COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 18.9.2008
SEC(2008) 2455

COMMISSION STAFF WORKING DOCUMENT

Accompanying the

COMMUNICATION FROM THE COMMISSION TO THE COUNCIL AND THE EUROPEAN PARLIAMENT

On an EU Action Plan on Drugs (2009-2012)

IMPACT ASSESSMENT

{COM(2008) 567}
{SEC(2008) 2454}
{SEC(2008) 2456}

Table of contents

1. PROCEDURAL ISSUES AND STAKEHOLDER CONSULTATION

1.1. Institutional background

Illicit drugs are substances controlled by the UN Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. These are the main international legal instruments for addressing the global drugs problem and providing a framework for Member States' drug legislation.

All EU Member States and Candidate Countries have signed and ratified these Conventions. As a consequence Member States are obliged to establish as criminal offences all activities with regards to the substances listed in the 1961 and 1971 Conventions, including their cultivation, transport, import, export, distribution, possession and purchasing. Consumption of the substances controlled under these Conventions is not explicitly criminalised.

Member States must guarantee fundamental rights, including those of the drug users, when implementing policies on drugs, as set out in the Charter of Fundamental Rights of the European Union, the European Convention on Human Rights. The UN Convention on the Rights of the Child requires that States must protect children from the illicit use of narcotic drugs and psychotropic substances and drug production and trafficking[1]. The EU framework for drug policy was developed during the 1990s: The importance of European level cooperation in the field of drug dependence was reflected in the 1994 Communication from the Commission[2]. The creation of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in 1993 and the Drugs Unit of Europol in 1994 were further signs of the importance and added value of drug policy at the European level.

A first EU Drug Strategy (1995-1999) was adopted in 1995[3], promoting enhanced cooperation between Member States with the aim to reduce both the demand for and supply of drugs towards and within the EU. The EU Drug Strategy 2000-2004 and the EU Action Plan on Drugs (2000-2004)[4] introduced new possibilities for cooperation at EU level that became available in the through the adoption of the Treaty of Amsterdam.

The EU Drugs Strategy (2005-2012)[5] endorsed in December 2004 by the European Council, is an integral part of the multi-annual programme "*The Hague Programme' for strengthening freedom, security and justice in the EU*[6]*"*. It is based first and foremost on the fundamental principles of EU law and, in every regard, upholds the founding values of the Union: respect for human dignity, liberty, democracy, equality, solidarity, the rule of law and fundamental rights. It aims to guarantee a high level of security for the general public, to protect public

---

1 Article 33 of the UN Convention on the Rights of the Child: "States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances."

2 COM (1994) 223 final; 21.6.1994

3 9012/99 CORDROGUE 33;

4 12555/3/99 CORDROGUE 64; 9283/00 CORDROGUE 3

5 CORDROGUE 77, 22.11.200

6 COM (2005) 184 final, 10.5.200

health and to protect and improve the well-being of society and of the individual, by taking a balanced, integrated approach to the drugs problem.

The Strategy sets the framework, objectives and priorities for all drug-related activities in the EU by means of **two consecutive four-year Drug Action Plans to be brought forward by the Commission**. The first of these Action Plans, the EU Action Plan on Drugs (2005-2008), was endorsed by the Council on 8 July 2005[7]. The objectives and actions in the Strategy and Action Plans are partly structured as a logical framework (see Annex 1).

The EU Action Plan on Drugs (2005-2008) stipulates that the Commission is to organise an evaluation and calls upon the Commission to organise an impact assessment with a view of proposing a new EU Action Plan on Drugs (2009-2012)[8]. The final evaluation has taken place largely in parallel with the development of this impact assessment report.

The new EU Action Plan on Drugs covering the period from 2009 to 2012 together with the conclusions of the final evaluation are to be presented in the **Communication on an EU Action Plan on Drugs (2009-2012),** which is scheduled for adoption in September 2008. The full report of the evaluation can be found in the annex to the Communication.

1.2. Methodology for the impact assessment and procedural issues

This impact assessment is based to a great extent on the results of the evaluation of the Drugs Action Plan (2005-2008) and on the Annual Progress Reviews of that Action Plan (2006 and 2007) as well as information provided by the EMCDDA and Europol.

This Impact Assessment process has been managed internally by DG JLS complemented by the advice of an external contractor[9] that performed the role of 'critical friend' during the analysis and drafting phases of this impact assessment. They also provided technical advice with regards to the indicators for the monitoring and evaluation of the new EU Action Plan on Drugs (2009-2012).

The Commission also drew on external expertise for the evaluation methodology to improve the quality and scope of the work[10].

1.3. Dialogue with key stakeholders

In order to improve the quality and support for the new proposal, the Commission has consulted with different groups of stakeholders and experts. This consultation has provided valuable views on the necessity and priorities of the new Action Plan.

---

7 OJ C 168, 8.7.200

8 OJ C168, 8.7.2005: Action 45.3; Note: the term impact assessment in this context should be read as an ex-post evaluation of the implementation of the current EU Action Plan on Drugs (2005-2008) implementation of the current plan, as such different from the technical term 'Impact Assessment' as used in the Commission's policy making process.

9 Ernst & Young; Multiple Framework Service Contract JLS/2006/A1/004

10 GHK Consultants International; Multiple Framework Contract JLS/2006/A1/004

Ongoing dialogue with Member States

Overseeing the implementation of the current Action Plan on Drugs is one of the key tasks of the Horizontal Working Party on Drugs (HDG) in the Council. Through the Commission's annual Progress Reviews on the implementation of the Action Plan as well as through the publication of the Annual Reports of EMCDDA and Europol, the HDG is well-informed about the developments in the drug situation and the EU responses to it. The HDG and the successive Council Presidencies have constantly supported the view expressed in the EU Drugs Strategy that the Commission will not only evaluate the current Action Plan but also propose a new one for 2009-2012. This is of particular and explicit interest of France holding the Presidency at the later part of 2008 when the current Action Plan finishes.

Inter Service Steering Group on the Impact Assessment

For the purpose of ensuring a broad input from Commission Services in this impact assessment process, an Inter Service Steering Group (ISSG) was set up, consisting of representatives of 14 Directorate Generals in the Commission[11], reflecting the broad range of aspects covered by the EU Action Plan on Drugs. This group met three times and their comments have been included in this report. Furthermore, as the reporting on and implementation of a range of actions in the EU Drugs Action Plan (2005-2008) is the task of several of these Commission departments, many of the DGs represented in the ISSG have also actively contributed to the evaluation of the Action Plan, such in correspondence with the implementation road map that was agreed between services in 2005.

Steering Group for the final Evaluation of the EU Action Plan on Drugs

The Commission established a Steering Group for the final evaluation of the current Action Plan consisting of representatives from the respective Member States holding the EU Presidency between July 2006 and December 2008, the European Parliament, the EMCDDA and Europol. The Steering Group had the task to give advice to the methodology for the evaluation, on the evaluation tools the Commission planned to use and commented the outcomes resulting from the final evaluation. The Steering Group met four times between in 2007 and 2008.

Civil Society Forum on Drugs

In 2006, the Commission published a Green Paper on the role of Civil Society in the European Union[12]. The open consultation of stakeholders on the Green Paper yielded 65 replies and there was strong support for a Civil Society Forum on Drugs, which was established by the Commission in 2007. The Forum involves 26 organisations from civil society active in the drug field across Europe. The Forum gathered in December 2007 and May 2008, during which members of the Forum were asked to provide their views on the evaluation and the assessment of the implementation of the current EU Action Plan as well as their views regarding a new EU Action Plan on Drugs (2009-2012). Generally, there was a strong support for an EU level approach among the Forum members, and they saw added value in continuing a European level dialogue.

---

11 SG, SJ, ENTR, EMPL, TREN, RTD, TAXUD, EAC, SANCO, RELEX, ELARG, AIDCO, ESTAT, DEV and JLS

12 COM (2006) 0316 final; http://ec.europa.eu/justice_home/doc_centre/drugs/doc_drugs_intro_en.htm

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

The Commission receives substantial support from the EMCDDA in Lisbon for the monitoring and evaluation of the EU Drug Strategy (2005-2012) and the current EU Action Plan. Through the REITOX network of National Focal Points, the EMCDDA monitors the evolution of the drug situation and drug policy responses through key epidemiological indicators and a variety of additional reporting instruments.

Europol

The Drugs Unit of Europol provides information on law enforcement activities carried out in the framework of the Action Plan. It also reports on trends in drug trafficking routes, organised criminal groups involved in drug trafficking, seizures and numbers of dismantled laboratories for the manufacture of illicit drugs and chemical substances used in their manufacture (precursors). Europol assists Member States in operational activities like controlled deliveries and joint operations.

Open consultation

Due to time constraints, DG JLS did not to organise an open consultation exclusively for this impact assessment or on the proposal for a new EU Action Plan on Drugs (2009-2012). However, a Youth Eurobarometer on Drugs covering a limited number of policy aspects was organised in March 2008, in which 12.500 respondents aged 15-24 were asked questions about how they think governments could best deal with the drug problem, their opinion on the legal status of licit and illicit substances (and if changes are needed) and questions on the availability of prevention and how easy they would have access to drugs.

Input from the most relevant organisations and the Member States has been provided through the final evaluation process of the EU Action Plan on Drugs (2005-2008) and through the channels described below. Furthermore, any new Action Plan will be largely based on the overall aims and priorities of the existing EU Drug Strategy (2005-2012) and no major changes in the mandates of respective actors are foreseen even in the light of the future Lisbon Treaty.

Table 1.1 presents some of the main feedback received from the stakeholder consultations. References to reports can be found in Annex 2.

Table 1.1 – Results of the consultation of stakeholders

Dialogue with Member States / Horizontal Working Party on Drugs (HDG)	Between 2006 and 2008 the HDG has organised a great number of thematic debates on specific actions from the EU Drugs Action Plan (2005-2008) as well as on emerging and relevant issues, including progress reports and studies presented by the Commission. A considerable number of Presidency and Council conclusions have been adopted, relevant to the evaluation topics and the new Action Plan.
InterService Steering Group (ISSG)	The InterService Steering Group met on the 14th of February 2008, the 26th of February 2008 and 31 March 2008. The Group provided input and advice to the Impact Assessment Report, primarily regarding the structure and problem definition, but also on potential policy options to further implement the Strategy. Overall, the input was consistent with the options chosen. One specific proposed option was worked out but deleted during the Impact Assessment process. This option proposed an limited EU Action Plan for activities that covered EU competence only, disregarding actions that call upon Member

	States to act but that are not binding.
Steering Group for the Evaluation of the EU Drugs Action Plan (2005-2008)	This Steering Group was primarily established to reflect on the methodology and outcome of the evaluation of the EU Drugs Action Plan (2005-2008). But as one of the key purposes of the evaluation was to inform a future EU Drugs Action Plan as well, the feedback provided by the Steering Group on the conclusions and subsequent recommendations resulting from the evaluation process has had an important impact on the proposed new policy objectives for the new EU Drugs Action Plan. The Steering Group stressed that a new plan should be improved in terms of consistency and measurability, and that emphasis should be placed on new trends and threats emerging in the field of drugs. Furthermore, the Steering Group stressed the importance of continuation and strengthening those objectives and actions that have shown result and the potential reformulation or shifting of focus in objectives that turned out to be difficult to implement (or influence) at the level of Member States.
Civil Society Forum on Drugs	The Civil Society Forum on Drugs met in December 2007 and in May 2008. The meeting in December – the first ever – focused on the EU Drugs Action Plan Progress Review 2007, discussing potential difficulties in the implementation of the EU Drugs Action Plan (2005-2008). In the meeting of May 2008, the first results of the evaluation process were presented and discussed and participants were encouraged to present ideas and recommendations for the evaluation and/or for a future Action Plan. Key points raised included: – EU Policy must be based on the principles of public health and human rights. – Coordination between civil society, EU institutions and EU Member States should be strengthened and encouraged. – Specific attention should be paid to the needs of vulnerable groups. – A new Action Plan should encourage the development of quality standards in the full spectrum of drug demand reduction. – Poly drug use needs to be addressed in more detail – The new Action Plan should advocate alternative development, while taking into account local needs. – The new Action Plan should address on drug-related harms in prison and potential harms that may occur upon release of prisoners. – Drug-related deaths should be further reduced by further implementation of demand reduction measures, including harm reduction. Many of the issues raised had been discussed before, among others within the Council in the past years.
Europol/ EMCDDA	Input from Europol and EMCDDA has been instrumental throughout the evaluation and impact assessment process. By providing information on the current state-of-play, information on trends and on implementation of actions from the EU Drugs Action Plan (2005-2008) in Member States has been essential for the evaluation process and for the formulation of new proposals for a new Action Plan.

Impact Assessment Board opinion

The Impact Assessment Report was submitted to the Impact Assessment Board on 28 May 2008. On the 13th of June 2008, the IAB provided an Impact Assessment Quality Checklist for the IAB Opinion, pointing out a number of key questions and suggestions for adjustment of

the Impact Assessment Report, for the consideration of the author DG. On the 27th of June, the Impact Assessment Board presented its opinion, in which it called for a number of important changes to the report.

The general opinion was as follows: *"The IA report should focus on the main outcomes of the evaluation of the first Action Plan and the main improvements which will consequently be made in the second Action Plan. In addition, the assessment of some impacts and the general presentation of the report should be improved. In its written exchange with the Board, DG JLS agree to change the report on all of these points. Given the nature of the recommendations, the Board would like to examine a revised draft IA report on which it will issue a new opinion".*

On the 18th of July the Impact Assessment Board resubmitted its opinion on this Impact Assessment. The revised opinion asked for a further clarification of the importance of the ten problem-objective combinations identified in Chapters 3 and further analysis of each of the problems against three options examined. Furthermore, the Impact Assessment Board recommended that results of stakeholder consultation be included in the main body of this report, with references in annex.

The issues identified by the Impact Assessment Board have been incorporated in this report.

2. PROBLEM DEFINITION

2.1. Evaluation of the implementation of the EU Drugs Action Plan (2005-2008)

The EU Drugs Strategy (2005-2012) and the EU Drugs Action Plan (2005-2008) are developed around the two main dimensions of drug policy, *drug demand reduction* and *drug supply reduction*. The European approach takes these as equally important and mutually reinforcing each other when implemented as parts of integrated drug policy. These two 'pillars' are complemented by three cross cutting themes, *coordination*, *international cooperation* and *information, research and evaluation*. The Drug Strategy and Action Plans have been designed in the format of a Logical Framework, identifying Strategy objectives, Strategy priorities, Action Plan objectives and actions[13].

2.1.1. Main conclusions from the evaluation of the EU Drugs Action Plan (2005-2008)

Evaluating the impact of public policy plans such as the EU Action Plan on Drugs 2005-2008 is by nature a very complicated exercise. The Action Plan had the aim to coordinate and influence major areas of government interventions in the field of drugs (public health/ security/ external relations) targeting a complex social phenomenon that is still insufficiently understood, that largely takes place outside the scope and control of public authorities and that requires a coherent long-term approach.

The Action Plan is a non-binding coordination instrument primarily for Member States, who are autonomous in implementing its aims and objectives. A limited number of objectives and actions are implemented only at EU level, i.e. through Commission activities. This indirect implementation may be effective in providing guidance for national policy level, but it does make assessment of direct consequences of the plan more complicated. An additional complicating factor is that most objectives and actions in the Action Plan are implemented indirectly: the Action Plan aims to influence the actions of others[14].

Information on the implementation of the Action Plan at EU level is gathered from several Commission services and agencies. Information on the implementation of the Action Plan at the level of Member States is mainly provided through the EMCDDA and Europol. For the evaluation of the Action Plan, the Commission has also conducted a written survey among Member States and a limited evaluation survey on intra-institutional cooperation and coordination conducted by an external evaluator.

2.1.1.1. Overall conclusions of the evaluation

(1) The evaluation shows that the EU Drugs Strategy and Action Plan are well reflected in national policies. Member States have translated the objectives of the Action Plan in national policy, and/ or these objectives were already reflected in existing documents.

---

13 See Annex 1 for a brief overview of the key objectives of the current EU Drugs Action Plan

14 The Commission is involved in the implementation of 44 of the 86 objectives and actions in the EU Drugs Action Plan (2005-2008), but directly responsible for only 8 of them. Member States are involved in the implementation of 64 of 86 objectives and actions, but directly responsible for the implementation of 23 of them. 14 of 86 are a shared responsibility between Member States and the Commission. The remaining 41 actions are the shared responsibility of the Member States, Commission, Presidency/ Council, Europol, EMCDDA and a limited number of other stakeholders.

(2) Overall, the evaluation suggests that the current EU Action Plan on Drugs (2005-2008) has initiated a broad range of activities and cooperation. The Action Plan has been more than a paper plan: on practically all specific objectives and actions progress has been made, with varying degrees of success.

(3) The Action Plan suffers from a number of internal inconsistencies as well as from the large number of objectives and actions, and the lack of prioritisation between them.

2.1.1.2. Cross cutting theme: coordination

(1) The evaluation shows that the HDG is the main forum of drug coordination at EU level and that the European Commission is well coordinated in the Council. **At the same time, coordination within the Commission regarding the implementation of the Action Plan could be improved, among others by setting clearer priorities and by improving the communication on EU drug policy objectives across policy fields.**

(2) All EU Member States have a national drug strategy, action plan and/ or other overarching drug policy in place. In over half of the countries, these policy documents reflect the structure and set up of the EU Drug Strategy or EU Action Plan on Drugs.

(3) In all agreements the EU has finalised with third countries/ regions, a specific clause on drugs has been included. **However, the impact of these clauses still needs to be examined and more information on their follow up is needed.**

(4) Annually, a rich body of monitoring information and situation reports are published on the drug situation. However, the utilisation of these reports by EU policymakers, linking the phenomena described in them need for further policy analysis needs improvement.

2.1.1.3. Drug demand reduction

(1) Member States have invested in universal, selective and indicated prevention programmes across the board, but the evidence-base underpinning these programmes is still insufficient as they are seldom evaluated. **Only a few Member States have introduced general quality guidelines for prevention.**

(2) The level of availability, coverage and accessibility of prevention programmes is unclear. Overall, according to the EMCDDA the quality of selective prevention programmes is not regarded highly by experts and in the field of indicated prevention – covering among others drug use in recreational settings – not enough information is available on such programmes in Member States.

(3) A majority of Member States report that they offer a variation of treatment programmes to dependent drug users, including drug-free treatment, psychosocial treatment and substitution treatment. An increasing number of Member States have also developed quality guidelines for these programmes, but their applicability is still unclear. **Further improvements are needed in improving the effectiveness, accessibility, availability and coverage of treatment services and for developing quality guidelines.**

(4) New treatment options and/ or settings are required for new types of drug problems, e.g. problematic cannabis use requires a different treatment response than opioid dependence. **Member States need to invest in adapting/ adjusting to new trends in treatment demand.**

(5) In the field of harm reduction, major progress has been achieved in recent years. All EU Member States run harm reduction programmes. **However, the effective coverage, availability and accessibility of these programmes in Member States are still a cause of concern.** Furthermore, in some Member States an increasing lack of political support for harm reduction can potentially result in higher levels of risk taking among new, younger generations of heroin injectors.

(6) **The availability of standardised data on the social consequences of drug use is still very limited.** This also includes information of efforts made by Member States to rehabilitate and reintegrate (problematic) drug users in society.

(7) The provision of continued and equal care for inmates in prison as compared to care available in society in general is of great importance to reduce drug-related harms. **The infection rates for drug-related infectious diseases as well as the mortality rates for drug-related deaths are considerably higher inside prison (and immediately after release from prison).**

(8) Treatment and harm reduction programmes **are often not tailor made to address specific needs and problems of different groups of problematic or dependent drug users**, e.g. women, minors, migrants, specific ethnic groups and vulnerable groups. This conclusion is confirmed by civil society organisations.

2.1.1.4. Drug supply reduction

(1) Law enforcement cooperation in the field of drugs between Member States shows and increasing trend. However, existing instruments such as Joint Investigation Teams and Joint Customs Organisations are not used to the full extent.

(2) Member States overall contribute well to the activities of Europol and are – in return – supported in investigations involving internationally operating organised crime groups. However**, there is still substantial room for improvement, e.g. in information sharing and intelligence gathering through closer coordination between law enforcement services at national level.**

(3) The results of various operational and intelligence law enforcement cross-border projects in the EU, e.g. **MAOC-N**, show the importance of strengthening intelligence gathering and sharing as a basis for enhanced intelligence led law enforcement.

(4) The Drug Strategy objective to make supply reduction and law enforcement output better measurable and therefore more accountable, is complicated by a lack of availability of standardised key indicators in this area. **Drug seizures are collected through different methods and channels.**

(5) A long-term solution on **forensic profiling for synthetic drugs** is not yet in place, but considerable progress was made in 2007 and 2008.

(6) The number of arrests for **drug related offences** has risen considerably. In most cases the rise is due to arrests for consumption of drugs. It is unclear to which extent these arrests result in actual sentences.

(7) In almost all Member States, there is a lack of priority in national **Customs organisations** when drug precursor control is concerned**.**

(8) Member States cooperation in the field of **anti-money laundering** and asset confiscation has progressed in recent years, and the number of investigations is increasing.

2.1.1.5. Cross cutting theme: International Cooperation

(1) According to the Member States, the Action Plan has been important for achieving coherence and consensus between EU Member States at international level. Increasingly, the Action Plan is considered as a 'model' of EU drugs policy.

(2) The EU's has increasingly acted coherently, in particular in the Commission of Narcotic Drugs (CND) of the United Nations. However, a systematic procedure should be developed to ensure that the EU speaks with one voice in the CND plenary meetings. .

(3) A great number of assistance projects with candidate, stabilisation and association process countries have been supported in recent years. Furthermore, (negotiations on) agreements have started or already finalised with many of the countries involved, in particular regarding their participation in the EMCDDA and cooperation with Europol and Eurojust. **However, the outcome of assistance projects is difficult to assess due to a lack of assessment tools and indicators.**

(4) External funding programmes and projects of both EC and the Member States should be linked more explicitly to the priorities of EU drug policy.

(5) The EU integrated and balanced approach on drugs has served as a model for Candidate Countries as well as many Neighbourhood Policy Countries in developing their national drug strategies and action plans.

(6) The EU is a major player when assistance to third countries in the field of drugs is concerned. Afghanistan and the Andean countries are the main beneficiaries of the EUR 760 Million the EU spent in 2005 on drug-related projects, two-thirds of which was allocated to alternative development. **With approximately 5% of overall external funding, the area of demand reduction is not well-represented in international assistance projects.**

(7) New drug trafficking routes, especially for heroin and cocaine, emerge on the Eastern border of the EU and through West-Africa. The diversification of routes suggests that anti-trafficking measures may be effective on traditional routes, **but at the same time the number of routes increases and asks for flexible and broad cooperation with countries in this region.**

(8) With specific donations of over EU 20 Million a year, the EU Member States are major contributors to UNODC (EC contributions not included).

2.1.1.6. Cross cutting theme: Information, Research and Evaluation

(1) The quality of information that is available on the drug situation in Europe has improved in recent years, mostly due to the work of Europol and EMCDDA.

(2) Further steps might be considered to contribute to greater coordination and complementarity between research and funding structures at national and EU level.

(3) Diminishing support from national governments to National Focal Points is an increasing cause for concern as National Focal Points are an essential part of the information infrastructure of the EMCDDA.

(4) Monitoring in the field of drug demand reduction is improving but requires continued attention and support for implementation of data collection at the level of Member States.

(5) The availability of reliable, comparable and usable information and data in the field of drug supply and supply reduction is an ongoing cause of concern, **as the lack of it does not allow for a proper analysis of the EU drug market and the effectiveness of law enforcement interventions.**

(6) The need for evaluation of drug policies continues to be of great importance. **Improvements are required in order to better assess policy impacts.**

2.2. Current state-of-play

As such, the EU Action Plan on Drugs (2005-2008) is the most specific and best-monitored EU Action Plan so far. However, as the evaluation above also shows, there is still room for improvement and new trends in the drug situation also require new or further measures. Despite the results of the implementation of the current Action Plan as presented above, it is clear that the scale and seriousness of the drug problem in the EU remains considerable.

2.2.1. Trends in the demand for drugs and adverse health and social problems

In many respects, the European drug situation appears to have moved into a more stable period after the sometimes dramatic increases that were seen in the 1990s and early part of this decade. Drug use levels remain high by historical standards and although considerable differences exist between Member States, to some extent these are less pronounced than in the past.

Cannabis remains the most commonly consumed illicit drug and **with 17.5 million Europeans using the substance last year, prevalence estimates are high by historical standards,** but again the available trend data points overall to a stabilisation or even to some limited decline in the popularity of cannabis. Stimulant use patterns are more difficult to summarise. **Cocaine was used by 4.5 million Europeans last year and has grown dramatically in some Member States although not in all,** while ecstasy use seems to have moderately decreased overall and amphetamine use remains an important element in the drug problem in some Nordic countries. The use of heroin and drug injecting appear generally stable

A **decreasing age of first use** among young people as well as **the increase in poly-drug use, especially also involving licit substances such as alcohol**, poses major challenges to

prevention and treatment and there is a need to develop evaluated best practises, benchmarks and guidelines in these fields.

In the EU between 1 and 8 people on 1.000 inhabitants classify as **problem drug user**. Around 1.1 million people in the EU inject drugs, mainly opiates[15]. These problem drug users are at risk of death by overdose and/ or at risk of developing **serious drug-related infectious diseases**. Drug related deaths, mainly **overdose deaths**, currently more than 7.500 cases annually in the EU[16], constitute a significant cause of avoidable mortality among young adults. The downward trend in the EU in drug related deaths that was visible for several years tailed off between 2004 and 2005, in order to drop again in 2006.

EMCDDA reports that between 100.000 – 200.000 Europeans who have ever injected drugs live with HIV and around one million with Hepatitis C. Injecting drug use still accounts for 3.500 newly diagnosed cases of HIV in the EU every year. **The risk of infection is particularly high in exceptional circumstances, where needle sharing is common e.g. in prisons, with infection rates up to 80%.** Harm reduction policies (e.g. providing clean syringes and needles), when implemented as part of a coordinated and coherent public health policy approach, can be effective in reducing risk behaviours and as a result the spread of infectious diseases among drug users.

In 2005, 21 EU countries have reported information on 326.000 new drug treatment clients attending outpatient centres. Approximately 40% of these new clients are treated for opioid use, 20% for cannabis use, and 13% for cocaine use and the remaining clients for other drug use. In 2005, it is estimated that 585.000 dependent drug users received substitution treatment in the EU and Norway. **In recent years, the share of clients seeking treatment for other than opioid addiction is increasing.**

Negative social consequences are reported to be generally linked with problem drug use. For instance, **homelessness, together with living in unstable accommodation, was affecting about 10% of drug users entering treatment in 2006, while one in every two clients entering treatment was unemployed.**

2.2.2. Supply of drugs, related crime and law enforcement

Production, manufacture and trafficking of drugs remain amongst the primary activities of organised crime networks operating towards and within the European Union posing serious challenges for EU policies, in particular in the area of justice, freedom and security. Whilst principle drug trafficking routes remain prominent there is a growing diversification of trafficking patterns. Also, with a variety of European Union drug production and entry points, there is a large-scale intra-EU trafficking. Criminal networks no longer limit their activities to one type of drug as reflected in the prevalence of 'cocktail' or 'poly-drug' seizures.

According to the United Nations, most of the world's illicit **heroin** comes from only three countries: Afghanistan, Myanmar and Laos. Afghanistan continues to be the major supplier of

[15] EMCDDA Annual Report 2007

[16] EMCDDA Annual Report 2007, 2004 data; in 70% of drug-related death cases opioids are involved.

heroin, accounting for over 90% of global opium production. In 2007, the estimated opium output increased 34 % to 8,200 tonnes[17].

Regarding the manufacturing of **cocaine**, the Andean region remains the major cocaine producing area in the world, with an estimated output in 2006 of 910 tons of cocaine. Colombia accounts for 70% of global production (640 tons), Peru for 20% (180 tons) and Bolivia for 10% (90 tons).

Cannabis continues to be the most widely produced, trafficked and consumed plant-based drug worldwide. In the absence of cultivation monitoring systems and surveys, the UNODC estimates that in 2006 there were 231,000 hectares of illicit cannabis cultivation in the world, capable of producing 45,000 tons of herbal cannabis. The plant is grown in 176 countries around the world, notably in the Americas (54%), Africa (26%), Asia (15%), Europe (4%) and Oceania (1%).

Two key corridors are used for the **trafficking of opiates**. Significant heroin trafficking takes place along the *Northern Route*, which starts in Afghanistan and crosses the central Asian States of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. It is estimated that some 25% of smuggled heroin stays in central Asia for domestic consumption, while the remaining 75% is smuggled onward to Russia and Europe[18]

Most heroin reaches Western Europe via the *Balkan Routes*, starting in Turkey, facilitated by Turkey's geographical position in handling extensive commercial trade between Asia and Europe and good transport infrastructure. There is an increased use of the *central Balkan Route* from Turkey, via Bulgaria, the former Yugoslav Republic of Macedonia, Montenegro, Bosnia and Herzegovina and Croatia into Italy or Slovenia and from FYROM via Kosovo under UNSC Resolution 1244 and/or Albania into Greece. The *route via Ukraine and Romania* is also gaining importance.

Three main **cocaine sea routes** to Europe have been identified. The *Northern route runs* from the Caribbean via the Azores to Portugal and Galicia in Spain. The *Central route* runs from South America via Cape Verde or Madeira and the Canary Islands to Europe. More recently, the *African route* has evolved, which runs from South America to Western Africa and from there to Portugal and Spain.

In recent years, West Africa has emerged as a transit and storage zone for Maritime trafficking of cocaine from South America to Europe. At least 33 tons of cocaine has been seized en route to Europe via West Africa between 2005 and 2007. Prior to this, the entire continent rarely seized more than a ton per year. This criminal development poses a further threat to the fragile stability of the region, exploiting, inter-alia, the capacity of West African law enforcement agencies, high levels of corruption and the lack of port / coastline controls.

An estimated 100 tons of **heroin** are needed annually to supply European Union heroin markets[19]. There is large-scale secondary or intra-European Union trafficking, particularly from the Netherlands and Belgium.

---

17 UNODC, Afghan Survey, Winter 2007; as presented during the EU Troika with Western Balkans, Brussels, April 2008.

18 Council document 11159/07 CORDROGUE 40: Regional report on Central Asia. Brussels, 20 June 2007.

19 UNODC World Drug Report, 2006

The European Union remains, next to the United States, the second largest **cocaine** consumer market in the world. An estimated 250 tons of cocaine enter the Union annually via maritime shipments, air freight and couriers. In 2006, almost 120 tons of cocaine was seized in the Member States.

Due to its proximity to Morocco, most **cannabis resin** enters the European Union through Spain, with the vast majority destined for other Member States.

The European Union is a major production region for synthetic drugs, in particular amphetamine and MDMA (ecstasy). Annually, some 70 to 90 significant scale synthetic drug production and storage sites are seized, with the vast majority in the Netherlands and, to a lesser extent, Belgium. In addition, Poland, Estonia and Lithuania have played important roles especially in supplying Germany and Nordic Member States.

A relatively recent phenomenon in the European Union is the increased transit/transhipment of suspicious large scale consignments of ephedrine and pseudo-ephedrine, the principal precursors for methamphetamine manufacture, *mostly en route from Asia with final destination to the Americas.*

Despite the measures implemented through the Action Plan, the global illicit drugs market seems to have its own dynamics. Based on data available from a limited number of EU countries, the street prices corrected for inflation *declined* for all drugs mentioned above over the period 2000–2006. Most reported decreases are in a range of 10–30%, *but street prices for ecstasy seem to have declined even more.*

A second indicator for developments on the illicit drug market concerns the **potency/ purity** of substances purchased or seized in a number of EU Member States[20]. In 2006, reported THC content of cannabis resin samples ranged from 2.3% to 18.4%, while that of **herbal cannabis** ranged from under 1% to 13%. In most reporting countries, the typical MDMA content of an **ecstasy tablet** was between 25 and 65 mg in 2006, and high-dose tablets (containing over 130 mg of MDMA) were reported in some European countries. The typical **purity of cocaine** in Europe ranged between considerably, with most countries reporting values between 25% and 55%.

Trends in potency are difficult to establish because of the important variability in purity levels. Furthermore, reliability and comparability problems exist as well as non-standardised methods of sample strategies and calculation. However, from the available data it can be estimated that potency levels remained stable or declined for cannabis resin and herbal cannabis, for amphetamine and for cocaine. No clear European trend is apparent in the data on the MDMA content of ecstasy tablets and in the data on heroin.

Drug use and drug trafficking continue to pose an important burden on the criminal justice system. With almost 740.000 arrests for drug-related offenses in 2006, 80% of which for use-related offences and 20% for drug trafficking, drugs are a major concern for police and prosecution.

---

[20] It should be recognised that purity levels will invariably reflect the stage at which the drug is taken out of the illicit market i.e. from higher purity bulk quantities to lower purity consumer doses. The available data should reflect street level prices, but not all countries make this distinction with good precision. Furthermore, the sampling is biased towards which samples get tested in forensic laboratories as considerable inter-sampling differences exist.

And according to the *2003 European Sourcebook of Crime and Criminal Justice Statistics*[21], covering statistical information from over 35 Member States of the Council of Europe, drug trafficking offences[22] accounted for 10% of all detainees in penitentiaries. However, considerable variations exist between countries and depending on the method of registration of convictions in each reporting country, the share of drug-related offences may be higher than reported[23].

2.2.3. Economic and social burden of the drug problem

The abuse of illicit drugs results in considerable **social costs** for EU Member States. In the field of drugs, ***'social costs'*** are defined as the total of all of the costs to society, direct and indirect caused by drug use[24]. The output, expressed in monetary terms, is an estimate of the total burden that drug use places on society[25].

Recently, the EMCDDA has made efforts to make an estimation of the social costs of the drug phenomenon to society. Due to a lack of definitions and data, this exercise is difficult to achieve and only a few European countries have made rough estimations of the social costs of drug use to society.

One of the more visible elements of social costs related to drug use, concerns public expenditures on the drug phenomenon. Six EU Member States[26] reported on their *direct* and *labelled* drug-related public expenditure regarding drugs. These countries estimated this expenditure to represent – on average – 0.32% of the total annual government spending, with variations from 0.11% to 0.96%. In terms of GDP, public expenditure on drugs represents a median of 0.15% of these countries, with variations from 0.05% to 0.46%[27]. This expenditure includes – in most cases – a variety of drug policy responses. In the six countries, 40-60% of the direct public expenditures concern prevention, treatment and harm reduction measures. The remaining expenditure concerns the costs of law enforcement and e.g. imprisonment. However, when indirect and/ or non-labelled public expenditure is taken into account, the balance between the different types of drug policy will look very different (e.g. incorporating drug-related costs of policing, prosecution, etc.).

---

21 European Sourcebook of Crime and Criminal Justice Statistics [2003] 2nd ed., WODC, The Hague

22 The category 'drug trafficking offences' may also possession of drugs for own consumption.

23 Certain crimes may not be registered as a drug-related offence, but according to the primary act, e.g. theft, assault, rape or unintended homicide.

24 Single et.al. [2001]; Direct social costs include e.g. public expenditures on prevention of drug abuse, treatment and rehabilitation of drug addiction but also law enforcement costs aimed at tackling drug-related crime, prosecution and the costs of imprisonment of drug offenders. Indirect social costs include – among others – the loss of productivity due to drug-related death and drug-related (infectious) diseases, imprisonment and indirect costs of social marginalisation of drug offenders or drug users, but also indirect costs related to a lack of public safety through fraud and corruption.

25 EMCDDA Annual Report 2007, p.21

26 Belgium, Hungary, The Netherlands, Finland, Sweden and the UK; Source: EMCDDA Annual Report 2007, p.21

27 Overall, the amounts of public expenditure related to drug-related issues in the reporting Member States ranges from EUR 200 000 to EUR 2 290 Million.

Based on reports from these Member States and Norway, the EMCDDA estimates that the total drug-related public expenditure in these 28 countries lays between 13 and 36 billion EUR annually, representing up to 0.33% of the GDP of EU Member States[28]. Taking into account that public expenditure only represents a proportion of the overall social costs, the conclusion is justified that the drug phenomenon has a considerable social and monetary impact on European societies.

[28] EMCDDA Annual Report 2007

2.3. Subsidiarity

The EU Member States are the main actors in the drugs field and drug legislation is primarily a matter of national competence. However, the Treaties explicitly acknowledge the need to deal with drug issues at the EU level, in particular on justice and home affairs[29] and in public health[30].

The Community competence covers the control of the trade in chemical precursors[31], the prevention of money laundering[32] and the assessment of emerging psychoactive substances[33]. In the field of drug trafficking, a Co*uncil Framework Decision laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking*[34] has been adopted, while the *Council Decision on the Information Exchange, Risk Assessment and Control on new Psychoactive Substances*[35] provides the EU with an instrument to act on new drugs emerging in the market. The Community role in many fields like research, social policy, education and youth also covers drug related actions even if not specifically mentioned in the Treaty.

The EU Drug Strategy (2005-2012) was drafted within the current legal framework of the EU and EC Treaties and based on the respective competences of the Union, Community and individual Member States, with due regard to subsidiarity and proportionality

2.3.1. The need for EU action

The complexity and global dimension of the world drug problem requires policy action at supra national level for reasons of efficiency (shared efforts), effectiveness (exchange of know-how and best practice), policy impact (avoiding displacement and spill over effects) and political influence in the international (UN) drug policy arena.

Even if detailed characteristics of drugs scenes are different from one Member State to another and inside Member States, all EU Member States are affected by the adverse consequences of drug abuse and drug-related crime to more or lesser extent. In a Europe without borders, drugs and drug users can move rather freely and more sophisticated methods need to be developed to detect illicit drugs as well as providing services for drug users. As indicated above, organised crime groups increasingly organise themselves at through international crime consortiums. Cooperation on law enforcement, agreed procedures, joint investigative teams and effective sharing of intelligence e.g. through Europol all contribute towards creating and area of Freedom Security and Justice while at the same time guaranteeing full respect of fundamental rights.

---

29 Title VI articles 29 and 31(1)e TEU

30 Article 152 TEC

31 Community Precursor Legislation (Regulation (EC) no. 273/2004 of the European Parliament and of the Council of 11 February 2004 on drug precursors

32 2005/60/EC – Directive of the European Parliament and of the Council on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing, 26.10.2005

33 Council Decision on the Information Exchange, Risk Assessment and Control of new Psychoactive Substances (2005/387/JHA)

34 2004/757/JHA

35 2005/387/JHA

Isolated policy initiatives by one Member State have often resulted in displacing the problem to neighbouring countries (shift or diversion of production, drug tourism, cross-border crime & trafficking). Efficiency, effectiveness and transparency in drug policy requires exchange of best practices, common approaches and definitions and joint actions in order to detect the "loopholes" that are utilised by drug traffickers.

In the field of international cooperation, the EU Member States pursue the principle of shared responsibility and are increasingly aware that the European drug problem is part of a global context with patterns in drug production and trafficking reflecting to the EU drug scene. Over the past ten years, EU has developed into a major actor at international level providing at least EUR 760 million for demand and supply reduction activities in third countries. Further assistance is provided for Candidate Countries and European Neighbourhood Policy countries.

2.3.2. Added value of the EU Drugs Action Plan

The evaluation of the EU Action Plan on Drugs (2005-2008) shows that practically all Member States consider that there is an added value of having an Action Plan on Drugs at EU level. The key features of the added value can be listed as follows;

- Action Plan provides **clear European level objectives** and guidance for setting national priorities, resulting in greater coherence and convergence of drug policies between countries on a voluntary basis.

- Action Plan provides guidance for **sharing of best practise** and development of common standards on many key areas both on drug demand and drug supply reduction.

- Member States share the view that the Action Plan provides a **comprehensive drug policy framework**, and that it has encouraged the development of high quality, broad national strategies and action plans across the EU.

- Many Member States indicated that the EU Action Plan was **important for international cooperation**. The EU has gained influence in the international arena in the field of drugs due to the fact that it could work on the basis of the consensus reflected in the Strategy and Action Plan.

- The EU Action Plan plays an important role in **presenting the European model of drug policy,** with the balanced approach and fundamental rights as its cornerstones.

Synergies created by the Action Plan help to avoid displacement effects caused by diverging policies among Member States. The Action Plan and its large number of objectives and actions provide priorities, indicators and clarify responsibilities between EU institutions and Member States. The Action Plan is also seen as an instrument to promote cooperation among Member States and between Member States and third countries and regions.

Regarding the added value of the Action Plan for national level, the evaluation shows that the Action Plan is seen as a catalyst for the development of national policies and that it helped to raise debate on sensitive policy issues at national level, for example on the introduction of harm reduction as part of drug demand reduction policies.

Member States referred to the EU Action Plan as being generally consistent and relevant for national drug policy by providing recommendations and argumentation for national policy discussions and developments in legislation. The Action Plan has encouraged initiating joint activities and operations in the field of law enforcement, both within the EU but also towards the main producing countries.

Finally, the focus on evidence-based policy making, monitoring, evaluation and information has been an important added value for national drug policies, resulting in greater attention for effectiveness and efficiency at national level and in identifying and comparing trends.

So overall, the EU Action Plan on Drugs (2005-2008) is considered by Member States as an important policy instrument, with a clear added value for both EU and international cooperation in the field of drugs, but also for the development of national drug policies.

The Action Plan offers guidance for coordination between Member States, without which the EU's representation in international forums would be fragmented and less influential. Given the fact that the EU Action Plan on Drugs is based upon a broad consensus among Member States and in fact reflects to a great extent the existing political reality in the Member States, it functions as a representative model of EU drug policy in international settings, something which is impossible for individual EU Member States.

3. OBJECTIVES

3.1. General objectives

This impact assessment has as its main purpose to assess the most appropriate policy instrument to **implement the EU Drug Strategy (2005-2012).** As presented before, the Strategy is to be implemented through **two consecutive EU Drugs Action Plans**. The general policy aims of the Strategy are as follows:

- The EU aims at attainment of high level of health protection, well-being and social cohesion by complementing Member States' action in preventing and reducing drug use, dependence and drug-related harms to health and society

- The EU and Member States aim to ensure a high level of security for general public by taking action against drug production, cross-border trafficking in drugs and diversion of precursors, and by intensifying preventive action against drug related crime, through effective cooperation embedded in joint approach.

The Strategy clearly states that the integrated, multidisciplinary and balanced approach of combining demand and supply reduction is the basis of the Union's answer to the drugs problem. This approach requires cooperation and coordination and further development not only in numerous sectors, including welfare, health, education and justice and home affairs, but also in relation with non-Member States and relevant international forums.

3.2. Specific and Operational objectives

As the EU Drugs Strategy (2005-2012) remains the overarching policy for the development of any new EU Action Plan on Drugs, the objectives and priorities as defined in the Strategy remain valid.

As the problem definition showed, the implementation of the EU Drugs Action Plan (2005-2008) has seen progress in quite a few areas, there is also room for further improvement and amendments.

The overall conclusions on the evaluation showed that the current Action Plan has a number of internal consistency problems, which have resulted in some cases in confusion about objectives and actions (e.g. unspecific formulation; definition problems, etc.), the availability of relevant indicators to measure progress (sometimes indicators were assessment tools and vice versa). A future policy plan should aim to avoid these problems.

At the same time, for each of the five constituting policy elements in the Action Plan, the conclusions also reflected shortcomings. These shortcomings are important for the development of a new EU Action Plan on Drugs. Such a plan would on the one hand have to reflect the broad range of priorities as identified in the Drugs Strategy, at the same time lessons learnt from the evaluation and the experience gained through the past five years should be taken on board.

Annex 3 presents a schematic overview of the (provisionally) proposed objectives for a new Action Plan. It would go beyond the possibilities and restraints of this impact assessment to

include all potential new objectives and actions in a new Action Plan or reflect on each of the 30 or more conclusions as identified in the problem definition.

As an alternative, for each of the five key policy fields in the Strategy, two important problems identified by the evaluation have been matched with an example for an operational objective for a new EU Drugs Action Plan in this section. These examples of new objectives might still change as the final drafting of a possible new Action Plan is ongoing and part of a political process. The ten examples for each of the policy fields can be considered key problems following the evaluation process. As the Strategy and Action Plans aim to foster progress and synergy across the board of EU drug policy, no hierarchy in importance has been given between the policy fields.

The overall impacts of the policy options are still based on the whole framework of an Action Plan, but each of the policy option will also be analysed against the operational objectives. A focus on the examples only would ignore the synergies created through the multidisciplinary, balanced and integrated approach which the whole constellation of Drug Strategy and Action Plan objectives represent.

3.2.1. Specific Objective Enhancing Coordination

The Strategy states that *"the Action Plans should include actions that will contribute to the further development of a European coordination mechanism"*.

Example: Conclusion from the evaluation
The evaluation shows that the Horizontal Drugs Group is the main forum of drug coordination at EU level. The European Commission is well coordinated in the Council. At the same time, coordination within the Commission regarding the implementation of the Action Plan can be improved, among others by setting clearer priorities and by improving the communication on EU drug policy objectives across policy fields.
Proposed action according option 1
As there is no guiding Action Plan and the Drugs, Commission coordination is limited to possible tasks identified through the Drugs Strategy, which have no operational character
Proposed action according option 2
Commission coordination in the field of drugs is not specifically addressed in the current Action Plan 2005-2008.
Proposed action according option 3.2
The Commission will ensure coherence between the internal and external aspects of its involvement in drug policy, including the management of relevant funding mechanisms.
Motivation: The evaluation has showed that the coordination of drug policy within Commission services needs further clarification, clearer prioritisation and task-division. This includes the input of drug issues into annual work planning of the existing available funding programmes.

Example: Conclusion from the evaluation
Annually, a rich body of monitoring information and situation reports are published on the drug situation. However, the utilisation of these reports by EU policymakers, linking the phenomena described in them for further policy analysis needs improvement.
Proposed action according option 1
Monitoring reports of e.g. EMCDDA and Europol will continue to be published as these are based on specific founding regulations. However, the Commission will not produce progress reviews under this option.
Proposed action according option 2
The current Action Plan only refers to the general role of the Council to implement the Action Plan. This problem focuses on an annual reporting and reflection cycle, which is not explicitly foreseen in the current EU Drugs Action Plan. The publication of Commissions Annual Progress Reviews and EMCDDA/ Europol monitoring reports is foreseen in objectives 40 and 45 of the current Action Plan.
Proposed action according option 3.2
The Council to critically examine the state-of-the-drug problem once a year, on the basis of the relevant annual reports from EMCDDA, EUROPOL, EUROJUST and the annual review of the Commission
Motivation: So far, the EMCDDA annual report is primarily presented in the European Parliament, the Commission annual progress review in the Horizontal Drugs Group in the Council and Europol's Organised Crime Threat Analyses on drugs in the Police Chiefs Task Force in the Council. A more comprehensive discussion, bringing together trends in demand and supply reduction can strengthen the analytical work in the HDG.

3.2.2. Specific Objective Drug Demand Reduction

In the policy field of drug demand reduction, the Strategy aims for the following identifiable result by 2012: *"**A measurable reduction of the use of drugs, of dependence and of drug-related health and social risks**[36]"*.

[36] EU Drug Strategy (2005-2012); § 3, article 22.

Example: Conclusion from the evaluation
Member States have invested in universal, selective and indicated prevention programmes across the board, but the evidence-base underpinning these programmes is still weak as they are seldom evaluated. Only a few Member States have introduced general quality guidelines for prevention.
Proposed action according option 1
No further impetus is given in the field of drug demand reduction. The establishment of quality standards is not mentioned as such in the Strategy and will therefore not be further encouraged.
Proposed action according option 2
The current Action Plan calls for the implementation of effective prevention programmes at MS level. However, indicators are geared towards measuring outputs while this info is not available. Objectives 7, 8, 9 and 10 of the current Action Plan call upon Member States to improve the availability, accessibility, coverage and effectiveness of prevention activities, but do not call for the establishment of quality standards.
Proposed action according option 3.2
Develop and implement at national level quality standards for prevention, treatment, harm reduction and rehabilitation
Motivation: In recent years, Member States have been encouraged to implement prevention programmes where these did not exist. However, effective prevention programmes are based on evaluation and specific quality criteria derived from research. As it is impossible to assess the availability of effective programmes in schools and other settings in Member States, it is more efficient to assess whether Member States have set quality standards, which elements are part of these standards and how these are implemented (e.g. as funding condition).

Example: Conclusion from the evaluation
The provision of continued and equal care for inmates in prison as compared to care available in society in general is of great importance to reduce drug-related harms. The infection rates for drug-related infectious diseases as well as the mortality rates for drug-related deaths are considerably higher inside prison (and immediately after release from prison).
Proposed action according option 1
Harm reduction and health care for people in prisons is not specifically covered by the Drugs Strategy. No further steps will be undertaken other than potential – ad-hoc – follows ups related to the 2003 Council Recommendation (2003/488/EC).
Proposed action according option 2
The health situation in prisons is indirectly covered in the current action plan through the implementation of the Council Recommendation from 2003 (2003/488/EC). The current Action Plan places specific emphasis for additional focus on the drug-related health situation in prisons (objective 13). However, the implementation of the Action Plan in the past 3 years shows that more specific activities are required which are not specified in the plan..

Proposed action according option 3.2
Develop prevention, treatment, harm reduction and reintegration services for people in or released from prison. Develop methods to monitor/ analyse prison drug use and service delivery, in line with the Council Recommendation on the prevention and reduction of health related harm associated with drug dependence.
Motivation: Prisons remain among the most important settings where drug-related infectious diseases but also drug-related deaths occur, despite existing evidence and best-practices to avoid them. As over 600.000 people are detained in a prison every year, the great majority for a relatively short period of time, the risk of infection for society outside prison is an important cause for concern. Furthermore, the fundamental right of inmates to health care facilities and treatment are concerned here as well.

3.2.3. Specific Objective Drug Supply Reduction

In the policy field of drug supply reduction, the Strategy aims for the following identifiable result by 2012: ***"A measurable improvement in the effectiveness, efficiency and knowledge base of law enforcement interventions and actions by the EU and its Member States targeting production, trafficking of drugs, the diversion of precursor, including the diversion of synthetic drug precursors imported into the EU, drug trafficking and the financing of terrorism, money laundering in relation to drug crime.[37] "***.

Example: Conclusion from the evaluation
The results of various operational and intelligence law enforcement cross-border projects in the EU, e.g. MAOC-N, show the importance of strengthening intelligence gathering and sharing as a basis for enhanced intelligence led law enforcement along air, sea and land vectors.
Proposed action according option 1
The possibility exists that Member States set up collaborative platforms, but the involvement of EU structures is not arranged and therefore not required, with potential adverse consequences on coordination and cooperation in the field of intelligence sharing.
Proposed action according option 2
The current Action Plan allows for cooperation between Member States on the basis of existing instruments (objective 18). In recent years a number of Member States have taken the initiative to set up long-lasting collaborations to tackle emerging trends in drug trafficking. However, as the current plan provides no guidance on the interaction between MS and EU level as well as towards the role of EU structures such as Europol in these initiatives, fragmentation of intelligence collection and sharing continues to pose a potential risk to success and efficacy.

[37] EU Drug Strategy (2005-2012); § 4, article 26.

Proposed action according option 3.2
To set up, where necessary, regional security platforms to counter emerging threats by means of coordinated operational responses. Such action to be compatible with existing operational arrangements at EU level and based on specific threat assessments, using existing resources where possible (e.g. MAOC-N, Baltic Sea Task Force, etc.).
Motivation: Diverging trends in drug trafficking routes make a swift response to new threats essential, so that preventive measures to pro-actively handle risks and the minimisation of threats can be put in place. The focus on making use of existing operational arrangements at EU level is key to avoid an emerging spectrum of individual initiatives from several Member States that do not fit in with intelligence sharing practices, jeopardising the exchange of information between initiatives and this rendering these initiatives less effective.

Example: Conclusion from the evaluation
In almost all Member States, there is a lack of priority among national Customs organisations when drug precursor control is concerned.
Proposed action according option 1
The existing precursor legislation remains unchanged, but the prioritisation at Strategic level among Customs organisations is not a specific aim in this legislation or in the Drugs Strategy. The status-quo will continue.
Proposed action according option 2
The current Action Plan calls upon Member States to strengthen drug precursor controls at their borders (objective 21), however, the Plan does not give details at which level specifically initiatives need to be taken.
Proposed action according option 3.2
Effective and uniform external border control management. Customs services to integrate precursor controls at a strategic level and to coordinate more closely with other law enforcement agencies engaged in anti-drug operations (mutual support).
Motivation: The conclusion was partly based on a Commission survey in 2007, identifying a lack of political priority setting in drug precursor control at strategic level within Customs organisations. Without such a strategic notion, a coherent drug precursor control on external EU borders is not feasible.

3.2.4. Specific Objective International Cooperation

Regarding the cross-cutting theme of International Cooperation, the Strategy aims for the following result by 2012: ***"A measurable improvement in effective and more visible coordination between Member States and between them and the Commission in promoting and furthering a balanced approach to the drugs and precursor problem in dealings with international organisations, in international fora and with third countries[38]".***

Example: Conclusion from the evaluation
The priorities of EU drug policy are not well translated into external funding programmes and projects in third countries
Proposed action according option 1
Without specific priorities for external agreements coherence will be difficult to achieve.
Proposed action according option 2
The current Action Plan already asked for the integration of the balanced approach in external agreements and programmes (objective 5). This objective needs to be reiterated and formalised
Proposed action according option 3.2
Ensure the integration of projects in the drugs field into the EU's cooperation and assistance programmes with third countries/ regions. This should cover demand and supply reduction, as well as alternative development in producer and transit countries.

[38] EU Drug Strategy (2005-2012); § 4, article 28.

Motivation: EU assistance to third countries has been increasingly decentralised and a direct translation of the horizontal policy aspects in EU drug policy is not automatically translated into funding priorities. As the EU Action Plan on Drugs does not have its own budgetary resources, a proper translation of its objectives into existing funding sources is essential for implementation.

Example: Conclusion from the evaluation
The EU integrated and balanced approach on drugs has served as a model for Candidate Countries as well as many Neighbourhood Policy Countries in developing their national drug strategies and action plans.
Proposed action according option 1
As the funding programmes exist independently from the Action Plans, project funding in the field of drugs may continue, but coherence and integration of policy issues in funding will be extremely difficult due to a lack of a coordination mechanism and due to a lack of priorities.
Proposed action according option 2
The current Action Plan already asked for a coherent approach, linking EU drug policy to EU funding mechanisms towards third countries (objective 35). This objective needs to be reiterated and strengthened through the Commission's coordination mechanism as mentioned under section coordination.
Proposed action according option 3.2
Further develop regional cooperation initiatives and assistance programs to address demand and supply reduction to be strengthen with countries covered by Development Cooperation Instruments (DCI) and European Development Fund (EDF), with a particular attention to new regions that are in the front line, such as in Africa and in Asia.
Motivation: Continue support to these countries by providing technical and other assistance for their alignment with and implementation of the EU acquis.

3.2.5. Information, research and evaluation

Regarding the cross-cutting theme of information and research, the Strategy aims for the following result by 2012: ***"A better understanding of the drugs problem and the development of an optimal response to it through a measurable and sustainable improvement in the knowledge base and knowledge infrastructure[39]"***.

Regarding the cross-cutting theme of evaluation, the Strategy aims for the following result by 2012: ***"To give clear indications about the merits and shortcoming of current actions and activities on EU level, evaluation should continue to be an integral part of an EU approach to drugs policy[40]".***

[39] EU Drug Strategy (2005-2012); § 6, article 31.

[40] EU Drug Strategy (2005-2012); § 6, article 32.

Example: Conclusion from the evaluation
Diminishing support from national governments to National Focal Points is an increasing cause for concern. National Focal Points are an essential part of the information infrastructure of the EMCDDA.
Proposed action according option 1
Without an EU Action Plan, the EMCDDA will continue to collect data on key indicators. However, no new or additional policy relevant information is identified that could feed into the EU policy process. A framework for the utilisation of monitoring data will not be available.
Proposed action according option 2
This is primarily a political objective, reiterating the importance of data collection at national level. The current Action Plan calls upon on the EMCDDA to produce timely and accurate data on the drug situation (objectives 39, 40); however, the indispensible support of Member States to National Focal Points is not stressed.
Proposed action according option 3.2
Member States to continue to support the EMCDDA Reitox National Focal Points
Motivation: National Focal Points report national data to the EMCDDA. Without the data from all Member states, an EU wide standardised comparison and trend analysis is virtually impossible. The evaluation report showed that two Member States have stopped national funding of their NFP's. Other Member States have reduced funding in recent years (or not adjusted to inflation). The result is that the Reitox network becomes more vulnerable and ultimately, EU wide monitoring of the drug situation is placed at risk.

Example: Conclusion from the evaluation
The availability of reliable, comparable and usable information and data in the field of drug supply and supply reduction is an ongoing cause of concern, as the lack of it does not allow for a proper analysis of the EU drug market and the effectiveness of law enforcement interventions.
Proposed action according option 1
This objective will not be achieved due to a lack of agreement and prioritisation. The status quo will continue.
Proposed action according option 2
Strengthening information and data collection in the field of supply reduction is not and objective in the current Action Plan and therefore the status quo would continue to exist.
Proposed action according option 3.2
Development of policy relevant data on the illicit drug market, supply reduction and law enforcement and the structures required for their collection.
Motivation: As the annual reviews and the evaluation report show, the data collection in the field of supply reduction is often incomplete, not standardised and difficult to compare. No key indicators have been identified. Without improved data on supply reduction, the Drug Strategy objectives of attaining 'measurable reductions in drug supply to the EU' cannot be assessed due to a lack of data.

4. IDENTIFICATION AND ASSESSMENT OF POLICY OPTIONS

The European Commission has **the following options** at its disposal when determining the need for policy development in the field of drug policy. These options are:

Option 1	Do nothing. No new Action Plan is proposed (baseline scenario)
Option 2	The EU Action Plan on Drugs (2005-2008) is renewed for another four year period
Option 3	A new EU Action Plan on Drugs (2009-2012) is presented
	3.1 An EU Action Plan on Drugs (2009-2012) is presented that is limited to the Commission competences in the field of drugs
	3.2 A detailed EU Action Plan on Drugs (2009-2012) is presented, covering operational objectives and actions for EU and Member State level
	3.3 A Binding EU Action Plan on Drugs (2009-2012) is proposed
Option 4	Spend EU resources

For this impact assessment, **option 3.1** is not explored further, since it is inconsistent with clear objectives on coordination as presented in the EU Drugs Strategy (2005-2012). **Option 3.3** on a binding EU action plan (i.e. through legislation) is also not explored further, as there is no specific legal base for the Commission to propose an EU Action Plan on Drugs that would be legally binding on the Member States and constitute 'de jure' common drugs policy in the EU. Member States remain the main actors in the drugs field with the Community having a competence in money laundering and precursors and complementing competence in some other areas.

The current EU Action Plan on Drugs (2005-2008) does make reference to existing legal instruments such as Council Decisions and Council Framework Decisions and promotes the development of a Council Recommendation on drug services in custodial settings. Possible future legislative proposals have not been included in the EU Action Plan on Drugs as each of them will be subject to a separate impact assessment.

Option 4 of **spending EU resources** is also ruled out as there is no specific budget line committed to the implementation of the EU Drug Strategy and its Action Plans on Drugs. A specific budget-line for this purpose – if it is to have any impact – would involve extensive financial resources. As section 2.3 shows, the direct annual spending of Member State in tackling the drug problem at national level is estimated at app. EUR 13 to 36 billion. Nonetheless there are several EU funding instruments available which support the objectives of the EU Drugs Strategy of which one programme *explicitly* aims to support the implementation of the EU Drugs Strategy (2005-2012) and the activities of the EU Action Plan. The Commission funding in these cases is mostly limited to the funding of innovation and the exchange of best-practices.

With a total budget of EUR 21.35 million, the objectives of the **Drug Prevention and Information Programme 2007-2013 a**re to prevent and reduce drug use, dependence and

drug-related harms; to contribute to the improvement of information on drug use; and to support the work on the EU Drugs Strategy (2005-2012). The programme highlights under its specific objective *"monitor, implement and evaluate the implementation and development of the EU Drugs Strategy and EU Action Plans (2005-2008) and (2009-2012)"*[41] .

Other budgetary resources are available that can be *indirectly* used to fund specific elements of the EU Drugs Strategy and EU Action Plans on Drugs, especially in the field of public health and in the relations with Candidate, Associated and third countries[42].

The introduction – under this option – of a specific EU budget-line for the implementation of the EU Drug Strategy and/ or its Action Plans would require considerably higher resources and a specific legal basis and is highly unlikely during the remaining implementation period of the EU Drug Strategy.

The remaining **alternative options** are being explored further in this impact assessment and will be compared with option one – do nothing, considered here as the baseline scenario.

41 OJ L 257, 3.10.2007, Art. 3c; Specific Programme on 'Drug Prevention and Information' (2007-2013), as part of the General Programme 'Fundamental Rights and Justice'

42 Funding for drug-related activities is furthermore available through the Programme for the Prevention of and Fight against Crime (2007-2013), the Public Health Programme (2008-2013), the European Neighbourhood Policy Instrument (2007-2013), the European Development Fund (2008-2013), the Development Cooperation Instrument (2007-2013), the 7th Research Framework Programme (2007-2013) and the Stability Instrument (2007-2013).

Option 1 Do nothing. No new Action Plan is proposed (baseline scenario)

According to this option, no Action Plan for the implementation of the latter half of the EU Drugs Strategy (2005-2012) is proposed. The Strategy will continue to provide a general framework for drug related activities in the EU but no operational objectives or actions are identified, no indicators for implementation are developed and no deadlines for actions are set. The responsible partners for achieving the targets set in the Strategy are not specified on a more detailed level than is already done in the Strategy.

The EU Drug Strategy becomes a 'declaration of intent' rather than a 'Strategy' and as a result, actions in the field of drugs are left almost exclusively to the Member States. The Commission will continue to work with precursors and money laundering in accordance with its legal mandate and complement Member States' actions in the field of public health and in justice and home affairs.

Member States will continue to coordinate their policies in the Horizontal Drugs Group of the Council within the framework provided by the EU Drugs Strategy and actions needed for its implementation are discussed on an ad hoc basis and probably in the form of informal 'progress reviews' by each Presidency to which the Commission is likely to be asked to 'contribute' as it does for similar Presidency reports.

The Commission, Europol and the EMCDDA will continue working with their respective mandates. Different Community Programs continue to complement Member States activities in the drugs field, in particular in research and prevention according to the program guidelines and annual work programs discussed according to the comitology procedure. Member States will revert to acting more individually in international fora, especially in more sensitive policy areas where the Strategy is not explicit.

Option 2 The EU Action Plan on Drugs (2005-2008) is renewed for another four year period

This option includes that the EU Action Plan on Drugs (2005-2008)[43] will be renewed. Ongoing actions will be continued. Completed actions will be removed.

The EU Action Plan on Drugs (2005-2008) is considered to be a 'living' document' in the sense that those operational objectives or actions that are no longer considered relevant or that have been completed can be removed upon recommendation from the Commission's annual progress review.

The EU Action Plan on Drugs (2005-2008) includes assessment tools and indicators for measuring the implementation of each action. Developing measurable indicators for some of the objectives of the Action Plan has been very difficult and according to the final evaluation of the current Action Plan problems remain, previously already highlighted in the annual Progress Reviews.

The EU Action Plan on Drugs (2005-2008) is not a legally binding document but having been unanimously approved by the European Council, it does provide the framework for all drug related activities in the EU. As the subsidiarity test clarified, it has added value for Member

[43] See Annex 3 for an overview of objectives

States and it functions as a model for e.g. the Candidate Countries and the Neighbourhood Policy Countries in developing their national strategies and action plans.

Option 3.2 A new EU Action Plan on Drugs (2009-2012) is presented

This option builds on the main lessons from the final evaluation of the EU Action Plan (2005-2008) as requested in the EU Drugs Strategy (2005-2012). No new budgetary resources are foreseen for the new Action Plan.

The evaluation has provided some important elements for this policy option which aims to provide guidance for EU and Member State level. As the overarching specific objectives from the EU Drug Strategy (2005-2012) continue for another four years, quite a few of the operational objectives of the EU Action Plan on Drugs (2005-2008) as presented in *Table 1.1* will return in the new Action Plan, possibly in a revised and reworded format. In Annex 4, a provisional overview is presented of reformulated operational objectives for a new comprehensive Action Plan foreseen in this option.

The evaluation revealed that there is a certain level of overlap between specific objectives and actions in the EU Action Plan on Drugs (2005-2008) and some actions are too detailed or not detailed enough for implementation, while others did not seem to contribute enough to the specific objectives in the Strategy. Furthermore, certain indicators and assessment tools as presented in the current Action Plan need to be corrected or adapted. Operational objectives will be revised accordingly. Most changes in the actual plan as pursued in this option will concern the specific actions. Any new operational objectives and actions will 'screened' against the criteria for objectives and actions[44] as identified in the EU Drug Strategy (2005-2012).

A proposal for a new and detailed EU Action Plan on Drugs (2009-2012) for both EU and Member State will take on board evaluation findings and can adapt to the most recent changes in the drug situation and the most recent insights in the responses to it.

[44] Criteria include: actions must offer EU added value and be measurable and realistic, include a clear timeframe and reference to a responsible party, must contribute directly to the achievement of the Strategy goals & priorities, be cost-effective. Finally, the number of actions should be limited.

5. ANALYSIS OF IMPACTS

As for most complex social problems, government interventions require a long-term planning, investment and implementation. It is very difficult, if not impossible, to establish the direct impact of any particular policy option on the drug situation. External factors other than drug policies, such as economic and social change, the level of employment or changes in the youth culture clearly also have a major impact.

The International Drug Conventions limit the use of drugs to scientific and medical purposes.. There is a substantial law enforcement mechanism to control the supply of drugs (production, trade and trafficking). The evaluation of the current Action Plan shows that the indicators developed so far on the supply side mainly provide information on the output of operations (e.g. drug seizures, number of operations) but little on the impact on the drug situation, in particular the availability of drugs. Under the new Action Plan, shared EU indicators and parameters will need to be developed to improve the monitoring of law enforcement interventions.

Given the complexity of conceiving an impact evaluation of drug policies at the European level and the difficulties of estimating drug related expenses and of cost benefit analysis of drug related actions at any level, it is currently not possible to make more than an educated guess of the monetary impact in this field.

A comprehensive Action Plan – when implemented - will ideally have impact on the amelioration of the many areas in society affected by the drug problem and on the policies dealing with them. These areas cover the security of the citizen in its widest sense: public health and social wellbeing, security, safety and public order, economic and social costs, fundamental rights and environmental impacts. Annex 5 includes the tables with the potential impacts of the three policy options.

Table A5.1 is the baseline scenario. Tables A5.2 and A5.4 reflect the impacts of the alternative options. Tables A5.3 and A5.5 include an assessment of strengths, weaknesses, opportunities and threats of the two alternative options 2 and 3.2. The rating of impacts is done against the baseline scenario ('0' impact).

The overall rating per impact has been done taking into account the impacts of the whole Action Plan and not the specific objectives used as an example in Chapter 3. The ratings in the 'relevance sections' in tables A4.1, A4.2 and A4.4 reflect the relevance of the options in addressing the problems identified by means of example in Section 3.

The rating exercise shows that option 3.2 scores the more positively when compared to option 2 and especially when compared to option 1.

6. COMPARING THE OPTIONS

Due to the presence of an overarching and continuing EU Drug Strategy (2005-2012), none of the options presented will lead to major policy shifts. However, as the overview of impacts shows, the EU Action Plan on Drugs (2005-2008) and a potential new EU Action Plan on Drugs (2009-2012) have the function of translating the objectives and priorities of the Drug Strategy so that these can be implemented.

Table 6.1 presents the rating of the four different policy options for which impacts have been identified in section 5. As indicated above, it is very difficult to assess impacts of a broad action plan that aims to influence a very broad range of government activities and activities in civil society. The comparison between option 1 and option 2, and between option 1 and option 3.2 is therefore somewhat artificial. Again, the Action Plan is a non-binding coordination instrument! Therefore impacts depend on the extent of transposition and adaptation by Member States of the objectives in the plan. This can not be pre-assessed. The Action Plan in option 3.2 places more emphasis on coordinative instruments and indicators through which compliance and progress become better measurable. Overall, the expectation is that by building on the lessons of the first Action Plan (option 2), a new Action Plan (option 3.2) will have greater impact in specific areas. But both option 2 and 3.2 are strongly preferred when compared to the baseline.

Table 6.1 Comparison table policy impacts

	Option 1	**Option 2**	**Option 3.2**
Impact	**Rating**	**Rating**	**Rating**
Health impact	0	++	+++
Security impact	0	++	+++
Other social impacts	0	+	++
Fundamental rights impact	0	+	++
Environmental impact	0	+	+
Economic impact	0	0	0
Social costs	0	+	+
Impact on (informal) political influence of Commission in drug policy	0	+	++
Impact on EU coordination	0	+	++
Impact on third countries and organisations	0	++	++
Relevance			
Coordination	0	+	++
Demand reduction	0	++	+++
Supply reduction	0	++	+++
International cooperation	0	0	+
Information, research, evaluation	0	+	++

The EU Drug Strategy (2005-2012) clearly states that the Commission is asked to present two consecutive EU Action Plans on Drugs with the aim to translate and implement the specific objectives of the Strategy.

All proposed policy options have something positive to offer in terms of impact but the evaluation of the current Action Plan clearly shows that Member States recognise the added value of an EU level Action Plan. **Option 1** would, in effect, represent a step backwards and one that is not supported by the main stakeholders, namely the Member States and by secondary stakeholders such as civil society. In fact, a failure of the Commission to come up with a proposal for a full fledged new Action Plan will lead to a proposal from the Presidency reflecting - at least in part - priorities, which in turn may jeopardise the consensus on and convergence of policies noted by the evaluation(s).

The evaluation of the current Action Plan also clearly shows that there is a need for a more concise, prioritised Action Plan that takes on board new insights and challenges that have emerged and that ask for a rethinking and especially rewording of the existing EU Action Plan on Drugs. This is one of the reasons why **option 2** is not recommendable.

A new EU Action Plan on Drugs (2009-2012) as presented in **option 3** will allow the EU and Member States the broadest and most efficient instrument to implement the Strategy. It should consolidate the balanced and integrated approach as a European drug policy model and develop the knowledge and evidence base to support the policy and be open to adjustments, when necessary and justified. **Option 3** is therefore the preferred option.

7. MONITORING AND EVALUATION

An action plan is a tool for turning a strategy into concrete, measurable actions and objectives. The progress reviews and evaluation on the EU Action Plan on Drugs (2005-2008) showed clearly that it is not always possible to identify causal relationships between policy actions and interventions in practice, let alone on the drug situation.

Despite all the difficulties in defining the impact and as already indicated in the current Action Plan, the ultimate goal of the Strategy and Action Plans by 2012 should be a measurable reduction of drug related problems in our societies. Much of this can be measured with already existing epidemiological indicators, including the five EMCDDA key epidemiological indicators, or with their slight improvement. Key impacts would then be:

- Reduction in the availability of illicit drugs at the local level and of drug related nuisance and increased feeling of security of EU citizens[45]

- Reduction on the prevalence of drug use, in particular problematic use and of drug related deaths.

- Reduction of the spread of drug related infectious diseases[46]

- Increase of the age of onset of first drug use[47].

Even if indicators and assessment tools in many cases, in the case of the current Action Plan, have turned out to measure mainly progress made, the work done so far in elaborating and refining them will continue with the assistance of the EMCDDA and Europol. Indicators will be developed in such a way that information and data needed for the evaluation of the proposed Action Plan will mostly be collected as part of the standardized information collection process and less questionnaires would be used.

The Action Plan will continue to seek to provide for each action an indicator, a timeframe and assign the responsible parties for its implementation. The Commission will continue to prepare annual Progress Reviews and present these to the Horizontal Drugs Group and to the European Parliament[48]. The Commission will carry out an overall evaluation of the Action Plan and the EU Drugs Strategy in 2012.

The EMCDDA and Europol will continue producing Annual Reports on the state of the drugs problem for their areas of competence. An important part of evaluation and monitoring will be to develop indicators for the supply side that measure the impact especially on the availability of drugs but also on the level of drug related crime, illicit trade in precursors and money laundering.

---

45 To be measured using Eurostat Crime data (e.g. victimisation survey – under development)

46 In coherence with policy of combating HIV/AIDS; See Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009, COM/2005/0654 final

47 To be measured using HBSC and ESPAD data and other surveys available through the EMCDDA

48 A new practise in line with the Lisbon Treaty on enhancing the role of the European Parliament

By the end of 2008, the Commission will publish the results of a major study[49] into the evolution of the global drug problem and the characteristics of the global illicit drug market. It should help to provide tools for developing policy impact indicators for the evaluation of the Strategy in 2012.

Evidence based policy can only be established as a result of a long process including continuous evaluation but a major impact of the new Action Plan would be to further develop the evidence base for the future Strategy.

[49] http://ec.europa.eu/justice_home/funding/tenders/funding_calls_en.htm

Annex 1 - Logical Framework model

Intervention logic	**Objectively Verifiable Indicators**	**Means of verification/ assessment tools**	**Assumptions, risks & conditions**
Global objectives of the EU Drug Strategy 2005-2012 *(long-term **impact**)*	*Measures (direct or indirect) to prove the **extent to which the overall objectives are fulfilled***	*Data sources and methods used to **show fulfillment** of overall objectives*	
Identifiable result per strategy policy field *(envisaged **outcome** of the policy)*	*Measures (direct or indirect) to verify **to what extent the policy result is achieved***	*Information sources and methods used to **show achievement** of strategy goal*	*Conditions, events & decisions beyond the policies control relevant to the achievement of goal*
Specific objectives/ strategy priorities	*Measures (direct or indirect) to verify **to what extent objectives are achieved***	*Information sources and methods used to **show achievement** of specific objectives*	*Conditions, events & decisions beyond the policies control key to achievement of result*
Operational objectives in Action Plan *(building blocks for results)*	*Measures (direct or indirect) to verify **to what extent the priorities have been realised***	*Information sources and methods used to **show realisation** of priorities*	*Conditions, events & decisions beyond the policies control key to realisation of priorities*
Actions	*Measures (direct or indirect) to **show realisation of actions***	*Information sources and methods used to **show delivery** of outputs*	*Conditions, events & decisions beyond the policies control key to realisation of outputs*
Policy inputs	**Instruments to implement the policy, e.g.:** **Type and level of resources needed to implement the actions** **Budget** **Time** **Legislation** **Actors and stakeholders**		

Annex 2 – Stakeholder consultation reference documents

As explained in section 1.3, a wide range of stakeholders have been consulted in preparation of the evaluation of the EU Drugs Action Plan (2005-2008) and this Impact Assessment. Underneath a range of reference documents is provided, relevant for the consultation process.

Horizontal Working Party on Drugs (2007-2008) – relevant documents

- Council Conclusions on the 2006 Progress Review on the Implementation of the EU Drugs Action Plan (2005-2008); *10301/07 CORDROGUE 32, 4.6.2007*
- Reducing the production and cross-border trafficking of heroin, cocaine and cannabis (action 19 of the EU Drugs Action Plan (2005-2008); Conclusions on the thematic debate within the meeting of 20 June 2007; *12540/07 CORDROGUE 58, 3.9.2007*
- Conference on Evaluation of Public Policies and Programmes on Drugs, 19 and 20 September, Lisbon, Portugal – Conclusions of the Presidency; *13493/07 CORDROGUE 70, 4.10.2007*
- Conclusions by the Presidency on the Thematic debate of 11 July 2007 – Cooperation with West Africa in the field of Drugs (actions 35 and 36.4 of the EU Drugs Action Plan (2005-2008)); *13620/07 CORDROGUE 71, 8.10.2007*
- Council Conclusions on drug trafficking along the cocaine route; *15483/07 CORDROGUE 82, 20.11.2007*
- Conclusions of the thematic debate - Interventions in prisons: the role of harm reduction measures (actions 13.2 and 15 of the EU Drugs Action Plan (2005-2008)); *5609/08 CORDROGUE 13, 23.01.2008*
- Conclusions of the thematic debate - Information exchange mechanisms in the field of drugs (actions 18.1 and 19 of the EU Drugs Action Plan (2005-2008); *5641/08 CORDROGUE 15, 23.1.2008*
- Conclusions of the thematic debate – Preventing the Distribution of Drugs at Street Level (action 25.2 of the EU Drugs Action Plan (2005-2008)); *5615/08 CORDROGUE 14, 23.1.2008*
- Conclusions on Afghanistan; 8273/1/08 CORDROGUE 33, 11.4.2008

InterService Steering Group on the Impact Assessment for a new EU Drugs Action Plan (2009-2012)

- Report of the meeting of 26 Febr/uary 2008/
- Report of the meeting of 31 March 2008
- Report of the meeting of 19 May 2008

Steering Group for the Evaluation of the EU Drugs Action Plan (2005-2012)

- Terms of reference
- Report of the Steering Group meeting of 14 February 2007
- Report of the Steering Group meeting of 17 January 2008

Civil Society Forum on Drugs in the European Union

- Final Report of the meeting on 13 and 14 December 2007
- Final Report of the meeting on 20 and 21 May 2008

Europol/ EMCDDA

- Several technical reports, Annual Reports, contributions to the evaluation and impact assessment

Annex 3 – The EU Drugs Action Plan (2005-2008)

As the first Action Plan to implement the objectives and priorities of the EU Drugs Strategy (2005-2008) in practice, the EU Drugs Action Plan (2005-2008) is the most detailed in this field to date at EU level, covering the full range of EU drug policy and unanimously endorsed by the Council, reflecting the broad consensus between Member States on this issue. The Action Plan proposes policy action at national, EU and international level and asks for the commitment of the 27 Member States to work more closely together, to share information and best-practices, to jointly promote the EU model in drugs policy and to base drug policy on scientific facts and evidence.

A global overview of the structure and key objectives in the EU Drugs Action Plan (2005-2008) can be found in *Table 1*. The EU Drugs Strategy (2005-2012), as an overarching and balanced coordination document for EU drug policy, reflecting concerns, priorities and consensus of 27 Member States, has been translated into a large number of objectives (46) and actions (86) in the current Action Plan.

Table 1- Schematic overview of objectives in EU Drugs Action Plan (2005-2008)

<table>
<tr><th colspan="2">Coordination</th></tr>
<tr><td colspan="2">(1) MS adopting national strategies and action plans in line with the EU Drug Strategy/ Action Plan to ensure the integrated, balanced approach in drug policy
(2) Coordination at national and EU level
(3) Strengthen involvement of civil society
(4, 6) Effective coordination in the Council
(5) Systematic mainstreaming of drugs policy in relations and agreements with 3rd countries</td></tr>
<tr><th>Drug Demand Reduction</th><th>Drug Supply Reduction & security</th></tr>
<tr><td>(7) Encouraging improvement of coverage of, access to and effectiveness of demand reduction measures in Member States
(8-10) Encouraging implementation of prevention in Member States (universal, selective, indicative, early detection)
(11-12) Encouraging improvement and implementation of treatment and rehabilitation in Member States (early intervention, brief treatment, long-term treatment, etc.)
(13) Encouraging development of alternatives to imprisonment and of drug services in prisons in Member States
(14-17) Encouraging implementation of harm reduction in Member States (reducing drug related deaths, drug-related infectious diseases)</td><td>(18) Improve law enforcement cooperation between Member States, Europol, Eurojust, third countries and international organisations
(19) Reducing production and cross border trafficking of heroin, cocaine and cannabis
(20) Reducing the manufacture and supply of synthetic drugs (ATS)
(21) Combat serious criminal activity in chemical precursors diversion and smuggling through law enforcement cooperation between Member States, Europol, Eurojust, third countries and international organisations
(22) Preventing the diversion of precursors, in particular synthetic precursors imported into the EU
(23) Reducing money laundering and increasing the seizure of accumulated assets in relation to drug crime
(24) Exploring links between drug production and trafficking and the financing of terrorism
(25-26) Improving the prevention of drug-related crime and developments of new methods and best practices to curtail it
(27) Increasing training for law enforcement agencies</td></tr>
<tr><th colspan="2">International Cooperation</th></tr>
<tr><td colspan="2">(28, 31) Adopting EU common positions on drugs in international for a, including on UNGASS
(29) Articulation and promotion of the EU approach on drugs
(30) Bringing forward joint EU resolutions and co-sponsor others
(32) Support the candidate and stabilisation and association process countries
(33) Enable candidate countries to participate in the work of EMCDDA, Europol and Eurojust
(34) Assist European neighbours
(35) Ensure that drugs concerns are taken on board in priority setting of EU versus 3rd countries/ regions and continue and develop an active engagement with them
(36) Intensify law enforcement efforts directed at non-EU countries, especially producer countries and regions along trafficking routes
(37) Continue to develop an active political engagement by the EU with third countries
(38) Improve the coherence, visibility and efficiency of the assistance to candidate countries and 3rd countries/ regions</td></tr>
<tr><th colspan="2">Information, evaluation and research</th></tr>
<tr><td colspan="2">(39) Provide reliable and comparable data on key epidemiological indicators
(40) Provide reliable information on the drug situation
(41) Develop clear information on emerging trends and patterns of drug use and drug markets
(42) Produce estimates on public expenditures on drug issues
(43, 44) Promote research in the field of drugs and create networks of excellence in research
(45) Continuous and overall evaluation
(46) Follow up of the mutual evaluation of drug law enforcement systems in the Member States</td></tr>
</table>

8. ANNEX 4 – PROVISIONAL OVERVIEW AGGREGATED OBJECTIVES ACTION PLAN (2009-2012)

<table>
<tr><th colspan="2">Coordination (provisional)</th></tr>
<tr><td colspan="2">(1) Ensure that a balanced and integrated approach, with due regard for fundamental rights, is reflected in national policies and in the EU approach towards 3rd countries and in international fora
(2) Ensuring effective coordination at EU level
(3) Ensuring effective coordination at national level
(4) Ensure the participation of civil society in drug policy</td></tr>
<tr><th>Drug Demand Reduction</th><th>Drug Supply Reduction & security</th></tr>
<tr><td>(5) Prevent the use of drugs and the risks associated with it
(6) Prevent problem use of drugs - including injecting drug use - through targeted prevention
(7) Enhance the effectiveness of drug treatment and rehabilitation by improving the availability, accessibility and quality of services
(8) Enhance quality and effectiveness of drug demand reduction activities, taking account of specific needs of drug users according to e.g. gender, cultural background, age, etc.
(9) Ensure health care to drug users in prison to prevent and reduce health-harms associated with drug use
(10) Ensure access to harm reduction services, in order to reduce the spread of HIV/ AIDS, hepatitis C and other drug-related blood-borne infectious diseases and to reduce the number drug-related deaths in the EU</td><td>(11) Enhance effective law enforcement cooperation in the EU to counter drug production and trafficking
(12) To respond rapidly and effectively to emerging threats
(13) To reduce the manufacture and supply of synthetic drugs
(14) Reduce the diversion and trafficking in the EU of chemical precursors used for the manufacturing of illicit drugs, in particular synthetic drug precursors
(15) To reduce the impact on society of organised crime active in drug production and trafficking</td></tr>
<tr><th colspan="2">International Cooperation</th></tr>
<tr><td colspan="2">(16) To include systematically EU drug concerns in relations with third countries where appropriate. To do so on the basis of strategic planning and coordination between all actors concerned
(17) To strengthen EU coordination in the multilateral context and promote an integrated and balanced approach
(18) Improve cooperation with Candidate, Stabilisation and Association Process and European Neighbourhood Policy countries (ENP)
(19) Improve cooperation at regional and/ or inter-regional level</td></tr>
<tr><th colspan="2">Information, evaluation and research</th></tr>
<tr><td colspan="2">(20) To expand the knowledge base in the field of drugs by promoting research
(21) To ensure the exchange of accurate and policy relevant information in the field of illicit drugs
(22) To further develop instruments to monitor the drug situation and the effectiveness of responses to it
(23) To ensure ongoing evaluation of drug policy</td></tr>
</table>

9. ANNEX 5 – IMPACT ASSESSMENT TABLES AND SWOT ANALYSIS

Underneath, the three policy options are compared, in which option 1 is the 'Do nothing' option in which no new action plan is proposed (baseline scenario), option 2 involves the extension (without modification) of the current EU Drugs Action Plan (2005-2008) and option 3.2 the option proposing a new EU Drugs Action Plan (2009-2012). The impacts of options 2 and 3.2 are always rated against the baseline scenario (option 1).

Explanation of ratings		
0	=	baseline (no change in impact)
+/-	=	small positive or negative impact compared to baseline
++/--	=	medium positive or negative impact compared to baseline
+++/---	=	big positive or negative impact compared to baseline

Table A5.1 - Impacts relative to the scenario of option 1

Option 1 – Do Nothing! No action plan proposed		
Assessment Criteria	**Rating**	**Motivation**
Impacts		
Health impact	**0**	• Member States continue to provide a high level of health protection but mutual cooperation and the sharing of best practise may be hampered by the lack of an overall policy framework and the resulting lack of priorities in the EU drug policies • The complementary nature of EU public health policies (e.g. through implementation of Community Programs) is more difficult to ensure. • No intensifying of support to reduce drug-related harms and no focus on emerging health problems such as co-occurring health problems
Security impact	**0**	• The EU Drug Strategy reflects priorities to enhance safety and security. These are not operationalised and depend completely on the question if and how MS implement them. • Without a policy and cooperation framework, Member States are not encouraged to work together to tackle cross-border trafficking
Other social impacts	**0**	• Exchange of best practice, information and data collection (e.g. on effective treatment; know-how on safe dismantling of illegal drug laboratories) increasingly difficult due to the lack of common framework
Fundamental rights impact	**0**	• Member States and the EC continue to guarantee Fundamental Rights • Social inclusion, non-discrimination, and access to treatment are defined at national level. *(comment: there are two EU Directives on non-discrimination, and also on access to services, which includes health care)*

Environmental impact	**0**	• Potential environment impacts of reducing drug production are not taken into consideration in Strategy
Economic impact	**0**	• No additional financial cost for EU budget is foreseen as existing resources are in place and will continue until 2012/2013 • Less efficient spending of EU funds may occur because of the difficulty in ensuring coherence between national and Community Programs but also due to the doubling of investments in knowledge infrastructure, in law enforcement capacity and in international assistance • No extra administrative costs for the EU or for the Member States
Social costs[50]	**0**	• Potential increase in costs (burden of crime to society) as Member States have no shared framework to tackle cross-border drug-related crime • Increased costs because of the difficulties in tackling drug related crime, in particular cross border crime • Increased costs because of the problems in controlling illegal drug trafficking, and illegal trafficking in precursors and money laundering • Increased costs because of a lack of cooperation and coordination in reducing drug-related harms with cross-border spill over effects (e.g. infectious diseases)
Impact on (informal) political influence of Commission in drug policy	**0**	• The Commission retreats from its "acquis" of proposing drug policies from a neutral and professional perspective, which has come to be accepted by the Member States. • In this option, the Commission's (informal) political influence in EU drug policy is compromised. • The participation of the Commission in the Council coordination structures will be mainly passive due to a lack of a clear working agenda. • The Commission's visibility in drugs will decline.
Impact on EU coordination	**0**	• MS policies may drift apart with potential effects for neighbouring countries • Potential diminishing attention for the need to collectively monitor the drug situation (diminishing support for EMCDDA activities)
Impact on third countries and organisations	**0**	• The impact of this policy option on third countries and organisations will be limited from the perspective of formal cooperation. • However, due to the absence of an actual policy plan that offers guidance for cooperation with third countries and organisations, the quality of cooperation will not benefit and will retain a bilateral and fragmented nature.

[50] See section 2.2.3 for an explanation of social costs in the drug field.

Relevance of the options for the achievement of the objectives		
Problem identified in evaluation		**Potential action based on this policy option**
Coordination		
The evaluation shows that the Horizontal Drugs Group is the main forum of drug coordination at EU level. The European Commission is well coordinated in the Council. At the same time, coordination within the Commission regarding the implementation of the Action Plan can be improved, among others by setting clearer priorities and by improving the communication on EU drug policy objectives across policy fields.	**0**	.
Annually, a rich body of monitoring information and situation reports are published on the drug situation. However, the utilisation of these reports by EU policymakers, linking the phenomena described in them for further policy analysis needs improvement.	**0**	.
Demand reduction		
Member States have invested in universal, selective and indicated prevention programmes across the board, but the evidence-base underpinning these programmes is still weak as they are seldom evaluated. Only a few Member States have introduced general quality guidelines for prevention.	**0**	
The provision of continued and equal care for inmates in prison as compared to care available in society in general is of great importance to reduce drug-related harms. The infection rates for drug-related infectious diseases as well as the mortality rates for drug-related deaths are considerably higher inside prison (and immediately after release from prison).	**0**	
Supply reduction		
The results of various operational and intelligence law enforcement cross-border projects in the EU, e.g. MAOC-N, show the importance of strengthening intelligence gathering and sharing as a basis for enhanced intelligence led law enforcement along air, sea and land vectors.	**0**	
In almost all Member States, there is a lack of priority among national Customs organisations when drug precursor control is concerned.	**0**	
International cooperation		
The priorities of EU drug policy are not well translated into external funding programmes and projects in third countries	**0**	
The EU integrated and balanced approach on drugs has served as a model for Candidate Countries as well as many Neighbourhood Policy Countries in developing their national drug strategies and action plans.	**0**	

Information, research, evaluation		
Diminishing support from national governments to National Focal Points is an increasing cause for concern. National Focal Points are an essential part of the information infrastructure of the EMCDDA.	**0**	
The availability of reliable, comparable and usable information and data in the field of drug supply and supply reduction is an ongoing cause of concern, as the lack of it does not allow for a proper analysis of the EU drug market and the effectiveness of law enforcement interventions.	**0**	

Table A5.2 - Impacts relative to the scenario of option 2

Option 2 – Action Plan on Drugs (2005-2008) extended with 4 years		
Assessment Criteria	**Rating**	**Motivation**
Impacts		
Health impact	++	• Overall, the measures in the current AP cover a general and broad range of drug demand reduction objectives. However, recent changes in drug use patterns are not properly addressed. • Increasing drug-related public health threat on EU's borders are not addressed(Africa, Eastern Europe) • No intensifying of support to reduce drug-related harms and no focus on emerging health problems such as co-occurring disorders
Security impact	++	• Overall, the measures in the current AP cover traditional supply reduction as a whole and will continue to do so. However, recent trends in drug-related security issues are not covered well.
Other social impacts	+	• Exchange of best practice, information and data collection difficult due to the lack of an updated common framework and priority setting • Social reintegration and rehabilitation receives no further attention in the AP and continues to be underdeveloped in Member States • The prevention of social exclusion (and poverty) among drug dependent users is addressed by the existing programmes but does not receive additional attention.
Fundamental rights impact	+	• Fundamental Rights are taken as a starting point for drug policies at the European level • Access to services is part of the Action Plan while non discrimination and social inclusion are not.
Environmental impact	+	• The current Action Plan prioritises collaboration at UN level and towards 3rd countries, allowing the EU to promote the balanced and also proportionate approach, which does not support aggressive chemical eradication policies as pursued by some 3rd countries and international organisations • Exchange of best-practice in drug-lab dismantling techniques can help identify environmental spills and/ or reduce environmental risks during operations
Economic impact	**0**	• No additional financial cost for EU budget is foreseen as existing resources are in place and will continue until 2012/2013 • No impact on Member States' budget • The are financial advantages (efficiency, effectiveness) possible due to a commonly

		agreed framework but, due to lack of priority setting and duplication, these are rather limited
Social costs	+	• Provides a framework for coherent action against organised drug related crime but increased costs if this framework is not updated according to the evaluation and if no clear priorities are set • Increased costs because of the problems in controlling illegal drug trafficking, and illegal trafficking in precursors and money laundering unless clear priorities are set • Provides a framework for coherent action against public health threats in and between Member States
Impact on (informal) political influence of Commission in drug policy	+	• The Commission is considered by Member States as a neutral and expert 'broker' in the field of drugs, entrusted with the political task of drafting a new Action Plan. • The Commission has fulfilled most tasks assigned to her in the current Action Plan. The role of the Commission would become less initiating and more technical-administrative.
Impact on EU coordination	+	• The convergence of policies between Member States will not change immediately. But there is a risk that Member States become 'weary' of the existing Action Plan and continue to develop their own (and possibly diverging) policies to address new trends and developments. • The contribution to the further development of a European coordination mechanism in the field of drugs is not strengthened and lessons learned through the evaluation not taken on board.
Impact on third countries and organisations	++	• The collaboration and assistance to 3rd countries and regions (as well as to Candidate and Associated countries) will continue. But new trends in drug trafficking routes and consumption patters, with adverse consequences on safety & security as well as on Fundamental rights, social and health problems, will not be addressed
Relevance of the options for the achievement of the objectives		
Problem identified in evaluation		**Potential action based on this policy option**
Coordination		
The evaluation shows that the Horizontal Drugs Group is the main forum of drug coordination at EU level. The European Commission is well coordinated in the Council. At the same time, coordination within the Commission regarding the implementation of the Action Plan can be improved, among others by setting clearer priorities and by improving the communication on EU drug policy objectives across policy fields.	+	

Annually, a rich body of monitoring information and situation reports are published on the drug situation. However, the utilisation of these reports by EU policymakers, linking the phenomena described in them for further policy analysis needs improvement.	+	
Demand reduction		
Member States have invested in universal, selective and indicated prevention programmes across the board, but the evidence-base underpinning these programmes is still weak as they are seldom evaluated. Only a few Member States have introduced general quality guidelines for prevention.	+	
The provision of continued and equal care for inmates in prison as compared to care available in society in general is of great importance to reduce drug-related harms. The infection rates for drug-related infectious diseases as well as the mortality rates for drug-related deaths are considerably higher inside prison (and immediately after release from prison).	++	
Supply reduction		
The results of various operational and intelligence law enforcement cross-border projects in the EU, e.g. MAOC-N, show the importance of strengthening intelligence gathering and sharing as a basis for enhanced intelligence led law enforcement along air, sea and land vectors.	++	
In almost all Member States, there is a lack of priority among national Customs organisations when drug precursor control is concerned.	+	
International cooperation		
The priorities of EU drug policy are not well translated into external funding programmes and projects in third countries	**0**	
The EU integrated and balanced approach on drugs has served as a model for Candidate Countries as well as many Neighbourhood Policy Countries in developing their national drug strategies and action plans.	**0**	
Information, research, evaluation		
Diminishing support from national governments to National Focal Points is an increasing cause for concern. National Focal Points are an essential part of the information infrastructure of the EMCDDA.	+	
The availability of reliable, comparable and usable information and data in the field of drug supply and supply reduction is an ongoing cause of concern, as the lack of it does not allow for a proper analysis of the EU drug market and the effectiveness of law enforcement interventions.	**0**	

In addition to the impact assessment above, strengths and weaknesses, opportunities and threats can be assessed for option 2.

Table A5.3 SWOT analysis of option 2	
Strengths – The current Action Plan represents a European added value in committing, albeit not legally, the Member States, the Commission and other relevant actors towards achieving commonly agreed objectives. – The current Action Plan is a tool for developing and Area for Freedom Security and Justice and explicitly confirms the commitment in having full respect for fundamental rights. – The Action Plan provides a framework for strengthening coordination structures at the EU level and for coherent approach on drugs. – The coherence of drugs related actions and the complementarity between different Community Programs and action at the national level is partly ensured. – Provides a framework for coordination but no new policy incentives – The ongoing objectives in the current Action Plan can be implemented in full, allowing for a larger implementation period and therefore for a potential more rigorous evaluation by 2012.	**Weaknesses** – The Implementation of the current Action Plan is a particularly difficult process due to the non-binding character of the plan. The Action Plan has an indirect implementation effect on MS policies. – A further prioritisation inside the Action Plan would be beneficial for it to have a more explicit input in the planning and implementation of the Community Programs. – Information and data available are not always available and/or relevant in measuring the achievements of the objectives. There is an overall lack of information on if and to what extent the actions have an impact on the drug situation. – A more effective implementation of the EU Drug Strategy requires a revision of operational objectives specific actions and indicators in the EU Action Plan on Drugs, acceptable to all Member States and the Commission.
Opportunities – Indicators for the evaluation of the current Action Plan can be further elaborated to improve further on the final evaluation of 2008. – The objectives and actions as implemented through the current Action Plan will have more time to 'trickle' down to national level. As a result, implementation results may be enhanced over time.	**Threats** – The current Action Plan does not establish a hierarchy of new priorities. It risks becoming only a list of ongoing activities if not updated. – The full impact of the expansion of the EU since 2004 can not be assessed, with its impact on trafficking routes of (illegal) goods, intra-EU migration, the spread of drug-related infectious diseases, new neighbouring countries (Ukraine, Russia).

Table A5.4 - Impacts relative to the scenario of option 3.2

Option 3.2 – A complete new EU Action Plan on Drugs (2009-2012) is proposed		
Assessment Criteria	**Rating**	**Motivation**
Impact		
Health impact	+++	• Recent changes in the drug situation can be taken on board • A more proactive AP can be more sensitive in emerging trends • New insights can be translated in quality requirements, increasing effectiveness and efficiency • More ambitious action can be taken to reduce avoidable drug-related harms • Assistance to neighbouring and third countries in reducing drug-related harms can be prioritised

Security impact	+++	• A new Action Plan can take on board recent trends in drug-related security issues, including:
		  • New trafficking routes through Western Africa and Balkans: impact on societies concerned, including some Member States.
		  • Broad security issues e.g. increasing opium production in Afghanistan
		  • Drugs and driving; drugs in the workplace
		  • Funding of terrorism

Other social impacts	++	• Exchange of best practice, information and data collection enhanced through updated common framework and priority setting • Social reintegration and rehabilitation can be improved • The prevention of social exclusion (and poverty) among drug dependent users is better addressed by placing emphasis on fundamental rights, rehabilitation and on a broader implementation of demand reduction interventions, including early intervention and harm reduction.
Fundamental rights impact	++	• Fundamental Rights are taken as a starting point at European level and more strongly promoted in cooperation with 3rd countries. • An updated EU model, based on an integrated, balanced approach and on Fundamental Rights would not be available to civil society in countries with very restrictive policies • Access to services, non-discrimination and social inclusion part of the new AP
Environmental impact	+	• Prioritising alternative development, taking into concern social and environmental aspects of local populations in production countries can be better prioritised • Promoting exchange of best-practice in drug-lab dismantling techniques can help identify environmental spills and/ or reduce environmental risks during operations
Economic impact	0	• No additional financial cost for EU budget is

		foreseen as existing resources are in place and will continue until 2012/2013. • Potential voluntary extra spending on priorities and cooperation by Member States • Financial advantages both for the EU budget and for the Member States because of the enhanced complementarity as a result of clear priority setting (e.g. EU spends EUR 760 million annually on international cooperation and coordination)
Social costs	+	• Reduced costs, since provides an updated framework and clear priorities in tackling organised crime • Reduced costs because an updated approach e.g. on exchange of best practice in tackling drug related crime • Decreased costs because of the problems in controlling illegal drug trafficking, and illegal trafficking in precursors and money laundering unless clear priorities are set • Greater focus on public health threats
Impact on (informal) political influence of Commission in drug policy	++	• The Commission's position as a neutral and expert broker in the EU drug policy field can be further reinforced. • The Commission, supported by EMCDDA and Europol can actively work to help create improved conditions for policy analysis and information collection, necessary for the further development of EU drug policy.
Impact on EU coordination	++	• New Action Plan will reiterate commitment of Member States to policy objectives • New policy insights in Member States can be included within framework of Strategy
Impact on third countries and organisations	++	• The collaboration and assistance to 3rd countries and regions (as well as to Candidate and Associated countries) will continue. New trends in drug trafficking routes and consumption patters, with adverse consequences on safety & security as well as on Fundamental rights, social and health problems, can be taken on board • The EU model of drug policy will be further enhanced based on new insights and evidence and can continue to function as a model for the rest of the world. This is also very relevant and important in the upcoming UNGASS evaluation and follow up discussion in 2009.

Relevance of the options for the achievement of the objectives		
Coordination		
The evaluation shows that the Horizontal Drugs Group is the main forum of drug coordination at EU level. The European Commission is well coordinated in the Council. At the same time, coordination within the Commission regarding the implementation of the Action Plan can be improved, among others by setting clearer priorities and by improving the communication on EU drug policy objectives across policy fields.	++	**Proposed objective:** ***The Commission will ensure coherence between the internal and external aspects of its involvement in drug policy, including the management of relevant funding mechanisms.*** **Motivation:** The evaluation has showed that the coordination of drug policy within Commission services needs further clarification, clearer prioritisation and task-division. This includes the input of drug issues into annual work planning of the existing available funding programmes.
Annually, a rich body of monitoring information and situation reports are published on the drug situation. However, the utilisation of these reports by EU policymakers, linking the phenomena described in them for further policy analysis needs improvement.	++	**Proposed objective:** ***The Council to critically examine the state-of-the-drug problem once a year, on the basis of the relevant annual reports from EMCDDA, EUROPOL, EUROJUST and the annual review of the Commission*** **Motivation:** So far, the EMCDDA annual report is primarily presented in the European Parliament, the Commission annual progress review in the Horizontal Drugs Group in the Council and Europol's Organised Crime Threat Analyses on drugs in the Police Chiefs Task Force in the Council. A more comprehensive discussion, bringing together trends in demand and supply reduction can strengthen the analytical work in the HDG.
Demand reduction		
Member States have invested in universal, selective and indicated prevention programmes across the board, but the evidence-base underpinning these programmes is still weak as they are seldom evaluated. Only a few Member States have introduced general quality guidelines for prevention.	++	**Proposed objective:** ***Develop and implement at national level quality standards for prevention, treatment, harm reduction and rehabilitation*** **Motivation:** In recent years, Member States have been encouraged to implement prevention programmes where these did not exist. However, effective prevention programmes are based on evaluation and specific quality criteria derived from research. As it is impossible to assess the availability of effective programmes in schools and other settings in Member States, it is more efficient to assess whether Member States have set quality standards, which elements are part of these standards and how these are implemented (e.g. as funding condition).
The provision of continued and equal care for inmates in prison as compared to care available in society in general is of great importance to reduce drug-related harms. The infection rates for drug-related infectious diseases as well as the mortality rates for drug-related deaths are considerably higher inside prison (and immediately after release from prison).	+++	**Proposed objective:** ***Develop prevention, treatment, harm reduction and reintegration services for people in or released from prison. Develop methods to monitor/ analyse prison drug use and service delivery, in line with the Council Recommendation on the prevention and reduction of health related harm associated with drug dependence.***

		Motivation: Prisons remain among the most important settings where drug-related infectious diseases but also drug-related deaths occur, despite existing evidence and best-practices to avoid them. As over 600.000 people are detained in a prison every year, the great majority for a relatively short period of time, the risk of infection for society outside prison is an important cause for concern. Furthermore, the fundamental right of inmates to health care facilities and treatment are concerned here as well.
Supply reduction		
The results of various operational and intelligence law enforcement cross-border projects in the EU, e.g. MAOC-N, show the importance of strengthening intelligence gathering and sharing as a basis for enhanced intelligence led law enforcement along air, sea and land vectors.	+++	**Proposed objective:** ***To set up, where necessary, regional security platforms to counter emerging threats by means of coordinated operational responses. Such action to be compatible with existing operational arrangements at EU level and based on specific threat assessments, using existing resources where possible (e.g. MAOC-N, Baltic Sea Task Force, etc.).*** **Motivation:** Diverging trends in drug trafficking routes make a swift response to new threats essential, so that preventive measures to pro-actively handle risks and the minimisation of threats can be put in place. The focus on making use of existing operational arrangements at EU level is key to avoid an emerging spectrum of individual initiatives from several Member States that do not fit in with intelligence sharing practices, jeopardising the exchange of information between initiatives and this rendering these initiatives less effective.
In almost all Member States, there is a lack of priority among national Customs organisations when drug precursor control is concerned.	++	**Proposed objective:** ***Effective and uniform external border control management. Customs services to integrate precursor controls at a strategic level and to coordinate more closely with other law enforcement agencies engaged in anti-drug operations (mutual support).*** **Motivation:** The conclusion was partly based on a Commission survey in 2007, identifying a lack of political priority setting in drug precursor control at strategic level within Customs organisations. Without such a strategic notion, a coherent drug precursor control on external EU borders is not feasible.
International cooperation		
The priorities of EU drug policy are not well translated into external funding programmes and projects in third countries	+	**Proposed objective:** ***Ensure the integration of projects in the drugs field into the EU's cooperation and assistance programmes with third countries/ regions. This should cover demand and supply reduction, as well as alternative development in producer and transit countries.*** **Motivation:** EU assistance to third countries has been increasingly decentralised and a direct translation of the horizontal policy aspects in EU drug policy is not automatically translated into funding

		priorities. As the EU Action Plan on Drugs does not have its own budgetary resources, a proper translation of its objectives into existing funding sources is essential for implementation.
The EU integrated and balanced approach on drugs has served as a model for Candidate Countries as well as many Neighbourhood Policy Countries in developing their national drug strategies and action plans.	+	**Proposed objective:** ***Further develop regional cooperation initiatives and assistance programs to address demand and supply reduction to be strengthen with countries covered by Development Cooperation Instruments (DCI) and European Development Fund (EDF), with a particular attention to new regions that are in the front line, such as in Africa and in Asia.*** **Motivation:** Continue support to these countries by providing technical and other assistance for their alignment with and implementation of the EU acquis.
Information, research, evaluation		
Diminishing support from national governments to National Focal Points is an increasing cause for concern. National Focal Points are an essential part of the information infrastructure of the EMCDDA.	+	**Proposed objective:** ***Member States to continue to support the EMCDDA Reitox National Focal Points.*** **Motivation:** National Focal Points report national data to the EMCDDA. Without the data from all Member states, an EU wide standardised comparison and trend analysis is virtually impossible to make, as secondary data sources are often not available and no quality check is conducted. As the evaluation report showed, two out of 27 National Focal Points have stopped their funding of their NFP's. Other Member States have reduced funding in recent years (or not adjusted to inflation). The result is that the Reitox network becomes more vulnerable and ultimately, EU wide monitoring of the drug situation is placed at risk.
The availability of reliable, comparable and usable information and data in the field of drug supply and supply reduction is an ongoing cause of concern, as the lack of it does not allow for a proper analysis of the EU drug market and the effectiveness of law enforcement interventions.	++	**Proposed objective:** **Development of policy relevant data on the illicit drug market, supply reduction and law enforcement and the structures required for their collection.** **Motivation:** As the annual reviews and the evaluation report show, the data collection in the field of supply reduction is often incomplete, not standardised and difficult to compare. No key indicators have been identified. Without improved data on supply reduction, the Drug Strategy objectives of attaining 'measurable reductions in drug supply to the EU' cannot be assessed due to a lack of data.

In addition to the impact assessment above, strengths and weaknesses, opportunities and threats can be assessed for option 3.2.

Table A5.5 SWOT analysis of option 3.2

Strengths	**Weaknesses**
• This option allows for the defining of a smaller number of objectives and actions within the framework provided by the EU Drugs Strategy and for development of improved indicators to assess the extent to which the Action Plan achieved its aims. • Further consolidating the balanced approach as an EU approach on drugs. • Complementarity between policies and funding instruments at the EU level during the present funding period and in preparing for the next funding period from 2013 onwards. • Coordination mechanisms are consolidated based on the evaluation, new policy incentives are introduced within a coherent framework • The work towards measuring drug policy impacts and national and EU level can continue.	• Implementation of the new Action Plan will continue to be particularly difficult process due to the non-binding character of the plan. The Action Plan has an indirect implementation effect on MS policies. • A new Action Plan may terminate existing initiatives that are still developing, causing upheaval and an inefficient use of resources.
Opportunities	**Threats**
• A new Action Plan can take on board key findings from the evaluation of the current Action Plan on Drugs, including a focus on setting quality standards, taking on board new insights, evidence and know-how regarding effective responses to the drug phenomenon. • Flaws and shortcomings from the current Action Plan can be avoided while formulating new objectives. • Emphasis can be placed on new developments, trends and patterns in the field of drug supply and drug demand, including new drug use trends, new trafficking routes and new international developments e.g. a greater focus on alternative development and security. • Taking into account the developments in the drug situation, as reported by the EMCDDA and Europol, as well as lessons learned from the evaluation, the new Action Plan would concentrate on the most relevant ways of moving towards an Area of Freedom, Security and Justice. The starting point of this approach would continue to be the relevant Treaties and the respect of fundamental rights and other basic European values. • Developing and improving, together with the EMCDDA and Europol, indicators and assessment tools providing for a systematic collection of information and data supporting the evaluation of the Action Plan especially in the area of supply reduction. • Some of the key objectives and actions as implemented through the current Action Plan will be continued in the new Action Plan and will have more time to 'trickle' down to national level. As a	• A very specific new Action Plan on Drugs may cause disagreement among Member States due to a changed political situation. • Some key achievements/ principles of the current EU Action Plan on Drugs may be seriously scrutinised due to changing political perspectives in some Member States on e.g. prevention and harm reduction, but also on the importance of monitoring and evaluation.

result, implementation results may be enhanced over time.	

10. ANNEX 6 - LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and other Drugs
HBSC	Health Behaviour in School Children (WHO)
HDG	Horizontal Working Party on Drugs (Council)
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug User
INCB	International Narcotics Control Board
MAOC - N	Maritime Analysis Operations Centre - Narcotics
MS	Member State
NFP	National Focal Point
NGO	Non Governmental Organization
REITOX	Réseau Européen d'Information sur les Drogues et les Toxicomanies
UNODC	United Nations Office on Drugs and Crime
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

11. ANNEX 7 -GLOSSARY

A

Amphetamine Type Stimulants

The term of amphetamine-type stimulants is used to refer to amphetamines (amphetamine, meth-amphetamine and related substances) and ecstasy (MDMA and related analogues). Amphetamine and methamphetamine are central nervous system stimulants. Ecstasy refers to synthetic substances that are chemically related to amphetamines but which differ to some extent in their effects. The best-known member of the ecstasy group of drugs is 3,4-methylenedioxy-methamphetamine (MDMA), but other analogues are also occasionally found in ecstasy tablets (MDA, MDEA).

Assessment tool

An **assessment tool** is a means by which this progress or achievement of the implementation of an action can be verified.

C

CND

The Commission on Narcotic Drugs (CND) is the central policy-making body within the United Nations system dealing with drug-related matters. It analyses the world drug situation and develops proposals to strengthen the international drug control system to combat the world drug problem. In 1991, the UN General Assembly established the Fund of the United Nations International Drug Control Programme (UNDCP) and expanded the mandate of the Commission to enable it to function as the governing body of UNDCP. UNDCP is administered as part of the United Nations Office on Drugs and Crime (UNODC).

D

Drug dependence

Drug dependence is often defined as: a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time within a 12-month period. **(1)** Tolerance, as defined by either of the following: (a) need for markedly increased amounts of the substance to achieve intoxication or desired effect; (b) markedly diminished effect with continued use of the same amount of the substance. **(2)** Withdrawal, as manifested by either of the following: (a) the withdrawal characteristic for the substance (refers to Criteria A and B of the criteria sets for withdrawal from the specific substances; (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms; **(3)** the substance is often taken in larger amounts or over a longer period than was intended; **(4)** there is a persistent desire or unsuccessful effort to cut down or control substance use; **(5)** a great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use of the substance (e.g. chain-smoking), or recovering from its effects; **(6)** Important social, occupational or recreational activities are given up or reduced because of substance use; **(7)** the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (*source: DSM IV*).

Drug-related death

Drug-related death is defined in this report as: deaths caused directly by the consumption of one or more drug and generally occurring shortly after the consumption of the substance(s). These deaths are known as ‘overdoses’, ‘poisonings’ or drug-induced deaths.

Drug-related infectious diseases

The most prevalent types of drug-related infectious diseases are Hepatitis B and C, HIV/ AIDS and Tuberculosis.

H

Harm Reduction

There is no universal definition of the term harm reduction. For this report the definition of the International Harm Reduction Association (IHRA) is used: “policies and programmes which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and their communities”

Hepatitis B

Hepatitis B is a virus spread through the blood and bodily fluids of an infected person. Many people do not realise they have been infected with the virus, because symptoms may not develop immediately, or at all. The hepatitis B virus can then go on to cause a chronic (long-term) illness, which follows the acute infection. This is very common if babies or children contract the virus, but can also occur in adults. The virus is present in body fluids such as blood, saliva, semen and vaginal fluid. It can be passed from person to person, through unprotected sex (without using a condom) and sharing needles to inject drugs. Infected mothers can also transmit the virus to their baby during the delivery process (often without the woman being aware that she is infected). The incubation period (i.e. the time from coming into contact with the virus to developing the infection) is between one and six months. There is a blood test to detect the virus. There is also a vaccine to protect you against hepatitis B.

Hepatitis C

Hepatitis C is a blood-borne viral infection. At times it is also passed on through other body fluids. Drug users sharing needles are particularly at risk. Anyone whose blood has come into contact with the blood of someone infected with the hepatitis C virus is also at risk. Approximately 20% of people will fight the infection and naturally clear it from their bodies within two to six months. Of the rest some will remain well, and never develop liver damage but many will develop mild to moderate liver damage (with or without symptoms). A further 20% will progress to cirrhosis of the liver over a period of 20- 30 years. Excessive drinking of alcohol is often associated with increased likelihood of progression to severe liver complications. There is no vaccine to prevent hepatitis C but treatment can clear the infection in approximately half those infected.

HIV/ AIDS

AIDS was first recognised as a new condition in 1981. Since then around 40 million people worldwide have been infected with HIV, the virus which can lead to AIDS. About a third of them have died. However, developments in treatment since the mid-nineties have dramatically improved the life expectancy for those diagnosed with HIV. People with HIV may not have any symptoms at all while they are in the latent phase. However, many people experience symptoms in the first couple of months after getting infected. These symptoms may include high temperature and fever, fatigue, skin rash, muscle pains, headache, nausea, vomiting and diarrhoea. Once someone becomes ill with HIV, they are open to many infections. These can include infections of the mouth, such as thrush (oral candidiasis), unusual types of pneumonia, tuberculosis (TB), infections of the brain and eyes, unusual skin problems and odd infections of the gastrointestinal tract. Most people with severe HIV infection also experience weight loss, enlargement of their lymph glands and persistent diarrhoea.

I

Injecting Drug User (IDU)

Injections are usually intravenous, but may also be intramuscular, subcutaneous.

Indicator

An **indicator** is a tool by which the progress or achievement of an action or objective can be measured.

M

Maintenance treatment

Maintenance treatment is a harm reduction intervention aiming at stabilizing opiate users medically and socially allowing for genuine social re-integration. To avoid criminal activity when acquiring the illicit drugs and eliminating high risk situation when administrating the drug via injecting, the treatment provides the patient with a substitution drug, mostly orally administered methadone or buprenorphine. Often maintenance treatment is provided as DOT (Daily Observed Therapy) which allows for thorough monitoring of the effects of the provision of substitution drugs in every patient. Furthermore patients are supported by medical and social service professionals to guarantee beneficial long-term effects on social re-integration of the individual patient.

Medically assisted treatment

Medically assisted treatment (MAT) covers both substitution treatment with agonists (methadone, buprenorphine, dihydrocodeine, heroin, slow-release morphine) and other pharmacological treatments (e.g. with antagonists such as naltrexone) which is targeted at the drug use itself (not anti-depressives and benzodiazepines).

N

Needle and syringe exchange

An intervention in which needles, syringes, other injecting equipment (such as alcohol swabs to clean injecting sites, and water with which to mix powdered drugs) are provided to IDUs through outreach, drop-in centres, clinics or shop fronts, mobile units such as vans and buses and/ or vending machines. Most NSPs include a retrieval service for used syringes.

P

Problem use

In its 'Methodological guidelines to estimate the prevalence of problem use at national level (1999), the EMCDDA defines problem drug use as "injecting drug use" or "long duration/ regular use of opiates, cocaine and/ or amphetamines". At international level, the APA Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) and the WHO International Classification of Diseases (ICD-10) use a somewhat broader definition of problem use, which also includes social aspects of problem use.

Prevalence

Prevalence is a statistic of primary interest in public health because it identifies the level of burden of disease or health-related events on the population and health care system. Prevalence represents new and pre-existing cases alive on a certain date, in contrast to incidence which reflects new cases of a condition diagnosed during a given period of time. Prevalence is a function of both the incidence of the disease and survival.

Prevention

The term prevention generally covers three different types of drug prevention, each with distinctive characteristics. **Universal prevention** used to be referred to as primary prevention. This type of prevention is aimed at the general population or parts of it (e.g. young people) that is not identified on the basis of individual risk factors. **Selective prevention** aims at specific groups of individuals who have an increased risk of developing drug problems (e.g. children of alcoholics or drug addicts, socially deprived youth, etc.). **Indicated prevention** aims at individuals who do not have drug or addiction problems according to the international diagnostic criteria for substance use disorders, but who do have some early characteristics of problematic use

(e.g. young people using drugs with high frequency). Practically all prevention programmes (school-based, family-oriented, mass media, community) cover one or more of these types of prevention.

R

Risk factors

Risk factors are personal or social conditions that are considered mediating factors to increase the probability that an individual develops problem drug use or drug dependence. Scientific literature roughly differentiates between early childhood risk factors (e.g. lack of social skills, lack of social support in families) and late childhood risk factors (lack of problem solving skills, dysfunctional families, mental health/ addiction problems in family, lack of self-esteem) and adolescent risk factors (negative influence of peers, lowered self-esteem during adolescence).

S

Social costs

In the scientific literature on drug policy, social costs related to drugs include both direct and indirect social costs. Direct social costs include e.g. public expenditures on prevention, treatment, harm reduction, law enforcement & prosecution, penitentiaries, etc. Indirect social costs include e.g. loss of life (drug-related death), loss of productivity due to drug-related infectious diseases or imprisonment, social marginalisation of drug users, the indirect economic impact of open drug scenes, fraud and corruption. Social costs can be both material and immaterial, but the social cost model aims to estimate the economic value of both types of costs.

Substitution treatment

Substitution treatment is a form of medical care offered to opiate addicts (primarily heroin addicts) based on a similar or identical substance to the drug normally used. It is offered in two forms: *maintenance* — providing the user with enough of the substance to reduce risky or harmful behaviour; or *detoxification* — gradually cutting the quantity of the drug to zero. Treatment comes either with or without psycho-social support.