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**REPORT OF THE FINAL EVALUATION OF THE EU DRUGS ACTION PLAN
(2005-2008)**

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INTRODUCTION

Institutional background

The EU Member States are the main actors in the drugs field, and drug legislation is primarily a matter of national competence. However, the Treaties explicitly acknowledge the need to deal with drug issues at EU level, in particular in the fields of justice and home affairs¹ and public health².

Community competences include the control of the trade in drug precursors³ and the prevention of money laundering⁴. In the field of drug trafficking, a *Council Framework Decision laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking*⁵ has been adopted, while the *Council Decision on the information exchange, risk assessment and control of new psychoactive substances*⁶ provides the EU with an instrument to act on new drugs emerging in the market. The Community role in many fields such as research, social policy, education and youth also covers drug-related actions, even if not specifically mentioned in the Treaty.

The EU framework for drug policy goes back to the early 1990s. A first European plan to combat drugs was adopted by the European Council in 1990⁷. The importance of European-level cooperation to tackle drug dependence was reflected in a 1994 Communication from the Commission.⁸ The creation of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in 1993 and the Drugs Unit of Europol in 1994 was a further strong sign of the importance and added value of drug policy at European level.

A first EU Drugs Strategy (1995-1999) was adopted in 1995⁹ to promote enhanced cooperation between Member States with the aim of reducing both the demand for and supply of drugs towards and within the EU. The EU Drugs Strategy (2000-2004) and the

¹ Title VI, Articles 29 and 31(1)(e), TEU.

² Article 152 TEC: 'The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.'

³ Community Drug Precursor Legislation: Regulation (EC) No 273/2004 of the European Parliament and of the Council of 11 February 2004 on drug precursors (OJ L 47, 18.2.2004, p. 1), Council Regulation (EC) No 111/2005 of 22 December 2004 laying down rules for the monitoring of trade between the Community and third countries in drug precursors (OJ L22, 26.1.2005, p. 1). Commission Regulation (EC) No 1277/2005 of 27 July 2005 laying down implementing rules for Regulation (EC) No 273/2004 of the European Parliament and of the Council on drug precursors and for Council Regulation (EC) No 111/2005 laying down rules for the monitoring of trade between the Community and third countries (OJ L 202, 3.8.2005, p. 7).

⁴ 2005/60/EC — Directive of the European Parliament and of the Council on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing, 26.10.2005.

⁵ 2004/757/JHA.

⁶ 2005/387/JHA.

⁷ 10234/1/90, 10.12.1990; adopted by the European Council in Rome on 13 & 14 December 1990.

⁸ COM (1994) 223 final; 21.6.1994.

⁹ 9012/99 CORDROGUE 33.

EU Action Plan on Drugs (2000-2004)¹⁰ introduced new possibilities for cooperation at EU level.

In December 2004, the European Council endorsed the European Drugs Strategy (2005-2012)¹¹, which set the framework, objectives and priorities for two consecutive four-year Drugs Action Plans to be brought forward by the Commission. The Strategy was an integral part of the multi-annual programme *'The Hague Programme for strengthening freedom, security and justice in the EU'*¹². It is based first and foremost on the fundamental principles of EU law and 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 ensure for the general public a high level of security and to take a balanced, integrated approach to the drugs problem.

The EU Drugs Strategy (2005-2012) sets out two general aims:

- (1) The EU aims at a contribution to the attainment of a high level of health protection, well-being and social cohesion by complementing Member States' action in preventing and reducing drug use, dependence and drug-related harms to health and society.
- (2) The EU and its Member States aim to ensure a high level of security for the general public by taking action against drug production, cross-border trafficking in drugs and diversion of precursors, and by intensifying preventive action against drug-related crime, through effective cooperation embedded in a joint approach.

The Strategy sets the framework, objectives and priorities for all drug-related activities in the EU in the shape of **two consecutive four-year Drugs Action Plans to be brought forward by the Commission**. The first of these Action Plans, the EU Action Plan on Drugs (2005-2008), was endorsed by the Council on 8 July 2005¹³. The Action Plans aim to translate the broad objectives and priorities of the Strategy into specific actions with objectively verifiable indicators to measure progress.

The Strategy also specifies that *'the evaluation of the Strategy and the Action Plans on Drugs will be conducted by the Commission, in cooperation with the EMCDDA, Europol and the Member States'*. The EU Drugs Action Plan 2005-2008 calls upon the Commission to organise an impact assessment with a view to proposing a new EU Drugs Action Plan for (2009-2012)¹⁴.

¹⁰ 12555/3/99 CORDROGUE 64; 9283/00 CORDROGUE 3.

¹¹ CORDROGUE 77, 22.11.2004.

¹² COM(2005) 184 final, 10.5.2005.

¹³ OJ C 168, 8.7.2005.

¹⁴ OJ C168, 8.7.2005: Action 45.3; Note: the term 'impact assessment' in this context should be read as an ex-post evaluation of the implementation of the current EU Action Plan on Drugs (2005-2008), and as such is different from the technical term 'Impact Assessment' as used in the Commission's policy-making process.

The EU Drugs Strategy (2005-2012) and EU Drugs Action Plan (2005-2008) were drafted under the current legal framework provided by the EU and EC Treaties and based on the respective competences of the Union, Community and individual Member States, with due regard to subsidiarity and proportionality

The EU Drugs Action Plan (2005-2008)

The EU Drugs Strategy (2005-2012) and its two consecutive Action Plans have been developed around the two main dimensions of drug policy, *drug demand reduction* and *drug supply reduction*. These two ‘pillars’ are complemented by three cross-cutting themes, *coordination*, *international cooperation* and *information, research and evaluation*. The Drugs Strategy and Action Plans have been designed in the form of a ‘logical framework’ identifying the Strategy’s objectives and priorities and the Action Plan objectives and actions.

As the first Action Plan to implement the objectives and priorities of the EU Drugs Strategy (2005-2008) in practice, the EU Drugs Action Plan (2005-2008) is the most detailed in this field to date at EU level, covering the full range of EU drugs policy and unanimously endorsed by the Council, reflecting the broad consensus between Member States on this issue.

The Action Plan proposes policy action at national, EU and international level and asks for the commitment of the 27 Member States to work more closely together, to share information and best practices, to jointly promote the EU model in drugs policy and to base drugs policy on scientific facts and evidence.

Table 1 provides a global overview of the structure and key objectives of the EU Drugs Action Plan (2005-2008). The EU Drugs Strategy (2005-2008), as an overarching and balanced coordination document for EU drugs policy, reflecting the concerns and priorities of the 27 Member States and the consensus between them, has translated into a large number of objectives (46) and actions (86) in the Action Plan. In addition, the international dimension of the drug problem is involving more and more regions in the world, as trafficking routes and the related organised criminal activity proliferate. The complexity of the health, social and security problems resulting from this development continues to pose challenges to the EU if it is to tackle the drug issue in a unified and coherent manner.

Table 1— Schematic overview of objectives in the EU Drugs Action Plan (2005-2008)

Coordination	
<ul style="list-style-type: none"> • MS adopting national strategies and action plans in line with the EU Drug Strategy/ Action Plan to ensure the integrated, balanced approach in drug policy <ul style="list-style-type: none"> • Coordination at national and EU level • Strengthen involvement of civil society • Effective coordination in the Council • Systematic mainstreaming of drugs policy in relations and agreements with 3rd countries 	
Drug demand reduction	Drug supply reduction & security
<ul style="list-style-type: none"> • Encouraging improvement of coverage of, access to and effectiveness of demand reduction measures in Member States • Encouraging implementation of prevention in Member States (<i>universal, selective, indicative, early detection</i>) • Encouraging improvement and implementation of treatment and rehabilitation in Member States (<i>early intervention, brief treatment, long-term treatment, etc.</i>) • Encouraging development of alternatives to imprisonment and of drug services in prisons in Member States • Encouraging implementation of harm reduction in Member States (<i>reducing drug related deaths, drug-related infectious diseases</i>) 	<ul style="list-style-type: none"> • Improve law enforcement cooperation between Member States, Europol, Eurojust, third countries and international organisations • Reducing production and cross border trafficking of heroin, cocaine and cannabis • Reducing the manufacture and supply of synthetic drugs (ATS) • Combat serious criminal activity in chemical precursors diversion and smuggling through law enforcement cooperation between Member States, Europol, Eurojust, third countries and international organisations • Preventing the diversion of precursors, in particular synthetic precursors imported to EU • Reducing money laundering & increasing the seizure of accumulated assets in relation to drug crime • Exploring links between drug production and trafficking and the financing of terrorism • Improving the prevention of drug-related crime and developments of new methods and best practices to curtail it • Increasing training for law enforcement agencies
International cooperation	
	<ul style="list-style-type: none"> • Intensify law enforcement efforts directed at non-EU countries, especially producer countries and regions along trafficking routes
<ul style="list-style-type: none"> • Adopting EU common positions on drugs in international for a, including on UNGASS <ul style="list-style-type: none"> • Articulation and promotion of the EU approach on drugs • Bringing forward joint EU resolutions and co-sponsor others • Support the candidate and stabilisation and association process countries • Enable candidate countries to participate in the work of EMCDDA, Europol and Eurojust <ul style="list-style-type: none"> • Assist European neighbours • Improve the coherence, visibility and efficiency of the assistance to candidate and 3rd countries/ regions • Ensure that drugs concerns are taken on board in priority setting of EU versus 3rd countries/ regions and continue and develop an active engagement with them • Improve the coherence, visibility and efficiency of assistance to candidate and 3rd countries/ regions 	
Information, evaluation and research	
<ul style="list-style-type: none"> • Provide reliable and comparable data on key epidemiological indicators 	<ul style="list-style-type: none"> • Follow up of the mutual evaluation of drug law enforcement systems in the Member States
<ul style="list-style-type: none"> • Provide reliable information on the drug situation (incl. EMCDDA) • Develop clear information on emerging trends and patterns of drug use and drug markets <ul style="list-style-type: none"> • Produce estimates on public expenditures on drug issues <ul style="list-style-type: none"> • Promote research in the field of drugs • Create networks of excellence in research • Continuous and overall evaluation 	

Aims and methodology of the evaluation

Introduction

The Strategy and the EU Drugs Action Plan (2005-2008)¹⁵ call upon the Commission to draw up annual progress reviews on the implementation of the Action Plan for consideration by the Council. The objective of these reviews is not only to report on progress but also to deal with identified gaps and possible new challenges, should any significant changes in the EU Drugs situation emerge during the implementation of the Action Plans.

To date, the Commission has published annual progress reviews of the EU Drugs Action Plan (2005-2008) for the years 2006¹⁶ and 2007¹⁷. These reviews showed progress in the vast majority of actions implemented in these years, but some structural problems emerged that will influence the outcome of the final evaluation of the current Drugs Action Plan.

The 2006 progress review¹⁸ concluded — among other things — that coordination could be improved between public health and law enforcement. Furthermore, in the field of monitoring, progress in the field of supply reduction and implementation at national level proved difficult to assess. The Commission also proposed a number of amendments to the existing indicators and assessment tools in the Action Plan. Based on the 2007 progress review¹⁹, the Commission concluded that progress was being made across the board in the Action Plan, but that the assessment of actual impacts on Member State policies and — indirectly — on the drugs situation in the EU was proving difficult. Again, the Commission pointed out that there was a structural lack of reliable and comparable data and information at EU level, in the supply reduction field in particular.

The Commission is responsible for conducting the final evaluation of the EU Drugs Action Plan (2005-2008). In order to improve the quality and scope of the work, an independent consultant²⁰ was asked in 2007 to advice on developing a methodology for evaluation. As part of this task, the consultant also conducted an analysis of the extent to which the current Action Plan on Drugs can in fact be evaluated. Overall, the consultant concluded that a one-on-one impact assessment of the Action Plan on the drugs situation in Europe was not feasible due to a variety of reasons, some of which are explained in the following sections.

Scope of the evaluation

This final evaluation of the EU Drugs Action Plan (2005-2008) is the most extensive assessment of the implementation of EU drug policy so far. As such, it is also the most extensive drug policy evaluation conducted in the global drug field, actively involving 27 countries representing 490 million citizens.

¹⁵ Action 45.2.

¹⁶ SEC (2006) 1803, 21.12.06.

¹⁷ COM (2007) 781 final, 11.12.07; SEC (2007) 1739, 18.12.2007

¹⁸ SEC (2006) 1803, 21.12.06.

¹⁹ COM (2007) 781 final, 11.12.07; SEC (2007) 1739, 18.12.2007

²⁰ GHK Consultants International, London, UK.

It builds on the experiences gained through the evaluation of the EU Drugs Strategy and Action Plan on Drugs for (2000-2004)²¹, which was the first time that such an evaluation exercise had been undertaken in the drugs field at EU level. Some of the key recommendations of the 2004 evaluation for the next EU Drugs Strategy and Action Plans included:

- Clear and precise objectives and priorities need to be set that can be translated into operational indicators and actions in future Action Plans, with clearly defined responsibilities and deadlines for their implementation;
- Continued progress should be made in the availability, quality and comparability of information on monitoring the drugs situation;
- The primary focus of the work of the Horizontal Working Party on Drugs (HDG) should be on moving forward with monitoring of the implementation of the actions set out in the future EU Action Plan on Drugs and on playing a leading role in coordinating the work of the other Council groups on drugs issues.

This evaluation aims to go a step further in assessing the implementation of the activities set out in the Action Plan and the achievement of the Action Plan's objectives, which in turn are related to the overall priorities of the EU Drugs Strategy (2005-2012). Because the Action Plan objectives and actions have all been assigned indicators / assessment tools, responsible parties and deadlines, more data and information on the drug situation and the responses to it are available in the EU today, even though this mainly concerns the field of drug demand reduction.

At the same time, the complexity of evaluating the Action Plan has increased. Since 2004, the EU has expanded from 15 to 27 Member States, resulting in the need to collect data and information on how the new countries have implemented the objectives of the Action Plan.

Evaluation questions

The Strategy sets a clear aim for the outcome of policy efforts by 2012 in stipulating that *'by the end of 2012, progress should have been made on all the priorities in the fields defined in the Strategy. This will be achieved through interventions and actions at the level of individual Member States, groups of Member States or the EU as a whole and in cooperation with third countries and international organisations such as the Council of Europe and the United Nations'*.

Furthermore, when drafting the Strategy, the Member States agreed that its aim is to *'add value to national strategies while respecting the principles of subsidiarity and proportionality as set out in the Treaties. (...) Member States should consider the impact of their national strategies on other Member States, the ways national strategies can be*

²¹ COM (2004) 707 final, 22.10.2004

mutually supportive, and the contributions such strategies can make towards achieving the objectives of this European Union Strategy’.

The EU Action Plan on Drugs (2005-2008) is quite adamant on what should be the ultimate goal of current EU drug policy: *‘it should be clearly understood that the Strategy and Action Plan are not an end in themselves: even if all the objectives they contain are reached, we must conclude that they have failed if the result is not a measurable reduction of the drug problem in our societies. The citizens of Europe expect this. The ultimate aim of the Action Plan is to significantly reduce the prevalence of drug use among the population and to reduce the social harm and health damage caused by the use of and trade in illicit drugs’.*

Accordingly, this evaluation aims to assess the extent to which the objectives and actions of the EU Drugs Action Plan (2005-2008) have been achieved, how the Action Plan relates to the actual drug situation, and the added value it offers to drug policy in the EU as a whole.

The following evaluation questions have thus been formulated:

- (1) To what extent have the operational objectives and actions in the current EU Action Plan on Drugs been implemented and what are the main outputs?
- (2) Have the specific priorities in the Strategy and the operational objectives in the Action Plan been adopted by Member States?
- (3) What are the overall changes in the drug situation in recent years?
- (4) To what extent can these changes be linked to the implementation of the EU Action Plan on Drugs?
- (5) What is the overall EU added value of the EU Drugs Action Plan 2005-2008?
- (6) What key conclusions and lessons can be drawn from this evaluation for the next plan covering the years 2009-2012?

Methodology and data sources

In preparing for the evaluation of the EU Drugs Action Plan 2005-2008, the Commission contracted an external consultant in 2007 to help in the development of an evaluation methodology. Key elements of the consultant’s²² report have been incorporated in the final evaluation methodology used by the Commission.

As the evaluation had to be conducted under pressure of time and partly in parallel with the development of the new EU Drugs Action Plan for (2009-2012), the Commission decided in 2008 to bring in a second external contractor to act as an independent ‘critical

²² GHK Consultants International, Study in view of designing a methodology to assess the impact of the EU Action Plan on Drugs, Specific Contract No JLS/2006/A1/FWC/004-3, 24 October 2007.

friend' for the evaluation process. The contractor provided the Commission with critical reflections on the evaluation process and on draft documents.

The key evaluation tasks identified by the Commission were as follows:

- (1) Reflection on the structure of the EU Drugs Strategy (2005-2012) and the EU Drugs Action Plan (2005-2008).

This task aimed to analyse the internal consistency of the Action Plan in terms of structure, the relationship between objectives, actions, indicators and assessment tools, the clarity of formulation and an analysis of priorities across objectives. This work was mostly carried out by the first contractor mentioned above.

- (2) The EMCDDA and Europol to be asked to provide summary reports on trends in the drug situation in Europe and the responses to it.

The trend reports were necessary to identify key developments in the drug situation during the implementation of the Action Plan (2005-2008), some of which might — hypothetically — be attributed to the implementation of the Action Plan. The trend information on responses was meant to complement information from other sources.

- (3) The Commission to send out a survey to the Member States to obtain the Member States' views on the EU Drugs Action Plan (2005-2008).

The survey was sent out in March 2008 and included over 20 questions on the inclusion of objectives and actions of the Action Plan within national drug policy, Member States' views on the strengths and weaknesses of the Action Plan, and their assessment of the added value of the Plan for EU and national drug policy.

- (4) The Commission to launch a review of the implementation of each of the specific objectives and actions of the EU Drugs Action Plan (2005-2008).

This information gathering process was similar to that for the Annual Reviews, although the information requested covered the period 2005-2008 and the emphasis was on whether objectives and actions had been achieved or not (as far as respondents could make such a judgment).

- (5) Finally, assessment of intra-institutional coordination and cooperation in the implementation of the EU Drugs Action Plan (2005-2008).

This task was conducted by the 'critical friend', the external contractor that provided support and advice to the Commission throughout the evaluation process. The scope of the task was limited due to time restraints, but included a series of interviews with key Commission departments involved in the implementation of parts of the Action Plan. The purpose of the exercise was to obtain a better picture of potential coordination issues that might affect the implementation of the Action Plan. The assessment did not cover inter-institutional cooperation between the Commission and the Council.

Data sources

The data and information in this report were collected from the sources available to the European Commission.

For assessing the implementation of the objectives and actions of the EU Drugs Action Plan (2005-2008), information on progress and achievement was gathered through the relevant Commission services, the EMCDDA and Europol. All relevant Commission services were asked to report on those objectives and actions they were (co-)responsible for. Europol was asked to report on those actions relevant to its mandate and activities. The EMCDDA was asked to provide on information on those actions for which it collects information from Member States. Both the EMCDDA and Europol were also asked to contribute to reporting on key developments in the drug situation at EU and national level for which the Commission had no direct sources of information.

In order to assess the impact of the Action Plan at national level, the Commission asked the Member States to complete a survey focusing on the translation of the Action Plan objectives into national drug policy and on the perceived added value of the EU Drugs Action Plan at national and EU level.

The information provided by the EMCDDA is collected through a network of national focal points (Reitox). These data are summarised every year, together with other information, in the EMCDDA's Annual Report on the State of the Drugs Problem in Europe²³ and in a Statistical Bulletin²⁴. As this final evaluation report was prepared during the data verification phase for the EMCDDA Annual Report 2008, some of the most recent statistical data should be considered as provisional. However, although some individual items may be subject to revision, this is unlikely to influence the interpretation of overall trends at European level.

Europol information is provided by its Drugs Unit. Member State information is collected in the course of various project-related activities through the Europol Information Exchange System connecting Europol and all National Units. Each Member State has only one official data communication channel with Europol: all operational and strategic information must be delivered by working partners via their respective Europol National Units. Coordination of the information flows between Member State bodies and the Europol Drugs Unit is therefore crucial. Information on drug precursor control legislation and on seizures and stopped shipments is collected by the Member States under a Community Regulation.

Other sources also include studies and reports funded by the Commission.

Stakeholder involvement

To facilitate the involvement of the Member States and the EU institutions, agencies and structures in the evaluation process, a Steering Group was set up to advice on the evaluation methodology and the interpretation of the evaluation outcomes. The Steering Group consisted of representatives from the Member States holding the EU Presidency between the second half of 2006 and the end of 2008²⁵ and representatives of the European Parliament, Europol, the EMCDDA, EUROSTAT and the Commission. The Steering Group convened four times in 2007 and 2008. Its input enabled the Commission

²³ Available in print and online: <http://www.emcdda.europa.eu/publications/online/ar2007/en>.

²⁴ Available online: <http://www.emcdda.europa.eu/stats07/main>.

²⁵ Finland, Germany, Portugal, Slovenia and France.

to verify key evaluation questions as well as to identify potential problems and shortcomings that might emerge during the evaluation process.

The Commission also specifically asked for the input of the newly established Civil Society Forum on Drugs, which convened in December 2007 and in May 2008. The members of the Forum were asked to share their thoughts and experiences regarding the current EU Drugs Action Plan (2005-2008), which resulted in a number of important observations being taken on board in this evaluation report.

Limitations of the evaluation

Evaluating the impact of public policy plans such as the EU Drugs Action Plan (2005-2008) is by nature not a simple exercise. The Action Plan aims to coordinate and influence major areas of government intervention in the field of drugs (public health / security / external relations) at EU and Member State level, targeting a complex social phenomenon that is still insufficiently understood, that largely takes place outside the scope and control of public authorities and that requires a long-term approach.

At the same time, the policy responses to the drug problem within the Member States are heterogeneous. These responses may reinforce each other, interact with or diverge from one other (un-)intentionally, and are implemented by a broad range of different actors in each country, with specific interests and different levels of intensity and efficiency. As with other complex social problems, this environment makes the identification and evaluation of *causal relationships* between changes in the drug situation and the policy responses a complicated exercise, if not impossible.

Inconsistencies of the EU Drugs Action Plan (2005-2008)

As indicated above, one of the evaluation tasks was to analyse the internal consistency of the EU Drugs Action Plan (2005-2008). In preparing the methodology for the final evaluation, the external consultants identified the following key inconsistencies:

- The coherence of the Action Plan suffers from a large number of objectives, several of which seem to overlap with one other.
- Most objectives in the Action Plan can be categorised as ‘general’ or ‘specific’, with few operational objectives. A considerable number of general objectives are often vaguely formulated, while specific objectives are not specific enough to prevent broad interpretation of what is meant and which activities are covered.
- No clear hierarchy is provided in the Action Plan. The objectives are indirectly linked to overarching priorities in the Drugs Strategy, but these are rather broadly formulated. The priorities in the Drugs Strategy are not accompanied by output or outcome indicators.
- The links between objectives and actions in the Action Plan are sometimes problematic. Some actions restate the objective, making it difficult to identify indicators and assessment criteria.

- Some objectives and actions lack (subsidiary) actions that break down implementation into clear stages. Progress is difficult to measure in these cases.
- Regarding indicators, the Action Plan provides a mix of output, outcome and impact indicators, but, in a considerable number of cases, no indicators are provided at all but only assessment tools / data sources.

The problems identified with the internal consistency of the Action Plan may influence the implementation of specific objectives and actions or make assessment of the progress achieved difficult if not impossible.

Other limitations

A number of further challenges have been found to have a specific impact on this evaluation.

- **The Action Plan is a coordination instrument with non-binding recommendations**

The Action Plan is primarily a non-binding instrument for coordination among the Member States, which are autonomous in implementing its aims and objectives. A limited number of objectives and actions are implemented only at EU level, i.e. through Commission activities. Most objectives and actions in the Action Plan are implemented indirectly: the Action Plan aims to influence the actions of others. This indirect implementation may be effective in providing guidance for national policy level, but it does make assessment of the direct consequences of the plan more complicated.²⁶

- **The horizontal nature and broad scope of the Drugs Action Plan**

As the drugs phenomenon is a broad and complex social problem, the Drugs Action Plan tries to influence various fields of public policy simultaneously in a coherent and coordinated way. These fields are all major areas of public policy (e.g. public health) with existing systems and structures that need to be 'tempted' to take action. An in-depth ex-ante or ex-post evaluation of the actual impact of the Action Plan on any one of these policy fields would already require major resources.

- **Lack of relevant comparable and reliable data on the drug phenomenon, drug demand and drug supply reduction**

The annual progress reviews have highlighted that there is a lack of information and data to show progress for quite a few indicators in the Action Plan, while there is also little information and data available on the outcomes and impacts of the Drugs Action Plan

²⁶ The Commission is involved in the implementation of 44 of the 86 objectives and actions in the EU Drugs Action Plan 2005-2008, but directly responsible for only 8 of them. Member States are involved in the implementation of 64 of the 86 objectives and actions, but directly responsible for the implementation of 23. Responsibility for 14 of the 86 is shared between Member States and the Commission. The remaining 41 actions are the shared responsibility of the Member States, Commission, Presidency/Council, Europol, EMCDDA and a limited number of other stakeholders.

regarding the actual drug situation. The collection of data is primarily the task of the Member States. The progress reviews provide information mostly on the results of the operational objectives and actions, but much less on the outcomes of the implementation of these specific objectives and their impact on the global objectives of the Drugs Strategy. The lack of relevant data and information applies to both drug demand reduction and, in particular, drug supply reduction, but also concerns international cooperation.

The information available on the drug situation and the responses to it is still insufficient to support a detailed analysis of developments in the illicit drug market and the impact of drug policies on this market (see 3.1.5 for further details).

- **Other data limitations**

Obtaining European data depends on participating Member States having national data collection activities that conform to common reporting standards and use appropriately robust methods. Considerable progress has been made in this respect, especially regarding key epidemiological indicators. However, it is important to note that differences still remain between countries in both the availability and quality of the data. Direct comparisons between countries should therefore be made with caution, although time series data can point to general changes over time even when reporting systems are imperfect. Understanding differences in national data collection systems is a key element to understanding the European situation, and sufficient analytical capacity now exists in Europe to permit qualified statements to be made on the overall situation with some confidence. Data on drug responses are generally less standardised and assessment is more reliant on qualitative measures. Even here, however, there has been some progress and, provided sufficient caution is exercised, comments can be made on the overall situation, although any precise quantification is generally more difficult.

- **Delays in data collection**

The collection of epidemiological data on the drug situation is complex and time-consuming. The necessary compiling, reconciling and approving of national statistics and the high quality standards needed to ensure the reliability of data mean that international public health and law enforcement monitoring systems have a reporting lag. Much of the EMCDDA information on drug trends and developments is collected at national level, often compiled from local and regional data collections within Member States, resulting in a time gap between the moment of collection and the report. For this evaluation report, epidemiological data are available for the year 2006 at best. EMCDDA national reports and the narrative reports on the implementation of the EU Drugs Action Plan (2005-2008) are usually more recent, and will in most cases include information up to the end of 2007. However, trends in the drug situation generally unfold over a longer period of time.

- **Timing of this evaluation**

Finally, it is important to note the actual period of implementation of the current EU Drugs Action Plan (2005-2008). Originally, the two envisaged Action Plans implementing the Drugs Strategy were supposed to have a 3-year implementation period (2005-2007 and 2009-2011, respectively) followed by a 1-year evaluation period (2008

and 2012). Even though the current Action Plan officially covers the period from 2005 to 2008, it was adopted in mid-2005 and evaluated in the first half of 2008, resulting effectively in an evaluation of implementation in the years 2006 and 2007. As policy needs time to ‘trickle down’, the structural effects of this Action Plan might be difficult to identify. Furthermore, the time constraints accompanying this evaluation ruled out a number of potential evaluation methods, including case studies and interviews at national level.

Taking all these limitations into account, this final evaluation of the EU Action Plan on Drugs focused on the implementation of objectives and actions for which information was available and/or could be retrieved from existing sources of information, which comprised mostly self-reported information from Member States gathered through the EMCDDA’s Reitox Network of National Focal Points and the Europol National Units, collected for monitoring purposes or for investigations to support ongoing analysis. Information on the implementation of objectives and actions was also collected through the Commission services and, where information was insufficient for this evaluation, the Commission put specific queries to the Member States, among others.

Accordingly, it is not possible to assess in full the impact of the EU Drugs Action Plan 2005-2008 on the drug situation in the EU.

Structure of this report

The report is structured around the main evaluation questions identified in point 1.2. Chapter 2 provides an overview of the implementation of the objectives and actions of the EU Drugs Action Plan (2005-2008). Implementation is examined at the level of objectives, but a report on each action can be found in Annex 1.

Chapter 3 provides an answer to the question as to the extent to which Member States have translated the EU Drugs Action Plan (2005-2008) into national policy and/or if EU policy is reflected in national policy where it predated the Action Plan. Member States’ perceptions of the strengths and weaknesses of the Action Plan can be found here as well.

Chapter 4 provides a concise overview of the trends in the EU drug situation — for both drug demand and drug supply — including trends in the adverse social and health consequences of the drug problem. Where possible, a brief comparison with other countries and regions in the world is provided.

Chapter 5 briefly reflects on the important but difficult question as to what impact the Action Plan has had on the drug situation in the EU as well as what added value it has achieved. In Chapter 6, the main conclusions and recommendations for the next Action Plan are presented.

Annex 1 includes the detailed reports for each of the actions and objectives. Annex 2 contains a list of abbreviations. Annex 3 provides a glossary of the terms used in this report, while annex 4 provides references on some of the information obtained from the EMCDDA.

IMPLEMENTATION OF THE ACTION PLAN AT EU AND NATIONAL LEVEL

Introduction

As an overall coordinating plan, the Action Plan does not have instruments to directly influence the policy decisions of Member States. At EU level, the Commission has competence in the field of precursor legislation and in the area of international cooperation and external relations. The information presented in this chapter is obtained from several sources, including the European Commission, Europol and the EMCDDA but also the Member States directly. The state-of-play is described in Annex 1 in detail, with information on implementation and performance per action.

Cross-cutting theme: Coordination

National drug policies (*obj. 1*)

For this evaluation, Member States were asked about the existence of national drug policy documents. Between 2005 and early 2008, 18 Member States implemented new or updated drug strategies and/or action plans. All Member States reported that one or more relevant drug strategies or national drug action plans were in place. Most of these documents are recent and/or ongoing. For the majority of Member States, one or more of these existing policy documents will expire in the period 2008-2009, after which they will be renewed or redrafted. Of these Member States, 14 countries stated that their drug policy will be subject to evaluation. *Table 2* provides an overview of the most important policy documents that are currently effective in the Member States, their life-cycle and intended follow-up.

A 2006 data collection exercise showed that the scope of intervention fields (prevention, treatment, law enforcement, etc.) covered by national drug strategies and action plans in the EU is very wide, reflecting the comprehensive and multidisciplinary approach to the drugs field in Europe. Convergence can also be seen in the format of drug strategies and action plans. Fourteen countries now structure their national drug-policy documents along lines similar to those of the current EU drug strategy and action plan. Moreover, the same number of countries now organise their national drug policies using two complementary instruments: a strategic framework and an action plan. More information on national drug policies can be found in the next chapter.

Most EU Member States have recently produced or plan to produce a progress review of the implementation of their drug strategies or action plans, and some might produce more in-depth evaluations in 2008. This reflects the growing recognition of the need to include monitoring and evaluation as an essential component in national drug strategies and action plans. EU Member States differ, however, in their methods and approaches for evaluating national drug strategies and action plans, and best practices in this field need to be identified.

All EU Member States have a recent and/or updated drug policy. In more than half of the countries, these policy plans reflect the structure and set-up of the EU Drugs Strategy (2005-2012) and/ or the EU Drugs Action Plan (2005-2008).

Table 2 — Overview of national drug strategies & national drug action plans in the Member States

MS	Type	Current	Future	MS	Type	Current	Future
BE	DS	ongoing		LU	DS/AP ²⁷	2005-2009	2010-2015
	Other ²⁸	2004-2007	2008-2011	HU	DS	2000-2009	2010-2015
BG	DS	2003-2008	2009-2012		AP	2008-2009	2010-2012
	AP	2003-2008 ²⁹	2009-2012	MT	DS ³⁰	2007-	n.a.
CZ	DS	2005-2009	2010-2012		AP	n.a.	n.a.
	AP	2007-2009 ³¹	2010-2012	NL	DS ³²	1995-	2009-
DK	DS	2003-	-		Other ³³		
	AP	2003-	-	AT	Other ³⁴	1998-	2008 ³⁵
DE	DS ³⁶	2003-	2008- ³⁷		PL	DS	2005-2010
	AP	2003-	2008-2013	AP		2005-2010	2010-2014
EE	DS	2005-2012	2013-2025	PT	DS	2005-2012	-
	AP	2007-2009	2010-2012		AP	2005-2008	2009-2012
IE	DS	2001-2008	2009-2016	RO	DS	2005-2012	-
	AP	2001-2008	2009-2016		AP	2005-2008	2009-2012
EL	DS	2006-2012	n.a.	SI	DS	2004-2009	2010-
	AP	2006-2012	n.a.		Other ³⁸	-	
ES	DS	2000-2008	2009-2016	SK	DS	2004-2008	2009-2012
	AP	2005-2008	2009-2012		AP	2005-2008	2009-2012
FR	AP	2005-2008	2008-2011	FI	DS	1997-	
IT	DS	n.a.	n.a.		AP	2008-2011	2012-2016
	AP	2008	2009-2012	SE	AP	2006-2010	2010-
CY	DS	2004-2008	2009-2013	UK	DS	2008-2018	
	AP	2004-2008	2009-2013		AP	2008-2011	
LV	Other ³⁹	2005-2008	2010-2013	DS = Drug Strategy			
LT	DS	2004-2008	2009-2016	AP = Drug Action Plan			
	AP	2004-2008	2009-2016	Other = Other drug-related policy document			
	Other ⁴⁰	2004-2008		n.a. = Information not available			

27 The Strategy and Action Plan are one and the same.
 28 Security Action Plan.
 29 Updated in 2006 (source: EMCDDA overview).
 30 Source: EMCDDA overview.
 31 Previous Action Plan covered 2005-2006.
 32 Ongoing policy document.
 33 Specific action papers on: Schiphol Airport, cannabis, XTC and the tackling of organised crime.
 34 Narcotic Substances Act; the Austrian provinces have their own policy documents.
 35 Act will be revised.
 36 The German Laender also have programmes to combat drug addiction.
 37 Renewal will include concrete actions on licit substances.
 38 Specific Acts on production & trade and consumption.
 39 State programme for the restriction and control of addiction and the spread of narcotic and psychotropic substances.
 40 National Programme for Drug Control and Prevention.

Coordination at national level (*obj. 2*)

All EU Member States have at least one national coordination unit or body in the drugs field which coordinates fully or partially the implementation of the national drug strategy/action plan. In most countries, the drug coordination mechanism has three levels. Firstly, a strategic, often inter-ministerial, board, commission, committee, council or coordination group on drugs defines the general framework for drugs policy and adopts the national strategies and action plans. Secondly, an operative body acting as e.g. the secretariat of the strategic 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) handles day-to-day coordination in the drug policy field and oversees the implementation and monitoring of the drug strategies and action plans. Finally, regional and/or municipal bodies exist to coordinate the implementation of drug-related interventions at local level. (*Ref. objective 2*).

Coordination at EU level: the Council (*obj. 4, 6*)

Overall, the Presidencies of the Horizontal Working Group on Drugs (HDG) have chosen policy priorities closely linked to the Action Plan on Drugs; they have liaised well with other relevant Council working parties and reported on other drug-related policy discussions in the Council. The participation of other Council working party members at HDG meetings should be encouraged where relevant. Coordination is essential, and should remain an objective of the new action plan.

All HDG Presidencies organise meetings of the National Drug Coordinators. However, consideration might be given to ensuring greater synergy between the activities of the HDG and the meetings of the national drug coordinators.

Coordination at EU level: Commission, Europol & agencies (*obj. 1, 2, 6*)

Responsibility for implementing the EU Drugs Action Plan (2005-2008) is shared between the Member States, the Council, the Presidencies, the Commission, Europol and EU agencies such as the EMCDDA, Eurojust and EMEA. The Commission is involved in the implementation of over half of the actions in the Action Plan, but is directly responsible for only 8 of them. The Commission's influence on implementation is strong in the field of precursor legislation and where external cooperation is concerned. In the field of (public) health, the Commission primarily has a complementary role to the Member States, while in the field of drug supply reduction the Member States are relatively autonomous (with the exception of specific areas such as anti-money laundering).

Within the European Commission, responsibility for the implementation of the EU Drugs Action Plan (2005-2008) is shared between over thirteen Directorate Generals⁴¹. The drug policy coordination unit of DG JLS is responsible for the horizontal coordination of drug policy within the Commission. Directly after the adoption of the EU Drugs Action

⁴¹ DGs involved include: DG Justice, Freedom & Security; DG Health & Consumers, DG Enterprise & Industry, DG Taxation & Customs Union, DG External Relations, EuropeAid, DG Enlargement, DG Development, DG Research, Eurostat, DG Employment, Social Affairs & Equal Opportunities, DG Energy and Transport and DG Education & Culture.

Plan 2005-2008, an internal roadmap was drawn up specifying the services responsible for implementing the actions the Commission was involved in and/or for reporting on their progress. Coordination clusters have been set up in the field of drug precursor legislation (Taxation & Customs Union, Enterprise & Industry DGs) and in the area of external relations (External Relations, Enlargement, Development and EuropeAid DGs). DG External Relations is responsible for coordinating the Commission's position vis-à-vis international organisations and third countries.

As one element in the evaluation, the Commission also decided to assess the effectiveness of its own coordination structures for the implementation of the Action Plan. For this purpose, the external consultant brought in for the evaluation process was asked to conduct a limited assessment of the main services involved.

The consultant came to the following findings:

- The implementation of the EU Drugs Action Plan (2005-2008) in the Commission is supported by strong coordinating mechanisms, which results in a unified approach in the Council, in particular the Horizontal Working Party on Drugs (HDG). Preparatory work for the HDG is undertaken by a permanent Inter-Service Group on Drugs (ISG), which brings together all the relevant DGs involved in the implementation of drug policy within the Commission.
- However, coordination within DGs, or among groups of DGs on sectoral issues, is mostly informal and not very structured.
- Commission coordination could be strengthened to improve the coherence between the principles and priorities of EU drugs policy and how they are reflected in EU funding and external assistance programmes.
- The Action Plan itself (or its successor) could contribute more to the implementation of activities through better prioritisation of objectives and a more operationalised description of actions.
- The non-binding status of the Action Plan has an impact on its implementation by the different Commission services. The absence of a specific budget line for the implementation of actions that the Commission is (co-)responsible for means that Commission services have only limited resources available to support the implementation of objectives⁴².
- Furthermore, as a result of the above, actions are often implemented by including them under one or other thematic or regional priorities of the Commission. The result is that reporting on progress then often relates to these priorities and not specifically to the implementation of the actions themselves.

⁴² The specific Programme for Drug Prevention and Information is the only programme with a budget specifically for supporting the implementation of priorities in the field of prevention, harm reduction and information & evaluation as identified in the EU Drugs Strategy 2005-2012. Other funding programmes may support the implementation of the EU Drugs Action Plan, but do not refer to the EU Drugs Strategy or its Action Plans directly, although they do include actions to tackle illicit drugs, for example the Community Public Health Programme 2003-2008 (established by Decision 1786/2002/EC of the European Parliament and of the Council, 23.09.2002).

- Where the Drugs Action Plan relates to specific Community competences, more resources are available and a more structured approach is visible.
- A clearer description of actions and objectives as well as more focus in the Action Plan could strengthen its implementation, as these actions and objectives could then be translated more easily into specific activities, which may better support the achievement of the overall objective.

Several tasks for the EU Drugs Action Plan (2005-2008) also require the involvement of EU agencies such as the EMCDDA and intergovernmental structures such as Europol.

The EMCDDA is a key information source for assessing the drug situation and responses to it at the level of the Member States. Cooperation between the Commission and the EMCDDA was assessed in 2007 as part of the external evaluation of the monitoring centre. The evaluation showed that cooperation between the Commission and the EMCDDA, in particular with the 'home' DG, Justice, Freedom and Security, had very much improved in recent years and was in general considered to be good.

The cooperation between the Commission and the Drugs Unit at Europol is considered constructive, both inside the HDG and in daily cooperation. However, collaboration is of a slightly different character, as Europol activities are more operational than policy- or information-oriented and Europol has its own intergovernmental mandate.

Drug policy is a horizontal issue within the European Commission. Due to its non-binding character, the *acquis* and consequent tasks for the Commission in this area are limited. **Overall, the Commission is well-prepared and well-coordinated where its representation vis-à-vis the Council is concerned. However, the informal coordination structures within the Commission, especially between DGs, can be improved by setting clearer priorities and by enhancing the flow of information.** The Commission may consider further assessing and reinforcing its coordination and implementation mechanisms once the next EU Drugs Action Plan for (2009-2012) is adopted by the Council.

Involvement of civil society (*obj. 3*)

As proposed in the EU Drugs Action Plan (2005-2008), the European Commission established a Civil Society Forum on Drugs in 2007, bringing together representatives from 29 NGOs and professionals in the field of prevention, treatment, harm reduction, fundamental rights, etc. The Forum gives input to the Commission on EU drug policy as set out in the Strategy and Action Plan. Furthermore, it is a meeting place for civil society representatives and mirrors the broad range of interests, views and approaches that exist in EU society regarding drugs.

One issue addressed during this evaluation concerned the position of civil society at national level. Member States were asked to reflect on the level of involvement of civil society in the formulation or implementation of national drug policy. In reply to the question whether opinion surveys or public consultations had been conducted recently to sound out public opinion on national drug policy, twelve Member States responded in the affirmative.

In Hungary and Slovakia, national and smaller-scale consultation surveys, targeted at specific groups, are being conducted. In Ireland, in view of the development of a new National Drugs Strategy, public consultation meetings are being organised around the country. Meetings with various sectoral groups and with community and voluntary organisations involved with drugs have been organised, along with focus groups with drug users and immigrants, and Government departments and agencies in the drug field meet on a regular basis. NGOs have also been consulted during the development of national drug strategies and/or drug action plans in Lithuania, Luxembourg, Poland, and the UK.

Civil society — as represented by relevant NGOs in the drug field — is also involved in official structures dealing with drug issues at national level, such as national drug councils of advisory forums. Such formal involvement exists in Austria, Cyprus, Ireland, Germany, Hungary, Portugal and Spain. In Bulgaria, Hungary, Ireland and the UK, civil society involvement is also ensured through local coordination and cooperation mechanisms.

There is informal consultation and involvement in drug policy development and implementation in France, Lithuania, Luxembourg, Slovakia and Romania. This type of consultation includes meetings, NGO contributions to public debate, advocacy through EU-funded projects and programmes, informal discussions, websites, surveys, etc.

In Member States such as Ireland, Slovakia and Slovenia, civil society also plays an important role in the delivery of specific activities and services, for example in the field of harm reduction.

In Estonia, Finland, Latvia, the Netherlands and Sweden, no specific options are available for civil society to engage in a dialogue with the public authorities responsible for drug policy. Civil society involvement is through the political system (parliament), public discussions in the media, and bilateral contacts between civil society organisations and the public administration.

Despite the examples reported by the Member States, organisations participating in the Commission's Civil Society Forum on Drugs have indicated that civil society involvement could be more substantial and also support the collection of qualitative information on the delivery of services.

Drug demand reduction

Quality standards for demand reduction (obj. 7)

In the field of drug demand reduction, the differences between Member States in terms of prevention, treatment, harm reduction and rehabilitation projects are substantial. In recent years, the evidence base underpinning these interventions has increased. However, the available best evidence and practices are not always translated into national policy and service delivery. **Accurate and comparable information on the coverage and accessibility of drug demand reduction facilities and measures is lacking at EU level, and the terms themselves are defined differently in each Member State.** However, the EMCDDA does collect information from Member States on whether they have quality-assurance⁴³ mechanisms in place to increase the effectiveness of drug demand reduction activities in the areas of treatment and prevention. Furthermore, the EMCDDA addresses the issue of the reliability of data and definitions across countries.

In the area of **treatment**, over half of the Member States report the availability of national quality standards for drug-free treatment and medically assisted treatment (19 MS). Quality standards for the evaluation of drug treatment exist in 12 Member States. Quality management systems using international quality standards (ISO 9000ff and EFQM⁴⁴) are available in only 2 countries. In 2008, the Commission published a study entitled: 'The quality of treatment services in Europe — drug treatment situation and exchange of good practice'⁴⁵. It includes country reports on treatments available in the Member States as well as an assessment of the effectiveness of the treatments most used in the EU.

In the area of **prevention**, quality standards for school-based prevention exist in 10 Member States, for selective prevention in 8 and for community-based prevention in 6 countries. National standards for the evaluation of prevention seem to be less common and are reported only by a few Member States. The existing data provide only a basic and rather crude picture of the availability of quality assurance mechanisms, and the content and scope of these mechanisms needs to be further investigated, for instance, the concept of what exactly constitutes a 'standard' or a 'guideline' seems to differ across Member States.

In short, the existing data provide only a basic picture of the availability of quality assurance mechanisms among EU Member States in the field of drug demand reduction, although they do show that efforts to develop quality standards or guidelines are being made in most countries. **The content and scope of these measures should be investigated further. The development of definitions and quality models at EU level could also be further considered.**

⁴³ Quality assurance can be defined as a system of procedures, checks, audits and corrective actions to ensure that a service and reporting activities are of the highest achievable quality. Quality assurance can be implemented as a more or less formal control measure, and with a higher or lower level of reporting, through providers and public control institutions. Among the most traditional measures are quality standards, evaluation, quality management systems and training of staff.

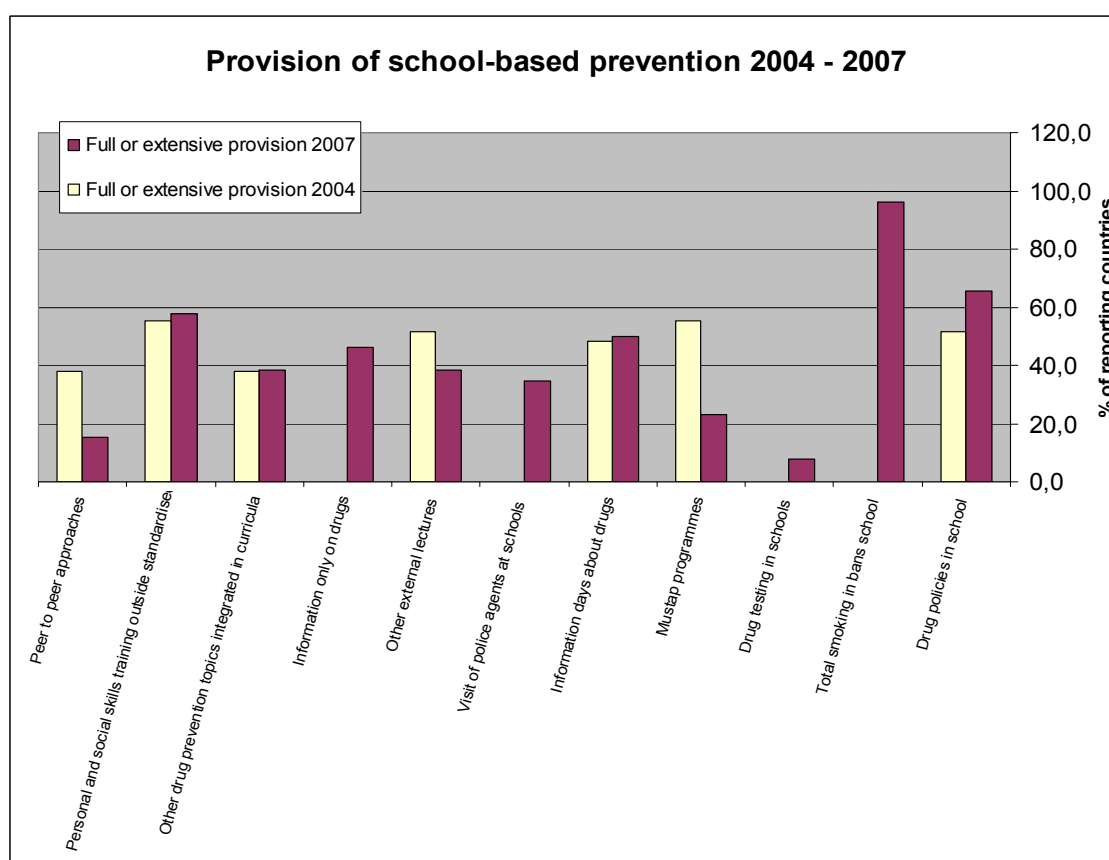
⁴⁴ European Foundation for Quality Management.

⁴⁵ http://ec.europa.eu/health/ph_determinants/life_style/drug/documents/drug_treatment_frep_en.pdf.

Universal prevention (*obj. 8*)

The type of universal school-based drug prevention interventions reported by the largest number of countries concerns mostly events for parents and personal and social skills training for pupils, followed by merely informative strategies (information days, visits by experts or police officers to schools — see *Figure 1*). These interventions are usually also less intensive than other kinds. In contrast, standardised programmes, peer approaches or interventions specifically for boys, which all aim to improve communication skills, correct normative misperceptions about drug use or increase the ability to handle conflicts, stress and frustration, are reported in only a few countries. The overall predominance of interventions that have no, or only a relatively weak evidence base might be due to the fact that they are less demanding in terms of resources, training and implementation efforts. Many EU countries run a variety of school-based prevention programmes, but a considerable number of these might not be effective at all.

Figure 1 -Provision of school-based prevention⁴⁶



School settings tend to match overall prevention policies, which now increasingly embrace stricter regulations on tobacco and alcohol and aim to create protective and normative social environments to influence young people's choices regarding drug use. Most countries now report total smoking bans in all schools and extensive application of drug policies in schools. Particularly in Central and Western Europe, Member States report comprehensive prevention of substance use at school, especially with regard to

⁴⁶ Comparisons between 2004 and 2007 should be regarded with caution as the data are based on expert group ratings and can therefore vary with the composition of these groups.

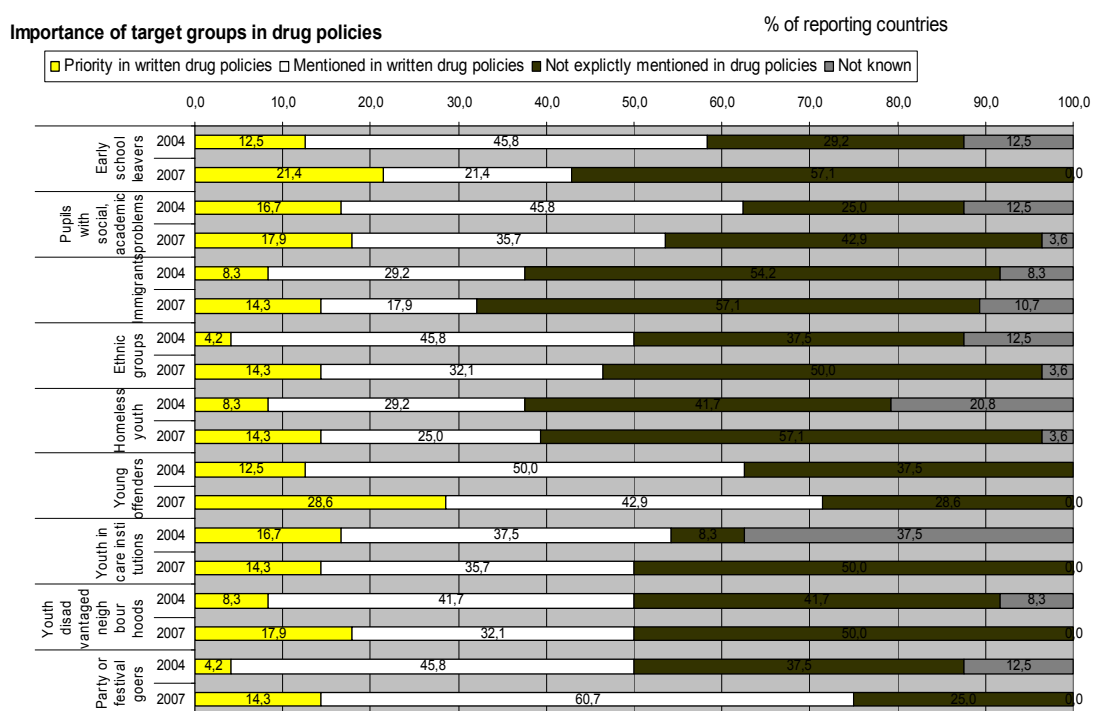
nicotine and alcohol, which may also be complemented by structural measures such as improving the design of school buildings and school life. A focus on information remains the most frequent approach, also in family-based prevention. Despite demonstrating a consistent effectiveness across studies, intensive coaching and training sessions for families remain less common.

Finally, developing standards for the delivery and content of prevention projects is one way to improve the evidence base for prevention and to reduce iatrogenic risks. The number of Member States reporting standards for project design and evaluation increased from three in 2004 to nine in 2007. **The setting of standards could be an important step for the future development of prevention policies at EU level.**

Selective and indicated prevention (*obj. 9, 10*)

Selective prevention targets vulnerable groups prone to risk factors that may contribute to future problem substance use. Almost half of the EU countries report that their family-based prevention is mostly selective. Across reporting countries, only a very small minority of Member States report extensive provision for intervention to address e.g. substance abuse in the family, family conflict and neglect, social disadvantage (e.g. unemployment), criminal justice problems, ethnic families subject to marginalisation, and families with mental health problems.

Figure 2 — Importance of vulnerable groups within drug policies, percentage of reporting countries 2004 / 2007⁴⁷



⁴⁷ Comparisons between 2004 and 2007 should be regarded with caution as the data are based on expert group ratings and can therefore vary with the composition of these groups.

The situation is similar for the most relevant vulnerable groups, such as, for example, young offenders, the homeless, truants, and disadvantaged or minority young people. They have become the priority target for intervention in an increasing number of drug policies since 2004, but the actual level of intervention appears not have increased during this period (see Figure 2).

There is no information available on the overall number and coverage of indicated prevention projects in recreational settings, as this indicator was found to be difficult to implement in practice and therefore was eliminated. Information is available about the rated provision of intervention for party/festival goers and the policy importance given to work in recreational settings is reported to have increased.

Treatment and social rehabilitation (*obj. 11, 12*)

All EU Member States provide substitution treatment for opioid dependence. Substitution treatment is typically provided at specialised outpatient treatment facilities, in shared-care arrangements with office-based general practitioners, and integrated with psychosocial care.

More than half a million opioid users receive drug substitution treatment in the EU countries, with the vast majority reported by the ‘old’ EU Member States. This represents more than one third of the total estimated number of problem opiate users in the EU. Between 2005 and 2006, the number of clients receiving this type of treatment saw an overall increase of around 12% (data available for 19 EU Member States) with the strongest relative growth observed in some of the ‘new’ Member States. Data from a number of individual EU countries — where recent estimates of the prevalence of problem opiate use were available — show that the current coverage of opioid substitution treatment varies significantly between countries, with rates ranging from 5% to more than 50% of opiate users.

The main drug used in opioid maintenance treatment is oral methadone, but buprenorphine maintenance treatment (BMT) is steadily increasing, especially among clients treated by office-based medical doctors. Compared to methadone, buprenorphine is associated with lower rates of mortality. Other substances, like heroin (diamorphine), slow-release morphine or codeine, are also used in substitution treatment in some countries.

Member States have considerably developed their legal frameworks regulating substitution treatment for addiction. National laws normally designate those substances that can be used, the admission criteria for such programmes, and who is permitted to prescribe.

All EU Member States also provide the option of drug-free treatment, and three reported in 2005 that the treatment of opioid dependence was predominantly based on drug-free approaches. In outpatient care, traditional psychotherapeutic treatment and ‘supportive’ methods are applied, but Member States differ according to the type or combination of methods used. In inpatient care, the 12-step Minnesota model is used in a few countries, while others use psychotherapeutic treatment and/or ‘supportive’ methods.

Following the increase in cocaine use and associated problems in several Member States, specialised drug treatment facilities face the difficult task of adapting their services to the heterogeneous cocaine and crack-using populations. However, the latest available data show that, with the exception of Spain, **Member States assessed the availability and accessibility of cocaine-specific treatment programmes as low in 2006**. However, the recent introduction of a cocaine-specific national action plan in Spain is likely to further increase the availability of cocaine treatment options in this country.

A survey commissioned by the EMCDDA on cannabis treatment provision in a sample of drug treatment services in 19 Member States showed that half of the services surveyed did not have programmes dedicated to cannabis problems. **This finding suggests that numerous cannabis users in Europe are treated within the same settings as other drug users with more severe drug problems**, which entails a number of difficulties for users (e.g. stigmatisation, reluctance to seek help), but also for staff (e.g. lack of experience in adolescent drug and social behaviour). The survey also showed that most treatment services surveyed provided no more than 20 sessions for cannabis users. The main treatment methods were individual counselling and talk therapy/counselling about cannabis and about conditions of life. Longer residential care for cannabis problems is generally provided for respite purposes in connection with socio-behavioural problems.

The level of drug treatment provision in prison remains low, compared to that in the community, though the prevalence of drug use is high among prisoners. In recent years, however, interventions targeting drug-using prisoners have expanded in the EU. Compared to five years ago, more countries now report activities in the following areas: drug-related information and prevention; screening for infectious diseases and vaccinations; and drug dependence treatment, including substitution treatment — while the provision of these interventions has become more widespread within countries. Prison-based substitution treatment is now officially available in all but six Member States, although with very different levels of availability.

In 2005, 22 of the 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. However, **none of them rated the availability of these programmes as being very good and one third considered the general availability of such social reintegration services to be low**. The political attention devoted to and investment in the reintegration sector has nevertheless risen in some Member States, and quality standards for drug treatment often stipulate that social care and reintegration services should be made available to clients.

While housing support is provided to drug treatment clients in many countries, shortages have also been documented, and four countries report that it is difficult for drug users to gain access to the general services for the homeless that are traditionally used by problem alcohol users. New measures that can help meet the accommodation needs of drug users are being undertaken in three countries, which report that facilities for homeless long-term addicts are being centralised and specialised care homes are being opened for drug users with problem behaviour or co-morbidity. New approaches to helping clients to find and hold down employment are also reported to have had success, including: ‘mentoring schemes’ subsidised workplaces, and special coaching of employers and employees.

Overall, drug treatment in the EU has seen a steady development in recent years. However, in terms of accessibility, coverage and the dissemination of evidence and best-practices in treatment, gains still have to be made. In 2008, the Commission has published a report on the quality of treatment services in Europe⁴⁸.

Harm reduction (*obj. 14, 15, 16, 17*)

In 2007, the Commission published a report⁴⁹ on the implementation of the Council Recommendation of 18 June 2003 on the prevention and reduction of health harm associated with drug dependence⁵⁰. The study showed that the prevention and reduction of drug-related harm is a public health objective in all Member States.

A multi-component response to the prevention of infectious diseases, combining measures to reduce injecting-related harm and effective drug treatment, is common in the EU. The main interventions in this field are opioid substitution treatment and needle and syringe exchange programmes (NSPs), which aim to prevent overdose deaths and the spread of infectious diseases. These measures are reported to be available in all countries and, while considerable differences exist in the range and levels of service provision, the general European trend is one of growth and consolidation in harm reduction measures. **However, some countries have recently reported that the implementation of such measures has been delayed due to the lack of political support.**

The exchange or distribution of syringes is in general implemented in conjunction with information, education and counselling interventions and complemented by outreach health education and, in a few countries, by supervised drug consumption facilities. Needle and syringe programmes are often delivered by specialist low-threshold drugs agencies and in eight countries through pharmacy-based programmes as well, which considerably increases the geographical availability of sterile injecting equipment. While low-threshold agencies with syringe exchange are continuously expanding in many of the countries where the spread of problem heroin injecting is more recent, a stagnation or decrease in such services is reported by other countries in this group, partly due to the lack of political support and funding. **This raises the concern that decreases in syringe turnover could result in higher levels of risk-taking among new, younger generations of heroin injectors, who have not been reached by prevention messages.** In some of the countries with older heroin epidemics and extensive treatment provision, however, a stabilisation and decrease in syringe demand has been noted in recent years.

The integration of services and facilities that aim to prevent infectious diseases among drug users (VCT, vaccination, infectious disease treatment services) within general health and social care is current practice in a number of countries, which increases their availability and facilitates and promotes drug users' access to a more complete spectrum of care if needed.

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http://ec.europa.eu/health/ph_determinants/life_style/drug/documents/drug_treatment_fre_p_en.pdf. E.g. the Stability instrument has not been assessed so far, in particular the consequences of the CES in EU and background information (SANCO/2006/C4/02)

49 COM(2007) 199;

http://eur-lex.europa.eu/LexUriServ/site/en/com/2007/com2007_0199en01.pdf.
50 2003/488/EC.

Due to the high proportion of injecting drug users among *prison inmates* and the potential for rapid spread of infections among prisoners, prisons are important settings for interventions targeting infectious disease related to drug use. Spain is, however, currently the only European country that provides a wide range of harm-reduction measures in prisons.

As Chapter 4 shows, drug-related deaths (DRD), which soared over the 1980s and 1990s, showed a decreasing overall trend between 2000 and 2003. The positive trend over 2000-2003 was reversed in 2004 and 2005, with increases observed again in the majority of countries (15 out of 24 with information), although increases remained in general moderate. This recent trend contrasts with the wide expansion of treatment over the 1990s in particular. **The reduction of drug-related deaths is a goal of most national drug strategies, but few countries have so far adopted concrete action plans or provide systematic guidance on measures to be taken.**

All Member States have stepped up their levels of treatment provision, and several have removed access barriers. In so far as information is available, there are still strong variations in opioid substitution coverage (between 5% to 54% in 8 EU countries), and services are located mainly in metropolitan areas with a bigger than average number of users, while in rural areas treatment provision is limited. The past years have also seen increased efforts to improve treatment standards and qualifications among providers, which should also help to reduce the risk of DRD. A wider choice of pharmaceutical options is available, including the increased use of opiate substitution drugs such as buprenorphine which may have a lower overdose potential if misused.

Reasons for the recent stabilisation in DRD (see Chapter 4) are unclear but it could be influenced by a combination of factors, which may include an further increase in poly-drug use (including alcohol and cocaine)⁵¹ among opiate users, increased heroin availability (UNODC)⁵², aging of opiate users, or treatment possibly not reaching some of the more excluded groups of users. Another possibility, which will be analysed by the EMCDDA in the near future, is a more risky lifestyle amongst a new generation of intravenous drug users who are not reached by harm reduction measures and messages in the same way as older users.

Despite the known connection between release from prison and drug-induced deaths, few countries are systematically investing in educating prisoners on the risk of overdose on release from custody. The period after release from prison or treatment is especially critical, and research shows that the risk of drug-induced death is substantially higher for the first two to four weeks. The number of people with past or current drug experience passing through European prisons each year is estimated to be 607 000 (stock) with an estimated turnover of 860 000 prisoners — among them many problem drug users. Continuity of care and rehabilitation of drug users released from prison require serious attention, as they are important in preventing drug-related deaths.

Drug supply reduction

Introduction

Drugs and precursor trafficking routes have become more diversified, and criminal groups are becoming increasingly cooperative with the formation of large international

⁵¹ A field trial conducted by the EMCDDA in 2006 on substances involved in drug-related deaths observed that in a high proportion of cases several substances were found in the toxicological examinations. However, this is a cross-sectional study and trends cannot be assessed yet.

⁵² The United Nations Office for Drugs and Crime (UNODC) has issued a warning on this possible effect, http://www.unodc.org/unodc/press_release_2006_10_05.html.

coalitions, which are constantly searching for loopholes in the international drug control system. In order to tackle international organised crime, the Member States have established Europol, Eurojust and the Police Chiefs Task Force (EPCTF), the European Joint Unit on Precursors (EJUP), Joint Investigation Teams (JITs) and regional initiatives such as the Maritime Analysis and Operational Centre on Narcotics (MAOC-N).

To strengthen their law enforcement capacities, Member States are developing the model of *intelligence-led law enforcement*, which aims to make the exchange of information more efficient and effective by selecting the most appropriate targets for police investigation based on the assessment of their roles, their impact on society and the environment in which they operate. The concept also permits a more efficient use of human and financial resources.

The main tool for implementing the concept of intelligence-led law enforcement is the European Criminal Intelligence Model (ECIM), a cyclical process that starts with the Organised Crime Threat Assessment (OCTA), produced by Europol in close cooperation with the Member States. The OCTA is designed to identify current and future trends, knowledge gaps and intelligence requirements for data collection programmes in Member States and at European Union level. The aim is to develop intelligence products that provide the basis for targeting top criminal organisations in the Member States, where appropriate with the support of Europol and Eurojust and by making use, where feasible, of Joint Investigation Teams (JITs).

This concept is supported at the highest level by the Police Chiefs Task Force through its COSPOL Projects.⁵³ The objective of COSPOL projects is to facilitate best use of information, to identify opportunities for operational projects and to solve constraints in day-to-day cooperation, by making use of existing tools, in particular Europol's analytical capacities. There are COSPOL projects on cocaine, heroin and synthetic drugs.

Cooperation between Member States and at EU level (*obj. 18, 19*)

Europol runs drug-related projects, implementing joint multidisciplinary intelligence gathering and operational initiatives. It provides operational and strategic reports and expertise to Member States. In addition to the OCTA, situation reports and ad hoc reports on specific crime phenomena are provided to enhance the intelligence picture of Member States and support their investigations. The drug-related projects include Project MUSTARD (heroin trafficking), Project COLA (cocaine trafficking) and Project SYNERGY (production and trafficking of synthetic drugs, chemical precursors and production equipment).

Joint Investigation Teams (JIT) and Joint Customs Cooperation (JCOs) could be used to a greater extent by the Member States in collaboration with Europol.

At national level, Member States carry out various investigations and projects annually to stem the flow of drugs into the EU through its external borders, including land borders, sea ports and airports. These projects include several Joint Customs Cooperation activities.

⁵³ Comprehensive Operational Strategic Planning for the Police.

Regional drug enforcement initiatives, involving several Member States, focus on intelligence sharing, and operational cooperation has evolved in the *maritime* sphere. In 2007, an informal working group working in close cooperation with Europol prepared the ground for the *Maritime Analysis and Operations Centre — Narcotics* (MAOC-N), which focuses on cocaine trafficking by air and sea in the Eastern Atlantic Ocean region. In 2008, the ‘*Centre de Coordination et de Lutte Antidrogué pour la Méditerranée*’ (CECLAD-M) is to be set up to counter drug trafficking in the Mediterranean. The Bucharest-based *Southeast European Cooperation Initiative* (SECI) also includes a specialised task force on illegal drugs trafficking. In the Baltic region, cooperation is through the *Baltic Sea Task Force*.

The results of the various cross-border operational and intelligence law-enforcement projects in the EU, in particular the success of MAOC-N with almost 27 tonnes of cocaine seized in one year, show the importance of strengthening intelligence gathering and sharing as a basis for enhanced intelligence-led law enforcement by land, sea and air.

Moreover, to effectively address the threat of international drug trafficking, EU-based counter-narcotics efforts must be accompanied by enhanced inter-regional drug enforcement cooperation, such as the EU-LAC intelligence sharing network. In this context, the setting up of an EU model platform for intelligence sharing and capacity building is being explored by some Member States in cooperation with (and complementing) Europol and the European Commission, together with increased use of EU funding instruments such as the Stability Instrument and the Fight Against and Prevention of Crime Programme⁵⁴.

An indicator identified in the Action Plan for the outcome of law enforcement activities comprises the number and quantities of drugs seized. The data available for the period 2004-2006 (see *Table 3*) show that the number of cocaine seizures and the quantity of cocaine seized are increasing.

Table 3 — Estimated number of seizures and quantities seized in the EU

Year	2004		2005		2006	
Type of substance	Seizures x1000	Quantity x1000 kg	Seizures x1000	Quantity x 1000 kg	Seizures x1000	Quantity x1000 kg
Cannabis resin	270	1 080	292	890	314	709
Herbal cannabis	136	55	159	54	167	64
Cocaine	55	72	66	106	72	121
Heroin	42	10	48	8	46	9
Amphetamines	36	7	34	7	33	6
Ecstasy (tablets x millions)	21	19	20	13	19	12

Source: EMCDDA

It must be noted that the registration of drug seizures is not standardised and that there are differences in calculation and registration methods between Member States. **Furthermore, seizure statistics are not always easy to obtain as some major**

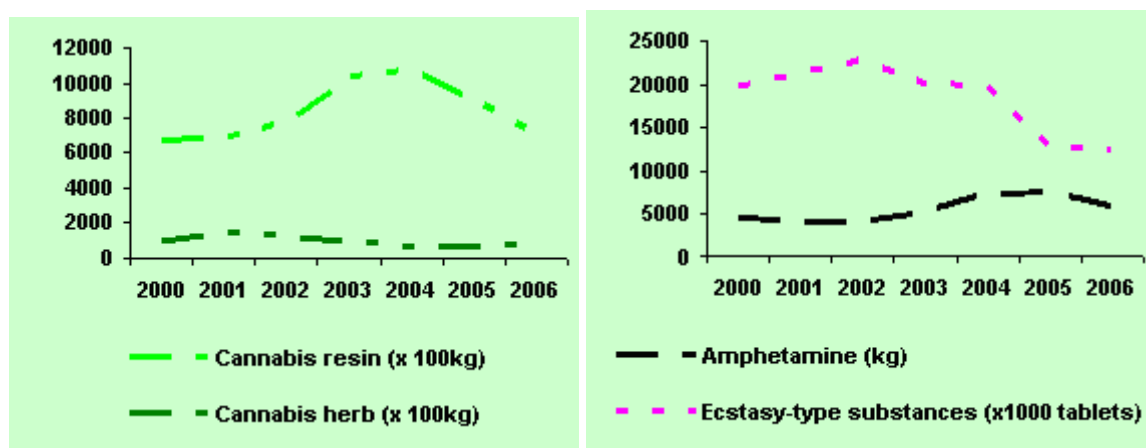
⁵⁴ OJ L 58, 24.02.2007.

destination countries accounting for large proportion of total EU seizures do not report at all or report with a delay of over two years⁵⁵.

Figures 3 and 4 reflect longer-term trends in drug seizures over the period 2000–2006⁵⁶. As Figure 3 shows, the number of seizures grew for both types of cannabis, while the quantities seized were stable overall (resin) or declined (herbal cannabis) over the same period. The most recent data, however, show a decrease in the quantities of resin seized and a small increase in quantities of herbal cannabis and number of plants seized, indicating a possible increase in local cannabis production (hydroponics) and shifts in cannabis markets.

Furthermore, a decline in ecstasy seizures was seen. For amphetamines, the number of seizures and quantities seized increased, but, in the last years of this period, these figures were stable or declining.

Figure 3 — Trends in quantities of seizures (cannabis resin, cannabis herbs, amphetamines and ecstasy)

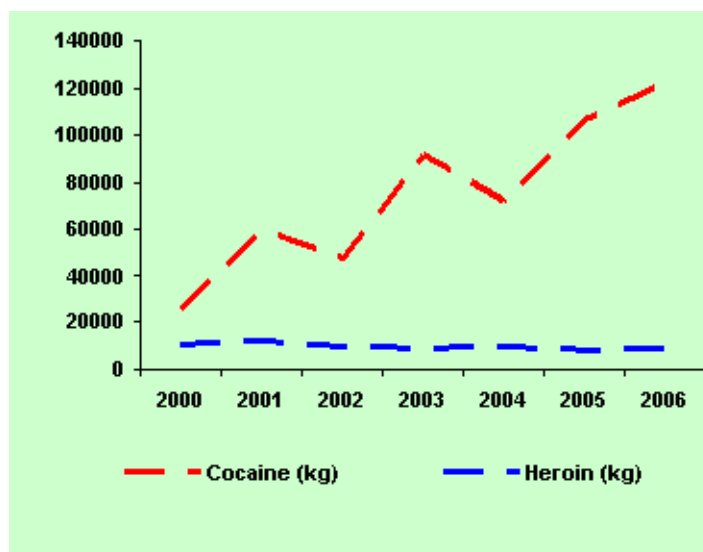


As Figure 4 shows, there was a considerable increase of over 350% in cocaine seizures over the period 2000–2006, both in numbers and in quantity. Finally, heroin seizures were relatively stable during the same period, with a slightly declining trend.

⁵⁵ E.g. Europol has not received seizure statistics from one specific Member State since 2003, while the EMCDDA receives seizure statistics from this country with a delay of two years or more.

⁵⁶ Note to Figures 3 and 4: The total amounts seized are based on data from all EMCDDA reporting countries (27 EU Member States). For countries included in the totals per year, missing data have been extrapolated from adjacent years.

Figure 4 — Trend in quantities of seizures of cocaine and heroin



As the price and purity data in **chapter 4** shows, the increase in seizures of e.g. cannabis and cocaine has not resulted in higher prices or in major changes in the potency of these substances on the illicit market. In fact, prices have fallen sharply, especially for ecstasy.

Reducing the manufacture and trafficking of synthetic drugs (*obj. 20*)

Europol's Project SYNERGY — which gathers and exploits information, knowledge and experience in the area of synthetic drugs, related precursors and equipment — supported various major criminal investigations carried out by law enforcement agencies in the Member States during the reporting period. The quality and quantity of the data supplied for the Analysis Work Files and the EILCS by several Member States remains high. This cooperation is an indicator of satisfaction among operational partners regarding SYNERGY and its added value. **However, not all crucial Member States are fully contributing.** *Table 4* presents an overview of dismantled illicit synthetic drug facilities in the years 2005-2007.

Project SYNERGY supports, and is supported by, the activities of the European Joint Unit on Precursors (EJUP) and the European Police Chiefs Task Force's COSPOL initiative on synthetic drugs. During the reporting period, several meetings were organised by the European Commission to develop a long-term solution for the forensic profiling of synthetic drugs, involving representatives of forensic laboratories as well as law enforcement agencies, EUROPOL and the Commission. It has been agreed that any future European long-term solution should build on the experience of projects co-funded by the European Commission (mainly SYNERGY and CHAIN). A European structure available to all Member States, with the potential to cover all drugs, synthetic or non-synthetic, and catering to national or regional needs, is to be set up. Decisions on a final structure are expected to be taken in the second half of 2008 or early 2009.

The Council Decision on information exchange, risk assessment and control of new psychoactive substances⁵⁷ has been fully implemented in the reporting period, but might require amendment to improve information collection and to align the Decision with existing EU legislation, e.g. with the EU pharmacovigilance system.

<i>Member State⁵⁹</i>	2005	2006	2007
Austria	-	3	-
Belgium	11	4	8
Bulgaria	n.a.	n.a.	1
Czech Republic	6	-	10
Denmark	-	1	-
Estonia	3	3	2
Germany	6	7	10
Greece	2	-	-
Hungary	1	-	1
Lithuania	1	1	-
Netherlands	35	47	41
Poland	23	9	16
Portugal	-	-	2
Romania	n.a.	n.a.	-
Spain	1	-	-
United Kingdom	1	-	-
Total	90	75	91

Drug precursor legislation (*obj. 22*)

In August 2005, new Community legislation on drug precursor control came into force. The main aim of this new legislation was to introduce specific import controls for drug precursors in order to address the heightened concern about synthetic drug manufacture in the European Union. The precursors required to produce such drugs are generally not available in the EU and must be sourced outside. The new legislation further strengthened export controls, introduced Community rules for the authorisation of operators engaged in the trading of sensitive precursors, and strengthened common rules for monitoring the intra-Community trade in drug precursors. In order to measure the results of the monitoring activities and to enable competent authorities to react to changing patterns in the diversion and trafficking of drug precursors, Member States are further required to report seizures and stopped shipments on a quarterly basis

⁵⁷ 2005/387/JHA, 10.5.2005.

⁵⁸ This overview includes major storage sites, synthesis production facilities and tableting units, but not small-scale or kitchen-type production facilities. Countries that reported no dismantled sites have not been included.

⁵⁹ Note: data for Bulgaria and Romania in 2005 and 2006 are not available.

On the basis of the information provided by Member States' competent authorities on drug precursors, the Commission issued the first annual report on drug precursor seizures in the EU for the year 2006⁶⁰. **This stated that the seizures in 2006 for just two key synthetic drug precursors would be enough to produce drugs with an estimated street value of more than EUR 2.5 billion.**

Furthermore, an external consultancy⁶¹ report on customs controls of drug precursors in the EU, which was prepared at the request of the Commission, shows that Member State customs administrations still have important steps to take to ensure effective customs control of drug precursors. **The report concludes that in almost all Member States drug precursor control lacks priority for national Customs organisations either at national, regional or local level due to a lack of legitimacy and support from the authorising environment at Member State level.** Furthermore, specific problems are mentioned, including a lack of focus and expertise at operational level, as well as insufficient resources (equipment), monitoring and operational capacity. Customs officials often also lack the knowledge and equipment to recognise and detect suspicious precursor consignments. Information from European level is not always considered to be specific enough, even though it should be noted that EU-level information depends to a great extent on the input provided by Member States. **A Community- wide approach in addressing these challenges is recommended in order to reduce the capacity to manufacture and supply synthetic drugs.**

Under the new Community drug precursor legislation, new 'Guidelines for operators' were adopted in 2006 with the aim of further exploiting the potential benefits of cooperation with the private sector by structuring the procedures used for the notification of suspicious orders and transactions to the competent authorities. A specific list of non-controlled substances is reviewed on a regular basis to allow the competent authorities to draw industry's attention to the risk of the diversion of non-controlled substances. In 2006, more than 30% of EU precursor seizures were thanks to cooperation with the private sector. Member States have subsequently adopted Memoranda of Understanding and Codes of Conduct in conjunction with their operators. In 2007, the EU tabled a resolution on drug precursor control to the United Nations' Commission on Narcotic Drugs, specifically to promote the principle of cooperation.

Money laundering and asset confiscation (*obj.* 23)

The European Criminal Assets Bureau (ECAB), launched by Europol under its Money Laundering Action Plan, handles the work carried out by Europol on asset recovery, including operational support for Member States' investigations (including drugs investigations) to trace criminal proceeds, managing the Financial Crime Information Centre's website and acting as the CARIN permanent secretariat. ECAB provides operational support to Member States in identifying criminal proceeds where the assets are located outside their jurisdictional area and the investigation falls within Europol's

⁶⁰ 2006 annual report on EU drug precursor seizure,
http://ec.europa.eu/taxation_customs/customs/customs_controls/drugs_precursors/seizures/index_en.htm.

⁶¹ Matrix Knowledge Group, Fact Finding Study on Customs Controls of Drugs Precursors in the European Union, Final Report, December 2007.

mandate. **From 2005 to 2007, the ECAB supported a total of 244 investigations in the Member States concerned with asset tracing and identification⁶².**

The Europol Money Laundering Project, SUSTRANS, supports Europol projects, including drugs projects, in gathering and analysing financial data on criminal activities through which substantial illegal profits are generated. As part of SUSTRANS, a project on the intra-Community cross-border movement of cash is being developed, reflecting the fact that a cross-border reporting system is in place. It addresses the emerging trend of cash being moved in bulk throughout Europe without being detected. The use of money couriers is still a growing phenomenon in money laundering operations within the European Union. A questionnaire has been sent to Member States to gain a better understanding of cash smuggling routes and features.

The Financial Intelligence Units (FIUs) of 18 Member States are connected to the FIU.NET system. The ultimate objective of this project is to establish a secure and complete computer network for the exchange of financial intelligence among the 27 EU FIUs in combating money laundering and the financing of terrorism.

The Council Decision on cooperation between the asset recovery offices of the Member States⁶³ was adopted on 6 December 2007. It aims to have Member States set up or designate, by 18 December 2008, national asset recovery offices to act as national contact points for confiscation-related activities. In particular, they will promote, through enhanced cooperation, speedy EU-wide tracing of assets derived from crime.

Drug-related crime (*obj. 25*)

The EU Drugs Action Plan 2005-2008 proposes developing an EU-wide definition of drug-related crime, by analogy with the EU definition of organised crime. The evaluation has shown that only few Member States have definitions of drug-related crime at national level, and those that do exist differ widely. In 2007, the EMCDDA presented a publication setting out a broad definition of the term 'drug-related crime', with four crime categories: psychopharmacological crimes, economic-compulsive crimes, systemic crimes and drug law offences.

As similar breakdown of the term had already been proposed in 2003, following which the Council asked for simplification. The Commission is preparing a paper on further steps regarding this definition and intends to link this exercise to a broader assessment of policy needs for drug-related crime information and statistics at EU level. A study on drug-related crime statistics and law enforcement information has been launched and will be finalised in the first half of 2009. The outcomes of the study should form the basis of a broader proposal concerning drug-related crime and indicators to measure it, based on policy needs at EU level.

Drug-related arrests represent an important part of all police arrests in the EU. The data currently available on drug-related offences at EU level is not very differentiated, but does show certain specific trends. Data exists on drug-related arrests, collected by EMCDDA and data on drug-trafficking, collected by Eurostat.

⁶² Investigations supported in 2005: 57, 2006: 53 and 2007: 134.

⁶³ 2007/845/JHA, 6.12.2007.

Figure 5 shows that the total number of arrest-reports for drug use/ possession has increased with almost 75% in the period to over 600.000 in 2006, while the total number of arrest-reports for supply-related offences has marginally increased with 11% in the same period to a reported total of over 134.000 in 2006 and seems to be levelling off. As

Figure 6 shows, with over 440.000 arrests, cannabis use/possession accounts for over 70% of the total number of arrests for drug use/ possession. The largest increase in arrest reports in recent years can be seen for the use/ possession of cannabis and cocaine. Despite a trend in some EU Member States towards decriminalisation and/ or the differentiation between drug (dependent) users and drug traffickers in terms of penalties, this does not seem to lead to fewer arrests.

Figure 5 — Indexed trends in reports of drug-related offences by broad type of offence in EU member states 2000-2006⁶⁴

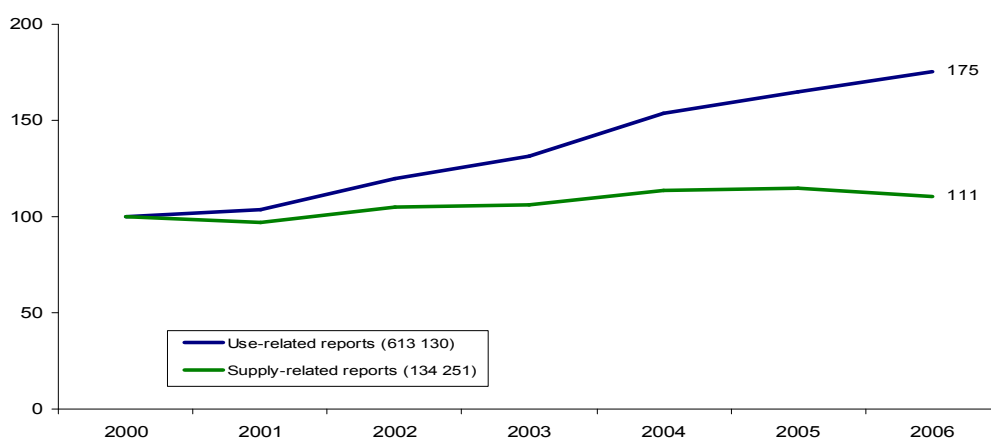
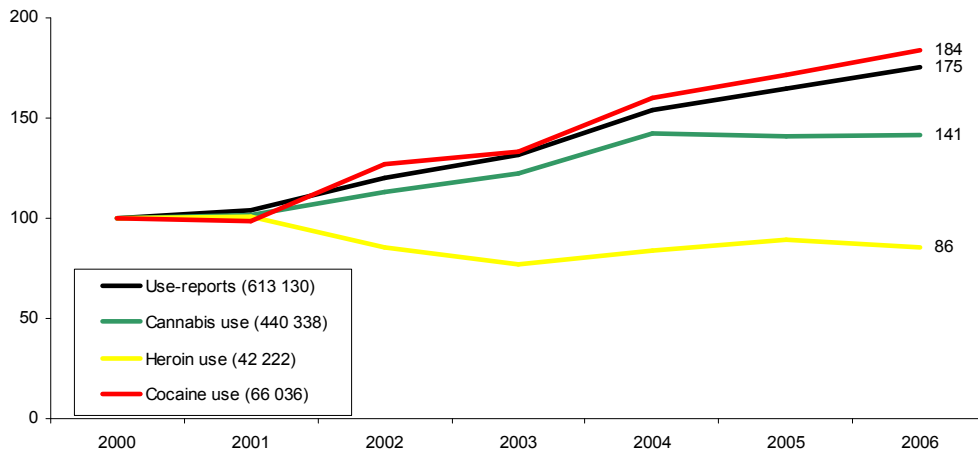


Figure 6 — Indexed trends in reports of offences related to drug use/possession for use in EU Member States 2000-2006⁶⁵

⁶⁴ Notes to Figure 6: 1. The trends represent the available information on the national number of drug-related offences reported by all law enforcement agencies in the EU Member States; all series are indexed to a base of 100 in 2000 and weighted by country population sizes to form an overall EU trend; the figures between brackets refer to the total number of offences reported in 2006 (before weighting). 2. The general term ‘reports of drug-law offences’ is used since definitions and study units differ widely between countries. 3. Both trends are based on 17 countries. 4. Additionally, where 2000 data are missing (3 cases for both use-related and supply-related reports) 2001 data are used. Sources: Reitox national focal points and, for population data, <http://epp.eurostat.ec.europa.eu/>.

⁶⁵ Notes to Figure 7: 1. The trends represent the available information on the national number of drug-law offences (criminal and non-criminal) reported by all law enforcement agencies in the EU Member States; all series are indexed to a base of 100 in 2000 and weighted by country population sizes to form an overall EU trend; the figures between brackets refer to the total number of offences related to drug use/possession as reported in 2006 in countries included in the trends (before weighting). 2. The general term ‘reports of drug-law offences’ is used since definitions and study units differ widely between countries. 3. The overall trend is based on 13 countries, the trend for heroin, cocaine and cannabis on 11. 4. Additionally, where 2000 data are missing (3 cases for all use reports, cannabis, heroin and cocaine) 2001 data are used, and for missing 2002 data (1 case for cannabis, heroin and cocaine) data have been interpolated from adjacent years. 5. The Czech Republic was not included in the trend calculation for cocaine due to the small number of cases reported. Sources: Reitox national focal points and, for population data, <http://epp.eurostat.ec.europa.eu/>.



Cross cutting theme: International cooperation

Promoting the EU approach to drugs (*obj. 29*)

The EU is a key actor in the field of international cooperation on illicit drugs. It is engaged in active dialogue with the key production and trafficking countries affected by the drug problem and plays a major role in supporting them with financial and technical assistance. The EU's commitment to promoting the balanced approach, whereby drug demand and supply reduction need to be addressed in tandem, reflects the fundamental values and principles of the Union and is seen as an example of good practice for other countries in the world. The action taken by the EU Presidencies and the Commission to promote the EU approach is reflected in statements in international fora such as the UN Commission on Narcotic Drugs (CND), and in cooperation agreements with third countries, which generally include provisions on illegal drugs. Increasing attention, albeit starting from a very low level, is being devoted to funding projects in the field of demand reduction in third countries to address drug use as well as drug trafficking and drug production. The results of such activities are mainly quantitative. However, a detailed assessment of the policy outcomes of these activities is lacking.

EU drug policy at international and UN level (*obj. 28, 30, 31*)

The EU is increasingly speaking with one voice in international fora, notably in the UN Commission on Narcotic Drugs. During the period under review, the EU maintained a unified position in the UNGASS review process. During the CND Working Sessions in 2006-2008, the successive EU Presidencies (AT, DE, SI) delivered joint EU statements on the follow-up to UNGASS, drug demand reduction, illicit drug trafficking and supply, the INCB and policy directives to strengthen the UNODC Drug Programme and the role of the CND as its governing body. The Commission, on behalf of the European Community, delivered its traditional statement on precursors at each CND session. **However, a harmonised approach among EU actors during the plenary meetings should be agreed to ensure the EU speaks with one voice.**

With regard to its collaboration with the International Narcotics Control Board (INCB), the Community is active in the international initiatives 'Project Prism' (addressing the diversion and trafficking of synthetic drug precursors) and 'Project Cohesion' (diversion and trafficking of heroin and cocaine chemicals). Successful operations have been launched, which have yielded tangible results. Especially under Project Prism, large amounts of synthetic drug precursors have been stopped or seized, thereby preventing the illicit production of more than 50 tonnes of amphetamines. Most EU Member States have actively participated in these operations. The role of the INCB as the global focal point for the exchange of information has been vital in achieving this success.

Support for candidate, stabilisation and association process countries (*obj. 32, 33*)

Action to tackle drugs is regularly discussed in the meetings with candidate and potential candidate countries and with the European Neighbourhood partners. The candidate countries are increasingly participating in the work of the EMCDDA, Europol and Eurojust and the EU provides **support to these countries to develop their capacity to implement the *acquis* and related action**, e.g. developing national drug action plans and strategies.

Negotiations are still under way between the Commission and Croatia on its participation in the EMCDDA, and ratification of the agreement with Turkey is expected shortly. In 2007, **Romania** and **Bulgaria** became full members of the EMCDDA with their accession to the EU. Operational agreements were signed between Europol and Croatia in 2006. A strategic agreement between **Europol** and **Turkey** was signed in 2004 and strategic agreements between **Europol** and **Albania** and between Europol and Bosnia-Herzegovina entered into force in 2007. This was followed by a strategic agreement between **Europol** and *the former Yugoslav Republic of Macedonia* in 2008. Agreements on strategic cooperation between Europol and Montenegro and between Europol and **Serbia** are currently being negotiated.

Eurojust has concluded a formal third country agreement with **Romania**, while **Turkey** and **Croatia** have appointed contact points for cooperation with **Eurojust**. Furthermore, Eurojust signed a cooperation agreement with **Croatia** in 2007 and concluded a draft cooperation agreement with *the former Yugoslav Republic of Macedonia* in 2008.

Assistance to European neighbours and cooperation with Russia (*obj. 34*)

The European Neighbourhood Policy has paved the way towards closer cooperation on drugs with the ENP partners, based on regular dialogue coupled with dedicated financial instruments. A drugs ‘Troika’ with Ukraine took place in 2007 and 2008, while the first EU-Morocco ‘Troika’ was held in 2008. Enhanced dialogue with Morocco is envisaged as part of this country’s ‘Statut Avancé’. **More impetus is needed to cooperate with those ENP countries which are major drug producers and/or affected by drug trafficking to and from Europe.** Developing regional approaches between ENP countries (East European ENP countries such as Ukraine and Russia and those of the Mediterranean) could be considered in future.

Since the Warsaw Conference of EU/Russian drugs experts in November 2006, EU-Russia cooperation in the field of drugs has made some progress at operational level with the creation of an EU-Russia liaison officers’ network, an expert meeting on precursors, and progress on the operational agreement between the Federal Russian Drugs Control Service (FDSC) and Europol. A Memorandum of Understanding has been signed with the FDSC and the EMCDDA. There is considerable interest in a strategic partnership involving countries on the trafficking routes and a possible dialogue on drug enforcement cooperation in the Black Sea region. The negotiation mandate for a new cooperation agreement between the EU and Russia could also provide a political framework to reinforce cooperation in the drugs field.

Cooperation with third countries

At the end of 2007, the Commission published an update of EU assistance to third countries. As *Table 5* shows, EU international cooperation projects in the area of drugs accounted for over EUR 760 million in 2005, making the EU one of the strongest players in the global effort against drugs. Most funding was provided for alternative development (66%), institution building (17%, mostly law enforcement), supply reduction and law enforcement cooperation (11.4%), and demand reduction, including harm reduction (5%). Of the total spending, two thirds was allocated to activities in Afghanistan (EUR 452 million) and almost one third to the three main coca growing countries, Colombia, Bolivia and Peru (EUR 220 million).

Table 5 – Projects funded by the European Union as of December 2005

Summary — Thematic Distribution of Funds			
Themes	No of Projects	Amount in Euros	Beneficiary countries & regions
Institution Building	42	131 023 909 (17.3%)	Afghanistan (16), Central Asia (1), Southern Caucasus (1), Eastern Europe (1), SADC (1), Mediterranean region (1), former Yugoslav Republic of Macedonia (1), Bulgaria & Romania (1), Turkey (1), Global (8), West Africa (1), Middle East (1), Laos (4), Peru (1), Myanmar (1), Belarus (1), Burma (1), Peru & Bolivia (1), Trinidad & Tobago (1)
Alternative Development	70	503 109 797 (66.4%)	Bolivia (12), Colombia (14), Peru (10), Afghanistan (23), Global (3), Morocco (1), Laos (3), Vietnam (1), Thailand & Burma (1), South-East Asia (1), Paraguay (1)
Anti Precursor Diversion	6	3 203 024 (0.4%)	Afghanistan (1), Andean Region (1), Central Asia (2), Latin America (2)
Anti Money Laundering	17	7 303 499 (1%)	CARDS (1), ASEM Region (2), Global (2), Zambia (1), AML (1), Iran (1), Latin America (1), China (1), Nigeria (4), UAE (1), East/Southern Africa (1), COT/other Caribbean States (1)
Other Supply Reduction	58	76 339 605 (10%)	Afghanistan (13), Southern Caucasus (1), Western Balkans and Mediterranean Region (1), LAC (2), BIH (1), Global (1), Central Asia (2), Venezuela (1), AMLAT (1), Iran (2), China (1), Eastern Europe (1), Russia (2), Tajikistan (3), Africa (1), Eastern & South Eastern Africa (1), Palestinian Territories (1), West and Central Asia (1), Cape Verde (4), Colombia (3), Latin America (1), Barbados (1), Brazil (2), Iraq (1), Jamaica (3), Pakistan (2), Turkey (3), UAE (1), Ukraine/Poland (1)
Harm Reduction	11	4 876 054 (0.6%)	Global (1), Eastern Europe (1), South-Eastern Europe (1), South East Asia (1), Global (3), Ukraine (1), Belarus (1), Europe / Central Asia (1), Eastern Europe (1)
Demand Reduction	59	32 343 660 (4.3%)	Latin America — Caribbean (1), Asia-Caribbean (2), Caribbean (1), Dominican Republic (1), Surinam (1), Afghanistan (4), Russia (12), Myanmar (1), Pakistan (1), Iran (40), Venezuela (1), Montenegro (1), Serbia (2), KOS (1), Global (6), Peru (3), Central Asia (2), South Africa (1), Lebanon (1), Cape Verde (1), Laos (2), Central America (1), Chile (1), Zambia (1), Bolivia (1), LAC (1), Andean Countries (1), South America (1), Honduras (1), Thailand & Burma (2)
Total	263	758 199 548	

Source: Progress Review 2007

The remainder was spread throughout the rest of the world, particularly in the Mediterranean/Balkan region, South-East Asia, South Caucasus and Central Asia. More than half of the EU Member States plus the European Commission had international cooperation projects in the area of drugs.

Despite the considerable amount of funding provided by the Commission to drug-related assistance projects in third countries until end 2006, the consequences of the lack of a thematic budget line for drugs under the new EC external funding instruments for project funding in 2007 and 2008 has not been assessed so far .

In the drug precursor area, the Community has concluded several bilateral drug precursor cooperation agreements with major players (Andean Countries, USA, Mexico, Chile, and Turkey) and has embarked on negotiating a bilateral precursor agreement with China in order to strengthen controls over synthetic drug precursors. During the period under review, key milestones included the first meeting of experts in the field of both demand

reduction and supply reduction as part of the ‘Paris Pact’ process on heroin trafficking, and an agreement on the review of the 1999 Panama Action Plan between the EU and Latin America and the Caribbean, which identified new priorities for cooperation.

Looking to the future, the Commission and the Member States should work towards improving the link between political priorities in the drugs field and the funding available to support the implementation of the political objectives in order to secure funding to address, for example, the growing problem of illicit drug trafficking in West Africa and other new emerging routes, but also to actively support third countries in tackling the adverse consequences of drugs in their society through demand reduction activities.

Member State donations to international organisations (*obj. 37*)

The Member States were asked to report on their donations and contributions to international organisations for drug-related activities in the years 2005 to 2007. Of the 24 Member States that participated in the survey, 19 reported donations to UNODC, the WHO, UNAIDS, the Pompidou Group (Council of Europe) and other organisations.

Table 6 — Donations to international organisations for drug-related activities per MS 2005-2007

	UNODC (EUR)	WHO (EUR)	UNAIDS (EUR)	PG (EUR)	Other ⁶⁶ (EUR)	Total (EUR)
UK ⁶⁷	5 810 000		65 440 000	725 716	13 452 200	85 427 916
FI ⁶⁸	2 400 000	5 400 000	21 520 000			29 320 000
SE	24 770 000			113 575		24 883 575
FR	8 300 000	100 000		60 000	262 000	8 722 000
BE	1 157 457		6 325 080	116 940		7 599 477
DE	2 110 000				5 000 000	7 462 000
EL	566 350	6 341 300 ⁶⁹	650 000	71 000		6 143 650
NL	6 355 356			135 000		6 490 356
IE	3 540 000			55 356		3 595 356
DK	2 680 964			79 517		2 760 481
ES	1 720 000				600 000	2 320 000
LU	1 989 900					1 989 900
AT	1 372 095					1 372 095
CZ	329 326					329 326
PL	177 500			15 000	76 600	269 100
LT		223 128				223 128
PT	48 231			50 000		98 231
HU	50 000					50 000
SI	13 000					13 000
CY					6 322	6 322
	63 390 179	12 064 428	93 935 080	1 422 104	19 397 122	188 723 913

⁶⁶ Contributions were made to UNDP, OAS/CICAD, UNICEF, ARTF and CNTF.

⁶⁷ The UK contributions for 2005 are not available except for the contribution to the Pompidou Group. The UK contribution to UNAIDS for 2006 and 2007 is generic and not specifically for drug-related activities. The amount reported is the overall contribution of the UK to UNAIDS.

⁶⁸ The Finnish contributions to UNODC, UNAIDS and WHO are generic and therefore not specifically for drug-related activities. The amounts reported comprise the overall contributions of Finland to these organisations.

⁶⁹ The Greek contribution to WHO is generic and therefore not specifically for drug-related activities.

Table 6 provides an overview of the information provided by the Member States for the period 2005-2007. The overall amount of funds donated in these years adds up to approximately EUR 182.5 million, or EUR 61 million on average per year.

The largest donors are the UK and Finland, although it must be noted that the contributions of these countries to UNODC, WHO and UNAIDS are not specified and comprise the overall amounts given to these organisations.

Between 2004 and 2008 the European Commission has made financial pledges towards UNODC's Drugs Programme with an estimated total of EUR 13.5 million. Financial support to several other projects is expected to be approved in 2008, with a potential value of over EUR 2 million. The table shows furthermore that, between 2005 and 2007, UNODC received EUR 62.8 million from 17 Member States for activities in the field of drug-supply reduction, but also for specific activities in the field of demand reduction, including the prevention of HIV infections among injecting drug users. Of the reporting Member States, Sweden is the largest donor to UNODC, followed by France and the Netherlands. The UK and Germany donated over EUR 18 million to the United Nations Development Programme (UNDP) for institution building and alternative development activities.

Introduction

The cross-cutting theme ‘information, research and evaluation’ is a fundamental part of the EU Drugs Action Plan 2005-2008. The activities covered under this heading provide information on the implementation of other objectives and actions in the Action Plan or are instrumental for the development of indicators to measure the Action Plan’s impact.

Providing reliable information on the drug situation (*obj. 40*)

In the period covered by the Action Plan, both the EMCDDA and Europol have published information on the drug situation. The EMCDDA has been publishing an increasing number of reports and publications covering a wide variety of issues relating to the drug phenomenon. Europol contributes specific analysis reports on drug-related organised crime and the Organised Crime Threat Assessments (OCTA).

The EMCDDA plays a central role in the collection and interpretation of drug-related data and information at EU level. This role is recognised by the European Commission and the Member States. Between 2005 and 2008, the EMCDDA received over EUR 50.5 million in Commission funding⁷⁰ for the collection and analysis of (national) data and information. As the EMCDDA relies heavily on the information collected through its Reitox network of National Focal Points (NFP), approximately 20% of the EMCDDA budget is allocated to these 27 National Focal Points. Each National Focal Point receives a maximum grant from the EMCDDA every year⁷¹. National governments co-fund this grant, in most cases on a 50-50 basis. Due to the enlargement of the EU, the total available budget for the National Focal Points has remained relatively stable compared to the situation before 2004, while the number of countries receiving funding has increased.

In recent years, some Member States have reduced their national funding for the National Focal Points. The EMCDDA grant provides a maximum of 50% to match the grant provided by the national government. However, not every NFP can apply for the maximum grant, as the national funding is less. In some Member States, the national funding for the NFP has faced serious difficulties in recent times. **Member States should realise that a coherent and overall picture of the EU drugs situation cannot be maintained without making available adequate resources to the National Focal Points.** If this tendency to reduce funding persists, the EMCDDA will not be able to continue its EU-wide data collection and analysis of the drug problem.

Monitoring of drug trends and markets (*obj. 39, 41, 42*)

Information on the drug situation is mainly available through the EMCDDA key epidemiological indicators⁷² and data collections on drug production⁷³, retail prices, and

⁷⁰ 2005: EUR 12.0 million; 2006: EUR 12.1 million; 2007: 13.0 million and 2008: 13.4 million.

⁷¹ In 2004 the ceiling for the EMCDDA contribution was approx. EUR 115 000 per year; following EU enlargement, this ceiling was reduced to approx. EUR 97 000 per year in 2007.

⁷² The five EMCDDA key epidemiological indicators are: drug use in the general population, problem drug use, drug-related infectious diseases, drug-related deaths & mortality, and demand for treatment.

⁷³ This primarily concerns production estimates by UNODC.

potency of drugs and composition of tablets⁷⁴. Europol draws its data from the three drug-related projects, incorporating Analysis Work Files and related expert systems, for which data are provided by the Member States and third parties.

In the field of drug demand reduction, information is also available from the EMCDDA (prevention, treatment, drug-related harm, social reintegration, new and emerging trends, etc.) in the form of a variety of standard tables and structured questionnaires put to Member States to obtain information on e.g. the availability of demand reduction interventions in Member States, the demand for drug treatment, types of treatment interventions, harm reduction interventions, etc. **In recent years, major investments have been made to increase the reliability, comparability and availability of these data.**

In the past 3 years, a steady improvement can be observed in the implementation of the key indicators (KIs) by Member States. Moreover, these indicators are increasingly viewed as global standards for information collection in these areas. Nearly all Member States now collect some information in each indicator area, although the quality of information varies. For assessing implementation levels, three key dimensions have now been formalised: a) *the extent to which national approaches meet accepted methodological standards*; b) *the extent to which reporting can be carried out using agreed common categories*; c) *the availability of contemporary information* (timeliness — i.e. availability of recent data within a reasonable time limit). As of 2009, minimum implementation targets will be available to facilitate future dialogue on the progress made by Member States in each information domain and to provide policy-makers with a clearer understanding of the resource implications of KI implementation.

Nevertheless, a clear problem area is that many countries have not invested in recent estimates of problem drug use (PDU indicator).

In the field of drug supply reduction, the situation is more problematic as data are often not available, not consistent and/or not comparable. Both Europol and the EMCDDA collect data on drug seizures in the Member States. However, discrepancies between the two data collections can be substantial, mainly due to the fact that Europol does not receive information from one or more key destination countries. Data on drug-related arrest reports are collected by the EMCDDA, while EUROSTAT collects statistics on reported drug trafficking crimes, which include a broad range of offences. Information on the outcome of arrests (e.g. sentences) is not available on a structural basis.

Data on drug precursor seizures and stopped shipments have been collected by the Commission since 2005. Member States are legally bound to provide the necessary data in a standardised format⁷⁵. **However, the collection of much of the other data available in the field of supply reduction is not standardised, not always reliable and often difficult to compare. Furthermore, not every EU Member State collects the necessary information.**

⁷⁴ Information on price and purity is collected by the EMCDDA, but from a limited number of Member States and using non-standardised collection methods.

⁷⁵ Article 29 of Commission Regulation (EC) No 1277/2005 (OJ L 202, 3.8.2005, p. 7).

It is very important to have the collection, processing and analysis of data in the field of drug supply (the market) and supply reduction (incl. law enforcement) standardised in the next few years. **The available information does not offer enough evidence to monitor trends, to assess the effectiveness of law enforcement interventions or to analyse the impact of this part of drug policy on the EU drug situation. The development of a number of key indicators in this field should therefore be considered.**

In 2007, the Commission called for a major study on the characteristics and operating mechanisms of the global illicit drug market. This study is expected to provide more reliable data on the size of the market, main trafficking routes, the characteristics of drug policies in different parts of the world, and estimations of the costs to society.

As indicated in 2.1.3, the Commission has also called for a study on existing drug market and law enforcement data in the EU, which — when linked to the need to formulate a operational and measurable definition of drug-related crime — will hopefully provide the basis for developing a limited set of key indicators over the next few years. Europol and the EMCDDA will be closely involved in this process.

As regards the estimation of public expenditure by Member States on drug issues, progress has been made using estimation techniques developed by the EMCDDA. In its most recent work, the EMCDDA estimates that Member State spending on drug-related issues represents on average 0.15% of GDP⁷⁶, which — when extrapolated to the EU-27 countries — would represent a total sum of EUR 13 to 36 billion annually. However, in this area too, there are major difficulties in identifying and making available reliable and standardised information on direct and indirect public expenditure in the field of drugs. In addition to the efforts by the EMCDDA, the Commission is funding a project under the Sixth RTD Framework Programme which focuses on the development of a methodology for the estimation of the costs of crimes, including certain elements of drug-related crimes. Finally, in the area of freedom, justice and home affairs, the Commission is also working on improving the measurability of crime and law enforcement. One activity in this field is the development of methods to estimate the cost of law enforcement.

These activities will yield results during the implementation of the EU Drugs Action Plan 2009-2012.

In May 2008, a new Flash Eurobarometer on '*Young People and Drugs*' was conducted at the request of the European Commission. Over 12 500 randomly selected young people (15-24 years of age) were interviewed across the 27 EU Member States. The objective was to examine the attitudes and perceptions of young EU citizens regarding drug-related issues and policies.

Young people seem to support the EU's balanced approach to drug policy by advocating 'tough' measures against drug dealers and traffickers (63%) but 'soft' measures to be used against drug users, e.g. information and prevention campaigns (47%) and the treatment and rehabilitation of offenders (33%).

⁷⁶ Data from six Member States only; variation from 0.05% to 0.46%.

Young people increasingly seem to make a distinction between substances in their perception of risks, since 81% and 96% of respondents thought heroin, cocaine and ecstasy pose a high risk to users, while only 41% thought that of cannabis. As regards the risks of licit substances, 70% of respondents thought that tobacco smoking posed a medium to low health risk, while 75% thought alcohol posed a medium to low risk.

When asked about possible options for government control of licit and illicit substances, almost all respondents thought heroin (97%), cocaine (95%) and ecstasy (94%) should remain under strict control. Regarding cannabis, one third (31%) of respondents thought a regulation model similar to that for alcohol and tobacco could be introduced, while 67% thought that controls should remain unchanged.

Among all respondents, heroin was seen to be the most difficult illicit drug to obtain, followed by cocaine, ecstasy and cannabis. Cocaine was considered to be easily or very easily available by 35% of respondents aged 15-24. Cannabis was considered fairly easy or very easy to obtain by almost 63% of respondents aged 15-24. Where licit substances are concerned, 72% of 15-18 year-olds thought it would be easy or very easy for them to get hold of tobacco as against 87% of those aged 22-24. Over 90% of respondents in all Member States but one indicated that it would be fairly easy or very easy for them to obtain alcohol.

Promoting drug-related research (*obj. 43, 44*)

One of the cornerstones of EU drugs policy is development of the knowledge base on the drug phenomenon, as a crucial element to support drug policy.

During the meeting of the National Drug Coordinators in Berlin in March 2007, the issue of drug-related research within the EU and compared to other regions in the world was discussed, highlighting the importance for the EU to make the best use of available research capacity and knowledge in the field of drugs. The Commission presented a 'non-paper' on this issue for the HDG at the end of 2007, when it also launched a study entitled '*A comparative analysis of research into illicit drugs in the European Union,*' which will provide an overview of the research areas, trends and infrastructures in the EU and make recommendations on how to encourage the development of networks of excellence in the field of drug-related research, with a possible emphasis on increased coordination and prioritisation at EU level. The final report will be available in 2009.

The EU Research Programmes⁷⁷ increasingly provide opportunities for EU research organisations and networks in the field of drugs to collaborate at European level. The Seventh Framework Programme (2007-2013) provides researchers and their networks in the EU with opportunities to submit proposals on a variety of research topics under the programmes on health, socio-economic sciences and humanities, and security research.

However, the first results of the Seventh RTD Framework Programme reveal a very limited number of projects of only indirect interest to the drug-related research field.

The Commission also launches several calls for tender every year with the aim of obtaining an overview and/or exploring further specific elements of the drug problem.

⁷⁷ Fifth, Sixth and Seventh Framework Programmes, run by the European Commission.

Table 7 presents an overview of Commission drug-related studies that have been conducted in recent years or are still ongoing.

Table 7 — European Commission Calls for Tender for specific studies and reports

Study or evaluation title / contents	Relevance objective/ action	Date issued	Date (to be) published	European Commission DG
Commission study on the influence of alcohol, drugs and medicines on driving, by 2008	9	2006	2010	DG Energy & Transport
Commission work on drugs policy and harm reduction, including a report on drug treatment and good practices in EU and background information on health issues related to drug use in prison	12/13	2006	2008	DG Health & Consumers
Background document on prevention and reduction of health-related harm associated with drug-dependence in the EU in view of a Commission report on the implementation of the Council Recommendation of 18 June 2003 (2003/488/EC)	14 & 15	2004	2007	DG Health & Consumers
Commission report on the creation of national multi-disciplinary units for the detection and investigation of criminals' finances and assets	23.3	2007	2008	DG Justice, Freedom & Security
Commission study on best practices in Member States which have established and implemented a national fund to provide funding for projects in the drug field and financed from the confiscation of assets earned through drug production and trafficking	23.5	2007	2008	DG Justice, Freedom & Security
Commission study on drug-related crime prevention practices in third countries	25.3	2008	2009	DG Justice, Freedom & Security
Commission report on the level of networking and acquired funding in research	44	2007	2008	DG Justice, Freedom & Security
Review of the Panama Action Plan and Harm Reduction (cost efficiency of harm reduction on third countries)	29/34/35/37	2006	2008	DG External Relations
Assessment of the characteristics and mechanisms of the Global Illicit Drug Market	Overall	2007	2008	Justice, Freedom & Security
Fact Finding Study on Customs Control of Drug Precursors in the EU	22/36	2007	2007	DG Taxation & Customs Union
Evaluation of the Community drug precursor legislation	22	2008	2009	DG Enterprise & Industry; DG Taxation & Customs Union
Evaluation of the EMCDDA	41	2006	2007	Justice, Freedom & Security

Continuous evaluation (*obj. 45*)

The final evaluation of the EU Drugs Action Plan 2005-2008 demonstrates that the EU is resolved to base its policies increasingly on information obtained through evaluation. The annual progress reviews published in 2006 and 2007 have provided the Commission and Member States with up-to-date information on the progress made with the implementation of the Action Plan. The final evaluation provides further insight into the extent to which objectives and actions have been realised.

At national level, an increasing number of Member States have conducted evaluations of their national drug policies in recent years⁷⁸. The survey of Member States conducted for this evaluation reveals that at least 15 countries expect to conduct some type of evaluation of their national drug policy in the next few years.

The quality and the comprehensiveness of evaluations at national level differ considerably, and most Member States end up with a process evaluation rather than an outcome evaluation. Further research and exchange of best evaluation practices could support Member States in improving the quality of evaluation.

In 2004, the EU Member States decided to adopt an EU Drugs Strategy to be implemented over a total period of 8 years. This relatively long implementation period was considered necessary to ensure that measures adopted and implemented through the Action Plans could be put into practice.

This evaluation examines the extent to which the objectives and actions in the Action Plan have been implemented. For the final evaluation of the next EU Drugs Plan (2009-2012) and the EU Drugs Strategy 2005-2012 at the end of the implementation period, it might be useful for the EU to have a reflection period of at least one year during which the evaluation results can be analysed and discussed and the challenges for future action can be properly assessed, as in the case of the reflection period the EU has intensively supported for the UNGASS 1998 evaluation and follow-up.

⁷⁸ E.g. Spain, Portugal, Hungary, United Kingdom, France.

IMPACT OF THE EU DRUGS ACTION PLAN ON MEMBER STATES' DRUG POLICY

As part of this evaluation, Member States were sent a survey containing questions on the consistency and relevance of the EU Drugs Action Plan (2005-2008) with their national policy. Member States were also asked to provide details on how the Action Plan has played a role in activities at national level. Of the 27 Member States, 25 responded to the survey⁷⁹.

All Member States that participated in the evaluation survey were able to **report clearly on who was responsible for the implementation of those objectives and actions** under the EU Drugs Action Plan (2005-2008) that are the responsibility of the Member States. In general, this task is the responsibility of the National Drugs Coordinator and/or the national coordination body for drug policy. In some Member States this task is shared through interdepartmental coordination structures and working groups⁸⁰.

Incorporation of EU Action Plan objectives in national drug policy

Member States were also asked **whether and how the objectives of the EU Drugs Action Plan (2005-2008) have been incorporated in these national policy documents**. Objectives are often not directly incorporated in national policy, but 'translated' to make them relevant for the national level.

In Estonia, Luxembourg, Poland, Portugal, Slovakia, Spain and Romania, the development of the national drug action plan took place almost in parallel with the development of the EU Drug Action Plan (2005-2008), allowing optimal alignment between national and EU priorities and actions, where relevant. In several other EU Member States, national drug policy documents were developed prior to the EU Drugs Action Plan (2005-2008). This was the case for Belgium, Bulgaria, Denmark, Germany, France, Ireland, Lithuania, Hungary, the Netherlands, Austria, Slovenia, Slovakia, Spain, Finland, Sweden and the UK. However, the EU Drugs Action has played a role in these countries too.

In Bulgaria, the National Anti-Drugs Action Plan 2003-2008 was amended in 2006 and aligned with the EU Action Plan. The Danish Action Plan is subject to an ongoing evaluation and, as a result, insights from the EU Action Plan have been taken into consideration where relevant. In Austria and the Netherlands, the implementation of drug policy is an ongoing process and can be adapted to new trends and developments, including the requirements of the EU Drug Action Plan. In Austria, the Länder have also been informed about the EU Drug Action Plan and have incorporated elements of it in their particular drug strategies and action plans. For the development of the Czech National Drug Action Plan 2007-2009, the EU Drug Action Plan (2005-2008) was assessed and elements were incorporated, complemented by the inclusion of priorities that were relevant for the national level.

The new Security Action Plan (2008-2011) in Belgium will take into account objectives from the EU Drug Action Plan (2005-2008). France, the UK and Slovenia reported that

⁷⁹ At the time of drafting of this report, Italy and Malta had not responded to the survey.

⁸⁰ e.g. France, Netherlands and Hungary

their existing national policies at the time of the adoption of the EU Drug Action Plan (2005-2008) were highly consistent with its objectives. An external mid-term evaluation of the Hungarian National Drug Strategy (2000-2009) revealed that it was consistent with both the EU Drugs Strategy (2005-2012) and the EU Drugs Action Plan (2005-2008).

Practically all of the reporting Member States stated that the current and next EU Drugs Action Plans (2009-2012) will be taken into consideration when a new national drug strategy or national drug action plan is developed. For some countries, the EU Action Plans will form a framework for their new policies; other Member States will ensure coherence and coordination between national and EU priorities.

Table 8 presents a brief overview of the number of Member States indicating that one or more of the key priorities from the EU Drug Strategy (2005-2012) which form the basis for the specific objectives in the EU Drugs Action Plan (2005-2008) have been reflected in their national policy. The priorities seem to be well represented

Table 8 – Reflection of EU Drug Strategy and EU Drugs Action Plan priorities in national drug policy

Priority objective	Nr. MS Reflected
1. Improving access to and effectiveness of a broad range of prevention programmes and raising awareness about the risk of the use of psychoactive substances and related consequences.	25
2. Development and improvement of access to and effectiveness of selective and indicated prevention programmes, including early detection and early intervention.	24
3. Improving coverage, access to, quality and effectiveness of targeted and diversified treatment and rehabilitation programmes, including integrated psychosocial and pharmacological care and integrating these in general public health policies.	25
4. Improving access to harm reduction services for the prevention and reduction of drug-related health and social damage, including drug-related infectious diseases such as HIV/AIDS, hepatitis C and other blood borne diseases.	25
5. Reduction of drug related deaths.	25
6. Further develop alternatives to imprisonment for drug abusers and making available drug services for people in prison.	22
7. Strengthening EU law enforcement cooperation on both strategic and crime prevention levels, in order to enhance operational activities in the field of drugs and the diversion of precursors production and (intra-EU) cross-border trafficking of drugs and precursors, while respecting the principle of subsidiarity.	23
8. Intensifying effective (<i>bi- and multilateral</i>) law enforcement cooperation, criminal investigation and forensic science cooperation between Member States, within an EU Framework, that have common interests and/ or face the same drug problems by using existing instruments and frameworks.	24
9. Intensifying law enforcement efforts directed at non-EU Countries, especially producing countries and those along trafficking routes, including the strengthening of external borders of the EU, with the aim to stem the flow of drugs from these third countries.	21
10. Target money laundering and seizure of accumulated assets in relation to drug-related crime.	23
11. Support the <i>candidate</i> and <i>stabilisation</i> and <i>association</i> process countries with technical and other assistance to familiarise them with the EU <i>acquis</i> and to assist them in carrying out the required actions.	12
12. Assisting third countries, including European Neighbourhood countries, and key drug producing and transit countries to be more effective in both drug demand and drug supply reduction, among others through closer cooperation among EU-Member States.	15
13. Provide reliable information on the drug situation, both on drug demand and drug supply, among others by implementing the five key epidemiological indicators and by ensuring the continued work of the Reitox national focal points and Europol National Drugs Units.	24

Coherence between the Action Plan and national policy objectives

Member States were also asked whether they had made **an assessment of which of the specific objectives and actions of the EU Drugs Action Plan (2005-2008) were part of their national drug policy and which of the EU specific objectives and actions required further action** at national level. This was especially relevant to those objectives for which the Member States are responsible.

Most Member States reported that no such an assessment had been made on a one-on-one basis. Poland, Portugal, Sweden and the UK reported that their national drug policy reflected all the relevant objectives and actions of the EU Drugs Action Plan (2005-2008).

Estonia, the Czech Republic, Ireland, Lithuania and Slovakia reported that an analysis of this kind will be conducted when they draft their new national action plan on drugs. Bulgaria, Cyprus, Latvia and Romania reported that such an assessment will be taken on board during the evaluation of their existing action plans. The Netherlands reported that it has introduced specific national policy measures (as part of an ongoing process) that contribute to specific objectives and actions in the EU Drugs Action Plan (2005-2008) and that were not previously covered. This includes, for example, specific actions on law enforcement cooperation with other Member States, a strong emphasis on reducing the production of synthetic drugs, etc.

All Member States that participated in the survey say that the Action Plan is **consistent with and relevant to national drug policy**. The main dimensions, objectives and actions will form an important basis for the upcoming implementation of Austria's National Drugs Strategy. For Belgium, the section of the Action Plan concerning supply reduction is consistent with and relevant to national drug policy. The main aims of the EU Drug Strategy are also reflected in the Cypriot National Drug Strategy, but the implementation of these aims is restricted by available financial and other resources. For France, a reference in the national drug policy to the EU Drug Action Plan is crucial for specific policy fields, such as harm reduction.

However, the EU Drug Action Plan would be more consistent with French policy if a clear link were established with licit substances, including alcohol and tobacco. As the EU Drug Action Plan (2005-2008) was developed during the Luxembourg Presidency, at the same time as the National Action Plan on Drugs (2005-2009), there is a high level of consistency between the two plans. For the purposes of evaluating the EU Drug Action Plan (2005-2008), Portugal developed its National Drug Action Plan (2005-2008) which closely follows the structure of the EU Action Plan, while reflecting Portugal's needs and reality. The broad scope and detail of the EU Drug Action Plan has been instrumental for Slovakia by providing guidance for national activities.

National priorities not covered by the Action Plan

As table 2 in Chapter 2 showed, a number of countries adopted the EU Drug Action Plan after they had adopted their national drug strategy and/or national drug action plans. Some divergence between national policies and the Action Plan was therefore to be expected.

Furthermore, most national action plans take account of national priorities, needs and realities. The EU Drug Action Plan may function as a supporting document in those cases.

Member States were asked which specific national priorities were relevant but not covered by the EU Drugs Action Plan. Belgium's drug policy places emphasis on synthetic drugs, street dealing and the cultivation of cannabis. Estonia places greater emphasis on drugs and drug-related harms in prison, while in the Czech Republic emphasis is placed on the development of quality standards and cost-effectiveness of drug services. In France and Germany, licit drugs – mainly alcohol and tobacco - are also part of overall drug policy. In both of these countries and the Netherlands, greater emphasis is also placed on prevention and harm reduction⁸¹. For Luxembourg, risk and harm reduction is a cross-cutting theme for reducing both demand and supply. The UK, Hungary and Ireland report that the cornerstone of their national policy is the involvement of civil society⁸² through community and local cooperation as well as in the planning and delivery of services.

In Ireland and the UK, priority is given to the rehabilitation and reintegration of drug users (e.g. through public services). Portugal reports on its Dissuasion Policy, which includes the decriminalisation of consumption and possession of drugs for personal use. Ireland, furthermore, reports priorities being given to community policing and the use of awareness campaigns. Finally, Slovakia reports that the EU Action Plan could place more emphasis on the control of drug-trafficking at the external borders of the EU with Eastern Europe, including the Ukraine.

Action Plan objectives covered by national drug policies

Most Member States report that the objectives and actions in the EU Drug Action Plan (2005-2008) are covered by their national drug strategy and/ or action plans. For obvious reasons, objectives and actions that are implemented at EU level are not included. A number of countries reported on some substantial differences. In Belgium, the Czech Republic, Ireland and Slovenia, the national drug strategy and/or action plan neither specifies nor addresses the cross-cutting theme of international cooperation and assistance.

Some detailed actions under the various chapters are not always covered in Member State policies. For example, early detection and intervention is not covered in Estonia. Poland and Romania highlight the fact that their national policy does not include the 'efficient utilisation and development of alternatives to imprisonment'. Romania also reported that some specific actions in the field of supply reduction were not covered, including the forensic profiling of heroin and cocaine⁸³, cooperation under Project Synergy and the forensic profiling of synthetic drugs⁸⁴. In Bulgaria, there is no coverage of objectives on anti-money laundering⁸⁵, the link between drug production and the

⁸¹ In Germany, harm reduction (survival assistance) is one of the four pillars of drug policy: prevention, treatment, repression and survival assistance

⁸² The community and voluntary sector

⁸³ EU Drug Action Plan (2005-2008); objective 18.5

⁸⁴ Ibid.; objective 20.1, 20.2

⁸⁵ Ibid.; objective 23

financing of terrorism⁸⁶ and drug-related crimes and precursor diversion committed with the aid of information technology⁸⁷, although these will be included in the next national action plan.

As the Danish national drug strategy is universal, it does not specifically include any of the EU drug policy objectives, although all aspects of the drug problem are covered in both policies. The same is the case with Latvia's State Programme on drugs, which despite its different structure does cover many of the EU Action Plan objectives. France, Spain and Slovenia reported that coordination aspects were not (always) included in their national policy. In Slovenia this specifically concerns coordination at national level. Ireland, Romania, Slovakia and Slovenia reported that specific actions in the field of information, research and evaluation were not covered.

Most of the Member States that reported differences between national and EU drug policy indicated that these issues would be addressed when renewing and/ or re-drafting new national drug policy documents in the next years.

Strengths and weaknesses of the Action Plan

The Member States were asked to report on the weaknesses of the EU Drug Action Plan (2005-2008). Several Member States report that the current Action Plan is too long in their view, that it has too many actions and that it is difficult to read or translate into policy discussions at national level. At the same time, other Member States indicate that they think that important issues have been omitted.

Examples include greater attention to illicit crop production and alternative development and the inclusion of cooperation with South East Asia. Licit drugs, such as alcohol and tobacco, are also not properly covered by the Action Plan. Some Member States mention that there is no overall threat assessment for the objectives in the Action Plan, while at the same time the plan is not flexible enough to address new trends and developments that may occur during the four-year implementation period. The need for closer links with other policy fields, such as employment (rehabilitation of drug users) and mental health, was also mentioned. The Action Plan ought to have placed more emphasis on cooperation between the drug demand and drug supply sector, and thus concentrate more on an integrated approach to drug policy.

Furthermore, even though the definition of objectives, actions, indicators and assessment tools has enhanced the measurability of the outcomes of the Action Plan, some of the objectives and actions are considered too vague or not relevant. Several indicators and assessment tools are not adequately calibrated, with the result that these do not provide a satisfactory picture of the achievement of objectives.

Some Member States also point out that the Action Plan has a limited impact in the Member States because it is non-binding and that a large number of objectives and actions have to be implemented by Member States.

⁸⁶ Ibid.; objective 24

⁸⁷ Ibid.; objective 26

A number of Member States also mention the lack of financial resources for the implementation of the Action Plan. It is unclear whether these countries are referring to national or EC level funding, which is available through a number of specific funding programmes, although not in the form of a specific budget line for the implementation of the Action Plan.

As to the strengths of the EU Drugs Action Plan (2005-2008), Member States also had strong opinions. The EU Action Plan reflects the key principles of the EU model of drug policy, fostering an integrated and balanced approach to the drug problem. It also strengthens coordination of drug policy within the EU and reinforces EU participation and coherence at international level and within the UN in particular.

The EU Action Plan provides a comprehensive framework for EU drug policy and – despite some of its shortcomings – sets priorities and provides indicators for each objective and action. As such, the Action Plan facilitates a process in which similar policy measures are introduced in all EU Member States. As such, it supports a process of convergence between Member States' drug policies and helps to achieve policy consistency between these countries. For some Member States, the Action Plan functions as a useful 'benchmark' against which to compare their national drug policies.

Another strong point that was mentioned was the Action Plan's focus on strengthening the knowledge base underpinning drugs policy through research and monitoring.

TRENDS IN THE DRUG SITUATION IN THE EUROPEAN UNION

Drug use in the European Union

In many respects, the European drug situation appears to have moved into a more stable period after the sometimes dramatic increases that were witnessed in the 1990s and early part of the current decade. Levels of drug use remain high by historical standards and, although there are considerable differences between Member States, to some extent these are less pronounced than in the past.

Heroin use and drug injecting appear to be generally stable. Cannabis remains the most commonly consumed illicit drug, and prevalence estimates are high by historical standards; but again the available trend data point overall to a stabilisation or even possibly to a limited decline in the popularity of cannabis. Patterns of stimulant use are more difficult to summarise. Cocaine use has increased dramatically in some Member States - although not in all - while ecstasy use seems to have moderately decreased overall and amphetamine use remains an important aspect of the drug problem in some Nordic countries. In the Czech Republic, and to a lesser extent in Slovakia, methamphetamine problems have been observed, but elsewhere in Europe methamphetamine use remains rare.

Finally, polydrug use is increasingly found to be a dominant pattern of use among many populations of drug users, and problematic use of illicit drugs often overlaps with concurrent problems of alcohol use. This kind of drug consumption pattern is poorly understood and presents a challenge to conventional monitoring approaches.

Drug use among school students (15-16 years)

After tobacco and alcohol, cannabis continues to be the psychoactive substance most commonly used by school pupils. According to the **2003 ESPAD⁸⁸ survey**, between 1% and 13 % (on average 4 %) of pupils reported having tried cannabis for the first time when they were 13 years old or younger. Among 15–16 year olds, lifetime cannabis use ranges from more than 40 % in some European countries to below 10 % in others⁸⁹.

It is estimated that, in 2003, in the EU Member States around 3.5 million (or 22.1%) 15-16 year old students had used cannabis at least once in their lifetime, and around 1.7 million (11%) had used cannabis during the month prior to the survey. On average, about 4 % of 15–16 year olds report having used the drug 40 or more times in their lives the range in prevalence by country is between 0 and 10 %), thereby reflecting the existence of a group of regular cannabis users among school students.

⁸⁸ European School Survey Project on Alcohol and other Drugs, a 4-yearly survey in 35 countries aimed at pupils that turn 16 during the calendar year. The survey is coordinated by the Swedish Council for Information on Alcohol and other Drugs (CAN).

⁸⁹ Countries with high prevalence rates include the UK and Ireland; countries with lower prevalence rates include Finland, Sweden, Greece, Cyprus and Malta. Source: EMCDDA Annual Report 2007.

Data from the ESPAD survey show an overall increase in prevalence of cannabis use among pupils in the period between 1995 and 2003, with a more marked increase between 1995 and 1999. There are, however, pronounced geographical differences in trends.

At the time of this evaluation, the 2007 ESPAD data were not available. However, a more recent comparison of HBSC⁹⁰ data for 2001–2002 and 2005–2006 shows a stable or decreasing trend in both lifetime and other more frequent cannabis use among 15 year olds. Other recent national school surveys conducted in Spain, Portugal, Slovakia, Sweden and the United Kingdom also report stable or decreasing trends.

Overall prevalence rates for use of other illicit drugs are much lower than for cannabis among 15–16 year olds. In most countries, lifetime prevalence of cocaine use in 2003 was 2 % or lower, but rising to 4% in Spain and 5% in the United Kingdom. Lifetime ecstasy use was reported by 0 to 8% of school students, with six EU countries reaching a prevalence of 5 % or more. Between 0 and 7% of amphetamines had been used by pupils, with four EU countries having a prevalence of 5 % or more. There was an increase in the lifetime prevalence of the use of drugs other than cannabis between 1995 and 2003, but the newly available national school surveys in 2007 (Spain, Portugal, Slovakia, Sweden, the United Kingdom) reported either no change, or even a slight decrease in ever-in-lifetime use of amphetamines and ecstasy.

Drug use among young adults (15–34 years)

Most drug use occurs among 15–34 year olds, and lifetime prevalence usually grows dramatically in the early part of this age range (15–24 year olds).

On average, it is estimated that about one in eight (or 13%) young European adults aged 15-34 have used cannabis during the past year (range at national level: 1.9–20.3%). Among the youngest in this age group (15-24 year olds), the estimated average is higher at 16.7% (range 3.6–28.2%), which translates into one in six of them reporting having used cannabis in the past year.

Comparing EU data with other regions of the world is made difficult by methodological differences in surveys. However, based on available data, the prevalence levels among young European adults aged 15-34 appear to be generally lower than those observed in Australia, USA or Canada⁹¹. *Figure 7* presents an overview of **last-year prevalence of cannabis use** in EU countries, the USA, Australia and Canada.

After having shown a marked increase in almost all EU countries during the 1990s⁹² and around the year 2000, with last-year prevalence of cannabis use among young adults in the 15-34 age group reaching 15-20% in seven countries, cannabis use in Europe seems

⁹⁰ Health Behaviour among School Children: a WHO collaborative survey which investigates school children's health and health behaviour and has included since 2001 mandatory questions about cannabis use among 15-year-old students.

⁹¹ Important differences exist among Member States. Some countries have similar prevalence compared to Australia or the USA average.

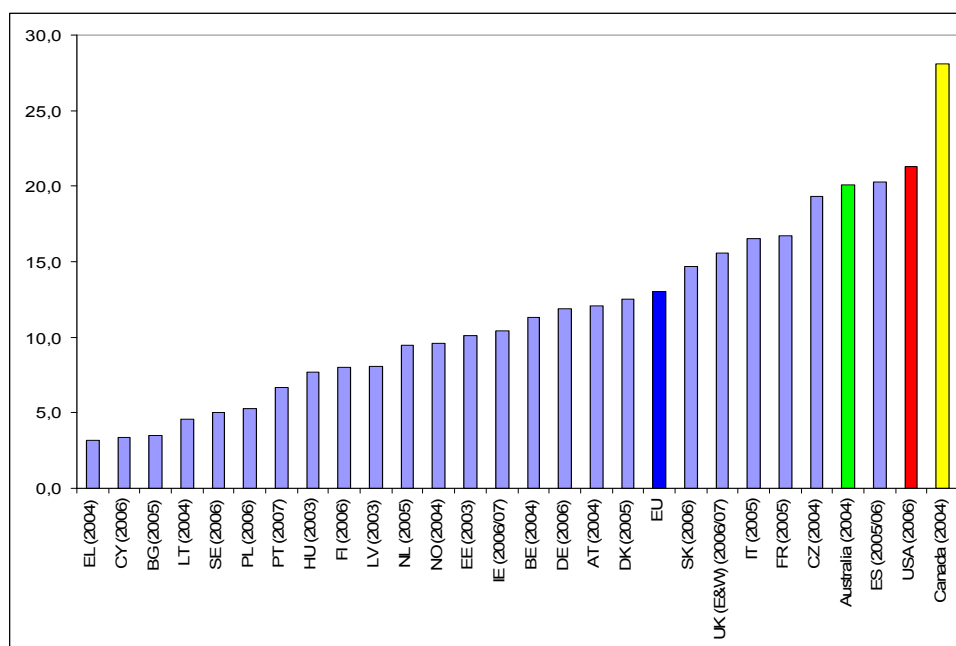
⁹² EMCDDA Annual Report, 2007

to have recently stabilised at a historically high level. Information from the most recent national surveys currently shows a stabilisation of cannabis use in most EU countries⁹³.

Australia and the USA also report stabilising or declining trends in cannabis use among young people, while Canada's last survey dates back to 2004, thus making it difficult to interpret recent trends.

⁹³ If an upward or downward change of 20% or more from the baseline figure is considered as a significant difference, there was an increase in cannabis use in five countries, a decrease in two countries and a stable situation in nine countries between 2001 and 2006.

Figure 7 - Cannabis use among young adults (aged 15-34): last year prevalence of use. EU by country including USA, Canada and Australia



Last-year prevalence of **amphetamine use** among young adults in the EU is estimated at 1.3% (range 0.1% to 2.9%), while the equivalent figure for the use of ecstasy is 1.8% (range 0.4% to 7.7 %).

Figure 8 presents an overview of **last-year prevalence of** ecstasy use in EU countries, USA, Canada and Australia⁹⁴. The EU average figure is similar to the US figure but much lower than Australia⁹⁵. After general increases in the 1990s, last-year prevalence indicates stabilisation or even moderate decreases in amphetamine and ecstasy consumption in Europe⁹⁶. Data from some countries suggest that cocaine could be replacing amphetamines and ecstasy among some sectors of the drug-using population.

Australia and the USA report similar trends, with a stabilisation or small decreases/increases in ecstasy use among young people in recent years.

On average, 2.3% of young European adults report having used cocaine in the past year (range). This figure is highest among the 15–24 age group (2.6%), although the difference is less marked than in the case of cannabis or ecstasy.

⁹⁴ See sources of data in annex 4.1

⁹⁵ Five EU Member States report higher last year prevalence of ecstasy use than the USA average and one Member State has a higher last year prevalence than Australia.

⁹⁶ During the period 2001–2006, of the 15 countries with sufficient data on last-year prevalence of amphetamine use among young adults, five report a decrease, four report stabilisation and six report an increase. For last-year ecstasy use, seven of these countries report a decrease, five countries reported a stable situation and three countries reported an increase.

Figure 8 - Ecstasy use among young adults (aged 15-34): last year prevalence of use. EU by country, including USA, Canada and Australia

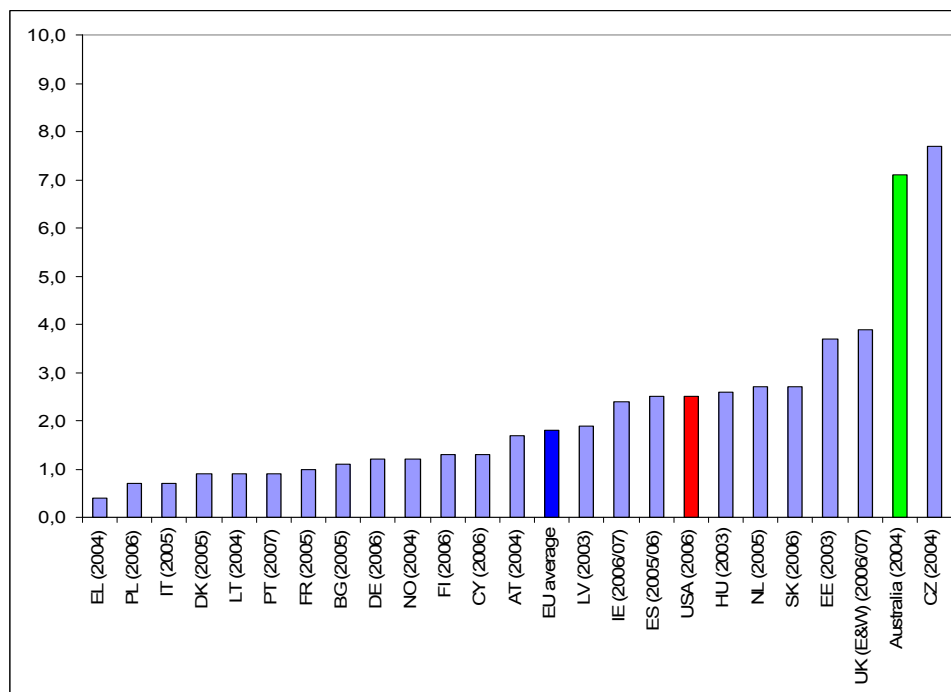


Figure 9 presents an overview of last-year prevalence of cocaine use among young adults (15-34) in EU countries, the USA, Canada and Australia. The average last-year prevalence of cocaine use in young European adults⁹⁷ is less than half that reported by young American adults, and similar to that of young Australian adults.

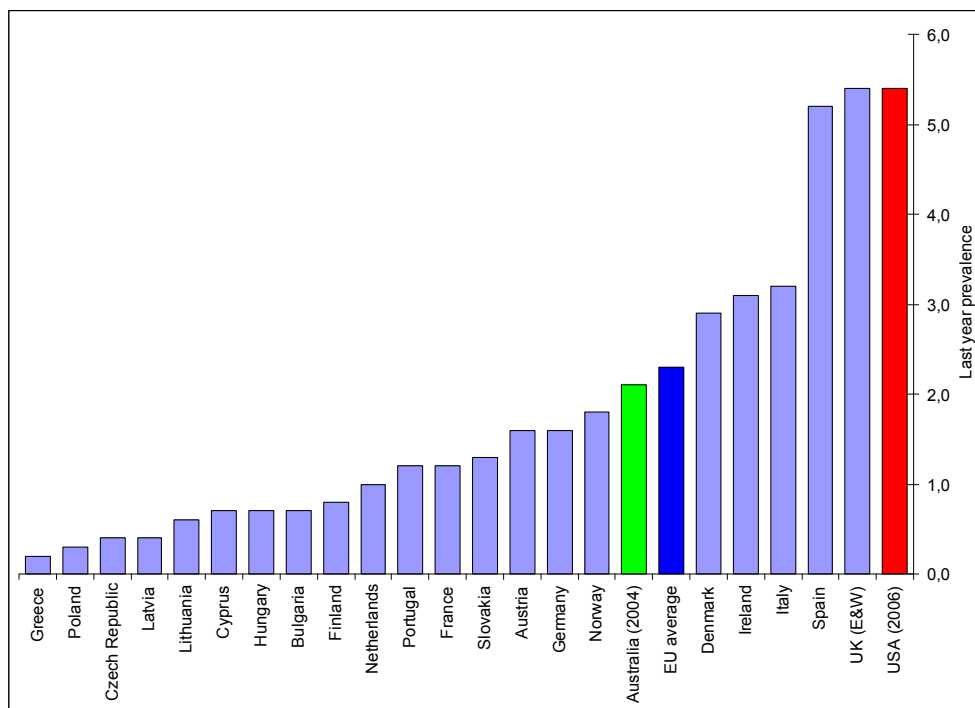
Data from general population surveys show that there was an upward trend in cocaine use among young adults during the 1990s and the early years of the new Millennium in many European countries. New data (2005-2007 surveys) show that this trend is continuing in most reporting countries⁹⁸.

Data from Australia and the USA reveal a more fluctuating trend in recent years, with the latest data showing an increase in Australia and a stable situation in the USA.

⁹⁷ There are big differences between EU Member States. On one hand, there are many EU countries where the prevalence of cocaine use remains relatively low (e.g. Greece, Finland), while others are up to the levels of prevalence observed in the US (UK, Spain, Germany). Source: EMCDDA Annual Report, 2007.

⁹⁸ Last year, prevalence increased in seven countries, remained stable in four countries and declined in one country.

Figure 9 - Cocaine use among young adults (aged 15 to 34): last year prevalence of use. EU by country, including Australia and the USA - last survey available for each country



Drug use among older adults (35–64 years)

General population surveys show that recent drug use is declining among all successive age groups, and particularly rapidly after 35 years. Last-year prevalence of cannabis use, which is 13 % on average among young adults aged 15–34, is below 3 % among 35–44 year-olds in most EU countries and exceeds 7 % in only two countries. In the next age group (45–54), all countries report last-year cannabis use prevalence rates of under 3 %. Cocaine use is also mainly concentrated among young adults aged 15–34, with about seven out of eight last-year users being young adults.

Overall, it can be roughly estimated that 5.5 million European adults aged 35–64 years have used cannabis in the last year and about 0.5 million have used cocaine during the same period. The use of ecstasy is confined almost entirely to younger age groups.

Current data therefore do not confirm ongoing drug use among generations which have been confronted with earlier drug use trends in the 1960s and 1970s. However, data show the existence of some groups of users aged over 35 which are typically located in high-prevalence countries.

Problem drug use

Problem drug use is defined by the EMCDDA as *‘injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines’*⁹⁹. It is usually estimated

⁹⁹ Note: the EMCDDA definition of problem use is somewhat different from international standards as adopted in the APA Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) and the WHO International Classification of Diseases (ICD-10), which include a broader definition of problem use, which - for example - also includes social aspects of problem use.

as the yearly prevalence rate per inhabitant aged 15–64 and is calculated by indirect statistical methods. Cannabis use is not included in this definition because of difficulties in defining what problem use is. However, based on a recent study in Europe, it can be estimated that 2 to 2.5% of all young adults aged 15–34 are using cannabis daily or almost daily (20 days or more in the last 30 days).

Problem opioid use

Recent estimates¹⁰⁰ of the prevalence of **problem opioid use** at national level range roughly between one and six cases per 1,000 inhabitants aged 15–64. From the limited data available, an average annual prevalence of between four and five cases per 1,000 of the population aged 15–64 can be derived. This translates into some 1.5 million (range 1.3–1.7) problem opioid users in the EU and Norway.

Time trends in the prevalence of problem opioid use should be interpreted with caution because of the limited number of repeated estimates and the uncertainty surrounding individual estimates. Data from 10 European countries with repeated estimates during the period 2001–2006, point to diverse developments, with six countries showing a relatively stable prevalence, one showing a clear increase and three showing unclear trends. Other data from police seizures, drug-related deaths and treatment demand indicate that there might be a recent increase in problem opioid use in some EU countries. This is related not only to problem heroin use, but increasingly also to the use of illicitly produced opioids (e.g. fentanyl) and the diversion of substitution medications, in particular of buprenorphine.

Injecting drug users (IDUs) run a high risk of experiencing health problems, such as infection with HIV or hepatitis, or drug overdose. National estimates of IDUs typically range between 0.5 and 6 cases per year per 1,000 inhabitants aged 15–64 in the period 2001 to 2005. Extrapolation from the limited data available suggests an average prevalence of IDU (current injectors) of between 3 and 4 cases per 1,000 of the adult population. This would translate into around 1.1 million (0.9–1.3 million) injectors in the EU and Norway. These are predominantly problem opioid injectors, although they may inject other drugs as well.

Overall, 43% of all opioid users entering outpatient drug treatment reported injecting the drug, and among clients in long-term treatment the proportion is higher. Around 40% of opioid users entering treatment for the first time in 2006 report injecting the drug. Looking at time trends, the proportion of injectors among new opioid clients decreased from 43% in 2003 to 35% in 2006 in the 13 countries where sufficient data are available, which may indicate a slight decreasing trend in heroin injection. However, studies among injecting drug users show differences between European countries with high proportions of new IDUs (injecting for less than two years) and young IDUs (under 25) in some of the new Member States.

¹⁰⁰ Opioid use cannot be reliably understood by general population survey data due to its very low prevalence, lack of suitable frame and likely denials of socially undesirable and even illegal behaviours. Therefore, indirect estimates are considered as 'the gold standard'.

Problem cocaine use

National estimates of problem cocaine use (injection or long duration/regular use) are available *only* for Spain and Italy. According to the most recent data for Spain, there were between 4.5 and 6 problem cocaine users per 1,000 adult inhabitants (aged 15–64 years) in 2002. Similarly, in Italy, in 2006, there were estimated to be between 3.7 and 4.5 problem cocaine users per 1 000 adults.

Cocaine - mainly in powder form - was cited as the principal reason for entering drug treatment in Europe in 2006 by about 16% of all treatment clients and 24% of those entering drug treatment for the first time (against 13% in 2002). There is, however, a wide variation between countries: only in Spain (47%), the Netherlands (35%) and Italy (25%) do cocaine users make up a high proportion of treatment clients. Elsewhere in Europe, cocaine accounts in general for less than 10% of all treatment demands, and in many Member States only negligible proportions of treated drug users report having cocaine problems.

Problem amphetamine/methamphetamine use

Only one Member State (Finland) provided a recent national estimate of problem amphetamine use, which in 2005 was estimated to amount to between 12,000 and 22,000 problem amphetamine users (4.3 to 7.9 cases per 1,000, aged 15–64 years).

Treatment for the use of amphetamines accounts for a sizeable proportion of the overall reported treatment demand in Latvia, Sweden and Finland, where between 25% and 35% of drug clients entering treatment mention it as their primary drug. From 2001 to 2006, the proportion of new clients entering treatment for primary amphetamine use has been relatively stable in Europe as a whole.

By comparison with other parts of the world, where the use of methamphetamine has increased in recent years, its levels of use in Europe seem to be limited. Historically, methamphetamine use in Europe has been concentrated in the Czech Republic and, to some extent, Slovakia. In 2006, in the Czech Republic there were estimated to be 17,500–22,500 methamphetamine users (2.4 to 3.9 cases per 1,000 aged 15–64 years) and in Slovakia 6,200–15,500 methamphetamine users (1.6 to 4.0 cases per 1,000 aged 15–64 years). In the last five years, the reported demand for treatment related to methamphetamine use has increased in both the Czech Republic and Slovakia. Clients in treatment for methamphetamine also report high rates of injecting drug use: around 45 % in Slovakia and 80 % in the Czech Republic.

Health and social consequences of drug use

Drug-related infectious diseases

Data on **newly-diagnosed cases** of **HIV** related to injecting drug use for 2006 suggest that infection rates are still falling overall in the EU, following the peak in 2001–2002 that was due to outbreaks in Estonia, Latvia and Lithuania. In 2006, the overall rate of **newly-diagnosed infections** among IDUs in the 25 EU Member States for which national data are available has decreased. Between 2001 and 2006, **no strong increases** were observed in the rate per million inhabitants in any country.

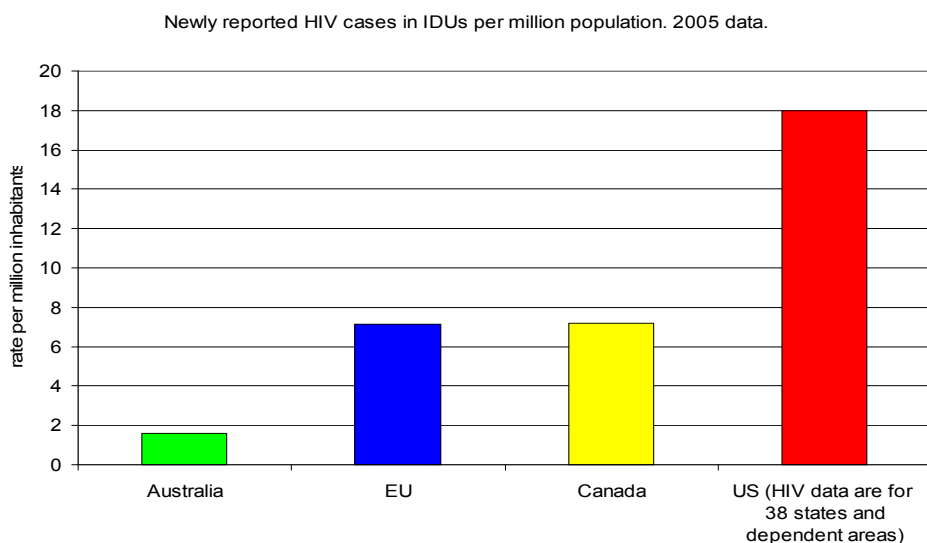
The high annual rate of new HIV diagnoses related to injecting drug use in Estonia, Latvia and Portugal suggests that transmission is still occurring in these countries at a high level, although there has been a gradual improvement in the situation in all three countries.

Figure 10 presents a comparison of the 2005 data on newly reported HIV cases in injecting drug users in the EU, USA, Canada and Australia¹⁰¹. The incidence rate of newly diagnosed cases per million inhabitants is higher than in Australia, comparable to Canada but considerably lower than in the USA.

Trend data from HIV prevalence monitoring in samples of IDUs are available from 25 countries over the period 2002–2006. In 15 countries, HIV prevalence remained unchanged during the period, while prevalence in three countries showed statistically significant decreases. In two countries, however, decreasing trends at national level were contradicted by reports of some regional increases. Finally, in five countries, at least one sample indicated an increasing trend, even if this was for the most part still at low levels.

From the available data and estimates of the number of IDUs and problem drug users, it is estimated that there might be between 100 000 and 200 000 people living with HIV in the EU, who have ever in their lives been drug injectors.

Figure 10 - Newly diagnosed HIV infections in IDU per million population: 2005 rates for the Australia, the EU, Canada and USA



While high prevalence levels of HIV infection are found only in some EU Member States, viral hepatitis, and in particular infection caused by the hepatitis C virus (HCV), is more highly prevalent in IDUs across Europe. HCV antibody levels among national samples of IDUs in 2005-2006 vary from around 15% to 90%, with most countries typically reporting levels in excess of 40%.

The prevalence of antibodies to HBV infection varies to an even greater extent than that of HCV antibodies, due to differences in vaccination levels and many other possible

¹⁰¹ See sources of data in annex 4.2

factors. The most complete data set available is for the antibody to the hepatitis B core antigen (anti-HBc), which indicates a history of infection (or vaccination). In 2005–2006, prevalence levels for anti-HBc of over 40% were reported from six out of the 11 countries where data were available.

Trends over time in notified cases of hepatitis B and C show a different picture. The proportion of IDUs among all notified cases of hepatitis B may have declined slightly in some countries. In the case of hepatitis C, the proportion of IDUs among notified cases has declined in five countries, but has increased in five other countries. For both hepatitis B and hepatitis C, the proportion of IDUs among the notified cases continued to differ markedly between countries in 2006, suggesting geographic differences in the epidemiology of these infections.

From the available data and estimates of the number of IDUs and problem drug users, it is estimated that there are around **one million people living with an HCV infection** in the EU who have ever in their lives been drug injectors.

Drug-related deaths

During the period 1990–2005, between 6,500 and over 8,500 **drug-induced deaths**¹⁰² were reported each year by EU Member States, totalling around 130,000 deaths during this period. These figures should be considered as a minimum estimate, given data limitations and under-reporting in Member States.

Average population mortality due to drug-induced death in the EU is 21 deaths aged 15 to 64 per million inhabitants (range 3-5 to over 70) deaths. This rate is more than doubled (44 deaths per million) among males aged 15-39 years. In 2005-2006, drug-induced deaths accounted for 3.5% of all deaths among Europeans aged 13 to 39.

Opioids, mainly heroin or its metabolites, are present in the majority of drug-induced deaths reported in the EU, accounting for between 55% and almost 100% of all cases. A recent EMCDDA data collection also found that more than one drug was mentioned in the toxicological results of between 60% and 90% of opioid-induced deaths.

Most cocaine deaths seem to be the result of the chronic toxicity of the drug, which leads to cardiovascular and neurological complications, some of which may not be identified in existing reporting systems as being related to cocaine. Deaths actually recorded as attributable to cocaine usually also mention the presence of other substances. Allowing for the likely under-reporting of cocaine-induced deaths in the EU, the most recent data reported from 14 Member States identified over 450 cocaine deaths.

Deaths in which ecstasy is present continue to be rare, according to the limited information available. Amphetamine deaths are also infrequently reported in most countries, although in the Czech Republic a substantial number of drug-induced deaths have been attributed to pervitin (methamphetamine).

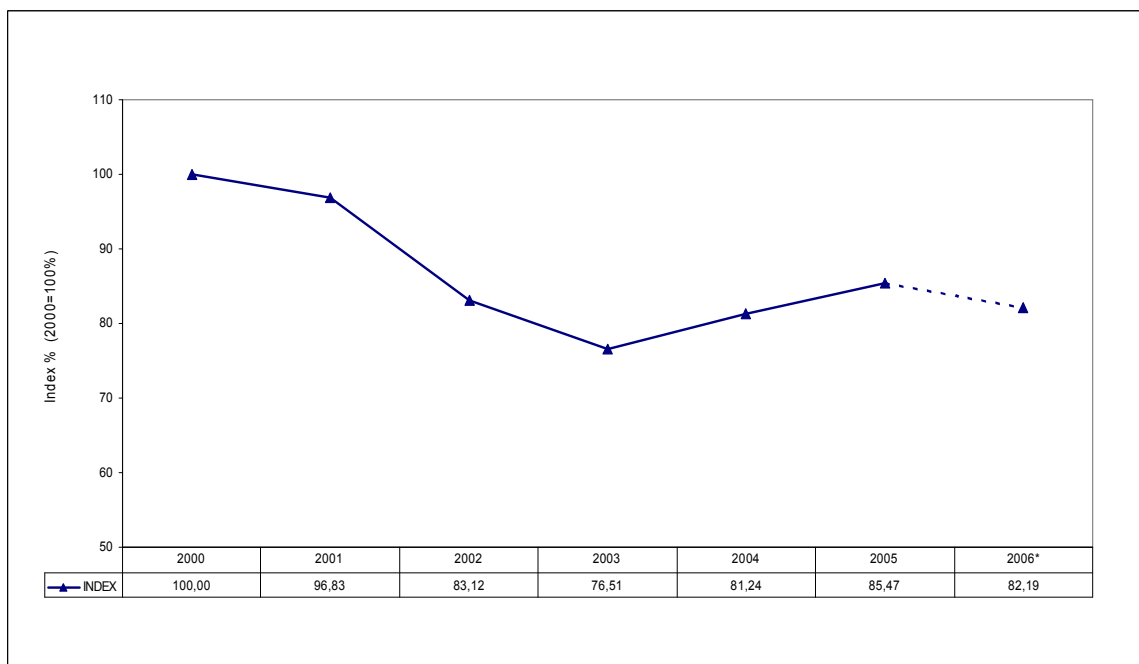
Drug-induced deaths increased sharply in Europe during the 1980s and early 1990s, possibly paralleling the expansion of heroin use and injection, and have remained at high

¹⁰² Deaths caused directly by the consumption of one or more drugs and that occur, generally, shortly after the consumption of the substance(s).

levels up to the present day. *Figure 11* presents the indexed long-term trend in drug-induced deaths in the EU Member States and Norway in the period 2000-2006¹⁰³.

Trends over the period 2001 to 2005/2006 show a more mixed picture. In the first years of the period (2000–2003), many EU countries reported decreases in the numbers of drug-induced deaths, which fell overall in Europe. However, in 2004 and 2005, small increases in reported deaths were observed in most European countries, which could be linked with growing polydrug use by opioid users and a possible increase in the availability of heroin.

Figure 11- Indexed long term trend in drug-induced deaths in the EU Member States and Norway¹⁰⁴ - 2000 to 2006



Social consequences of drug use

The availability of standardised data on the social consequences of drug use is still very limited, but adverse social consequences are reported to be generally linked with problem drug use. For instance, homelessness, together with living in unstable accommodation, was affecting about 10 % of drug users entering treatment in 2006, while one in every two clients entering treatment was unemployed.

¹⁰³ For 2006 data for Denmark, Spain, France, Poland, Slovenia, United Kingdom and Norway have been extrapolated from 2005.

¹⁰⁴ Note to Figure 11: A few countries did not provide data for some years. To correct this situation, the computation method defined in the following report was used: 'European Monitoring Centre for Drugs and Drug Addiction (2001). Coordination of the implementation of EMCDDA standard guidelines on drug-related deaths in the EU Member States, and the collection and analysis of information on drug-related deaths', Project CT.99.RTX.04, coordinated by the Trimbos Institute, Lisbon, EMCDDA. Sources: Reitox National Focal Points.

Drug supply to the European Union

Introduction

Production and trafficking of drugs remains one of the primary activities of organised crime networks operating towards and within the European Union, posing serious challenges for EU policies, in particular in the area of justice, freedom and security. Whilst the principal drug trafficking routes remain prominent, there is a growing diversification of trafficking patterns. Also, with a variety of European Union drug production and entry points, there is large-scale intra-EU trafficking. Criminal networks no longer confine their activities to one type of drug, as reflected in the prevalence of 'cocktail' or 'poly-drug' seizures.

The single market and free movement of goods, services, people and capital have not only brought benefits, but have also increased possibilities for organised crime to move people and/or goods across and beyond national borders within the EU.

Source countries of heroin, cocaine and cannabis

According to the United Nations, most of the world's illicit **heroin** comes from only three countries: Afghanistan, Myanmar and Laos. Afghanistan continues to be the major supplier of heroin, accounting for over 90% of global opium production. In 2007 the estimated opium output increased by 34 % to 8,200 tons¹⁰⁵.

The United Nations Office for Drugs and Crime estimates that a considerable amount of Afghan opium is converted into morphine base or heroin in the country itself, in areas with *limited governmental control*. Such processing requires some 10 000 tons of chemicals per year, including more than 1 000 tons of the principal precursor, acetic anhydride.

The National Drug Control Strategy of Afghanistan was adopted in January 2006. It identified four priority areas: the targeting of drug traffickers and the drugs trade; treatment of drug users and reduction of demand; strengthening of alternative livelihoods and institution building. However, particularly in the Helmand province, where more than 50% of Afghan poppy cultivation takes place, drugs and insecurity are self-reinforcing. Alternative development and commercial trading is difficult during the conflicts¹⁰⁶.

Regarding the manufacture of **cocaine**, the Andean region remains the major cocaine producing area in the world, with an estimated output in 2006 of 910 tons of cocaine. Colombia accounts for 70% of global production (640 tons), Peru for 20% (180 tons) and Bolivia for 10% (90 tons).

¹⁰⁵ UNODC, Afghan Survey, Winter 2007; as presented during the EU Troika with Western Balkans, Brussels, April 2008.

¹⁰⁶ UNODC, Afghan Survey, Winter 2007; as presented during the EU Troika with Western Balkans, Brussels, April 2008. .

Cocaine processing is controlled by Colombian, Peruvian and Bolivian organised crime groups. They pressurise farmers to grow coca bush and use violence to protect their laboratories against other groups or law enforcement officials.

Cannabis continues to be the most widely produced, trafficked and consumed plant-based drug worldwide. In the absence of cultivation monitoring systems and surveys, the UNODC estimates that in 2006 there were 231,000 hectares of illicit cannabis cultivation in the world, capable of producing 45,000 tons of herbal cannabis. The plant is grown in 176 countries around the world, particularly in the Americas (54%), Africa (26%), Asia (15%), Europe (4%) and Oceania (1%).

Morocco continues to be the main global source of cannabis resin with an estimated 80% of global production taking place in the country; most of this is for European and North African markets. Herbal cannabis is supplied to the Member States mainly from Colombia, Jamaica, South Africa and Nigeria, with Egypt as an additional notable source.

Albania has also developed into a major source of herbal cannabis, which is grown over large areas; most of the product is destined for Greece and Italy. Cannabis cultivation also takes place in Bulgaria and Poland with some 50% destined for export.

Transit routes of heroin, cocaine and cannabis into Europe

Two key corridors are used for the **trafficking of opiates**. Significant heroin trafficking takes place along the *Northern Route*, which starts in Afghanistan and crosses the central Asian States of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. It is estimated that some 25% of smuggled heroin stays in central Asia for domestic consumption, while the remaining 75% is smuggled onward to Russia and Europe¹⁰⁷

Most heroin reaches Western Europe via the *Balkan Routes*, starting in Turkey, facilitated by Turkey's geographical position in handling extensive commercial trade between Asia and Europe and its good transport infrastructure. Increasing use is being made of the *central Balkan Route* from Turkey, via Bulgaria, the former Yugoslav Republic of Macedonia, Montenegro, Bosnia and Herzegovina and Croatia into Italy or Slovenia and from the former Yugoslav Republic of Macedonia via Kosovo under UNSC Resolution 1244 and/or Albania into Greece. The *route via Ukraine and Romania* is also gaining in importance. Furthermore, of additional note is the use of the 'roll-on, roll-off' transport of trucks on trains along the Balkan Routes, in particular from Hungary, Italy and Slovenia into Austria.

Whilst awaiting onward transportation into Western Europe, heroin is often stockpiled in countries such as Albania, Bosnia and Herzegovina, Serbia, Kosovo under UNSC Resolution 1244, Bulgaria, Romania and Hungary. The dual use of the Balkan Routes for smuggling heroin to and ecstasy from the European Union is a noteworthy feature. The *Northern Black Sea route* is also prominent, while Africa is turning into a crossroads for heroin trafficking. Heroin is also trafficked from Afghanistan to Pakistan and onwards from there.

¹⁰⁷ Council document 11159/07 CORDROGUE 40: Regional report on Central Asia. Brussels, 20 June 2007.

Three main **cocaine sea routes** to Europe have been identified. The *Northern route* runs from the Caribbean via the Azores to Portugal and Galicia in Spain. The *Central route* runs from South America via Cape Verde or Madeira and the Canary Islands to Europe. More recently, the *African route* has evolved, which runs from South America to Western Africa and from there to Portugal and Spain.

Huge amounts of cocaine are transported from South America to the European Union across the Atlantic Ocean, mainly via maritime routes. Multi-tonne shipments take place from Colombia, Venezuela, Brazil, Ecuador, Chile, Argentina and Suriname to the coasts of Spain and Portugal and major ports of Belgium, the Netherlands and Italy. Historical and linguistic ties with Latin America influence the role of Spain and Portugal.

Significant amounts of cocaine are smuggled from South America to Europe via the Caribbean, aided by the region's geographical proximity to cocaine source countries and cultural links with some Member States, for example between Curacao and the Netherlands and between Jamaica and the United Kingdom. The French overseas territories of Martinique and Guadeloupe are also becoming increasingly important as transit areas. Fast boats, cargo freighters and container ships remain the most common means of moving the drug through the region, but traffickers also use aircraft for drops in international waters.

In recent years, West Africa has emerged as a transit and storage zone for maritime trafficking of cocaine from South America to Europe. This is controlled by South American and European criminals, the former having established businesses in West-Africa to cover their illicit activities and justify their presence. Subsequent transportation by sea to Europe takes place in fishing boats, from where the drugs are often unloaded on the northern coast of Portugal or in Galicia in Spain. Again, cultural ties (e.g. Ghana and Nigeria with the United Kingdom and Cape Verde with Portugal) facilitate this kind of trafficking. At least 33 tons of cocaine was seized en route to Europe via West Africa between 2005 and 2007. Prior to this, the entire continent rarely seized more than a ton per year. This criminal development poses a further threat to the fragile stability of the region, exploiting, inter alia, the capacity of West African law enforcement agencies, high levels of corruption and the lack of port / coastline controls.

Colombian criminal groups have also established alliances with Moroccan networks to set up smuggling routes from Western to Northern Africa. These link up with cannabis smuggling routes into the European Union and utilise the logistics and know-how of well-established cannabis trafficking groups. Cocaine is also transported by air from West African countries to European airports. To avoid controls, couriers frequently use indirect flights via Morocco or Libya.

The EU illicit drug market

An estimated 100 tons of **heroin** are needed annually to supply European Union heroin markets¹⁰⁸. There is large-scale secondary or intra-European Union trafficking, particularly from the Netherlands and Belgium. Most heroin destined for the major market of United Kingdom, as well to France, Germany and Spain, is supplied via these

¹⁰⁸ UNODC World Drug Report, 2006

two countries. Heroin is often transported from the Netherlands by trucks, sometimes in multi-drug consignments, which may include synthetic drugs, cocaine and cannabis.

Trafficking of heroin towards and within the European Union continues to be dominated by Turkish criminal groups, with a significant and increasing involvement of Albanian criminal networks. Turkish groups make use of facilitators in Southwest Asia to liaise with domestic criminals or brokers, who can purchase large quantities of heroin directly from the source region. Very rarely do heroin consignments travel to Europe in a single journey; they are bought and sold by different criminal groups along the route.

The presence of large Turkish or Kurdish communities in Belgium, France, Germany, the Netherlands and the United Kingdom facilitates the activities of Turkish organised crime, with increased involvement of third generation Turks. Ethnic Albanian groups control the wholesale markets for heroin in several Member States, particular in the northern and eastern parts of the European Union. The drugs are obtained from depots located in Central and Eastern Europe.

The European Union remains, next to the United States, the second largest **cocaine** consumer market in the world. An estimated 250 tons of cocaine enter the Union annually via maritime shipments, air freight and couriers. In 2006, almost 120 tons of cocaine was seized in the Member States. According to the 2007 World Drug Report of UNODC, more than 45% of produced cocaine is intercepted worldwide.

Spain, Portugal, the Netherlands, Belgium and Italy continue to be the principal entry points of maritime cocaine shipments into the European Union. In 2006, Spanish law enforcement agencies seized 49,650 kg of cocaine, with 66% being seized on the high seas and another 11% in sea-container traffic. Trafficking towards the Iberian Peninsula is dominated by the Colombian-Galician connection. In 2006, Portuguese and Spanish authorities dismantled several cocaine processing laboratories operated by criminal groups comprising Spanish, Colombian, Venezuelan and Ecuadorian nationals. Cocaine base was being transformed into cocaine hydrochloride or extracted from clothes or liquids.

Considerable amounts of cocaine are trafficked from depots in Spain to other Member States, with France being an important transit country. The Netherlands is another nexus point from where cocaine is distributed. Although large amounts of cocaine are smuggled to Europe in sea freight, the role of couriers and air freight is also significant. Each year, about 30 tons of cocaine is transported by couriers from South America and the Caribbean to airports in the Netherlands, Spain, Portugal, the United Kingdom and France.

Colombian groups operating in the Netherlands are almost exclusively engaged in the importation of cocaine, with subsequent wholesale distribution being carried out by Dutch, Surinamese and Antillean groups. However, distribution to the United Kingdom is mainly organised by British criminals, often based in the Netherlands. Colombians also control the importation of cocaine into Italy with the actual smuggling being carried out by Italian-based groups, in particular Calabrians and Albanians. According to the Italian authorities, illicit cocaine processing facilities are also located in Albania, from where cocaine is transported to Italy by powerful speedboats that cross the Adriatic Sea in less than one hour.

Criminal coalitions involved in international cocaine trafficking are increasingly diverse in their make-up. For example, Russian criminals in the United States organise cocaine importations from South America to Austria in close association with Slovenians, Croatians and Montenegrans.

Due to its proximity to Morocco, most **cannabis resin** enters the European Union through Spain, with the vast majority destined for other Member States.

The Netherlands is another major nexus point for Moroccan-sourced cannabis resin, which is largely trafficked overland, through Spain, France and Belgium. Large amounts of Moroccan cannabis resin are for secondary distribution to other Member States, predominantly to the United Kingdom, Germany and Denmark.

Over recent years, Albania has become a considerable source country of herbal cannabis which is smuggled, not only into Greece and Italy, but also through former Yugoslav Republic of Macedonia and Bulgaria into Turkey and to Croatia, Bosnia and Herzegovina, Montenegro, Serbia and Slovenia.

Spanish organised crime groups, in addition to Moroccan groups, are heavily involved in the trafficking of cannabis resin into Spain and its subsequent distribution to other Member States, closely co-operating with other indigenous groups, such as British, Dutch and Scandinavians. Some of these groups have established bases in Spain to facilitate such trafficking. French criminal groups, in co-operation with Spanish, Moroccan and Algerian nationals, are also involved in large-scale cannabis trafficking from Spain to their country.

Hydroponic cannabis cultivation takes place in many Member States. Whilst home-grown cultivation for personal use is frequently discovered, sophisticated higher capacity facilities are commonplace in the Netherlands, and to a lesser extent Belgium and the United Kingdom. Germany has also reported an increasing prevalence of professional indoor cannabis cultivation.

Synthetic Drugs and drug precursors

The European Union is a major production region for synthetic drugs, in particular amphetamine and MDMA (ecstasy). Annually, some 70 to 90 sites for drug production and storage on a significant scale are seized, the vast majority of them being in the Netherlands and, to a lesser extent, Belgium¹⁰⁹. In addition, Poland, Estonia and Lithuania have played important roles, especially in supplying Germany and the Nordic Member States. Furthermore, amphetamine tableted with the 'captagon' logo is produced on a substantial scale in Bulgaria for the domestic market as well as for the export to Turkey and Middle Eastern countries.

Since 2002, large-scale facilities, i.e. sophisticated laboratories of MDMA, were only seized in Belgium and the Netherlands. However, dismantling of small-scale production units of various sizes and stages of development have also been reported in many other Member States.

¹⁰⁹ Source: Europol data on dismantled sites; see table 4

As higher-capacity production spreads, legitimate chemical companies are likely to be exploited for the acquisition of chemicals, industrial equipment, specialist glassware and other materials. Increased and pro-active law enforcement co-operation with industry will be necessary.

Whilst synthetic drugs are trafficked from the Netherlands and Belgium throughout the European Union, the main European market for both MDMA and amphetamine is the United Kingdom. Many consignments to the country have been part of so-called 'cocktail' loads, involving substantial quantities of amphetamine, MDMA, cannabis, cocaine and heroin. This highlights the need to target facilitating transport organisations, where illicit loads for different criminal groups may merge. Other significant or emerging markets include Germany, Scandinavian countries, Spain and Italy.

The processing of synthetic drugs, in particular the tableting and packing phases is spreading gradually, reducing the risk of an inclusive production criminal network being dismantled. For instance, amphetamine is often exported in wet form from the Netherlands and Belgium to the United Kingdom, where it is dried and re-packed for subsequent distribution. Furthermore, MDMA has been trafficked to the United Kingdom in powder form which, together with the seizure of tableting machines, indicates the existence of tableting facilities in that country. With regard to MDMA, this is symptomatic of the trafficking trends to Australia and Canada before these countries started seizing large scale production facilities.

MDMA is smuggled to global markets, with large amounts being trafficked via various European ports and airports. This may decrease in frequency and volume due to increasing production capacities in Asia, North America and Oceania, in particular in Indonesia, Canada and Australia, where there is sometimes a Dutch connection. In view of this development, it is believed that these regions will eventually become self-sufficient in MDMA production and distribution. Whilst production of MDMA and amphetamine in the European Union is under the control of indigenous organised crime groups, there is an increase in the involvement of other domiciled or part-domiciled ethnic groups in synthetic drug production i.e. Turks, Moroccans and Chinese.

As Dutch and Belgian criminality continues to maintain its advantage with regard to logistics, expertise, use of technology, improved methodology, professionalism and production capacity, it is unlikely that their dominance, at least in the short to medium-term, will diminish significantly on the European Union level.

Major synthetic drug production in the European Union requires the global diversion of drug precursors, in particular BMK (1-Phenyl-2-Propanone) and PMK (3,4-Methylenedioxyphenyl-2-propanone), and regional trafficking of other chemicals.

Illicit traffic in drug precursors is based on the source and existence of legal manufacture, geography, availability, demand, regular trade routes, ease of initial diversion and communication between organised crime in both source and trafficking regions and their domiciled counterparts in the European Union.

In the European Union there is limited legal use of BMK and no legal use of PMK. Both are thus sourced from outside the region, mainly from China where they are legitimately and heavily used in the polymer, pharmaceutical and cosmetic industries. Since 2004, legitimate industries in the Russian Federation have been identified as sources of diverted

BMK. Drug precursors that are traded legitimately within these countries are exported to Western Europe via legitimate intermediary companies and brokers or (cover) companies that have been infiltrated, established or corrupted by organised crime. Equally, companies are established by synthetic drug producers to ‘legitimise’ the acquisition and/or trade in chemicals and thus conceal their subsequent diversion from the authorities.

A relatively recent phenomenon in the European Union is the increased transshipment of suspicious large-scale consignments of ephedrine and pseudo-ephedrine, the principal precursors for methamphetamine manufacture, *mostly en route from Asia with their final destination the Americas*. This includes (wrongly labelled) air cargo transshipments of pseudo-ephedrine shipped from Congo to Belgium for onward transfer to Mexico and from Iran to France destined for Congo; of ephedrine consignments from the Balkans to the Czech Republic for methamphetamine production and from Pakistan to Greece ultimately bound for the Netherlands; of ephedrine tablets from Pakistan directly to the United Kingdom, as well as attempted ephedrine export to Mexico from Belgium.

In the light of recent discoveries in the European Union of recipes for large-scale methamphetamine production, methamphetamine production facilities and increasing seizures, the movement and potential diversion of (pseudo)ephedrine should be closely monitored.

New psychoactive substances on the EU drug market

A significant development in recent years is the spread of various piperazine derivatives. This group of synthetic substances includes BZP (1-benzylpiperazine) and mCPP (1-(3-chlorophenyl) piperazine). BZP has been found in a majority of EU Member States and, in March 2008, the Council adopted a Decision¹¹⁰ defining BZP as a new psychoactive substance which is to be made subject to control measures and criminal sanctions in the EU.

The substance mCPP has been found in almost all Member States and is described as producing stimulant and hallucinogenic effects similar to those of ecstasy (MDMA). In March 2007, the EMCDDA and Europol submitted to the Commission a concise report on the active monitoring of mCPP which concluded that ‘mCPP is unlikely to establish itself as a recreational drug in its own right’, due to its indistinct psychoactive properties and some adverse effects. Since mCPP has no particular appeal to users, it seems that its market in the EU is driven by a supply push rather than a demand pull.

Measuring trends in the drug market

The annual monetary value of the global illicit drug market is estimated at between EUR 160-200 billion¹¹¹, making it one of the largest informal economic markets in the world, operating beyond the control and supervision of governments and feeding into illegal organised crime activities, including money-laundering. It is to be expected that the global illicit drug market is influenced by changes in market conditions, as for any other

¹¹⁰ Based on the Council Decision on the Information Exchange, Risk Assessment and Control of new Psychoactive Substances (2005/387/JHA)

¹¹¹ US\$ 250-320; source: UNODC

group of commodities. But due to a lack of precise information on the global production of illicit drugs, as well as due to a lack of precise information on drug consumption and reliable and comparable information on drug seizures, more precise details on the volume and other key characteristics of the market are still unknown. The lack of this information makes law enforcement impact difficult to assess.

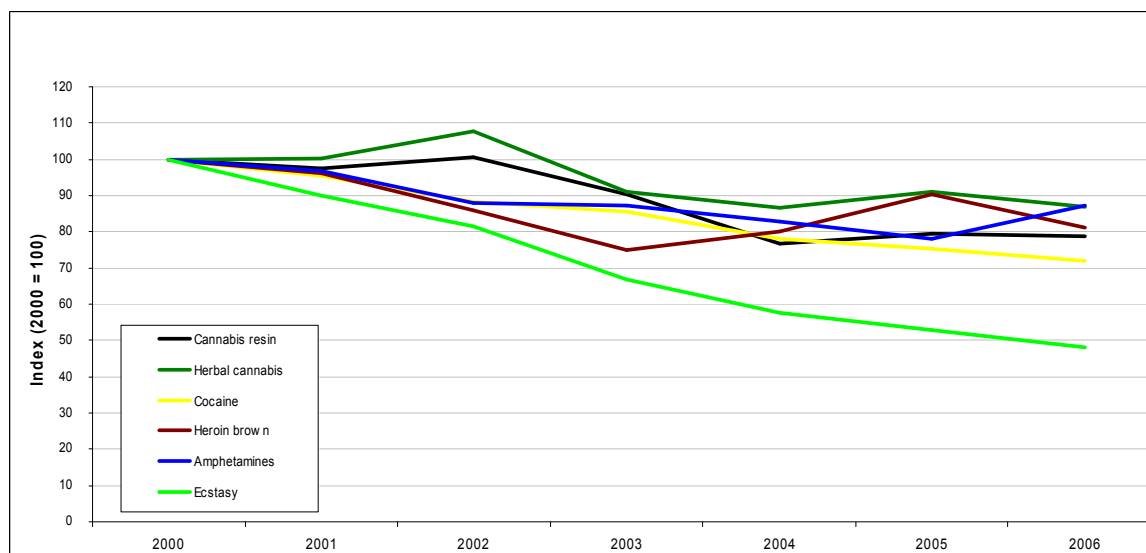
A limited number of market indicators are available in a number of EU countries that can provide some detail on the drug market. ***Drug retail prices*** are available from a limited number of Member States, even though these need to be interpreted with caution due to reliability and comparability problems and non-standardised methods of calculation and collection. Furthermore, prices may be influenced by 'normal' economic factors such as exchange rate developments between e.g. the US dollar and the Euro. *Table 9* presents the typical retail prices (range of most frequent (modal) prices in most reporting Member States) in Europe reported to the EMCDDA. However, the variability of prices is much greater, for instance, in the case of heroin, with prices ranging from EUR 15 to EUR 110 per gram depending on the country of purchase.

Table 9 – Typical retail prices (range of most frequent (modal) prices in reporting MS)

Substance	Typical retail price in EUR	Unit
Herbal cannabis/ cannabis resin	4-10	Gram
Cocaine	50-75	Gram
Ecstasy	3-9	Tablet
Amphetamines	10-15	Gram
Brown heroin	30-45	Gram

Figure 12 presents an overview of the indexed trends in EU retail prices for major drug types in the period from 2000 to 2006¹¹². Based on data available from a limited number of EU countries, the street prices corrected for inflation *declined* for all drugs mentioned above over the period 2000–2006. Most reported decreases are in a range of 10–30%, *but street prices for ecstasy seem to have declined even more.*

Figure 12 - Indexed trends in EU retail prices for major drug types, adjusting for inflation, 2000-2006



A second indicator for developments on the illicit drug market concerns the **potency/purity** of substances purchased or seized in a number of EU Member States¹¹³. In 2006,

¹¹² **Notes to Figure 12:** 1. The trends represent the available information on national street-level prices for each drug in the EU Member States and Norway, weighted by country population sizes to form an overall EU trend. Prices have been adjusted for national inflation rates (base year 2000) and all series indexed to a base of 100 in 2000. 2. Countries missing drug price information for two or more consecutive years are not included in the trend calculations for the drug: the trend for heroin brown on 6 (40% of the EU population), amphetamine on 8 (55% of the EU population), cocaine on 9 (58% of the EU population), ecstasy on 10 (58% of the EU population), herbal cannabis on 10 (61% of the EU population), and cannabis resin on 12 (67% of the EU population). 3. Additionally, where 2006 data are missing (6 cases) 2005 prices are used; for missing 2001 data (3 cases) 2002 prices are used; data missing for other years (14 cases) have been interpolated from adjacent years. **Sources:** Price data: Reitox National Focal Points

¹¹³ It should be recognised that purity levels will invariably reflect the stage at which the drug is taken out of the illicit market i.e. from higher purity bulk quantities to lower purity consumer doses. The available data should reflect street level prices, but not all countries make this

the reported THC content of cannabis resin samples ranged from 2.3% to 18.4%, while that of **herbal cannabis** ranged from less than 1% to 13%. For **amphetamines**, major variations in purity were observed: several countries reported purities of 10% or less, while others reported levels between 25% and 47%.

In most reporting countries, the typical MDMA content of an **ecstasy tablet** was between 25 and 65 mg in 2006, and high-dose tablets (containing over 130 mg of MDMA) were reported in some European countries. The typical **purity of cocaine** in Europe varied considerably, with most countries reporting values between 25% and 55%. The typical purity of **brown heroin** ranged between 15% and 25% in most reporting countries.

Trends in potency are difficult to establish because of the considerable variability in purity levels. Furthermore, there are reliability and comparability problems as well as non-standardised methods of sample strategies and calculation. However, from the available data it can be estimated that potency levels remained stable or declined for cannabis resin and herbal cannabis, for amphetamine and for cocaine. No clear European trend is apparent in the data on the MDMA content of ecstasy tablets or in the data on heroin.

Trends in national drug laws

Over the past 10 years, most European countries have adopted an approach in their legal system that distinguishes between the drug trafficker, who is considered as an operator in the drug market, and drug (dependent) users, who are considered as consumers and/or victims possibly in need of treatment. However, individual Member States draw different distinctions between trafficker and user, and '*threshold quantities*' for personal possession has been one of the key issues in this area. Maximum or probable penalties for use or possession for personal use, in the absence of aggravating circumstances, have been reduced in various European countries since 2001.

Member States have introduced or widened options for drug users to undergo treatment or counselling, instead of punishment. Nevertheless, these options are overwhelmingly conditional; breach of the treatment order will restart the procedure of criminal charge, prosecution or punishment.

A general trend can be observed in Europe in the development of alternatives to criminal conviction for cases of use and possession of small quantities of cannabis for personal use without aggravating circumstances. Cannabis is now frequently distinguished from other illicit substances either in the law, by prosecutorial directive, or by judiciary practice. For those suspected of drug trafficking, the trend is to increase the possible penalty. In addition, there has been an increased emphasis in recent years on penalising the specific offence of distributing to young people.

According to the *2003 European Sourcebook of Crime and Criminal Justice Statistics*¹¹⁴, covering statistical information from over 35 Member States of the Council of Europe, drug trafficking offences¹¹⁵ accounted for 10% of all detainees in penitentiaries.

distinction very precisely. Furthermore, the sampling is biased towards which samples are tested in forensic laboratories, as there are considerable inter-sampling differences.

¹¹⁴ European Sourcebook of Crime and Criminal Justice Statistics [2003] 2nd ed., WODC, The Hague

¹¹⁵ The category 'drug trafficking offences' may also possession of drugs for own consumption.

However, considerable variations exist between countries and, depending on the method of registration of convictions in each reporting country, the share of drug-related offences may be higher than reported¹¹⁶.

Drugs and road transport are an issue that has seen considerable legislative developments in recent years. Yet there is a great variation in the individual countries' legal responses to drug-driving, between zero tolerance or impairment laws, and in the range of penalties available. To facilitate rapid detection, several countries have recently passed laws to permit or define roadside drug testing, often using on-site rapid testing devices. Three countries have also specifically legislated on testing for drugs in the workplace, while in other countries there are new laws to regulate drug testing of drivers, arrestees, prisoners or employees in different situations.

A large Commission project on the influence of alcohol, drugs and medicines on driving, funded by the 6th Framework Programme and involving 19 Member States, will be finalised in 2010¹¹⁷. The project will – among others – examine legislative options to cover the use of illicit and medical substances in traffic legislation, examine possibilities and techniques for road-side screening and provide further estimates of road accidents related to substance use.

¹¹⁶ Certain crimes may not be registered as a drug-related offence, but according to the primary act, e.g. theft, assault, rape or unintended homicide.

¹¹⁷ http://www.druid-project.eu/cln_007/nn_107542/Druid/EN/home/homepage__node.html?__nnn=true

IMPACT AND ADDED VALUE OF THE EU DRUGS ACTION PLAN (2005-2008)

Impact of the EU Drugs Action Plan (2005-2008) on the drug situation

As indicated at the beginning of this report, the limitations that accompany this evaluation in particular, and evaluation of public policy in general, makes it very difficult to identify direct causal relationships between the impact of the implementation of the Action Plan and the drugs situation in the EU.

Nonetheless, this evaluation process carried out by the Commission is relatively unique compared to other regions in the world. Through the evaluation exercise and the continuing monitoring of the drug situation, EU policymakers have a wealth of information to their disposal for further analysis.

As already indicated in Chapter 1, the Action Plan should primarily be considered as a coordination instrument and a 'guidance document' for EU level and Member States where drugs policy is concerned. The Action Plan covers a wide range of initiatives and activities – some of which have been in existence for quite a long time – and add new priorities. The potential impact of the Action Plan – and for that matter – of the Drug Strategy (2005-2012) lies in the comprehensive and simultaneous implementation of its objectives and actions, reflected in the integrated and balanced approach which has been embraced by the Member States.

The vast majority of the objectives in the Action Plan do not have a single significant and direct effect on the drug situation, which includes drug use, adverse consequences of drug use and drug-related crimes. The rationale of intervention that underpins the Strategy and Action Plan is that when the different policy elements are implemented in conjunction with each other, synergies can emerge that influence drug demand on the one hand and drug supply on the other.

The information gathered through this report is detailed, but in most cases it is the output of specific objectives and actions in the Action Plan that is presented and not the outcome of those actions. For example, if all Member States had adopted the aim of implementing specific selective prevention programmes for vulnerable groups in society, this could be considered as an **output**. But the available information would not reveal the content and quality of these programmes or their accessibility to the target groups. The **outcome** of these interventions, when fully implemented, would be such that fewer people who belong to vulnerable groups would develop a drug problem, ultimately resulting in a visible **impact** on the drug situation, i.e. a reduced demand for drugs from these groups and a reduction of the adverse consequences of drug use. Often information on output is available, but not information on outcome, let alone on impact.

The Action Plan states that *"the ultimate aim of the Action Plan is to significantly reduce the prevalence of drug use among the population and to reduce the social harm and health damage caused by the use of and trade in illicit drugs"*.

This is an ambitious aim given the relatively short period for the implementation of the actions and objectives. On the basis of this report's findings, we can conclude that the aim has, **at best, been partly achieved**, even though it must be noted that some measures

have been in place for a longer period of time. When taking the information in this report into account, the conclusion can be drawn that the ultimate aim of the Action Plan has at best been partly achieved. **The prevalence of drug use among the population** has not been significantly reduced, but has stabilised at a historically high level (possibly reflecting a global trend), while cocaine use has increased considerably in a growing number of Member States. This is despite the fact that Member States report that they have increasingly implemented a wide range of drug prevention programmes (see objectives 8, 9 and 10). Nevertheless, the prevalence rates of drug use in the EU are modest when put beside other comparable regions and countries in the world where such information is available.

As regards the **damage to the health of the population caused by drug use**, some positive signs can be identified. An increasing number of problematic or dependent drug users are receiving treatment (obj. 11, 12). However, not much is known about treatment outcome, while treatment demand is increasing for non-opioid type drug users (e.g. cannabis and cocaine). Furthermore, the interaction between licit drug use, especially alcohol, and illicit drug use (cocaine, cannabis) has become an important concern. As a consequence, it is not possible to assess whether the Action Plan has had a positive impact on reducing the adverse consequences of drug use through the availability of more treatment. The available indicators do not explain whether an increase in treatment demand is the result of an increase in the scale of the problem or in dependent drug use, or that treatment services are better equipped to reach out to people who need treatment. Probably both are true.

Nonetheless, a positive impact on reducing the adverse consequences of drug use can be seen if we look at the rates of HIV/ AIDS infections among injecting drug users in the EU, which have fallen steadily in recent years. In this area, the broad implementation of harm reduction measures (obj. 14, 15, 16, 17) and in the HIV/AIDS infection rates seem to be linked, even though scientific validation is needed in order to establish a conclusive direct relationship. The same is true for the reduction of drug-related deaths and mortality among drug users, even though the downward trend appeared to tail off in 2004 and 2005.

In relation to the drugs-crime nexus, the **social harm caused by the use of and trade in illicit drugs** has not diminished. As indicated above, the level of drug use prevalence has stabilised or increased in the past years. At the same time, EU law enforcement has produced an overall stable output in the number and quantities of seizures of the most prevalent illicit drugs throughout the EU and a marked increase in cocaine seizures in recent years. The number of arrests for possession of drugs for personal use has increased by 75% since 2000 and the number of arrests for trafficking by 11%. At the same time, prices for most illicit drugs have fallen, some sharply. The purity of seized drugs has remained relatively stable. These data – of imperfect quality – suggest that drug supply to the EU has not been affected. Furthermore, there are no signs that drug-related crime in the EU has diminished.

The EU's activities in curbing drug trafficking from e.g. South America towards the EU might have had an impact on traditional trafficking routes (obj. 35, 36, 37), but this conclusion is not supported by evidence. At the same time, trafficking routes are becoming increasingly divergent and a growing number of neighbouring countries surrounding the EU seem to be targeted by organised crime groups. Furthermore, some

neighbouring countries, in particular Eastern European neighbours that have a serious HIV/ AIDS epidemic among injecting drug users, may increasingly pose a serious public health threat to Member States in the EU.

Added value of the EU Drugs Action Plan (2005-2008)

Added value of the Action Plan according to Member States

As already described in Chapter 1, the EU Drugs Strategy emphasises the requirement that drug policy at EU level should have added value for Member States, by creating synergies between Member States' drug policies and by tackling the drug problem at EU level, if it has the potential to achieve better results.

The survey conducted for the purpose of this evaluation showed that practically all Member States consider that there is an **added value** in having an Action Plan on Drugs at **EU level**. The key features of the added value can be listed as follows:

- An Action Plan provides **clear European-level objectives** and guidance for setting national priorities, resulting in greater coherence and convergence of drug policies between countries on a voluntary basis.
- An Action Plan provides guidance for **sharing of best practice** and development of common standards in many key areas on both drug demand and drug supply reduction.
- Member States share the view that the Action Plan provides a **comprehensive drug policy framework**, and that it has encouraged the development of high quality, broad national strategies and action plans across the EU.
- Many Member States indicated that the EU Action Plan was **important for international cooperation**. The EU has gained influence in the international arena in the field of drugs, because it has been able to work on the basis of the consensus reflected in the Strategy and Action Plan.
- The EU Action Plan plays an important role in presenting the **European model of drug policy**, with the balanced approach and Fundamental Rights as its cornerstones.

Synergies created by the Action Plan help to **avoid displacement effects** caused by diverging policies among Member States. The Action Plan and its objectives and actions provide priorities and indicators, and clarify responsibilities between EU institutions and Member States. The Action Plan is also seen as an instrument to promote cooperation among Member States and between Member States and third countries and regions.

Regarding the **added value** of the Action Plan for the **national level**, the evaluation shows that the Action Plan is seen as a catalyst for the development of national policies and that it has helped to raise the level of debate on sensitive policy issues at national level, for example on the introduction of harm reduction as part of drug demand reduction policies.

Member States still consider national policy documents as the primary source of reference for national drug policy. Nevertheless, all Member States referred to the EU Action Plan as being **generally consistent and relevant for national drug policy** by providing recommendations and arguments for national policy discussions and developments in legislation. The Action Plan has encouraged the initiation of joint

activities and operations in the field of law enforcement, both within the EU but also towards the main producing countries.

Finally, the **focus on evidence-based policymaking, monitoring, evaluation and information** has provided important added value for national drug policies, resulting in greater attention being paid to effectiveness and efficiency at national level.

So, overall, the **EU Action Plan on Drugs (2005-2008)** is considered by Member States as an **important policy instrument**, with a clear added value for both EU and international cooperation in the field of drugs, but also for the development of national drug policies.

The Action Plan offers **guidance for coordination between Member States**, without which the EU's **representation in international forums** would be fragmented and less influential. Given the fact that the EU Action Plan on Drugs is based upon a broad consensus among Member States and in fact reflects to a great extent the existing political reality in the Member States, it functions as a representative model of EU drug policy in international settings, something which is impossible for individual EU Member States.

Added value of the Action Plan

What the Member States have to say about the added value of the Action Plan has already revealed many of its strengths. The fact that so many Member States consider the Action Plan positively is one example of the growing convergence between drugs policies in the Member States. As Chapter 3 shows, Member State drug policy to a large extent reflects EU drug policy and vice versa.

For the new Member States, the (previous) EU Drugs Strategy and Action Plan set a benchmark for overarching drug policy during the accession process.

As the Action Plan brings together many different policy initiatives to deal with the drug problem across the board, it encourages coherence and fosters bilateral and multilateral cooperation between Member States.

As indicated above, at UN level the EU increasingly speaks with one voice, which strengthens the position of the EU as a region in UN cooperation.

In the field of monitoring and evaluation, the attention being directed at these cornerstones of policy making has helped to consolidate the ongoing and expanding collection of information and data on the drug situation through structures such as the EMCDDA.

Although one cannot conclude that some of these developments might not have taken place without the Action Plan, it does still provide the framework and policy agenda for cooperation.

CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE DRUG POLICY

Introduction

The EU Drugs Action Plan (2005-2008) is generally regarded as an important coordination instrument for drug policy at EU level, enhancing cooperation and coordination between Member States, and resulting in a broad variety of activities carried out at all levels of drug policy. The Action Plan has not remained a 'dead letter'.

The EU's resolve to base drug policy on scientific information and best available evidence and to foster the monitoring and evaluation of these policies remains strong. In practice, such an approach involves bringing the strengths and weaknesses of these policies into the open. This makes the EU vulnerable to criticism from other structures, countries and regions that do not pursue the same level of transparency. At the same time, it is the process of "trial and error" that provides the impetus for innovation and effectiveness.

Evaluating the impact of public policy plans such as the EU Action Plan on Drugs 2005-2008 is by nature not a simple exercise. The aim of the Action Plan was to coordinate and influence major areas of government interventions in the field of drugs (public health/ security/ external relations), targeting a complex social phenomenon that is still insufficiently understood, which largely takes place outside the scope and control of public authorities and which demands a long-term approach.

The EU Drug Strategy (2005-2012) and the EU Action Plan on Drugs (2005-2008) pay a great deal of attention to the important role of **coordination** at EU level as a **pre-condition for the implementation of the drug policy objectives and priorities**. Overall, the evaluation suggests that the current EU Action Plan on Drugs (2005-2008) has initiated a broad range of activities and cooperation. The Action Plan has been more than a plan on paper: progress has been made on nearly all specific objectives and actions, with varying degrees of success.

To what extent have the operational objectives and actions in the current EU Action Plan on Drugs been implemented and what have been the main outputs?

Overall conclusions

The EU Drugs Action Plan (2005-2008) is mainly a coordination instrument, pulling together the main strands of drug policy. The Action Plan is a non-binding coordination document for Member States, who are autonomous in implementing its aims and objectives.

- (1) This indirect implementation may be effective in providing guidance for national policy level, but it does make assessment of the direct consequences of the plan more complicated.
- (2) The Action Plan suffers from a number of internal inconsistencies as well as from the large number of objectives and actions, and the lack of prioritisation between them. These inconsistencies need to be avoided when drafting the next Action Plan.

Coordination

The evaluation shows that the Horizontal Drugs Group is the main forum of drug coordination at EU level. The European Commission is well coordinated in the Council. At the same time, coordination within the Commission regarding the implementation of the Action Plan can be improved, among others by setting clearer priorities and by improving the communication on EU drug policy objectives across policy fields.

- (1) All EU Member States have a national drug strategy, action plan and/or other overarching drug policy in place. In over half of the countries, these policy documents reflect the structure and set-up of the EU Drug Strategy or EU Action Plan on Drugs. Most Member States have also appointed a central coordinating body for the coordination of drug policy, but the form and shape of these structures may vary.
- (2) In all agreements that the EU has finalised with third countries/ regions, a specific clause on drugs has been included. However, the exact value of having these clauses on drugs has yet to be examined, as no information is available on their follow-up.
- (3) Furthermore, there is a lack of strategic coordination of EU assistance to third countries, in particular between Member States and between national and EU level.
- (4) In a large number of EU Member States, civil society is actively involved in drug policy-making at national level. In some Member States, active involvement also includes the local level and/ or involvement in delivery of services.
- (5) The feedback and interpretation of drug-related data by policy makers needs to be improved. The annual reports of the Commission, EMCDDA and Europol are not presented together and analysed in coherence and the results are seldom translated into new insights or policy proposals.

Drug demand reduction

Member States have invested in universal, selective and indicated prevention programmes across the board, but the evidence base underpinning these programmes is still weak and they are seldom evaluated, and therefore often not evidence-based. Only a handful of Member States have introduced general quality guidelines for prevention.

- (1) The coverage, content and effectiveness of these prevention programmes is unclear. Overall, the quality of selective prevention programmes is not highly regarded by experts. In the field of indicated prevention – covering, among others, drug use in recreational settings – there is very little information on the existence of such programmes in Member States.
- (2) A majority of Member States report that they offer a variety of treatment programmes to dependent drug users, including drug-free treatment, psychosocial treatment and substitution treatment. An increasing number of Member States have also developed quality guidelines for treatment programmes, but the level of

application is still unclear. Further improvements are also needed in accessibility, availability and coverage of treatment services.

- (3) New treatment options and/or settings are required for new or emerging types of drug problems, including polydrug use, intensive cannabis use or crack cocaine addiction. Member States need to invest in adapting/adjusting to new trends in demand for treatment.
- (4) In the field of harm reduction, major progress has been achieved in recent years. In all EU Member States the prevention and reduction of drug-related harm is a defined public health objective at national level. Among the most prevalent interventions are needle and syringe exchange programmes, combined with health education and advice, outreach workers and opioid substitution treatment combined with psycho-social assistance. However, availability and accessibility of these programmes are variable among the Member States and in some countries with low coverage there are signs of higher levels of risk-taking among new, younger generations of – in particular - heroin injectors, who have not been reached by prevention and harm reduction messages.
- (5) The availability of standardised information and data on the social consequences of drug use is very limited. This also includes information on the efforts made by Member States to rehabilitate and reintegrate (problematic) drug users in society.
- (6) Many countries have acknowledged the major importance of equivalence of care between prison and community and the continuity of services for released prisoners with drug-use related problems. However, drug services in prison and other custodial settings still need to be improved so as to prevent and reduce infectious diseases and to reduce the risks of drug-related deaths, which are increasing (in the period immediately after release from prison).
- (7) Treatment and harm reduction programmes are often not tailored to address the specific needs and problems of different groups of problem or dependent drug users, e.g. women, under-aged young people, migrants, specific ethnic groups and vulnerable groups. This conclusion was confirmed by civil society organisations represented in the Commission's Civil Society Forum on Drugs.

Reduction of drug supply

Law enforcement cooperation between Member States through existing instruments is on the increase, even though the existing instruments such as JITs and JCOs are not being used to the full extent.

- (1) Whilst Member State support to Europol has been enhanced, in particular in the area of synthetic drugs and related precursors, there remains substantial room for improvement in all areas. This requires, inter alia, enhanced information and intelligence collation and coordination between law enforcement services at the national level.
- (2) The results of various operational and intelligence law enforcement cross-border projects in the EU highlight the importance of strengthening intelligence

gathering and sharing as a basis for enhanced, intelligence-led law enforcement along air, sea and land routes.

- (3) Nevertheless, despite the increased investment in law enforcement cooperation, arrests and seizures, the overall drug market is stable, and prices have fallen in recent years.
- (4) The Drug Strategy's objective of making it easier to measure supply reduction and law enforcement output more effectively and therefore make it more accountable, is complicated by a lack of availability of standardised key indicators in this area. Various different methods and channels are used to collect data on drug seizures. Furthermore, not all Member States contribute actively to this data collection, and these include some major destination countries.
- (5) A long-term solution on forensic profiling for synthetic drugs is not yet in place, but considerable progress has been made.
- (6) The number of arrests for drug related offences rose considerably between 2000 and 2006, although in most cases the rise is due to arrests for consumption of drugs. It is unclear to what extent these arrests result in actual sentences. The number of arrests for drug-trafficking has increased marginally in the same period.
- (7) In almost all Member States, there is a lack of priority accorded to drug precursor control by national Customs organisations.
- (8) Member States' cooperation in the field of combating money laundering and confiscation of assets has progressed in recent years, and the number of investigations is increasing.

International cooperation

According to the Member States, the Action Plan has been important in terms of achieving coherence and consensus between EU Member States at international level. Increasingly, the Action Plan is regarded as the "showcase" of the EU drugs policy outside the EU.

- (1) The EU has increasingly taken a consistent position, in particular in the United Nations Commission on Narcotic Drugs (CND). However, in the Plenary Sessions, the EU does not yet always speak with one voice.
- (2) A large number of assistance projects with candidate, stabilisation and association process countries have been supported in recent years. Furthermore, (negotiations on) agreements have started or already been finalised with many of the countries involved, in particular regarding their participation in the EMCDDA and cooperation with Europol and Eurojust.
- (3) The EU's integrated and balanced approach on drugs has served as a model for Candidate Countries, Stabilisation and Association Process countries, as well as many European Neighbourhood Policy Countries in developing their national drug strategies and action plans.

- (4) The EU is a major player where assistance to third countries in the field of drugs is concerned. Based on the total stock of drug-related projects in 2005, Afghanistan and the Andean countries are the main beneficiaries of the EUR 760 million spent by the EU in 2005, two-thirds of which was allocated to alternative development. With 5% of the overall external funding, current spending on demand reduction is not well-balanced in international assistance projects, but it is increasing slightly.
- (5) The priorities of EU drug policy are not always explicitly linked into external funding programmes and projects in third countries.
- (6) With specific donations of over EUR 20 Million a year, the EU Member States are major contributors to UNODC (excluding EC contributions).

Information, research and evaluation

The quality of information that is available on the drug situation in Europe has improved in recent years, with the support for the activities of Europol and the EMCDDA, assisted and enabled through enhanced Member State provision.

- (1) Research cooperation in the field of illegal drugs needs more stimulation. A Commission study launched in 2008 will provide insight into research in the field of illicit drugs in the EU, and the results of its findings in 2009 will pave the way for greater coordination between researchers in the EU, as well as identifying future priorities to bridge the knowledge gaps in the field of drugs research.
- (2) The Commission acknowledges the importance of monitoring and information sharing in the drugs field through its funding programmes and the funding of the EMCDDA. Diminishing support from national governments to National Focal Points is giving increasing cause for concern, as they are an essential part of the information infrastructure of the EMCDDA.
- (3) Monitoring of drug demand reduction is improving, but demands continued attention and support for implementation of common data collection standards and methodologies at the level of the Member States.
- (4) The availability of reliable, comparable and usable information and data in the field of drug supply and supply reduction is an ongoing cause for concern, preventing a proper analysis of the EU drug market and the effectiveness of law enforcement actions.
- (5) The need for evaluation of drug policies continues to be very important. The final evaluation of the EU Drugs Action Plan (2005-2008) can be considered as the most detailed evaluation of EU drug policy ever. But improvements are required in order to better assess policy impacts.

Have the specific priorities in the Strategy and the operational objectives in the Action Plan been adopted by Member States?

The EU Drugs Strategy and Action Plan are suitably reflected in national policies. The evaluation shows that Member States have translated the objectives of the Action Plan

into national policy, and/or that these objectives were already reflected in existing documents.

- (1) Member States report that the Action Plan reflects the main policy fields at national level. Some national priorities are not covered, mostly owing to differences in the drug situations in Member States.
- (2) The evaluation shows that the Action Plan supports a process of convergence between Member States' drug policies and helps to achieve policy consistency between countries.

What have been the overall changes in the drug situation in recent years?

Although there has not been a significant reduction in the prevalence of drug use, the use of the most prevalent drugs seems to have stabilised and/or fallen slightly. The use of cocaine is showing an upward trend in some Member States.

- (1) The long-term trend in the EU in the prevalence of drug-related infectious diseases, especially HIV/ AIDS infections, is that these have been reduced in recent years, as have drug-related deaths (except for the years 2004 and 2005). Nevertheless, major efforts still have to be made.
- (2) New trends in drug use, especially poly-drug use, have emerged in recent years. This involves in particular the combined use of illicit and licit substances, including alcohol.
- (3) The number and size of cocaine seizures are rising, while for herbal cannabis, heroin and amphetamines seizures appear to be stabilising. The number of seizures of cannabis resin has increased, while the quantity seized has decreased. Prices for illicit substances in general have fallen, while purity levels seem to be fairly stable. As a result, it is difficult to draw conclusions about whether seizure levels have an effect on the availability of drugs and/or on the organised crime groups involved.
- (4) In the light of the above, it is clear that the scale and seriousness of the drug problem in the EU continues to be considerable, in terms of both health and social costs.

To what extent can these changes be associated with the implementation of the EU Action Plan on Drugs?

The stabilisation in prevalence levels of most illicit drugs except for cocaine cannot be linked to specific interventions implemented through the Action Plan.

- (1) At the same time, the ongoing reduction in drug-related infectious diseases and drug-related deaths, on the one hand, and the EU wide implementation of harm reduction measures, on the other, suggests a correlation, even though such a link cannot be proven. However, some Member States have achieved dramatic reductions in drug-related health harms after the introduction of harm reduction measures.

- (2) The ongoing and apparently stable supply of illicit drugs into Europe does not seem to be affected by existing interventions, including those implemented through the Action Plan. Whilst it may be suggested that the changing trafficking routes are a consequence of law enforcement operations, such actions do not appear to have had any effect on supply, price or purity. However, the lack of reliable statistical information and data prevents any credible conclusions being drawn.

What is the overall EU added value of the EU Drugs Action Plan 2005-2008?

Member States consider that the Action Plan has added value at both EU level as for national policy, where the Action Plan functions as a guiding document.

- (1) Furthermore, the current Action Plan represents a European added value in committing the Member States, the Commission and other relevant actors - albeit not in a mandatory form - to achieving commonly agreed objectives.
- (2) The Action Plan provides a framework for strengthening coordination structures at the EU level and for a coherent approach on drugs.
- (3) The Action Plan has a specific added value at international level, where the EU's integrated, balanced approach between demand and supply reduction, with due respect for Fundamental Rights, is seen as the EU model of drug policy.

Recommendations for the EU Drugs Action Plan (2009-2012)

The EU Action Plan on Drugs (2005-2008) was the most detailed Action Plan to date, constructed to implement the objectives of the Strategy. The final evaluation showed that progress has been made on many operational objectives defined in the Action Plan. However, there are also a number of important lessons to be learned for the EU Drugs Action Plan (2009-2012).

The implementation of the EU Action Plan will continue to face significant difficulties due to the non-binding nature of the plan. The Action Plan can only have an indirect effect on the implementation of drug policies in Member States.

- (1) The next EU Drugs Action Plan (2009-2012) may benefit from a reduced number of objectives and actions and the formulation of a limited number of priorities. It is also important to identify responsibilities for implementing the specific activities more closely and following up on them.
- (2) On the other hand, it is also important to note that the next Action Plan will continue to be based on the Strategy and on the EU model of an integrated and balanced approach. An Action Plan that aims to function as a coordinating and guiding document in all key areas of drug policy, that requires the participation and involvement of 27 Member States with different drug problems and different responses to them, will by its very nature not have to be too detailed nor too concise and limited in scope and size if it is to appeal to all stakeholders.

Recommendations in the field of coordination

- (1) Initiatives by EU Member States can be further supported, where necessary, by the Commission using existing budgetary resources and technical support in order to foster EU coherence of such initiatives.
- (2) Greater emphasis could be placed on the cycle of reporting on the drug situation in Europe. The current annual reports of Commission, EMCDDA and Europol could be analysed in more detail, when necessary culminating in specific Council conclusions.
- (3) The role of the National Drug Coordinators could be enhanced and brought into line with the work of the HDG, and a review could be conducted of the extent to which Member States' drug policies are consistent with the EU Action Plan.

Recommendations in the field of drug demand reduction

- (1) Greater attention should be paid to the development and actual implementation of quality guidelines and benchmarks for effective interventions in the field of drug demand. There are no interventions at EU level.
- (2) Greater attention should be paid to the roll-out and dissemination of effective interventions. The knowledge base in the field of drugs is expanding and improving, but the dissemination of knowledge at the professional level is still inadequate.

- (3) More attention should be focused on objectives in the field of drug prevention, for example by emphasising the importance of delaying first use and by focusing on poly drug use, including licit substances such as alcohol.
- (4) Member States should develop the availability of treatment options for non-traditional types of problematic drug use, such as cannabis use and amphetamine use.
- (5) The Member States should invest more efforts in reducing avoidable drug-related infectious diseases, in particular HIV/ AIDS and Hepatitis C.
- (6) The Member States should invest more efforts in reducing avoidable drug-related deaths – currently around 7.500 per year - by investing in prison health-care and after care and by further rolling out harm reduction interventions.
- (7) More attention should be given to the needs of specific groups in prevention, treatment and rehabilitation, e.g. drug dependent (pregnant) women, under-aged children, ethnic groups, etc.

Recommendations in the field of drug supply reduction

- (1) Greater attention should be given to the development of quality guidelines and benchmarks for measuring effective interventions in the field of drug supply reduction, both at national level – with due regard to national practices and legislation – and at EU level.
- (2) More and better use should be made of existing instruments in the field of law enforcement cooperation between Member States.
- (3) More emphasis should be placed on identifying and reporting new trends in drug trafficking routes with a view to analysing related data and developing rapid and effective responses, by exploiting Europol capacity as appropriate.
- (4) With regard to multilateral cooperation, in particular in the framework of Europol activities, the focus should be on the coordinated efforts and contributions of those Member States most highly exposed to or impacting on a particular drug production / trafficking phenomenon.
- (5) EU activities in the field of supply reduction should increasingly be based on a proper analysis of the mechanisms that govern the illicit drug market and be based on the principle of intelligence-led law enforcement.
- (6) More emphasis could be placed on law enforcement objectives that aim to reduce the negative consequences of the drug trade and the impact of organised crime on society at relevant phases in the chain from drug production to retail, including anti-fraud and anti-money laundering activities and the confiscation of financial assets.
- (7) The evidence base for supply reduction measures should be strengthened. Often the complexity of the law enforcement system, its operational character and the need for confidentiality in operations are mentioned as significant obstacles to

achieving greater transparency and insight on the impact of law enforcement activities. Such a lack of transparency is unsatisfactory and cannot continue. By placing greater emphasis on monitoring, the effectiveness and efficiency of evaluation and research can be enhanced, which is essential when allocating finite resources.

Recommendations in the field of international cooperation

- (1) The balanced approach, reflecting a proportionate response in drug demand and drug supply reduction while respecting EU fundamental rights, should be emphasised more strongly in the EU's cooperation with third countries, including those along trafficking routes.
- (2) This involves identifying complementarities and coherence between the funding instruments at EU level and national level through explicit policy priorities during the present funding period and in preparing for the next funding period from 2013 onwards.
- (3) The coherence between political decisions/strategies taken, for example, in Troikas, political dialogues and mechanisms such as EU-LAC and in the funding of drug-related projects through regionally oriented EC funding programmes should be improved
- (4) International cooperation should monitor and – if possible – anticipate new drug trafficking routes, which can help prioritise EU assistance to countries and regions along these routes, to support law enforcement cooperation and address emerging drug-related health and social problems.
- (5) Alternative livelihoods, taking into account specific economic and social problems of local crop producers, has become a major tool for the EU in its Strategy to reduce the growing of coca, opium poppy and cannabis in producer countries, and might be further strengthened in the new Action Plan.
- (6) Existing cooperation mechanisms, such as EU-LAC Mechanism for Cooperation and Coordination, should be further supported and developed, and action plans need to be implemented.
- (7) The Action Plans on Drugs (Central Asia, Western Balkans, Afghanistan) and the drug-related provisions in the action plans with the European Neighbourhood countries and third country cooperation agreements need to be fully implemented with financial assistance from the Member States and the EU

Recommendations in the field of information, research and evaluation

- (1) The quality and availability at EU level of relevant data and information in the field of drug supply reduction and drug-related crime should be improved, while comparable indicators in the field of drug demand reduction should be further developed and implemented.
- (2) Research into the evidence base underpinning drug demand and drug supply reduction policies should be further developed through better coordination and

cooperation between Member States and at EU level. An effective research priority identification and setting should be ensured by a coordinated approach between stakeholders and the relevant Commission services. Drug related research priorities should be included in future Community Research Programmes. All Presidencies during the current EU Action Plan on Drugs (2005-2008) have made a strong case for enhanced coordination.

- (3) There is a need for further consolidation of information structures at national and EU levels, in particular those of the EMCDDA and Europol, so that the information needed for the monitoring and evaluation of the EU Action Plans is provided and collected in a systematic and comparable manner. Work towards measuring drug policy impacts at national and EU level should continue.
- (4) To support collation at EU-level, the data collection and information gathering via National Focal Points of the Reitox network and through Europol National Units should be maintained and, where necessary, strengthened.
- (5) Information exchange mechanisms could be developed to measure practical delivery of policy outputs against political commitment, in particular regarding key conditions for the implementation and effectiveness of objectives and actions in the Action Plan.
- (6) The integrated, balanced approach should be further strengthened by closer collaboration between the demand reduction and supply reduction sectors, the aim being to identify possible unintended consequences of one policy on another and to better understand the (local) drugs phenomenon and related market, allowing the identification of and effective response to new trends and to health and social threats.
- (7) Evaluation of drug policies at national and EU level, and the exchange of related best practices, should be further encouraged as a way of providing a solid foundation for an evidence-based EU drug policy.
- (8) By the end of the implementation of the EU Drugs Action Plan (2009-2012) and the EU Drugs Strategy (2005-2012), the outcomes of EU drug policy should be evaluated. On the basis of the evaluation, a reflection period of at least one year should take place to allow for a proper analysis of achievements and follow-up.

Annex 1 — Overview of objectives and actions of the EU Drugs Action Plan (2005-2008)

This is a simplified table compared to the progress reviews 2006/2007. No indicators are mentioned (though progress reporting will involve the indicator and assessment tool).

Number	Objective/ action	Responsible	Level of achievement
1	<p>Ensure a balanced, multidisciplinary approach.</p> <p>Member States, with due regard to their national legislation and administrative structures, to adopt an overall national strategy and one or more action plans on drugs and to ensure that national strategies/action plans are in line with the EU Strategy/Action Plans.</p>	MS	<p><i>This objective has been partly achieved</i></p> <p>In early 2008, all EU Member States except Austria¹¹⁸ had a national drug strategy and/or a national drug action plan. During the period 2005-2008, two countries which had previously no such documents adopted one: Italy (action plan) and Malta (drug policy document).</p> <p>The United Kingdom, in 2008, adopted for the first time both a drug strategy and an action plan. This approach to planning exists now in almost half of EU Member States.</p> <p>Overall, between 2005 and early 2008, 18 Member States implemented new or updated drug strategies and/or action plans¹¹⁹. In addition, nine Member States¹²⁰ have drug policy documents which are due to end in 2008, and these policies are likely to be revised shortly.</p> <p>The average duration of national drug strategies or single policy documents (programme, action plan) in the EU is currently around seven years, while the average duration of complementary action plans tends to be about four years. Exceptions to this include the Dutch drug policy document, which dates back to 1995, and the new 2008 drug action plan for Italy, which has a duration of only one year.</p>
2	<p>Effective coordination at EU and national level</p> <p>Member States and the Commission to have a fully operational drugs coordination mechanism and to designate a person, department or body to act as</p>	MS COM	<p><i>This objective has been achieved</i></p> <p>Information on this action was reported by the Member States' National Focal Points to the EMCDDA. Member States were also asked to confirm their coordination structure through the Commission's survey. Drug coordination mechanisms exist in all EU Member States. However, their characteristics vary as they reflect the political structure, administrative culture and size of each country. The most frequent mechanism (20 Member States) has three components to it:</p>

¹¹⁸ Austria has a regional drug or addiction strategy in all its nine Provinces.

¹¹⁹ Bulgaria (updated action plan), Czech Republic (strategy and two successive action plans), Estonia (action plan), Greece (strategy), Spain (action plan), France (plan addiction), Italy (action plan), Latvia (programme), Luxembourg (strategy and action plan), Hungary (action plan), Malta (policy document), Poland (programme), Portugal (action plan), Romania (action plan), Finland (programme), Slovakia (action plans), Sweden (action plan), United Kingdom (strategy and action plan)

¹²⁰ Bulgaria, Ireland, Spain, Italy, Cyprus, Lithuania, Portugal, Romania and Slovakia

	drugs coordinator.		<p>an inter-ministerial body which defines the drug policy and adopts the national strategies and action plans;</p> <p>an operational body which does the day-to-day coordination in the drug policy field;</p> <p>regional and/or municipal bodies which coordinate drug-related measures at the local level</p> <p>Twenty-five Member States have one or more designated coordinators or coordination bodies in the drugs field: eleven report that they have one (or two) specialised agency(ies) or department(s), five that they have a national drug coordinator and nine that they have both. In the two remaining Member States, the responsibility lies with one (or more) member(s) of the government.</p> <p>The current drug coordination mechanisms were implemented before 2005. However, a few changes at national and regional/local level have occurred since then.</p> <p>At EU level, all Member States participate in the meetings of the National Drug Coordinators, though the representation in these meetings is not always consistent for each country.</p> <p>Conclusions</p> <p>Drug policy coordination mechanisms are in place in every Member States, but the available information does not indicate whether these mechanisms are ‘fully operational’ and whether they are influential enough to have a coordinated impact on the policies of the Member States. The impact depends on the policy implementation mechanisms available to the coordination structure as well as on the quality of information and feedback on achievements and the extent to which implementation of drug policy is a shared concern within governments. The presence of a coordinating entity at national level is in itself an acknowledgement of the crosscutting nature of drugs as a policy area and the need for a balanced approach in this field. It is recommendable to include the issue of coordination and implementation in national drug policy evaluations.</p>
3	Strengthen the involvement of civil society		
3.1	The Commission to issue a Green Paper on ways of cooperating effectively with civil society.	COM	<p><i>This objective has been achieved</i></p> <p>In 2006 the Commission published a Green Paper on the role of Civil Society in Drugs Policy in the European Union. After a wide—ranging consultation on how to organise a structured and continuous dialogue between the Commission and Civil Society, 26 organisations were selected as Members of the Forum out of 75 on the basis of the conditions set out in a report published in June 2007. The first meeting of the Civil Society Forum was held in December 2007, with informal exchanges and views between the Commission and the Civil Society on the 2007 Progress Review of the EU Action Plan. Moreover, as part of the work of the Final Evaluation and the new action plan, the Commission consulted civil society in the 2nd Forum in May 2008, generating constructive suggestions and</p>

			recommendations on the part of the civil society.
3.2	Member States to give the opportunity to civil society to present their opinion.	MS	<p><i>The achievement of this objective cannot be assessed</i></p> <p>Thus far, no debate has been organised in Council on the involvement of Civil Society in the Horizontal Drugs Group. Nevertheless, with a view to this present evaluation, the Commission asked the Member States to report on the existence of public consultation mechanisms and the involvement of civil society in national (or regional/ local) drug policy. Responses varied as to whether civil society is consulted by authorities and institutions at national level. Civil society was consulted at national level by 13 Member States during the process of formulation and adoption of (re-) newed national drug policy. The majority of countries reported frequent consultation between national institutions and NGOs through informal discussions, websites and surveys. Six countries reported that a representative from civil society takes part in meetings of the central authorities and/ or national drug coordinating mechanism on drugs related matters.</p> <p>In Estonia, Finland, Latvia, the Netherlands and Sweden, no specific options are available for civil society to have a dialogue with public authorities on drug policy. Involvement takes place through the political system, public debate and contacts between NGOs and government.</p> <p>Conclusion</p> <p>A majority of Member States have developed consultation mechanisms for the involvement of civil society in drug policy. Some Member States have also introduced such mechanisms at local level. However, organisations that participate in the Commission's Civil Society Forum on Drugs have indicated that civil society involvement could be more substantial and also support the collection of qualitative information on the delivery of services.</p>
4	Effective coordination in the Council		
4.1	The HDG to focus its activities on monitoring implementation of the EU Action Plan.	Council	<p><i>This objective has been achieved</i></p> <p>The EU Action Plan on Drugs (2005-2008) has played a consistent role in the agenda planning of HDG Presidencies between 2005 and 2008. Most Presidencies identified current or upcoming actions under the Action Plan timetable. The HDG Presidencies managed specific priorities or profiles during their term. After the adoption of the Action Plan during the UK Presidency, the Austrian Presidency stressed International Cooperation (UN), while the Finnish Presidency emphasised EU research and the involvement of Civil Society and organised a conference in the 2nd half of 2006. The German Presidency placed much emphasis on drug demand reduction, in particular on harm reduction (drug-</p>

			<p>related infectious diseases) but also on drug prevention programmes, early detection and early intervention¹²¹. In supply reduction, the Germans stressed the control of cross-border trafficking, including joint interdisciplinary operation projects, etc. The German Presidency was also very active in the field of <i>international cooperation</i>, especially cooperation with Latin America.</p> <p>The agenda of the Portuguese Presidency focused on two main objectives: responding to the changing dynamics of drug supply and drug demand and proposing future actions to take forward the Action Plan. The Presidency placed West Africa — a rapidly growing platform for the redistribution to Europe of cocaine produced in South America — on the top of the Group’s agenda. The Portuguese Presidency also highlighted the importance of high quality evaluation of drug policies and organised a conference around this theme. One of the main objectives of the Slovenian Presidency’s agenda was enhancing relations with the Western Balkans, third countries and international organisations, including the work for the UNGASS assessment process and preparation of the 51st session of the CND, while gradually launching preparations for the 52nd session of the CND. The French Presidency has indicated that it will place emphasis on the adoption of the new EU Drugs Action Plan (2009-2012) by December 2008, on enhanced cooperation between Member States to enhance the EU external security in the field of drugs.</p>
4.2	The HDG to be the leading forum in the Council for EU coordination on drugs. Effective coordination between it and other Council Working Parties dealing with drug issues, including external relations (e.g. police cooperation WG, customs cooperation WG, Multidisciplinary Group on organised crime, public health WG, etc.).	PRES Council	<p><i>This objective has been achieved</i></p> <p>Over the years, presidencies have regularly ensured feedback from and interaction with other relevant Council working parties, providing key input to drug-related activities and strengthening its coordination and leading role within the Council on drugs. The item “coordination with other Council working groups” was systematically on the agenda; sometimes, a room document describing drug-related activities in other Council working groups was distributed. The HDG was involved in discussions on drugs in external relations geographical groups which have been reported (by the Council and the Commission) to main meetings on drugs. Reporting on external relations, however, should be more systematic and generalised as a regular practice. Other than geographic WGs, the Customs Cooperation WG is particularly concerned, because of precursors. A thematic debate on improving cooperation between these two groups took place in December 2005.</p> <p>Conclusions</p> <p>Coordination through the HDG remains an essential condition for the coherence of EU drug policy. Overall, the HDG Presidencies have chosen priorities closely connected to the Action Plan on Drugs, and they have liaised well with other relevant Council working parties. Reporting on different meetings/actions on drugs should be generalised. The participation of other WG members at HDG</p>

¹²¹ This priority was discussed during the meeting of National Drug Coordinators.

			meetings should be encouraged when necessary.
5	Systematic mainstreaming of drugs policy into relations and agreements with relevant third countries		
5.1	Ensure that EU action plans for various regions are only adopted if adequate resources for their implementation are allocated.	Council	<p><i>This objective has been achieved, but nothing can be said about its outcomes</i></p> <p>With the exception of the new action-oriented paper on Afghanistan adopted in 2006, there were no new action plans on drugs with a country/ region during the 2005-2008 reporting period. However, the Panama Action Plan within the EU-LAC coordination and cooperation framework was revised in 2007 and the review of the Action Plan on Drugs with the Western Balkans was launched in 2008. Within the framework of an EU-Brazil Strategic Partnership, an EU-Brazil Action Plan was agreed in 2008, including a chapter on illicit drugs and related crime. In 2008, the action-oriented paper on Afghanistan will be reviewed but the results of this assessment are not available so far. Under the European Neighbourhood Policy¹²², a large number of the Action Plans adopted so far contain provisions on drugs. Drugs cooperation is also extensively addressed in the EU-Russia Action Plan against organised crime and Common Space on Justice, Freedom and Security (<i>cf. Action 34.2</i>).</p> <p>Conclusions</p> <p>Activities undertaken under the Action Plans on Drugs have no dedicated budgets, but can receive budget allocations via national and EU assistance programmes. With regard to the ENP action plans, drug-related activities can be financed through the European Neighbourhood Policy Instrument. The EU should adopt new action plans with third countries only if dedicated funding is available. Third countries should be encouraged to assume ownership of collaborative activities by taking responsibility for their own policies and for collaborative projects.</p>
5.2	Include a specific provision on drugs cooperation in new agreements with third countries/regions. HDG should be informed of the opening of relevant negotiations.	Council COM	<p><i>This objective has been achieved, but nothing can be said about its outcomes</i></p> <p>In general, agreements with third countries — under negotiation or signed/ concluded — include a substantive article on drugs cooperation. Negotiations on Justice and Home Affairs provisions are not yet final with Serbia. Negotiations with Ukraine are well advanced while those with China are at the initial phase. Negotiations with Russia are expected to start soon. Negotiations with ASEAN countries are at different stages: with Indonesia (not yet signed), with Singapore (to be concluded) and with Vietnam, Malaysia, the Philippines and Brunei (not yet formally started). Negotiations with South Africa have been concluded. Negotiations with the Andean Community and Central American Republic made progress in 2007 and 2008. The Commission has proposed negotiating directives as regards Libya. Negotiations with Iraq are in their initial phase. All cooperation and association agreements</p>

¹²² ENP countries: Algeria, Armenia, Azerbaijan, Belarus, Egypt, Georgia, Israel, Jordan, Lebanon, Libya, Moldova, Morocco, Palestinian Authority, Syria, Tunisia, Ukraine.

			between the EU and third countries and regions incorporate drug related elements. These agreements need to be concluded/ ratified and fully implemented.
6	<p>Maintain a regular forum for EU coordination.</p> <p>The Presidency to provide the opportunity to those responsible for drug coordination to meet to exchange information on national developments, to review the scope for greater cooperation and to focus on the implementation of the EU Action Plan.</p>	PRES MS COM	<p><i>This objective has been achieved</i></p> <p>Within the lifetime of the current EU Action Plan, all so far HDG Presidencies have held a meeting of the National Drugs Coordinators. Some of these were open to external parties, such as representatives of civil society, to UN organisations or the Pompidou Group. The meetings of the National Drug Coordinators in general offer an opportunity for sharing best practices at EU level and for focusing on specific concerns. Nevertheless, the HDG meetings seem somewhat distanced from the work that is done in the horizontal working group.</p> <p>Conclusions</p> <p>All HDG Presidencies organise meetings of the National Drug Coordinators. These might be seen as creating more synergy between the activities of the HDG and the meetings of the national drug coordinators.</p>
7	<p>Improve coverage of, access to and effectiveness of drug demand reduction measures.</p> <p>Improve coverage of, access to, quality and evaluation of drug demand reduction programmes and ensure effective dissemination of evaluated best practices. More effective use and regular updating of the EMCDDA based EDDRA (Exchange on Drug Demand Reduction Action) and other databases.</p>	MS EMCDDA	<p><i>The achievement of this objective cannot be assessed through this evaluation</i></p> <p>In the field of drug demand reduction, the differences between Member States in terms of prevention, treatment, harm reduction and rehabilitation projects are substantial. In recent years, the evidence base underpinning these interventions has increased. However, available best-evidence and best-practice is not always translated into national policy and service delivery. Accurate and comparable information on the coverage and accessibility of drug demand reduction facilities and measures is lacking at EU level, and the terms themselves are defined differently in each Member State. The EMCDDA does, however, collect information from Member States on whether they have quality-assurance¹²³ mechanisms in place to increase the effectiveness of drug demand reduction activities in the areas of treatment and prevention. Furthermore, the EMCDDA addresses the issue of reliability of data and definitions across countries.</p> <p>In the area of treatment, over half of the Member States report the availability of national quality standards for drug-free treatment (16 MS); medically-assisted treatment (19 MS); and the evaluation of drug treatment at national level (12 MS). Quality-management systems using international quality standards (ISO 9000ff and EFQM) are available in only two countries. In the area of prevention, quality standards for school-based prevention by ten Member States; for selective prevention by eight;</p>

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Quality assurance can be defined as a system of procedures, checks, audits and corrective actions to ensure that service and reporting activities are of the highest achievable quality. Quality assurance can be a more or less formal control measure, and with a higher or lower level of reporting, by providers and public control institutions. Among the most traditional measures are quality standards, evaluation, quality management systems and training of staff.

			<p>and community-based prevention by six. National standards for the evaluation of prevention seem to be less common and are only reported by a few Member States. The existing data provide only a basic and rather crude picture of the availability of quality-assurance mechanisms and the content and scope of these measures has to be further investigated as, for instance, the concept of what exactly and correctly constitutes a 'standard' or a 'guideline' seems to differ across Member States. There are also considerable methodological difficulties associated with measuring the effectiveness of drug demand reduction activities at population level, taking into account the level of drug use and risk perception.</p> <p>Conclusions</p> <p>The existing data provide only a basic picture of the availability of quality assurance mechanisms among EU Member States in the field of drug demand reduction, but show that efforts to develop quality standards or guidelines exist in most countries. The content and scope of these measures have however to be investigated further. The development of definitions and quality models at EU level may be further considered.</p>
8	Improve access to and effectiveness of school-based prevention programmes, in accordance with national legislation.		
8.1	Improve access to and effectiveness of school-based prevention programmes, in accordance with national legislation.	MS	<p><i>This objective has been partly achieved</i></p> <p>The evidence-base for effective school-based drug prevention programmes is expanding, but most research has been done in the United States or — on smaller scale — within a limited number of EU Member States. The effectiveness of programmes can be assessed through systematic and long-term randomised controlled trials. At EU level such research is rare, and EU funded projects do not always fit in well with existing prevention practices in Member States. Research shows that programmes that delay the age of first use of licit and illicit substances and/ or that reduce the frequency of use may have health benefits as younger adolescents may be more vulnerable to the adverse consequences of drug use and only a limited group of adolescents continue to use at a later age. Where the direct assessment of intervention effects is lacking, as an alternative, effectiveness can be estimated on the basis of the quality of its components. Here life-skills approaches and the correction of normative beliefs have been found to be relatively effective, while information provision alone is considered ineffective.</p> <p>In 2007 58% of the programmes had process and outcome evaluation, compared to 32% in 2004. This partly reflects a reduction in the number of reported programmes following a more strict application of the definitions provided and may not mean that evaluation has become a standard component of prevention programmes in general.</p>
8.2	Support implementation and development of joint prevention programmes of public services, school communities and NGOs.	MS	<p><i>This objective has been achieved, but nothing can be said about its outcomes</i></p> <p>As indicated in action 7, the lack of shared definitions between Member States sometimes makes comparison difficult. In some reports from Member States, manuals or isolated interventions are</p>

			<p>considered as “programme”. For monitoring purposes (EMCDDA), the concept of “programme” has been applied here in the more strict sense as comprehensive, multi-session, standardised and manualised interventions, content-defined for each session and with printed material (so-called MUSTAP) that provide a defined and sequenced protocol of interconnected activities. These elements do not reflect a quality standard as such, but interventions that lack these elements are generally too ad-hoc based and difficult to evaluate and therefore often not consistent. Data provided by the EU Member States through their National Focal Points shows that ‘programmes’ in a more strict sense (as mentioned above) still remain rare in Europe and no information exists to suggest that the situation has improved since 2004¹²⁴.</p> <p>In order to respond to the prevailing broader interpretations of the term “programme” in Member States, EMCDDA data collection also covers the provision of other kinds of drug prevention activities in school. The analysis shows an overall stable situation: some types of interventions (e.g. peer approaches) decreased between 2004 and 2007, while others increased and the rest remained stable.</p> <p>The Drug Prevention and Information Programme¹²⁵ (2007-2013) co-fund initiatives from Member States in which collaboration between varieties of stakeholders is made possible.</p>
9	<p>Set up, develop and improve selective prevention and new ways of reaching target groups, e.g. by using different media and new information methodologies.</p> <p>Develop and improve prevention programmes for selected target groups (e.g. street operators, socially disadvantaged groups, socially excluded children and families at risk, young people in the out of school sector) and specific settings (e.g. drugs and driving, drugs in the work place, drugs in recreational settings), taking into account gender differences.</p>	MS COM	<p><i>The achievement of this objective cannot be assessed</i></p> <p>Research findings and reviews have identified a number of particularly vulnerable groups for increased use of drugs, the development of drug problems or rapid progression into dependency. These include: young offenders, early school leavers and pupils with social or academic problems, young people in socially disadvantaged neighbourhoods, and party or festival goers. Also some living conditions and family situations are known to increase the risk of problem drug use for children. These include: parental or sibling drug and/ or mental health problems, conflict, neglect, and social disadvantage.</p> <p>In a majority of Member States (between 17 and 25) these types of vulnerable families are not explicitly mentioned in drug policies. <i>This does not however rule out</i> generic programmes — not related to drug prevention policies — might be in place for these groups or that drug issues might not be addressed in more generic practice.</p> <p>Overall since 2004, some relevant vulnerable groups, especially young offenders, the homeless, truant, disadvantaged and minority youth groups, became priority groups in an increasing number of drug policies. The level of provision of interventions to vulnerable groups, however, did not consistently</p>

¹²⁴ Findings have to be treated with caution due to the limited number of Focal Points reporting (2004: 13; 2007:9) and the small number of programmes covered.
¹²⁵ OJ L 257, 03.10.2007

			<p>increase since 2004 if judged on the basis of Member States' reports. It only increased for young people in care institutions and immigrants, whereas for some other groups the number decreased¹²⁶.</p> <p>The approaches used in selective prevention range from structural improvements for social inclusion (providing opportunities to young people in deprived neighbourhoods) to intensive personalised interventions (e.g. courses for young drug law offenders).</p> <p>There is no information in 2007 about the overall number and coverage of prevention projects in recreational settings as this indicator was found to be difficult to implement in practice and was therefore eliminated from the questionnaire after discussions with REITOX focal points. Information is available about the rated provision of interventions for party/ festival goers and the policy importance given to working in recreational settings is reported to have increased.</p>
10	Improve methods for early detection of risk factors and early intervention.		<p><i>The achievement of this objective cannot be assessed</i></p> <p>This objective is difficult to implement and compliance is difficult to assess due to a lack of clear formulation of the actions and a lack of definition of the concepts 'early detection, early intervention' and of the specific groups involved.</p> <p>The EMCDDA has made use of the age of first use/ first treatment demand indicator as an indirect measure for the effectiveness of early detection and early intervention programmes. As the indicator does not cover the background of drug users seeking treatment in the context of risk factors relevant for early detection, and drug problems may develop over time due to changes in personal situation, it is an imperfect measure. However, the indicator may provide trend information on changes in the age of first use and possible correlation with increased needs for treatment.</p> <p>The figures reported last year are confirmed in this year's new reporting. According to the treatment demand indicator (TDI), among the entire treated population in the European countries in 2005 around half of the clients started to use their main drug between the age of 15 and 19, and 15% before the age of 15 — regardless of the type of drug. Among new outpatient clients with volatile substances and cannabis as primary substances for entering treatment, 51% and 33% respectively started to use the drug before the age of 15. The mean age of new drug clients is 28.5 years and the time lag between first 'primary drug use' and first treatment request is around 8 years (¹²⁷). However, differences are found in this time lag according to the main drug of use. Among new outpatient clients, it is around 7 years for</p>

¹²⁶ Note: percentage changes reporting in this data need to be interpreted with caution as the number of countries reporting or not reporting in each wave is different and therefore reporting artefacts cannot be ruled out. All data presented on importance of vulnerable groups in drug policies and the level of provision of interventions has been obtained through qualitative ratings by experts or expert panels from each Member State. As rating categories have slightly changed since 2004 and countries reporting are not exactly the same in 2007 as in 2004 results have to be interpreted with caution.

¹²⁷ The 'primary drug' means the drug for which treatment is requested.

			cannabis (7.4) and more than 9 for opiates and cocaine.
10.1	Detection of risk factors related to experimental use by different target groups, especially by young people, and the dissemination thereof for the benefit of early intervention programmes and the training of professionals.	MS	<i>The achievement of this objective cannot be assessed</i> All Member States have been reporting on national studies and, to a more limited extent, on the corresponding interventions that address risk factors and predictors for drug use among minors. In particular, children from families with substance use problems are targeted by research or intervention programmes and services.
10.2	Ensure the provision of training for relevant professionals who come into contact with potential drug users, especially young people.	MS	<i>The achievement of this objective cannot be assessed</i> No structured information is provided on ‘training for professionals who come into contact with potential drug users, especially young people’. However, some ad-hoc information is collected in the EMCDDA’s data gathering process. For example, in Germany, Italy and Poland, teaching packages or intensive training courses for teachers on motivational short interventions are provided. These packages/courses aim to assist schools in setting their own rules and help teachers to know how to deal with pupils displaying conspicuous behaviour, or are designed to provide support to teachers in early identification, intervention or transferral to specialised services. However, it is clear that there is an insufficient level of data available to respond to this action.
10.3	Implementation of the early intervention programmes, including measures especially related to experimental use of psychoactive substances.	MS	<i>The achievement of this objective cannot be assessed</i> An account of developments in early intervention programmes will be provided by an upcoming EMCDDA publication. Some information is available for this update. For example, in Germany, Greece, and the Netherlands, some specialised facilities exist that offer counselling and care to children and teenagers with drug problems. In Denmark and Ireland, SMS messaging services are being used for interactive counselling and for support to stop cannabis smoking. Overall, it is important to point out that many facilities combine inpatient and outpatient measures and include key elements from both addiction therapy and youth welfare. Early intervention is also provided by specialised centres for drug treatment.
11	Ensure the availability of and access to targeted and diversified treatment and rehabilitation programmes.		
11.1	Evidence based treatment options covering a variety of psychosocial and pharmacological approaches to be available and correspond	MS	<i>This action has been partially, but not sufficiently, achieved as quality of services can be improved</i> Data on clients who entered drug treatment (due to any illicit drug) in the course of 2006 are available from 22 EU countries ¹²⁸ . Coverage data show that among the 355 000, clients who entered drug

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No data were available from: Belgium, Estonia, Spain, Latvia, Poland, Portugal and Slovenia.

	to demand for treatment.		<p>treatment, around 186 000 reported heroin as the primary drug for which they were seeking assistance¹²⁹. Around 30% of clients entering the facilities received treatment for the first time in their life. While rates vary between countries, and data mainly reflect the situation in specialised outpatient and inpatient drug treatment services, it is important to note that in these 22 countries alone at least 178 000 drug users are newly being reached by structured treatment services in one year. It is also important to note that the percentage of clients entering treatment for cocaine or cannabis-related problems has been increasing in recent years, with cannabis seeing a slight increase from 2005 to 2006.</p> <p>In 2006 for the first time ever all EU Member States provided opioid substitution treatment, even if levels of provision and coverage clearly differ. More than half a million opioid users receive drug substitution treatment in the EU countries, the vast majority of cases reported from the ‘old’ EU Member States. This represents more than one third of the total estimated number of problem opiate users in the EU. Between 2005 and 2006, the number of clients receiving this type of treatment increased overall by around 12%¹³⁰.</p> <p>The substance predominantly used was methadone (70% of all substitution treatment), but the share of buprenorphine has increased quickly over the past few years, especially among clients treated by office-based medical doctors. Other substances — especially buprenorphine — have become equally important or even more important in the maintenance treatment of opioid dependence in a growing number of European countries. Prescription of medical heroin (diamorphine), which showed positive results among chronic treatment-resistant opioid users, is a treatment option in the Netherlands, the United Kingdom and Germany partly making use of special regulations. Additionally, a randomised trial of injectable opioids (RIOTT) started in 2005 in the United Kingdom comparing the effectiveness of injectable diamorphine, injectable methadone and oral methadone, and the results are expected at the end of 2008. A concept for a heroin prescription pilot project was submitted to the Minister of Health of Luxembourg in April 2008 while, in February 2008, the Danish parliament approved a diamorphine prescription pilot project.</p> <p>Data from a number of individual EU countries — where recent estimates of the prevalence of problem opiate use were available — show that the current coverage of opioid substitution treatment varies between countries with an in-treatment-rate of 5% to about 54% of all current opiate users.</p>
11.2	Establish strategies and guidelines for increasing availability of and access to services for drug users not reached by	MS	<p><i>This action is partially but not sufficiently achieved</i></p> <p>Findings from a survey commissioned by the EMCDDA on cannabis treatment provision in a sample of drug treatment services in 19 Member States revealed a relative lack of treatment programmes</p>

¹²⁹ According to the available coverage information, the data cover approximately 60% of the specialised inpatient and 80% of outpatient drug treatment units in these countries, but only a minor proportion of other treatment facilities or of general practitioners (GPs) providing treatment.

¹³⁰ Data available from 19 Member States

	existing services.		<p>dedicated to problem cannabis users. To overcome this, four Member States¹³¹ report concrete efforts to develop treatment offers specifically for young cannabis users, collaborating in a study on the effectiveness of a comprehensive family-based treatment focusing on problematic cannabis use (INCANT). Promising results have been observed in a German randomised control study examining a treatment program for adolescents with cannabis disorder (CANDIS), showing that half of the patients had stopped their cannabis use by the end of the treatment, while another 30% reduced their consumption.</p> <p>The latest available data show that, with the exception of Spain, Member States assessed the availability and accessibility of cocaine specific treatment programmes as low. The recent introduction of a cocaine-specific national action plan in Spain and Ireland is likely to further increase the availability of cocaine treatment options in these two countries. Little evidence has so far been found of psychosocial treatment interventions being effective in treating cocaine dependence, although a combination with contingency management approaches has shown promise in reducing cocaine use. To date, no effective pharmacological treatment options for cocaine dependence are available, but several therapeutic drugs (e.g. Modafinil, Topiramate) have shown potential in clinical trials. The results from clinical trials of a vaccine for immunotherapy of cocaine dependence (TA-CD) are keenly awaited. However, the effectiveness of such an approach is uncertain and even if successful; it would raise a number of ethical concerns.</p>
11.3	Improve access to and coverage of rehabilitation and social reintegration programmes, paying special attention to specialised (social, psychological, medical) services for young people who use drugs.	MS	<p><i>This action is partially but not sufficiently achieved</i></p> <p>Political attention and investment in the reintegration sector has risen in some Member States and quality standards in drug treatment provide for social care and reintegration services to be made available to clients. The socio-demographic profile of clients entering treatment reveals their specific needs: they are characterised by disadvantaged social conditions, a low level of school and professional education and often an unstable living situation.</p> <p>Homelessness, together with living in unstable accommodation, is one of the most serious forms of social exclusion facing drug users, affecting about 10% of drug users entering treatment in 2006. While housing support is provided to drug treatment clients in many countries, shortages have also been documented, and four countries report that it is difficult for drug users to gain access to the general services for the homeless that are traditionally used by problem alcohol users (Ireland, Italy, Hungary, and Austria). New centralised facilities for homeless chronic addicts or alternative care homes for drug users with problem behaviour or mental illness have been established in Denmark, Belgium and the Netherlands.</p> <p>Programmes and actions in many countries do not aim at drug users alone but address vulnerable social</p>

¹³¹ France, Germany, Netherlands, Belgium

			<p>groups in general and are typically run at local or regional level. While the creation of new opportunities for training and access to education is reported as common in many countries, waged work is harder to obtain for the target group. A number of projects have been developed in some Member States under the EU Commission's EQUAL initiative in the area of employment and social inclusion.</p> <p>Helping drug treatment clients find employment is a key element in social reintegration, as one in every two clients entering treatment is unemployed. New approaches to helping clients to find and hold down employment are reported to have shown success. These include: 'mentoring schemes', subsidised workplaces and the coaching of employers and employees during the first months by specifically assigned social reintegration workers.</p>
11.4	Organise and promote dissemination of information on the availability of treatment and rehabilitation programmes.	MS	<p><i>This action is partially but not sufficiently achieved</i></p> <p>The use of information, education and communication techniques with regard to drug prevention and risk reduction is a common approach in all Member States and specific educational materials, telephone help lines and websites exist in all, or most, countries.</p> <p>In 22 Member States, online inventories of national treatment and rehabilitation resources are available. Innovative internet-based and SMS-based initiatives in counselling, support and dissemination of information — especially dedicated to problem cannabis use — have also been reported by Denmark, Germany and Ireland.</p> <p>The EMCDDA launched in May 2008 the first module of its Internet portal on best practice in the fields of drug-related prevention, treatment, harm reduction and social reintegration. The portal provides an overview on the latest evidence on the efficacy and effectiveness of different interventions, presenting tools and standards aimed at improving the quality of interventions, as well as highlighting examples of evaluated practice from across Europe. It is aimed at professionals, policy-makers and researchers in the drugs field.</p>
12	Improve the quality of treatment services Support development of know-how on drug treatment while continuing to develop and support the exchange of best practices in this field.	Council COM	<p><i>Objective achieved — report published</i></p> <p>To complement Member States' activities in this field, the Programme for Community Action in the field of Public Health¹³² (2003-2008) continues to support a range of projects in the field of drug demand reduction, including prevention, harm reduction and treatment. Other projects funded by the Programme and dealing with health determinants (e.g. mental health, alcohol and tobacco) and drug-related infectious diseases (in particular HIV/AIDS) are often linked to drug demand reduction activities. Funding for these kinds of activities will continue under the second Community action</p>

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OJ L 271, 09.10.2002

			<p>Programme for Public Health 2008-2013 and will be enhanced by the new Drug Prevention and Information Programme¹³³ (2007-2013) and the 7th Research, Technological and Development Framework Programme¹³⁴ (2007-2013).</p> <p>In 2006, the Commission launched preparatory work on drugs policy and harm reduction, including a report on drug treatment and good practices across Europe¹³⁵. The tender called for a study providing an overview and analysis of available drug treatment options in the Member States, including efficacy of treatment in EU, types, characteristics, level of provision and models of transfer of know how. The results of the study and the country profiles have been double checked with the Reitox Network. The final report has been published.¹³⁶</p>
13	Further develop alternatives to imprisonment for drug abusers and drug services for people in prisons, with due regard to national legislation.		
13.1	Make effective use of and develop further alternatives to prison for drug abusers.	MS	<p><i>The achievement of this objective cannot be assessed</i></p> <p>Available data on Alternatives to prison need to be interpreted with caution. <i>Alternatives to prison</i> (ATP) are provisionally defined as therapeutic measures or treatment for <i>adult drug-using offenders</i> that take place outside prison. <i>Alternatives</i> can include therapeutic measures where no prison sentence may be given under the law.</p> <p>A wide variety of alternatives to prison are available in almost all the EU Member States, for different types of user and for different types of offence. In 14 EU Member States, the concept of alternatives to prison is supported in national drug strategies or action plans, with the primary aim being to prevent future use, reduce crime and prevent infectious diseases, rather than to cut the prison population or public expenditure. In thirteen countries, standards for delivery of treatment as an alternative are available.</p> <p>Member States, through the Reitox network, were asked what proportion of drug-using offenders might have faced a prison sentence under national law but were diverted to treatment. No country could give exact percentages for all its ATPs. Details of completion rates were available for some of the ATP options in some countries, ranging from approximately 30% in Ireland (graduations from the Drug Court) to 70% or 80% for Spain and Italy (prison terms served outside prison). The majority of Member</p>

¹³³ OJ L 257, 03.10.2007

¹³⁴ OJ L 412/1, 30.12.2006

¹³⁵ Call for tender published on 10/05/2006 — ref: 2006-92638.

¹³⁶ http://ec.europa.eu/health/ph_determinants/life_style/drug/drug_call_en.htm

			<p>States had no information on this matter. Few countries have a tracking system in place to follow all those who have been diverted to various treatment options. There have been developments in legislation in various countries during the period of the EU Action Plan. Legislation has brought new possibilities for ATPs, including suspension of custodial sentences (for treatment) in Spain and Hungary; encouragement of probation with treatment in Hungary; and educational measures in an outpatient facility in Slovakia. A further four countries have passed laws to widen the scope of existing ATPs. In Italy, eligibility for ATPs has been extended to those convicted of an offence punishable by up to six years in prison (previously it was four years); in Poland, the new limit is five years. In the United Kingdom, testing on arrest is now permitted, with those testing positive being required to undergo an assessment.</p> <p>There were also developments in terms of law enforcement. In Belgium, public prosecutors are developing closer cooperation with treatment organisations. In the Netherlands, a more stringent selection of offenders for treatment is seeking to make the system more efficient, and there are efforts to increase the use of ‘conditional release’ (release conditional on treatment) after prison.</p>
13.2	Develop prevention, treatment and harm reduction services for people in prison, reintegration services on release from prison and methods to monitor/ analyse drug use among prisoners.	MS COM	<p><i>This action has been (partially) achieved</i></p> <p>In 2006, the Commission launched a call for tenders for work on drug policy and harm reduction, including a study on the status quo of prevention, treatment and harm reduction services for people in prisons and in reintegration services for persons on release from prisons, and for approaches to monitoring/analysing the situation.</p> <p>In November 2007 a debate on interventions in prisons and the role of harm reduction was held in the Horizontal Working Party on Drugs (HDG). The Member States concluded that there is a need to implement the same standards on the prevention of infectious diseases and treatment of drug-related diseases across Europe as well as improve the information at EU level on the prevalence of infectious diseases in prisons and ways of preventing them. Member States recommended the introduction of specific harm reduction measures, including substitution treatment, drug free treatment and the creation of drug free units within prisons. The need to develop a common methodology and terminology for collecting data, having comparable EU data and subsequently defining and exchanging best practices was also identified. To ensure coherence and sustainability of interventions before, during and after imprisonment, excellent networking is required. This should include, in particular, helpers in prisons and institutions and NGOs involved in reintegration after release, for example ensuring the continuation of methadone maintenance programmes that started in prison. It was concluded that there should be equitable delivery and availability of prevention tools and therapeutic possibilities offered to inmates in comparison to the general population. Finally, the Presidency conclusions¹³⁷ of the HDG</p>

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			debate called on the Commission to put forward a proposal for a Council Recommendation on drugs in prison.
14	<p>Prevention of health risks related to drug use</p> <p>Implementation of the Council Recommendation on the prevention and reduction of health related harm associated with drug dependence</p>	MS	<p><i>This objective has been achieved (but still ongoing for MS), Commission report was published</i></p> <p>On 18 April 2007, the Commission adopted and published the final report¹³⁸ of a study into the implementation of the Council Recommendation of 18 June 2003, presenting key conclusions and recommendations on the implementation of the Council Recommendation, based on a background study¹³⁹ that included a comprehensive overview of the situation in each of the Member States. The report concluded that 25 EU Member States have defined prevention and reduction of health-related harm associated with drug dependence as a national public health objective and as part of the national response to the drug problem. Harm reduction facilities and services are available in all EU Member States, although they vary widely between Member States.</p> <p>The Commission report was discussed in the Horizontal Working Party on Drugs (HDG). The conclusions of the report were endorsed by the HDG and it was agreed that this reporting exercise should be repeated under the next EU Drugs Action Plan (2009-2012). The Council debate resulted in Member States' conclusions¹⁴⁰ in particular on harm reduction constituting an essential component of demand reduction, on the need for improving the knowledge and understanding on the impact of harm reduction measures, on the attention to be given to areas of harm reduction where a need for improvement is identified (such as the prevention of hepatitis B and C infections). An important conclusion was that the improved response to drug-related health issues in custodial settings could prevent and limit drug-related health damage among those in prison especially when supported by post release care. There is therefore a strong need to improve harm reduction measures in prisons as well as reintegration services.</p>
15	<p>Availability and access to harm reduction services</p> <p>Improve access for addicts to all relevant services and treatment options designed to reduce harm, with due regard to national legislation.</p>	MS	<p><i>This objective has been partly achieved, but requires further implementation</i></p> <p>Needle and syringe programmes (NSPs) and opioid substitution treatment is available in all EU Member States. They can be effective in reducing risk behaviour (needle sharing) and of drug-related infectious diseases. They are usually delivered by specialist low-threshold drugs agencies, and in eight countries also through pharmacy-based programmes, which considerably increases the geographical availability of sterile injecting equipment. While the continuous expansion of low-threshold agencies</p>

¹³⁸ COM (2007) 199 final; http://eur-lex.europa.eu/LexUriServ/site/en/com/2007/com2007_0199en01.pdf

¹³⁹ Gouwe, 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', Trimbos Institute; http://ec.europa.eu/health/ph_determinants/life_style/drug/documents/drug_report_en.pdf

¹⁴⁰ CORDROGUE 43, 02/07/2007

			<p>with syringe exchange can be documented for many of the countries where the spread of problem heroin injecting is more recent, a stagnation or decrease of such services was reported by other countries in this group (Bulgaria, Poland and Romania), partly due to lack of support and funding. While overall levels of drug maintenance treatment and harm reduction service provision in the EU have increased considerably over the past decades, coverage of these interventions is limited in some countries.</p> <p>In some of the countries with older heroin epidemics and extensive treatment provision, however, a stabilisation and decrease of syringe demand can be noted over the past years. Specialist drugs agencies with syringe programmes have low access barriers, work with peer educators and outreach teams, and increasingly offer basic medical care services, thus functioning as street-hospitals, mobile surgeries, and field nursing stations, health suites or health counselling centres for the broader target group of socially marginalised, excluded or homeless people.</p> <p>With regard to recreational drug use, harm reduction is a common approach in European nightlife settings (clubs, raves, festivals) and consists in providing users with information (via leaflets, websites) on the potential harm associated with recreational drug use. Safedance guidelines are implemented in the UK and locally in Belgium, Denmark, Germany, France, Italy, Luxembourg, Hungary and the Netherlands. Two Member States officially provide on-site pill testing (Austria and Spain) at large festivals or rave parties, while this harm reduction approach has been discontinued for legal reasons in France, Germany and the Czech Republic or due to a lack of funds in Belgium. An important role in raising awareness of risks and providing support to drug users in crisis is furthermore played by telephone and internet-based drug help lines in a majority of Member States.</p> <p>In the vast majority of countries, the level of provision of and access to services for preventing and reducing health-related harm associated with drug use in prisons cannot be considered as equivalent to the community. Spain is currently the only European country that provides a wide range of harm-reduction measures in prisons.</p>
16	<p>Prevention of the spread of HIV/AIDS, hepatitis C, other blood-borne infections and diseases</p> <p>Ensure the implementation of comprehensive and coordinated national and/or regional programmes on HIV/AIDS, hepatitis C and other blood-borne diseases. These programmes should be integrated into general social and health care services.</p>	MS COM	<p><i>This objective is partly achieved but requires further implementation</i></p> <p>Recent data on newly diagnosed cases of HIV related to injecting drug use (IDU) suggest that, in most EU countries, infection rates are low (under 5 cases per million inhabitants in 2006). Case reporting data for IDUs are not available for two countries, both with high levels of HIV infection among IDUs. Complementary surveillance of HIV prevalence among samples of IDUs confirms an overall stable situation in most regions although among the minority of regions showing changes in prevalence between 2002 and 2006 more are increasing (16 MS) than declining (12 MS), though changes are generally not pronounced.</p> <p>Six new Member States report a consistently low prevalence of less than 1% in all studies carried out since 2002. This may be at least partly due to prevention measures for IDUs but other factors may also</p>

			<p>play a role. Nonetheless, complacency concerning the provision of prevention measures to IDUs should be avoided. In the EU, since 2002, increases in HIV prevalence among IDUs have been observed in repeated regional or national studies across seven countries, albeit in some cases alongside stable or declining trends in other regions of the same country.</p> <p>Furthermore, the incidence of AIDS related to injecting drug use is high in five countries (over 5 cases per million in 2006), suggesting the need for continued alertness regarding the timely access of infected drug users to diagnosis and highly active antiretroviral therapy (HAART).</p> <p>Hepatitis C virus (HCV) antibody levels of over 60% in at least one sample of IDUs are reported from 18 countries. It is estimated that there may be around one million people living in the EU with an HCV infection who have been drug injectors at some point in their lives.</p> <p>A multi-component response to the prevention of infectious diseases, combining measures to reduce injecting-related harm and effective drug treatment, is common in the EU.</p> <p>The integration of services and facilities that aim to prevent infectious diseases for drug users (VCT, vaccination, infectious disease treatment services) within general health and social care is current practice in a number of countries, increases the availability and facilitates and promotes drug users' access to a more complete spectrum of care if needed.</p> <p>Between 2005 and 2006, many countries with recent heroin epidemics reported increasing numbers of syringes exchanged or distributed through specialised NSPs, but there is a large group of countries where syringe exchange is now stable or has been declining (see also thematic paper 15). While decreasing syringe trends in countries with older heroin epidemics might be due to higher availability of effective drug treatment, there are some countries where decreases are attributed to a lack of support and/or funding. This raises the concern that decreases in syringe turnover could result in higher levels of risk taking among new, younger generations of heroin injectors, who not been reached by prevention messages.</p>
17	<p>Reduction of drug related deaths</p> <p>Reduction of drug related deaths to be included as a specific target at all levels with interventions specifically designed for this purpose, such as promoting outreach work, e.g. the work of street units, through well-trained healthcare</p>	MS	<p><i>This objective has been partly achieved, but requires further priority</i></p> <p>Drug-related deaths (overdoses) are one of the major causes of death among young people in Europe. Even with a likely underestimation, they account for 3.5% of all deaths among Europeans aged 15-39 years; in eight Member States this rate reaches 7%. Over the past 15 years, there have been yearly between 6 500 to 8 500 overdose deaths, totalling some 130 000 cases over that period. <i>The scale of the problem of overdose deaths can be illustrated by comparing it to AIDS mortality related to injection drug use, which was estimated to be around 2 600 cases in 2003¹⁴¹.</i></p>

¹⁴¹ EMCDDA, draft 2008 AR, based on data from Eurostat and EuroHIV

	<p>operators.</p>	<p>Drug-related deaths soared over the 1980s and 1990s and showed a decreasing overall trend between 2000 and 2003. The positive 2000-2003 trend was reverted in 2004 and 2005 with increases observed again in the majority of countries (15 out of 24 with information), although increases remained in general moderate.</p> <p>This recent trend contrasts with the wide expansion of treatment that took place over the 1990s in particular. <i>The reduction of drug-related deaths is a goal of most national drug strategies, but few countries have so far adopted concrete action plans or provide systematic guidance on measures to be taken.</i> All Member States have stepped up their levels of treatment provision, and several have removed access barriers. As far as information is available, there are still strong variations in opioid substitution coverage (between 5% and 54% in 8 EU countries) and services are located especially in metropolitan areas with a bigger than average number of users, while in rural areas, treatment provision is limited.</p> <p>The past years have also seen increased efforts to improve treatment standards and qualifications among providers, which should also help to reduce the risk for DRD. A wider choice of pharmaceutical options are available, including the increased use of opiate substitution drugs such as buprenorphine, that may have a lower overdose potential if misused.</p> <p>Reasons for the recent stabilisation in DRD are unclear but could be influenced by a combination of factors, e.g. an increase in polydrug use (including alcohol and cocaine) ⁽¹⁴²⁾ among opiate users, and increased heroin availability (UNODC) ⁽¹⁴³⁾, aging of opiate users, eventually treatment not reaching some of the more excluded groups of users. Another possibility, which will be analysed by the EMCDDA in the near future, is a more risky lifestyle amongst a new generation of intravenous drug users which are not reached by harm reduction measures and messages in the same way as older ones.</p> <p>Data on other ways of reducing drug-related deaths, e.g. information dissemination, awareness raising, individual risk assessment and counselling, training in overdose management and prison pre-release counselling, are limited in Europe.</p> <p>The time after release from prison or treatment is especially critical, and research shows that the risk of drug-induced death is substantially higher for the first two to four weeks. The number of people with past or current drug experience passing through European prisons each year is estimated to be 607 000 (stock) with an estimated turnover of 860 000 prisoners — among them many problem drug users. Considering research results on drug-induced mortality in the year following release, a considerable proportion of drug-related deaths in the EU could happen around prison release.</p>
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¹⁴² A field trial conducted by the EMCDDA in 2006 on substances involved in drug-related deaths observed that in a high proportion of cases several substances were found in the toxicological examinations. However, this is a cross-sectional study and trends cannot be assessed yet.

¹⁴³ UNODC issued a warning on this possible effect http://www.unodc.org/unodc/press_release_2006_10_05.html

			Despite the obvious connection between prison release and drug-induced deaths, few countries are systematically investing in educating prisoners about the risk of overdose on release from custody. Also the continuity of care and rehabilitation of drug users released from prison require serious attention. The differential rate of drug related deaths reported by MS suggests that even when reporting artefacts are considered, considerable potential exists to share experiences on what measures may impact on this problem.
18	Step up and develop law enforcement cooperation between Member States and, where appropriate, with Europol, Eurojust and third countries and international organisations, against international organised drug production and trafficking.		
18.1/ 18.4	<p>Member States, where appropriate with Europol and Eurojust, third countries and international organisations, shall carry out specific actions in the fight against organised international drug production and trafficking and cross-border drug trafficking and criminal networks engaged in these activities inside the EU, by implementing:</p> <p>Operational law enforcement projects, such as joint investigation teams, joint customs operations and joint investigations.</p> <p>Law enforcement intelligence projects to improve both the intelligence picture and interventions made. These projects should involve at least two MS and should be focused on production, illicit cross border trafficking and criminal networks engaged in these activities.</p>	<p>MS</p> <p>Europol</p> <p>Eurojust</p>	<p><i>The achievement of this action cannot be assessed</i></p> <p>In line with its mandate, Europol contributed through drug-related projects to joint multidisciplinary operational and intelligence gathering projects. Europol runs Project MUSTARD on heroin trafficking with an emphasis on Turkish criminal and associated groups, Project COLA on cocaine with an emphasis on Latin American criminal organisations and Project SYNERGY on the production and trafficking of synthetic drugs, chemical precursors and production equipment with a focus on indigenous criminal organisations. In addition to the central AWF components, Project COLA includes the Europol Cocaine Logo System (ECLS) whilst Project Synergy includes the Europol Ecstasy Logo System (EELS) and the Europol Illicit Laboratory Comparison System (EILCS). These make it possible to achieve a match between seizures with a view to promoting international law enforcement cooperation and exchange of information. Further details under Action 18.2.</p> <p>As reported in 2007, Joint Investigation Teams (JIT) and Joint Customs Cooperation (JCOs) could be used more by the Member States in collaboration with Europol. Information on the quantities of precursors and drugs seized in the framework of sub-projects, JITs and JCOs is only partially provided to Europol by the Member States and therefore not available.</p> <p>Other cooperation mechanisms comprise: COSPOL (Comprehensive Operational Strategy Planning for Police), the European Joint Unit on Precursors (EJUP), an inter-disciplinary law enforcement coordination mechanism to tackle drug precursors smuggling, using the auspices of Europol, and the Bucharest based Southeast European Cooperation Initiative (SECI), which includes a specialised task force on illegal drugs trafficking. The Baltic Sea Task Force has been set up.</p> <p>Regional drug enforcement initiatives focusing on intelligence sharing and operational cooperation have evolved in the <i>maritime</i> sphere. In 2007, an informal working group working in close cooperation</p>

			<p>with Europol prepared the Maritime Analysis and Operations Centre — Narcotics (MAOC-N), focusing on cocaine trafficking by air and sea in the Eastern Atlantic Ocean region. In 2008 the ‘Centre de Coordination et de Lutte Antidrogué pour la Méditerranée’ (CECLAD-M) is expected to be set up, aimed at drug trafficking in the Mediterranean Sea.</p> <p>With regard to <i>drug trafficking by air</i>, the UNODC led Airport Communication Project (Aircop) aims at improving controls, particularly at airports, through enhanced inter-agency and regional cooperation. In parallel, MAOC-N has launched an analysis on possible operational measures to curb or interdict uncanalised flights trafficking bulk cocaine. The work of the Airports Platform of the Pompidou Group is being taken into consideration.</p> <p>With regard to inter-regional cooperation on intelligence sharing and capacity building, the EU-LAC Intelligence Sharing Working Group (ISWG) was set up in 2007, supported by 7 Member States and Europol. Under the EC’s Stability Instrument, dedicated projects will address the inter-regional challenges of heroin trafficking (project set up in 2007) and cocaine trafficking (being set up in 2008).</p> <p>The Portuguese Presidency of the Council HDG established an inventory of information exchange mechanisms in the field of drugs to provide guidance for further policy development and strengthen operational effectiveness in intelligence-led law enforcement.</p> <p>Conclusions</p> <p>The results of the various operational and intelligence law enforcement cross-border projects in the EU, in particular the success of MAOC-N with almost 27 tons of cocaine seized in one year, show the importance of strengthening intelligence gathering and sharing as a basis for enhanced intelligence led law enforcement along air, sea and land vectors.</p> <p>Moreover, to address the threats from international drug trafficking, EU based counter narcotics efforts must be accompanied by enhanced inter-regional drug enforcement cooperation such as the EU-LAC intelligence sharing network. In this context, the EU model platform for intelligence sharing and capacity building is being explored by some Member States in cooperation with Europol and the European Commission together with increased use of EU funding instruments such as the Stability Instrument and the Fight Against and Prevention of Crime Programme.</p>
18.2	<p>Seek to exploit to the full the operational and strategic potential of Europol, building on existing collaboration between Europol and the Europol National Units and improving the intelligence picture of supply and distribution, by:</p> <p>Member States improving the consistency with which live information (information as</p>	<p>MS Europol</p>	<p><i>This action has been partly achieved</i></p> <p>The Europol Drugs Unit provides operational and strategic reports (over 400 in 2007) and expertise to the Member States in the framework of three drug related projects supported by analysis work files (AWFs) and expert systems. In addition to the Organised Crime Threat Assessment (OCTA), situation reports and ad hoc reports on specific crime phenomena are provided to enhance the intelligence picture of the Member States and support their investigations.</p> <p>More input by the Member States to the AWFs of the Europol projects COLA, MUSTARD and</p>

	<p>specified in the opening orders of Analysis Work Files) on drug trafficking groups and routes is forwarded to the agency in accordance with the Europol Convention for such exchange of information;</p> <p>Member States improving the consistency with which they forward seizure data to Europol;</p> <p>Europol ensuring that the accumulated information is available for Member States' operational and strategic use;</p> <p>Europol providing periodic strategic threat assessments based on this data;</p> <p>Evaluating the success and operational impact of the cycle of intelligence gathering, analysis, distribution and consequent operational action, and making systematic improvements.</p>		<p>SYNERGY should be noted over the reporting period: In 2007 — there were a total of 1950 contributions from the Member States compared to 1461 in 2006</p> <p>With the odd exception, the Member States generally provide seizure data to Europol on request only. However, not all data is comprehensive and received in time. Complete seizure statistics for 2007 are not yet available.</p> <p>The registration and reporting of seizures is not standardised in the Member States, resulting in variances in registration and reporting and thus difficulties in EU. The 2001 <i>Council Recommendation on the alignment of statistics on seizures of drugs and diverted precursors</i>,¹⁴⁴ which provides detailed guidelines for collection of this type of data at national level, has not been implemented.</p>
18.3	Strengthen controls at the external borders of the EU to stem the flow of drugs from third countries.	MS	<p><i>The achievement of this action cannot be assessed</i></p> <p>In 2007, a greater number of Member States provided information regarding this action for the present Progress Review than in 2006. However, the information provided does not reveal the impact of these efforts on the flow of drugs from third countries into the EU. Due to the fact that there are no agreed standards and rules at EU level for registering and differentiating drugs seizures made at external borders, data provided by Member States are difficult to interpret. Furthermore, the information obtained does not show which operations have led to what kind of seizures.</p>
18.4	See 18.1	MS	See 18.1
18.5	Assess the feasibility of developing a strategy for the use of heroin and cocaine forensic profiling results for law enforcement strategic and operational purposes and make recommendations	MS	<p><i>This action has not been achieved</i></p> <p>No assessment has taken place for developing a strategy for the use of heroin and cocaine forensic profiling results. However, such a strategy may be addressed in the future within the context of the ongoing cooperation on the long-term solution at EU level for the forensic profiling of synthetic drugs (see Action 20.2)</p>

¹⁴⁴ Decision of 707/12/01; 13618/01 STUP 29 / 12411/01 STUP 26 ADD 1 & ADD 1 COR 1 (NL, EN) & ADD 1 COR 2 (FR, EN, DK) / 12411/1/01 REV 1 STUP 26.

	regarding same.		
19	Implement joint multidisciplinary operational and intelligence gathering projects, share best practice, and increase counter narcotics work. Focus this work on external countries and regions associated with the production of and cross-border trafficking in heroin, cocaine and cannabis into the EU.	MS Europol	<i>The achievement of this objective cannot be assessed</i> As noted under Action 18.1/ 18.4, there are a growing number of joint multidisciplinary operational and intelligence gathering networks. Whilst Europol-led Projects COLA and MUSTARD have supported many investigations, including via JITs and JCOs, contributions from the Member States most affected by these phenomena are generally insufficient. The European Police Chiefs Task Force COSPOL initiatives (the Comprehensive Operational Strategy Planning for Police) on heroin and cocaine provide platforms to address this concern. As indicated under action 18.1, in 2007 and 2008 a number of law enforcement projects involving at least two Member States have been or are about to be established, including MAOC-N, CECLAD-M and the Baltic Sea Task Force Cooperation.
20	Reduce the manufacture and supply of synthetic drugs (ATS).		
20.1	Develop operations and intelligence gathering projects to prevent and combat synthetic drug manufacture and trafficking. These operations should involve at least 2 Member States. In this regard full use should be made of the Synergy Project.	MS Europol	<i>This action has been partly achieved</i> Europol's Project SYNERGY — which gathers and uses information, knowledge and experience in the area of synthetic drugs, related precursors and equipment — supported various major criminal investigations carried out by law enforcement in the Member States during the reporting period. Project Synergy also includes the Europol Illicit Laboratory Comparison System (EILCS) , which collates technical information on synthetic drug production, and the Europol Ecstasy Logo System (EELS) — the latter incorporated within the general Europol Synthetic Drug Seizure System (ESDSS) . The quality and quantity of data supplied for the Analysis Work Files and the EILCS from several Member States remains high. This cooperation is an indicator of satisfaction among operational partners concerning their relationship with SYNERGY and its added value. However, not all crucial Member States are contributing fully. Project SYNERGY supports, and is supported by, the activities of the European Joint Unit on Precursors (EJUP) and the European Police Chiefs Task Force's COSPOL initiative on synthetic drugs. SYNERGY also supports and is supported by the CHAIN Project, a European Union initiative on the profiling of amphetamine for law enforcement purposes, whereby significant seizures may be forensically matched, leading to or supporting ongoing intelligence analysis.
20.2	Develop a long term solution at EU level for the use of synthetic drug forensic profiling results for law enforcement strategic and operational purposes. The development of	MS COM Europol	<i>This action has not yet been achieved, but results are expected shortly</i> Several meetings have been organised by the European Commission on a long term solution on forensic profiling of synthetic drugs. The meetings were attended by representatives of forensic laboratories and

	such a solution should be done by law enforcement agencies and forensic authorities working together and building upon experiences in this field.		<p>law enforcement agencies, mainly of those Member States that are involved in a series of projects aimed at developing reliable methods of profiling of amphetamines. Other participants were representatives of EUROPOL and the Commission (Joint Research Centre and DG Justice, Freedom and Security, DG Research).</p> <p>It is agreed that any future European long term solution should be built on the experience of Projects co-funded by the European Commission (mainly SYNERGY and CHAIN). The role of Europol and JRC Ispra has been recognised. The European structure available to all MS, with the potential to cover all drugs, synthetics or otherwise — depending on national or regional needs — should be set up. The idea is that the exact form will be decided by the Council on a proposal from the COM.</p> <p>The Commission will inform the Council (HDG) of the conclusions reached when operational, legal, and budgetary aspects have been clarified with Europol and the JRC.</p>
20.3	Implement fully the Council Decision on information exchange, risk assessment and control of new psychoactive substances.	Council MS COM Europol EMCDDA EMEA	<p><i>This objective has been achieved</i></p> <p>The implementation of the Council Decision in 2005, 2006 and 2007 is described in the corresponding EMCDDA-Europol Annual Reports on the implementation of Council Decision 2005/387/JHA. In 2007 the Commission decided not to take further steps regarding 1-(3-chlorophenyl) piperazine (mCPP) as the substance was not eligible for a risk assessment, being used as an intermediate in the manufacturing of a medicinal product. However, in 2006 and 2007 EMCDDA and Europol actively monitored and assessed the available data on mCPP. The Council Decision has been fully implemented in 2007 through the risk assessment procedure on 1-Benzylpiperazine, resulting in a Decision of the Council in March 2008 to control the substance. The final decision-making procedure took as much time as the risk assessment process.</p> <p>Conclusions</p> <p>The Council Decision has proven to be a rapid and effective instrument in identifying and assessing new psychoactive substances that appear on the market. Some issues need further consideration. The deadlines as adopted in the Council Decision may need to be reconsidered, allowing more time for information collection and risk assessment. An active monitoring component may be formally introduced in the mechanism, allowing more information to be collected before a risk assessment takes place or where assessment cannot be requested for legal reasons. And finally, the link between the Council Decision and the EU Pharmacovigilance system might be further explored for those substances that also have medical purposes.</p>
21	Combat serious criminal activity in the field of chemical precursor diversion and smuggling by stepping up law enforcement cooperation between Member States and, as appropriate, with	MS Europol Eurojust	<p><i>This objective has been partly achieved</i></p> <p>Supported by Europol Project Synergy, the European Joint Unit on Precursors (EJUP), a multinational, multi-disciplinary joint unit consisting of law enforcement national experts from Austria, Belgium, France, Germany, the Netherlands and the United Kingdom, continues to be a significant supportive tool for the numerous investigations in the Member States on precursor chemicals trafficking</p>

	Europol, Eurojust, and third countries and international organisations. Implement law enforcement projects such as the European Joint Unit on Precursors. These projects should involve at least 2 Member States.		from the source countries to the large scale synthetic drug production sites. No new law enforcement projects such as the EJUP have been set up since January 2005. In addition, Project SYNERGY reports, in the framework of COSPOL activities, have led to enhanced awareness and cooperation with industry in relation to scheduled and non-scheduled chemicals used in synthetic drug production, diverted from particular companies. This has led to increased Member States cooperation with industry.
22	Prevent the diversion of precursors, in particular synthetic drug precursors imported into the EU.		
22.1	Implement the Community drug precursor legislation, in particular the cooperation between MS in relation to controls of imports of synthetic drug precursors. Strengthen external border controls by customs or other competent authorities and strengthen intra-Community controls.	MS COM	<i>This action has been partly achieved</i> EU law enforcement authorities continue to be active in detecting suspicious consignments of drug precursors. In 2006, the number of cases increased further. These cases involve higher quantities of ephedrines stopped or seized, while the quantities of P-2-P (the key amphetamine precursor which is now also increasingly found being diverted for use in illicit methamphetamine manufacture) seem to be stable in comparison with 2005. In turn, seizures of 3, 4 MDP-2-P have decreased. Acetic anhydride (the key heroin precursor) and potassium permanganate (the key precursor for making cocaine) continue to be seized or stopped, but have decreased in comparison with 2005. In 2006, there were no further cases reported with regard to Ephedra. Moreover, suspicious consignments of a relatively high number of pharmaceutical preparations under transshipment through the EU were stopped. As in 2005, GBL and BDO (precursors used to make GHB) continue to be seized by using the EU voluntary monitoring control mechanisms, based on the voluntary partnership with industrial sectors. <i>See EU drug Precursors seizures in 2006:</i> http://ec.europa.eu/taxation_customs/resources/documents/customs/customs_controls/drugs_precursors/seizures/report_2006_en.pdf
22.2	Support international operations of the UN INCB (International Narcotics Control Board), in particular Project Prism.	MS COM Europol	<i>This action has been achieved</i> The Commission is directly supporting INCB-led operations, including Operation Transshipment and Operation Target, via its UNODC-implemented project to strengthen efforts against drug precursors in Afghanistan, and between Afghanistan and its neighbours.
22.3	Develop cooperation between Member States' authorities competent for precursor control and Industry.	MS COM	<i>This action has been achieved</i> The Commission, together with a group of experts from Member States and from Industry, has drafted a guidance document " <i>Drug precursors' control in the EU — guidelines for operators</i> " which has been distributed among operators legally trading in drug precursors. This document sets out

			<p>recommendations to help operators detect and report suspicious transactions and orders of so-called scheduled drug precursors. It also provides them with an updated list of “non-scheduled substances”, where operators have agreed to collaborate actively and voluntarily with Member States to notify any suspicious transactions with non-scheduled substances, as they can nevertheless be used in the illicit manufacture of narcotic drugs and psychotropic substances.</p> <p>Both mandatory (scheduled drug precursors) and voluntary (non-scheduled drug precursor) systems allow continuous and increased number of seizures and stopped shipments.</p> <p>The systems in place fully reflect and acknowledge the vital nature of the principle of co-operation with industry and prove to be very effective in combating the diversion of drug precursors for illicit drug manufacturing, while offering the necessary flexibility to respond quickly to changing trends and patterns of diversion.</p> <p>The Commission and the national competent authorities took part in various seminars aimed at facilitating implementation of the legislation in the new Member States. The Commission has further undertaken to provide an “e-learning” tool to trained operators on their responsibilities and duties in the field of drug precursor's control. This eLearning will be ready by end 2008. At international level, the EU proposal for a United Nations Resolution¹⁴⁵ adopted by the Commission on Narcotic Drugs (CND) invited UN Contracting Parties to set up guidelines for operators and to set up guidelines at international levels.</p>
23	Target money laundering and seizure of accumulated assets in relation to drug crime.		
23.1	<p>Implement operational law enforcement projects such as</p> <p>Projects to pursue drug trafficking organisations, including concurrent and in depth investigation of the criminals’ finances and assets (of whatever kind) aimed at maximising recovery of assets and the compilation/sharing of associated intelligence; and</p> <p>Projects aimed at detecting and disrupting criminal cash flows within the EU and from</p>	<p>MS</p> <p>Europol</p> <p>Eurojust</p>	<p><i>The achievement of this action cannot be assessed</i></p> <p>Number of operational law enforcement projects initiated or completed:</p> <p>The Criminal Assets Bureau (ECAB), launched by Europol under its Money Laundering Action Plan, encompasses the work carried out by Europol on asset recovery, including operational support for Member States’ investigations (including drugs investigations) to trace criminal proceeds, managing the Financial Crime Information Centre Website and acting as the CARIN permanent secretariat. The Europol Criminal Assets Bureau provides operational support to MS in identifying criminal proceeds, when the assets are located outside their jurisdictional area and the investigation falls within Europol’s mandate. In 2007, the ECAB supported a total of 134 investigations in the Member States relating to asset tracing and identification (2005: 57; 2006: 53).</p>

¹⁴⁵ 50th CND (March 2007), Resolution 50/10

	<p>the EU to specific high-risk destinations outside the EU and source countries.</p> <p>These operational law enforcement projects should involve at least two Member States.</p>		<p>The Europol Money Laundering Project, SUSTRANS, supports the drug related Project Synergy in gathering and analysing financial related data, where substantial illegal profits were generated. Within Project SUSTRANS, a project on intra-Community cross-border movement of cash is being developed, reflecting the presence of a cross-border reporting system. It addresses the emerging trend of cash being moved in bulk throughout Europe without being detected. The use of money couriers is still a growing phenomenon in money laundering operations within the European Union. A questionnaire has been sent to Member States to gain a better understanding of cash smuggling routes and features.</p> <p>Cash and assets seized as a result of drug related investigations:</p> <p>In 2007, the ECAB helped in 48 cases to identify criminal proceeds originating specifically from drug trafficking investigations. In 2005, there were 20 such cases, and in 2006 15 cases were dealt with.</p> <p>In conclusion, cross-cutting cooperation between Europol's drugs, money laundering and assets tracing projects has led to enhanced support to Member States. In this regard and in the framework of the COSPOL-Synergy partnership a major new initiative has started involving several Member States.</p>
23.2	<p>Develop cooperation in the exchange of information between Financial Intelligence Units (FIUs) by utilising FIU-Net as a means of exchanging information between them.</p>	MS	<p><i>The achievement of this action cannot be assessed</i></p> <p>The Financial Intelligence Units (FIUs) of 18 Member States are connected to the FIU.NET system. The ultimate objective of the project is to establish a secure and complete computer network for the exchange of financial intelligence among the 27 EU FIUs in combating money laundering and the financing of terrorism.</p> <p>It is expected that the Commission will provide co-financing to the project for the period 2007-2009 under the financial programme "Prevention of and Fight against Crime".</p>
23.3	<p>Consider the possibility of creating national multi-disciplinary Units for the detection and investigation of criminals' finances and assets.</p>	MS COM	<p><i>The achievement of this action cannot be assessed</i></p> <p>The Council Decision on cooperation between Asset Recovery Offices of the Member States¹⁴⁶ was adopted on 6 December 2007 to ensure that Member States set up or designate, by 18 December 2008, national Asset Recovery Offices which will act as national contact points for confiscation-related activities. They will notably promote, through enhanced cooperation, the fastest possible EU-wide tracing of assets derived from crime.</p> <p>A Europol project to support this instrument has been launched for the period 2008-2010. It will coordinate expert onsite support missions, on the request of MS, to provide advice and guidance on the establishment and effective operation of national Asset Recovery Offices.</p>
23.4	<p>Identify and evaluate best practice in</p>	COM	<p><i>This objective has not been achieved, but results are expected shortly</i></p>

¹⁴⁶

2007/845/JHA, 6.12.2007

	criminal asset confiscation legislation and procedures of the Member States, taking into account all relevant EU instruments.		The Commission signed a contract for a study analysing Member States' legislation and practices in criminal confiscation. The study will focus on what has proven to be effective at national level with a view to promoting and exchanging best practice. The results of this study are expected to be available by end 2008.
23.5	Explore best practice in Member States which have established and implemented a national fund used to provide funding for projects in the drugs field and financed from the confiscation of assets earned through drug production and trafficking.	COM	<i>This action has not been achieved</i> The Commission is not planning to contract out a specific study on the use of confiscated funds for police/community drugs projects. Information on best practice related to the use of confiscated assets may become available through the Commission study on Member States' best practices in confiscation and asset recovery. The results are expected to be available by end 2008.
24	Explore possible links between drug production and trafficking and financing of terrorism. Identify possible links between drug production and trafficking and financing of terrorism and use this information to support or initiate investigations and/or actions.	COM Europol MS	<i>This objective has not been achieved</i> To date no major project or programmes investigating the links between drug production and the financing of terrorism are running at EU level. However, the Council's working party on terrorism concluded in March 2008 that the links between drug trafficking and terrorism should be explored further at EU level, including action to draw up a list of major drug traffickers. Links between drug trafficking and terrorism are most evident in certain parts of Afghanistan. Although evidence is hard to find, the EU should be vigilant about a possible occurrence of similar trends closer to the EU. Member States could make better use of existing financing programmes at EU level to initiate, develop and support activities in this field with a view to reflection and dialogue at European level.
25	Step up work on prevention of drug related crime.		
25.1	Adopting a common definition of the term 'drug-related crime'.	Council COM	<i>This action has not yet been achieved, but will see further work in 2008 and 2009</i> In 2007, the EMCDDA presented in a publication a broad definition of the term 'drug-related crime', identifying 4 crime categories: psychopharmacological crimes, economic-compulsive crimes, systemic crimes and drug law offences. A similar breakdown of the term had been proposed in 2003, and is still relevant when taking the international scientific literature into account. The Commission is preparing a paper on further steps regarding this definition, but intends to link this exercise to a broader debate on policy needs for drug-related crime information and statistics at EU level. The evaluation showed that only few Member States have defined drug-related crime at national level. A study on drug-related crime statistics and law enforcement information has been launched and will be finalised in the first half of 2009. The outcomes of the study should form the

			basis of a broader proposal on drug-related crime and indicators, based on policy needs at EU level.
25.2	Share experiences and best practices in preventing the distribution of drugs at street level and present the results.	MS Council	<i>This action has been partly achieved</i> The Portuguese Presidency of the HDG instigated a debate on “Preventing the distribution of drugs at street level” in December 2007, which concluded that <ul style="list-style-type: none"> • There is added value in a European common approach to preventing the distribution at street level although the national and local particularities have to be taken into account. • The information exchange and sharing of best practices is crucial. The work already developed by some organisations in this field (like the Pompidou Group, the European Forum for Urban Security and the European Crime Prevention Network) should be considered. • There is a need to develop synergies between law enforcement authorities and social/health services. As it is a local problem, all the stakeholders should be involved.
26	Develop new methods and best practice to combat drug-related crimes and to prevent the diversion of precursors committed with the aid of information technology. MS to collect data on drug-related crime and precursor diversion committed with the aid of information technology with a view to developing new methods and best practice to combat these phenomena.	MS Council	<i>This objective has not been achieved</i> The collection of data on drug-related crime and precursor diversion committed with the aid of information technology differs from one Member State to the other. Nine Member States indicate that they collect this type of data. Belgium and the UK specify that they collect data on suspicious activities of internet-based companies (precursors). Sweden only collects such data on drug offences. The Czech Republic and Slovakia indicate that this task is currently being implemented. Estonia and Lithuania state that this type of data collection exists, but do not specify its contents. In Latvia, the Register of Criminal Offences includes a codification for ‘crimes committed with the aid of information technologies’. In Denmark, there are cases reported of drug-related crimes in which the internet was used as a communication tool, but no details are given about specific data collections.
27	Increase training for law enforcement agencies. MS and CEPOL, within their respective competences, to include in their annual work (training) programmes more training courses for law enforcement officers specifically relating to combating drug production and trafficking.	MS CEPOL	<i>This objective has been partly achieved</i> CEPOL organised for the first time two specific training courses (in Slovakia and Greece) in the field of fighting drug related crime in 2008. The latter course will help develop a common curriculum. As drug crime cannot be isolated from the overall phenomenon of organised crime, there are two other courses on Northeast Europe and Southeast Europe Organised Crime Organisations foreseen by CEPOL in 2008. All courses are supported by Europol.
28	Adopt EU common positions on drugs in international fora. EU positions at international meetings	PRES MS	<i>This objective has been achieved</i> The role played by the EU in international fora, in particular in the Commission on Narcotic Drugs

	<p>dealing with drugs issues to be prepared in the HDG and other coordination fora. EU coordination meetings to take place in the Commission on Narcotic Drugs (CND) and other meetings.</p>	COM	<p>(CND), has proved to be increasingly important over the years.</p> <p>Over the past three years the HDG has proven its worth as the prime forum for prior coordination between Member States — and Commission — positions. In particular, common EU positions were defined during HDG meetings for the annual sessions of the Commission on Narcotic Drugs with regard to draft resolutions, EU statements and other important drug-related issues, like the follow-up to the UNGASS or the Second Ministerial Conference on Drug Trafficking Routes from Afghanistan (“Paris 2 — Moscow 1”) in June 2006 in the framework of the Paris Pact Initiative. Supplementing the HDG, preparatory EU Coordination meetings also took place regularly in Vienna and were organised on a daily basis during the CND sessions, as well as on an ad hoc basis when needed.</p> <p>During the CND Sessions in 2006-2008, the respective EU Presidencies (AT, DE, SI) delivered EU Statements on the follow up to UNGASS, drug demand reduction, illicit drug trafficking and supply, the INCB and policy directives to strengthen the Drug Programme of UNODC and the role of the CND as its governing body. The EC, on behalf of the European Community, delivered its traditional statement on precursors during each CND session. However, a harmonised approach among EU actors during the plenary meetings should be agreed to ensure the EU speaks with one voice.</p> <p>Conclusions</p> <ul style="list-style-type: none"> • To remain a major world player on drugs issues, it is of paramount importance that the EU maintains common positions and speaks with one voice in international fora, and in particular during the annual sessions of the CND. It is, therefore, fundamental to continue the trend towards a reinforced, unified role for the EU and to reaffirm the coordinating role of the HDG.
29	<p>Articulate and promote the EU approach on drugs.</p> <p>The Presidency and/or Commission to take the lead role in articulating and promoting the EU’s balanced approach.</p>	PRES MS COM	<p><i>This objective has been achieved</i></p> <p>See also Actions 28 and 30. The EU statements and positions in all external fora have promoted the EU’s balanced approach. Furthermore, statements on drugs issues by the Commissioners and Commission officials have consistently referred to the balanced approach on drugs. The balanced approach is the guideline of the EU and Commission dialogues with third countries; troika agendas are built up around this concept and action plans for cooperation are structured as such. The Commission is increasingly assisting third countries on demand reduction, in parallel with more traditional assistance concerning alternative development and supply reduction. The balanced approach seems to be reflected in national strategies of many of the third countries with which the EU has established dialogues.</p> <p>Conclusions</p> <p>The activities undertaken by the EU Presidencies and Commission for this objective mainly reflect the policy outputs as the quantitative expression of success. However, for an assessment of the policy outcomes of this action, it is important to assess the scope and level of detail of these EU sponsored statements, the extent to which they actually reflect the balanced approach between supply and demand</p>

			reduction, and their follow-up in practice.
30	<p>Bring forward EU joint resolutions and co-sponsor other resolutions.</p> <p>At the UN, in particular the CND, the Presidency to endeavour to have resolutions brought forward as EU joint resolutions and/or EU co-sponsoring of other resolutions.</p>	<p>PRES</p> <p>MS</p> <p>COM</p>	<p><i>This objective has been achieved (to a great extent)</i></p> <p>During the 51st session of the CND¹⁴⁷, the EU played an active role in the negotiation of resolutions and tabled two resolutions, on the “Preparations for the high-level segment of the 52nd session relating to the UNGASS20 follow-up” and together with Nigeria on “Strengthening international support to countries of W-Africa in their efforts to combat illicit drug trafficking”.</p> <p>Furthermore, the following resolutions were co-sponsored by the EU:</p> <ul style="list-style-type: none"> – “Follow-up to the 2nd Ministerial Conference on Drug Trafficking Routes from Afghanistan” – “Marking the Centennial of the convening of the International Opium Commission” – “Provision of International Assistance to States neighbouring Afghanistan based on their performance” – “Strengthening International Cooperation for the control of precursor chemicals used for the manufacture of synthetic drugs” – “Strengthening cooperation between the UNODC and other UN bodies for the promotion of human rights in the implementation of the international drug control treaties” – “Responding to the threat posed by the distribution of internationally controlled drugs on the unregulated market” – “Promoting coordination and alignment of decisions between the CND and the Programme Coordinating Board of the Joint UN Programme on HIV/AIDS” – Sharing of information regarding the use of non-scheduled substances as substitutes for scheduled substances frequently used in the illicit manufacture of narcotic drugs and psychotropic substances and new methods of manufacture of illicit drugs” – “Strengthening international support for States in West Africa and their efforts to combat drug trafficking”

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The 51st CND took place from 10-14 March 2008.

			<p>– “Improving the governance and financial situation of the UNODC”</p> <p>No <i>individual</i> EU MS tabled a resolution. However, Sweden co-sponsored the resolution on “The consequences of cannabis use” (tabled by the US), while Spain and France co-sponsored the resolution on “Control of international movement of poppy seeds obtained from illicitly grown opium poppy plants” (tabled by India), and the resolution tabled by the Arab Group on “Reducing the demand for and abuse of cannabis” was co-sponsored by France.</p> <p>The EC conducted the negotiations on behalf of the EU on the two resolutions on precursors. In addition, the EU spoke with one voice during the negotiations of the 2 US resolutions on Cannabis and Early Detection (former SBIRT).</p>
31	Formulate an EU contribution to the final evaluation of the implementation of the results of the 1998 UN General Assembly Special Session on Drugs (UNGASS).		
31.1	Take an initiative to propose common EU criteria, in the framework of the Commission on Narcotic Drugs, for the final evaluation of the implementation of the Political Declaration, the Declaration on the guiding principles of drug demand reduction and the Measures to enhance international cooperation to counter the world drug problem adopted at UNGASS 1998.	COM Council PRES MS	<p><i>This action has been achieved</i></p> <p>In 2006, the CND adopted the EU-tabled Resolution (49/1), based on a Commission initiative, on the assessment of the ten-year review of the UNGASS 1998 process. As provided for in the resolution, UNODC engaged with experts from all geographical regions and international organisations, for the collection of supplementary data and expertise to support the global assessment by Member States. In 2007, the Commission financed this expert working group.</p> <p>In 2008, the CND adopted the EU-tabled Resolution (51/4) on the preparations for the high-level segment of the 52nd CND in 2009, relating to the follow-up to the UNGASS 1998 process. The resolution decided to establish open-ended expert working groups to work on the following UNGASS-related topics: (a) Drug demand reduction; (b) Supply reduction (manufacture and trafficking); (c) Countering money-laundering and promoting judicial cooperation; (d) International cooperation on the eradication of illicit drug crops and on alternative development; (e) Control of precursors and of amphetamine-type stimulants.</p> <p>The objective of the working group was to assess progress achieved and difficulties encountered by Member States in meeting the goals set out in the UNGASS Political Declaration, and to identify areas requiring further action. The conclusions of the expert working groups feed into the intersessional meetings of the CND which prepare recommendations for decisions to be adopted by the CND at its 52nd session in 2009.</p> <p>Conclusion</p> <p>By proposing the resolutions, providing funding and by active participation in the working groups, the</p>

			EU confirmed its commitment to help improve the evidence base that supports drug policies at UN level.
31.2	Support an EU common position on the results of the final evaluation of the implementation of the Political Declaration, the Declaration on the guiding principles of drug demand reduction and the Measures to enhance international cooperation to counter the world drug problem adopted at UNGASS 1998.	COM Council PRES MS	<p><i>This objective has been partly achieved, work is ongoing</i></p> <p>Since 2006 the EU has worked on an EU position on UNGASS on the basis of a Commission initiative. The common position refers both to a global assessment of the declarations and Action Plans adopted by UNGASS 1998 and the identification of future action: what should be the final outcome of the high-level segment in 2009 and what elements should guide future UN drug policy?</p> <p>Concerning the future, the common position emphasises the main elements of EU drugs policy — compliance with international drug control and human rights instruments, the balanced and multidisciplinary approach, policies based on monitoring and scientific evidence, cooperation, strategic coherence across UN bodies — to address future challenges in an efficient and cost effective way.</p> <p>Conclusion</p> <p>The EU has participated constructively in the UNGASS debate, speaking, based on the common position, with one voice.</p>
32	<p>Support the candidate and stabilisation and association process countries.</p> <p>Provide the necessary technical and other assistance to these countries to familiarise them with the EU acquis and to assist them in carrying out the required actions.</p>	MS COM EMCDDA Europol	<p><i>This objective has been achieved</i></p> <p><i>Candidate countries (Croatia, Turkey and Former Yugoslav Republic of Macedonia)</i></p> <p>Technical cooperation with Croatia started in June 2006 and is currently continuing under the IPA project. The objective of this project is to strengthen the activities launched under Phare IV. Croatia provided the EMCDDA with a national report, statistical tables and structured questionnaires for the first time in 2007 and delivered its 2008 national report. Croatia is currently negotiating with the Commission an agreement on its participation in the work of the EMCDDA.</p> <p>The progress made by Turkey on setting up its national focal point and its national data-collection system on drugs was maintained in 2007, and Turkey published for the second time its national report to the EMCDDA. While the joint work programme was officially endorsed by the national authorities in March 2007 and was implemented smoothly, some obstacles have appeared for the implementation of the ESPAD school survey in the country. Technical cooperation with Turkey is currently continuing under the IPA project, which aims at strengthening the activities under Phare IV. Turkey is currently ratifying the agreement on its participation in the EMCDDA.</p> <p>The former Yugoslav Republic of Macedonia and the EMCDDA are currently cooperating under the CARDS project, described below. So far, this country has not yet applied officially for membership in the EMCDDA.</p> <p>Potential candidate countries</p>

			<p><i>Western Balkans (Albania, Bosnia Herzegovina, former Yugoslav Republic of Macedonia, Montenegro, Serbia and Kosovo under UNSC Resolution 1244)</i></p> <p>Direct cooperation between the EMCDDA and the Western Balkans started at the end of November 2007 under the CARDS–EMCDDA project, aimed at assessing the capacity of the countries to establish a drug information system compatible with the EMCDDA. It is expected that they will be able to provide a first Country Situation Summary (CSS) on the respective drugs situation on the basis of existing information and will have received targeted support for that purpose. A second result of the project will be the assessment of the potential for the creation and/or strengthening of a National Focal Point in the Western Balkans countries with a view to their possible participation in the work of the EMCDDA.</p>
33	<p>Enable candidate countries to participate in the work of EMCDDA, Europol and Eurojust.¹⁴⁸</p> <p>Conclude agreements with candidate countries.</p>	Council COM	<p><i>This objective has been largely achieved</i></p> <p>In July 2006, the Council adopted a mandate authorising the Commission to open negotiations with Croatia with a view to its participation in the EMCDDA. Turkey has initialled agreements with the European Community. These agreements have yet to be formally signed and concluded before they enter into force. In January 2007 Romania and Bulgaria became full members of the EMCDDA with their accession to the EU. An operational agreement between Croatia and Europol was signed on 16.01.2006 and entered into force on 16.08.2006. Croatia now has a liaison officer in The Hague (since March 2008).</p> <p>A strategic agreement between Europol and <i>former Yugoslav Republic of Macedonia</i> was signed on 16.01.2007 and entered into force on 14.03.2008. A strategic agreement between Europol and Turkey was signed in May 2004. A decision on extending this agreement to operational status is still under negotiation. A strategic agreement between Europol and Albania was signed on 26.03.2007 and entered into force on 10.05.2007. A strategic agreement between Europol and Bosnia-Herzegovina was signed and entered into force on 26.01.2007. Montenegro was added to the Council list of third countries with which European sign a cooperation agreement in February 2007. Negotiations on a draft Agreement on Strategic Co-operation were finalised at working level on 24 April 2008 and will be submitted to the Europol MB in May, after which it will be submitted to the Council for approval. Finally, Serbia was added to the Council list in June 2002. Negotiations of a draft Agreement on Strategic Co-operation were finalised at working level on 24 April 2008 and will be submitted to the Europol Management Board in May 2008, after which it will be submitted to the Council for approval. Eurojust has concluded a formal third country agreement with Romania. Turkey and Croatia have appointed contact points for cooperation with Eurojust. Eurojust and Croatia signed a cooperation</p>

¹⁴⁸ Eurojust to cooperate with the candidate countries through nomination of contact points and consideration of cooperation agreements in line with the Council conclusions on Eurojust of 2 December 2004.

			agreement on 8 November 2007. Preparations for the entry into force of the cooperation agreement are on-going. Eurojust concluded a draft cooperation agreement with <i>the former Yugoslav Republic of Macedonia</i> on 10 April 2008. Preparations for formal approval by the Council and the subsequent signature of the agreement are on-going. Turkey has appointed two contact points for Eurojust .
34	Assist European neighbours.		
34.1	Implement drugs sections of European Neighbourhood Policy Action Plans.	MS COM	<p><i>This action has been achieved, but the outcome cannot be assessed</i></p> <p>The Commission published progress reports on the European Neighbourhood Policy Action Plans in 2008. These and other sources demonstrate progress, but more effort is needed.</p> <p><i>Armenia</i> needs to develop a comprehensive and balanced national anti-drugs strategy. It is fully engaged in the SCAD programme (Southern Caucasus Anti-Drug) at regional level. <i>Azerbaijan</i> has made improvements. It formulated its national strategy in June 2007, and approved a five year action programme to combat drug addiction. Legislation has been adopted to implement the 1988 UN Convention, and a State Commission on antinarcotics has been established. Azerbaijan is fully engaged in the SCAD (Southern Caucasus Anti-Drugs) programme.</p> <p><i>Georgia</i> adopted, but has not yet implemented, a concept paper for a national drugs strategy in February 2007. It is fully engaged in the SCAD programme. <i>Moldova</i> adopted in March 2007 an AP on “fighting the use of drugs and drug business” for the years 2007-2009. Although Moldova participates in BUMAD (Belarus, Ukraine, Moldova Anti-Drugs) and EUBAM (EU Border Assistance in Moldova and Ukraine), but still needs support in implementing its strategy.</p> <p>Concerning <i>Ukraine</i>, the EU-Ukraine JHA Action Plan was streamlined in 2006 and cooperation in the field of drugs updated. This country’s work in the fight against drugs continued in line with international commitments, with an additional focus on cooperation with other countries in the Black Sea region. It actively participated in BUMAD and EUBAM.</p> <p><i>Egypt’s</i> legislation is in compliance with UN conventions. It has a coordinating “Anti-Narcotics General Authority”. Drugs were discussed in the EU-Egypt JLS subcommittee late 2007. The years 2006-2008 show that <i>Israel</i> intensified its fight against drug abuse, through the establishment of a special Knesset committee on drugs and the implementation of a comprehensive set of measures.</p> <p>No progress is noted for <i>Jordan</i>, apart from new money laundering legislation endorsed in May 2007, which is in line with the 1988 UN Convention. <i>Lebanon’s</i> efforts should be intensified and sustained. No progress is registered in the implementation of the National Drugs Action Plan. A Mini-Dublin Group took place in December 2007. The internal security forces postponed the eradication of hashish in the Beqaa scheduled for the second half of 2007 due to violence by drug growers.</p> <p>Cooperation with <i>Morocco</i> has improved. This country has had a National Drugs Strategy since 2006 and in the JLS subcommittee, which took place in April 2008, requested EU assistance for its</p>

			<p>implementation. The establishment of a dialogue/operational cooperation with Morocco is a priority for the EU, which organised the first TROIKA on drugs in 2008 and supports its full involvement in operational anti-drugs activities in the Mediterranean. Although <i>Tunisia</i> is not a producing country, it is increasingly a transit country and should therefore be fully involved in operational activities in the Mediterranean.</p> <p>Conclusions</p> <p>The European Neighbourhood Policy has paved the way towards closer cooperation on drugs with the ENP partners, based on regular dialogue (via subcommittees) coupled with dedicated financial instruments. A specific drug Troika with the Ukraine took place in 2007 and in 2008, while the first Troika with Morocco was held in 2008. More impetus is needed, however, regarding other cannabis producing countries (particularly Lebanon) as well as countries affected by trafficking towards and from Europe. Furthermore, the principle of the EU balanced approach requires further strengthening and prioritisation in the funding of ENP programmes. Developing regional approaches between ENP countries, East European countries including Russia and the Mediterranean is an important issue for future policy consideration.</p>
34.2	Implement the drugs section of the EU-Russia Action Plan against organised crime and of the Roadmap to the Common Space of Freedom, Security and Justice; explore scope for enhanced action with Russia, especially in this roadmap, and other neighbouring countries to reduce the drug-related risk.	MS COM	<p><i>This action has been partly achieved</i></p> <p>EU-Russia cooperation on drugs fits in the framework established by the Road Map for the Common Space of Freedom, Security and Justice, adopted by the EU-Russia Summit in May 2005, and the EU-Russia Action Plan against Organised Crime.</p> <p>In October 2005 the JHA Permanent Partnership Council endorsed broad areas of cooperation to take forward EU/Russia cooperation on drugs. Several activities have since been undertaken, including:</p> <ul style="list-style-type: none"> • An EU-Russia conference on drugs that helped to identify joint initiatives and actions to complete key elements of the Road Map. In 2007, further initiatives in the field of drugs were recommended. • An Action-Oriented Paper on Russia to implement aspects of the EU-Russia Road Map, including drugs, was adopted at the end of 2006, with a progress report adopted in 2008. • A training course on synthetic drugs was organised by Poland in 2007, involving Russian law enforcement officers. • In May 2007 the Russian Advanced Training Police Academy (VIPK) hosted an EU-Russia expert meeting on controlled delivery of synthetic drugs precursors from Russia to Belgium and the Netherlands, with a follow-up meeting held in 2008. • The EMCDDA and the Russian Federal Drug Control Service (FDCS) signed a Memorandum of Understanding in 2007, enabling the FDCS to participate in EMCDDA activities and to foster exchanges, gatherings and analysis of information on drug use.

			<ul style="list-style-type: none"> • Contacts were established between the FDCS and the Maritime Analysis and Cooperation Centre — Narcotics (MAOC-N) with a view to cooperating and/or drawing inspiration for future cooperation arrangements, in particular as regard the Black Sea region. • EU-Russia focal points on drugs were established, in the Russian Ministry of Foreign Affairs and in the European Commission, to facilitate informal contacts and exchange of information. An EU-Russia liaison officers' network was created, which met 4 times, with a widespread exchange of information and enhanced networking at experts level. Other meetings were organised on synthetic drugs and precursors, on the Black Sea region cooperation and on drugs from Afghanistan. • Finally, work on an operational agreement between FDCS and Europol has progressed, in particular following Europol's assessment on Russia's data protection system. <p>A negotiating mandate for a new agreement on a comprehensive framework for EU/Russia relations, including drugs, has been adopted by the Council, and the negotiations with Russia are to commence.</p> <p>Conclusion</p> <p>Russia is an important partner with whom there is considerable interest to engage and reinforce a strategic partnership on drugs, both at bilateral basis and vis-à-vis other third countries and regions as well as in the relevant international organisations and fora. EU support for the enhancement of Russian law enforcement capacities in Central Asia was specifically requested by Russia. The EU and Russia should also pursue the idea of a dialogue on enhanced maritime drug enforcement cooperation in the Black Sea region, drawing inspiration from MAOC-N and the respective operational cooperation arrangements being set up for the Atlantic Ocean.</p> <p>Cooperation between EU and Russia in the field of drug demand reduction, reflecting the EU's balanced approach to drugs, should be highlighted in future developments of the partnership, e.g. regarding the drug-related HIV/ AIDS epidemic in the Russian Federation. Russia should be encouraged to make more use of the instruments at its disposal, including under the ENP-I regime (see also Action 34.1) like TAIEX or Twinnings or the new "Common Space Facility".</p>
35	<p>Ensure that drugs concerns are taken on board when establishing priorities in the EU's cooperation with third countries/regions.</p> <p>Mainstream projects in the drugs field into the EU's cooperation with third countries/regions, especially those affected by drug problems. Particular</p>	MS COM	<p><i>This objective has been partly achieved</i></p> <p>The EC's external funding priorities as set out in the country and regional strategy papers for the period 2007-2013 continue to make provision for EC external assistance in third countries particularly affected by drug problems, such as the Andean Region and Afghanistan.</p> <p>With regard to the countries at the Eastern border of the EU, the BUMAD (Belarus, Ukraine, Moldova Anti-Drug Programme), SCAD (South Caucasus Anti-Drug Programme) and EUBAM (EU Border Assistance Mission Moldova/Ukraine) continue to be implemented. A Border Management programme</p>

<p>attention should be paid to providing assistance to and cooperating with:</p> <ul style="list-style-type: none"> • the countries on the Eastern border of the EU • the Balkan States • Afghanistan (particularly in the context of the delivery of its 2005 Counter-Narcotics Implementation Plan and future implementation plans) and its neighbours; the EU and Member States should aim to increase their assistance • the Latin American and Caribbean countries • Morocco • countries on other drug routes <p>This assistance and cooperation to be linked to the drugs action plans adopted by the EU with various regions and the drug sections of other action plans with EU partners, where applicable.</p>		<p>in the South Caucasus region (SCIBM) has been launched, and will be implemented as of the beginning of 2009. As explained under Objective 32, the general capacity building efforts in the area of Justice and Home Affairs in the Western Balkans have been complemented with drug specific initiatives, including three TAIEX regional workshops. For the Western Balkans and Turkey, CARDS and IPA assistance helps strengthen police and judicial capacities against OC, including drug trafficking. Various projects on demand reduction, including harm reduction or combating illicit drug trafficking, are being implemented, as well as with the EMCDDA to establish drug compatible information systems in the region. Under IPA, the EU is programming regional support to the Western Balkans for an amount of EUR 2,5 million to improve, <i>inter alia</i>, their capacities to prevent and combat organised crime and drug trafficking. (Please refer to objective 32 for more information).</p> <p>In Afghanistan, the EC has made a multi-annual commitment of EUR 200 million to the rule of law sector, which now represents 40% of the EC's total assistance to Afghanistan. In parallel, a new police mission, EUPOL, was sent to Afghanistan with 200 police officers on the ground to give training and mentoring to the Afghan National Police (ANP). In terms of strengthening the state, the EC is a key donor to the Law and Order Trust Fund for Afghanistan (LOTFA), funding the Afghan National Police (EUR 200 million since 2002), making the EU the biggest donor to LOTFA) with a further EUR 15 million into the new Counter-Narcotics Trust Fund. In terms of the rural economy, the EC has so far committed EUR 280 million for rural development, food security and alternative livelihoods since 2002.</p> <p>Concerning other assistance in the region, the assistance to Pakistan targets rural development in provinces bordering Afghanistan. The Commission also supports regional cooperation between Pakistan and Afghanistan, addressing border management. In Central Asia, the programmes BOMCA (Border Management for Central Asia) and CADAP (Central Asia Drugs Programme) are being implemented. Work for the Afghani borders with Tajikistan is underway (EUR 18 million). In 2007, an additional EUR 19.7 million for construction of two further Border Crossing Points (Afghanistan- Uzbekistan and Afghanistan-Turkmenistan borders) has been made available. With effect from 2008, the Instrument for Stability is supporting trans-regional co-operation in the countries of the Economic Cooperation Organisation (ECO) with EUR 9.5 million for the fight against trafficking from/to Afghanistan.</p> <p>LAC countries are the second largest beneficiary of all the EU international assistance against drugs. The EC funding has mainly been targeted at alternative development projects.</p> <p>In the area of demand reduction and harm reduction, an initiative to support twinning between LAC and European cities was launched in April 2008. For the Andean Community, an EC-financed regional project is aimed at addressing the emerging and growing problem of synthetic drugs in the Andean countries. On supply reduction, a project to promote intelligence exchange between law enforcement representatives from the LAC region and European Drug Liaison Officers posted in the region has been launched, an initiative to tackle the growing trend of cocaine trafficking from Latin America to and via West Africa. A supply and demand reduction programme focusing on the Caribbean was financed</p>
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			<p>through the EDF funded regional programme. The programme includes a component aimed at enhancing law enforcement capacity in the region. The Suriname “Drug Demand Reduction Programme” was completed successfully in 2007.</p> <p>Concerning precursors, the PRECAN project, for the Andean Region, reached its conclusion in April 2007; a follow-up a project against precursor's diversion will be launched at the end of 2008 under the Stability Instrument, extending its scope to other Latin America and Caribbean countries. In 2008, finally, the Commission has started working on the identification of a large-scale project under the Instrument for Stability to address the cocaine route passing through West Africa.</p> <p>Conclusions</p> <p>Drug-related projects have remained a priority in EU cooperation with countries which are particularly affected by the cultivation, transit, trafficking and use of drugs¹⁴⁹. Consideration should be given to devoting more resources to strengthening cooperation with countries in the frontline of trafficking, such as Iran, Pakistan and the Caribbean, as well as to emerging routes such as West Africa. It is important that EC funded activities in these regions and countries consistently reflect the priorities and principles of the EU’s balanced approach.</p>
36	Intensify law enforcement efforts directed at non-EU countries, especially producer countries and regions along trafficking routes.		
36.1	Create and/or further develop MS liaison officers’ networks. Each network to meet, at least on a six monthly basis, to improve operational cooperation and coordination of MS action in third countries.	MS	<p><i>This action has been partly achieved</i></p> <p>This action aims to monitor the application by customs administrations of the <i>Council Decision on Common Use of Liaison Officers (LO)</i>, which includes the network of Liaison Officers on drugs trafficking.</p> <p>During the reporting period, four EU-Russia Liaison Officers Meetings took place in 2006, 2007 and 2008. In September 2006, a first meeting of senior level officials took place. Furthermore, two Western Balkan Lead Liaison Officers Meetings took place in 2006 and 2007, focusing on cooperation in the field of drugs. Spain ran an AGIS funded project from January 2006 to March 2007 to establish a network in Latin America (ELON-LAC), the main aim of which is to exchange information on drugs within the network of Liaison Officers posted in Latin America and the Caribbean.</p>
36.2	Provide relevant training to MS liaison officers.	MS	<p><i>The achievement of this action cannot be assessed</i></p> <p>Training for Liaison Officers is mainly at national level by their national administration. However</p>

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Under Action 38.2 details are given of anti-drugs projects funded by the EU and EC (data from 2005).

			<p>training carried out at EU level by CEPOL could be of benefit to Liaison Officers also, along with one-off seminars organised by Europol and the Member States. CEPOL does not, however, organise any specific training course just for Liaison officers. Such specific training is hardly feasible since Liaison officers normally cover a wide array of crimes (if not all) and are not employed as specialists for a particular type of crime when posted abroad.</p> <p>Training for liaison officers is normally delivered at MS level. In general, only highly trained and experienced officers are taken into consideration for liaison officer posts.</p>
36.3	Implement or support, as appropriate, operational law enforcement projects, share best practice and increase counter narcotics work in the countries/ regions listed in Action 35.	MS	<p><i>The achievement of this objective cannot be assessed</i></p> <p>Member States implement a broad variety of activities and cooperations with countries and regions listed under action 35. The results are unknown and have not been evaluated.</p>
36.4	Provide assistance to the law enforcement agencies of the countries/regions listed in Action 35, in the field of counteracting the production and trafficking of drugs and diversion of precursors. This assistance should include assistance in the field of training.	MS COM	<p><i>The achievement of this objective cannot be assessed</i></p> <p>Law enforcement cooperation with third countries is included in the drug cooperation chapters in all association and cooperation agreements with non-EU countries in the field of drugs. The feedback received from the Member States in this specific field prompted practical information on activities carried out in the past year and — in one or two cases — on seizures. Unfortunately, reports on activities and data on numbers and quantities do not reveal much about the success of the action. It is recommended to amend the first and delete the second and third indicators for this action in future progress reports.</p>
37	Continue and develop an active political engagement by the EU with third countries/regions.		
37.1	Use mechanisms, such as the Coordination and Cooperation Mechanism on Drugs between the EU/ Latin America and the Caribbean, EU specialised dialogue on drugs with the Andean community and Drug Troika meetings to pursue an active political dialogue with the countries and regions concerned.	Council COM	<p><i>This action has been partly achieved, but its outcome cannot be assessed</i></p> <p>The EU-LAC Drugs Coordination and Cooperation Mechanism met regularly during the reporting period, both at Technical and High levels. In 2006, the May EU-LAC Summit reiterated the commitment to cooperate, in accordance with the principle of shared responsibility, in tackling the illicit drugs problem and endorsed the proposal of the High Level Meeting of the Mechanism that a full review be conducted of the 1999 Panama Action Plan and the Lisbon areas for action.</p> <p>In 2007, the High Level Meeting of the Mechanism that took place in Trinidad and Tobago concluded with the Port of Spain Declaration, which identified new priorities for future cooperation in the field of drugs (see action 37.2). The High Level meeting that took place in Vienna in March 2008 resulted in the adoption of the 'Hofburg Declaration', in which the parties identified the next steps towards the implementation of the revised Panama Action Plan. The LAC side proposed Rules of Procedure.</p>

			<p>Concerning the EU-CAN Specialised High Level Dialogue on Drugs, there were constructive and fruitful meetings in June 2005 and in September 2006. The latest High Level Specialised Dialogue was held in Bogota on 1 and 2 November 2007, allowing for a most fruitful exchange of views both on demand and supply reduction.</p> <p>Between 2005 and 2008, regular bilateral and regional Troika meetings have been organised, involving the main producer and transit countries (like Afghanistan, Western Balkans, ECOWAS, Russia, Morocco, etc.) and main partners such as the United States.</p> <p>Conclusion</p> <p>Over the years, the EU-LAC Drugs Coordination and Cooperation Mechanism have played a significant role in highlighting the drugs issue on the EU/LAC agenda. The Mechanism facilitated and strengthened coordination between both regions in UN fora, in particular during annual CND meetings and by the co-sponsoring or supporting of resolutions. The Mechanism has helped to bring out regions' efforts in the field of drugs and to pinpoint the needs for mutual cooperation. However, the mechanism has experienced operational and procedural difficulties that have prevented better results being achieved. This is why Rules of Procedure for the Mechanism were proposed and a reflection period initiated during the High Level Dialogue in 2008. This process will focus on how to review procedures and establish new instruments/tools. The rules of procedure should be endorsed by the next High-Level meeting in 2009.</p>
37.2	<p>Review the activities and measures and, where appropriate, establish new priorities in the drugs action plans the EU has adopted with:</p> <ul style="list-style-type: none"> • Latin America and the Caribbean • Central Asia <p>Western Balkan countries.</p>	<p>Council COM</p>	<p><i>This action has been partly achieved, but its outcome cannot be assessed</i></p> <p>The review of the Panama Action Plan, agreed with Latin American and Caribbean countries, was launched in Cartagena in 2007 and concluded in May 2007 at the High Level Meeting of the EU-LAC Coordination and Cooperation Mechanism in Trinidad and Tobago. The Port of Spain Declaration sets out future priorities for cooperation in the fields of demand and supply reduction and other areas related to drugs, such as money laundering, customs, police and judicial cooperation. During the last meeting of the EU-LAC High-level meeting, in Vienna on 4-5 March, the Hofburg Declaration identified the next steps towards the implementation of the revised Panama Action Plan.</p> <p>The review of the action plan with the Western Balkans took place in 2008. Concerning Central Asia, the review will start and be based on the evaluation of the two main programmes in the region, BOMCA and CADAP.</p>
37.3	<p>Participate fully in the work of international organisations and fora concerned with the drugs problem, such as the Council of Europe (Pompidou Group), UNODC, WHO and UNAIDS.</p>	<p>Council MS COM</p>	<p><i>This action has been achieved</i></p> <p>The Member States and European Commission participated in the meetings of the Permanent Representatives of the Pompidou Group. Member States and the European Commission (observer) actively participate in the work of the UNODC, as well as in the Commission on Narcotic Drugs (CND) and the Commission on Crime Prevention and Criminal Justice (CCPCJ) and the Paris Pact. Several EU Member States are major donors of the activities of WHO and UNAIDS, which include activities in the</p>

			field of drugs.
37.4	Utilise fully the Dublin Group as a flexible, informal consultation and coordination mechanism for global, regional and country-specific problems of illicit drugs production, trafficking and demand.	Council MS COM	<i>The achievement of this action cannot be assessed</i> In the period 2005-2008, the regional chairs of the Dublin Group (mostly EU Member States) produced regular detailed reports on the drugs situation in the Caribbean, North, East, West and South Africa, Central America and Mexico, and South America, the Balkans, Eastern Europe, Central Asia, South East Asia and China and South West Asia. These provide a lot of on-site information. Nevertheless, the follow-up of the recommendations in countries concerned made through the Dublin Group mechanism needs further attention as these are often rather extensive and detailed and it is unclear if they are being implemented.
37.5	Maintain an active dialogue with third countries for the implementation of the Mini Dublin Group's recommendations.	Council Dublin Group	<i>The achievement of this action cannot be assessed</i> The Dublin Group remains a very valuable instrument for Member States and the Commission for consultations and inspiring cooperation activities. The Group's reports are detailed and informative. Nevertheless, the follow-up of the recommendations through the Dublin Group mechanism needs further attention as these are often rather extensive and detailed and it is unclear to what extent they are being implemented. It may be suggested that the regional chairs of the Dublin Group monitor the implementation of these recommendations as well.
38	Improve the coherence, visibility and efficiency of the assistance to candidate countries and third countries/ regions.		
38.1	Exchange information on drug related technical assistance projects and operational activities in candidate countries and third countries/regions, in particular to identify duplication and gaps in technical assistance and operational activities.	Council COM	<i>This objective has been partly achieved</i> In June 2006, the HDG agreed on a set of conclusions and recommendations on the level and nature of Member States' and the Commission's external assistance in the area of drugs. The conclusions were based on a 2004 Commission report. At the end of 2007, the Commission published an update of this 'Drug Matrix' table for the year 2005. The exercise revealed that nearly EUR 760 million, the stock of EU international cooperation projects in the area of drugs in 2005, made the EU one of the strongest players in the global efforts against drugs. Of the total spending, two-thirds was allocated to activities in Afghanistan and almost one third to the three main coca growing countries (Colombia, Bolivia and Peru). Most funding was provided for alternative development (66%), institution building (17%, mostly law enforcement), supply reduction and law enforcement cooperation (11.4%) and demand reduction including harm reduction (5%). In 2005, more than half of the EU Member States plus the European Commission had international cooperation projects in the area of drugs. This includes fourteen of the fifteen countries that were members of the EU before January 2005 and one of the twelve new Member States since that date. Approximately 80% of the value of the stock of projects is accounted for by the EC and one Member State; seven Member States account for another 15%. The collection of data for the 2006 Drugs Matrix was launched in September 2007 and had not been completed at the time of

			<p>finalisation of this evaluation.</p> <p>Conclusions</p> <p>With EUR 760 million in 2005, the EU is one of the major funders of drug-related assistance projects in the world, with major contributions allocated to alternative development, institution building and supply reduction activities in mainly Afghanistan and the Andean Region. Notwithstanding the above, the projects to which these figures correspond reflect only the most visible and easily measurable part of the efforts undertaken by the EU. There are other cooperation and coordination initiatives that, by their nature, are confidential, do not take the form of projects and/ or are part of continuous undertakings the cost of which is difficult to ascertain. Furthermore, the data collection process is very complicated and time consuming, in terms of identifying Member State projects and funding, and of retrieving EC funded projects, as drug projects are not registered as such and much of the expenditure is decentralised.</p>
38.2	Evaluate EC and Member States drug projects included in cooperation programmes.	MS COM	<p><i>This objective has not been achieved</i></p> <p>No evaluation has taken place</p>
39	<p>Provide reliable and comparable data on key epidemiological indicators.</p> <p>Full implementation of the five key epidemiological indicators and, as appropriate, fine tuning of these indicators.</p>	MS EMCDDA	<p><i>This objective has been achieved, but requires ongoing investment and attention</i></p> <p>In the past 3 years, a steady improvement can be observed in the implementation of the Key indicators (KIs) by Member States. Moreover, these measures are increasingly viewed as global standards for information collection in these areas. Nearly all Member States now collect some information in each indicator area, although the quality varies. For assessing implementation levels, three key dimensions have now been formalised: a) <i>the extent to which national approaches meet accepted methodological standards</i>; b) <i>the extent to which reporting can be made using agreed common categories</i>; c) the availability of fresh information (timeliness — i.e. availability of recent data within reasonable time limit). As of 2009, minimum implementation targets will be available for progress made by Member States in each information domain and provide policymakers with a clearer understanding of the resource implications of KI implementation.</p> <p>It is clear that Member States must try to meet minimum implementation criteria of each KI. These criteria need to be drawn up and subsequently interpreted with due regard for different national contexts. As the number of countries participating in the European system has now grown to 30, the need for a common, transparent and simple system has become ever clearer.</p> <p>The overall picture of the implementation level of the KIs is relatively positive with the majority of countries reporting both recent and compliant data. However, a clear problem area is that <i>many countries have not invested in recent estimates of problem drug use</i> (PDU indicator). A project assessing and improving data coverage in the area of treatment demand showed that the <i>treatment demand indicator</i> currently has good data coverage on outpatient and inpatient treatment centres, but that data coverage remains quite limited in low threshold agencies, treatment units in prison and general</p>

			<p>practitioners treating drug users. A related project focusing on ‘prevalence’ is looking at the total number of drug patients attending treatment centres, including clients in continuous treatment. The study shows that a significant proportion (around 65%) of the treatment population in Europe are now long-stayers (one year and more) and do not therefore feature among those entering treatment. Changes in data collection, following new trends in the treatment sector (new patterns of drug use, expansion and diversification of drug treatment availability) has shown the need for a revision of the EMCDDA data collection tools in the area of drug treatment. For this purpose, two main activities will be developed in the field of data collection on drug treatment in the following period:</p> <ul style="list-style-type: none"> • a revision of the TDI over the next two years • a more integrated approach to information collected at European level on treatment clients and treatment organisation <p>During 2007, the component of DRD indicator based on population statistics on poisonings or overdoses (drug-induced deaths) continued its consolidation. Considerable work to improve quality, validity and comparability were carried out in several countries, although further improvements are still needed, in particular cross validation studies between different mortality registries, with mortality cohorts and with other indicators such as problem drug use estimations. New data collection started in 2007 to assess in more detail the combinations of substances involved in drug-induced deaths, following a first data collection in which eight countries participated. These two data collections aimed to obtain more information on the role of poly drug use in these deaths.</p> <p>Conclusions</p> <p>MS and the Commission to consider how best to obtain reliable and comparable data on key epidemiological indicators.</p>
40	Provide reliable information on the drug situation.		
40.1	Reitox National Focal Points and Europol National Drugs Units to pursue their work to ensure their annual and standardised reporting on national drugs situations.	MS	<p><i>This action has been achieved</i></p> <p>Quality management procedures are constantly being improved by the EMCDDA, in close collaboration with the Reitox national focal points, in order to fulfil the objective of ‘providing reliable information on the drug situation’. The quality of the Reitox national reports has been continuously improving over the last year, although the quality of single chapters can vary. In 2007, improvements were also related to adherence to guidelines, layout rules and the common referencing of sources. Regarding timeliness in national report deliveries, in 2007 only 50% of the countries met the deadline (14 countries), compared to 61% in 2005 (17 countries). The EMCDDA is currently taking measures in close collaboration with the Reitox network to improve the timeliness of reports. The description of trends plays a major role in</p>

			<p>national reports, but in some countries reliable quantitative data are still missing to base this information on. Some reports are oriented towards scientific standards, but in the majority of cases a more comprehensive analysis and interpretation of data is still lacking. In line with the conclusions of the Reitox Head of focal points meeting in May 2007, and also as a result of the current reflection carried out at the EMCDDA in close collaboration with the Reitox NFPs, the national reporting system and the quality criteria will be revised in 2008-2009.</p> <p>Europol reports have different levels of detail, depending on relevant target groups and sensitivity. Europol contributes to the EU's Organised Crime Threat Assessment Reports. In 2007, Europol and EMCDDA also contributed to the UNGASS assessment expert group of UNODC.</p>
40.2	EMCDDA and Europol to pursue annual reporting on the drug phenomenon at EU scale.	EMCDDA Europol	<p><i>This action has been achieved</i></p> <p>Overall, in 2006 and 2007 both EMCDDA (including the Reitox Network) and Europol delivered a series of reports on the drug demand and drug supply situation in Europe, providing policy makers and implementing agencies with up-to-date information on the drug situation and the responses to it.</p>
41	Develop clear information on emerging trends and patterns of drug use and drug markets.	Council COM	
41.1	Achieve an agreement on EU guidelines and mechanisms on detecting, monitoring and responding to emerging trends.	COM	<p><i>This action has not been achieved, but progress was made</i></p> <p>The Commission intends to present a Commission Services Working Paper to the Council in the second half of 2008. It will identify the possibilities and relevance of EU guidelines and mechanisms for detecting, monitoring and responding to emerging trends in drug users and the drug market, complementary to the existing systems such as the Early Warning System and the Council Decision on the Information Exchange, Risk Assessment and Control of new Psychoactive Substances¹⁵⁰. The paper will address the importance of national and local information exchange on new trends and the difficulties accompanying early detection of new trends at EU level.</p> <p>In the field of monitoring new trends, the EMCDDA has set up the E-POD project (European Perspectives on Drugs), which includes the Early Warning System and Council Decision implementation and through which case studies — based on qualitative review techniques — on specific types of substances or trends are being developed. A study on hallucinogenic mushrooms and on GHB/ GBL has been published, while a factsheet on Methamphetamine is being developed. In November 2007 the EMCDDA also held an expert meeting to explore the use of health emergency data to help detect, track and understand emerging drug trends. In 2008 the EMCDDA is launching a feasibility study to explore the potential for collecting hospital emergencies data, with a view to</p>

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			understanding and responding to emerging drug trends.
41.2	The Commission to provide for a Eurobarometer survey on youth attitude regarding drugs. The results of the Eurobarometer should be analysed in conjunction with the data from the EMCDDA ‘Population survey’ key indicator.	MS	<p><i>This action has been achieved</i></p> <p>A Flash Eurobarometer on “<i>Young People and Drugs</i>” was conducted between in May 2008. Over 12 500 randomly selected young people (15-24 years-of-age) were interviewed across the 27 EU Member States. The objective was to study young EU citizens’ attitudes and perceptions about drug-related issues and policies.</p> <p>Young people seem to support the EU’s balanced approach in drug policy by advocating “tough” measures to be taken against drug dealers and traffickers (63%) but also advocating “soft” measures to be used against drug users, e.g. through information and prevention campaigns (47%) and the treatment and rehabilitation of offenders (33%).</p> <p>Young people increasingly seem to make a distinction in risk perception between substances, as 81% and 96% of respondents thought heroin, cocaine and ecstasy pose a high risk for users, while only 41% thought that of cannabis. When compared to the risks of licit substances, 70% of respondents thought the smoking of tobacco posed a medium to low health risk, while 75% thought alcohol posed a medium to low risk.</p> <p>When asked about possible options for government control of licit and illicit substances, almost all respondents thought heroin (97%), cocaine (95%) and ecstasy (94%) should remain under strict control. Regarding cannabis, one-third (31%) of respondents thought a model similar to alcohol and tobacco could be introduced, while 67% thought that controls should remain unchanged.</p> <p>Among all respondents, heroin was seen to be the most difficult illicit drug to obtain, followed by cocaine, ecstasy and cannabis. Cocaine was considered to be easy or very available to 35% of the respondents aged 15-24. Cannabis was considered fairly easy or very easy to obtain by almost 63% of respondents aged 15-24. 72% of 15-18 year-olds thought it would be easy to very easy for them to get hold of tobacco against 87% of those aged 22-24. Over 90% of respondents in all Member States but one indicated that it would be fairly easy to very easy for them to obtain alcohol.</p>
42	<p>Produce estimates on public expenditures on drug issues.</p> <p>Member States and Commission to consider the development of compatible methodologies on direct and indirect</p>	MS COM EMCDDA	<p><i>This objective has not been achieved</i></p> <p>Estimates of public expenditures on drug issues can provide important information to policy makers on how to improve the efficiency and effectiveness of their interventions in demand and supply reduction. In recent years, research on drug-related expenditure has been undertaken in some EU countries and internationally¹⁵¹, resulting in different approaches regarding methodology and quality.</p>

¹⁵¹ Kopp P., Fenoglio P. (2003), Public spending on drugs in the European Union during the 1990s.; <http://www.emcdda.europa.eu/?nnodeid=1357>; Postma M. (2004). Public expenditure on drugs in the European Union 2000-2004.; <http://www.emcdda.europa.eu/?nnodeid=1357>;

	expenditure on drug-related measures, with the support of the EMCDDA.		<p>Under the 6th RTD Framework Programme, the Commission is funding a project which aims to develop ways of estimating the cost of crime, including a number of drug-related offences. In 2008 and 2009 the Commission will invest in developing ways of measuring the costs of law enforcement. Finally, in 2008 the Commission is funding a study that will provide estimates on social costs of the drug problem in a number of countries worldwide and produce estimates on the size of the global drug market.</p> <p>Recently, the EMCDDA considered setting up a common methodology to collect details of public expenditure by Member States.</p> <p>The methodology proposes a unified and standardised approach that maximises the validity and the cross-country comparability of the results on the basis of <i>labelled</i> and <i>non-labelled</i> expenditures. Public expenditures explicitly "<i>labelled</i>" as drug-related must be traced back by exhaustively reviewing official accountancy documents in MS, in accordance with a classification on the basis of the COFOG¹⁵², the International Classification of the Functions of Government and Reuter's¹⁵³ drug programs division (i.e. Prevention Treatment, Enforcement, or Harm reduction). "<i>Non-labelled</i>" drug-related expenditures should be estimated through a modelling top-down approach. Starting from overall aggregated expenditures, this procedure will estimate the proportion causally attributable to drug use. As a first step in exploring a broader scope of drug-related expenditures, efforts are proposed to focus initially on two government functions as defined by COFOG: Public order and safety, and Health.</p> <p>Within EMCDDA reflection on the feasibility of setting up a common methodology to collect details of public expenditure at EU level, a test has been conducted involving 30 European countries. Its results and opinions of experts suggest that the twofold strategy proposed could be subject to regular monitoring by the EMCDDA.</p> <p>Therefore, and as a fundamental prerequisite, the implementation should follow a progressive and incremental approach in those MS which have shown interest and have the analytical capacity to do so. The EMCDDA will be able to offer technical and operational counselling on the topic aimed at keeping the cross-country comparability of the results provided by MS.</p>
43	Promote research in the field of drugs.		
43.1	Promote research in the context of the Community Programme for Research and Development and of Member States' research programmes	MS COM	<p><i>The achievement of this action ca not be assessed</i></p> <p>The EU Research Programmes¹⁵⁴ increasingly provide opportunities for EU research organisations and networks in the field of drugs to collaborate at international level.</p>

¹⁵² United Nations (2008) COFOG Detailed structure and explanatory notes.; <http://unstats.un.org/unsd/cr/registry/regcst.asp?Cl=4>

¹⁵³ Reuter, P. (2006). What drug policies cost. Estimating government drug policy expenditures. In: Addiction, 101: 315-322;

¹⁵⁴ 5th, 6th and 7th Framework Programmes run by the European Commission.

	<ul style="list-style-type: none"> • on biomedical, psychosocial and other factors contributing to drug use and addiction, and; • on other relevant issues, such as the effectiveness of primary awareness campaigns, effective interventions to prevent HIV/AIDS and hepatitis C, and the long term effects of Ecstasy use. 		<p>Activities in these fields have previously received support from the 6th Research Framework Programme (2002-2006) and earlier Framework Programmes. For example, research carried out under the 6th Research Framework Programme included the development of methods for profiling amphetamines¹⁵⁵, research into organised crime (Assessing Organised Crime)¹⁵⁶ and Increased Knowledge on Organised Crime,¹⁵⁷ and underlined the usefulness of such research.</p> <p>The 7th Framework Programme (2007-2013) provides the opportunity to researchers and their networks in the EU to submit proposals on a variety of research topics under the programmes on health, socio-economic sciences and humanities and security research.</p> <p>However, the first results of the 7th RTD Framework Programme show a very limited number of projects of only indirect interest to the drug-related research field.</p>
43.2	Promote research on identifying protective factors in countries with low HIV/AIDS prevalence rates in drug users.	MS Support EMCDDA	<p><i>The achievement of this objective cannot be assessed</i></p> <p>The preliminary work undertaken so far demonstrates that research activities into protective factors in countries with low HIV/ AIDS prevalence rates in drug users are relatively scarce. Considerable potential exists for further studies in this area. Any future research will need to be sensitive to ethnographic and social risk factors in IDUs, population dynamics and service utilisation issues.</p> <p>An EMCDDA study from 2007 included a literature review of protective factors for HIV infection and brought together mathematical modellers and epidemiologists to develop new analysis of existing data sets that may give some further insights into this issue. The literature review itself has not identified individual factors that could easily explain persistent low HIV prevalence in IDUs in some EU countries. Early intervention is likely to have had a protective effect in at least some low prevalence countries. Furthermore:</p> <ul style="list-style-type: none"> – Estimates have been developed for the level of infection of HIV, HCV and HBV in IDUs depending on duration of exposure for various EU countries. These methods may be used for monitoring the incidence of infection from repeated cross-sectional studies in IDUs. – The association between HIV and HCV prevalence in IDU populations reveals a threshold effect, where under a certain HCV prevalence HIV prevalence is likely to be around zero. This may be further developed towards using HCV data as an indicator of the risk of HIV outbreaks.

¹⁵⁵ CHAMP project (http://ec.europa.eu/research/fp6/ssp/champ_en.htm)
¹⁵⁶ Assessing Organised Crime (<http://www.assessingorganisedcrime.net>)
¹⁵⁷ Increased Knowledge on Organised Crime (<http://ikoc.unicatt.it>)

			<ul style="list-style-type: none"> – Estimates of the heterogeneity in risk of infection among IDU populations have been developed based on different statistical approaches which may be developed into proxy indicators of risk behaviour distribution, as a complement to data on self-reported behaviour and potentially as a tool to evaluate the effect of prevention efforts. – An exploratory model of drug users moving in and out of drug treatment has been developed that can be used for analyses on the effects of HIV testing and other interventions. – Two additional literature reviews have been done: 1) on mathematical modelling of HIV and hepatitis in IDUs (AIDS, in press), 2) An analysis of published data on IDU risk behaviour in Europe
43.3	Make full use of the research capacity of the Council of Europe (Pompidou Group).	MS COM	<p><i>The achievement of this action cannot be assessed</i></p> <p>The Council of Europe (Pompidou Group) has established a collaboration platform on drug-related research in which experts explore gaps and priorities in this field. The platform works together with the Commission and EMCDDA on setting up a database on existing EU drug-related research.</p>
44	<p>Create networks of excellence in drug research.</p> <p>Encourage research networks, universities and professionals to develop/create networks of excellence for the optimal use of resources and effective dissemination of results.</p>	COM	<p><i>This objective has not yet been achieved, but results are expected in 2008 and 2009</i></p> <p>The Commission has launched a study on “A comparative analysis of research into illicit drugs in the European Union” which will provide an overview of the research areas, trends and infrastructures in the EU and make recommendations on how to encourage networks of excellence in the field of drug-related research. The final report will be available in 2009.</p>
45	Continuous and overall evaluation		
45.1	Establish a consolidated list of indicators and assessment tools for the evaluation of the EU Drug Strategy and Action Plans.	COM EMCDDA Europol	<p><i>This action has been achieved, but is ongoing</i></p> <p>With a view to the final evaluation of the EU Action Plan on Drugs (2005-2008), the Commission developed an evaluation methodology based on the advice of an external contractor and a Steering Group, consisting of representatives of the HDG Presidencies (2nd half 2005 to end 2007), the EMCDDA, Europol and the European Parliament.</p>
45.2	Commission to present progress reviews to the Council and the European Parliament on the implementation of the Action Plan and proposals to deal with identified gaps and possible new challenges.	COM	<p><i>This action has been achieved</i></p> <p>As the current EU Drugs Action Plan (2005-2008) was adopted by the European Council in July 2005, a first progress review was published in December 2006, covering activities in the second half of 2005 and the first half of 2006. The 2007 progress review was published in December 2007, covering activities in the second half of 2006 to the first half of 2007. The 2007 progress review was presented as a Commission Communication with detailed information annexed to it.</p>

45.3	Commission to organise an impact assessment with a view of proposing a new Action Plan for 2009-2012.	COM	<p><i>This action has been achieved</i></p> <p>This evaluation report presents the state of play on the EU Drugs Action Plan (2005-2009) and is annexed to the Commission's proposal for the new EU Drugs Action Plan (2009-2012).</p>
46	<p>Follow-up of the mutual evaluation of drug law enforcement systems in the Member States.</p> <p>Extent of implementation of recommendations for best practices.</p>	Council	<p><i>The achievement of this objective cannot be assessed</i></p> <p>In 1999 and 2000 the Council conducted an evaluation of drug law enforcement systems in the Member States (ref.). This resulted in a number of recommendations to the Member States for improvement. There is no information available about the extent to which these recommendations have been followed up by the Member States. The implementation of this objective cannot be held to be satisfactory.</p>

Annex 2 — List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AWF	Analysis Work Files
BMK	1 Phenyl 2 propanone
BOMCA	Border Management for Central Asia
BUMAD	Belarus, Ukraine, Moldova Anti-Drug Programme
CADAP	Central Asia Drug Programme
CCPCJ	Commission on Crime Prevention and Criminal Justice
CECLAD-M	Centre de Coordination et de Lutte Antidroque pour la Méditerranée
CEPOL	European Police College
CICAD	Inter-American Drug Abuse Control Commission
CND	Commission on Narcotic Drugs
COSPOL	Comprehensive Operational Strategic Planning for the Police
CWP	Customs Working Party
DRD	Drug-related Deaths
DRID	Drug-related Infectious Diseases
ECAB	European Criminal Assets Bureau
EJUP	European Joint Unit on Precursors
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
ENP	European Neighbourhood Policy
EPCTF	European Police Chiefs Task Force
EU LAC	EU — Latin American Cooperation
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HDG	Horizontal Working Party on Drugs (Council)
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
INCB	International Narcotics Control Board
IPA	Instrument for Pre-Accession Assistance
JCO	Joint Customs Cooperation
JIT	Joint Investigation Team
JRC	Joint Research Centre
MAOC — N	Maritime Analysis Operations Centre — Narcotics
MS	Member State
NFP	National Focal Point
NSP	Needle and Syringe exchange Programmes
NGO	Non Governmental Organisation
PMK	3,4 Methylenedioxyphenyl propan 2 one
PRECAN	Prevention of Precursor Diversion in the Andean Region Project
REITOX	Réseau Européen d'Information sur les Drogues et les Toxicomanies
SCAD	South Caucasus Anti-Drug Programme
SECI	Southeast European Cooperation Initiative
SUSTRANS	Suspicious Transactions Project (Europol)
TAIEX	Technical Assistance and Information Exchange
UNODC	United Nations Office on Drugs and Crime
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organisation

Annex 3 — Glossary of terms

A

Amphetamine Type Stimulants

The term amphetamine-type stimulants is used to refer to amphetamines (amphetamine, meth-amphetamine and related substances) and ecstasy (MDMA and related analogues). Amphetamine and methamphetamine are central nervous system stimulants. Ecstasy refers to synthetic substances that are chemically related to amphetamines but which differ to some extent in their effects. The best-known member of the ecstasy group of drugs is 3,4-methylenedioxy-methamphetamine (MDMA), but other analogues are also occasionally found in ecstasy tablets (MDA, MDEA).

Assessment tool

An **assessment tool** is a means of verifying progress on or achievement of an action.

B

Buprenorphine

Buprenorphine is a mixed opioid agonist/ antagonist which can be used in substitution treatment. It has been used extensively in many countries for the short term treatment of moderate to severe pain. The mixed opioid-action/ blocking-action appears to make buprenorphine safe in overdose. It may also provide an easier withdrawal phase, and due to a longer action, may allow for alternate day dosing. Buprenorphine is also available under the brand name Subutex ®. See also: Methadone, Maintenance treatment.

C

CND

The Commission on Narcotic Drugs (CND) is the central policy-making body within the United Nations system dealing with drug-related matters. It analyses the world drug situation and develops proposals to strengthen the international drug control system and combat the world drug problem. In 1991, the UN General Assembly established the Fund of the United Nations International Drug Control Programme (UNDCP) and expanded the mandate of the Commission to enable it to function as the governing body of UNDCP. UNDCP is part of the United Nations Office on Drugs and Crime (UNODC).

D

Drug dependence

Drug dependence is often defined as: a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time within a 12-month period. **(1)** Tolerance, as defined by either of the following: (a) need for markedly increased amounts of the substance to achieve intoxication or desired effect; (b) markedly diminished effect with continued use of the same amount of the substance. **(2)** Withdrawal, as manifested by either of the following: (a) the withdrawal characteristic for the substance (refers to Criteria A and B of the criteria sets for withdrawal from the specific substances; (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms; **(3)** the substance is often taken in larger amounts or over a longer period than was intended; **(4)** there is a persistent desire or unsuccessful effort to cut down or control substance use; **(5)** a great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use of the substance (e.g. chain-smoking), or recovering from its effects; **(6)** Important social, occupational or recreational activities are given up or reduced because of substance use; **(7)** the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (*source: DSM IV*).

Drug free treatment

Drug free treatment involves the application of psychosocial and educational techniques to achieve long-term abstinence from drugs. Traditionally, drug-free treatment has been residential and long term, e.g. in therapeutic communities. Today, it is also offered in community-based settings.

Drug-related death

Drug-related death is defined in this report as: deaths caused directly by the consumption of one or more drugs and generally occurring shortly after the consumption of the substance(s). These deaths are known as ‘overdoses’, ‘poisonings’ or drug-induced deaths.

Drug-related infectious diseases

The most prevalent types of drug-related infectious diseases are Hepatitis B and C, HIV/ AIDS and Tuberculosis.

H

Harm Reduction

There is no universal definition of the term harm reduction. For this report the definition of the International Harm Reduction Association (IHRA) is used: “policies and programmes which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and their communities”.

Hepatitis B

Hepatitis B is a virus spread through the blood and bodily fluids of an infected person. Many people do not realise they have been infected with the virus, because symptoms may not develop immediately, or at all. The hepatitis B virus can then go on to cause a chronic (long-term) illness, which follows the acute infection. This is very common if babies or children contract the virus, but can also occur in adults. The virus is present in body fluids such as blood, saliva, semen and vaginal fluid. It can be passed from person to person, through unprotected sex (without using a condom) and sharing needles to inject drugs. Infected mothers can also transmit the virus to their baby during the delivery process (often without the woman being aware that she is infected). The incubation period (i.e. the time from coming into contact with the virus to developing the infection) is between one and six months. There is a blood test to detect the virus. There is also a vaccine to protect you against hepatitis B.

Hepatitis C

Hepatitis C is a blood-borne viral infection. At times it is also passed on through other body fluids. Drug users sharing needles are particularly at risk. Anyone whose blood has come into contact with the blood of someone infected with the hepatitis C virus is also at risk. Approximately 20% of people will fight the infection and naturally clear it from their bodies within two to six months. Of the rest some will remain well, and never develop liver damage but many will develop mild to moderate liver damage (with or without symptoms). A further 20% will progress to cirrhosis of the liver over a period of 20- 30 years. Excessive drinking of alcohol is often associated with increased likelihood of progression to severe liver complications. There is no vaccine to prevent hepatitis C but treatment can clear the infection in approximately half those infected.

HIV/ AIDS

AIDS was first recognised as a new condition in 1981. Since then around 40 million people worldwide have been infected with HIV, the virus which can lead to AIDS. About a third of them have died. However, developments in treatment since the mid-nineties have dramatically improved the life expectancy for those diagnosed with HIV. People with HIV may not have any symptoms at all while they are in the latent phase. However, many people experience symptoms in the first couple of months after getting infected. These symptoms may include high temperature and fever, fatigue, skin rash, muscle pains, headache, nausea, vomiting and diarrhoea. Once someone becomes ill with HIV, they are open to many infections. These can include infections of the mouth, such as thrush (oral candidiasis), unusual types of pneumonia, tuberculosis (TB), infections of the brain and eyes, unusual skin problems and odd infections of the gastrointestinal tract. Most people with severe HIV infection also experience weight loss, enlargement of their lymph glands and persistent diarrhoea.

I

Injecting Drug User (IDU)

Injections are usually intravenous, but may also be intramuscular, subcutaneous.

Indicator

An **indicator** is a tool by which the progress or achievement of an action or objective can be measured.

M

Maintenance treatment

Maintenance treatment is a harm reduction intervention aiming at stabilising opiate users medically and socially allowing for genuine social re-integration. To avoid criminal activity when acquiring the illicit drugs and eliminating high risk situation when administering the drug via injecting, the treatment provides the patient with a substitution drug, mostly orally administered methadone or buprenorphine. Often maintenance treatment is provided as DOT (Daily Observed Therapy) which allows for thorough monitoring of the effects of substitution drugs in every patient. Furthermore patients are supported by medical and social service professionals to guarantee beneficial long-term effects on social re-integration.

Medically assisted treatment

Medically assisted treatment (MAT) covers both substitution treatment with agonists (methadone, buprenorphine, dihydrocodeine, heroin, slow-release morphine) and other pharmacological treatments (e.g. with antagonists such as naltrexone) which is targeted at the drug use itself (not anti-depressives and benzodiazepines).

Methadone

A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision. Methadone acts as a replacement for opiates in the body and thus can lessen withdrawal symptoms and cravings. At higher doses, it can also reduce the euphoric effects of opiates, thereby further protecting opiate users from relapse. Methadone is provided under several brand names.

N

Needle and syringe exchange

An intervention in which needles, syringes, other injecting equipment (such as alcohol swabs to clean injecting sites, and water with which to mix powdered drugs) are provided to IDUs through outreach, drop-in centres, clinics or shop fronts, mobile units such as vans and buses and/ or vending machines. Most NSPs include a retrieval service for used syringes.

P

Prevalence

Prevalence is a statistic of primary interest in public health because it identifies the level of burden of disease or health-related events on the population and health care system. Prevalence represents new and pre-existing cases alive on a certain date, in contrast to incidence, which reflects new cases of a condition diagnosed during a given period of time. Prevalence is a function of both the incidence of the disease and survival.

Prevention

The term generally covers three different types of drug prevention, each with distinctive characteristics. **Universal prevention** used to be referred to as primary prevention. This is aimed at the general population or parts of it (e.g. young people) that are not identified on the basis of individual risk factors. **Selective prevention** aims at specific groups of individuals who have an increased risk of developing drug problems (e.g. children of alcoholics or drug addicts, socially deprived young people, etc.). **Indicated prevention** aims at individuals who do not have drug or addiction problems according to the international diagnostic criteria for substance use disorders, but who do have some early characteristics of problematic use (e.g. young people using drugs with

high frequency). Practically all prevention programmes (school-based, family-oriented, mass media, community) cover one or more of these types of prevention.

Problem use

In its ‘Methodological guidelines to estimate the prevalence of problem use at national level (1999), the EMCDDA defines problem drug use as “injecting drug use” or “long duration/ regular use of opiates, cocaine and/ or amphetamines”. At international level, the APA Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) and the WHO International Classification of Diseases (ICD-10) use a somewhat broader definition of problem use, which also includes social aspects of problem use.

R

Risk factors

Risk factors are personal or social conditions that are considered mediating factors in increasing the probability that an individual will develop problem drug use or drug dependence. Scientific literature roughly differentiates between early childhood risk factors (e.g. lack of social skills, lack of social support in families) and late childhood risk factors (lack of problem solving skills, dysfunctional families, mental health/ addiction problems in family, lack of self-esteem) and adolescent risk factors (negative influence of peers, lowered self-esteem during adolescence).

S

Social costs

In the scientific literature on drug policy, social costs related to drugs include both direct and indirect social costs. Direct social costs include public expenditures on prevention, treatment, harm reduction, law enforcement & prosecution, penitentiaries, etc. Indirect social costs include loss of life (drug-related death), loss of productivity due to drug-related infectious diseases or imprisonment, social marginalisation of drug users, the indirect economic impact of open drug scenes, fraud and corruption. Social costs can be both material and immaterial, but the social cost model aims to estimate the economic value of both types of costs.

Substitution treatment

Substitution treatment is a form of medical care offered to opiate addicts (primarily heroin addicts) based on a similar or identical substance to the drug normally used. It is offered in two forms: *maintenance* — providing the user with enough of the substance to reduce risky or harmful behaviour; or *detoxification* — gradually cutting the quantity of the drug to zero. Treatment comes either with or without psycho-social support.

Annex 4 — EMCDDA data sources international comparison

4.1. General population surveys (Prevalence and trends).

Comment on methodology: The basic behavioural concepts asked in different general population surveys are roughly comparable (lifetime, last year or last month use). However, sample selection, data collection method (e.g. face to face interview or computer-assisted questionnaire) as well as the survey and social context (e.g. social disapproval) can differ and can have some effect on the resulting figures.

European Union — European Monitoring Centre for Drugs and Drug Addiction

- *Reitox National reports.* General population surveys indicator. See tables GPS-2 and GPS-4 in the EMCDDA Statistical Bulletin.

Australia — Australian Institute of Health and Welfare

- For prevalence data: 2004 National Drug Strategy Household Survey: Detailed Findings. AIHW cat. no. PHE 66. Canberra, 2005. AIHW (Drug Statistics Series No.16).
- For trends information: 2007 National Drug Strategy Household Survey: First results. Canberra, April 2008. Cat. no. PHE 98 (Drug Statistics Series No.20).

United States — Substance Abuse and Mental Health Services Administration (SAMHSA)

- Office of Applied Studies, National Survey on Drug use and Health, 2006; <http://www.samhsa.gov>; <http://oas.samhsa.gov/nhsda.htm#NHSDA.info>;
- For trends information: results from the 2006 National Survey on Drug Use and Health: National Findings; <http://www.oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.cfm#Ch9>

Canada

- Adlaf, E.M., Begin, P., & Sawka, E. (Eds.). (2005). Canadian Addiction Survey (CAS): A national survey of Canadians' use of alcohol and other drugs: Prevalence of use and related harms: Detailed report. Ottawa: Canadian Centre on Substance Abuse.

4.2. HIV infections in injecting drug users

A) Numbers of newly diagnosed HIV infections:

European Union — European Monitoring Centre for Drugs and Drug Addiction

- Annual report on the state of the drugs problem in Europe. EMCDDA, 2007

Australia — National Centre in HIV Epidemiology and Clinical Research

- HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2007, p42.; [http://www.ncheer.unsw.edu.au/NCECRweb.nsf/resources/SurvRep07/\\$file/ASR2007.pdf](http://www.ncheer.unsw.edu.au/NCECRweb.nsf/resources/SurvRep07/$file/ASR2007.pdf)

United States -- Centers for Disease Control and Prevention

- HIV/AIDS Surveillance Report, 2005, p37; <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/#surveillance>

Canada

- Public Health Agency of Canada. HIV and AIDS in Canada. Surveillance Report to December 31, 2006, p17; <http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/index-eng.html>.

B) Population sizes:

European Union — Eurostat

- <http://epp.eurostat.ec.europa.eu>

Australia, United States and Canada and USA

- US Census Bureau; <http://www.census.gov>

4.3. Direct drug-related mortality

European Union — European Monitoring Centre for Drugs and Drug Addiction

- Reitox National reports.

Australia

- Degenhardt, L., and Roxburgh, A. (2007). Accidental drug-induced deaths due to opioids in Australia, 2005. Sydney: National Drug and Alcohol Research Centre.

United States — Substance Abuse and Mental Health Services Administration

- Office of Applied Studies. Drug Abuse Warning Network, 2003: Area Profiles of Drug-Related Mortality. DAWN Series D-27, DHHS Publication No. (SMA) 05-4023. Rockville, MD, 2005.

Canada

- Popova S, Rehm J and Fischer B: An overview of illegal opioid use and health services utilisation in Canada. Public Health. Vol. 120, Issue 4, 2006, pp. 320-328.

Population sizes:

European Union — Eurostat

- <http://epp.eurostat.ec.europa.eu>

Australia — Australian Bureau of Statistics

- estimated resident population on 30 June 2005;
<http://www.abs.gov.au/ausstats/abs@.nsf/ProductsbyReleaseDate/1F51406DCEEBAAC14CA256EC7007B5B4E?OpenDocument>

Canada — Statistics Canada

- population on 1 July 2007 aged 15-64; <http://www40.statcan.ca/101/cst01/demo31a.htm>