1998

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

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

European Monitoring Centre for Drugs and Drug Addiction

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# Preface

The 1998 'Annual report on the state of the drugs problem in the European Union' is central to the continued advancement of a concerted knowledge base on which to build a strategic approach to drug policy within and beyond the Member States that constitute the European Union. The EMCDDA both instigates and reflects improvements in communication and shared awareness of the extent of drug problems and the suitability of specific markers as epidemiological indicators within and between nations.

As stated in the declaration on demand reduction adopted by the United Nations in June 1998 'demand reduction programmes should be based on a regular assessment of the nature and magnitude of drug use and abuse and drug-related problems in the population. This is imperative for the identification of any emerging trends. Assessments should be undertaken by States in a comprehensive, systematic and periodic manner, drawing on results of relevant studies, allowing for geographical considerations and using similar definitions, indicators and procedures to assess the drug situation. Demand reduction strategies should be built on knowledge acquired from research as well as lessons derived from past programmes. These strategies should take into account the scientific advances in the field, in accordance with the existing treaty obligations, subject to national legislation and the comprehensive multidisciplinary outline of future activities in drug abuse control'. It is exactly this approach that is reflected in the work of the EMCDDA in general, and the content of its annual report in particular.

Each annual report contributes to a developing understanding of both the need for monitoring and the recognition that effective policy is contingent on a satisfactory and accessible information base. The EMCDDA is increasingly recognised as an invaluable source of information, whose autonomy and political independence guarantee that its annual reports are viewed as key documents for understanding the major features of drug problems and the legal, political and social responses to them initiated within the European Union. However, each report also represents a reconfiguration of the central themes that address policy and practice-related concerns and this is most obviously manifested in Chapter 3 of the 1998 report.

This chapter examines the drug situation in the 10 central and east European countries (CEECs) which are part of the PHARE project for accession countries to the EU. As with the 15 Member States, the goal of the EMCDDA's project remains twofold — to report on those existing indicators that provide the most accurate picture of drug problems and responses in each nation, while encouraging participants to improve the quality, reliability, comparability and accuracy of the information they gather. Although the EMCDDA is aware of resource restrictions, gradual improvements in multi-method collection and dissemination remain central to the objective of improving communication and cooperation.

In Chapter 1, a new distinction is made between current trends and directions (based on a combination of informal and less systematic sources) and key epidemiological indicators (structured around agreed definitions where these are available). Thus, the current trends section allows the incorporation of qualitative measures and informed opinions on recent events, where the pay-off is timeliness rather than precision. In contrast, in the key indicators section, drug trends are slightly less up-to-date, but are more likely to fulfil scientific criteria of reliability and validity. The overall objective is to employ a variety of methodologies in establishing a wide-ranging series of images of drug activity and response, rather than to be over-reliant on snapshots whose clarity is compromised by their processing time.

However, the EMCDDA's aim of improving the overall quality of data available is evidenced in the structure of the chapter on demand reduction, where emphasis is given to those projects which have been adequately evaluated. Particularly in the area of primary prevention there is a paucity of scientific evidence, not only in Europe but also internationally, and so the aim has been to present not only those projects that appear important and indicative, but also those that make some attempt at satisfactory evaluation. Thus, while there is thorough consideration of new projects that may shed

light on the direction, for example, of drug education, the EMCDDA approach is to encourage innovation married to systematic and scientific method.

The later chapters emphasise, in particular, the financial structures in place. Chapter 7 examines the data available on public spending in response to drug problems, with examples given from the limited data sources available. Chapter 5 outlines the changes that have occurred in EU spending in the past year and, in particular, the shifts in the breakdown of spending between money spent within the Union and that spent internationally. Chapter 6 provides an up-to-date account of more general global activity and the recent work of the main international bodies to combat the drugs problem.

While there is still much work to be done, the successes of the last year clearly vindicate the work of the EMCDDA. The overall role of the Centre has expanded as a centre of excellence for addiction information, but the Centre has also become increasingly active in improving the knowledge base for policy-makers, practitioners and researchers alike. The annual report, as an integral component of EU activity, not only reflects with increasing accuracy and clarity the drug situation in the EU countries, but it increasingly provides an invaluable basis for initiating systematic research and evaluation carried out comparatively by the EU and beyond.

We are, however, aware that the EU can be no more insular than the Member States from which it is constituted, and the EMCDDA will continue to promote collaborative endeavour between these Member States, bodies and organisations whose work is more international. The EMCDDA is increasingly at the core of the relationship between key European informants through the national and international networks of its focal points and the EMCDDA's Reitox network.

Yet our work is essentially educational, progressive and proactive — we must promote the role of information collection, management and dissemination as the critical base for all policy decision-making and it is here that the annual report reflects the success of the efforts made by both the EMCDDA and the national focal points. With each annual report, we are conscious of increased impact and readership and of improvements in comparability and quality. This is a slow and gradual progress, but with the continued commitment and goodwill of contributors, both the quality and impact of the document will gain further ground.

I hope you find this report both interesting and useful to you in your work, and that it encourages you to support what we at the EMCDDA are trying to do. Our success requires your cooperation and we are aware that without the support and feedback of readers we will be foiled in our task of striving for clarity and quality. We are committed to the task of improving awareness and information and I hope you are stimulated by our endeavours

**Georges Estievenart**
Executive Director
EMCDDA

# Acknowledgements


### Focal points and their staff

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

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### All the services within each Member State

For the work of the many ministries, departments and services across the 15 Member States which collected raw data for their national centres

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### Members of the Management Board and the Scientific Committee of the EMCDDA

For their time, support, advice, constructive criticism and understanding throughout the project

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For the support of its committees

### The Council of the European Union and in particular its Horizontal Drugs Group

For their interest in the work of the EMCDDA

### The European Commission

For its detailed description of EU action against drugs

•

### International organisations: the Pompidou Group, the UNDCP, the WHO, Europol, Interpol and the WCO

For providing the Centre with information about their work and laying the foundations for future cooperation across a range of issues

•

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**The staff of the EMCDDA**

For their dedication, expertise and meticulous analyses

Our sincerest thanks to all the abovementioned and to all who have not been named but whose contributions made this report possible.

# Contents

# Trends, prevalence and patterns of use

Chapter 1

**This chapter is divided between emerging trends and key epidemiological indicators of drug use and supply. The aim of the chapter is to help policy-makers develop appropriate responses in a timely fashion.**

Information on emerging trends, although drawing on key indicators, relies on more qualitative assessments, local as well as national, that may lack comparability or validity, with rapidity achieved at the expense of scientific precision. Although less timely, epidemiological indicators may be more reliable and comparable, and are essential for scientific comparisons and to explain observed trends.

Although the EMCDDA is improving the availability, quality and comparability of key indicators, and the timeliness of emerging trends data, much remains to be done.

As present coverage of different kinds of information is incomplete, the degree of comparability is variable making direct comparisons misleading. Even where data quality and comparability are good, the diversity of local cultures, and of different approaches to, and definitions of, drug concepts must be considered.

## Emerging trends in drug use and drug problems

**Cannabis:** Stable after increases in the early 1990s, especially in higher prevalence countries, some rise in others.

Some rise in populations entering treatment, but this may in part reflect recording practices and other factors.

**Amphetamines:** Continuing to rise, likely to be more significant in future than Ecstasy.

**Ecstasy:** No longer rising in those Member States where it appeared earlier and prevalence is higher, but still rising in others. Some diffusion to other populations.

**Other synthetic drugs:** New products reported in some Member States, but not replacing amphetamines and Ecstasy.

**Cocaine:** Modest but steady rise in use, although prevalence is still low.

Crack remains localised, but some spread in selected areas.

**Heroin:** Increases among some synthetic drug users and other young populations reported by some Member States.

**Problematic patterns of use:** Diffusion to small towns and rural areas reported in some countries.

**Deaths:** Generally stable or decreasing, although with some exceptions.

**Infectious diseases:** Rates of new AIDS cases strongly declining as a result of new treatments which delay disease progression. AIDS changing into an indicator of treatment uptake rather than of HIV infection.

Prevalence of HIV infection stable or declining in most countries, but continued transmission in young and new injectors.

Prevalence of hepatitis C infections remains extremely high.

For further information on methods and sources, the reader is referred to previous annual reports and to the recently published report on information sources.

# Overview

## Cannabis

Although the most common illicit drug in EU countries, there are considerable differences in patterns of use over time and between countries.

Following significant increases in use in many Member States in the late 1980s or early 1990s, prevalence has now stabilised in some countries, though it continues to increase in others. Seizures of cannabis increased fourfold from 1985 to 1994, but have stabilised since.

This is not the first time that cannabis use has increased, stabilised and in some cases declined. Cannabis first emerged as a significant phenomenon at the end of the 1960s and early 1970s, when sharp increases in use were observed, mainly in north European countries. Prevalence seems to have stabilised or decreased in the late 1970s and 1980s before increasing again late in the 1980s.

Of the total adult population, 5 to 30 % have ever tried cannabis and 1 to 9 % in the past 12 months, depending on the country. The proportions are higher among younger adults with 10 to 40 % having ever used and up to 20 % in the last year. In most countries, rates are higher in urban areas.

Amongst current or recent users, use is more commonly occasional or intermittent. Cannabis is not often the primary drug in health and social care indicators, though a minority of heavy users seek help. In most countries, cannabis accounts for between 2 and 10 % of treatment admissions, although in a few it is between 13 and 16 %.

**Suggested explanation:** National variations in the proportion of cannabis users seeking treatment could reflect the extent of heavy cannabis use, the range of services available, or factors such as court requirements for drug offenders. Cannabis may be one component of a wider range of personal, social and legal problems, including alcohol and other drugs.

## Amphetamines, Ecstasy and LSD — synthetic drugs

A major issue for young people's drug use is the emergence, since the late 1980s, of 'dance drugs', dominated by Ecstasy, though also including amphetamines and LSD. These drugs became popular within a broader evolution of youth culture over the last 10 years, and, in particular, were associated with clubs, raves and house parties. The main groups involved have been socially integrated adolescents and young adults in the 15 to 25 age range. Initially, users did not tend to mix Ecstasy with other substances, but subsequent reports indicated a diffusion of Ecstasy use across social groups and an increased use of Ecstasy in addition to, or in combination with, alcohol, cannabis, amphetamines, benzodiazepines, LSD, or cocaine.

These developments are described in the 1997 annual report and in 'New trends in synthetic drugs in the European Union' (EMCDDA Insight series).

Recent indications suggest that, in some countries at least, Ecstasy use may have ceased increasing, and has been tried by 0.5 to 3.0 % of the total adult population, a proportion that is higher among older adolescents and young adults (up to 9 % in 16 to 29-year-old populations). Recent use is less common than experimentation.

**Suggested explanation:** The impression that house culture, in which Ecstasy played a symbolic as well as psycho-pharmacological role, is diverging is supported by predominantly anecdotal information from diverse sources — specialised youth media, local researchers and front-line agencies. Ecstasy has become just another drug on the market and is decreasingly a unifying cultural symbol.

These sources note increasing availability and use of amphetamines (tried by between 1 and 9 % of all adults, but by up to 16 % of young adults) and

cocaine, while alcohol remains prominent in youth culture. Although historically more common in northern Europe, amphetamines are now found across the EU. While usually consumed orally or by snorting, amphetamine injecting is reported in some countries.

Indicators of supply and availability reinforce the impression that amphetamines and cocaine may be the growth area in the stimulant-type drug market, rather than Ecstasy. These indicators suggest that although seizures of synthetic drugs have increased substantially since the late 1980s current trends are now diverging. Market indicators of LSD declined following a peak in 1993-94.

In 1997, market indicators for Ecstasy showed signs of stabilising in countries that first experienced an increase in the late 1980s, whereas they are still increasing in countries where Ecstasy emerged more recently and where the extent of use is lower. In contrast, market indicators of amphetamines show a continuing rise across the EU.

Among treatment populations, these substances are not usually the primary problem. Amphetamines are the main drug in a minority of the treated population, although amphetamine problems are more common in parts of northern Europe. Ecstasy and LSD are very unusual, though small increases are being reported for Ecstasy.

Fatalities from amphetamines and Ecstasy are relatively rare and are often associated with the context of use — continuous dancing in hot, crowded conditions. In many countries, there are no recorded cases of fatalities, though some may be missed.

Recorded health problems are also low, given the number of people who have taken amphetamines or Ecstasy, although they may be under-recorded. More problems arise if use becomes chronic, involves high doses or is in combination with other drugs.

Temporary depression and short-term deficits of memory and concentration have been reported following Ecstasy use. Evidence on the long-term neurotoxicity of Ecstasy remains unclear in humans, although indicated in animal studies.

## Cocaine

Law enforcement indicators, especially the quantities of cocaine seized, increased sharply in 1996 and 1997 after a pause in the rapid increase observed from the mid-1980s. Prices show little sign of increase, and the long-term trend has been a substantial fall in retail price.

Indicators of the demand for cocaine do not show such a marked rise. A small proportion of adults, 1 to 3 %, have tried cocaine, with recent experience usually reported at less than 1 %, although rates are higher amongst younger adults. Use of cocaine among school-age children is also low, 1 % or less in many countries, although 3 to 4 % in some Member States.

**Suggested explanation:** The discrepancy between supply and demand indicators for cocaine may occur because, although supply has increased substantially, perhaps as a result of changes in the global market, demand has grown more slowly. The long-term fall in price is consistent with this. It is also possible that law enforcement agencies have been intercepting an increasing proportion of cocaine imported into the EU, but that since supply exceeds demand, this has had little impact on price or availability.

The most plausible interpretation of cocaine indicators suggests modest but steady increases in the use and availability of cocaine in many Member States. Prevalence of use is higher than for heroin, but remains relatively low in comparison with amphetamines or Ecstasy (and of course cannabis). Cocaine use tends to occur in recreational contexts, tends to be sniffed (snorted) and is taken on an occasional basis. A minority use cocaine much more frequently and experience problems.

Cocaine is rarely mentioned as the main drug in treatment clients; in most cases less than 5 %, although in a few countries it is 10 to 15 %. However, it is commonly reported as being used in conjunction with heroin. The smoking of crack cocaine has been identified for several years among heroin users and marginalised groups in some Member States, but is limited.

## Heroin and other opiates

Despite increasing attention to 'new' problem drugs, heroin continues to be a major threat to public health and safety. In most Member States heroin addiction represents a substantial and disproportionate burden in terms of treatment, health-care costs, deaths and drug-related crime.

In general, trends in both the supply of heroin and in levels of use and dependence are relatively

stable (under 1 % of the general population, up to 2 % in younger age groups, although it may be higher in some 'at risk' areas). However, prevalence is increasing in some Member States, and several countries report heroin smoking by new groups of young people, both from socially integrated populations and from minority groups.

Member States use different definitions and methods for estimating problem drug use and addiction, but generalised indicators suggest that between 0.2 and 0.3 % of the total population in the EU are addicted to heroin. In most treatment centres, heroin is the main drug (Finland and Sweden are exceptions). Whilst differences between countries exist, those within countries can be considerably greater.

In many countries, heroin dependence is concentrated among marginalised subgroups in urban areas, although diffusion to rural areas seems to be taking place in some countries. Problems linked to increased social exclusion of marginal groups, including addicts, are reported in some countries.

Opiates are present in most acute drug-related deaths, although other substances are often also present. The proportion of heroin users who inject has been decreasing in most EU countries, with smoking the most common route in some Member States.

### Other significant substances

The misuse of solvents and other volatile inhalants is primarily a phenomenon found among younger adolescents. In schoolchildren aged 15 to 16 years, they are usually the second most common substance after cannabis, though in some countries with a low prevalence of cannabis, use of solvents is more common than that of cannabis.

An increase in the non-medical use of medicines is noted in several countries, often in combination with alcohol. Benzodiazepines are commonly reported as a secondary drug amongst people entering treatment, and are also often detected in acute deaths of opiate addicts. Systematic information is limited at EU level.

## New areas of development

A priority for the EMCDDA and national focal points is to improve the timeliness and relevance of information, to make information more useful to policy-makers, by:

1. extending coverage beyond institutional sources and research studies to include more informal or unconventional sources;
2. improving existing indicators, and giving more attention to analysing and exploiting the data these indicators provide;
3. developing more innovative methods of data collection, analysis and forecasting to better identify, monitor and understand changing patterns of drug use.

**Geographical diffusion**

Although uneven, there is a geographical diffusion of drug use from cities to towns and rural areas, which has implications for needs assessment, service provision and training. Differences in patterns of diffusion may also improve our understanding of the distribution of drug behaviours at European, local and regional levels.

**Youth culture and drugs**

The emergence of Ecstasy illustrates clearly the need for analysis of drug trends to occur in the context of wider social and economic trends, in particular those that relate to youth culture. Similarly, the role of young people in the consumer market for recreational products, including drugs, must be considered.

**Social exclusion, drug use, drug problems**

Social exclusion, marginalisation, minorities and migration are often intertwined with drug trafficking, drug use and drug-related problems, though the relationship is neither simple nor unidirectional. Developing effective strategies to respond to drug problems requires a broader and more thorough analysis.

**Drug-related crime and public safety**

Little information is provided on this in national reports, yet a 1996 EMCDDA pilot project indicated that considerable local information exists, although it may be hard to find. If questions about drug-related crime or public safety measures are to be addressed, then the availability and quality of information must be improved.

**Drug markets, availability and supply**

The main focus of the Centre's work in epidemiology has been on the demand for drugs. This will remain a central theme, but it will be necessary to pay more attention to supply and to drug markets, which is where demand and supply meet.

### Drugs and health

One of the strongest associations between illicit drug use and health problems is found among injectors. Although rare in the general population, injecting rates range from 10 to 15 % to 80 % among opiate addicts entering treatment. Injecting drug users (mainly heroin addicts) are many times more likely to die than non-injectors, and are at much higher risk of infectious diseases such as AIDS and hepatitis.

The proportion of injectors among treated heroin users is decreasing in almost all countries, particularly among clients coming to treatment for the first time. Injecting rates vary considerably between countries. Heroin is the most common drug involved, although amphetamines are injected in parts of northern Europe. Opiate injectors often inject other substances like cocaine, while some reports mention new injection substances, like anabolic steroids

In the European Union, most cases of death from acute intoxication involve opiates, although other substances such as alcohol and benzodiazepines are also frequently found. After increases in the 1980s and early 1990s, the number of acute drug-related deaths are generally stable or decreasing, although the increase continues in some countries.

In almost all countries, the prevalence of HIV infection in drug injectors is declining or stable. Modelling studies, however, show that new generations of injecting drug users continue to be infected meaning that HIV has become endemic. Young and new injectors often show more risk behaviour than more experienced drug users.

The incidence of new AIDS cases is falling sharply as a result of new treatments that delay disease progression. As a consequence, AIDS reporting is becoming more an indicator of treatment uptake and less an indicator of HIV infection. Early extreme optimism about the effectiveness of new treatments for AIDS has recently been tempered.

Hepatitis in drug injectors, in particular hepatitis C, remains a serious problem with potentially large implications for health services. The extremely high prevalences of hepatitis C in most countries indicate ongoing risk behaviour among injectors, much of which is probably unnoticed — sharing spoons, cottons and other 'works'.

## Indicators of prevalence, consequences and patterns of use

This section provides a comparative account of drug use and consequences in Member States, by examining indicators of prevalence, health consequences, the criminal justice system, and illicit drug markets, several of which are key indicators in the Centre's work programme in epidemiology. The Centre is seeking to establish common EU standards governing the comparability and quality of data collection, analysis and reporting. At present these key indicators concern prevalence (population surveys, prevalence estimates of problem drug use) and health consequences (demand for treatment, drug-related deaths and drug-related infectious diseases).

Establishing common standards is a slow process. Many of the factors responsible for the lack of comparability and variable data quality are being clarified through analyses of definitions, methods, coverage of information sources and procedures for data handling. However, it will take time for these to be implemented and for this to become apparent in the comparability of indicators. As a result, more attention is given in this annual report to the analysis of indicators of the illicit drug market.

### General population surveys

Population surveys, assessing the extent and patterns of drug use, generally provide information on whether a person has ever tried a drug (lifetime prevalence) or has taken it recently (last 12 months or last 30 days), along with sociodemographic characteristics and attitudes towards drugs. This methodology is useful for substances whose use is relatively extensive, but is more limited for more marginalised forms of drug use which require large samples and which may exclude those without a stable address or telephone number.

## Table 1: Lifetime prevalence of drug use in recent nationwide surveys among the general population in some EU countries

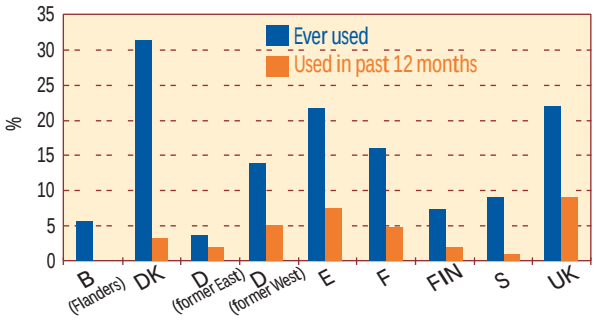
| Country | Year | Method | Sample | Age range | All adults (%) Cannabis | Cocaine | Amphetamines | Ecstasy | Younger adults (%) Age range | Cannabis | Cocaine | Amphetamines | Ecstasy |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium (Flanders) | 1995 | Phone | 1 142 | 18-65 | 5.5 | 0.5 | 0.9 | 0.5 | 18-39 | 9.5 | 1.0 | 1.7 | 1.1 |
| Denmark (1) | 1994 | Inter. | 2 521 | | | | | | 16-44 | 37.0 | | 5.0[a] | |
| (2) | 1994 | Mail | 1 390 | 18-69 | 31.3 | 2.0 | 4.0 | | 16-44 | 43.0 | | | |
| Ger (former West) | 1995 | Mail | 6 292 | 18-59 | 13.9 | 2.2 | 2.8 | 1.6 | 18-39 | 21.0 | 3.7 | 4.1 | 2.8 |
| (former East) | 1995 | Mail | 1 541 | 18-59 | 3.6 | 0.2 | 0.7 | 0.7 | 18-39 | 6.4 | 0.3 | 1.3 | 1.3 |
| Spain (1) | 1995 | Interv. | 9 984 | 15-70 | 13.0 | 3.3[b] | 2.3 | 1.8[c] | 15-39 | 21.9 | 5.7[b] | 3.8 | 3.1[c] |
| (2) | 1997 | Interv. | 12 445 | 15-65 | 21.7 | 3.2 | 2.5 | 2.5 | | | | | |
| France | 1995 | Phone | 1 993 | 18-69 | 16.0 | 1.2 | 0.7[d] | | 18-39 | 25.7 | 1.8 | 1.4[d] | |
| Finland (1) | 1992 | Mail | 4 892 | 18-74 | 4.8 | | 0.6[a] | | 18-34 | 10.1 | | 1.1[a] | |
| (2) | 1996 | Mail | 4 429 | 16-74 | 7.3 | | 0.7 | | 16-29 | 15.0 | | | |
| Sweden (1) | 1994 | Interv. | 933 | 15-69 | 7.0 | 0.0 | 1.0 | 0.0 | 15-34 | 9.0 | 0.0 | 3.0 | 0.0 |
| (2) | 1996 | Interv. | 1 500 | 15-69 | 9.0 | 1.0 | 2.0 | 0.0 | 15-34 | 12.0 | 1.0 | 3.0 | 1.0 |
| U. Kingdom (1) | 1994 | Interv. | 9 646 | 16-59 | 21.0 | 2.0 | 8.0 | 2.0 | 16-29 | 34.0 | 3.0 | 14.0 | 6.0 |
| (2) | 1996 | Interv. | 10 940 | 16-59 | 22.0 | 3.0 | 9.0 | 3.0 | 16-29 | 36.0 | 4.0 | 16.0 | 9.0 |

[a] Hard drugs. [b] Cocaine or crack. [c] Designer drugs. [d] Amphetamines + Ecstasy.
**Note:** In some countries (Finland and the United Kingdom) the age range for young adults is more restricted than in other countries. This may tend to produce higher prevalence figures among young adults in these countries.

During the last four years, eight EU countries have conducted national, or near national, population surveys measuring drug use (Belgium (Flanders), Denmark, Finland, France, Germany, Spain, Sweden and the United Kingdom). Several of them conducted new surveys in 1997 (Germany and Spain) or are conducting them in 1998 (Sweden and the UK) or 1999 (France and Denmark). In addition, other countries are conducting national surveys in 1998 (Greece, Ireland and the Netherlands), although they had previously conducted local surveys.

Several countries have set up a series of similar surveys (Finland, Germany, Spain, Sweden and the UK) which will enable evaluations of trends at national level. These become increasingly valuable as more surveys are repeated in each country.

Figure 1: Cannabis use in the adult population




Although prevalence differences between countries exist, international comparisons should be made with caution, as differences may result from methodological factors such as data collection

methods and the sampling frame used, or the context. Countries may use different age ranges to report results, when even slight age differences may markedly shift prevalence rates. Also, factors such as the country's proportion of rural and urban populations may influence the overall prevalence figure.

Most drug experimentation in the EU has been with cannabis. Lifetime experience of cannabis in the population ranges from 5 to 7 % in Belgium (Flanders) and Finland to 20 to 30 % in Denmark, Spain and the UK. Young adults report higher rates ranging from 10 % in Belgium (Flanders) to 35 to 40 % in Denmark and the UK. In general, prevalence of use in big cities is higher than in the whole country.

The figures for lifetime experience of illegal substances other than cannabis should be considered with caution, as their low prevalence makes them more susceptible to random variations, and social reactions may decrease willingness to report use. Amphetamines are generally the second most prevalent substance, with 1 to 4 % having experimented with them. The UK figure is significantly higher than other countries (9 %). Cocaine has been tried by 1 to 3 % of the population, and by 1 to 6 % of young adults. Ecstasy has been tried by 0.5 to 3 % of the general population, while Ecstasy use is concentrated among young adults (1 to 9 %), with prevalence higher among people in their 20s.

That recent use (last 12 months) is much less common than lifetime experience may indicate that, for most people, drug use is an occasional experience, and that in only a limited proportion of cases does drug use become continuous.

Recent cannabis use (last 12 months) is reported by 1 to 9 % of the adult population, depending on the country; Finland, Sweden and eastern Germany present the lowest rates, and Spain and the UK the highest. As with lifetime experience, recent use is higher among young adults; in most countries between 3 and 10 %, although reaching 20 % in the UK.

Prevalence of recent use of substances other than cannabis is very low. Among the adult population, use in the last 12 months has rarely exceeded 1 %, and among young adults has generally been below 2 %. Higher levels are reported for cocaine and Ecstasy in Spain, and for amphetamines and Ecstasy in the UK.

Consistent trend information is limited, as few EU countries have serial surveys using the same methods or follow-ups. However, cannabis use has increased in most EU countries in the last three to four years, although in countries with medium or high use (Denmark, Germany and the UK) the increase has been small. Trend information on other substances is even more limited at population level; a small increase in cocaine, and clear but moderate increases in amphetamines and Ecstasy. However, trends based on the whole population may be not accurate for amphetamines and Ecstasy, as they are mainly used by people in their early 20s.

## School surveys

School survey (generally of 12 to 18-year-olds) methodology is similar to general population surveys, although in this case the information is usually collected in the classroom with anonymous self-administered questionnaires. In schoolchildren lifetime experience is generally recent, so lifetime and last 12 months' prevalence do not have the big differences found in adults. All EU countries have conducted national school surveys in the last five years except in Germany, where a regular youth (12 to 25-year) survey is conducted. In 1995, an international study (ESPAD) was carried out in 25 European countries (EU and non-EU) by the Swedish Council for Information on Alcohol and other Drugs (CAD) and the Pompidou Group.

As with adults, there are differences in school populations in drug-use patterns between countries. Reported prevalence may be influenced by the same factors as general population surveys (methodology, sampling and context). The exact age of the students is also important as, in this age range, one or two years of difference may double prevalence rates. Opportunities for drug use are influenced by social factors, and experiences frequent at 16 years in one country, may occur at 18 in another. For instance, in Finland, the 1995 national school survey reported a lifetime prevalence of 5 % for cannabis among 15 to 16-year-olds, but in the same year, 17 to 18-year-olds in Helsinki reported a 30 % lifetime prevalence rate for cannabis.

The proportion of 15 to 16-year-olds who report cannabis use ranges from 3 to 5 % to 40 %, depending on the country. Finland and Portugal report the lowest rates, Ireland and the UK the highest. However, some countries with low cannabis prevalence report higher levels of solvent or amphetamine use.

## Table 2: Last 12 months' prevalence of drug use in recent nationwide surveys among the general population in some EU countries

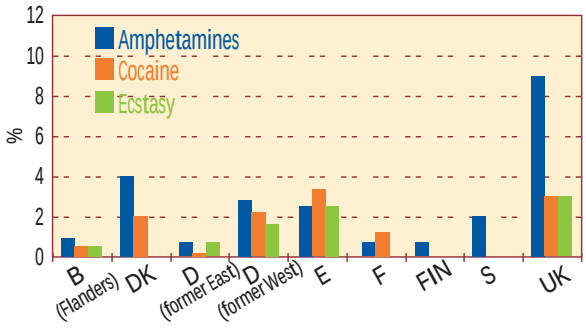
| Country | Year | Method | Sample | Age range | All adults (%) Cannabis | Cocaine | Amphetamines | Ecstasy | Younger adults (%) Age range | Cannabis | Cocaine | Amphetamines | Ecstasy |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium (Flanders) | 1995 | Phone | 1 142 | 18-65 | | | | | 18-39 | 2.7 | 0.5 | 0.7 | 0.5 |
| Denmark (1) | 1994 | Interv. | 2 521 | | | | | | 16-44 | 7.0 | | 0.5[a] | |
| (2) | 1994 | Mail | 1 390 | 18-69 | 3.3 | | | | 16-44 | 6.0 | | | |
| Ger (former West) | 1995 | Mail | 6 292 | 18-59 | 5.0 | 0.9 | 0.8 | 0.9 | 18-39 | 8.8 | 1.6 | 1.5 | 1.6 |
| (former East) | 1995 | Mail | 1 541 | 18-59 | 1.9 | 0.2 | 0.2 | 0.6 | 18-39 | 3.5 | 0.3 | 0.4 | 1.2 |
| Spain (1) | 1995 | Interv. | 9 984 | 15-70 | 6.6 | 1.7[b] | 1.0 | 1.2[c] | 15-39 | 11.6 | 3.2[b] | 1.7 | 2.2[c] |
| (2) | 1997 | Interv. | 12 445 | 15-65 | 7.5 | 1.5 | 0.9 | 1.0 | | | | | |
| France | 1995 | Phone | 1 993 | 18-69 | 4.7 | 0.2 | 0.3[e] | | 18-39 | 8.9 | 0.3 | 0.6[e] | |
| Finland (1) | 1992 | Mail | 4 892 | 18-74 | 1.2 | | | | 18-34 | 3.0 | | | |
| (2) | 1996 | Mail | 4 429 | 16-74 | 1.9 | | | | 16-34 | 5.2 | | | |
| Sweden (1) | 1994 | Interv. | 933 | 15-69 | 0[d] | | | | 15-34 | 1.0[d] | | | |
| (2) | 1996 | Interv. | 1 500 | 15-69 | 1[d] | | | | 15-34 | 1.0[d] | | | |
| U. Kingdom (1) | 1994 | Interv. | 10 000 | 16-59 | 8.0 | < 0.5 | 2.0 | 1.0 | 16-29 | 20.0 | 1.0 | 7.0 | 3.0 |
| (2) | 1996 | Interv. | 10 940 | 16-59 | 9.0 | < 0.5 | 3.0 | 1.0 | 16-29 | 21.0 | 1.0 | 8.0 | 4.0 |

[a] Hard drugs. [b] Cocaine or crack. [c] Designer drugs. [d] All illegal drugs. [e] Amphetamines + Ecstasy.
**Note:** In some countries (Finland and the United Kingdom) the age range for young adults is more restricted than in other countries. This may tend to produce higher prevalence figures among young adults in these countries.

In most countries, solvents are the second most common substance used among 15 to 16-year-olds, ranging from about 3 % (Belgium (Flanders), Luxembourg and Spain) to 20 % (UK). In some countries solvents are more prevalent than cannabis (Greece and Sweden). Amphetamines have been used by 1 to 13 % of 15 to 16-year-olds, Ecstasy by 1 to 9 % and LSD and hallucinogens by 1 % to more than 10 %. Ireland, the Netherlands and the UK report relatively higher figures for amphetamines, hallucinogens and Ecstasy. The lowest prevalence figures are for cocaine, with a range of 1 to 4 %, and heroin, with 1 % or less in most countries, although 2 % in Denmark, Ireland, Italy and the UK.

Trend information on recent years is available in Belgium (Flanders), Denmark, Ireland, the Netherlands, Sweden and the UK. In most of these countries lifetime experience with cannabis shows a clear increase. Lifetime experience with amphetamines and Ecstasy also increased, although at lower

Figure 2: Use of amphetamines, cocaine and Ecstasy in the adult population (ever used)



## Table 3: Lifetime prevalence of use of different illegal drugs among 15 to 16-year-old students in recent nationwide school surveys in some EU countries

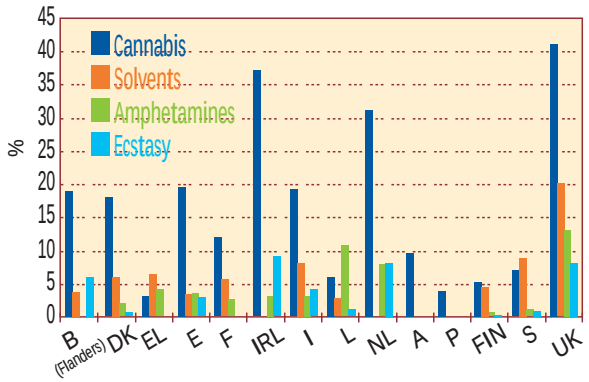
| Country | Year | Sample | Lifetime prevalence among students 15-16 years old (%) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | All illegal drugs | Cannabis | Solvents | Amphetamines | Ecstasy | LSD | Cocaine | Heroin |
| Belgium (Flanders) | 1996 | 4 771 | | 18.9 | 3.6 | | 6.0 | 2.5 | 1.1 | 1.0 |
| Denmark | 1995 | 2 571 | | 18.0 | 6.0 | 1.9 | 0.5 | 0.4 | 0.5 | 2.0 |
| Greece | 1993 | 10 543 | 4.8 | 3.0 | 6.3 | 4.0 | | 1.1 | 0.9 | 0.6 |
| Spain | 1994 | 21 094 | **22.1** | **19.4** | **3.2** | **3.5** | **2.9**[a] | **4.5** | **1.7** | **0.5** |
| France | 1993 | 12 391 | 15.3 | 11.9 | 5.5 | 2.5[b] | | 1.5 | 1.1 | 0.8 |
| Ireland | 1995 | 1 849 | 37.0 | 37.0 | | 3.0 | 9.0 | 13.0 | 2.0 | 2.0 |
| Italy | 1995 | 1 641 | 21.0 | 19.0 | 8.0 | 3.0 | 4.0 | 5.0 | 3.0 | 2.0 |
| Luxembourg | 1995 | 1 341 | 15.0 | 6.0 | 2.6 | 10.6 | 0.9 | 0.9 | 0.9 | 0.0 |
| Netherlands | 1996 | 10 455 | 31.7 | 31.1 | | 7.8 | 8.1 | | 4.3 | 1.3 |
| Austria | 1994 | 2 250 | **9.9** | **9.5** | | | | | **2.0**[c] | |
| Portugal | 1995 | 4 767 | 4.7 | 3.8 | | | | 0.2 | 1.0 | 0.9 |
| Finland | 1995 | 2 300 | **5.5** | **5.2** | **4.4** | **0.5** | **0.2** | **0.3** | **0.2** | **0.1** |
| Sweden | 1997 | 5 683 | 7.6 | 6.8 | 8.7 | 0.9 | 0.8 | 0.5 | 0.5[d] | 0.5 |
| U. Kingdom | 1995 | 7 722 | 42.0 | 41.0 | 20.0 | 13.0 | 8.0 | 14.0 | 3.0 | 2.0 |

[a] Spain: (= plus other synthetic drugs). [b] France: (= amphetamines, Ecstasy and stimulants). [c] Austria: (= hard drugs). [d] Sweden: (= cocaine and crack) — Ireland, Italy and United Kingdom: LSD (='LSD and other hallucinogens').
In some countries, crack use has been reported independently of cocaine: Ireland, 3 %; Italy, 2 %; United Kingdom, 3 %.

In Germany a youth survey (12 to 25-year-olds) has been conducted every three to four years since 1970 instead of the school survey. In the 1994 survey the total sample was 4 000 (12-25 years): lifetime prevalence for any illegal drug among 14 to 17-year-olds was 12 % (former West Germany) and 4 % (former East Germany). *Source:* Bundeszentrale für gesundheitliche Aufklärung, *Die Drogenaffinittät Jugendlicher in der Bundesrepublik Deutschland. Wiederholungsbefragung 1993/1994*: Köln.

**Notes:** (1) Due to the differences in reporting of results, in some cases it was necessary to make some reasonable estimates (results are presented in bold).
(2) In all the surveys the method for data collection was written questionnaires.

Figure 3: Drug use among 15 to 16-year-old school students (ever used)



levels. On the other hand, cocaine experience shows only a small increase. As in adult surveys, generalisation of trend information drawn from school surveys has some limits; some trends may not be well represented in the age group covered (mainly the 15 to 16-year-olds).

## Estimates of problem drug use

Problem drug use, injecting or use associated with criminal behaviour, is rare in the adult population and practically absent at school ages. Therefore, it is not possible to obtain reliable prevalence figures through general population or school surveys. To

### Table 4: National prevalence estimates of problem drug use in EU countries

| Country | Year | Data[a] | Methods[a] | Definition[a] | Prevalence | Rate/1 000 | |
|---|---|---|---|---|---|---|---|
| | | | | | | All ages | Ages 15-54 |
| Denmark (1) | 1996 | mortality data | multiplier | 'heavy drug abusers'[b] | 12 500 | 2.4 | 4.2 |
| Germany (2) | 1995 | arrests, treatment, deaths, surveys; GPs | multiplier, other methods | IDUs or frequent hard drug users[c] | 100 000-150 000 | 1.2-1.8 | 2.2-3.3 |
| France (3) | 1993 | treatment surveys (November census) | demographic model | heroin addicts (mostly IDUs)[d] | 160 000 | 2.8 | 5.0 |
| Italy (4,5,6) | 1992 | treatment, police, prison, deaths, AIDS, cohort studies | C-RC, multiplier | opiate addicts (mostly IDUs) | 190 000-313 000 | 3.3-5.5 | 5.9-9.7 |
| Luxembourg (7) | 1997 | treatment, drug offences, prison | multi-indicator, register demographic model, police multiplier | 'high-risk drug consumers'[e] | 1 900-2 300 | 4.6-5.5 | 8.0-9.7 |
| Netherlands (8,9) | 1993 | treatment, police, experts municipalities | multiplier, extrapolation | opiate addicts (including IDUs) | 25 000-28 000 | 1.6-1.8 | 2.7-3.1 |
| Austria (10) | 1993 | ambulance calls, deaths, other overdoses, drug register | 'consistency checks', case-finding | 'illegal opiate consumers' | 10 000-15 000 | 1.3-1.9 | 2.2-3.3 |
| Finland (11) | 1995 | hospital treatments, penal actions, traffic offences | C-RC, multiplier | amphetamine and opiate users | 5 300-10 500 | 1.0-2.1 | 1.8-3.6 |
| Sweden (12) | 1992 | social services, treatment, correctional system | case-finding, C-RC | 'severe drug abusers' [f] | 14 000-20 000 | 1.6-2.3 | 3.0-4.3 |

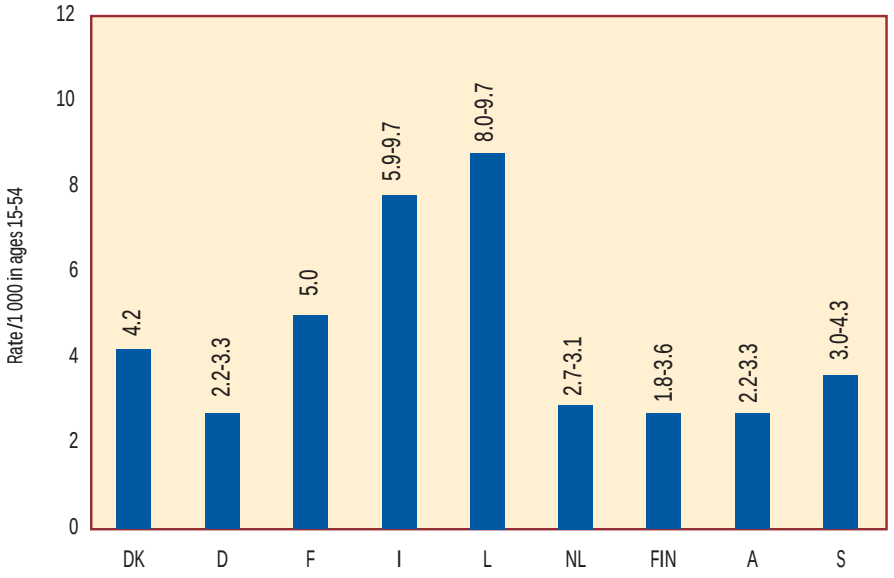
[a] C-RC = capture-recapture, IDUs = injecting drug users, GPs = general practitioners.
[b] Opiate addicts (IDUs as well as smokers), amphetamine addicts, cocaine addicts and patients undergoing methadone treatment.
[c] Almost all are opiate misusers (using at least 100 times /year) or injecting drug users.
[d] This estimate assumes opiate addicts show up in the health or social system at least once in their career; those who do not are excluded.
[e] Almost all are opiate misusers or injecting drug users.
[f] Injected at least once in last year, or daily/almost daily use of any illegal drug (including cannabis and Ecstasy). Of these, 19 % had opiates as primary drug, 34 % had used opiates at some time and 93 % injected in the last year (mostly amphetamines).

estimate prevalence, one must employ multiplier techniques or advanced statistical models like three-sample capture-recapture.

These estimates were first developed, and are more easily applied, at local level. An updated overview is presented of local prevalence estimates. Even when techniques vary and definitions are not always compatible, it suggests that important differences exist between cities and towns in Europe, estimates in ages 15 to 54 varying from 1.8 per 1 000 for one small Dutch town to between 22 and 39 per 1 000 for a small Scottish town. Less dramatic but still important differences are observed between major cities. However, differences within a country may be just as pronounced, as illustrated by the Netherlands (from 1.8 up to 10.1 to 11.5 per 1 000 aged 15 to 54) and UK (from 5.3 up to 22 to 39 per 1 000 aged 15 to 54). In 1997, a study commissioned by the EMCDDA produced estimates for opiate use in six cities using similar methods and definitions. Estimated prevalence in ages 15 to 54 ranged from between 4.2 and 8.1 per 1 000 in Helsinki (Finland) to between 12.7 and 29 per 1 000 in Setúbal (Portugal). This suggests that the wide range of prevalence found in other studies cannot be attributed to methodological differences only.

Prevalence estimates at national level are more problematic, as within-country heterogeneity and lack of data are more pertinent, and so should again only be used as a crude indication of prevalence. Updated national estimates are presented for the nine countries that could provide an estimate and give methodological details. Methods and definitions vary significantly, from 'opiate addicts' or 'heroin addicts' in some countries to a wider definition of 'heavy/severe drug abusers' or 'high-risk drug consumers' in others. In Sweden even frequent users of cannabis and Ecstasy are counted, although more than 90 % are amphetamine injectors. Even though these methodological differences make the picture more diffuse, it is clear that differences in prevalence between countries cannot be very large. Estimates for all countries in ages 15 to 54 vary by about a factor of 2 to 3, for example from 1.8 to 3.6 per 1 000 in Finland to 5.9 to 9.7 per 1 000 in Italy and 8.0 to 9.7 in Luxembourg.

Figure 4: National prevalence estimates of problem drug use



## Table 5: Local prevalence estimates of problem drug use in EU countries

| | City | Year | Data[a] | Methods[a] | Definition[a] | Prevalence Rate/1 000 | In ages 15-54 |
|---|---|---|---|---|---|---|---|
| D | Berlin (1) | 1995/96 | GPs | C-RC, monitor GPs | IDUs | 6 500-8 000 | 3.2-3.9 |
| | Bremen (2) | 1996/97 | medical/social, justice | case-finding | illegal drug users in contact with services | 4 347 | 11.9 |
| E | Barcelona (3) | 1993 | emergencies, treatment, prison | 3-sample C-RC | opiate addicts | 10 594-16 132 | 7.2-11.0 |
| | Madrid (4) | 1992 | deaths, treatment, AIDS regist., prison | 3-sample C-RC and multipliers | heroin addicts | 41 000 | 14.1 |
| | Navarra region (5) | 1990 | health and justice systems | case-finding | heroin users in treatment | 1 231 | 4.2 |
| F | Toulouse (6) | 1995 | repressive, medical/social, low-threshold | case-finding, 3-sample C-RC | opiate users in difficulty | 1 700-2 600 | 4.3-6.5 |
| I | Lazio region (7) | 1992 | publ. treatment, therapeut. comm., police | 3-sample C-RC | opiate addicts | 24 060 | 8.0 |
| | Rome (8) | 1996 | surveillance system, hospital, emergencies | 3-sample C-RC | drug abusers (mostly opiate users) | 12 742-16 167 | 7.9-10.1 |
| L | Luxembourg City (9) | 1997 | treatment, drug offences, prison | multi-indicator register, demographic model, police multiplier | 'high-risk drug consumers'[b] | 760 | 16.2 |
| NL | Alkmaar (10) | 1991 | field study | case-finding, nomination, snowball | opiate users | 98 | 1.8 |
| | Amsterdam (11) | 1996 | treatment regist., methadone in police cells | 2-sample C-RC | opiate addicts | 3 564-5 769[c] | 7.8-12.7 |
| | Rotterdam (12) | 1994 | low-threshold methadone treatment | truncated Poisson | problematic opiate users | 3 497-3 990 | 10.1-11.5 |
| | Utrecht (13) | 1993 | police, methadone, field study | C-RC, nomination, network analysis | opiate users | 950 | 6.3 |
| A | Vienna (14) | 1993 | hospital, ambulance, police, deaths | 4-sample C-RC | opiate addicts | 4 332-11 668 | 4.6-12.4 |
| P | Setúbal (15) | 1996 | health centre, specialised centre (2 semesters) | 3-sample C-RC | opiate users with health problems | 620-1 423 | 12.7-29.0 |
| FIN | Helsinki (16) | 1995 | hospital drug treatments, police, traffic offences | 3-sample C-RC | amphetamine and opiate users | 2 280-4 450[d] | 4.2-8.1 |
| S | Malmö (17, 18) | 1992 | needle exch., treatment, social serv., detention | case-finding, C-RC | severe drug abusers[e] | 1 100-1 300 | 8.8-10.4 |
| | Stockholm (19) | 1996 | treatment, social services | case-finding | drug users in contact with services [f] | 1 633 | 3.9 |
| UK | Dundee (20) | 1990/94 | treatment, police, HIV test | 4-sample C-RC | misusers of opiates/benzod. | 1 974-3 458 | 22.3-39.0 |
| | Glasgow (21) | 1990 | treatment, police, HIV test, needle exch. | 4-sample C-RC | IDUs | 7 491-9 721 | 11.9-15.4 |
| | Liverpool (22) | 1991 | treatment, police, infectious diseases unit | 3-sample C-RC | users of opiates/cocaine | 2 344 | 9.8 |
| | South and East Cheshire region (23) | 1993 | police, GPs, needle exch., comm. drug teams | 4-sample C-RC | opiate, amphetamine or cocaine misusers | 682-4 153 | 2.7-16.3 |
| | Wales region (24) | 1994 | treatment, police, needle exch., probation | C-RC | serious drug users[g] | 8 357 | 5.3 |

[a] C-RC = capture-recapture, IDUs = injecting drug users, GPs = general practitioners.
[b] Almost all are opiate misusers or injecting drug users.
[c] Dutch 3 564 foreign; 2 205; total 5 769. The estimate of foreigners and thus the total could be too high, as these form an open population.
[d] Amphetamine users: 1 590-3 780: opiate users: 490-1 390.
[e] Injected at least once in last year, or daily/almost daily use of any illegal drug (including cannabis and Ecstasy).
[f] Includes cannabis and Ecstasy users in contact with social services. Of these 44 % were opiate users and 95 % injected in the last year (mostly amphetamines).
[g] Includes IDUs, arrest data may be confined to problem users of opiates and amphetamines.

## Demand for treatment

Information on treatment admissions provides useful information on characteristics and patterns of drug use (injection, multiple drug use, etc.) among problematic users and may be a useful indirect indicator of trends in problematic drug use and as a basis for other prevalence estimation methods. However, changes in treatment modalities or reporting procedures must be taken into account. Finally, this information is valuable from a public health perspective to assess needs, to identify patterns of service uptake and to plan and evaluate services.

Almost all EU countries provide information on drug treatment, but sources and methods vary according to the types of treatment centres which provide reports. This may explain some of the cross-national differences reported in substances and other characteristics. New services (e.g. substitution, low threshold) may attract new users, increase the number of treatment admissions, or change trends and profiles (e.g. age, sex, route of administration). With these limitations in mind, some common features can be identified among clients entering treatment in EU countries.

The majority of clients (70 to 95 %) require treatment for opiate (mainly heroin) use. Finland and Sweden are the exception, with only 34.8 and 39 % of cases presenting for opiates, although in both countries treatment information is based on hospital discharges only and so biases the population. In some countries, methadone is increasingly mentioned as the primary drug, but this may be a result of data collection methods; for example, clients already enrolled in a methadone programme are admitted to another clinic and then recorded as a 'methadone case'.

Cocaine is usually reported as a main drug by less than 5 % of treatment admissions. In Belgium (Flanders) (9 %), Luxembourg (11 %) and the Netherlands (14,5 %) the proportion is higher. Cocaine is frequently reported as a secondary drug by heroin users.

Cannabis is generally reported as a main drug by about 10 % or less of treatment admissions. In Finland, Germany, Greece, Ireland and the Netherlands the proportion is higher and some countries have recently recorded increases. This requires more detailed examination, as other factors should be considered, such as the type of reporting centres, the sources of referral, and other characteristics of the client. For instance, in Spain, a significant proportion of cannabis cases reported opiates (heroin 19.8 %) or cocaine (30.9 %) as 'secondary drugs' and in the Netherlands 40 % of them reported alcohol, cocaine or Ecstasy as the secondary drug.

Amphetamines, Ecstasy and hallucinogens are primary drugs for generally less than 1 to 2 % of treatment cases. However, amphetamines are reported more in Finland (39.5 %), Belgium (Flanders) (24.4 %), Sweden (20 %) and the UK (9 %).

Prevalence of injecting among treatment admissions varies between countries, although differences also exist within countries. The substances most commonly injected are opiates, ranging from 10 to 15 % (Belgium (Flanders) and the Netherlands) to more than 80 % (Luxembourg and Greece). In the Scandinavian countries and the UK, amphetamines are often injected. In some countries, an important proportion of clients admitted for cocaine inject it, but this is not the common pattern of cocaine use in the EU.

In recent years the proportion of cases for opiates has decreased, while cases of cocaine and cannabis have increased, although at low levels. The proportion of injectors in the treated population is decreasing in almost all countries. These trends are more pronounced among clients seeking treatment for the first time, suggesting real changes in patterns of use among problem drug users.

Gender and age distribution of treatment admissions are relatively similar across the EU. Most are male (70 to 90 %), a figure which has remained stable in recent years. Treatment clients are generally in their 20s or 30s, with a mean age ranging from 23.7 years (Ireland) to 33.0 years (Sweden). In recent years a moderate increase in clients' mean age has been noted.

**Suggested explanation:** It has been suggested that this indicates an ageing cohort of problem drug users, with few new cases. If this were true, the mean age of clients should increase by almost one year annually, but the observed increase is smaller, and does not occur in all EU countries.

## Table 6: Some characteristics of persons treated for drug problems in different EU countries

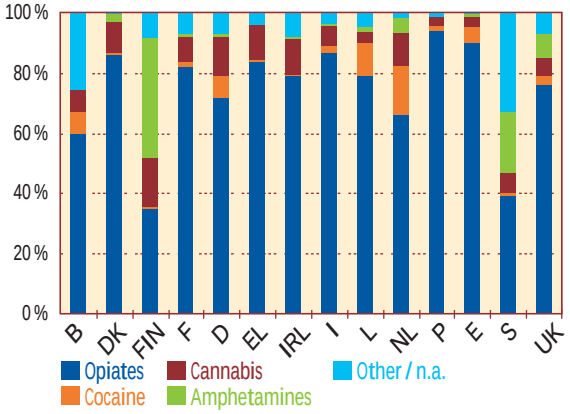
| Country | Sources | Year | Mean age | Age distribution <25 | Age distribution >35 | Sex distr. male/female | IV route of ad. main drug (%) | Distribution of main drug in percentages (% IV route of adm.) Opiates | Cocaine | Amphetamines | Hallucinogens | Cannabis | Others |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium (Brussels) | (1) | 1996 | | 22 | 25 | 70/30 | | 73.6 (9) | | 2.8 (9) | 1 | 2.1 | 16.3 |
| Belgium (Flanders) | | 1996 | | 52 | 9 | 84/16 | | 54.8 | 9.2 | 24.4 | 1.3 | 7.4 | |
| Belgium (Wallonia) | | 1996 | 29.6 | 33.5 | 24.2 | 72/28 | 18.3 | 57 (32) | 2.2 (23) | 2.1 | 0.2 | 9.1 | 26.2 |
| Denmark | (2) | 1997 | 32.5 | 20 | 40 | 73/27 | 27 | 84.6 (53) | 0.7 | 2 | | 10.5 | 0.6 |
| Germany | (3) | 1997 | 27.8 | 37 | 21 | 77/23 | 36.3 | 72 (47) | 7(36) | 1 | 2 | 13 | 2 |
| Greece | (4) | 1997 | 29.3 | 26.7 | 21.7 | 86/14 | 69.1 | 83.7 (82) | 0.4 (50) | 0.0 | 0.2 | 11.6 | 1.1 |
| Spain | (5) | 1996 | 29.2 | 26.7 | 16.3 | 84/16 | 32.5 | 89.7 (36) | 5.6 (8) | 1(1) | | 3.0 | 0.6 |
| France | (6) | 1995 | 28.9 | 24 | 17 | 73/27 | | 81.6 | 2.1 | 0.8 | 0.4 | 8.1 | 6.7 |
| Ireland | (7) | 1996 | 23.7 | 65 | 7 | 72/28 | 42.6 | 79 | 0.5 | 0.4 | 0.4 | 12 | 7.7 |
| Italy | (8) | 1997 | 30 | 21.2 | 21.9 | 86/14 | | 86.7 (75) | 2.3 (26) | 0.7 (7) | 0.4 | 6.7 | 3.2 |
| Luxembourg | (9) | 1997 | 28.5 | 27 | 15 | 81/19 | 79 | 79 (87) | 11 (82) | 1 | | 4 | 4 |
| Netherlands | (10) | 1997 | 30.4 | 25.1 | 25 | 80/20 | 10.3 | 66 (14) | 16.3 (3) | 4.6 (6) | 0.2 | 11.2 | 2 |
| Austria | | | | | | | | | | | | | |
| Portugal | (11) | 1996 | 27 | 37.6 | 9.7 | 81/19 | 45 | 93.3 (49) | 1.5 (57) | | | 3 | 0 |
| Finland | (12) | 1996 | | 32 | 30 | 66/33 | | 34.8 | 0.6 | 39.5 | 8.6 | 16.5 | |
| Sweden | (13) | 1996 | 33 | 17 | 42 | 72/28 | | 39 | < 1 | 20 | < 1 | 7 | 33 |
| U. Kingdom | (14) | 1996/97 | | 43 | 15 | 75/25 | 37 | 76 (43) | 3 (5) | 8 (42) | 0 | 6 | 7 |

Belgium (Brussels): amphetamines (= stimulants including amphetamines). Germany: 'IV route of ad. main drug' (%) and ('% IV route of adm.') (= currently injecting the drug). Portugal: IV route of ad. main drug (%) (= currently injecting any drug).
In Germany, Italy and Luxembourg the '% IV route of adm.' refers to heroin.

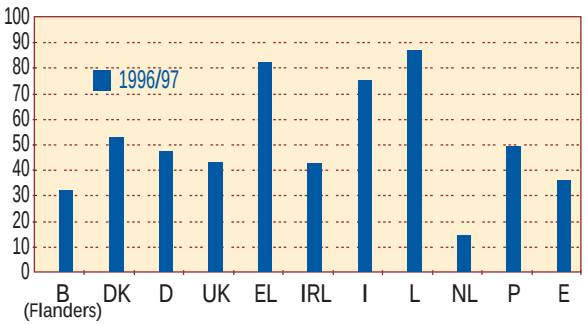
In several countries 'Amphetamines' also include Ecstasy: Belgium (Flanders) 3.7 %; Belgium (Wallonia) 1.6 %; Greece 0.2 %; Italy 0.4 %; Netherlands 1.6 %; Spain 0.4 %.

Others: Belgium — Brussels (include alcohol).
Belgium — Wallonia (include alcohol).
France (solvents, hypnotics-sedative).
Sweden (multiple abuse).

### Figure 6: Main drug for which clients demanded treatment in different EU countries




### Figure 6.1: Proportion of clients treated for opiate problems using the IV route (1996/97)




In Germany, Italy and Luxembourg data refer to heroin. In Ireland data refer to main drug.

## Deaths and mortality

Deaths related to the use of drugs are a cause of social concern, and their number is often simplistically used as a marker of a country's drug situation. However, statistics on drug-related deaths depend not only on the prevalence and patterns of use, but also on the methods and definitions used to record cases.

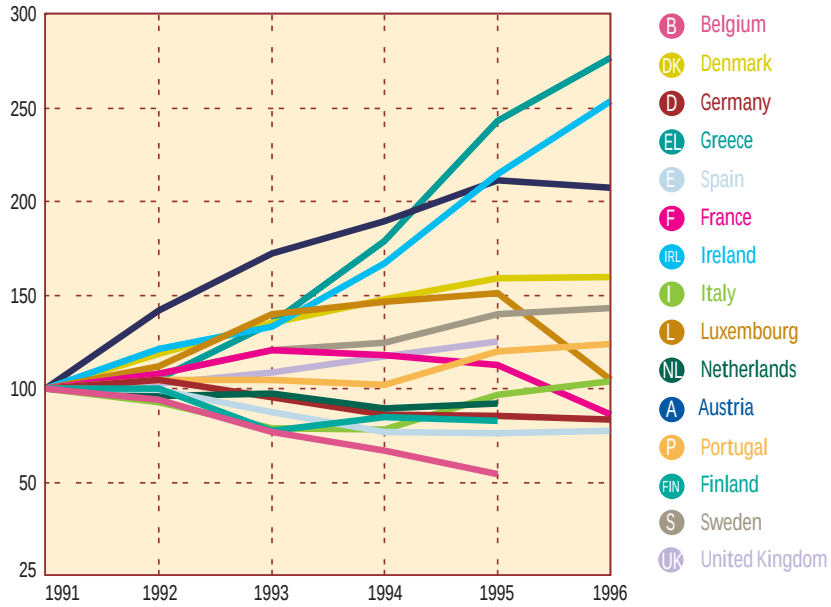
In the EU, statistics refer mainly to acute deaths shortly after the use of drugs, called 'acute intoxication' or 'overdoses'. Direct comparisons between countries cannot be made but, if recording methods are maintained consistently, drug-related deaths can be a useful indicator of trends for severe forms of drug use. Improving data quality and comparability is difficult, as countries rely on different types of registries, and use different recording and reporting procedures. The EMCDDA has been analysing national recording procedures, and standards for reporting have been developed. The feasibility of implementing these standards will be tested in all EU countries. Information has been exchanged with Eurostat and the World Health Organisation (WHO), whose representatives participated in the EMCDDA working group.

### Table 7: Number of acute drug-related deaths recorded in EU countries, 1985-97

| Country | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | Pop.at risk(1) (mil.) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium | 12 | 20 | 17 | 37 | 49 | 96 | 90 | 75 | 80 | 46 | 48 | | | 10.1 |
| Denmark | 150 | 109 | 140 | 135 | 123 | 115 | 188 | 208 | 210 | 271 | 274 | 266 | 274 | 5.2 |
| Germany (2) | 324 | 348 | 442 | 670 | 991 | 1 491 | 2 125 | 2 099 | 1 738 | 1 624 | 1 565 | 1 699 | 1 486 | 81.8 |
| Greece | 10 | 28 | 56 | 62 | 72 | 66 | 79 | 79 | 78 | 146 | 176 | 222 | 222 | 10.4 |
| Spain | 143 | 163 | 234 | 337 | 455 | 455 | 579 | 556 | 442 | 388 | 394 | 429 | | 14.5(3) |
| France | 172 | 185 | 228 | 236 | 318 | 350 | 411 | 499 | 454 | 564 | 465 | 393 | 228 | 58.2 |
| Ireland | 22 | 8 | 7 | 15 | 8 | 11 | 14 | 17 | 20 | 19 | 31 | 40 | | 1.8 (4) |
| Italy | 242 | 292 | 543 | 809 | 974 | 1 161 | 1 383 | 1 217 | 888 | 867 | 1 195 | 1 566 | 1 153 | 57.1 |
| Luxembourg | 1 | 3 | 5 | 4 | 8 | 9 | 17 | 17 | 14 | 29 | 20 | 16 | 9 | 0.23(4) |
| Netherlands (5) | 40 | 42 | 23 | 33 | 30 | 43 | 49 | 43 | 38 | 50 | 33 | | | 15.4 |
| Austria (6) | da | da | da | da | 20 | 36 | 70 | 121 | 130 | 140 | 160 | 179 | 132 | 7.9 |
| Portugal | | 18 | 22 | 33 | 52 | 82 | 143 | 155 | 100 | 142 | 145 | 169 | | 9.8 |
| Finland | | | 3 | 11 | 14 | 17 | 26 | 15 | 17 | 13 | 19 | | | 5.1 |
| Sweden | 150 | 138 | 141 | 125 | 113 | 143 | 147 | 175 | 181 | 205 | 194 | 250 | | 8.8 |
| U. Kingdom | da | da | da | 1 212 | 1 191 | 1 284 | 1 402 | 1 450 | 1 399 | 1 651 | 1 805 | | | 58 |

(da) data available but not comparable with other years.
(1) It is considered different from the total population only when the cases of death are obtained from a clearly defined subgroup of the population.
(2) Cases from the former West Germany. Former East Germany: 1996 (13 cases), 1997 (15 cases).
(3) Population and cases refer to six large cities.
(4) Population aged 15-49.
(5) In this table, cases included are only those whose underlying cause of death was the ICD-9 codes 292, 304, 305.2-9, E850.0, E854.1 or E854.2. In 1996 ICD-10 was implemented; but although data are available there is not yet an agreement on the codes to be selected.
(6) For comparability reasons only overdoses were taken from all national data on drug-related deaths.
**Important note (for all countries):**
Data from different countries are not directly comparable, as there are some differences in case definition and methods of data collection (see Table 8 of the 1997 EMCDDA annual report).

Figure 7: Trends in the number of drug-related deaths in EU countries, 1991-96
Three years' moving averages indexed (1991 = 100)




Absolute numbers of acute drug-related deaths cannot be directly compared between countries due to differences in definitions and methods of data collection.
Note that here trends but not numbers are presented.

Other types of deaths (infectious diseases, accidents, suicides) should be included in evaluations of the overall impact of drug use in society, although information sources and methods for recording cases are different than those for acute intoxications.

Some groups of drug users are at increased risk of death. Opiate injectors have a mortality which is 20 to 30 times higher than non-drug users of the same age from overdoses, infectious diseases (AIDS and others), accidents and suicides. If opiates are not injected, or combinations of substances are avoided, the risk is lower. Users of other substances, that do not inject, have a much lower risk of death, especially from acute intoxication. Other potential mortality risks, such as substance-related traffic accidents, should be evaluated.

In the EU, opiates are found in most cases of deaths from acute intoxication, although other substances are often present. Alcohol and benzodiazepines are frequently found and may be risk factors for fatality in cases of opiate intoxication. Acute deaths relating solely to cocaine or amphetamines are unusual. Deaths related to Ecstasy or similar substances, although widely publicised, are few in number. This may change if chronic intense use develops, or if use in combination with other substances increases.

Some general trends in drug-related deaths can be outlined, although the effects of changes in recording procedures cannot be ruled out. In most EU countries, acute drug-related deaths increased markedly during the late 1980s and early 1990s. Since then, trends have diverged, although with a general trend towards stabilisation or decrease. In several countries, the highest were from 1990-92, with a downward trend since, albeit accompanied by transitory rises. In other countries there has been an upward trend until recently (1994-96), followed by a decrease, whereas in some countries the upward trend still continues. Finally, in a few countries (Finland and the Netherlands) there has been no clear trend in recent years, with the number of reported deaths having been relatively stable.

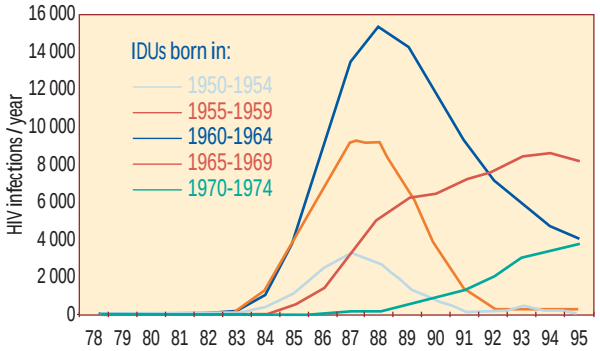
**Suggested explanations:** The underlying causes of these trends are difficult to identify and interpretations should be made with caution. Changes in trends in drug-related deaths may be related to stabilisation in problematic drug-use prevalence, to changes in the patterns of use (e.g. decrease of injection), to the effects of interventions, or changes in registration practices.

## Infectious diseases

There are large differences in prevalence rates for HIV infection among injectors between countries, ranging from 0 % (Finland) to 30 % (Spain). Large differences also exist within countries, between regions and cities. There is no simple explanation for this. In some countries, the cities with high prevalence (Edinburgh and Amsterdam) were among those first affected by the epidemic, so awareness and prevention responses were too late to prevent the strong rise. In others, risk behaviour may have been so extensive that an epidemic was unavoidable (Spain and Italy), irrespective of awareness and prevention measures.

HIV backcalculation models show that new generations of injecting drug users continue to be infected, though at lower levels than in the 1980s

(EU Concerted Action BMH1-CT94-1723, RIVM, NL)




## Table 8: Prevalence of HIV infection among injecting drug users in EU countries

| Country | Year | Data | Number tested | % infected | Prevalence trend |
|---|---|---|---|---|---|
| Belgium (Wallonia) (1) | 1996 | first treatments, self-reports | 294 | 1.4([a]) | n.a. |
| Belgium (Flanders) (2) | 1993 | Antwerp: study treatment/streets | 217 | (5) | n.a. |
| Denmark (3) | 1995 | estimate from HIV notification | | 4 | n.a. |
| Germany (4) | 1996 | drug users in treatment, self-reports | 2 074 | 3.9([a]) | stable |
| Greece (5) | 1997 | treatment, screening/self-reports | 708 | 0.5-2.0 | stable |
| Spain (6) | 1996 | survey treatment centres | 871 | 30 | decrease |
| France (7) | 1995 | survey treatment centres, self-reports | 6 429 | 16-20 | decrease |
| Ireland (2) | 1993 | Dublin: study treatment/streets | 185 | (8) | n.a. |
| Italy (8) | 1997 | treatment in public services | 73 784 | 16 / 1-28 | decrease |
| Luxembourg (9) | 1997 | treatment reporting system, self-reports | 280 | 2-4 | stable |
| Netherlands (10) | 1996/97 | repeated treatment/street studies | 1 333 | 2-26 | stable |
| Austria (11) | 1997 | opiate overdose deaths | 132 | 1.5 | (stable) |
| Portugal (12) | 1996 | survey treatment centres, self-reports | 379 | 14 | stable |
| Finland (13) | 1997 | Helsinki: needle exchange, self-reports | 131 | (0) | (stable) |
| Sweden (14) | 1997 | study nine prisons | 196 | 3 | stable |
| United Kingdom (England+Wales) (15) | 1996 | unlinked anonymous | 3 373 | 0.6 | decrease |

Information based on local data is given between parentheses.
([a]) In all problem drug users, % in injecting drug users (IDUs) not known but almost certainly higher.
Data based on self-reports may be unreliable.

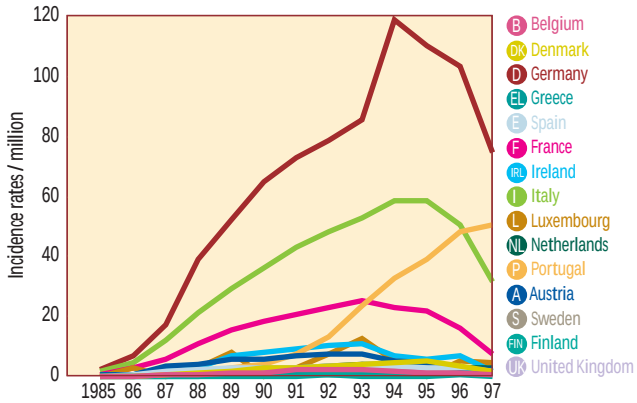
## Table 9: AIDS incidence related to injecting drug use (IDU) in countries of the European Union (by 31 March 1998)

(Annual incidence rates per million population and cumulative % of AIDS cases related to IDU)

| Country | Annual incidence rates per million population | | | | | | | | | | | | | % of cases related to IDU |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | |
| Belgium | 0.0 | 0.1 | 0.5 | 0.7 | 1.0 | 1.2 | 2.2 | 2.2 | 2.1 | 2.0 | 1.3 | 1.0 | 0.6 | 6.5 |
| Denmark | 0.0 | 0.2 | 0.6 | 1.2 | 1.6 | 3.1 | 3.1 | 3.5 | 4.1 | 4.6 | 5.4 | 3.3 | 1.8 | 7.9 |
| Germany | 0.2 | 0.6 | 1.6 | 2.3 | 2.9 | 2.9 | 2.9 | 3.3 | 3.4 | 3.6 | 3.1 | 2.6 | 1.7 | 14.2 |
| Greece | 0.0 | 0.1 | 0.1 | 0.2 | 0.5 | 0.6 | 1.2 | 0.6 | 0.8 | 0.5 | 0.4 | 0.9 | 1.2 | 4.0 |
| Spain | 2.4 | 7.1 | 17.0 | 38.8 | 52.0 | 64.7 | 73.2 | 78.6 | 85.5 | 119.0 | 110.3 | 103.1 | 74.7 | 65.4 |
| France | 0.8 | 2.7 | 6.0 | 11.1 | 15.6 | 18.5 | 20.8 | 22.8 | 25.2 | 23.1 | 22.0 | 16.1 | 7.2 | 23.8 |
| Ireland | 0.6 | 0.3 | 2.8 | 3.1 | 6.8 | 8.3 | 9.4 | 10.3 | 10.8 | 6.8 | 6.0 | 7.1 | 1.6 | 43.0 |
| Italy | 1.7 | 4.8 | 12.0 | 21.3 | 29.0 | 36.1 | 43.3 | 48.2 | 52.6 | 58.8 | 58.4 | 50.3 | 31.6 | 62.4 |
| Luxembourg | 0.0 | 2.7 | 0.0 | 2.7 | 8.0 | 0.0 | 2.6 | 7.7 | 12.7 | 5.0 | 0.0 | 4.9 | 4.8 | 15.7 |
| Netherlands | 0.1 | 0.4 | 1.1 | 2.3 | 2.3 | 2.7 | 2.9 | 3.7 | 3.9 | 3.9 | 4.8 | 3.0 | 2.8 | 10.9 |
| Austria | 0.8 | 0.4 | 3.6 | 4.3 | 5.6 | 5.8 | 7.0 | 7.2 | 7.4 | 5.2 | 4.7 | 3.1 | 2.3 | 25.5 |
| Portugal | 0.1 | 0.3 | 0.7 | 1.0 | 3.0 | 4.2 | 7.3 | 13.0 | 23.6 | 32.6 | 39.3 | 48.0 | 50.5 | 43.5 |
| Finland | 0.0 | 0.0 | 0.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.6 | 0.2 | 0.2 | 0.2 | 0.4 | 0.2 | 3.7 |
| Sweden | 0.0 | 0.0 | 0.1 | 0.6 | 0.5 | 1.3 | 2.3 | 2.5 | 3.8 | 3.0 | 2.7 | 2.5 | 1.0 | 11.5 |
| U. Kingdom | 0.0 | 0.1 | 0.3 | 0.5 | 1.1 | 1.4 | 1.5 | 1.4 | 2.6 | 2.3 | 2.5 | 2.1 | 1.4 | 6.5 |

**Notes:** (1) Figures for the years 1995, 1996 and 1997 are adjusted for reporting delays.
(2) In some countries there may be small differences between incidence rates provided by the European Centre and national figures due to reporting delays.

Figure 9: AIDS incidence related to injecting drug use in countries of the EU

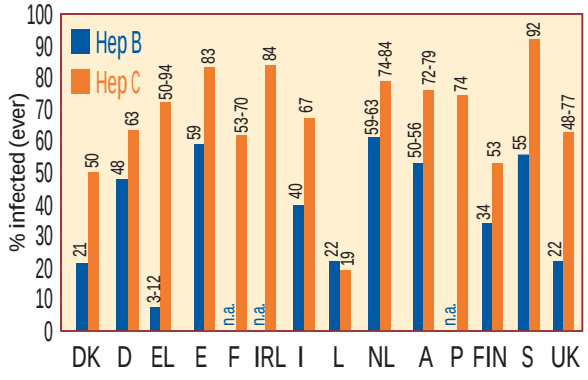


## Table 10: Prevalence of antibodies against hepatitis B and C among injecting drug users in EU countries

| Country | Hepatitis B Year | Hepatitis B Data | Hepatitis B % infected | Hepatitis C Year | Hepatitis C Data | Hepatitis C % infected |
|---|---|---|---|---|---|---|
| Denmark (1) | 1995 | estimate | 21 | 1995 | estimate | 50 |
| Germany (2) | 1996 | Dortmund: treatment | (48) | 1996 | Dortmund: treatment | (63) |
| Greece (3) | 1997 | methadone/drug-free treatment | 3-12 | 1997 | methadone/drug-free treatment | 50-94 |
| Spain (4) | 1996 | treatment | 59 | 1996 | treatment | 83 |
| France (5) | | n.a. | | 1995 | survey treatment centres, self-reports | 53-70 |
| Ireland (6) | | n.a. | | 1995 | Dublin: treatment | (84) |
| Italy (7) | 1997 | treatment | 40 | 1997 | treatment | 67 |
| Luxembourg (8) | 1997 | treatment, self-reports | 22 | 1997 | treatment, self-reports | 19 |
| Netherlands (9) | 1994/96 | Rotterdam/Heerlen/Maastricht: treatment | (59-63) | 1994/96 | Rotterdam/Heerlen/ Maastricht: treatment | (74-84) |
| Austria (10) | 1996 | Vienna: hospital, low-threshold treatment | (50-56) | 1996 | Vienna: hospital, low-threshold treatment | (72-79) |
| Portugal (11) | | n.a. | | | treatment, self-reports | 74 |
| Finland (12) | 1997 | Helsinki: needle exchange, self-reports | (34) | 1997 | Helsinki: needle exchange, self-reports | (53) |
| Sweden | 1997 | study nine prisons, saliva (13) | 55 | 1994 | Stockholm: study prison/treatment (14) | (92) |
| United Kingdom | 1996 | unlinked anonymous, England + Wales (15) | 22 | 1994 | survey treatment centres (16) | 48-77 |

Information based on local data is given between parentheses. Self-reports on hepatitis infection may be unreliable.

## Figure 10: Hepatitis B and C infection among injecting drug users in the EU




n.a.: data not available.

As an infected person can remain in a drug-using population for more than 10 years, the prevalence of HIV infection mainly depends on population dynamic factors like deaths (e.g. AIDS-related deaths or overdose) and migration. Therefore, once high prevalence has developed it may take many years to diminish.

Prevalence rates of HIV among injectors are stable or declining in most EU countries. This is the result of different factors, like spontaneous behaviour change among injecting drug users aware of AIDS, behaviour change as a result of harm reduction measures like needle exchanges and methadone programmes, and because many of those engaging in the greatest risk behaviour have already been infected and died.

Modelling studies, based on estimates of HIV incidence from reported AIDS cases, show that new generations of users continue to be infected. This, however, is masked by the overall decline in incidence rates after the explosive first phase of the epidemic, occurring in most countries in the second half of the 1980s. The HIV epidemic has now entered the endemic phase in most west European countries meaning that new infections balance deaths and migration.

Incidence rates for AIDS show large differences between countries. The proportion of AIDS cases related to injecting also differs between countries. Although some of this may be explained by differences in injecting rates, these are not sufficient to explain the large differences found between countries. Therefore, risk behaviours among injecting drug users must have significantly differed between countries around the time of introduction of HIV. AIDS monitoring is becoming less useful as an indicator of the extent of HIV infection due to new and highly effective AIDS treatments. Declines now seen in AIDS incidence mainly result from the delay of the onset of AIDS in HIV-infected persons. Therefore, AIDS is becoming an indicator of treatment uptake rather than of HIV infection. Centralised reporting of known HIV cases is under consideration in Europe to complement the existing AIDS reporting.

Prevalence of hepatitis B infection differs markedly between countries; from 3 to 12 % (Greece) up to about 60 % (Spain, the Netherlands). Hepatitis C infection in general shows higher and more similar rates, to over 90 %, even in countries with low rates of hepatitis B and HIV infection (Greece). High rates of hepatitis infection may imply that risky injecting practices are ongoing but at rates insufficient for HIV. Rates of hepatitis B infection are probably lower than hepatitis C because most infected people do not become chronic carriers and can only infect others for a limited period. In contrast, hepatitis C becomes chronic in most cases and can lead to long-term liver disease like cirrhosis and liver cancer.

It is estimated that around 500 000 injecting drug users are infected with hepatitis C in the EU. These infections may lead to significant disease burden and health-care costs, possibly comparable to HIV, and may include persons who have stopped using drugs for a long time. It is therefore important to develop a detailed understanding of which measures are most effective in preventing transmission. As those most at risk of developing long-term liver problems may be those infected by both hepatitis B and C, the vaccine for hepatitis B may be one cost-effective method of preventing disease. Treatment for hepatitis C is rapidly improving, which may have important implications for drugs and health-care services.

## Police arrests and prison data

The only data systematically available on police interventions refer to offences against drug laws (trafficking, possession, etc.). These reflect the legislation of each Member State, the administrative procedures for recording, and police resources and priorities. It is not possible to compare data directly, so emphasis is given to time trends.

Since 1985, there have been moderate increases (less than twofold) in Denmark, Luxembourg, Sweden and Italy, but in Belgium, Finland, Greece, Portugal, Spain and the UK increases have been more than fourfold. In recent years these increases have accelerated in many countries, though in Denmark, Ireland, Italy, Sweden and the United Kingdom they have stabilised or decreased.

Not all countries provide data that distinguish use-related from traffic-related offences. In those that do, use-related offences predominate, ranging from 60 % in Portugal and Germany, to over 85 % in Austria, Sweden and the UK. In most countries, the proportion of use-related offences is either increasing or stable. In most, cannabis is the predominant drug, although changes vary between countries. Only in Italy and Portugal is heroin the main drug, in the Netherlands 'hard drugs', and in Sweden amphetamines.

## Table 11: Drug-related arrests in EU countries: trend over the last three years (1)

| Country | Number of arrests: trend | Proportion of main drug involved: In 1997 | Proportion of main drug involved: Trend | Proportion of main type of offence: In 1997 | Proportion of main type of offence: Trend |
|---|---|---|---|---|---|
| Belgium | ++ | cannabis: 65% | n.a. | use [IV]: 72% | n.a. |
| Denmark | – | n.a. | n.a. | n.a. | n.a. |
| Germany | + | cannabis: 43% (a) | 0 | use: 64% | 0 |
| Greece | + | n.a. | n.a. | n.a. | n.a. |
| Spain | ++ | cannabis: 56% | + | trafficking only | |
| France | + | cannabis: 79% | + | use: 79% [III] | + |
| Ireland | – | cannabis: 63% (a) | 0 | use: 75% (a) | – |
| Italy | 0 | heroin: 45% | – | sale: 80% | + |
| Luxembourg | + | opiates | n.a. | n.a. | n.a. |
| Netherlands [VI] | ++ | 'hard drugs' [V]: 81% (a) | + | trafficking only | |
| Austria | + | cannabis: 63% [I] (a) | + | use [II]: 86% (a) | + |
| Portugal | ++ | heroin: 58% (a) | – | use: 54% [III] (a) | + |
| Finland | ++ | cannabis: 47% | – | use: 76% | + |
| Sweden | 0 | amphetamines: 51% (b) | + | use: 91% (a) | 0 |
| United Kingdom | + | cannabis: 77% (a) | 0 | use: 88% (a) | 0 |

(1) Trend: over the three last years available.
(2) **–** : <-7 %; **0** : +/- 7 %; **+** : between + 7 % and + 40 %; **+ +** : > +40 %.

(a) Data refer to 1996. (b) Data refer to 1995.

**I.** Among all drugs mentioned (alone or not). **II.** Possession and small-scale trafficking (the law just differs between small and large quantities). **III.** Use/trafficking excluded. **IV.** Use and possession together. **V.** All illicit drugs except hashish and marijuana. **VI.** Criminal offences related to import/export, sale delivery, transportation, production, possession, etc.

**n.a.:** data not available.

Few Member States have reliable information on drug users in prison, and the type of data varies widely, from people imprisoned for drug offences, to drug users identified on entry to prison, to levels of use revealed by surveys or tests in prison. Drug users constitute a significant proportion of the prison population in many countries, from 25 to 70 % or more. It is not always clear whether these estimates refer to users or to problematic users, though when specified, the proportions of problematic users is typically 20 to 50 %.

## Table 12: Arrests for drug law offences in EU countries, 1987-97

| Country | Study unit | Offences | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium | P | U/T | 6 393 | 7 000 | 6 093 | 7 051 | 10 720 | 18 179 | 19 482 | 19 467 | 18 376 | 36 872 | |
| Denmark | P | U/T | 7 862 | 7 031 | 7 566 | 8 915 | 9 535 | 10 290 | 12 421 | 9 536 | 9 008 | 8 678 | 8 234 |
| Germany | O | U/T | 74 894 | 84 998 | 94 000 | 103 629 | 117 046 | 123 903 | 122 240 | 132 389 | 158 477 | 187 022 | 205 099 |
| Greece | P | U/T | 2 257 | 2 471 | 2 660 | 3 081 | 3 197 | 2 966 | 2 636 | 3 340 | 4 400 | 6 420 | 6 040 |
| Spain | P | T | 25 545 | 27 911 | 27 407 | 24 812 | 28 581 | 27 713 | 30 161 | 31 703 | 44 318 | 65 707 | 78 847 |
| France | A | U/T | 31 105 | 31 213 | 33 510 | 34 213 | 45 063 | 54 468 | 51 657 | 59 697 | 69 432 | 77 640 | 89 285 |
| Ireland | C | U/T | 1 196 | 1 333 | 1 344 | 2 071 | 3 088 | 3 494 | 3 833 | 4 443 | 4 164 | 3 278 | |
| Italy | P | U/T | 19 373 | 23 320 | 20 582 | 18 343 | 22 966 | 27 617 | 23 525 | 25 957 | 21 913 | 22 171 | 22 705 |
| Luxembourg | A | U/T | 89 | 138 | 102 | 151 | 130 | 172 | 91 | 152 | 128 | 149 | 154 |
| Netherlands[a] | O | T | 5 420 | 4 820 | 4 700 | 5 900 | 4 430 | 3 380 | 3 010 | 4 040 | 3 470 | 6 593 | |
| Austria | O | U/T | 4 778 | 4 963 | 4 474 | 4 829 | 5 392 | 7 805 | 10 915 | 12 632 | 13 093 | 16 196 | 17 868 |
| Portugal | O | U/T | 2 192 | 1 845 | 2 534 | 3 586 | 4 667 | 6 280 | 5 197 | 4 708 | 6 380 | 9 054 | 9 333 |
| Finland | P | U/T | 1 203 | 1 024 | 741 | 1 346 | 1 969 | 2 399 | 3 063 | 3 175 | 3 944 | 6 059 | 7 015 |
| Sweden | P | U/T | 6 533 | 6 697 | 6 625 | 7 676 | 8 123 | 7 974 | 7 394 | 8 604 | 9 573 | 8 810 | |
| United Kingdom | P | U/T | 26 278 | 30 515 | 38 415 | 44 922 | 47 616 | 48 927 | 68 480 | 85 691 | 93 631 | 95 010 | |
| **Total** | | | **182 850** | **212 861** | **232 808** | **248 093** | **267 444** | **309 326** | **342 601** | **361 469** | **402 194** | **455 907** | |

### Definitions

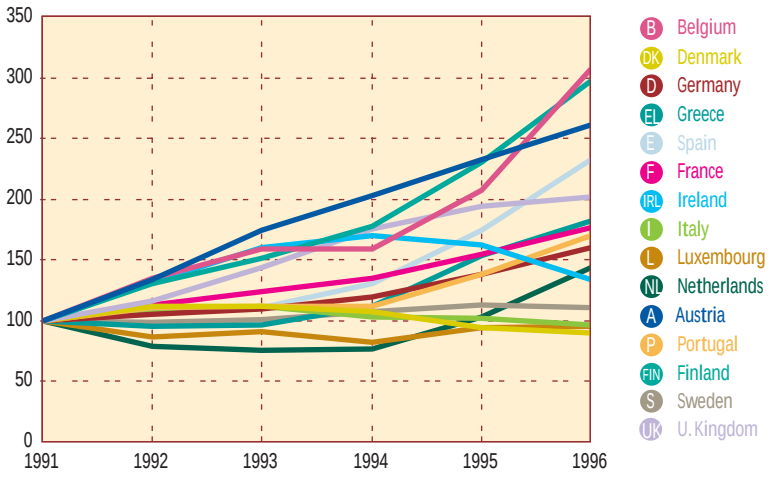
**Belgium:** persons concerned in cases of illicit drugs registered by the police; **Denmark:** charges for violations of drug laws; **Germany:** drug offences (directly supply-related crimes not included); **Greece:** arrests (caught by the police); **Spain:** arrests related to illicit drug trafficking; **France:** arrests for violation of drug laws; **Ireland:** charges for drug offences; **Italy:** arrests; **Luxembourg:** arrests for violation of the 1973 drug law; **Netherlands:** offences against the Opium Act; **Austria:** reports for violations of the Narcotic Drugs Act; **Portugal:** presumed offences against the drug law; **Finland:** suspects of narcotics offences; **Sweden:** suspects of offences against the Narcotic Drugs Act or the Goods Smuggling Act; **United Kingdom:** persons found guilty of drug law offences.

**Study unit:** P: persons; O: offences; A: arrests; C: charges.

**U/T:** use/traffick; **T:** traffick.

(a) Criminal offences related to import/export, sale delivery, transportation, production, possession, etc.

Figure 12: Arrests for drug law offences in EU countries, 1991-96
Three years' moving averages indexed (1991 = 100)



## Drug market indicators — seizures, price, purity

The quantities of drugs seized by law enforcement agencies are indirect indicators of the supply and availability of drugs. However, seizures reflect a range of factors other than the quantities of drugs imported and distributed, including law enforcement resources, priorities and strategies, as well as the vulnerability of traffickers to enforcement efforts. Only a proportion is seized, but there is no factual basis for the assumption that seizures represent 10 % of the total supply. This proportion will vary over time, between countries and between drugs. In addition, one exceptionally large seizure can seriously distort the figures for a given year or country. In general, consistent changes are a surer guide to trends than year-by-year fluctuations.

Variations in seizures between Member States do not always reflect differences in availability or consumption in these countries. This applies particularly to countries which, for reasons of geography or history, are the first destination for importation (of cannabis, heroin and cocaine) or are producers (of synthetic drugs). Thus it is valuable to take into ac-

### Table 13: Number of drug seizures: trend over the last three years (1)

| Country | Cannabis | | | | Cocaine | | Heroin | | Ecstasy | | LSD | | Amphetamines |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number of seizures (1997) | Trend (2) | Number of seizures (1997) | Trend (2) | Number of seizures (1997) | Trend (2) | Number of seizures (1997) | Trend (2) | Number of seizures (1997) | Trend (2) | Number of seizures (1997) | Trend (2) | Trend (2) |
| Belgium (b) | 5 714 | +– | 1 046 | + | 3 158 | 0 | 1 002 | ++ | 281 | + | 102 | – | |
| Denmark | 4 886 | – | 723 | + | 2 509 | – | 110 | ++ | 15 | ++ | 1 324 | + | |
| Germany | 29 826 | + | 5 482 | + | 9 509 | 0 | 2 368 | 0 | 727 | – | 3 571 | + | |
| Greece | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | |
| Spain | 44 227 | ++ | 12 275 | ++ | 15 399 | + | 2 474III | + | n.a. | n.a. | 2 474 | +– | |
| France | 34 266 | ++ | 1 471 | + | 3 924 | – | 628 | 0 | 171 | + | 163 | ++ | |
| Ireland (a) | 3 449 | +– | 93 | ++ | 664 | ++ | 405 | ++ | 42 | –– | 217 | +– | |
| Italy | 11 423 | + | 3 163 | + | 6 851 | – | 847 | +– | 173 | – | 53 | + | |
| Luxembourg | 190 | +– | 54 | + | 237 | 0 | 12 | – | 3I | n.a. | 3I | n.a. | |
| Netherlands | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | |
| Austria | 4 973 | + | 65 | ++ | 861 | – | 253 | ++ | 113 | ++ | 221 | ++ | |
| Portugal | 1 566 | ++ | 1 234 | ++ | 3 458 | + | 34 | ++ | n.a. | n.a. | n.a. | n.a. | |
| Finland | 1 686II | + | 16 | 0 | 153 | ++ | 74 | ++ | 14 | 0 | 1 339(a) | ++ | |
| Sweden | 4 545 | + | 116 | ++ | 833 | 0 | 203 | ++ | 86 | ++ | 4 639 | 0 | |
| U. Kingdom (a) | 91 432 | 0 | 4 093 | + | 9 819 | ++ | 6 173 | ++ | 1 133 | –– | 18 207 | ++ | |

(1) Trend: over the three last years available.
(2) **– –** : <-40 %; **–** : <-7 %; 0 : +/- 7 %; **+** : between **+** 7 % and +40 %; **++** : >+40 % and + - : fluctuation.
(a) Data refer to 1996. (b) Data refer to 1995.

**I.** Too small figure to estimate a trend. **II.** Hashish only. **III.** Ecstasy and LSD together.

**n.a.:** data not available.

count the number of seizures of different drugs which, in many countries, includes a proportion of small seizures from the retail/consumer level of the market. This may be a better indirect indicator of availability than total quantities, which are skewed by small numbers of large seizures.

Confirmation of this would be assisted by breaking down seizure data into quantities involved. At present, seizure data should be treated with caution and interpreted alongside other indicators, such as number of seizures, price and purity, availability at consumer level and qualitative information from experts.

**Future direction:** Ideally, the analysis of drug markets should be based on information on the structure of drug markets and the actors involved, but this is not available for most countries. The annual report of the Europol Drugs Unit (EDU) contains further information, but work remains to be done, in cooperation with the EDU, national focal points, and other organisations, to elaborate useful indicators. This requires improvements in the quality of data (e.g. on price and purity at different levels of the market).

For this report, the quantities seized were available from all Member States [1]. Data on the number of seizures, from all but Greece and the Netherlands, data on prices and purity, from some (though of uncertain quality and comparability), and observations figured in a few national reports. The key points below should be read within this context.

### Cannabis

The total quantity of cannabis seized increased rapidly in the early 1990s, from 160 tonnes in 1985, 230 tonnes in 1989 to over 740 tonnes in 1994. Following modest decreases in 1995 and 1996, this indicator has been relatively stable for three years at about four times the level recorded in the mid-1980s. The largest quantities in 1997 were seized in Spain.

In 10 of the 13 Member States who provided data, cannabis accounted for the greatest number of seizures. Like data on quantities, the number of seizures shows an increase from the mid-1980s, but at a slower and steadier rate. In most countries, the increase in the number of seizures continued after 1994 and, where 1997 data are available, a rising trend is still observed, especially in Austria, Finland, France, Germany, Italy, Portugal, Spain and Sweden.

The data are not reliable enough to make price comparisons between Member States, though generally cannabis prices appear to be stable. The cannabis market is entrenched in most of the EU and, depending on country, availability is high and stable, or is increasing.

### Heroin

The quantities of heroin seized increased threefold in the late 1980s and early 1990s, from under 2 tonnes in 1985 to over 6 tonnes in 1991. Since then, the quantities have fluctuated at a slightly lower level within a 5 to 6 tonne range, the total for 1997 showing a decrease on previous years. Fluctuating patterns are observed in most Member States. In 1997, the largest amounts were seized in Germany, followed by Spain, Italy (down from previous years) and France [2].

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

The reported street price of heroin varies considerably within and between EU countries, but data are too unreliable for comparisons. The general impression is of price stability after a decrease in previous years, though a few countries report decreases in 1997 and Italy reports an increase. From limited reports, purity ranges from under 25 to over 40 %.

Overall, there are no major indications of change in the heroin market. Whilst heroin is less widely available than cannabis, there appear to be few difficulties in obtaining supplies for users in most Member States, especially in major cities, and there are reports of increased availability in smaller cities and towns.

[1] The UK and Ireland did not provide data for 1997.
[2] Data from the UK are missing. The UK accounted for large quantities seized in previous years.

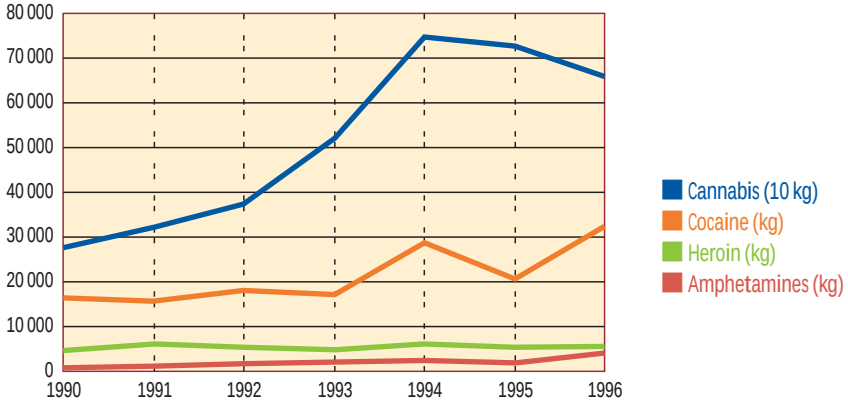
## Table 14: Quantities of cannabis seized in EU countries, 1985-97

kilograms

| Country | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium | 10 429 | 3 791 | 6 562 | 13 008 | 9 844 | 7 918 | 6 021 | 9 504 | 35 217 | 59 903 | 38 104 | 106 690[b] | 48 705[b] |
| Denmark | 510 | 472 | 1 243 | 1 369 | 729 | 1 250 | 1 703 | 2 152 | 1 273 | 10 665 | 2 414 | 1 772 | 467 |
| Germany | 11 498 | 2 675 | 2 998 | 11 350 | 12 073 | 13 641 | 12 343 | 12 166 | 11 353 | 25 693 | 14 245 | 9 355 | 11 495 |
| Greece[a] | 524 | 638 | 136 | 170 | 683 | 726 | 1 985 | 3 458 | 485 | 6 142 | 1 162 | 3 374 | 19 331 |
| Spain | 66 400 | 47 867 | 59 210 | 90 940 | 64 225 | 70 076 | 104 751 | 121 439 | 160 169 | 219 176 | 197 024 | 247 321 | 315 328 |
| France | 8 248 | 13 777 | 12 613 | 24 425 | 17 852 | 21 754 | 33 121 | 42 070 | 45 784 | 58 015 | 42 270 | 66 861 | 55 122 |
| Ireland | 147 | 16 | 102 | 237 | 191 | 119 | 1 154 | 516 | 4 205 | 1 527 | 15 616 | 1 940 | |
| Italy | 1 437 | 16 026 | 13 028 | 7 149 | 23 215 | 7 879 | 9 722 | 23 233 | 12 019 | 18 931 | 15 392 | 11 868 | 59 765 |
| Luxembourg | 55 | 15 | 21 | 190 | 11 | 33 | 24 | 35 | 403 | 317 | 12 | 21 | 35 |
| Netherlands[c] | 34 901 | 47 855 | 48 617 | 68 238 | 42 305 | 109 762 | 96 292 | 94 593 | 138 222 | 238 258 | 332 086 | 102 957 | 31 513 |
| Austria | 390 | 300 | 175 | 205 | 192 | 320 | 12166 | 248 | 546 | 394 | 697 | 517 | 915 |
| Portugal | 1 869 | 5 502 | 4 933 | 354 | 4 631 | 9 606 | 7 753 | 11 720 | 52 527 | 40 425 | 7 493 | 5 360 | 9 693 |
| Finland | 15 | 10 | 25 | 24 | 167 | 72 | 107 | 48 | 118 | 69 | 152 | 103 | 210 |
| Sweden | 1 414 | 326 | 579 | 423 | 470 | 601 | 639 | 376 | 563 | 457 | 527 | 287 | 660 |
| U. Kingdom | 22 165 | 25 136 | 16 936 | 45 476 | 59 369 | 30 889 | 32 204 | 51 103 | 53 574 | 63 021 | 58 484 | 101 127 | |
| **Total** | **160 002** | **164 405** | **167 177** | **263 557** | **235 957** | **274 644** | **319 985** | **372 661** | **516 458** | **742 993** | **725 679** | **659 553** | |

([a]) From 1985 to 1994 only police seizures are included. Since 1995, all seizures are included (police, coastguard and customs).
([b]) Cannabis leaves + resin + plants.
([c]) Since 1991, a significant number of 'nederwiet plants' have been annually seized in addition: 71 945 in 1991, 313 242 in 1992, 194 413 in 1993, 558 706 in 1994, 549 337 in 1995, 1 272 526 in 1996 and 1 479 821 in 1997.

Figure 14: Quantities of cannabis, heroin, cocaine and amphetamines seized in EU countries, 1990-96



## Table 15: Quantities of heroin seized in EU countries, 1985-97

kilograms

| Country | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium | 92 | 78 | 141 | 116 | 89 | 291 | 186 | 107 | 76 | 137 | 129 | 133 | 55 |
| Denmark | 5.4 | 17 | 13 | 29 | 37 | 27 | 31 | 39 | 28 | 29 | 37 | 61 | 38 |
| Germany | 208 | 157 | 320 | 537 | 727 | 847 | 1 595 | 1 438 | 1 095 | 1 590 | 933 | 898 | 722 |
| Greece([a]) | 11 | 22 | 65 | 53 | 34 | 51 | 279 | 165 | 148 | 283 | 173 | 190 | 146 |
| Spain | 253 | 407 | 413 | 480 | 713 | 886 | 741 | 672 | 604 | 824 | 546 | 537 | 479 |
| France | 278 | 220 | 213 | 221 | 295 | 405 | 561 | 328 | 386 | 661 | 499 | 617 | 415 |
| Ireland | 1.2 | 1.9 | 0.1 | 0.4 | 0.4 | 0.6 | 0.2 | 0.8 | 1.3 | 4.7 | 6.4 | 10.8 | |
| Italy | 275 | 329 | 321 | 573 | 648 | 900 | 1 541 | 1 358 | 651 | 1 150 | 954 | 1 270 | 472 |
| Luxembourg | 6.8 | 7.8 | 0.3 | 15 | 0.5 | 0.5 | 10 | 6.7 | 10.8 | 0.9 | 13.2 | 2.9 | 2.5 |
| Netherlands | 364 | 542 | 517 | 510 | 492 | 532 | 406 | 570 | 916 | 246 | 351 | 516 | 194 |
| Austria | 115 | 43 | 33 | 51 | 101 | 72 | 103 | 78 | 105 | 80 | 47 | 81 | 102 |
| Portugal | 3.5 | 19 | 30 | 33 | 61 | 36 | 62 | 41 | 92 | 89 | 66 | 47 | 57 |
| Finland | 0.8 | 0 | 0 | 0.2 | 0.2 | 0 | 0.7 | 1.9 | 0.7 | 1.6 | 16.1 | 6.5 | 2.4 |
| Sweden | 6 | 4 | 5 | 9 | 9 | 12 | 11 | 25 | 22 | 21 | 31 | 26 | 12 |
| U. Kingdom | 366 | 223 | 236 | 237 | 351 | 603 | 493 | 547 | 656 | 744 | 1 395 | 1 070 | |
| **Total** | **1 985** | **2 070** | **2 308** | **2 865** | **3 559** | **4 663** | **6 020** | **5 377** | **4 791** | **5 862** | **5 197** | **5 467** | |

([a]) From 1985 to 1994, only police seizures are included. Since 1995, all seizures are included (police, coastguard and customs).

### Cocaine

The quantities of cocaine seized increased from 1 tonne in 1985 to over 16 tonnes in 1990. Following four years of stability, the amounts rose sharply to 29 tonnes in 1994, dropped a third in 1995, but rose to over 32 tonnes in 1996 and in 1997. Spain remains the country where larger quantities of cocaine were seized.

The number of seizures showed a more steady increase from 1985 to 1997, without any of the sharp peaks and troughs seen in the data on quantities, though the numbers were small in Finland, Sweden and Ireland. This increase was reflected in almost every Member State, but was most marked in Spain and Portugal.

The amounts of cocaine seized have increasingly exceeded those for heroin since 1987, and in recent years have been four to six times greater. In contrast, the number of seizures have been lower, at around 40 % of those for heroin.

**Suggested explanation:** This may reflect a tendency for cocaine to be trafficked in larger quantities than heroin, and a lower vulnerability of cocaine retail suppliers and consumers to law enforcement interventions compared with heroin.

## Table 16: Quantities of cocaine seized in EU countries, 1985-97

kilograms

| Country | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium | 62 | 116 | 270 | 404 | 89 | 537 | 756 | 1 222 | 2 892 | 479 | 576 | 838 | 3 329(b) |
| Denmark | 0.5 | 7.1 | 26 | 10 | 55 | 28 | 40 | 21 | 11 | 30 | 110 | 32 | 58 |
| Germany | 165 | 186 | 296 | 496 | 1 406 | 2 474 | 964 | 1 332 | 1 051 | 767 | 1 846 | 1 373 | 1 721 |
| Greece(a) | 0 | 2.9 | 24 | 2.2 | 2.3 | 34 | 13 | 9 | 5 | 176 | 9 | 156 | 17 |
| Spain | 303 | 669 | 1 134 | 3 461 | 1 852 | 5 382 | 7 574 | 4 454 | 5 350 | 4 016 | 6 897 | 13 743 | 18 418 |
| France | 96 | 258 | 754 | 593 | 939 | 1 845 | 831 | 1 625 | 1 715 | 4 743 | 865 | 1 742 | 844 |
| Ireland | 0.3 | 0.2 | 0 | 0 | 3 | 1 | 0 | 10 | 0.4 | 0.1 | 22 | 642 | |
| Italy | 104 | 127 | 321 | 616 | 668 | 805 | 1 300 | 1 345 | 1 101 | 6 636 | 2 603 | 2 379 | 1 594 |
| Luxembourg | 27 | 6.5 | 18 | 4.6 | 21 | 23 | 14 | 12 | 16 | 16 | 0.53 | 13 | 9 |
| Netherlands | 124 | 274 | 406 | 517 | 1 425 | 4 288 | 2 492 | 3 433 | 3 720 | 8 200 | 4 851 | 9 222 | 6 744 |
| Austria | 5.3 | 7.4 | 27 | 14 | 21 | 41 | 84 | 58 | 84 | 53 | 55 | 73 | 87 |
| Portugal | 70 | 165 | 222 | 302 | 793 | 360 | 1 094 | 1 860 | 216 | 1 719 | 2 116 | 812 | 3 163 |
| Finland | 0 | 0 | 0 | 0.1 | 11 | 0 | 38 | 0.1 | 0 | 0 | 0.1 | 0.1 | 0.1 |
| Sweden | 0.8 | 3 | 1.4 | 6.5 | 4.6 | 8.8 | 226 | 61 | 14 | 29 | 3.7 | 18 | 34 |
| U. Kingdom | 85 | 103 | 407 | 323 | 499 | 611 | 1 078 | 2 248 | 717 | 2 261 | 672 | 1 219 | |
| **Total** | **1 043** | **1 924** | **3 906** | **6 749** | **7 787** | **16 438** | **16 505** | **17 690** | **16 893** | **29 124** | **20 626** | **32 262** | |

(a) From 1985 to 1994, only police seizures are included. Since 1995, all seizures are included (police, coastguard and customs).
(b) 3 321 kg cocaine salts + 8 kg cocaine base.

As with heroin, there is considerable variation in the reported street price of cocaine, but the data are too unreliable for comparisons. After decreases in previous years, price is relatively stable in most reporting countries. Limited data suggest that retail purity is generally over 50 %. The overall picture is of an expanding market with increased availability in recent years, especially in metropolitan areas. There are few markets in crack cocaine in the EU countries apart from those established in areas of the UK, in the Netherlands and France.

**Synthetic drugs: amphetamines, Ecstasy, LSD**

The quantities of amphetamines seized increased slowly in the late 1980s. Although relatively low in 1985, there were rapid increases to more than 3 tonnes in 1996. Most of this is accounted for by seizures in the UK, though there have been significant seizures in the Netherlands, Germany, France and Sweden.

The quantities of Ecstasy seized increased sharply up to 1996 with larger amounts in the UK, the Netherlands and Germany. The quantities of LSD increased from low levels in the 1980s to over 1 million units in 1993 but have fallen substantially since.

The number of seizures has increased since the late 1980s for amphetamines, Ecstasy and LSD in nearly all Member States, but with recent differences. While there has been an upward trend in most

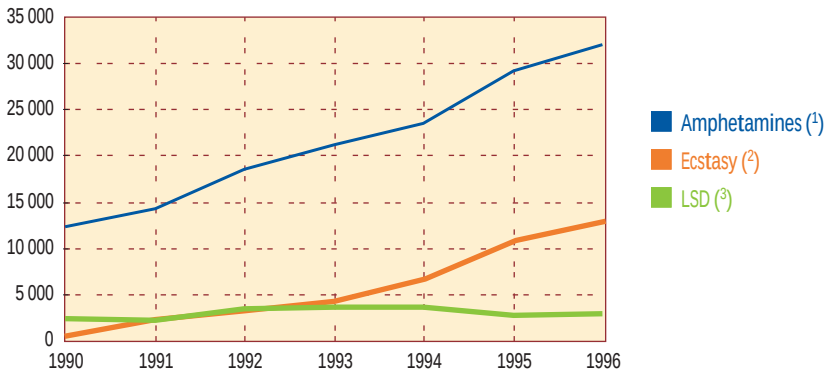
## Table 17: Quantities of amphetamines seized in EU countries, 1985-97

kilograms

| Country | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium | 3.5 | 2.4 | 9.0 | 47 | 4.2 | 15 | 77 | 96 | 19 | 23 | 68 | 24 | |
| Denmark | 4.0 | 10 | 52 | 30 | 24 | 26 | 24 | 74 | 12 | 13 | 40 | 27 | 119 |
| Germany | 28 | 85 | 62 | 91 | 67 | 85 | 88 | 105 | 109 | 120 | 138 | 160 | 234 |
| Greece([a]) | 0 | 0 | ([b]) | ([b]) | ([b]) | 0 | ([b]) | ([b]) | 0.6([b]) | 0.01([b]) | 0.11 | 0.08 | 0.05 |
| Spain | 1.0 | 5.8 | 5.2 | 9.2 | 22.4 | 0.3 | 4.2 | 22.8 | 34.2 | 31.7 | 35.0 | 53.4 | 119.6 |
| France | 0.60 | 1.6 | 6.8 | 4.0 | 13 | 16 | 20 | 13 | 43 | 80 | 104 | 128 | 194 |
| Ireland | 0.1 | 0 | 0.1 | 0 | 0.1 | 0.3 | 0.1 | 0.1 | 0.7 | 0.4 | 1.5 | 7.6 | |
| Italy | 0.2 | 0.4 | 2.9 | 1 | 0.6 | 0.7 | 0.7 | 15 | 0.5 | 3.4 | 1.1 | 2.0 | 0.4 |
| Luxembourg | 0.01 | 0 | 0.3 | 0.4 | 0 | 0 | 0.1 | 0.3 | 0.4 | 0.1 | 0.03 | 0.02 | 0.01 |
| Netherlands([c]) | 42 | 86 | 125 | 53 | 65 | 47 | 128 | 267 | 293 | 215 | 45 | 324 | |
| Austria | | | 0.3 | 0.1 | 0.1 | 0.2 | 0.3 | 0.4 | 0.3 | 0.7 | 1.6 | 3.7 | 7.9 |
| Portugal([d]) | | | | | | | | | | | | | |
| Finland | 0.4 | 0.1 | 1.2 | 2.1 | 1 | 1.4 | 5.3 | 11.6 | 18.7 | 9.1 | 20.1 | 22.1 | 22.2 |
| Sweden | 106 | 78 | 157 | 98 | 104 | 108 | 104 | 121 | 142 | 210 | 279 | 127 | 186 |
| U. Kingdom | 77 | 116 | 152 | 137 | 108 | 304 | 421 | 569 | 975 | 1 305 | 819 | 2 622 | |
| **Total** | **263** | **384** | **574** | **473** | **409** | **604** | **872** | **1 296** | **1 648** | **2 010** | **1 552** | **3 501** | |

([a]) From 1985 to 1994, only police seizures are included. Since 1995, all seizures are included (police, coastguard and customs); 958 pills were also seized in 1997.
([b]) A small number of items were also seized.
([c]) Amphetamine pills were also seized: 2 500 in 1990, 30 705 in 1992, 142 in 1993, 11 025 in 1994 and 850 in 1995.
([d]) 39 pills were seized in 1990.

## Figure 17: Number of synthetic drug seizures in selected EU countries, 1990-96




([1]) Austria, Belgium, Denmark, France, Germany, Ireland, Italy, Luxembourg, Spain, Sweden, UK.
([2]) Austria, Belgium, Denmark, France, Ireland, Italy, Luxembourg, Spain, Sweden, UK.
([3]) Austria, Belgium, Denmark, France, Germany, Ireland, Italy, Luxembourg, Spain, Sweden, UK.
**Note:** For Belgium, Ireland and UK, missing data for 1996 and 1997 have been extrapolated on general trend of other countries.

countries in the last three years, 1997 data show a levelling or decrease in the number of seizures of Ecstasy in Austria, France, Germany, Italy, Luxembourg and Spain. However, there are increases in Finland, Sweden and Denmark. In most Member States, LSD seizures have levelled or fallen since 1993-94.

Apart from trends over time, there are differences between Member States. In Denmark, Finland, Sweden, the UK and Spain, amphetamines predominate. In most other countries it is Ecstasy, while seizures of LSD are less common. Amphetamines are more frequently seized in Sweden than any other drug, and are the second most commonly seized drug in Finland and the United Kingdom.

As with other drugs, the data available make comparisons of price and purity difficult. The general recent trend has been a decrease in the price of both amphetamines and Ecstasy, while purity varies considerably for both. Various reports from both countries and cities suggest that, during 1997, the methylenedioxymethamphetamine (MDMA) content of Ecstasy declined but the amphetamine content of pills increased. Other synthetic drugs have been reported from Member States in recent years, including analogues of MDMA sold as Ecstasy (e.g. MDA, MDEA, MBDB) as well as ketamine and DOB. This may reflect market testing by illicit manufacturers, but so far there is no indication that any of these alternatives are achieving a significant proportion of the market.

Despite rising concern about Ecstasy in recent years, it is amphetamines that may increasingly dominate the market in synthetic drugs in the future.

## Final remark

The trend in amphetamine and multiple drug use, including alcohol, requires more rapid and sensitive assessments of changing needs and more flexible planning that is not based on anachronistic images of the Ecstasy raves of 1988.

Many problems related to illegal drugs apply to legal substances, not only alcohol, but also medicinal and industrial products, which reinforces the need for a more integrated approach.

Recognition of social exclusion as a key dimension of drug problems implies broadening the framework of analysis and extending the range of partners involved in treatment responses to include urban planning or employment.

The output of the Centre depends on the availability and quality of data from Member States, and on the resources of focal points and experts from Member States. Much of the data from Member States are incomplete, of variable quality and not comparable. This limits the extent to which the Centre can fulfil its tasks, at least in the short term. Improving this depends not only on the Centre, but on the willingness and ability of Member States to implement measures to improve the availability, quality and comparability of data.

## Sources

**Table 1:** **Belgium** (Flanders) CATI, COOV, IHE 1995 • **Denmark** (1) Health and morbidity in Denmark 1994 — DIKE — (2) Nordic alcohol and drug-use survey (CFR) • **Germany** Representative survey on the use and abuse of alcohol, medicines, tobacco products and illegal drugs (BUND) • **Spain** (1) Household survey on drugs 1995. National plan on drugs • (2) Household survey on drugs 1997. National plan on drugs • **France** Baromètre Santé 1995, CFES • **Finland** (1) Drug use and opinions on drugs — Osmo Kontula and Kaj Kostela — (2) Drugs in Finland in the 1990s. Kontula O. • **Sweden** (1) Swedish Council for Information on Alcohol and other Drugs (CAN) 1994 — (2) Swedish Council for Information on Alcohol and other Drugs (CAN) 1996 • **United Kingdom** (1) The British crime survey 1994 (Home Office) — (2) The British crime survey 1996 (Home Office)

**Table 2:** The same as for Table 1

**Table 3:** **Belgium** (Flanders) HBSC study 1996 • **Denmark** ESPAD study 1995, Svend Sabroe et al. 1996 • **Greece** A. Kokkevi, K. Stefanis — University Mental Health Research Institute Athens 1994 • **Spain** School survey on drugs 1994. Plan Nacional Sobre Drogas • **France** Enquête Santé des Adolescents 1993, Inserm-U169 • **Ireland** ESPAD study 1995, Morgan M. • **Italy** ESPAD study 1995, Mariani F., di Fiandra T., Schiallero L., Rico G. • **Luxembourg** 'Shüler an Drogen' — Matheis J., Prussen P., Renter P. IEES. Luxembourg 1995 • **Netherlands** 'Key data; smoking, drinking, drug use and gambling among pupils aged 10 years or older' (Trimbos Institute; De Zwart et al. 1997) • **Austria** Schuller — Suchtmittelstudie/student drug survey by the Ludwing Boltzmann Institute for Addiction Research • **Portugal** Machado Rodrigues, L. et al.; Estudos em Meio Escolar — 3° ciclo — GPCCD, Lisboa 1996 • **Finland** ESPAD study 1995. Ahlstrom Salrue et al.; 1996. Finnish Social Research Institute of Alcohol Studies • **Sweden** School survey — Sweden 1997 • **United Kingdom** ESPAD study 1995, Miller P., Plant M.

**Table 4:** **(1)** Denmark National Focal Point, 1998. (Epidemiological study supported by estimates of the total number of addicts made by each of the 16 Danish counties) • **(2)** Germany National Focal Point, 1998. (Bühringer G., Adelsberger F., Heinemann A., Kirschner J., Knauß I., Kraus L., Püschel K. and Simon R. (1997) *Schätzverfahren und Schätzungen 1997 zum Umfang der Drogenproblematik in Deutschland*. München: IFT-Berichte 94) • **(3)** France National Focal Point, Paris: OFDT, 1995 • **(4)** Mariani F., Guaiana R., Di Fiandra T. *The Journal of Drug Issues* 1994; 24: 579-595 • **(5)** Perucci C.A. Prevalence Seminar EMCDDA/Pompidou Group, Strasbourg 1996 • **(6)** Rossi C. 'Measuring the extent of illicit drug use by means of dynamic models of data production processes', in: *Methods to integrate epidemiological indicators to address policy-related questions on drug use*. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon (in press) • **(7)** Luxembourg National Focal Point, 1998. (Origer A. et al. 1995, in: *Report on the national information network on drugs and drug addiction* — RELIS/Lindda 1995. Ministry of Health, AST, Luxembourg) • **(8)** Netherlands National Focal Point (*Continuity and change*. Rijswijk: Ministry of Health, Welfare and Sports, 1995) • **(9)** Bieleman B., Snippe J. and De Bie E. Groningen: Intraval, 1995. (The authors state 'a minimum of 28 000') • **(10)** Austria National Focal Point, 1998 (Österreichisches Bundesinstitut für Gesundheitswesen: *Bericht zur Drogensituation 1996*. Wien: Öbig, November 1996.) Confirmed by local C-RC study for Vienna • **(11)** Finland National Focal Point, 1998 (Partanen P. *Report on the number of amphetamine and opiate users in the Greater Helsinki area in 1995*. Helsinki: Stakes, Aiheita 40/1997) • **(12)** Sweden National Focal Point, 1998. (Olsson O., Byqvist S. and Gomér G. (1993) *Det tunga narkotikamisbrukets omfattning i Sverige 1992*. CAN Rapport-serie Nr 28. Stockholm)

**Table 5:** **(1)** Kirschner W., Kunert M. Berlin: EFB, 1996 • **(2)** Zenker C., Greiser E. *Erprobungsvorhaben zur Prävalenzschätzung des regionalen illegalen Drogenmißbrauchs und seiner Folgen*. Bremen: Bremer Institut für Präventionsforschung und Sozialmedizin (BIPS), 1998. • **(3)** Domingo-Salvany A. Hartnoll R.L., Maguire A., Brugal T., Albertin P., Caylà J.A., Casabona J., Suelves J.M. 'Analytical considerations in the use of capture-recapture to estimate prevalence: case studies of estimating opiate use in the metropolitan area of Barcelona'. *Am J Epidemiol*, 1998; 148: 732-40. • **(4)** Paredes D., del Llano J., et al. Comunidad de Madrid, *Plan Regional sobre Drogas*, 1994. (Estimate refers to Madrid metropolitan area) • **(5)** Moreno Iribas C., Urtiaga Dominguez M. *Gaceta Sanitaria*, 1993; 7: 55-62. • **(6)** Bello P.-Y., Chéne G. *Methodological pilot study of local level prevalence estimates*. Lisbon: EMCDDA, December 1997 • **(7)** Department of Epidemiology, Lazio region 1998 • **(8)** D'Ippoliti D. *Methodological pilot study of local level prevalence estimates*. Lisbon: EMCDDA, December 1997 • **(9)** Origer A. Luxembourg National Focal Point, 1998. • **(10)** Korf D.J., Hes J., Van Aalderen H. Alkmaar: Brijder Stichting, 1991. • **(11)** Van Brussel G., et al., Amsterdam: Municipal Health Services, 1997. • **(12)** Netherlands Focal Point, 1998. (Smit F., Toet J., van der Heijden P. In preparation) • **(13)** Ten Den C., Bieleman B., de Bie E., Snippe J. Groningen: Intraval, 1995. • **(14)** Seidler D., Uhl A., in: *Methodological pilot study of local level prevalence estimates*. Lisbon: EMCDDA, December 1997. • **(15)** Freire S., Moreira M., in: *Methodological pilot study of local level prevalence estimates*. Lisbon: EMCDDA, December 1997 • **(16)** Partanen P. *Report on the number of amphetamine and opiate users in the Greater Helsinki area in 1995*. Helsinki: Stakes, Aiheita 40/1997) • **(17)** Swedish Council for Information on Alcohol and other Drugs (CAN), UNO-92 (report 34), Stockholm, 1993 • **(18)** Department of Social Welfare and Public Health, City Office, Malmö • **(19)** Finne E. (1997) *Socialtjänstens kontakter med missbrukare, psykiskt störda och hemlösa 1996*. FoU-rapport 1997:15. Stockholm • **(20)** Hay G., McKeganey N. *Journal of Epidemiology and Community Health* 1996; 50: 469-472 • **(21)** Frischer M., Leyland A., Cormack R., et al. *American Journal of Epidemiology* 1993; 138: 170-181 • **(22)** Squires N.F., Beeching N.J., Schlecht B.J.M., et al. *Journal of Public Health Medicine* 1995; 17: 103-109 • **(23)** Brugha, R.F., Swan, A.V., Hayhurst, G.K., Fallon, M.P. (1998) 'A drug misuser prevalence study in a rural English district'. *European Journal of Public Health*, 8: 1101-1262 • **(24)** Bloor M., Wood F., Palmer S. Cardiff: University of Wales, 1997.

**Table 6:** **(1)** Reporting system — Brussels (all treatments). Reporting system — Flemish Community (all treatments — only specialised residential treatment). Reporting system — French Community (all treatments) • **(2)** Reporting system. Nationwide • **(3)** EBIS reporting system. Nationwide • **(4)** Reporting system. Nationwide • **(5)** SEIT reporting system. Nationwide • **(6)** SESI (Enquête toxicomanie de novembre). Data refer to specialised centres only. Nationwide • **(7)** Reporting system. Nation-wide • **(8)** Health Ministry. Nationwide • **(9)** RELIS/Lindda reporting system. Nationwide • **(10)** IVV/LADIS reporting system. Nationwide • **(11)** Portugal National Focal Point, 1998. Treatment survey • **(12)** National Hospital Register • **(13)** National Hospital Discharge registry • **(14)** RDMD reporting system for new treatment clients. Presented six month data are for Great Britain (England, Scotland and Wales).

**Table 7:** Sources of information are described in Table 8 of 1997 EMCDDA annual report. Data are submited to the EMCDDA by the national focal points

**Table 8:** **(1)** Belgium French Community Sub-Focal Point, CCDA 1998 • **(2)** Papaevangelou G., Richardson S.C. 'HIV prevalence and risk factors among injecting drug users in EC and COST countries', in: *AIDS research at EC level*. Edited by Baert A.E., Koch M.A., Montagnier L., Razquin M.C., Tyrrell D. Amsterdam:

IOS Press; 1995:73-82. • **(3)** Denmark National Focal Point, 1997. (Smith E. *Status of the HIV/AIDS epidemic in Denmark by the end of 1995*. Ugeskr Læger 1997; 159: 585-90.) • **(4)** Germany National Focal Point, 1998. (EBIS 1996). • **(5)** Greece National Focal Point, 1998 (screening drug-free treatment: n=409, 0.48 %; treatment reporting system, self-reports: n=299, 2 %) • **(6)** Plan National Sobre Drogas, ECHT, 1996 • **(7)** France National Focal Point, 1998. (Sesi, *La prise en charge des toxicomanes dans les structures sanitaires et sociales*, novembre 1995, Documents statistiques No 298, février 1998). The range given is not geographical: upper limit gives the seropositives among all known test results while the lower limit assumes those who do not know their test result are seronegative. • **(8)** Italy National Focal Point, 1998 (Prevalence of HIV antibodies in SER.T users by region 1990-97, Ministry of Health). National average and range of seroprevalences by region. • **(9)** Luxembourg National Focal Point, 1998. (RELIS-Lindda, 1997) 2 % assumes all with unknown test result are seronegative, 3 % is prevalence in all those with known test result, 4 % if also corrected for 79 % IDUs and assuming all seropositives are IDUs. • **(10)** Netherlands National Focal Point, 1998. (National surveillance of HIV in IDUs. Report series. Bilthoven: RIVM, 1998. 1996: Amsterdam 26 %, Arnhem 2 %, Utrecht 5 %, 1997: Heerlen 16 %, Maastricht 3 %, Rotterdam 9 %) • **(11)** Austria National Focal Point, 1998. (Trend in prevalence from Vienna low-threshold service (Ganslwirt 93-97)) • **(12)** Portugal National Focal Point, 1998. • **(13)** Finland National Focal Point 1998. (Ovaska A., Holopainen A., Annala T., 1998. Information Service Vinkki: Final report on the activities in the health information service experiment on 4 April - 31 December 1997) of 1995. Ugeskr Læger 1997; 159: 585-90 • **(14)** Sweden National Focal Point, 1998. (Kalk K., Thorstensson, R. 12 th World AIDS Conference, Geneva, 25 June, 3 July 1998 (abstract 23552). Trend in prevalence based on notifications of IDUs) • **(15)** Public Health Laboratory Service, 1998

**Table 9:** European Centre for the Epidemiological Monitoring of AIDS

**Table 10:** **(1)** Denmark National Focal Point, 1997. (Estimates from HIV notification and study on national prevalence of drug use: Statens Serums Institut.) • **(2)** Germany National Focal Point, 1998. (Bätz B., Reymann G. 1997. 'A diagnostic scheme for virus hepatitis in drug addicts during a qualified detoxification treatment.' *Sucht*, 1997; 43: 264-66.) • **(3)** Greece National Focal Point, 1998. (Centre for Control of AIDS and STDs, 1998. n=140 tested.) • **(4)** National plan on drugs: Survey of heroin users in treatment, 1996. (Only heroin IDUs.) • **(5)** France National Focal Point, 1998. (Sesi, *La prise en charge des toxicomanes dans les structures sanitaires et sociales*, novembre 1995, Documents statistiques No 298, février 1998) • **(6)** Smyth R., Keenan E.A., O'Connor J. *Irish Journal of Medical Science*, 1995; 164: 267-268. (n=272 tested.) • **(7)** Italy National Focal Point, 1998. (Ministerio della Sanità — Sistema Informativo Sanitario — Dipartimento della Prevenzione — Ufficio Dipendenze da Farmaci e Sostanze d'abuso e AIDS. n=66623 tested.) • **(8)** Luxembourg National Focal Point, 1998. (RELIS-Lindda, 1997.) • **(9)** Netherlands National Focal Point, 1998. (*National surveillance of HIV in IDUs.* Report series. Bilthoven: RIVM, 1998.) • **(10)** Austria National Focal Point, 1998. (*Drogenambulanz Jahresbericht 1996; Jahresbericht 1996/1997 des Ambulatoriums Ganslwirt*; HIOB) • **(11)** Portugal National Focal Point, 1998 • **(12)** Finland National Focal Point, 1998 • **(12)** (Kalk K., Thorstensson, R., 12 th World AIDS Conference, Geneva, June 28-July 3 1998 (abstract 23552). **(14)** Sweden National Focal Point, 1998. (Krook A., Albert J. Andersson S., et al. J. Acquir Immune Defic Syndr Hum Retroviral 1997: 15, 381-6) • **(15)** Public Health Laboratory Service, 1998 • (16) Waller T., and Holmes R. *Druglink*, 1995; 10: 8-11. (n=2 081 test results reported by treatment centres in the survey.)

**Table 11:** Reitox focal points

**Table 12:** Reitox focal points

**Table 13:** Reitox focal points

**Table 14:** Reitox focal points

**Table 15:** Reitox focal points

**Table 16:** Reitox focal points

**Table 17:** Reitox focal points

**Note:** References for figures are as for tables except where indicated.

# Demand reduction

Chapter 2

**The EMCDDA collects, analyses and disseminates information on European Union drug demand reduction activities. The EMCDDA definition incorporates activities within health, social, educational and criminal justice systems aimed at preventing drug use, assisting and treating users, reducing harmful consequences of use and promoting (re)integration of (former) users.**

Demand reduction targets individuals, families, groups and whole communities. Unfortunately many projects do not properly document their work which impedes information collection. However, the EMCDDA focal points are building up national information networks. This report provides an indicative picture of new developments in demand reduction in the EU during 1997. In order to facilitate easier access to best practice the special focus of this chapter is on evaluation practice and evaluated projects.

## Demand reduction and drug policy

Drug use occurs in a cultural context and demand reduction is part of social policy. As drug taking has become more widespread, there has been a shift from a predominantly medical approach to including social factors and there are calls for community-based approaches tackling environmental determinants of drug-taking. Demand reduction may be a starting point for broader general health policy, based on cooperation between statutory bodies and community groups.

### Major strategies in drug demand reduction

The health promotion approach dominates prevention, integrating prevention measures (in schools, youth clubs, workplaces etc.), following WHO principles on health promotion. The focus is on healthy lifestyle and life-skills, rather than drug use, as outlined in the UK strategy 'Tackling drugs to build a better Britain' (1998), with its vision of a healthy and confident society, free from drug-related harm.

The relationship between legal and illegal drugs is acknowledged in an Austrian survey [1] of youths who had experience with heroin and/or cocaine, two thirds of whom could be described as problem drinkers.

Increasingly, prevention strategies apply a two-pronged complementary preventive strategy: a broad, population-targeted, intervention and life-skills training approach, and a narrower, specific action targeting high-risk groups. The broad strategy aims to identify and strengthen factors which promote healthy lifestyles and facilitate the development of autonomy, responsibility and critical sense.

High-risk group interventions focus on a framework offering alternatives to drug use. Specific interventions also provide solutions for youths engaged in risk behaviours, and may include accessing drug services. The Netherlands introduced 'focused

prevention' for interventions aimed at information and at changing behaviour.

Local initiatives and face-to-face communications are essential, accompanied by a holistic approach coordinating programmes and services at local level, involving communities in the development and delivery of local strategies, and focusing action where it is most needed.

### Harm reduction

Harm reduction is an integral part of drug policy in most countries. A 1997 bill was introduced in Luxembourg to revise drug law, outline policy needs and assess the political feasibility of new approaches. It considers the legal frameworks for substitution and maintenance programmes, and the establishing of safe and hygienic injecting rooms.

## Specific intervention areas

### Pre-school interventions

In Germany and Austria, the model of 'toy-free kindergartens' aims to counteract the targeting of children as consumers, by promoting children's ability to enjoy themselves and enhancing their social competence. The first evaluation in Bavaria shows that the capacity to establish and maintain personal relationships, self-reliance, language skills, creativity and critical thinking, frustration tolerance and play skills all improved ([2]). In Austria, a 1998 evaluation studies whether a toy-free period of three months influences social and emotional skills.

The Italian Ministry of Education's 'Arcobaleno' (Rainbow) project for nursery schools and kindergartens aims at positive child development, acquisition of social skills, perception of limits and capacities, handling aggression and the first elements of developing personal identity. The main themes chosen for the Arcobaleno project are interpersonal relationships, personal hygiene, environmental education, nutritional education and image education.

### Drug prevention in the family

A supportive family environment is important for demand reduction, based on a caring relationship with at least one adult and a support system that encourages positive values. However, prevention programmes targeting parents are rare. Some countries provide parents with brochures and other support to improve general parenting skills.

The British SCODA's review 'Drug-related early intervention: developing services for young people and families' provides good practice guidance and advice to professionals on delivering services that meet the needs of young people. In Scotland, involving parents and carers in planning and care delivery is emphasised.

A six week, 12-hour course in the Gaeltacht area of Ireland provides drug information and skills using focus groups with parents to determine location, timing and content. The course addresses alcohol, cannabis, LSD, Ecstasy, and amphetamine use.

In Luxembourg, the father's role in children's education is emphasised, since professional constraints on fathers may reduce their involvement.

Some parents of today will have used drugs themselves even if they no longer do so. The messages and examples they give their children may be as damaging as those of parents ignorant about drugs. On the other hand, parents with some drug experience may be less likely to panic if they discover their children using or experimenting.

### School programmes

**Strategies**

School is the main arena for drug prevention with prevention included in a broader health or health promotion curriculum, often from primary level, becoming more drug specific with older students. In Ireland a pre-school education programme has started in 38 disadvantaged areas. The new British strategy also recognises the need for drug education to start early to provide knowledge and skills to resist drugs.

In all countries, comprehensive prevention programmes remain an exception, even if promising models have developed in recent years. Some programmes target all substances (alcohol, tobacco and illegal drugs) using a life skills approach. While

effectiveness has been demonstrated, they have yet to be widely applied.

Prevention programmes have been introduced formally in the school curriculum of all Member States except Greece and Portugal. In 1997, the Greek Ministry of Education requested that a health education course be introduced in the high school curriculum.

The UK strategy 'Tackling drugs together', launched in 1995, called on schools to develop policies to manage drug-related incidents and drug education, which 80% of secondary schools and 28% of primary schools have now done. A British problem is the tendency to expel school pupils involved in drug incidents, thus promoting social exclusion and increasing the risk of more severe drug problems.

In all countries, teacher training in drug prevention is offered. The involvement of parents is considered essential in comprehensive drug prevention.

**Evaluated programmes**

1. In 1994, a prevention programme, 'On my own two feet', was introduced in schools in Ireland to develop interpersonal skills and knowledge enabling young people to lead healthy lives without drugs. The materials are designed for schools but are suitable in a variety of settings. An evaluation of this programme ([3]), suggests that educational efforts have a role to play in coping with drug problems. Building on this, a programme for primary schools has been piloted.

2. The Dutch secondary schools programme 'The healthy school and stimulants' informs pupils of the risks of substance use and gambling. The approach teaches facts, and resistance to peer pressure. In addition, teachers and parents are taught to recognise problematic behaviour and set rules. The programme is independently evaluated annually, comparing programme participants with a control group. The 'experimental' pupils felt more free 'to say no' to substances than the control pupils. Use of alcohol, tobacco and cannabis was less in the experimental group than in the control group ([4]).

| | alcohol | tobacco | cannabis |
|---|---|---|---|
| experimental group | 58.3% | 25.4% | 9.1% |
| control group | 66.7% | 29.3% | 13.5% |

3. In Greece a health education programme was implemented in five secondary schools between 1994 and 1997, by teachers trained to use specific material. Evaluation was carried out before and after implementation in target and control schools. Although most were not significant, changes after implementation were in the desired direction, specifically for girls.

4. The Portuguese 'Viva a escola' project aimed to 'provide controlled conditions for experiencing feelings of pleasure, emotion and risk; to develop capabilities which allow one to assume the principles of health promotion on individual and collective levels; to construct a creative, dynamic and stimulating school environment; to develop autonomous behaviour, responsibility and critical sense'. One evaluation ([5]) demonstrated that the greatest impact was on violence, that it had a strong impact on interpersonal relations and the school atmosphere. Another evaluation ([6]) showed that it increased diversification to extra-curricular activities.

5. Swedish evaluations in 1994 and 1995 showed school drug prevention to be of little benefit and concluded that drug education has low status in schools and prevention should be integrated into a wider programme of community activities ([7]).

**Peer programmes**

As well as traditional approaches, peer education projects are emerging in several parts of Europe.

In an EU financed project, Europeers, individuals are selected by classmates and trained to lead debates on drug issues. The Austrian partner of Europeers reported that most teachers in Europeers schools thought that peers showed clear positive changes (in self-confidence, knowledge about addiction processes, conflict-mastering, resistance to group-pressure). All pupils increased knowledge about addiction and there was a more positive atmosphere in class.

The Danish county of Vejle used the peer approach in the 'Stormfulde højder' (Wuthering Heights) project which provided information and created dialogue. Activities ranged from debates, schools and workshops, to rave parties and a media campaign.

## Youth leisure time activities

Youth organisations play an important role in prevention in many countries.

1. In Austria, a youth centre was designed with prevention experts giving advice on integration. This collaboration will continue on a permanent basis in

the form of theme-oriented groups and crisis intervention.

2. The Danish Inter-Ministerial Children's Committee has published an overview on the use of culture by 12 preventive initiatives working with young people ([8]). The use of the concept of culture differs between projects. The concept is divided into:

- relations between people (socialisation);
- art and culture (theatre, art, music, books, etc.);
- values and norms (organisational culture);
- cultural landscapes (areas with diverse demography, history and geography).

3. In Finland, adventure camps reach young people not accessed by traditional education. Young people who suffer from insecurity, loneliness, parental substance abuse or other problems are targeted. Meeting places with the possibility of overnight stay have been set up.

4. Independent evaluation found participation in the Youth Awareness Programme (YAP) in London consolidated anti-drugs views, and discouraged existing users from extending their use ([9]). YAP works with young people's services, visits schools, colleges, youth clubs and nightclubs, produces posters, flyers and leaflets, and trains workers in counselling, first aid and advice. The Merton YAP project collaborates with projects in France and Denmark.

5. Training and networking between youth workers promotes prevention. In Austria, following a similar activity in 1994, a one-month programme in 1997, 'Preventive autumn', gathered over 700 youth workers at six regional meetings. From the first initiative 'Compass — Prevention knowledge exchange' emanated which seeks quality assurance, assessment of prevention methods, including reflection, training and networking.

## Dance drug interventions

### Information material

A collaboration between organisers of rave parties and the Danish National Board of Health led to the production of material for distribution at rave parties. The 'SafeRave' campaign, relaunched in June 1997, focused on information. A process evaluation ([10]) concluded that the strength of the campaign lay in cooperation with the techno environment. The report stated that the campaign did not obtain optimum success, but achieved a degree of motivation to take a stand against drugs among some of the target group.

### Activities at dance events

A youth programme in Hanover, Germany, focuses on the Ecstasy problem. For young people experimenting with drugs, prevention means 'disseminating information about responsible, hedonistic and controlled use of drugs (safer use)' ([11]). The project runs mainly 'on site', with a 'drugs info-mobile'. A flyer ('ravers' guide') has been devised, directed specifically at new users of Ecstasy or other drugs. For parents and teachers a brochure 'Ecstasy, LSD, speed' offers information. One finding was that new groups could be reached who had no access to counselling facilities.

In Italy, outreach work in pubs and clubs targets new users of cannabis and synthetic drugs. Informed peer groups, often using charismatic leaders, have obtained significant changes in attitudes and behaviour. Prevention activities on Ecstasy, LSD analogues and cannabinoids involve restructuring leisure time, accurate information, and involving club proprietors. Checks by traffic police intensified, along with preventive control activities by disc jockeys, proprietors and youth organisations.

### Drug testing

Since 1992, information on the composition (dose, ingredients) of synthetic drug preparations has been generated by the Dutch Drugs Information Monitoring System (DIMS). DIMS aims to prevent health damage from overdose or toxicity. Drug samples are sent in or collected during fieldwork and tested at affiliated offices or in a specialised laboratory. Preparations containing dangerous ingredients lead to warning campaigns.

The pilot project 'Check it!' was initiated in Vienna, in May 1997 to test the contents of Ecstasy tablets at rave parties. Fifteen samples can be tested simultaneously for drug adulteration. The first tests, organised at one of the largest rave locations, analysed 70 samples handed in by ravers. Only half of the tablets sold as Ecstasy were pure MDMA or MDE ([12]). This project has a prevention component. During events, streetworkers offer information and counselling to ravers. In the tent, samples were handed in, information and counselling were provided as well as drinking water, and a zone for relaxing. Vienna is planning to implement the project at European level.

**Guidelines for dance events**

The publication 'City Hall and House'([13]) of the Dutch Ministry of Health, Welfare and Sports gives advice on measures for large recreational events: free drinking water, adequate ventilation, cooling-off rooms; presence of first aid staff; entrance checks for drug possession; access for emergency services. The evaluation of the publication sees it as clearly written, containing valuable information and useful in policy-making. However, it is only suitable for 'house' parties.

The London dance safety campaign developed guidelines on the licensing of dance venues. Methods included dissemination of accurate information in clubs and training for professionals in clubs. The evaluation found an increase in knowledge while 33 % said the campaign might affect their future actions. Sixty-two per cent of professionals in clubs reported learning new information from the training.

In Sweden, the police control rave parties and permission to arrange a rave party is accompanied by police supervision and control. Unauthorised parties are at risk of being raided by police searching for Ecstasy and other drugs. Youngsters arrested are subjected to a urine test for drugs, and, if the result is positive, parents and social services are informed.

## Mass media campaigns

Mass media campaigns have been launched in several countries with those evaluated revealing some impact. In Scandinavia, experts are more sceptical about national campaigns. Priority is given to community action and personal communication.

A campaign in the Netherlands, launched in 1997, targeted young people and dealt with cannabis. It contained television spots and a leaflet on young people's experiences, which was distributed in secondary schools. Half the young people surveyed had spoken to others about the campaign, of whom 94 % had a positive opinion. Supplementary activities in coffeeshops ensured the target group was reached. Seventy-nine per cent of coffeeshop visitors knew about the campaign, while coffeeshop owners were willing to continue using the materials.

During 1997 a media campaign launched by the Irish Department of Health and Children alerted people to the dangers of drug misuse. The target audiences for this campaign were 15 to 25-year-olds experimenting with drugs or at risk of use, and parents. The campaign initiated a telephone information line which is now permanent.

Since 1990, there have been six editions of an information campaign in Italy. The 1996-97 campaign was evaluated in relation to the message given. While adults (30-55 years) prefer moderate messages, young people (14-24 years) prefer stronger, more emotionally charged, images. The seventh campaign will have 'new drugs' as its theme and will attempt to reach youth in their gathering places and leisure time.

'D-Day', a day of national reflection on drug addiction was held in Portugal in January 1997, to make society aware of the problem, to stimulate debate, and to give information about resources. The impact was evaluated by the Lisbon telephone help line Linha VIDA, which observed an increase in calls during the campaign.

In Spain, two nationwide campaigns were launched in 1997: 'Enjoy sport — avoid drugs' with the objective to foster sports activities as a preventive strategy against drugs, and 'Do you know how to have fun without drugs?' with the objective of making people aware of the risks entailed in drug taking and emphasising the fact that having fun does not have to be associated with drugs.

In the UK an unofficial campaign followed the death of a young woman, Leah Betts, who took an Ecstasy tablet and drank excessive amounts of water. Although not the first Ecstasy death in the UK, it received the most publicity because her parents allowed photographs of their daughter in intensive care to be taken. Media coverage was followed by a poster campaign and a video, which anecdotal evidence suggests has impacted on young people.

The Finnish 'Päihdelinkki' (Drug Link) information service provides drug-related information on paper, by phone, fax and through the Internet. The Internet is increasingly used for dissemination of information, including personal advice.

## Community programmes

Early drug abuse can be handled in informal social networks with little intervention, as with Swedish work on community networking. Recent evaluations of drug education recommended that it be integrated into a wider programme of activities, in

which the authorities, voluntary organisations and others cooperate. The National Institute for Public Health has funded local community schemes with strict evaluation.

The UK Home Office spends GBP 6 million per annum on community-based prevention. Twelve local teams have been set up to support community partners, involving over 70 projects. This focuses on work with parents; young people outside school; support for drugs education; peer approaches; rural communities; criminal justice; training for professionals; local information campaigns; racially and culturally diverse groups; and combined approaches. The first phase supports neighbourhood practitioners, community networks, training and action research.

A community-based drug prevention programme including seven different districts in Luxembourg was implemented in 1996 and 1997 by the National Drug Prevention Centre ([14]). The one-year evaluation showed that about half the community members had heard about the activities, although only one tenth participated. The project provoked more communication between youth and parents about drugs. Only minor changes in consumption were registered, e.g. a decline in smoking among 26 to 40-year-olds.

The inter-agency drugs project (IADP), based in Dublin, is made up of three sub-committees — education and prevention; treatment and rehabilitation; and supply control. It acts as a forum for inter-agency interaction and contributes to the development of policy and legislation.

## Outreach work

A 1997 EMCDDA study describes four models of outreach work ([15]) ('Concepts, practice and terminology in the field of outreach work', available from the EMCDDA):

### The youth work model

Some outreach projects contact marginalised youth and help them access 'natural' social networks. In Finland some of this work is done in homes with a 'Tupperware methodology'. In French cities street educators have operated since the 1970s, and in Vienna 'park workers' work liaise with groups.

In Denmark, the county of Ribe Youth Centre employs staff who act as soon as there is a suspicion of young people experimenting with drugs. The staff member initiates preventive and information work, to raise awareness concerning drugs and drug attitudes and to divert the energies of the group to more rewarding activities.

### The 'catching client' model

The 'catching client' model employs outreach workers to motivate drug users to enter treatment. 'Catching clients' can also be seen as looking for clients not in treatment.

Swedish social services ensure that drug users receive the assistance and care they need. A 'waiting approach' is not in accordance with the legislation. NGOs are also involved in outreach work, cooperating with social services and health care.

### The public health model

As part of the public health response to the HIV/AIDS epidemic in the 1980s, outreach workers provided clean needles, syringes and condoms, and information about safer use and safer sex. A problem for outreach work is the relationship with the police and so specific arrangements and training must be organised with the police.

Italian drug services launched street operations in 1997 to provide social and therapeutic support for users who do not access health services. Most patients, who never use services, or who abandon services after relapse, live in conditions of economic and housing difficulty, are exposed to risk of infectious disease, and are at greatest risk of heroin overdose and/or collapse from polydrug use.

### The self help model

The Dutch Mainline project was started eight years ago by the drug users' self-help group Jonkiebond who publish a magazine with hands-on tips for drug users. A special project concerns a photo-novel booklet for women users, about half of whom are sex workers. Similar initiatives have been reported from other countries engaging drug users in writing journals or pamphlets. Another type of the self-help model is initiatives for synthetic drug users in the dance scene.

## Prevention of infectious diseases

Drug users are among the groups most affected by HIV infection. But other blood-borne infectious diseases, such as hepatitis, also affect drug users. Of

recent concern is infection with tuberculosis in this group.

The UK was one of the first countries with HIV prevention programmes, and due to these early responses in service provision and prevention, there are comparatively low rates of seroprevalence among injecting drug users (1% outside London, 7% in London). However, the whole range of sharing activities needs to be addressed if other infectious diseases are to be controlled. It has been estimated that as many as 61% of injecting drug users in England test positive for hepatitis C ([16]). A 1997 survey assessed sharing in people not in contact with services, to target prevention messages better.

In Italy, following the alarming spread of HIV, harm reduction policies have gradually advanced, leading to greater methadone maintenance provision, and to 'street units'. At national level, harm reduction was formally accepted at the National Conference on Drug Addiction (Naples, 1997), as part of the National AIDS Commission prevention guidelines. Data collected in 1997 show a discrepancy in the activation of general measures, which 94% of services implemented, and specific actions (syringe exchange, distribution of condoms), which did not reach 25%.

Recently, an AIDS prevention project based on peer education has been initiated in Greece. The project aims to reach drug users not easily accessed through snowballing. Former users are trained to apply prevention and harm reduction techniques with contacts in the drug scene (also participating are Belgium, France, Spain and Italy).

The Health Council of the Netherlands advised the Dutch Government in 1996 to execute an immunisation programme for hepatitis B, directed at the total population with specific programmes for high-risk groups. Vaccinations and registration will be executed by the Municipal Health Service. The implementation process will be guided by an evaluation. In Austria, a hepatitis vaccination programme started in 1995.

For tuberculosis, the Italian National Institute of Health financed a project to evaluate the feasibility of chemoprophylaxis in drug addicts.

Syringe exchange programmes exist in most EU countries, but differ in scale and impact. However, due to methodological issues, evidence for the effectiveness of specific programmes is scant ([17]) and there is no evidence that exchange schemes have an impact on hepatitis C transmission ([18]).

Exchange schemes have been rare so far in Finland, although a pilot health education project for injectors recently started in Helsinki. Attenders may exchange their syringes and needles, condoms are available and clients are informed about the risks of contaminated paraphernalia and about sexually transmitted diseases. Around 500 addicts used the service in 1997, but accurate information is limited as exchanges were anonymous. One hundred and thirty clients were interviewed and the results were used to improve content and methods.

The Portuguese syringe exchange programme 'Say no to a used syringe' was implemented in 1994 and was evaluated for the first time in 1996 ([19]). Two hundred and ninety-six drug addicts with a recent history of injecting were questioned; 78.7% injected more than once per day and most had injected in the last 24 hours. Most users questioned (80.7%) reuse the same syringe, but do exchange it at least once a day. The majority of women share injecting material and it is among women that HIV infection is more common. This greater vulnerability to developing risk behaviours in women may necessitate the development of gender-specific prevention.

German findings also show that women heroin users are significantly more HIV-infected than men. In Luxembourg, several local outreach prevention activities contact prostitutes within their work environment for HIV and hepatitis testing.

The Vienna syringe exchange programme has more than doubled the number of exchanged syringes since 1993. These measures ensure that drug addicts are aware of risks, reflected in the decreased number of new drug-related HIV infections. In Amsterdam, syringes distributed decreased from 745 000 in 1995 to 600 000 in 1996, probably due to changes in injecting behaviour.

## Low-threshold services

In Germany there is an ongoing debate on the best way to organise low-threshold services. Instead of setting up distinct units for low-threshold and high-threshold services, the underlying concept of individual tailoring suggests that the threshold should be set on the basis of the situation, motivation and ability of the client. Accordingly, more German services have

created comprehensive and interlinked services for addicts which also include 'low-threshold' measures.

In Luxembourg a bill foresees the establishment of a legal framework for the creation of shelter and first aid facilities for drug addicts that provide hygienic conditions, meals and sleeping facilities.

The Netherlands has introduced brief interventions for teaching users self-control (taking drugs in a non-problematic way). 'Gebruik(er)sruimten' buildings or rooms allow users to take drugs under hygienic circumstances, and lessen public nuisance. The addiction care sector also offers possibilities for supervised accommodation, for daytime drop-in and night-time shelter. These facilities bridge the gap between inpatient and outpatient treatment or between prison and resettlement.

The number of low-threshold day centres in Finland has increased offering counselling, hygiene and catering services and some offer health care. Shelters provide temporary accommodation, assess clients' needs and may instigate more permanent treatment processes.

The United Kingdom has few low-threshold services other than syringe exchange and counselling services. For physical problems, users often use accident and emergency (A&E) departments. The NTORS treatment study found that half the cohort had attended an A&E department in the previous two years.

## Substitution and maintenance programmes

### Legislation

On 1 January 1996 Danish legislation made methadone treatment a county council remit. One objective of the change is to ensure that methadone prescription is coordinated with other treatment, that the circumstances of the user are scrutinised before prescribing and alternative treatment is offered.

Practical changes in the prescription of narcotics and painkillers and for substitution treatment came into effect in February 1998 in Germany. The revision was caused by an increase in 'grey' substitution and deaths caused by codeine. It controls the use of codeine more closely and attempts to reduce the availability of substitution substances on the black market.

Until 1997, methadone programmes had only been tolerated by the Luxembourg Government, but a 1997 bill still to be voted by Parliament establishes a legal framework for substitution and maintenance programmes.

On 8 July 1997, the Ministry of Social Affairs and Health in Finland issued regulations on pharmaceutical treatment of opiate addicts based on medical treatment, psychosocial therapy and follow-up care. The Ministry's decision was provoked by substitute prescribing by private physicians. The authorities were critical of which medicines were administered and of the quality of psychosocial treatment.

### Substitution treatment

Throughout Europe methadone treatment is increasing. In Germany, treatment data suggest that whilst heroin is mentioned slightly less frequently among the main diagnoses, treatment centres are increasingly seeing users of methadone and codeine. Codeine substitution was formally far less regulated than methadone.

The Danish National Narcotic Council reported problems linked to methadone treatment — differences in councils' administration of methadone are too great, rules for appeals are unclear, and that there is a lack of consistency in control measures and sanctions in methadone treatment. The government has recommended that common appeal regulations be adopted.

The Italian services report a number of dysfunctional methadone patients injecting heroin even at high methadone dosages; who continue to use benzodiazepines, stimulants, other drugs along with increased alcohol intake. They will have to be studied better, be subject to more complex processes and must not simply be excluded or given higher dosages.

LAAM is prescribed in 12 treatment centres in Portugal. In Denmark, a one-year project of 200 clients on LAAM will be launched in 1998. Problems encountered transferring from methadone to LAAM will be recorded along with satisfaction, withdrawal problems, side effects and retention. In Italy, LAAM is proposed as an alternative to methadone, and may foster social integration of addicts.

### Admission criteria

Some countries have strict admission criteria for substitution treatment whereas others use addiction as the only criterion.

In Greece, admission criteria include being an IV heroin addict of more than 22 years of age, having at least

two years' drug use and having unsuccessfully tried other treatment. The Swedish and Finnish criteria are similar: four years of IV opiate use, failed drug-free treatment, no use of other drugs, lower age limit of 20 years.

By the end of 1997, the Luxembourg methadone programme published revised admission criteria:

- age > 18 years,
- resident of Luxembourg,
- confirmed dependency (DSM IV, urine test),
- unsuccessful detoxicification attempts,
- priority for pregnant women and HIV positive addicts.

Buprenorphine (Subutex) has been available in France since February 1996 as an alternative substitution treatment. In contrast to methadone, the prescription of which has to be initiated in specialised centres under certain conditions, buprenorphine can be prescribed by general practitioners with no specific admission criteria.

## Table 1: Estimated numbers in substitution treatment (generally methadone)

| Member State | Estimated number | Comment |
|---|---|---|
| Belgium | 6 617 | |
| Denmark | 2 400 | |
| Germany | 60 000 | 40 000 methadone / 20 000 codeine |
| Greece | 400 | |
| Spain | 51 000 | |
| France | 46 700 - 56 700 | 41 000 - 51 000 buprenorphine / 5 700 methadone |
| Ireland | 3 000 | |
| Italy | 40 864 | |
| Luxembourg | 158 | |
| Netherlands | 11 676 | |
| Austria | 2 966 | |
| Portugal | 2 324 | 2 007 methadone / 317 LAAM |
| Finland | 200 | |
| Sweden | 600 | |
| United Kingdom | 28 776 | Notified addicts receiving substitution treatment in 1996 |
| **Total** | **More than 265 664** | |

**Evaluation**

Substitution treatment is the best evaluated field of demand reduction with generally positive results: increases in employment, improvement in emotional status, physical appearance, health, family and social relations, finances and vocational skills, while there are reductions in criminality, in pending trials, debts, and heroin use. Generally, HIV positive patients comply with monitoring and treatment.

A Swedish evaluation study of 655 patients found that half did not interrupt their treatment. The ma-

jority of 205 methadone clients improved their situation concerning housing, work/studies, social relationships, health, family relationships and alcohol and drug use; 38 % had improved in six of the seven areas. Hospitalisation and criminality decreased significantly ([20]).

A recent study in Rotterdam ([21]) showed that 90 % of methadone clients also use cocaine and heroin and 70 % use alcohol. In a southern region of the country, the figures were 55 % and 40 % (average methadone-dose is 50 mg). There is no correlation between dose and other substances used. It is not clear whether methadone regulates the use of other substances.

In Luxembourg a new evaluation software is being developed in collaboration with the national focal point. It is an information system for collecting, analysing and storing patient information in a complete dossier at patient level, with automatic generation of statistics, and can be used for quality control.

An evaluation of the Dutch experiment with palfium illustrates that this is an alternative in the short term but not in the long term as few users experience palfium as attractive, as its effects are shorter-lasting and more stimulating than heroin. Between March 1995 and October 1996, 53 heroin addicts started on palfium. Sixty per cent judged the treatment as positive and considered palfium a surrogate for heroin. Only a small group stopped using heroin. It was no problem for clients to return to methadone.

In 1997, a randomised controlled double-blind trial comparing buprenorphine with methadone was conducted in Italy. The outcomes considered are retention in treatment, use of street heroin and different psychosocial health parameters. Another randomised controlled, not blind, study compares oral methadone with LAAM.

## Medical prescription of heroin

All 15 EU Member States are signatories to the 1961 Single Convention on Narcotic Drugs which limits the 'quasi-medical' use of opium, while heroin used in medical prescriptions must be approved by the International Narcotics Control Board of the United Nations. In the EU, only the Netherlands has so far requested and been granted permission to use heroin.

For years, prescribing injectable heroin to addicts has been a unique feature of the 'British system'. Since the late 1960s, treatment of addicts in the UK has shifted to specialised clinics resulting in a shift from heroin via injectable methadone to oral methadone. The number of drug users prescribed heroin is currently less than 100 in the UK and only a handful of clinicians prescribe heroin to drug users.

The Dutch Government agreed to an evaluation of the effectiveness of prescribing heroin in addition to oral methadone in treatment-resistant heroin addicts, over a period of 12 months. The positive and negative effects will be assessed for medical (somatic and psychiatric) status; social functioning; and illicit use.

In 1992, a Spanish regulation on maintenance treatment with 14 different substances, such as methadone, LAAM, buprenorphine, opium, heroin, etc. entrusted the Autonomous Communities to implement these practices.

In Germany, applications have been made by the Bundesrat (Federal Chamber of the Länder) to reform narcotics legislation to allow a study of treatment with heroin. Modifications of this application are being discussed in different federal Länder.

## Treatment systems

A general tendency in EU Member States is increasing interinstitutional cooperation and network building. The improvement of cooperation between addiction services and those for general health care are particularly effective. The intention is to link drug services into a network of local services.

A review of services in the Eastern Health Board Area, including Dublin, Ireland, concluded that 'there is now a wide range of treatment options available ranging from drug-free therapeutic communities, drug-free counselling, in-patient detoxification to methadone substitution and methadone maintenance to needle exchange and outreach services. There is also a strong voluntary and community organisation voice to complement and support the statutory sector input' ([22]).

In 1997 the UK Department of Health published 'Purchasing effective treatment and care for drug misusers', which recommended:

- greater involvement of primary care professionals, such as general practitioners and community pharmacists, in the care of stable drug users;

- the need to develop accessible and appropriate services for young drug users;
- the need to improve care for users within the criminal justice system; and
- the need to support well-managed methadone programmes and associated counselling programmes.

The first In-patient Motivation Centre (IMC), opened in Amsterdam in 1990. IMCs try to reach drug users who do not have sufficient motivation to achieve abstinence and to help them structure their lives, to learn social and labour skills, and to prepare for a regular treatment setting. An evaluation showed that 70% of clients went to regular in-patient treatment after three months in the IMC. This success led a national working group to advise the Minister for Health to set up 10 IMCs across the country to reduce nuisance and to prepare drug users for in-patient treatment. The IMC offers a safe and stimulating environment which provides concrete working and learning goals, adjusted to the abilities, cultural identity and psychological situation of the client.

In Sweden, Italy, and other countries, attention has focused on co-morbidity in recent years. Swedish estimates indicate that between 15 and 85% of drug users in treatment are suffering from mental disturbance, depending on treatment location. Aalborg University in Denmark in 1996 showed that it is possible to reach mentally ill abusers with care and support ([23]).

Treatment for Ecstasy users is rarely reported. In some cities in Italy, however, specialised help and counselling services for 'new users' operate: in Padua for psychiatric aspects, in Rimini and Cesena for cultural attitudes, and in Parma for studies on neuroendocrine effects.

Drug treatment is basically voluntary, but in Sweden, as a last resort, young people exposed to risk through abuse of addictive substances can be removed from the risk situation against their will. Similarly, adult users can be placed in care against their will to relieve a life-threatening situation. There are 34 special institutions for young people with about 595 places and 15 homes with about 343 adult substance abusers.

Monitoring and evaluation are key issues in treatment as in other areas of demand reduction but evaluation practice is underdeveloped. Austria, Denmark and Sweden are currently improving their treatment monitoring and assessment systems and, in Finland, research projects on the treatment system were launched in 1997.

In 1997, a therapeutic model of treatment-rehabilitation, 'integrated treatment of drug addicts', was evaluated in Portugal ([24]). In the first week, abstinence is attempted without any medication. In the second phase, detoxification takes place at home. Simultaneously, family therapy, takes place. In the third phase, individual and couple therapy, aimed at the parents, follows. The evaluation ([25]) studied those who did not join the programme (N=20), those who did not finish the second phase (N=20), and those who finished the second phase (N=20):

More women than men gave up before finishing the second phase;

People with higher levels of schooling were more likely to finish the programme;

Failure was associated with unemployment and onset of drug use at an early age.

Addicts who did not enter or complete the programme maintained less contact with family, partners and close friends. On the other hand, those who completed the programme had more frequent contact with their family and social network, and greater emotional and material support.

The national treatment outcome research study (NTORS) assesses the effectiveness of community and residential (inpatient and rehabilitation) programmes in England. It is the largest study of treatment outcome for drug users ever conducted in Europe and provides information about the drug-related, social, psychological and health problems of treatment entrants and studies the structure and content of services. One-year follow-ups show significant reductions in the quantity and frequency of drug use, reductions in sharing of injecting equipment (to less than half the pre-admission levels), improvements in physical and psychological health, and marked reductions in criminal activity (estimated to be worth ECU 6 million per year). The NTORS findings demonstrate the 'substantial improvements made after treatment by people with serious and long-term drug problems'.

In Denmark, an evaluation of residential treatment in seven treatment centres, started in 1996 and to

be completed in 1999, documents organisational aspects, client characteristics, treatment effects and treatment processes ([26]).

The Trimbos Institute has reviewed the published Dutch and international evidence on effectiveness and efficiency. The main results of this study are presented below ([27]).

## Aftercare

After treatment, drug users often find themselves without adequate housing, employment and education. Different aftercare services assist ex-users in education, work and housing, with a focus on vocational training in many countries.

'Needles or Pins' is a cooperative project between six Member States, including Austria and Spain, to reintegrate addicts into the labour market and educational system. Outpatient medical, psychotherapeutic and social treatment (including substitution treatment) are the methods used in the project. It is evaluated with the Europasi questionnaire.

In France, there are 280 places in 'familles d'accueil'. Former users stay with a family for four to five months monitored by drug services. The families are paid, but basically it is a voluntary service.

In Greece, employment and social rehabilitation efforts are made by offering incentives to private enterprises for employing ex-addicts by subsidising their salaries for two years. In December 1997, a social rehabilitation centre was opened to provide relapse prevention services, and vocational training to programme graduates.

In Portugal, social reintegration programmes are included in more than 80 % of treatment centres, frequently in collaboration with NGOs, even if the numbers utilising them are low. One task of Projecto VIDA — national programme for the prevention of Drug Addiction — is to promote reintegration initiatives through the Reintegrar support programme, created in 1997.

## Self-help groups

Self-help groups have emerged among drug users, for example, in Germany, Luxembourg and Denmark. Brugerforeningen in Copenhagen is an association of drug users who want to initiate treatment on the users' own conditions and to involve drug users in the decision-making process. It organises conferences, meetings and provides counselling.

'Alpenrausch', the first Austrian public periodical about drugs, first appeared in June 1997 as a public voice for those concerned. It offers information on drugs, drug facilities and is produced and sold in the streets by (former) drug addicts.

## General health care

In the UK GPs are currently the main providers of generic health care to drug users although they are frequently reluctant to get involved with 'troublesome and chaotic' drug users. However, as there are 32 000 GPs in the UK, even a minor shift in GP involvement can have a major impact on service provision.

In 1997 one-day training sessions on drug issues were held for personnel in all 21 Finnish specialised health care districts, on the detection of drug use, dealing with client contact and effective treatment. In Austria, drug-related training events are organised in areas of general health care. As part of the cooperation with Hungary, a joint training programme for medical and nursing staff was initiated in Burgenland.

A project set up in Frankfurt, Germany, is a model of cooperation between a general hospital and a drug centre to improve care for drug-related emergencies and to reintegrate addicts into regular care as early as possible. First results from this project show that care has improved and 'new' addicts have been reached who previously had no contact with services. The quality and duration of inpatient care has improved. Cooperation has developed and there is more follow-up care of emergency patients without previous attachment to the treatment centre. Similar models are run in other parts of Germany as well.

Student nurses have been involved in prevention in primary schools in the Paris region. The students gain legitimacy through their youth and through their status as future health professionals.

## Criminal justice system

### Prevention activities by the police

The police are often involved in prevention, in schools and leisure settings. Relationships between the police, social and youth workers have improved in many countries.

The criminal police information service of Vienna has a special department for prevention of addiction with some officers mainly working with young

## Table 2: Overview of evidence for effectiveness of interventions in the Dutch addiction treatment and care system

| Type of intervention | Evidence | Remarks |
|---|---|---|
| Methadone detoxification | S | One Dutch study |
| Methadone maintenance treatment | E | Only international studies:<br>• decrease in heroin use and criminal behaviour<br>• less nuisance and infectious diseases |
| Other medication | I | Further research is needed:<br>• detoxification with clonidine, naltrexon, naloxon<br>• maintenance with LAAM |
| Combination therapy | I | Further research is needed |
| Psychological/social intervention | E<br>S | • Especially behavioural-oriented interventions are effective; ambulatory as well as residential<br>• Some evidence for short-term behavioural-oriented family therapy:<br>• reduction of drug use and criminal behaviour |
| Alternative intervention | I | Many foreign studies but no clear effect |
| Self-help | I | No adequate study |
| Therapeutic community | E | • Reduction of drug use and criminal behaviour<br>• more coping strategies and better social functioning |
| Penitentiary/residential treatment | I | Dutch and foreign studies |
| Supply of heroin, morphine | I | One Dutch study |
| Intervention for employees and users in search of employment | I | Dutch studies |

* E= enough scientific evidence; S= some evidence; I= insufficient or no evidence.

people having taken a one-year training course to become 'youth addiction counsellors'. A prevention scheme approved by the Vienna Drug Coordinator was devised for the police.

In many municipalities in Finland, cooperation between organisations aims to tackle drug abuse at an early stage. Street control potentiates interventions in the criminal career of drug experimenters through instruction and treatment. Police projects also take care of local criminal problems by utilising police expertise in cooperation with municipal authorities. By targeting resources to common issues, e.g. juvenile delinquency, it is possible to prevent, detect and intervene efficiently and early.

In 1997, the Greek Centre for the Promotion of Health and the Prevention of Drug Abuse trained 20 police officers, sensitising them to drug use. Police prevention initiatives reinforced patrolling of schools to hinder dealing within or near schools.

### Dealing with drug offenders

All EU countries have alternative sanctions for drug offenders, especially for first and/or minor offences.

In Greece 1996 legislation introduced more lenient treatment by treating the offences of dependent users as misdemeanours and not felonies. Non-dependent users whose offences are not serious can be released, provided they attend a treatment centre.

In Ireland, the police juvenile diversion programme diverts offenders from criminal activity and provides an alternative to the formal criminal justice system. The Children Bill, 1996, proposes that elig-

ible juvenile offenders are dealt with caution rather than being prosecuted. The programme is operated by juvenile liaison officers who complete a substance abuse course. A proposal to establish special courts for non-violent drug offenders is to be examined by experts. Provision is made for 'certain cases to arrange for the medical or other treatment or for the care' of a person dependent on drugs and convicted of an offence.

In 1997, provisions were made in the United Kingdom's Crime and Disorder Bill for Treatment and Testing Orders. These court orders are designed to break the links between addiction and offending, by requiring offenders on non-custodial sentences to undergo treatment for drug problems and regular drug testing. Diversion from the criminal justice system occurs either before court (police cautioning, or 'discontinuance', with advice on health/welfare), or at court (a range of sentencing options with health/welfare/control components) for those unlikely to receive a custodial sentence. Before sentencing, these offenders would be subject to compulsory drug tests, and if positive, they would undertake a four-week addiction assessment. Those continuing to test positive for heroin or cocaine would be sentenced to an order, run concurrently with probation. The treatment could range from counselling to residential rehabilitation. Testing would involve regular random tests. A clear test would lead to a reduction in testing; a positive, to more frequent tests. After four months,offenders return to court for review. If they had complied, the order would be ended, but if they had failed to comply, a further four months would be imposed.

In Sweden, outreach workers visit drug users upon arrest. Police report users who need help to social services and probation officers cooperate with police and social services. Magistrates may send a case to social services if the offender is under the age of 20.

### Alternatives to prison

All EU Member States permit suspended sentences for addicts. The tendency is to extend this practice. This could include postponement, exemption from liability, release on probation, dispensation of the sentence, or suspension of application of the sentence, the most common measure. There are specific regulations for addicts in Denmark, Germany, Greece, Spain, Italy, Austria and Portugal. Depending on the country, suspension may be simple or with conditions, e.g. the obligation to undergo treatment. If conditions are violated, the offender may go to prison. A recent study on alternatives to prison — 'Study on alternatives to imprisonment for drug addicts' — is available from the EMCDDA.

Under new Austrian law, suspended prison sentences for convicted addicts have been extended to sentences of up to three years (formerly two) to facilitate health measures. In addition the model of 'therapy instead of punishment' may be applied for petty offences associated with drug acquisition. The courts are requested to report on implementation of the law.

In the Netherlands, imprisoned users can be coerced to undergo treatment. Inmates choose between serving full sentences or substituting treatment for part of the sentence. Convicted drug users may also avoid imprisonment by accepting early intervention (supervision and treatment). There are about 20 such projects. The GAVO project in Utrecht targets long-term drug users who have committed at least five offences in the previous year. Upon court approval, these users may choose between 'care' and continued detention. A case manager defines care needs, usually including inpatient treatment, training and supervised accommodation. If the user violates the agreements, the sentence may be enforced. Six months after entry into GAVO, 70 % were still 'clean'. That dropped to 45 % at one-year follow-up ([28]). There was a decrease in registered offences committed by participants of more than 70 %. The strategies are multidisciplinary, as police, judicial authorities and addiction treatment and care centres join forces.

### Prison

Drug trafficking in prisons may be more problematic than outside. Non-availability of sterile syringes results in widespread sharing of needles. Attempts have been made in recent years to provide syringe exchange services in German prisons. A study in Amsterdam showed that, although drug use occurs in prison, users seldom inject ([29]).

A pilot project at an Austrian prison consisted of 21 inmates who committed themselves to abstinence and agreed to have this checked by urine samples. In return they were granted privileges, such as freedom to decorate their cells. Due to high acceptability, the number of inmates involved, and the range of privileges granted, increased. By the end of 1996,

## Table 3: Estimated rates of drug users in prisons

| Definition | Country | Rate (%) | Remarks |
|---|---|---|---|
| 'Drug addicts' | Germany<br>Italy | 33.0<br>29.0 | |
| 'Imprisoned for drug-related offences' | Luxembourg<br>Greece<br>UK<br>France | 17.0<br>40.0<br>10.0 -12.0<br>18.6 | 70 % have used before prison |
| Drug users/abusers/drug-related problems | Spain<br>Sweden<br>Portugal | 40.0<br>30.0 - 40.0<br>70.0 - 80.0 | 10 % use in prison |
| i.v. drug use | Austria | 15.0 - 20.0 | |
| Used addictive substances in last 6 months | Netherlands | 48.0 | |
| Not defined | Belgium<br>Denmark<br>Finland | 40.0<br>33.0<br>31.0 | <br>8 % i.v. users<br>11 % i.v. users |
| No data provided | Ireland | | |

about half of the 300 inmates were integrated in the project. An evaluation study (30) found that three quarters of all drug-free wing inmates in the study experienced improvement in their conditions and well-being. The conclusion is that the opportunity to influence prison stay in the drug-free wing triggered positive effects.

In Portugal there are seven drug-free units, with two opened in 1997. In Greece, detoxification units are to be inaugurated in most prisons in 1998. Apart from treatment these offer training and rehabilitation. In Sweden, 40 % of users in prisons participate in a drug-related programme, one third of these outside prison (31).

In Amsterdam, public prosecutors have the option to place addicts in one prison in which inmates must participate in treatment. If they resist, their stay in prison will be devoid of luxury. In general the results are not too promising(32). There are some slight positive changes in self-esteem and self-efficacy. The use of hard drugs decreased but 70 % of the inmates do not sign a treatment contract.

A three-year project in Finnish prisons began in 1996. Consisting of four subprojects, it concerns the treatment of alcohol, medicine and drug abuse. In the first, prisoners undergo a four-week rehabilitation outside the prison to which they return at night. In the second, a drug worker looks for motivated prisoners to participate in after-care activities after release. The third starts with a detoxification of one week, isolated from other inmates, followed by transfer for after-care to an outpatient prison unit, then sheltered housing on probation. The fourth provides a one week rehabilitation and prison staff are trained to support inmates. Following release services are developed with sheltered housing services and for training and job opportunities.

Substitution treatment is provided in prisons in, for example, Denmark, Germany, Spain, France, Ireland, Austria and Portugal. In some cases, only prisoners already in methadone programmes were eligible for prescription, but other prisoners can now also receive methadone.

Some French prisons have developed a programme for the last month of incarceration in which group dynamic techniques are used to enhance physical and psychological health and to plan for the future. The prisoners are also connected with social, health and drug services. The programme is currently being evaluated.

## Gender-specific issues

Gender-specific prevention approaches are reported in Sweden, Germany and Austria. Recently a report on gender-related drug prevention among youth was published in Germany([33]). In 1996 a 'Book of ideas for girls' specific addiction prevention' and in 1997 a 'Book of ideas for boys' specific addiction prevention' were published.

Facilities that meet the specific needs of women users have become more common in Europe, although in many countries there is still a need for services. Important issues are prostitution, sexually transmitted diseases, pregnancy and motherhood.

An Italian study showed that over half of drug services had begun activities directed at women. Projects focusing on women's problems, addiction and AIDS were financed in the past year. There is a growing interest in 'AIDS and women', due to increased prevalence of HIV infection in women addicts and/or sexual partners of drug addicts.

The SAOL programme is a Dublin project which offers women in recovery or stabilised on methadone a chance to acquire skills including literacy, numeracy and other social skills to give them a better opportunity to return to normal living. This two-year pilot programme aims to move participants from addiction to self-reliance. The project gives women the opportunity to explore their potential through participative learning that incorporates a community development approach. The women are encouraged to have a sense of ownership and to become involved in reviews of course design, delivery and management. An initial needs-assessment allowed SAOL to develop a framework covering training, education and development.

## Children of drug users

Many addicts have children who often find it difficult to lead a normal childhood. Their everyday life may lack stability, and material and emotional resources. Moreover, they are at risk of being stigmatised, disadvantaged, and there is the threat of being removed from their family. Support systems are necessary for these children and their parents, but few exist.

Last year a Swedish conference about families affected by drug use highlighted 80 support groups for children of substance abusers (mainly alcohol). In these groups children play and talk about their sorrows and needs. It helps them understand that they are not alone, and identifies their feelings, defence mechanisms and strengths.

## Parents of drug users

Especially in southern Europe, but also elsewhere, parents of drug users are involved in counselling or family therapy. The involvement of the family is a characteristic of treatment in Italy, although not always possible in countries where the relationships between children and parents are less close. However, the treatment of co-dependence has led several services to provide specific groups for mothers of patients. Even three-generation-long problems appear: often the 'interventions' of the grandparents oblige the services to deal with the whole family, involving the preceding generation also.

There is an increasing involvement of parents in drug prevention and community action facilitated by UK drugs prevention teams. Surveys report that most people see parents as responsible for dealing with drug-using children. These findings support involving parents in contracts to control unruly children.

## Ethnic minorities

Drug use among ethnic minorities has risen or become more visible, suggesting a need for targeted intervention.

In Sweden, the proportion of heroin users with foreign background in treatment has grown. Anecdotal evidence suggests that immigrants had been afraid to seek help as they feared incarceration and deportation.

The drug population of Luxembourg is heterogeneous. More than 50 % of foreign users in Luxembourg are of Portuguese origin. These observations have led the Luxembourg Focal Point, in cooperation with the Portuguese Focal Point, to commission a study on populations demanding treatment: native clients, Portuguese clients living in Luxembourg and a sample of Portuguese addicts treated in Portugal. The comparison of socio-demographics revealed important differences as Portuguese drug addicts treated in Luxembourg are very young (M=25 years), with lower educational level than the other populations.

In Spain, efforts have been taken to counter the drug problems in the gypsy population, taking into consideration ethnic and cultural factors. The involvement of indigenous mediators is one of the strong points of the project.

## References


[1] Borhn A., Bohrn K., 'Drogenmißbrauch bei Kindern und Jugendlichen, Kärntener Bundesregierung', Vienna, 1996.

[2] Winner, 1997.

[3] Morgan M. et al, 'Prevention of substance misuse: rationale and effectiveness of the programme "On my own two feet', in OIDEAS, Journal of the Department of Education, Vol 44, pp. 5-25.

[4] Weerdt I de, Jonkers R, Nierkens V, Jonkind S. 'Begeleidend onderzoek De Gezonde School en Genotmiddelen: Stand van zaken van het effect- en implementatieonderzoek per november 1997'. Haarlem: ResCon, 1997.

[5] Pestana, C, Carvalho, L M, 'Initiatives on the evaluation of the project "Viva a escola"', Toxicodependências, 1997, 3 (3), pp. 17-22.

[6] Idem

[7] Jertfelt Gustafsson T, 'ANT – Inte bara skolans ansvar'. Alkohol och narkotika 6/1997, pp. 19-21.

[8] Gade Nielsen, J, 'Kultur som dynamo i det forebyggende arbejde. En undersøgelse af 12 udvalgte initiativers brug af kultur i det forebyggende arbejde med børn og unge'. Det Tværministerielle Børneudvalg, Copenhagen, 1996.

[9] Shiner, M. and Newburn, T., 'Young people, drugs and peer education: an evaluation of the youth awareness programme (YAP)', Drugs Prevention Initiative Paper 13.

[10] Konsulentkompagniet, 'Evaluering af Safe Rave-kampagnen i Technomiljøet', Copenhagen, 1997.

[11] Grube L, 'Funktion des Ecstasy-Konsums bei Jugendlichen', in: Niedersächsische Landesstelle gegen die Suchtgefahren (ed.), Ecstasy – Konsum, Missbrauch, Präventionsstrategien, Hanover, 1995.

[12] Schmied R, Seidler D, 'Bericht zum wissenschaftlichen Project 'Check it!"', inoffizieller Bericht, Vienna, 1997.

[13] Dutch Ministry of Health Welfare and Sports, 'City Hall and House', Rijswijk, 1995.

[14] Centre de prévention des toxicomanies/Zentrum für empirische pädagogische Forschung, Suchtprävention an der Gemeng, Luxembourg, 1998.

[15] 'O+S, Concepts, practice and terminology in the field of outreach work', EMCDDA, Lisbon, 1998.

[16] Waller T., Holmes Reitox, 'The sleeping giant wakes. Hepatitis C: scale and impact in Britain', Druglink, 1995, 10(5), pp. 8-11.

[17] Ameijden E.J.C. van, Hoek J.A.R. van den, Couthinho R.A., 'Injecting risk behaviour among drug users in Amsterdam, 1986 and 1992, and its relationship to AIDS prevention programs', Am J Public Health 1994: 84(2): pp. 275-81.

[18] Farrell M., Buning E., Review of Drugs Services in the Eastern Health Board Area, Eastern Health Board, Dublin, 1996.

[19] Félix da Costa, N.; Ferraz de Oliveira, F. (1997). Evaluation of the programme: 'Say no to a second hand needle' through a questionnaire on users. Toxicodependências, 3 (2), pp. 23-40.

[20] Stenbacka M., Romelsjö A., 'Methadonbehandling i Sverige', SoS-rapport 1997:22, Socialstyrelsen, Stockholm, 1997.

[21] Schellings Reitox, Benschop A, Kessels A, Meutders W, 'Bijgebruik van drugs door langduring heroineverslaafsden in methadononderhoudsprogramma's'. Paper presented at the Forum Alcohol- en Drugsonderzoek (FADO), Amersfoort, 1997.

[22] Farrell M., Buning E., 'Review of Drugs Services in the Eastern Health Board Area', Eastern Health Board, Dublin, 1996.

[23] Ålborg University, 'En anden hverdag', Ålbrog Universitetscenter, Ålborg, 1997.

[24] Vilhena e Silva, F. Ribeiro, L., Santos, A.J., Veríssimo, M. 'Integrated treatment for addicts (TIT) and results' (1997). Toxicodependências 3 (1), pp. 45-57.

[25] Ferreira EVALUATION, 'Socio-demographic and socio-related effect of the addition treatment process', Toxicodependências (1997), 3 (3), pp 55-64.

[26] Center for Rusmiddelforskning, 'Årsberetning 1997', Århus, 1998.

[27] Gageldonk A. van, Zwart W. de, Stel J. van der, Donker M., 'De Nederlandse verslavingszorg:overzicht van de kennis over aanbod, vraag en effect', Trimbos-instituut, Utrecht, 1997.

[28] Oosterhoff S, Vermeulen K, 'Tussentijds evaluatieonderzoek naar de effecten van en de samenwerking binnen het GAVO-project', Centrum Maliebaan, Utrecht, 1995.

[29] Haastrecht H.J.A. van, Bax J.S., Hoek J.A.R. van den. 'Weinig HIV-risicogedrag bij drugsgebruikers tijdens detentie in Nederlandse strafinrichtingen'. Ned Tijdschr Geneeskunde 1997 Mar;141(9): p. 429-432.

[30] Schweinschwaller T., 'Hafterleben im Normalstrafvollzug. Analyse der drogenfreien Abteilung (KDM) der Strafvollzugsanstalt Hirtenberg', Diplomarbeit zur Erlangung des Magistergrads der Philosophie an der Grund- und Integrativwissenschaftlichen Fakultät der Universität Wien, Wien, 1997.

[31] 'Kriminalvårdens Redovisning om Drogsituationen', Kriminalvårdsstyrelsen, Stockholm, 1998.

[32] Jongerius J.A.H.M., Koeter M.W.J., 'Drang tot verandering: haalbaarheid en effecten van een drang- en dwangbenadering van drugsverslaafden in detentie: eerste fase', Amsterdam Institute for Addiction Research, Amsterdam, 1997.

[33] Franzkowiak P, Helfferich C, Weise, 'Praxisansätze und Theroieentwicklung der geschlechtsbezogenen Suchtprävention in der Jugendphase', Bundeszentrale für gesundheitliche Aufklärung, Köln, 1996.

# The nature and extent of drug use in central and eastern Europe

Chapter 3

**Most of the central and east European countries (CEECs) face increasing problems associated with the traffic and transit of illicit drugs as well as a rise in local drug consumption. Despite the shared experiences over the last few decades the region cannot be seen as homogeneous. Firstly, the geographical, historical and cultural differences between the countries are at least as great as those between the EU Member States. Secondly, in some countries, important changes began taking place as early as the 1970s and 1980s, which might have influenced present drug use patterns.**

## Background

This chapter is based on national and international research, expert missions, and national- and city-reports provided by the central and east European countries for the European Commission, mainly for the PHARE multi-beneficiary programme for the fight against drugs, and international organisations (WHO, UNDCP, Council of Europe). Although in recent years drug-related information in the region has increased in both quality and quantity, only a few countries have developed standardised methodologies for epidemiological monitoring. Information flow within countries relies to a large extent on personal contacts between individuals working in different sectors. Data collection and exchange from regional to national levels is well organised within some subsectors (hospitals, police, customs), but is insufficient from national to regional and local levels. Non-governmental organisations (NGOs) rarely communicate data on a regular basis to governmental structures.

In parallel with developments in the framework of the EMCDDA and Reitox, focal points have been designated in most central and east European countries. Depending on the country's priorities in drug matters, the focal points are based in institutions specialised more in either supply reduction or demand-reduction activities. All countries recognise the multidisciplinary role of the focal point and in some countries it is located at inter-ministerial level. The role and function of some focal points is already formally included in the national drugs programme but most have limited financial and human resources. In an attempt to raise their profile and effectiveness, changes are occurring in the location and position of

## Central and east European countries

the focal points, but more political support is needed to further develop their role (See map on p. 68).

### School surveys — ESPAD

Valuable progress has been made in prevalence estimations and descriptions of the pattern of drug use amongst young people in the CEECs. The European schools survey reports on alcohol and other drug use (ESPAD) among 15 and 16-year-old students (born 1979), was conducted in spring 1995, including the following CEECs; the Czech Republic, Estonia, Hungary, Lithuania, Poland, the Slovak Republic and Slovenia ([15]). Bulgaria conducted school surveys in two main cities in 1995/96; the Slovak Republic extended the age range of ESPAD to include 14 to 18-year-olds, and repeated the survey in one main city in 1996; the Czech Republic conducted a school survey in 1994 and in 1997, and plans to repeat it every three years. ([2,8])

### Other information sources

Three countries, the Czech Republic, Estonia and the Slovak Republic, have conducted surveys (1994/95/96) on drug use in the population. The Slovak Republic plans to repeat its survey every two years. Slovenia and Poland conducted prevalence estimation studies in 1996 and 1993 respectively. ([2,8])

Information on arrests, seizures and court data, as well as information on price and purity, is collected by almost all of the countries. Law-enforcement sources often do not distinguish between seizures of drugs in transit through the country and those destined for the domestic market. It is not always clear whether general indications of an increase or a decrease in seizures is based on the quantity seized or on the number of seizures. ([17])

Because of differences in drug information systems across the CEECs countries and in the operational definitions of terms such as drugs, hard drugs, abusers, etc., it is difficult to compare the prevalence of problematic use across countries. As a result, most prevalence estimates published to date are based on indirect indicators of drug use, data of uncertain validity and representativeness, or on the perceptions of law enforcement, treatment or prevention professionals. ([16])

## Historical and current patterns of drug use

### Traditional patterns of use

During the 1970s and 1980s, drug use within the CEECs was quite different from that found in western Europe. Countries such as Poland, Hungary, Slovenia and the former Czechoslovakia have a longer history of use of illicit drugs and non-medical use of pharmaceutical drugs. Having identified the problem, several countries developed treatment and research activities. Others, which had tighter socio-political control structures such as Romania and Albania, have a much shorter history of identified drug use. In the region as a whole, drug use and related problems became a matter of concern only after the political changes of the early 1990s. ([1,5,8,12,16])

### Domestically produced drugs

In the late 1970s, the intravenous use of domestically produced drugs, such as the amphetamine-type stimulant Pervitin and hydrocodeine, called 'Brown', was reported in the former Czechoslovakia (mainly in the Czech part). At the same time in Poland intravenous use of home-produced opiates, made out of locally grown poppies and called 'Kompot' or 'Polish heroin', became popular. Later, use of home-produced opiates appeared in Lithuania, Latvia and Estonia. Consumption of tea made from dried poppy-heads was common among opiate users in Bulgaria, Hungary and Poland. Local cultivation of cannabis was reported from several countries, but the extent of use during the 1970s and 1980s is unclear. ([1,5,8,10,12,13,16])

### Misuse of legal drugs

The misuse of legally manufactured medicines, like barbiturates, tranquillisers (often in combination with alcohol) and opiate-containing medicines became widespread in Hungary, the former Czechoslovakia and Bulgaria during the 1970s and into the 1980s. ([1,5,16]) In Poland barbiturates and tranquillisers have been used in combination with 'Polish heroin' since the late 1970s. In Albania, Bosnia and Herzegovina, and the former Yugoslav Republic of Macedonia (FYROM), the non-medical use of prescription drugs is a more recent phenomenon. ([5,12])

Solvent misuse increased during the early 1970s in Czechoslovakia and during the mid-1970s in Hungary, but declined after 1975 and 1985, respectively. Solvent use amongst adolescents and ethnic minorities was also reported from Bulgaria, Romania and the Baltic States. Those involved were mainly 13 to 14 year-olds. ([1,5,16])

### Imported drugs

In the early 1980s, the use of imported heroin increased in parts of former Yugoslavia, partly due to

changes in the social attitudes and values of young people.[16] In the 1990s, most countries in the region experienced an increase in heroin transit.[1,5,8,12,16] Domestic markets for imported drugs established themselves in many countries of the region in the early 1990s, probably as a result of a combination of various factors such as the opening of borders, travel, convertibility of currencies, trafficking practices and domestic changes affecting demand.[5,12,16]

## Specific trends in individual drugs

### Cannabis

In most CEECs the use of cannabis products, mainly marijuana, has been increasing since the beginning of the 1990s, but its use varies substantially across the region. It appears to be the most frequently used drug among adolescents and young adults, with Albania and Romania reporting the lowest levels of use. Two patterns of use can be distinguished: occasional and recreational use, and use as a secondary drug by problematic drug users.

The ESPAD survey shows that the lowest lifetime prevalence rates are reported from Lithuania and Hungary, medium rates from Estonia, Poland, the Slovak Republic and Slovenia, and that the Czech Republic ranges at the top (25% for boys, 18% for girls) (see Table 1).

Surveys among older students show higher lifetime prevalence rates for cannabis products: for example, in 1994, 20 to 25% of 15 to 18-year-olds in the Czech Republic; 21% for marijuana and 23% for hashish among Estonian 10th to 12th graders (1997, telephone survey); and 15% in a survey among 14 to 18-year-olds in Bulgaria (1996). The percentage of students that have experimented with cannabis is in general higher in cities: for example, 28% of students at Warsaw University (1992), 32% of secondary school students in Ljubljana (1992)[5,13] and nearly 40% of 17-year-old students in a national school survey in the Czech Republic (1996) had experimented with cannabis. However, the interpretation of these figures is difficult, as some surveys have been conducted locally, and there is often no information about how representative the samples are.

Data from a Slovak Republic population survey conducted in 1996 shows a lifetime prevalence for cannabis of 2.6% (age range 18 to 60 years), but a survey among the 15 to 64-year-old population of the Czech Republic conducted in 1994 shows that 13.4% of the population had used cannabis at some time. This high prevalence rate was supported by a similar study conducted in 1996, which also showed a diminishing difference between Prague and other parts of the country.

Cannabis cases are rarely recorded by the treatment system. Hungary and the Czech Republic are the exceptions: in Hungary 6.8% of all treated in 1996[8] identified cannabis as their primary drug, while in the Czech Republic the figure was 16.3% of all first treatment demand in 1997.[2]

Table 1: Lifetime cannabis use by schoolchildren (15-16 years old)

| Country | Sample size | (%) Boys | (%) Girls |
|---|---|---|---|
| Czech Republic | 2 962 | 25 | 18 |
| Estonia | 3 118 | 10 | 5 |
| Hungary | 2 571 | 5 | 4 |
| Lithuania | 3 196 | 2 | 1 |
| Poland | 8 940 | 2 | 5 |
| Slovak Republic | 2 376 | 12 | 6 |
| Slovenia | 3 306 | 4 | 12 |

Various levels of cannabis cultivation are reported from all countries of the region, but production mainly feeds the local markets. However, law enforcement sources in some countries also report production for the neighbouring markets (e.g. Albania — Greece), or for western Europe. ([12]) Trafficking through the region has been intensifying and big single seizures were reported in 1996 (e.g. 11 tonnes in the Czech Republic and 5 tonnes in Bulgaria) and in 1997 (2 tonnes in Hungary). ([2,12])

### Heroin

Since the early 1990s, many countries in the region have experienced a considerable increase in heroin consumption (Bulgaria, the former Yugoslav Republic of Macedonia, Hungary, the Czech Republic, the Slovak Republic and Slovenia). Drug-use patterns are slowly changing towards the use of imported heroin, and injection is the most common route of administration. Smoking or chasing is reported from Albania and the former Yugoslav Republic of Macedonia and more recently from Bulgaria. In Latvia, Lithuania and Poland injection of imported heroin coexists beside the use of home-made opiates. In Romania and Bosnia and Herzegovina the level of heroin use appears to be relatively low. The socio-demographic characteristics of those involved vary between the countries. ([1,2,3,5,7,8,10,12,13])

Illicit drug use is predominantly a city phenomenon. Treatment data collected within several CEEC cities show heroin to be the most frequently used primary drug amongst problematic drug users (see Table 2).

In Warsaw, a new pattern of amphetamines or cannabis use has become visible among addicts in treatment. This pattern arises in combination with the use of home-made opiates, and yet has led to a decrease in the percentage of clients identifying opiates as their main problem drug. Drug users in treatment in 1996 reported a lower age of first use of their primary drug than in the previous two years in Bratislava, Gdansk, Prague, Sofia and Szeged.

The percentage of injecting opiate users in the region is high, despite recent decreases in some countries. In Poland 2 463 intravenous drug users were known to be HIV positive by June 1995. ([18]) Other countries reported much lower numbers, or none (Hungary). ([2]) Comparable data do not exist for the drug-using population across the region, as levels of HIV testing vary substantially between

## Table 2: Percentage of users in CEEC cities who primarily use heroin

| Country | City | Treatment demand (1996) | Primary drug heroin (1994-96) % | Primary drug heroin (1994-96) Trend | IV injection (1994-96) % | IV injection (1994-96) Trend |
|---|---|---|---|---|---|---|
| Bulgaria | Sofia | 449 | 95 | up | 63 | down |
| Bulgaria | Varna | 70 | 86 | up | 73 | stable |
| Czech Republic | Prague | 634 | 38 | up | 72 | stable |
| Hungary | Szeged | 378 | 52 | stable | 50 | up |
| Poland | Gdansk | 955 | 77 | stable | 77 | stable |
| Poland | Warsaw | 1 023 | 57 | down | 59 | down |
| Slovak Republic | Bratislava | 829 | 95 | stable | 86 | up |
| Slovenia | Ljubljana | 139 | 69 | stable | 84 | down |

Treatment demand — heroin/opiates
(M. Stauffacher, November 1997. P-PG/Epid (97) 24/draft).

CEECs. Fewer positive cases of HIV have been recorded in Poland over the last few years, which may be linked to the introduction of health education programmes.

Information on the prevalence of hepatitis B and C among injecting drug users is scarce, but some data have been collected among users in treatment in Bulgaria, the Czech Republic, Estonia, Slovenia and the former Yugoslav Republic of Macedonia.

Information about drug-related deaths is irregular within the region. Some CEECs have reported an increase (Bulgaria, Hungary, Latvia, the Slovak Republic), although a lack of reliable prevalence estimates, combined with differences in reporting and definition, cloud the issue.

Heroin seizures by customs and police appear to be rising within the region, although variations exist between countries. The figures are difficult to interpret as they may simply reflect the increased resources designated to law enforcement and border control. Although there is a trend towards an increase in prices throughout the region, prices are lower than those found in western Europe.

**Prescription drugs**

The non-medical use of prescription drugs remains an important and, in some countries, predominant pattern, both in terms of consumption and indicators such as hospital admissions. ([16]) In Hungary clients reporting benzodiazepines to be their primary drug constituted 9.4 % of all treatment cases in 1996. ([8]) The ESPAD survey shows that lifetime use of tranquillisers and sedatives without a doctor's prescription varies between 2 and 8 % for boys and between 2 and 25 % for girls, in the seven CEECs studied. Poly-drug use and combinations of medicines and illicit drugs have become more common in recent years in Bulgaria, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Hungary, the Slovak Republic and Slovenia.

**Solvents**

The ESPAD study shows solvents to be the second most prevalent drug after marijuana among 16-year-old schoolchildren (excluding alcohol and tobacco), with lifetime prevalence ranging from 5 % to 10 % for girls and from 7 % to 18 % for boys in the seven CEECs covered.

Clients with solvents as the primary drug are registered by the treatment systems of the Czech Republic, Hungary and the Slovak Republic, and are also reported from Bosnia and Herzegovina. Treatment demands for solvent abuse have levelled off in the latter two countries, but have been rising in Poland. Deaths related to solvent use have been registered in some countries (e.g. 12 cases in 1995 and 8 in 1996 in Hungary).

**Cocaine**

Although cocaine seizures suggest an increasing popularity of some countries such as Poland, the Czech Republic, Hungary and Romania for trafficking, the level of use is still low and is limited to particular segments of the population who are often difficult to reach through conventional research methods, or through existing monitoring and care systems. ([1,2,3,4,5,8,9,12,13,14,15,16,17])

## The legal responses

A particular effort is being made by the candidate countries to adapt their legislation to meet EU standards, specifically in terms of money laundering and chemical precursor control. Structures will need to be reinforced or put into place to ensure that legislation is effectively enforced. All countries have adopted new legislation in the drug field (most laws dating from 1996 onwards), often influenced by and derived from international policies.

Table 3 is a synopsis of the current drug control situation in the CEECs. For the different categories of drugs contained in the national legislation, the majority of the CEECs used the lists of the UN Conventions and adapted them to their own legislative framework. The new legislation on the control of chemical precursors is mostly based on the EU regulations. In general, illicit drug consumption in itself is not an offence, although drug dealers are sanctioned. Drug production and trafficking are crimes with penal sanctions in all countries. In a small number of countries, treatment as an alternative to penal procedures exists. ([2,3,6,7])

All countries except Albania are signatories to the three UN Conventions on narcotic drugs, psychotropic substances and against illicit trafficking (1961, 1971 and 1988) and have ratified them, except Estonia which has not yet ratified the 1988 Convention. The Strasbourg Convention (the Council of Europe Convention on Laundering, Search, Seizure and Confiscation of the Proceeds of Crime) of 1990 has been signed by Hungary, Poland, Slovenia, the

Slovak Republic, Bulgaria, the Czech Republic and Lithuania; the last three have already ratified the Convention. ([2,3,6,7,12])

## Inter-ministerial bodies

All countries, except Bosnia and Herzegovina and Romania, have established an inter-ministerial body on drugs for planning and coordinating drug control efforts between different ministries. Often, sub-committees or working groups are created, involving experts of the participating ministries, to deal with specific issues. At a more technical level, these groups have been charged with the preparation of new legislation, projects and reports, and of national programmes on drugs. As a result, a comprehensive, multidisciplinary national programme on drugs has been adopted in several of the CEECs. Decentralisation of drug control efforts, including consultation with NGOs, is in its infancy. The map on page 68 presents an overview of the current situation.

## Demand reduction

### Resources

In countries such as Poland, drug demand reduction has been implemented for more than two decades, while in others, such as Romania, systematic efforts have only been made over the last two to three years. Despite the efforts made in recent years, drug demand reduction is still a low priority in most countries, or is no priority at all as is the case in both Albania and Bosnia and Herzegovina. This is reflected in the allocated budget. In most countries, the balance of the division of resources between law enforcement (supply reduction) and the drug demand reduction sectors comes out largely in favour of the former. Where formal drug demand reduction policies and strategies have been adopted and the legal framework is modern and supportive (e.g. the Czech Republic, Hungary, Poland, the Slovak Republic, Slovenia), drug demand reduction is better positioned. Resources designated to demand reduction vary greatly. Most structures are understaffed and there is a need for more trained personnel. This problem has been addressed in recent years, with the establishment of a pool of well-trained experts, mainly supported by bilateral and international assistance.

### Treatment

Treatment in hospital settings, by psychiatrists and other health professionals, still predominates. Inpatient treatment services, often limited to detoxification, are available in all countries, with the total number of beds varying between 10 (Bosnia and Herzegovina) and 1 300 (Poland). Specialised outpatient and non-residential services are less well developed with the exceptions of the Czech Republic, Poland, Hungary, the Slovak Republic and Slovenia. Some countries (Hungary, Slovenia, the Slovak Republic and the Czech Republic) have developed regional treatment systems, but in most CEECs treatment services are available predominantly in the capital cities. Out-patient drug-free and long-term residential treatment are the modalities with the fastest development, with a number of new services having been set up over the last few years in almost all of the countries. Even as the current state of drug demand reduction in most CEECs is characterised by a dominance of the treatment sector, only a few countries can offer a range of treatment and rehabilitation services. However, Poland has developed a wide residential rehabilitation network since the end of the 1970s. Early intervention, alternatives to imprisonment, social reintegration, aftercare, self-help groups and other components of the care cycle are rarely offered or are unavailable. ([5])

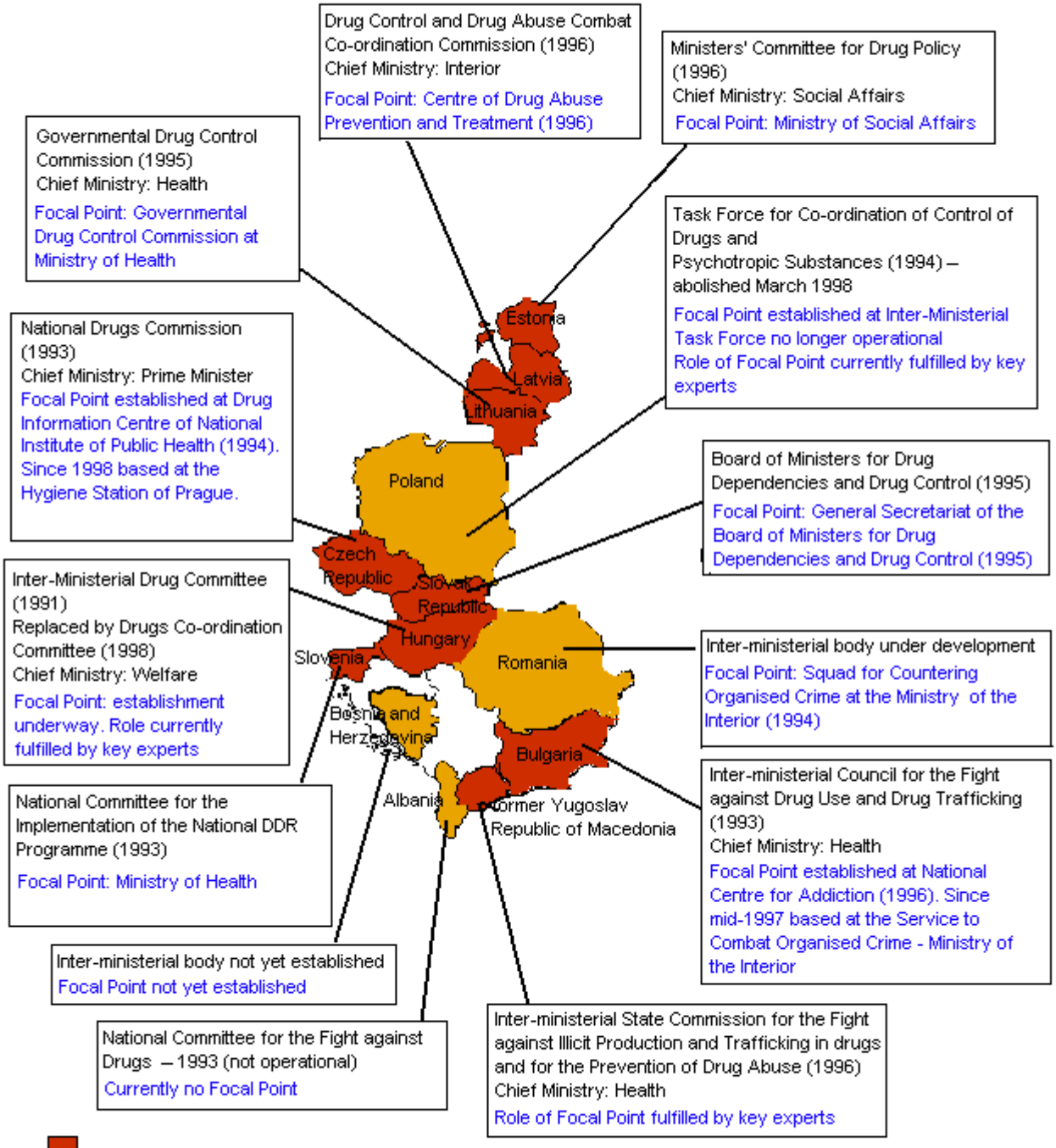
### Prevention

In some countries like Poland, Hungary and to some extent Bulgaria the preventative effort started earlier than in the rest of the region. Prevention is a top priority in most national strategies and programmes, and drug awareness and prevention programmes have been developed over the last few years, including school-based drug education and health promotion. Greater emphasis needs to be placed on evaluation in order to increase effectiveness. In some countries positive recent developments have been observed, such as the involvement of the media in supporting awareness and preventative efforts. The community, in particular the family, is increasingly recognised as playing an important role in prevention strategies, but efforts to secure their effective involvement are at an early stage.

### Harm reduction

Within the last few years, outreach and harm reduction services have been added to the demand reduction sector. The availability of substitution (methadone maintenance) programmes has increased throughout the region. They constitute one of the main treatment modalities in Slovenia and

## Inter-Ministerial Bodies and Focal Points in Central and Eastern Europe




Year in brackets denotes year of formal establishment of an Inter-Ministerial body or Focal Point

Lithuania, while in Bulgaria, the Czech Republic, Estonia, the former Yugoslav Republic of Macedonia, Latvia, and Poland substitution programmes are operated on a pilot basis or as a single treatment service. In Hungary, substitution programmes do not exist but methadone is prescribed by psychiatrists and general practitioners on an individual basis. Low-threshold services and syringe and needle exchange schemes are increasingly available with more non-governmental organisations focusing their activities on this field. However, harm reduction options are rarely available, even in major cities.

### Non-governmental organisations

The need for active involvement of non-governmental organisations in demand reduction is not fully recognised and they often remain underutilised in most CEECs. NGOs are frequently inexperienced, relying on a single source of funding, often from international organisations. For the majority of CEECs, NGOs specialised in demand reduction are uncommon. In those countries where they do exist, their involvement is primarily in prevention. A disadvantage that has become apparent in the last few years is the lack of community orientation. Only the Czech Republic, Hungary, Poland, the Slovak Republic and Slovenia regularly allocate funds from their drug demand reduction budget to NGOs. Although largely inexperienced, a small number of NGOs do have relatively well-trained staff with developed skills and competence. Poland, for example, has more than 100 NGOs active in demand reduction. The main needs in all the countries are for a strengthening of capacity and performance, enlarging the funding basis, and building cooperation with governmental organisations.

A positive general trend is that drug research and needs assessment are attracting increasing attention, while evaluation and qualitative studies have recently been introduced. Several countries are planning or have recently completed studies of specific populations, often using qualitative methodologies. Many countries are striving to involve more professions and to adopt a more multi disciplinary approach.

## Synthetic drugs

It is difficult to assess the extent of consumption of synthetic drugs. Traditional monitoring systems, as far as they exist, are unlikely to generate an accurate picture of recreational drug use. Almost all countries report an increase in seizures and consider synthetic drug use a worrying new trend, but in many countries there is only anecdotal informa-

## Main trends and recent developments

**Heroin use** is still on the increase in many countries such as the Czech Republic, the Slovak Republic, Hungary and the former Yugoslav Republic of Macedonia.

Use of illicit drugs is concentrated in **big cities**.

**Changing patterns** of use have been recently observed in Poland, where opiate users are increasingly combining with amphetamines, and in the Czech Republic, where Pervitin retains its dominant position for problematic drug users, but a shift towards heroin can be observed.

**Injecting** remains the predominant route of administration of opiates (and of Pervitin in the Czech Republic), but in some countries smoking and chasing have become more common in recent years; these low-risk routes of administration seem to be chosen by 'beginners' in countries with higher availability of opiates: Bulgaria and the former Yugoslav Republic of Macedonia.

**HIV** prevalence in the region as a whole remains low among the drug-using population.

**Cocaine** is increasingly available on domestic markets but consumption seems low and limited to specific groups.

Recreational use of **cannabis** is increasing.

The use of **amphetamine-type** stimulants seems to play an important role in the northern part of the region (Poland, the Czech Republic and the Baltic States).

The use of **synthetic drugs**, in the context of a 'dance-culture' is a recent phenomenon throughout the region.

The awareness about drug use and of the needs of **specific populations** (women, prisoners and ethnic minorities) is rising.

tion, and few cases have been reported by the health systems.

The ESPAD survey showed a lifetime prevalence of Ecstasy use of 0.8% among Polish and Hungarian 16-years-olds, and 1.8% among Slovenian 16-year-olds. In the same survey, big differences in knowledge about synthetic drugs became apparent between countries. When asked whether they had ever heard of LSD, 87% of 16-year-old Hungarians but only 6% of Lithuanian students replied positively. Ecstasy was in general less known by this age group: only between 17% and 27% of students in the seven participating central and east European countries had ever heard of this drug. (15)

## Table 3: Legislation: Current status and under development

| Country | Current status | Legislation being developed |
|---|---|---|
| Albania | • 1953, 1988: Existing legislation (narcotics).<br>• 1995: Penal Code updated (money laundering). | • 1994: National laws under preparation.<br>• 1995: Draft precursor law prepared. |
| Bosnia and Herzegovina | • Based on sections of Penal Code. | |
| Bulgaria | • 1974: Drug control based on 28 different texts.<br>• 1988: Public Health Act: Regulation of licit activities.<br>• 1995: Act on Medicines and Chemists in Human Medicine (narcotic drugs and psychotropic substances).<br>• 1995: Inter-ministerial Committee regulation prohibiting cultivation of cannabis and poppy.<br>• 1997: Precursors: Council of Ministers' Governmental Decree No 38. | • 1996: Special Act against Money Laundering; Implementation rules still to be enacted.<br>• Special Law for control of Drugs and Precursors (will incorporate Decree No. 38). |
| Czech Republic | • 1995: Amendments to Criminal Code (conspiracy and organised crime with regard to trafficking).<br>• 1996: Money laundering legislation included in Act prohibiting legalisation of gains from criminal activities. | • 1999: Draft bill on narcotic drugs, psychotropic substances, precursors and essential substances expected to come into force. |
| Estonia | • 1997: Narcotic Drugs and Psychotropic Substances Act.<br>• 1997: Governmental regulation regarding precursors. | • Act on Preventing Money Laundering. |
| Hungary | • 1991: Law on Financial Institutions amended.<br>• 1993: Penal Code + penal procedure on drugs amended.<br>• 1991: Regulation of trade in precursors. 1996: replaced by Governmental Order on Precursor Control.<br>• 1994: Order on drug treatment data collection (OSAP).<br>• 1994: Law on the Prevention and Hindering of Money Laundering; related amendments to Penal Code.<br>• 1994: Law on the Police.<br>• 1996: Customs Law.<br>• 1997: Bill on the control of cultivation of poppy and cannabis for industrial purposes. | |
| Latvia | • 1997: Criminal Code of 1974 amended.<br>• 1996: Law on Licit Control of Narcotic Drugs and Psychotropic Substances and connected governmental decrees.<br>• 1996: Precursors Law.<br>• 1997: Related Acts: Medical Law, Pharmacy Law, Epidemiological Surveillance Law.<br>• 1997: Regulation defining ministries responsibilities in licit drugs and international activities.<br>• 1998: Money Laundering Law. | • Criminal Code under a process of revision. |

| | | |
|---|---|---|
| Lithuania | • 1997: Law on Narcological Supervision (regulation of treatment of drugs and alcohol addicts; primary prevention).<br>• 1997: Decree No 702 on approval of regulation of substitutive; amended by Decree 68 in 1998: substitution therapy limited to methadone substitution.<br>• 1998: Law on the Prevention of Money Laundering<br>• 1997-8: Amendments to Penal Code: stricter penalties for illicit drug trafficking.<br>• 1998: Law on Narcotic Drugs and Psychotropic Substances Control. | • Draft law on precursors control (precursors decrees already exist).<br>• Treatment of drug addicts under examination by Health Committee of the Lithuanian Parliament. |
| Former Yugoslav Republic of Macedonia | • Based on Law on Traffic and Production of Drugs, and on a range of public order and health laws.<br>• Ministry of Health controls the legal trade in precursors scheduled and classified by INCB. | • Draft law on the control of production and trafficking of psychotropic substances and precursors and for the prevention of drugs and Psychotropic substances under examination.<br>• Draft opium code.<br>• Draft money laundering law. |
| Poland | • 1994: Law on Protection of Economic Transactions (laundering of proceeds from drug trafficking punishable).<br>• 1997: Law on counteracting Drug Addiction (trafficking, production and smuggling; precursors control; substitution therapy; establishment of advisory governmental council; prevention; monitoring). | • Executive acts of the new law are under development.<br>• Draft bill on money laundering. |
| Romania | • Precursors measures based on Decree 466/1979 (Toxic Substances Regime).<br>• 1996: Amendment to Penal Code (consumption, possession, dealing and trafficking penalised).<br>• 1997: Customs Regulation 141 prohibits narcotics, psychotropic substances, and precursors from transit across the border without authorisation. | • Law against illicit trafficking under preparation, (reclassifies narcotic drugs into high and low risk; drugs purchase operations; witness protection; precursors; money laundering).<br>• Draft money laundering law.<br>• Precursors legislation planned. |
| Slovak Republic | • 1994: Amendments to Criminal Code regarding money laundering, possession, production, trafficking.<br>• 1997: Regulation 181 (suspicious bank transactions).<br>• 1997: Law on Anti-Drug Funding came into force (anti-drugs programmes and projects). | • Draft law on narcotic and hypnotic substances.<br>• Draft law on precursors.<br>• Recodification of the Criminal Code of 1994 (stronger penalties for drug trafficking and smuggling).<br>• Draft act on psychotropic substances.<br>• Data protection law to be updated. |
| Slovenia | • 1978, 1985: Law on Production and Trade in Drugs.<br>• 1995: Penal Law 1995.<br>• 1994: Law on Money Laundering. | • Act on Drugs and Psychotropic Substances (provides for Inter-ministerial Committee).<br>• Law on the Prevention of Illegal Drug Use and Treatment of the Users of Illegal Drugs (provides for Drug Committee and an Information Unit for Drugs).<br>• Precursors Law expected. |

## Table 4: National coordination: Ministries and coordination structures

| Country subgroups | Coordinating body; Ministries involved | Structures and activities |
|---|---|---|
| Albania | **National Committee for the Fight against Drugs (1993)** ([1]) — not operational | • Role of defining strategy • Restructured in 1996 and given decision-making powers. |
| Bosnia and Herzegovina | No inter-ministerial body at present. | |
| Bulgaria | **Inter-ministerial Council for the Fight against Drug Use and Drug Trafficking (1993)** • **Health** ([2]) • Interior • Justice • Finance (Customs) • External Affairs • Labour and Social Affairs • Education • Industry • Commerce and Tourism • Youth and Sports Committee • National Service on Drugs • National Centre for Drug Addiction • National Service for Combating Organised Crime • National PHARE Coordinator | • Serves directly under Council of Ministers • Coordination role • Currently preparing a new law on drugs control and precursors, which will set out its structures and functions, and bring in additional members. Also foreseen is a multidisciplinary expert group to develop programmes, project proposals, budgets and reports. |
| Czech Republic | **National Drugs Commission (1993)** • **Prime Minister** • Health • Social Affairs • Education • Interior • Justice • Defence | • 1995: Raised to a higher level to include prime ministerial participation • Coordination role • Contact person from each ministry communicates with the Secretariat of the Commission • Meetings twice annually • Regular coordination meetings of inter-ministerial task force groups, in the field of law enforcement and prevention. |
| Estonia | **Ministers' Committee for Drugs Policy (1996) Social Affairs** • Education • Finance • Foreign Affairs • Interior • Justice • European Integration | • 1994: National Committee on Narcotic Drugs established at the Ministry of Social Affairs comprising experts from ministries, State agencies and hospitals — Multidisciplinary networks of experts then formed to prepare national drug legislation, a national programme for the prevention of alcoholism and drug addiction and principles of drug policy. |
| Hungary | **Inter-ministerial Drug Committee (1991)** • **Welfare** • Interior • Agriculture • Justice • Industry • Commerce and Tourism • Traffic • Telecommunications and Water Management • Foreign Affairs • Education and Culture • Defence • National Security Office • National Bank • National Health Protection Institute • National Pharmaceutical Institute • National Police Headquarters • National Customs Directorate • Supreme Prosecutor's Office • Highest Court.<br>Since March 1998 replaced by **Drugs Coordination Committee**, chaired by the head of the Ministerial Presidential Office and co-chaired by the Minister for Welfare | • Meets twice annually, and more often if necessary • Role of developing coherent strategy; coordination • Has established working groups to elaborate recommendations, ensure coordination among professionals and plan legislation • Parliamentary ad hoc Committee for the Reduction of the Drug Abuse Problem was established (Jan. 1997-March 1998) to examine the drug abuse situation, the anti-drug measures of the government, and to enhance the role of the IMDC. |
| Latvia | **Drug Control and Drug Abuse Combat Coordination Commission (1996)** • **Interior** • Education and Science • Welfare • Finance (Customs) • Foreign Affairs • Defence • Justice | • 1997: Amendments made to the statute underlying the Committee strengthened its structure and political support • Commission consists of subcommittees whose work formed the basis of national programme for the fight against drugs and drug addiction (1997-98). |

| | | |
|---|---|---|
| Lithuania | **Governmental Drug Control Commission (1995) • Health** • Interior • Education and Science • Foreign Affairs • Agriculture • Finance • Customs Department • Justice • Economy • Environment Protection • Social Affairs and Labour • Narcotic Commission of State Medicine Control Agency | • 1995: Narcotic Commission for Licit Traffic Control of Narcotic Drugs and Psychotropic Substances established within the State Medicine Control Agency (Ministry of Health) • Drugs Control Unit against illicit trafficking of drugs established in Ministry of the Interior. |
| Former Yugoslav Republic of Macedonia | Inter-ministerial State Commission for the Fight against Illicit Production and Trafficking in Drugs and for the Prevention of Drug Abuse (1996) • Health • Education • Agriculture and Forestry • Social Welfare • Justice • Foreign Affairs • Internal Affairs • Customs • a pedagogical institute • National Institute for Social Welfare | • Since 1991 the Ministry of Health has also housed a Commission on Narcotic Drugs and Psychotropic Substances • Within the Ministry of Internal Affairs, there is a Unit for Combating Organised Crime and Drug Trafficking. |
| Poland | Inter-ministerial Task Force for Coordination of Control of Drugs and Psychotropic Substances (1994) — abolished March 1998. • Health • Education • Justice • Home Affairs • Agriculture • Customs Office • NGOs • Church • Researchers | • Task Force has an advisory role • Responsible for the preparation of the draft national programme and submits annual reports to government • 1997 Law foresees the establishment of an advisory governmental council . |
| Romania | An inter-ministerial body for drugs and drug addiction is under development. | • National Council for Action against Organised Crime and Corruption, coordinated by the President, is active. • National multidisciplinary networks are in their infancy but the fight against the drugs phenomenon is included in the strategy of the Romanian Government. |
| Slovak Republic | Board of Ministers for Drug Addiction and Drug Control (1995) • Health • Education • Transport • Post Office and Telecommunications • Finance • Economy • Culture • Defence • Agriculture • Labour • Social Affairs and Family • Justice • Interior • Foreign Affairs • the Prosecutor General | • Regulated by statute • Meets at least twice annually • Has as an executive board, a supra-ministerial body: the General Secretariat • Chairman: Deputy Prime Minister; vice-chairmen are Minister for Health and Minister for Education • Submits twice annually a report to the government and the Parliament on the implementation and actualisation of the national programme for the fight against drugs. |
| Slovenia | National Committee for the Implementation of the National DDR Programme (1993) • Health • Internal Affairs • Justice • Sports and Education • representatives of media, NGOs, insurance • experts | • Meets once a month • Task: to carry out the national programme • Government has set up Special Bureau for Drugs at Ministry of Interior, for coordination of repressive measures (not yet operational) • Proposal for new committee, comprising a State Secretary for Drugs, the Inter-ministerial Council, a Coordination Unit, and a Council of Experts; will be given some executive power. |

(1) Year of establishment.
(2) In bold — Ministry at which body is based.

# References


**EU PHARE multi-beneficiary programme for the fight against drugs**

[1] 'Drug demand reduction in the central and eastern European countries', Second regional report, December 1995.

[2] National report to PHARE Drugs PCU, 1997.

[3] Reports to Liaison Group meeting, February 1998.

[4] Report on the project on licit drugs and illicit synthetic drugs, 1997-98.

[5] 'Technical assistance on drug demand reduction strategy development in central and eastern European countries', Final report, 1997-98.

[6] Reports of the PHARE project on drugs information systems, 1996-98.

[7] De Torres S. and Ballotta D. (1997), 'Analysis of the legal framework related to drugs concerning legislation, judicial application, and the organisation of operational structures in the CEECs'.

**Council of Europe Cooperation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group)**

[8] National reports of Bulgaria, the Czech Republic, Estonia, Hungary, Poland, Romania, the Slovak Republic, Slovenia, submitted to the 26th Meeting of Experts in Epidemiology in Drug Problems (16 and 17 June 1997) and national report of Albania submitted to the 25th Meeting of Experts in Epidemiology in Drug Problems (25 and 26 November 1996).

[9] Antoine D. (1997), 'Synthesis of the 1995 national reports', P-PG/Epid (96) 9 rev. 2.

[10] 'Compilation of highlights at city level', P-PG/Epid (97) 31.

[11] Stauffacher M., November 1997, 'Treatment demands in 23 European cities', Annual update 1996 and Trends 1992-96, P-PG/Epid (97) 24 draft.

**UNDCP coordination mechanism for eastern Europe, the Baltic States and the CIS**

[12] Strategic country profiles — Albania, Bosnia and Herzegovina, Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, the Slovak Republic and Slovenia, Updates 1996-97.

**World Health Organisation**

[13] Harkin A.M., Anderson P. and Goos C. (1997), 'Smoking, drinking and drug taking in the European region', Regional Office for Europe, Copenhagen 1997.

[14] Report based on the WHO meeting on amphetamines, MDMA and other psychostimulants, November 1997 (pre-publication issue).

**The Swedish Council for Information on Alcohol and other Drugs (CAN) and the Council of Europe Pompidou Group (1997)**

[15] The 1995 ESPAD report, 1997.

**Richard Hartnoll (1994)**

[16] 'Drug use and drug problems in the countries of central and eastern Europe: Cultural, social and economic factors', Paper presented at the Congress on Treatment of Addiction: 'Treatment concepts for special risk populations and their evaluation', Zürich, 14 to 16 September 1994.

**Delphine Antoine (1996)**

[17] 'The drug problem in Europe: Prevalence and patterns', CEWG, December 1996.

**European Centre for the Epidemiological Monitoring of AIDS**

[18] 'HIV/AIDS surveillance in Europe, 1994-96'.

Chapter 4

# National strategies

**In this chapter a comparative country analysis of drug laws within the European Union (EU) will summarise the similarities and differences which exist between Member States. National and international drug laws, established during the 1970s in response to a rapid rise in drug consumption, have been modified several times since. The drug laws of the Member States vary in approach and measures used.**

Over the last year coordinated national policies involving various ministries (health, justice, home affairs) have contributed to national drug strategies and responses, including prevention programmes, ministerial task forces, inter-ministerial coordination bodies and parliamentary committees. There has been a decentralisation of power from national to local levels, with policies initiated by the State being developed by local authorities.

The range of anti-drug measures applied in EU Member States is outlined. As all 15 Member States regard drug-related problems as a top priority, countries are keen to exchange relevant information and experiences and to tackle the drug problem in a collaborative manner although national policies differ.

How the 15 States control drug use, possession, dealing and trafficking, and how drugs are classified to define offences and set penalties, forms an important part of domestic drug laws.

## Action taken in 1997 by Member States

### Belgium

A decree of 14 July 1997 reforms and reorganises the structure of health promotion in Belgium (Wallonia).

### Germany

Practical changes in the justice system will define more operationally the legal distinction between criminal offences of drug users and traffickers.

### Greece

The legal provision is based on the distinction between addicts and non-addicts. New laws were introduced for the protection of personal data Law 2472/97, while definitions such as 'especially dangerous' have been reintroduced for drug dealers; penalties have increased for those dealing to minors.

## Spain

Royal Decree 79/1997, of 24 January 1997, modifying the composition and structure of the Interministerial Group for the Execution of the National Plan on Drugs (PNSD).

Royal Decree 364/1997, 14 March 1997, modifying the structure and functions of various officially recognised organisations under the Ministry of the Interior on points relating to the fight against drug trafficking.

Act 5/1997, of 24 March, on amendments to the text of the Traffic, Circulation of Motor Vehicles and Road Safety Act, modifies this Act increasing measures for those driving a vehicle following the ingestion of alcohol, or under the effect of narcotics, psychotropics or whatsoever other analogous substances.

Royal Decree 864/1997, of 6 June, by which is approved the Regulations of the Fund deriving from goods confiscated due to drug trafficking and other related offences.

Royal Decree 865/1997, of 6 June, by which is approved the Regulations developing Act 3/1996, of 10 January, on control measures for catalogued chemical substances liable to being diverted for the illicit manufacture of drugs.

Moreover, in 1997 laws on prevention, care and social incorporation were passed by various Autonomous Communities (Cantabria, Andalusia, Murcia, Valencia) and in the Autonomous Community of Extremadura where a law on prevention and control of the sale and advertising of alcoholic drinks to the under-aged was adopted.

## Ireland

A number of legislative changes were made in 1997:

- the Licensing (Combating Drug Abuse) Act;
- the Europol Act;
- the Criminal Justice Bill;
- the Bail Act;
- the Freedom of Information Act;
- the Non-Fatal Offences Against the Person Act;
- the Housing (Miscellaneous Provisions) Act;
- the Criminal Justice (Miscellaneous Provisions) Act.

There is a proposal to establish special courts for non-violent drug offenders, which will order rehabilitation, rather than imprisonment. Statutes were enacted covering the control, use, supply and criminal activities associated with drugs. This legislation gives law enforcement agencies more powers to respond to criminal activities.

## Netherlands

(a) Measures to combat public nuisance include:

- Act on the Closing Down of Premises causing Public Nuisance, 26 March 1997: this law, adding Article 174a to the Municipality Act, allows mayors of municipalities to close down premises when drug use or trafficking causes public nuisance.

(b) Increasing the scope of law enforcement and improving investigation methods:

- setting up a synthetic drug unit, 1 January 1998.
- assessing the medical prescription of heroin,
- setting up a HARC team to improve investigational efforts in harbours and airports,
- a memorandum of understanding between the Netherlands and France on customs cooperation, 3 February 1997.

## Austria

A law passed in 1997 came into force in January 1998, the main subjects of which are:

- reaffirmation of the basic principle 'therapy instead of punishment';
- increasing the distinction between medical, preventive and therapeutic approaches from the fight against organised crime and money laundering;
- new regulations concerning cannabis for 'first consumers'.

## Portugal

- The Portuguese Parliament approved a law (7/97) broadening the network of services for the treatment and rehabilitation of drug addicts, guaranteeing access to prevention, treatment, and rehabilitation.
- The Joint Dispatch established the criteria for candidature of non-governmental organisations, to help projects develop secondary and tertiary prevention activities.

- Joint Dispatch No 1-A/97 of 08-05 set out the means of distributing money (raised by the social game called 'The Joker') to services and activities in prevention, treatment and rehabilitation.

### Finland

The National Commission on Drug Policy presented the plan of action 1997-2001:

- an amendment to the Coercive Criminal Investigation Means Act 565/1997 empowered authorities on technical surveillance, on use of controlled delivery of drugs, and compulsory DNA testing;
- Order 28/1997 regulated medical detoxification and substitute treatment for opiate addicts.

### Sweden

The Act prohibiting Certain Doping Agents has been reviewed along with the Motor Traffic Crime Act, in an attempt to reduce driving while under the influence of alcohol or drugs.

### United Kingdom

- The Public Entertainment Licences Act empowers authorities to close down clubs where 'herbal highs' (drugs promoted as legal alternatives to cannabis, Ecstasy or LSD) are supplied and consumed.
- The Misuse of Drugs Regulations 1997 (supply to addicts) revoked the legal requirement in the Misuse of Drugs Regulation 1973, so doctors are no longer required to provide the Home Office with information on drug addicts.
- The first UK anti-drugs coordinator and deputy co-ordinator were appointed.
- In December 1997, drug treatment and testing orders introduced as part of the Crime and Disorder Bill to break the links between addiction and offending, with offenders on non-custodial sentences undergoing treatment, as well as regular drug testing (see Chapter 2).

## Substances

All EU Member States classify narcotic drugs and psychotropic substances according to the model set by the United Nations Conventions. This classification is twofold: according to the medical value and abuse potential of the substance; and in terms of controlling and regulating their licit trade. This classification is not related to the penalties imposed for trafficking, possession or consumption.

Some Member States classify substances in terms of medical use and health risks, and also by the ways in which illicit activities are punished. These countries distinguish between the nature of the substance, varying the penalty accordingly. The countries in which this happens are Ireland, Italy, the Netherlands, Spain and the United Kingdom. In the remaining 10 EU countries a drugs offence may have the same outcome regardless of the drug involved, although, in practice, most prosecuting authorities will decide each case individually and will take into account several circumstances including the nature of the drug.

**Special item: Cannabis**

Cannabis is one of the most controversial policy issues in EU countries. Although it is a classified narcotic drug placed under control by the United Nations and by all Member States, the measures adopted to control it vary considerably.

While all Member States' drug laws involve severe measures against trafficking in cannabis, there are significant differences for 'personal use' consumption or possession, which themselves are defined and regulated in different ways from one country to another.

- Some countries or regions tolerate some forms of cannabis possession and consumption.
- Some countries apply less severe penalties when cannabis is involved in the offence.
- Even in countries where the formal legislation is severe concerning penalisation for cannabis offences (for instance in Member States which do not differentiate between drugs), there are in-

creasingly pragmatic approaches to the implementation of drug legislation.

- As most legislations adopt either a punitive or clinical perspective for dealing with drug use offences, the concept of 'recreational use' is not generally recognised and poses practical difficulties for the implementation of criminal justice policy.

The following table highlights Member States' policy with regard to the use of cannabis.

## Table 1: Cannabis

| Member States | Law measures concerning cannabis |
|---|---|
| Belgium | • Possession and cultivation for personal use less likely to be punished.<br>• To use in public, incite use, sell or traffic remain serious offences. |
| Denmark | • No formal distinction between drugs.<br>• A first offence results in entry in Central Criminal Register.<br>• Subsequent offences result in fines or penalties.<br>• Recommendation of cautions for possession of small quantities. |
| Germany | • Possession of small quantities for personal use is a criminal offence, but will not be prosecuted/punished as long as there is no harm to third persons. |
| Greece | • No distinction made between 'soft' and 'hard' drugs.<br>• It is considered that use can result in psychological and/or physical dependence, acts as a 'gateway drug' and a risk to society. |
| Spain | • Possession and use in public places is sanctioned by administrative measures.<br>• Distinction is made between drugs which cause serious health problems and those that do not, for cultivation and dealing. |
| France | • No legal distinction between drugs, the use of which can result in a fine and/or up to one year imprisonment. Medical treatment and social care for heavy cannabis users, acceptance of teratment being an alternative to penalties.<br>• Warning for first offence of cannabis use, if use is occasional and the user socially integrated. |
| Ireland | • Distinction made between possession for personal use and possession with intent to supply.<br>• Fines for possession of cannabis for personal use for first or second offences. |
| Italy | • Warning for first offence of possession for personal use.<br>• Subsequent offences having the purposes of personal use result in administrative sanctions (suspension of driving licence, gun licence or passport). |
| Luxembourg | No distinction between soft and hard drugs, but courts distinguish between:<br>• users who can receive a single warning (in case of very first time) or treatment (consumption not usually prosecuted), and<br>• dealers who are pursued with repressive measures. |
| Netherlands | • Possession and sale of up to 5g is generally not investigated.<br>• 'AHOJ-G' guidelines specify terms and conditions for sale, possession and use.<br>• Possession up to 30g is a minor offence, with a maximum sentence of one month's imprisonment and/or fine. |
| Austria | • Withdrawal of reports in case of first consumption of cannabis.<br>• Penalties are defined also according to the quantity of drug involved; petty crimes (small quantity) fine and/or up to six months' imprisonment. |
| Portugal | • Each drug has an official daily dose limit.<br>• Possession is criminal offence. Small quantities may be regarded as a crime of use and therefore be punished less severely with an "exemption from punishment"' (which is nevertheless registered in the criminal record) if proven that they are for personal use only and that the individual is an occasional user.<br>If quantity is above three times the average daily permitted it is punished more severely depending on the fact that the substance is exclusively for personal use or for traffic. |

| | |
|---|---|
| Finland | • Use sentenced with a fine, or a maximum of 2 years' imprisonment.<br>• In the application of penalties no distinction is made between drugs. However, Finnish law contains the concept of 'very dangerous drug', which refers to a narcotic drug, which may cause death by overdose or serious damage to health. |
| Sweden | • Possession and use of cannabis are prohibited.<br>• Penalties are defined according to the quantities involved.<br>• Use of cannabis is sentenced with a fine. On a voluntary basis the fine could be exchanged for counselling. |
| United Kingdom | • Possession of cannabis (a class B drug) carries a maximum prison sentence of 5 years and/or an unlimited fine.<br>• Supply of cannabis carries a maximum sentence of 14 years and/or an unlimited fine.<br>• Courts may also apply caution, probation or community service. |

## Illegal consumption

Laws on illicit drug use vary across Europe. In nine of the 15 Member States, drug use is prohibited and penal sanctions can be applied. In four States, illicit drug consumption is not mentioned in law as a specific offence, although it is controlled by prohibiting the receipt and/or possession of drugs. Spain punishes public drug use by administrative [1] rather than penal sanctions, and Italy makes no reference to illicit drug consumption but sanctions possession for personal use of any drug.

Although the offence of illegal drug consumption is defined differently in Member States, a common principle is: 'the defence of public health and protection of society from drug-related crimes'.

### Table 2: Illicit consumption of drugs

| Law | Notes on Member States |
|---|---|
| Illicit consumption prohibited | • **Greece, France, Luxembourg, Portugal, Finland and Sweden:** prohibit the illicit use of narcotics with penal laws, while stressing therapeutic and social approaches to drug use as an alternative to proceedings. In the practical application of the law, under various circumstances and for individual cases the police and/or prosecutors can issue warnings, suspend proceedings, or impose fines. |
| Illicit consumption 'partially prohibited' | • **Belgium:** Group drug use prohibited. Penal sanctions are often applied, especially when users are suspected of selling.<br>• **Ireland and the United Kingdom:** Only formal prohibition is the consumption of prepared opium. Use of other narcotics is indirectly prohibited by measures covering illicit possession and supply. |
| No reference made in law concerning illicit consumption | • **Denmark, Germany, the Netherlands and Austria**: The criminal law does not refer to use of drugs. However, possession of small quantities for personal use is a criminal offence and can be sanctioned by penal code.<br>• **Germany and Austria**: Federal states apply different conditions in deciding whether or not to sanction the 'possession of small quantities of drugs' with intent to use.<br>• **The Netherlands**: A distinction exists between drugs with an unacceptable risk, and cannabis. Private consumption is normally not prosecuted. |
| Decriminalisation of any illicit drug consumption | • **Italy:** Illicit activities such as import, acquisition or possession for personal use are regulated by administrative sanctions. No sanction is made in the law to the use of illicit drugs.<br>• **Spain:** Use of narcotics in public is prohibited and regulated by administrative sanctions. |

# Illegal possession

The possession of illicit drugs without scientific or medical reasons is forbidden and defined as a criminal offence in all Member States. A major difference between Member States concerns the purpose of possession. Some countries take into account the reason for possession, for example, those possessing small quantities for personal use, while others regard illicit possession of any amount as a criminal offence. The EU countries which do not take account of reasons for possession (using versus dealing) are Belgium, Denmark, Greece, France, Ireland, Finland and the United Kingdom.

When applying the law, prosecuting authorities decide the sentence according to the circumstances [1] of the offence.

## Table 3: Illegal possession

| Member States | Notes on Member States |
|---|---|
| Belgium | • For occasional and habitual use, the police file information on the user, but normally do not prosecute.<br>• No distinction made concerning quantity and substance type, but this may be modified to condemn marketing and trafficking in cannabis.<br>• Penal code unaltered, but prosecutors will apply the lowest legal measures to possession of cannabis for personal use. |
| Denmark | • Offences may be classified as 'minor', 'ordinary' or 'serious'. The final decision is left to the judicial authorities depending on the circumstances. |
| Germany | • Definitions such as 'personal use', 'minor infraction', 'absence of public interest in the punishment', and 'minor guilt' are used to determine whether or not an individual offence will be prosecuted and punished. |
| Greece | • Possession of drugs is a criminal offence.<br>• Addicts undergo compulsory treatment. |
| Spain | • Possession for personal use results in administrative sanctions being applied. |
| France | • Possession of drugs is a criminal offence, regardless of purpose. |
| Ireland | • Possession for personal use does not automatically lead to prison sentence. Probation report issued and offender encouraged to seek treatment.<br>• Possession with purposes of unlawful sale or supply results in penalties varying according to the type of procedures: 'on indictment or summary'. |
| Italy | • Possession for personal use subject to administrative sanctions. |
| Luxembourg | • Possession of small amounts for personal use can result in a warning.<br>• Possession of drug will be prosecuted and punished. |
| Netherlands | • Possession of cannabis up to 30g is a minor offence. Possession of other illegal drugs (hard drugs) is a criminal offence. Guidelines for the investigation and prosecution of Opium Act offences assign low priority to the possession of small quantities of drugs for personal use.. |
| Austria | • Possession of small quantities, for personal use, where the offender is willing to undergo treatment, result in charges being provisionally set aside.<br>• Classification of quantity defines the offence and penalty. |
| Portugal | • Possession is a criminal offence but it is punished according to the intention: use or traffic. Quantity is an indication which may be used to distinguish between use and traffic crimes or to distinguish between different categories of gravity within these two crimes |

| | |
|---|---|
| Finland | • Possession of drugs is a criminal offence, regardless of purpose. |
| Sweden | • The purpose of drug possession is not taken into account, although offences may be judged to be 'minor', 'ordinary' or 'serious'. |
| United Kingdom | • No guidelines on possession for personal use.<br>• Quantity may be taken into account.<br>• A formal caution is followed by encouragement to seek treatment. |

## Alternative measures to imprisonment or prosecution*

In the drugs field 'alternative measures' to prosecution or imprisonment are a concept defining those measures which, depending on circumstances, allow individuals to be treated for their addictions or to receive counselling, even when they have committed an offence in law.

All Member States foresee a comprehensive range of 'alternative measures' that can be implemented at different stages of the criminal justice system (police inquiry, prosecution level and courts) in different ways (therapeutic treatment, counselling, social work, etc.) and on a voluntary or compulsory basis.

Despite these different options it is, however, important to note that even if not harmonised, laws on alternative measures in the EU follow the basic principle of a social and medical approach towards drug addicted offenders.

**Belgium:** Prosecutors can propose that offenders who admit addiction undergo treatment. Cases can then be dropped and declared closed. Courts can order probation and defer or suspend sentence, including the obligation to carry out work of social value. Treatment is commonly a condition of probation.

**Denmark:** Alternatives to prison include suspended sentences and conditional discharge. Prosecutors may order treatment as an alternative to imprisonment.

**Germany:** Prosecution may be waived for offences involving small quantities for personal use. Sentences of less than two years' imprisonment can be suspended if an addicted offender is undergoing or intends to undergo treatment.

**Greece:** Prosecution can be postponed if drug addicts agree to treatment and permanently suspended if the programme is successfully completed. Treatment in a closed establishment can be ordered, time spent in treatment being deducted from the sentence. Non-dependent users arrested can be obliged to follow a counselling programme.

**Spain:** Courts may encourage addicts to seek treatment. Sentence may be conditionally suspended for addicts sentenced to less than three years who opt for treatment.

**France:** Prosecutors can order treatment as an alternative to proceedings. Courts can decide to postpone sentencing and order therapeutic treatment as a condition of probation.

**Ireland:** Sentence may be deferred if the offender volunteers to undergo treatment. Offenders are offered treatment while in custody.

**Italy:** Courts can offer alternative measures for addicts who volunteer for treatment. Sentences up to four years are suspended for a probation period of five years. If treatment is successful the case is closed.

**Luxembourg:** Magistrates may order detoxification. If treatment is successful the offender will not be prosecuted. Offenders volunteering for treatment may have their sentence suspended for a probation period of two years.

**Netherlands:** Prosecutors may drop proceedings if addicts volunteer for treatment. Courts can give a provisional judgment if a drug user attends a treatment centre or, rarely, order a drug addict to be treated in a psychiatric institution.

**Austria:** if a drug user acquired, imported, exported, offered or supplied drugs in small quantities and voluntarily undergoes treatment, the prosecutor may suspend proceedings for up to three years, if a drug addict voluntarily undergoes treatment. Courts can suspend the sentence and send the person to treatment.

**Portugal:** Proceedings may be suspended if the offender volunteers for and successfully concludes treatment. This may be accompanied by a probation order.

* The information presented here is only a summary and is not exhaustive. The EMCDDA is preparing a specific publication on the subject.

**Finland:** Prosecutors and courts can withdraw from proceedings or waive punishment when the offender voluntarily undergoes treatment.

**Sweden:** Courts may substitute treatment for imprisonment. Imprisoned drug users may serve the last part of their sentence in a treatment programme. The investigating magistrate may send the case to social services. This practice is very often used in the event of minor offences.

**United Kingdom:** In addition to a range of general non-custodial alternatives (probation, community service, or both), treatment may be made a condition for granting probation.

## Illicit drugs trafficking

In recent years the European Union has drawn attention to the illicit trafficking of drugs and invited Member States to apply the most severe penalties to drug trafficking offences*. All Member States are agreed in regarding illicit drug trafficking as a very serious criminal offence and will apply the most severe penalties available.

* Joint Action 17 December 1996 on approximation of drugs laws, Art. 4: 'Member States shall ensure that under their legal systems the penalties imposed for serious drug trafficking are among the most severe penalties available for crime of comparable gravity'.

### Table 4: Penalties for drug trafficking

| Member States | Sanctions |
|---|---|
| Belgium | Addict-dealers – 3 months to 5 years;<br>Aggravating circumstances – 10 to 20 years. |
| Denmark | Addict-dealers – max. 2 years;<br>Other (serious) offenders – max. 10 years. |
| Germany | Basic offence – max. 5 years; severe cases – max. 15 years;<br>Trafficking – minimum 1 year. Special cases minimum 5 years<br>Money laundering – minimum 2 years.<br>Receiving proceeds of trafficking or possessing equipment for illicit production – minimum 3 years. |
| Greece | 5 years to perpetuity. |
| Spain | Addict-dealers – substances causing less serious health hazard – 1 to 3 years; hazardous drugs – 3 to 9 years.<br>Aggravating circumstances – less hazardous substances – 3 to 4 years; hazardous drugs – 9 to 13 years.<br>Severe circumstances – less hazardous drugs – 4 to 6 years; hazardous drugs – 13 to 20 years. |
| France | Addict-dealers – max. 5 years;<br>Drug-traffickers – max. 30 years; Leader – life sentence. |
| Ireland | Penalties range from a fine or imprisonment for 1 year to an unlimited fine or imprisonment for life. |
| Italy | Basic offence (depending on drug) – 2 to 20 years and/or a fine.<br>Minor traffic – 6 months to 6 years and/or a fine.<br>Member of drug traffickers group – min. 10 yrs; leader – min. 20 yrs. |
| Luxembourg | 1-5 years to perpetuity (minor involved). |
| Netherlands | National traffic – Unacceptable risk drugs - up to 8 years and/or a fine.<br>Other drugs – max. 2 years and/or a fine, max. 5 years if member of a criminal organisation.<br>International traffic – Unacceptable risk drugs – max. 12 yrs and/or fine.<br>Other drugs – max. 4 years and/or fine.<br>Penalties may be increased in cases where there are repeated violations of the Opium Act. |
| Austria | Max. 5 years for basic offence;<br>1 to 10 years for drug traffickers (up to 15 years, large quantity) up to 20 years for gang leaders |
| Portugal | 1-25 years depending on drug, quantity involved and circumstances. |
| Finland | Addict-dealers – max. 2 years, or fine;<br>Aggravating circumstances – 1 to 10 years. |

| | |
|---|---|
| Sweden | Minor offences – max. 6 months sentence or fine.<br>Basic offences – max. 3 years sentence.<br>Serious offences – 2 to 10 years imprisonment. |
| United Kingdom | For less serious cases: Class A – 6 months and/or fine.<br>B – 6 months and/or fine.<br>C – 3 months and/or fine.<br>For serious cases: A – imprisonment up to life.<br>B – max. 14 years and/or fine.<br>C – max. 5 years and/or fine. |

## Law enforcement measures

International cooperation between the Member States has increased in several sectors, including police forces, judicial authorities and customs, in an attempt to combat drug-related criminality. Laws also cover the following subjects.

### Money laundering

One of the most important achievements is the guidelines about money laundering contained in EC Directive 91/308 that have been subsequently transposed into national laws. With these laws, the acquisition, use, conversion or transfer of property derived from criminal activities related to psychoactive substances, is defined as a criminal offence.

All EU Member States have adopted measures to prevent, control and if necessary, repress activities connected to money laundering. Each country has developed legislation which covers the laundering of proceeds linked to a wide variety of crimes, including drug related crimes.

Some international agreements have established guidelines for an international anti-money laundering strategy ([2]).

Although EU Directive 91/308 applies primarily to credit and financial institutions, Member States already apply anti-money laundering legislation to activities beyond the financial sector or have draft legislation pending on the subject.

### Precursors

Control in those substances frequently used in the illicit manufacture of narcotic or psychotropic substances, the so-called 'precursors', was introduced in 1988 by the UN Convention against illicit trafficking. Since 1990 the European Community has approved a series of legal instruments ([3]) to put precursors under control in Europe. All 15 Member States now have national regulations to control their production and trade.

### Controlled deliveries

Introduced by Article 11 of the 1998 UN Convention the controlled deliveries are collaborative activities between Member States that also allow illicit consignments to pass through the territory of one or more countries, under supervision, with a view to identifying persons involved.

### Extradition

The arrest and delivery of a fugitive wanted for a crime committed in another country is usually under the terms of an extradition treaty. Extradition is an option if both countries involved perceive the crime as warranting imprisonment, with the offender undergoing penal procedures in the petitioner State.

In some countries the Penal Procedure Code permits the searching of houses without a court warrant, as long as a judge subsequently validates the procedure.

## References

[1] Health of the subject, evidence of trafficking, quantity.

[2] EU Directive on prevention of money laundering – 91/308/EEC, UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances1988, FACT recommendations, Convention of the Council of Europe on Laundering, Search, Seizure and Confiscation of the Proceeds from Crime 1990.

[3] Precursors: Regulation No 3677/90 of 13.12.90 – Regulation No 900/92 of 31.03.92 – Regulation No 3769/92 of 21.12.92 – Regulation No 2959/93 of 27.10.93 – Regulation No 1485/96 of 26/7/96 – Regulation No 2093/97 of 24.10.97 – Directive No 92/109 of 14.12.92 – Directive No 93/46 of 22.06.93.

## Table 5: Money laundering

| Money laundering (criminal activities covered by Member States in the anti-money laundering legislation) | |
|---|---|
| Belgium | The Penal Code (Art 505) covers the laundering of the proceeds of crime with imprisonment from 15 days to 5 years and /or fine. The specific anti-money laundering legislation (Law of 11/1/93) as amended) covers the laundering of proceeds linked to crimes including drugs trafficking. |
| Denmark | The Danish Money Laundering Act refers to assets originating from violation of the Danish Criminal Code. Money laundering is not a separate offence under Danish law but is dealt with under two 'receiving' sections of the criminal code: Section 191 (a) which makes it an offence to receive profit from a drug offence and Section 284 which creates an offence of accepting profits or helping others to enjoy profits from crime. |
| Germany | Money laundering is a criminal offence pursuant to Section 261 of the Criminal Code (money laundering; disguising of illegal assets). The EC directive on money laundering of June 1991 was incorporated into national law by the Money Laundering Act of 1993. The Act on the Improvement of the Control of Organised Crime of May 1998 on the one hand particularly improved the taxation of the offenders' assets and thus the absorption of illegal profits by means of early disclosure of information to the tax offices and, on the other hand, it introduced the supervision of the cross-border transfer of cash by the customs and the Federal Border Police. |
| Greece | The Greek Money Laundering Law covers trafficking in drugs. |
| Spain | The Penal code Article 301 covers money laundering with penalties ranging from 6 months to 6 years. It refers to all serious crime (any crime carrying a prison sentence of more than 3 years). The offence is considered to be aggravated when it relates to a drugs trafficking offence. The Spanish Money Laundering Law of December 1993 has the objective of combating the laundering of the proceeds of organised crime, terrorism and drugs trafficking. Royal Decree 864/1997 regulates the funds deriving from goods confiscated due to drug trafficking. |
| France | The law of 13 May 1996 criminalises the laundering of the proceeds of all criminal activities. (The 1990 law covered only the proceeds of drug trafficking). |
| Ireland | The Criminal Justice Act 1994 criminalises the laundering of the proceeds of 'drug trafficking or other criminal activity'. The Proceeds of Crime Act 1996 complements the confiscations under the Criminal Justice Act 1994 and the Criminal Assets Bureau Act 1996. |
| Italy | Law 328/93 modified the Articles 648 bis and ter of the Criminal Code to criminalise the laundering of the proceeds of all international criminal activities. |
| Luxembourg | Current legislation covers only offences linked to drug-related money laundering. However, a draft law currently before the Luxembourg Parliament would extend the range of predicate offences to any crime carrying a penalty of more than 5 years' imprisonment to offences involving organised crime and certain offences involving minors, prostitution and corruption of young people. |
| Netherlands | The Dutch law foresees a comprehensive range of measures to control money laundering which is a criminal offence under Articles 416/417. The maximum penalty is 4 years' imprisonment or a fine. |
| Austria | The Austrian Penal Code criminalises the laundering of assets derived from serious crimes which, under Art. 165 of the Criminal Code, carry a prison sentence of 3 years. |
| Portugal | Decree Law 15/93 made drug and precursor trafficking a criminal offence and criminalised money laundering. Decree Law 313/93 transposed the money laundering EC Directive into Portuguese law. |
| Finland | The relevant offence in the Finnish Penal Code covers the proceeds of all offences (the maximum sentence for money laundering associated with narcotic offences is 18 months, 4 years in aggravated circumstances). |
| Sweden | It is an offence to launder the proceeds of serious crime. Section 9 of the Swedish Penal Code states that it is an offence to launder the proceeds of any serious criminal offence carrying a penalty of imprisonment of more than 6 months. Complicity in money laundering is also criminalised. |
| United Kingdom | There is no general definition of the term 'money laundering' but in effect it is an offence to launder the proceeds of serious crime including drug trafficking or any other 'indictable offence'. |

# Action taken by the European Union

Chapter 5

**The EMCDDA's first two annual reports dealt thoroughly with the history of the action taken by the European Union on drugs and the organisational, legal and political framework of that action. In 1997, the European Union's legal and political framework did not change, nor did its organisational and institutional context.**

The third European action plan to combat drugs (adopted following the 1993 Treaty on European Union coming into force) still provides the general framework for anti-drug action in the European Union. It emphasises coherence and coordination of mutually reinforcing demand- and supply-reduction policies both at EU level and in the 15 Member States, as well as in their articulation at international level.

Similarly, the institutional and organisational context remained almost unchanged in 1997. There were no modifications to the legal and political framework that could alter the roles of the four EU institutions who are most actively involved in the drugs phenomenon (European Parliament, European Council, Council of Ministers and European Commission). Their roles have been outlined in previous annual reports and no further reference will be made to them or to other bodies within the Community framework.

## Advances in 1997

### General measures and political context

In 1997, the European Council Summits in Amsterdam and Luxembourg followed the lead of previous summits and addressed the drugs issue, maintaining the policy impetus and confirming its top profile among the Union's political concerns. The issues of new synthetic drugs, reliability of comparable information on all drug issues, increased R & D provision, training and interdisciplinary demand-reduction programmes designed especially for the young, prepared the way for the fourth EU plan for 2000-04.

#### Coordination

Coordinating anti-drug action continues to play a key role in EU action in 1997. The Horizontal Drugs Group (HDG), which held 12 monthly meetings during the year (7 under the Dutch presidency and 5 under the presidency of Luxembourg), has continued its work. This group, an heir to the CELAD and the Drug Experts Group, links the specialised groups of the Council addressing drug issues and thus the coherence of 15 national anti-drug policies, within both themselves and EU policy. In 1997,

the HDG prepared two reports for the Summits of Amsterdam and Luxembourg followed by joint preparatory work for Ungass and other external issues.

### Information

The EMCDDA and the EDU provide information on drugs in the EU. The EMCDDA compiles and disseminates non-confidential data on drug abuse to support policy making. The EDU exchanges and analyses data on organised drug trafficking and related criminal activities to support police operations. Both information bodies are involved in the implementation of the early-warning mechanism on new synthetic drugs (NSD), being joined for this purpose by the EMEA.

The EMCDDA focuses on common indicators of drug issues in the EC, developing appropriate methods for the collection of comparable health data to establish these indicators. As for the EDU, it is developing, in cooperation with the European Network of Forensic Laboratories, the drug purity indicator system in order to obtain an EU-wide overview of the average purity of the major types of drugs, through analyses of samples by Member States' forensic laboratories that can be linked to the already running EDU LOGO project database system on the ballistic profiling of Ecstasy pills.

### Training

During 1997, EU training and education programmes became more aware of drugs issues. As a follow-up to the 'Inventory of Community training programmes' the Commission organised a seminar on 'Training and drugs' jointly held with the Luxembourg presidency, to identify training needs for trainers and addicts within Member States. The conclusions of the seminar will be valuable in designing future programmes.

### Research

Following the Florence seminar on drug-related research initiatives in the EU, a synthesis report was published and national reports compiled by the Reitox focal points in a joint initiative of the Commission and EMCDDA. A high level workshop was organised in September at the initiative of the Commission, with the support of the Dutch and Luxembourg presidencies where clear priorities for research in the field of synthetic drugs were identified mainly in the medical, pharmaco-toxicological, psycho-sociological, epidemiological and monitoring fields.

The Commission also proposed a fifth R & D framework programme for 1998-2002, with a focus on medical, socioeconomic and detection aspects. The proposal sought the inclusion of drugs as a research topic under the public-health and health-services research area of 'Theme 1: Quality of life and management of living resources.'

### Other

The Youth for Europe Programme III funds projects in many different areas, for example: youth exchanges, initiatives, training, research, and information. Recently this programme has been emphasising its role in preventing drug use in young people and the integration of drug users into society. Funding for drugs-related projects is possible under the Leonardo da Vinci vocational training programme. A small number of projects were financed, focusing in particular on the design of interactive information and communication tools for professionals in this field and a number of initiatives were undertaken to promote the integration of drug abusers and the development of social skills in particular in deprived areas.

Under the initiative URBAN, the EU has supported a number of drug related projects proposed by national or local authorities. The Commission has also encouraged the exchange of knowledge and experience of drugs and security issues in the context of the URBAN initiative, highlighting drug abuse as a rising problem affecting Europe's towns and cities.

The report presented by Mrs Hedy d'Ancona (NL/PSE), chairperson of the Committee on Civil Liberties and Public Affairs of the European Parliament on the 'Harmonisation of drug legislation in the Member States' adopted by this committee in November 1997 is also worthy of mentioning in this context.

## Demand reduction

The EU's most relevant demand reduction action in 1997 was the implementation of the Community action programme on the prevention of drug dependence, within the objectives of public health for 1996-2000. This aimed to encourage coordination and cooperation between Member States and to support action preventing drug dependence and associated risks. In 1997, 33 projects were supported with a priority given to activities developed by European networks of professionals and to promoting transnational cooperation. Public health Commu-

nity action programmes, adopted in 1996 and developed in 1997, included health promotion, information, education and training, the prevention of AIDS and other communicable diseases, and health monitoring. Representatives of the EFTA countries that are members of the EEA attended the'Drug Dependence' Committee as observers, to facilitate their full participation in the programme once the participation procedures have been completed.

Social policy was more consistently reinforced by the EU in 1997. This was primarily achieved through the allocation of a substantial part of the Employment-Integra initiative for rehabilitation of drug addicts.

The Commission presented a proposal to the Council promoting road safety in the EU by reducing the incidence of driving under the influence of alcohol, medicines or illicit drugs.

## Supply reduction

### Precursors and money laundering

The Community monitors the intra-Community and the external trade of precursor chemicals frequently used for the illicit manufacture of narcotic drugs and psychotropic substances. This is done at legislative and policy level in the Council and at the committee of drugs precursors under Article 10 of Regulation 3677/90 laying down measures to be taken to discourage the diversion of certain substances to the illicit manufacture of narcotic drugs and psychotropic substances.

Anti-money laundering measures continue to be seen as crucial. Under the action plan to combat organised crime approved by the Amsterdam Summit, any Member States not having achieved ratification/implementation of the Vienna and Strasbourg Conventions will have to report to the Council in writing on the reasons for this.

### Cooperation in the field of justice and home affairs

Greater cooperation was implemented between police, customs and judicial authorities, and customs cooperation at external borders. Priority was given to the eight joint actions and six resolutions adopted in 1996 which focused on supply reduction. Its measures covered:

- customs control at external borders
- customs/business cooperation
- trafficking on European routes
- police and customs cooperation
- domestic cultivation and production of illicit drugs
- chemical profiling of drugs seized
- a drugs purity indicator system
- combating drug tourism
- establishment of directory of skills
- OISIN (cooperation between law enforcement authorities of Member States)
- Grotius (cooperation between practitioners of the judicial system)
- Falcone (cooperation on combating organised crime).

## Joint action on new synthetic drugs

In June 1997, the Council of the EU adopted a joint action aiming at the creation of an early warning system on new synthetic drugs and the assessment of their risks in order to permit the application of the measures of control on psychotropic substances applicable in the Member States, equally to new synthetic drugs. The EMCDDA and the EDU have been mandated to collect the required information and to participate in the committee tasked to assess the possible risks caused by the use of and traffic in new synthetic drugs. This new outfit is expected to characterise the period ahead with a view to support the EU objective to tackle the spreading drug problem, so that the entirely new aspect of NSD can be progressively curbed. The initiative relates to new synthetic drugs which are not currently listed in the Schedules to the UN Convention on Psychotropic Substances (Vienna 1971) and which pose a threat to public health. This joint action meets the need to provide the EU with a more flexible and rapid mechanism for tackling synthetic drugs. However, it does not prevent any Member State from maintaining or introducing on its territory any national control measure it deems appropriate once a new synthetic drug has been identified by a Member State.

## Table 1: EU actions and events in 1997 relating to drugs

| | January-March | April -June |
|---|---|---|
| European Parliament (EP) | • Resolution on the communication of the Commission to the Council and to the EP on 'The EU and Latin America: the present situation and prospects for closer partnership 1996-2000'.<br>• Resolution on the functioning and future of the Schengen Agreement.<br>• Decision on the connor position adapted by the Council with a wiew to the adaption of a Council regulation on North-South cooperation in the campaign against drugs and drug addiction. | |
| European Council (EC) | • Decision concerning the conclusion of the cooperation agreement between the EC and Mexico on cooperation regarding the control of precursors and chemical substances frequently used in the illicit manufacture of narcotic drugs or psychotropic substances. | • Convention against corruption involving officials of the EC or Member States.<br>• Joint action with regard to cooperation on law and order and security.<br>• Decision concerning the conclusion of an agreement between the European Community and the United States on precursors and chemical substances frequently used in the illicit manufacture of narcotic drugs or psychotropic substances.<br>• Joint action concerning information exchange, risk assessment and control of new synthetic drugs (see previous page).<br>• Resolution concerning a handbook for joint customs surveillance operations. |
| Co-decision | | • Decision No 1400/97/EC adopting a programme of Community action monitoring public health.<br>• Common position with a view to adopting a directive amending Directive 76/769/EEC on the approximation of the laws, regulations and administrative provisions of the Member States relating to restrictions on the marketing and use of certain dangerous substances and preparations. |
| Commission | | • Fifth R & D framework programme for 1998-2002.<br>• Communication to EP and EC on the action plan for transit in Europe — a new policy COM/97/0188.I<br>• Report on activities of EMCDDA (1994-96) to the EP and the Council of the EU, for information to the Economic and Social Committee and Committee of the Regions in accordance with Article 18 of Council Regulation (EEC) No 302/93.<br>• Communication to EC and EP on the control of new synthetic drugs. |
| Other | • First European Conference on Evaluation of Prevention organised by the EMCDDA | • Joint assembly of the convention concluded between the African, Caribbean and Pacific States and the EC (ACP-EU) resolutions adopted on orphan drugs (ACP-EC /2098/97/fin) |

| July-September | October-December |
|---|---|
| | • Resolution on the action plan to combat organised crime.<br>• Report on the 'Harmonisation of drug legislation in the Member States' adopted by the Committee on Civil Liberties and Public Affairs. |
| Conclusions on health aspects of the drug problem | • Common position on negotiations in the Council of Europe and OECD relating to corruption.<br>• Proposal for a Council regulation amending Regulation (EEC) No 302/93 of 8 February 1993 establishing an EMCDDA.<br>• Regulation (EC) No 2046/97 on North-South cooperation against drugs and addiction.<br>• Resolution on priorities for cooperation in JHA for the period until 1.1.98 from the date of activation of the Treaty of Amsterdam.<br>• Convention on mutual assistance and cooperation between customs administrations.<br>• Joint action establishing a mechanism for evaluating and implementing international undertakings against organised crime. |
| | |
| | • Regulation (EC) No 2093/97 amending Regulation (EEC) No 3769/92 implementing and amending Council Regulation (EEC) No 3677/92 laying down measures to be taken to discourage the diversion of certain substances to the illicit manufacture of narcotic drugs and psychotropic substances.<br>• Seminar on training and drugs jointly held with the Luxembourg Presidency. |
| Third annual EU situation report on drug production and drug trafficking.<br>(EDU). | • Financial report of the EMCDDA together with Centre's replies.<br>• Second Annual Report on the State of the Drugs Problem in the EU produced by the EMCDDA.<br>• Seminar on the evaluation of prevention, treatment and drug policy jointly organised by the EMCDDA and COST A6. |

## International action

### Coordination

The increasing importance of a common international strategy on drugs reinforced the need for a more coherent EU international policy. Cooperating under the common foreign and security policy, Member States are increasingly pooling their diplomatic efforts; using the weight of the Union to reinforce their positions in international forums and external political dialogue.

Together with efforts enhanced by the Lomé Convention, the main initiatives supported by the EU focused on central and eastern Europe, the Andean region, the Caribbean, central Asia/NIS, south-east and south-west Asia, south and west Africa. The following areas were addressed: demand reduction; adoption of national master plans; alternative development; institution-building; and precursor control.

### Accession countries

Ten central and east European countries (CEECs) are currently preparing for accession to the EU. The multi-country PHARE programme for the fight against drugs is monitoring the efforts of each candidate country in drug control.

The PHARE programme was established to help the CEECs integrate into the Union during the pre-accession period. Programmes include the multi-country programme for the fight against drugs, the horizontal programme on justice and home affairs, and the multi-country programme for transit facilitation and customs modernisation.

The multi-country programme for the fight against drugs helps the CEECs develop a comprehensive policy, and promotes cooperation intra-regionally, with the EU and with Member States. More specifically, it features a project on precursor control

Table 2: Cooperation with non-EU countries

| | Framework | Action | Target |
|---|---|---|---|
| NIS | Tacis programme. | Visits to former Soviet Union (Feb-June) | Greater cooperation in justice and home affairs |
| North-South cooperation on drugs | Cooperation with Third World Countries | Council regulation allowing the Community to cooperate in the field of drugs with developing countries. | Combat drug production, trafficking and abuse. |
| USA | EU-US summit at The Hague | Agreement signed on controlling chemical drug precursors.<br><br>Conference | Implementing Caribbean drug initiative: combating international drug trafficking in central and eastern Europe and the former Soviet Union.<br>Intensify efforts to combat illicit drug production,trafficking and use. |
| Asia | Heads of State or Government Summit | Conference | Greater effectiveness at combating drug trafficking and money laundering. |
| Africa | Regional drugs control action plan for southern Africa | Conference | To enhance the 'conditional development' approach to the region. |
| Europe | Pan-European International Conference of the Pompidou Group. | Financial and technical support | Greater effectiveness at combating drug trafficking and money laundering. |
| Latin America | EU/Rio Group Ministerial Meeting (Noordwijk) | Meeting of both partners on drugs (Brussels) | Implementation of the commitments of the Noordwijk meeting |
| ACP countries | European Development Fund | Allocation of a cooperation budget | Substantial adoption of national plans on drugs and promotion of demand reduction activities |

which aims at setting up Community-compatible precursor control legislation across the PHARE countries and its administrative implementation by the competent administrations. Steps have also been taken as regards the participation of the associated CEECs in the Community's public health action programmes, including drug dependence.

**Cooperation with non-EU countries**

As for cooperation with non-EU countries please refer to the Table 2.

**Cooperation with international forums**

In 1997, the EU actively participated in the preparations and outcome of the Ungass. At internal level, the Commission issued a communication to the Council and the European Parliament attempting to establish a common platform for statements of the EU and its Member States. The EU also participated in the meetings of the UNDCP Major Donors Group and in meetings of the Committee on Narcotic Drugs.

Another forum followed closely by the European Union is the Financial Action Task Force (FATF), which analyses the implications of money laundering for the international financial system (see Chapter 6 on international action).

## Anti-drug programmes funded by the EU in 1997

The European Union gives support to the fight against drugs by funding anti-drug activities within the EU or supporting the activities of its international partners. The allocation of funding reflects the political priorities of the EU.

### Internal funding

In 1997 the EU supported nine budget lines, totalling ECU 33.3 million, for internal use only, three on drug specific lines and six on programmes not exclusively devoted to drugs.

**Specific drug related budget lines**

Prevention of drug dependence

The programme of Community action on the prevention of drug dependence (1996-2000) funds actions on public health aspects of drug issues. It hosts the Community action programme on the prevention of drug dependence in a public health framework (1996-2000), adopted by the EP and the Council in December 1996. It was first implemented in 1997 with an annual budget of approximately ECU 4.9 million. From the 157 proposals submitted, 19 projects were selected for funding. Priority was given to projects involving cross-border networks of professionals: 63% of the budget was spent by networks involving at least nine Member States. It addressed:

- development of cooperation between cities,
- promotion and evaluation of best practices with regard to specific target groups,
- training for professionals in contact with target groups of young people,
- responses to new synthetic drugs.

Global aspects of the fight against drugs

This budget funds anti-drug actions contributing to the EU action plan to combat drugs (1995-99). This covers drug demand reduction, supply reduction, international cooperation, and coordination of multidisciplinary issues, such as research and training. Since demand reduction and international cooperation are covered by other budgets, the focus is mainly on the funding of actions on supply reduction and horizontal issues.

Supply reduction accounts for 67% of this budget line:

- projects which further implement existing Community legislation on precursors (30%)
- to fund anti-money laundering practices (4%)
- reinforcement of the EC-Reitox legal database and the production of publications (12%)
- training in demand reduction (12%)
- the organisation of two seminars on synthetic drugs (9%).

EMCDDA

In 1997 the EMCDDA had an operational budget of about ECU 3.2 million (51% of its overall funding). It supported studies, surveys, consultations, training and production of specialised publications to facilitate data analysis and exchange of information.

## Table 3: EU budget lines supporting action on drugs in 1997

| Budget items | Line | ECU |
|---|---|---|
| **Internal** | | |
| **Specific drug related items** | | |
| Programme of Community action on the prevention of drug dependence (1996-2000) | B3-4302 | 4 900 000 |
| Measures to combat drugs | B3-440 | 1 160 000 |
| EMCDDA | B3-441 | 6 300 000 |
| **Non-specific drug-related items** | | |
| Youth for Europe | B3-1010 | 132 000 |
| Leonardo da Vinci | B3-1021 | 600 000 |
| Biomed | B6-7142 | 1 000 000 |
| Employment-Integra | B2-1422 | 18 400 000 |
| Cooperation in the field of justice and home affairs (Grotius+OISIN) | B5-800 | 822 000 |
| IDA | B5-7210 | 50 000 |
| **Total internal** | | **33 364 000** |
| **External** | | |
| **Specific drug-related items** | | |
| North-South cooperation on drugs and drug addiction | B7-6210 | 8 900 000 |
| PHARE multi-country programme for the fight against drugs | B7-5000 | 5 000 000 |
| **Non-specific drug-related budget items** | | |
| Development cooperation constituted by Lomé Convention (ACP) | EDF | 6 200 000 |
| **Total external** | | **20 100 000** |
| **Total spending** | | **53 464 000** |

### Non-specific drug related budget lines

#### Youth for Europe

This programme funded 15 drug-related projects in 1997, costing ECU 132 000. A variety of actions were covered, including youth exchanges, training and research, promoting prevention, and advancing the need for reintegrating addicts into society.

#### Leonardo da Vinci

Four projects were funded by this programme (totalling about ECU 600 000) including vocational training in the field of drugs.

#### Employment-Integra programme

The E-I programme supported about 230 projects, targeting the problems of substance abusers. The average contribution to each project was about ECU 240 000 (total = ECU 55.2 million). Though funded by the 1997 budget, implementation will take place up to 1999. To avoid disproportionate figures that fail to correspond to real implementation, it has been estimated that an average of ECU 18.4 million per year will be spent under this heading until 1999.

### Biomed

This research programme funded projects for ECU 1 million on neuro-physiological aspects of drug addiction. An increase of funding for areas including biomedical and socioeconomic research, and research on drug consumption (including NSD), will start following implementation of the fifth framework programme on R & D (1998-2002).

### Cooperation in the field of justice and home affairs

Two multiannual programmes intend to foster cooperation between law enforcement bodies and practitioners of the Member States (GROTIUS and OISIN) were allocated altogether ECU 822 000 for anti-drug actions.

### IDA/Reitox project

A total of ECU 50 000 was allocated to this programme to establish a public open access information resource linking the EMCDDA, the focal points, the Commission and six international organisations.

**Summary of internal spending:** In 1997 the European Community spent ECU 33.3 million on drug-related activities within the Union. It was divided amongst the following projects:

- social and professional reintegration of drug addicts (55 %)
- information and harmonisation of data, mainly through the EMCDDA (19 %)
- public health projects (15 %)
- increasing cooperation in the field of justice and home affairs (3 %)
- vocational training, youth education and research (6 %)
- precursor and money laundering control (2 %).

A decisive increase of the total budget allocated to anti-drug actions within the EU took place in 1997. The total internal investment in 1996 totalled ECU 15.2 million; in 1997 this went up to ECU 33.3 million. This increase is due to the inclusion of social reintegration figures (ECU 18.4 million) in the calculations. In comparison with 1996, the other anti-drug budget lines were slightly reduced: health aspects of drug abuse (ECU 6.5 million in 1996; only ECU 4.9 million in 1997) and the IDA/Reitox programme (ECU 750 000 in 1996; ECU 50 000 in 1997).

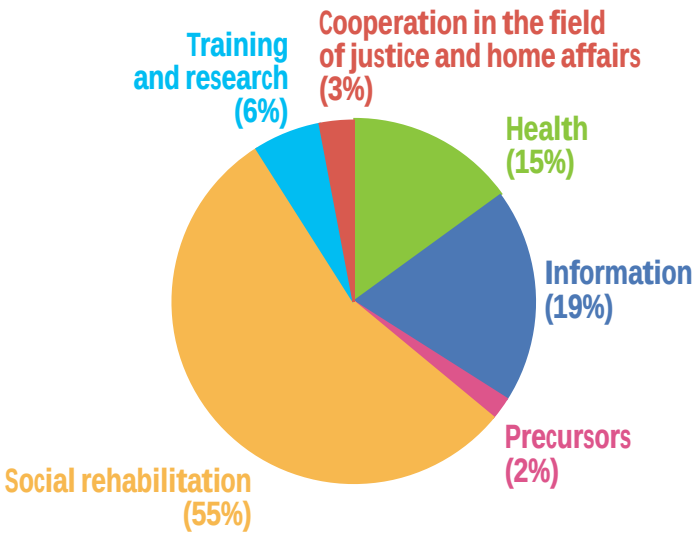
## External actions

**Specific drug related budget lines**

### North-South cooperation

This allows funding of direct actions in developing countries (demand and supply reduction). Four regions (Latin America, Asia, the Caribbean and Africa and the Mediterranean region including the Maghreb and Mashreq) are covered. In comparison

Chart1: Analysis of internal spending %



with 1996 (when 75% of the budget was spent on the Asian and Latin-American region against 56% in 1997), there is a budgetary move towards the Caribbean and Maghreb and the Mashreq region, which received 44% of the total budget. The following received priority:

- drug demand reduction
- strengthening of judicial and law enforcement system
- chemical precursor control.

### PHARE multi-country programme for the fight against drugs

The main objective of this programme is to prepare the associated countries to be in line with the EU action plan to combat drugs (1995-99) and the Member States' drugs policies. The PHARE budget was about ECU 5 million. This money was spent on:

- establishment of multi-country information system
- creation of money laundering legislation
- EU compatible precursor control legislation
- drug demand reduction strategy
- staff training.

### Non-specific drug related budget lines

### European Development Fund (EDF)

In 1997 the EDF allocated a budget of ECU 6.2 million for drug-related projects: 92% being spent in the African region, mainly in Guinea-Bissau, Zambia and Botswana; the remaining 8% in the Caribbean region (Trinidad and Tobago and the Dominican Republic). The vast majority (81%) of the drug related EDF budget was spent on demand reduction projects.

**Summary of external expenditure:** In 1997 the European Community spent a total budget of ECU 20.1 million on drug-related projects outside the EU. The breakdown is shown in Chart 2.

The external expenditure was allocated in such a way that 53% went to drug demand reduction activities; 15% to capacity building and the remaining budget on actions in the fields of money laundering, precursors, alternative development, research, information, etc. (see Chart 3).

## Overall analysis

In 1997, more than ECU 53 million was spent on drug related actions: 62% for actions within the EU; 38% for actions outside the EU.

Within the EU, more than half of the budget (55%) was spent on rehabilitation actions (mainly funded by Employment-Integra), 19% was allocated to the EMCDDA to collect information on drugs and 15% to reduce demand for drugs (mainly funded by the Community prevention programme).

Outside the EU, due to the support of the EDF and PHARE programme, the African and the CEEC region received more than 60% of the 'external' budget. The majority was spent on actions reducing demand (more on prevention and treatment than rehabilitation). In 1997 capacity building became the second most funded field.

Chart 2: External drug-related Community expenditure according to the region

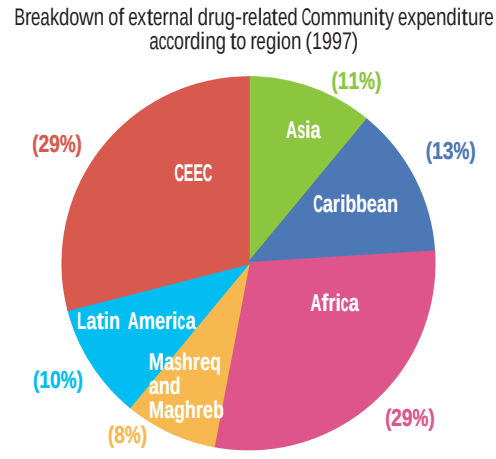
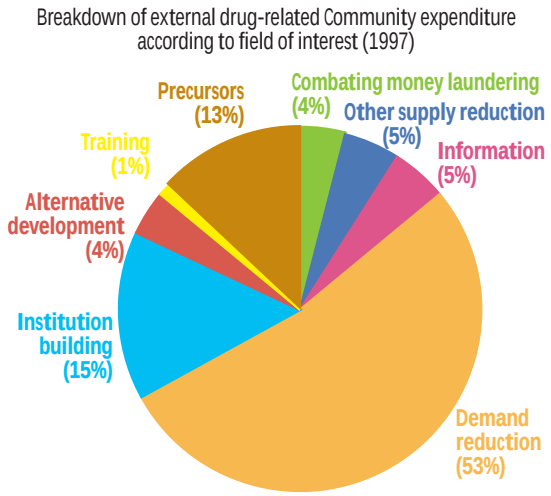
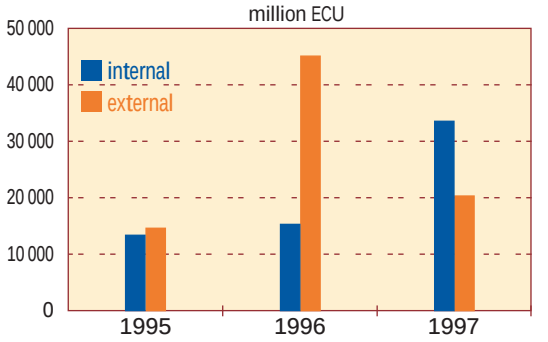



Chart 3: External drug-related Community expenditure according to the field of interest



In 1996, the total drug-related budget was ECU 61 million of which ECU 46 million was spent on external actions, and ECU 15 million within the EU. In 1997 there was an overall decrease. However, there is a huge modification in budget allocation between 1996 and 1997. The majority of the budget in 1997 (62%) was allocated internally, for use within the EU. This change in ratio can probably be explained by two main factors: firstly, in 1996, ECU 30 million (about half of the total budget) was allocated to Bolivia for a crop substitution programme in the framework of cooperation with Latin-American countries. In 1997, there were no new drug-related allocations for this budget item. Although this budget will be spent over a period of five years, it has not been included again in the 1997 budget. The 1996 allocation of ECU 30 million to one specific project has given a disproportional weighting to external expenditure; secondly, more internal budget items have been included in this year's report (e.g. Integra, research, training, etc.). This is partly due to the consolidation of the EC-Reitox Focal Points' work, partly due to new policy developments within the Commission.

Chart 4: All funding 1995-97




## References

Contribution au rapport annuel 1998 de l'OEDT sur l'état du phénomène de la drogue dans l'Union Européenne, Commission européenne, Secrétariat Général, Groupe Interservices 'Drogues', Brussels, March 1998.

'The European Union in action against drugs', European Commission, Secretariat General/Directorate-General X, CM-05-97-632-EN-C. ISBN 92-828-0426-7.

'General Report on the Activities of the European Union 1997', European Commission, EUR-OP – 1998. ISBN 92-828-2445-4.

'General Report on the Activities of the European Union 1996', European Commission, EUR-OP – 1997. ISBN 92-827-9426-1.

# International action

Chapter 6

**Efforts to combat the drugs problem at national level in the EU are enhanced and supported by international organisations operating globally, regionally or sub-regionally. These organisations play different roles, including the overall coordination of regional policies; the control of narcotic drugs, information and statistics; or operational coordination.**

The work of these bodies has both a direct and an indirect impact on the situation within the EU. As a result, European national administrations and EU institutions can no longer function outside the framework of the work undertaken by these international organisations.

## International organisations

### United Nations

Since 1946, the United Nations has played a major role in international drug control. Since that time, several UN programmes have been established to deal with this phenomenon.

#### Commission on Narcotic Drugs

This was established in 1946 by the Economic and Social Council. The Commission is the central policy-making body of the UN system that deals with drug-related matters. It analyses drug abuse and develops proposals to strengthen international drug control. Its functions include monitoring new trends, preparing international conventions, updating the drug-control system, and overseeing the international obligations of Member States.

The Commission, in collaboration with the World Health Organisation (WHO), may place a new substance on one of the schedules that control the availability of narcotic or psychotropic substances and drug precursors (in 1986, for instance, it placed MDMA ('Ecstasy') under formal control). It may transfer a substance from one schedule to another or remove substances from control.

In response to the need for closer cooperation and coordination in drug law enforcement matters at the regional level, the Commission established five regional subsidiary bodies of heads of national drug law enforcement agencies (Honlea) between 1974 and 1990 which regularly meet, exchange information and elaborate common strategies.

### International Narcotics Control Board (INCB)

This is an independent and quasi-judicial body set up to monitor the implementation of international drug-control conventions. It was established by the 1961 Single Convention on Narcotic Drugs and became operational in 1968. With regard to the licit manufacture of and trade in drugs, the Board seeks to ensure that adequate supplies are available for medical and scientific uses and that leakage leading to illicit traffic does not occur. The Board identifies weaknesses in national and international drug-control systems and helps correct them. In cases where the INCB finds that governments are not meeting their treaty obligations, it urges them to adopt remedial measures. It may bring violations to the attention of the parties involved, the Commission and the Economic and Social Council.

Under the UN 1988 Convention, the INCB monitors international trade in 22 substances with a view to preventing their diversion for use in the illicit manufacture of narcotics. It is also responsible for assessing new chemicals found to be used in the illicit manufacture of drugs, for possible international control.

### United Nations International Drug Control Programme (UNDCP)

In 1991, the three UN drugs units — the Division of Narcotic Drugs (DND), the United Nations Fund for Drug Abuse Control (Unfdac) and the INCB Secretariat — merged into a single drug-control programme responsible for coordinating all UN drug-control activities. UNDCP with its network of field offices provides legal assistance and trains government officials to set up adequate drug-control structures and to elaborate national, regional and sub-regional strategies and programmes. UNDCP also collects, analyses and disseminates data, information and experience on drug control and provides technical assistance in the fields of demand reduction, alternative development, law enforcement, forensic laboratories, precursor control, prevention of money laundering and institution building.

### World Health Organisation (WHO)

The WHO, based in Geneva, is required by international treaties to play an active role in promoting public health and better life conditions, and in reducing abuse of all psychoactive substances. It provides training in collecting accurate and relevant information on drug use and its health consequences. The WHO is also actively involved in scheduling drugs under the 1961 and 1971 Conventions.

Through regional offices and national contacts, the WHO's programme on substance abuse collects, analyses and disseminates data on prevention, demand reduction and the negative effects of drug consumption (including tobacco and alcohol). The headquarters in Geneva houses a global database on tobacco that will soon also include data on alcohol. Epidemiological networks and existing sources provide the WHO with information about illicit drugs. The WHO develops and tests epidemiological methodologies and indicators in cooperation with UNDCP.

The Regional Office for Europe (WHO-Europe), based in Copenhagen, assesses regional trends in drug abuse, the risks of licit consumption and evaluates prevention policies. In 1991, health data from 41 countries were included in the first European summary on drugs, tobacco and alcohol (ESDA). The Office has also published a directory of European research centres on alcohol, tobacco and drugs.

WHO-Europe and the EMCDDA are increasing cooperation on epidemiology and methodology. This will increase the quality and quantity of information on drug abuse. The WHO-Europe acts as an observer in the EMCDDA's Management Board meetings.

### Other United Nations bodies

The following specialised UN agencies play a significant role in drug control:

- the **International Labour Organisation (ILO)** deals with drug-related problems in the workplace;
- the **Centre for International Crime Prevention (CICP)** is concerned with aspects of the drug phenomenon linked to criminality, money laundering and the judicial system; together with the UNDCP, the CICP forms part of the **United Nations Office for Drug Control and Crime Prevention (ODCCP)**;
- the **United Nation Children's Fund (Unicef)** focuses its drug-prevention activities on vulnerable groups of children and young people;
- the **United Nations Educational, Scientific and Cultural Organisation (Unesco)** underlines prevention policy in schools;
- the **United Nations Industrial Development Organisation (UNIDO)** cooperates with governments to set up agro-industries in areas where illicit crops are grown;

- the **United Nations Development Programme (UNDP)** incorporates drug-control elements in its development programmes;
- the **United Nations Food and Agriculture Organisation (FAO)** assists projects which raise the income levels of farmers and reduce incentives to cultivate illicit crops;
- the **United Nations Joint Programme on HIV/AIDS (UNAIDS)** focuses on the link between injecting drug use and the spread of the HIV virus;
- the **United Nations Interregional Crime and Justice Research Centre (Unicri)** operates in the field of documentary research into criminal behaviour and drug abuse;
- the **United Nations Population Fund (UNFPA)** addresses drug abuse within its educational programmes;

## Other international organisations

Of the international organisations involved in drug control, Interpol and the World Customs Organisation (WCO) play an active role in Europe.

### Interpol

The **International Criminal Police Organisation (ICPO or Interpol),** based in Lyon, France, comprises a general assembly, a general secretariat, national central offices and advisers. Interpol promotes cooperation between law enforcement services on international drug-related crime such as illicit drug production, manufacture and trafficking. Interpol is not a police force and does not have supranational authority. Interpol focuses on increasing cooperation between national police services. It uses a sophisticated telecommunications network to optimise communication.

In the 1970s, Interpol established a drugs subdivision, with an operation group and an intelligence group. Since then, the functions of the sub-directorate have become twofold in the area of drug-related activity with both functions extending to all the 177 member countries. These functions are the liaison and specialised functions. The first covers coordination, exchange of information and drug information assistance. The second addresses collection and analysis of data, preparation of analytical/strategic intelligence reports, analysis of drug trafficking trends and the preparation of drug statistical reports.

A data bank of identified drug traffickers, information on investigations, and tactical and strategic intelligence has been established to provide national services with information on illicit drug-related activities. In addition, Interpol now also provides information on international organised crime and money laundering.

The Fonds Provenant d'Activités Criminelles (FOPAC) targets money laundering, the confiscation of assets and related financial investigation techniques.

Interpol's first contact with the EMCDDA was in 1995 and information exchange between the organisations will be strengthened. With the WCO and UNDCP, Interpol has established programmes for training police and customs officers.

### World Customs Organisation (WCO)

The WCO attempts to increase the effectiveness of customs enforcement activities.

A legal framework for these activities, provided by the 1977 Nairobi Convention, still forms the basis for exchanging intelligence and mutual technical support. The WCO is also developing a comprehensive programme of memoranda of understanding (MoU) with other agencies and commercial organisations to enhance its ability to support members' law enforcement capabilities. Recent signatories include the UNDCP, the International Chamber of Commerce, and Commercial Crime Services. Negotiations with Interpol are also under way.

The EU Member States, as member administrations of the WCO, play an active role in the law enforcement programmes developed by the Council's working parties and committees.

In 1992, the WCO developed a regional reporting system for drug seizures and has 10 regional intelligence liaison offices (RILOs) reporting to a central information system in Brussels.

## Regional organisations

### Pompidou Group

The Cooperation Group to Combat Drug Abuse and Illicit Trafficking in Drugs — the Pompidou Group — is an intergovernmental structure within the Council of Europe. It aims to 'promote and support the establishment of national policies and programmes, and the strengthening of international cooperation allowing a multidisciplinary approach to the problem of drug abuse and illicit trafficking, in a pan-European context'.

The Group includes the 15 EU Member States, the European Commission, Bulgaria, Croatia, Cyprus, the Czech Republic, Hungary, Liechtenstein, Malta, Norway, Poland, San Marino, the Slovak Republic, Slovenia, Switzerland and Turkey. In 1991 the group extended technical cooperation to Albania, Belarus, Estonia, Latvia, Lithuania, Romania, Russia and Ukraine. Non-European countries may also be invited to participate in the group's activities.

The Pompidou Group functions on three levels: ministerial; senior civil servants (or 'permanent correspondents'); and technical experts and officials. The permanent correspondents make public the majority of studies carried out on its behalf; but information is not made public on airport drug seizures with details of how drugs are transported (data collected by the Cooperation Group of Drug Control Services at European airports).

### Dublin Group

Created, on the initiative of CELAD, as an informal body to coordinate international drug-control policy, the Dublin Group includes the EU Member States, Australia, Canada, Japan, Norway and the USA. The European Commission and the UNDCP are also represented. The group exchanges information on drug actions and measures taken in member countries. The Dublin Group consists of central political, regional and local working groups.

The **Mini Dublin Group** is composed of the heads of local missions, diplomats with expert knowledge and liaison officers from law enforcement agencies. It assesses a country's drug-related political, social and economic state and identifies the need for assistance. This information is reported to the Regional Dublin Group.

The **Regional Dublin Group**, composed of ministerial experts, meets twice a year to summarise the reports supplied by the Mini Dublin Group. The group submits a regional report to the Central Dublin Group consisting of an overview, recommendations and draft resolutions to be adopted. Once the Central Dublin Group adopts a decision, it is implemented by the Regional Dublin Group.

The **Central Dublin Group** consists of all Member States and meets annually in Brussels. Its primary task is coordination and decision-making, and it discusses the recommendations of the Regional Dublin Group and adopts measures/actions.

### Inter-American Drug Abuse Control Commission (CICAD)

This Commission, with 31 member States, was established by the Organisation of American States (OAS) to 'promote and facilitate multilateral cooperation among the member countries in the control of drug trafficking, production and use'.

CICAD has 34 drug information centres throughout the western hemisphere (IADIS) and publishes an annual statistical summary. Each year, CICAD adopts an action plan which includes cooperation with EU Member States and institutions. CICAD focuses on demand reduction, supply reduction, assistance to member states and information exchange.

### The Financial Action Task Force (FATF)

The FATF was created by the G7 to analyse the implications of money laundering in the financial system and propose measures to control it. In 1990, the task force made 40 recommendations to its 28 member countries and international organisations. EU Directive 91/308/EEC on money laundering has put into practice many of the FATF's recommendations.

# Advances in 1997

## International cooperation

### Legal framework

Approximately 74% of countries worldwide have signed UN international drug control treaties. All 15 EU Member States are now parties to the three UN Conventions. Cooperation and coordination among international organisations are essential if drug problems are to be tackled without duplication of effort or resources.

### Main events relevant to the EU in 1997

- Much of 1997 was spent preparing a UN General Assembly Special Session (Ungass) on illicit drugs (held from 8 to 10 June 1998) to adopt a political declaration, a declaration on the guid-

ing principles of drug demand reduction, an action plan against illicit manufacture, trafficking and abuse of amphetamine-type stimulants and their precursors, an action plan on international cooperation on the eradication of illicit drug crops and on alternative development, as well as a set of measures to control precursors, to promote judicial cooperation and to counter money laundering.

- Two special meetings took place (in Sydney in August and in Vienna in October) to discuss the demand-reduction resource book series developed by UNDCP to complement the Ungass demand-reduction declaration.
- The UNDCP produced its first 'World drug report' — an all-embracing publication covering a broad range of issues, from cultivation, production, trafficking and consumption trends, theories of drug use, health consequences, organisational structures of the illicit drug industry, money laundering, to drug policies, including a review of the legalisation debate and strategies to counter the drug threat.
- In April, the UNDCP and the United Nations Development Programme signed a working agreement on division of tasks between the two.
- The WHO programme on substance abuse, consists of prevention, advocacy and promotion (PAP), treatment and care (TAC), and regulatory control.
- A WHO report, 'Smoking, Drinking and Drug-taking in the European Region', was published in April.
- The Interpol network communicated about two million messages relating to criminal activities in 177 countries in 1997, 55 % of which were related to drug offences. The 66th session of the Interpol General Assembly in New Delhi, India, in October 1997 passed 18 resolutions, including resolutions on anti-money laundering.
- In 1997, the WCO Central Information System (CIS) published its 'Customs and drugs report 1996' and began the 1997 version. The number of detections increased by more than 10 % from 1996.
- The Dublin Group's 1997 work focused on controlling chemical precursors.

## Illegal cultivation, production and trafficking of narcotic drugs

### Summary of international reports on drug supply to the EU

According to data collected and treated by the UNDCP, the INCB, Interpol, the WCO and the Europol Drugs Unit (EDU), drug supply continues to increase. Despite national and international improvements in law enforcement cooperation, traffickers are augmenting supplies to consumer markets, especially of synthetic drugs. An increase in quantities of drugs seized, without a corresponding increase in price or decrease in availability, is evidence of this increase.

According to Interpol, about 800 tonnes of cocaine and 450 tonnes of heroin are produced annually worldwide. UNDCP data for 1995 and 1996 suggest availability of heroin on the market — after seizures — of some 380 tonnes. Much of this ends up in the EU (38 tonnes of cocaine and 4.4 tonnes of heroin were seized in the European Union in 1997, according to the EDU). As it is impossible to quantify precisely drugs supplied and consumed, drug seizures represent an important indirect indicator.

Some of the data mentioned here refer to all of Europe and not exclusively to the European Union as all the international organisations mentioned above, apart from the EDU, work at global level.

Both police and customs data indicate that there was a significant increase in cocaine and amphetamine seizures in 1997, a slight increase in cannabis resin (hashish) seizures, and a slight decrease in heroin and cannabis leaf (marijuana) seizures in the European region.

Trafficking routes remain largely unchanged. The Balkan route from South-West Asia is used primarily to supply Europe with heroin. The maritime route across the North Atlantic from Central America remains the most popular method for transporting cocaine to Europe. There has been an increase in production and trade in synthetic drugs in Europe, especially eastern Europe, including the export of synthetic drugs to other regions.

### Cannabis

Cannabis remained the principal drug of abuse in Europe and cultivation and trafficking of high potency cannabis is increasing.

The UNDCP reports that, in the EU, seizures of cannabis resin increased. Morocco is a major suppli-

er of cannabis resin to the Member States. More than 315 tonnes (much of it of Moroccan origin) were seized in Spain. The UK and France recorded 23% and 19% of total cannabis resin seizures in Europe respectively in accordance with WCO data. Cannabis resin was also smuggled into Europe from Pakistan. A seizure of 6.4 tonnes in Greece demonstrates that South-West Asia is an important resin provider. Large-scale smuggling takes place in lorries, vans and campers, and by sea in trawlers and yachts.

The WCO reports that as for herbal cannabis (leaf) most seizures were made in the UK (23%), Belgium (22%), and Spain (13%). The Netherlands, the traditional entry point for cannabis smuggled into Europe, recorded 12% of herbal cannabis seizures. Two large seizures, originating in Ghana, were made in Rotterdam and Hamburg (2.8 and 2.5 tonnes respectively). This may indicate an increase of West African drug trafficking groups in Europe. Colombia, South Africa, Nigeria and Thailand are also suppliers of herbal cannabis to the EU. Albania is developing into a major source of herbal cannabis for Greece and Italy.

**Heroin**

Heroin entering the EU comes mainly (about 80%) from South-West Asia (the 'golden crescent' of Afghanistan, Iran and Pakistan), through Turkey to Germany. According to the INCB, the Balkan route is most frequently used by traffickers — significant seizures taking place in 1997 in Turkey, Germany, Bulgaria and Yugoslavia. The increasing importance of Central Asia for markets in Europe, as reported by the UNDCP, must also be noted. Sea transport has been used but the overland system presents the most consistent threat.

However, the largest amounts seized were in the UK and Germany. As a consequence of the turmoil in the former Yugoslavia, Romania has become an important transit route for trafficking, its territory being used to store illicit drugs in transit. However, increasingly, the 'traditional' route through the former Yugoslavia is once again being used.

According to the EDU, Turkish organised crime syndicates, often using local Turkish communities as cover for their activities, remain an active force in heroin trafficking and have been identified as operating in 12 Member States. Ethnic Albanian-Yugoslav groups are also prominent in heroin trafficking.

**Cocaine**

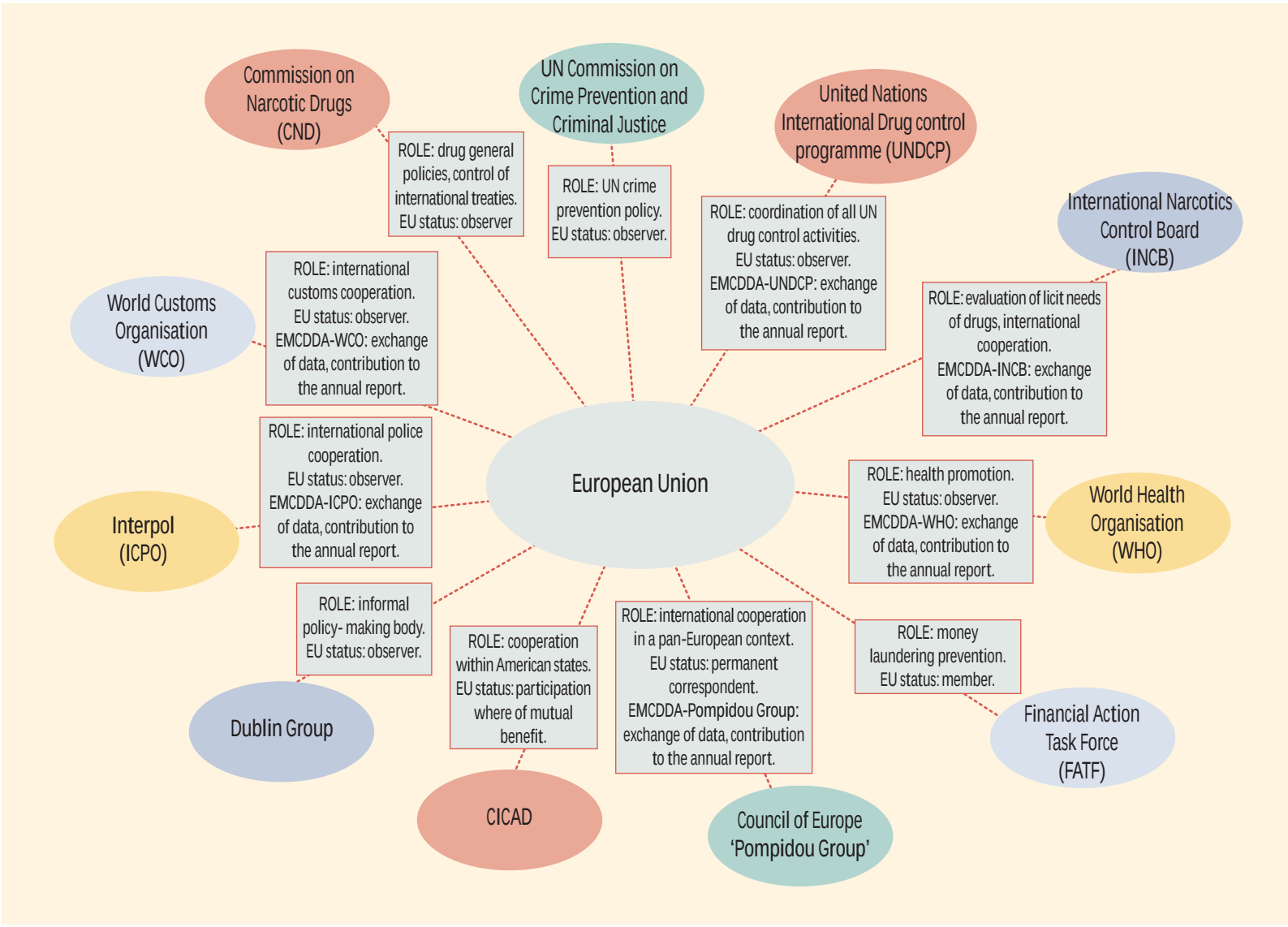
Bolivia, Colombia and Peru are the main producers of cocaine destined for the EU, with Argentina, Venezuela, Brazil, Ecuador and Suriname as major transit countries. The EDU reports that the transit role of central and east European countries is increasing. Colombia remains, however, the main producer of cocaine destined for the Member States. Transported mainly by sea (75%), cocaine spreads quickly through EU countries with a maritime border — Spain, Portugal, the Netherlands, Germany, Belgium and the UK. The WCO reports that cocaine seizures increased by about 30% in Europe in 1997. Most of this was seized in Spain (over 45% of total seizures in the region), the Netherlands (about 17%) and Portugal and Belgium (both over 10%). Several Member States have noted a trend towards the trafficking of smaller quantities rather than multi-tonne shipments. According to the EDU, despite the increase in seizures, no lasting effects have been detected in price.

**Synthetic drugs**

Synthetic drugs are difficult to seize, as trafficking and smuggling routes are simpler than for other drugs, as they are produced within the EU or in the CEECs and so are close to their consumer markets. Profit margins ensure continued production. According to the EDU, the cost of producing one Ecstasy pill is less than ECU 0.3, compared with a retail price of ECU 7 to 18 (a 2 300 to 4 600% profit).

The European Union is one of the world's major production regions of amphetamine- and Ecstasy-type stimulants, with illicit laboratories operating in most Member States. Intra-EU trafficking predominantly takes place overland in cars, lorries and trains. In 1997, eastern Europe emerged as a major supplier of amphetamine-type stimulants. The Czech Republic, Poland, Bulgaria and the Baltic States are major source countries and the production in central and eastern Europe is partly destined for the northern Member States. Synthetic drugs used within the EU are also produced in Asia and China. Simultaneously, and according to the UNDCP, Ecstasy manufactured in Europe is increasingly being abused in several Asian countries. In 1997, the importance of eastern Europe as a supplier of amphetamine-type stimulants continued to grow.

The WCO and the INCB report that laboratories for the illicit manufacture of amphetamines and/or MDMA or other 'Ecstasy-type' hallucinogenic amphetamine derivatives were dismantled in several European countries.




**Amphetamines**

Both the EDU and WCO report an increase of amphetamine seizures from 1996 to 1997. The EDU claims that, of the 1.9 tonnes seized in the European Union, 46% were seized in the UK, 11% in Germany and 10% in France. The WCO estimates that Poland supplies 40% of the Scandinavian market and 20% of German seizures were from Poland. Other amphetamine producers are Lithuania, Latvia, Hungary, the Czech Republic (for the methamphetamine 'Pervitin') and Ukraine.

**Ecstasy (MDMA)**

The WCO reports that the total amount seized in 1997 in Europe was 578.1 kg (925 623 tablets), a slight increase in weight compared with 1996 (498 kg), but a slight decrease in terms of dose (1 009 205 tablets). According to Interpol and the WCO, the Netherlands is believed to be the main source in the region. Europe seems to be at the centre of world Ecstasy activity as 70% of global seizures occurred there. It is also now an exporting region, particularly to South-East Asia (5 out of the 12 largest Ecstasy seizures were destined for Asia).

**LSD**

There was a considerable decrease in seizures in 1997 (the EDU reports a fall in doses of 22% compared with 1996 in the European Union).

# References

'European Union situation report on drug production and drug trafficking', Europol. Europol Drugs Unit, The Hague, Netherlands, 1998. File No 2564-47.

'European Union situation report on drug production and drug trafficking', Europol, Europol Drugs Unit, The Hague, Netherlands, 1997. File No 2564-20

'World drug report', United Nations International Drug Control Programme, Oxford University Press, 1997. ISBN 0-190829299-6.

'Report of the International Narcotics Control Board for 1998', United Nations, printed in Austria, Vol. 97-28447-January 1998. ISSN 92-1-148103-1, ISSN 0257-3717, E/INCB/1997/1.

'Strategy framework and work plan 1997', Programme on substance abuse, Division of Mental Health and Prevention of Substance Abuse, World Health Organisation. WHO/MSA/PSA/97.2.

'Report on the 1996 programme activities', Programme on substance abuse, Division of Mental Health and Prevention of Substance Abuse, World Health Organisation. WHO/MSA/PSA/97.1.

'Strategy framework and work plan 1998-1999', Programme on substance abuse, Division of Mental Health and Prevention of Substance Abuse, World Health Organisation. WHO/MSA/PSA/98.2.

'Customs and drugs 1997', World Customs Organisation.

'The world geopolitics of drugs 1995/96', Annual report, September 1997, OGD-Observatoire Géopolitique des Drogues, Dépot légal, September 1997.

# Analysis of public spending on drugs

Chapter 7

**Drug use and drug trafficking impose costs on the community. Although the governments of the EU allocate significant resources to combating drug use, little attempt is made to assess and compare the effectiveness of methods employed by different countries.**

## The field of public spending on drugs

Examining public spending on various drug policies is a way of attempting to identify the most effective policy. Even if this is not possible, the mirror of public spending should shed greater light on the relationship between spending and outcome.

Identifying spending linked to drug policies in public administration budgets poses problems of definition. What are the domains of drug policies? The question is not only theoretical — it has concrete applications in three areas: enforcement, treatment, and prevention.

Enforcement

Any person violating national drug legislation will encounter an action by the State. The spending tied to the enforcement of the law on drugs is clearly and easily defined. The problem lies with crimes committed by drug users: is crime a direct consequence of drug addiction?

Treatment

A significant number of HIV infections are drug-related. Should the cost of AIDS patient care be included as part of public drug spending, if they are infected through their drug use? If AIDS is a direct consequence of drug use, the mechanisms and spending are no longer geared to drug addicts but to individuals with AIDS.

Prevention

As primary prevention covers the whole population, it is tempting to just consider the nature of the preventive actions and not to include actions that explicitly address addiction, such as publicity campaigns against drug use. However, this reductionist idea of prevention is disputable. Conversely, an inclusive concept would include everything that promotes health as preventing risk behaviour, without specifying the prevention of addiction.

## A preliminary collection of statistics

The EMCDDA collects and analyses data gathered by Reitox in order to allow an international comparison of public spending on drugs. The elements that follow are incomplete and efforts must continue.

In general, public spending on drugs takes two forms.

Firstly, spending directly allotted to a drug mission, where the title leaves no doubt about the destination of the money and so accounting for this spending poses no problems. A problem arises because the drug problem remains a significant concern, and so certain administrations are tempted to apply for drug funding, only to use the funds for other projects. A careful calculation would demand that budgets specifically allocated for drugs be subtracted from the sums labelled as such to thwart such management control and to oppose the general tendency of reducing public spending.

Secondly, a proportion of the activity of ministries and public administrations (police, courts, customs, health) is dedicated to combating drugs and addiction. Given that public administrations present their budgets by spending lines and not by functions, the difficulty lies in interpreting distribution to calculate the funds actually allocated to drugs. It is thus necessary to consider all relevant budgets, and estimate the part of each that corresponds to the drug activity of the service.

The results presented below constitute only an intermediary step. Table 1, which regroups eight countries (seven countries of the EU and Switzerland) is constructed for five countries of the EU studied here (Belgium, Ireland, Spain, Portugal and Denmark) on the basis of a questionnaire given to the correspondents of Reitox. It is complemented by data from the study on France (which remains the most complete and on which the Reitox questionnaire is based) and by the results of a Swiss study.

Table 1 retraces public spending lines and calculates elements that, following the method used in the French study, permit calculations of the drug budget of each country.

The information in Table 1 is linked to the information furnished by the national correspondents of Reitox, which are themselves constrained by availability of source information. Table 1 is incomplete as a large amount of information is not the object of systematic study in each of the countries examined. In the same manner, note that the information presented in Table 1 is not 'adjusted' on the same year of reference which has no significant effect on the results if one accepts that spending on drugs is quite stable from one year to the next.

The data provided by Reitox correspondents vary from one country to another. The most salient example is that of arrests for 'drug offences' in the first section of Table 1 (see Chapter 2). Certain countries include the number of people the police record as having infringed drug laws, whilst other countries count the number of infringements. The perceived degree of seriousness for crimes also varies from one country to another. Such problems of definition emphasise the urgency of developing a comparative method.

**Belgium**

The police budget is divided into expenses for personnel (BEF 60 681 851 270), operations (BEF 5 878 325 143) and investments (BEF 3 758 154 231). The police workforce consists of 18 745 community officers, 15 929 gendarmes, and 1 440 police judicial officers. Police arrests for drugs (1996 statistics) show a distinction between arrests for drug possession (13 812), for importing, exporting, manufacturing and trafficking (8 362) and a category labelled 'diverse' (1 588). The total judicial budget (1998 statistics) includes expenses for personnel, buildings, and equipment. Finally, for the line 'social, health and prevention' a total has been given (BEF 280 000 000), without a breakdown between 'social and health' and 'prevention'. It should be noted that BEF 3 350 million (from the budget for 'mental health'), for the care of drug addicts, should be added to this sum.

**Denmark**

The police force (10 034 individuals) is the sole security force. All statistics date from 1997, apart from the number of customs guards, which dates from 1998.

**France**

Budget lines for all police forces, the total number of police officers, and the total number of specialised drugs officers come only from the national police, and do not include the State police force (gendarmerie).

**Ireland**

The police budget is derived from 1997 statistics. The specialised forces for combating drugs comprised 50 individuals grouped in a special 'Garda National Drugs Unit' and 246 national police officers. The customs budget comprises both the 'customs budget' and taxes. There are 85 customs officers specialised in drugs. However, 'pensions and salaries' are excluded from this budget.

The operational budget for penal institutions (1997 statistics) includes the operating costs of central stores and the training centre. The number of individuals incarcerated for drug offences dates from 1994, while the total number of prisoners dates from 1997. Finally, the number concerning actions at international level represents the Irish contribution to the UNDCP for 1997.

The line 'budget of institutions specialising in treating drug addiction', IEP 7 788 000 (i.e. ECU 10.09 million ) includes IEP 6 788 000 which was allocated to the Department of Health and Children for drug treatment services in regional health board areas.

## Table 1: Public spending and 'drug-budget'

| | Belgium | Denmark | France (2) | Ireland | Portugal | Spain | Switzerland(4) | UK(3) |
|---|---|---|---|---|---|---|---|---|
| **1. Law-enforcement costs** | | | | | | | | |
| **1.1. Police** | | | | | | | | |
| Budget of all national police forces(1) | 1 724.71 | 667.37 | 3 780.15 | 620.61 | n.a. | 3 166.43 | 865.77 | 12 516.37 |
| Police manpower | 36 114 | 12 965 | 132 626 | 10 968 | 2 300 | 121 376 | n.a. | 210 472 |
| Police manpower specialising in the fight against drugs | n.a | n.a. | 2 194 | 296 | 200 | 1 643 | n.a. | n.a. |
| Interpellations for drug offences | 23 762 | 13 992 | 79 271 | n.a. | 9 333 | 79 445 | 42 000 | 998 |
| Total number of interpellations | n.a. | 531 115 | 790 000 | n.a. | 321 643 | 1 984 755 | n.a. | 26 062 |
| **1.2. Customs** | | | | | | | | |
| Customs budget(1) | n.a. | n.a. | 585.32 | 65.05 | n.a. | n.a. | n.a. | 1 282.28 |
| Number of customs officers | n.a. | 250 | 20 000 | 85 | n.a. | n.a. | n.a. | 24 778 |
| Number of customs offences involving drugs | n.a. | 217 | 25 195 | 483 | 76 | n.a. | n.a. | 2 257 |
| Total number of customs offences | n.a. | n.a. | 100 000 | 2 354 | n.a. | n.a. | n.a. | 3 259 |
| **1.3. Justice** | | | | | | | | |
| Budget of the criminal justice system(1) | 463.83 | 1 062.28 | 3 094.73 | 894.44 | n.a. | 707.12 | n.a. | 2 024.92 |
| Number of prosecutions for drug offences | n.a. | n.a. | n.a. | 4 156 | 4 433 | 34 772 | 41 000 | 53 545 |
| Total number of prosecutions (excluding minor offences) | n.a. | n.a. | n.a. | 30 768 | 420 217 | n.a. | n.a. | 2 134 425 |
| **1.4. Custodial institutions** | | | | | | | | |
| Operational budget of all custodial institutions(1) | n.a. | 178.99 | 866.11 | 163.21 | n.a. | 479.69 | 285.44 | 2 591.59 |
| Number of persons imprisoned for drug offences | n.a. | 1 282 | 11 816 | 225 | 3 653 | 9 925 | n.a. | 6 400 |
| Total number of persons imprisoned | n.a. | 3 533 | 51 325 | 11 620 | 14 634 | 43 147 | n.a. | 57 598 |
| **2. Health and social services** | | | | | | | | |
| Budget of institutions specialising in treating drug addiction(1) | 69.38 | n.a. | n.a. | 10.09 | 3.77 | 94.61 | n.a. | 273.27 |
| State(1) | 69.38 | n.a. | n.a. | 8.79 | n.a. | 16.12 | n.a. | n.a. |
| Regions(1) | n.a. | n.a. | n.a. | 1.30 | n.a. | 78.49 | n.a. | n.a. |
| Budget of non-specialised institutions or cost indicators(1) | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Statistics identifying which patients out of all admissions were treated for drug addiction | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| **3. Prevention** | | | | | | | | |
| Budgetary lines allocated to drug prevention(1) | n.a. | n.a. | n.a. | 0.46 | 12.14 | 36.77 | n.a. | 252.25 |
| State(1) | n.a. | n.a. | n.a. | n.a. | n.a. | 16.12 | n.a. | n.a. |
| Regions(1) | n.a. | n.a. | n.a. | n.a. | n.a. | 20.66 | n.a. | n.a. |
| Local(1) | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Budget of institutions specialising in drug prevention(1) | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Budget of non-specialised institutions(1) | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Activities that ascribe part of their costs to the fight against drugs | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| **4. Research** | | | | | | | | |
| Amount spent on research(1) | n.a. | n.a. | 6.35 | 1.30 | n.a. | 7.35 | n.a. | n.a. |
| State(1) | n.a. | n.a. | 6.35 | n.a. | n.a. | 3.22 | n.a. | n.a. |
| Regions(1) | n.a. | n.a. | n.a. | n.a. | n.a. | 4.13 | n.a. | n.a. |
| **5. Action at international level** | | | | | | | | |
| Amount spent on international action(1) | n.a. | n.a. | 10.58 | 0.19 | 0.01 | 4.26 | n.a. | 273.27 |
| UNDCP(1) | n.a. | n.a. | n.a. | 0.19 | 0.01 | 0.39 | n.a. | n.a. |
| National plan on drugs(1) | n.a. | n.a. | n.a. | n.a. | n.a. | 3.87 | n.a. | n.a. |

(1) In million ECU. ECU conversion based on average 1997 exchange rate for each national currency.
(2) Kopp and Palle, MILDT report (1996).
(3) 'Tackling drugs together strategy for England 1995-98', HMSO, May 1995.
(4) J. Estermann, 'Consommation et trafic de drogues: les coûts de la répression (estimation pour la Suisse 1991)'.

IEP 5 475 000 of this was allocated to the Eastern Health Board. It is important to note that the Eastern Health Board is the only health board with specific specialised drug treatment facilities. Moreover, the Eastern Health Board budget incorporates HIV/AIDS with drug treatment. Other health board treatment activities include alcohol and drugs. On another side, IEP1 000 000 was allocated to local area drug task forces arising from the ministerial task force reports on measures to reduce the demand for drugs. IEP 355 231 was allocated for prevention to the Health Promotion Unit at the Department of Health and Children for drug prevention activities, and IEP 1 000 000 was allocated for research under the 'Science and technology against drugs' initiative.

**Portugal**

All data refer to 1997. The number given for the police force is for the judicial police force only, while the total number of police officers should be counted as the judicial police (Policia Judiciara), the civil security officers (Policia de Seguranca Publica) and the national guard (Guardia Nacional Republicana). Unfortunately, there was no data available at the time for the last two categories. Only officers of the judicial police are considered drug specialists. The line 'criminal justice system budget' is the budget for criminal costs. The line 'operational budget for all judicial institutions' is the budget of the general management of penal services. Finally, the line 'budget of institutions specialised in the treatment of drug users' includes the budgets of public (PTE 148 587 000) and private institutions (PTE 614 348 000).

**Spain**

The police force comprises the National Police Corps and the Guardia Civil. The role of the Customs Surveillance Service, which carries out its work in the fight against drugs at sea and at the borders, should also be highlighted.

**Switzerland**

The number for arrests corresponds to the number of proceedings initiated by the police in 1996, rather than the actual number of arrests. The number of judicial proceedings for drug abuse (41 000) represents the number of convictions for 1993. The Swiss study also presents CHF 500 million as the total cost of repressive activities by the law and the police in 1991. Unfortunately, it is not possible to divide this between the two institutions. Finally, the police budget (1991 statistics) accounts for the costs of regional police forces and does not include traffic police.

**United Kingdom**

The total police budget for the UK (1998/99) is divided into GBP 7.15 billion for England and Wales, GBP 650.9 million for Scotland and GBP 535 million for Northern Ireland. There are 179 480 persons in the total police manpower in England and Wales (126 862 'officers' and 52 618 'civilians'); 19 235 for Scotland (14 788 'regular police officers' and 4 477 'support staff'); in Northern Ireland 11 757 (8 429 'officers' and 3 328 'civilians').

The number of 998 arrested persons for drug offences and the total number of arrested persons (26 062) do not give a clear picture of the situation in the UK because they cover only Northern Ireland. Data for England, Wales and Scotland are not available.

The justice budget for England and Wales is GBP 590 million for all justice courts (criminal and non criminal courts), GBP 300 million for the Prosecution Service and GBP 225.7 million for legal aid. In Scotland, GBP 28.8 million goes to justice courts, GBP 46.3 million for prosecutions (the Crown Office and the Procurator Fiscal Service), GBP 89.7 million for Legal Aid. In Northern Ireland, GBP 31.5 million is dedicated to justice courts, GBP 8 million to prosecutions and GBP 28.6 million for legal aid. There are 3 259 customs offences implying persons and companies.

There are 49 897 persons prosecuted in court for drug offences in Wales and England, 2 900 in Scotland, and 748 in Northern Ireland. There were 1 923 000 persons prosecuted in England and Wales, 175 457 in Scotland and 35 968 in Northern Ireland. The budget for custodial institutions is GBP 1.401 billion for England and Wales, GBP 183 million for Scotland and GBP 142 million for Northern Ireland.

In 1997 5 269 persons were imprisoned for drug offences in England and Wales, 1 011 in Scotland and 120 in Northern Ireland among the 43 055 prisoners in England and Wales, 13 150 in Scotland and 1 393 in Northern Ireland. The budget of all the agencies dedicated to drug treatment represents 13 % of a total amount of GBP 1.4 billion. 12 % of this sum goes to prevention and 13 % to actions at the international level.

## Outline of a method of calculating a 'drug budget'

It is possible, using Table 1, to calculate the drug budget of each country; that is national public

spending on drugs by adding the funds directly related to public activity on drugs, to the drug budget of major administrations (police, law, customs, health).

The spending directly allotted to combating drug use (in Table 1) can be used as the basis for calculating approximate values for the public expenditure of major administrations.

For police forces, we generally take the number of officers involved and the budget. It is then possible to calculate the hourly cost of a police officer. Subsequently, we can calculate the number of hours spent by the police officers on drug-related affairs to obtain the total spending of the police in terms of drugs.

Take as an example the French police force. Public security officers spend 70% of their time on penal matters and the remaining 30% on general matters. The penal matters can be divided into two equal parts: repressive activities and preventive activities.

Approximately 12% of violations concern drug laws. The amount of the police budget allocated to repressing drug trafficking and drug use can thus be estimated at 4% of the total. One study indicates that 3% of police officials' drug work involves prevention. The addition of funds allocated to specialised drug forces gives a total estimate for French police funding devoted to drug matters of ECU 186.74 million. Although these calculations are approximate, sources of error are similar from one country to another.

To use the relationship between drug law violations and all judicial infractions as a criterion for breaking down the work time of police officers rests on the hypothesis that the police treat drug issues and other crimes in an identical manner. In reality, although the frequency varies from country to country, the arrest of a person involved in drugs does not involve a hearing. This type of intervention is not accounted for.

Similar calculations provide an approximate total for judicial spending on drug matters. Knowing the hourly median cost of a magistrate, one can estimate the number of hours devoted to drugs. In total hours worked, one can distinguish those allotted to penal affairs; then those that concern violations of drug laws. Besides magistrates, one must also consider court clerks, and attribute to total drug spending part of the general expenses of the ministry, of judicial aid, expenses and controls.

The calculation of prison spending poses more complex problems, due to the high levels of expenditure involved. In theory, it should simply be a case of multiplying the annual cost of incarcerating one individual by the number of individuals incarcerated for violating drug laws, which would provide an estimate of total spending by the prison administration on drugs. Such a calculation, however, is biased as a number of prisoners are in prison for crimes other than drug law infractions. These crimes (robbery, prostitution, etc.) may be committed to procure drugs or under the influence of drugs. This raises the question of whether a part of the cost of detaining non-drug offenders should be linked to the drug budget. Existing studies generally decline to do this but the question remains open.

## Some results

The work of gathering and analysing the statistics for public drug spending is not finished. It is impossible to analyse definitively the allocation of State spending to a 'drug budget', following the method outlined above, without the cooperation of statisticians from the various EU countries. The lack of standardisation in criminal and public health statistics makes comparison and statistical re-analysis problematic, particularly without a thorough knowledge of the terrain described. The need for a European study on the comparison of 'drug budgets' is evident.

Such a comparison would allow clear measurement of the size of each country's effort against drugs in which public spending on drugs is assessed as a function of a GDP percentage or State budget. As an indication, it is interesting to present such a comparison for five countries.

The results, with the exception of those for France, have not been furnished by 1998 EMCDDA and Reitox data, but come from a range of diverse, earlier sources. These studies, using a related (though less detailed) method, permit comparison between France, the Netherlands and the UK, as well as Switzerland and the USA which, although they do not belong to the EU, are useful for comparison (see Table 2).

According to these statistics, the drug budget expressed as a percentage of GDP (gross domestic product), is very similar in the three European coun-

tries (1%), and substantially higher in the USA (1.6%). Expressed as a percentage of public spending, the proportion dedicated to drugs by the American public administrations (0.87% each) is much higher than that of France (0.29%), the Netherlands (0.32%) and the United Kingdom (0.34%).

The apportionment of the drug budget between repression and prevention/treatment differs between Europe and the USA. In Europe, the parts of the budget allotted to repression (between 70% and 80%) and prevention/treatment (20%) are quite stable despite marked political differences. However, the budget for repression (93%) is clearly greater in the United States than in Europe. It is still possible that prevention/treatment spending (7%) is underestimated due to the decentralisation of health care in the USA.

However, a distribution of budgets to repression versus prevention/treatment is inevitably cursory.

The prevention part is often underestimated since it is difficult to take into account the cost of general public prevention campaigns that reduce addiction, but are not explicitly anti-drug.

The repression part is probably overestimated since the greater degree of centralisation of enforcement administrations allows accurate accounting of expenses. Inversely, the decentralised character of treatment leads to underestimates. Generally, the greater the degree of centralisation, the easier it becomes to attribute budget money to a particular action, which is practically impossible when the action is decentralised among several agencies.

To distinguish repression and prevention/treatment in the presentation of drug budgets suggests that it would be possible to reattribute a part of the spending in favour of repression at the expense of care or prevention. However, a sizeable part of public spending cannot be reassigned. It is, for example, often impossible, in the short and medium term, to reduce national police spending at the expense of health (and the reverse holds true, as well), since such a reallocation would mean eliminating lines in one area to create them in another, which is administratively complex.

Experience has shown that when an effort is made in one part of the budget, it requires greater finance, but not tapping into another budget line.

## Table 2: Drug budget and public spending

| | France | Netherlands | UK | USA |
|---|---|---|---|---|
| All State expenditure (1), (2) | 233.522% | 80.520 | 233.829 | 1 273.954 |
| GDP (2) | 1 190.005 | 297.038 | 1 113.739 | 6 915.414 |
| State expenditure as % of GDP | 19.62% | 27.11% | 20.99% | 18.42% |
| Anti-drug expenditure (1) | 0.683 | 0.260 | 0.790 | 11.140 |
| Enforcement | 0.54 (80%) | 0.180 (70%) | 0.542 (68%) | 10.380 (93%) |
| Treatment, prevention | 0.14 (20%) | 0.080 (30%) | 0.248 (32%) | 0.760 (7%) |
| As % of GDP | 0.06% | 0.09% | 0.07% | 0.16% |
| As % of State expenditure | 0.29% | 0.32% | 0.34% | 0.87% |
| Population (3) | 58.15 | 15.45 | 58.26 | 263.17 |

(1) All figures are in billion ECU. ECU conversion based on average 1997 exchange rate for each national currency.
(2) Figures for 1996.
(3) Millions (figures for 1995).

Reinforcing a budget line supposes, in general, a rise in the global budget. In a context of meagre budgetary resources, it is very difficult to reattribute budgets among different agencies.

The redeployment of funds should be negotiated within the agency in question. Since budgetary expenses are more or less fixed, an increase in one drug programme is to the detriment of another programme. The idea that a political authority will modify the allocation of resources between sectors, depending on well-defined priorities, seems contrary to reality.

## References


Kopp P. and Palle C. 'Le coût de la politique publique de la drogue. Essai de mesure des dépenses des administrations d'Etat', OFDT, Paris, France, 1996.

Estermann J. 'Consommation et trafic de drogues: les coûts de la répression (estimation pour la Suisse 1991)'.

Kopp P. and Palle C. 'Le coût de la politique publique de la drogue. Essai de mesure des dépenses des administrations d'Etat' OFDT, Paris, France, 1996.

Kraan Dirk 'An economic view on Dutch drugs policy' in 'Between prohibition and legalization: the Dutch experiment on drug policy', eds E. Leuw; I. Haen Marshall 'Studies on crime and justice', Kugler Publications, Amsterdam, 1994, pp. 283-309.

'Tackling drugs together. A strategy for England 1995-1998' HMSO, May1995.

Estermann J. 'Consommation et trafic de drogues: les coûts de la répression (estimation pour la Suisse 1991)'.

Reuter Peter 'Setting priorities. Budget and program choices for drug control' in 'Toward a rational drug policy' , The University of Chicago Legal Forum, Vol 1994, 99, pp. 145-173.

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# Glossary

| Term | Definition |
|---|---|
| **Accession countries** | Central and east European countries (CEECs) currently preparing for accession to the EU (Hungary, Poland, Estonia, the Czech Republic, the Slovak Republic and Cyprus) |
| **ACP** | African, Caribbean and Pacific countries |
| **Autonomous communities** | Regional governments (Spain) |
| **Biomed research programme** | Biomedical/health research programme (DG XII of the European Commission) |
| **CAN** | Swedish Council for Information on Alcohol and other Drugs |
| **CEECs** | Central and east European countries |
| **CELAD** | Ad hoc political group of national drug coordinators set up in 1989 to assist the Council of the European Union. The group drew up the first two European action plans to combat drugs, adopted in 1990 and 1992 |
| **Chemical precursor** | Substance used in the conversion of licit substances into illicit drugs |
| **CND** | Commission on Narcotic Drugs: a United Nations committee established in 1946 and responsible for controlling implementation of international treaties in the drug field |
| **COST A6** | A programme run by the European Commission's Directorate-General XII (Science, Research and Development) to stimulate research into the impact of various drug policies and measures on the extent, nature and consequences of drug abuse |
| **Council of Europe** | Set up in 1949, the Council of Europe, based in Strasbourg, France, is an intergovernmental political organisation of some 40 European pluralist democracies. Although often confused with the European Union, the Council is a distinct organisation primarily concerned with strengthening political, social, legal and cultural cooperation and promoting human values throughout Europe |

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| **DATs** | Drug action teams (UK) |
| **Demand reduction** | Activities aimed at preventing drug use, assisting and treating drug users, reducing the harmful consequences of such use and promoting positive health |
| **Depenalisation** | The sanctions to be applied in case of an offence are administrative. The Criminal Code is not applied so that instead of a sentence of imprisonment the offender will be find or restricted in some rights (e.g. suspension of driving licence, suspension of passport) |
| **DIMS** | Drugs information monitoring system (NL) |
| **D.O.B.** | Dihydroxybenzoic acid<br>Formula — $C_7H_6O_4$ (amphetamine) |
| **Domestically produced drugs** | Home-made illicit drugs (frequently produced by consumers). 'Domestic' in law enforcement and street language, particularly in the United States, means produced within the Member State rather than imported |
| **Drug Experts Group** | A group of national experts on drugs, meeting within the Council of the European Union, now known as the Horizontal Drugs Group |
| **Drug tourism** | Phenomenon of people going from one country to another to buy and/or use drugs |
| **DSM IV** | Diagnostic statistical manual, fourth edition |
| **Dublin Group** | An informal body formed to coordinate international drug policy. It includes EU Member States, Australia, Canada, Japan, Norway and the United States |
| **EC** | European Commission |
| **EC focal point** | Interface of the European Commission with the EMCDDA Reitox network, currently the C/5 unit within the Secretariat-General |
| **EDF** | European Development Fund |
| **EDU** | Europol Drugs Unit |
| **EMEA** | European Agency for the Evaluation of Medicinal Products, a London-based EU agency |
| **Employment-Integra** | EU programme for social and professional reintegration |
| **ESPAD** | European school survey report on alcohol and other drug use among 15- to 16-year-olds |
| **EU action plan to combat drugs** | European Community programme outlining the main policy orientations in the field of drugs at EU level |
| **Europasi** | European addiction severity index |
| **Eurostat** | Statistical Office of the European Communities |
| **Falcone** | EU programme to reinforce cooperation to combat organised crime (including drug-related aspects) |
| **FATF** | Financial Action Task Force: created by the G7 industrialised nations to analyse the implications of money laundering for the international financial system |

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| **Fifth framework programme** | An overall EU framework programme which defines priorities of the EU research, development and technology programmes for a five-year period (1998-2002) |
| **Front-line agencies** | Bodies and agencies that deal directly with substance misusers |
| **G7** | Group of Seven industrialised nations |
| **GP** | General practitioner |
| **Grotius** | EU programme designed to develop training, exchange and work programmes for the criminal justice system, strengthening cooperation between the respective practitioners |
| **High-Level Group** | Group created by the Dublin Summit of December 1996 to draw up a comprehensive action plan containing specific recommendations to fight organised crime |
| **High-threshold services** | Services with high entry barriers requiring a high level of commitment on the part of the client |
| **Horizontal Drugs Group (HDG)** | A group of national experts on drugs, meeting within the Council of the European Union, formerly known as the Drug Experts Group |
| **IDA** | Interchange of data between administrations (EU programme to develop computerised information exchange) |
| **IMC** | In-patient Motivation Centre (NL) |
| **INCB** | International Narcotics Control Board established in 1961 to analyse and evaluate the legitimate demand for narcotic drugs, psychotropic substances and drug precursors |
| **JHA** | Justice and home affairs |
| **LAAM** | Levo-alpha acetyl methadol — a longer-acting alternative to methadone |
| **Legalisation** | Legal measure aimed at controlling a substance and its related market. With legalisation, the production process belongs to the authority, the State, that through laws and regulations may control production, cultivation, sale and consumption |
| **Leonardo da Vinci** | EU vocational training programme |
| **Liberalisation** | This is a term used to indicate the political approach of a drug policy or strategy; when it refers to a substance (e.g. liberalisation of soft drugs), this means that the drug will be available on the market and regulated by the economic law of supply and demand (often the term is improperly used meaning legalisation or depenalisation) |
| **Linha VIDA** | Telephone helpline in Portugal for the prevention of drug addiction |
| **Lomé Convention** | Convention between the EC and African, Caribbean and Pacific countries to support development efforts |
| **Low-threshold services** | Treatment facilities with easy access and reduced time delays (frequently part of harm-reduction strategies) |
| **MCPPAD** | Multi-country PHARE programme for the fight against drugs |
| **MCPTFCM** | Multi-country programme for transit facilitation and customs modernisation |

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| **Money laundering** | The conversion or transfer of money, assets and property derived from criminal activities to apparently legitimate status by disguising their origin through a variety of financial manoeuvres |
| **MS** | Member States of the European Union |
| **National focal points (NFPs)** | National expert monitoring centres forming the EMCDDA Reitox network |
| **NGOs** | Non-governmental organisations |
| **NIS** | New independent States |
| **North-South cooperation on drugs and drug addiction** | EU programme which funds actions in developing countries in the field of drug demand and drug supply reduction |
| **NSD** | New synthetic drugs; laboratory-made substances that are similar to controlled drugs, for example Ecstasy or amphetamines, but which are not controlled under the 1972 UN Convention on Psychotropic Substances |
| **NTORS** | National treatment outcome research study (UK) |
| **OECD** | Organisation for Economic Cooperation and Development |
| **OISIN** | EU programme to enhance cooperation between law enforcement authorities |
| **PCAPDD** | Programme of Community action on the prevention of drug dependence |
| **PHARE drugs programme** | EU programme established to help the CEECs integrate into the EU and to monitor the efforts of each candidate country in drug control |
| **Poly-drug use** | Concurrent or consecutive use of more than one illicit substance, alcohol and/or non-medical use of pharmaceuticals |
| **Pompidou Group** | An intergovernmental structure within the Council of Europe which aims to 'promote and support the establishment of national policies and programmes and the strengthening of international cooperation allowing a multidisciplinary approach to the problem of drug abuse and illicit trafficking in a pan-European context' |
| **Precursor control** | Measures to avoid diversion of precursor chemicals used in the preparation of illicit drugs |
| **R & D** | Research and development |
| **RDT** | Research, development and technology |
| **Reitox** | European information network on drugs and drug addiction (Réseau européen d'information sur les drogues et les toxicomanies) |
| **SCODA** | Standing Conference on Drug Abuse (UK) |
| **Social reintegration figures** | Rates for the successful rehabilitation of problem substance users — i.e. the extent of employment and home ownership following treatment |
| **Strasbourg Convention** | 1990 Council of Europe Convention on the laundering, search, seizure and confiscation of the proceeds from crime |
| **Supply reduction** | Strategies aimed at reducing availability of illicit drugs by targeting producers, importers and traffickers |

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| **TACIS programme** | EU cooperation programme with the new independent States of the former Soviet Union |
| **Third countries** | Non-EU countries |
| **Trafficking** | Transportation and bulk trading in illicit drugs, usually at international level, for the purpose of distribution or sale |
| **UNDCP** | United Nations Drug-Control Programme. In 1991 the three UN drug units — the Division of Narcotic Drugs (DND), the United Nations Foundation for Drug Abuse Control (Unfdac) and the INCB Secretariat — merged into a single drug-control programme responsible for coordinating all UN drug-control activities |
| **Ungass** | United Nations General Assembly Special Session (on drugs, New York, June 1998) |
| **Vienna Convention** | United Nations Convention against illicit traffic in narcotic drugs and psychotropic substances (1988) |
| **WCO** | World Customs Organisation |
| **WHO** | World Health Organisation (based in Geneva) |
| **WHO-Europe** | World Health Organisation regional office for Europe (based in Copenhagen) |
| **Youth for Europe** | EU programme for the promotion of general youth activities |

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