news release

from the EU drugs agency in Lisbon

E.M.C.D.D.A.
European Monitoring Centre for Drugs and Drug Addiction

No. 13/2001 – 20 November 2001
EMBARGO 11H00 (BRUSSELS) 20/11/2001

2001 *Annual report* on EU drugs problem

'BLURRING OF TRADITIONAL BOUNDARIES' IN USE OF COCAINE

Signs of HIV up in six EU countries. Growing concern over long-term effects of ecstasy

➔ Traditional boundaries are blurring in the **EU** between affluent recreational users of cocaine *powder* and dependent and marginalised '*base/crack*' injectors or smokers.

➔ Although the overall picture is stable, HIV may be rising again among sub-groups of intravenous drug users (IDUs) in **Ireland**, **Luxembourg**, the **Netherlands**, **Austria**, **Portugal** and **Finland**. Drug-related HIV and hepatitis pose a major health-care challenge in the **EU**.

➔ Concern is growing around the dangers of long-term effects of ecstasy (MDMA), especially among binge and heavy users.

These highlights emerge from a special focus on cocaine, infectious diseases and synthetic drugs in the ***2001 Annual report on the state of the drugs problem in the European Union***, out today from the **Lisbon-based EU drugs agency**, **the EMCDDA**.

COCAINE: A COMPLEX PICTURE

Today's report says that, as trends and markets change, traditional boundaries between affluent and marginalised cocaine users might be blurring.

One factor is a new upmarket trend of cocaine smoking in recreational nightlife. Signs include mixing 'base/crack' cocaine with tobacco in a 'joint' – now reported in five countries: **Greece, France**, **Italy**, the **Netherlands** and the **UK**. And in the **UK**, 'base/crack' is being turned into ready-to-smoke 'rock' or 'stone' and pushed 'up-market'. Such nuances need to be fully understood for effective policy-making, urges the **EMCDDA**.

Despite some worries over a Europe-wide rise in cocaine use, available evi dence does not point to increases among the **EU** population as a whole. But there is concern about marked increases in specific geographical areas (parts of some cities), age groups and social milieus.

For example, in the **UK** there is a confirmed rise among 16 to 29-year-olds who have tried cocaine at least once. And some cities in **Italy** put cocaine use in second place to cannabis and higher than amphetamines or ecstasy.

More generally, school surveys show that, among 15 to 16-year-olds, experimental cocaine use remains low (4) and that, Europe-wide, cocaine is less available to this age group than to their **US** counterparts. Cocaine appears less available than ecstasy, but with national variations – it is perceived by schoolchildren to be most available in **Ireland** (21%) and the **UK** (20%), and least so in **Finland** (6%). Among this age group, disapproval of cocaine use is still very high across the **EU** – as high as it is for heroin.

The **EMCDDA** says cocaine is used much more by groups with higher levels of illicit drug use in general than by young adults as a whole. For example, the drug is used by socially-excluded groups such as homeless young people, sex workers and problem opiate users. And socially integrated youngsters, who choose to use a range of recreational drugs, increasingly use cocaine in nightlife settings combined with alcohol. But the report says that the drug's relatively high cost, combined with its short effect, mitigates against regular recreational consumption, which demands a high disposable income.

Among the population of drug users receiving treatment, the proportion of problems associated with cocaine use is rising in some countries. For example, in **Spain** and the **Netherlands** there are rises in people seeking treatment for problems associated with cocaine as their main drug. **Germany**, **Greece** and **Italy** also show a proportional increase in cocaine treatment, as did **Ireland** until 1998. But these increases may largely not be due to a real rise in cocaine use but rather an improvement in cocaine services or the result of opiate users switching to cocaine. **Italy, Luxembourg** and the **Netherlands** report a rise in drug deaths – and **Spain** in hospital emergencies – where cocaine is implicated with other drugs.

Prices range from € 24 per gram to € 170, with cities like **Amsterdam** and **Frankfurt** at the lower end and **Member States** such as **Finland** and **Sweden** at the higher. On the street, cocaine is sometimes sold already mixed with heroin.

Belgium, Spain and the **Netherlands** are reported as major **EU** transit points for cocaine from **Latin America** – **Brazil, Colombia** and **Venezuela** in particular.

The drugs agency says the **EU** Member States response to rises in cocaine and crack use has taken three main forms of demand reduction. A few cities with a rather high prevalence of cocaine use have developed special services for primary cocaine problems tailored to individual needs. Some **Member States** adapt existing models and treatment to provide services that will be more effective for cocaine and crack users (e.g. through training of professionals). And some countries address the criminality and health consequences of multiple drug use in general prevention and outreach work. Private clinics are likely to play a significant role in the treatment of more socially privileged cocaine problem users.

INFECTIOUS DISEASES: HIV MAY BE UP AGAIN IN SIX COUNTRIES

The report says that – although HIV prevalence seems to have stabilised in most **EU** countries since the mid-1990s – it might be rising again among sub-groups of intravenous drug users (IDUs) in six **Member States Ireland**, **Luxembourg**, the **Netherlands**, **Austria**, **Portugal** and **Finland**. Meanwhile, hepatitis C virus (HCV) remains extremely high **EU**-wide.

A preliminary estimate of future health care costs of one year of drug-related infections of HIV, hepatitis B virus (HBV) and HCV in the **EU** amounts to about 0.5% of the total **Member States'** health-care budget: € 1.89 billion.

The rises in HIV might be evidence of continuing high-risk behaviour among injectors, the report suggests, despite an overall reduction in injecting itself in most **EU** countries. HIV prevalence is consistently higher in women IDUs. The agency explains: 'This may be due to [their] higher levels or different ways of needle sharing and/or higher sexual risk…'

On AIDS, the report says there's a continued general downward trend. 'This decline is probably the result of new treatments among IDUs that delay the onset of AIDS.' **Portugal** is the only **EU** country not yet showing a fall, although the rise of the disease there in recent years now appears to be stabilising. Countries where IDUs are most affected are mainly in the south-west of the **EU** – **Spain**, **France**, **Italy** and **Portugal**.

Hepatitis C infection is higher and more evenly-spread **EU**-wide than HIV, notes the report. This could 'lead to a large health burden due to liver disease…over the coming decades'. Between 40% and 90% of IDUs are infected with HCV in the **EU.**

Hepatitis B infection is also high in the **EU** but is not as evenly spread as HCV. Recent data in **Portugal** indicate a decline in current HBV infection. Data from **Norway** point to a strong rise in HBV. Roughly between 20% and 60% of IDUs in the **EU** have antibodies against HBV but only between 10% and 30% may have been fully vaccinated (3 injections). This suggests a large potential health gain through vaccination.

The agency underlines the high risk of tuberculosis among IDUs, especially in **Spain** and **Portugal**. This is not transmitted by injecting drugs but does have a strong association with drug-injecting related HIV and AIDS due to weakened immunity.

A recent outbreak of unexplained illness with 43 deaths among IDUs in **Ireland** and the **UK** illustrates 'how large the potential is for severe health problems among IDUs, which can be much larger and more life-threatening than problems due to other and more prevalent patterns of drug use'.

Injecting drug use has fallen strongly in the last decade in most **EU** countries, although it is rising again in **Ireland**. Rates of injecting among opiate users entering treatment now vary from a low of around 10% in the **Netherlands** to a high of some 70% in **Greece**.

At present, there is only limited knowledge of how to prevent injecting drug use. However, says the report, substitution treatment can be an effective response, while needle exchange is important in preventing infections. Some countries are considering innovative harm-reduction approaches such as medically-supervised injecting rooms and controlled heroin distribution. But both pose ethical and legal difficulties and might require changes in national drug laws. Among countries where injecting rooms have been established (**Australia**, **Switzerland**, **USA, Germany, Spain** and the **Netherlands**), their effectiveness needs to be fully assessed.

SYNTHETIC DRUGS: GROWING CONCERN OVER LONG-TERM EFFECTS OF ECSTASY

The report highlights growing concern about the dangers of long-term effects of ecstasy. Effects on the brain are still under discussion and, among heavy ecstasy users, there is increasing evidence of damage to serotonergic neurons. This might affect future trends in use.

The report says the spread of synthetic drug use in the **EU** 'has generally stabilised'. However, upward trends in ecstasy use 'are still observed in some regions where cities or holiday resorts are more likely to attract young European tourists…' And urban areas where youth cultures have established 'may continue to provide a setting for recreational drugs to anchor and develop'. Consumption of such drugs seems to have spread beyond the 'techno-scene' to discotheques, nightclubs and private settings.

The agency says combined use of various substances, licit and illicit, is common among young people with an outgoing lifestyle. Poly-use – mixing or alternating a large range of substances, synthetic and non-synthetic – is the main trend.

A trend that 'needs to be monitored closely' is the increasing number of psychotropic medicines such as ketamine, diverted from legitimate sources.

However, since outreach and other prevention measures have been taken at techno/house events and parties, there has been a fall in deaths since the early-1990s. Such steps include 'chill-out rooms' and on-site pill-testing.

The **Netherlands** is still the main country for production and export of ecstasy. The **Baltic States, Bulgaria,** the **Czech Republic** and **Poland** are also significant suppliers. By far the most seizures of ecstasy tablets in 1999 was in the **UK** – over 6,000 seizures of six million tablets. Next largest amounts were in the **Netherlands** and **France**.

Synthetic drugs 'are in the political limelight' states the report. 'Their high level of use among socially-integrated groups, their role as a reference model within youth culture and the fact that production and trafficking are set up in Europe…exert strong pressure for responsible action by the **EU**'.

The **EU** now has an early-warning system to detect particular dangers posed by such substances. Four drugs – MBDB, 4-MTA, GHB and ketamine – have undergone **EMCDDA** risk assessments and one involving PMMA is currently underway. As a result, 4-MTA (known on the street as 'flat-liners') is now subject to control measures in all **EU** Member States.

Notes to editors:

([1]) Figures from the European school survey project (ESPAD).

This year, the EMCDDA offers you a special website: ***Annual report 2001 online*** at http://annualreport.emcdda.org or http://emcdda.kpnqwest.pt The site contains downloadable PDF files of the report and this and other news releases in 12 languages (11 **EU** + **Norwegian**).

Contact: Kathy Robertson, European Monitoring Centre for Drugs and Drug Addiction
EMCDDA, Rua da Cruz de Santa Apolónia 23–25, PT-1149-045 Lisbon, Portugal.
Tel: ++ 351 21 811 3000 • Fax: ++ 351 21 813 1711
***2001 Annual report online:* http://annualreport.emcdda.org or http://emcdda.kpnqwest.pt**