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European Monitoring Centre
for Drugs and Drug Addiction

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European Drug Report

Trends and developments

2013



European Monitoring Centre
for Drugs and Drug Addiction

| European | Drug | Report

Trends and developments

2013

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| Contents

| | |
|----|--|
| 5 | Preface |
| 9 | Introductory note and acknowledgements |
| 11 | SUMMARY Old and new drug problems — the European landscape in 2013 |
| 15 | CHAPTER 1 Drug supply in Europe |
| 29 | CHAPTER 2 Drug use and drug-related problems |
| 47 | CHAPTER 3 Responding to drugs |
| 59 | CHAPTER 4 Drug policies |
| 65 | ANNEX National data tables |

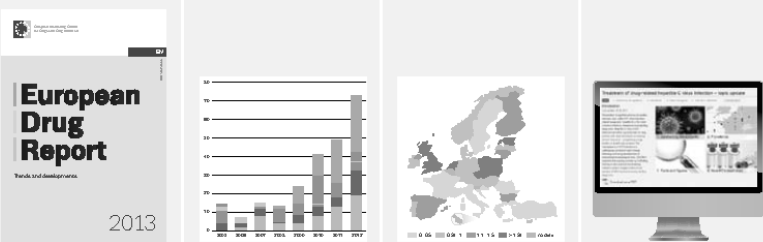
Preface

This year, the EMCDDA's annual analysis of the drug situation is presented in a new format. Consisting of a set of interlinked products, the European Drug Report (EDR) 2013 package aims to provide a common entry point to the work of the EMCDDA and allow different audiences easy access to the specific information they require. It provides an analysis that is more timely, interactive and interlinked. These developments are necessary to keep pace with both the rapidly shifting drug situation and the growing needs and changing expectations of our audiences.

Central to the EDR package is this report (also available in print), which provides a top-level summary of trends and developments. The accompanying Perspectives on drugs (PODs) provide deeper insights into important issues, which this year include new treatment approaches for hepatitis C, high-risk cannabis use and the control of increasingly available new psychoactive substances. Additional layers to the package are provided by the Statistical bulletin and Country overviews, where national-level data and analysis can be found.

EUROPEAN DRUG REPORT 2013

A set of interlinked elements allowing full access to the available data and analysis on the drugs problem in Europe



Trends and developments
providing a top-level analysis of key developments

Statistical bulletin
containing full data arrays, explanatory graphics and methodological information

Country overviews
national data and analysis at your fingertips

Perspectives on drugs
interactive windows on key issues

This approach coincides with the launch of a new EU drugs strategy for 2013–20, in which the European Union reaffirms its commitment to a balanced and evidence-based approach to drug issues. An important part of the EMCDDA's mission is to help provide the information necessary to implement this strategy. Many of the positive developments surrounding drugs in Europe have been the result of a debate that has been informed by both an increasingly sound understanding of the problems and a scientifically rigorous assessment of the measures required to address them. We are proud of the part that the EMCDDA has played in this.

However, we are also aware of the challenges that lie ahead. The EU drugs strategy will have to address a new policy landscape, many dimensions of which are elaborated in this report, including the necessary improvement of service provision for drug users in prison and the growing importance of synthetic drugs. The strategy will be implemented during a period of economic uncertainty and considerable global developmental and social change. Globalisation and technological innovation have an impact on all areas of modern life; not surprisingly, they affect the drug problems we face. As an information agency, we are responding to this with up-to-date and adaptable resources covering a broad perspective. We believe the EDR 2013, in both substance and form, represents an important step forward in addressing the challenges presented to us. Whether it is quick access to a strategic overview of the drug situation or an in-depth analysis of the statistical data that is required, we hope that the EDR 2013 will be a valuable and user-friendly access point for the considerable resources that are now available in this area.

João Goulão

Chairman of the EMCDDA Management Board

Wolfgang Götz

Director, EMCDDA

Introductory note and acknowledgements

This report is based on information provided to the EMCDDA by the EU Member States, the candidate countries Croatia and Turkey, and Norway.

Statistical data reported here are for 2011, or the most recent year available. European totals and trends are based on those countries providing sufficient and relevant data for the period specified. The data analysis prioritises levels, trends and geographical distribution. The necessary technical caveats and qualifications of the data may be found in the English language online version of this report and in the EMCDDA Statistical bulletin 2013, where information on methodology, reporting countries and years is available. In addition, the online version provides links to further resources.

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

- | the heads of the Reitox national focal points and their staff;
- | the services and experts within each Member State that collected the raw data for this report;
- | the members of the Management Board and the Scientific Committee of the EMCDDA;
- | the European Parliament, the Council of the European Union — in particular its Horizontal Working Party on Drugs — and the European Commission;
- | the European Centre for Disease Prevention and Control (ECDC), the European Medicines Agency (EMA) and Europol;
- | the Pompidou Group of the Council of Europe, the United Nations Office on Drugs and Crime, the WHO Regional Office for Europe, Interpol, the World Customs Organisation, the European school survey project on alcohol and other drugs (ESPAD) and the Swedish Council for Information on Alcohol and other Drugs (CAN);
- | the Translation Centre for the Bodies of the European Union, Missing Element Designers and Compositores Rali.

Reitox national focal points

Reitox is the European information network on drugs and drug addiction. The network is comprised of national focal points in the EU Member States, Norway, the candidate countries and at the European Commission. Under the responsibility of their governments, the focal points are the national authorities providing drug information to the EMCDDA. The contact details of the national focal points may be found on the EMCDDA website emcdda.europa.eu.

Summary

Today's drug market appears to be more fluid and dynamic, and less structured around plant-based substances shipped over long distances to consumer markets in Europe

Old and new drug problems — the European landscape in 2013

The major features of the European drug landscape have remained relatively stable in recent years. Drug use remains high by historical standards, but positive changes can be seen, with record levels of treatment provision accompanied by some signs of erosion in injecting, new heroin use, cocaine consumption and cannabis smoking. Any optimism, however, must be tempered by concerns that youth unemployment and service cuts could lead to the re-emergence of 'old' problems. Moreover, a closer examination suggests that the drug situation may now be in a state of flux, with 'new' problems emerging that challenge current policy and practice models: new synthetic drugs and patterns of use are appearing, both on the illicit drug market and in the context of non-controlled substances.

Today's drug market appears to be more fluid and dynamic, and less structured around plant-based substances shipped over long distances to consumer markets in Europe. Globalisation and developments in information technology are important drivers here. Patterns of drug use in low and middle income countries are changing, and this may also have implications for Europe's drug problems in the future. The Internet presents growing challenges, both as a mechanism for rapid diffusion of new trends and as a burgeoning anonymous marketplace with global reach. It creates a new interconnectedness in drug use and drug supply. It also, however, offers opportunities for finding innovative ways to deliver treatment, prevention and harm reduction interventions.

The implications of these changes for public health are not yet fully understood. Signs that current policies have found traction in some important areas must be viewed in the light of an evolving drug situation, which will require adjustments to be made to current practices if they are to remain on target and fit for purpose.

Cannabis

Despite some evidence of decreasing trends, especially in countries with a long and established history of high prevalence, cannabis use in Europe remains high by historical standards, with a large and relatively robust market existing for this substance. There is also increasing diversity in the types of cannabis products available. Herbal cannabis, sometimes of high potency, now plays a more important role, accompanied by the recent emergence of synthetic 'cannabis-like' products. Both are developments that are potentially worrying from a public health perspective. Given its status as the most commonly used drug, cannabis is an important issue for prevention work with young people, and in this area there is growing interest in the use of environmental prevention strategies. This reflects the evidence that suggests that environmental approaches have proved useful for reducing problems associated with the use of licit substances such as tobacco and alcohol.

Any positive changes in indicators of overall use of cannabis in Europe need to be understood in the context of a fairly heterogeneous situation at national level; for example, some countries consistently report low and stable prevalence levels, whereas the use of cannabis in many central and eastern European countries increased considerably during the 2000s. Trends also need to be viewed alongside different use patterns, with regular and long-term use being most associated with harm. Cannabis problems are now better recognised and understood in Europe; the drug represents the second most commonly reported substance for clients entering specialised drug treatment. While most cannabis treatment entrants tend to be male and relatively young, problems among older chronic users are becoming more recognised.

Cannabis is also the drug that divides public attitudes, with some countries making an explicit distinction between cannabis and other substances in their drug control policies.

Heroin and other opioids

Against the background of an overall increase in treatment availability for heroin users, indicators now suggest a downward trend in both use and availability of this drug. The long-term trend in the amount of heroin seized is downwards and, more recently, the number of seizures has also begun to fall. Some countries report that, over the last decade, heroin has been displaced from the market by other opioid drugs. Other countries have experienced more recent market shocks or shortages, generally followed by a partial recovery.

The number of heroin users entering treatment for the first time also continues to fall, and overall those in heroin treatment are an ageing population. Opioid-related deaths have also decreased in recent years. Historically, heroin use has been characterised by injecting, but a long-term decline has been seen in this behaviour. This, together with the impact of interventions, is likely to have contributed to the decline seen in the number of new HIV infections attributed to drug use. A worrying observation here, however, is that recent HIV outbreaks related to drug injection in Greece and Romania have interrupted this positive trend. This emphasises the continued need to consolidate responses, especially with respect to harm reduction and effective drug treatment, if Europe is to continue to see a decrease in problems in this area. Regardless of any new trends in heroin use, the intractable nature of this problem means it will remain a key issue for drug services for many years to come. Faced with a large number of drug users now in contact with services, there is a growing need to focus on continuity of care, social reintegration services and building a consensus on what constitutes realistic long-term outcomes for recovery.

Cocaine

Only a few countries report problems with crack cocaine use, and where this is found it often overlaps with the problematic use of other substances, including heroin. The use of powder cocaine is far more common but tends to be concentrated in a relatively small number of western European countries. Overall, both cocaine use and supply indicators have been trending downwards in recent years, and the dramatic decrease in the amount seized is probably influenced, in part, by organised crime groups diversifying trafficking routes and techniques. The Iberian Peninsula remains important for seizures, but proportionally less so than in the past, while reports of cocaine seizures in eastern Europe are worrying and raise questions about the potential for further diffusion of use.

Against the background of an overall increase in treatment availability for heroin users, indicators now suggest a downward trend in both use and availability of this drug

In the higher-prevalence countries, both survey and treatment entry data suggest a recent decline in cocaine use, although levels still remain high by historical standards. The number of deaths associated with cocaine use has fallen slightly, although caution is required when interpreting the data in this area. Acute problems related to the use of cocaine have resulted in presentations at hospital emergency departments in parts of Europe, but our capacity to monitor problems in this area is limited. In terms of treatment, specialist services are now available to problem cocaine users in many countries, with the current evidence base in this area supporting the use of psychosocial interventions.

| Synthetic stimulants

Understanding overall trends in the use of synthetic stimulant drugs is complicated by the fact that they are often substituted for each other, as consumers make choices influenced by availability, price and perceived 'quality'. Amphetamine and ecstasy remain the most commonly used synthetic stimulants in Europe and compete to some extent with cocaine. Amphetamine remains an important component of the drug consumption picture in many countries, and injecting amphetamine use has historically been a significant part of the chronic drug problem found in many northern countries. Over the longer term, most amphetamines indicators have remained stable; however, recent data suggest increasing methamphetamine availability, and in some markets this substance is now displacing amphetamine. Some evidence exists to suggest a decline over the last few years in the popularity of ecstasy, probably reflecting the fact that many pills sold as ecstasy did not contain MDMA or were of low purity. Recently, ecstasy producers appear to have become more efficient at sourcing MDMA and the content of tablets has correspondingly changed. It remains to be seen whether this will result in renewed interest in this drug, but there is some initial evidence that points in this direction.

Stimulants, especially at high doses, can have adverse health consequences, and some deaths are reported annually. For stimulant users experiencing problems, their first point of contact with services will often be with hospital emergency departments. European projects are currently under way to improve monitoring of this area and provide guidelines on effective responses to drug emergencies in nightlife settings. Although stimulant-related deaths are relatively uncommon, they do generate considerable concern, especially when they occur among young, otherwise healthy, adults. The emergence of new psychoactive substances with unknown toxicity adds

further complications. A recent example is the emergence of the non-controlled stimulant substance 4-MA, which was first notified 2009, on the illicit drug market, either sold as or mixed with amphetamine. Clusters of deaths associated with this substance triggered a risk assessment exercise and subsequent recommendation for control at European level.

| New psychoactive substances

An increasing number of new psychoactive substances, often intended to mimic the effects of controlled drugs, can be found in Europe. Some substances are sold directly on the illicit market, while others, the so-called 'legal highs' are sold more openly. Developments move rapidly in this area, with substances appearing at a fast rate. Occasionally a substance appears which makes the crossover to become a drug of choice on the illicit marketplace, the most recent example being mephedrone. The EU Early warning system continues to receive reports of around one new substance a week in 2013. Recent years have been dominated by the appearance of new synthetic cannabinoid receptor agonists (CRAs), phenethylamines and cathinones, mirroring to a large extent the most popular illicit drugs. A recent development, however, is an increasing proportion of substances reported that are from less known and more obscure chemical groups. Many of the products on sale contain mixtures of substances, and the lack of pharmacological and toxicological data means it is hard to speculate on long term health implications of use, but increasingly data shows that some of these substances cause problems requiring clinical interventions, and fatalities have been recorded.

The European Commission is preparing a new proposal for strengthening the EU response to new psychoactive substances. Although use of new psychoactive substances is seen mainly among young recreational users, there has been some diffusion into problem drug user populations. Some replacement of opioids by synthetic stimulants, especially cathinones, was noted in countries reporting heroin shortages. The motive for the transition from injecting heroin to cathinones is unclear, but may be linked to easy availability and perceived high quality of the new drugs. Public health concerns exist regarding increased levels of injection, mental health problems and physical damage. To date, countries have experimented with a range of control measures to respond to the new-drug problem. Less well developed, but equally important, is the need to identify and introduce appropriate demand reduction responses.

1

**Reflecting its high prevalence of use,
cannabis is by far the most seized
drug in Europe**

Drug supply in Europe

Europe is a major destination for controlled substances and also plays a limited role as a transit point for drugs en route to other regions. Latin America, West Asia and North Africa are important source areas for drugs entering Europe; however, the dynamics of the modern drug market mean that other regions of the world are now of growing importance. Europe is also a producing region for cannabis and synthetic drugs. While virtually all cannabis produced is intended for local consumption, some synthetic drugs are also manufactured for export to other regions.

The growing availability of 'new psychoactive substances' that are not controlled under international drug control treaties represents a relatively new development on European drug markets. Commonly produced outside of Europe, these substances can be obtained through online retailers, specialised shops, and are also sometimes being sold along with controlled substances on the illicit drug market.

Monitoring drug supply

Analysis in this section is based on a range of data sources: drug seizures; dismantled drug production facilities; seizures of precursor chemicals; drug supply offences; retail drug prices, as well as forensic analyses of drug seizures. Full data sets and extensive methodological notes can be found in the Statistical bulletin. It should be noted that trends can be influenced by a range of factors which include law enforcement activity levels and the effectiveness of interdiction measures.

Data on new psychoactive substances are based on notifications to the EU Early warning system, which relies on data provided by the EMCDDA's and Europol's national networks. A full description of this mechanism can be found on the EMCDDA website under Action on new drugs.

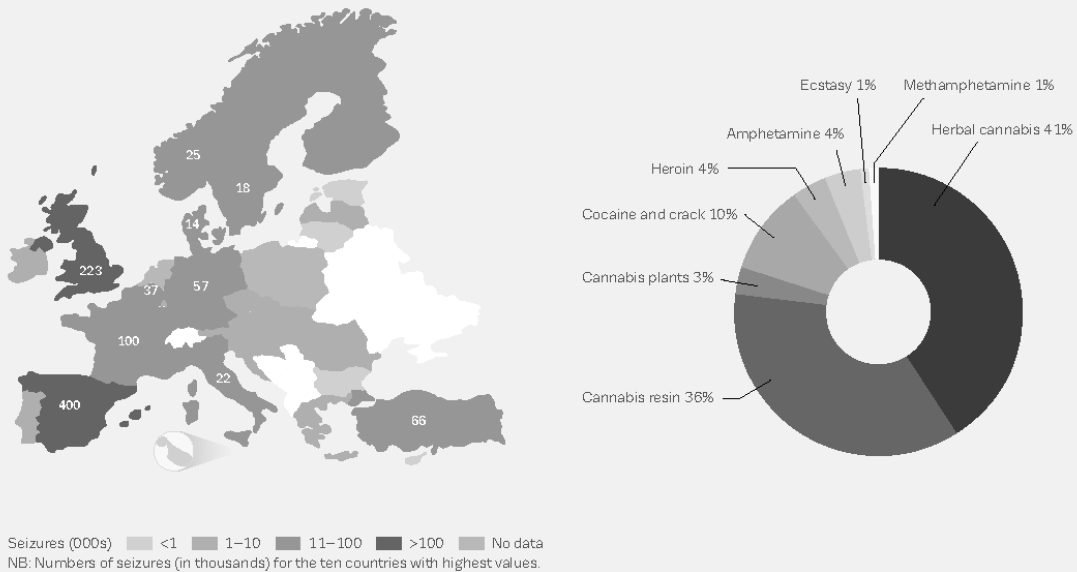
| One million seizures of illicit drugs in Europe

A substantial increase has been seen in the long-term trend in the number of seizures of illicit drugs made in Europe, with about one million seizures reported for 2011. Most of these were small quantities of drugs confiscated from users, although this total also includes multi-kilogram consignments seized from traffickers and producers.

The majority of seizures in 2011 were reported by just two countries, Spain and the United Kingdom, however, Belgium and four Nordic countries also reported relatively high numbers. Another important country in respect to drug seizures is Turkey, with some of the drugs intercepted

FIGURE 1.1

Number of reported seizures by country (left), and proportion of seizures for the main drugs (right), 2011



being intended for consumption in other countries, both in Europe and in the Middle East.

Reflecting its high prevalence of use, cannabis is by far the most seized drug in Europe (Figure 1.1). Cocaine ranks second overall, with about double the number of seizures reported for either amphetamines or heroin. The number of ecstasy seizures is lower, and has declined considerably in recent years.

| Cannabis: changes in supply

Two distinct cannabis products are commonly found on the European drugs market: herbal cannabis ('marijuana') and cannabis resin ('hashish'). The annual consumption of these products can be roughly estimated at around 2 500 tonnes.

Herbal cannabis found in Europe is both cultivated domestically and trafficked from neighbouring countries, although some reports mention herb originating in other regions including Africa. Most cannabis resin is imported by sea or by air from Morocco. At European level, interceptions of resin are on average larger in size than those of herb.

Over the past ten years, the number of herbal seizures has overtaken that of resin, and now represents more than half

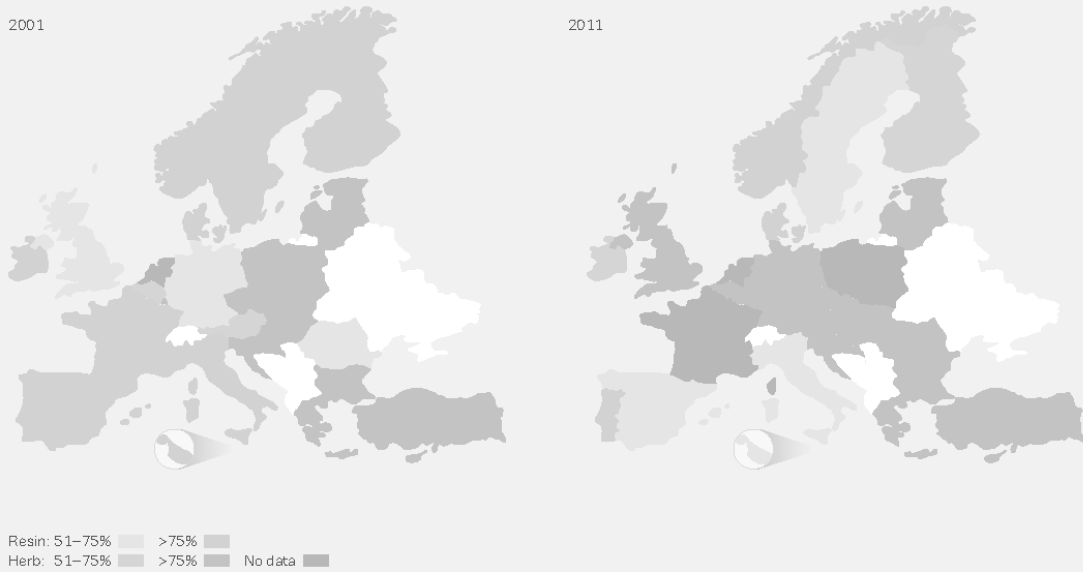
of all cannabis seizures (Figure 1.3). This reflects, in part, the growing availability of domestically produced herbal cannabis in many countries. The quantity of cannabis resin seized, however, although falling in recent years, is still much higher than the quantity of herbal cannabis reported (483 tonnes versus 92 tonnes in 2011).

European trends in cannabis seizures have to be understood in the context that data from a limited number of countries are disproportionately important (Figure 1.4). Spain, for example, with its close proximity to Morocco, and substantial internal market, reported around two-thirds of the quantity of resin seized in Europe in 2011. In respect to herbal cannabis, Greece and Italy both reported recent large increases in quantities seized. Since 2007, Turkey has been the country seizing the largest quantities of herbal cannabis.

Over the past ten years, the number of herbal seizures has overtaken that of resin, and now represents more than half of all cannabis seizures

FIGURE 1.2

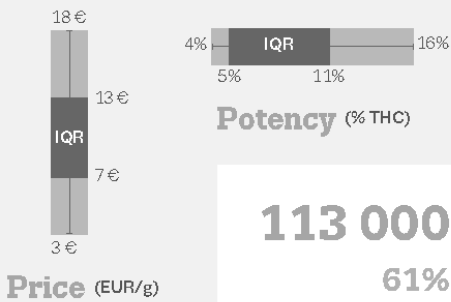
Predominant cannabis type, resin or herb, among number of seizures in 2001 and 2011



CANNABIS

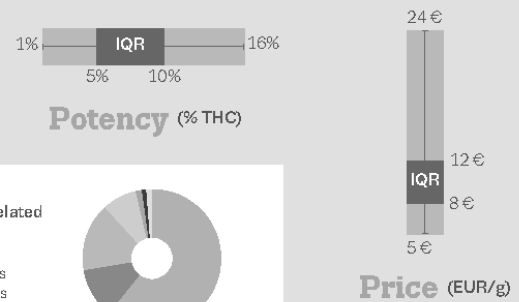
Resin

483 tonnes seized **345 000** seizures
504 tonnes seized including Turkey **353 000** seizures including Turkey

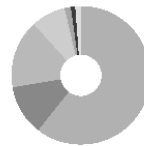


Herb

92 tonnes seized **398 000** seizures
147 tonnes seized including Turkey **439 000** seizures including Turkey



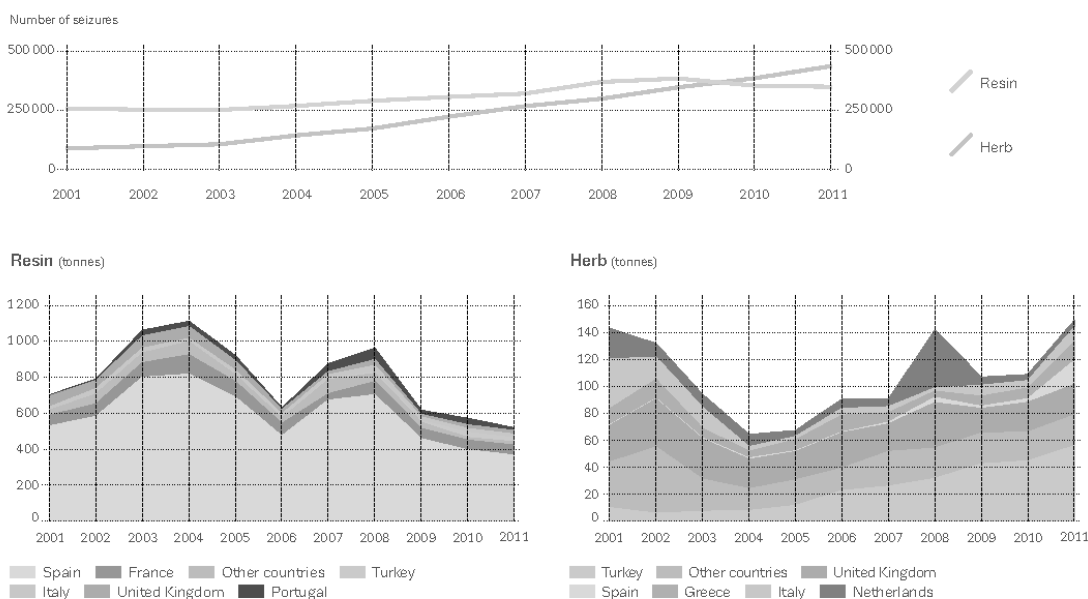
113 000 reported supply-related offences
61% of trafficking offences for the six main drugs



Price and purity of cannabis product: national mean values, minimum, maximum and interquartile range (IQR). Countries covered vary by indicator.

FIGURE 1.3

Number of cannabis seizures, and quantity seized in tonnes: resin and herb, 2001–11



Seizures of cannabis plants can be regarded as an indicator of domestic production, although the quality of data available in this area poses problems for purposes of comparison. In 2011, 31 000 seizures of cannabis plants were reported in Europe. This includes reports of numbers of plants seized (4.4 million in total) as well as quantities (33 tonnes). The highest numbers of plants seized were reported by the Netherlands (2 million), Italy (1 million) and the United Kingdom (627 000), while Spain (26 tonnes) and Bulgaria (5 tonnes) reported the largest seizures by weight.

Heroin: signs of a decline

Two forms of imported heroin have historically been available in Europe: the more common of these is brown heroin (its chemical base form), originating mainly from Afghanistan. Far less common is white heroin (a salt form), which historically came from South-East Asia, but now may be produced elsewhere. Some limited production of opioid drugs also still takes place in Europe, principally homemade poppy products reported in parts of eastern Europe.

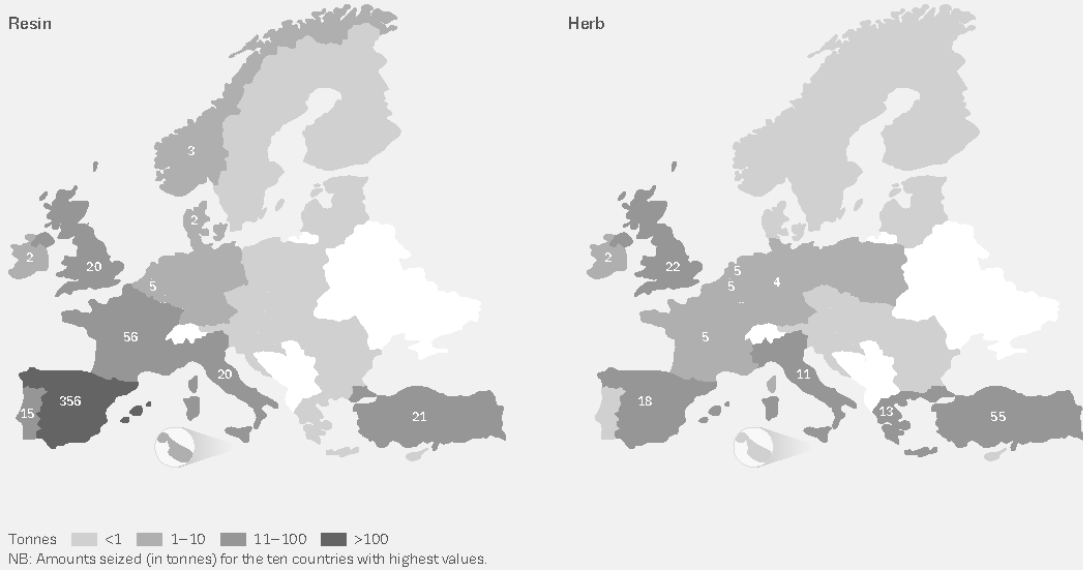
A new dimension: synthetic cannabinoid receptor agonists

The recent availability of products containing synthetic cannabinoid receptor agonists (CRAs), which mimic the effects of the naturally occurring psychoactive compounds found in cannabis, adds a new dimension to the cannabis market. These products, which can be extremely potent, have now been reported in virtually all European countries. Multi-kilogram quantities in powder form are usually imported from Asia, with processing and packaging then occurring in Europe. Some evidence also exists of source chemicals being transited through Europe, such as a recent seizure of almost 15 kilograms of a pure CRA powder originating from China, but en route to Russia.

The quantity of heroin seized in 2011 was the lowest reported in the last decade, and equivalent to only about half of the quantity seized in 2001

FIGURE 1.4

Quantity of cannabis resin (left) and herbal cannabis (right) seized, 2011



Afghanistan remains the world's largest illicit producer of opium, and most heroin found in Europe is thought to be manufactured there or, to a lesser extent, in neighbouring Iran or Pakistan. Two loosely defined trafficking routes exist for transporting the drug to Europe: historically, the more important of these has been the 'Balkan route', running west through Turkey, into Balkan countries (Bulgaria, Romania or Albania) and on to central, southern and

western Europe. A more recent trafficking route is the 'Northern' or 'Silk route', which heads north to Russia, via the former Soviet republics of Central Asia. Generally, however, the situation now appears to have become more fluid, with heroin shipments from Iran and Pakistan entering Europe by air or sea, either directly or transiting through west and east African countries.

HEROIN

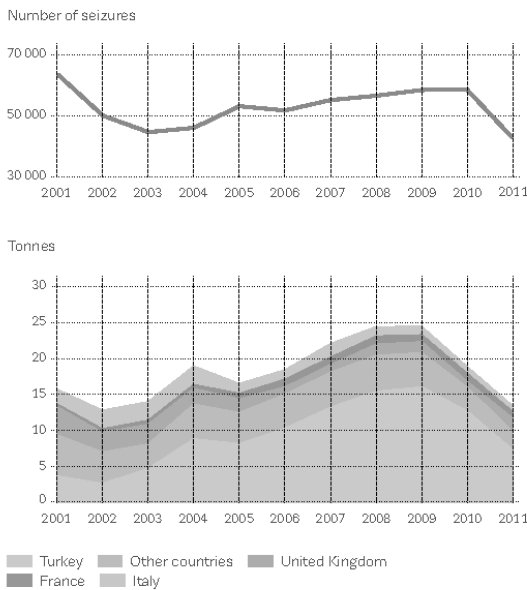


Price and purity of 'brown heroin': national mean values, minimum, maximum and interquartile range (IQR).

Countries covered vary by indicator.

FIGURE 1.5

Number of heroin seizures and quantity seized, 2001–11



The quantity of heroin seized in 2011 (6.1 tonnes) was the lowest reported in the last decade, and equivalent to only about half of the quantity seized in 2001 (12 tonnes). The number of seizures reported over the same period (2001–11) also fell, from a peak of 63 000 in 2001, to an estimated 40 500 in 2011. To some extent, this drop may be explained by the growth of seizures between 2002 and 2009 in Turkey, which has been consistently seizing more of the drug than all other countries combined since 2006 (Figure 1.5). Substantial declines in quantities seized, however, have been reported in Turkey in 2010 and 2011.

In addition to the decline seen in heroin seizures and supply offences related to the drug, more acute short-term market shocks, probably resulting from successful interdiction efforts on the Balkan route, have been reported recently. A number of countries with relatively large populations of heroin users experienced a significant heroin drought in late 2010 and early 2011, from which only some markets appear to have recovered.

FIGURE 1.6

Quantity of heroin seized, 2011



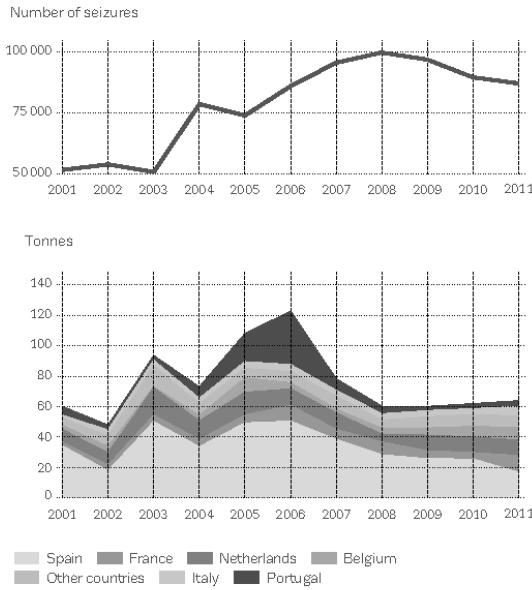
Cocaine: changes in trafficking?

Two forms of cocaine are available in Europe, the most common of which is cocaine powder (a hydrochloride salt, HCl). Less commonly available is crack cocaine, a smokeable form of the drug. Cocaine is produced from the leaves of the coca bush. The drug is produced almost exclusively in Bolivia, Colombia and Peru and is transported to Europe by both air and sea routes. The main trafficking route into Europe appears to be through the Iberian Peninsula (Spain and Portugal), although increased use of container shipments means that the large ports of Belgium, the Netherlands and other western European countries may have gained in importance. Recent signs of the ongoing diversification of cocaine trafficking routes into Europe include large individual seizures in ports in Bulgaria, Greece, Romania, and Baltic countries.

Not all cocaine reaches Europe in a form ready for marketing, and a number of illicit ‘laboratories’ have been dismantled in Europe in recent years. Spain detected and dismantled 73 facilities between 2008 and 2010, the majority of these were secondary extraction labs, used to extract cocaine from other materials in which it had been concealed, such as beeswax, fertiliser, plastic, foodstuffs or clothing.

FIGURE 1.7

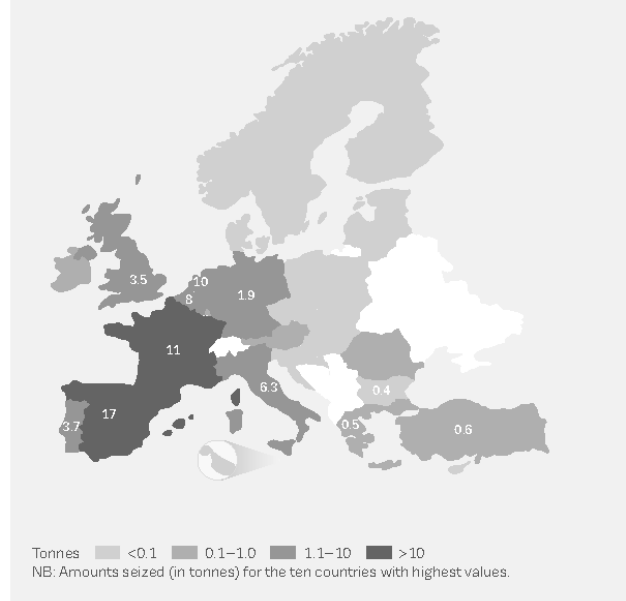
Number of cocaine seizures and quantity seized, 2001–11



In 2011, around 86 000 seizures of cocaine were reported in Europe, amounting to 62 tonnes of the drug being intercepted. This represents an almost 50% fall from the 120 tonnes of cocaine seized in the peak year 2006. The number of seizures has also fallen, but less markedly, having peaked at 100 000 seizures in 2008 (Figure 1.7). Decreases in the quantity of cocaine seized are most observable in the Iberian Peninsula, where the total intercepted by Spain and Portugal fell from 84 tonnes in 2006 to 20 tonnes in 2011.

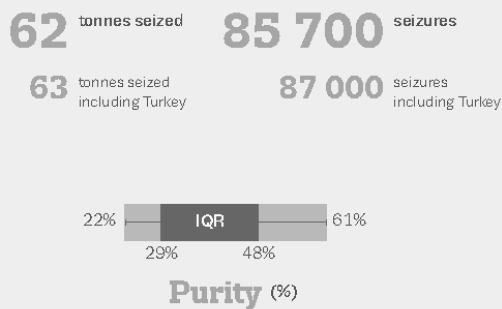
FIGURE 1.8

Quantity of cocaine seized, 2011

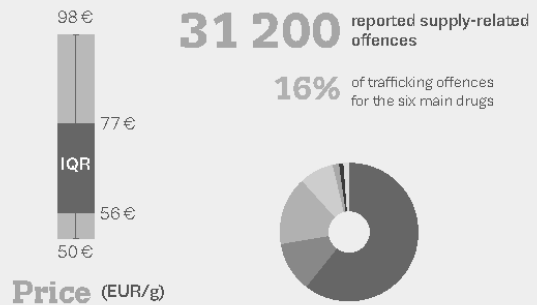


This is similar to the quantity seized in the Netherlands and Belgium, which reported combined seizures of 18 tonnes of the drug in 2011. Record seizures of cocaine were reported in 2011 by France (11 tonnes) and Italy (6 tonnes). It is unclear to what extent the changes in quantities of cocaine seized in European countries reflect overall changes in supply to the European market, changes in law enforcement practices, or the introduction of new operational approaches by drug trafficking organisations.

COCAINE



Price and purity of cocaine: national mean values, minimum, maximum and interquartile range (IQR).



Countries covered vary by indicator.

| Amphetamines: signs of more methamphetamine

Initially developed for therapeutic purposes and generically known as amphetamines, methamphetamine and amphetamine are closely related synthetic stimulants. Of the two, amphetamine has always been the more common in Europe, but there are now signs of the increasing availability of methamphetamine.

Both drugs are manufactured in Europe for domestic use, although some amphetamine is also manufactured for exportation, principally to the Middle East. Production techniques can be relatively sophisticated, resulting in large production runs. The same equipment and personnel may also be used for the production of other synthetic substances such as MDMA (ecstasy). Significant production is known to take place in Belgium and the Netherlands, as well as in Poland and in the Baltic countries; labs have also been found in other countries, including Bulgaria, Germany and Hungary. A large number of methamphetamine production sites are reported by the Czech Republic, most of which are small-scale operations intended to provide drugs for the personal use of those involved although some larger-scale production has also been noted, with methamphetamine produced for both domestic consumption and export to bordering countries. Methamphetamine production in the Baltic countries also appears to have been scaled-up, with the drug being produced for export to Scandinavian countries, where it may be beginning to displace amphetamine.



After a period of higher levels, both in terms of numbers and quantity, amphetamine seizures in 2011 have returned to about the same level found in 2002

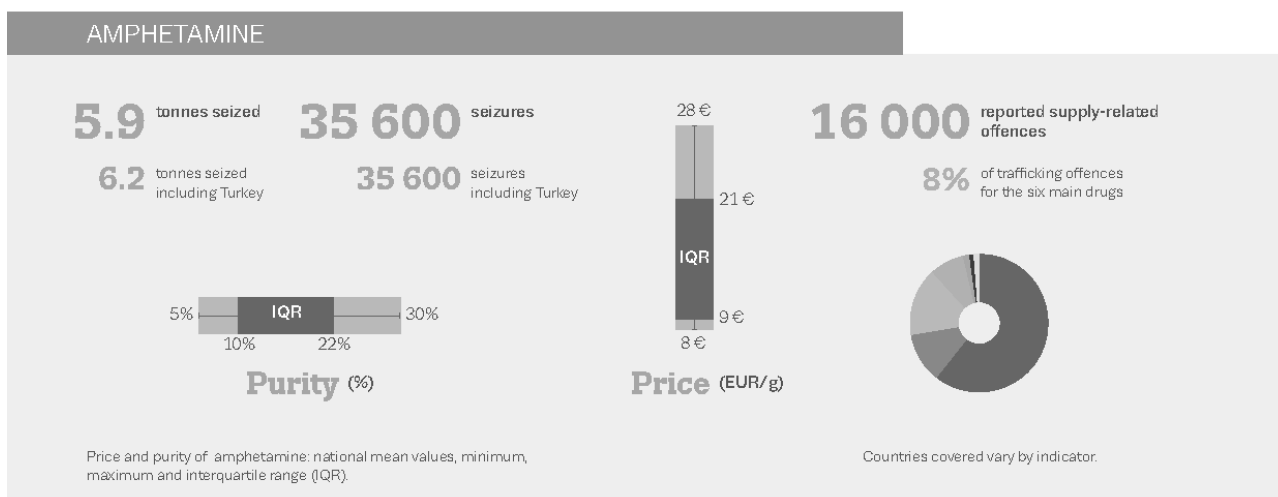
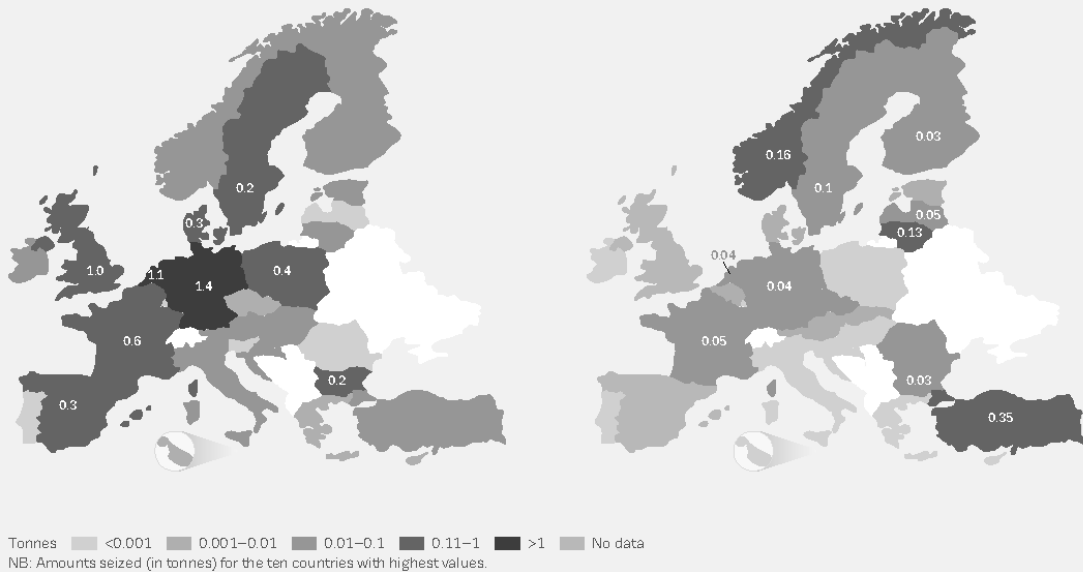


FIGURE 1.9

Quantity of amphetamine (left) and methamphetamine (right) seized, 2011



In 2011, about 45 000 seizures of amphetamines were reported. These can be broken down into 35 600 seizures and 5.9 tonnes of amphetamine, and 9 400 seizures amounting to 0.7 tonnes of methamphetamine. After a period of higher levels, both in terms of numbers and quantity, amphetamine seizures in 2011 have returned to about the same level found in 2002 (Figure 1.10). In

contrast, methamphetamine seizures, though still small in number and quantity, have increased over the same period (Figure 1.11).

METHAMPHETAMINE



Price and purity of methamphetamine: national mean values, minimum, maximum and interquartile range (IQR).

Countries covered vary by indicator.

FIGURE 1.10

Number of amphetamine seizures and quantity seized, 2001–11

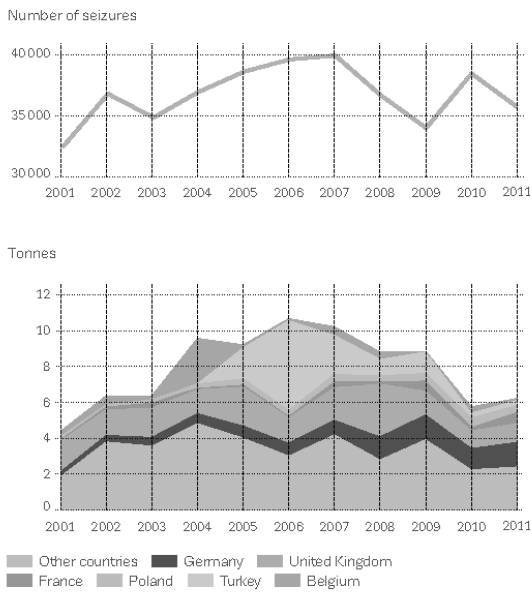
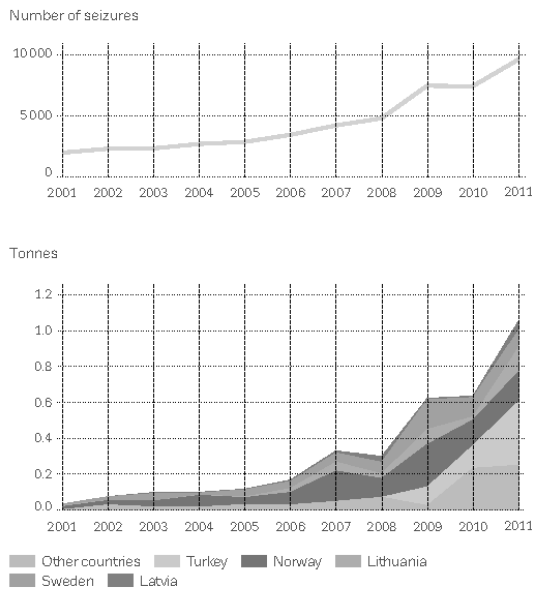


FIGURE 1.11

Number of methamphetamine seizures and quantity seized, 2001–11



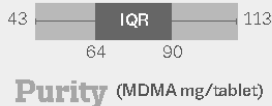
Ecstasy: making a comeback?

Ecstasy usually refers to the synthetic substance MDMA, which is chemically related to amphetamines, but which differs to some extent in its effects. Tablets sold as ecstasy, however, may contain any of a range of MDMA-like substances and unrelated chemicals.

Ecstasy manufacture in Europe may have peaked in 2000, when 50 laboratories were reported to have been dismantled. These decreased to three dismantled in 2010 and five in 2011, suggesting that production levels across Europe have dropped. The Netherlands, followed by Belgium, have reported the highest numbers of dismantled laboratories over the last decade, and this is thought to reflect geographically the main production area for this drug.

ECSTASY

4.3 million tablets seized 10 000 seizures
 5.7 million tablets seized, including Turkey 13 000 seizures including Turkey



Purity (MDMA mg/tablet)



Price (EUR/tablet)

3 000 reported supply-related offences
 1% of trafficking offences for the six main drugs

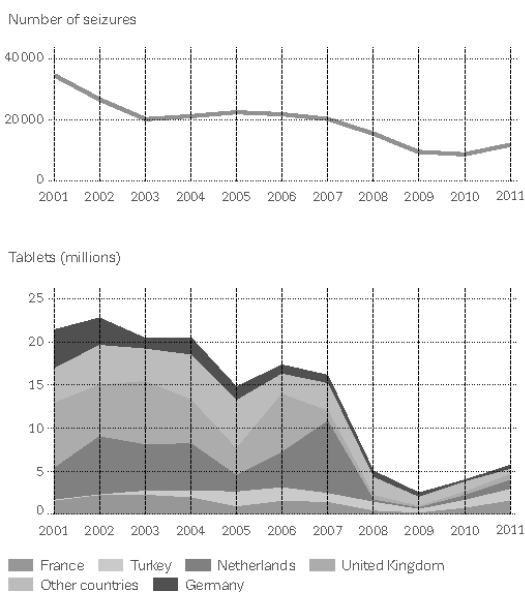


Countries covered vary by indicator.

Price and purity of ecstasy tablets: national mean values, minimum, maximum and interquartile range (IQR).

FIGURE 1.12

Numbers of ecstasy seizures and tablets seized, 2001–11



Seizures of the drug have fallen sharply since 2007 (Figure 1.12), and current figures of 4.3 million ecstasy tablets seized represent only a small fraction of what they were in the peak year of 2002 (23 million). A sharp drop has also been observed in drug supply offences related to ecstasy, which fell by about two-thirds between 2006 and 2011, and now represent about 1% of offences related to the supply of the main drugs. These downward trends have been attributed to strengthened controls and the targeted seizure of PMK, the main precursor chemical for the manufacture of MDMA. This may also have been reflected in a substantial change in the contents of 'ecstasy' tablets available in Europe, with only three countries reporting that MDMA-like substances accounted for the largest proportion of tablets analysed in 2009. There are, however, indications of a recent resurgence of the ecstasy market, although not to the levels seen earlier. MDMA appears to be becoming more common, and high purity powder is available in parts of Europe. Ecstasy producers may have responded to precursor controls by moving to the use of 'pre-precursors' or 'masked precursors' — essential chemicals that can be legally imported as non-controlled substances and then converted into the precursor chemicals necessary for MDMA production.

FIGURE 1.13

Quantity of ecstasy seized, 2011



Seizures of the drug have fallen sharply since 2007, and current figures of 4.3 million ecstasy tablets seized represent only a small fraction of what they were in the peak year of 2002

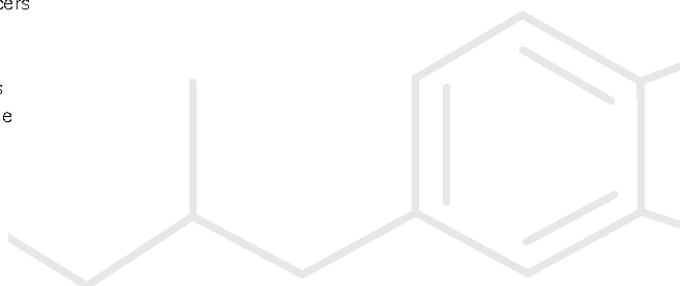
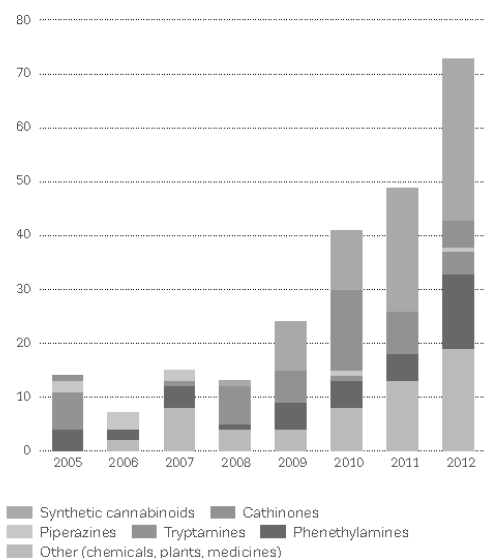


FIGURE 1.14

Number and main groups of new psychoactive substances notified to the EU Early warning system, 2005–2012



During 2012, 73 new psychoactive substances were notified by the Member States for the first time through the EU Early warning system

New drugs: more substances available

Analysis of the drug market is complicated by the emergence of new drugs (new psychoactive substances) — chemical or natural substances that are not controlled under international law, and produced with the intention of mimicking the effects of controlled drugs. In some cases, new drugs are produced in Europe in clandestine laboratories and sold directly on the market. Other chemicals are imported from suppliers, often in China or India, and then attractively packaged and marketed as ‘legal highs’ in Europe. The term ‘legal highs’ is a misnomer, as substances may be controlled in some Member States, or if sold for consumption, contravene consumer safety or marketing regulations. To avoid controls, products are often mislabelled, for example as ‘research chemicals’ or ‘plant food’ with disclaimers that state the product is not intended for human consumption.

During 2012, 73 new psychoactive substances were notified by the Member States for the first time through the EU Early warning system (Figure 1.14). Reflecting consumer demand for cannabis-like products, 30 of these substances were synthetic cannabinoid receptor agonists. Nineteen compounds did not conform to the readily recognised chemical groups (including plants and medicines), while there were also 14 new substituted phenethylamines reported, the highest number since 2005.

As the Internet is an important marketplace for new psychoactive substances, the EMCDDA undertakes a regular snapshot exercise to monitor the number of online shops offering products to European consumers. This number of shops identified continues to grow, with 693 online shops identified in January 2012.

After they are subjected to control measures, most new psychoactive substances tend to be rapidly replaced, making intervention measures particularly challenging in this area. Mephedrone, however, is a rare example of a new drug that may have made the crossover to become a sought-after substance on the illicit stimulant market. Despite controls across the European Union, the drug appears still to be available in some countries, where it is now sold on the illicit market. Although stocks obtained pre-ban may exist and clandestine importation may still take place, a worrying development is the recent discovery of a mephedrone production site in Poland, with links to international organised crime groups and evidence of trafficking to other European countries.

FIND OUT MORE

EMCDDA publications**2012**

Cannabis production and markets in Europe, EMCDDA Insights 12.

2011

Report on the risk assessment of mephedrone in the framework of the Council Decision on new psychoactive substances.

Recent shocks in the European heroin market: explanations and ramifications. Summary report from EMCDDA Trendspotter, meeting 18–19 October 2011.

Responding to new psychoactive substances, Drugs in focus, No 22.

EMCDDA and Europol publications**2013**

Annual report on the Implementation of Council Decision 2005/387/JHA.

EU Drug markets report: a strategic analysis.

2011

Amphetamine: a European Union perspective in the global context.

2010

Cocaine: a European Union perspective in the global context.

2009

Methamphetamine: a European Union perspective in the global context.

All publications are available at
www.emcdda.europa.eu/publications

2

At least 85 million adult Europeans have used an illicit drug at some point in their lives, representing around a quarter of Europe's adult population

Drug use and drug-related problems

Monitoring drug use and its associated harms is complicated by many factors. There is considerable variation in the ways in which illicit drugs are used, for example, with consumption patterns varying from the experimental and occasional to the daily and long-term. The risks that individuals are exposed to will also be mediated by numerous factors which include: the dose consumed, route of administration, the co-consumption of other substances, number and length of drug consumption episodes and individual vulnerability.

Monitoring drug use and drug-related problems

Monitoring of drug use and drug-related harms in Europe is based mainly upon five key epidemiological indicators: drug use among the general population, problem drug use, drug-related deaths and mortality, drug-related infectious diseases and drug treatment demand. Information on these indicators, including methodological notes can be found on the EMCDDA website under the Key indicators gateway and in the Statistical bulletin.

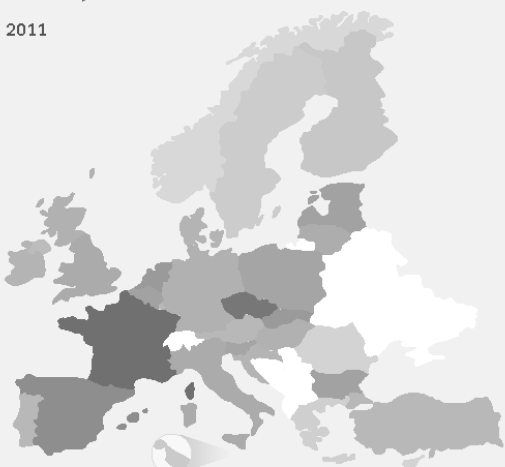
A quarter of European adults have used illicit drugs

At least 85 million adult Europeans have used an illicit drug at some point in their lives, representing around a quarter of Europe's adult population. Most report having used cannabis (77 million), with much lower estimates for lifetime use of other drugs: 14.5 million for cocaine, 12.7 million for amphetamines and 11.4 million for ecstasy. There is considerable variation in levels of lifetime drug use reported in Europe, ranging from around a third of adults in Denmark, France and the United Kingdom, to less than one in ten in Bulgaria, Greece, Hungary, Romania and Turkey.

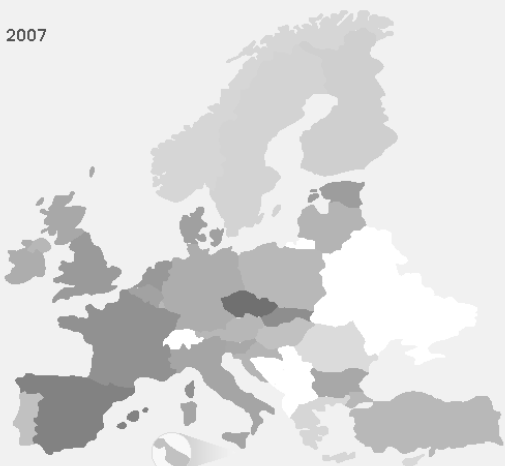
FIGURE 2.1

Lifetime prevalence of cannabis use among
15- to 16-year-old school students

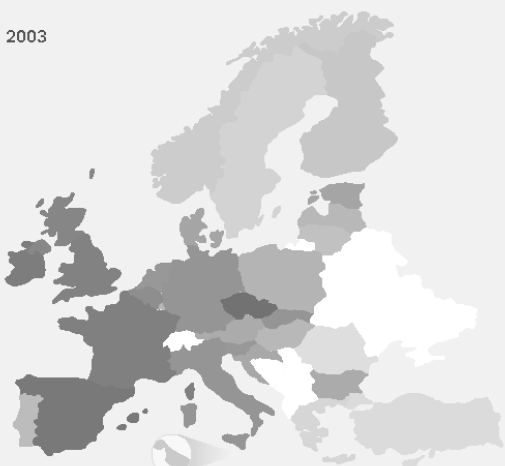
2011



2007



2003



2% 10 20 30 40 45% No data

NB: ESPAD data and national surveys for Spain and the United Kingdom.

Cannabis: stable or decreasing trends in higher-prevalence countries

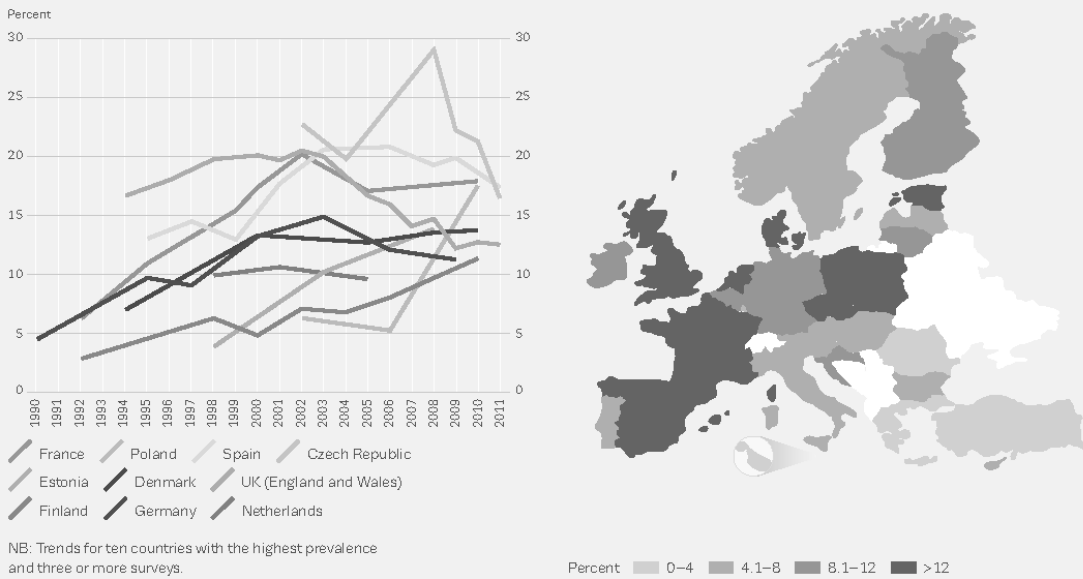
Cannabis products are generally smoked and commonly mixed with tobacco. Patterns of cannabis use range from the occasional or experimental to the regular and dependent, with cannabis-related problems strongly associated with frequent use and higher amounts used. Health effects may include respiratory problems, mental health problems and dependence. Some of the new synthetic cannabinoid receptor agonists can be extremely potent, and acute adverse consequences are increasingly reported.

Cannabis is the illicit drug most likely to be tried by European students. In the 2011 ESPAD surveys, lifetime cannabis use among 15- to 16-year-olds ranged from 5% in Norway to 42% in the Czech Republic (Figure 2.1). Gender ratios also varied, from unity to about 2.5 boys to each girl. In terms of the overall European trend, school students' cannabis use increased between 1995 and 2003, dropped slightly in 2007 and since then has remained stable. During this period, a noticeable trend has been a reduction in cannabis use in many of the countries that reported high levels of prevalence in early surveys. Over the same period, levels of cannabis use among school students increased in many of the countries in central and eastern Europe, showing a degree of convergence across Europe as a whole. In the six countries that have reported national school surveys undertaken after the ESPAD study (2011/12), prevalence of cannabis use among students remains stable or is slightly decreasing.

An estimated 15.4 million young Europeans (15–34) (11.7% of this age group) used cannabis in the last year, with 9.2 million of these aged 15–24 (14.9%). Cannabis use is generally higher among males. Longer-term trends among young adults are broadly in line with those for students, with gradual increases in use among some lower-prevalence countries, alongside decreases among higher-prevalence countries. With the exception of Poland and Finland, countries with recent surveys (2010 or later) report stable or decreasing trends among young adults (Figure 2.2). Few national surveys currently report on use of synthetic cannabinoid receptor agonists; for those that do, prevalence levels are generally low.

FIGURE 2.2

Last year prevalence of cannabis use among young adults: selected trends (left) and most recent data (right)



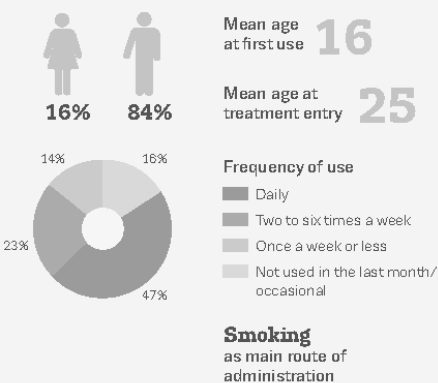
Over 3 million daily cannabis users and rising treatment demand

A significant minority of cannabis users consume the substance intensively. Daily or almost daily cannabis use is defined as use on 20 or more days in the month

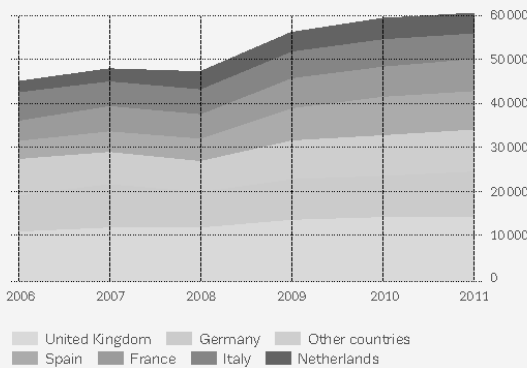
preceding survey. Data from 22 countries, suggest that around 1% of adults, at least three million, report using the drug in this way. Over two-thirds of these are aged between 15 and 34 years, and in this age group, over three-quarters are male.

CANNABIS USERS IN TREATMENT

Characteristics



Trends in first-time entrants



NB: Characteristics are for all treatment entrants with cannabis as primary drug. Trends are for first-time treatment entrants with cannabis as primary drug. Countries covered vary by indicator.

FIGURE 2.3

Predominant stimulant drug by last year prevalence among 15- to 34-year-olds (left) and by primary drug in first-time treatment entrants (right)



In 2011, cannabis was the second most frequently reported primary drug, after heroin, for clients entering specialised drug treatment in Europe (109 000) and the most frequently mentioned drug among those entering treatment for the first time. However, considerable national variation can be seen, ranging from 4% of all drug clients reporting this drug as a reason for entering treatment in Bulgaria to 69% in Hungary. These differences can be explained by differences in referral practices, the type of treatment services available and national prevalence levels. Europe has seen the numbers of cannabis clients entering treatment for the first time increase from about 45 000 in 2006 to 60 000 in 2011.

Cannabis... the most frequently mentioned drug among those entering treatment for the first time

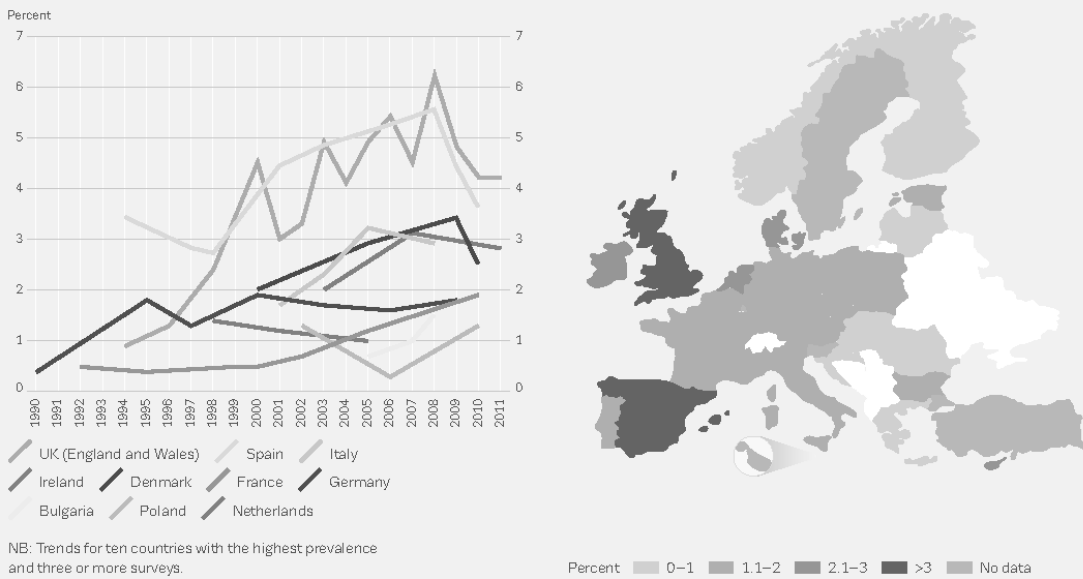
Illicit stimulants in Europe: regional patterns of use

Cocaine, amphetamines and ecstasy are the most commonly used illicit stimulants in Europe, while some lesser-known substances, including piperazines (e.g. BZP) and synthetic cathinones (e.g. mephedrone and MDPV), may also be used illicitly for their stimulant effects. High levels of stimulant use tend to be associated with specific dance, music and nightlife settings, where these drugs are often used in combination with alcohol.

Prevalence data illustrate the geographically divergent stimulant market in Europe, with cocaine more prevalent in the south and west of Europe, amphetamines more common in central and northern countries, and ecstasy the most prevalent stimulant in countries in the south and east (Figure 2.3). Treatment data show similar patterns for cocaine and amphetamine, while the numbers entering treatment for ecstasy problems are low.

FIGURE 2.4

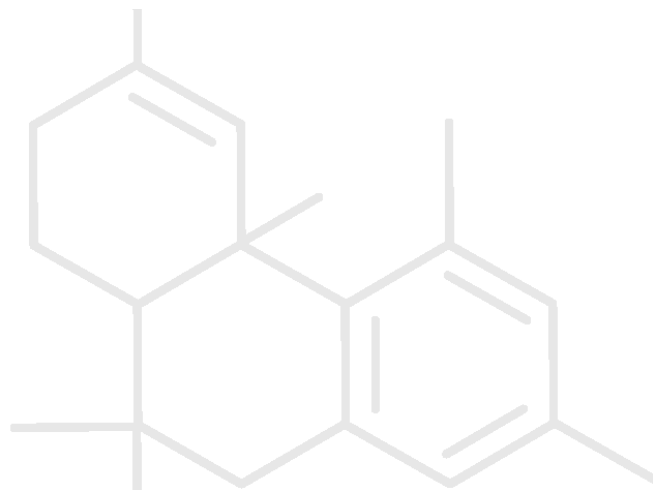
Last year prevalence of cocaine use among young adults: selected trends (left) and most recent data (right)



Cocaine: decreasing use in high prevalence countries

Cocaine powder is primarily sniffed or snorted, but is also sometimes injected, while crack cocaine is usually smoked. Among regular users, a broad distinction can be made between more socially integrated consumers, who may be using the drug in a recreational context, and more marginalised drug users, who use cocaine, often along with other substances, as part of a chronic drug problem. Regular cocaine use has been associated with cardiovascular, neurological and mental health problems, and with an elevated risk of accident and dependence. Cocaine injection and crack use are associated with the highest health risks, including the transmission of infectious diseases.

Cocaine, amphetamines and ecstasy are the most commonly used illicit stimulants in Europe



Cocaine is the most commonly used illicit stimulant drug in Europe, although most users are found in a relatively small number of countries. It is estimated that about 2.5 million young Europeans (1.9% of this age group), used cocaine in the last year. Relatively high levels of last year cocaine use among young adults (2.5–4.2%) were reported by Denmark, Ireland, Spain and the United Kingdom (Figure 2.4). In the higher-prevalence countries with more recent surveys, levels of last year cocaine use among young adults tended to peak in 2008/09 and have subsequently shown modest declines or stabilisation. In other countries, levels of cocaine use have remained relatively low and stable, although France and Poland both reported increases in 2010.

Signs of decline in cocaine treatment demand

Only four countries have relatively recent estimates of intensive or problem cocaine use, and these are difficult to compare, as the definitions used differ. In 2009, among the adult population: Spain estimated 'intensive cocaine use' at 0.45%; Germany estimated 'cocaine-related problems' at 0.20%; and Italy produced an estimate of 0.34% for 'potentially problem cocaine use'. For 2009/10, the United Kingdom estimated crack cocaine use among the adult population in England at 0.54%, but noted that many of these were likely to be both crack and opioid users.

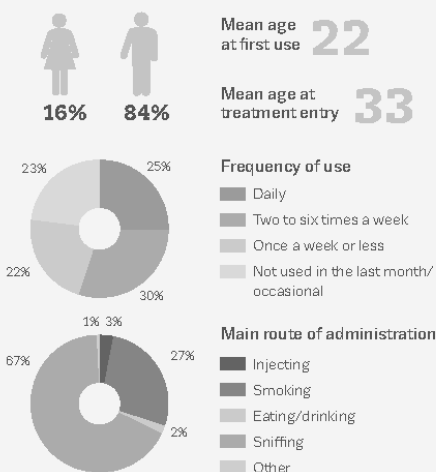
Cocaine was cited as the primary drug for 14% of all reported clients entering specialised drug treatment in 2011 (60 000), and 19% of those entering treatment for the first time (31 000). Wide differences exist between countries, with around 90% of all cocaine clients being reported by only five countries (Germany, Spain, Italy, Netherlands, United Kingdom). The number of clients entering treatment for the first time in their life for primary cocaine use increased from 35 000 in 2006 to 37 000 in 2009 and then decreased to 31 000 in 2011 (23 countries). Spain has seen a small, but steady reduction in numbers of new cocaine clients entering treatment since 2005, the United Kingdom since 2008 and Italy since 2009. Only about 3 000 new primary users of crack cocaine entered treatment in Europe in 2011, with the United Kingdom accounting for around two-thirds of these, and Spain and the Netherlands most of the rest.

Longer-term increase in cocaine hospital emergencies

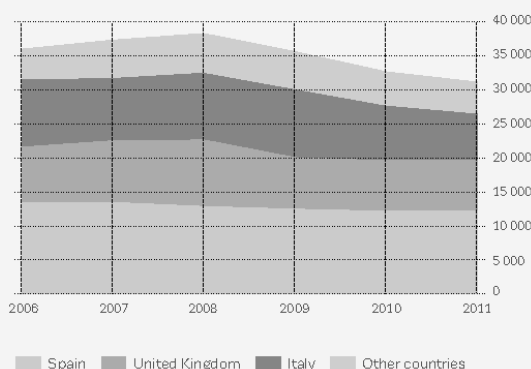
A recent European review identified a threefold increase in indicators of cocaine-related hospital emergencies in some countries since the end of the 1990s, with a peak observed around 2008 in Spain and the United Kingdom (England). Most cocaine-related emergencies occurred among young males. Deaths caused by acute cocaine poisoning seem to be relatively uncommon. In 2011, at least 475 deaths

COCAINE USERS IN TREATMENT

Characteristics



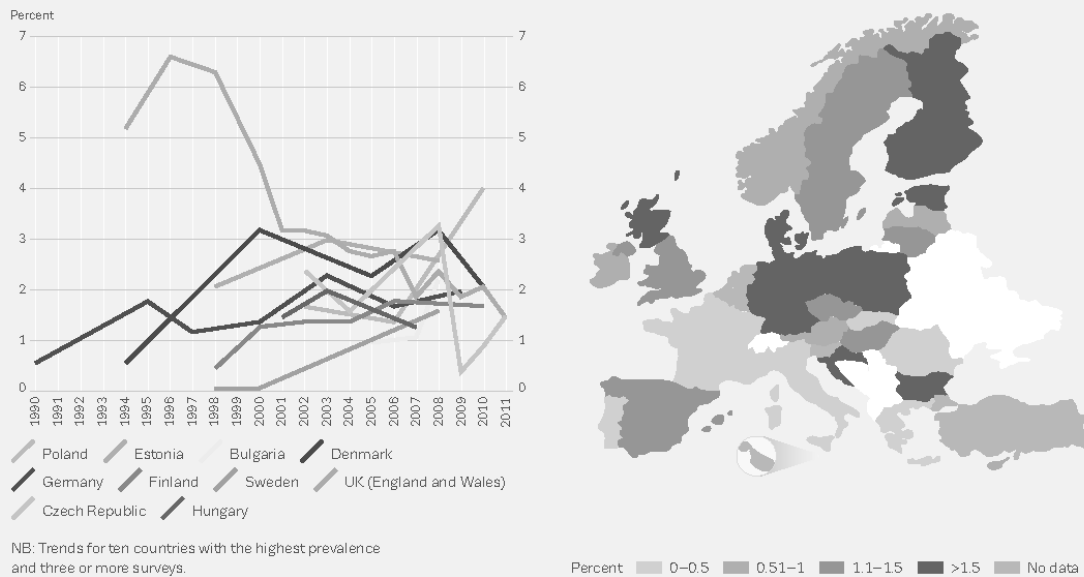
Trends in first-time entrants



NB: Characteristics are for all treatment entrants with cocaine/crack as primary drug. Trends are for first-time treatment entrants with cocaine/crack as primary drug. Countries covered vary by indicator.

FIGURE 2.5

Last year prevalence of amphetamines use among young adults: selected trends and most recent data



related to cocaine were reported in 17 countries, although other drugs were also often present. Recent data from Spain and the United Kingdom suggest a decrease in cocaine-related deaths since 2008. Cocaine is also likely to play a role in some deaths related to cardiovascular problems, but data in this area are limited.

Amphetamines: use stable but health risks continue

In Europe, amphetamine is more widely available than methamphetamine, use of which has historically been restricted to the Czech Republic and, more recently, Slovakia. Amphetamines are usually taken orally or snorted, but in a few countries, injection of these drugs is relatively common among problem drug users and treatment clients.

Most studies on adverse health effects linked with amphetamines use are from Australia and the United States, where crystal methamphetamine smoking is prevalent, and their findings may not be directly transferable to the European situation. These studies identify effects including cardiovascular, pulmonary, neurological and mental health problems, ranging from anxiety, aggression and depression, to acute paranoid psychosis, while injection is a risk factor for infectious

diseases. Deaths related to amphetamines, though rare in comparison to those related to opioid drugs, are reported by some countries, particularly those with relatively large amphetamine-using populations. Overdoses due to amphetamines may, however, be more difficult to identify, as the symptoms may be less specific. This problem is complicated by the emergence of new stimulant drugs. For example, over 20 fatalities in 2011 and 2012 have been associated with the amphetamine-related compound 4-methylamphetamine, prompting the EMCDDA and Europol to undertake a European-level risk assessment, and the European Commission to recommend EU-wide control measures.

**In Europe,
amphetamine is more
widely available than
methamphetamine**

An estimated 1.7 million (1.3%) young adults (15–34) used amphetamines during the last year. Between 2006 and 2011, last year amphetamines use remained relatively low and stable among young adults in most European countries, with prevalence levels of around 2% or less in all reporting countries with the exception of Bulgaria (2.1%), Estonia (2.5%) and Poland (3.9%). Among the countries with recent surveys (2010 or later), all reported stable or decreasing amphetamine prevalence levels, with the exception of Poland, which reported an increase (Figure 2.5).

Increase in methamphetamine treatment demand

Only two countries have recent estimates of the number of problem methamphetamine users, with estimates for adults (15–64) of around 0.42% for the Czech Republic (2011) and about 0.21% in Slovakia (2007). Indications of problem methamphetamine use have recently been noted in Germany, Greece, Cyprus and Turkey.

Around 6% of clients entering specialised drug treatment in Europe in 2011 report amphetamines as their primary drug (approximately 24 000 clients, of whom 10 000 entered treatment for the first time in their life). Primary amphetamine users account for a sizeable proportion of reported first-time treatment entries only in Latvia, Poland and Sweden, while methamphetamine is cited

as the primary drug by a large proportion of first-time clients in the Czech Republic and Slovakia. Between 2006 and 2011, trends for amphetamines users entering treatment for the first time largely remained stable, with the exception of the Czech Republic and Slovakia, which reported increased numbers of first-time methamphetamine clients.

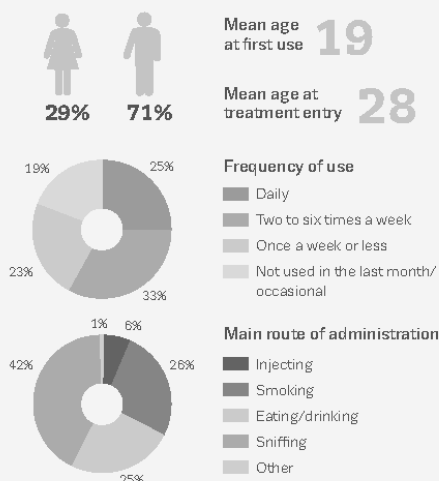
Ecstasy: low treatment demand

Ecstasy usually refers to the synthetic substance MDMA. The drug is mostly used in tablet form, but is sometimes available as a powder; it can be swallowed, snorted or (rarely) injected. Ecstasy use has historically been linked to the electronic dance-music scene, and is concentrated among young adults, particularly young males. Problems associated with use of this drug include acute hyperthermia and mental health problems. Ecstasy-related deaths are rare.

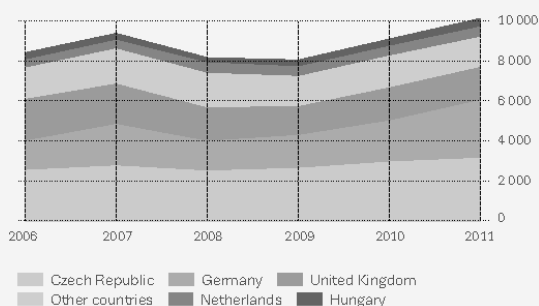
It is estimated that 1.8 million young adults used ecstasy in the last year, with national estimates ranging from under 0.1% to 3.1%. Consumption of the drug typically peaked in the early to mid 2000s, before declining (Figure 2.6). Between 2006 and 2011, most countries have reported stable or declining trends in ecstasy use. With the exception of Poland, this decline continues to be seen in data from countries reporting surveys since 2010. Few users entered treatment for problems relating to ecstasy

AMPHETAMINES USERS IN TREATMENT

Characteristics



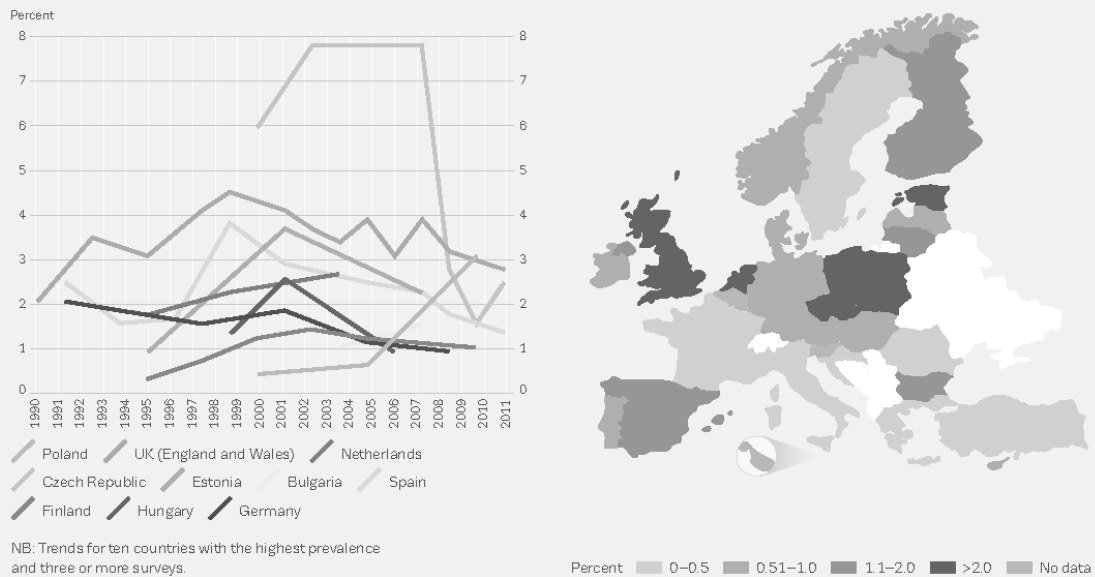
Trends in first-time entrants



NB: Characteristics are for all treatment entrants with amphetamines as primary drug. Trends are for first-time treatment entrants with amphetamines as primary drug. Countries covered vary by indicator.

FIGURE 2.6

Last year prevalence of ecstasy use among young adults: selected trends (left) and most recent data (right)



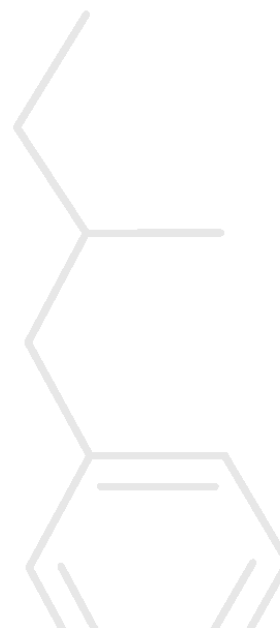
in 2011: ecstasy was mentioned as the primary drug by less than 1% (around 600 clients) of reported first-time treatment entrants in Europe.

Mephedrone: new contender on the stimulant market

There are signs that synthetic cathinones, including mephedrone, may have carved a space in the illicit stimulants market in some countries. At present, however, only the United Kingdom has repeat surveys that include these drugs. In the most recent data, 1.1% of adults (16–59) in England and Wales reported using mephedrone in the last year, making it the fourth most commonly used illicit drug. Among 16- to 24-year-olds, last year prevalence was the same as that of ecstasy (3.3%), the third most prevalent drug among this age group. A decrease in levels of use, however, was noted for all groups compared with the 2010/11 survey.

More generally, mephedrone-related mortality and morbidity continue to be reported in Europe, although at relatively low levels. Some countries also report the injection of mephedrone, MDPV and other synthetic cathinones, among groups of problem drug users and drug treatment clients (Hungary, Austria, Romania, United Kingdom).

Synthetic cathinones, including mephedrone, may have carved a space in the illicit stimulants market in some countries



Hallucinogens, GHB and ketamine: still in the picture

A number of psychoactive substances with hallucinogenic, anaesthetic and depressant properties are available on the illicit drug market in Europe: these may be used on their own, alongside, or in place of other more common drugs. The overall prevalence levels of hallucinogenic mushrooms and LSD use in Europe have been generally low and stable for a number of years. Among young adults (15–34), national surveys report last year prevalence estimates for the use of hallucinogenic mushrooms ranging from 0% to 2.2%, and for LSD from 0% to 1.7%.

Since the mid 1990s, recreational use of ketamine and gamma-hydroxybutyrate (GHB) has been reported among subgroups of drug users in Europe. Recognition is growing of the health problems related to these substances, for example, damage to the urinary tract associated with long-term ketamine use. Loss of consciousness and dependence are risks linked to use of GHB, and withdrawal syndrome has been documented. Where they exist, national estimates of the prevalence of GHB and ketamine use in both adult and school populations remain low. In the United Kingdom, 1.8% of 16- to 24-year-olds reported last year ketamine use, with levels remaining stable between 2008 and 2012, although increasing from 0.8% in 2006. Targeted surveys in nightlife settings report higher levels of lifetime prevalence, for example, a survey among Danish clubbers reported 10% had tried ketamine. Among UK respondents to an Internet survey who were identified as regular clubbers, 40% reported last year use of ketamine and 2% last year use of GHB.

Opioids: more than 1.4 million problem users

Use of opioids remains responsible for a disproportionately large share of the mortality and morbidity resulting from drug use in Europe. The main opioid used in Europe is heroin, which may be smoked, snorted or injected. A range of other synthetic opioids, such as buprenorphine, methadone and fentanyl, are also available on the illicit market. Most opioid users are polydrug users, and prevalence figures are higher in urban areas and among marginalised groups. In addition to health problems, opioid users entering treatment generally report higher levels of homelessness and unemployment and lower levels of education compared with users of other drugs.

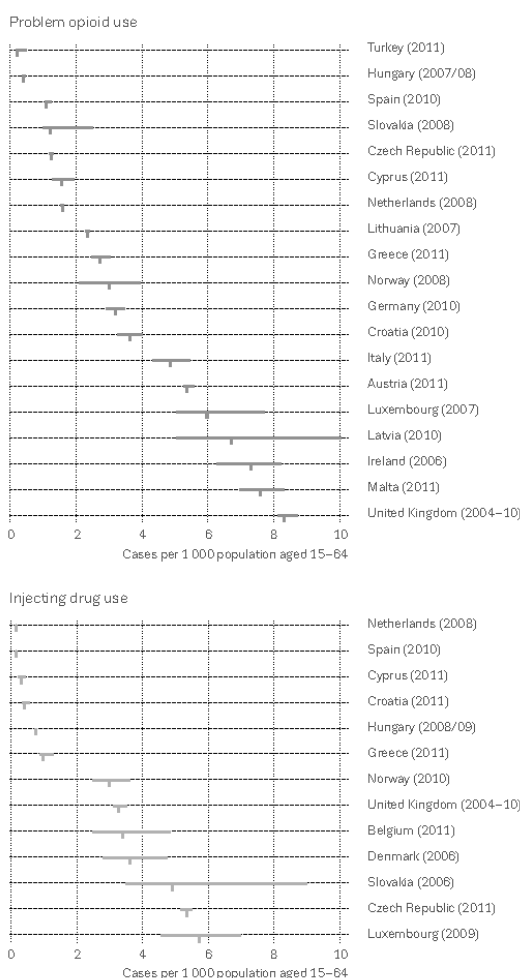
Europe has experienced different waves of heroin addiction, the first affecting many western European countries from the mid 1970s and a second wave affected

central and eastern Europe in the mid to late 1990s. Although trends have varied over the last decade, overall, new recruitment into heroin use now appears to be on the decline.

The average prevalence of problem opioid use among adults (15–64) is estimated at 0.41%, the equivalent of 1.4 million problem opioid users in Europe in 2011. At national level, prevalence estimates of problem opioid use vary between less than one and around eight cases per 1 000 population aged 15–64 (Figure 2.7).

FIGURE 2.7

National estimates of prevalence of problem opioid use and injecting drug use



NB: Data displayed as point estimates and uncertainty intervals.

FIGURE 2.8

Estimates of problem opioid use in Europe



Rate per 1000 0.0-2.5 2.51-5.0 >5.0 No data
 NB: Data for Poland and Finland from 2005.

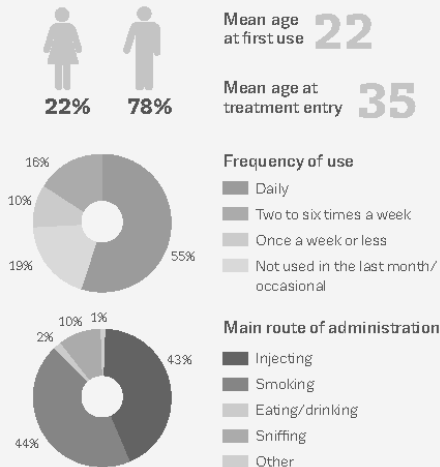
Heroin: decline in new clients entering treatment

Users of opioids (mainly heroin) represent 48% of all clients who entered specialised treatment in 2011 in Europe (197 000 clients) and around 30% of those entering treatment for the first time. In terms of trends, overall numbers of new heroin clients are on the decline in Europe, dropping from a peak of 59 000 in 2007 to 41 000 in 2011 and with reductions most apparent in western European countries. Overall, it appears that recruitment into heroin use may have been in decline, and that this is now impacting on treatment demand.

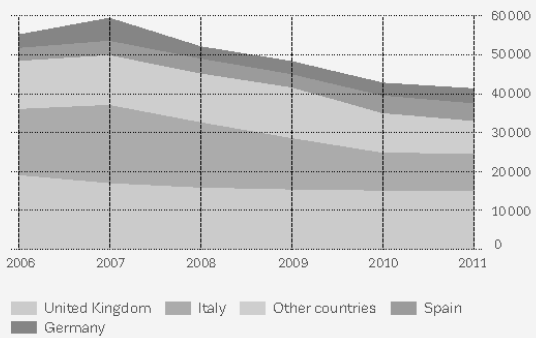
New recruitment into heroin use now appears to be on the decline

HEROIN USERS IN TREATMENT

Characteristics



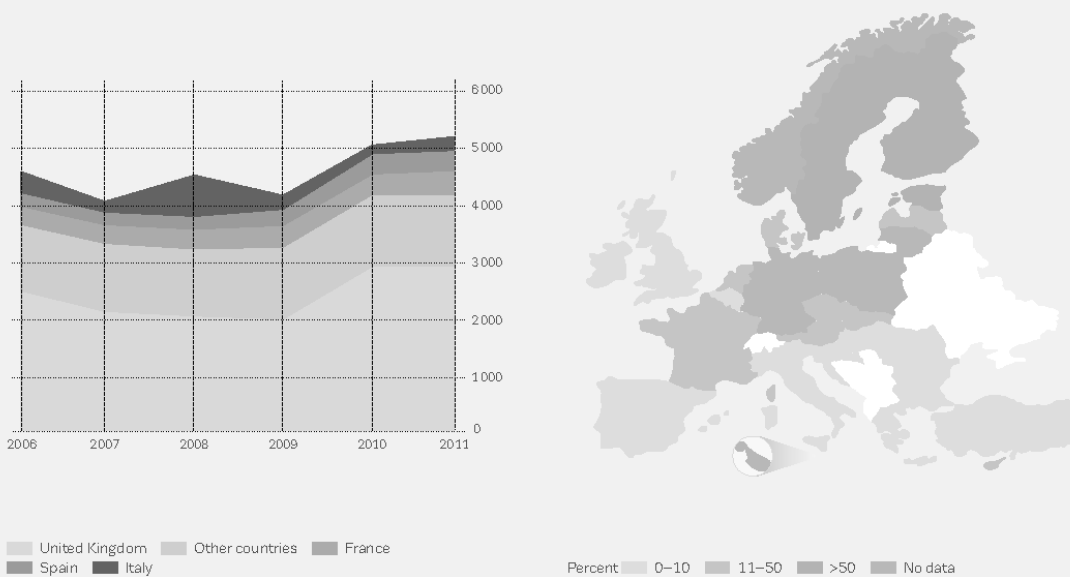
Trends in first-time entrants



NB: Characteristics are for all treatment entrants with heroin as primary drug. Trends are for first-time treatment entrants with heroin as primary drug. Countries covered vary by indicator.

FIGURE 2.9

First-time treatment entrants for opioids other than heroin: trends in numbers (left) and as a percentage of all first-time entrants with opioids as primary drug (right)



**Opioids other than heroin:
a challenge in some countries**

In 2011, eleven European countries reported that 10% or more of their first-time opioid clients entering specialised treatment were using opioids other than heroin, including fentanyl, methadone and buprenorphine (Figure 2.9). In some countries, these drugs now represent the most common form of opioid use: in Estonia, the majority of treatment entrants for opioids were using illicit fentanyl, while in Finland most opioid clients are reported to be primary users of buprenorphine.

Injecting drug use: long-term decline

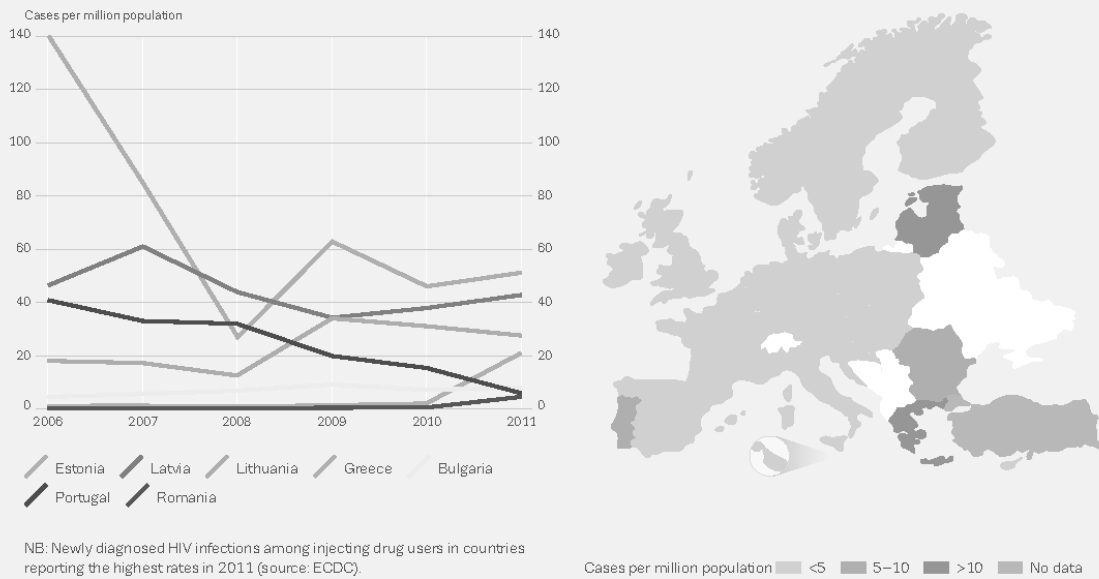
Injecting drug users are among those at highest risk of experiencing health problems from their drug use, such as blood-borne infections or drug overdoses. Injection is commonly associated with opioid use, although in a few countries, amphetamines injection is a major problem. Thirteen countries have recent estimates of the prevalence of injecting drug use, ranging from less than one to approximately six cases per 1 000 population aged 15–64. Among clients entering specialised treatment, 38% of opioid clients and 24% of amphetamines clients report injecting the drug. Levels of injecting among opioid clients vary between countries, from less than 9% in the Netherlands to more than 93% in Latvia. Between 2006 and 2011, there has been an overall decrease in the proportion of injectors among heroin clients entering drug treatment for the first time; the most recent data, however, show a small upturn.

40



FIGURE 2.10

Newly diagnosed HIV infections related to injecting drug use: selected trends (left) and most recent data (right)



Outbreaks threaten long-term decline in HIV

The injection of drugs continues to be an important mechanism for the transmission of infectious diseases, including HIV/AIDS and hepatitis C. The latest figures show that the long-term decline in the number of new HIV diagnoses in Europe might be interrupted as a result of outbreaks among injecting drug users in Greece and Romania (Figure 2.10). In 2011, the average rate of newly reported HIV diagnoses attributed to injecting drug use was 3.03 per million population. Although the figures are subject to revision, there were 1 507 newly reported cases in 2011, slightly more than in 2010, disrupting the overall downward trend observed since 2004.

The European figure masks important differences in levels and trends in new diagnoses of HIV in individual countries. In 2011, Greece and Romania accounted for 353 diagnoses, or 23% of the total, whereas in 2010 these countries represented just over 2% (31/1 469). Bulgaria, Estonia and Latvia reported slight increases in rates of newly diagnosed HIV infections among injecting drug users in 2011, while in contrast, the rates reported by Ireland, Spain and Portugal all continued to fall, in line with the downward trend observable since 2004.

Injecting drug users are among those at highest risk of experiencing health problems from their drug use

Hepatitis and other infections: major health issues

Viral hepatitis, in particular infection caused by the hepatitis C virus (HCV), is highly prevalent among injecting drug users across Europe. HCV antibody levels among national samples of injecting drug users in 2010–11 varied from 18% to 80%, with eight of the 12 countries with national data reporting a prevalence rate in excess of 40% (Figure 2.11). Prevalence at or above this level may indicate that a potential exists for new outbreaks of injecting-related HIV transmission. Among countries with national trend data for the period 2006–11, declining HCV prevalence in injecting drug users was reported in three countries (Italy, Portugal, Norway), while two others observed an increase (Greece, Cyprus).

Averaged across the 18 countries for which data are available for the period 2010–11, injecting drug use accounts for 58% of all HCV diagnoses and 41% of the acute diagnoses notified (where the risk category is

known). For hepatitis B, injecting drug users represent 7% of all diagnoses and 15% of acute diagnoses notified. Drug use may be a risk factor for other infectious diseases including: hepatitis A and D, sexually transmitted diseases, tuberculosis, tetanus, and botulism. Outbreaks of anthrax infection, probably caused by contaminated heroin, are also sporadically reported in Europe. For example, between June 2012 and early March 2013, 15 drug-related anthrax cases were reported, of which seven resulted in fatalities. This may be related to an earlier outbreak of anthrax cases reported in 2009/10.

Drug-related deaths: not only overdoses

Drug use is one of the major causes of mortality among young people in Europe, both directly through overdose (drug-induced deaths) and indirectly through drug-related diseases and accidents, violence and suicide. Most studies on cohorts of problem drug users show mortality rates in the range of 1–2% per year, representing an excess mortality 10 to 20 times greater than expected. A recent EMCDDA analysis estimated that between 10 000 and 20 000 opioid users die each year in Europe. Most of these deaths occur among males in their thirties; however, age, mortality rates, and causes of death vary across countries and time.

HIV-related mortality is the best documented indirect cause of death among drug users. The most recent estimate suggests that about 1 700 people died of HIV/AIDS attributable to injecting drug use in Europe in 2010, and the trend is downward. Liver disease is also likely to account for considerable numbers of deaths among drug users, mainly due to HCV infection, and often worsened by heavy alcohol use, though European figures are not available. Suicide, injuries and homicide also have an impact on excess mortality among drug users although again reliable estimates are lacking.

The main cause of death among problem drug users in Europe is drug overdose, and opioids, mainly heroin or its metabolites, are present in the majority of reported cases, often in combination with other substances such as alcohol or benzodiazepines. In addition to heroin, other opioids found in toxicological reports include methadone, buprenorphine and fentanyl.

Approximately 90% of overdose deaths reported in Europe occur among those aged over 25 years, and the average age of those dying from overdoses is rising, suggesting an ageing cohort of problem opioid users. Most overdose deaths (80%) are reported among men.

FIGURE 2.11

HCV antibody prevalence among injecting drug users, 2010/2011

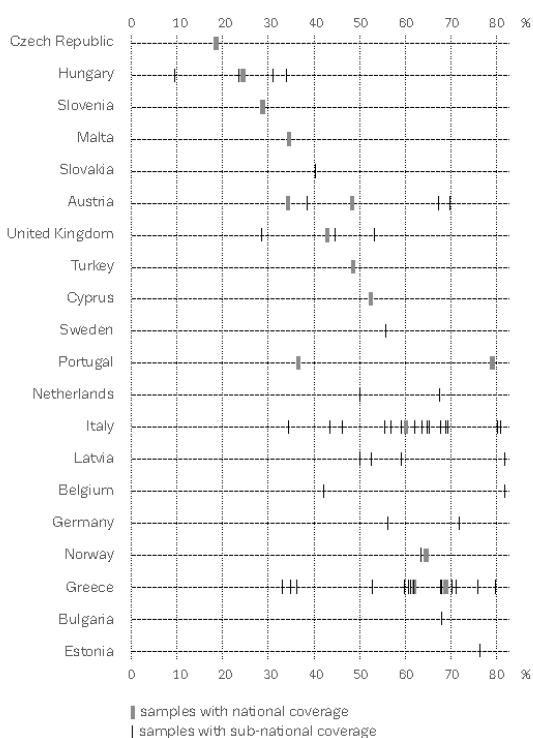
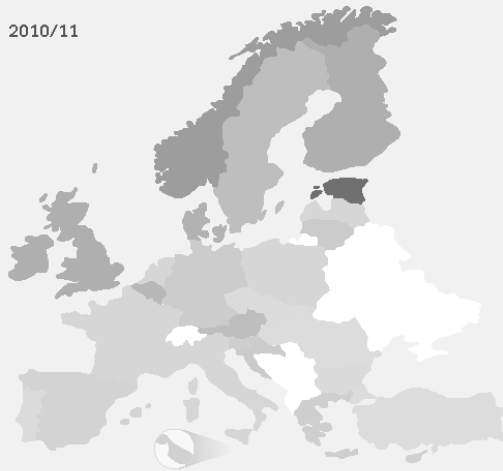


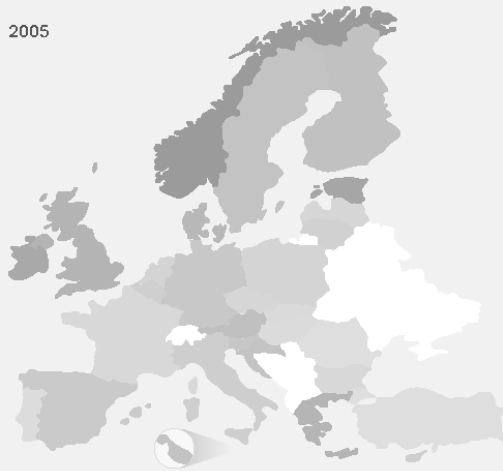
FIGURE 2.12

Drug-induced mortality rates among adults (15–64)

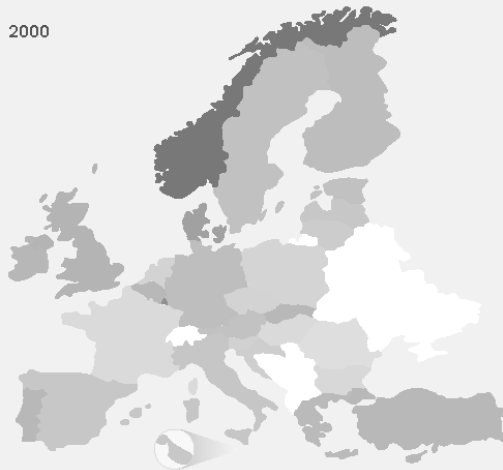
2010/11



2005



2000



1 17 51 85 119 136
Cases per million population

No data

For 2011, the average mortality rate due to overdoses in Europe is estimated at 18 deaths per million population aged 15–64. Rates of over 40 deaths per million were reported in six countries, with the highest rates reported in Norway (73 per million) and Estonia (136 per million) (Figure 2.12).

Most countries reported an increasing trend in overdose deaths from 2003 until 2008/09, when overall levels first stabilised and then began to decline. Overall, around 6 500 overdose deaths were reported in 2011, a decrease from the 7 000 cases in 2010 and 7 700 in 2009. Nevertheless, the situation varies for individual countries, with some still reporting increases.

Around 6 500 overdose deaths were reported in 2011, a decrease from the 7 000 cases in 2010 and 7 700 in 2009

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Driving under the influence of drugs, alcohol and medicines in Europe: findings from the DRUID project, Thematic paper.

Fentanyl in Europe. EMCDDA Trendspotter study.

Prevalence of daily cannabis use in the European Union and Norway, Thematic paper.

2011

Mortality related to drug use in Europe, Selected issue.

2010

Problem amphetamine and methamphetamine use in Europe, Selected issue.

Trends in injecting drug use in Europe, Selected issue.

2009

Polydrug use: patterns and responses, Selected issue.

2008

A cannabis reader: global issues and local experiences, Volume 2, Part I: Epidemiology, and Part II: Health effects of cannabis use, EMCDDA Monographs.

EMCDDA and ESPAD publications

2012

Summary of the 2011 ESPAD report.

EMCDDA and ECDC publications

2012

HIV in injecting drug users in the EU/EEA, following a reported increase of cases in Greece and Romania.

All publications are available at
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3

Drug-related responses may be broadly categorised as either drug demand reduction or drug supply reduction activities

Responding to drugs

Drug-related responses may be broadly categorised as either drug demand reduction or drug supply reduction activities. The former includes health and social interventions, such as prevention, harm reduction, treatment and social reintegration. The latter includes the enforcement of drug-related legislation, mainly by police, customs and the judiciary, with a primary aim of reducing the availability of drugs.

Monitoring drug-related responses

Responses to drugs are currently monitored using a combination of routine data sources and national assessments and expert ratings. Health and social responses data include estimates on the provision of opioid substitution treatment and needle and syringe provision. In addition, reviews of scientific evidence, such as those provided by the Cochrane Collaboration, provide information on the effectiveness of public health interventions. Further information on the data presented here and on the evidence base for responses can be found on the EMCDDA website in the Statistical bulletin and the Best practice portal.

Progress towards evidence-based prevention in schools

A number of prevention strategies are used to tackle drug use and drug-related problems. Environmental and universal approaches target entire populations, selective prevention targets vulnerable groups and indicated prevention focuses on at-risk individuals. In Europe, most prevention activity tends to take place in schools (Figure 3.1), although it is also implemented in other settings.

FIGURE 3.1

Availability of specific drug prevention interventions in schools
(expert ratings, 2010)School drug
policiesInterventions for social and
academic problemsEarly identification
approaches

■ Full/extensive ■ Limited/rare ■ Not available ■ No data

Evidence suggests that environmental prevention strategies, which aim at altering cultural, social, physical and economic environments, can be effective in changing normative beliefs and, consequently, substance use. In Europe as a whole, the use of environmental interventions in school settings remains rare. In some areas, however, such as the promotion of protective school climates and the development of school drug policies (e.g. guidelines on responding to use or sale of drugs by pupils), progress has been made. A small shift has also been noted towards the use of positively evaluated universal prevention approaches in schools, such as personal and social skills training, and a move away from activities such as basic information provision, where the evidence for effectiveness is weak. There has been an increasing number of reports of the successful transfer of positively evaluated North American and European prevention programmes (e.g. Good Behaviour Game, EUDAP (Unplugged), Örebro and Prevention).

Selective prevention interventions target vulnerable groups of young people who may be at greater risk of developing drug use problems. Expert reports indicate an overall increase in the availability of interventions for some vulnerable groups in Europe, in particular increased activity geared towards pupils with social and academic problems. Schools also represent an important setting for indicated prevention activities, including the use of approaches geared towards the early identification of pupils with behavioural and drug problems.

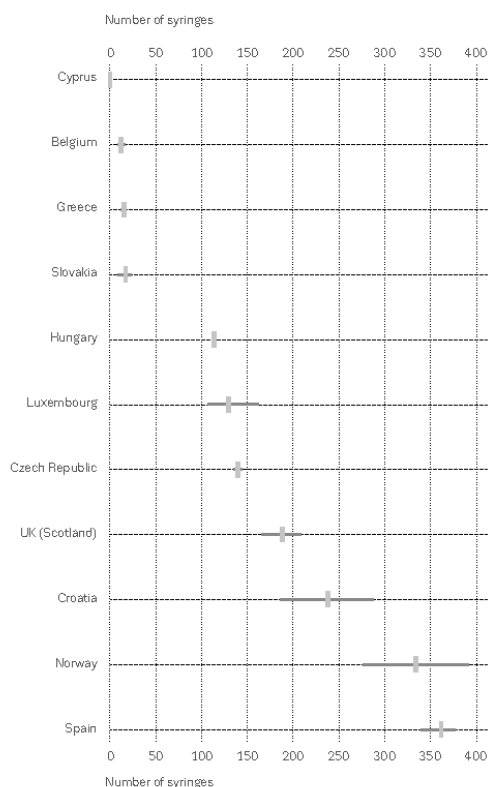
Interventions in nightlife settings: the need for an integrated approach

The use of illicit drugs, particularly stimulants, is known to be associated with nightlife settings, and young people attending some types of events may engage in patterns of drug and alcohol use that can place them at a high risk of experiencing health problems, accidents or injury. A European initiative, the Healthy Nightlife Toolbox, emphasises the importance of ensuring that recreational settings have a comprehensive set of measures in place to address these risks; the recommended approach integrates prevention, harm reduction, regulation and law enforcement interventions.

The use of prevention and harm-reduction strategies in recreational settings is reported by just over a third of countries. Some of these strategies target individuals, through the distribution of information leaflets, peer education interventions and use of mobile teams. Other strategies have an environmental focus: for example, regulating and licensing premises that sell

FIGURE 3.3

Number of syringes provided through specialised programmes per injecting drug user (estimate)



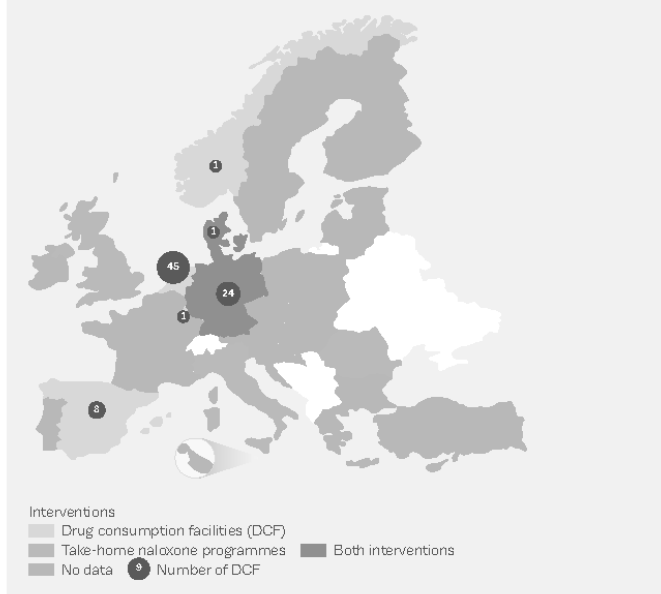
NB. Data displayed as point estimates and uncertainty intervals.

The number of syringes distributed through specialised programmes has increased from 34.2 million in 2005 to 46.3 million in 2011 in the 23 countries providing national data for both years. In the 11 countries for which recent estimates of the number of injecting drug users are available, specialised programmes distributed an average of 127 syringes per injecting drug user in 2011, ranging from less than 50 to more than 300 syringes per user (Figure 3.3).

A safe and effective vaccine exists to prevent the spread of hepatitis B virus (HBV), and 25 European countries have incorporated it into national vaccination programmes. Sixteen countries also report targeted HBV vaccination programmes for injecting drug users. For hepatitis C, for which a vaccine does not exist, similar prevention measures as for HIV transmission apply. However, in some European countries, initiatives directed at testing and counselling injecting drug users about hepatitis C are still limited and poorly funded. Modelling studies

FIGURE 3.4

Countries with take-home naloxone programmes and supervised drug consumption facilities in Europe



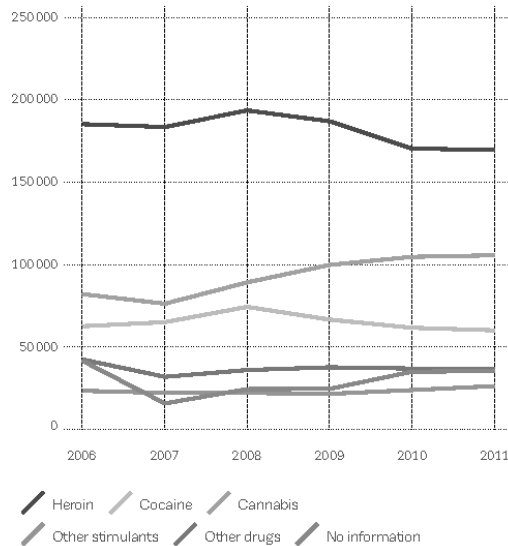
also suggest that getting infected users into hepatitis C antiviral treatment may reduce transmission of the virus. Despite this, and growing evidence supporting its effective use with injecting drug users, relatively few are currently receiving hepatitis C antiviral treatment in Europe.

Preventing drug-related deaths: a major public health challenge

Reducing drug overdoses and other drug-related deaths remains a major challenge for public health policy in Europe. Being in drug treatment, particularly opioid substitution treatment, significantly reduces the mortality risk of drug users, and improving access to, and retention in treatment can be viewed as an important overdose prevention measure. Overdose risks, however, are known to increase for opioid users on leaving prison and some forms of treatment, probably due to reduced levels of tolerance. One innovative approach to addressing these risks is to make the opioid antagonist drug naloxone more widely available. Five countries report pilot projects or programmes that provide take-home naloxone to opioid users, their family members and carers (Figure 3.4). In the United Kingdom, a study showed that, with minimal training, healthcare professionals, including drug workers, could increase their knowledge, skills and confidence for managing an opioid overdose and administering naloxone.

FIGURE 3.5

Numbers of clients entering specialised drug treatment services, by primary drug



The majority of countries report distribution of information on overdose risk to problem drug users. Overdose risk assessment by trained drug or health workers can also assist in the early identification of high-risk individuals, while supervised drug consumption facilities can reach groups of marginalised drug users. Such facilities exist in six countries, and may contribute to the prevention of overdose deaths and to reducing the impact of non-fatal overdoses.

More than a million Europeans in drug treatment

It is estimated that at least 1.2 million people received treatment for illicit drug use in Europe during 2011. Opioid users represent the largest group undergoing treatment, while data on treatment entries (Figure 3.5) suggest that cannabis and cocaine users are likely to be the second and third largest groups, although with differences observable between countries.

Psychosocial interventions, opioid substitution and detoxification are the main drug treatment modalities in Europe, and most treatment is provided in outpatient settings, such as specialised centres, general practitioners' surgeries and low-threshold facilities. A significant, although decreasing proportion of drug treatment is also provided in inpatient settings.

FIGURE 3.6

Predominant opioid substitution medication by number of clients



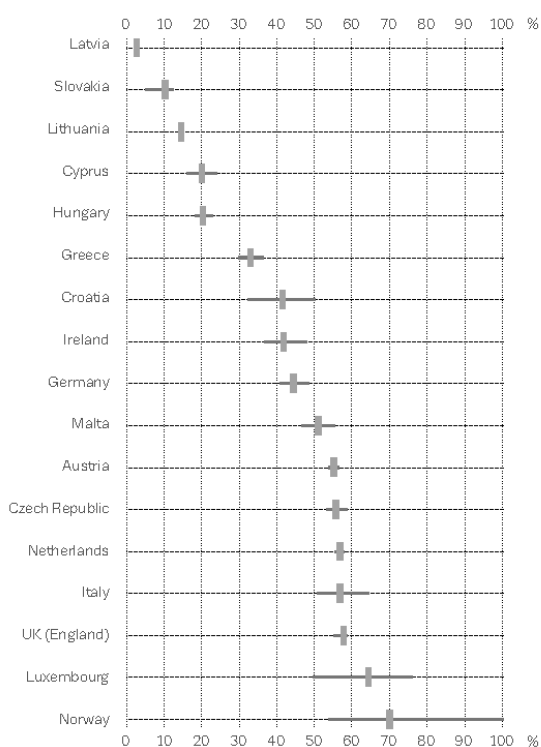
Opioid users: substitution treatment is the first choice

The most common treatment for opioid dependence in Europe is substitution treatment, typically integrated with psychosocial care and provided at specialised outpatient centres or by general practitioners. Methadone is the most commonly prescribed medication, received by up to three-quarters of clients, while buprenorphine is prescribed to most of the remaining clients, and is the principal substitution medication in five countries (Figure 3.6). Less than 5% of all substitution treatments in Europe rely on the prescription of other substances, such as slow-release morphine or diacetylmorphine (heroin).

It is estimated that at least 1.2 million people received treatment for illicit drug use in Europe during 2011

FIGURE 3.7

Percentage of problem opioid users in substitution treatment (estimate)



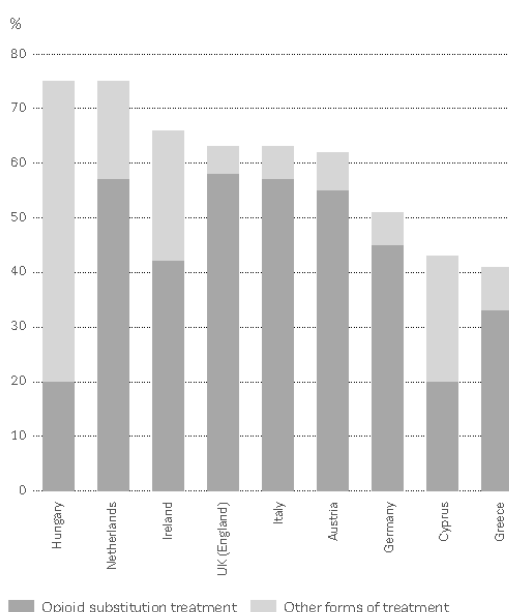
NB: Data displayed as point estimates and uncertainty intervals.

The available evidence supports opioid substitution treatment, combined with psychosocial care, for keeping patients in treatment, as well as reducing illicit opioid use and drug-related harms and mortality. Methadone, buprenorphine and diacetylmorphine have been shown to be effective in interrupting the cycle of intoxication and withdrawal, and thereby helping patients to stabilise and to comply with other types of interventions (treatment for HIV/AIDS and hepatitis, for example). Substitution treatment has also been shown to improve quality of life and facilitate social reintegration.

The total number of opioid users receiving substitution treatment in Europe is estimated at 730 000 in 2011, up from 650 000 in 2008. This probably represents about 50% of problem opioid users in Europe, an estimated coverage rate that is comparable to those reported for Australia and the United States. In Europe, however, large national differences in coverage rates exist, with the lowest estimated rates (3–20%) reported in Latvia, Slovakia and

FIGURE 3.8

Percentage of problem opioid users receiving drug treatment (estimate)



Lithuania (Figure 3.7). Long waiting times of between one and six months were reported by five countries, while waiting times exceeding six months were reported in Bulgaria and Greece. However, following HIV outbreaks among heroin injectors in 2010, Greece has recently scaled-up the provision of substitution treatment and waiting times have been reduced.

Other treatment for opioid users: available in all countries

Treatment without substitution medication is provided to opioid users in all European countries. It can take place in outpatient and residential facilities, and includes psychosocial interventions, such as cognitive-behavioural therapy, therapeutic communities and other approaches. Treatment is sometimes preceded by a detoxification programme, which provides pharmaceutical assistance to manage physical withdrawal symptoms. Cognitive-behavioural interventions have shown some effectiveness with opioid users, but evidence is not sufficiently robust to allow the identification of which intervention is the most effective. There is no conclusive evidence on the effectiveness of drug-free therapeutic communities.

The coverage of treatment approaches other than substitution medication, ranges from 5% to over 50% of all problem opioid users across the nine countries providing

FIGURE 3.9

Availability of specific treatment programmes for cocaine users (expert ratings, 2011)



FIGURE 3.10

Availability of specific treatment programmes for amphetamines users (expert ratings, 2011)



sufficient data (Figure 3.8). All of these countries have coverage rates for all type of treatments for problem opioid users exceeding 40%.

Treatment for cocaine users: specific programmes exist

The primary treatment options for cocaine dependence are psychosocial interventions, with contingency management appearing to be the intervention with the highest efficacy. In terms of medications, dopamine agonists and antipsychotic drugs may be effective in reducing cocaine use.

Although those with cocaine problems may be seen in generic treatment services, specialised programmes for cocaine or crack cocaine users exist in 12 countries (Figure 3.9), including the countries with the highest levels of cocaine use. In some countries, such programmes target socially integrated cocaine users who may be reluctant to attend other services. In Denmark and Austria, treatment for cocaine users is also provided in polydrug use programmes. Bulgaria, Malta and the Netherlands report that plans exist to provide specific treatment programmes in the near future. Specific guidelines for treating cocaine users have been developed in Denmark, Germany and the United Kingdom.

Amphetamines treatment: geographical differences

Psychosocial interventions provided in outpatient drug services are the primary treatment options for amphetamines users. Both cognitive-behavioural therapy and contingency management, sometimes in combination, appear to be associated with positive results. Several drugs have been studied to treat amphetamine and methamphetamine dependence, but robust evidence has yet to be provided for any pharmacological therapy.

The treatment options available for amphetamines users in Europe differ considerably between countries. Specifically tailored treatment programmes are primarily available in countries with a long history of treating amphetamines users (Figure 3.10). In addition, Bulgaria and Hungary report that plans exist to implement specific treatment programmes for amphetamine users in the near future.

FIGURE 3.11

Availability of specific treatment programmes for cannabis users (expert ratings, 2011)



Cannabis treatment: multiple approaches

In Europe, treatment for cannabis users spans a broad range of approaches including Internet-based treatment, brief interventions, multidimensional family therapy, cognitive-behavioural therapy and other structured psychosocial interventions in outpatient or inpatient settings. The criminal justice system, accident and emergency rooms, and mental health treatment units are important sources of referral in some countries. The availability of cannabis treatment evaluation studies has increased in recent years with, for example, a recent meta-analysis on multidimensional family therapy showing positive results in terms of reducing substance use and retention in treatment. Research is also being conducted on pharmaceuticals that may support psychosocial interventions. For example, rimonabant, an antagonist, has shown positive results for reducing acute physiological problems linked to cannabis smoking.

In 2011, more than half of European countries reported that specific cannabis treatment programmes were available (Figure 3.11), while Bulgaria, Cyprus, Hungary and Poland are planning to introduce programmes in this area.

Data on clients who entered specialised drug treatment in 2011 show that about half of them were unemployed and almost one in ten lacked stable accommodation

GHB: treatment options explored

Dependence on gamma-hydroxybutyrate (GHB) is a recognised clinical condition, with a potentially severe withdrawal syndrome following regular or chronic use. To date, research has focused on the description of that syndrome and the related complications, which can be difficult to recognise in emergency cases. As yet, standard protocols have not been devised for the treatment of GHB withdrawal syndrome, although investigations are being carried out in the Netherlands into controlled detoxification using medicinal products containing GHB.

Social reintegration: the missing element?

Data on clients who entered specialised drug treatment in 2011 show that about half of them were unemployed (47%) and almost one in ten lacked stable accommodation (9%). Low educational attainment is also common among this group, with 36% having completed only primary education, and 2% not even achieving this level of education.

Social reintegration services, which include improvement of social skills, promoting education and employability, and meeting housing needs, may either be provided alongside or after completion of drug treatment. While most countries report the existence of such reintegration services (Figure 3.12), levels of provision are generally insufficient in relation to needs. In addition, access to services is often conditional, for example, it may be dependent on drug-free status or stable housing, and this may exclude some of those most in need of support.

The success of social reintegration measures often relies on effective collaboration between different types of support services. This topic was explored in a recent EMCDDA survey, where 17 out of 28 countries reported the existence of some form of partnership agreements between drug treatment agencies and services offering support in areas such as housing and employment.

FIGURE 3.12

Availability of social reintegration programmes for drug users in treatment (expert ratings, 2010)



| Services for prisoners: still underdeveloped

Prisoners report higher overall rates of drug use than the general population and more harmful patterns of use, as indicated by recent studies reporting that between 5% and 31% of prisoners have ever injected drugs. On admission to prison, most users reduce or stop consuming drugs. Illicit drugs do, however, find their way into many prisons, and some prisoners continue or initiate use during incarceration.

As prisoners with drug problems often have multiple and complex health needs, which may require multi-disciplinary and specialist input from medical services, needs assessment upon prison entry is an important intervention. Most countries have now established interagency partnerships, between prison health services and providers in the community, to deliver health education and treatment interventions in prison, but also to ensure continuity of care upon prison entry and release. Seven European countries have assigned prison health to fall under the responsibility of the health ministries. Overall, however, the provision of drug services in prisons still often lags behind that available to the wider community, despite a general commitment to the principle of equivalence of care.

Drug-related services provided in European prisons cover a range of interventions which include: information provision, counselling and treatment, harm-reduction measures and preparation for release. Screening for infections, principally HIV, is frequently offered at prison entry, and in a few countries also upon release. HCV screening, however, is not always included in existing testing programmes. The provision of clean injecting equipment in prison settings is rare, with only four countries reporting that syringes are available in at least one prison.



FIGURE 3.13

Availability of opioid substitution treatment in prisons



FIGURE 3.14

Types of specialised drug law enforcement organisations in Europe



Opioid substitution treatment now exists in prisons in most countries, but its introduction has been slower than in the community. A recent estimate suggests that at least 74 000 prisoners have received this treatment during the year, although levels of provision vary considerably between countries. Restrictions may also exist, for example, some countries only provide substitution treatment to prisoners who were already receiving it prior to incarceration (Figure 3.13).

Drug supply reduction: a shift away from drug squads

Although demand reduction interventions are commonly documented, systematic data collection on supply reduction activities is much rarer, despite the fact that such activities often consume the greater share of national drug budgets. Drug law enforcement is a key component of supply reduction and the EMCDDA has recently initiated a pilot project to improve description and understanding of the organisation of activities in this area. A starting point for this has been a mapping of formally established law enforcement organisations that have as their primary mission the detection and investigation of breaches of

drug legislation. These include two main types: dedicated ‘drug squads’ and organised crime agencies with a specific drug supply reduction mandate.

At least one of these two types of organisations exists in 26 countries, which reported a total of more than 1 000 units with specific drug law enforcement mandates (Figure 3.14). The number of law enforcement officers specialising in work with illicit drugs was estimated for 23 countries, amounting to a minimum of 17 000 specialised officers, mostly from police forces. Although the numbers reported are not always directly comparable, specialised officers can be estimated to represent between 0.2% and 3.3% of all law enforcement officers at national level.

The majority of drug squads and organised crime agencies with a drug supply reduction mandate are affiliated with police forces, although a small number are also attached to customs services. Furthermore, 11 countries report the existence of multi-agency cooperation, usually in the

form of joint police and customs squads or units, but also sometimes including other agencies such as coastguards or border control agencies. These, however, amounted to only 42 out of the more than 1 000 bodies identified.

Although 21 countries report the existence of dedicated drug squads, data suggest that overall, this form of specialised unit is declining in Europe, in favour of the establishment of more comprehensive 'serious and organised crime' agencies. This mirrors, to some extent, developments at EU level, with drug supply being increasingly considered as one of several interlinked dimensions of the fight against organised crime by both Europol's Serious and Organised Crime Threat Assessment and within the European Council's policy cycle for organised and serious international crime.

The number of law enforcement officers specialising in work with illicit drugs was estimated for 23 countries, amounting to a minimum of 17 000 specialised officers

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EMCDDA and ECDC publications

2011

ECDC and EMCDDA guidance. Prevention and control of infectious diseases among people who inject drugs.

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4

**Drug control policies in Europe
work in the overall context provided
by the international control system
built on three United Nations Conventions**

Drug policies

In Europe, it is the responsibility of national governments and parliaments to adopt the legal, strategic, organisational and budgetary frameworks necessary to respond to drug-related problems, while EU drugs legislation and multi-annual strategies and action plans provide a framework for coordinated action. Together, these elements build the drug policies that allow countries to develop and implement the drug demand and supply reduction interventions reviewed in this report.

Monitoring drug policies

Key policy dimensions that can be monitored at European level include: drug laws and drug law offences, national drug strategies and action plans, policy coordination and evaluation mechanisms, as well as drug-related budgets and public expenditure. Data are collected via two EMCDDA networks: the national focal points and the legal correspondents. Data and methodological notes on drug law offences can be found in the Statistical bulletin, and comprehensive information on European drug policy and law is available online.

Drug laws: a common framework

Drug control policies in Europe work in the overall context provided by the international control system built on three United Nations Conventions. This system sets out a framework for controlling the production, trade and possession of over 240 psychoactive substances, most of which have a recognised medical use. The Conventions oblige each country to treat unauthorised supply as a criminal offence. The same is required for possession of drugs for personal use, but subject to a country's 'constitutional principles and the basic concepts of its legal system'. This clause has not been uniformly interpreted by European countries, and this is reflected in different legal approaches in this area.

Possession of drugs for personal use: moving away from prison sentences

In most European countries, the possession of drugs for personal use (and sometimes drug use) is a criminal offence punishable by a prison sentence. In some countries, however, it can only be punished by non-criminal sanctions such as fines or suspension of driving licence. An additional factor is the drug involved. In two-thirds of European countries, national laws prescribe the same penalty for a personal possession offence, regardless of the substance. For the remaining countries, the possible penalty varies according to the substance.

Overall, from around 2000, there has been a general trend across Europe to reduce the possibility of imprisonment for possession of drugs for personal use. Some countries have changed their legislation to remove prison penalties (for example Portugal, Slovenia, Bulgaria and, most recently, Croatia), while others have issued national directives to police or prosecutors to use sanctions other than prison. The approach taken in Portugal has received considerable international attention. The measures introduced in 2001 reduced the emphasis on punishment and direct drug users to a network of 'commissions for dissuasion of drug addiction', managed by the ministry of health.

In most European countries, the majority of reports of drug law offences relate to drug use or possession for use; overall in Europe, these totalled more than a million in 2011, a 15% increase compared to 2006. More than three-quarters of these offences involve cannabis (Figure 4.1).

Sentencing practices shed some light on the implementation and actual outcomes for drug use or personal possession offences in Europe. In 2009, an EMCDDA data collection indicated that many countries give fines, warnings or community work orders for possession of drugs for personal use, although some central and eastern European countries, such as Bulgaria, Poland, Romania, Slovakia and Croatia, were more likely to use suspended prison sentences.

Supply of drugs: variations in penalties

Illegal drug supply is always a crime in Europe, but the maximum possible penalties vary considerably. In some countries, a supply offence may be subject to a single wide penalty range (up to life in prison). Other countries differentiate between minor and major supply offences, determined by factors such as the quantity of drugs found, with corresponding maximum penalties. Another approach, found in 14 of the 30 countries considered here, is to vary penalties according to the drug involved (Figure 4.2).

Reports of drug supply offences have increased by one-quarter since 2006, reaching more than 225 000 cases in 2011. As for possession offences, cannabis accounted for the majority of reported supply offences. Cocaine, heroin and amphetamines, however, accounted for a larger share of offences for supply than for personal possession (Figure 4.3).

FIGURE 4.1

Reported offences related to drug use or possession for use in Europe, trends and breakdown by drug (main drugs)

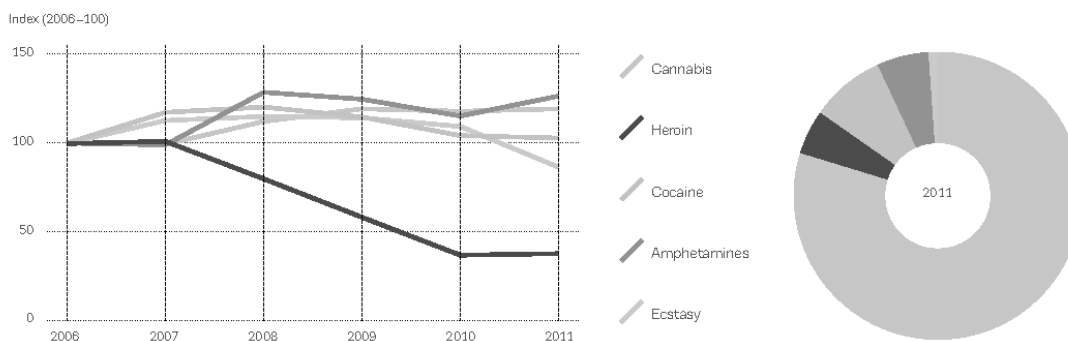


FIGURE 4.2

Penalties for drug law offences: variation by drug



FIGURE 4.4

National drug strategies and action plans, availability and scope



Sentencing statistics for a selected number of countries from 2009 show that a supply offence was more likely to receive a prison sentence than one for possession for use. However, maximum sentences were rarely or never imposed, while average prison sentences were short and often suspended, suggesting that only a small number of offenders were considered to be major traffickers. Results

also indicated that the average sentences differed by type of drug, even in those countries where the drugs are viewed equally under the law.

FIGURE 4.3

Reported offences related to drug supply in Europe, trends and breakdown by drug (main drugs)

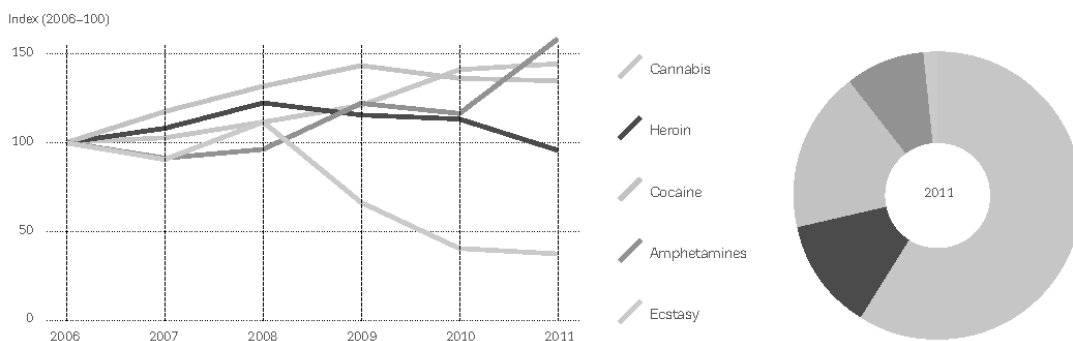
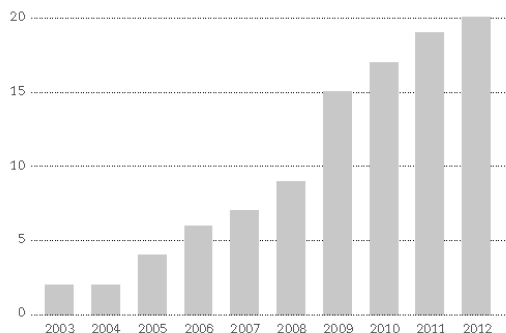


FIGURE 4.5

Cumulative number of countries with an evaluated national drug strategy



National drug strategies: a European standard

Since the late 1990s it has become established practice for national governments in Europe to adopt drug strategies and action plans. These time-limited documents contain a set of general principles, objectives and priorities, specifying actions and the parties responsible for their implementation. Currently, all countries have a national drug strategy or action plan, except Austria which has provincial plans. Five countries have adopted national strategies and action plans that cover both licit and illicit drugs (Figure 4.4).

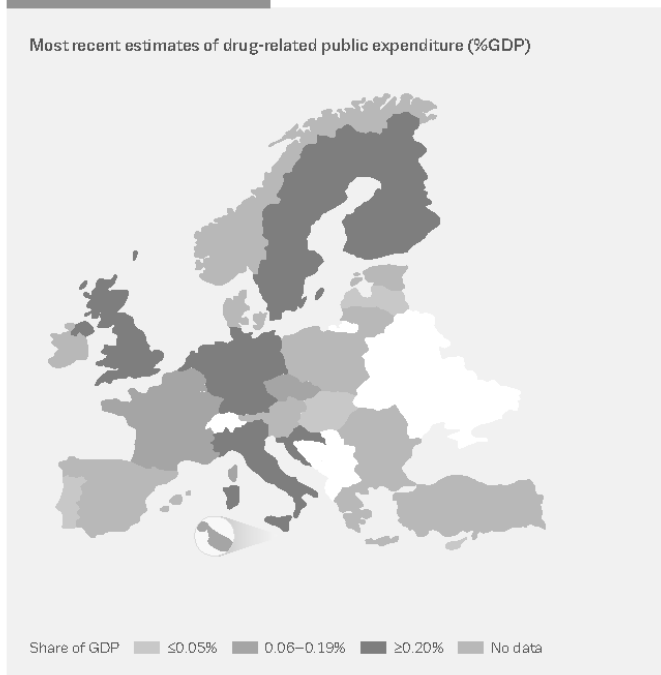
Supporting drug strategies: coordination and evaluation mechanisms

In parallel with the development of national drug strategies, countries have also set up mechanisms to coordinate the implementation of their drug policy. At national level, most countries now have an inter-ministerial committee on drugs, supplemented by a national drug coordination body, which is responsible for the day-to-day management of activities. In 14 countries, it is attached to the ministry of health, while elsewhere, it is attached to the office of government or the prime minister’s office, to the ministry of interior or to other ministries. Twenty-two countries also report having a formally appointed national drug coordinator, who is often the head of the national coordination body. National coordinators meet at EU level.

At the regional or local level, drug coordination agencies, drug coordinators, or both exist in most countries. In addition, in some countries, particularly those with a federal structure, vertical coordination bodies promote cooperation between the national and the local level. In

FIGURE 4.6

Most recent estimates of drug-related public expenditure (%GDP)



other countries, coordination at regional or local level is often directly supervised by the national bodies.

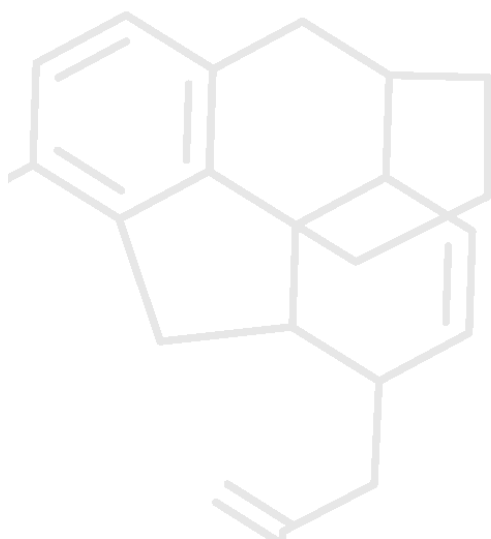
In recent years, both the European Union and an increasing number of countries have performed a final evaluation of their drug strategy or action plan (Figure 4.5). The aim is generally to assess the level of implementation achieved, as well as the changes in the overall drug situation, in order to inform the development of the next strategy. Across Europe, most evaluations are internal, performed by the agency or institution responsible for the plan, but an increasing number of countries have commissioned joint or external evaluations. Currently, most European countries have plans to undertake a final evaluation of their ongoing drug strategy.

Most countries now have an inter-ministerial committee on drugs, supplemented by a national drug coordination body, which is responsible for the day-to-day management of activities

Economic evaluation: the need for better data

Economic evaluation, by exploring the comparative costs and benefits of alternative courses of action, can be an important tool for policy evaluation. However, the quantity and quality of information available on drug-related public expenditure in Europe remains very limited, and this represents a major obstacle for cost-effectiveness analysis. There has, nevertheless, been an increase in the number of countries that have attempted to estimate, at least once over the last decade, how much government was spending on drug policy. These countries report expenditure estimates ranging from 0.01% to 0.7% of GDP (Figure 4.6), although comparisons between countries are difficult to make as the scope and quality of the estimates vary greatly. Despite these limitations, however, it appears from the information available that drug supply reduction activities account for the largest share of drug-related public expenditure in most countries.

Europe, like many other parts of the world is still facing the consequences of the recent economic downturn. These can include negative economic growth, increasing unemployment rates, particularly among young people, and reductions in government spending. Available budgets for health, public order and safety measures may have been affected, and this is where most drug-related public expenditure originates. Currently, the extent of the fiscal consolidation or austerity measures and their impact appear to differ considerably between European countries. Latvia, Lithuania and Estonia were among the countries with the largest reduction in public expenditure. Cuts in drug-related programmes and services are also now being reported by a number of European countries.



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Annex

National data presented here are drawn from and are a subset of the EMCDDA Statistical bulletin 2013, where further data, years, notes and meta-data are available

TABLE 1

OPIOIDS

| Country | Problem opioid use estimate cases per 1 000 | Treatment demand indicator, primary drug | | | | Clients in substitution treatment count |
|----------------|--|---|---------------------|---|---------------------|--|
| | | Opioid clients as % of treatment entrants | | % opioid clients injecting (main route of administration) | | |
| | | All entrants | First-time entrants | All entrants | First-time entrants | |
| | | % (count) | % (count) | % (count) | % (count) | count |
| Belgium | – | 36.8 (2 176) | 18 (403) | 19.7 (399) | 16.3 (60) | 17 701 |
| Bulgaria | – | 79.3 (1 877) | 93.2 (275) | 85.9 (1 300) | 84.2 (223) | 3 452 |
| Czech Republic | 1.2–1.3 | 19.4 (1 791) | 9.9 (443) | 86.3 (1 528) | 83.1 (359) | 5 200 |
| Denmark | – | 17.5 (663) | 7.1 (102) | 33.9 (193) | 23 (20) | 7 600 |
| Germany | 2.9–3.4 | 44.3 (31 450) | 19.2 (3 576) | 36.2 (13 827) | 33.2 (1 491) | 76 200 |
| Estonia | – | 91.4 (486) | 80.4 (131) | 84.5 (410) | 84 (110) | 1 076 |
| Ireland | 6.2–8.1 | 57.9 (4 930) | 39 (1 457) | 31 (1 488) | 22.9 (327) | 8 729 |
| Greece | 2.5–3.0 | 80.6 (4 693) | 73.4 (1 886) | 41.3 (1 930) | 38.7 (729) | 6 783 |
| Spain | 1.1–1.3 | 34.3 (18 374) | 18.2 (4 881) | 15.8 (2 756) | 10.2 (481) | 82 372 |
| France | – | 40.7 (14 987) | 20.2 (2 042) | 17.7 (2 097) | 12.3 (226) | 145 000 |
| Italy | 4.3–5.4 | 55.3 (23 416) | 42.4 (9 706) | 57.5 (12 566) | 50.5 (4 603) | 109 987 |
| Cyprus | 1.3–2.0 | 36.7 (365) | 10.8 (48) | 52.6 (191) | 46.8 (22) | 188 |
| Latvia | 5.0–9.9 | 52.9 (1 044) | 34.1 (126) | 93.3 (935) | 88.4 (107) | 277 |
| Lithuania | 2.3–2.4 | – | 72.1 (181) | – | 98.6 (136) | 798 |
| Luxembourg | 5.0–7.6 | 67.4 (151) | – | 58.9 (89) | – | 1 228 |
| Hungary | 0.4–0.5 | 6.8 (325) | 2.3 (75) | 66.8 (203) | 49.3 (34) | 639 |
| Malta | 6.9–8.2 | 78.7 (1 434) | 45.4 (83) | 62.5 (893) | 59 (49) | 1 107 |
| Netherlands | 1.6–1.6 | 12.8 (1 674) | 6 (461) | 8.9 (91) | 16 (46) | 10 085 |
| Austria | 5.2–5.5 | 64.5 (2 426) | 41.3 (566) | 42.2 (987) | 26.8 (146) | 16 782 |
| Poland | – | 48.2 (643) | 14.7 (53) | 77 (488) | 46.2 (24) | 2 200 |
| Portugal | – | 70.1 (2 637) | 54.4 (980) | 15.4 (147) | 13.1 (80) | 26 531 |
| Romania | – | 35 (648) | 29.6 (339) | 91.5 (590) | 90.2 (305) | 742 |
| Slovenia | – | 86.6 (451) | 74.9 (155) | 56.8 (256) | 49.7 (77) | 3 557 |
| Slovakia | 1.0–2.5 | 33.7 (691) | 22.7 (217) | 75.7 (514) | 63.1 (137) | 500 |
| Finland | – | 62.2 (898) | 43.8 (109) | 81.8 (719) | 66.7 (72) | 2 000 |
| Sweden | – | 24.8 (1 541) | 16.5 (255) | 55.7 (857) | 26.6 (69) | 3 115 |
| United Kingdom | 8.0–8.6 | 59.3 (68 112) | 40 (18 005) | 33.2 (22 081) | 29.2 (5 156) | 177 993 |
| Croatia | 3.2–4.0 | 80.9 (6 198) | 29.8 (343) | 74.5 (4 530) | 53.3 (171) | 4 074 |
| Turkey | 0.2–0.5 | 70.3 (1 488) | 64.7 (701) | 50.9 (746) | 48 (333) | 8 074 |
| Norway | 2.1–3.9 | 37.5 (2 884) | – | 73.1 (160) | – | 6 640 |

TABLE 2

COCAINE

| Country | Prevalence estimates | | | Treatment demand indicator, primary drug | | | |
|----------------|-------------------------|-------------------------------------|----------------------------|--|---------------------|--|---------------------|
| | General population | | School population | Cocaine clients as % of treatment entrants | | % cocaine clients injecting (main route of administration) | |
| | Lifetime, adult (15–64) | Last 12 months, young adult (15–34) | Lifetime, students (15–16) | All entrants | First-time entrants | All entrants | First-time entrants |
| | % | % | % | % (count) | % (count) | % (count) | % (count) |
| Belgium | – | 2 | 4 | 12.9 (764) | 13.6 (304) | 6.0 (37) | 1.2 (3) |
| Bulgaria | 1.7 | 1.5 | 3 | 0.8 (20) | 1.4 (4) | 3.0 (3) | 0 (0) |
| Czech Republic | 1.4 | 1.1 | 1 | 0.3 (30) | 0.3 (14) | 3.4 (1) | 0 (0) |
| Denmark | 4.4 | 2.5 | 2 | 5.1 (193) | 5.8 (84) | 10.1 (17) | 0 (0) |
| Germany | 3.3 | 1.8 | 3 | 5.9 (4 212) | 6.2 (1 164) | 19.8 (3 007) | 8.7 (256) |
| Estonia | – | 1.3 | – | – | – | – | – |
| Ireland | 6.8 | 2.8 | 3 | 10 (850) | 13.3 (496) | 1.3 (11) | 0.4 (2) |
| Greece | 0.7 | 0.2 | 1 | 4.3 (248) | 4.2 (109) | 1.9 (47) | 10.1 (11) |
| Spain | 8.8 | 3.6 | 3 | 41.4 (22 131) | 45.3 (12 148) | 2.3 (480) | 1.4 (167) |
| France | 3.66 | 1.85 | 4 | 6.9 (2 544) | 5.1 (519) | 10.2 (215) | 4.4 (21) |
| Italy | 4.2 | 1.3 | 2 | 24.3 (10 271) | 30.3 (6 938) | 5.3 (516) | 4.1 (273) |
| Cyprus | 3 | 2.2 | 4 | 10.1 (100) | 7 (31) | 1 (1) | 0 (0) |
| Latvia | 1.5 | 0.3 | 4 | 0.4 (7) | 0.3 (1) | 0 (0) | 0 (0) |
| Lithuania | 0.5 | 0.3 | 2 | – | 0.8 (2) | – | 0 (0) |
| Luxembourg | – | – | – | 18.3 (41) | – | 3.9 (16) | – |
| Hungary | 0.9 | 0.4 | 2 | 1.6 (78) | 1.6 (52) | 2.7 (2) | 0 (0) |
| Malta | 0.4 | – | 4 | 12.5 (228) | 28.4 (52) | 24.8 (56) | 17.6 (9) |
| Netherlands | 5.2 | 2.4 | 2 | 24.6 (3 220) | 20.3 (1 560) | 0.3 (6) | 0 (0) |
| Austria | 2.2 | 1.2 | – | 6 (226) | 7.6 (104) | 7 (15) | 3 (3) |
| Poland | 1.3 | 1.3 | 3 | 1.3 (17) | 2.2 (8) | 0 (0) | 0 (0) |
| Portugal | 1.9 | 1.2 | 4 | 10.5 (397) | 14.4 (259) | 3.6 (8) | 1 (2) |
| Romania | 0.3 | 0.2 | 2 | 1.2 (22) | 1.6 (18) | 4.8 (1) | 5.9 (1) |
| Slovenia | – | – | 3 | 3.5 (18) | 3.9 (8) | 44.4 (8) | 2.5 (2) |
| Slovakia | 0.6 | 0.4 | 2 | 0.8 (17) | 1.6 (15) | 0 (0) | 0 (0) |
| Finland | 1.7 | 0.6 | 1 | 0.1 (1) | 0 (0) | – | – |
| Sweden | 3.3 | 1.2 | 1 | 1.5 (91) | 1.7 (27) | 0 (0) | 0 (0) |
| United Kingdom | 9.6 | 4.2 | 3 | 12.3 (14 077) | 1.6 (7 185) | 2.1 (284) | 1 (68) |
| Croatia | 2.3 | 0.9 | 2 | 1.6 (126) | 2.6 (30) | 1.7 (2) | 3.6 (1) |
| Turkey | – | – | – | 2.2 (46) | 2.3 (25) | 2.2 (1) | 4 (1) |
| Norway | 2.5 | 0.6 | 1 | 1 (78) | – | 2.5 (2) | – |

TABLE 3

AMPHETAMINES

| Country | Prevalence estimates | | | Treatment demand indicator, primary drug | | | |
|----------------|-------------------------|-------------------------------------|----------------------------|---|---------------------|---|---------------------|
| | General population | | School population | Amphetamines clients as % of treatment entrants | | % amphetamines clients injecting (main route of administration) | |
| | Lifetime, adult (15–64) | Last 12 months, young adult (15–34) | Lifetime, students (15–16) | All entrants | First-time entrants | All entrants | First-time entrants |
| | % | % | % | % (count) | % (count) | % (count) | % (count) |
| Belgium | – | – | 5 | 9.8 (581) | 11.2 (250) | 9.1 (50) | 5 (12) |
| Bulgaria | 2.1 | 2.1 | 6 | 1.4 (33) | 1.7 (5) | 0 (0) | 0 (0) |
| Czech Republic | 2.1 | 0.8 | 2 | 65.2 (6 008) | 69.6 (3 122) | 77.4 (4 601) | 71.9 (2 210) |
| Denmark | 6.2 | 2 | 2 | 9.5 (358) | 10.3 (149) | 3.1 (9) | 0 (0) |
| Germany | 3.7 | 1.9 | 4 | 11 (7 785) | 15.2 (2 839) | 1.7 (246) | 0.7 (31) |
| Estonia | – | 2.5 | 3 | – | – | 61.5 (8) | 50 (4) |
| Ireland | 4.5 | 0.8 | 2 | 0.6 (53) | 0.9 (33) | 6 (3) | 6.3 (2) |
| Greece | 0.1 | 0.1 | 2 | 0.1 (6) | 0.1 (2) | 0 (0) | 0 (0) |
| Spain | 3.3 | 1.4 | 2 | 1 (517) | 1.2 (320) | 0.6 (3) | 0.6 (2) |
| France | 1.69 | 0.46 | 4 | 0.3 (107) | 0.3 (31) | 14.9 (13) | 0 (0) |
| Italy | 1.8 | 0.1 | 1 | 0.1 (38) | 0.1 (16) | 0 (0) | 0 (0) |
| Cyprus | 0.7 | 0.7 | 4 | 0.2 (2) | 0.2 (1) | 50 (1) | 0 (0) |
| Latvia | 2.2 | 1.9 | 4 | 19.3 (380) | 28.2 (104) | 60.9 (206) | 53.9 (48) |
| Lithuania | 1.6 | 1.1 | 3 | – | 2 (5) | – | 60 (3) |
| Luxembourg | – | – | – | 0.4 (1) | – | 0 (0) | – |
| Hungary | 1.8 | 1.2 | 6 | 11.9 (567) | 11 (354) | 23.3 (130) | 19.2 (67) |
| Malta | 0.4 | – | 3 | 0.2 (3) | – | 33.3 (1) | – |
| Netherlands | 3.1 | – | 3 | 6.2 (818) | 6.5 (499) | 0.6 (3) | 1 (3) |
| Austria | 2.5 | 0.9 | – | 2.2 (83) | 3.5 (48) | 3.7 (3) | 2.2 (1) |
| Poland | 4.2 | 1.3 | 4 | 21.4 (285) | 26.7 (96) | 9.4 (25) | 8.4 (8) |
| Portugal | 0.9 | 0.4 | 3 | 0 (1) | 0.1 (1) | – | – |
| Romania | 0.1 | 0 | 2 | 0.6 (12) | 0.9 (10) | 0 (0) | 0 (0) |
| Slovenia | – | – | 2 | 0.4 (2) | 0.5 (1) | 50 (1) | 0 (0) |
| Slovakia | 0.5 | 0.7 | 2 | 38.2 (784) | 41.9 (400) | 32.1 (243) | 25.4 (99) |
| Finland | 2.3 | 1.6 | 1 | 14.1 (204) | 11.6 (29) | 78.6 (154) | 64.3 (18) |
| Sweden | 5 | 1.5 | 1 | 27.8 (1 728) | 19.4 (301) | 68.6 (1 137) | 49.7 (149) |
| United Kingdom | 11.5 | 1.4 | 2 | 3 (3 486) | 3.6 (1 615) | 22.1 (714) | 16 (241) |
| Croatia | 2.6 | – | 2 | 1 (80) | 2.2 (25) | 0 (0) | 0 (0) |
| Turkey | 0.3 | – | – | 0.9 (18) | 0.8 (9) | 5.6 (1) | 0 (0) |
| Norway | 3.8 | 0.8 | 1 | 0 (0) | – | 75.1 (205) | – |

TABLE 4

ECSTASY

| Country | Prevalence estimates | | | Treatment demand indicator, primary drug | |
|----------------|-------------------------|-------------------------------------|----------------------------|--|---------------------|
| | General population | | School population | Ecstasy clients as % of treatment entrants | |
| | Lifetime, adult (15–64) | Last 12 months, young adult (15–34) | Lifetime, students (15–16) | All entrants | First-time entrants |
| | % | % | % | % (count) | % (count) |
| Belgium | – | – | 4.0 | 0.6 (38) | 1 (23) |
| Bulgaria | 1.7 | 1.6 | 4.0 | 0.3 (6) | 0.3 (1) |
| Czech Republic | 5.8 | 2.5 | 3.0 | 0.1 (6) | 0.1 (3) |
| Denmark | 2.1 | 0.8 | 1.0 | 0.3 (13) | 0.5 (7) |
| Germany | 2.4 | 1.0 | 2.0 | 0 (0) | 0 (0) |
| Estonia | – | 2.3 | 3.0 | – | – |
| Ireland | 6.9 | 0.9 | 2.0 | 0.6 (51) | 0.6 (24) |
| Greece | 0.4 | 0.4 | 2.0 | 0.2 (9) | 0.2 (5) |
| Spain | 3.6 | 1.4 | 2.0 | 0.2 (98) | 0.2 (66) |
| France | 2.4 | 0.4 | 3.0 | 0.3 (118) | 0.2 (24) |
| Italy | 1.8 | 0.1 | 1.0 | 0.3 (129) | 0.5 (107) |
| Cyprus | 2.0 | 1.0 | 3.0 | 0.3 (3) | 0.2 (1) |
| Latvia | 2.7 | 0.8 | 4.0 | 0.1 (2) | 0 (0) |
| Lithuania | 2.1 | 1.9 | 2.0 | – | – |
| Luxembourg | – | – | – | – | – |
| Hungary | 2.4 | 1.0 | 4.0 | 1 (50) | 1.2 (38) |
| Malta | 0.7 | – | 3.0 | 0.7 (13) | 1.6 (3) |
| Netherlands | 6.2 | 3.1 | 3.0 | 0.5 (69) | 0.8 (58) |
| Austria | 2.3 | 1.0 | – | 0.5 (19) | 1.2 (16) |
| Poland | 3.4 | 3.1 | 2.0 | 0.1 (1) | 0.3 (1) |
| Portugal | 1.3 | 0.9 | 3.0 | 0.1 (4) | 0.2 (4) |
| Romania | 0.7 | 0.4 | 2.0 | 0.5 (9) | 0.6 (7) |
| Slovenia | – | – | 2.0 | 0.2 (1) | 0.5 (1) |
| Slovakia | 1.9 | 0.9 | 4.0 | 0.1 (2) | 0.2 (2) |
| Finland | 1.8 | 1.1 | 1.0 | 0.3 (4) | 0.8 (2) |
| Sweden | 2.1 | 0.2 | 1.0 | 0.3 (17) | 0.5 (7) |
| United Kingdom | 8.6 | 2.8 | 3.0 | 0.2 (229) | 0.3 (141) |
| Croatia | 2.5 | 0.5 | 2.0 | 0.3 (23) | 0.5 (6) |
| Turkey | 0.1 | 0.1 | – | 0 (1) | 0.1 (1) |
| Norway | 1.0 | 0.6 | 1.0 | 0 (0) | – |

TABLE 5

CANNABIS

| Country | Prevalence estimates | | | Treatment demand indicator, primary drug | |
|----------------|-------------------------|-------------------------------------|----------------------------|---|---------------------|
| | General population | | School population | Cannabis clients as % of treatment entrants | |
| | Lifetime, adult (15–64) | Last 12 months, young adult (15–34) | Lifetime, students (15–16) | All entrants | First-time entrants |
| | % | % | % | % (count) | % (count) |
| Belgium | 14.3 | 11.2 | 24 | 31 (1 832) | 48.2 (1 077) |
| Bulgaria | 7.3 | 6 | 21 | 4.3 (101) | 3.1 (9) |
| Czech Republic | 24.9 | 16.1 | 42 | 13.2 (1 214) | 18.7 (839) |
| Denmark | 32.5 | 13.5 | 18 | 63.4 (2 397) | 72.6 (1 048) |
| Germany | 25.6 | 11.1 | 19 | 33 (23 418) | 54.9 (10 236) |
| Estonia | – | 13.6 | 24 | 5.3 (28) | – |
| Ireland | 25.3 | 10.3 | 18 | 22.9 (1 951) | 35.7 (1 336) |
| Greece | 8.9 | 3.2 | 8 | 12.8 (746) | 20.2 (518) |
| Spain | 27.4 | 17 | 32 | 21 (11 210) | 32.3 (8 653) |
| France | 32.12 | 17.54 | 39 | 47.8 (17 621) | 71.1 (7 193) |
| Italy | 21.7 | 8 | 13 | 18.8 (7 957) | 25.2 (5 781) |
| Cyprus | 11.6 | 7.9 | 7 | 48.8 (485) | 78.1 (346) |
| Latvia | 12.5 | 7.3 | 24 | 11.8 (232) | 19.8 (73) |
| Lithuania | 11.9 | 9.9 | 20 | – | 3.6 (9) |
| Luxembourg | – | – | – | 12.9 (29) | – |
| Hungary | 8.5 | 5.7 | 19 | 69.4 (3 321) | 77.3 (2 492) |
| Malta | 3.5 | 1.9 | 10 | 6.7 (122) | 20.8 (38) |
| Netherlands | 25.7 | 13.7 | 26 | 48.3 (6 334) | 58 (4 446) |
| Austria | 14.2 | 6.6 | – | 22.5 (848) | 41.8 (574) |
| Poland | 17.3 | 17.1 | 23 | 23.5 (313) | 44.4 (160) |
| Portugal | 11.7 | 6.7 | 14 | 13.9 (525) | 25.4 (457) |
| Romania | 1.6 | 0.6 | 7 | 8.6 (160) | 11.3 (130) |
| Slovenia | – | 6.9 | 23 | 8.4 (44) | 18.8 (39) |
| Slovakia | 10.5 | 7.3 | 27 | 19.2 (394) | 27.3 (260) |
| Finland | 18.3 | 11.2 | 11 | 13.4 (193) | 32.9 (82) |
| Sweden | 21.4 | 6.1 | 6 | 24.9 (1 550) | 45.1 (699) |
| United Kingdom | 31 | 12.3 | 21 | 20.3 (23 378) | 32.4 (14 559) |
| Croatia | 15.6 | 10.5 | 18 | 12.5 (957) | 52.7 (607) |
| Turkey | 0.7 | 0.4 | – | 17.1 (363) | 22.1 (240) |
| Norway | 14.6 | 7 | 5 | 20.3 (1561) | – |

TABLE 6

OTHER INDICATORS

| | Drug-induced deaths (aged 15–64) | HIV diagnoses among injecting drug users (ECDC) | Injecting drug use estimate | Syringes distributed through specialised programmes |
|----------------|---|---|--------------------------------|---|
| Country | cases per million population (count) | cases per million population (count) | cases per 1 000 population | count |
| Belgium | 19.6 (142) | 1 (11) | 2.5–4.8 | 938 674 |
| Bulgaria | 4.8 (24) | 8.4 (63) | – | 643 377 |
| Czech Republic | 3.8 (28) | 0.9 (9) | 5.1–5.5 | 5 398 317 |
| Denmark | 49.8 (181) | 1.8 (10) | 2.8–4.7 | – |
| Germany | 17.9 (966) | 1.1 (90) | – | – |
| Estonia | 135.7 (123) | 51.5 (69) | – | 2 130 306 |
| Ireland | 51.8 (159) | 3.6 (16) | – | 1 097 000 |
| Greece | – | 21.7 (245) | 0.9–1.3 | 119 397 |
| Spain | 12.5 (392) | 4.5 (148) | 0.2–0.2 | 2 672 228 |
| France | 7.9 (331) | 1.3 (87) | – | – |
| Italy | 9.1 (362) | 2.7 (161) | – | – |
| Cyprus | 16.3 (9.66) | 0 (0) | 0.3–0.5 | 42 |
| Latvia | 7.9 (11) | 40.4 (90) | – | 310 774 |
| Lithuania | 20.9 (43) | 26.5 (86) | – | 181 408 |
| Luxembourg | 17.1 (6) | 0 (0) | 4.5–6.9 | 246 858 |
| Hungary | 2 (14) | 0 (0) | 0.8 | 648 269 |
| Malta | 17.3 (5) | 0 (0) | – | 289 940 |
| Netherlands | 9.1 (101) | 0.2 (4) | 0.2–0.2 | – |
| Austria | 35.3 (201) | 4.3 (36) | – | 4 329 424 |
| Poland | 8.4 (232) | 1.2 (47) | – | 175 902 |
| Portugal | 2.7 (19) | 5.8 (62) | – | 1 650 951 |
| Romania | 1 (15) | 5 (108) | – | 901 410 |
| Slovenia | 16.9 (24) | 0 (0) | – | 632 462 |
| Slovakia | 3.9 (15) | 0.2 (1) | 3.5–8.9 | 15 064 |
| Finland | 53.3 (189) | 1.5 (8) | – | 3 539 009 |
| Sweden | 35.5 (217) | 1.3 (12) | – | 244 493 |
| United Kingdom | 52.3 (2 153) | 2.1 (131) | 3.1–3.5 | – |
| Croatia | 19.8 (59) | 0.7 (3) | 0.4–0.6 | 340 357 |
| Turkey | 1.9 (93) | 0.1 (5) | – | 0 |
| Norway | 73.1 (238) | 2 (10) | 2.5–3.6 | 2 639 000 |

TABLE 7

SEIZURES

| Country | Heroin | | Cocaine | | Amphetamines | | Ecstasy | |
|----------------|-----------------------|-----------------------------|-----------------------|-----------------------------|-----------------------|-----------------------------|----------------------------|-----------------------------|
| | Quantity seized kg | Number of seizures count | Quantity seized kg | Number of seizures count | Quantity seized kg | Number of seizures count | Quantity seized tablets | Number of seizures count |
| Belgium | 140 | 2 176 | 7 999 | 3 263 | 112 | 2 699 | 64 384 | 838 |
| Bulgaria | 385 | 41 | 4 | 22 | 233 | 38 | 7 879 | 11 |
| Czech Republic | 5 | 34 | 16 | 44 | 120 | 3 | 13 000 | 15 |
| Denmark | 37 | 484 | 43 | 1 756 | 255 | 1 733 | 16 000 | 197 |
| Germany | 498 | 4 361 | 1 941 | 3 335 | 1 368 | 9 131 | 484 992 | 1 322 |
| Estonia | 0.048 | 5 | 1 | 34 | 42 | 215 | 11 496 | 44 |
| Ireland | 32 | 752 | 179 | 476 | 23 | 104 | 97 882 | 272 |
| Greece | 307 | 2 477 | 463 | 466 | 184 | 17 | 70 | 8 |
| Spain | 412 | 7 587 | 16 609 | 42 659 | 278 | 3 178 | 183 028 | 2 123 |
| France | 883 | 4 834 | 10 834 | 4 538 | 601 | 387 | 1 510 500 | 781 |
| Italy | 811 | 3 588 | 6 342 | 6 859 | 19 | 124 | 14 108 | 114 |
| Cyprus | 0.6 | 49 | 3 | 79 | 0.011 | 5 | 653 | 13 |
| Latvia | 0 | 329 | 81 | 25 | 0.1 | 29 | 3 592 | 13 |
| Lithuania | 11 | 234 | 10 | 23 | 13 | 46 | 303 | 5 |
| Luxembourg | 24 | 244 | 24 | 94 | 3 | 15 | 91 | 6 |
| Hungary | 3 | 22 | 13 | 108 | 24 | 483 | 270 | 22 |
| Malta | 4 | 39 | 5 | 86 | 0.50 | 1 | 2 171 | 30 |
| Netherlands | 400 | – | 10 000 | – | 1 074 | – | 1 059 534 | – |
| Austria | 65 | 640 | 139 | 970 | 13 | 383 | 45 780 | 90 |
| Poland | 51 | – | 78 | – | 395 | – | 75 082 | – |
| Portugal | 73 | 1 169 | 3 678 | 1 385 | 0.2 | 26 | 7 791 | 95 |
| Romania | 13 | 314 | 161 | 73 | 0.4 | 28 | 7 594 | 96 |
| Slovenia | 4 | 503 | 2 | 272 | 1 | 204 | 34 | 14 |
| Slovakia | 0 | 33 | 35.3 | 30 | 13.22 | 10 | 27 | 5 |
| Finland | 1.0 | 3 | 4 | 81 | 71 | 3 157 | 17 800 | 300 |
| Sweden | 21 | 314 | 89 | 618 | 168 | 3 542 | 17 060 | 189 |
| United Kingdom | 1 850 | 9 174 | 3 468 | 17 751 | 1 048 | 6 801 | 686 000 | 3 346 |
| Croatia | 33 | 185 | 4 | 142 | 15 | 372 | 2 898 | 75 |
| Turkey | 7 294 | 3 306 | 592 | 1 457 | 14 | 6 | 1 364 253 | 2 587 |
| Norway | 15 | 1 364 | 46 | 840 | 75 | 2 894 | 5 327 | 198 |

TABLE 7

SEIZURES (continued)

| Country | Cannabis resin | | Herbal cannabis | | Cannabis plants | |
|----------------|-----------------------|-----------------------------|-----------------------|-----------------------------|--------------------------------|-----------------------------|
| | Quantity seized kg | Number of seizures count | Quantity seized kg | Number of seizures count | Quantity seized plants (kg) | Number of seizures count |
| Belgium | 5 020 | 5 156 | 5 095 | 21 784 | 337 955 (-) | 1 070 |
| Bulgaria | 16.8 | 11 | 1 035 | 168 | 7 456 (4 658) | 24 |
| Czech Republic | 2 | 24 | 441 | 508 | 62 817 (-) | 240 |
| Denmark | 2 267 | 8 403 | 168 | 891 | - (1 452) | 710 |
| Germany | 1 748 | 7 285 | 3 957 | 27 144 | - 133 650 | 1 804 |
| Estonia | 46 | 22 | 53 | 409 | - (29.3) | 25 |
| Ireland | 1 814 | 722 | 1 865 | 1 833 | 6 606 (-) | 582 |
| Greece | 122 | 172 | 13 393 | 5 774 | 33 242 (-) | 460 |
| Spain | 355 904 | 199 770 | 17 535 | 140 952 | - (26 108) | 1 438 |
| France | 55 641 | 85 096 | 5 450 | 12 155 | 73 572 (-) | 2 146 |
| Italy | 20 258 | 6 244 | 10 908 | 4 007 | 1 008 215 (-) | 1 208 |
| Cyprus | 1 | 33 | 76 | 758 | 86 (-) | 27 |
| Latvia | 283 | 55 | 34 | 399 | - (497) | 7 |
| Lithuania | 168 | 31 | 43 | 311 | - (-) | 0 |
| Luxembourg | 2 | 171 | 11 | 833 | 81 (-) | 5 |
| Hungary | 18 | 63 | 209 | 2 073 | 14 121 (-) | 192 |
| Malta | 89 | 48 | 1.5 | 32 | 44 (-) | 7 |
| Netherlands | 1 000 | - | 5 000 | - | 2 000 000 (-) | - |
| Austria | 75 | 1 197 | 621 | 5 272 | - (219) | 261 |
| Poland | - | - | 1 265 | - | 52 914 (-) | - |
| Portugal | 14 633 | 3 093 | 108 | 460 | 5 523 (-) | 304 |
| Romania | 18 | 328 | 252 | 1 365 | 897 (-) | 9 |
| Slovenia | 4.2 | 89 | 613 | 3 306 | 12 836 (-) | 178 |
| Slovakia | 0.0 | 22 | 137 | 1 512 | 10 045 (18) | 45 |
| Finland | 860 | 1 829 | 97 | 4 281 | 16 400 (42) | 3 187 |
| Sweden | 950 | 7 465 | 264 | 5 272 | - (-) | 92 |
| United Kingdom | 19 665 | 15 094 | 22 402 | 149 411 | 626 680 (-) | 16 672 |
| Croatia | 2 | 373 | 421 | 3 684 | 4 136 (-) | 195 |
| Turkey | 21 141 | 8 192 | 55 251 | 43 217 | - (-) | 7 318 |
| Norway | 2 548 | 11 232 | 219 | 3 631 | 1 099 (214) | 381 |

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About this report

The *Trends and developments* report presents a top-level overview of the drug phenomenon in Europe, covering drug supply, use and public health problems as well as drug policy and responses. Together with the online *Statistical bulletin*, *Country overviews* and *Perspectives on drugs*, it makes up the 2013 European Drug Report package.

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The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the hub of drug-related information in Europe. Its mission is to provide the EU and its Member States with 'factual, objective, reliable and comparable information' on drugs, drug addiction and their consequences. Established in 1993, it opened its doors in Lisbon in 1995 and is one of the EU's decentralised agencies. With a strong multidisciplinary team, the agency offers policymakers the evidence base they need for drawing up drug laws and strategies. It also helps professionals and researchers pinpoint best practice and new areas for analysis.

