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From:	EMCDDA
To:	Delegations
Subject:	European Drug Report 2014

Delegations will find in annex the EMCDDA's European Drug Report 2014.

European Monitoring Centre
for Drugs and Drug Addiction

European Drug Report

Trends and developments

2014

Legal notice

This report is available in Bulgarian, Spanish, Czech, Danish, German, Estonian, Greek, English, French, Croatian, Italian, Latvian, Lithuanian, Hungarian, Dutch, Polish, Portuguese, Romanian, Slovak, Slovenian, Finnish, Swedish and Norwegian. All translations were made by the Translation Centre for the Bodies of the European Union.

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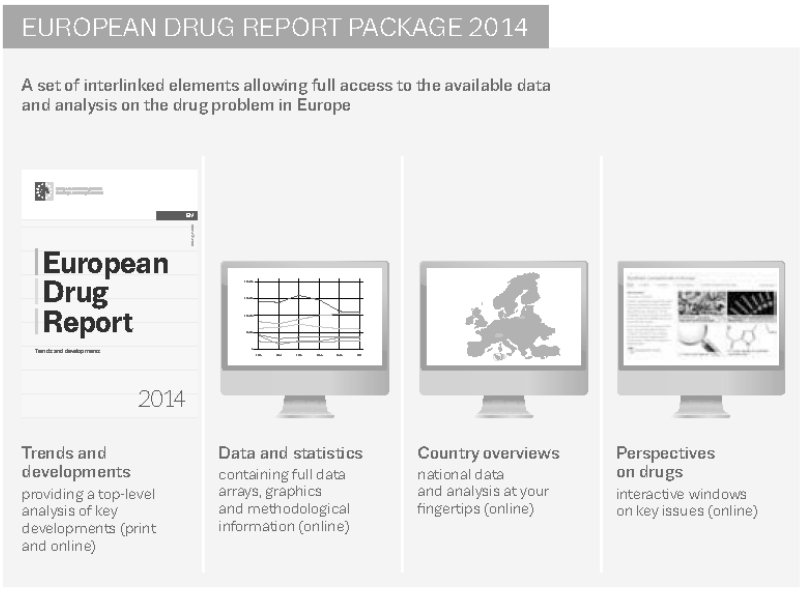
Preface

The EMCDDA's 2014 European Drug Report (EDR) presents a new analysis of the drug situation, accompanied by an overview of developments in interventions and policies. Rooted in a comprehensive review of both European and national data, the EDR package offers an interlinked range of products, with the Trends and developments report at its centre. By taking a multi-dimensional approach, an in-depth analysis of key topics is presented alongside a more top-level overview of major issues and long-term trends. This perspective is of value, as it allows differing national experiences to be understood within the broader context offered by European-level data. Whatever your interests in the European drug situation, we are confident that the new EDR package will allow you easy access to high-quality information and analysis in a form appropriate to your specific needs.



Progress has been made in developing a balanced policy response to drug problems in Europe, and this is an important message coming from this year's analysis. In some key public health areas, the overall trends are now positive, and in relative global terms, the European model appears to be a successful one. The drug phenomenon is dynamic and continues to evolve, leaving us no room for complacency, as new threats emerge to accompany residual and long-established problems. The drugs that we see today are, in many ways, different from those we knew in the past. We see this in the established drugs, a notable example being cannabis, where new production techniques are impacting on the potency of both resin and herbal products. We see this also in synthetic drug production, with a plethora of new substances appearing. It must be a serious concern that, recently, we have witnessed the emergence of both new synthetic opioids and hallucinogenic substances that are so highly pharmacologically active that even tiny quantities can be used to produce multiple doses. We are only beginning to grasp the future implications of these developments for both public health and drug control, but they do appear to have the potential to transform the nature of the problems we face.

Not only are important changes taking place in the European drug market, they are occurring at an ever greater pace and within the context of an increasingly interconnected world. The EMCDDA recognises the global and dynamic nature of our subject matter, and the challenges this poses. Moreover, these developments place our current monitoring systems under increasing strain, and it is critical to ensure that our surveillance tools remain fit for purpose. Nearly two decades ago, Europe was the first to establish an early-warning system to identify potential new threats in this area. Today, the system has proved its worth, but nevertheless our overall forensic capacity to identify and report on the public health consequences of both established and new substances remains insufficient. We can only note here the importance of ensuring that sufficient resources are made available for maintaining and strengthening work in this area, and highlight the added value that this provides to the European community as a whole.

Finally, we take pride in the comprehensive analysis provided by the EDR package and that our work continues to provide a scientific bedrock for informing European policies and responses. We strongly believe, now more than ever, that this is important, and we will continue to strive to provide a timely, objective and balanced analysis of today's complex and changing drug problem.

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 in the form of a national report by the EU Member States, the candidate country Turkey, and Norway.

Statistical data reported here are for 2012, 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 online *European Drug Report: Data and statistics*, 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), the Sewage Analysis Core Group Europe (SCORE) 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 Composiciones 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, the candidate country Turkey, Norway 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.

Summary

This report provides a top-level overview of the long-term trends and developments in Europe, while also focusing in on emerging drug-related problems

Charting the public health impact of drugs in a changing European market

The main findings in the EMCDDA's new analysis of the European drug problem remain consistent with our 2013 report: the overall situation is generally stable, with positive signs in some areas, but new challenges continue to emerge. The old dichotomy between a relatively small number of highly problematic drug users, often injecting, and a larger number of recreational and experimental users, is breaking down and being replaced by a more graduated and complex situation. In Europe's drug problem today, heroin plays a lesser part than it did in the past, and stimulants, synthetic drugs, cannabis and medicinal products are all becoming more important.

Looking at the 'big picture', progress has been made on a number of the major public health policy objectives of the past. A European-level perspective can, however, obscure important national differences. This is illustrated by data on overdose deaths and drug-related HIV infections; two of the most serious consequences of drug use. Here, an overall positive EU trend sits in sharp contrast to worrying developments in some countries. Recognising this complexity, this report provides a top-level overview of the long-term trends and developments in Europe, while also focusing in on emerging drug-related problems.

Heroin in decline, but replacement substances cause concern

While noting that globally, heroin production estimates remain high, and seizures in Turkey have partially rebounded, overall, heroin indicators are generally stable or trending downwards. This includes data showing a continuing decline in heroin-related treatment entry, alongside overall, long-term downward trends in drug overdose deaths and drug-acquired HIV infection — both historically linked to injecting heroin use. These positive developments are put in question, however, by some national data. Recent outbreaks of HIV among drug users in Greece and Romania, together with ongoing problems in some Baltic countries, have stalled Europe's progress in reducing the number of new drug-related infections. In part, this seems to be associated with the replacement of heroin by other substances, including synthetic opioids and stimulants. In addition, the absence of sufficient demand reduction interventions, particularly treatment

availability, and harm reduction measures is also likely to be an important contributory factor. Worryingly, a recent EMCDDA–ECDC risk assessment exercise also identified a number of other European countries where behavioural or response indicators suggested a potential elevated risk for future harms and health problems.

Multiple substances identified in drug-induced deaths

Drug overdose remains a major cause of avoidable mortality among young Europeans, in recent years, however, progress has been made in reducing this problem. In part, this can be explained by both a scaling-up in responses and by declines in contributory risk behaviours. In contrast to the overall trends, in a number of countries, mostly in the north of Europe, overdose deaths remain relatively high, and are increasing.

While deaths related to heroin are generally falling, deaths related to synthetic opioids are increasing, and in some countries now exceed those attributed to heroin. Exceptionally high rates of drug overdose deaths reported by Estonia, for example, are associated with the use of fentanyls, a family of highly potent synthetic opioids. In 2013, the EMCDDA continued to receive reports of both controlled and non-controlled fentanyls appearing on the European drug market. Among the drugs reported to the EU Early Warning System in 2013 was a fentanyl never previously noted on the EU drug market. These substances pose a challenge for identification, as they may be present in toxicological samples in very small quantities.

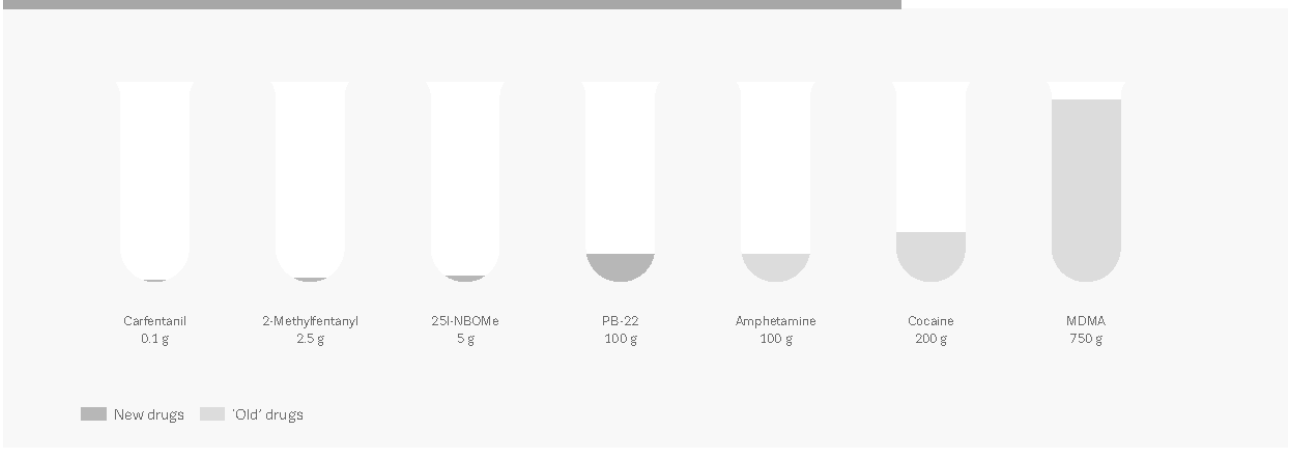
New psychoactive substances: no signs of abating

Most overdoses occur among individuals who have consumed multiple substances, and attributing causality is often problematic. With the continuing release of new psychoactive substances on the drug market, there is concern that new or obscure substances that have contributed to deaths may escape detection. The high potency of some synthetic substances further complicates their detection, as they will be present only at very low concentrations in the blood. The emergence of highly potent synthetic substances also has implications for law enforcement, as even small quantities of these drugs can be converted into multiple doses (Figure).

In 2013, 81 new psychoactive substances were notified to the EU Early Warning System, bringing the number of substances monitored to more than 350. Formal risk assessments are launched for substances suspected of causing significant harm at the European level. Risk assessments were carried out on two substances in 2013, and on a further four by April 2014, with more expected. This means that at a time when new EU legislation in this area is being discussed, the Early Warning System is coming under increasing pressure from the volume and variety of substances appearing on the market.

Central to the work of the Early Warning System are reports on adverse events, principally deaths and acute intoxications. However, robust monitoring systems for drug-related health emergencies exist in only a few countries. Standardised reporting on this topic does not take place at EU level and the lack of systematic

HOW MUCH PURE DRUG IS NEEDED TO MAKE 10 000 DOSES?



monitoring in this area represents a blind spot in Europe's surveillance of emerging health threats. An example of this is the difficulties in determining the implications at European level of reports from some countries of severe reactions to the use of synthetic cannabinoids.

Cannabis: controversies, contrasts and contradictions

Attitudinal data from the European Union suggests that cannabis is the drug where public opinion remains most polarised. This contributes to a lively public debate, which has recently been fuelled by international developments in the way cannabis availability and use is controlled, notably regulatory changes in parts of the United States and Latin America.

In Europe, in contrast to elsewhere, the overall use of cannabis appears to be stable or even declining, especially in younger age groups. The picture, however, is not uniform. A number of generally low-prevalence countries have observed recent increases in use.

In contrast to a policy debate characterised by discussion of regulatory options, practice developments primarily focus on measures to respond to the social problems and harms associated with cannabis production and use. The health implications of different patterns of cannabis use are becoming better understood. The availability and uptake of treatment for cannabis problems has increased, although the number of cannabis clients entering specialised drug treatment has stabilised. Cannabis is now the most commonly reported drug for receiving help among clients entering treatment for the first time in their life. The understanding of what constitutes an effective response in this area is also growing, with countries investing in a broad range of services, from intensive support sessions involving family members to brief interventions delivered over the Internet.

Since about 2000, many countries have reduced the severity of penalties applied for simple use or possession offences. More generally, European discussions on cannabis control have tended to focus on targeting drug supply and trafficking rather than use. In contradiction to this, however, the overall number of possession and use offences related to cannabis has been steadily increasing for nearly a decade.

At a glance — estimates of drug use in the European Union

Cannabis
73.6 million or 21.7 % of adults (15–64) used cannabis in their lifetime
18.1 million or 5.3 % of adults (15–64) used cannabis in the last year
14.6 million or 11.2 % of young adults (15–34) used cannabis in the last year
0.4 % and 18.5 % — lowest and highest national estimates of last year cannabis use among young adults
Cocaine
14.1 million or 4.2 % of adults (15–64) used cocaine in their lifetime
3.1 million or 0.9 % of adults (15–64) used cocaine in the last year
2.2 million or 1.7 % of young adults (15–34) used cocaine in the last year
0.2 % and 3.6 % — lowest and highest national estimates of last year cocaine use among young adults
Amphetamines
11.4 million or 3.4 % of adults (15–64) used amphetamines in their lifetime
1.5 million or 0.4 % of adults (15–64) used amphetamines in the last year
1.2 million or 0.9 % of young adults (15–34) used amphetamines in the last year
0.0 % and 2.5 % — lowest and highest national estimates of last year amphetamines use among young adults
Ecstasy
10.6 million or 3.1 % of adults (15–64) used ecstasy in their lifetime
1.6 million or 0.5 % of adults (15–64) used ecstasy in the last year
1.3 million or 1.0 % of young adults (15–34) used ecstasy in the last year
0.1 % and 3.1 % — lowest and highest national estimates of last year ecstasy use among young adults
Opioids
1.3 million problem opioid users (15–64)
3.5 % of all deaths of Europeans 15–39 years old are drug overdoses, opioids are found in about three-quarters of fatal overdoses
Principal drug in about 45 % of all drug treatment requests in the European Union
700 000 opioid users received substitution treatment in 2012

NB: For the complete set of data and information on the methodology see the accompanying online *European Drug Report: Data and statistics*.

Drug production and supply: core business for organised crime

The scale of the cannabis market combined with an increase in domestic production has led to a growing recognition of the importance of the drug as a cash generator for organised crime groups. Also now receiving more attention are the attendant social costs, which include violence and other forms of offending, and the strain that policing drug production places on law enforcement services.

Both internationally and within the European Union, South-East Asian organised crime groups, among others, have been associated with cannabis production. Worryingly, there are signs that they are now diversifying into methamphetamine production and sale in parts of central Europe. This reflects a more general development noted in the recent EMCDDA–Europol analysis of the drug market: for crime groups to take a more multi-commodity, opportunistic and interlinked approach. This can be seen in the case of crime groups historically involved in the heroin trade, and now reported to be trafficking cocaine and methamphetamine in the European Union, using established heroin routes.

The 2014 report raises new concerns about the evidence of increasing availability of methamphetamine in Europe. As well as domestic production in central and northern Europe, this drug is also produced in the Middle East and sometimes imported into the European Union for re-export to South-East Asian countries. Increasingly, however, some of this production is contributing to availability within Europe. New reports of the emergence of the smoking of methamphetamine in Greece and Turkey are particularly worrying, given the potential health risks associated with the use of the drug in this way.

The increasingly dynamic, global and innovative nature of the modern drug market is also illustrated by the re-emergence of high-quality ecstasy powders and pills

The increasingly dynamic, global and innovative nature of the modern drug market is also illustrated by the re emergence of high-quality ecstasy powders and pills in the European Union and elsewhere. This appears to result from illicit producers importing non-controlled or 'masked' chemicals for the manufacture of the drug. Recently, Europol noted the dismantling in Belgium of the two largest drug production sites ever found within the European Union, which were capable of rapidly producing large volumes of MDMA (3,4-methylenedioxy-methamphetamine). Seizures and reports of adverse health events have also prompted Europol and the EMCDDA to release a joint warning on the availability of extremely high-potency products containing MDMA.

A volatile stimulants market

It remains to be seen if the increases observed in the MDMA content of ecstasy tablets will result in renewed consumer interest in this drug. The overall European market for illicit stimulants appears to be relatively stable, with cocaine remaining the stimulant of choice in southern and western countries and amphetamine more prevalent in northern and eastern countries. Indicators for both cocaine and amphetamine use are generally downward.

The significance of geographical differences in Europe's stimulant market is supported by new wastewater studies, which are increasingly capable of providing data on drug consumption behaviours at the city level and in specific settings.

Availability is a key factor in stimulant consumption. Scarcity of a drug may cause consumers to try another substance, and price and perceptions of quality will be important considerations. This has been seen in recreational settings and among injecting drug users. A backdrop to this is the increasing number of products now available on the stimulants market, which includes synthetic cathinones, along with methamphetamine, amphetamine, ecstasy and cocaine.

The long-term costs of treating drug problems

Europe faces the dual challenge of developing effective responses to emerging problems and continuing to address the needs of drug users in long-term treatment.

This report highlights changes and the emergence of new patterns in epidemiology and responses. Nevertheless, the bulk of costs related to treating drug use continue to stem from problems that are rooted in the heroin 'epidemics' of the 1980s and 1990s. Although initiation into heroin use may be in decline, heroin dependence, characterised by a chronic disease model with cycles of relapse and treatment entry, remains a key focus for interventions. The European Union has invested considerably in providing treatment opportunities for this group, with an estimated three-quarters of a million currently in opioid substitution treatment. A strong argument can be made for the public health benefits of this intervention, and its contribution to weakening the illicit market. Europe is now faced with caring for an ageing cohort of current and former heroin users, many of whom are socially disadvantaged and excluded. In this context, there is growing policy interest in what constitutes recovery and social reintegration. Moreover, as this population ages, their vulnerabilities to a range of health problems are likely to increase.

1

Around one million seizures of illicit drugs are reported annually in Europe

Drug supply

Europe is a major destination for controlled substances and also plays a more 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. Europe is also a producing region for cannabis and synthetic drugs. Whereas virtually all cannabis produced in Europe is intended for local consumption, some synthetic drugs are also manufactured for export to other regions.

The availability of 'new psychoactive substances' that are not controlled under international drug control treaties represents a relatively new development in European drug markets. Commonly produced outside of Europe, these substances can be obtained through online retailers, specialised shops, and are also sometimes sold on to 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, and forensic analyses of drug seizures. Full data sets and methodological notes can be found in the online *European Drug Report: Data and statistics*. 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*.

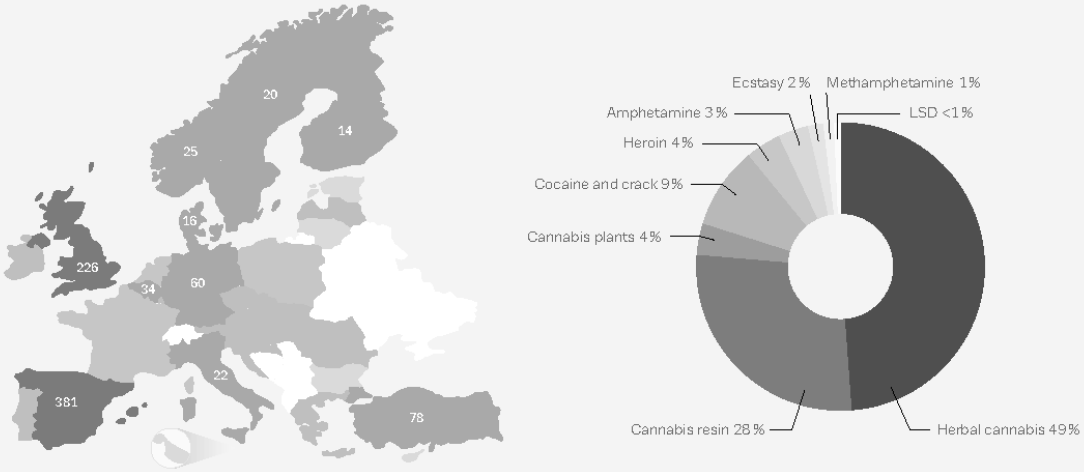
80 % of seizures in Europe are for cannabis

Around one million seizures of illicit drugs are reported annually in Europe. Most of these are small quantities of drugs confiscated from users, although this total also includes multi-kilogram consignments seized from traffickers and producers.

In 2012, two-thirds of all seizures in the European Union were reported by just two countries, Spain and the United Kingdom. Smaller, but non-trivial numbers of seizures were reported by Germany, Belgium, Italy and four Nordic countries (Figure 1.1). It should be noted that recent data are not available for three countries that reported sizeable

FIGURE 1.1

Number of reported seizures by country (left), and proportion of seizures for the main drugs (right), 2012



NB: Numbers of seizures (in thousands) for the ten countries with highest values.

numbers of seizures in the past. In addition, Turkey is an important country for drug seizures, with some of the drugs intercepted being intended for consumption in other countries, both in Europe and in the Middle East.

Over 80 % of seizures in Europe are for cannabis (Figure 1.1), reflecting its relatively high prevalence of use. Cocaine ranks second overall, with about double the number of seizures reported for either amphetamines or heroin. The number of ecstasy seizures is lower, but has been increasing in recent years.

Over 80 % of seizures in Europe are for cannabis, reflecting its relatively high prevalence of use

Cannabis: increasing availability of herbal products

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 2 000 tonnes.

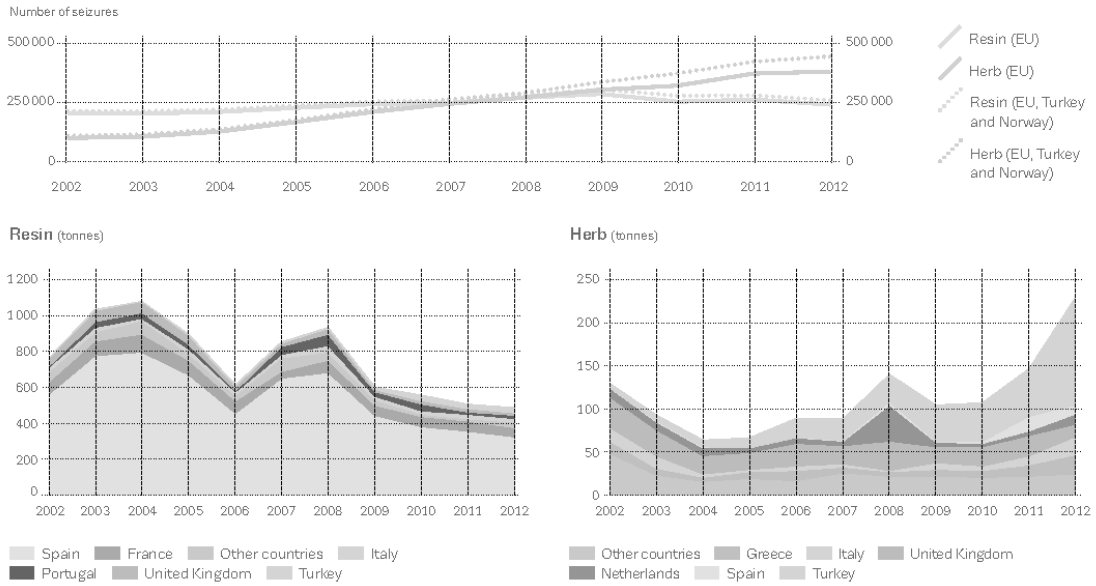
Herbal cannabis found in Europe is both cultivated domestically and trafficked from external countries. Most cannabis resin is imported by sea or by air from Morocco.

Over the past ten years, the number of herbal seizures has overtaken that of resin, and now represents almost two-thirds of all cannabis seizures (Figure 1.2). This reflects the growing availability of domestically produced herbal cannabis in many countries. The quantity of cannabis resin seized in the European Union, although falling in recent years, is still much higher than the quantity of herbal cannabis reported (457 tonnes versus 105 tonnes in 2012). This is probably explained by the fact that cannabis resin is more likely to be moved in volume across greater geographical distances and across borders, and is therefore more vulnerable to interdiction.

In terms of quantities seized, a small number of countries are disproportionately important, in part because of their location on major trafficking routes (Figures 1.2 and 1.3). Spain, for example, with its close proximity to Morocco, and substantial internal market, reported around

FIGURE 1.2

Number of cannabis seizures, and quantity seized in tonnes: resin and herb, 2002–12



CANNABIS

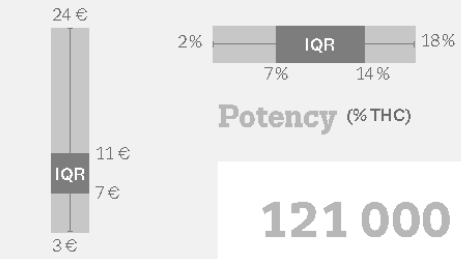
Resin

457 tonnes seized

240 000 seizures

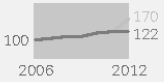
486 tonnes seized (EU + 2)

258 000 seizures (EU + 2)



Potency (% THC)

Price (EUR/g)



Price and potency indexes

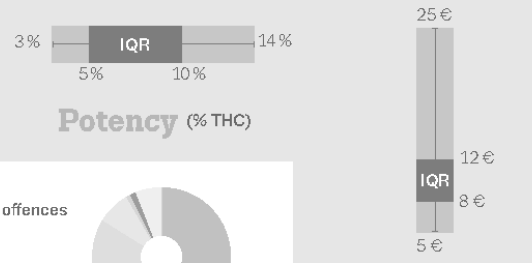
Herb

105 tonnes seized

395 000 seizures

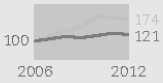
230 tonnes seized (EU + 2)

457 000 seizures (EU + 2)



Potency (% THC)

Price (EUR/g)



Price and potency indexes

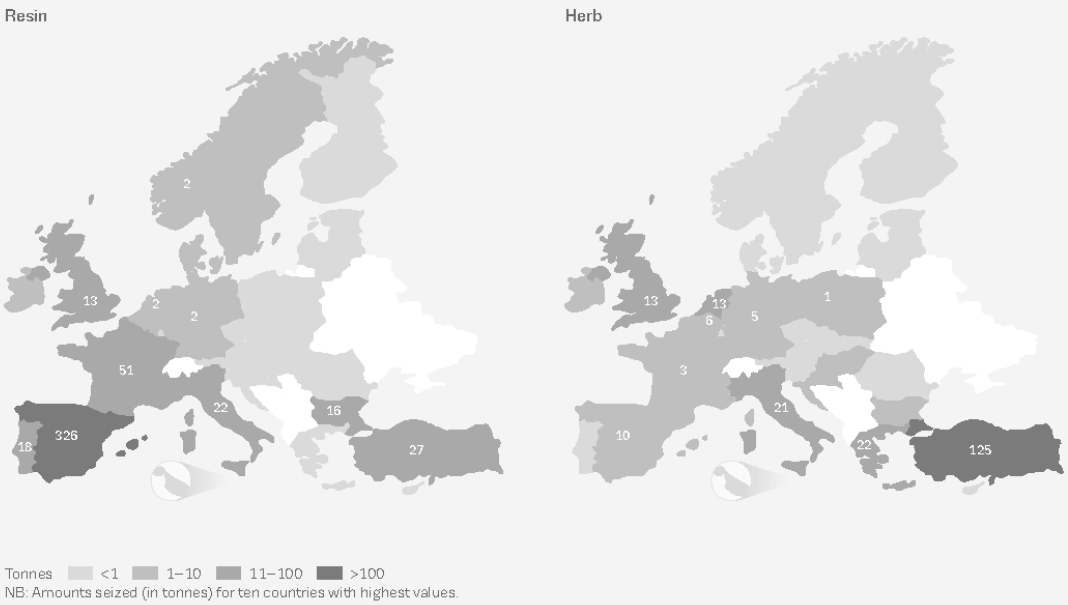
121 000 cannabis supply offences reported

59 % of reported supply offences

EU + 2 refers to EU Member States, Turkey and Norway. Price and potency of cannabis products: national mean values – minimum, maximum and interquartile range (IQR). Countries covered vary by indicator.

FIGURE 1.3

Quantity of cannabis resin and herbal cannabis seized, 2012



NB: Amounts seized (in tonnes) for ten countries with highest values.

two-thirds of the total quantity of resin seized in Europe in 2012. In respect to herbal cannabis, both Greece, and Italy reported recent large increases in quantities seized. Since 2007, Turkey has seized larger quantities of herbal cannabis than any of the EU Member States, and the amount reported in 2012 was more than double that reported in 2011.

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 2012, 33 000 seizures of cannabis plants were reported in Europe. Between 2011 and 2012, reports of numbers of cannabis plants seized increased from 5 million to 7 million, largely accounted for by a quadrupling of seizures reported from Italy. During the same period, quantities seized increased from 33 tonnes to 45 tonnes.

European-level indexed trends show increases in both the retail price and the potency (level of tetrahydrocannabinol, THC) of herbal cannabis and cannabis resin between 2006 and 2012. The potency of both forms of cannabis has increased since 2006, though, for resin, much of the increase is observed between 2011 and 2012.

The emergence of synthetic cannabinoids, chemicals that mimic the effects of cannabis, has added a new dimension to the cannabis market. Most synthetic cannabinoid powders appear to be manufactured in China, and are then shipped in bulk, using established legitimate transport and distribution networks. Once in the European Union, the chemicals are typically mixed with or sprayed onto herbs and packaged as 'legal high' products for sale either on the Internet or via other retailers. In the first six months of 2013, eighteen countries reported more than 1 800 seizures of synthetic cannabinoids. The largest seizures were reported by Spain (20 kg) and Finland (7 kg).

Heroin: overall decline in seizures, but increases in Turkey

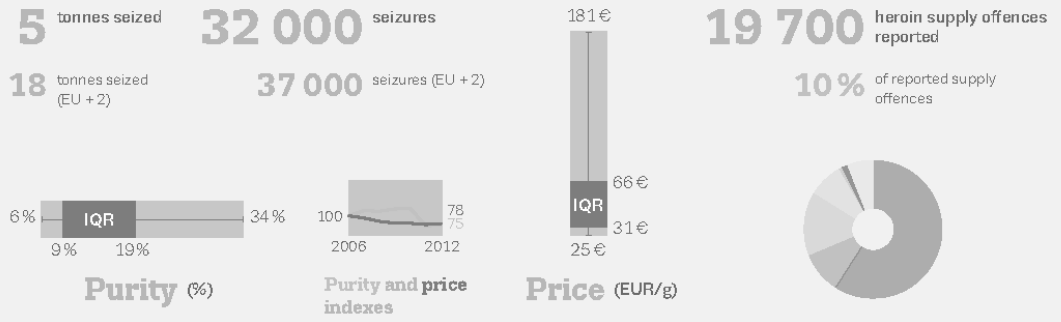
Two forms of imported heroin have historically been available in Europe: the more common of these is brown heroin (its chemical base form), originating mainly from Afghanistan. Far less common is white heroin (a salt form), which historically came from South-East Asia, but now may be produced elsewhere.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

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. The drug may enter Europe by a number of trafficking routes. One of these routes runs through Turkey, into Balkan countries (Bulgaria, Romania or Albania) and on to central, southern and western Europe. Another route runs through Russia, via the former Soviet republics of Central Asia. Heroin shipments from Iran and Pakistan may also enter Europe by air or sea, either directly or transiting through west and east African countries.

Between 2002 and 2010, the number of heroin seizures reported in Europe was relatively stable, with annual levels at around 50 000. However, since 2010, the number of heroin seizures has decreased considerably, with an estimated 32 000 seizures reported in 2012. The quantity of heroin seized in 2012 (5 tonnes) was the lowest reported in the last decade, and equivalent to only half of the quantity seized in 2002 (10 tonnes). Declining seizures in the European Union have been accompanied by

Since 2010, the number of heroin seizures has decreased considerably, with an estimated 32 000 seizures reported in 2012

HEROIN



EU + 2 refers to EU Member States, Turkey and Norway. Price and purity of 'brown heroin': national mean values – minimum, maximum and mean interquartile range (IQR). Countries covered vary by indicator.

FIGURE 1.4

Number of heroin seizures and quantity seized, 2002–12

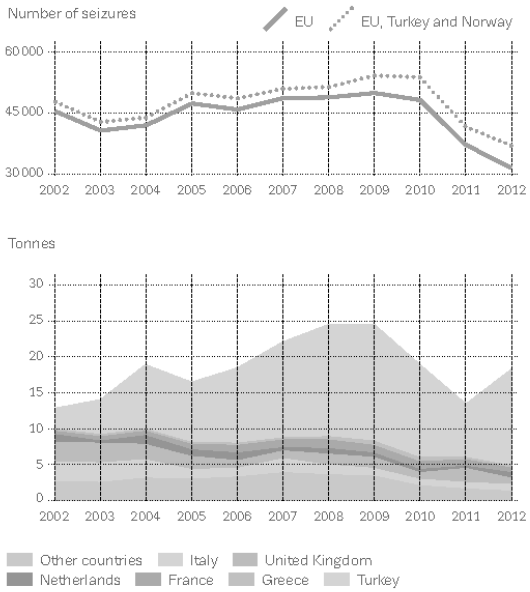


FIGURE 1.5

Quantity of heroin seized, 2012

NB: Amounts seized (in tonnes) for ten countries with highest values.

increasing seizures in Turkey, where, each year since 2006, more heroin has been seized than in all EU countries combined (Figures 1.4 and 1.5).

The decline seen in heroin seizures since 2010/11 is mirrored both in trends in purity data and supply offences related to the drug (see Chapter 4). A number of countries experienced significant market shortages at this time, from which few markets appear to have fully recovered. In Turkey, however, the quantities of heroin seized decreased in 2011, before returning to higher levels in 2012.

Synthetic opioids that can be used as alternatives to heroin have been reported to the EU Early Warning System. These include the highly potent fentanyls, which may be diverted from pharmaceutical supplies, including inadequately disposed analgesic patches, or they may be manufactured specifically for the illicit market. Between 2012 and 2013, 28 seizures were reported of a new synthetic opioid, AH-7921, which is similar to morphine in terms of pharmacology (see page 28).

Cocaine: number of seizures continues to decline

In Europe, cocaine is available in two forms, 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. Trafficking of cocaine into Europe — and law enforcement efforts against this trafficking — appears to take place mainly through western and southern countries, with Spain, Belgium, the Netherlands, France and Italy together accounting for 85 % of the 71 tonnes seized in 2012 (Figure 1.6). Signs of the ongoing diversification of cocaine trafficking routes into Europe include large individual seizures in ports in Bulgaria, Greece, Romania and Baltic countries.

In 2012, around 77 000 seizures of cocaine were reported in the European Union, amounting to 71 tonnes of the drug being intercepted. The number of cocaine seizures reported in 2012 remains at a high level compared to 2002. However, it has declined from an estimated peak of around 95 000 seizures in 2008. The quantity of cocaine

FIGURE 1.6

Number of cocaine seizures and quantity seized, 2002–12

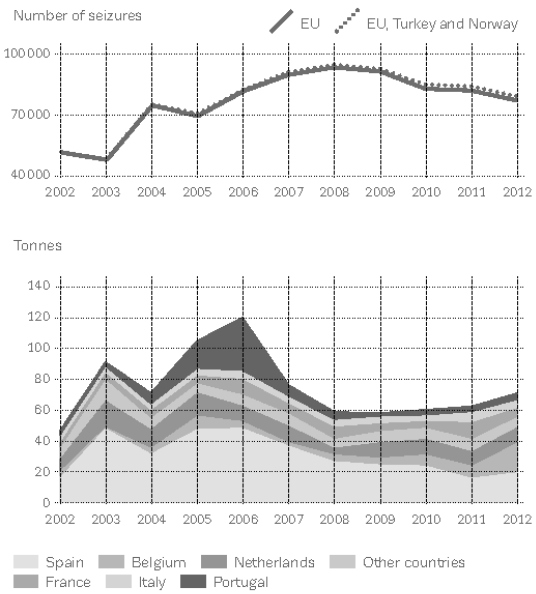
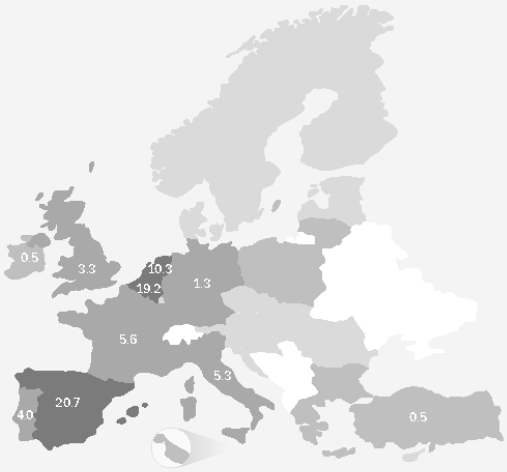


FIGURE 1.7

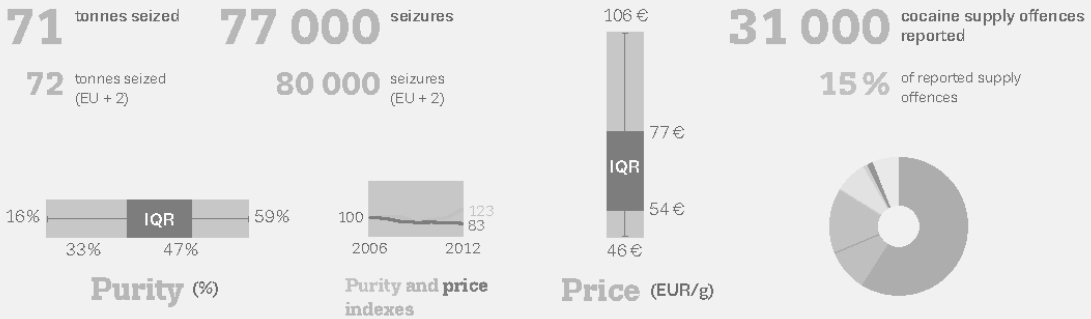
Quantity of cocaine seized, 2012



NB: Amounts seized (in tonnes) for ten countries with highest values.

seized in 2012 increased by around 10 tonnes over the previous year, but is still well below the peak of 120 tonnes seized in 2006 (Figure 1.6). Decreases in the quantity of cocaine seized are most observable in the Iberian Peninsula, particularly in Portugal between 2006 and 2007, and more gradually in Spain between 2006 and 2011. Record seizures of cocaine were reported in 2012 by Belgium (19 tonnes) (Figure 1.7).

COCAINE



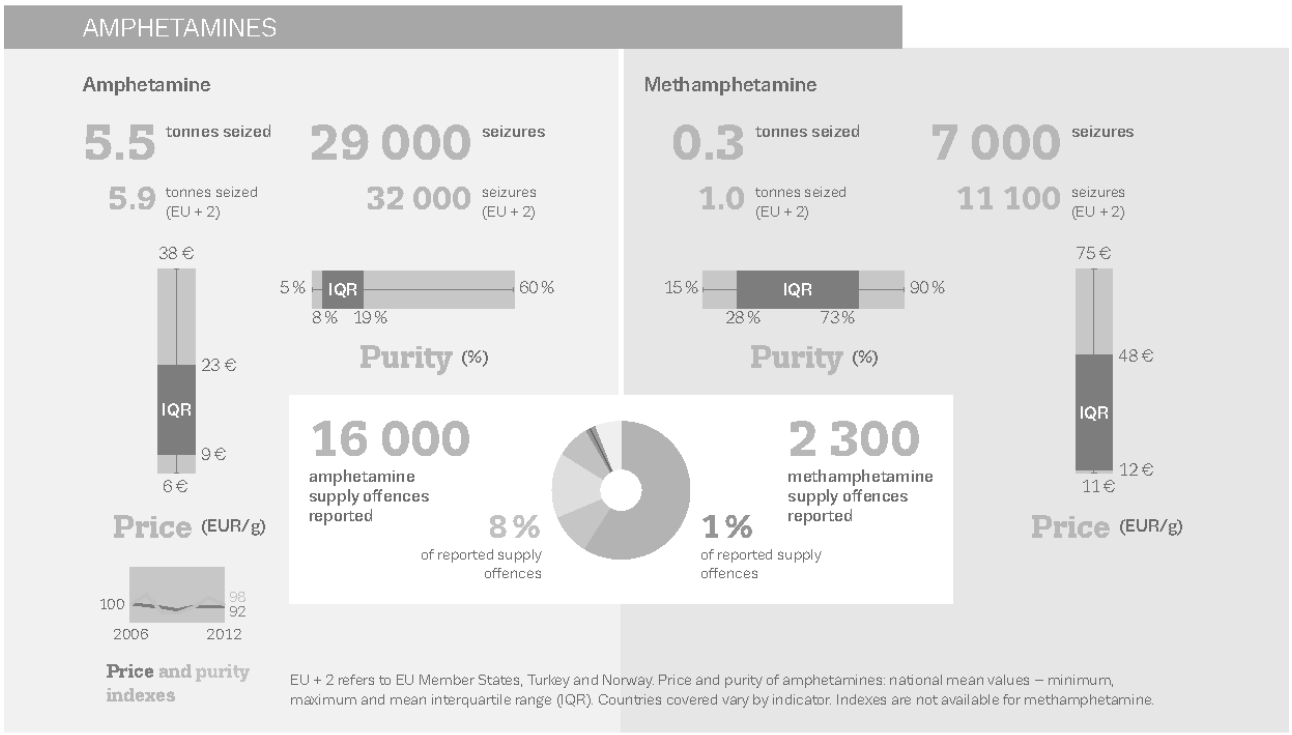
EU + 2 refers to EU Member States, Turkey and Norway. Price and purity of 'brown heroin': national mean values – minimum, maximum and mean interquartile range (IQR). Countries covered vary by indicator.

Amphetamines: signs of increased production of methamphetamine

Amphetamine and methamphetamine are closely related synthetic stimulants, generically known as amphetamines. Of the two, amphetamine has always been the more common in Europe, but there have been recent signs of the increasing availability of methamphetamine.

Both drugs are manufactured in Europe for domestic use, although some amphetamine is also manufactured for export, principally to the Middle East. Production of amphetamine is known to take place in Belgium and the Netherlands, as well as in Poland and in the Baltic countries. For methamphetamine production, two main areas can be identified. First, in the Baltic States, production is centred around Lithuania for export to Norway, Sweden and the United Kingdom. In this region, BMK (benzyl methyl ketone) is used as a principal precursor. In a second area, focused around the Czech Republic and neighbouring countries Slovakia and Germany, production is mainly based on ephedrine and pseudoephedrine and takes place in small-scale so-called kitchen laboratories. Here, the output is destined primarily for distribution within the country. In the last two years, there have been signs of increased involvement of Vietnamese organised crime groups in Czech methamphetamine markets and scaling-up of production. In 2011, there were 350 reports of dismantled methamphetamine production sites in Europe, most of these, however, were small-scale sites reported by the Czech Republic (338).

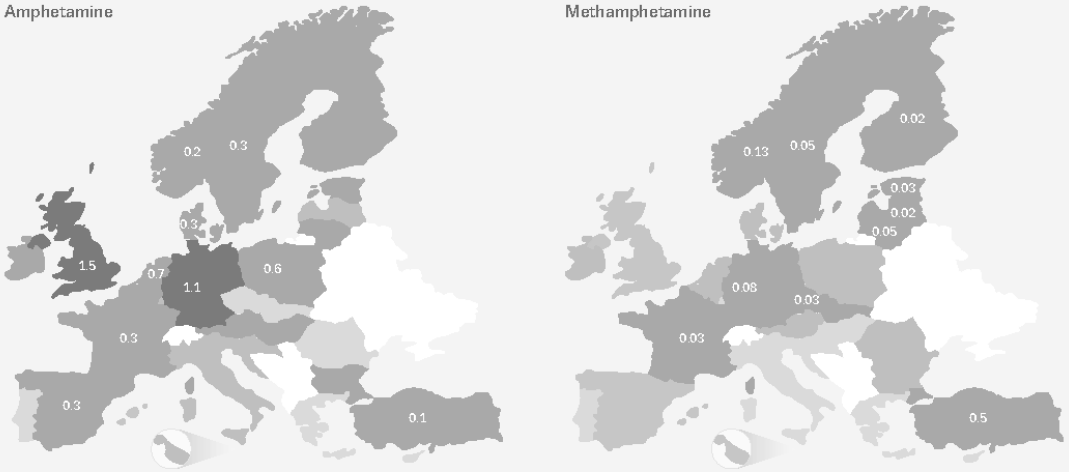
In 2012, 29 000 seizures of amphetamine were reported by Member States, amounting to 5.5 tonnes. More than half of the total quantity of amphetamine seized was accounted for by Germany, the Netherlands and the United Kingdom (Figure 1.8). After a period of higher levels, both in terms of numbers and quantity, amphetamine seizures in 2012 have returned to about the same level found in 2003 (Figure 1.9). Methamphetamine seizures, though still small in number and quantity, have increased over the same period (Figure 1.10). In 2012, 7 000 seizures amounting to 0.34 tonnes of methamphetamine were reported in the European Union. A further 4 000 seizures amounting to 0.64 tonnes were reported by Turkey and Norway, which together reported about twice the amount seized in the European Union.



EU + 2 refers to EU Member States, Turkey and Norway. Price and purity of amphetamines: national mean values – minimum, maximum and mean interquartile range (IQR). Countries covered vary by indicator. Indexes are not available for methamphetamine.

FIGURE 1.8

Quantity of amphetamine and methamphetamine seized, 2012



NB: Amounts seized (in tonnes) for the ten countries with highest values.

FIGURE 1.9

Number of amphetamine seizures and quantity seized, 2002–12

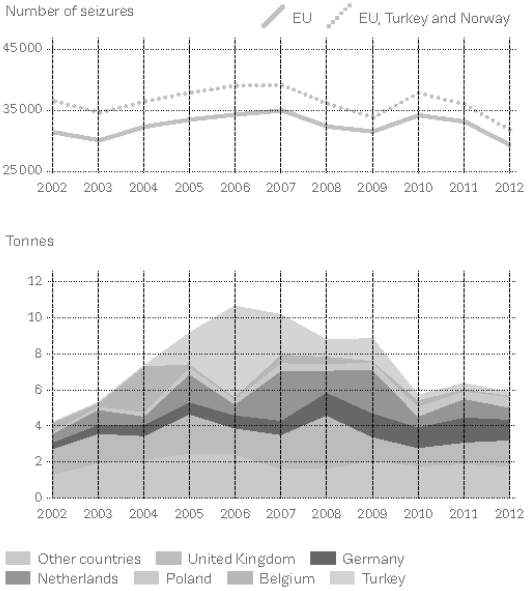
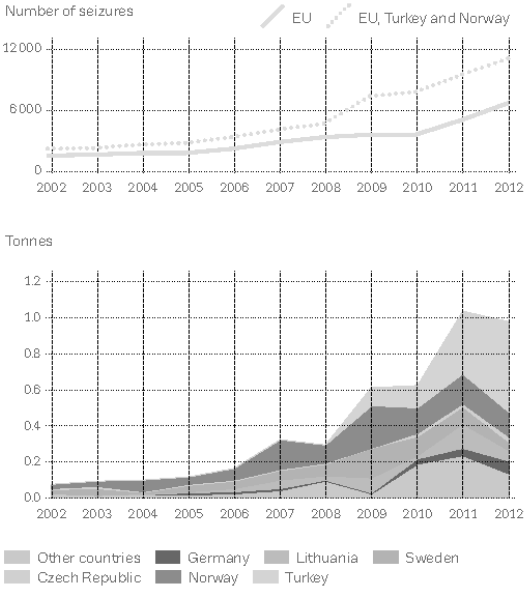


FIGURE 1.10

Number of methamphetamine seizures and quantity seized, 2002–12



Ecstasy: high purity powder available

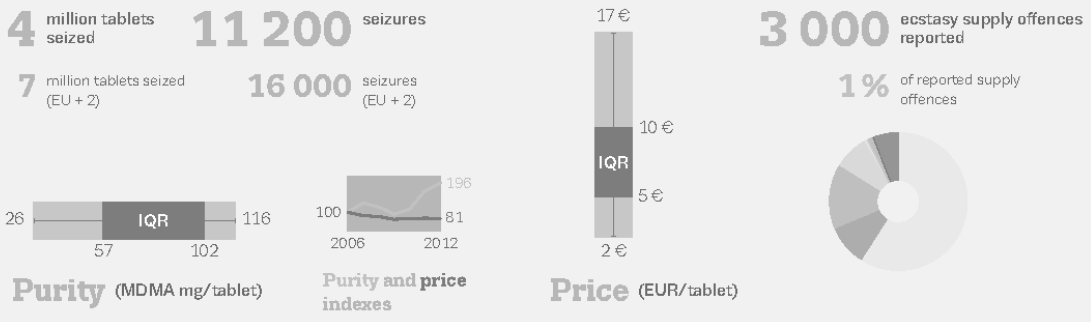
Ecstasy usually refers to the synthetic substance MDMA (3,4-methylenedioxy-methamphetamine), which is chemically related to amphetamines, but which differs to some extent in its effects. Tablets sold as ecstasy, however, may contain any of a range of MDMA-like substances and unrelated chemicals. Both MDMA powder and crystals appear to be becoming more common, and high purity powder is available in parts of Europe.

Production of ecstasy in Europe appears to be concentrated in Belgium and the Netherlands, as evidenced by the number of laboratories dismantled in these countries over the last decade. The number of ecstasy laboratories dismantled in Europe fell from 50 in 2002 to three in 2010, suggesting a large decrease in production of the drug. More recently, there have been signs that the ecstasy market is recovering, with several large MDMA production sites dismantled in Belgium and the Netherlands in 2013.

In 2012, 4 million ecstasy tablets were seized in the European Union, mainly in the Netherlands (2.4 million), followed by the United Kingdom (0.5 million) and Germany (0.3 million). In addition, Turkey seized 3.0 million ecstasy tablets in the same year (Figures 1.11 and 1.12). The quantity of ecstasy tablets seized in the European Union in 2012 represents less than one-fifth of the quantity seized in 2002 (23 million). Overall, seizures of ecstasy decreased between 2002 and 2009, before increasing slowly in subsequent years (Figure 1.11). This trend is also mirrored in the data available on the MDMA content of analysed ecstasy tablets, which decreased until 2009, and increased in the last three reporting years.

Both MDMA powder and crystals appear to be becoming more common, and high purity powder is available in parts of Europe

ECSTASY



EU + 2 refers to EU Member States, Turkey and Norway. Price and purity of ecstasy – national mean values: minimum, maximum and ean interquartile range (IQR). Countries covered vary by indicator.

FIGURE 1.11

Numbers of ecstasy seizures and tablets seized, 2002–12

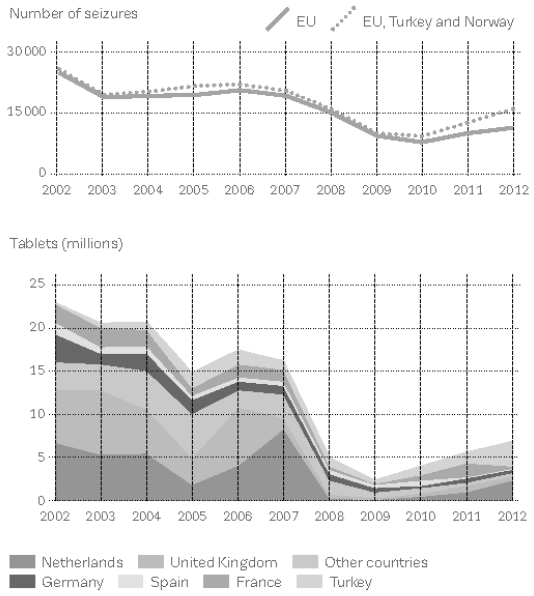
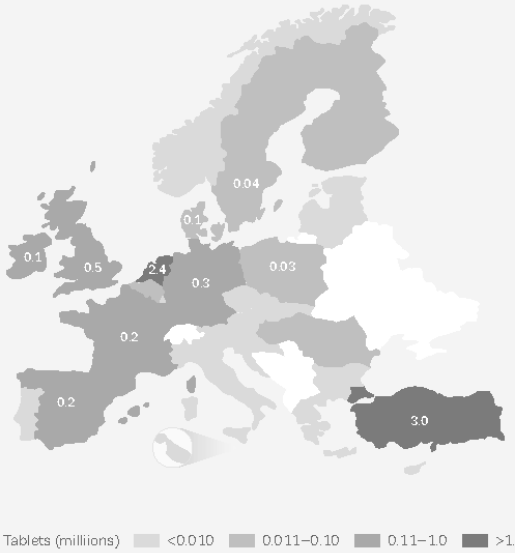


FIGURE 1.12

Quantity of ecstasy seized, 2012



NB: Amounts seized (in millions of tablets) for the ten countries with highest values.

Trends observed in ecstasy supply may, in part, be attributed to strengthened controls and the targeted seizure of PMK (piperonyl methyl ketone), the main precursor chemical for the manufacture of MDMA. Ecstasy producers have reportedly responded to precursor controls by using '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.

Cathinones, a new class of stimulants in Europe

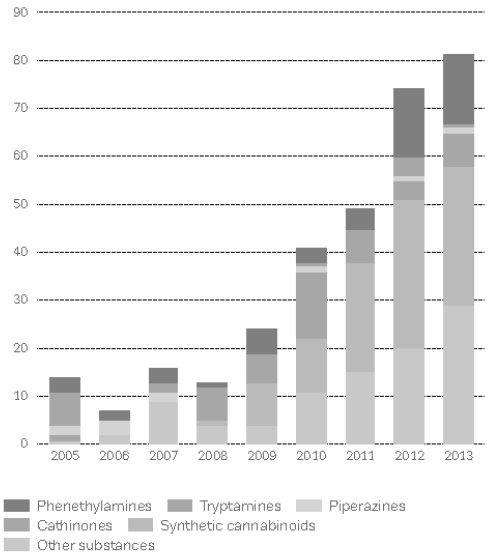
In recent years, more than 50 substituted cathinone derivatives have been identified in Europe. The best known example, mephedrone, has established itself on the stimulants market in some countries. Another cathinone, MDPV (3,4-methylenedioxypyrovalerone), is sold on the European market predominantly in powder and tablet form as a 'legal high', but also directly on the illicit market. More than 5 500 seizures of MDPV powder have been reported from 29 countries between 2008 and 2013, amounting to over 200 kilograms of the drug.

Increasing diversity in new drugs identified

Analysis of the drug market is complicated by the emergence of new drugs (new psychoactive substances) — synthetic or naturally occurring substances that are not controlled under international law, and often 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

FIGURE 1.13

Number and main groups of new psychoactive substances notified to the EU Early Warning System, 2005–13



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 2013, 81 new psychoactive substances were notified by the Member States for the first time through the EU Early Warning System (Figure 1.13). Twenty-nine of these substances were synthetic cannabinoids and another 30 compounds did not conform to the readily recognised chemical groups (including plants and medicines). There were also 13 new substituted phenethylamines reported, seven synthetic cathinones, a tryptamine and a piperazine.

During 2013, 81 new psychoactive substances were notified by the Member States for the first time through the EU Early Warning System

Assessing the risk of new drugs

European-level risk assessments were undertaken on 4-methylamphetamine (in 2012) and 5-(2-aminopropyl) indole (in 2013), in response to emerging evidence of harms that included over 20 fatalities associated with each substance over a short period of time. Both of these substances were subjected to control measures throughout Europe. Four new psychoactive substances (25I-NBOMe, AH-7921, MDPV, methoxetamine) were risk-assessed in April 2014.

25I-NBOMe is a substituted phenethylamine and a potent full agonist of the serotonin 5-HT2A receptor, which appears to have hallucinogenic effects. It has been available on the EU drug market since at least May 2012. Severe toxicity associated with its use has been reported in four Member States, including one death where the substance was detected.

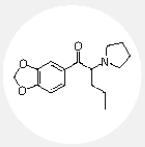
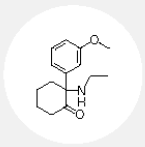
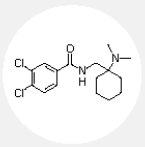
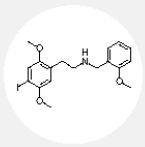
AH-7921 is a synthetic opioid, which has been available in the European Union since at least July 2012. In most cases, it has been seized in small quantities as a powder. This opioid has been detected in six non-fatal intoxications and fifteen deaths in Sweden, the United Kingdom and Norway.

MDPV is a synthetic cathinone derivative closely related to pyrovalerone. MDPV has been present in the EU drug market since at least November 2008, and has been detected in up to 107 non-fatal intoxications and 99 deaths, particularly in Finland and the United Kingdom. There are some indications that it has been sold as a 'legal' or synthetic version of cocaine, and it has also been found in tablets resembling 'ecstasy'.

Methoxetamine is an arylcyclohexylamine closely related to ketamine, and has been available on the EU drug market since at least September 2010. Multi-kilogram quantities of the substance in powder form have been seized. Twenty deaths and 110 non-fatal intoxications associated with the substance have been reported.

New psychoactive substances can appear on the market either under the guise of a controlled drug, or as an alternative to a controlled drug. For example, 4-methylamphetamine was sold directly on the illicit drug market as amphetamine, methoxetamine is marketed as a legal alternative to ketamine and 25I-NBOMe is sold as a 'legal' alternative to LSD (lysergic acid diethylamide).

FOUR SUBSTANCES RISK-ASSESSED IN 2014

MDPV	Methoxetamine	AH-7921	25I-NBOMe	Substance
Cathinones	Arylcyclohexylamines	Opioids	Phenethylamines	Drug family
2008	2010	2012	2012	Year of first notification to the EU Early Warning System
99	20	15	1	Number of deaths associated with the substance
107	110	6	15	Number of non-fatal intoxications
29	24	8	24	Number of countries where it has been detected (EU, Turkey and Norway)
22	9	1	6	Number of countries where it is subject to control measures under drug control legislation (EU, Turkey and Norway)

The Internet as a growing marketplace

The Internet is playing a growing role in shaping how drugs are being sold and poses unique challenges to disrupting the supply of both 'new' and 'old' drugs. The fact that manufacturers, suppliers, retailers, website-hosting and payment processing services may all be based in different countries makes it particularly difficult to control. The growing use of anonymising networks — so-called 'darknets' — for the sale of drugs to dealers and consumers adds to these challenges. The technology to access these sites is increasingly being incorporated into consumer software, opening up these marketplaces to more people. In addition, the open sale of 'legal highs' on the Internet appears to have increased their availability to distributors and consumers. In 2013, EMCDDA monitoring identified 651 websites selling 'legal highs' to Europeans.

More medicines detected

A growing number of new drugs that are detected on the drug market have legitimate use as medicines. Sometimes they are sold as medicines, in other cases they are sold clandestinely as illicit drugs such as heroin, or they may be sold as 'legal highs', 'research chemicals', and even as 'food supplements'. Recent examples, all reportedly injected by opioid users include: pregabalin, used for treating neuropathic pain, epilepsy and generalised anxiety; tropicamide, used during eye examinations to dilate the pupils; and carfentanil, an opioid used to tranquillise large animals.

Other medicinal products recently reported to the Early-warning system include: phenazepam, a benzodiazepine, which has been sold as a 'legal' benzodiazepine, as a 'research chemical' and as the controlled drug diazepam; and, phenibut, an anxiolytic used to treat alcohol dependency in Russia, which has been sold online as a 'food supplement'. These medicines may be sourced in a number of ways: licensed medicines can be diverted from the regulated market and unlicensed medicines can be imported from outside the European Union. In addition, the component drugs can be imported in bulk from countries such as China, then processed and packaged in European countries and sold directly on the illicit drug market, on the 'legal highs' market, or on e-commerce sites.

A growing number of new drugs that are detected on the drug market have legitimate use as medicines

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Report on the risk assessment of 5-(2-aminopropyl) indole in the framework of the Council Decision on new psychoactive substances, Risk assessments.

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EMCDDA–Europol Joint Report on a new psychoactive substance: AH-7921 (3,4-dichloro-N-[[1-(dimethylamino)cyclohexyl]methyl]benzamide).

EMCDDA–Europol Joint Report on a new psychoactive substance: methoxetamine (2-(3-methoxyphenyl)-2-(ethylamino)cyclohexanone).

EMCDDA–Europol Joint Report on a new psychoactive substance: 25I-NBOMe (4-iodo-2,5-dimethoxy-N-(2-methoxybenzyl)phenethylamine).

EMCDDA–Europol Joint Report on a new psychoactive substance: MDPV (3,4-methylenedioxypyrovalerone).

2013

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2

Almost a quarter of the adult population in the European Union, or over 80 million adults, are estimated to have used illicit drugs at some point in their lives

Drug use and drug-related problems

The term 'drug use' covers many different patterns of consumption that range across a continuum from one-off experimental use to habitual and dependent use. Different consumption patterns are associated with different levels of risk and harm. Overall, the risks that an individual will be exposed to through their use of drugs will be influenced by factors including the context in which drugs are used, the dose consumed, route of administration, co-consumption of other substances, number and length of drug consumption episodes and individual vulnerability.

Monitoring drug use and drug-related problems

A common approach to monitoring drug use in Europe is provided by the EMCDDA's five key epidemiological indicators. These data sets cover: surveys of use, estimates of problem use, drug-related deaths, infectious diseases and drug treatment entry. Taken together they provide an important resource for the EMCDDA's analysis of trends and developments. Technical Information on the indicators can be found online in the *Key indicators gateway* and in the *European Drug Report: Data and statistics*.

Over 80 million Europeans have used an illicit drug

Almost a quarter of the adult population in the European Union, or over 80 million adults, are estimated to have used illicit drugs at some point in their lives. In most cases, they have used cannabis (73.6 million), with lower estimates reported for the lifetime use of cocaine (14.1 million), amphetamines (11.4 million) and ecstasy (10.6 million). Levels of lifetime use vary considerably between countries, from around one-third of adults in Denmark, France and the United Kingdom, to less than one in 10 in Bulgaria, Greece, Cyprus, Hungary, Portugal, Romania and Turkey.

Drug use among school students

Monitoring substance use among students provides an important window on current youth risk behaviours and a pointer to potential future trends. In Europe, the ESPAD study provides a valuable resource for tracking trends over time in substance use among 15- to 16-year-old school students. In the most recent data, from 2011, one in four 15- to 16-year-olds is estimated to have ever used an illicit drug, although prevalence levels vary considerably between countries. Cannabis accounts for the vast majority of illicit drug use in this group, with about 24 % reporting lifetime use, 20 % use in the last year and 12 % use in the month prior to the survey. Compared to their female counterparts, male students were 1.5 times more likely to report last month cannabis use.

Many of those reporting ever using cannabis have only used the substance once or twice. A minority of students, however, report more intensive patterns of use, with around 2 % of students reporting using the drug more than 10 times in the month prior to the survey.

The prevalence of use of illicit drugs other than cannabis is far lower, although in a few countries the use of ecstasy and amphetamines feature more prominently. Overall, around 7 % of students report lifetime use of more than one illicit drug. ESPAD also reports on the use of alcohol and tobacco. Both of these substances were more commonly used by students than cannabis, and those who had used cannabis were also more likely to be regular users of alcohol and tobacco. In the month prior to the survey, 19 % of students report smoking one or more cigarettes a day, with 4 % smoking more than 10 a day. Almost two-thirds of students report drinking alcohol at least once in the last month, with 20 % being intoxicated at least once in this period.

One in four 15- to 16-year-olds is estimated to have ever used an illicit drug

Cannabis: divergent national trends

Cannabis is generally smoked and, in Europe, commonly mixed with tobacco. Patterns of cannabis use range from the occasional or experimental to the regular and dependent, with problems strongly associated with more frequent use and higher doses.

Cannabis is the illicit drug most likely to be used by all age groups. An estimated 14.6 million young Europeans (15–34), or 11.2 % of this age group, used cannabis in the last year, with 8.5 million of these aged 15–24 (13.9 %). Cannabis use is generally higher among males, and this

SUBSTANCE USE BY EUROPEAN SCHOOL STUDENTS AGED 15–16 (ESPAD, 2011)

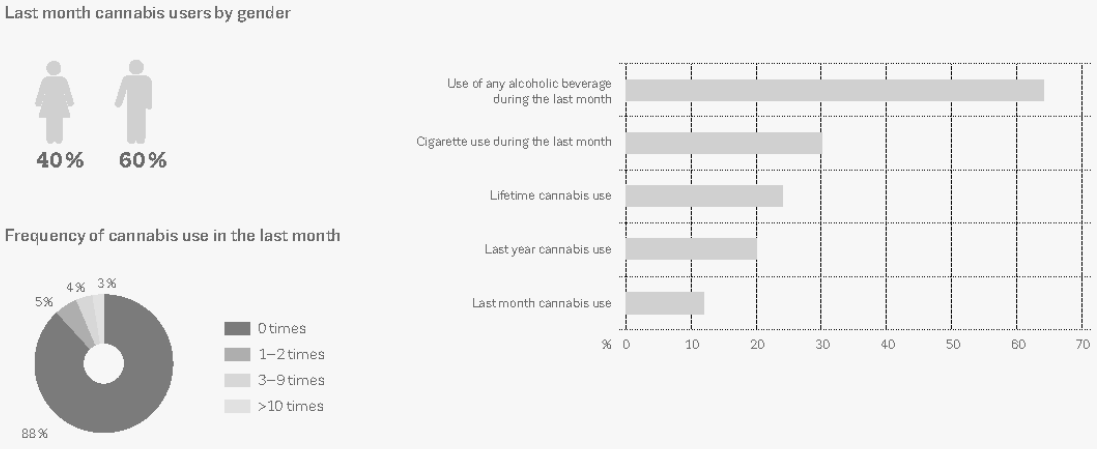
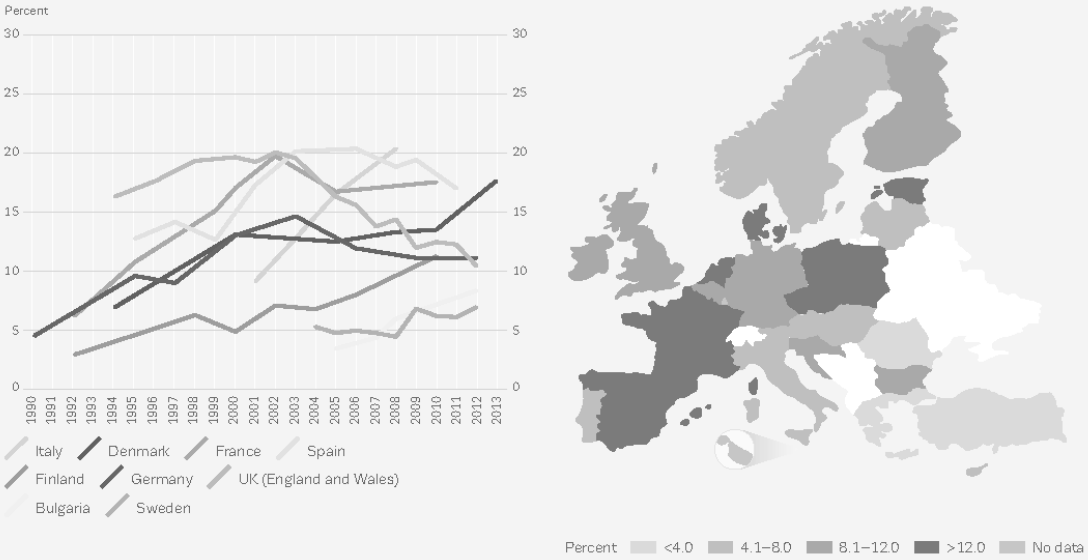


FIGURE 2.1

Last year prevalence of cannabis use among young adults (15–34): countries with statistically significant trends (left) and most recent data (right)



difference is usually accentuated for more intensive or regular patterns of use. Current trends in use appear divergent, as illustrated by the fact that of the countries that reported new surveys since 2011, eight reported decreases and five reported increases in last year prevalence. Few national surveys currently report on use of synthetic cannabinoid receptor agonists; for those that do, prevalence levels are generally low.

A growing number of countries now have sufficient survey data to allow a statistical analysis of long-term time trends in cannabis use among young adults (15–34). In Denmark, Finland and Sweden, upward trends in last year cannabis use among young adults can be observed, although at different levels of prevalence (Figure 2.1). In contrast, prevalence rates in Norway have remained relatively stable. Interestingly, Germany, France and the United Kingdom have seen either a stable or falling trend in use in the last decade, having observed increases before this period. Spain also reported lower prevalence in the last decade. Together these four countries account for almost half of the EU population. Bulgaria and Italy, with shorter time series, both have upward trends. More recently, Italy has reported lower prevalence levels, although due to methodological issues the surveys are not directly comparable.

Concern about cannabis users

A minority of cannabis users consume the substance intensively. Daily or almost daily cannabis use is defined as use on 20 days or more in the last month. Following these criteria, just under 1 % of European adults are estimated to be daily or almost daily cannabis users. Over two-thirds of daily or almost daily cannabis users are aged between 15 and 34 years, and in this age group over three-quarters are male. Among the countries providing data, the estimated percentage of daily or almost daily users among young adults (15–34) varies from 0.1 % in Slovakia to 4.4 % in Spain (Figure 2.2).

In 2012, cannabis was the drug most frequently reported as the principal reason for entering drug treatment by first-time clients. Having risen from 45 000 to 61 000 between 2006 and 2011, the overall number of reported first-time treatment entrants stabilised in 2012 (59 000). Cannabis was the second most frequently reported drug among all entrants to treatment in 2012 (110 000). Considerable national variation can be seen, however, ranging from 2 % of all treatment entrants reporting primary cannabis use in Bulgaria to 66 % in Hungary. This heterogeneity might be explained by national differences in referral practices, legislation, the type of treatment services available and cannabis prevalence levels.

FIGURE 2.2

Prevalence of daily and almost daily cannabis use among young adults (15–34)

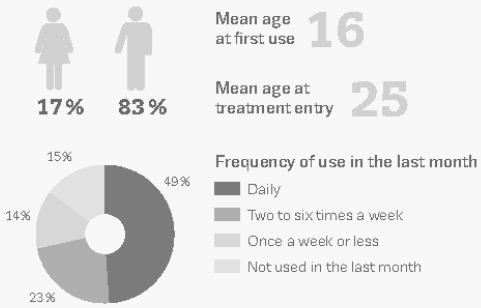
Percent <0.50 0.51–1.0 >1.0 No data

Acute emergencies associated with cannabis and synthetic cannabinoid products

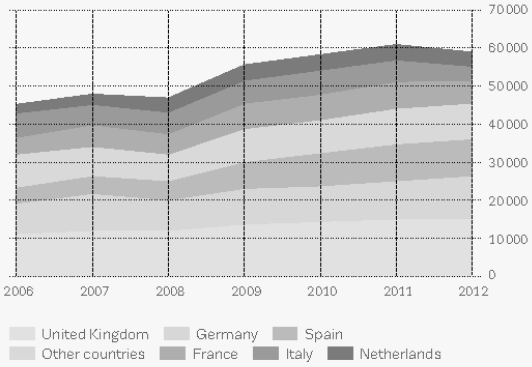
Although rare, acute emergencies can occur after consuming cannabis, especially at high doses. In countries with higher prevalence levels, cannabis-related emergencies appear to be a growing problem. Recent increases in emergencies related to cannabis have been reported in the Czech Republic, Denmark and Spain. Most cannabis-related emergencies occur among young males, and are often associated with alcohol intoxication. Symptoms can include anxiety, psychosis or other psychiatric symptoms and, in most cases, hospitalisation is not required. An additional worrying development has been the emergence of synthetic cannabinoids. These substances can be extremely potent, but are not chemically similar to cannabis, and therefore may result in different and potentially more serious health consequences. Although our current understanding of the health implications of consuming these substances remains limited, there is increasing concern about reports of acute adverse consequences associated with their use.

CANNABIS USERS ENTERING TREATMENT

Characteristics



Trends in first-time entrants



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

Geographic variation in patterns of stimulant use

Cocaine, amphetamines and ecstasy are the most commonly used illicit stimulants in Europe, while some lesser-known substances, including piperazines (e.g. BZP, benzylpiperazine) 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.

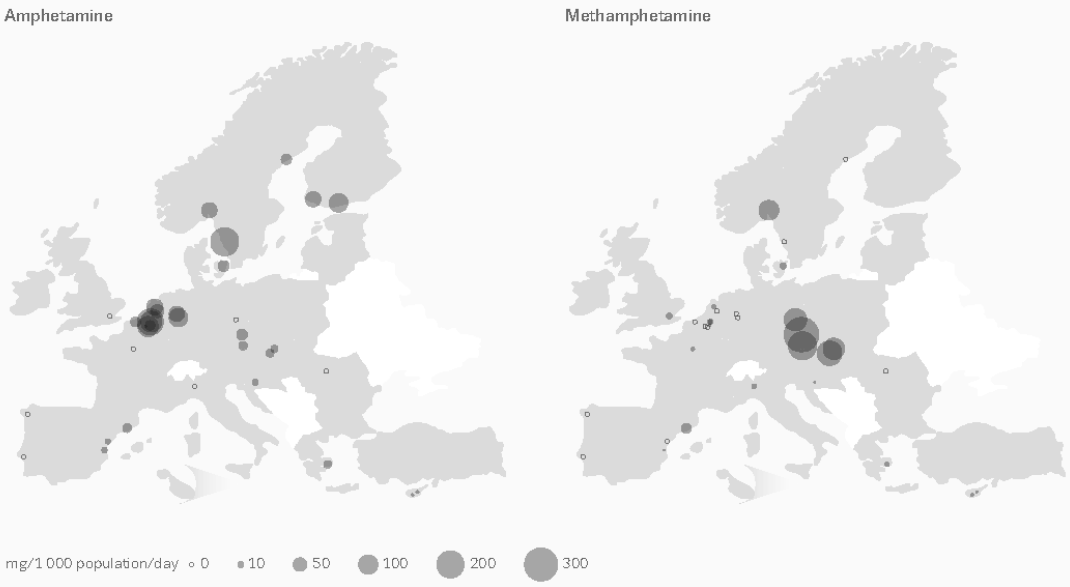
Survey data illustrate the geographical differences in stimulant use patterns in Europe. Cocaine is more prevalent in the south and west of Europe, amphetamines in central and northern countries, and ecstasy — albeit at low prevalence levels — in countries in the south and east (Figure 2.3). Data from wastewater analysis carried out in a European multi-city study also shows a difference in regional patterns of use. Relatively high concentrations of amphetamine were found in wastewater samples from a number of cities in the north and northwest of Europe, whereas the highest methamphetamine levels were found in cities in the Czech Republic and Slovakia (Figure 2.4).

FIGURE 2.3

Predominant stimulant drug by last year prevalence among young adults (15–34)

FIGURE 2.4

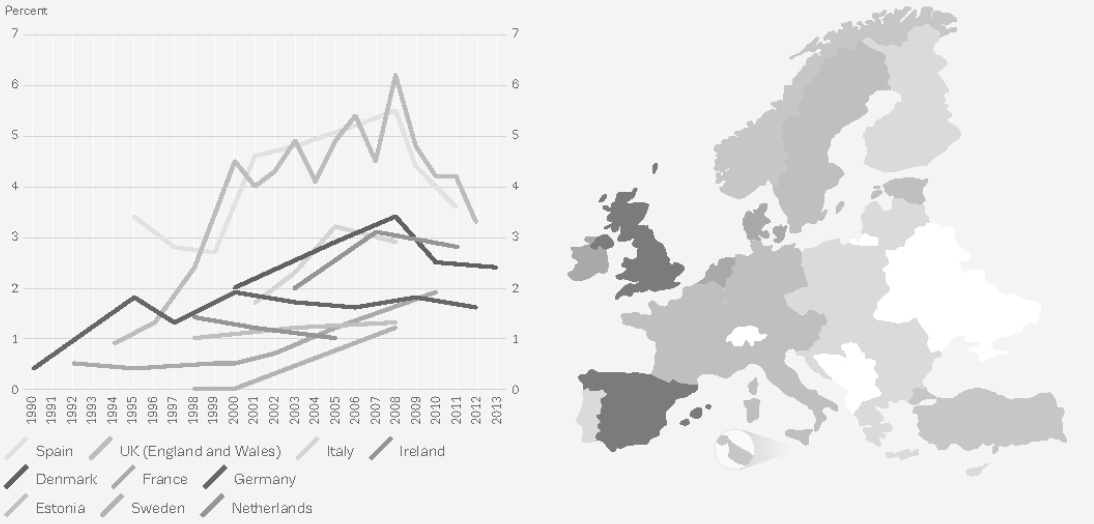
Amphetamines in wastewater of selected European cities



NB: Mean daily amounts of amphetamines in milligrams per 1 000 population, from sampling over a one-week period in 2013.
Source: Sewage Analysis Core Group Europe (SCORE).

FIGURE 2.5

Last year prevalence of cocaine use among young adults (15–34): selected trends (left) and most recent data (right)



NB: Trends for ten countries with the highest prevalence and three or more surveys. Percent 0.1–1.0 1.1–2.0 2.1–3.0 >3.0 No data

Cocaine: prevalence continues to decline

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 opioids, 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 use of crack cocaine are associated with the highest health risks, including the transmission of infectious diseases.

Cocaine is the most commonly used illicit stimulant drug in Europe, although most users are found in a restricted number of countries. It is estimated that about 2.2 million young adults aged 15 to 34 (1.7 % of this age group) used cocaine in the last year.

Considering longer term trends in use of cocaine, for Denmark, Spain and the United Kingdom, all countries reporting relatively high prevalence rates, declines are observable after a peak in 2008 (Figure 2.5). Most other countries show stable or declining trends.

Decreases in cocaine use are also observable in the most recent data, with 11 out of the 12 countries with surveys between 2011 to 2013 reporting falls in prevalence.

Cocaine is the most commonly used illicit stimulant drug in Europe

Continued decline in cocaine treatment demand

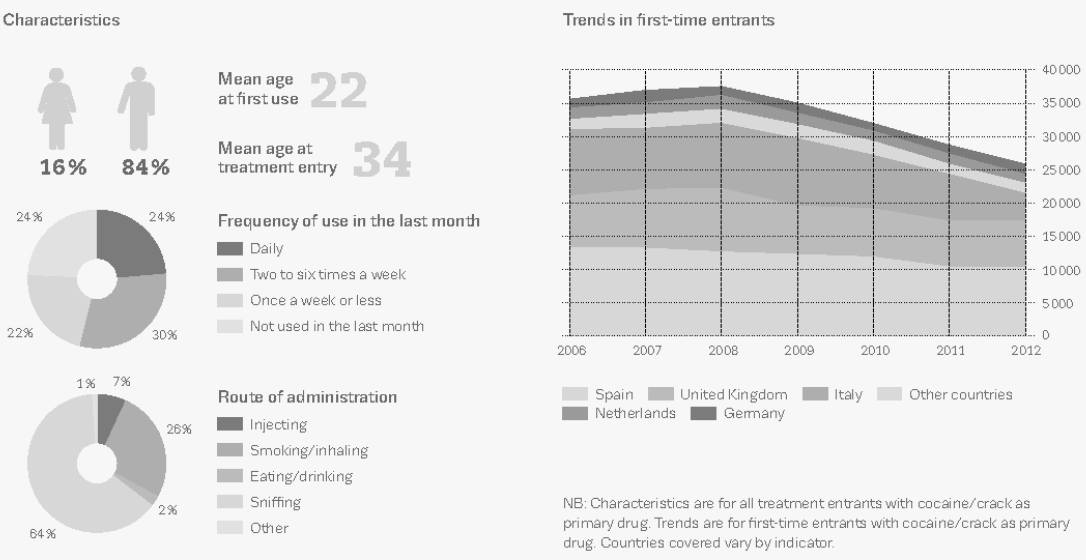
Only four countries have relatively recent estimates of intensive or problem cocaine use, and these are difficult to compare, as the definitions used differ. In 2012, among the adult population, Germany estimated 'cocaine-dependency' at 0.20 %, Italy produced an estimate of 0.26 % for those 'in need of treatment for cocaine use', and in 2011, Spain estimated 'high-risk cocaine use' at 0.4 %. For 2010/11, the United Kingdom estimated crack cocaine use among the adult population in England at 0.49 %, although the majority of these were also opioid users.

Cocaine was cited as the primary drug for 14 % of all reported clients entering specialised drug treatment in 2012 (55 000), and 18 % of those entering treatment for the first time (26 000). Differences exist between countries, with around 90 % of all cocaine clients being reported by only five countries (Germany, Spain, Italy, Netherlands, United Kingdom). Together, these five countries account for just over half of the EU population. The number of clients entering treatment for the first time in their life for primary cocaine use has been decreasing in recent years, from a peak of 38 000 in 2008 to 26 000 in 2012. Much of this decrease can be accounted for by a drop in numbers reported from Italy. In 2012, only a small number (2 300) of first-time treatment entrants in Europe reported primary crack cocaine use, with the United Kingdom accounting for around two-thirds of these, and Spain and the Netherlands most of the rest.

Cocaine is also responsible for acute hospital admissions and deaths. The drug may also be a factor in some mortality attributed to cardiovascular problems. While data in this area are limited, 19 countries reported cocaine-related deaths in 2012, with over 500 cases identified.

19 countries reported cocaine-related deaths in 2012, with over 500 cases identified

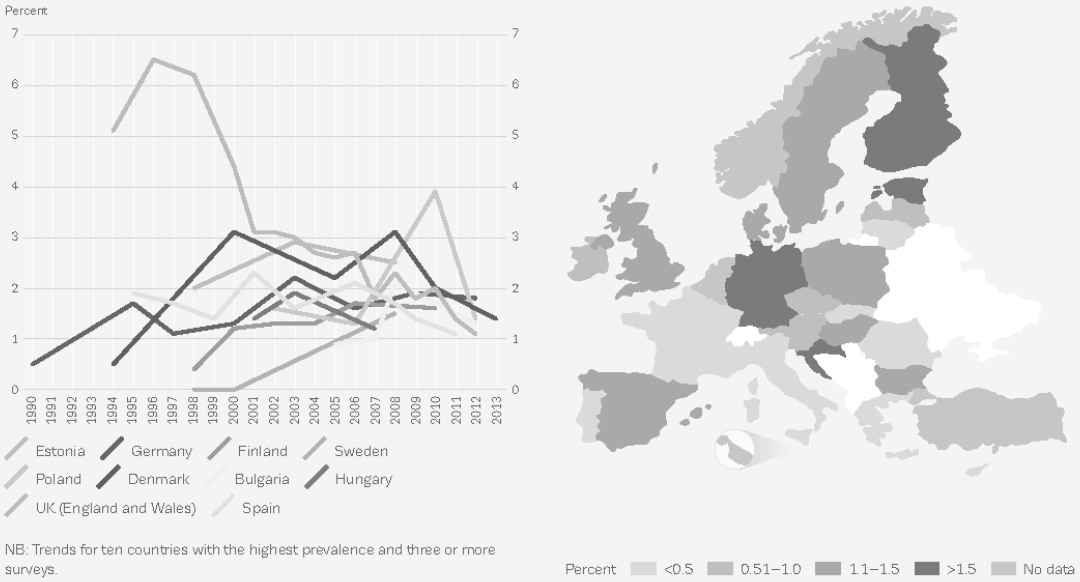
COCAINE USERS ENTERING TREATMENT



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

FIGURE 2.6

Last year prevalence of amphetamines use among young adults (15–34): selected trends (left) and most recent data (right)



NB: Trends for ten countries with the highest prevalence and three or more surveys.

Amphetamines: use decreasing but health risks continue

Amphetamine and methamphetamine, two closely related stimulants, are both used in Europe, although amphetamine is by far the more commonly available. Methamphetamine consumption has historically been restricted to the Czech Republic and, more recently, Slovakia, although this is now changing.

Both drugs can be taken orally and snorted, in addition injection is relatively common among problem drug users in some countries. Methamphetamine can also be smoked, but this route of administration has only recently been reported in Europe.

Adverse health effects linked with amphetamines use include cardiovascular, pulmonary, neurological and mental health problems, while as with other drugs, injection is a risk factor for infectious diseases. As with other stimulants, deaths related to amphetamines can be difficult to identify. However, small numbers are reported annually, usually by countries where prevalence levels are high.

An estimated 1.2 million (0.9 %) young adults (15–34) used amphetamines during the last year. Between 2007 and 2012, annual prevalence estimates for young adults remained relatively low and stable in most European countries, with prevalence levels of 2.5 % or less in all reporting countries. Among the 12 countries with surveys since 2011, 11 reported decreasing amphetamine prevalence levels (Figure 2.6).

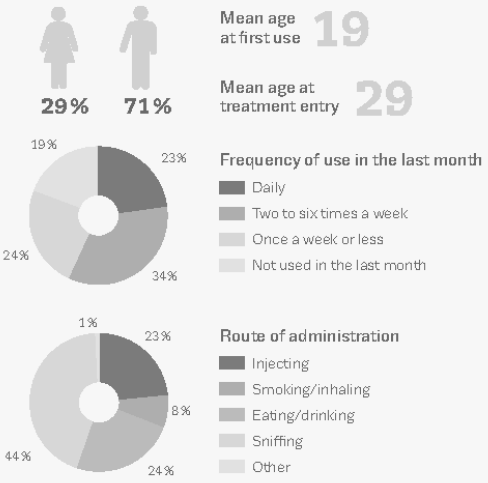
Amphetamines use: a multi-faceted phenomenon

Both the Czech Republic and Slovakia report longer-term entrenched patterns of methamphetamine use, with the most recent estimates of problem use among adults (15–64) at around 0.42 % for the Czech Republic (2012) and 0.21 % in Slovakia (2007). Recently, indications of problem methamphetamine use have also been reported among high-risk drug users in some regions in Germany and in Greece, Cyprus, Latvia and Turkey. This includes worrying signs from southern European countries of crystal methamphetamine smoking among sub-populations of opioid injectors. In addition, new injection trends have been detected among small groups of men who have sex with men in some large European cities.

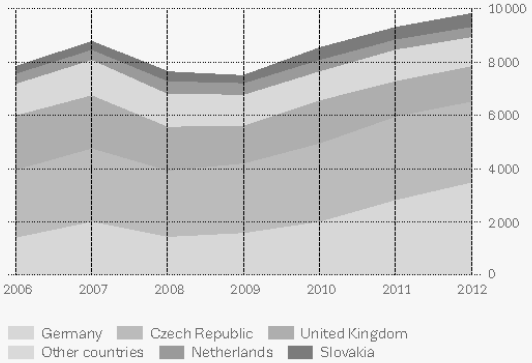
Around 6 % of clients entering specialised drug treatment in Europe in 2012 report amphetamines as their primary drug (approximately 25 000 clients, of whom 10 000 entered treatment for the first time in their life). Primary amphetamine users account for a sizeable proportion of reported first-time treatment entries only in Germany, Latvia and Poland, while methamphetamine is cited as the primary drug by a large proportion of first-time clients in the Czech Republic and Slovakia. Recent increases in first-time entrants for amphetamines are accounted for primarily by Germany and by increases in first-time methamphetamine clients in the Czech Republic and Slovakia.

AMPHETAMINES USERS ENTERING TREATMENT

Characteristics



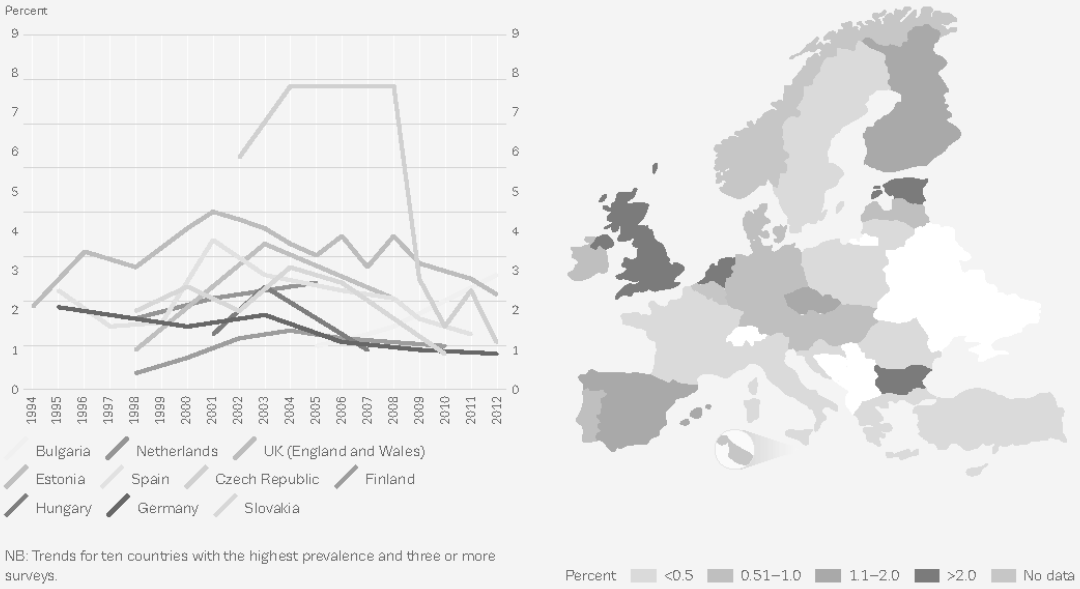
Trends in first-time entrants



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

FIGURE 2.7

Last year prevalence of ecstasy use among young adults (15–34): selected trends (left) and most recent data (right)



NB: Trends for ten countries with the highest prevalence and three or more surveys.

Ecstasy use: low and stable trends in the general population

Ecstasy usually refers to the synthetic substance MDMA. The drug is commonly used in tablet form, but is also available in crystal or powder form; it is usually swallowed or snorted. 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 reported, but are rare.

It is estimated that 1.3 million young adults (15–34) used ecstasy in the last year (1.0 % of this age group), with national estimates ranging from under 0.1 % to 3.1 %. In Europe, consumption of the drug typically peaked in the early to mid-2000s, before declining (Figure 2.7). Between 2007 and 2012, most countries have reported stable or declining trends in ecstasy use. With the exception of Bulgaria, which has an upward trend in prevalence since 2005, this decline continues to be evident for the 12 countries reporting surveys since 2011. Few users entered treatment for problems relating to ecstasy in 2012: ecstasy was mentioned as the primary drug by less than 1 % (around 550 clients) of reported first-time treatment entrants in Europe.

Between 2007 and 2012, most countries have reported stable or declining trends in ecstasy use

Synthetic cathinones: injection a concern

Synthetic cathinones, such as mephedrone and MPDV, have now carved a space in the illicit stimulants market in some countries. The limited information available suggests that prevalence levels remain low. Repeat surveys that include cathinones are only available for the United Kingdom (England and Wales). In the most recent survey (2012/13), last year use of mephedrone among adults aged 16 to 59 was estimated at 0.5 %, a decrease from 1.1 % in 2011/12 and 1.4 % in 2010/11. Results from a non-representative survey of regular clubbers in the United Kingdom also show a decrease in last year mephedrone use (from 19.5 % in 2011 to 13.8 % in 2012).

The injection of cathinones, including mephedrone, MDPV and pentedrone, continues to be a concern and has been reported among diverse populations, including opioid injectors, drug treatment clients, prisoners and small populations of men who have sex with men. An increase in treatment demand associated with synthetic cathinone use problems has been reported in Hungary, Romania and the United Kingdom. In Romania, a higher share of first-time treatment entrants reported new psychoactive substances as primary drug (37 %) than reported heroin (21 %). There were an estimated 1 900 mephedrone users entering treatment in the United Kingdom in 2011/12, with more than half of them under the age of 18.

Low level of use of hallucinogens, GHB and ketamine

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 (lysergic acid diethylamide) 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 0.8 %, and for LSD from 0 % to 0.7 %.

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 bladder associated with long-term ketamine use. Loss of consciousness, withdrawal syndrome and dependence are risks linked to use of GHB, with Belgium and the Netherlands reporting some requests for treatment.

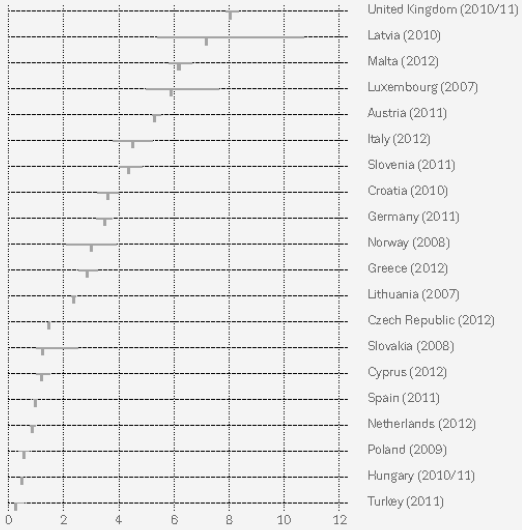
Where they exist, national estimates of the prevalence of GHB and ketamine use in both adult and school populations remain low. Denmark reports last year prevalence of ketamine use at 0.3 % among young adults (15–34), with 0.8 % of 16- to 24-year-olds reporting last year ketamine use in the United Kingdom, a drop from a peak of 2.1 % in 2010. Targeted surveys in nightlife settings typically report higher levels of prevalence. Among UK respondents to a 2013 self-selecting Internet survey who were identified as regular clubbers, 31 % reported last year use of ketamine, and 2 % reported last year use of GHB.

A number of psychoactive substances with hallucinogenic, anaesthetic and depressant properties are available on the illicit drug market in Europe

FIGURE 2.8

National estimates of last year prevalence of problem opioid use

Cases per 1 000 population aged 15–64



NB: Data displayed as point estimates and uncertainty intervals.

Rate per 1 000 <2.50 2.51–5.0 >5.0 No data

NB: Data for Finland are from 2005 and for Ireland from 2006.

Opioids: 1.3 million problem users

The illicit use of opioids remains responsible for a disproportionately large share of the morbidity and mortality 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. Opioid use tends to be highest among marginalised populations in urban areas.

Europe has experienced different waves of heroin addiction, the first affecting many western European countries from the mid-1970s onwards and a second wave affecting 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 annual prevalence of problem opioid use among adults (15–64) is estimated at around 0.4 %, the equivalent of 1.3 million problem opioid users in Europe in 2012. 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 2.8).

Heroin: continued reductions in treatment demand

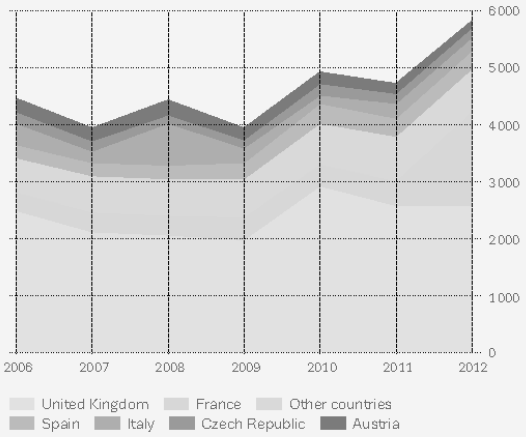
Clients using opioids mainly heroin, as their primary drug, represent 46 % of all drug users who entered specialised treatment in 2012 in Europe (180 000 clients), and around 26 % of those entering treatment for the first time. The overall numbers of new heroin clients are declining in Europe, almost halving from a peak of 59 000 in 2007 to 31 000 in 2012. Overall, it appears that recruitment into heroin use has decreased and that this is now impacting on treatment demand.

Opioids other than heroin: of increasing concern

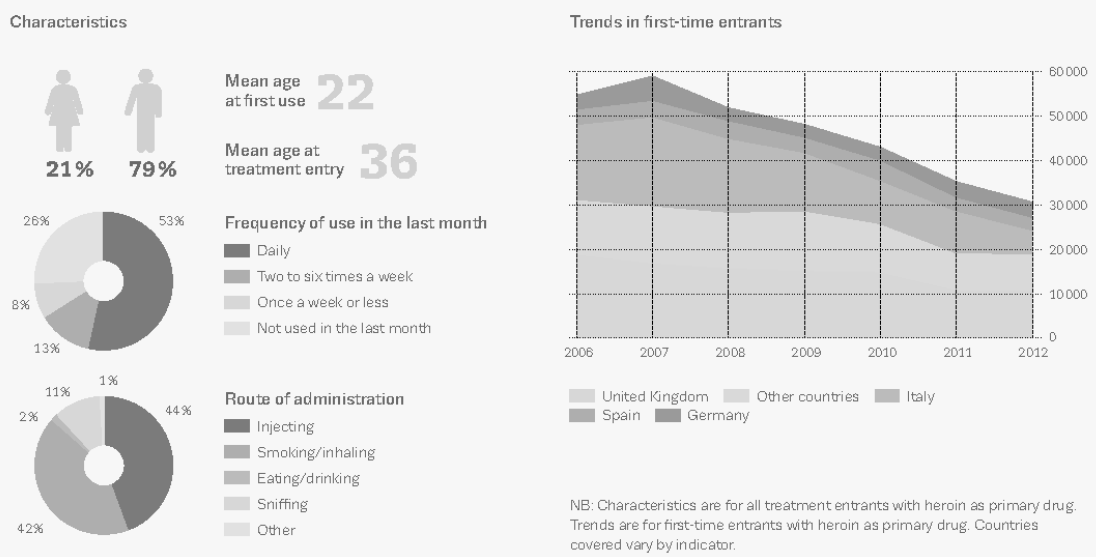
In 2012, in the majority of European countries (17) more than 10 % of first-time opioid clients entering specialised treatment were misusing opioids other than heroin (Figure 2.9). These included methadone, buprenorphine and fentanyl. In some countries, these drugs now represent the most common form 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 misusers of buprenorphine.

FIGURE 2.9

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



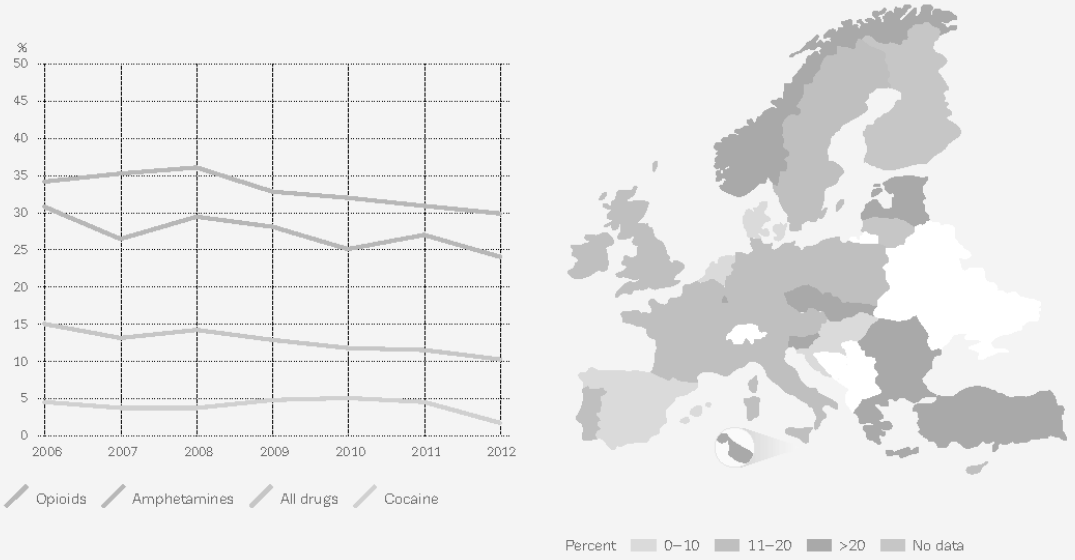
HEROIN USERS ENTERING TREATMENT



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

FIGURE 2.10

Prevalence of injecting in last month among treatment entrants: trends among new entrants (left) and national rates among all entrants (right)



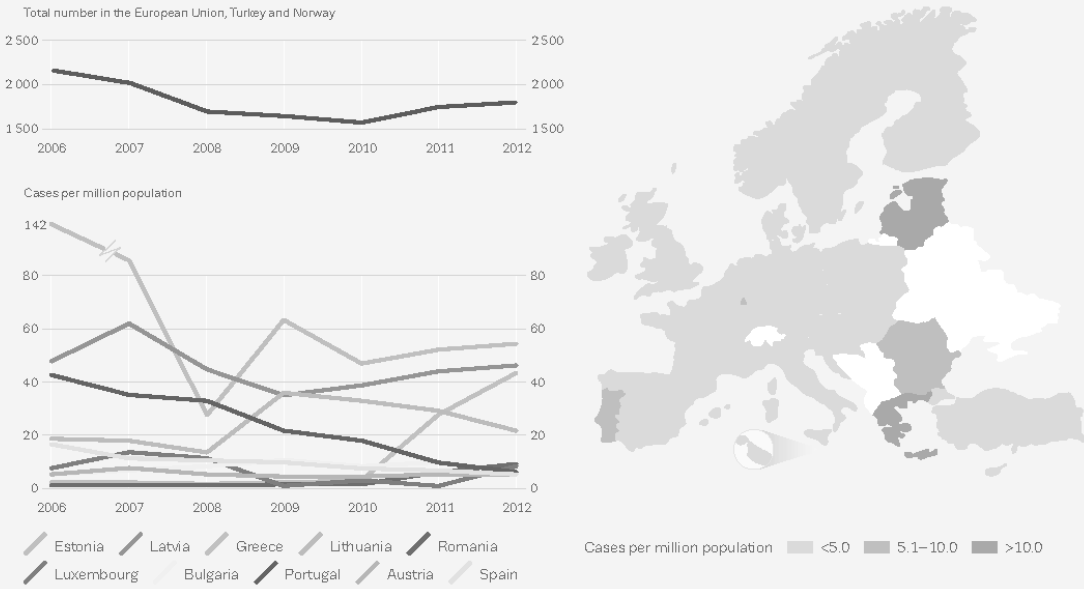
Injecting drug use: long-term decline

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. Twelve 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 23 % of amphetamine clients report injecting the drug. Levels of injecting among opioid clients vary between countries, from less than 6 % in the Netherlands to 100 % in Lithuania.

An analysis of time trends among clients entering treatment for the first time in Europe indicates that injecting as the main route of administration has fallen since 2006 (Figure 2.10). The proportion of new clients reporting having injected amphetamines, cocaine or opioids in the last month has also fallen over the same time period.

FIGURE 2.11

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



NB: Newly diagnosed HIV infections among injecting drug users in 10 countries reporting the highest rates in 2012 (source: ECDC).

HIV: outbreaks impact on EU trend

The injection of drugs continues to play a major role in the transmission of blood-borne infectious diseases such as hepatitis C and, in some countries, HIV/AIDS. 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 2.11). In 2012, the average rate of newly reported HIV diagnoses attributed to injecting drug use was 3.09 per million population. Although the figures are subject to revision, there were 1 788 newly reported cases in 2012, slightly more than in 2011 (1 732), continuing the upward trend observed since 2010.

Whereas in 2010, Greece and Romania contributed just over 2 % of the total number of newly reported diagnoses, by 2012 this figure had increased to 37 %. In other countries such as Spain and Portugal, which have experienced periods with high rates of infection in the past, trends in rates of newly reported diagnoses continue to decline. The situation is less positive, however, in Estonia, where the rate of new diagnoses remains high, and in Latvia, where annual rates have been increasing since 2009.

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 and increasing numbers of deaths among injecting drug users, mainly due to HCV infection, and often worsened by heavy alcohol use.

HIV-related mortality is the best documented indirect cause of death among drug users

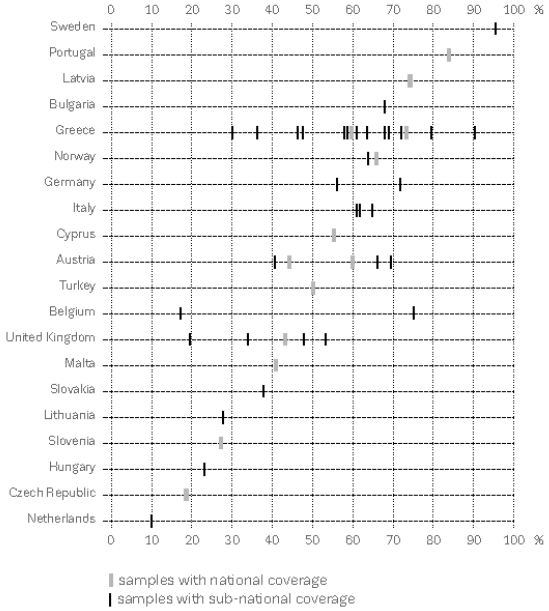
Hepatitis and other infections: major health issues

Viral hepatitis, and 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 2011–12 varied from 19 % to 84 %, with seven of the 11 countries with national data reporting a prevalence rate in excess of 50 % (Figure 2.12). Among countries with national trend data for the period 2007–12, declining HCV prevalence in injecting drug users was reported in Norway, while seven others observed an increase.

Averaged across the 18 countries for which data are available for the period 2011–12, injecting drug use accounts for 64 % of all HCV diagnoses and 50 % of the acute diagnoses notified (where the risk category is known). For hepatitis B, injecting drug users represent 9 % of all diagnoses and 21 % 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 March 2013, 15 drug-related anthrax cases were reported, of which seven resulted in fatalities.

FIGURE 2.12

HCV antibody prevalence among injecting drug users, 2011/2012



Typically, those dying of drug overdoses are in their mid-thirties or older, and their average age at death is rising

Overdose deaths: overall reduction, but increases in some countries

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, accidents, violence and suicide. Most studies on cohorts of problem drug users show mortality rates in the range of 1–2 % per year, and it has been estimated that between 10 000 and 20 000 opioid users die each year in Europe. Overall, opioid users are at least 10 times more likely to die than their peers of the same age and gender. For female opioid users, in some countries, the risk of dying may be up to 30 times that of their peers.

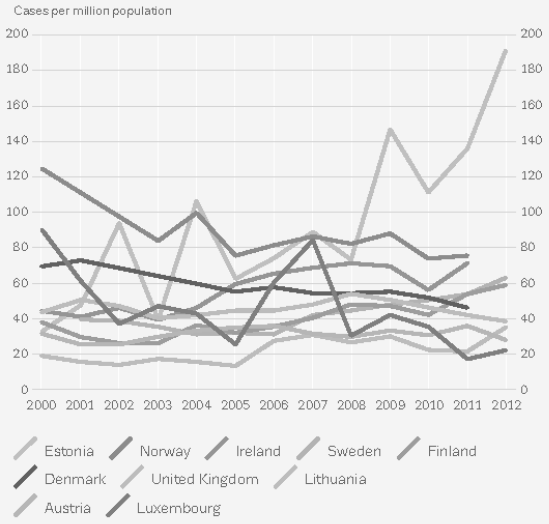
Drug overdose continues to be the main cause of death among problem drug users. Heroin or its metabolites are present in the majority of reported fatal overdoses, often in combination with other substances such as alcohol or benzodiazepines. In addition to heroin, other opioids are regularly found in toxicological reports. These include methadone, buprenorphine, fentanyls and tramadol, with some countries reporting that such substances are responsible for a substantial share of overdose deaths. In two countries, the number of methadone-related overdoses exceeds those related to heroin. In most of cases where methadone is identified, the victim is not in substitution treatment at the time of death, but has used diverted methadone in the context of polydrug use.

While drug-related deaths among the very young generate considerable concern, only 10 % of overdose deaths reported in Europe occur among those aged under 25 years. Typically, those dying of drug overdoses are in their mid-thirties or older, and their average age at death is rising, suggesting an ageing cohort of problem opioid users. Most overdose deaths (78 %) are reported among men.

For 2012, the average mortality rate due to overdoses in Europe is estimated at 17 deaths per million population aged 15–64. National mortality rates vary considerably and are influenced by factors such as patterns of drug use, particularly injecting use, the characteristics of drug-using populations and reporting practices. Rates of over 40

FIGURE 2.13

Drug-induced mortality rates among adults (15–64): selected trends (left) and most recent data (right)



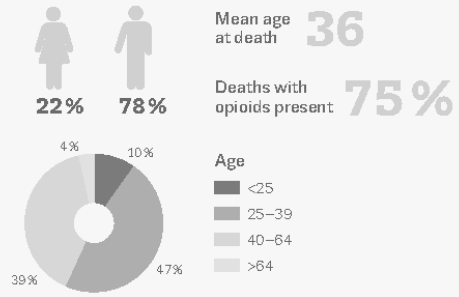
NB: Trends in the ten countries reporting the highest rates in 2011 or 2012.

deaths per million were reported in six countries, with the highest rates reported in Norway (76 per million) and Estonia (191 per million) (Figure 2.13). Overdose deaths in Estonia have increased sharply, and illustrate the impact that different drug consumption patterns can have on national figures — in Estonia, overdose deaths are mostly related to the use of fentanyls, which are highly potent synthetic opioids.

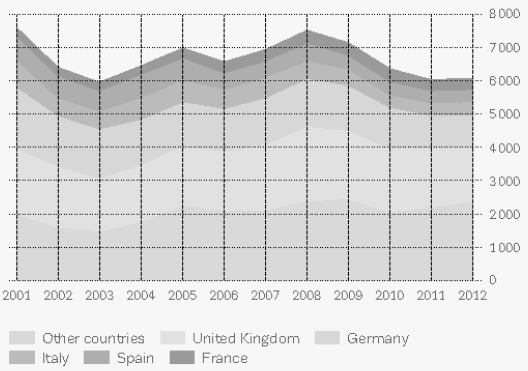
Most countries reported an increasing trend in overdose deaths from 2003 until 2008/09, when overall levels first stabilised and then began to decline. Overall, around 6 100 overdose deaths were reported in 2012. This is similar to the number reported in 2011, and a decrease from the 7 100 cases in 2009. Nevertheless, the situation varies for individual countries, with some still reporting increases.

DRUG-INDUCED DEATHS

Characteristics



Trends in overdose deaths



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Injection of synthetic cathinones, Perspectives on drugs.

Wastewater analysis and drugs: results from a European multi-city study, Perspectives on drugs.

2013

Characteristics of frequent and high-risk cannabis users, Perspectives on drugs.

Emergency health consequences of cocaine use in Europe, Perspectives on drugs.

Trends in heroin use in Europe — what do treatment demand data tell us?, Perspectives on drugs.

2012

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, Monographs.

EMCDDA and ESPAD joint publications

2012

Summary of the 2011 ESPAD report.

EMCDDA and ECDC joint 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 www.emcdda.europa.eu/publications

3

Interventions designed to prevent, treat and reduce the harms related to drug use are reviewed in this chapter

Health and social responses to drug problems

Interventions designed to prevent, treat and reduce the harms related to drug use are reviewed in this chapter. The chapter considers whether countries have adopted common approaches, to what extent are they informed by evidence, and if service availability matches estimated needs.

Monitoring health and social responses

This chapter draws on annual national assessments provided by EMCDDA focal points. These are complemented by data on treatment demand, opioid substitution treatment and needle and syringe provision. Expert ratings provide supplementary information on the availability of services, where more formalised datasets are unavailable. The chapter is also informed by reviews of the available scientific evidence on the effectiveness of public health interventions.

Supporting information can be found on the EMCDDA website in the *Health and social responses profiles*, the *European Drug Report: Data and statistics* and the *Best practice portal*.

Drug prevention for vulnerable groups of young people

A range 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 who may be at greater risk of developing drug use problems, and indicated prevention focuses on at-risk individuals. In this year's report, the focus is on selective prevention, an approach for which there is growing evidence of effectiveness for programmes that focus on norm-setting, environmental restructuring, motivation, skills and decision-making. Many programmes, however, continue to be based on information provision, awareness-raising and

FIGURE 3.1

Availability of specific drug prevention interventions for selected vulnerable groups (expert ratings, 2012)

counselling; approaches where the evidence of effectiveness is scarce.

Two important target groups for selective prevention interventions are school students with academic and social problems and young offenders (Figure 3.1). Expert assessments suggested an increase in overall provision for both these groups between 2007 and 2010, although no further changes were observed in 2013.

For interventions targeting students, evidence suggests that strategies that improve school climate may lead to reductions in substance use. Approaches in this area include teacher training and measures to improve student participation and promote a positive school ethos. Other prevention approaches focusing on students aim to increase self-control and build social competences, while family-focused approaches aim to improve parenting skills.

For young offenders, the majority of countries now report the introduction of alternative measures to penal sanctions. One programme of note in this area is FreD, a set of manual-based interventions, which has now been implemented in 15 EU Member States. Evaluations of this programme have shown a fall in repeat offending rates.

Reducing harm in nightlife settings: the need for an integrated approach

The association between nightlife settings and some patterns of high-risk drug and alcohol use is well known. Despite this, only a limited number of European countries report implementing prevention strategies in this area (Figure 3.2), and expert ratings suggest an overall decrease in activities between 2010 and 2013.

At European level, standards produced by Club Health and Safer Nightlife offer guidance for the implementation of prevention programmes in recreational settings. With regard to reducing harms, positive results have been obtained from integrated, environmental prevention approaches, which include components such as responsible serving, the training of bar and security staff and cooperation with law enforcement agencies.

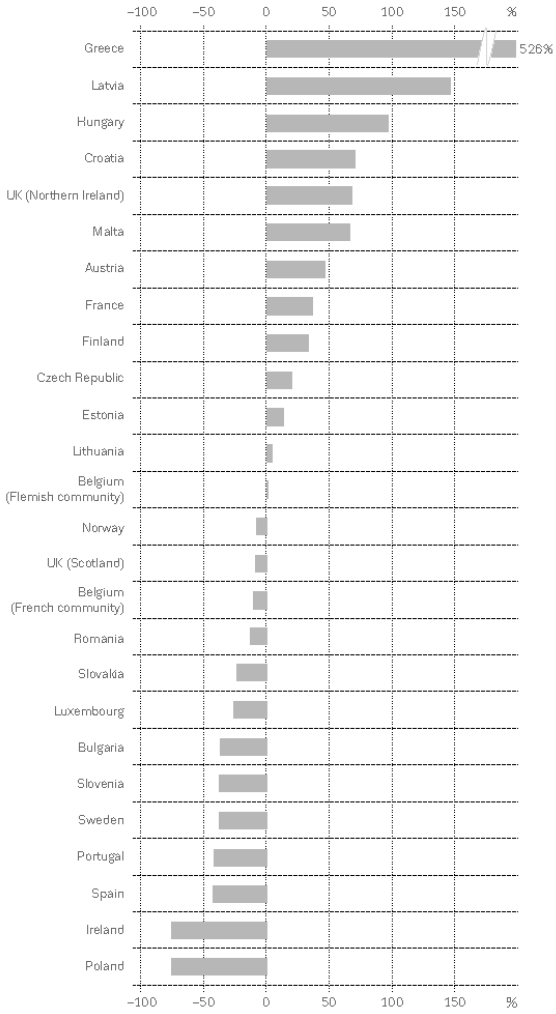
A particular concern is the risk posed by young people driving home from nightlife venues after consuming alcohol and drugs. A recent review found that targeted media campaigns, together with the offer of free late night transport, can reduce the number of traffic accidents caused by drink-driving. However, interventions targeting drug-driving are uncommon.

FIGURE 3.2

Availability of drug prevention interventions in nightlife settings (expert ratings, 2012)

FIGURE 3.3

Change in number of syringes distributed through specialised programmes between 2007 and 2012



Preventing the spread of infectious diseases

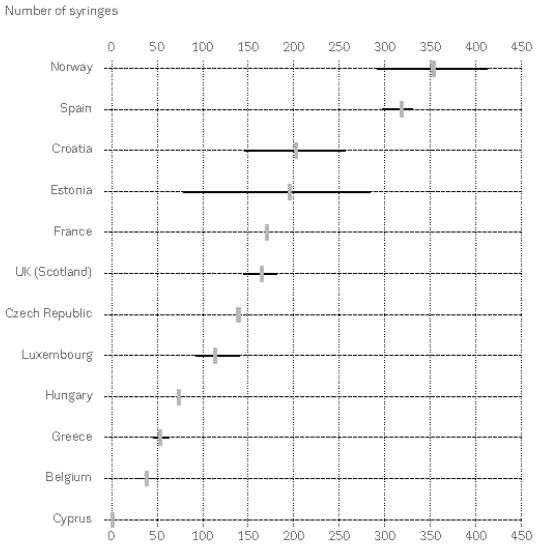
Drug users, and particularly injecting drug users, are at risk of contracting infectious diseases through the sharing of drug use material and through unprotected sex. Preventing the transmission of HIV, viral hepatitis and other infections is therefore an important objective for European drug policies. For injecting opioid users, it is now well demonstrated that substitution treatment reduces reported risk behaviour, with some studies suggesting that the protective effect increases when combined with needle and syringe programmes.

The number of syringes distributed through specialised programmes has increased in Europe (26 countries), rising from 42.9 million syringes in 2007 to 46.0 million in 2012. At country level, a divergent picture is evident, with around half of countries reporting an increase in provision and half a decrease (Figure 3.3). Increases can be explained by the expansion of provision, sometimes from a low base. Decreases may be explained by either a fall in service availability or a drop in client numbers. Among the 12 countries with recent estimates of numbers of injectors, the average number of syringes distributed per injecting drug user through specialised programmes in 2012 ranged from zero in Cyprus to more than 300 in Spain and Norway (Figure 3.4).

Drug users, and particularly injecting drug users, are at risk of contracting infectious diseases through the sharing of drug use material and through unprotected sex

FIGURE 3.4

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



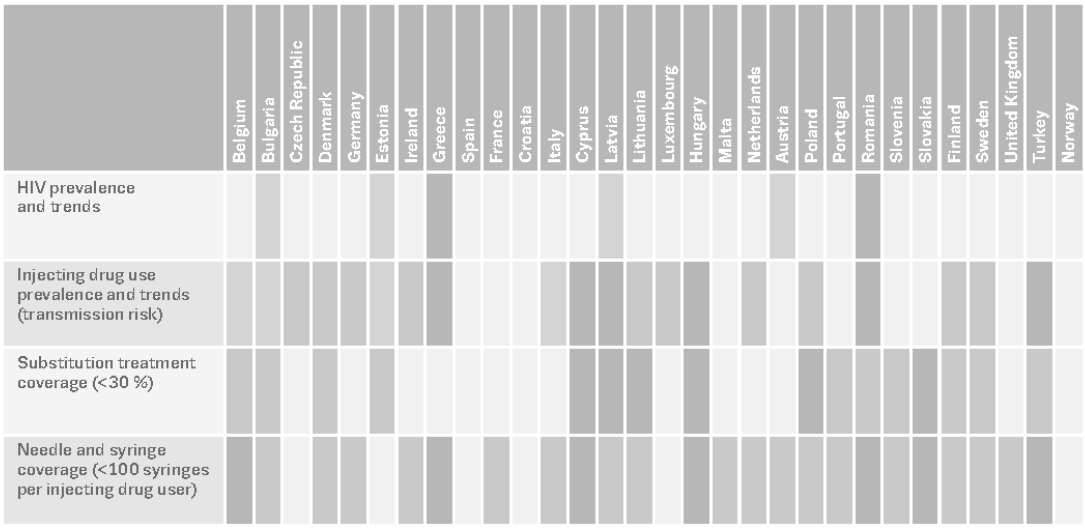
NB: Data displayed as point estimates and uncertainty intervals.

Outbreaks of new HIV infections among injecting drug users have been reported recently in Greece and Romania, as noted in Chapter 2. This prompted a risk assessment exercise to identify if other countries might be vulnerable to new HIV outbreaks. An overview of some top-level indicators of potential risk is provided in Figure 3.5. Based on this simple analysis, around one-third of the countries can be regarded as having some risk factors present, suggesting a need for continued vigilance and for consideration of increasing the coverage of HIV prevention measures.

Prevention measures targeting the transmission of hepatitis C are similar to those for HIV. At the policy level, an increasing number of countries have adopted or are preparing specific hepatitis C strategies. Initiatives directed at testing and counselling injecting drug users about hepatitis C remain limited. Despite growing evidence of the effectiveness of hepatitis C antiviral treatment for infected injecting drug users, levels of provision remain low.

FIGURE 3.5

Summary indicators for potential elevated risk for HIV infections among injecting drug users

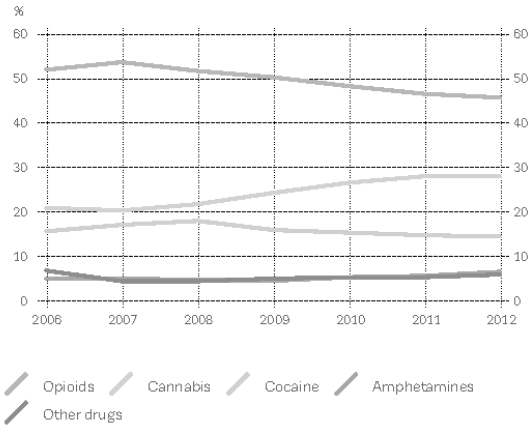


None of the following risk factors identified: increase in HIV case reports or prevalence of HIV or HCV; increase in transmission risk; low intervention coverage.
Risk factors possibly present: subnational increase in HIV or HCV prevalence or transmission risk; consistent but non-significant rise at national level.
Risk factor present: significant increase in HIV case reports or HIV or HCV prevalence; increase in transmission risk; low intervention coverage.
Information not available to ECDC or EMCDDA.

Adapted from *Eurosurveillance* 2013;18(48):pii=20648.

FIGURE 3.6

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



Preventing overdoses and drug-related deaths

Reducing fatal drug overdoses and other drug-related deaths remains a major challenge for public health policy in Europe. Targeted responses in this area focus either on preventing the occurrence of overdoses, or on improving the likelihood of surviving an overdose. Drug treatment, particularly opioid substitution treatment, prevents overdoses and reduces the mortality risk of drug users. Training in responding to overdoses with the distribution of the opioid antagonist drug naloxone can save lives in overdose situations. One type of intervention that aims both to reduce the occurrence of overdose and to increase the chance of surviving an overdose is the use of supervised consumption facilities. Six EU Member States and Norway currently provide such facilities — 73 in total. In the past three years, a number of facilities have been closed in the Netherlands, due to falling demand, while four new facilities were opened in Denmark and one in Greece.

More than a million Europeans in drug treatment

It is estimated that at least 1.3 million people received treatment for illicit drug use in Europe during 2012. Opioid users represent the largest group undergoing treatment, while data on treatment entries (Figure 3.6) suggest that cannabis and cocaine users are the second and third largest groups entering treatment services, although there are differences observable between countries.

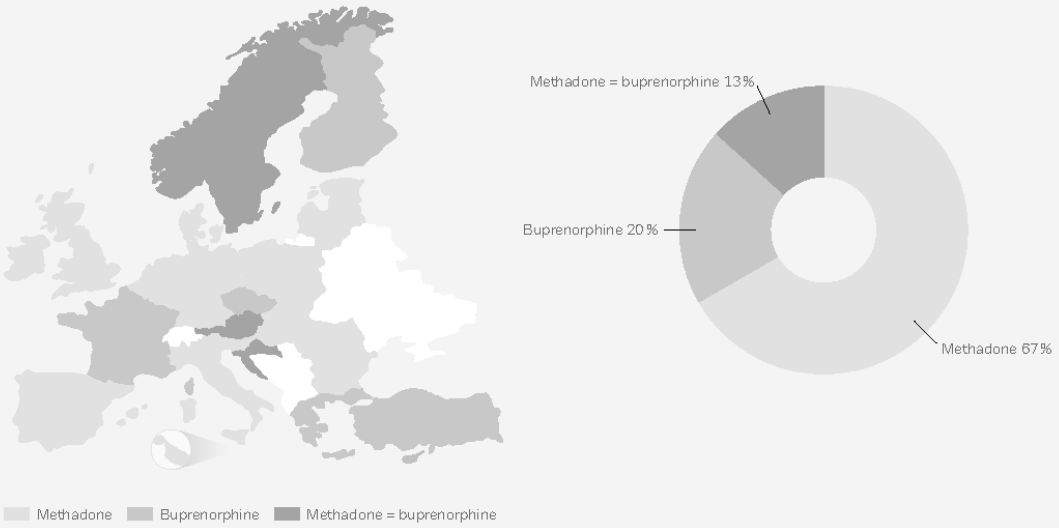
Most treatment is provided in outpatient settings, such as specialised centres, general healthcare centres, including general practitioners' surgeries, and low-threshold facilities. A sizeable proportion of drug treatment is also provided in residential settings, such as specialised residential treatment centres, therapeutic communities and hospital-based residential centres (e.g. psychiatric hospitals). A new and innovative approach to treatment is the provision of services via the Internet, allowing those seeking help with a drug problem to access treatment programmes from their own home.

Substitution treatment, typically combined with psychosocial interventions, is the most common treatment for opioid dependence in Europe. The available evidence supports this combined approach for keeping patients in treatment, as well as for reducing illicit opioid use, drug-related harms and mortality. Psychosocial interventions are the main treatment modality used for stimulant-dependent users, with studies suggesting that both cognitive-behavioural therapy and contingency management are associated with positive results.
A growing number of countries now offer cannabis-specific treatments, with the available evidence supporting the use of a combination of cognitive-behavioural therapy, motivational interviewing and contingency management approaches. Some evidence supports the use of multidimensional family therapy for young cannabis users.

Reducing fatal drug overdoses and other drug-related deaths remains a major challenge for public health policy in Europe

FIGURE 3.7

Predominant opioid substitution medication at national level (left) and as a proportion of substitution clients in Europe (right)



Substitution treatment: the main outpatient treatment modality

Methadone is the most commonly prescribed substitution medication, received by up to two-thirds of substitution clients, while buprenorphine is prescribed to most of the remaining clients (about 20 %), and is the principal substitution medication in six countries (Figure 3.7). About 6 % of all substitution treatments in Europe rely on the prescription of other substances, such as slow-release morphine or diacetylmorphine (heroin).

An estimated 734 000 opioid users received substitution treatment in Europe in 2012. This figure is relatively stable when compared with 2011 (726 000), but higher than the 630 000 estimate for 2007 (Figure 3.8). In 2012, five countries reported increases of more than 25 % in client numbers compared to the previous year's estimate. The highest percentage increase was noted in Turkey (250 %), followed by Greece (45 %) and Latvia (28 %). The percentage increases in these three countries, however, occurred in the context of relatively low base numbers. In contrast, during the same period, Romania (–30 %) reported the largest percentage decrease in estimated client numbers.

FIGURE 3.8

Trends in number of clients in opioid substitution treatment

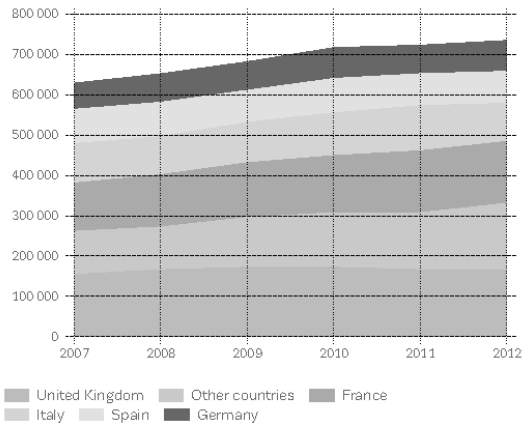
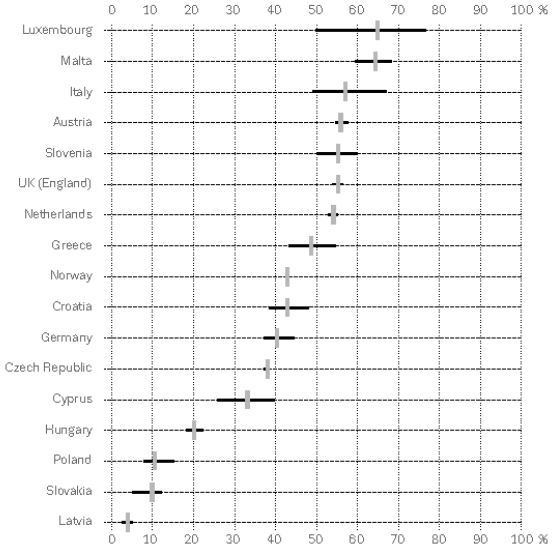


FIGURE 3.9

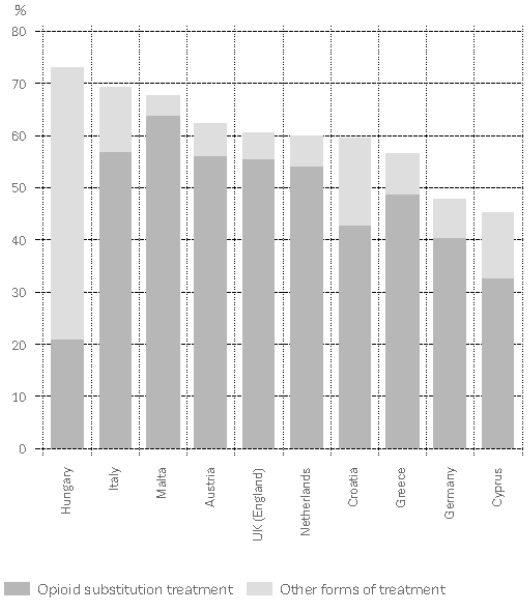
Percentage of problem opioid users receiving substitution treatment (estimate)



NB: Data displayed as point estimates and uncertainty intervals.

FIGURE 3.10

Percentage of problem opioid users receiving drug treatment (estimate)



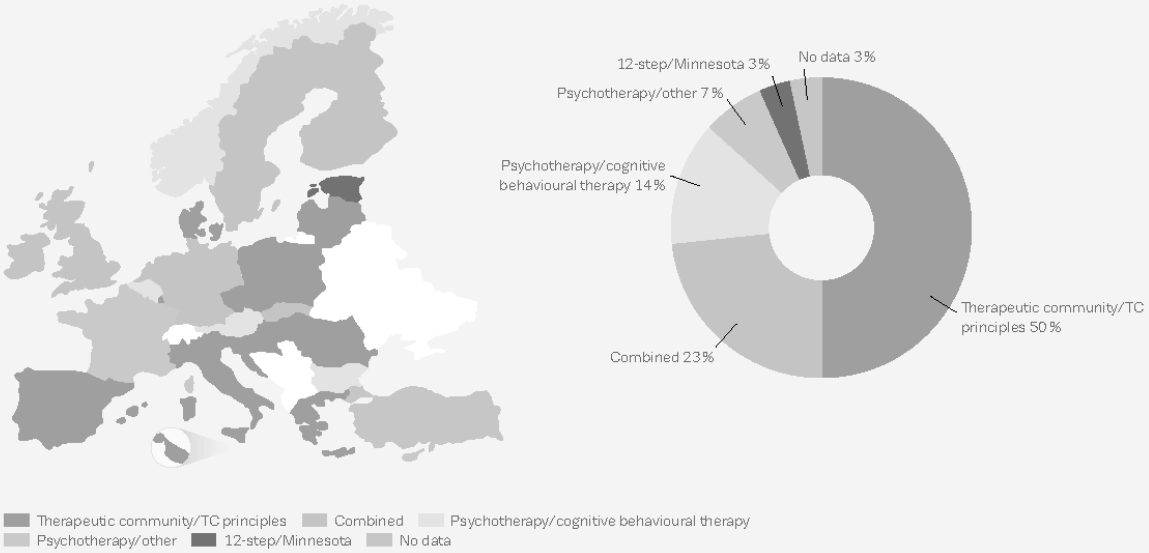
Treatment coverage: over half of opioid users are in substitution treatment

Coverage of opioid substitution treatment — the proportion of those in need receiving the intervention — is estimated at more than 50 % of Europe's problem opioid users. This estimate needs to be treated with caution for methodological reasons, but in many countries a majority of opioid users are, or have been, in contact with treatment services. At national level, however, large differences in coverage rates still exist, with the lowest estimated rates (around 10 % or less) reported in Latvia, Slovakia and Poland (Figure 3.9).

Treatment without substitution medication is provided to opioid users in all European countries. In the ten countries providing sufficient data, the coverage of treatment approaches not involving substitution medication is generally within the range of 3 % to 17 % of all problem opioid users, reaching over 50 % in Hungary (Figure 3.10).

FIGURE 3.11

Predominant therapeutic approach in residential programmes, by overall number at national (left) and European (right) levels, 2011



Residential treatment: therapeutic community approaches predominate

In most European countries, residential treatment programmes form an important element of the treatment and rehabilitation options for drug users. A recent EMCDDA study identified 2 500 residential treatment centres in Europe, with over two-thirds of the facilities concentrated in six countries: Germany, Spain, Ireland, Italy, Sweden and the United Kingdom. Community-residential facilities form the largest group (2 330), with 17 countries reporting all of their residential facilities to be of this variety. In addition, 170 hospital-based residential treatment programmes were also identified across Europe.

The focus for many residential programmes is on health, personal and social functioning and enhanced quality of life. Residential programmes can be characterised by four main therapeutic approaches: the 12-step or Minnesota model; the therapeutic community approach; psychotherapy using cognitive behavioural therapy; and psychotherapy using other care models. Of these, the 'therapeutic community model' is predominant in 15 countries (Figure 3.11).

The evidence on the effectiveness of drug-free therapeutic communities is inconclusive, in part because of methodological difficulties in conducting treatment outcome research in this area. Most research on this subject in Europe is limited to observational studies, and conclusions are therefore necessarily tentative. Generally, however, these studies report positive treatment outcomes, associated with longer retention in treatment and treatment completion. Almost all of the observational studies report that therapeutic community residents show reductions in drug use and arrests, as well as improvements in quality of life measures.

Although, historically, residential treatment programmes have been exclusively drug-free, current data indicate that the provision of substitution medication as a component of residential treatment programmes for opioid users is increasing. Some level of integration of opioid substitution in residential drug treatment was reported by 18 of 25 reporting countries (Figure 3.12).

FIGURE 3.12

Availability of opioid substitution within residential programmes, 2011

FIGURE 3.13

Availability of intermediate labour market interventions for drug treatment clients (expert ratings, 2011)

Social reintegration: focusing on employability

Social reintegration services support treatment and prevent relapse by addressing key aspects of the social exclusion of drug users. In 2012, about half of the clients who entered specialised drug treatment in Europe were unemployed (47 %) and almost one in ten lacked stable accommodation (9 %). Low educational attainment was also common among this group. Although the social reintegration of drug users is mentioned as a key objective of national drug strategies, provision of these interventions varies considerably between countries.

Increasing the employability of drug treatment clients can help them to reintegrate into society. For individuals, employability depends on the knowledge, skills and attitudes they possess, the way they use those assets and the context within which they seek work. One way to achieve this is through a supportive system targeted at disadvantaged individuals, which aims to bridge the gap between long-term unemployment and the labour market. This system is often referred to as the intermediate labour market. Treatment clients may be offered temporary employment contracts, together with training, work experience, personal development and job search activities. Social enterprise projects are a type of initiative that is commonly considered under this heading. These enterprises produce socially useful goods or services and employ groups that face disadvantages on the labour market. Although these interventions are available in most Member States (see Figure 3.13), access for people in drug treatment appears to be limited, and may be complicated by high unemployment rates in the general population.

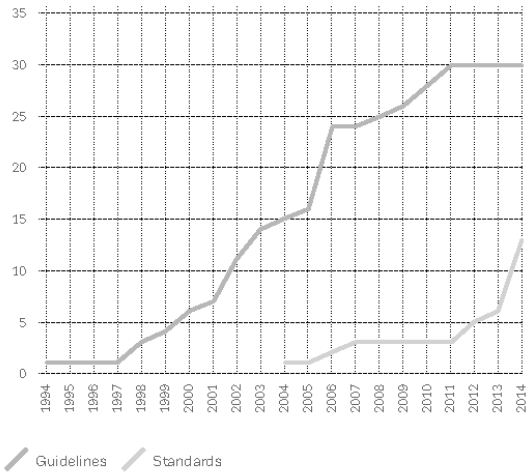
Social reintegration services support treatment and prevent relapse by addressing key aspects of the social exclusion of drug users

FIGURE 3.14

Ministerial responsibility for prison health service provision

FIGURE 3.15

Cumulative number of countries that have published guidelines and quality standards for health and social interventions in the drugs field, by year of publication



Prison health largely remains with justice and interior ministries

Prisoners report higher overall rates of drug use than the general population and more harmful patterns of use, illustrated by recent studies showing 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.

Most countries have established interagency partnerships between prison health services and providers in the community. Such partnerships deliver health education and treatment interventions in prison and ensure continuity of care upon prison entry and release. Generally, prison health services remain the responsibility of ministries of justice or interior. In some countries, however, the ministry of health now has responsibility for the delivery of prison health service (Figure 3.14), facilitating greater integration with general health service provision in the community.

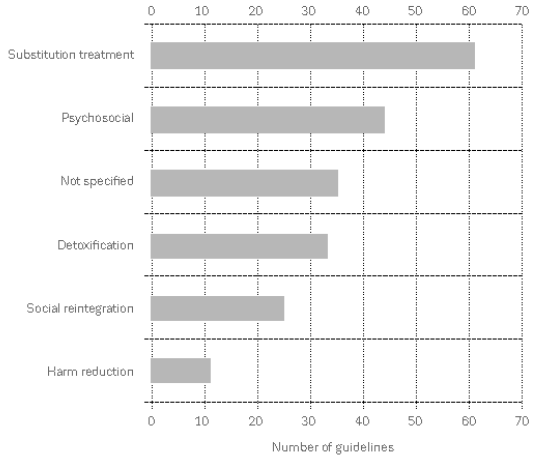
Opioid substitution treatment is now provided in prisons in 26 of the 30 countries monitored by the EMCDDA, although its introduction was generally later than for community provision. Restrictions may also exist. For example, in four countries, substitution treatment in prison is limited to those already having a prescription prior to incarceration.

Evidence-informed responses: use of guidelines and standards

Europe's health and social responses to drug problems are increasingly supported by guidelines and quality standards, which exist to translate evidence into satisfactory and sustainable results. In general, a process can be observed whereby guidelines precede by several years the introduction of quality standards (Figure 3.15).

FIGURE 3.16

National drug-related guidelines for health and social interventions in the drugs field reported in Europe up to 2013



Europe's health and social responses to drug problems are increasingly supported by guidelines and quality standards

Guidelines are statements that include recommendations intended to optimise client care. They are usually based on a systematic review of evidence and an assessment of the benefits and harms of alternative care options. The purpose of guidelines is to assist clients, carers and service providers in making decisions on the choice of appropriate interventions. During the last 20 years more than 150 sets of drug-related guidelines have been published, with guidelines available in all Member States since 2011. Guidelines span the full range of health and social interventions in the drugs field, although there are a larger number on health interventions such as substitution treatment and detoxification than on harm reduction and social reintegration (Figure 3.16).

Quality standards are principles and sets of rules based on evidence, which are used to help implement the interventions recommended in guidelines. They can refer to content issues, processes or to structural aspects of quality assurance, such as the working environment and staffing composition. In the field of drug prevention, a European-level set of quality standards is available to support programme development. These standards highlight factors such as ensuring the relevance of activities to target populations, adherence to accepted ethical principles, and integration and promotion of the scientific evidence base.

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EMCDDA publications

2014

Treatment of cocaine dependence: reviewing current evidence, Perspectives on drugs.

Health and social responses for methamphetamine users in Europe, Perspectives on drugs.

Internet-based drug treatment, Perspectives on drugs.

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Can mass media campaigns prevent young people from using drugs?, Perspectives on drugs.

Drug prevention interventions targeting minority ethnic populations, Thematic papers.

Hepatitis C treatment for injecting drug users, Perspectives on drugs.

North American drug prevention programmes: are they feasible in European cultures and contexts?, Thematic papers.

Preventing overdose deaths in Europe, Perspectives on drugs.

2012

Drug demand reduction: global evidence for local actions, Drugs in focus.

Guidelines for the evaluation of drug prevention: a manual for programme planners and evaluators (second edition), Manuals.

New heroin-assisted treatment, Insights.

Prisons and drugs in Europe: the problem and responses, Selected issues.

Social reintegration and employment: evidence and interventions for drug users in treatment, Insights.

2011

European drug prevention quality standards, Manuals.

Guidelines for the treatment of drug dependence: a European perspective, Selected issues.

2010

Harm reduction: evidence, impacts and challenges, Monographs.

Treatment and care for older drug users, Selected issues.

2009

Internet-based drug treatment interventions, Insights.

Preventing later substance use disorders in at-risk children and adolescents, Thematic papers.

2008

A cannabis reader: global issues and local experiences, volume 2, part III, Prevention and treatment, Monographs.

Drugs and vulnerable groups of young people, Selected issues.

EMCDDA and ECDC joint publications

2011

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

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

4

The international framework for control of production, trade and possession of over 240 psychoactive substances is set out in three United Nations Conventions

Drug policies

At a European level, EU drugs legislation alongside multi-annual strategies and action plans provide a framework for coordinated action. At the national level, it is the responsibility of governments and parliaments to adopt the legal, strategic, organisational and budgetary frameworks necessary to respond to drug-related problems.

Monitoring drug policies

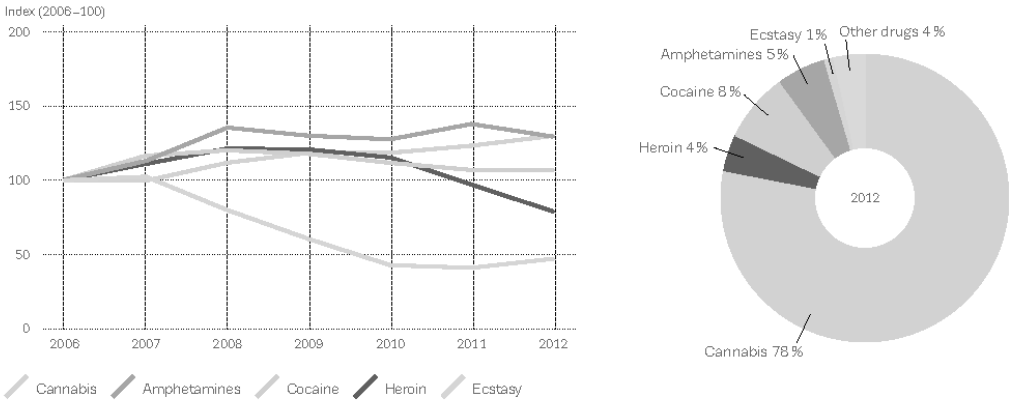
Key policy dimensions that can be monitored at European level include: drug laws and drug law offences, national drug strategies and action plans, policy coordination and evaluation mechanisms, as well as drug-related budgets and public expenditure. Data are collected via two EMCDDA networks: the national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

Drug laws: a common framework

The international framework for control of production, trade and possession of over 240 psychoactive substances is set out in three United Nations Conventions. These 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, and this is reflected in different legal approaches in European countries and elsewhere.

FIGURE 4.1

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



Possession for use: moving away from prison sentences

The possession of drugs for personal use — and sometimes drug use — is a criminal offence in most European countries, where it can be punished by a custodial sentence. In many European countries, however, imprisonment is uncommon, and since around 2000, there has been an overall trend across Europe to reduce the possibility of imprisonment for offences related to personal use. Some countries have removed the possibility of incarceration entirely, and some countries have gone further so that personal possession offences can only be punished by non-criminal sanctions, usually a fine.

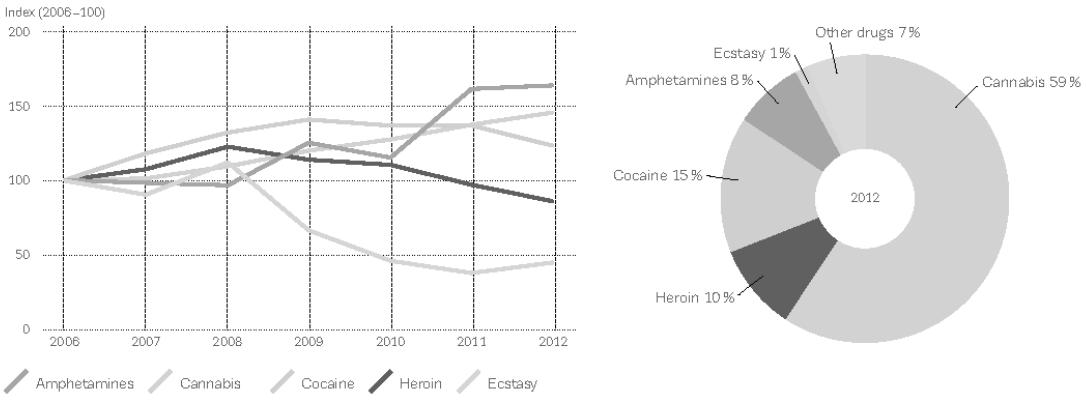
In most European countries, the majority of reports of drug law offences relate to drug use or possession for use. In Europe, overall, it is estimated that more than one million of these offences were reported in 2012, a 17 % increase compared to 2006. More than three-quarters of the reported drug offences involve cannabis (Figure 4.1).

Drug supply: large variation in penalties

Illegal drug supply is always a crime across Europe, but the possible penalties vary considerably between countries. In some countries, supply offences may be subject to a single wide penalty range (up to life in prison). Other countries

FIGURE 4.2

Reported offences related to drug supply in Europe, trends and breakdown by drug



differentiate between minor and major supply offences, determined by factors such as the quantity or type of drugs found, with corresponding maximum and minimum penalties.

Overall, reports of drug supply offences have increased by 28 % since 2006, reaching more than 230 000 cases in 2012. As with possession offences, cannabis accounted for the majority. Cocaine, heroin and amphetamines, however, accounted for a larger share of offences for supply than for personal possession. The downward trends in offences for cocaine and heroin supply have continued (Figure 4.2).

New psychoactive substances: evolving control systems

The speed at which recently controlled substances have been replaced by new substances and the diversity of available products has severely challenged Europe's lawmakers.

At national level, these challenges have prompted a variety of innovative legal responses among European countries. Broadly speaking, three types can be identified. First, countries may use existing laws that cover issues unrelated to controlled drugs, such as consumer safety legislation or medicines control legislation: in Poland, over 1 000 retail outlets were closed over a weekend in 2010 by using existing health protection powers. Secondly, countries may extend or adapt existing drug laws or processes: in the United Kingdom in 2011, Temporary Class Drug Orders were introduced to control supply while the risks to health are examined. Thirdly, countries may design new legislation: in 2013, Portugal and Slovakia introduced laws specifically to stop the unauthorised sale of certain new substances.

This fast-moving area of law continues to evolve. In recent developments, Poland and Romania strengthened existing laws by introducing specially designed new legislation; old and new are now used in parallel. In 2012, Cyprus redrafted their generic definitions to cover substances outside the current definitions, while in the same year the Netherlands rejected generic definitions on the basis that they were not sufficiently targeted.

Among these different responses, there is wide variation in the criteria for triggering a legislative response and in the penalties for non-compliance. Nevertheless, there seems to be a trend towards countries focusing on penalising supply rather than possession of these substances.

FIGURE 4.3

National drug strategies and action plans: availability and scope

NB: While the United Kingdom has an illicit drug strategy, both Wales and Northern Ireland have combined strategies which include alcohol.

National drug strategies

It is now 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 document, except Austria which has provincial plans. Seven countries have adopted national strategies and action plans that cover both licit and illicit drugs (Figure 4.3). Many countries now systematically evaluate their drug strategies and action plans. The aim of evaluation is generally to assess the level of implementation achieved, as well as the changes in the overall drug situation.

It is now established practice for national governments in Europe to adopt drug strategies and action plans

Diverse drug policy advocacy organisations

Recent years have seen an increased involvement of civil society organisations, including drug policy advocacy groups, in the development of drug strategies. A recent EMCDDA study identified more than 200 organisations involved in drug policy advocacy in Europe, with around 70 % of them active at national level and the remainder equally divided between local or European level advocacy. Almost two-thirds of these organisations had objectives focused on practice development, with 39 % advocating harm reduction approaches and 26 % advocating prevention and drug use reduction. The remaining organisations were focused on legislative change, with 23 % favouring reduction of drug controls and 12 % advocating control reinforcement.

Most advocacy organisations are engaged in targeted activities, aimed at influencing the attitudes and opinions of the public and policymakers on drug service provision and drug controls. They use awareness raising activities such as participating in public debates, or maintaining social media sites in order to influence drug policy. Organisations promoting control reduction or harm reduction mainly advocated on behalf of drug users, whereas organisations supporting drug use reduction and control reinforcement mainly advocated on behalf of the wider society and, in particular, young people and families.

Economic evaluation: funds for interventions affected by austerity

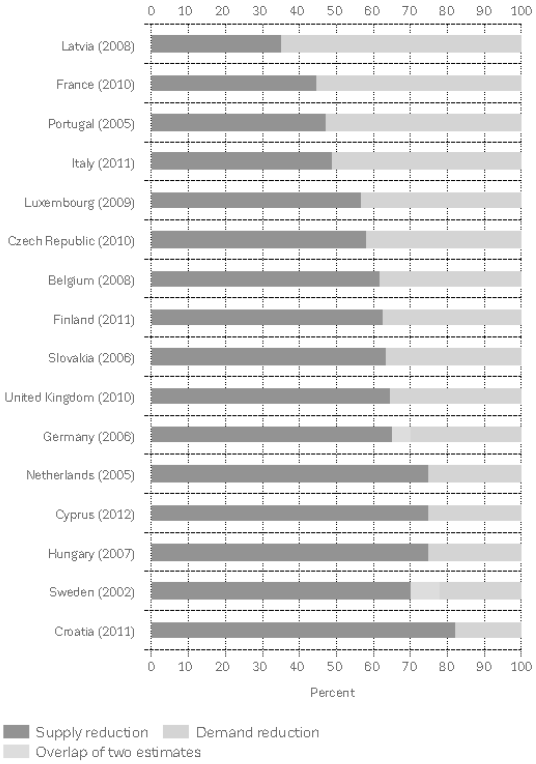
Many European countries continue to face the consequences of the recent economic downturn. The extent of fiscal consolidation or austerity measures and their impact differs between European countries. Among the 18 countries with sufficient data to make a comparison, reductions were reported in health and public order and safety — the areas of government spending where most drug-related public expenditure originates. Overall, between 2009 and 2011, greater reductions in public expenditure were observed in the health sector.

Cuts in funds available for drug-related programmes and services have also been reported by European countries, with drug prevention interventions and drug-related research particularly affected. Several countries also report that attempts to ring-fence the financing of drug treatment have not always succeeded.

Economic analysis can be an important tool for policy evaluation, although the limited information available on drug-related public expenditure in Europe represents a major obstacle and makes comparison between countries difficult. For the 16 countries that have produced estimates since 2002, drug-related public expenditure ranges from 0.01 % to 0.5 % of their gross domestic product (GDP). From the information available, it appears that the largest share of drug-related public expenditure is allocated to drug supply reduction activities (Figure 4.4).

FIGURE 4.4

Breakdown of drug-related public expenditure between demand reduction and supply reduction



Public expenditure on supply reduction includes, among other things, expenditure on drug-law offenders in prisons. The EMCDDA calculated a range of estimates, where the low estimate considers only those prisoners who have been sentenced for a drug-law offence and the high estimate also includes pre-trial prisoners who may be sentenced for a drug-law offence. Applying these criteria, European countries spent an estimated 0.03% of GDP, or EUR 3.7 billion, on drug-law offenders in prison in 2010. Including pre-trial prisoners, the estimate rises to 0.05 % of GDP or EUR 5.9 billion.

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2014

Drug policy profiles — Austria, EMCDDA Papers.

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

Annex

National data presented here are drawn from the *European Drug Report: Data and statistics*, where further data, years, notes and meta-data are available

TABLE 1

OPIOIDS

	Problem opioid use estimate	Treatment demand indicator, primary drug				Clients in substitution treatment
		Opioid clients as % of treatment entrants		% opioid clients injecting (main route of administration)		
		All entrants	First-time entrants	All entrants	First-time entrants	
Country	cases per 1 000	% (count)	% (count)	% (count)	% (count)	count
Belgium	–	34.5 (2 335)	17.1 (290)	21.7 (480)	12.4 (35)	17 351
Bulgaria	–	82.5 (1 631)	84.3 (253)	78.5 (963)	80.3 (196)	3 445
Czech Republic	1.5–1.5	18.2 (1 615)	9.7 (417)	85.8 (1 370)	84.5 (348)	4 000
Denmark	–	17.5 (663)	7.1 (102)	33.9 (193)	23 (20)	7 600
Germany	3.2–3.8	40.4 (30 841)	15.9 (3 343)	–	–	75 400
Estonia	–	93.4 (510)	85.6 (107)	80.7 (406)	79.4 (85)	1 157
Ireland	–	51.6 (3 971)	32.4 (1 058)	42.5 (1 633)	34.4 (353)	8 923
Greece	2.6–3.2	77.5 (4 399)	68.9 (1 652)	39.7 (1 744)	36.3 (600)	9 878
Spain	0.9–1.0	29.7 (14 925)	13.2 (3 289)	18.1 (2 537)	12.1 (384)	76 263
France	–	43.1 (15 641)	27.1 (2 690)	14.2 (1 836)	6.8 (172)	152 000
Croatia	3.2–4.0	80.9 (6 357)	27.9 (313)	74.5 (4 678)	42.3 (126)	4 565
Italy	3.8–5.2	55.5 (16 751)	39 (5 451)	55.7 (8 507)	46.4 (2 185)	98 460
Cyprus	1.0–1.5	27.9 (278)	8.4 (41)	57.2 (159)	57.5 (23)	239
Latvia	5.4–10.7	49.9 (1 071)	26.3 (104)	91.3 (935)	80.9 (76)	355
Lithuania	2.3–2.4	–	66 (140)	–	100 (140)	687
Luxembourg	5.0–7.6	58.8 (163)	–	44.1 (71)	–	1 226
Hungary	0.4–0.5	5.9 (230)	1.8 (47)	70.9 (156)	56.8 (25)	637
Malta	5.8–6.6	75.4 (1 410)	35.2 (93)	61 (840)	53.9 (48)	1 094
Netherlands	0.8–1.0	12.1 (1 302)	5.7 (352)	5.8 (45)	9 (19)	9 556
Austria	5.2–5.5	58 (2 110)	35.5 (488)	46.5 (727)	33.6 (127)	16 892
Poland	0.4–0.7	28.7 (808)	9 (104)	62.7 (449)	39.4 (39)	1 583
Portugal	–	70.1 (2 637)	54.4 (980)	15.4 (147)	13.1 (80)	24 027
Romania	–	37.4 (745)	25 (251)	89.3 (609)	86.5 (199)	531
Slovenia	4.0–4.8	81.1 (519)	64 (189)	50.6 (212)	39.7 (48)	3 345
Slovakia	1.0–2.5	26.3 (528)	13.1 (126)	74 (382)	69.6 (87)	465
Finland	–	61.9 (920)	38.1 (101)	81 (728)	74 (74)	2 439
Sweden	–	20.1 (248)	–	60.9 (148)	–	5 200
United Kingdom	7.9–8.3	56.4 (61 737)	33.4 (13 586)	34.5 (20 804)	30.6 (4 085)	171 082
Turkey	0.2–0.5	75.4 (3 557)	67.3 (1 695)	48.7 (1 734)	43.1 (730)	28 656
Norway	2.1–3.9	32.6 (2 902)	–	77.1 (145)	–	7 038
European Union	–	45.5 (174 345)	25.0 (35 567)	38.2 (50 759)	31.8 (9 574)	698 441
EU, Turkey and Norway	–	45.5 (181 804)	25.7 (37 262)	38.5 (52 638)	32.4 (10 304)	734 135

TABLE 2

COCAINE

	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
Country	%	%	%	% (count)	% (count)	% (count)	% (count)
Belgium	–	2.0	4	15.3 (1 031)	16.3 (277)	7.4 (72)	2.2 (6)
Bulgaria	0.9	0.3	3	0.5 (9)	1 (3)	0 (0)	0 (0)
Czech Republic	2.3	0.5	1	0.2 (19)	0.2 (10)	0 (0)	0 (0)
Denmark	5.2	2.4	2	5.1 (193)	5.8 (84)	10.1 (17)	0 (0)
Germany	3.4	1.6	3	6.1 (4 620)	6 (1 267)	–	–
Estonia	–	1.3	2	–	–	–	–
Ireland	6.8	2.8	3	8.5 (654)	9.1 (297)	1.5 (9)	0 (0)
Greece	0.7	0.2	1	4.1 (235)	4.2 (101)	19.4 (45)	8.9 (9)
Spain	8.8	3.6	3	40.4 (20 335)	42.5 (10 637)	1.9 (371)	0.9 (97)
France	3.7	1.9	4	6.4 (2 311)	4.1 (411)	9.9 (192)	4.1 (16)
Croatia	2.3	0.9	2	1.9 (147)	4.3 (48)	3.5 (5)	2.2 (1)
Italy	4.2	1.3	1	24.2 (7 299)	30 (4 187)	4.1 (282)	3.4 (134)
Cyprus	1.3	0.6	4	12.1 (121)	6.2 (30)	2.5 (3)	0 (0)
Latvia	1.5	0.3	–	0.3 (6)	0.5 (2)	0 (0)	0 (0)
Lithuania	0.9	0.3	2	–	–	–	–
Luxembourg	–	–	–	12.6 (35)	–	39.4 (13)	–
Hungary	0.9	0.4	2	1.6 (62)	1.6 (41)	11.5 (7)	7.5 (3)
Malta	0.4	–	4	13.4 (251)	28 (74)	30.7 (75)	14.5 (10)
Netherlands	5.2	2.4	2	26.5 (2 867)	21.7 (1 328)	0.1 (2)	0.1 (1)
Austria	2.2	1.2	–	8.3 (301)	10.2 (140)	6.5 (19)	1.5 (2)
Poland	0.9	0.3	3	2.4 (69)	2.7 (31)	6.1 (4)	3.2 (1)
Portugal	1.2	0.4	4	10.5 (397)	14.4 (259)	3.6 (8)	1 (2)
Romania	0.3	0.2	2	1.2 (23)	1.9 (19)	0 (0)	0 (0)
Slovenia	2.1	1.2	3	4.8 (25)	4.2 (8)	40 (10)	12.5 (1)
Slovakia	0.6	0.4	2	0.5 (11)	0.9 (9)	0 (0)	0 (0)
Finland	1.7	0.6	1	–	–	–	–
Sweden	3.3	1.2	1	1.8 (16)	–	0 (0)	–
United Kingdom	9.0	3.3	4	12.6 (13 787)	16.9 (6 887)	2.1 (279)	0.9 (58)
Turkey	–	–	–	1.7 (82)	2 (50)	0 (0)	0 (0)
Norway	–	–	1	0.8 (67)	–	0 (0)	–
European Union	4.2	1.7	–	14.3 (54 824)	18.4 (26 150)	3 (1 413)	1.5 (341)
EU, Turkey and Norway	–	–	–	13.9 (54 973)	18.1 (26 200)	3 (1 413)	1.5 (341)

TABLE 3

AMPHETAMINES

	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
Country	%	%	%	% (count)	% (count)	% (count)	% (count)
Belgium	–	–	5	9.4 (639)	7.4 (125)	15.4 (86)	9.8 (12)
Bulgaria	1.2	1.3	6	2.2 (43)	8 (24)	0 (0)	0 (0)
Czech Republic	2.5	0.8	2	67.4 (5 999)	71 (3 040)	80.1 (4 761)	75.2 (2 255)
Denmark	6.6	1.4	2	9.5 (358)	10.3 (149)	3.1 (9)	0 (0)
Germany	3.1	1.8	4	13.1 (9 959)	16.7 (3 498)	–	–
Estonia	–	2.5	3	2.4 (13)	2.4 (3)	75 (9)	66.7 (2)
Ireland	4.5	0.8	2	0.6 (45)	0.8 (25)	0 (0)	0 (0)
Greece	0.1	0.1	2	0.1 (7)	0.1 (2)	0 (0)	0 (0)
Spain	3.3	1.1	2	1.2 (595)	1.5 (363)	0.3 (2)	0 (0)
France	1.7	0.5	4	0.3 (98)	0.2 (22)	22.5 (18)	15.8 (3)
Croatia	2.6	1.6	2	1.1 (85)	2 (22)	1.2 (1)	0 (0)
Italy	1.8	0.1	1	0.1 (33)	0.2 (22)	0 (0)	0 (0)
Cyprus	0.7	0.4	4	–	–	–	–
Latvia	2.2	0.6	–	19.8 (426)	27.1 (107)	60.4 (223)	56.3 (54)
Lithuania	1.2	0.5	3	–	5.7 (12)	–	75 (9)
Luxembourg	–	–	–	0.7 (2)	–	0 (0)	–
Hungary	1.8	1.2	6	12.3 (476)	11.1 (285)	20 (94)	16 (45)
Malta	0.4	–	3	0.3 (5)	0.4 (1)	20 (1)	0 (0)
Netherlands	3.1	–	3	5.9 (633)	6.1 (372)	1.8 (6)	0.5 (1)
Austria	2.5	0.9	–	3.2 (117)	4.3 (59)	0 (0)	0 (0)
Poland	2.9	1.4	4	21.7 (611)	22.4 (260)	10.1 (60)	3.5 (9)
Portugal	0.5	0.1	3	0.03 (1)	0.1 (1)	–	–
Romania	0.1	0.0	2	0.5 (9)	0.4 (4)	0 (0)	0 (0)
Slovenia	0.9	0.8	2	1 (5)	2.1 (4)	0 (0)	0 (0)
Slovakia	0.5	0.3	2	44.7 (895)	49.3 (474)	27.8 (244)	19.2 (90)
Finland	2.3	1.6	1	12.2 (181)	9.8 (26)	80.4 (135)	68 (17)
Sweden	5.0	1.5	1	14.9 (130)	–	76.5 (176)	–
United Kingdom	10.6	1.1	2	2.8 (3 084)	3.3 (1 329)	26.1 (744)	19.4 (241)
Turkey	0.3	–	–	–	–	–	–
Norway	–	–	1	11.9 (1 057)	–	70.2 (203)	–
European Union	3.4	0.9	–	6.5 (24 553)	7.2 (10 229)	48 (6 569)	43 (2 738)
EU, Turkey and Norway	–	–	–	6.5 (25 610)	7.1 (10 229)	48.5 (6 772)	43 (2 738)

TABLE 4

ECSTASY

	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
Country	%	%	%	% (count)	% (count)
Belgium	–	–	4	0.5 (36)	1.1 (19)
Bulgaria	2.0	2.9	4	–	–
Czech Republic	3.6	1.2	3	0.1 (6)	0.1 (3)
Denmark	2.3	0.7	1	0.3 (13)	0.5 (7)
Germany	2.7	0.9	2	–	–
Estonia	–	2.3	3	–	–
Ireland	6.9	0.9	2	0.6 (46)	1 (32)
Greece	0.4	0.4	2	0.2 (10)	0.2 (4)
Spain	3.6	1.4	2	0.2 (103)	0.3 (78)
France	2.4	0.4	3	0.5 (186)	0.2 (22)
Croatia	2.5	0.5	2	0.4 (31)	0.4 (4)
Italy	1.8	0.1	1	0.2 (61)	0.2 (32)
Cyprus	0.9	0.3	3	0.2 (2)	0.2 (1)
Latvia	2.7	0.8	3	0.2 (4)	0.5 (2)
Lithuania	1.3	0.3	2	–	–
Luxembourg	–	–	–	–	–
Hungary	2.4	1.0	4	1.5 (57)	1.3 (34)
Malta	0.7	–	3	1.1 (20)	2.7 (7)
Netherlands	6.2	3.1	3	0.6 (66)	0.9 (58)
Austria	2.3	1.0	–	0.7 (24)	0.9 (13)
Poland	1.1	0.3	2	0.2 (7)	0.2 (2)
Portugal	1.3	0.6	3	0.1 (4)	0.2 (4)
Romania	0.7	0.4	2	0.2 (3)	0.2 (2)
Slovenia	2.1	0.8	2	0.4 (2)	1.1 (2)
Slovakia	1.9	0.9	4	–	–
Finland	1.8	1.1	1	0.1 (2)	0.4 (1)
Sweden	2.1	0.2	1	–	–
United Kingdom	8.3	2.4	4	0.2 (270)	0.4 (166)
Turkey	0.1	0.1	–	1.1 (53)	1.6 (41)
Norway	–	–	1	–	–
European Union	3.1	1.0	–	0.2 (953)	0.3 (493)
EU, Turkey and Norway	–	–	–	0.3 (1 006)	0.4 (534)

TABLE 5

CANNABIS

	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
Country	%	%	%	% (count)	% (count)
Belgium	14.3	11.2	24	31.2 (2 112)	49.4 (839)
Bulgaria	7.5	8.3	21	3.4 (67)	5.7 (17)
Czech Republic	27.9	18.5	42	12.5 (1 111)	17.5 (747)
Denmark	35.6	17.6	18	63.4 (2 397)	72.6 (1 048)
Germany	23.1	11.1	19	34.4 (26 208)	54.5 (11 431)
Estonia	–	13.6	24	2.9 (16)	8 (10)
Ireland	25.3	10.3	18	28.8 (2 216)	45.8 (1 498)
Greece	8.9	3.2	8	15.7 (889)	24.6 (589)
Spain	27.4	17.0	28	25.6 (12 873)	38.9 (9 736)
France	32.1	17.5	39	44.1 (16 020)	62.5 (6 206)
Croatia	15.6	10.5	18	12.7 (1 001)	56.3 (630)
Italy	21.7	8.0	14	17.1 (5 176)	26 (3 629)
Cyprus	9.9	4.2	7	53.3 (532)	81.9 (399)
Latvia	12.5	7.3	25	14.6 (314)	26.8 (106)
Lithuania	10.5	5.1	20	–	3.3 (7)
Luxembourg	–	–	–	26 (72)	–
Hungary	8.5	5.7	19	65.9 (2 560)	74.9 (1 927)
Malta	3.5	1.9	10	8.4 (157)	29.2 (77)
Netherlands	25.7	13.7	26	47.6 (5 143)	57.8 (3 542)
Austria	14.2	6.6	–	25.3 (919)	45.4 (623)
Poland	12.2	12.1	23	35.6 (1 003)	53.6 (623)
Portugal	9.4	5.1	14	13.9 (525)	25.4 (457)
Romania	1.6	0.6	7	11.1 (222)	18.1 (182)
Slovenia	15.8	10.3	23	10.4 (54)	26.5 (50)
Slovakia	10.5	7.3	27	21.6 (432)	32 (308)
Finland	18.3	11.2	11	18 (267)	42.6 (113)
Sweden	14.9	6.9	7	16 (197)	–
United Kingdom	30.0	10.5	24	22.4 (24 498)	37.1 (15 107)
Turkey	0.7	0.4	–	15.8 (744)	22 (555)
Norway	19.2	7.9	5	19.2 (1 711)	–
European Union	21.7	11.2	–	27.9 (106 981)	42.2 (59 901)
EU, Turkey and Norway	–	–	–	27.6 (109 436)	41.8 (60 456)

TABLE 6

OTHER INDICATORS

Country	Drug-induced deaths (aged 15–64) cases per million population (count)	HIV diagnoses among injecting drug users (ECDC) cases per million population (count)	Injecting drug use estimate cases per 1 000 population	Syringes distributed through specialised programmes count
Belgium	17.4 (127)	0.4 (4)	2.5–4.8	937 924
Bulgaria	4.8 (24)	5.5 (40)	–	466 603
Czech Republic	3.9 (28)	0.6 (6)	5.32–5.38	5 362 334
Denmark	46.3 (168)	2 (11)	–	–
Germany	16.8 (908)	1 (81)	–	–
Estonia	190.8 (170)	53.7 (72)	4.3–10.8	2 228 082
Ireland	70.5 (215)	2.8 (13)	–	274 475
Greece	–	42.9 (484)	0.93–1.25	406 898
Spain	11.4 (360)	4.4 (166)	0.19–0.21	1 990 136
France	6.7 (283)	1.2 (76)	–	13 800 000
Croatia	16.1 (46)	0.2 (1)	0.3–0.6	256 544
Italy	10.1 (390)	3.4 (208)	–	–
Cyprus	12 (7)	0 (0)	0.2–0.4	0
Latvia	12.4 (17)	46 (94)	–	311 188
Lithuania	34.7 (70)	20.6 (62)	–	196 446
Luxembourg	22.1 (8)	7.6 (4)	4.5–6.85	212 822
Hungary	3.5 (24)	0 (0)	0.8	420 812
Malta	16.2 (4)	0 (0)	–	376 104
Netherlands	10.2 (113)	0.4 (7)	0.21–0.22	237 400
Austria	28.1 (160)	4.5 (38)	–	4 625 121
Poland	9.9 (271)	1.1 (42)	–	98 000
Portugal	4.2 (29)	5.3 (56)	–	1 341 710
Romania	2 (28)	8 (170)	–	1 074 394
Slovenia	18.4 (26)	0.5 (1)	–	553 426
Slovakia	6.2 (24)	0.2 (1)	–	11 691
Finland	58 (205)	1.3 (7)	–	3 539 009
Sweden	62.6 (383)	1.7 (16)	–	73 125
United Kingdom	38.3 (1 598)	1.8 (111)	2.9–3.2	9 349 940
Turkey	3.1 (154)	0.1 (6)	–	–
Norway	75.9 (250)	2.2 (11)	2.2–3.1	3 011 000
European Union	17.1 (5 686)	3.5 (1 771)	–	–
EU, Turkey and Norway	–	3.1 (1 788)	–	–

TABLE 7

SEIZURES

	Heroin		Cocaine		Amphetamines		Ecstasy	
	Quantity seized	Number of seizures	Quantity seized	Number of seizures	Quantity seized	Number of seizures	Quantity seized	Number of seizures
Country	kg	count	kg	count	kg	count	tablets (kg)	count
Belgium	112	1 953	19 178	3 349	58	2 641	26 874 (–)	1 015
Bulgaria	285	44	115	30	84	68	6 164 (30)	3
Czech Republic	8	41	8	44	32	357	1 782 (0.01)	12
Denmark	41	430	42	2 056	303	1 817	72 654 (–)	523
Germany	242	3 381	1 258	3 618	1 196	11 919	313 179 (–)	1 786
Estonia	0.0004	1	3	49	41	319	9 210 (0.01)	56
Ireland	60	766	459	391	23	143	148 195 (6)	311
Greece	331	2 045	201	432	0.3	22	3 253 (0.4)	7
Spain	229	5 822	20 754	37 880	251	2 511	175 381 (–)	2 128
France	701	–	5 602	–	307	–	156 337 (–)	–
Croatia	30	192	6	132	3	268	– (1.1)	105
Italy	951	2 983	5 319	6 633	12	63	19 051 (20)	138
Cyprus	1	34	7	88	0.5	50	102 (0.1)	9
Latvia	1	427	1	28	30	820	847 (–)	24
Lithuania	0.5	112	120	10	80	119	54 (–)	8
Luxembourg	3	190	2	122	1	13	137 (–)	10
Hungary	3	26	13	118	30	492	12 437 (0.8)	91
Malta	1	44	143	80	0.2	3	1 080 (–)	27
Netherlands	750	–	10 000	–	681	–	2 442 200 (61)	–
Austria	222	393	65	912	35	607	8 998 (–)	113
Poland	36	–	213	–	618	–	31 092 (0.01)	–
Portugal	66	971	4 020	1 238	0.2	44	867 (7)	101
Romania	45	215	55	85	4	16	12 861 (0.02)	112
Slovenia	20	439	27	251	9	203	960 (–)	16
Slovakia	0.3	82	2	19	11	607	529 (–)	16
Finland	0.07	47	26	147	139	2 616	23 623 (–)	513
Sweden	7	363	34	1 010	361	3 609	38 630 (3)	441
United Kingdom	831	10 624	3 324	18 569	1 491	6515	473 000 (–)	3 716
Turkey	13 301	4 155	476	1 434	619	108	2 961 553 (357)	4 445
Norway	45	1 277	67	860	317	6 801	6 579 (2)	274
European Union	4 977	31 625	70 997	77 291	5 802	35 842	3 979 497 (130)	11 281
EU, Turkey and Norway	18 323	37 057	71 540	79 585	6 737	42 751	6 947 629 (489)	16 000

TABLE 7

SEIZURES (continued)

	Cannabis resin		Herbal cannabis		Cannabis plants	
	Quantity seized	Number of seizures	Quantity seized	Number of seizures	Quantity seized	Number of seizures
Country	kg	count	kg	count	plants (kg)	count
Belgium	1 338	4 500	5 635	19 672	330 675	1 111
Bulgaria	15 967	4	1 319	127	13 072 (2 517)	26
Czech Republic	21	24	563	558	90 091 (–)	259
Denmark	1 334	9 239	223	1 287	– (1 401)	675
Germany	2 386	6 490	4 942	28 744	97 829 (–)	2 204
Estonia	5	48	25	466	– (7)	12
Ireland	1 185	527	1 020	1 843	11 601 (–)	542
Greece	44	145	22 383	6 262	34 040 (–)	831
Spain	325 563	179 993	10 457	150 206	– (39 932)	1 677
France	51 118	–	3 270	–	131 307 (–)	–
Croatia	23	343	1 070	4 098	6 703 (–)	211
Italy	21 893	6 184	21 496	4 660	4 122 617 (–)	1 216
Cyprus	0.1	20	100	863	385 (–)	39
Latvia	117	64	74	414	– (335)	4
Lithuania	424	23	96	242	– (–)	–
Luxembourg	1	83	30	774	39 (–)	9
Hungary	3	103	1 777	2 092	7 382 (–)	193
Malta	16	96	3	50	46 (–)	5
Netherlands	2 200	–	12 600	–	1 400 000 (–)	–
Austria	174	1 192	812	5 732	– (173)	210
Poland	39	–	1 489	–	61 585 (–)	–
Portugal	18 304	3 298	49	554	7 788 (–)	397
Romania	27	1 492	335	262	3 125 (300)	30
Slovenia	3	66	706	3 350	11 166 (–)	174
Slovakia	1	17	177	1 242	2 927 (–)	38
Finland	714	1 870	–	5 036	18 150 (66)	3 339
Sweden	1 091	6 761	641	7 611	–	–
United Kingdom	13 432	17 360	13 243	148 746	555 625	15 846
Turkey	27 413	6 881	124 673	57 744	–	3 646
Norway	1 605	10 985	314	4 402	– (133)	364
European Union	457 424	239 942	104 535	394 891	6 906 153 (44 730)	29 048
EU, Turkey and Norway	486 442	257 808	229 522	457 037	6 906 153 (44 863)	33 058

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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 *Data and statistics*, *Country overviews* and *Perspectives on drugs*, it makes up the 2014 European Drug Report package.

About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

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