& Summary highlights

Established in Lisbon in 1994, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) gathers and disseminates information on:

- the demand for drugs and measures to reduce that demand;
- national and European Community strategies and policies;
- international cooperation and the geopolitics of the supply of drugs;
- control of trade in narcotic drugs, psychotropic substances and precursor chemicals;
- implications of the drugs phenomenon for producer, consumer and transit countries.

In line with the EMCDDA's initial priorities, this report concentrates on what is known about the extent and nature of the demand for drugs (epidemiology) in the European Union and measures to reduce that demand, respectively the subjects of **chapters 1 and 2** in **part I**. The context for demand reduction and other anti-drug measures in Europe is provided largely by the national and European strategies described in **part II**.

For this first report especially, it is important not just to deliver the end results of the EMCDDA's information collection programmes, but also to enable policymakers at national and European level to understand the infrastructure on which those results expert centres which process information from those sources.

Part III reports on information sources for epidemiology and demand reduction, and explores the degree to which the information held and systems developed by the EMCDDA's priority international partners can help meet the EMCDDA's objectives. **Part IV** describes the nature and capacities of the National Focal Points which support the European Information Network on Drugs and Drug Addiction, then goes beyond these to survey the drug documentation centres on which, in turn, many of the Focal Points depend.

Throughout it is emphasised that this first report reveals as much (or more) about what needs to be done to *improve* the information infrastructure (especially in terms of cross-national compatibility) as it does about the current fruits of that infrastructure. The EMCDDA and its key international partners, the National Focal Points, are embarked on a process that will not quickly or easily reach the objective of a drug information system fit to serve not just national, but also European needs. However, this first report delivers sufficient substantive information to justify the task and confirm the promise of the journey.

1 Prevalence & patterns of use

· The proportion of the general adult population who say they have tried an illegal drug typically ranges from about 5-8 per cent in several countries to 11-16 per cent in several others, but is higher (10 to 20 per cent) among younger adults.

· Much lower percentages admit drug use in the last 12 months. For cannabis this ranges from 1 to about 4-5 per cent, but 5 to 15 per cent in younger age groups.

· Cannabis continues to be the most common illegal drug throughout the European Union. The most common pattern of use is occasional or intermittent rather than frequent.

· Cocaine use is rare but there have been modest increases in prevalence in most countries. Typically, use is social and intermittent. Crack smoking has recently emerged as a significant problem among some urban marginalised groups.

· Typically about 1 per cent or less of the general population have tried heroin. However heroin-related problems are the most prominent of all the drugs. The total number of heroin addicts in the EU could be between 500,000 and one million.

· Since the late '80s amphetamines, ecstasy and sometimes LSD, have become more popular among young people. By age 18 to 20, in some countries 3-4 per cent and in others 9-10 per cent of young adults have tried amphetamines and similar proportions have tried ecstasy and LSD.

PART I

Demand & demand reduction

related deaths in the last half of the 1980s and in some the total may now again be increasing.

· Increased misuse of medicines and problems arising from drug combinations are reported but generally the main problem drug for new treatment clients is heroin; amphetamines are important in northern Europe.

· Average ages of new treatment clients are between the early 20s and early 30s and two-thirds or more are men.

· There are extreme differences in drug-related HIV and AIDS rates among drug injectors. The rate of new HIV infections has been falling but the behaviours that transmit HIV continue to be practised.

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· Since the 1980s most countries have witnessed rising totals for offences against the drug laws; drug users often form 30-40 per cent of the prison population.

Demand reduction

· Most EU Member States have increased their investment in demand reduction and all agree that demand reduction is a multidisciplinary, community responsibility. This philosophy is matched by the predominance of decentralised initiatives.

· Preventing drug use is a universal priority. Common across the EU are approaches which focus on the factors which lead to drugtaking or protect young people from drug use, moving the emphasis from drugs to wider family and social

- School programmes are the most widespread form of primary prevention in Europe and often a legally required component of secondary education.

- Primary prevention seems most effective when it starts early and continues seamlessly through to secondary school. Addressing young people's attitudes to drugs and to themselves appears to improve outcomes. Experts favour programmes dealing with illegal drugs in the context of legally available substances and general health promotion.

- Mass media campaigns raise awareness but do not of themselves cause behaviour change or significant shifts in attitude. Member States which conduct mass media campaigns often aim to raise awareness or transmit information.

- The classical treatment chain has given way to much more flexible and differentiated services. Treatment now includes a comprehensive range of community-based care services which may aim to help drug users give up drugs and maintain abstinence and/or to reduce the risks of drug misuse.

- Therapeutic communities are more common in southern European countries than in the north. Programmes have moved towards shorter stays, greater professionalism, individualised therapy, and preparing residents for life after treatment.

- There are few consistent studies on treatment impact. Completing the programme is the most stable prognostic factor; the longer abstinence has been maintained, the more likely it is to continue.

- Preventing (further) damage among those who use drugs features in many national policies. Typically the focus is on reducing health risks, especially the risk of contracting HIV and other infections, and encouraging early entry into treatment.

- Though long-term methadone prescribing is available in all EU Member States, its scale, the entry criteria for patients, and the degree of official regulation, all differ widely. In several states such prescribing has recently expanded rapidly.

- Lack of knowledge and confidence often impedes the involvement of generic professionals in drug prevention or treatment, depriving drug users of the range of general health and welfare services available to the rest of the population. This is partly a symptom of the need to develop professional training programmes in all Member States.

PART II

Anti-drug strategies

3 National strategies

- National drug strategies in the EU typically aim to maintain a balance between policies to reduce the demand for drugs and those

- The fundamental administrative tasks are to create structures capable of coordinating the policies of national ministries, and co-ordinating the national administration with

- National policies are increasingly defined by supranational policies or by a nation's obligations under United Nations conventions. Nevertheless, drug laws vary considerably across the EU Member States.

- Drug use is always indirectly prevented by prohibiting possession but less than half the EU Member States prohibit it directly. Some states punish possession for personal use only by administrative sanctions.
- Studying national strategies and laws in the context of the European Union can help nations understand how other EU Member States organise their strategies and widen perspectives on the policy options available.

4 Action taken by the European Union

- Since 1987 the European Community as such has been a party to international action against drugs.

- Arguments that the new Single Market demanded a high level of coordination led to the development of European Action Plans on Drugs. To underpin these it was considered essential to set up a European drugs information centre.

- Entry into force of the Treaty on European Union in 1993 offered the potential for a fully integrated approach, resulting in a new plan for 1995-1999.

- The two major ways for the European Union to deal with drugs are firstly in policy areas where Community institutions are empowered to represent Member States, and secondly by cooperation between Member States. The first includes public health, money laundering, and diversion of precursor chemicals, the second foreign and security policy and justice and home affairs.

- In 1995 the EU spent 27.9 million ECUs on anti-drugs action, about half within the European Union and half outside.

- Both European Council meetings in 1995 addressed the drugs issue, confirming its high profile. Steps taken that year significantly advanced coordination and cooperation among enforcement officials and placed drugs on the agendas of the international events in which the Community participated.

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5 Epidemiology

- Epidemiological information of sufficient quality and relevance enables policymakers to monitor the impact of their interventions, identify unmet needs and of options for responding to those needs, and allocate resources accordingly.

- As applied to illicit drug use, epidemiology is a relatively young science; assessing drug abuse at European level adds a further layer of complexity as data needs to be

- The data most used to assess drug use are records of demand for treatment, drug-related deaths, arrests and drug seizures, and household and school surveys.

- Surveys are the main tool to assess the extent of drug use in the general population. The most common regular surveys sample the general population and schoolchildren, but differing methodologies in Member States mean data is not comparable.

- Assessing the prevalence of heavier, more problematic, and less common patterns of drug use usually entails alternative methods to study hidden populations.
- Repeated studies or surveys are valuable ways to track trends over time. Such trends can also be tracked by various indirect indicators based on routine statistics from welfare or enforcement services.

- Improvements are seen in the quality of data based on drug-related services or cases, such as treatment or morbidity; surveys are generally of good quality but results cannot easily be pooled or compared and they tend not to be regularly repeated, reducing their utility as a means of monitoring trends.

- Data based on hospital admissions is frequently available. Of the diseases related to drug use, information on AIDS is most complete. Diverse definitions and criteria are used for collecting data on drug-related deaths.

- Law enforcement data is available in most Member States as part of the relevant overall data collection system; differences comparability.

- Data compatibility between EU countries is very limited but a few nuclei can be identified which could be used as a focus around which to extend compatibility, both in terms of indicators and in terms of Member States.

- The process of exploring similarities and differences in meanings in different nations could move on to agreeing where compatibility can be improved within the limitations of different policies, laws, and treatment systems.

- The next step would be the selection of common definitions and classifications, and the development of protocols similar to the Pompidou Group's treatment demand protocol.

6 Demand reduction

- Constructing an overview is hindered by the lack of consensus on what 'demand reduction' is. Boundaries between primary prevention, secondary prevention and treatment are unclear and variously drawn. This terminology itself is not universally accepted. A priority task for the Monitoring Centre is to overcome these obstacles.

- Information on demand reduction programmes is difficult to access. Many involve disparate authorities and organisations and are localised rather than organised according to a national agenda, reducing the incentive to maintain adequate national documentation.

- School programmes appear to be the best

PART III
Information sources

prevention. Only for these and for general prevention programmes do more than ten Member States claim to have centralised data. Otherwise in no more than six countries is information said to be centralised at the country's Focal Point.

- Information on treatment programmes was said to be available in just five Member States, but this low figure may reflect confusion over the category. Nine Member States have information on harm reduction programmes.

- Most Member States either have access to one or more databases on demand reduction programmes or are developing one. Systematic application of quality criteria before adding information to databases appears uncommon, but some Member States are moving to rectify this situation.

- The technology via which information reaches Focal Points is relatively rudimentary. Most receive most types of information only on paper.

- There are few reliable evaluations of the impact of demand reduction programmes. Programme planners and funders must be encouraged to incorporate evaluation.

- Rarely is information from different programmes or countries presented in a common format which would enable comparison between approaches.

- Improving information collection requires upgraded information transmission systems and comparability requires a consensus over language.

7 Exchange between national and international levels

- The six priority international partners for the EMCDDA are the UNDCP, the Pompidou Group, WHO, Interpol, Europol, and the World Customs Organisation.
- Among these are to be found some of the world's most extensive and technologically advanced information systems on aspects of drug misuse which could provide key foci around which to improve the quality and comparability of epidemiological information in the European Union.

- However, data collection and analysis systems differ widely and the interfaces between them are underdeveloped, impeding the extent to which they can be integrated into a comprehensive European picture.

- In part this is due to the organisations' differing remits, most confining themselves to illegal drugs but others treating these in the context of substance use in general and health.

- Rather than creating yet another system for collecting national reports, the EMCDDA might best contribute by helping to strengthen and unify Member States' participation in existing international systems.

8 National Focal Points

· Focal Points are key information collection and exchange points in the European Information Network on Drugs and Drug Addiction (REITOX), the network which supports the work of the EMCDDA.

· Focal Points are almost all expert centres in their own right. As Focal Points, they are all still developing structures and functions to suit emerging needs.

· However, there is consensus that being a Focal Point means coordinating their own national information networks to meet the EMCDDA's requirements for a core set of data, annual national reports on drugs, and a national information network.

· National networks to support the Focal Points are varied and in different stages of development. Most rely on a few key partners.

· Focal Points outside national administrations and/or which receive data mainly in aggregated form have less scope to influence the quality, presentation and cross-national compatibility of the information they handle.

· National Focal Points can add value to European drugs initiatives by helping to upgrade the cross-EU compatibility and comparability of information, harmonising the collection, storage, processing and dissemination of data.

· Arguably, Focal Points are now at the stage the EMCDDA agree on their roles and responsibilities and how they should be supported by European and national funding.

9 Documentation centres

· Each nation of the European Union has at least the beginnings of a drug specialist documentation centre.

· There are wide differences in their nature, size and coverage. Some countries have large, well-established services but several are at the initial stages.

· Together their coverage of the subject is sufficient to provide for a comprehensive European documentation service on drugs and drug addiction.

· Electronic access to information is limited to a minority of Member States.

· Resourcing and levels of communication technology, professionalism and standardisation are currently below that needed to create and sustain an effective European documentation network.

· Initiatives at European level could free resources by reducing overlap and improve services by encouraging standardisation and the networking of documentation centres across the European Union.

· The EMCDDA could act as a European clearing house for information on research programmes and initiatives on drugs, in partnership with the European

PART IV
Information structures

networks and centres.