



INTERNATIONAL DRUG POLICY CONSORTIUM

**THE EUROPEAN UNION
DRUG STRATEGY
Progress And Problems**

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THE EUROPEAN UNION DRUG STRATEGY

Progress And Problems

The International Drug Policy Consortium (IDPC) is a global network of 25 NGOs and professional networks that specialise in issues related to illegal drug use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces occasional briefing papers, disseminates the reports of its member organisations about particular drug-related matters, and offers expert consultancy services to policymakers and officials around the world.

SUMMARY

The European Union has been a useful vehicle for the discussion and co-ordination of drug policies between the 27 member states. Over the last 10 years, significant progress has been achieved across Europe in the monitoring and description of drug problems, and policy and programme responses, and greater understanding gained of policy similarities and differences. In addition, Member States, the Commission, Parliament, and relevant agencies have been able to agree a clear strategy and set of actions for the coming years that are directed at increasing co-operation and effectiveness in reducing illegal drug use and associated problems across the Union. However, current evaluation data suggest that drug use in Europe is only being contained at best and, despite several successes in reducing the harmful consequences, problems such as drug related crime, drug related deaths, and rates of Hepatitis infection among drug injectors, remain unacceptably high. We therefore suggest ways in which current EU strategy and actions could be strengthened in the coming months and years, and commend these recommendations to the members of the Horizontal Working Party on Drugs, the group responsible for co-ordinating EU action in this field.

BACKGROUND

The short history of EU drug policy originates in the early 1990s. The Maastricht Treaty¹ of 1993 transformed the European Community into the European Union. This measure represented a major shift in the conceptualisation and the process of the creation of the EU: whereas the beginning of the community was based on mostly economic co-operation, from this moment the political and social elements of the integration have been equally emphasised.

The expanded mandate of the EU opened up new opportunities to address the drug issue in relation to fight against international crime, tackling social exclusion and promoting higher standards of public health. Although drug policy formation still remains the competence of national governments of Member States, a series of drug strategies and action plans² have been adopted, implemented, monitored and evaluated³ since the early 1990s. This trend demonstrates that the EU Member States - while maintaining a diverse set of drug policies on a local and national level - recognise the added value of a joint EU approach to tackle their drug situations.

The current EU Drug Strategy⁴ was adopted by the European Council in December 2004, and covers a period of 8 years from 2005 until 2012. The Strategy is developed by taking account of the spirit and principles of the EU Founding Treaties and fundamental legislation as well as the experience of the implementation of previous strategies and action plans. While holding the utmost respect for 'human dignity, liberty, democracy, equality, solidarity, the rule of law and human rights', the Strategy *'aims to protect and improve the well-being of society and of the individual, to protect public health, to offer a high level of security for the general public'*. (EU Drug Strategy 2005-2012, Preface, Paragraph 2, pp. 2). The EU plans to achieve these objectives by applying an integrated, multidisciplinary and balanced approach of combining demand and supply reduction supported by two cross-cutting themes of international co-operation and research, information and evaluation. It includes the prevention and reduction of drug use, dependence and drug related-harm to the individual and the society as well as the fight against drugs production, cross-border

¹ Treaty of Maastricht <http://www.eurotreaties.com/maastrichteu.pdf>

² Decision No 102/97/EC of the European Parliament and of the Council Of 16 December 1996 Adopting a Programme of Community Action on the Prevention of Drug Dependence within the Framework for Action in the Field of Public Health (1996-2000) *Official Journal of the European Union* L 035, 5 Feb 1997
EU Drug Strategy 2000-2004 <http://register.consilium.europa.eu/pdf/en/99/st12/12555-r3en9.pdf>
EU Action Plan on Drugs 2000-2004 <http://register.consilium.europa.eu/pdf/en/00/st09/09283en0.pdf>

³ EMCDDA Annual Reports
<http://www.emcdda.europa.eu/index.cfm?fuseaction=public.Content&nnodeid=419&slanguageiso=EN>
 Snapshots <http://snapshot.emcdda.europa.eu/?nNodeID=5563>

⁴ *EU Drug Strategy 2005-2012*
<http://www.emcdda.europa.eu/index.cfm?fuseaction=public.AttachmentDownload&nNodeID=10375&slanguageISO=EN>

trafficking in drugs and the diversion of precursors used in drug production, and the intensification of preventive action against drug-related crime. The Strategy acknowledges the ‘horizontal nature of the problem’ and calls for their further development of that co-operation

‘...not only in numerous sectors, including welfare, health, education and justice and home affairs, but also in relations with non-Member States and relevant international fora. A balanced approach to the drugs problem also requires adequate consultation with a broad group of scientific centres, professionals, representative NGOs, civil society and local communities.’ (EU Drug Strategy 2005-2012, Introduction, Paragraph 11, pp. 5)

The implementation of the Strategy is guided by the first of two EU Drugs Action Plans⁵. This document was adopted by the Council in 2005, and lists the specific actions covering the years 2005-2008. The Action Plan targets those areas where the evaluation of the EU Drug Strategy 2000-2004⁶ recommended further improvements. The programme clearly stipulates that:

- Actions at EU level must offer clear added value and results must be realistic and measurable.
 - Actions must be cost-effective and contribute directly to the achievement of at least one of the goals or priorities set out in the Strategy.
 - The number of actions in each field should be targeted and realistic.
- (EU Action Plan 2005-2008, pp. 2)

The document divides the agreed actions and deadlines into five main areas: co-ordination, demand reduction, supply reduction, international co-operation as well as information, research and evaluation. Responsibilities for the actions are delegated to various stakeholders within the EU.

The group of responsible actors consists of the Council of the European Union, the Presidency, Member States, the European Commission, EMCDDA, Europol, Eurojust and the EMEA.

The *Council of the European Union*⁷ is the forum of the ministers of the Member States and it is the main decision making body of the EU. Decisions are prepared in the Committee of Permanent Representatives (COREPER) consisting of the member states’ representatives to the EU and in various Council working groups comprising officials and experts of Member State. EU-level co-

ordination of drug policy in the Council is managed through the Horizontal Working Party on Drugs (commonly referred to as the Horizontal Drugs Group or HDG). All drug-related decisions are discussed and/or prepared here before being submitted to the COREPER and the Ministers Council for adoption. The HDG has a key role in monitoring of the implementation of the drug strategy action plan. In order to fulfil its mandate in this area, the HDG co-operates with other working groups of the Council that have functions in preparing drug-related decisions, such as the Police and Customs Cooperation Working Parties, the Multidisciplinary Group on Organised Crime, the Health Working Group or the Economic Issues Working Group. It is also informed about the activities of the Common Foreign and Security Policy working groups.

The role of the *European Commission*⁸ is to represent the common interest and values of the European Union. It can initiate discussions and decisions, as well as implementing and monitoring the implementation of EU decisions. Several Directorates General of the Commission have an interest in drug policy. The Directorate-General for Freedom, Security and Justice is responsible for the co-ordination of drug affairs within the Commission through its Drugs Co-ordination Unit.

In general, the majority of internal drug strategy issues are addressed by DG Freedom, Security and Justice, and DG Health and Consumer Protection⁹. They include a combination of initiating and supporting both law enforcement activities (e.g. legislation approximation, law enforcement co-operation and border protection) and various demand reduction interventions (e.g. drug prevention programmes, harm reduction projects, drug treatment and social reintegration). The external drug affairs of the EU are managed by the External Relations Directorate-General¹⁰, the Directorate-General Development and Relations with African, Caribbean and Pacific States¹¹, the EuropeAid Co-operation Office¹² and the Directorate-General for Enlargement¹³ (the so-called ‘RELEX family’). The Inter-Relex DGs Drugs Co-ordination Group provides a platform to ensure the consistent representation of the EU’s interests in third countries and in particular international organisations. In its international work the EU is guided by the five main principles of shared responsibility, emphasis on multilateralism, balanced approach, development mainstreaming and respect for human rights. Through its RELEX family, the European Commission is the main supporter of alternative development programmes and civil society initiatives in the world.

⁵ EU Drugs Action Plan 2005-2008 (2005/C168/01), *Official Journal of the European Union*, 8 July 2005

⁶ COM(2004) 707 Final. *Evaluation of the EU Drug Strategy and EU Action Plan on Drugs 2000-2004*

⁷ <http://ue.eu.int>

⁸ <http://ec.europa.eu>

⁹ http://ec.europa.eu/dgs/health_consumer/index_en.htm

¹⁰ http://ec.europa.eu/comm/dgs/external_relations/index_en.htm

¹¹ http://ec.europa.eu/dgs/development/index_en.htm

¹² http://ec.europa.eu/europeaid/index_en.htm

¹³ http://ec.europa.eu/dgs/enlargement/index_en.htm

¹⁴ SEC(2006) 1803 COMMISSION STAFF WORKING DOCUMENT 2006 Progress Review on the implementation of the EU Drugs Action Plan (2005-2008)

http://ec.europa.eu/justice_home/doc_centre/drugs/strategy/doc/sec_2006_1803_en.pdf

With the support of European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol, the Commission is tasked to deliver annual progress reviews to the Council and the European Parliament on the implementation of the action plan. The first review was presented at the end of 2006.¹⁴ As it is articulated by the current Action Plan, the Commission will also 'organise an impact assessment with a view to proposing a new Action Plan for 2009 – 2012' (EU Drugs Action Plan 2005-2008, Obj. 45, Action 3, pp. 18)

Among the decentralised bodies of the EU, there are four agencies with essential role in the implementation of EU drug policy: *EMCDDA*, *EMEA*, *Europol* and *Eurojust*. Each of these agencies were established to carry out a very specific technical, scientific or managerial task:

The *European Monitoring Centre for Drugs and Drug Addiction*¹⁵ is the focal point for drug-related data in the EU. It collects, analyses and disseminates objective and comparable information hence providing decision makers on the EU and national-level with a solid evidence-based support to draft effective policies.

The *European Medicines Agency (EMA)*¹⁶ aims to ensure the quality and safety of human and veterinary medicines to protect human and animal health. The EU Drugs Action Plan requires the agency to implement fully the Council Decision on Information Exchange, Risk-assessment and Control of New Psychoactive Substances¹⁷.

The main objective of *Europol*¹⁸ in the implementation of drug policy is to assist Member States to co-operate in order to prevent and fight organised crime of drug trafficking and drug money laundering.

*Eurojust*¹⁹ is tasked to assist relevant authorities of Member States to investigate and prosecute serious cross-border and organised crime. Eurojust participates in the implementation of supply reduction projects (e.g. projects on precursors or disrupting cash-flows within and from the EU).

Further to the stakeholders indicated by the Action Plan, the *European Parliament*²⁰ has been developing a growing interest in EU drug policy. Some of its political groups and parliamentary committees have been placing drug policy high on their agenda recently. Nevertheless, despite its keen interest and its legislative power shared with the Council of the European Union, its ability to directly influence drug policy is very limited. Its mandate allows the EP to co-decide with the Council only on the few particular elements of drug policy in which responsibility has

been transferred to the EU (e.g. the protection of public health, or the prevention of money laundering, or precursor control). Notwithstanding this limited formal power, the Parliament has representatives on key working groups, and holds occasional debates on drug policy issues.

The latest statement of the situation regarding drug use prevalence and problems in Europe is contained within the 2006 EMCDDA Report. We summarise the main data at the end of this report, but the report broadly paints a picture of stable overall prevalence, with varying trends with different drugs in different countries, and some encouraging, albeit limited, reductions in some of the harmful consequences.

LIMITATIONS OF CURRENT ARRANGEMENTS

While the creation of a comprehensive strategy, that covers the actions of the 27 EU Member States and all Commission departments and agencies, is an impressive achievement, we have to acknowledge that some of the institutional and structural arrangements that are currently in place to implement the strategy are not ideal. The IDPC has three main areas of concern in this respect:

1. The strategy and action plan still do not give a sufficiently clear statement of the fundamental objectives that we are trying to achieve on behalf of EU Citizens. The strategy, in its introduction, states that one lesson from the previous strategy was that '...clear and precise objectives and priorities should be set...'. However, the new strategy objectives confuse the issue of 'outcomes' (eg reductions in the use of drugs) with the implementation of processes to achieve those outcomes (eg '...the development and improvement of an effective and integrated knowledge based demand reduction system...'). A clearer description to citizens of the desired outcomes would be provided by a simple list of objectives that would be aimed for and reviewed over the lifetime of the strategy - reading between the lines of the strategy documents, we can see that the following desired outcomes are incorporated:

- A reduction in overall prevalence of illegal drug use.
- A reduction in the level of dependence on illegal drugs.
- A reduction in the level of health and social harms associated with illegal drug use.

Worryingly, there are no outcome objectives in the strategy or action plan relating to supply reduction efforts. In these sections, objectives entirely relate to the improvement of operational

¹⁵ <http://www.emcdda.europa.eu>

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¹⁷ COUNCIL DECISION 2005/387/JHA of 10 May 2005 on the Information Exchange, Risk-assessment and Control of New Psychoactive Substance, *Official Journal of the European Union*, 20 May 2005

¹⁸ <http://www.europol.europa.eu>

¹⁹ <http://www.eurojust.europa.eu>

²⁰ <http://www.europarl.europa.eu>

performance and co-operation, with no statement of what this improved performance is designed to achieve. This is a common problem with national and international drug strategies that has to be confronted. Our assumption is that the desired outcome is a reduction in the supply and availability of illegal drugs to those citizens who may wish to use them. If this objective was added to the three listed above, we consider that these together would form a perfectly adequate set of high-level outcome objectives that the general public could understand.

While we think these four objectives are implicit in the text of the strategy documents, they will need to be articulated directly as the headline objectives in future strategies, and clear mechanisms created for definition and measurement of achievement against them across the lifetime of the strategy.

2. The mechanisms for co-ordination of the agreed actions within the strategy are insufficiently robust. Many of the barriers to effective leadership and co-ordination are inevitable given the institutional nature of the EU, but it is worth stating them openly to help us to understand the challenges. The problem here is with the sheer number of different stakeholders in this process - there are at least 8 Commission Directorates with responsibilities and interests in the drug strategy, and at least 4 arms-length agencies (EMCDDA, EMEA, Europol, and Eurostat). Each of these has its own governance structures and priorities, and only the EMCDDA and the Drug Co-ordination Unit in Brussels have a specific focus on the drug strategy. Then there is the European Parliament, whose political groupings have divergent, and often directly opposing, views on drug policy approaches and priorities. Finally, there are the 27 Member States, all of which are represented at the HDG, but have their own domestic perspectives and interests to consider. The Drugs Co-ordination Unit (based in the Directorate of Justice, Freedom and Security, and with a staff complement of less than 10 officials) has the responsibility to harness all of these diverse interests to agree a unified strategy, and work together on its implementation. While this challenge is by its nature complex, the EU's ability to achieve its aims in this policy field could be enhanced by increasing the resources available for co-ordination, and at least ensuring that all relevant Commission activities directly contribute to the objectives of the drug strategy. Two areas where this process could be improved are the planning and prioritisation of research programmes in DG Research, and the level of priority given to drugs issues in the public health programme in DG Health and Consumer Protection (SANCO).

3. The 'Democratic Deficit'. In surveys of European citizens, the problems associated with illegal drug use consistently rate highly amongst their concerns, so there is likely also to be an interest in what the EU is doing on their behalf to try to tackle these problems. However, the debate, development, implementation and review of drug strategy at the EU level takes place away from

the sight of the general public, and even to some extent from the Civil Society organisations that specialise in this area. There are two ways that the EU institutions can address this deficit:

- Better involvement of Civil Society in these processes. After a long period of resistance to NGO engagement in EU drug strategy, the current strategy and action plan include a very clear commitment to find a workable mechanism for open and respectful communication between policymakers and Civil Society representatives. A recent Green Paper launched by the Commission sets out recommendations for how such communication can be embedded in the routine management and review of the strategy - these are to be welcomed, and we look forward to their implementation through 2007.
- Better direct communication to the public through the media. At the moment, the only aspect of EU drug policy that gets any media attention is the publication of the EMCDDA Annual Report. Traditionally, national media simply lift off the most worrying statistic from this report, and run stories implying the latest failure of policy. A much more proactive media strategy is required, that aims to raise awareness amongst key media outlets of the thinking behind the EU approach, details of the successes (and of the challenges) of policy in this area, and that creates an ongoing line of communication between the authorities and the media that can work to avoid misunderstandings and inaccurate reporting. Creating this enhanced media and public engagement capacity would be relatively cheap, and would go a long way to countering the criticism that EU activity in this area lacks transparency.

Having summarised the institutional structures and strategies that have been created to tackle illegal drug use in Europe, we now move on to consider in more detail the progress achieved so far, and challenges remaining, under each of the four headings of the strategy.

DEMAND REDUCTION

The strategy aims to reduce the overall prevalence of illegal drug use, and also the level of dependent or 'problem' patterns of use. Demand reduction activities are designed therefore to minimise the number of people initiated into illegal drug use, to minimise the number progressing to become regular or dependent users, and to help with the rehabilitation of dependent users. Successful demand reduction activities will minimise the level of drug use in society, irrespective of the availability of drugs to potential users. European governments can demonstrate an impressive track record of supporting, implementing and evaluating a wide range of demand reduction activities - information campaigns, education and prevention programmes, and various forms of

treatment and rehabilitation for dependent users. Many of these programmes have demonstrated positive outcomes with particular populations, but the desired continent-wide reduction in demand has not yet been achieved. As reported in the EMCDDA Annual Report for 2006, the overall level of illegal drug use in the EU is stable at best.

While technically not a pure demand reduction set of activities – the objectives are to reduce the harmful consequences of drug use, rather than its overall prevalence – the demand reduction section of the EU Strategy also covers activities targeted at reducing drug related deaths, and other health problems such as HIV or Hepatitis infection. Much clearer evidence of achievement can be found in this area. While systems for measuring the level of drug related deaths are in their infancy – and are still too diverse to draw detailed comparisons and conclusions – where data are available, the trend is downwards, and seems to bear some correlation with the availability of easily accessible treatment and harm reduction services. Even clearer evidence of impact can be seen with efforts to tackle HIV infections transmitted through sharing of injecting equipment. In the late 1980s and early 1990s, HIV prevalence rates amongst injecting drug users reached levels of 30 or 40% in some areas. Following two decades of progressive implementation of harm reduction activities targeted directly at problematic drug users – health education and information campaigns, wider access to treatment, needle exchange schemes, and outreach services – these infection rates have plummeted. While a set of measures that are effective in containing HIV infection are now well established in Europe, Hepatitis infections related to injecting drug use have not been so successfully contained. This may be due to its greater penetration into drug injecting populations before the risk was understood, or the greater resistance of the virus to hygiene measures, but is a significant public health threat across Europe, with rates of liver disease resulting from Hepatitis C transmitted through drug injecting due to increase significantly over the next 20 years.

National governments, supported and encouraged by the European Union, have made good progress in recent years in developing and expanding their prevention, treatment and harm reduction services. This is an ongoing challenge, however, and new member states, in particular, need to find the resources (and access the expertise) to strengthen this process – rates of HIV infection, for example, in some new member states are rising rapidly, a situation that requires rapid upscaling of the coverage of preventative programmes. The EU, and its agencies, need to actively support this process of expansion and refinement of effective programmes by:

- Collating and disseminating more comprehensive and accurate information on the extent and nature of demand reduction activities across Europe. There is currently no reliable description of which programmes are delivered

in which member states, or their coverage in terms of geographical area or numbers served. The Commission has taken steps to address this issue in 2006, for example an inventory of Harm Reduction activities will be published in 2007, but this work needs to be expanded to all areas covered by the demand reduction section of the Action Plan. The REITOX network administered by the EMCDDA is well structured to deliver this information, and should be expected to include it as a specific data set in successive annual reports.

- Based on the information on programme availability and coverage above, the EU should facilitate regular reviews of the evidence of effectiveness of various programmes and activities. A constantly improving evidence base can be generated by the Commission directing research funds at subject areas where the evidence base is currently thin, and commissioning a series of ‘Cochrane-style’ reviews on particular subjects – for example, school-based prevention, treatment, overdose prevention – that can inform policymakers on the latest available evidence.
- The EU should also facilitate networks of professionals that can exchange and disseminate this learning, and best practices. As a result of the long history of investment in demand reduction activities in many European countries, there is a reservoir of knowledge and expertise, and examples of effective practice, that can be used to demonstrate best practices to those policymakers and practitioners engaged in developing services in their own countries. Such networks, through study tours and professional exchanges, can facilitate the dissemination of best practices to professionals across the European Union, but also is a valuable resource for demonstrating this learning to those in other parts of the world who are building demand reduction services from a lower base.

Demand and harm reduction activities, if designed and delivered to a high standard, have been shown to contribute to the reduction of drug related problems. The key challenge for the EU is now to facilitate the expansion of effective programmes (and, by implication, the rejection of ineffective ones), across all member states, in order to achieve a more significant impact on overall rates of drug use and dependence.

SUPPLY REDUCTION

The other general aim of the EU Drugs Strategy is to ensure a high level of security for the general public by taking action against drugs production, cross-border trafficking in drugs and diversion of precursors, and by intensifying preventive action against drug-related crime, through effective co-operation embedded in a joint approach. Successful supply reduction activities, regardless of

the level of demand for illegal substances, should minimise the availability of drugs for potential users.

Despite the long history of actions and the enormous amount of resources invested, the achievements are controversial. Although precise estimates do not exist, it seems that the overall supply of drugs has not decreased over the recent years²¹. Not only has the trafficking of particular substances been growing from external sources, but the production and trafficking within the enlarged EU (particularly of Cannabis and Amphetamine-Type Stimulants) have increased, too. The analysis of price and purity suggests that the prices of cannabis, heroin, amphetamine, ecstasy and cocaine have substantially dropped over recent years. At the same time, the number of cannabis, cocaine, ecstasy and amphetamine users has been growing.

The measurement of the extent of availability is a complicated endeavour. The problem lies in the fact that it requires knowledge about hidden markets, which is problematic to access. Furthermore, drug-availability is not a well-defined concept, at the very least. In general, information on drug seizures, prices at various levels, the purity and potency of particular drugs are taken into account for analysing and assessing availability, but these pieces of information may only indirectly indicate the real situation. According to EMCDDA, neither national governments, nor the EU have introduced systematic surveillance methods to monitor the availability of drugs²².

Under the supply reduction category, the Strategy combines law enforcement and judicial approaches together. For instance, the disruption of the laundering of profits originating in drug crime, or the intervention into processes of structural interconnectedness of various illegal activities (e.g. drug trafficking and the financing of terrorism).

Although these interventions are not supply reduction in the narrow sense, they are of wider importance. However, very little is known about their impact on the availability of drugs. Apart from the information on the adoption or amendments of resolutions as well as strengthening of legal instruments concerning precursors or addressing money laundering and confiscation of assets²³, there is hardly any knowledge available on the implementation and impact of these pieces of legislation.

The current Strategy declares, and the Action Plan reinforces, the commitment of the EU and its Member States to a measurable improvement in the effectiveness and knowledge base of supply reduction activities. The Action Plan proceeds to list particular actions with deadlines, responsible agencies and identified performance indicators associated with them. For example, Objective 18 aims to develop law enforcement co-operation between Member States and, where appropriate, with Europol, Eurojust, third countries and international organisations, against

international organised drug production and trafficking. One of the actions behind this objective is to implement various law enforcement projects (e.g. joint investigation teams, joint customs operations, intelligence projects). The indicators of success are then listed as the numbers of implemented and completed projects; the quantity and value of seized substances; number of criminal groups disrupted and number of illicit laboratories dismantled²⁴.

This example illustrates the problem with this section of the strategy – that the objectives do not focus on outcomes. Instead, they focus on enhanced operational performance and institutional co-operation, as if they were the ultimate objectives themselves. In the light of this, it is particularly disturbing that, in its first review of the Action Plan, the Commission declares itself unable to make any sort of assessment against the agreed objectives in the Supply Reduction section, due to the limited nature of information made available by Member States and Europol. Put simply, this means that we do not have a clear statement of what would be considered success in the field of supply reduction, no mechanism to measure outcomes in this field, strategic objectives that seek only improvements in operational processes and co-operation, and an inability to even measure their implementation. In an area of drug strategy that receives by far the greatest proportion of resources and political attention, this is an unacceptable state of affairs. While the need for reduction of supply is implicit in the spirit of the Strategy and more explicit in the text of the Action Plan, it needs to be articulated and measured better. National governments and EU/international agencies need to be committed to disclosing information gathered and be held responsible for achieving measurable outcomes. If the EU and its Member States' commitment to measurable improvement in the area of supply reduction leads to improved evaluation in this area, this can be considered as a positive change. To achieve this, evaluation must be based on developing appropriate and clear mechanisms to assess achievements against the outcome objective of supply reduction efforts, rather than just paying attention to the improvement of operational performance.

INTERNATIONAL CO-OPERATION

The EU Strategy emphasizes a developmental approach to the drugs issue in its international cooperation efforts. For Afghanistan, the main recipient of EU cooperation in this area, a common EU policy was agreed in May 2006 that specifies: "Only when farmers have access to sustainable legal rural livelihoods will they be able to abandon opium poppy cultivation for good."²⁵ The Action-

²¹ EMCDDA Annual Reports <http://www.emcdda.europa.eu/index.cfm?fuseaction=public.Content&nnod eid=419&sLanguageiso=EN>

²² EMCDDA website: Availability of Illicit Drugs www.emcdda.europa.eu/?nnodeid=1549

²³ EMCDDA Annual Report on the State of the Drugs Problem 2006, pp. 19-20 <http://ar2006.emcdda.europa.eu/download/ar2006-en.pdf>

²⁴ EU Drugs Action Plan 2005-2008 (2005/C168/01), *Official Journal of the European Union*, 8 July 2005, pp. 7

Oriented paper mentions that the “EU measures undertaken in the field of alternative development should be in line with the EU approach agreed by the Council bodies.” This EU approach on alternative development – also adopted in May 2006 – states that “forced eradication should remain an option but should only be pursued when ground conditions ensure that small-scale farmers have had access to alternative livelihoods for a sufficient time period.” Forced eradication when alternative livelihoods are not available according to the EU tends to generate social and political violence, to displace cultivation to more inaccessible spots and is unlikely to succeed in the long term²⁶. The IDPC welcomes this approach as an example where the EU shows its ability to incorporate into its own policy making the key lessons learned through global evaluations.²⁷

This position sometimes puts the EU in a conflicting position with that of other partners, such as the USA or the UNODC. Given current escalation of eradication operations on the ground in Afghanistan (and Colombia), however, we urge the EU to put the agreed approach to practice and to undertake all efforts necessary to prevent that forced eradication is undertaken in areas where farmers have not had access to alternative livelihoods for a sufficient time period. The EU should also actively support the decision of the Afghan government to not apply chemical means of eradication.

In broader policy terms, the EU Drug Strategy, and the national strategies of many Member States, are among the most comprehensive and well resourced in the world. There are several positive principles contained within these strategies – an acknowledgment that different forms of drug use impact on society in different ways; a balance between supply reduction, demand reduction and harm reduction activities; investment in research and evaluation; and a commitment to objective review of progress – that enable governments with varying domestic challenges and priorities to co-operate on a shared programme of activities. These principles should be incorporated into any national or international strategy to tackle drug problems. Given this relative level of policy sophistication, and the relative strength of policy structures and resources in Europe, it is appropriate that the EU and Member States play a positive and assertive role in international debates around drug policy.

Ironically, despite a strong track record of investment in drug strategies and activities that are, at least loosely, based on the available evidence of effectiveness, Europe often finds itself in the position of having to defend itself against charges of a lack of commitment to the global ‘war on drugs’. These criticisms arise from the view that only high levels of enforcement of drug laws, and strong primary prevention campaigns, can ultimately reduce drug problems. In general, European governments have increasingly pursued policies that rely less on strong enforcement, and that focus more on tackling the harmful consequences of

drug use. The IDPC considers that this trend is justified by the evidence, and that the EU should be more proactive in articulating and promoting its balanced and evidence based approach in discussion with other governments and international agencies. This can be achieved through a number of channels:

- The production of a simple summary guide to EU policy and strategy, and the reasoning and evidence that supports it. Such a document can be distributed to politicians, professionals and the media to articulate the EU position.
- A proactive programme of engaging with other countries (the strategy specifically lists EU candidate countries, European Neighbourhood countries, Afghanistan, Latin American countries, and Morocco) to explain EU policies and programmes, and offer EU experience and expertise to support their own programme development.
- A more efficient approach to preparations and engagement at the annual Commission on Narcotic Drugs (CND). At the moment, this task is largely left to the respective EU ‘presidencies’, which entails a lack of continuity and specific expertise. To support the presidencies (who are the appropriate lead spokesperson for the EU at international gatherings), the European Commission should allocate a clear permanent lead responsibility for administering the process of engagement with the UN system on drug policy issues. This individual or agency could be responsible for keeping Member States informed of developments at the UN, help prepare for CND and inter-sessional meetings, and support the presidency in preparing shared EU positions.²⁸
- The promotion of an objective and comprehensive approach to the review of progress in the implementation of the global drug control system, in the run up to the forthcoming United Nations General Assembly Special Session (UNGASS). There are signs that the UN Office on Drugs and Crime (UNODC – the agency responsible for conducting this review) is not approaching this task objectively – the Executive Director of the UNODC has already announced, in the 2006 World Drug Report, that the system he oversees is a success, although there are clearly significant and complex evaluation questions that remain

²⁶ Council of the European Union, 9370/1/06 REV 1, Action-Oriented Paper Increasing EU support for combating drug production in and trafficking from Afghanistan, including transit routes, Brussels, 22 May 2006.

²⁶ Council of the European Union, The EU Approach on alternative Development, 9597/06, Brussels, 18 May 2006

²⁷ See: UNODC, Thematic Evaluation of UNODC Alternative Development Initiatives, Independent Evaluation Unit, November 2005. http://www.unodc.org/pdf/publications/Thematic_eval_AD_Nov05.pdf And: United Nations, Alternative Development: a Global Thematic Evaluation, New York, December 2005. http://www.unodc.org/pdf/Alternative_Development_Evaluation_Dec-05.pdf

²⁸ See Tom Blickman and Dave Bewley-Taylor, *The UNGASS Evaluation Process Evaluated*, IDPC Briefing Paper, May 2006 http://www.idpc.info/docs/Ungass_evaluation.pdf

to be addressed. The EU has given welcome support to a working group convened by UNODC to assemble the available evidence and make it available to delegates of the UNGASS, and should take any further steps necessary to ensure that the eventual reports presented are comprehensive and free of bias.

INFORMATION, RESEARCH AND EVALUATION

As has been mentioned above, investment in the availability of reliable data on drug use, problems and responses has been growing across the EU in recent years. This is a welcome trend, as it is only through a greater understanding of the nature and extent of drug problems, and the impact of efforts to reduce them, that effective policies will emerge. The EMCDDA is a centre of expertise, and a mechanism for international co-operation in data gathering and analysis, that is unrivalled around the world. Great progress has been made in the definition of methodologies for gathering consistent and comparable data, and in using that data to inform policy. However, the continuing development of a comprehensive research, data analysis and evaluation framework that can provide a comprehensive evidence base for policy discussions remains a massive challenge, given the resource constraints faced by national governments and the EU itself, and the complexity of different policy, service provision, and information structures across the 27 Member States.

The drug strategy and action plan has the overall objective of ‘a better understanding of the drugs problem, and the development of an optimal response to it, through a measurable and sustainable improvement in the knowledge base and knowledge infrastructure’. Significant progress towards this objective could be achieved by:

- Improving compliance with the existing 5 key harmonised indicators administered by the EMCDDA. EU agencies and Member States have been working for over a decade on the development of common methodologies for tracking five aspects of the drug phenomenon – prevalence, problem use, treatment demand, drug-related deaths, drug-related infections. While national data gathering and reporting against these indicators has improved significantly, there is still a long way to go to achieve a consistent and comparable picture across the 27 Member States. The EMCDDA publishes implementation standards for all countries – the HDG should routinely review countries’ compliance with these standards.
- Developing and agreeing indicators on drug related crime and social problems. The 5 indicators above cover issues of drug use, demand, and health problems, but the methods for gathering and comparing data on drug related crime, and other social harms, are not well developed. The EU has for 5 years had a commitment to making progress on a drug related crime indicator – indeed, this is a specific action in the current action plan. Targeted efforts are therefore needed now to agree definitions and counting mechanisms, and initiate surveys to allow the tracking of trends in this important area of policy. Ideally, similar efforts should be made to track the impact of drug use on other social harms such as family break-up or failure in school.
- Developing a framework for measuring drug availability, and for evaluating the impact of supply reduction on it. The most glaring gap in the evaluation and information framework in Europe is the lack of regular and consistent information on drug availability. Whether this is measured in terms of price, purity, the overall scale of the market, or the ease with which consumers can get access to drugs, it is crucial that a picture is developed of the patterns of availability of particular drugs across Europe. Without such a picture, it is very hard to make a judgment on the effectiveness of attempts to reduce supply and availability, which are some of the most expensive and controversial programmes within the drug strategy. The EU should start this process by commissioning initial surveys, and convening an expert group to design an evaluation approach to this issue. More basic research that helps to understand the dynamics of illicit drug markets, and the market responses to policy interventions, would also provide useful tools for evaluating the effectiveness of supply reduction efforts.
- Developing a model for assessing the effectiveness of drug policies and strategies. There are a number of interesting developments around the world – at the United Nations, the Organisation of American States, and in the UK, Australia and Canada – that aim to create a comprehensive methodology for assessing the effectiveness of drug policies.²⁹ A range of approaches are being investigated. As a global leader in its commitment to evaluation and review, the EU should take a lead in supporting and promoting this work, which could be easily achieved through the commissioning of a working group of academics and analysts to come up with a workable methodology that national governments and international agencies can apply in their own evaluations.

²⁹ See for example Marcus Roberts, Dave Bewley-Taylor and Mike Trace, *Monitoring Drug Policy Outcomes: The Measurement of Drug Related Harm*, Beckley Foundation Drug Policy Programme, Report 9, July 2006, http://www.internationaldrugpolicy.net/reports/BeckleyFoundation_Report_09.pdf

- Supporting mechanisms for bringing academics and analysts together to develop methodologies, and, share findings. There are a growing number of experts and academics conducting research and evaluations that have relevance to drug policy. The EU could easily create an informal network that would allow the discussion of emerging methods, the sharing of findings, and the production of useful information in an accessible format for policymakers.

The Commission's co-ordination unit should ensure that all research and evaluation resources within the Commission, that are available to spend on the drug strategy, are directed towards these priorities, and the others activities listed in the research and evaluation section of the Action Plan.

CONCLUSION

The International Drug Policy Consortium commends the EU, its agencies and Member States, for their commitment to a balanced and evidence-based approach to this difficult policy area. The creation of successive strategies, and the increasingly clear definition of evaluation processes and mechanisms, provides analysts, and potentially the general public, with a clearer picture of what policy is trying to achieve, and what is being done in support of these objectives. A notable exception in this trend of improving evaluation mechanisms is the current weakness of structures and processes for assessing the achievements of supply reduction efforts. The key political and institutional challenge for the coming years is to use the evaluation data and analysis that is available in a transparent and rigorous way. It seems unlikely that we will be able to report clear success in significantly reducing the scale of illegal drug use across Europe during the lifetime of this strategy. Conversely, it is likely that some areas of existing investment are shown to be ineffective, and that therefore patterns of investment will need to change. Policymakers need to have the courage to face these dilemmas constructively, and facilitate a mature debate about how best to protect the health and security of EU citizens over the medium and long term.

ANNEX - Current Trends In Prevalence And Problems

We reproduce here a summary of European evidence on the prevalence of drug use, on the prevalence of problematic drug use, and on the consequences of drug use. It relies on data provided in the EMCDDA's 2006 *Annual Report*. This data is based on methods that provide estimates (not definitive counts) of drug use and problems, based on harmonised definitions and data gathering mechanisms agreed by all EU Member States. The data given here are from the most recent years reported by the EMCDDA, and therefore come from different years for different countries and sometimes use different methodologies and definitions. Full details of these differences are provided in the EMCDDA Report.

Prevalence

Figure 1: Estimated lifetime prevalence of cannabis use

See <http://stats06.emcdda.europa.eu/en/elements/gpstab02a-en.html>

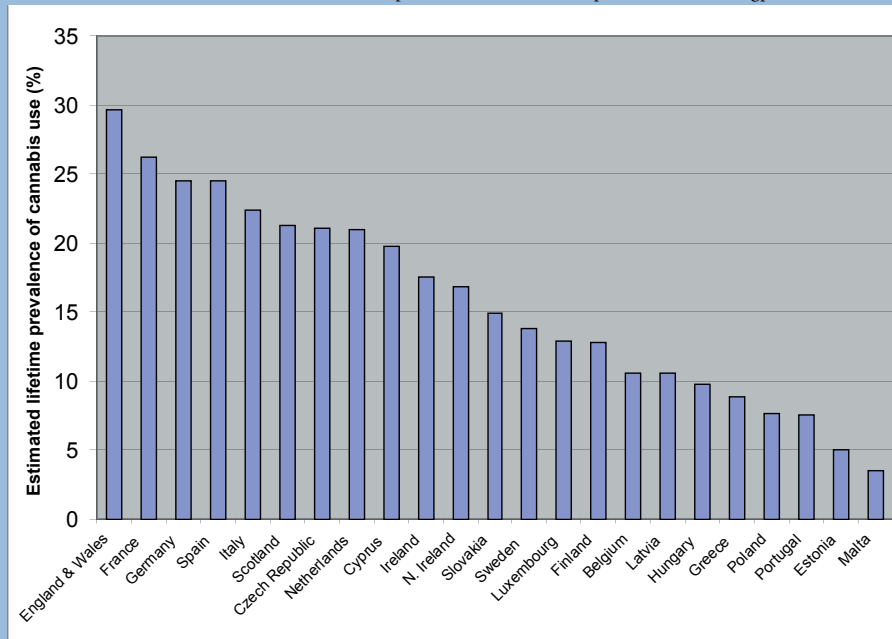


Figure 1 shows the estimated prevalence of lifetime cannabis use by adults in the EU. As cannabis is by far the most widely used drug, this also gives an indication of the proportion of national populations who have ever used an illicit drug. As the graph shows, rates of use vary widely between countries. In recent years, however, there are signs that levels of use are stabilising in higher prevalence countries, while continuing to rise in the lower prevalence countries.

Figure 2: Last year use of cannabis, cocaine and ecstasy by adults

See <http://stats06.emcdda.europa.eu/en/elements/gpstab04-en.html>

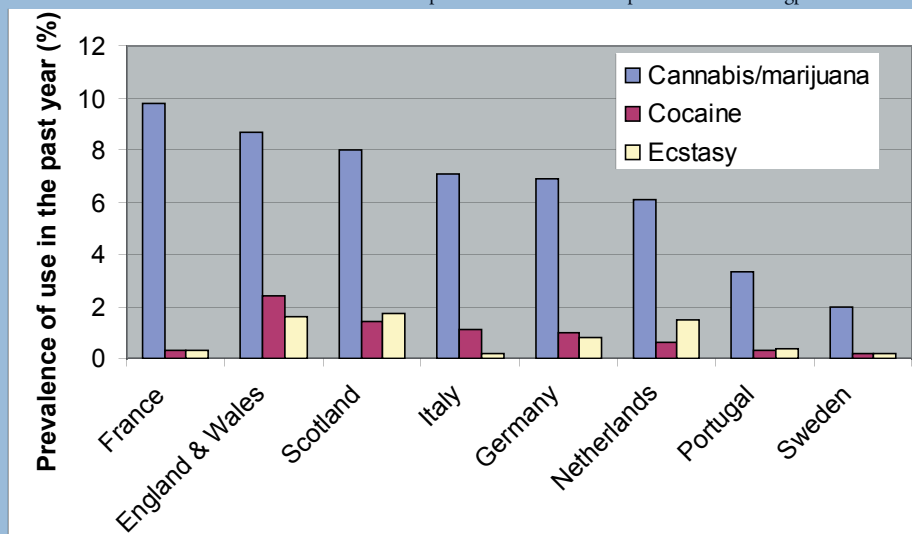


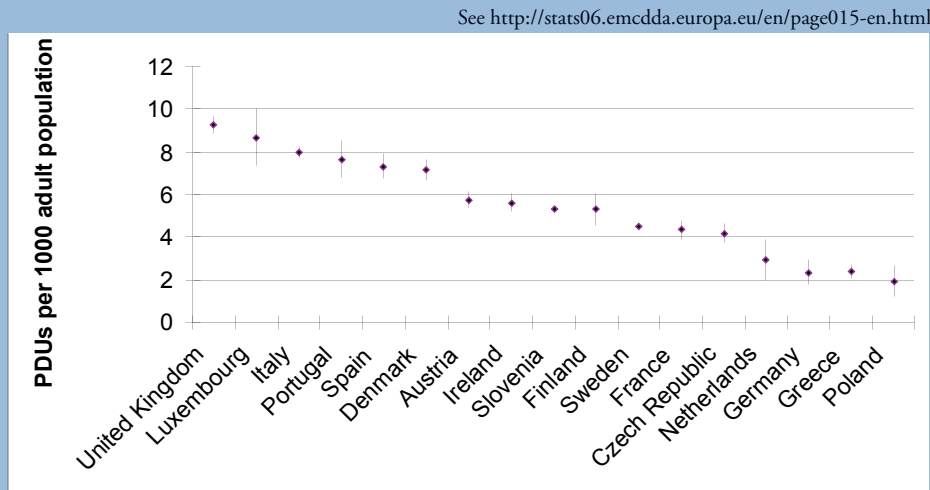
Figure 2 shows the rates of more recent use of the three most commonly used illicit drugs for some countries. Recent or current drug use is concentrated in the 15-35 age group, with rates tailing off amongst older age cohorts. Current use of all drugs except cannabis remains a relatively minority activity in Europe, although upward trends in cocaine use have recently been observed in some countries.

Prevalence for different drugs fluctuates between countries. For example, Britain has slightly lower estimated recent use of cannabis than France, but has the highest rates of use of cocaine and ecstasy. Generally across Europe there were significant increases in the use of these drugs in the 1990s.

Problematic drug use

Problematic drug use is defined as the daily use of any drug, or patterns of use that involve significant risk of harm, such as injecting. Caution needs to be applied when making comparisons of the numbers of problem drug users between countries, as the methods for estimating these numbers rely on data sets that are of varying quality and reliability.

Figure 3: Estimated numbers of problematic drug users (PDUs) as a proportion of the population



The general European trend in problem drug use is for steady increases through the 1980s and 1990s, with some evidence of stabilisation in more recent years. New member states are reporting continuing increases, but these figures may be affected by improved data collection, or visibility of PDUs, rather than real trends.

Consequences of drug use

Two of the most concerning consequences of drug use are drug-related death and drug-related infections (including HIV and Hepatitis C).

Figure 4: Drug related deaths (DRD) as a proportion of the national population

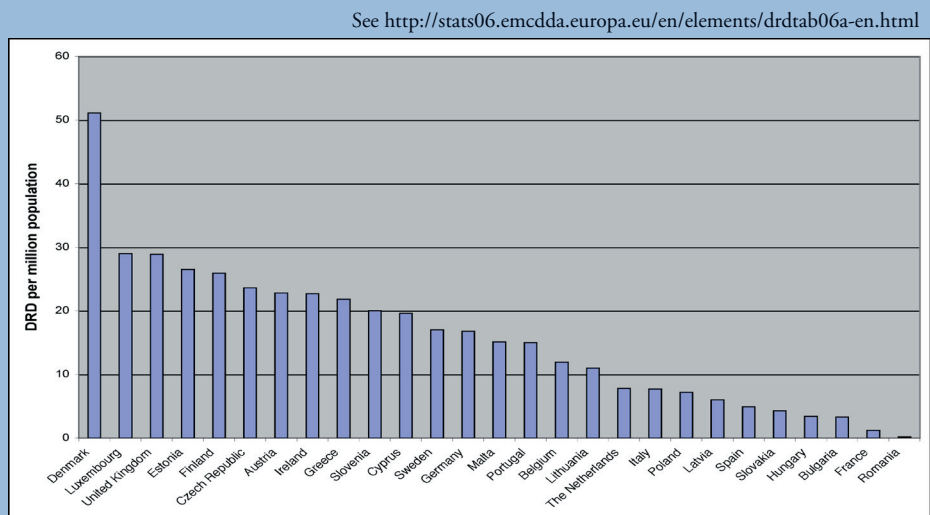


Figure 4 shows the rates of drug-related death. It should be noted that these data rely on differing definitions of drug-related death. Denmark uses a particularly wide definition, so reports a high figure. Similarly, countries at the bottom of the scale may be using a tight definition, or have less well developed reporting systems. Given the complexity of national systems for recording drug related deaths, it is perhaps more instructive to look at trends rather than absolute figures.

See <http://stats06.emcdda.europa.eu/en/elements/drdrtab03a-en.html>

Figure 5: Trends in drug-related death in selected EU countries

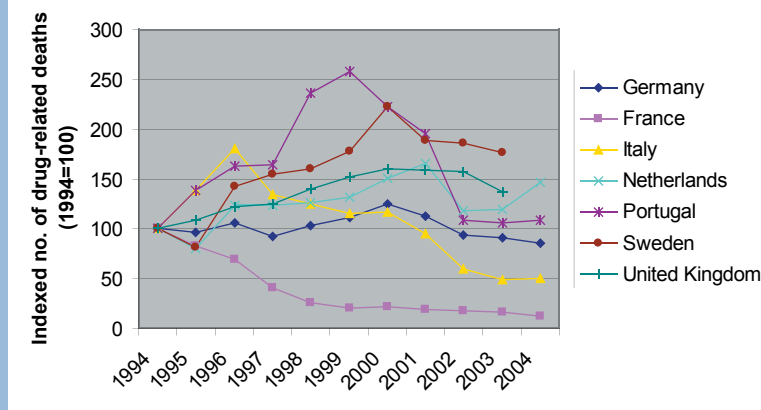


Figure 5 shows the trends in drug-related death in EU countries, which provide interesting comparisons. The general trend in these countries is downwards in recent years. Deaths peaked in several countries in the late 1990s and early 2000s. Significant declines, for example in Portugal and France, have been attributed to the increased availability of opiate substitution treatment and other harm reduction measures in those countries. For example, downward trends in Italy have coincided with the wider use of Naloxone in response to overdoses, and in France with the wider availability of Buprenorphine.

See <http://stats06.emcdda.europa.eu/en/elements/inftab02-en.html>

Figure 6: Estimated prevalence of HIV infection among injecting drug users (IDUs)

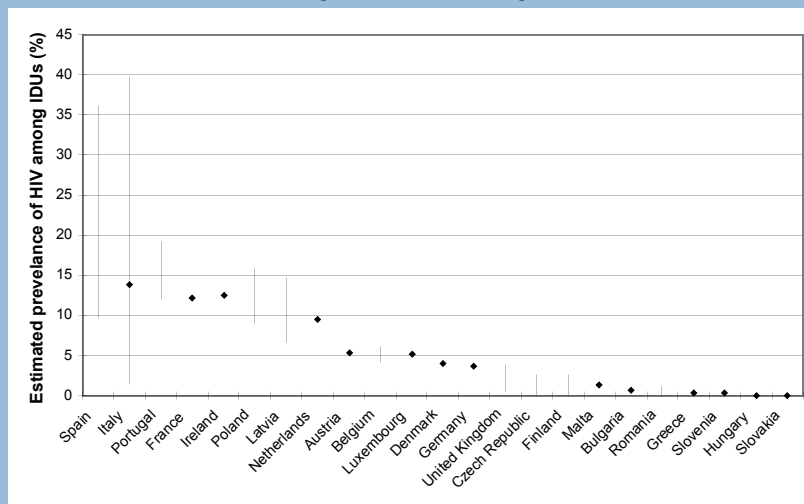


Figure 6 shows the estimated prevalence of HIV infection among injecting drug users. It should again be noted that these data come from different methods in different countries. In some countries these methods produce wide estimated ranges, often as a result of regional or local concentrations of infection.

See <http://stats06.emcdda.europa.eu/en/elements/inftab03-en.html>

Figure 7: Estimated prevalence of Hepatitis C (HCV) infection among IDUs

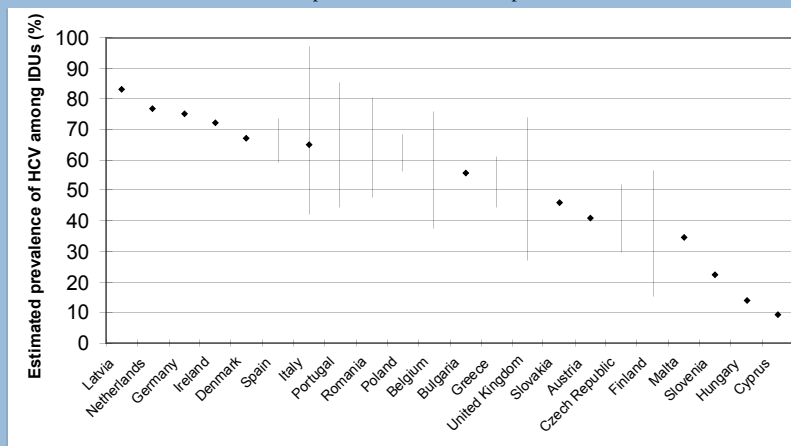


Figure 7 shows the estimated rates of Hepatitis C infection among IDUs. These rates tend to be much higher than rates of HIV infection, as the Hepatitis C virus is easier to pass on through the sharing of injecting equipment than HIV. Consequently, there is much less variation between countries, with infection rates at worryingly high levels across the EU.

While there are many impressive achievements in the development of harm reduction programmes in European countries, surveys show that all countries need to do more to ensure optimum coverage of these services to minimise infection. There remains a resistance in some administrations to resource allocation to infection prevention amongst drug injectors due to the politically sensitive nature of the issue. This reluctance to take action needs to be overcome if the much greater future costs of increased infection are to be avoided.

Overall, these figures paint an increasingly reliable picture of the nature and consequences of drug use across Europe. In this paper, we suggest priority actions for the European Commission and member states to continue the improvement in data availability and analysis. However, it is clear for the moment that the available data show clearly that the desired significant reductions in prevalence, problem use, and harmful consequences, are not being achieved.