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European Monitoring Centre
for Drugs and Drug Addiction

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

1999

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Preface

It gives me great pleasure to introduce the EMCDDA's annual report for 1999. This is the fourth annual report that the Centre has produced. It has undergone some minor changes in form and content since the last report. These have been made so that the report can reflect more clearly the rapidly evolving trends and patterns in drug use in Europe, as well as make it more accessible to its varied readership. Our aim is to provide up-to-date, quality information as a basis for sound decision-making. The collection and collation of comparable, reliable and useful information takes a great deal of time and effort, as does the creation of the local, national and European networks through which such information is gathered.

Action on drugs and problems related to drugs has been high on the agenda, both in Europe and elsewhere. Significant progress was made during 1998. At the special session on drugs of the United Nations General Assembly (8-10 June 1998), the world community strengthened its commitment to confronting the world drug problem in a collaborative, balanced way. The adoption of a political declaration on the guiding principles of drug demand reduction by 185 participating countries constituted a considerable advance in the international 'drugs debate'. It was the first time at this level that demand reduction was recognised as an indispensable component of any global approach to the world drug problem. The General Assembly requested the Commission on Narcotic Drugs to explore a proposed action plan based on this declaration. The United Nations International Drug Control Programme (UNDCP) prepared a preliminary draft that was discussed and amended by an intergovernmental working group with specialised agencies, that included the EMCDDA, in December 1998.

The 42nd session of the Commission on Narcotic Drugs (1) ended with the adoption of a resolution on the first United Nations action plan on drug demand reduction. The plan focused on identifying, assessing and communicating information on the causes and consequences of

substance use; coordination mechanisms and the participation of all relevant authorities and sectors of society; the implementation of research and the dissemination of results; the development of customised programmes ranging from the discouragement of initial use to reduction of the negative health and social consequences of drug use; the enhancement of information and services offered to the public and to drug users in particular; and the development of evaluation strategies.

Action against drug trafficking and drug misuse was also a major priority at European Union level. The Europol Convention entered into force on 1 October, following its ratification in June 1998 by all Member States, providing the EU with a complementary tool to prevent and combat unlawful drug trafficking. The coordination and implementation of a third European Drug Prevention Week during the Austrian Presidency was an important step in the implementation of the first Community action programme for the prevention of drug dependence.

The United Kingdom and Austrian Presidencies played a central role in developing a wide range of initiatives. In early 1998 the United Kingdom Presidency invited Horizontal Drug Group (HDG) members to outline their likely priorities for inclusion in a post-1999 European drugs strategy. The HDG (2) coordinated the European Union input for the UN General Assembly session on drugs. The Cardiff European Council (3) endorsed a set of key elements for a European Union strategy to tackle all aspects of the problem in 2000-04 (4). The Austrian Presidency pursued the task and the Vienna European Council (5), having examined the report on drugs and drug-related issues of the Presidency period, invited European institutions to develop an integrated and balanced post-1999 drugs strategy further, in line with the new opportunities offered by the Amsterdam Treaty. The Council specified that full use should be made of the expertise of the European Monitoring Centre for Drugs and Drug Addiction.

(1) Vienna, 16 to 25 March 1999.

(2) This Horizontal Drug Group was created by the Permanent Representatives Committee (Coreper) in February 1997 as a forum to coordinate the drugs activities of the Union, especially when they are of a trans-pillar nature. The HDG met 11 times in 1998.

(3) 15 and 16 June 1998 — Presidency conclusions.

(4) Based on the Council report to the European Council on activities on drugs and drug-related issues under the UK Presidency, including key elements of a post-1999 EU drugs strategy (7930/2/98 REV 2).

(5) 11 and 12 December 1998.

The European Parliament examined and commented on the Council report (6). It especially emphasised the need to ensure maximum synergy between all Community efforts, and called upon the Commission and the Council to record all initiatives on drugs in one single document. The requirement for reliable and comparable information on drugs was stressed through the adoption by the European Parliament of the document on the EMCDDA's annual report (7).

The post-1999 EU drug strategy is envisaged as multidisciplinary, balanced and integrated, covering a range of actions on demand and supply reduction involving international cooperation across the three pillars of the EU. Both the European Parliament and Council stated the importance of focusing upon the improvement of cooperation with EU accession countries, and in assistance for facilitating the taking of the Community drug *acquis*.

The Commission took advantage of the work already completed by the Centre between 1995–99 and the inputs of both the European Parliament and Council in the preparation of its proposal for an EU action plan to combat drugs (2000–04). The action plan foresees an important role for the EMCDDA in providing the European institutions and Member States with relevant information, observing that 'the extent and magnitude of the drugs phenomenon is now better known thanks to the valuable work carried out by the European Monitoring Centre for Drugs and Drug Addiction'.

The launching in 1998 of the fifth framework programme for research for 1998–2002 should also be noted. It includes support for research activities into the psychological and socioeconomic factors involved in drug use in order to develop a better understanding of long-term health and social consequences and the pursuit of more effective treatment strategies.

Efforts have been made with the Phare programme to develop information systems for collecting, processing and distributing data on drug use, and to achieve convergence between the central and east European countries (CEECs) and the tasks and data currently being pursued by

the EMCDDA Reitox national focal point network. Much remains to be done and the Centre and its partners are aware that they are standing at the threshold of a major, new venture.

The EMCDDA, in close collaboration with the Reitox national focal points, will continue to concentrate its efforts on the regular collection, analysis and dissemination of data at European level; the improvement of data comparison methods; the implementation of key harmonised epidemiological indicators; the systematic and scientific evaluation of demand reduction initiatives; and cooperation with European and international bodies and organisations.

The Centre's core tasks include, in epidemiology, the implementation of five harmonised key indicators (demand for treatment by drug users; drug-related deaths, mortality and causes of death among drug users; the incidence of drug-related infectious diseases; the comparability of surveys of drug use, behaviour and attitudes in the general population; and the comparability of prevalence estimates of problem drug use). Enhancement of the European database on demand reduction activities (EDDRA) is the leading project in the identification, assessment and promotion of routine, scientific evaluation in the demand reduction field. Scientific investigation and collaboration with institutional partners continue in the implementation of the joint action on new synthetic drugs, as does the annual preparation and publication of this report and a series of research monographs and other studies.

I believe that this report demonstrates the real progress made by the Centre since its foundation. This has been achieved through the commitment and hard work of those involved in the process at all levels throughout the European Union. I am confident that the EMCDDA is now well placed to respond to the challenges that the next millennium is bound to present.

Georges Estievenart

Executive Director EMCDDA

(6) EP resolution on the report, including key elements of a post-1999 EU drugs strategy, from the Council to the European Council on activities on drugs and drug-related issues under the UK Presidency (7930/2/98 — C4-0409/98).

(7) Report on the 1997 annual report of the European Monitoring Centre for Drugs and Drug Addiction on the state of the drugs problem in the European Union (C4-0552/97).

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Developments in drug use, problems and responses

Throughout the European Union (EU), national, regional and local policies for the prevention of drug use and addiction, as well as assistance to and treatment of drug users, are changing. More efforts are being made at all levels and by all sectors to ensure that cooperation and coordination between the educational, health, social and criminal justice systems become more effective and efficient.

Despite the considerable differences between EU countries, and between drug users and patterns of use, some clear trends in, and consequences of, drug use are emerging throughout the Union. More details about patterns and consequences of drug use are provided in Chapter 2.

Prevalence and patterns of problem drug use

In most Member States, the main substance recorded by indicators of problem drug use has been heroin. In some northern States, amphetamines are significant in admissions to treatment, although overdoses and drug-related infectious diseases often also involve heroin. Estimates of the prevalence of the overall number of problem drug users thus largely refer to problem opiate use.

Surveys, although usually unreliable for measuring problem drug use, suggest that up to 1 % of the general population and 1 to 2 % of the school or youth population have tried heroin or other illicit opiates in the EU. Thus the total number of people who have tried heroin at least once could be around 3 to 5 million.

The overall prevalence of problem drug use appears to be largely stable in most EU countries, although there is a continuing incidence of new cases balanced by others who become abstinent or die. The estimate for the EU as a whole (1 to 1.5 million out of a total population of about 375 million) is higher than in previous annual reports due to new or improved estimates from more countries. Since most indicators used to estimate prevalence are more likely to detect injecting drug users (IDUs), heroin smokers may be under-represented.

Defining problem drug use

'Problem drug use' is defined as the use of drugs in a way that significantly increases the risk of serious, adverse physical, psychological or social consequences for the user. This definition includes dependence (addiction), but also covers patterns of non-dependent use that may lead the user to seek help or that are associated with increased mortality or morbidity, such as overdoses or infectious diseases.

The operational definition used by the EMCDDA to compare estimates of the prevalence of problem drug use is limited to intravenous drug use or long duration/regular use of opiates, cocaine or amphetamines. For practical reasons, ecstasy and cannabis are not included when comparing estimates for different countries, even though, as shown elsewhere in this report, the use of these drugs may sometimes be associated with personal or social problems.

The known or treated population is predominantly male with an average age of about 30. The figure is slowly increasing in most Member States, but the trend may be in part a result of expanded substitution treatment. This population is also associated with serious health and social problems, linked to multiple drug use, psychiatric co-morbidity, infectious diseases, crime, imprisonment and social exclusion.

Social distribution and diffusion

Problem drug use is unequally distributed between and within countries with large differences found between and within cities. Higher prevalence is usually found in more socially deprived areas, but the relationship between prevalence and socioeconomic factors is complex. The relation between heroin and urban deprivation should not be oversimplified. While in general heroin is more prevalent in urban areas, it is spreading to smaller towns and rural areas. There are also reports of heroin smoking by new groups, including young people from socially integrated backgrounds, heavy recreational users of ecstasy, amphetamines and other drugs, individuals from some minority groups and older people with problematic heavy consumption of alcohol and/or medicines.

Treatment responses

Challenges for treatment services

Poly-drug use, co-morbidity and an ageing population challenge treatment services. This development is crucial when determining the best approach to delivering high-quality treatment. As patterns of drug use change, the number of multiple patterns of response also increases.

Primary care

The primary healthcare system throughout the EU is increasing its involvement in the care of drug users, probably due to the expansion of substitution treatment and financial cutbacks in the social sector in many countries. At the same time, there is a move away from residential to out-patient treatment.

Heroin dependence and substitution treatment

Substitution treatment for opiate dependencies is rapidly expanding and general practitioners (GPs) are often involved. About 300 000 persons in the EU are thought to be receiving substitution treatment, mainly with methadone. Within the Union, perhaps 20 % of all problem opiate users and 30 % of those who are dependent users receive substitution treatment. In 1998, an experiment to supply heroin on strictly medical grounds began in the Netherlands. Medical prescription of heroin was also under discussion in Denmark, Germany, Spain and Luxembourg. In 1999, the EMCDDA is publishing an in-depth study on substitution treatment in the EU.

Towards some answers?

At present, there are only limited data on research and evaluation of treatment processes, its benefits and the factors associated with good treatment. These include the quality of the management and organisation of services, of the staff and the level of multidisciplinary and inter-agency work to ensure good relations and links across a range of community institutions.

Methadone is by far the most common opiate substitute in the EU and there is now substantial consensus on the benefits of methadone maintenance. Treatment can improve psychological and social well-being, reduce

French alternative

In France, the prescription of buprenorphine has increased rapidly since its introduction in 1996. French GPs prescribe buprenorphine to about one third of heroin users who consult them. According to an evaluation study, the social background of such clients is usually poor and clients are generally older users (45 % of the clients are over 30 years of age).

After one year, the progress of around 69 % of these clients is still monitored by their GP. Of this group, 9 out of 10 are still taking buprenorphine. Although overall heroin consumption has fallen by 43 %, just over one

fifth of users are still injecting and in many cases buprenorphine is also injected. It is thought that users continue to inject because they are dependent on the ritual itself and its social context (injecting with others), and because the effect of the drug is insufficient if taken orally.

Deaths seem to have occurred mainly from mixing buprenorphine and benzodiazepines, particularly in countries with a high level of substitution medication where it is often combined with benzodiazepines.

illicit heroin use and criminality, and reduce HIV transmission, although further research is needed to determine the role of such treatment in reducing hepatitis C transmission. Over the past five years, there has been a substantial growth in the evaluation of treatment.

Community responses

A broad range of drug-use patterns in the EU involves more than experimental or intermittent recreational use but is not usually reflected in problem indicators, such as treatment demand, nor covered by prevalence estimates of problem drug use. Responses to drug use by younger people mainly focus on synthetic drug use. However, some initiatives for experimental users of different drugs have been reported from Belgium, Denmark, Greece, Spain, France and Austria. Often these try to involve young people in alternative activities within and outside the educational system, increase the awareness of drug behaviour and other life choices and involve peer groups, parents and teachers in activities.

Social exclusion

Social exclusion and drug problems are closely related to marginalised communities and individuals where the health and social conditions of the (often ageing) clients are deteriorating. This suggests that both structural responses and more specific interventions are needed. Although some publicity has been given to the increasing use of drugs by relatively affluent young people, drug

services are aware that problems mainly arise in socially marginalised groups and areas. In disadvantaged areas there is a growing focus on the need for community work involving cooperation between the education, health, social and criminal justice systems, employers and non-governmental organisations (NGOs).

Roma and drugs

In Spain, drug addiction affects specific groups of Roma, leading to increased social, family and cultural fragmentation and alienation in a community already vulnerable. The sale of drugs by some members of the community reinforces the stereotype of Roma as drug dealers.

Generally Roma addicts do not benefit adequately from treatment and harm reduction services. This leads to a higher rate of HIV infection among the community, although methadone-maintenance programmes have been accepted and may be a solution to this problem.

Outreach work and early intervention

An EMCDDA pilot study analyses how long heroin users who undergo treatment had used the drug before first entering treatment. The study found that the younger the age of first heroin use, the longer the time lag before treatment. Younger users take 7 to 8 years or longer to seek treatment. Treatment-demand indicators therefore miss new epidemics among younger people and treatment services have little contact with them. This factor raises issues of availability, accessibility and attractiveness of

Analysis of treatment data using statistical and mathematical models

An EMCDDA project analysed the 'latency time' between first use of opiates (mainly heroin) and first demand for treatment in Amsterdam, Lisbon, London and Rome. The table below, giving the results for Rome, shows that the mean latency time differs greatly according to age, being much longer in those who started using drugs at a young age. There is also much variability within each age group — of those who started using drugs under 16 years of age, 25 % enter treatment within six years, 50 % (including the first group) within eight years and 75 % (including

both previous groups) within 13 years. This information is important for treatment services as it may partly reflect 'treatment attraction'.

It is now clear that treatment services do not attract young drug users. This may be either because these users do not feel the need for treatment, or because the services are less well suited to treat them. This should be studied further at local level, for example by interviewing users on the streets and in treatment about their reasons for attending or not.

Latency time between first use of opiates and first demand for treatment in Rome (years)

Age at first use	Sample size	Mean	25 %	Median (50 %)	75 %
Under 16	555	9.2	6	8	13
16-21	2 675	7.0	3	6	10
Over 21	1 426	4.7	1	3	7

treatment, and the need to investigate obstacles to obtaining treatment, especially for younger users.

Challenges for healthcare systems

Mortality and morbidity

In recent years, 6 000 to 7 000 acute drug-related deaths (overdoses) have been officially recorded each year in the EU. This figure has remained relatively stable, although differences may be observed within individual countries. The large majority of such deaths involve opiates, mainly heroin, but other substances such as benzodiazepines and alcohol are also often present. The actual number of acute deaths directly attributed to intoxication with heroin or other opiates is likely to be somewhat higher due to under-recording. HIV infection and hepatitis B and C remain important health problems linked to drug injecting.

Services available

Low-threshold services now exist in all EU countries, but differ in availability and type of services. Generally, they provide individual assistance, medical, psychological and social care to mainly very deprived users, mostly older drug users with a long history of addiction. Needle exchanges exist in all countries, although provision varies. In some countries pharmacies provide free or cheap needles. Injecting rooms are a controversial service available in some Member States.

Drug users and the criminal justice system

Between 15 and 50 % or more of prisoners in the EU have or have had problems with substance use. Several Member States report that overcrowding in prisons often hinders progress in appropriate care for drug users. Syringe exchange exists in a few prisons in Germany and Spain, and, in the UK, inmates who inject have recently been allowed sterilising tablets. Lack of trained prison personnel is another problem.

An EMCDDA study, 'Alternatives to prison in cases of drug addiction', gives an overview of the various options available in the Member States studied, ranging from postponement of or exemption from criminal responsibility to parole.

Only the Netherlands and Sweden report compulsory care, although the choice of terminology may hide the

fact that there is more or less compulsory care in most EU countries when addicts have to or can choose between imprisonment or treatment alternatives.

The principle of therapy instead of punishment has been adopted in the general guidelines of the drug policies in a growing number of countries. Some Member States have consolidated social and medical support towards drug-addicted offenders using the first contact with enforcement authorities as a door to treatment or counselling facilities.

Prevention and health promotion

Family, parents and schools all have a role to play in preventing drug use. School is still the main setting for prevention activities and is possibly one of the best ways to reach the majority of children. Teacher training and parental involvement is crucial and is promoted throughout the EU, although the role of the family, and especially parents, varies.

Policy developments

Towards a balanced approach

Striking a balance between demand and supply reduction is a major political consideration. Europe is gradually moving away from repressive responses and focusing more on prevention and treatment and the need to reduce the risks caused by drug use.

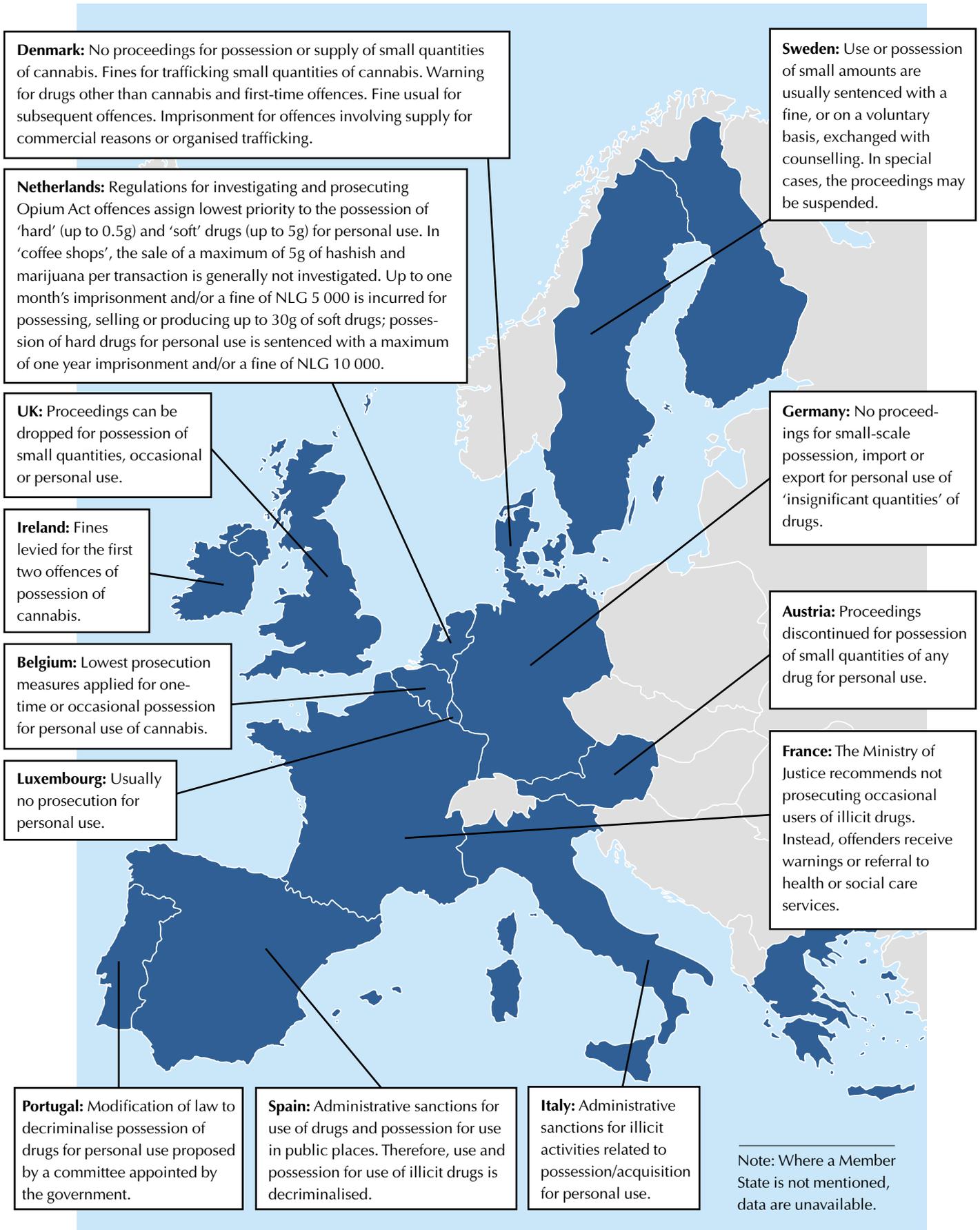
Harm reduction

After years of semi-marginal status in many countries, harm reduction is increasingly recognised as an important tool in national and local drug policies. The debate now focuses mostly on scientific evidence. Projects aim to give legal, professional or political recognition to a range of activities, such as needle exchange, injecting rooms or substitution treatment which attempt to reduce the health and social damage caused by drug addiction.

Decriminalisation

Prohibition of possession and/or use of drugs is the general concept followed by all EU countries. Legalisation is not considered an option in any Member State, but they are aware that prosecution and imprisonment of individuals with drug problems causes even greater problems.

Summary of EU responses to minor drug-related offences



The line between users and traffickers has widened in Europe under new drug strategies that focus on issues such as prevention, help and treatment for drug users even if they are convicted offenders, and punishment for drug traffickers even if they are users. Drug consumption in general seems not to be prosecuted in most EU countries. However, debate continues on how to deal with consumers in possession of small quantities of drugs for personal use, or who commit petty crimes because of their drug dependence.

Developments in European drug policies and new legal approaches towards illicit drugs show a shift towards decriminalising some behaviour linked to consuming and possessing drugs for personal use. Most Member States reject extreme solutions — such as full legalisation or harsh repression — but continue to prohibit drug consumption while modifying the penalties and measures applied to it.

Although the trend in many Member States is to reduce the emphasis on prosecuting and imprisoning drug users, police arrests and indicators of drug use in prison suggest some contradiction between theory and practice within some areas of the criminal justice system.

Licit and illicit drugs

The distinction between licit and illicit drugs is blurring. Debate centres on the extent to which it is useful to maintain the traditional distinctions between illicit drugs (cannabis or cocaine), licit ‘recreational’ substances (alcohol and tobacco) and licit psychoactive medicines (tranquillisers or analgesics). The status of other substances (solvents or steroids) adds a further dimension.

Illicit drug-use patterns frequently also involve licit substances, notably alcohol, tobacco and tranquillisers (taken for non-medical purposes). More problematic patterns of drug use are characterised by multiple use of licit and illicit substances, while treatment centres are reporting more poly-drug use. Prevention initiatives are generally geared to preventing the use of any drug, illicit or licit. Increasingly this trend is also being recognised in the treatment field with the tendency towards merging care for those with drug, alcohol or prescription drug problems.

Cooperation at all levels

Across Europe, cooperation between national, regional and local health, social, education and criminal justice systems appears to be increasing. This trend is also being encouraged among Member States.

As the borders between prevention and treatment blur, drug users at different stages depend on varying structures for help. The nature of drug use itself is characterised by ups and downs, and this is reflected in the way prevention and treatment are implemented and used. In most countries, outreach work and low-threshold facilities are developing fast. Cooperation between the criminal justice system and health and social sectors is also developing with diversion schemes for drug-using offenders and projects for imprisoned drug users.

A clear trend is the development of horizontal drug coordination bodies within national administrations. These groups coordinate national drug strategies and reinforce local authorities who implement national political and legal guidelines. European Drug Prevention Week (see Chapter 3) has clearly helped to increase cooperation in Europe in the area of prevention. But Europe is also improving its cooperation in other areas, including cross-border partnerships and exchange of experiences.

Information, evaluation and research

Harmonising key indicators

Improving comparability of data is a central task for the EMCDDA. The Centre is working with scientific experts and partners from various national focal points (NFPs) to develop five key epidemiological indicators on the prevalence and health consequences of drug use. The five indicators concern:

- surveys of drug use, behaviour and attitudes in the general population;
- prevalence estimates of problematic drug use;
- demand for treatment by drug users;
- drug-related deaths, mortality and causes of death in drug users; and
- drug-related infectious diseases (HIV, AIDS, hepatitis B and C).

Although the nature of the standards to be implemented vary according to the indicator, each will include a core data set, definitions and methodological guidelines for data collection, analysis and reporting.

Since structures for collecting data on each indicator differ between Member States, and the NFPs themselves vary considerably in terms of their expertise and potential

to influence the implementation of standards, the first task will be for each focal point to identify realistic targets and implement concrete work plans for progressively achieving these goals. It is important for the focal points to set up national reference groups to carry out work on each indicator.

Evaluation and research

Evaluation practice has improved in the EU, although many gaps still remain. The EMCDDA's 'Guidelines for the evaluation of drug prevention' and the promotion of its exchange on drug demand reduction action (EDDRA)

information system by the NFPs should put evaluation on the agenda of national administrations and professionals alike throughout the EU.

The EU is also taking research into drugs more seriously. For the first time, drugs are specifically included in the fifth framework programme (1998-2002) of European Commission Directorate-General XII (Science, Research and Development). This provides an excellent opportunity to strengthen the scientific knowledge base needed to improve understanding of drug-related problems and to develop evidence of the impact and effectiveness of public health responses.

Prevalence, patterns and consequences of drug use

This chapter presents updated information on indicators of the prevalence of drug use, health consequences, law enforcement and illicit drug markets in the EU. It is largely based on national reports provided by the national focal points, supplemented by results of published research or scientific studies carried out by the EMCDDA.

Prevalence of drug use

Drug use in the general population

The extent and pattern of consumption of different illegal drugs in the mainstream population, as well as characteristics and behaviour of users and attitudes towards drugs of different sections of the population, can be estimated through general population surveys. This methodology is useful for substances whose use is relatively common and not socially stigmatised, but is more limited for studying more marginalised forms of drug use.

Differences in prevalence of drug use between countries do exist, but direct comparisons should be made with caution since variations may result from methodological factors such as data-collection methods, the sampling frame used, the age ranges chosen in reporting results, and social and cultural differences regarding drug use. In addition, the relative proportion of a country's rural and urban populations may influence its overall prevalence figures. In an attempt to reduce these differences, the EMCDDA has been developing common European guidelines for population surveys on drugs.

Despite the differences between countries and varying reporting methods, some patterns do emerge. Cannabis is the illegal substance most frequently used in all countries, whereas other drugs have much lower prevalence rates. Lifetime experience of cannabis among adults ranges from 10 % in Finland to 20 to 30 % in Denmark, Spain and the UK. For young adults, the rates are higher: 16 to

17 % in Finland and Sweden and 35 to 40 % in Denmark, Spain and the UK.

Lifetime experience of amphetamines, generally the second most prevalent substance, is reported by about 1 to 4 % of all adults, and 1 to 5 % of young adults in the EU. Ecstasy has been tried by 0.5 to 3 % of all European adults and by 1 to 5 % of young adults. Rates for both amphetamines and ecstasy are significantly higher in the UK.

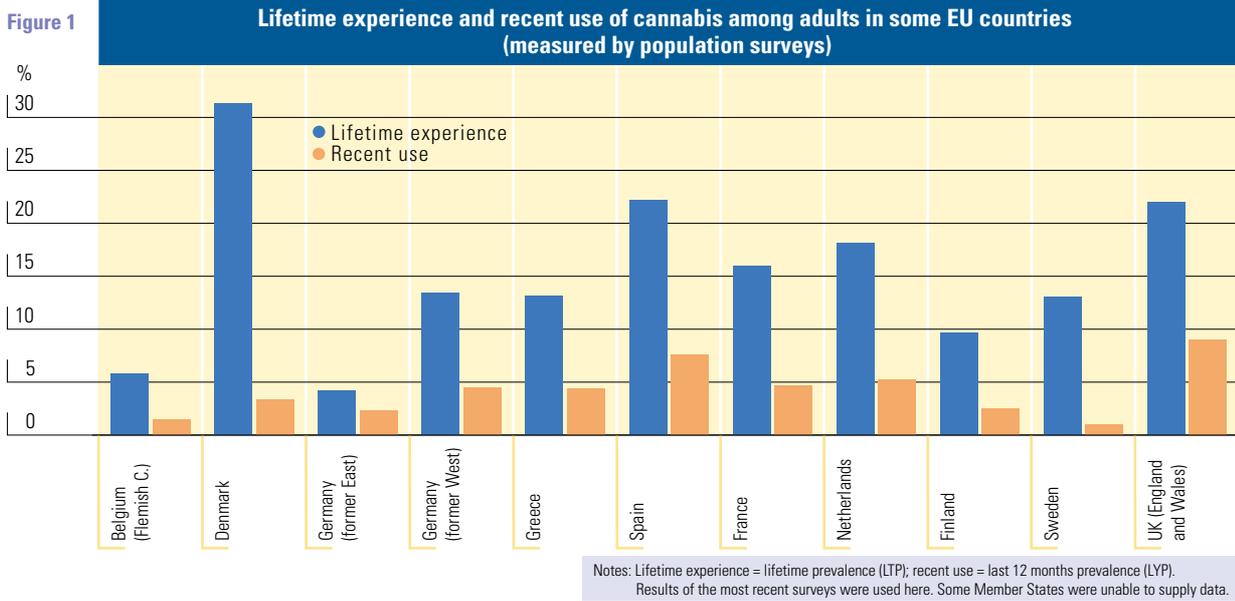
Cocaine has been tried by 1 to 3 % of all adults, and by 1 to 5 % of young adults in Europe. In Spain and France, rates for cocaine are higher than for amphetamines.

Recent cannabis use (last 12 months prevalence) is reported by 1 to 9 % of all European adults and 2 to 20 % of young adults (6 to 10 % in most countries). Recent use of other substances is generally very low: not more than 1 % in all adults and under 2 % in young adults, although higher levels are reported for cocaine in Spain and for amphetamines and ecstasy in the UK.

Consistent information on trends is limited, but evidence shows that cannabis use increased in the 1990s in most countries. It seems to have levelled off over recent years in countries with medium-to-high prevalence figures, but has increased in low-prevalence countries.

Drug use among schoolchildren

Most EU countries have conducted national school surveys over recent years, some as part of the European



school survey project on alcohol and other drugs (ESPAD). However, variations in the schools selected, age groups and social context may influence results substantially.

In most Member States, cannabis is the most widely used illegal substance. Lifetime use among 15- to 16-year-olds ranges from about 5 % (Portugal and Finland) to 40 % (Ireland and the UK).

Figures on solvent use should be interpreted with caution. In general, solvents are the second most commonly used substance among 15- to 16-year-olds, ranging from about 3 to 4 % (the Flemish Community in Belgium, Spain and Luxembourg,) to 20 % (UK). In Greece and Sweden, experience with solvents is more frequent than with cannabis.

Amphetamine use is reported by 1 to 13 % of 15- to 16-year-olds (2 to 8 % in most cases), ecstasy use by 1 to 9 % and LSD and hallucinogens by 1 to 10 % (2 to 5 % in most cases). Ireland, the Netherlands and the UK report comparatively higher figures for amphetamine, hallucinogen and ecstasy experience in this age group than other countries.

Cocaine has been tried by 1 to 3 % of schoolchildren, and heroin by less than 1 %, although this rises to 2 % in Denmark, Ireland, Italy and the UK.

In general, the upward trend in cannabis use by young people has continued in recent years, as has amphetamine and ecstasy use albeit at lower levels. Cannabis use in Finland and the UK among the young, however, has stabilised or even decreased.

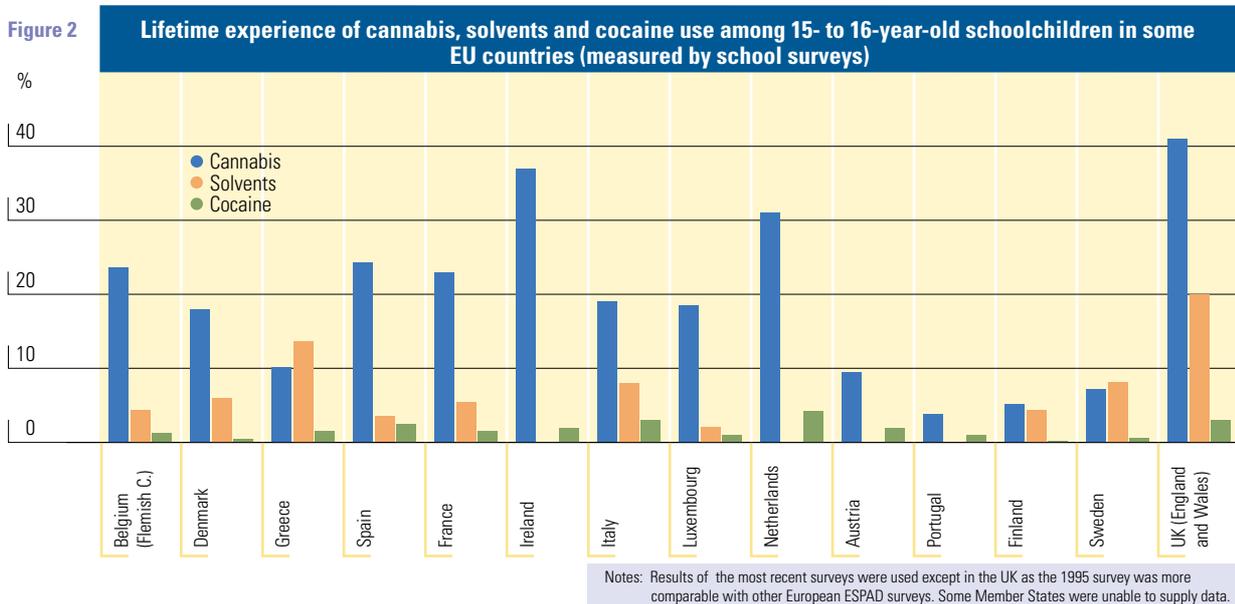
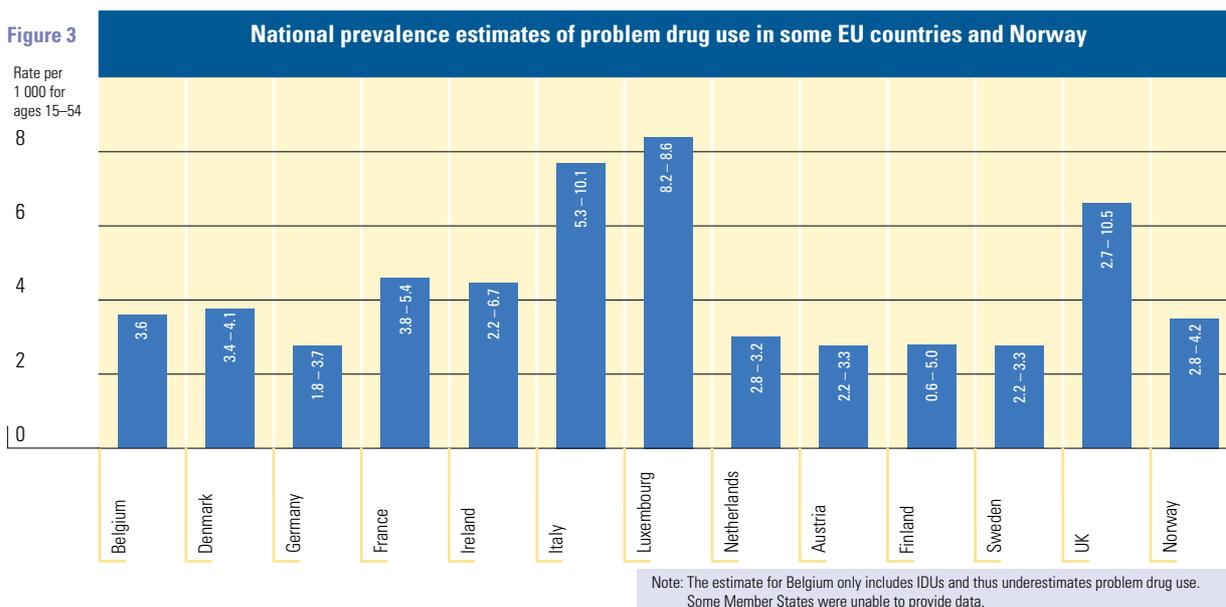


Figure 3



Estimating problem drug use

Despite the large impact made by problem drug users, their numbers are relatively small in comparison to the mostly recreational users of cannabis or ecstasy. Opiate addiction or injecting drug use are generally low in the adult population and almost absent at school age. But use of hard drugs is usually hidden and users fear stigmatisation if they admit to it. General population or school surveys thus cannot provide reliable prevalence figures.

For reasons of methodology, within-country heterogeneity or lack of data, national prevalence estimates are difficult to obtain. Prevalence figures should thus be interpreted as only crude indications or 'best estimates'.

Updated national estimates are presented here for countries that participated in an EMCDDA study to improve prevalence estimates at national level (see Figure 3). Until recently, methods and definitions varied significantly — the terms 'opiate addicts' or 'heroin addicts' were used in some countries, while a wider definition of 'heavy/severe drug abusers' or 'high-risk drug consumers' was used in others.

In the study, all countries provided figures using the same definition of problem drug use — intravenous drug use (IDU) or long duration/regular use of opiates, cocaine and/or amphetamines. This definition excludes ecstasy and cannabis users and those who do not regularly use opiates, cocaine or amphetamines.

In general, prevalence of problem drug use seems lowest in Germany, Austria, Finland and Sweden and highest in Italy, Luxembourg and the UK. In countries with intermediate prevalence, the estimates range between three

and five problem drug users per 1 000 population aged between 15 and 54.

A new EMCDDA study is investigating social indicators to estimate prevalence of problem drug use using statistical modelling techniques. Possible indicators include unemployment, property crimes, migration, housing density and socioeconomic status.

Another EMCDDA study has examined ways of using observed incidence of new drug users in treatment to estimate real incidence of problem drug use.

A third EMCDDA project evaluated the possible use of geographic information systems (GIS) to map drug-use data and estimates and develop models of geographic spread between cities and towns.

Indicators of health consequences

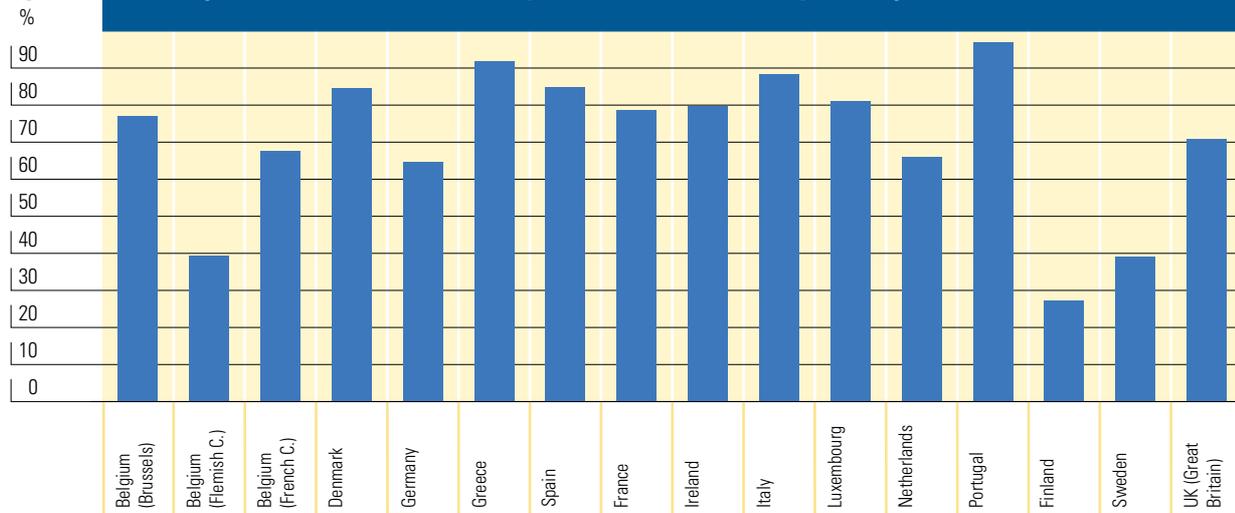
Demand for treatment

The number of admissions to drug treatment is another useful indirect indicator of trends in prevalence of problematic drug use, although changes in service availability, treatment modalities or reporting procedures must be taken into account. This information may be especially useful in describing characteristics and patterns of drug use (injection, multiple drug use) among problematic users, and in identifying patterns of service uptake, so helping to assess service needs.

Almost all EU countries provide information on drug treatment, but data collection and coverage of various

Figure 4

Proportion of clients admitted to drug treatment whose main drugs were opiates in some EU countries



Note: Some Member States were unable to provide data.

types of treatment centres vary. New services may attract new users, increase the number of treatment admissions or change profiles like age, sex and route of administration. Other characteristics, especially the proportion of injectors among treated clients, differ from country to country. Building on previous work undertaken by the Pompidou Group, a new common European protocol to improve the quality and comparability of treatment demand information has been drawn up by the EMCDDA. This protocol will be adopted and promoted by both organisations.

The majority (70 to 95 %) of treatment admissions are for opiate (mainly heroin) use, although in the Flemish Community in Belgium, Finland and Sweden opiate cases represent less than 40 % of admissions. This lower figure may reflect differences in methodology.

In most countries, cocaine is reported as the main drug by less than 10 % of treatment admissions, although this rises to 15 % in Luxembourg and 18 % in the Netherlands. Heroin users frequently report cocaine as a second drug.

Cannabis is generally reported as the main drug of 2 to 10 % of treatment clients, although this is higher (13 to 22 %) in Belgium, Germany and Finland.

Amphetamines, amphetamine-type stimulants (such as ecstasy) and hallucinogens are primary drugs for generally less than 1 to 2 % of treatment cases. However, the proportion is higher in the Flemish Community in Belgium (19 %), Finland (48 %), Sweden (20 %) and the UK (9 %).

Prevalence of injecting drug use is more common among opiate users, ranging from about 14 % (the Netherlands) to over 80 % (Greece and Luxembourg). Injection of

amphetamines is reported frequently in the Scandinavian countries and the UK, although this is not a common pattern in most countries.

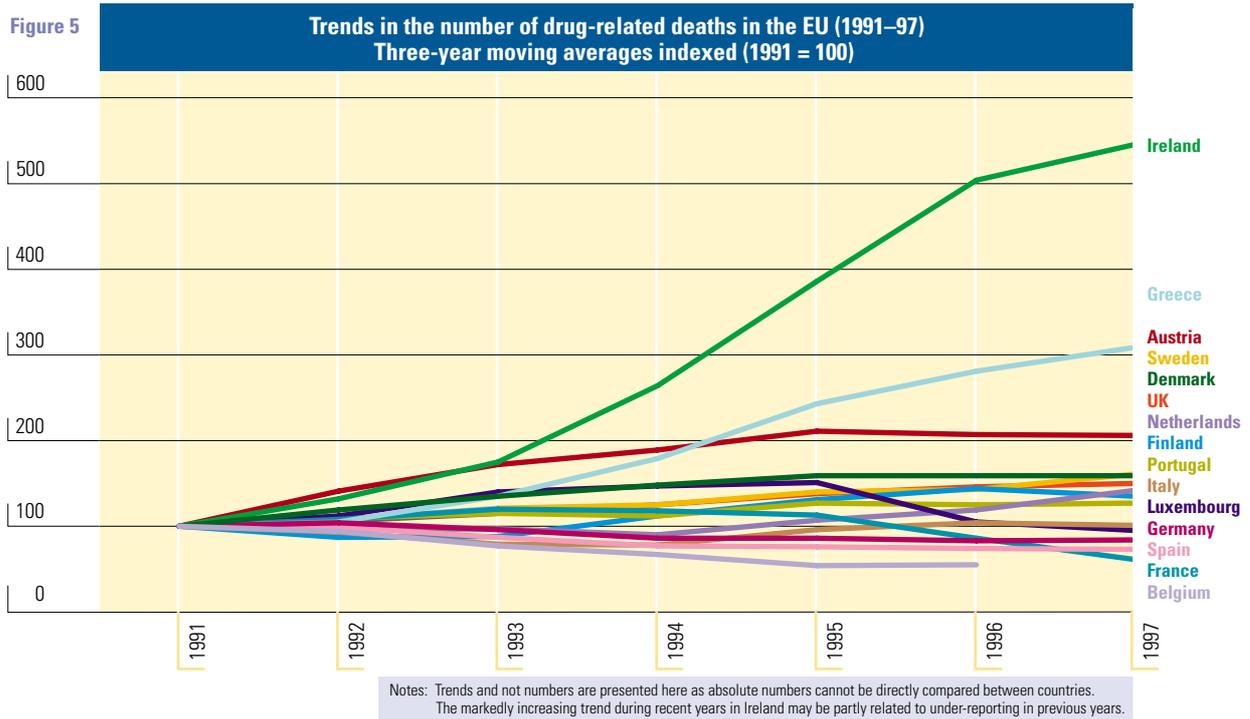
In all EU countries, males represent 70 to 85 % of clients admitted to treatment. The mean age of clients in treatment is 25 to 35 in most cases. Some countries report an increase in this mean age.

Available treatment information indicates that in general the proportion of treatment admissions for opiates is decreasing, while cases of treatment for cocaine and cannabis are increasing although they remain at lower levels than opiates. Recently, some countries pointed out the increase in cannabis cases, especially among clients treated for the first time. However, this trend requires more detailed examination, as other factors should also be considered. Most EU countries report a decrease in the proportion of injectors among treated opiate users.

Drug-related deaths and mortality of drug users

Death is a possible consequence of some forms of drug use, although the risk varies according to the substance and the pattern of use. The number of acute drug-related deaths (overdoses) is often simplistically used as a marker of a country's drug situation.

EU statistics on drug-related deaths refer generally to deaths occurring shortly after drug use (sometimes known as acute intoxication, overdose, poisoning or drug-induced deaths), although other types of deaths should also be taken into account. Direct comparisons of national statistics cannot be made because of differences in the prevalence of drug use, and the methods and



definitions used to record cases. The EMCDDA is collaborating with Eurostat and the World Health Organisation to produce standard guidelines for reporting results from general mortality and forensic/police registries.

In many EU countries, the number of drug-related deaths has stabilised or even decreased following marked increases in the late 1980s and early 1990s, although the increase continued until recently in some countries.

Most deaths by acute intoxication involve opiates, although alcohol and benzodiazepines are also often present. Acute deaths relating solely to cocaine or amphetamines are unusual. Deaths related to ecstasy or similar substances, although widely publicised, are few in number.

In addition to national statistics on drug-related deaths, mortality risk associated with some forms of drug use may be assessed by following groups of drug users and monitoring their mortality (cohort studies). Problem drug users have a much higher risk of death than the general population, from a wide range of causes and not just acute intoxication. Studies indicate that opiate injectors have a 20 to 30 times higher risk of death by overdose, HIV infection, accident and suicide than non-drug users of the same age. Mortality among injectors increased with the spread of HIV infection, while non-injectors or users of other psychoactive substances have a much lower risk of death.

In order to improve comparability between results in different EU locations, the EMCDDA has developed a

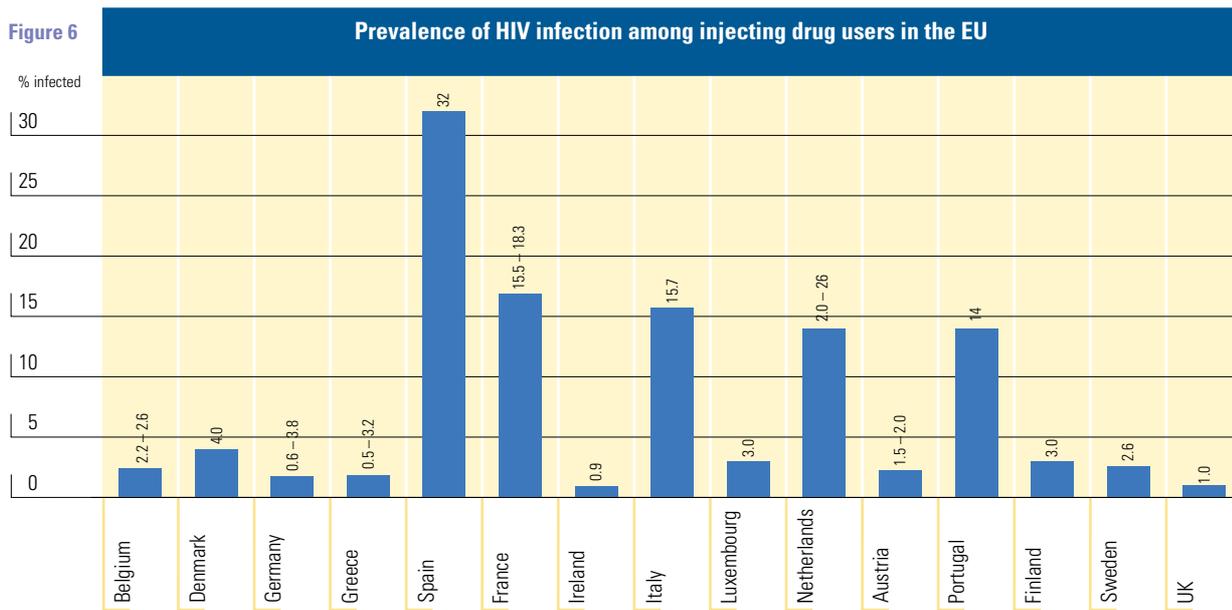
standard protocol to conduct mortality cohort studies among drug users recruited in treatment centres.

Drug-related infectious diseases

Infectious diseases, such as HIV and hepatitis B and C, have reached high prevalence among IDUs. There are, however, major differences between countries in prevalence rates for HIV infection, ranging from 1 % in England, Ireland and Wales to 32 % in Spain (see Figure 6). Differences in prevalence also exist within countries, between regions and cities. Prevalence seems to decline slowly in some countries (France, Italy), but not in others (Spain). Even in countries where prevalence remains stable, transmission probably continues among IDUs. The HIV epidemic has now entered a stable (endemic) phase in most west European countries.

Incidence rates for AIDS also vary greatly between countries and in general continue to decline (see Figure 7). This is probably the effect of a steady increase in uptake of new combination treatments among IDUs which delay the onset of AIDS. In some countries (Portugal), AIDS is not declining, which might indicate lack of access to HIV treatment. The proportion of IDUs among all cumulative AIDS cases differs significantly between countries, illustrating variations in the relative importance of IDUs in the AIDS epidemic. AIDS monitoring is becoming less useful as an indicator of the extent of HIV infection and is instead becoming an indicator of treatment uptake. Centralised reporting of known HIV cases is now being considered in Europe to complement existing AIDS reporting.

Figure 6



To help combat infection, syringes are easily available in most countries (except Finland and Sweden) and condoms and HIV counselling and testing also seem to be widely available. Substitution treatment, which reduces injecting, also exists in all countries, mostly in the form of oral methadone.

Many studies among IDUs show higher prevalence of infectious diseases among those who have ever been imprisoned.

Hepatitis C infection shows higher and more similar prevalence rates across the EU than hepatitis B, generally between about 50 % and over 90 %, even in countries with low rates of HIV infection like Greece (see Figure 8). For years, HCV prevalence seemed not to follow the decline observed in HIV infections. More recently, HCV prevalence may be declining in the UK, suggesting that harm reduction measures might have affected HCV transmission. On the other hand, a local rise from 89 to 95 % is reported by the drugs emergency service in Frankfurt, Germany.

HIV, hepatitis C and injecting risk behaviour among intravenous drug users in prison (%)

Prison location	IDUs infected with HIV	IDUs infected with HCV	IDUs who shared materials during last injection outside prison in previous four weeks	IDUs who injected in prison	IDUs who began injecting in prison
Belgium (one site)	0	38.5	47	35 (10*)	15
Germany (one site)	1.4	14.4	n.a.	36 (18*)	9
Spain (one site)	23.4	n.a.	32	79	10
France (three sites)	13.3	53.2	34	37 (29*)	7
Italy (three sites)	16.1	64.2	32	25	6
Portugal (three sites)	28.1	61.9	49	57	5
Sweden (nine sites)	2.6	57.6	30	64	5

n.a. = not available

(*) Figure in parentheses refers to the percentage of the total who have injected in the past four weeks.

Source: European network on HIV/AIDS and hepatitis prevention in prison, 'Annual report to the European Commission', May 1998.

Figure 7

AIDS incidence in injecting drug users in the EU (1987-98)

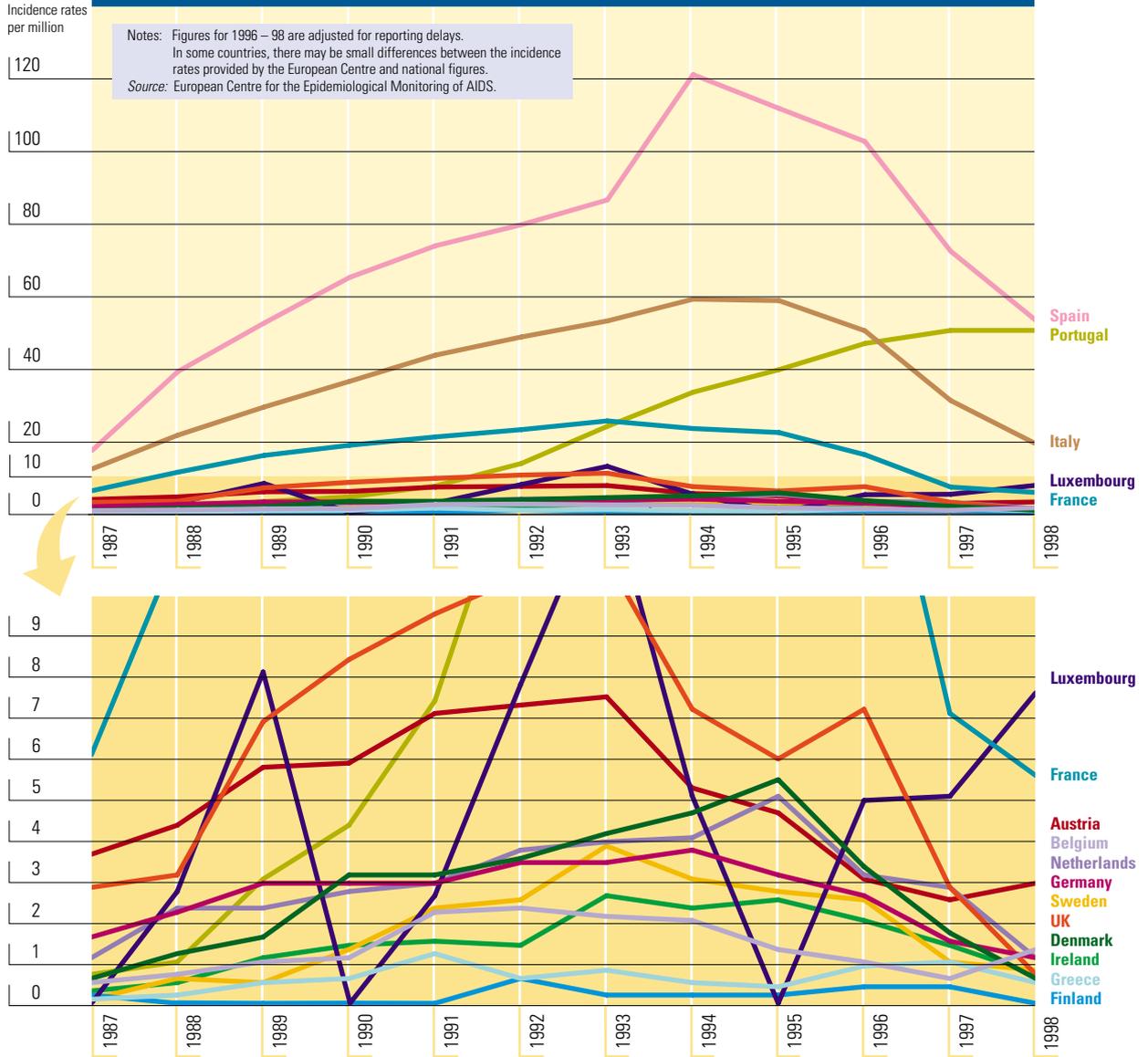
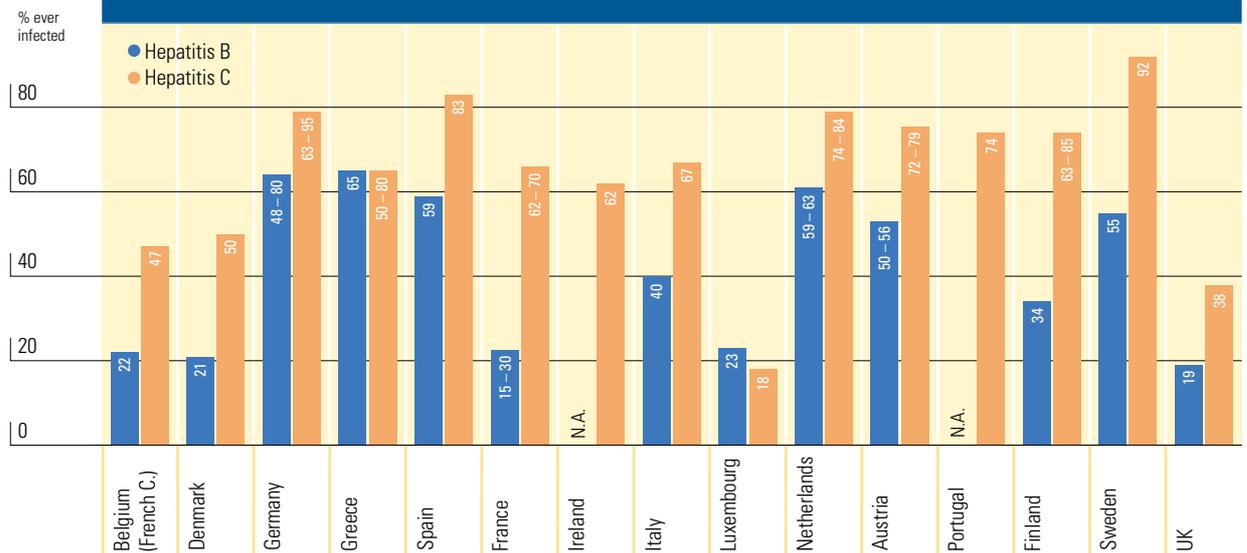
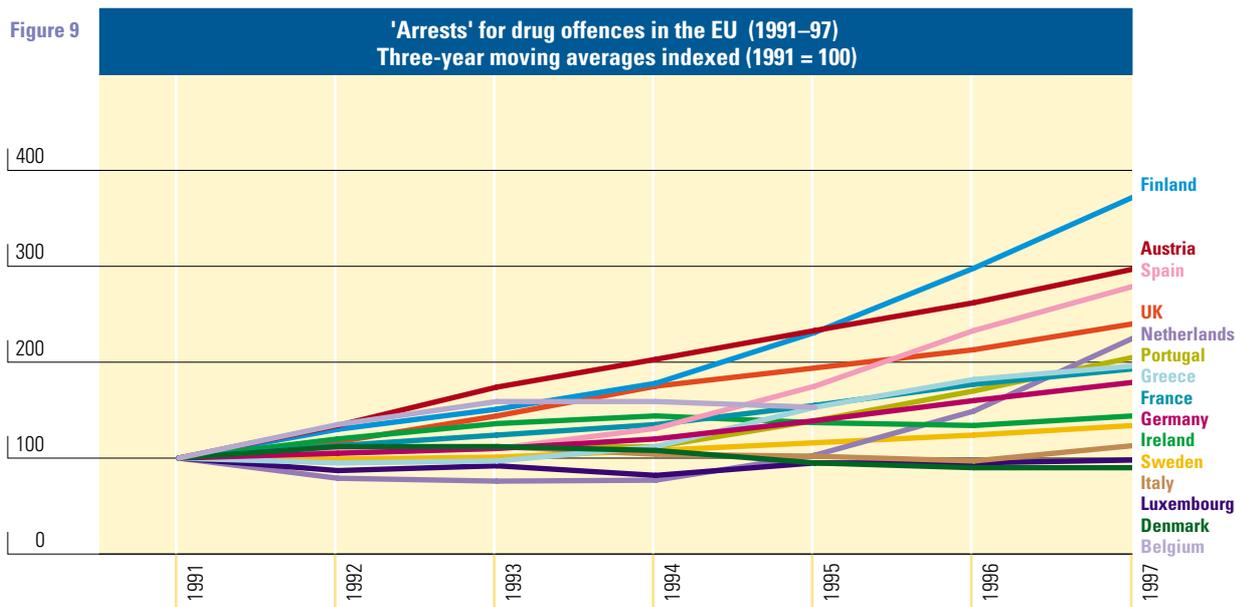


Figure 8

Antibodies to hepatitis B and C among injecting drug users in the EU





Law-enforcement indicators

Police 'arrests' for drug offences

The only data systematically available on law-enforcement interventions refer to offences against national drug laws (trafficking, possession, use and others). These reflect individual Member State legislation, recording procedures and police resources and priorities. Given the difficulty of comparing data directly, emphasis is placed on time trends.

The number of arrests for drug-related offences has been steadily increasing since the mid-1980s in the EU: up twofold in Denmark, Italy, Luxembourg and Sweden and over six times in Belgium, Greece, Spain, Portugal and Finland. (For definitions of 'arrests' for drug offences in each Member State, see the extended version of this present report.) In these last five countries plus Italy and the Netherlands, this trend has accelerated in recent years. In Denmark, Ireland and Luxembourg the number of drug-related arrests has stabilised.

In 10 Member States, cannabis is the main drug involved in 46 to 85 % of arrests. In Luxembourg and Portugal, heroin is the predominant drug, in the Netherlands it is 'hard drugs', while in Sweden amphetamines are most common.

Use-related offences remain predominant, ranging from 61 % in Portugal to over 85 % in Austria and Sweden. In all the countries, except Belgium and Ireland, where it is decreasing, the proportion of use-related offences is increasing or stable.

Rates of drug-related arrests per 1 000 inhabitants range from 0.4 to 2.5. Since the statistical unit (offence, person, arrest) varies by country, comparisons should be made with caution.

Prison data

National level information on drug use in prison remains very limited and reliable data are rare.

Drug offenders in EU prisons range between 15 and 50 % of the total jail population. In over 75 % of these cases the main drug offence relates to dealing/trafficking.

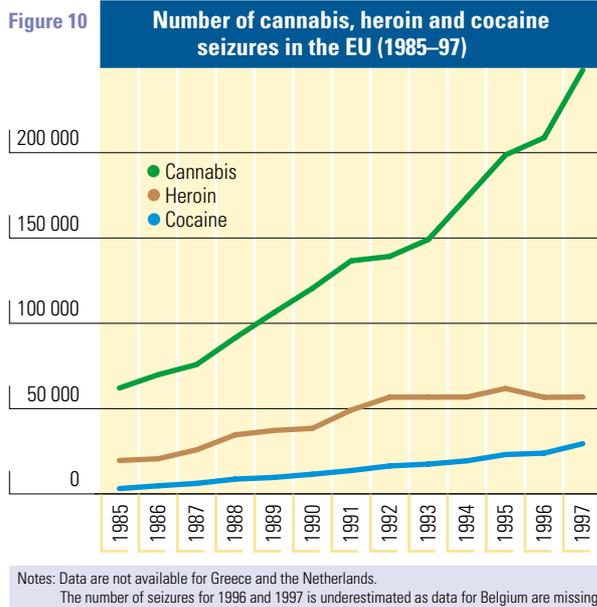
Data on drug users in prison refer to different definitions and cannot be directly compared. Drug use is reported for 30 to 90 % of prisoners, while problematic drug use concerns 10 to 45 % of prisoners.

Drug market indicators

Drug seizures, price and purity

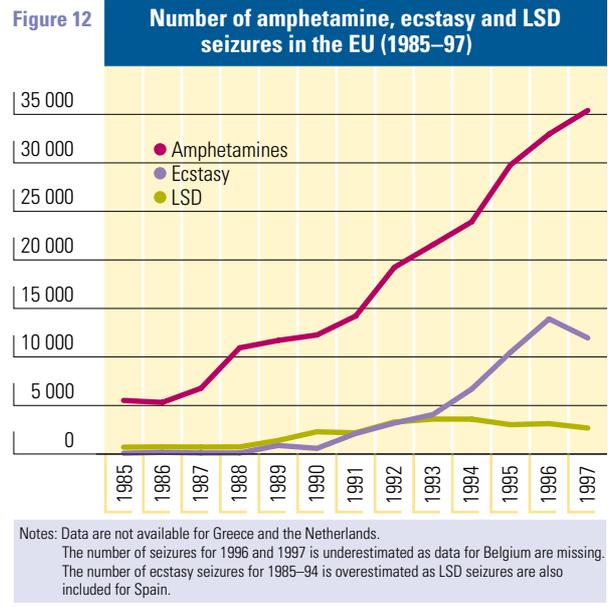
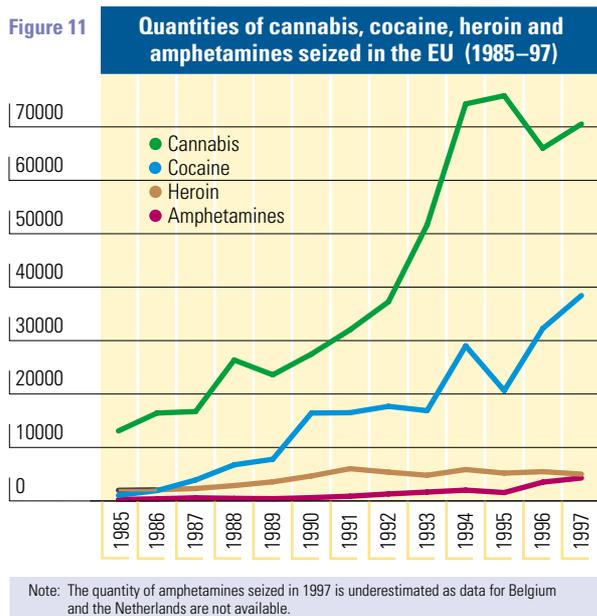
Cannabis accounts for a greater number of seizures than any other drug. The total quantity of cannabis seized increased rapidly up to 1995, but has since stabilised with the largest seizures in Spain in 1998. In most countries, the number of seizures, unlike the quantities seized, are still increasing. The price of cannabis appears to be stable or decreasing.

After peaking in 1991, the quantities of heroin seized have fluctuated within a range of 5 to 6 tonnes. Since 1995, the UK has seized the greatest quantities, accounting for nearly half the total amount seized in the EU in 1997. Overall, the total number of seizures rose to 1992



and have now stabilised, although clear decreases have been reported in some countries in the last three years and marked increases in others. The average quantity of heroin per seizure at EU level has remained stable since the mid-1980s at about 60 to 80g. The street price of heroin is stable in most countries, and the purity is reported to range from 10 to 50 %.

The quantities of cocaine seized peaked at 38 tonnes in 1997, with the largest seizures being in Spain the same year. Available data for 1998 seem to indicate that the amount of cocaine seized in the EU has decreased,



especially in Spain. The number of seizures, however, have been increasing at a steady rate. The average quantity of cocaine seized at EU level is much higher than for heroin, and has increased since 1985 from about 250g per seizure to over 1kg in 1997. The street price of cocaine is relatively stable in most reporting countries, and retail purity ranges from 50 to 70 %, although Greece reports 5 to 10 % purity at user level.

The number of amphetamine seizures and the quantities seized in the EU have been increasing since 1985, with an acceleration since the early 1990s. The quantities of ecstasy seized increased sharply from 1987–96 before decreasing by half in 1997. More than 75 % of this is accounted for by seizures in the UK. Following a steady upward trend, the number of ecstasy seizures declined or stabilised in most countries in 1997 and 1998. Data on 1998 seizures appear to confirm that, despite rising concern about ecstasy in recent years, amphetamines are actually increasingly dominating the market in synthetic drugs.

A recent decrease in prices of both amphetamines and ecstasy is reported. Purity of amphetamines appears to range between 10 and 100 %. The purity and composition of pills sold as ecstasy vary considerably.

Seizures of LSD are less common than amphetamines or ecstasy. Since 1993–94, they have levelled off or fallen in all Member States except Austria, which saw a continuous rise to 1997.

Established responses to drug misuse in the EU

European Drug Prevention Week

Cannabis: trends and responses

Synthetic drugs: developments and responses

European Drug Prevention Week

Drug prevention, already high on the EU agenda, was given a boost with the launch of the third European Drug Prevention Week (EDPW) from 16 to 22 November 1998 under the Austrian Presidency of the Council of the European Union. The event highlighted a variety of initiatives and projects throughout the EU, as well as in participating non-member countries, such as Norway.

The main aim of the EDPW is to reinforce cooperation at European level on health aspects of the drugs phenomenon, highlight long-term prevention activities in the Member States and raise public awareness of the issue.

Since the first EDPW in 1992, the Week has helped to strengthen cooperation between professionals involved in drug prevention, particularly those in the health, education and social services, youth work and law enforcement agencies, within and among the Member States.

Prevention and policy events

The 1998 Week was the first organised and held in the context of the EU's action programme for the prevention of drug dependency (1996-2000). For the first time new Member States, Austria, Finland and Sweden took part along with non-member Norway. The theme was multi-disciplinary: to raise awareness in society and to increase working partnerships.

The EDPW, held during the Austrian Presidency of the Council of the European Union, opened with a conference in Vienna attended by 300 experts and politicians

from all Member States as well as representatives from Liechtenstein, Norway and central and eastern Europe. The conference, conceived as a forum for exchanging information and good practice, discussed ways of cooperating on and coordinating drug-prevention strategies at local, national and European level, and examined health and social policy, education and youth issues, security policies, regional and local politics and public relations.

Delegates concluded that more work was needed to improve the quality and comparability of data on the drug phenomenon in the EU and globally. Such information would help substantially in drawing up current and new strategies.

An EU-wide campaign, 'Talking is the first step', highlighted the importance of dialogue in drug prevention. The campaign was directed mainly at adults in permanent contact with young people, including parents, teachers, youth workers, instructors and sports trainers.

The media campaign consisted of a television commercial in 18 languages, a radio commercial in six languages, a poster produced in 19 language versions, a leaflet in 13 languages, a press advertisement in 12 languages and a press release in 18 languages.

In the Member States, over 1000 initiatives were launched at EU, national, regional and local level to which the Commission contributed about EUR 950 000. The Member States tended to incorporate the Week into their national annual drug-prevention strategies and used

it to draw public attention to long-term projects. Some Member States held debates on existing national prevention strategies and new approaches to prevention during the EDPW.

Young people and youth workers, families, professionals in the field, politicians and the media were all targeted by EDPW activities. Some Member States also identified other groups, such as ethnic minorities, drug users and very young children. For example, in France, 39 out of 46 projects targeted the young, reaching 18 000 people. In Austria during 'Summer Talks '98', Austrian, German and Hungarian experts discussed a variety of drug prevention possibilities for children aged three to six, and a conference on drug prevention in kindergartens was organised by the Vienna Information Centre on Addiction Prevention.

In addition to conferences, seminars and training courses, all Member States organised activities that encouraged dialogue with young people, raised awareness and reinforced self-esteem. A large number of artistic and cultural events were held throughout the EU, involving music, theatre, dance, games, photography, films and video.

Peer-to-peer approaches were highlighted in most Member States covering issues such as peer-group communication among young people, alcohol and drugs.

New media, in particular the Internet, but also CD-ROMs, chat-boxes and video, also played a role during the EDPW, providing harm reduction and preventive information and assessing knowledge about and attitudes towards drugs.

Each Member State responded to the challenge of reinforcing partnership and interdisciplinary approaches in different ways. The Netherlands created a national steering committee of representatives from government and NGOs responsible for drug prevention to draw up and implement national programmes following European Commission guidelines. Other Member State initiatives attempted to raise the visibility of drug prevention efforts by targeting those working with young people, structures already active in drug prevention and the general public and promoting cooperation among them.

Follow-up

The European Commission is currently evaluating the EDPW and other activities implemented as a part of the EU action programme for the prevention of drug dependence (1996–2000). The global evaluation of the action programme is being carried out with the support of the Association of Schools of Public Health in the European Region (Aspher).

Lessons from the European Drug Prevention Week

Although the European Commission's final evaluation of European Drug Prevention Week events throughout the participating countries is still to be finalised, some observations can already be made about the 1998 event. Information from the national reports of the Reitox national focal points has helped to highlight some of the Week's key elements.

- The European Drug Prevention Weeks are efficient tools for promoting both EU and national prevention activities. The events help to encourage and promote the exchange of information on best practice in prevention at European level.
- The organisation of the 1998 Week itself highlighted the benefits of coordination at EU level, as well as helping national agencies to collaborate in a wider European context.

- The European media campaign did have an impact, but would have benefited from addressing a specific and common drug-prevention message — similar to the Europe Against Cancer Weeks.
- Taking into account the difficulties encountered by some project leaders to develop the European component of their initiatives, support at an early stage should be envisaged for the next EDPW to facilitate the development of projects with a Europe-wide dimension that focus on a common European-defined theme.
- The use of EMCDDA reporting tools will allow for a standardised presentation of the Weeks' activities. Nevertheless, the evaluation procedure was not begun early enough and it will therefore take some time until reporting is completed.

The evaluation methodology aims to ensure standardised information from Member States on the Week. To do so, the Commission provided all national coordinators with a reporting questionnaire produced by the EMCDDA for its exchange on drug demand reduction action (EDDRA) information system. The EMCDDA also provided the

Commission and national coordinators with its guidelines for the evaluation of drug prevention for distribution to project leaders. This tool aims to promote the evaluation of preventative activities and to provide guidance to project leaders when conceiving activities and related evaluation.

Cannabis: trends and responses

Cannabis is the most common illicit drug in Europe. During the 1990s, the extent and patterns of cannabis use and availability have been changing, health and social issues related to cannabis and appropriate responses are being re-examined, and debates have intensified over the legal status and possible medical uses of cannabis.

Cannabis, marijuana and hashish

The plant *cannabis sativa* contains the psychoactive substance delta9-tetrahydrocannabinol (THC), the principal psychoactive ingredient of the drug cannabis. ‘Marijuana’ is another name for the same plant and is used most often to refer to its dried leaves and flowering tops. The resin extracted from the buds and flower heads of the cannabis plant is known as hashish, and hash oil can be extracted from the resin. The terms ‘cannabis’, ‘marijuana’ and ‘hashish’ are all commonly used, sometimes without any differentiation.

Cannabis extracts — marijuana, hashish and oil — are classified as narcotic drugs under Schedule I of the 1961 United Nations Single Convention on Narcotic Drugs. The Convention provides for strong control measures for the production, trade, possession or use of narcotic drugs, except for amounts necessary for medical or scientific research. These obligations are further reinforced by the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

EU Member States apply the UN conventions according to their own local or regional circumstances. Some countries or regions tolerate certain forms of possession and consumption; other countries apply administrative sanctions or fines; while still others impose penal sanctions.

Despite these different legal approaches to cannabis, at the prosecution stage a common trend can be seen across the Member States — the development of a range of

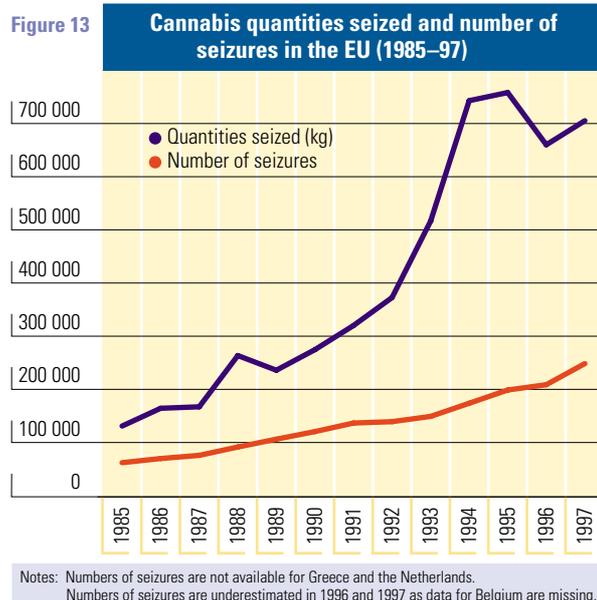
alternative measures in cases of possession of small quantities of cannabis for personal use without aggravating circumstances.

Fines, cautions, probation, exemption from punishment and counselling are the most common responses of European justice systems to cannabis offences. At the same time, however, police arrests for drug offences — mainly for cannabis and for use-related offences — are increasing in several countries.

A more accurate understanding of how drug policy is applied in practice in relation to cannabis can only be achieved through specific studies that analyse data from police forces and prosecutors in more detail.

Patterns of use

Recent surveys suggest that over 40 million people in the EU have used cannabis. On average, about one in every five 15- to 16-year-olds and at least one in four 15- to 34-year-olds has tried cannabis.



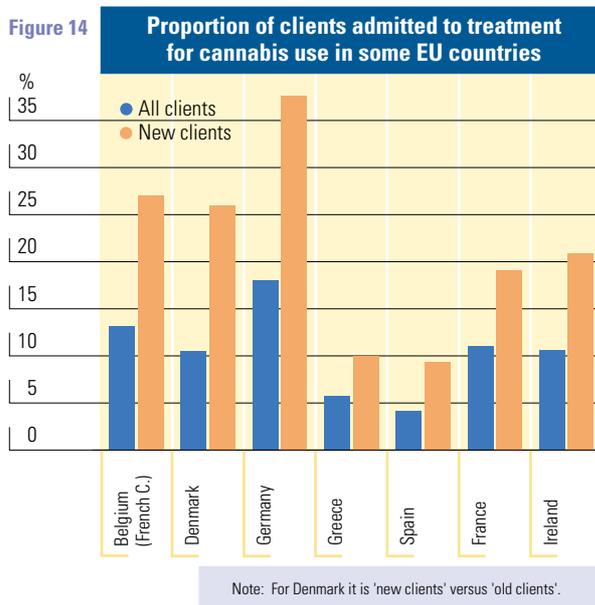
Cannabis and driving

A review of the scientific literature on drugs and driving commissioned by the EMCDDA found that evidence as to whether cannabis impairs driving and increases the risk of road accidents was inconclusive.

Experimental studies are not entirely consistent, with some finding no significant effects on perception, and others pointing to some impairment of attention and short-term memory, although these effects are typically observed at higher doses.

In some field studies which tested the bodily fluids of drivers involved in accidents, cannabis has been found to be quite prevalent, but since these tests may give positive results up to one month after the cannabis has been used, they may not be a reliable measure in this case.

Interpretation of the causal contribution of cannabis to road accidents is further complicated by the concurrent presence of other drugs, especially alcohol. Some studies suggest that cannabis does not appear to pose a high risk for drivers since it was found that drivers under the influence of cannabis actually drive more carefully.



Considerable differences remain between countries in the extent of cannabis use, but there are indications of a convergence in prevalence levels. In higher-prevalence countries, the trend appears to be stable or decreasing following increases in the 1990s. In lower-prevalence countries, use is increasing.

In much of the EU, cannabis use is not associated with any specific social or recreational context or group. In many Member States, there appears to be a trend towards perceiving cannabis use as normal or mundane rather than as deviant. However, cannabis users cannot be considered as a homogenous group and different patterns of use are reported. For example in Germany, cannabis users frequently live inconspicuously and without great problems, although in the last few years there has been a marked increase in the number of clients starting treatment for cannabis problems in out-patient centres.

Seizures

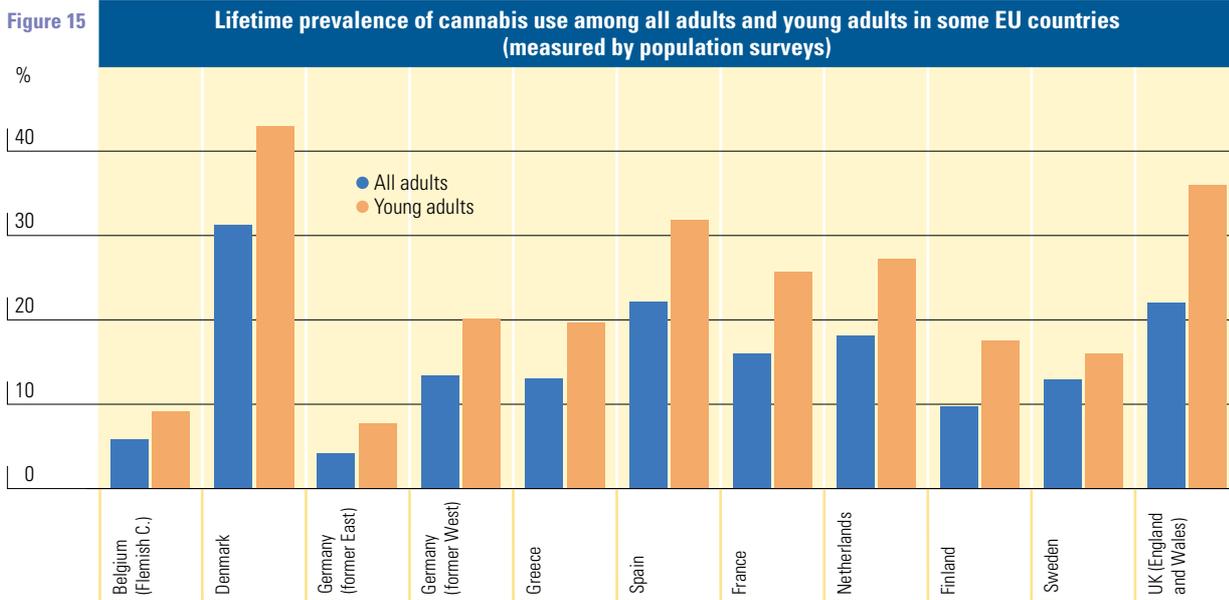
The quantities of cannabis seized each year in the EU have remained stable since 1994, although the number of seizures is steadily increasing. Availability remains high across most of the Union and the market for cannabis appears entrenched with relatively stable prices. The cannabis seized in the EU comes mainly from Morocco, although smaller seizures originate in Afghanistan, Lebanon and Pakistan. Spain and the Netherlands are often reported as transit countries for cannabis imported into the EU.

Herbal marijuana seized in the EU largely comes from Colombia, Nigeria, South Africa and Thailand. Cannabis is also grown domestically in almost every Member State, although there is little evidence of large-scale trafficking.

Potency

In some countries, a variety of 'pedigree' cannabis seeds (indica) are bred specifically for indoor cultivation, giving bushy plants and high-quality flowering tops. Many of the newer strains appear to have been developed from Himalayan plants, whereas domestically produced cannabis had previously used seeds that give taller plants from Africa, the Caribbean and the Far East.

Some countries report an increase in the potency of cannabis, in particular of herbal cannabis (marijuana), over recent years, and concern over this has been expressed by law enforcement agencies amongst others. The limited data available from national focal points give ranges for the THC content of cannabis as predominantly 5 to 11 % in Germany, 6 to 9 % in the Netherlands and 2 to 14 % in the UK. In a few cases higher potency is reported, but it is not always specified if this is for hashish, marijuana



or oil. Others suggest that marijuana contains 0.5 to 5.0 % THC, hashish 2 to 20 % and hash oil 15 to 50 %.

Neither the typical content of different forms of cannabis on the market nor to what extent the potency has actually increased are clear. Furthermore, consumer behaviours and preferences are not known. Detailed, systematic studies would thus help to establish a more informed basis for discussion.

Treatment

Cannabis is considered the main drug in only a minority of clients starting treatment, typically around 10 % or less, but is more commonly reported as a secondary drug for those entering treatment for other substances. Some increase has been noted in several countries, and the proportion is higher in new clients entering treatment for the first time. Most treatment demands for cannabis involve clients who are much younger than those whose main drug is heroin or other drugs.

There are very few services targeted specifically at cannabis users, so clients seeking treatment for cannabis-related problems usually do so in settings where most clients seek treatment for other substances, such as heroin or cocaine. Since clients with cannabis-related problems constitute only a minority of those in treatment throughout Europe, and since they present a different profile compared to other treated drug users, it is difficult to know if the treatment on offer is appropriate, and what kind of alternative approaches might be most helpful.

Much more information is needed on the nature of the problems associated with cannabis. Since people who

experience difficulties with cannabis may also be using other substances or may have a range of psychosocial problems, it is important to clarify the extent to which cannabis-specific services are needed and how far improved assistance might be provided within the framework of other interventions.

Prevention

Most prevention initiatives try to talk people out of taking cannabis. As with treatment, few prevention initiatives target just cannabis. Telephone helplines are open to cannabis users, but none are devoted purely to cannabis.

All Member States distribute information on drugs which includes cannabis, and some have produced material specially on cannabis. Some initiatives are meant to provide general information about cannabis and the effects of THC, while other measures are aimed at parents.

Debates and discussions

Debate on whether cannabis can or should be used for medical purposes in Europe has intensified. In most countries, the debate is informal, but in Denmark, Germany, Spain, the Netherlands, Austria and the UK it has become more official.

In other regions of the world, debate on the therapeutic value of marijuana has led to political discussions, mainly focusing on initiatives to reform 'prohibitive laws' to allow medical doctors to prescribe marijuana.

Synthetic drugs: developments and responses

Political and public concern about synthetic drugs escalated during the 1990s in response to increasing and apparently widespread use of ecstasy by a broad spectrum of mainstream youth. Control of these drugs — easily manufactured at low cost within the European Union from readily available materials — was becoming increasingly difficult.

Understanding dance culture

'You can't have any understanding of dance culture without understanding ecstasy. It's like trying to understand pub culture without understanding beer... DJs and record producers who say they have nothing to do with drugs are hypocrites. They owe their whole career to drugs. In the old days, people used to dance for ages to get themselves worked up. Now, you're taking the lift, rather than the stairs.'

Irvine Welsh (widely acclaimed author of *Trainspotting* and *Ecstasy*). Interview in *Ministry Magazine*, April 1999.

Defining synthetic drugs

The term 'synthetic' drug strictly refers to psychoactive substances manufactured in a laboratory rather than derived from natural sources, and thus includes tranquilisers, methadone, amphetamines, ecstasy and LSD. The term is also used for new substances that have appeared on the ecstasy market that fall outside existing legal controls — some deliberately manufactured to do so. This use of the term thus indicates a preoccupation with the particular problems of controlling the production and distribution of synthetic drugs, rather than reflecting the patterns of their use.

In many recreational settings, young people are likely to use not only ecstasy, but also amphetamines, LSD and benzodiazepines — which are 'old' synthetic drugs — as well as substances that are not synthetic, such as alcohol, cannabis, cocaine, magic mushrooms and, sometimes, heroin.

What is ecstasy?

'Ecstasy' is the common name for the ring-substituted amphetamine MDMA. Most users assume that pills called 'ecstasy' contain MDMA, but this is only one of a family of phenethylamines which includes MDA, MDEA and MBDB.

In the early 1990s, ecstasy gained in popularity among young people who believed MDMA to be safe and non-addictive. This new trend in drug use developed within a mass recreation and music culture known as 'rave', 'acid house' or 'techno'.

Compared with other stimulants, ecstasy does not tend to produce the extreme mood swings characteristic of amphetamines and, compared with cocaine, the positive effects of ecstasy last much longer. These effects are generally experienced as energising, euphoric and entactogenic, a combination that led to the drug's key role at music and dance events. In turn, ecstasy contributed to the success of commercial party events by facilitating the inclusive, bonding atmosphere and the drive to dance.

What's in an ecstasy pill?

In the manufacture of pills aimed at the ecstasy market, producers consistently use brand names and logos as marketing tools and to distinguish their product from that of competitors. Despite these names and logos, there is

Entactogenic effect

Dr David Nichols, Professor of Medicinal Chemistry and Pharmacology at Purdue University in the United States coined the term 'entactogen' for drugs such as MDMA (ecstasy). The entactogenic effect of a drug is the way it acts as an emotional 'brace', facilitating the retrieval of inner material and enhancing introspective states. In Nichols' words, an entactogenic effect 'means essentially to produce a touching within'. In the words of an MDMA user, it provides a sense that the world is 'an okay place to be'.

Other ecstasy users comment that they feel no need for affirmation, recognition or judgment, as in the following statement: 'I felt I could handle the entire world and at the same time I felt no need at all to do so. I had conversations without feeling restricted, obliged or having the urge to compete with the other person.'

Health risks of ecstasy

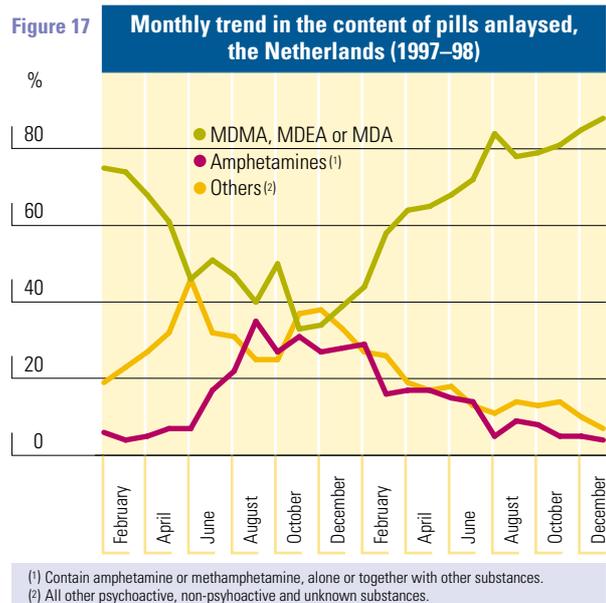
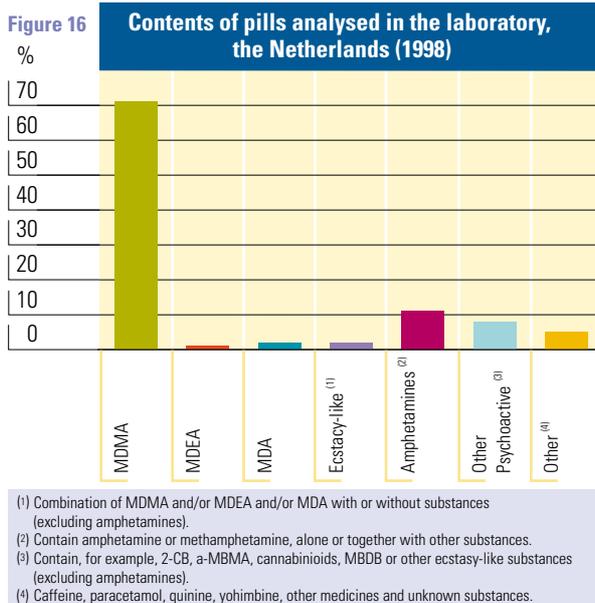
Heavy or frequent ecstasy use reduces, or eliminates, the entactogenic effect, although the energising effect remains. Consequently, ecstasy has been largely confined to weekend use which acts as a safety valve against problems developing as a result of daily or heavy use.

Acute risks

Conservative estimates of ecstasy use in the UK in the mid-1990s put consumption at over a million doses taken in dance clubs every weekend. This led to calculations of the risk of death from ecstasy consumption as approximately one dose in 6.8 million. Acute health risks increase with diversification to more intense consumption and when ecstasy is used in combination with drugs with sedative effects, such as alcohol, heroin and benzodiazepines.

Chronic risks

Research into the chronic effects of ecstasy use has been limited by bias and lack of data. Accumulating scientific evidence points towards some degree of neurotoxicity associated with heavy ecstasy use. Recent results of experiments with monkeys show that four days of exposure to MDMA caused some damage to areas of the brain that persisted for six to seven years, although the consequences of this damage are not yet clearly understood. Human studies have shown damage to the serotonin-producing neurones and the memory impairment related to the toxic effect of MDMA on those brain cells.



no guarantee of what type of pill is being bought or what it contains.

The difficulty of assessing pill contents is a key feature of the ecstasy market and laboratory analyses have proved experienced ecstasy users to be wrong in their personal assessment of pill contents.

Recent studies in a few Member States which analysed ecstasy pills have found that their contents vary considerably. Some contain pure MDMA, others high levels of amphetamines and still others a mixture of lactose and caffeine.

Synthetic drugs are reported to be produced mainly in clandestine laboratories in the Netherlands, Poland,

Spain and the UK. Organised crime is involved in manufacturing and distributing ecstasy-like drugs in a number of countries. Some young drug users involved in distributing such pills have been threatened by more organised distributors.

Prevalence of synthetic drug use

The major source of information about synthetic drug use has been young people in dance and party settings, although synthetic drug use also takes place in other settings.

School surveys report that the proportion of 15- to 16-year-olds who admit having tried amphetamines

is typically between 2 and 4 %, but ranges from under 1 % in Finland to nearly 8 % in the Netherlands and 13 % in the UK. There is a wide variation in ecstasy use among this age group; under 1 % in Finland, 5 to 6 % in Belgium and Spain, and 8 to 9 % in Ireland, the Netherlands and the UK.

The lifetime prevalence figures for LSD among school-children is around 13 to 14 % in Ireland and the UK, 5 to 6 % in Spain and Italy and 2 % or less in the other States. The proportion of young adults who have used amphetamines and ecstasy typically falls in the range of 2 to 5 %, although the rates are higher in the 18 to 25 age range.

In terms of recent use of amphetamines, ecstasy and LSD in the past year, the rates are mostly in the 1 to 2 % range, although higher for the UK.

Recent trends

Recent reports from several Member States suggest a stabilisation or decline in the level of ecstasy use and some disenchantment with what is being sold as ecstasy. Music media articles complain about the loss of exclusivity on the dance floors of the ecstasy market and criticise the physical manifestations of amphetamine-type drug use in terms of 'lolling tongues, red faces and grimaces'. This does not mean, however, that ecstasy is disappearing, but that patterns of use are diversifying.

Availability and use of amphetamines continues to rise. Within the broad, recreational youth culture, they are mostly taken by sniffing as powder or orally as pills or added to drinks.

As with ecstasy, increases in amphetamine use are barely reflected in indicators such as treatment demand. This is not surprising in view of the lack of young people attending treatment services. It may mean that the sharp increase in use is not creating health problems or that the problems have not been recorded or that drug services are not adequately responding to this trend.

Divergent patterns, divergent drugs

In recent years both dance drugs and dance music have appeared in mainstream night clubs, and alcohol consumption is beginning to rise. The lucrative nature of the music/dance market appears to have drawn the alcohol industry into sponsoring, advertising and promoting alcohol aimed specifically at the dance drug or ecstasy market, often using drug imagery in its strategies.

More specific patterns of diversification in the use of synthetic drugs are difficult to define. Various reports point to increased use of alcohol and an interest in stimulant-type drugs such as amphetamines and/or cocaine and hallucinogens (such as LSD or mushrooms). Some low-threshold drug agencies have reported an increase in requests for help from young people who have developed some degree of psychological dependence on heavy drug consumption in party and dance settings. In a minority of these cases heroin has also been involved.

Other developments include reports of Viagra and various steroids being sold as recreational drugs.

Demand reduction activities

The main demand reduction strategies concerning synthetic drugs in the EU can be classified by how they intend to reach the non-homogeneous target group of users. Information, however, is available from only a few countries.

As increasing numbers of users integrate drug use into their daily life or leisure activities, preventing health damage means providing information about the risks of excessive use and adulterated pills.

Aside from 'rave' parties, wider community approaches in specific neighbourhoods and youth centres aim to involve 'techno' clubs in preventive efforts.

Guidelines for safe dancing developed by local authorities and NGOs have a tradition in the UK and are also being adopted in Denmark and Germany. At the same time, associated drug counselling centres are running campaigns addressing different target groups with a variety of 'safer use' or 'clean use' messages.

Pill testing

On-the-spot toxicological pill tests are carried out in only a few countries and reports are therefore sketchy. Some countries, such as the Netherlands, find anonymous, cost-free testing of tablets sold as ecstasy at major 'rave' events, together with information and on-the-spot counselling, a good prevention approach. In Austria, pill testing is used for research and prevention purposes.

The 'rave' mission operated by Médecins du Monde tests pills during 'raves'. It also gathers information on synthetic drug consumption and on users and tries to engage participants in discussions about drug use.

The media

The mass media are used in many countries as a means of raising awareness among young people. The subject most frequently targeted is alcohol, but in some cases synthetic drugs take centre stage. Other campaigns address narrow target groups.

The Internet is one of the newest media for finding out about drugs, and to be used in drug demand reduction activities.

An Internet site called Drugsmart, run by the Swedish Ministry of Health and Social Affairs, targets younger age groups, but includes information for teachers as well. The aim is to strengthen the resistance of teenagers who have not so far taken drugs or who have stopped experimenting with drugs. Aside from detailed information on various substances, the site provides answers to e-mailed questions and a chat service for those who wish to discuss drug-related topics. Other similar Internet sites are being developed throughout Europe.

Evaluation

Evaluations of interventions on synthetic drugs are rare. One exception is the 1997 and 1998 'SafeRave' campaign in Denmark which highlighted an interest within the 'techno' environment to take a stand against drugs, which could be influential in further prevention work.

In the Netherlands, evaluation of peer-group approaches has contributed to a more realistic and non-moralistic approach to drug prevention.

Overall, the evaluation of 'Safer Dancing' in London increased understanding about the effects of ecstasy, cannabis and amphetamines.

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