1998

Summary and highlights

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

Trends, patterns and prevalence of use

This section identifies key emerging trends in drug use and problems in the EU, gives an overview of the drug situation and summarises key epidemiological indicators that permit comparisons in the areas of prevalence, consequences, characteristics and patterns of use and supply. This information is based on two approaches to data collection. The indicators are more systematic and scientific though less up to date, while information on emerging trends is more timely but necessarily more qualitative. Both approaches must be regarded as complementary components of presenting a more grounded overall picture.

At present, coverage of information across the EU is still inconsistent, making direct comparisons sometimes misleading. Even where information is available, cultural and methodological differences between Member States must be taken into account. The work of the EMCDDA on implementation of standardised indicators in the EU will improve this situation gradually.

Overview

Cannabis. Cannabis is the most commonly used illicit drug across the EU, having been tried by between 5 and 20 to 30 % of the total population and up to 40 % of younger adults. Recent use is less frequent: 1 to 9 % of the adult population and up to 20 % of young adults have used cannabis in the last 12 months. After rapid increases between 1985 and 1994, levels of quantities seized have recently stabilised. As use is most often intermittent, cannabis is not very often the primary drug problem (accounting for 2 to 16 % of treatment admissions).

Synthetic drugs. Amphetamine is the second most used illegal drug in most countries (tried by 1 to 9 % of the adult population and up to 16 % of young adults) while Ecstasy has been used by 0.5 to 3.0 % of the adult population, with moderate increases over time reported in both substances in school and population surveys. Fatalities from synthetic drugs are rare, and treatment is infrequently sought. However amphetamine problems are more frequently encountered in Finland, Sweden, Belgium and the United Kingdom, and are most common among those whose use is chronic and among injectors [1].

[1] See 'New trends in synthetic drugs in the European Union', EMCDDA Insight series.

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.

Cocaine. Quantities of cocaine seized increased sharply in 1996 although this does not appear to have influenced price or availability. Between 1 and 3 % of adults have tried cocaine, with use lower among school age children. Frequent, problematic use is not common and cocaine is usually mentioned as the primary drug in less than 5 % of treatment admissions, while the misuse of crack, primarily in opiate misusing groups, remains a limited phenomenon.

Heroin and other opiates. Trends in supply, use and dependence appear relatively constant although there is some evidence of a new generation of young heroin smokers. Between 0.2 and 0.3 % of the EU population are addicted to opiates, lower than many other illicit drugs but responsible for disproportionate social costs in terms of criminal justice, health, social welfare and mortality. There is some evidence that heroin is diffusing both geographically (from cities to rural areas) and socio-culturally. Opiates are the primary problem drug in most treatment centres, and are associated with most acute drug-related deaths.

Other substances. Solvents are often the second most abused substances by adolescents. Misuse by adults of medicines such as benzodiazepines, often in combination with alcohol, is reported to be increasing.

Drugs and health. The strongest link between illicit use and health damage is among injectors. Drug injectors are significantly more likely to contract blood-borne diseases (AIDS, hepatitis). While rates of AIDS have levelled the extreme levels of hepatitis C may have serious public health implications.

The number of acute drug-related deaths is generally stable or decreasing, although with exceptions. In most cases opiates are involved.

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

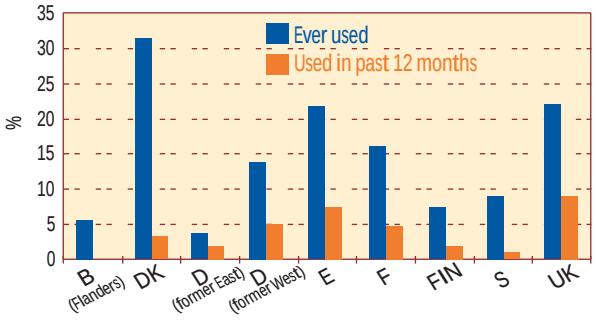
The main focus of the Centre's work in epidemiology has been on the demand for drugs. This will remain a central theme, but it will be necessary to pay more attention to supply and to drug markets, which is where demand and supply meet.

Indicators of prevalence, consequences and patterns of use

General population surveys

- Differences between countries do exist, but should be treated with caution as a result of methodological factors, sampling issues and contextual factors.
- Lifetime use of cannabis is reported by between 5 and 7 % (in Finland and Belgium (Flanders)) to 20 to 30 % in Denmark, Spain and the United Kingdom, with higher levels for younger adults (10 to 40 %). Lifetime experience of amphetamines ranges from 1 to 9 % (although most countries are in the range 1 to 4 %), for cocaine from 1 to 3 %, and for Ecstasy from 0.5 to 3 %. All figures are higher for younger adults.
- For recent use (last 12 months) cannabis is reported by 1 to 9 %, lowest in eastern Germany, Finland and Sweden and highest in Spain and the United Kingdom.

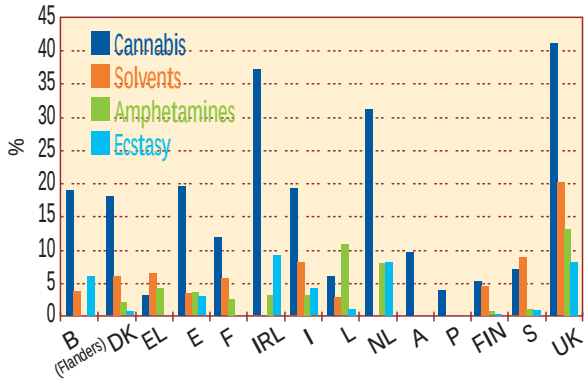
Figure 1: Cannabis use in the adult population



School surveys

- In this age group, age variations and social context may influence results substantially — for instance, in Finland 5 % of 15- to16-year-olds reported lifetime cannabis use in the same year that 30 % of 17- to18-year-olds in Helsinki reported ever having used cannabis. Therefore, individual school surveys must be interpreted with caution.
- Lifetime cannabis use of 15- to 16-year-olds ranges from 3 to 5 % (Finland, Greece and Portugal) to around 40 % (Ireland and the United Kingdom). In most countries solvents are the second most commonly abused substance, with lifetime use ranging from around 3 % (Belgium, Luxembourg and Spain) to 20 % in the United Kingdom.
- Amphetamines have been used by 1 to 13 % of 15- to 16-year-olds, Ecstasy by 1 to 9 % and LSD by 1 to 10 %. The lowest figures are for cocaine (1 to 3 %) and heroin (1 to 2 %).
- Trend data suggest a gradual increase in the lifetime use of cannabis, increases for amphetamines and Ecstasy and a small increase for cocaine.

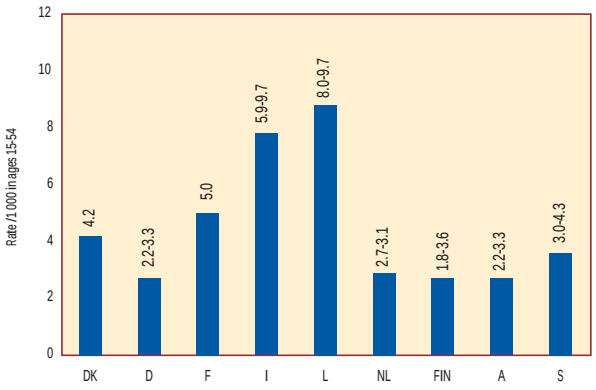
Figure 2: Drug use among 15- to 16-year-old school students (ever used)



Estimates of problem drug use

- Estimates are more reliable at local than at national level because of the sometimes large differences in prevalence within a country and lack of national data.
- Estimates of problem drug use for different cities in Europe range from 1.8 to about 30 (22-39) per 1 000 inhabitants aged 15 to 54 in smaller cities and from about 3.5 (3.2-3.9) to 14.1 per 1 000 in larger cities. Although methods and definitions differ between studies, these figures suggest important differences in prevalence of problem drug use.
- Estimates for countries show less extreme variation, ranging from about 3 (1.8-3.6) to about 9 (8.0-9.7) per 1 000 population aged 15 to 54.

Figure 3: National prevalence estimates of problem drug use

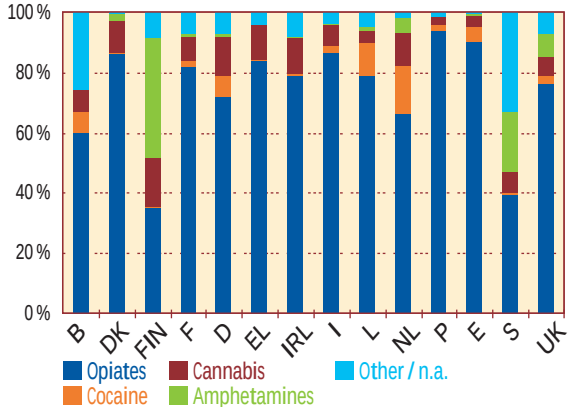


- The character of problem drug use differs between countries with mainly opiate addiction in southern and western Europe, but mainly amphetamine injection in northern countries.

Demand for treatment

- Treatment demand data are a useful indirect indicator of problem drug use — with opiates representing 70 to 95 % of treatment admissions in all countries other than Finland (35 %) and Sweden (39 %). In these latter countries amphetamine problems are commonly encountered.
- Cocaine use is usually reported by less than 5 % of treatment seekers, although this rises to 11 % in Luxembourg and 16 % in the Netherlands. Cocaine is also reported as a secondary drug problem by many opiate users.
- Cannabis accounts for 2 to 16 % of treatment cases. In most countries the proportion ranges from 2 % to about 10 % but rises to 13 % in Germany and 16.5 % in Finland.
- Amphetamines are reported by 1 to 2 % of admissions in most countries but by as many as 39.5 % in Finland and 24.4 % Belgium (Flanders).
- Most treatment seekers are male (70 to 90 %), in their 20s or 30s. The mean age of drug users in treatment is still slightly rising in most of the countries.
- Prevalence of injection among clients admitted to treatment varies substantially between countries, ranging from 10 to 15 % to more than 80 %.

Figure 4: Main drug for which clients demanded treatment in different EU countries



The proportion of injectors is decreasing in most countries.

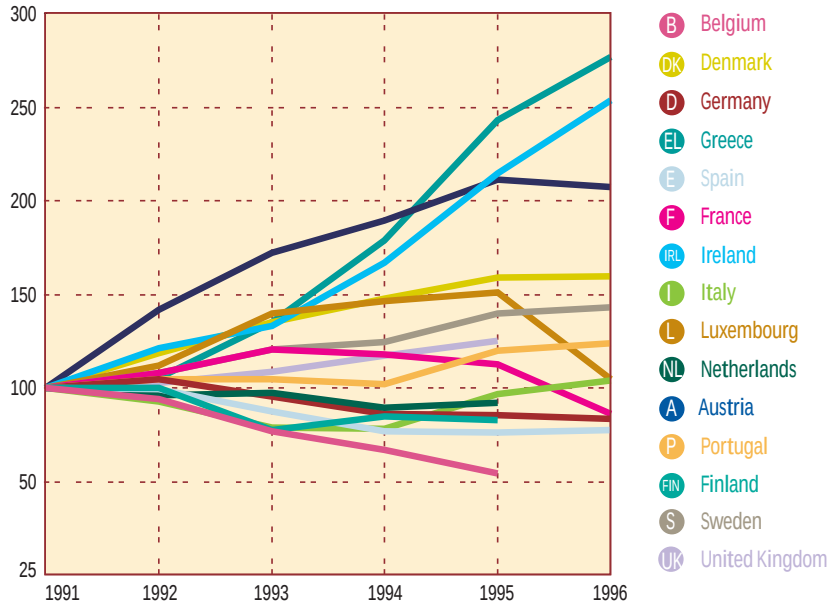
Deaths and mortality

- Cross-national comparisons are difficult as countries use different types of registries and recording procedures. The EMCDDA is working to improve comparability of these data.
- Opiate injectors have a 20 to 30 times greater risk of dying than the general population of the same age (from overdose, infectious diseases, suicide or accident).
- Most deaths from acute intoxication involve opiates, although alcohol and benzodiazepines are also frequently found.
- Although deaths related to Ecstasy have received much publicity, deaths related to synthetic drug use are few in number.
- After sharp earlier rises, most EU countries have shown stabilisation or decrease in acute drug-related deaths although the increase continues in some countries.
- Interpreting changes in death rates is complicated by changing patterns of use which may or may not result from targeted interventions. In addition, changes in definitions and recording procedures may interfere with real trends.

Infectious diseases

- HIV infection rates in injecting drug users (IDUs) vary from 0 to 30 % between countries, and even more between regions and cities. The explanation for this relates to both time of introduction of the virus, impact and timeliness of interventions, and behaviour change of IDUs.
- Prevalence of HIV among IDUs is stable or decreasing in all EU countries; however young IDUs continue to be infected.
- Rates of new AIDS cases are strongly declining due to the new treatments which delay the onset of the disease. This changes AIDS into an indicator of treatment uptake rather than of HIV infection.
- Prevalence of hepatitis B ranges from 3 to 75 % while rates of over 90 % for hepatitis C have been reported even in countries with low rates of HIV.
- There are an estimated 500 000 IDUs who are hepatitis C infected in the EU, which may have important implications for future health care needs.

Figure 5: 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.

Figure 6: AIDS incidence related to injecting drug use in countries of the EU

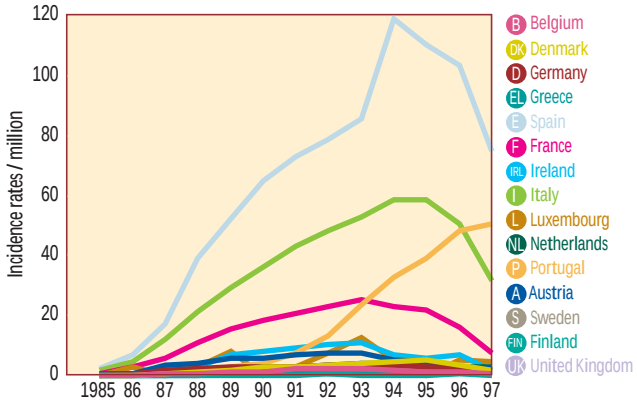
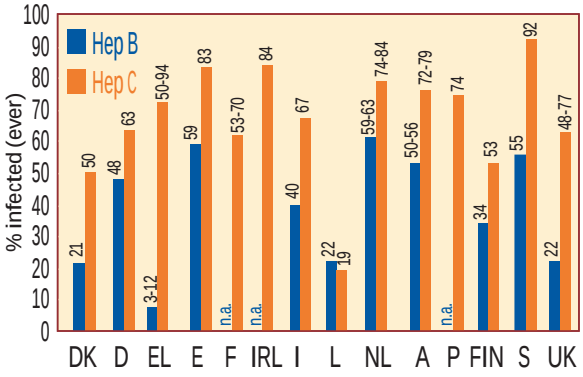


Figure 7: Hepatitis B and C infection among injecting drug users in the EU

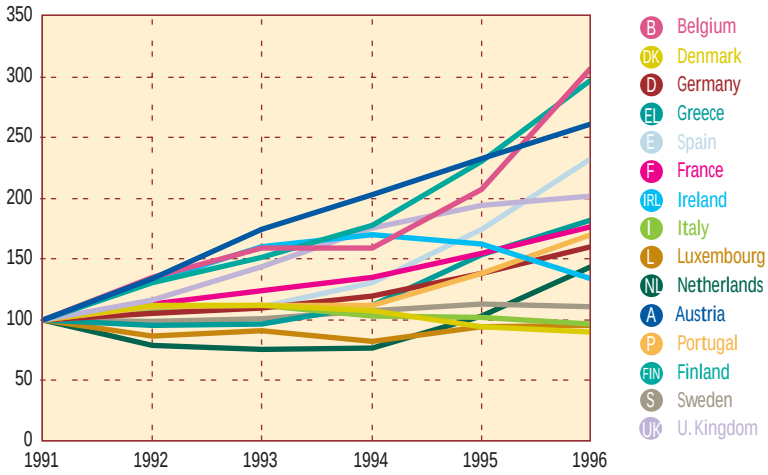


n.a.: data not available.

Police arrests and prison data

- Data here refer to law enforcement interventions and so vary according to differences in legislation, recording procedures and police resources and priorities within the Member States.
- Arrests have increased in every country since 1985, more than fourfold in Belgium, Greece, Spain, Portugal, Finland and the United Kingdom. In recent years, these increases accelerated in many countries, though in Denmark, Ireland, Italy, Sweden and the United Kingdom they have stabilised or decreased. In countries which provided such data, use-related offences are predominant, ranging from 65 % to over 85 % of all the offences involved in arrests. In all except Italy, Portugal, the Netherlands and Sweden, cannabis is the predominant drug.

Figure 8: Arrests for drug law offences in EU countries, 1991-96
Three years' moving averages indexed (1991 = 100)

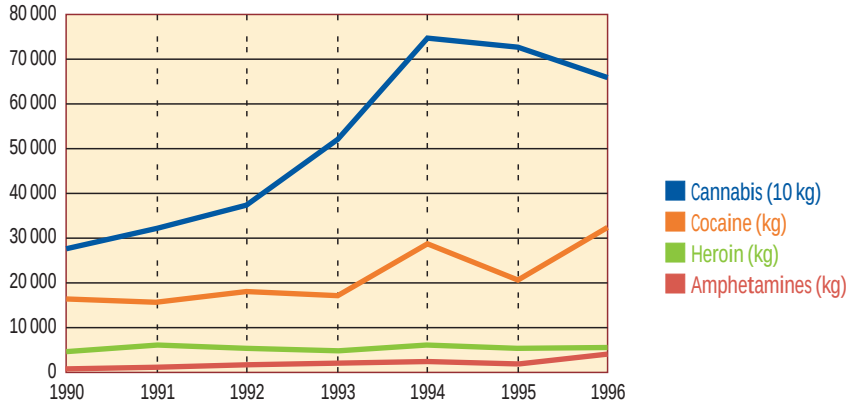


- Few countries have reliable information on drug use in prison and the type of data vary widely but estimates suggest that drug users account for 25 to 70 % of the prison population, 20 to 50 % if we consider problematic drug users.

Drug market indicators — seizures, price, purity

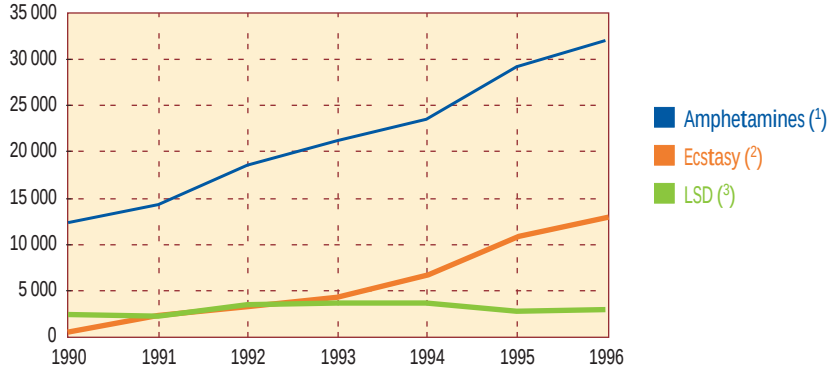
- The total quantity of cannabis seized has been stable in recent years, with the largest quantities seized in 1997 being in Spain. In most countries the number of cannabis seizures, unlike the quantities seized, are still increasing. Cannabis accounts for a greater number of seizures than any other drug. The price of cannabis appears to be relatively stable.
- Since 1991, quantities of heroin seized have fluctuated around 5 to 6 tonnes with the largest seizures in Germany and the United Kingdom. After rising steadily between 1985 and 1992, the number of seizures has since stabilised. The price of heroin varies significantly within and between countries, but it seems to be stable. Purity ranges from under 25 % to over 40 %.
- There have been significant increases in quantity and number of cocaine seizures since 1994, with the largest seizures in 1997 being in Spain. The price of cocaine is relatively stable in most countries, and purity is generally over 50 %.

Figure 9: Quantities of cannabis, heroin, cocaine and amphetamines seized in EU countries, 1990-96



- The quantities of amphetamines and Ecstasy seized have shown rapid increases in the early 1990s, with a sharp increase in 1996 for Ecstasy. The United Kingdom, the Netherlands and Germany account for the greatest quantities seized. Seizures of LSD are less common. The price of amphetamines and Ecstasy has been decreasing recently while purity varies considerably for both.

Figure 10: 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 have been extrapolated on general trend of other countries.

Final remark

The trend to multiple drug use, including alcohol and diverted medicines, as well as the increasing profile of amphetamines, requires rapid and sensitive assessment and service planning that is flexible and responsive. Furthermore, the focus needs to be extended to incorporate the interpersonal, cultural and demographic substrata of both experimentation and problem substance use. Finally, the quality of data must be improved so that interventions can be more expeditiously targeted and more sensitively evaluated.

Demand reduction

The EMCDDA defines drug demand reduction as encompassing all activities within the health, social, educational and criminal justice systems that aim to prevent drug use, to assist and treat drug users, to reduce the harmful consequences of drug use and to promote the social (re)integration of former users. Demand reduction targets individuals, families, groups and communities as the basis for a broader social approach to substance misuse, in which cooperation between statutory bodies, individuals and community groups is a fundamental prerequisite.

General trends show a diversification in the prevention field, employing a two-pronged strategy — broad education and health promotion targeting the general population supplemented by specific actions targeting vulnerable and at-risk groups. Assistance to drug users has increasingly taken the form of differentiated services oriented at the individual case, while seeking simultaneous coordination of existing services and the improvement of cooperating structures.

In the 1997 report the EMCDDA focuses on projects and interventions that have received adequate evaluation, as a quality criterion for determining policy relevance. The fact that many projects and programmes are not evaluated is detrimental to quality assurance in demand reduction. Key areas of activity in 1997 have included:

Prevention

The target audience for prevention is both young people perceived to be at risk and young people in general.

There is increased emphasis on initiating education programmes at an early age as a means of establishing protective factors against subsequent drug use. This is based on a rationale of drug prevention in the context of healthy living, and extends the focus to the family, school and the wider community

as key players. However, comprehensive community prevention programmes remain rare. Evaluation results provide evidence for improved interpersonal relationships, autonomy and resistance to peer pressure as critical protective factors. Peer projects have shown their utility as a means of incorporating primary prevention within the leisure time activities of young people. Although there has been little evaluation of mass media campaigns, some evidence suggests that these may have an awareness-raising effect. The Internet is increasingly used for dissemination of information.

While much work has already been expended in this direction, the key to future progress is coordination and community participation, underpinned by clear criteria for assessing the objectives and impact of projects (by process evaluation and outcome research).

Early intervention and at-risk groups

Throughout the EU there is an increasing harm reduction focus on groups experimenting with Ecstasy and other drugs in the dance scene. Specific measures have included guidelines on 'safe raves', including free drinking water, rest areas, information and counselling, as well as the initiation of on-site testing facilities.

Outreach strategies have accessed at-risk and marginalised groups, often in the context of natural social support networks. This has achieved encouraging results both for changing health and risk behaviours, in the context of a harm reduction strategy, and in reaching groups experimenting with drugs at an early stage.

A range of demand and harm reduction strategies have been employed to reduce the risks of substance use to young people. These have included safety measures for raves, outreach approaches and community projects that attempt to mobilise local resources in the fight against drug-related harm.

Prevention of infectious disease

Harm reduction measures have played an important role in combating the spread of HIV. A range of strategies — from maintenance prescription of substitutes such as methadone, syringe and needle exchange schemes, easily accessed ('low threshold') services, and education and information campaigns — have combined to make a positive impact in a number of EU countries. However, there is no evidence of an impact on hepatitis C transmission. Tuberculosis infection among drug users is also of concern.

The prevention of the spread of infectious disease in drug-using populations has been shown to be possible if a range of harm reduction strategies are implemented. Whilst the range available is extensive, it is likely to include substitution treatments, needle and syringe exchange schemes, aftercare provision and a range of matched facilities that are easily accessed.

Substitution and treatment programmes

Increases in the availability of substitute programmes in many EU countries have been accompanied by the need for consistency in provision and clear markers for outcome effectiveness (for estimates of Member States' substitute prescribing see below). Although the efficacy of methadone in terms of health and social integration is recognised, the expanding practice of substitution treatment might have brought with it issues of quality control.

In addition to methadone, a number of alternatives are currently explored in several European countries — LAAM, buprenorphine and prescribed heroin. All EU countries recognise the importance of a range of substitution and drug-free out-patient and residential treatment options, matched to individual needs. There is also widespread recognition of the need for effective aftercare, and cooperation between treatment facilities and general health and social service providers. Finally, the need for primary health care delivery to drug users has been recognised and collaborative programmes with general practitioners and hospitals have developed.

The effectiveness of interventions requires considerably greater evaluation both between and within Member States. While we know that drug treatments work, they should be matched to individual needs and they must be provided within a broader framework of community involvement and aftercare provision.

Criminal justice policy

In addition to their traditional role in supply reduction, the police are increasingly involved in demand reduction and education, and in strategies to support community partnership. All EU members provide alternatives to custody for drug offenders, based on diversion of the individual from prison to treatment, or to work in the community. A number of projects have explored training and rehabilita-

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**	

tion as alternatives, while some countries employ compulsory treatment for addicted offenders. Comparisons between the prevalence of drug users in prison are complicated by differing definitions and criteria for addiction but are generally in the range of 15 to 50 %. Drug-free as well as substitution programmes are becoming increasingly common in prisons and have shown some success.

There is widespread recognition of the need for alternatives to custody for drug users especially for first or minor offences, with treatment options in prison complementing alternatives to custody. These schemes have been cost-effective and are sensitive mechanisms for providing alternatives to the drug escalations (and consequent public health concerns) that have occurred when addicts are simply incarcerated.

Specific target groups

A number of countries have recognised the need for gender-specific approaches to prevention, while facilities that address the specific treatment needs of women — motherhood, sexual violence and prostitution — are becoming increasingly common throughout Europe. Some countries have attempted to address the needs of addicts from particular ethnic and cultural backgrounds. Finally provision for the care of children of users has also become increasingly significant in prevention and treatment programmes.

The need to tackle addiction problems in a sensitive manner has led to the development of specialist facilities and treatment options for those with specific needs — women, ethnic groups and both parents and offspring of problem drug users.

In conclusion, the achievements of 1997 have supported preceding work in emphasising the need for community partnership as the foundation for treating and preventing substance abuse, with evaluation increasingly prominent as the yardstick with which to assess effectiveness. While much ongoing work is both admirable and locally successful, coordination and cooperation both within and between Member States through dialogue and evaluation are critical to achieving a consistently high standard of service provision.

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

Scope

The countries covered are: Albania, Bosnia and Herzegovina, Bulgaria, the Czech Republic, Estonia, FYROM (the former Yugoslav Republic of Macedonia), Hungary, Latvia, Lithuania, Poland, Romania, the Slovak Republic and Slovenia. Information is based on national and international research, expert missions, and national and city-reports provided by the central and east European countries (CEECs) for the European Commission, mainly for the PHARE multibeneficiary programme for the fight against drugs, and international organisations (WHO, UNDCP, Council of Europe).

Historical and current patterns of drug use

Illicit drug use within CEECs became a matter of concern only after the political changes of the early 1990s. However, some countries (Poland, Hungary, Slovenia, the former Czechoslovakia) had identified drug use as a problem before this, developing some research and treatment strategies.

In the late 1970s the use of domestically produced drugs was reported in some CEECs (Bulgaria, Czechoslovakia, Lithuania, Latvia, Hungary and Poland). The misuse of pharmaceutical drugs was common during this same period in former Czechoslovakia, Hungary and Poland, and to a lesser extent in Bulgaria. More recently, it has also emerged as a problem in Albania, Bosnia and Herzegovina and the former Yugoslav Republic of Macedonia. The political changes in the region in the early 1990s led to an increase not only of drug trafficking through many CEECs, but also increased domestic consumption of imported drugs.

Specific trends for individual drugs

The ESPAD (European school-survey project) study conducted in 1995 under the auspices of the Pompidou Group of the Council of Europe included seven

Table 2: 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

CEECs (Czech Republic, Estonia, Hungary, Lithuania, Poland, Slovak Republik, Slovenia) and provided valuable information on drug use amongst 15- to 16- year-old students in these countries. It highlighted cannabis as the most frequently used drug amongst adolescents and young adults within the seven participating CEECs.

In the same survey solvents were shown to be the second most prevalent substance of misuse. Since the early 1990s, many CEECs have experienced an increase in heroin consumption (Bulgaria, the Czech Republic, the former Yugoslav Republic of Macedonia, Hungary, Slovak Republic and Slovenia). More recent trends have shown a gradual move towards the injection of imported heroin (see Table 3 below). The use of pharmaceutical drugs in combination with illicit drugs has become more common in recent years in Bulgaria, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Hungary, Slovak Republic and Slovenia. The level of cocaine use is still low, although seizures suggest an increase in trafficking in Poland, the Czech Republic, Hungary and Romania.

Table 3: 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).

The legal response

Efforts are being made by the CEECs to adapt their legislation to meet EU standards in law. All have adopted new legislation in the drug field (most dating from 1996 onwards). Drug production and trafficking is a crime with penal sanctions in all countries, although illicit drug use, in general, is not. All countries except Albania are signatories to the three UN Conventions on narcotic drugs, psychotropic substances and illicit trafficking and all have ratified them except Estonia which has not yet ratified the 1988 Convention.

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 (the inter-ministerial body in Albania is not operational). Within these bodies, working groups at technical level have been charged with the preparation of new legislation, of projects and of national programmes on drugs. As a result a comprehensive, multidisciplinary national programme on drugs has been adopted in several CEECs.

Drug demand reduction

The history of drug demand reduction varies across the region. It has been implemented in Poland for over two decades, but for only a few years in Romania. In general drug demand reduction is still a low priority in most CEECs, which allocate greater resources to law enforcement (supply reduction). Treatment in hospital settings, by psychiatrists and other health professionals predominates. In most CEECs treatment services are available only in the largest cities. Out-patient drug-free and long-term residential treatment are developing at a fast rate in the majority of CEECs. Prevention is a top priority in most national strategies and programmes, including school-based education and health promotion. Within the last few years, outreach and harm reduction services have been added to drug demand reduction strategies. Although the availability of substitution programmes (methadone maintenance) and needle exchange schemes has increased throughout the region, such harm reduction options are still rarely available, even in major cities. Non-governmental organisations often remain underutilised and underfunded. The main needs are for a strengthening of capacity and performance, enlargement of funds and for improved communication and cooperation with governmental organisations.

Synthetic drugs

Almost all countries report an increase in seizures, but reports on use remain largely anecdotal.

National strategies

Changes in legislation have to be interpreted in the context of a balanced approach between demand and supply reduction activities and the role of alternative sanctions and cooperative approaches in tackling drug problems in the EU.

Specific legislative developments are outlined with particular emphasis placed on the distinction between medical and therapeutic approaches to the fight against crime linked to traffic, and specific responses to cannabis control, the profile of which as a focus for public and policy debate intensified in 1997 throughout the Member States. In individual cases and under certain circumstances certain EU countries tolerate cannabis consumption and possession while, in practice, others apply less severe penalties for cannabis offences. All Member States resolutely combat crime linked to the trafficking of cannabis.

Anti-drud action is located within national structures in which legal responses are drug-specific or generic (i.e. the legal response to all illicit drugs is uniform). However, even those countries whose laws do not differentiate by substance tend to have implementation procedures that are sensitive to the circumstances and to the type or quantity of the illicit substance involved. Thus, in certain European countries penalties are, in part, determined by categorisation of the seizure into one of three quantity bands, and possession of small quantities for personal use, is more likely to result in a warning or alternative measures than in prosecution. Table 4 highlights Member States' policy with regard to the use of cannabis:

Table 4: Member States' policy with regard to the use of cannabis

Belgium	• Possession and cultivation for personal use less likely to be punished. • To use in public, incite use, sell or traffic remain serious offences.
Denmark	• No formal distinction between drugs. • A first offence results in entry in central criminal register. • Subsequent offences result in fines or penalties. • 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. • 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. • 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 treatment being an alternative to penalties. • 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. • Fines for possession of cannabis for personal use for first or second offences.
Italy	• Warning for first offence of possession for personal use. • Subsequent offences involving 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: • users who are not usually prosecuted but receive treatment or a warning on the first occasion, and • dealers who are pursued with repressive measures.
Netherlands	• Consumption and possession of up to 5g allowed in coffee shops. • Directives specify terms and conditions for possession and use.
Austria	• Withdrawal of reports in case of first consumption of cannabis. • Penalties are defined according to the quantity of drug involved. Petty crimes (small quantity) fine and/or up to six months of imprisonment.
Portugal	• Each drug has an official daily dose limit. • Possession is a 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 it is proven that they are for personal use only and that the individual is an occasional user. • Possession of more than three times the official daily dose limit is punished more severely depending on whether it occurs for trafficking or exclusively for personal use.
Finland	• Use sentenced with a fine, or a maximum of two years' imprisonment. • 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. • Penalties are defined according to the quantities involved. • Use of cannabis is sentenced with a fine. On a voluntary basis the fine could be exchanged for counselling.
United Kingdom	• Controlled substances are divided in three classes, A, B and C. • Possession of up to 30g of cannabis (a class B drug) carries a maximum sentence of five years in prison. • Maximum sentence of 14 years for dealing in cannabis. • Courts may also use caution, probation or community service.

Actions taken by the European Union

With no substantial political or organisational changes in the EU, the third European action plan to combat drugs remains the general framework for anti-drug action with regard to the new framework established by the Treaty of Maastricht to combat drugs in an integrated approach. This focuses on three areas: demand reduction, supply reduction and international cooperation, with reinforced cooperation between drug policies. Reliable and scientifically based information is increasingly considered an essential prerequisite for any effective strategy against drugs. The most significant developments in 1997 relate to targeted areas of activity, changes in internal funding arrangements and developments in external funding.

Areas of activity. The most significant measure within the demand reduction area was the implementation of the Community action programme on the prevention of drug dependence, which aimed to encourage cooperation between Member States and support their efforts. Actions will be promoted in the area of data collection, research and evaluation and in the field of information, health education and training. In 1997, 22 prevention projects have been supported. Further demand reduction activities related to the reintegration of addicts (through the Employment-Integra initiative) and a proposal to reduce the incidence of driving while under the influence of alcohol, medicines or illicit drugs. The major supply reduction initiatives related to monitoring of trade in chemicals used in the manufacture of illicit drugs ('precursors') and increased emphasis on anti-money-laundering strategies. Within a general initiative promoting international cooperation, the multi-country PHARE programme for the fight against drugs monitors the drug control efforts of the 10 CEECs currently preparing for accession to the EU. A regulation setting down the principles, objectives and modalities of the EU/North-South cooperation in the drugs field was adopted and entered into force (Regulation (EC) No 2046/97 of 13 October 1997). In June 1997, the Amsterdam Treaty reinforced Community actions to reduce drugs-related health damage, including information and prevention to consolidate new objectives and Community action on security and justice.

Internal funding activity. In 1997, at a cost of ECU 33 million, the EU supported eight budget lines, three of which were specific to drugs. These were the programme of Community action on the prevention of drug dependence (with an annual budget of ECU 4.9 million of which 69 % was spent to support European networks), global aspects of the fight against drugs (with an annual budget of ECU 1.2 million, 67 % of which was spent on supply reduction), and EMCDDA (with an overall budget of ECU 6.3 million, which supports research, training and information production, analysis and exchange). The other major areas of internal spending are on the Employment-Integra programme for the reintegration of addicts (ECU 18.4 million), cooperation in the field of justice and home affairs (ECU 4.5 million) and the Biomed research programme on neuro-physiological aspects of addiction (ECU 1 million). The total figure for internal spending in 1997 was ECU 33.3 million, an increase on the ECU 15.2 million spent in 1996.

External spending activities. There were two specific drug-related budget lines funded in 1997. They were for:

- North-South cooperation (ECU 8.9 million to fund demand reduction, the law enforcement efforts and chemical precursor controls in Latin America, Asia, the Caribbean and Africa, and the Mediterranean region);

Early warning system on new synthetic drugs

In June, 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 so that the controls on psychotropic substances applicable in the Member States could be applied equally to new synthetic drugs. The EMCDDA and the EDU have been mandated to collect the required information and to participate in the scientific committee (an extension of the EMCDDA scientific committee) tasked with assessing the possible risks caused by the use of and traffic in new synthetic drugs.

- the PHARE multi-country programme for the fight against drugs (ECU 5.0 million to establish information systems, to create money-laundering legislation, to make precursor control compatible with the EU, to develop demand reduction strategy and for staff training).

Non-specific budget lines for drug-related projects totalled ECU 6.2 million in 1997, of which 92 % was spent in the African region and 8 % in the Caribbean region. 81 % of the total was dedicated to demand reduction projects.

Overall, more than ECU 53 million was spent on drug-related actions in 1997 — 62 % for actions within the EU, and 38 % on actions outside. Within the EU, the vast majority was spent on rehabilitation actions, while outside the EU, 60 % of the external budget was spent on the African and CEEC regions. This represents a slight decrease on the total of ECU 61 million spent in 1996, with the proportion for internal spending having increased considerably since 1996.

Chart 1: Analysis of internal spending %

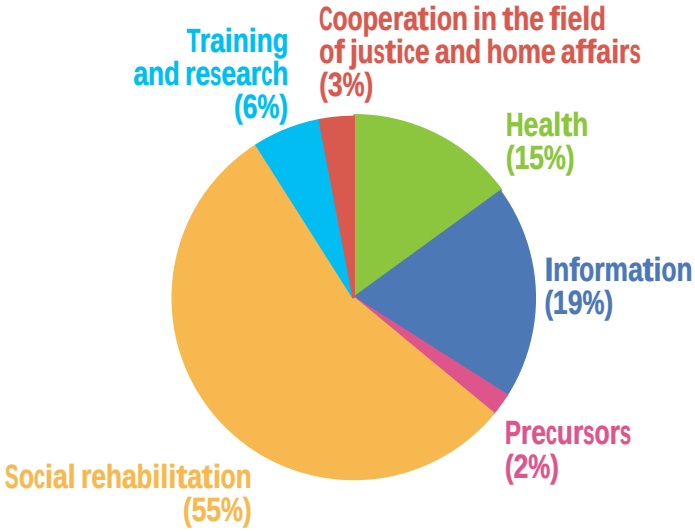
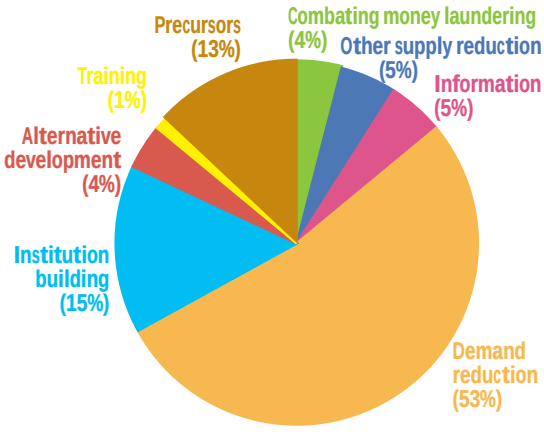


Chart 2: External drug-related Community expenditure according to the field of interest



International action

International action in the drug field is characterised by the role and activities of key organisations involved in tackling drug issues at an international level, and their activities and achievements in 1997. Reports on patterns and trends in seizures of specific narcotics and psychotropic substances are also among the important indicators in 1997.

Advances in 1997

With Austria becoming a signatory in 1997, all EU Member States have now signed the UN international drug control treaties. A key development was the preparation of the UN General Assembly Special Session (Ungass) on illicit drugs (8 to 10 June), at which the UNDCP adopted an important political declaration and an unprecedented demand reduction declaration. The UNDCP published its first 'World drugs report'. The WHO continued to develop its programme on substance abuse, while Interpol transmitted over two million messages relating to criminal activity in the course of the year and held a general assembly meeting at which 18 resolutions, including anti-money-laundering resolutions, were passed. The World Customs Organisation (WCO) reported an increase in detections of drugs of more than 10 % from 1996.

Changes in drug supply to the EU

Despite increased law enforcement efforts, the drug supply is still increasing, as indicated by price stability and availability. In 1997, there were significant increases in cocaine and amphetamine seizures, a slight increase in seizures of cannabis resin (hashish) and small decreases in heroin and cannabis leaf (marijuana) seizures. While trafficking routes have remained largely unchanged, there has been an increase in the production and trade of new synthetic drugs in EU and east European countries, with some evidence of export of synthetic drugs to other regions. According to Interpol, about 800 tonnes of cocaine and 450 tonnes of heroin are produced annually worldwide. 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 in accordance with data provided by the Europol drugs unit)

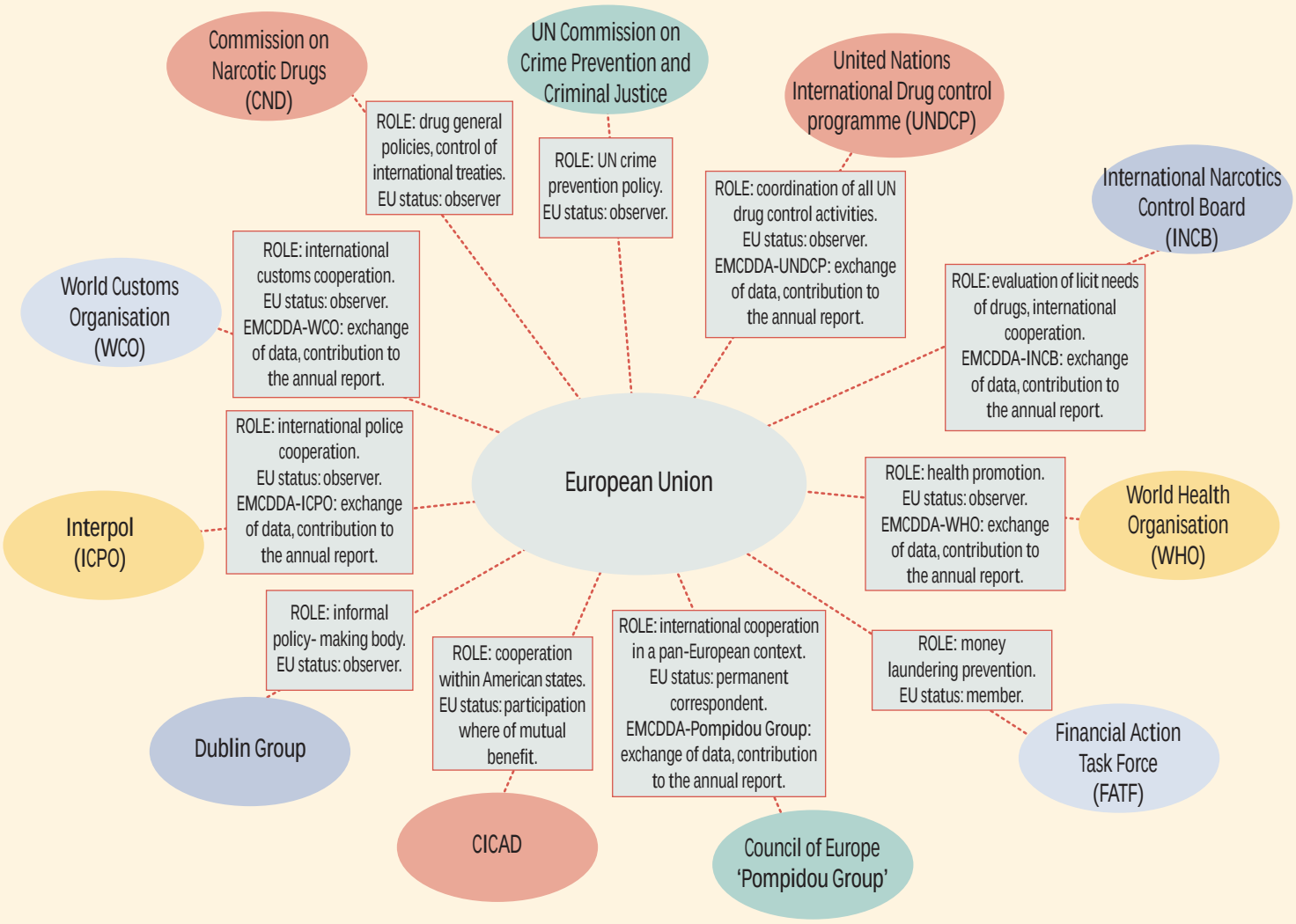
International players

International players on the drugs scene can be divided into three categories:

- United Nations. The UN has established a number of bodies to deal with drug issues which are responsible for monitoring the implementation of international treaties. Specifically, the INCB (the International Control Board) is the independent and quasi-judicial organ responsible for how international drug control conventions are implemented and monitored; the CND (Commission on Narcotic Drugs) is the central policy-making body within the UN for all questions related to drug control; and the UNDCP (United Nations Drug Control Programme) acts as the secretariat for both the CND and INCB, assisting Member States in implementing the decisions of the policy-making bodies. In addition, the UN's World Health Organisation (WHO) promotes public health and better living conditions. A number of other specialist UN bodies are also involved in drug control issues.
- Other international agencies. Interpol promotes international cooperation in the enforcement of laws curbing illicit drug production, manufacture and trafficking. Links between the EMCDDA and Interpol, established in 1995, are to be strengthened. The World Customs Organisation (WCO) attempts to harmonise customs procedures and to increase the effectiveness of targeting drug consignments.
- Regional organisations. The Council of Europe's Pompidou Group promotes a multidisciplinary approach to tackling drug problems on a pan-European basis, while the Dublin Group is an international body for coordinating international drug control policy. The Inter-American Drug Abuse Control Commission (CICAD) targets trafficking, production and use and the Financial Action Task Force (FATF) targets money-laundering in the financial system.

In conclusion, increased international cooperation and coordination have continued in 1997 but must be augmented in future years if the ongoing increases in availability of narcotic drugs and psychotropic substances is to be halted.

Table 5: The European Union and the international community in the drugs field



Analysis of public spending on drugs

The EMCDDA aims to study the financial impact of drug policies in the EU and to analyse the break-down of public spending on drug matters and to outline approaches allowing a comparative analysis of public spending effectiveness. The three do-mains of public spending considered are repression (concerned with enforcing drug laws), treatment (particularly around the health costs associated with AIDS) and prevention.

Spending is divided between that spent directly on drug projects and spending within ministries and

Table 6: Public spending and the 'drug budget'

Public spending	Belgium	Denmark	France (2)	Ireland	Portugal	Spain	Switzerland (3)	UK (4)
Budget of all national police forces (1)	1 724.71	667.37	3 780.15	620.61	n.a.	3166.43	865.77	12 516.37
Interpellations for drug offences	23 762	13 992	79 271	n.a.	9 333	79 445	42 000	998
Customs budget (1)	n.a.	n.a.	585.32	65.05	n.a.	n.a.	n.a.	1 282.28
Budget of the criminal justice system (1)	463.83	1 062.28	3 094.73	894.44	707.12	n.a.	n.a.	2 024.92
Number of persons imprisoned for drug offences	n.a.	1 282	11 816	225	3 653	9 925	n.a.	6 400
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
Budgetary lines allocated to drug prevention (1)	n.a.	n.a.	n.a.	0.46	12.14	36.77	n.a.	252.25
Budget of institutions specialising in drug prevention (1)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Amount spent on research (1)	n.a.	n.a.	6.35	1.30	n.a.	7.35	n.a.	n.a.
Amount spent on international action (1)	n.a.	n.a.	10.58	0.19	0.01	4.26	n.a.	273.27

(1) Million ECU.
(2) Kopp and Palle — MILDT report (1996).
(3) Estermann, J., *Consommation et trafic de drogues: les coûts de la répression* (estimation pour la Suisse 1991).
(4) *Tackling drugs together — strategy for England*, 1995-98, HMSO, May 1995.

public administrations that includes the so-called anti-drugs effort (although the exact proportion spent in this way is difficult to calculate).

Table 6 is based on French and Swiss projects, with data also gathered in Belgium, Denmark, Ireland, Portugal, Spain and the United Kingdom. The data exemplify many of the problems of non-availability of data and lack of comparability between countries. Thus, data on arrests for 'drug offences' may include either the number of people arrested or the number of infringements of the law.

A method is outlined for calculating a 'drug budget' in which direct spending on drug action is used as the basis for calculating public administration spending. The example used, of calculating the allocation of police time, can also be applied, for example, to expenditure on the judicial system. However for the prison system the calculation is complicated by the commission of non-drug crimes either to finance drug activity or while under the effects of drugs.

The need for a European comparative study on 'drug budgets' is identified as a means of assessing the extent of each country's public spending effort. The drug budget as a proportion of GDP is similar in the three European countries studied, but substantially higher in the United States. As a proportion of public spending, the figures for the United States and the United Kingdom are significantly higher than for France and the Netherlands.

In Europe the proportion of the budget allocated to law enforcement (around 80 % in the three countries) is significantly lower than in the United States (93 %). However, in all countries, it is difficult to calculate the amount spent on prevention because of its decentralised nature. The reinforcing of resources for one budget line tends to be at the expense of one of the others, as increases in overall spending are unlikely at times of limited resources.

In conclusion, more analysis will require greater comparable information from Member States as the first step in developing a greater understanding of improved efficiency in public spending on drug issues and evaluating the social costs generated by the drug problem.

European Monitoring Centre for Drugs and Drug Addiction

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