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Commission on Narcotic Drugs**Fifty-first session**

Vienna, 10-14 March 2008

Item 3 of the provisional agenda*

Thematic debate on the follow-up to the twentieth special session of the General Assembly: general overview and progress achieved by Governments in meeting the goals and targets for the years 2003 and 2008 set out in the Political Declaration adopted by the Assembly at its twentieth special session**Complementary drug-related data and expertise to support the global assessment by Member States of the implementation of the declarations and measures adopted by the General Assembly at its twentieth special session****Report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)*****Summary*

Pursuant to Commission of Narcotic Drugs resolutions 49/1 “Collection and use of complementary drug-related data and expertise to support the global assessment by Member States of the implementation of the declarations and measures adopted by the General Assembly at its twentieth special session” and 50/12 “Measures to meet the goal of establishing by 2009 the progress achieved in implementing the declarations and measures adopted by the General Assembly at its twentieth special session”, intergovernmental organizations active in the field of international drug control were invited to submit regionally consolidated comparative analyses of the current situation and trends in various areas of drug control in their fields of action with that prevailing in the period 1998-2000. Organizations were also invited to present the actions and changes that had taken

* E/CN.7/2008/1.

** The text of the report is reproduced as it was received by the Secretariat.



place in their regions or fields of action in relation to the implementation of the goals and targets set in the Political Declaration and the measures to enhance international cooperation to counter the world drug problem, and related action plans, adopted at the twentieth special session of the General Assembly, 8 to 10 June 1998 (A/RES/S-20/2, A/RES/S-20/3 and A/RES/S-20/4).

Several organizations provided information in response to the above request. In addition, UNODC also received unprocessed data from a number of organizations.¹ Where relevant, this information was used to complement the data provided by Member States through the Biennial Reports Questionnaire (BRQ) and reflected in the fifth report of the Executive Director on the world drug problem (E/CN.7/2008/2 and Addenda 1 to 6).

The following report by **EMCDDA** contains development of national drug strategies and drug demand reduction interventions in Europe since 1998, according to the indicators selected by UNODC.

¹ ASEAN and China Cooperative Operations in Response to Dangerous Drugs (ACCORD); Caribbean Financial Action Task Force (CFATF); South-American Financial Action Task Force (GAFISUD); South-Caucasus Anti-Drug Programme (SCAD) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

European Monitoring Centre for Drugs and Drug Addiction - Development of national drug strategies and drug demand reduction interventions in Europe since 1998, according to indicators selected by the UNODC²

Executive summary

This report is the result of a request by the United Nations Office on Drugs and Crime (UNODC) for a regional analysis of data on national drug strategies and drug demand reduction interventions in Europe. The data and analysis presented below are intended to support the 10-year review of the implementation of declarations and measures adopted at the 1998 United Nations General Assembly Special Session (UNGASS) by complementing the data collected through the biennial reports questionnaire (BRQ).

The European Commission and Europol are best placed to report on international efforts regarding precursor control and actions against illicit manufacture and trafficking of ATS and their precursors. These two subjects are therefore not addressed in this document.

General

The increase in number and the improvement of national drug strategies/action plans and of drug demand reduction interventions in Europe since the late 1990s is linked to the growing involvement of the European Union in the drugs field. The EU drug strategies and action plans, the coordination efforts at EU level, the support offered to candidate countries and new Member States, the work of EU agencies and other related activities have been driving forces in changing and improving the response to the drugs phenomenon in Europe.

Nearly all of the 30 countries currently monitored by the EMCDDA now have national drug strategies/action plans. Since 1998, there has been both a quantitative increase (the proportion of monitored countries that have a national drug strategy/action plan has grown from 50% to 90%) and qualitative improvements (for instance the number of countries that have adopted both a drug strategy and an action plan has grown from two to twelve) in this field.

National drug strategies and action plans in the EU are comprehensive, covering both drug demand and drug supply reduction, and they always include a large number of intervention fields (prevention, treatment, harm reduction, law enforcement, training, etc.) which reflects their multi-sectoral dimension. These characteristics were already evident in the late 1990s but have probably extended during the timeframe of the UNGASS. Drug-related expenditure also seems to have been on the rise and dedicated budgets are now reported to be attached to about half of the national drug strategies/action plans.

Central coordination entities exist in all EU Member States and Norway, and this was already the case among the EU-15 in 1998. However, there has been a

² This working document was prepared at the request of the UNODC in the framework of the expert consultations for the 10-year review of the implementation of declarations and measures adopted at the 1998 United Nations General Assembly Special Session (UNGASS). For fuller information on the European drug situation, please consult EMCDDA's annual report and website (<http://www.emcdda.europa.eu/>).

qualitative improvement in this field as most countries now have a three-level drug coordination mechanism including an inter-ministerial coordination entity, an operative day-to-day national coordination body and regional or municipal coordination entities.

The evaluation, and more frequently, the systematic follow-up of the national drug strategy/action plan has been a growing trend in Europe during the last decade with a majority of EU Member States, candidate countries and Norway, now having a mechanism to assess the implementation of their drug strategy/action plan.

Data collection mechanisms have also improved: National Focal Points exist in all 30 countries monitored by the EMCDDA and their concept is also progressively adopted in other neighbouring countries. Furthermore, data availability has been extended and data quality has improved overall since 1998.

Drug demand reduction

It is not possible to quantify the developments that have occurred in the prevention field since the late 1990s. However, some significant changes have been observed by the EMCDDA. New approaches, such as environmental strategies and especially selective prevention, have been introduced in many Member States and have progressively complemented the more classical universal school-based and community-based prevention. There has also been a qualitative improvement in the prevention field overall with the introduction and extension of quality assurance and evaluation mechanisms. Prevention activities are therefore more diverse and often more evidence-based than they were in 1998.

Drug treatment expanded rapidly in Europe since 1998 and, ten years on, there are probably at least twice as many people in treatment. This development is strongly linked to the increase in outpatient methadone and high-dosage buprenorphine substitution treatment in Europe, and more recently to an increase in specialized treatment services for cannabis and cocaine users. Drug-free inpatient and outpatient treatment is available in all EU Member States and it is the main type of drug treatment in some of them. The reported number of individuals in such treatment is however smaller than in substitution treatment. Social rehabilitation programmes exist in almost all EU Member States but their level of availability is still considered to be limited. Finally, many qualitative improvements – through quality assurance and evaluation mechanisms, as well as through the publication of science-based guidelines – have also occurred in the treatment field.

Harm reduction is now part of a large majority of national drug strategies and action plans in the EU, a development supported by the 2003 EU Council Recommendation on the prevention and reduction of health-related harm associated with drug dependence. Needle and syringe programmes had already been introduced in almost all EU Member States and Norway before 1998, but the size of these programmes and the number of needle and syringe provision points has increased overall. Other interventions to reduce drug-related infectious diseases and deaths, including substitution treatment, low-threshold services, information material, etc., have also been developed and extended.

As mentioned above, programmes targeting specific at-risk population groups have increased overall in prevention (selective prevention), treatment (specialized

treatment services) and also in harm reduction (interventions for different groups of drug users).

Media/public information campaigns are not systematically monitored by the EMCDDA but information provided by EU Member States indicates that there has been no major change in the number of media and information campaigns during the last decade. It does seem, however, that there is an increasing trend to evaluate them.

Introduction

Resolution 49/1 adopted at the 2006 Commission on Narcotic Drugs (CND), asked the United Nations Office on Drugs and Crime (UNODC) to collect complementary data and expertise to support the 10-year review of the implementation of the declarations and measures adopted at the 1998 United Nations General Assembly Special Session (UNGASS).

In a subsequent letter, the UNODC requested the EMCDDA to produce a regional data analysis on Europe to complement the data collected through the official UNGASS follow-up instrument, the biennial reports questionnaire (BRQ). The EMCDDA first produced a comparison between its own indicators and those used in the BRQ and proposed to draft a short report in 2007 on the development of drug strategies and responses in Europe. The document also mentioned that the European Commission and Europol were best placed to respond to most questions regarding the control of precursors and the fight against illicit manufacture and trafficking of ATS and their precursors.

On 6-8 February 2007, the UNODC organised an expert meeting in Vienna to discuss possible complementary data and analysis to support the 10-year review of the implementation of the UNGASS declarations and measures. The EMCDDA participated in the meeting and repeated its proposal to produce a report on national drug strategies and drug demand reduction measures in Europe later in the year.

Resolution 50/12 adopted at the 2007 CND, reiterated the UN Member States' request for the collection and analysis of data from specialized and regional bodies in the context of the UNGASS review. In May 2007, the UNODC again sent a request for such information to the EMCDDA which covered four fields: general, control of precursors, illicit manufacture, trafficking and abuse of ATS and their precursors, and drug demand reduction. As mentioned in the first document sent in 2006 and in the presentation made in Vienna, the EMCDDA is in a position to produce an overview of only two of these topics: drug strategies and drug demand reduction measures.

Method

General

The EMCDDA collects data through its network of National focal points in the EU Member States, candidate countries, Norway as well as at the European Commission.

Data on drug strategies and drug demand reduction interventions are collected through structured questionnaires and standard tables which are filled in by the National focal points. The frequency of data collection depends on the type of instrument used but the EMCDDA also receives updates on the changes occurring in every monitored country through yearly national reports.

Timeframe

Systematic data collection in some of the drug demand reduction fields started later than 1998 and comparable data are only available since the early years of 2000. Therefore it is not always possible to document the main trends in drug demand reduction with graphs and figures. However, the EMCDDA is able to provide a qualitative description of the changes that have occurred in Europe.

Scope

In 1998, the EMCDDA was monitoring 15 countries. This number has successively grown to 16, with the participation of Norway, to 26 with the ten new EU Member States in 2004, and to 30 with the two new EU Member States and the two 2007 candidate countries.

Retrospective data are sometimes available which enable all 30 countries currently monitored by the EMCDDA to be covered in the regional analysis. This is, however, not frequent and in many cases references to the EU-15 Member States of the late 1990s or to the 26 countries of the early years of 2000 (EU-15, ten candidate countries and Norway) have to be made. The first choice is always to include as many countries as possible in the analysis.

Indicators

In some cases the indicators used by the EMCDDA are slightly different from those used in the BRQ but they cover the same subject. For a comparison of EMCDDA and BRQ indicators, please refer to the document sent last year by the EMCDDA.

Part 2³ – General

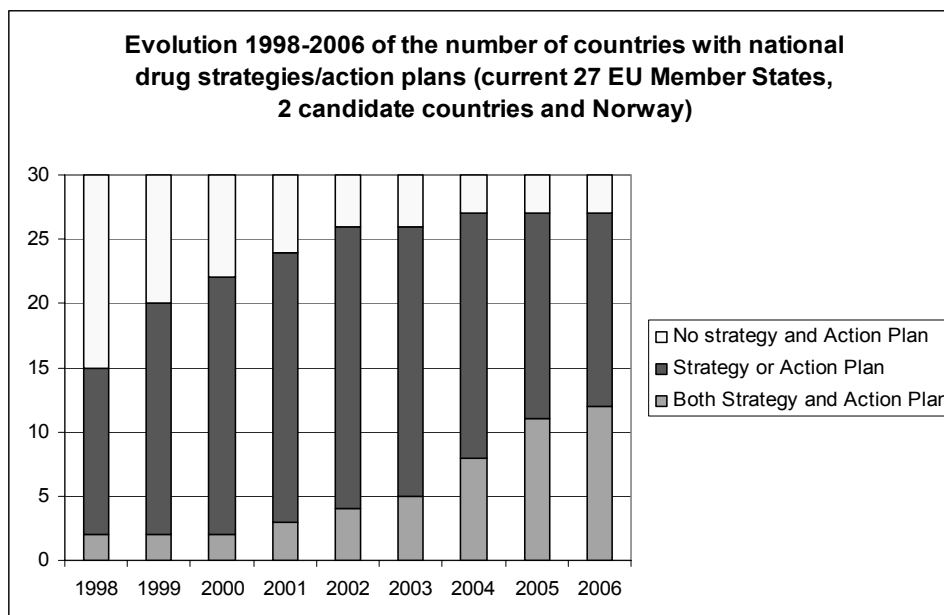
Development of drug strategies and coordination mechanisms in the European Union

Implementation of national drug strategies and action plans

Among the 30 countries currently monitored by the EMCDDA (27 EU Member States, Croatia, Turkey and Norway), half of them already had a national drug strategy and/or a national drug action plan in 1998. Eight years later this proportion reached nine out of ten, and, among the three countries which had no drug strategy

³ These part numbers refer to the original structure of the request made by the UNODC.

or action plan in 2006, two should be in a position to adopt one before the end of 2007, and one last Member State could also develop one in the very near future. It is therefore possible that all or almost all of the 30 countries will have a national drug strategy and/or a national drug action plan at the end of 2008.



Beyond quantitative changes with regard to the number of countries with a national drug strategy/action plan, there have also been qualitative changes in this area. For example, the number of countries adopting both a national drug strategy and an action plan, to better define the overall approach and goals on the one hand and the more operational objectives and responsibilities on the other, has increased from only two in 1998 to 12 in 2006 – and this number is likely to grow by the end of 2008.

This increase in number and these qualitative developments in national drug strategies/action plans reflect a similar phenomenon going on at EU level. In 1995, the EU adopted an action plan on drugs for the period 1995-1999 which was then followed in 2000 by both a drug strategy and an action plan. The EU also encouraged Member States, and especially new Member States, to adopt national drug strategies and action plans. This is again the case with the latest EU drug strategy (2005-2012) and action plan (2005-2008) which both promote the adoption of national drug strategies by EU Member States and candidate countries.

Establishment of central coordination entities for implementing national drug strategies or action plans

Given the limited historical data in this field, it is not possible to provide a full overview of the establishment of central coordination entities for implementing national drug strategies and action plans in the EU, candidate countries and Norway. However, two ad hoc data collection rounds made by the EMCDDA in 2002 and 2006 provide a useful basis for identifying some of the changes.

In 2002,⁴ all 15 EU Member States and Norway had appointed a specific national coordination unit for the implementation of their drug policy. The vast majority of these units already existed in 1998.

In 2006, the situation observed among the current 27 EU Member States and Norway was the same: all countries had at least one national coordination unit or body in the drugs field which coordinated fully or partially the implementation of the national drug strategy/action plan. In most cases, the drug coordination mechanisms had the following three levels:

1. An **inter-ministerial board**, commission, committee, council or coordination group on drugs which defines the general framework of the drug policy and adopts the national strategies and action plans. Usually this body includes all Ministers concerned by drug-related matters. Experts and regional authorities are also sometimes members of these bodies.
2. An **operative** body which can be the secretariat of the inter-ministerial body, a national drug coordinator, a national drug agency or drug strategy team and/or a department in a given ministry (usually the Ministry of Health). These bodies perform the day-to-day coordination in the drug policy field and oversee the implementation and monitoring of the drug strategies and action plans.
3. **Regional** and/or municipal bodies which coordinate at local level. These bodies may be set up by local or national authorities, depending on who has responsibility for implementing drug-related measures. Their task is to coordinate the implementation of drug-related interventions.

Such sophisticated drug coordination mechanisms reflect a qualitative improvement in European drug policies as the refinement and extension of drug coordination mechanisms should allow national drug strategies/action plans to be better implemented and assessed.

The European Union has played an important role in enabling and promoting coordination and cooperation among Member States, in particular through the Horizontal Drugs Group (HDG) which was set up in 1997. Coordination is also promoted in the current EU drugs action plan 2005-2008, where objective 2 is to have 'effective coordination both at EU and at national level'.

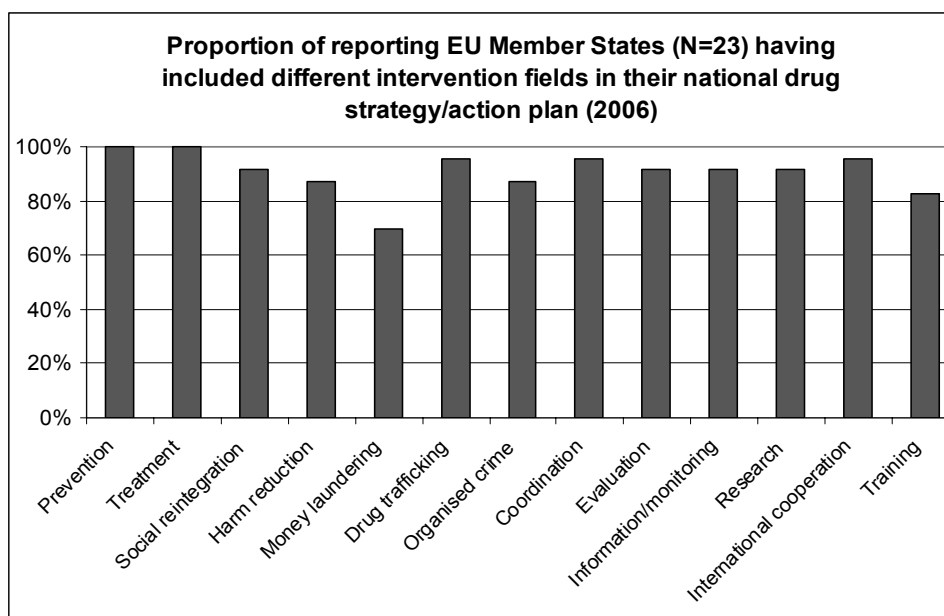
⁴ EMCDDA (2002), Strategies and coordination in the field of drugs in the European Union: a descriptive review (<http://www.emcdda.europa.eu/index.cfm?fuseaction=public.AttachmentDownload&nNodeID=1355>).

Multi-sectoral nature of national drug strategies and action plans

Again it is not possible to have a full historical overview of the multi-sectoral dimension of national drug strategies and action plans in the EU because no systematic monitoring of this dimension was in place in the 1990s. However, ad hoc data collection rounds made by the EMCDDA in 2002 and 2006 can help to understand the current situation and the main developments.

In 2002, a study covering the 15 EU Member States and Norway showed that the national drug strategies and action plans adopted in the 1990s or early years of 2000 were already comprehensive, covering both drug demand and drug supply reduction. Another common feature of these strategies was that they all included a large number of intervention fields (prevention, treatment, harm reduction, law enforcement, training, etc.).

The 2006 data collection exercise confirmed the observations made in 2002, but this time for all 27 current EU Member States and Norway. The number of intervention fields covered by national drug strategies/action plans also remained extensive as can be seen in the graph below. With the exception of money laundering, all domains were mentioned in more than 80% of national drug strategies/action plans.



The EU has actively promoted a comprehensive, balanced and multidisciplinary approach in the drugs field. The third general aim of the EU drug strategy 2000-2004 was ‘to continue the EU global, multidisciplinary, integrated and balanced strategy, in which supply and demand reduction are seen as mutually reinforcing elements, as underlined by the UNGASS’, while objective 1 of the EU drugs action plan 2005-2008 is to ‘ensure a balanced and multidisciplinary approach’, which is also one of the features of the current EU drug strategy and action plan.

Main sectors represented in the national drug strategy or action plan (health, social programmes, education, law enforcement, justice and employment)

There is no systematic monitoring of the governmental sectors represented or involved in defining national drug strategies/action plans. However, nowadays, all or almost all of the sectors mentioned above (health, social programmes, education, law enforcement, justice and employment) directly or indirectly participate in the national drug strategies and action plans adopted in EU Member States, candidate countries and Norway. These governmental sectors are also represented in the inter-ministerial drug coordination bodies which can be found in most countries monitored by the EMCDDA.

Comprehensive, balanced and multidisciplinary strategies have been implemented in the EU since the 1990s but their scope and domains have increasingly enlarged during the last decade which could also signify that more governmental sectors are involved in national drug policies.

**Part 8 – Demand reduction
Development of drug demand reduction activities in the European Union**

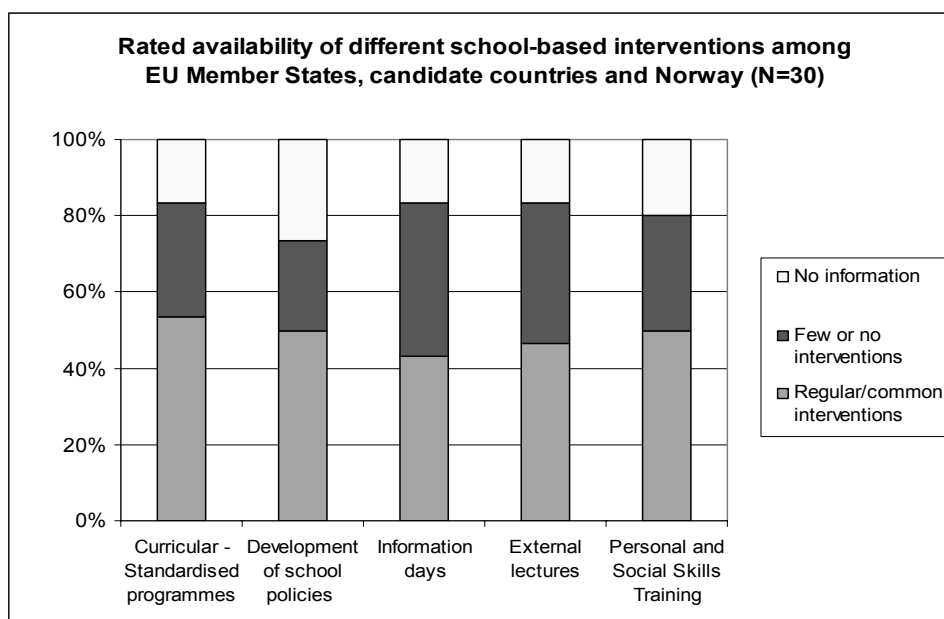
Part A – Extent of responses

Prevention

Prevention has always been part of all national drug strategies/action plans in the EU, candidate countries and Norway, and it is generally presented as one of the first priorities to reduce drug-related problems in Europe. However, several problems encountered in the collection of comparable and reliable data make it difficult to present a quantitative evolution of prevention programmes in Europe since the late 1990s. The EMCDDA has nevertheless recorded the main changes in this field and they are presented below.

School-based universal prevention

Currently, school-based universal prevention exists in all 30 countries monitored by the EMCDDA and already existed among the EU-15 Member States in the late 1990s. There are, however, different types of school-based universal prevention implemented in Europe.



Curricular-standardised programmes, for which more evidence is available, are now reported to be available in most European countries. This reflects an increased level of concern about the effectiveness of school-based prevention which has triggered the development of quality assurance and evaluation mechanisms and the introduction of such standardised programmes. Another qualitative change has been the improvement in programme content with a growing emphasis on social influence instead of information and awareness raising. Nevertheless, ineffective approaches such as one-off events based on information provision are still applied. Finally, the monitoring of prevention activities has also increased and some countries now have systematic data collection systems to monitor the quantity and quality of school-based universal prevention.

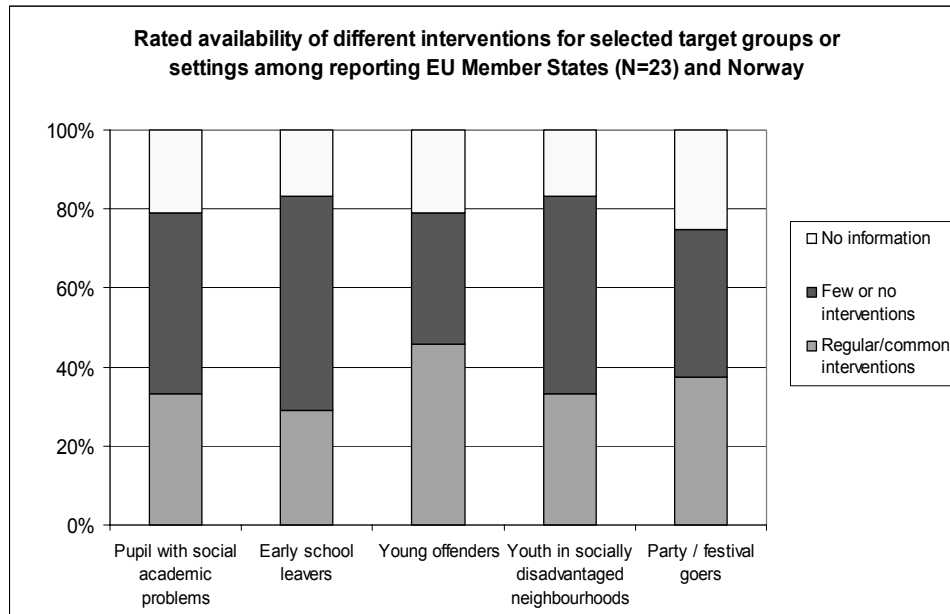
Community-based universal prevention

Community-based universal prevention has followed a similar pattern with qualitative improvements and some changes in the type of interventions provided. Currently, municipal drug plans and mobile youth teams are the most reported interventions among EU Member States. Most of the time, these interventions are not specific to illegal drugs and they also address the use of alcohol and tobacco. Environmental strategies, focusing on the availability and social acceptability of the use of legal and illegal substances, are another type of approach currently developing in the EU. Over the past decade, the most visible changes in community-located prevention can be seen in the Nordic countries, the UK and Ireland.

Selective prevention

Selective prevention interventions targeting different at-risk groups or settings have become common in Europe over the last decade and nowadays they complement universal prevention interventions in most reporting countries. The most visible re-orientation towards selective prevention and vulnerable groups can be seen among

new Member States. Pupils with academic problems and school drop-outs, young offenders and young people living in socially disadvantaged neighbourhoods are the most frequently targeted groups. The recreational nightlife setting is the most often targeted setting in selective prevention in Europe.



Qualitative changes, similar to those in universal prevention, can also be observed with selective prevention. Quality standards, evaluations and monitoring systems all progressively improved over the last decade.

Treatment and rehabilitation

Treatment is part of all national drug strategies/action plans in the EU, while social rehabilitation is reported to be included in more than nine out of ten.

Most drug treatment in the EU, candidate countries and Norway is focused on opioid dependence, takes place in outpatient settings and is provided through specialized centres or by general practitioners, psychiatrists or other health professionals. Inpatient treatment is also available in all monitored countries and is provided in therapeutic communities, psychiatric hospitals or other similar structures.

Drug-free treatment

Drug-free inpatient and outpatient treatment exists in all Member States. In 2005, six countries reported that it was the main type of treatment for opioid dependence.

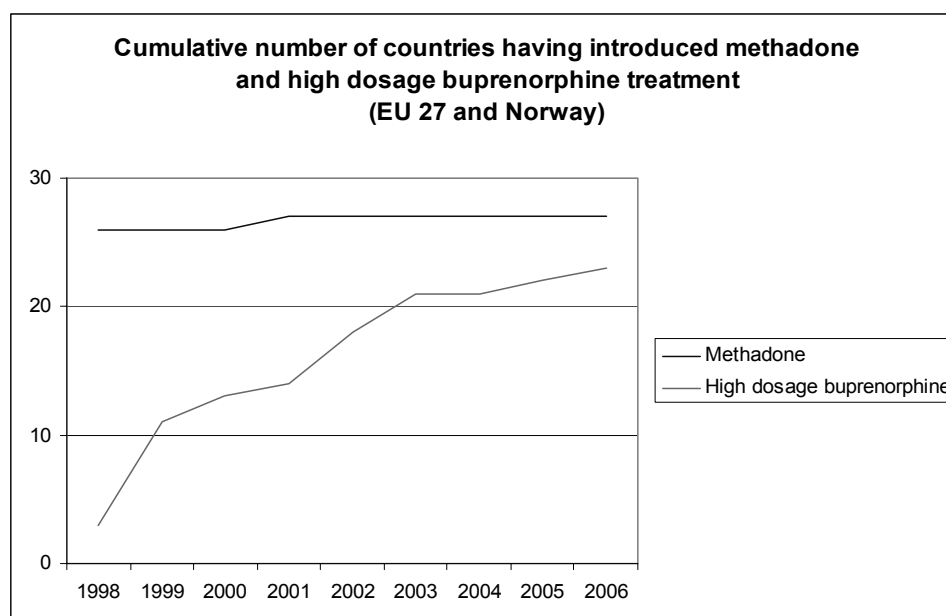
In outpatient care traditional psychotherapeutic treatment modalities (psychodynamic, cognitive-behavioural, systemic/family therapy or Gestalt therapy) and 'supportive' methods (which can include counselling, socio-educative and environmental therapy, motivational interviewing or relaxation techniques and acupuncture) are applied, and Member States differ according to the type or combination of methods used. All these different methods can also be found in

outpatient substitution treatment (see below). In inpatient care, the 12-step Minnesota model is used in a few countries, while the others apply psychotherapeutic treatment modalities and/or 'supportive' methods.

Substitution treatment

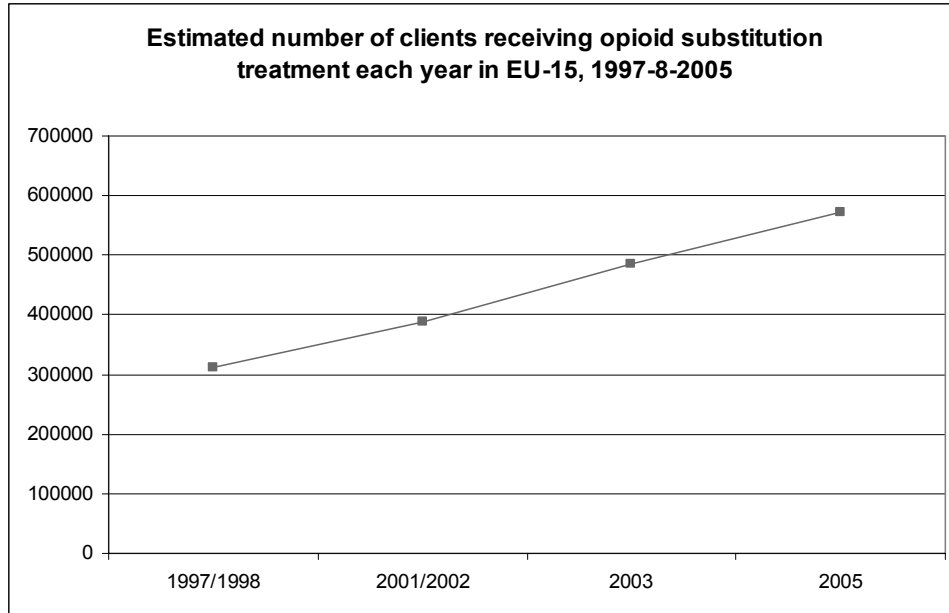
Opioid substitution treatment is the most frequent treatment modality for problem heroin users in Europe. Methadone was first introduced in the late sixties, has been available in a majority of countries since 1993 and in almost all current 27 Member States and Norway in 1998. During the timeframe of the UNGASS action plan, one more country has introduced methadone and, in 2006, there was only one Member State in which it was still not available but likely to be introduced before 2008. In general, methadone treatment is based around specialist outpatient centres, but in some countries it may also be delivered in general practice settings or, when patients have been stabilised, in community-based care settings. Methadone dispensing practice varies; sometimes it is only available from specialist centres and consumption is supervised, but in some countries pharmacies also play an important role, and take-home prescriptions are allowed.

The availability of high dosage buprenorphine treatment, often as an alternative to methadone treatment, has increased in recent years. In 1998, it was available in only three out of 28 countries but in 2006, it was available in 23 countries. Other substitution treatments (Codeine, Morphine, Diamorphin) for heroin and other opioid problem drug users have also been introduced over the last decade, although on a much smaller scale.



The number of opioid users receiving substitution treatment has grown rapidly since 1998 and is likely to have more than doubled in 2008. In 2005, over 585,000 opioid users received drug substitution treatment in the EU, the vast majority of cases reported from the EU-15 Member States as the provision of

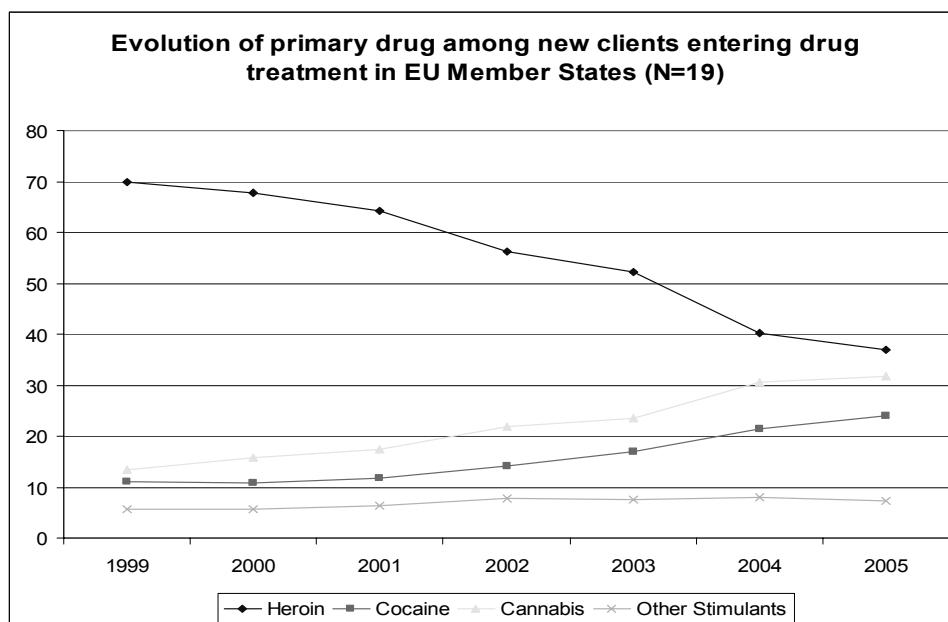
substitution treatment remains low in most new central European and eastern European Member States. Overall, it is estimated that between 34% and 45% of problem opioid users in the EU are in substitution treatment. However, data from a number of individual EU countries – where recent estimates of the prevalence of problem opioid use are available – show that the current coverage of substitution treatment varies significantly with rates from 5% to about 50% of problem opioid users receiving such treatment.



The substance predominantly used for substitution treatment is methadone (72% of all treatment), but the use of buprenorphine has rapidly increased over the past few years, especially among clients treated by doctors based in the community.

Specialized treatment for cannabis, amphetamine or cocaine dependence

The majority of drug users in treatment in Europe are problem opioid users but there has been an increase of new clients entering treatment reporting cannabis and cocaine as their primary drug.



This evolution has encouraged the development of new services. In 2005, facilities that specialize in the treatment of cannabis or cocaine users have been reported from 13 and seven countries, respectively. General availability and accessibility of such services were however still considered to be low in most countries. Specialized programmes for amphetamine users were reported from three Member States.

Social rehabilitation

In 2005, 22 out of 24 reporting Member States mentioned that social rehabilitation programmes (including housing and/or education and/or employment and/or training) for problem drug users were available. The extent of availability of these programmes was however never rated as being 'very good', and half of the reporting Member States considered it as 'reasonable' while one third of them judged the general availability of such social reintegration services as 'low'.

Reducing negative health and social consequences of drug abuse

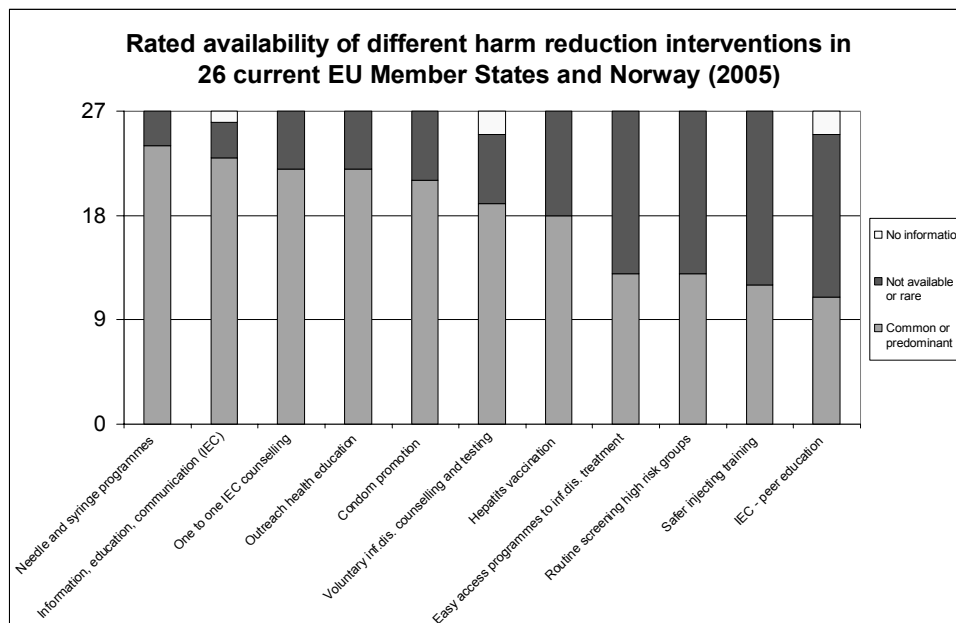
Harm reduction is now reported to be part of more than eight out of ten national drug strategies/action plans of EU Member States. The introduction and increase of harm reduction services was an important trend in Europe over the last decade. More recently, this development is reflected in the 'EU Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence' which recommended the development of strategies, services and facilities, and evaluation mechanisms in this field. This was followed in 2006 by an assessment of the harm reduction activities in the EU.⁵

⁵ Van der Gouwe, D. et al. (2006) Prevention and reduction of health-related harm associated with drug dependence: An inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2003. Utrecht: Trimbos Institute.

The last decade has also seen a consensus emerging at EU level on the key elements for an effective response to infectious diseases among injecting drug users: access to adequate drug treatment, especially substitution treatment; needle and syringe programmes; information and distribution of prevention material; education, including peer education, on how to reduce risks; voluntary counselling and testing of infectious diseases; vaccination and treatment of infectious diseases.

Needle and syringe programmes

Before 1998, 25 EU Member States and Norway had introduced needle and syringe programmes (NSPs), while one EU Member State has introduced it in 2000 and one has not yet implemented such a programme. In 2005, NSPs were identified as a common or predominantly available measure to reduce the spread of infectious disease among drug injectors in almost all EU countries and Norway.



The amount of sterile injecting material distributed through NSPs varies greatly between countries. However, a growing number of countries have nationwide networks of NSPs with a hundred or more needle and syringe provision points, while some countries consider pharmacy sales as largely sufficient.

In general, syringe provision outlets are located in specialized drugs agencies and are complemented by mobile outreach services. Syringe vending machines can also be found in ten countries. Three countries offer needle and syringe exchange in at least one prison.

Syringe exchange through pharmacies can considerably improve the geographical availability of syringes and complement provision by specialist drug agencies. Formally organised pharmacy-based syringe exchange or distribution schemes are reported in eight European countries.

The coverage of the need for sterile injection material is still very difficult to establish because data on prevalence and patterns of injecting drug use are still limited. Some available data show however that important differences in terms of coverage exist between EU Member States.

Reducing drug-related death

Member States, especially those with older heroin epidemics, have increasingly stepped up their level of provision of drug treatment over the past years and are now reaching an increasing number of hard-to-reach problem drug users (see also the section on treatment). Several countries have lowered accessibility thresholds to drug maintenance treatment, and changes in philosophy towards expediting entry and re-enrolling in methadone maintenance treatment (measures which have been shown to increase survival) have occurred.

Some experimental work has looked at the possibility of providing opioid antagonists such as Naloxone to drug users, their families and friends. This approach has not been widely developed in Europe to date. The availability of opioid antagonists in ambulances, treatment facilities or other settings where emergencies due to drug overdoses are likely to be encountered is a more common approach, though not universal.

Other overdose prevention approaches include teaching drug users the recovery position and how to respond better to emergency situations, as well as working with the police, ambulance service and drug users themselves to encourage the calling of emergency medical services at an early stage in an overdose event.

Information, education and communication (IEC) techniques are used throughout Europe in initiatives that aim to reduce drug-related deaths. Several countries report that specifically developed information materials are distributed among drug users, their peers and families, or police. However, besides first aid courses for staff at drugs agencies or for drug users themselves, overdose risk assessment and counselling about risk management seems to be becoming more common in Europe. Finally, there are supervised drug consumption rooms in four EU Member States and in Norway which provide overdose prevention measures and aim to reduce other risks associated with injecting drug use.

Part B – Policy and strategic responses (national strategy, coordination, budget, evaluation)

National strategy and coordination

All EU Member States, candidate countries and Norway which have a national drug strategy/action plan have a dedicated section or a specific chapter or document on drug demand reduction. Therefore, please refer to the chapter on national drug strategies and drug coordination at the beginning of this document for further information regarding national strategic responses in drug demand reduction.

Budgets

About half of the reporting EU Member States indicate that their national drug strategy includes a budget for execution. However, this reflects many different realities including theoretical budgets, budgets which have to be negotiated yearly

or renegotiated after another given period, etc. Furthermore, the distinction between drug strategies that include a budget for execution and those that do not include one is difficult as this depends very much on the budgetary and administrative practices in the Member State.

Two data collection rounds on drug-related public expenditures showed that for the 5 EU Member States where estimates were available in both exercises, expenditure ranged from 0.04% to 0.13% of their GDP in the 1990s⁶ and from 0.07% to 0.46% of their GDP in recent years. This could reflect an overall increase in drug-related public expenditure among EU Member States during the UNGASS timeframe. In addition, as of 2005, the EC and the Member States had co-financed drug-related assistance projects in third countries to the value of over EUR 750 million.

Evaluation

Since 1998, several national drug strategies and action plans have been evaluated in the EU. Portugal, Hungary, Spain and Ireland are examples of countries that have invested efforts in this area. However, the main trend in recent years has been the development of follow-up mechanisms – mostly annual progress reports and final overviews – of the implementation of national drug strategies and action plans. Currently, about half of the countries that have a drug strategy/action plan have foreseen an evaluation or follow-up mechanism to analyse and improve its implementation.

The EU has included an evaluation mechanism in its current action plan on drugs (2005-2008). Annual implementation progress reports as well as a final impact evaluation are carried out by the European Commission.

Part C – Drug abuse data collection systems

The EMCDDA coordinates a network of National Focal Points (NFPs) which together form Reitox, the European Information Network on Drugs and Drug Addiction. The Reitox network acts as a practical instrument for the collection and exchange of data and information. One important step since 1998 has been the setting up of National Focal Points in the countries which joined the EU in 2004 and 2007, as well as in the two current candidate countries. Twinning projects and other types of support have enabled capacities and structures in drug monitoring to be developed in fourteen countries.

The EMCDDA develops and recommends new methods and instruments in order to collect and analyse harmonised, good quality data at European level. The EU action plan on drugs (2005–2008) calls for Member States to provide reliable and comparable information on five key epidemiological indicators according to the EMCDDA's recommended technical tools and guidelines. The EMCDDA's five key indicators are:

- prevalence and patterns of drug use among the general population (population surveys);

⁶ Kopp P., Fenoglio P.(2003), Public spending on drugs in the European Union during the 1990s, EMCDDA (<http://www.emcdda.europa.eu/index.cfm?fuseaction=public.AttachmentDownload&nNodeID=1362&slanguageISO=EN>).

- prevalence and patterns of problem drug use (statistical prevalence/incidence estimates and surveys among drug users);
- drug-related infectious diseases (prevalence and incidence rates of HIV, hepatitis B and C in injecting drug users);
- drug-related deaths and mortality of drug users (general population mortality special registers statistics, and mortality cohort studies among drug users);
- demand for drug treatment (statistics from drug treatment centres on clients starting treatment).

NFPs report annually on these indicators through the use of standard tables. Data are also presented in national reports provided every year by the NFPs which give an overview of the most recent information on the drug situation in each country. Data on responses to drug problems (prevention, treatment, harm reduction, etc.) are collected through structured questionnaires and sometimes through standard tables if quantitative information is available. The frequency of data collection in the responses field is 2–4 years depending on the indicator and instrument.

Every year, the EMCDDA carries out an evaluation exercise and quality feedbacks on reports and data provided by the NFPs. Individual feedback is sent to countries for quality improvement of the report. In 2006, a project was launched to: standardise and rationalise key indicator (KI) guidelines, training material and reporting tools; develop a new KI resource area on the EMCDDA website; and, for the first time, explicitly identify minimum implementation targets. By the beginning of 2008, this project will not only facilitate work to improve the implementation of the indicators but will also allow policy makers to have a clear perspective of the measures necessary to achieve the goal of the action plan in this area.

Part D – Programmes for specific at-risk population groups

As already mentioned, selective prevention interventions became common in Europe over the last decade, including among new Member States. Pupils with academic problems and school drop-outs, young offenders and young people living in socially disadvantaged neighbourhoods are the most frequently targeted groups, while the recreational nightlife setting is the most often targeted setting in selective prevention in Europe.

Specialized treatment and sometimes specialized treatment services for cannabis and for cocaine users have been developed in several European countries in recent years. Treatment units or programmes that exclusively service one specified target group are also increasingly reported by Member States, but they are generally not numerous. Children and young people under the age of 18 can be treated in specialized agencies in 22 countries; the treatment of drug users with psychiatric comorbidity takes place in specialized agencies in 17 countries; and women-specific services are reported to exist in all countries except three. Services designed to meet the needs of immigrant drug users or of groups with specific language requirements or religious or cultural backgrounds are less common, but have been reported from one third of the Member States. Harm reduction services and interventions targeting specific groups (crack cocaine users, partygoers, etc.) have also been developed in several countries in recent years.

Part E – Media/public information campaigns

The EMCDDA does not systematically monitor media and public information campaigns but some information is provided by EU Member States. This information indicates that there does not seem to have been a change in the number and diversity of media and information campaigns over the last decade. In particular, it can be observed that this type of intervention is not used on a regular basis and that countries use it occasionally and sometimes with long delays between two campaigns. One increasingly common feature is the external evaluation of the impact of these campaigns.

Part F – National training schemes for planners and practitioners involved in service delivery

More than eight out of ten reporting countries mention that training is part of their national drug strategy. Training schemes for professionals working in the fields of prevention, treatment and harm reduction exist in several Member States, but it is not possible to assess if there was a quantitative or qualitative change in this field since 1998.

Part G – Participation in international coordinating mechanisms

The European Commission is best placed to report on participation in international coordinating mechanisms and this topic is therefore not covered in this document.
