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1. **Number of New Psychoactive Substances Continues to Grow**
"By the end of December 2017, the EMCDDA was monitoring more than 670 new substances that have appeared on Europe's drug market over the past 20 years. This total includes 51 substances that were reported for the first time during 2017

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(Figure 1), namely 13 opioids, 12 cathinones, 10 cannabinoids, 4 phenethylamines, 3 benzodiazepines, 2 tryptamines, 1 arylcyclohexylamine, 1 arylalkylamine, 1 piperidine/pyrrolidine and 4 substances that do not belong to these other groups. This was the second year in a row when the number of new substances reported for the first time has decreased, from a high of around 100 substances in 2014 and 2015 to around 50 to 60 substances per year (roughly one new substance every week). It also marked the first time when the new opioids were the single largest group of new substances to appear on the drug market in any one year — a position that has previously been dominated by the cannabinoids and cathinones. With 38 substances overall, 2017 saw the opioids become the fourth largest group of substances monitored, after synthetic cannabinoids (179 substances), cathinones (130) and phenethylamines (94) and not including the miscellaneous category 'other substances'."

European Monitoring Centre for Drugs and Drug Addiction (2018), Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation. An update from the EU Early Warning System (June 2018), Publications Office of the European Union, Luxembourg.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/sy...

2. Prevalence of Substance Use in the European Union
"More than 92 million or just over a quarter of 15- to 64-year-olds in the European Union are estimated to have tried illicit drugs during their lives. Experience of drug use is more frequently reported by males (56.0 million) than females (36.3 million). The most commonly tried drug is cannabis (53.5 million males and 34.3 million females), with much lower estimates reported for the lifetime use of cocaine (11.8 million males and 5.2 million females), MDMA (9.0 million males and 4.5 million females) and amphetamines (8.0 million males and 4.0 million females). Levels of lifetime use of cannabis differ considerably between countries, ranging from around 41 % of adults in France to less than 5 % in Malta.

"Last year drug use provides a measure of recent drug use and is largely concentrated among young adults. An estimated 18.9 million young adults (aged 15–34) used drugs in the last year, with twice as many males as females reporting doing so."

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European Monitoring Centre for Drugs and Drug Addiction (2018), European Drug Report 2018: Trends and Developments, Publications Office of the European Union, Luxembourg.
http://www.emcdda.europa.eu/ed...
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3. Estimated Prevalence of Illegal Substance Use by People Aged 15-64 in Several EU Nations
Click here for complete datatable of Estimated Prevalence of Illegal Substance Use by People Aged 15-64 in Several EU Nations

European Monitoring Centre on Drugs and Drug Addiction, "Statistical Bulletin 2013. Table GPS-2 General Population Surveys: Data Tables" (Lisbon, Portugal: EMCDDA, 2013).
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/st...
http://www.emcdda.europa.eu/...

4. Impact of National Policies on Drug Use Prevalence in the EU
"Differences in the prevalence of drug use are influenced by a variety of factors in each country. As countries with more liberal drug policies (such as the Netherlands) and those with a more restricted approach (such as Sweden) have not very different prevalence rates, the impact of national drug policies (more liberal versus more restrictive approaches) on the prevalence of drug use and especially problem drug use remains unclear. However, comprehensive national drug policies are of high importance in reducing adverse consequences of problem drug use such as HIV infections, hepatitis B and C and overdose deaths."

European Monitoring Center for Drugs and Drug Addiction, "2001 Annual Report on the State of the Drugs Problem in the European Union" (Brussells, Belgium: Office for Official Publications of the European Communities, 2001), p. 12.
http://www.emcdda.europa.eu/at...

5. Prevalence of Cannabis Use Among Young People in the European Union

"The most prevalent illicit drug in all ESPAD countries is cannabis. On average, 16 % of the students have used cannabis at least once in their lifetime (Table 7a). The country with the highest prevalence of cannabis use was the Czech Republic (37 %). High prevalence rates (30% or more) were also reported in France, Liechtenstein and Monaco. The lowest levels of cannabis use (4-7%) were reported in Albania, Cyprus, the Faroes, the former Yugoslav Republic of Macedonia, Iceland, Moldova, Norway and Sweden. On average, boys reported cannabis use to a larger extent than girls (19 % versus 14 %). This was the case in nearly all countries except the Czech Republic, the Faroes, Hungary, Iceland, Malta, Slovenia and Sweden, where rates were about the same for boys and girls. The largest gender differences (10 percentage points or more, higher rates among boys) were found in Albania, Georgia and Liechtenstein."

The ESPAD Group. ESPAD Report 2015: Results from the European School Survey Project on Alcohol and Other Drugs. (2016). European Monitoring Centre on Drugs and Drug Addiction (EMCDDA). Luxembourg: Publications Office of the European Union. Page 39. PDF ISBN 978-92-9168-919-4 doi: 10.2810/86718
http://www.espad.org/sites/esp...
http://www.espad.org/report/home

6. Opioids Do Not Have Potential To Cause Malformations To An Embryo Or Fetus
"It is important to note that, contrary to alcohol, benzodiazepines and nicotine, opioids do not have teratogenic potential (3). Thus, special attention needs to be paid to dependence and abuse of legal substances and prescription drugs that can have severe consequences for the foetus and newborn, such as foetal developmental disorders or sudden infant death syndrome (Fetal Alcohol Spectrum Disorders Center for Excellence, 2013; McDonnell-Naughton et al., 2012)."

European Monitoring Centre for Drugs and Drug Addiction, "Pregnancy and opioid use: strategies for treatment," EMCDDA Papers (Publications Office of the European Union: Luxembourg, 2014), p. 3.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

- Hungary
- Ireland
- Mexico
- Netherlands
- Norway
- Portugal
- Russian Federation
- Scotland
- Spain
- Sweden
- Switzerland
- United Kingdom

7. **Ninety Officially Sanctioned Drug Consumption Rooms in Operation in the EU and Switzerland**

"In terms of the historical development of this intervention, the first supervised drug consumption room was opened in Berne, Switzerland in June 1986. Further facilities of this type were established in subsequent years in Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece and France. A total of 78 official drug consumption facilities currently operate in seven EMCDDA reporting countries, following the opening of the first two drug consumption facilities in the framework of a 6-year trial in France in 2016. There are also 12 facilities in Switzerland (see 'Facts and figures')."

"Perspectives On Drugs: Drug consumption rooms: an overview of provision and evidence," European Monitoring Centre for Drugs and Drug Addiction, June 2017, p. 2, last accessed Nov. 8, 2017.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/sy...

8. **Drug Consumption Rooms in Operation Around the World**

"Breaking this down further, as of February 2017 there are: 31 facilities in 25 cities in the Netherlands; 24 in 15 cities in Germany; five in four cities in Denmark 13 in seven cities in Spain; two in two cities in Norway; two in two cities in France; and one in Luxembourg (Luxembourg is preparing to open a second facility in 2018); and 12 in eight cities in Switzerland. In Slovenia following a change in the penal code that created an enabling environment for the opening of supervised consumption facilities, a planned pilot project is pending. Following HIV outbreaks among people who inject drugs, discussions about the introduction of supervised drug consumption facilities are ongoing in Glasgow (Scotland) and Dublin (Ireland). A study to explore the feasibility of drug consumption facilities in five major cities in Belgium (Ghent, Antwerp, Brussels, Liège and Charleroi) was launched in 2016. Outside Europe there are two facilities in Vancouver (Canada) and one medically supervised injecting centre in Sydney (Australia)."

"Perspectives On Drugs: Drug consumption rooms: an overview of provision and evidence," European Monitoring Centre for Drugs and Drug Addiction, June 2017, p. 3, last accessed Nov. 8,

2017.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/sy...

9. Synthetic Cathinones
"Reflecting their use as legal replacements for cocaine, amphetamine and other controlled stimulants, there were more than 23 000 seizures of synthetic cathinones reported from across Europe in 2016 (Figure 3). These account for almost one-third of the total number of seizures of new substances over the year, and amounted to almost 1.9 tonnes, making synthetic cathinones the most commonly seized new psychoactive substances by quantity in 2016. The EMCDDA is currently monitoring 130 of these substances, including 14 that were reported for the first time in 2016 and 12 during 2017. Synthetic cathinones are generally found in powder form. The five most commonly seized cathinones in 2016 were alpha-PVP, 4-chloromethcathinone, 3-chloromethcathinone, 4-methyl-N,N-dimethylcathinone and 3-methylmethcathinone. The top five cathinones detected in powders were 4 chloromethcathinone (890 kg), 4-chloroethcathinone (247 kg), N-ethylhexedrone (186 kg), 3-methylmethcathinone (126 kg) and mexedrone (50 kg). In recent years, there have been indications of increasing interest in making synthetic cathinones in Europe, including seizures of precursors, equipment and illicit laboratories used to make mephedrone (which is now under international control), as well as 4-chloromethcathinone and 3-chloromethcathinone."

European Monitoring Centre for Drugs and Drug Addiction (2018), Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation. An update from the EU Early Warning System (June 2018), Publications Office of the European Union, Luxembourg.
http://www.emcdda.europa.eu/pu...
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10. New Benzodiazepines
"Reflecting consumer demand, the market in new benzodiazepines appears to have grown over the past few years. The EMCDDA is currently monitoring 23 of these substances, including six that were reported for the first time in 2016 and three during 2017. While the overall number of seizures

reported by law enforcement during 2016 decreased compared with 2015, the quantity reported increased. More than half a million tablets containing new benzodiazepines such as diclazepam, etizolam, flubromazolam, flunitrazolam and fonazepam were reported during 2016 — which was about 70 % more than in 2015. Some of these new benzodiazepines were sold as tablets, capsules or powders under their own names. In other cases, they were used to make fake versions of commonly prescribed benzodiazepine medicines, such as diazepam and alprazolam, and sold directly on the illicit drug market."

European Monitoring Centre for Drugs and Drug Addiction (2018), Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation. An update from the EU Early Warning System (June 2018), Publications Office of the European Union, Luxembourg.
http://www.emcdda.europa.eu/pu...
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11. Synthetic Opioids, Including Fentanyl
"With a total of 38 different opioids reported, the number of synthetic opioids has grown rapidly in Europe since the first substance was reported in 2009. In fact, most of these substances have been reported for the first time during the past two years, with 9 reported in 2016 and 13 during 2017. Although they play a small overall role in Europe's drug market, many of the new opioids are highly potent substances that pose a risk of life-threatening poisoning because an overdose can cause respiratory depression (slowing down of breathing), which can lead to respiratory arrest (stopping breathing) and death. The public health importance of this risk is reflected in the fact that most deaths involving illicit opioid use are caused by respiratory depression (White and Irvine, 1999). Of particular concern are the new fentanils. These substances currently dominate this group, with a total of 28 reported since they first appeared in 2012.

"Reflecting their small share of the market as well as their high potency, new opioids accounted for only around 2% of the total number of seizures of new substances and about 0.2% of the total quantity reported to the EU Early Warning System during 2016. New opioids are found mainly in powders but also in tablets and, since 2014, liquids. For the most part, seizures are dominated by fentanils. There were around 1,600 seizures of

new opioids reported by law enforcement during 2016, of which 70% were related to fentanils. These included 7.7 kg of powders (of which 60% contained fentanils), approximately 23,000 tablets (of which 13% contained fentanils) and 4.5 litres of liquids (of which fentanils accounted for 96% of the total). Some of these liquids are from seizures made by police and customs of nasal sprays, which appear to be growing in popularity as a way of using these substances."

European Monitoring Centre for Drugs and Drug Addiction (2018), Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation. An update from the EU Early Warning System (June 2018), Publications Office of the European Union, Luxembourg.
http://www.emcdda.europa.eu/pu...
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12. Growth of Fentanyl on the Illegal Market
"Alongside their legitimate uses as medicines and in research, the fentanils also have a long history of illicit use as replacements for heroin and other controlled opioids. Between 1979 and 1988, more than 10 fentanils that had been made in illicit laboratories were detected on the drug market in the United States (Henderson, 1991). The first was alpha-methylfentanyl, followed by substances such as 3-methylfentanyl and 4-fluorofentanyl. Typically, they were sold as heroin or 'synthetic heroin'. Together, these substances were involved in more than 100 deaths, mostly in the state of California. Later, in the mid-2000s, illicitly manufactured fentanyl was sold as heroin or in mixtures with heroin, and was responsible for outbreaks of overdoses that involved hundreds of deaths in the eastern United States (Schumann et al., 2008). It appears that, with the exception of Estonia, where 3-methylfentanyl and fentanyl were responsible for an epidemic of fatal poisonings during this time, these substances caused limited problems elsewhere in Europe (Berens et al., 1996; de Boer et al., 2003; Fritschi and Klein, 1995; Kronstrand et al., 1997; Ojanperä et al., 2008; Poortman-van der Meer and Huizer, 1996).

"Over the past few years, there has been a large increase in the availability of fentanils in the United States, Canada and Europe (Gladden et al., 2016; US CDC, 2015). This has been

driven by the opioid epidemics in North America, interest in selling these substances in Europe and broader changes in the illicit drug market."

European Monitoring Centre for Drugs and Drug Addiction (2018), Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation. An update from the EU Early Warning System (June 2018), Publications Office of the European Union, Luxembourg.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/sy...

13. Fentanyl in the Context of New Psychoactive Substances
"Since 2012, a total of 28 new fentanils have been identified on Europe's drug market. This includes eight substances that were reported for the first time in 2016 and 10 during 2017. During this period, there has also been a large increase in seizures reported by customs at international borders and police at street-level (Figure 4) (see also 'Reducing the risk of occupational exposure to fentanils', page 11). While the picture differs widely across Europe, 23 countries have reported detections of one or more of these substances (Figure 5) (2). Reports to the EMCDDA of fatal poisonings have also increased substantially from some countries (EMCDDA, 2016a; EMCDDA, 2017a,b,c,d,e,f,g; EMCDDA, 2018a,b).

"It appears that most shipments of new fentanils coming into Europe originate from companies based in China. Production in illicit laboratories, including in Europe, has also been reported occasionally. Typically, production of fentanyl and other fentanils is relatively straightforward, which adds to the challenges in responding to these substances.

"Like other new substances, one of the reasons behind the increase in these fentanils is that they are not controlled under the United Nations drug control conventions. This means that in many countries they can be manufactured and traded relatively freely and openly — a situation which has been exploited by entrepreneurs and crime groups using companies based in China to make the substances. The fentanils are typically shipped to Europe by express mail services and courier services. From here, they are then sold as 'legal' replacements for illicit opioids on the surface web and on the darknet. Unknown to users, they are also sold as heroin or

mixed with heroin and other illicit opioids. Occasionally they have also been used to make fake medicines and, less commonly, sold as cocaine (see 'Fentanils in fake medicines and cocaine', page 12).

"Fentanils have been found in a variety of physical and dosage forms in Europe. The most common form is powders, but they have also been detected in liquids and tablets. Depending on the circumstances, seizures of powders have ranged from milligram to kilogram quantities. They may be relatively pure, especially when seized coming into the European Union. They may also be mixed with one or more substances. In the latter case, these include commonly used cutting agents (such as mannitol, lactose and paracetamol), as well as heroin and other fentanils/opioids. To a much smaller degree, other drugs, such as cocaine and other stimulants, have also been detected in mixtures with fentanils in Europe. During 2016, more than 4.6 kg of powder containing fentanils was reported, while almost 4.5 litres of liquid and around 2 900 tablets were also reported. Less commonly, fentanils have also been found in blotters and plant material. In these cases, there may be no indication that they contain fentanils, which could pose a risk of poisoning to people who use them."

European Monitoring Centre for Drugs and Drug Addiction (2018), Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation. An update from the EU Early Warning System (June 2018), Publications Office of the European Union, Luxembourg.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/sy...

14. Synthetic Cannabinoids
"Synthetic cannabinoids, also known as synthetic cannabinoid receptor agonists, are a group of drugs that mimic the effects of a substance found in cannabis called tetrahydrocannabinol (THC). THC is responsible for many of the psychoactive effects of cannabis which give that feeling of being 'stoned' or 'high' (Gaoni and Mechoulam, 1964; Huestis et al., 2001; Pertwee, 2005a; Pertwee, 2014). These effects are caused by activating a receptor in the brain called the cannabinoid receptor type 1 (CB1 receptor) (Huestis et al., 2001; Pertwee, 2014). The receptor is part of a signalling system in the body called the

endocannabinoid system, which helps regulate, among other things, behaviour, mood, pain, appetite, sleep and the immune system (Pertwee, 2015).

"Similar to the fentanils, the synthetic cannabinoids were originally developed by scientists to study the body, provide insights into disease and help develop new medicines (Pertwee, 2005b; Reggio, 2009). Around the mid-2000s, they began to appear in Europe in products called 'Spice' that were sold as 'legal' replacements to cannabis. In these products, powders containing synthetic cannabinoids were mixed with plant material which could then be smoked as cigarettes ('joints') (Auwärter et al., 2009; EMCDDA, 2009; Jack, 2009). Since then, 179 cannabinoids have been identified on the drug market in hundreds of different products (Figure 7). The products are commonly referred to as 'herbal smoking mixtures', 'Spice', 'K2', 'synthetic cannabis' and 'synthetic marijuana'. Most of the synthetic cannabinoid powders are made in China, with the final products made in Europe.

"Because synthetic cannabinoids work in a similar way to THC, many of their effects are similar to those of cannabis (Auwärter et al., 2009). Most prominently, they are able to create the feeling of being 'stoned'. This includes relaxation, euphoria, lethargy, depersonalisation, distorted perception of time, impaired motor performance, hallucinations, paranoia, confusion, fear, anxiety, dry mouth, bloodshot eyes, tachycardia (an abnormally fast heart rate), nausea and vomiting. In some cases, these effects appear to be much more pronounced and severe than those produced by cannabis (Ford et al., 2017; Zaurova et al., 2016)."

European Monitoring Centre for Drugs and Drug Addiction (2018), Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation. An update from the EU Early Warning System (June 2018), Publications Office of the European Union, Luxembourg.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/sy...

15. **Effects of Synthetic Cannabinoids More Severe and Can Include Fatal Poisoning**

"The reasons for the more pronounced psychoactive effects and severe and fatal poisoning seen with synthetic cannabinoids

are not particularly well understood, but at least two factors are likely to be important: the high potency of the substances and the unintentionally high doses that users are exposed to.

"Firstly, studies have found that many of the cannabinoids sold on the drug market are much more potent than THC (behaving as so-called 'full agonists'). This means that even at very small doses they can activate the CB1 receptor much more strongly than THC (Banister et al., 2016; Ford et al., 2017; Longworth et al., 2017a,b; Reggio, 2009; Tai and Fantegrossi, 2017). It is worth noting that little is known about the effects of synthetic cannabinoids on other signalling systems in the body, which may also explain some of the effects of these substances.

"Secondly, the process for mixing the synthetic cannabinoids with the plant material to make smoking mixtures (which are the most common way of using these substances) can lead to dangerous amounts of the substances in the products. This is because producers have to guess the amount of cannabinoids to add, while the mixing process makes it difficult to dilute the cannabinoids sufficiently and distribute them consistently throughout the plant material. This can result both in products that contain toxic amounts of the substances in general, as well as in products where the cannabinoids are clumped together, forming highly concentrated pockets among the plant material (Figure 9) (Ernst et al., 2017; Frinculescu et al., 2017; Langer et al., 2014, 2016; Moosmann et al., 2015; Schäper, 2016). These issues are made worse because the products are smoked (or vaped), allowing the substances to be rapidly absorbed into the bloodstream and to reach the brain, where they cause many of their effects.

"The combination of these two factors makes it difficult for users to control the dose that they are exposed to. This can lead them to unintentionally administer a toxic dose (see 'Other risks related to synthetic cannabinoids and smoking mixtures', page 18). Accounts from patients and people who witness poisonings suggest that in some cases a small number of puffs from a joint have been sufficient to cause severe and fatal poisoning."

European Monitoring Centre for Drugs and Drug Addiction (2018), Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation. An update from the EU Early Warning System (June 2018), Publications Office of the

European Union, Luxembourg.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/sy...

16. **MDMA (Ecstasy or Molly), Harm Reduction, and Dosage Information**

"Apart from warnings issued against dangerous and unexpected pills, dosage makes a difference. In terms of neurotoxicity, several scientific studies pointed out that, among other factors, the probability for possible neurotoxic damage in the serotonergic system grows with the amount of MDMA being consumed. Therefore, most pill-testing projects inform potential consumers that they should not, if at all, consume more than 1,5–1,8 mg MDMA/kg bodyweight because of possible long-term damages to an important region of the brain. These messages, that are often followed by consumers of ecstasy, are only meaningful if consumers are in a position to have their pills chemically analysed. Otherwise they are unable to follow this or similar advice."

Kriener, Harald, Renate Billeth, Christoph Gollner, Sophie Lachout, Paul Neubauer, Rainer Schmid, "An Inventory of On-Site Pill-Testing Interventions in the EU" (Lisbon, Portugal: European Monitoring Centre for Drugs and Drug Addiction, 2001), p. 12.
http://www.emcdda.europa.eu/at...

17. **Hemp Cultivation in EU**

"The survey covers the harvest of 2013, related to a total cultivation area of 15,700 ha. The first figure shows the development of the cultivation area since 1993. Between 1993 and 1996 the cultivation of industrial hemp was legalised in most of the member states, others followed later. In 2011 the cultivation area decreased to its lowest value since 1994 (ca. 8,000 ha), but increased in 2012, 2013 and 2014, to finally reach 25,000 ha in 2015. In 2016 a further increase is expected. The main cultivation member states are France and The Netherlands. In recent years, many new European countries started or expanded their hemp cultivation, mainly for the production of hemp seeds.
"From the 15,700 ha in the year 2013, 85,000 tonnes of hemp

straw were harvested and processed to:
" 25,000 metric tonnes fibre
" 43,000 metric tonnes shivs (woody core of the stem)
" The relation between shivs and fibres (shivs : fibres) is of 1.7 to 1
" 13,000 metric tonnes of dust (60% pelletized for incineration, 40% for compost and other uses)
"Hemp straw in Europe is only processed in a so called total fibre line, producing random nonaligned technical fibre. This is in contrast to flax, processed in long fibre processing lines, which produces a high value aligned, long textile fibre and a technical short fibre in a similar form to Hemp.
"Some companies also or exclusively processed hemp seeds or hemp flowers:
" 11,500 tonnes (compared to only 6,000 tonnes in 2010) seeds
" 240 tonnes (compared to only 7.5 tonnes in 2010) of flowers & leaves for medical applications (THC/CBD), food supplements (CBD) and the production of essential oil (for food and beverages)
"Whereas fibres and shivs did not show any significant difference between 2010 and 2013, the production of seeds increased by 92% and the production of flowers and leaves by 3,000%. The flowers for CBD production gave hemp farmers a considerable extra profit in 2013. It should also be mentioned that hemp is one of the very few crops in Europe that is cultivated on non-organic farms without the use of any agrochemicals. Strong, fast growing hemp crops are able to supress weeds without chemical support and the crop does not suffer from any pests or diseases that would warrant a spray. Hemp also grows well under an organic regime."

Michael Carus and Luis Sarmentano. "The European Hemp Industry: Cultivation, processing and applications for fibres, shivs, seeds and flowers." Huerth, Germany: European Industrial Hemp Association. May 2016, pp. 1-3.
http://eiha.org/media/2016/05/...

18. Estimated Prevalence of Cannabis Use Among Young Adults in the EU
"An estimated 16.6 million young Europeans (aged 15–34), or 13.3 % of this age group, used cannabis in the last year, with 9.6 million of these aged 15–24 (16.4 % of this age group). Among young people using cannabis in the last year, the ratio of males

to females is two to one.
"The most recent survey results show that countries continue to follow divergent paths in last year cannabis use (Figure 2.1). Of the countries that have produced surveys since 2013, eight reported higher estimates, four were stable and one reported a lower estimate than in the previous comparable survey.
"Only a limited number of countries have sufficient survey data to allow a statistical analysis of medium and longterm trends in last year cannabis use among young adults (15–34). Surveys for relatively high-prevalence countries, such as Germany, Spain and the United Kingdom, all show decreasing or stable cannabis prevalence over the past decade, while France shows increases in prevalence after 2010. Among countries that have historically lower rates of cannabis use, Finland has consistently reported increases in prevalence over the long term, moving from a low prevalence towards the European average, while Sweden retains a low level with data showing a modest increase over the last decade. Among the countries with fewer comparable data points, the Bulgarian data continues an increasing trend until 2012, while an annual survey in the Czech Republic found increases from 2011 to 2014."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, p. 38.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

19. MDMA (Ecstasy) and Harm Reduction
"In the context of new synthetic drugs there are some well-established approaches to reduce harm such as handing out condoms for free or giving out drinking water to reduce or stabilise body temperature and to avoid heatstroke. In addition, there are possible harms in the party scene that can be countered by pill-testing projects only. All pill-testing projects inform consumers about very dangerous and unexpected pills on site, through magazines and posters or through the Internet."

Kriener, Harald, Renate Billeth, Christoph Gollner, Sophie Lachout, Paul Neubauer, Rainer Schmid, "An Inventory of On-Site Pill-Testing Interventions in the EU" (Lisbon, Portugal:

European Monitoring Centre for Drugs and Drug Addiction, 2001), p. 12.
http://www.emcdda.europa.eu/at...

20. Prevalence of Heroin and Illegal Opioid Use in the EU
"In Europe, the most commonly used illicit opioid is heroin, which may be smoked, snorted or injected. A range of synthetic opioids such as methadone, buprenorphine and fentanyl are also misused.
"The average prevalence of high-risk opioid use among adults (15–64) is estimated at 0.4 %, the equivalent of 1.3 million high-risk opioid users in Europe in 2014. At national level, prevalence estimates of high-risk opioid use range from less than 1 to around 8 cases per 1 000 population aged 15–64 (Figure 2.8). Around 75 % of the estimated high-risk opioid users in the European Union are reported in the United Kingdom, France, Italy, Germany and Spain.
"Of the 11 countries with repeated estimates of high-risk opioid use between 2008 and 2014, Spain and Turkey show a statistically significant decrease, with stable trends in the other countries (Figure 2.8).
"Europe has experienced different waves of heroin addiction, the first affecting many western countries from the mid-1970s and a second wave affecting other countries especially those in central and eastern Europe in the mid to late 1990s. Subsequently there has been diffusion from urban centres to more rural areas and smaller cities in some countries. From 2010/11, indicators in many European countries highlighted a decline in new recruitment into heroin use and the existence of an ageing cohort of high-risk opioid users, many of whom were receiving substitution treatment. The most recent data suggest the downward trend in new treatment entrants may be levelling off."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, p. 47.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

21. Estimated Prevalence of Cocaine Use in the EU

"Cocaine is the most commonly used illicit stimulant drug in Europe, although its use is more prevalent in the south and west of Europe. Cocaine powder (cocaine hydrochloride) is primarily sniffed (nasal insufflation), but is also sometimes injected, whereas crack cocaine (cocaine base) is usually smoked.

"It is estimated that about 2.4 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. Among regular users, a broad distinction can be made between more socially integrated consumers, who often sniff powder cocaine, and marginalised users, who inject cocaine or smoke crack sometimes alongside the use of opioids.

"Only Spain, the Netherlands and the United Kingdom report last year prevalence of cocaine use among young adults of 3 % or more. The decreases in cocaine use reported in previous years have not been observed in the most recent surveys; of the countries that have produced surveys since 2013, six reported higher estimates, two reported a stable trend and four reported lower estimates than in the previous comparable survey.

"A statistical analysis of long-term trends in last year use of cocaine among young adults is only possible for a small number of countries. Spain and the United Kingdom both reported trends of increasing prevalence until 2008, followed by stability or decline. Reports from the United Kingdom suggest that this decline is limited to younger adults (16–24), with prevalence in the older age group remaining stable or increasing. France has an increasing trend, moving above 2 % in 2014. In Finland, prevalence has increased but the overall levels of use remain low, only reaching 1 % for the first time in 2014."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, p. 40.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

22. International Comparisons of Cocaine Prevalence

"Compared with some other parts of the world for which reliable data exist, the estimated last year prevalence of

cocaine use among young adults in Europe (2.1%) is below the levels reported for young adults in Australia (4.8 %) and the United States (4.0% among 16- to 34-year-olds), but close to that reported for Canada (1.8%). Two European countries, Spain (4.4%) and the United Kingdom (4.2%), report figures similar to those of Australia and the United States (Figure 9)."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 63.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

23. Estimated Prevalence of Amphetamine and Methamphetamine Use in the EU
"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 recent years have seen increases in 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.
"An estimated 1.3 million (1.0 %) young adults (15–34) used amphetamines during the last year, with the most recent national prevalence estimates ranging from 0.1 % to 2.9 %. The available data suggest that since around 2000, most European countries have experienced a relatively stable situation in respect to trends in use. Of the countries that have produced surveys since 2013, seven reported higher estimates, one reported a stable trend and four reported lower estimates than in the previous comparable survey. Although not comparable with earlier surveys, the Netherlands recently reported a prevalence of 2.9 % among young adults.
"In the limited number of countries where it is possible to analyse longer term statistically significant trends, both Spain

and the United Kingdom show a decrease in prevalence since 2000 (Figure 2.6). In contrast, Finland has shown a steady increase in prevalence over the same period and now reports one of the highest levels in Europe.
"Analysis of municipal wastewater carried out in 2015 found amphetamines at appreciable levels in cities across Europe. The mass loads of amphetamine varied considerably, with the highest levels reported in cities in the north of Europe (see Figure 2.7). Amphetamine was found at much lower levels in cities in the south of Europe. The highest mass loads of methamphetamine were found in cities in the Czech Republic, Slovakia and Norway. Overall, the data from 2011 to 2015 showed relatively stable trends for both drugs."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, p. 44.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

24. Estimated Prevalence of LSD, Mushroom, GHB, and Ketamine Use in the EU
"A number of other substances with hallucinogenic, anaesthetic, dissociative and depressant properties are used in Europe: these include LSD (lysergic acid diethylamide), hallucinogenic mushrooms, ketamine and GHB (gamma-hydroxybutyrate).
"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. 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, the Netherlands reported last year prevalence of GHB use at 0.4% for adults (15–64) and Norway at 0.1% (16–64), while and Romania reported 0.5% for young adults (15–34). Higher levels of both GHB use and related problems have been reported among particular social groups at the city and local level in some countries, including the Netherlands, Norway and the United Kingdom. Last year prevalence of ketamine use among young adults (15–34) was estimated at 0.3% in Denmark and Spain, and the United Kingdom reported last year ketamine use at 1.6% among 16- to

24-year-olds, a stable trend since 2008.
"The overall prevalence levels of LSD and hallucinogenic mushroom 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 less than 1% for both substances, with the exception of Finland with a prevalence of 1.3% for LSD, and for hallucinogenic mushrooms the United Kingdom (1%), the Netherlands (1.3%), Finland (1.9%) and the Czech Republic (2.3%)."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, pp. 45-46.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

25. Estimated Prevalence of MDMA (Ecstasy) Use in the EU
"MDMA (3,4-methylenedioxy-methamphetamine) is commonly used in the form of ecstasy tablets, but is also increasingly available as crystals and powders; tablets are usually swallowed, but in powder form the drug is also snorted (nasal insufflation).
"In recent years, monitoring sources based in a number of countries have been signalling new developments within Europe's MDMA market, including reports of increased use.
"Most European surveys have historically collected data on ecstasy rather than MDMA use, although this is now changing. It is estimated that 2.1 million young adults (15–34) used MDMA/ecstasy in the last year (1.7% of this age group), with national estimates ranging from 0.3% to 5.5%. Among young people using MDMA in the last year, the ratio of males to females is 2.4 to 1.
"Until recently, in many countries, MDMA prevalence has been on the decline from peak levels attained in the early to mid-2000s. This appears now to be changing. Among the countries that have produced new surveys since 2013, results point to an overall increase in Europe, with nine countries reporting higher estimates and three reporting lower estimates than in the previous comparable survey.
"Where data exist for a more robust analysis of trends in last year use of MDMA among young adults, increases are observed

in some countries since 2010. Bulgaria, Finland and France all continue long-term upward trends over this period, while in the United Kingdom a break in 2011/2012 from a downward trend is followed by statistically significant increases (Figure 2.4). Though not directly comparable with earlier surveys, the Netherlands reports a prevalence of 5.5% in 2014."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, pp. 42-43.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

26. Per Capita Alcohol Consumption in the EU
"The European Union (EU) is the region with the highest alcohol consumption in the world: in 2009, average adult (aged 15+ years) alcohol consumption in the EU was 12.5 litres of pure alcohol – 27g of pure alcohol or nearly three drinks a day, more than double the world average. Although there are many individual country differences, alcohol consumption in the EU as a whole has continued at a stable level over the past decade."

"Introduction," by Lars Møller and Peter Anderson, published in Alcohol in the European Union: Consumption, Harm and Policy Approaches (Copenhagen, Denmark: World Health Organization Regional Office for Europe, March 2012), p. 1.
http://www.euro.who.int/__data...

27. European Union - Data - 12-3-12
(Alcohol Consumption Trends in the EU) "Although the European per capita consumption of alcohol has remained nearly constant over the past decade, this apparent steadiness hides two opposing trends. The Nordic countries and eastern Europe have seen an increase in adult per capita consumption, whereas western and southern Europe have experienced a decrease. Beer is the most prominent alcoholic beverage in almost all regions. Only in southern Europe does wine remain the most frequently consumed alcoholic drink, but even in southern Europe, the consumption of wine has been decreasing at a high rate whereas beer consumption is only rising slightly. This decrease in wine intake is mainly responsible for the

strong downward trend in total alcohol consumption in southern Europe. The Nordic countries are moving in the opposite direction to the southern countries, although the changes are not as marked: wine consumption has steadily increased in the past decade while beer has lost some of its popularity. Southern and eastern Europe are the two regions that show the largest amount of change in their total alcohol consumption, but these changes tend to cancel each other out and are not reflected in the EU average."

"Societal burden of alcohol," by Kevin D Shield, Tara Kehoe, Gerrit Gmel, Maximilien X Rehm and Jürgen Rehm, published in Alcohol in the European Union: Consumption, Harm and Policy Approaches (Copenhagen, Denmark: World Health Organization Regional Office for Europe, March 2012), p. 15.
http://www.euro.who.int/__data...

28. Estimated Prevalence of Use of New Psychoactive Substances and 'Legal Highs' in the EU
"Insights into the use of new drugs are 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. Although primarily an attitudinal survey, the Eurobarometer includes a question on the use of 'substances that imitate the effects of illicit drugs'.
"Currently, these data represent the only EU-wide information source on this topic, although for methodological reasons caution is required when
interpreting the results. Overall, 8% of respondents reported lifetime use of such substances, with 3% reporting use in the last year. This represents an increase from the 5% reporting lifetime use in a similar survey in 2011. Of those reporting use in the last year, 68% had obtained the substance from a friend.
"An increasing number of countries are including new psychoactive substances in their general population surveys, though differences in methods and questions limit the comparability of the results between countries. Since 2011, 11 European countries have reported national estimates of the use of new psychoactive substances (not including ketamine and GHB). For the age group covered in the Flash Eurobarometer study, younger adults (aged 15–24), last year prevalence of use of these substances ranges from 0.0% in Poland to 9.7% in Ireland. Survey data for the United Kingdom (England and

Wales) are available on the use of mephedrone. In the most recent survey (2014/15), last year use of this drug among young people aged 16 to 24 was estimated at 1.9 %; this figure was the same as the previous survey, but down from 4.4% in 2010/11, before control measures were introduced. In 2014, a survey in Finland estimated last year use of synthetic cathinones to be 0.2% among young people aged 15 to 24, while in France an estimated 4% of 18- to 34-year-olds reported having ever smoked synthetic cannabinoids."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, p. 47.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

29. Prevalence of Mephedrone and Synthetic Cathinone Use in the EU
"Synthetic cathinones, such as mephedrone and MPDV, have now carved a space in the illicit stimulants market in some countries. The limited information available suggests that prevalence levels remain low. Repeat surveys that include cathinones are only available for the United Kingdom (England and Wales). In the most recent survey (2012/13), last year use of mephedrone among adults aged 16 to 59 was estimated at 0.5 %, a decrease from 1.1 % in 2011/12 and 1.4 % in 2010/11. Results from a non-representative survey of regular clubbers in the United Kingdom also show a decrease in last year mephedrone use (from 19.5 % in 2011 to 13.8 % in 2012).
"The injection of cathinones, including mephedrone, MDPV and pentedrone, continues to be a concern and has been reported among diverse populations, including opioid injectors, drug treatment clients, prisoners and small populations of men who have sex with men. An increase in treatment demand associated with synthetic cathinone use problems has been reported in Hungary, Romania and the United Kingdom. In Romania, a higher share of first-time treatment entrants reported new psychoactive substances as primary drug (37 %) than reported heroin (21 %). There were an estimated 1 900 mephedrone users entering treatment in the United Kingdom in 2011/12, with more than half of them under the age of 18."

European Monitoring Centre on Drugs and Drug Addiction,

"European Drug Report 2014: Trends and Developments" (Lisbon, Portugal: EMCDDA, 2014), p. 43.
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

30. Trends and Policies Regarding Drug Supply and Possession Offenses in the EU, 2016
Crime, Courts, and Prisons

"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 drug trafficking as a criminal offence, but the penalties written in the law vary between states. In some countries, drug supply offences may be subject to a single wide penalty range, while other countries differentiate between minor and major supply offences with corresponding penalty ranges.
"Each country is also obliged to treat possession of drugs for personal use as a criminal offence, 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. Since around 2000, there has been an overall trend across Europe towards reducing the likelihood of imprisonment or other incarceration for minor offences related to personal drug use. Some countries have gone further, so that possession of drugs for personal use can only be punished by non-criminal sanctions, usually a fine (Figure 1.14).
"The implementation of laws to curb drug supply and use is monitored through data on reported drug law offences. In the European Union, there were an estimated 1.6 million offences reported (most of them related to cannabis; 57%) in 2014, involving around 1 million offenders. Reported offences increased by almost a third (34%) between 2006 and 2014.
"In most European countries, the majority of reported drug law offences relate to use or possession for use. In Europe, overall, it is estimated that more than 1 million of these offences were reported in 2014, a 24% increase compared with 2006. Of the reported drug offences related to possession, more than three-quarters involve cannabis. The upward trends in offences for

cannabis, amphetamines and MDMA possession have continued in 2014 (Figure 1.15).
"Overall, reports of drug supply offences have increased by 10% since 2006, reaching an estimate of more than 214,000 cases in 2014. As with possession offences, cannabis accounted for the majority. Cocaine, heroin and amphetamines, however, accounted for a larger share of offences for supply than for personal possession. The downward trends in offences for heroin and cocaine supply have not continued into 2014, and there has been a sharp increase in reports of supply offences for MDMA (Figure 1.15)."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, pp. 33-34.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

31. Prevalence of Substance Use Among Drivers in EU
"Roadside surveys conducted in 13 countries across Europe, in which blood or oral fluid samples from 50 000 drivers were analysed, revealed that alcohol was present in 3.48 %, illicit drugs in 1.90 %, medicines in 1.36 %, combinations of drugs or medicines in 0.39 % and alcohol combined with drugs or medicines in 0.37 %. However, there were large differences among the mean values in the regions of northern, eastern, southern and western Europe. Although the absolute numbers were quite low, the prevalence of alcohol, cocaine, cannabis and combined substance use was higher in southern Europe, and to some extent in western Europe, than in the other two regions, whereas medicinal opioids and 'z-drugs', such as zopiclone and zolpidem, were detected more in northern Europe."

European Monitoring Centre for Drugs and Drug Addiction, "Driving Under the Influence of Drugs, Alcohol and Medicines in Europe — findings from the DRUID project" (Luxembourg: Publications Office of the European Union, 2012), doi: 10.2810/74023, p. 6.
http://www.emcdda.europa.eu/at...

32. **Trends in Drug Supply and Possession Offenses in the EU, 2012**

"There has been no major shift in the balance between drug law offences related to use and those related to supply compared with previous years. In most (22) European countries, offences related to drug use or possession for use continued to comprise the majority of drug law offences in 2010, with Spain, France, Hungary, Austria and Turkey reporting the highest proportions (85–93%) [(32)].

"Between 2005 and 2010, there was an estimated 19% increase in the number of offences related to drug use in Europe. Some country differences can be seen in this analysis, as the number of offences related to use increased in 18 countries and fell in seven during this period. There has, however, been an overall decrease in drug use offences reported in the most recent data (2009–10) (Figure 3). Offences related to the supply of drugs show an estimated increase during the period 2005–10 of about 17% in the European Union. Over this period, 20 countries report an increase in supply-related offences, while Germany, Estonia, the Netherlands, Austria and Poland report an overall decline [(33)]."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, pp. 35-36.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

33. **Prevalence of Substance Use Among Injured Drivers**

"Studies of hospitalised, seriously injured car drivers were conducted in six countries, and studies of car drivers killed in accidents took place in four countries. Among the injured or killed drivers, the most commonly consumed substance was alcohol alone, followed by alcohol combined with another substance. The use of illicit drugs alone was not frequently detected. After alcohol, the most frequently found substance among injured drivers was tetrahydrocannabinol (THC) followed by benzodiazepines, whereas, among drivers killed in accidents, it was benzodiazepines."

European Monitoring Centre for Drugs and Drug Addiction, "Driving Under the Influence of Drugs, Alcohol and Medicines in

Europe — findings from the DRUID project" (Luxembourg: Publications Office of the European Union, 2012), doi: 10.2810/74023, p. 6.
http://www.emcdda.europa.eu/at...

34. Cannabis Offenses in the EU
"Cannabis continues to be the illicit drug most often mentioned in reported drug law offences in Europe (34). In the majority of European countries, offences involving cannabis accounted for between 50% and 90% of reported drug law offences in 2010. Offences related to other drugs exceeded those related to cannabis in only four countries: the Czech Republic and Latvia with methamphetamine (54% and 34%); and Lithuania and Malta with heroin (34% and 30%).
"In the period 2005–10, the number of drug law offences involving cannabis increased in 15 reporting countries, resulting in an estimated increase of 20% in the European Union. Downward trends are reported by Germany, Italy, Malta, the Netherlands and Austria (35)."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 36.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

35. Cannabis Offenses in the EU, 1999-2004
"In 19992004, the number of 'reports' of drug law offences involving cannabis increased overall in the majority of reporting countries, while decreases were evident in Italy and Slovenia. Over the same period, the proportion of drug offences involving cannabis increased in Germany, Spain, France, Lithuania, Luxembourg, Portugal, the United Kingdom and Bulgaria, while it remained stable overall in Ireland and the Netherlands, and decreased in Belgium, Italy, Austria, Slovenia and Sweden. Although in all reporting countries (except in the Czech Republic and Bulgaria and for a few years in Belgium) cannabis is more predominant in offences for use/possession than in other drug law offences, the proportion of use-related offences involving cannabis has decreased since 1999 in several countries -- namely Italy, Cyprus (200204), Austria,

Slovenia and Turkey (200204) -- and has fallen over the last year (200304) in most reporting countries, possibly indicating a reduced targeting of cannabis users by law enforcement agencies in these countries."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 24.
http://www.emcdda.europa.eu/at...

36. International Comparison of Homicide Rates
"With averages of over 25 victims per 100,000 population, Southern Africa and Central America are the sub-regions with the highest homicide rates on record, followed by South America, Middle Africa and the Caribbean, with average rates of between 16 and 23 homicides per 100,000 population (see figure 1.3). This sub-regional picture has hardly changed since 2011. Likewise, as discussed later in this chapter, the fact that homicide rates are significantly higher in the Americas in comparison to other regions is not a new phenomenon. Indeed, according to available time series since 1955, the Americas have consistently experienced homicide levels five to eight times higher than those in Europe or Asia (see figure 1.17, page 35).
"In addition to the entire region of Oceania, sub-regions with relatively low rates of homicide (less than 3 per 100,000 population) include all the sub-regions of Europe (with the exception of Eastern Europe, which has a medium rate of homicide)
and Eastern Asia.
"Sub-regional averages can, however, hide disparities in homicide rates at the national level. As map 1.1 demonstrates, for example, countries in the southern part of South America, such as Argentina, Chile and Uruguay, have considerably lower levels of homicide than countries further north, such as Brazil, Colombia and the Bolivarian Republic of Venezuela. Eastern Europe and South-Eastern Asia are other examples of sub-regions that show large disparities at the national level (see figure 1.5). For example, in the former, though decreasing, the Russian Federation has a homicide rate slightly less than double the sub-regional average (9.2 versus 5.8 per 100,000 population); in the latter, the Philippines has a homicide rate

slightly more than double the sub-regional average (8.8 versus 4.3 per 100,000 population)."

UNODC Global Study on Homicide 2013 (United Nations publication, Sales No. 14.IV.1), p. 20.
http://www.unodc.org/documents...

37. European Homicide Rates

"Countries in Europe have some of the lowest homicide rates in the world, but sub-national data can paint some interesting pictures within those countries and in certain trans-border regions (see map 1.4). The most significant differences lie in the west-to-east geographical distribution of homicide, as homicide rates increase eastwards across Europe, and there are also higher homicide rates in certain parts of Northern Europe. Available data indicate that this phenomenon is associated with patterns of alcohol consumption (see chapter 3), among other factors.

"While homicide rates are generally low in the rest of Europe, certain spots with consistently higher homicide rates over time can be noted. At the national level, they include Albania and Montenegro. Sub-nationally they can be found in the Algarve, the southernmost part of Portugal, which has a homicide rate of 2.5 per 100,000; in the southern tip of Italy, whose homicide rate is attributable to the prevalence of Mafia-related killings (see chapter 2.1); on the French island of Corsica; and in certain more densely-populated urban areas that have higher homicide rates than the rest of their respective countries, such as Amsterdam, Brussels, Prague and Vienna."

UNODC Global Study on Homicide 2013 (United Nations publication, Sales No. 14.IV.1), p. 27.
http://www.unodc.org/documents...

38. Public Expenditure on Drug Law Offenders in Prison in the European Union

"Within this framework, the EMCDDA has calculated a range of estimates of public expenditures on drug-law offenders in prison. The low estimate considers only those prisoners who have been sentenced for a drug-law offence. The high estimate also includes pre-trial prisoners who may be sentenced for a drug-law offence (assuming that the proportion of drug-law

offenders among pre-trial prisoners is identical to that of drug-law offenders among sentenced prisoners). Applying these low and high estimates, between 2000 and 2010, public expenditure on drug-law offenders in 22 European countries is estimated to have been within the range of 0.03 %–0.05 % of GDP. With the exception of the first two years, when the number of countries with available information was limited, these proportions of GDP remained stable. When applying these percentages to the whole EU for the year 2010, public expenditure on drug-law offenders in prison is estimated to have been within the range of EUR 3.7 billion to EUR 5.9 billion.
"Over the period 2000–10, it is estimated that 12 out of the 22 countries spent on average between 0.01 % and 0.03 % of GDP on drug offenders in prisons, if we account only for expenditure on sentenced prisoners. If public spending on pre-trial prisoners is included, then the estimates exceeded 0.03 % of GDP in 10 countries, reaching a maximum of approximately 0.08 % of GDP in 2 countries."

European Monitoring Centre for Drugs and Drug Addiction, "Estimating public expenditure on drug-law offenders in prison in Europe," EMCDDA Papers, Publications Office of the European Union, Luxembourg, February 2014, p. 14.
http://www.emcdda.europa.eu/pu...

39. Median Prison Population Rate and Number of People Serving Time in Prisons in the Europe
"2. The median European Prison Population Rate [PPR] was 124.0 inmates per 100 000 inhabitants.
There was noted an increase of +4% compared to 2012 (125.6 inmates per 100,000 inhabitants). As median calculated values are less sensitive to the extreme figures (i.e. very low prison population rates in small countries with less than 1mln inhabitants), it is preferable to use these values as a more(reliable alternative to the average figures.
"3. On 1st September 2014, there were 1,600,324 inmates held in penal institutions across Europe. On the(same date in 2013, there were 1,530,222 inmates (this total does not include Ukrainian figures which(were missing for 2013) and, in 2012 there were 1,737,061 inmates.
"4. On average, on 1st September 2014, European prisons were at the top of their capacity, holding 91 inmates per 100 places (median values being higher: 93). In particular, 27.5% of the

Prison
Administrations were experiencing overcrowding. Since 2009, the European prison density remains(close to full."

Aebi, M. F., Tiago, M. M. & Burkhardt, C. (Dec. 23, 2015). SPACE I – Council of Europe Annual Penal Statistics: Prison populations. Survey 2014. Strasbourg: Council of Europe, p. 2.
http://wp.unil.ch/space/files/...
http://wp.unil.ch/space/space-...

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40. People Serving Time in Prison in the EU for Drug Offenses
"Inmates were sentenced mainly for the following types of criminal offences: drug offences (18%), theft (16%), robbery (14%), and homicide (12%)."

Aebi, M.F. & Delgrande, N. (2015). SPACE I – Council of Europe Annual Penal Statistics: Prison populations. Survey 2013. Strasbourg: Council of Europe, p. 2.
http://www3.unil.ch/wpmu/space...
http://www3.unil.ch/wpmu/space...

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41. Total Prison Population and Drug-Law Offenders in Prison in Several European Union Nations
Click here for complete datatable of Total Prison Population and Drug-Law Offenders in Prison in Several European Union Nations

European Monitoring Centre for Drugs and Drug Addiction, "Estimating public expenditure on drug-law offenders in prison in Europe," EMCDDA Papers, Publications Office of the European Union, Luxembourg, February 2014, p. 5, Table 1.
http://www.emcdda.europa.eu/pu...

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42. Heroin Offenses in the EU, Trends 1999-2004
"Over the same five-year period, the number of 'reports' and/or the proportion of drug law offences involving heroin decreased in the majority of reporting countries, except Belgium, Austria, Slovenia and Sweden, which reported upward trends in the number of 'reports' involving heroin and/or the proportion of drug offences that involved heroin.
"The opposite trend can be observed for cocaine-related offences: in terms of both number of 'reports' and the

proportion of all drug offences, cocaine-related offences have increased since 1999 in most reporting countries. Bulgaria is the only country to report a downward trend in cocaine offences (both numbers and proportions of drug offences)."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 24.
http://www.emcdda.europa.eu/at...

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43. European Union - 6-21-11
(Cocaine Smuggling Routes and Transshipment Countries)
"Increasing amounts of Latin American cocaine are now also being sent to Europe (see Figure 2.2). Most consignments are smuggled in container vessels and dispatched directly to ports in Spain (Barcelona), Portugal (Lisbon), the Netherlands (Rotterdam), and Belgium (Antwerp).[9] The growing emphasis on Europe reflects higher street prices than those in the United States[10] (see Table 2.4) and shifting consumer demand patterns toward this particular narcotic (and derivates, such as crack).[11] Based on prevalence rates in 2008, the United States accounted for roughly 44 percent of global cocaine consumption, Europe 25 percent. In the latter case, the UK constitutes the largest cocaine market on the continent in absolute terms, with usage among the general population standing at 1.2 million in 2009.[12]
"The more-common route, however, runs via hubs in West Africa, especially Sierra Leone, Guinea-Bissau, Guinea, Ghana, Mali, and Senegal (see Figure 2.3). All of these countries have weak judicial institutions, lack the resources for effective (or, indeed, even rudimentary) coastal surveillance, and are beset by endemic corruption—making them ideal transshipment hubs for moving narcotics out of Latin America.[13] According to U.S. officials, between 25 and 35 percent of all Andean cocaine consumed in Europe arrives from one of these states.[14] A 2008 report by UNODC similarly estimated that at least 50 tons of Colombian drugs pass through West Africa every year, with cocaine seizures doubling annually from 1.32 tons in 2005 to 3.16 tons in 2006 to 6.46 tons in 2007.[15] In the words of Antonio María Costa, the former executive director of UNODC, the illicit trade has become so endemic that it has now effectively turned "the Gold Coast into the Coke Coast."[16]"

Chalk, Peter, "The Latin American Drug Trade: Scope,

Dimensions, Impact, and Response," RAND Corporation for the United States Air Force (Santa Monica, CA: 2011), pp. 6-9. ***http://www.rand.org/content/da...***

44. Consequences of Cocaine Transshipping in Guinea-Bissau
"Demand for cocaine in Europe, combined with the stepping up of policing in the Caribbean has simply shifted transit routes to West Africa – *the balloon effect.* Guinea Bissau, already with weak governance, endemic poverty and negligible police infrastructure, has been particularly affected - with serious consequences for one of the most underdeveloped countries on Earth.
"In 2006, the entire GDP of Guinea-Bissau was only US$304 million, the equivalent of six tons of cocaine sold in Europe at the wholesale level. UNODC estimates approximately 40 tons of the cocaine consumed in Europe passes through West Africa. The disparity in wealth between trafficking organisations and authorities has facilitated infiltration and bribery of the little state infrastructure that exists. Investigations show extensive involvement of police, military , government ministers and the presidential family in the cocaine trade, the arrival of which has also triggered cocaine and crack misuse.(16)
"The war on drugs has turned Guinea Bissau from a fragile state into a narco-state in just five years."

"The War on Drugs: Undermining international development and security, increasing conflict" from the "Count the Costs: 50 Years of the War on Drugs," Transform Drug Policy Foundation (United Kingdom, 2011), p. 10.
http://www.countthecosts.org/s...

45. European Union - Data - Sources of Heroin Trafficked to European Union
***(Sources of Heroin Trafficked to European Union)* "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 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 2014 included**

opium and the medicines morphine, methadone, buprenorphine, tramadol and fentanyl. Some medicinal opioids may have been diverted from pharmaceutical supplies, while others are manufactured specifically for the illicit market.
"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. Opioid production in Europe has historically been limited to homemade poppy products produced in some eastern countries. However, the discovery of two laboratories converting morphine to heroin in Spain and one in the Czech Republic in 2013/14 indicates that heroin may also now be manufactured in 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 Greece) and on to central, southern and western Europe. An offshoot to the Balkan route involving Syria and Iraq has emerged recently. The southern route seems to have gained importance in recent years. This sees heroin shipments from Iran and Pakistan entering Europe by air or sea, either directly or transiting through west, southern and east African countries. Other, currently less important routes include the 'northern route' and a new heroin route that appears to be developing through the southern Caucasus and across the Black Sea."

European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg, p. 22.
http://www.emcdda.europa.eu/sy...
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

46. European Union - Data - Problem Drug Use in the EU Problem Drug Use and Its Correlates

***(Problem Drug Use in the EU)* "Drug use is associated, both directly and indirectly with a range of negative health and social consequences. Problems are disproportionately found among long-term users of opioids, some forms of stimulants and among those who inject. The use of opioid drugs in particular is associated with drug overdose deaths, and the**

scale of this problem is illustrated by the fact that, over the last decade, Europe has experienced about one overdose death every hour. However, it is also important to remember that chronic drug users are also at a far greater risk of dying from other causes, including organic diseases, suicide, accidents and trauma. Regardless of the substance used, drug injecting continues to be an important vector for the transmission of infectious diseases, including HIV and hepatitis C, with new HIV outbreaks recently experienced by some European countries underlining the importance of maintaining effective public health responses in this area."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 79.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

47. Problem Opioid Use in the EU, 1995-2004
"Reports from some countries, supported by other indicator data, suggest that problem opioid use continued to increase during the latter half of the 1990s (Figure 9) but appears to have stabilised or declined somewhat in more recent years. Repeated estimates on problem opioid use for the period between 2000 and 2004 are available from seven countries (the Czech Republic, Germany, Greece, Spain, Ireland, Italy, Austria): four countries (the Czech Republic, Germany, Greece, Spain) have recorded a decrease in problem opioid use, while one reported an increase (Austria -- although this is difficult to interpret as the data collection system changed during this period). Evidence from people entering treatment for the first time suggests that the incidence of problem opioid use may in general be slowly declining; therefore in the near future a decline in prevalence is to be expected."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 69.
http://www.emcdda.europa.eu/at...

48. HIV Related to Injection Drug Use in the EU

"Data on reported newly diagnosed cases related to injecting drug use for 2010 suggest that, overall, infection rates are still falling in the European Union, following a peak in 2001–02. Of the five countries reporting the highest rates of newly diagnosed infections among injecting drug users between 2005 and 2010, Spain and Portugal continued their downward trend, while, among the others, only Latvia reported a small increase (Figure 17) (108).

"These data are positive, but they must be viewed in the knowledge that potential for new HIV outbreaks among injectors continues to exist in some countries. Taking a two-year perspective (between 2008 and 2010), increases were observed in Estonia, from 26.8 cases per million to 46.3 per million, and in Lithuania, from 12.5 cases per million to 31.8 per million. Bulgaria, a country with, historically, a very low rate of infection, also saw a peak of 9.7 per million in 2009, before falling back to 7.4 per million in 2010."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 80.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

49. Prevalence of HIV Among IDUs in the EU

"Prevalence data from samples of drug injectors are available for 25 European countries over the period 2005–10 (109), and although sampling differences mean this information needs to be carefully interpreted, it does provide a complementary data source. In 17 of these countries, HIV prevalence estimates remained unchanged. In seven (Germany, Spain, Italy, Latvia, Poland, Portugal, Norway), HIV prevalence data showed a decrease. Only one country (Bulgaria) reported increasing HIV prevalence: in the capital city, Sofia, consistent with the increase in cases of newly diagnosed infections. The increases in HIV transmission in Greece and Romania reported in 2011 were not observed in HIV prevalence or case reporting data before 2011. Possible further indications of ongoing HIV transmission were observed among small samples of young injecting drug users (aged under 25) in six countries:

prevalence levels above 5 % were recorded in Estonia, France, Latvia, Lithuania and Poland, and increasing prevalence in Bulgaria, over the period 2005–10."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 80.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

50. Prevalence of HIV/AIDS in the EU
"In the EU/EEA [European Union/European Economic Area], 28,038 HIV infections were diagnosed in 2011 and reported by 29 EU/EEA countries, a rate of 6.3 per 100,000 population when adjusted for reporting delay [1]. The overall rate for men was 8.7 per 100,000 population and 2.8 per 100,000 population for women. The highest rates (per 100,000 population) were observed in Estonia (27.3), Latvia (13.4), Belgium (10.7) and the United Kingdom (10.0). The lowest rates were reported by the Czech Republic (1.5) and Slovakia (0.9). Some 11% of HIV infections were reported among young people aged 15–24 years and 25% were female. The overall male-to-female ratio was 3.0 and highest in Slovakia (15.3), Hungary (11.1), Czech Republic (10.8) and Slovenia (6.9) (Figure 1)."

van de Laar, MJ, and Likatavicius, G, "HIV and AIDS in the European Union, 2011," Eurosurveillance, Volume 17, Issue 48, 29 November 2012.
http://www.eurosurveillance.or...

51. New HIV Diagnoses in the EU by Method of Transmission
"Men who have sex with men (MSM) accounted for 39% of new HIV diagnoses (n=10,885) in 2011 in the EU/EEA (38% in 2010 [2]; 35% in 2009 [3]). MSM accounted for more than 50% of the cases in nine countries and more than 30% in another eight countries. Heterosexual transmission accounted for 36% of the HIV infections (n=10,118): more than a third of those cases originated from sub-Saharan Africa countries with a generalised HIV epidemic. More than half of the heterosexually acquired HIV infections in Belgium, Sweden, United Kingdom, Ireland and Norway were reported in persons originating from

sub-Saharan Africa. There were 4,384 HIV cases (16%) reported in persons from sub-Saharan Africa in total: they were over-represented in the following transmission modes, as shown in the Table: heterosexual contacts (37%) and mother-to-child transmission (46%). Only 5% (n=1,516) of HIV diagnoses were reported in injecting drug users (IDU). Injecting drug use as predominant mode of transmission was reported in only two countries: Lithuania and Iceland. IDU accounted for 25% or more of the cases in Bulgaria, Greece, Latvia and Romania. Of the remaining 297 cases with reported transmission mode, 222 (1%) were classified as due to mother-to-child transmission and 75 (0.3%) due to transfusion of blood or its products and nosocomial transmission."

van de Laar, MJ, and Likatavicius, G, "HIV and AIDS in the European Union, 2011," Eurosurveillance, Volume 17, Issue 48, 29 November 2012.
http://www.eurosurveillance.or...

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52. Prevalence and Trends in IDU-Related Hepatitis C in the EU
"Viral hepatitis, in particular infection caused by the hepatitis C virus (HCV), is highly prevalent in injecting drug users across Europe (Figure 18). HCV antibody levels among national samples of injecting drug users in 2009–10 varied from 14% to 70%, with seven of the 11 countries with national data (Greece, Italy, Cyprus, Austria, Portugal, Finland, Norway), reporting prevalence over 40% [111], a level that may indicate that injecting risks are sufficient for HIV transmission (Vickerman et al., 2010). HCV antibody prevalence levels of over 40 % were also reported in the most recent national data available for Denmark, Luxembourg and Croatia and in nine other countries providing sub-national data (2005–10). The Czech Republic, Hungary, Slovenia (all national, 2009–10) and Turkey (sub-national, 2008) report HCV prevalence of under 25% (5–24%), although infection rates at this level still constitute a significant public health problem.
"Over 2005–10, declining HCV prevalence in injecting drug users at either national or sub-national level was reported in six countries, while five others observed an increase (Bulgaria, Greece, Cyprus, Austria, Romania). Italy reported a decline at national level between 2005 and 2009 — more recent data are not available — with increases in three of the 21 regions (Abruzzo, Umbria, Valle d'Aosta)."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 81.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

53. School-Based Prevention
"Interactive programmes based on the model of social influence or life skill competence have been shown to be effective in schools, but individual measures carried out in isolation (for example, only communication of information, affective education or other non-interactive measures) have been negatively evaluated (Bühler and Kröger, 2006). For organisational reasons, school-based prevention is usually the responsibility of local authorities, especially in the Nordic countries, France and Poland."

"Selected Issues: Annual Report 2007: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2007), p. 30.
http://www.emcdda.europa.eu/at...

54. Hepatitis C Prevalence Among Young Injectors in the EU
"Studies on young injectors (under 25) suggest a decline in prevalence of HCV at sub-national level in Slovakia, which may indicate falling transmission rates. Increases among young injecting drug users were reported in Bulgaria, Greece, Cyprus and Austria, although sample sizes in Greece, Cyprus and Austria were small. Increasing HCV prevalence among new injecting drug users (injecting for less than two years) was reported in Greece (nationally and in one region) [(112)]. These studies, while difficult to interpret for methodological reasons, do illustrate that many injectors continue to contract the virus early in their injecting career, suggesting that the time window for initiating HCV prevention measures may often be small."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union,

November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 81.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

55. Drug Users and Homelessness in the EU
"Getting homeless problem drug users into stable accommodation is the first step towards stabilisation and rehabilitation. Based on the estimated numbers of problem drug users and the proportion of homeless people among clients in treatment, there are approximately 75,600 to 123,300 homeless problem drug users in Europe. As facilities are currently available in most countries, and as some countries continue to implement new structures, the effect of these measures will depend on ensuring that homeless problem drug users can access these services."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), pp. 34-35.
http://www.emcdda.europa.eu/at...

56. Homelessness and Drug Use
"Abstaining from or reducing drug use, engaging with and completing education, as well as securing and sustaining employment can all be great challenges if an individual has no access to supportive structures such as stable accommodation. Eight per cent of all outpatient clients in the EU starting a new treatment episode in 2009 were living in unstable accommodation (see Figure 1 on p. 45). This ranged from 2 % in Estonia to 20 % in France, 21 % in the Czech Republic and 33 % in Luxembourg. Within this population of drug users there are those subgroups that may be vulnerable or face additional barriers obtaining appropriate accommodation, such as women and young people, or those with enduring mental health problems (Shaw and McVeigh, 2008). There are many reasons why drug users may develop severe accommodation needs (whether they are defined as homeless or inappropriately accommodated), or why homeless people may start using drugs, and such progressions are rarely due to a single factor alone (Pleace, 2008). Typical reasons for homelessness may include a combination of mental health problems, unemployment,

financial difficulties, criminal behaviour, relationship problems, family breakdown and difficulties in progressing into independent living after release from an institution (e.g. prison) (UKDPC, 2008a). Conversely, high-risk behaviours such as injecting drug use are reported to be prevalent among homeless people (EMCDDA, 2003a)."

European Monitoring Centre for Drugs and Drug Addiction, "EMCDDA Insights Series No 13: Social reintegration and employment: evidence and interventions for drug users in treatment" (Luxembourg: Publications Office of the European Union, 2012), doi: 10.2810/72023, p. 37.
http://www.emcdda.europa.eu/at...

57. Health Impact of Opiate Use
"The first and most direct impact of opiates is on health, including heroin-related deaths. Opiates (including synthetics) account for 35% to almost 100% of all drug-related deaths in the 22 European countries that have provided data, and over 85% in 11 of those countries.[69] In addition, heroin abuse by injection contributes to high rates of serious diseases such as hepatitis B, hepatitis C and HIV.[70] The HIV epidemic among injecting drug users continues to develop at varying rates across Europe. In the countries of the European Union, the rates of reported newly diagnosed cases of HIV infection among injecting drug users are mostly at stable and low levels, or in decline. However, in post-soviet European countries such as Ukraine, Belarus and the Republic of Moldova, those rates increased in 2007."

UNODC, World Drug Report 2010 (United Nations Publication, Sales No. E.10.XI.13), p. 59.
http://www.unodc.org/documents...

58. Initiation of Drug Use While In Prison
"Imprisonment forces some drug users to stop using drugs, and some will see this as an opportunity to improve their lives. For others, however, prison may be a setting for initiation into drug use or for switching from one drug to another, often due to lack of availability of the preferred drug inside prison (Fazel et al., 2006; Stöver and Weilandt, 2007) and other possible reasons (e.g. use of substances for which avoiding control measures is easier). Sometimes, this change leads to more harmful patterns

of drug use (Niveau and Ritter, 2008). For example, a Belgian study carried out in 2008 found that more than one-third of drug-using prisoners had started to use an additional drug during detention, one that they were not using before entering prison, with heroin being the drug most frequently mentioned (Todts et al., 2008)."

European Monitoring Centre for Drugs and Drug Addiction, "Prisons and drugs in Europe: the problem and responses" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDSI12002ENC, doi: 10.2810/73390, p. 10.
http://www.emcdda.europa.eu/at...

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59. Drug Use in Prison
"Studies carried out in 15 European countries since 2000 estimated that between 2% and 56% of prisoners have ever used any type of drug while incarcerated, with nine countries reporting levels in the range 20–40% (3). The drug most frequently used by prisoners is cannabis, followed by cocaine and heroin. Estimates of heroin use while in prison ranged from 1% to 21% of prisoners [4]. The wide variation in prevalence levels between countries may reflect methodological differences in data collection and reporting. Factors such as price and availability will influence the substances used within prison, but studies suggest a tendency towards the use of depressant-type drugs such as heroin, hypnotics and sedatives or drugs with depressant effects such as cannabis. Stimulant drugs may be less popular, as the effects can be more difficult to manage, for both prisoners and prison staff, within the confined prison setting (Bullock, 2003)."

European Monitoring Centre for Drugs and Drug Addiction, "Prisons and drugs in Europe: the problem and responses" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDSI12002ENC, doi: 10.2810/73390, pp. 10-11.
http://www.emcdda.europa.eu/at...

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60. Drug Users in Prison
"Cannabis is the illicit drug with the highest reported level of lifetime prevalence among prisoners, with between 12% and 70%

having tried it at some time in their lives. This reflects drug use experience in the general population, although the levels there are lower (1.6% to 33% among 15- to 64-year-olds). Levels of use of cocaine, Europe's second most commonly reported illicit drug, both inside and outside prison, are also much higher among prisoners (lifetime prevalence of 6–53%) than among the general population (0.3–10%). Experience of amphetamines among prisoners ranges from 1% to 45%, whereas among the general population the range is from almost zero to 12%. Data on lifetime misuse of other substances (such as volatile substances, hypnotics and sedatives) are limited, and prevalence levels, among both prisoners and the general population, are usually low (EMCDDA, 2012).
"Prisoners differ greatly from the general population in their reported experience of heroin. Whereas less than 1% of the general population have ever used heroin, lifetime prevalence levels among European prisoners are much higher, with eight of the 13 countries that were able to provide information on heroin use reporting levels between 15% and 39%."

European Monitoring Centre for Drugs and Drug Addiction, "Prisons and drugs in Europe: the problem and responses" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDSI12002ENC, doi: 10.2810/73390, p. 9.
http://www.emcdda.europa.eu/at...

61. DRUID Project Evaluation of Oral Fluid (Saliva) Testing Devices for DUI Enforcement
"Using the above model of evaluation it can be seen that the DrugWipe 5 delivers the best results for sensitivity (91%) whilst also performing very highly in terms of specificity (95%). However the margins of error (95% confidence interval) displayed in Figure 43 show that this value could vary between 78-97%, this margin of error would seem to be due to the size of the study population (135 tests performed) since the device was only tested in Finland. The strong results for this device probably reflect largely on the device?s high performing individual amphetamines test in a country with a relatively high prevalence for amphetamines. However, this overall sensitivity is still higher than the individual sensitivity of the amphetamines test for DrugWipe 5 (87%) indicating that the device was successful in screening for other drugs. Both

DrugTest 5000 and Rapid STAT also performed strongly in this evaluation both for sensitivity (85% and 82% respectively) and specificity (86% and 88% respectively), which is a reflection of their generally relatively good performance for each individual substance test. The sensitivity error margins are also somewhat narrower for these two devices that were tested on a greater number of subjects (220 and 342 tests performed respectively). The OrAlert device also performs at a high level of sensitivity (81%) in this evaluation, however the specificity is somewhat lower at 70% - which is the lowest score for any of the devices. The sensitivities of the other four devices included in the study range between 64% and 32%, which are quite low values. The specificities are, however, very high, or excellent, at between 93% and 100%. The relatively large error bars for the Oratect III device and BIOSENS can be attributed to the number of successful evaluations (58 and 25 respectively)."

Tom Blencowe, Anna Pehrsson and Pirjo Lillsunde, Editors. "Analytical evaluation of oral fluid screening devices and preceding selection procedures." Project Funded by the European Commission under the Transport RTD Programme of the 6th Framework Program, Project No: TREN-05-FP6TR-S07.61320-518404-DRUID (National Institute For Health and Welfare, Finland, Sept. 2010), pp. 93-94. http://www.druid-project.eu/Dr...

62. DRUID Project Evaluation of Oral Fluid (Saliva) Testing Devices for DUI Enforcement

"It is disturbing that the sensitivities of the cannabis and cocaine tests were all quite low, although further testing of the cocaine tests is desirable due to the low prevalences and the low concentrations encountered in this study. There are several countries in Central and Southern Europe for which these two substance classes are of special interest. On the other hand, it seems the sensitivities of the devices are generally better for amphetamines, a frequently encountered drug class among the DUI drivers in the Nordic countries. The suitability of the device for the intended national DUI population should also be considered, for example, PCP is rarely, if ever, found in Europe, therefore at the current time utilising a PCP test is unnecessary. Since the on-site tests are relatively expensive the suitability of all the individual substance tests incorporated in the device should be considered.

"The evaluation showed that none of the evaluated tests is on a desirable level (>80% for sensitivity, specificity and accuracy) for all of the separate tests that they comprised. However, there were tests that performed already on a promising level for one or more substance classes. The DrugTest 5000 had the best overall results. The next best device was Rapid STAT, which performed at a similar level, except for the cocaine test which was somewhat less sensitive. Clearly the best device in terms of sensitivity for amphetamines was the DrugWipe 5."

Tom Blencowe, Anna Pehrsson and Pirjo Lillsunde, Editors. "Analytical evaluation of oral fluid screening devices and preceding selection procedures." Project Funded by the European Commission under the Transport RTD Programme of the 6th Framework Program, Project No: TREN-05-FP6TR-S07.61320-518404-DRUID (National Institute For Health and Welfare, Finland, Sept. 2010), p. 95.
http://www.druid-project.eu/Dr...

63. Spending on Treatment in the EU
Treatment

"In terms of unit costs (per person per day) across treatment modalities, there are clear differences between the treatment types. The highest unit costs are reported for inpatient modalities. The unit cost of inpatient psychosocial treatment is estimated to range from EUR 59 to EUR 404 per patient per day, with Sweden reporting the highest unit cost for this treatment. Detoxification carried out in inpatient settings is reported to cost between EUR 110 and EUR 303, with both the highest and the lowest estimates referring to treatment centres in the United Kingdom. Oral substitution treatment with methadone is reported to cost the least of the other treatment modalities, its unit cost ranging EUR 2 to about EUR 37 per patient per day, with the highest cost estimated in Norway. Although the unit costs of opioid substitution treatment are lower than those of the three other treatment modalities, due to the widespread use of this modality, the overall annual expenditure of reporting countries on opioid substitution treatment is higher than their annual expenditure for other treatment types."

European Monitoring Centre for Drugs and Drug Addiction, "Cost and financing of drug treatment services in Europe: an exploratory study" (Luxembourg: Publications Office of the

European Union, 2011), p. 20.
http://www.emcdda.europa.eu/at...

64. **Availability of Substitution Treatment in the EU**
"Methadone is the most commonly prescribed substitution medication, received by up to two-thirds of substitution clients, while buprenorphine is prescribed to most of the remaining clients (about 20%), and is the principal substitution medication in six countries (Figure 3.7). About 6% of all substitution treatments in Europe rely on the prescription of other substances, such as slow-release morphine or diacetylmorphine (heroin).
"An estimated 734,000 opioid users received substitution treatment in Europe in 2012. This figure is relatively stable when compared with 2011 (726,000), but higher than the 630,000 estimate for 2007 (Figure 3.8). In 2012, five countries reported increases of more than 25 % in client numbers compared to the previous year's estimate. The highest percentage increase was noted in Turkey (250 %), followed by Greece (45%) and Latvia (28%). The percentage increases in these three countries, however, occurred in the context of relatively low base numbers. In contrast, during the same period, Romania (?30 %) reported the largest percentage decrease in estimated client numbers."

European Monitoring Centre on Drugs and Drug Addiction, "European Drug Report 2014: Trends and Developments" (Lisbon, Portugal: EMCDDA, 2014), p. 58.
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

65. **Availability of Psychosocial Treatment in the EU**
"In a 2010 survey, national experts reported outpatient psychosocial treatment in Europe to be available to nearly all who seek it in 14 countries, and to the majority of those who seek it in 11 countries. In three countries (Bulgaria, Estonia, Romania) however, outpatient psychosocial treatment is estimated to be available to fewer than half of those who actively seek it. These ratings may hide considerable variation within countries and differences in the availability of specialised treatment programmes for specific target groups,

such as older drug users or ethnic minorities. Some countries report difficulties in providing specialised services at a time of economic recession and budgetary cuts."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 31.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

66. Types of Opiate Substitution Treatment Available in the EU
"In Europe, methadone is the most commonly prescribed opioid substitute, received by up to three quarters of substitution clients. Buprenorphine-based substitution medications are prescribed to up to a quarter of European substitution clients, and are the principal substitution medications in the Czech Republic, Greece, France, Cyprus, Finland and Sweden (103). The combination buprenorphine-naloxone is available in 15 countries. Treatments with slow-release morphine (Bulgaria, Austria, Slovenia), codeine (Germany, Cyprus) and diacetylmorphine (Belgium, Denmark, Germany, Spain, Netherlands, United Kingdom) represent a small proportion of all treatments."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 76.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

67. Global Heroin Treatment Need and Overdose Deaths
"More than 60 per cent of drug treatment demand in Asia and Europe relate to opiates that are, especially heroin, the most deadly drugs. Deaths due to overdose are, in any single year, as high as 5,000-8,000 in Europe, and several times this amount in the Russian Federation alone."

United Nations Office on Drugs and Crime, "Addiction, Crime and Insurgency: The transnational threat of Afghan opium"

(Vienna, Austria: October 2009, p. 7.
http://www.unodc.org/documents...

68. Opioid Substitution Treatment in the EU

"Substitution treatment is the predominant treatment option for opioid users in Europe. It is generally provided in specialist outpatient settings, though in some countries it is also available in inpatient settings, and is increasingly provided in prisons [20]. In addition, office-based general practitioners, often in shared-care arrangements with specialist centres, increasingly play a role. Opioid substitution is available in all EU Member States and in Croatia, Turkey and Norway [21]. Overall, it is estimated that there were about 710 000 substitution treatments in Europe in 2010. Compared with 2009, the number of clients in substitution treatment increased in most countries, though Spain and Slovakia report small decreases [22]."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 41.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

69. Increasing Availability of Opioid Substitution Treatment in the EU

"The most common type of treatment for opioid dependence in Europe is substitution treatment, typically integrated with psychosocial care and provided at specialist outpatient centres. Sixteen countries report that it is also provided by general practitioners. In some countries, general practitioners provide this treatment in a shared-care arrangement with specialist treatment centres. The total number of opioid users receiving substitution treatment in the European Union, Croatia, Turkey and Norway is estimated at 709,000 (698 000 for EU Member States) in 2010, up from 650,000 in 2008, and about half a million in 2003[101]. The vast majority of substitution treatments continue to be provided in the 15 pre?2004 EU Member States (about 95% of the total), and medium-term trends (2003–10) show continuous increases (Figure 14). The greatest increases

in provision among these countries were observed in Greece, Austria and Finland, where treatment numbers almost tripled. "An even higher rate of increase was observed in the 12 countries that have joined the European Union since 2004. In these countries, the number of substitution clients rose from 7,800 in 2003 to 20,400 in 2010, with much of the increase occurring after 2005. Proportionally, the expansion of substitution treatment in these countries over the seven-year period was highest in Estonia (sixteenfold from 60 to over 1,000 clients, though still reaching only 5% of opioid injectors) and Bulgaria (eightfold). The smallest increases were reported in Lithuania, Hungary and Slovakia.
"A comparison of the estimated number of problem opioid users with the number of clients in substitution treatment suggests varying coverage levels in Europe. Of the 18 countries for which reliable estimates of the number of problem opioid users are available, nine report a number of clients in substitution treatment corresponding to about 50% or more of the target population[102]. Six of those countries are pre?2004 EU Member States, and the remaining countries are the Czech Republic, Malta and Norway."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 75.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

70. Availability of Heroin-Assisted Treatment in the EU
"A number of European countries have remained at the forefront of innovation with regards to OST and drug dependence therapies. For those who cannot or do not wish to stop injecting, a small number of European countries prescribe injectable OST medicines (including the Netherlands, Switzerland and the United Kingdom) (Cook and Kanaef, 2008). The prescription of pharmaceutical heroin (diacetylmorphine) remains limited to a few European countries (Fischer et al., 2007; EMCDDA, 2009a, Table HSR-1). Despite positive findings from randomised controlled trials in several countries (indicating that diacetylmorphine is effective, safe, and cost-effective, and can reduce drug-related crime and improve

patient health), only Denmark, Germany, the Netherlands, Switzerland and the United Kingdom include this intervention as part of the national response to drugs. Pilot programmes are currently underway in Belgium and Luxembourg (EMCDDA, 2009a, Table HSR-1)."

Catherine Cook, Jamie Bridge and Gerry V. Stimson, "The diffusion of harm reduction in Europe and beyond," in EMCDDA MONOGRAPHS No. 10: Harm reduction: evidence, impacts and challenges (Luxembourg: Publications Office of the European Union, 2010), doi: 10.2810/29497, p. 49.
http://www.emcdda.europa.eu/at...

71. Availability of Specialized Treatment Services
"Treatment units or programmes that exclusively service one specified target group are a common phenomenon across the EU. Children and young people under the age of 18 are treated in specialised agencies in 23 countries; the treatment of drug users with psychiatric co-morbidity takes place in specialised agencies in 18 countries; and women-specific services are reported to exist in all countries except Cyprus, Latvia, Lithuania, Bulgaria and Turkey. Services designed to meet the needs of immigrant drug users or of groups with specific language requirements or religious or cultural backgrounds are less common but have been reported from Belgium, Germany, Greece, Spain, Lithuania, the Netherlands, Finland, Sweden and the United Kingdom."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 33.
http://www.emcdda.europa.eu/at...

72. Cost of Opioid Substitution Treatment
"From published studies, it is possible to extract additional data on unit costs. In England, a research study, based on 401 clients from seven clinics specialising in substitution treatment, estimated the range of costs of 'treatment as usual' (Raistrick et al., 2007). The average total cost of treatment per patient per day was EUR 3 (EUR 3, price year 2007), excluding the cost of prescribed drugs, and EUR 6 (EUR 5, price year 2007) including prescribed drugs. The study found that among the

key factors influencing treatment costs across agencies were the complexity of the case mix, the amount of drugs prescribed, and the gender mix. In England, methadone maintenance was estimated to cost between EUR 2 (EUR 2, price year 2007) and EUR 24 (EUR 22, price year 2007) per patient per day in the 15 programmes studied (Curtis, 2008), while the DTORS research team, reported specialist prescribing at EUR 18 (EUR 17, price year 2006/07) per patient per day (Davies et al., 2009).
"In Spain, Martinez-Raga et al. (2009) reported estimates of EUR 4 (EUR 4, price year 2004) per patient per day in methadone maintenance treatment and EUR 5 (EUR 5, price year 2004) per patient per day in buprenorphine maintenance treatment. As these estimates exclude medication costs, they are not full unit costs. In Lithuania, (3) Vanagas et al. (2010), based on 102 treatment clients, estimated the cost of methadone maintenance treatment at EUR 4 per patient per day (2004 prices, no CPI identified).
"In Germany, the unit cost of oral methadone maintenance treatment (3) was estimated at EUR 10 (EUR 9, price year 2006) per client per day or EUR 3 490 (EUR 3 314, price year 2006) for the 12 month trial period, of which the cost of methadone accounted for about 12 % (von der Schulenburg and Claes, 2006). An estimate for Norway puts the average cost of methadone substitution treatment in that country at EUR 37 (EUR 32, price year 2001) per patient per day (Melberg et al., 2003).
"The unit cost estimates for opioid substitution treatment with methadone reviewed here range from EUR 2 to EUR 37 per patient per day. This variation may reflect differences in one or more of several possible factors: national and regional drug situations and treatment systems, the case mix of patients, year of data collection, and inclusion of medication cost."

European Monitoring Centre for Drugs and Drug Addiction, "Cost and financing of drug treatment services in Europe: an exploratory study" (Luxembourg: Publications Office of the European Union, 2011), p. 17.
http://www.emcdda.europa.eu/at...

73. Availability of Opiate Treatment
"Both drug-free and substitution treatments for opioid users are available in all EU Member States, Croatia, Turkey and Norway. In most countries, treatment is conducted in outpatient settings, which can include specialised centres, general

practitioners' surgeries and low-threshold facilities. In a few countries, residential treatment plays an important role in the treatment of opioid dependence[100]. A small number of countries offer heroin-assisted treatment for a selected group of chronic heroin users."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 75.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

74. **Effectiveness of Treatment on Employment and Social Reintegration**
"The Drug Treatment Outcomes Research Study (DTORS) was one example of European research with encouraging results regarding employment (Jones et al., 2009). This study investigated drug use, health and psychosocial outcomes in 1 796 English drug users attending a range of different types of treatment service. Follow-up interviews were conducted between 3 and 13 months after baseline (soon after initial treatment entry). Regardless of the type of treatment received or drug use outcomes, employment levels increased from 9 % at baseline to 16 % at follow-up. This was accompanied by a corresponding increase in the amount of legitimate income earned per week. The proportion reporting being unemployed but actively looking for work decreased slightly from 27 % to 24 %, reflecting the increase in employment and a 5 percentage point increase in those reporting being unable to work (because of long-term sickness or disability). The proportion of participants classed as unemployed and not looking for work also fell from 24 % to 11 %. Treatment attendance was also associated with changes in housing status; the proportion staying in stable accommodation increased from 60 % to 77 % at follow-up. It should be noted that the findings of this study were weakened by use of a non-experimental design, failure to separate outcomes according to client type and treatment modality, and insufficient detail on the nature of the employment obtained."

European Monitoring Centre for Drugs and Drug Addiction, EMCDDA Insights Series No 13, "Social reintegration and

employment: evidence and interventions for drug users in treatment" (Luxembourg: Publications Office of the European Union, 2012), ISBN: 978-92-9168-557-8, doi: 10.2810/72023, p. 67.
emcdda.europa.eu

75. Safe Smoking Devices
"Provision of specific harm-reduction programmes for crack cocaine smokers in Europe is limited. Some drug consumption facilities in three countries (Germany, Spain, Netherlands) provide facilities for inhalation of drugs, including crack cocaine. Hygienic inhalation devices including clean crack pipes or 'crack kits' (glass stem with mouth piece, metal screen, lip balm and hand wipes) are reported to be sporadically provided to drug users who are smoking crack cocaine by some low-threshold facilities in Belgium, Germany, Spain, France, Luxembourg and the Netherlands. Foil is also made available to heroin or cocaine smokers at some low-threshold facilities in 13 EU Member States. In the United Kingdom, the Advisory Council on the Misuse of Drugs recently reviewed the use of foil as a harm-reduction intervention, finding evidence that its provision may promote smoking over injecting use (ACMD, 2010)."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 68.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

76. Supervised Injection Facilities in the EU
"Highly targeted interventions, such as supervised injecting facilities, reach specific subgroups of highly marginalised drug users and contribute to reducing morbidity and mortality. In Denmark, a mobile injection room, providing a safer injecting environment and medical supervision was established in Copenhagen in 2011 by a private organisation (131). Similar to the supervised drug consumption facilities in Germany, Spain, Luxembourg, the Netherlands and Norway, the new facility in Denmark is equipped to reduce the impact of non-fatal

overdoses."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 87.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

77. Safe Consumption Rooms in the EU
Harm Reduction

"A more controversial approach has been adopted in some cities in Europe, where the concept of safe consumption rooms, usually targeting drug injection, has been extended to drug inhalation. Rooms for supervised inhalation have been opened in several Dutch, German and Swiss cities (EMCDDA, 2004c). Although the supervision of consumption hygiene is a main objective of such services, there is some evidence that they could also act as a conduit to other care options; for example, monitoring of one service in Frankfurt, Germany, reported that, during a six-month evaluation period in 2004, more than 1,400 consumptions were supervised, while 332 contact talks, 40 counselling sessions and 99 referrals to other drugs services were documented."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 64.
http://www.emcdda.europa.eu/at...

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

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

European Monitoring Centre on Drugs and Drug Addiction, "European Drug Report 2014: Trends and Developments" (Lisbon, Portugal: EMCDDA, 2014), p. 55.
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

79. Syringe Availability Through Pharmacies
"The purchase of syringes through pharmacies may be a major source of contact with the health service for some injectors, and the potential to exploit this contact point as a conduit to other services clearly exists. Work to motivate and support pharmacists to develop the services they offer to drug users could form an important part of extending the role of pharmacies, but to date only France, Portugal and the United Kingdom appear to be making significant investments in this direction."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 80.
http://www.emcdda.europa.eu/at...

80. SIFs and Referrals to Treatment
"A more controversial approach has been adopted in some cities in Europe, where the concept of safe consumption rooms, usually targeting drug injection, has been extended to drug inhalation. Rooms for supervised inhalation have been opened

in several Dutch, German and Swiss cities (EMCDDA, 2004c). Although the supervision of consumption hygiene is a main objective of such services, there is some evidence that they could also act as a conduit to other care options; for example, monitoring of one service in Frankfurt, Germany, reported that, during a six-month evaluation period in 2004, more than 1,400 consumptions were supervised, while 332 contact talks, 40 counselling sessions and 99 referrals to other drugs services were documented."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 64.
http://www.emcdda.europa.eu/at...

81. Pharmacy-Based Syringe Exchange
"Pharmacy-based exchange schemes also help to extend the geographical coverage of the provision and, in addition, the sale of clean syringes in pharmacies may increase their availability. The sale of syringes without prescription is permitted in all EU countries except Sweden, although some pharmacists are unwilling to do so and some will even actively discourage drug users from patronising their premises."

"Annual Report 2006: The State of the Drugs Problem in Europe," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 79.
http://www.emcdda.europa.eu/at...

82. Syringe Exchange Through Pharmacies
"Formally organised pharmacy syringe exchange or distribution networks exist in nine European countries (Belgium, Denmark, Germany, Spain, France, the Netherlands, Portugal, Slovenia and the United Kingdom), although participation in the schemes varies considerably, from nearly half of pharmacies (45%) in Portugal to less than 1% in Belgium. In Northern Ireland, needle and syringe exchange is currently organised exclusively through pharmacies."

"Annual Report 2006: The State of the Drugs Problem in Europe,"

European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2006), p. 80.
http://www.emcdda.europa.eu/at...

83. **Naloxone and Overdose Prevention in the EU**
"In 2011, two thirds of European countries reported that ambulance personnel are trained in naloxone use; in just over half of these countries, naloxone is reported to be one of the standard medications carried in ambulances. Only Italy, Romania and the United Kingdom report the existence of community-based harm-reduction programmes that provide take-home naloxone to opioid users, their family members and carers. Legal barriers remain in place in other European countries, including Estonia, which has the highest drug-related mortality rate among adults (15–64) in the European Union. However, it was demonstrated in the United Kingdom that, with minimal training, healthcare professionals, including drug workers, can increase their knowledge, skills and confidence for managing an opioid overdose and administering naloxone (Mayet at al., 2011)."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 87.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

84. **Drug-Related Public Expenditures in the EU**
Economics

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

(Figure 4.4).
"Public expenditure on supply reduction includes, among other things, expenditure on drug-law offenders in prisons. The EMCDDA calculated a range of estimates, where the low estimate considers only those prisoners who have been sentenced for a drug-law offence and the high estimate also includes pre-trial prisoners who may be sentenced for a drug-law offence. Applying these criteria, European countries spent an estimated 0.03% of GDP, or EUR 3.7 billion, on drug-law offenders in prison in 2010. Including pre-trial prisoners, the estimate rises to 0.05% of GDP or EUR 5.9 billion."

European Monitoring Centre on Drugs and Drug Addiction, "European Drug Report 2014: Trends and Developments" (Lisbon, Portugal: EMCDDA, 2014), p. 70.
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

85. Drug Control Spending Cuts in the EU Caused by Economic Downturn
"Many European countries continue to face the consequences of the recent economic downturn. The extent of fiscal consolidation or austerity measures and their impact differs between European countries. Among the 18 countries with sufficient data to make a comparison, reductions were reported in health and public order and safety — the areas of government spending where most drug-related public expenditure originates.
"Overall, between 2009 and 2011, greater reductions in public expenditure were observed in the health sector. Cuts in funds available for drug-related programmes and services have also been reported by European countries, with drug prevention interventions and drug-related
research particularly affected. Several countries also report that attempts to ring-fence the financing of drug treatment have not always succeeded."

European Monitoring Centre on Drugs and Drug Addiction, "European Drug Report 2014: Trends and Developments" (Lisbon, Portugal: EMCDDA, 2014), p. 70.
http://www.emcdda.europa.eu/ed...
http://www.emcdda.europa.eu/pu...

http://www.emcdda.europa.eu/at...

86. **International Drug Conventions and Heroin-Assisted Treatment**
"Many countries believe (erroneously) that the international drug conventions prohibit the use of heroin in medical treatment. Furthermore, the International Narcotics Control Board (INCB) has exerted great pressure on countries to cease prescribing heroin for any medical purpose. Nevertheless, a few countries, including the UK, Belgium, the Netherlands, Iceland, Malta, Canada and Switzerland, continue to use heroin (diamorphine) for general medical purposes, mostly in hospital settings (usually for severe pain relief). Until recently, however, Britain was the only country that allowed doctors to prescribe heroin for the treatment of drug dependence."

Stimson, Gerry V., and Nicky Metrebian, Centre for Research on Drugs and Health Behavior, "Prescribing Heroin: What is the Evidence?" (London, England: Rowntree Foundation, 2003), p. 4.
http://www.jrf.org.uk/sites/fi...

87. **European Union - 6-26-10**
Laws and Policies

"The current EU drugs strategy (2005–12) is the first to be submitted to external evaluation. The evaluators found that the strategy has provided added value to the efforts of the Member States in the drugs field and that the promotion of evidence-based interventions in the EU strategy was commended by stakeholders (Rand Europe, 2012). The report highlighted the area of information, research and evaluation, where the EU approach and infrastructures actively support knowledge transfer within Europe. For the next strategy, which will be drafted during 2012, the evaluators recommended maintaining the balanced approach, adopting integrated policy approaches across licit and illicit substances including new psychoactive substances, building up the evidence base in drug supply reduction and clarifying the roles of EU coordination bodies. Given the current political interest in the topic and its clear European dimension, an important issue for the upcoming strategy will be responses to new psychoactive substances."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 20.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

88. Legal Distinctions Between Drugs and Amounts
"In Belgium, Bulgaria, Czech Republic, Spain, Ireland, Italy, Cyprus, Luxembourg, Malta, the Netherlands, Portugal, Romania and the UK, the penalty for a drugs offence officially varies according to the nature of the substance involved. Thus the law in those 13 countries instructs or requests the judicial authorities to distinguish between drugs when prosecuting. Of these 13 countries, in Malta the penalty is only varied for a charge of drug trafficking, whereas in Belgium, Czech Republic, Ireland and Luxembourg it is only different for the offence of possession of (a small amount of) cannabis for personal use.
"In the remaining 14 EU Member States, Croatia and Norway, the law officially does not recognise differences between drugs, and drugs offences may incur the same penalty regardless of the substances involved. However, there is a discrepancy between the formal legal texts and actual practice; the judicial authorities do consider the nature of the substances (as well as the quantity and other determining factors) when sentencing, either using their discretionary power or by applying circulars or directives.

Note: A list of the "Main laws and lists of substances (with examples) can be found at:
http://eldd.emcdda.europa.eu/h....

European Monitoring Centre for Drugs and Addiction, Classification of Controlled Drugs, from the web at
http://eldd.emcdda.europa.eu/h...
last accessed Dec. 4, 2012.

89. EU Drug Strategy
"The EU Drug Strategy has no main priorities specifically focusing on national strategies, laws and public expenditure, however, the cross-cutting theme of coordination does include

an objective to: 'Ensure that a balanced and integrated approach is reflected in national policies and in the EU approach towards third countries and in international fora'. In addition, included under the Strategy's cross-cutting theme of evaluation, an expected result is: 'To give clear indications about the merits and shortcoming of current actions and activities on EU level, evaluation should continue to be an integral part of an EU approach to drugs policy'.
"National Drug Strategies In Place
"Over the 2005-2012 period, EU Member States have continued to develop detailed strategies and action plans in the drugs field. As of mid 2011, two more countries have national drug policy documents than was the case in 2005, and it is reasonable to predict that more than 50 separate drug strategies and action plans will have come into force over the eight-year period of the strategy — an average of almost two per country. In terms of content, changes are difficult to assess and might have been relatively limited as the documents are still comprehensive and cover all or most areas of drug policy. On the whole, countries have not extended drug policies into the broader field of addictions, and/or towards the inclusion of licit drugs such as alcohol."

European Monitoring Centre for Drugs and Drug Addiction, "EMCDDA trend report for the evaluation of the 2005–12 EU drugs strategy" (Lisbon, Portugal: EMCDDA, April 2012), pp. 7-8. http://www.emcdda.europa.eu/at...

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90. 'Global' Scope
"Five countries have adopted strategies or action plans that have a 'global' scope, covering licit and illicit drugs and, in some cases, addictive behaviours. The broad approach is reflected in the policy document titles: Belgium's 'Comprehensive and integrated policy on drugs'; France's 'Governmental plan to fight drugs and drug addiction'; Germany's 'National strategy for drug and addiction policy'; Sweden's 'Cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy'; and Norway's 'Action plan for the drugs and alcohol field'. With the exception of Norway, which has separate tobacco and gambling strategies, there are no separate national strategies for other licit drugs or addictive behaviours in these countries."

European Monitoring Centre for Drugs and Drug Addiction,

"Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 22.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

91. Harm Reduction Measures
"In 2003, the Council of the European Union recommended a number of policies and interventions to the EU Member States to tackle health-related harm associated with drug dependence (26). In a follow-up report in 2007, the Commission of the European Communities confirmed that the prevention and reduction of drug-related harm is a public health objective in all countries (27). National drug policies have been increasingly covering the harm-reduction objectives defined in the EU drugs strategy, and there is now broad agreement among countries on the importance of reducing the spread of infectious diseases and overdose-related morbidity and mortality and other harms.
"During the past two decades, harm-reduction policies have promoted the adoption of evidence-based approaches and helped to remove barriers to service access. One result has been a significant increase in the number of drug users that are in contact with health services and undergoing treatment in Europe. Harm-reduction interventions for drug users now exist in all EU Member States, and while some are just starting to develop services, most can report high levels of provision and coverage."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 33.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

92. Reducing Loss of Life as Policy Priority
"Reducing the loss of life due to drug use is a key policy priority in the majority of European countries, with 16 reporting that it is a focus in their national or regional drug policy documents, or that it is the subject of a specific action plan. In some other European countries, such as Austria and Norway,

increases in drug-related deaths observed in previous years have raised awareness of the need for improved responses."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 86.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

93. Alcohol
"When it comes to alcohol policy, it seems that the 15 'old' EU member states have converged to some extent. While alcohol policy has grown weaker in Finland and Sweden, several other countries -- including Southern European ones -- have reinforced their policies, for instance by lowering legal blood-alcohol levels for drivers and introducing stricter age limits for purchasing alcohol in both shops and restaurants."

Centralförbundet för alkohol- och narkotikaupplysning, "Drogutvecklingen i Sverige 2006" ((Drug Trends in Sweden 2006) (Stockholm, Sweden: CAN, 2006), Report No. 98, p. 34.
http://www.can.se/PageFiles/16...

94. Need for Social Reintegration and Services for Drug Users
"Drug use is an important factor that increases the likelihood of concurrent social exclusion (EMCDDA, 2003a). However, there is no clear causality between drug use and social exclusion, as either may lead to the other, and both may be preceded and caused by (unknown) third factors. Many problem drug users already experienced problems in other spheres of life, including social exclusion, prior to their drug use. In this sense, problem drug users can also belong to other vulnerable groups, such as homeless people or people with mental health problems. Likewise, it is important to note that not all drug users are socially excluded (and vice versa).
However, this report focuses on social reintegration of problem drug users, who are at greater risk of social exclusion than non-problem drug users (EMCDDA, 2003a).
"Thus it becomes evident that problem drug users are not a distinct and exclusive population. As a consequence, overlaps

exist between social reintegration activities targeted specifically at problem drug users and social reintegration activities for other vulnerable groups. This is reflected in the fact that many social reintegration programmes in the EU target not only problem drug users but a wider population at risk of social exclusion, including, for example, former prisoners and homeless people.
"Finally, European countries have set up a wide range of generic policies and structures that allow their citizens to maintain a minimum standard of life, to strengthen their abilities to be self-dependent and to protect them from the risk of social exclusion. Such generic structures or policies are generally referred to as welfare states. They are expected to provide social security, education and healthcare. European welfare policies generally include a commitment to full employment, social protection for all citizens and social inclusion (see Europe 2020 (1))."

EMCDDA Insights No. 13: Social reintegration and employment: evidence and interventions for drug users in treatment (Luxembourg: Publications Office of the European Union, 2012), doi: 10.2810/72023, p. 23.
http://www.emcdda.europa.eu/at...

95. Homeless and Housing Assistance
"Four countries (16 %; n = 25) reported that the accommodation needs of problem drug users were specifically addressed by actions set out in national social protection and inclusion plans. In Austria the National Action Plan on Social Inclusion (Nationaler Aktionsplan Soziale Eingliederung) states that socially assisted housing should be increasingly provided to drug-dependent people in the future. In the Netherlands, the national government and the municipalities of the four largest cities signed and funded the Strategy Plan for Social Relief (Plan van Aanpak Maatschappelijke Opvang) for those groups with the most complex and persistent needs. In a second phase of the plan, starting in 2010, the remaining 39 municipalities began implementation. In Portugal, the accommodation needs of drug users are addressed through explicit mention of the population in the National Strategy for the Integration of Homeless People.
"Of the 21 (84 %, n = 25) countries reporting that accommodation needs are not specifically addressed, 10 (48 %) stated that drug-

using groups are included in plans as part of other targeted populations, most often socially excluded or vulnerable populations. For instance, Denmark, Ireland, Poland, Romania and Sweden address these needs through homelessness strategies. In Germany the Social Service Code guarantees basic social care for all people needing social support including accommodation.
"Six countries (25 %; n = 24) reported that accommodation needs of drug users are explicitly addressed in separate plans that support national employment strategies. These include policies on offender rehabilitation, mental health needs or other disadvantages."

European Monitoring Centre for Drugs and Drug Addiction, "EMCDDA Insights Series No 13: Social reintegration and employment: evidence and interventions for drug users in treatment" (Luxembourg: Publications Office of the European Union, 2012), doi: 10.2810/72023, p. 181.
http://www.emcdda.europa.eu/at...

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96. Prevention Strategies
"Environmental prevention strategies are designed to change the cultural, social, physical and economic environments in which people make their choices about drug use. These strategies typically include measures such as alcohol pricing, and bans on tobacco advertising and smoking where there is good evidence of effectiveness. Other environmental strategies focus on developing protective school environments. Among the examples reported by European countries are: promotion of a positive and supportive learning climate (Poland, Finland); provision of education in citizenship norms and values (France); and making schools safer through the presence of police in the neighbourhood (Portugal).
"It has been argued that a range of social problems, including substance use, teenage pregnancy and violence, are more prevalent in countries with high levels of social and health inequality (Wilkinson and Pickett, 2010). Many Scandinavian countries, such as Finland, invest heavily in broader environmental policies that are geared towards increasing social inclusion at family, school, community and society level and which contribute to, and help maintain, lower levels of drug use. Prevention programmes and interventions targeting specific problems or drugs are less used in these countries."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 28.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

97. Universal Prevention Strategies
"Universal prevention addresses entire populations, predominantly in school and community settings. It aims to reduce substance-related risk behaviour by providing young people with the necessary competences to avoid or delay initiation into substance use. A recent evaluation of the 'Unplugged' prevention programme in the Czech Republic found that participating students reported significantly reduced rates of smoking, as well as less frequent smoking, drunkenness, cannabis use, and use of any drug (Gabrhelik et al., 2012). However, there have been recent reports of reductions in the provision of universal prevention in Greece and Spain, and in prevention staffing levels in Latvia, which supports earlier suggestions that prevention is an area affected by budgetary cuts in this period of economic downturn
(EMCDDA, 2011a)."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 29.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

98. Selective Prevention Strategies
"Selective prevention intervenes in specific groups, families or communities who, due to their reduced social ties and resources, may be more likely to develop drug use or progress into dependency. Denmark, Germany, Spain, Austria and Portugal have implemented targeted prevention interventions for pupils in vocational schools, a group of young people identified as being at elevated risk of developing drug use problems. Ireland has taken a broader approach in terms of

prevention work with at-risk youth, by working to improve literacy and numeracy among disadvantaged students. Community-level interventions targeting high-risk groups of young people, such as reported by Italy and municipalities in the north of Europe, combine individual and environmental strategies through outreach, youth work, and formal cooperation between local authorities and non-governmental organisations. Such approaches aim to target high-risk youth without recruiting them into specific programmes."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publications Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 29.
http://www.emcdda.europa.eu/pu...
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99. Definitions
"According to our convention *'decriminalisation'* comprises removal of a conduct or activity from the sphere of criminal law. Prohibition remains the rule, but sanctions for use (and its preparatory acts) no longer fall within the framework of the criminal law (elimination of the notion of a criminal offence). This may be reflected either by the imposition of sanctions of a different kind (administrative sanctions without the establishment of a police record – even if certain administrative measures are included in the police record in some countries, such as France), or the abolition of all sanctions. Other (non-criminal) laws can then regulate the conduct or activity that has been decriminalised.
"According to our convention *'depenalisation'* means relaxation of the penal sanction provided for by law. In the case of drugs, and cannabis in particular, depenalisation generally signifies the elimination of custodial penalties. Prohibition remains the rule, but imprisonment is no longer provided for, even if other penal sanctions may be retained (fines, establishment of a police record, or other penal sanctions)."

European Monitoring Center on Drugs and Drug Addiction, "Illicit drug use in the EU: legislative approaches" (Lisbon, Portugal: EMCDDA, 2005), p. 12,
http://eldd.emcdda.europa.eu/a...

100. Integrated Approach to Licit and Illicit Drugs

"The trend towards an integrated approach to substance use appears to exist primarily among the pre-2004 EU Member States. It is these countries that have adopted a global strategy, or that are in the process of integrating their illicit drug and alcohol strategies or that have included many licit drug objectives in their illicit drug strategy. In central and eastern Europe, the picture is mainly one of separate strategies or just illicit drug strategies, with limited mention of licit drugs."

European Monitoring Centre for Drugs and Drug Addiction, "Annual report 2012: the state of the drugs problem in Europe" (Luxembourg: Publicatons Office of the European Union, November 2012), Catalog No. TDAC12001ENC, doi:10.2810/64775, p. 22.
http://www.emcdda.europa.eu/pu...
http://www.emcdda.europa.eu/at...

101. SEPs and HIV

A literature review in 2004 by the European Union's drug monitoring agency, the European Monitoring Centre on Drugs and Drug Addiction, found that "Major reviews (summarised in Vlahov and Junge, 1998; Bastos and Strathdee, 2000; Ferrini, 2000) suggest that NSPs (Needle and Syringe Programs) may reduce rates of seroconversion to HIV and hepatitis by one third or more, without negative side effects on the number of IDUs (Vlahov and Junge, 1998). A landmark study from Hurley et al. combined HIV seroprevalence data from 81 cities with (n=52) or without (n=29) NSPs (Hurley et al., 1997). They showed that the average annual seroprevalence was 11% lower in cities with an NSP than in cities without an NSP, providing important evidence on the effectiveness of NSPs in reducing the spread of HIV."

de Wit, Ardine and Jasper Bos, "Cost-Effectiveness of Needle and Syringe Programmes: A Review of the Literature," in Hepatitis C and Injecting Drug Use: Impact, Costs and Policy Options, Johannes Jager, Wien Limburg, Mirjam Kretzschmar, Maarten Postma, Lucas Wiessing (eds.), European Monitoring Centre on Drugs and Drug Addiction, 2004.

102. "Spice" and Other Herbal Highs

"'Spice' and other 'herbal' products are often referred to as 'legal highs' or 'herbal highs', in reference to their legal status and purported natural herbal make-up (McLachlan, 2009; Lindigkeit et al., 2009; Zimmermann et al., 2009). However, albeit not controlled, it appears that most of the ingredients listed on the packaging are actually not present in the 'Spice' products and it is seems likely that the psychoactive effects reported are most probably due to added synthetic cannabinoids, which are not shown on the label. There is no evidence that JWH, CP and/or HU [three chemically distinct groups of synthetic cannabinoids] compounds are present in all 'Spice' products or even batches of the same product. Different amounts or combinations of these substances seem to have been used in different 'Spice' products to produce cannabis-like effects. It is possible that substances from these or other chemical groups with a cannabinoid agonist or other pharmacological activity could be added to any herbal mixture ([17]) (Griffiths et al., 2009).

"The emergence of new, smokable herbal products laced with synthetic cannabinoids can also be seen as a significant new development in the field of so-called 'designer drugs'. With the appearance, for the first time, of new synthetic cannabinoids, it can be anticipated that the concept of 'designer drugs' being almost exclusively linked to the large series of compounds with phenethylamine and tryptamine nucleus will change significantly ([18]). There are more than 100 known compounds with cannabinoid receptor activity and it can be assumed that further such substances from different chemical groups will appear (with direct or indirect stimulation of CB1 receptors)."

"Understanding the 'Spice' phenomenon," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2009), p. 21.
http://www.emcdda.europa.eu...

103. Monitoring of Spice and New Psychoactive Substances

"A dramatic online snapshot of the Spice phenomenon as an emerging trend has been recently given by an important web mapping program, the Psychonaut Web Mapping Project, a European Commission-funded project involving researchers from seven European countries (Belgium, Finland, Germany, Italy, Norway, Spain, and UK), which aims to develop a web

scanning system to identify newly marketed psychoactive compounds, and their combinations (e.g., ketamine and Spice, cannabis and Spice), on the basis of the information available on the Internet (Psychonaut Web Mapping Research Group, 2010). As a major result of the Project, a new and updated web-based database is now widely accessible to implement a regular monitoring of the web for novel and recreational drugs."

Fattore, Liana and Fratta, Walter "Beyond THC: the new generation of cannabinoid designer drugs," Frontiers in Behaviorial Neuroscience (Lausanne, Switzerland: September 2011) Volume 5, Article 60, p. 3.
http://www.ncbi.nlm.nih.gov...

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104. Harm Reduction Defined
"Harm reduction encompasses interventions, programmes and policies that seek to reduce the health, social and economic harms of drug use to individuals, communities and societies. A core principle of harm reduction is the development of pragmatic responses to dealing with drug use through a hierarchy of intervention goals that place primary emphasis on reducing the health-related harms of continued drug use (Des Jarlais, 1995; Lenton and Single, 2004). Harm reduction approaches neither exclude nor presume a treatment goal of abstinence, and this means that abstinence-oriented interventions can also fall within the hierarchy of harm reduction goals. We therefore envisage harm reduction as a 'combination intervention', made up of a package of interventions tailored to local setting and need that give primary emphasis to reducing the harms of drug use. In relation to reducing the harms of injecting drug use, for example, this combination of interventions may draw upon needle and syringe programmes (NSPs), opioid substitution treatment (OST), counselling services, the provision of drug consumption rooms (DCRs), peer education and outreach, and the promotion of public policies conducive to protecting the health of populations at risk (WHO, 2009)."

"Harm reduction: evidence, impacts and challenges," European Monitoring Centre for Drugs and Drug Addiction (Luxembourg: Office for Official Publications of the European Communities, 2010), p. 19.
http://www.emcdda.europa.eu/at...

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