European Monitoring Centre
for Drugs and Drug Addiction

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European Drug Report

Trends and Developments

2015

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Preface

We are proud to present the 20th annual analysis of Europe's drug situation in the form of the European Drug Report (EDR) 2015.

This year's report contains a comprehensive overview of Europe's drug problem and the measures being taken to tackle it. The Trends and Developments report is at the centre of the interlinked set of products comprising the EDR package. Building on European and national data, it provides top-level insights into key trends, responses and policies, together with in-depth analyses of topical issues. Brand new analyses on psychosocial interventions, drug consumption facilities, misuse of benzodiazepines and heroin trafficking routes are included in the package.

The integrated, multimedia information package that forms the EDR today, however, sits in contrast to the EMCDDA annual report on the drug situation released in 1996. For the EMCDDA, 20 years ago, the challenge of establishing surveillance systems, harmonised among 15 EU Member States, must have seemed daunting. It is, therefore, an impressive achievement that the fledgling monitoring mechanisms established in 1995 have now matured into a European system encompassing 30 countries, which is globally recognised.

While we believe the EMCDDA has made a valuable contribution to the progress that has been achieved, we also acknowledge that our work is dependent on close collaboration with our partners. Fundamentally, it is the investment made by Member States in developing robust national drug information systems that makes the European analysis provided here possible.

This report is based on data collected by the Reitox network of national focal points, working closely with national experts. The analysis also benefits from ongoing collaboration with our European partners: the European Commission, Europol, the European Medicines Agency and the European Centre for Disease Prevention and Control. We also wish to acknowledge the contribution of numerous European research groups and initiatives, without whose work our report would be far less rich.

Not only has our report changed beyond recognition in the last 20 years. So too has the extent and nature of the European drug problem. When the agency was established, Europe was in the middle of a heroin epidemic, and the need to reduce HIV transmission and AIDS-related deaths were main drivers of drug policy. Today, both heroin use and HIV problems remain central to our reporting — but they sit in a context that is more optimistic in terms of developments and more informed in terms of what constitutes effective public health responses. The complexity of the problem, however, is now far greater. This is reflected by the fact that many of the substances featured in this report were virtually unknown in Europe when the agency was established.

Today, the European drug markets continue to change and evolve rapidly. This is illustrated by the fact that, in 2014, over a hundred new psychoactive substances were detected, and risk assessments were conducted on six new drugs — both of these numbers are record highs. To keep pace with these changes, and to ensure that the analysis we provide is informed by new developments, the EMCDDA continues to work closely with researchers and practitioners. As an agency, we have always recognised the importance of delivering sound and policy-relevant information in a timely fashion. We remain committed to this goal, and to ensuring that whatever the nature of the drug problem we face, Europe's responses will be supported by an information system that remains viable, relevant and fit for purpose.

João Goulão
Chairman, EMCDDA Management Board

Wolfgang Götz
Director, EMCDDA

Introductory note and acknowledgements

This report is based on information provided to the EMCDDA by the EU Member States, the candidate country Turkey, and Norway, in the form of a national report.

The purpose of the current report is to prove an overview and summary of the European drug situation and responses to it. The statistical data reported here relate to 2013 (or the most recent year available). Analysis of trends is based only on those countries providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Although considerable improvements can be noted, both nationally and in respect to what is possible to achieve in a European-level analysis, the methodological difficulties in this area must be acknowledged. Caution is therefore required in interpretation, in particular when countries are compared on any single measure. Caveats and qualifications relating to the data are to be found in the online version of this report and in the Statistical Bulletin, where detailed information on methodology, qualifications on analysis and comments on the limitations in the information set available can be found. Information is also available there on the methods and data used for European-level estimates, where interpolation may be used.

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, Nigel Hawtin 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

The importance of global factors on drug supply and policy discussions are evident in this year's analysis

Drug market dynamics in Europe: global influences and local differences

The main findings of the EMCDDA's latest analysis of the drug problem in Europe point to a situation where long-term patterns and trends continue, but new developments in patterns of use and responses are emerging. The importance of global factors on drug supply and policy discussions are evident in this year's analysis, while local patterns of use and responses to problems are both at the forefront of new trends. The boundary between the market categories of 'old' and new drugs is becoming harder to define, and just as new drugs increasingly mimic established substance types, so responses to new drugs may mirror evidence-based responses to problems with established drugs.

Cannabis in the spotlight

While initiatives being undertaken in the Americas on the regulated sale of cannabis and cannabis products are generating international interest and debate, in Europe, discussion on cannabis remains largely focused on the potential health costs associated with this drug. New data highlight the major role played by cannabis in drug-related crime statistics, with the drug accounting for 80 % of seizures and cannabis use or possession for personal use accounting for over 60 % of all reported drug law offences in Europe (see figure). In addition, the production and trafficking of this drug is recognised as an area of growing importance for law enforcement efforts due to the increased involvement of organised crime. Considerable diversity exists, however, between countries in sentencing practices for cannabis-related supply offences, with national experts indicating that penalties for a first-time offence of supplying one kilogram of cannabis may range from less than 1 year to 10 years in prison.

New data also show the growing importance of cannabis within drug treatment systems in Europe, with an increase in the number of treatment demands for cannabis-related problems. This increase needs to be understood in the context of service provision and referral practice. For example, in some countries, directive referrals from the criminal justice system account for a high proportion of treatment entrants. The data are also influenced by differing national definitions and practices in respect to what constitutes treatment for cannabis-related disorders, which can range from a brief intervention session delivered online to admission to residential care. The availability of

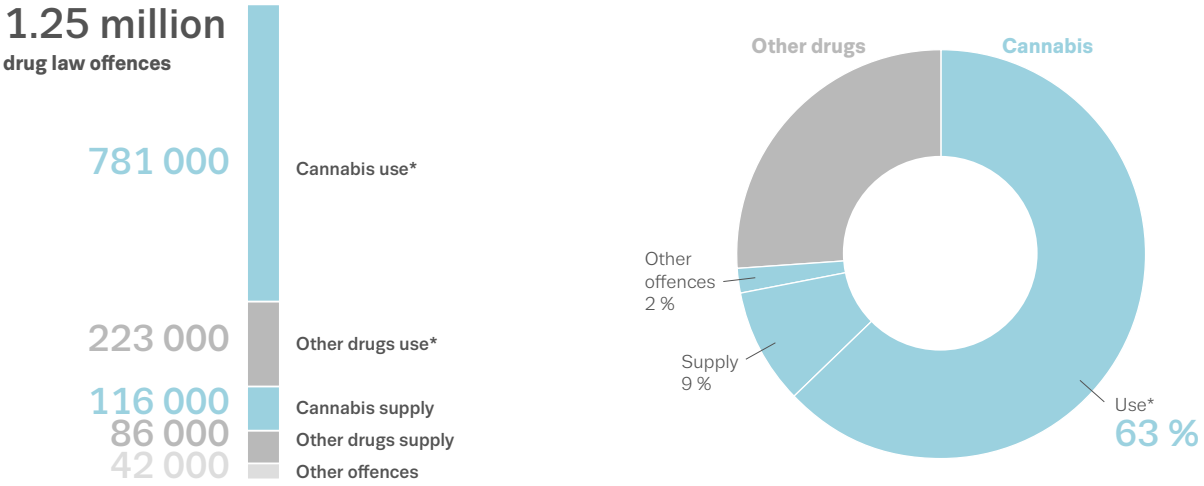
treatment for cannabis users appears also to be changing, probably in response to both a greater awareness of the need for services and, in some countries, treatment capacity becoming available due to a decline in demand for services for other types of drug use. Irrespective of treatment type, for cannabis-related problems, the evidence supports psychosocial interventions — these approaches are explored in an analysis accompanying this report. In addition, evidence is emerging from studies in accident and emergency settings of increasing cases of acute health problems associated with high-potency cannabis products. Against a background of the greater availability of high-potency cannabis products, improvements are clearly now required in the monitoring of acute problems associated with the use of this drug.

Is market competition leading to higher strength products?

This year's round of data collection found evidence of purity or potency increases in the medium or short term for all the most commonly used drugs in Europe. The reasons for this are likely to be complex, but appear to include both technical innovation and market competition. In the case of cannabis, where domestically produced, high-potency herbal products have taken an increasing market share in recent years, the data now point to an increase in the potency of imported resin, which is likely to be associated with changes in production practices. Innovation in the market and increased purity are also evident in the case of MDMA. After a period in which tablets sold as 'ecstasy' had a reputation among consumers for poor quality and product adulteration, which was supported by forensic evidence, high-purity MDMA powder and tablets are now more commonly available. The introduction of high-purity powder or crystal MDMA appears to be a deliberate strategy for differentiating this form of MDMA and making it more attractive to consumers. Similarly, high-dose tablets with distinctive shapes and logos are appearing, presumably with the same marketing objective. Over the last year, the EMCDDA and Europol have issued an alert warning of health risks linked to the consumption of very high purity MDMA products. In addition, alerts have also been issued about tablets sold as ecstasy, but containing PMMA, sometimes in combination with MDMA. The pharmacology of this drug makes it particularly worrying from a public health point of view.

For MDMA, and synthetic substances in general, product quality and supply is largely driven by the availability of precursor chemicals. Innovation in this area is also apparent, particularly in relation to production practices. This can be seen in respect to routes of chemical synthesis and in the high capacity of some of the production sites recently detected. It has also been suggested that, in some countries, the availability of new psychoactive substances may play a role. For example, the availability of high-quality synthetic cannabinoids and cathinones has sometimes been reported as offering direct competition to low-quality, and relatively more expensive, established drugs.

MOST DRUG LAW OFFENCES RELATE TO CANNABIS



* 'Use' includes offences for use and possession for personal use.

Changes in the European heroin market

Problems related to heroin still account for a large share of the drug-related health and social costs in Europe, although recent trends in this area have been relatively positive. Recent data continue to show declining treatment demand and heroin-related harms, but a number of market indicators raise concern. UN estimates suggest a substantial increase in opium production in Afghanistan, the country supplying most of the heroin consumed in Europe. A potential knock-on effect in availability is therefore possible, and it is worrying that estimates of the purity of heroin available in Europe are on the rise. In some countries where purity increases have been observed, overdose deaths have also increased in recent data. It is unclear if these increases are linked, but this question warrants research attention. The clandestine nature of the drug market means that any analysis of its dynamics must be made with caution. Nonetheless, evidence is emerging of innovation in the supply of heroin to markets in Europe, and potential for a resurgence of the drug exists. Signs of change in heroin supply include the detection of heroin processing laboratories in Europe — not seen before — as well as evidence of adaptation in heroin trafficking routes and in the modus operandi of criminal groups. The transit of heroin from Pakistan and Afghanistan into Europe through Africa continues to cause concern. Seizure data also point strongly to the role that Turkey plays as a geographical gateway for drugs being shipped into and out of the European Union, and heroin seizures in that country have partially recovered from a low point recorded in 2011. These issues are explored in an analysis on heroin trafficking accompanying this report.

Older clients bringing new challenges to services

Any potential increases in heroin availability must be viewed in the context of the overall stagnation in demand for this drug, driven in a large part by both a decline in recruitment into heroin use and the enrolment of many of those with heroin problems into treatment services. In addition to the therapeutic benefits of treatment provision, Europe's overall high rate of treatment coverage, estimated at 50 % of cases or more, is likely to make the European Union a smaller and potentially less attractive market for those supplying this drug. Heroin dependence is a chronic condition, and earlier predictions that services would need to adapt to the needs of an ageing cohort are borne out in the analysis presented in this report. Provision of an appropriate health and social service response for this group is therefore a growing challenge for drug services. Responses are complicated by problems experienced by this cohort related to long-term use of other substances, including tobacco and alcohol. Less well documented, but explored in a new analysis accompanying this report, is misuse of benzodiazepines among high-risk drug users. The misuse of benzodiazepines in combination with opioids is associated with elevated risk of drug overdose. Formulating effective responses to reduce overdose deaths remains a key policy challenge in Europe. Developments in this area include the introduction of targeted strategies, the provision of naloxone programmes and prevention initiatives targeting high-risk groups. Some countries have a long-established practice of providing 'supervised drug consumption rooms', with the intention of engaging with hard-to-reach drug users and reducing drug-related harms, including overdose deaths. A review of services delivered in these settings accompanies this report.

Historically, a main driver for drug policy and responses in respect to heroin, particularly injecting use, was the need to reduce HIV risk behaviour and transmission. Recent outbreaks and the situation in a few European countries underline the need for continued vigilance and ensuring that service provision levels are adequate. Nonetheless, the long-term picture shows clear improvement overall and illustrates the impact that provision of appropriate services can have. This message is relevant to efforts to address the relatively high rates of hepatitis C infection still found among injecting drug users. Here, new and effective treatments are becoming available, although treatment costs are high. The EMCDDA notes, however, that in some countries, and with support at European level, efforts are being made to improve the situation.

Combination of sexual and drug risk-taking behaviour: a growing area of concern

Situational analyses provided here often focus on comparing differences between countries. It is important to remember, however, that some drug-taking behaviour is linked to socio-cultural factors that are not necessarily country-specific. An example of this can be seen in some large European cities, where concerns exist about the spread of stimulant injection among small groups of men who have sex with men. Practices involving the so-called slamming of methamphetamine, cathinones and other substances in the context of 'chem-sex' parties have implications for both HIV transmission and sexual health services and highlight a need for joined-up responses in this area. This phenomenon runs contrary to the overall European trend in injecting drug use, which is declining in most populations, and underlines a general need to increase the attention given to the link between drugs and sexual risk-taking behaviour.

The Internet and apps: emerging virtual drug markets

Reflecting developments elsewhere, there is a growing trend for both drug and sexual health services to utilise the Internet and apps as platforms for delivering services. Information provision on drugs, prevention programmes and outreach services are, in varying degrees, relocating from physical spaces to virtual environments. Following suit, many drug treatment programmes are now established online, increasing their accessibility to both new and existing target groups.

Awareness is also growing of the potential role of the Internet in drug supply and marketing. Both new psychoactive substances and established drugs are being offered for sale on the surface and deep web, although the extent to which this occurs is unknown. Bearing in mind that in most other fields of commerce, consumer activity is moving from physical to online marketplaces, online drug markets may become an important area for focusing our monitoring activity in the future. This is also likely to be a challenging area for drug control policies, as developments can occur rapidly, such as the introduction of new marketplaces and cryptocurrencies. Existing regulatory models will need to be adapted to perform in a global and virtual context.

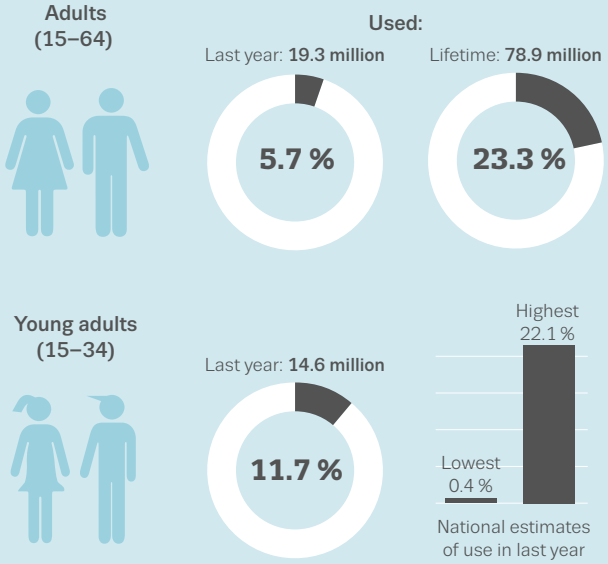
Prevalence of new psychoactive substances: the need to improve our understanding

The Internet has also been an important driver for the development of the market for new psychoactive substances, both directly, through online stores, and indirectly, by allowing producers easy access to research and pharmaceutical data, and by providing potential consumers with a forum for information exchange. Public and policy concern about the use of new psychoactive substances has grown considerably in a short time. However, our understanding of both the extent of use and the associated harms has not kept pace with developments. This is beginning to change, with more countries attempting to estimate the prevalence of use of these substances. Estimation in this area is challenging for methodological reasons; to date, national estimates have been difficult to compare. Some comparable data are available, however. While acknowledging that the recent Flash Eurobarometer on young people and drugs has methodological limitations as a prevalence estimation tool, it does provide data from all EU Member States, using a standardised questionnaire. The study results would suggest that lifetime use of new psychoactive substances remains at low levels among young people in most countries.

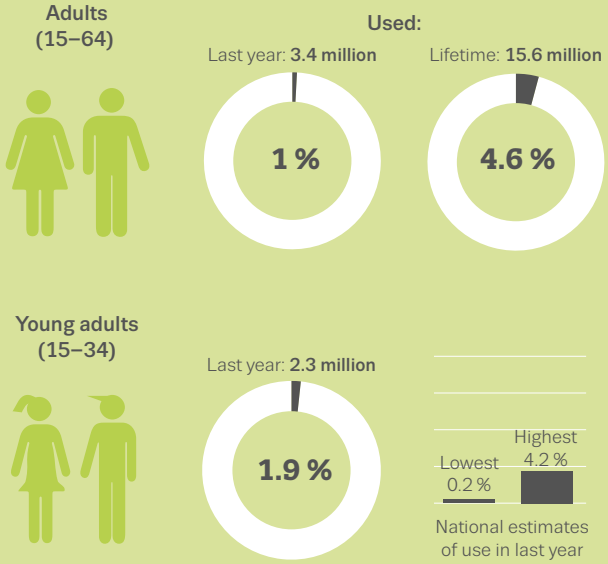
Other studies now becoming available provide windows on particular forms of new psychoactive substance use. Although these studies cannot be considered representative, they show that the use of new psychoactive substances occurs among groups as diverse as school students, party-goers, psychonauts, prisoners and injecting drug users. There is a growing understanding of motivations for use. Again, these are diverse, and include factors such as legal status, availability and cost, as well as the desire to avoid detection and user preferences for particular pharmacological properties. There is also evidence to suggest that new psychoactive substances have functioned as market substitutes at times of low availability and poor quality of established illicit drugs. For example, the popularity of mephedrone in some countries at the start of this decade has been attributed in part to the poor quality of illicit stimulants such as MDMA and cocaine. It will be interesting to see whether the increases now being observed in the potency and purity of established drugs will have implications for the consumption of new psychoactive substances.

AT A GLANCE — ESTIMATES OF DRUG USE IN THE EUROPEAN UNION

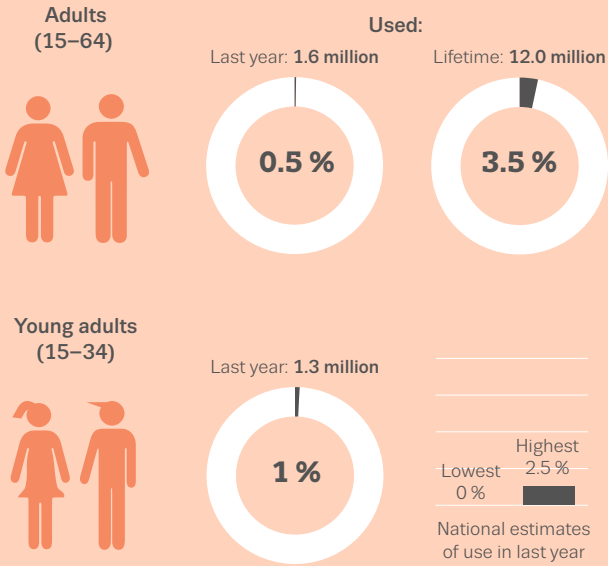
Cannabis



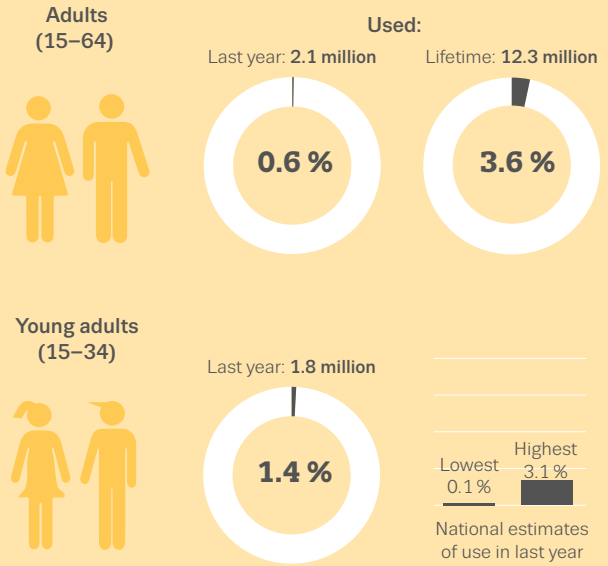
Cocaine



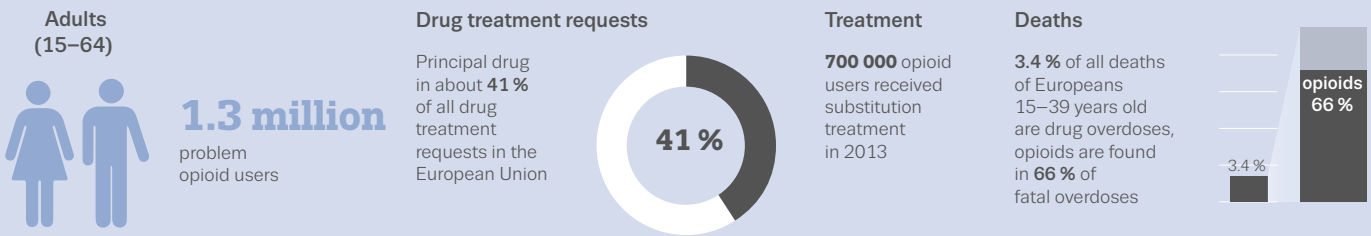
Amphetamines



Ecstasy



Opioids



NB: For the complete set of data and information on the methodology see the accompanying online Statistical Bulletin.

Number of new psychoactive substances identified on the drug market continues to increase

While the use of new psychoactive substances appears to be limited overall, the pace of emergence of new drugs has not diminished. Reports to the EU Early Warning System indicate that both the variety and the quantity of new psychoactive substances on Europe's market are still increasing. In 2014, 101 new psychoactive substances were detected for the first time, and it is interesting to note how the new drugs coming onto the market, mainly synthetic cannabinoids, stimulants, hallucinogens and opioids, mirror the established substances. Also in this report, the EMCDDA presents new data on the seizure of these substances. An important clarification here is that the method of data collection differs from that used for the regular monitoring of drug seizures, and the two datasets cannot be directly compared.

An unprecedented six risk assessments were conducted in 2014; a reminder of the importance of keeping a focus on the substances that cause particular harm. This achievement was helped by the improved availability of information on both hospital emergencies and toxicology. Despite improvements in the monitoring of acute drug-related harms, the limited capacity in this area continues to restrict our view of the public health consequences related not just to new psychoactive substances but, more generally, to contemporary drug consumption patterns.

Health and social responses to the challenges posed by new drugs have been piecemeal and slow to emerge, but are now gathering momentum. These include a wide range of efforts mirroring the full spectrum of responses to established illicit substances, from drug education and training activities, to user-led consumer protection interventions on the Internet and needle and syringe exchange programmes based in low-threshold services.

1

Europe is an important market for drugs, supported by both domestic production and drugs trafficked from other regions

Drug supply and the market

In the global context, Europe is an important market for drugs, supported by both domestic production and drugs trafficked from other regions. Latin America, West Asia and North Africa are important source areas for drugs entering Europe, and some drugs and precursors are transited through Europe en route to other continents. Europe is also a producing region for cannabis and synthetic drugs, with cannabis mostly being produced for local consumption, while some of the synthetic drugs are being manufactured for export to other parts of the world.

Monitoring drug markets, supply and laws

The analysis presented in this chapter draws on reported data on drug seizures, dismantled drug production facilities, drug law offences, retail drug prices, purity and potency. In some areas, the absence of seizure data from some countries makes the analysis of trends difficult. Full data sets and methodological notes can be found in the online Statistical Bulletin. It should be noted that trends can be influenced by a range of factors which include law enforcement activity levels and the effectiveness of interdiction measures.

Also presented here are data on seizures of new psychoactive substances reported to the EU Early Warning System by the national partners of the EMCDDA and Europol. As this information is drawn from case reports rather than routine monitoring systems, these seizure estimates represent a minimum. Data will be influenced by factors such as increasing awareness of these substances, their changing legal status and the reporting practices of law enforcement agencies. A full description of the Early Warning System can be found on the EMCDDA website under Action on new drugs.

Comprehensive data on European drug laws is available in the online European Legal Database on Drugs. The implementation of these laws is monitored through reports on drug law offences.

Sizeable markets for cannabis, heroin and amphetamines have existed in many European countries since the 1970s and 1980s. Over time, other substances also established

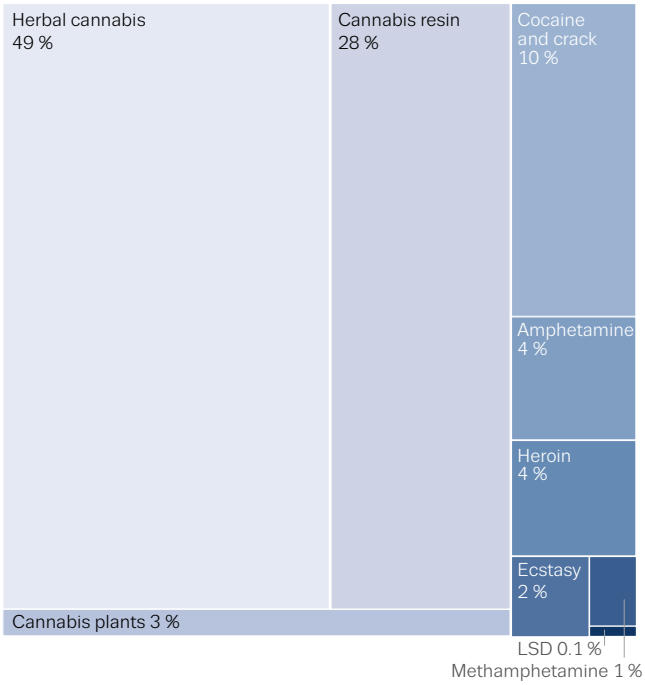
themselves — including MDMA in the 1990s and cocaine in the 2000s. The market continues to evolve, with the last decade witnessing the emergence of a wide range of new psychoactive substances. The nature of the illicit drug market has also been changing as a result of globalisation, technology and the Internet. Additional challenges are presented by innovation in drug production and trafficking methods and the establishment of new trafficking routes.

Measures aimed at preventing the supply of drugs involve many players in government and law enforcement and often depend on international cooperation. The stance that countries take is also reflected in their national drug laws. Data on arrests and seizures are the most well-documented indicators of drug-supply disruption efforts.

Cannabis is the most commonly seized drug, accounting for about eight out of ten seizures in Europe

FIGURE 1.1

Proportion of reported number of seizures for the main illicit drugs, 2013



Drug seizures in Europe: dominated by cannabis

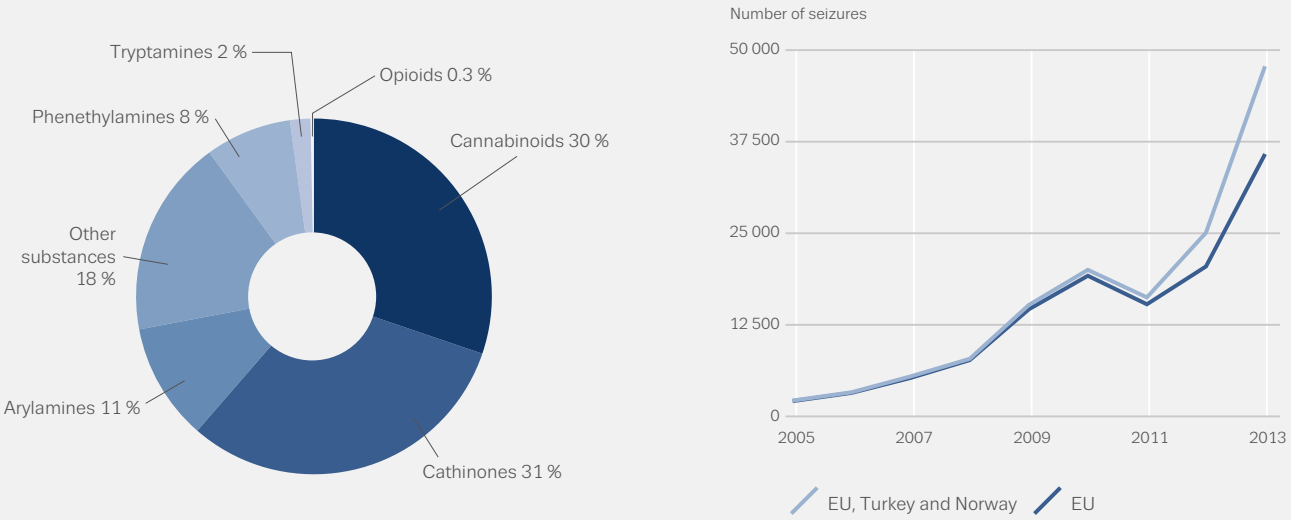
Around one million seizures of illicit drugs are reported annually in Europe. Most of these are small quantities of drugs confiscated from users, although multi-kilogram consignments seized from traffickers and producers account for a large proportion of the overall quantity of drugs seized.

Cannabis is the most commonly seized drug, accounting for about eight out of ten seizures in Europe (Figure 1.1), and reflecting its relatively high prevalence of use. Cocaine ranks second overall, with more than double the number of seizures reported for either amphetamines or heroin. The number of ecstasy seizures is relatively low.

In 2013, about two-thirds of all seizures in the European Union were reported by just two countries, Spain and the United Kingdom, although considerable numbers of seizures were also reported by Belgium, Germany, Italy and four Nordic countries. It should also be noted that recent data on the number of seizures are not available for France and the Netherlands — countries that reported large numbers of seizures in the past — and Poland. The absence of these data adds uncertainty to the analysis reported here. In addition, Turkey is an important country

FIGURE 1.2

Number of seizures of new psychoactive substances reported to the EU Early Warning System: breakdown by main substance category of seizures in 2013 (left) and trends (right)



for drug seizures, with some of the drugs intercepted there being intended for consumption in other countries, both in Europe and in the Middle East.

Data are also presented here on the growing number of seizures of new psychoactive substances reported to the EU Early Warning System. In 2013, about 35 000 seizures were reported, primarily synthetic cannabinoids and cathinones (Figure 1.2). This should be regarded as a minimum estimate due to the lack of routine reporting in this area. It should be noted that these data are not directly comparable with the data on established drugs such as cannabis.

Cannabis products: a diverse market

Two main cannabis products are found on the European drugs market: herbal cannabis (marijuana) and cannabis resin (hashish). Herbal cannabis consumed in Europe is both cultivated domestically and trafficked from external countries. Most cannabis resin is imported by sea or by air from Morocco.

The number of seizures of herbal cannabis overtook that of cannabis resin in Europe in 2009, and the gap has continued to widen (Figure 1.3). This is probably driven, to a large extent, by the growing availability of domestically produced herbal cannabis in many European countries and is mirrored in increasing seizures of cannabis plants.

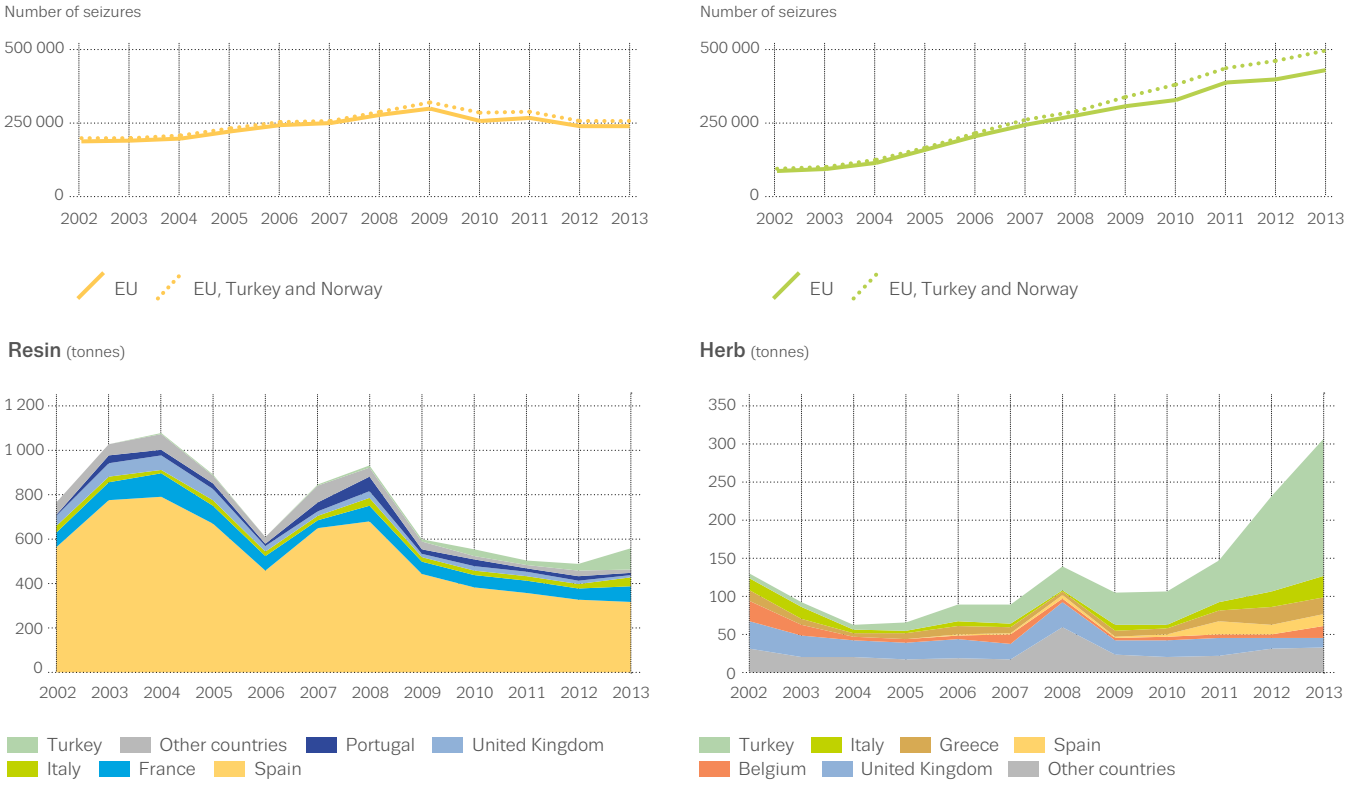
Nevertheless, the quantity of cannabis resin seized in the European Union is still much higher than that of herbal cannabis (460 tonnes versus 130 tonnes). This is, in part, explained by the fact that cannabis resin is trafficked in volume over large distances and across national borders, making it more vulnerable to interdiction.

The recent emergence of synthetic cannabinoid products has added a new dimension to the cannabis market. Over 130 different synthetic cannabinoids have been detected in recent years. Most of these substances appear to be manufactured in China. After being shipped in powder form to Europe, the chemicals are typically added to plant material and packaged for sale as ‘legal high’ products.

In 2013, 671 000 seizures of cannabis were reported in the European Union (431 000 of herbal cannabis, 240 000 of cannabis resin). There were a further 30 000 seizures of

FIGURE 1.3

Trends in number of cannabis seizures and quantity seized: resin (left) and herb (right)



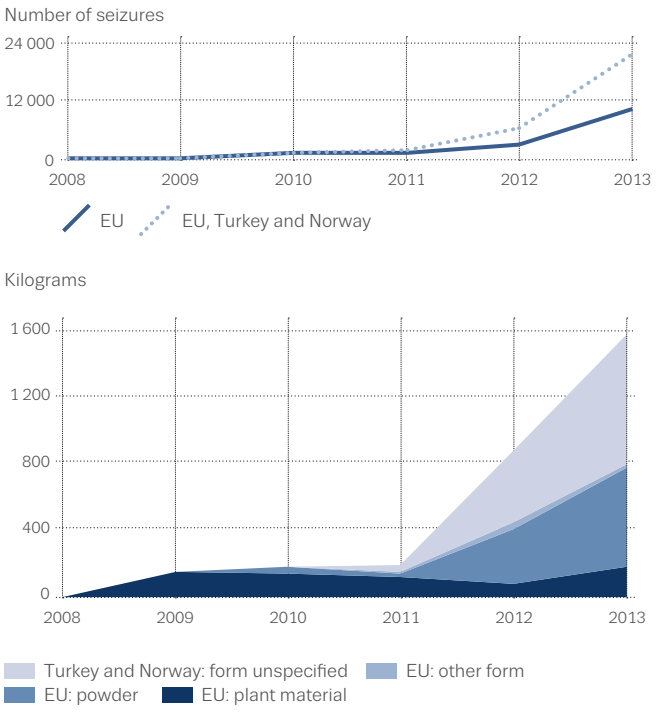
cannabis plants. In addition, over 10 000 seizures of synthetic cannabinoids were reported by EU countries to the Early Warning System in 2013, rising sharply from 2011 levels and a further 11 000 seizures were reported by Turkey (see Figure 1.4).

In the analysis of the quantity of cannabis seized, a small number of countries are disproportionately important due to their location on major cannabis trafficking routes. Spain, for example, as a major point of entry for cannabis produced in Morocco, reported more than two-thirds of the total quantity of cannabis resin seized in Europe in 2013 (Figure 1.5). In respect to herbal cannabis, recent large increases have been reported in Greece, Spain and Italy. In recent years, Turkey has been seizing larger quantities of herbal cannabis than any other European country, and the amount reported in 2013 (180 tonnes) was more than all the EU Member States combined.

Seizures of cannabis plants may be regarded as an indicator of the production of the drug within a country. Methodological problems mean that data on cannabis plant seizures must be considered with caution, nevertheless the number of plants seized increased from 1.5 million in 2002 to 3.7 million in 2013.

FIGURE 1.4

Seizures of synthetic cannabinoids reported to the EU Early Warning System: number of seizures and quantity seized



Analysis of indexed trends among those countries reporting consistently show a large increase in the potency (level of tetrahydrocannabinol, THC) of both herbal cannabis and cannabis resin between 2006 and 2013. Drivers of this increasing potency may include the introduction of intensive production techniques within Europe and, more recently, the introduction of high potency plants in Morocco.

Indexed trends for cannabis-related drug law offences in the European Union also show marked increases between 2006 and 2013.

CANNABIS

Resin

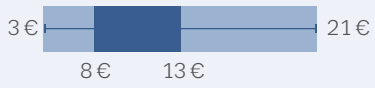
Seizures

240 000 seizures **257 000** seizures (EU + 2)

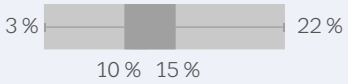
460 tonnes seized

560 tonnes seized (EU + 2)

Price (EUR/g)



Potency (% THC)



Indexed trends:
price and potency

Cannabis plants

30 000 seizures **3.7** million plants seized

Drug law offences

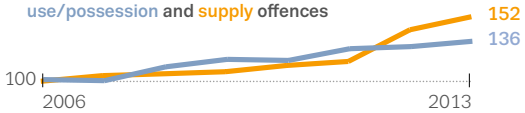
782 000 cannabis use/possession offences reported

116 000 cannabis supply offences reported

78 % of reported use/possession offences

57 % of reported supply offences

Indexed trends:
use/possession and supply offences



Herb

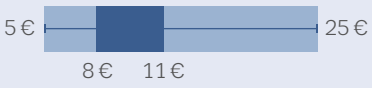
Seizures

431 000 seizures **497 000** seizures (EU + 2)

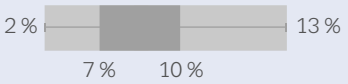
130 tonnes seized

310 tonnes seized (EU + 2)

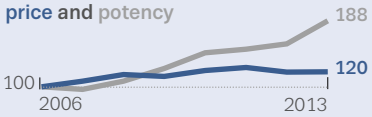
Price (EUR/g)



Potency (% THC)



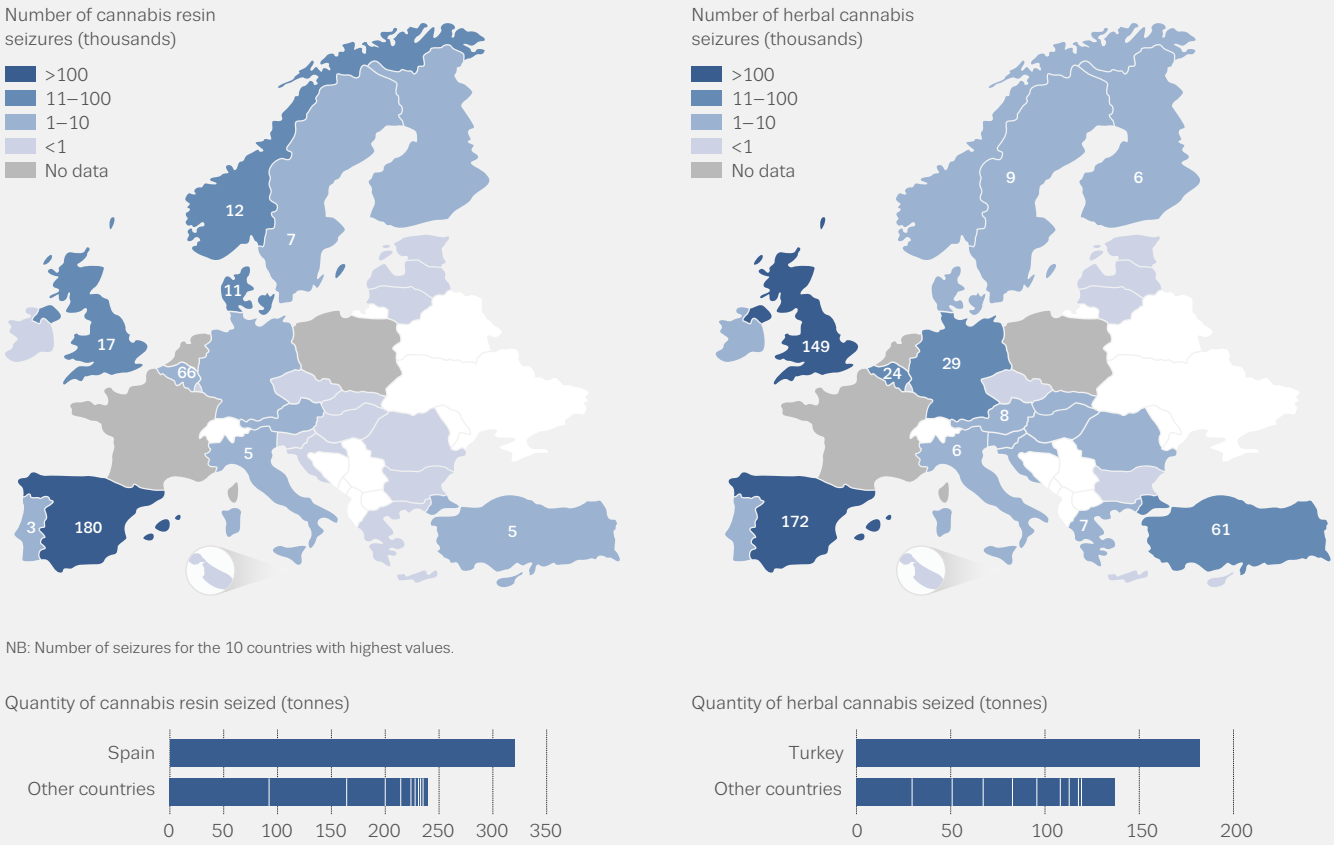
Indexed trends:
price and potency



EU + 2 refers to EU Member States, Turkey and Norway. Indexed trends for offences refer to cases involving any cannabis product.
Price and potency of cannabis products: national mean values – minimum, maximum and interquartile range. Countries covered vary by indicator.

FIGURE 1.5

Seizures of cannabis resin and herbal cannabis, 2013



Opioids: a changing market?

Heroin is the most common opioid on the European drug market. Imported heroin has historically been available in Europe in two forms: 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 also be produced in Afghanistan or in neighbouring countries. Other opioids seized by law enforcement agencies in European countries in 2013 included opium and the medicinal products morphine, methadone, buprenorphine, fentanyl and tramadol. Some medicinal opioids may have been diverted from pharmaceutical supplies, while others are manufactured specifically for the illicit market. Worryingly, 14 new synthetic opioids have been reported to the EU Early Warning System since 2005, among which are several highly potent uncontrolled fentanyls.

Afghanistan remains the world's largest illicit producer of opium, and most heroin found in Europe is thought to be manufactured there or in neighbouring Iran or Pakistan. There are signs that the final stages of heroin manufacturing may now be carried out in Europe, as indicated by the discovery of two laboratories converting morphine into heroin in Spain in 2013–14. Historically, reports of illicit opioid drugs originating in Europe have been limited to the production of homemade poppy products in parts of eastern Europe.

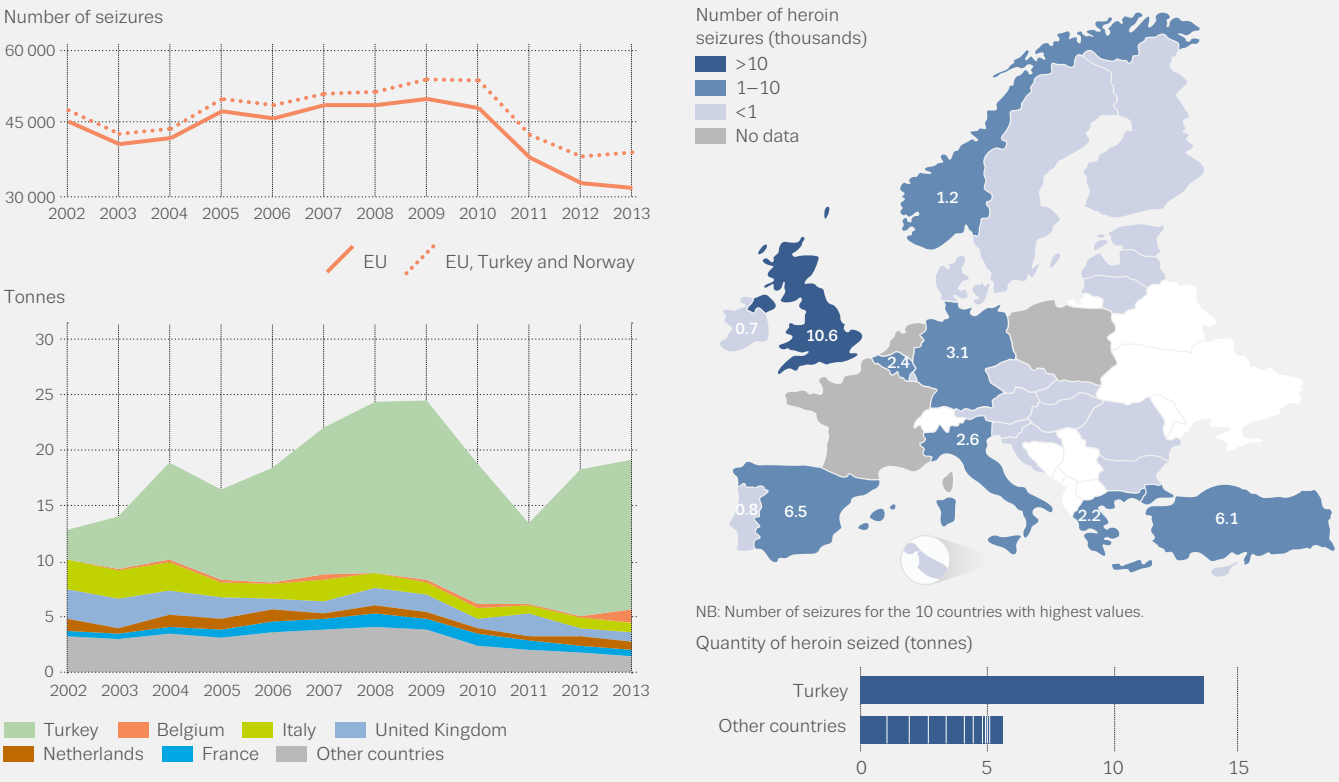
Heroin enters Europe along four trafficking routes. The two most important are the 'Balkan route' and the 'southern route'. The first of these runs through Turkey, into Balkan countries (Bulgaria, Romania or Albania) and on to central, southern and western Europe. Heroin shipments from Iran and Pakistan may also enter Europe by air or sea, either directly or transiting through west, southern and east African countries. The southern route seems to have gained importance in recent years.

Europe has seen a considerable decline in heroin seizures from 2010 onwards, following almost a decade of relative stability. Both the number of heroin seizures (32 000) and the quantity seized in 2013 (5.6 tonnes) are among the lowest levels reported in the last decade. Declining seizures in the European Union have coincided with the increasing importance of seizures in Turkey (13.5 tonnes in 2013) where, in each year since 2006, more heroin has been seized than in all EU countries combined (Figure 1.6).

Alongside recent declines in the number of heroin seizures, decreases were also observed in indexed trends for price and supply offences (see heroin infographic).

FIGURE 1.6

Number of heroin seizures and quantity seized: trends (left) and in 2013 (right)



Markets in a number of countries experienced heroin shortages in 2010/11, from which few appear to have fully recovered. Nonetheless, among those countries reporting consistently, indexed trends suggest that heroin purity increased in Europe in 2013; and some countries have expressed concern about possible increased availability. In Turkey, the number of seizures rose in 2013 and the quantity seized continued to increase from 2012 levels. In addition the United Nations reports a substantial increase in opium production in Afghanistan. Taken together, there are signals suggesting there is potential for the availability of this drug to increase.

HEROIN

Seizures

32 000
seizures

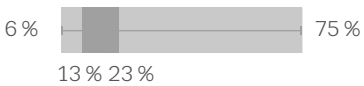
39 000
seizures (EU + 2)

5.6
tonnes seized

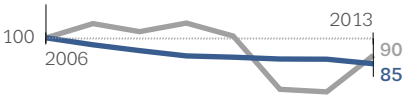
19.1
tonnes seized (EU + 2)

Price (EUR/g)

Purity (%)



Indexed trends:
price and purity



Drug law offences

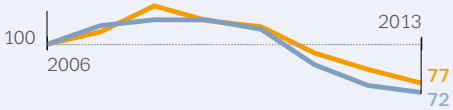
37 800
heroin use/possession offences reported

17 000
heroin supply offences reported

4 %
of reported use/possession offences

9 %
of reported supply offences

Indexed trends:
use/possession and supply offences



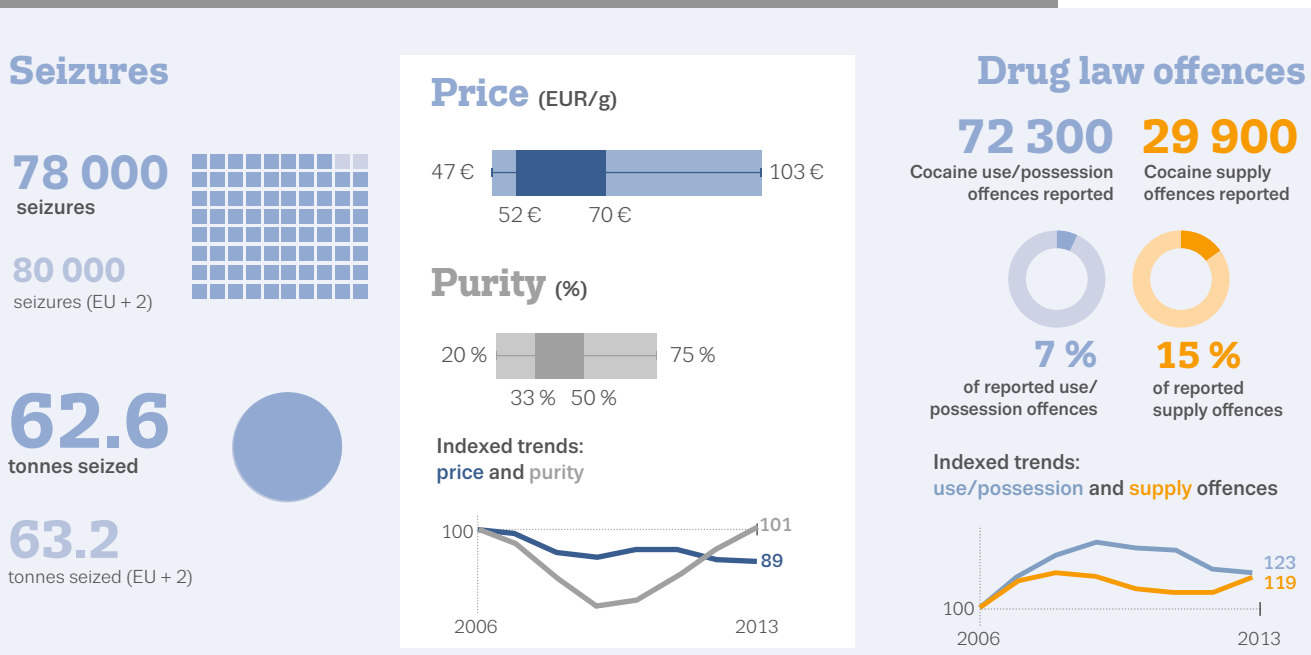
EU + 2 refers to EU Member States, Turkey and Norway. Price and purity of 'brown heroin': national mean values – minimum, maximum and interquartile range. Countries covered vary by indicator.

Cocaine: stable seizures and increased purity

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 (free base) form of the drug. Cocaine is produced from the leaves of the coca bush. The drug is produced almost exclusively in Bolivia, Colombia and Peru, and is transported to Europe by both air and sea routes. The available data indicate that trafficking of cocaine into Europe mainly takes place through western and southern countries, with Spain, Belgium, the Netherlands, France and Italy together accounting for 86 % of the 62.6 tonnes seized in 2013 (Figure 1.7).

In 2013, about 78 000 seizures of cocaine were reported in the European Union, amounting to 63 tonnes of the drug. The situation has been relatively stable since 2010, although both the number of seizures and the volume seized are at levels considerably lower than the peak values reached in 2006 and 2008 (Figure 1.7). While Spain continues to be the country seizing the most cocaine in Europe, there are signs of the ongoing diversification of trafficking routes into Europe, with seizures of the drug recently reported in ports on the eastern Mediterranean, Baltic and Black Seas. Overall, indexed trends suggest that the purity of cocaine has increased in recent years, while the price has remained relatively stable. Indexed trends for cocaine-related offences show an increase since 2006.

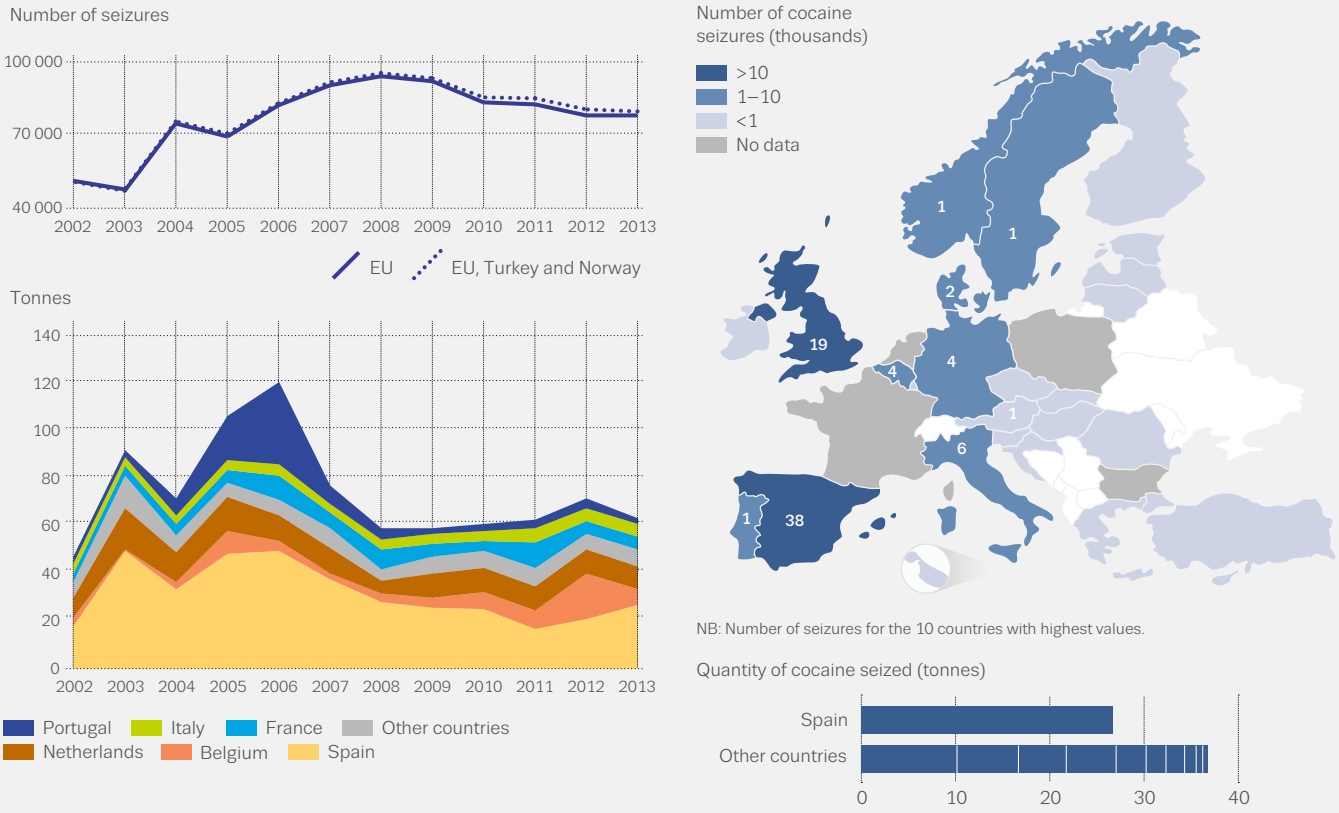
COCAINE



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

FIGURE 1.7

Number of cocaine seizures and quantity seized: trends (left) and 2013 or most recent year (right)



Amphetamines: increased amphetamine and methamphetamine seizures

Amphetamine and methamphetamine are closely related synthetic stimulants, generically known as amphetamines, and these are difficult to differentiate in some datasets. Of the two, amphetamine has always been the more common in Europe, but recent years have seen increasing reports of the availability of methamphetamine on the market.

Both drugs are manufactured in Europe for domestic use, although some amphetamine and methamphetamine is also manufactured for export, principally to the Middle East and the Far East, respectively. Europe is also a transit hub for methamphetamine being trafficked from Africa and Iran to the Far East. Data available indicate that amphetamine production mainly takes place in Belgium, the Netherlands, Poland and the Baltic States and, to a lesser extent, in Germany, while methamphetamine production is concentrated in the Baltic States and central Europe.

The production of methamphetamine in Europe appears to be changing, partly driven by the availability of precursors. Methamphetamine production using BMK (benzyl methyl ketone) as a principal precursor is centred on Lithuania; the drug is exported mainly to northern European countries, where it has impacted on the amphetamine market. This can be seen in the relatively high seizures reported in Norway. Production based on ephedrine and pseudoephedrine is centred on the Czech Republic, although some is also occurring in Slovakia and now Germany. Historically, in the Czech Republic, methamphetamine has mainly been produced in small-scale facilities by users for their own or local use. This is reflected in the high number of production sites detected in this country (261 dismantled in 2013, out of a total of 294 in Europe). Recently, however, signs of larger-scale production have emerged, with reports of Vietnamese organised crime groups producing large volumes of this drug for both domestic and external markets.

In 2013, 34 000 seizures of amphetamine were reported by EU Member States, amounting to 6.7 tonnes. More than half of the total quantity of amphetamine seized was accounted for by Germany, the Netherlands and the United Kingdom. After a period of relative stability, there was an increase in the quantity of amphetamine seized in 2013 (Figure 1.8). Methamphetamine seizures are far lower, accounting for around a sixth of all amphetamines seizures in 2013, with 7 000 seizures reported in the European Union, amounting to 0.5 tonnes (Figure 1.9). There have been increasing trends for both number and quantity of methamphetamine seized since 2002.

Typically, the average reported purity is higher for methamphetamine than for amphetamine samples. And although indexed trends, among those countries reporting consistently, suggest that amphetamine purity has increased in the latest data, the average purity of this drug continues to be relatively low.

AMPHETAMINES

Amphetamine

Seizures

34 000 seizures

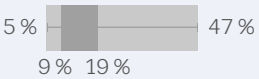
37 000 seizures (EU + 2)

6.7 tonnes seized

8.2 tonnes seized (EU + 2)

Price (EUR/g)

Purity (%)



Indexed trends:
Price and purity

Methamphetamine

Seizures

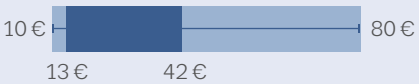
7 000 seizures

11 300 seizures (EU + 2)

0.5 tonnes seized

0.8 tonnes seized (EU + 2)

Price (EUR/g)



Purity (%)

Drug law offences

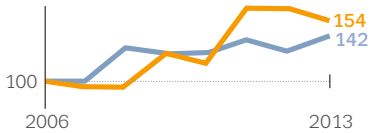
55 000 Amphetamine use/possession offences reported

1 900 Methamphetamine use/possession offences reported

5 % of reported use/possession offences

<1 % of reported use/possession offences

Indexed trends:
use/possession and supply offences



16 000 Amphetamine supply offences reported

2 700 Methamphetamine supply offences reported

8 % of reported supply offences

1 % of reported supply offences

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

FIGURE 1.8

Number of amphetamine seizures and quantity seized: trends (left) and 2013 or most recent year (right)

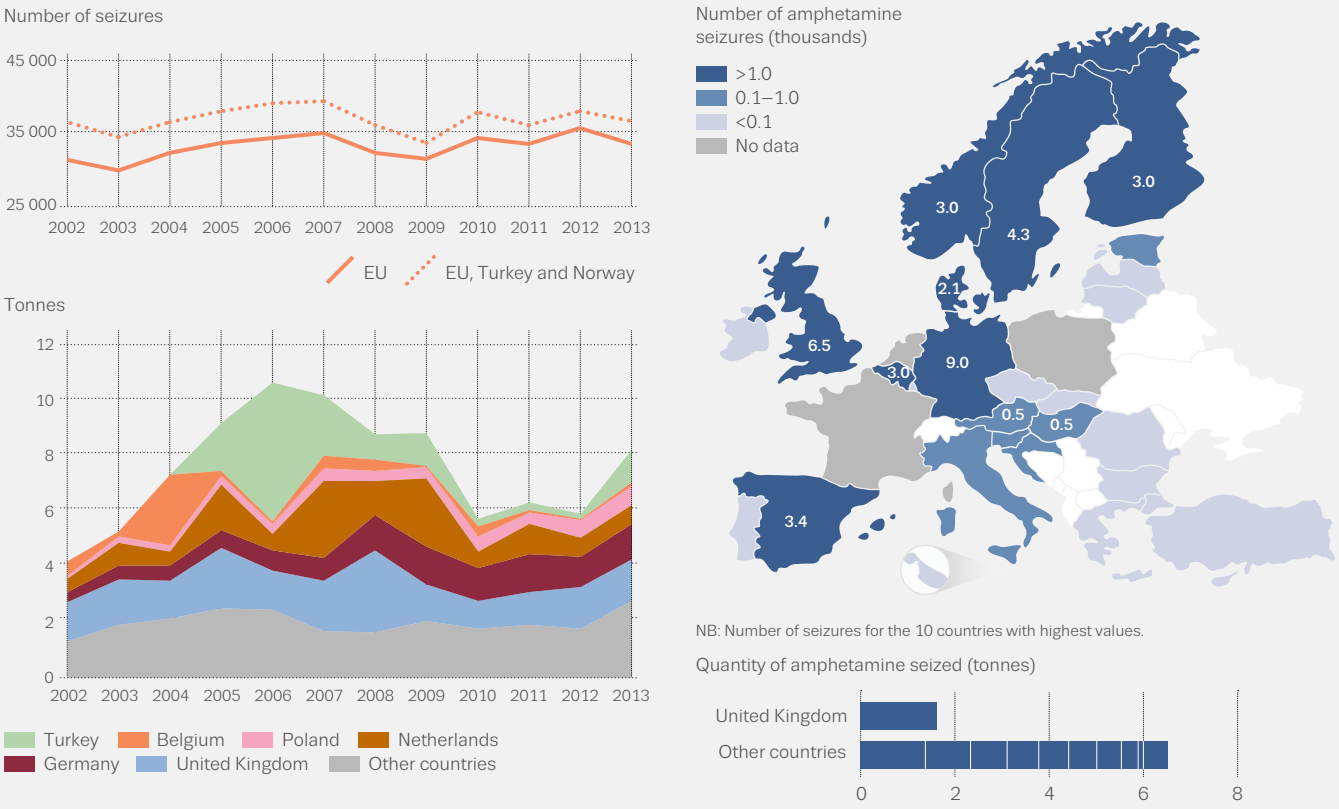
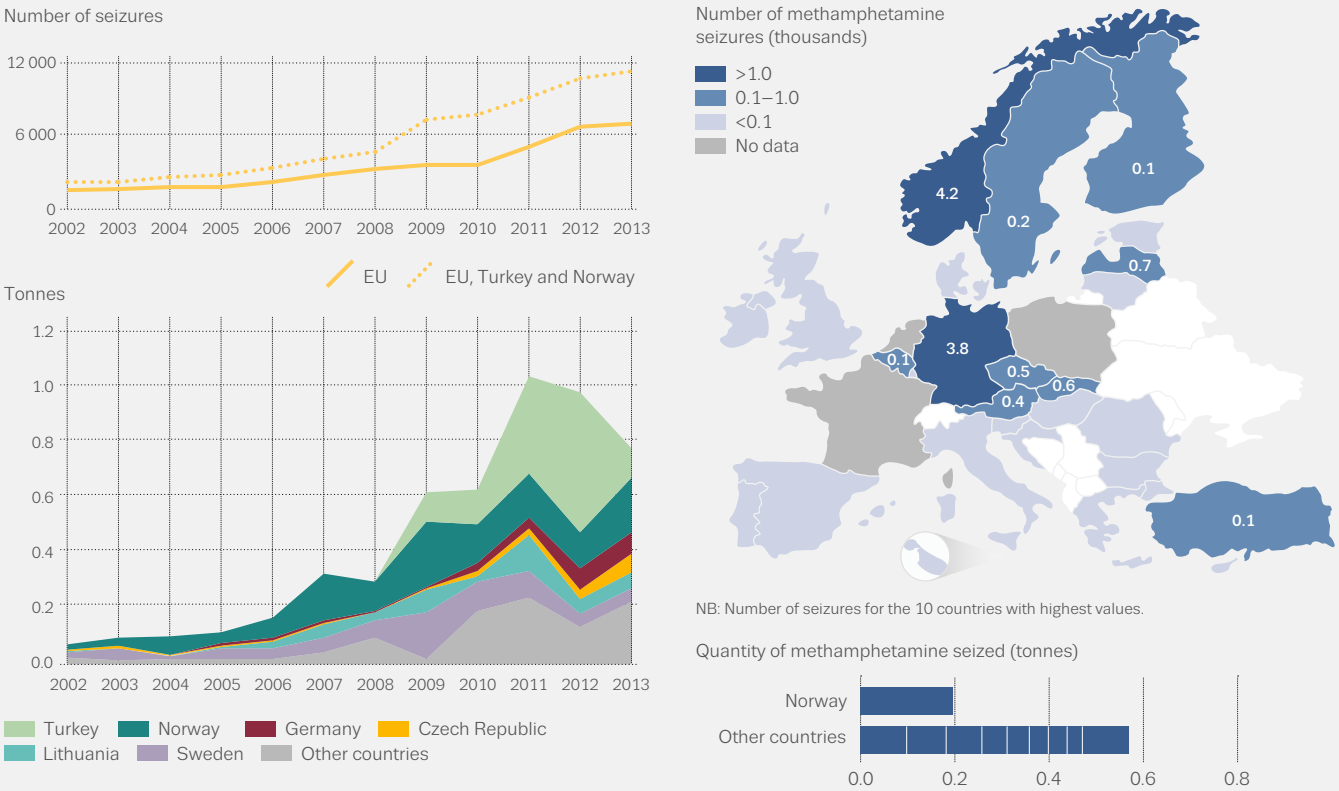


FIGURE 1.9

Number of methamphetamine seizures and quantity seized: trends (left) and 2013 or most recent year (right)



MDMA/ecstasy: increase in high-purity products

The synthetic substance MDMA (3,4-methylenedioxy-methamphetamine) is chemically related to amphetamines, but differs to some extent in its effects. Ecstasy tablets have historically been the main MDMA product on the market, although they may often contain a range of MDMA-like substances and unrelated chemicals. After a period when reports suggested that the majority of tablets sold as ecstasy in Europe contained low doses of MDMA or none at all, recent evidence indicates that this may be changing. New data suggest an increased availability both of high-content MDMA tablets and of MDMA in powder and crystal form.

Production of MDMA in Europe appears to be concentrated around the Netherlands and Belgium, the countries that have historically reported the largest numbers of production sites for the drug. After evidence of a decline in MDMA production at the end of the last decade, there have been signs of a resurgence, illustrated by reports of large-scale production facilities recently dismantled in Belgium and the Netherlands.

Assessing recent trends in MDMA seizures is difficult due to the absence of data from some countries that are likely to make important contributions to this total. For 2013, no data are available from the Netherlands and the number of seizures is not available from France and Poland. The Netherlands reported seizing 2.4 million MDMA tablets in 2012, and if a similar figure may be assumed for 2013, it can be estimated that 4.8 million MDMA tablets were seized in the European Union in that year. This would be roughly double the amount seized in 2009. Of note, the quantity of MDMA now seized in Turkey (4.4 million MDMA tablets) is equal to the total seized in all EU Member States (Figure 1.10). This raises questions as to whether these drugs were intended for domestic use or for export to the European Union or elsewhere.

A recent upturn is also evident in indexed trends of MDMA-related offences. Among those countries reporting consistently, indexed trends also point to increases in MDMA-content since 2010, and the availability of high MDMA-content products has prompted joint alerts from Europol and the EMCDDA in 2014. Taken together, these indicators of the MDMA market all point to recovery from a low reached about 5 years ago.

ECSTASY

Seizures

13 400
seizures

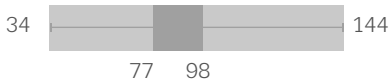
18 000
seizures (EU + 2)

4.8
million tablets seized

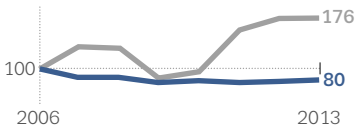
9.3
million tablets seized (EU + 2)

Price (EUR/tablet)

Purity (MDMA mg/tablet)



Indexed trends:
price and purity



Drug law offences

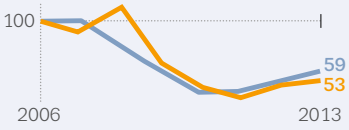
11 000
Ecstasy use/possession offences reported

3 700
Ecstasy supply offences reported

1 %
of reported use/possession offences

2 %
of reported supply offences

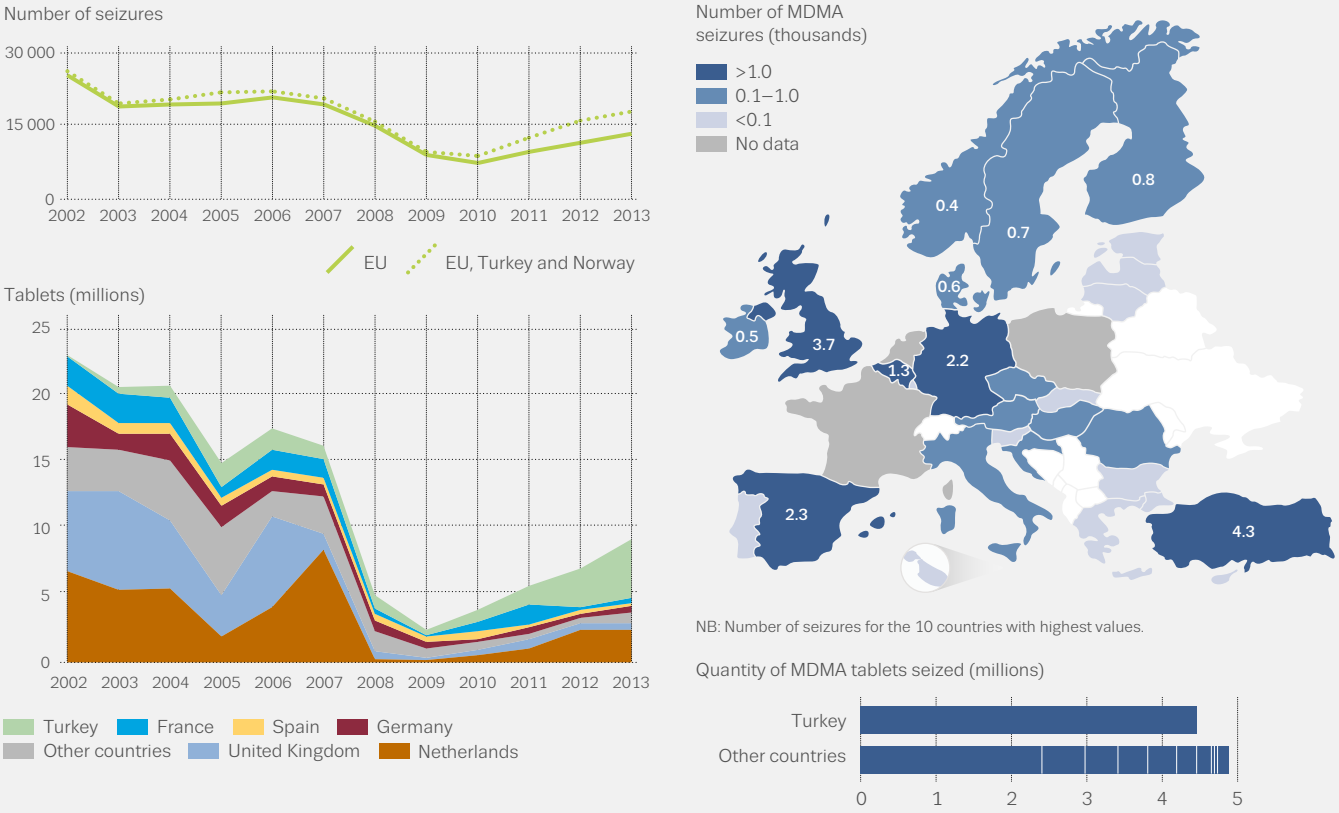
Indexed trends:
use/possession and supply offences



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

FIGURE 1.10

Numbers of MDMA seizures and tablets seized: trends (left) and 2013 or most recent year (right)



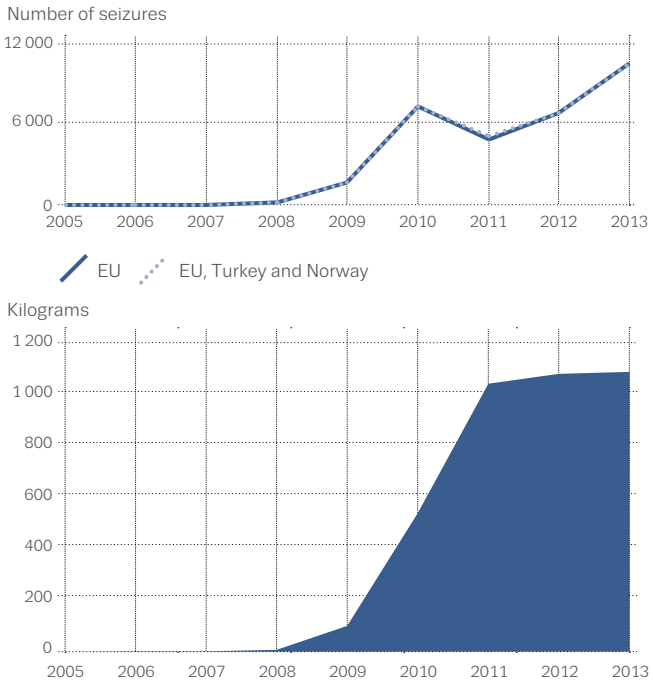
New stimulants on the illicit market

First introduced as new psychoactive substances, not controlled under drug laws, synthetic cathinones such as mephedrone, pentedrone and MDPV (3,4-methylenedioxypyrovalerone) have become a fixture on the illicit drug market in some European countries. Cathinones are used in similar ways to, and often interchangeably with, other stimulants such as amphetamine and MDMA. Most often they are available as powders or tablets. Production of cathinones appears to take place primarily in China and India. The drugs are then imported into Europe, where they are packaged and marketed as 'legal highs' or sold in the illicit market. The Early Warning System has identified more than 70 new cathinones in Europe. In 2013, over 10 000 seizures of synthetic cathinones were reported to the Early Warning System (Figure 1.11).

Cathinones are used in similar ways to, and often interchangeably with, other stimulants such as amphetamine and MDMA

FIGURE 1.11

Seizures of synthetic cathinones reported to the EU Early Warning System: number of seizures and quantity seized



substances most commonly seized, reflecting the relatively high demand of cannabis and stimulants on the illicit drug market.

In addition to the increasing number of seizures of new drugs reported each year in Europe, the number of new substances detected continues to grow. In 2014, Member States notified the EU Early Warning System of 101 new psychoactive substances not previously reported. This represented an increase of 25 % compared with 2013 (Figure 1.12). Thirty-one of these substances are synthetic cathinones, making this the largest category of new drugs identified in Europe in 2014, followed by 30 synthetic cannabinoids. However, another 13 compounds do not fit easily into any of the substance groups that are monitored. Four of the new psychoactive substances notified in 2014 are used as active substances in medicines. The EU Early Warning System is currently monitoring more than 450 new psychoactive substances.

New psychoactive substances: a marketplace of increasing diversity

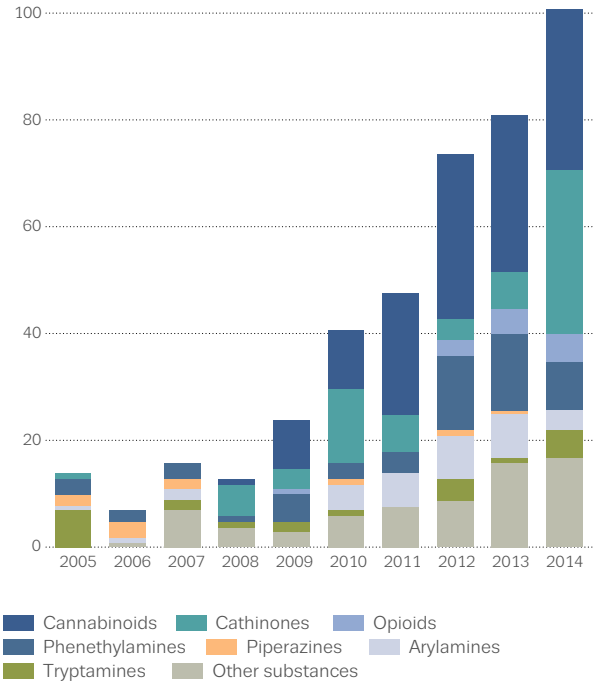
The availability of new psychoactive substances on Europe's drug market has rapidly increased over the last decade, as evidenced by growing numbers of seizures reported to both the Early Warning System and through standard monitoring mechanisms. These new drugs include substances, synthetic and naturally occurring, that are not controlled under international law, and are often produced with the intention of mimicking the effects of controlled substances. Typically, chemicals are imported from suppliers outside Europe, and then prepared, packaged and marketed in Europe. Increasingly, however, new drugs are produced in Europe in clandestine laboratories and sold directly on the market.

To avoid controls, products are often mislabelled, for example as 'research chemicals', with disclaimers that state the product is not intended for human consumption. These substances are marketed through online retailers and specialised shops, and increasingly they are offered through the same channels used for the supply of illicit substances. This market, as well as its relationship to the illicit market, is a dynamic one, characterised by the continual introduction of new products and control measures. Synthetic cannabinoids and synthetic cathinones are the groups of new psychoactive

In 2014, Member States notified the EU Early Warning System of 101 new psychoactive substances not previously reported

FIGURE 1.12

Number and categories of new psychoactive substances notified to the EU Early Warning System



New substances risk-assessed in Europe in 2014

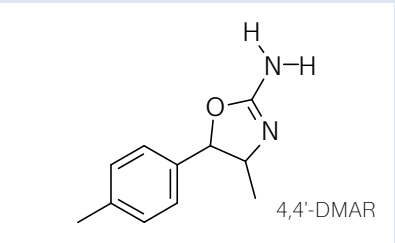
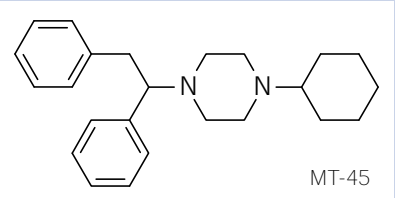
An EU mechanism exists for the identification, assessment and possible control of new psychoactive substances in Europe. In 2014, six new psychoactive substances were risk-assessed (see Table 1.1). These new drugs emerged in Europe in the past few years and have been linked to growing numbers of reports of harm, including hospitalisations and deaths. As of February 2015, four of the six substances have since been subjected to control measures throughout Europe.

In 2014, six new psychoactive substances were risk-assessed

TABLE 1.1

New psychoactive substances risk-assessed in 2014

In September 2014, European-level risk assessments were conducted on 4,4'-DMAR and MT-45. These add to the four risk assessments conducted in April 2014 on 25I-NBOMe (a substituted phenethylamine with hallucinogenic effects, sold as a 'legal' alternative to LSD), AH-7921 (a synthetic opioid), MDPV (a synthetic cathinone derivative) and methoxetamine (an arylcyclohexylamine closely related to ketamine, marketed as its 'legal' alternative).

 4,4'-DMAR	4,4'-DMAR is a psycho-stimulant which has been available on the EU drug market since at least December 2012 and detected in nine Member States. In about 20 % of detections 4,4'-DMAR was found in combination with other drugs (predominantly stimulants). It has been detected in 31 deaths in Hungary, Poland and the United Kingdom, over a 12-month period.
 MT-45	MT-45 is a synthetic opioid, with analgesic potency similar to morphine, first detected in October 2013. It has been detected in 28 deaths, and 12 non-fatal intoxications in Sweden, over a nine-month period. In 19 of the deaths, MT-45 was either reported as the cause of death or contributing to death.

Legal responses to evolving drug markets

The rapid emergence of new psychoactive substances and the diversity of available products has proved challenging for Europe's policymakers. At EU level, a surveillance system linked with a legal mechanism for control has existed since 1997 — the EU Early Warning System. This was strengthened in 2005. The current system has been reviewed and a proposal for a new legal framework is under discussion.

At national level, a range of measures have been used to control new substances, and three broad types of legal response can be identified. In some countries, existing laws that cover issues unrelated to controlled drugs, such as consumer safety legislation, have been used; in others existing drug laws or processes have been extended or adapted; and in some countries new legislation has been designed. While there is wide variation in the definitions of the offences and the penalties, responses tend to focus on supply rather than possession of these substances.

The Internet: a marketplace for both new and established drugs

It has been recognised for some time that the Internet is an important marketplace for the sale of new psychoactive substances to Europeans. In 2013, an EMCDDA snapshot identified 651 websites selling 'legal highs' to Europeans, and targeted Internet snapshots carried out in 2014 identified websites offering specific drugs such as the synthetic opioid MT-45 for sale, sometimes in kilogram quantities.

The Internet and social media have also become increasingly important in the market for illicit drugs. Evidence is emerging of so-called grey marketplaces — online sites selling new psychoactive substances which operate on both the surface and the deep web. The deep web is part of the Internet that is not accessible using standard search engines. There, drug sales can take place within marketplaces, within decentralised networks and between individuals. Most attention has been received by drug cryptomarkets such as Silk Road, Evolution and Agora. These online markets are only accessible through the use of encryption software, which offers a high level of anonymity. Cryptomarkets, in common with online marketplaces such as eBay, provide sellers and buyers with an infrastructure to conduct transactions and services, such as seller and buyer ratings and hosting of discussion forums. Cryptocurrencies, like Bitcoin, are used to facilitate anonymous transactions, and stealth packaging is used to facilitate transportation of small quantities of drugs through established commercial channels. Among the various products advertised on cryptomarkets, established illicit drugs and prescribed medicines are reported to be the most commonly available. Evidence suggests that many illicit drug purchases made on the deep web are intended for resale.

Another development relates to drug supply and the sharing of drugs or drug experiences via social media, including mobile apps. This area remains both poorly understood and difficult to monitor. Together, the growth of online and virtual drug markets poses major challenges to law enforcement and drug control policies. The fact that manufacturers, suppliers, retailers, website-hosting and payment processing services may all be based in different countries makes online drug markets particularly difficult to control.

The Internet is an important marketplace for the sale of new psychoactive substances to Europeans

Responding to drug supply: common principles but differences in practice

Member States take measures to prevent the supply of illicit drugs under three United Nations Conventions, which provide an international framework for control of production, trade and possession of over 240 psychoactive substances. Each country is obliged 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.

The implementation of laws to curb drug supply and use is monitored through data on reported drug law offences. Overall, the number of reported offences related to drug supply in Europe has been increasing since 2006. An estimated 230 000 supply offences were reported in 2013, most of which (57 %) related to cannabis. In the same year, of the estimated 1.1 million reported offences for drug use or possession for use, three-quarters (76 %) related to cannabis.

Overall, the number of reported offences related to drug supply in Europe has been increasing since 2006

Wide variation in sentencing practice in Europe

Unauthorised drug supply is a crime in all European countries, but the penalties written in the law vary between states. In some countries, supply offences may be subject to a single wide penalty range (up to life in prison). Other countries differentiate between minor and major supply offences, determined by factors such as the quantity or type of drugs found, with corresponding maximum and minimum penalties. A recent EMCDDA case-scenario analysis found no clear relationship between the maximum penalties provided by the law and the sentences handed out by the courts. It also found that the penalties expected for drug trafficking offences varied between countries. For example, a first-time offender trafficking 1 kg of cannabis may expect a prison sentence varying from less than 1 year in some countries to 10 years in others. Similarly, depending on the country, trafficking 1 kg of heroin could result in a penalty varying between 2 and 15 years.

Seizures and control of precursor chemicals

Drug precursors are chemicals that can be used in the manufacture of illicit drugs, and preventing their diversion from legitimate use is an important element in international efforts against illicit drug production. Most drug precursors have legitimate industrial uses, such as the production of plastics, medicinal products and cosmetics. For example, ephedrine — an ingredient in cold and decongestant medicines — may be used to produce methamphetamine. Due to their legitimate uses, production of and trade in precursor chemicals cannot be prohibited. Instead, drug precursors are controlled by monitoring their licit production and trade.

Data from EU Member States on seizures and stopped shipments of drug precursors confirm the continued use of both scheduled and non-scheduled substances for the production of illicit drugs in the European Union (Table 1.2). In 2013, more than 48 000 kg of the pre-precursor APAAN (alpha-phenylacetoacetonitrile) was seized under national legislation, an amount sufficient to produce over 22 tonnes of amphetamine or methamphetamine. To increase the powers of law enforcement agencies to act on this substance, APAAN was scheduled as a precursor chemical under EU legislation in December 2013, and it was scheduled internationally in October 2014. Major seizures of precursors for MDMA confirm the return of large-scale ecstasy production to the European Union. In 2013, 5 061 kg of PMK (3,4-methylenedioxyphenyl-2-propanone) and 13 837 litres of safrole were seized, which together would be capable of producing about 170 million ecstasy tablets.

New EU legislation was introduced in 2013 to strengthen controls over the trade in some drug precursors, both within the European Union and between Member States and third countries. Among the measures introduced are stricter controls on trade in acetic anhydride, a chemical needed to produce heroin, and in ephedrine and pseudoephedrine, precursors of methamphetamine. The new legislation also introduced a mechanism for rapid response to the diversion of non-scheduled substances.

TABLE 1.2

Summary of seizures and stopped shipments of precursors used for selected synthetic drugs produced in Europe, 2013

	Seizures		Stopped shipments ([1])		TOTALS	
Precursor/*pre-precursor*	**Cases**	**Quantity**	**Cases**	**Quantity**	**Cases**	**Quantity**
MDMA or related substances						
PMK (litres)	12	5 061	0	0	**12**	**5061**
Safrole (litres)	4	13 837	1	574	**5**	**14 411**
Iso safrole (litres)	1	10	0	0	**1**	**10**
Piperonal (kg)	5	5	5	1 400	**10**	**1 404**
PMK glycidid/glycidate (kg)	5	2 077	0	0	**5**	**2 077**
Amphetamine and methamphetamine						
BMK (litres)	5	32	0	0	**5**	**32**
PAA, phenylacetic acid (kg)	1	97	6	225	**7**	**322**
Ephedrine, bulk (kg)	15	13	0	0	**15**	**13**
Pseudoephedrine, bulk (kg)	11	64	0	0	**11**	**64**
***APAAN* (kg)**	71	48 802	0	0	**71**	**48 802**

([1]) A 'stopped' shipment is one that has been denied, suspended or voluntarily withdrawn by the exporter because of suspicion of diversion for illicit purposes.
Source: European Commission.

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Report on the risk assessment of 1-(1,3-benzodioxol-5-yl)-2-(pyrrolidin-1-yl)pentan-1-one (MDPV) in the framework of the Council Decision on new psychoactive substances, Risk assessments.

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2

The prevalence of cannabis use is about five times that of other substances

Drug use and drug-related problems

In a top-level analysis of patterns and trends in drug use and their related harms, it is helpful to differentiate between three broad groups of substances: cannabis products, various stimulants and opioid drugs. The prevalence of cannabis use is about five times that of other substances, and the number of users entering treatment for cannabis problems has increased in recent years. While the use of heroin and other opioids remains relatively rare, these continue to be the drugs associated with most of the morbidity, mortality and cost of treatment related to drug use in Europe.

Monitoring drug use and drug-related problems

The EMCDDA's five key epidemiological indicators are used as a basis for monitoring drug use and problems in Europe. These indicators incorporate data sets that cover estimates of recreational use (based mainly on surveys), estimates of high-risk use, drug-related deaths, infectious diseases and drug treatment entry. Taken together they provide the pillars supporting the European analysis of trends and developments in drug use and related harms. Technical information on the indicators can be found online in the Key indicators gateway and in the online Statistical Bulletin. In this chapter, data from the key indicators are complemented by additional data provided by Reitox focal points and other sources.

Drug use is also characterised by different patterns of consumption, ranging from single experimental use to habitual and dependent use. Use of all drugs is generally higher among males, and this difference is often accentuated for more intensive or regular patterns of use. Different consumption patterns are also associated with different levels and types of harm; and more frequent use, high doses, concurrent use of several substances and injection are all linked to elevated health risks.

Almost one in four Europeans have tried illicit drugs

Over 80 million adults, or almost a quarter of the adult population in the European Union, are estimated to have tried illicit drugs at some point in their lives. The most commonly used drug is cannabis (78.9 million), with lower estimates reported for the lifetime use of cocaine (15.6 million), amphetamines (12.0 million) and MDMA (12.3 million). Levels of lifetime use differ considerably between countries, ranging from around one-third of adults in Denmark, France and the United Kingdom, to 8 % or less than one in 10 in Bulgaria, Romania and Turkey.

Cannabis use: rising in Nordic countries

Cannabis is the illicit drug most likely to be used by all age groups. The drug is generally smoked and, in Europe, is commonly mixed with tobacco. Patterns of cannabis use can range from the occasional to the regular and dependent.

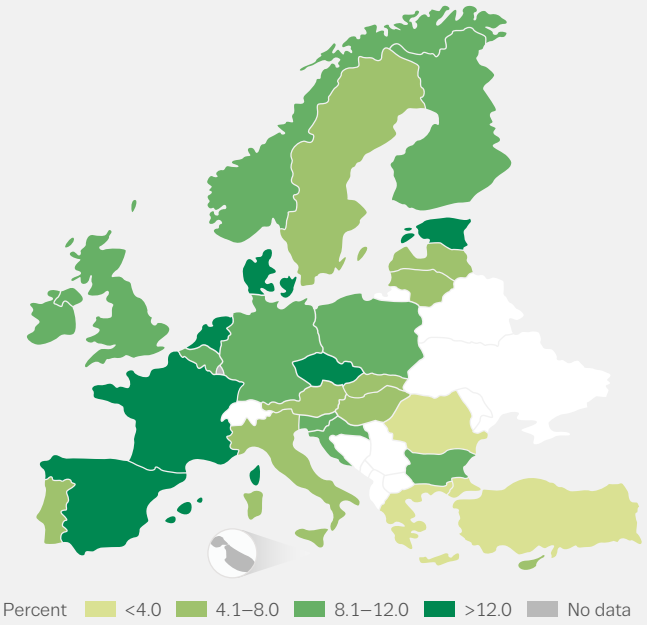
An estimated 14.6 million young Europeans (aged 15–34), or 11.7 % of this age group, used cannabis in the last year, with 8.8 million of these aged 15–24 (15.2 % of this age group).

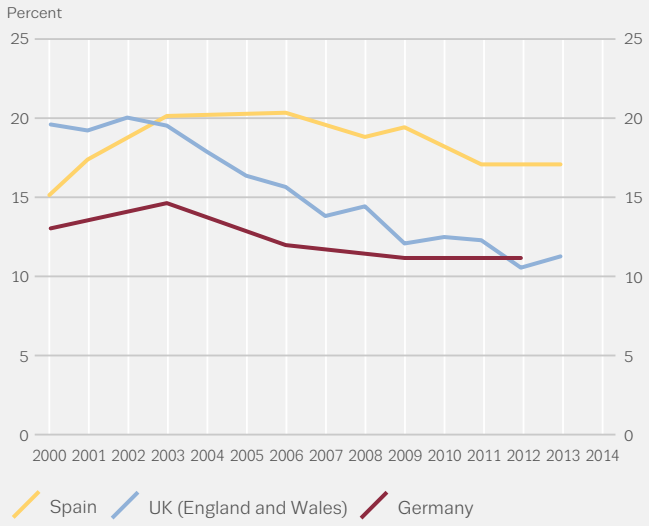
A number of countries have sufficient survey data to allow a statistical analysis of long-term time trends in last year cannabis use among young adults (15–34). Population surveys for Germany, Spain and the United Kingdom report decreasing or stable cannabis prevalence over the past decade. In contrast, increasing prevalence can be observed for Bulgaria, France and three of the Nordic countries, (Denmark, Finland, Sweden). In addition, Norway reported an increase to a new high of 12 % in its most recent survey, although the current time series is insufficient for a statistical analysis of trends.

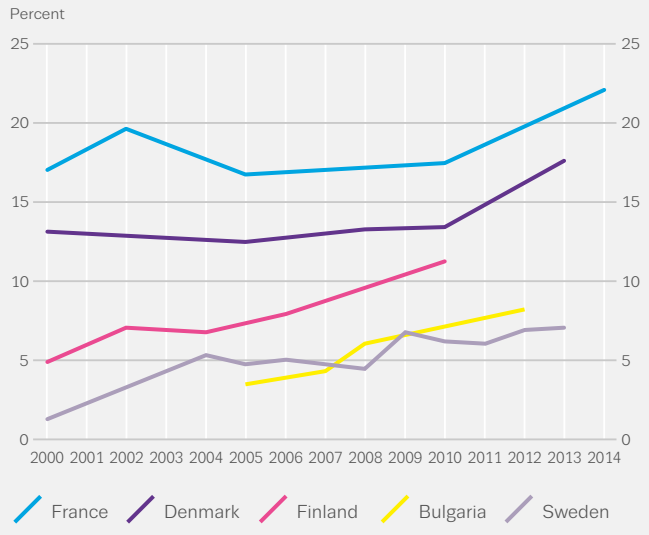
Taken as a whole, the most recent survey results continue to show divergent patterns in last year cannabis use (Figure 2.1). Of the countries that have produced surveys since 2012, four reported lower estimates, two were stable and eight reported higher estimates than in the previous comparable survey. Few national surveys currently report on the use of synthetic cannabinoids; for those that do, last year prevalence levels are generally low.

FIGURE 2.1

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







Cannabis use among school students

Monitoring substance use among students provides an important window on current youth risk behaviours. In Europe, the European School Survey Project on Alcohol and Other Drugs (ESPAD) study allows some insight into trends over time in substance use among 15- to 16-year-old school students. In the last round of data collection (2011), cannabis accounted for the majority of illicit drug use in this group, with about 24 % reporting having ever used the drug, ranging from 5 % in Norway to 42 % in the Czech Republic. The prevalence of use of illicit drugs other than cannabis was far lower.

In the seven countries that have reported national school surveys undertaken after the ESPAD study (2011), trends in prevalence of cannabis use among students show considerable variation.

Concern about cannabis users

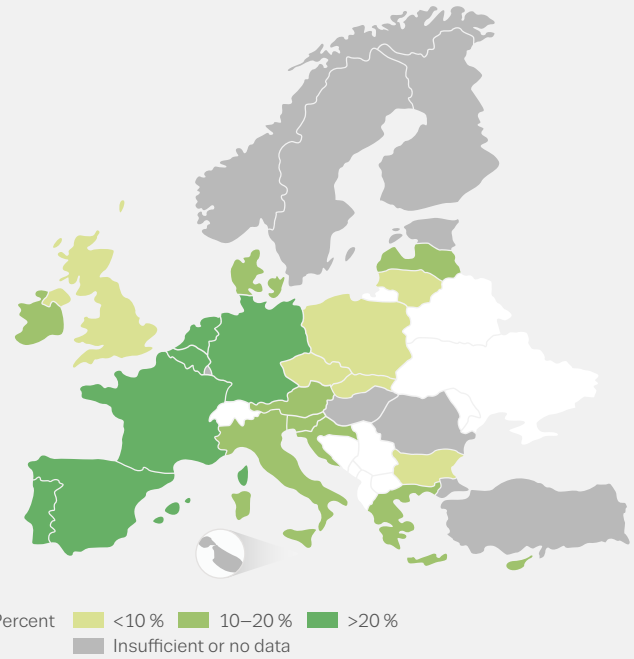
A minority of cannabis users consume the substance intensively. Daily or almost daily cannabis use is defined as use on 20 days or more in the last month. Based on surveys of the general population, it is estimated that almost 1 % of European adults are daily or almost daily cannabis users. Around three-quarters of these are aged between 15 and 34 years, and over three-quarters are male.

While daily cannabis use is rare in the general population, among the nearly 3 % of adults (15–64) who used cannabis in the last month, around one-quarter used the substance daily or almost daily. This proportion varies substantially by country (see Figure 2.2). For the countries with a sufficient number of surveys to identify trends, the proportion of daily or almost daily users among all adults has remained stable over the last decade.

Cannabis is the drug most frequently reported as the principal reason for entering drug treatment by first-time clients in Europe, although what constitutes a treatment response for cannabis users varies considerably. The overall number of reported first-time treatment entrants rose from 45 000 to 61 000 between 2006 and 2013. Taking into account repeat entrants, cannabis was the second most frequently reported drug among all entrants to treatment in 2013 (123 000, 29 %). Considerable national variation exists, however, with reports of primary cannabis use ranging from 3 % of all treatment entrants in Lithuania to over 60 % in Denmark and Hungary. Various factors may contribute to this heterogeneity. For example, around one-quarter of those entering treatment in Europe for primary cannabis use are referred by the criminal justice system (23 000); this ranges from less than 5 % of primary cannabis clients in Bulgaria, Estonia, Latvia and the Netherlands to over 80 % in Hungary.

FIGURE 2.2

Proportion of last month cannabis users (15–64) who used the substance daily or almost daily



Cannabis is the drug most frequently reported as the principal reason for entering drug treatment by first-time clients in Europe

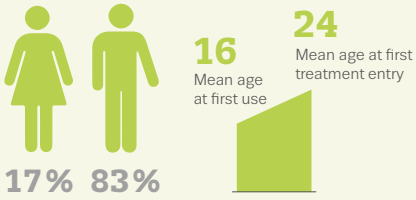
Hospital emergencies associated with cannabis

Although rare, acute emergencies can occur after consuming cannabis, especially at high doses. In countries with higher prevalence levels, cannabis accounts for a sizeable share of drug-related emergencies. A recent study identified an increase in the numbers of cannabis-related emergencies between 2008 and 2012 in 11 of the 13 European countries analysed. In Spain, for example, the number of emergencies related to cannabis increased from 1 589 (25 % of all drug-related emergencies) in 2008 to 1 980 (33 %) in 2011.

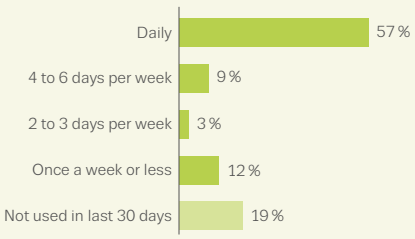
The European Drug Emergencies Network (Euro-DEN), which monitors drug-related emergency presentations in 16 sites in 10 European countries, reported that between 10 % and 48 % (16 % on average) of all drug-related presentations involved cannabis, although other substances were present in 90 % of these cases. Most commonly, cannabis was found alongside alcohol, benzodiazepines and stimulants. The most frequently reported problems were neuro-behavioural (agitation, aggression, psychosis and anxiety) and vomiting. In most cases, patients were discharged without the need for inpatient admission.

CANNABIS USERS ENTERING TREATMENT

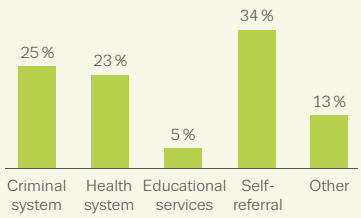
Characteristics



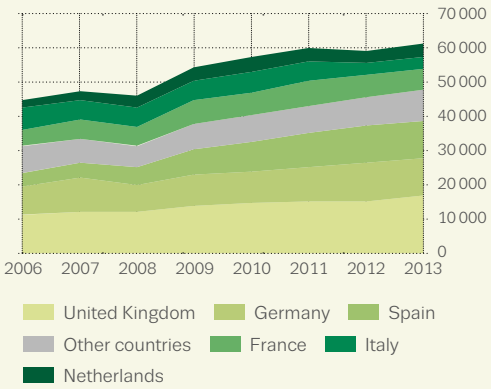
Frequency of use in the last month



Source of referral



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.
Source of referral: 'criminal system' includes courts, police and probation; 'health system' includes general practitioners, other drug treatment centres and health, medical and social services; 'self-referral' includes the client, family and friends.

Cocaine: Europe's most commonly used stimulant

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 often sniff powder cocaine in a recreational context, and marginalised users, who inject cocaine or smoke crack often alongside the use of opioids. Regular cocaine use has been associated with dependence, cardiovascular, neurological and mental health problems, and with an elevated risk of accidents. Cocaine injection and use of crack cocaine are associated with the greatest health risks, including the transmission of infectious diseases.

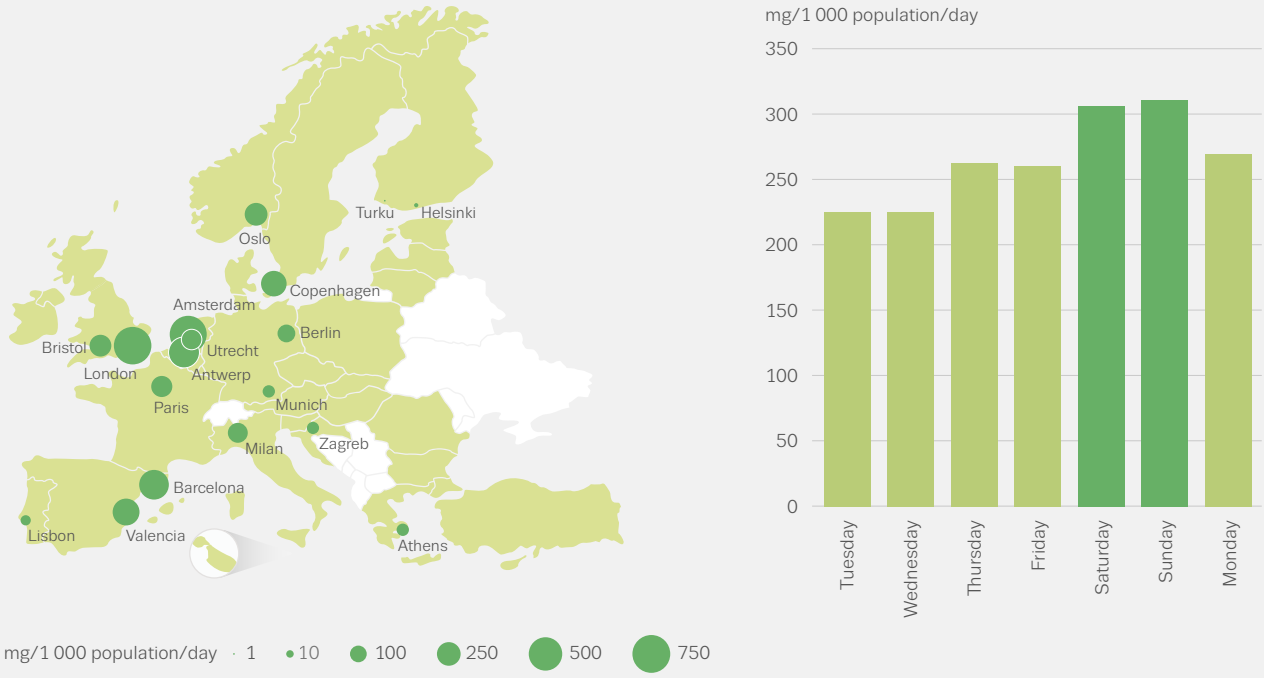
Cocaine is the most commonly used illicit stimulant drug in Europe, although most users are found in a restricted number of countries. This is illustrated by survey data which show cocaine use to be more prevalent in the south and west of Europe.

It is estimated that about 2.3 million young adults aged 15 to 34 (1.9 % of this age group) used cocaine in the last year. Many cocaine users consume the drug recreationally, with use highest during weekends and holidays. Data from wastewater analysis carried out in a 2014 European multi-city study confirm daily differences in use. Higher concentrations of benzoylecgonine — the main metabolite of cocaine — were found in samples collected during the weekend (Figure 2.3).

Only a few countries report last year prevalence of cocaine use among young adults of more than 3 % (Figure 2.4). Among these countries, Spain and the United Kingdom observed statistically significant increasing trends in prevalence until 2008, after which the trend changed to become stable or declining. Below 3 % prevalence, Ireland and Denmark report falls in the most recent data, but as yet this is not statistically discernible, while French surveys up until 2014 show an increasing trend in use.

FIGURE 2.3

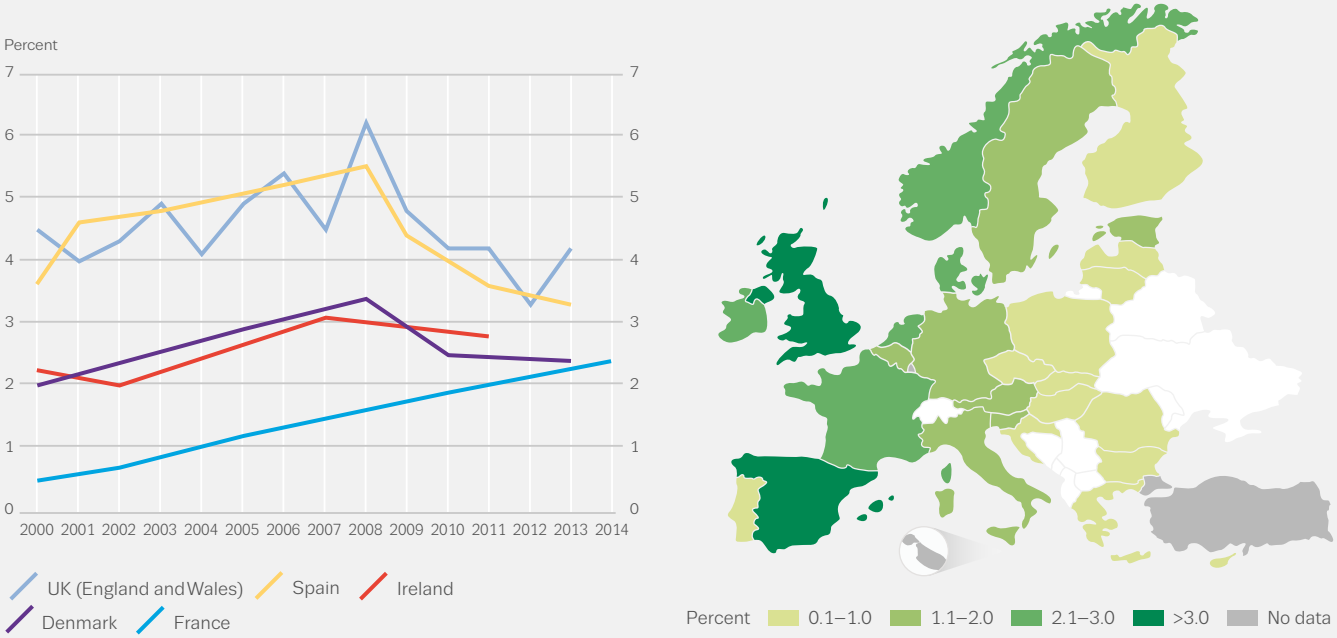
Cocaine residues in wastewater: in selected European cities (left) and daily averages (right)



NB: Mean daily amounts of cocaine in milligrams per 1 000 population, from sampling over a one-week period in 2014.
Source: Sewage Analysis Core Group Europe (SCORE).

FIGURE 2.4

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



Decreases in cocaine use are observable in the most recent data; of the countries that have produced surveys since 2012, eight reported lower estimates and three reported higher estimates than in the previous comparable survey.

Continued decline in cocaine treatment demand

The prevalence of problematic forms of cocaine use in Europe is difficult to gauge as only four countries have recent estimates and, for methodological reasons, these are not easy to compare. In 2012, Germany estimated 'cocaine-dependency' among the adult population at 0.20 %. In 2013, Italy produced an estimate of 0.23 % for those 'in need of treatment for cocaine use', and Spain estimated 'high-risk cocaine use' at 0.29 %. For 2011/12, the United Kingdom estimated crack cocaine use among the adult population in England at 0.48 %, and the majority of these were also opioid users.

Cocaine was cited as the primary drug for 13 % of all reported clients entering specialised drug treatment in 2013 (55 000), and 16 % of those entering treatment for the first time (25 000). Differences exist between countries, with more than 70 % of all cocaine clients being reported by only three countries (Spain, Italy, United Kingdom). In the most recent data, the number of cocaine clients entering treatment for the first time has stabilised at around 24 000; this number has declined from a peak of 38 000 in 2008. In 2013, 6 000 clients entering treatment in Europe reported primary crack cocaine use, with the United Kingdom accounting for more than half of these (3 500), and Spain, France and the Netherlands most of the remainder (2 200).

Interpreting the available data on cocaine associated mortality is challenging, in part because this drug may be a factor in some deaths that are attributed to cardiovascular

problems. Nonetheless, over 800 deaths associated with cocaine use were reported in 2013 (data from 27 countries). Most of these were attributed to drug overdose, with other substances also being detected in many cases, primarily opioids. At the European level, data quality issues mean that it is not possible to comment on trends. Some countries, however, do have limited information available. For example, between 2012 and 2013, the number of deaths in which the presence of cocaine was recorded increased from 174 to 215 in the United Kingdom and from 19 to 29 in Turkey.

Over 800 deaths associated with cocaine use were reported in 2013

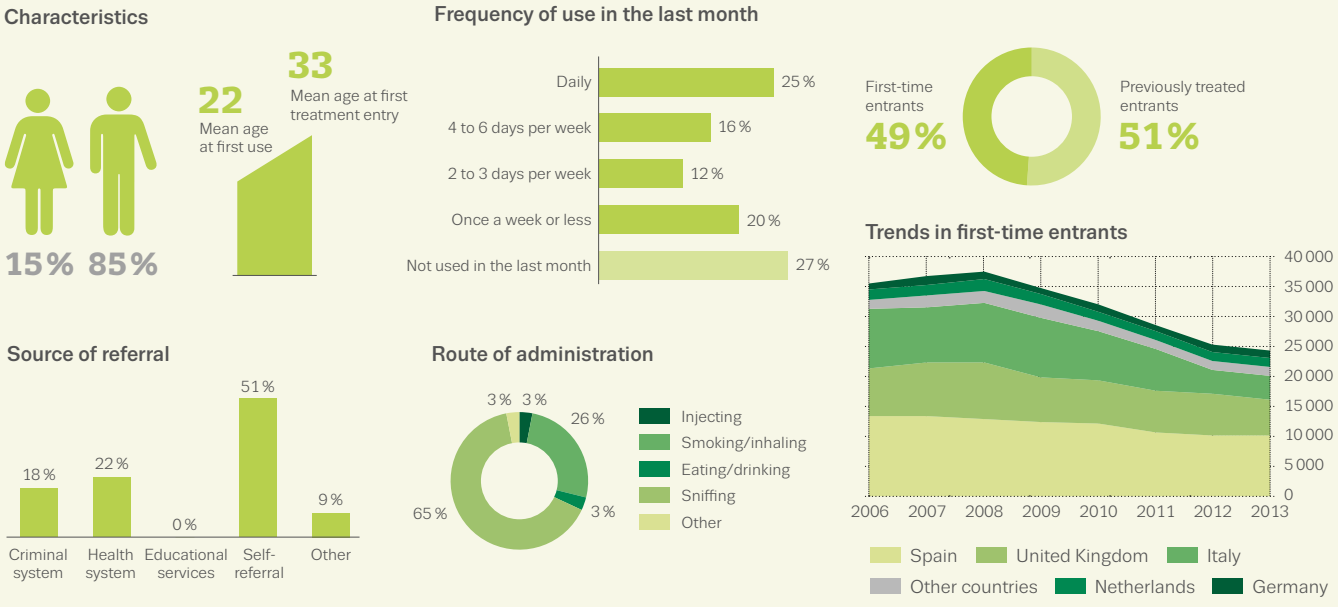
Amphetamines: use stable in many countries

Amphetamine and methamphetamine, two closely related stimulants, are both consumed in Europe, although amphetamine is by far the more commonly used. Methamphetamine consumption has historically been restricted to the Czech Republic and, more recently, Slovakia, although there are now signs of growing use in other countries. In some data sets, it is not possible to distinguish between these two substances; in these cases, the generic term amphetamines is used.

Both drugs can be taken orally or nasally; in addition, injection is common among high-risk users in some countries. Methamphetamine can also be smoked, but this route of administration is not commonly reported in Europe.

Adverse health effects linked with amphetamines use include cardiovascular, pulmonary, neurological and

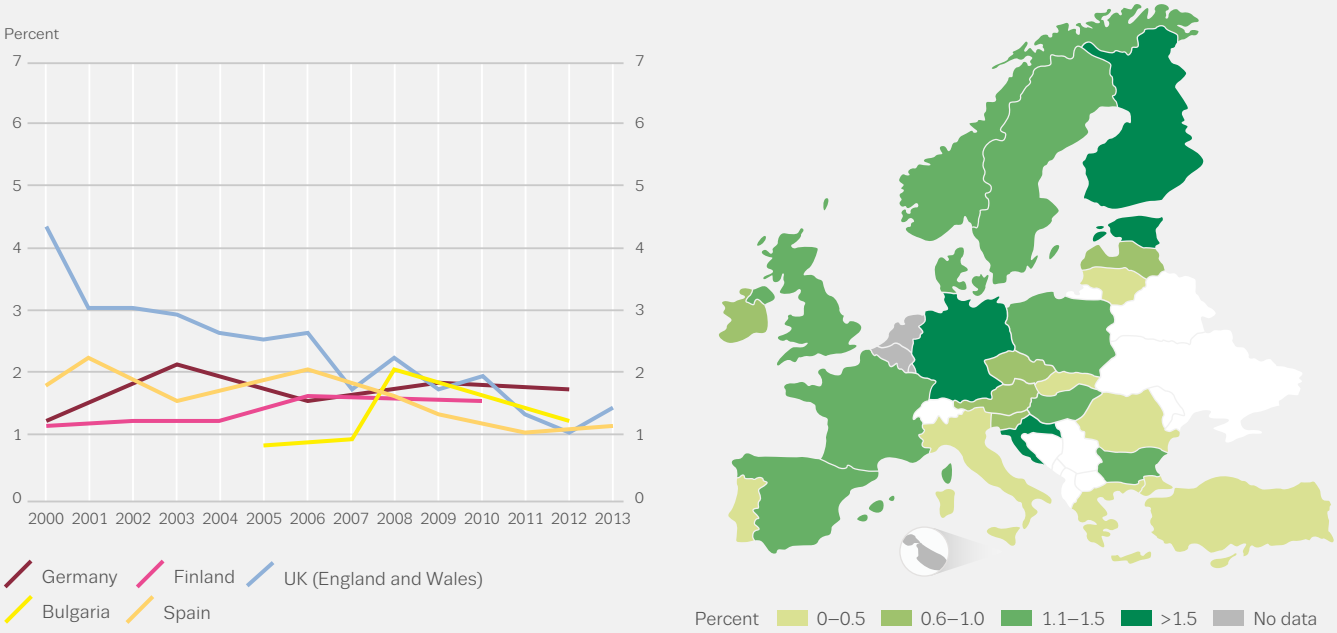
COCAINE USERS ENTERING TREATMENT



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.
Source of referral: 'criminal system' includes courts, police and probation; 'health system' includes general practitioners, other drug treatment centres and health, medical and social services; 'self-referral' includes the client, family and friends.

FIGURE 2.5

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



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.

An estimated 1.3 million (1.0 %) young adults (15–34) used amphetamines during the last year. The most recent national prevalence estimates range from 0.1 % to 1.8 % (Figure 2.5). The data available suggest that from around 2000, most European countries have experienced a relatively stable situation in respect to trends in use. Exceptions here are Spain and the United Kingdom, where a statistically significant decrease in prevalence can be observed since 2000.

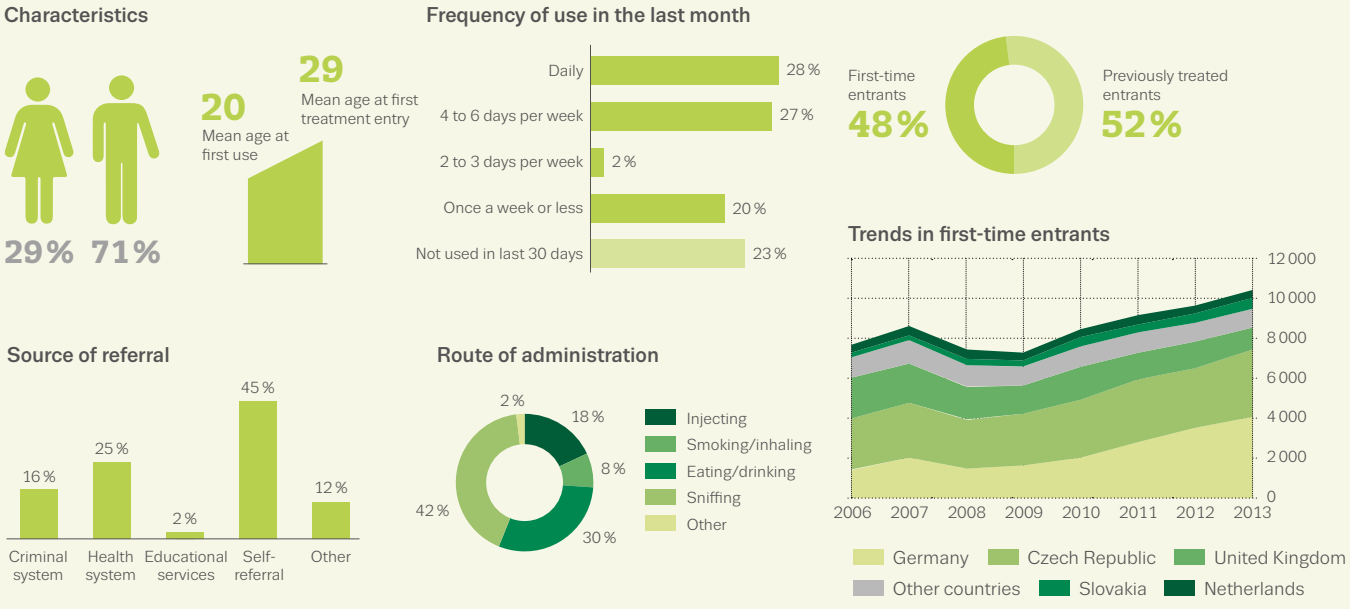
New patterns in problem amphetamines use

In respect to long-term, chronic and injecting amphetamine use, historically, problems have mostly been observed in northern European countries. In contrast, long-term methamphetamine problems have been most apparent in the Czech Republic and Slovakia. These countries report estimates of problem use among adults (15–64) at around 0.48 % for the Czech Republic (2013) and 0.21 % in Slovakia (2007). In the Czech Republic, a marked increase in problem or high-risk methamphetamine use, mainly injection, has been observed between 2007 and 2013 (from around 20 000 to over 34 000). There are recent indications that methamphetamine use is diffusing to other countries and new populations, with the use of the drug being reported in

countries bordering the Czech Republic (Germany, Austria) in parts of southern Europe (Greece, Cyprus, Turkey) and in northern European countries (Latvia, Norway). A new pattern of methamphetamine use continues to be reported in a number of European countries, where the drug is injected, often alongside other stimulants, among small groups of men who have sex with men. These so-called slamming parties are a concern because of the combination of risk-taking in both drug-use and sexual behaviours.

Around 7 % of clients entering specialised drug treatment in Europe in 2013 report amphetamines (amphetamine and methamphetamine) as their primary drug. This amounts to approximately 29 000 clients, of whom 12 000 entered treatment for the first time in their life. Primary amphetamine users account for a sizeable proportion of reported first-time treatment entries in only Germany, Latvia and Poland. Treatment entrants reporting primary methamphetamine use are concentrated in the Czech Republic and Slovakia, which together account for 95 % of the 8 000 methamphetamine clients in Europe. Increases in first-time entrants for amphetamines are accounted for primarily by Germany, the Czech Republic and Slovakia.

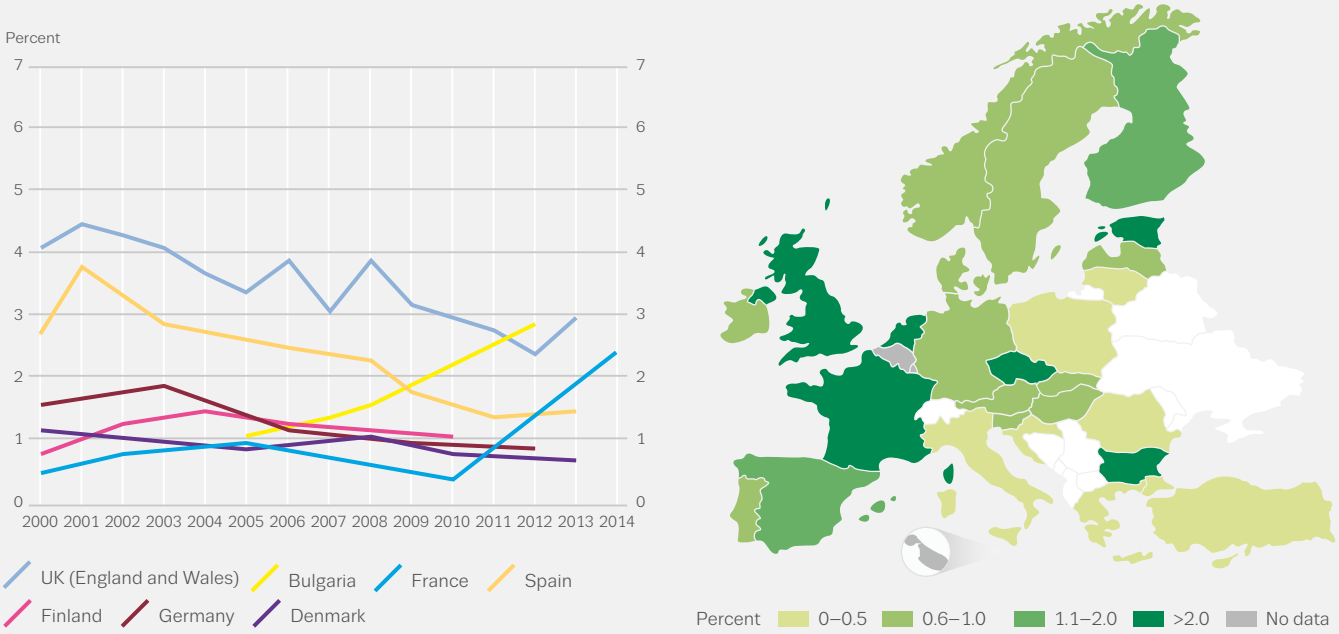
AMPHETAMINES USERS ENTERING TREATMENT



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.
Source of referral: 'criminal system' includes courts, police and probation; 'health system' includes general practitioners, other drug treatment centres and health, medical and social services; 'self-referral' includes the client, family and friends.

FIGURE 2.6

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



MDMA/ecstasy use

MDMA (3,4-methylenedioxy-methamphetamine) is commonly used in the form of ecstasy tablets, but is now also increasingly available as crystals and powders; tablets are usually swallowed, but in powder form the drug is also snorted (nasal insufflation). Problems associated with use of this drug include acute hyperthermia, increased heart rate and multi-organ failure, and long-term use has been linked with liver and heart problems. Deaths associated with this drug remain relatively rare, and are sometimes caused by other substances sold as MDMA. There have been recent concerns about acute problems linked with high-dose MDMA tablets and powders. In addition, warnings have been issued in 2014 about ecstasy tablets that contained high concentrations of PMMA — a drug with a worrying safety profile.

Most European surveys have historically collected data on ecstasy rather than MDMA use. It is estimated that 1.8 million young adults (15–34) used ecstasy in the last year (1.4 % of this age group), with national estimates ranging from under 0.1 % to 3.1 %. Among those countries with sufficient data to explore trends statistically, decreasing prevalence can be observed since 2000 in Germany, Spain and the United Kingdom. Denmark has a similar pattern of decreasing prevalence, but at a lower level of statistical certainty (Figure 2.6). In contrast, a pattern of increasing prevalence estimates continues in Bulgaria. Among the countries that have produced new surveys since 2012 results diverge: six reported lower prevalence estimates and seven reported higher estimates than in the previous comparable survey. Ecstasy use is rarely reported as a reason for entering drug treatment, with the drug being responsible for less than 1 % (around 600 cases) of reported first-time treatment entrants in 2013.

Most European surveys have historically collected data on ecstasy rather than MDMA use

GHB, ketamine and hallucinogens: still causing concern in some countries

A number of other psychoactive substances with hallucinogenic, anaesthetic and depressant properties are used in Europe: these include LSD (lysergic acid diethylamide), ketamine, GHB (gamma-hydroxybutyrate) and hallucinogenic mushrooms.

The recreational use of ketamine and GHB (including its precursor GBL, gamma-butyrolactone) has been reported among subgroups of drug users in Europe for the last two decades. There is growing recognition 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. Treatment requests related to GHB are reported in Belgium, the Netherlands and the United Kingdom.

Where they exist, national estimates of the prevalence of GHB and ketamine use in both adult and school populations remain low. In their most recent surveys, Norway reported last year prevalence of GHB use at 0.1 % for adults (15–64), while Denmark and Spain reported last year prevalence of ketamine use at 0.3 % among young adults (15–34), and the United Kingdom reported last year ketamine use at 1.8 % among 16- to 24-year-olds, a stable trend since 2008.

The overall prevalence levels of hallucinogenic mushrooms and LSD use in Europe have been generally low and stable for a number of years. Among young adults (15–34), national surveys report last year prevalence estimates of under 1 % for both substances.

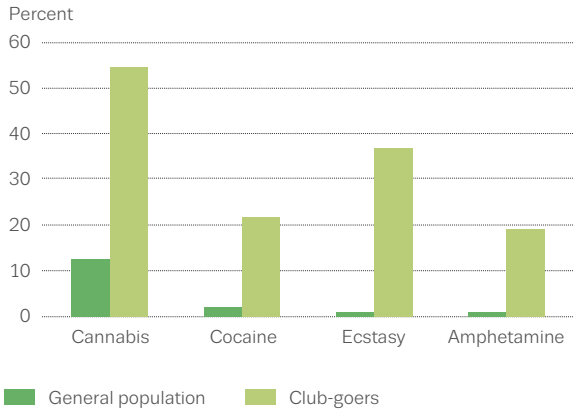
Higher levels of drug use among nightclub goers

It is well known that some social settings are particularly associated with elevated levels of drug and alcohol consumption. Typically, surveys of young people who regularly attend nightlife events indicate higher levels of drug use compared with the general population. This can been seen in information from the Internet-based Global Drug Survey, where the EMCDDA has commissioned a special analysis of drug use among young adults who self-identified as regular nightclub goers (defined as attending at least every three months). Analysis was performed on a sample of 25 790 young people aged 15–34, from 10 European countries. It should be noted that this is a non-representative, self-selected sample who responded to an online drug survey, and therefore the results must be interpreted with caution. Among this sample, depending on the substance, last year prevalence was between 4 and nearly 25 times higher than that found among the same age group in the general population of the European Union. Grouping together the available countries for each drug and comparing with the weighted average from general population surveys (GPS), around 55 % of the regular club-goers reported last year use of cannabis (GPS weighted country average 12.9 %), with high figures for other drugs: cocaine 22 % (GPS 2.4 %); amphetamines 19 % (GPS 1.2 %); ecstasy 37 % (GPS 1.5 %) (Figure 2.7). Last year prevalence levels among the club-goers were also reported for other drugs, including ketamine (11 %), mephedrone (3 %), synthetic cannabinoids (3 %) and GHB (2 %).

A small number of club-goers reported experiencing problems with their drug use, with cannabis and ecstasy the drugs most commonly associated with acute emergency presentations among this group.

FIGURE 2.7

Last year prevalence among young adults (15–34): general population and club-goers (10 countries)



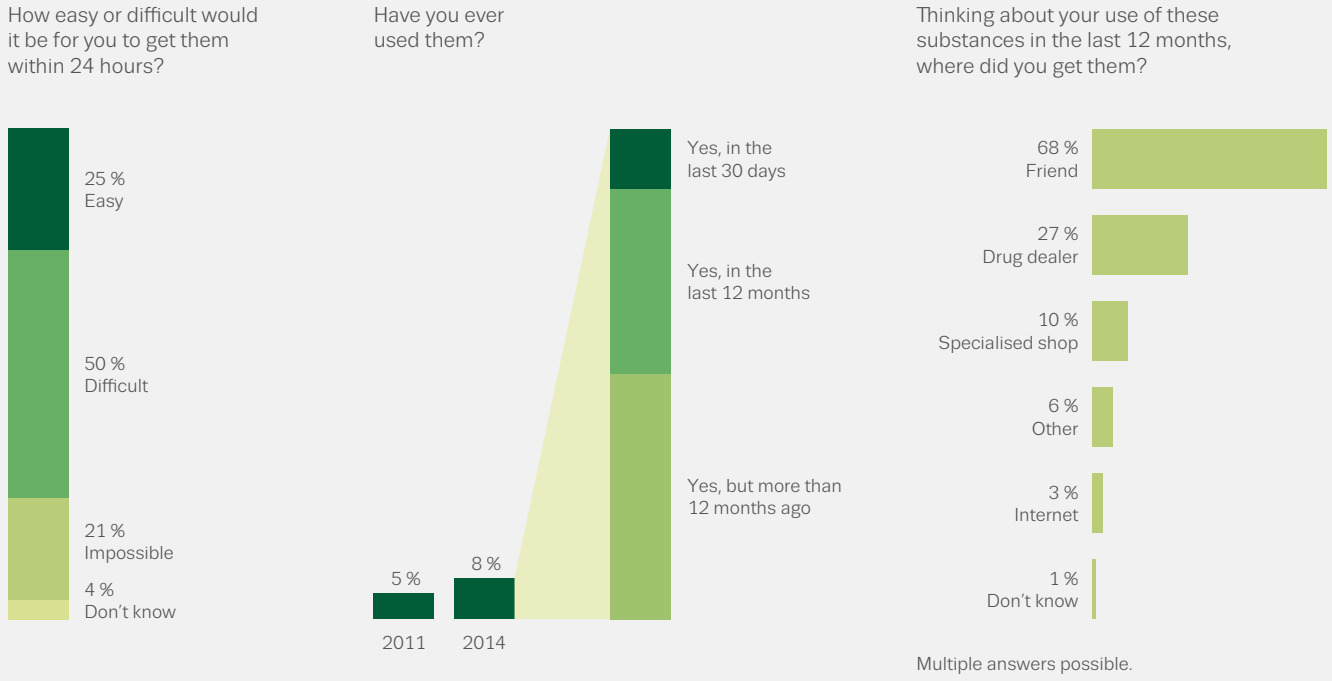
Sources: Global Drug Survey 2014 and the most recent general population surveys for the following countries: Belgium, Germany, Ireland, Spain, France, Hungary, Netherlands, Austria, Portugal, United Kingdom. Amphetamines: minus Belgium and Netherlands. Ecstasy: minus Netherlands.

Use of 'legal highs' among young people

The prevalence of use of new psychoactive substances in Europe is hard to ascertain. Where these substances are incorporated in national surveys, the lack of a common methodology means that the data are rarely comparable between countries, and definitional problems complicate things further, especially as the legal status of substances can change rapidly. Nevertheless, some insights into use of these substances is provided by the 2014 Flash Eurobarometer on young people and drugs, a telephone survey of 13 128 young adults aged 15–24 in the 28 EU Member States. In response to a question on perceived

FIGURE 2.8

Availability and use of 'legal highs', defined as new substances that imitate the effects of illicit drugs



Source: Flash Eurobarometer Survey 401.

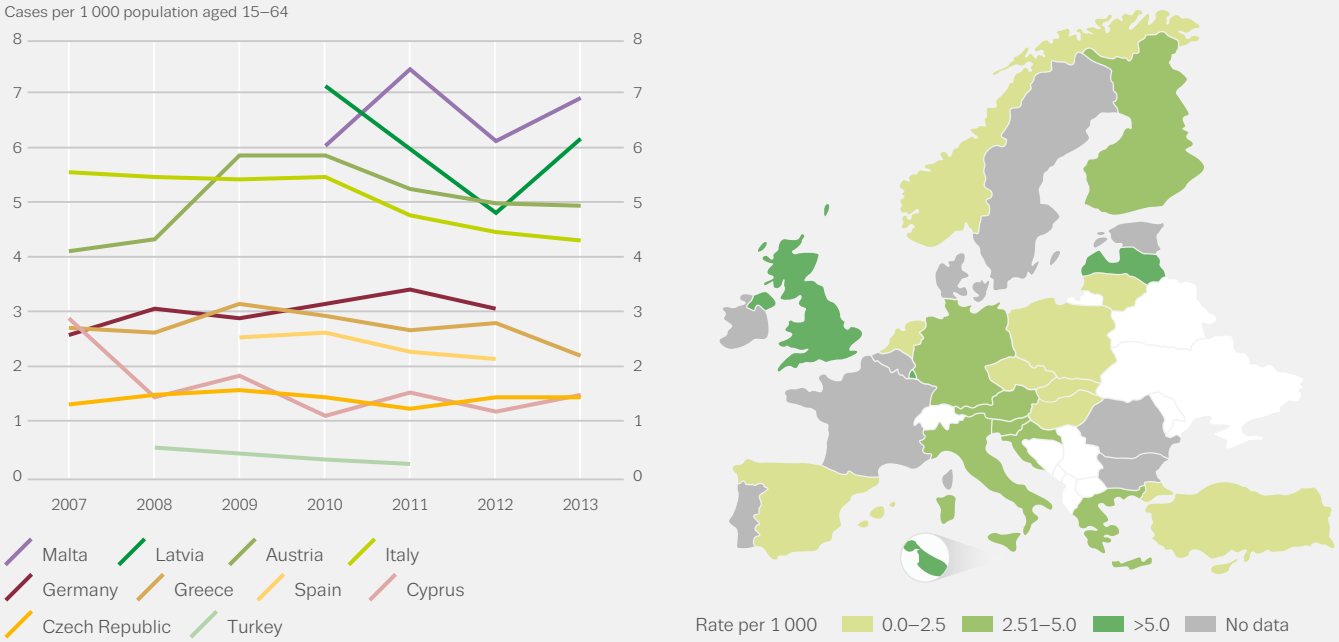
availability, over two-thirds of respondents thought it would be difficult or impossible to obtain 'legal highs' — defined as new substances that imitate the effects of illicit drugs. Although primarily an attitudinal survey, the Eurobarometer included a question on the use of 'legal highs'. Currently, these data represent the only EU-wide information source on this topic, although for methodological reasons caution is required in interpreting the results. Overall, 8 % of respondents reported lifetime use of 'legal highs', with 3 % reporting use in the last year (Figure 2.8). This represents an increase from the 5 % reporting lifetime use in a similar survey in 2011. The highest levels of use in the last year were reported by young people from Ireland (9 %), while use of 'legal highs' in the last year was not reported in the samples from Cyprus and Malta. Of those reporting use in the last year, 68 % had obtained the substance from a friend.

It is of interest to consider the Eurobarometer results alongside those from other surveys, while noting that different methods and questions are being employed. Nine European countries have reported national estimates of the use of new psychoactive substances or 'legal highs' (not including ketamine and GHB), since 2011. Last year prevalence of use of these substances among young adults (aged 15–24) ranges from 9.7 % in Ireland to 0.2 % in Portugal. It should be noted that in both of these countries, measures have been introduced to restrict the direct availability of 'legal highs' by closing shops where these products were being sold. Survey data for the United Kingdom (England and Wales) are available on the use of mephedrone. In the most recent survey (2013/14), last year use of this drug among young people aged 16 to 24 was estimated at 1.9 %; this figure was stable compared with the previous year, but down from 4.4 % in 2010/11, before control measures were introduced.

The injection of synthetic cathinones, although not a widespread phenomenon, continues to be reported in some specific populations, including opioid injectors, drug treatment clients in some countries 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 the United Kingdom (England), the number of first-time treatment entrants reporting any use of mephedrone increased from 900 to 1 630 between 2011/12 and 2012/13, with numbers stabilising in 2013/14 at 1 641.

FIGURE 2.9

National estimates of last year prevalence of high-risk opioid use: trends (left) and most recent data (right)



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 misused.

The average annual prevalence of high-risk opioid use among adults (15–64) is estimated at around 0.4 % (4 per 1 000 population), the equivalent of 1.3 million problem opioid users in Europe in 2013. Prevalence estimates of high-risk opioid use vary between countries from less than one to around eight cases per 1 000 population aged 15–64. Ten countries have repeated estimates of high-risk opioid use between 2006 and 2013 and these show relatively stable trends (Figure 2.9).

Clients using opioids, mainly heroin, as their primary drug represent 41 % of all drug users who entered specialised treatment in 2013 in Europe (175 000 clients), and 20 % of those entering treatment for the first time (31 000 clients). The number of new heroin clients has more than halved from a peak of 59 000 in 2007 to 23 000 in 2013. Overall, it appears likely that recruitment into heroin use has decreased and that this is now impacting on treatment demand.

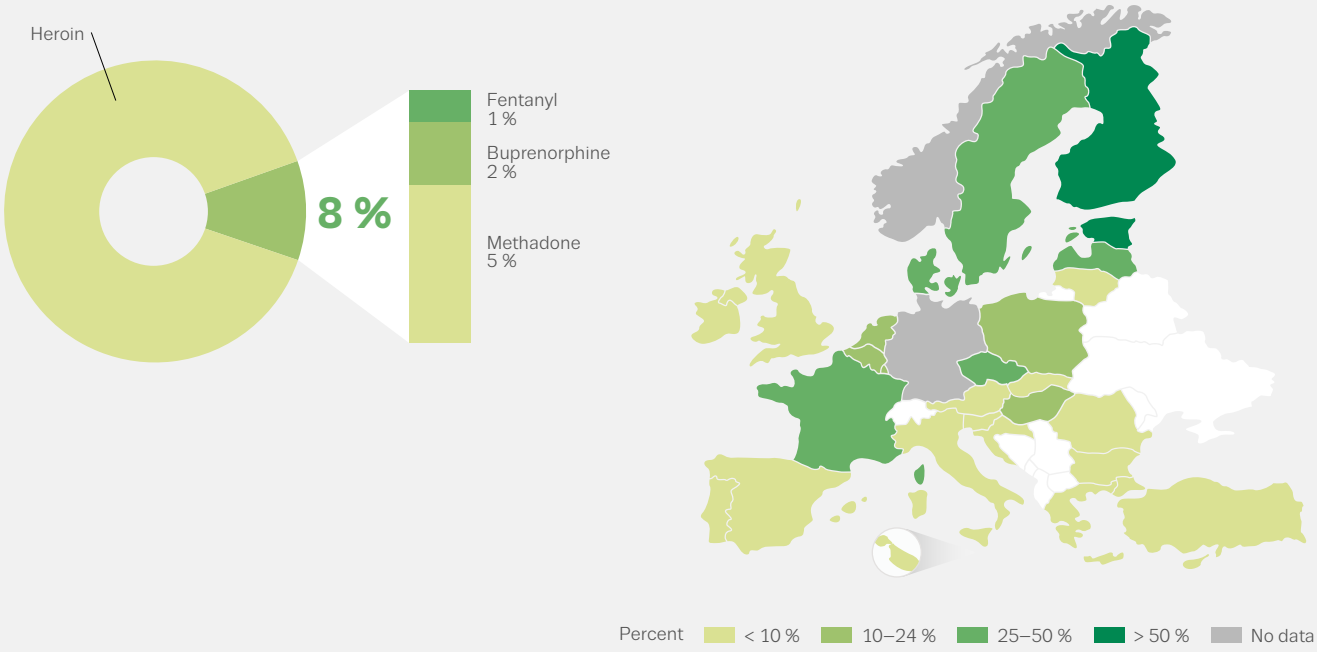
Opioids other than heroin: of increasing concern

In just over a third (11) of European countries, more than 10 % of all opioid clients entering specialised services in 2013 were treated for problems primarily related to opioids other than heroin (Figure 2.10). These substances include methadone, buprenorphine and fentanyl. Overall, misused methadone is the most commonly reported opioid other than heroin, followed by buprenorphine; respectively, these drugs account for 60 % and 30 % of all treatment demands from clients whose primary drug problem relates to opioids other than heroin. In some countries, other opioids now represent the most common form of problem opioid use. In Estonia, for example, the majority of treatment entrants reporting an opioid as their primary drug were using illicit fentanyl, while in Finland most opioid clients are reported to be primary misusers of buprenorphine.

The main opioid used in Europe is heroin

FIGURE 2.10

Treatment entrants citing opioids as primary drug: by type of opioid (left) and percentage reporting opioids other than heroin (right)

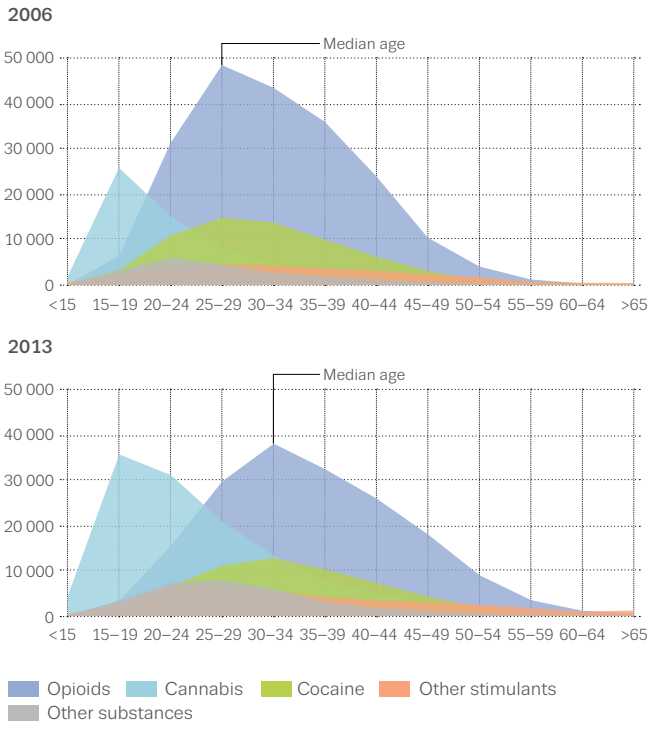


High-risk opioid users: an ageing population

Two trends are evident among opioid users entering treatment: their numbers are declining and the average age is increasing (Figure 2.11). Between 2006 and 2013, the median age of clients entering treatment for problems related to opioid use increased by 5 years. During the same period, the average age of drug-induced deaths (which are mainly related to opioids) increased from 33 to 37 years. A significant number of problem opioid users in Europe with long-term polydrug use histories are now aged in their 40s and 50s. A history of poor health, bad living conditions, tobacco and alcohol use, and age-related deterioration of the immune system make these users susceptible to a range of chronic health problems. Among these are cardiovascular and lung problems resulting from chronic tobacco use and injecting drug use. Long-term heroin users are also reporting chronic pain conditions, while infection with hepatitis virus can place them at increased risk of cirrhosis and other liver problems. The cumulative effects of polydrug use, overdose and infections over many years accelerate physical ageing among these users, with growing implications for treatment and social support services.

FIGURE 2.11

Trends in age structure of clients entering treatment by primary drug, 2006 and 2013



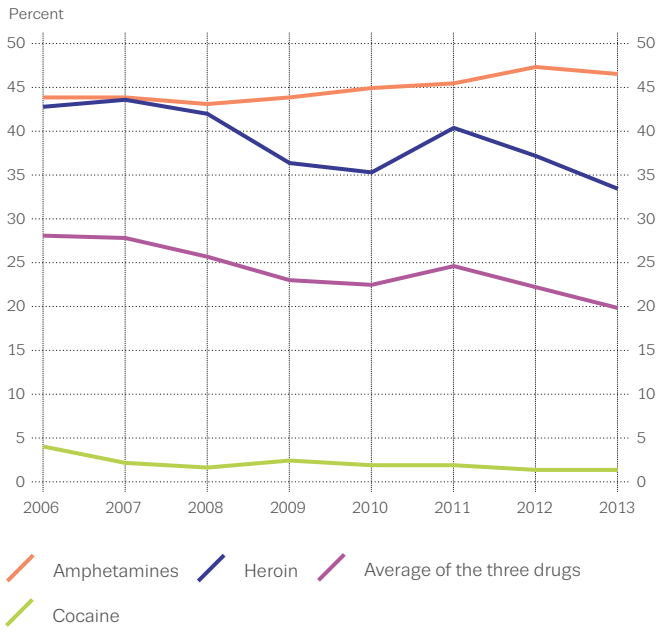
Injecting drug use: long-term decline

Injecting drug users are among those at highest risk of experiencing harms from their drug use, including blood-borne infections or drug overdoses. Injection is most commonly associated with opioid use, although in a few countries, amphetamines injection is a major problem. Recent estimates of the prevalence of injecting drug use are available for 14 countries, where they range from less than one to more than nine cases per 1 000 population aged 15–64.

Among those entering specialised treatment for the first time with amphetamines as their primary drug, 46 % report injecting as their main route of administration, with a stable overall trend (Figure 2.12). Each year, over 70 % of these are reported by the Czech Republic, where the trend has been increasing. For the remaining European countries, injecting as the main route of administration for new amphetamine clients is in decline. Among first-time clients reporting heroin as their primary drug, 33 % reported injecting as their main route of administration, down from 43 % in 2006. Levels of injecting among heroin clients vary between countries, from 8 % in the Netherlands to 100 % in Lithuania. Taking the main three injected drugs together, among first-time entrants to treatment in Europe, injecting as the main route of administration has declined from 28 % in 2006 to 20 % in 2013.

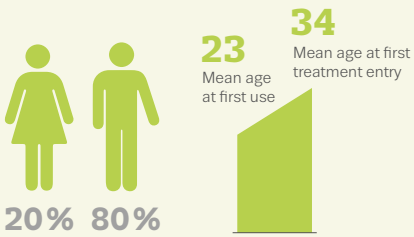
FIGURE 2.12

First-time treatment entrants reporting injecting as the main route of administration of their primary drug

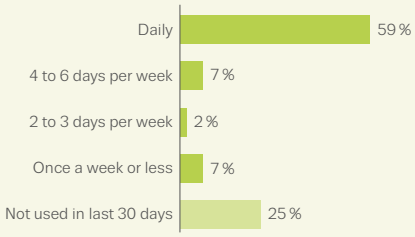


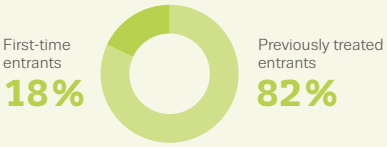
HEROIN USERS ENTERING TREATMENT

Characteristics

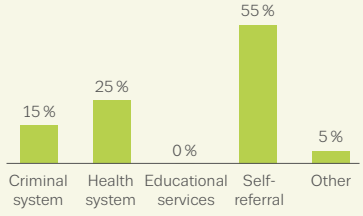


Frequency of use in the last month

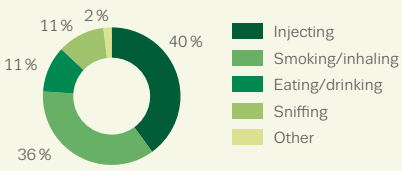




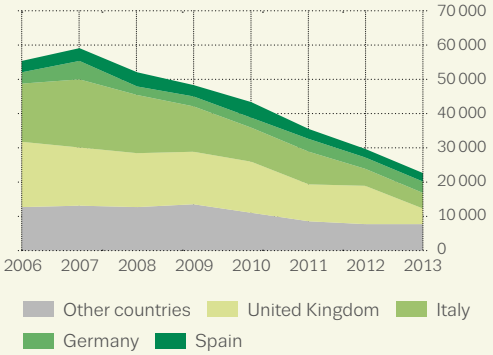
Source of referral



Route of administration



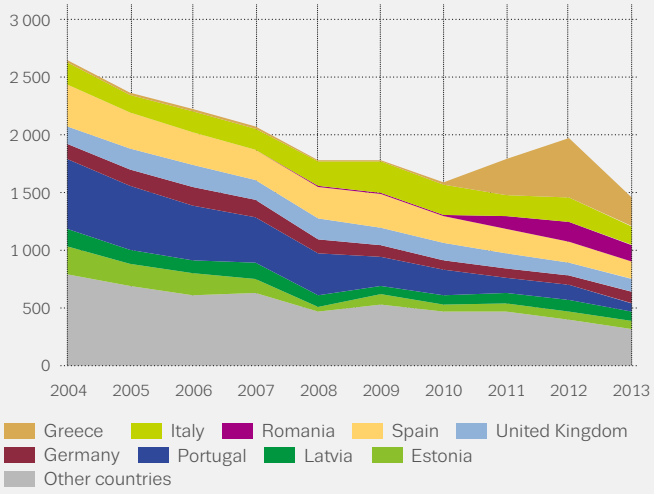
Trends in first-time entrants

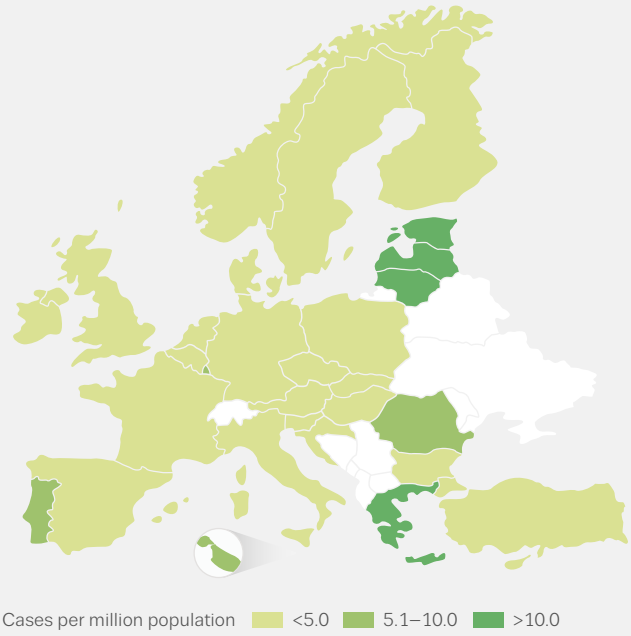


NB: Characteristics are for all treatment entrants with heroin as primary drug. Trends are for first-time entrants with heroin as primary drug. Countries covered vary by indicator.
Source of referral: 'criminal system' includes courts, police and probation; 'health system' includes general practitioners, other drug treatment centres and health, medical and social services; 'self-referral' includes the client, family and friends.

FIGURE 2.13

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





Data for 2013 (source: ECDC).

New HIV cases among injectors fall as Greece curbs outbreak

Drug injection continues to play a central role in the transmission of blood-borne infections such as the hepatitis C virus (HCV) and, in some countries, the human immunodeficiency virus (HIV). Among all HIV cases notified in Europe where the route of transmission is known, the percentage attributable to injecting drug use has remained low and stable (under 8 % for the last decade).

The latest figures show that the increase in the number of new HIV diagnoses in Europe, which resulted from outbreaks in Greece and Romania, has halted and the EU total has dropped to pre-outbreak levels (Figure 2.13). Provisional figures for 2013 show 1 458 newly reported cases, compared with 1 974 in 2012, reversing the upward trend observed since 2010. This drop is largely explained by decreases in Greece, where the number of new cases more than halved from 2012 to 2013, and to a lesser extent, Romania. Although the outbreaks seem to have peaked in these two countries, the number of new diagnoses in 2013 remains at least 10 times higher than the pre-outbreak level in 2010.

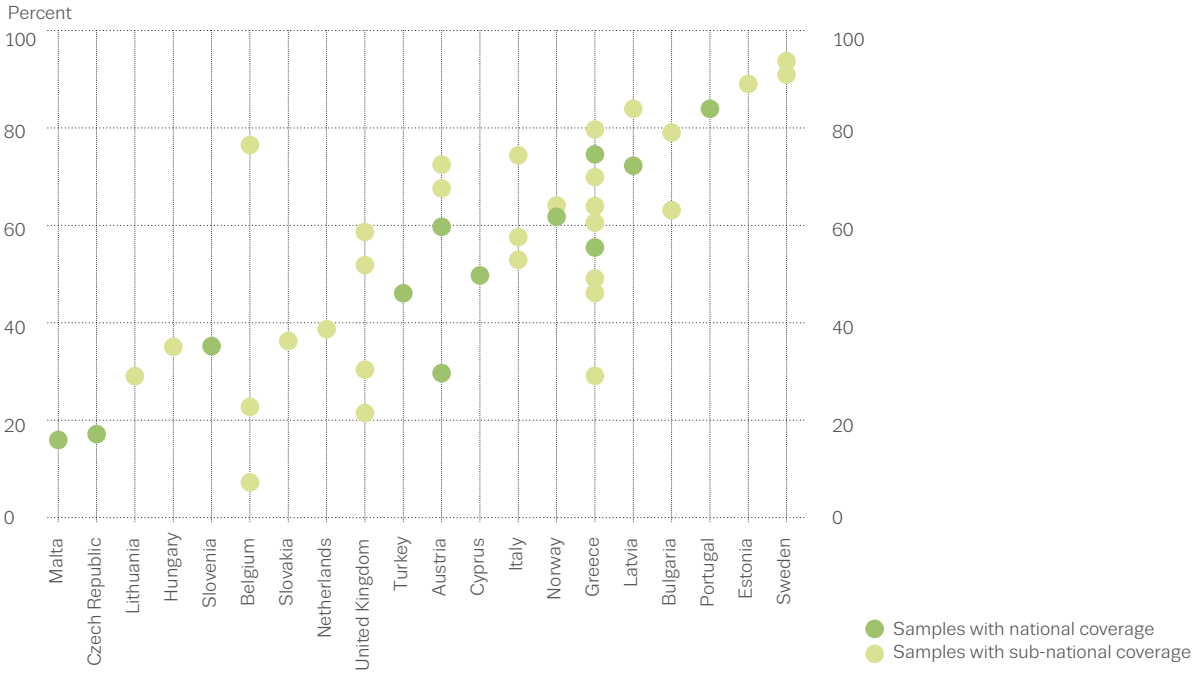
In 2013, the average rate of newly reported HIV diagnoses attributed to injecting drug use was 2.5 per million population, with the three Baltic States showing rates 8 to 22 times higher than the EU average. In other countries that have experienced periods with high rates of infection in the past, such as Spain and Portugal, rates of newly reported diagnoses continue to decline.

Early diagnosis and prompt appropriate treatment are important in preventing progression from HIV infection to AIDS. In 2013, there were 769 notifications of new AIDS cases in Europe attributable to injecting drug use. The relatively high numbers of new diagnoses coming from Bulgaria, Latvia, Greece and Romania suggests that AIDS prevention and HIV treatment responses in these countries require strengthening.

HIV-related mortality is one of the best documented indirect causes 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.

FIGURE 2.14

HCV antibody prevalence among injecting drug users, 2012/2013



Hepatitis and other infections associated with drug use

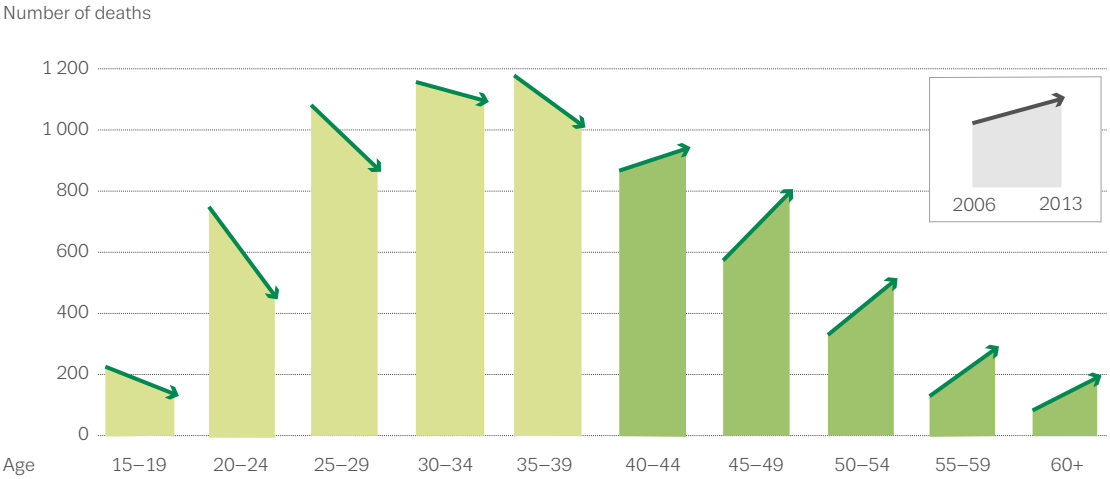
Viral hepatitis, particularly infection caused by the hepatitis C virus (HCV), is highly prevalent among injecting drug users across Europe. This may have important long-term consequences, as HCV infection, often worsened by heavy alcohol use, is likely to account for increasing numbers of cases of cirrhosis, liver cancer and death among injecting drug users.

HCV antibody levels among national samples of injecting drug users in 2012–13 varied from 14 % to 84 %, with 5 of the 10 countries with national data reporting a prevalence rate in excess of 50 % (Figure 2.14). Among countries with national trend data for the period 2006–13, declining HCV prevalence in injecting drug users was only reported in Norway, while six other countries observed an increase.

Drug use may be a risk factor for other infectious diseases including hepatitis A and B, sexually transmitted diseases, tuberculosis, tetanus and botulism. Sporadic cases of wound botulism among injecting drug users have been reported in Europe. In Norway, six confirmed cases were reported between September and November 2013. Two clusters of wound botulism cases — in Norway and Scotland — were identified in December 2014, and these were under investigation into 2015.

FIGURE 2.15

Number of drug-induced deaths by age group in 2006 and in 2013



Drug-related deaths

Drug use is one of the major causes of avoidable 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. A recent EMCDDA multisite study with data from nine European countries found that most deaths among problem drug users are premature and preventable. The study recorded 2 886 deaths among a sample of over 31 000 participants, with an overall annual mortality rate of 14.2 per 1 000. Cause of death was identified for 71 % of the cases, and half of these deaths were accounted for by external causes, mostly overdose and to a lesser extent suicide, and the other half were attributed to somatic causes including HIV/AIDS, and circulatory and respiratory diseases.

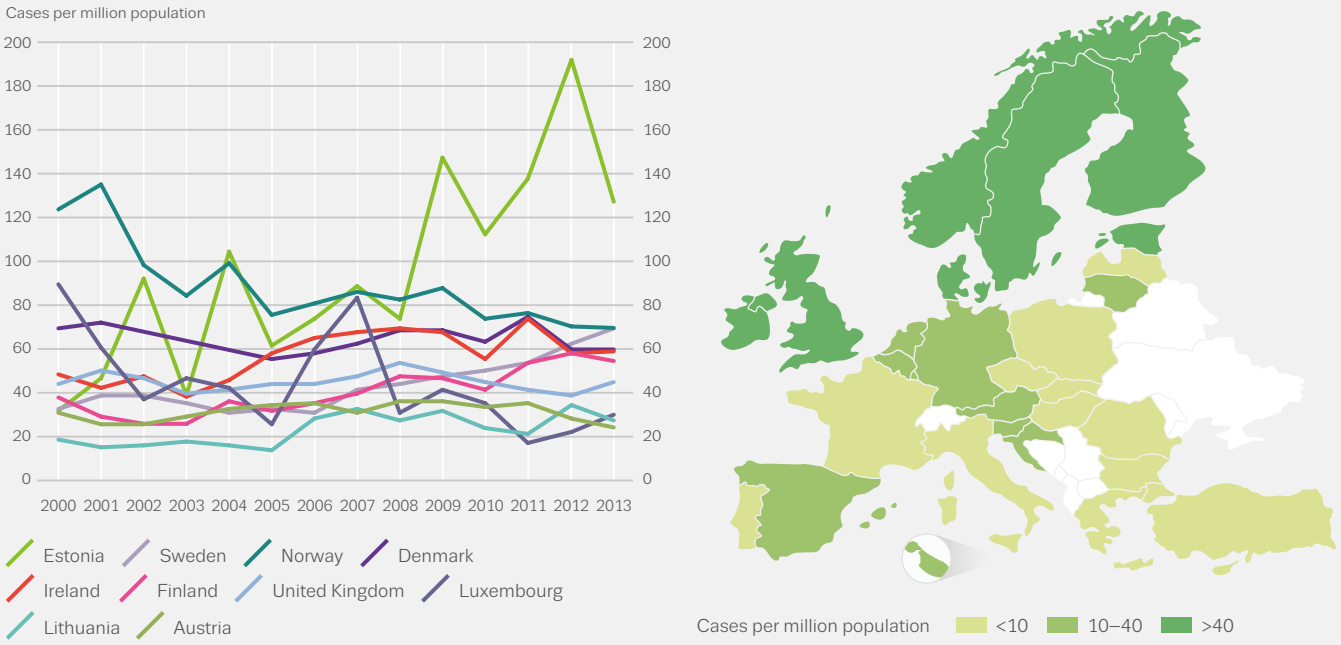
Overdose deaths: recent increases in some countries

Overall, drug overdose continues to be the main cause of death among problem drug users, and over three-quarters of overdose victims are male (78 %). While it is often the deaths among the very young that generate concern, only 8 % of the overdose deaths reported in Europe in 2013 were aged under 25 years. Between 2006 and 2013, a pattern can be observed of decreasing numbers of overdose deaths among younger drug users and increasing numbers among older users (Figure 2.15). This reflects the ageing nature of Europe's opioid-using population, who are at greatest risk of drug overdose death.

Most countries reported an increasing trend in overdose deaths from 2003 until around 2008/09, when overall levels first stabilised and then began to decline. Caution is required when interpreting overdose data, and especially the EU cumulative total, for a number of reasons, which include systematic under-reporting in some countries and registration processes that result in reporting delays, both for cases and national totals. Because of these delays, the EU total for the current year is a provisional value which is subject to revision as new data become available. The EU estimate for 2013 is a minimum of 6 100 deaths. This is a slight increase from the revised 2012 figure. It is of

FIGURE 2.16

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 values in 2013.

particular concern that increases are evident in the most recent data from a number of countries with relatively robust reporting systems, including Germany, Sweden and the United Kingdom. Turkey is also showing increases, but this may partly reflect improved reporting.

Heroin or its metabolites are present in the majority of fatal overdoses reported in Europe, often in combination with other substances. In the United Kingdom (England) and Turkey, increases in reported deaths are driven to a large extent by deaths where heroin is implicated. In addition to heroin, other opioids including methadone, buprenorphine, fentanyls and tramadol are regularly found in toxicological reports, and these substances are now associated with a substantial share of overdose deaths in some countries.

For 2013, the average mortality rate due to overdoses in Europe is estimated at 16 deaths per million population aged 15–64. National mortality rates vary considerably and are influenced by factors such as prevalence and patterns of drug use, particularly injecting and opioid use, the characteristics of drug-using populations, the availability and purity of the drugs, reporting practices and provision of services. Rates of over 40 deaths per million were reported in seven countries, with the highest rates reported in Estonia (127 per million), Norway (70 per million) and Sweden (70 per million) (Figure 2.16). Although national differences in coding and reporting practices, as well as possible under-reporting, make it difficult to compare countries, analysing trends over time within individual countries is valuable. Recent improvements have been observed in the mortality rate due to overdose in Estonia, although the rates still remain eight times higher than the EU average. Overdose deaths there are mostly related to the injection of fentanyls — highly potent opioids.

Heroin or its metabolites are present in the majority of fatal overdoses reported in Europe

New drugs: increasingly linked with drug-related harms and deaths

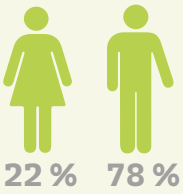
Overall, there is increasing evidence of the role that new psychoactive substances play in hospital emergencies and some drug-induced deaths in Europe. In 2014, the EU Early Warning System issued 16 alerts in relation to new substances being monitored by the mechanism, with many concerning serious adverse events such as deaths. A recent analysis by the European Drug Emergencies Network, which monitors emergency presentations in sites in 10 European countries, found that 9 % of all drug-related emergencies involved new psychoactive substances, primarily cathinones. In addition, 12 % of all presentations were for GHB or GBL and 2 % were for ketamine.

Recent reports of acute adverse health consequences associated with synthetic cannabinoids indicate that use of these substances may in some circumstances result in serious health consequences, including mortality. A 2015 review reported the most common adverse health effects associated with synthetic cannabinoids to be tachycardia, extreme agitation and hallucinations.

Evaluating the toxicological significance of any substance in a death is often complicated, especially given that in most drug-induced deaths multiple substances will have been consumed. These problems are accentuated for new drugs, which may be difficult to detect and not be included in commonly used screening tools. Despite these limitations, some data are available. In Hungary, for example, new psychoactive substances were detected in around half of the reported drug-induced deaths in 2013 (14 out of 31 cases), all in the presence of other substances. Case reports are also collected by the Early Warning System as part of the risk assessment of new drugs. These data indicate the role some new psychoactive substances can play in drug-related morbidity and mortality: for example, the synthetic cathinone MDPV, which was first detected in 2008, had been found in 99 deaths at the time of its risk assessment in 2014.

DRUG-INDUCED DEATHS

Characteristics



Mean age at death

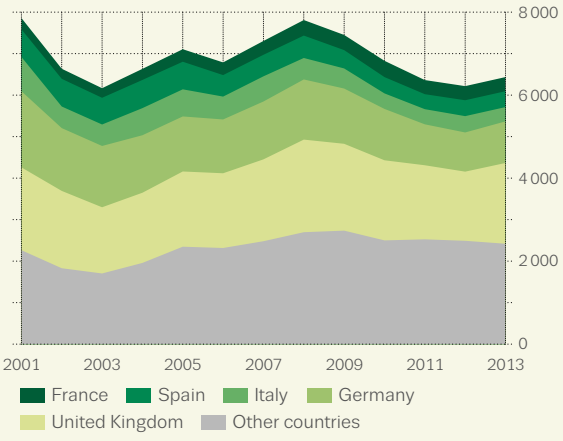
37

Deaths with opioids present

81 %

Age at death

Trends in overdose deaths



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EMCDDA publications

2015

Mortality among drug users in Europe: new and old challenges for public health, EMCDDA Paper.

Misuse of benzodiazepines among high-risk drug users, Perspectives on Drugs.

2014

Injection of cathinones, 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

In this chapter, policies and interventions designed to prevent, treat and reduce harms related to drug use are reviewed

Health and social responses to drug problems

In this chapter, policies and interventions designed to prevent, treat and reduce harms related to drug use are reviewed. The focus is on the extent to which countries have adopted common approaches, which of these are informed by evidence, and whether service provision matches estimated need. The key policy areas monitored at European level include national drug strategies and action plans, drug-related budgets and public expenditure estimates.

Monitoring health and social responses

Data used here are provided by Reitox focal points and expert working groups, complemented by reports on treatment demands, 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 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 Statistical Bulletin, the Best practice portal and under European drug policy and law.

National and city level drug strategies

The European Drugs strategy 2013–20 and accompanying action plans provide a framework for coordinated responses to drug problems in Europe. At the country level, this is mirrored in national drug strategies, budgetary frameworks and plans. These time-limited documents usually contain a set of general principles, objectives and priorities, specifying actions and the parties responsible for their implementation. All countries have now a national drug policy and, in all but two countries, this can be found in a national drug strategy document. The exceptions are Austria, where drug strategy is included in regional plans, and Denmark, where the issue is addressed in a number of

FIGURE 3.1

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.

policy documents and actions. National strategies and action plans that cover both licit and illicit drugs have been adopted by eight countries (Figure 3.1). Evaluation of drug strategies and action plans has been conducted in many countries. The aim of evaluation is generally to assess the changes in the overall drug situation as well as the level of implementation achieved.

City authorities in Europe are often responsible for coordinating local drug policy, in some instances with dedicated budgets. In many countries, strategic planning documents also exist to support policy implementation. A recent EMCDDA study reported on 10 capital cities with a dedicated drugs strategy, and in some cases an accompanying action plan. Some of these had broad coverage, while others focused on a specific issue such as overdose deaths, use of GHB or problems linked to open drug scenes. In some cities without a specific drug strategy, drug policy objectives were incorporated into wider local health or crime reduction strategies. In others, drug issues were covered by broader regional or national policy documents.

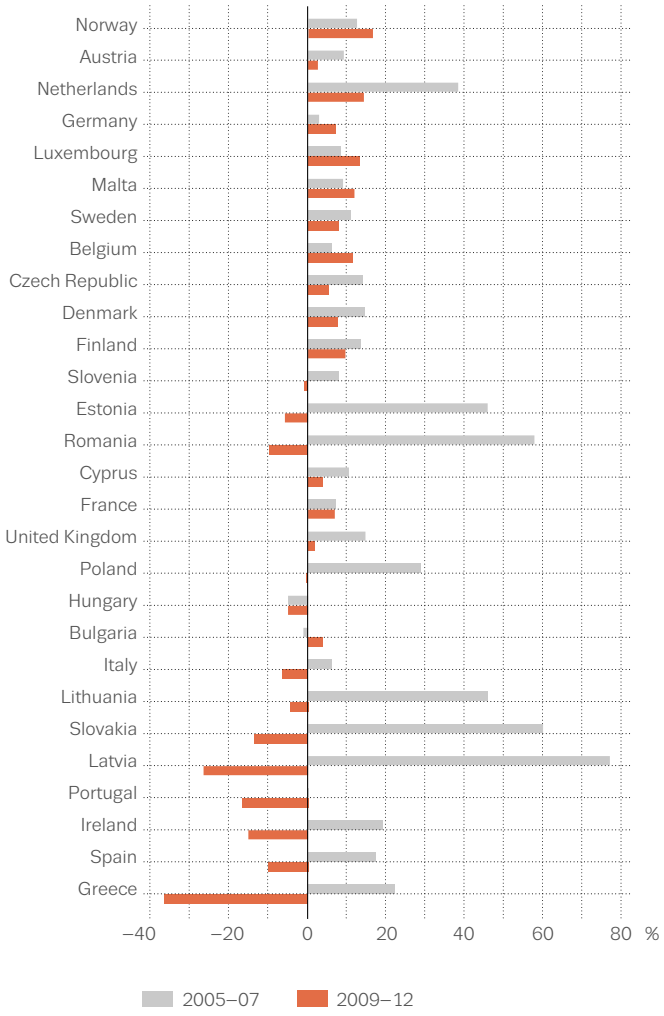
Austerity impacts on funding for health interventions

The information available on drug-related public expenditure in Europe, at both local and national level, remains sparse and heterogeneous. For the 18 countries that have produced estimates in the past 10 years, drug-related public expenditure is estimated at between 0.01 % and 0.5 % of gross domestic product, with health interventions representing between 24 % and 73 % of total drug-related expenditure. Differences in the scope and quality of the estimates make it difficult to compare drug-related public expenditure between countries.

In the wake of the 2008 economic recession, many European governments imposed fiscal consolidation measures, often referred to as austerity measures. The size of the economic downturn, its impact and the timing and the scale of fiscal measures varied markedly between countries. In many countries, austerity measures led to reductions in public spending in those categories of government activity that encompass the bulk of drug-related initiatives. Analysis carried out by the EMCDDA suggests that overall, bigger cuts were more often registered in the health sector than in other areas such as public order and safety or social protection. Data for the period 2009–12 show a decline in public spending on health in most countries, compared with the pre-recession period 2005–07, with reductions of more than 10 percentage points in many European countries, at constant prices (Figure 3.2). As drug-related health expenditure represents a small proportion of total public health spending (often less than 1 %), trends in drug-related funding cannot be directly inferred from this data. Nevertheless, reductions in health funding are likely to have a negative impact on drug-related initiatives and EMCDDA reporting suggests that funding of drug-related research and prevention activities may have been particularly affected.

FIGURE 3.2

Estimated accumulated growth of public expenditure on health (2005–07 and 2009–12), at constant prices



Source: Eurostat

Prevention of drug use among young people

The prevention of drug use and drug-related problems among young people is a key policy objective and is one of the pillars of the European Drugs Strategy 2013–20. Drug prevention encompasses a wide range of approaches. Environmental and universal strategies 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. Over the last decade, the availability of quality standards, which can support intervention delivery and best practice, has grown. The European Drug Prevention Quality Standards Project provides toolkits to support the implementation of standards in this area.

A relatively robust evidence base exists for some prevention approaches that may be implemented in school settings. While countries report extensive implementation of smoking bans in schools and school drug policies, approaches for which an evidence base exists, prevention approaches solely based on the provision of information are also reported to be quite widely available (Figure 3.3). Providing health-related information may be important in educational terms, however, there is little evidence available to suggest that this form of prevention impacts on future drug-taking behaviour.

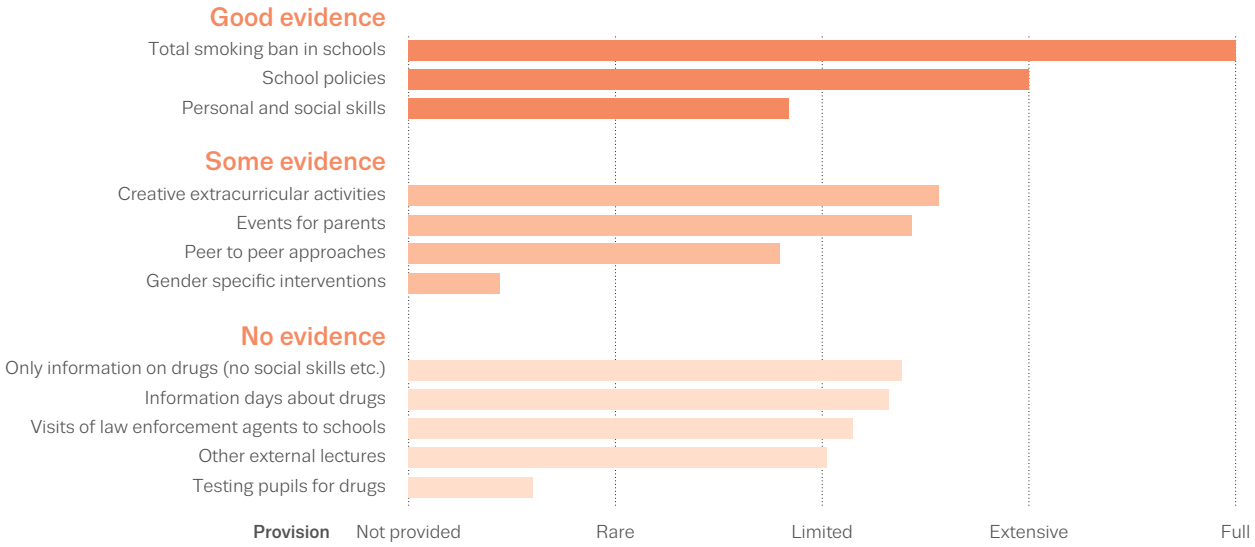
Early detection and intervention approaches are used in some schools, often based on the provision of counselling to young substance users. A Canadian programme (Preventure) that targets young sensation-seeking drinkers has been positively evaluated; it has been adapted for use in the Czech Republic, the Netherlands and the United Kingdom.

With regard to the provision of prevention interventions to specific vulnerable groups, the approaches with the highest availability are reported to be those targeting families with substance misuse problems, the provision of interventions for pupils with social and academic problems and interventions for young offenders. One programme of note targeting young offenders is FreD, a set of manual-based interventions, which has been implemented in 15 EU Member States. Evaluations of this programme have shown a fall in repeat-offending rates.

The prevention of drug use and drug-related problems among young people is a key policy objective

FIGURE 3.3

School-based interventions to prevent substance use: provision and evidence of effectiveness (European averages based on expert ratings, 2013)



NB: Evidence statements are based on the EMCDDA Best practice portal and UNODC evidence standards.

New drugs and new challenges

In European countries, initial responses to the emergence of new psychoactive substances have been predominantly regulatory in nature, focused on tackling their supply using legislative tools. Increasingly, however, more attention is being paid to the development of targeted education and prevention activities, as well as training and awareness-raising activities for professionals. In addition, services working in nightlife and recreational settings have tended to integrate their response to new substances within established approaches. The Internet is also increasingly important as a platform for the provision of information and counselling. One development has been the use of 'online-outreach' interventions to reach the new target groups. Examples include drug user-led initiatives, such as forums and blogs, which provide consumer protection information and advice. In a few cases, these interventions have been linked with drug testing and pill-checking services, with results and harm reduction messages disseminated online.

Currently, in Europe, new psychoactive substances are not associated with a significant demand for specialist treatment, although service developments are now seen in some countries. The emergence of new drugs has manifested itself in different ways in individual countries, and national responses reflect these differences. In Hungary and Romania, where the injecting of cathinones has been reported, needle and syringe exchange services play an important role. In the United Kingdom, where significant use of mephedrone has been recorded, specialist 'club-drug clinics' are engaging with this client group and treatment guidelines are being developed.

The Internet is also increasingly important as a platform for the provision of information and counselling

FIGURE 3.4

Numbers receiving drug treatment in Europe in 2013, by setting

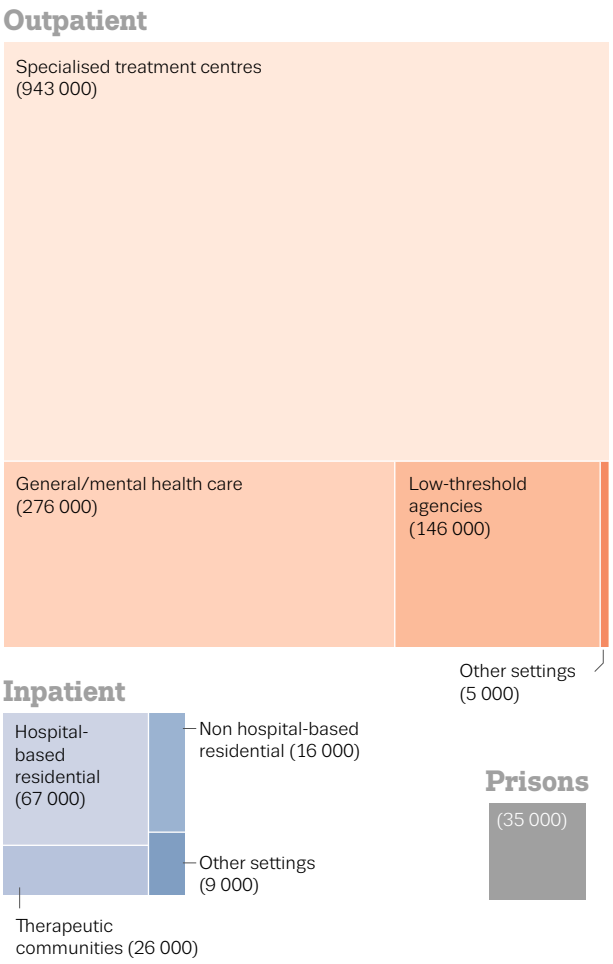
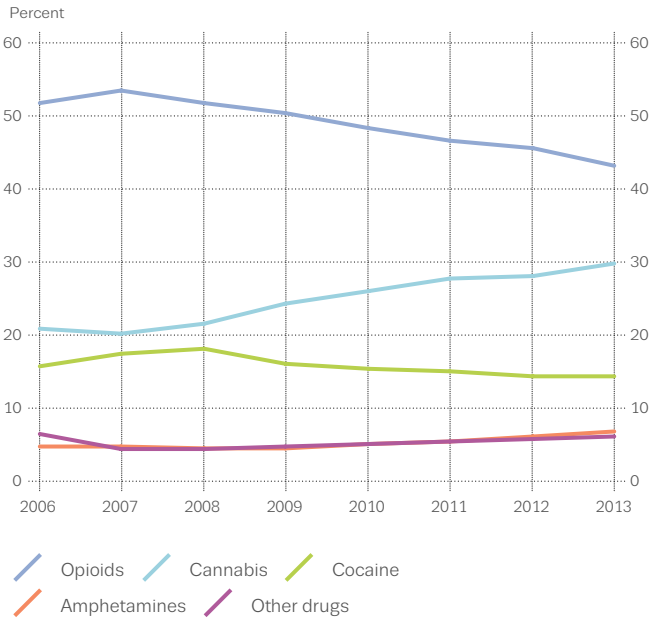


FIGURE 3.5

Trends in percentage of clients entering specialised drug treatment services, by primary drug



Most drug treatment provided in outpatient settings

Most drug treatment in Europe is provided in outpatient settings, with specialised outpatient centres representing the largest provider in terms of drug users reached, followed by general healthcare centres (Figure 3.4). These include general practitioners' surgeries, reflecting their role as prescribers of opioid substitution treatment in some large countries, such as Germany and France. A sizeable proportion of drug treatment in Europe is also provided in inpatient settings, such as hospital-based residential centres (e.g. psychiatric hospitals), therapeutic communities and specialised residential treatment centres. The relative importance of outpatient and inpatient provision within national treatment systems varies greatly between countries. In addition, many countries have low-threshold services, and although many of these do not provide structured treatment, in some countries, like France and the Czech Republic, these agencies are considered as an integral part of the national treatment system.

An estimated 1.6 million people received treatment for illicit drug use in Europe (1.4 million in the European Union) during 2013. This number is 0.3 million above the 2012 estimate. The increase is in part due to improved reporting methods and new data, in particular the inclusion of 200 000 outpatient clients from Turkey.

Data from monitoring treatment entries show that after opioids, cannabis and cocaine users are the second and third largest groups entering specialised drug treatment services (Figure 3.5). Psychosocial interventions are the main treatment modality used with these clients.

Most drug treatment in Europe is provided in outpatient settings

Opioid substitution treatment: the most common modality, but numbers decreasing

Opioid users represent the largest group undergoing specialised treatment in Europe and consume the greatest share of available treatment resources. Substitution treatment, typically combined with psychosocial interventions, is the most common treatment for opioid dependence. This approach is supported by the available evidence, with positive outcomes found in respect to treatment retention, reduced illicit opioid use, reported risk behaviour, and reductions in drug-related harms and mortality.

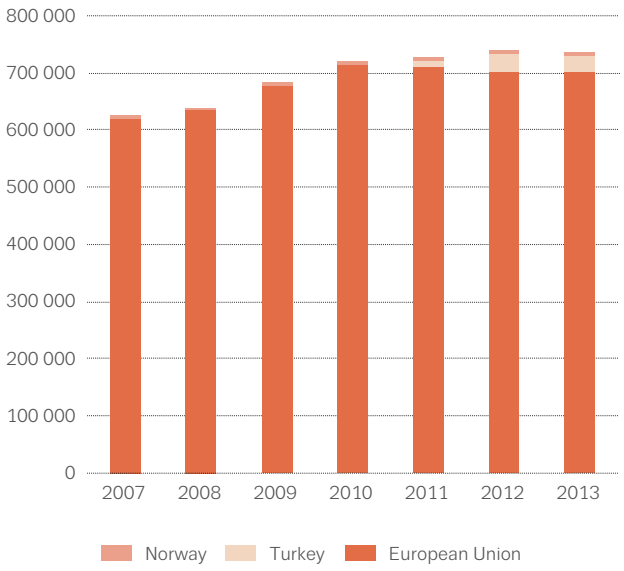
Methadone is the most commonly prescribed opioid substitution medication, received by over two-thirds (69 %) of substitution clients. A further 28 % of clients are treated with buprenorphine, which is the principal substitution medication used in six countries. Other substances, such as slow-release morphine or diacetylmorphine (heroin), are only prescribed occasionally in Europe, and are estimated to be received by around 3 % of those receiving substitution treatment.

An estimated 700 000 opioid users received substitution treatment in the European Union in 2013, and a slight downtrend has been observed in these data since 2011 (Figure 3.6). Between 2010 and 2013, the largest relative decreases were observed the Czech Republic (41 %, based on estimates), Cyprus (39 %) and Romania (36 %). The highest relative increases over the same period were observed in Poland (80 %), from a low base, and Greece (59 %). When data from Turkey and Norway are included, the 2013 estimate for those receiving substitution treatment increases to 737 000.

Opioid users represent the largest group undergoing specialised treatment in Europe

FIGURE 3.6

Trends in number of clients in opioid substitution treatment



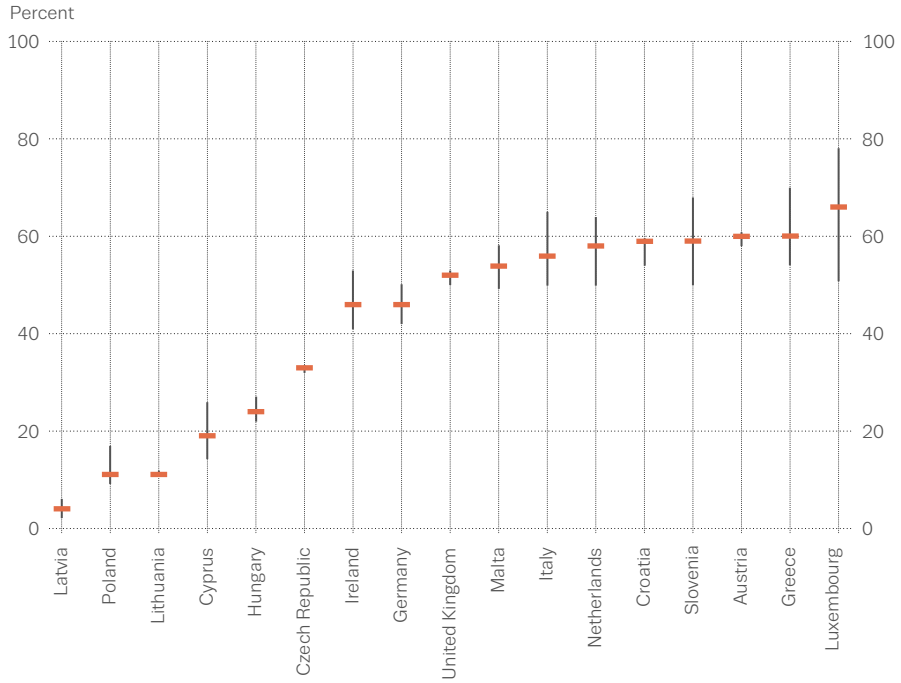
Over half of opioid users are in substitution treatment

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 still exist in coverage rates, with the lowest estimates reported by Latvia, Poland and Lithuania (around 10 % or less) (Figure 3.7).

Although less common, alternative treatment options for opioid users are available in all European countries. In the 10 countries providing sufficient data, the coverage of treatment approaches not involving substitution medication is generally within the range of 4 % to 71 % of all problem opioid users in treatment.

FIGURE 3.7

Percentage of problem opioid users receiving substitution treatment (estimate)



NB: Data displayed as point estimates and uncertainty intervals.

Responding to diverse needs though targeted interventions

Targeted interventions can facilitate access to treatment and ensure that the needs of different groups are met. The available information suggests that this kind of approach is currently most commonly available to young drug users, those referred from the criminal justice system and pregnant women (Figure 3.8). Targeted programmes for homeless drug users, older drug users and lesbian, gay, bisexual and transgender drug users were less frequently available, despite many countries reporting that there was a need for this kind of provision.

FIGURE 3.8

Availability of drug treatment programmes for target groups in Europe (expert ratings, 2013)

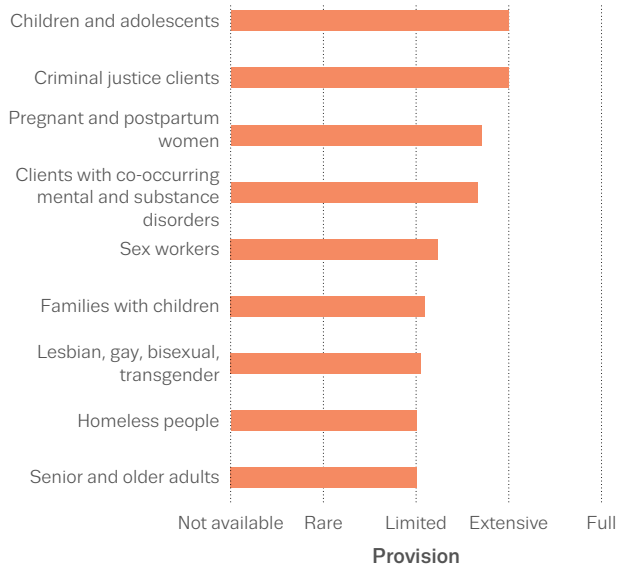
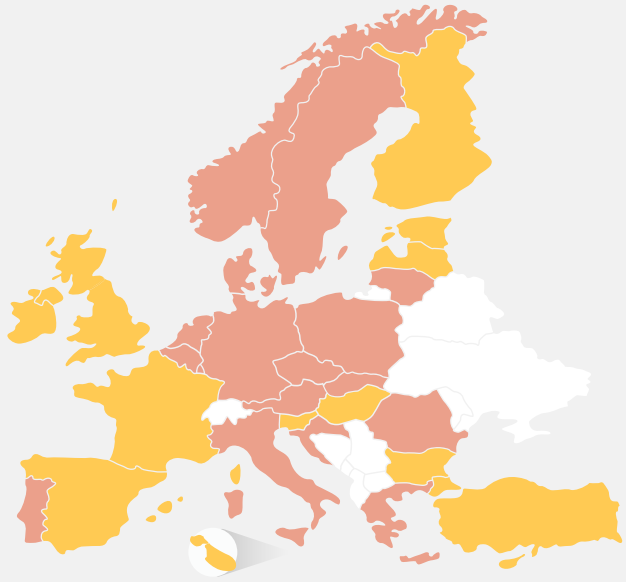


FIGURE 3.9

Existence of specialised treatment programmes for cannabis users in European countries



Cannabis-specific treatment available in half of countries

The provision of cannabis-specific treatment is increasing in Europe, with half of the countries now reporting its availability. Elsewhere, cannabis treatment is provided within general substance use programmes (Figure 3.9). Services for cannabis users can be diverse, ranging from brief interventions delivered online, to long-term therapeutic engagement in specialist centres. Although most treatment for this group takes place in community or outpatient settings this is not always the case, with around one in five of those entering specialist inpatient drug treatment services now being reported to have a primary cannabis-related problem.

Treatment for cannabis problems utilises psychosocial approaches; family based interventions are often used for adolescents and cognitive-behavioural interventions for adults. The available evidence supports the use of a combination of cognitive-behavioural therapy, motivational interviewing and contingency management approaches. In addition, there is some evidence to support the use of multidimensional family therapy for young cannabis users.

Internet-based interventions have extended the reach and geographical coverage of cannabis programmes. These interventions offer a new way to engage with people experiencing drug problems and have the potential to access some user groups that are not currently in contact with specialist drug services.

Tailoring treatment for ageing drug users

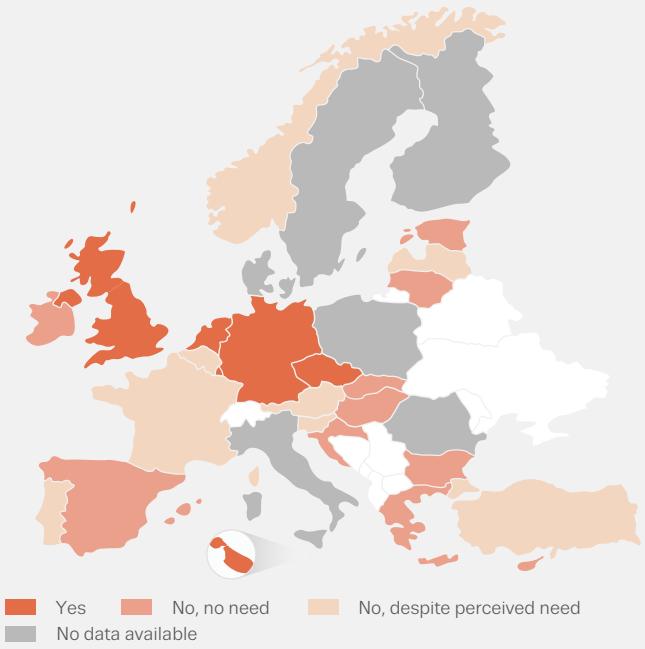
Demographic trends among Europe's problem drug-using population raise important questions about the appropriateness of drug treatment interventions for ageing clients. Those above the age of 40 will soon comprise the majority of problem opioid users in treatment. In addition to drug-related health problems, opioid users are also increasingly facing health problems related to ageing, often exacerbated by lifestyle factors. Clinical guidelines that take account of the demographic shift in Europe's problem opioid users are needed. This will support effective clinical practice, as issues around drug interactions, modes of administration, take-home dosages and pain treatment become more complex and important.

Few countries report the availability of targeted programmes for older drug users. This client group is generally integrated within existing drug treatment services (see Figure 3.10). However, both Germany and the Netherlands have set up retirement homes catering for the needs of older drug users. In the future, drug treatment and care programmes will have to be modified and developed if this ageing cohort is to receive an appropriate level of care. This is likely to require staff training and changes in care provision. As this is a client group with relatively poor engagement with the general health system and poor adherence to treatment for drug-related infections, the importance of a multi-disciplinary approach that continues after drug treatment is clear.

Few countries report the availability of targeted programmes for older drug users

FIGURE 3.10

Availability of targeted programmes for older drug users (expert ratings, 2013)



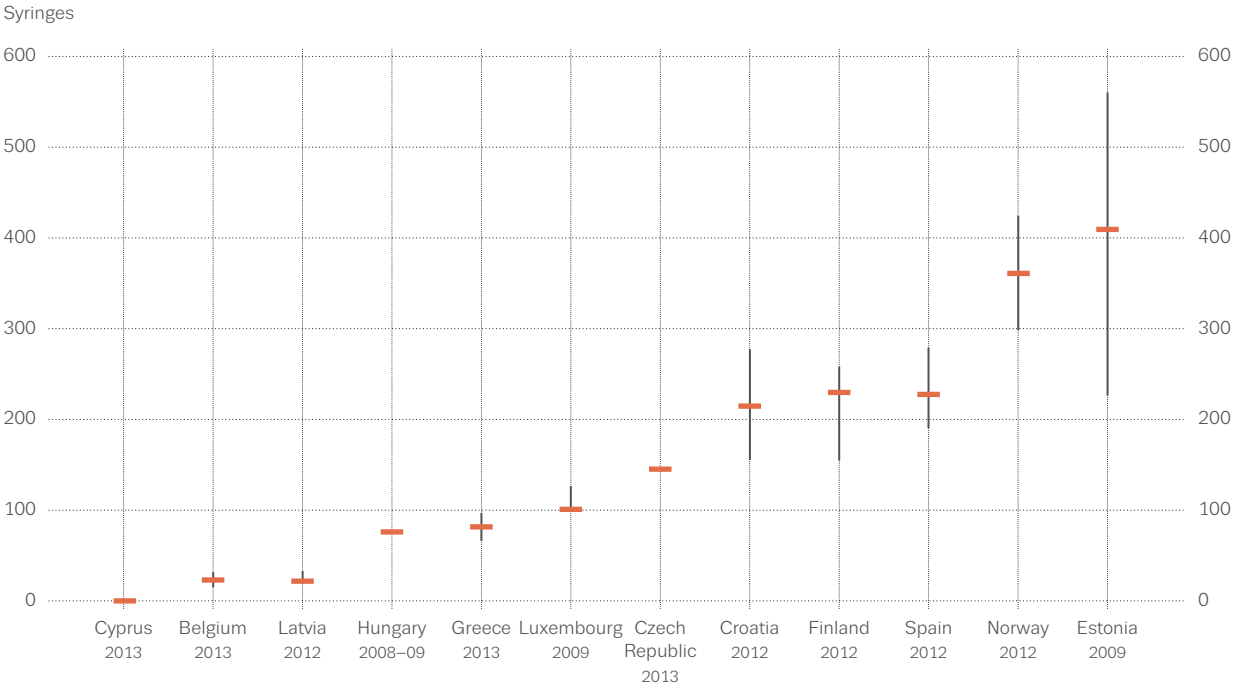
Preventing the spread of infectious diseases

Drug users, and particularly those who inject drugs, 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, substitution treatment reduces reported risk behaviour, with some studies suggesting that the protective effect increases when combined with needle and syringe programmes.

Between 2007 and 2013, the reported number of syringes distributed through specialised programmes increased from 43 million to 49 million in 24 countries representing 48 % of the EU population. A divergent picture is evident at country level, with around half reporting an increase in syringe distribution and half a decrease. Among the 12 countries with recent estimates of injection prevalence, the reported number of syringes distributed through specialised programmes in 2013 ranged from less than one in Cyprus to more than 300 per injecting drug users in Estonia and Norway (Figure 3.11).

FIGURE 3.11

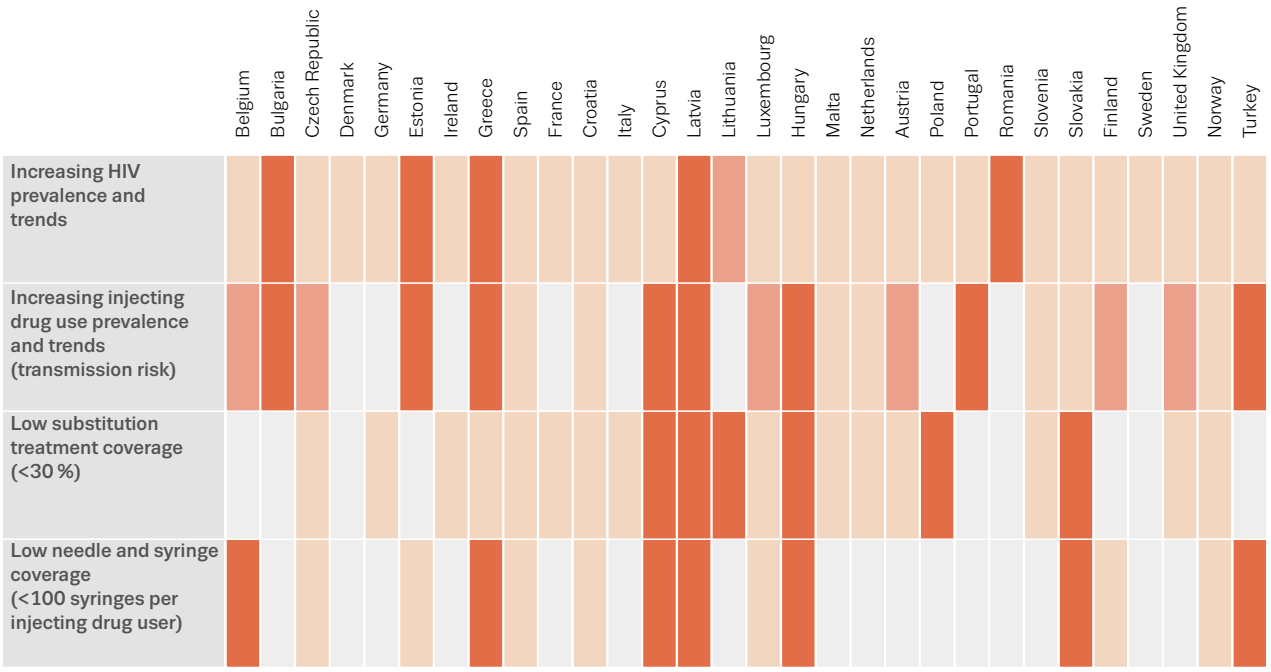
Number of syringes provided through specialised programmes per injecting drug user (estimate)



NB: Data displayed as point estimates and uncertainty intervals.

FIGURE 3.12

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



Risk factor present: significant increase in HIV case reports or HIV prevalence; increase in transmission risk; low intervention coverage.

Risk factors possibly present: HIV or HCV prevalence or transmission risk showing increase at subnational level or consistent but non-significant increase at national level.

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.

Information not available to ECDC or the EMCDDA.

NB: For information, see the online supplementary table.

While overall in Europe, the coverage of HIV prevention measures has been increasing, significant populations of injecting drug users continue to have limited access to services. An overview of some top-level indicators of potential risk is provided in Figure 3.12. Based on this simple analysis, around one-third of the countries display some elevated risk, suggesting a need for continued vigilance and for increasing the scaling up of HIV prevention measures.

Hepatitis C treatment improves

Prevention measures targeting the transmission of hepatitis C virus 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 have been increasing in the past years, but still remain limited. New diagnostic tools (such as the Fibroscan) have been introduced, and new medications have reduced treatment duration and negative side-effects, facilitating compliance. However, despite growing evidence of the effectiveness of hepatitis C antiviral treatment for infected injecting drug users, reported levels of availability remain limited in a number of countries (see Figure 3.13). This may in part be due to the high costs of the new medications.

FIGURE 3.13

Availability of hepatitis C virus testing and treatment (expert ratings, 2013)

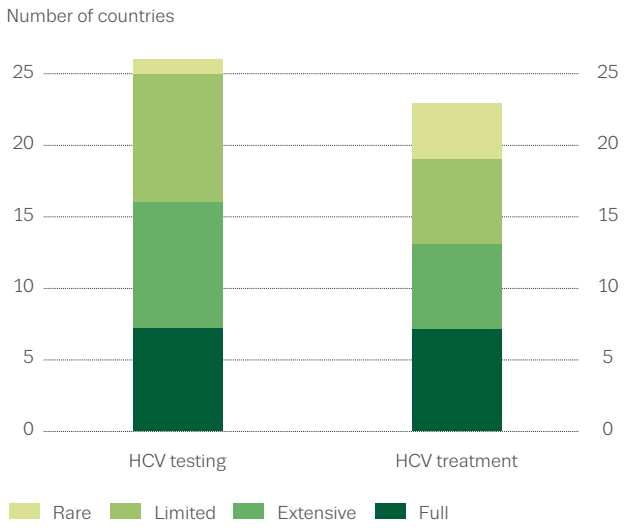
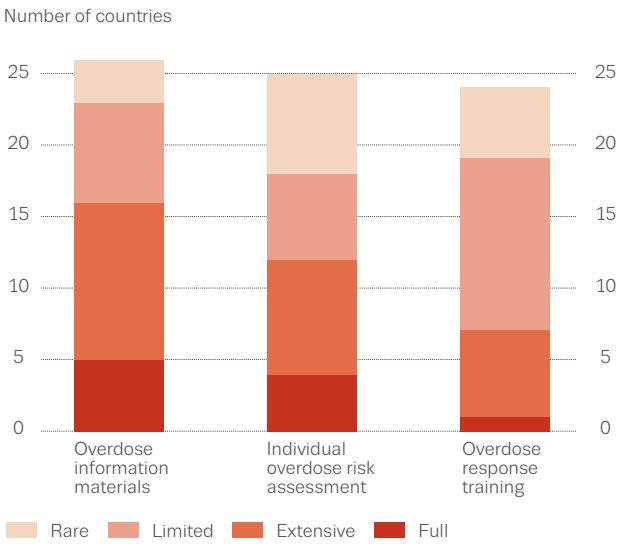


FIGURE 3.14

Availability of responses to drug-induced deaths (expert ratings, 2013)



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.

Among a selection of interventions targeting drug-related deaths, the provision of information and materials on overdose prevention is reported to be most widely available (Figure 3.14). Training in responding to overdoses, including the distribution of the opioid antagonist drug naloxone, can save lives in overdose situations. However, this form of response is less commonly available. New WHO guidelines strongly recommend that people who are likely to witness an overdose should have access to naloxone and be instructed in its administration to enable them to use it for the emergency management of suspected opioid overdose. Naloxone schemes currently exist in seven countries, with schemes established in recent years in Denmark, Estonia and Norway, countries where overdose rates are high. A recent study from Scotland (UK) showed that increased provision of naloxone kits to 'at risk' prisoners on liberation coincided with a significant reduction in opioid-related deaths occurring in the first four weeks after prison release.

One of the aims of supervised drug consumption facilities is to reduce the occurrence of overdose and to increase the chance of survival should one occur. Six countries currently provide such facilities — around 70 in total. In recent years, a number of facilities have been closed due to falling demand.

Prison health: a comprehensive response required

Prisoners report higher lifetime rates of drug use than the general population and more harmful patterns of use, illustrated by recent studies showing that between 6 % and 31 % of prisoners have ever injected drugs. On admission to prison, most users reduce or cease consumption of drugs. Illicit drugs do, however, find their way into many prisons, and some prisoners continue or even initiate use

Drug treatment, particularly opioid substitution treatment, prevents overdoses and reduces the mortality risk of drug users

during incarceration. High rates of hepatitis C and other infectious diseases have also been observed among prisoner populations. The high incidence of drug problems among prisoners means that health assessment upon prison entry is an important intervention. The WHO have recently recommended that a package of prevention responses, including free and voluntary testing for infectious diseases, distribution of condoms and sterile injecting equipment, infectious diseases treatment and treatment of drug dependence is made available.

Many 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, potentially facilitating greater integration with general health service provision in the community.

The availability of opioid substitution treatment in prisons is reported by 26 of the 30 countries monitored by the EMCDDA, although no activities were reported in three of these countries in 2013. Overall, it appears that the level of coverage of prisoner populations is increasing, reflecting the widespread availability of this intervention in the community. Restrictions on eligibility may exist however, for example in the Czech Republic and Latvia, treatment in prison is limited to those already having a prescription prior to incarceration. The provision of clean injecting equipment is less common, with only four countries reporting its availability in prisons.

The high incidence of drug problems among prisoners means that health assessment upon prison entry is an important intervention

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Annex

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

TABLE A1

OPIOIDS

	Problem opioid use estimate	Treatment demand indicator, primary drug						Clients in substi-tution treatment
		Opioid clients as % of treatment entrants			% opioid clients injecting (main route of administration)			
		All entrants	First-time entrants	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants	
Country	cases per 1 000	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	count
Belgium	–	30.8 (2 816)	13 (416)	39 (2 024)	20.1 (547)	14.1 (57)	21.5 (420)	17 482
Bulgaria	–	88.8 (1 744)	79.3 (211)	95.2 (954)	73.8 (876)	68.8 (141)	74.4 (585)	3 563
Czech Republic	1.5–1.5	17.2 (1 681)	7.8 (362)	25.6 (1 319)	89.4 (1 493)	86.9 (312)	90.1 (1 181)	3 500
Denmark	–	17.5 (663)	7.1 (102)	26.3 (502)	23 (20)	33.9 (193)	–	7 600
Germany	2.8–3.4	37.1 (29 891)	13.7 (3 217)	–	–	–	–	77 300
Estonia	–	92.9 (403)	81 (102)	98.6 (284)	84.8 (339)	90.2 (92)	83 (235)	1 166
Ireland	–	51.3 (4 451)	29.7 (1 032)	66.8 (3 291)	41.3 (1 762)	33.7 (344)	43.6 (1 362)	9 640
Greece	2.0–2.6	69.3 (3 367)	54.9 (1 145)	80 (2 194)	36.8 (1 227)	32.8 (372)	39.1 (850)	9 973
Spain	1.7–2.6	26.8 (13 333)	11.4 (2 866)	43.7 (10 050)	17.8 (2 195)	11 (295)	19.6 (1 859)	69 111
France	–	43.1 (15 641)	27.1 (2 690)	53.5 (11 275)	14.2 (1 836)	6.8 (172)	–	163 000
Croatia	3.2–4.0	80.4 (6 315)	24 (270)	90 (5 992)	73.7 (4 581)	42.6 (104)	75.1 (4 446)	6 357
Italy	3.8–4.9	54.7 (18 072)	37.2 (4 782)	65.7 (13 290)	57 (9 678)	44.4 (1 906)	61.3 (7 772)	94 376
Cyprus	1.2–2.1	26.5 (270)	7.7 (37)	43.8 (232)	48.1 (126)	40 (14)	49.3 (112)	180
Latvia	4.1–9.7	52.1 (783)	19.7 (104)	69.6 (679)	63.7 (495)	84.6 (88)	60.5 (407)	328
Lithuania	2.3–2.4	86.8 (1 918)	62.8 (214)	91.9 (1 671)	–	100 (140)	–	592
Luxembourg	5.0–7.6	50.2 (145)	42.1 (8)	49.8 (116)	48.2 (68)	28.6 (2)	47 (54)	1 254
Hungary	0.4–0.5	5.9 (236)	2.1 (54)	13.6 (160)	70.1 (157)	60.4 (32)	71.8 (112)	786
Malta	6.5–7.7	74.8 (1 352)	33.7 (67)	79.9 (1 285)	61.8 (816)	54.2 (32)	62.2 (784)	1 078
Netherlands	1.1–1.5	10.2 (1 195)	5.1 (343)	17 (852)	4.6 (51)	5.4 (16)	4.3 (35)	8 185
Austria	4.9–5.1	52 (1 537)	29.5 (361)	67.9 (1 176)	43.4 (536)	31.1 (100)	47.8 (436)	24 027
Poland	0.4–0.7	26.4 (724)	8.2 (91)	39.3 (621)	58 (391)	43.4 (36)	60.3 (349)	1 725
Portugal	–	54.3 (1 634)	27.3 (380)	77.6 (1 254)	15.9 (238)	11.2 (38)	17.3 (200)	16 858
Romania	–	48.8 (802)	33.6 (240)	63.3 (543)	84.5 (622)	84.8 (189)	84.8 (420)	387
Slovenia	4.3–5.8	81.5 (234)	60.6 (57)	91.7 (176)	48.7 (113)	36.8 (21)	52.3 (91)	4 065
Slovakia	1.0–2.5	24.7 (558)	16 (185)	34.1 (363)	66.8 (367)	48.4 (89)	76.4 (272)	408
Finland	3.8–4.5	64.2 (706)	40.4 (65)	69.2 (619)	81.6 (567)	73 (46)	82.5 (504)	2 439
Sweden	–	27.3 (7 760)	17.2 (2 211)	35.7 (5 549)	59.6 (140)	33.3 (11)	63.9 (129)	3 425
United Kingdom	7.9–8.4	50.3 (49 871)	19.7 (6 813)	66.6 (42 636)	34.5 (16 871)	22.5 (1 484)	36.3 (15 191)	172 513
Turkey	0.2–0.5	76.3 (5 542)	68 (2 540)	85.1 (3 002)	39.7 (2 201)	29.3 (745)	48.5 (1 456)	28 656
Norway	1.9–3.1	26.9 (2 266)	–	–	–	–	–	7 055
European Union	**–**	**41 (168 102)**	**18.7 (28 425)**	**57.1 (109 107)**	**38.2 (46 285)**	**28.4 (6 153)**	**43.3 (37 806)**	701 449
EU, Turkey and Norway	**–**	**41.3 (175 910)**	**19.9 (30 965)**	**57.6 (112 109)**	**30.4 (48 486)**	**28.5 (6 898)**	**43.5 (39 262)**	737 160

Year and method of estimate for problem opioid use vary between countries.
The treatment demand indicator monitors entrants into treatment within a given year.

TABLE A2

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	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants
Country	%	%	%	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)
Belgium	–	2.0	2	15.6 (1 430)	15.2 (488)	15.9 (825)	6 (83)	1.3 (6)	7.1 (57)
Bulgaria	0.9	0.3	4	0 (0)	2.6 (7)	0.3 (3)	0 (0)	0 (0)	0 (0)
Czech Republic	0.4	0.3	1	0.2 (19)	0.3 (12)	0.1 (7)	11.1 (2)	16.7 (2)	0 (0)
Denmark	5.2	2.4	2	5.1 (193)	5.8 (84)	5.2 (99)	10.1 (17)	0 (0)	–
Germany	3.4	1.6	3	5.9 (4 788)	5.6 (1 322)	–	–	–	–
Estonia	–	1.3	2	0 (0)	0 (0)	0 (0)	–	–	–
Ireland	6.8	2.8	3	7.8 (680)	9.2 (320)	6.6 (324)	1.7 (11)	0.3 (1)	2.9 (9)
Greece	0.7	0.2	1	5.1 (250)	5.9 (122)	4.6 (127)	19.8 (49)	12.4 (15)	27 (34)
Spain	10.3	3.3	3	39.2 (19 497)	40.2 (10 142)	38.5 (8 855)	2 (365)	1 (95)	3 (260)
France	5.4	2.3	4	6.4 (2 311)	4.1 (411)	7.5 (1 573)	9.9 (192)	4.1 (16)	–
Croatia	2.3	0.9	2	1.5 (119)	2.6 (29)	1.3 (84)	0.9 (1)	0 (0)	1.2 (1)
Italy	4.2	1.3	1	25.8 (8 529)	31.4 (4 037)	22.2 (4 492)	3.5 (289)	2.9 (114)	4 (175)
Cyprus	1.3	0.6	4	12.2 (124)	9.3 (45)	14.7 (78)	5.8 (7)	0 (0)	9.3 (7)
Latvia	1.5	0.3	4	0.3 (5)	0.8 (4)	0.1 (1)	0 (0)	0 (0)	0 (0)
Lithuania	0.9	0.3	2	0.6 (14)	1.8 (6)	0.3 (5)	–	–	–
Luxembourg	–	–	–	17.3 (50)	10.5 (2)	18 (42)	39.1 (18)	–	39 (16)
Hungary	0.9	0.4	2	2 (81)	2.4 (60)	1.4 (17)	8.9 (7)	8.3 (5)	5.9 (1)
Malta	0.5	–	4	14.4 (260)	32.2 (64)	12.2 (196)	25.6 (65)	11.3 (7)	30.2 (58)
Netherlands	5.2	2.4	2	26.5 (3 113)	22.2 (1 494)	32.3 (1 619)	0.3 (8)	0.3 (4)	0.3 (4)
Austria	2.2	1.2	–	10.2 (301)	11.8 (145)	9 (156)	7.6 (18)	2.7 (3)	12.2 (15)
Poland	0.9	0.3	3	2.4 (67)	1.9 (21)	2.8 (44)	6.3 (4)	4.8 (1)	7.3 (3)
Portugal	1.2	0.4	4	12.9 (388)	17.2 (239)	9.2 (149)	4.1 (14)	1.9 (4)	7.7 (10)
Romania	0.3	0.2	2	0.7 (11)	1.3 (9)	0.2 (2)	–	–	–
Slovenia	2.1	1.2	3	3.5 (10)	6.4 (6)	2.1 (4)	30 (3)	16.7 (1)	50 (2)
Slovakia	0.6	0.4	1	0.6 (13)	0.4 (5)	0.8 (8)	8.3 (1)	0 (0)	14.3 (1)
Finland	1.7	0.6	1	0.1 (1)	0 (0)	0 (0)	100 (1)	–	–
Sweden	–	1.2	1	0.8 (236)	1.2 (151)	0.5 (85)	6.3 (2)	0 (0)	18.2 (2)
United Kingdom	9.5	4.2	2	12.9 (12 756)	17.1 (5 888)	10.7 (6 851)	1.7 (204)	0.5 (29)	2.6 (175)
Turkey	–	–	–	1.1 (81)	1.1 (41)	1.1 (40)	0 (0)	0 (0)	0 (0)
Norway	4.2	2.2	1	0.9 (79)	–	–	–	–	–
European Union	**4.6**	**1.9**	**–**	**13.5 (55 246)**	**16.5 (25 113)**	**13.4 (25 646)**	**2.8 (1 361)**	**1.3 (303)**	**3.6 (830)**
EU, Turkey and Norway	**–**	**–**	**–**	**13 (55 406)**	**16.2 (25 154)**	**13.2 (25 686)**	**2.8 (1 361)**	**1.3 (303)**	**3.6 (830)**

Prevalence estimates for the general population are derived from representative national surveys. The year and method of survey varies by country.
Prevalence estimates for the school population are taken from national school surveys or the ESPAD project.

TABLE A3

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	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants
Country	%	%	%	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)
Belgium	–	–	2	10.1 (925)	9.1 (292)	11 (574)	13.3 (118)	5.3 (15)	17.7 (97)
Bulgaria	1.2	1.3	5	4.7 (93)	10.9 (29)	1.8 (18)	0 (0)	0 (0)	0 (0)
Czech Republic	1.1	0.7	2	70.3 (6 865)	74.2 (3 431)	66.7 (3 434)	78.6 (5 365)	72.6 (2 473)	84.5 (2 892)
Denmark	6.6	1.4	2	9.5 (358)	10.3 (149)	8.9 (170)	3.1 (9)	0 (0)	–
Germany	3.1	1.8	4	14.9 (12 026)	18.7 (4 365)	–	–	–	–
Estonia	–	2.5	3	3 (13)	5.6 (7)	1.4 (4)	76.9 (10)	57.1 (4)	100 (4)
Ireland	4.5	0.8	2	0.6 (52)	0.9 (32)	0.4 (18)	5.9 (3)	9.7 (3)	0 (0)
Greece	0.1	0.1	2	0.2 (12)	0.3 (7)	0.2 (5)	0 (0)	0 (0)	0 (0)
Spain	3.8	1.2	2	1 (512)	1.2 (307)	0.8 (186)	0.6 (3)	0.7 (2)	0.6 (1)
France	2.2	0.7	4	0.3 (98)	0.2 (22)	0.3 (60)	22.5 (18)	15.8 (3)	–
Croatia	2.6	1.6	1	0.9 (69)	2 (22)	0.7 (46)	0 (0)	0 (0)	0 (0)
Italy	1.8	0.1	1	0.2 (51)	0.3 (37)	0.1 (14)	2 (1)	2.9 (1)	0 (0)
Cyprus	0.7	0.4	4	2.6 (26)	1.7 (8)	3.4 (18)	7.7 (2)	0 (0)	11.1 (2)
Latvia	2.2	0.6	4	15.1 (227)	21 (111)	11.9 (116)	68.2 (152)	64.2 (70)	71.9 (82)
Lithuania	1.2	0.5	3	3.4 (76)	10 (34)	1.9 (34)	–	–	–
Luxembourg	–	–	–	0 (0)	0 (0)	0 (0)	–	–	–
Hungary	1.8	1.2	6	11.6 (461)	11.6 (297)	11 (130)	15.3 (68)	11.3 (33)	24.2 (30)
Malta	0.3	–	3	0.2 (4)	0 (0)	0.2 (4)	25 (1)	-	25 (1)
Netherlands	3.1	–	1	6.5 (760)	6.6 (445)	6.3 (315)	0.6 (4)	0.5 (2)	0.7 (2)
Austria	2.5	0.9	–	3.4 (102)	4.7 (58)	2.5 (44)	1.2 (1)	2 (1)	0 (0)
Poland	2.9	1.4	4	25.9 (711)	25.8 (287)	26.5 (419)	10.8 (76)	3.9 (11)	15.7 (65)
Portugal	0.5	0.1	3	0.1 (2)	0.1 (1)	0.1 (1)	0 (0)	0 (0)	–
Romania	0.1	0.0	2	0.5 (8)	1 (7)	0 (0)	–	–	–
Slovenia	0.9	0.8	2	0.7 (2)	1.1 (1)	0.5 (1)	–	–	–
Slovakia	0.5	0.3	1	43.2 (978)	46.4 (535)	39.9 (425)	31.8 (300)	27.1 (142)	38 (154)
Finland	2.3	1.6	–	11 (121)	11.8 (19)	10.8 (97)	76.7 (89)	52.6 (10)	81.9 (77)
Sweden	–	1.3	0	0.4 (112)	0 (6)	0.7 (105)	78.3 (83)	80 (4)	78 (78)
United Kingdom	11.1	1.5	1	2.7 (2 725)	3.1 (1 058)	2.6 (1 656)	24 (607)	13 (125)	31.1 (482)
Turkey	0.1	0.1	2	0 (0)	0 (0)	0 (0)	–	–	–
Norway	3.7	1.1	1	13.1 (1 104)	–	–	–	–	–
European Union	**3.5**	**1.0**	**–**	**6.7 (27 389)**	**7.6 (11 567)**	**4.1 (7 894)**	**47 (6 910)**	**41.9 (2 899)**	**53.6 (3 967)**
EU, Turkey and Norway	**–**	**–**	**–**	**6.7 (28 493)**	**7.4 (11 567)**	**4.1 (7 894)**	**47 (6 910)**	**41.9 (2 899)**	**53.6 (3 967)**

TABLE A4

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	Previously treated entrants
Country	%	%	%	% (count)	% (count)	% (count)
Belgium	–	–	2	0.5 (43)	0.7 (23)	0.4 (19)
Bulgaria	2.0	2.9	4	0.1 (1)	0 (0)	0.1 (1)
Czech Republic	5.1	3.0	3	0.1 (8)	0.1 (4)	0.1 (4)
Denmark	2.3	0.7	1	0.3 (13)	0.5 (7)	0.3 (5)
Germany	2.7	0.9	2	–	–	–
Estonia	–	2.3	3	0 (0)	0 (0)	0 (0)
Ireland	6.9	0.9	2	0.5 (43)	0.8 (27)	0.3 (16)
Greece	0.4	0.4	2	0.2 (8)	0.2 (5)	0.1 (3)
Spain	4.3	1.5	2	0.3 (134)	0.4 (103)	0.1 (29)
France	4.2	2.3	3	0.5 (186)	0.2 (22)	0.6 (122)
Croatia	2.5	0.5	2	0.3 (27)	0.6 (7)	0.3 (19)
Italy	1.8	0.1	1	0.2 (55)	0.2 (23)	0.2 (32)
Cyprus	0.9	0.3	3	0.1 (1)	0 (0)	0.2 (1)
Latvia	2.7	0.8	4	0.2 (3)	0.4 (2)	0.1 (1)
Lithuania	1.3	0.3	2	0 (1)	0 (0)	0.1 (1)
Luxembourg	–	–	–	0.3 (1)	0 (0)	0.4 (1)
Hungary	2.4	1.0	4	1.7 (69)	1.7 (43)	2 (23)
Malta	0.7	–	3	1.2 (22)	3.5 (7)	0.9 (15)
Netherlands	6.2	3.1	4	0.6 (67)	0.8 (55)	0.2 (12)
Austria	2.3	1.0	–	0.8 (23)	1.1 (13)	0.6 (10)
Poland	1.1	0.3	2	0.2 (6)	0.1 (1)	0.3 (5)
Portugal	1.3	0.6	3	0.2 (5)	0.4 (5)	0 (0)
Romania	0.7	0.4	2	0.1 (1)	0.1 (1)	0 (0)
Slovenia	2.1	0.8	2	0 (0)	0 (0)	0 (0)
Slovakia	1.9	0.9	0	0.1 (2)	0.1 (1)	0.1 (1)
Finland	1.8	1.1	2	0.3 (3)	0.6 (1)	0.2 (2)
Sweden	–	1.0	1	0 (3)	0 (1)	0 (1)
United Kingdom	9.3	3.0	2	0.3 (325)	0.7 (232)	0.1 (92)
Turkey	0.1	0.1	2	0.8 (55)	1.1 (41)	0.4 (14)
Norway	2.3	1.0	1	0 (0)	–	–
European Union	**3.6**	**1.4**	**–**	**0.3 (1 050)**	**0.4 (583)**	**0.2 (415)**
EU, Turkey and Norway	**–**	**–**	**–**	**0.3 (1 105)**	**0.4 (624)**	**0.2 (429)**

TABLE A5

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	Previously treated entrants
Country	%	%	%	% (count)	% (count)	% (count)
Belgium	14.3	11.2	21	33.6 (3 077)	54.3 (1 744)	23.1 (1 201)
Bulgaria	7.5	8.3	22	3.9 (77)	4.5 (12)	1.8 (18)
Czech Republic	22.8	21.6	42	11 (1 077)	16.5 (763)	6.1 (314)
Denmark	35.6	17.6	18	63.4 (2 397)	72.6 (1 048)	55.5 (1 061)
Germany	23.1	11.1	19	36.3 (29 252)	56.1 (13 138)	–
Estonia	–	13.6	24	3.7 (16)	12.7 (16)	0 (0)
Ireland	25.3	10.3	18	28.9 (2 511)	47 (1 631)	16 (790)
Greece	8.9	3.2	8	21.5 (1 045)	35.4 (737)	11 (302)
Spain	30.4	17.0	28	29.9 (14 869)	43.6 (10 982)	14.8 (3 402)
France	40.9	22.1	39	44.1 (16 020)	62.5 (6 206)	32.3 (6 804)
Croatia	15.6	10.5	18	13.3 (1 047)	58.4 (658)	5.7 (381)
Italy	21.7	8.0	16	17.4 (5 766)	28 (3 593)	10.7 (2 173)
Cyprus	9.9	4.2	7	56.8 (579)	80.5 (388)	35.3 (187)
Latvia	12.5	7.3	24	27.3 (411)	51.4 (272)	14.3 (139)
Lithuania	10.5	5.1	20	2.9 (65)	11.7 (40)	1.3 (23)
Luxembourg	–	–	–	31.1 (90)	47.4 (9)	30.5 (71)
Hungary	8.5	5.7	19	61 (2 429)	70 (1 787)	43.4 (511)
Malta	4.3	–	10	7.9 (142)	25.1 (50)	5.7 (92)
Netherlands	25.7	13.7	27	47.8 (5 613)	56.7 (3 826)	35.7 (1 787)
Austria	14.2	6.6	14	30 (887)	50.6 (620)	15.4 (267)
Poland	12.2	8.1	23	33.4 (914)	51.6 (575)	20.3 (321)
Portugal	9.4	5.1	16	26.8 (806)	48.4 (674)	8.2 (132)
Romania	1.6	0.6	7	17 (279)	27.3 (195)	7.9 (68)
Slovenia	15.8	10.3	23	12.5 (36)	31.9 (30)	3.1 (6)
Slovakia	10.5	7.3	16	24.6 (557)	32 (369)	16.6 (177)
Finland	18.3	11.2	12	14.6 (161)	34.2 (55)	10.8 (97)
Sweden	–	7.1	5	13.2 (3 763)	22.4 (2 881)	5.7 (882)
United Kingdom	29.9	11.2	22	26.8 (26 618)	48.6 (16 775)	15.3 (9 771)
Turkey	0.7	0.4	4	12.7 (920)	17.5 (653)	7.6 (267)
Norway	23.3	12.0	5	20.3 (1 705)	–	–
European Union	**23.3**	**11.7**	**–**	**29.4 (120 504)**	**45.5 (69 074)**	**16.2 (30 977)**
EU, Turkey and Norway	**–**	**–**	**–**	**28.9 (123 129)**	**44.8 (69 727)**	**16.1 (31 244)**

TABLE A6

OTHER INDICATORS

Country	Drug-induced deaths (aged 15–64) cases per million population (count)	HIV diagnoses attributed to injecting drug use cases per million population (count)	Injecting drug use estimate cases per 1 000 population	Syringes distributed through specialised programmes count
Belgium	10.5 (77)	1.5 (17)	2.5–4.8	907 504
Bulgaria	4.3 (21)	4.5 (33)	–	431 568
Czech Republic	5.1 (37)	0.6 (6)	5.9–6.0	6 181 134
Denmark	60 (218)	2.3 (13)	–	–
Germany	17.6 (956)	1.2 (100)	–	–
Estonia	126.8 (111)	54.5 (72)	4.3–10.8	2 183 933
Ireland	58.5 (177)	3.9 (18)	–	360 041
Greece	–	22.4 (248)	0.6–0.9	429 517
Spain	12.2 (383)	3.1 (145)	0.3–0.4	2 684 251
France	6.8 (283)	1 (67)	–	–
Croatia	16.8 (48)	0 (0)	0.3–0.6	273 972
Italy	8.9 (343)	2.7 (162)	–	–
Cyprus	4.9 (3)	0 (0)	0.2–0.5	0
Latvia	8.1 (11)	38 (77)	7.3–11.7	341 421
Lithuania	27.1 (54)	20.9 (62)	–	168 943
Luxembourg	29.7 (11)	9.3 (5)	4.5–6.9	191 983
Hungary	4.6 (31)	0.1 (1)	0.8	435 817
Malta	10.4 (3)	7.1 (3)	–	357 691
Netherlands	10.2 (113)	0.3 (5)	0.2–0.2	–
Austria	24.2 (138)	2.5 (21)	–	4 762 999
Poland	7.6 (207)	1 (39)	–	–
Portugal	3.0 (21)	7.4 (78)	–	950 652
Romania	2.2 (30)	7.4 (149)	–	2 051 770
Slovenia	19.9 (28)	1 (2)	–	513 272
Slovakia	6.5 (25)	0 (0)	–	321 339
Finland	54.3 (191)	0.6 (3)	4.1–6.7	3 834 262
Sweden	69.7 (426)	0.8 (8)	–	229 362
United Kingdom	44.6 (1 858)	1.8 (112)	2.9–3.2	9 457 256 (1)
Turkey	4.4 (224)	0.1 (4)	–	–
Norway	69.6 (232)	1.6 (8)	2.2–3.0	3 011 000
European Union	**17.3 (5 804)**	**2.9 (1 446)**	**–**	**–**
EU, Turkey and Norway	**16 (6 260)**	**2.5 (1 458)**	**–**	**–**

Injecting drug use estimates are derived by indirect methods, with year of estimate varying between countries.
(1) Data refer to Scotland and Wales (2013) and Northern Ireland (2012).

TABLE A7

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	1 182	2 431	6 486	3 653	216	3 085	37 152 (–)	1 338
Bulgaria	157	32	20	–	193	8	4 169 (29)	–
Czech Republic	5	38	36	106	70	495	5 061 (0.04)	114
Denmark	14	461	681	2 286	341	2 167	7 706 (–)	590
Germany	270	3 065	1 315	3 622	1 339	12 801	480 839 (–)	2 233
Estonia	0	2	2	47	28	290	3 341 (0.2)	92
Ireland	61	690	66	366	23	114	465 083 (–)	464
Greece	235	2 158	706	437	16	81	34 579 (0.4)	47
Spain	291	6 502	26 701	38 033	497	3 471	154 732 (–)	2 301
France	570	–	5 612	–	501	–	414 800 (–)	–
Croatia	10	167	9	171	13	414	0 (0.9)	170
Italy	882	2 560	4 966	6 031	103	128	4 713 (17)	136
Cyprus	0.7	16	3	105	1	38	504 (0.1)	14
Latvia	0.7	288	1	34	46	744	60 (0.003)	18
Lithuania	13	100	3	12	71	97	54 (0.5)	13
Luxembourg	4	127	1	103	5	6	13 (–)	3
Hungary	6	32	8	117	75	586	17 664 (2)	181
Malta	1	51	4	115	0	3	30 375 (–)	45
Netherlands (1)	750	–	10 000	–	681	–	–	–
Austria	80	346	25	992	29	859	5 768 (–)	119
Poland	49	–	21	–	685	–	45 997 (–)	–
Portugal	55	792	2 440	1 108	5	48	2 160 (1)	80
Romania	112	273	53	75	0	42	27 506 (0.04)	142
Slovenia	7	339	3	196	16	273	922 (0.9)	53
Slovakia	0.2	73	1	23	4	634	47 (–)	17
Finland	0.2	113	5	205	91	3 149	121 600 (–)	795
Sweden	6	485	81	1 452	677	4 541	26 919 (16)	743
United Kingdom (1)	831	10 648	3 324	18 569	1 491	6 515	1 173 100 (–)	3 716
Turkey	13 480	6 096	450	863	1 242	132	4 441 217 (–)	4 274
Norway	55	1 192	188	1 086	514	7 229	7 298 (3)	411
European Union	**5 593**	**31 789**	**62 573**	**77 858**	**7 217**	**40 589**	**3 064 864 (68)**	**13 424**
EU, Turkey and Norway	**19 128**	**39 077**	**63 211**	**79 807**	**8 973**	**47 950**	**7 513 379 (71)**	**18 109**

Amphetamines includes amphetamine and methamphetamine.
(1) Seizures data refer to 2012.

TABLE A7

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	4 275	5 529	14 882	23 900	396 758 (–)	1 212
Bulgaria	5	9	579	69	18 126 (24)	11
Czech Republic	1	28	735	875	73 639 (–)	361
Denmark	3 292	11 030	394	1 896	– (5634)	645
Germany	1 770	5 638	4 827	28 875	107 766 (–)	2 026
Estonia	109	24	51	524	– (16)	42
Ireland	677	367	1 102	1 770	6 309 (–)	427
Greece	8	143	20 942	6 743	23 008 (0)	599
Spain	319 257	180 342	16 298	172 341	176 879 (–)	2 305
France	70 918	–	4 758	–	141 374 (–)	–
Croatia	5	359	1 047	4 171	3 957 (–)	213
Italy	36 347	5 261	28 821	5 701	894 862 (–)	1 227
Cyprus	1	16	99	849	403 (–)	62
Latvia	106	28	29	412	– (344)	31
Lithuania	1 088	11	124	199	– (–)	–
Luxembourg	8	81	11	832	8 (–)	6
Hungary	5	103	863	2 040	5 307 (–)	196
Malta	1	71	10	85	27 (–)	3
Netherlands (1)	2 200	–	12 600	–	1 218 000 (–)	–
Austria	130	1 512	1 432	8 270	– (196)	327
Poland	208	–	1 243	–	69 285 (–)	–
Portugal	8 681	3 087	96	559	8 462 (–)	354
Romania	25	284	165	1 799	8 835 (110)	79
Slovenia	0.5	73	810	3 673	9 515 (–)	212
Slovakia	0.0	21	81	1 307	1 039 (–)	32
Finland	122	1 467	285	6 167	23 000 (63)	3 409
Sweden	1 160	6 937	928	9 221	– (–)	–
United Kingdom (1)	13 432	17 360	13 243	148 746	555 625 (–)	15 846
Turkey	94 279	5 331	180 101	60 742	– (–)	3 706
Norway	2 283	11 875	491	5 444	– (159)	386
European Union	**463 831**	**239 781**	**126 455**	**431 024**	**3 742 184 (6 387)**	**29 625**
EU, Turkey and Norway	**560 393**	**256 987**	**307 047**	**497 210**	**3 742 184 (6 546)**	**33 717**

(1) Seizures data refer to 2012, apart from the number of cannabis plants seized in the Netherlands, which refers to 2013.

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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 Statistical Bulletin, Country Overviews and Perspectives on Drugs, it makes up the 2015 European Drug Report package.

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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.

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