

2002

**Annual report on the state of  
the drugs problem in the European Union  
and Norway**

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

European Monitoring Centre  
for Drugs and Drug Addiction

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Cataloguing data can be found at the end of this publication.

Luxembourg: Office for Official Publications of the European Communities, 2002

ISBN 92-9168-129-6

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*Printed in Italy*



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# Acknowledgements

The EMCDDA would like to thank the following for their help in producing this report:

- the heads of the Reitox national focal points and their staff;
- the services within each Member State that collected the raw data for this report;
- the members of the Management Board and the Scientific Committee of the EMCDDA;
- the European Parliament, the Council of the European Union — in particular its Horizontal Working Party on Drugs — and the European Commission;
- the Pompidou Group of the Council of Europe, the United Nations International Drug Control Programme, the World Health Organisation, Europol, Interpol, the World Customs Organisation and the Centre for the Epidemiological Monitoring of AIDS;
- the Translation Centre for Bodies of the European Union and the Office for Official Publications of the European Communities.

# Preface

In our 2002 Annual report, we show that it is difficult to capture ‘the European drug problem’ in one statement, as it presents a very diverse picture. Trends and levels of illicit drug use differ between countries and regions, as well as between its different aspects and consequences. Looking solely at national averages may mask strongly diverging trends at regional or local level. However, where increases are still noted in some indicators in some countries or regions, the general picture seems now more similar to a stable ‘endemic’ situation, with constant recruitment and exit rates. This is contrary to the situation in the 1980s and first half of the 1990s, when many countries in the European Union experienced extreme and epidemic rises in drug use and related problems.

The long-time reported increases in cannabis use show signs of stabilisation in some countries, although at markedly different levels, while cannabis and cocaine problems may now be increasing. For problem drug use, 7 out of 15 countries have adjusted their estimates upwards, suggesting some increase although at the same time most countries report a relative stability. Overall, HIV prevalence seems stable; however, levels differ strongly between countries and important increases are found in some regions and subgroups of injectors. The number of acute drug-related deaths seems now to have reached a plateau, but trends are divergent between countries. Prices of most drugs seem generally stable or decreasing.

Yet, even if ‘the drug problem’ in the European Union seems now to have become an established phenomenon, there is clearly no room for complacency. There are an estimated two to nine problem drug users per 1 000 of the population aged 15 to 64. In some areas, over 25 % of injecting drug users are infected with HIV, and HCV prevalence continues to be extremely high (40 to 90 %). Between 7 000 and 8 000 acute drug-related deaths occur every year, and, worryingly, increases are seen in some countries where trends were previously stable or decreasing. Risk of death is up to 20 times higher among opiate users than in their non-drug using peers of the same age. The number of clients in treatment has increased and even if treatment facilities are also expanding, they are still clearly not sufficient, especially in prisons. It is therefore paramount that the political effort put into tackling the drug problem is continued and even stepped up.

We do note more consensus about the measures to address some of the principal problems, and evidence

on their effectiveness is increasing. For example, the value of low-threshold services and the importance of access to sterile injecting equipment to reduce blood-borne infections are widely acknowledged. The protective effect of methadone maintenance on mortality and morbidity, the additional value of voluntary drug-free treatment and the role of medically-assisted treatment in reducing illegal drug consumption, risky behaviour and crime are now broadly recognised.

The widespread recognition of the value of these measures is a contributing factor, perhaps, to the relative convergence of public policy in the areas of prevention and treatment in the European Union. We must bear in mind that this convergence, taking place especially in the social and health areas, is occurring in a non-uniform way across countries — for example, the distribution of syringes is much more developed in some countries than in others. The approach is also not necessarily consistent within a country — substitution treatment may be widely available in treatment centres, for example, but much less so in prisons.

Nevertheless, national political and legislative approaches are increasingly promoting similar social and public health measures. In many countries, prominent developments in the legislative area include moves to target substances regardless of their legal status, to widen the distinction between drug users and drug-law offenders, to reduce or remove penalties for personal use or possession of cannabis and to strengthen the legal framework for substitution treatment. Focus in the prevention area has turned to assuring the quality of interventions through introducing national standards and accreditation procedures.

The growing consensus in the European Union clearly points towards greater efficiency and effectiveness in continuing the fight against drug problems, by reducing morbidity, mortality, stigma and social exclusion among problem users, while giving truthful information about potential risks to non-problematic users. It also represents a stronger and united response to the great priority European citizens have given to addressing the drug problem. I trust that this 2002 Annual report will make an important contribution towards establishing an evidence base for sound policy-making and strategic planning, both at national and local as at the European level.

**Georges Estievenart**  
Executive Director



# Overview

## Drug situation

### Drug use in the general population

- Use of illegal substances is concentrated among young adults and particularly males in urban areas, although some spreading to smaller towns and rural areas may be taking place.
- Recent cannabis use (last 12 months) was reported by 5 to 15 % of young adults in most countries. Recent amphetamine use was reported by 0.5 to 6 %, cocaine use by 0.5 to 3.5 %, and ecstasy use by 0.5 to 5 %.
- Lifetime experience of cannabis is reported by 10 to 30 % of European adults, while amphetamines, cocaine and ecstasy have been tried by about 1 to 5 %.
- Cannabis use increased markedly during the 1990s in most EU countries, particularly among young people, although in recent years its use may be levelling off in some countries. Cocaine use may have increased in recent years in some countries, although this trend is less clear.

### Problem drug use

- In general, levels of problem drug use seem stable, although some countries do report changes in estimates which taken together suggest increases of problem drug use since 1996.
- Possible increases at national level are reported from Belgium and Norway (data available only for injectors), Germany, Italy, Luxembourg, Sweden and the United Kingdom.
- Estimates of problem drug use are all between two and nine cases per 1 000 population aged 15 to 64.

- Estimates of injecting drug use are in general between two and five cases per 1 000 population aged 15 to 64.

### Treatment demand

- Countries report an increase in the number of clients in treatment.
- Opiates remain the main substance for clients seeking treatment, followed by cannabis, cocaine and amphetamines. Many differences are found among countries.
- Trends per drug among new clients entering treatment show that the number of heroin users remains stable or decreasing, and cannabis users are increasing in some countries (Germany, Denmark). The number of cocaine clients — rising in number until last year — now seems stable.
- The main routes of administration among new clients are injecting for heroin (45.9 %), sniffing for cocaine (47.1 %), eating/drinking for stimulants (56.4 %).
- The social conditions for drug users are worse than in the general population of the same age, namely higher unemployment rates and lower levels of education.

### Drug-related infectious diseases

- Levels of HIV infection roughly vary from 1 % in the United Kingdom to 34 % in Spain but in general they are stable.
- HIV prevalence was over 25 % among injecting drug users (IDUs) routinely tested in drug treatment in the Italian regions of Emilia-Romagna, Lombardy and Sardinia, in France, in Lisbon and Porto in Portugal, and in Spain.

- Increases in HIV transmission (in subgroups of IDUs) may have occurred in regions or cities in Ireland, Italy, the Netherlands, Portugal and Finland.
- HCV prevalence is extremely high in all countries and settings, with infection rates of between 40 and 90 % among different subgroups of IDUs.

### Drug-related deaths

- In all, 7 000 to 8 000 acute drug-related deaths are reported each year in the EU, and the real number of cases is probably higher. Opiates are present in most overdose deaths, although presence of additional substances is frequent.
- There is a relatively stable trend at EU level, although with divergent national trends. However, it is worrying that some EU countries report recent new increases after a period of stabilisation or decrease.
- Mortality of opiate users, in particular injectors, is up to 20 times higher than the general population of the same age, due to overdoses, infectious diseases, accidents, suicides, etc.

### Drug-related crime

- In all countries — except Norway, the Netherlands, Italy and Spain — drug law offences reported by the police continue to concern mainly drug use/possession.
- According to prisons and countries, between 29 and 86 % (over 50 % in most studies) of prisoners report having ever used an illicit drug.
- Though most drug users tend to stop or reduce their drug use after imprisonment due to the low availability of illicit drugs, some continue to use drugs, and others commence once incarcerated.

### Drug markets and availability

- Cannabis is the most seized drug in all countries except Portugal (heroin). In 2000, quantities seized went down in most of the Member States.
- At EU level, the number of seizures of cannabis and ecstasy continued to increase in 2000, while they decreased for heroin, cocaine and amphetamines.
- In 2000, a marked decrease in the quantities of cocaine seized was reported — mainly due to high decreases in countries seizing most of the cocaine in the EU (Spain, France, the Netherlands).
- The price of all illicit drugs is generally stable or decreasing in the EU, although some increases were reported regarding brown heroin.

## Responses to drug use

### National strategies

- The recent tendency to produce strategic responses to the drugs situation continues. Objectives and targets are better identified than in the past. Implementation and evaluation are now the main challenges for national drug strategies.
- Increased attention is given to prevention and treatment activities regarding alcohol and tobacco. Strategies tend to target the substances causing addiction regardless of their legal status.

### National legislation

- There is a trend to widen the distinction between drug users and other drug law offenders, either through legal or policy distinctions, or by establishing a more specialised court system, or both.
- At the same time, a number of countries have chosen to reduce or remove penalties for personal use or possession of cannabis, distinct from other substances.
- New legislation on drugs in road traffic specifies individuals and methods for testing, and may improve statistical collection to serve as a scientific base for future legislation on the topic.
- National legal frameworks for substitution treatment are being established or strengthened.

### Demand reduction

- All national drug strategies include priorities in the field of responses. School prevention is seen as a priority in ten Member States, prevention and early intervention for young people at risk in nine, and responses in the criminal-justice system in seven. Eight countries see a need to strengthen treatment structures.
- The quality of demand-reduction responses is assured with the introduction in some countries of national standards, accreditation procedures or guidelines.

### Prevention in schools, local settings and the community

- All Member States stress the high priority of prevention and report numerous preventive activities in different settings, at schools most notably. However, there is a substantial gap between policy aims and the reality and quality of prevention.
- Objectives for school prevention range from all-inclusive health promotion principles, the develop-



## Overview

ment of social/personal skills to the promotion of identity/personality. Awareness and information are often prominent, although such approaches alone have proven ineffective.

- Wide disparities exist between Member States concerning the role of mass media in prevention strategies — from none at all to very prominent.

### Prevention in recreational settings

- Prevention in recreational settings is based on three intervention strategies: the production of information material on drugs; personalised interventions in discotheques or raves; and structural measures such as safe-clubbing guidelines.
- The value of on-site pill testing interventions for intense interactive preventive counselling has been overshadowed by discussions focusing on questions of its pharmacological accuracy and its legal implications.

### Prevention of infectious diseases

- Evidence-based responses to prevent infectious diseases among drug users are hepatitis immunisation, drug treatment — in particular the prescription of substitution drugs — community-based outreach, access to sterile injection equipment and safer use information and training.
- Access to sterile injecting equipment is of major importance for minimising the rate of HIV and other blood-borne viral infections. Even though syringe exchange programmes have become more widely available, the coverage of the target population shows large differences between and within countries.
- Hepatitis immunisation rates among drug users are very low. Systematic efforts are underway in some countries to make the vaccination more accessible.

### Prevention of drug-related deaths

- A significant proportion of overdoses could be avoided.
- Methadone maintenance has a substantial protective effect on mortality from opioid overdose.
- Innovative approaches to preventing and managing overdoses are reported from some countries — such as the training of drug users to protect themselves and to better manage overdoses they witness, naloxone administration training as well as basic resuscitation techniques, or the development of specific prevention information materials.

### Availability of treatment facilities

- The past five years have seen a considerable increase in the availability of treatment facilities in the EU and Norway. Medically-assisted treatment appears to have grown more rapidly than drug-free treatment.
- Evaluations of drug-free treatment interventions have shown that it is effective. Evaluation results fluctuate, but generally 30 to 50 % of clients entering drug-free treatment complete it successfully.
- Medically-assisted treatment with methadone or buprenorphine has proved effective in reducing the consumption of illegal drugs, risk behaviour and crime. Sufficient dosages have shown to be imperative to ensuring positive outcomes. Accompanying psycho-social interventions contribute to success, but are still underdeveloped.

### Criminal-justice responses

- Judicial authorities in EU countries dispose of a range of measures at different stages of the criminal-justice system to divert into treatment drug users who have committed a criminal offence.
- Most EU countries have abstinence-oriented treatment programmes and/or drug-free units inside prisons. However, the number of places is, compared to the estimated number of prisoners with drug problems, low.
- Substitution treatment is now available in prisons in almost all EU countries and in Norway. However, even in countries where a large percentage of problem drug users in the community are in substitution treatment, prisons often follow a detoxification policy.
- There is evidence for the need for ‘stepped care’ arrangements/continuous treatment to reduce recidivism among drug using offenders.
- There is an increasing effort to document and evaluate other criminal-justice system responses, but there is not much scientific evidence (yet).

### Supply reduction

- Combating organised drug trafficking is a priority for Member States through the improvement of database systems and crime analysis techniques, together with increased development of international cooperation.
- Fighting against the diversion of chemical products and precursors under control is an important part of

the increased international cooperation. Additional resources to guarantee an adequate level of surveillance are required.

- International customs cooperation and the activities of the OECD Financial Action Task Force (FATF) play a very important role in measures against money laundering.

# Drug situation

This chapter provides an overview of the situation of drug use and supply in the EU and Norway and highlights recent developments and emerging trends.

## Drug use in the general population <sup>(1)</sup>

Population surveys provide estimates of the proportion of the population who have used different drugs during certain periods of time, in addition to providing information on the behaviour and characteristics of respondents. For illegal drugs, the more usual measures are:

- any use during the person's life (lifetime prevalence), often called 'lifetime experience' with drugs;
- any use during the previous year (last-12-months prevalence), often called 'recent use' of drugs; and
- any use during the previous month (last-30-days prevalence), often called 'current use' of drugs.

'Lifetime experience' always produces higher figures, and is widely used in reports and assessments of a country's drug situation. However, lifetime experience alone does not capture well the current situation as it also includes all those who have ever tried drugs, whether once or a few times many years ago.

'Recent use' produces lower figures, but reflects better the current situation. The combination of lifetime experience and recent use can give basic information on drug use patterns (e.g. continuation rates). 'Current use' may give some indication of regular use, but figures are generally quite low when the whole population is considered.

Many surveys investigate the age of the onset of drug use and the frequency of use, which allow estimations of incidence and patterns of use. Other individual variables (sociodemographic variables, opinions and risk perceptions, lifestyles, health problems, etc.) can help to establish correlations between use and other individual factors.

Age ranges used to report results may have an important influence in prevalence estimates. Comparisons should be based on the same age groups. The EMCDDA recommends the age range of 15–64 years for the whole adult population and 15–34 years for young adults but there are still small national differences in the data reported.

### Patterns of drug use

Basic common and divergent patterns of drug use can be identified across EU Member States, despite the methodological limitations.

Cannabis continues to be the illegal substance most commonly used in all EU countries. Lifetime experience is much more common than recent or current use, indicating that use tends to be occasional or to be discontinued after some time. There is a small proportion of users that consume the substance daily, and particular attention should be paid to this group.

Substances other than cannabis are used by much smaller proportions of the population, although there are considerable differences between countries. In this case, too, lifetime experience is clearly higher than recent use <sup>(2)</sup><sup>(3)</sup>.

<sup>(1)</sup> The methods used to estimate drug use in the general population are explained online (<http://annualreport.emcdda.eu.int>).

<sup>(2)</sup> Figure 1 OL: Patterns of drug use among the general population (online version). Cannabis use as example: lifetime experience versus current use (last 30 days) in Dutch national survey 1997.

<sup>(3)</sup> Figure 2 OL: Continuation rates for some substances in recent European population surveys, among the whole adult population (online version).

Use of illegal substances is concentrated among young adults, who have prevalence rates roughly double that of all adults. Males outnumber women among people who have tried drugs in all countries and all age groups, although these differences tend to decrease in younger groups <sup>(4)</sup>. Drug use is more prevalent in urban areas, although some spread to smaller towns and rural areas may be taking place.

Lifetime experience of cannabis is reported to range from 10 % (Finland) to 25 to 30 % (Denmark and the United Kingdom) of the whole adult population, with a substantial number of countries reporting figures of around 20 % (Belgium, Germany, Spain, France, Ireland and the Netherlands). Amphetamines have been tried by 1 to 6 % of the population (11 % in the United Kingdom), cocaine and ecstasy have been tried each by about 0.5 to 4.5 % of the population. Heroin has been tried generally by less than 1 % of the population, although by up to 2 to 3 % of young males of some countries. As a reference outside Europe, in the 2000 US household survey, 34 % of adults (12 years and older) reported lifetime experience of cannabis and 11 % of cocaine <sup>(5)</sup>.

Recent use of cannabis is reported from 1 to 10 % of all adults, although most countries that have information report levels of between 5 and 10 %. Recent use of amphetamines, cocaine or ecstasy was reported in general by less than 1 % of adults, although Ireland and the United Kingdom have somewhat higher figures for the three substances, together with Denmark and Norway for amphetamines and Spain for cocaine. In the 2000 US household survey, 8.3 % of adults (12 years and older) reported recent use (past year) of cannabis and 1.5 % of cocaine.

Young adults report clearly higher rates of recent drug use. In most countries, recent cannabis use was reported by 5 to 18 % of young adults (Sweden 1 to 2 %). Recent amphetamine use was reported by 0.5 to 6 %, cocaine use by 0.5 to 3.5 % and ecstasy use by 0.5 to 5 % <sup>(6)</sup>.

<sup>(4)</sup> Figure 3 OL: Gender differences in drug use (recent use, last 12 months), reported in general population surveys of European countries (online version).

<sup>(5)</sup> Source: SAMHSA, Office of Applied Studies, *National household survey on drug abuse*, 1999 and 2000 (<http://www.samhsa.gov/oas/oas.html>). Note that the age range (12 years and over) is wider than the age range reported by the EMCDDA for EU surveys (15–64 years).

<sup>(6)</sup> Figure 4 OL: Recent use (last 12 months) of amphetamines, ecstasy and cocaine among young adults in European countries, measured by national population surveys (online version).

Figure 1

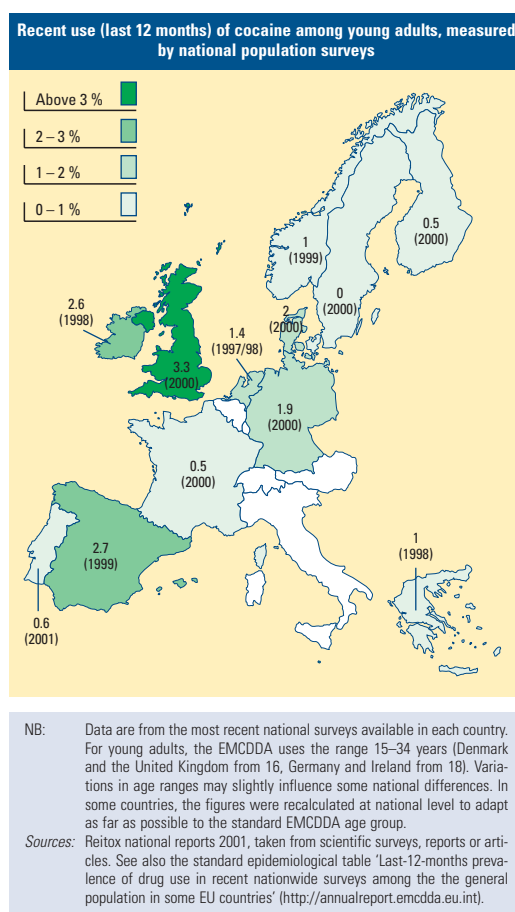
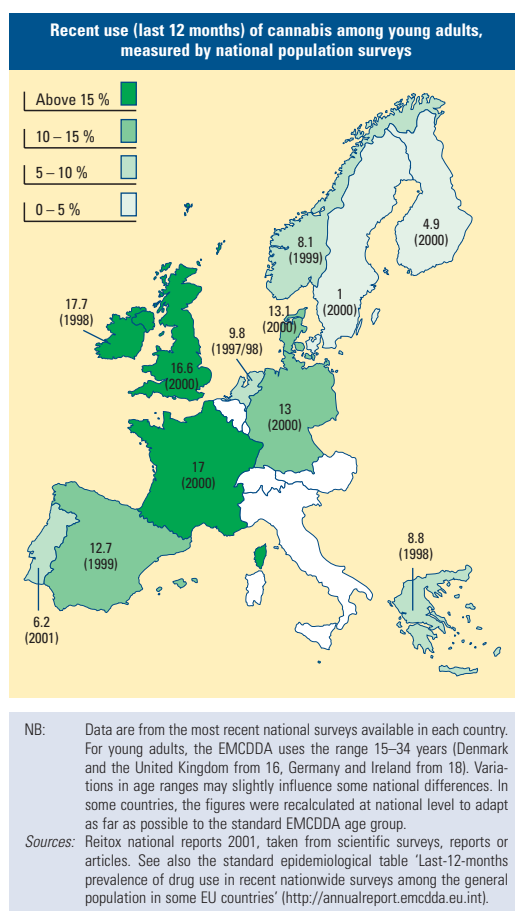


Figure 2



## Drug situation

In addition to real differences in drug use, several factors can contribute to differences in national figures. Overall national figures can be explained in part by generational factors, including the convergence between the lifestyles of males and females. Shares of urban population in each country may explain in part some overall national figures. Comparative analysis and policy formulation and evaluation should take into consideration precise age groups, gender and urbanisation, among other criteria <sup>(7)</sup><sup>(8)</sup>.

### Trends in drug use among the general population

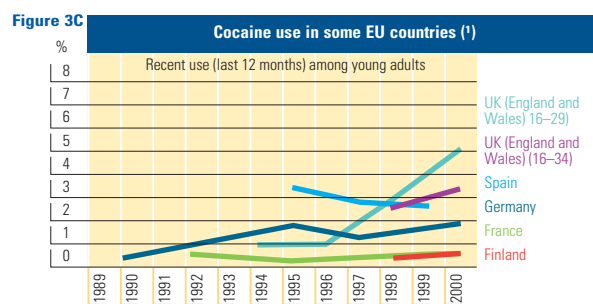
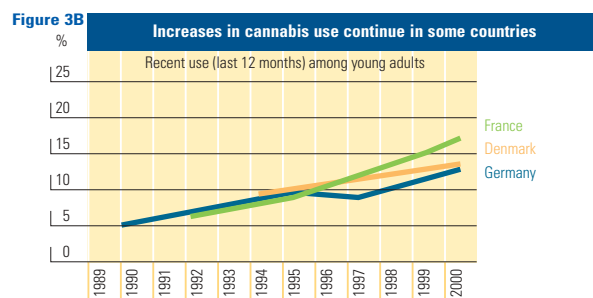
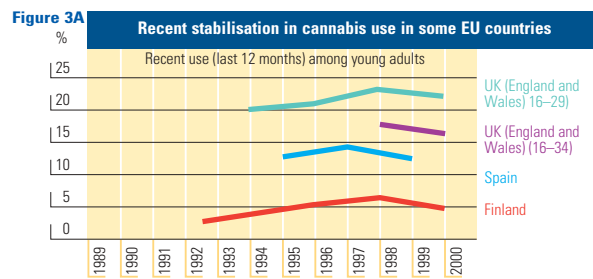
It is difficult to define clear-cut trends that apply to the EU as a whole, due to the limitations of information sources (few consistent series) and the differences in national social/cultural context and development. Lifetime experience should be used with caution when analysing trends, since it is an accumulative measure that will not decrease for a long time, even if current drug use decreases.

National and local population surveys, as well as conscript and school surveys, show that cannabis use increased markedly during the 1990s in almost all EU countries, particularly among young people. At the same time, some convergence in cannabis use can be suggested across countries, with a significant number of countries reporting around 20 to 25 % of lifetime experience and 5 to 10 % of recent use.

In more recent years, cannabis use seems to be levelling off or even decreasing in some countries (Ireland, the Netherlands, Finland and Norway) among young people, conscripts or school students. However, increases continue in other countries.

European trends in other substances (e.g. cocaine, ecstasy and amphetamines) are more difficult to track, which underlines the need to maintain consistent series of surveys with appropriate sample sizes.

There has been growing concern about possible increases in cocaine use in the EU, due to increases of cocaine problems reported in some countries. Increase of recent cocaine use seems consistent among young people in the United Kingdom and, possibly to a lesser extent, in Denmark, Germany and Greece. In Spain, France and Finland, no increase is apparent among young adults, although in Spain figures are comparatively high and a consistent increase among students has been observed (Figure 3).



NB: Data taken from national surveys, available in each country. For young adults, the EMCDDA uses the range 15–34 years (Denmark and UK from 16, Germany and Ireland from 18, France (1992: 25–34 and 1995: 18–39)).

<sup>(1)</sup> Although not presented in the graphic, information from Denmark and Greece suggests some increases.

Sources: Reitox national reports 2001, taken from scientific surveys, reports or articles. See also the standard epidemiological table 'Last-12-months prevalence of drug use in recent nationwide surveys among the general population in some EU countries' (<http://annualreport.emcdda.eu.int>).

See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

- Lifetime prevalence (LTP) of drug use in recent nationwide surveys among the general population in some EU countries
- Last-12-months prevalence (LYP) of drug use in recent nationwide surveys among the general population in some EU countries
- School surveys: lifetime prevalence among students, 15–16 years of age

<sup>(7)</sup> Figure 5 OL: How to look at different figures on drug use between countries — An example using Denmark and France (online version).

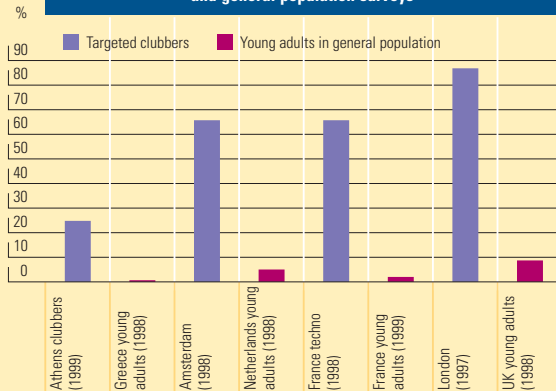
<sup>(8)</sup> Figure 6 OL: Recent cannabis use (last 12 months) by age group in European countries, measured by population surveys — Recent cocaine use (last 12 months) by age group in European countries, measured by population surveys (online version).

### Drug use among young people

Only five Member States made data available from school surveys during 2000 concerning school students aged 15–16 years. Sweden showed an increase in cannabis use and Italy showed an increase in cannabis, ecstasy and cocaine. The other three Member States showed either stable or declining prevalence of drug use in this age group.

A number of Member States conduct surveys of young people above the 15–16 age range and outside of the school environment. School surveys across age ranges show that lifetime drug prevalence increases considerably with age, although the level of increase varies between countries. Compared with general population surveys, young people in nightlife and club settings also show much higher average prevalence for recreational drug use; ecstasy in particular. (See Figure 4, which should be interpreted with caution as the targeted surveys are not strictly comparable.)

**Figure 4** Differences in lifetime prevalence of ecstasy use between targeted and general population surveys



NB: In targeted survey n = range 100–986.  
 Sources: Athens: Calafat, A., Bohrn, K., Juan, M., Kokkevi, A., Maalsté, N., Mendes, F., Palmer, A., Sherlock, K., Simon, J., Stocco, P., Sureda, M. P., Tossmann, P., van de Wijngaert, G. and Zavatti, P. (1999): *Night life in Europe and recreative drug use, Irefrea and European Commission, Valencia.*  
 Amsterdam: Korf, D. J., Nabben, T., Lettink, D. and Bouma, H. (1999): *Antenne 1998. Trends in alcohol, tabak, drugs en gokken bij jonge Amsterdammers*, Jellinek, Amsterdam.  
 France: Médecins du Monde (1999): *Techno rave parties.*  
 London: Release (1997): *Release drugs and dance survey: an insight into the culture*, Release, London.

In general, levels of problem drug use seem stable, although, with the current estimation methods, data quality and data availability, it is still not possible to reliably calculate trends in the prevalence of problem drug use in most countries.

However, some countries do report changes in estimates and/or other indicator data, which taken together suggest increases in problem use since 1996. Possible increases at national level are reported from Belgium and Norway (data available only for injectors), Germany, Italy, Luxembourg, Sweden and the United Kingdom, while increases at local or regional level are reported from some other countries (10).

Estimates of problem drug use are all between two and nine cases per 1 000 of the population aged 15–64 (this is using the midpoints of the estimates). The highest estimates are reported for Italy, Luxembourg, Portugal and the United Kingdom, with between six and nine problem drug users per 1 000 inhabitants aged 15–64. Estimates are lowest in Austria, Germany and the Netherlands, with about three problem drug users per 1 000 inhabitants aged 15–64. Data are not available from Belgium, Greece and Norway (see Figure 5).

In Finland and Sweden, the majority of problem drug users are primary amphetamine users (an estimated 70 to 80 % in Finland in 1997). This is contrary to other countries where problem drug users are mostly primary opiate users (and at the same time polydrug users).

This year, separate estimates are given for injecting drug use, a subcategory of all problem drug use. The increased quality of the estimates based on mortality data and HIV data enables them to be presented separately from problem drug use. Estimates of injecting drug use are in general between two and five cases per 1 000 of the population aged 15–64, but data are not available for six Member States. The estimate for Luxembourg is higher, at almost seven per 1 000. Estimates of injecting drug use indicate the population at risk for serious health consequences or drug-related death (see Figure 6).

### Problem drug use

Problem drug use is defined as ‘injecting drug use or long-duration/regular use of opiates, cocaine and/or amphetamines’ (9).

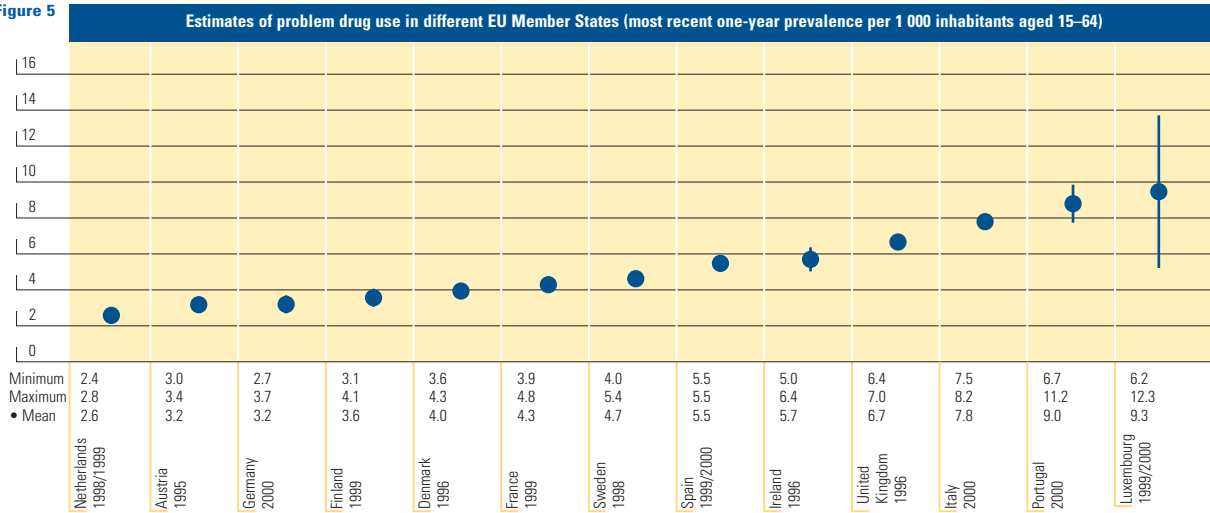
See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

- Estimated number of problem drug users in EU Member States, 1995–2000
- Estimated rate of problem drug users in EU Member States, 1995–2000 (rate per 1 000 aged 15–64)

(9) More details on the definitions and methods used to estimate problem drug use are given online (<http://annualreport.emcdda.eu.int>).  
 (10) Trends and patterns per country are presented online (<http://annualreport.emcdda.eu.int>).

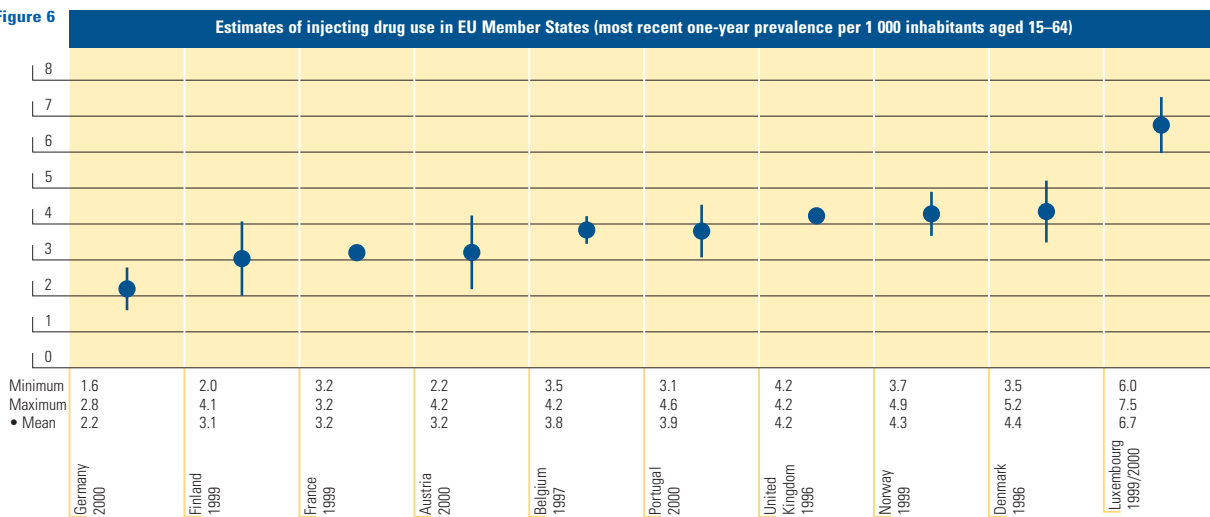
## Drug situation

Figure 5



NB: The dot shows the central estimate, while the line represents the uncertainty range or 95 % confidence interval. The longer this line, the less certain the prevalence estimate is (not available for Spain). The Swedish estimate includes problem cannabis users (estimated to be about 8 % of the total sample).  
Sources: National focal points through EMCDDA project: 'State of the art regarding national prevalence estimates of problem drug use in the EU Member States', CT.00.RTX.23, Lisbon, EMCDDA, 2002. Coordinated by the Institut für Therapieforschung, Munich.

Figure 6



NB: The dot shows the central estimate, while the line represents the uncertainty range or 95 % confidence interval. The longer this line, the less certain the prevalence estimate is (not available for France and the United Kingdom).  
Sources: National focal points through EMCDDA project: 'State of the art regarding national prevalence estimates of problem drug use in the EU Member States', CT.00.RTX.23, Lisbon, EMCDDA, 2002. Coordinated by the Institut für Therapieforschung, Munich.

## Demand for treatment

Characteristics of clients entering treatment (such as social characteristics) and consumption behaviours (such as the proportion of injectors or opiate users) are potential indicators of wider trends in problem drug use. They also offer a view of the organisation of treatment centres in Europe. Biases may, however, arise owing to different methods of information collection and the varying level of the offer of treatment services between countries.

### Substances

Despite differences in treatment policies and recording practices, it is possible to identify both common and divergent trends across Europe.

In 2000, countries report an increase in the overall number of people treated for drug problems. According to the reports, this seems to be attributed to two main factors — improved methods of data collection (an increased number of persons treated are reported) and expansion of treatment facilities, especially those providing substitution treatment. The creation of new specialised services for specific target groups (e.g. minors) could also have influenced this increase.

Opiates (especially heroin) remain the main substance for clients seeking treatment in most countries. This could be partly due to the fact that many services are organised around the needs of opiate users. Overall, between 50 and 70 % of clients requesting treatment are

**Protocol on the Treatment Demand Indicator (TDI)**

This year, and for the first time, 12 of the 15 EU Member States have provided the EMCDDA with data on clients demanding treatment for drugs in line with the TDI protocol. The TDI protocol <sup>(1)</sup> is a joint EMCDDA–Pompidou Group initiative adopted by the 15 Member States. The information collected covers among others: types of treatment offered; substances used; and clients’ socio-demographic details.

The data-collection exercise, covering the year 2000, involved a total of 1 702 treatment units across Europe. Using the same standards, the units together provided information on 170 444 patients.

<sup>(1)</sup> A full report on the Treatment Demand Indicator is available online ([http://www.emcdda.eu.int/multimedia/project\\_reports/situation/treatment\\_indicator\\_report.pdf](http://www.emcdda.eu.int/multimedia/project_reports/situation/treatment_indicator_report.pdf)).

heroin users but this varies largely between countries — from 89.6 % in Greece to 19 % in Sweden.

The number of clients seeking treatment for cannabis as their main illegal drug varies from 2.5 % in Portugal to 24 % in Germany. Often use of cannabis is combined with other substances (see selected issue on polydrug use in Chapter 3).

Spain (18 %) and the Netherlands (29 %) remain the countries with the highest percentages of clients seeking treatment for cocaine as their main drug. Rates in other countries are lower — from 6 % in Germany to 0.8 % in Greece.

The widest disparity between countries is evident with amphetamines, with 33 % of clients in Finland and 29 % in Sweden seeking treatment. The rate in Germany, the United

Kingdom, Denmark and the Netherlands ranges from 7 to 2 % and is around 0 % in other countries (see Figure 7).

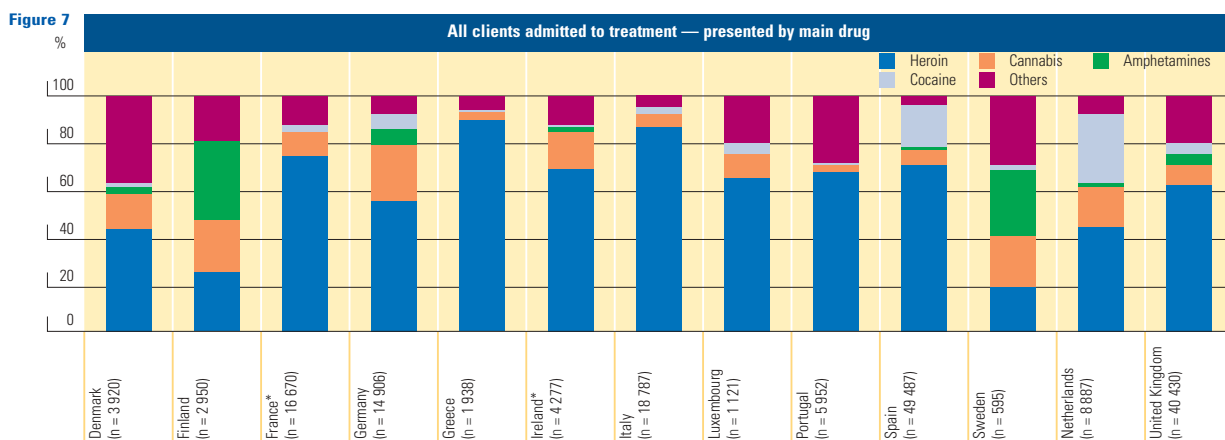
Polydrug use is increasingly apparent in treatment data.

**Trends**

New clients demanding treatment for heroin appear to be stable or decreasing. Possible reasons for this include: the proportional increase of consumers of other drugs; the end of the heroin epidemic evident in the late 1980s and early 1990s (the clients commencing during this period have already requested treatment, usually five years after starting use); a parallel trend in prevalence data; and the creation of new services targeted at other consumer profiles.

The number of clients requesting treatment for cannabis is increasing in some countries. Germany reports the highest increase in cannabis clients requesting treatment for the first time — from 16.7 % in 1996 to 42.6 % in 2000 (although it is important to note that these data only refer to outpatient units). Denmark follows with an increase from 25 % in 1996 to 30 % in 2000. Similar trends are apparent in other countries, although not to the same extent (Figure 8).

This increase in cannabis users is confirmed in data on all clients admitted to treatment over the years and it is relatively consistent among countries. Furthermore, an increase in the use of cannabis as a secondary drug together with another main substance is especially visible in clients using opiates as a main substance. This increase does not have a clear and unique explanation and reasons could include, among others, an increase in the prevalence of cannabis use, an increase in the number of cases reported by the criminal-justice system and an increase in the number of adolescents with social or psychological problems.

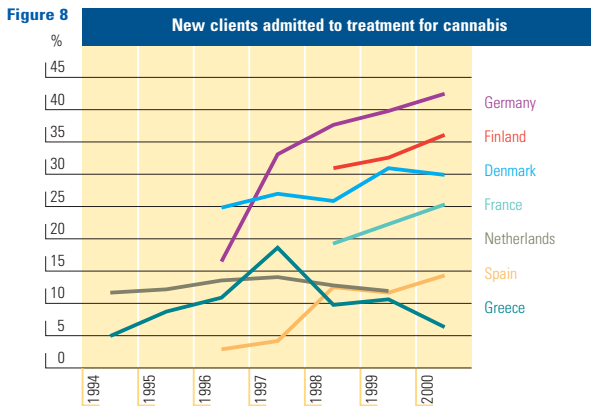


NB: \* = 1999 data.

Sources: Reitox national reports 2001. See also the statistical table 'Some characteristics of persons treated for drug problems in the EU' (<http://annualreport.emcdda.eu.int>).



## Drug situation



Sources: Reitox national reports 2001.

The increase in cocaine treatments shown in 1999 seems to have stabilised in 2000, especially in the countries where the increase was highest last year (the Netherlands and Spain) but this apparent trend should be monitored in the coming years. Cocaine consumption is reported to be an increasing problem in European countries over recent years and cocaine seems to play an important role as a secondary drug combined with heroin and alcohol. However, most countries remark that persons asking for treatment represent only a small percentage of cocaine users.

### Routes of administration

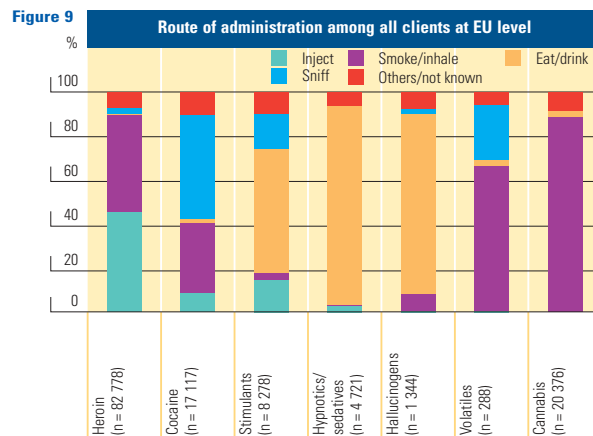
The three routes of administration of the primary drugs most frequently reported are: injection for heroin (45.9 % among first treatments), sniffing for cocaine (47.1 %) and eating/drinking for stimulants (56.4 %) (Figure 9).

The proportion of heroin injectors varies markedly between countries — from 13 % in the Netherlands to 73.8 % in Greece. Although a general decrease in injecting heroin is quite common, an opposite trend was visible in some countries (e.g. in Finland an increase from 61.1 to 68.7 %). The rapid decrease of the injecting pattern in Spain from 1991 to 2000 should be noted in particular (Figure 10). At market level, three main factors could influence the route of administration: the relative availability of smokeable heroin (base form) or injecting (hydrochloride) heroin; heroin price (a higher price leads to more injecting); and heroin purity (lower purity is related to a higher level of injecting use).

### Social characteristics

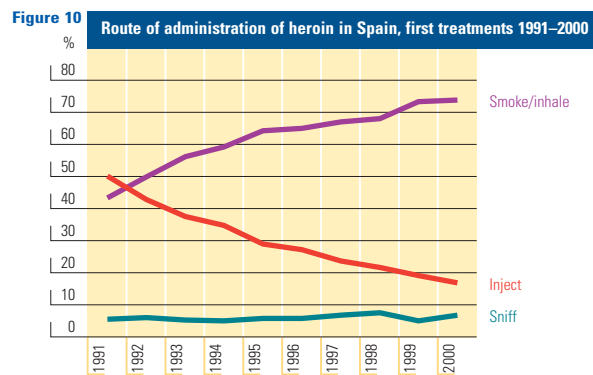
Clients entering treatment tend to be males in their 20s or 30s. The mean age is 29 years and 27 for clients entering treatment for the first time. Ireland and Finland have the

youngest treated population, whilst Greece and the Netherlands have the oldest clients seeking treatment<sup>(11)</sup>. The age distribution among the general population is different from the age distribution among clients, that is to say that the countries with the oldest (or youngest) population do not have the oldest (or youngest) clients in treatment. Ireland and Greece are the exceptions, where the young and the old age of clients in treatment reflects that of their general population<sup>(12)</sup>. The age distribution of clients seeking treatment seems indeed to be related to the type of substances consumed — in general, cannabis consumers are younger, whilst heroin and cocaine users are older. For example, the youngest clients are found in Belgium, where there is the highest percentage of cannabis consumption, whilst the oldest are found in Greece and the Netherlands, where there is a high percentage of heroin and cocaine consumption.



NB: Data not available for France, Ireland, Austria and Portugal.

Sources: Reitox national reports 2001. TDI data 2000 from outpatient treatment centres.



Source: Álvarez Requejo, A., 'TDI in Spain: evolution of heroin admissions', presentation to a training seminar, Plan Nacional de Droga, Regional Commissioner for Drugs, Junta de Castilla y León, Valladolid.

<sup>(11)</sup> Figure 7 OL: Mean age of clients in treatment (online version).

<sup>(12)</sup> Data from Eurostat (1999) have been used as a reference point for the analysis.

The gender distribution varies from a male:female ratio of 2:1 to 6:1. There is a similarity among southern countries with a higher percentage of men and among northern countries with a lower percentage of men. Reasons for this distribution seem to be due to the different drug consumption patterns among women and men, but could also be due to a different approach to services among the genders. Women generally ask for services less than men, although some studies based on comparison between gender distribution in prevalence data and in treatment data show that a higher percentage of women using drugs ask for treatment.

In general, the social conditions of clients demanding treatment are worsening compared to the general population. There are, for example, rates of unemployment of up to 50 to 55 %, even in countries where the unemployment rate among the general population in the same age group is less than 5 % — such as Denmark <sup>(13)</sup>. Low levels of education are also apparent. Up to 13.2 % have not completed primary school and up to 65.8 % have attended primary school only <sup>(14)</sup>.

With regard to nationality, characteristics resemble the general population structure: clients are mainly nationals of the country where they request treatment and the rate of people coming from other countries (European or non-European) is consistent with the proportion of foreigners in the general population <sup>(15)</sup>.

See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

- Some characteristics of persons treated for drug problems in the EU
- Some characteristics of persons in the EU treated for drug problems for the first time
- Some characteristics of women treated for drug problems in the EU
- Some characteristics of men treated for drug problems in the EU

## Drug-related infectious diseases <sup>(16)</sup>

### Prevalence and trends in HIV and AIDS

Infectious diseases related to injecting drug users (IDUs) cause the largest health care costs of all types of illegal drug use. They can be prevented by providing information and clean injecting material to IDUs, and by vaccination for the hepatitis B virus. This, and the often very high prevalence of infections among IDUs, makes policies aimed at prevention of infections in IDUs among the most cost-effective in the field of drugs.

The EMCDDA has only recently started to systematically collect data on HIV and hepatitis B and C among IDUs. Aggregated prevalence (overall and by subgroups) is collected from different routine settings (drug treatment, needle exchange, prisons, etc.) as well as from special studies <sup>(17)</sup>. Although the data obtained to present are still difficult to compare, they provide a global sense of differences by country or region and by setting, among others. The longer-term aim is to improve data quality and comparability from existing routine sources and to set up truly comparable local European sero-prevalence studies among injecting drug users.

As far as data are available, they suggest that large differences exist in HIV prevalence among IDUs, between, as well as within, countries. Levels of infection in the different sources roughly vary from about 1 % in the UK (surveys and unlinked anonymous screening) to 34 % in Spain (routine diagnostic tests in drug treatment), but they are in general stable <sup>(18)</sup>. This overall picture has not changed in recent years (Figure 11).

In some regions, extremely high HIV prevalence has still been found between 1996 and 2001. Although in most cases this reflects old epidemics, special prevention efforts are very important (e.g. efforts to prevent transmission to new IDUs, to sexual partners of IDUs and from mother to child). Prevalence was over 25 % among IDUs routinely tested in drug treatment in the Italian regions of Emilia-Romagna, Lombardy and Sardinia; in France (IDUs aged over 34); in Lisbon and Porto (Portu-

<sup>(13)</sup> Figure 8 OL: Labour status in some countries (online version).

<sup>(14)</sup> Figure 9 OL: Level of education in some countries (online version).

<sup>(15)</sup> Figure 10 OL: Percentage of non-nationals among clients in first treatment in some countries (online version).

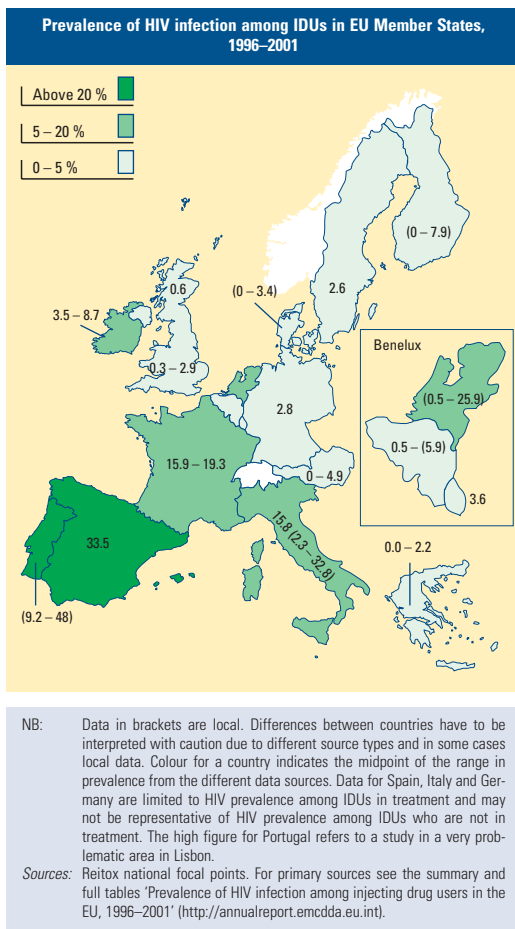
<sup>(16)</sup> A more detailed insight into this issue is provided in the 2001 annual report, Chapter 3, Selected issues — Drug-related infectious diseases available online (<http://ar2001.emcdda.eu.int>).

<sup>(17)</sup> See [http://www.emcdda.eu.int/situation/themes/infectious\\_diseases.shtml](http://www.emcdda.eu.int/situation/themes/infectious_diseases.shtml) for more detail on methods and guidelines of data collection.

<sup>(18)</sup> For more detail on these data and for original sources see the complementary statistical tables online (<http://annualreport.emcdda.eu.int>).

## Drug situation

Figure 11



gal); and in Spain. Studies that included IDUs both recruited in treatment and in out-of-treatment settings (the latter being more representative) have also found prevalence over 25 %, in Lisbon (Portugal), Barcelona, Madrid, Seville (Spain, 1995), Amsterdam (the Netherlands) and Dundee (Scotland, 1995).

Trends over time in HIV prevalence are important for policy and evaluation purposes. More action is needed where trends are increasing and may be sufficient where they are decreasing. However, in areas with decreasing prevalence new infections may still occur. In recent years, increases in HIV transmission in (subgroups of) IDUs have occurred in regions or cities in Ireland, Italy, the Netherlands, Portugal and Finland<sup>(19)</sup>. The Italian data shows that a national average is of very limited value for policy purposes and breakdowns by smaller regions or cities are extremely important to evaluate the success of prevention (see Figure 12). However, very few countries can yet provide national data broken down by region. Decreases in HIV prevalence were found in IDUs in treatment in the Italian regions of Lazio, Marche and Umbria and in needle exchange attendees in Helsinki,

Finland, in 2000 (following the earlier strong increase in 1998/99). For following trends over time, the prevalence data are complemented by notifications of newly diagnosed cases. Although not yet available for the most affected countries, and still much depending on testing patterns, notification data have helped identify the new increases in transmission in Finland (Figure 13).

Prevalence in young IDUs may provide further feedback on the effectiveness of prevention, as they will on average have been infected more recently than the total group. Prevalence in IDUs aged less than 25, for those countries where a breakdown by age was available, was highest in Spain (drug treatment, declining from 20 % in 1996 to 13 % in 2000), France (declining from 6 % in 1997 to 3 % in 1999 in drug treatment, but 8 % in 1998 in needle exchange attendees), Italy (drug treatment, 8 %

Figure 12

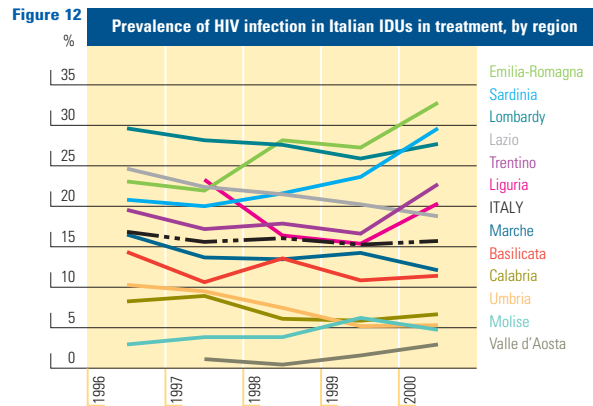
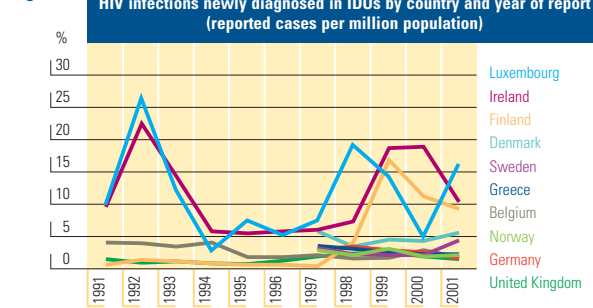


Figure 13



<sup>(19)</sup> See Box OL: Increases in HIV transmission among IDUs in some EU countries (online version) for details.

in 1998) and among IDUs in drug treatment in Portugal: Coimbra (7 % in 1999/2000), Lisbon (6 to 11 % in 1998–2000), Porto (57 % in 1997).

For some countries, information is available on HIV prevalence in new injectors. This is an even better indicator for recent HIV infections (HIV incidence) and thus stronger evidence for the effectiveness of prevention measures. In new injectors, incidence per 100 person-years of exposure may vary from 0 in England and Wales (prevalence 0/122, 1998), 3.9 in the Belgian Flemish Community (3/77, 1998/99), 9.4 in Coimbra, Portugal (12/127, 1999–2000) to 10 in France (11/111, self-reported serostatus in needle exchange attendees, 1998) (Figure 13).

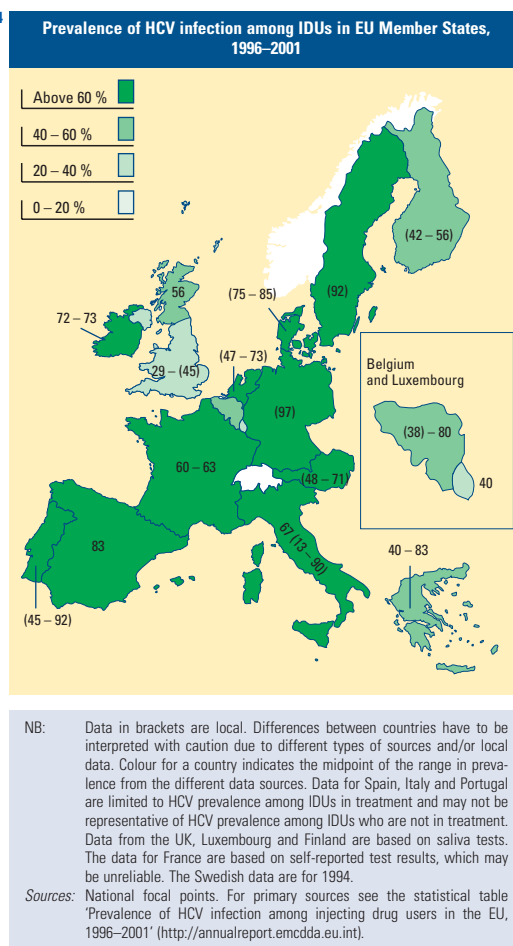
AIDS data can no longer be used to follow trends in HIV infection, due to improved HIV treatments that delay the onset of AIDS. AIDS incidence, however, still shows the burden of newly occurring HIV disease in the different countries. AIDS incidence has dropped in most countries since about 1996, due to the improved treatments and possibly lower infection rates in the 1990s. In Portugal, IDU-related AIDS continued increasing in the late 1990s, indicating a lack of HIV treatment uptake and/or increased HIV transmission among IDUs. The increase in Portugal has stabilised since 1997, leaving the country with the highest yearly incidence of AIDS among IDUs in the EU <sup>(20)</sup>.

### Prevalence and trends in infection with the hepatitis C virus

Data on prevalence of infection with the hepatitis C virus (HCV) are less available and, where available, are subject to the same limitations as the HIV data. However, the overall picture is also clear — HCV prevalence is extremely high in all countries and settings, with infection rates of between 40 and 90 % among different sub-groups of IDUs (Figure 14).

Although all prevalence figures show very high levels of infection, the range in prevalence is still large. As for HIV, this may partly reflect different selection mechanisms in the different data sources, and comparisons should be made with caution. Several countries have not reported updated figures. In 2000 and 2001, levels over 75 % were reported for Antwerp, Belgium (80 % in drug treatment and low threshold services 2001), northern Greece (83 % in methadone treatment), the Italian regions of Piedmont, Trentino, Friuli-Venezia Giulia, Liguria, Emilia-Romagna, Basilicata and Sardinia (drug

Figure 14



treatment), and some smaller cities in Portugal, outside Lisbon (drug treatment) <sup>(21)</sup>.

For injecting risk behaviour and for measuring the effectiveness of prevention, trends in HCV prevalence can be a much more sensitive indicator than trends in HIV. HCV is more infective than HIV and can be transmitted more easily through injecting materials other than syringes, such as cotton, spoons, water (but very much less easily sexually). Increasing trends in HCV prevalence are reported from Frankfurt (drugs emergency service), northern Greece (methadone treatment) and some regions in Italy (drug treatment: Piedmont, Trentino, Emilia-Romagna, Marche, Basilicata and Sardinia, consistent with increases in HIV in some of those regions). Decreases are reported from Austria (drug treatment and low threshold services), Lisbon, Portugal (drug treatment), Helsinki, Finland (needle exchanges), London, UK (drug treatment), and other Italian regions (Veneto, Tuscany, Umbria and Abruzzi), once more demonstrating the policy relevance of monitoring

<sup>(20)</sup> Figure 11 OL: Incidence of AIDS related to IDU in EU Member States (online version).

<sup>(21)</sup> Further country and regional details can be found online (<http://annualreport.emcdda.eu.int>) (online version).

## Drug situation

prevalence not only nationally, but also by region, city or other small area.

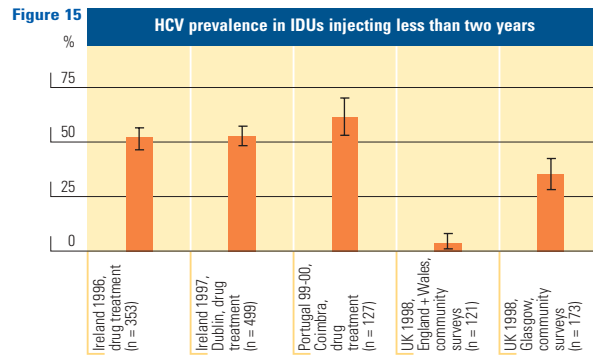
As far as they are available, data on prevalence in IDUs aged under 25 indicate levels of HCV infection of from about 20 % (Flemish Community, Belgium, treatment, 1997/98) to over 74 % (Coimbra, Portugal, treatment, 2000). Prevalence in young IDUs seems to be decreasing in France (43 % 1997 to 37 % in 1999), but data are based on self-reported test results and may be unreliable.

Prevalence data of HCV in new injectors (injecting less than two years) are still not available from most sources. Where data are available, in general they indicate prevalence of 40 % or higher. This suggests that new injectors are infected at very high rates. However, it cannot be excluded that acute infections are over-represented, and thus prevalence overestimated in sources reporting prevalence among routine diagnostic testing (Coimbra, Portugal) or based on self-reported test results (France). In community-wide surveys in England and Wales, rates in new injectors as low as 2 % are reported from outside London. This suggests that incidence of new infections is very low and possibly that HCV prevention efforts in England and Wales are relatively effective (see Figure 15).

### Prevalence and trends in the hepatitis B virus

Antibodies for the hepatitis B virus (HBV) indicate whether somebody has ever been infected or vaccinated. Thus, the proportion with no antibodies, i.e. the potential for vaccination among IDUs, is important to know for vaccination policy. Antibody prevalence for HBV seems less similar across the EU than prevalence of HCV. In the EU, roughly between 20 and 60 % of IDUs have antibodies against hepatitis B, suggesting a large potential for vaccination programmes (40 to 80 %).

Current hepatitis B infection can be either a recent or chronic infection, and is indicated in the blood by a serological marker named HbsAg. Levels of current infection indicate the potential for severe long-term complications and for spread to others through injecting risk behaviour or sexual transmission. Prevalence of current HBV infection is only available from a limited number of countries, but appears to differ much and is in some cases high. In northern Greece, IDUs in methadone programmes may have experienced an important outbreak of hepatitis B infection prior to 1998, as levels were extremely high in 1998 but declined strongly between 1998 and 1999. In Belgium,



Sources: National focal points. For primary sources see the table 'Prevalence of HCV infection among new injecting drug users, 1996–2000' (<http://annualreport.emcdda.eu.int>). The 95% confidence interval is indicated.

data from IDUs in treatment indicate a steady increase in current HBV infection between 1997 and 1999. In Portugal, recent drug treatment data indicate a decline in current HBV infection. In Norway, notification data indicate a strong increase in current HBV (and HAV) infections among IDUs.

See <http://annualreport.emcdda.eu.int> for the detailed statistical tables related to this section:

- Summary table of 'Prevalence of HIV infection among injecting drug users in the EU, 1996–2001'
- Summary table of 'Prevalence of HCV infection among injecting drug users in the EU, 1996–2001'
- Prevalence of HIV infection among injecting drug users in the EU, 1996–2001
- Prevalence of HIV infection among injecting drug users under age 25, EU, 1996–2000
- Prevalence of HIV infection among new injecting drug users in the EU, 1996–2000
- Notified cases of HIV among injecting drug users in the EU, 1991–2001
- Prevalence of HCV infection among injecting drug users in the EU, 1996–2001
- Prevalence of HCV infection among injecting drug users under age 25, EU, 1997–2000
- Prevalence of HCV infection among new injecting drug users in the EU, 1996–2000
- Prevalence of current hepatitis B infection (HbsAg) among injecting drug users in the EU, 1996–2001
- Prevalence of HBV antibodies among injecting drug users in the EU, 1996–2001

## Drug-related deaths and mortality among drug users

The number of 'drug deaths' is often used in public debates and the media, and in discussions about illegal drug problems. These deaths create serious social concern and can influence the formulation and evaluation of drug policies.

National statistics on 'drug deaths' usually refer to acute deaths directly related to drug consumption or 'overdoses' <sup>(22)</sup>. The definition used in the EMCDDA key indicator also refers to these deaths <sup>(23)</sup>. In addition, problem drug users — in particular opiate users — suffer a high overall mortality rate mainly due to overdoses, but also due to AIDS, accidents, violence, etc.

### Impact and characteristics of acute drug-related deaths

The impact of acute drug-related deaths becomes evident when it is considered that each year between 7 000 and 8 000 deaths are reported by EU countries. Most countries consider that there is some level of under-notification, in some cases significant under-notification.

Opiates are present in most cases of overdose deaths, although concentrations found in toxicology vary widely, with very frequent presence of other substances, which in some cases may play a contributory role to the fatal outcome.

Most victims of overdoses are young males, in their 20s or 30s, who have been using opiates for several years. Injection represents a major risk factor, whereas non-injectors have a lower risk of overdose. Similarly to clients entering treatment, a clear ageing trend among victims is observed in most countries. Finland, and to a lesser extent, the United Kingdom are exceptions to this ageing trend <sup>(24)(25)</sup>.

There is enough information to conclude that a significant proportion of overdoses (fatal and non-fatal) could be avoided. Firstly, some risk factors for opiate overdoses are known: injection in comparison to other routes; combined use with other depressants; use after a period of abstinence (e.g. after prison or treatment release); injecting alone; and probably unexpected changes in

purity. In addition, most overdoses happen in the presence of other users, and usually death is not immediate, allowing time for intervention. However, reactions of witnesses are often inappropriate or delayed, due to lack of knowledge or fear of police intervention.

For the time being, deaths due to intoxication by cocaine, amphetamine or ecstasy without the presence of opiates are infrequent in Europe. However, several countries (Spain, France, Italy, the Netherlands and the United Kingdom) have reported national or local increases of cases where cocaine is found (generally in addition to other substances). In addition, some deaths related to cocaine may take the form of cardiovascular problems and pass unnoticed.

Deaths directly caused by ecstasy are unusual, but they raise serious concern because they happen unexpectedly among very young people, and because some could be prevented through simple measures, such as proper ventilation and the availability of water in dance places, in addition to health education.

Methadone has been detected in a certain number of deaths, although several sources (e.g. from the United Kingdom or Germany) indicate that deaths involving methadone were more likely to be the result of illicit rather than prescribed use. It should be underlined that research shows that substitution programmes reduce the risk of mortality among programme participants.

### Trends in acute drug-related deaths

In a long-term perspective of trends in EU countries (15–20 years), a marked increase of drug-related deaths was observed during the 1980s and early 1990s. During recent years, the number of acute deaths has stabilised at this higher level of between 7 000 and 8 000 per year in the EU as a whole, although with different national trends (Figure 16).

It is worrying that some EU countries report recent increases after a period of stabilisation or decreases. Other countries, such as Australia and the United States, have also reported increases of opiate-related deaths in recent years.

These overall trends may be explained by the expansion of heroin injection in many European countries during the 1980s and early 1990s. The recent levelling off might be

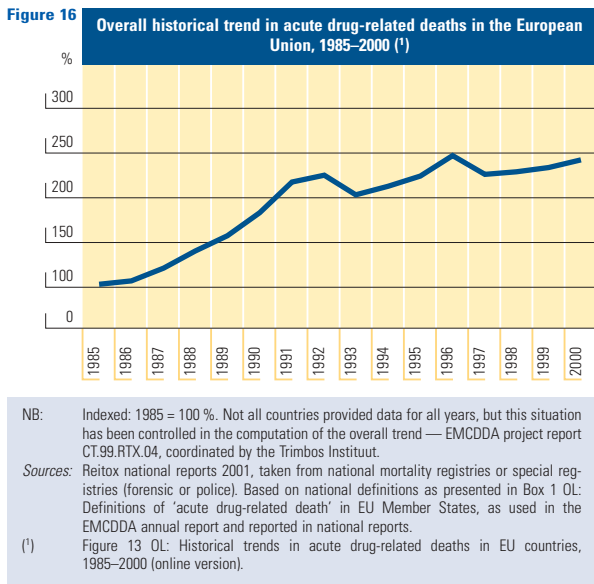
<sup>(22)</sup> Box 1 OL: Definitions of 'acute drug-related death' in EU Member States, as used in the EMCDDA annual report and reported in national reports (online version).

<sup>(23)</sup> Box 2 OL: Drug-related deaths — EMCDDA definition (online version).

<sup>(24)</sup> Table 1 OL: Summary of characteristics of deceased due to acute drug-related deaths in the EU (online version).

<sup>(25)</sup> Figure 12 OL: Evolution of the proportion of people over 35 years among drug-related deaths in some EU countries (online version).

## Drug situation



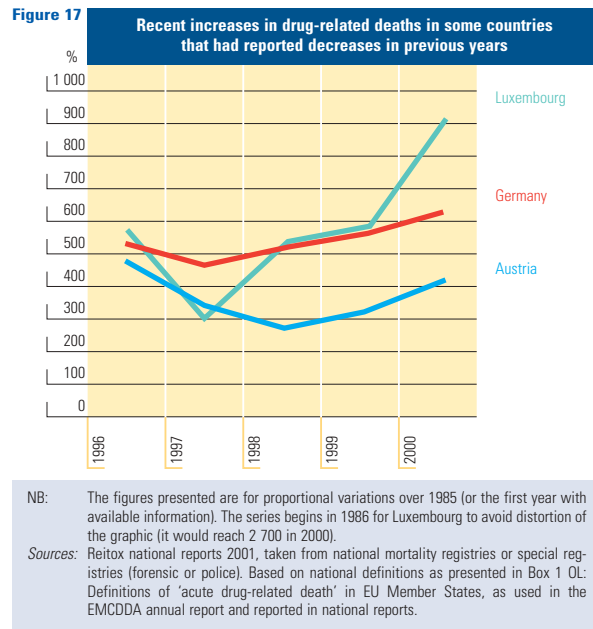
related to the stabilisation of the prevalence of problem drug use in some countries, the decrease in risk practices (injection) in others and, probably, the increase of treatment availability — including substitution programmes.

The fact that there are no indications of a decrease at EU level underlines the reality that drug-related health damage is far from being overcome, stresses the need to further investigate risk factors and reinforces the need for appropriate targeted interventions. It is important to stress that within the overall EU trend described, different, and sometimes divergent, national trends exist.

Several countries presented a downward trend during the second half of the 1990s (Germany, Spain, France, Italy, Luxembourg and Austria), possibly for the reasons mentioned above. In some of them the decrease or stabilisation has continued (Spain, France and Italy). However, it is worrying that, in others, the number of reported deaths has increased again in recent years (Germany, Luxembourg and Austria) (Figure 17). The ageing of problem drug users and the increase in polydrug use are considered to be contributing factors.

Some countries reported substantial upward trends in the second half of the 1990s (e.g. Greece, Ireland, Portugal and Norway). In Ireland (1999) and Portugal, this trend has been halted. Finland presents an increasing trend in recent years, with an increase of the number of young people among the deceased. These increases may be related to the later expansion of heroin use in these countries, although improved reporting systems may have played a role in some cases.

The United Kingdom has presented a steady, although moderate, increasing trend of drug-related deaths. Their



national definition includes medicine-related deaths, but if heroin–morphine cases are considered independently, a more marked upward trend is evident.

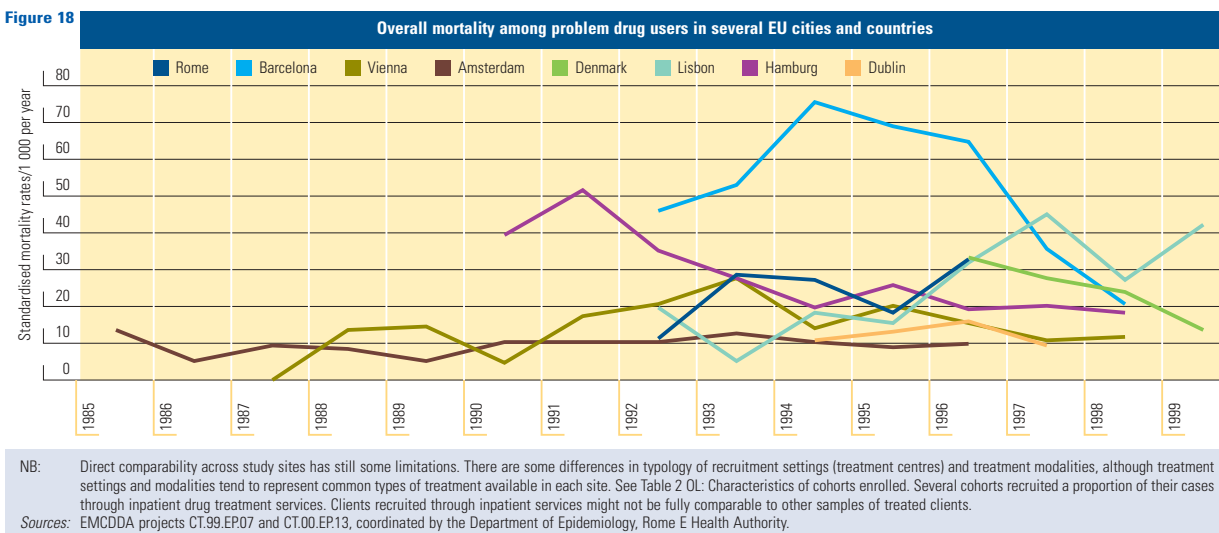
Other countries present less clearly defined trends, or changes are more difficult to interpret, due to the switch between ICD classifications (from 9th to 10th edition) or changes in national definitions.

### Overall mortality among problem drug users

Problem drug users account for less than 1 % of the adult population of the EU but significant health and social problems are concentrated within this limited group. Even several city-based studies have shown that a significant proportion of the mortality of young adults in the EU can be attributed to problem drug (in particular opiate) use. For instance, in Glasgow, a third of deaths among those aged 15–35 years could be attributed to acute drug deaths during the early 1990s and, in Madrid, a quarter of deaths among males aged 15–39 years in 1990 were attributed to overdoses or AIDS related to drug injection. Further studies are needed to monitor the impact of drug-related mortality in other places and in more recent years.

Mortality cohort studies show that mortality among problem drug users is up to 20 times higher than among the general population of the same age. This high mortality is due mainly to overdoses, but also due to AIDS and other infectious diseases, accidents, suicides, etc. Overdoses and external causes account for an important part of this mortality, in particular in countries with low HIV prevalence among drug users, whereas AIDS plays a significant role in countries with high HIV prevalence. Chronic health problems (cirrhosis following hepatitis, cancer, etc.) may play an important role in the longer term.

Figure 18



Mortality of injectors is two to four times higher than non-injectors and (until recently) mortality of drug users infected by HIV was two to six times higher than non-infected users. With recent improvements in HIV treatment, this difference might be decreasing.

Mortality of problem drug users other than opiate users or non-injectors seems clearly lower, although new methodological approaches may be needed to assess mortality among these users.

### Trends in mortality among problem drug users

The multi-site study coordinated by the EMCDDA shows differences in overall mortality rates and distribution of causes of death between participating sites. The study also reveals relevant changes over time in overall and cause-specific mortality.

Barcelona presented the highest mortality rates and Vienna and Dublin the lowest. In several locations, mortality rates were higher during the early or mid-1990s and have decreased in recent years. In Barcelona, rates were particularly high between 1992 and 1996, but have decreased sharply in recent years, due mainly to the decrease in AIDS mortality. In Lisbon, mortality rates have been increasing until recent years (Figure 19).

Direct comparisons across sites should be made with caution, since profiles of recruitment centres are different, although in general they would tend to represent the common types of treatment available. With this limita-

tion in mind, trends on overall and cause-specific rates within each site can give valuable insights.

See <http://annualreport.emcdda.eu.int> for tables related to this section:

- Number of 'acute drug-related deaths' recorded in EU countries (according to national definitions used to report cases to the EMCDDA), 1985–2000
- Box 1 OL: Definitions of 'acute drug-related death' in EU Member States, as used in the EMCDDA annual report, and reported in national reports
- Box 2 OL: Drug-related deaths — EMCDDA definition

### Drug-related crime

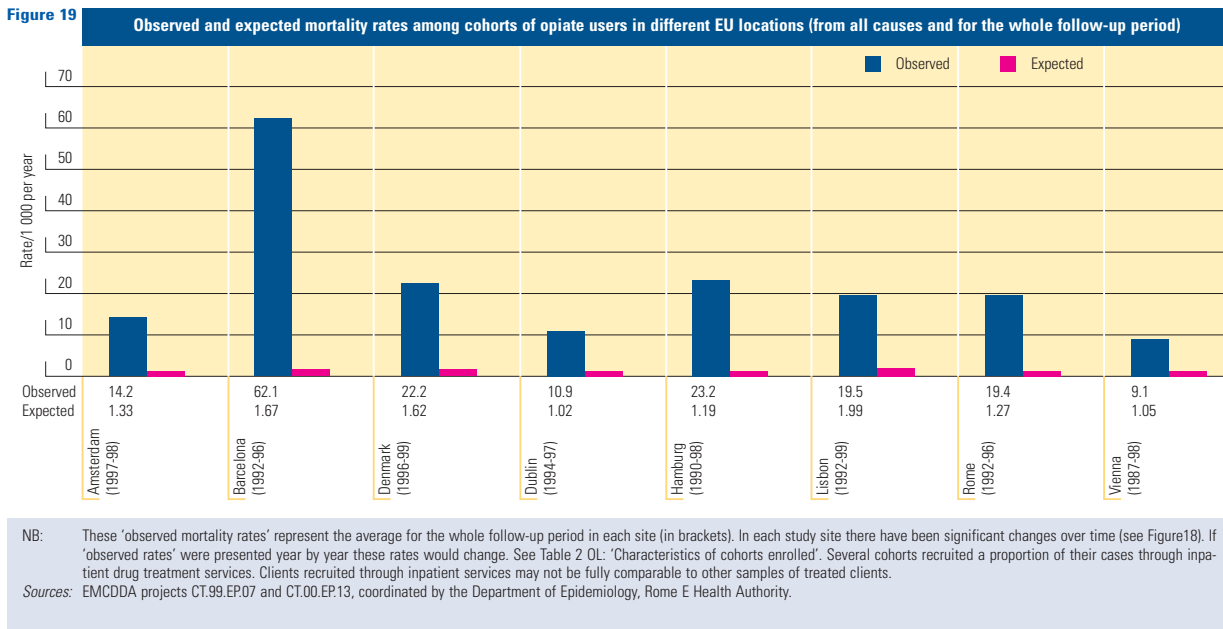
Drug-related crime can be considered as covering criminal offences against drug legislation, crimes committed under the influence of illicit drugs, economically driven crimes committed by users to support their drug habit (mainly acquisitive crime and dealing) and systemic crimes committed as part of the functioning of illicit markets (fight for territories, punishment of dealers, etc.). Except for drug law offences, these categories do not transpose into routinely available data and when available come from ad hoc local studies that are difficult to extrapolate.

Arrests <sup>(26)</sup> for offences against national drug legislation (use, possession, trafficking, etc.) reflect differences in law as well as priorities and resources for law enforcement. Differences in recording procedures and definitions affect comparisons. Whenever possible, trends are compared.

<sup>(26)</sup> The term 'arrest' covers different concepts, varying between countries (police reports of suspected drug law offenders, charges for drug law offences, etc.). Please refer to the online table on 'arrests' for an exact definition per country.



## Drug situation



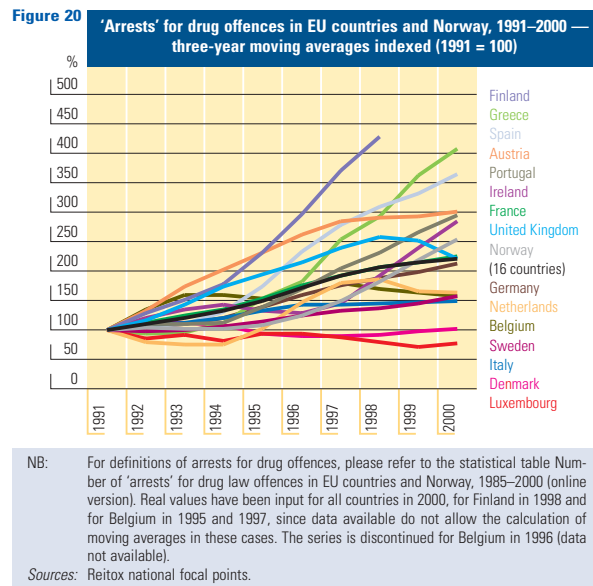
Cannabis remains in 2000 the most common drug involved in 'arrests' — accounting for 37 % of the drug-related arrests in Sweden and up to 85 % in France. In Portugal and Luxembourg, heroin is predominant while in the Netherlands, most of the drug offences are related to 'hard drugs' (drugs other than cannabis and its derivatives) <sup>(27)</sup>.

The majority of reported drug offences are related to drug use or possession for use — from 55 % in Portugal to 90 % in Austria. In Norway, 60 % relate to drug dealing and trafficking. In Italy, the Netherlands and Spain, where drug use is not considered as a criminal offence, all drug offences relate to dealing or trafficking. As in previous years, Luxembourg reports the highest number of arrests involving offences for both drug use and drug trafficking.

### Trends

In the EU as a whole, 'arrests' for drug law offences have been steadily increasing since 1985. Increases by over 10-fold were reported in Greece and Portugal while in Denmark, Luxembourg, the Netherlands and Sweden, increases were much lower (less than twofold).

Over the last three years, the number of drug-related 'arrests' increased in most EU countries. The highest increases were reported by Greece, Ireland and Norway. In 2000, the Netherlands and the United Kingdom were the only countries reporting a fall in the number of drug-related 'arrests' <sup>(28)</sup> (Figure 20).



See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

- Drug mostly involved in the 'arrests' for drug offences in EU countries and Norway
- Offence type mostly involved in the 'arrests' for drug offences in EU countries and Norway
- Number of 'arrests' for drug law offences in EU countries and Norway, 1985–2000
- References to graph 'Arrests for drug offences, 1991–2000. Three-year moving averages indexed (1991 = 100)'

<sup>(27)</sup> Figure 14 OL: Drug mostly involved in the 'arrests' for drug offences in EU countries (online version).

<sup>(28)</sup> There was a fall in 'arrests' in Belgium too, but it is due to a change in recording procedures.

## Drug markets and availability

Drug seizures are usually considered as indirect indicators of supply and availability of drugs, although they reflect law enforcement resources, priorities and strategies, as well as vulnerability of traffickers to enforcement. Quantities seized may fluctuate from one year to another due to a small number of large seizures<sup>(29)</sup>. For this reason, the numbers of seizures are usually considered as a better indicator of trends<sup>(30)</sup>. In all countries, they include a major proportion of small seizures from the retail level of the market. Where known, origin and destination of drugs seized may indicate trafficking routes and producing areas. Price and purity of drugs at retail level are reported by most of the Member States, but data are too scarce to allow for accurate comparisons.

### Cannabis

Cannabis is the most seized drug in every Member State except Portugal, where heroin seizures predominate. Since 1996, Spain has been seizing the largest quantities of cannabis, more than half the total amount seized in the EU. The United Kingdom reports a higher number of cannabis seizures but on average they involve smaller quantities.

Cannabis resin comes mainly from Morocco via Spain and the Netherlands. The cannabis herb originates in Afghanistan, Pakistan and Lebanon, as well as coming from Albania to Italy and Greece, and from Angola to Portugal. Local production takes place in most Member States, especially 'nederwiet'<sup>(31)</sup> production in the Netherlands.

In 2000, the retail price of cannabis was reported to vary between EUR 1 and EUR 20 per gram of cannabis resin and between EUR 2 and EUR 8 per gram of cannabis leaves. The percentage of THC content in cannabis resin ranges between 2 and 13 % on average, although samples ranging from 0 to 50 % of THC have been reported in the EU. The THC content in cannabis leaves is generally lower, around 1 to 6 %, with the exception of Belgium (17 % on average) and 'nederwiet' in the Netherlands, which rates higher (10 % on average).

### Trends

The number of cannabis seizures has increased steadily in the EU since 1985 and seems to have stabilised over the last three years. This trend is especially due to a decreasing number of cannabis seizures in Belgium, the Netherlands, Portugal, Austria and the United Kingdom in recent years. Quantities increased too, but have sta-

bilised since 1995. In 2000, quantities seized went down in most of the Member States.

The price of cannabis is generally stable in the EU, although increasing in Luxembourg and Portugal (resin) in 2000.

### Heroin

In 2000, almost 9 tonnes of heroin were seized in the EU, of which over a third was accountable to the United Kingdom (Figure 21). Heroin seized in the EU comes mainly from the Golden Crescent (south-west Asia: Afghanistan and Pakistan), followed by the Golden Triangle (south-east Asia: Myanmar, Laos and Thailand), via Turkey, the Balkan route and the Netherlands. However, increased trafficking via eastern Europe (Russia, Estonia, Bosnia and Slovenia) and central Asian countries from the former USSR was reported.

At street level, heroin prices varied between EUR 25 and EUR 330 per gram in 2000 across the EU. The highest prices are reported by Ireland, Finland and Norway. Heroin purity ranges typically from under 20 to 45 %, but higher average purity is reported by Belgium, Denmark, Spain and Norway regarding brown heroin.

### Trends

At EU level, heroin seizures increased up until 1991–92 and then stabilised. In 2000, they decreased in Ireland, Luxembourg, Norway, Portugal and Spain. Compared to the situation in 1985, quantities seized at EU level have been increasing. They stabilised during the period 1991–98, but have been increasing again since then. In 2000, all countries, except Denmark, Germany, Spain, Italy and Sweden, reported increases in the amount of heroin seized.

Heroin street prices are generally stable or decreasing, though brown heroin was reported to increase in 2000 in Portugal, Sweden and the United Kingdom. Heroin purity is reported to be stable or decreasing in all countries, except Denmark, Germany, Luxembourg and the United Kingdom, where it has been recently increasing, especially brown heroin.

### Cocaine

Spain remains the country in the EU with the highest level of cocaine seizures. The cocaine used in Europe comes from Latin America (especially Colombia, Brazil and Venezuela) via Central America and the Caribbean. For several countries, Spain is the main entry point to the rest of the EU, although cocaine is then often redistributed via the Netherlands.

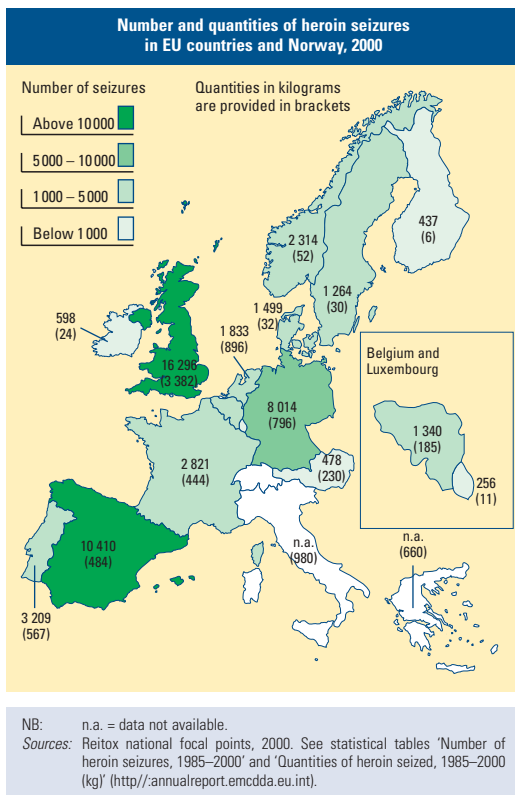
<sup>(29)</sup> Figure 15 OL: Quantities of cannabis, cocaine, heroin and amphetamines seized in EU countries (1985–2000) (online version).

<sup>(30)</sup> Caution is required when analysing trends at EU level, as series start at different years in different countries. See the statistical tables (<http://annualreport.emcdda.eu.int>) for more information.

<sup>(31)</sup> 'Nederwiet': Dutch cannabis leaves grown locally in the Netherlands.

## Drug situation

Figure 21



The retail price of cocaine varied from EUR 45 to EUR 170 per gram in 2000. The lowest prices are found in Spain and the United Kingdom, and the highest in Finland. Cocaine purity is generally high, between 50 and 85 % in most countries, except in Denmark and Germany, where it was on average lower in 2000.

### Trends

The total number of cocaine seizures rose steadily since the mid-1980s in the EU and stabilised in 2000. The quantities of cocaine seized had been fluctuating within an upward trend but, in 2000, a marked decrease was reported — mainly due to very large decreases in countries seizing most of the cocaine in the EU (Spain, France and the Netherlands).

Cocaine prices are stable or decreasing in most countries, but increased in 2000 in Denmark, Portugal and the United Kingdom. Purity remains stable or is decreasing in every Member State.

### Synthetic drugs: amphetamines, ecstasy and LSD

In Finland, Norway and Sweden, amphetamines are the second most commonly seized drug (after cannabis). The United Kingdom accounts for most of the amounts of amphetamines, ecstasy and LSD seized in the EU.

The Netherlands is a major site for the production of ecstasy, amphetamines and related drugs but evidence of production in other Member States (Belgium and the United Kingdom) and in east European countries (the Czech Republic and Estonia) is also reported.

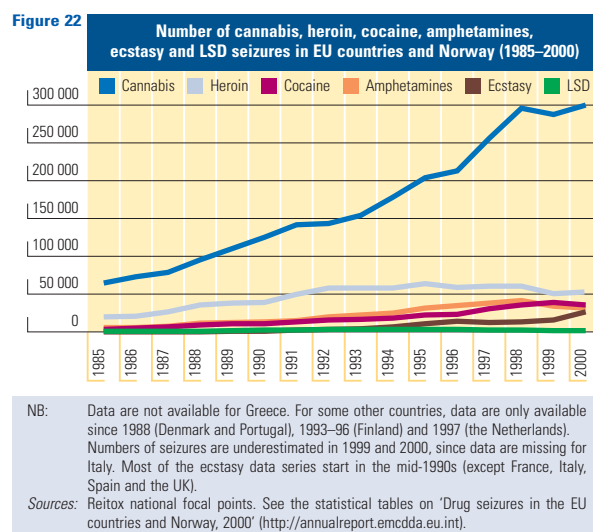
Amphetamines are reported to be sold at between EUR 5 and EUR 35 per gram on average, while ecstasy tablets vary from EUR 5 to EUR 15 each. Data for 2000 show that synthetic drugs are cheaper in Belgium and the United Kingdom. Amphetamine purity is very variable, from 3 % in Ireland to 46 % in Finland, but is typically between 10 and 15 % in the EU. In 2 % of cases in Greece to 100 % in Finland, tablets sold as ecstasy contain ecstasy or ecstasy-like substances (MDMA, MDEA, MDA). Amphetamines (or metamphetamines) are found in 2 to 22 % of tablets, but various other psychoactive substances (2-CB, 2-CT7, 4-MTA and recently PMA and PMMA) may also be found.

### Trends

Amphetamine seizures — both numbers and quantities — have been rising since 1985. The number of amphetamine seizures went down in 1999 and 2000, especially in the United Kingdom. After decreases in 1998 and 1999, quantities rose again in 2000, particularly in Germany.

Ecstasy seizures have been increasing in most of the EU since 1985, with marked increases in 2000. Amounts of ecstasy seized followed the same upward trend since 1985, and then stabilised from 1993 to peak in 1996 and increase again since 1999. In 2000, they rose in all countries except Denmark, Luxembourg and Portugal.

LSD seizures are less common. Both numbers and quantities went up until 1993, decreased from then, but rose



slightly in 2000. Denmark, Germany, Spain, France, Ireland, the Netherlands, Portugal and Finland report major increases in quantities of LSD seized in 2000.

After significant decreases in the 1990s, amphetamine and ecstasy prices have stabilised in the EU. However, in 2000, Ireland reported an increase in both synthetic drug prices, while Germany reported a rise for amphetamine only. Spain, Sweden and the United Kingdom reported cheaper ecstasy tablets in 2000. In recent years, the proportion of tablets containing ecstasy or ecstasy-like substances has increased in many countries while those containing amphetamines (and metamphetamines) decreased. Greece reported a shift from MDMA to amphetamines as the main substance in the majority of tablets in 1999 and 2000.

See <http://annualreport.emcdda.eu.int> for statistical tables related to this section:

- Drug seizures in the EU countries and Norway, 2000
- Number of amphetamine seizures, 1985–2000
- Number of cannabis seizures, 1985–2000
- Number of cocaine seizures, 1985–2000
- Number of ecstasy seizures, 1985–2000
- Number of heroin seizures, 1985–2000
- Number of LSD seizures, 1985–2000
- Quantities of amphetamine seized, 1985–2000 (kg)
- Quantities of cannabis seized, 1985–2000 (kg)
- Quantities of cocaine seized, 1985–2000 (kg)
- Quantities of ecstasy seized, 1985–2000 (tablets)
- Quantities of heroin seized, 1985–2000 (kg)
- Quantities of LSD seized, 1985–2000 (doses)

# Responses to drug use

This chapter presents an overview of developments in national and EU drug policies and strategies. Responses to the drugs problem in the fields of education, health, social care and criminal justice are also covered.

## National and European drug strategies

### Drug policy into action plans

#### EU strategy

In October 2001, the Council's Horizontal Working Party on Drugs examined the 'Report on the identification of criteria for an evaluation of the European Union strategy on drugs (2000–04)', drawn up by the EMCDDA and Europol. It offers an analysis of each of the six targets of the EU action plan<sup>(32)</sup> and underlines monitoring and evaluation potentials and constraints. It also includes a set of parameters on which to establish a situation baseline using 1999 data<sup>(33)</sup> and against which the situation in 2004 will be measured.

#### National drugs strategies<sup>(34)</sup>

The EU action plan on drugs has contributed to promoting awareness on the need for coordinated activities in Member States in the field of drugs. Article 1.1.3 calls on the Council to provide regular opportunities for those responsible for drugs at national level to meet and exchange information on national developments and increase cooperation. In Sweden, one such meeting was organised among national drug coordinators in 2001<sup>(35)</sup>.

As far as national strategies are concerned, the trend established over the past few years to translate drug policy frameworks into an action plan, drug strategy or pol-

icy document has continued, although a gap between the written strategy and its implementation still remains.

In March 2001, the Portuguese Government approved an action plan on drugs entitled *Horizonte 2004*, which identifies detailed objectives, goals and specific actions to be developed over a period of four years. One month later, the Irish Government approved a national drugs strategy for the period 2001–08 which elaborates specific objectives, key performance indicators and individual actions to be taken by each minister involved in the delivery of drugs policy. In June, the Greek Ministerial Council adopted a number of decisions directed towards a holistic, unified and coordinated policy on drugs. In these decisions, the government commits itself to introducing to parliament a five-year national action plan with specific targets to be met, activities to be developed and measures to be taken.

In Finland, an action plan for 2001–03 was adopted (in February 2002) and specific drug strategies drawn up between customs and the frontier guard. In Austria, all nine provinces now have a drugs or addiction coordinator and seven have drugs action plans while, in Belgium, the *Cel-lule drogue santé* was created in June 2001 and a coordination body is planned for the end of 2002. Italy, following the new government approach on drugs, announced the creation of an anti-drugs department headed by a drug coordinator, in November 2001. In Germany, a team of *Länder* coordinators has been working on improving coordination for many years. In January 2002, the Swedish Government presented its new drugs action plan for

<sup>(32)</sup> Details on the EU drugs strategy and action plan can be found online ([http://www.emcdda.eu.int/policy\\_law/eu/eu\\_actionplan.shtml](http://www.emcdda.eu.int/policy_law/eu/eu_actionplan.shtml)).

<sup>(33)</sup> Available online (<http://snapshot.emcdda.eu.int>).

<sup>(34)</sup> Table 3 OL: Action plans and coordinators (online version).

<sup>(35)</sup> The EMCDDA contributed with the publication of a comparative study on drug coordination in the EU ([http://www.emcdda.eu.int/multimedia/project\\_reports/policy\\_law/drug\\_coordination\\_oct\\_01.pdf](http://www.emcdda.eu.int/multimedia/project_reports/policy_law/drug_coordination_oct_01.pdf)).

2002–05 before the parliament. A ‘drug commissioner’ has also been appointed to coordinate and stimulate the actions at different levels of society.

In the United Kingdom, contrary to the general tendency, responsibility for drugs within government was moved from the Central Drug Coordination Unit (now dissolved) and its ‘drug tsar’ in the Cabinet Office to the Home Office and lies under the responsibility of the Secretary of State for Home Affairs.

### **Assessment of the impact of the drug strategies**

Although all Member States have now more or less defined drug strategies, the assessment of their impact is not yet common practice. Progress has been made in evaluating specific programmes or activities, usually in the demand-reduction field. However, when legal instruments or national strategies are considered as a whole, evaluation does not feature as a priority.

A few promising examples among the newly adopted strategies can, however, be mentioned. In Ireland and Portugal, the new national drugs plans adopted in 2001 both aim to establish evaluation mechanisms to assess their overall results. In Finland, evaluation is part of the new action plan for 2001–03 and it will concern the effectiveness of the plan as a whole, including treatment measures and actions relating to drug control.

In France, the Observatoire français des drogues et des toxicomanies (OFDT) has received a mandate from the mission interministérielle lutte contre la drogue et la toxicomanie (MILDT) to evaluate the effectiveness of the most important aspects of the French drugs plan for 1999–2001. Evaluation is a priority in the Netherlands, not only with regard to demand-reduction programmes but also with regard to other policy aspects (e.g. the coffee shop policy and changes in AHOJ-G criteria). The extended monitoring practices (national drug monitor) in the field of drug use and health — and related development of activities in law enforcement criminal justice — also contribute to the evaluation of policies. Other national drug strategies announce evaluation as a tool for measuring individual activities such as treatment methods or prevention techniques, as for example in the new Belgian ‘political note’ where evaluation is to be applied to treatment methods, health, care circuits and prevention techniques.

### **Member States look at legal and illegal substances together**

Increased attention to legal and illegal substances in drugs national policies is visible. If France was among

the first countries to extend reflection on preventive and rehabilitative measures in terms of addiction and not just on substances in 1998, over the last year the Norwegian Government further developed a comprehensive ‘substance abuse policy’ including alcohol, with regard to prevention, care and treatment. In Germany, the new Federal Drug Commissioner’s report in April 2001 also highlighted its intention to extend prevention, above all, to legal drugs, alcohol and tobacco. In Belgium, one of the four aims of the new federal government policy is to prevent young people from using drugs (including tobacco and alcohol). This trend is also apparent in the new drug strategy in Ireland, where in 2001 formal links at local, regional and national levels with the national alcohol policy have been developed to ensure complementarity between the different measures being undertaken. In the United Kingdom, in May 2001 the Northern Ireland Executive endorsed a joint implementation model. Through this structure, the strategies on alcohol and illicit drugs will be taken forward together. The Welsh drug strategy also includes legal substances.

## **Drug laws in the EU <sup>(36)</sup>**

### **At European level**

On 23 May 2001, the European Commission adopted the proposal of a Council framework decision laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking. This Commission initiative provides a common definition of illicit drug trafficking as well as common penalties concerning large-scale transnational trafficking. The proposal is currently (March 2002) being examined by the European Parliament and the Council of Ministers of the EU.

### **At national level**

Legal developments in the field of drugs in the reporting period comprise mainly measures towards drug users, driving under the influence of drugs, and substitution treatment.

#### *Legal approaches towards (drugs and) drug users*

There has been a trend over the year 2001 for some EU Member States to propose and enact legal changes directed at distinguishing more clearly drug users from other drug law offenders and at distinguishing cannabis from other illicit substances. Countries are considering various options, which may include a more specialised court system or a change in the law or policy regarding drug users.

<sup>(36)</sup> For the latest news and information on developments in Member States’ legal systems on drugs, see the European Legal Database on Drugs (<http://eldd.emcdda.eu.int/>).

## Responses to drug use

This is prominent in Portugal, which has removed the offences of drug use, acquisition and possession for personal use from the status of criminal law, and instead sanctions these offences administratively through the commissions for the dissuasion of drug abuse, established in July 2001. The commissions are composed of three members (appointed by the Ministries of Justice and Health and the member of government responsible for the area of drug abuse), a technical team of three to five professionals (psychologists, social workers and legal experts) and administrative staff. Cases are assessed individually, and reports by the technical team support the members' decisions for procedures and/or sanctions necessary. In April 2001, Luxembourg reduced the penalties for cannabis-related offences, by removing the option of a prison sentence for possession for personal use and personal use itself, and declared a prosecution policy aiming to concentrate only on problematic use. The political note released by the Belgian Government on 19 January 2001 outlines a similar idea. Luxembourg and Belgium have also used the law to make a distinction between cannabis and other substances for the first time, as does a cross-party draft of an amendment to the drug law in Greece that was put to the Greek Parliament in April 2001; though this was eventually rejected by the Greek Parliament in May 2002. In the United Kingdom, a reclassification of cannabis from class B drugs to class C drugs (moving possession for use from an arrestable to a non-arrestable offence) is expected in 2002. In Ireland, non-violent drug addict offenders will be directed to a drug court that was established on a pilot basis in January 2001 in Dublin — a similar project was launched in Glasgow, Scotland, in November. For those eligible for imprisonment not exceeding six months, the Dutch Government's new law on alternative sanctions came into force on 1 February 2001, permitting the imposition of combined work and educational penalties together with or instead of prison and/or fines.

However, this trend is not universal; in Finland, an amendment to the Penal Code in the summer of 2001 removed the right to waive prosecution of drug crimes, if the offence was considered not detrimental to the obedience of law, and enabled the prosecutor to conduct summary proceedings outside court, with a penalty of a fine or up to six months' imprisonment. Nevertheless, provisions remain that permit the waiving of prosecution or punishment if the offence is considered insignificant.

### *Drugs and driving*

There is increasing activity in the field of legislation governing driving under the influence of drugs, at both policy and operational levels.

At policy level, in June 2001, the Finnish working group appointed to implement the new government resolution on road safety proposed zero tolerance for drugs in road traffic. Other Member States have strengthened their regulations regarding who to test and how. In Austria, at the time of amending the Road Traffic Act in spring 2001, the decision was made to exclude a provision on obligatory drug tests for drivers. In Portugal in May and France in November, legislation was put in place for testing individuals involved in traffic accidents, in order to conduct research on drugs and driving so as to study the level and type of drug use among drivers and their contribution to accidents and to design a specific and effective law to address driving under the influence of drugs. The UK Government also implemented legislation, in March 2001, regulating the testing and related procedures on individuals suspected of driving under the influence of illicit substances.

### *Substitution treatment*

Member States are continuing to work on legislation regarding substitution treatment for addiction. Some countries are considering it, and those who have implemented it are improving their legal frameworks.

In Belgium, following the political note of January 2001, legislation is under preparation to control substitution treatment. In July 2001, Germany established a central substitution register, in order to avoid repeated prescriptions of substitution medicaments, and specified an additional qualification for doctors practising substitution. In Luxembourg, following a Grand Ducal decree of February 2002, medical doctors prescribing substitution drugs have to be granted a State licence by the Minister for Health. The same decree foresees the creation of a special surveillance commission and the setting up of a national substitution register. In Greece, in the framework established by Law 2716/1999, further steps are planned to strengthen the structure of substitution treatment by expanding the administration of substitutes through the national health system. Meanwhile, in the United Kingdom, there is now a legal mechanism (in place since April 2001) for prescribing buprenorphine for substitution treatment when previously only methadone could be prescribed.

## Demand reduction

As described above, most EU Member States have a national drug strategy or similar arrangements <sup>(37)</sup>, as does Norway, and all include priorities in the field of

<sup>(37)</sup> Table 4 OL: Introduction to demand-reduction responses in the EU Member States and Norway (online version).

responses, with some countries (Spain, Ireland, Portugal and the United Kingdom) having set quantitative targets.

Naturally, national strategies include a comprehensive range of responses. However, tentatively, some priorities can be discerned either to reinforce certain types of responses and/or to develop more efficient structures<sup>(38)</sup>. School prevention is seen as a priority in 10 Member States, whereas importance is given to community prevention in seven. Prevention and early intervention for young people at risk is high on the agenda in nine countries. Harm reduction and medically assisted treatment are each considered a priority in six Member States, whereas Italy and Sweden put increased emphasis on drug-free treatment. Seven countries mention responses in the criminal-justice system as high priorities and six social reintegration. Eight countries see a need to improve the treatment structure and four to strengthen prevention structures in the country.

In most countries, the implementation of demand-reduction responses is decentralised due to the nature of the activities. Nevertheless, the priorities set in the national strategies and the associated funding for research and practice are essential for realisation at regional or local levels. The relative importance of policy, practice and research in implementing responses differs between countries. Evidently, all influence each other reciprocally but, in some countries, national policy seems to have a greater influence on practice while in others, often at regional level, practice influences policy.

The quality of demand-reduction responses is assured with the introduction (in some countries) of national standards, accreditation procedures or guidelines. Treatment has to adhere to quality standards in more countries than prevention does<sup>(39)</sup>.

### **Prevention in schools, local settings and the community**

All Member States stress the high priority of prevention in their national strategies and in the numerous preventive activities in different settings, most notably in schools. However, in many Member States, it is becoming increasingly obvious that there is a substantial gap between policy aims and the reality and the quality of prevention<sup>(40)</sup>. The real extent of prevention (e.g. in schools) can be measured ap-

proximately if it is done in a structured way through clearly defined programmes<sup>(41)</sup>. Only then can key parameters be assessed — parameters such as content (models and risk factors addressed) and the number of schools, pupils and teachers covered. This is the case in some Member States (Flemish Community of Belgium, Germany, Greece, Spain, Ireland and the United Kingdom) where programme-based information is available and can be evaluated. However, often the prevention of addiction is embedded into broader school policies with the aim of enhancing healthy lifestyles in daily (school) life. In this 'unstructured' context, prevention is carried out ad hoc through local advisory groups or councils (in Denmark, France and Norway), and/or is closely related to specific needs emerging and to resources (e.g. in France, Italy, Austria, Portugal and Finland). However, this approach is hard to capture in a standardised way and difficult to evaluate.

The range of objectives in school prevention is wide: besides the frequent mention of all-inclusive health promotion principles, the scope ranges from development of social/personal skills to the promotion of identity/personality. Awareness and information are often at the core of drug prevention, although such approaches alone have proven ineffective (Skolverket, 2000). There is no common European, evidence/research-based prevention principle in this field. The transnational 'Healthy school and drugs' project, financed by the European Commission, applies evidence-based quality elements in school prevention (<http://www.school-and-drugs.org>).

Another key problem is the logistical and administrative step of implementing the good practice model programmes (including evaluation) on a large scale within a country. Germany and the Netherlands explicitly refer to this challenge. Attention to prevention in some Member States (e.g. in Denmark and Germany) is experiencing a recent shift towards recreational settings in response to changing consumption trends and is moving in terms of content from risk avoidance to risk management. A European web site (<http://www.drug-prevention.de>) gathers projects that operate according to this philosophy. Overall, web sites for preventive purposes have increased in number and attractiveness in most Member States<sup>(42)</sup>. Another additional element is a set of guidelines on how to identify and deal with pupils that are taking drugs.

<sup>(38)</sup> Table 5 OL: Overview of the demand-reduction priorities in the Member States and Norway (online version).

<sup>(39)</sup> Table 6 OL: Overview of quality standards for prevention and treatment in the Member States and Norway (online version).

<sup>(40)</sup> Table 7 OL: An overview of prevention objectives, school programmes, web sites and prevention activities organised in recreational settings (online version).

<sup>(41)</sup> An overview of prevention programmes in schools is provided online in Table 7 OL (School programmes) (online version).

<sup>(42)</sup> A list of prevention web sites is provided online in Table 7 OL (Web sites) (online version).



## Responses to drug use

A recent growing interest and allocation of resources to quality assurance and evidence-based prevention can be clearly noticed in some Member States (Spain, Ireland, the Netherlands and the United Kingdom). As a parallel development, Germany, Greece, France, Ireland, the Netherlands and the United Kingdom are setting up databases to assess and monitor their national 'prevention coverage'. Spain already has an established information system.

As far as community programmes are concerned, there is no common concept among Member States. To begin with, this activity is not limited to prevention only: reduction of drug-related risks is often also included in community programmes. Besides, 'community programme' in some Member States means a programme carried out **in** a community (i.e. top-down), in others a programme carried out **by** a community (i.e. bottom-up).

Wide disparities also exist between Member States concerning the role of mass media in prevention strategies — from none at all (in Austria and the United Kingdom) to very prominent (in France and Italy). Peer-group approaches are strongly contested as well; they are extensively used in the Flemish Community (De Sleutel) of Belgium and in Denmark (Guardian Angels), while in some Austrian provinces they are rejected as being ineffective.

### Prevention in recreational settings

From a conceptual point of view, prevention in recreational settings can be seen as the overlap zone between prevention and risk reduction and thus often embraces conflicting ideological factions. In some Member States, the projects see themselves as 'secondary prevention', while others seek to conceptualise their work as 'harm reduction'. In broad terms, this form of prevention is based on three intervention strategies: the production of information material on drugs and the health, legal and emotional issues related to them; related personalised interventions in discotheques or raves; and structural measures such as safe-clubbing guidelines<sup>(43)</sup>.

Producing and distributing information material is traditionally the preferred and most widespread activity in recreational settings. In Germany, Spain and the United Kingdom particularly, numerous leaflets, posters and flyers are produced by diverse actors, but little is known about the impact of these unidirectional and anonymous communication strategies.

In fewer countries (Germany, Spain, the Netherlands and the United Kingdom), peer-group approaches are applied to reach clubbers in order to transmit preventive information in a more interactive and personal way, still using information material as handouts.

The importance and impact of simple but basic rules for safety in party settings has become increasingly recognised. These means of structural prevention, already available in the United Kingdom as official safer dancing guidelines (<http://www.clubhealth.org.uk/pages/downloads.htm>), are the most direct way of preventing drug-related problems in party settings. They aim to assure that the most frequent health hazards are minimised through the provision of fresh drinking water and chill-out areas to avoid overheating, through the training of staff in first aid and monitoring and in the detection of early problems through facilitating the work of outreach teams for prevention. These guidelines exist in several countries but their implementation by club owners or by the responsible local authorities in Member States is still very irregular. There are, however, initiatives to have a harmonised set of safe-clubbing guidelines Europe-wide.

More infrequently, for example in Belgium and Germany, specific interventions are offered, such as the management of 'bad trips' — that is how to deal with the adverse and unexpected effects of drugs without resorting to hospitalisation — and, in some Member States, the analysis of pills at festivities.

The value of on-site pill testing interventions for selectively attracting a target group of experienced or experimenting party-drug users for intense interactive preventive counselling<sup>(44)</sup> has been overshadowed by discussions focusing on questions of its pharmacological accuracy (Winstock et al., 2001) and its ideological<sup>(45)</sup> or legal implications.

### Prevention of infectious diseases

Major evidence-based responses to prevent infectious diseases among drug users are community-based outreach, drug treatment — in particular the prescription of methadone or other substitution drugs (which has expanded considerably in the EU and Norway over recent years, see the section on 'Treatment') — hepatitis immunisation, access to sterile injection equipment and safer use information and training<sup>(46)</sup>.

<sup>(43)</sup> An overview of prevention initiatives in recreational settings is provided in Table 7 OL (Recreational settings) (online version).

<sup>(44)</sup> See the EMCDDA study ([http://www.emcdda.eu.int/multimedia/project\\_reports/responses/pill\\_testing\\_report.pdf](http://www.emcdda.eu.int/multimedia/project_reports/responses/pill_testing_report.pdf)), pp. 35–37.

<sup>(45)</sup> Article in *Corriere della Sera*, 2 November 2001.

<sup>(46)</sup> See also: *Drugs in focus*, Briefing 4, EMCDDA, Office for Official Publications of the European Communities, 2002.

Some outreach services are available in all EU countries and Norway, but the degree to which staff of drugs agencies set off and bring their services to where the clients are varies considerably between and within countries. Low-threshold services remain an important access point to inform and educate drug users about the risks of use and how to reduce them. Their role in providing basic health care services to drug users that can contribute to reducing the risk of acquiring infectious diseases is increasingly recognised and low-threshold services have been further expanded in several EU countries and Norway in 2000.

Special programmes that provide access to sterile injecting equipment are of major importance for minimising the rate of HIV and other blood-borne viral infections in drug users; and syringe exchange programmes (SEPs), through drugs agencies and pharmacies, or vending machines exist in all EU countries and Norway. SEPs have been expanding in 2000<sup>(47)</sup>. Large differences in availability and coverage between and within countries still remain (Wiessing et al., 2001).

In Helsinki and several other Finnish municipalities, injecting equipment has become more available in 2001. In the Flemish Community of Belgium, the first needle exchange was opened at the end of 2000 — six years after the first such service was available in the French Community. The Irish national drugs strategy 2001–08 includes risk reduction as part of its treatment pillar; and the Portuguese national drug action plan *Horizonte 2004* has ambitious harm-reduction objectives, for example the expansion of needle exchanges to all districts by 2004. However, only 5 % of the available budget in Portugal has been allocated to the reduction of drug-related harm and 95 % to prevention, treatment and rehabilitation. The UK Department of Health launched the campaign ‘Making harm reduction work’ in England, to encourage and develop harm reduction with drug users (Hunt et al., 2001).

The impact of harm-reduction policies on the hepatitis C epidemic was explored in research studies in England and Wales (Hope et al., 2001) and in Ireland (Smyth et al., 1999), and indications of reduced risk behaviour as a consequence of such strategies have been found.

Systematic efforts are under way in Germany, Ireland, the Netherlands, Portugal, Austria, Finland, the United Kingdom and Norway to make hepatitis B vaccination more accessible and achieve full immunisation among a higher percentage of drug users. Currently, the vaccination does not seem very accessible to drug users and immunisation rates are low in general. Costs might also play a role — for example, in the Flemish Community of Belgium, drug users are not a priority group within the Ministry of Health’s immunisation policy, and consequently, the vaccination is not free<sup>(48)</sup>.

### Prevention of drug-related deaths

In 2000, an estimated number of 7 000 to 8 000 drug-related deaths due to accidental or intentional overdose were recorded in the EU. Research has shown an increased risk for drug injectors, and in particular for those who combine heroin with central nervous system depressants such as alcohol or benzodiazepines (see the ‘Drug-related deaths’ section).

Scientific evidence indicates that methadone maintenance has a substantial protective effect on mortality from opioid overdose and mortality from all causes (WHO, 1998). Innovative approaches to preventing and managing overdoses — such as the training of drug users to protect themselves against overdosing and to better manage overdoses they witness, naloxone administration training as well as basic resuscitation techniques, or the development of specific prevention information materials — are reported from Belgium, Germany, Finland, Norway and the United Kingdom. In the latter, the government launched an action plan to prevent drug-related deaths in November 2001, which includes training and information campaigns, as well as monitoring and research activities<sup>(49)</sup>.

### Availability of treatment facilities

The past five years have seen a considerable increase in the availability of treatment facilities in the European Union and Norway<sup>(50)</sup>. The provision of both medically assisted treatment (substitution treatment) and drug-free treatment has increased, although the degree of increase varies largely between countries.

On the whole, medically assisted treatment appears to have grown more rapidly than drug-free treatment. Rapid

<sup>(47)</sup> Table 8 OL: Provision and types of syringe exchange programmes (SEPs), pharmacy involvement, number of syringes distributed/sold (online version).

<sup>(48)</sup> Table 9 OL: Provision of HIV counselling and testing, HIV treatment and HBV vaccination for injecting drug users (IDUs) in some European countries, as reported by national focal points, 2000 and 2001 (online version).

<sup>(49)</sup> Examples of overdose prevention messages used in the campaign are available online (online version).

<sup>(50)</sup> Table 10: Availability of drug-free treatment in the European Union plus Norway (in units) and Table 11 OL: Substitution treatment amongst problem drug users (in number of persons) (online version).

### Drug consumption facilities

By September 2001, there were 19 consumption rooms in Germany (Stöver, 2002); over 20 official drug consumption facilities operated in 2002 in several Dutch cities. Spain opened an injection room in May 2000 in Las Barranquillas, near Madrid and a mobile injection facility has been operating in Barcelona since 2001. Facilities for supervised drug use are part of the Portuguese harm-reduction policy framework and foreseen within the national drug action plan *Horizonte 2004*. In Luxembourg, legal obstacles were removed for injecting rooms to be considered as drug care services and it is planned to integrate an injecting room into the expanded services of an 'emergency shelter centre' by 2003.

In Norway, the outgoing government suggested (in autumn 2001) that a trial be conducted, preceded by a public hearing. The current government decided in May 2002 against the trial, supported by the majority of replies to the hearing. An injection-room initiative in

Denmark was shelved by the Ministry of Health in 2000 as a result of international conventions dealing with this matter. A survey in Austria (Feistritz, 2001), where the establishment of a drug consumption facility (health room) has been discussed for several years, showed more favourable attitudes among the general public towards injection rooms in 2001 (28 %) than in 1997 (20 %).

Objectives, services provided and the utilisation of consumption rooms have been described in several studies, which '... provide some evidence in relation to the four main expected benefits of such facilities: reduced public nuisance; improved access and uptake of health and other welfare services; reduced opioid-related overdose risk; and reduced risk of blood-borne virus transmission' (Dolan et al., 2000). The EMCDDA is currently preparing a summary of the experiences, challenges and lessons learned from drug consumption facilities.

increases in medically assisted treatment have taken place in France (from 500 to more than 78 000 clients in the period 1993–2000), Norway (from 50 to 1 100 clients in the period 1997–2001), Finland (from 10 to 240 clients in the period 1996–2001) and Spain (from 12 000 to 72 000 clients in the period 1993–99). Drug-free treatment slots are not recorded in the same systematic and quantitative manner but they rose, for example, in Denmark (from one specialised drug therapeutic community in 1994 to around 35 in 1999) and in Greece (from one specialised drug therapeutic community in 1983 to eight in 1999).

The increase in treatment facilities is not only welcome but needed to tackle the problem of drug addiction in Europe. However, there are still reports from Greece and Portugal, for example, that the supply of treatment does not meet the demands of clients, and research on a systematic matching of clients to treatment has not been very conclusive. These crucial matters must be dealt with in order to improve the responses to drug addiction and to improve treatment outcomes <sup>(51)</sup>.

#### Criminal-justice responses

Judicial authorities in EU countries dispose of a range of measures at different stages of the criminal-justice system to divert into treatment drug users who have committed

a criminal offence <sup>(52)</sup>. An increasing effort among Member States can be noted to better document the available range of measures, to map their level of application and to evaluate their efficiency. These initiatives are relevant for the assessment of progress with regard to Target 5 of the European Union drugs strategy — 'to reduce substantially over five years the number of drug-related crimes' — insofar as alternative measures are ultimately aimed at a reduction in criminal recidivism and relapse into drug use among drug-using offenders. Some examples are given below.

#### Referral to treatment

Arrest-referral schemes and 'drug treatment and testing order schemes' (DTTOs) have been found useful in the United Kingdom to increase the number of drug-using offenders in treatment. Research has demonstrated that the crisis of arrest is an important opportunity to target drug-misusing offenders with prevention and treatment services (DPAS, 2000) and it is planned to extend the schemes to all police forces in the country by May 2002. The first evaluation of DTTOs (carried out 18 months after they were set up) found a reduction in the amount of money spent on drugs and of the number of offences committed (Turnbull and Sweeney, 2000) and they were subsequently introduced in October 2000 after the successful pilot phase.

<sup>(51)</sup> Successful treatment is one of the selected issues covered in Chapter 3 of this report.

<sup>(52)</sup> See also: *Drugs in focus*, Briefing 2, EMCDDA Office for Official Publications of the European Communities, 2002.

An experimental four-year project on treatment for local criminal addicts conducted in The Hague (Netherlands), consisting of detoxification and aftercare, showed an encouraging level of 40 % of programme participants abstaining from drug use in the two years following the intervention but also a high interrelation of positive outcomes to continuous treatment (Vermeulen et al., 1999). An evaluation of the treatment order policy *injonction thérapeutique* in France (Setbon et al., 2000) showed, however, a lack of effectiveness. A drug court, which provides a scheme for the rehabilitation and structured supervision of persons who committed minor drug offences, was established in Ireland in January 2001 on a pilot basis. It should be noted, however, that so far neither the DTTOs in the UK or the Irish drug court have been subject to a more rigorous evaluation, using randomised controlled trials.

### Treatment in prison

This item is covered in Chapter 3 of this report in the selected issue 'Drug use in prison' (page 46).

### Probation

Release on probation is a measure that is available under certain conditions to convicted offenders in all EU countries, but some jurisdictions define special conditions for drug users. Attempts to analyse the outcome of these alternative measures are still very scarce. However, in Italy, an analysis of the revocation of probation awarded to drug-using offenders found low rates: of a sample of 4 237 drug users under probation supervision in the first half of 2000, only 253 (6 %) had their sentence revoked and were sent to prison.

Further evaluation studies of referral to care instead of punishment (Finland), treatment in the correctional system (Sweden), treatment of criminal addicts outside prisons (Denmark), and forensic addiction care (the Netherlands) are still under way. Luxembourg's new global drug care programme will have an important evaluation component right from its start in mid-2002. All prison-based treatment programmes in the United Kingdom are currently in the process of quality evaluation to obtain their official accreditation.

A literature survey about the effectiveness of judicial sanction programmes in general (Beenackers, 2000), commissioned by the Dutch Ministry of the Interior, concluded that effectiveness depends on adjacent interventions or treatments, and advises the use of cognitive-behavioural approaches and 'stepped care' arrangements to reduce recidivism. The latter finding was confirmed by further specific reviews carried out in the Netherlands in 1998 and 1999, which focused on measures directed at drug-using offenders.

## Supply reduction

Drug production and drug trafficking in the European Union 2000/01 remain the primary activities of criminal groups in the EU (Europol, 2001). These groups are taking full advantage of the opportunities created by a globalising market economy, including the use of modern technologies. They tend to be engaged in more than one type of crime, not limiting their activities to one single type of drug, as reflected by the increasing number of polydrug seizures.

Combating organised drug trafficking is a priority for Member States. An effort to improve database systems and crime analysis techniques, together with the assignment of additional resources, is taking place in several Member States. At the same time there is increased development of international cooperation, involving some international organisations as well as Interpol and the World Customs Organisation (WCO).

Increased international cooperation is resulting in the establishment of specific task forces, such as the one created with a view to pooling and processing all information regarding drug trafficking along the Silk Route, currently involving Interpol, Europol, the World Customs Organisation and the German Bundeskriminalamt (BKA). Under this scheme, the BKA is carrying out analyses based on information provided by other members of the task force. Another example is 'Operation Road Runner II', funded by the European Commission, aiming at surveillance action to combat drug trafficking along the Balkan route. This has resulted in the seizure of significant amounts of drugs, with the participation of the 15 EU Member States and 13 central and east European countries (see <http://www.europol.eu.int>).

Fighting against the diversion of chemical products and precursors under control is an important part of the increased international cooperation. It is believed that 1 500 tonnes of acetic anhydride out of an annual global production of 2.5 million tonnes are being diverted for heroin processing. About 20 % of the global output of acetic anhydride is produced in the European Union.

'Operation Topaz', an action against the diversion of acetic anhydride includes a system aimed at identifying the origin of seized chemicals. This operation has enabled the intervention of 11 shipments with almost 230 tonnes of acetic anhydride which could have been used in the production of between 55 and 230 tonnes of heroin. The volume of international legal trade represented some 180 000 tonnes in 2001. As most of the

## Responses to drug use

shipments do not go directly from producer to consumer countries, additional resources to guarantee an adequate level of surveillance are required. The INCB (International Narcotics Control Board) has noticed that some key national authorities, such as the Dutch ones, which control a large proportion of transit operations, have significantly increased their resources for this purpose (see <http://www.undcp.org>).

The international surveillance programme concerning potassium permanganate has led to the confiscation of 1 100 tonnes of this chemical. Surveillance programmes concerning potassium permanganate have led to a situation in which export notifications from the main exporting countries have to be communicated beforehand. 'Operation Purple', which started in 2000, continued to increase its results during 2001, with 17 shipments to the illicit market stopped, representing 1 100 chemical tonnes. In 2000, 13 shipments were stopped and some 655 tonnes were seized. The volume of international legal trade relating to potassium permanganate during 2001 represents some 19 000 tonnes. The volume in 2000 was 11 000 tonnes. This programme has also allowed new methods and new routeing concerning the diversion of this chemical to be identified, without imposing undue delays to licit international trade. However, the INCB has noticed a constant increase in the number and the volume of shipments towards countries not participating in 'Operation Purple' (see the INCB 2001 report on precursors (<http://www.undcp.org>)).

International customs cooperation and the activities of the OECD Financial Action Task Force (FATF) play a very important role in measures against money laundering. In November 2000, the United Nations Convention against Organised Transborder Criminality acknowledged the importance of measures concerning detection and surveillance of the flow of transborder cash and bonds. The importance of cash flows related to drug trafficking has been acknowledged by international organisations cooperating against money laundering (see the FATF report 2001/02 (<http://www.oecd.org/FATF>)). One example of the significance of regional cooperation is 'Operation Goldfinger', involving customs authorities in the Baltic region, devoted to collecting information relating to operations of more than USD 10 000. The main conclusions to be drawn from this operation are the deterrent effect that regional customs cooperation has on money-laundering activities and the great divergences that exist in national legislation concerning cash flows (see the 2000 customs and drugs report (<http://www.wcoomd.org>)).

The main FATF activities have been related to spreading the message of anti-money-laundering to all continents

and regions of the globe, to improve members' implementations of the 40 FATF recommendations adopted in 1990 and modified in 1996, and to strengthen the review of money-laundering methods and counter-measures. In June 2000, the FATF began its non-cooperative countries and territories exercise (NCCT), aiming to identify the countries and jurisdiction that do not meet the FATF anti-money-laundering criteria. The FATF has also fostered the creation and strengthening of FATF regional-style bodies. The annual survey of money-laundering typologies, chaired by Norway in 2001, focused on a number of major issues such as: online banking and Internet casinos; trusts; non-corporate vehicles and money laundering; lawyers, notaries, accountants and other professionals; the role of cash in money-laundering schemes; and terrorist-related money laundering. Finally, the European Central Bank and Europol were granted observer status within the FATF (see <http://www.oecd.org/FATF>).

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# Selected issues

This chapter highlights three specific issues relating to the drug problem in Europe: polydrug use, successful treatment and drug use in prison.

## Polydrug use

The broad definition of ‘polydrug’ used by many Member States is the use of more than one drug or type of drug by an individual — consumed at the same time or sequentially (as defined in the WHO lexicon). In Europe, the concept of polydrug use dates back to the 1970s. In its broadest terms, polydrug use is defined as the use of an illegal drug plus another legal or illegal drug. However, considerable differences exist in the substances included and in the time frames employed by different Member States. Differences appear to depend on the survey data available and on the perceptions of risk associated with particular substances or combinations. The substances included are usually the main illegal drugs, alcohol and medicines. Energy drinks are sometimes included and France includes tobacco. Time frames for consumption range from a six-hour period to ever experienced during an individual’s lifetime.

According to the broad definition, all illegal drug users would be defined as polydrug users as they almost always use alcohol and/or tobacco at some time in their life. Even when polydrug use is defined according to the more narrow range of ‘illegal drugs’, the combinations and patterns of use vary so much that there is little value in adopting a standard definition. For the purposes of addressing general concerns about polydrug use in the EU, we take acute risks for health as a main focus.

There is general consensus that polydrug use has four main functions: it maximises effects, balances or controls negative effects and substitutes sought after effects. Information about the functions of combining particular drugs is based on descriptions by users of attempts to have, and prolong, pleasurable experiences (Seppälä, 1999; Strang et al., 1993). The substances that are used depend on local availability, fashion and local prescribing practices where

they include medical drugs prescribed to drug users in treatment (in Germany, France, Ireland and the United Kingdom).

## Health risks

The combinations of drugs identified in mortality and overdoses provide indications of particular risks associated with drug combinations (see box below).

Health risks associated with combinations of psychotropic substances depend not only on the pharmacological properties and amounts of the substances consumed but also on a range of individual characteristics and social and environmental factors.

### Examples of drug combinations considered high risk

- Whilst it is difficult to overdose on benzodiazepines alone, the combination of a large dose of benzodiazepines and a large dose of alcohol or an opiate drug such as heroin or methadone may be fatal.
- When ecstasy is used with alcohol, health risks increase because alcohol impairs thermal regulation and increases dehydration.
- When cocaine is combined with alcohol, the combination may be more directly toxic to the heart and liver than either cocaine or alcohol alone. Alcohol is often present in cocaine cardiac deaths.
- The combined use of different stimulants, including energy drinks, can lead to sympathetic hyperactivity that may result in impaired thermal regulation and cardiac functioning.

Sources: Leccese et al. (2000), DrugScope (2001).

In the context of 'early-warning systems', there is growing concern about the potential mixture of psychoactive substances in tablets sold as ecstasy, which, despite the lack of intention on the part of users, may constitute polydrug health risks. For example, in Denmark during 2001 a range of 10 to 32 % of tablets analysed contained more than one active substance. These tablets primarily contained MDMA and PMA, PMMA, MDE and MDA. In France, two thirds of an analysed sample of tablets sold as ecstasy contained MDMA combined with other active ingredients — mostly medicaments.

### Fatal and non-fatal overdose

During the last decade, press attention on drug deaths has focused mainly on rare cases of ecstasy death (Belgium, Denmark, Italy and the United Kingdom). Press interest is not generally captured by the death of problem drug users. The large proportion of the 7 000 to 8 000 acute drug deaths (overdoses) recorded in the EU each year are males who have been using opiates for several years (see the 'Drug-related deaths' section).

Results of toxicological analyses of fatal and non-fatal overdoses associated<sup>(53)</sup> with illegal drug use are not widely available but those that are consistently reveal that most of the deaths are associated with the injecting of heroin combined with other drugs. A recent study of 153 drug users in the United Kingdom who had experienced non-fatal overdose found that more than one drug had been used in 111 (73 %) of cases (Neale 2001). In fatal overdoses, at least one other drug or alcohol is involved in over 50 % of cases in the United Kingdom and up to 90 % in Ireland. Benzodiazepines, alcohol, methadone and cocaine are the substances most frequently found combined with opiates and a common explanation for the overdose in question is that these combinations caused it (ONS, 2000a and b; Farrell, 1989; Bennet and Higgins, 1999; Strang et al., 1999; Taylor et al., 1996)<sup>(54)</sup>.

Deaths associated with cocaine, amphetamine or MDMA (ecstasy) without the presence of opiates or benzodiazepines are infrequent and are usually combined with other drugs or alcohol.

### Other risks

Polydrug use is also considered to be a particularly high risk for dangerous driving but EU data on drugs and driving is very limited. Violent or aggressive behaviour has

recently been associated with patterns of increased use of alcohol combined with stimulant drugs (Snippe and Bieleman, 1997; Vermaas, 1999).

### Trends

In some countries, the number of fatalities that constitute the most serious consequences of polydrug use are still increasing. The substances detected most often were combinations of morphine, benzodiazepine and alcohol, with recent national or local increases in cocaine reported in Spain, France, Italy, the Netherlands and the United Kingdom (see the 'Drug-related deaths' section for more details).

### Concern about groups at risk

Social and public concern associated with patterns of polydrug use generally focuses on two groups that are distinct with regard to the type of substances and combinations they use and the environments where their consumption occurs.

- The greatest scientifically evidenced health risk occurs among problem drug users, particularly those who inject opiates and other drugs.
- Media and general public concern also exists about the risk of death and overdose for recreational drug users who are not addicts and whose consumption of illegal drugs is mostly limited to specific social settings or a certain phase in their lives. This concern is disproportionate in view of the relatively limited number of deaths.

For problem users, the number and characteristics of clients seeking treatment in the specialised centres in Europe are used as an indirect indicator. For recreational drug users, the results of a large European survey of recreational drug users in nine European cities and a number of ad hoc 'clubbers' surveys are available.

### Problem drug users

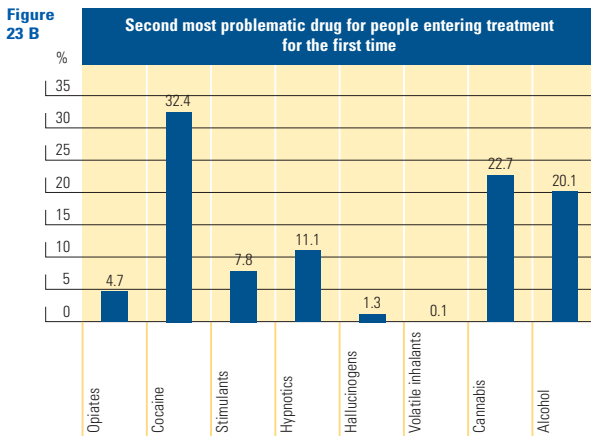
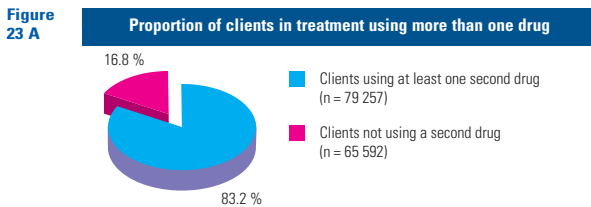
Since the 1970s, problem drug users have been shown to adjust the ingredients of their drug menus according to the availability of drugs on the market and at different stages in their lives. They may substitute the unavailable substance with another, not necessarily of the same type (Haw, 1993; Strang et al., 1993; Fountain et al., 1999).

<sup>(53)</sup> A drug is deemed implicated, or associated, when it is proven positive at toxicology or when evidence was presented that the drug had been consumed prior to death. This is not to infer that the drug is the cause of death. It may imply the drug(s) as being a contributory factor in the death.

<sup>(54)</sup> Table 12 OL provides an example of the number of drugs implicated in opiate deaths in Ireland (online version).



## Selected issues



Sources: 2000 Treatment Demand Indicator (TDI) data on outpatient treatment centres. Reitox national reports 2001.

### Polydrug use among clients in treatment

At European level, treatment data provide information on primary and secondary drugs: the primary drug is the 'drug that causes the client the most problems' <sup>(55)</sup> and the secondary drugs are the next most problematic drugs after that. The European information system on treatment, based on the Treatment Demand Indicator (TDI) protocol, which registers up to four substances used by each person, could be taken as an indirect indication of problematic polydrug use <sup>(56)</sup>, although it is limited to users in treatment.

Most clients in treatment use secondary drugs combined with their main drug (83.2 %) (Figure 23). Many countries report an increase in polydrug use <sup>(57)</sup>.

The most common patterns of problematic polydrug use are: heroin combined with other opiates such as diverted methadone or with benzodiazepines; heroin combined with cocaine, cannabis and stimulants or alcohol; and cocaine used with alcohol or stimulants <sup>(58)</sup>.

The patterns of use change markedly among countries and sexes. The available data show that in some countries a single pattern prevails, whilst others present different drug combinations. From the available data, homogeneous patterns seem to be found in some countries, for example, in Greece and Italy for primary drug distribution, where heroin is used simultaneously with hypnotics, sedatives, other opiates or cannabis. In Spain and the Netherlands, where the proportion of clients seeking treatment for cocaine as primary drug is rather high, cocaine also frequently appears as a secondary drug combined with heroin or stimulants.

As far as gender distribution is concerned, polydrug users in treatment are mainly men, especially among those using heroin combined with opiates and cocaine or alcohol; a higher proportion of women is found among those using stimulants with cannabis, stimulants, and other substances (hypnotics/sedatives, volatiles) <sup>(59)</sup>.

Persons accompanying their main drug with cannabis are mainly aged between 15 and 24; the polydrug users of opiates and cocaine are older (20–39) and those who use other drugs simultaneously with alcohol are the oldest polydrug users in treatment <sup>(60)</sup>.

From the data available, the following patterns of use among clients in treatment can be identified:

- older clients, mainly males, using opiates as the main drug combined with other opiates, or cannabis;
- younger clients, males and females, using cannabis and stimulants combined with alcohol or other substances (such as hallucinogens);
- males, under 30, using cocaine combined with alcohol and other stimulants; and
- males, 20–39, using heroin and cocaine.

<sup>(55)</sup> In the Treatment Demand Indicator standard protocol 2.0, item 14, primary drug is defined as the 'drug that causes the client the most problems' and item 19, other (= secondary) drug in addition to primary drug, as an indication of multiple drug use (see the web site [http://www.emcdda.eu.int/multimedia/project\\_reports/situation/treatment\\_indicator\\_report.pdf](http://www.emcdda.eu.int/multimedia/project_reports/situation/treatment_indicator_report.pdf)).

<sup>(56)</sup> Countries where data were available on this topic were: Belgium, Spain, Greece, Italy, the Netherlands, Sweden and Finland.

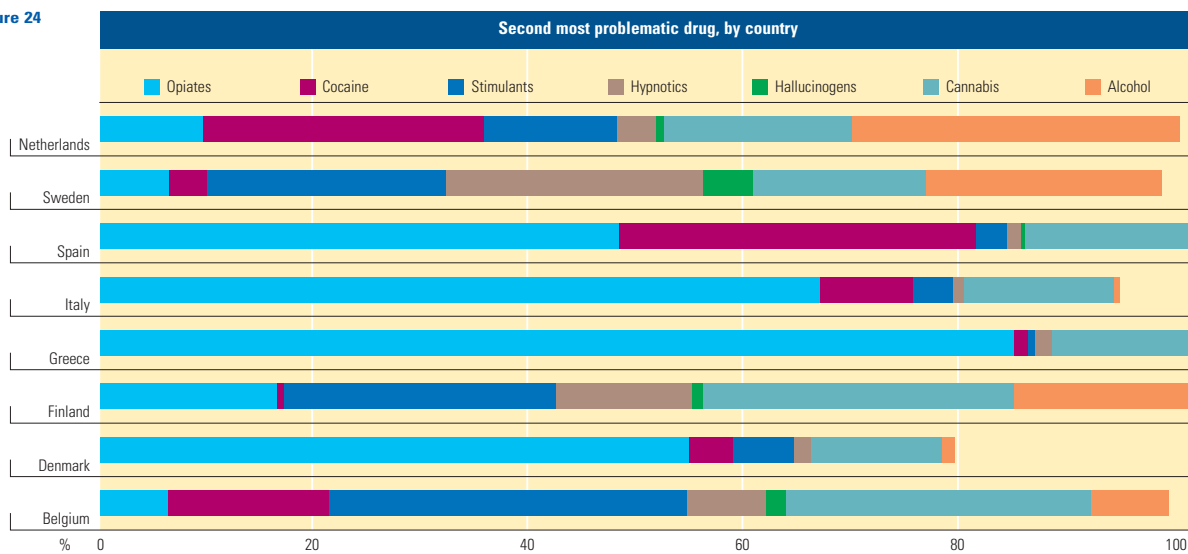
<sup>(57)</sup> See Reitox national reports, 'Treatment demand' section, Chapter 1, Figure 6, 'All clients admitted to treatment'.

<sup>(58)</sup> Figure 16 OL: Common patterns in the combination of drugs: most problematic drug used together with secondary drug(s) (online version).

<sup>(59)</sup> Figure 17 OL: Second most problematic drug by gender (% on the total, by drug) (online version).

<sup>(60)</sup> Figure 18 OL: Second most problematic drug, by age (online version).

Figure 24



Sources: 2000 Treatment Demand Indicator (TDI) data on outpatient treatment centres. Reitox national reports 2001.

**Recreational drug users**

Prevalence of polydrug use is higher among young people in dance club settings than among young people in other settings, particularly the use of alcohol, cannabis and stimulant drugs (Calafat et al., 1999; ESPAD, 2000). There is also some evidence that, across Europe in general, prevalence of recreational polydrug use is higher among males and regular users of cannabis than it is among females and cannabis experimenters, although there are geographical differences. A large European study of drug users in targeted nightlife settings in 1998 showed that approximately half of all drug users in the techno party scene reported that they combined alcohol and cannabis, followed by alcohol and ecstasy, and cannabis and ecstasy (Calafat et al., 1999). Table 1 shows that recreational drug use is heavily dominated by alcohol. The majority of leisure-time drug users do not consume large quantities of illegal drugs and alcohol in combination. However, studies suggest that the proportion of people adopting ‘heavy’ patterns of drug use is increasing and there are growing concerns about the health risks and potential long-term damage from specif-

ic patterns of recreational drug use (Club Health, 2002; Hunt, 2002; McElrath and McEvoy, 1999; Reitox).

Heavy polydrug use in leisure-time settings is associated with repeated exposure to drug availability and positive images of drug combinations among peers. However, heavy drug use is generally confined to particular social events, holiday periods or during particularly social and outgoing phases in life (Bellis et al., 2000).

An increase in heroin smoking has been reported by some Member States (France and Italy). In recent years, there have been particular concerns about people smoking heroin to come down from ecstasy but the evidence for this is mixed or contradictory. For example, studies in treatment and prison settings in Ireland report that over half of the drug users interviewed had smoked heroin to ‘come down’ off ecstasy whilst surveys of recreational drug users and school students aged 15–16 show that heroin still has a very negative image (ESPAD, 2000).

**Local market**

Little research has been conducted on drug markets in the EU and it is therefore not possible to provide accurate details on the combinations of drugs available on local markets.

In terms of ‘marketplaces’, in the United Kingdom there are regular media reports of ecstasy, amphetamine, cocaine powder and cannabis dealing in clubs and bars for the clubbing population. However, research in the Netherlands has shown that many young clubbers obtain their drugs via friends rather than dealers. Some of the marketplaces patronised by those who buy and sell heroin, crack cocaine and prescription drugs (such as ben-

Table 1

Drug combinations used by recreational drug users in the same night	
	%
Alcohol and cannabis	50.6
Alcohol and ecstasy	11.9
Alcohol and cannabis and ecstasy	10.4
Cannabis and ecstasy	8.4
Alcohol and cocaine	7.8
Cannabis and ecstasy, alcohol and cocaine	7.8
Cannabis, alcohol and cocaine	2

Source: Calafat et al. (1999).

## Selected issues

zodiazepines) are well known, but are usually separate from those for clubbers. Different substances are sold in different marketplaces: some concentrate on diverted prescription drugs whilst others trade primarily in heroin and/or crack cocaine. In the case of diverted prescribed drugs, distribution is conducted by a large number of people each selling some or all of their own prescribed drugs (Edmunds et al., 1996; Fountain et al., 1999).

### Polydrug use interventions

Two distinct target groups can be defined for which interventions are designed: older problem polydrug users and young recreational drug users.

#### Older problem polydrug users

In the context of older problem polydrug users, prevention of drug-related harm is of importance due to the possible unexpected consequences. Interventions include providing drug users with adequate knowledge on the effects of specific drugs and the consequences of multiple drug use and how to handle drug emergencies.

Polydrug use has shown to be more difficult to treat than single drug use. Member States do not report specific treatment programmes for particular drug combinations but nearly all services are open to polydrug users. The focus is on behaviour rather than substances. However, in acute treatment and in withdrawal, polydrug use might be very relevant.

The combination of heroin and benzodiazepines has implications for the efficacy of treatment. If opiate use is being addressed while coexisting benzodiazepine use is neglected, there is potential for reducing the efficacy of substitution treatment, for example with methadone. In the United Kingdom, the official prescribing guidelines (Department of Health et al., 1999) stress that stimulants should not be prescribed to polydrug users.

In all countries except Sweden, a considerable problem consists in getting substances other than opiates under control in medically assisted treatment, for example with methadone. In countries other than Sweden, the advantage of having regular contact with drug users in substitution programmes is obviously considered more important than the disadvantage of concurrent use of other drugs. In Sweden, however, polydrug users are not accepted in methadone treatment irrespective of the seriousness of the heroin problem.

Psychiatric comorbidity is often diagnosed in polydrug users. Denmark, the Netherlands, Austria, and Sweden report on a high and possibly increasing number of polydrug users admitted to psychiatric hospitals.

There is little research on the effectiveness of the treatment of polydrug users. Generally, the adjustment of treatment to each specific case contributes to treatment success. The UK NTORS study found that after one year, opiate users who were frequent users of stimulants at intake showed marked improvements in terms of reduced levels of opiate **and** stimulant use (Gossop et al, 1998). Greece reports that substitution programmes claim that the treatment interventions contribute to a reduction in polydrug use (Kethea — NSPH, 2001).

The development of special treatment programmes for specific groups such as polydrug users is considered a need in the German national report, and the United Kingdom suggests disseminating examples of good practice. Finland states the need for training, and some activities to train treatment staff in dealing with polydrug users are already under way.

#### Recreational drug users

Some countries (Spain, France and Italy) have launched broad mass-media campaigns to warn against multiple drug use in recreational settings. In Italy, the campaign was supported by local initiatives at major youth events. Specific substances are not always mentioned and the consequences of use are not clearly spelled out. In other countries (Belgium, Germany, the Netherlands, Austria and the United Kingdom) these health warnings and advice are passed through drug workers or peers and self-help groups.

Pill-testing projects may inform users about dangerous and unexpected pill contents on site, by magazines and posters or through the Internet. For example, in autumn 2000, Austrian *ChEck iT!* found several pills sold as ecstasy containing PMA/PMMA and immediately put out warnings on site and through the Internet (Kriener et al., 2001). In November 2001, the Dutch DIMS project, for example, provided a rapid alert about pills containing PMA.

Treatment for users of several drugs in the recreational scene is virtually non-existent. One reason could be that most drug services are only equipped to deal with opiate and severe dependence problems.

### Policy issues

The rituals and social controls polydrug users employ to achieve the sought-after effects whilst simultaneously reducing risk need to be studied for better understanding of the social and environmental circumstances that contribute to risk among different drug-using groups (Boys et al., 2000; Decorte, 1999; Akram and Galt, 1999).

Prevention, especially in recreational settings should include clear guidance and advice on risks involved in

multiple drug use. More evidence-based knowledge is needed to ascertain the best possible care for polydrug users and especially for problem drug users with mental disorders.

For better understanding of pharmacotoxicological risks from specific combinations, a priority is for clinicians to follow up patients with suspected drug intoxications and to provide evidence-based information about acute and long-term damage to health.

### Successful treatment

In the EU action plan on drugs (2000–04), the third strategy target is ‘to increase substantially the number of successfully treated addicts’. No aggregated data exist at European level to directly measure the level of achievement of this objective. However, many evaluations have been carried out across Europe exploring if and what type of treatment works. Findings on successful treatment are presented here according to the type of treatment intervention: withdrawal treatment, drug-free treatment and medically assisted treatment. The success criteria vary between the different types of treatment and are also related to social reintegration and rehabilitation after treatment.

#### Withdrawal treatment

Withdrawal treatment, or detoxification, is generally considered the first step in a complete treatment process. This intervention aims, firstly, at arriving at a stage where the client is physically drug free and no longer craves for illegal drugs and, secondly, at transferring or referring the client to drug-free treatment. In Sweden and Finland, this process is a prerequisite for starting methadone treatment.

Evaluations of withdrawal treatment have been carried out across the Member States and Norway but nevertheless, globally, it is the least evaluated type of treatment intervention. Overall, withdrawal treatment with medicaments such as Naltrexone, clonidine, lofexidine and buprenorphine have proved effective in decreasing withdrawal signs and symptoms, although the effect on different kinds of withdrawal symptom varies between medicaments (Greenstein et al., 1997). Methadone is widely used for treating withdrawal symptoms although research findings suggest that methadone’s strength lies in maintenance therapy.

Withdrawal treatment with no use of medicaments, also known as ‘cold turkey’, exists although its extent is not really known. Nor are there any reports on the effects and outcomes of non-medically based withdrawal treatment compared to medically assisted withdrawal treat-

ment. The recently emerged concept of rapid detoxification with Naltrexone under full narcosis (sometimes referred to as ‘turbo withdrawal treatment’) should be investigated in more depth.

One intervention in Portugal which combined the delivery of naltrexone and psychotherapy found that after three months there were notable improvements in socio-demographic and psychological variables as well as in risk behaviour (Costa, 2000). An experiment in Germany detoxified methadone users with naltrexone under full narcosis. The patients’ satisfaction was fair but as many as 50 % reported severe discomfort in the first month following the intervention. Six months after discharge one third of the patients had not consumed hard drugs (Tretter et al., 2001).

Although some withdrawal treatment interventions have been subject to evaluation, more in-depth knowledge is needed on the pros and cons of the different modalities and on which type of withdrawal treatment should be used for which type of patient.

#### Drug-free treatment

Drug-free treatment applies physic-social techniques in its aim for the client to become, first, abstinent and, then, long-term free of drug craving. The primary success criterion used for drug-free treatment is the completion of treatment as planned drug free, although others such as improvements in psychological, social and economic well-being are also essential. Important ‘spin-off’ effects are a reduction in crime and risk behaviour as well as an improvement in the health and general welfare of the client.

Evaluations of drug-free treatment interventions have shown that, to a greater or lesser extent, it succeeds in fulfilling these objectives (Gossop et al., 2001). Evaluation results fluctuate greatly, but generally 30 to 50 % of clients entering drug-free treatment complete it successfully. A Danish study concluded that, depending on the kind of drug-free treatment interventions, successful completion rates spanned from 17 to 58 % of the clients entering treatment (Pedersen, 2000).

Another widely acknowledged notion is that treatment duration is closely linked to treatment outcome or, in other words, the longer the time spent in drug-free treatment the better. This idea is backed up by a German study which suggested that retention rates/duration in drug-free treatment correlate with its outcomes (Sonntag and Künzel J., 2000). Some research has tried to identify the threshold at which successful treatment outcomes are likely to increase. One study found that clients

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staying in drug-free inpatient treatment for 90 days achieved better outcomes — in terms of abstinence from opiates, stimulants and in the reduction of injecting drug use — one year after discharge than those who left earlier (Gossop et al., 1998). This is confirmed by a Greek study which found that those clients who left treatment within the first three months only decreased heroin consumption after discharge by 11 % compared with 76 % for those who stayed at least a year (Kethea, 2001).

Regarding the issue of long-term effectiveness, an Austrian study concluded that a treatment scheme with a focus on social and psychotherapy interventions markedly increased the social competence and the subjective satisfaction of the clients, which results in their long-term stability (Wirth, 2001).

The National Treatment Outcome Research Study (NTORS) was established in 1994 at the request of the British Minister of Health to assess the effectiveness of drug misuse treatment services in the United Kingdom. NTORS recruited 1075 clients for the project in 1995 and followed them for five consecutive years. A random stratified sample of 650 clients was selected and followed in four different treatment modalities: inpatient, residential rehabilitation, methadone reduction or methadone maintenance. The main finding of the study is that treated individuals do improve on outcome parameters such as drugs intake, injection frequency, needle sharing and psychological health. The total aggregated cohort showed statistically significant improvements in heroin intake — around 75 % had regular heroin use at intake compared to around 40 % four to five years on. Regular use of non-prescribed methadone had gone down from around 30 % at intake to under 10 % and needle sharing had decreased from around 20 % at intake to around 5 %. Scorings on psychological health also showed statistically significant improvement between the state at intake and the state four to five years on.

Drug-free treatment has been evaluated across Europe applying different methodologies, and substantial insights have been gained especially over the last decade. However, there are still areas where further research is needed to respond to phenomena that have recently emerged. One example is on the efficiency of drug-free treatment for predominant cocaine users and amphetamine users as well as other specific sub-populations. Furthermore, there are few large-scale studies on how many remain drug free in a longer-term perspective after the successful completion of treatment.

### Medically assisted treatment

Medically assisted treatment (which includes substitution treatment) uses agonist or antagonistic medicaments in

its therapy of clients. Agonist medicaments (e.g. methadone) activate the opiate receptors in the brain and antagonistic medicaments (e.g. naltrexone) limit or eliminate the effect of other illicit drugs taken. The aim of medically assisted treatment can be abstinence but may also be to maintain the client in long-term medical treatment. Whether the end goal be to achieve abstinence or to reduce the harmful effects of drug addiction, common interim goals include: reducing the consumption of illegal drugs and the risk of infectious diseases; improving the mental and physical state of the client; and reducing drug-related crime.

Methadone maintenance is the most widely diffused type of medically assisted treatment. As 'maintenance' implies, the objective of this type of intervention treatment is not abstinence but to keep the client in maintenance treatment thereby reducing criminal activity and risk behaviour (and consequently the risk of the acquiring infectious diseases), as well as improving health and social functioning.

Medically assisted treatment has been widely evaluated across Europe and has generally proved effective in achieving goals such as reducing the consumption of illegal drugs, risk behaviour and crime. In particular, medically assisted treatment interventions with methadone have been evaluated and found effective in relation to these goals (Lowinson et al., 1997; EMCDDA, 2000), although buprenorphine has proved effective too. One structured literature review of buprenorphine trials found that its main strength was in lowering the risk of overdosing and lowering the level of parallel illicit drug use (Berglund et al., 2001). For both methadone and buprenorphine, sufficient dosages have shown to be imperative to ensuring positive outcomes.

Despite these apparent 'successes', some countries consider that neither methadone nor buprenorphine have sufficiently improved the general welfare of particularly deprived street addicts and have sought other alternatives.

In February 2002, the findings of a Dutch randomised controlled trial with co-prescription of heroin for methadone clients were published. The target groups of the intervention were severely addicted, older, heroin users who had not benefited sufficiently from methadone maintenance treatment. In order to define this target group, a predefined set of inclusion and exclusion criteria were established and subjects were selected from the local methadone maintenance treatment registration system. A total of 625 patients treated in six units located around the Netherlands were selected and randomly divided into an experimental group and control group. First, the patients

were divided according to their route of administration, inhaling or injecting, and then subdivided according to the intervention — those receiving only methadone and those receiving a combination of methadone and heroin. The main finding of the study was that for severely addicted, older, heroin users methadone plus heroin was more effective than treatment with methadone alone, irrespective of the route of administration. The study furthermore showed that at the end of the trial, 30 % of the clients in the experimental group no longer met the inclusion criteria (their general condition having improved considerably), whereas it was only 11 % in the control group (van den Brink et al., 2002).

In Germany, a trial with the prescription of medical heroin for opiate addicts has been developed and refined over the past couple of years. The trial which began in spring 2002 will last for three years with seven German cities participating. The main question to be answered is if and under which condition the prescription of heroin for an extremely deprived group of opiate addicts can contribute to improving their situation in terms of health, social and legal aspects. The patients in the trial will be divided randomly into an experimental group and a control group. These groups will be further divided into two groups receiving different types of psycho-social intervention — one group 'case management' and the other 'psycho-education'. The study is expected to provide further insights on psycho-social intervention and its efficiency in the treatment of opioid addiction (<http://www.heroinstudie.de/>).

In Denmark, an alternative to a heroin project was launched for 2000–02 with the aim of initiating special pilot projects for drug addicts in methadone treatment, involving massive psycho-social activities. The qualitative and quantitative evaluation will study the extent to which results can be achieved in the form of better social, health-related and mental functioning, reduction of drug use, reduction of infectious diseases and crime, as well as an extension of network relations.

### Conclusions and future perspectives

Success depends on the purpose of a given treatment intervention and consequently that success should be assessed in accordance with the pre-established objectives. There is already a considerable wealth of research that, when comparing objectives with outcomes, has enabled insight and knowledge to be gained on the effectiveness and/or success of various types of treatment.

It is, for instance, an important outcome that retention rates are crucial for treatment outcomes or 'success', but

knowledge needs to be gathered on how to keep clients in treatment or, in other words, on which elements in treatment are crucial for increasing the retention rate. Identifying the 'active ingredient' in any kind of treatment is a difficult task and it is essential to improve the performance of treatment services, thereby improving treatment outcomes.

However, having the theoretical knowledge and insight is one thing and implementing it another. An example of this is the importance of accompanying psycho-social interventions in medically assisted treatment, which much research has found to contribute to success but which nevertheless are still not adequately implemented in practice.

In recent years, much emphasis has been placed on expanding treatment services and this has to a rather large extent been achieved. The challenge now is to widen the fan of treatment services and refine the interventions themselves, thereby increasing the 'success' of these.

## Drug use in prison

The presence of drugs and drug use has fundamentally changed the prison reality over the past two decades and, nowadays, all countries in Europe experience major problems due to drugs and drug-related infectious diseases in prisons.

### Drug demand in prison <sup>(61)</sup>

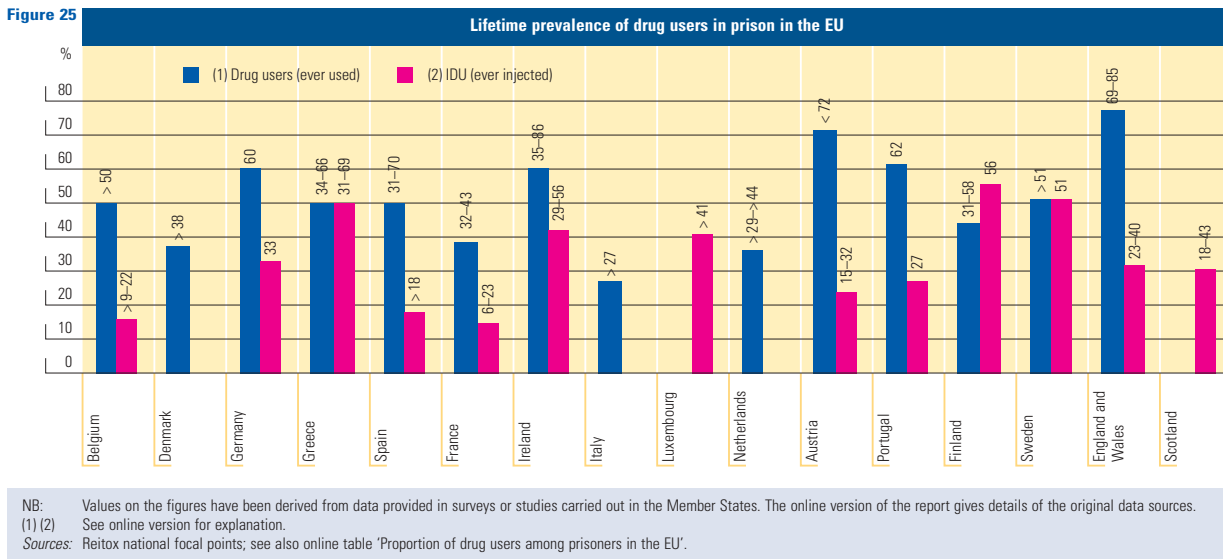
National routine information on drug use, patterns and consequences amongst prisoners is rare. Most of the data available in the EU come from ad hoc studies carried out at local level amongst a small sample of prisoners. This makes extrapolations very difficult.

### Prevalence of drug users in prison

The prison population can be considered as a high risk group in terms of drug use. Indeed, compared with the community, drug users are over-represented in prison. The proportion of inmates in the EU reporting ever having used an illicit drug varies according to prisons and countries between 29 and 86 % (over 50 % in most studies) (Figure 25). As in the community, cannabis is the most frequently experienced substance, but several studies also show high levels of heroin experience (close to 50 % of the inmates or more in some cases).

<sup>(61)</sup> See also the table: Proportion of drug users among prisoners in the EU (online version).

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According to different studies, prisoners reporting more regular and/or harmful use such as intravenous drug use, regular use or dependence, represent 6 to 69 % of the prison population.

### Level of drug use within prison

Incarceration does not mean cessation of drug use. Most drug users tend to stop or reduce their drug use after imprisonment due to the low availability of illicit drugs. However, some continue to use drugs, to an even greater extent in some cases, and others commence once incarcerated.

Drug use within prison is reported by 16 to 54 % of inmates; regular drug use by 5 to 36 %. Between 0.3 and 34 % of the prison population have ever injected while incarcerated.

### Women drug users in prison

The number of women in prison is lower than the number of men. However, drug use seems to be particularly acute amongst the female prison population. Where data are available, they show a higher proportion of drug users among women in prison — considering last six months prevalence of drug use in Denmark, last year and lifetime prevalence of heroin use in Ireland, and proportion of prisoners with a drug problem and with a severe drug problem in Sweden.

As regards risk behaviours within prison, studies carried out in Germany (NR, 2001) and France (WIAD-ORS, 2001) show a higher proportion of prisoners sharing drugs, sharing injecting material and prostituting themselves amongst female drug users, compared to males. Whereas other studies carried out in Austria (NR, 2001) and England and Wales (WIAD-ORS, 2001) report more injecting material sharing amongst male prisoners.

Initiation to drug use and injecting also takes place in prison. According to several studies in Belgium, Germany, Spain, France, Ireland, Italy, Austria, Portugal and Sweden between 3 and 26 % of drug users in prison report their first use of drugs while in prison, while between 0.4 and 21 % of IDUs in prison started injecting in prison (NR, 2001; WIAD-ORS, 1998).

## Health and legal consequences

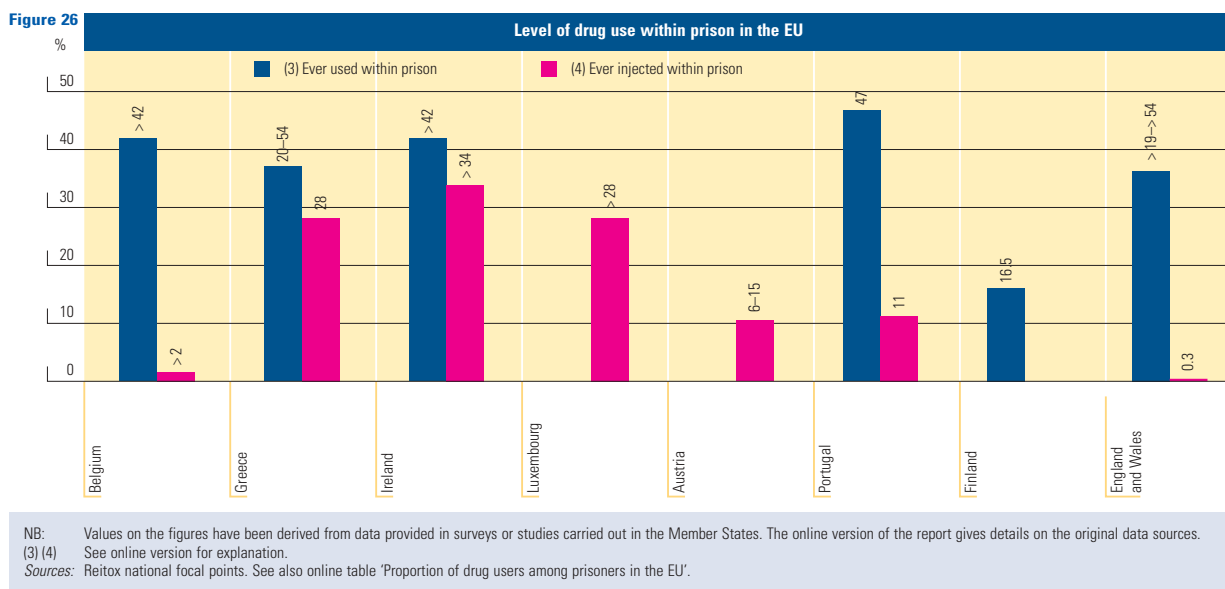
### Risk behaviours

Studies conducted in Belgium, Germany, Greece, France, Ireland, Luxembourg, Austria and the United Kingdom (NR, 2001) show that a high proportion of IDUs in prison share injection equipment. Within prison, intravenous drug use is often associated with the sharing of injecting material, and in some cases up to 100 % of IDUs report sharing behaviours. A Luxembourg study (NR, 2001) reports that, in 70 % of cases, syringes are cleaned with water only and, in 22 % of cases, they are not cleaned. The data available show that sharing injection equipment in prison is more frequent than in the community.

A multi-centre study carried out in some prisons in Belgium, Germany, Spain, France, Italy, Portugal and Sweden in 1996/97 (WIAD-ORS, 2001) reports more tattoos and piercings during incarceration among IDUs, compared with non-IDUs. IDUs also report a higher level of unprotected sexual intercourse in Belgium, Germany, Portugal and Sweden, but less in other countries.

### Infectious diseases

Data on HIV and HCV status among injecting drug users (IDUs) in prison were provided by Belgium, Germany, Spain (HCV only), France, Ireland and Luxembourg (NR, 2001).



They come from local studies carried out in a few prisons, and thus are not representative of the national level. The prevalence of HIV among IDUs varies between 0 and 13 % in the prisons investigated. Levels of HCV positive status are much higher, between 14 and 100 % among IDUs according to the prison centre and the country. As in the community, the prevalence of HIV and HCV is higher in IDUs than non-IDUs.

**Sanctions for drug use/possession**

Prisoners caught in possession of illicit drugs are usually sanctioned and punished under prison regulation. The incident might be reported in the personal file of the prisoner. The common sanctions applied include restriction of rights (visits from friends or family, telephone calls), deprivation of prison leave, expulsion from specialised treatment wings and/or punishment in an isolation cell.

Possession can have consequences on the execution of the conviction. For example in Denmark, there is a risk not to be granted release on parole after having served two thirds of the sentence. In the United Kingdom, when a urine test is found to be positive, the sentence can be lengthened by at least a few extra days.

Prisoners caught with drugs might also be charged and prosecuted for it out of the realm of the prison.

**Drug availability and supply in prison**

**Availability of drugs**

Access to illicit drugs is far more difficult within prison than in the community. However, illicit drugs are reported to be easily available in prison for those wanting to use drugs — mostly cannabis, heroin and medicines

(benzodiazepines) — but anything is obtainable in exchange for payment.

Prisoners report large variations in quality, continuity and the price of illicit drugs within prison. Prices of drugs are estimated to be two to four times higher than outside prison, which makes drugs 10 to 20 times more expensive in terms of spending power. Payment forms other than money are extensively used: exchange of services (prostitution, cell cleaning) or goods (telephone cards, tobacco) and/or participation in drug distribution.

**Smuggling and trafficking**

There are many ways of accessing drugs in prison. All contacts with the outside world are occasions for smuggling drugs into prison: during visits (on visitors' clothes or in their body cavities or inside food), transfers or transportation to court for trial, after prison leave, through the mail (parcels). Drugs can be thrown inside balls over the prison walls. They are also smuggled in by prison staff.

Drug distribution and trafficking varies from one prison to another and between countries. Belgium reports (NR, 2001) trafficking at individual level as well as pyramidal networks in which (as in the community) high-level dealers organise the drug trade but do not use drugs themselves. Germany mentions (NR, 2001) small-scale trafficking in which many prisoners are involved through several channels without central organisation. A study recently carried out in Mountjoy prison in Ireland (NR, 2001) shows a system based on personal arrangements: those having access to drugs in the community, smuggle them into prison and distribute them to their personal network. Drug trading within prison is reported to be far



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more distressing than in the community, leading to intimidation, bullying and criminality.

To prevent drug smuggling, several measures are implemented — on a routine basis or on suspicion. These include searches of cells, body searches after prison leave, interdiction of parcels, monitoring of visits and placing a net over exercise yards. The United Kingdom has recently set up measures to reduce supply, such as increasing the use of dogs to deter and discover smugglers and banning visitors caught smuggling drugs into prison.

Seizures of illicit drugs within prison or at the entrance are reported by many countries, usually of small quantities. Drug injection material, chillums and other paraphernalia are also found during inspections.

### Demand-reduction policy in prison

Current demand-reduction measures inside prisons consist predominantly of discouraging drug use through increased control, such as cell searches and random drug testing combined with sanctions or loss of privileges. For example, in Sweden, prisoners undergo an average of two to three urine tests per month.

Confronted with an increasing number of drug users, prison systems have set up specialised addiction care units (e.g. in the Netherlands), have centralised drugs services in specific prisons (Ireland and Austria), or ‘imported’ expertise in addiction care from external drugs agencies.

Since 1995, an expansion of services for drug users in prisons has been noted (Ambrosini, 2001) and measures to prevent the transmission of infectious diseases introduced. Compared to the community, however, there was a considerable time lag. The current offer of addiction care services does not match the potential need of the estimated over 50 % of drug users among the prison population.

Since many drug users return to prison various times with the same or even worse problems of drug use and infectious diseases, prison administrations have had to acknowledge the need to tackle addiction, drug use, related risks and health consequences in a more systematic way within prison settings. A recent development in many EU countries that reflects this is the adoption of genuine ‘prison drugs strategies’, the provision of directives on the care and treatment of addicted prisoners, or

the development of quality standards for specific services<sup>(62)</sup>. Prison drug strategies usually cover a range of measures to treat prisoners, discourage drug use and reduce the supply of drugs.

### Addiction care

Health care services in prisons are traditionally provided by the prison’s own health care staff under the authority of the Ministries of Justice, but prison systems across the EU and in Norway rely to a large extent on additional external expertise and resources in the care of drug users. Striving towards ‘equivalence of care’ between the community and the prison (Council of Europe, 1993; WHO, 1993), France, in 1994, and Italy, in 2000, have moved the responsibility for the care of addicted prisoners to their Ministries of Health and thus involved local and regional health care agencies on a statutory basis. Concrete cooperation agreements between the judiciary system and public or non-governmental health services were also established in Ireland in 1999, Portugal in 1999 and Spain in 2000, to increase the quality and coverage of care for imprisoned drug users.

External drugs specialists play an important role in the support to drug users in most, if not all, European prison systems. However, the extent to which prisons are covered and the level of service provision vary considerably between and within countries. Notable exceptions in terms of coverage are: Scotland, which has drug counsellors in every prison; Spain, where addiction care services are available in 71 out of 73 prisons; Sweden, where a third of the estimated number of inmates with drug problems were covered by treatment motivation programmes in the year 2000; and England and Wales, where since 1999 all prisons have specialised external teams (CARAT — Counselling, Assessment, Referral Advice and Throughcare Services) which aim to cover drug-using prisoners’ needs from intake to aftercare — although a bottleneck seems to be the lack of referral possibilities (Spacca, 2002). In Scotland, prisoners can now also receive transitional care during the first 12 weeks after release, to facilitate their return to the community.

The services provided by external agencies are general drug prevention information and education, treatment motivation programmes and preparation for release, including referral to community-based treatment and to aftercare. In Belgium and Greece, non-governmental organisations (NGOs) are so far the primary providers of the limited services that are available to drug users in prisons. In

<sup>(62)</sup> Table 13 OL: Recent prison drug strategies, ministerial directives and service standards in the EU and Norway (online version).

Germany, the history of the work in prisons of external drugs agencies and of specialised internal drugs services dates back to the mid-1980s and, in 2000, more than 350 drugs counsellors provided their services in German prisons; however, the coverage of this service varies between the federal states (*Länder*). In 2000, the involvement of external professionals continued to be an important trend in France; and, in Italy, the public drugs services SerT noted a large increase in client numbers, due to their new responsibility with regard to prisoners. The Spanish national strategy on drugs (2000–08) defined the participation of external specialists in the care of drug users in prisons as a priority, and multiannual cooperation plans between prisons and NGOs have resulted in more than half of the addiction care services (GAD) in Spanish prisons being staffed by external NGO experts.

### *Services provided*

Written information materials on drugs and drug-related infectious diseases seem to be available in most prisons in the EU and Norway; however, systematic and repeated opportunities to address prevention issues face-to-face are rare and often depend on the initiative of external agencies or individual prison staff.

Detoxification is in general offered through medical prison services or in specialised detoxification wards, but quality guidelines are often lacking. A programme through which 1 200 to 1 500 prisoners received detoxification per year has been described as being provided in an ‘essentially unstructured and unsupervised fashion, with no follow-up or medium to long-term planning’ (Department of Justice Equality and Law Reform, 1999). However, quality standards are starting to be introduced, for example the prison service order of December 2000 requests that all prisons in England and Wales offer qualified detoxification services.

In some countries, external agencies are also directly involved in providing longer-term treatment of addiction. Examples are the small intramural programmes for drug users in Denmark and Norway, which are run by specialised external drugs agencies (‘import model’), and substitution treatment in Spanish, French and Italian prisons. The high coverage in Spain has been achieved through the massive involvement of external drugs services.

Nine EU countries have structured abstinence-oriented treatment programmes inside prisons and Norway provides a treatment motivation programme. The total num-

ber of places is, compared with the estimated number of prisoners with drug problems, very low. However, in Spain, 8 984 prisoners participated in the 18 available drug-free treatment programmes in 2000 and, in England and Wales, 3 100 entrants were registered in the 50 intensive treatment programmes in 2000/01. In Sweden, 10 % of prison facilities, with a capacity to receive 500 prisoners, are specially reserved for voluntary and compulsory treatment of drug users (Lýsen, 2001) and, in Finland, 18 % of incoming prisoners participate in alcohol or drug rehabilitation programmes (Jungner, 2001). In the Austrian prison Favoriten, specialised exclusively in the care of addicts, 110 treatment places are available; Denmark has 30 places and Ireland has nine. The Norwegian treatment motivation programme can take 18 prisoners in charge per year<sup>(63)</sup>.

Except for Greece, Sweden and two *Länder* in Germany (Bavaria and Baden-Württemberg), substitution treatment is now available in prisons in all EU countries and Norway. However, even in countries where a large percentage of problem drug users in the community are in substitution treatment, prisons often follow a detoxification policy. For example, rates in prisons in Germany and the Netherlands are thought to be between 1 and 4 % (Stöver, 2001; WIAD-ORS, 2001) compared to an estimated coverage of 30 to 50 % in the community. Most prison maintenance policies indicate the treatment only during short-term sentences, for pregnant drug users, and for those with long addiction careers or severe mental or physical health problems. Initiation of substitution treatment in prisons is rare, even though it is legally possible in most countries. The major exception is Spain, where substitution rates inside and outside prison correspond<sup>(64)</sup>.

Ten EU countries and Norway run drug-free units or prisons. The purpose of some of them is not only to protect non-dependent inmates from drugs, but also to provide treatment for addicts. Prisoners under methadone substitution are usually excluded from drug-free units. The 20 drug-free addiction guidance departments in Dutch prisons can cater for 446 prisoners; however, one third of the capacity remained unused in 1999. Sweden has 356 places in drug-free units and, in Finland, where currently 10 % of all prison wards are drug free, an expansion to 50 % is envisaged. Portugal recently opened seven drug-free units with 195 places, evaluated it as a ‘great success’ and is planning two more units. An analysis of research on penitentiary addiction care (Rigter, 1998)

<sup>(63)</sup> Table 14 OL: Abstinence-oriented treatment and drug-free units in prisons in selected EU countries and Norway (online version).

<sup>(64)</sup> Table 15 OL: Substitution treatment in prisons in the EU and Norway (online version).

## Selected issues

concluded, however, that there was a shortage of reliable and valid results worldwide.

### Prevention of infectious diseases

The prevention of the transmission of blood-borne diseases during incarceration has become a priority target for several prison systems in Europe — also with regard to the notable increases in pharmaceutical expenditure due to the treatment of drug-related infections (e.g. HAART, interferon) that prisons have to cover.

Many countries aim to follow the general principles and specific recommendations made by the WHO in their *Guidelines on HIV infection and AIDS in prison* (WHO,

1993). Several risk-reduction measures are difficult to implement, because they are politically loaded, meet resistance from staff and are perceived inadequate in prison settings. Selected prevention measures of the WHO guidelines and the extent to which EU countries and Norway implement them are presented in Table 2. Even though the coverage of these measures appears still to be insufficient in many countries, some progress has been made <sup>(65)</sup>. Needle exchange programmes can be implemented now in all Spanish prisons <sup>(66)</sup> and Luxembourg and Portugal are discussing their introduction. More countries recommend prisoners' access to diluted bleach and implementation of this measure has improved.

**Table 2** Overview of selected measures to prevent blood-borne diseases in prisons in the EU and Norway

	Information/education	Hepatitis B vaccination	Provision of disinfectants	Needle/syringe exchange
Belgium	++ but not in all prisons	+ protocol being developed by MoH	+	0
Denmark	0	++ but coverage very low (2 %)	++ with instructions	0
Germany	+	n.a.	+	+
Greece	+ but provision relies primarily on external agencies	+ only one prison	+ only one prison	0
Spain	++	++ and encouraged	++	++
France	+	++	++	0
Ireland	0	++	+ but ++ recommended by Review Group on Prison Health Care, 2001	0 Review Group on Prison Health Care does not recommend N/S exchange, because of risks of attacks
Italy	0	n.a. (mandatory vaccination at age 12, whole population, introduced early 1990s)	++	0
Luxembourg	+	++	0	0 under discussion
Netherlands	+	++	++	0
Austria	+	+ (!)	++ with instructions on cleaning	0
Portugal	+	++ national vaccination programme	++ in practice: +	0 under discussion
Finland	+	++	++	0
Sweden	0 depends upon prison	0 decision on general introduction of vaccination pending	0	0
UK	+	++ (Scotland)	++ England/Wales: not easy to access. After pilot study, tablets are being made available Scotland: ++ with instructions	0
Norway	n.a.	n.a.	0 health authorities asked prisons to make bleach available	0

NB: n.a. = information not available

#### Information/education

0 general written materials  
+ written materials specifically developed for prison setting  
++ prison-specific materials plus safer use training

#### Hepatitis vaccination

0 not systematically available  
+ available in few prisons  
++ available in all prisons

#### Disinfectants

0 not available  
+ in some prisons  
++ in all prisons (at least in theory)

#### Needle/syringe exchange

0 not available  
+ programme in few prisons  
++ programme in all prisons

Sources: Reitox national reports.

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(!) Spiring, H. and Ess-Dietz, O. (2001): 'Preventive measures in Austrian prisons', in WIAD-ORS, pp. 234–300.

<sup>(65)</sup> For information on the situation up to 2000, see the web site ([http://ar2001.emcdda.eu.int/en/chap2/specific\\_demand.html#table2](http://ar2001.emcdda.eu.int/en/chap2/specific_demand.html#table2)).

<sup>(66)</sup> Except prisons located in Ceuta and Melilla. The autonomous community of Cataluña has its own competence in management of prisons.

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European Monitoring Centre for Drugs and Drug Addiction

**2002 Annual report on the state of the drugs problem in the European Union and Norway**

Luxembourg: Office for Official Publications of the European Communities

2002 — 54 pp. — 21 x 29.7 cm

ISBN 92-9168-129-6





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The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of 12 decentralised agencies set up by the European Union to carry out specialised technical or scientific work.

Established in 1993 and operational since 1995, the Centre's main goal is to provide objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences.

Through the statistical, documentary and technical information it gathers, analyses and disseminates, the EMCDDA provides its audience — whether policy-makers, practitioners in the drugs field or European citizens — with an overall picture of the drug phenomenon in Europe.

The Centre's main tasks are:

- collecting and analysing existing data;
- improving data-comparison methods;
- disseminating information; and
- cooperating with European and international organisations and with non-EU countries.

The EMCDDA works exclusively in the field of information.

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ISBN 92-9168-129-6



9 789291 681297