

Amphetamine and methamphetamine

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

Both drugs are manufactured in Europe for domestic use. Some amphetamine and methamphetamine is also manufactured for export, principally to the Middle East, where there is a market for 'captagon' tablets — which are reported to contain amphetamines — the Far East and Oceania. Europe is also a transit hub for

methamphetamine being trafficked from West Africa and Iran to markets in the Middle East. Amphetamine production mainly takes place in Belgium, the Netherlands, Poland, Germany, and to a lesser extent the Baltic States. A recent development has seen the relocation of the final production stage, with several countries now reporting the conversion of amphetamine base oil to amphetamine sulphate on their territories.

Much of Europe's methamphetamine is produced in and around the Czech Republic. Some production capacity, however, also exists in the Netherlands and Lithuania, while Bulgaria has noted an increase in the number of laboratories dismantled.

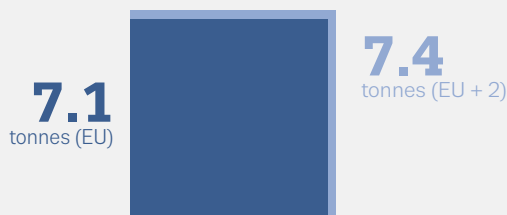
AMPHETAMINES

Amphetamine

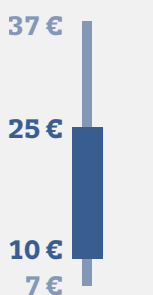
Number of seizures



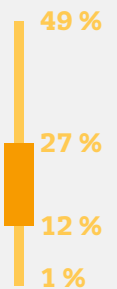
Quantities seized



Price (EUR/g)

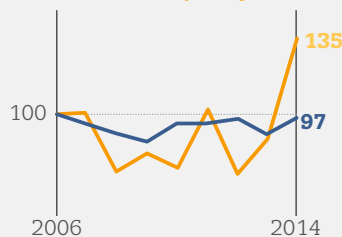


Purity (%)



Indexed trends:

Price and purity



Methamphetamine

Number of seizures



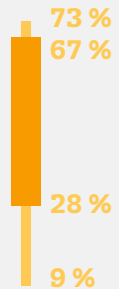
Quantities seized



Price (EUR/g)



Purity (%)



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

FIGURE 1.7

Number of amphetamine seizures and quantity seized: trends and 2014 or most recent year

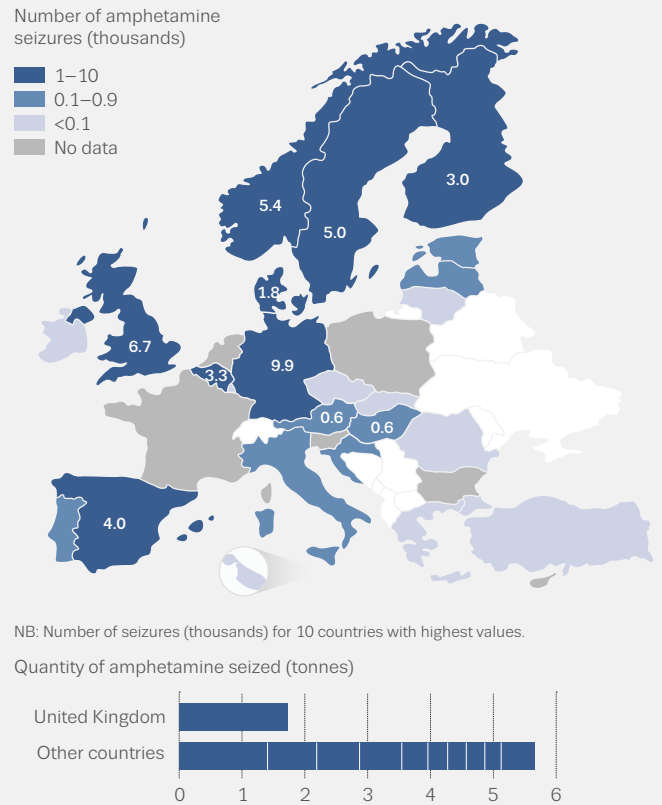
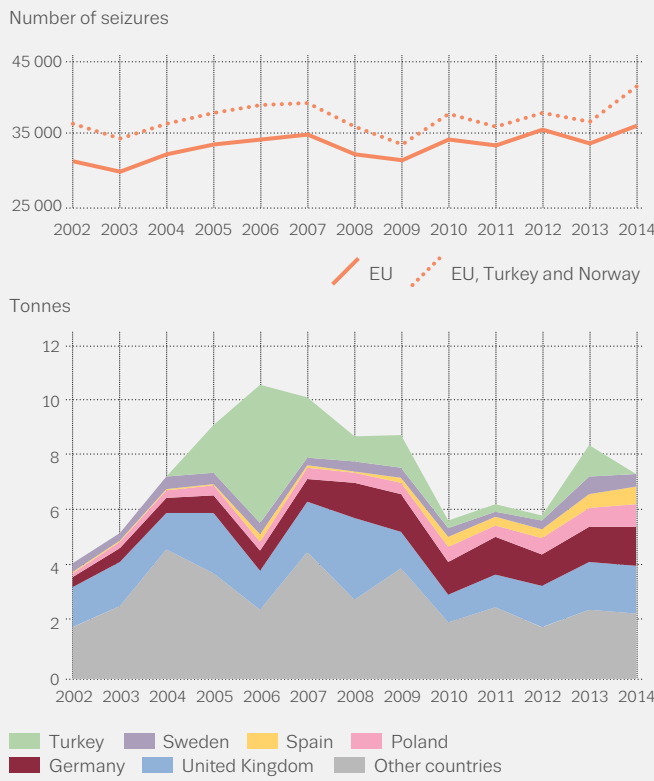
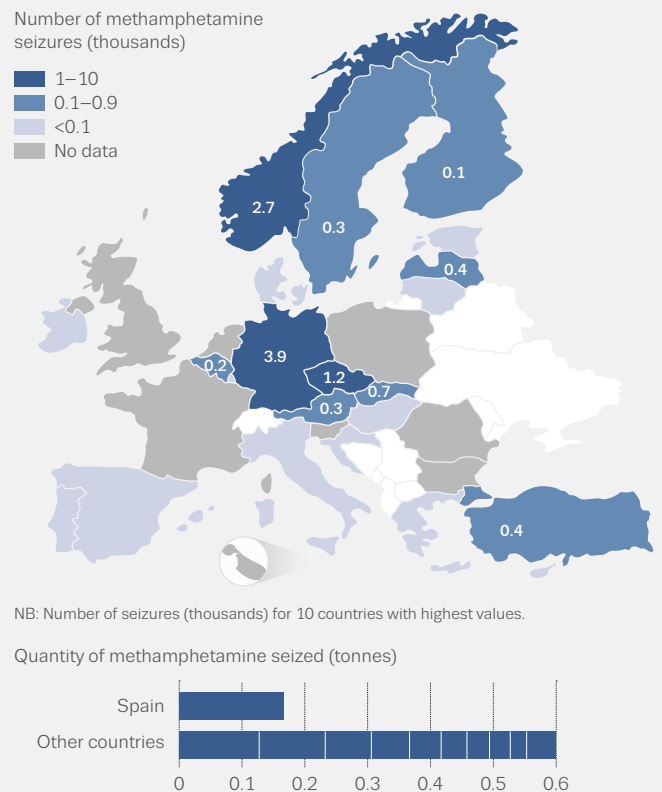
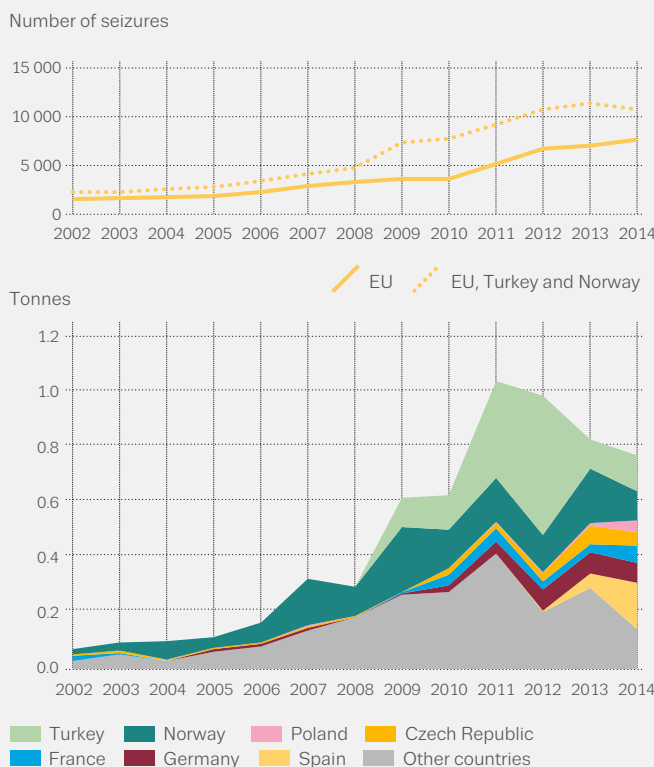


FIGURE 1.8

Number of methamphetamine seizures and quantity seized: trends and 2014 or most recent year



Methamphetamine produced using BMK (benzyl methyl ketone) is reported by Lithuania and Bulgaria, while in and around the Czech Republic, ephedrine and pseudoephedrine is used. Historically, in the Czech Republic, methamphetamine has mainly been produced in small-scale facilities by users for their own or local use. This is reflected in the high number of production sites detected in this country (261 dismantled in 2013, out of 294 in Europe). Recently, however, production volumes have been increasing and new pre-precursors have been used, with reports of organised crime groups producing this drug for both domestic and external markets.

In 2014, 36 000 seizures of amphetamine were reported by EU Member States, amounting to 7.1 tonnes. Overall, the quantity of amphetamine seized in the European Union has increased since 2002 (Figure 1.7). Methamphetamine seizures are far lower, accounting for around a fifth of all amphetamines seizures in 2014, with 7 600 seizures reported in the European Union, amounting to 0.5 tonnes (Figure 1.8). Both number and quantity of methamphetamine seized show an upward trend since 2002.

Typically, the average reported purity is higher for methamphetamine than for amphetamine samples. Although indexed trends suggest that amphetamine purity has increased in the latest data, the average purity of this drug continues to be relatively low.

MDMA: increase in high-dose products

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

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

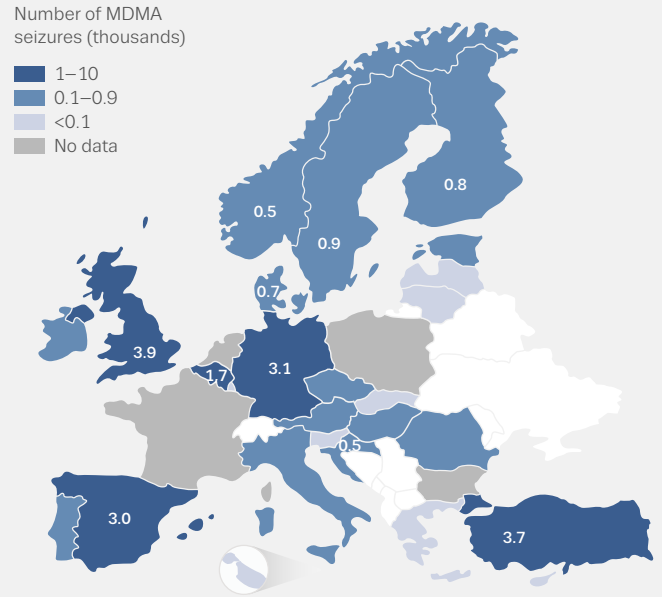
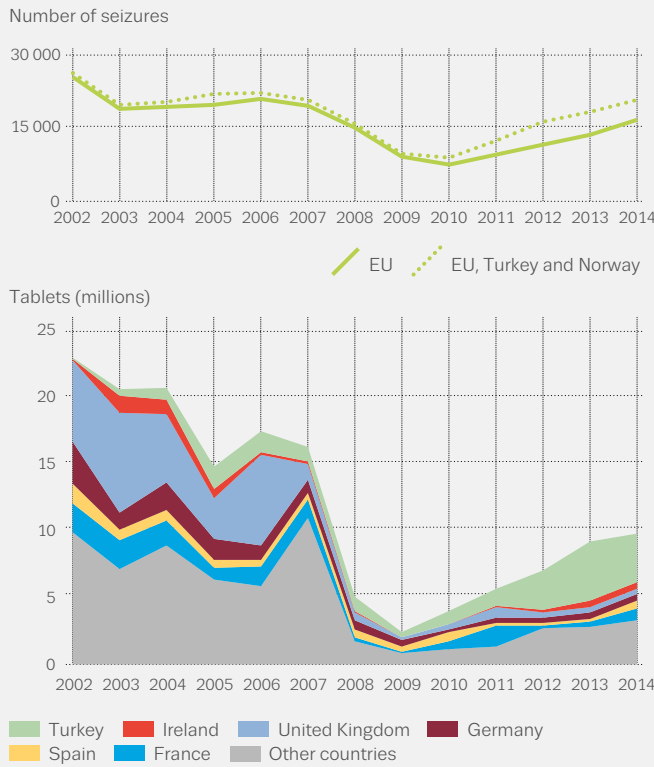
Assessing recent trends in MDMA seizures is difficult due to the absence of data from some countries that are likely to make important contributions to this total. For 2014, no data are available from the Netherlands and the numbers of seizures are not available from Finland, France, Poland and Slovenia. The Netherlands reported seizing 2.4 million MDMA tablets in 2012, and if a similar figure may be assumed for 2014, it is estimated that around 6.1 million MDMA tablets were seized in the European Union in that year. This would be more than double the amount seized in 2009. In addition, 0.2 tonnes of MDMA powder was seized in 2014. Large quantities of MDMA are also seized in Turkey, amounting to 3.6 million MDMA tablets in 2014 (Figure 1.9).

Among those countries reporting consistently, indexed trends also point to increases in MDMA-content since 2010, and the availability of high MDMA-content products prompted joint alerts from Europol and the EMCDDA in 2014.

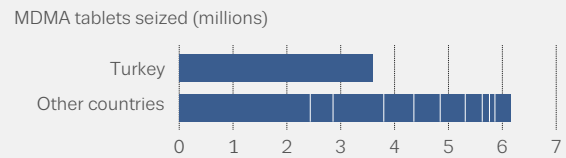
**High MDMA-content products
prompted joint alerts from
Europol and the EMCDDA**

FIGURE 1.9

Number of MDMA seizures and quantity seized: trends and 2014 or most recent year



NB: Number of seizures (thousands) for 10 countries with highest values.



MDMA

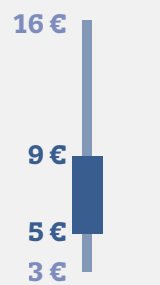
Number of seizures



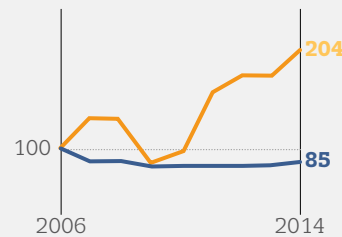
Quantities seized



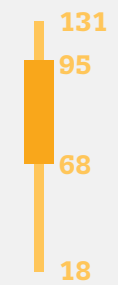
Price (EUR/tablet)



Indexed trends: Price and purity



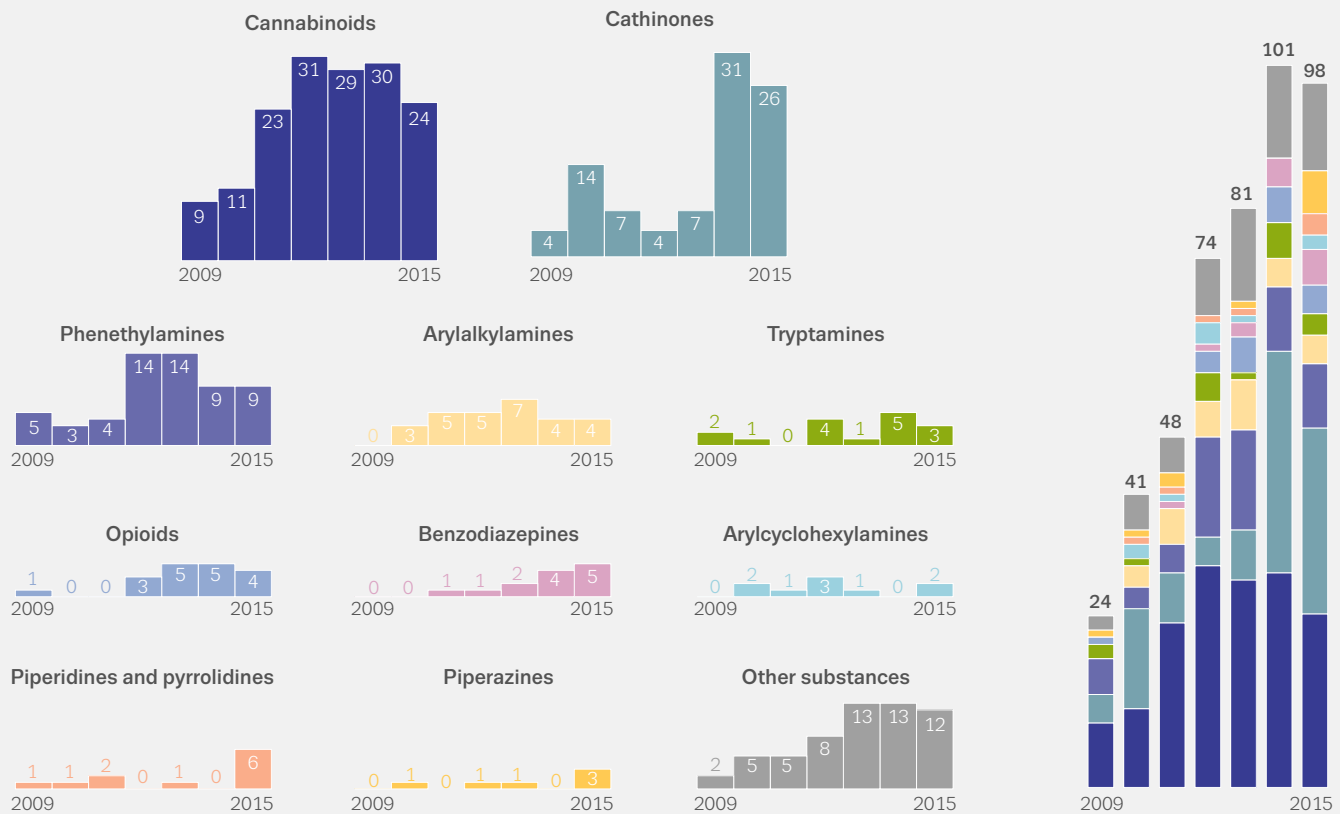
Purity (MDMA mg/tablet)



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

FIGURE 1.10

Number and categories of new psychoactive substances notified to the EU Early Warning System for the first time, 2009–15



Seizures of LSD, GHB, ketamine and mephedrone

A number of other illicit drugs are seized in the European Union, and among these were 1 700 seizures of LSD in 2014 representing 156 000 doses. In addition, Belgium seized 3 kg of the drug, the largest quantity ever recorded for that country. For most other drugs, incomplete datasets do not allow comparison between countries or analysis of trends. In 2014, seizures of GHB or GBL were reported by 18 countries. The 1 243 seizures amounted to 176 kg and 544 litres of the drug, with Belgium (40 %) and Norway (34 %) each accounting for over a third of these seizures. Eleven countries reported 793 seizures of ketamine, amounting to 246 kg of the drug. Over half of these seizures were in the United Kingdom. The 1 645 seizures of mephedrone reported by 10 countries amounted to 203 kg of the drug. Almost all of the mephedrone seized was reported by the United Kingdom (101 kg) and Cyprus (99 kg).

New psychoactive substances: market diversity

The EMCDDA monitors a broad range of new psychoactive substances. These include synthetic cannabinoids, synthetic cathinones, phenethylamines, opioids, tryptamines, benzodiazepines, arylalkylamines and a range

of other substances. In 2015, 98 new substances were detected for the first time, bringing the number of new substances monitored to more than 560, of which 380 (70 %) were detected in the last 5 years (Figure 1.10).

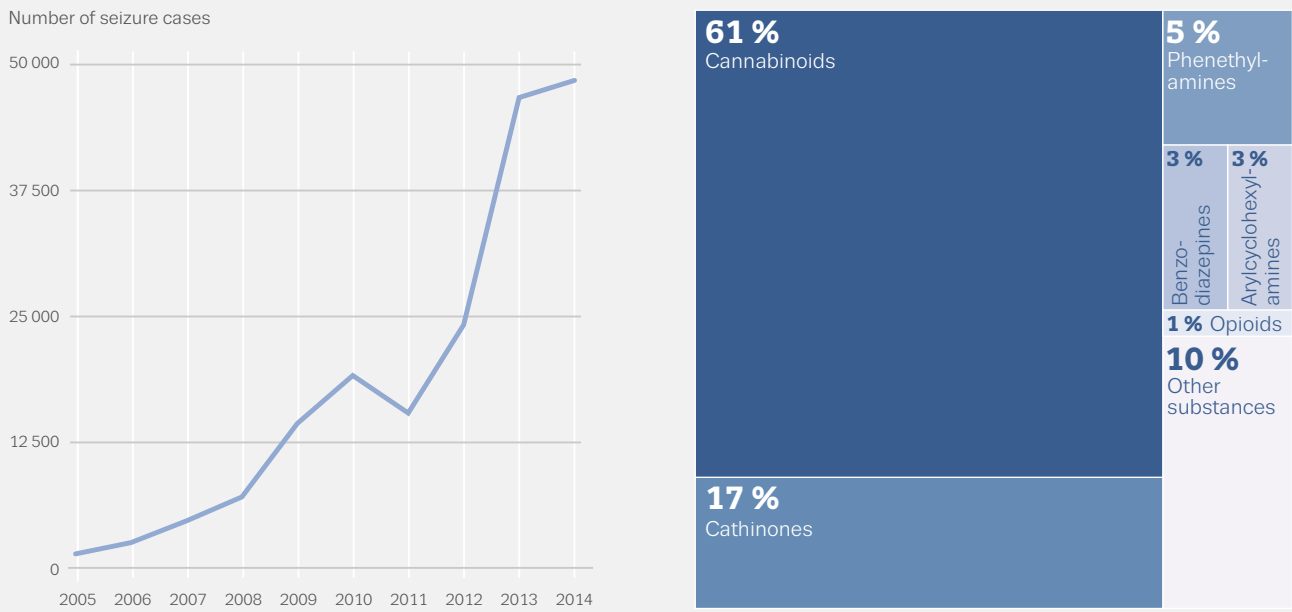
Since 2008, over 160 synthetic cannabinoids have been detected in a range of different products — including 24 new cannabinoids reported in 2015. Synthetic cannabinoids are sold as ‘legal’ replacements for cannabis and may be advertised as ‘exotic incense blends’, and ‘not for human consumption’, in order to circumvent consumer protection and medicine laws. This is the largest group of new drugs monitored by the EMCDDA, reflecting both the large demand for cannabis within Europe and the ability of manufacturers to place new cannabinoids on the market when existing ones are subjected to control measures.

Synthetic cathinones are the second largest group of substances monitored by the EMCDDA. These were first detected in Europe in 2004 and since then, 103 new cathinones have been identified, 26 in 2015. Synthetic cathinones are typically sold as ‘legal’ replacements for stimulants such as amphetamine, MDMA and cocaine.

The EMCDDA currently monitors 14 new and non-controlled benzodiazepines. These are sometimes used by

FIGURE 1.11

Number of seizures of new psychoactive substances reported to the EU Early Warning System: trends and by category in 2014



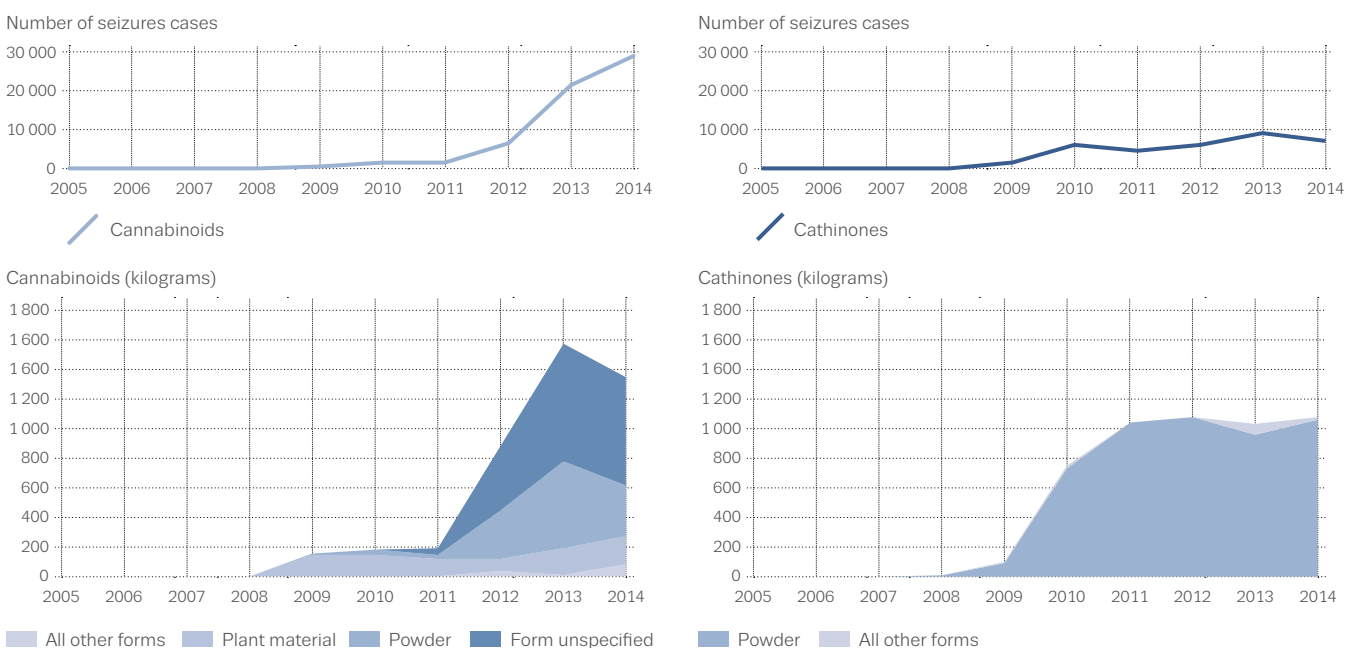
NB: Data for EU Member States, Turkey and Norway.

counterfeiters to produce fake medicines that are sold in Europe. Examples of this practice include fake alprazolam tablets, intercepted in 2015, that were found to contain flubromazolam, and fake diazepam tablets which

contained phenazepam. In some European countries, these counterfeit medicines have become an important part of the illicit drug market.

FIGURE 1.12

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



NB: Data for EU, Turkey and Norway.

Increased seizures of new psychoactive substances

Case level seizure data reported to the EU Early Warning System point to the continued growth of the new drugs market. In 2014, almost 50 000 seizures of new substances, weighing almost 4 tonnes, were made across Europe (Figure 1.11). Synthetic cannabinoids accounted for the majority of these, with almost 30 000 seizures weighing more than 1.3 tonnes (Figure 1.12). Synthetic cathinones were the second largest group, with more than 8 000 seizures weighing more than 1 tonne. Together, synthetic cannabinoids and cathinones accounted for almost 80 % of the total number of seizures and over 60 % of the quantity seized during 2014. Other groups included non-controlled benzodiazepines and potent narcotic analgesics, such as fentanyl, which may be sold as heroin.

Seizures of new psychoactive substances in 2014 were dominated by synthetic cannabinoids, which accounted for more than 60 % of the total number of seizures and almost 35 % of the quantity seized (Figure 1.11). Most were powder seizures, often in bulk amounts; the rest was typically seized as plant material with the substance sprayed onto it. The powders are used to manufacture products sold as 'legal highs', and seizures represent millions of doses. The top five cannabinoids seized in powder form in 2014 were AM-2201 (70 kg), MDMB-CHMICA (40 kg), AB-FUBINACA (35 kg), MAM-2201 (27 kg) and XLR-11 (5F-UR-144) (26 kg).

In 2014, synthetic cathinones accounted for more than 15 % of all seizures of new psychoactive substances and almost 30 % of the total quantity seized (Figure 1.11). The top five cathinones seized included mephedrone (222 kg) and its isomers 3-MMC (388 kg) and 2-MMC (55 kg) as well as pentedrone (136 kg) and alpha-PVP (135 kg).

Drug markets: policy responses

The global nature of illicit drug supply and trafficking means implementing counter measures is complex. A range of supply reduction options are available to policymakers including drug strategy and legal interventions alongside regulatory and law enforcement approaches. The coordination of European supply reduction initiatives is undertaken by a number of EU institutions. Several strategic planning tools are used in this process: the EU drugs strategy 2013–20 and its current action plan 2013–16, the EU policy cycle on organised and serious international crime and the EU security strategies. The breadth of the challenges facing law enforcement and the increasing sophistication of

organised crime groups involved in the drugs trade is evident from the array of policy areas these strategies cover. These include, for example, the areas of security, maritime, migration and development policies. They span actions to enhance intelligence led policing, maritime surveillance and transportation, detection and targeting of illicit financial flows, border control, the movement of industrial chemicals, and alternative development measures. The European Union also cooperates with a range of international partners to implement these supply reduction policies.

At the national level, Member States are required to address an equally complex set of drug market dynamics and most have national security and policing strategies that cover drug supply reduction. In addition, all but two countries use national drug strategies to express their drug policies often encompassing supply reduction alongside demand reduction initiatives. The exceptions are Austria, which has regional drug strategies, and Denmark, which has a national drug policy that is expressed in a range of strategic documents, legislation and concrete actions. Drug strategies are documents, usually time-limited, typically containing objectives and priorities, alongside specific actions and the parties responsible for implementing them. The drug policy arena has become increasingly complex in recent years. This is reflected in the situation with nearly a third of EU Member States' national strategies having their scope extended beyond illicit drugs to encompass licit drugs and in some cases addictive behaviours (see Figure 1.13).

Countries use national drug strategies to express their drug policies

FIGURE 1.13

National drug strategies and action plans: availability and scope

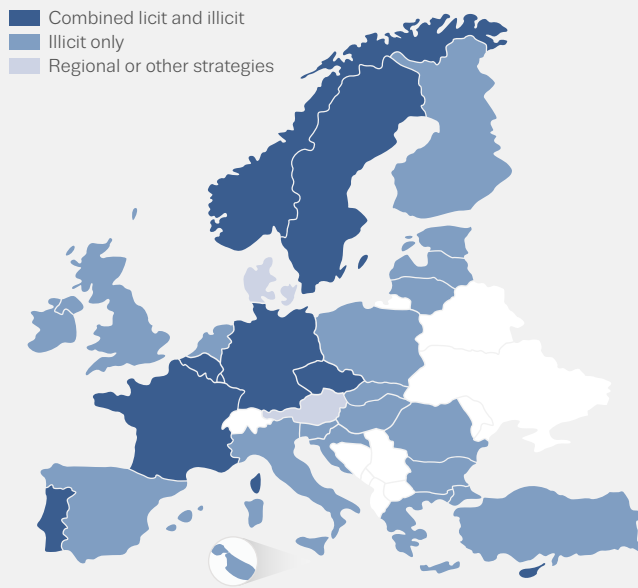
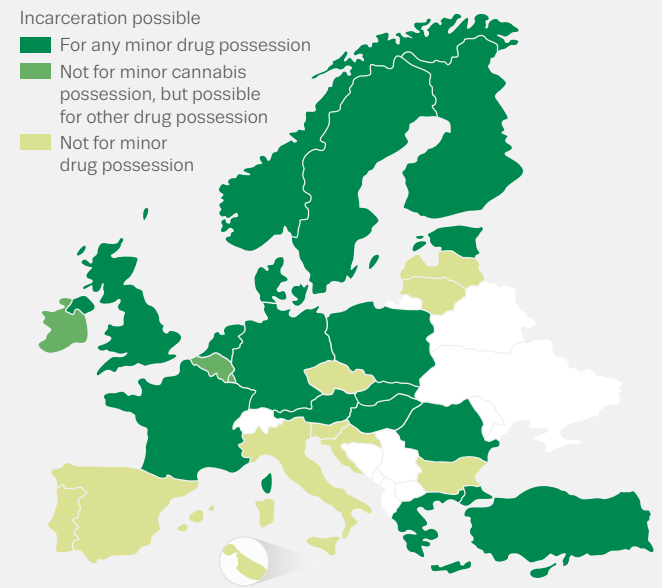


FIGURE 1.14

Penalties in laws: possibility of incarceration for possession of drugs for personal use (minor offences)



Legal responses to drug supply and possession

Member States take measures to prevent the supply of illicit drugs under three United Nations Conventions, which provide an international framework for control of production, trade and possession of over 240 psychoactive substances. Each country is obliged to treat drug trafficking as a criminal offence, but the penalties written in the law vary between states. In some countries, drug supply offences may be subject to a single wide penalty range, while other countries differentiate between minor and major supply offences with corresponding penalty ranges.

Each country is also obliged to treat possession of drugs for personal use as a criminal offence, but subject to a country's 'constitutional principles and the basic concepts of its legal system'. This clause has not been uniformly interpreted, and this is reflected in different legal approaches in European countries and elsewhere. Since around 2000, there has been an overall trend across Europe towards reducing the likelihood of imprisonment or other incarceration for minor offences related to personal drug use. Some countries have gone further, so that possession of drugs for personal use can only be punished by non-criminal sanctions, usually a fine (Figure 1.14).

Drug law offences: longer term increases

The implementation of laws to curb drug supply and use is monitored through data on reported drug law offences. In the European Union, there were an estimated 1.6 million offences reported (most of them related to cannabis; 57 %) in 2014, involving around 1 million offenders. Reported offences increased by almost a third (34 %) between 2006 and 2014.

In most European countries, the majority of reported drug law offences relate to use or possession for use. In Europe, overall, it is estimated that more than 1 million of these offences were reported in 2014, a 24 % increase compared with 2006. Of the reported drug offences related to possession, more than three-quarters involve cannabis. The upward trends in offences for cannabis, amphetamines and MDMA possession have continued in 2014 (Figure 1.15).

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

Preventing the diversion of substitution medicines

The diversion of opioid substitution medicines from their intended use in drug treatment to non-medical use and sale on illicit drug markets is a cause for concern. Diversion here refers to the sharing, selling, trading, or giving away of prescription medications to others. This may occur voluntarily (intentional supply to another person) or involuntarily (inadvertent supply such as lost doses and theft).

At a national level, various strategies are implemented to prevent diversion of substitution medicines. These include providing training for clinicians and patients; implementing strategies to assure treatment compliance by appropriate prescription and supervision of dosing; providing medicine

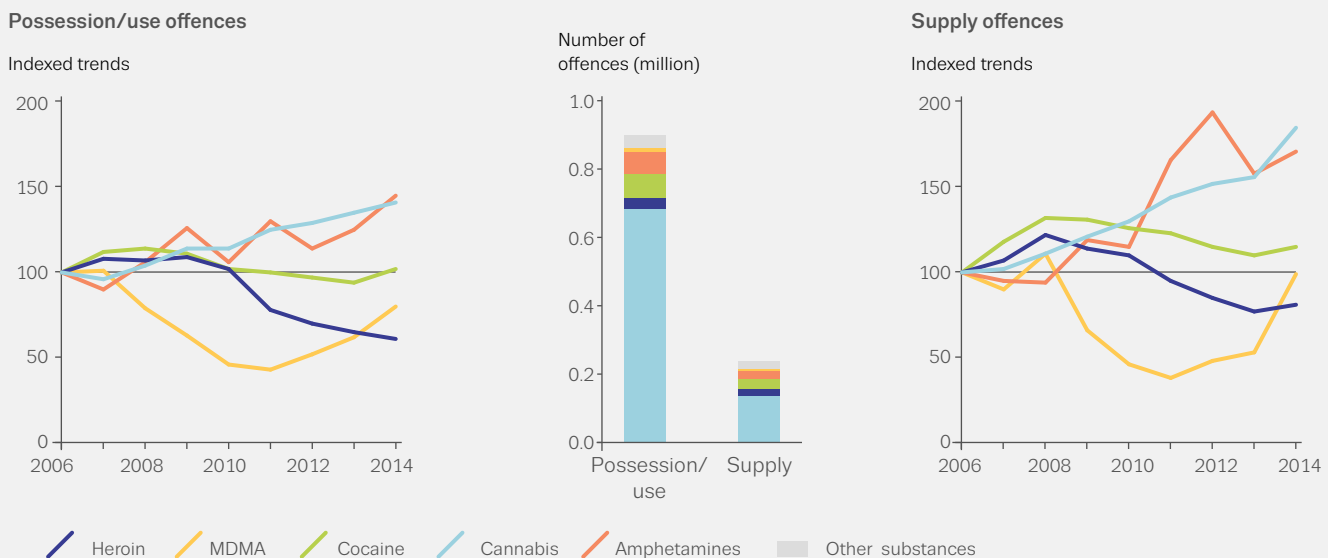
formulations designed to deter misuse; use of electronic medicine dispensers; and employing control measures such as patient toxicology tests, pill counts, and unannounced monitoring. Regulation at a system level may occur through registers of pharmacy transactions and use of disciplinary measures to address inappropriate prescribing.

A recent European review suggests that many of these interventions have the potential to reduce the occurrence of diversion, although information on the possible unintended consequences of their implementation is rarely reported. At present, the challenge remains one of maintaining good patient access to substitution medicines while establishing appropriate prevention and regulation responses that minimise the leakage of these medicines onto the illicit market.

Various strategies are implemented to prevent diversion of substitution medicines

FIGURE 1.15

Drug law offences in Europe related to drug use or possession for use or drug supply: indexed trends and reported offences in 2014



NB: Data for offences for which the drug involved has been reported.

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Cocaine trafficking to Europe, Perspectives on Drugs.

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EMCDDA–Europol Joint Report on a new psychoactive substance: 1-phenyl-2-(1-pyrrolidinyl)-1-pentanone (α -PVP), Joint Reports.

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2

**Drug use in Europe now encompasses
a wider range of substances**

Drug use prevalence and trends

Drug use in Europe now encompasses a wider range of substances than in the past. Among drug users, polydrug consumption is common and individual patterns of use range from experimental to habitual and dependent consumption. Use of all drugs is generally higher among males, and this difference is often accentuated for more intensive or regular patterns of use. The prevalence of cannabis use is about five times that of other substances. While the use of heroin and other opioids remains relatively rare, these continue to be the drugs most commonly associated with the more harmful forms of use including injecting drug use.

Monitoring drug use

The EMCDDA collects and maintains datasets that cover drug use and patterns of use in Europe. Data from general population surveys can provide an overview of the prevalence of recreational drug use.

These survey results can be complemented by community level analyses of drug residues in municipal wastewater, carried out in cities across Europe.

Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on those entering specialised drug treatment systems, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use.

One in four Europeans have tried illicit drugs

Over 88 million adults, or just over a quarter of the 15- to 64-year-olds in the European Union, are estimated to have tried illicit drugs at some point in their lives. Drug use is more frequently reported by males (54.3 million) than females (34.8 million). The most commonly used drug is cannabis (51.5 million males and 32.4 million females), with much lower estimates reported for the lifetime use of cocaine (11.9 million males and 5.3 million females), MDMA (9.1 million males and 3.9 million females) and amphetamines (8.3 million males and 3.8 million females). Levels of lifetime use of cannabis differ considerably between countries, ranging from around four in 10 adults

in France and one-third of adults in Denmark and Italy, to less than one in 10 in Bulgaria, Hungary, Malta, Romania and Turkey.

Last year drug use provides a good measure of recent drug use and is largely concentrated among young people (15–34). An estimated 17.8 million young adults used drugs in the last year, with males outnumbering females by a factor of two.

Cannabis use: different national pictures

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

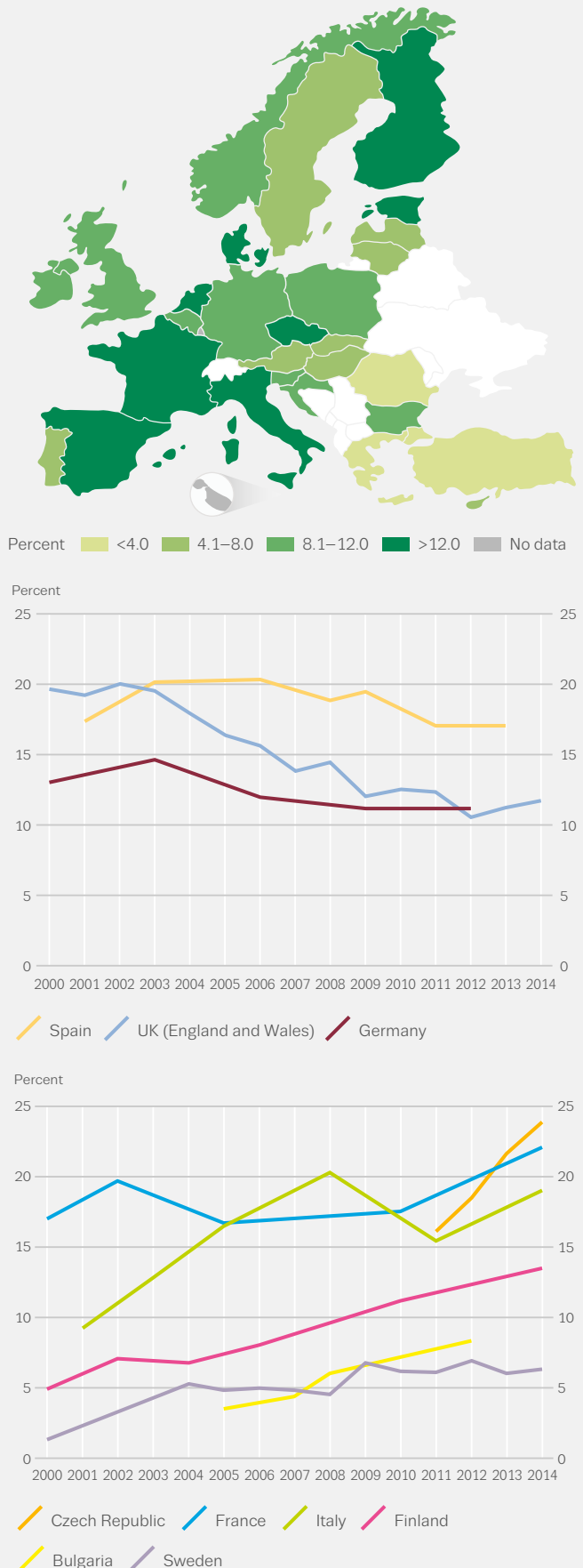
An estimated 16.6 million young Europeans (aged 15–34), or 13.3 % of this age group, used cannabis in the last year, with 9.6 million of these aged 15–24 (16.4 % of this age group). Among young people using cannabis in the last year, the ratio of males to females is two to one.

The most recent survey results show that countries continue to follow divergent paths in last year cannabis use (Figure 2.1). Of the countries that have produced surveys since 2013, eight reported higher estimates, four were stable and one reported a lower estimate than in the previous comparable survey.

Only a limited number of countries have sufficient survey data to allow a statistical analysis of medium and long-term trends in last year cannabis use among young adults (15–34). Surveys for relatively high-prevalence countries, such as Germany, Spain and the United Kingdom, all show decreasing or stable cannabis prevalence over the past decade, while France shows increases in prevalence after 2010. Among countries that have historically lower rates of cannabis use, Finland has consistently reported increases in prevalence over the long term, moving from a low prevalence towards the European average, while Sweden retains a low level with data showing a modest increase over the last decade. Among the countries with fewer comparable data points, the Bulgarian data continues an increasing trend until 2012, while an annual survey in the Czech Republic found increases from 2011 to 2014.

FIGURE 2.1

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



Cannabis accounted for the majority of illicit drug use among 15- to 16-year-old school students reported by the last round of the European School Survey Project on Alcohol and Other Drugs (ESPAD), published in 2011. More recent data on schoolchildren, in this case aged 15, are provided by the Health Behaviour in School-aged Children (HBSC) study. In the 2013/14 HBSC survey, levels of lifetime cannabis use ranged from 5 % among girls and 7 % among boys in Sweden to 26 % among girls and 30 % among boys in France.

number of treatment entrants are unclear, but may be linked to changes in the prevalence of cannabis use and intensive use and other factors such as the availability of more harmful and higher-potency products, an increase in cannabis treatment availability and changing treatment referral practices.

Treating cannabis users: increased demand

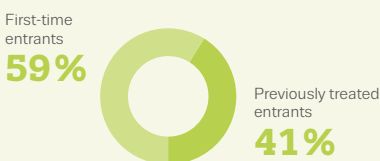
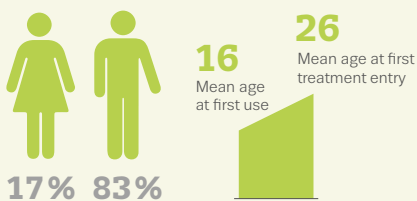
Based on surveys of the general population, it is estimated that around 1 % of European adults are daily or almost daily cannabis users — that is, they have used the drug on 20 days or more in the last month. Around 60 % of these are aged between 15 and 34 years, and over three-quarters are male.

When considered alongside other indicators, data on those entering treatment for cannabis problems can inform understanding of the nature and scale of high-risk cannabis use in Europe. Overall, the number of first-time treatment entrants for cannabis problems increased from 45 000 in 2006 to 69 000 in 2014. Among this group, those reporting daily use of the substance rose from 46 % in 2006 to 54 % in 2014. The causes of the increase in the



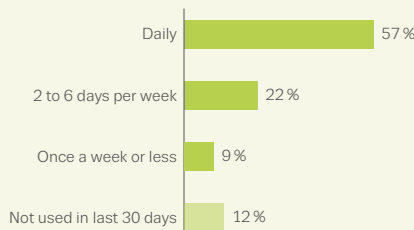
CANNABIS USERS ENTERING TREATMENT

Characteristics

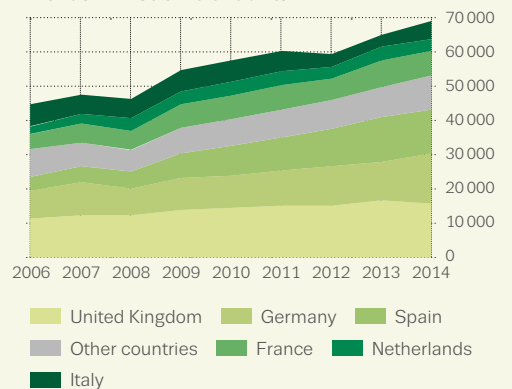


Frequency of use in the last month

mean use 5.4 days per week



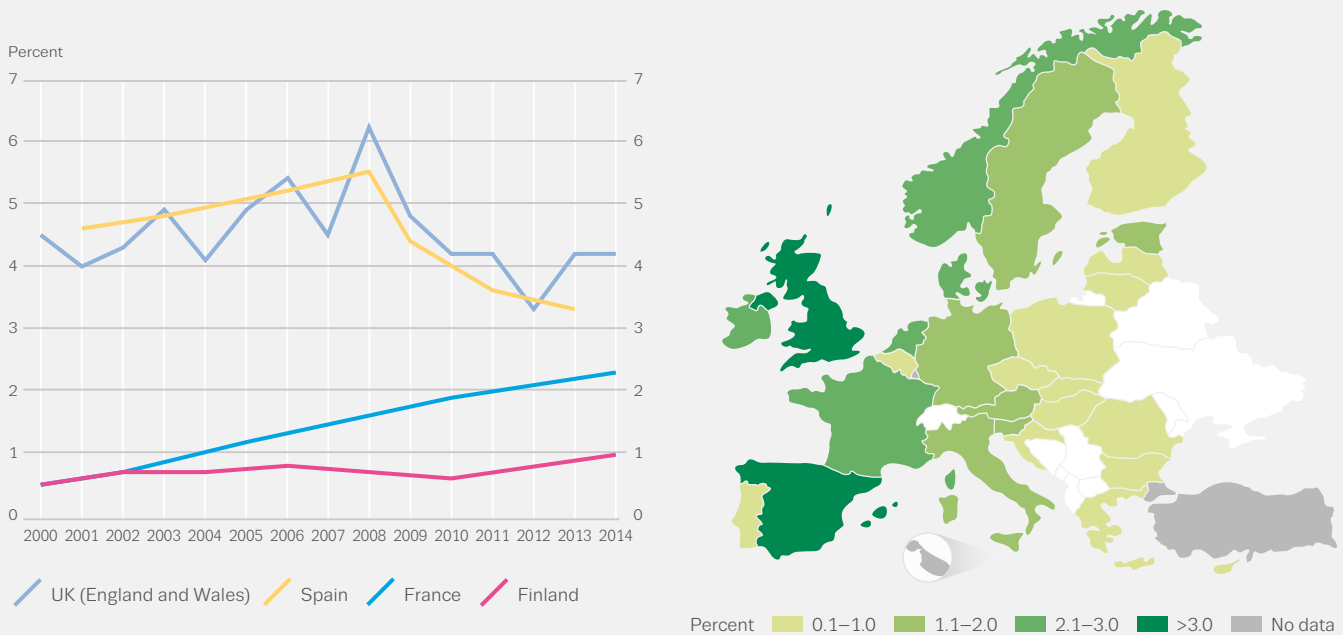
Trends in first-time entrants



NB: Characteristics are for all treatment entrants with cannabis as primary drug. Due to changes in the flow of data at national level, 2014 data for Italy is not directly comparable with earlier years.

FIGURE 2.2

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



Cocaine: changing prevalence

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

It is estimated that about 2.4 million young adults aged 15 to 34 (1.9 % of this age group) used cocaine in the last year. Many cocaine users consume the drug recreationally, with use highest during weekends and holidays. Among regular users, a broad distinction can be made between more socially integrated consumers, who often sniff powder cocaine, and marginalised users, who inject cocaine or smoke crack sometimes alongside the use of opioids.

Only Spain, the Netherlands and the United Kingdom report last year prevalence of cocaine use among young adults of 3 % or more. The decreases in cocaine use

reported in previous years have not been observed in the most recent surveys; of the countries that have produced surveys since 2013, six reported higher estimates, two reported a stable trend and four reported lower estimates than in the previous comparable survey.

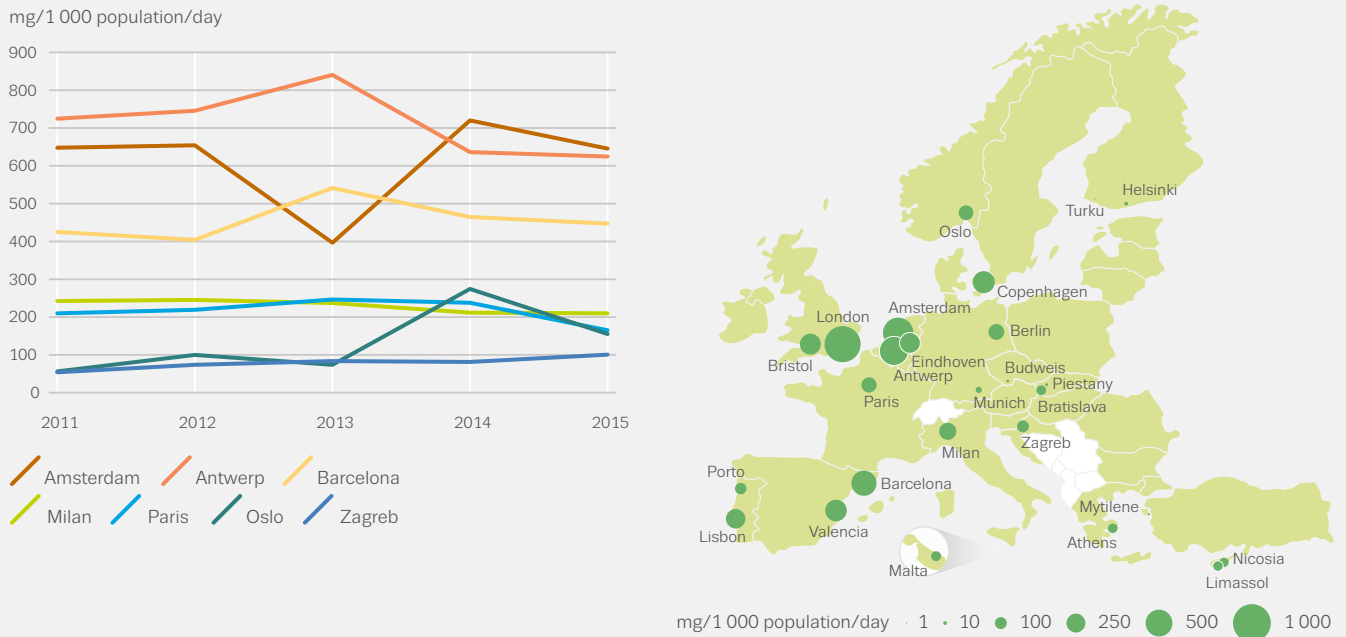
A statistical analysis of long-term trends in last year use of cocaine among young adults is only possible for a small number of countries. Spain and the United Kingdom both reported trends of increasing prevalence until 2008, followed by stability or decline. Reports from the United Kingdom suggest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

Analysis of municipal wastewater for cocaine residues carried out in a multi-city study complements the results from population surveys. The results of the study are presented in standardised amounts (mass loads) of drug residue per 1 000 population per day. The 2015 analysis found the highest mass loads of benzoylecgonine — the main metabolite of cocaine — in cities in Belgium, Spain, the Netherlands and the United Kingdom (see Figure 2.3). The general patterns detected in 2015 are similar to those in previous years, with most cities showing either a decreasing or a stable trend between 2011 and 2015.

Cocaine is the most commonly used illicit stimulant drug in Europe

FIGURE 2.3

Cocaine residues in wastewater in selected European cities: trends and most recent data



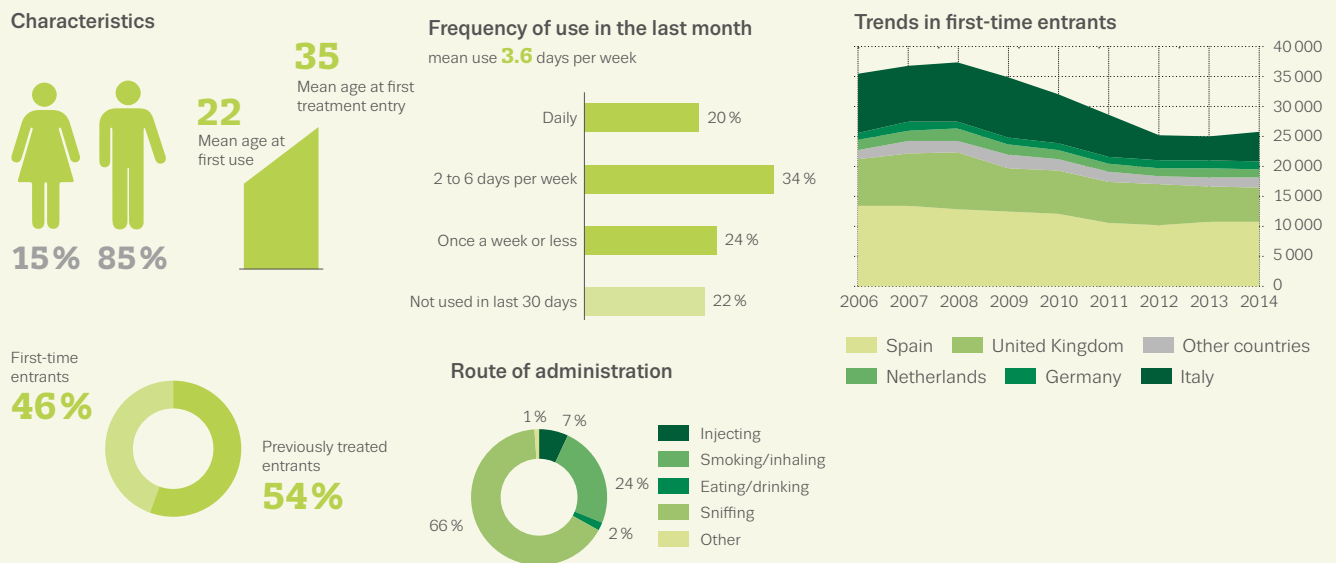
NB: Mean daily amounts of benzoylecognine in milligrams per 1 000 population. Map: from sampling over a one-week period in 2015. Source: Sewage Analysis Core Group Europe (SCORE).

Treating cocaine use: stable demand

The prevalence of particularly problematic patterns of cocaine use in Europe is difficult to gauge as only five countries have recent estimates and different definitions

and methodologies have been used. In 2012, Germany estimated cocaine-dependency among the adult population at 0.20 %. In 2014, Italy produced an estimate of 0.64 % for those in need of treatment for cocaine use and in 2013, Spain estimated high-risk cocaine use at

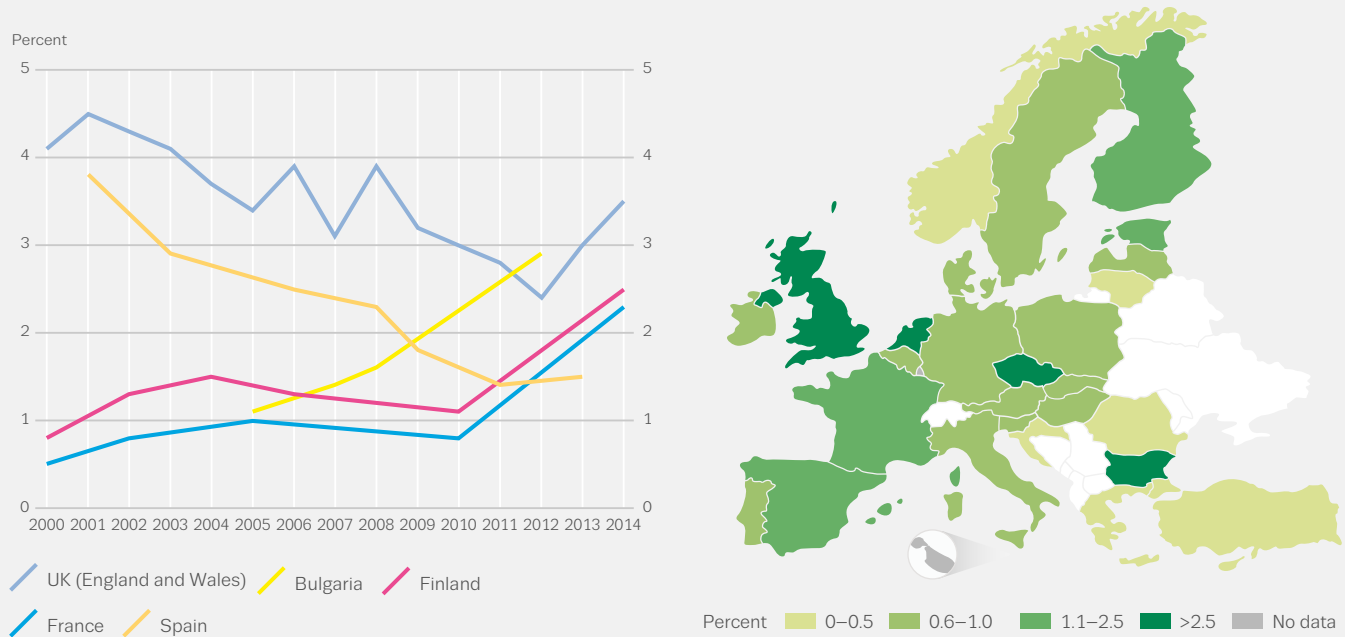
COCAINE USERS ENTERING TREATMENT



NB: Characteristics are for all treatment entrants with cocaine or crack as primary drug. Due to changes in the flow of data at national level, 2014 data for Italy is not directly comparable with earlier years.

FIGURE 2.4

Last year prevalence of MDMA use among young adults (15–34): statistically significant trends and most recent data



0.29 %. For 2011/2012, the United Kingdom estimated crack cocaine use among the adult population in England at 0.48 % and the majority of these were also opioid users. High-risk cocaine use in Portugal is estimated at 0.62 %, based on reported last year use.

Spain, Italy and the United Kingdom account for 74 % of all reported treatment entries related to cocaine in Europe. Overall, cocaine was cited as the primary drug by 60 000 clients entering specialised drug treatment in 2014 and by 27 000 first-time clients. After a period of decline, the overall number of cocaine first-time treatment entrants has been stable since 2012.

In 2014, almost 5 500 clients entering treatment in Europe reported primary crack cocaine use, with the United Kingdom accounting for more than half of these (3 000), and Spain, France and the Netherlands most of the remainder (2 000).

MDMA: changing trends and increasing use

MDMA (3,4-methylenedioxy-methamphetamine) is commonly used in the form of ecstasy tablets, but is also increasingly available as crystals and powders; tablets are usually swallowed, but in powder form the drug is also snorted (nasal insufflation).

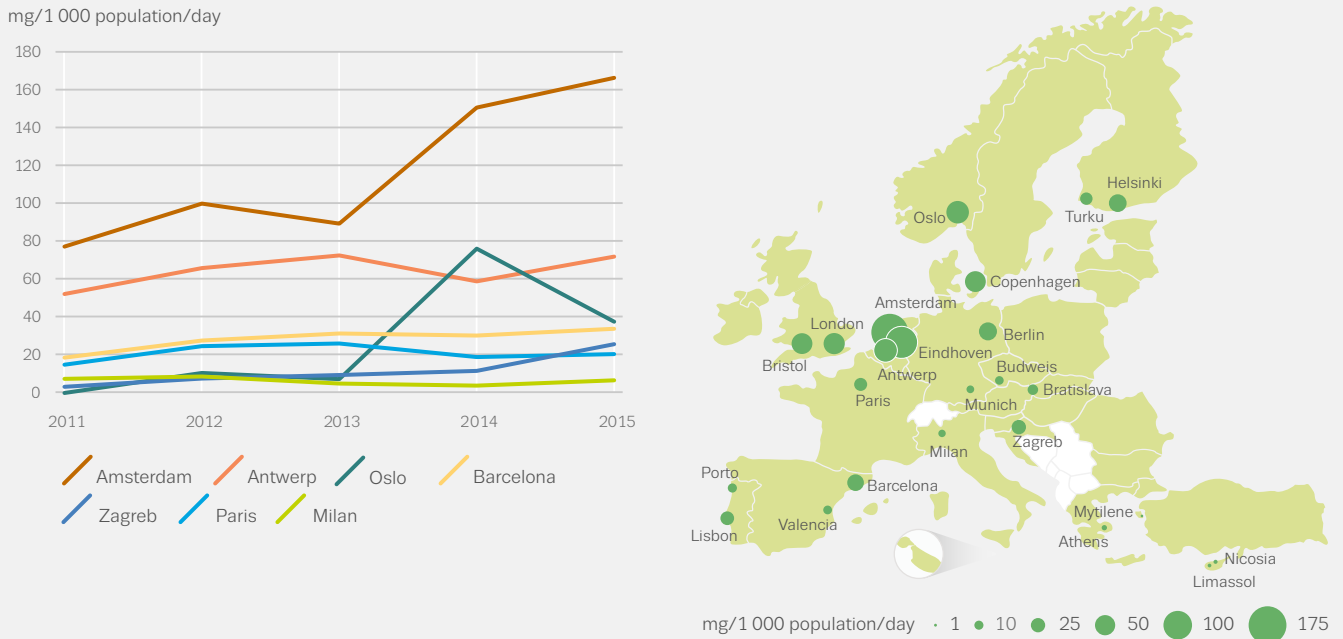
In recent years, monitoring sources based in a number of countries have been signalling new developments within Europe’s MDMA market, including reports of increased use.

Most European surveys have historically collected data on ecstasy rather than MDMA use, although this is now changing. It is estimated that 2.1 million young adults (15–34) used MDMA/ecstasy in the last year (1.7 % of this age group), with national estimates ranging from 0.3 % to 5.5 %. Among young people using MDMA in the last year, the ratio of males to females is 2.4 to 1.

Until recently, in many countries, MDMA prevalence has been on the decline from peak levels attained in the early to mid-2000s. This appears now to be changing. Among the countries that have produced new surveys since 2013, results point to an overall increase in Europe, with nine countries reporting higher estimates and three reporting lower estimates than in the previous comparable survey. Where data exist for a more robust analysis of trends in

FIGURE 2.5

MDMA residues in wastewater in selected European cities: trends and most recent data



NB: Mean daily amounts of MDMA in milligrams per 1 000 population. Map: from sampling over a one-week period in 2015. Source: Sewage Analysis Core Group Europe (SCORE).

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

A 2015 multi-city analysis found the highest mass loads of MDMA in the wastewater of Belgian and Dutch cities (Figure 2.5). In most cities, wastewater MDMA loads were higher in 2015 than in 2011, with sharp increases observed in some cities, which may be related to the increased purity of MDMA or increased availability and consumption of the drug.

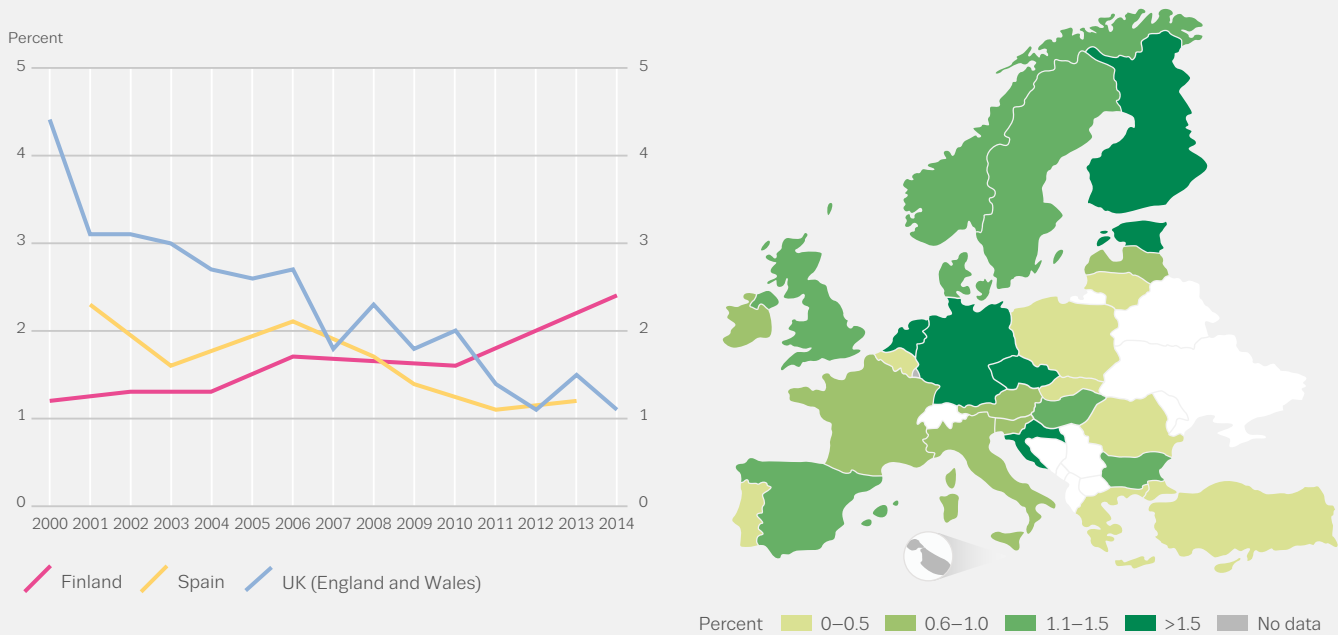
MDMA is often taken alongside other substances, including alcohol. Typically, surveys of young people who regularly attend nightlife events indicate higher levels of drug use compared with the general population. This is particularly the case for MDMA, which has historically been closely linked with nightlife settings and especially with electronic dance music. Current indications suggest that in higher-prevalence countries, the use of MDMA is no longer a niche or subcultural drug; it is not limited to dance clubs and parties, but is used by a wider range of young people in mainstream nightlife settings such as bars and house parties.

MDMA use is rarely cited as a reason for entering specialised drug treatment. In 2014, MDMA was reported by less than 1 % (almost 800 cases) of first-time treatment entrants in Europe.

MDMA is often taken alongside other substances

FIGURE 2.6

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



Amphetamines use: divergent national trends

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

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

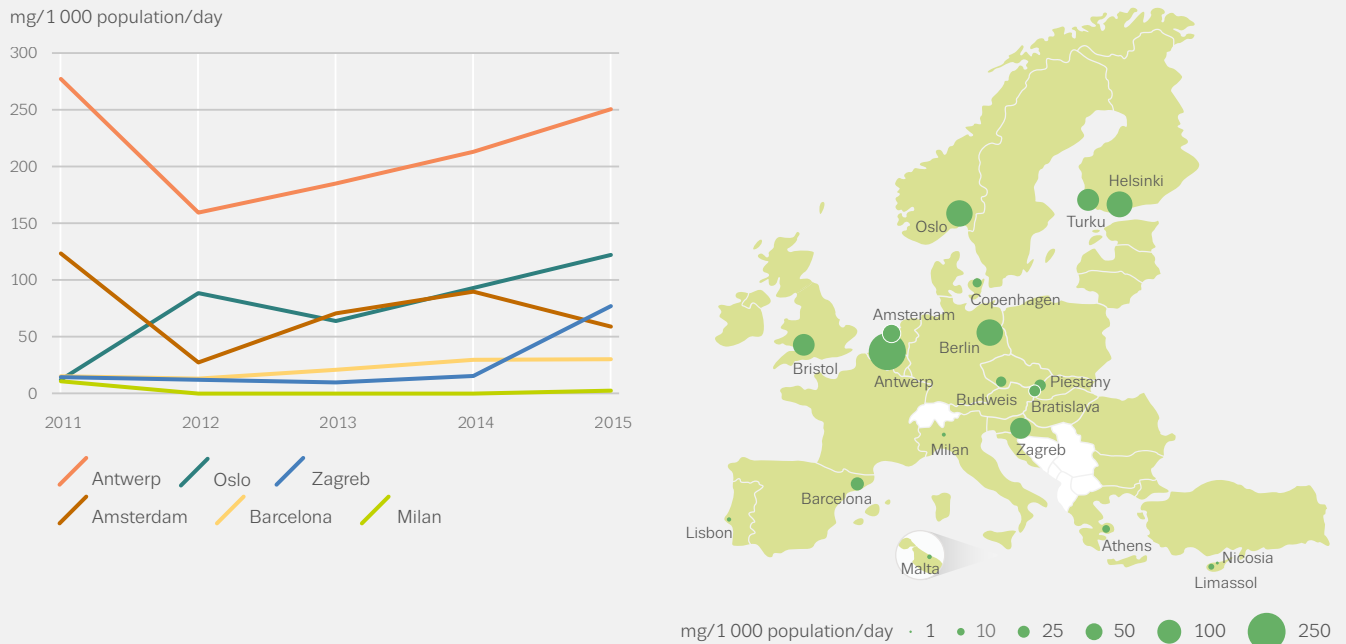
An estimated 1.3 million (1.0 %) young adults (15–34) used amphetamines during the last year, with the most recent national prevalence estimates ranging from 0.1 % to 2.9 %. The available data suggest that since around 2000, most European countries have experienced a relatively stable situation in respect to trends in use. Of the countries that have produced surveys since 2013, seven reported higher estimates, one reported a stable trend and four reported lower estimates than in the previous comparable survey. Although not comparable with earlier surveys, the Netherlands recently reported a prevalence of 2.9 % among young adults.

In the limited number of countries where it is possible to analyse longer term statistically significant trends, both Spain and the United Kingdom show a decrease in prevalence since 2000 (Figure 2.6). In contrast, Finland has shown a steady increase in prevalence over the same period and now reports one of the highest levels in Europe.

Analysis of municipal wastewater carried out in 2015 found amphetamines at appreciable levels in cities across Europe. The mass loads of amphetamine varied considerably, with the highest levels reported in cities in the north of Europe (see Figure 2.7). Amphetamine was found at much lower levels in cities in the south of Europe. The highest mass loads of methamphetamine were found in cities in the Czech Republic, Slovakia and Norway. Overall, the data from 2011 to 2015 showed relatively stable trends for both drugs.

FIGURE 2.7

Amphetamine residues in wastewater in selected European cities: trends and most recent data



NB: Mean daily amounts of amphetamine in milligrams per 1 000 population. Map: from sampling over a one-week period in 2015. Source: Sewage Analysis Core Group Europe (SCORE).

Treating amphetamine users: rising demand

Problems related to long-term, chronic and injecting amphetamine use have, historically, been most evident in northern European countries. In contrast, long-term methamphetamine problems have been most apparent in the Czech Republic and Slovakia. Recent estimates of high-risk use of methamphetamine are available for the Czech Republic and Cyprus. In the Czech Republic, high-risk methamphetamine use among adults (15–64) was estimated at around 0.51 % for 2014, with a marked increase in use, mainly injecting, observed between 2007 and 2014 (from around 20 000 users to over 36 000). The estimate for Cyprus is 0.02 % or 127 users in 2014. For Norway, in 2013, high-risk use of amphetamine and methamphetamine is estimated at 0.33 % or 11 200 adults. Users of amphetamines are likely to make up the majority of the estimated 2 177 (0.17 %) high-risk stimulant users reported by Latvia, down from 6 540 (0.46 %) in 2010.

Injection of methamphetamine alongside use of other stimulants and GHB (gamma-hydroxybutyrate) continues to be reported in a number of countries among small groups of men who have sex with men. These so-called slamming practices are a concern because of the combination of risk-taking in both drug use and sexual behaviours.

Approximately 32 000 clients entering specialised drug treatment in Europe in 2014 reported amphetamines as their primary drug, of whom around 13 000 were first-time clients. Primary amphetamine users account for a sizeable proportion of reported first-time treatment entrants in Bulgaria, Germany, Latvia, Hungary, Poland and Finland. Treatment entrants reporting primary methamphetamine use are concentrated in the Czech Republic and Slovakia, which together account for almost 95 % of the 8 700 methamphetamine clients in Europe. Overall, Europe has seen a 50 % increase in the number of first-time entrants for primary use of amphetamines since 2006, largely driven by increases in Germany and, to a lesser extent, the Czech Republic.

Use of ketamine, GHB and hallucinogens

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

The recreational use of ketamine and GHB (including its precursor GBL, gamma-butyrolactone) has been reported among subgroups of drug users in Europe for the last two decades. Where they exist, national estimates of the prevalence of GHB and ketamine use in both adult and

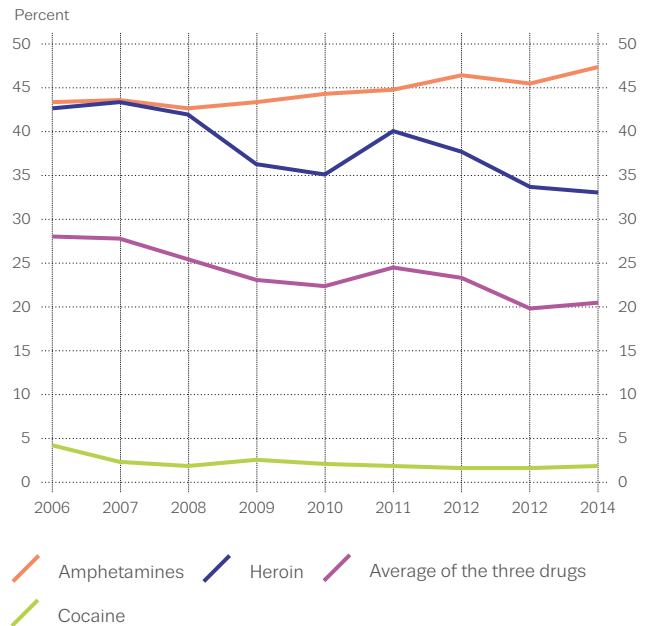
FIGURE 2.10

Injecting drug use: heroin in decline

Injecting drug use is most commonly associated with opioids, although in a few countries, the injection of stimulants such as amphetamines or cocaine is a major problem. The injection of synthetic cathinones, although not a widespread phenomenon, continues to be reported in some specific populations, including opioid injectors, drug treatment clients in some countries and small populations of men who have sex with men. Recent estimates of the prevalence of injecting drug use are available for 16 countries, where they range from less than 1 to more than 9 cases per 1 000 population aged 15–64.

Among first-time clients entering drug treatment in 2014 with heroin as their primary drug, 33 % reported injecting as their main route of administration, down from 43 % in 2006 (Figure 2.10). In this group, levels of injecting vary between countries, from 11 % in Spain to more than 90 % in Latvia and Romania. Among first-time clients with amphetamines as their primary drug, 47 % report injecting as their main route of administration, with a small overall increase since 2006. More than 70 % of this group are from the Czech Republic and users of methamphetamine. Taking the main three injected drugs together, among first-time entrants to treatment in Europe, injecting as the main route of administration has declined from 28 % in 2006 to 20 % in 2014.

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



Injecting drug use is most commonly associated with opioids

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EMCDDA publications

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Assessing illicit drugs in wastewater: advances in wastewater-based drug epidemiology, Insights.

Recent changes in Europe's MDMA/ecstasy market, Rapid communication.

2015

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

2014

Exploring methamphetamine trends in Europe, EMCDDA Papers.

Injection of cathinones, Perspectives on Drugs.

2013

Characteristics of frequent and high-risk cannabis users, Perspectives on Drugs.

Trends in heroin use in Europe — what do treatment demand data tell us?, Perspectives on Drugs.

2012

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

Fentanyl in Europe. EMCDDA Trendspotter study.

Prevalence of daily cannabis use in the European Union and Norway, Thematic paper.

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Problem amphetamine and methamphetamine use in Europe, Selected issue.

Trends in injecting drug use in Europe, Selected issue.

2009

Polydrug use: patterns and responses, Selected issue.

2008

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

EMCDDA and ESPAD joint publications

2012

Summary of the 2011 ESPAD report.

All publications are available at
www.emcdda.europa.eu/publications

3

**Illicit drug use is a recognised
contributor to the global
burden of disease**

Drug-related harms and responses

Illicit drug use is a recognised contributor to the global burden of disease. Chronic and acute health problems are associated with the use of illicit drugs, and these are compounded by various factors including the route of administration, individual vulnerability and the social context in which drugs are consumed. Chronic problems include dependence and drug-related infectious disease, while there is a range of acute harms, some of which depend on the drug consumed, with drug overdose the best documented of these. Although relatively rare, the use of opioids still accounts for much of the morbidity and mortality associated with drug use. Risks are elevated through injecting drug use. In comparison, although the health problems associated with cannabis use are clearly lower, the high prevalence of use of this drug may have implications for public health. Commenting on the harms linked to the use of new psychoactive substances is difficult because of both the number of substances in this group and the lack of information on them.

Monitoring drug-related harms and responses

Drug-related infectious diseases and mortality and morbidity associated with drug use are the principal harms monitored systematically by the EMCDDA. These are complemented by more limited data on acute drug-related hospital presentations and data from the EU Early Warning System, which monitors harms associated with new psychoactive substances. Further information is available online under Key epidemiological indicators, the Statistical Bulletin and the Early Warning System.

Information on health and social responses to drug use and related harms are provided to the EMCDDA by Reitox national focal points and expert working groups. Expert ratings provide supplementary information on the availability of interventions where more formalised datasets are unavailable. This chapter is also informed by reviews of the scientific evidence on the effectiveness of public health interventions. Supporting information can be found on the EMCDDA website in the Health and social responses profiles and the Best practice portal.

Drug prevention and early intervention approaches aim to prevent drug use and related problems, while drug treatment, including both psychosocial and pharmacological approaches, represents the primary response to dependence. Some core interventions, such as opioid substitution treatment and needle and syringe programmes, were developed in part as a response to injecting opioid use and related problems, particularly the spread of infectious diseases and overdose deaths.

| Cannabis harms: new research insights

While research frequently highlights associations between drug use and various harms, causality is more difficult to demonstrate. As Europe's most prevalent drug, harms associated with cannabis use may have an impact at a population level. A recent international (WHO) review analysed the evidence around cannabis-related harms. It concluded that, while a causal relationship between the consumption of cannabis and health and social consequences is difficult to establish, some associations can be derived from observational studies. In terms of adverse effects of chronic cannabis use, regular and long-term cannabis users were found to have twice the risk of experiencing psychotic symptoms and disorders, a higher risk of developing respiratory problems and could develop a dependence syndrome. Regular cannabis use in adolescence was linked with increased risk of being diagnosed with schizophrenia, and if use continued throughout young adulthood, it appeared to be associated with intellectual impairment. Nevertheless, the role of pre-existing somatic and mental health conditions and other confounding factors may play a role, and this is a topic warranting further research.

| Prevention: family-based programmes

The use of cannabis by young people, often alongside the use of alcohol and tobacco, is one of the focuses for prevention strategies in Europe. The prevention of drug use and drug-related problems among young people encompasses a wide range of approaches. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups who may be at greater risk of developing drug use problems, and indicated prevention focuses on at-risk individuals.

Many drug prevention activities take place in school settings, where a relatively robust evidence base exists for some approaches. Similarly, interventions that target families have been positively evaluated in the prevention of a range of problem behaviours including drug use.

Family-based prevention programmes typically train parents to support their children to achieve age-specific developmental outcomes (including impulse control, social competence and gratification delay) that are associated with reduced risk of substance use and other behavioural problems. Family-based universal prevention is targeted at all families in the population, with interventions focusing on different stages of a child's development, whereas selective programmes address marginalised and vulnerable families, including those affected by parental substance use problems. Although prevention interventions for vulnerable families exist in the majority of countries, expert ratings from 2013 indicate that their coverage is often limited.

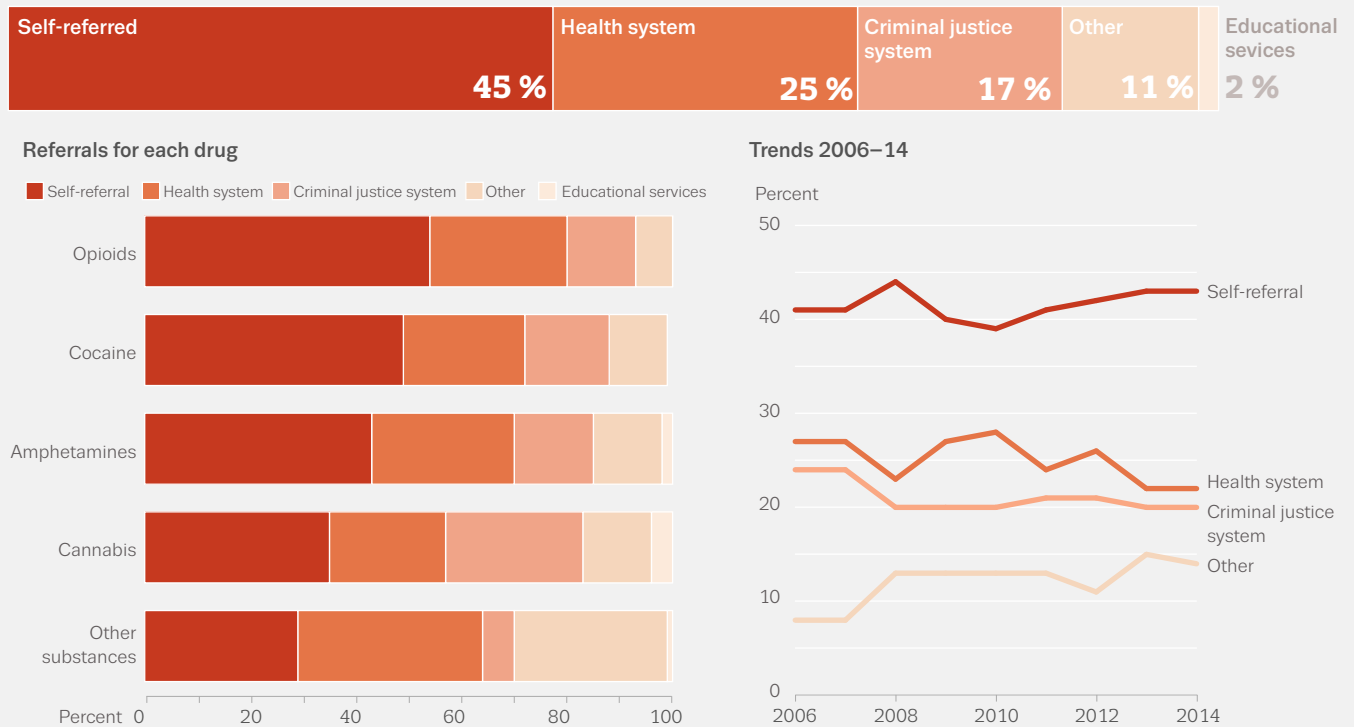
Relatively little is known about the contents of many family-based interventions. One exception is the Strengthening Families Programme, which provides training in parenting skills, and has now been implemented in 13 European countries. This internationally recommended programme also seeks to remove obstacles to participation for vulnerable parents, by providing transport and childcare.

New approaches have also been developed that are time-limited and require fewer resources to implement. The EFFEKT programme for example, consisting of a few short sessions, has shown that improved parental monitoring and rule-setting can be effective in curbing alcohol use and improving impulse control among young people in the Netherlands and Sweden.

Many drug prevention activities take place in school settings

FIGURE 3.1

Source of referral of clients entering specialised drug treatment in Europe in 2014



NB: 'Self-referral' includes the client, family and friends; 'health system' includes general practitioners, other drug treatment centres and health, medical and social services; 'criminal justice system' includes courts, police and probation. In the trends graph, referrals via educational services are included under 'other'.

Specialised treatment: referral paths

For the relatively small but significant number of individuals who experience problems with their drug use, including dependence, drug treatment is the primary intervention. Ensuring good access to appropriate treatment services is a key policy aim.

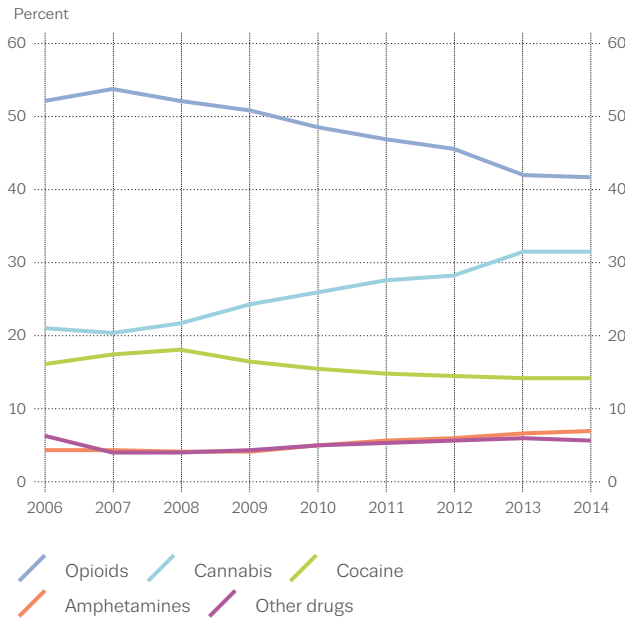
Insight into the paths and routes individuals take into drug treatment is provided by data on sources of referral. In 2014, 45 % of clients entering specialised drug treatment in Europe were either self-referred or referred by a family member, although this varied by drug (see Figure 3.1) and by country. Overall, a quarter of treatment entrants were referred by health services and 17 % by the criminal justice system. Of all treatment clients, cannabis clients were the most likely to be referred by the criminal justice system. In Hungary, around three-quarters (74 %) of cannabis

treatment referrals came from this source. Overall trends in sources of referral have remained largely stable between 2006 and 2014.

In a number of countries, schemes are in place to divert drug offenders away from the criminal justice system and into drug treatment programmes. This may involve a court order to attend treatment or a suspended sentence conditional on treatment, but in some countries diversion is also possible at earlier stages.

FIGURE 3.2

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



Drug treatment: most often in outpatient settings

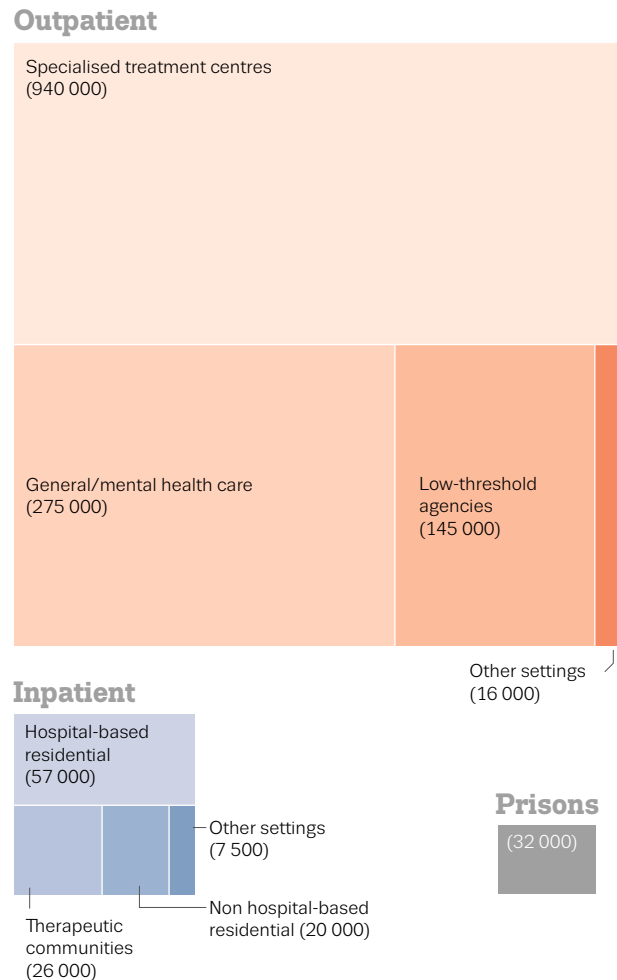
An estimated 1.2 million people received treatment for illicit drug use in the European Union during 2014 (1.5 million including Norway and Turkey). Opioid users represent the largest group undergoing specialised treatment and consume the greatest share of available treatment resources, mainly in the form of substitution treatment. Cannabis and cocaine users are the second and third largest groups entering these services (Figure 3.2), with psychosocial interventions the main treatment modality for these clients. Differences between countries, however, can be very large, with opioid users accounting for up to 88 % of treatment entrants in some countries and less than 10 % in some others.

Most drug treatment in Europe is provided in outpatient settings, with specialised outpatient centres representing the largest provider in terms of number of drug users treated (Figure 3.3). Healthcare centres are the second largest providers. This category includes general practitioners' surgeries, which are important prescribers of opioid substitution treatment in some large countries such as Germany and France. Elsewhere, for example in Slovenia and Finland, mental healthcare centres may play a central role in outpatient treatment provision.

A smaller proportion of drug treatment in Europe is provided in inpatient settings, including hospital-based

FIGURE 3.3

Numbers receiving drug treatment in Europe in 2014, by setting

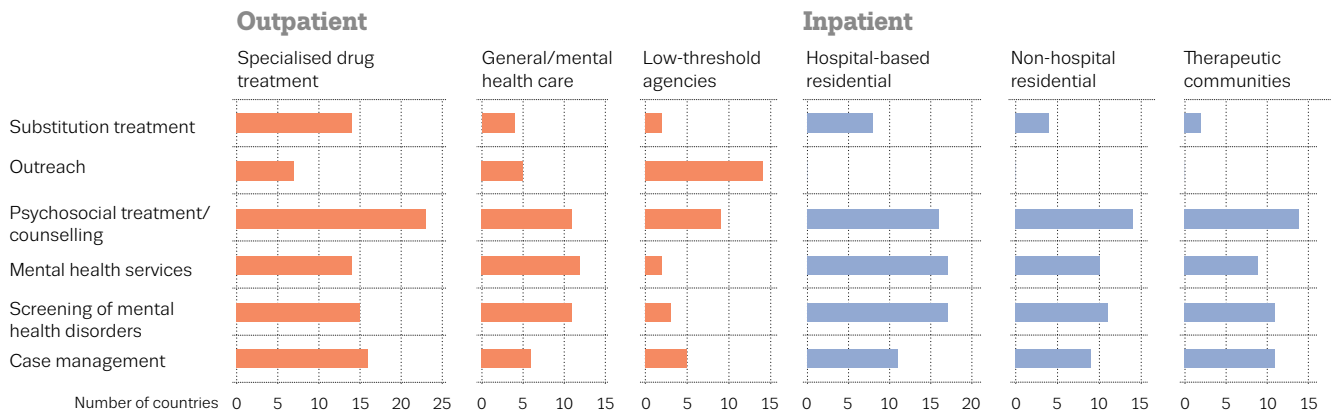


residential centres (e.g. psychiatric hospitals), therapeutic communities and specialised residential treatment centres. The relative importance of outpatient and inpatient provision within national treatment systems varies greatly between countries. Expert opinion can provide an overview of the availability of selected interventions in different treatment settings in Europe (see Figure 3.4).

Increasingly, a wide range of drug prevention and treatment interventions are provided online. Internet-based interventions have the potential to extend the reach and geographical coverage of treatment programmes to people experiencing drug use problems who may not otherwise access specialist drug services.

FIGURE 3.4

Overview of high availability (>75 %) of selected interventions by setting (expert ratings)



Substitution treatment for opioid use problems

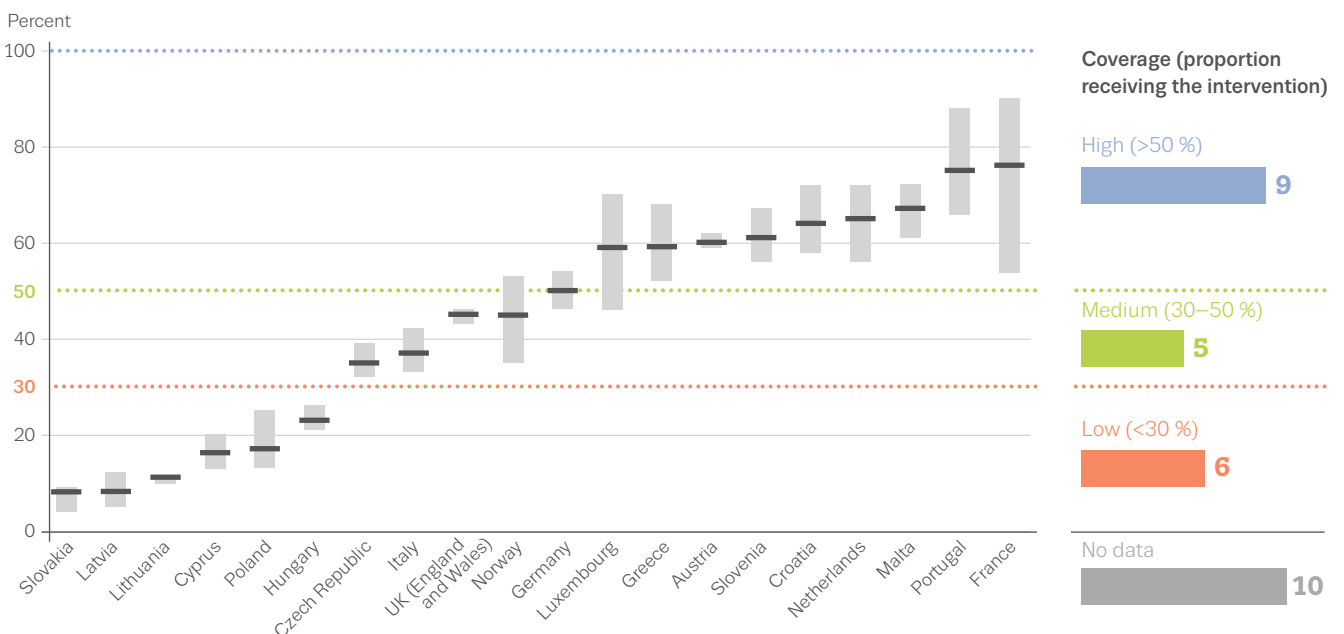
Substitution treatment, typically combined with psychosocial interventions, is the most common treatment for opioid dependence. The available evidence supports this approach, with positive outcomes found in respect to treatment retention, illicit opioid use, reported risk behaviour and drug-related harms and mortality.

including Norway and Turkey), and numbers have fallen by around 50 000 since 2010. Estimates of opioid users would suggest that overall at least 50 % receive substitution treatment. However, this estimate must be treated with caution for methodological reasons and there are considerable national differences (Figure 3.5).

An estimated 644 000 opioid users received substitution treatment in the European Union in 2014 (680 000

FIGURE 3.5

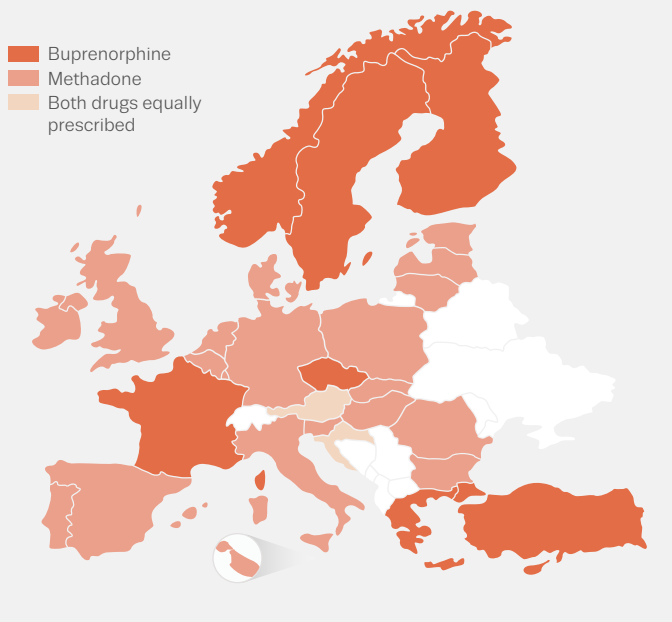
Percentage of high-risk opioid users receiving substitution treatment (estimate)



NB: Data displayed as point estimates and uncertainty intervals.

FIGURE 3.6

Principal opioid substitution drug prescribed



Methadone is the most commonly prescribed opioid substitution drug

Methadone is the most commonly prescribed opioid substitution drug, received by 61 % of substitution clients. A further 37 % of clients are treated with buprenorphine-based medications, which is the principal substitution drug in seven countries (Figure 3.6). Other substances, such as slow-release morphine or diacetylmorphine (heroin), are more rarely prescribed, being received by an estimated 2 % of substitution clients in Europe.

Although less common than substitution treatment, alternative treatment options for opioid users are available in all European countries. In the nine countries for which data are available, between 2 % and 30 % of all opioid users in treatment receive interventions not involving opioid substitution (Figure 3.7).



FIGURE 3.7

Matching treatment provision to client needs

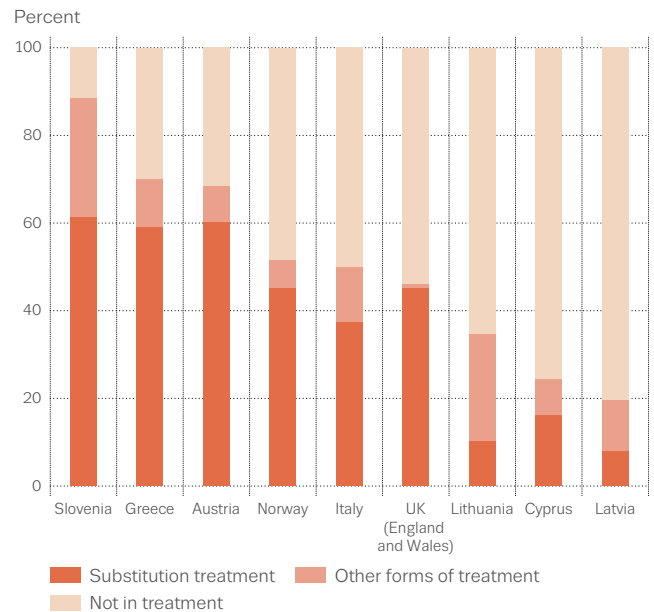
Clients accessing treatment services in Europe have differing needs and often require interventions that have to address a complex range of problems. Ensuring cooperation between drug services and other health and social providers is therefore a key component of an effective response in this area.

As most of those entering drug treatment will be using more than one psychoactive substance, and some will be experiencing problems with multiple substances, drug services assessment and treatment plans that address polydrug use are important. Some combinations of substances may be particularly important to identify because of the high risk they pose — including a greater risk of overdose. One example is the use of opioids in combination with benzodiazepines. Analysis shows that three-quarters of clients entering treatment for problems related to their drug use are formally recorded as using multiple substances with primary opioid, cocaine and amphetamine users most frequently reporting cannabis and alcohol as secondary drugs. In addition, many primary opioid users also report the secondary use of cocaine.

Comorbidity of substance use and mental health disorders refers to the co-occurrence of the two clinical conditions in the same individual. There is also an association between some mental health disorders and substance use disorders. Thus, comorbidity is a challenge for both drug and mental health services. In a recent review, the most frequently identified psychiatric comorbidities among users of illicit substances were major depression, anxiety disorders (mainly panic and post-traumatic stress disorders) and personality disorders (mainly antisocial and borderline). Despite the importance of this issue, establishing the extent of the problem is difficult, as the data available are both limited and heterogeneous.

There are indications that women in drug treatment may have more complex needs, particularly in relation to comorbidity and childcare responsibilities, and require more targeted and gender-sensitive services. While overall women represent only 20 % of specialised treatment entrants (i.e. male to female ratio of 4:1), this difference varies by country, ranging from 5 % to 34 %, and is less marked among first-time entrants. The reasons for lower numbers of women entering drug treatment are various, and may include differences between the sexes in the prevalence of problem use, the likelihood of reporting problem use, and issues of access and appropriateness of service provision.

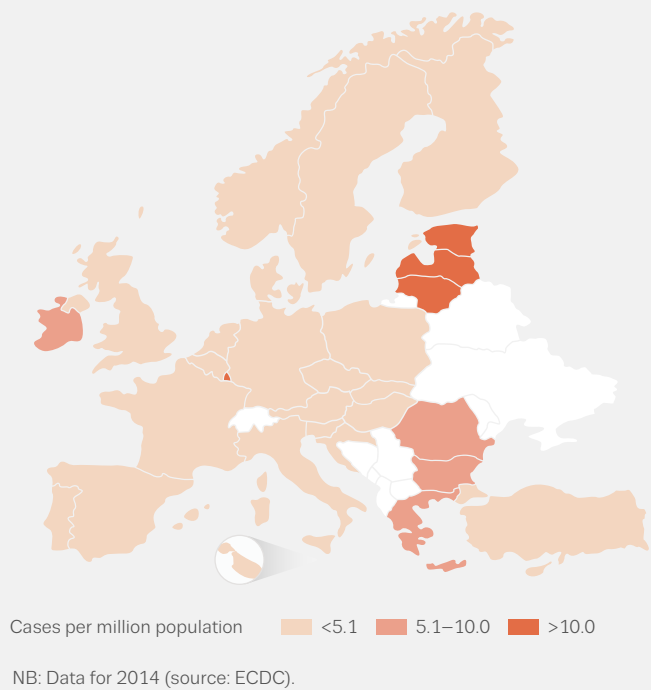
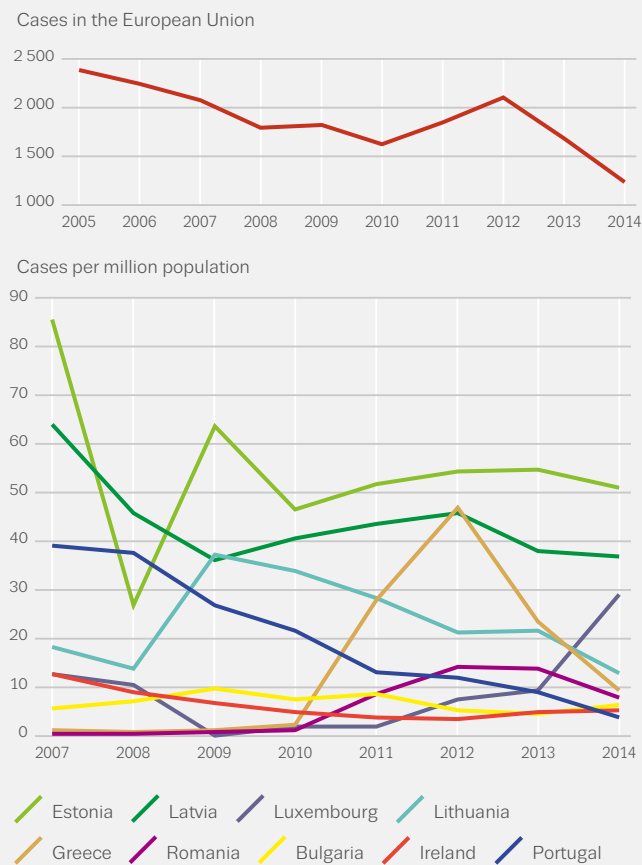
Percentage of high-risk opioid users receiving drug treatment (estimate)



Women in drug treatment may have more complex needs

FIGURE 3.8

Newly diagnosed HIV cases related to injecting drug use: overall and selected trends and most recent data



HIV outbreaks: stimulant injectors

Drug users, and particularly those who inject drugs, are at risk of contracting infectious diseases through the sharing of drug use material and through unprotected sex. Drug injection continues to play a central role in the transmission of blood-borne infections such as the hepatitis C virus (HCV) and, in some countries, the human immunodeficiency virus (HIV). Among all HIV cases notified in Europe where the route of transmission is known, the percentage attributable to injecting drug use remains low and stable (under 8 % for the last decade). Higher rates, however, were reported for Lithuania (32 %), Latvia (31 %), Estonia (28 %) and Romania (25 %).

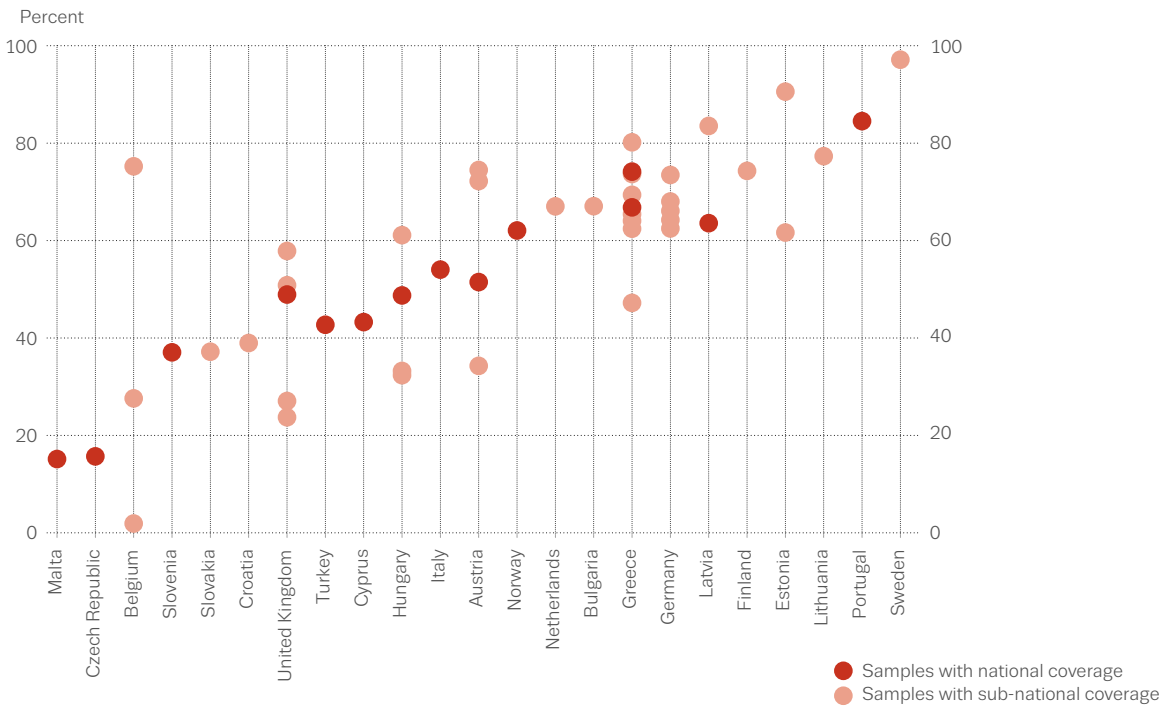
The latest data show that the long-term decline in the number of new HIV diagnoses among injectors in the European Union continues. In 2014, the average rate of newly reported HIV diagnoses attributed to injecting drug use was 2.4 per million population, which is less than half that for 2005 (5.6 per million). Higher rates, however, were reported in a number of countries, particularly Estonia and Latvia. In Greece and Romania, countries that have previously experienced local outbreaks, rates of newly reported diagnoses have declined since 2012 (Figure 3.8).

There were 1 236 newly reported drug injection-related HIV diagnoses in the European Union in 2014, the lowest number reported for more than a decade. Nevertheless, localised outbreaks in new HIV infections among people who inject drugs have been documented in Ireland, the United Kingdom (Scotland) and Luxembourg in 2015. Changes in drug use patterns, particularly increased stimulant injection, and high levels of marginalisation have been common factors in a number of these recent HIV outbreaks.

In 2014, 15 % of new AIDS cases in Europe were attributed to injecting drug use, with the 590 notifications representing just over a quarter of the number reported a decade ago. Early diagnosis is crucial in preventing progression from HIV infection to AIDS, and this is particularly relevant in relation to drug injectors, who are the transmission group with the highest share presenting to health services at a late stage of infection (61 %). Moreover, in some countries such as Greece, Latvia and Romania, where the numbers of new AIDS diagnoses remain at high levels, HIV testing and treatment responses may require strengthening.

FIGURE 3.9

HCV antibody prevalence among injecting drug users, 2013/14



High HCV prevalence among injectors

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

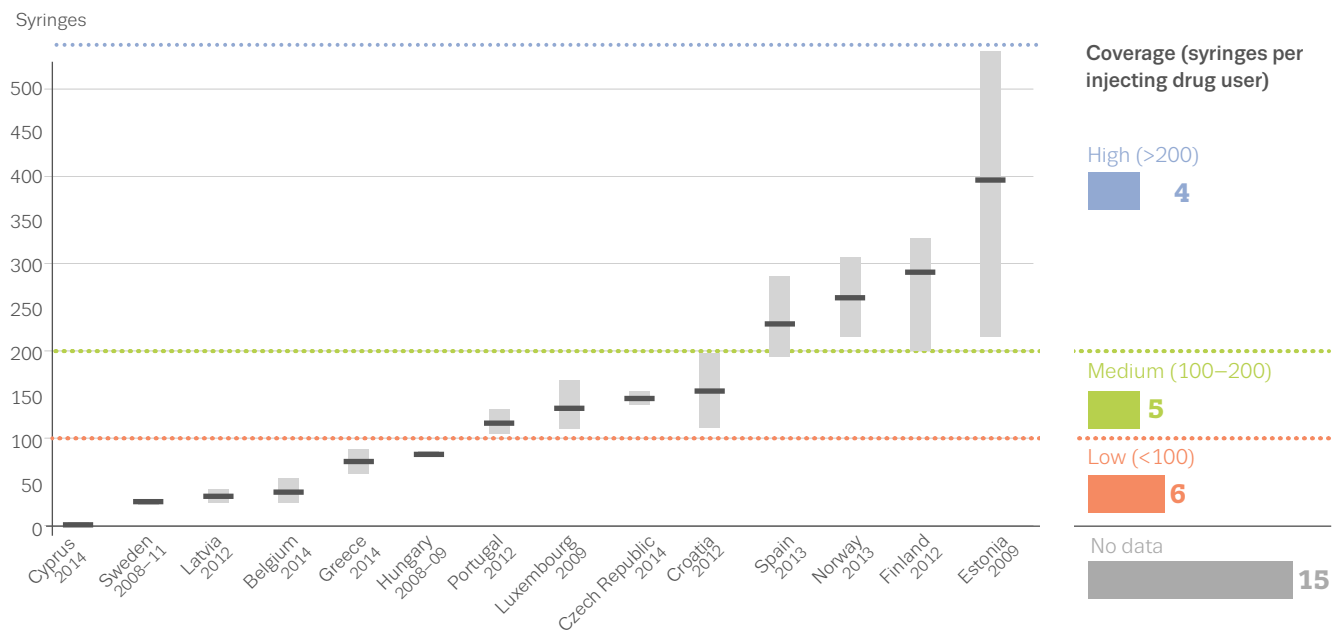
The prevalence of antibodies to HCV, indicating present or past infection, among national samples of injecting drug users in 2013–14 varied from 15 % to 84 %, with 6 of the 13 countries with national data reporting rates in excess of 50 % (Figure 3.9). Among countries with national trend data for the period 2006–14, five countries observed an increasing trend in HCV-antibody prevalence in injecting drug users, while Malta and Norway observed a decrease.

Drug injection is a risk factor for other infectious diseases including hepatitis B, tetanus and botulism. Clusters and sporadic cases of wound botulism among injecting drug users have been reported in Europe, including in Norway and the United Kingdom between 2013 and 2015. Bacterial injection site infections are also common, with a large outbreak of soft tissue infections reported in Scotland in 2015.



FIGURE 3.10

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



NB: Data displayed as point estimates and uncertainty intervals.

Infectious diseases: prevention measures

The main approaches taken to reduce drug-related infectious diseases among people who inject drugs include provision of opioid substitution treatment, provision of injecting equipment, testing, hepatitis C treatment and antiretroviral treatment for HIV.

For injecting opioid users, being in substitution treatment significantly lowers infection risk, with some analyses indicating increasing protective effects when high treatment coverage is combined with high levels of syringe provision.

Evidence shows that needle and syringe programmes can reduce injecting risk behaviour and may therefore reduce the transmission of HIV among people who inject drugs. Almost all countries provide clean injecting equipment at specialised outlets free of charge. However, the geographical distribution of syringe outlets as well as the estimates of numbers of syringes given out varies considerably between countries (Figure 3.10). Information on the provision of syringes through specialised programmes is available from 23 countries, which together report the distribution of around 36 million syringes in 2014. This number is an underestimate, as several large countries, such as France, Germany, Italy and the United Kingdom, do not report full national data on syringe provision.

Testing for and treatment of infectious diseases can help to reduce incidence and prevalence of infections among drug users. Testing can both increase individual awareness of infection status and support earlier treatment uptake. However, stigma and marginalisation as well as limited knowledge about screening and treatment options remain barriers to uptake. Clinical data support the initiation of antiretroviral treatment immediately after diagnosis of HIV infection, in order to prevent any further decline of immune function.

Targeted harm reduction and sexual health interventions are also important when addressing the new patterns of injecting and sexual behaviours reported among small groups of men who have sex with men. Establishing links between drug and sexual health services may be particularly important alongside provision of health education, sterile injecting equipment and, in some cases, pre-exposure prophylaxis with antiretroviral drugs.

| Hepatitis C: new treatments

Prevention measures targeting the transmission of the hepatitis C virus are similar to those for HIV. As HCV infection is highly prevalent among people who inject drugs, reducing the number of people who can transmit the infection, by offering HCV treatment, is an essential component of a comprehensive prevention response. New European guidelines recommend providing HCV treatment to drug users on an individualised basis and delivering it in a multidisciplinary setting. Since 2013, all-oral, interferon-free regimens with direct-acting antiviral agents have been available and are becoming the mainstay of the treatment of HCV infection. These medicines are highly effective, require shorter treatment time and have fewer side-effects than older medicines. Furthermore, treatment with these medicines may be offered in specialised drug services in community settings, which may increase uptake and availability.

The new anti-HCV medicines are expensive compared with the older medicines. In a survey of 21 EU countries in 2015, the EMCDDA found that the average reference cost of three months' treatment with a new medicine was around EUR 60 000, whereas treatment with medicines from the previous generation cost between EUR 17 000 and EUR 26 000. Considering the high prevalence of HCV infection among injecting drug users, ensuring optimum access to promising new medicines continues to be a key challenge for policymakers.

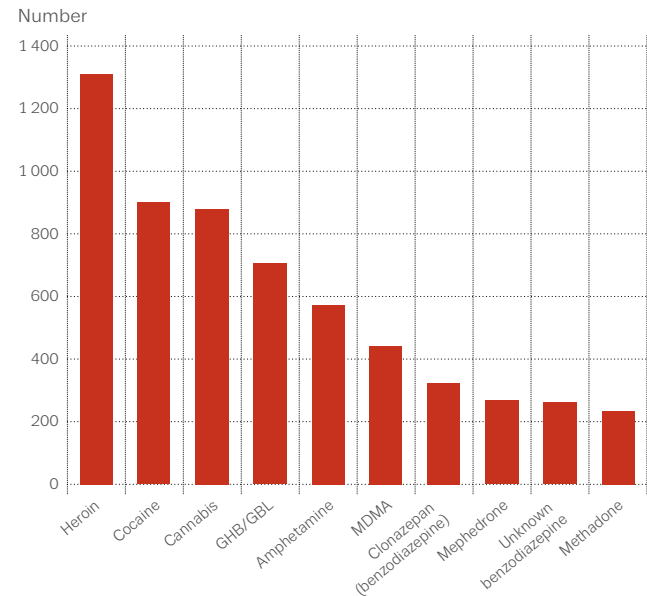
| Prison health: comprehensive response needed

Prisoners report higher lifetime rates of drug use than the general population and more harmful patterns of use, illustrated by recent studies showing that between 6 % and 48 % of prisoners have ever injected drugs. The high lifetime prevalence of drug use makes prisoners a population with complex healthcare needs, and a thorough health assessment upon prison entry is an important intervention. The WHO recommends a package of prevention responses for prisons, including free and voluntary testing for infectious diseases, distribution of condoms and sterile injecting equipment, infectious diseases treatment and treatment of drug dependence.

Many countries have interagency partnerships between prison health services and providers in the community, which ensure delivery of health education and treatment interventions in prison and continuity of care upon prison entry and release. The availability of opioid substitution treatment in prisons is reported by 27 of the 30 countries monitored by the EMCDDA. Overall, it appears that substitution treatment is available to a growing share of the prison population, increasingly reflecting its widespread availability in the community. The provision of clean injecting equipment is less common, with only three countries reporting the existence of syringe programmes in this setting.

FIGURE 3.11

Top 10 drugs recorded in emergency presentations to sentinel hospitals in 2014



NB: Results from 5 409 emergency presentations in 16 sentinel sites in 10 European countries.
Source: European Drug Emergencies Network (Euro-DEN).

Hospital emergencies: a window on acute harms

A unique insight into acute health harms is provided by hospital emergency data. A 2014 analysis by the European Drug Emergencies Network (Euro-DEN), which monitors drug-related emergency presentations in 16 selected (sentinel) hospitals in 10 European countries, found that most of the 5 409 presentations reported were in males (76 %) and young adults (median age 32 years for males and 28 years for females). Heroin was reported in 24 % of the presentations, cocaine in 17 % and cannabis in 16 %.

In many of the presentations, more than one drug was found, with 8 358 drug identifications among the 5 409 presentations (Figure 3.11). Two-thirds of presentations involved the use of established drugs such as heroin, cocaine, cannabis, amphetamine and MDMA; one quarter involved prescription or over the counter drugs (most commonly opioids and benzodiazepines); and 6 % involved new psychoactive substances. Heroin was the most commonly reported drug overall and the most commonly reported opioid (67 % of reported opioids), followed by methadone (12 %) and buprenorphine (5 %), with patterns varying between sites. Over three-quarters of the new psychoactive substance presentations involved a cathinone and two-thirds of these involved mephedrone.

The drugs involved in emergency presentations differed between sites, reflecting local patterns of risky drug use. For example, emergencies related to heroin and amphetamine were the most common presentations in Oslo, whereas presentations related to GHB/GBL, cocaine, mephedrone and MDMA were predominant in London, mirroring the local patterns of use associated with recreational nightlife settings.

The majority (79 %) of those presenting with a drug-related problem were discharged from hospital within 12 hours. In total, 27 deaths were recorded (0.5 % of all presentations), most of which involved opioids.

Few countries have national monitoring systems in place that allow an analysis of trends in drug-related acute intoxications. Of the countries with longer term monitoring, reports show acute heroin emergencies are increasing in the United Kingdom, while decreasing in the Czech Republic and Denmark. These latter two countries have reported an increase in the number of emergencies related to other opioids. A continued increase in acute emergencies related to cannabis has been observed in Spain, while the Netherlands reports increases in MDMA intoxications presenting at first aid stations at festivals, and in acute intoxications related to the new psychoactive substance 4-FA (4-fluoroamphetamine).

A unique insight into acute health harms is provided by hospital emergency data

| New drugs: health challenges

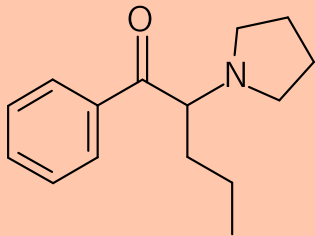
New substances have been associated with a range of serious harms in Europe including acute poisonings and deaths. There are also harms associated with patterns of drug injection, in particular with stimulants such as mephedrone, alpha-PVP, MDPV and pentedrone. Mass poisonings, although rare, can place heavy demands on healthcare systems. In one such incident, reported in Poland in 2015, synthetic cannabinoids were linked to over 200 hospital emergency presentations in less than a week.

Since early 2014, serious harms associated with the use of a new substance have led to 34 public health alerts being issued by the EMCDDA to members of the EU Early Warning System. Over this period, seven new substances were risk-assessed. Most recently, concerns have arisen around new opioids such as acetylfentanyl, which was subject to an EMCDDA–Europol joint report in 2015, after being associated with 32 deaths. Many fentanyl derivatives are highly potent, and may be sold as heroin to unsuspecting users, thus posing a high risk of overdose and death.

| Responding to new drugs: key interventions

In general, existing prevention, treatment and harm reduction interventions for problems associated with established drugs are reported to be adequate for, or could be easily adapted to, the needs of users of new drugs. However, problems associated with the use of new psychoactive substances and other drugs such as GHB, ketamine and mephedrone, pose specific challenges in a number of settings, such as prisons, sexual health clinics and low-threshold drug services. Reports of challenges encountered in delivering interventions targeting these substances include accessing hard to reach drug-using populations (e.g. men who have sex with men), managing chaotic injecting behaviours among vulnerable groups, and supporting acute psychotic episodes linked with use of new drugs among prisoners. In these particular cases, the development of interventions that focus specifically on use of new drugs and related health harms are important, including for example, targeted harm reduction material and advice, and specialised treatment guidelines.

Risk assessment of alpha-PVP



In November 2015, a European-level risk assessment was conducted on alpha-PVP (alpha-pyrrolidinopentiophenone). Alpha-PVP is a synthetic cathinone and a potent psychostimulant, and is similar to MDPV. It has been available on the drug market in the European Union since at least February 2011 and has been detected in all 28 Member States. Alpha-PVP was detected in 191 acute intoxications and 115 deaths. In 20 % of the deaths, alpha-PVP was reported as either the cause of death or a contributor to the death; in five of these cases, alpha-PVP was the only substance detected.

Overdose deaths: recent increases

Drug use is a recognised cause of avoidable mortality among European adults. Studies on cohorts of high-risk drug users commonly show overall mortality rates in the range of 1–2 % per year. Overall, opioid users in Europe are 5 to 10 times more likely to die than their peers of the same age and gender. Increased mortality among opioid users is primarily related to overdose, but other causes of death indirectly related to drug use, such as infections, accidents, violence and suicide, are also important.

In Europe, drug overdose continues to be the main cause of death among drug users, and over three-quarters of overdose victims are male (78 %). Most EU countries reported an increasing trend in overdose deaths from 2003 until around 2008/09, when overall levels first began to decline. Caution is required when interpreting overdose data, and especially the EU cumulative total, for reasons which include systematic under-reporting in some countries and registration processes that result in reporting delays. Annual estimates therefore represent a provisional minimum value. For 2014, it is estimated that at least 6 800 overdose deaths occurred in the European Union. This represents an increase from the revised 2013 figure and, as in previous years, the United Kingdom (36 %) and Germany (15 %) together account for a large part of the total. Increases are evident in the most recent data from a number of countries with relatively robust reporting

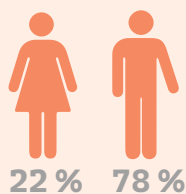
systems, including Ireland, Lithuania and the United Kingdom. A marked upward trend is also observed in Sweden, though it may be partly due to the inclusion of some cases aged 50 and over not related to illicit drug use. Turkey is also showing large increases, but this may partly reflect improved reporting practices.

Reflecting the ageing nature of Europe's opioid-using population, who are at greatest risk of drug overdose death, the reported number of overdose deaths increased among older age groups between 2006 and 2014, while those among younger age groups decreased. However, there has recently been a slight increase in the number of overdose deaths reported among those aged under 25 in some countries.

Opioid users in Europe are 5 to 10 times more likely to die than their peers

DRUG-INDUCED DEATHS

Characteristics



Mean age at death

38

Deaths with opioids present

82 %

Age at death



Trends in overdose deaths

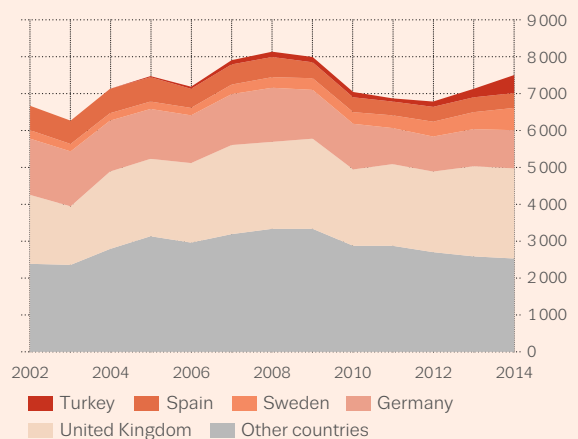
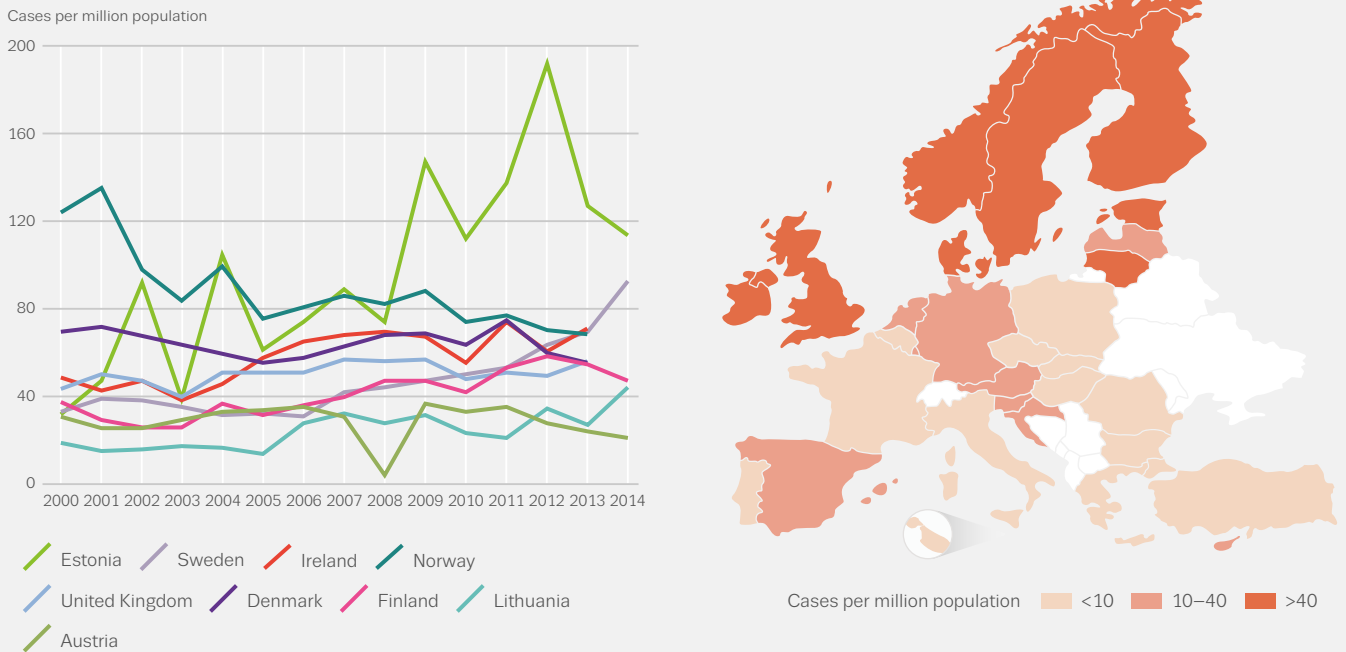


FIGURE 3.12

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



NB: Trends in the nine countries reporting the highest values in 2014 or 2013.

Heroin or its metabolites are present in the majority of fatal overdoses reported in Europe, often in combination with other substances. Other opioids including methadone, buprenorphine, fentanyl and tramadol are also regularly found in toxicological reports, and these substances are associated with a substantial share of overdose deaths in some countries. In the United Kingdom (England and Wales) for example, out of the 1 786 deaths registered in 2014 where opioids were mentioned, methadone was recorded in 394 and tramadol in 240. Among the other countries reporting the occurrence of opioids other than heroin in fatal overdoses are France and Ireland (mainly methadone), and Finland, where buprenorphine was mentioned in 75 cases in 2014.

Stimulants such as cocaine, amphetamines, MDMA and cathinones are implicated in a smaller number of overdose deaths in Europe, although their significance varies by country. In the United Kingdom (England and Wales), deaths involving cocaine increased from 169 in 2013 to 247 in 2014. In Spain, where cocaine-related deaths have been stable for some years, the drug continued to be the second most often cited drug in overdose deaths in 2013 (236 cases).

Mortality rates highest in northern Europe

For 2014, the mortality rate due to overdoses in Europe is estimated at 18.3 deaths per million population aged 15–64. National mortality rates vary considerably and are influenced by factors such as prevalence and patterns of drug use and methodological issues such as under-reporting and coding practices. Rates of over 40 deaths per million were reported in 8 countries, with the highest rates reported in Estonia (113 per million), Sweden (93 per million) and Ireland (71 per million) (Figure 3.12). The most recent data show varying trends.

Preventing overdoses and drug-related deaths

Reducing fatal drug overdoses and other drug-related deaths is a major public health challenge in Europe. Targeted responses in this area focus either on preventing the occurrence of overdoses, or on improving the likelihood of surviving an overdose. Drug treatment, particularly opioid substitution treatment, prevents overdoses and reduces the mortality risk of drug users in treatment. Supervised drug consumption facilities aim both to prevent overdoses from happening and to ensure professional support is available if an overdose occurs. Six countries currently provide such facilities — around 70 in total.

Naloxone is an opioid antagonist medication that can reverse opioid overdose and is used in hospital emergency departments and by ambulance personnel. In recent years, there has been a growth in the provision of 'take-home' naloxone to opioid users, their partners, peers and families, alongside training in recognising and responding to overdose. Naloxone has also been made available for use by staff of services that regularly come into contact with drug users. A recent European review found that take-home naloxone programmes exist in eight European countries. Naloxone kits are generally provided by drug and health services in the form of pre-filled syringes, although in Norway and Denmark an adaptor allows naloxone to be administered intra-nasally. A recent systematic review of the effectiveness of take-home naloxone found evidence that educational and training interventions with provision of take-home naloxone decrease overdose-related mortality. Some populations with an elevated risk of overdose, such as recently released prisoners, may particularly benefit. A recent Scottish evaluation of the national naloxone programme found that it was associated with a 36 % reduction in the proportion of opioid-related deaths that occurred within a month of prison release.

Demand reduction services: quality standards

As demand reduction services have become widespread, increasing focus has been placed on service quality, culminating in the adoption of 'Minimum quality standards in drug demand reduction in the European Union' by the EU Council of Ministers in September 2015. Sixteen standards for prevention, treatment, harm reduction and social reintegration set minimum quality benchmarks for interventions. The newly adopted standards represent a major development in the drugs field at EU level, bringing together expert knowledge and political decision-making across 28 countries. The standards reinforce the need to base interventions on evidence and to provide staff with appropriate training. They also facilitate the sharing of best practice at a European level and promote knowledge exchange.

Understanding costs of drug-related actions

Understanding the costs of drug-related actions is an important aspect of policy evaluation. Nevertheless, the information available on drug-related public expenditure in Europe, at both local and national level, remains sparse and heterogeneous. For the 18 countries that have produced estimates in the past 10 years, drug-related public expenditure is estimated at between 0.01 % and 0.5 % of gross domestic product (GDP), with health interventions representing between 15 % and 53 % of all drug-related public expenditure.

A recent exercise estimated that the provision of inpatient treatment for drug-related health problems in hospitals represented, on average, 0.013 % of GDP in the 15 countries with available data. However, this proportion differed considerably across countries. To provide a more comprehensive estimate of the costs of treating drug-related health problems in hospitals, more systematic recording of emergency presentations would be required.

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EMCDDA publications

2016

Comorbidity of substance use and mental disorders, Perspectives on Drugs.

Preventing opioid overdose deaths with take-home naloxone, Insights.

2015

Comorbidity of substance use and mental disorders in Europe, Insights.

Drug-related infectious diseases in Europe. Update from the EMCDDA expert network, Rapid communications.

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

Preventing fatal overdoses: a systematic review of the effectiveness of take-home naloxone, EMCDDA Papers.

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Drug consumption room, Perspectives on Drugs.

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MT-45 [Council Decision 2015/1873/EU].
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Health and social responses for methamphetamine users in Europe, Perspectives on Drugs.

Internet-based drug treatment, Perspectives on Drugs.

Risk assessment reports
MDPV [Council Decision 2015/1875/EU].
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Can mass media campaigns prevent young people from using drugs?, Perspectives on Drugs.

Emergency health consequences of cocaine use in Europe, Perspectives on Drugs.

Drug prevention interventions targeting minority ethnic populations, Thematic papers.

Hepatitis C treatment for injecting drug users, Perspectives on Drugs.

North American drug prevention programmes: are they feasible in European cultures and contexts?, Thematic papers.

Preventing overdose deaths in Europe, Perspectives on Drugs.

2012

Drug demand reduction: global evidence for local actions, Drugs in focus.

Guidelines for the evaluation of drug prevention: a manual for programme planners and evaluators (second edition), Manuals.

New heroin-assisted treatment, Insights.

Prisons and drugs in Europe: the problem and responses, Selected issues.

Social reintegration and employment: evidence and interventions for drug users in treatment, Insights.

2011

European drug prevention quality standards, Manuals.

Guidelines for the treatment of drug dependence: a European perspective, Selected issues.

Risk assessment report Mephedrone [Council Decision 2010/759/EU].

EMCDDA and ECDC joint publications

2011

ECDC and EMCDDA guidance. Prevention and control of infectious diseases among people who inject drugs.

All publications are available at
www.emcdda.europa.eu/publications

Annex

National data for estimates of drug use prevalence including high-risk opioid use, substitution treatment, treatment entry, injecting drug use, drug-induced deaths, drug-related infectious diseases, syringe distribution and seizures. The data are drawn from and are a subset of the EMCDDA Statistical Bulletin 2016, where notes and meta-data are available. Data refer to 2014 unless otherwise indicated.

TABLE A1

OPIOIDS

Country	High-risk opioid use estimate		Entrants into treatment during the year						Clients in substitution treatment
			Opioids clients as % of treatment entrants			% opioids clients injecting (main route of administration)			
			All entrants	First-time entrants	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants	
Year of estimate	cases per 1 000	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	count	
Belgium	–	–	28.9 (3 079)	11.5 (434)	37.5 (2 352)	18.4 (541)	12 (51)	19.3 (431)	17 026
Bulgaria	–	–	84.8 (1 530)	64.5 (207)	96 (932)	73 (772)	69.9 (116)	75.5 (580)	3 414
Czech Republic	2014	1.4–1.8	17 (1 720)	7 (333)	25.9 (1 387)	82.6 (1 412)	79.8 (264)	83.2 (1 148)	4 000
Denmark	–	–	17.5 (663)	7.1 (102)	26.3 (502)	33.9 (193)	23 (20)	–	2 600
Germany	2013	2.7–3.2	34.9 (29 655)	13.1 (3 304)	44 (26 351)	34.1 (11 225)	32.2 (1 460)	34.4 (9 765)	77 500
Estonia	–	–	90 (253)	89.5 (51)	97.3 (179)	78.8 (197)	64.7 (33)	83.2 (149)	919
Ireland	–	–	49.8 (4 745)	27.5 (1 036)	65.5 (3 456)	42.2 (1 908)	35.7 (362)	43.6 (1 441)	9 764
Greece	2014	2.1–2.8	69.2 (3 250)	55.3 (1 060)	78.9 (2 176)	33.4 (1 078)	27.7 (291)	36.3 (786)	10 226
Spain	2013	1.6–2.5	24.8 (12 863)	10.9 (3 066)	42.1 (9 515)	15.8 (1 916)	9.9 (282)	17.7 (1 608)	61 954
France	2013–14	4.4–7.4	30.5 (12 634)	13.8 (1 240)	44.5 (8 662)	19.9 (2 119)	13.8 (155)	22 (1 620)	161 388
Croatia	2010	3.2–4	79.9 (6 241)	19.9 (210)	89 (5 516)	73.3 (4 529)	44.9 (88)	74.3 (4 063)	6 867
Italy	2014	4.6–5.8	56 (28 671)	40.6 (7 416)	64.5 (21 255)	47.2 (13 209)	45.9 (2 992)	58.4 (10 217)	75 964
Cyprus	2014	1.5–2.4	25.4 (271)	11.5 (65)	42.2 (204)	56.8 (154)	50.8 (33)	59.3 (121)	178
Latvia	2014	3.4–7.5	46.2 (382)	24.7 (102)	67.8 (280)	91 (343)	87.1 (88)	92.4 (255)	518
Lithuania	2007	2.3–2.4	88.2 (1 905)	66.6 (227)	92.6 (1 665)	84.4 (1 607)	84.6 (192)	84.3 (1 402)	585
Luxembourg	2007	5–7.6	53.9 (146)	46.4 (13)	51 (100)	50.3 (72)	15.4 (2)	52 (51)	1 121
Hungary	2010–11	0.4–0.5	4.2 (196)	1.6 (51)	9.5 (118)	60.2 (109)	55.1 (27)	63.5 (73)	745
Malta	2014	5.3–6.2	72.8 (1 277)	27.5 (58)	79 (1 219)	63.4 (786)	47.3 (26)	64.1 (760)	1 013
Netherlands	2012	1.1–1.5	10.5 (1 113)	5.7 (346)	16.9 (767)	6.5 (44)	9.3 (18)	5.4 (26)	7 569
Austria	2013	4.9–5.1	50.8 (1 737)	29.2 (435)	67.3 (1 302)	35.9 (479)	23.1 (79)	40.3 (400)	17 272
Poland	2009	0.4–0.7	14.8 (1 061)	4.7 (162)	25 (877)	61.5 (632)	39.1 (61)	65.1 (555)	2 586
Portugal	2012	4.2–5.5	53.8 (1 538)	26.3 (357)	78.8 (1 180)	18.3 (255)	12.5 (39)	19.9 (216)	16 587
Romania	–	–	41.8 (1 094)	15.1 (211)	74 (852)	92.4 (1 007)	85.7 (180)	94 (799)	593
Slovenia	2013	3.4–4.1	75.9 (318)	55.5 (61)	83.1 (250)	32.3 (101)	20.7 (12)	35.7 (89)	3 190
Slovakia	2008	1–2.5	21.9 (543)	12.7 (147)	30.5 (387)	71.2 (376)	55.9 (81)	76.8 (288)	375
Finland	2012	3.8–4.5	57.8 (372)	41.9 (111)	68.9 (261)	79.1 (291)	68.2 (75)	83.7 (216)	3 000
Sweden	–	–	24.7 (7 737)	14.7 (1 680)	30.2 (5 838)	62.1 (175)	20 (4)	47.4 (27)	3 502
United Kingdom	2010–11	7.9–8.4	52.1 (50 592)	23.2 (7 911)	68 (42 045)	33.3 (15 380)	20.8 (1 217)	35 (13 892)	148 868
Turkey	2011	0.2–0.5	70.3 (7 476)	61.1 (3 420)	80.6 (4 056)	30 (2 243)	20.5 (702)	38 (1 541)	28 656
Norway	2013	2–4.2	23 (1 974)	–	–	–	–	–	7 433
European Union	–	–	39.2 (175 586)	18.6 (30 396)	52.6 (139 628)	37.8 (60 910)	31.4 (8 248)	40.4 (50 978)	644 324
EU, Turkey and Norway	–	–	39.6 (185 036)	20.0 (33 816)	53.2 (143 684)	37.4 (63 153)	30.2 (8 950)	40.3 (52 519)	680 413

Data on clients in substitution treatment are for 2014, or most recent year available: Denmark and Finland, 2011; Turkey, 2012; Spain and Malta, 2013; data for Ireland are based on a census taken on 31 December 2013.

TABLE A2

COCAINE

Country	Prevalence estimates				Entrants into treatment during the year					
	General population			School population	Cocaine clients as % of treatment entrants			% cocaine clients injecting (main route of administration)		
	Year of survey	Lifetime, adults (15–64)	Last 12 months, young adults (15–34)	Lifetime, students (15–16)	All entrants	First-time entrants	Previously treated entrants	All clients	First-time entrants	Previously treated entrants
	%	%	%		% (count)	% (count)	% (count)	% (count)	% (count)	% (count)
Belgium	2013	–	0.9	2	17 (1 809)	16.7 (628)	16.9 (1 058)	4.9 (84)	1.2 (7)	6.1 (60)
Bulgaria	2012	0.9	0.3	4	1.6 (29)	6.5 (21)	0.8 (8)	7.1 (2)	0 (0)	25 (2)
Czech Republic	2014	0.9	0.6	1	0.3 (27)	0.3 (12)	0.3 (15)	0 (0)	0 (0)	0 (0)
Denmark	2013	5.2	2.4	2	5.1 (193)	5.8 (84)	5.2 (99)	10.1 (17)	0 (0)	–
Germany	2012	3.4	1.6	3	5.9 (4 978)	5.3 (1 340)	6.1 (3 638)	16.9 (2 650)	7.8 (292)	19.8 (2 358)
Estonia	2008	–	1.3	2	0.4 (1)	–	–	–	–	–
Ireland	2011	6.8	2.8	3	8.7 (828)	11.2 (424)	6.8 (358)	1.4 (11)	0.5 (2)	2.6 (9)
Greece	2004	0.7	0.2	1	5.1 (239)	5.2 (100)	5 (139)	14.7 (35)	6 (6)	21 (29)
Spain	2013	10.3	3.3	3	38.2 (19 848)	38 (10 734)	38.6 (8 726)	2.3 (426)	1.2 (128)	3.5 (291)
France	2014	5.4	2.4	4	6.1 (2 530)	5.4 (489)	7.7 (1 508)	9.9 (224)	2.6 (12)	13.7 (186)
Croatia	2012	2.3	0.9	2	1.7 (132)	3.1 (33)	1.5 (90)	3.1 (4)	3.4 (1)	3.3 (3)
Italy	2014	7.6	1.8	2	23.7 (12 165)	27.4 (5 006)	21.7 (7 159)	6.2 (739)	4.7 (227)	7.4 (512)
Cyprus	2012	1.3	0.6	4	10.3 (110)	7.1 (40)	14.1 (68)	9.2 (10)	7.5 (3)	10.4 (7)
Latvia	2011	1.5	0.3	4	0.7 (6)	1.2 (5)	0.2 (1)	0 (0)	0 (0)	0 (0)
Lithuania	2012	0.9	0.3	2	0.2 (5)	0.3 (1)	0.2 (4)	20 (1)	0 (0)	25 (1)
Luxembourg	–	–	–	–	19.9 (54)	25 (7)	18.4 (36)	34.7 (17)	50 (3)	31.4 (11)
Hungary	2007	0.9	0.4	2	1.8 (86)	1.9 (59)	1.9 (23)	5.9 (5)	1.7 (1)	17.4 (4)
Malta	2013	0.5	–	4	15.9 (279)	40.3 (85)	12.6 (194)	21.9 (60)	9.4 (8)	27.5 (52)
Netherlands	2014	5.1	3.0	2	26.3 (2 791)	22 (1 344)	31.9 (1 447)	0.2 (4)	0.1 (1)	0.3 (3)
Austria	2008	2.2	1.2	–	8.4 (288)	9.7 (145)	7.4 (143)	4.2 (10)	1.6 (2)	7.2 (8)
Poland	2014	1.3	0.4	3	1.4 (98)	1.3 (44)	1.5 (51)	1.1 (1)	0 (0)	2.1 (1)
Portugal	2012	1.2	0.4	4	13.5 (385)	17.5 (237)	9.8 (147)	5.7 (20)	2.8 (6)	10.4 (14)
Romania	2013	0.8	0.2	2	0.8 (21)	1.1 (15)	0.5 (6)	0 (0)	0 (0)	0 (0)
Slovenia	2012	2.1	1.2	3	6 (25)	5.5 (6)	6.3 (19)	62.5 (15)	16.7 (1)	77.8 (14)
Slovakia	2010	0.6	0.4	1	0.9 (23)	1.4 (16)	0.6 (7)	4.3 (1)	6.3 (1)	0 (0)
Finland	2014	1.9	1.0	1	0 (0)	0 (0)	0 (0)	–	–	–
Sweden	2008	3.3	1.2	1	0.9 (284)	1.6 (189)	0.5 (87)	3.1 (1)	0 (0)	0 (0)
United Kingdom (¹)	2014	9.8	4.2	2	12.6 (12 236)	16.9 (5 752)	10.4 (6 399)	1.4 (161)	0.3 (16)	2.3 (144)
Turkey	–	–	–	–	1.3 (134)	1.2 (66)	1.4 (68)	–	–	–
Norway	2014	5.0	2.3	1	1 (84)	–	–	–	–	–
European Union	–	5.1	1.9	–	13.3 (59 470)	16.4 (26 816)	11.8 (31 430)	6.7 (4 498)	2.6 (717)	9.8 (3 709)
EU, Turkey and Norway	–	–	–	–	12.8 (59 688)	15.9 (26 882)	11.6 (31 498)	6.7 (4 498)	2.6 (717)	9.7 (3 709)

Prevalence estimates for the school population are taken from national school surveys or the ESPAD project.

(¹) Prevalence estimates for the general population refer to England and Wales only.

TABLE A3

AMPHETAMINES

Country	Prevalence estimates				Entrants into treatment during the year					
	General population			School population	Amphetamines clients as % of treatment entrants			% amphetamines clients injecting (main route of administration)		
	Year of survey	Lifetime, adults (15–64)	Last 12 months, young adults (15–34)	Lifetime, students (15–16)	All entrants	First-time entrants	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants
	%	%	%		% (count)	% (count)	% (count)	% (count)	% (count)	% (count)
Belgium	2013	–	0.5	2	9.8 (1 047)	9.4 (353)	10.7 (669)	12.6 (128)	5.3 (18)	–
Bulgaria	2012	1.2	1.3	5	4.7 (84)	15.9 (51)	1.6 (16)	2 (1)	0 (0)	0 (0)
Czech Republic	2014	2.6	2.3	2	69.7 (7 033)	75.1 (3 550)	65 (3 483)	78.1 (5 446)	73.8 (2 586)	82.6 (2 860)
Denmark	2013	6.6	1.4	2	9.5 (358)	10.3 (149)	8.9 (170)	3.1 (9)	0 (0)	–
Germany	2012	3.1	1.8	4	16.1 (13 664)	19.3 (4 860)	14.7 (8 804)	1.5 (277)	0.9 (55)	1.8 (222)
Estonia	2008	–	2.5	3	3.9 (11)	3.5 (2)	1.6 (3)	72.7 (8)	100 (2)	66.7 (2)
Ireland	2011	4.5	0.8	2	0.6 (55)	0.8 (30)	0.5 (24)	5.5 (3)	3.3 (1)	8.3 (2)
Greece	2004	0.1	0.1	2	0.4 (18)	0.7 (13)	0.2 (5)	22.2 (4)	30.8 (4)	0 (0)
Spain	2013	3.8	1.2	1	1.3 (671)	1.4 (391)	1.2 (261)	1.2 (8)	0.8 (3)	1.6 (4)
France	2014	2.2	0.7	4	0.6 (232)	0.7 (66)	0.5 (96)	8.2 (16)	9.7 (6)	11.4 (9)
Croatia	2012	2.6	1.6	1	1.2 (96)	2.7 (28)	1 (65)	0 (0)	0 (0)	0 (0)
Italy	2014	2.8	0.6	1	0.2 (83)	0.3 (57)	0.1 (26)	6.1 (5)	7.1 (4)	4.3 (1)
Cyprus	2012	0.7	0.4	4	4.3 (46)	3.5 (20)	5.4 (26)	4.3 (2)	5 (1)	3.8 (1)
Latvia	2011	2.2	0.6	4	13.9 (115)	15 (62)	12.8 (53)	63.1 (70)	66.7 (40)	58.8 (30)
Lithuania	2012	1.2	0.5	3	3.4 (73)	8.2 (28)	2.3 (42)	32.9 (24)	32.1 (9)	35.7 (15)
Luxembourg	–	–	–	–	–	–	–	–	–	–
Hungary	2007	1.8	1.2	6	12.5 (584)	12.3 (383)	12.4 (154)	13 (74)	9.6 (36)	22.2 (34)
Malta	2013	0.3	–	3	0.2 (4)	–	0.3 (4)	25 (1)	–	25 (1)
Netherlands	2014	4.4	2.9	1	6.6 (702)	6.2 (376)	7.2 (326)	0.8 (3)	0 (0)	1.8 (3)
Austria	2008	2.5	0.9	–	4.6 (157)	5.9 (88)	3.6 (69)	5.3 (7)	5.2 (4)	5.4 (3)
Poland	2014	1.7	0.4	4	28.1 (2 019)	27.7 (956)	29.5 (1 036)	4.8 (91)	2.3 (21)	7.5 (70)
Portugal	2012	0.5	0.1	3	0 (1)	0.1 (1)	0 (0)	–	0 (0)	–
Romania	2013	0.3	0.1	2	0.2 (4)	0.2 (3)	0.1 (1)	25 (1)	0 (0)	100 (1)
Slovenia	2012	0.9	0.8	2	0.5 (2)	–	0.7 (2)	–	–	–
Slovakia	2010	0.5	0.3	1	42.7 (1 060)	47.8 (553)	38.9 (493)	32.8 (337)	26.1 (140)	40.3 (194)
Finland	2014	3.4	2.4	–	12.1 (78)	13.2 (35)	11.3 (43)	84.2 (64)	80 (28)	87.8 (36)
Sweden	2008	5	1.3	1	0.5 (141)	–	–	–	–	–
United Kingdom (1)	2014	10.3	1.1	1	2.9 (2 830)	3.7 (1 250)	2.5 (1 540)	21.6 (464)	12.2 (101)	27.6 (354)
Turkey	2011	0.1	0.1	2	0.3 (27)	0.4 (21)	0.1 (6)	–	–	–
Norway (2)	2014	4.1	1.1	1	13.4 (1 147)	–	–	–	–	–
European Union	–	3.6	1	–	7 (31 168)	8.2 (13 305)	6.6 (17 411)	20.8 (7 139)	22.5 (3 059)	19.7 (3 950)
EU, Turkey and Norway	–	–	–	–	6.9 (32 342)	7.9 (13 326)	6.5 (17 417)	20.8 (7 139)	22.4 (3 059)	19.7 (3 950)

Amphetamines refers to both amphetamine and methamphetamine.

Prevalence estimates for the school population are taken from national school surveys or the ESPAD project.

(1) Prevalence estimates for the general population refer to England and Wales only.

(2) Entrants into treatment refer to clients reporting stimulants other than cocaine, not just amphetamines.

TABLE A4

MDMA

Country	Prevalence estimates				Entrants into treatment during the year		
	Year of survey	General population		School population	MDMA clients as % of treatment entrants		
		Lifetime, adults (15–64)	Last 12 months, young adults (15–34)	Lifetime, students (15–16)	All entrants	First-time entrants	Previously treated entrants
		%	%	%	% (count)	% (count)	% (count)
Belgium	2013	–	0.8	2	0.6 (65)	0.9 (34)	0.5 (31)
Bulgaria	2012	2.0	2.9	4	0.2 (3)	0.6 (2)	0.1 (1)
Czech Republic	2014	6.0	3.6	3	0 (4)	0.1 (3)	0 (1)
Denmark	2013	2.3	0.7	1	0.3 (13)	0.5 (7)	0.3 (5)
Germany	2012	2.7	0.9	2	–	–	–
Estonia	2008	–	2.3	3	–	–	–
Ireland	2011	6.9	0.9	2	0.6 (56)	1 (37)	0.3 (18)
Greece	2004	0.4	0.4	2	0.1 (4)	0.1 (1)	0.1 (3)
Spain	2013	4.3	1.5	1	0.4 (201)	0.6 (167)	0.1 (27)
France	2014	4.2	2.3	3	0.4 (148)	0.6 (57)	0.3 (63)
Croatia	2012	2.5	0.5	2	0.4 (32)	1.3 (14)	0.3 (17)
Italy	2014	3.1	1.0	1	0.3 (147)	0.3 (48)	0.3 (99)
Cyprus	2012	0.9	0.3	3	0.1 (1)	–	0.2 (1)
Latvia	2011	2.7	0.8	4	0.4 (3)	0.7 (3)	0 (0)
Lithuania	2012	1.3	0.3	2	0 (1)	0 (0)	0.1 (1)
Luxembourg	–	–	–	–	–	–	–
Hungary	2007	2.4	1.0	4	1.7 (82)	1.8 (55)	1.9 (23)
Malta	2013	0.7	–	3	0.9 (16)	–	1 (16)
Netherlands	2014	7.4	5.5	4	0.4 (45)	0.7 (40)	0.1 (5)
Austria	2008	2.3	1.0		0.8 (27)	1.3 (19)	0.4 (8)
Poland	2014	1.6	0.9	2	0.2 (11)	0.1 (5)	0.2 (6)
Portugal	2012	1.3	0.6	3	0.2 (5)	0.4 (5)	0 (0)
Romania	2013	0.9	0.3	2	0.5 (14)	1 (14)	0 (0)
Slovenia	2012	2.1	0.8	2	–	–	–
Slovakia	2010	1.9	0.9	1	0.1 (2)	0.1 (1)	0.1 (1)
Finland	2014	3.0	2.5	2	0.2 (1)	0 (0)	0.3 (1)
Sweden	2008	2.1	1.0	1	–	–	–
United Kingdom (1)	2014	9.2	3.5	3	0.3 (302)	0.6 (200)	0.2 (97)
Turkey	2011	0.1	0.1	2	1 (103)	1.3 (74)	0.6 (29)
Norway	2014	2.3	0.4	1	–	–	–
European Union	–	3.9	1.7	–	0.3 (1 184)	0.4 (712)	0.2 (424)
EU, Turkey and Norway	–	–	–	–	0.3 (1 287)	0.5 (786)	0.2 (453)

Prevalence estimates for the school population are taken from national school surveys or the ESPAD project.

(1) Prevalence estimates for the general population refer to England and Wales.

TABLE A5

CANNABIS

Country	Prevalence estimates				Entrants into treatment during the year		
	Year of survey	General population		School population	Cannabis clients as % of treatment entrants		
		Lifetime, adults (15–64)	Last 12 months, young adults (15–34)	Lifetime, students (15–16)	All entrants	First-time entrants	Previously treated entrants
	%	%	%	% (count)	% (count)	% (count)	
Belgium	2013	15	10.1	21	32.9 (3 501)	52.8 (1 984)	22.4 (1 403)
Bulgaria	2012	7.5	8.3	22	3.2 (58)	8.4 (27)	0.7 (7)
Czech Republic	2014	28.7	23.9	42	11.8 (1 195)	16.4 (776)	7.8 (419)
Denmark	2013	35.6	17.6	18	63.4 (2 397)	72.6 (1 048)	55.5 (1 061)
Germany	2012	23.1	11.1	19	37.9 (32 225)	57.5 (14 458)	29.7 (17 767)
Estonia	2008	–	13.6	24	3.2 (9)	7 (4)	0.5 (1)
Ireland	2011	25.3	10.3	18	27.8 (2 645)	44.9 (1 696)	16 (847)
Greece	2004	8.9	3.2	8	22.3 (1 046)	36.5 (699)	12.3 (338)
Spain	2013	30.4	17.0	27	32.6 (16 914)	45.7 (12 912)	15.9 (3 585)
France	2014	40.9	22.1	39	58 (24 003)	76.7 (6 897)	42.3 (8 248)
Croatia	2012	15.6	10.5	18	14.1 (1 103)	64.4 (679)	6.5 (401)
Italy	2014	31.9	19.0	20	18.2 (9 321)	28.8 (5 267)	12.3 (4 054)
Cyprus	2012	9.9	4.2	7	59.4 (634)	77.2 (436)	37.7 (182)
Latvia	2011	12.5	7.3	24	32.6 (269)	50.8 (210)	14.3 (59)
Lithuania	2012	10.5	5.1	20	4.3 (92)	14.7 (50)	2.3 (42)
Luxembourg	–	–	–	–	25.5 (69)	28.6 (8)	29.6 (58)
Hungary	2007	8.5	5.7	19	55.5 (2 603)	61.2 (1 910)	43.2 (537)
Malta	2013	4.3	–	10	9 (158)	31.8 (67)	5.9 (91)
Netherlands	2014	24.1	15.6	27	47.6 (5 061)	56.2 (3 429)	36 (1 632)
Austria	2008	14.2	6.6	14	32.2 (1 101)	50.9 (757)	17.8 (344)
Poland	2014	16.2	9.8	23	34.6 (2 483)	44.6 (1 540)	25 (877)
Portugal	2012	9.4	5.1	16	28.4 (812)	50.8 (690)	8.1 (122)
Romania	2013	4.6	3.3	7	37.2 (973)	61.4 (858)	9 (104)
Slovenia	2012	15.8	10.3	23	12.2 (51)	36.4 (40)	3.3 (10)
Slovakia	2010	10.5	7.3	21	20.5 (509)	28.6 (331)	12.5 (159)
Finland	2014	21.7	13.5	12	20.5 (132)	35.1 (93)	10.3 (39)
Sweden	2014	14.4	6.3	6	13.2 (4 141)	20.7 (2 372)	8.9 (1 717)
United Kingdom (¹)	2014	29.2	11.7	19	26 (25 278)	46.6 (15 895)	14.8 (9 137)
Turkey	2011	0.7	0.4	4	9 (955)	11.3 (634)	6.4 (321)
Norway	2014	21.9	8.6	5	22.7 (1 946)	–	–
European Union	–	24.8	13.3	–	31 (138 783)	46 (75 133)	20.1 (53 241)
EU, Turkey and Norway	–	–	–	–	30.4 (141 684)	44.9 (75 767)	19.8 (53 562)

Prevalence estimates for the school population are taken from national school surveys or the ESPAD project.

(¹) Prevalence estimates for the general population refer to England and Wales.

TABLE A6

OTHER INDICATORS

Country	Drug-induced deaths (aged 15–64)	HIV diagnoses attributed to injecting drug use (ECDC)	Injecting drug use estimate		Syringes distributed through specialised programmes
	cases per million population (count)	cases per million population (count)	Year of estimate	cases per 1 000 population	count
Belgium	9 (66)	1 (11)	2014	2.4–4.9	926 391
Bulgaria	3.1 (15)	6.3 (46)	–	–	417 677
Czech Republic	5.2 (37)	1 (10)	2014	6.1–6.8	6 610 788
Denmark	55.1 (200)	2 (11)	–	–	–
Germany	18.6 (993)	1.4 (111)	–	–	–
Estonia	113.2 (98)	50.9 (67)	2009	4.3–10.8	2 110 527
Ireland	71.1 (214)	5.4 (25)	–	–	393 275
Greece	–	9.3 (102)	2014	0.6–0.9	368 246
Spain	13 (402)	2.5 (115)	2013	0.2–0.4	2 269 112
France	5.4 (227)	1 (64)	–	–	–
Croatia	20.8 (59)	0 (0)	2012	0.4–0.6	196 150
Italy	8 (313)	2.3 (141)	–	–	–
Cyprus	10 (6)	3.5 (3)	2014	0.4–0.7	382
Latvia	10.6 (14)	37 (74)	2012	7.3–11.7	409 869
Lithuania	44.2 (87)	12.9 (38)	–	–	154 889
Luxembourg	21.1 (8)	29.1 (16)	2009	4.5–6.9	253 011
Hungary	3.4 (23)	0.1 (1)	2008–09	0.8	460 977
Malta	6.9 (2)	0 (0)	–	–	314 027
Netherlands	10.8 (119)	0 (0)	2008	0.2–0.2	–
Austria	21.1 (121)	2.5 (21)	–	–	5 157 666
Poland	8.5 (225)	1 (37)	–	–	105 890
Portugal	4.5 (31)	3.8 (40)	2012	1.9–2.5	1 677 329
Romania	2.4 (33)	7.7 (154)	–	–	1 979 259
Slovenia	20 (28)	1 (2)	–	–	494 890
Slovakia	3.1 (12)	0.2 (1)	–	–	274 942
Finland	47.4 (166)	1.3 (7)	2012	4.1–6.7	4 522 738
Sweden	92.9 (569)	0.8 (8)	2008–11	1.3	203 847
United Kingdom (¹)	55.9 (2 332)	2 (131)	2004–11	2.9–3.2	7 199 660
Turkey	9.2 (479)	0.1 (10)	–	–	–
Norway	67.8 (228)	1.4 (7)	2013	2.1–2.9	2 124 180
European Union	19.2 (6 400)	2.4 (1 236)	–	–	–
EU, Turkey and Norway	18.3 (7 107)	2.1 (1 253)	–	–	–

Caution is required when comparing drug-induced deaths due to issues of coding, coverage and under-reporting in some countries.
 (¹) Syringe data refers to Wales and Scotland (2014) and Northern Ireland (2013).

TABLE A7

SEIZURES

Country	Heroin		Cocaine		Amphetamines		MDMA	
	Quantity seized	Number of seizures	Quantity seized	Number of seizures	Quantity seized	Number of seizures	Quantity seized	Number of seizures
	kg	count	kg	count	kg	count	tablets (kg)	count
Belgium	149	2 288	9 293	4 268	208	3 434	44 422 (3)	1 693
Bulgaria	940	137	27	39	216	–	16 845 (148)	–
Czech Republic	157	65	5	144	51	1 179	1 338 (0.08)	119
Denmark	13	447	90	2 395	295	1 867	54 690 (–)	688
Germany	780	2 857	1 568	3 395	1 484	13 759	486 852 (–)	3 122
Estonia	<0.01	8	3	57	67	319	9 822 (3)	147
Ireland	61	954	66	405	23	75	465 083 (–)	402
Greece	2 528	2 277	297	418	6	64	102 299 (9)	42
Spain	244	6 671	21 685	38 458	839	4 079	559 221 (–)	3 054
France	990	–	6 876	–	321	–	940 389 (–)	–
Croatia	47	132	6	231	14	582	– (3)	517
Italy	931	2 123	3 866	4 783	6	184	– (29)	262
Cyprus	0	11	32	107	1	73	17 247 (1.1)	28
Latvia	0.8	229	8	44	15	640	119 (0.3)	15
Lithuania	7	129	116	13	10	130	– (1.9)	16
Luxembourg	7	150	5	169	0.07	9	247 (–)	4
Hungary	70	31	40	143	17	673	13 020 (0.4)	275
Malta	2	33	5	136	0.01	3	334 (–)	31
Netherlands	750	–	10 000	–	681	–	2 442 190 (–)	–
Austria	56	428	31	1 078	21	930	5 001 (–)	212
Poland	273	–	31	–	824	–	62 028 (–)	–
Portugal	39	690	3 715	1 042	2	77	684 (0.6)	145
Romania	26	218	34	79	4	40	317 966 (0.03)	212
Slovenia	5	289	182	179	22	–	218 (0.1)	–
Slovakia	0.1	78	0.02	17	6	672	419 (–)	44
Finland	0.09	113	6	205	298	3 149	131 700 (–)	795
Sweden	24	514	29	142	439	5 286	6 105 (8)	920
United Kingdom	785	10 913	3 562	19 820	1 730	6 725	423 000 (–)	3 913
Turkey	12 756	7 008	393	784	142	403	3 600 831 (–)	3 706
Norway	44	1 294	149	1 101	420	8 145	54 185 (11)	502
European Union	8 883	31 785	61 578	77 767	7 599	43 949	6 101 249 (209)	16 656
EU, Turkey and Norway	21 683	40 087	62 120	79 652	8 162	52 497	9 756 265 (219)	20 864

Amphetamines refers to both amphetamine and methamphetamine.

All data are for 2014, except the Netherlands (2012), Finland (numbers of seizures, 2013) and the United Kingdom (2013).

TABLE A7

SEIZURES (continued)

Country	Cannabis resin		Herbal cannabis		Cannabis plants	
	Quantity seized kg	Number of seizures count	Quantity seized kg	Number of seizures count	Quantity seized plants (kg)	Number of seizures count
Belgium	841	5 554	10 744	28 086	356 388 (-)	1 227
Bulgaria	2	14	1 674	3 516	21 516 (-)	100
Czech Republic	15	73	570	2 833	77 685 (-)	484
Denmark	2 211	9 988	58	3 000	11 792 (675)	262
Germany	1 755	5 201	8 515	31 519	132 257 (-)	2 400
Estonia	273	31	352	507	- (13)	30
Ireland	677	258	1 102	1 770	6 309 (-)	340
Greece	36	176	19 568	6 985	14 173 (-)	587
Spain	379 762	174 566	15 174	175 086	270 741 (-)	2 252
France	36 917	-	10 073	-	158 592 (-)	-
Croatia	2	371	1 640	5 591	3 602 (-)	188
Italy	113 152	5 303	33 441	8 294	121 659 (-)	1 773
Cyprus	0.1	12	203	901	487 (-)	44
Latvia	30	38	27	366	- (11)	16
Lithuania	841	24	79	341	- (-)	-
Luxembourg	1	78	13	1 015	97 (-)	11
Hungary	8	101	529	2 058	3 288 (-)	146
Malta	42	39	70	176	8 (-)	5
Netherlands	2 200	-	12 600	-	1 600 000 (-)	-
Austria	101	1 380	1 326	10 088	- (281)	408
Poland	99	-	270	-	95 214 (-)	-
Portugal	32 877	3 472	108	555	4 517 (-)	302
Romania	15	154	145	1 967	- (422)	93
Slovenia	2	73	535	3 673	11 067 (-)	212
Slovakia	0.1	12	113	1 061	496 (-)	20
Finland	52	1 467	313	6 167	21 800 (189)	3 409
Sweden	877	6 547	1 041	10 028	- (-)	-
United Kingdom	1 134	14 105	18 705	147 309	484 645 (-)	15 744
Turkey	30 635	3 972	92 481	41 594	- (-)	3 017
Norway	1 919	10 509	505	6 534	- (276)	383
European Union	573 921	229 037	139 286	452 892	3 396 333 (1 592)	30 053
EU, Turkey and Norway	606 475	243 518	232 271	501 020	3 396 333 (1 868)	33 453

All data are for 2014, except the Netherlands (2012), Finland (numbers of seizures, 2013) and the United Kingdom (2013).