EUROPEAN

MONITORING

CENTRE

Annual Report on the State of the Drugs Problem in the European Union

FOR DRUGS

AND DRUG

ADDICTION

1997

SUMMARY & HIGHLIGHT

A great deal of additional information on the European Union is available on the Internet. It can be accessed through the Europa server – **http://europa.eu.int** • Information on the EMCDDA can be accessed at its web site – **http://www.emcdda.org**

This summary is also available in Danish, Dutch, Finnish, French, German, Greek, Italian, Portuguese, Spanish and Swedish.

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

The *Annual Report on the State of the Drugs Problem in the European Union 1997* is important not just for what it says about drug problems in Europe (summarised in this document), but also for its revelation of major advances in our *ability to make* such statements. Increasingly the nations of Europe speak the same language on drugs and drug policy – a prerequisite for profiting from each others' experiences and cooperating to safeguard Europe's populations. In this process the EMCDDA can claim a major role as instigator and midwife. The fruits of these advances are seen in the enhanced policy relevance of this year's report, most obviously where it branched into new areas:

- A new chapter (chapter 3) on abuse of drugs such as ecstasy shows how systems and networks have developed to the point where information can rapidly be disseminated in response to an emerging concern – and how important this is when drug use itself disseminates with alarming rapidity.
- Last year's discussion of the relation between the EMCDDA and its international partners is supplemented (in chapter 6) by a practical demonstration of those relations in action, providing the perspectives and the data to define Europe's place in international drug trafficking patterns.
- This year's analysis of demand reduction activities (chapter 2) broke new ground through a special study of interventions in Europe's criminal justice systems, giving Member States pointers to where they can learn from each other in this key sector.
- Last year we admitted that funding was a major gap in our knowledge of national strategies. It remains so, but now the new section in chapter 4 clearly defines the gap, analyses the issues involved in filling it, and draws on new data from the EU and elsewhere which shows the way forward.
- Chapter 1 now documents the worrying extent of hepatitis (especially hepatitis C) infection among injecting drug users, and data has improved to the extent that we can present meaningful figures on problem drug use – key inputs for Europe's policymakers and planners.

Other advances will be less apparent but still solidify the platform for policy making at national and EU level. These are just a few examples:

- For chapter 1 new surveys have enabled us to cover more drugs and to document the extent of relatively *current* drug use in the general population, a major advance in policy-relevant information.
- An EMCDDA study of the language of demand reduction sharpened the categories in this sector and led (in chapter 2) to a more

diversified description and analysis of such activities.

In chapter 4 we see clear evidence of a spiralling process where increased scope for meaningful debate between EU nations produces benefits which encourage more of the same. Information from the EMCDDA (and the Europol Drugs Unit) was commended as "particularly helpful" by the Conference on Drugs Policy in Europe held in 1995–96 and by the subsequent European summits. Such events stimulate national developments which in turn improve the information available to the EMCDDA.

Last year I said the results presented in our first report justified the efforts required. That is even more so for this report. Investing relatively small sums in comparability improvements clearly has the ability to maximise the targeting, effectiveness and quality of national anti-drug expenditures. It is also clear that achieving this benefit demands deepened cooperation between data providers and those charged with producing EU-level information for policy makers. At the heart of this system is the EMCDDA's REITOX network and its focal points in each Member State. Focal points must have the resources and the freedom to work with their data providers on the one hand and with the EMCDDA on the other to create the scope for even more useful analyses. Progress entails being in a position to adopt common standards for best practice from wherever these derive, even if this means amending national data collections systems.

A companion technical report based on this year's findings is being disseminated to Europe's leaders, administrators and experts in the drug information field. As empowered under the EMCDDA's founding regulation, in that report we will make our recommendations with the force justified by the ultimate aim – to safeguard Europe's people, and especially our children, from the risks of drug misuse.

But there is one very basic objective, to which the coming millennium attaches an obvious time scale: by the year 2000, to have promoted a survey of the extent and nature of drug use across the European Union, with each country adopting compatible methodologies to enable us to define the scale of the problem with unprecedented confidence. The Treaty on European Union created the necessary framework for taking this decisive step forward. If we enter the new era without having grasped this opportunity, we will have failed even to approach the sophistication our people deserve.

I hope you find this summary useful, will be stimulated to obtain the full report, and will support our work for those affected by drug problems in Europe.

Georges Estievenart
DIRECTOR, EMCDDA

Established in Lisbon in 1994, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a European Community information agency charged by its founding regulation to provide "objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences". It 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.

The Centre's *Annual Report on the State of the Drugs Problem in the European Union* (this publication is a summary of the 1997 report) is its main information dissemination vehicle. Much of the data for the report derives directly or indirectly from the EMCDDA's partners in the national focal points of the 15 Member States and in the European Commission, or from the EMCDDA's six priority international partners. The core problem with which the EMCDDA and its partners grapple is ensuring the availability and comparability of information from varied national data collection systems embedded in divergent cultures and administrative structures. A simple example is that cannabis arrests in a country which generally deals with cannabis through non-penal measures may be far fewer than in a country which strictly enforces its prohibition, yet cannabis use may be higher.

The ultimate objective is to provide policymakers and others with an information base from which they can compare the effectiveness of policies and practices; as noted in this report and acknowledged in other EU documents, progress this year has been clear and decisive. This summary presents essential background information and highlights from a report of over 140 pages in length. Copies of the full report are easily available in each Member State – see back page.

Annual Report on the State of the Drugs Problem in the European Union • 1997

The report's major contents are listed below. Chapters 1–6 are summarised in this boooklet.

Chapter 1 Prevalence & patterns of use

- In many countries epidemiological research on illegal drug use is a developing science and information is inadequate. At European level national differences render data from one nation incompatible with seemingly similar data from another nation. However, converging conclusions from several sources permit some general observations to be made.
- In many countries there appears to be increasing use of 'new' drugs such as ecstasy and, in some countries, crack cocaine, as well as of more familiar drugs such as powdered cocaine, cannabis and amphetamines.
- In general, only a small minority of people who have tried a drug have done so recently or repeatedly, yet 'ever used' figures are often the only ones available. Policy responses based on these figures alone risk over-reaction.
- In most EU Member States heroin dominates indicators which reflect various problematic consequences of drug use, such as the demand for treatment, drug-related deaths and HIV infection. Combinations of drugs, including medicines and alcohol, play a continuing and increasingly important part in problems associated with illegal drugs.

• Extent of use •

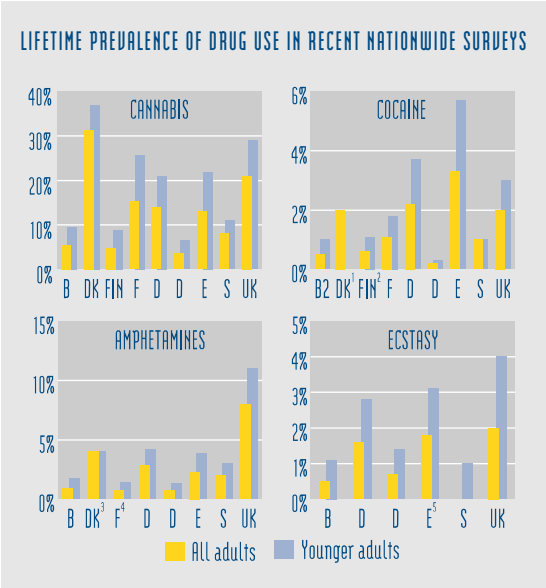
- Throughout the European Union cannabis is the most commonly used illegal drug; depending on the country, from 5–8% to 20–30% of the population have at least tried the drug. However, use is

commonly occasional or intermittent rather than frequent and the drug rarely appears as the primary drug in health and social care indicators.

▶ European populations usually have less experience of heroin than of almost any other drug. Typically under 1% of the general adult population have ever tried the drug, but among younger adults in major cities heroin addiction can be much more prevalent than the national average. Heroin remains a major threat to public health and public safety.

All charts:
B = Belgium, Flemish speaking regions only;
D = Denmark
FIN = Finland
F = France
D (1st) = W. Germany
D (2nd) = E. Germany.
E = Spain
S = Sweden
UK = United Kingdom
Age ranges and dates vary between countries.

1. Younger adults unavailable.
2. 'Hard drugs'.
3. 'Hard drugs'; results for younger adults from a different survey than for all adults and for other drugs.
4. Amphetamines and ecstasy.
5. 'Designer drugs'.



▶ More people may have tried cocaine than have tried heroin, ranging from 1 to 4% of the general population. Users tend to be socially integrated young adults who use intermittently, but cocaine also has more marginalised adherents; heroin addicts who also take cocaine have a profile typical of most heroin addicts.

▶ Crack smoking has been reported in several countries in groups similar to heroin users and in other marginalised groups, but it remains a limited phenomenon.

▶ In most countries amphetamines are the second most frequently used illegal drug, generally tried by up to 3% of adults. From the late '80s many countries reported that amphetamines, ecstasy and in some cases LSD had become more popular among young people, linked to a youth culture based around discotheques and large 'house' parties (more in chapter 3).

▶ Among young adolescents prevalence of solvent misuse may be higher than of any other drug apart from cannabis.

• Indicators of drug problems •

▶ In most countries opiates (heroin mainly) are reported most often as the primary substances used by problem drug users; however most of these opiate users also use other drugs, especially cocaine ('polydrug use'). Some countries in northern Europe have significant numbers of amphetamine injectors, who tend not to use opiates; in a few countries these form the majority of problem drug users.

▶ Although there are exceptions, capital cities tend to have problem use rates higher than those of provincial cities and also higher than the national rate.

▶ Between EU nations, monitoring methods and definitions still differ to such an extent that variations in reported rates of problem drug use are difficult to attribute to real differences in prevalence.

▶ In almost all countries, heroin is the main drug (generally 70–95%) among clients starting treatment; the proportion who inject ranges from 14% to around 90%, generally lower than the figures reported last year. In some countries amphetamines are also important. In general, cocaine remains relatively rare as the main problem drug.

▶ Treatment clients tend to be aged between their early 20s and early 30s; 70–85% are men.

▶ Injection seems to be less common among younger drug users and probably also among those who started drug use most recently. Compared to existing clients, a higher proportion of new clients (who tend to be younger) have problems involving cocaine and/or cannabis and fewer (but still the majority) have problems with opiates.

▶ Addicted heroin injectors face a risk of death which may be 20 or 30 times higher than in the general population of the same age. Other forms of drug use pose a far lower risk. Many EU countries witnessed a marked rise in drug-related deaths in the second half of the '80s and the early '90s. Since then trends have diverged with continuing increases in some countries and decreases and/or or stabilisation in others.

▶ Sharing contaminated injecting equipment and sexual contact are the main transmission routes for HIV and hepatitis. In many countries injectors have reduced their sharing of injecting equipment. This and other infection control measures appear to have impacted on HIV transmission (in most countries, the prevalence of HIV infection is stable or decreasing) but not on hepatitis C. Generally, the rate of new cases of AIDS is decreasing.

▶ Hepatitis C is estimated to be 50 to 100 times more infectious than HIV and can lead to chronic hepatitis and extensive liver damage and/or cancer.

The potential burden on society is comparable to that of the recent HIV epidemic.

▶ There may be half a million drug users infected with hepatitis C in the European Union. Prevalences of hepatitis C in injecting drug users are substantially higher than for hepatitis B, even in countries with a low prevalence of hepatitis B and/or HIV infection. The high rates imply that the risk behaviours which transmit viruses such as HIV are continuing, if at a lower rate.

▶ Since the '80s all but a few countries have reported increasing numbers of drug offences; in some, cannabis accounts for the large majority; in others, it is heroin. Everywhere the proportion of offences involving cocaine is low. Drug users constitute a significant proportion of the prison population in several, probably many, countries.

• Drug availability and supply •

▶ Drug seizures by law enforcement agencies are thought indirectly to reflect drug supply and availability and therefore, possibly, drug consumption. However, the link is complicated because seizures are also heavily affected by other factors.

▶ The number of ecstasy seizures is increasing in all countries. In many northern countries these remain well below those for amphetamines; in others the situation is the reverse.

▶ The price and purity of drugs on the illicit market is not always reported and available data is of unknown reliability. In general, retail prices of cannabis are stable or slightly increasing, and for heroin and cocaine are either stable or falling. All other things being equal, stable or falling prices imply that supply is *not* being reduced relative to demand.

Chapter 2 Demand reduction

▶ Drug demand reduction interventions aim to decrease the demand for drugs or reduce the harmful consequences of drug use at an individual or collective level; they range from work with the very young to prevent the onset of demand for drugs to substitution programmes which prescribe drugs to addicts. Prevention, outreach, treatment, rehabilitation and harm reduction are all included.

▶ Major dimensions along which such activities may be categorised are:

- **basic strategy**, such as whether the aim is to avoid the onset of drug demand or to help drug users reduce an existing drug demand;
- **objectives**, eg, abstinence or controlled use;
- **target groups**, often defined by their degree of known involvement with drugs;
- **type of drug**; some programmes aim to affect use of all licit and illicit substances, others target specific substances;
- **setting;** where the intervention takes place.

▶ Health, social, educational and criminal justice systems, and voluntary organisations, are implementing a broad range of demand reduction activities, with different approaches according to the accessibility and lifestyles of the target populations.

▶ At national level responsibility for demand reduction is commonly placed in ministries of health, the interior, education, justice, and defence. They disseminate guidelines and methodologies for local implementation, initiate certain activities and help coordinate local activities. Many EU countries have new or revised anti-drug policies and have increased funding for demand reduction.

▶ In all countries vocational and continuing training in addiction has become more available.

▶ Despite growing demand for evaluations of demand reduction activities, research is inadequate.

• Prevention •

▶ Previously prevention featured fear arousal, punishment and prohibition; now the emphasis is less on dysfunction and deficiency, more on empowerment and strengthening.

▶ A major trend is the increasing professionalisation of prevention workers due to increases in the amount of specialised training and posts.

▶ Prevention is thought most effective when organised close to its targets. The overwhelming majority of demand reduction work is locally based, focused on units such as the neighbourhood, the family, schools or local associations.

▶ While potentially effective, sustained and comprehensive community programmes are highly demanding due to the range of people and organisations which must be reached and involved.

▶ School programmes are at the heart of prevention in all EU countries.

• Help for drug users •

▶ Expansion, diversification and increasing differentiation characterise developments in helping services across Europe. Drug services tend to cater more for individual needs and increasingly cooperate with health, social and criminal justice systems. In several countries, treatment systems are being reorganised to improve responsiveness to emerging needs.

▶ Community-based outreach services set out to reach and maintain contact with high-risk groups in their own settings; many operate a peer-to-peer approach relying on (ex-) drug users. Low threshold services help the most deprived addicts with daily survival, preventing further deterioration.

▶ Harm reduction approaches have expanded due to fears over HIV infection and public concern about the growing drug problem; such approaches have reduced HIV spread in many countries.

▶ Substitution treatment is available in all EU countries, but to a widely varying degree. In recent years most countries have expanded methadone treatment. Eventual abstinence is usually the goal but treatment may be designed to continue indefinitely.

▶ Non-residential programmes aims to improve the quality of life of substance users and safeguard their health while if possible motivating them to seek addiction treatment. Residential facilities range from detoxification to comprehensive therapy programmes and may also include services for women or special groups such as very young drug users or parents with children.

▶ Treatment and rehabilitation programmes generally attempt to (re)integrate problem drug users into society (housing, work, etc) – the process of 'normalisation'.

▶ Aftercare to reinsert ex-drug users into social networks and employment constitute the last phase of long-term treatment, offering job training, halfway housing, family care, etc.

▶ Significantly more drug users may have contact with the criminal justice system than with treatment services. Demand reduction interventions in this system commonly involve criminal justice agencies referring drug users to health and social services.

A SCENE FROM THE EARLY DAYS OF THE RAVE SCENE – THE YOUTH DANCE CULTURE NOW CLOSELY ASSOCIATED WITH NEW TRENDS IN USE OF SYNTHETIC DRUGS

CHAPTER 4 NEW TRENDS IN SYNTHETIC DRUGS

▶ In some EU countries unprecedented numbers of increasingly young Europeans have adopted the use of synthetic drugs such as ecstasy, LSD and amphetamines in the context of a mass youth culture variously described by the terms 'rave', 'techno' or, more generically, 'dance'.

▶ The ease with which synthetic drug use transcends national boundaries and the common cultural context of dance music mean that much can be gained by sharing experiences.

▶ Ecstasy and amphetamines share stimulant effects while LSD's effects are primarily emotional and perceptual. The effects of all three share an affinity with the energetic, mind-altering context of all-night, rave-type dance events.

▶ The numbers who have tried these drugs and the frequency of their use have increased since the advent of rave culture in the late '80s but they remain a small minority; usually well below 10% of all young people have tried them and regular use is uncommon. Generally fewer people have tried ecstasy than LSD and amphetamines, but recent ecstasy use often exceeds that of the other two drugs.

▶ Users are not concentrated among the marginalised or deprived, but are mostly young, employed or students, and relatively affluent.

▶ Fatalities and less dramatic harm from amphetamines, ecstasy or LSD seem relatively rare. Annual recorded national death totals for each drug are often zero and rarely exceed 10. However, the context of some deaths – 'normal' young people enjoying a night out – heightens their impact, and problems may be hidden by the inadequacy of the data or develop if use patterns become chronic.

▶ Adverse physical effects of amphetamines and ecstasy are largely related to their stimulant properties, which can stress the circulatory and other systems, and to their use during prolonged bouts of energetic dancing in hot venues, which can lead to heatstroke. LSD's physical effects are relatively mild. Lasting neural impairment has yet to be demonstrated in human beings though animal experiments suggest this could arise from ecstasy use.

▶ Stimulant-induced anxiety and paranoia followed by depression can occur with amphetamines and ecstasy, and LSD can cause distressing but usually temporary symptoms similar to psychosis. Though rarely seen, heavy amphetamine use can cause a transient drug-induced psychotic episode. Whether these drugs can cause lasting psychosis is debatable.

▶ Dependent patterns of use are not uncommon with amphetamines, but usually not in the context

of use at dance events. Dependence is not a recognised feature of LSD or ecstasy use. Social and health problems can arise from excessive or particularly ill-advised use; impaired driving has received increasing attention. Criminalisation of otherwise socially integrated youngsters is also a concern.

▶ A wide range of localities, municipalities and national bodies have recognised the importance of harm reduction strategies. These have usually been instigated by non-governmental bodies rather than by official drug services. Often they seek to persuade club owners and event organisers to provide safety features such as improved ventilation, drinking water and first aid. Increasingly clubs are taking on these responsibilities.

▶ Prevention tactics often involve adopting the language and images of rave culture and using this culture as a means to promote drug-free events or safer drug use. Peer education and projects initiated from within the dance scene are important contributors.

▶ The widespread but illegal nature of drug use at many dance events means authorities oscillate between repression and the pragmatic view that on occasions this might cause more harm than good, eg, by encouraging illegal events at remote venues.

▶ Synthetic drug use is poorly understood compared to opiate use or the problems of drug injection. There is a need for studies both of patterns of use and of the consequences, including those which follow up users to monitor possible harmful effects.

Chapter 4 National strategies

▶ National drug policies emerged in EU Member States as drug use increased, demanding a nationally coordinated interdepartmental response. Key tasks are to balance supply and demand reduction and to achieve coordination across national bodies and between national and more local levels.

▶ The major provisions of national laws are increasingly confined by supranational policies deriving from the UN and the European Community; differences relate mainly to the severity of punishments, how major provisions are implemented, and enforcement practices.

▶ European nations generally recognise addiction as an illness but the extent to which this perception pervades penal policy and practice differs.

▶ Although coordination structures and drug laws changed little in 1996, analysis reveals some important policy trends. Radical change is not on the mainstream political agenda, but in most European Union countries drug policies are under review in response to:

- EU-level analyses of drug policy divergences and convergences between Member States;
- participation of a wider range of people and viewpoints due to decentralisation and increasing community involvement;
- increasingly sound and comparable information enabling a degree of scientific evaluation of policies, in turn encouraging a less ideological and more pragmatic perspective.

▶ New decentralising measures place a premium on coordination; where this fails to keep pace, intranational policy divergence is apparent.

▶ Despite its policy importance, no EU nation can claim a comprehensive and reliable accounting of its anti-drug expenditures or the costs imposed by drug misuse. Core problems are defining boundaries and accounting for subnational expenditure.

▶ A relatively small drug budget does not necessarily mean less, or less effective, social action against drug problems. For example, a more relaxed (and less expensive) legal approach can foster social action, and some anti-drug measures can aggravate problems arising from the drug use that they fail to prevent.

▶ Because it is more centralised, spending on supply reduction is more easily accounted for, so may seem larger relative to demand reduction than is actually the case.

▶ Though it may seem attractive to move resources between demand and supply reduction, in practice, when resources on both sides are stretched, required increases are made by raising the global budget or reallocating within sectors.

▶ A critical issue in assessing the costs imposed on society by drug use is placing a monetary value on human life. However, such an accounting is needed to gain a perspective on the appropriate level and mix of investments devoted to curbing these costs.

"THE ULTIMATE AIM ... TO SAFEGUARD EUROPE'S PEOPLE, ESPECIALLY OUR CHILDREN, FROM THE RISKS OF DRUG MISUSE."
Georges Estievenart

Chapter 5 Action taken by the European Union

- Joint European action against drugs dates back at least to 1972 and accelerated in the '90s when the European Council adopted three European Action Plans on drugs, the last strengthened by the increased scope for cooperation within the Treaty on European Union.
- In 1996 the high profile of the drugs problem was confirmed when both European Council meetings addressed the issue in depth, underlining the importance of an integrated approach.
- Within a stable institutional, organisational, legal and political framework, EU action progressed rapidly, especially in the second half of 1996 with the adoption of nine joint actions or common positions and five resolutions relating to home affairs and justice cooperation. The co-decision procedure between Parliament and the Council of Ministers produced three important public health decisions, including the Community Action Programme on the Prevention of Drug Dependence, supported by a budget of 27m ECUs over five years.
- Anti-money laundering measures continued to be seen as crucial. Progress was made on implementing the anti-laundering directive and Parliament called for the legislation to be extended.
- Available information was greatly enhanced when the EMCDDA and the Europol Drugs Unit both produced their first annual reports. Information agencies were increasingly called upon to provide the European Council and Parliament with reliable information on aspects of the problem.
- Action in 1996 was marked by an increasing concern with synthetic drugs and with mechanisms to enable rapid updating of information about their spread, the resulting problems and responses to these problems.
- In 1996 the global spend on action against drugs more than doubled to over 61m ECUs. Nearly all budget lines at least maintained last year's levels and most increased.
- Where last year's funding was evenly split between internal and external programmes, in 1996 75% was allocated for external action, representing a tripling of the external budget. There was a decisive increase in internal funding for monitoring and demand reduction.
- Helping Latin American countries eradicate illicit drug production and trafficking is a foreign policy priority for the EU. In 1996 political dialogue with the region was enriched and a new budget line allocated 30m ECUs to Bolivia for crop eradication and substitution programmes.

ACROSS THE TOP OF THE PAGE, THE SYMBOLS (EXCEPT UNDCP) OF THE EMCDDA'S SIX PRIORITY INTERNATIONAL PARTNERS

Chapter 6 The international environment

- Since the beginning of this century nations have set up international instruments binding them to adapt their own national policies and laws relating to drug misuse in order to create a common legal approach, combating an international phenomenon with international measures.
- The current international legal framework mainly derives from three major United Nations drug control treaties: the Single Convention on Narcotic Drugs of 1961 (amended in 1972); the Convention on Psychotropic Substances of 1971; and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.
- The core objective of the first two of these treaties was to confine use of listed drugs to approved medical and scientific purposes. The third sought to strengthen international cooperation to combat illicit trafficking. All 15 EU nations have ratified the first two of the conventions and all plus the European Community itself have at least signed the third.
- The need for international cooperation in information provision was recognised by the European Community when it stipulated six priority international partners for the EMCDDA: the United Nations International Drug Control Programme (UNDCP); the World Health Organisation (WHO); the International Criminal Police Organisation (ICPO or Interpol); the European Police Office (Europol); the Pompidou Group of the Council of Europe; and the World Customs Organisation (WCO). A synthesis of their latest reports provides a perspective on Europe's position in global illegal drug markets.
- EU Members States are primarily recipients of drugs. However, most are also transit countries, some are now significant producers of synthetic drugs, and a few act as secondary distribution points.
- Highly developed international trade and transportation systems combined with geographical,

cultural, historic and economic factors affect the role of individual Member States as entry points and transit routes. Large seaports in Germany, the Netherlands, the UK and Belgium make these countries vulnerable to the smuggling of major consignments in legitimate container-transported freight. Linguistic and historic ties influence the role of Spain and Portugal as entry points for South American cocaine.

- The vast majority of heroin seized in the EU originates from South West Asia before being transported mainly by lorries starting in Turkey and traversing neighbouring Balkan states. The creation of depots in Central and Eastern European countries has led to a shift to a two-stage smuggling pattern with lorries transferring their loads to private cars at these depots for delivery mainly to Turkish networks in EU Member States.
- The proliferation of road frontier crossing points, diversification of trafficking gangs and networks, the use of air transport and the increasing involvement of traffickers and couriers of different nationalities make enforcement increasingly difficult.
- The European Union remains in 1996 a major market for cocaine, second only to the United States. Morocco and Colombia remain the main providers of cannabis derivatives for the EU markets, the first of resin (hashish), the second of herbal cannabis (marijuana). Indoor cultivation within the EU is now important in European cannabis markets.
- The European Union has become one of the world's major illicit production regions for amphetamine and ecstasy-type stimulants. Increasingly these and other synthetic drugs are being exported by Central and Eastern Europe and the Baltic States.

Get the full picture

This publication is a highly condensed summary of the *Annual Report on the State of the Drugs Problem in the European Union 1997* from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The full report also includes annexes covering:

- the effects and risks of the major drugs or drug groups misused in Europe;
- the role and structure of the EMCDDA and partners in the REITOX network linking national focal points in each Member State and in the European Commission;
- contact details for the EMCDDA Management Board and the EMCDDA's international partners.

To obtain a copy of the report contact the EMCDDA via e-mail at info@emcdda.org or contact the EMCDDA or your national focal point at the following addresses:

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