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for Drugs and Drug Addiction

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DRUGS AND VULNERABLE  
GROUPS OF YOUNG PEOPLE





European Monitoring Centre  
for Drugs and Drug Addiction

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2020

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## Introductory note

Three in-depth reviews of topical interest are published as 'Selected issues' each year. These Selected issues are based on information provided to the EMCDDA by the EU Member States and candidate countries and Norway (participating in the work of the EMCDDA since 2001) as part of the national reporting process.

The three issues selected for 2008 are:

- Towards a better understanding of drug-related public expenditure in Europe
- National drug-related research in Europe
- Drugs and vulnerable groups of young people

All Selected issues (in English) and summaries (in 23 languages) are available on the EMCDDA website:

<http://www.emcdda.europa.eu/publications/selected-issues>

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## Reitox national focal points

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

The contact details of the national focal points may be found at: <http://www.emcdda.europa.eu/index.cfm?nodeid=403>



## Introduction

Social policy in Europe has long identified disadvantaged populations who manifest potential for marginalisation and social exclusion. These 'vulnerable groups' are specific groups among the wider population that may be more prone to a range of problems, from ill health, substance use and poor diet, to lower educational achievement. In the area of illicit drug use, vulnerability (see box, p. 9) and vulnerable groups are gaining increased attention on the European drug policy agenda, particularly as regards young people and drug use. Vulnerability as it relates to drugs is defined in this Selected issue as whether a specific group, based on sociodemographic profile and related risk factors, has an increased susceptibility to drug use and related problems.

Groups identified as vulnerable – examples include 'children in care institutions' or 'homeless young people' – might be prone to earlier, more frequent, or more problematic drug use. They might also experience faster progression to problem drug use. As levels of both current drug use and the risks of developing drug-related problems are likely to be much higher among vulnerable groups, these groups are being given special attention in terms of demand reduction responses.

Identifying these groups is important because direct assessment of drug use at the population level – for example, through large-scale screening – is often not feasible. Furthermore, selecting individuals based on individual risk factors may prove both difficult and problematic. So identifying vulnerable groups is becoming an important tool for directing or channelling policy responses at those groups or geographical areas where problem drug use is more likely to develop. This is particularly the case for those groups which might not perceive their drug use as problematic. In Europe, interventions targeted at vulnerable groups – referred to as 'selective prevention' <sup>(1)</sup> – are gaining both increased policy visibility, and maturity in terms of design and evaluation.

This Selected issue examines aspects of social vulnerability at the group or geographical level in Europe, focusing specifically on young people in the age-group 15-24. There is a need to find more effective ways to approach and involve vulnerable young people in demand reduction interventions, in a manner which reflects their immediate sociodemographic context. The report includes examples drawn from the EDDRA database (see box, p. 12) to illustrate some of the interventions carried out in Europe.

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<sup>(1)</sup> Prevention programmes are placed into a number of categories: (i) 'environmental' strategies, aimed at influencing social, formal and cultural norms about drugs (e.g. alcohol taxes and labelling, smoking bans); (ii) 'universal' programmes which serve the entire population (e.g. school-based programmes); (iii) 'selective' prevention, aimed at specific sub-populations whose risk of a disorder is significantly higher than average, either imminently or over a lifetime and (iv) 'indicated prevention', which identifies individuals with an individual risk of developing substance abuse. For more information, see: <http://www.emcdda.europa.eu/themes/prevention/responses-in-eu>

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## Identifying groups most at risk of developing drug problems

Young people are in general considered to be vulnerable. However, beyond factors based on age alone, there is broad consensus among Member States about specific groups of young people that are especially vulnerable, and this is in line with research on vulnerable groups from Europe and North America <sup>(2)</sup>. Groups that are particularly vulnerable include young offenders, young people in institutional care, early school leavers and students with social or academic problems, and young people who live in disadvantaged families or neighbourhoods where multiple risk factors and problems associated with drug use are concentrated. However, overlaps between these groups may exist. For example, children taken into government care for a particular reason may also be

experiencing other problems, such as problems in the family, juvenile crime, poor school attendance or poor academic performance. Furthermore, there may be cumulative effects of belonging to more than one vulnerability category, which may be associated with an even greater likelihood of drug use.

The number of vulnerable young people in EU Member States, particularly of those who fall into more than one vulnerability category, is a cause for concern in terms of Europe's future drug situation. Socioeconomic inequalities lie at the core of vulnerability, and drug consumption is just one of a number of behaviours – including poor diet and lack of exercise – that may link low socioeconomic status and ill health (Eurothine Project, 2008; Shaw et al., 2007).

### Defining 'vulnerable groups of young people'

For the purposes of this selected issue, 'vulnerability' at the group level is interpreted in a purely sociodemographic sense, i.e. groups that can be described by sociodemographic or geographic characteristics with known concentrated risk factors for drug use. The use of the word 'vulnerable' indicates a group's exposure to social disadvantage or inequality that may result in limited individual choice.

Vulnerability should thus be distinguished from drug-using 'risk groups', e.g. 'heroin users', which usually implies that all members of the group engage in a particular risk behaviour. Settings where drug use is not linked to social exclusion, for example recreational settings <sup>(1)</sup> (e.g. clubs or music festivals) are beyond the scope of this report. Furthermore, a distinction should also be made with issues of vulnerability at the 'intrapersonal' level, for example vulnerabilities linked to an individual's psychological, genetic or behavioural traits, which are not considered

here <sup>(2)</sup>. This distinction is particularly important in the area of prevention: indicated prevention addresses intrapersonal factors, while selective prevention addresses social vulnerability.

When defining group vulnerability, it is vital to underline that membership of a specific group implies no direct causal link to drug use or drug-related problems. Social vulnerabilities are only contextual factors that may moderate, trigger or attenuate young people's underlying psychological, personal and genetic risk factors. Nonetheless, the concept of vulnerable groups helps to identify and quantify the needs of populations who are socially excluded and are at the edge of society, where drug use is more likely to be a problem. Vulnerability in this sense is a proxy for 'susceptibility for drug problems', and is useful in guiding appropriate responses.

<sup>(1)</sup> Drug use in recreational settings was the subject of a 2006 selected issue, see: <http://www.emcdda.europa.eu/html.cfm/index34883EN.html>

<sup>(2)</sup> A body of scientific literature has sought to define social vulnerability factors, such as social exclusion and socioeconomic factors, together with the boundaries to be drawn with 'intrapersonal' risk factors. Examples include Rhodes et al., 2003 and Pearson et al., 2006.

<sup>(2)</sup> See: Rhodes et al., 2003; Najaka et al., 2001, Cannings et al., 2002, Frisher et al., 2007; Edmonds et al., 2005.

European longitudinal studies suggest that adolescent substance use is not a disorder that exists in isolation, but is just one part of an array of problems that adolescents may encounter. An increase or decrease in substance use usually co-occurs with an increase or decrease in other areas of problem behaviours or risk factors <sup>(3)</sup>. Thus, European drug policy has experienced a shift away from drug use alone towards social factors that may aggravate, predict or accelerate related health problems. Furthermore, recognising the role of social factors in vulnerability helps us to understand that drug use among vulnerable groups may

be the result of restricted or impaired individual choice, rather than a free personal decision to use drugs.

Selective prevention is based on the premise that vulnerable groups can be identified by simple social and demographic characteristics, and that these groups can receive interventions that reduce the risk of their potential future problem drug use. These interventions attempt to identify those who are vulnerable to drug-related problems – independent of their level of current drug use – and to intervene at the earliest opportunity <sup>(4)</sup>.

## Other publications on vulnerable groups in the EU

The concept of vulnerability has been addressed before in a number of publications produced by EU institutions and the EMCDDA:

- Drugs in focus 10, a policy briefing published by the EMCDDA entitled 'Drug use amongst vulnerable young people'. <http://www.emcdda.europa.eu/html.cfm/index33727EN.html>
- Sections on 'Selective prevention' in the EMCDDA Annual report on the state of the drug problem in Europe, published each year in November. <http://www.emcdda.europa.eu/publications/annual-report>
- A 2003 EMCDDA report entitled 'Selective prevention: First overview on the European situation'. <http://www.emcdda.europa.eu/html.cfm/index1569EN.html>
- A chapter entitled 'Drug and alcohol use among young people' in the EMCDDA's 2003 Annual report on the state of the drug problem in Europe. <http://www.emcdda.europa.eu/html.cfm/index37261EN.html>
- Council Resolution 5034/4/03 of the Council of the European Union entitled 'Resolution of the Council on the importance of early intervention to prevent drug dependence and drug related harm among young people using drugs' (13 June 2003).
- A 2008 Flash Eurobarometer survey (No 233) entitled 'Young people and drugs, commissioned by the European Commissions DG Justice, Liberty and Security'. [http://ec.europa.eu/public\\_opinion/flash/fl\\_233\\_en.pdf](http://ec.europa.eu/public_opinion/flash/fl_233_en.pdf)

<sup>(3)</sup> See also: Bolognini et al, 2005 and McCrystal et al, 2006.

<sup>(4)</sup> See: UK NICE, 2007; Roe and Becker, 2005; Edmonds et al., 2005; Canning et al., 2002. For more information on specific projects in Europe, see <http://www.emcdda.europa.eu/themes/prevention/responses-in-eu> and <http://www.emcdda.europa.eu/html.cfm/index1569EN.html>.

## Monitoring vulnerability in Europe

Standardised European definitions of vulnerability or vulnerable groups as they relate to problem drug use (e.g. 'ethnic group' or 'truant') do not yet exist. Moreover, the factors that make a certain group vulnerable may vary from one Member State to another, and within regions of Member States. In addition, people belonging to one vulnerable group are often afflicted by other vulnerability factors, and vulnerable groups often overlap. Due to the different methodologies used when studying socioeconomic conditions, prevalence measures of vulnerability factors vary substantially between reporting countries. Furthermore, the number of young vulnerable individuals cannot be estimated based on surveys among the general population, because those who are most vulnerable may be the least likely to be reached by population-based surveys, and/or complete questionnaires.

Some estimates are, however, available from some countries regarding the size of their vulnerable young populations. Denmark, for example, provides a rough estimate that 15-20% of young people may be considered vulnerable, while Norway reports that around 2% of children may have a high risk and further 5-10% may have a moderate risk of developing severe behavioural problems, problem drug use included. Most commonly, the numbers of vulnerable young people that are reported by Member States refer to the number of young people in government care institutions and young offenders.

### Methodology: how the EMCDDA monitors interventions for vulnerable groups

Monitoring of vulnerable groups in Europe is carried out periodically, and experts or expert panels from 30 reporting countries submit ratings to the EMCDDA in structured questionnaires. Currently, interventions for vulnerable groups are monitored on three levels across reporting countries, based on: (i) policy importance, for example mentions of vulnerable groups within national drug policy documents (ii) reports on the extent of intervention provision (see Table 1), and (iii) the delivery mode of interventions (see Figure 1, p. 29). Countries currently provide qualitative ratings on these three levels. However, information on the coverage, adequacy and contents of interventions is not yet systematically monitored. Some descriptions about specific projects are available in Reitox national reports<sup>(5)</sup> and in the evaluated interventions inserted in the EMCDDA's EDDRA database (see box, p. 12).

Data are also collected on the delivery mode used to reach vulnerable groups, which may depend on the healthcare systems of the individual reporting countries. Countries are assessed on whether each vulnerable group, respectively, is predominantly approached (i) via office-based services and institutions, or (ii) using a more proactive approach, such as

**Table 1: How countries report the provision of interventions for vulnerable groups, and the consideration given to them in national policy documents**

|                             | Priority or mentioned in policies | Not mentioned in policies |
|-----------------------------|-----------------------------------|---------------------------|
| Full or extensive provision | Maximum consideration             |                           |
| Limited provision           |                                   |                           |
| No or rare provision        |                                   | Minimal consideration     |

*Note:* This simplified view allows us to identify (i) countries that place a high emphasis on addressing the needs of vulnerable groups, i.e. countries with maximum consideration, which report 'high priority' and 'full or extensive provision', and (ii) countries where the needs of vulnerable groups may be unmet, i.e. countries with minimal consideration which report 'low priority' and 'no or rare provision'. At this time, almost half of the 30 reporting countries report minimal consideration for most vulnerable groups. Information about the extent of provision at the national level according to specific vulnerable groups can be found later in this report.

<sup>(5)</sup> National reports are produced by Reitox national focal points each year, and are available at: <http://www.emcdda.europa.eu/publications/national-reports>

outreach programmes to provide services at home or through street-work. Finally, vulnerable groups may be placed into the following three categories based on their social context:

institutionalised (those in school, young people care or criminal justice system); families; and special populations within communities.

### **EDDRA: the Exchange on Drug Demand Reduction Action**

Details on the contents, acceptance and outcomes of interventions aimed at vulnerable youth are not systematically monitored. Some of them are available in Reitox national reports, or in the Exchange on Drug Demand Reduction Action (EDDRA) <sup>(1)</sup>. EDDRA is an information system maintained by the EMCDDA that presents information on interventions that have been implemented and evaluated in Member States and Norway. The system aims to generate European evidence of effectiveness of projects implemented in real-world settings. All projects in EDDRA are categorised according to three quality levels based on a point system. Points are assigned according to (i) the extent to which

evaluation components logically link to each other (e.g. how objectives are connected to indicators), (ii) whether the project is theory-based, and (iii) whether a needs assessment was carried out before implementation. The type of evaluation design or the instruments used are among additional criteria also considered. Based on this point system, projects are categorised as 'evaluated' (level 1), 'promising projects' (level 2), or 'top level' (level 3). As of May 2008, classification of all EDDRA projects according to the three quality levels revealed that 90.3% (438 interventions) were classified as quality level 1, 9.3% (45 interventions) as level 2 promising projects and only 0.4% (2 interventions) as level 3, top level projects.

<sup>(1)</sup> For more information on EDDRA, see: <http://www.emcdda.europa.eu/themes/best-practices>

## Building resilience to drug problems

### Protective and resilience factors: a key for response policies

Interventions among vulnerable and socially-excluded groups recognise that drug use is just one behaviour among other developmental problems for vulnerable people. Thus, the rationale of many responses is to improve the personal skills and resources of vulnerable people or groups (i.e. increase resilience), so that they may better cope with their adverse social conditions.

Risk and protective factors are context-dependent and influence people for a variety of reasons. Some, such as gender and ethnicity, are permanent and cannot be changed. Others, such as social conditions, are difficult to change. Ideally, response policies would address the underlying problems of social exclusion – for example homelessness, family problems, educational inequalities – together with drug use.

While adverse social conditions may be hard to change, intervention on the individual level (personal coping), on the family level (parenting styles) or on the community level (community cohesion and community organisation) may nonetheless provide protection. Such personal, familial or community protection against adverse social conditions is termed ‘resilience’<sup>(6)</sup> (Dillon et al., 2007). Resilience results from a complex interplay of factors which can be conceptualised as inter-related thinking styles and behaviours – such as the views that ‘drugs are not for me’ and ‘drugs are incompatible with my personal goals’ – together with interpersonal skills and the ability to resist (Brown, 2007). In this regard, many intervention strategies are based on the ‘Social Development Model’ of Hawkins and Catalano<sup>(7)</sup>. This model suggests that vulnerable young people need to have meaningful opportunities to feel lovable, capable and important. The skills required to take advantage of these opportunities, and related messages, need to be continually

reinforced for a long-lasting effect. The model focuses on protective factors that can help young people to develop the resilience needed to resist drug use even under adverse social conditions.

### Resilience at the individual level

As is the case for all young people, simply providing vulnerable young people with information alone is not effective per se in changing drug – related behaviours or attitudes (Roe and Becker, 2005), in particular because vulnerable young people sometimes already show considerable substance use. Instead, interventions which are not restricted to addressing drug use alone have proven to be more effective, because they also address relevant needs that are connected to drug use (Steiker, 2008).

Preventive interventions aiming to increase attachment and commitment to school are often accompanied by reductions in problem behaviours (Najaka et al., 2001). Similarly, interventions are effective when they address motivation, skills, and decision-making as well as erroneous normative beliefs – in a similar way to effective universal interventions (Sussman et al., 2004). Effectiveness in interventions has also been linked to programmes that offer strong behavioural life skills development, interpersonal communication methods, and introspective learning approaches focusing on self-reflection (Sale et al., 2005; Springer et al., 2004). The most effective programmes to reduce substance use among vulnerable young people are based upon a clearly articulated and coherent programme theory, and provide quality contact with young people.

Prevention interventions among vulnerable young people need to adapt to their experiences and avoid rigid abstinence-oriented messages. When such adaptations are made, programmes targeting general young people are

<sup>(6)</sup> Resilience is sometimes used interchangeably with ‘resiliency’ in the literature.

<sup>(7)</sup> For more information, see the EMCDDA’s Prevention and Evaluation Resources Kit (PERK): <http://www.emcdda.europa.eu/?nNodeID=9824>

also effective among vulnerable young people (Steiker, 2008; Jalongo et al., 1999). By these means, selecting and grouping together vulnerable young people with problem behaviour in school or other settings should be avoided. Avoiding such grouping for prevention interventions will also prevent often documented counterproductive effects, like norm narrowing and deviance modelling, that might even increase drug use<sup>(8)</sup>.

## Resilience at the family level

The risk conditions of families – including problem substance use, conflict, neglect, lack of parental monitoring, lower levels of interaction between young people and their families and social disadvantage – are also known to increase the risk of problem drug use for their offspring. While lack of parental monitoring can occur both in single-parent and in economically affluent families, parental discipline and monitoring, and family cohesion, all play an important protective role<sup>(9)</sup>.

Interventions on the family level are based on the notion that increasing parental involvement and monitoring appear to be among the most effective strategies among vulnerable young people to increase resilience and decrease vulnerability to risk factors. Family-level prevention programmes not only aim to increase parental supervision but they also strive to develop strong connections between young people and their family, peers and school (Sale et al., 2005). Effective programmes for vulnerable families employ techniques that overcome key obstacles for attracting and involving often hard-to-reach families by, for example, offering food, financial incentives, transport and babysitting, and family home visits<sup>(10)</sup>. Many of them are based on the United States-based ‘Strengthening Families Program’<sup>(11)</sup>. In this context, prevention interventions aim to reduce pathways to drug-related harm by working with vulnerable families to improve conditions for healthy development from the earliest years all the way through adolescence. However, in contrast to individual-level interventions where both

vulnerable and non-vulnerable young people can benefit from the same programme, family-level interventions might not demonstrate benefits where they are applied more universally to include families with low rates of child development problems (Toumbourou et al., 2007).

## Resilience at the community level

Community-level programmes aim to increase resilience in deprived and marginalised neighbourhoods by improving the general social environment of children, and by increasing community cohesion and group identity. Resilience can be strengthened by improving interpersonal communication, social skills, expression of feelings, and social support through community mobilisation, by reaching out to families in need. Intervention studies with these components – implemented through community mobilisation, parent and youth training, early intervention services and follow-up case management – have shown positive effects on young people and family resilience, and also moderating effects on onset and frequency of alcohol and drug use (Johnson et al., 1996). In addition, organised community involvement – through community coalitions, after-school activities and facilities or student organisations – were associated with lower smoking and binge drinking (VanderWaal et al., 2005). Most controlled studies and theory frameworks, especially comprehensive community interventions, are, however, of American provenance<sup>(12)</sup>.

Selective prevention is based on the premise that we can identify those vulnerable groups by simple social and demographic characteristics and deliver interventions that reduce the risk of their potential future problem drug use. These interventions strive to identify those who are vulnerable to drug problems (independent of their level of current drug use) and intervene at the earliest opportunity<sup>(13)</sup>. This section presents information on responses at the Member State level, ordered in terms of how easily to accessible a specific vulnerable group might be.

<sup>(8)</sup> Authors on this issue include Dodge et al., 2006; Dishion et al., 1999; Mager et al., 2005; Poulin et al., 2001.

<sup>(9)</sup> The role of parental discipline and monitoring, and family cohesion in the drug use of children is a much-studied topic. See: Petrie et al, 2007; Sale et al, 2005; McArdle et al, 2002; Velleman and Templeton, 2007. Further information on parent-focused programmes in individual Member States can be found in Reitox national reports.

<sup>(10)</sup> See: Kumpfer et al, 2003; Kumpfer and Johnson, 2007.

<sup>(11)</sup> <http://www.strengtheningfamiliesprogram.org/>

<sup>(12)</sup> See: Yabiku et al., 2007; Dzierzawski et al., 2004; Dedobbeleer and Desjardins, 2001; Johnson et al., 1996.

<sup>(13)</sup> See: UK NICE, 2007; Roe and Becker, 2005; Edmonds et al., 2005; Canning et al. 2002.

## Identifying and responding to the needs of vulnerable groups in the EU, Norway, Croatia and Turkey

### General responses in policies and legislation

Of the reports analysed, 13 countries reported primary legislation that in some way referred to vulnerable groups of young people. The laws reported can be classified into two broad types: (i) those setting out the definitions of certain groups, and (ii) those establishing certain responses, either general or specific responses. The laws usually refer to vulnerable groups or vulnerable young people in general, but rarely focus on a specific subset of vulnerable young people. It is noteworthy that similarities in the titles of laws across countries – e.g. social codes, child protection laws – are not always reflected in similarities in the contents of these laws.

The term ‘vulnerable young people’ may be defined differently in the laws of different countries. The Danish Social Services Act provides various definitions of socially vulnerable groups. In Poland, the Act of Law on Welfare Benefits defines homelessness, and in Romania an order approving the action plan for reinsertion of street children defines homeless children as children who live permanently in the streets and have no connection with their family. Definitions of minorities are also addressed through general equality legislation, for example in Cyprus.

Policy responses reported in national legislation range from the general to the specific. In Romania, the Law on Children’s Rights Protection and Promotion lays down social impact measures, specifying the right of children to optimal health and to information on the harms of substance abuse and drug-related infectious diseases. The law also provides care and counselling to children and their families. The United Kingdom’s Children’s Act aims to coordinate various child welfare actions and strategies. The new Child Welfare Act in Finland aims to systematise community child welfare interventions, and to take a stronger role in prevention by lowering the threshold for issuing a child protection report. It also emphasises the need for placing a child, where necessary, within the network of family or friends rather

than with strangers. Austria is the only country that reported some sort of protection of vulnerable groups in its main drug control legislation, where a requirement for offering help to school students is written into the Narcotic Substances Act. This requirement states that heads of school are obliged to offer students suspected of using drugs to be tested by school experts, and if the student accepts to be tested it absolves the school of any obligation to report the student to the authorities. If the student tests positive, treatment or counselling referral is offered. This measure is aimed to prevent marginalisation.

Laws also touched on the requirements of care institutions. While Germany reported that the notion of vulnerability in connection with social inequality and addiction is still relatively new, the federal Social Code sets out legal regulations of inpatient help for those children who can no longer stay in their parents’ homes. The Länder then implement this inpatient help. In Bulgaria, the Supplementary Provisions to the Child Protection Act define the concept of ‘specialised institutions’ as being ‘boarding-house type of homes for upbringing and educating children, where they are permanently separated from their home environment.’ In Turkey, a decree defines ‘children and youth centres’ for those children living outdoors for various reasons. In Poland, regulations from the Ministry of Health govern the sheltering of minors in public health care units, indicating one facility with heightened security and six public inpatient units for addicted minors. Another regulation from the Polish Ministry of Education includes the provision that youth development facilities may require the use of special educational techniques and working methods for young people who suffer from addiction.

Countries also reported that some laws exist that govern the difficult phase of transferring young people to or from such institutions. In Romania, for example, institutionalised children are obliged to leave the child protection system at age 18, and approximately 5 000 young people leave the system

each year. As a response to this problem, a decision by the Romanian Government in 2006 approved the national strategy for the social inclusion of young people leaving the protection system. According to this decision, children who had been institutionalised for re-education or detention, or for being homeless, are supported in their transition to responsible adult life. A law with a similar objective was

passed in Northern Ireland in the UK in 2002, though this law is not limited to those children leaving care due to attaining the age of majority. Lithuania reported even more specific legislation, approving guidelines to assist children returning to schools who had been absent due to social or psychological difficulties.

## Vulnerable young people with ties to institutions

### Early school leavers and truants

#### Definition and national studies

Numerous school surveys and reports from problem drug users have shown a strong correlation between truancy and drug use. In Ireland, for example, 26% of surveyed problem drug users report having left school before the age of 15, and, in school surveys, students with high rates of unauthorised absenteeism from school have considerably higher prevalence of drug use than those who attend school regularly. In addition, both truancy and drug use are highly correlated with poor academic achievement, leaving school early, behavioural and social problems, and the ratio of males in these groups is generally much higher than that of females.

Lithuania, Romania, Netherlands, Slovakia and Poland all report concerns about high or growing numbers of students who have not attended school or who have been excluded from school due to discipline problems. Finland reports concern about a higher proportion of students who require special needs teaching. Comparable estimates from the 1999 ESPAD school surveys<sup>(14)</sup> show that truancy, defined as having unauthorised absence from school for more than three days during the last 30 days, ranged from 3% to 24%. Studies also show that 44% of outpatient clients entering treatment in 2006 have completed only primary education. There are, however, substantial differences between countries in terms of the level of education among drug users.

#### Prevention and care

Early school leavers or truants are given maximum consideration in four and minimal consideration in 11 of 30 reporting countries. Outreach services are reported as more common settings for delivery in eight, while office-based services are reported as more common in 17. The predominance of office-based services, even though truants

may have given up school, suggests there may be a need to also approach them outside of school settings.

There is little information provided about the contents of interventions targeting early school leavers. As a general approach, several countries have alternative curricula in place, but only Ireland, Slovakia and the United Kingdom specifically make references to interventions provided in the framework of drug prevention strategies. An example is reported in Germany, where the German 'Jugend Institut' organised a network of projects within the framework of the programme 'Promoting Skills – Vocational Qualification for Target Groups with Special Promotional Needs'. In this project, young people, social workers and schools joined forces to counteract 'school fatigue' and refusal to attend school.

#### Pupils with academic or social problems

Pupils with academic or social problems are a vulnerable group that can be approached at school, and this group has a high risk of dropping out of school. This group is given maximum consideration in eight and minimal consideration in five countries. Outreach strategies are reported as being more common in five countries, and office-based strategies are more common in 18 countries.

In several Member States (Belgium, Czech Republic, Germany, France, Slovakia, Slovenia, Finland) there are pedagogical-psychological counselling offices for pupils with academic or social problems. These counselling offices focus on working with children, parents and teachers, and use both individual and group counselling to focus on personality and social behaviour development. Counselling aims to prevent school failure, and to correct learning and behavioural disorders. The main objective of other interventions is to prevent further social marginalisation. In Germany and Austria, specific programmes ('Step-by-Step')

<sup>(14)</sup> ESPAD, the European School Survey Project on Alcohol and Other Drugs, carries out school surveys to estimate drug and alcohol use among the general population of students aged 15–16 years. Truancy results are provided in Table 48 of the 1999 ESPAD report, see: <http://www.espad.org/documents/Espad/>

assist teachers in identifying and helping students who show distress or use drugs<sup>(15)</sup>. Another example in EDDRA is a promising intervention in Ireland called STAY (the St. Aengus Stay-In-School Young People Project), which targets pupils with academic or social problems<sup>(16)</sup> between the ages of 10 and 14 who are at risk of dropping out of school. The project offers a range of activities including after-school homework clubs, cultural, social and sports events. Evaluation demonstrated that all of the young people who joined the project were still within the formal education system two years later.

## Children in care institutions

### Definition and national studies

Drug-taking was found to be strongly correlated with being in institutional care and being homeless. In Slovakia, a survey of 425 young people aged 15–19 in 36 selected government care institutions found that over 30% had ever used an average of 10 different drugs. By contrast, only 17% of students in a school survey of 15–17-year-olds reported having ever used an average of only four different drugs.

Estimates of the number of young people in institutional care are not comparable across reporting countries due to differences in definitions and measures used for assessment. For example, some countries report percentages, others absolute totals etc. Denmark reports that approximately 1% of children have been put into care away from home at some point in their lives. In Germany, 0.26% of young people live in care or in assisted homes. In Greece, 0.03% of children under the age of three are placed in residential care. In Hungary, 17 456 children were in the care of local government authorities in 2005 (equivalent to 1.1% of the population under 15). In 2006, in Bulgaria 0.45% of young people were reported to be in full-time government care, in Poland 0.5%, in Romania 2.3%, in the United Kingdom 1% and in Finland 2.4%<sup>(17)</sup>.

### Prevention and care

Children in the care of the local authority (excluding prisons) receive maximum consideration in 10 and minimal

consideration in nine of 30 reporting countries. Outreach services are reported as more common in four, and office-based services are reported as more common in 21 countries. The United Kingdom is an example of several countries, where the education and other needs of children both within and leaving foster care are addressed at least at the policy level. Limited information is available, however, about the implementation of such policy. Slovakia aims to promote forms of surrogate family upbringing, which improve the emotional lives of children in foster care and reduce the effect of being institutionalised. Other interventions are aimed at children and young people in children's homes, especially at re-education homes, with the goal to increase the social and communication skills, and the self-esteem, of children and young people. EDDRA contains no examples of evaluated interventions for children in care institutions.

## Young offenders

### Definition and national studies

Estimates of the number of young people registered as having committed a criminal offence are also limited, due to different age definitions and recording systems. Italy reported 5 985 young offenders, Luxembourg reported 1 701, Poland reported that the number of young offenders had risen to 53 783, Slovenia reported 3–4 000 cases of crime by young offenders a year, and Bulgaria reported 15 969 minors registered for begging and robbery. The United Kingdom reported 3 424 young offenders aged 15–17 in custody and 85 467 young people in contact with youth justice.

### Prevention and care

Young offenders – mostly those offending against drug laws – receive maximum consideration in seven and minimal consideration in six of 30 reporting countries. Outreach services are predominant in two countries, and office-based services are reported as more common in 24 countries. By definition, young offenders are identified and targeted within a fully institutional context. However, in Ireland and the United Kingdom they are also followed-up by groups of street workers<sup>(18)</sup>.

<sup>(15)</sup> In Germany: [http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project\\_id=5957](http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=5957). In Austria: [http://www.emcdda.europa.eu/html.cfm/index-52035EN.html?project\\_id=36](http://www.emcdda.europa.eu/html.cfm/index-52035EN.html?project_id=36)

<sup>(16)</sup> [http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project\\_id=2247](http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=2247)

<sup>(17)</sup> Percentages calculated on demographic data found in Eurostat by age group, i.e. young people 15–24 years, by country and year.

<sup>(18)</sup> See <http://www.yjb.gov.uk/en-gb/yjs/YouthOffendingTeams/>

In almost all Member States there are provisions that underage drug law offenders should be provided with alternatives to imprisonment or penal sanctions. There are, however, important differences in the practical implementation of these alternatives. Young offenders in need of drug treatment are usually referred to community drug treatment services (e.g. in Ireland, Greece, Latvia, Slovenia and Finland), although some countries report limited appropriateness or effectiveness of such programmes. In some Member States, special treatment services are available for young offenders, one example being the Young Offenders Unit Rehabilitation Services ('YOURS') in Malta. In the majority of countries alternatives to penal sanctions are discussed with the offenders, criminal justice staff, and social workers or therapists (Italy, Portugal, the Netherlands). Clearly structured intervention protocols that allow for evaluation and controlled implementation exist only in Germany<sup>(19)</sup>, Luxembourg and Austria, and the evaluations of these programmes have yielded positive results.

An example of an effective prevention program among young offenders is the Austrian project 'Way out'<sup>(20)</sup>. This targets young offenders and is classified as a promising project in EDDRA. 'Way out' is a structured intervention offered over a period of approximately six months, with the aim to encourage abstinence from illicit drugs and limited consumption of licit substances, thereby avoiding problems related to drugs. It offers individual and group counselling and care facilities. A process and outcome evaluation with a pre- and post-test design carried out in 2004 revealed that 89% of clients showed an improvement, and 54% of clients became drug-free. While the programmes described above address young offenders in general, international experience shows that court-mandated treatment is effective even for young offenders with personality disorders (Daughters et al., 2008).

## Vulnerable families

### Definition and national studies

Despite a lack of common European definition vulnerable families can be considered as families where one or more members abuse alcohol and/or drugs, and/or families with

high levels of parental conflict and violence, poor quality of relations and/or serious economic problems.

Consensus exists in the scientific literature and in Reitox national reports that children living in vulnerable families are at greater risk of developing psychological and social problems, including drug use. These additional risk factors may exacerbate children's risk status and facilitate the development of their drug use<sup>(21)</sup>. Although research has been carried out on the role of genetic factors as they relate to vulnerability to drug use, as this report focuses on social vulnerability, the influence of genetic factors is not covered here.

Studies from Member States most frequently reported the following factors to be associated with drug use among children: drug and alcohol abuse among parents, substance use of older siblings, lack of parental supervision, low quality of family relations and problematic economic conditions (Velleman et al., 2005). European and international research indicates that children of drug-dependent parents have an increased risk of substance use, abuse, and dependence in later adolescence (Sumnall et al., 2006). The German data estimated that there are 2.5 million children and adolescents living in families with an alcohol problem (German national report).

New findings from the Health Behaviour in School-Aged Children (HBSC) study<sup>(22)</sup> indicate that weekly tobacco smoking is associated with lower family affluence in most countries. This association is strongest for female students in northern Europe. Contrarily, higher family affluence is significantly associated with weekly drinking and trying cannabis in around a third of the countries surveyed, particularly in eastern and central Europe. These differences highlight the need for better understanding about factors that influence patterns and trends as they relate to different types of substance use.

In European countries, between 50% and 70% of current problem drug users report that one or both parents abused alcohol or drugs. However, the causal relationship between drug/alcohol abuse in the family and the drug use of children is unclear. Besides substance use in the family, other factors, such as peer drug use and stressful life events, may play an important role in such relationships (Hoffmann and Su, 1998).

<sup>(19)</sup> [http://www.lwl.org/LWL/Jugend/lwl\\_ks/Projekte\\_KS1/FreD/FreD-Basics](http://www.lwl.org/LWL/Jugend/lwl_ks/Projekte_KS1/FreD/FreD-Basics)

<sup>(20)</sup> [http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project\\_id=5038](http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=5038)

<sup>(21)</sup> See Velleman and Templeton (2007), and EMCDDA 2003 Annual report section, p. 65, on 'Social exclusion': <http://www.emcdda.europa.eu/html.cfm/index-37257EN.html>

<sup>(22)</sup> <http://www.hbsc.org>

In addition to the drug problems of parents, drug use among older siblings is another vulnerability factor which may increase the risk of drug-taking among children. There are several reasons for this. Children who see the older sibling using substances may have low risk perception, and may also wish to imitate the older brother or sister. In addition, ESPAD findings suggest that children with a substance-using sibling may also live in vulnerable families and/or in marginalised social environments (Hibell et al., 2004), sharing the same risk environment.

The number of children in Europe that currently live in substance-using families is unknown, but some countries

have produced estimations at the national level. However, definitions of 'addicted' and 'drug-using' parents differ across Member States, and the important role of drug-using siblings is often not considered in these statistics. This makes it difficult to assess across Member States the role that illicit drugs and alcohol play in destabilising families. Nonetheless, these estimations show that a large number of children have drug and alcohol abusing parents, and that alcohol may play a larger role. Table 2 provides estimates of the number and percent of children living in families with alcohol and/or drug problems. The table illustrates the need to disentangle the different definitions of substance use, including the role of illicit drugs and alcohol.

**Table 2: Estimates of number of children with one or both parents with alcohol/drugs related problems in the population aged under 20 years**

|  | Denmark                | Finland               | Germany                            | Poland                             | United Kingdom                 | Norway                 |
|--|------------------------|-----------------------|------------------------------------|------------------------------------|--------------------------------|------------------------|
| <b>Population under 20 (as of 1st January 2007)</b>                                  | 1 336 974              | 1 226 528             | 16 203 730                         | 8 810 480                          | 14 728 786                     | 1 214 201              |
| <b>Children with one or both parents abusing alcohol</b>                             | 140 000 <sup>(1)</sup> | 70 000 <sup>(3)</sup> | 5 000 000–6 000 000 <sup>(4)</sup> | 1 500 000–2 000 000 <sup>(6)</sup> | NA                             | NA                     |
| <b>Children with one or both parents using drugs</b>                                 | 3 000 <sup>(2)</sup>   | NA                    | 30 000–40 000 <sup>(5)</sup>       | NA                                 | 250 000–350 000 <sup>(7)</sup> | NA                     |
| <b>Children with one or both parents abusing drugs and alcohol</b>                   | 143 000                | NA                    | NA                                 | NA                                 |                                | 200 000 <sup>(8)</sup> |
| <b>% of children with alcohol abusing parents among population under 20</b>          | 10.5 %                 | 5.7 %                 | 15.4 %                             | 17–23 %                            | NA                             |                        |
| <b>% of children with drug using parents among population under 20</b>               | 0.2 %                  | NA                    | 0.2 %                              | NA                                 | 1.7–2.4 %                      | NA                     |
| <b>% of children with drug and alcohol abusing parents among population under 20</b> | 10.7 %                 | NA                    | NA                                 | NA                                 | NA                             | 16.5 %                 |

<sup>(1)</sup> in families with alcohol problems

<sup>(2)</sup> with a parent having custody of the children

<sup>(3)</sup> with parents with excess alcohol use

<sup>(4)</sup> with alcoholic parents

<sup>(5)</sup> drug dependent parents

<sup>(6)</sup> parents suffering from alcohol addiction or abuse alcohol

<sup>(7)</sup> children with one or both parents with serious drug problems

<sup>(8)</sup> children with parents using drugs and/or alcohol or with mental problems

N/A data not available

Source: Reitox national focal points

European data on people entering treatment for drug use can provide an indirect estimate of the proportion of children with drug-using parents. In countries where information about the living arrangements of clients in drug treatment is available, data show that about 31 000 (14%) out of the 220 000 clients who entered outpatient or inpatient drug treatment in 2006 live with one or more children<sup>(23)</sup>. However, these figures need to be interpreted with caution. First, numbers are underestimated because data were not reported from all treatment centres in Europe. Second, mothers in particular may be underrepresented in drug treatment, largely because of their role in caring for children. Third, some patients will have been forced to put their children into care. In addition, numbers are based only on people entering drug treatment and not on all clients currently in treatment, and also on clients living with children and not on all clients who have children. Finally, the figures include all clients entering drug treatment regardless of the primary drug of use, and do not differentiate between problem drug users<sup>(24)</sup> and treatment clients using drugs not included in the problem drug use definition (e.g. cannabis).

### Prevention and care

While 13 countries report that their family-based prevention is predominantly selective (i.e. it mostly targets vulnerable families), important risk conditions of families are not addressed. Only seven of 30 reporting countries report full or extensive provision of interventions for substance abuse in the family, five countries for family conflict and neglect, four countries for social disadvantage (e.g. unemployment), criminal justice problems or marginalised ethnic families, and three countries for families with mental health problems. However, generic programmes, i.e. programmes not related to drug prevention policies, may be in place for these vulnerable groups in these countries. In the majority of Member States – between 17 and 25 countries, depending on risk condition – these types of vulnerable families are not explicitly mentioned in drug policies.

The contents of many prevention projects aimed at vulnerable families concentrate on increasing awareness about the health-damaging effects or the risks of consuming substances at a young age, and providing immediate help when necessary. Examples of such programmes include 'Stop – and go!' in Germany<sup>(25)</sup>, and 'Bouncing Back!'<sup>(26)</sup> in the United Kingdom.

Some interventions attempt to achieve close networking between existing aid programmes and partners from a wide range of action fields. These networks approach hard-to-reach families by, for example, providing young people with work, help facilities for young people, school work and social work in schools. These offer police and juvenile court aid as well as enlisting the help of general practitioners and hospitals (Mir, 2005). Such aid networks are multifaceted in a way that they also aim to prevent other problem behaviours, such as violence.

Most interventions for vulnerable families, however, are not evaluated and have no sound theory framework, thus very little information on effectiveness is available. In addition, most Member States tend to report a predominant focus on families with drug use problems. This may be attributed to the professional bias of treatment services, or to the fact that families with a substance abuse problem are easier to approach and identify<sup>(27)</sup>. Interventions for socially disadvantaged families are reported, albeit to a lesser extent, in Germany<sup>(28)</sup>, Lithuania, Poland and the United Kingdom, where children growing up in low-income families are provided with more favourable conditions – for example, material goods, breakfast, lunch and food during summer vacations – for their education in general schools. Interventions based on the Strengthening Families model are being implemented and evaluated in Ireland, Spain (Balearic Islands and Catalonia), the Netherlands, Portugal and Sweden.

<sup>(23)</sup> See the EMCDDA's 2008 Annual report and statistical bulletin, table TDI-14 (part ii) and (part iv): <http://www.emcdda.europa.eu/html.cfm/index52945EN.html>

<sup>(24)</sup> The EMCDDA defines problem drug use as intravenous drug use (IDU) or long duration/regular drug use of opiates, cocaine and/or amphetamines. Ecstasy and cannabis are not included in this category.

<sup>(25)</sup> See: <http://www.caritas-ulm.de/34318.html> and <http://www.fitkids-wesel.de>

<sup>(26)</sup> [http://www.adfam.org.uk/index.php?content=our\\_work\\_fsupp&include=no](http://www.adfam.org.uk/index.php?content=our_work_fsupp&include=no)

<sup>(27)</sup> See also: <http://www.vulnerablepeople.org/manual.html>

<sup>(28)</sup> For example, the German project 'Eltern-AG' aims to contribute to an improvement in the child-raising skills of parents. The project promotes the social and educational skills of parents while fostering the emotional, cognitive and social development of children during the first seven years of their lives, alleviating risk factors associated with certain socio-economic strata and stimulating the formation of neighbourhood networks of parents. 'Eltern-AG' has the potential to have an impact beyond the project itself by encouraging autonomy and self-help skills. The project receives support from social scientists and has been given a 'good practice' label. For more information, see <http://www.eltern-ag.de>

In the United Kingdom the 'Families First Project' <sup>(29)</sup> helps families with problematic drug and/or alcohol use where there is a likelihood of children being removed from the family by the local authorities. It offers multi-disciplinary services, incorporating adult and children's services, and offers assessment, intervention and a family support package. The project helps families to make changes to their lifestyle which are necessary to ensure the safety and stability of the child within the home environment. Evaluation after six months of follow-up showed that none of the children who participated in the project entered into a children's home or foster care outside of the family. In addition, compared to the baseline, parents reported using illicit drugs half as often at the sixth-month follow-up, and parents reported significantly less arguing and fighting.

In Finland, special attention is given to substance-using mothers and pregnant women. Mother-and-child homes have been set up which combine child welfare and treatment services, while several maternity clinics dedicated specifically to substance-using pregnant women are available. Norway and Sweden have been implementing and evaluating multisystemic therapy (MST) programmes for vulnerable families. An example of MST is the 'Parent Management Training - the Oregon Model' (PMTO), which

is an intervention program targeting children aged four to twelve. Evaluation of this randomised control trial shows that PMTO reduced externalising problems and increased social competence and parental discipline, and had other positive effects. Municipal services are currently in the process of implementing this method.

A 'promising' intervention according to EDDRA criteria is the Portuguese project 'Searching for family treasure' <sup>(30)</sup>, a selective family prevention programme targeting vulnerable families with children aged between six and 12 years old. One key objective is to support vulnerable families by reducing social isolation and the impact of social and economic conditions, strengthening the social support network, and promoting family management skills. The project includes several modules such as crisis intervention, parents' groups and teaching packages. In 2003, an outcome evaluation with pre-and post-test design demonstrated positive results. For example, there was a statistically significant increase in the capacity to develop autonomy among the children and an observed improvement regarding the emotional expression of children, i.e. increased emotional regulation, self esteem and social skills, and decreased psychopathology.

<sup>(29)</sup> <http://www.standards.dfes.gov.uk/sie/si/eips/casestudies/fam1st>

<sup>(30)</sup> <http://www.idt.pt/id.asp?id=p3p682p686>

## Vulnerable populations in the community

### Homeless young people

#### Definition and national studies

Homeless people are defined as persons who do not have or are at risk of losing stable accommodation. This can range from rooflessness or 'sleeping rough' to living in bed and breakfast accommodation and hostels. Homelessness is usually associated with social exclusion, which includes poor and unhealthy living conditions, unemployment, low education, socially disadvantaged background, poor physical and mental health, and substance use. The association between homelessness and problem alcohol and drug use is largely recognised in the literature (e.g. Fountain et al., 2003). Homeless people using drugs and/or alcohol may have started substance use after becoming homeless, or they may have become homeless after starting to abuse alcohol/drugs. In some studies substance use is reported to be the second most common reason for becoming homeless (UK Department of Health et al., 2003). Alcohol is the most frequent substance used, but other drugs are also often consumed. Polydrug use and heroin injection is also common. Most European countries report high levels of problematic substance use among homeless people, ranging from 30% to 70%. In the United Kingdom, one study reported that 95% of a sample of young homeless people had used drugs. 17% of the sample were identified as problem drug users and a further 14% had been in the past. A study of homelessness in Ireland reported that up to 50% of homeless people had used heroin, mainly after they became homeless. It should be noted that in recent years polydrug use has been replacing heroin use in this group.

Problem drug users often live in poor living conditions. In those countries reporting the living conditions of people entering treatment for drug use in 2006, around 20 000 clients, or 9% of outpatient and 12% of inpatient clients (N=210 000) are reported to live in unstable accommodation, or are homeless. However, it should be noted that only a small proportion of drug users who are homeless enter treatment (Lawless and Corr, 2005).

An especially vulnerable group of children are those who run away from home or, more commonly, from institutional care, and subsequently become homeless. However, it is difficult to obtain accurate and comparable figures on homeless young people. Thus, only few countries attempt to estimate the size of this population. In Germany, between 7 000 and 9 000 children are thought to be living on the street and a third of these homeless children live in Berlin (German national report). In Romania, between 10 000 and 11 000 children are thought to be living on the streets, and almost half are in Bucharest. The Netherlands reports that 5 000 young people are homeless and the United Kingdom estimates that about 51 000 young people under the age of 25 are homeless.

Most homeless people who use drugs start their substance use career at an early age, but little is known about homeless children using substances. A Romanian study among street children shows that 95% of them use alcohol, 70% use volatile substances and 13% use heroin. Some countries report an increase in recent years in the number of young people without stable accommodation who regularly use drugs (Reitox national reports). Compared to young problem drug users with stable living conditions, drug using young people who are homeless are more likely to be female, foreigners, to have no identity papers and no access to general health care, including drug treatment.

#### Prevention and care

Homeless young people receive maximum consideration in three and minimal consideration in 11 of 30 reporting countries. Two countries report full provision for the homeless without the mention of drug policies. Outreach services are predominant in 14 countries, and office-based services are more common in eight countries.

Descriptions of interventions are rarely reported by Member States. It is estimated that in the Netherlands there are about 5 000 young homeless people who are socially excluded from accessing social services. If these vulnerable young people are between the ages of 17 and 23 years, they can

stay at specialised boarding houses in the cities of Amsterdam, Rotterdam, Utrecht and Heerlen. These young people are isolated from the boarding houses for adults, which protects them from coming into contact with the hard-drug scene and from losing the motivation to fight for a better life.

The EMCDDA project data base (EDDRA) includes several evaluated projects targeting exclusively homeless young people. Projects that have been evaluated at quality level 1, and where homeless young people are mentioned include a 'pump-priming initiative' in the United Kingdom and the 'Streetwork Mobile Young People Work: Rumtrieb' in Wiener Neustadt, Austria.

A 'pump-priming initiative' in the United Kingdom was established in 1998 in order to develop new types of drug prevention projects for vulnerable young people. Funding was allocated to Health Action Zones (HAZs) – multi-agency partnerships aiming to improve health and reduce health inequalities – to target some of England's most disadvantaged communities. The initiative involved the distribution of just over GBP 7 million between 26 HAZs. These funds were used to develop 160 distinct activities or projects, the vast majority of which involved the direct provision of drug prevention to young people, or activities to enable provision of programmes, such as the training of professionals. The initiative seems to have led to a significant expansion of drug prevention for vulnerable young people. However, the evaluation also showed that the provision of short-term funding for a specific purpose does not always lead to sustainable services.

The project 'Streetwork Mobile Youth Work: Rumtrieb' in Wiener Neustadt, Austria is an outreach project that aims to prevent the development of problem drug use. The project contacts problematic young people aged between 11 and 20 and offers specific help that is relevant to their lives. Rumtrieb was initiated as a response to the growing number of groups of problematic young people in two parts of the city of Wiener Neustadt (skinheads, punks, homeless young people, very young drug users and underprivileged young people who cannot be reached by conventional drug help or prevention facilities). The number of contacts with problematic young people was doubled within a year. In addition, the number of interactions between outreach workers and young people increased, and the relationship between outreach workers and young people improved.

## Young people in deprived neighbourhoods

### Definition and national studies

There is no common European definition of 'deprived living areas', but several countries identify deprived areas according to the level of general wellbeing and other social factors. For example, in the United Kingdom indices of multiple deprivation have been developed using variables relating to current income, employment status, education, skills and training, geographic access, housing and crime. (England, Wales, Scotland and Northern Ireland each have a different formulation). These can be applied at different geographical scales, including local authorities and neighbourhoods within them. In addition, Belgium, France, Ireland, Sweden, Croatia and Turkey report full or extensive use of methods to define entire geographical areas or neighbourhoods as vulnerable. Vulnerable neighbourhoods in these countries are defined using indicators such as population density, quality of housing, crime rates, level of deprivation, income per inhabitant, number of people in drug treatment programmes, prevalence of drug use, availability of services, family living conditions and number of public complaints. Portugal began to identify and map vulnerable neighbourhoods in a joint effort between governmental and non-governmental organisations in order to design adequate responses in these areas. In 2006 and 2007, 163 priority territories across 80 of the 278 municipalities in mainland Portugal were identified as vulnerable. European countries report that deprived neighbourhoods are mainly concentrated in urban areas, often in specific blocks of buildings inhabited by low-income populations. The population of these areas often develops a cultural identity, which includes specific behaviours, language and relations, and renders it a close-knit community (Shildrick, 2006).

Reporting is limited regarding geographical areas of deprivation. Only Cyprus, Germany, Ireland, Luxembourg, the Netherlands, Portugal, Poland and the United Kingdom mention vulnerable young people living in specific inner city areas or in specific housing schemes on urban peripheries. Ethnicity is often linked to geographic location. France has identified 'sensitive urban zones' or, for schools, 'educational priority zones', which facilitate the allocation of specific funding. In the United Kingdom the indices of multiple deprivation referred to above are used for allocating specific funding to areas classified as the most deprived.

The association between drug use and living in deprived areas is found to be weaker than the association between drug use and other social and individual characteristics. A Scottish study comparing people living in deprived areas with a control group did not find any significant difference in the level of drug use. Heroin use is more common in deprived urban areas, whereas cocaine is reported in richer areas. Cannabis use frequency is commonly higher in prosperous areas. Rural areas are reported to have a lower prevalence of drug use, but adolescent drug use in rural areas is often hidden.

### Prevention and care

Young people in deprived neighbourhoods receive maximum consideration in seven and minimal consideration in nine of 30 reporting countries. Outreach services are predominant in 11, and office-based services are more common in 12 countries.

Approaching and engaging vulnerable young people in disadvantaged neighbourhoods has been reported as a major challenge in selective prevention. In Italy, Hungary, Sweden and Finland, municipalities provide street level outreach work or support activities and workshops directed at young people. Many interventions consist of either individual consultations or structured, scheduled or spontaneous group discussions. Group discussions mostly involve conversations about self-knowledge and about issues teenagers are most occupied by, such as relationships, sexuality, and drug use. In Hungary, low-threshold services were installed in shopping malls, based on research that found more drug use among young people that often visit malls than among those that do not or only rarely visit malls.

Interventions or low-threshold clubs in the Czech Republic for young people in deprived neighbourhoods often serve as a bridge between youth services and the high-risk aspects of the neighbourhood, because they direct young people to the appropriate services and activities. They may also provide counselling and psychological and social assistance in crises.

In general, the goals of interventions among young people in deprived neighbourhoods are manifold. They aim to provide children and young people with constructive pastime activities, they seek out and establish contact with vulnerable or disadvantaged individuals and groups, and they strive to reduce the potential marginalising effect of deprived neighbourhoods. According to Finnish reviews of youth

workshops that aim to prevent the social exclusion of young people (Kaljärvi et al., 2007), such workshops are good examples of multi-professional cooperation. Participation in the workshops improved the life management skills of young people and often increased their likelihood of staying in school. The workshops were most beneficial for those young people who had no upper secondary education, i.e. secondary education in the age group 16–19 years. Similarly, the Czech Republic, Poland and Slovakia provide preparatory classes for pre-school children and tutors for pupils from socioculturally disadvantaged environments, with the aim to prevent both school absenteeism and dropout rates and to improve the academic success of children.

The Irish Young People's Facilities and Services Fund (YPFSS) provides funding for sporting and recreational activities in disadvantaged communities. In 2005, the Fund provided approximately EUR 85 million to about 450 facilities and projects. Little is known about the contents or the effectiveness of the programme, as it has not been evaluated due to a lack of standardised data collection across the various projects. The Positive Futures Projects is another example of projects that aim to reduce risk among young people in deprived neighbourhoods.

There are no projects in EDDRA specifically targeting young people in deprived neighbourhoods, but there are some aimed at high-risk children in communities. An example of an intervention that has been evaluated (quality level 1) is the selective community programme targeting vulnerable young people that was implemented in seven local communities of Lublin and Pulawy in eastern Poland. The main aim of the programme is to prevent pathological and antisocial behaviours and social pathology among vulnerable children, to create favourable conditions for the healthy psychosocial development of these children in their local community and to initiate activities in the community that promote healthy lifestyles. In 2004, 23 health promotion fairs were organised in five intervention communities, which facilitated contact with more than 60 families and 80 young persons. The evaluation of the intervention showed improvements in the emotional and social functioning among the participating vulnerable young people and their families, and a reduction in psychoactive substance use and violent behaviours. In addition, the sense of security among residents of the communities, and their level of openness and trust improved.

## Ethnic minorities and immigrants

### Definition and national studies

In anthropology, ethnicity means that people define and perceive themselves by language, habits and traditions as 'different' and are also perceived like that by others (Barth, 1969; Putignat and Streiff-Fénart, 1995). If there is both an endogenous and exogenous perception of different identity, EU nationals may also be considered ethnic groups in other Member States, for instance the Irish in the United Kingdom. The most common areas of origin of migrants in European countries are as follows: north and central Africa, Latin America, Asia, the Caribbean, eastern Europe, Russia, and southern Europe (the latter being an older generation of immigrants). The Roma community represents a specific ethnic group with diversified behaviours and cultural traditions that vary by the country of their residence. Considering all existing ethnic groups in the EU, each is very different, because they have different origins and cultural backgrounds. In addition, even the same ethnic groups may differ in behaviours if they reside in different countries. For these reasons, a common European definition of ethnic groups or migrants does not exist and each European country defines these populations according to different criteria, which are related to the social context and the historical migration processes of the country. Thus the respective responses need to be specific for the respective national situation and needs.

Ethnicity per se does not equal vulnerability to drug use. In some Member States, however, some ethnic and minority groups, or some migrant populations that are not yet established in the host country, suffer from disadvantaged social conditions, including low education, unemployment, poor living conditions, housing problems, and lack of economic resources<sup>(31)</sup>. In July 2008, the European Commission adopted a Green Paper regarding the educational disadvantage of many migrant children and the associated risks for social exclusion<sup>(32)</sup>. Ethnicity, however, indicates only sociocultural differences, and it must not be consequentially associated with poverty or lack of education. Therefore, ethnicity is not a straightforward identifier of vulnerability, but is a construct that allows to target responses more specifically to those few ethnic groups that are vulnerable, e.g. by using language, cultural codes, norms and leadership as resources, to create resilience.

In the majority of studies, ethnicity may be a protective factor for drug use. Research in several European countries and in the US has found lower prevalence of substance use among some migrant and ethnic groups compared to the general population. Spanish research comparing drug use among Latin American immigrants and native inhabitants show that, after controlling for socioeconomic background, immigrant young people had lower intentions to use substances than native young people (Marsiglia et al., 2008). This may be related to a range of protective factors, such as stronger social norms and cultural identity and higher protection from the ethnic community in terms of substance use norms etc. (Marsiglia et al., 2008). However, epidemiological research on drug use and related problems among migrant children or children belonging to ethnic minorities is limited. Such dedicated studies can help to build a more nuanced picture of drug use. For example, the Netherlands reports that, for ethnic minorities, protective factors may only apply to less intensive forms of drug use. While ethnic minorities showed relatively low overall drug prevalence compared to the general population, they seemed to be overrepresented among problem drug users. However, studies of young people from ethnic minorities have been mainly carried out at national or local level, and therefore little common European conclusions can be drawn.

Differences between ethnic minorities and the general population are reported in the patterns of drug use. For example, the use of khat is reported by Somali and other African populations, and sedatives and tranquillisers by the Roma community in Ireland. Higher prevalence of drug use are reported by populations from mixed ethnicity in the United Kingdom (EMCDDA, 2003; Reitox national reports).

In several European countries ethnic minorities, especially migrant women, are reported to have lower access to specialised drug treatment compared to the general population. Difficulties in access to drug treatment services might be related to language problems, low awareness about service organisation, different approaches to health and social services, specific sensitiveness to drug problems and social stigma (London Drug and Alcohol Network, 2007). However, a Dutch study among drug users entering drug treatment shows that the proportion of people from ethnic minorities is higher than among the general Dutch population (LADIS, 2005).

<sup>(31)</sup> EMCDDA 2003 Annual report, p. 65.

<sup>(32)</sup> The debate to follow the Green Paper will inform a decision on the future of Directive 77/486/CEE.

## Prevention and care

Immigrants receive maximum consideration in three and minimal consideration in 13 of 30 reporting countries. Outreach services for immigrants are predominant in three, and office-based services are more common in 12 countries. In addition, ethnic groups receive maximum consideration in four and minimal consideration in nine countries. Outreach services for ethnic groups are predominant in five countries, and office-based services are more common in 13 countries. It is noteworthy that proactive outreach is relatively uncommon for a target group that, due to its potential exclusion, is not likely to actively approach office-based services.

The Minorities Integration Centres in the Czech Republic were established to support working with socially and culturally disadvantaged children. They aim to increase the involvement of members of these groups into mainstream society. The centres focus on identifying vulnerable groups, and, within these groups, to intervene with individuals who are at risk of dropping out of school, engaging in criminal behaviour, and using substances.

In Slovakia, the Roma minority receives considerable attention regarding the range of measures and the services available for them. Such services include the training of community workers and providing continuing education for Roma women who did not finish school. In addition, special interventions are aimed at minors who make up a considerable proportion of the Roma population (40% are children under 15). Various tools are available to help the integration of disadvantaged Roma children into the mainstream school environment. These tools include pre-school education, transition classes, teaching assistants who speak the Roma language, extracurricular education, and programmes working with parents in schools or community centres.

Substance abuse services are increasingly adapting to ethnic and immigrant groups. This trend is reflected in the increased number of staff members with an immigrant background in various substance abuse prevention projects. There are also services directed entirely at specific population groups, and educational and information material is produced in the languages of various population groups.

While there is a common focus on social integration in the objectives of these programmes aimed at ethnic and immigrant populations in the reporting countries, most of the time it is unclear what the operational contents of the interventions are, besides the production of multilingual information leaflets or training ethnic community workers (Germany, Luxembourg, Hungary, Finland).

'Kamelamos Guinar' (meaning 'we want to be heard') is a process and outcome evaluated promising project that was implemented in Galicia, Spain. As part of the project, teenagers from the Santiago Gypsy community discussed issues related to drug use, HIV/AIDS and sexually transmitted diseases in a way that is sensitive to their culture. As part of the project, young people participated in an HIV/AIDS prevention workshop, leisure and free time activities, and organised a total of four flamenco music and training performances that dealt with racism and drug use in the community. There was an 11% reduction in misconceptions related to HIV/AIDS as a result of participating in the HIV/AIDS prevention workshop. A number of different cross-curricular techniques were used with the target group, including techniques to find information in different media (books, experts, peers) and to compare the information obtained from different sources. In 90% of the cases, youngsters found information more reliable if provided by their peers or someone close to and/or accepted by the target group.

## Overall findings and common trends

Vulnerability is a construct that helps to identify, find and contact certain groups which have a higher risk of using drugs. The pathways from vulnerability to drug use among these groups are mediated by social exclusion. In other words, vulnerability relates to social exclusion, and drug use is one among several problem behaviours that arise within these groups.

### Responses

#### Importance in policies

Importance of vulnerable groups in drugs policies and in social policies has risen. Overall in the last three years, the most vulnerable groups, such as young offenders, the homeless, truants, disadvantaged and minority youth, have been listed as a priority in an increasing number of drug policies. In addition, these groups are also included in social policies of a majority of the 30 reporting countries – between 16 and 22, depending on the 30 reporting countries.

#### Provision of interventions

There is, however, no indication, that the actual provision of specific interventions for vulnerable groups has increased

between 2004 and 2007 in the same period in Member States (Table 3). Provision of interventions has only increased for young people in institutional care, slightly for youth in disadvantaged neighbourhoods, homeless youth and for immigrants, while for all other interventions the percentage of countries providing interventions has decreased. There was no relationship between the importance given to certain vulnerable groups in drug policies – in terms of whether they were priority, mentioned or not mentioned – and the level of provision of intervention in Member States. In other words, a given vulnerable group may not be mentioned in a single country's drug policy even though interventions are extensively provided, or a vulnerable group may be priority in the country's policy even though the level of service provision is low.

### Delivery methods

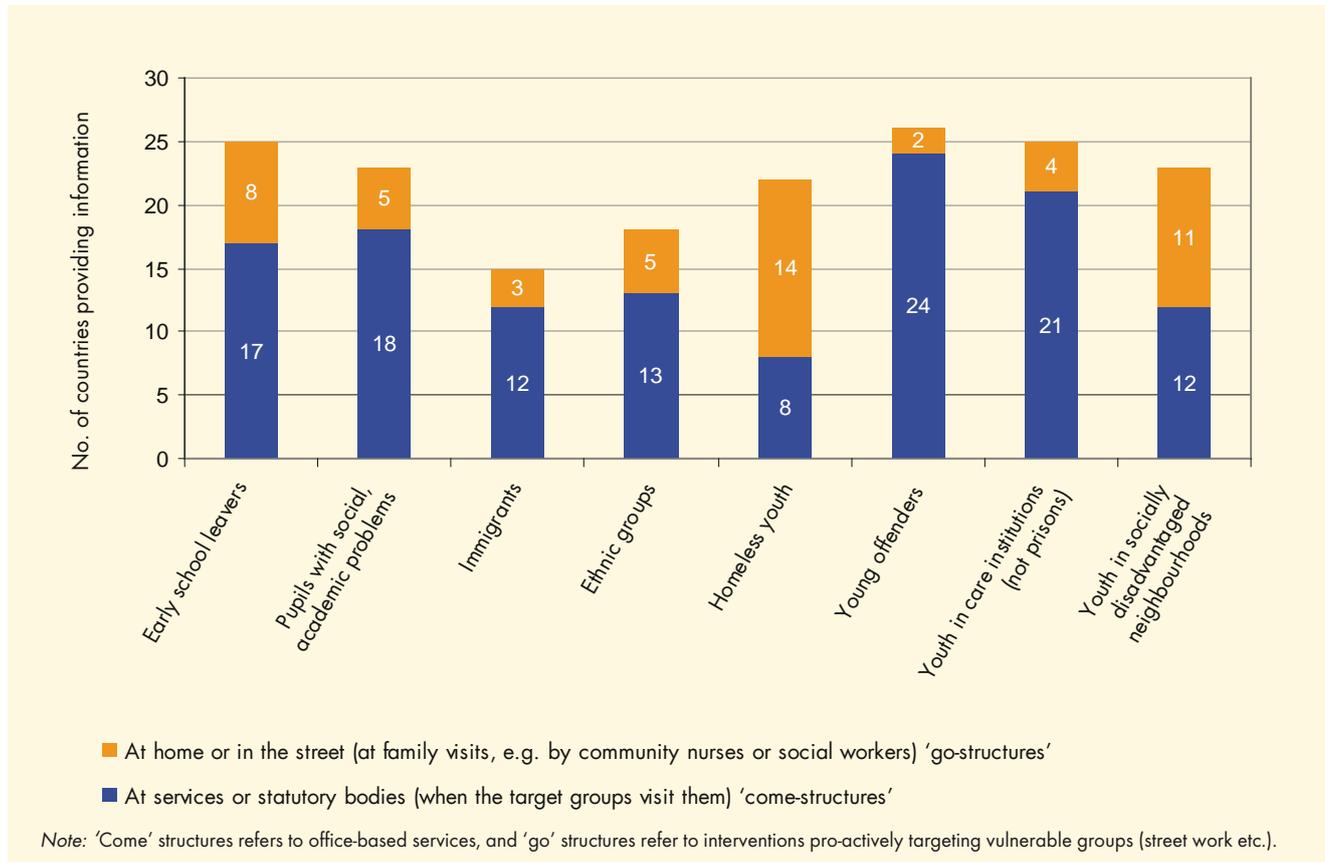
Outreach services are less commonly used for the delivery of interventions. Currently intervention monitoring in the EU assesses only the level of intervention provision, and not whether these interventions reach the target groups or are accepted by them. Intervention monitoring has shown that outreach on the street or at the homes of vulnerable people is

**Table 3: A comparison of number of 23 reporting countries reporting full or extensive provision of interventions to vulnerable groups in 2004 and 2007**

| Groups reported to be provided with interventions | Number of countries 2004 | Number of countries 2007 |
|---|--------------------------|--------------------------|
| Early school leavers                              | 7                        | 6                        |
| Pupils with social or academic problems           | 8                        | 6                        |
| Immigrants  | 1                        | 2                        |
| Ethnic groups                                     | 5                        | 5                        |
| Homeless youth                                    | 5                        | 6                        |
| Young offenders                                   | 11                       | 5                        |
| Youth in care institutions                        | 7                        | 11                       |
| Youth in disadvantaged neighbourhoods             | 7                        | 8                        |

Note: 23 countries counted: BE (FR,NL), BG, IE, ES, CY, CZ, DE, GR, FR, FI, HU, LU, NL, AT, PL, PT, RO, SL, SK, SE, UK, NO.

**Figure 1:** The vulnerable groups targeted in reporting countries, and the channels ('come' and 'go' structures) used to deliver interventions



less frequently utilised than office-based services, probably because office-based services may be easier to administer (Figure 1). None of the countries reported that they consistently preferred outreach to access non-institutionalised vulnerable groups in prevention interventions. On the contrary, Cyprus, the Czech Republic, France, Lithuania, Malta, Portugal and Slovenia reported that services to all vulnerable groups are predominantly provided through office-based services. For example, in the majority of the countries, office-based services are predominant for vulnerable families, whereas only Denmark, the Netherlands, Romania, Sweden and the United Kingdom tend to actively reach out to vulnerable families. Similar hard-to-reach populations such as ethnic groups are approached at their homes or in the street only in five countries, and outreach is available for immigrants only in three countries. On the other hand, eight countries offer only office-based

services and no street outreach for homeless young people. For several vulnerable groups, higher level of provision is more likely to be reported by countries where delivery is predominantly office-based rather than through outreach. For example, Slovenia and Norway are the only countries which report full or extensive provision across all vulnerable groups, although in both countries delivery is almost exclusively through office-based services.

### Contents of prevention interventions

Intervention types used in selective prevention range from structural improvements for social inclusion, such as providing job and leisure time opportunities to young people in deprived neighbourhoods, to intensive personalised interventions, such as courses for young drug law offenders. Information provision about drug risks still seems to predominate in this field.

There is increasing evidence and recognition of social risk profiles, but there are still few policy responses in this regard. 'Early intervention', that is intervening with those who need help because of their drug use, seems to be predominant in many Reitox national reports. There has not been a considerable increase in the number of evaluated projects since the 2004 EMCDDA report on selective prevention. Only very few evaluated programmes from a total of nine Member States (Germany, Spain, Ireland, the Netherlands, Austria, Portugal, Poland, Finland and the United Kingdom) have been added to those already reported four years ago.

As regards vulnerable young people with ties to institutions (truants, those in foster care), the most active countries, which report consistent provision for all vulnerable groups, are Lithuania, Poland, Slovenia and Finland. Countries that report consistent provision for all types of vulnerable families are the Czech Republic, Denmark, Spain, Poland, Finland, Croatia and Norway. Countries that report consistent provision across vulnerable groups which are hard to reach in the community (the homeless, minorities, deprived neighbourhoods) are the Czech Republic, Denmark, Slovenia, Sweden and Norway.

Content-wise, responses may be placed on a continuum between (i) general policies of social inclusion, which offer positive and fostering environmental strategies on the macro level, and (ii) personalised proactive and street-based outreach approaches for hard-to-reach groups on the micro/individual-centred level. There exist especially strong evidence and European examples for selective family-based prevention with a strong focus on education styles. The best results have been found so far from interventions delivered via young people's families, or which involve their families alongside other components such as school or community level interventions (Velleman et al., 2005; Velleman and Templeton, 2007).

### **Provision of drug treatment: not specific, but focused on young drug users in general**

Most Member States report that, when no specific drug treatment service or intervention exists for a distinct vulnerable group, young members of this group who are in need of drug treatment are catered for by the existing treatment services dedicated to young drug users in general. In 2006, the EMCDDA collected 2005 data from 29 countries (27 EU Member States plus Norway and Turkey) on the availability and accessibility of treatment services for drug users under

18 years of age. The Czech Republic and Latvia rated the availability as 'very good', while 18 countries rated the availability as 'reasonable'. Of these 18 countries, two countries rated the accessibility as 'very good' (Greece, the Netherlands) and 14 countries rated it as 'reasonable'. Luxembourg and Germany rated the availability as 'low'. Bulgaria, France, Hungary and Romania reported a lack of treatment services for young drug users.

Since 2005 about 250 'cannabis clinics' have been set up in France for cannabis users, the majority of whom are young. Romania's 2007 national report mentions the recent opening of an adult daycare centre for young people in Bucharest, and the establishment of working groups of social care specialists who provide specialised services to almost 100 young heroin users and their families.

The 2007 Reitox national reports also show that in a number of Member States (e.g. Denmark, Germany, Austria, Finland), treatment services dedicated to young drug users appear to be well developed. In Denmark, about 75 % of Danish counties/municipalities have specific treatment services for problem drug users under 18 years of age. In Germany, a broad range of programmes is available specifically for young people in the area of drug counselling and treatment. The register of institutions kept by the German Centre for Addiction Issues lists 401 counselling and treatment offices, which specifically focus on adolescents or offer programmes specifically for adolescents. In addition, there are 60 withdrawal clinics and 105 inpatient rehabilitation facilities which admit children and adolescents, as well as 196 assisted living facilities for adolescents. In Finland, the provision of such services is also reported as important but it is noteworthy that 40 % of young drug users enter drug treatment through child welfare services, which indicates that many of these young people have been through other services before accessing treatment. In the Netherlands, where several treatment services for young drug users are available, the drug problem is not seen as an isolated problem. Instead, therapeutic emphasis is placed on the psychological development of young people, especially as regards dealing with emotions and other factors perceived as the underlying cause of the problem drug use. Finally, many Member States report the priority to develop more adequate and attractive treatment services for young drug users. This need is due to changing trends in problematic drug use and to the heterogeneity of groups of young drug users in need of treatment.

## Data and limitations

Vulnerability tends to congregate in and around cities. There is a need to explore the environmental impact of rapid urbanisation on the lives of young people and to their drug use, particularly in countries that have recently joined the EU and where rapid urbanisation is taking place. Sharp disparities in income distribution; an increase in urban poverty; profound disturbances of social structure, crime and violence; and escalating drug misuse all suggest the need for 'macro strategies to prevent substance use and related harms, including restructuring economic incentives and disincentive, poverty and disparity alleviation enhancing access to education and housing, strengthening of community mechanisms' (Edwards, 2006).

Almost all Member States report on national studies on vulnerable groups and on vulnerability factors that are predictive for problem substance use. However, despite a plethora of local studies on vulnerable populations reported in Reitox national reports, comparable epidemiological data across reporting countries are not available, due to different definitions of vulnerable groups and data collection methods. Therefore not all the information could be used for this selected issue. Still, there is strong agreement across Member States in terms of identifying the main vulnerable groups. Strikingly, there are also different ways of defining the role of drugs and alcohol in families. Definitions range from 'addicted parents' to 'families with alcohol problems' and 'families with drug problems'. Often, the role of drug-using siblings is not taken into account, suggesting the need for better standardised data on this issue.

Rating data on responses are available for programme provision (but not on acceptance nor adequacy), for policy importance, and for delivery of interventions at home or at offices. Some examples exist on the content and organisation of interventions from national reports and EDDRA. Expert panels from Member States provided comparable qualitative ratings about the prevention responses for vulnerable groups as regards the geographical availability of interventions, the importance of target groups in policies (for 2004 and 2007), and how vulnerable groups are approached (for 2007). National reports and EDDRA contain sporadic – i.e. not consistently available – information about the contents of interventions. Limitations for interpretation of data include the

fact that rating categories have slightly changed since 2004. Countries reporting in 2007 were slightly different from those in 2004, and the number of countries providing information increased between 2004 and 2007. The EDDRA database of the EMCDDA includes results of the evaluations of about 50 interventions in 11 countries that targeted vulnerable young people and/or vulnerable families. The largest proportion of evaluated projects in EDDRA is from Spain, followed by the United Kingdom, Portugal, Ireland and Austria. A promising project has been presented in this selected issue for each type of vulnerable group.

## Ethical aspects

The association between several risk and protective factors and problematic drug use among young people are not necessarily causal. Identifying vulnerable groups of young people does not establish hard-and-fast prediction of drug use, but rather facilitates an important entry-point for policies and interventions. One frequently-mentioned concern is that identifying groups vulnerable to drug use may equate to labelling them as drug users. However, by identifying them as vulnerable, they also receive adequate benefits and additional resources (McGovern, 1998).

Many interventions for vulnerable young people involve their segregation from mainstream peers and aggregation into settings with other problematic young people. However, the desired positive effects of such group interventions in education, mental health, juvenile justice, and community programming may be offset by deviant peer influences in these settings due to negative reinforcements (Gifford-Smith et al., 2005). Therefore, it remains unclear whether selective interventions should be carried out among selected groups of vulnerable young people, or whether integration with the general youth population should be encouraged. It is a point of concern that consideration of these risks is not reported in any of the national reports.

The vulnerability concept stresses that drug use alone, as the result of an individual drug user's choice, is not responsible for escalating drug problems, but that some groups – due to environmental and social risk conditions – are vulnerable to drug problems or drug-related problems and are therefore entitled to support.

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

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

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