Strategies in Combating Narcotics and Psychotropic Substances – Europe and Germany

NAUSS, Riyadh, 21-22.01.2015
Georg Schuh - Liaison Officer
German Embassy Riyadh
Content

- Situation in Germany
- EU Drug Report 2013
- EU Drugs Strategy 2013-2020: Recommendations
- National Strategy and Addiction Policy
- Cooperation
Population: approx. 81 m
Area: 357,168 sq. km
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal offences</td>
<td>5,961,662</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Suspects</td>
<td>2,094,160</td>
<td>0.0%</td>
</tr>
<tr>
<td>Clear-up rate</td>
<td>54.5%</td>
<td>54.4%</td>
</tr>
</tbody>
</table>
Number of recorded criminal offences in 2013: 5,961,662 (2012: 5,997,040)
Drug-related offences in Germany in 2013: **253,525** dealing/trafficking offences
Drug-related death cases

2012: 944 persons (-4 %)
2013: 1,002 persons (+6 %)
hard-drug-users (HDU) who came to police notice for the first time

- 19,210 persons in 2013 (-1,8 %)

- + 7,4 %
- + 17,7 %

- meth-/amphetamine: 2013: 13,721
- Ecstasy: 2013: 1,480
Organisation of the German Police

**Fundamental Principle:**

The Federal States (Länder) are in charge of police matters

**Exceptions:**

Federal Criminal Police Office (Bundeskriminalamt)
Federal Police (Bundespolizei)

**Relation to Intelligence Services:**

Organisational separation
Section 4 (1) no. 1 BKA Law

**Internationally organised crime:**

- arms trafficking
- trafficking in ammunition and explosives
- trafficking in drugs or pharmaceutical products
- production or distribution of counterfeit money

as well as respective associated offences including money laundering
SO 2 – Drug-related and pharmaceutical Crime

Subdivision SO 2

- **SO 21**
  - Analysis of heroin, cocaine and cannabis, central situation and information service
  - **SO 21 - 1**
    - Cocaine
  - **SO 21 - 2**
    - Heroin/Cannabis, central situation and information service

- **SO 22**
  - Analysis of synthetic drugs, pharmaceutical crime, Joint Customs/Police Precursor Control Unit
  - **SO 22 - 1**
    - Synthetic Drugs
  - **SO 22 – 2**
    - Pharmaceutical Crime
  - **SO 22 – 3**
    - Joint Customs/Police Precursor Control Unit

- **SO 23**
  - Investigations
  - **SO 23 - 1**

- **SO 24**
  - Investigations
  - **SO 24 - 1**
  - **SO 24 - 2**
  - **SO 24 - 3**

SO 2-C – Coordination and Secretary’s Office
Trafficking of cocaine to Germany

- Hamburg
- Bremerhaven
- Frankfurt am Main

- in container
- in/on the body
- in the baggage
Main smuggling routes heroine
big heroin seizure in germany

Seizure of 330 kg heroine (Origin: Iran, „Balkanroute“)
Synthetic Drugs

- Approx. 90% of the amphetamine and ecstasy seized in Germany with known origin came from the Netherlands.
Approx. 95% of the crystalline methamphetamine seized in Germany origin came from the Czech Republic.
Cannabis - "Indoor-cultivation" 2013

691 cultivation sites  =>  93,771 plants
so called “Legal Highs”

Bath salts, air freshener, plant fertilizers, incense mixtures or similar declared products in the form of powder, pills, capsules or herbal mixtures
Offers on the Internet

Willkommen bei BeSeiShop Ihr preisbewusster Headshop
für Räucherzeugungen und Budeabzweige

Ab 100 € Warenwert 5% Rabatt
Wir sind stets bemüht, unsere Kunden mit einer schnellen und direkten Lieferung zu versorgen. Die Kundenfreundlichkeit steht bei uns an erster Stelle. Bei Fragen und Anliegen unserer Seite steigen Sie per Email unter info@ allesessenzshop.de, unser Team bleibt Ihnen umgehend Ihr Anliegen zu beheben. Unser Shop bemüht alle neuen Produkte, die es auf dem Markt gibt.

Einsatzverbot an Jugendliche Personen unter 18 Jahren

TüV
Geprüfter Datenschutz

Überweisung
Nachname
### SO 2 - current priorities of analysis

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Region/Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>Afghanistan and neighbouring countries</td>
</tr>
<tr>
<td></td>
<td>Balkan Route/Turkey (inter alia Turkish and ethnic-Albanian, and „ex-Yugoslavia“ groups)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>South and Central America (countries of origin and transit)</td>
</tr>
<tr>
<td></td>
<td>Africa (especially criminals/organisers from/via West Africa)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>Professional indoor plantations in Germany</td>
</tr>
<tr>
<td>Synth. Drugs/ Precursors</td>
<td>Current developments in the area of designer drugs (especially “New Psychoactive Substances”)</td>
</tr>
<tr>
<td></td>
<td>Methamphetamine/Crystal</td>
</tr>
<tr>
<td></td>
<td>Laboratory equipment (voluntary cooperation with the industry)</td>
</tr>
<tr>
<td></td>
<td>new precursors which are not controlled and regulated by law</td>
</tr>
<tr>
<td>Internet</td>
<td>Drug offers</td>
</tr>
</tbody>
</table>
In addition: Money laundering

- Seizure of 8.7 million € in the luggage of German and Lebanese citizens at Frankfurt Airport
Links at International Level

- **Institutional co-operation**
  - ICPO-Interpol
  - EUROPOL
  - SELEC
  - Joint Border Centres
  - G 8-co-operation
  - Task Force on Organized Crime in the Baltic Sea Region
  - Frontex

- **Schengen Agreement**, 1985
- **Convention Implementing the Schengen Agreement**, 1990
- **Prüm co-operation** since 2005
Tasks
International Co-operation

- National Central Bureau of ICPO-Interpol
- Official relations with foreign police forces and judicial authorities, legal assistance
- Europol National Unit (ENU) Germany (Europol Convention)
- National central office (SIRENE) for Schengen Information System searches (Convention Implementing the Schengen Agreement)
- Liaison officers
Bundeskriminalamt Liaison Officers

66 Liaison officers
53 Locations
51 Countries
102 Additional responsibilities

America
- Bogotá*
- Brasilia
- Buenos Aires
- Caracas
- Lima*
- Mexico City
- Panama City
- Santo Domingo
- São Paulo
- Washington*

Europe
- Ankara
- Athens
- Belgrade
- Bucharest*
- The Hague
- Istanbul
- Kiev
- Lisbon
- London*
- Madrid*
- Moscow*
- Paris*
- Prague
- Pristina
- Riga
- Rome*
- Sofia
- Stockholm
- Tirana
- Warsaw*
- Vienna
- Zagreb

Asien
- Abu Dhabi
- Amman
- Astana
- Bangkok*
- Beirut
- Islamabad
- Jakarta
- Kabul*
- Muscat
- New Delhi
- Riad
- Beijing*
- Tashkent

Africa
- Accra
- Algiers
- Cairo
- Lagos
- Nairobi*

* 2 officers
CHAPTER 1 Illicit Drug supply
CHAPTER 2 Drug use and drug-related problems
CHAPTER 3 Health and social responses to drug problems

CHAPTER 4 Drug policies:

→ EU: multi-annual strategies action plans provide a framework for coordinated action.

→ At the national level: responsibility of governments and parliaments legal, strategic, organisational, budgetary frameworks necessary to respond to drug-related problems.
EU Drug Report 2014 – proportion of seizures
heroin plays a lesser part than it did in the past

stimulants*, synthetic drugs, cannabis and medicinal products are all becoming more important

replacement of heroin by other substances, including synthetic opioids and stimulants

cocaine remaining the stimulant of choice in southern and western countries - (meth)amphetamine more prevalent in northern and eastern countries.

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

*psychostimulants, like Ritalin  ** legal highs, research drugs
Almost a *quarter* of the adult population in the European Union *or over 80 million* adults, are estimated to have used *illicit* drugs at some point in their lives.
EU Drugs Strategy 2013 - 2020

EU DRUGS STRATEGY 2013 – 2020

political framework for member states and EU institutions

- EU ACTION PLAN ON DRUGS 2013 - 2016

road map for the EU with

*Drug policy issues in the various areas of the EU (including health, interior and justice, criminal law, customs) are coordinated and combined to form a European drug policy*

with **five** priority areas:
EU ACTION PLAN ON DRUGS 2013 – 2016

1. Drug demand reduction
Contribute to a measurable reduction in the use of illicit drugs, in problem drug use, in drug dependence and in drug-related health and social harms as well as contributing to a delay in the onset of drug use

2. Drug supply reduction
Contribute to a measurable reduction of the availability and supply of illicit drugs in the EU (Law Enforcement, Justice ..)
3. Coordination

Member States and EU to effectively coordinate drugs policy

4. International Cooperation

Strengthen dialogue and cooperation between the EU and third countries and international organizations on drugs issues in a comprehensive and balanced manner

5. Information, research, monitoring and evaluation

Contribute to a better understanding of all aspects of the drugs phenomenon and of the impact of measures in order to provide sound and comprehensive evidence for policies and actions
The focus of the federal government’s drug and addiction policy is on the person suffering from addiction as an individual and not on their disease or the drug.

including alcohol, tobacco, illegal drugs, prescription drugs

The guiding principle of the National Strategy is: "People First". The strategy sees the addicted person and his individual needs in the center
The Four Levels of Drug and Addiction Policy

1. Prevention

2. Counselling and Treatment, Help in Overcoming, Addiction

3. Harm Reduction Measures

4. Repression
NOTICES FROM EUROPEAN UNION INSTITUTIONS, BODIES, OFFICES AND AGENCIES

COUNCIL

EU ACTION PLAN ON DRUGS 2013-2016
(2013/C 351/01)

CONTENTS

Introduction 1
1. Drug demand reduction 3
2. Drug supply reduction 6
3. Coordination 10
4. International cooperation 12
5. Information, research, monitoring and evaluation 17
Annex 1 — 15 over-arching indicators for the EU Action Plan on Drugs 2013-2016 (existing reporting mechanisms) 21
Annex 2 — Glossary of acronyms 22

Introduction

The use of illicit drugs and the misuse of drugs generally, is a major problem for individuals, families and communities across Europe. Apart from the health and social implications of drug misuse, the illicit drugs market constitutes a major element of criminal activity across European society and, indeed, on a global level.

In December 2012, the Council adopted the EU Drugs Strategy for 2013-2020. The Strategy aims to contribute to a reduction in drug demand and drug supply within the EU. It also aims to reduce the health and social risks and harms caused by drugs through a strategic approach that supports and complements national policies, that provides a framework for coordinated and joint actions and that forms the basis and political framework for EU external cooperation in this field. This will be achieved through an integrated, balanced and evidence-based approach.

The objectives of the Strategy are:

— to contribute to a measurable reduction of the use of drugs, of drug dependence and of drug-related health and social risks and harms,

— to contribute to a disruption of the illicit drugs market and a measurable reduction of the availability of illicit drugs,

— to encourage coordination through active discourse and analysis of developments and challenges in the field of drugs at EU and international level,
— to further strengthen dialogue and cooperation between the EU and third countries, international
organisations and fora on drug issues,
— to contribute to a better understanding of all aspects of the drugs phenomenon and of the impact of
interventions in order to provide a sound and comprehensive evidence-base for policies and actions.

This EU Drugs Action Plan, like the EU Drugs Strategy, is based on the fundamental principles of EU law
and it upholds the founding values of the Union — respect for human dignity, liberty, democracy, equality,
solidarity, the rule of law and human rights. It is also based on the UN conventions that provide the
international legal framework to address, inter alia, the use of illicit drugs, as well as on the Universal
Declaration on Human Rights.

The Plan sets out the actions that will be implemented to achieve the objectives of the Strategy. Actions are
set out under the two policy areas of the Strategy:
— drug demand reduction, and
— drug supply reduction;
and the three cross-cutting themes of the Strategy:
— coordination,
— international cooperation, and
— information, research, monitoring and evaluation.

Actions are aligned to objectives of the EU Drugs Strategy 2013-2020. In drawing up the actions, account
was taken of the need to be evidence-based, scientifically sound, realistic, time-bound and measurable with a
clear EU relevance and added value. This Action Plan indicates timetables, responsible parties, indicators and
data collection/assessment mechanisms.

Based on existing reporting mechanisms, a number of over-arching indicators are set out in Annex 1. These
facilitate the measurement of the overall effectiveness of this EU Drugs Action Plan and do not involve an
additional reporting burden. A number of these are referenced, as appropriate, across the Plan. Furthermore,
throughout the Plan, indicators are set out that draw on programme, evaluative and other data sources.
Utilisation of these indicators is dependent on data collection processes in each Member State or at EU
institution level.

In line with the Strategy stipulation that its detailed implementation should be set out in two consecutive
Action Plans, this Action Plan covers the four years from 2013 until 2016. A second Action Plan for the
period 2017-2020 will be prepared following an external mid-term assessment of the EU Drugs Strategy by
2016 and taking account of any other relevant strategies and evaluations.
1. **Drug demand reduction**

Contribute to a measurable reduction in the use of illicit drugs, in problem drug use, in drug dependence and in drug-related health and social harms as well as contributing to a delay in the onset of drug use

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Timetable</th>
<th>Responsible party</th>
<th>Indicator(s)</th>
<th>Data collection/assessment mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevent drug use and, secondly, delay the onset of drug use</td>
<td>Improve the availability and effectiveness of prevention measures that take account of: (a) population risk factors such as age; gender; cultural and social factors; (b) situational risk factors such as homelessness; drug use in nightlife and recreational settings; the workplace; and driving under the influence of drugs; and (c) individual risk factors such as mental health; problem behaviour and psychosocial development; and other factors known to affect individual vulnerability to drug use such as genetic influences and family circumstances</td>
<td>Ongoing</td>
<td>MS</td>
<td>— Overarching indicators 1, 12 — Level of provision at MS level of evidence-based universal and environmental prevention measures — Level of provision at MS level of targeted prevention measures, including family- and community-based measures — Level of provision at MS level of indicated prevention measures</td>
<td>EMCDDA reporting Reitox national reports MS reporting on results of measures</td>
</tr>
<tr>
<td>2. In addition to the prevention of drug use, strengthen and better target prevention and diversionary measures to delay the age of first use of illicit drugs</td>
<td></td>
<td>Ongoing</td>
<td>MS</td>
<td>— Overarching indicators 1, 5, 12 — Level of provision at MS level of evidence-based prevention and diversionary measures that target young people in family, community, and formal/non-formal education settings</td>
<td>EMCDDA reporting MS reporting on results of measures</td>
</tr>
<tr>
<td>3. Raise awareness of the risks and consequences associated with the use of illicit drugs and other psychoactive substances</td>
<td></td>
<td>Ongoing</td>
<td>MS</td>
<td>— Overarching indicators 5, 12</td>
<td>EMCDDA reporting Eurobarometer surveys ESPAD HBSC</td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>4. Enable a more informed response to the challenge of the misuse of prescribed and ‘over the counter’ opioids and other psychoactive medicines</td>
<td>2014-2016</td>
<td>MS, HDG, EMA, EMCDDA</td>
<td>— Collation of data by MS on levels and patterns of prescribing of psychoactive medicines by end-2014 — Number of initiatives that focus on the promotion of appropriate use of prescribed and ‘over the counter’ opioids and other psychoactive medicines</td>
<td>MS reporting Report of ALICE RAP project</td>
<td></td>
</tr>
<tr>
<td>2. Enhance the effectiveness of drug treatment and rehabilitation, including services for people with co-morbidity, to reduce the use of illicit drugs; problem drug use; the incidence of drug dependency and drug-related health and social risks and harms and to support the recovery and social re/integration of problematic and dependent drug users</td>
<td>Ongoing</td>
<td>MS</td>
<td>— Overarching indicators 1, 6, 11 — Extent of the diversity of comprehensive and integrated treatment services at MS level including those which address polydrug use — MS data on treatment retention and outcomes</td>
<td>EMCDDA reporting Reitox national reports EMCDDA Best practice portal</td>
<td></td>
</tr>
<tr>
<td>5. Develop and expand the diversity, availability, coverage and accessibility of comprehensive and integrated treatment services including those which address polydrug use (combined use of illicit and/or licit substances including alcohol)</td>
<td>Ongoing</td>
<td>MS</td>
<td>— Overarching indicator 11 MS data on: — Extent of increase in rehabilitation/recovery services adopting case management and inter-agency approaches — Extent of increase in the number of programmes, specifically targeted at drug users with co-morbidity, involving partnerships between both mental health and drug rehabilitation/recovery services — Level and duration of abstentions from consumption of illicit and/or licit drugs by people leaving drug treatment — Availability of treatment options to meet needs of people who experience relapses to drug use</td>
<td>EMCDDA reporting MS reporting on results of services</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>7. Ensure that treatment and outreach services incorporate greater access to risk and harm reduction options to lessen the negative consequences of drug use and to substantially reduce the number of direct and indirect drug-related deaths and infectious blood-borne diseases associated with drug use but not limited to HIV and viral hepatitis, as well as sexually transmittable diseases and tuberculosis</td>
<td>Ongoing</td>
<td>MS</td>
<td>— Overarching indicators 2, 3, 4, 11 — Extent of increased availability of and access to evidence-based risk and harm reduction measures in MS</td>
<td>EMCDDA reporting Reitox national reports MS reporting on services</td>
<td></td>
</tr>
<tr>
<td>8. Scale up the development, availability and coverage of health care measures for drug users in prison and after release with the aim of achieving a quality of care equivalent to that provided in the community</td>
<td>Ongoing</td>
<td>MS</td>
<td>— Overarching indicator 10 — Availability of services for drug users in prisons and the extent to which prison health care policies and practices incorporate care models comprising best practices in needs assessment and continuity of care for prisoners during imprisonment — Extent of decrease in drug-related physical and mental health problems amongst prisoners — Extent to which prison-based services and community-based services provide continuity of care for prisoners upon release with particular emphasis on avoiding drug overdoses</td>
<td>EMCDDA reporting Reitox national reports MS reporting on services</td>
<td></td>
</tr>
<tr>
<td>3. Embed coordinated, best practice and quality approaches in drug demand reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Agree and commence the implementation of EU minimum quality standards, that help bridge the gap between science and practice, for: (a) environmental, universal, selective and indicated prevention measures; (b) early detection and intervention measures;</td>
<td>2014-2016</td>
<td>Council HDG MS COM EMCDDA</td>
<td>— Consensus achieved by MS on minimum quality standards building on previous EU preparatory studies</td>
<td>EMCDDA Best practice portal COM biennial progress report</td>
<td></td>
</tr>
</tbody>
</table>
## 2. Drug supply reduction

Contribute to a measurable reduction of the availability and supply of illicit drugs in the EU

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Timetable</th>
<th>Responsible party</th>
<th>Indicator(s)</th>
<th>Data collection/assessment mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Enhance effective law enforcement coordination and cooperation within the EU to counter illicit drug activity, in coherence, as appropriate, with relevant actions determined through the EU policy cycle</td>
<td>10. Utilise to best effect available intelligence and information-sharing law enforcement instruments, channels and communication tools used to collate and analyse drug-related information</td>
<td>Ongoing</td>
<td>MS</td>
<td>Overarching indicator 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Europol</td>
<td>— Extent of high impact intelligence led and targeted activities, of joint operations, joint investigation teams and cross-border cooperation initiatives focusing on criminal organisations engaged in illicit drug activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Eurojust</td>
<td>— Increased use of Europol's drug-related information sharing, analysis and expert systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COSI</td>
<td>— Results achieved from EMPACT projects and bilateral and multilateral initiatives</td>
<td></td>
</tr>
<tr>
<td>11. Identify and prioritise the most pressing threats associated with drug-related organised crime</td>
<td>2014</td>
<td>Council</td>
<td>COSI</td>
<td>EU policy cycle and crime priorities for 2014-2017 in place</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Europol</td>
<td>Council conclusions on EU policy cycle</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS</td>
<td>EU SOCTA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COM</td>
<td>EMPACT evaluation</td>
<td></td>
</tr>
<tr>
<td>12. Strengthen CEPOL's training for law enforcement officers in relation to illicit drug production and trafficking, particularly training methods and techniques:</td>
<td>2014-2016</td>
<td>MS</td>
<td>CEPOL</td>
<td>Training needs assessment carried out by end-2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Europol</td>
<td>— Availability and uptake of relevant training courses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COSI</td>
<td>— Number of law enforcement officers trained and effectively deployed as a result</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>------------------</td>
<td>--------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td></td>
<td>(a) to combat the use of new communication technologies in illicit drug production and trafficking; (b) to enhance asset confiscation; (c) to combat money laundering; and (d) to detect and dismantle illicit clandestine laboratories and cannabis cultivation sites</td>
<td>Ongoing</td>
<td>COM MS Europol COSI Regional information-sharing platforms Regional security-sharing platforms</td>
<td>— Overarching indicator 7 — Number of intelligence led activities leading to the disruption and suppression of drug trafficking routes — Level of information sharing through effective activity of the liaison officer network</td>
<td>EMCDDA reporting Security/information-sharing platforms and evaluation reports EU SOCTA EMPACT evaluation</td>
</tr>
<tr>
<td>13. Improve counter narcotic activities through strengthening and monitoring the effectiveness of regional information-sharing platforms and regional security-sharing platforms with the aim of disrupting and suppressing emerging threats from changing drug trafficking routes</td>
<td>Ongoing</td>
<td>MS Europol COSI Regional information-sharing platforms</td>
<td>— Number of cases and quantity of stopped or seized shipments of precursors intended for illicit use — Results achieved from EMPACT projects — Use of Pre-Export Notification (PEN) Online System and increased use of the Precursors Incident Communication System (PICS) — Number of joint follow-up meetings and other activities linked to the prevention of the diversion of precursors and pre-precursors</td>
<td>Reports from EU and MS law enforcement agencies EMPACT evaluation Driver reports</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15. Counter cross-border drug trafficking and improve border security notably at EU seaports, airports and land border crossing points through intensified efforts, including information and intelligence sharing, by relevant law enforcement agencies</td>
<td>Ongoing</td>
<td>MS</td>
<td>Europol</td>
<td>— Increased number of multi-disciplinary/multi-agency joint operations and cross-border cooperation initiatives&lt;br&gt;— Number of effective memoranda of understanding (MOU) agreed between law enforcement agencies and relevant bodies such as airlines, air express couriers, shipping companies, harbour authorities and chemical companies&lt;br&gt;— Results achieved from EMPACT projects&lt;br&gt;— Improved intelligence and information sharing on cross-border drug trafficking utilising, inter alia, available border surveillance systems</td>
<td>COM biennial progress report&lt;br&gt;EMPACT evaluation and driver reports&lt;br&gt;MS reporting</td>
</tr>
<tr>
<td>16. Develop and progressively implement key indicators on drug supply by standardising, improving and streamlining data collection in this field, building on currently available data</td>
<td>2013-2016</td>
<td>COM</td>
<td>MS</td>
<td>— Roadmap developed and agreed on the implementation of key drug supply indicators&lt;br&gt;— MS agreement reached on key drug supply indicators</td>
<td>Overview of existing supply data collection in MS&lt;br&gt;EMCDDA reporting&lt;br&gt;COM biennial progress report</td>
</tr>
<tr>
<td>5. Enhance effective judicial cooperation and legislation within the EU</td>
<td>2013-2016</td>
<td>Council</td>
<td>COM</td>
<td>— Adoption and timely implementation of agreed EU measures and legislation on (a) confiscation and recovery of criminal assets; (b) money laundering; (c) approximation of drug trafficking offences and sanctions across the EU&lt;br&gt;— Increased number of financial investigations and confiscations in relation to the proceeds of drug-related organised crime through EU judicial cooperation&lt;br&gt;— Timely and effective responses to mutual assistance requests and European Arrest Warrants in relation to illicit drug trafficking</td>
<td>Eurojust reporting&lt;br&gt;COM biennial progress report</td>
</tr>
<tr>
<td>17. Strengthen EU judicial cooperation in targeting cross-border drug trafficking, money laundering, and in the confiscation of the proceeds of drug-related organised crime</td>
<td>2013-2016</td>
<td>COM</td>
<td>MS</td>
<td>— Adoption and timely implementation of agreed EU measures and legislation on (a) confiscation and recovery of criminal assets; (b) money laundering; (c) approximation of drug trafficking offences and sanctions across the EU&lt;br&gt;— Increased number of financial investigations and confiscations in relation to the proceeds of drug-related organised crime through EU judicial cooperation&lt;br&gt;— Timely and effective responses to mutual assistance requests and European Arrest Warrants in relation to illicit drug trafficking</td>
<td>Eurojust reporting&lt;br&gt;COM biennial progress report</td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>18. Introduce and adopt new EU legislative measures to address the emergence, use and rapid spread of new psychoactive substances</td>
<td></td>
<td>2013-2016</td>
<td>COM, Council, HDG, MS</td>
<td>EU legislation in place, Implementation of EU legislation in MS</td>
<td>COM biennial progress report</td>
</tr>
<tr>
<td>20. Combat the use of certain pharmacologically active substances (as defined in Directive 2011/62/EU) as cutting agents for illicit drugs</td>
<td></td>
<td>Ongoing</td>
<td>MS, COM, EMA, EMCDDA, Europol</td>
<td>Number of seizures of active substances used as cutting agents for illicit drugs, Timely implementation of new EU legislative requirements aimed at securing the supply chain for active substances under Directive 2011/62/EU, the Falsified Medicines Directive</td>
<td>Reports from the CCWP and CUG, MS reporting</td>
</tr>
<tr>
<td>21. Members States to provide, where appropriate and in accordance with their legal frameworks, alternatives to coercive sanctions (such as education, treatment, rehabilitation, aftercare and social integration) for drug-using offenders</td>
<td></td>
<td>2015</td>
<td>MS</td>
<td>Increased availability and implementation of alternatives to prison for drug-using offenders in the areas of education, treatment, rehabilitation, aftercare and social integration, Increased monitoring, implementation and evaluation of alternatives to coercive sanctions</td>
<td>Reitox national reports</td>
</tr>
<tr>
<td>6. Respond effectively to current and emerging trends in illicit drug activity</td>
<td></td>
<td>Ongoing</td>
<td>Council, COM, HDG, MS, Europol, COSI</td>
<td>Results achieved from law enforcement actions targeting drug-related crime via the Internet, Increased number of joint operations and cross-border cooperation initiatives</td>
<td>Progress review of EU policy cycle priorities, EMPACT evaluation and driver reports, MS reporting, Reports from EU agencies</td>
</tr>
</tbody>
</table>
## 3. Coordination

**Member States and EU to effectively coordinate drugs policy**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Timetable</th>
<th>Responsible party</th>
<th>Indicator(s)</th>
<th>Data collection/assessment mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Ensure effective EU coordination in the drugs field</td>
<td>Enhance information sharing between the HDG and other relevant Council Working Groups</td>
<td>Ongoing</td>
<td>PRES Council EEAS HDG</td>
<td>— Extent to which the EU Drugs Strategy and Action Plan are taken into account in the programmes of other Council Working Groups including COAFR, COASI, COEST, COLAT and COWEB</td>
<td>Council Working Group reporting</td>
</tr>
<tr>
<td></td>
<td>Each presidency may convene meetings of the National Drugs Coordinators, and of other groupings as appropriate, to consider emerging trends, effective interventions and other policy developments of added value to the EU Drugs Strategy and to MS</td>
<td>Biannually</td>
<td>PRES MS</td>
<td>— Extent to which National Drug Coordinators’ meeting agenda reflects developments, trends and new insights in policy responses and provides for improved communication and information exchange</td>
<td>Presidency reporting</td>
</tr>
<tr>
<td></td>
<td>The HDG will facilitate: (a) monitoring of the implementation of the Action Plan through thematic debates; and (b) an annual dialogue on the state of the drugs phenomenon in Europe</td>
<td>(a) Biannually (b) Annually</td>
<td>PRES HDG MS COM EMCDDA Europol</td>
<td>— Extent of implementation of the Action Plan — Timeliness of dialogue at the HDG on latest drug-related trends and data</td>
<td>Presidency reporting</td>
</tr>
<tr>
<td></td>
<td>Ensure consistency and continuity of MS and EU actions across presidencies to strengthen the integrated, balanced and evidence-based approach to drugs in the EU</td>
<td>Biannually</td>
<td>PRES PRES Trio MS COM HDG EMCDDA Europol</td>
<td>— Extent of consistency and continuity of actions across presidencies — Advancement in implementation of EU Drugs Strategy priorities across presidencies</td>
<td>Presidency reporting</td>
</tr>
<tr>
<td></td>
<td>Ensure coordination of EU drugs policies and responses, to support international cooperation between the EU, third countries and international organisations</td>
<td>Ongoing</td>
<td>EEAS COM HDG MS</td>
<td>— Level of consistency and coherence in the objectives, expected results and measures foreseen in EU actions on drugs</td>
<td>Annual EEAS report to the HDG COM biennial progress report</td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>---------------------------------------</td>
</tr>
</tbody>
</table>
|           | 28. Achieve a coordinated and appropriate level of resources at EU level and Member State level to fulfil the priorities of the EU Drugs Strategy | Annually | MS COM EEAS Council HDG | — Inclusion of drug-related priorities in strategies of relevant EU bodies  
— Intensified cooperation between the HDG and the geographical/regional working groups, including COAFR, COASI, COEST, COLAT and COWEB | EMCDDA reporting |
|           | 8. Ensure effective coordination of drug-related policy at national level | Ongoing | MS | — Overarching indicator 14  
— Extent of coordination on drugs-related financial programmes across Council Working Groups | EMCDDA reporting |
|           | 9. Ensure the participation of civil society in drugs policy | Ongoing | MS COM HDG PRES | — Timely dialogues between EU Civil Society Forum on Drugs and the HDG during each Presidency period  
— Engagement of EU Civil Society Forum in reviewing implementation of the EU Drugs Action Plan  
— Level of involvement of civil society in MS and EU drugs policy development and implementation with particular regard to the involvement of drug users, clients of drug-related services and young people  
— Timely dialogue between the scientific community (natural and social sciences, including neuroscience and behavioural research) and the HDG | COM biennial progress report  
Feedback from EU Civil Society Forum on Drugs and from civil society representatives at MS level  
Feedback from scientific community through the EMCDDA Scientific Committee |
4. **International Cooperation**

Strengthen dialogue and cooperation between the EU and third countries and international organisations on drugs issues in a comprehensive and balanced manner

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Timetable</th>
<th>Responsible party</th>
<th>Indicator(s)</th>
<th>Data collection/assessment mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Integrate the EU Drugs Strategy within the EU’s overall foreign policy framework as part of a comprehensive approach that makes full use of the variety of policies and diplomatic, political and financial instruments at the EU’s disposal in a coherent and coordinated manner</td>
<td>31. Ensure policy coherence between the internal and external aspects of the EU drugs policies and fully integrate drugs issues within the political dialogues and framework agreements between the EU and its partners and in the EU advocacy on global issues or challenges</td>
<td>Ongoing</td>
<td>COM</td>
<td>— Overarching indicator 13</td>
<td>EEAS reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EEAS</td>
<td>— Drug policy priorities increasingly reflected in EU’s external policies and actions</td>
<td>Mid-term review of EU Drugs Strategy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PRES</td>
<td>— Inclusion of drug-related priorities in EU strategies with third countries and regions</td>
<td>COM biennial progress report</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HDG</td>
<td>— Number of agreements, strategy papers, action plans in place</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Ensure that the policy priorities and the balance between demand and supply reduction are well reflected in policy options and in the programming and implementation of external assistance, particularly in source and transit countries, through projects involving:</td>
<td>32. Ensure that the policy priorities and the balance between demand and supply reduction are well reflected in policy options and in the programming and implementation of external assistance, particularly in source and transit countries, through projects involving:</td>
<td>Ongoing</td>
<td>COM</td>
<td>— Extent to which EU’s drug policy priorities, especially the balance between demand and supply reduction, are reflected in funded priorities and projects</td>
<td>COM biennial progress report</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS</td>
<td>— Level of implementation of coordinated actions in action plans between the EU and third countries and regions</td>
<td>EEAS reporting on programming</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EEAS</td>
<td>— Number of third country national strategies and action plans that incorporate integrated drug policies</td>
<td>Monitoring and evaluation by MS</td>
</tr>
<tr>
<td>33. Improve capacity and strengthen the role of EU Delegations to enable them to proactively engage on drugs policy issues</td>
<td>33. Improve capacity and strengthen the role of EU Delegations to enable them to proactively engage on drugs policy issues</td>
<td>2013-2016</td>
<td>EEAS</td>
<td>— Relevant expertise, training and policy guidance provided to EU Delegations</td>
<td>EEAS reporting on EU Delegations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COM</td>
<td>— Regional networking among EU Delegations on drug issues enhanced</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>34. Ensure an appropriate level of EU and MS funding and expertise to further strengthen and support third countries’ efforts in addressing and preventing illicit drug crop cultivation, through rural development measures, in order to deal with the challenges to public health, safety and security</td>
<td>Ongoing</td>
<td>MS, EEAS, COM</td>
<td>— Coordination with MS enhanced</td>
<td>— Number of third country national policies, strategies and action plans that incorporate integrated approaches to the problem of illicit drug crop cultivation</td>
<td>EU and MS project and programme monitoring and evaluation systems and reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>— Improvements in human development indicators in drug-cultivating areas</td>
<td>UNDP human development reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>— Number of rural development projects and programmes funded by the EU and MS in regions where illicit crop cultivation is taking place, or in regions at risk of illicit crop cultivation</td>
<td>Third country reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>— Reported local decrease in illicit drug crop cultivation in the long term</td>
<td></td>
</tr>
<tr>
<td>35. Promote and implement the EU approach to alternative development (consistent with the EU Drugs Strategy 2013-2020; the EU Approach to Alternative Development and the United Nations Guiding Principles on Alternative Development 2013) in cooperation with third countries, taking into account human rights, human security and specific framework conditions, including: (a) incorporating alternative development into the broader agenda of Member States, encouraging third countries that wish to do so to integrate alternative development into their national strategies; (b) contributing to initiatives that aim to reduce poverty, conflict and vulnerability by supporting sustainable, legal and gender sensitive livelihoods for people</td>
<td>Ongoing</td>
<td>MS, COM, EEAS</td>
<td>— Number of third country national policies, strategies and action plans that incorporate:</td>
<td>— integrated approaches to the problem of illicit drug cultivation, and</td>
<td>EU and MS project and programme monitoring and evaluation systems and reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>— effectively organised alternative development initiatives</td>
<td>UNDP human development reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>— Number of evaluated projects that demonstrate positive outcomes relating to sustainable, legal and gender sensitive livelihoods</td>
<td>Third countries’ implementation reports of national drugs strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>— Improvements in human development indicators</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>who were previously, or are currently, involved in illicit drug production</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Support third countries, including civil society in those countries, to develop and implement risk and harm reduction initiatives particularly where there is a growing threat of transmission of drug-related blood-borne viruses associated with drug use including but not limited to HIV and viral hepatitis, as well as sexually transmittable diseases and tuberculosis</td>
<td>Ongoing</td>
<td>MS</td>
<td>— Number and quality of risk and harm reduction initiatives developed</td>
<td>Third country reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>COM</td>
<td>— Prevalence of drug-related deaths in third countries and drug-related blood-borne viruses including but not limited to HIV and viral hepatitis, as well as sexually transmittable diseases and tuberculosis</td>
<td>COM biennial progress report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EEAS</td>
<td></td>
<td>WHO reports</td>
<td></td>
</tr>
<tr>
<td>37. Support third countries to tackle drug-related organised crime, including drug trafficking, by:</td>
<td>Ongoing</td>
<td>MS</td>
<td>— Number and effectiveness of projects and programmes</td>
<td>COM biennial progress report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EEAS</td>
<td>— Sustained reduction in drug trafficking</td>
<td>MS reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>COM</td>
<td></td>
<td>Europol reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Europol</td>
<td></td>
<td>EEAS reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UNODC annual world drug report</td>
<td></td>
</tr>
<tr>
<td>(a) intelligence sharing and the exchange of best practices;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) strengthening counter-narcotics capacity and developing expertise of source and transit countries;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) working with international partners to tackle the enablers of drug trafficking such as corruption, weak institutions, poor governance and lack of financial regulatory controls;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) strengthening cooperation in the field of asset identification and recovery, in particular through the creation of dedicated national platforms; and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) intensifying regional and intra-regional cooperation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>38. Reinforce cooperation and update and implement dialogues, declarations and EU Drugs Action Plans with partners, including: (a) acceding countries, candidate countries and potential candidates; (b) European Neighbourhood Policy countries; (c) United States of America, the Russian Federation; (d) other countries or regions of priority notably: — Afghanistan and Pakistan, — Central Asian republics, — China, — Latin American and the Caribbean (CELAC), — Africa, in particular West Africa</td>
<td>Ongoing</td>
<td>PRES Trio, COM, EEAS, MS</td>
<td>— Overarching indicator 13 — Strengthened cooperation in the field of drugs with relevant partners — Dialogues organised — Declarations agreed — Programmes and action plans implemented</td>
<td>EEAS reporting Mid-term review of EU Drugs Strategy COM biennial progress report EU reporting matrices Implementation reports of the relevant action plans</td>
<td></td>
</tr>
<tr>
<td>39. Improve the Dublin Group consultative mechanism through intensified EU coordination and participation, better implementation and dissemination of the recommendations of the Mini Dublin Group reports</td>
<td>Ongoing</td>
<td>Dublin Group, COM, EEAS, MS</td>
<td>— Level of activity across Dublin Group structures including number of Dublin Group recommendations effectively implemented</td>
<td>Dublin Group reports</td>
<td></td>
</tr>
<tr>
<td>40. Hold an annual dialogue on EU and MS drugs-related assistance to third countries accompanied by a written update</td>
<td>From 2014</td>
<td>COM, EEAS, MS</td>
<td>— Annual dialogue on funding held</td>
<td>COM biennial progress report MS reporting EEAS reporting Project and programme monitoring and evaluation system and reports</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>41. Ensure that the promotion and protection of human rights are fully integrated in political dialogues and in the planning and implementation of relevant drugs-related programmes and projects including through the development of a human rights guidance and impact assessment tool</td>
<td>Ongoing</td>
<td>COM EEAS MS</td>
<td>— Human rights effectively mainstreamed into EU external drugs action</td>
<td>COM biennial progress report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Human rights guidance and assessment tool developed and implemented</td>
<td>COHOM annual human rights report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Overarching indicator 13</td>
<td>MS reporting</td>
<td></td>
</tr>
<tr>
<td>11. Improve cohesiveness of EU approach and EU visibility in the United Nations (UN) and strengthen EU coordination with international bodies related to the drugs field</td>
<td>Ongoing</td>
<td>EEAS PRES MS COM Council HDG</td>
<td>— Overarching indicator 13</td>
<td>EEAS reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Effective promotion of EU policies in the UN, including at the CND</td>
<td>Mid-term review of the EU Drugs Strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Number of EU common positions supported by other regions and international bodies</td>
<td>COM biennial progress report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Frequency with which EU speaks with a single effective voice in international fora and in dialogues with third countries</td>
<td>Convergence indicator</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Level of successful adoption of EU resolutions at UN including at the CND</td>
<td>Mid-term review</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Outcome of the mid-term review of the 2009 UN Political Declaration and Action Plan on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem</td>
<td>UNGASS outcome</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Adoption of an EU Joint Position Paper for the 2016 UNGASS and reflection of the EU positions in the UNGASS outcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Contribute to shaping the agenda on international drugs policy, including through: (a) action by EU and MS Delegations at the UN General Assembly and the Commission on Narcotic Drugs (CND); (b) preparation, coordination and adoption of EU common positions and joint resolutions in the UN General Assembly and the CND and ensuring that the EU speaks with one strong voice in these and other international fora; (c) the mid-term review process of the 2009 UN Political Declaration and Action Plan on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem; and (d) the 2016 UN General Assembly Special Session on Drugs</td>
<td>Ongoing</td>
<td>EEAS PRES MS COM COUNCIL HDG</td>
<td>— Overarching indicator 13</td>
<td>EEAS reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Effective promotion of EU policies in the UN, including at the CND</td>
<td>Mid-term review of the EU Drugs Strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Number of EU common positions supported by other regions and international bodies</td>
<td>COM biennial progress report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Frequency with which EU speaks with a single effective voice in international fora and in dialogues with third countries</td>
<td>Convergence indicator</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Level of successful adoption of EU resolutions at UN including at the CND</td>
<td>Mid-term review</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Outcome of the mid-term review of the 2009 UN Political Declaration and Action Plan on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem</td>
<td>UNGASS outcome</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Adoption of an EU Joint Position Paper for the 2016 UNGASS and reflection of the EU positions in the UNGASS outcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. Strengthen partnerships with the UNODC, WHO UNAIDS and other relevant UN agencies, international and regional bodies and organisations and initiatives (such as the Council of Europe and the Paris Pact Initiative)</td>
<td>Ongoing</td>
<td>Council EEAS PRES HDG</td>
<td>— Overarching indicator 13</td>
<td>EEAS reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Number of information exchanges and activities between the EU and relevant international and regional bodies and organisations and initiatives</td>
<td>Mid-term review of the EU Drugs Strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>— Effectiveness of partnerships with relevant bodies</td>
<td>COM biennial progress report</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
</tbody>
</table>
| 12. Support the process for acceding countries, candidate countries, and potential candidates to adapt to and align with the EU acquis in the drugs field, through targeted assistance and monitoring | 44. Provide targeted technical assistance, and other assistance and support as necessary, to acceding countries, candidate countries, and potential candidates to facilitate their adaptation to and alignment with the EU acquis in the drugs field | Ongoing    | COM               | — Increased compliance by countries with EU acquis  
— Number and quality of completed projects  
— National Drugs Strategies and national drugs coordinating structures established | COM biennial progress report  
Acceding countries, candidate countries and potential candidates reports |

5. Information, research, monitoring and evaluation
Contribute to a better understanding of all aspects of the drugs phenomenon and of the impact of measures in order to provide sound and comprehensive evidence for policies and actions

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Timetable</th>
<th>Responsible party</th>
<th>Indicator(s)</th>
<th>Data collection/assessment mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Ensure adequate investment in research, data collection, monitoring, evaluation and information exchange on all aspects of the drug phenomenon</td>
<td>45. Promote appropriate financing of EU-level drug-related multi-disciplinary research and studies including through EU related financial programmes (2014-2020)</td>
<td>2014-2016</td>
<td>MS, COM, EMCDDA</td>
<td>— Amount and type of EU funding provided across the different programme and projects</td>
<td>COM biennial progress report</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                                                                           | 46. Ensure that EU-supported projects:                                 | 2014-2016  | COM, EMCDDA       | — The inclusion of the priorities of the EU Strategy and Action Plan on Drugs in the funding and assessment criteria of EU-funded drugs-related research  
— Number, impact, complementarity and value of EU-funded drugs-related research grants and contracts awarded  
— Number of EU-funded drugs-related articles and research reports published in peer-reviewed journals with high impact factors  
— Annual debate at the HDG on drug-related research projects funded by the EU | COM biennial progress report  
Research project reports  
EMCDDA Scientific Committee recommendations on research priorities  
Science Citation Index and similar bibliometric tools  
Strategic research agenda and projects stemming from the ERA-net on drug demand and supply reduction |

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Timetable</th>
<th>Responsible party</th>
<th>Indicator(s)</th>
<th>Data collection/assessment mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>47. Promote scientific evaluations of policies and interventions at national, EU and international level</td>
<td><strong>Objective</strong></td>
<td>2013-2016</td>
<td>COM MS EMCDDA</td>
<td>— Overarching indicator 14 &lt;br&gt;— Regular progress review to the Council and European Parliament on Strategy and Action Plan implementation &lt;br&gt;— External mid-term assessment of the Strategy/Action Plan completed — 2016 &lt;br&gt;— European guidelines for the evaluation of national drug strategies and action plans published &lt;br&gt;— Delivery of dedicated studies into the effectiveness and impacts of EU and international drug policies &lt;br&gt;— Completed evaluation of the implementation of the 2003 Council Recommendation on the prevention and reduction of health-related harm associated with drug dependence</td>
<td>EMCDDA reporting COM biennial progress report Mid-term assessment report of EU drugs strategy EMCDDA reporting EMCDDA Scientific Committee reporting Reports of ALICE RAP and LINKSCH and ERA-net Reitox national reports</td>
</tr>
<tr>
<td>14. Maintain networking and cooperation and develop capacity within and across the EU’s knowledge infrastructure for information, research, monitoring and evaluation of drugs, particularly illicit drugs</td>
<td><strong>Objective</strong></td>
<td>Ongoing</td>
<td>EMCDDA Europol MS</td>
<td>— Overarching indicators 1-15 &lt;br&gt;— Current deficits in the knowledge base established and an EU level framework developed to maximise analyses from current data holdings &lt;br&gt;— Number of overviews and topic analyses on the drug situation</td>
<td>EMCDDA reporting MS reporting</td>
</tr>
<tr>
<td>48. In collaboration with relevant parties as appropriate, continue to provide comprehensive analyses of:</td>
<td>2014-2016</td>
<td>MS EMCDDA CEPOL</td>
<td>— Number of initiatives at MS and EU level to train professionals in aspects of drug demand reduction and drug supply reduction &lt;br&gt;— Number of initiatives at MS and EU level implemented to train professionals related to data collection and reporting of drug demand reduction and drug supply reduction</td>
<td>MS reporting EMCDDA training report CEPOL annual report Reitox annual reports</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>50. Enhance data collection, research, analysis and reporting on:</td>
<td>Ongoing</td>
<td>MS</td>
<td>— Increased availability and implementation of evidence-based and scientifically sound indicators on drug supply reduction and drug demand reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>COM</td>
<td>— At MS level, extent of new research initiated on emerging trends such as polydrug use and the misuse of prescribed controlled medicines, blood-borne diseases associated with drug use including but not limited to HIV and viral hepatitis, as well as sexually transmittable diseases and tuberculosis; psychiatric and physical co-morbidity; and other drug-related consequences</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EMCDDA</td>
<td>— EU-wide study carried out on drug-related community intimidation and its impact on individuals, families and communities most affected and effective responses to it</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Europol</td>
<td>— Adoption of evidence-based and scientifically sound indicators on drug problems among prisoners</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ECDC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EMA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) drug demand reduction;</td>
<td></td>
<td>MS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) drug supply reduction;</td>
<td></td>
<td>COM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) emerging trends, such as polydrug use and misuse of prescribed controlled medicines, that pose risks to health and safety;</td>
<td></td>
<td>EMCDDA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) blood-borne viruses associated with drug use including but not limited to HIV and viral hepatitis, as well as sexually transmittable diseases and tuberculosis;</td>
<td></td>
<td>Europol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) psychiatric and physical co-morbidity;</td>
<td></td>
<td>ECDC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f) drug problems among prisoners and the availability and coverage of drug demand reduction interventions and services in prison settings; and</td>
<td></td>
<td>EMA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(g) other drug-related consequences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51. Improve the capacity to detect, assess and respond effectively to the emergence and use of new psychoactive substances and monitor the extent to which such new substances impact on the number and profile of users</td>
<td>Ongoing</td>
<td>COM</td>
<td></td>
<td>EMCDDA reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>MS</td>
<td></td>
<td>MS reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EMCDDA</td>
<td></td>
<td>Harmonised data reports from EU bodies including EMCDDA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Europol</td>
<td></td>
<td>EU SOCTA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Timetable</td>
<td>Responsible party</td>
<td>Indicator(s)</td>
<td>Data collection/assessment mechanisms</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
</tbody>
</table>
| 52. Strengthen efforts to share forensic science data, including laboratory reference standards, on new psychoactive substances, by enhancing cooperation through existing networks, such as the Drugs Working Group of the European Network of Forensic Science Institutes in the framework of the JHA Council conclusions on the vision for European Forensic Science 2020 | 2016                                                                 | COM MS EMCDDA           | — Overarching indicator 15  
— Extent of sharing of forensic science data on new psychoactive substances  
— Ease of access to laboratory reference standards by forensic science laboratories and institutes | EMCDDA/Europol reporting  
COM biennial progress report |
| 53. Improve the ability to identify, assess and respond at MS and EU levels to (a) behavioural changes in drug consumption and (b) to epidemic outbreaks | Ongoing                                                                | MS EMCDDA ECDC EMA     | — Number and effectiveness of new drug-related public health initiatives developed and implemented  
— Number and effectiveness of existing initiatives that are adjusted to take account of drug consumption or epidemic outbreaks  
— Number and impact of early warning reports, risk assessment and alerts | Reitox national reports  
Early Warning System reports  
EMCDDA reporting |
| 54. Member States continue to support EU monitoring and information exchange efforts, including cooperation with, and adequate support for, Reitox national focal points | Ongoing                                                                | MS EMCDDA             | — Open-access outputs from EU-funded studies disseminated  
— Extent to which Reitox national focal points funding and other resources match requirements  
— Number and effectiveness of Reitox national focal points dissemination initiatives | Web dissemination including OpenAire, Cordis  
EMCDDA website  
Reitox national reports |
| 15. Enhance dissemination of monitoring, research and evaluation results at EU and national level |                                                                        |                   |                   |                                                                              |                                             |
ANNEX 1

15 over-arching indicators for the EU Action Plan on Drugs 2013-2016 (existing reporting mechanisms)

1. Percentage of population who use drugs currently (within last month), used drugs recently (within last year), and who have ever used (lifetime use) by drug and age group (EMCDDA General population survey)

2. Estimated trends in the prevalence of problem and injecting drug use (EMCDDA Problem drug use)

3. Trends in drug-induced deaths and mortality amongst drug users (according to national definitions) (EMCDDA Drug-related deaths)

4. Prevalence and incidence, among injecting drug users, of infectious diseases attributable to drug use, including HIV and viral hepatitis, sexually transmittable diseases and tuberculosis (EMCDDA Drug-related infectious diseases)

5. Trends in the age of first use of illicit drugs (European School Survey Project on Alcohol and Other Drugs (ESPAD), Health Behaviour in School-aged Children (HBSC) and General Population Drug Use Survey (EMCDDA Key epidemiological indicator))

6. Trends in numbers of people entering drug treatment (EMCDDA Treatment demand) and the estimated total number of people in drug treatment (EMCDDA Treatment demand and health and social responses)

7. Trends in number of and quantities of seized illicit drugs (EMCDDA Drug seizures: cannabis incl. herbal cannabis, heroin, cocaine, crack cocaine, amphetamine, methamphetamine, ecstasy, LSD and other substances)

8. Trends in retail price and purity of illicit drugs (EMCDDA Price and purity: cannabis incl. herbal cannabis, heroin, cocaine, crack cocaine, amphetamine, methamphetamine, ecstasy, LSD, other substances and composition of drug tablets)

9. Trends in the number of initial reports of drug law offences, by drug and type of offence (supply vs use/possession) (EMCDDA Drug offences)

10. Prevalence of drug use amongst prisoners (EMCDDA Drug use in prisons)

11. Assessment of availability, coverage and quality of services and interventions in the areas of prevention, harm reduction, social integration and treatment (EMCDDA Health and social responses)

12. Evidence-based interventions on prevention, treatment, social integration and recovery and their expected impact on drug use prevalence and problem drug use (EMCDDA Best practice portal)

13. Strong dialogue and cooperation, in the drugs-related field, with other regions, third countries, international organisations and other parties (External Mid-Term Evaluation of Strategy/Action Plan; EEAS reporting)

14. Developments in national drug strategies, evaluations, legislation, coordination mechanisms and public expenditure estimates in EU Member States (EMCDDA)

15. Early warning system on new psychoactive substances (EMCDDA/Europol)
AGNEX 2

Glossary of acronyms

ALICE RAP Addiction and Lifestyles in Contemporary Europe — Reframing Addictions Project

ASEAN Association of South-East Asian Nations

CCWP Council of the EU — Customs Cooperation Working Party

CELAC Comunidad de Estados Latinoamericanos y Caribeños (Community of Latin American and Caribbean States)

CEPOL European Police College

CICAD La Comisión Interamericana para el Control del Abuso de Drogas (The Inter-American Drug Abuse Control Commission)

CND Commission on Narcotic Drugs (UN)

COAFR Council of the EU — África Working Party

COASI Council of the EU — Asia-Oceania Working Party

COEST Council of the EU — Working Party on Eastern Europe and Central Asia

COHOM Council of the EU — Working Party on Human Rights

COLAT Council of the EU — Working Party on Latin America

COM European Union Commission

COSI Council of the EU — Standing Committee on Operational Cooperation on Internal Security

COWEB Council of the EU — Working Party on the Western Balkans Region

CUG Council of the EU — Customs Union Group

ECDC European Centre for Disease Prevention and Control

ECOWAS Economic Community of West African States

EEAS European External Action Service

EMA European Medicines Agency

EMCDDA European Monitoring Centre for Drugs and Drug Addiction

EMPACT European Multidisciplinary Platform against Criminal Threats

ENFSI European Network of Forensic Science Institutes

ERA-net European Research Area — Network

ESPAD European School Survey Project on Alcohol and Other Drugs

EU SOCTA EU Serious and Organised Crime Threat Assessment

Frontex European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBSC</td>
<td>Health Behaviour in School-aged Children Survey</td>
</tr>
<tr>
<td>HDG</td>
<td>Council of the EU — Horizontal Working Group on Drugs</td>
</tr>
<tr>
<td>INCB</td>
<td>International Narcotics Control Board (UN)</td>
</tr>
<tr>
<td>JHA</td>
<td>Justice and Home Affairs</td>
</tr>
<tr>
<td>LINKSCH</td>
<td>The LINKSCH project is a comparative study of two major drug markets, cannabis and heroin, through the prism of the transit chains operating between Central Asia and the EU and those between North Africa and the EU</td>
</tr>
<tr>
<td>MS</td>
<td>Member State</td>
</tr>
<tr>
<td>PEN</td>
<td>UNODC/INCB developed Pre-Export Notification Online System</td>
</tr>
<tr>
<td>PICS</td>
<td>Precursors Incident Communication System</td>
</tr>
<tr>
<td>PRES</td>
<td>Rotating presidency of the Council of the European Union</td>
</tr>
<tr>
<td>PRES Trio</td>
<td>Grouping of three consecutive rotating presidencies of the Council of the European Union</td>
</tr>
<tr>
<td>Reitox</td>
<td>Réseau Européen d'Information sur les Drogues et les Toxicomanies</td>
</tr>
<tr>
<td>SOCTA</td>
<td>Serious and Organised Crime Threat Assessment</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>WCO</td>
<td>World Customs Organisation</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation (UN)</td>
</tr>
</tbody>
</table>
This report is available in Bulgarian, Spanish, Czech, Danish, German, Estonian, Greek, English, French, Croatian, Italian, Latvian, Lithuanian, Hungarian, Dutch, Polish, Portuguese, Romanian, Slovak, Slovenian, Finnish, Swedish and Norwegian. All translations were made by the Translation Centre for the Bodies of the European Union.

Cataloguing data can be found at the end of this publication.


ISBN: 978-92-9168-694-0
doi:10.2810/32306

© European Monitoring Centre for Drugs and Drug Addiction, 2014
Reproduction is authorised provided the source is acknowledged.

Printed in Spain

PRINTED ON ELEMENTAL CHLORINE-FREE BLEACHED PAPER (ECF)
Preface

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

Progress has been made in developing a balanced policy response to drug problems in Europe, and this is an important message coming from this year’s analysis. In some key public health areas, the overall trends are now positive, and in relative global terms, the European model appears to be a successful one. The drug phenomenon is dynamic and continues to evolve, leaving us no room for complacency, as new threats emerge to accompany residual and long-established problems. The drugs that we see today are, in many ways, different from those we knew in the past. We see this in the established drugs, a notable example being cannabis, where new production techniques are impacting on the potency of both resin and herbal products. We see this also in synthetic drug production, with a plethora of new substances appearing. It must be a serious concern that, recently, we have witnessed the emergence of both new synthetic opioids and hallucinogenic substances that are so highly pharmacologically active that even tiny quantities can be used to produce multiple doses. We are only beginning to grasp the future implications of these developments for both public health and drug control, but they do appear to have the potential to transform the nature of the problems we face.
Not only are important changes taking place in the European drug market, they are occurring at an ever greater pace and within the context of an increasingly interconnected world. The EMCDDA recognises the global and dynamic nature of our subject matter, and the challenges this poses. Moreover, these developments place our current monitoring systems under increasing strain, and it is critical to ensure that our surveillance tools remain fit for purpose. Nearly two decades ago, Europe was the first to establish an early-warning system to identify potential new threats in this area. Today, the system has proved its worth, but nevertheless our overall forensic capacity to identify and report on the public health consequences of both established and new substances remains insufficient. We can only note here the importance of ensuring that sufficient resources are made available for maintaining and strengthening work in this area, and highlight the added value that this provides to the European community as a whole.

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

 João Goulão  
Chairman of the EMCDDA Management Board

Wolfgang Götz  
Director, EMCDDA
Introductory note and acknowledgements

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

Statistical data reported here are for 2012, or the most recent year available. European totals and trends are based on those countries providing sufficient and relevant data for the period specified. The data analysis prioritises levels, trends and geographical distribution. The necessary technical caveats and qualifications of the data may be found in the English language online version of this report and in the online European Drug Report: Data and statistics, where information on methodology, reporting countries and years is available. In addition, the online version provides links to further resources.

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

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

Reitox national focal points

Reitox is the European information network on drugs and drug addiction. The network is comprised of national focal points in the EU Member States, the candidate country Turkey, Norway and at the European Commission. Under the responsibility of their governments, the focal points are the national authorities providing drug information to the EMCDDA. The contact details of the national focal points may be found on the EMCDDA website.
This report provides a top-level overview of the long-term trends and developments in Europe, while also focusing in on emerging drug-related problems.
Charting the public health impact of drugs in a changing European market

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

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

Heroin in decline, but replacement substances cause concern

While noting that globally, heroin production estimates remain high, and seizures in Turkey have partially rebounded, overall, heroin indicators are generally stable or trending downwards. This includes data showing a continuing decline in heroin-related treatment entry, alongside overall, long-term downward trends in drug overdose deaths and drug-acquired HIV infection — both historically linked to injecting heroin use. These positive developments are put in question, however, by some national data. Recent outbreaks of HIV among drug users in Greece and Romania, together with ongoing problems in some Baltic countries, have stalled Europe’s progress in reducing the number of new drug-related infections. In part, this seems to be associated with the replacement of heroin by other substances, including synthetic opioids and stimulants. In addition, the absence of sufficient demand reduction interventions, particularly treatment...
availability, and harm reduction measures is also likely to be an important contributory factor. Worryingly, a recent EMCDDA–ECDC risk assessment exercise also identified a number of other European countries where behavioural or response indicators suggested a potential elevated risk for future harms and health problems.

### Multiple substances identified in drug-induced deaths

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

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

### New psychoactive substances: no signs of abating

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

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

Central to the work of the Early Warning System are reports on adverse events, principally deaths and acute intoxications. However, robust monitoring systems for drug-related health emergencies exist in only a few countries. Standardised reporting on this topic does not take place at EU level and the lack of systematic...
monitoring in this area represents a blind spot in Europe’s surveillance of emerging health threats. An example of this is the difficulties in determining the implications at European level of reports from some countries of severe reactions to the use of synthetic cannabinoids.

Cannabis: controversies, contrasts and contradictions

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

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

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

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

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Lifetime Use</th>
<th>Last Year Use</th>
<th>Young Adult Use</th>
<th>National Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cannabis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>73.6 million</td>
<td>21.7%</td>
<td>18.1 million</td>
<td>14.6 million</td>
<td>0.4% and 18.5%</td>
</tr>
<tr>
<td>18.1 million</td>
<td>5.3%</td>
<td>18.1 million</td>
<td>14.6 million</td>
<td></td>
</tr>
<tr>
<td>14.6 million</td>
<td>11.2%</td>
<td>18.6 million</td>
<td>14.6 million</td>
<td></td>
</tr>
<tr>
<td><strong>Cocaine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.1 million</td>
<td>4.2%</td>
<td>3.1 million</td>
<td>2.2 million</td>
<td>0.2% and 3.6%</td>
</tr>
<tr>
<td>3.1 million</td>
<td>0.9%</td>
<td>2.2 million</td>
<td>2.2 million</td>
<td></td>
</tr>
<tr>
<td>2.2 million</td>
<td>1.7%</td>
<td>2.2 million</td>
<td>2.2 million</td>
<td></td>
</tr>
<tr>
<td><strong>Amphetamines</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.4 million</td>
<td>3.4%</td>
<td>1.5 million</td>
<td>1.2 million</td>
<td>0.0% and 2.5%</td>
</tr>
<tr>
<td>1.5 million</td>
<td>0.4%</td>
<td>1.5 million</td>
<td>1.2 million</td>
<td></td>
</tr>
<tr>
<td>1.2 million</td>
<td>0.9%</td>
<td>1.2 million</td>
<td>1.2 million</td>
<td></td>
</tr>
<tr>
<td><strong>Ecstasy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.6 million</td>
<td>3.1%</td>
<td>1.6 million</td>
<td>1.3 million</td>
<td>0.1% and 3.1%</td>
</tr>
<tr>
<td>1.6 million</td>
<td>0.5%</td>
<td>1.6 million</td>
<td>1.3 million</td>
<td></td>
</tr>
<tr>
<td>1.3 million</td>
<td>1.0%</td>
<td>1.3 million</td>
<td>1.3 million</td>
<td></td>
</tr>
<tr>
<td><strong>Opioids</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 million</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5% of all deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5% of all deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal drug in about 45% of all drug treatment requests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>700 000 opioid users received substitution treatment in 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NB: For the complete set of data and information on the methodology see the accompanying online European Drug Report: Data and statistics.
Drug production and supply: core business for organised crime

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

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

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

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

A volatile stimulants market

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

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

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

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

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

Europe is a major destination for controlled substances and also plays a more limited role as a transit point for drugs en route to other regions. Latin America, West Asia and North Africa are important source areas for drugs entering Europe. Europe is also a producing region for cannabis and synthetic drugs. Whereas virtually all cannabis produced in Europe is intended for local consumption, some synthetic drugs are also manufactured for export to other regions.

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

80% of seizures in Europe are for cannabis

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

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

Monitoring drug supply

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

Data on new psychoactive substances are based on notifications to the EU Early Warning System, which relies on data provided by the EMCDDA’s and Europol’s national networks. A full description of this mechanism can be found on the EMCDDA website under Action on new drugs.
numbers of seizures in the past. In addition, Turkey is an important country for drug seizures, with some of the drugs intercepted being intended for consumption in other countries, both in Europe and in the Middle East.

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

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

Cannabis: increasing availability of herbal products

Two distinct cannabis products are commonly found on the European drugs market: herbal cannabis (‘marijuana’) and cannabis resin (‘hashish’). The annual consumption of these products can be roughly estimated at around 2 000 tonnes.

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

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

In terms of quantities seized, a small number of countries are disproportionately important, in part because of their location on major trafficking routes (Figures 1.2 and 1.3). Spain, for example, with its close proximity to Morocco, and substantial internal market, reported around
Chapter 1

Drug supply

CANNABIS

Resin

457 tonnes seized
240,000 seizures

Herb

105 tonnes seized
395,000 seizures

Price (EUR/g)

24 €

IQR 7 €

11 €

3 €

Potency (% THC)

2% 14% 18%

IQR 7% 14%

3% 10% 14%

IQR 5% 10%

Price and potency indexes

Price (EUR/g)

100

2006 2012

2006 2012

EU + 2 refers to EU Member States, Turkey and Norway. Price and potency of cannabis products: national mean values – minimum, maximum and interquartile range (IQR). Countries covered vary by indicator.
two-thirds of the total quantity of resin seized in Europe in 2012. In respect to herbal cannabis, both Greece, and Italy reported recent large increases in quantities seized. Since 2007, Turkey has seized larger quantities of herbal cannabis than any of the EU Member States, and the amount reported in 2012 was more than double that reported in 2011.

Seizures of cannabis plants can be regarded as an indicator of domestic production, although the quality of data available in this area poses problems for purposes of comparison. In 2012, 33,000 seizures of cannabis plants were reported in Europe. Between 2011 and 2012, reports of numbers of cannabis plants seized increased from 5 million to 7 million, largely accounted for by a quadrupling of seizures reported from Italy. During the same period, quantities seized increased from 33 tonnes to 45 tonnes.

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

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

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

Afghanistan remains the world’s largest illicit producer of opium, and most heroin found in Europe is thought to be manufactured there or, to a lesser extent, in neighbouring Iran or Pakistan. The drug may enter Europe by a number of trafficking routes. One of these routes runs through Turkey, into Balkan countries (Bulgaria, Romania or Albania) and on to central, southern and western Europe. Another route runs through Russia, via the former Soviet republics of Central Asia. Heroin shipments from Iran and Pakistan may also enter Europe by air or sea, either directly or transiting through west and east African countries.

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

In Europe, cocaine is available in two forms, the most common of which is cocaine powder (a hydrochloride salt, HCl). Less commonly available is crack cocaine, a smokeable form of the drug. Cocaine is produced from the leaves of the coca bush. The drug is produced almost exclusively in Bolivia, Colombia and Peru, and is transported to Europe by both air and sea routes. Trafficking of cocaine into Europe — and law enforcement efforts against this trafficking — appears to take place mainly through western and southern countries, with Spain, Belgium, the Netherlands, France and Italy together accounting for 85% of the 71 tonnes seized in 2012 (Figure 1.6). Signs of the ongoing diversification of cocaine trafficking routes into Europe include large individual seizures in ports in Bulgaria, Greece, Romania and Baltic countries.

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

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

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

Synthetic opioids that can be used as alternatives to heroin have been reported to the EU Early Warning System. These include the highly potent fentanyls, which may be diverted from pharmaceutical supplies, including inadequately disposed analgesic patches, or they may be manufactured specifically for the illicit market. Between 2012 and 2013, 28 seizures were reported of a new synthetic opioid, AH-7921, which is similar to morphine in terms of pharmacology (see page 28).
seized in 2012 increased by around 10 tonnes over the previous year, but is still well below the peak of 120 tonnes seized in 2006 (Figure 1.6). Decreases in the quantity of cocaine seized are most observable in the Iberian Peninsula, particularly in Portugal between 2006 and 2007, and more gradually in Spain between 2006 and 2011. Record seizures of cocaine were reported in 2012 by Belgium (19 tonnes) (Figure 1.7).
Amphetamines: signs of increased production of methamphetamine

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

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

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

EU + 2 refers to EU Member States, Turkey and Norway. Price and purity of amphetamines: national mean values – minimum, maximum and mean interquartile range (IQR). Countries covered vary by indicator. Indexes are not available for methamphetamine.
**FIGURE 1.8**

Quantity of amphetamine and methamphetamine seized, 2012

**Amphetamine**

**Methamphetamine**

Tonnes ≤0.001 0.001–0.010 0.011–1.0 >1.0 No data

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

**FIGURE 1.9**

Number of amphetamine seizures and quantity seized, 2002–12

**FIGURE 1.10**

Number of methamphetamine seizures and quantity seized, 2002–12
Ecstasy: high purity powder available

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

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

In 2012, 4 million ecstasy tablets were seized in the European Union, mainly in the Netherlands (2.4 million), followed by the United Kingdom (0.5 million) and Germany (0.3 million). In addition, Turkey seized 3.0 million ecstasy tablets in the same year (Figures 1.11 and 1.12). The quantity of ecstasy tablets seized in the European Union in 2012 represents less than one-fifth of the quantity seized in 2002 (23 million). Overall, seizures of ecstasy decreased between 2002 and 2009, before increasing slowly in subsequent years (Figure 1.11). This trend is also mirrored in the data available on the MDMA content of analysed ecstasy tablets, which decreased until 2009, and increased in the last three reporting years.
Chapter 1

Drug supply

Cathinones, a new class of stimulants in Europe

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

Increasing diversity in new drugs identified

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

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

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

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

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

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

New psychoactive substances can appear on the market either under the guise of a controlled drug, or as an alternative to a controlled drug. For example, 4-methylamphetaemine was sold directly on the illicit drug market as amphetamine, methoxetamine is marketed as a legal alternative to ketamine and 25I-NBOMe is sold as a ‘legal’ alternative to LSD (lysergic acid diethylamide).
Chapter 1 | Drug supply

The Internet as a growing marketplace

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

More medicines detected

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

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

### 2014
- New developments in Europe’s cannabis markets, Perspectives on drugs.
- Exploring methamphetamine trends in Europe, EMCDDA Papers.

### 2013
- Synthetic cannabinoids in Europe, Perspectives on drugs.
- Synthetic drug production in Europe, Perspectives on drugs.

### 2012
- Cannabis production and markets in Europe, Insights.

### 2011
- Recent shocks in the European heroin market: explanations and ramifications, Trendspotter meeting reports.
- Responding to new psychoactive substances, Drugs in focus.

### 2010
- Risk assessment of new psychoactive substances: operating guidelines.

### 2007
- Early-warning system on new psychoactive substances: operating guidelines.

## EMCDDA and Europol joint publications

### 2014

### 2013
- Amphetamine: a European Union perspective in the global context.

### 2010
- Cocaine: a European Union perspective in the global context.

### 2009
- Methamphetamine: a European Union perspective in the global context.

---

All publications are available at [www.emcdda.europa.eu/publications](http://www.emcdda.europa.eu/publications)
Almost a quarter of the adult population in the European Union, or over 80 million adults, are estimated to have used illicit drugs at some point in their lives.
Drug use and drug-related problems

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

### Monitoring drug use and drug-related problems

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

| Over 80 million Europeans have used an illicit drug

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

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

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

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

Cannabis: divergent national trends

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

Cannabis is the illicit drug most likely to be used by all age groups. An estimated 14.6 million young Europeans (15–34), or 11.2 % of this age group, used cannabis in the last year, with 8.5 million of these aged 15–24 (13.9 %). Cannabis use is generally higher among males, and this
difference is usually accentuated for more intensive or regular patterns of use. Current trends in use appear divergent, as illustrated by the fact that of the countries that reported new surveys since 2011, eight reported decreases and five reported increases in last year prevalence. Few national surveys currently report on use of synthetic cannabinoid receptor agonists; for those that do, prevalence levels are generally low.

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

### Concern about cannabis users

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

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

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

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

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

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

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

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

Decreases in cocaine use are also observable in the most recent data, with 11 out of the 12 countries with surveys between 2011 to 2013 reporting falls in prevalence.
Chapter 2: Drug use and drug-related problems

Continued decline in cocaine treatment demand

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

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

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

COCAINE USERS ENTERING TREATMENT

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Mean age at first use</th>
<th>Mean age at treatment entry</th>
<th>Frequency of use in the last month</th>
<th>Route of administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22</td>
<td>34</td>
<td>Daily</td>
<td>Injecting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Two to six times a week</td>
<td>Smoking/inhaling</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Once a week or less</td>
<td>Eating/drinking</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not used in the last month</td>
<td>Sniffing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

COCaine USERS ENTERING TREATMENT

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

Trends in first-time entrants

NB: Characteristics are for all treatment entrants with cocaine/crack as primary drug. Trends are for first-time entrants with cocaine/crack as primary drug. Countries covered vary by indicator.
An estimated 1.2 million (0.9%) young adults (15–34) used amphetamines during the last year. Between 2007 and 2012, annual prevalence estimates for young adults remained relatively low and stable in most European countries, with prevalence levels of 2.5% or less in all reporting countries. Among the 12 countries with surveys since 2011, 11 reported decreasing amphetamine prevalence levels (Figure 2.6).

Amphetamines: use decreasing but health risks continue

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

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

Adverse health effects linked with amphetamines use include cardiovascular, pulmonary, neurological and mental health problems, while as with other drugs, injection is a risk factor for infectious diseases. As with other stimulants, deaths related to amphetamines can be difficult to identify. However, small numbers are reported annually, usually by countries where prevalence levels are high.
Chapter 2 | Drug use and drug-related problems

Amphetamines use: a multi-faceted phenomenon

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

Around 6 % of clients entering specialised drug treatment in Europe in 2012 report amphetamines as their primary drug (approximately 25 000 clients, of whom 10 000 entered treatment for the first time in their life). Primary amphetamine users account for a sizeable proportion of reported first-time treatment entries only in Germany, Latvia and Poland, while methamphetamine is cited as the primary drug by a large proportion of first-time clients in the Czech Republic and Slovakia. Recent increases in first-time entrants for amphetamines are accounted for primarily by Germany and by increases in first-time methamphetamine clients in the Czech Republic and Slovakia.
Bulgaria, which has an upward trend in prevalence since 2005, this decline continues to be evident for the 12 countries reporting surveys since 2011. Few users entered treatment for problems relating to ecstasy in 2012: ecstasy was mentioned as the primary drug by less than 1% (around 550 clients) of reported first-time treatment entrants in Europe.

### Ecstasy use: low and stable trends in the general population

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

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

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

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

**Low level of use of hallucinogens, GHB and ketamine**

A number of psychoactive substances with hallucinogenic, anaesthetic and depressant properties are available on the illicit drug market in Europe: these may be used on their own, alongside, or in place of other more common drugs. The overall prevalence levels of hallucinogenic mushrooms and LSD (lysergic acid diethylamide) use in Europe have been generally low and stable for a number of years. Among young adults (15–34), national surveys report last year prevalence estimates for the use of hallucinogenic mushrooms ranging from 0 % to 0.8 %, and for LSD from 0 % to 0.7 %.

Since the mid-1990s, recreational use of ketamine and gamma-hydroxybutyrate (GHB) has been reported among subgroups of drug users in Europe. Recognition is growing of the health problems related to these substances, for example, damage to the bladder associated with long-term ketamine use. Loss of consciousness, withdrawal syndrome and dependence are risks linked to use of GHB, with Belgium and the Netherlands reporting some requests for treatment.

Where they exist, national estimates of the prevalence of GHB and ketamine use in both adult and school populations remain low. Denmark reports last year prevalence of ketamine use at 0.3 % among young adults (15–34), with 0.8 % of 16- to 24-year-olds reporting last year ketamine use in the United Kingdom, a drop from a peak of 2.1 % in 2010. Targeted surveys in nightlife settings typically report higher levels of prevalence. Among UK respondents to a 2013 self-selecting Internet survey who were identified as regular clubbers, 31 % reported last year use of ketamine, and 2 % reported last year use of GHB.
The illicit use of opioids remains responsible for a disproportionately large share of the morbidity and mortality resulting from drug use in Europe. The main opioid used in Europe is heroin, which may be smoked, snorted or injected. A range of other synthetic opioids, such as buprenorphine, methadone and fentanyl, are also available on the illicit market. Opioid use tends to be highest among marginalised populations in urban areas.

Europe has experienced different waves of heroin addiction, the first affecting many western European countries from the mid-1970s onwards and a second wave affecting central and eastern Europe in the mid- to late 1990s. Although trends have varied over the last decade, overall, new recruitment into heroin use now appears to be on the decline.

The average annual prevalence of problem opioid use among adults (15–64) is estimated at around 0.4 %, the equivalent of 1.3 million problem opioid users in Europe in 2012. At national level, prevalence estimates of problem opioid use vary between less than one and around eight cases per 1 000 population aged 15–64 (Figure 2.8).

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

In 2012, in the majority of European countries (17) more than 10 % of first-time opioid clients entering specialised treatment were misusing opioids other than heroin (Figure 2.9). These included methadone, buprenorphine and fentanyl. In some countries, these drugs now represent the most common form of opioid use. In Estonia, the majority of treatment entrants for opioids were using illicit fentanyl, while in Finland most opioid clients are reported to be primary misusers of buprenorphine.
HEROIN USERS ENTERING TREATMENT

**Characteristics**

- **Mean age at first use**: 22
- **Mean age at treatment entry**: 36

**Frequency of use in the last month**
- Daily: 26%
- Two to six times a week: 8%
- Once a week or less: 13%
- Not used in the last month: 11%

**Route of administration**
- Injecting: 53%
- Smoking/inhaling: 42%
- Eating/drinking: 2%
- Sniffing: 44%
- Other: 1%

**Trends in first-time entrants**

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

Injecting drug users are among those at highest risk of experiencing health problems from their drug use, such as blood-borne infections or drug overdoses. Injection is commonly associated with opioid use, although in a few countries, amphetamines injection is a major problem. Twelve countries have recent estimates of the prevalence of injecting drug use, ranging from less than one to approximately six cases per 1,000 population aged 15–64. Among clients entering specialised treatment, 38% of opioid clients and 23% of amphetamine clients report injecting the drug. Levels of injecting among opioid clients vary between countries, from less than 6% in the Netherlands to 100% in Lithuania.

An analysis of time trends among clients entering treatment for the first time in Europe indicates that injecting as the main route of administration has fallen since 2006 (Figure 2.10). The proportion of new clients reporting having injected amphetamines, cocaine or opioids in the last month has also fallen over the same time period.
Chapter 2 | Drug use and drug-related problems

HIV-related mortality is the best documented indirect cause of death among drug users. The most recent estimate suggests that about 1 700 people died of HIV/AIDS attributable to injecting drug use in Europe in 2010, and the trend is downward. Liver disease is also likely to account for considerable and increasing numbers of deaths among injecting drug users, mainly due to HCV infection, and often worsened by heavy alcohol use.

HIV: outbreaks impact on EU trend

The injection of drugs continues to play a major role in the transmission of blood-borne infectious diseases such as hepatitis C and, in some countries, HIV/AIDS. The latest figures show that the long-term decline in the number of new HIV diagnoses in Europe might be interrupted as a result of outbreaks among injecting drug users in Greece and Romania (Figure 2.11). In 2012, the average rate of newly reported HIV diagnoses attributed to injecting drug use was 3.09 per million population. Although the figures are subject to revision, there were 1 788 newly reported cases in 2012, slightly more than in 2011 (1 732), continuing the upward trend observed since 2010.

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

**FIGURE 2.11**

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

HIV-related mortality is the best documented indirect cause of death among drug users.
Hepatitis and other infections: major health issues

Viral hepatitis, and in particular infection caused by the hepatitis C virus (HCV), is highly prevalent among injecting drug users across Europe. HCV antibody levels among national samples of injecting drug users in 2011–12 varied from 19 % to 84 %, with seven of the 11 countries with national data reporting a prevalence rate in excess of 50 % (Figure 2.12). Among countries with national trend data for the period 2007–12, declining HCV prevalence in injecting drug users was reported in Norway, while seven others observed an increase.

Averaged across the 18 countries for which data are available for the period 2011–12, injecting drug use accounts for 64 % of all HCV diagnoses and 50 % of the acute diagnoses notified (where the risk category is known). For hepatitis B, injecting drug users represent 9 % of all diagnoses and 21 % of acute diagnoses notified. Drug use may be a risk factor for other infectious diseases including hepatitis A and D, sexually transmitted diseases, tuberculosis, tetanus and botulism. Outbreaks of anthrax infection, probably caused by contaminated heroin, are also sporadically reported in Europe. For example, between June 2012 and March 2013, 15 drug-related anthrax cases were reported, of which seven resulted in fatalities.

FIGURE 2.12
HCV antibody prevalence among injecting drug users, 2011/2012

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

Overdose deaths: overall reduction, but increases in some countries

Drug use is one of the major causes of mortality among young people in Europe, both directly through overdose (drug-induced deaths) and indirectly through drug-related diseases, accidents, violence and suicide. Most studies on cohorts of problem drug users show mortality rates in the range of 1–2 % per year, and it has been estimated that between 10 000 and 20 000 opioid users die each year in Europe. Overall, opioid users are at least 10 times more likely to die than their peers of the same age and gender. For female opioid users, in some countries, the risk of dying may be up to 30 times that of their peers.

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

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

For 2012, the average mortality rate due to overdoses in Europe is estimated at 17 deaths per million population aged 15–64. National mortality rates vary considerably and are influenced by factors such as patterns of drug use, particularly injecting use, the characteristics of drug-using populations and reporting practices. Rates of over 40
Chapter 2 | Drug use and drug-related problems

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

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

**Figure 2.13**

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

**Characteristics**

- Mean age at death: 36
- Deaths with opioids present: 75%

**Age**

- <25: 39%
- 25–39: 47%
- 40–64: 10%
- >64: 4%
- Other countries: 22%
- United Kingdom: 78%

**Trends in overdose deaths**
EMCDDA publications

2014
Injection of synthetic cathinones, Perspectives on drugs.
Wastewater analysis and drugs: results from a European multi-city study, Perspectives on drugs.

2013
Characteristics of frequent and high-risk cannabis users, Perspectives on drugs.
Emergency health consequences of cocaine use in Europe, Perspectives on drugs.
Trends in heroin use in Europe — what do treatment demand data tell us?, Perspectives on drugs.

2012
Driving under the influence of drugs, alcohol and medicines in Europe: findings from the DRUID project, Thematic paper.
Fentanyl in Europe, EMCDDA Trendspotter study.

2011
Mortality related to drug use in Europe, Selected issue.

2010
Problem amphetamine and methamphetamine use in Europe, Selected issue.

2009
Polydrug use: patterns and responses, Selected issue.

2008
A cannabis reader: global issues and local experiences, volume 2, part I: Epidemiology, and part II: Health effects of cannabis use, Monographs.

EMCDDA and ESPAD joint publications

2012
Summary of the 2011 ESPAD report.

EMCDDA and ECDC joint publications

2012
HIV in injecting drug users in the EU/EEA, following a reported increase of cases in Greece and Romania.

All publications are available at www.emcdda.europa.eu/publications
Interventions designed to prevent, treat and reduce the harms related to drug use are reviewed in this chapter.
Health and social responses to drug problems

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

Monitoring health and social responses

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

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

Drug prevention for vulnerable groups of young people

A range of prevention strategies are used to tackle drug use and drug-related problems. Environmental and universal approaches target entire populations, selective prevention targets vulnerable groups who may be at greater risk of developing drug use problems, and indicated prevention focuses on at-risk individuals. In this year’s report, the focus is on selective prevention, an approach for which there is growing evidence of effectiveness for programmes that focus on norm-setting, environmental restructuring, motivation, skills and decision-making. Many programmes, however, continue to be based on information provision, awareness-raising and
Reducing harm in nightlife settings: the need for an integrated approach

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

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

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

counselling; approaches where the evidence of effectiveness is scarce.

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

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

For young offenders, the majority of countries now report the introduction of alternative measures to penal sanctions. One programme of note in this area is FreD, a set of manual-based interventions, which has now been implemented in 15 EU Member States. Evaluations of this programme have shown a fall in repeat offending rates.
Chapter 3 | Health and social responses to drug problems

Preventing the spread of infectious diseases

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

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

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

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

FIGURE 3.4
Number of syringes provided through specialised programmes per injecting drug user (estimate)

Number of syringes

Norway
Spain
Croatia
Estonia
France
UK (Scotland)
Czech Republic
Luxembourg
Hungary
Greece
Belgium
Cyprus

NB: Data displayed as point estimates and uncertainty intervals.

FIGURE 3.5
Summary indicators for potential elevated risk for HIV infections among injecting drug users

HIV prevalence and trends

Injecting drug use prevalence and trends (transmission risk)

Substitution treatment coverage (<30 %)

Needle and syringe coverage (<100 syringes per injecting drug user)

None of the following risk factors identified: increase in HIV case reports or prevalence of HIV or HCV; increase in transmission risk; low intervention coverage.

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

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

Information not available to ECDC or EMCDDA.

Adapted from Eurosurveillance 2013;18(48):pii=20648.
More than a million Europeans in drug treatment

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

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

FIGURE 3.6

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

Reducing overdoses and drug-related deaths

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

Reducing fatal drug overdoses and other drug-related deaths remains a major challenge for public health policy in Europe.
Substitution treatment: the main outpatient treatment modality

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

An estimated 734 000 opioid users received substitution treatment in Europe in 2012. This figure is relatively stable when compared with 2011 (726 000), but higher than the 630 000 estimate for 2007 (Figure 3.8). In 2012, five countries reported increases of more than 25 % in client numbers compared to the previous year’s estimate. The highest percentage increase was noted in Turkey (250 %), followed by Greece (45 %) and Latvia (28 %). The percentage increases in these three countries, however, occurred in the context of relatively low base numbers. In contrast, during the same period, Romania (−30 %) reported the largest percentage decrease in estimated client numbers.
Chapter 3 | Health and social responses to drug problems

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

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

Treatment without substitution medication is provided to opioid users in all European countries. In the ten countries providing sufficient data, the coverage of treatment approaches not involving substitution medication is generally within the range of 3% to 17% of all problem opioid users, reaching over 50% in Hungary (Figure 3.10).
The evidence on the effectiveness of drug-free therapeutic communities is inconclusive, in part because of methodological difficulties in conducting treatment outcome research in this area. Most research on this subject in Europe is limited to observational studies, and conclusions are therefore necessarily tentative. Generally, however, these studies report positive treatment outcomes, associated with longer retention in treatment and treatment completion. Almost all of the observational studies report that therapeutic community residents show reductions in drug use and arrests, as well as improvements in quality of life measures.

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

**Residential treatment: therapeutic community approaches predominate**

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

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

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

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

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

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

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

Evidence-informed responses: use of guidelines and standards

Europe’s health and social responses to drug problems are increasingly supported by guidelines and quality standards, which exist to translate evidence into satisfactory and sustainable results. In general, a process can be observed whereby guidelines precede by several years the introduction of quality standards (Figure 3.15).
Guidelines are statements that include recommendations intended to optimise client care. They are usually based on a systematic review of evidence and an assessment of the benefits and harms of alternative care options. The purpose of guidelines is to assist clients, carers and service providers in making decisions on the choice of appropriate interventions. During the last 20 years more than 150 sets of drug-related guidelines have been published, with guidelines available in all Member States since 2011. Guidelines span the full range of health and social interventions in the drugs field, although there are a larger number on health interventions such as substitution treatment and detoxification than on harm reduction and social reintegration (Figure 3.16).

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

### EMCDDA publications

<table>
<thead>
<tr>
<th>Year</th>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Treatment of cocaine dependence: reviewing current evidence</td>
<td>Perspectives on drugs</td>
</tr>
<tr>
<td></td>
<td>Health and social responses for methamphetamine users in Europe</td>
<td>Perspectives on drugs</td>
</tr>
<tr>
<td></td>
<td>Internet-based drug treatment</td>
<td>Perspectives on drugs</td>
</tr>
<tr>
<td>2013</td>
<td>Can mass media campaigns prevent young people from using drugs?</td>
<td>Perspectives on drugs</td>
</tr>
<tr>
<td></td>
<td>Drug prevention interventions targeting minority ethnic populations</td>
<td>Thematic papers</td>
</tr>
<tr>
<td></td>
<td>Hepatitis C treatment for injecting drug users</td>
<td>Perspectives on drugs</td>
</tr>
<tr>
<td></td>
<td>North American drug prevention programmes: are they feasible in</td>
<td>Thematic papers</td>
</tr>
<tr>
<td></td>
<td>European cultures and contexts?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventing overdose deaths in Europe</td>
<td>Perspectives on drugs</td>
</tr>
<tr>
<td>2012</td>
<td>Drug demand reduction: global evidence for local actions</td>
<td>Drugs in focus</td>
</tr>
<tr>
<td></td>
<td>Guidelines for the evaluation of drug prevention: a manual</td>
<td>Manuals</td>
</tr>
<tr>
<td></td>
<td>New heroin-assisted treatment</td>
<td>Insights</td>
</tr>
<tr>
<td></td>
<td>Prisons and drugs in Europe: the problem and responses</td>
<td>Selected issues</td>
</tr>
<tr>
<td></td>
<td>Social reintegration and employment: evidence and interventions for</td>
<td>Insights</td>
</tr>
<tr>
<td></td>
<td>drug users in treatment</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>European drug prevention quality standards</td>
<td>Manuals</td>
</tr>
<tr>
<td></td>
<td>Guidelines for the treatment of drug dependence: a European</td>
<td>Selected issues</td>
</tr>
<tr>
<td></td>
<td>perspective</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>Harm reduction: evidence, impacts and challenges</td>
<td>Monographs</td>
</tr>
<tr>
<td></td>
<td>Treatment and care for older drug users</td>
<td>Selected issues</td>
</tr>
</tbody>
</table>

### EMCDDA and ECDC joint publications

<table>
<thead>
<tr>
<th>Year</th>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>Internet-based drug treatment interventions</td>
<td>Insights</td>
</tr>
<tr>
<td></td>
<td>Preventing later substance use disorders in at-risk children and</td>
<td>Thematic papers</td>
</tr>
<tr>
<td></td>
<td>adolescents</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>A cannabis reader: global issues and local experiences, volume</td>
<td>Prevention and treatment, Monographs</td>
</tr>
<tr>
<td></td>
<td>2, part III</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drugs and vulnerable groups of young people</td>
<td>Selected issues</td>
</tr>
</tbody>
</table>

## All publications are available at
The international framework for control of production, trade and possession of over 240 psychoactive substances is set out in three United Nations Conventions.
Drug policies

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

Monitoring drug policies

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

Drug laws: a common framework

The international framework for control of production, trade and possession of over 240 psychoactive substances is set out in three United Nations Conventions. These oblige each country to treat unauthorised supply as a criminal offence. The same is required for possession of drugs for personal use, but subject to a country’s ‘constitutional principles and the basic concepts of its legal system’. This clause has not been uniformly interpreted, and this is reflected in different legal approaches in European countries and elsewhere.
Possession for use: moving away from prison sentences

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

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

Drug supply: large variation in penalties

Illegal drug supply is always a crime across Europe, but the possible penalties vary considerably between countries. In some countries, supply offences may be subject to a single wide penalty range (up to life in prison). Other countries
differentiate between minor and major supply offences, determined by factors such as the quantity or type of drugs found, with corresponding maximum and minimum penalties.

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

| New psychoactive substances: evolving control systems |

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

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

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

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

| National drug strategies |

It is now established practice for national governments in Europe to adopt drug strategies and action plans. These time-limited documents contain a set of general principles, objectives and priorities, specifying actions and the parties responsible for their implementation. Currently, all countries have a national drug strategy or action plan document, except Austria which has provincial plans. Seven countries have adopted national strategies and action plans that cover both licit and illicit drugs (Figure 4.3). Many countries now systematically evaluate their drug strategies and action plans. The aim of evaluation is generally to assess the level of implementation achieved, as well as the changes in the overall drug situation.
**Diverse drug policy advocacy organisations**

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

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

**Economic evaluation: funds for interventions affected by austerity**

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

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

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

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.
### EMCDDA publications

**2014**
- Drug policy profiles — Austria, EMCDDA Papers.
- Drug policy profiles — Poland, EMCDDA Papers.

**2013**
- Drug policy advocacy organisations, EMCDDA Papers.
- Drug policy profiles: Ireland.
- Drug supply reduction and internal security, EMCDDA Papers.
- Legal approaches to controlling new psychoactive substances, Perspectives on drugs.
- Models for the legal supply of cannabis: recent developments, Perspectives on drugs.
- The new EU drugs strategy (2013–20), Perspectives on drugs.

**2012**
- Drug-related research in Europe: recent developments and future perspectives, Thematic papers.

**2011**
- Drug policy profiles: Portugal.

**2009**
- Drug offences: sentencing and other outcomes, Selected issues.

**2008**
- Towards a better understanding of drug-related public expenditure in Europe, Selected issues.

### EMCDDA and the European Commission joint publications

**2010**
- The European Union and the drug phenomenon: frequently asked questions.

---

All publications are available at www.emcdda.europa.eu/publications
National data presented here are drawn from the *European Drug Report: Data and statistics*, where further data, years, notes and meta-data are available.
## TABLE 1

### OPIOIDS

<table>
<thead>
<tr>
<th>Country</th>
<th>Problem opioid use estimate</th>
<th>Treatment demand indicator, primary drug</th>
<th>Opioid clients as % of treatment entrants</th>
<th>% opioid clients injecting (main route of administration)</th>
<th>Clients in substitution treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All entrants % (count)</td>
<td>First-time entrants % (count)</td>
<td>All entrants % (count)</td>
<td>First-time entrants % (count)</td>
<td></td>
</tr>
<tr>
<td>Belgium</td>
<td>–</td>
<td>34.5 (2335)</td>
<td>17.1 (290)</td>
<td>21.7 (480)</td>
<td>12.4 (35)</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>–</td>
<td>82.5 (1,631)</td>
<td>84.3 (253)</td>
<td>78.5 (963)</td>
<td>80.3 (196)</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1.5–1.5</td>
<td>18.2 (1,615)</td>
<td>9.7 (417)</td>
<td>85.8 (1,370)</td>
<td>84.5 (348)</td>
</tr>
<tr>
<td>Denmark</td>
<td>–</td>
<td>17.5 (663)</td>
<td>71 (102)</td>
<td>33.9 (193)</td>
<td>23 (20)</td>
</tr>
<tr>
<td>Germany</td>
<td>3.2–3.8</td>
<td>40.4 (30,841)</td>
<td>15.9 (3,343)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estonia</td>
<td>–</td>
<td>93.4 (510)</td>
<td>85.6 (107)</td>
<td>80.7 (406)</td>
<td>79.4 (85)</td>
</tr>
<tr>
<td>Ireland</td>
<td>–</td>
<td>51.6 (3,971)</td>
<td>32.4 (1,058)</td>
<td>42.5 (1,633)</td>
<td>34.4 (353)</td>
</tr>
<tr>
<td>Greece</td>
<td>2.6–3.2</td>
<td>77.5 (4,399)</td>
<td>68.9 (1,652)</td>
<td>39.7 (1,744)</td>
<td>36.3 (600)</td>
</tr>
<tr>
<td>Spain</td>
<td>0.9–1.0</td>
<td>29.7 (14,925)</td>
<td>13.2 (3,289)</td>
<td>18.1 (2,537)</td>
<td>12.1 (384)</td>
</tr>
<tr>
<td>France</td>
<td>–</td>
<td>43.1 (15,641)</td>
<td>27.1 (2,690)</td>
<td>14.2 (1,836)</td>
<td>6.8 (172)</td>
</tr>
<tr>
<td>Croatia</td>
<td>3.2–4.0</td>
<td>80.9 (6,357)</td>
<td>27.9 (313)</td>
<td>74.5 (4,678)</td>
<td>42.3 (126)</td>
</tr>
<tr>
<td>Italy</td>
<td>3.8–5.2</td>
<td>55.5 (16,751)</td>
<td>39 (5,451)</td>
<td>55.7 (8,507)</td>
<td>46.4 (2,185)</td>
</tr>
<tr>
<td>Cyprus</td>
<td>1.0–1.5</td>
<td>27.9 (278)</td>
<td>8.4 (41)</td>
<td>57.2 (159)</td>
<td>57.5 (23)</td>
</tr>
<tr>
<td>Latvia</td>
<td>5.4–10.7</td>
<td>49.9 (1,071)</td>
<td>26.3 (104)</td>
<td>91.3 (935)</td>
<td>80.9 (76)</td>
</tr>
<tr>
<td>Lithuania</td>
<td>2.3–2.4</td>
<td>–</td>
<td>66 (140)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luxembourg</td>
<td>5.0–7.6</td>
<td>58.8 (163)</td>
<td>–</td>
<td>44.1 (71)</td>
<td>–</td>
</tr>
<tr>
<td>Hungary</td>
<td>0.4–0.5</td>
<td>5.9 (230)</td>
<td>1.8 (47)</td>
<td>70.9 (156)</td>
<td>56.8 (25)</td>
</tr>
<tr>
<td>Malta</td>
<td>5.8–6.6</td>
<td>75.4 (1,410)</td>
<td>35.2 (93)</td>
<td>61 (840)</td>
<td>53.9 (48)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>0.8–1.0</td>
<td>12.1 (1,302)</td>
<td>5.7 (352)</td>
<td>5.8 (45)</td>
<td>9 (19)</td>
</tr>
<tr>
<td>Austria</td>
<td>5.2–5.5</td>
<td>58 (2,110)</td>
<td>35.5 (488)</td>
<td>46.5 (727)</td>
<td>33.6 (127)</td>
</tr>
<tr>
<td>Poland</td>
<td>0.4–0.7</td>
<td>28.7 (808)</td>
<td>9 (104)</td>
<td>62.7 (449)</td>
<td>39.4 (39)</td>
</tr>
<tr>
<td>Portugal</td>
<td>–</td>
<td>70.1 (2,637)</td>
<td>54.4 (980)</td>
<td>15.4 (147)</td>
<td>13.1 (80)</td>
</tr>
<tr>
<td>Romania</td>
<td>–</td>
<td>37.4 (745)</td>
<td>25 (251)</td>
<td>89.3 (609)</td>
<td>86.5 (199)</td>
</tr>
<tr>
<td>Slovenia</td>
<td>4.0–4.8</td>
<td>81.1 (519)</td>
<td>64 (189)</td>
<td>50.6 (212)</td>
<td>39.7 (48)</td>
</tr>
<tr>
<td>Slovakia</td>
<td>1.0–2.5</td>
<td>26.3 (528)</td>
<td>13.1 (126)</td>
<td>74 (382)</td>
<td>69.6 (87)</td>
</tr>
<tr>
<td>Finland</td>
<td>–</td>
<td>61.9 (920)</td>
<td>38.1 (101)</td>
<td>81.7 (28)</td>
<td>74 (74)</td>
</tr>
<tr>
<td>Sweden</td>
<td>–</td>
<td>20.1 (248)</td>
<td>–</td>
<td>60.9 (148)</td>
<td>–</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>7.9–8.3</td>
<td>56.4 (61,737)</td>
<td>33.4 (13,586)</td>
<td>34.5 (20,804)</td>
<td>30.6 (4,085)</td>
</tr>
<tr>
<td>Turkey</td>
<td>0.2–0.5</td>
<td>75.4 (3,557)</td>
<td>67.3 (1,695)</td>
<td>48.7 (1,734)</td>
<td>43.1 (730)</td>
</tr>
<tr>
<td>Norway</td>
<td>2.1–3.9</td>
<td>32.6 (2,902)</td>
<td>–</td>
<td>77.1 (145)</td>
<td>–</td>
</tr>
<tr>
<td>European Union</td>
<td>–</td>
<td>45.5 (174,345)</td>
<td>25.0 (35,567)</td>
<td>38.2 (50,750)</td>
<td>31.8 (7574)</td>
</tr>
<tr>
<td>EU, Turkey and Norway</td>
<td>–</td>
<td>45.5 (181,804)</td>
<td>25.7 (37,262)</td>
<td>38.5 (52,638)</td>
<td>32.4 (10,304)</td>
</tr>
</tbody>
</table>
### COCAINE

<table>
<thead>
<tr>
<th>Country</th>
<th>Lifetime, adult (15–64) %</th>
<th>Last 12 months, young adult (15–34) %</th>
<th>Lifetime, students (15–16) %</th>
<th>Cocaine clients as % of treatment entrants</th>
<th>% cocaine clients injecting (main route of administration)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All entrants</td>
<td>First-time entrants</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>% (count)</td>
<td>% (count)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>% (count)</td>
<td>% (count)</td>
</tr>
<tr>
<td>Belgium</td>
<td>2.0</td>
<td>3</td>
<td></td>
<td>16.3 (277)</td>
<td>7.4 (72)</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>0.3</td>
<td>3</td>
<td></td>
<td>0.5 (9)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>0.5</td>
<td>1</td>
<td></td>
<td>0.2 (10)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Denmark</td>
<td>2.4</td>
<td>2</td>
<td></td>
<td>5.1 (193)</td>
<td>10.1 (17)</td>
</tr>
<tr>
<td>Germany</td>
<td>1.6</td>
<td>3</td>
<td></td>
<td>6.1 (4 620)</td>
<td>–</td>
</tr>
<tr>
<td>Estonia</td>
<td>1.3</td>
<td>2</td>
<td></td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Ireland</td>
<td>2.8</td>
<td>3</td>
<td></td>
<td>8.5 (654)</td>
<td>1.5 (9)</td>
</tr>
<tr>
<td>Greece</td>
<td>0.2</td>
<td>1</td>
<td></td>
<td>4.1 (235)</td>
<td>19.4 (45)</td>
</tr>
<tr>
<td>Spain</td>
<td>3.6</td>
<td>3</td>
<td></td>
<td>40.4 (20 335)</td>
<td>1.9 (371)</td>
</tr>
<tr>
<td>France</td>
<td>1.9</td>
<td>4</td>
<td></td>
<td>6.4 (2 311)</td>
<td>4.1 (411)</td>
</tr>
<tr>
<td>Croatia</td>
<td>0.9</td>
<td>2</td>
<td></td>
<td>1.9 (147)</td>
<td>3.5 (5)</td>
</tr>
<tr>
<td>Italy</td>
<td>1.3</td>
<td>4</td>
<td></td>
<td>12.1 (121)</td>
<td>2.5 (3)</td>
</tr>
<tr>
<td>Latvia</td>
<td>0.3</td>
<td>–</td>
<td></td>
<td>0.3 (6)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Lithuania</td>
<td>0.3</td>
<td>2</td>
<td></td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>–</td>
<td>–</td>
<td></td>
<td>12.6 (35)</td>
<td>39.4 (13)</td>
</tr>
<tr>
<td>Hungary</td>
<td>0.4</td>
<td>2</td>
<td></td>
<td>1.6 (62)</td>
<td>11.5 (7)</td>
</tr>
<tr>
<td>Malta</td>
<td>–</td>
<td>4</td>
<td></td>
<td>14.1 (251)</td>
<td>30.7 (75)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2.4</td>
<td>2</td>
<td></td>
<td>26.5 (2 867)</td>
<td>1.6 (23)</td>
</tr>
<tr>
<td>Austria</td>
<td>1.2</td>
<td>–</td>
<td></td>
<td>8.3 (301)</td>
<td>6.5 (19)</td>
</tr>
<tr>
<td>Poland</td>
<td>0.3</td>
<td>3</td>
<td></td>
<td>2.4 (69)</td>
<td>6.1 (4)</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.4</td>
<td>4</td>
<td></td>
<td>10.5 (397)</td>
<td>3.6 (8)</td>
</tr>
<tr>
<td>Romania</td>
<td>0.2</td>
<td>2</td>
<td></td>
<td>1.2 (23)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Slovenia</td>
<td>1.2</td>
<td>3</td>
<td></td>
<td>4.8 (25)</td>
<td>40 (10)</td>
</tr>
<tr>
<td>Slovakia</td>
<td>0.4</td>
<td>2</td>
<td></td>
<td>0.5 (11)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Finland</td>
<td>0.6</td>
<td>1</td>
<td></td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Sweden</td>
<td>1.2</td>
<td>1</td>
<td></td>
<td>1.8 (36)</td>
<td>–</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>3.3</td>
<td>4</td>
<td></td>
<td>12.6 (13 787)</td>
<td>2.1 (279)</td>
</tr>
<tr>
<td>Turkey</td>
<td>–</td>
<td>–</td>
<td></td>
<td>1.7 (82)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Norway</td>
<td>–</td>
<td>1</td>
<td></td>
<td>0.8 (67)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>European Union</td>
<td>1.7</td>
<td>–</td>
<td></td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>EU, Turkey and Norway</td>
<td>–</td>
<td>–</td>
<td></td>
<td>13.9 (54 973)</td>
<td>18.1 (26 200)</td>
</tr>
</tbody>
</table>

**TABLE 2**
## AMPHETAMINES

<table>
<thead>
<tr>
<th>Country</th>
<th>Prevalence estimates</th>
<th>Treatment demand indicator, primary drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General population</td>
<td>School population</td>
</tr>
<tr>
<td>Lifetime, adult (15–64)</td>
<td>Last 12 months, young adult (15–34)</td>
<td>Lifetime, students (15–16)</td>
</tr>
<tr>
<td>Belgium</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>1.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>2.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Denmark</td>
<td>6.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Germany</td>
<td>3.1</td>
<td>1.8</td>
</tr>
<tr>
<td>Estonia</td>
<td>–</td>
<td>2.5</td>
</tr>
<tr>
<td>Ireland</td>
<td>4.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Greece</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Spain</td>
<td>3.3</td>
<td>1.1</td>
</tr>
<tr>
<td>France</td>
<td>1.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Croatia</td>
<td>2.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Italy</td>
<td>1.8</td>
<td>0.1</td>
</tr>
<tr>
<td>Cyprus</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Latvia</td>
<td>2.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Lithuania</td>
<td>1.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Hungary</td>
<td>1.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Malta</td>
<td>0.4</td>
<td>–</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3.1</td>
<td>–</td>
</tr>
<tr>
<td>Austria</td>
<td>2.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Poland</td>
<td>2.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Romania</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Slovenia</td>
<td>0.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Slovakia</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Finland</td>
<td>2.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Sweden</td>
<td>5.0</td>
<td>1.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>10.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Turkey</td>
<td>0.3</td>
<td>–</td>
</tr>
<tr>
<td>Norway</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>European Union</td>
<td>3.4</td>
<td>0.9</td>
</tr>
<tr>
<td>EU, Turkey and Norway</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>
### TABLE 4

**ECSTASY**

<table>
<thead>
<tr>
<th>Country</th>
<th>General population</th>
<th>School population</th>
<th>Ecstasy clients as % of treatment entrants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lifetime, adult (15–64)</td>
<td>Last 12 months, young adult (15–34)</td>
<td>Lifetime, students (15–16)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Belgium</td>
<td>–</td>
<td>–</td>
<td>4</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>2.0</td>
<td>2.9</td>
<td>4</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>3.6</td>
<td>1.2</td>
<td>3</td>
</tr>
<tr>
<td>Denmark</td>
<td>2.3</td>
<td>0.7</td>
<td>1</td>
</tr>
<tr>
<td>Germany</td>
<td>2.7</td>
<td>0.9</td>
<td>2</td>
</tr>
<tr>
<td>Estonia</td>
<td>–</td>
<td>2.3</td>
<td>3</td>
</tr>
<tr>
<td>Ireland</td>
<td>6.9</td>
<td>0.9</td>
<td>2</td>
</tr>
<tr>
<td>Greece</td>
<td>0.4</td>
<td>0.4</td>
<td>2</td>
</tr>
<tr>
<td>Spain</td>
<td>3.6</td>
<td>1.4</td>
<td>2</td>
</tr>
<tr>
<td>France</td>
<td>2.4</td>
<td>0.4</td>
<td>3</td>
</tr>
<tr>
<td>Croatia</td>
<td>2.5</td>
<td>0.5</td>
<td>2</td>
</tr>
<tr>
<td>Italy</td>
<td>1.8</td>
<td>0.1</td>
<td>1</td>
</tr>
<tr>
<td>Cyprus</td>
<td>0.9</td>
<td>0.3</td>
<td>3</td>
</tr>
<tr>
<td>Latvia</td>
<td>2.7</td>
<td>0.8</td>
<td>3</td>
</tr>
<tr>
<td>Lithuania</td>
<td>1.3</td>
<td>0.3</td>
<td>2</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Hungary</td>
<td>2.4</td>
<td>1.0</td>
<td>4</td>
</tr>
<tr>
<td>Malta</td>
<td>0.7</td>
<td>–</td>
<td>3</td>
</tr>
<tr>
<td>Netherlands</td>
<td>6.2</td>
<td>3.1</td>
<td>3</td>
</tr>
<tr>
<td>Austria</td>
<td>2.3</td>
<td>1.0</td>
<td>–</td>
</tr>
<tr>
<td>Poland</td>
<td>1.1</td>
<td>0.3</td>
<td>2</td>
</tr>
<tr>
<td>Portugal</td>
<td>1.3</td>
<td>0.6</td>
<td>3</td>
</tr>
<tr>
<td>Romania</td>
<td>0.7</td>
<td>0.4</td>
<td>2</td>
</tr>
<tr>
<td>Slovenia</td>
<td>2.1</td>
<td>0.8</td>
<td>2</td>
</tr>
<tr>
<td>Slovakia</td>
<td>1.9</td>
<td>0.9</td>
<td>4</td>
</tr>
<tr>
<td>Finland</td>
<td>1.8</td>
<td>1.1</td>
<td>1</td>
</tr>
<tr>
<td>Sweden</td>
<td>2.1</td>
<td>0.2</td>
<td>1</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>8.3</td>
<td>2.4</td>
<td>4</td>
</tr>
<tr>
<td>Turkey</td>
<td>0.1</td>
<td>0.1</td>
<td>–</td>
</tr>
<tr>
<td>Norway</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>European Union</td>
<td>3.1</td>
<td>1.0</td>
<td>–</td>
</tr>
<tr>
<td>EU, Turkey and Norway</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>
### CANNABIS

<table>
<thead>
<tr>
<th>Country</th>
<th>Lifetime, adult (15–64)</th>
<th>Last 12 months, young adult (15–34)</th>
<th>Lifetime, students (15–16)</th>
<th>All entrants</th>
<th>First-time entrants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>% (count)</td>
<td>% (count)</td>
</tr>
<tr>
<td>Belgium</td>
<td>14.3</td>
<td>11.2</td>
<td>24</td>
<td>312 (2 112)</td>
<td>49.4 (839)</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>7.5</td>
<td>8.3</td>
<td>21</td>
<td>3.4 (67)</td>
<td>5.7 (17)</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>27.9</td>
<td>18.5</td>
<td>42</td>
<td>12.5 (1 111)</td>
<td>17.5 (747)</td>
</tr>
<tr>
<td>Denmark</td>
<td>35.6</td>
<td>17.6</td>
<td>18</td>
<td>63.4 (2 397)</td>
<td>72.6 (1 048)</td>
</tr>
<tr>
<td>Germany</td>
<td>23.1</td>
<td>11.1</td>
<td>19</td>
<td>34.4 (26 208)</td>
<td>54.5 (11 431)</td>
</tr>
<tr>
<td>Estonia</td>
<td>–</td>
<td>13.6</td>
<td>24</td>
<td>2.9 (16)</td>
<td>8 (10)</td>
</tr>
<tr>
<td>Ireland</td>
<td>25.3</td>
<td>10.3</td>
<td>18</td>
<td>28.8 (2 216)</td>
<td>45.8 (1 498)</td>
</tr>
<tr>
<td>Greece</td>
<td>8.9</td>
<td>3.2</td>
<td>8</td>
<td>15.7 (889)</td>
<td>24.6 (589)</td>
</tr>
<tr>
<td>Spain</td>
<td>27.4</td>
<td>17.0</td>
<td>28</td>
<td>25.6 (12 873)</td>
<td>38.9 (9 736)</td>
</tr>
<tr>
<td>France</td>
<td>22.1</td>
<td>17.5</td>
<td>39</td>
<td>44.1 (16 020)</td>
<td>62.5 (6 066)</td>
</tr>
<tr>
<td>Croatia</td>
<td>15.6</td>
<td>10.5</td>
<td>18</td>
<td>12.7 (1 001)</td>
<td>56.3 (630)</td>
</tr>
<tr>
<td>Italy</td>
<td>21.7</td>
<td>8.0</td>
<td>14</td>
<td>17.1 (5 176)</td>
<td>26 (3 629)</td>
</tr>
<tr>
<td>Cyprus</td>
<td>9.9</td>
<td>4.2</td>
<td>7</td>
<td>53.3 (532)</td>
<td>81.9 (399)</td>
</tr>
<tr>
<td>Latvia</td>
<td>12.5</td>
<td>7.3</td>
<td>25</td>
<td>14.6 (314)</td>
<td>26.8 (106)</td>
</tr>
<tr>
<td>Lithuania</td>
<td>10.5</td>
<td>5.1</td>
<td>20</td>
<td>–</td>
<td>3.3 (7)</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>26 (72)</td>
<td>–</td>
</tr>
<tr>
<td>Hungary</td>
<td>8.5</td>
<td>5.7</td>
<td>19</td>
<td>65.9 (2 560)</td>
<td>74.9 (1 927)</td>
</tr>
<tr>
<td>Malta</td>
<td>3.5</td>
<td>1.9</td>
<td>10</td>
<td>8.4 (157)</td>
<td>29.2 (77)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>25.7</td>
<td>13.7</td>
<td>26</td>
<td>476 (5 143)</td>
<td>578 (3 542)</td>
</tr>
<tr>
<td>Austria</td>
<td>14.2</td>
<td>6.6</td>
<td>–</td>
<td>25.3 (919)</td>
<td>45.4 (623)</td>
</tr>
<tr>
<td>Poland</td>
<td>12.2</td>
<td>12.1</td>
<td>23</td>
<td>35.6 (1 003)</td>
<td>53.6 (623)</td>
</tr>
<tr>
<td>Portugal</td>
<td>9.4</td>
<td>5.1</td>
<td>14</td>
<td>13.9 (525)</td>
<td>25.4 (457)</td>
</tr>
<tr>
<td>Romania</td>
<td>1.6</td>
<td>0.6</td>
<td>7</td>
<td>11.1 (222)</td>
<td>18.1 (182)</td>
</tr>
<tr>
<td>Slovenia</td>
<td>15.8</td>
<td>10.3</td>
<td>23</td>
<td>10.4 (54)</td>
<td>26.5 (50)</td>
</tr>
<tr>
<td>Slovakia</td>
<td>10.5</td>
<td>7.3</td>
<td>27</td>
<td>21.6 (432)</td>
<td>32 (308)</td>
</tr>
<tr>
<td>Finland</td>
<td>18.3</td>
<td>11.2</td>
<td>11</td>
<td>18 (267)</td>
<td>42.6 (113)</td>
</tr>
<tr>
<td>Sweden</td>
<td>14.9</td>
<td>6.9</td>
<td>7</td>
<td>16 (197)</td>
<td>–</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>30.0</td>
<td>10.5</td>
<td>24</td>
<td>22.4 (24 498)</td>
<td>37.1 (15 107)</td>
</tr>
<tr>
<td>Turkey</td>
<td>0.7</td>
<td>0.4</td>
<td>–</td>
<td>15.8 (744)</td>
<td>22 (555)</td>
</tr>
<tr>
<td>Norway</td>
<td>19.2</td>
<td>7.9</td>
<td>5</td>
<td>19.2 (1 711)</td>
<td>–</td>
</tr>
<tr>
<td>European Union</td>
<td>21.7</td>
<td>11.2</td>
<td>–</td>
<td>27.9 (106 981)</td>
<td>42.2 (59 901)</td>
</tr>
<tr>
<td>EU, Turkey and Norway</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>27.6 (109 436)</td>
<td>41.8 (60 456)</td>
</tr>
</tbody>
</table>
## OTHER INDICATORS

<table>
<thead>
<tr>
<th>Country</th>
<th>Drug-induced deaths (aged 15–64) cases per million population (count)</th>
<th>HIV diagnoses among injecting drug users (ECDC) cases per million population (count)</th>
<th>Injecting drug use estimate cases per 1 000 population</th>
<th>Syringes distributed through specialised programmes count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>174 (127)</td>
<td>0.4 (4)</td>
<td>2.5–4.8</td>
<td>937 924</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>4.8 (24)</td>
<td>5.5 (40)</td>
<td>–</td>
<td>466 603</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>3.9 (28)</td>
<td>0.6 (6)</td>
<td>5.32–5.38</td>
<td>5 362 334</td>
</tr>
<tr>
<td>Denmark</td>
<td>46.3 (168)</td>
<td>2 (11)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Germany</td>
<td>16.8 (908)</td>
<td>1 (81)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Estonia</td>
<td>190.8 (170)</td>
<td>53.7 (72)</td>
<td>4.3–10.8</td>
<td>2 228 082</td>
</tr>
<tr>
<td>Ireland</td>
<td>70.5 (215)</td>
<td>2.8 (13)</td>
<td>–</td>
<td>274 475</td>
</tr>
<tr>
<td>Greece</td>
<td>–</td>
<td>42.9 (484)</td>
<td>0.93–1.25</td>
<td>406 898</td>
</tr>
<tr>
<td>Spain</td>
<td>11.4 (360)</td>
<td>4.4 (166)</td>
<td>0.19–0.21</td>
<td>1 990 136</td>
</tr>
<tr>
<td>France</td>
<td>6.7 (283)</td>
<td>1.2 (76)</td>
<td>–</td>
<td>13 800 000</td>
</tr>
<tr>
<td>Croatia</td>
<td>16.1 (46)</td>
<td>0.2 (1)</td>
<td>0.3–0.6</td>
<td>256 544</td>
</tr>
<tr>
<td>Italy</td>
<td>10.1 (390)</td>
<td>3.4 (208)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Cyprus</td>
<td>12 (7)</td>
<td>0 (0)</td>
<td>0.2–0.4</td>
<td>0</td>
</tr>
<tr>
<td>Latvia</td>
<td>12.4 (17)</td>
<td>46 (94)</td>
<td>–</td>
<td>311 188</td>
</tr>
<tr>
<td>Lithuania</td>
<td>34.7 (70)</td>
<td>20.6 (62)</td>
<td>–</td>
<td>196 446</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>22.1 (8)</td>
<td>7.6 (4)</td>
<td>4.5–6.85</td>
<td>212 822</td>
</tr>
<tr>
<td>Hungary</td>
<td>3.5 (24)</td>
<td>0 (0)</td>
<td>0.8</td>
<td>420 812</td>
</tr>
<tr>
<td>Malta</td>
<td>16.2 (4)</td>
<td>0 (0)</td>
<td>–</td>
<td>376 104</td>
</tr>
<tr>
<td>Netherlands</td>
<td>10.2 (113)</td>
<td>0.4 (7)</td>
<td>0.21–0.22</td>
<td>237 400</td>
</tr>
<tr>
<td>Austria</td>
<td>28.1 (160)</td>
<td>4.5 (38)</td>
<td>–</td>
<td>4 625 121</td>
</tr>
<tr>
<td>Poland</td>
<td>9.9 (271)</td>
<td>1.1 (42)</td>
<td>–</td>
<td>98 000</td>
</tr>
<tr>
<td>Portugal</td>
<td>4.2 (29)</td>
<td>5.3 (56)</td>
<td>–</td>
<td>1 341 710</td>
</tr>
<tr>
<td>Romania</td>
<td>2 (28)</td>
<td>8 (170)</td>
<td>–</td>
<td>1 074 394</td>
</tr>
<tr>
<td>Slovenia</td>
<td>18.4 (26)</td>
<td>0.5 (1)</td>
<td>–</td>
<td>553 426</td>
</tr>
<tr>
<td>Slovakia</td>
<td>6.2 (24)</td>
<td>0.2 (1)</td>
<td>–</td>
<td>11 691</td>
</tr>
<tr>
<td>Finland</td>
<td>58 (205)</td>
<td>1.3 (7)</td>
<td>–</td>
<td>3 539 009</td>
</tr>
<tr>
<td>Sweden</td>
<td>62.6 (383)</td>
<td>1.7 (16)</td>
<td>–</td>
<td>73 125</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>38.3 (1 598)</td>
<td>1.8 (111)</td>
<td>2.9–3.2</td>
<td>9 349 940</td>
</tr>
<tr>
<td>Turkey</td>
<td>3.1 (154)</td>
<td>0.1 (6)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Norway</td>
<td>75.9 (250)</td>
<td>2.2 (11)</td>
<td>2.2–3.1</td>
<td>3 011 000</td>
</tr>
<tr>
<td>European Union</td>
<td><strong>17.1 (5 686)</strong></td>
<td><strong>3.5 (1 771)</strong></td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>EU, Turkey and Norway</td>
<td>–</td>
<td>3.1 (1 788)</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>
## SEIZURES

<table>
<thead>
<tr>
<th>Country</th>
<th>Heroin</th>
<th>Cocaine</th>
<th>Amphetamines</th>
<th>Ecstasy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quantity seized</td>
<td>Number of seizures</td>
<td>Quantity seized</td>
<td>Number of seizures</td>
</tr>
<tr>
<td>Belgium</td>
<td>112 kg</td>
<td>1,953 count</td>
<td>19,178 kg</td>
<td>3,349 count</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>285 kg</td>
<td>44 count</td>
<td>115 kg</td>
<td>30 count</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>8 kg</td>
<td>41 count</td>
<td>8 kg</td>
<td>44 count</td>
</tr>
<tr>
<td>Denmark</td>
<td>41 kg</td>
<td>430 count</td>
<td>42 kg</td>
<td>2,056 count</td>
</tr>
<tr>
<td>Germany</td>
<td>242 kg</td>
<td>3,381 count</td>
<td>1,258 kg</td>
<td>3,618 count</td>
</tr>
<tr>
<td>Estonia</td>
<td>0.0004 kg</td>
<td>1 count</td>
<td>3 kg</td>
<td>49 count</td>
</tr>
<tr>
<td>Ireland</td>
<td>60 kg</td>
<td>766 count</td>
<td>459 kg</td>
<td>391 count</td>
</tr>
<tr>
<td>Greece</td>
<td>331 kg</td>
<td>2,045 count</td>
<td>201 kg</td>
<td>432 count</td>
</tr>
<tr>
<td>Spain</td>
<td>229 kg</td>
<td>5,822 count</td>
<td>20,754 kg</td>
<td>37,880 count</td>
</tr>
<tr>
<td>France</td>
<td>701 kg</td>
<td>– count</td>
<td>5,602 kg</td>
<td>– count</td>
</tr>
<tr>
<td>Croatia</td>
<td>30 kg</td>
<td>192 count</td>
<td>6 kg</td>
<td>132 count</td>
</tr>
<tr>
<td>Italy</td>
<td>951 kg</td>
<td>2,983 count</td>
<td>5,319 kg</td>
<td>6,633 count</td>
</tr>
<tr>
<td>Cyprus</td>
<td>1 kg</td>
<td>34 count</td>
<td>7 kg</td>
<td>88 count</td>
</tr>
<tr>
<td>Latvia</td>
<td>1 kg</td>
<td>427 count</td>
<td>1 kg</td>
<td>28 count</td>
</tr>
<tr>
<td>Lithuania</td>
<td>0.5 kg</td>
<td>112 count</td>
<td>120 kg</td>
<td>10 count</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>3 kg</td>
<td>190 count</td>
<td>2 kg</td>
<td>122 count</td>
</tr>
<tr>
<td>Hungary</td>
<td>3 kg</td>
<td>26 count</td>
<td>13 kg</td>
<td>118 count</td>
</tr>
<tr>
<td>Malta</td>
<td>1 kg</td>
<td>44 count</td>
<td>143 kg</td>
<td>80 count</td>
</tr>
<tr>
<td>Netherlands</td>
<td>750 kg</td>
<td>– count</td>
<td>10,000 kg</td>
<td>– count</td>
</tr>
<tr>
<td>Austria</td>
<td>222 kg</td>
<td>393 count</td>
<td>65 kg</td>
<td>912 count</td>
</tr>
<tr>
<td>Poland</td>
<td>36 kg</td>
<td>– count</td>
<td>213 kg</td>
<td>– count</td>
</tr>
<tr>
<td>Portugal</td>
<td>66 kg</td>
<td>971 count</td>
<td>4,020 kg</td>
<td>1,238 count</td>
</tr>
<tr>
<td>Romania</td>
<td>45 kg</td>
<td>215 count</td>
<td>55 kg</td>
<td>85 count</td>
</tr>
<tr>
<td>Slovenia</td>
<td>20 kg</td>
<td>439 count</td>
<td>27 kg</td>
<td>251 count</td>
</tr>
<tr>
<td>Slovakia</td>
<td>0.3 kg</td>
<td>82 count</td>
<td>2 kg</td>
<td>19 count</td>
</tr>
<tr>
<td>Finland</td>
<td>0.07 kg</td>
<td>47 count</td>
<td>26 kg</td>
<td>147 count</td>
</tr>
<tr>
<td>Sweden</td>
<td>7 kg</td>
<td>363 count</td>
<td>34 kg</td>
<td>1,010 count</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>831 kg</td>
<td>10,624 count</td>
<td>3,324 kg</td>
<td>18,569 count</td>
</tr>
<tr>
<td>Turkey</td>
<td>13,301 kg</td>
<td>4,155 count</td>
<td>476 kg</td>
<td>1,434 count</td>
</tr>
<tr>
<td>Norway</td>
<td>45 kg</td>
<td>1,277 count</td>
<td>67 kg</td>
<td>860 count</td>
</tr>
<tr>
<td>European Union</td>
<td>4,977 kg</td>
<td>31,625 count</td>
<td>70,997 kg</td>
<td>77,291 count</td>
</tr>
<tr>
<td>EU, Turkey and Norway</td>
<td>18,323 kg</td>
<td>37,057 count</td>
<td>71,540 kg</td>
<td>79,585 count</td>
</tr>
<tr>
<td>Country</td>
<td>Cannabis resin</td>
<td>Herbal cannabis</td>
<td>Cannabis plants</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quantity seized</td>
<td>Number of seizures</td>
<td>Quantity seized</td>
<td>Number of seizures</td>
</tr>
<tr>
<td>Belgium</td>
<td>1 338</td>
<td>4 500</td>
<td>5 635</td>
<td>19 672</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>15 967</td>
<td>4</td>
<td>1 319</td>
<td>127</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>21</td>
<td>24</td>
<td>563</td>
<td>558</td>
</tr>
<tr>
<td>Denmark</td>
<td>1 334</td>
<td>9 239</td>
<td>223</td>
<td>1 287</td>
</tr>
<tr>
<td>Germany</td>
<td>2 386</td>
<td>6 490</td>
<td>4 942</td>
<td>28 744</td>
</tr>
<tr>
<td>Estonia</td>
<td>5</td>
<td>48</td>
<td>25</td>
<td>466</td>
</tr>
<tr>
<td>Ireland</td>
<td>1 185</td>
<td>527</td>
<td>1 020</td>
<td>1 843</td>
</tr>
<tr>
<td>Greece</td>
<td>44</td>
<td>145</td>
<td>22 383</td>
<td>6 262</td>
</tr>
<tr>
<td>Spain</td>
<td>325 563</td>
<td>179 993</td>
<td>10 457</td>
<td>150 206</td>
</tr>
<tr>
<td>France</td>
<td>51 118</td>
<td>–</td>
<td>3 270</td>
<td>–</td>
</tr>
<tr>
<td>Croatia</td>
<td>23</td>
<td>343</td>
<td>1 070</td>
<td>4 098</td>
</tr>
<tr>
<td>Italy</td>
<td>21 893</td>
<td>6 184</td>
<td>21 496</td>
<td>4 660</td>
</tr>
<tr>
<td>Cyprus</td>
<td>0.1</td>
<td>20</td>
<td>100</td>
<td>863</td>
</tr>
<tr>
<td>Latvia</td>
<td>117</td>
<td>64</td>
<td>74</td>
<td>414</td>
</tr>
<tr>
<td>Lithuania</td>
<td>424</td>
<td>23</td>
<td>96</td>
<td>242</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>1</td>
<td>83</td>
<td>30</td>
<td>774</td>
</tr>
<tr>
<td>Hungary</td>
<td>3</td>
<td>103</td>
<td>1 777</td>
<td>2 092</td>
</tr>
<tr>
<td>Malta</td>
<td>16</td>
<td>96</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2 200</td>
<td>–</td>
<td>12 600</td>
<td>–</td>
</tr>
<tr>
<td>Austria</td>
<td>174</td>
<td>1 192</td>
<td>812</td>
<td>5 732</td>
</tr>
<tr>
<td>Poland</td>
<td>39</td>
<td>–</td>
<td>1 489</td>
<td>–</td>
</tr>
<tr>
<td>Portugal</td>
<td>18 304</td>
<td>3 298</td>
<td>49</td>
<td>554</td>
</tr>
<tr>
<td>Romania</td>
<td>27</td>
<td>1 492</td>
<td>335</td>
<td>262</td>
</tr>
<tr>
<td>Slovenia</td>
<td>3</td>
<td>66</td>
<td>706</td>
<td>3 350</td>
</tr>
<tr>
<td>Slovakia</td>
<td>1</td>
<td>17</td>
<td>177</td>
<td>1 242</td>
</tr>
<tr>
<td>Finland</td>
<td>714</td>
<td>1 870</td>
<td>–</td>
<td>5 036</td>
</tr>
<tr>
<td>Sweden</td>
<td>1 091</td>
<td>6 761</td>
<td>641</td>
<td>7 611</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>13 432</td>
<td>17 360</td>
<td>13 243</td>
<td>148 746</td>
</tr>
<tr>
<td>Turkey</td>
<td>27 413</td>
<td>6 881</td>
<td>124 673</td>
<td>57 744</td>
</tr>
<tr>
<td>Norway</td>
<td>1 605</td>
<td>10 985</td>
<td>314</td>
<td>4 402</td>
</tr>
<tr>
<td>European Union</td>
<td>457 424</td>
<td>239 942</td>
<td>104 535</td>
<td>394 891</td>
</tr>
<tr>
<td>EU, Turkey and Norway</td>
<td>486 442</td>
<td>257 808</td>
<td>229 522</td>
<td>457 037</td>
</tr>
</tbody>
</table>
## HOW TO OBTAIN EU PUBLICATIONS

### Free publications

via EU Bookshop (http://bookshop.europa.eu)

at the European Union’s representations or delegations. You can obtain their contact details on the Internet (http://ec.europa.eu) or by sending a fax to +352 2929-42758

### Priced publications

via EU Bookshop (http://bookshop.europa.eu)

### Priced subscriptions

(e.g. annual series of the *Official Journal of the European Union* and reports of cases before the Court of Justice of the European Union)

via one of the sales agents of the Publications Office of the European Union (http://publications.europa.eu/others/agents/index_en.htm)
About this report

The Trends and developments report presents a top-level overview of the drug phenomenon in Europe, covering drug supply, use and public health problems as well as drug policy and responses. Together with the online Data and statistics, Country overviews and Perspectives on drugs, it makes up the 2014 European Drug Report package.

About the EMCDDA

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

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

When we think of preventive health, what mainly comes to mind is a great deal of exercise, a healthy diet and regular visits to the doctor for preventive check-ups. However, preventive health encompasses far more than just these aspects. Assuming a responsible attitude towards alcohol consumption is just as much a part of it as relinquishing tobacco and illicit drugs.

The health policy we pursue, as the Federal Government, provides framework conditions which make it easier for you to engage in preventive health. This includes supporting you in taking the right approach to the use of pleasurable and addictive substances.

This “National Strategy on Drug and Addiction Policy” consequently places special emphasis on addiction prevention and early intervention. With the aim of promoting a healthy lifestyle among the people of our country, it demonstrates ways of approaching the use of pleasurable and addictive substances responsibly, in day to day life, and finding the right balance.

The National Strategy on Drug and Addiction Policy, elaborated on the initiative of the Federal Government’s Drug Commissioner, Ms. Mechthild Dyckmans, places people, and the maintenance of their health, at the very centre of our efforts. It is a part of the general prevention strategy which is currently being drawn up by the Federal Government and therefore another important step on the path to comprehensive health promotion in Germany.

Daniel Bahr,
Federal Minister of Health,
Member of the Bundestag
On 15th February 2012, the National Strategy on Drug and Addiction Policy was adopted in the current version by the Federal Cabinet. It places Germany’s drug and addiction policy on a modern footing. The National Strategy describes the current challenges and the priorities which will determine the drug and addiction policy of the coming years and replaces the Action Plan on Drugs and Addiction which dates from 2003.

Addiction significantly affects many millions of people in Germany. In terms of numbers, the legal addictive substances such as tobacco, alcohol and medicinal products are the most prominent among the substances abused. New forms of addiction, such as gambling or internet addiction, are also coming to the fore. In the area of illicit drugs, it is particularly the spread of synthetic drugs which is posing new challenges both nationally and internationally.

In order for our drug and addiction policies to really reach the affected persons, the opportunities must be tailored to suit the reality in which they live. Persons at risk of or already affected by addiction are therefore at the focal point of our National Strategy, the primary aim of which is the avoidance and reduction of the consumption of addictive substances, whether legal or illicit. Prevention is consequently at the forefront of the National Strategy.

Drug and addiction policy is a community task. In the discussions held while visiting specialist prevention centres and facilities offering addict support, I have been able to satisfy myself of the challenging work that is being done in this field. All of those involved in the area of drugs and addiction are making a valuable and indispensable contribution to long-term behavioural and situational prevention.

I wish to express my gratitude for the substantive proposals and the constructive co-operation which characterised the consultations on the Strategy. The task before us now is to successfully implement the targets and measures contained in the National Strategy at the various levels and adapt them continuously.

Mechthild Dyckmans,  
Drug Commissioner of the Federal Government,  
Member of the Bundestag
## Contents

**Foreword** ................................................................. 2

**Introduction (Preamble)** .................................................. 6

**Part I – Goals of the National Strategy** .................................. 8

**A. The Basis of a Responsible Drug and Addiction Policy** ............... 8

I. The Four Levels of Drug and Addiction Policy ................................ 8

II. Our Image of the Individual – How do we see people? .................. 8

**B. New Challenges in Drug and Addiction Policy – What problems are we facing?** ................................................................. 10

I. Demographic and Social Change ............................................. 10

II. New Forms of Addiction ...................................................... 10

III. Trends and New Patterns of Consumption ................................. 11

**C. Cornerstones for the Formulation of Drug and Addiction Policy – Where do we want to go?** ......................................................... 12

I. Focus on the Individual ...................................................... 12

II. Directing Prevention towards High-Risk Groups .......................... 12

III. Expanding Early Intervention ............................................... 13

IV. Reaching More People in a Local Context – Expanding Addiction Prevention in the Workplace .................................................. 13

V. Improving Professional Cooperation at System Interfaces – Building Networks ................................................................. 14

VI. Consistently Establishing Gender Sensibility ............................. 15

VII. Targeting Research .......................................................... 15

VIII. Evaluate Measures .......................................................... 16

IX. Legislation when Necessary .................................................. 16

X. Enhance Addiction Self-Help .................................................. 17

XI. Individually Tailored Counselling and Treatment ........................ 17

**Part II – Sub-Areas of the National Strategy** .................................. 18

**A. Alcohol** ............................................................................ 18

I. General Situation: Alcohol Consumption and Abuse in Germany .... 18

Individuals and Addiction: Children from families with a history of addiction ................................................. 19

II. Goals and Measures .............................................................. 20

1. Alcohol Consumption by Children and Adolescents .................. 20

Goal 1: Reduction in the frequency of binge drinking among children and adolescents ................................................. 20

Goal 2: Rigorous Implementation of the Existing Regulations Found in the Protection of Young Persons Act ................................................. 21

Goal 3: Protect Children and Adolescents against Alcohol Advertising ................................................................. 22

2. Alcohol Consumption in the Adult Population ........................... 22

Goal 4: Reduce the Incidence of Driving under the Influence ............. 23

Goal 5: Absolute Sobriety in the Workplace .................................. 24

Goal 6: Absolute Sobriety during Pregnancy and while Nursing ........ 25

Goal 7: Reduce Alcohol-Related Violence ..................................... 26

Goal 8: Concentration on high-risk groups in the adult population ........ 27

**B. Tobacco** ............................................................................ 28

I. General Situation: Tobacco Consumption in Germany ................. 28

Individuals and Addiction: Adolescents ........................................ 29

II. Goals and Measures .............................................................. 30

1. Tobacco Consumption among children and adolescents .......... 30

Goal 1: Reduce tobacco consumption among children and adolescents ................................................................. 30

Goal 2: Support for weaning children and adolescents off of tobacco .... 31

Goal 3: Reduction of tobacco consumption by adults ....................... 32

Goal 4: Improving medical professionals’ competency in counselling patients to refrain from smoking ................................. 33

Goal 5: Improve protection of non-smokers .................................... 34
C. Prescription Drug Addiction and Prescription Drug Abuse ................................................. 36
   I. General Situation ................................................................. 36
      Individuals and Addiction:
      Addiction in Old Age .......................................................... 37
   II. Goals and Measures .......................................................... 38
      Goal 1: Improving the data base on performance
            enhancement through prescription drugs
            and the development of target-group
            specific prevention measures against
            prescription drug abuse .................................................. 38
      Goal 2: Provide better information
            concerning prescription drug addiction
            through pharmacists ...................................................... 39
      Goal 3: More appropriate prescription
            of psychotropic drugs by doctors ................................... 39
      Goal 4: Enhanced early detection and early
            intervention to reduce addiction to
            prescription drugs, especially among
            older people .................................................................... 40

D. Pathological Gambling ......................................................... 41
   I. General Situation ................................................................. 41
   II. Goals and Measures .......................................................... 42
      Goal 1: Preventing addiction and protecting
            gamblers ......................................................................... 42
      Goal 2: Higher degree of protection for people
            who gamble on slot machines ........................................ 43
      Goal 3: Practicable regulations for gambling
            on the Internet ................................................................. 43

E. Online/Media Addiction ......................................................... 44
   I. General Situation ................................................................. 44
   II. Goals and Measures .......................................................... 45
      Goal 1: Recognition as an independent disorder .................. 45
      Goal 2: Improvement of the data base ................................. 45
      Goal 3: Further development of the diagnostic
            and treatment instruments ............................................... 45
      Goal 4: Early training in the competent use
            of media ......................................................................... 46
      Goal 5: Improve the protection
            of children and young people in relation
            to computer games .......................................................... 46

F. Illegal Drugs ........................................................................... 46
   I. General Situation ................................................................. 46
      Individuals and Addiction: Migrants .................................... 48
   II. Goals and Measures .......................................................... 49
      Goal 1: Meeting the challenge of new synthetic
            drugs more rapidly and effectively ................................... 49
      Goal 2: Expansion of selective prevention in
            relation to illegal drugs ................................................... 50
      Goal 3: Expansion of medically indicated
            prevention and therapy measures
            for people with high-risk
            cannabis consumption ................................................... 50
      Goal 4: Enhance the preventive health effects
            in harm-reduction programmes ....................................... 52
      Goal 5: A sufficient number of opportunities for
            high quality, substitution-based treatment ..................... 53
      Goal 6: Prevention of drug-related crime ......................... 54
      Goal 7: Improve the living situations of
            older people with drug addictions ................................. 55
      Goal 8: Improve the situation of drug-consuming
            inmates ........................................................................... 56
      Goal 9: Combat international drug trafficking
            networks in a sustainable manner ..................................... 57

G. International and European Drug and Addiction Policy ............... 58
   I. Global Challenges – Global Approaches ......................... 58
      1. New Worldwide Trends .................................................. 59
      2. Development-Oriented Drug Policy ............................... 60
      3. Harm Reduction .............................................................. 60
      4. Global Strategy to Reduce Harmful Use
         of Alcohol ........................................................................ 61
      5. Global Measures to Prevent
         Tobacco Consumption and
         Weaning off of Tobacco ................................................... 62
   II. European Drug and Addiction Policy ............................... 62
      1. European Drug Policy ....................................................... 62
      2. The Alcohol Strategy
         of the European Union .................................................. 63
      3. European Tobacco Policy ............................................... 64

Imprint ....................................................................................... 68
Addiction and dependency are problems that affect society on the whole and their solution requires the cooperation of all forces in society, in the interest of those affected. This National Strategy on Drug and Addiction Policy describes the comprehensive national orientation of drug and addiction policy in Germany for the coming years, which will replace the Action Plan on Drugs and Addiction adopted in 2003. The many different joint efforts and initiatives to prevent addiction and to reduce the harmful consumption of and dependency on addictive substances and behaviours are thus to be coordinated with each other on the national and international level.

In our federal system, numerous people and organisations are active in the area of addiction prevention and addiction services. This spectrum includes municipal governments, the Länder, the federal government and the social insurance providers (statutory and private, pension insurance, as well as accident insurance). Providers of services on various levels also play a role, such as doctors, pharmacists, psychologists and psychotherapists, facilities that provide aid to addicts and social welfare associations, parent and family counselling, self-help groups and, not least of all, many people in the broader field of youth services, senior services, psychiatric institutions, schools, companies, industry, etc. The diversity of the many parties involved requires comprehensive coordination and integration into a single network. At the same time, every individual is also called upon to assume responsibility for their own behaviour and their own health. Parents and all other adults are important role models for children and adolescents.

Addiction is linked to personal misfortune. It affects not only the addicts, but also their family members, friends and co-workers. Dependency is a serious chronic illness, which can lead to considerable health problems and premature death.

Addictive substances and behaviours cause health, social and economic problems in Germany. According to a recent representative study, 16 million people smoke, 1.3 million people are addicted to alcohol, and 1.4 million people are addicted to prescription drugs. 600,000 people exhibit problematic cannabis consumption, and 220,000 people are addicted to cannabis. Over 200,000 people exhibit a problematic consumption of other illegal drugs. As many as 540,000 people are considered to be addicted to gambling. It is assumed that ca. 560,000 Internet users suffer from online addiction.

The development of an addiction has its roots in a complex network of previous individual experiences, certain living situations, interaction with other people, emotional disturbances, the influence of a significant figure and the availability of addictive substances. The effect of psychoactive substances can ultimately lead to lasting changes in the brain, which in turn make it more difficult to change behaviours. However, even in these cases, overcoming addiction opens up new perspec-

---

1 Cf. DHS (2011): Jahrbuch Sucht, p. 17
2 Cf. DHS (2011): Jahrbuch Sucht, p. 11
3 Cf. DHS (2011): Jahrbuch Sucht, p. 22
4 Cf. DHS (2011): Jahrbuch Sucht, p. 23
5 Cf. DHS (2011): Jahrbuch Sucht, p. 22 (Based on the figure of 66 million 15- to 64-year-olds in Germany – on 31 Dec. 2010 – this means exactly 217,800 problematic drug consumers.)
6 Cf. DHS (2011): Jahrbuch Sucht, p. 27
7 According to the study funded by the Federal Ministry of Health, “Prävalenz der Internetabhängigkeit (PINTA I)” (Prevalence of Internet Addiction (PINTA I)), compiled by the Universities of Lübeck and Greifswald, roughly 1 per cent of the 14- to 64-year-olds in Germany is considered to be addicted to the Internet. This equates to roughly 560,000 people.
tives and the possibility of participating in society, as well as greater satisfaction with one’s own life. Hence, our goal must be to help every individual in overcoming his or her dependency.

Prevention and the promotion of better health by avoiding addiction are at the very top of the federal government’s agenda. Preventive measures are directed primarily at high-risk groups. Children and adolescents are an especially important target group, because they must be prevented from ever engaging forms of behaviour that threaten their health and promote addiction.

The goal of our drug and addiction policy is to reduce the consumption of legal and illegal addictive substances and to avoid problems related to drugs and addiction in our society. In the ongoing development of our system of preventing addiction and providing aid for those suffering from addiction, special attention is devoted to legal substances that can lead to addiction, such as alcohol, tobacco and psychotropic drugs, because they are more widespread.

This national strategy is intended as a health policy guideline for a modern drug and addiction policy in Germany. It defines areas of focus and challenges faced by drug and addiction policy against the background of current developments, the existing system of providing help with addiction, the legal framework and proven concepts in addiction prevention. In this conjunction, the strategy integrates international initiatives and activities on the European level as well as on the level of the WHO and the United Nations.

In relation to the goals it sets and the steps it foresees, the national strategy on drug and addiction policy is part of the general prevention strategy currently being developed by the federal government in the field of drug and addiction policy. Both strategies emphasize the central importance of promoting health and prevention in health policy. Germany has extensive experience with successful measures in universal, selective and indicated prevention and places emphasis, in this conjunction, on children and adolescents, in order to promote healthy development early on, as well as on adults, in order to maintain their health.

Measures of proven quality and efficiency are to be included in the strategies in order to sustainably ensure and improve health and the quality of life and to meet the challenges of current demographic developments in a society that is growing older.

Primary importance is thus assigned to prevention and existing programmes for counselling and treatment, help in overcoming addiction, harm reduction measures and repression in drug and addiction policy.
Part I – Goals of the National Strategy

A. The Basis of a Responsible Drug and Addiction Policy

The federal government is in favour of a modern and progressive strategy to reduce drug and addiction problems in Germany.

We pursue an integrative approach to addiction policy. Unlike some other European countries, we take both legal and illegal addictive substances into consideration jointly. We do not orient our policy on individual substances, but rather on the needs of individuals – in keeping with our motto, “Focus on the individual”. In this conjunction, we adhere to the proven fundamentals of addiction policy – as described in the coalition agreement of 2009 – “Our drug and addiction policy focuses on prevention, therapy, aid in overcoming addiction and combating drug-related criminality.” This policy is augmented by harm reduction measures.

I. The Four Levels of Drug and Addiction Policy

Prevention
The purpose of prevention measures is to help people avoid ever engaging in the consumption of health-threatening substances and suffering from addiction by providing information regarding the dangers that they represent. Prevention measures directed towards children and adolescents are especially important. The earlier we succeed in reaching children and adolescents with preventive measures and programmes to promote health, the higher the probability that we will be able to prevent the development of problematic consumption patterns.

Counselling and Treatment, Help in Overcoming Addiction
Counselling and treatment programmes are necessary in order to help addicts break out of the vicious cycle of addiction. Many outpatient and inpatient programmes already exist in Germany. These must be maintained and enhanced so that every addict can take advantage of the counselling and treatment programmes that he or she needs.

Harm Reduction Measures
Aid in surviving from day to day and harm reduction measures, such as providing drug consumption rooms and opportunities to exchange hypodermic syringes, help to stabilise the addict’s health and social situation. This is an important precondition for eventually being able to overcome addiction.

Repression
Legal regulations aimed at reducing the supply of addictive substances and general bans are another element of our drug and addiction policy. These include, for example, laws protecting the rights of non-smokers, the Protection of Young Persons Act and the Narcotics Act. Efforts to combat drug-related crime are of greater, often international, importance.

II. Our Image of the Individual – How do we see people?

People suffering from addiction are afflicted with a disease and require extensive medical help and support. Addiction is a disease that can affect anyone. It is not a matter of personal failure, but often the result of personal circumstances or experience.

Our image of the individual is one of a person who is free and independent. People suffering from dependency have far less freedom in making decisions regarding their lives.

Our drug and addiction policy seeks to ensure that they have this freedom, to promote personal responsibility and – in cases where they have lost this freedom – to provide help in re-attaining it. It emphasizes insight and personal responsibility.

The goal of prevention is to ensure that an addiction is never developed. It provides encouragement to reflect upon and reconsider one’s own behaviour in order to be able to change it.
Our drug and addiction policy focuses primarily on prevention and help in overcoming addiction. Repressive measures by the state are a result of a social consensus regarding certain goods that warrant protection (such as the health of children and adolescents or the protection of society against particularly dangerous addictive substances and behaviours) and the need to prevent undesired consequences for society as a whole – such as accidents or crime. Wherever a free, self-responsible person injures not only himself, but also others, society and the state must institute and enforce regulations.

In our well-recognized, professional system of providing help, many thousands of people assume responsibility for others every day. They are essential for the success of the system of providing aid for addicts. Assuming responsibility is an essential principle of our drug and addiction policy. Everyone can contribute to preventing addiction and to helping people overcome their addictions.
B. New Challenges in Drug and Addiction Policy – What problems are we facing?

Drug and addiction policy is facing great challenges. These include, among others, the demographic transition, social change, old and new forms of addiction and the corresponding trends in consumption. To a greater extent than in the past, it is now also necessary to focus not only on addiction, but, above all, on forms of high-risk consumption, which are detrimental to health and to development, even when they do not necessarily lead to addiction.

I. Demographic and Social Change

In recent years and decades, our society has undergone fundamental change and is still changing. Social and interpersonal relationships have changed radically; new lifestyles and forms of cohabitation are on the rise. More and more people live alone. Increased individuality and a greater range of options in making personal decisions in modern society can also lead to insecurity and a loss of what were once self-evident certainties. People can sometimes feel overwhelmed in view of what seems to be an unlimited range of possible lifestyles. They may lack emotional support or be confronted with multiple demands in their everyday lives, for example from trying to balance working life and raising children, just as children and adolescents can feel excessive pressure from the behaviour and consumption patterns within their peer groups. Efforts to prevent addiction and help people suffering from addiction must take these circumstances into consideration.

One of the most important social changes in our time is the demographic transition. As a result, addiction in old age has come to play a greater role. Studies show a growing number of older people exhibiting higher consumption, abusive behaviour, and an increasing rate of addiction. This is especially true of alcohol and prescription drug consumption. While experts recognize the importance of addiction problems in old age, there are still many deficits in everyday practice with regard to dealing with such problems. There are many indications that counseling and the system of providing addiction aid are rarely suited to the needs of older people. Hence, there is a great need to take action to establish special programmes to help older people.

II. New Forms of Addiction

The development of our society into a knowledge-based economy and the growth in the use of digital media also presents new challenges in relation to addiction policy. The use of the Internet and of computers has become essential in people's everyday lives. On the one hand, the Internet offers numerous opportunities in the field of prevention; for example, as a means of reaching those who are affected at an early stage. On the other hand, for some people the use of computers and the Internet can become increasingly excessive, and lead, in extreme cases, to a loss of self-control and, ultimately, addiction. Various terms are used in the professional discussion. Pathological Internet use, media or online addiction – the designations are diverse. This is related to the fact that a diagnostic classification has not yet been adopted within the most common diagnostic systems. However, the fact remains that there are a growing number of people for whom suitable methods of help must still be developed.

Addiction policy is also faced with new challenges in relation to gambling addiction as a form of non-substance-related addiction, not least of all due to current technical, political and legal developments (e.g. due to the Internet and new regulations for commercial gaming machines).
III. Trends and New Patterns of Consumption

In recent years, patterns of behaviour have shifted in relation to the consumption of addictive substances. While, previously, the consumption of illegal drugs mainly affected a small group on the margins of society, the consumption of illegal addictive substances is now prevalent at the core of society.

A growing number of people of every age and level of education now demonstrate problematic and, in part, excessive patterns of consumption, also in relation to legal addictive substances, which do not inevitably lead to addiction. High-risk alcohol consumption, for example, is a phenomenon that affects adolescents today just as much as older and young people, successful women, and middle-aged men. This necessitates new approaches in drug and addiction policy.

Another challenge can be seen in the emergence of a growing number of new psychoactive substances (so-called “legal highs”). They include new synthetic ingredients and substances, such as the synthetic cannabinoids in products sold as herbal blends (e.g., “spice”) or cathinones in products sold as bath salts. An increasing volume of these substances and their chemical derivatives are now available on the market. It is difficult to assess what health risk they represent.

An addition problem is that young people increasingly consume various types of psychoactive substances simultaneously. The risks involved in polydrug use are, however, particularly high. The effects that result from the combination of two or more substances are difficult to calculate and, as a rule, do not correspond with the sum of individual effects. Depending on the substance, the effects of each are multiplied or amplified or they influence the body and the mind in different ways. In both cases, the body is subjected to an extreme level of stress. The danger of health-threatening incidents is increased by mixed consumption.

It is, therefore, necessary for us to devote more attention to preventive approaches to mixed consumption among younger consumers, to develop targeted prevention measures for this purpose, as well as for young partygoers, and to develop a system of providing more qualified help in this context.

The Internet also presents us with new challenges. Special websites provide access to some of these psychoactive substances and offer adolescents and young adults, in particular, an opportunity to share information on the consumption of various legal and illegal substances, often accompanied by detailed instructions on how to intensify the feeling of intoxication.
C. Cornerstones for the Formulation of Drug and Addiction Policy – Where do we want to go?

The existing system of prevention and aid with addiction offers a good basis for meeting the new challenges described above. In some areas, optimization is needed, in other areas, the approaches pursued thus far must continue, and, in some cases, there is a need to focus on new areas. This National Strategy paper will begin by outlining these areas of focus. In the second part our efforts in these areas will be underlined by citing concrete goals and measures.

The funds needed to ensure the ongoing and successful implementation of the National Strategy are to be appropriated by the responsible parties on various levels. Additional funds that may be required by the federal government to cover the cost of expenditures for material and personnel must be made available within the budgets of individual departments.

The presentation of drug and addiction policy from a perspective of individual addictive substances and behaviours, as in Part II, is intended to provide a better overview. Topics that cut across a broader spectrum are presented in highlighted boxes within the text; they provide examples of the effects people suffer beyond those stemming from individual addictive substances.

I. Focus on the Individual

The focus of the federal government’s drug and addiction policy is on the person suffering from addiction as an individual and not on their disease. In order to prevent addiction and to help people suffering from addiction, it is necessary to take people’s overall living situations into consideration. We must discover their backgrounds, their addictions and the individual help required, in order to determine where we to begin offering help. This also means that the segmentation of our system according to categories of social law, which has undoubtedly proven itself on the whole, does not always best serve the needs of the individual requiring help.

In addition, we also need people who are willing to help. Nothing can take the place of direct contact between someone suffering from addiction and other people, regardless of whether they are doctors, pharmacists, addiction service workers, psychologists, psychotherapists or relatives. They are, therefore, the most important starting point for our assistance-oriented drug and addiction policy.

II. Directing Prevention towards High-Risk Groups

Prevention and promoting good health will continue to remain at the forefront of modern drug and addiction policy in the future. They are essential elements in enhancing individual competency in responsibly structuring one's own life. Prevention must, however, be better targeted and focus more strongly on high-risk groups. For every addictive substance or behaviour, the groups at greatest risk must be identified and addressed directly. In order to avoid the development of an addiction later in life, children and adolescents must be able to develop self-confidence and strong personalities. In order to achieve this goal, they need a stable family and social environment while they are growing up, one that provides them with sufficient security, recognition and understanding. This support gives them the strength they need in order to meet the challenges with which they will be faced in life, even during critical periods.

In order to ensure that children and adolescents have the necessary resources at their disposal, and are able to say no to tobacco, alcohol and drugs, measures to prevent addiction and promote health must support disadvantaged children and adolescents with targeted programmes in close cooperation with schools, family and youth services and parental and family counselling. To a greater degree than has been the case up until now, the emphasis must be placed on the dangers of developing an addiction, on high-risk consumption patterns and, thus, on the development of competence in dealing with the risks. Young people who want to be “cool”
hardly see themselves as being in danger of becoming addicted. It is therefore necessary to develop specific prevention measures for endangered adolescents within the context of selective prevention.

High-risk groups include people who have had negative experiences, such as sexual abuse, neglect and violence during their childhoods, or with the addiction of one of their parents, which considerably increases the risk of later dependency. Stress situations, such as unemployment, also present a particular risk and must be more specifically addressed in addiction prevention and intervention. Approaches to prevention and treatment measures must be oriented increasingly towards high risk groups, so that the threat to their health resulting from high-risk or harmful consumption of legal and illegal addictive substances is realised and these groups are reached through appropriate aid measures.

III. Expanding Early Intervention

In Germany, a highly differentiated system of providing aid with addiction and drugs, which includes a wide variety of measures, is already available to people suffering from addiction. It is well developed and successful in both European and international comparison. Nevertheless, there are still deficits in relation to the use of counselling and treatment measures. The number of people suffering from addiction who are reached on time is too low. Many people suffering from addiction take advantage of the existing treatment measures much too late, often only after they have been addicted for many years. This is true of all forms of addiction, from alcohol through to tobacco and gambling.

The development of an addiction or abusive consumption can often be recognized early, provided that outpatient or inpatient medical care includes enquiries about problems with addiction. The context of medical treatment by a doctor is a highly appropriate setting for early intervention, because this is where the entire population has contact with the medical care system. Hence, in the future, the focus must be on enhancing the role of doctors – especially general practitioners and paediatricians – as initial contacts for people seeking help. National and international studies provide reliable evidence of the effectiveness of early intervention by general practitioners (in the sense of brief counselling sessions to motivate patients to reduce consumption) particularly in relation to alcohol.

IV. Reaching More People in a Local Context – Expanding Addiction Prevention in the Workplace

The workplace is another important location where people of different ages and social strata can be reached in order to promote healthier behaviour. According to the Safety and Health at Work Act, every employer is obliged to adopt measures to prevent accidents and occupational threats to health in the interest of his employees. According to the Occupational Safety Act, company doctors are obliged to support the employer in all questions of occupational health and safety. In this context, company doctors can also offer advice on company measures to prevent addiction. The Regulation on Occupational Preventive Healthcare Measures is aimed, in addition to the early recognition and prevention of occupational diseases, at contributing to the preservation of employability and the further development of occupational health and safety. Preventive occupational healthcare measures can, therefore, also include measures related to general preventive health care as well as individual addiction prevention and addiction counselling. Measures for the promotion of occupational health, which include measures to prevent addiction and alcohol abuse, are mandatory tasks of the health insurance funds. The potential for preventing addiction that exists in the workplace has already been recognised by larger enterprises. They offer their employees comprehensive programmes to promote health, which also address the topic of addiction (e.g. ceasing to consume tobacco as well as help with alcohol addiction). Our goal is to improve the framework conditions so that these instruments can be used on a broader front. Today, health insurance funds are already engaged in cooperative workplace measures with individual companies in order to prevent alcohol addiction.
These activities must be implemented more broadly and comprehensively. We also want to support small and mid-sized companies, which are the most important employers in Germany, in expanding occupational measures to prevent addiction and to promote health with the aid of self-help groups for addicts. Only in this manner will a situation be created in which employees will profit from improved health and higher motivation to work and companies from fewer sick days and improved performance.

V. Improving Professional Cooperation at System Interfaces – Building Networks

The system of providing services to people with drug and addiction problems in Germany has, for the most part, a subsidiary structure, in which responsibilities are distributed among various parties or institutions. Various, often independently operating, programmes offering aid and counselling for addiction, youth services, school, social and public employment services and the health care system, often work alongside each other rather than with one another.

Today, for example, counselling for problems with addictive substances or behaviours takes place in addiction counselling centres that are mainly funded by municipal governments. Detoxification or withdrawal treatment for addicts takes place in hospitals or in special wards of psychiatric hospitals, with the coverage of the costs negotiated with the health insurance funds. On the other hand, the German Federal Pension Insurance Fund is usually responsible for the costs of withdrawal treatment, which often follows withdrawal, i.e., the medical rehabilitation of addicts. Both the pension insurance fund and addiction counselling centres are responsible for immediate follow-up treatment as prophylaxis against a relapse. The office in charge of administering basic income support and the employment agencies are responsible for the integration of former addicts into some form of employment, the debt counselling centres are responsible for any debt, and psychiatric specialists, psychologists and psychological psychotherapists are to be contacted for the treatment of the psychological problems that often accompany addiction. Between all of these agencies, which each have their own procedures and sources of funding, one finds the addict in search of help. This is often especially problematic because addictions are, as a rule, accompanied by social problems and comorbidity. Hence, focusing solely on the addiction problem is insufficient if counselling and treatment are to be successful.

In order to achieve better integration, policy must focus on the interfaces between the systems of providing aid, so that no addict gets lost in it. In the interest of those affected, the different providers of funding and organisational support must ensure better linkage and cooperation between the services and programmes that they offer.

Networks and integrated care approaches, diverse forms of which have been long established in Germany, are one way of effectively managing interfaces. They facilitate the smoothest possible long-term cooperation between various professionals in the systems that must be coordinated with one and other and make it possible to comprehensively address the main problems of people seeking advice in relation to an addiction. In this conjunction, we must seek ways in which the necessary services provided by different parties can be synchronised with and augment each other.

In municipal or regionally oriented networks for providing help for addicts and preventing addiction, numerous parties from diverse professions and different sectors are involved. Not only numerous outpatient and inpatient facilities, organisations and health care organisations are involved here, but also organisations that provide aid in other areas, which overlap with the tasks for which addiction and drug aid organisations assume responsibility. This includes schools, companies, sports clubs, recreational facilities, youth services and youth social work, parent and debt counselling services and employment as well as occupational training projects.

The cooperation between addiction services, youth services and schools can be cited as an example of the sort of networking that is necessary to overcome coor-
The quality and effectiveness of networks are, in no small measure, dependent upon the parties involved; however, in the case of almost all of the parties involved, there is seldom continuity in terms of personnel over a longer period of time. Therefore, functioning networks require binding agreements between the institutions as an essential basis for their work. Thus, one ongoing challenge faced in the cooperation between networks is the task of filling them with new life.

VI. Consistently Establishing Gender Sensibility

Today, there are still considerable differences between the sexes in relation to addiction, even if a trend towards more similar consumption patterns has been exhibited in some areas in recent years, e.g., in relation to smoking or alcohol consumption by young women. Nevertheless, the consumption of illegal drugs and alcohol abuse are still more of a male problem, while women are more inclined to an above average rate of prescription drug abuse.

Hence, specific reasons for female and male addictive behaviour must be viewed separately in addiction prevention measures, along with their addiction careers and the underlying causes. This also includes developing gender-specific programmes, without further reinforcing gender role models.

Pregnant women are an important target group for prevention efforts. Many women begin to reconsider their consumption patterns when facing pregnancy and thus embark on new paths. By the same token, the continued consumption of alcohol, tobacco or prescription drugs during pregnancy involves risks for the unborn child. The consumption of addictive substances during pregnancy has considerable effects on every woman and her child. It is therefore our goal to specifically address pregnant women whose consumption threatens to become problematic.

VII. Targeting Research

There have been positive developments in addiction research in Germany in recent years. With the four addiction research groups funded by the Federal Ministry of Education and Research (BMBF) and the care-oriented departmental research funded by the Federal Ministry of Health and many additional grants, a viable structure has been developed over the last 15 years, one that can also stand up to international comparison. Addiction research in Germany encompasses both epidemiological as well as biological, psychological, social and legal aspects and combines diverse scientific traditions. In this context, the spectrum ranges from basic research to research on care for addicts. It is especially important that practice-related research in the field of addiction is further enhanced in order to increase the effectiveness of drug and addiction policy concepts and initiatives through evidenced-based and evaluated measures. Therefore, the study of research questions related to both specific substances and all substances will be supported within the context of the Federal Ministry of Health’s departmental research, in close cooperation with the facilities providing care, in order to further develop counselling and treatment concepts closely aligned with everyday practice and to apply the research findings as seamlessly as possible in the everyday practice of facilities that provide counselling and treatment. The model projects and research supported by the Federal Ministry of Health increasingly examine and test prevention and treatment approaches for all substances as well as for specific target groups; in recent years, there has also been more interest in the question of how the various sectors in the system of providing help can work together more effectively by better managing the interfaces between them. In addition to this, the Federal Ministry for Family Affairs, Senior
Citizens, Women and Youth supports measures related to the excessive use of the Internet. Along with clinical and therapeutic aspects, it is also a question of developing educational and pedagogical media approaches to prevention, as well as discovering possible connections between excessive computer and Internet use and family interaction. In view of the dynamic development of computer and Internet use as a share of our media consumption, it can be assumed that the average length of use, as well as the perception of the problem of time-consuming media use, will be subject to rapid change. In addition, research must meet new challenges such as online gaming addiction or the initial appearance of psychoactive substances.

**VIII. Evaluate Measures**

Measures and concepts to reduce the consumption of drugs and addictive substances must be effective. In order to be able to assess them in terms of the goals targeted and the funds invested, evaluation and accompanying research must automatically be a component of all development of measures. All approaches to prevention, addiction aid, harm reduction and repression must be examined in terms of their effectiveness and relevance. This is especially true in times when less funding is available in order to ensure that the funds available are employed to best advantage.

The effectiveness of measures must be proved before they are introduced on a broader scale. An empirically proven and reliable basis for the implementation and further development of prevention strategies is only possible on the basis of evaluated and evidence-based measures.

In this conjunction, measuring success, especially in the field of prevention, represents a considerable challenge. The goal of prevention is to avoid the occurrence of an event, whether this means the initial consumption of a substance, the emergence of abusive behaviour or addiction. Monitoring success therefore involves measuring the non-occurrence of an event. This is the main reason why the evaluation of prevention measures is one of the most difficult areas to evaluate in terms of methodology. Nevertheless, great advances have been made in his field in recent years. The federal government supports many projects by funding accompanying research studies. It only makes sense to broadly implement a measure in practice, when we have clear findings indicating that it is effective and that the target group has been reached.

**IX. Legislation when Necessary**

An important aspect of focussing on the individual in drug and addiction policy is to increase personal responsibility. It is of primary importance to establish a broad consensus among the diverse parties on various levels in society regarding the dangers related to the consumption of addictive substances or engaging in addictive behaviours. Nevertheless, legal norms can also be important in trying to promote healthy behaviour. When an individual is injured or endangered as a result of the health-threatening behaviour of others, legal measures, such as those to protect non-smokers, are imperative. The state is responsible for ensuring the protection of children and adolescents through legal regulations, when other measures are insufficient in providing effective protection. Legal measures must find adequate answers to the new challenges. In relation to the new synthetict substances, for example, we face the problem of only being able to ban ingredients and substances that have been specifically cited during the course of a relatively time-consuming legislative process. These bans can, however, easily be circumvented by synthesising new ingredients or by slightly altering the chemical composition of existing substances. There are international possibilities for circumvention; cross-border distribution via the Internet requires little effort. In this conjunction, means must be found to ensure fast and effective protection of the population against such substances.
X. Enhance Addiction Self-Help

As the oldest form of self-help in Germany, addiction self-help makes an essential contribution to the overall system of providing help for people suffering from addiction. Self-help facilities breathe life into our ideal of helping people to help themselves in overcoming addiction. The help they offer is directed at addicts before, during and after therapy, as well as their relatives and friends. Self-help organisations also serve as a contact for service providers (such as companies, doctors’ practices and counselling services). There are self-help groups for all types of addiction (e.g. alcohol, drugs, prescription drugs, gambling, computer and the Internet). They provide motivational aid and support for those affected, support for relatives and contribute, by providing information about addiction, to a change in the public’s perception of addiction.

Most of the addiction self-help organisations in Germany are members of the German Center for Addiction Issues (DHS): Blaues Kreuz in Deutschland, Blaues Kreuz in der Evangelischen Kirche, Bundesverband der Elternkreise drogengefährdeter und drogenabhängiger Jugendlicher (National Association of Parent’s Groups for Adolescents threatened by Drugs and Addiction), Deutscher Frauenbund für alkoholfreie Kultur, (German Women’s Association for Alcohol-free Culture), Freundeskreise für Suchtkrankenhilfe (Friends’ Circles for Addiction Aid), Good Templers in Germany and the Kreuzbund. There are a number of self-help groups that are directly tied to welfare associations such as the National Society for Workers’ Welfare, the German Caritas Association, der Service Agency of the Protestant Church in Germany or the German Red Cross, as well as professional associations, such as the Professional Association for Gambling Addiction. The majority of the self-help groups in the area of illegal drugs are associated with the JES Groups (Junkies, Ehemalige, Substituierten – Junkies, Former Users, Substitution Patients), an organisation supported by the Deutsche Aidshilfe (German Aids-Relief Association). With funding from the statutory health insurance funds and the statutory pension fund, self-help groups in the health sector have an excellent working basis in Germany.

XI. Individually Tailored Counselling and Treatment

All of the parties involved in providing help for addicts and drug users, or related forms of aid, are repeatedly faced with the challenge of re-examining proven and established programmes and aid measures. They must be modified as needed in order to suit new circumstances. Addicts and other people seeking advice are entitled to the type of aid that suits them personally. Providing such help is a complicated task, particularly when the cooperation of various parties is needed in order to provide optimal aid. Providing such complex services not only requires a clear division of labour, it must also take the different perspectives of those who provide the services into consideration. In the case of the highly desirable cooperation between addiction services and addiction self-help groups, for example, the divergent perspectives of professional and voluntary helpers play an important role.

In addition to continually improving programmes and services – especially in relation to new forms of addiction or new psychotropic substances – it is also necessary to create new, specialised forms of aid and programmes. The experience in the field of counselling and treating young people who seek help because of cannabis consumption has shown that the simple geographic separation in the counselling centres for different client groups or renaming an addiction counselling centre can lead to considerably more people seeking help and taking advantage of the services provided by the counselling centres than was previously the case. In the field of counselling people with migration backgrounds, it became clear that professionals with corresponding linguistic, cultural and migration-related backgrounds can make an essential contribution to increasing the number of people who take advantage of the given service. Addiction and drug services also face the challenge of reacting to the pathological use of the Internet in a suitable manner.
A. Alcohol

I. General Situation: Alcohol Consumption and Abuse in Germany

For many people, the consumption of alcohol is considered normal behaviour in our culture. Abusive or high-risk alcohol consumption, however, leads to considerable health risks and harm, both to the consumers themselves and to third parties. The basic goal of prevention is to preclude abuse and addiction, without fundamentally questioning the enjoyment of alcohol.

A precondition for successfully preventing alcohol abuse is a coordinated bundle of legal regulations, information, and preventive measures aimed at changing behaviour. Preventing alcohol abuse is a social policy measure that reaches across federal, Länder, municipal and self-administrative bodies, as well as additional interest groups in society such as employers, unions, associations and institutions involved in addiction prevention. Among the 20 most common diagnoses for male patients in inpatient hospital care, “psychological or behavioural disorders due to alcohol” (F10) is the most prevalent with a total of 334,000 cases diagnosed per year. In view of the population on the whole, 18.3% of all adults exhibit high-risk alcohol consumption, i.e., over 12 g of alcohol per day for women and over 24 g for men, this equates to 9.5 million.

2.4% of the adult population is addicted to alcohol, which corresponds to a total of 1.3 million people. A differentiation of consumption according to social strata shows that in most age groups there is a lower tendency towards alcohol consumption in the lower social strata. Every year, over 73,000 people in Germany die as a result of abusive or high-risk alcohol consumption. The costs of alcohol-related diseases in Germany total 26.7 billion euros per year. The connection between excessive alcohol consumption and violent altercations is a proven fact.

Alcohol consumption by children and adolescents has changed in recent years. On the one hand, the proportion of adolescents (12- to 17-year-olds) who consume alcohol at least once a week has declined since 2004; the figure was 13% in 2010. Hence, the vast majority of young people do not consume alcohol regularly. On the other hand, high-risk consumption behaviour is increasing. The number of adolescents between the ages of 10 and 20 who are admitted to hospital emergency rooms due to alcohol poisoning increased between 2000 and 2010 from 9,500 to 26,000.

This all serves to underline why a reduction in alcohol abuse must be seen as an urgent goal in health policy. Not least of all, because Germany, despite a gradual reduction in recent years, still has one of the highest levels of annual alcohol consumption. According to the most recent statistics, every citizen of the Federal Republic of Germany consumes 9.7 litres of pure alcohol per year.
Individuals and Addiction: Children from families with a history of addiction

In Germany, as many as 2.6 million children and adolescents under the age of 18 are affected by the alcohol addiction of a father, a mother, or both parents. Approx. 30,000 children have parents who are addicted to illegal drugs. These children have a much higher risk of developing a substance-related disorder during the course of their lives. Over 30% of the children from families with addiction histories will suffer from addiction themselves – usually early in their lives. Because addiction is still a stigmatised disease, and seen as a sign of weakness, failure, or even as a disgrace, it is difficult for those who are involved to admit to an addiction problem. As a result of the concerted efforts of all family members to create the impression that nothing is wrong, children often do not receive adequate help or support from external sources.

The Federal Ministry of Health supported the development and testing of a Modulares Preventionskonzept für Kinder aus suchtbelasteten Familien (Modular Prevention Concept for Children from Families with Addiction Histories) (www.projekt-trampolin.de) during a three-year project completed in 2011. The multi-centre study was conducted at 16 project locations in a total of ten Länder and assesses the effectiveness of a modular group programme for 8- to 12-year-old children from families with addiction histories under various structural and local framework conditions using standardised measuring instruments in the case of both the children and their parents. Parent training is integrated into the prevention measures. The goal of the project is to reduce the psychological strain on children from families with addiction histories, enhance their capacity to deal with various situations and to achieve a long-term increase in the children’s resources and resistance. The presentation of the findings will enable us to assess the possibility of reaching the target group and the effectiveness of these measures. Based on these results, the federal government will consider the transfer of these measures.

Within the context of the work of the Nationales Zentrum Frühe Hilfen (National Centre for Early Assistance), which was established, in part, in reaction to the tragic death of a child whose parents were addicted to opiates and were receiving substitute substances, all aspects that can contribute to discovering threats to the welfare of a child and to offering help to those affected on time are considered. One of the numerous model projects that test approaches to this problem is specifically dedicated to children from families with addiction histories and/or children of parents with psychological disorders.
II. Goals and Measures

1. Alcohol Consumption by Children and Adolescents

Goal 1: Reduction in the frequency of binge drinking among children and adolescents

The injurious effects of binge drinking on adolescents are considerable. Studies have shown that excessive consumption can lead to massive and sometimes irreversible damage to the health of adolescents, due to their higher susceptibility to alcohol. The probability of early addiction is considerably higher in this group than for adults. The increase in binge drinking among adolescents has many causes; important influencing factors are the family, peers, recreational behaviour, the tendency to seek borderline experiences as well as marketing campaigns by the alcohol industry. With the goal of promoting responsible alcohol consumption among adolescents, the campaign by the Federal Centre for Health Education (BzgA) Null Alkohol – Voll Power has been conducted in popular holiday destinations as well as within the context of recreational events and other events for young people. The prevention campaign staged by the Federal Centre for Health Education, Alkohol? Kenn dein Limit (Alcohol? Know your limit), is directed towards adolescents and provides information on the risks and threats to health that result, particularly from high and high-risk alcohol consumption among adolescents. In order to motivate adolescents to espouse prevention goals, it is especially important to increase measures that adopt a peer approach. While studies show that parents have an important influence on the drinking habits of their children, parents tend, for a variety of reasons, to refrain from talking to their children about alcohol. The federal government supports the intensification of measures, both within the context of schools and beyond, to help parents re-examine themselves as role models and the way they deal with the consumption habits of their own children.

Existing cooperative efforts between the BZgA and private organisations, such as private health insurance funds, provide important support for campaigns in the field of alcohol prevention among adolescents.

Measures

- Enhancement of manpower-intensive measures within the context of the Null Alkohol – Voll Power programme
- Development of evidence-based recommendations for parents on how to deal with their children’s consumption of alcoholic beverages
- Workshops for drug commissioners on the topic of parental competency
- Study on preventive measures related to alcohol consumption that address parents in the school setting
- Ensure that the HaLT – Hart am Limit project becomes widely known by enlisting the participation of the health insurance funds
- Further development of the BZgA campaigns Alkohol? Kenn Dein Limit

16 More under www.null-alkohol-voll-power.de
Goal 2: Rigorous Implementation of the Existing Regulations Found in the Protection of Young Persons Act

In Germany, the Protection of Young Persons Act prescribes a minimum age under which alcoholic beverages cannot be obtained or consumed in public – the minimum age for wine, beer, sparkling wine or beverages and foods containing beer is 16 years of age and the minimum age for spirits and other beverages containing spirits or brandy is 18 years of age. This legal regulation is intended to prevent alcohol from being made available to adolescents under a certain age. The federal government supports the rigorous adherence to the age limits for the protection of children and adolescents. Reducing the availability requires, among other things, a responsible attitude regarding the sale of alcohol through retail outlets (including petrol stations) and in pubs and restaurants. Since numerous reports have been submitted indicating deficits in the enforcement of the Protection of Young Persons Act, increased monitoring of retail sales of beer and wine to persons under 16 years of age, and of spirits to persons under 18 years of age, is imperative. The goal, in this context, is to identify violations of the Protection of Young Persons Act and to rigorously impose the corresponding sanctions. For this purpose, the Federal Government Commissioner on Narcotic Drugs has reached an agreement on action plans for the protection of young people in cooperation with the German Retail Federation and representatives of the petrol station owners that will also include training programmes for employees, warning signs at the cash registers, new cash register systems and internal test purchases by adult test purchasers.

Measures

- Oversee the implementation of the Action Plan for the Protection of Young Persons
- Implementation of the retail federation’s Guideline for Action to Ensure the Protection of Children and Young People (Aktionsleitfaden des Handels zur Sicherung des Jugendschutzes)
- Develop guidelines for preventing alcohol misuse in pubs and restaurants
- Intensify the acceptance of the need for the effective protection of young people through the Active Protection of Children and Young People (Jugendschutz aktiv) campaign
Goal 3:  
Protect Children and Adolescents against Alcohol Advertising

Advertising is a legitimate marketing instrument. Alcohol, however, is not like other consumer goods. Alcohol abuse can seriously compromise a person’s health. Hence, advertising for beverages containing alcohol must fulfill certain standards. The expenditures for alcohol advertising have ranged between 471 and 597 million euros since the year 2000. The federal government is in favour of effective self-control in industry. Companies that advertise, the media, retailers and agencies must adhere to the code of conduct introduced by the German Advertising Council regarding commercial communications to promote alcoholic beverages. It stipulates that all activities that can be interpreted as an encouragement of the abuse of alcoholic beverages must be avoided. Special regulations ensure the protection of young people. Hence, advertisements for alcoholic beverages are not to be featured in media in which the content is primarily geared towards children or adolescents and advertising is also prohibited from showing children or adolescents who are drinking or who are encouraging others to drink.

Measure

- Evaluation of the effectiveness of the self-control of advertising in Germany by an independent body (German Advertising Council)

2. Alcohol Consumption in the Adult Population

The goal of all efforts to communicate with the public must be to counteract the tendency to take a mild view of high-risk alcohol consumption and binge drinking, provide information about limits on the amount of alcohol that should be consumed and encourage critical reflection upon one’s own alcohol consumption. In this conjunction, references can be made to the BZgA’s campaign platform, Alkohol? – Verantwortung setzt die Grenze! (Alcohol? – Responsibility dictates the limits!).

The Internet site www.kenn-dein-limit.de (know-your-limit), maintained by the Federal Centre for Health Education, is directed specifically towards adults and provides important information on the topic of responsible drinking. In addition to an extensive range of information on the dangers and health risks that result from alcohol, an alcohol self-test is also available in order to assess one’s own alcohol consumption and to test one’s knowledge on the topic of alcohol.
Goal 4: Reduce the Incidence of Driving under the Influence

A positive development can be seen in relation to the topic of alcohol consumption and road traffic. For years now, the number of fatalities related to alcohol consumption has been sinking. In 1975, some 3,641 traffic fatalities were still attributed to alcohol, while the Federal Statistical Office registered only 342 fatalities in the wake of accidents caused by alcohol in 2010. This success is primarily due to the introduction of tougher legal regulations regarding the highest allowable blood alcohol level and the increase in police monitoring. Nevertheless, driving under the influence of alcohol is still a relevant factor in traffic accidents. In comparison to 1997, when the 0.5 limit on blood alcohol was introduced, the number of alcohol-related accidents has fallen by 52%, and the number of people killed in this context has fallen even more dramatically, namely by 76%. Nevertheless, there is no reason to be complacent: driving under the influence of alcohol is still one of the most important causes of traffic accidents and is responsible for roughly every tenth traffic fatality. Young adults and inexperienced drivers are particularly at risk.

The Federal Ministry of Transport, Building and Urban Development’s Traffic Safety Programme 2011 and the proposal by the governing factions in the German Bundestag for the Improvement of Traffic Safety in Germany (Printed Paper of the Bundestag, No. 17/5530) support the assessment of alcohol-activated vehicle immobilisers, which can only be deactivated after the breath alcohol level of the driver is tested. It is to be determined to what extent alcohol-activated vehicle immobilisers represent a suitable instrument for rehabilitating drivers with a history of alcohol offences. The possibilities and limits of implementing this technology within the context of driver rehabilitation is to be discussed on the basis of scientific findings.

Measure

- Assessment of the possibility of implementing alcohol activated vehicle immobilisers (alcolocks) as an aid during probation/rehabilitation of drivers with a history of driving under the influence
Goal 5: 
**Absolute Sobriety in the Workplace**

Absolute sobriety is the complete abstinence from alcohol in a certain situation (e.g., at work or while driving) or in a certain phase of life (e.g., during pregnancy). Some 5 to 10% of the employees in the private and public sectors in Germany have problems with alcohol.\(^\text{19}\)

Alcohol consumption in the workplace considerably reduces effectiveness, and the danger of occupational accidents increases. Absence from work and the incidence of job loss increases. Employees in the private and public sectors should be motivated to abstain completely from alcohol consumption in the workplace. In this context, the institutions and measures related to occupational addiction prevention play a central role, especially in smaller and mid-sized companies.

### Measures

- Scientific studies on the consumption of addictive substances in occupational addiction prevention programmes
- Support for company agreements on addiction prevention in the workplace
- Support for model projects in the field of occupational addiction prevention
- Implementation of occupational addiction prevention in small and mid-sized companies, through institutions such as the occupational accident insurance funds and chambers of crafts

\(^{19}\) Cf. Fuchs, Reinhard u. a. (eds.) (1998): Betriebliche Suchtprävention
Goal 6:
Absolute Sobriety during Pregnancy and while Nursing

In Germany, the health of some 10,000 children per year is detrimentally affected by their mothers’ alcohol consumption during pregnancy. A particularly grave form is Fetal Alcohol Syndrome (FAS), the most extensive form of Fetal Alcohol Spectrum Disorder (FASD). It counts among the most common congenital disabilities in Germany. Conservative estimates indicate that approx. 3,000 to 4,000 newborns are affected every year. Hence, complete abstinence from alcohol during pregnancy is of essential importance. Even the consumption of low levels of alcohol, or individual instances of excessive drinking, can lead to lasting physical and mental disabilities in the unborn child. Most women reduce their consumption or practice total abstinence. Nevertheless, there are still too many women in Germany who continue to drink alcohol during pregnancy.

What is required is an offensive, mainly in the field of medical care, to make use of the possibilities of recognising alcohol abuse by pregnant women at an early stage. Women of childbearing age should be warned of the risks for the unborn child resulting from alcohol consumption during pregnancy within the context of medical examinations. Medical counselling could also be conducted within the context of pre-natal examinations. Early detection and counselling appointments should be used for prevention.

Measures

- Priority funding for New Approaches to Prevention of Substance Abuse during Pregnancy and Nursing (Neue Präventionsansätze gegen Substanzmissbrauch in der Schwangerschaft und Stillzeit)
- Guideline process to develop diagnostic standards for FASD
- Expansion of the information campaign to prevent alcohol consumption during pregnancy, originally launched in conjunction with pharmacists, to include gynaecologists and midwives
- Changes in the maternal progress record to ensure that the topic of alcohol consumption is dealt with explicitly
Goal 7: 
**Reduce Alcohol-Related Violence**
In addition to endangering health, massive alcohol consumption is also a catalyst for violence. In 2009, 32% of all violent crimes in Germany, including grievous bodily harm, rape and sexual assault, were related to alcohol consumption. The police are frequently confronted with violent altercations in which alcohol has played a considerable role. Bodily harm resulting in death occurred in 28.0%, second degree murder in 42.3% and rape/sexual assault in 28.8% of the cases of violence under the influence of alcohol. The proportion of offences involving resistance against public authorities that take place under the influence of alcohol is remarkably high, namely 66.1%, i.e., nearly two-thirds of the delinquents had consumed alcohol.\(^{20}\)

**Measures**

- Support for the campaign *Don’t drink too much – Stay Gold*
- Support for rigorous regulatory action against violations of laws regulating pubs and restaurants and for the protection of young people

---

Goal 8: 
Concentration on high-risk groups in the adult population

Prevention measures among the adult population must concentrate on high-risk groups. In addition to certain groups of people, this also includes the proportion of the population that engages in high-risk alcohol consumption: hence, some 10% of the alcohol consumers account for 50% of all alcohol consumed. In Germany, there is a highly developed system of counselling, therapy and rehabilitation for people addicted to alcohol. People who engage in high-risk consumption or have a high risk of abuse are, on the other hand, only rarely taken into consideration in the system of providing aid. Particularly in the field of medical care, in which a large number of patients with alcohol-related diseases are under treatment, there is almost no implementation of procedures for early recognition and short-term intervention.

Hence, what is required is the implementation of short-term intervention in all areas of medical care, where, according to experience, a high percentage of patients with alcohol-related diseases are treated (including GP practices, emergency rooms and internal medicine wards). Here it is necessary to create the required professional and economic conditions so that patients with alcohol problems can be identified and receive counselling and treatment for their alcohol problems at an early stage. Proven methods of early detection and short-term intervention are already available for implementation in practice. The competence of doctors and other medical professionals in providing counseling should be supported by suitable tools. Resources must be made available to ensure the implementation of diagnoses and intervention programmes in the field of medical care.

Measures

- Enhancement of gender-related research on alcohol prevention
- Enhancement of early intervention by doctors and medical professionals
- Enhancement of the training and additional training of doctors in the field of early intervention against alcohol abuse
- Travelling exhibition on the prevention of alcohol abuse by adults
- Expansion of the BZgA campaign Alkohol? Kenn Dein Limit, adult age group
- Enhance the acceptance and the expansion of outpatient therapy
- Ensure subsequent treatment for older patients after alcohol withdrawal
- Model project on alcohol prevention in the party setting
B. Tobacco

I. General Situation: Tobacco Consumption in Germany

Tobacco smoke contains numerous toxic substances, which are quickly ingested into the system when inhaled, so that smoking can damage nearly every organ in the body. Smoking is therefore a risk factor for a number of diseases, above all cardiovascular diseases, respiratory diseases and various types of cancer, especially lung cancer. Tobacco products cause addiction, both physical as well as psychological. The costs that result from diseases caused by smoking tobacco are estimated to be approx. 21 billion euros per year in Germany. A third of the costs is incurred for medical care for tobacco-related diseases,\(^21\) which indicates the considerable burden that this places on the mandatory health insurance funds. The other expenditures result from premature death, occupational disability and early retirement.

Since roughly the 1980s, the proportion of smokers in the adult population has been declining slightly. Among men over the age of 20, a decline from a total of 41.8 %, in 1984, to 35.5 %, in 2006, was recorded. Among women, the proportion rose from 26.7 %, in 1984, to 31.1 %, in 2003, but had fallen to 27.8 % by 2006.\(^22\)

Among adolescents, a marked decline in the proportion of smokers can be observed. Among the 12- to 17-year-olds, a total of 13.5 % smoked in 2010, this was the lowest level measured to date. At the same time, the share of those who have never smoked rose to 68.1 %.\(^23\)

Smoking habits and social status are very closely related in Germany. Among adolescents, a marked difference can already be observed according to the type of school attended. Among pupils at secondary modern (lower level) schools, the share of smokers is twice as high as among pupils at grammar (higher level) schools. Therefore, the federal government will focus tobacco prevention measures on target groups that are especially in need of protection. These include not only children and adolescents, but also everyone from socially disadvantaged social strata, as well as pregnant women. In addition, measures to reduce the number of women who smoke, in the population at large, continue to be of great importance.

In the National Strategy for Sustainable Development, the federal government declared sustainability to be a central principle in German policy. In it, the reduction of the share of smokers among children and adolescents, as well as among adults, was adopted as a primary goal of prevention measures to reduce premature death. This foresees a reduction in the proportion of adolescent smokers aged 12 to 17 to a level of under 12 % and to a level of under 22 % among the adult population by 2015.

\(^{21}\) DHS (2009): Jahrbuch Sucht, p. 69
\(^{22}\) DKFZ (2009) Quelle Tabakatlas, p. 29
\(^{23}\) Cf. BZGa (2010): Aktuelle Daten zum Rauchverhalten von Jugendlichen und jungen Erwachsenen
Individuals and Addiction: Adolescents

It is with good reason that adolescents represent the central target group in addiction prevention. Why is the focus on young people? Arguments based both on developmental psychology and social and biographical factors support this focus.

Young people’s brains are not yet completely developed and thus react more sensitively to the influence of addictive substances. The later a person begins to consume alcohol or tobacco, the less likely it is that he or she will become addicted for life.

The developmental phases that a young person goes through, especially during puberty with its many changes, represent a great challenge to adolescents. The susceptibility to addiction during this phase of life is higher. Intoxicating substances, as well as non-substance-related behaviours, can become an inadequate strategy for coming to terms with problems that are either actually experienced or merely perceived. Psychoactive substances make it possible for them to leave the real world with all its hardships perceived as greater or lesser burdens.

In addition to these risks, adolescents are also more receptive to preventive messages than in later years. The willingness to learn something new and to change behaviours that represent a health risk as a result of new information make it possible to instil a low-risk lifestyle over the long-term. This includes the ability to say no to drugs, tobacco, gambling and alcohol abuse.

Adolescents are integrated into social structures that include their families, friends and school. The lifestyles that they observe and adopt in these contexts make a lasting mark on their lives, either consciously or subconsciously. Hence, social influences of this sort represent both a potential risk as well as a point of departure for preventive strategies.

Numerous studies emphasise the relevance of parents, both in terms of child raising as well as in the role of models for dealing with addictive substances and promoting healthy behaviour. The influence of friends – peers – and the immediate social context, for example in sports clubs, is also emphasised in the research. Schools are, in turn, a location at which nearly every adolescent can be reached; it is thus excellently suited for prevention. In this context, the quality of the programmes and, especially, the credibility of teachers play a decisive role in determining acceptance on the part of adolescents. If prevention is successful during this phase of life, it often has a lifelong effect. Hence, the focus of every sustainable and strategic addiction prevention programme must be on young people.
II. Goals and Measures

Goal 1: Reduce tobacco consumption among children and adolescents

Reducing the number of smokers is – and will continue to be – the most important goal of the federal government. Marked successes could be recorded along this path during recent years. A bundle of measures consisting of an increase in tobacco taxes, expansion of protection for non-smokers, increase in the minimum legal age and limits on advertising made a contribution to this in combination with the major prevention campaign rauchfrei (smoke-free) mounted by the BZgA.

In the long-term, the increase in the quota of adolescents who have never smoked represents a success. Scientific studies show that the danger of addiction is less pronounced, the later in life people start smoking. It is therefore to be expected that the quota of smokers will also continue to decrease in coming years. This should not, however, lead to a reduction in efforts to prevent the consumption of tobacco.

In order to address disadvantaged target groups specifically, existing prevention measures on the school level, the activities of the BZgA on the national level, as well as the competition Be smart – Don’t start are to focus on the lower, middle and comprehensive school forms.

**Measures**

- Continuation and expansion of the BZgA’s youth campaign rauchfrei
- Concentration of personal communication measures on disadvantaged target groups
Goal 2: Support for weaning children and adolescents off of tobacco

Children and adolescents begin to smoke without being able to assess the addictive effect of nicotine. The smoking habits of adolescents are also often underestimated by health experts, due to the false assumption that it is easy for them to quit smoking, because their smoking habits have not become as ingrained as in the case of someone who has smoked for decades. In this conjunction, one sees that, in reality, young people’s smoking habits progress in quick succession and pass through the same stages as is the case with adults (preliminary phase, experimental phase, regular smoking through to addiction). Many examples show that adolescents go through these stages from the first cigarette to the development of a strong nicotine addiction very quickly, often within just a few months.

When adolescents realise symptoms of their own addiction (withdrawal symptoms, loss of control), it is usually very difficult for them to quit smoking.

In order to provide targeted support in this context, a quality-assured programme to help adolescents quit smoking was developed in 2007, and is offered in course and group form (losgelöst (cut free)). It is comparable to the adult programme Rauchfrei in 10 Schritten (Smoke-free in 10 Steps). In 2008, the ability of the programme to reach the target group as well as its acceptance and possibilities for its execution were tested in regionally limited areas within the context of a pilot study. Subsequently, a national feasibility study was begun in order to verify whether the findings of the pilot study could be generalised for the entire country.
Goal 3: Reduction of tobacco consumption by adults

The reduction of tobacco consumption by adults is still one of the federal government’s goals. In this conjunction, efforts to enhance the protection of non-smokers have made an effective contribution. This is impressively documented by recent studies. Hence, the prohibition of smoking in the workplace has led to less smoking overall. The prohibition of smoking in public spaces has also led to an increased willingness to refrain from smoking in people’s own homes.

Nevertheless, prevention efforts must be continued. In the future, the federal government will continue to pursue the goal of increasing the population’s awareness of the negative effects of smoking, promoting the willingness to refrain from smoking and making the population more aware of the consequences of passive smoking.

In addition, the introduction of warning labels on cigarette packages has proved to be an effective means of prevention. Numerous studies have proven that they encourage smokers to think about their cigarette consumption.

The existing legal regulations on the European level now already allow Member States to require cigarette packages to include additional graphic warnings. To date, countries such as Belgium, the UK, Romania and Lettland have made use of this option. Currently, both the graphic warnings and the EU tobacco products guideline are being evaluated. The results of this evaluation will be forthcoming.

Studies prove that 80 to 90% of smokers are dissatisfied with their cigarette consumption, and that roughly every second smoker would like to quit. There is, however, also evidence of the fact that this succeeds in only a very few cases, due to tobacco addiction. Short counseling sessions, e.g., by doctors, can provide motivation to quit. Courses and repeated counselling make an important contribution to stopping smoking, provided that their quality is assured. The goal of the federal government is to support smokers who are willing to quit. The most important aspect, in this conjunction, is the provision of information about quality-assured measures.

Measures

- Continuation and expansion of the BZgA’s rauchfrei (smoke-free) campaign for adults
- Consideration of the introduction of graphic warnings on tobacco products on a national level after the results of an evaluation of graphic warnings on the EU level becomes available
- Proliferation of quality assured measures for weaning one’s self off of tobacco through a data bank of service providers
- Review of possible improvements in the treatment of seriously ill smokers by doctors with the aim of weaning them off of tobacco
Goal 4:
Improving medical professionals’ competency in counselling patients to refrain from smoking

In the perception of the public, smoke-free hospitals have become a matter of course since the non-smoker protection laws introduced by the Länder came into force in 2007. From the perspective of the federal government, hospitals and health care facilities can, however, play a much more important role than just being locations where smoking is not allowed. Hospitals, as teaching and training centres for doctors, nurses and other health care professionals, are very important. Their potential for contributing to the dissemination of concepts for actively promoting health should not be underestimated. The hospital setting combines the possibilities of working to promote the health of the hospital staff, patients and visitors, as well as of the region as a whole, through behavioural and conditional prevention in an ideal manner. Hence, the federal government supported the establishment of a network of smoke-free hospitals. With the expansion of the project rauchfrei plus to other health care facilities, the concept has become more widespread. The share of women in health professions who smoke, mainly caregivers to the elderly, assistant caregivers, healthcare nurses, (paediatric) nurses and midwives, is still higher on average than for the population at large. In the future, the question of how to increase the motivation on the part of these health care professionals to lead smoke-free lives will need to be addressed.

Measure

• Expansion of counselling measures in health care professions through support for training and further training measures on the topic of not smoking
Goal 5: Improve protection of non-smokers

The federal government has enacted concrete regulations for protection against passive smoking, above all in the workplace and other locations, within the framework of the federal legislation, namely the Federal Non-Smoker Protection Act and the Workplaces Ordinance. The Federal Non-Smoker Protection Act has been in force since 2007. Through this act, the federal government has realised its responsibilities and prerogatives in relation to the protection of non-smokers and ensured that federal institutions and public transit are smoke-free.

According to the Workplaces Ordinance, employers are obliged to make provisions for the protection of non-smoking employees against passive smoke in the workplace. This can entail generally prohibiting smoking throughout company facilities or the prohibition of smoking in individual areas of the workplace. In all of the 16 Länder there are also comprehensive regulations to protect non-smokers. These, however, allow different exceptions, particularly in relation to smoking in pubs and restaurants, discotheques or festival tents. The guidelines for sanctions also vary. The Federal Constitutional Court confirmed, in a decision handed down in 2008, that protection against the dangers of passive smoking is to be seen as a matter of outstanding importance to society on the whole. When a complete prohibition of smoking is not enacted, discrimination against smaller pubs and restaurants that have no side room must, however, be avoided.

A current study by the German Cancer Research Centre provides evidence of the major success of these measures. Before smoking was prohibited, roughly 75 % of the entire population was exposed to tobacco smoke during visits to restaurants, in 2009; this figure was down to roughly 20 %. The GEDA (German Health Update) study by the Robert Koch-Institute compared the exposure to passive smoke in 2009 to data from the Health Survey for 1998. This showed that the percentage fell during the same period from 22 % to 13 %.

The acceptance of a general prohibition on smoking in public buildings is very high – even among smokers – and has markedly increased for most areas in the wake of legislation. In the mid-term, this will also have effects on the incidence of disease, as studies from other European countries with a longer tradition of non-smoker protection show. The federal government intends to continue its support for the positive trend towards more protection for non-smokers and to continue monitoring tobacco control policy.

There are still problematic areas, where people continue to smoke. For example, smoking on playgrounds is not only such a critical issue because smoking adults are bad role models for children; cigarette butts that have been thrown away can also cause serious problems, especially for small children. Swallowing cigarette butts can lead to serious cases of poisoning, because the filters contain up to 50 % of the tar from the cigarette smoke. The Länder have the prerogative for passing laws to make playgrounds smoke free. The federal government is pleased that three Länder (Bavaria, Brandenburg and Saarland) have already enacted such a ban on smoking. Individual municipal governments have also enacted smoking bans on playgrounds. In this conjunction, it is of particular importance that clearly visible prohibition signs are posted on playgrounds.

Certain segments of the population know too little about the considerable impact of smoking in private vehicles, especially on the health of children. A broad consensus must be established among the population at large, in cooperation with various organisations, regarding the importance of refraining from smoking in automobiles. This can be achieved by ongoing measures to make more information available on the dangers of smoking in automobiles where children are present.
Measures

- Highlighting the topic of protection for non-smokers within the context of the *rauchfrei* (smoke-free) campaign, especially in relation to parents’ and guardians’ responsibility towards children

- Support for smoking bans on playgrounds

- Information campaign on refraining from smoking in the presence of children in private vehicles

- Monitoring existing regulations for the protection of non-smokers as well as their observance and adherence to them
C. Prescription Drug Addiction and Prescription Drug Abuse

I. General Situation

In Germany, roughly 1.4 million people are addicted to prescription drugs. Addiction to prescription drugs is thus a problem of similar magnitude as the addiction to alcohol. Roughly 4 to 5% of the frequently prescribed drugs are potentially addictive. They include, above all, sleeping pills and sedatives and drugs with similar effects. These substances can lead to addiction even after a short period of use and even at low doses. Another major group of addictive prescription drugs are painkillers.

We are currently witnessing the following trends: on the one hand, there has been a shift from prescriptions covered by insurance to prescriptions that are paid for out of pocket, on the other, the benzodiazepine analogs (e.g., so-called Z-drugs like zolpidem) are now prescribed more often than the classic forms of benzodiazepine. Initially, a low potential for addiction was anticipated for this group of drugs. In the meantime, however, the WHO has classified the abuse and addiction potential as being equal to that of benzodiazepines.

Addiction to prescription drugs, especially to sleeping pills or sedatives, increases with age. Many of those affected are not conscious of their own addiction. As long as the drugs are prescribed by doctors, they are viewed as part of a necessary therapy. Reasons for the low demand for help are that people who are addicted to prescription drugs remain inconspicuous for a long time, and since they often do not seem to be suffering, they are relatively unwilling to alter their behaviour.

Even when addiction often remains undiscovered, it still has considerable negative effects for those affected. A long-proven connection has been established between taking sedatives and the increased danger of falling among older people. Falling can have serious consequences for people in this age group: confidence in one’s own physical abilities is reduced, and this leads to a reduced quality of life. Moreover, the loss of mobility is often accompanied by a loss of social contacts and independence. Addiction to prescription drugs can also lead to memory and concentration loss, behavioural problems and sleep disorders.
Individuals and Addiction: Addiction in Old Age

German society is currently undergoing a far-reaching process of transformation. The demographic transition, e.g., the aging and reduction of the population combined with a low birth rate, and immigration are two of the more important reasons. In short, the German population is shrinking, is becoming older and more diverse. The ethnic, demographic, cultural and social diversity manifests itself differently from one region to the next, bringing different regional challenges for addiction and drug policy with it.

Even though the average consumption of alcohol and tobacco decreases with increasing age, substance abuse and addiction in old age are no longer a rarity. Among people over 60 years of age, the abuse of and addiction to prescription drugs and alcohol, are the most prominent problems. Current estimates indicate that among older people, alone, as many as 400,000 people have problems with alcohol. Due to the demographic transition, the number of older people who exhibit high-risk consumption is likely to increase in coming years. The trigger for abuse among older and old people can be a decisive personal experience, e.g. coming to terms with the transition from working life to retirement or the loss of a partner. Often, abuse and addiction already existed before entering this phase of life. Currently, a generation that traditionally consumed considerable amounts of alcohol is now reaching the age of 60 or older.

Contrary to common opinion, the few international studies on intervention that are available indicate that older people are often more receptive to offers of help than younger ones. They exhibit a considerable potential for success, especially when these measures are tailored specifically to an older target group.

In the existing system of providing help, the topic of “addiction in old age” is still only treated marginally. It must be admitted that the familiarity with the problem and with the likelihood of successful intervention among doctors and employees of addiction services and elder services is relatively low. The primary goal for the near future is, therefore, to raise awareness of the consequences of harmful consumption and addiction in old age within the system of providing care. An important focus of the model project launched by the Federal Ministry of Health in 2010 is on promoting training and cooperation between elder and addiction services.

Prescription drug abuse is also a topic of discussion in conjunction with the systematic use of substances to enhance the performance of healthy people, especially in mass sports, as well as to enhance intellectual performance. A recent survey shows that the use of doping substances among the adult population is, at a rate of 0.9 %, very low. The highest level of use was among 18- to 29-year-olds (approx. 2 %) and practically non-existent among men and women over the age of 45. In total, approx. 6 % of all of the participants in the survey indicated that they used prescription drugs without a medical indication within the previous twelve months.

27 RKI 2011. KOLIBRI – Studie zum Konsum leistungsbeeinflussender Mittel in Alltag und Freizeit
II. Goals and Measures

Goal 1: Improving the data base on performance enhancement through prescription drugs and the development of target-group specific prevention measures against prescription drug abuse

Estimating prescription drug abuse and prescription drug addiction is particularly challenging. The differentiation between the medically justified use of prescription drugs and their abuse is difficult to determine. To date, there has been very little or no reliable data on the abuse of performance-enhancing substances by healthy people or the use of prescription drugs in amateur and mass sports. Hence, the federal government began by funding a representative study by the Robert Koch Institute, the Study on the Consumption of Performance-Enhancing Substances in Everyday Life and in Leisure Time (KOLIBRI). In addition to assessing the extent of the problem, the KOLIBRI study makes it possible to identify groups of users who are more readily willing to abuse such substances (e.g. young male body builders).

In the media, there are widespread reports on the use of substances to enhance concentration by students. Due to the tremendous pressure to perform, it is assumed that an increasing number of students make use of performance-enhancing prescription drugs before examinations and during periods of stress. A survey among students is planned in order to attain a realistic picture.

The federal government will discuss the need for further initiatives based on the results of these studies.

Measures

- Clarification of the extent of the problem of Prescription Drug Abuse to Enhance Cognitive Abilities and to Improve Psychological Well-Being
- Support for the development of target-group specific prevention activities within the field of body building
Goal 2:  
**Provide better information concerning prescription drug addiction through pharmacists**

Pharmacists can play an essential role in providing advice concerning prescription drugs and, thus, in the prevention of prescription drug abuse. At a very early stage, they can clearly point out the risks of addiction, as well as other risks, and motivate people to use prescription drugs in a manner appropriate to the indicated reason.


**Measure**

- Increased circulation of the revised guideline by the National Council of Pharmacists *Medikamente: Abhängigkeit und Missbrauch. Leitfaden für die apothekerliche Praxis*

Goal 3:  
**More appropriate prescription of psychotrophic drugs by doctors**

The awareness of the abuse and addiction potential of many prescription drugs has increased in recent years within the German health care system. Nevertheless, the number of prescriptions for psychotropic drugs for purposes other than those for which they were intended, particularly in the case of benzodiazepines, remains high. Doctors play a key role in preventing addiction to prescription drugs.

The German Medical Association developed the guideline *Medikamente – schädlicher Gebrauch und Abhängigkeit* (Prescription Drugs – Dangerous Use and Addiction) in 2007 in order make general practitioners more aware of the relevance of the topic of prescription drug addiction and to give them practical tips on diagnostics and treatment. Adherence to the guideline was evaluated within the context of a grant by the Federal Ministry of Health. This showed that the guideline has, for the most part, fulfilled its purpose, but is still not sufficiently well known among doctors.

**Measures**

- Broad application of the German Medical Association’s guideline on prescription drug addiction
- Development of a curriculum for training and further training of doctors to prevent prescription drug abuse
Goal 4: **Enhanced early detection and early intervention to reduce addiction to prescription drugs, especially among older people**

Older people are affected by prescription drug addiction with greater frequency, hence roughly a third of all repeat prescriptions for benzodiazepines are for people over 70 years of age. They represent a serious threat to a healthy and self-determined life. The early recognition of prescription drug abuse and early intervention can reduce subsequent harm and improve the quality of life of those affected.

In 2010, the Federal Ministry of Health made the issue of *Sucht im Alter – Sensibilisierung und Qualifizierung von Fachkräften in der Alten- und Suchthilfe* (Addiction in Old Age – Raising Awareness and Qualifications among Professionals in Elderly and Addiction Services) a priority issue. The goal is to increase awareness and knowledge in elderly and addiction services regarding the dangers of dependency and addiction in old age through new cooperation structures. The specialised qualification of professionals can make it possible for older and old people to receive long-term and professional counselling and treatment in their living environments. Support is provided for local and regional model projects that develop and test new forms of cooperation regarding innovations, as well as concrete and demand-appropriate measures for training qualified experts in elderly and addiction services in an exemplary manner. The goal is both a specific increase in knowledge as well as the expansion of the options professionals have for taking action.

To date, too little use has been made of pharmacists’ competence in providing pharmacological advice in relation to prescription drug abuse, although they have often known the persons affected for many years and would be able to provide specific counselling and motivation to change their behaviour in cooperation with the doctor providing treatment. Within the context of a model project funded by the Federal Ministry of Health, pharmacists are being encouraged to pay more attention to patients who are addicted to benzodiazepine and to make active use of the legal framework that allows them to provide advice. On this basis, effective cooperation between pharmacists and doctors in relation to benzodiazepine addiction is to be tested.

**Measures**

- Promotion of effective cooperation between pharmacists and general practitioners within the context of a model project
- Expansion of the cooperation between elderly and addiction services
D. Pathological Gambling

I. General Situation

Playing games is a natural and widespread aspect of human behaviour – not only among children. Games played for money are, however, accompanied by the risk that certain individuals may lose control of their gaming habits and thus often suffer considerable financial losses and become entangled in emotional conflicts. Such cases involve what is called pathological gambling or gambling addiction. Pathological gambling is recognized as an independent psychological disorder according to the International Classification of Diseases (ICD-10).

The types of gambling that are available are highly diverse and differ greatly in terms of prevalence and legal regulation. It is of decisive importance that a high degree of protection for the gambler and effective measures to prevent addiction are ensured for all forms of gambling. What legal form they take is of secondary importance; recent decisions by German and European courts have also emphasised this.

Since the reform of Germany’s federal structure, gambling has been essentially subject to regulation by the Länder. According to the State Treaty on Gambling Concluded by the Länder, which is still in effect, lotteries and betting on sports are subject to a state monopoly. This is justified when it serves to channel the desire to gamble onto an orderly track and help to prevent gambling addiction. Staging and brokering any form of public gambling on the Internet is prohibited by the State Treaty on Gambling, with the exception of betting on sports and lotteries. The first State Treaty on Gambling was ratified by 15 Länder on 15 December 2011. It includes regulations related to gaming halls, which have been subject to the jurisdiction of the Länder since the reform in Germany’s federal structure. Machine-related regulations pertaining to slot machines in gaming halls and pubs or restaurants are not covered by the State Treaty on Gambling, but instead regulated by the Gambling Ordinance (SpielV). The Gambling Ordinance is also slated for revision.

Gambling is widespread. Nearly every second person in the age group between 16 and 65 in Germany (i.e. 46.5 per cent) has engaged in one or more forms of publicly offered gambling for money in recent months. On the whole, one per cent of the population aged between 16 and 65 exhibited problematic or even pathological gambling habits. That equates to 540,000 people affected nationally. The development of gambling on machines continues to be critical. Since 2007, the number of 18- to 20-year-olds who have gambled on machines during the past year has risen from 4 % to 13 %, i.e. more than tripled. Gambling is also increasing among adolescents between 16 and 17 years of age, who should not be allowed access to gambling according to the Protection of Young Persons Act.

A survey showed that male gamblers tended to gamble approx. four times more often on slot machines than the females surveyed.

Within the system of addiction services, gamblers who use slot machines represent the largest group of those affected. As a proportion of those seeking help, their share has increased in outpatient addiction services, for example, from 2.6 % to 3.1 % between 2006 and 2007.

In view of this, the Federal Ministry of Health has promoted increased competence on the part of addiction counselling services in recent years to include the field of gambling addiction through a national model project. Nationwide specialized counselling centres could be established at 18 different locations where an outpatient counselling and treatment concept had been successfully developed and tested. Through accompanying public relations efforts, it was also possible to increase the proportion of people with pathological gambling habits who could be reached through addiction services.

---

28 Cf. BZgA (2011): Glücksspielverhalten und Glücksspielsucht in Deutschland – Ergebnisse aus drei repräsentativen Bevölkerungs- befragungen
29 Cf. BZgA (2011): Glücksspielerverhalten und Glücksspielsucht in Deutschland – Ergebnisse aus drei repräsentativen Bevölkerungs- befragungen
Problematic and pathological gamblers find different types of gambling more or less attractive. In the case of gambling on slot machines and in the case of participation in live betting, the risk of developing problematic or pathological gambling habits is five times higher because of the fast pace of the betting and the games. There is no comparable risk for participation in the lottery “6 out of 49”.

Slot machines have a particularly high potential for addiction. From the perspective of addiction policy, many of the criteria regulated by the currently valid regulations on gambling must be critically assessed. Hence, the high frequency of new rounds and the possibility of playing on a number of machines simultaneously are considered to be particularly problematic, because the experience of loss takes place less often. With increasingly high wagers, the psychological effects, including stimulation, feelings of euphoria, the experience of success and the need to engage in chasing (to compensate losses), increases. Especially problematic in this context is the high degree of availability of slot machines in pubs and restaurants; here adolescents, in particular, have easy access to the machines and measures to protect gamblers are not sufficiently monitored by the authorities responsible for maintaining public order.

The dangers of addiction to gambling on the Internet have been attracting an increasing degree of attention. It is possible to gamble around the clock in one’s own home without any form of social control. This diminishes inhibitions and reservations and leads to a greater availability of all forms of gambling. In addition, it is possible to participate in gambling in this context anonymously, while using simple, if not always completely comprehensible, means of payment by credit card and other non-cash payment methods.

II. Goals and Measures

Goal 1: Preventing addiction and protecting gamblers
The goal of the federal government in the field of gambling is to improve protection for gamblers and to avoid addiction to gambling. This is to be taken into consideration in drafting all new regulations, not least of all because of the clear rulings handed down by the Federal Constitutional Court. The addictive potential of all forms of gambling must be determined and the measures for preventing addiction must be designed accordingly. This applies to lotteries just as much as to betting on sporting events, which has a high potential for addiction. The protection of children and young people must be improved for all forms of gambling.

Measures

- Continuation of proven – and development of new – prevention measures specifically geared towards different forms of gambling
- Improvement of the epidemiology of pathological gambling behaviour, especially in relation to adolescents

32 Cf. BZgA (2011): Glücksspielverhalten und Glücksspielsucht in Deutschland – Ergebnisse aus drei repräsentativen Bevölkerungsbefragungen
Goal 2:  
**Higher degree of protection for people who gamble on slot machines**

Despite the different approaches to regulating slot machines (slot play in casinos, on the one hand, and slot machines in gaming halls or pubs and restaurants, on the other hand) it can, in the meantime, be seen as a proven fact that the addictive potential in both areas is high. This knowledge makes it imperative that an equally high degree of protection is adopted for gamblers in both areas. Important in this conjunction is that the measures to protect gamblers are related to the person, i.e. are oriented on the gambler and not limited to technical measures on the machines. New legal regulations must be clearly formulated in order to avoid any subsequent circumvention.

**Goal 3:**  
**Practicable regulations for gambling on the Internet**

Gambling on the Internet has a special potential for addiction. Hence, it is the goal of the federal government to take account of this fact by introducing strict regulations.

Responsible and realistic addiction and drug policy must also take into account that prohibitions cannot be completely enforced within a worldwide web. Gambling opportunities can be offered by foreign providers who are subject to less strict or no regulations at all. This can lead to the circumvention of bans and the emergence of an illegal market that cannot be controlled at all. These circumstances must be brought into line with effective efforts to combat addiction. Hence, in the event of a relaxation of the ban on gambling on the Internet, strict measures to protect gamblers and to prevent addiction must be assured.

**Measures**

- Enhance protection of children and young people as well as protection for gamblers and addiction prevention in amending the Gambling Ordinance by introducing technical and gambler-related measures
- Mid-term: introduction of a gambling card
- Ensuring that the operators of gambling machines are better informed regarding the criteria for problematic and pathological gambling habits
- Introduction of stronger sanctions for infringements against legal regulations
- Limiting the number of gambling machines in pubs and restaurants

---

E. Online/Media Addiction

I. General Situation

Today it is nearly impossible to imagine a world without the Internet. However, for roughly ten years now, we have witnessed an increase in the excessive use of computers and, especially, the Internet, and this can even take on the form of addictive behaviour. In some cases, the term online or media addiction is used for this phenomenon, along with the term pathological Internet use.

While media addiction also encompasses other media, use of the Internet plays a primary role in online addiction. In this conjunction, online computer gaming addiction, e.g., the addiction to online games offered and played on the Internet, plays a major role. These games have a high potential for addiction due to various game-immanent factors (such as reward systems and the integration in a social gamer network).

The addiction counselling centres have registered an increasing demand for treatment for this disorder in recent years. However, up until now, it has yet to be ultimately determined at what point such behaviour can actually be considered an addiction. The net time spent online is not a viable criterion for determining pathological use of the Internet; other factors must also be involved. Gaming must become so excessive that the demands of everyday social and professional life are completely neglected. The person affected is unable, despite being aware of the detrimental effects, to limit his Internet use. Adolescents who are entering puberty and experiencing the accompanying developmental processes are particularly susceptible to such inadequate forms of dealing with stress by escaping into virtual worlds.

In various international studies, the data cited for the prevalence of pathological Internet use among adolescents varies between 1.6 % and 8.2 % of Internet users.\textsuperscript{34} For Germany, there are currently no valid data available from comprehensive long-term studies. In some cases, a rough estimate of 3 % of the 15- to 59-year-old Internet users is cited.\textsuperscript{35} A more recent study operates on the assumption of 1 % of the users between 14 and 64 years of age are addicted and 4.6 % can be seen as problematic users.\textsuperscript{36}

Those affected are often adolescents and young adults. Male users are also in the overwhelming majority. Excessive media use resulting from online addiction is, however, not a problem that affects any particular social strata, it is found among all social groups.

People who use the Internet pathologically are more likely to exhibit other psychological disorders, so-called comorbid disorders. These are primarily depression, affective disorders, ADHS, but also substance abuse in relation to alcohol and nicotine. Generally, medical and psychiatric treatment for online addiction is only provided via these accompanying disorders, due to its lack of recognition as an independent disorder.

\textsuperscript{34} Petersen, Weymann, Schelb, Thiel, Thomasius (2009): Fortschr Neurol Psychiat, p. 263
\textsuperscript{35} Peterson, Thomasius (2010): Psychiatrie und Psychotherapie up2date 4, pp. 100 f.
II. Goals and Measures

Goal 1: Recognition as an independent disorder
Online/media addiction is currently not recognised as an independent disorder. Unlike pathological gambling, it is not included in the ICD-10. The criteria that are applied must be oriented on the criteria for substance-related and non-substance-related addictions. The federal government’s goal is, therefore, to initiate and oversee a process for determining generally valid and universally applicable criteria for the diagnosis of online addiction. A clarification and further differentiation serves both those affected and their patients, as well as the agencies that organise the provision of service.

Measure

• Support for the process of adopting pathological online use in the diagnostic system, International Classification of Diseases (ICD-11), which is currently under revision

Goal 2: Improvement of the data base
The federal government is pursuing the goal, in cooperation with research and treatment facilities, of gaining more reliable information, particularly with regard to the prevalence of online addiction in Germany.

Measure

• Improvement of the epidemiology of online addiction

Goal 3: Further development of the diagnostic and treatment instruments
In this conjunction, the goal of the federal government, in cooperation with counselling and treatment centres, is to establish uniform and standardised instruments.

Measures

• Evaluate existing diagnostic and treatment instruments
• Initiate and oversee a process to establish uniform treatment instruments
Goal 4:
Early training in the competent use of media
Every addiction policy measure in the realm of online addiction must span the gamut between preventing undesired, pathological behaviours, on the one side, and responsible, controlled use, on the other. It is therefore the goal of the federal government to enhance children’s competency in the use of media at an early age, so that they can learn to use media, in general, and the Internet, in particular, in a responsible manner. Just as in the case of other addictions, efforts to prevent online/media addiction must start early.

F. Illegal Drugs

I. General Situation

Illegal drugs such as cannabis, heroin, cocaine, or amphetamines represent a considerable threat to people’s health. They also seriously interfere with the lives of friends and relatives of those who consume drugs. Tragic evidence of how dangerous these substances are can be seen in the number of deaths due to drugs every year. Currently, roughly 1,250 people in Germany die every year due to the consequences of their drug consumption. Drug dealing and drug-related crime represent a threat to society on the whole. Hence, the federal government’s addiction and drug policy aims to reduce drug consumption in order to lessen the harm to society and to health caused by the use of illegal drugs and to limit their availability through the rigorous prosecution of drug dealers.

A current challenge in relation to illegal drugs is now posed by the emergence of new psychoactive substances. In this context, the drugs are often synthetic substances, which are not subject to the Narcotics Act as a result of minor chemical alterations, but which still have psychoactive effects. A current study shows that 3.7% of the 15- to 24-year-olds in Germany has already had experience with the consumption of these substances.

In Germany, the lifetime prevalence of the consumption of illegal drugs among adults in the age group from 18 to 59 has, with the exception of cannabis, barely changed since 2003. The proportion of those who have consumed illegal drugs, such as amphetamines, ecstasy or cocaine, within the previous 12 months is less

than 1% in each case, with slight variations. The only relevant changes were recorded in relation to cannabis. After an increase in the 12-month-prevalence between 1997 and 2003, a decrease has been determined in the meantime. In 2009, 4.8% of the population between 18 and 64 years of age indicated that they had consumed cannabis during the previous 12 months. The number of people with cannabis-related disorders has also remained practically unchanged; hence the proportion of 18- to 59-year-olds with a cannabis addiction was 1.5% in 2006 and 1.3% in 2009.

The Drug Affinity Study (DAS) compiled by the Federal Centre for Health Education regularly provides data on the consumption of illegal drugs among adolescents and young adults. These surveys show a similar development. According to the last study, conducted in 2010, the 12-month-prevalence for the consumption of illegal drugs in the age group between 12 and 17 years of age was 5.0% and, thus, markedly lower than the figure of 10.1% reported in the 2004 survey. The illegal drug that is, by far, most frequently consumed in this age group is also cannabis (hash, marijuana). While in 2004 31% of the 12- to 25-year-olds still reported that they had consumed cannabis at least once in their lives; in 2010 the figure was down to 24%. In relation to all other drugs, so-called experimental consumption has been stagnant for years now at a very low level.

After a considerable increase in the prevalence of cannabis consumption and the proliferation of cannabis among adolescents and young adults, in particular, as of the mid-1990s, recently submitted findings show a decline. The police have also been able to determine a similar decline in relation to cannabis. Evidence of this is provided by the continual decline in the number of offences related to cannabis consumption since 2005, with the exception of 2009. On the other hand, indicators such as the large volume of cannabis products confiscated as well as the extensive cultivation of cannabis, especially in so-called indoor plantations, are evidence of a continued high demand for cannabis. The high content of the active ingredient THC in cannabis from indoor plantations is a reason for us to be especially cautious.

Numerous initiatives and projects that specifically address adolescent cannabis consumers have been developed with the support of the federal government, especially since 2003. These measures range from low-threshold measures through to psychotherapeutic intervention approaches. In addition, possible risks and long-term consequences of intensive or addictive cannabis consumption have been more seriously discussed, among both the public at large as well as professional and experts.

Germany has an extensive system for providing aid to people who seek to overcome their consumption of illegal drugs, or an addiction, with professional support. Numerous measures to provide help in quitting, as well as a variety of therapeutic options, are available and financed by the statutory social insurance system or supported by municipal and Länder governments. These include therapies based on abstinence and substitution options.

43 Cf. Polizeiliche Kriminalstatistik 2010; Herausgeber: Bundesministerium des Innern
Individuals and Addiction: Migrants

Germany is a country that attracts immigrants – this was confirmed by the Independent Commission on Immigration (Süssmuth Commission) in 2001. 15.6 million of the 82.1 people who resided in Germany in 2008 had a migrant background. This means that 19% of the entire population (2005: 18.3%, 2007: 18.7%) either immigrated to Germany after 1950 or are the descendants of immigrants. Of the 15.6 million people with migrant backgrounds, 8.3 million are ethnic Germans.

Some people with migrant backgrounds suffer from considerable disadvantages. This may result from the additional stress of adapting to a new culture as well as difficulties with the language in school, vocational training, working life and in seeking treatment, which can have a negative effect on people’s health.

For addiction and drug policy, eliminating the barriers to accessing counselling and treatment for people with migrant backgrounds represents a challenge that must be met across the board. Difficulty in accessing addiction and drug services can, for example, result from a lack of familiarity with the German language, or from a different view of the causes of addiction and of the addiction itself than in German society, or from cultural concepts of counselling and treatment that differ from the traditional measures offered here. Until 2012, the Federal Ministry of Health will be supporting a series of model projects in different settings, which are aimed at improving the access to and use of aid measures. The Federal Office for Migration and Refugees also supports community-oriented projects to prevent addiction and drug use as measures to promote the social integration of adolescent and adult immigrants. In this context, culture-specific phenomena must be taken into consideration: young repatriated Germans with a Russian background tend to use opiates, while Muslims exhibit a higher percentage of cannabis- or alcohol-related disorders. In addition, young men with migrant backgrounds exhibit a higher risk of becoming addicted to slot machines.

Everyone involved in addiction and drug policy faces the challenge of adapting more successfully to growing ethnic, cultural and social diversity and sufficiently taking these phenomena into account in all of these fields of activity, for example by recruiting personnel with culture-specific skills and the provision of information in a number of languages.
II. Goals and Measures

Goal 1: Meeting the challenge of new synthetic drugs more rapidly and effectively

Psychoactive substances and compounds with a potential for addiction listed in the appendix to the Narcotics Act (BtMG) are considered narcotics in the sense of the BtMG. In the case of the new synthetic psychoactive substances (e.g., herbal mixtures or so-called bath salts) we are dealing with substances and compounds that were hitherto unknown or not on the market, and which are not subject to regulation by the BtMG for this reason. Often, the chemical structure of a narcotic substance that has already been placed under regulation is changed so that the new substance that results is no longer subject to the Narcotics Act. At the same time, the psychotropic effect of the new substance, which represents a potential for abuse, is preserved or even enhanced. Those involved in drug dealing deliberately circumvent the legal bans on and the regulation of highly effective psychoactive substances through the BtMG and, thus, new markets are created. According to findings by the Federal Criminal Police Office, these new substances, which are sold through so-called head shops or on the Internet, are now found more often in the drug scene.

Up until now, the BtMG has only regulated individual substances, and not entire substance groups, in order to comply with the principle of precise definition dictated by the Basic Law. In actual practice, the chemical composition of the substances is frequently altered and thus no longer subject to the BtMG. Hence, making entire classes of chemically similar substances (= defined groups of substances) subject to the BtMG is to be assessed in relation to its conformity with the Basic Law. In addition, clarification is needed regarding which substance classes are suited for regulation in substance groups of this sort and which should be taken into consideration first.

Measures

- A feasibility study on including regulations on groups of substances in the Narcotics Act
- Expansion and increased linkage of the existing early warning systems in the field of new synthetic drugs
Goal 2:  
Expansion of selective prevention in relation to illegal drugs

Even if the consumption of, and addiction to, illegal drugs only affects a small part of society, the consumption of illegal substances not only has considerable negative consequences for the individual, but also for society as a whole. Therefore, the goal of the federal government is, and will continue to be, to reduce the number of consumers. Most importantly, adolescents must be prevented from embarking on a drug carrier.

It must be taken into consideration, particularly in relation to illegal drugs, that broad-based information campaigns can also have negative effects and may entail the risk of providing an impetus to consume drugs. Scientific findings have shown that effective prevention campaigns are not only designed for the mass media, but must also include personal communication and Internet-related measures.

The Internet has proved to be an especially good mode of access in reaching the adolescent and young adult target group that consumes cannabis and other illegal drugs. The BZgA's Internet site, www.drugcom.de, will therefore continue to play a central role within the framework of an overall concept for preventing the abuse of illegal drugs. Drugcom.de is a low-threshold Internet project to promote selective prevention, which addresses adolescents with an affinity to drugs via the leisure sector. With the help of anonymous Internet supported information and counselling options, adolescent drug consumers are to be encouraged to critically reconsider and modify their own drug consumption habits. Beyond this preventive information on individual substances and their potential dangers, there is also an option for ending or at least reducing one's own cannabis consumption by using the online-supported “Quit the shit” programme, which can be accessed via the homepage.

Measures

- Continue support for and promote awareness of www.drugcom.de
- Make the programme “Quit the shit” available nationwide
- Enhanced prevention approaches for the target group of young partygoers while focusing the risks of mixed consumption

Goal 3:  
Expansion of medically indicated prevention and therapy measures for people with high-risk cannabis consumption

People with high-risk cannabis consumption can be reached earlier when counselling centres design their programmes to specifically address people with different consumption disorders. In the past, counselling centres mainly focused on alcoholics and consumers of opiates; in recent years, these measures were augmented by special programmes for cannabis consumers. They are intended to address people with different patterns of consumption through tailored measures and thus make it possible for people to overcome addiction or at least to reduce their level of consumption.

In the past, the federal government has contributed to the development and testing of new approaches in the fields of selective and medically indicated prevention by supporting research and model projects. Results from some measures are already available for assessment, and others will follow soon. Hence, in the future, the federal government will primarily support the transfer and preparation of new approaches on the municipal level.
The Internet platform www.averca.de was developed in order to enable professionals to gain a better overview over all of the existing projects aimed at people with high-risk cannabis consumption. It consists of an Internet based toolbox (platform), which provides professional institutions with the tools to further develop the quality of prevention and counselling according to the principal, “from everyday practice for everyday practice”.

Within the context of developing programmes for cannabis consumers, it became clear that many of those affected also exhibited problematic alcohol consumption. This is why programmes like “realize it” and “FreD” were augmented and a new approach to comprehensive prevention was developed. The model project SKOLL combines behavioural and relational approaches to addiction prevention, regardless of the specific addictive substances or behaviours. In the case of SKOLL, a practice-oriented intervention approach on the level of secondary prevention is foremost and is aimed specifically at people whose goal is not abstinence, but rather a reduction in the consumption of addictive substances. SKOLL addresses people as of the age of 16 with different degrees of dependency. Stages ranging from the initial development of a dependency through to its chronification and, ultimately, addiction are addressed. In the spring of 2012, the results of the project and the accompanying study allowing the programme to be assessed will be available.

**Measures**

- Make professionals more aware of the availability of existing programmes for treating and counselling cannabis consumers through the Internet platform AVerCa
- The transfer and broad implementation of evaluated new intervention methods to reduce cannabis consumption, such as Quit the Shit, CANDIS, CANStop and INCANT by providing support for professional conferences and specific further training measures
- Development of a comprehensive approach for all substances and transfer into practice in addiction counselling through the SKOLL (Selbstkontrolltraining – Self-control Training) project
- Special assessment of the available representative surveys (ESA, DAS) as well as studies from individual Länder and cities on the consumption of illegal drugs (esp. cannabis) among adolescents and adults
- Expansion of the programme Early Intervention with First-Offence Drug Consumers, to include, especially, adolescents who have encountered problems in school because of cannabis consumption

---

44 AVerCa is the acronym for the model project “Aufbau einer effektiven Versorgungsstruktur zur Früherkennung und Frühintervention jugendlichen Cannabismissbrauchs” (Establishment of an Effective System for Early Detection and Early Intervention in the Case of Adolescent Cannabis Abuse)
Goal 4: 
Enhance the preventive health effects in harm-reduction programmes 

Germany has a very diverse system of drug services in relation to measures to reduce harm: it ranges from drug consumption rooms and contact stations for syringe exchange to substitution. In view of the high prevalence of hepatitis C among opiate addicts, effective measures for its prevention in this area are imperative.

In order to develop effective measures to prevent HCV among drug consumers, a model project was launched in conjunction with the organisation Fixpunkt e.V. The target group consists of opiate and cocaine consumers who are to be primarily reached through drug consumption rooms and Fixpunkt-mobiles. Various measures are being tested, such as training in lower risk consumption practices, short-term intervention in various settings (e.g., hospital emergency rooms, pharmacies, etc.) and test counselling. After the conclusion of the project, an assessment must be made to determine how the findings can be made accessible to other low-threshold facilities.

Measures

- Test new methods within the framework of the Early Intervention model project as a measure for preventing hepatitis C among drug consumers in Berlin
- Transfer of the findings of the model project into low-threshold measures in other municipalities
- Increase the testing rate and competence in HCV counselling in these facilities
Goal 5:
A sufficient number of opportunities for high quality, substitution-based treatment

The system of providing patients who are addicted to opiates with substitute substances has made great progress in Germany over the past ten years. Current figures and information confirm that Germany has, in the meantime, a broad-based programme of substitution-based treatment. The number of people in substitution programmes has risen and, in the meantime, encompasses some 77,000 people, while the number of doctors offering substitution-based treatment has remained the same, at roughly 2,700. Substitution therapy is a means of treating opiate addiction with the long-term goal of achieving opiate abstinence as well as of improving and stabilising the addict’s health and general situation. The federal government will continue to support the provision of high-level care for opiate-dependent patients in the future and to recruit doctors who will provide substitution-based treatment.

In order to gain representative results on the long-term development of, and care in, substitution programmes, the federal government has commissioned a comprehensive research study (PREMOS). The results will be discussed and any necessary adjustments undertaken within the framework for substitution treatment. Furthermore, the federal government continues to engage in discussions with all of the facilities involved in order to assess practical experience with substitution and, if needed, make adjustments in the conditions under which it is provided.

A considerable expansion in the substitution-based treatment of opiate addicts was achieved through the Act on Diamorphine-Based Substitution Treatment (Diamorphine Act) of 15 July 2009. The federal government is carefully observing how these new forms of substitution-based treatment develop under the framework conditions proscribed by the Federal Joint Committee (G-BA) and regulations adopted by the Committee for Rating Office-Based Doctor’s Services. This applies to the seven outpatient facilities, which have existed since the launch of the model heroin project, as well as to the establishment of new outpatient facilities for diamorphine substitution.

Measures

- Assessment and discussion of the findings of the study on the long-term treatment of opiate addicts (PREMOS Study) and adjustments in the framework conditions if indicated to be necessary by the study
- Continuation of the discussion in order to further develop substitution treatment with the relevant parties
- Evaluation of the results of the documentation and monitoring of diamorphine-supported treatment in Germany

45 BGBl. 2009 I p. 1801

46 The Federal Joint Committee (G-BA) ratified the amendment to it “Methoden vertragsärztliche Versorgung: Diamorphingestützte Substitution Opiatabhängiger” on 18 March 2010, which made it possible to conduct diamorphine supported substitution treatment at the cost of the statutory insurance funds. The amendment to the directive came into force on 12 June 2010.

47 The Committee for Rating Office-Based Doctor’s Services (Ger. abbr. = BWA) agreed to the change in the remuneration scale for office-based doctors’ services (Ger. abbr. = EBM) and ratified an Implementation Recommendation for the Financing of Services for the Diamorphine-Supported Treatment of Opiate Addicts, both of which came into force on 1 October 2010.
Goal 6: Prevention of drug-related crime

In addition to detrimental health and social effects, crime is one of the negative effects related to drug consumption. The statistics compiled by the Federal Criminal Police Office (BKA) differentiate drug-related offences according to the categories “crimes related to offences against the Narcotics Act (‘drug-related offences’)” and cases of direct procurement crime, which is mainly an issue in relation to theft and robbery. In 2010, a total of 231,007 drug crimes were registered. Hence, drug-related crime sank again in relation to the previous year.48

Measure

- Promotion of the awareness and implementation of the programme for Early Intervention with First-Offence Drug Consumers (FreD) among law enforcement authorities

---

48 Cf. Polizeiliche Kriminalstatistik 2010; Herausgeber: Bundesministerium des Innern
**Goal 7:**
**Improve the living situations of older people with drug addictions**

Studies and statistics indicate that there is now a larger proportion of older drug consumers than ten years ago. On the one hand, this is attributed to the fact that people with an addiction now live longer and, on the other hand, fewer younger people consume opioids, such as heroin. The increased survival rate, despite continued drug consumption, is a result primarily of the introduction of strategies to reduce harm. Since the mid-1980s, addiction services have been offering survival support measures, which are no longer solely oriented on becoming abstinent and, thus, now reach a greater number of addicts through low-threshold measures. The professionalisation of these measures has lead to a reduction in the risk of HIV infection, a reduction in the number of lethal overdoses and an overall increase in life expectancy. The expansion of substitution-based treatment has also made a considerable contribution to the survival of many drug addicts.

Despite this progress in terms of health, the health and social situations of older drug addicts are still extremely problematic. They exhibit grave physical and psychological health problems and are excluded from society. The complicated system of German social law, with different institutions assuming different responsibilities in relation to treatment and care, requires that the professionals in charge expend considerable effort in mastering the bureaucracy. This is the case, for example, in establishing living groups for older (ex-)drug addicts who are cared for on an outpatient basis. Experts recommend close cooperation between drug services and the system of care for the elderly based on legal regulations regarding the provision of care and other areas of responsibility.

**Measure**

- Promote awareness among professionals of existing models of living and working for older drug addicts
Goal 8:
Improve the situation of drug-consuming inmates

According to data from the Federal Statistical Office, the number of people incarcerated because of offences against the BtMG totalled 9,283 in 2009 (2008: 9,540). This equates to 15% of all prison inmates. Among male adults, the proportion is stable at 16.2% (2008: 16.3%). The share of women imprisoned due to offences against the BtMG is 17% and, thus, lower than the figure for 2008 (18.9%). Among adolescents, the share of inmates imprisoned due to BtMG offences was 5.2% (men) and 10.5% (women) in 2009. It must be assumed that a high proportion of people in prison due to offences against the BtMG are themselves addicted to drugs.

The prisons are faced with the challenge of executing diverse preventive measures and providing appropriate treatment for drug-addicted inmates, despite a low level of funding. In addition to detoxification measures and abstinence-based therapy, prisons should also offer long-term substitution treatment. The new guidelines for substitution-based treatment of opiate addicts, adopted by the German Medical Association in 2010, explicitly state that if patients are transferred to hospitals, rehabilitation centres, prisons or any other form of inpatient care, the continuity of treatment must be ensured by the institution assuming responsibility for the patient. In justified individual cases, substitution treatment can even be initiated in abstinent or protected environments, such as prisons.

Measures

- Encourage the development of a process for the uniform monitoring of health programmes for drug-addicted prison inmates in all 16 Länder
- Further testing of treatment programmes for cannabis consuming inmates in juvenile prisons, for example CANStop
- Improvement of testing and treatment of infectious diseases, such as hepatitis and HIV, among consumers of intravenous drugs in prison

49 Tim Pfeiffer-Gerschel, Ingo Kipke, Stephanie Flöter & Krystallia Karachalou, IFT Institut für Therapieforschung/Christiane Lieb, Federal Centre for Health Education/Peter Raiser, Deutsche Hauptstelle für Suchtfragen (2010): Bericht 2010 des nationalen REITOX-Knotenpunktes an die EBD; esp. paragraphs 9.4 to 9.7
Goal 9: Combat international drug trafficking networks in a sustainable manner

In addition to reducing the demand for illegal drugs, combating drug crime also plays an important role. The focus of police and customs authorities in combating drug crime is on preventing the illegal production and import of drugs as well as the illegal sale of drugs, rigorous confiscation of illegal drugs, the lasting destruction of organisational structures, the identification and confiscation of illegal profits, as well as making access to illegal drugs more difficult.

Since, in the case of drug crime, we are dealing mainly with internationally organised crime networks, it is essential to confront them with an effective international network of public safety authorities in order to combat this crime sustainably. Against this background, the concept of networked security as well as the rigorous continuation of the anticipatory strategy pursued by the Federal Criminal Police Office will also play a central role in the future. In a networked Europe without borders, it is necessary for concepts for combating drug crime to focus increasingly on joint European initiatives in the future.

In view of operative collaboration, the option of using the cooperation model established by the Joint Investigation Team will also be of importance. In order to recognise new developments and phenomena on the national market for drugs early on, and to be able to describe these precisely and back them up with reliable figures, a comprehensive and detailed survey of the data in the various drug-specific data banks is essential in order to identify or determine any needed action.

Measures

- Continuation and expansion of the operative and strategic alliances with the security authorities in the countries of origin and in transit countries relevant to drug crime
- Countering new phenomena in drug crime through the development of appropriate and effective measures
G. International and European Drug and Addiction Policy

Drugs and addiction are global problems that require joint activities by all parties in the international community. Germany cannot meet the challenge of the drug and addiction problem solely through national policies. The challenges that are evident in Germany reflect, as a rule, far-reaching international trends and causes.

I. Global Challenges – Global Approaches

The drug problem represents not only a risk to the health and safety of the population in many countries, but also a challenge to social coexistence, development and political stability as well as the safety of the community and the rule of law. Worldwide, the number of intravenous drug users, alone, is estimated to be roughly 13 million; approx. 78% of these people live in developing or transition countries. The prevalence of hepatitis and tuberculosis among intravenous drug users is a cause for tremendous concern. At the same time, the violent altercations and conflicts in many drug cultivation and transit regions in Asia, Latin America and Africa have rapidly increased in recent years.

The task of drug policy must be to confront the complex risks on individual and social levels with all suitable means. The health and welfare of people must be ensured by reducing the availability and illegal consumption of drugs as far as possible and by decreasing or eliminating the negative effects of drug abuse. It is Germany’s responsibility – not least of all in its own interest – to take part in the worldwide efforts to reduce and solve global drug problems.

The international drug problem encompasses three main elements, against which action must be taken within the context of a comprehensive drug policy:

- illegal cultivation and production of drugs,
- illegal drug dealing and drug smuggling,
- Drug consumption, abuse and addiction.

The United Nations has established special bodies and organs to address the problem of drugs:

- the United Nations Office on Drugs and Crime (UNODC) along with its annually convening Commission on Narcotic Drugs (CND) and
- the International Narcotics Control Board (INCB).

Germany is represented in the CND and works closely with the UNODC. The position that Germany takes in this international context is that the international community’s current drug control system has, in recent years, achieved ambitious goals, such as the reduction of drug cultivation in a number of countries as well as the stabilization of consumption rates for some types of drugs. Despite fundamental success in these areas, there are still a number of regional and strategic shortcomings in international drug policy. In order to overcome them, it is necessary to promote a concentration of responsibilities and a bundling of successful concepts with new approaches and partnerships. These approaches must be continued and developed further in all areas of policy. From a German perspective, more attention must be paid, above all, to the negative health and social effects of drug consumption. In the meantime, over 80 countries in the world – including Germany – make use of so-called harm reduction measures, such as syringe exchanges and substitution-based treatment.
1. **New Worldwide Trends**

The annual World Drug Reports and the Afghanistan Opium Survey, compiled by the United Nations Office of Drugs and Crime (UNODC), clearly illustrate that, when viewed over a long period of time, there has been a shift in drug consumption towards the consumption of new types of drugs and new markets and that drug production has always been subject to change. The fungus on the opium poppies in Afghanistan in 2010 has, for example, led to reductions in the harvest and, in early 2011, to prices three times as high as in 2009. The worldwide production of cocaine also varies due to alternating areas of cultivation for the coca bush, differing yearly yields of coca leaves in different cultivation areas and variations in the alkaloid content of the leaves and the ability of illegal laboratories to extract this content. Overall, it can be concluded that the cultivation of coca in Colombia has decreased markedly during recent years, while there has been a gradual increase in the cultivation areas in Peru since 2005, and the volume of cultivation in Bolivia is currently stable.\(^\text{50}\)

The consumption of organically based drugs such as heroin (opium) and cocaine (coca) has levelled off or declined in some countries. At the same time, the continued high demand for these drugs can be attributed to increasing consumption in developing countries, often in direct proximity to the countries of cultivation. At the same time, the abuse of amphetamine-type stimulants (ATS) and prescription narcotics has increased, both in industrial and in developing countries. Cannabis is still the drug that is produced and consumed most frequently worldwide. In contrast to opium and coca – for which 80% of the worldwide cultivation is concentrated in five countries – cannabis is cultivated in nearly every country in the world.

Developing and threshold countries are especially affected by drug consumption: they are no longer just regions of cultivation or transit countries, they are now rapidly becoming consumer countries and increasingly burdened by the negative health and social consequences that go along with this. Negative side effects, such as organised crime, excessive violence within illegal markets, arms dealing, money laundering and corruption, extend far into the already fragile political, economic and social processes in these countries. In some particularly fragile regions, such as in Central America and West Africa, the infiltration of illegal drug economies leads to a paralysation of government structures and the government’s ability to take action. In some cases, the countries affected are no longer able to ensure public health and safety.

Similar market shifts can also be observed for the legal substances alcohol and tobacco. While tobacco and alcohol consumption are stagnant or in decline in some countries in Europe, the consumption in middle- and low-income countries is increasing. As a consequence, alcohol- and tobacco-related diseases are increasing. WHO calculations on the global burden of disease indicate that alcohol and tobacco are, in the meantime, one of the highest risk factors for the loss of years lived without disability (DALYs) in middle-income countries.

In recent years, we have also seen that new and high-risk patterns of consumption do not stop at national borders. This applies both to illegal as well as legal addictive substances. The increasing consumption of different drugs simultaneously ("polydrug use"), or the increasing tendency by adolescents to engage in high-risk consumption, are only two examples of a development seen throughout Europe. Consequently, our neighbouring countries are also faced with the challenge of developing prevention and intervention approaches for high-risk forms of consumption, in order to prevent harmful consumption, even in cases where the consumers do not develop an addiction.

One of the consequences of a global society is the fact that tobacco, alcohol and prescription drugs are advertised and sold internationally. The Internet opens up new sources of procurement and enables producers to engage in new means of advertising. International cooperation is imperative in order to achieve responsible advertising for legal addictive substances.

\(^{50}\) See: http://www.unodc.org/documents/wdr/WDR_2010/2.3_Coca-cocaine.pdf (esp. p.4)
Internationally, Germany supports a balanced policy in the fields of prevention, counselling and treatment measures to reduce harm, and repression. An international drug and addiction policy, which focuses on the individual, integrates elements of health policy, social policy, law enforcement and development policy into a coherent overall concept and is oriented on the actual living situations of the people affected.

In German addiction and drug policy, an integrative approach to legal and illegal addictive substances has proven itself for years. In international bodies, drug policy is still, for the most part, separated from policies to promote health in relation to tobacco and alcohol. Germany champions an integrative policy that takes aspects that go beyond individual substances into consideration and avoids redundant structures and activities.

2. Development-Oriented Drug Policy

In relation to the problem of drug cultivation, the federal government is a proponent of sustainable development in regions where drugs are cultivated and pursues the internationally recognised approach of a development-oriented drug policy. Germany’s drug-specific developmental cooperation programme can now look back on over 20 years of experience with projects and providing policy advice. Germany’s partners in its international cooperation in the field of drugs include the EU, the UNDOC, non-governmental organisations, community and self-help groups. The federal government has supported developmental projects within the context of drug policy since 1981.

A central element of developmental cooperation within the context of drug policy is the Programme to Promote Development-Oriented Drug Policy in Developing Countries, conducted by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) on behalf of the Federal Ministry for Economic Cooperation and Development (GMZ). The project advises the federal government and international partners on development-oriented drug policy in regions of drug cultivation. Through its approaches and instruments, the programme aims to break the vicious circle of drug production, fragile statehood, poverty and violence through sustainable rural development in regions of drug cultivation and a transformation of the framework conditions that initially led to the establishment of drug economies.

The goal is to offset the negative individual and social consequences of drug production, dealing and consumption by creating economic and social alternatives to the illegal cultivation of drug crops. The federal government is of the opinion that successful rural development in regions of drug cultivation must be accompanied by a reform of state institutions, their enhanced presence, prevention of violence and sustainable local economic assistance in order to reduce drug economies in the long term. Projects for alternative development are currently (2011/2012) being funded in Afghanistan, Bolivia, Laos, Myanmar and Peru.

On an international level, the German approach of promoting alternative development and development in drug environments is widely recognized and Germany is a much sought-after partner in this context. The federal government promotes the approach on the levels of the UN and the EU and examines and advises numerous projects for alternative rural development in drug cultivation regions on this basis along with its partners.

3. Harm Reduction

The number of intravenous drug addicts worldwide is estimated to be roughly 16 million, 80 % of these addicts live in developing and transition countries. This must be seen, above all, against the background of the troubling epidemiological development of HIV-infections in Eastern Europe, Central Asia, South and Southeast Asia, which is mainly a result of intravenous drug use and prostitution. Worldwide, 10 % of all HIV infections outside of Sub-Saharan Africa can be attributed to intravenous drug consumption, and 30 % of all new infections are registered for intravenous drug users.

The recognition of the harm reduction approach within the context of the United Nations has grown markedly in recent years. Germany is also a proponent of the approach internationally and can draw on years of
broad experience in this area. Germany has established international standards in this context, such as in opiate substitution therapy (OST).

The federal government promotes harm reduction measures especially within the context of HIV prevention in Asia, the Ukraine and Central Asia and intends to continue its efforts in this area. In light of the international demand, Germany will increasingly deploy experienced professionals to foreign countries within the context of German developmental cooperation projects and programmes with a focus on substitution therapy and gender-specific approaches.

4. Global Strategy to Reduce Harmful Use of Alcohol

In May of 2010, the WHO ratified the Global Strategy to Reduce Harmful Use of Alcohol. Its goal is to create a global consciousness, increase the willingness to take action to address the problem, and to improve the knowledge base for effective measures to reduce and avoid harm caused by alcohol. In addition to an enhancement of technical support, especially in low- and middle-income countries, performance in the field of treatment and prevention is to be improved. The strategy aims at better cooperation between the representatives of interest groups and the provision of the necessary resources for coordinated measures to prevent alcohol misuse. Improvements must be made, not least of all, in the monitoring system for alcohol consumption, as well as in relation to morbidity and mortality due to alcohol.

The measures are to be implemented according to the discretion of the Member States in keeping with national, religious and cultural backgrounds, health care priorities and the available resources in harmony with the principals of the Basic Law or constitution and international obligations.

The recommendations for political interventions can be categorised in nine areas:

- setting priorities, increasing awareness and engagement,
- the role of the health care system,
- Inclusion of local parties and enhancement of local initiatives,
- Driving under the influence,
- Availability of alcohol,
- Marketing of alcoholic beverages,
- Price policy,
- Reduction in the negative effects of alcohol consumption and alcohol poisoning,
- Reduction in the negative influence of illegally or informally produced alcohol on health.

In the autumn of 2011, the WHO’s European Action Plan to Reduce Harmful Use of Alcohol (2012–2020), which is based on the WHO Global Strategy, was ratified. To accommodate the needs of the 53 Member States in the European region, the WHO made a broad spectrum of recommendations to the Member States regarding measures against the harmful use of alcohol in the Action Plan. Since many alcohol-related problems in the region are cross-border phenomena, the strategy also aims at a coordinated approach by the various countries. Indicators are determined for each of the ten areas of the Global Strategy, and the progress of the Member States and, thus, the region as a whole, will be measured accordingly.

Numerous measures cited in the Global Strategy and Action Plan of the European Region are already being implemented in Germany. Germany is, therefore, also involved in the exchange of best practices and contributes, through the evaluation of the executed measures, to increasing the body of evidence and assessing their effectiveness. As one of the first areas of focus, the WHO
will also address the problem of Fetal Alcohol Spectrum Disorder (FASD), especially in countries with low and middle incomes. Even though the epidemiological data for children with FASD are much higher in many threshold countries than in Germany, the opportunity to learn from each other and to promote international awareness is welcomed and actively supported by Germany.

5. Global Measures to Prevent Tobacco Consumption and Weaning off of Tobacco

International tobacco policy has an increasing influence on national measures to reduce tobacco use. Many of the measures and legal regulations which have also been implemented in Germany in recent years, with regard to tobacco policy, can be traced back to recommendations and initiatives by the WHO. The fundamental basis for this is the Framework Convention on Tobacco Control (FCTC), which was ratified in May 2003 by all 193 members of the WHO. It is the first global health agreement and aims at a global reduction of tobacco consumption. With the ratification of the International Tobacco Convention in 2005, Germany assumed obligations to reduce tobacco consumption, which were implemented in national law. The convention foresees the global reduction in tobacco consumption through national measures in the signatory countries, such as improving the protection of children and young people, reducing demand through instruments of tax policy, introducing regulations for the protection against passive smoking, banning advertising for tobacco products, regulating the additives in cigarettes as well as mounting extensive campaigns to provide information and raise awareness regarding the dangers of smoking.

In addition to the obligations stemming from the Framework Convention on Tobacco Control from 2005, the participating signatory states will draft guidelines for the implementation and updating of the Framework Convention on Tobacco Control during regularly held conferences. These are recommendations for legislative, administrative and other measures for formulating national tobacco policy in the signatory states. Germany participates in this process through active cooperation in various working groups. Since 2006, it has been possible to ratify a binding protocol to combat tobacco smuggling as well as to adopt guidelines regarding the individual articles of the convention. These are related to the following topics:

- Protection against commercial and other interests of the tobacco industry,
- Packaging and labelling of tobacco products,
- Tobacco advertising, sales promotion and sponsoring,
- Cross-border tobacco advertising,
- Protection against passive smoking,
- Measures to avoid tobacco addiction and to quit consuming tobacco,
- raising public awareness to reduce the consumption of tobacco as well as
- labelling of contents and tracing of the origins of tobacco products (partial guideline).

II. European Drug and Addiction Policy

1. European Drug Policy

Within the context of the European Union, Germany actively cooperates with the European Commission, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Europol and Eurojust. Representatives of federal ministries regularly participate in meetings of the responsible Council Working Groups (e.g., Horizontal Drug Group – HDG), which prepare the Council resolutions in relation to drugs. The EU Drugs Strategy 2005–2012 provides the framework for this cooperation. It has been implemented through two EU Drugs Action Plans (2005–2008 and 2009–2012).

Germany will continue to actively participate in bodies of the European Union, work towards bundling existing
activities and engage in a productive, fruitful exchange of ideas.

In November of 2010, the European Commission presented its progress report 2010 on the EU Drugs Action Plan. In this conjunction, the decline in HIV infections among drug users was seen as a positive development. Progress could also be made in cooperation on combating cross-border cocaine and heroin trafficking.

However, the commission also pointed out altered patterns of consumption, for example polydrug use. New psychoactive substances ("legal highs") are cited as a major problem for the future. The commission calls upon Member States to make their prevention programmes more effective by conducting prevention programmes aimed at certain target groups rather than broad ranging, but relatively ineffective, prevention programmes. On 3 June 2010, the justice and internal affairs ministers of the EU Member States ratified The European Pact to Combat International Drug Trafficking at the Justice and Internal Affairs Council meeting; it was based on a French initiative with Germany playing an essential role in its formulation.

The goal of the European Pact is the coordination and improvement of cooperation between the EU Member States in relation to drug crime. The “European Pact to Combat International Drug Trafficking” encompasses measures in the area of cocaine smuggling via West Africa, in the area of heroin smuggling via the so-called Balkan route, and in the area of asset recovery. Certain Member States have assumed the responsibility for the implementation of individual measures by 2012. Germany assumed responsibility, along with Italy, for the area of heroin smuggling via the so-called Balkan route.

Under the Polish Presidency of the Council of Europe, the European Pact against Synthetic Drugs was ratified at the Justice and Internal Affairs Council meeting on 27 October 2011. The implementation, along with corresponding operative measures, is taking place with the participation of Germany within the framework of the so-called EU policy cycle, which is dedicated to the strategic coordination of the fight against organised crime in the Member States on the EU level.

In November 2011, the Commission published its communication to the European Parliament and the Council, “Towards a Stronger European Response to Drugs”, with the intention of providing new impulses in EU drug policy; it included a number of legislative recommendations and other measures. In the Communication, the Commission submits suggestions on how to effectively counter the problem of illegal drugs and new psychoactive substances and calls for a broad debate on the subject. It is intended as a reaction to the new challenges in recent years: drugs and the chemical substances required for their production ("drug precursors") are being sold in new ways, soon new drugs will be on the market; and new channels of sales will be used for these new substances.

2. The Alcohol Strategy of the European Union

High-risk alcohol consumption is not solely a German phenomenon. On the contrary, a European trend shows that so-called binge drinking has also increased in many European countries and is, in the meantime, widespread. Therefore, an EU alcohol strategy to support the Member States in reducing harm caused by alcohol was ratified in the European Union in 2006. The European Commission and the EU Member States are thereby focusing on the following points:

- Protecting young people, children and the unborn child from alcohol,
- Reducing injuries and deaths due to alcohol-related road traffic accidents,
- Preventing alcohol-related harm among adults and reducing the negative impact on the workplace,
- Informing, educating and raising awareness on the impact of harmful and hazardous alcohol consumption and on appropriate consumption patterns,
• Developing, supporting and maintaining a common evidence base.

In Germany, measures related to these areas of focus have long since been implemented. In order to profit from experience in the various EU Member States and to promote the exchange of successful approaches within the EU, Germany is an active member in the Committee on National Alcohol Policy and Action. The regular meetings clearly illustrate that attempts are being made to make the protection of children and young people more effective not only in Germany, but also in many other European countries. In recent years, early interventions in a medical setting were comprehensively introduced in a number of Member States. In both areas, Germany will be able to profit from foreign experience. As one of the first countries, Germany has given the question of the demographic transition and the increasing phenomena of addiction in old age intensive consideration and thus plays a pioneering role. In addition, the Member States and the Commission jointly support effective self-control in the alcohol industry’s advertising. Due to the increasing level of advertising in new media and an industry that often operates internationally, this can only succeed through a targeted approach adopted by all of the European Member States and the international community.

In order to illustrate options for further development, the commission has, in the meantime, commissioned an external assessment of the EU Alcohol Strategy, in which the experience of the Member States, the associations of the alcoholic beverage industry and non-governmental organisations are to contribute to the development of addiction prevention measures.

Parallel to the EU Alcohol Strategy, the European Commission has also established the Health and Alcohol Forum, a platform, in which various parties can commit themselves to activities of their own to avoid harm related to alcohol. German participants can also be found here.

In addition, the new EU regulation regarding the provision of food information to consumers (No. 1169/2011, ABl. L 304 from 22 Nov. 2011, p. 18), which came into force on 12 December 2011, after three years of deliberation, foresees the submission of a report on alcoholic beverages by the European Commission within three years. It should express an opinion (and if necessary submit legislative recommendations), as to whether alcoholic beverages with an alcohol content of over 1.2 % vol. must be required to provide information on their contents and nutritional value (i.e., the energy value) in the EU in the future.

Furthermore, the Commission is to examine a definition of so-called alcopops, which are mainly consumed by adolescents or young adults. The goal in the labelling of alcopops is to create transparency regarding the ingredients and the nutritional value, and to thus make a direct contribution to reducing excessive alcohol consumption of younger consumers, in particular. Germany expressly supports the Commission’s being charged with reviewing this matter.

3. European Tobacco Policy

The European level is of central importance in the formulation of laws related to national tobacco policy. The EU is responsible for binding regulation in individual areas, such as in relation to tobacco products; these, in turn, are ratified as binding directives and adopted by the Member States. Hence, the EU’s Tobacco Product Directive of 2001 led to legislation on the national level in Germany as well as to initiatives for the protection of non-smokers.

In addition, European tobacco policy provides important impulses for the Member States. Hence, Germany continues to actively participate in the further development of tobacco policy on the European level.

On 28 May 2008, the European Commission submitted a report on the implementation of the Tobacco Advertising Directive (Directive 2003/33/EG of the European Parliament and of the Council of 26 May 2003), which was implemented in Germany with the First Act Altering the Provisional Tobacco Law, which came into force on 29 December 2007. As a result, advertising and spon-
soring on behalf of tobacco products with cross-border effects is prohibited in print media, radio and on the Internet.


In 2007, guidelines establishing a uniform format for reporting the additives used in tobacco products were published. The reported data are to be assessed by a working group at the Joint Research Centre of the European Commission regarding their toxicity and addictive effects with the goal of prohibiting the use of certain dangerous additives in tobacco products.

In a report from 27 November 2007, additional areas in which the Directive could possibly be altered are outlined, such as the establishment of legally binding formats for registering additives or the further development of warnings on tobacco products.

The revision of the Tobacco Products Directive introduced by the European Commission, which will be agreed upon within the context of a comprehensive discussion with the Member States and the European Parliament, is welcomed by the federal government. The commission will submit recommendations for changes in this directive based on this consultation process.

In order to revise the text warnings currently used for tobacco products according to the Tobacco Products Directive, the results of the TNS study commissioned by the European Commission were presented suggestions on 25 October 2010, which are to replace the warnings used up until now.

Within the context of the National Strategy, Germany is examining the implementation of EU recommendations on the inclusion of graphic warnings (2003/641/EG) on all tobacco products, provided that the effectiveness of graphic warnings is proven.
Imprint

Published by:
Federal Government's Drug Commissioner
Federal Ministry of Health
11055 Berlin
www.drogenbeauftragte.de

February 2012

If you wish to place an order:
Number of the article: BMG-D-11003

Telephone: 01805/77 80 90*
Text telephone for the deaf or hearing-impaired: 01805/99 66 07*

In writing: Publikationsversand der Bundesregierung
Postfach 48 10 09
18132 Rostock
E-Mail: publikationen@bundesregierung.de
Facsimilie: 01805/77 80 94*

*) The fee for this call is fixed at 14 cents per minute from German land lines
and a maximum of 42 cents per minute from mobile networks.

Design: A&B ONE Kommunikationsagentur GmbH, Frankfurt am Main
Printing: enka-druck GmbH, Berlin
Typesetting: da vinci design GmbH, Berlin

Images:
p. 2: Michael Dedek
p. 3: Dominique Willnauer

Content printed on recycled paper
This document is being published as a part of the public relations work of the German Federal Ministry of Health. It may not be used by political parties, election candidates or campaign workers for the purpose of election publicity during an election campaign. This applies to European, Federal Parliament, Land Parliament or local elections. In particular, distribution at election events and on the information stands of political parties constitutes an abuse. No party political information or advertising material may be inserted into this document or printed or attached to it. It may also not be passed to third parties for election publicity purposes. Irrespective of when, by what means and in what quantities this publication reached its recipient, even without a time relation to an imminent election, it may not be used in such a way as to suggest that the Federal Government takes sides in favour of individual political groups.
1. This EU Drugs Strategy provides the overarching political framework and priorities for EU drugs policy identified by Member States and EU institutions, for the period 2013-20. The framework, aim and objectives of this Strategy will serve as a basis for two consecutive 4-year EU Drugs Action plans.

2. This Drugs Strategy is based first and foremost on the fundamental principles of EU law and, in every regard, upholds the founding values of the Union: respect for human dignity, liberty, democracy, equality, solidarity, the rule of law and human rights. It aims to protect and improve the well-being of society and of the individual, to protect public health, to offer a high level of security for the general public and to take a balanced, integrated and evidence-based approach to the drugs phenomenon.

3. The Strategy is also based on international law, the relevant UN Conventions which provide the international legal framework for addressing the illicit drugs phenomenon and the Universal Declaration on Human Rights. This EU Drugs Strategy takes into account relevant UN political documents, including the UN Political Declaration and Action Plan on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, adopted in 2009, which states that drug demand reduction and drug supply reduction are mutually reinforcing elements in illicit drugs policy and the UN Political Declaration on HIV/AIDS. The Strategy has been drafted on the basis of the principles set out in the Lisbon Treaty and on the respective competences of the Union and individual Member States. Due regard is given to subsidiarity and proportionality, as this EU Strategy intends to add value to national strategies. The Strategy shall be implemented in accordance with these principles and competencies. Furthermore, the Strategy respects fully the European Convention on Human Rights and the EU Charter of Fundamental Rights.

4. By 2020, the priorities and actions in the field of illicit drugs, encouraged and coordinated through this EU Drugs Strategy, should have achieved an overall impact on key aspects of the EU drug situation. They shall ensure a high level of human health protection, social stability and security, through a coherent, effective and efficient implementation of measures, interventions and approaches in drug demand and drug supply reduction at national, EU and international level, and by minimising potential unintended negative consequences associated with the implementation of these actions.

5. The drugs phenomenon is a national and international issue that needs to be addressed in a global context. In this regard, coordinated action carried out at EU level plays an important role. This EU Drugs Strategy, based on international and EU principles, as well as on the direction of the Lisbon Treaty, is designed to ensure a balanced, integrated approach to the problem of drug abuse.

---

(*) The UN Single Convention on Narcotic Drugs of 1961 as amended by the 1972 protocol, the Convention on Psychotropic Substances (1971) and the Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).
Strategy provides a common and evidence-based framework for responding to the drugs phenomenon within and outside the EU. By providing a framework for joint and complementary actions, the Strategy ensures that resources invested in this area are used effectively and efficiently, whilst taking into account the institutional and financial constraints and capacities of Member States and of the EU institutions.

6. The Strategy aims to contribute to a reduction in drug demand and drug supply within the EU, as well as a reduction as regards the health and social risks and harms caused by drugs through a strategic approach that supports and complements national policies, that provides a framework for coordinated and joint actions and that forms the basis and political framework for EU external cooperation in this field. This will be achieved through an integrated, balanced and evidence-based approach.

7. Finally, this Strategy builds on the lessons learned from the implementation of previous EU Drugs Strategies and associated Action Plans, including the findings and recommendations from the external evaluation of the EU Drugs Strategy 2005-12, while taking into account other relevant policy developments and actions at EU level and international level in the field of drugs.

I. Introduction

8. The Strategy takes on board new approaches and addresses new challenges which have been identified in recent years, including:

— the increasing trend towards poly-substance use, including the combination of licit substances, such as alcohol and prescribed controlled medication, and illicit substances;

— the trends towards non-opioid drug use as well as the emergence and spread of new psychoactive substances;

— the need to ensure and improve access to prescribed controlled medications;

— the need to improve the quality, coverage and diversification of drug demand reduction services;

— the continued high incidence of blood-borne diseases, especially hepatitis C virus, among injecting drug users and potential risks of new outbreaks of HIV infections and other blood-borne diseases related to injecting drugs use;

— the continuing high prevalence of numbers of drug-related deaths within the EU;

— the need to target drug use through an integrated health care approach addressing — inter alia — psychiatric co-morbidity;

— the dynamics in the illicit drug markets, including shifting drug trafficking routes, cross-border organised crime and the use of new communication technologies as a facilitator for the distribution of illicit drugs and new psychoactive substances;

— the need to prevent diversion of precursors, pre-precursors and other essential chemicals used in the illicit manufacture of drugs from legal trade to the illicit market and the diversion of certain chemicals used as cutting agents.

9. The objectives of the EU Drugs Strategy are:

— to contribute to a measurable reduction of the demand for drugs, of drug dependence and of drug-related health and social risks and harms;

— to contribute to a disruption of the illicit drugs market and a measurable reduction of the availability of illicit drugs;

— to encourage coordination through active discourse and analysis of developments and challenges in the field of drugs at EU and international level;
— to further strengthen dialogue and cooperation between the EU and third countries and international organisations on drug issues;

— to contribute to a better dissemination of monitoring, research and evaluation results and a better understanding of all aspects of the drugs phenomenon and of the impact of interventions in order to provide sound and comprehensive evidence-base for policies and actions.

10. The Strategy builds upon the achievements (1) made by the EU in the field of illicit drugs and is informed by an ongoing, comprehensive assessment of the current drug situation in particular that provided by the EMCDDA, while recognising the need to proactively respond to developments and challenges.

11. The Strategy is structured around two policy areas; drug demand reduction and drug supply reduction, and three cross-cutting themes: (a) coordination, (b) international cooperation and (c) research, information, monitoring and evaluation. Its two consecutive Action Plans, drafted by corresponding Presidencies in 2013 and 2017, will provide a list of specific actions with a timetable, responsible parties, indicators and assessment tools.

12. Taking due account of the current drugs situation and the implementation needs of the Strategy, a limited number of targeted actions will be selected on each of the two policy areas and three cross-cutting themes, for inclusion in the Action Plans based on criteria which include the following:

(a) actions must be evidence-based, scientifically sound and cost-effective, and aim for realistic and measurable results that can be evaluated;

(b) actions will be time-bound, have associated benchmarks, performance indicators and identify responsible parties for their implementation, reporting and evaluation;

(c) actions must have a clear EU relevance and added value.

13. To safeguard a continued focus on the implementation of the Strategy and of its accompanying Action Plans, each Presidency, with the support of the Commission and the technical input from EMCDDA and Europol shall address priorities and actions that require follow up in the HDG during its term and shall monitor progress. The Commission, taking into account information provided by the Member States, the European External Action Service (EEAS), and available from the EMCDDA, Europol and other EU bodies, as well as from the civil society, shall provide biannual progress reports, with the purpose of assessing the implementation of objectives and priorities of the EU Drugs Strategy and its Action Plan(s).

14. The Commission, taking into account information provided by the Member States and available from the EMCDDA, Europol, other relevant EU institutions and bodies and civil society, will initiate an external midterm assessment of the Strategy by 2016, in view of preparing a second Action Plan for the period 2017-20. Upon conclusion of the Drugs Strategy and its Action Plans by 2020, the Commission will initiate an overall external evaluation of their implementation. This evaluation should also take into account information gathered from the Member States, the EMCDDA, Europol, other relevant EU institutions and bodies, civil society, and previous evaluations in order to provide input and recommendations for the future development of EU drugs policy.

15. To reach its objectives and to ensure efficiency, the EU Drugs Strategy 2013-20 will use, wherever possible, existing instruments and bodies operating in the drug field, within the respective mandate, or that have relevance for key aspects of it, both within the EU (in particular the EMCDDA, Europol, Eurojust, the European Centre for Disease Prevention and Control (ECDC) and the European Medicines Agency (EMA) and collaboration with bodies outside the EU (such as UNODC, WCO, WHO and the Pompidou Group). The Commission, the High Representative, the Council, the European Parliament will ensure that the EU’s activities in the field of illicit drugs are coordinated and that they complement each other.

16. Appropriate and targeted resources should be allocated for the implementation of the objectives of this EU Drugs Strategy at both EU and national level.

II. Policy field: drug demand reduction

17. Drug demand reduction consists of a range of equally important and mutually reinforcing measures, including prevention (environmental, universal, selective and indicated), early detection and intervention, risk and harm reduction, treatment, rehabilitation, social reintegration and recovery.

18. In the field of drug demand reduction, the objective of the EU Drugs Strategy 2013-20 is to contribute to the measurable reduction of the use of illicit drugs, to delay the age of onset, to prevent and reduce problem drug use, drug dependence and drug-related health and social risks and harms through an integrated, multidisciplinary and evidence-based approach, and by promoting and safeguarding coherence between health, social and justice policies.

19. In the field of drug demand reduction, the following priorities (not listed in the order of priority) are identified.

19.1. Improve the availability, accessibility and coverage of effective and diversified drug demand reduction measures, promote the use and exchange of best practices and develop and implement quality standards in prevention (environmental, universal, selective and indicated), early detection and intervention, risk and harm reduction, treatment, rehabilitation, social reintegration and recovery.

19.2. Improve the availability and effectiveness of prevention programmes (from initial impact to long-term sustainability), and raise awareness about the risk of the use of illicit drugs and other psychoactive substances and related consequences. To this end, prevention measures should include early detection and intervention, promotion of healthy lifestyles and targeted prevention (i.e. selective and indicated) directed also at families and communities.

19.3. Scale up and develop effective demand reduction measures to respond to challenges such as: polydrug use including the combined use of licit and illicit substances, misuse of prescribed controlled medications and the use of new psychoactive substances.

19.4. Invest in and further research on effective risk and harm reduction measures aimed at substantially reducing the number of direct and indirect drug-related deaths and infectious blood-borne diseases, associated with drug use, but not limited to, HIV and viral hepatitis as well as sexually transmittable diseases and tuberculosis.

19.5. Expand the availability, accessibility and coverage of effective and diversified drug treatment across the EU to problem and dependent drug users including non-opioids users, so that all those who wish to enter drug treatment can do so, according to relevant needs.

19.6. Scale up the development, availability and coverage of drug demand reduction measures in prison settings, as appropriate and based on a proper assessment of the health situation and the needs of prisoners, with the aim of achieving a quality of care equivalent to that provided in the community and in accordance with the right to health care and human dignity as enshrined in the European Convention on Human Rights and the EU Charter of Fundamental Rights. Continuity of care should be ensured at all stages of the criminal justice system and after release.

19.7. Develop and expand integrated models of care, covering needs related to mental and/or physical health-related problems, rehabilitation and social support in order to improve and increase the health and social situation, social reintegration and recovery of problem and dependent drug users, including those affected by co-morbidity.
19.8. Develop effective and differentiated drug demand reduction measures that aim to reduce and/or delay the onset of drug use and that are appropriate to the needs of specific groups, patterns of drug use and settings, with particular attention to be paid to vulnerable and marginalised groups.

19.9. Prevent local and regional drug use epidemics, which may threaten the public health within the EU by ensuring coordinated and effective common approaches.

19.10. Drug demand reduction priorities need to take into account the specific characteristics, needs and challenges posed by the drug phenomenon at national and EU level. It is imperative that an appropriate level of resources is provided for that purpose at local, national and EU level.

III. Policy field: drug supply reduction

20. Drug supply reduction includes the prevention and dissuasion and disruption of drug-related, in particular organised, crime, through judicial and law enforcement cooperation, interdiction, confiscation of criminal assets, investigations and border management.

21. In the field of drug supply reduction, the objective of the EU Drugs Strategy 2013-20 is to contribute to a measurable reduction of the availability of illicit drugs, through the disruption of illicit drug trafficking, the dismantling of organised crime groups that are involved in drug production and trafficking, efficient use of the criminal justice system, effective intelligence-led law enforcement and increased intelligence sharing. At EU level, emphasis will be placed on large-scale, cross-border and organised drug-related crime.

22. In the field of drug supply reduction, the following priorities (not listed in the order of priority) are identified.

22.1. Strengthen the cooperation and coordination between law enforcement agencies at strategic and operational level. This should include, but not be limited to, improving cross-border exchange of information (and intelligence) in real time, best practices and knowledge, as well as conducting joint operations and investigations. Cooperation with third countries as regards tackling drug-related organised crime operating towards and within the EU should be seen as important in this respect.

22.2. Reduce intra-EU and cross-border production, smuggling, trafficking, distribution and sale of illicit drugs and the facilitation of such activities, as well as reduce the diversion of drug precursors, pre-precursors and other essential chemicals used in the illicit manufacture of drugs.

22.3. Respond effectively to the evolving trends, such as the diversion of certain chemicals utilised as cutting agents for illicit drugs and the supply of drugs through the use of new technology.

22.4. Special attention must be given to new communication technologies as having a significant role as a facilitation for the production, marketing, trafficking and distribution of drugs (including controlled new psychoactive substances).

22.5. Member States shall continue to cooperate, and coordinate — where appropriate — their actions at EU level, together with relevant EU and international bodies and agencies, such as Europol, Eurojust, EMCDDA and fully exploit existing instruments and methods provided in the field of judicial and law enforcement cooperation, such as intelligence-led policing, drug profiling, Joint Investigation Teams, Joint Customs and Police Operations and relevant initiatives such as the EMPACT projects, Liaison Officer Platforms and through the use of regional platforms.

22.6. At EU level, emphasis shall be placed on intelligence-led law enforcement aimed at targeting large-scale drug production and trafficking. Closer coordination and cooperation between law enforcement agencies within and between Member States as well as with Europol should be further strengthened.
22.7. Where necessary, when such tasks are not initiated or implemented through Europol, ad hoc regional collaboration initiatives or platforms may be created within the EU, to counter emerging threats from shifting drug trafficking routes and emerging organised crime hubs. This shall be done by means of coordinated operation responses. Such actions need to be compatible with and complementary to existing legal and operational arrangements at EU level and shall be based on threat assessments and analysis. Such cooperation structures should be flexible, may have a temporary lifespan depending on the future development of the specific threat that they address and work in close cooperation with all relevant EU agencies and platforms, in particular with Europol.

22.8. Strengthen, where deemed necessary, the EU drug-related judicial and law enforcement cooperation and the use of existing practices by establishing faster and more accurate responses. Support judicial and law enforcement cooperation activities and exchange of information and intelligence.

22.9. Reinforce the European Union’s legislative framework in a targeted way as deemed necessary so as to strengthen the EU response in dealing with new trends, ensure that collaborative efforts complement each other with a view to dismantle cross-border organised crime groups, confiscate the proceeds of drug-related crime by fully utilising the EU network of asset recovery offices and thus ensure a more effective response to drug trafficking. The further development of relevant law enforcement instruments can be explored.

22.10. The EU shall work towards more effective policies in the field of drug supply reduction, by reinforcing policy evaluation and analysis to improve the understanding of drug-markets, drug-related crimes and the effectiveness of drug-related law enforcement responses.

22.11. In order to prevent crime, avoid recidivism and enhance the efficiency and effectiveness of the criminal justice system while ensuring proportionality, the EU shall encourage, where appropriate, the use, monitoring and effective implementation of drug policies and programmes including arrest referral and appropriate alternatives to coercive sanctions (such as education, treatment, rehabilitation, aftercare and social reintegration) for drug-using offenders.

IV. Cross-cutting theme: coordination

23. In the field of EU drugs policy, the objective of coordination is twofold, namely to ensure synergies, communication and an effective exchange of information and views in support of the policy objectives, while at the same time encouraging an active political discourse and analysis of developments and challenges in the field of drugs at EU and international levels.

Coordination is required within and among EU institutions, Member States, other relevant European bodies and civil society on the one hand, and between the EU, international bodies and third countries on the other hand.

24. In the field of coordination, the following priorities (not listed in the order of priority) are identified.

24.1. Ensure synergies, coherence and effective working practices among relevant Member States, EU institutions, bodies and initiatives, based on the principle of sincere cooperation (1), avoiding duplication of efforts, securing efficient exchange of information, using resources effectively and guaranteeing continuity of actions across Presidencies.

24.2. Given the role of the HDG as the main drugs coordinating body within the Council, its coordinating efforts need to be further strengthened to take account of the work of the various bodies, that include a drugs component such as the Standing Committee on Operational Cooperation on Internal Security (COSI) and the Working Party on Public Health. In addition, the balanced approach to the drugs

(1) TEU article 4.
problem, targeting with equal vigour the demand for and the supply of drugs, requires close cooperation, interaction and information exchange with relevant other Council preparatory bodies including those in the area of external action and other relevant EU initiatives, in the areas of judicial and criminal matters, law enforcement, public health, social affairs.

24.3. Ensure that the EU and Member States further develop and implement working methods and best practices for multidisciplinary cooperation in support of the objectives of the Strategy and that these are promoted at national level.

24.4. Provide opportunities under each Presidency to discuss, monitor and evaluate issues of coordination, cooperation, emerging trends, effective interventions and other policy developments of added value to the EU Drugs Strategy for instance during the National Drugs Coordinators’ Meetings.

24.5. Promote and encourage the active and meaningful participation and involvement of civil society, including non-governmental organisations as well as young people, drug users and clients of drug-related services, in the development and implementation of drug policies, at national, EU and international level. Also to ensure the engagement with the EU Civil Society Forum on Drugs at EU and international level.

24.6. Ensure that the EU speaks with one strong voice in international forums such as the Commission on Narcotic Drugs (CND) and in dialogues with third countries, promoting the integrated, balanced and evidence-based EU approach to drugs. In this framework, the EU Delegations can play a useful role in promoting such approach in the field of drugs and in facilitating a coherent discourse on drugs policy.

V. Cross-cutting theme: international cooperation

25. International cooperation is a key area where the EU adds value to Member States efforts in coordinating drug policies and addressing challenges. The EU external relations in the field of drugs are based on the principles of shared responsibility, multilateralism, an integrated, balanced and evidence-based approach, the mainstreaming of development, respect for human rights and human dignity and respect for international conventions.

26. The objective of the EU Drugs Strategy 2013-20 in the field of international cooperation, is to further strengthen dialogue and cooperation between the EU and third countries and international organisations on drug issues in a comprehensive and balanced manner.

27. The EU Drugs Strategy is part of an overall approach that enables the EU to speak with one voice in the international arena and with the partner countries. The EU will remain committed to international cooperation and debate on the fundamentals of drug policy, and actively share the achievements of the EU approach in drug policy that is balanced between drug demand reduction and drug supply reduction, based on scientific evidence and intelligence as well as respecting human rights.

This requires coherence between policies and actions at the EU level, including external cooperation on drug demand reduction, including risk and harm reduction, drug supply reduction, alternative development, the exchange and transfer of knowledge and the involvement of both state and non-state actors.

28. The EU and its Member States should guarantee the integration of the EU Drugs Strategy and its objectives within the EU’s overall foreign policy framework as part of a comprehensive approach that makes full use of the variety of policies and diplomatic, political and financial instruments at the EU’s disposal in a coherent and coordinated manner. The High Representative supported by the EEAS should facilitate this process.
29. The EU external action approach in the field of drugs aims to further strengthen and support third countries' efforts to deal with the challenges to public health, safety and security. This will be done through the implementation of initiatives set out in this Strategy and subsequent action plans, including alternative development, drug demand reduction, drug supply reduction, the promotion and protection of human rights and also taking into account regional initiatives. Given the impact of drug production and trafficking on the internal stability and security situation in source and transit countries, actions will also target corruption, money laundering and the proceeds of drug-related crime.

30. In the field of international cooperation, the following priorities (not listed in the order of priority) are identified.

30.1. Improve coherence between the internal and external aspects of the EU drugs policies and responses towards third countries in the field of drugs.

30.2. Increase the EU's engagement and coordination in the international drug policy discourse, both in respect of negotiations with international organisations and structures including the UN, G8 and the Council of Europe and relations with third countries by achieving common EU positions, and ensure an effective role within the UN drug policy process.

30.3. Ensure that international cooperation in the field of drugs is integrated within the overall political relations and framework agreements between the EU and its partners, both at national and/or regional level. It should reflect the integrated, balanced and evidence-based EU approach and include: political dialogue, drug coordination, demand reduction (including risk and harm reduction), supply reduction including alternative development and law enforcement, integration of drug policies within the broader development cooperation agenda, information, research, monitoring and evaluation.

30.4. Ensure that the EU international response and actions in priority third countries and regions around the world are comprehensive taking into account every dimension of the drug phenomenon, and address the development, stability and security of these countries and regions through enhanced partnership.

30.5. Ensure that the EU international drug response is evidence-based and includes a monitoring process on the situation and progress involving different information tools from the Commission, EEAS, including the EU Delegations, Member States, EMCDDA, Europol, Eurojust and the European Centre for Disease Prevention and Control in close cooperation with UNODC.

30.6. Ensure that support to the candidate and potential candidate countries, and the countries of the European Neighbourhood Policy, focuses on capacity-building on both supply and demand reduction and evidence-based, effective and balanced drug policies, through strengthened cooperation including sharing of EU best practices and participation, where appropriate, in EU agencies, such as the EMCDDA, Europol and Eurojust.

30.7. Ensure a sustainable level of policy dialogue and information sharing on the strategies, aims and relevant initiatives through the dialogues on drugs with international partners, both at regional and bilateral level. Key partners are identified on the basis of their status of cooperation with the EU and their relevance in addressing the global illicit drug phenomenon while taking account of partners emerging as a result of developments in the drug situation. The Political Dialogues should be complementary to and coherent with other external cooperation structures and their impact and, where appropriate, provide a forum for discussing priorities on cooperation and progress on EU-funded projects.

30.8. Ensure an appropriate level of funding and expertise (provided for by the EU and its Member States) including by reinforcing coordination, monitoring and evaluation of financial and technical support,
while striving for synergies and by continuously balancing the transparent allocation of cooperation, resources, financial and technical assistance, between drug demand and drug supply reduction measures reflecting the EU approach. The EU should work towards providing relevant expertise in EU Delegations to support the implementation of measures targeting third countries in the field of drugs. The midterm review and final assessment of this EU Drugs Strategy should reflect on the impact of EU spending in third countries and the Commission and the EEAS should provide updates on priorities and progress on the EU spending overseas to Member States when appropriate.

30.9. When providing financial and technical support to source countries, the EU and Member States shall ensure, in particular, that alternative development programmes:

— are non-conditional, non-discriminating and, if eradication is scheduled, properly sequenced,

— set realistic rural development-related objectives and indicators for success, ensuring ownership among target communities and

— support local development, while considering interactions with factors such as human security, governance, violence, human rights, development and food security.

30.10. Ensure that the protection of human rights is fully integrated in political dialogues and in the implementation and delivery of relevant programs and projects in the field of drugs.

VI. Cross-cutting theme: information, research, monitoring and evaluation

31. The objective of the EU Drugs Strategy 2013-20 in the field of information, research, monitoring and evaluation is to contribute to a better understanding of all aspects of the drugs phenomenon and of the impact of measures in order to provide sound and comprehensive evidence for policies and actions. Furthermore, the EU Drugs Strategy 2013-20 aims to contribute to a better dissemination of monitoring, research and evaluation results at EU and national level ensuring the strengthening of synergies, a balanced allocation of financial resources and avoiding duplication of efforts. This can be achieved through harmonisation of methodologies, networking and closer cooperation.

32. In the field of information, research, monitoring and evaluation the following priorities (not listed in the order of priority) are identified.

32.1. The EU and its Member States should continue to invest in information exchange, data collection and monitoring, and in research and evaluation of the drug situation and responses to it at national and EU level. This should cover all relevant aspects of the drug phenomenon, including drug demand and drug supply. Particular emphasis should be placed on maintaining and further enhancing data collection and reporting through the EMCDDA key indicators in drug demand reduction.

32.2. The EMCDDA should, within its mandate, further enhance the knowledge infrastructure and should continue to play a key role as the central facilitator, supporter and provider of information, research, monitoring and evaluation of illicit drugs across the EU. It should continue to provide a timely, holistic and comprehensive analysis of the European drugs situation and of responses to it, and collaborate with other relevant agencies, including, when relevant and appropriate, the European Centre for Disease Control (ECDC) and the European Medicines Agency (EMA) and WHO.

32.3. Europol should continue its efforts as regards information gathering and analysis in the area of drug-related organised crime, while Member States should deliver relevant information to the Agency. The Agency should continue the regular delivery of threat assessment reports (e.g. EU SOCTA) on EU drug-related organised crime.
32.4. Member States, EU institutions and agencies should enhance information and data collection on all aspects of drug supply, including on drug markets, drug-related crimes and drug supply reduction with the aim to improve analysis and informed decision making. Member States, the Commission, EMCDDA, Europol and — where appropriate — other EU agencies should work together to improve data collection and the development of policy-relevant and scientifically sound indicators.

32.5. The EU institutions, bodies and Member States should improve the capacity to detect, assess and respond rapidly and effectively to the emergence of new psychoactive substances, to behavioural changes in drugs consumption and epidemic outbreaks and to other emerging trends that pose risks to public health and safety. This can be achieved, inter alia, through the strengthening of existing EU legislation, the exchange of information, intelligence, knowledge and best practices.

32.6. Member States, EU institutions and agencies should promote and support research, including applied research, into new psychoactive substances and ensure cooperation and coordination between networks at national and EU level in order to strengthen the understanding of the phenomenon. Monitoring in this area should be scaled up in close coordination with the EMCDDA. In particular, emphasis should be placed on developing forensic and toxicological capacity as well as on improving the availability of epidemiological information.

32.7. Member States should continue efforts to maintain the achievements made within the EU in terms of monitoring and information exchange, including through the Reitox Network of National Focal Points, while supporting the further development of EU standardised data collection and analysis in the areas of drug demand and drug supply.

32.8. Ensure adequate financing for drug-related research and development projects at EU and national level, according to financial resources including through the EU financial programmes covering the period 2014-20. Projects supported at EU level should take into account the priorities of the Strategy and its Action Plans and deliver a clear EU added value, ensuring coherence and synergies while avoiding duplication within programmes and with EU bodies.

32.9. EU institutions, bodies and Member States should recognise the role of scientific evaluation of policies and interventions (with a focus on outcomes achieved) as a key element in strengthening of the EU approach to drugs, and should promote its use both at national, EU and international level.

32.10. Ensure and reinforce training of professionals involved with drug-related issues, both in the drug demand as well as the drug supply reduction field.