administrative alternatives by prosecutors and courts increased?

All these issues need more detailed investigation in order to identify appropriate responses.

Treatment responses

There are very few services targeted specifically at cannabis users, so clients seeking treatment for cannabis-related problems usually do so in settings where most clients seek treatment for other substances, for example heroin and/or cocaine. Since clients with cannabis-related

Figure 5 **Proportion of clients admitted to treatment in some EU countries whose main drug was cannabis**



Note: For more detailed information on characteristics of clients admitted to treatment for drug use, see Chapter 2, Table 6.

problems constitute only a minority of those in treatment throughout Europe, and since they present a different profile compared with other treated drug users, it is difficult to know if the treatment on offer is appropriate, and what kind of alternative approaches might be most helpful.

Examples of some of the few treatment initiatives targeted specifically at cannabis problems are reported from Denmark, Germany, the Netherlands and Sweden. The municipality of Århus in Denmark began out-patient treatment of cannabis users in 1993, offering them access to a psychologist on a more or less regular basis. The initiative is still running, although it has undergone some organisational change. It reserves 15 to 20 treatment slots, depending on the frequency of consultations, for cannabis users.

Germany has a special unit in Berlin specifically working on the treatment of cannabis users. An outcome evaluation is planned.

In the Netherlands, the Jellinek Centre in Amsterdam has for some years helped cannabis users to learn self-control and self-regulation. Relatives, family or social workers may be invited to take part in the treatment which aims at total abstinence or regulated use.

In Sweden, two specialised out-patient programmes for heavy cannabis smokers are run in Lund and Uppsala. The treatment focuses on cognitive impairment and on the need for personal support during the first three months of abstinence from cannabis. The Lund programme is scientifically evaluated while the Uppsala programme is evaluated on an ongoing, small-scale basis.

Much more information is needed on the nature of the problems associated with cannabis. Since people who experience difficulties with cannabis may also be using other substances or may have a range of psychosocial problems, it is important to clarify the extent to which cannabis-specific services are needed and how far improved assistance might be provided within the framework of other interventions.

Prevention

Most prevention initiatives try to talk people out of taking cannabis. Few of the reported campaigns aim at preventing excessive cannabis use in particular, with most aiming at total abstinence. As with treatment, few prevention initiatives solely target cannabis. Telephone helplines in all Member States are open to cannabis users, but none are devoted purely to cannabis. All Member States distribute information on drugs which includes cannabis, and some have produced material specially on cannabis. Some initiatives are meant to provide general information about cannabis and the effects of THC, while other measures are aimed at parents.

Belgium's Flemish Community established a self-help group for cannabis users in 1997. If this initiative is seen to work, it may be taken up by the French and German-speaking Communities in Belgium.

Also in 1997, Denmark produced material about cannabis for school pupils aged 13 to 16. The material includes information leaflets, books and video tapes for those who are curious about the drug or who have a

growing problem with it. One leaflet is aimed at parents who want to know more about cannabis.

Luxembourg has organised a series of training activities, including an information seminar on cannabis for social workers and other actors in the drug field. There are plans to evaluate the initiative to see whether the training session should be repeated in 1999.

In the Netherlands, prevention activities are directed at specific risk groups with some initiatives specifically about cannabis. Two mass-media campaigns were launched in 1996 and 1997, one directed at parents and the other at young people. The central message of the parental campaign was 'inform yourself', and was disseminated via a variety of media. Evaluation showed it was generally successful, although the information tended to reach those who were already well informed rather than the less informed. The campaign was restructured for youngsters in 1997, connecting activities to a regional and local level. Evaluation showed that its reach was considerably greater than the previous year's campaign.

Spain has launched prevention programmes in schools targeting 12- to 16-year-olds, involving non-governmental organisations (NGOs) and accompanied by nationwide campaigns using leaflets, television commercials and posters. Training programmes were offered to teachers, NGO volunteers and other professional groups for work on cannabis use.

Prevention of cannabis use among young people in Greece is thought to be more effective if it is approached through a holistic strategy (such as school health-education programmes) whereby, according to the particular needs of the target group, emphasis is given to preventing the use of a specific substance.

For many years, Sweden published *The hashish book* which was distributed to the parents of teenagers. In 1998, it was replaced with *The book on drugs,* which covers all drugs including alcohol and tobacco.

Medical uses of cannabis or derivatives

In recent years, debate in Europe has intensified around whether cannabis can or should be used for medical purposes. In most countries, the debate is informal, but in Denmark, Germany, Spain, the Netherlands, Austria and the UK the debate has moved into more formal settings.

The EU situation

In Austria in May 1999, the Viennese drug plan was presented. This stated that the medical use of cannabis should be scientifically investigated and that research projects should be carried out after clarifying the legal and organisational framework.

The Bispebjerg Hospital in Copenhagen recently initiated a survey into the medicinal potential of cannabis, but it will be some time before the results are made public.

Germany is the only country that has taken steps to allow cannabis derivatives for medical purposes. From February 1998, a change in the narcotic drug law has allowed THC to be used for medical purposes. Three German import companies may import the US artificially produced cannabis derivative Marinol. The product comes in the shape of a pill and is meant to be taken for pain relief by

Table 3

	Cannabis demand reduction measures			
	Treatment initiatives specifically for cannabis abuse	Prevention initiatives aimed mainly at the final target group [a]	Prevention initiatives aimed mainly at the intermediate target group [b]	Evaluation of cannabis demand reduction measures
Belgium	No	Yes	Yes	Yes
Denmark	Yes	Yes	Yes	Yes
Germany	Yes	No	No	Yes
Greece	No	Yes	No	No
Spain	No	Yes	Yes	No
Luxembourg	No	Yes	No	No
Netherlands	Yes	Yes	Yes	Yes
Sweden	Yes	Yes	Yes	No

[a] Final target group = abusers or potential abusers.
[b] Intermediate target group = those related to the final target group, whether parents, relatives or teachers.
Note: France, Ireland, Italy, Austria, Portugal, Finland and the UK have no reported demand reduction measures specifically for cannabis.

cancer patients receiving chemotherapy, as an appetite stimulator for AIDS patients, for asthma patients and to combat insomnia.

The Netherlands carried out a review in 1997 on the potential medical uses of cannabis and concluded that the evidence was insufficient to justify such use. Patients have called for more research into the possible medical uses of marijuana and clinical studies are planned. The government is considering establishing an official agency to approve and control the cultivation and processing of hemp for scientific purposes.

In 1998, Spain organised an international seminar, 'Scientific advances on cannabis derivatives', with the participation of Spanish and foreign experts. The seminar stressed that future research into cannabis for medical purposes should consider how it could be used without leading to problems of dependency.

In the UK, a House of Lords subcommittee launched an investigation in 1997 into the use of cannabis for medical and recreational purposes. The subcommittee's report in November 1998 concluded that there was sufficient clinical and anecdotal evidence to indicate the medical value of cannabis and recommended that doctors should be allowed to prescribe it to relieve pain, and for symptoms of multiple sclerosis. They did not recommend lifting the ban on cannabis for recreational use. The government rejected the subcommittee's recommendations on the grounds that there had been insufficient clinical trials. A new clinical study will begin in 1999 and the results are expected in 2004–05 when most informed observers believe a new form of cannabis will be patented and licensed as a prescription medicine.

The global context

In other regions of the world, debate on the therapeutic value of marijuana have led to political discussions, mainly focusing on initiatives to reform 'prohibitive laws' to allow medical doctors to prescribe marijuana. Australia, Canada and the United States are among the most active in this domain.

Synthetic drugs: developments and responses

Political and public concern about synthetic drugs escalated during the 1990s in response to increasing and apparently widespread use of ecstasy by a broad spectrum of mainstream youth. Concerns were also raised because control of these drugs, which are easily manufactured at low cost within the EU using readily available materials, was becoming increasingly difficult.

With the introduction of the single market and increased freedom of movement, particularly within the Schengen area, Europe's doors were opened to entrepreneurial activity. Drug traffickers were quick to take advantage of the looser controls. Trade in the precursors used to manufacture these drugs, as well as trade in the end products themselves, increased dramatically.

In the context of the widespread availability of synthetic drugs and the evolution of a vigorous youth/music/dance culture, new patterns of drug consumption established themselves rapidly across the EU. This phenomenon was described in the EMCDDA's 1997 annual report and in more detail in the first volume in the Centre's *Insights* series.

Defining synthetic drugs

The term 'synthetic drug' strictly refers to psychoactive substances that are manufactured in a laboratory rather than derived from natural sources, such as plants. In this sense, tranquillisers and methadone are synthetic drugs as well as amphetamines, ecstasy and lysergic acid diethylamide (LSD).

In recent years, however, 'synthetic drug' has come to be applied more loosely to drugs like MDMA (ecstasy) that are commonly used in party and dance settings. The term 'new synthetic drug' is also used to refer to new substances found on the ecstasy market that fall outside existing legal controls (and indeed may be manufactured in order to avoid such control). This use of the term 'synthetic drug' thus indicates a preoccupation with the particular problems of controlling the production and distribution of these substances, rather than reflecting the actual patterns of drug use observed amongst young people.

In many recreational settings, young people are likely to use not only ecstasy, but also amphetamines, LSD and benzodiazepines — which are 'old' synthetic drugs — as well as substances that are not synthetic, such as alcohol, cannabis, cocaine, magic mushrooms and, sometimes, heroin.

The present report uses the term 'synthetic' to describe drugs that include:

- amphetamines, first synthesised in 1887 and identified with music trends and dance settings since the 1960s;
- ring-substituted amphetamines such as MDMA, which were first synthesised in 1912 and used in the 1970s for psychotherapy before being used socially by young people in the 1980s as ecstasy;
- Lysergic acid diethylamide (LSD) which was accidentally discovered in 1943 by a Swiss chemist; and
- other newly synthesised drugs about which, by definition, little is known.

What is ecstasy?

Most users assume that pills called 'ecstasy' contain MDMA. However, MDMA is only one of a family of phenethylamines, which includes MDA, MDEA and MBDB. What is bought and used as ecstasy may, therefore, in fact be another ecstasy-like synthetic drug.

Box 1

Entactogenic effect

Dr David Nichols, Professor of Medicinal Chemistry and Pharmacology at Purdue University in the United States coined the term 'entactogen' for drugs such as MDMA (ecstasy). The entactogenic effect of a drug is the way it acts as an emotional 'brace', facilitating the retrieval of inner material and enhancing introspective states. In Nichols' words, an entactogenic effect 'means essentially to produce a touching within'. In the words of an MDMA user, it provides a sense that the world is 'an okay place to be'.

Other ecstasy users comment that they feel no need for affirmation, recognition or judgment, as in the following statement: 'I felt I could handle the entire world and at the same time I felt no need at all to do so. I had conversations without feeling restricted, obliged or having the urge to compete with the other person.'

Box 2

Health risks of ecstasy

Heavy or frequent ecstasy use reduces, or eliminates, the entactogenic effect, although the energising effect remains. Consequently, ecstasy has been largely confined to weekend use which acts as a safety valve against problems developing as a result of daily or heavy use.

Acute risks

Conservative estimates of ecstasy use in the UK in the mid-1990s put consumption at over a million doses taken in dance clubs every weekend. This led to calculations of the risk of death from ecstasy consumption as approximately one dose in 6.8 million. Acute health risks increase with diversification to more intense consumption and when ecstasy is used in combination with drugs with sedative effects, such as alcohol, heroin and benzodiazepines.

Chronic risks

Research into the chronic effects of ecstasy use has been limited by bias and lack of data. Accumulating scientific evidence points towards some degree of neurotoxicity associated with heavy ecstasy use. Recent results of experiments with monkeys show that four days of exposure to MDMA caused some damage to areas of the brain that persisted for six to seven years, although the consequences of this damage are not yet clearly understood. Human studies have shown damage to the serotonin-producing neurones and the memory impairment related to the toxic effect of MDMA on those brain cells.

These drugs are usually taken orally as a pill (what is contained in these pills is discussed in more detail later in the chapter). The effects of ecstasy are generally experienced as energising, euphoric and entactogenic.

In general, 30 to 60 minutes after taking ecstasy the effects begin to be experienced before peaking and falling away to a plateau which is maintained for another three hours. The effects are influenced not only by the pharmacological properties of the pill, but also by the individual and the setting. Different patterns are advocated and adopted to prolong the effects; for example, taking cannabis simultaneously, or taking further doses at intervals.

Compared with other stimulants, ecstasy does not tend to produce the extreme mood swings (high energy followed by feelings of deep depression) characteristic of amphetamines and, compared with cocaine, the positive effects of ecstasy last much longer. Some users do report feelings of depression and difficulty in concentrating in the days immediately following ecstasy use, although these effects could also result from sleep deprivation as well as from the concurrent use of other drugs such as amphetamines.

The rise of ecstasy

In the early 1990s, ecstasy rapidly gained popularity among middle-class students and other socially integrated young people who believed MDMA to be safe and non-addictive in comparison with hard drugs such as heroin which were associated with marginalisation and social deprivation. This new trend in drug use developed within a mass recreation and music culture known as 'rave', 'acid house' or 'techno'.

One of the most significant features of this trend was the way it transcended traditional social networks and national borders. Rapid communication gave young people access to new trends through the music industry, television (terrestrial, satellite and cable), fashion, the media (magazines and other publications) and the Internet.

In Belgium, Germany, Spain, Italy, the Netherlands and the UK, and possibly other Member States, young people travelled considerable distances to attend large, advertised, commercial parties where they could meet, make friends and exchange information. This facilitated the spread of knowledge about the different drugs as well as access to them.

The major predictor of a person's willingness to try ecstasy seems to be knowing, liking or admiring a person

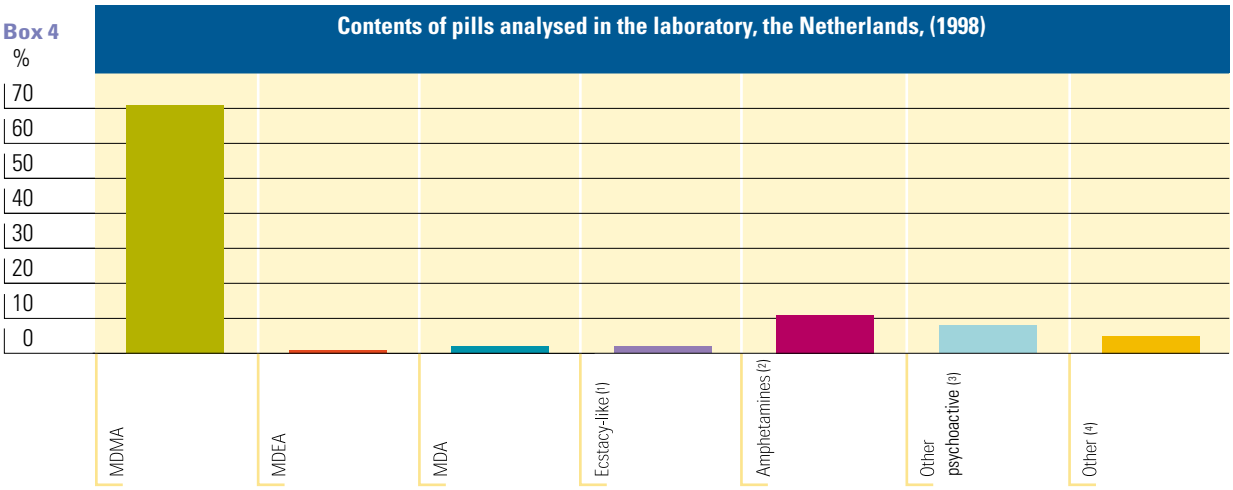
Box 3

Understanding dance culture

'You can't have any understanding of dance culture without understanding ecstasy. It's like trying to understand pub culture without understanding beer … DJs and record producers who say they have nothing to do with drugs are hypocrites. They owe their whole career to drugs. In the old days, people used to dance for ages to get themselves worked up. Now, you're taking the lift, rather than the stairs.'

Irvine Welsh (widely acclaimed author of *Trainspotting* and *Ecstasy*). Interview in *Ministry Magazine*, April 1999.

Box 4



(1) Combination of MDMA and/or MDEA and/or MDA with or without substances (excluding amphetamines).
(2) Contain amphetamine or methamphetamine, alone or together with other substances.
(3) Contain, for example, 2-CB, a-MBMA, cannabinioids, MBDB or other ecstasy-like substances (excluding amphetamines).
(4) Caffeine, paracetamol, quinine, yohimbine, other medicines and unknown substances.

who takes the drug. In the large party settings that became a prominent feature of youth culture during the 1990s, the effects of pills and powders were easy to observe and convenient to try. They were available and could be shared with friends at affordable prices. These extended networks also allowed information to be diffused about the negative as well as positive effects of different drugs or certain pills.

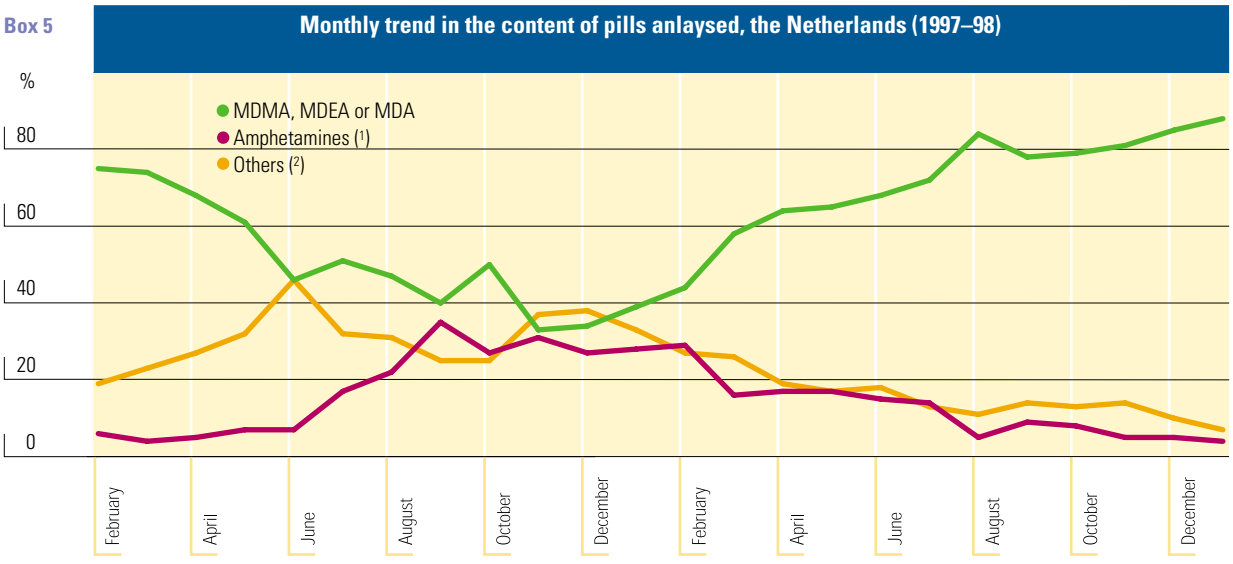
The combination of the stimulating and entactogenic effects of ecstasy gave it a key role in music and dance events. In the early phase, these events developed alongside a rejection of the alcohol-associated physical aggression and sexual harassment prevalent in many mainstream night clubs and licensed venues. Ecstasy, in turn, contributed to the success of commercial party/dance events by facilitating an inclusive, bonding atmosphere and the drive to dance.

What's in an ecstasy pill?

In the manufacture of pills aimed at the ecstasy market, producers consistently use brand names and logos as marketing tools and to distinguish their product from that of competitors. Among the more popular logos are the Mitsubishi symbol, a dove, a butterfly and a four-leaf clover which, in themselves, are no guarantee of the pill's contents.

In the absence of more reliable means for users to assess the contents of the pills they purchase or are given,

Box 5



(1) Contain amphetamine or methamphetamine, alone or together with other substances.
(2) All other psychoactive, non-psyhoactive and unknown substances.

conclusions are usually based on experience and judged in terms of the pills' strength and length of effect. If a new pill appears on the market or at an event, caution is generally exercised by consulting friends and taking limited doses such as a half or a quarter of a pill. After a chosen time interval, based on perceived effects and previous experience or information, another dose may be taken.

The difficulty of assessing pill contents is a key feature of the ecstasy market and laboratory analyses have proved experienced ecstasy users to be wrong in their personal assessment of pill contents. This feature of the consumer market is different from the heroin or cocaine markets where experienced users have the colour, structure and taste of powders on which to base and make more accurate personal judgments about contents.

Recent studies in a few Member States which analysed ecstasy pills have found that their contents vary considerably, from those containing pure MDMA, to ones with high levels of amphetamines, to a mixture of lactose and caffeine alone. In the Netherlands, ecstasy users are able to take their pills to street agencies where staff identify pills on the spot using a simple colour-change test (Marquis Reagent) and an identification checklist of known pills. If the pill cannot be identified in these ways, it is sent for laboratory analysis. In this way, low-threshold agencies ensure regular contact with drug users and, when laboratory analyses identify a drug which carries a health risk, warnings can be issued rapidly if necessary. Pill testing is discussed in more detail later in the chapter.

A particularly high proportion of pills sold as ecstasy were identified by the Drugs Information Monitoring System (DIMS) in the Netherlands between August 1997 and January 1998 as actually containing amphetamines. The 'Checkit' project in Vienna, which operates a drug-monitoring system with similar aims, also identified unusually high levels of amphetamine in spring 1998. Concerns about the amphetamine content of ecstasy pills have also been expressed in Germany, Spain, France and the UK. The reasons for the increase in amphetamine content during particular time periods are not clear, but it may indicate that producers are facing a shortage of the precursors needed to manufacture MDMA or its analogues.

Organised crime appears to be involved in the manufacture and distribution of ecstasy-like drugs in a number of countries. Synthetic drugs are reported to be produced mainly in clandestine laboratories in the Netherlands, Poland, Spain and the UK, and new manufacturers are said to be trying to enter the market. Some young drug users involved in the distribution of ecstasy-type pills have been threatened by more organised distributors.

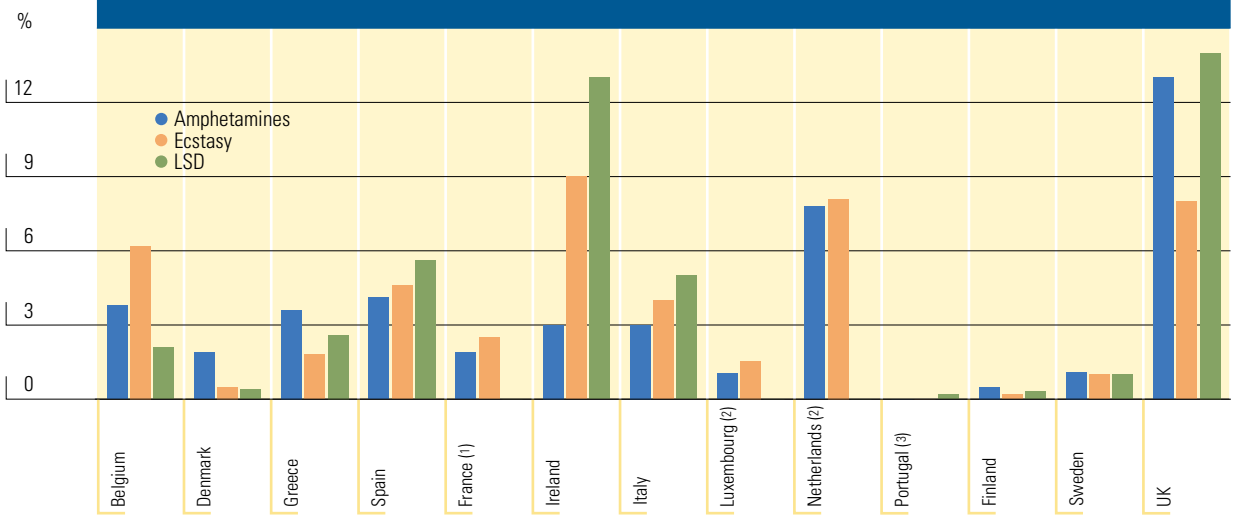
Prevalence of synthetic drug use

What is known about the current level of synthetic drug use in the EU? The data presented here relate to prevalence figures currently available from national sources and are limited to what users have believed to be ecstasy, amphetamines and LSD.

School pupils

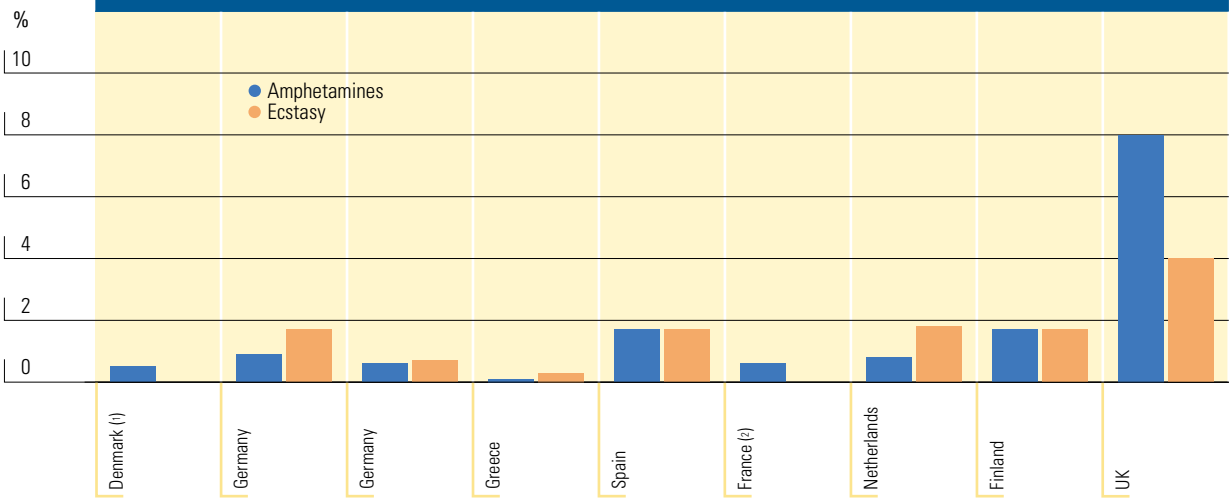
Among the countries that have conducted school surveys, the proportion of 15- to 16-year-olds who admit having

Figure 6 **Lifetime prevalence among pupils aged 15 to 16 (from school surveys)**



(1) Ecstasy and LSD not differentiated. (2) No data available for LSD. (3) No data available for amphetamines or ecstasy.
Note: For more detailed information on school surveys, see Chapter 2, Table 3.

Figure 7 National population surveys of last 12 months prevalence of drug use among young adults



Notes: (1) All hard drugs, including amphetamines and ecstasy. (2) Amphetamine and ecstasy not differentiated.
For more detailed information on national general population surveys, see Chapter 2, Table 2.

tried amphetamines is typically between 2 and 4 %, but ranges from under 1 % in Finland to nearly 8 % in the Netherlands and 13 % in the UK. There is also a wide variation in ecstasy use among this age group, from under 1 % in Finland to 5 to 6 % in Belgium and Spain, and 8 to 9 % in Ireland, the Netherlands and the UK. The lifetime prevalence figures for LSD among schoolchildren is around 13 to 14 % in Ireland and the UK, 5 to 6 % in Spain and Italy and 2 % or less in the other Member States. The marked differences in lifetime prevalence of LSD among schoolchildren are difficult to interpret and may be partially explained by some definitions which include hallucinogenic mushrooms.

Young adults

The proportion of young adults who have used amphetamines and ecstasy typically falls in the range of 2 to 5 %, although the rates are higher for those aged 18 to 25 (for exact age ranges, see Chapter 2). In terms of recent use in the past year, the rates are mostly in the 1 to 2 % range, although higher for the UK. This suggests that after experimenting with amphetamines at school, young people in the UK continue to take amphetamines in early adulthood in greater numbers than in other countries.

Recent trends: diversification, amphetamines and alcohol

Ecstasy

Recent reports from several Member States suggest a stabilisation or decline in the level of ecstasy use and some disenchantment with what is being sold as ecstasy. It is not, however, clear to what extent this disenchantment is the result of negative effects, adverse publicity about health risks, the loss of novelty value, or a combination of all these factors. Data on seizures of ecstasy show an overall decrease in both incidence and quantity of pills seized.

Recent articles in youth/music/style magazines reflect the 'passé' feelings surrounding some earlier rave-related behaviour such as hugging, 'gurning' (facial distortions) and other visible signs of stimulant consumption. Music media articles complain about the loss of exclusivity on the dance floors of the ecstasy market and expressly criticise the physical manifestations of amphetamine-type drug use in terms of 'lolling tongues, red faces and grimaces'.

This does not mean that ecstasy is disappearing. In many parts of the EU, it continues to be widely available and used within recreational dance and party settings as well as in more private situations, although there are considerable differences between countries (see Figures 1 and 2 and also Chapter 2). It does mean, however, that alongside the continuing use of ecstasy, there is a diversification in the patterns of use.

Amphetamines

The dominant trend, confirming the EMCDDA's 1998 annual report, is a long-term, and continuing, rise in the availability and use of amphetamines. Within the broad, recreational youth culture, amphetamines are mostly taken as powder by sniffing or orally as pills or added to drinks.

As with ecstasy, increases in amphetamine use are barely reflected in indicators such as treatment demand. This may mean that the sharp increase in use is not creating health problems. It is also possible that such problems have not been recorded or that drug services are not adequately responding to this trend. Amphetamines may play a significant role in some of the problems that are being observed by low-threshold agencies and attributed to ecstasy or cannabis.

In some northern countries, amphetamines have long been, and continue to be, used in other settings. They are often injected by chronic, problematic drug users in more socially marginalised situations usually not linked to the mainstream youth drug scene.

Alcohol

In recent years, both dance drugs and dance music — originally associated with unofficial large, out-of-town, commercial parties — have been found in downtown night clubs. There is also evidence of a parallel shift back to alcohol consumption. The lucrative nature of the music/dance market appears to have propelled the alcohol industry into sponsoring, advertising and promoting alcohol aimed specifically at the dance drug or ecstasy market and using drug imagery with the intention of reclaiming this market.

Although much attention in recent years has been focused on synthetic drugs such as ecstasy, the use of alcohol, including for the purpose of intoxication, may be (re)-emerging as an important component of the drug-use patterns found within the broader arena of youth leisure activities and youth markets.

Divergent patterns, divergent drugs

More specific patterns of diversification in the use of synthetic drugs are difficult to define. Various reports point to increased use of alcohol and an interest in stimulant-type drugs such as amphetamines and/or cocaine in some situations, and in hallucinogens such as LSD or mushrooms in others. Some low-threshold drug agencies have reported an increase in requests for help from young people who have developed some degree of psychological dependence on heavy drug consumption in party and dance settings. In a minority of these cases, heroin has also been involved. Other developments include reports of Viagra being sold as a recreational drug in the dance scene, as well as various steroids used to develop physique for non-sporting purposes.

The major source of information about synthetic drug use has been young people in dance and party settings. However, synthetic drug use also takes place in other contexts. For example, they may also be used in more private circumstances for their relaxing and libido-enhancing effects, for developing physical or mental capacities, or to self-treat insomnia, stress or drug-induced problems. Evidence of these other uses of synthetic drugs can be found on the Internet in specific websites and discussion groups and in other forms of mass and micro media.

Demand reduction activities

The main demand reduction strategies in the EU can be classified in terms of how they intend to reach the non-homogeneous target group of synthetic drug users. It is not possible to draw an overall picture of European strategies because sufficient information is available from only a few countries, but some examples may give an impression of the main activities.

In the cultural context of synthetic drugs described above, a special variety of peer-group education is used involving 'ravers', prevention staff and party organisers in a bottom-up strategy for prevention work. The underlying concept of these approaches is illustrated by the Dutch strategy which is a variation on the familiar 'just say no'. It has been changed to 'just say know', focusing on individualised counselling without encouraging drug use.

As increasing numbers of users integrate drug use into their daily life or leisure activities — like ecstasy at parties — preventing health damage means providing information about the risks of excessive use and of adulterated pills. In this context, prevention should mean that the consumer knows what he or she is doing.

Demand reduction activities can be seen as a consumer service delivered from experienced users to others. For example, a border zone cooperation project between Belgium, Germany and the Netherlands employs drug users as peer workers together with prevention workers to produce and disseminate information about party drugs (see the discussion of the peer-to-peer approach in the EDPW section above).

The approach is often highly targeted in order to protect non-drug users in recreational dance settings from exposure to information that might be thought to encourage drug use and to ensure that they are supported in maintaining abstinence. One approach is aimed at the experienced user who wants to use drugs in a responsible

and controlled way. Flyers or 'ravers' guides' have been compiled for this group, which evaluation has shown to be useful. For teachers and parents who want factual information, videos and brochures are available.

The police can also be involved in these activities. For example, the Belgian *Gendarmerie* organises training for those responsible for mega-dances.

Guidelines for safe dancing developed by local authorities, NGOs and 'rave' organisers have a tradition in the UK and are also being adopted in Denmark and Germany. In these countries, the organisers of 'rave' parties help to produce and distribute information on designer drugs, ecstasy and other substances commonly used at 'raves'.

Information materials

Distribution of information materials is still the most frequently reported strategy in the Member States' fight against drugs. The materials may be linked to peer approaches, to mass-media campaigns or to stand-alone projects.

In Denmark, materials consisting of a video programme, a magazine for young people, a computer programme, a poster and guidelines for teachers were distributed in all schools.

Another possible approach is to use cultural events — like EXPO '98 in Lisbon — to distribute information material to young adults attending 'house' and 'techno' parties together with personalised information using trained volunteers and professionals.

Almost all 17 of Spain's autonomous regions (comunidades autónomas) publish their own posters, brochures and leaflets with information concerning synthetic drugs.

Typically, such requests have come from the organisers themselves who want to provide factual information on drugs and their effects. At the same time, associated drug-counselling centres are running campaigns addressing different target groups with a variety of 'safer use' or 'clean use' messages. Members of specific youth environments are commonly motivated to ask for support in providing information and undertaking preventive activities on their own territory.

Some programmes use or organise parties in order to promote prevention. One example is a Franco-German youth organisation which organised a seminar on 'techno' culture and prevention. This was linked to a 'techno' parade and a street 'rave' attended by well-known 'rave' personalities. In Belgium, a mega-disco involving 1 500 to 2 000 young people was organised and included an exhibition and workshops.

Aside from 'rave' parties, wider community approaches in specific localities and youth centres aim to involve 'techno' clubs in preventive efforts by establishing peer networks which can be used as prevention agents among 'ravers'. This has been successfully achieved in France. Specific drug-related community activities may include events under a drug-free banner — like anti-drugs discos or 'rave' parties with a 'no-drugs' slogan, as in Germany and Portugal.

Pill testing

On-the-spot toxicological pill tests, mostly at 'raves', offer buyers a chance to have the purity and contents of tablets tested before use while also allowing demand reduction professionals to contact users directly. Such testing is a controversial practice in Europe and is carried out in only a few countries. Reporting of such tests is therefore sketchy (see also the discussion of ecstasy pill contents above). In Austria, pill testing is used for research and prevention purposes. Vienna's 'Check-it' project, focusing on 'ravers' and ecstasy users, interviews users during testing. This approach offers the possibility of intensified preventive activities aimed at specific groups.

Some countries find anonymous, cost-free testing of tablets sold as ecstasy at major 'rave' events, together with information and on-the-spot counselling, a good prevention approach. This approach mainly targets teenagers, since it is clear from various pilot studies that many young users do not distinguish between different pills. They see themselves as consumers of ecstasy, even if toxicological tests show the tablets are primarily made of some other substance.

Since 1992, the DIMS in the Netherlands has tried to limit health damage from overdoses or toxicity. Drug samples are sent or collected from fieldwork organisations and drug users before being tested at affiliated offices or in specialised hospital laboratories. Preparations containing especially dangerous ingredients are then the subject of a warning campaign aimed at potential users. Written information on the overall danger of drugs is also delivered to users.

Due to the semi-legal status of 'techno' parties in France, preventive and research access to this setting is difficult. The 'rave' mission operated by Médecins du monde

(http://www.medecinsdumonde.org/) tests pills during raves. It also gathers information on synthetic drug consumption and on users and tries to engage participants in discussions about drug use.

Mass-media campaigns

The mass media are used in many countries as a means of raising awareness among young people. A Spanish campaign publicised the risk of alcohol, hashish and synthetic drug use. These campaigns adopt specific slogans such as 'Enjoy yourself with sport. Avoid drugs'. In many cases, local organisations are responsible for awareness campaigns.

The substance most frequently targeted in mass-media campaigns is alcohol, but in some cases synthetic drugs take centre stage. Others address narrow target groups. For example, an Irish television campaign to alert, remind and warn people of the dangers of drug use was targeted at 15- to 25-year-olds who experiment with drugs and at parents of young people. A radio campaign was also aimed specifically at parents, urging them to seek advice if they thought their children were involved with drugs. Specific information about ecstasy and heroin was given in a radio spot and a permanent telephone information line was advertised.

Internet activities

The Internet is one of the newest media for finding out about drugs, and to be used in drug-demand reduction activities. An Internet site called Drugsmart (http://www.drugsmart.com), run by the Swedish Ministry of Health and Social Affairs, covers both new synthetic drugs and 'smart' drugs (licit products containing psychoactive substances such as magic mushrooms, amanita mushrooms or belladonna). The site is targeted at younger age groups, but includes information for teachers as well. The aim is to strengthen the resistance of teenagers who have not so far taken drugs or who have stopped experimenting with drugs. Aside from detailed information on various drugs, the site provides answers to e-mailed questions and a chat service for those who wish to discuss drug-related topics

Other Internet sites are also springing up in Europe. The Prevnet website (http://www.a-klinikka.fi/prevnet/euro/index.html), originally a Finnish initiative, has been expanded into the European network for prevention via the Internet. The site, however, is not dedicated exclusively to synthetic drugs.

Evaluation

Evaluations of interventions on synthetic drugs are rare. One exception is the 1997–98 'SafeRave' campaign in Denmark which targeted middle-class youth. The evaluation concluded that over time the campaign had lost its originally strong roots in the 'techno' environment, but that the clear attitude against ecstasy was well received and succeeded in motivating a limited section of the target group. The evaluation also highlighted an interest within the techno environment to take a stand against drugs, which could be influential in further prevention work.

Evaluation of peer-group approaches in the Netherlands concluded that small informal groups were easier to organise if ecstasy users were contacted at discotheques and at a so-called 'rave shuttle', a mobile intervention unit used at 'raves'. The project contributed to a more realistic and non-moralistic approach to drug prevention.

During the evaluation of 'Safer dancing' in London, around 300 'clubbers' were interviewed before, during and after the campaign. The programme targeted individual behaviour, the physical environment of the club and in-club outreach work through trained staff. Almost 90 % of clubbers said that they intended to keep the information booklet provided — an important result given the transient nature of the club environment. Thirty-three per cent said the campaign might change their attitude to drug use in future. Overall, understanding about the effects of ecstasy, cannabis and amphetamines increased.

Selective glossary

Term	Definition
Council of Europe	Set up in 1949, the Council of Europe, based in Strasbourg, is an intergovernmental political organisation of some 40 European pluralist democracies. Although often confused with the European Union, the Council is a distinct organisation primarily concerned with strengthening political, social, legal and cultural cooperation and promoting human values throughout Europe
Demand reduction	Activities aimed at preventing drug use, assisting and treating drug users, reducing the harmful consequences of such use and promoting positive health
Depenalisation	Administrative sanctions (such as suspension of driving licence, confiscation of passport) or fines are applied in response to an offence instead of the criminal code
Domestically produced drugs	Home-made illicit drugs (frequently produced by consumers). 'Domestic' in law-enforcement and street terminology, particularly in the United States, means produced within the Member State rather than imported
Entactogenic effect	The entactogenic effect of a drug is the way it acts as an emotional 'brace', facilitating the retrieval of inner material and enhancing introspective states. In the words of an MDMA user, it provides a sense that the world is 'an okay place to be'
ESPAD	European school survey project on alcohol and other drugs
Eurostat	Statistical Office of the European Communities
Fifth framework programme	An overall EU framework programme which defines priorities for EU research, development and technological programmes for a five-year period (1998–2002)
High-threshold services	Services with high entry barriers requiring a high level of commitment on the part of the client
LAAM	Levo-alpha-acetyl-methadole, a longer-acting alternative to methadone
Legalisation	Legal measure aimed at controlling a substance and its related market. With legalisation, the production process belongs to the authority, the State, that through laws and regulations may control production, cultivation, sale and consumption

Liberalisation	This term is used to indicate the political approach of a drug policy or strategy; when it refers to a substance (e.g. liberalisation of soft drugs), this means that the drug will be available on the market and regulated by the economic law of supply and demand (often the term is improperly used, meaning legalisation or depenalisation)
Low-threshold services or agencies	Treatment facilities with easy access and reduced time delays (frequently part of harm reduction strategies)
LSD	Lysergic acid diethylamide
National focal points (NFPs)	National expert monitoring centres forming the EMCDDA's Reitox network
NGOs	Non-governmental organisations
Poly-drug use	Concurrent or consecutive use of more than one illicit substance, alcohol and/or non-medical use of pharmaceuticals
Pompidou Group	An intergovernmental structure within the Council of Europe which aims to 'promote and support the establishment of national policies and programmes and the strengthening of international cooperation allowing a multidisciplinary approach to the problem of drug abuse and illicit trafficking in a pan-European context'
Precursors	Substances used in the manufacture or preparation of illicit drugs
Reitox	European information network on drugs and drug addiction (réseau européen d'information sur les drogues et les toxicomanies)
Supply reduction	Reducing the availability of illicit drugs by targeting producers, importers and traffickers
Synthetic drugs	Psychoactive substances that are manufactured in a laboratory rather than derived from natural sources, such as plants. Tranquillisers and methadone are synthetic drugs, as well as amphetamines, ecstasy and lysergic acid diethylamide (LSD)
Trafficking	Transportation and bulk trading in illicit drugs, usually at international level, for the purpose of distribution or sale
WHO	World Health Organisation (based in Geneva)

Selected references and sources of information

Chapter 1

EMCDDA (1997), 'Estimating the prevalence of problem drug use in Europe', Scientific Monograph No 1, EMCDDA, Lisbon.

EMCDDA (1998), 'Evaluating drug prevention in the European Union', Scientific Monograph No 2, EMCDDA, Lisbon.

EMCDDA (1998), 'Guidelines for the evaluation of drug prevention', *Manuals* No 1, EMCDDA, Lisbon.

EMCDDA (1999), 'Alternatives to prison in cases of drug addiction', unpublished project report.

EMCDDA (1999), 'Evaluating the treatment of drug abuse in the European Union', Scientific Monograph No 3, EMCDDA, Lisbon.

EMCDDA (1999), 'Reviewing current practice in drug substitution treatment in Europe', unpublished project report.

Morgan, Mark (1998) *The substance misuse prevention programme: a formative evaluation*, Department of Education and Science, Dublin.

Chapter 2

Brugha, R. F., Swan, A. V., Hayhurst, G. K. and Fallon, M. P. (1998), 'A drug misuser prevalence study in a rural English district', *European Journal of Public Health*, 8, pp. 1101–1262.

Centre for Drug Misuse Research (1997), *Estimating the prevalence of drug misuse in Lanarkshire: A report for the Lanarkshire Drug Action Team*, CDMR, Glasgow.

Centre for Drug Misuse Research (1998), *Estimating the prevalence of opiate and benzodiazepine misuse in Grampian: A report to the Grampian Health Board*, CDMR, Glasgow.

Domingo-Salvany, A., Hartnoll, R. L., Maguire, A., Brugal, T., Albertin, P., Caylà, J. A., Casabona, J. and Suelves, J. M. (1998), 'Analytical considerations in the use of capture–recapture to estimate prevalence: Case studies of the estimation of opiate use in the metropolitan area of Barcelona', *American Journal of Epidemiology*, 148, pp. 732–740.

EMCDDA (1997), 'Methodological pilot study of local level prevalence estimates', unpublished project report.

EMCDDA (1999), 'Pilot project to develop a model of geographic spread of drug use in the European Union', unpublished project report.

EMCDDA (1999), 'Pilot project to estimate time trends and incidence of problem drug use in the European Union', unpublished project report.

EMCDDA (1999), 'Study to obtain comparable national estimates of problem drug use prevalence for all EU Member States', unpublished project report.

Godinho, J., Costa, H. and Padre-Santo, D. (1998), 'Estimativa da prevalência de consumidores de heroína no Concelho de Setúbal', *Toxicodependências*, 4, pp. 27–32.

Jager, J. C. and Ruitenberg, E. J. (1997), *Concerted action multinational scenario analysis concerning epidemiological social and economic impact of HIV/AIDS on society*, BMH1-CT94-1723, May 1994–November 1997, RIVM and CLB, Bilthoven and Amsterdam.

Nalpas, B., Desenclos, J. C., Delarocques-Astagneau, E. and Drucker, J. (1998), 'State of epidemiological knowledge and national management of hepatitis C virus infection in the European Community', *European Journal of Public Health*, 8, pp. 305–312.

Partanen, P., Kinnunen, A., Leinikki, P., Nylander, O., Seppälä, T., Simpura, J., Virtanen, A. and Välkki, J. (1999), *Selvitys amfetamiinin ja opiaattien käyttäjien määrästä pääkaupunkiseudulla ja koko maassa vuonna 1997*, Stakes, Helsinki.

Programas Échange Seringues Europa Sud (Pesesud) (1998), Syringe-exchange programmes for HIV prevention in south European countries, final report to DG V on Project SOC 96 201324 05F02 (96CVVF2-230-0), Ceescat, Barcelona.

van Brussel, G. H. A. and Buster, M. C. A. (1999), *Zorg voor de toekomst, opiaatverslaafden in Amsterdam*, GG and GD Amsterdam, Amsterdam.

Zenker, C. and Greiser, E. (1998), *Erprobungsvorhaben zur Prävalenzschätzung des regionalen illegalen Drogenmißbrauchs und seiner Folgen*, Bremer Institut für Präventionsforschung und Sozialmedizin, Bremen.

Chapter 3

Adderley, J. (1996), 'Clubbers and drinking: Message in a bottle', *Muzik*, 15, August.

Bolla, K. I., McCann, U. D. and Ricaurte, G. A. (1998), 'Memory impairment in abstinent MDMA (''ecstasy'') users', *Neurology*, 51, pp. 1532–1537.

Chait, L. and Perry, J. (1994), 'Acute and residual effects of alcohol and marijuana, alone and in combination, on mood and performance', *Psychopharmacology*, 115(3), pp. 340–970.

Cohen, P. and Sas, A. (1997), 'Cannabis use, a stepping stone to other drugs? The case of Amsterdam' (http://www.frw.uva.nl/cedro).

de Loor, A. (1991), *The drug XTC does not exist: A survey drug*, Consultation Bureau, Amsterdam.

Drug Enforcement Administration (1999), 'Drug intelligence brief on MDMA ecstasy'.

EMCDDA (1997), 'New trends in synthetic drugs in the European Union', *Insights* No 1, EMCDDA, Lisbon.

EMCDDA (1999), 'Literature review on the relation between drug use, impaired driving and traffic accidents', unpublished project report.

Europol (1988), *European Union situation report on drug production and drug trafficking*, Europol, The Hague.

Grinspoon, L. (1977), *Marihuana reconsidered*, Harvard University, Cambridge, MA.

Hall, W. and Solowij, N. (1998), 'Adverse effects of cannabis', *The Lancet*, 352, pp. 1611–1616.

Jansen, K. L. (1999), 'Ecstasy (MDMA)', *Drug and Alcohol Dependence*, 53, pp. 121–124.

Klee, H. (1998), 'Attraction of amphetamine sulphate for British youth', *Journal of Drug Issues*, 28(1), pp. 33–56.

McCann, U. D., Szabo, Z., Scheffel, A., Donnals, R. F. and Ricaurte, G. A. (1998), 'Positron emission tomographic evidence of toxic effect by MDMA (''ecstasy'') on brain serotonin neurones in human beings', *The Lancet*, 352, pp. 1433–1437.

Measham, Aldridge and Parker (1998), 'Adolescent recreational drug use in Britain', *Journal of Drug Issues*, 28(1), pp. 9–32.

NIDA (1999), 'Long-term brain injury from use of ecstasy', news release.

Olesen, S. (1999), 'Hamp-tågen bliver tættere', *Jyllands-Posten*, 15 April.

WHO (1997), *Cannabis: a health perspective and research agenda*, WHO programme on substance abuse, Geneva.

Selected websites

History of medical cannabis
(http://www.hrc.wmin.ac.uk/hemp/histomed.html).

Cannabis information
(http://area51.upsu.plym.ac.uk/~harl/cannabis.html).

Erowid cannabis vault
(http://www.erowid.org/entheogens/cannabis).

Marijuana – a very brief history
(http://www.concentric.net/~Rattus/mari.html).

'The assassins' from *The book of grass: An anthology on Indian hemp*
(http://www.druglibrary.org/schaffer/hemp/assassin.htm).

History of marihuana use: medical and intoxicant
(http://www.druglibrary.org/schaffer/Library/studies/nc/nc1a.htm).

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