

2001

**Annual report on the state of
the drugs problem in the European Union**

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

European Monitoring Centre
for Drugs and Drug Addiction

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Preface

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has great pleasure in presenting its sixth *Annual report on the state of the drugs problem in the European Union*. The main purpose of the report is to help guide policy-making at EU, national and regional level.

This report presents an up-to-date picture of the drug situation in the EU and highlights new trends and developments. In addition to the general overview, the report addresses some key issues — cocaine, infectious diseases and synthetic drugs — in more detail. It also provides a general overview of the situation in the central and east European countries.

This year, the improvement in the quality and comparability of data produced by Member States is significant. Nevertheless, it is essential to maintain efforts in all Member States not only to enhance the comparability of data at EU level in all areas but also to ensure that these data are produced regularly.

This leads us to the very important issue of harmonising data which must be rapidly achieved to ensure that the information on drugs at EU level becomes more reliable and comparable than it is now. To facilitate this process, the EMCDDA has produced guidelines for the standardised implementation in the EU of its five key epidemiological indicators. In the coming year, the Member States will play a key role in ensuring the full implementation of these standardised indicators at national level.

It is of particular note that the EU strategy on drugs and its follow-up action plan (2000–04) highlight information

and evaluation as key priorities. Indeed, collecting and analysing information forms a preliminary step in assessing the impact of any action. The EU action plan also emphasises the importance of drawing on the different sources of information available in the European Union — in particular the EMCDDA and Europol.

The EMCDDA is working intensively to fulfil its key information role. It has fine tuned its 2001–03 work programme to align it with the six priority targets of the EU strategy on drugs. The Centre is also contributing to the process of evaluating the impact of the EU action plan and has worked with its national focal points and with Europol and its national drugs units to conceive appropriate tools for producing two snapshots composed of a set of variables adapted to the six priority targets of the EU strategy.

The first snapshot will show the situation and responses in place in 1999 prior to the adoption of the EU action plan and will provide a baseline against which the progress achieved at the end of the plan in 2004 can be measured. The second snapshot will show the situation and responses in place in 2004 on the basis of information available from the same set of variables.

All of these steps will go some way to fulfilling the EMCDDA's main challenge — that of providing policy-makers with a solid knowledge base for informed drug-policy planning.

Georges Estievenart
Executive Director

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- the heads of the Reitox national focal points and their staff;
- the services within each Member State that collected the raw data for this report;
- the Members of the Management Board and the Scientific Committee of the EMCDDA;
- the European Parliament, the Council of the European Union — in particular its Horizontal Working Party on Drugs — and the European Commission;
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An online, interactive version of the 2001 Annual report is also available at www.emcdda.org.

This version provides links to data sources, reports and background documents used in assembling this report.

Drug demand and drug supply

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

Improving the comparability of data — the EMCDDA key indicators

Improving the comparability of data across the Member States is a central task of the EMCDDA. The EMCDDA develops and recommends methods and instruments in order to collect and analyse harmonised, good quality data at European level. The EU action plan on drugs (2000–04) calls for Member States to provide reliable and comparable information on five key epidemiological indicators according to the EMCDDA's recommended technical tools and guidelines. These five key indicators are:

- prevalence and patterns of drug use among the general population (population surveys);
- prevalence and patterns of problem drug use (statistical estimates of prevalence/incidence supplemented by surveys among drug users);
- drug-related infectious diseases (prevalence and incidence rates of HIV, hepatitis B and C in injecting drug users);
- drug-related deaths and mortality of drug users (general population mortality registers and special registers statistics, and cohort studies among drug users of mortality and causes of death);
- demand for drug treatment (statistics from drug treatment centres on clients entering treatment).

Drug use

Drug use in the general population

An estimation of the proportion of the population that uses drugs, or that has experimented with them, is basic information to assess the drug situation, to develop policies and to evaluate them. It is necessary to know in which groups drug use is concentrated and the patterns of use.

Patterns of drug use

In all EU countries, cannabis is the illegal substance most commonly used, both in terms of lifetime experience (any use during a person's lifetime) and in recent use. Use of other illegal substances is less common.

Cannabis lifetime experience in the adult population (15 to 64 years according to the EMCDDA standard, although with some national differences) ranges from about 10 %

in Finland to about 20 to 25 % in Denmark, France, Ireland, the Netherlands, Spain and the United Kingdom⁽¹⁾.

Other substances have been experienced by far fewer persons. Experience with amphetamines is reported by 1 to 4 % of adults, but by up to 10 % in the United Kingdom. Ecstasy has been tried by 0.5 to 4 % of European adults and cocaine by 0.5 to 3 %. Heroin experience is reported generally by less than 1 % of adults, which contrasts with its high presence in drug-problem indicators.

Illegal drug use is concentrated in some groups of the population — in particular young adults, males and urban inhabitants. Young adults (aged 15 to 34 according to the EMCDDA standard with some national differences)

⁽¹⁾ Figure 1 OL: Lifetime experience of cannabis, amphetamines and cocaine among adults in some EU countries, measured by national population surveys (online version).

Methods employed to estimate drug use in the general population

General population surveys are employed to estimate drug use. Twelve Member States have conducted national surveys during recent years on drug use in the general population (although in Luxembourg the sample was small) and the remaining ones (Italy, Portugal and Austria) are currently organising them. Several countries have already established series of repeated national surveys using the same methodology (for example Germany, Spain, Sweden and the United Kingdom) and in Greece, France and the Netherlands series have been initiated. Some countries have successive ad hoc surveys which are comparable to some extent (for example Denmark, Finland and France).

There are differences across countries in methods of data collection, sampling sizes and frames, which could influence the precision and validity of estimates. Until these issues are solved, direct comparisons between levels of use in Member States should be made with caution, especially where differences are small.

The EMCDDA has developed guidelines to improve quality and comparability of population surveys in the EU. These guidelines include a set of common core items that can be used to report data from existing surveys or that can be inserted into broader questionnaires and basic methodological guidelines, and they are gradually being implemented in the Member States.

present rates up to double or more than those of the whole adult population for most drugs ⁽²⁾ ⁽³⁾.

For example, cannabis has been tried by about 15 % of young adults in Finland and Sweden, up to about 28 to 40 % in Denmark, France, Ireland, the Netherlands, Spain and the United Kingdom, while amphetamines, ecstasy and cocaine have been tried by about 1 to 6 % of young adults (although in the United Kingdom figures for amphetamine and ecstasy are around 16 and 8 % respectively). Higher rates of drug use are evident among males, although this varies across countries and differences tend to decrease over time ⁽⁴⁾.

Inhabitants of urban areas report higher rates of drug use than those of rural areas, and differences in overall national figures could be largely conditioned by the proportion of urban population ⁽⁵⁾.

Although widely used, lifetime experience is insufficient to estimate recent drug use since it includes all those who have ever tried drugs, whether once or years ago. Recent use is usually estimated as any use during the previous year (last-12-months prevalence).

Recent use (expressed as last-12-months use) of cannabis is reported by 1 to 9 % of European adults. Recent use of other illegal substances rarely exceeds 1 % among adults. Young adults report higher prevalence figures, roughly double that for all adults. In Ireland, Spain (for cocaine) and the United Kingdom figures tend to be somewhat higher than in other countries ⁽⁶⁾.

Trends

Information on drug trends can be more informative than a fixed picture. However, until now only Germany, Spain, Sweden and the United Kingdom have carried out series of comparable, national surveys. Other countries conducted several different surveys and trends have to be analysed with caution.

Lifetime experience of cannabis increased over the 1990s in most countries where information is available. In recent surveys, many countries report relatively similar prevalence figures — roughly 20 to 25 %. Where prevalence was low early in the 1990s (for example, in Greece, Finland and Sweden), increases seem to have been proportionally greater than where initial prevalence was higher (for example, in Denmark, Germany and the United Kingdom).

⁽²⁾ Figure 2 OL: Last-12-months prevalence of ecstasy and cocaine by age group in England and Wales, 1998 (online version).

⁽³⁾ Figure 3 OL: Lifetime experience of cannabis among all adults and among young adults in some EU countries, measured by national population surveys (online version).

⁽⁴⁾ Figure 4 OL: Lifetime experience of cannabis among adults (males and females) in some EU countries, measured by national population surveys (online version).

⁽⁵⁾ Figure 5 OL: Lifetime experience of cannabis among adults in Finland by level of urbanisation, 1998 (online version).

⁽⁶⁾ Figure 6 OL: Lifetime experience and last-12-months prevalence of cannabis among adults in some EU countries, measured by national population surveys (online version).

Drug use in the school population

For under-18-year-olds, the EMCDDA draws on information from a comparable schools survey which includes data from 30 participating countries in Europe and also data from the United States. Eleven EU Member States participated in the most recent 1999 European School survey project (ESPAD)⁽¹⁾, which describes tobacco, alcohol and other drug use among 15 to 16-year-old students. Belgium, Luxembourg, and Spain also conducted school surveys in 1998 or 1999 independently from the ESPAD survey and the results from these are consistent with those from ESPAD.

Situation and patterns

These surveys show that cannabis continues to be the most widely used illegal substance among school students. Lifetime experience among 15 to 16-year-old students ranges from 8 % in Sweden and Portugal to 35 % in France and the United Kingdom. In two Member States (Greece and Sweden), lifetime use of inhalants (volatile substances) is higher than, or equals, that of cannabis.

School surveys report lifetime use of amphetamine by 1 to 8 % of 15 to 16-year-old school students, ecstasy use by 1 to 5 %, and figures for lifetime use of cocaine are between 1 and 4 %, with Spain and the Netherlands at the higher end of cocaine use.

A different pattern occurs in illicit lifetime use of tranquilisers and sedatives (without a doctor's prescription) where the United Kingdom and Norway, at 4 %, are at the lowest end of illicit lifetime experience and France at the highest (12 %). Illicit lifetime use of tranquilisers and sedatives is higher amongst girls than boys in France, Portugal, Italy, Finland, and Sweden. In contrast, lifetime prevalence for illegal drugs is higher amongst boys than girls in all Member States.

It is worth noting that comparable data from the United States show that figures for lifetime use of a number of illegal drugs are higher than in any of the EU Member States: cannabis (41 %), amphetamine (16 %), ecstasy (6 %) and cocaine (8 %).

There is a negative relationship between the prevalence rate of illegal drug use in a country and the perceived risk attributed to that particular drug, and girls are generally more apt than boys to consider illegal drug use a risk. Disapproval of illegal drug use is consistently high among boys and girls in all the EU Member States at around 80 % on average, excluding disapproval of cannabis, which is lower at 70 % average.

Trends

In all except two of the Member States (United Kingdom and Ireland) that participated in both the early and later ESPAD surveys, the lifetime prevalence of all illegal drug use increased between 1995 and 1999.

Lifetime use of cannabis

Figures of illegal drug taking in general by 15 to 16-year-old school students are largely determined by cannabis figures. In the majority of countries the prevalence of lifetime cannabis has increased.

In Finland and Norway, lifetime use of cannabis figures doubled between 1995 and 1999. Increases also occurred in Sweden, Portugal, Denmark and Italy. However, there was a decrease in the two Member States which had the highest lifetime prevalence of cannabis in 1995. In the United Kingdom, between 1995 and 1999 it decreased from 41 to 35 % and in Ireland from 37 to 32 %.

Perceived availability of cannabis increased substantially in Denmark, Finland, Italy and Norway between 1995 and 1999. In Ireland and the United Kingdom, there were decreases in the perceived availability of cannabis but the decrease is less than the decrease in lifetime prevalence.

Lifetime use of 'other illicit drugs' (amphetamine, LSD/hallucinogen, crack, cocaine, ecstasy and heroin)

The ESPAD survey also shows an increase in lifetime use of collapsed categories of 'other illicit drugs' in the majority of Member States but a sharp decline in the United Kingdom and Ireland, where it fell from 22 to 12 % and from 16 to 9 % respectively. Increases in the majority of Member States and declines in the United Kingdom and Ireland confirm the trend towards convergence in patterns of drug use among the Member States. The substantial decrease in Ireland and the United Kingdom may imply that in advanced stages of drug diffusion the pool of 15 to 16-year-olds willing to experiment with illegal drugs is becoming saturated.

Lifetime use of tranquilisers or sedatives without a doctor's prescription

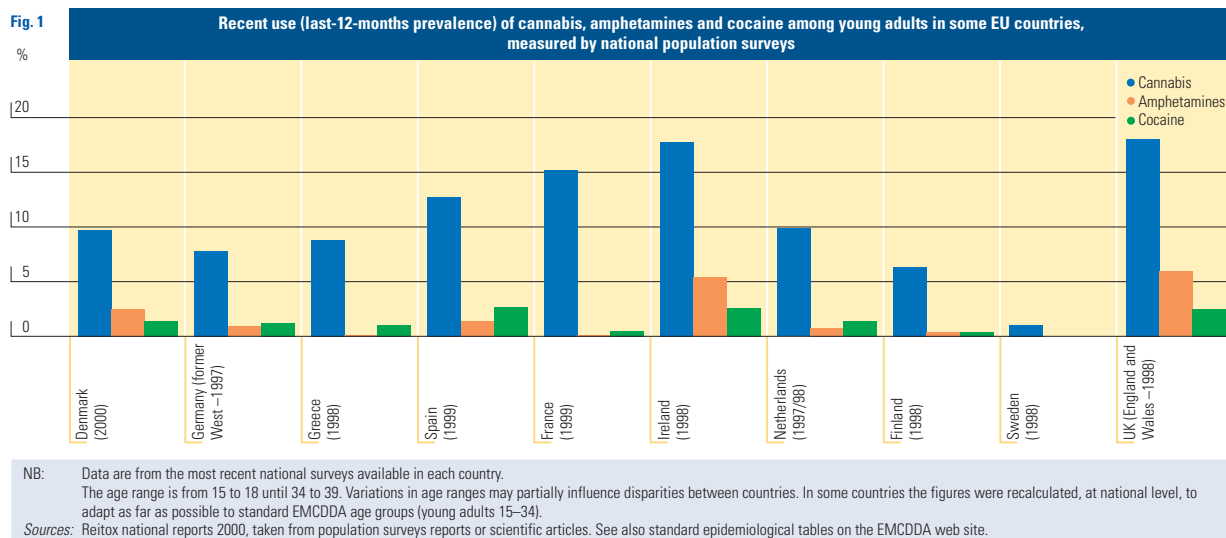
Traditionally, use of tranquilisers or sedatives without a doctor's prescription has been considerably higher amongst girls than boys. Between 1995 and 1999, girls in Denmark, Italy, Ireland, and the United Kingdom showed substantial decreases of around a half in the figures for lifetime prevalence of tranquilisers and sedatives without a doctor's prescription. In contrast, girls in Finland and Portugal showed increases (3 % and 2 % respectively), whilst boys in these two countries showed decreases.

Lifetime use of inhalants

There was little change in lifetime use of inhalants except in Sweden and the United Kingdom where there was a decrease between 1995 and 1999.

(1) The 1999 ESPAD report: 'Alcohol and other drug use among students in 30 European countries', B. Hibbell, B. Andersson, S. Ahlström, O. Balakireva, T. Bjarnson, A. Kokkevi, M. Morgan, the Swedish Council for Information on Alcohol and Other Drugs (CAN), the Pompidou Group of the Council of Europe, December 2000.

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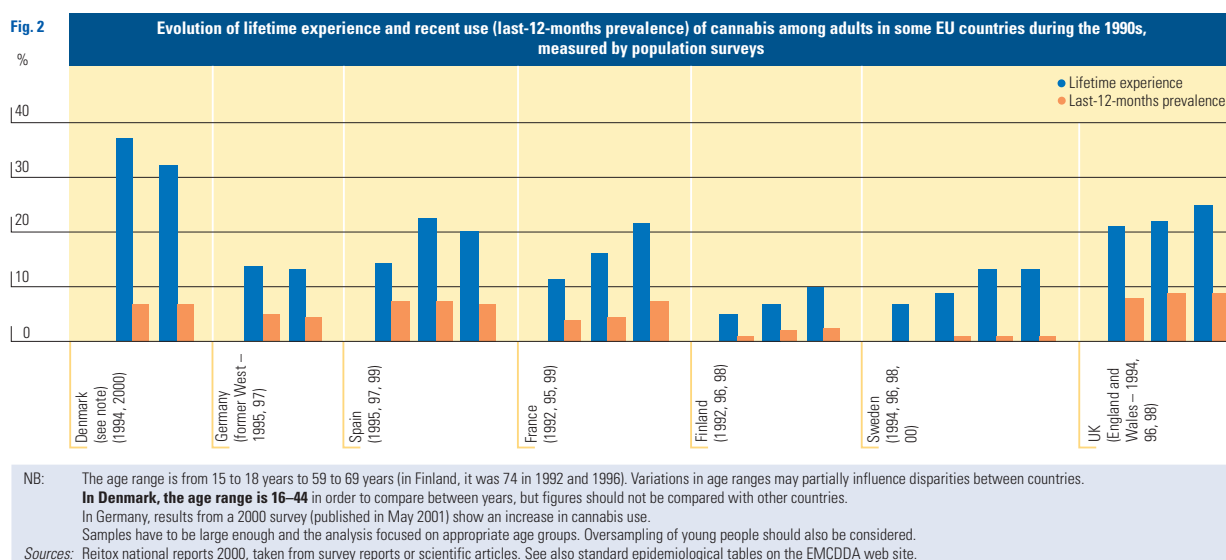


Increased lifetime experience of cannabis does not necessarily imply a parallel growth in recent use. Last-12-months prevalence has generally risen less than lifetime experience.

Trends in the use of other substances are more difficult to track. These developments tend to involve relatively limited groups of the population, but nevertheless they can have important implications on public health and drug policy. For example, the much-discussed possible increase in cocaine use still needs to be analysed in more detail in most countries. Also, recent increase in ecstasy use — well documented among groups of young people — does not show up clearly in population surveys covering the whole population. Samples have to be large enough and the analysis focused on appropriate age groups. Oversampling of young people should also be considered.

Problem drug use

In general, prevalence rates of problem drug use seem to be highest in Italy, Luxembourg, Portugal and the United Kingdom, with between five and eight problem drug users per 1 000 inhabitants aged 15 to 64 (this is taking the midpoints of the range within a country). Rates seem lowest in Belgium (but this data refers only to IDUs and thus is an underestimate), Germany and the Netherlands, with two to three problem drug users per 1 000 inhabitants aged 15 to 64. Intermediate rates range from between three and five problem drug users per 1 000 inhabitants aged 15 to 64 in Austria, Denmark, Finland, France, Ireland, Spain and Norway. Some countries report slightly different figures than in 2000 due to improved data and estimates. Denmark and especially Finland, however, have much higher figures owing to having suppressed less reliable (and in both cases lower) estimates.



Definition and methods used to estimate problem drug use

'Problem drug use' is defined here as 'injecting drug use or long-duration/regular use of opiates, cocaine and/or amphetamines'. This definition excludes ecstasy and cannabis users and those who never — or irregularly — use opiates, cocaine or amphetamines. Opiates include prescribed opiates such as methadone. The national estimates of problem drug use reported here for the EU and Norway (which also participated in the EMCDDA project on prevalence estimation) are for 1996 to 1998. Austria (1995) and Belgium (1995) could not provide estimates for this time period, due to lack of more recent data on which to base the calculations (see Figure 3), while Luxembourg, Portugal and Italy provided more recent ones (1999–2000).

The methods used to produce these estimates are mainly based on statistical models incorporating drug-related indicators and include:

- the multivariate indicator method;
- capture–recapture;
- three multiplier methods based on police data, treatment data and mortality rates; and

- a multiplier method using back-calculated numbers of intravenous drug users (IDUs) with HIV/AIDS, in combination with HIV/AIDS rates among IDUs.

The ranges given in Figure 3 are often derived from a multiple method approach; therefore the lowest and highest figures may have been obtained by different methods, both within and between countries. These methods do not always refer to the same target group — for example, HIV/AIDS back calculation and overdose mortality multipliers target IDUs, while multipliers from treatment data could only be used for the wider group of problem opiate users.

Several countries applied multiple estimation methods — two (Spain, Luxembourg and the Netherlands), three (Germany, France, Ireland, Finland and the United Kingdom) or even four (Italy and Portugal). Other countries (Belgium, Denmark, Austria, Sweden and Norway) could only apply one method, while Greece was still unable to provide an estimate. Using multiple independent estimates may cross-validate the single figures and lead to a more reliable overall estimate for a country. Therefore, a multiple method approach, if possible on a year-by-year basis, may ideally be applied.

Besides estimates of prevalence, data on patterns of use are important. However, there are little data on patterns of drug use among problem drug users who are not in treatment, although this is important information for guiding policy decisions on future treatment demand. In northern countries, notably Finland and Sweden, primary amphetamine users form the majority of problem drug users (an estimated 70 to 80 % in Finland in 1997). This is contrary to other countries where problem drug users are mostly primary opiate users (but often polydrug users).

Trends

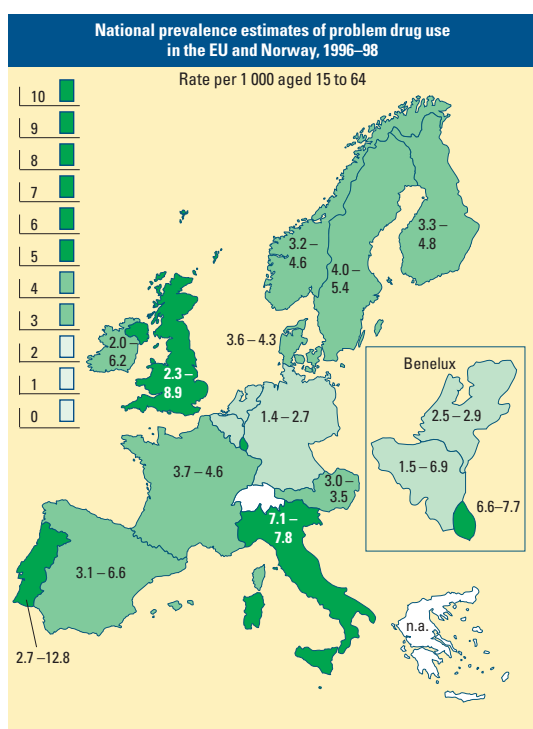
Although important for policy evaluation, it is still not possible to calculate trends in the prevalence of problem drug use with the current methods, data quality and data availability. Incidence of problem drug use may be an additional and important way of measuring trends. Incidence is the number of newly occurring cases in a year, while prevalence is the total of all existing cases, new and old. Therefore trends in incidence are much more sensitive to epidemiological changes and to interventions that prevent new cases from occurring.

An EMCDDA project produced new incidence estimates of heroin use for Belgium, Lisbon, Budapest, London and Amsterdam suggesting that the timing of heroin epidemics in those regions may have been very different (see Figure 4, London and Amsterdam not shown).

Figure 5 shows how, even within one country, in this case Italy, heroin epidemics may occur in different regions at different moments. The results also suggest that there might be an initial (epidemic) period of rapid spread followed by saturation effects (that is most susceptible persons have become heroin users) and lower but constant further spread (endemic situation) — a mechanism which is similar to the spread of infectious diseases. This may have important implications for decision-makers as regards the optimal balance between policy measures such as primary prevention, which needs to be timely to prevent high prevalence, and secondary prevention (drugs treatment and harm-reduction measures), which becomes more important once high prevalence has been established.

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Fig. 3



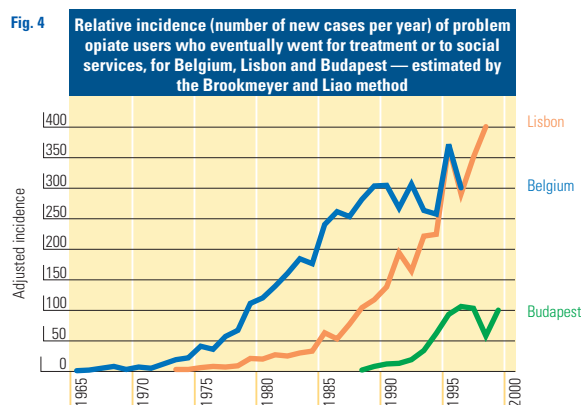
NB: n.a. = data not available. Differences between countries have to be interpreted with caution due to different methods and target groups. For more detail, see online Tables 1.0L and 2.0L at www.emcdda.org. Data for Austria and Belgium are for 1995, Italy for 1999 and Portugal for 1999-2000. The original Swedish estimate has been reduced by 8 % to exclude cannabis addicts, compatible with EMCDDA definition of problem drug use. Colour for a country indicates the midpoint of the range in estimates, except for Belgium (point estimate 3.0 and 95 % confidence interval). The Belgian estimate refers to IDUs and thus underestimates total problem drug use.

Sources: Reitox national focal points, 2000. For Sweden: B. Olsson, C.A. Wahren, S. Bygqvist, *Det tunga narkotikamisbrukets omfattning i Sverige 1998*, CAN, Stockholm, 2001.

In Figure 5, it is notable that the heroin epidemic in Puglia seems to have started earlier than in Sicilia and Campania. Puglia, the 'heel' of Italy, is situated on an important heroin trade route from the Balkan region into Europe, which may have led to earlier spread of heroin use. This confirms earlier results based on geographical analysis of treatment data (2000 annual report, EMCDDA).

Differences in the prevalence of drug use are influenced by a variety of factors in each country. As countries with more liberal drug policies (such as the Netherlands) and those with a more restrictive approach (such as Sweden) have not very different prevalence rates, the impact of national drug policies (more liberal versus more restrictive approaches) on the prevalence of drug use and especially problem drug use remains unclear. However, comprehensive national drug policies are of high importance in reducing adverse consequences of problem drug use such as HIV infections, hepatitis B and C and overdose deaths. Other factors that may affect prevalence of problem drug use are the availability and price of drugs, unemployment and poverty or other societal problems (war), the age structure of a country and the proportion of urban and

Fig. 4



NB: Relative incidence is the incidence (number of new users per year) of opiate users who will eventually go to services. Lisbon: extremely problematic area of Lisbon, users presenting themselves to social services. Belgium: sample going for treatment in French Community.

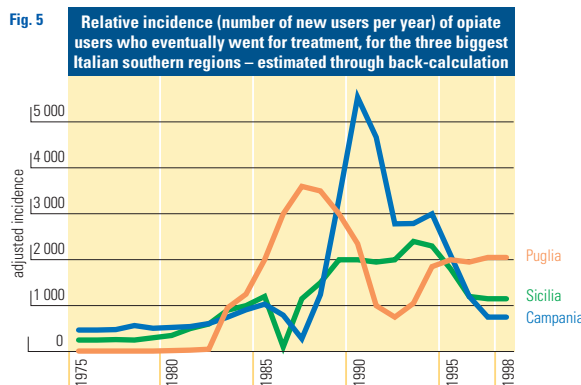
Source: EMCDDA project CT99.EP05, 'Study on incidence of problem drug use and latency time to treatment in the European Union', Lisbon 2001 (coordinated by University Rome 'Tor Vergata').

rural areas. Furthermore, drug use seems to behave in an epidemic manner (see for example Figures 4 and 5). It may thus follow long-term epidemic cycles that for a large part depend on the demographic replenishment of new generations of 'susceptible' young people, who have never experienced the problems associated with heavier patterns of use. At present, therefore, a final causal interpretation of varying prevalence rates within EU Member States cannot be made.

Additional qualitative or local information on trends in problem drug use is available for some countries or cities.

In Austria, problem drug use prevalence seems currently stable in most regions, although in Vienna street workers have registered a decline in the number of young newcomers on the scene. In France, heroin consumption is in general declining although it is not clear what this means in terms of numbers of heroin users and there are some indications of new, local increases. In Finland, prevalence estimates for the greater Helsinki area for

Fig. 5



NB: Relative incidence is the incidence (number of new users per year) of opiate users who will eventually go to services.

Source: EMCDDA project CT99.EP06, 'Study on incidence of problem drug use and latency time to treatment in the European Union', Lisbon 2001 (coordinated by University Rome 'Tor Vergata').

Drug demand and drug supply

1995–97 suggest that the use of hard drugs has increased in this area by a minimum of 40 % in two years. This increase was most pronounced in males, those over 26 years old and in amphetamine users.

In Germany, heroin use is primarily found in metropolitan areas, prevalence rates and seizures in rural areas being much lower. In the new *Länder*, heroin use is still scarce. Surveys suggest that heroin use is only slightly increasing or stagnating since 1992; however, cocaine shows stable and uniform growth. In Greece, data from indirect indicators (treatment, deaths, low-threshold services) suggest that problem drug use is increasing. In Ireland, drug users are young reflecting the general demographic situation. Until about 1996, the trend in heroin use was towards increased smoking; however, more recently, injecting is again increasing. In Italy, drug use levels seem higher in northern regions but problem drug use may be more evenly distributed between northern, central and southern regions even if the level of 'at risk' population is different between geographical areas. (The total population of 15–54-year olds is around 32 million — 44 % live in the northern regions, 19 % in the central regions and 37 % in the southern regions.) In addition, northern regions may have relatively more use of 'recreational drugs'.

In Luxembourg, the national registration system showed a marked increase of 42 % of new registrations between 1998 and 1999, however this is mainly due to drug law offenders and may reflect policing activity. There is a large proportion of non-natives from Luxembourg (48 %) among problem users. The estimated prevalence shows an upward trend; while injecting drug use has decreased from over 90 % to about 66 %. In Amsterdam, the Netherlands, the number of heroin users has moderately decreased over the years, while the proportion of injectors among them has strongly decreased. In Portugal, drug use problems are more significant in the districts of Lisbon, Porto, Setubal and Faro. In Spain, heroin use, especially injected, is becoming less relevant and cocaine problems are becoming more important among drug problems. In Sweden, there has been an increase in the number of severe drug users during the 1990s and heroin use is becoming more common in younger groups of problem users. In the United Kingdom, a report published in 1998 suggested an increase of new heroin outbreaks among young people in most regions of England since about 1996, while a recent study in London suggested a two-fold increase in incidence of non-injected heroin use between 1991 and 1997.

Health consequences of drug use

Demand for treatment

Characteristics of clients entering treatment (such as social characteristics) and consumption behaviours (such as the proportion of injectors or opiate users) are potential indicators of wider trends in problem drug use. However, biases may arise owing to different methods of collecting the information and differences in the offer of treatment services between countries.

Substances

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

In most countries, opiates are the main drug for new clients entering treatment (especially heroin). The variation between countries is quite high — from 22.4 % in Finland to 84.2 % in Greece, but the most frequent percentages are between 50 and 70 %. Apart from heroin, other main substances for which treatment is sought are cannabis (over 15 % in Belgium, Denmark, Finland and Ireland) and cocaine (especially the Netherlands at 15.4 % and Spain at 17 %). Ecstasy is the main drug only in a low number of cases, the highest value being 8.9 % in Ireland. Strong differences exist concerning amphetamines, the highest percentages being reported from Finland (39 %), Sweden (17 %) and Belgium (15 %).

Trends

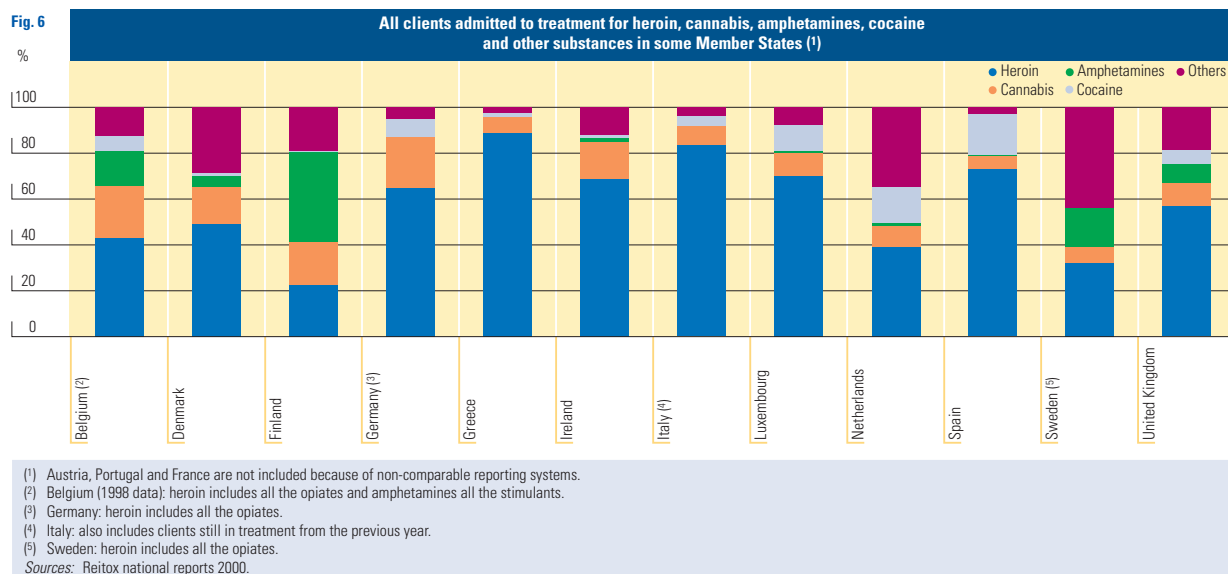
Common trends are identified in the number of new clients seeking treatment — new clients demanding treatment for heroin are decreasing while they are increasing for cannabis and especially cocaine use. The highest increase in cannabis clients regards Germany (from 16.7 % in 1996 to 40 % in 1999 although it is important to note that this data only refers to outpatient units) and Ireland (from 20.7 % in 1996 to 29.4 % in 1999) and Denmark (from 25 % in 1996 to 31 % in 1999), whilst the biggest rise in cocaine users is reported by Spain (from 21.6 % in 1998 to 30.9 % in 1999) and the Netherlands (from 14.7 % in 1994 to 23.2 % in 1999).

These trends are confirmed by data of all clients admitted to treatment over the years, where the increase in cocaine users is clear, as well as in the comparison between new and all clients admitted to treatment in some Member States. Furthermore, an increase in cocaine use as a secondary drug is shown in clients using opiates as a main substance⁽⁷⁾ ⁽⁸⁾. In general,

(7) Figure 7 OL: Trends for all clients admitted to treatment for heroin, cannabis and cocaine (online version).

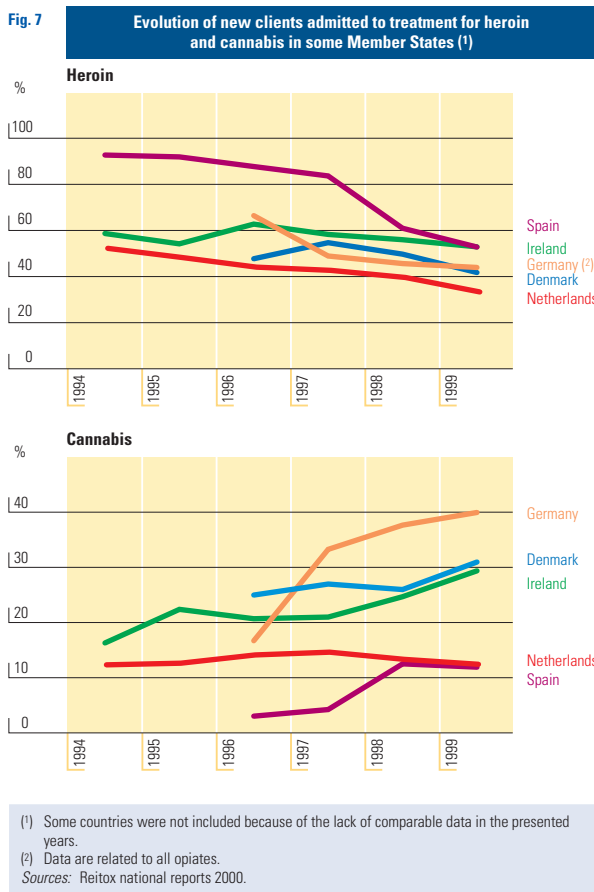
(8) Figure 8 OL: All and new clients admitted to treatment for cannabis and cocaine use, 1999 data (online version).

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clients demanding treatment use more than one drug and differences are identified in single user groups.

An increase in the demand for substitution treatment is reported in many countries, especially by pregnant women; it is probably due to these services being more widely available.



Injecting drug use and other routes of administration

The proportion of injectors among clients in treatment for heroin varies markedly, from 12.5 % of injectors in the Netherlands to 72.7 % in Greece. A general decrease in injecting heroin is quite common in most countries, even if variable (Ireland reports a contrary increasing trend in injecting drugs). A comparison between all and new clients demanding treatment for heroin seems to confirm the decrease in injecting heroin (an average of about 10 % fewer inject heroin) (9).

Many factors could influence the ways of administration and these are still not really clear or demonstrated by scientific studies, but could include market factors, cultural traditions and interventions.

At market level three main factors could influence the route of administration: the relative availability of smokeable heroin (base form) or injecting (hydrochloride) heroin, heroin price (a higher price leads to more injecting), heroin purity (lower purity is related to a higher level of injecting use).

From a cultural point of view, there are some traditions especially linked to ethnic minorities; within the Suriname's subgroup, aversion to injecting seems to have influenced the route of administration (sniffing or smoking) used by heroin consumers. The same influence was not found in other subgroups such as North African consumers in France or Antilleans, who also traditionally smoke or sniff heroin.

Various evaluation studies also highlight the relation between prevention activities (facilities, information on

(9) Figure 9 OL: Proportion of injectors among all and new clients admitted to treatment for heroin use in some Member States, 1999 data (online version).

Possible increases in HIV transmission among IDUs in some EU countries

Preliminary data suggest that increases in HIV infection may have occurred among subgroups of IDUs in some EU countries. The limitations of using routine data for detecting changes in transmission should be taken into account (see Chapter 3 page 37). For example, the increase in Ireland may partly be due to increased testing of IDUs. However, it is important to carefully monitor these possible increases and take appropriate action if necessary. Increases in HIV transmission may have occurred in Austria, Luxembourg, Ireland, the Netherlands, Portugal and Finland.

In Austria, HIV prevalence among opiate overdoses increased to 5 % in 1999 (from 3 % in 1996, 2 % in 1997 and 1 % in 1998).

In Luxembourg, notified HIV infections in IDUs rose, from 2–3 per year in 1995–97 to 6–7 per year in 1998 and 1999.

In Ireland, the number of IDU-related HIV positive tests tripled to 69 in 1999 (from 20–26 per year in the period 1994–98).

In Portugal data are from local sources. In Coimbra, prevalence among IDUs in treatment increased from 9 to

13 % between 1999 and 2000, while this was mainly among females and from 9.5 to 18 % in the age group 25–34. A street-based study among 250 homeless heroin users in a very problematic area in Lisbon found a prevalence of 48 % in 1998–99.

In Finland, a large increase in IDU-related HIV notifications occurred from 0–5 yearly cases during 1990–97, to 20 cases in 1998 and 84 cases in 1999. Prevalence among needle exchange attendees asking for an HIV test also increased, from 0 % in 1997 to 3 % in 1998, 8 % in 1999 and decreased back to 3 % in 2000.

In the Netherlands, HIV infection rose from 11 to 22 % between 1994 and 1998/99 among IDUs in the city of Heerlen, southern Netherlands.

NB: Sample sizes: Austria 1996 — 184, 1997 — 131, 1998 — 108, 1999 — 126; Netherlands Heerlen 1994 — 161, 1998/1999 — 116; Portugal Coimbra 1999 — 227, 2000 — 106, Lisbon 1998/1999 — 252; Finland 1997 — 131, 1998 — 135, 1999 — 63, 2000 — 356.

Sources: National focal points. For Lisbon data: H. Valle, L. Rodrigues, R. Coutinho, et al., *HIV, HCV and HBV infection in a group of drug addicts from Lisbon*, Seventh European Conference on Clinical Aspects of HIV infection, 23–27 October 1999, Lisbon, Portugal (abstract 866).

the risks of injecting) and changes in attitudes from injecting to sniffing or smoking as an influencing factor.

Social characteristics

Clients entering treatment tend to be males in their 20s or 30s. The mean age is 29 years for all clients and 27 for new clients. The women are usually younger than men, demanding treatment almost a year before men. The oldest clients are in Sweden and the Netherlands, whilst the youngest are in Ireland and Finland, although in the case of Ireland this also reflects the demographic situation in the country.

The gender distribution varies with a similarity among southern countries, where men are the largest majority (86/14 in Italy, 85/15 in Spain, 84/16 in Portugal, 84/16 in Greece) and among northern countries with a higher presence of women in treatment (70/30 in Ireland, 72/28 in Sweden).

The social conditions of clients demanding treatment seem to be worsening, in terms of level of education and employment. The majority of clients are concentrated in urban areas, but this could also be due to a different level of services provision in rural areas.

Drug-related infectious diseases

A more detailed insight into this issue is provided in Chapter 3, Selected issues — Drug-related infectious diseases.

Prevalence and trends

As available data are from different sources (sometimes local), only a general impression of HIV prevalence in injecting drug users (IDUs) can be given. However, large differences are apparent between, as well as within, countries. Available data indicate levels of infection among different subgroups of IDUs that roughly vary from about 1 % in the United Kingdom to 32 % in Spain. This overall picture has not changed in recent years. However, there are indications of new increases of HIV transmission in (subgroups of) IDUs in some countries (see box above).

Data on prevalence of infection with hepatitis C virus (HCV) are less available and, where available, are subject to the same limitations as the HIV data. However, the overall picture is clear — HCV prevalence is extremely high in the data from all countries of the EU, with infection rates of between 40 and 90 % in different subgroups of IDUs (Figure 9). As far as they are available, data on prevalence in IDUs aged under 25 indicate levels of HCV infection from 20 % (Belgium, treatment, 1998) to over

Fig. 8

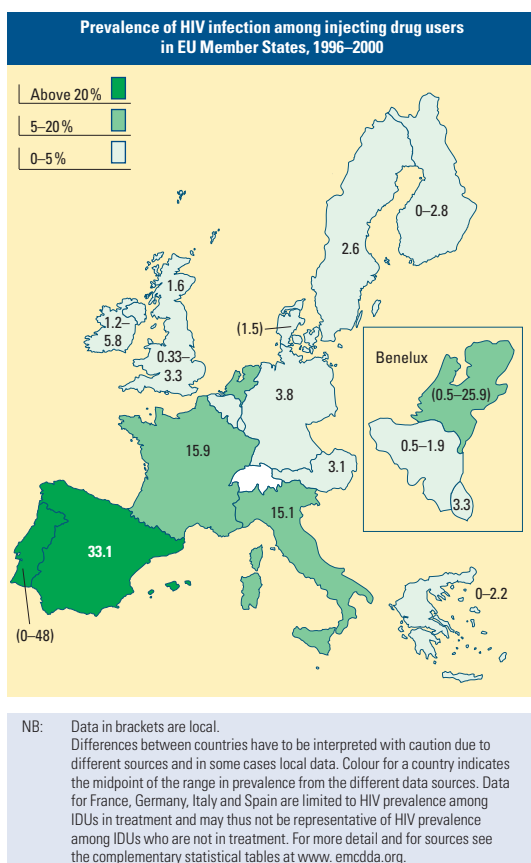
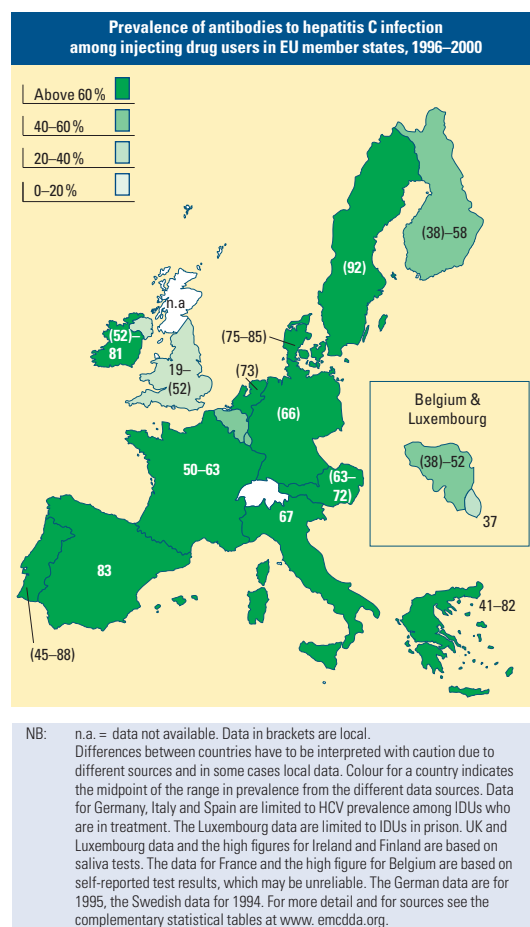


Fig. 9



74 % (Portugal, Coimbra treatment, 2000) (see Figure 27, in Chapter 3, Selected issues, Drug-related infectious diseases). This suggests that HCV transmission continues at high levels in several countries, although some studies indicate that introducing prevention measures might have reduced transmission (United Kingdom).

Drug-related deaths and mortality of drug users

The number of acute drug-related deaths ('overdoses') is sometimes used as a simplistic way of assessing a country's drug situation and to draw comparisons. Drug deaths are a source of social and political concern, especially acute deaths among young people.

Characteristics of acute drug-related deaths

In the last five years (1994 to 1999) based on the available information, the overall number of cases reported by EU countries has fluctuated between 7 000 and 8 000. In the EU, opiates continue to be present in most cases of acute drug-related deaths — 'overdoses' or 'poisonings' ⁽¹⁰⁾.

The presence of other substances, such as alcohol, benzodiazepines or cocaine is common. The presence of

depressant substances such as alcohol or benzodiazepines is considered a risk factor for opiate overdose. Acute deaths with presence of cocaine, amphetamine or ecstasy without opiates seem to be infrequent in Europe.

Many opiate deaths occur up to three hours after use, making medical intervention possible. In addition many fatal and non-fatal overdoses are witnessed by other users, which would make intervention possible — in such cases, it is important that users know how to seek effective assistance.

Most opiate deaths occur among injectors in their late 20s or 30s, usually after several years of use. The large majority of deaths occurred among males. As with clients entering treatment, a clear ageing trend is observed among deceased opiate users in many EU countries ⁽¹¹⁾.

Some cocaine-related deaths may pass unnoticed because of the social background of victims or because of a different clinical presentation of them (such as ischemic heart diseases or arrhythmia). Emergency services person-

⁽¹⁰⁾ Figure 10 OL: Proportion of abuse of opiate and non-opiate drugs among the cases of drug-related deaths, valid percentages based on cases with known toxicology (online version).

⁽¹¹⁾ Figure 11 OL: Proportion of people over 30 among drug-related deaths in some EU countries, 1986 and 1999 (online version).

Methodology and definitions for drug-related deaths

In this report the focus is placed on acute drug-related deaths (overdoses) unless stated otherwise.

Direct comparisons between countries can be misleading because the number of drug-related deaths depends not only on the prevalence of problem drug use and the risk patterns (such as injection) but also on national definitions and recording methods. For instance, Portugal has an inclusive definition whereas Sweden has recently changed from a broad to a more restrictive definition ⁽¹⁾.

Drug-related deaths and mortality among drug users is one of the EMCDDA's epidemiological key indicators. A European standard protocol has been developed to report cases from general mortality registries (GMR) and special registries (SR) — forensic or police. This standard protocol has been tested in all Member States, and active collaboration is maintained with Eurostat and the World Health Organisation ⁽²⁾.

Where definitions, methods and quality of reporting remain consistent within a given country, the statistics can indicate trends over time and, if correctly analysed and integrated with other indicators, can be valuable in monitoring the more extreme patterns of drug use.

Deaths indirectly associated with drug use — deaths from AIDS, traffic accidents, violence or suicide — should also be taken into account when assessing the overall impact of drug abuse, but they require different sources of information and a more research-oriented methodology.

⁽¹⁾ Box 1 OL: Definitions of 'acute drug-related death' in EU Member States, as used in the EMCDDA annual report, and reported in national reports (online version).

⁽²⁾ Box 2 OL: Proposed EMCDDA standard to count acute drug-related deaths — the DRD standard, Version 1.0 (online version).

nel should be aware of this possibility. Acute deaths related only to ecstasy seem to be rare, despite the public concern these caused during the mid-90s in some European countries.

Methadone has been identified in a number of drug deaths and its role has been discussed in several European countries. Since methadone substitution has become quite widespread in recent years, circumstantial toxicological findings of methadone are more frequent among drug users that die due to accidents, AIDS, etc. A few local studies suggest that some acute deaths may be caused by methadone diverted to the illegal market, perhaps facilitated by poorly organised prescription services. An improvement in the organisation of methadone substitution programmes has been recommended in some countries. Despite these problems, research shows that substitution treatment reduces the risks of drug-related death among programme participants.

Trends in acute drug-related deaths

Many EU countries witnessed a marked increase of acute drug-related deaths in the second half of the 1980s and the early 1990s. However, in recent years, the number of acute deaths at EU level as a whole has stabilised, between 7 000 to 8 000 per year, and in some countries they have even decreased.

Multiple factors probably contribute to the recent stabilisation of drug-related deaths. The number of problem drug users may have stabilised and treatment data suggest that risk practices, for example injecting, have also decreased in some countries. In addition, treatment interventions — including substitution programmes — have expanded in many countries and medical assistance for overdoses may have improved.

The stabilisation is consistent with the decrease in overall mortality (in some cases also in overdose deaths) among cohorts of problem drug users as described below (mortality of drug users section).

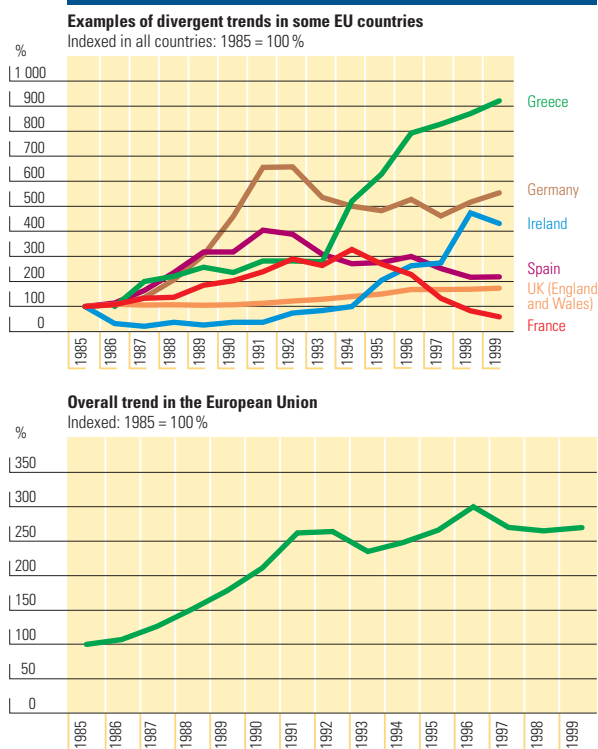
Within the overall EU trend, different national trends are observed.

- Several countries present a general downward trend, although with year-to-year fluctuations, for example, Austria, France, Germany, Luxembourg, Italy and Spain. Austria (1999), Germany (1999–2000) and Luxembourg (1997–98) reported new increases recently but they are not as high as previous values. This development has to be closely monitored.
- Some countries have reported a substantial upward trend until recently — for example, Greece, Ireland (a decrease observed in 1999) and Portugal. These

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Fig. 10

Trends in acute drug-related deaths in some EU countries, 1985–99



NB: These trends can be calculated for all EU countries. A few are presented as examples. Proportional variations over 1985 figures are presented. For Greece, the series begins in 1986 to avoid distortion. In some countries with an increasing trend, improved reporting may account for part of the increase. Not all countries provided data for all years, but this situation has been controlled in the analysis.
Sources: Reitox national reports 2000, taken from national mortality registries or special registries (forensic or police). See also standard epidemiological tables in EMCDDA web site.

increases are probably related to a later expansion of heroin use in these countries during the 1990s, which may be explained by their sociological evolution. Recording practices may also have improved. The broad case definition used may influence in part the marked increase observed recently in Portugal.

- The United Kingdom presents a moderate but continuously increasing trend. Other countries have a stable trend, or trends are difficult to assess due to the recent switch in the International Classification of Diseases (9th edition to 10th edition), or changes in national definitions.

Comparisons between estimates of drug-related deaths for the EU and the United States should be made and interpreted with extreme caution. Current European definitions of drug-related death are heterogeneous and the United States definition is somewhat broader and includes psychoactive medicines. Even so, it is worth noting that the number of cases recorded in the EU countries (376 million inhabitants) amounts to roughly

half of those recorded in the United States (270 million inhabitants). In recent years, the number of cases in the EU has fluctuated between 7 000 and 8 000, whereas the United States appears to present an upward trend from about 13 000 to almost 16 000 in the same period (ONDCP, the national drug control strategy, 2001 annual report).

Mortality among drug users

Problem drug users represent a very small proportion of the population, but they concentrate disproportional health problems and, in particular, suffer very high mortality.

Follow-up studies that consist of tracking groups of problem users (usually opiate users recruited from treatment centres) over several years have shown consistently that opiate users have an overall mortality rate (for all causes) of up to 20 times higher than that of the general population of the same age. This is due not only to drug overdose but also to accidents, suicides, AIDS and other infectious diseases. Further risk factors have been identified: the mortality of injectors is two to four times higher than that of non-injectors, while that of users infected by HIV is two to six times higher than of non-infected users. Combined use of opiates with other depressant substances such as alcohol or benzodiazepines may increase the risk of overdoses.

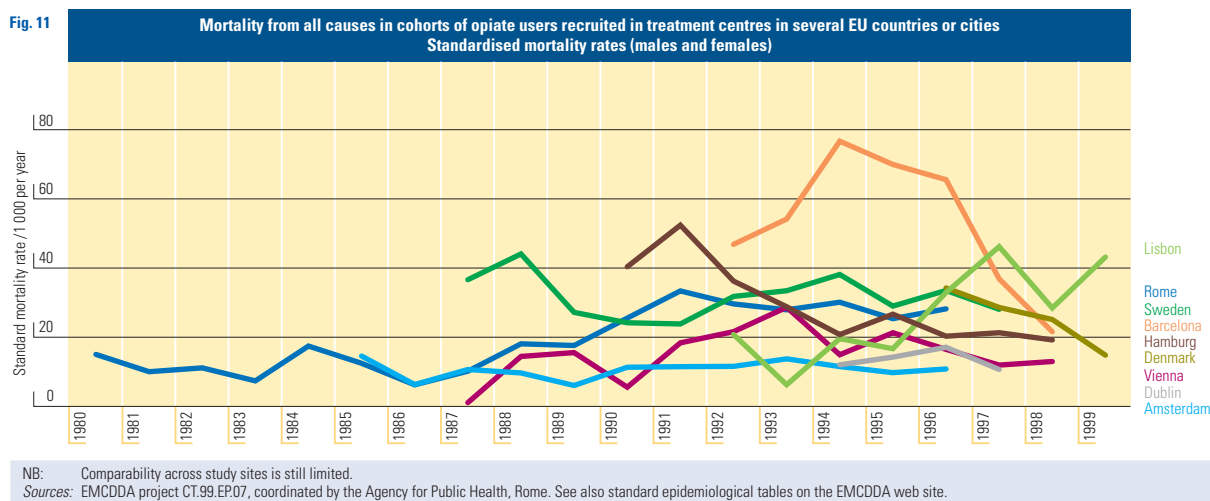
The mortality of problem drug users that do not use opiates or do not inject their drugs is visibly lower, although their health risks are more difficult to assess with precision. In general, traditional drug treatment centres record relatively few and selected cases of heavy cocaine or amphetamine users and a substantial proportion of them seem to be former or concomitant opiate users, former injectors, or socially excluded people. Different methodologies and/or sources may be needed for these drug users other than for traditional opiate users.

A multi-site study coordinated by the EMCDDA has established cohorts in nine European sites (cities or countries) following as far as possible a common protocol developed as part of the key indicator 'drug-related deaths and mortality among drug users'. The study shows substantial differences in overall mortality and causes of death between locations.

Trends in mortality among drug users

The EMCDDA study mentioned above reveals that in several locations mortality rates reached their highest levels in the early or mid-1990s, decreasing in more

Drug demand and drug supply



recent years (Barcelona, Hamburg, Vienna and perhaps Denmark — with information only in the last few years). In Barcelona, this phenomenon has been particularly evident: mortality reached over 50 per 1 000 users per year from 1992 to 1996 before falling markedly, reflecting mainly a drop in AIDS deaths and, to a lesser extent, in overdose deaths.

Law-enforcement indicators

Offences against national drug legislation (such as use, possession and trafficking) reflect differences in laws as well as the resources and priorities of enforcement forces. Variations in recording procedures and definitions affect comparisons. However, wherever possible, trends are compared.

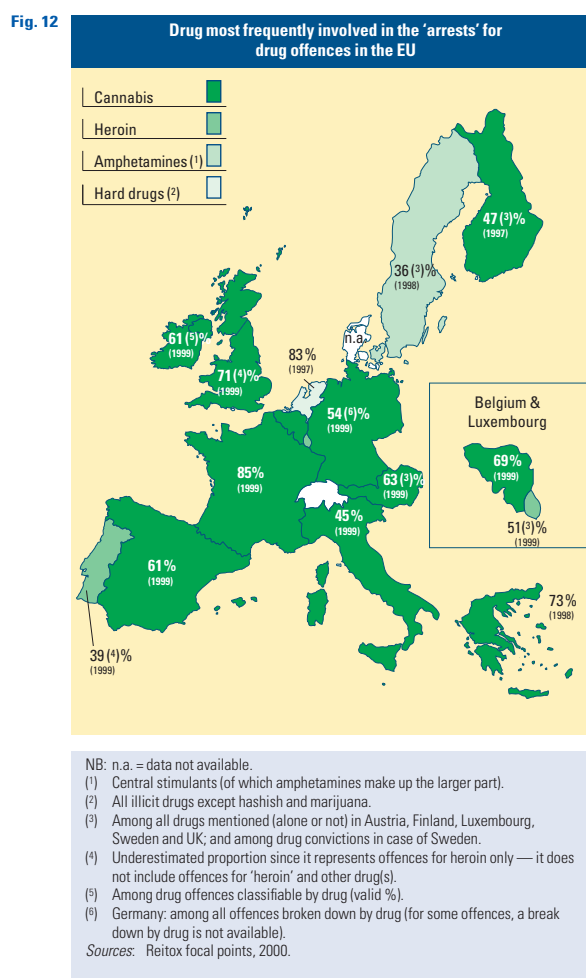
'Arrests' (12) for drug law offences

Cannabis remains, in 1999, the most common drug involved in 'arrests' — accounting for 45 % of the drug-related arrests in Italy to 85 % in France. In Sweden, amphetamines are slightly more frequent than cannabis. In Portugal and Luxembourg, heroin is predominant, while in the Netherlands most of the drug offences are related to 'hard drugs' (drugs other than cannabis and its derivatives).

The majority of the reported drug offences are related to drug use or possession for use, except in Italy, the Netherlands and Spain, where drug offences concern only dealing or trafficking activities. As in previous years, in 1999, Luxembourg reported the majority of arrests involving offences for both drug use and drug trafficking.

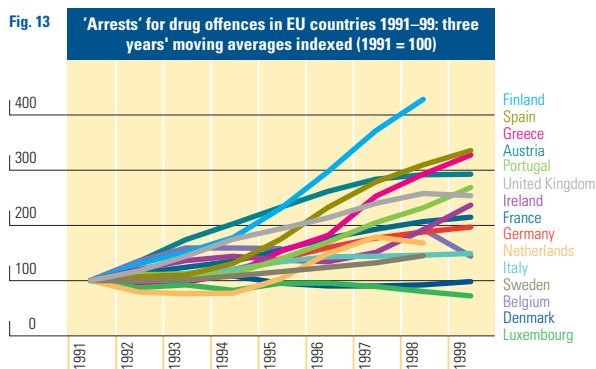
Trends

'Arrests' for drug law offences have been steadily increasing since 1985 in the EU as a whole. Increases by over sevenfold were reported in Finland, Greece and Portugal while in Denmark, Italy, the Netherlands and Sweden, increases were much lower (twofold or less).



(12) 'Arrests' for drug law offences are defined in different ways by the Member States. The term can, for example, refer to suspected offenders or to charges for drug law offences. Please, consult the *Statistical bulletin* at www.emcdda.org for exact definitions.

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NB: For definitions of 'arrests', please refer to the complementary statistical tables at www.emcdda.org. Real values have been input for all countries in 1999 and for Belgium, Finland, the Netherlands and Sweden in 1998 since data available do not allow the calculation of moving averages in these cases. The series is discontinued for Belgium in 1996 and 1997 (data not available). Greece: 1998 figure relate to a number of charges.

Sources: Reitox national focal points.

In the last three years, the number of drug-related 'arrests' rose in most of the EU countries. The highest increases were reported by Greece, Ireland, Portugal and Spain. In 1999, Belgium and the United Kingdom were the only countries reporting a fall in the number of drug-related 'arrests' (13).

Drug users in prison

The prevalence of drug users amongst prisoners is principally estimated through a number of ad hoc studies carried out at local level. Up to 90 % of prisoners report a lifetime use of an illicit drug. Problem drug users and/or intravenous drug users are less frequent but may represent up to 50 % of the prison population in some areas (14).

Drug use within prison is reported in several countries. Injecting drug users are less likely to inject inside prison than in the community, but they are much more likely to share injecting equipment inside prison.

Drug market indicators – seizures, price, purity

The data on drug seizures, price and purity analysed below were provided by the Reitox focal points. Differences with data published by Europol are due to differences in reporting procedures (15).

Drug seizures are usually considered as indirect indicators of supply and availability of drugs, although they also reflect law-enforcement resources, priorities and strategies, as well as the vulnerability of traffickers to enforcement. Trends in quantities seized are biased since they may fluctuate from one year to another due to a small number

of large seizures. The numbers of seizures are usually a more useful indicator of trends at user's level. This is because in all countries they include a major proportion of small seizures from the retail level of the market. Where known, origin and destination of drugs seized may indicate trafficking routes and producing areas. Price and purity of drugs at retail level are reported by most of the Member States, but data are scarce and do not allow for accurate comparisons. However, they may give a rough indication of the availability of different drugs, alongside information on access to drugs at user's level.

Heroin

In 1999, over seven tonnes of heroin were seized in the EU, of which one third was accountable to the United Kingdom. Heroin seized in the EU comes mainly from the Golden Crescent (south-west Asia: Afghanistan, Pakistan), followed by the Golden Triangle (south-east Asia: Myanmar, Laos, Thailand), via Turkey, the Balkan Route and the Netherlands. However, increased trafficking via northeastern European countries was reported, especially via Russia.

At street level, heroin prices varied between EUR 30 and 340 a gram in 1999 across the EU. The highest prices are reported by Finland and Sweden. Heroin purity ranges typically from under 20 to 35 %, but a higher average purity is reported by Denmark, Finland and the United Kingdom.

Trends

At EU level, heroin seizures increased up until 1991–92 and then stabilised. The number of heroin seizures has grown steadily in Luxembourg, Portugal and Sweden since 1985, while marked decreases were reported since

Access to drugs by 15 to 16-year-old students

From ESPAD school surveys, perceived access to drugs by 15 to 16-year-olds seems to have increased between 1995 and 1999 in all participating EU countries (1) except Ireland and the United Kingdom where it has been decreasing. In 1999, cannabis was perceived to be 'very easy' or 'fairly easy' to obtain by 20 to 60 % of the students, heroin and cocaine by 5 to 20 %, and amphetamines and ecstasy by 6 to 38 %. Perceived availability of illicit drugs is typically very low in Finland and quite high in Ireland, Denmark and the United Kingdom.

(1) Participating EU countries: Denmark, Finland, France, Greece, Ireland, Italy, Portugal, Sweden, United Kingdom. Source: The 1999 ESPAD report. See page 9 for full reference.

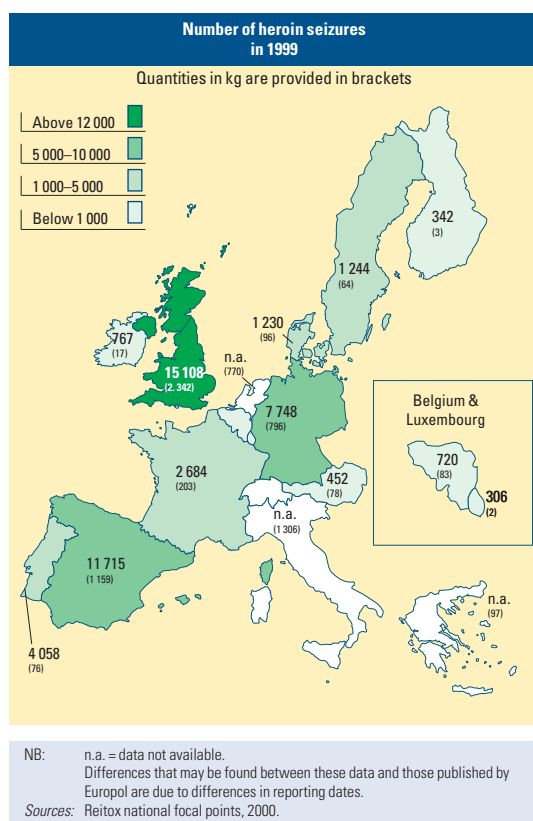
(13) Table 3 OL: Number of 'arrests' for drug law offences in EU countries (online version).

(14) Table 4 OL: Proportion of drug users among prisoners in EU countries (online version).

(15) Table 5 OL: Drug seizures in the EU countries, 1999 (online version).

Drug demand and drug supply

Fig. 14



1996–97 in Austria, Belgium, Denmark, France, Germany and Spain. In every Member State, the quantities seized fluctuated over the period. In 1999, marked decreases in the quantities of heroin seized were reported in Austria, France, Greece, Ireland and the Netherlands, while in Italy and Spain there were large increases in the amount of heroin seized.

Heroin street prices are generally stable, although Luxembourg, Portugal, Sweden and the United Kingdom reported a recent decrease. Heroin purity is reported to be stable or decreasing in all countries, except Germany and the United Kingdom where it has been recently increasing.

Cocaine (16)

Spain remains the country in the EU with the highest level of cocaine seizures. The cocaine used in Europe comes from Latin America (especially Colombia, Brazil and Venezuela) via Central America, Spain and the Netherlands.

Retail price of cocaine varies from EUR 35 to 170 per gram in 1999. The lowest prices are found in Belgium and Spain and the highest in Finland. Cocaine purity is generally high, between 55 to 70 % in most of the countries, except in Ireland which reported an average of 41 % purity in 1999.

Trends

The total number of cocaine seizures rose steadily since the mid – 1980s in the EU and seemed to stabilise in 1999. Cocaine seizures increased markedly in 1999 in Luxembourg and Sweden, while they were decreasing in Austria, Belgium and Denmark.

Following increases up until 1990, the quantities of cocaine seized stabilised, and from 1994 on fluctuated within an upward trend. In recent years, quantities went up in France and Sweden and decreased in Greece, Ireland and Luxembourg.

Cocaine prices are stable in most countries, but are falling in Luxembourg, Portugal and United Kingdom. Purity is generally stable, though increased in the United Kingdom in 1999.

Synthetic drugs: amphetamines, ecstasy and LSD (17)

In Finland and Sweden, amphetamines are the second most commonly seized drug. The United Kingdom accounts for most of the amounts of amphetamines, ecstasy and LSD seized in the EU.

There is a significant local production of synthetic drugs in the Netherlands but production in other Member States (Belgium and the United Kingdom) and in eastern European countries (the Czech Republic, Estonia, Poland) is also reported.

Amphetamines are reported to be sold at between EUR 5 and 60 per gram, while ecstasy tablets vary from EUR 5 to 25 each. Synthetic drugs are cheaper in Belgium and the United Kingdom. Amphetamine purity is very variable, from 3 % in Ireland to 55 % in Finland, but typically ranges between 10 and 20 % in the EU. Tablets sold as ecstasy contain — in 15 to 90 % of cases — ecstasy or ecstasy-like substances (MDMA, MDEA, MDA). Amphetamines (or metamphetamines) are found in 6 to 22 % of tablets, but various other psychoactive substances may also be found.

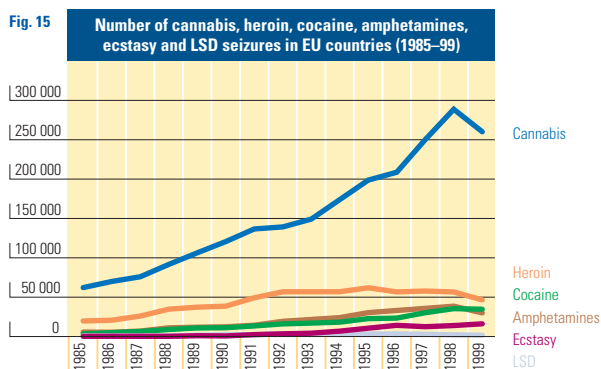
Trends

Amphetamine seizures — both numbers and quantities — have been on the rise since 1985. In 1999, the number of amphetamine seizures continued to increase in Finland and Sweden; while in other countries they were stable or decreasing. Quantities peaked in 1997–98 in most of the Member States.

(16) Figure 12 OL: Number of cocaine seizures in 1999 (online version).

(17) Figure 13 OL: Number of amphetamines seizures in 1999 (online version).

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NB: Data are not available for Greece; for some other countries, data are only available since 1988 (Denmark, Portugal), 1993–96 (Finland) and 1997 (the Netherlands). Numbers of seizures are underestimated in 1999 since data are missing for Italy and the Netherlands. Cannabis, heroin and cocaine data are not available in 1999 for Italy and the Netherlands. Amphetamines data are not available since 1998 for Austria and the Netherlands and in 1999 for Italy. 1998 and 1999 data for Belgium include ecstasy seizures too. Ecstasy — most of the data series start in the mid-1990s (except France, Italy, Spain, UK). Data are not available in 1999 for the Netherlands and Italy. 1998 and 1999 data for Belgium include amphetamines seizures too. Between 1985 and 1994, data for Spain include LSD seizures too. LSD data are not available in 1999 for Finland and the Netherlands.

Sources: Reitox national focal points.

Ecstasy seizures increased up until 1996, then stabilised and increased again in 1999 in all countries except Belgium and Luxembourg. Amounts of ecstasy seized followed the same upward trend since 1985, and then stabilised from 1993 to peak in 1996 and fall in 1997. They have been increasing again since then in all Member States except Austria and Ireland. The highest increases were reported in Finland, Germany, Greece, Portugal, Sweden and the United Kingdom.

LSD seizures are less common. Both numbers and quantities went up until 1993 and fell since then. In 1999, quantities continued to decrease in all countries except Austria, Greece, Portugal and the United Kingdom.

After significant decreases in the 1990s, amphetamine and ecstasy prices have stabilised in the EU. However, decreases were reported in 1999 for ecstasy in Portugal and for amphetamines in Sweden, while in Greece, the price of ecstasy tablets doubled. In recent years, the proportion of tablets containing ecstasy or ecstasy-like substances has increased in many countries while those containing amphetamines (and metamphetamines) decreased.

Cannabis

Cannabis is the most seized drug in every Member State except Portugal where heroin seizures predominate. Since 1996, Spain has been seizing the largest quantities of cannabis. The United Kingdom reports a higher

number of cannabis seizures but on average they involve smaller quantities⁽¹⁸⁾.

Cannabis resin comes mainly from Morocco via Spain and the Netherlands. The cannabis herb originates in Afghanistan, Pakistan, and Lebanon, as well as in former colonies. Local production is reported by most of the Member States, especially *nederwiet*⁽¹⁹⁾ production in the Netherlands.

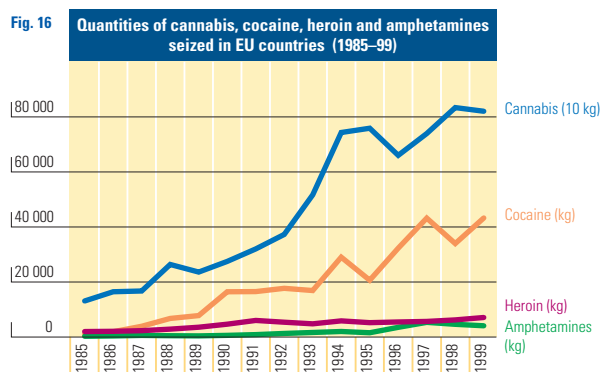
In 1999, the retail price of cannabis was reported to vary between EUR 3 and 18 per gram of cannabis resin and between EUR 3 and 12 per gram of cannabis leaves.

The percentage of the psychoactive substance in cannabis resin — delta-9-tetrahydrocannabinol (THC) — ranges from between 3 and 15 % on average, although samples ranging from 0 to 70 % of THC have been reported in the EU. THC content in cannabis leaves is generally lower, around 2 to 7 %, with the exception of cannabis *nederwiet* which rates higher (8.6 % on average).

Trends

The number of cannabis seizures has risen steadily in the EU since 1985. In 1999, they continued to rise in all countries except Belgium, Denmark and the United Kingdom where they decreased. Quantities increased too but stabilised between 1995 and 1997. Since then, most of the countries reported an upward trend, though substantial decreases took place in Austria, Belgium, Greece and the United Kingdom in 1999.

The price of cannabis is generally stable in the EU, though has been falling in Portugal since 1997.



NB: Some of the quantities seized are underestimated since data are not available. Amphetamines data are not available for Austria since 1998. Since 1996, data for Belgium include both amphetamines and ecstasy powder seized (tablets of amphetamine and ecstasy seized are not included here).

Sources: Reitox national focal points.

⁽¹⁸⁾ Figure 14 OL: Number of cannabis seizures in 1999 (online version).

⁽¹⁹⁾ *Nederwiet*: Dutch cannabis plants locally grown in the Netherlands.

Responses to drug use

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

Political and strategic responses

At European Union level

The EU action plan on drugs (2000–04)

In June 2000, the European Council of Santa Maria da Feira endorsed the EU action plan on drugs as a concrete follow-up to the EU drugs strategy (2000–04). The strategy set 11 general aims and six main targets for the EU and the action plan lists around 100 specific activities to be implemented by the EU by the end of 2004. The six main targets are:

- to reduce significantly over five years the prevalence of drug use, as well as new recruitment to it, particularly among young users under 18 years of age;
- to reduce substantially over five years the incidence of drug-related health damage (HIV, hepatitis, TBC, etc.) and the number of drug-related deaths;
- to increase substantially the number of successfully treated addicts;
- to reduce substantially over five years the availability of illicit drugs;
- to reduce substantially over five years the number of drug-related crimes;
- and to reduce substantially over five years money laundering and the illicit trafficking of precursors.

Although not a legally binding document, the action plan is another step forward in the fight against drugs in the EU as it demonstrates the commitment of

Member States towards implementing the goals set out in the strategy in 1999. The action plan contains guidelines and frameworks for the actions and stresses the importance of its regular evaluation — to be undertaken in 2002 and, on completion, at the end of 2004.

The action plan pays particular attention to coordination and information and it reflects the need for a balanced approach where drug demand reduction and supply reduction mutually reinforce one another. It also stresses the importance of integrating the candidate countries showing the EU's commitment to assisting these countries in dealing with the drugs problem as effectively as possible.

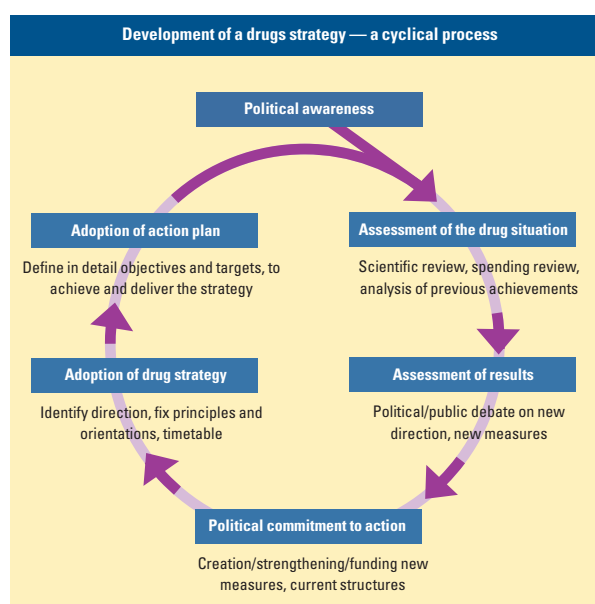
At national level — drug strategies in the European Union Member States

Heightened activity is reported in the Member States in the area of drug policy review and revision. The status, scope and content of these initiatives vary, but illustrate a visible trend towards strengthening and improving drug policy. This appears to be based on the mutual recognition that no single response is effective in tackling the multifaceted drugs problem — and that multifaceted responses are valuable when they form part of a coordinated, long-term strategy.

Scientific assessment and regular evaluation are recognised as essential in the review and revision of drug strategies. An approach used in several Member States is illustrated in Figure 17 which shows how renewed political awareness of the drug problem feeds into a cyclical process of scientific assessment, evaluation, political debate and formulation, adoption and action.

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Fig. 17



Drug coordination arrangements

The EU action plan on drugs (2000–04) encourages Member States to establish and strengthen national coordination mechanisms and/or to appoint a national drugs coordinator with the objective of tackling drugs with a global, multidisciplinary, integrated and balanced strategy. It also calls on the Council to provide regular opportunities for those responsible for drugs at a national level to meet and exchange information on national developments and increase cooperation ⁽²⁰⁾.

Drug coordination bodies or functions exist in all Member States, although major differences exist in their structure and organisation. To provide a clear picture of the drug coordination system in Europe, the EMCDDA undertook a preliminary review in 2000 which will be

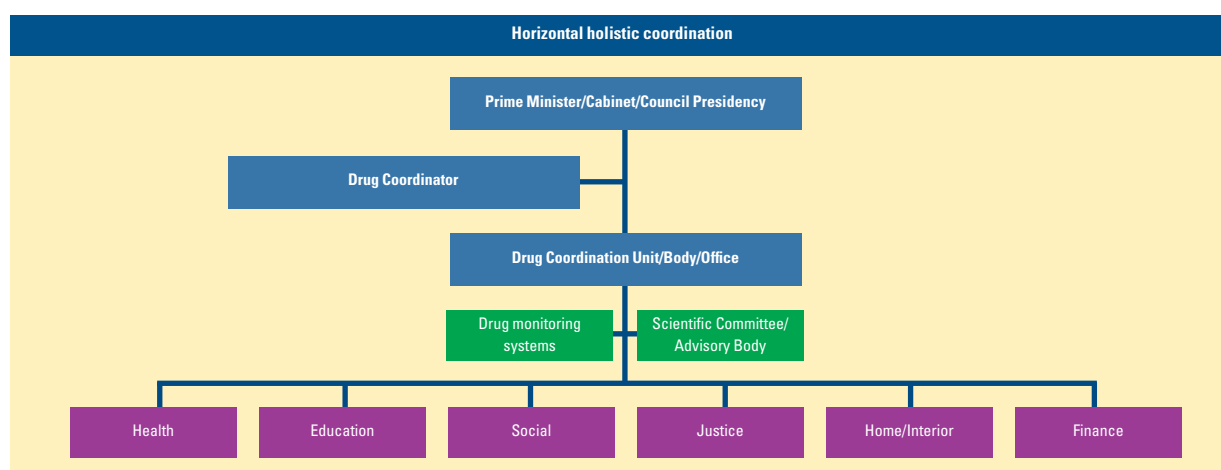
Fig. 18

Overview of recent drug strategy developments	
Adopted	1998–1999
Austria	The Vienna drug policy programme, 1999; Salzburg, action plan
France	French drug strategy, 1999–2001
Northern Ireland	Drug strategy: drug misuse in Northern Ireland: a policy statement, 1999
Norway	Action plan for drug use reduction, 1998–2000
Portugal	Portuguese drug strategy, 2000
Scotland	Drug strategy: tackling drugs in Scotland: action in partnership, 1999
Spain	Spanish drug strategy, 2000–08
United Kingdom	Drug strategy: 'Tackling drugs to build a better Britain', 1998–2008
Adopted	2000–2001
Austria	Action plans: Lower Austria, Styria
Belgium	Political note, 2001
Ireland	Building on experience, Ireland's National Drug Strategy, 2001–08
Luxembourg	Action plan, 2000–04
Portugal	Action plan, 2000–04
Scotland	Scottish executive action plan 'Protecting our future', 2001
Wales	Tackling substance misuse in Wales: a partnership approach, 2001
United Kingdom	National plan 2000/2001
Underway	2000–2001
Finland	Review of the decision-in-principle for 2001–03
Greece	All-parties parliamentary study on drug policy measures, 2000
Sweden	A plan of action regarding drugs is to be released in 2001

finalised in 2002. The results of this research (available at <http://www.emcdda.org>) show a move in some Member States to establish or strengthen coordination bodies at central level. Some Member States (such as France, Portugal and Spain) link all aspects related to drugs and drug addiction in a body with highly hierarchical decision-making powers and at the direct service of the Prime Minister (Figure 19).

In other EU countries (such as Germany, Finland, Greece, Italy and the United Kingdom) coordination takes place at

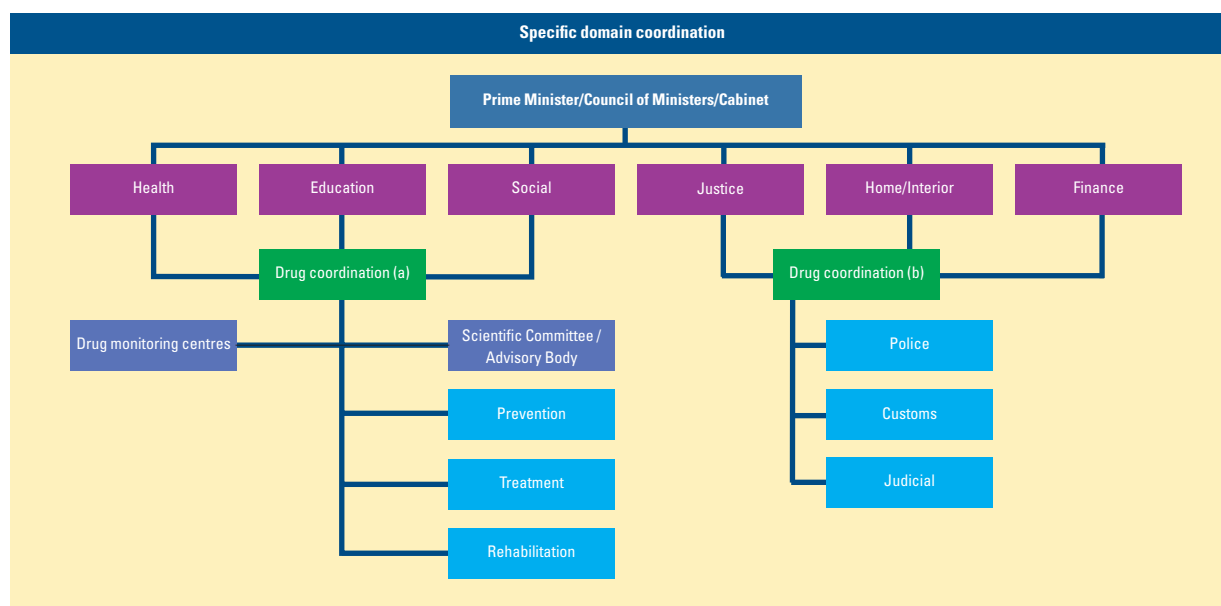
Fig. 19



⁽²⁰⁾ Article 1.1.3 of the EU action plan on drugs 2000–04, Cordroque 32 9283/00.

Responses to drug use

Fig. 20



an inter-ministerial level — without recourse to a central coordination body — through regular contact and meetings between the governmental administrations involved in each of the several facets of the drugs problem. Usually, in this second model, the responsibility for drug coordination lies within the ministry/department of social affairs or health. A drug coordinator might also be present — responsible for matters relating to health and social aspects but also in charge of liaising with the governmental department working in other drugs-related fields (Figure 20).

Legislation and prosecution

The EMCDDA is committed to monitoring main trends and changes in drug laws. To this end, a drugs legal database presenting EU drug laws, legal profiles and comparative studies is accessible online at <http://eldd.emcdda.org>.

Main developments recorded recently include that in Portugal no penal sanctions will be applied to repress the private use of illicit substances after 1 July 2001 (law 30/2000 adopted in November 2000). The drug-use offender will instead be oriented to treatment or counselling by specific commissions. Since May 2001, cannabis use and possession in Luxembourg is punished only with monetary fines (according to the law of 27 April 2001). The Belgian Government intends to issue a decree in order to consider not punishable the ‘non-problematic’ use of cannabis.

Several reports indicate that individual drug use or possession of illegal drugs for personal consumption are not amongst the top priorities of European law-

enforcement authorities: more serious crimes and drug trafficking are the main objects of judicial practice against drug-related offenders. The new measures towards the decriminalisation or non-prosecution of drug-use offences implemented in some Member States seem to confirm this tendency. A recent study on the prosecution of drug-related offences, commissioned by the EMCDDA in 2000, also found that the judicial process involving possession/use of small amounts of drugs in private is usually dropped before court stage. Public possession/use, sale by drug users and acquisitive crimes linked to drug addiction, however, often result in stronger measures by prosecutors and courts.

A drug court programme opened in Dublin in January 2001 with the objective of rehabilitating drug abuse offenders and tackling drug-related crime. This court — similar to the Canadian, Australian and American drug court models — is led by a judge specialised in drug issues who deals exclusively with non-violent drug-abuse offenders offering supervised treatment and rehabilitation instead of prison. The Scottish executive has also chosen to implement a drug court by the end of 2001, while in England a number of similar initiatives are being piloted.

A revision of the federal law in Austria entered into force on 8 April 2001 diminishing from 5 to 3 grams the threshold limit considered as a large ‘quantity’. This will have a repercussion on the distinction between misdemeanours (acquisition and possession of small quantities) and felonies (production and possession of large quantities). Discussions have also taken place on the legal status of medical cannabis.

In Germany, an amendment to the federal German narcotic law defined a basic framework in which each *Land* is able to define the minimum standards required for the establishment of users' rooms (that is, rooms where injecting drug users can use drugs under hygienic conditions). In this way the *Land* can decide whether to allow consumption rooms. The law also establishes a central register for substitution treatment and requires training for physicians offering such treatment. In Portugal, following public debate, a decree law is envisaged to regulate the setting up of users' rooms. In Luxembourg, the law 27 of April 2001 provides the legal basis for the creation of users' rooms.

As far as confiscation of criminal assets deriving from drugs crimes is concerned, a draft bill has been proposed in the United Kingdom to establish a Criminal Assets Recovery Agency and to introduce a civil recovery scheme to deprive criminals of illegal assets. Similarly, the government in Finland submitted a proposal to the parliament to confiscate proceeds of drug-related crime in cases where illegal provenance is suspected, the so-called reversal of burden of proof. In Ireland, since 1996 when the Criminal Assets Bureau (CAB) was established on a statutory footing⁽²¹⁾, the onus has been on the criminal to prove assets were obtained legitimately. In Spain, for five years the national plan on drugs has been administering confiscated illegal profits. In 2000 alone, more than EUR 4.5 million, derived from illegal, seized assets (boats, cars, money) were 'returned' to fight against drugs: EUR 1 543 137 to the repression of drug trafficking and EUR 2 978 014 to drug prevention and rehabilitation programmes.

Drugs expenditure

In the context of monitoring responses in the Member States to the drugs problem, comprehensive research

was carried out in 2000 to collect, analyse and estimate the level of public expenditure on drugs. A government's expenditure, both in the area of health care and law enforcement, was calculated through measuring direct costs (expenditure directly labelled as drug related) and indirect costs (expenditure incurred as a consequence of the drugs problem in generic administrations, such as prisons).

Despite a number of differences, a similar policy of allocation of resources in the drugs field can be seen across the EU Member States. Globally, between 70 and 75 % of the budget is spent on law enforcement and the rest on health care.

Specific responses

Demand reduction

A range of interventions with different objectives and operating in different settings are covered in this section. An overview of the various settings and approaches in demand reduction are provided in Figure 21.

Prevention measures

Prevention in schools

Drug prevention in schools remains a priority in all Member States. Many teaching guidelines exist on prevention and it may be necessary to carry out a market overview in order to select the most appropriate material (as has been done in Germany). In most curricula, drug prevention is included in a context of general health promotion. Peer-to-peer approaches (that is students educating one another) are considered advantageous, although they are difficult to establish and sustain. Parents' involvement is considered crucial.

Fig. 21

Setting	Classification of concepts in demand reduction		
	Prevention	Treatment	Harm reduction
Coercive (‘You have to stay with us’)		Treatment in prisons ⁽¹⁾ Alternatives to prisons Coercive care	Harm reduction in prisons ⁽¹⁾
Fixed settings (‘You are here with us’)	Schools ⁽¹⁾	Inpatient treatment	
Fixed premises (‘Come to us’)	Youth centres	Outpatient treatment GP treatment	Low threshold services ⁽¹⁾
Mobile (‘We look for you’)	Outreach and Community work ⁽¹⁾		Outreach work ⁽¹⁾
Media (‘You stay anonymous’)	Internet, mass media ⁽¹⁾ Early health responses ⁽¹⁾		Telephone help lines Early health responses ⁽¹⁾

⁽¹⁾ Indicates that the concepts are covered in this report.

⁽²¹⁾ Criminal Assets Bureau Act, 1996; Proceeds of Crime Act, 1999.

Mobilising pupils in prevention activities

At the request of the Ministry of Education in France, an evaluation was carried out of the schools that took part in a pilot programme 'Les élèves acteurs de prevention'. The pupils received guidance in organising campaigns and transmitting knowledge on the issues concerned to their fellow students. Their involvement in managing the programme earned them the recognition of their peers. The experiment proved a success for half of the schools involved but even where it was not, it attracted a great deal of interest from pupils in all schools. Its impact on the atmosphere and quality of life in schools was very positive, both in terms of the pupils' perception and the schools' external reputation.

Increasingly, the police take an interest in primary drug prevention in schools (in Belgium, France, the Netherlands, Austria and Sweden) although there has been some debate as to whether they are equipped with the necessary educational skills for this type of work.

Students do take drugs (see Chapter 1, Drug use in the school population) and are in the risk zone. This was formerly largely denied since schools feared damage to their image. Increasingly — in Spain, France, Luxembourg, the Netherlands, Austria and the United Kingdom — strategies are set up to develop school policies on the prevention of risk behaviour, early intervention and the facilitation of referral to addiction care. Of particular concern are young people who drop out of school or who are expelled. Spain reports standardised interventions for this group and in the United Kingdom 95 % of secondary schools have policies covering drug-related incidents.

Prevention in local settings and communities

Prevention activities in local communities have expanded in the past years and take varying shapes and forms. All Member States report different types of parents' training in the community. For example, in Spain, 25 000 families participated in *escuelas de padres* in 1999, and, in France, there are 75 special counselling centres for young people to provide help for emotional, family or social problems. In the Nordic countries, groups of parents walk the streets of their community in order to provide support to young people on weekend nights. In Denmark, 1 300 parents are involved in this activity.

Sports and athletic associations are given a more prominent role in drug prevention than reported in previous

years in many countries including Belgium, Germany, Greece, Spain, France, Italy and the United Kingdom. In Germany, cooperation between sports clubs and drug prevention has existed since 1994 and, in 2000, another 2 500 youth sports leaders were trained. A conference on addiction prevention in sports clubs focusing on the quality of drug prevention in sports clubs and on drug use and sports clubs' rituals and culture was organised in Potsdam, Germany, in March 2000.

Coordination between actors is crucial for success. In Denmark, Greece, Finland, France, Ireland, Italy, Portugal, Sweden and the United Kingdom agreements within local or regional authorities on drug prevention strategies are in place or under development countrywide.

Treatment

Drug-free treatment

Currently little is known about the availability of drug-free treatment across the EU. However, drug-free treatment seems to be dominating the treatment offered in Finland, Greece, Norway and Sweden. The tendency in those countries is to have shorter treatment periods of three to six months instead of one to two years, although in Greece the mean duration of treatment is 12 months. A recent meta-analysis carried out in Germany and covering several European countries concludes that there is a positive relationship between the length of treatment and treatment success. However, evaluation of different treatment options is still to be improved.

Case management (low-threshold, intensive, personalised assistance) is increasingly set up to guide a drug user through the treatment networks, for example in Belgium, Germany and the Netherlands. The results of five Dutch studies on dual diagnosis (the coincidence of drug and psychiatric problems) show that case management has slightly positive effects on patients' satisfaction, drug use, psychiatric symptoms, social skills and utilisation of care services.

Evaluating types of treatment

In Norway, a project is evaluating types of treatment for drug users to find out if some treatments obtain better results than others and to find out which clients benefit from which type of treatment. As drug users often use several different treatments, the point of departure is that each treatment builds on the achievements of any previous treatment — the hypothesis being that resources invested are not lost.

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The Netherlands provides a somewhat negative picture of a difficult target group who fail to change their drug using behaviour even after several attempts. The purpose of inpatient motivation centres is to offer the opportunity to drug users to recuperate, to help them develop their social skills and to structure daily life in order to increase their motivation to enter into regular care. However, the drop-out rate at these centres is 60 % and it is concluded that drug users who are not motivated cannot be helped successfully.

Substitution treatment

Substitution treatment has been expanding moderately in the EU over the last years. Greece, Finland, Norway and Sweden have recently facilitated access to substitution treatment, mainly methadone. Buprenorphine, which is the main substitution substance in France, has been introduced in Belgium, Denmark, Finland (for detoxification), Germany, Italy, Luxembourg, Norway, Portugal, Austria and the United Kingdom, whereas LAAM is prescribed in Denmark, Spain, and Portugal. Studies are in progress in the Netherlands concerning rapid detoxification with naltrexone as a medical treatment, and this may be considered as an alternative to other treatments. Naltrexone has been used in Portugal for the last 10 years.

Heroin continues to be prescribed on a selective basis in the United Kingdom. Experimental heroin prescrip-

tion for treatment of refractory chronic drug users is available in the Netherlands within the context of scientific experiment and a heroin prescription trial will be initiated in Germany in 2001. Luxembourg is also considering a heroin trial in 2002. Experts agree that heroin prescription should only be considered when all other treatment options available are exhausted. Heroin prescription puts a heavy burden on clients and the need to present themselves at the treatment centre two or three times a day is disruptive to them. However, there is evidence of its effectiveness for very deprived drug users in terms of crime reduction, health improvement and social integration.

Harm-reduction measures

Outreach work

Mapping outreach work (that is contacting drug users in their own setting) in the EU is not an easy endeavour since many activities are carried out locally by non-governmental organisations and by structures that tend to be quite complex.

The origins of outreach work lie in traditional youth work (with the aim of guiding drug users into treatment) and in public health concerns (especially the prevention of infectious diseases). Outreach work may include social work among addicts, needle exchange, low-threshold services and/or special services for ethnic minorities, prostitutes and other hard-to-reach groups and is avail-

Table 1

	Substitution treatment among problem drug users		
	Estimated prevalence of problem drug use ⁽¹⁾	Estimated number of clients in substitution treatment	Substitution coverage rate (%) ⁽²⁾
Belgium	20 200	7 000 (1996)	35 ⁽³⁾
Denmark	12 752–15 248	4 398 (4 298 methadone and 100 buprenorphine)(1 January 1999) ⁽⁴⁾	27–34
Germany	80 000–152 000	50 000 (2001) ⁽⁴⁾	33–63
Greece	n.a.	966 (1 January 2000) ⁽⁴⁾	
Spain	83 972–177 756	72 236 receiving methadone (1999)	41–86
France	142 000–176 000	71 260 (62 900 receiving buprenorphine and 8 360 receiving methadone) (December 1999) ⁽⁴⁾	40–50
Ireland	4 694–14 804	5 032 (31 December 2000) ⁽⁴⁾	34–100 ⁽⁵⁾
Italy	277 000–303 000	80 459 (1999) ⁽⁴⁾	27–29
Luxembourg	1 900–2 220	864 (164 in the official programme and +/- 700 prescribed mephenon [methadone in pill form] by GPs; 2000) ⁽⁴⁾	38–45
Netherlands	25 000–29 000	11 676 (1997)	40–47
Norway	9 000–13 000	1 100 (2001)	8–12
Austria	15 984–18 731	4 232 (1 January 2000) ⁽⁴⁾	23–26
Portugal	18 450–86 800	6 040 (1 January 2000)	7–33
Finland	1 800–2 700 ⁽⁶⁾	240 (170 buprenorphine and 70 methadone)	9–13
Sweden	1 700–3 350 ⁽⁶⁾	621 (31 May 2000) ⁽⁴⁾	19–37
United Kingdom	88 900–341 423	19 630	6–22

NB: n.a. = data not available.

⁽¹⁾ For more details on national prevalence and problem drug use see section on problem drug use in Chapter 1 and online table 1 OL at www.emcdda.org.

⁽²⁾ Estimated proportion of problem drug users in substitution treatment.

⁽³⁾ Prevalence figure only covers injecting drug users which may result in an overestimated substitution coverage rate.

⁽⁴⁾ Information collected directly from national focal point.

⁽⁵⁾ A substitution coverage rate of 100 % seems implausible, which suggests that the prevalence estimate of 4 694 (1 195) may underestimate current prevalence.

⁽⁶⁾ Opiate users only.

Responses to drug use

Outreach project for homeless women

In Sweden, the Stockholm Social Services started an outreach project in 2000 targeting homeless women, many of whom have little or no contact with social services. One of the aims is to motivate the women to increase their contacts by providing them initially with simple medical help. The project is exemplary in that it is a joint venture between the social services, voluntary organisations and the medical treatment sector.

able to problem drug users who are not in regular treatment services in all Member States. Peer support among drug users has been organised in Denmark, France, the Netherlands, Austria, and the United Kingdom in order to respond to the needs of drug users.

Outreach work is expanding in most Member States. However, in Sweden, outreach work was more common some 10 to 15 years ago and a new study reports that, owing to a reduction in resources, many drug users are not approached by any such services. New developments include outreach work for North-African drug users in the Netherlands, and the introduction of special services for women drug users in Denmark, Norway, Austria and Sweden.

One specific outreach activity, which has been adopted in France, the Netherlands, Austria and Spain is on-site pill testing at dance events. Pill testing attracts visitors because the content of pills is always of major concern to them. Most projects also offer information talks, harm reduction messages and crisis intervention. A recent EMCDDA study ('An inventory of on-site pill testing interventions in the EU', EMCDDA 2001) suggests that pill testing can efficiently warn against the unexpected and dangerous effects of dance drugs.

Low-threshold services

Low-threshold services are expanding in most Member States. Users' rooms — that is rooms where injecting drug users can use drugs under hygienic and safe conditions — were legalised in Germany in February 2000, and one users' room was introduced as a pilot project in Madrid, Spain in 2000. In the Netherlands, they have existed for several years where they also serve heroin smokers and cocaine and crack users. Similar initiatives are being discussed in Austria, Luxembourg and Portugal. In relation to a discussion in Denmark concerning the introduction of injection rooms in association with existing low-threshold services, the Danish Ministry of Health has chosen to

shelve this initiative as a result of international conventions dealing with this matter.

Early health responses to new synthetic drugs

These measures aim to avert potential health problems relating to the consumption of substances, unidentifiable to the users, who themselves are not seeking contact with treatment and counselling services i.e. unknown substances consumed by unknown users. These responses are implemented either through structural measures such as the organisation of safe raves (staff training, provision of water and chill-out facilities) or information measures on party drugs through media campaigns, interactive web sites and CD-ROMS, or by specifically providing information on the results of on-site or off-site pill testing through the Internet or special journals. Thus, these interventions are sometimes linked to outreach work measures such as on-site pill testing.

In Denmark, Spain, Ireland, Italy and the Netherlands local authorities approach young people's leisure venues (such as clubs, bars and discos) to provide the staff with training and support to enable them to respond more effectively to drug-related situations.

The concept of 'real time' monitoring of youth scenes is reported by Luxembourg. Following an initial evaluation phase, the game kit 'Ecstasy' has been applied to different youth settings and integrated in appropriate school courses. It boosts discussion, sharing experiences and finding alternatives to drug use, especially as regards synthetic drugs. The group dynamics stimulated by the

Training for nightclub staff

In Ireland, training and support is given to nightclub staff in order to enable them to respond more effectively to drug-related situations in nightclubs. The first two phases of the project involve the organisation of training programmes for club owners/managers and door supervisors. They focus on increasing their knowledge about drugs, exploring their attitudes towards drugs and examining legal, health and safety issues. The third phase is designed to disseminate accurate information on drugs to young club goers through distributing a credit card-sized booklet known as the vital information pack (VIP) in a number of venues including third level colleges and clubs. In phase four, a one-day conference will be organised to gain support from the music/dance industry for the development of acceptable policies in dance venues. The final phase involves standardising training for door supervisors and providing these elements in a modular form.

Drug treatment and testing order schemes in the United Kingdom

The UK Government has introduced drug treatment and testing order (DTTO) schemes whereby courts can make an order requiring offenders to undergo treatment either as an alternative to prison or as a sentence in its own right. The roll out of DTTO is estimated to result in some 3 425 orders being made by 2001. This is to be compared to some 120 000 persons convicted of drug offences in 1999. Drug prevention advisory services, in conjunction with probation services, will provide on-the-ground support for the national roll out of DTTO, disseminating practice findings from the pilot programmes and assisting local drug action teams in developing appropriate commissioning arrangements.

game enable issues to be addressed to which young people should be sensitised. The evaluation suggests increasing the creative and action-oriented elements of the game.

The Internet provides an enormous variety of drug information reflecting all positions on drug policy, although quality control of such information is not possible. Most national prevention organisations as well as NGOs have or plan their own homepage, mainly with information but also with interactive features, for example the Italian *Io non calo la mia vita* (<http://www.iononcalo.it>), the Swedish Drugsmart (<http://www.drugsmart.com>) and the

drug search facility (<http://www.drugscope.org>) provided by DrugScope in the United Kingdom. An innovative initiative is reported from Finland where an anonymous consultancy and self-assessment test is available on the Internet (<http://www.a-klinikka.fi/plimenu1.htm>). The EMCDDA database EDDRA (<http://www.emcdda.org>) gives references to over 250 evaluated projects in the field of demand reduction and is continuously growing.

Reduction of drug-related crime

Prevention of drug-related crime

All Member States have programmes for diversion to treatment under specific conditions, for example the gravity of the offence or the age of the offender. This is considered to decrease the rate of subsequent crime, although evaluation information is rarely available.

Drug users continue to pose a major problem in the criminal justice system with up to 50 % of prisoners with drug-related problems. Given the high turnover rate in prisons, it is estimated that 180 000 to 600 000 drug users pass through the system annually in the EU. The prevalence of drug use varies depending on the type of prison. It is more significant in large and in short-stay prisons, more prevalent in women's than in men's prisons.

Table 2 provides a rough overview of assistance to drug users in prisons in the EU — the EMCDDA report 'Assistance to drug users in prisons' provides full details.

Table 2

	Assistance to drug users in prison in the EU		
	Drug-free treatment in prisons	Substitution treatment in prisons	Reduction of drug-related harm in prisons
Belgium	Yes, in experimental phase	Gradual detoxification with methadone	Some local HIV prevention actions
Denmark	Cooperation with private treatment institution	Yes, if on methadone treatment before prison	Cleaning fluid provided, hepatitis B vaccination
Germany	Yes	Yes	Syringes exchanged in some prisons
Greece	Self-help groups	No	Information in some prisons
Spain	Yes	Yes	Yes
Finland	Substance abuse courses, drug-free wards	Yes, if on buprenorphine/methadone before prison	Cleaning fluid provided, hepatitis B vaccination
France	No	Yes (methadone or buprenorphine)	Information to prisoners, chlorine distribution
Ireland	Limited	Detoxification with methadone, maintenance for HIV positive prisoners	No
Italy	Yes	Yes	No
Luxembourg	Yes	Yes, if on methadone treatment before prison and treatment initiation before release	No
Netherlands	Yes, compulsory treatment for hard core drug users	Limited, reduction programmes for longer-term prisoners	Yes
Austria	Yes	Yes	Yes
Portugal	Yes	Yes	Information, training of guards, condoms and bleach distribution, hepatitis vaccination
Sweden	Yes	No	No
United Kingdom	Yes	Methadone detoxification. Also available: sofaxidine, dihydrocodeine and naltrexone	Disinfecting tablets in some prisons, counselling and information

'Back to the future' in Finland

In Finland, the programme 'Back to the future' (funded by the Integra programme of the EU) has been involved in projects with young drug addicts. The project results reinforce the notion that people facing unemployment and income problems after recovering from drug abuse problems are in an extremely difficult situation. The problems they encounter include inadequate housing, reduced working capacity, lack of vocational training and problems associated with work and maintaining a drug-free lifestyle. Education was available to the project participants but they found it hard to approach educational systems and work options and it was not easy for them to find employers willing to enter into apprenticeship contracts. Although the State automatically guarantees the study loan, the banks refused to provide personal loans because almost 90 % of the clients were not credit worthy. The project found that the actions available to social and health services are inadequate to resolve multiple welfare problems. Active measures are required of the rehabilitation system which involve an individual and tailor-made approach transcending administrative boundaries and adequate financing.

Social rehabilitation and reintegration

Education, training, housing and employment are key areas in the rehabilitation of drug users after treatment, after imprisonment or in long-term substitution maintenance programmes. However, it appears that this area of assistance is still rather undeveloped even though professionals often emphasise that aftercare and reintegration is a very important aspect of drug treatment and that improvements in this field would be needed.

Evaluation

Evaluation is the key to ensuring the quality of drug-related responses, as is adequate planning, infrastructure, professionalism, supervision, training, research and networking. Quality assurance procedures are increasingly being introduced in the demand reduction area in the EU. Quality assurance initiatives concerning prevention are reported from Germany, Greece, Finland, France, Italy, the Netherlands and Austria, and quality assurance of care from Germany, Greece, Luxembourg, the Netherlands, Norway, Austria, Portugal and the United Kingdom.

Training is established for general practitioners and other health care professionals in Belgium, Germany, Finland, Ireland, Italy, Austria and the United Kingdom, whereas other countries — Greece, France, Italy, Luxembourg,

the Netherlands and Sweden — state that even if some training is available for prevention, health and criminal justice professionals, there is still a need for courses of high quality.

Supply reduction

The following information has been extracted from Europol reports.

New techniques of prompt intervention and disruption at various levels of a criminal investigation avoid long, drawn out and resource-intensive inquiries. New EU judicial and law-enforcement cooperation structures should be fully exploited by Member States, so as to increase the sharing of information, both within Member States and at international level.

The level of organised crime in the EU is increasing. Production and trafficking of drugs appear to remain the prime activities of criminal networks. The continuing diversification and evolution of drug routes challenge law-enforcement efforts. Criminals continue to examine the successes and failures in the trafficking of their illegal commodities and change their operations accordingly, by altering routes, devising new methods of concealment or recruiting new couriers.

According to Europol (EU situation report on drug production and drug trafficking 1999/2000) an encouraging project against the diversion of chemical precursors was 'Operation purple', aimed at preventing the diversion of potassium permanganate — a chemical used in the production of cocaine — and bringing together 23 nations, including seven Member States, that produce, import, export, or transit the chemical, as well as the International Narcotics Control Board, ICPO/Interpol and the World Customs Organisation. The project aims at

Quality assurance in demand reduction

In Austria, quality assurance procedures are becoming increasingly important in the field of drug demand reduction. Guidelines for quality work and minimum standards for all fields of addiction activities as well as for the case management of substitution clients have been drawn up. Minimum standards, as quality prerequisites for drug and alcohol counselling, have been defined and will be implemented in a stage-by-stage plan. In Vienna, special competence centres were established, which are responsible for networking and ensuring the transfer of information to fields of activity that do not explicitly deal with drug issues (such as youth work and health care).

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preventing chemical diversion, taking into account that the availability of precursors plays a key role in the production of drugs. Since the start of its operation, 248 shipments of the chemical have been tracked, involving 7 778 tonnes. As a direct result, 32 shipments of potassium permanganate have been stopped or seized, totalling almost 2 226 tonnes. This is supposed to represent 29 % of all shipments monitored. A similar operation will be conducted on acetic anhydride, a chemical used in the processing of heroin.

Further to the political developments aimed at increasing judicial and law-enforcement cooperation, Europol's competence will be broadened to money laundering in general, regardless of the type of offence from which the laundered proceeds originate.

Currently, Europol and experts from Member States and the EMCDDA are developing a harmonised database on drug seizures, with common definitions and parameters, to be introduced in all Member States. This should lead to a standardised collection of data EU-wide, which will allow for a better comparison and analysis of the drug situation in the various Member States.

Selected issues

This chapter highlights three specific issues relating to the drug problem in Europe: cocaine and 'base/crack' cocaine, infectious diseases and synthetic drugs.

Cocaine and 'base/crack' cocaine

Concern has been growing in the EU about increasing use of cocaine; however, actual trends in cocaine use and their consequences across the EU are difficult to verify. Firstly, national data, for example, from surveys or treatment centres do not reflect changes in prevalence and problems that occur in geographic patches within specific cities or changes which are concentrated in particular social milieus. Secondly, current information about cocaine often lacks clear, scientific definitions — for example, information systems rarely distinguish cocaine 'base/crack' from cocaine hydrochloride or between the different 'base/crack' preparations. These different forms of cocaine have different market features, different patterns of use, and contribute to different problems, all of which need to be understood for effective policy-making and demand reduction responses.

Prevalence, patterns, and problems

Prevalence

Neither general population surveys nor school surveys reveal a general increase in levels of cocaine use in the EU. Only in the United Kingdom has there been a confirmed increase in lifetime prevalence of cocaine use among young adults aged 16 to 29. The Italian national focal point reports that a range of sources in Italy has shown that cocaine use is in second place to cannabis and higher than amphetamine or ecstasy use.

A 1999 European schools survey shows that experimental use of cocaine (lifetime prevalence) amongst students aged 15 to 16 remains low and is much lower than for cannabis. In all the Member States included in the survey, cocaine was reported to be less available than ecstasy although there was considerable variation between

countries. Cocaine is reported to be easily available by the greatest percentages of 15 to 16-year-olds in Ireland and the United Kingdom (21 % and 20 % respectively) and by the lowest percentage in Finland (6 %). However, in all the EU countries surveyed, availability of cocaine was considerably less than to the same age group in the United States (2). Disapproval of cocaine use is very high and more or less equal in strength throughout all the

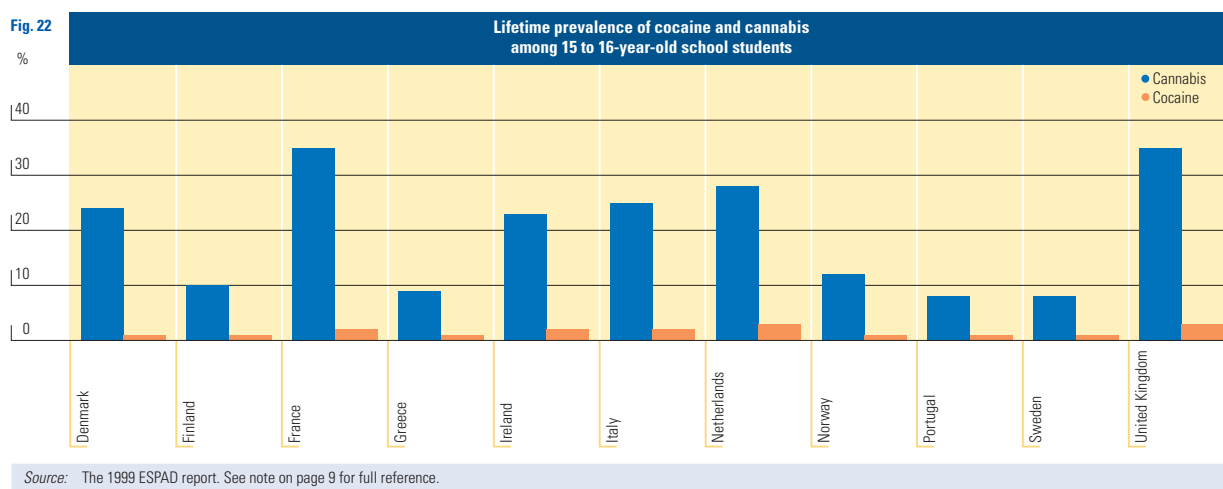
What are cocaine and crack?

Cocaine is a stimulant drug extracted from leaves of the *Erythroxylon coca* bush and was developed to treat a wide variety of illnesses in the mid-19th century. The chemical name of the processed drug is cocaine hydrochloride and it is generally sold 'on the street' as a crystalline powder, known by a range of street names, such as 'coke', 'snow' and 'Charlie'. It is generally taken intranasally and less frequently dissolved in water and injected.

Cocaine 'base/crack' is a street term for cocaine that has been treated for use by smoking or inhaling vapours to provide immediate and intense effects. There are at least three methods of 'base/crack' manufacture (1). One method results in a clean product — by adding hot water and ammonia or sodium bicarbonate and discarding the excess liquid layer containing diluents. Another method results in lower cocaine concentration — by heating a paste of cocaine and sodium bicarbonate in a microwave with all diluents remaining in the final product.

Cocaine and 'base/crack' are usually distinguished on the basis of physical appearance and purity and further complicated because some cocaine 'base/crack' is physically similar to cocaine hydrochloride.

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participating countries and equals the levels of disapproval applied to heroin.

Patterns

Although nothing dramatic is occurring in the general population at national level, there are more marked levels of cocaine use in certain social settings. Past research on cocaine users showed that firm boundaries distinguish recreational users of cocaine powder (hydrochloride) from problem 'base/crack' users, and cocaine injectors. A wide range of recreational cocaine powder consumption patterns is found among groups of people who frequent nightclubs and dance settings and who use powder cocaine for social and utilitarian purposes. These recreational users are distinct from the marginalised groups, such as homeless young people, sex workers and problem heroin users who smoke 'base/crack', or inject cocaine mixed with heroin, in

geographic patches within specific cities. However, the boundary between powder cocaine and 'base/crack' may be weakened by an emerging trend in cocaine smoking in recreational and nightlife settings and in recent changes in the market. Firstly, a new trend of mixing cocaine 'base/crack' with tobacco in a 'joint' for smoking has been reported in five Member States — the Netherlands, France, Greece, the United Kingdom and Italy. Secondly, forensic science services have reported that some cocaine 'base/crack' is physically similar to cocaine powder (hydrochloride), which makes it difficult for police and inexperienced users to make any distinction (8). And thirdly, in the United Kingdom, there are indications that cocaine 'base/crack' for smoking is being reconstructed and commodified with new names such as 'rock' and 'stone' and these serve to distinguish ready-to-smoke cocaine from 'base/crack' and push its image up-market and closer to powder cocaine (4).

Table 3

	Lifetime prevalence of cocaine in targeted users surveys compared with population surveys					
	Clubbers			Young adults from general population		
	LTP (%)	Sample size	(Year) and source	LTP (%)	Sample size	Year and age range
Austria	42	50	(1999) Austrian ravers	–	–	–
Belgium	45	154	(1998) Rock Festival, French Community	–	–	–
Denmark	–	–	–	3.1	14 228	2000 16–34
Finland	–	–	–	1.2	2 568	1998 15–34
France	56	896	(1999) Techno rave parties, Médecins du monde	1.9	2 003	1999 15–34
Germany Former West	–	–	–	2.2	6 380	1997 18–39
Former East	–	–	–	0.4	1 620	1997 18–39
Netherlands	48	456	(1998) Amsterdam clubbers, Questionnaire (23% response)	3.7	22 000	1997/98 15–34
Spain	–	–	–	4.8	12 488	1999 15–34
United Kingdom	62	517	(1997) Release drugs and dance (1)	6.4	10 293	1998 16–34
	18					
	'crack'					
	50	100	(1999) Clubbers in Liverpool (2)			
Northern Ireland	45	106	(2000) Ecstasy users in Northern Ireland			

(1) Release (1997), Release dance and drugs survey: an insight into the culture, London.

(2) S. Henderson (2000), 'Protecting and promoting the health of club-goers in Liverpool: An information campaign evaluation and market research project', 1999–2000.

Sources: National focal points and references as indicated below.

Selected issues

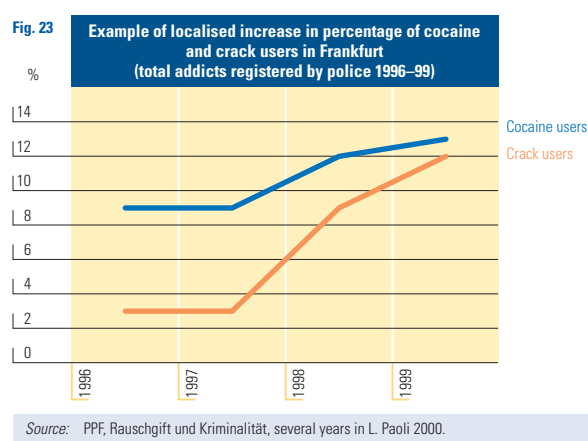
Prevalence of cocaine use is much higher among subpopulations with high prevalence of other drug taking than it is among the general population of young adults. Table 3 (Lifetime prevalence of cocaine in targeted user settings) illustrates a substantial difference between the relatively high lifetime prevalence of cocaine taking amongst young ‘dance goers/clubbers’ and the much lower rates amongst the more general population of young adults. The relatively high costs of cocaine, combined with the short duration of its effects, mitigate against regular recreational use and a high level of disposable income may be a significant factor in regular use. In recreational nightlife settings, there is a tendency for some people to drink significantly more alcohol than usual with cocaine. Cocaine serves to increase sociability by moderating the undesirable effects of alcohol.

Problems

Between 1994 and 1999 the number of clients seeking treatment for problems associated with cocaine as their main drug — as a proportion of the total clients seeking treatment — increased substantially in Spain and the Netherlands. Germany, Greece and Italy also show a proportional increase in cocaine treatment and Ireland showed an increase until 1998 (22). The United Kingdom and the French and Flemish-speaking parts of Belgium also reported an increase. There is a lack of comparable research on cocaine users in treatment in the EU and the proportional increases in clients seeking help for cocaine problems may indicate a real increase in cocaine problems but may also be the result of a reduction in the number of clients seeking help for opiate problems or a result of former opiate clients switching their main drug problem to cocaine. The development of services that are increasingly attractive to cocaine users may also influence treatment figures. Some drug treatment services have reported that, among clients in treatment for heroin dependence, there has been an increase in cocaine use, particularly smoked as ‘base/crack’ or taken intravenously with heroin.

Figure 23 provides an example of the localised increase in ‘base/crack’ users which are not reflected at national level. In Frankfurt, the percentage of ‘crack’ users amongst the total addicts registered by police increased fourfold between 1996 and 1999.

Health service providers and cocaine users rarely report fatalities, or negative physical health, as a direct consequence of sniffing powder cocaine and because recreational users tend to use cocaine alongside large amounts of alcohol, or other drugs, it is difficult to



identify the causes of negative experiences. However, Luxembourg, the Netherlands, and Italy report an increase in the number of drug fatalities and Spain reports an increase of hospital emergencies in which cocaine was implicated in addition to other drugs. Raised awareness among hospital emergency staff of the potential role of cocaine in cardiovascular disturbances could lead to higher rates of reporting (4).

Severe health, social and psychological problems associated with smoking cocaine ‘base/crack’ have been identified, particularly among marginalised groups, such as problem opiate users, homeless and other disadvantaged youth, and female sex workers. The extent to which problems are direct consequences of the use of this form of cocaine per se, or the frequency and amount of its use, or of pre-existing social/psychological and drug problems, is not clear.

Market

In 1999, the number of cocaine seizures increased markedly in Luxembourg and Sweden whilst they decreased in Austria, Belgium and Denmark. Retail level prices of cocaine reported range from EUR 24 per gram to EUR 170 with cities such as Amsterdam and Frankfurt at the lower end and Member States such as Sweden and Finland at the higher. In the United Kingdom and France, retail prices have decreased but purity remained generally high between 55 and 70 % until late 1999 when, in the United Kingdom, there was a sharp decline in the mean purities of crack (10). Geographical variations in price within Member States are marked. Small quantities of cocaine, in parts of a gram or in the form of ‘balls’ or ‘rocks’, are available for less than EUR 15 in some cities, particularly in those with open drug scenes and where the cocaine concentrations may drop substantially (for example, Frankfurt, Milan, Paris, London, Manchester and Liverpool). Cocaine distribution takes place primarily

(22) Figure 15 OL: Cocaine: trends for new clients admitted to treatment (online version).

through chains of friends of friends but in some cities open dealing takes place within recreational nightlife and street settings. House dealing and delivery services have been greatly facilitated by the increased convenience and protection (in the form of anonymity) afforded to dealers by mobile telephones (4, 5, 6, 7).

Increased availability of ready-to-smoke ('base/crack') cocaine in a number of European cities (Amsterdam, Rotterdam, London, Liverpool, Manchester, Frankfurt, Milan and Paris) has been reported but methods for preparing it (and the subsequent cocaine concentration levels, which can rise to 100 %) vary and create confusion for drug information systems, and the lack of scientific definition for street terms such as 'crack' and 'base' pose problems for education and prevention responses. At street level, cocaine may be sold already mixed with heroin.

Spain, Belgium and the Netherlands are reported to be major transit points for cocaine from Latin America (Colombia, Brazil and Venezuela in particular) to the rest of the EU. In 1999, six cocaine processing laboratories were reported as having been dismantled in Spain and subsequent increases in the wholesale price of cocaine in Spain have been attributed to this.

Intervention projects and new approaches

The EU response to the increase in cocaine and crack use has taken three main forms in the field of demand reduction. During the 1990s, a small number of cities developed specialised services to address the need of primary cocaine problems and to target especially vulnerable groups, such as Jugendberatung und Jugendhilfe e.V. in Frankfurt and 'Take five' in Rotterdam. Some Member States report efforts to adapt existing structures to meet the needs of problem cocaine and crack users. For example, in France and the United Kingdom multidisciplinary strategies are being developed among involved professionals to collect and exchange information about the needs of cocaine and crack users in order to develop appropriate training and adapt existing models and treatment services to provide the type of services which will be more effective in meeting the needs of cocaine and 'crack' users. Thirdly, some Member States have placed emphasis on the need to address the criminality and health consequences of multiple drug use in general.

Data on responses to cocaine problems from the private sector are difficult to obtain but, nevertheless, this sector is likely to play a significant role in the treatment of more socially privileged cocaine problem users.

Examples of treatment for cocaine problems

Few treatment responses have been described in the reports from the Member States. However, Germany and the Netherlands highlighted interventions specifically designed for cocaine problems.

In Frankfurt, the youth organisation, Jugendberatung und Jugendhilfe e.V. offers a treatment process targeted at cocaine addiction, which is tailored to the needs of each individual client. The initial 'crash phase', lasting a few days, takes place either in an outpatient setting with psychosocial support or as a detoxification process in a hospital. The next phase involves six weeks of inpatient treatment where the client follows a daily schedule, including group and individual treatment sessions. The recovery phase, either in an outpatient or inpatient setting, aims at re-establishing or improving contacts and relations with family, relatives or partners.

In Rotterdam, 'Take five', a treatment programme for heavy 'base/crack' users has been running since 1996. The programme, administered by municipal health services, operates like a low-threshold service. In the first phase, street workers contact 'base/crack' users at different locations such as drug dealing spots, user rooms or crisis centres. In the second phase, the patient frequents a so-called 'time out location' which offers support 24 hours a day with a general practitioner and psychiatrists available on request. The aim of the third phase is to stabilise the health of the client and start rehabilitation. The Rotterdam experiment reports that acupuncture is very popular among their clients for relaxation.

Policy issues

In the EU there is a market of recreational drug consumers with disposable incomes who are either wary of the unreliable content of 'ecstasy' tablets and the possibility of associated acute and long-term health risks, or are jaded with their past experiences of MDMA and its unpleasant early to mid-week after effects. Research shows that, from the perspective of recreational cocaine users, cocaine is considered more predictable, versatile and unobtrusive than ecstasy and the after effects of cocaine are considered less severe or unpleasant and shorter-lived than the after effects of ecstasy or amphetamines (3).

Research on cocaine users has identified clear social distinctions and sharply separate subcultures between users of cocaine powder (hydrochloride) and smokers of 'base/crack' — but the boundaries may be called into question by the recent changes in the market and an emerging trend of smoking cocaine 'base/crack' mixed

with tobacco in ‘joints’ in recreational and nightlife settings. The result of such changes may weaken the taboos against ‘base/crack’ smoking, which have existed and which have been providing informal controls to prevent diffusion of crack into mainstream recreational drug culture. These signs of erosion in informal social controls over the use of ‘base/crack’ cocaine make early response all the more urgent.

A positive utilitarian, and ‘up-market’ image of cocaine powder and perhaps also of cocaine ‘base/crack’, combined with the existence of affluent potential consumers, could lead to a diffusion of cocaine use in the EU, including ‘base/crack’. This potential for diffusion should be treated with caution as biased news coverage about ‘base/crack’ can lead to the construction of myths about its use, which may divert attention from persistent structural problems facing some inner city areas (9).

Sources

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Infectious diseases

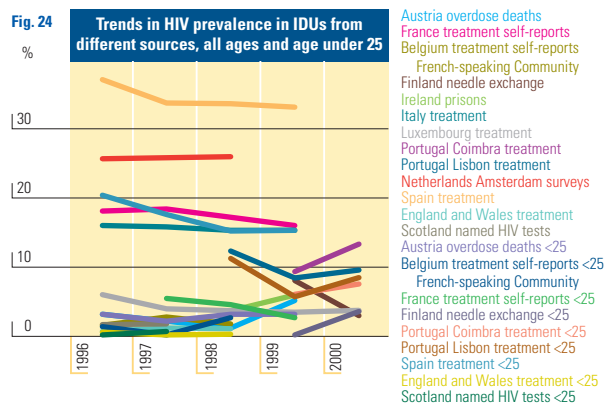
Prevalence and trends

HIV

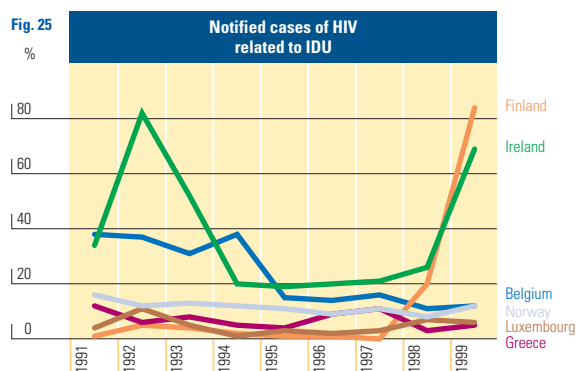
The prevalence of HIV infection differs much between countries — and within countries, between regions and cities. Although divergent sources and data-collection methods make comparisons difficult, available data indicate average levels of infection among different subgroups of injecting drug users (IDUs) that roughly vary from about 1 % in the United Kingdom to 32 % in Spain (see Figure 8, Chapter 1).

HIV prevalence seems to have stabilised in most countries since the mid-1990s after the sharp declines that followed the first major epidemic among IDUs in the 1980s (see Figure 24). In some countries (Austria, Luxembourg, Ireland, the Netherlands, Portugal and Finland) transmission may again be increasing among subgroups of IDUs (See box on page 16, Chapter 1).

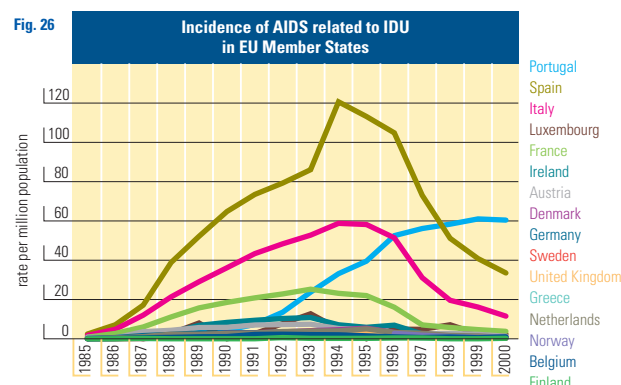
Recent transmission may be clearer if one looks specifically at prevalence in IDUs aged less than 25. HIV infections in this group must have occurred on average more recently, as most IDUs start injecting at between the ages of 16 and 20 (1, 2). The trends in this age group, as far as data are available, are more marked than general prevalence and sometimes even in the opposite direction. In Finland, for instance, a large outbreak occurred in 1998–99, as can be seen from HIV notifications data (Figure 25). After 1999, overall prevalence declined, as indicated by data from needle exchanges (Figure 24); however, prevalence in young IDUs increased from 0 % in 1999 to about 4 % in 2000. This might indicate that once new infections among older injectors began to decline due to saturation (most persons at risk have become infected) and/or behaviour change of those at risk, new infections mainly took place among younger injectors, who often have higher levels of risk behaviour.



Sources: National focal points. For primary sources see complementary statistical tables at <http://www.emcdda.org>.



NB: Data for Ireland are positive HIV tests in IDUs.
Sources: National focal points.



NB: Cases reported by 31 December 2000, adjusted for reporting delays.
Source: European Centre for the Epidemiological Monitoring of AIDS.

In several countries, HIV prevalence is consistently higher in female IDUs than in male IDUs. This may be due to higher levels or different ways of needle sharing and/or higher sexual risk of female IDUs.

AIDS

The countries that have been most affected with AIDS among IDUs are mainly in the south-western part of the EU, notably Portugal, Spain, France and Italy⁽²³⁾. Incidence of AIDS varies greatly between countries, as does HIV, but the general trend is downward (Figure 26). This decline is probably the result of new treatments among IDUs that delay the onset of AIDS. Therefore, AIDS incidence is now considered as a less reliable indicator of HIV transmission than before about 1996. Spain, which had the highest yearly AIDS incidence among drug users, has recently been surpassed by Portugal, the only country not showing a decrease. This may indicate limited uptake of HIV treatment (as shown by a recent study) and/or increased HIV transmission during the 1990s. However, the increase in Portugal shows signs of levelling off during 2000.

Hepatitis C

Prevalence of hepatitis C infection is higher and more similar across the EU than prevalence of HIV. Between 40 % and over 90 % of IDUs are infected with hepatitis C virus (HCV), even in countries with low rates of HIV infection such as Greece (see Figure 9, Chapter 1). Chronic HCV infection incurs substantial health problems, and in the long run (decades) may lead to serious health consequences, including severe liver damage and premature death. The proportion of chronic infections that lead to severe health problems is still very unclear, but there are recent indications that in IDUs it may be lower (perhaps 5 to 10 %) than previously thought (20 to 30 %) (3, 4). The extremely high levels of

HCV infection among IDUs in Europe may, however, still lead to a large health burden due to liver disease among (ex-) IDUs over the coming decades.

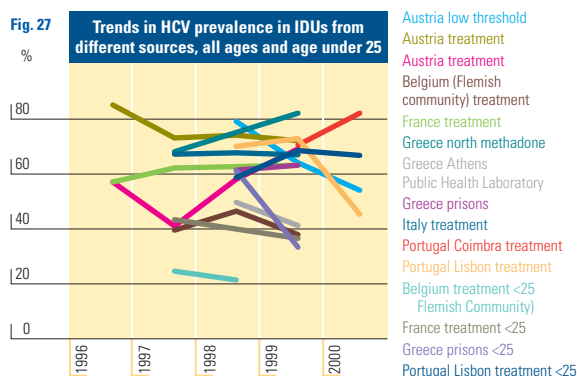
Trends in hepatitis C infection, for the few countries which could provide these, show both important decreases and increases in Austria, Portugal and Greece depending on source (geographic location) and age group (Figure 27). These may reflect different populations of IDUs with a different epidemiology of infections. However, it is also possible that the trends reflect testing policies that relate to the recent introduction of HCV testing. For example, those with highest risk may participate first when a voluntary HCV test is offered such that prevalence in subsequent years appears to decline. Only following the trends over a longer period can confirm the apparent trends. This potential bias may be less important for HIV tests, which have been available for many years.

Hepatitis B

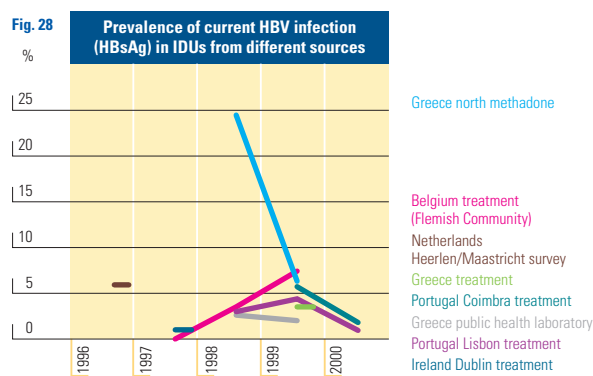
Prevalence of antibodies against hepatitis B virus (HBV) is also high, but seems less similar across the EU than prevalence of HCV. In the case of hepatitis B, the presence of antibodies indicates whether one has ever been infected, unlike for HCV and HIV, where a positive antibody test mostly indicates current infection. However, antibodies against HBV may also indicate vaccination. This means that vaccination practices, which may differ much between countries, need to be taken into account when interpreting HBV antibody prevalence. The proportion with no antibodies indicates IDUs who are still at risk of infection and should receive vaccination. Vaccination of IDUs is especially important as hepatitis B (also hepatitis A or D) infection can be very dangerous and even deadly if one is already infected with another hepatitis virus, such as HCV. In the EU, roughly between 20 and 60 % of

(23) Figure 16 OL: AIDS cases diagnosed in 1999 in injecting drug users per million population (online version).

Selected issues



Sources: National focal points. For primary sources see complementary statistical tables at <http://www.emcdda.org>.



Sources: National focal points. For primary sources see complementary statistical tables at <http://www.emcdda.org>.

IDUs have antibodies against hepatitis B. Self-reported data from studies in some countries suggests that only about 10 to 30 % of IDUs may have been fully vaccinated (5, 6, 7, 8). This suggests that a large potential health gain through vaccination exists (24).

Easier to interpret than HBV antibodies is the prevalence of HBsAg (the serological marker that indicates that the hepatitis B virus is still present). This indicates current hepatitis B infection, which can be either recent or chronic infection. The level of HBsAg thus indicates the potential for severe long-term complications and for spread to others through injecting risk behaviour or sexual transmission. Prevalence of HBsAg is only available from a limited number of countries, but appears to differ much and is in some cases high (Figure 28). In northern Greece, IDUs in methadone programmes may have experienced an important outbreak of hepatitis B infection prior to 1998, as levels were extremely high in 1998 but strongly declined between 1998 and 1999. In Belgium, data from IDUs in treatment indicate a steady increase in current HBV infection (HBsAg) between 1997 and 1999. In Portugal, recent data indicate a decline in current HBV infection. In Norway, notification data indicate a strong increase in HBV (and HAV) infections among IDUs.

Other STDs, TB, endocarditis and Clostridium outbreak

Other infectious diseases that can be important among IDUs are TB, which is not transmitted by injecting drug use but is especially high among drug users in Spain and Portugal, due to its strong association with HIV infection and AIDS. Other sexually transmitted diseases (STDs), such as syphilis and gonorrhoea, can also be high among drug users, especially drug-using street prostitutes, if they have no access to low-threshold medical services. This

may cause important transmission to non-drug users, while these STDs also form an important risk factor for HIV infection. Injecting drug users further often have high prevalence of other infections which can be life threatening, such as abscesses on injecting sites or endocarditis (infection of the heart valves), which can often easily be treated if services are available.

Between April and August 2000, a very large outbreak of *Clostridium novyi* infection occurred in Scotland, Ireland, England and Wales, resulting in 104 cases of severe illness and 43 deaths among young people. The outbreak was probably related to contaminated heroin in combination with specific modes of injection (intramuscular or subcutaneous rather than intravenous). It showed, in a dramatic way, how large the potential is for severe health problems among IDUs, which can be much larger and more life-threatening than health problems due to other and more prevalent patterns of drug use.

Determinants and consequences

Injecting drug use

Among drug users, infections such as HIV and hepatitis B and C are mainly transmitted through injecting drug use. This is largely due to sharing of injecting materials such as needles and syringes, and sharing of paraphernalia such as cotton, water and spoons. It is probable that in situations of increasing injecting drug use populations of injectors are especially vulnerable to rapid spread of HIV and hepatitis.

The timing and magnitude of the AIDS epidemics in different countries may have largely been determined by timing and magnitudes of epidemics of injecting drug use.

(24) Figure 17 OL: Prevalence of antibodies against hepatitis B virus among injecting drug users in EU Member States, 1996–2000 (online version).

These epidemics of injecting drug use probably occurred earlier in northern European countries such as the Netherlands (1970s and 1980s) but remained relatively contained, while occurring later in southern European countries such as Spain, Italy and Portugal (1980s and 1990s) and at higher rates. The occurrence of HIV epidemics may have therefore depended on a delicate balance between timing and magnitude of injecting drug use epidemics, awareness of AIDS (not existing in early years) and the timing and large-scale introduction of preventive measures.

The importance of injecting among drug users (in Europe mainly of heroin alone or together with other substances), may further depend on preferences and cultural habits of drug users or on the type of heroin available on the market (water-soluble and injectable or not). Also price and purity probably play a role, as injecting heroin is more efficient and therefore cheaper than smoking it. Fear of AIDS is thought to have much less influence on the decision to inject or not.

At the moment, it is not known how to prevent injecting drug use. Injecting drug use, or heroin use by any route, may depend on a range of personal and societal factors such as behavioural and/or family problems and unemployment. Substitution treatment, however, can be very effective in reducing injecting and injecting risk behaviour among heroin users (9).

Injecting drug use has decreased strongly during the 1990s in most, but not all, countries. As a consequence, rates of injecting drug use (measured among opiate users entering treatment) differ strongly, from a low of about 10 % in the Netherlands to a high of about 70 % in Greece. Recent trends in injecting are not available except for Ireland, where they show a continuous increase, consistent with a recent increase in the number of IDU-related HIV positive tests.

Injecting risk behaviour

Among IDUs, spread of infections is mainly determined by injecting risk behaviour, notably 'needle sharing' (giving or receiving a used needle from or to another person). Transmission is also possible through the sharing of injecting equipment such as water, cotton or spoons, which are probably even more important in the case of hepatitis B and C. Unhygienic injecting may even cause transmission of hepatitis if no materials are shared, for example via blood contamination of hands, tables or other surfaces.

Other risk behaviours include front or backloading (injecting heroin from one syringe into another in order to measure even shares). Preliminary data on needle sharing indicate that this is, in general, still very high among IDUs, ranging from 10 to 17 % in the Netherlands (recent borrowing of used needles), to 64 % in Ireland (needle sharing in last four weeks) and 75 % in England and Wales (sharing of needles and paraphernalia)⁽²⁵⁾. Most of these data may still underestimate the amount of risk behaviour through indirect sharing (front or backloading), sharing of materials other than needles, etc. On the other hand, needle sharing often occurs between steady partners who both know they are not infected, which may be relatively safe.

Sexual risk behaviour

Sexual transmission of HIV and HBV is much less efficient than transmission through needle sharing, while sexual transmission of HCV is thought to be very low. However, when the level of infection (prevalence) is high among IDUs, sexual transmission and transmission from mother to child of HIV and HBV may become important. IDUs may thus form so-called core groups or pockets of infection for continued transmission to the wider population. An efficient way of preventing sexual transmission is the use of condoms. Condom use has greatly increased among drug users since the 1980s, especially among sex workers who usually report high rates of condom use with their clients. However, condom use is usually low with private partners who therefore remain a major risk group for infection.

Consequences and costs

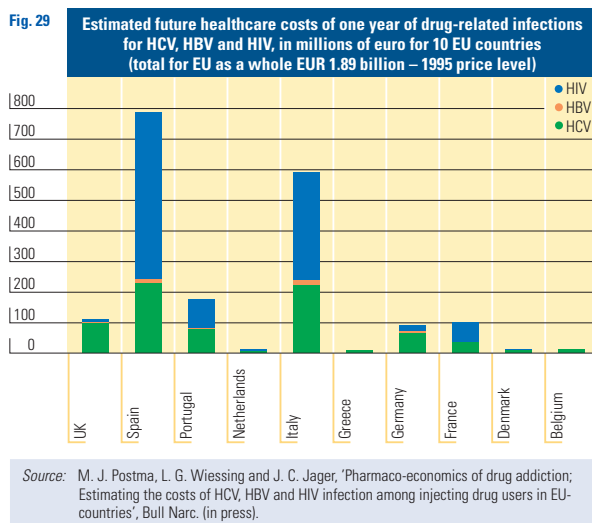
The consequences of an infection with HIV are severe. HIV infection leads to AIDS on average after about 10 years, which by that time incurs great costs to the individual and to society due to chronic infections, hospitalisations and premature death.

Infection with hepatitis B in the majority of cases resolves itself spontaneously, however, in an important proportion of cases (2 to 8 % among adults, 10 to 15 % in adolescents and much higher in children) it leads to chronic infection, which in the long term can lead to severe liver disease and premature death. As hepatitis B and HIV can easily be transmitted sexually or from mother to child, these infections among IDUs are an important threat to the population at large.

Hepatitis C remains chronic in most cases (possibly 70 to 80 %) and therefore IDUs are still a potential major

⁽²⁵⁾ Table 6 OL: Needle sharing among injecting drug users in some EU Member States (online version).

Selected issues



source of infection. Hepatitis C infection, like hepatitis B, has the potential of severe liver disease and premature death in the long run (decades). The combination of different hepatitis infections (including hepatitis A) at the same time can be especially dangerous and often leads to acute liver failure and death.

A preliminary estimate of future health care costs of one year of drug-related infections of HIV, HBV and HCV in the EU amounted to about 0.5 % of the total EU budget for health care (Figure 29).

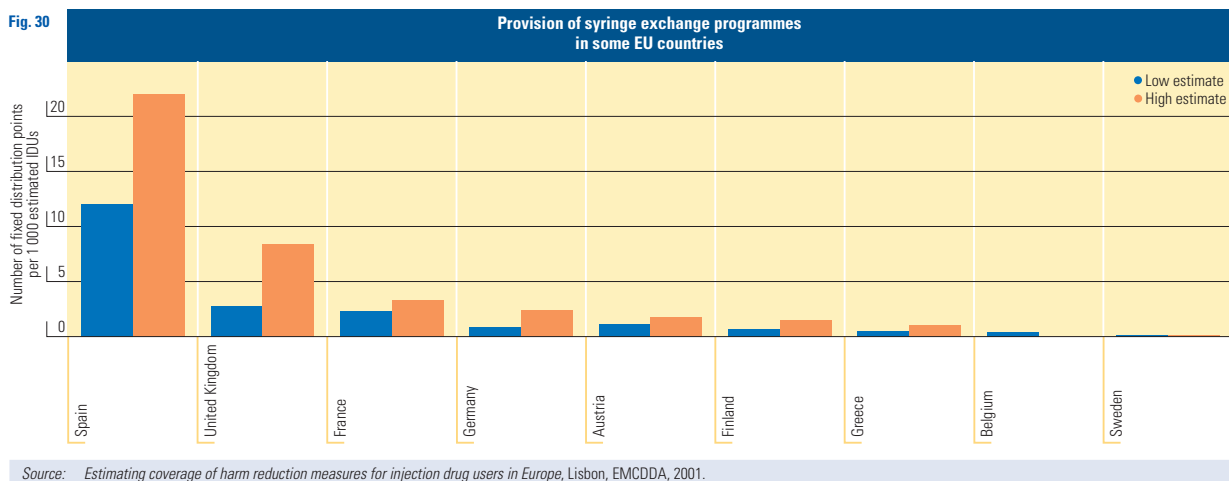
Harm-reduction responses

In most of the EU, the introduction of harm-reduction measures — such as increased access to sterile needles and syringes, greater availability of condoms, and HIV counselling and testing — has helped to control HIV transmission among injectors. Substitution treatment, which can greatly reduce the frequency of injecting, is also available in all Member States, mostly in the form of

oral methadone, but in most countries large improvement is still possible in terms of coverage. (See Chapter 2, demand reduction, treatment, substitution treatment).

While there is evidence that harm-reduction measures have helped to reduce the prevalence of hepatitis C among injectors, it has not controlled its spread (10). The persistence of hepatitis C infection among young injectors requires innovative approaches to harm reduction. The introduction of medically supervised injecting rooms and controlled heroin distribution are two such approaches being considered by some EU countries. However, both pose ethical and legal difficulties and may necessitate a change in drug laws. In those countries where injecting rooms have been established (United States, Australia, Germany, Switzerland and the Netherlands), their effectiveness has yet to be assessed.

Important aspects for gauging the availability of harm-reduction measures are provision of services and coverage of the IDU population. Based on estimates of problem drug use and rates of IDU among opiate users in treatment, preliminary estimates have been derived of the size of the IDU population in EU countries. Using these estimates a rough picture emerges of the provision of syringe exchange programmes (SEPs) (distribution points) per country (see Figure 30) and the number of needles exchanged through syringe exchange programmes per 1 000 IDUs per year⁽²⁶⁾. Although country specific estimates may not be reliable, overall it appears that syringe exchange programmes in most countries for which data are available are still not providing a sufficient number of clean needles for IDUs, with the possible exception of the United Kingdom (England and Wales) and Spain.



(26) Figure 18 OL: Syringes distributed or exchanged through syringe exchange programmes per estimated IDU per year (online version).

A French study estimated the average number of injections for a daily injector (in the previous month) to be 3.6 per day, implying more than 1 300 injections per year per daily injector. (93 % of the sample of needle exchange attenders were daily injectors.) (11) However, this average may strongly depend on substances injected (opiate users who also inject cocaine may inject much more frequently) or income (IDUs with little money may inject much less). Better and country specific estimates of IDU population size and number of injections are needed in order to assess the coverage of syringe exchange programmes and thus their potential for effective prevention of drug-related infections⁽²⁷⁾ ⁽²⁸⁾.

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Synthetic drugs

This section completes the data and analysis provided in other sections of the annual report with a summary of the main questions, concerns and challenges surrounding synthetic drugs.

Spread of use

While the global picture in 2000 confirms that the spread of synthetic drugs use in the EU has generally stabilised, upward trends in ecstasy use are still observed in some regions where cities or holiday resorts are more likely to attract young European tourists owing to their location and larger offer of youth-oriented events. More generally, urban areas where youth cultures have been established may continue to provide a setting for 'recreational drugs' to anchor and develop.

Cross-analysis of qualitative surveys suggests that the consumption of synthetic drugs has spread beyond the 'techno scene' to discotheques, nightclubs and also private settings. Other settings are also reported. For example, a 1998 study found that, in Greece, 35 % of student ecstasy users have used the drug at football matches.

Behaviours and patterns of use

A growing behaviour trend is not so much the consumption of one particular drug above another, but rather a tendency to instrument different drugs in relation to needs and situations.

Changing patterns in youth behaviour have been highlighted in some Member States as a subject for more in-depth investigation.

- Most countries underline the phenomenon of quickly changing patterns among a broad public to experiment and/or combine different substances to get 'high' and/or to balance the respective effects.
- In the Netherlands, the phenomenon of 'ecstasy-fatigue' is currently being assessed. The reasons for this trend may be due to various factors, for example that there is no logo proof of exact contents or a heightened awareness (raised through the media) of the adverse residual effects on mood and feelings. The question as to whether cocaine plays an alternate role as a basic

⁽²⁷⁾ Table 7 OL: Provision, utilisation and coverage of syringe exchange programmes (SEPs) for injecting drug users (IDUs) and coverage of pharmacies in some European countries, as reported by national focal points, 2000 (online version).

⁽²⁸⁾ Table 8 OL: Provision of HIV counselling and testing, HIV treatment and HBV vaccination for injecting drug users (IDUs) in some European countries, as reported by national focal points, 2000 (online version).

Selected issues

stimulant with regular and known effects is also posed. The combination of cocaine and alcohol is reputed to be a 'good mix' among experienced users, while the combination of ecstasy and alcohol is considered more difficult to manage.

- As far as ecstasy problem users are concerned, some studies on addiction point out that the addictive potential of the substance itself may play a lesser role than the non-chemical and behavioural addiction patterns associated with it.

All Member States, when drawing up strategies, attach importance to differentiating between groups of synthetic drugs users. A first and very broad differentiation of ecstasy users can be made.

- Excessive users. Even if MDMA has a low dependence potential, a minority of users show a compulsive pattern of use — more than once a week, more than one pill at a time, use of multiple other substances, intensive party activity throughout the weekend and a lack of sleep. They are frequently part of a network where drug use is very common.

- Cautious users, with a less extensive pattern of use.
- Occasional users, with less knowledge and awareness of possible risks.

Combined use of various substances, licit and illicit, is a common behaviour pattern among young people with an outgoing lifestyle (bars, discotheques, 'rave' and techno parties, private parties). Polyuse — mixing or alternating a large range of substances, synthetics or non-synthetics — is the main trend, and 'self-management' of polyuse in a changing context is a predominant pattern.

Shifting from one product to another and polyuse patterns are linked to a certain extent to the availability of different substances and opportunism plays a role. Personal/in-group strategies are often mobilised to obtain a particular substance and group dynamics play an important role.

A distinction should be made between substances which are believed to be more adapted to the music event itself and other drugs (such as after-dance drugs or not-dance drugs) or substances experimented within an initiation circle led by experienced users with at least some

What are synthetic drugs?

The term 'synthetic drug' strictly refers to psychoactive substances that are manufactured through a chemical process in which the essential psychoactive constituents are not derived from naturally occurring substances. The term 'synthetic drug' began to be used synonymously with dance or recreational drugs following the emergence of the synthetic drug ecstasy (MDMA) and other ring-substituted amphetamines in the recreational dance drug scene, although non-synthetic drugs, such as cannabis, cocaine and magic mushrooms, are also consumed in these settings. Synthetic drugs with long histories of illicit use include amphetamines and lysergic acid diethylamide (LSD), while ecstasy (MDMA) and other drugs listed in Alexander Shulgin's Pihkal list⁽¹⁾ have much shorter histories of illicit use. There is growing global concern about the potential manufacture of other and newer synthetic drugs sold as an alternative to MDMA, or added to MDMA tablets. The ease with which many 'synthetic drugs' can be manufactured constitutes a challenge to efforts to control supply, as laboratories can be set up and moved with relative ease.

Some synthetic drugs, not all, have hallucinogenic effects and may be either stimulants or depressants of the central nervous system (CNS), the latter being the case for GHB.

There are also synthetic opiates, such as methadone, pethidine (MPPP, MPTP), fentanyl, 3-methyl-fentanyl, etc.

'Designer drugs' are chemical analogues of controlled drugs. Illegal producers modify slightly the molecular structure of a prohibited substance in order to obtain similar or stronger pharmacological effects, thereby avoiding prosecution. The EU joint action on new synthetic drugs (see box on page 46) was launched in June 1997 with the purpose of preventing and/or limiting the extension of such practices.

Amphetamines are synthetic drugs. They may be injected, as is the case in Sweden and Finland, or taken in tablet or powder form. Amphetamines are frequently mixed in ecstasy-like tablets with MDMA or ecstasy analogues.

Methamphetamines are methyl derivatives of amphetamines (mainly but not exclusively of the unsubstituted-ring type). They include 'methedrine' as well as 'crystal' and 'ice' which are forms that can be smoked.

⁽¹⁾ A. and A. Shulgin (1991), *Pihkal: A chemical love story*, Transform Press.

empirical knowledge about dosages and side-effects. For a limited number of synthetic drugs, the lack of such an environment could possibly present greater risks.

Availability of substances

MDMA is still the favoured product of the ecstasy market and appears under numerous different logos and many different names. For example, the German Criminal Police Laboratory in Wiesbaden which monitored tablets stamped with a 'Mitsubishi' three diamond-triangle logo has issued a list of more than 200 different end-products.

Overdosed MDMA tablets were detected through seizures and toxicological analysis or through on-site pill testing by prevention teams at music events, allowing information on their characteristics to be rapidly disseminated to all EU countries through the EU early warning system.

A trend that needs to be monitored closely is the increasing number of psychotropic medicines such as ketamine, diverted from legitimate sources.

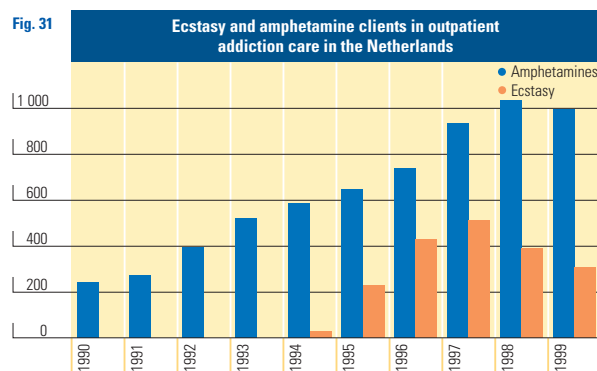
Lower purity and availability is noted for amphetamine (or 'speed' — amphetamine sulphate). Scandinavian countries are still the main market for injected amphetamine and the United Kingdom for non-injected amphetamine.

The average consumption of methamphetamines is still very limited in the EU. However, according to Europol (29), evidence of production (laboratories dismantled) has been confirmed for Germany and the Netherlands. Estonia and especially the Czech Republic have also been involved in production and trafficking. Methamphetamine, probably produced in the Czech Republic has progressively replaced amphetamine for consumers in Bavaria and Saxony, two bordering German *Länder*. Several seizures of this substance were reported to Europol in 1999 by the law-enforcement agencies of Finland, Sweden, Germany and the Netherlands.

Although still present on the drug scene, the market for LSD and other hallucinogens has stabilised or levelled off in most EU countries.

Treatment data

Treatment data, as an indication of the level of problem drug use, provides very little coverage for synthetic drugs with the exception of injected amphetamine. Ecstasy is scarcely ever recorded as the primary drug in demand for treatment, the patients typically being polydrug users. The



higher level of treatment demand for amphetamines as primary drug with respect to Sweden and Finland can be explained by the historical pattern of injecting amphetamine sulphate in these countries.

In the Netherlands, the introduction of a specific entry for ecstasy use in 1994 has resulted in a complete registration in 1995 in the outpatient care system. Figures show a declining trend in treatment demand for ecstasy since 1997, taking into account the apparent initial increase in the two preceding years and this may be due — at least in part — to improved registration. Still, ecstasy makes up no more than 1 % of all drug clients (3.1 % for amphetamines). In 1999, the number of clients reporting ecstasy as secondary drug was twice the number of clients with ecstasy as main drug, a figure consistent with the fact that ecstasy users are typically polyusers.

Health risks

Although rare and poorly documented, there are possible acute effects of ecstasy-type substances, especially when taken with other licit or illicit drugs (such as GHB and alcohol), when mixed with other drugs with less potential of acute adverse effects, or when tablets are strongly overdosed and/or taken repeatedly over a short period of time.

Clinicians emphasise the role of risk behaviour (such as the compulsive search for a 'high' and ignorance of composition and/or effects) rather than the toxicity of a particular substance isolated from its context and patterns of use. Personal health background may also be a determinant.

In most cases, poly-intoxication is the diagnosis, it being impossible to point to one substance above another.

In order to understand the nature and possible long-term risks and neuro-psychic aspects which frequently

(29) Europol 2000 report, The Hague, the Netherlands.

Selected issues

emerge in acute intoxication cases, the priority for clinicians is now the follow-up of non-fatal intoxications among young users of ecstasy (mostly mixed with other drugs).

Long-term use may produce adverse effects. Reversible and/or non-reversible effects on the brain are still under discussion. In heavy ecstasy users, there is increasing evidence of damage to serotonergic neurons. Clinical implications indicate cognitive deficits but research projects in this area (under way in the United Kingdom and United States) are still few and far between.

Related deaths

Since outreach and other prevention measures have been undertaken at techno/house events and parties, a decrease in fatal incidents has been observed compared with the early nineties, at least in countries where emergency cases were recorded and documented.

Apparent overdose by amphetamine or phenylpropanolamine derivatives, where these derivatives were considered as the main cause of death, were attributed to 50 % of fatal cases in the Netherlands during the period 1994–97. In the remaining cases, amphetamine derivatives were present but death was attributed to other drugs and/or alcohol or unknown causes.

One new synthetic drug, 4-methylthioamphetamine (4-MTA, with the street name 'flatliner') has been implicated in a number of deaths in the EU (four deaths in the United Kingdom, one in the Netherlands). Another 'new' synthetic drug, GHB (gamma-hydroxybutyrate), has also been linked to some deaths, generally in association with alcohol and/or other drugs. These two substances have been subject to monitoring and risk assessment in the framework of the EU joint action on new synthetic drugs (see box on page 46).

Responses

Responses to synthetic drugs are organised at different levels of intervention.

Primary prevention concentrates on providing information on synthetic drugs and is usually carried out through public campaigns and in-school interventions.

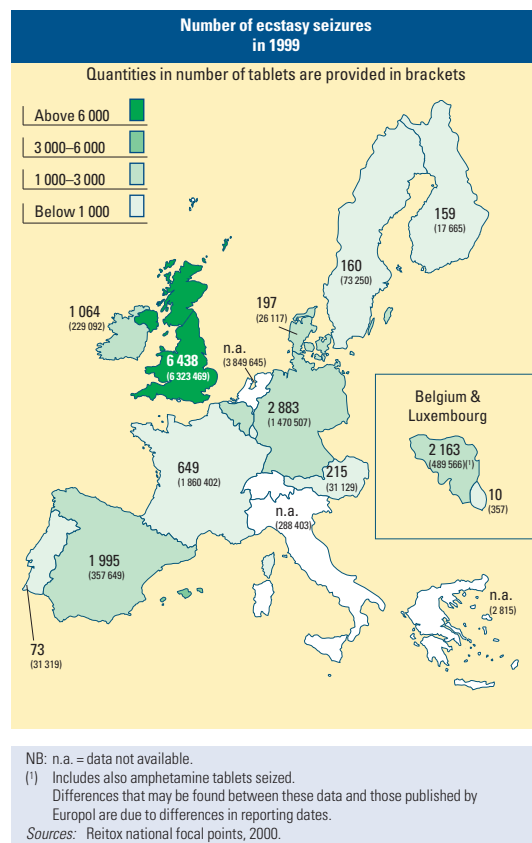
Harm-reduction/outreach activities in recreational settings consist of chill-out rooms, pill testing, information leaflets and on-site desks. There are also 'auto-support' initiatives in the techno scene which aim to include information on synthetic drugs and associated substances in a range of music-oriented activities.

Information among users about the risks of mixing substances (especially the risk of alcohol) and the early detection of new risk groups among young people is now considered crucial.

The aim of quick health responses is to provide targeted prevention information which allows professionals in emergency rooms and poison units, GPs, field health workers, etc. to detect and respond better to cases of acute intoxication. In France, since 1998, Médecins du monde has ensured medical stand-by assistance at raves and other 'free-parties'. Difficulties include the lack of clinically related literature on acute intoxication episodes, and the impossibility of referring to the individual's medical history.

Even if they have a less problematic drug-use profile, 'new' drug users (new or experienced users not known by treatment services) may be provided with improved information on how to identify signs of problem drug use and the need for assistance. Self-perception of one's state of health, awareness of losing control of 'self-managed' use and knowledge about access to counselling services are possible indicators to be combined with preventive outreach actions. However, the lack of diversity and/or relevance of existing treatment offer may limit the effect of such efforts.

Fig. 32



Supply reduction

According to Europol (Annual report 2000), the Netherlands is still the primary country for the production and export of ecstasy: 36 production sites were identified in 1999. During the same year, four laboratories were dismantled in Belgium, two in Spain, and one in Germany. One of the largest amphetamine laboratories ever found was dismantled in Greece in February 2000. Production and export also involve a number of the east European countries (the Czech Republic, Poland and Bulgaria) and the Baltic States.

By way of example, 10 to 20 % of synthetic drugs for the UK market are manufactured in the United Kingdom, while the rest are thought to be manufactured on the continent (predominantly the Netherlands and Belgium) and enter the United Kingdom at Channel ports or airports.

The average wholesale price (sales per kilogram) for tablets marketed as ecstasy ranges from EUR 4 to EUR 5 per tablet, with a minimum price of EUR 1 in Portugal and a maximum price of EUR 13 in Denmark⁽³⁰⁾. The average retail price ranges from EUR 4 to EUR 28 per gram, with a minimum of price of EUR 4 in the Netherlands and a maximum of EUR 34 in Denmark.

New initiatives and challenges for policy-making

Synthetic drugs are in the political limelight despite the limited scientific evidence available in terms of public health risks. Their high level of use among socially integrated groups, their role as a reference model within youth culture and the fact that production and trafficking are set up in Europe (for both internal and external markets) exert strong pressure for responsible action by the EU.

Synthetic substances and their risk assessment are progressively included in a broader view of changing patterns and behaviours, subcultures and evolutions. This has resulted in the following actions:

- setting up efficient communication channels between all actors involved in rapid-response systems;
- setting up better communication between scientifically based information and policy responses;
- improving capacity for obtaining specific information on synthetic drugs and more generally on emerging

The EU joint action on new synthetic drugs

During the period 1998–2000, the EU joint action 'early-warning system' for the rapid collection and exchange of information on new synthetic drugs detected a number of substances which appeared on the illegal market in the European Union. Joint progress reports summarising the information collected at this preliminary stage were presented by the EMCDDA and Europol to the Horizontal Working Party on Drugs of the Council of the European Union. At a second stage, following a request by the Council, four of these substances — MBDB, 4-MTA, GHB and ketamine — have been subject to a risk assessment by the enlarged Scientific Committee of the EMCDDA.

On the basis of its risk-assessment report and an opinion of the European Commission, one new synthetic drug, 4-MTA, is subject to control measures in all EU Member States by a Council decision of 13 September 1999.

Other new synthetic drugs, such as PMMA, 2-CT-5 and 2-CT-7 have recently been detected under the joint action 'early-warning system' mechanism and are currently being monitored jointly by the EMCDDA and Europol, in close cooperation with the European Commission and the European Medicines Evaluation Agency (EMA).

As an instrument to define whether or not a particular substance should be placed under control at EU level, the joint action also provides Member States and European institutions with a regular insight into the context of drug use in recreational settings and gives early indications on trafficking trends in synthetic drugs. The risk-assessment exercises bring sound material to the attention of policy-makers for their reflection on possible options for a balanced approach between law enforcement and preventive measures.

trends in drug use through national and local prevalence estimates, treatment demand records, also taking into account the main orientation of treatment services towards opiates users.

⁽³⁰⁾ Last data: July 1999. The prices vary within different Member States depending on purity rate, amount purchased and location of purchase (Source: Europol, annual report 2000).

The drugs problem in central and east European countries

This chapter makes use of the recent information made available through the Phare multi-beneficiary drugs programme. Currently, partnership between the EMCDDA and the candidate countries is in a transition period during which direct technical cooperation will be expanded to further develop the institutional basis for national drug information systems, to consolidate relations and to establish permanent structural links.

Situation and trends

On the whole, the major trends identified in 2000 are confirmed:

- an increase in the percentage of the general population, especially schoolchildren who have tried illicit drugs at least once in their lifetime;
- an increase in demand for treatment, mostly for opiate dependency;
- change in the patterns of drug use, with imported heroin increasingly taking the place of locally produced opiates;
- a spread of drug use from major urban centres to all regions;

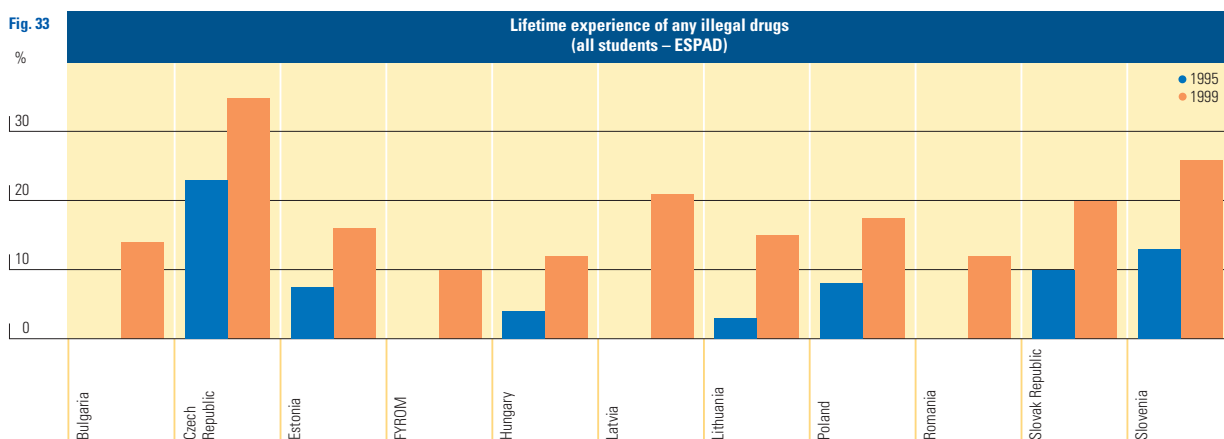
- an increase in the problems and challenges associated with the trafficking and transit of illicit drugs.

Prevalence and patterns of drug use

According to the data collected by the European school survey project on alcohol and other drugs (ESPAD) in 1995 and 1999, lifetime experience of illicit drug use among schoolchildren (15 to 16-year-olds) doubled during the same period in all central and east European countries (CEECs), except in the Czech Republic, where this prevalence was already quite high and increased one and a half times (see Figure 33).

This increase reflects mostly the rise in the use of cannabis, which remains the most common drug used among teenagers.

In parallel, a significant but smaller increase, has been detected in the use of drugs like ecstasy, amphetamines, or LSD (Table 4).



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Table 4 Lifetime experience of ecstasy, amphetamines and LSD use among schoolchildren, ESPAD 1995–99

	Ecstasy		Amphetamines		LSD	
	1995	1999	1995	1999	1995	1999
Bulgaria	–	1	–	1	–	1
Czech Republic	0	4	2	5	2	7
Estonia	0	3	0	7	1	3
Former Yugoslav Republic of Macedonia	–	1	–	0	–	1
Hungary	1	3	0	2	1	4
Latvia	0	6	0	4	0	4
Lithuania	0	4	0	2	0	2
Poland	0	3	2	7	1	5
Romania	–	0	–	0	–	0
Slovak Republic	–	2	0	1	0	4
Slovenia	1	4	0	1	1	3

However, some data collected at city level or in more targeted subgroups reveal that the prevalence of synthetic drugs use may be greater than that suggested by national figures, although accurate data on the number of users in the population are not available.

In Lithuania, in the 1999 ESPAD study, lifetime prevalence of any illicit drugs among schoolchildren was found to be at 22.7 % in Vilnius, and at 23.9 % in Klaipeda, while the national average was 15.5 %.

In the Czech Republic, in a study carried out on the ‘techno’ party scene in Prague during 1998 and 1999, lifetime prevalence was found to be at 44.5 % for amphetamines, 35.7 % for ecstasy and 47.7 % for hallucinogens (compared respectively with 5 %, 4 % and 7 % in the ESPAD study carried out at national level).

Treatment demand

The demand for treatment — mostly for opiate use — still appears to be increasing (Table 5).

However, it should be underlined that patterns of consumption, as well as the problem substances themselves, may differ substantially from one country or one region to another.

Availability

Major seizures along the Balkan route and in central Europe in 1999 and 2000 confirm the role of the region in the transit and storage of heroin. It is notable that the total amount of heroin seized by the Bulgarian authorities in 2000 is 2 079 kilograms, which is more than the total amount seized during the preceding six years. Most of these seizures are made at the main checkpoint with Turkey. Corresponding increases cannot be seen elsewhere on the Balkan route. However, as heroin

consumption rises, it seems that the CEEC countries are increasingly becoming targets as well.

Central and eastern Europe continues to be a transit region for cannabis destined for the EU Member States. In 2000, seizures are reported from most of the countries. Studies show that cannabis is the most widely used drug in the CEECs and there are suggestions that, as is the case in the EU, there has been a noticeable increase not only in illegal traffic but also in the cultivation of cannabis in the region.

The transit role of central and eastern Europe in cocaine trafficking seems to have developed further during 1999 and 2000. Major cocaine seizures involved Hungary, the Czech Republic and Romania. Yet consumption seems to be limited to particular segments of the population, the size of which is difficult to estimate through existing monitoring systems.

Popularity of synthetic drugs is growing among young people (Table 4) and there are worrying signs that an increased number of juveniles are involved in the trafficking and selling of drugs. The production of synthetic drugs has increased and its consumption influences the life of more and more young people. Illegal laboratories producing amphetamines exist in most of the CEECs, and precursors for production purposes are being smuggled from other CEECs, the EU or third countries.

Illegal laboratories have been dismantled in almost all of the countries in the region. In particular, Poland, the Czech Republic, Hungary, Bulgaria and the Baltic States seem to be major producers. For example, despite the

Table 5 Number of demands for treatment in the CEECs since 1993 (all demands)

	1993	1994	1995	1996	1997	1998	1999
Albania	n.a.	n.a.	27	63	334	523	615
Bulgaria	n.a.	n.a.	254	449	582	974	1071
Czech Republic ⁽¹⁾	n.a.	n.a.	2 470	3 252	3 132	3 858	3 889
Estonia	n.a.	246	366	755	n.a.	n.a.	n.a.
FYROM	82	116	242	301	431	n.a.	n.a.
Hungary ⁽²⁾	n.a.	2 806	3 263	4 233	7 945	8 957	12 765
Latvia	n.a.	781	804	904	992	1 080	1 512
Lithuania ⁽³⁾	n.a.	n.a.	n.a.	1 804	2 871	2 862	3 082
Poland	3 783	4 107	4 223	4 772	n.a.	n.a.	n.a.
Romania	n.a.	n.a.	n.a.	n.a.	646	650	n.a.
Slovakia	n.a.	1 189	1 239	1 594	2 074	2 199	2 236
Slovenia ⁽¹⁾	141	187	125	309	n.a.	n.a.	n.a.

NB: n.a. = data not available.
⁽¹⁾ First demand for treatment.
⁽²⁾ Number of treatment cases (non harmonised indicator).
⁽³⁾ Number of registered users.

The drugs problem in central and east European countries

dismantling of seven laboratories in Poland in early 2000, it is estimated that at least the same number could still be operational. The worldwide prevalence of ecstasy use has led to the export of the drug from the EU to markets in central and eastern Europe. Law-enforcement agencies report that a significant proportion of the ecstasy used in the CEECs originates in the Netherlands.

Policy and institutional responses to the drug phenomenon

Since the mid-1990s, drug policy and strategy developments in the central and east European countries (similarly to the EU Member States) have two main roots: firstly, the changing nature of the drug phenomenon which increasingly affects broader segments of society; and secondly, the multidimensional character of the problem which demands a nationally coordinated multidisciplinary response. The actions of various international organisations, notably the European Commission, have provided a catalyst for the development of national responses to the drug phenomenon.

Within this context, the central and east European countries have taken substantial steps to developing the appropriate legislative measures and administrative and coordination structures. In addition, as part of the process of EU enlargement, under the pre-accession strategy, the 10 candidate CEECs⁽³¹⁾ have adjusted or reoriented their drug control actions towards adopting and implementing the *acquis communautaire*. A similar process is taking place in the Former Yugoslav Republic of Macedonia despite the fact that it is not yet an applicant to join the EU.

Legislation

All candidate CEECs have signed and ratified the three UN drug control conventions — these being regarded as inseparable from achieving the objectives of the EU drugs strategy. Estonia, in 2000, was the most recent country to ratify the 1988 'UN convention against Illicit traffic in narcotic drugs and psychotropic substances'. All candidate CEECs have signed and ratified the 1990 Council of Europe Convention on Laundering, Search, Seizure and Confiscation of the Proceeds of Crime (Strasbourg Convention).

The process of adopting national legislation varies in its intensity and approach throughout the region, from the adoption of several laws addressing specific drug-related

Slovenian drug law

The Slovenian Law on the Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs (1999), besides setting out measures for preventing the use of illicit drugs, also sets out measures on: information, medical, educational, and consulting activities; medical treatment; social security services and programmes for resolving social problems related to the consumption of illicit drugs; and for monitoring the consumption of illicit drugs. The law addresses, among others, the need for the involvement of non-governmental organisations and the coordination of their activities with the national programme. It is foreseen that the funds for co-financing the implementation of prevention programmes and for monitoring consumption will be provided from the national budget.

issues — such as is the case of Hungary — to the concept of a single wide-ranging 'umbrella-type' drug law — for example, the 1997 Law on Counteracting Drug Addiction in Poland. The latter was amended in 2000 to make more restrictive the provisions regarding the possession of small quantities of drugs and also to strengthen the role of demand reduction. A similar type of law has recently been passed in Bulgaria (1999). In the last two years, Slovenia adopted three major drug laws: on production and trade in illicit drugs (1999); on precursors for illicit drugs (2000); and a law dealing exclusively with the prevention of drug consumption, treatment and the reintegration of drug addicts (1999). The 2000 Romanian Law on Combating Illicit Drugs Trafficking and Consumption is rather brief and will probably be followed up by a substantial number of secondary legislative measures. All candidate countries have adopted specific precursors control legislation, largely compatible with EU regulations. For example, in 2000, laws were passed in Slovenia and Slovakia, as well as regulations on precursors introduced in Lithuania, Poland and Bulgaria.

National coordination

In line with the new legislation, the national coordination and decision-making structures in most of the candidate CEECs have undergone significant changes in 1999 and 2000. In 1999, the Czech National Drug Commission approved the statute of its consulting body — the board of representatives of ministries — and tasked it with the preparation of a new national strategy. The Hungarian Drugs Coordination Commission was reformed so as to

⁽³¹⁾ The following CEECs are candidates to join the EU: Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia.

strengthen its mandate and operational capacity. The new laws passed in Slovenia and Bulgaria firmly established inter-ministerial coordinating bodies in these countries enhancing their role through the creation of permanent support structures — the Governmental Drugs Office and the National Drug Council Secretariat respectively — similar to those in the Czech Republic and Slovakia. The Romanian ‘inter-ministerial committee for the fight against drugs’ was established in 1999 and is yet to become fully operational, whereas in Poland such a body has not been functioning since 1998. Most of this reorganising has successfully enabled the countries to set up a structure with a view to meeting the specific needs of a changing society and the problems it is confronted with.

The leadership of the inter-ministerial coordinating body is usually ensured by one of the participating ministries. In most of the countries this is a ministry dealing with social matters — the Ministry of Health in Bulgaria, Lithuania and Slovenia, the Ministry of Social Affairs in Estonia, and the Ministry of Youth and Sports in Hungary. In other countries, it falls directly under the government’s office — chaired by the Prime Minister in the Czech Republic and the Deputy Prime Minister in Slovakia — or lies with the Ministry of Interior, as is the case in Latvia. In Romania, the inter-ministerial body is by definition ‘under the leadership’ of the Prime Minister but its work is organised by the Ministry of the Interior.

For the purpose of implementing and coordinating national policy at local level, local drug commissions were set up in the Czech Republic in 1999 and in Bulgaria in 2000, the establishment of municipal multidisciplinary drug councils was initiated. These are similar to the regional and district drug commissions established in Slovakia in 1997.

National strategies and action plans

In countries where the inter-ministerial drugs body is well positioned, such as in the Czech Republic and Slovakia, multidisciplinary national strategies are elaborated and implemented in a more consistent manner. The Czech Republic, for example, has adopted its third consecutive national strategy. The process of elaborating strategic documents and action plans intensified in 1999 and 2000, and national drug strategies were adopted in Slovakia (1999), Poland (1999), Hungary (2000) and the Czech Republic (2000).

The Estonian ‘Alcoholism and drug abuse prevention programme’ (1997–2007), the Latvian ‘Drug control and drug abuse prevention master plan’ (1999–2003) and the Lithuanian ‘National drug control and drug prevention programme’ (1999–2003) are under revision. In Slovenia,

a ‘National programme for prevention of drug misuse’ adopted in 1992 has been implemented over the past years. A new programme is due to be adopted based on recent legislation. Comprehensive drug control and prevention strategies are still to be adopted in Romania and Bulgaria. The latter has adopted a national programme for prevention treatment and rehabilitation of drug addicts for the period 2001–05.

The new strategies demonstrate commitment, in that the drug problem is acknowledged at the highest political and executive level. They also provide the basis for multidisciplinary programmes. Most of the recently adopted strategic documents are concrete action plans in themselves, stating objectives, targets, achievement indicators, etc., and often securing or bidding for increased financial resources. The need for improved drug information and evaluation of the interventions is increasingly recognised and included as an integral part of the national actions. The partnership between governmental and non-governmental sectors in policy development and programme implementation appears to be increasingly responding to the individual and collective needs of the general population as well as to the drug-using population. It is worth noting that all new strategies in the candidate countries strive to ensure consistency between domestic policies and policies and strategies endorsed at EU level.

Czech Republic

At the end of 2000, the Government of the Czech Republic adopted a national drug policy strategy for 2001–04. The strategy lists 82 specific tasks and stipulates that all relevant ministries with a mandate in the drugs field, as well as the regional and district authorities responsible for drug policy, have the task of preparing a specific drug action plan for 2001–04 in line with the strategy. The strategy takes into account the administrative reorganisation and the creation of larger administrative and territorial units and provides for enhanced regional coordination.

Hungary

The national strategy for the suppression of the drug phenomenon, elaborated by the Ministry of Youth and Sports, was passed by the Parliament at the end of 2000. This is the first comprehensive, officially adopted strategic document addressing the drug phenomenon in Hungary. To justify the ‘target-setting’ multidisciplinary approach employed, the strategy largely relies on the analysis of available data and previous national and international experiences. The strategy identifies long- (2009), medium- (2002) and short-term objectives and achievement indicators to monitor progress. It also sets

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out the necessary organisational and financial framework for implementing the actions. The strategy comprises four main objectives: efficient community and cooperation capabilities; availability of prevention measures; access to social work therapy and rehabilitation; and reduction of supply.

Poland

Despite the absence of an inter-ministerial coordination body, the national programme for counteracting drug addiction in Poland 1999–2001 was adopted at the end of 1999. In the same vein as the EU action plan on drugs (2000–04), the programme lists eight objectives designed to strengthen demand-reduction interventions, to increase the effectiveness of actions on the reduction of illicit trafficking in narcotic drugs and psychotropic substances, as well as measures to reinforce the national coordination structures and international cooperation. In the area of demand reduction, the programme pays specific attention to objectives that are highly compatible with those of the EU strategy such as preventive activities targeting young people, the improvement of various measures in rehabilitation and social reintegration, the reduction of health consequences of drug use, etc. The need to evaluate the actions and to set up monitoring modalities is also addressed.

Slovakia

The national programme for the fight against drugs till the year 2003 with a prospect to the year 2008 is a policy document adopted further to the implementation of the first national programme (1995–99). The programme strives to achieve a balance between demand and supply reduction actions through addressing four main objectives: primary prevention, treatment and reintegration; drug supply reduction and law

enforcement in combating drugs; mass-media policy; and international cooperation, where the preparation for accession and the need for continuous cooperation with the EU and its institutions, including the EMCDDA is seen as a priority. The programme also addresses the need to implement the decisions of the 20th UN General Assembly Special Session. The principal sources of funding for programme activities are the State health fund mainly for prevention activities, the anti-drug fund mainly for NGO activities in the field of rehabilitation and aftercare, and the State budget mainly for ministries or implementation of projects defined in the programme.

Money laundering

The majority of the candidate central and east European countries have implemented anti-money laundering measures. Almost all of them have established a legal, institutional and judicial anti-money laundering framework and a financial intelligence unit either became operational or was further strengthened in the last two years. Furthermore, most of these units have formally been accepted as full Egmont Group⁽³²⁾ members and may thus be considered as both complete in compliance with the EU standards and practices, and to a large extent able to fulfil their future obligations towards the EU.

New anti-money laundering legislation came into force in Romania in 1999 and was passed by the Parliament in Slovakia and Poland in 2000. In 1999, the Bulgarian Law on Banks was amended and an amendment to the money laundering act entered into force in the Czech Republic in 2000.

Summary

Despite the fact that, in general, the legal and institutional framework in the CEECs is in place, the overall capacities to implement the adopted measures effectively, as well as the resources allocated, remain on the whole limited. The low operational level of the national coordination mechanisms in some countries obstructs the effectiveness of policy implementation and there is a deficiency in regional cooperation. In most countries, this affects the capacity of the institutions concerned to tackle the problem and constrains their ability to participate effectively in international cooperation measures designed to

deal with the trans-frontier threats with which both the CEECs and the EU are faced. It is therefore essential that the countries concerned continue to reinforce their policies, institutions and coordination mechanisms and allocate the necessary resources to achieve this. To further boost this process in 2000, the European Commission allocated an additional EUR 1 million to each candidate country for the purpose of developing a specific drug component in their national Phare programmes. Most of these projects will be developed through twinning with EU Member States.

⁽³²⁾ The Egmont Group is an informal organisation established in 1995 with the goal of providing a forum for financial intelligence units (FIUs) to improve support to their respective national anti-money laundering programmes. Currently 53 FIUs are members of the group.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of 12 decentralised agencies set up by the European Union to carry out specialised technical or scientific work.

‘Established in 1993 and operational since 1995, the Centre’s main goal is to provide objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences’.

Through the statistical, documentary and technical information it gathers, analyses and disseminates, the EMCDDA provides its audience — whether policy-makers, practitioners in the drugs field or European citizens — with an overall picture of the drug phenomenon in Europe.

The Centre’s main tasks are:

- collecting and analysing existing data;
- improving data-comparison methods;
- disseminating information; and
- cooperating with European and international organisations and with non-EU countries.

The EMCDDA works exclusively in the field of information.

The EMCDDA online

An online, interactive version of the 2001 Annual report is also available on the Internet (<http://www.emcdda.org>). This version provides links to data sources, reports and background documents used in assembling this report.

Detailed information on drug use in Europe, downloadable publications in all 11 official EU languages, links to specialised drug-information centres in Europe and beyond, and free access to specialised databases can all be found on the EMCDDA website.



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