



European Monitoring Centre
for Drugs and Drug Addiction

EN

European Drug Report

Trends and Developments

Cannabis

Cocaine

MDMA

Amphetamines

Drug-related infectious diseases

Injecting drug use

Heroin and other opioids

New psychoactive substances

Hospital emergencies

2020



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Preface

This year, the EMCDDA marks 25 years of reporting on the European drug situation. We are proud of the contribution the agency has made during this period to foster the European dialogue on drugs. Our approach has been to provide stakeholders with a neutral and balanced assessment of not only the problems Europe faces, but also what constitutes effective solutions. The agency's work is now recognised as one of the foundations for drug policy discussions. In a field in which many hold strong personal views and consensus is not always easy to reach, we believe the impartiality and objectivity of our work is a core strength of the EMCDDA. The European drug problem has changed substantially over the last 25 years, but our primary objective of providing reliable evidence remains as important today as it was when the agency was founded. We are pleased, therefore, to present here the European Drug Report (EDR) 2020, which comes along with a concise multilingual summary (the EDR Key Issues).

This year is different, however. Our annual reporting exercise is intended to provide a synthesis of the most recent data available; in this case describing the European drug situation up to the end of 2019. From early 2020 the global COVID-19 pandemic has dramatically altered all aspects of modern life and this includes drug use, the drug market and the ability of European countries to provide help and support to those with drug problems. Our immediate response to the pandemic was to help our stakeholders through the sharing of information on how services could both protect their staff and continue to deliver essential care and support to those in need.

We have also launched a series of ongoing rapid assessments to understand the impact of the pandemic on drug use, associated problems and the market. This information is available on our dedicated [webpages for COVID-19](#). As the situation is highly dynamic, assessments can quickly become obsolete. The online resources therefore provide the most up-to-date analysis of the current situation.

As we move forward, we must also recognise that the events of 2020 are likely to have a long-term impact on the future challenges arising in the drugs area. As the 'new normal' begins to take shape, we will need to monitor if and how quickly the situation returns to how it was before COVID-19. This year's EDR will function as a baseline for this further analysis. Many of the developments we note here will remain serious challenges in the coming years. At the same time, the economic impact of the pandemic and the legacy effects on behaviours and services are likely to have lasting repercussions that will feed into the challenges awaiting us in the future. We believe that the European Drug Report of 2020 provides a sound evidence base for preparing for the post-pandemic period. The problems we face may differ but the EMCDDA remains committed to providing in the coming years the same high-quality, impartial and evidence-based assessments as we have in the past.

Finally, at this time of significant upheaval, we wish to extend a special thanks to our partners in the Reitox network of national focal points, our other national and international partners and the Scientific Committee of the EMCDDA, whose support has been essential for this report. We also gratefully acknowledge the contribution of the many European research groups who have helped enrich the analysis presented here and the input we have received from our European partners: the European Commission, Europol, the European Medicines Agency and the European Centre for Disease Prevention and Control.

Laura d'Arrigo
Chair, EMCDDA Management Board

Alexis Goosdeel
Director, EMCDDA

Introductory note and acknowledgements

This report is based on information provided to the EMCDDA by the EU Member States, the candidate country Turkey, and Norway, in an annual reporting process.

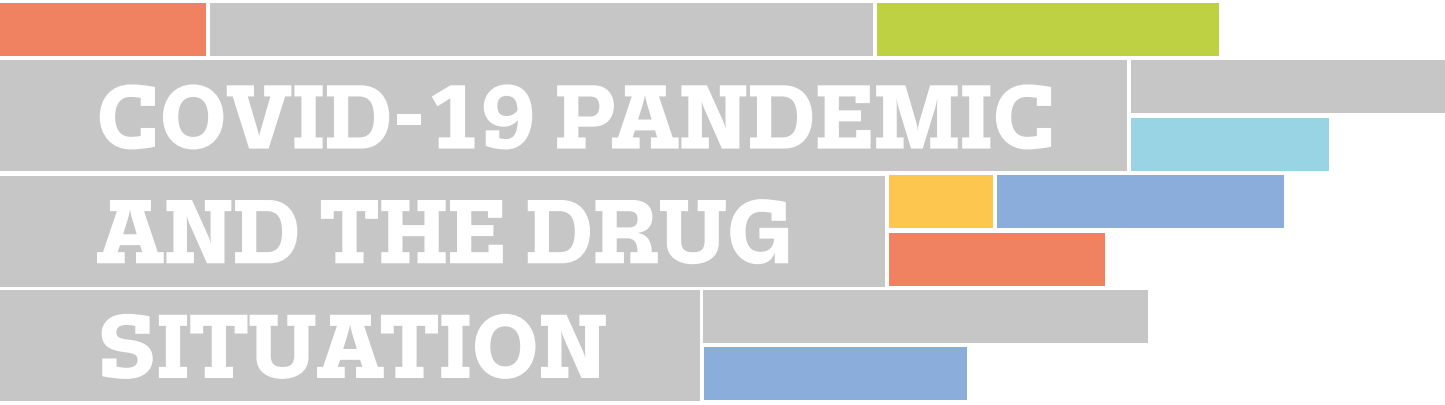
The purpose of the current report is to provide an overview and summary of the European drug situation up to the end of 2019. All grouping, aggregates and labels therefore reflect the situation based on the available data in 2019 in respect to the composition of the European Union and the countries participating in EMCDDA reporting exercises. However, not all data will cover the full period. Due to the time needed to compile and submit data, many of the annual national data sets included here are from the reference year January to December 2018. Analysis of trends is based only on those countries providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Although considerable improvements can be noted, both nationally and in respect to what is possible to achieve in a European level analysis, the methodological difficulties in this area must be acknowledged. Caution is therefore required in interpretation, in particular when countries are compared on any single measure. Caveats relating to the data are to be found in the online [Statistical Bulletin](#), which contains detailed information on methodology, qualifications on analysis and comments on the limitations in the information set available. Information is also available there on the methods and data used for European level estimates, where interpolation may be used.

The EMCDDA would like to thank the following for their help in producing this report:

- the heads of the Reitox national focal points and their staff;
- the services and experts within each Member State that collected the raw data for this report;
- the members of the Management Board and the Scientific Committee of the EMCDDA;
- the European Parliament, the Council of the European Union — in particular its Horizontal Working Party on Drugs — and the European Commission;
- the European Centre for Disease Prevention and Control (ECDC), the European Medicines Agency (EMA) and Europol;
- the Pompidou Group of the Council of Europe, the United Nations Office on Drugs and Crime, the WHO Regional Office for Europe, Interpol, the World Customs Organisation, the European School Survey Project on Alcohol and Other Drugs (ESPAD), the Sewage Analysis Core Group Europe (SCORE), the European Drug Emergencies Network (Euro-DEN Plus), the European Syringe Collection and Analysis Project Enterprise (ESCAPE) network and the Trans-European Drug Information network (TEDI).

Reitox national focal points

Reitox is the European information network on drugs and drug addiction. The network is comprised of national focal points in the EU Member States, the candidate country Turkey, Norway and at the European Commission. Under the responsibility of their governments, the focal points are the national authorities providing drug information to the EMCDDA. The contact details of the national focal points may be found on the [EMCDDA website](#).



COVID-19 PANDEMIC AND THE DRUG SITUATION

The analysis presented in this report is based on the most recent data available from routine monitoring and describes the drug situation in Europe at the end of 2019. Since then, European countries have been greatly affected by the outbreak and rapid spread of the coronavirus disease 2019 (COVID-19) pandemic. The enforcement of restrictive public health measures necessary to curb transmission of the virus have impacted all areas of life including drug use, drug markets and the implementation of law enforcement and health and social responses to the drug phenomenon. Across Europe, 2020 has seen, to varying degrees, the introduction of restrictive measures unprecedented in peacetime, including closure of non-essential services, border closures, and limitations on the right to assembly and freedom of movement. This situation has had an immediate impact on many behaviours linked to drug use and drug supply, as well as disrupting health provision and some law enforcement activities. Subsequently, the relaxing or lifting of some of the public health measures has created the conditions for a rebound towards the pre-COVID-19 situation. However, at the time of writing, the situation remains volatile and the pandemic continues to have an impact across many key policy areas, including drugs. Importantly, COVID-19 still poses a major threat to global health and security and is likely to do so for some time. The pandemic is also likely to have, in the medium to long term, an economic and social impact that will have wide-ranging implications, including some for the future problems we are likely to face in the drugs area.

From the start of the pandemic, the EMCDDA has been committed to supporting its stakeholders in responding to the immediate challenges in this area. The EMCDDA has been closely following the development of the situation and responses to it, acting as a conduit for information-sharing. In a series of rapid studies, we have also reported on the

impact of COVID-19 on drug use and associated problems, help-seeking, service provision and the operation of the drug market. The situation requires regular review and our ongoing work on it can be accessed from our [COVID-19 web area](#).

This includes an analysis of the special needs and risks for people who use drugs, in order to prevent coronavirus infections among this group. While people who use drugs run the same risk of coronavirus infection as the general population, they also face additional risks and vulnerabilities that need both consideration and mitigation. A [rapid trendspotter assessment](#) conducted by the EMCDDA found that some behaviours associated with drug taking prior to the COVID-19 pandemic may now be considered 'high-risk' in terms of infection. For example, sharing cannabis joints or cocaine straws, sharing preparation equipment among high-risk drug users (e.g. crack pipes, spoons, filters), and splitting and handing over MDMA tablets may all pose potentially new and little-explored risks of coronavirus transmission at the moment of drug taking. Moreover, some conditions linked to drug use may make individuals more likely to experience adverse outcomes if they do become infected. For example, people with chronic opioid and stimulant use problems are more likely to have compromised immune systems, chronic respiratory disease — for example linked to smoking tobacco and other drugs — and cardiovascular disease. Chronic health problems combined with the poor living conditions often associated with high-risk drug use may make people both more susceptible to coronavirus infection and in danger of more severe consequences if infected. Drug problems are also commonly found in marginalised groups like the homeless and in criminal justice settings, where COVID-19 prevention measures can be particularly challenging. There is also a concern that any disruptions to the drug market may result in dependent drug users

turning to different substances or engaging in more risky behaviours. It also appears that in some countries, possibly as a result of disruptions to local drug markets, COVID-19 has resulted in greater help-seeking among people who use drugs. This added to the operational pressures on services that were introducing measures to mitigate the impact of the pandemic on their clients and staff.


During the initial lockdown period, harm reduction and drug treatment services, like all healthcare providers, were faced with the difficulties of providing continuity of care while reducing face-to-face contact and respecting travel bans and other social distancing measures. While services have experienced disruptions, innovative approaches to providing care have helped to counteract this. These innovations include introducing more flexibility in substitution treatment prescribing and the provision of harm reduction material, greater use of e-and m-health options and a more proactive approach to outreach with clients who faced mobility restrictions. It will be interesting to see if these changes alter service provision in the long term. A less positive observation is that as some services for people who use drugs are often delivered by voluntary or civil society groups, they may not always be well integrated into healthcare systems. During the initial stages of the pandemic, this resulted in concerns that these kinds of services were not included in COVID-19 prevention measures being applied to other areas of healthcare, such as ensuring the availability of personal protective equipment. A valuable lesson for the future is the need to ensure the inclusion of community-based services in crisis response and contingency planning.

The EMCDDA, in collaboration with Europol, has released an initial analysis of the of impact of COVID-19 on drug markets in the European Union. At first, local drug markets appeared to be affected by social distancing measures as people who use drugs reported that supplies of some drugs were disrupted, resulting in higher prices. However, these changes appeared short-lived, with subsequent reports indicating that retail markets are reappearing as social distancing measures are relaxed. Other changes in the drugs market were observed, including a possible increased interest in online sales via darknet markets, with drug distributors adapting their methods to fit the COVID-19 situation. Generally, since the emergence of the pandemic, surface web and darknet markets, social media and secure encrypted communication applications now appear to be playing a more prominent role in the sourcing of drugs at the user level. Less face-to-face dealing and less reliance on cash as a form of payment seem to be increasing for individual transactions, and it is possible that behavioural changes, once established, will persist. There were also some signs of declining interest in substances like MDMA and cocaine that are commonly used in social

settings, which were not operational during lockdowns. There were, however, also reports of a greater interest in or use of some more novel substances. An example was the appearance of benzodiazepines on the new psychoactive substances market, possibly driven in part by shortages of more established drugs. From the information currently available, the overall impact on patterns of drug taking appears somewhat mixed, with differences observed between countries. It will remain to be seen whether any trends triggered or accelerated by the pandemic take root and become part of future consumption patterns; for example, in more interest in online drug sales or increased popularity of some previous novel substances.

Regarding international drug trafficking and the operation of organised crime groups, an initial observation was that, unsurprisingly, trafficking using couriers on commercial airlines or other forms of public transportation was disrupted. However, seizures and intelligence data did not suggest any immediate major disruption to major drug trafficking activities using other methods, particularly those exploiting the movement of commercial goods, in particular concealing drugs in shipping containers. Concerns have also been raised that organised crime groups may be attempting to exploit the current situation, where law enforcement officers have been assigned to COVID-19 prevention activities. There does not appear to have been a significant impact on drug production within the European Union. Synthetic drug production, for example, continues in the main European producing zone in the Netherlands and Belgium, as evidenced by the number of illicit laboratories dismantled and dumpsites reported. The domestic production of herbal cannabis also appears not to have been significantly disrupted. Additionally, the movement of bulk quantities of drugs between EU Member States has continued, despite the introduction of border controls, due to the continued commercial transportation of goods throughout the European Union. Nonetheless, the current instability has led to an increasingly volatile environment for criminal businesses along the supply chain in Europe and appears to have resulted in increased levels of violence among mid-level suppliers and distributors.

Looking to the future, three important questions remain to be answered. Will we see a full return to the situation at the end of 2019 and, if so, how quickly will this happen? In addition, will there be important medium and long-term implications for drug use and the future drug problems we face, or for how services respond to problems in this area? And finally, what lessons can be learnt from the pandemic in order to increase the resilience of our policy responses in this area if faced by future crises? The data reported here provide a valuable baseline for these considerations, and the EMCDDA is committed to following these issues closely.



EUROPE'S DRUG SITUATION UP TO 2020: CURRENT AND EMERGING THREATS

Large drug shipments are increasingly intercepted

Many indicators for the most commonly used substances suggest drug availability remains high. Alongside developments in production, an increase in the interception of large quantities of cocaine, cannabis resin and increasingly heroin transported by sea often in intermodal containers raises concerns around the infiltration by organised crime groups of logistical supply chains, shipping routes and large ports.

Cocaine's role in Europe's drug problem is increasing

The number and quantity of cocaine seizures are now the highest ever reported, with over 181 tonnes of the drug seized in 2018. Belgium, Spain and the Netherlands are key countries for the interception of large quantities. Indicators point to high availability of cocaine on the European market and signs of growth in countries where it was previously uncommon. Crack cocaine use, while still uncommon, is now reported by more countries. The purity of cocaine at retail level has increased almost every year since 2009, and in 2018 it reached the highest level in the last decade. Collectively, the high purity of the drug, along with data from treatment services, emergency presentations and drug-induced deaths, suggest that cocaine is now playing a more important role in the European drug problem. The cocaine market also appears an important driver for drug-related violence.

The potential for increased heroin use and existing harms raise concerns

Indicators of heroin use continue to suggest an ageing cohort of users with low rates of initiation. In addition, new drug treatment entries associated with heroin have fallen in many countries. However, a doubling of the volumes of heroin seized within the European Union and increasing volumes seized in Turkey are worrying, as are reports of heroin manufacturing taking place within the European Union. This suggests more vigilance is necessary to detect any signs of increased consumer interest in a drug associated with serious health and social problems.

Understanding the public health impact of high-potency cannabis and new products

Cannabis now plays a major role in drug treatment admissions, but the relationship between cannabis problems and developments in the drug market remains poorly understood. This is at a time when the cannabis market is changing, with the presence of high-THC (tetrahydrocannabinol) content products, and new forms of cannabis and commercial products based on extracts from the cannabis plant becoming increasingly available. Moreover, cannabis resin and herb now contain on average about twice as much THC as they did just a decade ago. Taken together this suggests that there is a pressing need

for greater surveillance in this area. These issues and others like the availability of low-THC products marketed for their high CBD (cannabidiol) content are examined in a forthcoming edition of EMCDDA's Cannabis: controversies and challenges series of briefings.

Increased and diverse drug production within Europe

Established and new drugs continue to be produced in Europe, for local and global markets, with more laboratories and production sites detected by law enforcement. Changes in the production tactics of organised crime groups are part of the reason behind this trend, but also access to cheaper and novel precursor chemicals and processing equipment. The production of illicit drugs is now based on a more diverse set of chemicals, which are both difficult to respond to under European and international laws and challenging to monitor.

Continuing availability of high-strength MDMA products highlights need for greater user awareness

Innovation and scaling-up of synthetic drug production in Europe is evident in the continued availability of high-content MDMA tablets and high-purity powders. Alongside increases in both the average MDMA content in tablets and the purity of powders in 2018, data show that products containing extremely high levels of MDMA are also being detected. These products pose considerable health risks for people using them and raise an important issue for prevention and harm reduction messaging and interventions.

Growing complexity in the drug market poses regulatory challenges and health risks

A better understanding of the availability of both uncontrolled and less common substances, and their impact on public health, is clearly needed. These substances are often poorly monitored, but there is evidence to suggest they may constitute a growing problem, as indicated for example by the increased quantities seized of ketamine, GHB (gamma-hydroxybutyrate) and LSD (lysergic acid diethylamide). In addition, concerns have been raised by some countries about the use of substances like nitrous oxide (N₂O, laughing gas). Non-controlled and new benzodiazepines, obtained online or through the more conventional illicit drug market, are also a growing concern. Etizolam, for example, which is not an authorised medicine in most countries, appears to be commonly available on drug markets in some countries and has been linked to increases in drug-induced deaths among people who use opioids.

Drug overdose is increasingly associated with an ageing population

Between 2012 and 2018 the number of drug overdose deaths among the 50-plus age group increased by 75 %, indicating that this problem is increasingly associated with older long-term users. This underlines the need to recognise the increasing vulnerability of an ageing cohort of life-long drug users and make this group an important target for treatment, social reintegration and harm reduction measures.

New tools and innovative strategies are needed to support the scaling-up of hepatitis C treatment

Drug injection remains a major route for hepatitis C virus (HCV) infections in Europe, and access of people who inject drugs to prevention, testing and treatment for hepatitis C is therefore a critical requirement for the elimination of this disease. While effective oral direct-acting antiviral medications are now more available, scaling up the provision of these medicines remains a challenge for many countries. The introduction of improved diagnostic and surveillance techniques to identify those chronically infected with this disease is important for the targeting of treatment to those most in need.

New psychoactive substances have become a more persistent problem

The pace at which new psychoactive substances are being introduced onto the market has stabilised in recent years. Nonetheless, more than 50 new psychoactive substances continue to be detected for the first time annually by the EU Early Warning System (EWS). Alongside this, each year about 400 previously reported new psychoactive substances are detected on the European market.

Appearance of new synthetic opioids is a worrying example of continuing market adaptability

Growing awareness about the individual and public health risks associated with fentanyl derivatives has resulted in actions that include increased restrictions in producer countries. One sign of the market adapting may be that of the eight new synthetic opioids detected for the first time in 2019 by the EWS, six were not fentanyl derivatives, though potentially presenting a similar threat to public health.

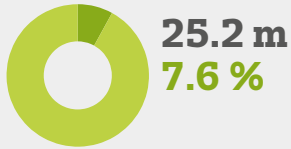
AT A GLANCE — ESTIMATES OF DRUG USE IN EUROPE

Cannabis

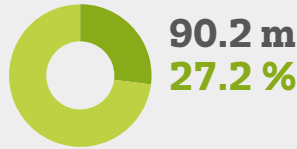


Adults (15-64)

Last year use

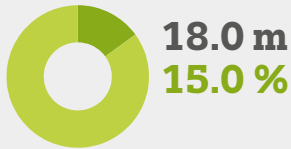


Lifetime use

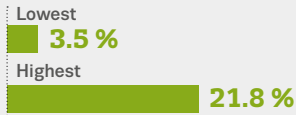


Young adults (15-34)

Last year use



National estimates of use in last year

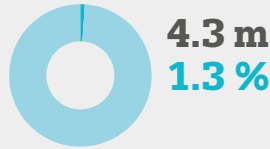


Cocaine

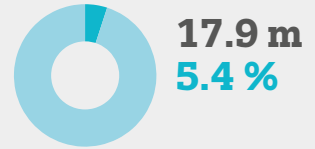


Adults (15-64)

Last year use

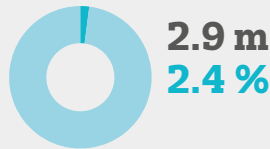


Lifetime use

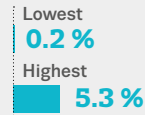


Young adults (15-34)

Last year use



National estimates of use in last year

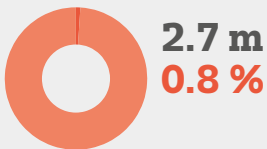


MDMA

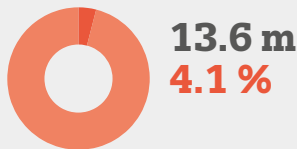


Adults (15-64)

Last year use

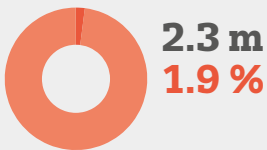


Lifetime use

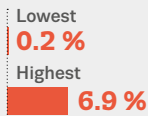


Young adults (15-34)

Last year use



National estimates of use in last year

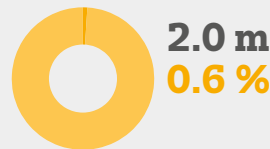


Amphetamines

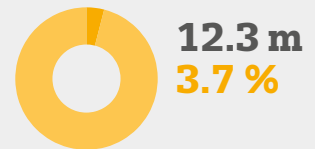


Adults (15-64)

Last year use

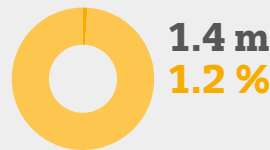


Lifetime use

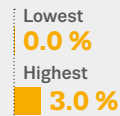


Young adults (15-34)

Last year use



National estimates of use in last year



Heroin and other opioids



High-risk opioid users

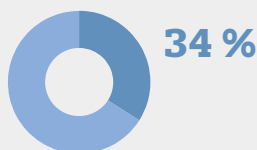
1.3 million

660 000

opioid users received substitution treatment in 2018

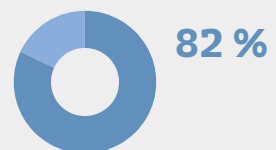
Drug treatment requests

Principal drug in about 34 % of all drug treatment requests in the European Union



Fatal overdoses

Opioids are found in 82 % of fatal overdoses



For the complete set of data and information on the methodology, see the accompanying online [Statistical Bulletin](#).



EUROPE'S DRUG SITUATION UP TO 2020

Drug use encompasses a set of complex and often hidden behaviours that are challenging to monitor. Data sources are often partial or incomplete, they may not always be directly comparable, and they may suffer from time delays in reporting. Practical and methodological issues therefore exist that impact on the collection, reporting and analysis of information in this area. The EMCDDA approach is to consider multiple indicators and review the data regularly over time to help detect important underlying trends.

Drug supply and the market

Sizeable markets for cannabis, heroin and amphetamines have existed in many European countries since the 1970s and 1980s. Over time, other substances also became established — including MDMA and cocaine in the 1990s. The European drug market continues to evolve, with a wide range of new psychoactive substances emerging over the last decade. Recent changes in the illicit drug market, largely linked to globalisation and new technology, include innovation in drug production and trafficking methods, the establishment of new trafficking routes and the growth of online markets.

In the global context, Europe is an important market for drugs, supplied from both domestic production and trafficking from other world regions. South America, West Asia and North Africa are important source areas for illicit drugs entering Europe, while China is an important source country for new psychoactive substances, drug precursors and related chemicals. In addition, some drugs transit Europe en route to other continents. Europe is also a producing region for cannabis and synthetic drugs; cannabis production is mostly for European consumption, while synthetic drugs are manufactured for the European market and exported to other parts of the world.

The recent (2019) joint EMCDDA-Europol analysis of developments in the drug market also provides context for the update on trends presented here. That report noted that the drug supply chain was more globally connected and increasingly digitally enabled, resulting in drug markets that are quick to innovate and to exploit new opportunities. This presents increasing challenges for current regulatory models and law enforcement strategies and accounts for the increasing diversity in drug availability and use described in this report. The increasing importance of the drug market as a driver of crime, particularly corruption and violence within EU countries, as well as in other source and transit regions, was also noted. This underlines the need to recognise both the direct and indirect negative impact of drugs on the health and security of European citizens.

More than a million seizures of illicit drugs: cannabis dominates

Seizures of illicit drugs by law enforcement agencies are an important market indicator, with around 1.3 million seizures reported in 2018 in Europe, with cannabis products most often seized (Figure 1). The majority of reported seizures involve small quantities of drugs confiscated from users. However, a small number of multi-kilogram consignments

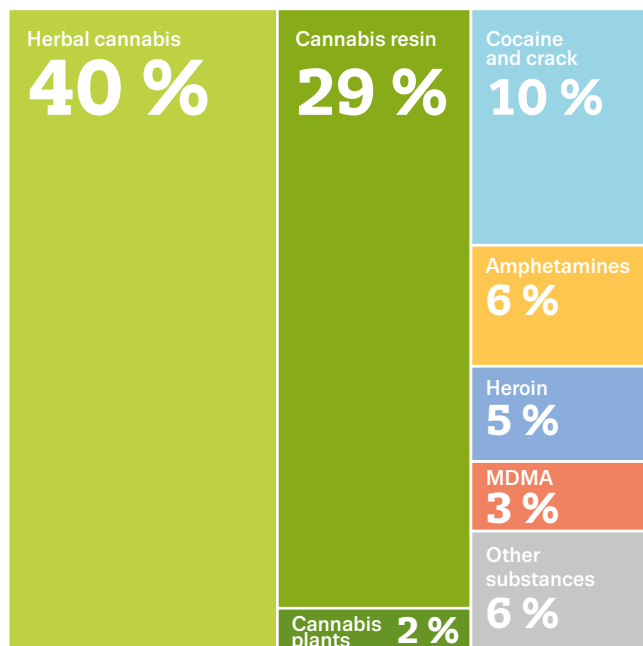
account for most of the total quantity of drugs seized. This underlines the importance of big seizures in interpreting data in this area: the detection or non-detection of small numbers of shipments can have a significant impact on overall totals. The three countries that report the highest numbers of seizures, together accounting for over half of all drug seizures reported in the European Union, are Spain, the United Kingdom and France. However, data on the number of seizures are not available for the Netherlands, an important country for synthetic drug production, while 2015 data are the most recent available for Germany, adding a considerable degree of uncertainty to the analysis of total European seizures.

Drug use prevalence and trends

Drug use in Europe encompasses a wide range of substances. Among people who use drugs, polydrug consumption is common but challenging to measure, and individual patterns of use range from experimental to habitual and dependent consumption. Cannabis is the most commonly used drug — the prevalence of 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. The extent of stimulant use and the types that are most common vary across countries, and evidence is growing of a potential increase in stimulant injecting. Use of all drugs is generally higher among males, and this difference is often accentuated for more intensive or regular patterns of use.

FIGURE 1

Number of reported drug seizures, breakdown by drug, 2018



Around 96 million adults have used illicit drugs

Around 96 million or 29 % of adults (aged 15-64) in the European Union are estimated to have used illicit drugs at least once in their lifetime. This should be regarded as a minimum estimate due to reporting biases. Experience of drug use is more frequently reported by males (57.8 million) than females (38.4 million). The most commonly tried drug is cannabis (54.6 million males and 35.7 million females), with much lower estimates reported for the lifetime use of cocaine (12.1 million males and 5.8 million females), MDMA (9.1 million males and 4.6 million females) and amphetamines (8.1 million males and 4.1 million females). Levels of lifetime use of cannabis differ considerably between countries, ranging from around 4 % of adults in Malta to 45 % in France.

Last year drug use provides a measure of recent drug use and is largely concentrated among young adults. An estimated 20.0 million young adults (aged 15-34) used drugs in the last year (16.6 %), with about twice as many males (21 %) as females (12 %) reporting doing so.

Data sources: monitoring drug supply, use and harms

The analysis presented here draws on data from both demand side and supply side indicators. As noted above all indicators are imperfect in some respects and therefore analysis needs to take into consideration different data sets, and conclusions can only be drawn with caution.

Supply side sources considered here include data on drug seizures, drug precursor seizures and stopped shipments, dismantled drug production facilities, retail drug prices, purity and potency. In some cases, the absence of seizure data from key countries makes the analysis of trends difficult. A range of factors can influence trends, including user preferences, changes in production and trafficking, law enforcement priorities, activity levels and effectiveness.

Also presented here are data on notifications and seizures of new psychoactive substances reported to the EU Early Warning System (see the [EMCDDA website](#) for more information). As this information is drawn from case reports rather than routine monitoring systems, seizure estimates represent a minimum.

A wide range of demand-side data sources are also included in this analysis. The EMCDDA collects and maintains datasets that cover drug use and patterns of use in Europe. Surveys undertaken among school students and the general population provide an overview of the self-reported prevalence of drug use. These survey results are 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 are used to identify the extent of the more entrenched drug use problems, while data on those entering specialised drug treatment systems increase our understanding of the nature and trends in high-risk drug use.

Other, more targeted data sources are also used here. Data collections from the analysis of wastewater, syringe residues, drug content and drug-related hospital emergencies provide insights into changing drug-use patterns and types of drug used. While not representative of the general population, these sources provide timely supplementary data. All data sources on drug use have strengths and weaknesses, and both the availability and the quality of data can vary by country.

Drug-related infectious diseases and mortality associated with drug use are the principal health harms monitored systematically by the EMCDDA. These are complemented by more limited data on acute drug-related hospital emergency presentations and data from the EU Early Warning System, which monitors harms associated with new psychoactive substances.

Full data sets and methodological notes can be found in the online [Statistical Bulletin](#).

CANNABIS

risks

use

trends

prevention

seizures

treatment



Cannabis is the illicit drug most widely available in Europe, where it is both produced domestically and imported. It is also the most commonly used illicit drug. This section analyses the latest data from law enforcement, general population surveys and specialised drug treatment centres in order to draw a picture of cannabis in Europe, encompassing the market, use and related problems.



Cannabis seizures: quantity of resin increases, herb fluctuates

In 2018 EU Member States reported 760 000 seizures of cannabis products, including 412 000 seizures of herbal cannabis, 318 000 of cannabis resin and 21 000 of cannabis plants. However, the quantity of cannabis resin seized was more than three times that of herbal cannabis (668 versus 194 tonnes). In part, this is a consequence of cannabis resin being trafficked in larger volumes across international borders, making it more likely to be seized. Because of its proximity to Morocco, Spain is particularly important when it comes to cannabis resin seizures, accounting for more than two thirds (65 %) of the total quantity seized in the European Union in 2018 (Figure 2).

The numbers of cannabis seizures reported in the European Union, both for resin and herbal products, have been relatively stable since 2012 (Figure 3). In recent years, the trend in the volume of seizures has been upwards. Following a decline in 2015 the quantity of herbal cannabis seized

has been fluctuating in many countries. The overall increase between 2016 and 2017, mainly due to increases reported in Greece, Spain and in particular Italy, was not sustained in 2018. However, a number of countries that generally seize small quantities of herbal cannabis showed considerable increases in 2018. One example is Belgium, where the 17.3 tonnes seized was 18 times the amount seized in the previous year. In each year since 2009 Turkey has seized more herbal cannabis than any EU country.

Seizures of cannabis plants may be regarded as an indicator of the production of the drug within a country. However, differences between countries, both in law enforcement priorities and reporting practices, mean the data must be interpreted with caution. The number of plants seized in Europe peaked at 7 million in 2012, before dropping to 2.5 million plants in 2015, and increasing to 3.3 million plants in 2018. European countries reported 350 seizures of cannabis oil in 2018, with Belgium (178 litres in 53 seizures) and Italy (143 litres and 8 kilograms in 33 seizures) accounting for the largest quantities.

CANNABIS

RESIN

Seizures

Number



Quantity



Price (EUR/g)



Potency (% THC)



Indexed trends

Price and potency



HERB

Seizures

Number



Quantity



Price (EUR/g)



Potency (% THC)



Indexed trends

Price and potency

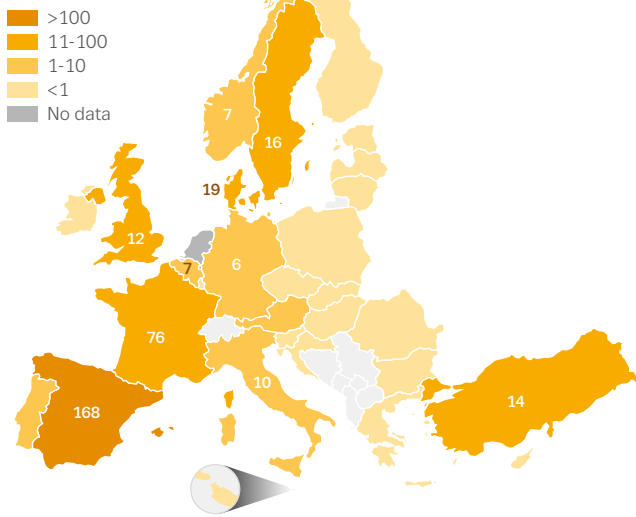


EU + 2 refers to EU Member States, Turkey and Norway. Price and potency of cannabis products: national mean values – minimum, maximum and interquartile range. Countries covered vary by indicator.

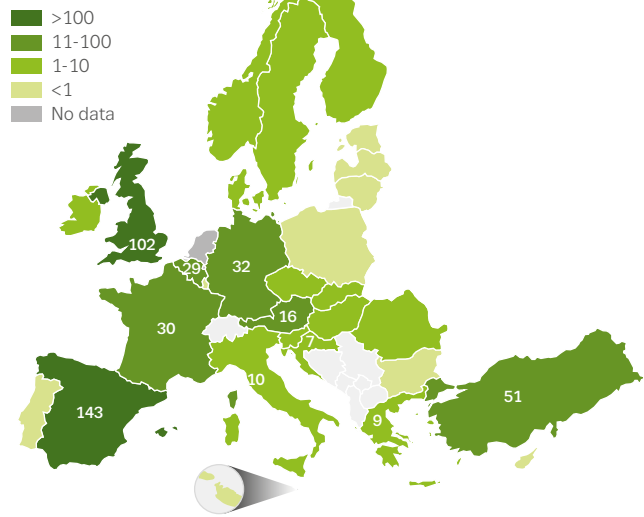
FIGURE 2

SEIZURES OF CANNABIS RESIN AND HERBAL CANNABIS, 2018 OR MOST RECENT YEAR

Number of cannabis resin seizures (thousands)

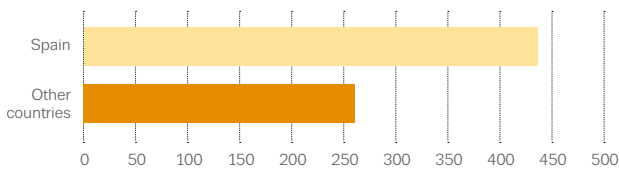


Number of herbal cannabis seizures (thousands)



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

Quantity of cannabis resin seized (tonnes)



Quantity of herbal cannabis seized (tonnes)

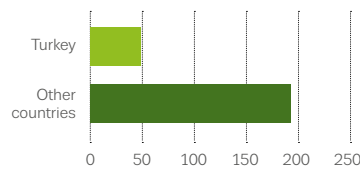
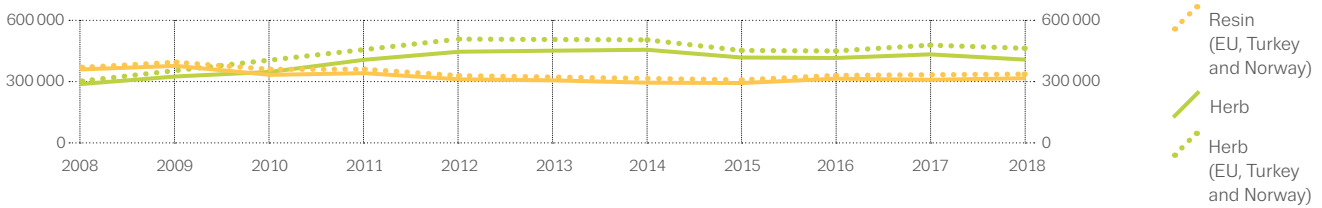


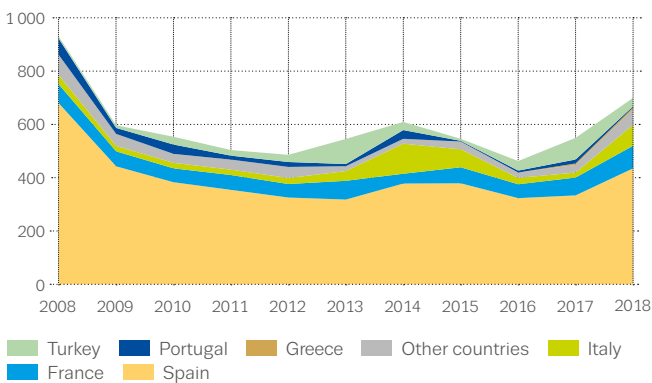
FIGURE 3

TRENDS IN THE NUMBER OF CANNABIS SEIZURES AND QUANTITY OF CANNABIS SEIZED: RESIN AND HERB

Number of seizures



Resin (tonnes)



Herb (tonnes)

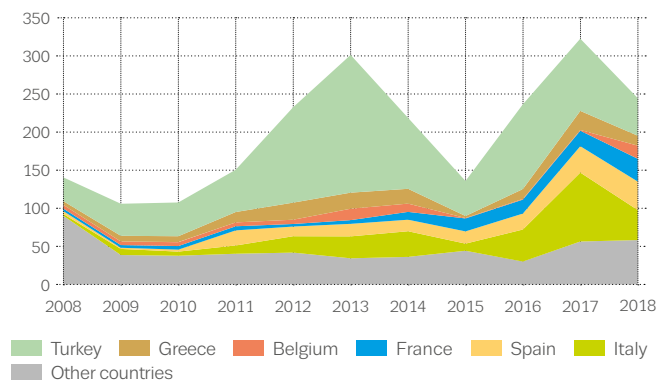
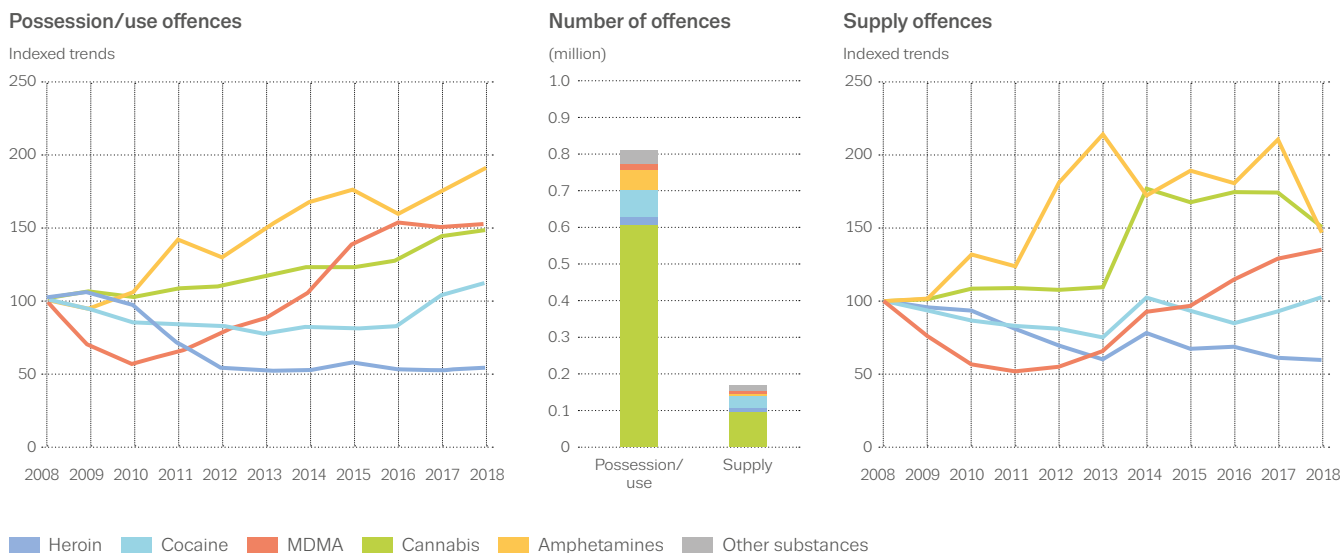


FIGURE 4

DRUG LAW OFFENCES IN THE EUROPEAN UNION RELATED TO DRUG USE OR POSSESSION FOR USE OR DRUG SUPPLY: INDEXED TRENDS AND REPORTED OFFENCES IN 2018



Data are for offences for which the drug has been reported.

Analysis of indexed trends among those countries consistently reporting price and potency data shows an overall increase in the potency of both herbal cannabis and cannabis resin since 2008. The latest data suggest that the THC content of resin sold in Europe is now on average almost twice that of herbal cannabis, with half the countries reporting a mean potency of 9-12 % for herbal cannabis, compared with 13-24 % for resin. Drivers of this increasing average potency in resin may include the introduction of high-potency cannabis plants and new production techniques in Morocco and, to a lesser extent, the greater use within Europe of extraction techniques that produce higher-potency products. Data suggest that the retail price per gram is similar for resin and herbal cannabis and that the prices have remained relatively stable since about 2009.

Drug law offences: cannabis predominates

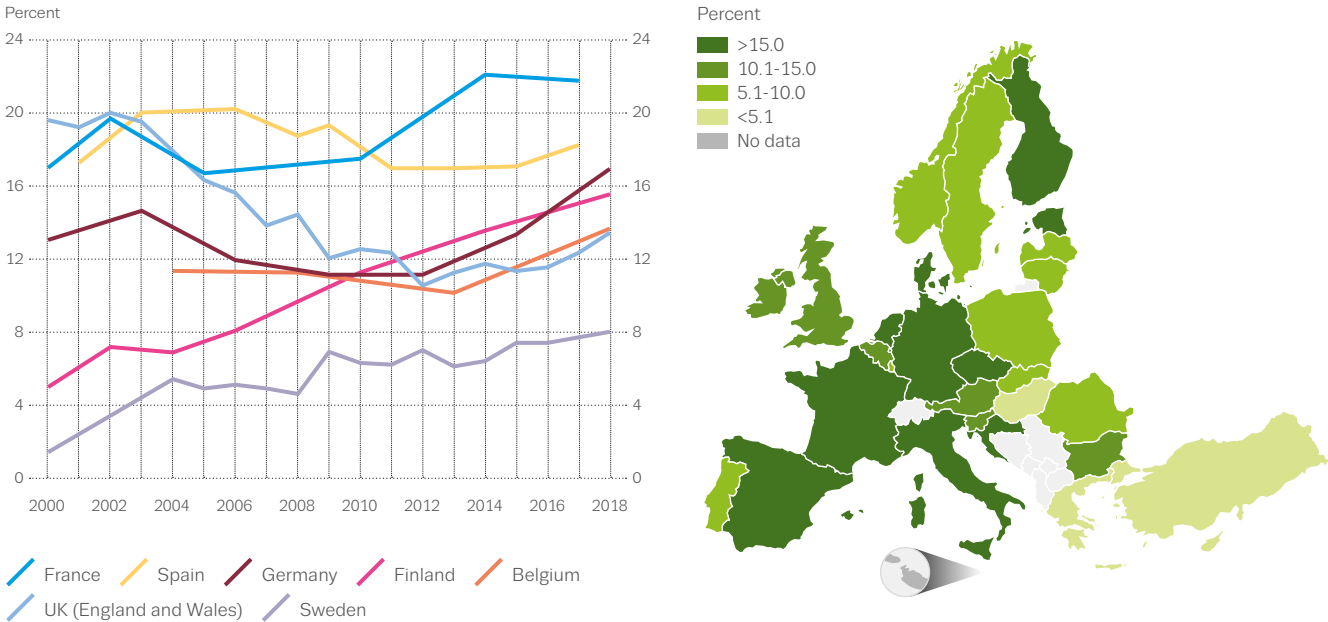
The implementation of laws is monitored through data on reported drug law offences. The numbers reflect differences in national legislation and priorities and also the different ways in which the laws are applied and enforced.

In 2018 an estimated 1.5 million drug law offences were reported in the European Union, an increase of about a fifth (22 %) since 2008. Most of these offences (75 %) related to use or possession, totalling around 1.2 million offences. Drug use or possession offences involving cannabis continued to increase. Three quarters (75 %) of use or possession offences involved cannabis. The upward trend in offences for MDMA use or possession continued in 2018, although they still only accounted for 2 % of use-related offences (Figure 4).

Overall, the number of drug supply offences in the European Union has increased by 7 % since 2008, with an estimate of more than 230 000 cases in 2018. Again, cannabis dominates, accounting for 57 % of supply offences. Reports of supply offences for MDMA have been rising since 2011 (Figure 4), whereas offences related to the supply of cocaine have increased mainly in the last two years. The situation for heroin was relatively stable over the same period.

FIGURE 5

LAST YEAR PREVALENCE OF CANNABIS USE AMONG YOUNG ADULTS (15-34): SELECTED TRENDS AND MOST RECENT DATA



Age ranges other than 15-34 are reported by Denmark, Estonia, Sweden, United Kingdom and Norway (16-34), Germany, France, Greece, Hungary and Malta (18-34).

Cannabis use among young people

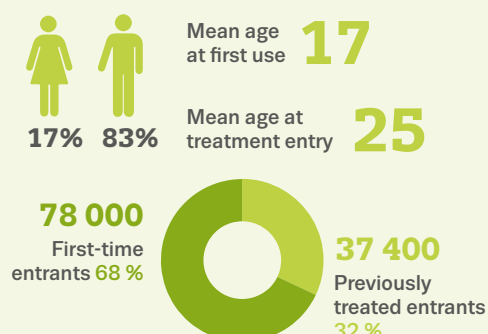
It is estimated that 90.2 million adults in the European Union (aged 15-64), or 27.2 % of this age group, have used cannabis at least once in their lifetime. Around 15 % (18.0 million) of young adults (aged 15-34) report using cannabis in the last year, with males being typically twice as likely to report use than females. Among the 27 countries that undertook surveys between 2014 and 2018, considerable variation exists, with last year use rates among young adults ranging from 3.5 % in Hungary to 21.8 % in France. When only 15- to 24-year-olds are considered, the prevalence of cannabis use is higher, with 19 % (10.4 million) having used the drug in the last year and 10 % in the last month (5.5 million).

In most countries, recent survey results show either stable or increasing last year cannabis use among young adults. Of the countries that have produced surveys since 2017 and reported confidence intervals, eight reported higher estimates, three were stable and one reported a decrease compared with the previous comparable survey. In eight of these countries, an increase in use among 15- to 24-year-olds has been reported in the most recent survey.

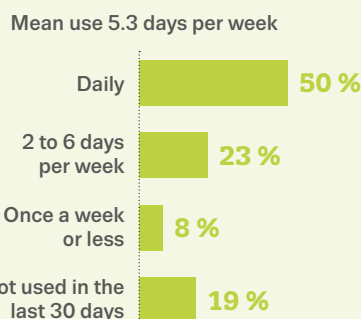
Few countries have sufficient survey data to permit statistical analysis of long-term trends in last year use among young adults (15-34). Where these exist, the results vary, although among some of the higher-prevalence countries there are increases between the most recent surveys. France shows a weak upward movement since 2005, with similar values for 2014 and 2017 of 22.1 % and 21.8 % respectively (Figure 5). Prevalence is stable in Spain at a relatively high rate but with an increase between 2015 and 2017 from 17.1 % to 18.3 %, while Germany has a weak upward movement since 2012, with an increase between 2015 and 2018 from 13.3 % to 16.9 %. Finland has an upward trend since 2000 and the United Kingdom since 2012, both with increases in 2018, reaching 15.5 % and 13.4 % respectively. Belgium reported new survey results for 2018, with a prevalence of 13.6 %, up from 10.1 % in 2013. In contrast, the three surveys in Sweden since 2015 have reported a stable prevalence, with 7.9 % in 2018.

CANNABIS USERS IN TREATMENT

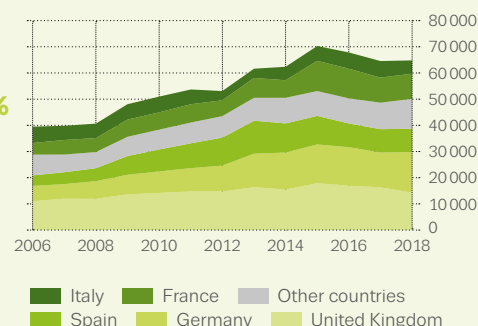
Characteristics



Frequency of use in the last month



Trends in first-time entrants



Apart from trends, data are for all treatment entrants with cannabis as primary drug. Trends in first-time entrants are based on 24 countries. Only countries with data for at least 11 of the 13 years are included in the trends graph. Missing values are interpolated from adjacent years. Due to changes in the flow of data at national level, data since 2014 for Italy are not comparable with earlier years. United Kingdom data for 2018 do not include Northern Ireland.

High-risk cannabis use: a stable picture

From surveys of the general population, it is estimated that around 1 % of adults in the European Union are daily or almost daily cannabis users — that is, they have used the drug on 20 days or more in the last month. The majority of these (60 %) are under 35 and around three quarters are male.

When considered alongside other indicators, data on those entering treatment for cannabis problems can provide information on the nature and scale of high-risk cannabis use in Europe. In 2018 around 135 000 people entered specialised drug treatment in Europe for problems related

to cannabis use (32 % of all treatment demands); of those, about 80 000 were entering treatment for the first time. In the 24 countries with available data, the overall number of first-time entrants for cannabis problems increased by 64 % between 2006 and 2018. Fifteen countries reported an increase between 2006 and 2018 and 14 reported an increase in the last year (2017-2018).

Overall, 50 % of primary cannabis users entering treatment for the first time in 2018 reported daily use of the drug in the last month, with figures ranging from 10 % or less in Latvia, Hungary and Romania to 68 % or more in Spain, France, Lithuania and Turkey. Those entering treatment for problems related to cannabis are predominantly male, with a ratio of just under five males to each female.

Health and social response options for cannabis problems

- *Prevention programmes*, such as multicomponent school interventions that develop social competences and refusal skills, healthy decision-making and coping, and correct normative misperceptions about drug use; family interventions; and structured computer-based interventions.
- *Brief interventions*, for example, motivational interviewing delivered in emergency departments or primary care settings.
- *Treatment*: research suggests that cognitive behavioural therapy, motivational interviewing and contingency management can reduce cannabis use and harm in the short term; multidimensional family therapy can help reduce use in high-severity young patients; and some web- and computer-based interventions can reduce cannabis use in the short term.
- *Harm reduction* interventions, for example, addressing the harms associated with smoking cannabis, especially when used together with tobacco.

These and other responses are further explained in the EMCDDA's *Health and Social Responses to Drug Problems: A European Guide* supported by the online [Best Practice Portal](#).

COCAINE

risks

use

trends

prevention

seizures

treatment



Cocaine is the second most commonly used illicit drug in Europe overall, although prevalence levels and trends differ considerably between countries. The drug is produced from the leaves of the coca plant, grown in South America, from where it is trafficked into Europe. Data presented in this chapter from law enforcement sources, population surveys and specialised drug treatment centres are complemented by findings from wastewater analyses and drug checking services.



Cocaine seizures reach record levels

In 2018 the number of cocaine seizures and the quantity seized in the European Union reached the highest levels ever recorded, with more than 110 000 seizures of cocaine reported, amounting to 181 tonnes. The quantity of cocaine seized surpassed the previous record, from 2017, by more than 42 tonnes (see Figure 6). Belgium (53 tonnes), Spain (48 tonnes) and the Netherlands (40 tonnes) together accounted for 78 % of the estimated EU total in 2018, but large quantities were also reported by France (16.3 tonnes), Portugal (5.5 tonnes) and Italy (3.6 tonnes).

Small but increasing seizures of coca leaves have also been observed (243 kilograms in 2018), as have small seizures of coca paste (184 kilograms). This may indicate a diversification in production tactics by some criminal organisations. Cocaine laboratories found in Europe in the past have mainly been 'secondary extraction facilities', where cocaine is recovered from materials in which it has been

incorporated (such as wines, clothes and plastics), rather than laboratories manufacturing cocaine from coca leaves or paste. Seizures of certain chemicals in Spain and the Netherlands also support this finding.

The average purity of cocaine at retail level varied from 23 % to 87 % across Europe in 2018, with half the countries reporting an average purity between 53 % and 69 %. Among those countries consistently providing data on purity and price, the purity of cocaine has been on an upward trend over the past decade and in 2018 reached a level 44 % higher than the index year of 2008. Over the same period, the retail price of cocaine has remained stable. Considered along with the seizure data, these indicators suggest that cocaine availability in Europe is at an unprecedented level.

Limited data on drug purity are also available from European drug checking services, which test samples submitted by individuals. While these services only exist in some countries and the data they provide are not representative of the market as a whole, the picture emerging lends support to recent reports on the increased availability and use of high-purity cocaine.

In the period January-June 2019 cocaine was the substance most frequently submitted to European drug checking services for testing. In total, 1011 samples presented as cocaine were analysed and reported by 11 services operating in eight EU Member States. More than half (57 %) of all samples presented as cocaine contained only cocaine and inactive compounds (e.g. milk powder). In 4 % of the samples, cocaine was not detected. The remaining 40 % of samples contained a combination of cocaine and one or more pharmacologically active adulterants, with levamisole the most common, found in 184 samples, followed by caffeine (146 samples). Data on cocaine purity were available for 852 cocaine samples from seven drug checking services operating in six EU Member States. The average purity of cocaine samples was 69 % (73 % during the same period in 2018), with one in every two samples containing more than 75 % cocaine (Figure 7). According to information provided by the clients, about two thirds (65 %) of the samples presented as cocaine were obtained through direct contact with a known supplier.

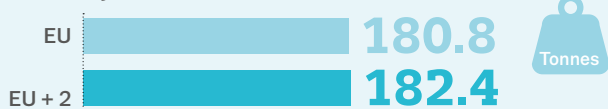
COCAINE

Seizures

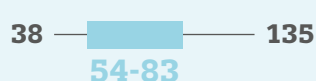
Number



Quantity



Price (EUR/g)

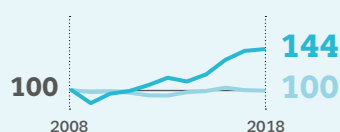


Purity (%)



Indexed trends

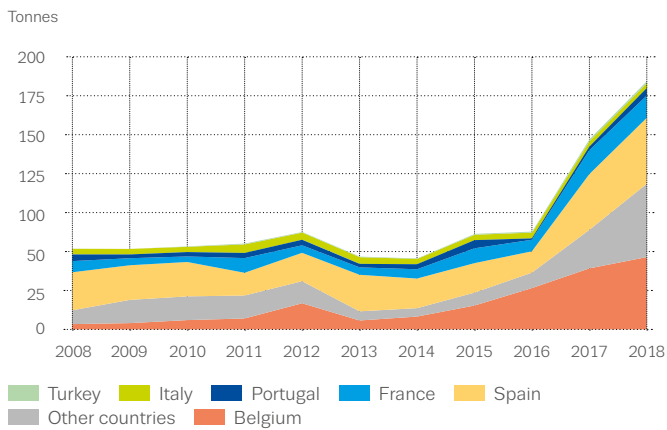
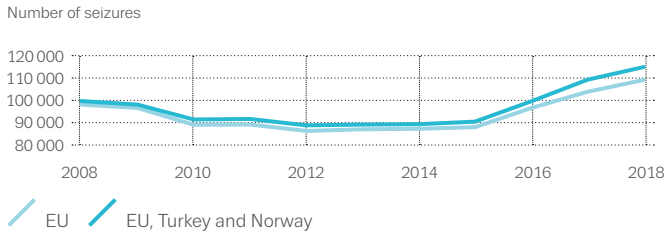
Price and purity



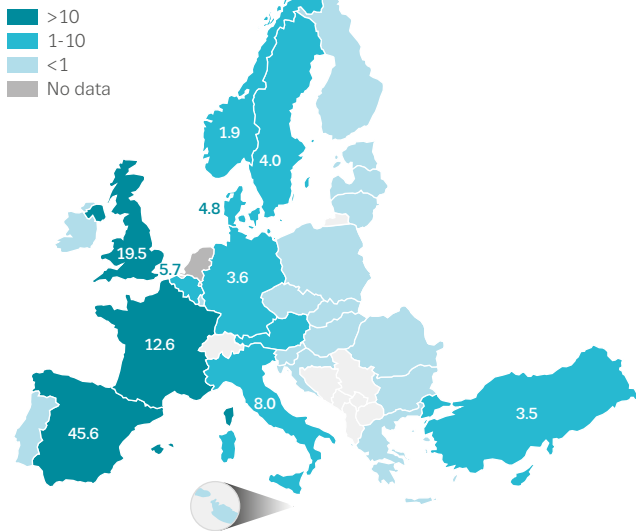
EU + 2 refers to EU Member States, Turkey and Norway. Price and purity of cocaine: national mean values — minimum, maximum and interquartile range. Countries covered vary by indicator.

FIGURE 6

NUMBER OF POWDER COCAINE SEIZURES AND QUANTITY SEIZED: TRENDS AND 2018 OR MOST RECENT YEAR



Number of cocaine seizures (thousands)



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

Quantity of cocaine seized (tonnes)

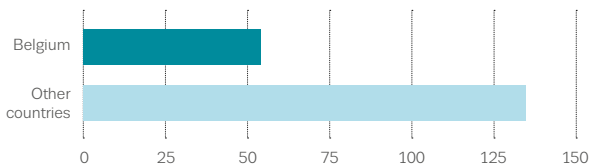
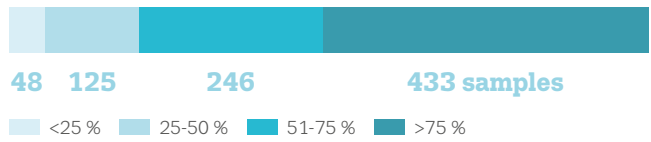


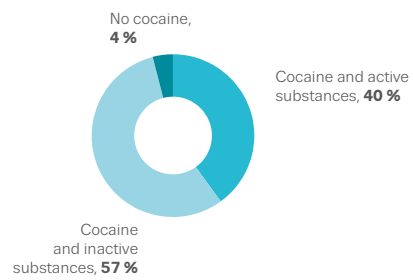
FIGURE 7

COCAINE SAMPLES TESTED BY DRUG CHECKING SERVICES BETWEEN JANUARY AND JUNE 2019

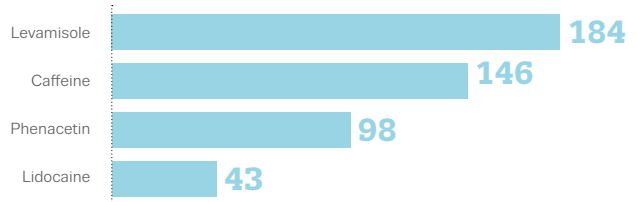
Purity (% cocaine)



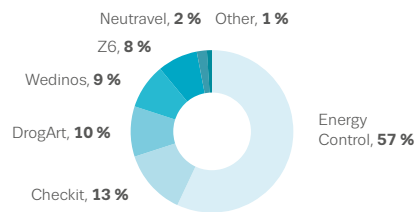
Adulteration (1011 'cocaine' samples)



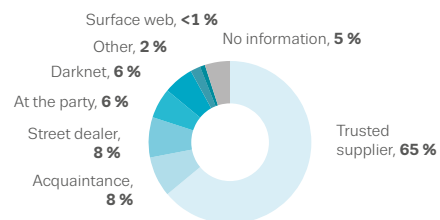
Most frequent adulterants (number of samples)



Services providing samples



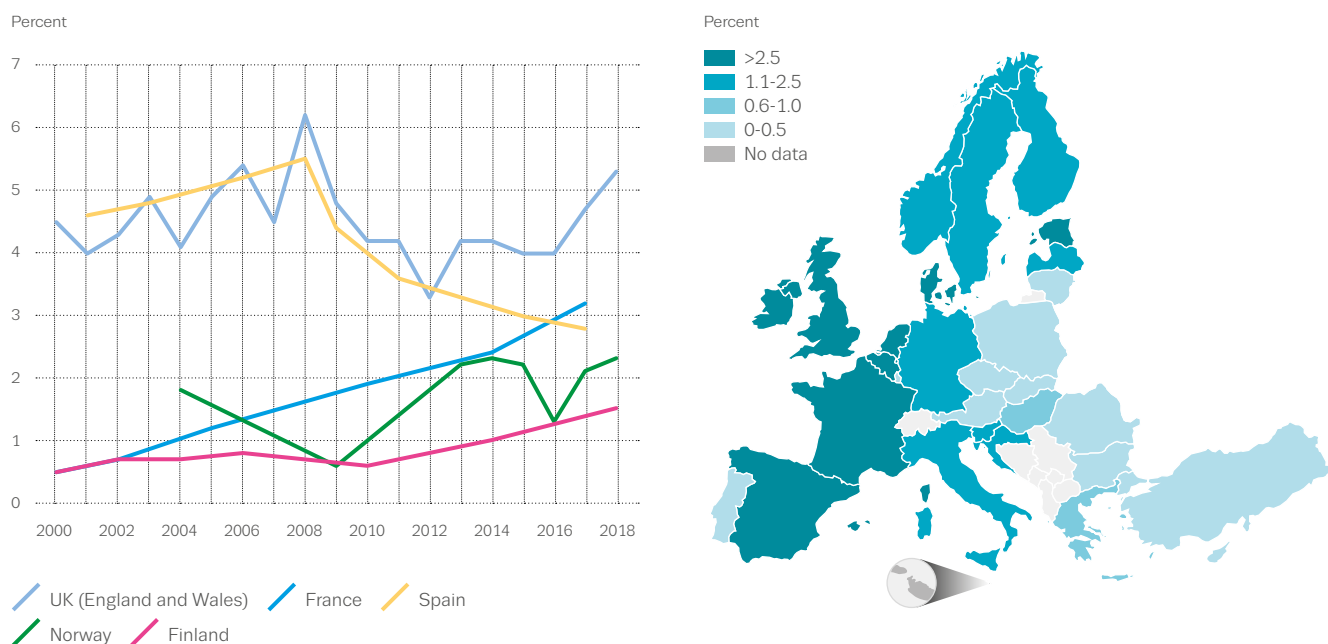
Reported source of the drug



Samples were collected during the period January to June 2019. Data were provided by drug checking services in Austria (Checkit and Z6), Belgium (Modus Vivendi), Italy (Neutravel and SottoKassa), Luxembourg (PiPaPo), Slovenia (DrogArt), Spain (Energy Control and Ai Laket) and the United Kingdom (Wedinos) and a research project in Finland (A-Clinic Foundation).

FIGURE 8

LAST YEAR PREVALENCE OF COCAINE USE AMONG YOUNG ADULTS (15-34): SELECTED TRENDS AND MOST RECENT DATA



Age ranges other than 15-34 are reported by Denmark, Estonia, United Kingdom and Norway (16-34), Sweden (17-34), Germany, France, Greece and Hungary (18-34).

Indications of increased cocaine use

Surveys suggest that around 18 million adults aged 15-64 in the European Union (5.4 %) have used cocaine at least once in their lifetime. Of those aged 15-34, nearly 3 million (2.4 % of this age group) are estimated to have used the drug in the last year.

Among the 27 countries that undertook a survey between 2014 and 2018, prevalence of last year cocaine use among young adults ranged from 0.2 % to 5.3 %, with eight countries reporting rates of more than 2.5 % (Figure 8). Of the 12 countries that have conducted surveys since 2017 and reported confidence intervals, five reported higher estimates than their previous survey and seven had stable estimates.

A statistical analysis of long-term trends in last year use of cocaine among young adults (15-34) is only possible for a small number of countries, among which there is some evidence of increased use. The United Kingdom has observed an upward trend since 2015, reaching 5.3 % in 2018. Upward trends have also been reported by France (2000 to 2017), reaching 3.2 %, and by Finland (2010 to

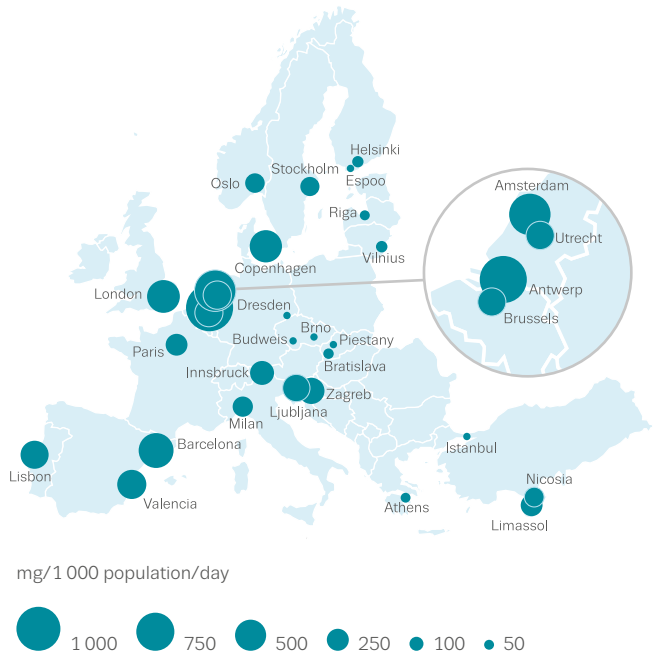
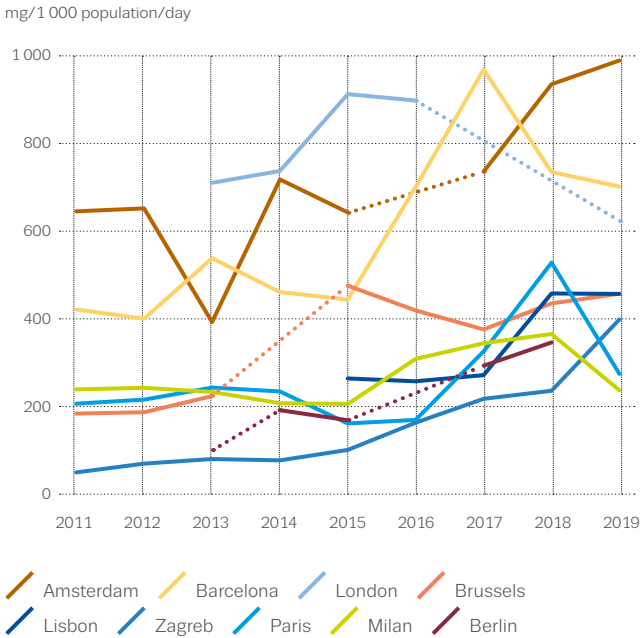
2018), reaching 1.5 %. Not all trends are upward. Spain has reported a decline in use since 2008, though prevalence in the last two years has been stable, and prevalence in Norway has remained largely stable since 2013. Without notable trends, increases in prevalence between the last two surveys were reported for 2018 by Germany (2.4 % as opposed to 1.2 % in 2015) and Estonia (2.8 % as opposed to 1.3 % in 2008). Similarly, increases were reported for 2017 by Denmark (3.9 % as opposed to 2.4 % in 2013) and Sweden (2.5 % as opposed to 1.2 % in 2013).

Analysis of municipal wastewater for cocaine residues carried out in a multi-city study complements, but is not directly comparable to, the results from population surveys. A 2019 analysis found the highest mass loads of benzoylecgonine — the main metabolite of cocaine — in cities in Belgium, Spain, the Netherlands and the United Kingdom.

The most recent data indicate that cocaine is becoming more common in eastern European cities, although detection levels remain low (see Figure 9). Of the 45 cities that have data for 2018 and 2019, 27 reported an increase, 10 a stable situation and 8 a decrease. Increasing longer-term trends are observable for most of the 14 cities with data covering the 2011 to 2019 period.

FIGURE 9

COCAINE RESIDUES IN WASTEWATER IN SELECTED EUROPEAN CITIES: TRENDS AND MOST RECENT DATA



Mean daily amounts of benzoylecgonine in milligrams per 1 000 population. Sampling was carried out in selected European cities over a week in each year from 2011 to 2019. Source: Sewage Analysis Core Group Europe (SCORE).

Increase in people seeking treatment related to cocaine use

The prevalence of high-risk cocaine use among adults in Europe is difficult to gauge as only four countries have recent estimates. In addition, these estimates are not directly comparable, as they have been generated using different definitions and methodologies. In Spain, a general population survey used high frequency of use to estimate high-risk cocaine use at 0.3 % among people aged 15-64 in 2017/18. In 2018, based on a national survey, Germany estimated that 0.1 % of the adult population showed indications of cocaine dependence; Italy, using treatment and criminal justice data, estimated that 0.7 % of the adult population could be classified as high-risk cocaine users. In France, a 2017 capture-recapture study estimated the prevalence of high-risk crack cocaine use at 0.07 %. In the United Kingdom, a study covering the 2016-17 period estimated the prevalence of crack use among the population aged 15-64 years in England to be 0.5 %.

Spain, Italy and the United Kingdom account for almost three quarters (72 %) of all reported specialised treatment entries related to cocaine in Europe. Overall, cocaine was cited as the primary drug by 75 000 clients entering specialised drug treatment in 2018 of which 34 000 were first-time (new) clients.

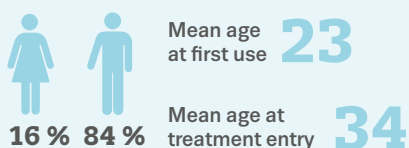
After a period of decline, the overall number of cocaine first-time treatment entrants has been on an upward trend, with 22 countries reporting increases between 2014 and 2018.

The latest European data reveal a time lag of 11 years between first cocaine use, on average at the age of 23, and first treatment for cocaine-related problems, on average at the age of 34.

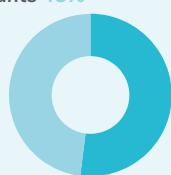
The majority of those who enter specialised treatment citing cocaine as their main problem drug are powder cocaine users (57 000 or 13 % of all drug clients in 2018). Around half of Europe's 15 000 crack-related treatment demands are reported by the United Kingdom, where it is also the substance most often reported as a secondary drug by all drug clients. The remaining crack users are reported mainly by Belgium, Spain and France. A caveat here is that the term 'crack' may not be used consistently by all countries.

COCAINE USERS ENTERING TREATMENT

Characteristics



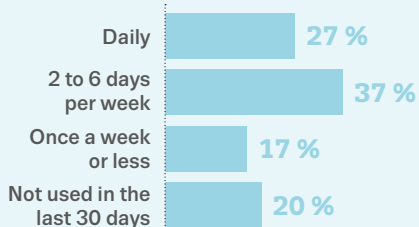
34 200
First-time entrants
48%



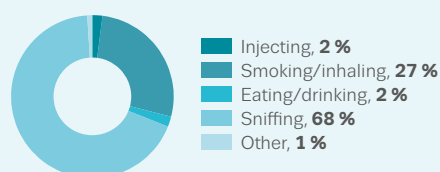
36 900
Previously treated entrants
52%

Frequency of use in the last month

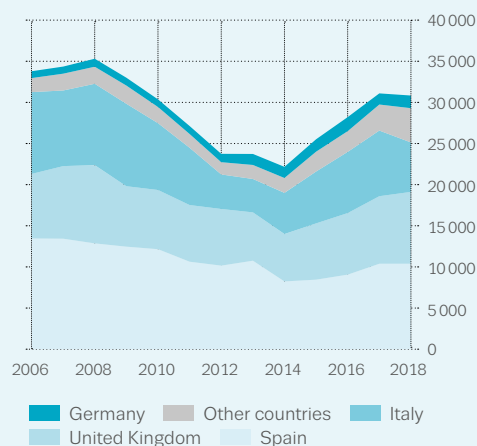
Mean use 4.1 days per week



Route of administration



Trends in first-time entrants



Apart from trends, data are for all treatment entrants with cocaine as primary drug. Trends in first-time entrants are based on 24 countries. Only countries with data for at least 11 of the 13 years are included in the trends graph. Missing values are interpolated from adjacent years. Due to changes in the flow of data at national level, data since 2014 for Italy are not comparable with earlier years. United Kingdom data for 2018 do not include Northern Ireland.

The use of cocaine in combination with heroin or other opioids was reported by 59 500 clients entering specialised drug treatment in Europe in 2018. This number represents 15 % of all treatment entrants for whom both primary and secondary drug information is available.

Health and social response options for cocaine problems

- Brief interventions, referral to treatment programmes or harm reduction services can be offered when users seek help at emergency departments for problems related to intoxication or high-dose use.
- Stimulant injectors need regular access to needle and syringe programmes because they may inject more often than opioid users during the course of a binge.
- Outreach programmes may be necessary to deliver harm reduction interventions to stimulant users who would not otherwise access services.
- Treatment using psychosocial interventions, and especially contingency management, can be effective for problematic cocaine use.
- Pharmacological treatments may help reduce cocaine use in people with concurrent opioid use problems.

These and other responses are further explained in the EMCDDA's *Health and Social Responses to Drug Problems: A European Guide* supported by the online [Best Practice Portal](#).

risks use

AMPHETAMINES

trends

prevention seizures

treatment



The synthetic drugs amphetamine and methamphetamine are central nervous system stimulants, which in many data sets are grouped together as amphetamines. Of the two drugs, amphetamine is more commonly available in Europe, whereas significant methamphetamine use has historically been restricted to the Czechia and, more recently, Slovakia. Data presented in this chapter from law enforcement sources, population surveys and specialised drug treatment centres are complemented by findings from wastewater analyses and drug checking services.



Amphetamine and methamphetamine seizures: domestic production

Both methamphetamine and amphetamine are produced in Europe. Amphetamine is more widely available, but seizure data suggest that methamphetamine availability has increased, with the drug being detected in more countries. Data indicate that amphetamine production takes place mainly in the Netherlands, Belgium and Poland, and to a lesser extent in the Baltic States and Germany. Seizures of concentrated amphetamine oil, which is converted through crystallisation into the salt form, represent a new challenge for law enforcement within the European Union, as this suggests that the final stage of production is now sometimes occurring at or near its intended destination point.

Some amphetamine is also manufactured in the European Union for export, principally to the Middle East. Large seizures of amphetamine tablets with a 'Captagon' logo have been made in Turkey and Greece.

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.

Methamphetamine seized in Europe is mainly produced in Czechia and the border areas of neighbouring countries, although some producers have relocated their operations to the Netherlands. In Czechia, methamphetamine is produced mainly from pseudoephedrine, which is extracted from medicinal products. An important development, detected in the Netherlands in 2019, was the production of methamphetamine from BMK, with the involvement of Mexican nationals.

Data on seizures of precursors confirm the use of both scheduled and non-scheduled chemicals in the production of amphetamine and methamphetamine in the European Union (Table 1). The scheduling of APAAN (used to make BMK, the precursor of amphetamine) in late 2013 continues to have an impact, with seizures falling from 48 tonnes in 2013 to 13.5 tonnes in 2018. Seizures of the alternative

AMPHETAMINES

AMPHETAMINE

Seizures

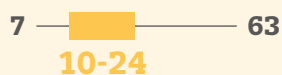
Number



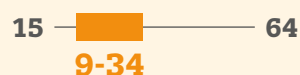
Quantity



Price (EUR/g)



Purity (%)



Indexed trends

Price and purity



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.

METAMPHETAMINE

Seizures

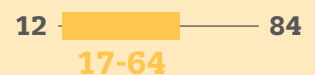
Number



Quantity



Price (EUR/g)



Purity (%)



chemical APAA have increased sharply in the last few years, tripling to over 30 tonnes in 2018 compared with 2017. The forthcoming scheduling of APAA appears to have led to a preference for a new alternative substance, MAPA, of which 7 tonnes were seized in 2018. Seizures of glycidic derivatives of BMK, which can be readily converted to BMK, declined in 2018. The total quantity of precursors and alternative chemicals used for the production of amphetamine seized in the European Union reached an all-time high in 2018 at 73 tonnes, with 29 tonnes seized in the Netherlands, confirming the country's central role in synthetic drug production in Europe.

In 2018 EU Member States reported 37 000 seizures of amphetamine, amounting to 8 tonnes, and there have been increases in each of the past three years (Figure 10). Methamphetamine seizures are far lower, with 9 000 seizures reported in the European Union in 2018, amounting to 0.62 tonnes, with France (126 kilograms) and Czechia

(106 kilograms) seizing the largest quantities (Figure 11). The number of seizures of methamphetamine has shown an overall upward trend since 2002, but with signs of recent stabilisation; the quantity seized has been relatively stable in EU countries since 2013.

In 2018 Turkey seized 5.7 tonnes of amphetamine. Almost all the amphetamine seized in Turkey was in the form of tablets (22.7 million tablets — over 87 % of the total estimated amount seized), including large quantities of 'Captagon' tablets containing amphetamine. Turkey also seized an exceptionally large quantity of methamphetamine in 2018 (564 kilograms), an amount approaching that reported for the entire European Union (646 kilograms).

The average purity of amphetamine at retail level varied from 15 % to 64 % across Europe in 2018, with half the countries reporting an average purity between 19 % and 34 %. Among those countries consistently providing data

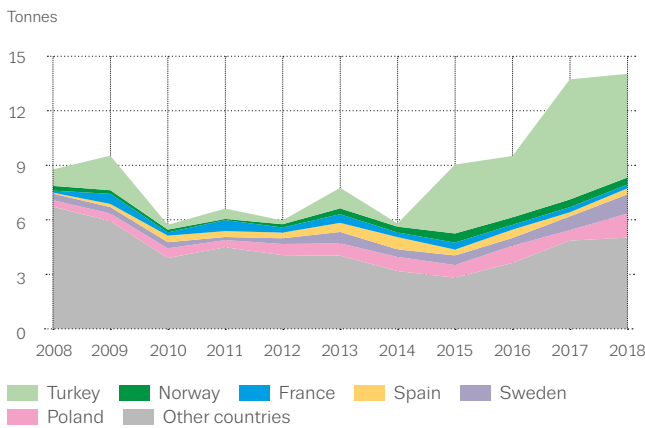
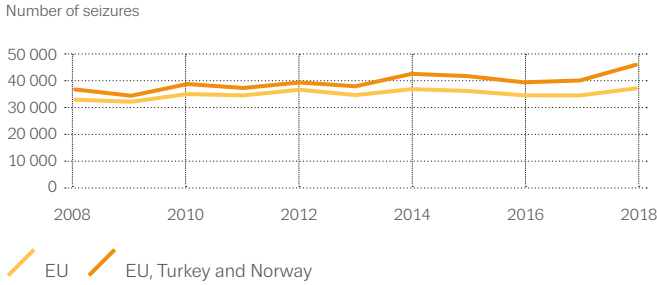
TABLE 1

SUMMARY OF SEIZURES AND STOPPED SHIPMENTS OF EU SCHEDULED PRECURSORS AND NON-SCHEDULED CHEMICALS USED FOR SELECTED DRUGS PRODUCED IN THE EUROPEAN UNION, 2018

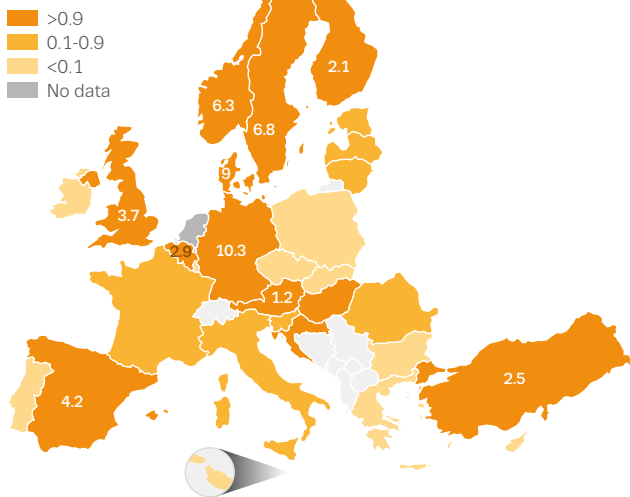
Scheduled/non-scheduled	Seizures		Stopped shipments		Totals	
	number	quantity	number	quantity	number	quantity
MDMA and related substances						
PMK (litres)	9	717	0	0	9	717
Safrole (litres)	2	175	0	0	2	175
Piperonal (kg)	2	29	5	950	7	979
Glycidic derivatives of PMK (kg)	109	15 741	0	0	109	15 741
Amphetamine and methamphetamine						
BMK (litres)	22	9 253	0	0	29	9 253
Ephedrine bulk (kg)	14	39	0	0	14	39
Pseudoephedrine bulk (kg)	14	93	0	0	14	93
APAAN (kg)	13	13 535	0	0	13	13 535
Benzaldehyde (litres)	3	268	0	0	3	268
Benzylcyanide (litres)	3	9 060	0	0	3	9 060
PAA, phenylacetic acid (kg)	5	133	0	0	5	133
APAA (kg)	34	31 513	0	0	34	31 513
MAPA (kg)	19	7 027	0	0	19	7 027
Glycidic derivatives of BMK (kg)	11	2 340	0	0	11	2 340
Others						
Acetic anhydride (litres)	12	15 667	8	8 888	20	24 555
4-anilino-N-phenethylpiperidine (ANPP) (kg)	1	0.6	0	0	1	0.6
N-phenethyl-4-piperidone (NPP) (kg)	0	0	1	3	1	3
2-bromo-4-methylpropiophenone (kg)	5	50	0	0	5	50

FIGURE 10

NUMBER OF AMPHETAMINE SEIZURES AND QUANTITY SEIZED: TRENDS AND 2018 OR MOST RECENT YEAR



Number of amphetamine seizures (thousands)



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

Quantity of amphetamine seized (tonnes)

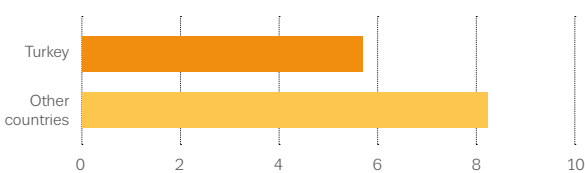
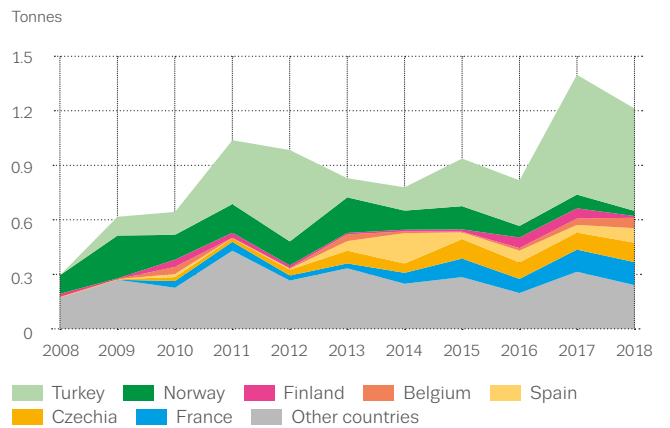
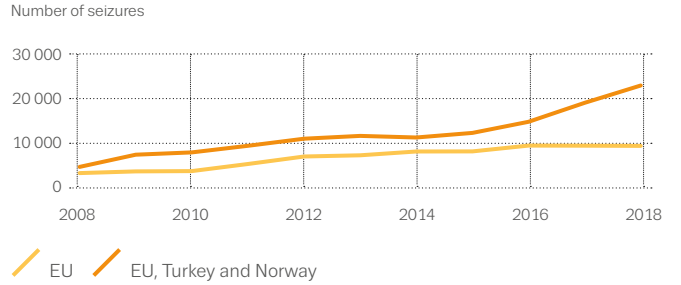
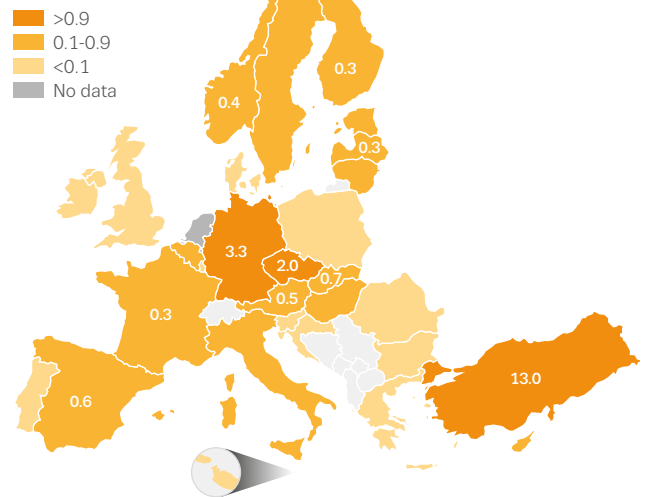


FIGURE 11

NUMBER OF METAMPHETAMINE SEIZURES AND QUANTITY SEIZED: TRENDS AND 2018 OR MOST RECENT YEAR



Number of metamphetamine seizures (thousands)



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

Quantity of metamphetamine seized (tonnes)

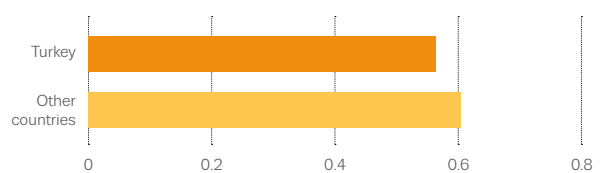
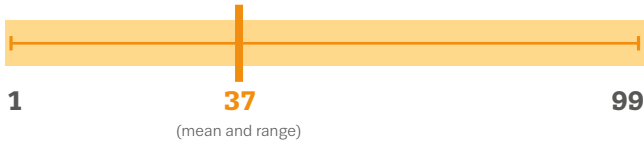


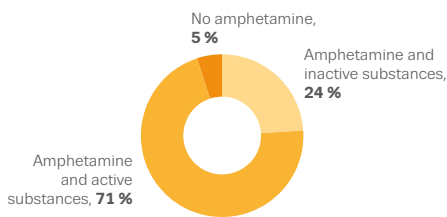
FIGURE 12

AMPHETAMINE SAMPLES TESTED BY DRUG CHECKING SERVICES

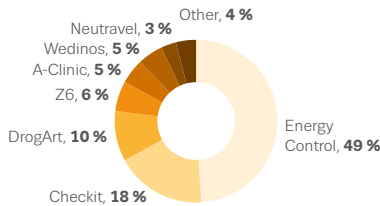
Purity (% amphetamine)



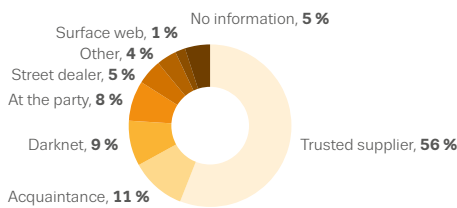
Adulteration (1 011 'cocaine' samples)



Services providing samples



Reported source of the drug



Samples were collected during the period January to June 2019. Data were provided by drug checking services in Austria (Checkit and Z6), Belgium (Modus Vivendi), Italy (Neutravel and SottoKassa), Luxembourg (PiPaPo), Slovenia (DrogArt), Spain (Energy Control and Ai Laket) and the United Kingdom (Wedinos) and a research project in Finland (A-Clinic Foundation).

on purity and price, the average purity of amphetamine has increased markedly over the past decade, albeit with some dips. Over the same period, the average price of amphetamine has decreased slightly. In 2018 the average purity of methamphetamine ranged from 21 % to 100 %, with half of the countries reporting an average purity between 26 % and 81 %. It is not possible to analyse trends over time for methamphetamine. However, the overall average purity and price in 2018 were comparable to the values reported in 2008.

Data on the contents of amphetamines sold in Europe are also available from drug checking services. Their results indicated that samples presented as amphetamine had on average the lowest purity level and were more likely to contain pharmacologically active adulterants, compared with the other stimulant drugs tested (see Figure 12). In the period January-June 2019 a total of 652 samples presented as amphetamine were analysed by 11 European drug checking services. Three quarters (75 %) of these contained amphetamine and one or more pharmacologically active substance, whereas 20 % contained amphetamine as the sole pharmacologically active substance. The average purity of amphetamine samples submitted for testing in 2019 was 37 %. The majority (56 %) of the samples presented as amphetamine were obtained through direct contact with a known supplier. Obtaining the drug through an acquaintance (12 %) was the next most common means of acquisition. Methamphetamine accounted for only 1 % of all samples submitted to drug checking services during the first half of 2019. Fifty-four samples presented as methamphetamine were submitted for testing, 48 of them to Austrian and Spanish drug checking services.

Amphetamines use: stable, but with signs of increasing availability of methamphetamine

It is estimated that 12.3 million adults in the European Union (aged 15-64), or 3.7 % of this age group, have used amphetamines at least once in their lifetime. Figures from the 26 countries that report a survey between 2014 and 2018 suggest that 1.4 million (1.2 %) young adults (aged 15-34) used amphetamines during the last year, with national prevalence estimates ranging from zero in Portugal to 3 % in Finland (Figure 13). The available data suggest that over the longer term, prevalence levels have been relatively stable in most countries. Of the countries that have provided new survey results since 2017 and reported confidence intervals, two reported higher estimates than

in the previous comparable survey, seven reported a stable trend and one a lower estimate.

A statistical analysis of trends in last year prevalence of use of amphetamines in young adults is only possible in a small number of countries and variations in patterns exist. Long-term downward trends are observable in Denmark, Spain and the United Kingdom (Figure 13).

Recent surveys in Czechia found prevalence levels of less than 1 %, trending downwards. In contrast, Norway has an upward trend since 2015, reporting 0.9 % for 2018. At higher levels of prevalence, Finland has a long-term upward trend reaching 3 % in 2018. In their 2018 survey, the Netherlands reported the prevalence of amphetamine use as 2.7 %, a decrease from 3.9 % in 2017. Both Germany and Poland report increases from previous surveys.

Methamphetamine in Europe now appears in both powder and crystalline form and is consumed by injecting or smoking by various sub-groups of people who use drugs, including problem drug users and people in the ‘chemsex’ scene.

Analysis of municipal wastewater carried out in 2019 found that mass loads of amphetamine varied considerably across

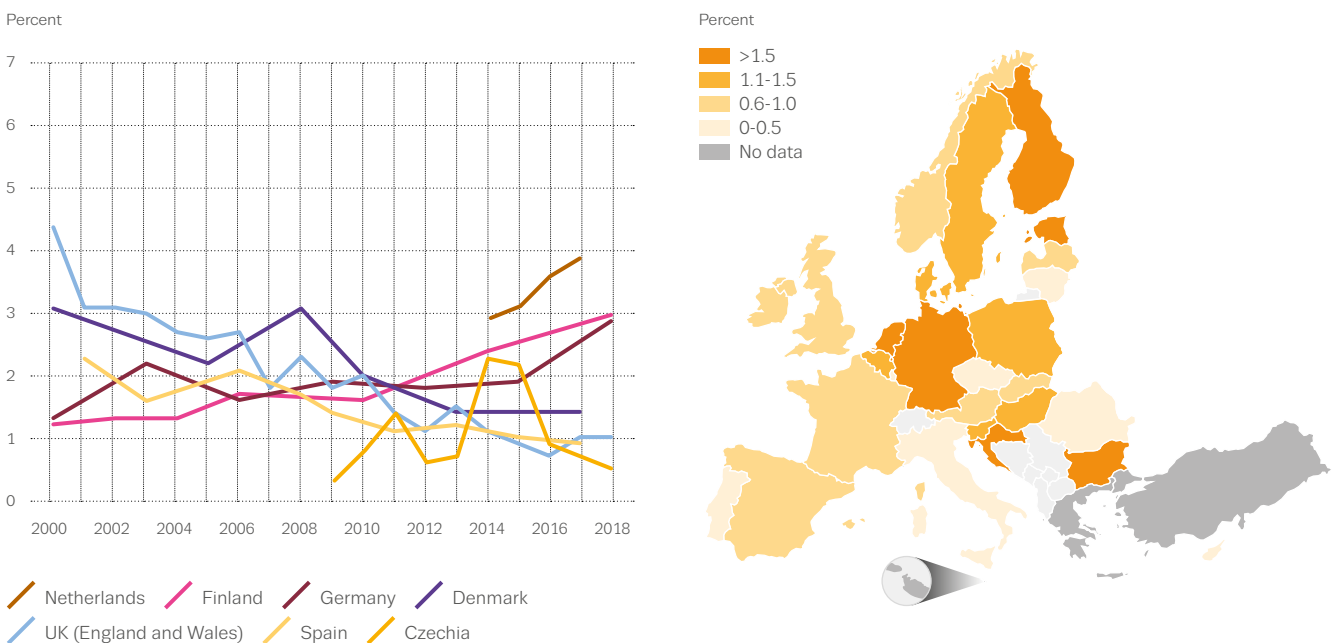
Europe, with the highest levels reported in cities in the north and east of Europe (Figure 14). Amphetamine was found at much lower levels in most cities in the south of Europe.

Of the 41 cities that have data for 2018 and 2019, 21 reported an increase, 9 a stable situation and 11 a decrease. Overall, the results from 11 cities with data from 2011 to 2019 showed a diverse picture, with increasing trends observed in most cities.

Wastewater analysis suggests that use of methamphetamine, generally low and historically concentrated in Czechia and Slovakia, now appears to be also present in other European countries (Figure 15). In 2018 and 2019, of the 42 cities that have data on methamphetamine in wastewater, 17 reported an increase, 16 a stable situation and 9 a decrease.

FIGURE 13

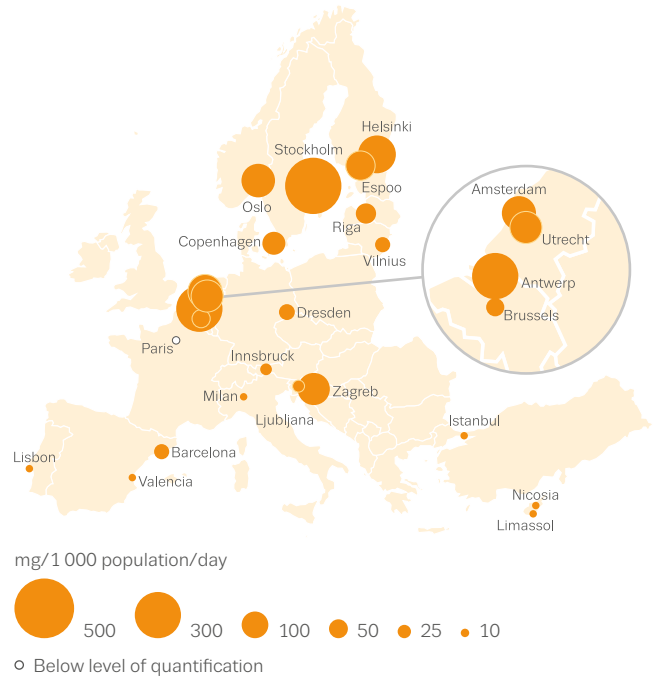
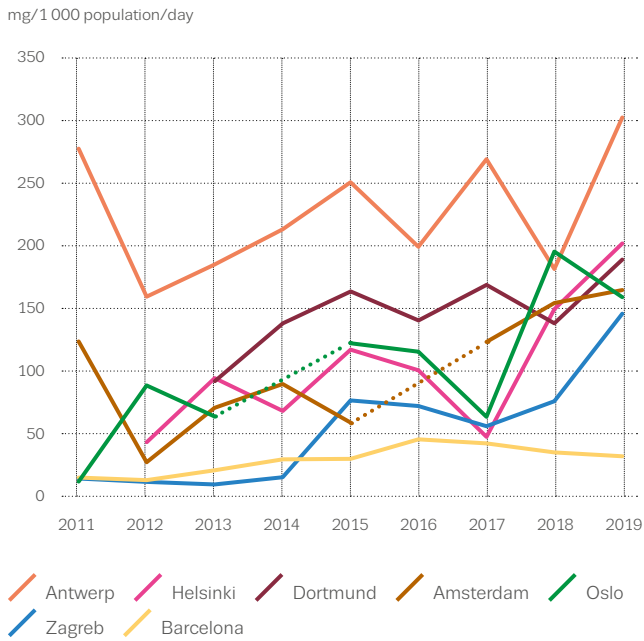
LAST YEAR PREVALENCE OF AMPHETAMINES USE AMONG YOUNG ADULTS (15-34): SELECTED TRENDS AND MOST RECENT DATA



Age ranges other than 15-34 are reported by Denmark, Estonia, United Kingdom and Norway (16-34), Sweden (17-34), Germany, France and Hungary (18-34).

FIGURE 14

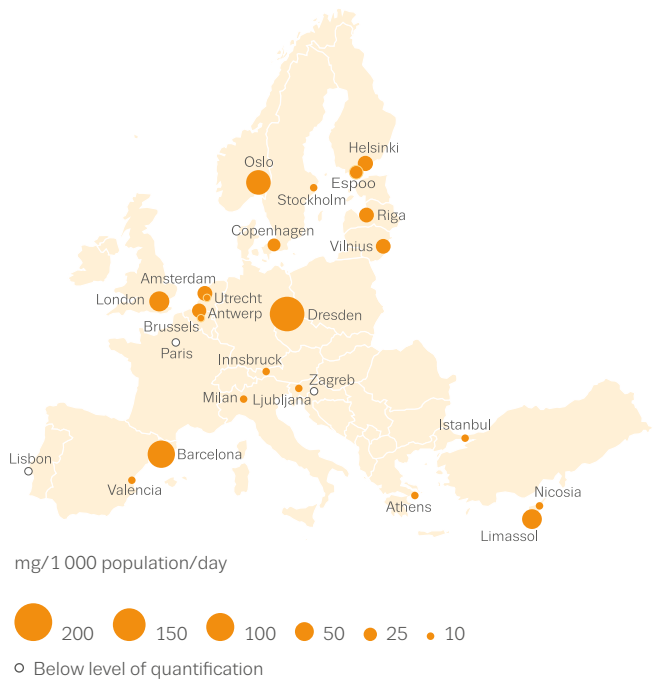
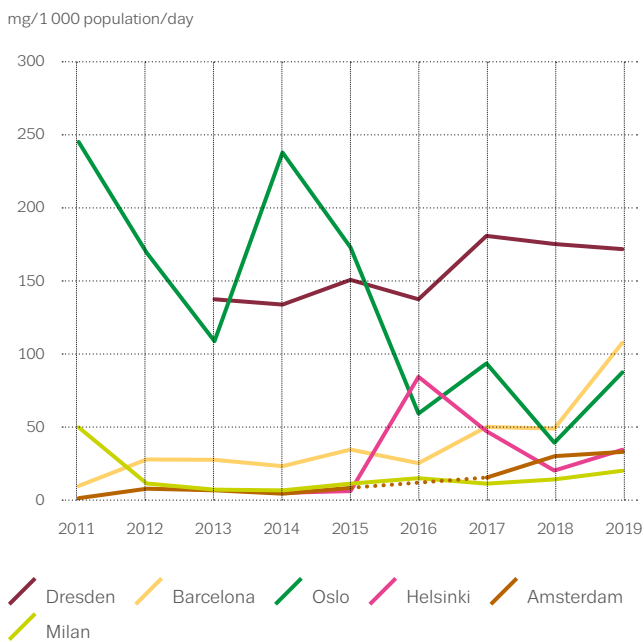
AMPHETAMINE RESIDUES IN WASTEWATER IN SELECTED EUROPEAN CITIES: TRENDS AND MOST RECENT DATA



Mean daily amounts of amphetamine in milligrams per 1 000 population. Sampling was carried out in selected European cities over a week in each year from 2011 to 2019. Source: Sewage Analysis Core Group Europe (SCORE).

FIGURE 15

METAMPHETAMINE RESIDUES IN WASTEWATER IN SELECTED EUROPEAN CITIES: TRENDS AND MOST RECENT DATA



Mean daily amounts of methamphetamine in milligrams per 1 000 population. Sampling was carried out in selected European cities over a week in each year from 2011 to 2019. Source: Sewage Analysis Core Group Europe (SCORE).

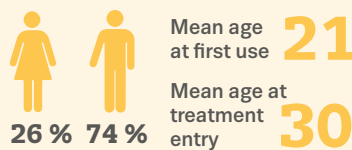
Patterns of problematic amphetamines use vary considerably across countries

Problems related to long-term and injecting amphetamine use have, historically, been most evident in northern European countries, while methamphetamine problems have been concentrated in Czechia and Slovakia. A 2018 estimate for Germany reported 0.2 % or 103 000 high-risk adult amphetamines users. In Finland, the estimated prevalence of high-risk amphetamine use was 0.7 % in 2017. In Czechia, high-risk methamphetamine use among adults (15-64) was estimated at 0.50 % in 2018 (corresponding to 33 500 users). This represents an increase from 20 900 users in 2007, though numbers have been relatively stable in recent years. Users of amphetamines are likely to make up the majority of the estimated 2 234 (0.18 %) high-risk stimulant users reported by Latvia in 2017, down from 6 540 (0.46 %) in 2010. In Slovakia, the prevalence derived from a treatment multiplier was estimated at 0.15 % in 2018. The estimate for Cyprus was 0.03 % or 155 high-risk methamphetamine users in 2018.

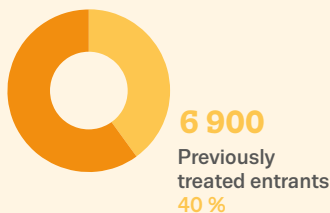
More than 20 000 clients entering specialised drug treatment in Europe in 2018 reported amphetamines as their primary drug, of whom about 10 000 were first-time clients. Amphetamine users account for at least 15 % of first-time treatment entrants in Bulgaria, Latvia, Poland and Finland. Treatment entrants reporting primary methamphetamine use are concentrated in Czechia, Germany, Slovakia, Poland and Turkey, which together account for 92 % of the 8 300 methamphetamine clients reported in 2018. Amphetamines are the drugs with the smallest gender gap, though women still represent only about one-quarter (26 %) of amphetamines clients. Considering route of administration, 15 % of all amphetamines entrants reported oral consumption of the drug, 52 % reported sniffing and 17 % reported injecting.

AMPHETAMINES USERS ENTERING TREATMENT

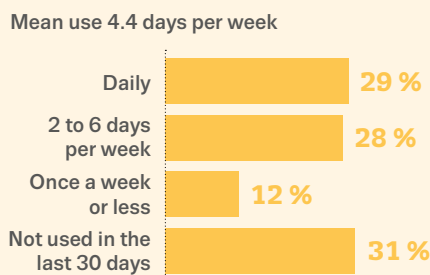
Characteristics



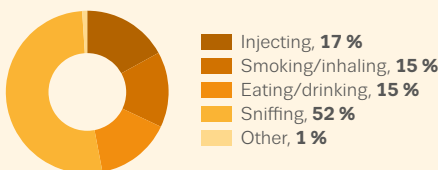
10 200
First-time entrants 60 %



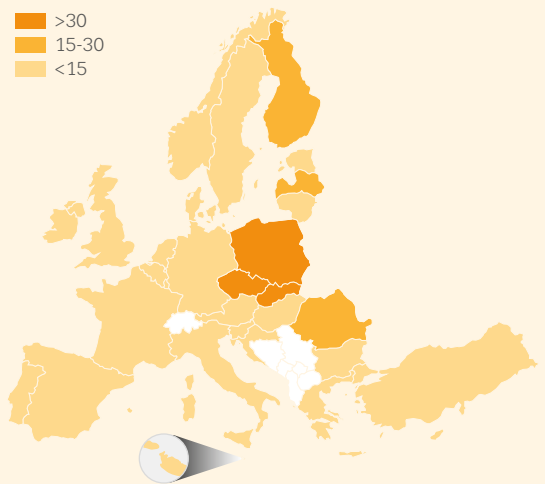
Frequency of use in the last month



Route of administration



Share of first-time entrants for all drugs (percent)



Apart from the map, data are for all treatment entrants with amphetamines as primary drug. Data from Germany, Sweden and Norway relate to clients citing a stimulant other than cocaine as primary drug. United Kingdom data for 2018 do not include Northern Ireland.

Health and social response options for amphetamines problems

- Brief interventions, referral to treatment programmes or harm reduction services can be offered when users seek help at emergency departments for problems related to intoxication or high-dose use.
- Stimulant injectors need regular access to needle and syringe programmes because they may inject more often than opioid users during the course of a binge.
- Outreach programmes may be necessary to deliver harm reduction interventions to stimulant users who would not otherwise access services.
- Treatment using psychosocial interventions can be effective for problematic stimulant use. There are no pharmacological treatments with good evidence of effectiveness in treating problematic stimulant users, but some drugs used to treat depression have been shown to help retain amphetamine users in treatment.

These and other responses are further explained in the EMCDDA's [Health and Social Responses to Drug Problems: A European Guide](#) supported by the online [Best Practice Portal](#).

MDMA

risks

use

trends

prevention

seizures

treatment



MDMA is a synthetic drug that is chemically related to amphetamine and methamphetamine, but which differs to some extent in its effects. It is also known as ecstasy, when in tablet form or MD in crystal form. Data on MDMA from law enforcement and population surveys are augmented by findings from wastewater studies and drug checking services. This section also reviews the limited data available on hallucinogens and two anaesthetics, ketamine and gamma-hydroxybutyrate (GHB).



European production for a global MDMA market

Twenty-three active MDMA laboratories were reported to have been dismantled in the European Union in 2018, with most (20) detected in the Netherlands. The discovery of two MDMA laboratories in Spain and one in Sweden suggest a diversification of production locations may be under way however. The seized quantities of the MDMA precursor PMK (piperonyl methyl ketone) and non-scheduled chemicals for MDMA manufacture have decreased from 26 tonnes in 2017 to under 16 tonnes in 2018. Despite the decrease in precursor seizures, there is no indication that the production of MDMA is going down, which may suggest an alternative trafficking route is being used. All seizures of PMK and most seizures of the glycidic derivatives of PMK in 2018 occurred in the Netherlands and Belgium.

Seizure reports from outside Europe, identified through the monitoring of open source information, and analysis of darknet market sales suggest that European producers

play an important role in the global supply of MDMA. For example, darknet market monitoring data show that as well as facilitating direct sales to consumers, these markets are used by distributors across the globe to purchase MDMA produced in Europe. Analysis shows that transactions involving quantities of MDMA tablets indicative of the middle level of the market account for more than double the revenue of sales of retail-level quantities. In contrast, darknet cannabis and cocaine transactions are overwhelmingly at the retail level.

The number of reported MDMA seizures in the European Union has been on an upward trend since 2010. The quantity of MDMA seized is more often reported in number of tablets than by weight, and the estimated 4.7 million MDMA tablets reported seized in 2018 is the first decrease seen since 2015. However, this finding needs to be interpreted with caution due to the impact that a few large individual seizures can have on the number of tablets reported annually. Seizures of MDMA powder in the European Union increased from 0.3 tonnes in 2016 to 2.2 tonnes in 2018. This increase is mainly due to seizures reported by Belgium, Poland, Bulgaria

MDMA

Seizures

Number



Quantity



Quantity



Price (EUR/tablet)

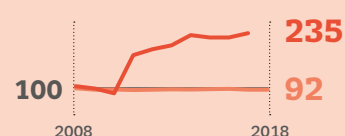


MDMA content (mg/tablet)



Indexed trends

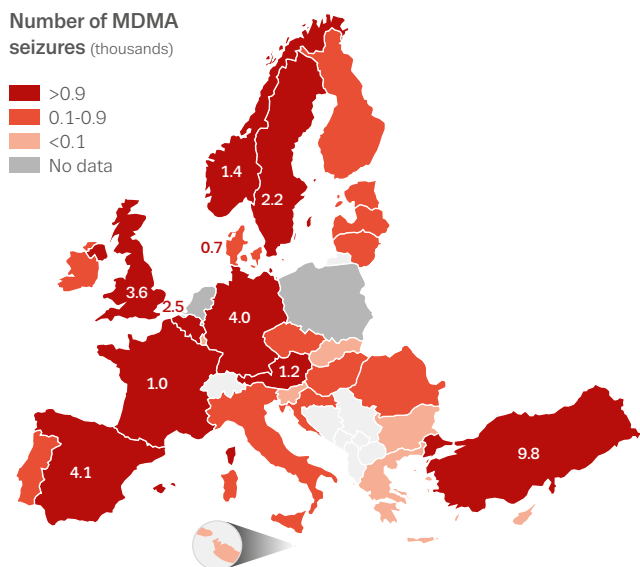
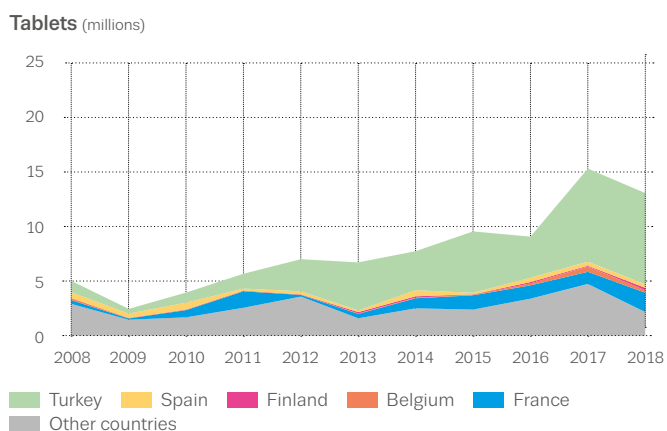
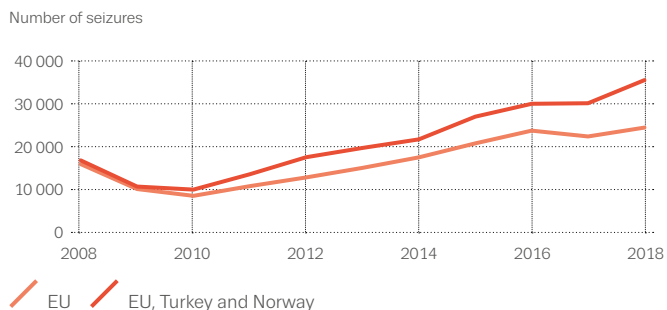
Price and MDMA content



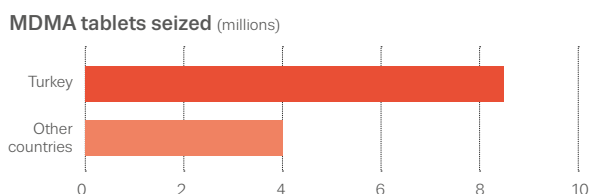
EU + 2 refers to EU Member States, Turkey and Norway. Price and content of MDMA tablets: national mean values – minimum, maximum and interquartile range. Countries covered vary by indicator.

FIGURE 16

NUMBER OF MDMA SEIZURES (ALL FORMS) AND QUANTITY OF TABLETS SEIZED: TRENDS AND 2018 OR MOST RECENT YEAR



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



and Spain — however, gaps in the data from the Netherlands prevents a more comprehensive analysis in this area.

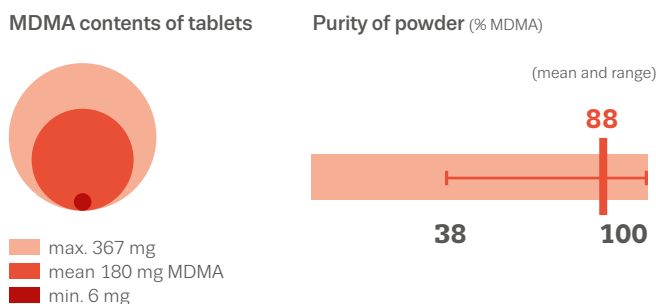
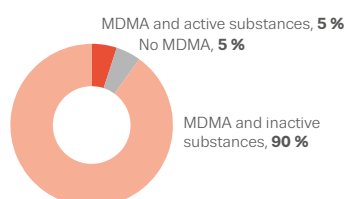
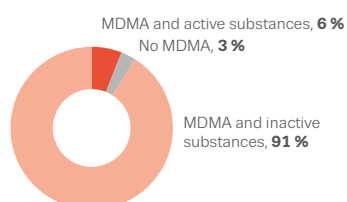
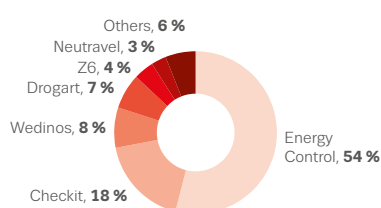
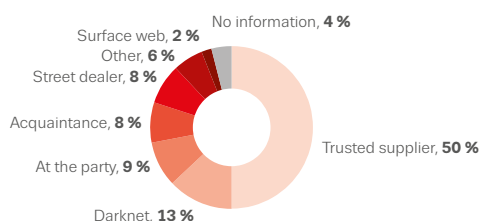
Large quantities of MDMA tablets were seized in Turkey in 2017 and 2018, amounting in both years to more than 8 million tablets and exceeding the total amount seized in the European Union (Figure 16).

In 2018 the average drug content of MDMA tablets seized in Europe ranged from 39 to 188 milligrams MDMA per tablet, with half the countries reporting an average between 132 and 181 milligrams. Among those countries consistently reporting data between 2008 and 2017, the average drug content of MDMA tablets increased by 135 % over the period. While data limitations prevent the inclusion of 2018 in the analysis, average MDMA content remained stable compared with 2017. The average price of an MDMA tablet in 2018 ranged from EUR 4 to EUR 16, with half the countries reporting average prices of EUR 6 to EUR 10. Over the past decade, the average price of MDMA tablets has decreased slightly.

Further data on MDMA dosage and purity are available from drug checking services operating in a number of European countries. These data, while not a representative sample, also point to the high MDMA content of tablets available in Europe and an increase in dosage over time. In the period January-June 2019, samples presented as MDMA (both tablets and powders) were the second most common substance received for testing by European drug checking services. About 70 % of the 969 samples presented as MDMA were submitted for testing in drop-in centres and 25 % at music events. The average amount of MDMA per tablet tested in drug checking services was 180 milligrams, a slight increase on the 172 milligrams found during the same period in 2018, but much higher than the average of 102 milligrams found by the same network in 2012. Individual tablets with exceptionally high amounts of MDMA (in excess of 270 milligrams) were reported by services in five countries. High-purity MDMA in powder form was reported by all services, with an average purity of 88 %, compared with 72 % during the same period in 2018. Overall, samples presented to the services as MDMA were unlikely to contain any other pharmacologically active component, with such adulterants found in only 5 % of the powder samples and 6 % of the tablets tested (Figure 17). Caffeine was the most common adulterant in these samples, although the drug ketamine was detected in four MDMA samples. Half of the samples presented as MDMA were obtained through direct contact with a known supplier. Obtaining the drug through the darknet (13 %) was the next most common means of acquisition.

FIGURE 17

MDMA SAMPLES TESTED BY DRUG CHECKING SERVICES BETWEEN JANUARY AND JUNE 2019

**Adulteration** (tablets 525 samples)**Adulteration** (powder 414 samples)**Services providing samples****Reported source of the drug**

Samples were collected during the period January to June 2019. Data were provided by drug checking services in Austria (Checkit and Z6), Belgium (Modus Vivendi), Italy (Neutravel and SottoKassa), Luxembourg (PiPaPo), Slovenia (DrogArt), Spain (Energy Control and Ai Laket) and the United Kingdom (Wedinos) and a research project in Finland (A-Clinic Foundation).

MDMA use: national variability

It is estimated that 13.6 million adults in the European Union (aged 15-64), or 4.1 % of this age group, have used MDMA/ecstasy at least once in their lifetime. Figures from the 27 countries that conducted surveys between 2014 and 2018 suggest that 2.3 million young adults (15-34) used MDMA in the last year (1.9 % of this age group), with national estimates ranging from 0.2 % in Portugal and Romania to 6.9 % in the Netherlands (Figure 18). Prevalence estimates for those aged 15-24 years are higher, with 2.4 % (1.3 million) estimated to have used MDMA in the last year.

Until recently, MDMA prevalence in many countries had been on the decline from the peak levels seen in the early to mid-2000s. No overall trend emerges from the data available on recent MDMA use. Among the 12 countries that have provided new survey results since 2017 and reported confidence intervals, four reported higher estimates than in the previous comparable survey, and eight reported stable estimates.

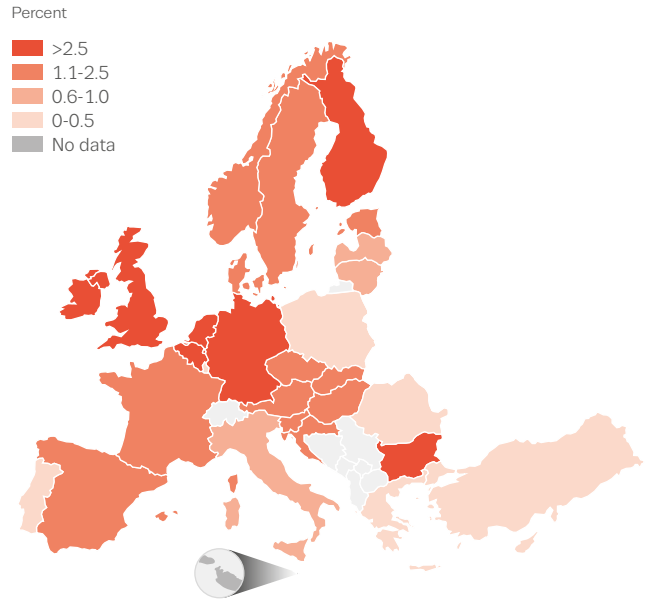
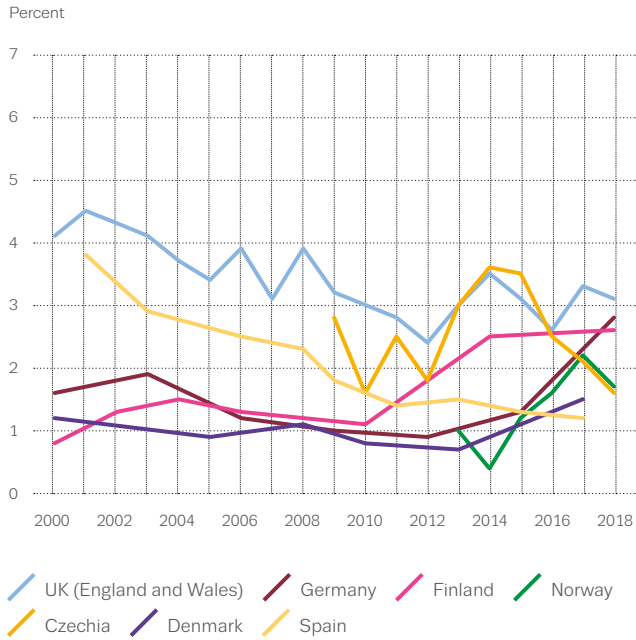
Where data exist for a statistical analysis of trends in last year use of MDMA among young adults, some countries with longer-term trends now show stability (Figure 18). Following downward trends from peak rates at the start of the century, MDMA prevalence in Spain and the United Kingdom (England and Wales) is now stable, though at different levels. Spain reported a prevalence of 1.4 % in 2011 and 1.2 % in 2017, while the prevalence in the United Kingdom fluctuated between 2.4 % and 3.5 % over the period 2012-18, with a value of 3.1 % in 2018. Surveys in Finland show stability between 2014 and 2018; 2.5 % as opposed to 2.6 %, though an increase since earlier years. A recent stable trend is also observed in the Netherlands, where the prevalence of 6.9 % reported in 2018 is similar to the values reported since 2015. In contrast, Germany's prevalence level more than doubled, from 1.3 % in 2015 to 2.8 % in 2018, while Denmark reported an increase to 1.5 % for 2017, from 0.7 % for 2013. Norway observed an upward trend in between 2014 and 2017 and reports 1.7 % for 2018, while annual surveys carried out in Czechia saw a decline from 3.6 % in 2014 to 1.6 % in 2018.

A 2019 multi-city analysis found the highest mass loads of MDMA in the wastewater in cities in Belgium, Germany and the Netherlands (Figure 19). Of the 42 cities that have data for 2018 and 2019, 23 reported an increase, 4 a stable situation and 15 a decrease. Looking at longer-term trends, in most cities with data for both 2011 and 2019 (12 cities), wastewater MDMA loads were higher in 2019 than in 2011; most initial increases were observed in the 2011-16 period, with further rises in the 2016-19 period in some cities.

Most of the health concerns around MDMA use centre on their possible toxicity, especially at high dose or toxicity from

FIGURE 18

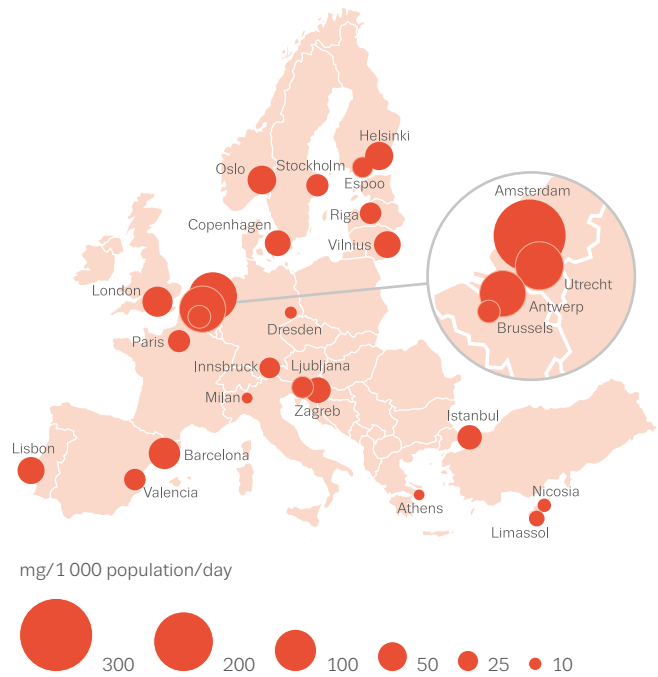
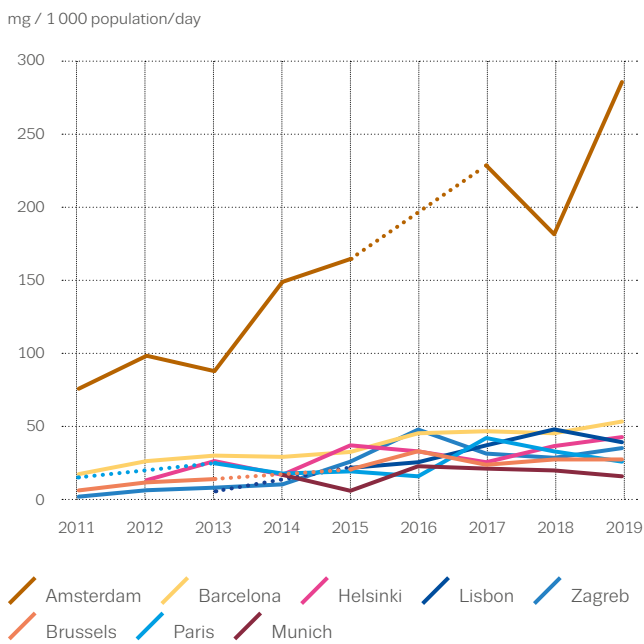
LAST YEAR PREVALENCE OF MDMA USE AMONG YOUNG ADULTS (15-34): SELECTED TRENDS AND MOST RECENT DATA



Age ranges other than 15-34 are reported by Denmark, Estonia, United Kingdom and Norway (16-34), Sweden (17-34), Germany, France, Greece and Hungary (18-34).

FIGURE 19

MDMA RESIDUES IN WASTEWATER IN SELECTED EUROPEAN CITIES: TRENDS AND MOST RECENT DATA



Mean daily amounts of MDMA in milligrams per 1 000 population. Sampling was carried out in selected European cities over a week in each year from 2011 to 2019. Source: Sewage Analysis Core Group Europe (SCORE).

adulterants sold as or mixed with MDMA. Correspondingly, MDMA use is rarely cited as a reason for entering specialised drug treatment in Europe.

Ketamine, GHB and hallucinogens: more seized but use low and stable

A number of other substances with hallucinogenic, anaesthetic, dissociative or depressant properties are used in Europe: these include LSD, hallucinogenic mushrooms, ketamine and GHB (including its precursor GBL).

LSD, a drug that has been uncommon in Europe for the last two decades, appears to be becoming more available. Over 2 400 seizures of LSD (lysergic acid diethylamide) were reported in 2018, amounting to 1.06 million units. Most of these (93 %) were seized in Spain. The overall number of LSD seizures has more than doubled since 2010, although the quantity seized has fluctuated. Fifteen EU countries reported around 1 900 seizures of ketamine, amounting to an estimated 328 kilograms and 12 litres of the drug, most of which was accounted for by France (249 kilograms), Belgium (30 kilograms) and Spain (8 litres). In 2018 seizures of GHB (gamma-hydroxybutyrate) or its precursor GBL (gamma-butyrolactone) were also reported by 13 EU countries, Norway and Turkey, with Norway accounting for over a

third of the total number of seizures. The estimated 1 500 seizures of GHB and GBL amounted to almost 3.3 tonnes and 1 732 litres. Belgium seized 92 % (3 tonnes) of the total quantity of powder, mainly as GHB, and Poland seized 64 % of the total quantity in liquid (1 100 litres), mainly as GBL.

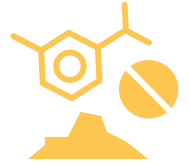
The recreational use of ketamine and GHB (including GBL) has been reported among subgroups of drug users in Europe for the last two decades. National estimates, where they exist, of the prevalence of ketamine and GHB use in adult and school populations appear low. However, the Netherlands reports that ketamine has become a mainstream drug among young people in the nightlife scene, although use of the drug remains low in the general population. Last year prevalence of ketamine use among young adults (16-34) was estimated at 0.6 % in Denmark in 2017 and 1.7 % in the United Kingdom (England and Wales, 2018). In their 2018 survey, Norway reported last year prevalence of GHB use at 0.3 % for adults (16-64) and 0.7 % for young adults (16-34); Poland reported last year prevalence of GHB use at 0.1 % for adults (15-64) and 0.2 % for young adults (15-34).

The overall prevalence levels of LSD and hallucinogenic mushroom use in Europe have been generally low and stable for a number of years. Among young adults (15-34), national surveys report last year prevalence estimates equal to or less than 1 % for both substances in 2018 or most recent survey year, with the exception of Finland (2.0 %) and Estonia (1.6 %, 16-34) for hallucinogenic mushrooms, and Finland (2.0 %), Estonia (1.7 %, 16-34) and Norway (1.3 %, 16-34) for LSD.

Health and social response options for problems related to drug use in recreational settings

- Prevention or harm reduction information material can be provided to young people in recreational settings. Peer educators disseminating this type of information may be seen as more credible. These activities can be supported by websites and apps providing more detailed information on drugs, alcohol and related harms, and tips on avoiding them. However, the evidence for behavioural change effects from these interventions is scarce.
- Environmental strategies have a better evidence base. This approach includes measures that target factors that promote excessive consumption (e.g. discounted drinks, loud music and poor serving practices) or that create safer spaces and venues (e.g. by reducing crowding, providing chill-out rooms and free water, serving food, enforcing rules on behaviour and access).
- Drug-checking services (sometimes called pill testing) enable individual drug users to have their synthetic drugs chemically analysed, providing information on the content of the samples as well as advice, and, in some cases, counselling or brief interventions. An understanding of the effectiveness of this approach in changing behaviours is still developing, but it may provide a valuable opportunity for engaging drug users, influencing consumption practices and for drug monitoring purposes.

These and other responses are further explained in the EMCDDA's *Health and Social Responses to Drug Problems: A European Guide* supported by the online [Best Practice Portal](#).



NEW PSYCHOACTIVE SUBSTANCES

risks

use

trends

prevention

seizures

treatment

The new psychoactive substance market comprises a large number of substances, with new compounds being introduced continually, at a rate of more than 50 new drugs per year since 2012. These substances are drawn from a broad range of drug types and are not controlled by international drug laws. They include stimulants, synthetic cannabinoids, benzodiazepines, opioids, hallucinogens and dissociatives. This section presents seizure and forensic data from law enforcement sources compiled by the EU Early Warning System on New Psychoactive Substances together with the findings of population surveys.



Diversity of new psychoactive substances available

At the end of 2019 the EMCDDA was monitoring around 790 new psychoactive substances, 53 of which were reported for the first time in Europe in 2019. This represents a decrease from the close to 100 new psychoactive substances introduced to the European market each year in 2014-15 (Figure 20). The decrease may reflect the results of sustained efforts to control new substances in Europe, as well as legal changes in source countries, such as China, to restrict production, including generic drug controls that cover chemical classes.

Despite the apparent decrease in the number of substances newly introduced to the European market each year, the catalogue of new psychoactive substances remains vast. Since 2015 approximately 400 previously reported new psychoactive substances have been detected each year (Figure 21). This illustrates the dynamic nature of this part of the drug market: substances may appear and then disappear rapidly, but the number of substances in circulation remains high.

Synthetic cannabinoids and cathinones dominate seizures of new psychoactive substances

The frequency and quantities of new psychoactive substances seized in Europe rose sharply until 2015. Since then, this trend seems to have reversed towards a stabilisation or slow decline, depending on the region. Even so, overall availability remains high.

During 2018 law enforcement agencies from across Europe reported close to 64 800 seizures of new psychoactive substances to the EU Early Warning System. Of these, approximately 40 200 seizures were reported by EU Member States (Figure 22), a slight decrease compared with 2017.

In 2018 more than 5.6 tonnes of new synthetic psychoactive substances, mostly in the form of powders, was reported to the EU Early Warning System, 4.4 tonnes of which by Member States. In addition, 4 212 litres of liquids and 1.6 million tablets and capsules were also found to contain new psychoactive substances.

FIGURE 20

NUMBER AND CATEGORIES OF NEW PSYCHOACTIVE SUBSTANCES REPORTED TO THE EU EARLY WARNING SYSTEM FOR THE FIRST TIME, 2008-19

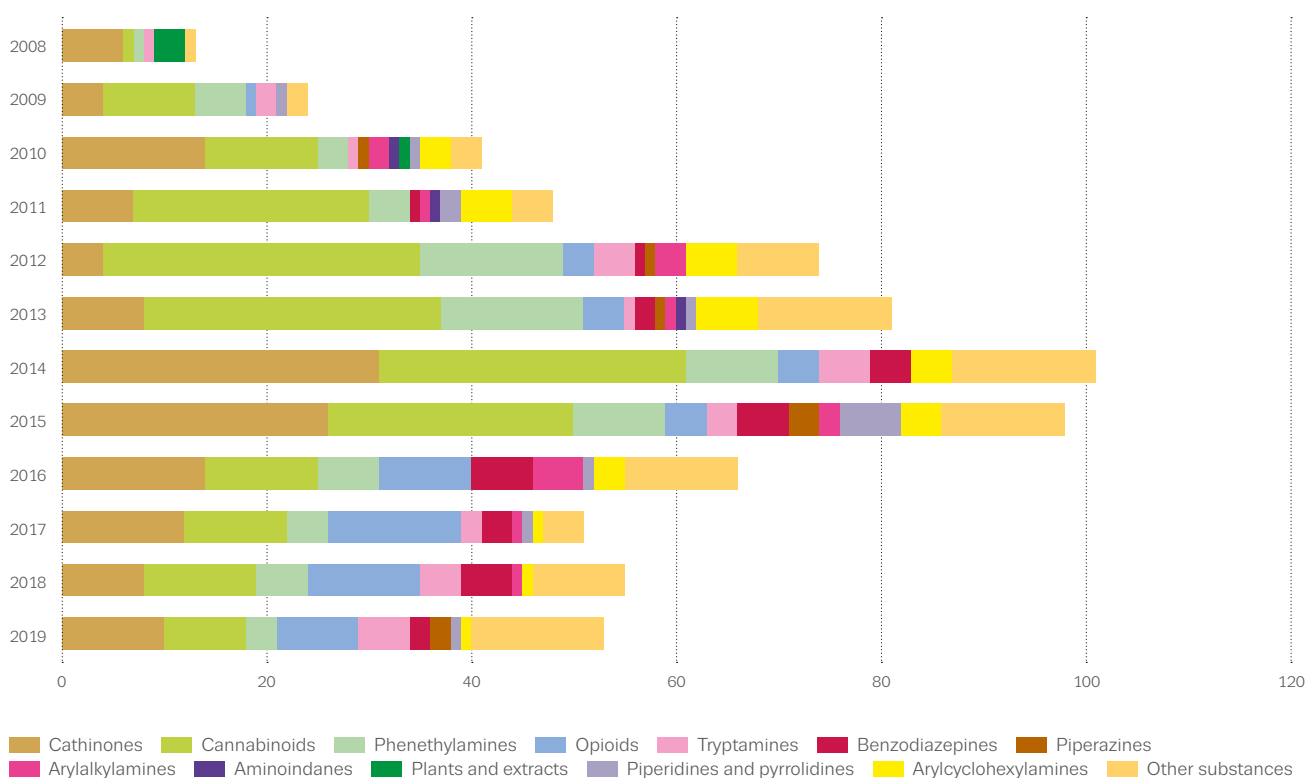


FIGURE 21

NUMBER AND CATEGORIES OF SUBSTANCES DETECTED EACH YEAR, FOLLOWING THEIR FIRST DETECTION, 2008-18

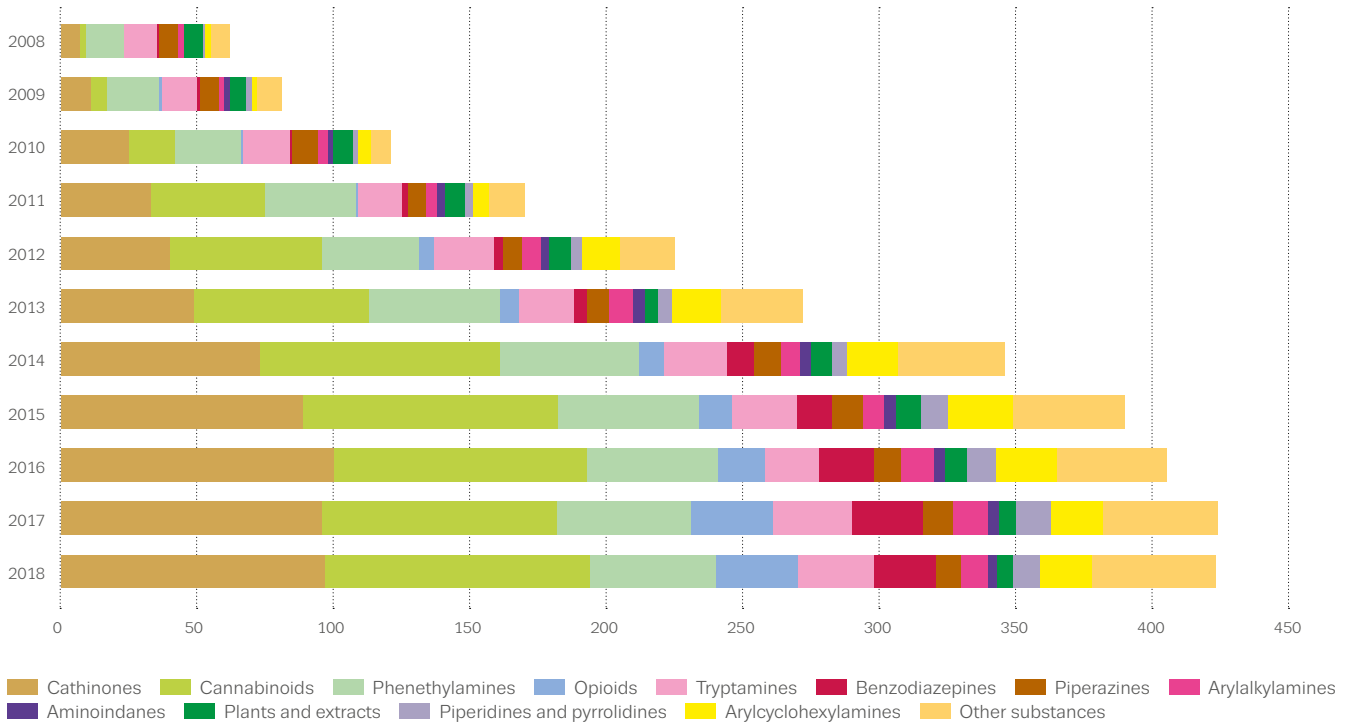
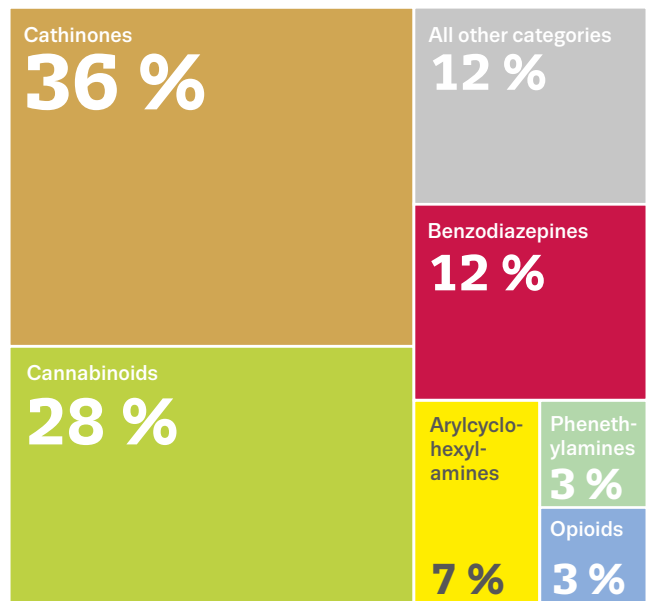
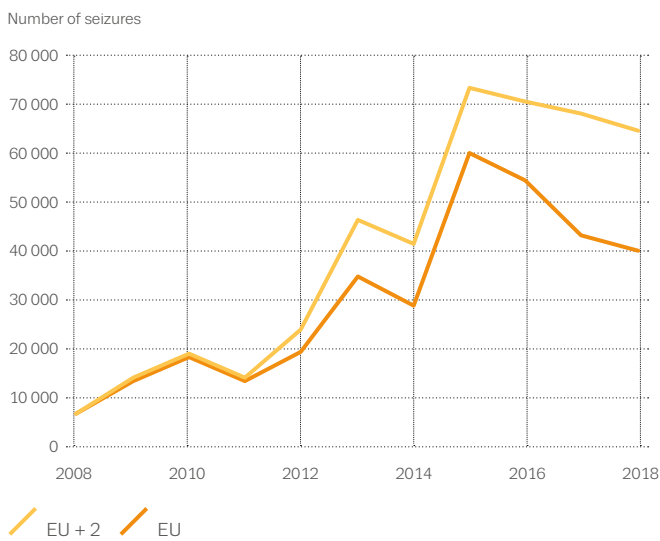


FIGURE 22

SEIZURES OF NEW PSYCHOACTIVE SUBSTANCES REPORTED TO THE EU EARLY WARNING SYSTEM: TRENDS IN TOTAL NUMBER OF SEIZURES (2008-18) AND BREAKDOWN OF NUMBER OF SEIZURES BY CATEGORY (EUROPEAN UNION) IN 2018



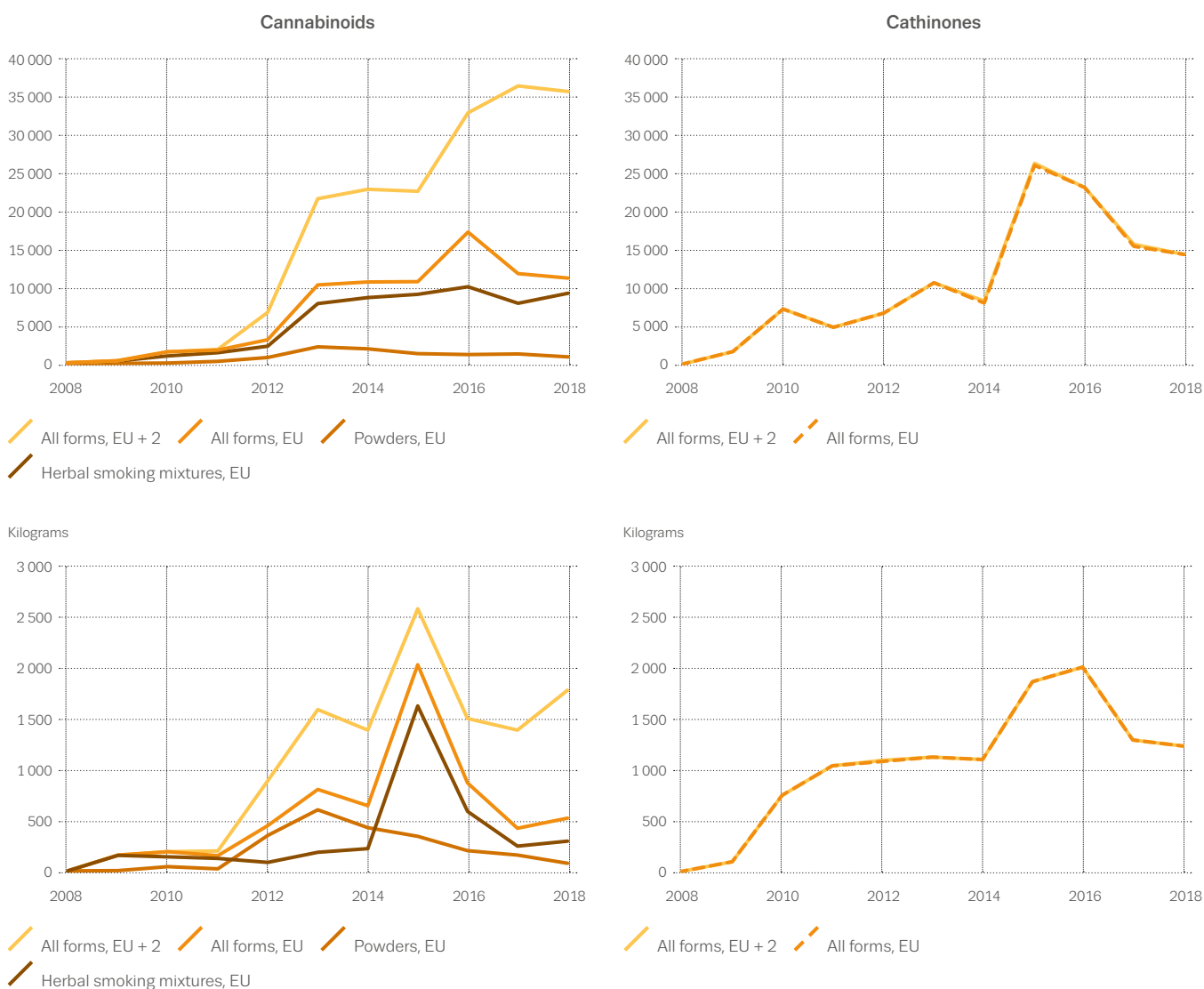
In Europe, seizures of new psychoactive substances are typically dominated by synthetic cannabinoids and cathinones, which together accounted for 77 % of all seizures reported in 2018 (64 % for the EU Member States) (Figure 22).

Products containing cannabinoids and cathinones, including herbal smoking mixtures and liquids for e-cigarettes are typically prepared from bulk powders. In recent years, there has been a decrease in the number and quantity of powders containing synthetic cannabinoids and cathinones seized in the European Union (Figure 23). For cannabinoids,

this may reflect a decrease in local processing of herbal smoking mixtures. For cathinones, more complex factors may be at play since the apparent drop in the quantity of powders seized, compared with 2015 and 2016, occurs in the context of a small but increasing number of cathinone production sites being discovered in Europe. In 2018 a total of 50 kilograms of the cathinone precursor 2-bromo-4-methylpropiofenone was seized within the European Union, while three laboratories were detected producing mephedrone (Spain, Netherlands, Poland), indicating the continued production of this drug within Europe.

FIGURE 23

SEIZURES OF SYNTHETIC CANNABINOIDS (LEFT) AND SYNTHETIC CATHINONES (RIGHT) REPORTED TO THE EU EARLY WARNING SYSTEM: TRENDS IN NUMBER OF SEIZURES AND QUANTITY SEIZED, 2008-18



Quantity reflects the bulk weight of the seizures, with no adjustment to purity or potency. In this context, quantity aggregates seizures by reported unit, regardless of physical form (powders, herbal smoking mixtures and others).

Fentanyl derivatives replaced by other new synthetic opioids

Synthetic opioids pose a very high risk of poisoning to consumers. Since 2009, 57 new synthetic opioids have been detected on Europe’s drug market — including eight reported for the first time in 2019. In 2019 only two of these opioids were fentanyl derivatives, which is a small proportion when compared with previous years (Figure 24). The remaining six opioids (2-fluoro-viminol, AP-237, 2-methyl-AP-237, piperidylthiambutene, furanyl UF-17 and isotonitazene) are all chemically different from fentanyl, despite posing similar concerns in respect to their toxicity.

In 2018 approximately 1 000 seizures of new opioids were reported to the EU Early Warning System (Figure 25). This amounted to approximately 9.3 kilograms of material, of which 7.3 kilograms was in the form of powders. Additionally, 5.4 litres of liquids and 21 500 tablets and capsules (excluding tramadol) were also reported. The high potency of some synthetic opioids means that even small volumes could equate to many thousands of street doses.

Less commonly, new opioids have also been found in blotters and in herbal smoking mixtures. In these cases, there may be no indication that they contain potent opioids, posing a poisoning risk to those who may use them, particularly people with no existing tolerance to opioids.

FIGURE 24

NUMBER OF NEW SYNTHETIC OPIOIDS REPORTED TO THE EU EARLY WARNING SYSTEM FOR THE FIRST TIME, 2008-19

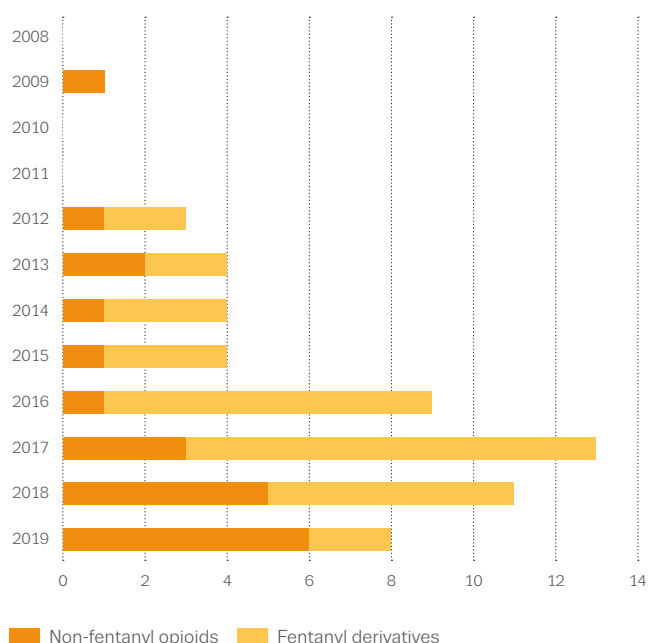
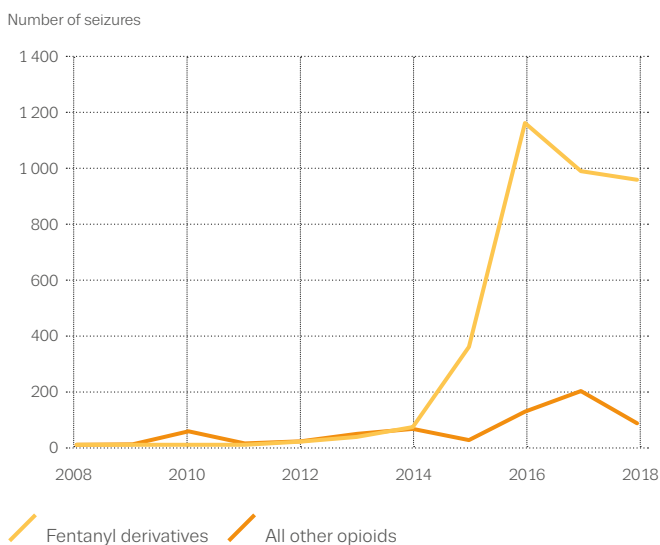


FIGURE 25

TRENDS IN NUMBER OF SEIZURES OF FENTANYL DERIVATIVES AND OTHER NEW SYNTHETIC OPIOIDS REPORTED TO THE EU EARLY WARNING SYSTEM, 2008-18



Seizures of tramadol were excluded.

In 2018 more than half a kilogram of 4-anilino-N-phenethylpiperidine (ANPP) was seized in France and a shipment of 3 kilograms of N-phenethyl-4-piperidone (NPP) was stopped in Belgium. Both are precursors for the manufacture of fentanyl and fentanyl derivatives.

New benzodiazepines associated with poisonings and deaths

Over the last few years reports have indicated an increase in the number, type and availability of new psychoactive substances belonging to the benzodiazepine class, which are not scheduled under international drug control laws. Some of these are sold as fake versions of commonly prescribed anti-anxiety medicines such as alprazolam (Xanax) and diazepam, making use of existing distribution networks in the illicit drug market. Others are sold online, sometimes under their own names, marketed as ‘legal’ versions of authorised medicines.

The EMCDDA is currently monitoring 30 new benzodiazepines — 21 of which were first detected in Europe since 2015. In 2018 close to 4 700 seizures of new benzodiazepines were reported to the EU Early Warning

System, amounting to 1.4 million tablets, 1.3 litres of liquids and under 8 kilograms of powders. Within the United Kingdom, in Scotland, criminal groups are known to be involved in the large-scale illicit manufacture and distribution of fake benzodiazepine medicines. Typically made to look like 10-milligram diazepam tablets, and known as 'street Valium', these fakes often contain new or uncontrolled benzodiazepines. Substances that pose a high risk of severe poisoning have also occasionally been used, such as opioids and scopolamine.

In some countries, new benzodiazepines have been associated with harms, including an increased risk of overdose. In particular, etizolam, monitored by the EU Early Warning System since 2011, and more recently flualprazolam, first detected in 2018, have been associated with poisonings and deaths.

Use of new psychoactive substances remains low

Since 2011 more than half of the European countries have reported national estimates of the use of new psychoactive substances (not including ketamine and GHB) in their general population surveys, although differences in methods and survey questions limit the comparability of the data. Among young adults (aged 15-34), estimates of last year prevalence of use of these substances ranged from zero in Norway to 1.9 % in Poland. Survey data on the use of mephedrone are available for the United Kingdom (England and Wales). In the most recent survey (2018), prevalence of last year use of this drug among 16- to 34-year-olds was 0.0 %, down from 1.1 % in 2014. In Finland, the prevalence of use of cathinones in the last year among young adults (aged 15-34) was 0.2 % in 2018. In their most recent surveys, last year use of synthetic cannabinoids among 15- to 34-year-olds ranged from 0.3 % in Spain and Lithuania to 0.6 % in Italy.

New psychoactive substances represented 5 % of all drugs submitted for testing by individuals to drug checking services operating in 11 European countries during the first half of 2019. It should be noted that these results are not representative of the market as a whole. The most common substances detected among samples sold as new psychoactive substances were stimulants, primarily 4-MMC and 3-MMC (synthetic cathinones), followed by hallucinogens (1P-LSD and 4-AcO-DMT) and new benzodiazepines (etizolam and flualprazolam). However, new psychoactive substances were occasionally found as adulterants in samples submitted as MDMA. Over 100 samples sold as well-known benzodiazepines, such as diazepam, alprazolam or Z-drugs like zopiclone, contained etizolam, a benzodiazepine recently controlled internationally.

While consumption levels of new psychoactive substances are low overall in Europe, in a 2016 EMCDDA study over two thirds of countries reported that their use by high-risk drug users resulted in health concerns. In particular, the use of synthetic cathinones by opioid and stimulant injectors has been linked to health and social problems. In addition, the smoking of synthetic cannabinoids in marginalised populations, including homeless people and prisoners, has been identified as a problem in a number of European countries. Overall, few people currently enter treatment in Europe for problems associated with use of new psychoactive substances.

Health and social response options to problems related to use of new psychoactive substances

- Early-warning and risk assessment supported by multidisciplinary data, including the chemical identification of new substances from forensic and toxicology laboratory networks.
- Risk communication with authorities, professionals and users related to particularly harmful new substances, new formats of use, and emerging health and social threats.
- Supporting policy makers by providing scientific and evidence-based information on new psychoactive substances posing health and social threats.
- Inclusion of new substances into effective generic prevention programmes, with specific education and harm reduction messages targeted towards those already using drugs, or at risk of using new substances.
- Training and awareness-raising activities for relevant professionals, including staff of forensic and toxicology laboratories, health professionals and first responders, professionals in prevention, treatment and harm reduction services, in order to enhance their competencies in identifying and responding to use of new psychoactive substances.
- Development of clinical guidelines for the management of acute toxicity caused by new psychoactive substances.
- Multidisciplinary approaches and the linking up of different services are needed to engage vulnerable groups who may not come into contact with traditional services.
- Many of the health and social responses to new psychoactive substances are adaptations of programmes for 'established' drugs. Responses have tended to target particular groups where problems have been observed. These vary by country but include recreational stimulant users, psychonauts, men who have sex with men, people avoiding drug tests, and high-risk drug users. There has also been a focus in many countries on strengthening legal responses and restricting the availability of these substances.

These and other responses are further explained in the EMCDDA's [*Health and Social Responses to Drug Problems: A European Guide*](#) supported by the online [Best Practice Portal](#).



HEROIN

risks

use

trends

AND OTHER OPIOIDS

prevention

seizures

treatment

Opioid use is a major contributor to the harms associated with drug use in Europe. Heroin is the most frequently used opioid, but others such as methadone, buprenorphine, tramadol and fentanyl derivatives are also available on the illicit market. This section relies on law enforcement data to describe the opioids market and on prevalence studies and data from specialised drug treatment centres for information on the prevalence and patterns of opioid use.



Quantity of heroin seized within the European Union doubles

Afghanistan remains the world's largest producer of illicit opium, the raw material for heroin, and most heroin found in Europe is thought to be manufactured in Afghanistan or in neighbouring Iran or Pakistan. Heroin enters Europe along four main trafficking routes, of which the Balkan route is considered the most important. A recent development is the emergence of trafficking through the Suez Canal and across the Mediterranean Sea. The discovery of laboratories producing heroin from morphine in Bulgaria, Czechia, Spain and the Netherlands in recent years, together with an increase in morphine and opium seizures suggests, however, that some heroin is now manufactured in the European Union. This may reflect suppliers seeking to reduce costs, as the heroin precursor chemical acetic anhydride is more expensive in opium-producing countries.

In 2018 law enforcement agencies in the European Union seized almost 16 tonnes of acetic anhydride and a further 9 tonnes was stopped before it entered the supply chain. These figures represent a large decrease compared with 2017 (81 tonnes). Analysis of stopped shipments of acetic anhydride indicate that groups producing heroin outside the European Union attempt to obtain supplies from European chemical suppliers.

A period of reduced heroin availability was observed in a number of European countries around 2010/11, accompanied by an overall drop in both numbers of seizures and quantities of heroin seized. Since then, seizures in the European Union have largely stabilised, with 37 000 seizures reported in both 2017 and 2018. However, the amount seized in the European Union in 2018 increased to 9.7 tonnes, up from 5.2 tonnes in 2017, mainly due to large individual seizures made in the port of Antwerp. Turkey continues to seize more heroin than all other European countries combined (Figure 26). Following a steep drop in seizures in the period 2014-16, from 12.8 to 5.6 tonnes, in 2017-18 Turkey seized around 17 tonnes of heroin each year (17.4 and 17.8), the largest quantities for a decade.

Among those countries consistently reporting price and purity data, indexed trends suggest that, following a sharp decrease between 2009 and 2011, heroin purity increased rapidly before stabilising in recent years. In contrast, the retail price of heroin declined between 2008 and 2014, and has been relatively stable since then. In 2018 half the countries reported a mean purity of heroin at retail level in the range 18-30 % and a mean price in the range EUR 29-79 per gram.

Although seizures of opioids other than heroin represent a small fraction of total opioid seizures, they have increased markedly in recent years. The non-heroin opioids most commonly seized include the medicinal opioids tramadol, buprenorphine and methadone (see Table 2). In 2018 the quantities of morphine, codeine and methadone seized were greater than in 2017, and seizure data support the concern that the interest in synthetic opioids of all types may be growing.

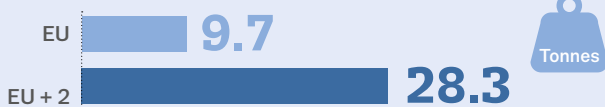
HEROIN

Seizures

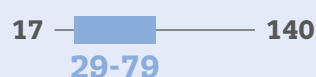
Number



Quantity



Price (EUR/g)

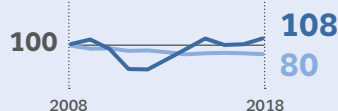


Purity (%)



Indexed trends

Price and purity

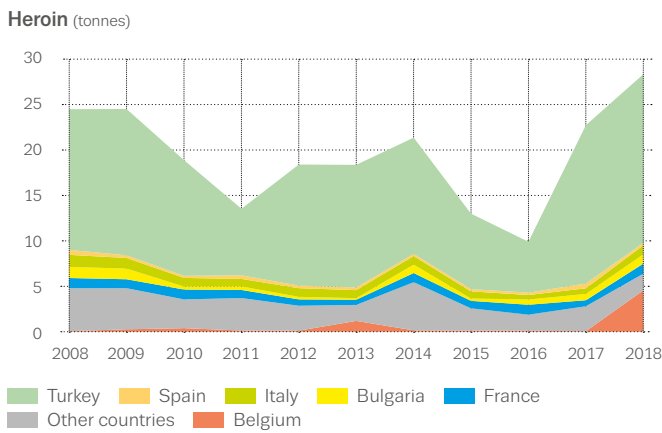
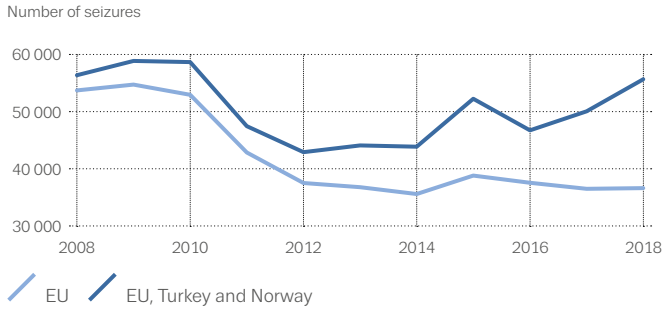


EU + 2 refers to EU Member States, Turkey and Norway.

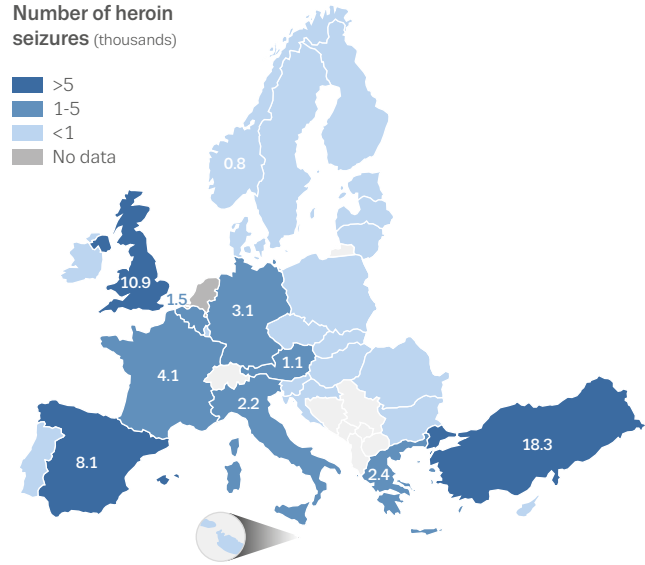
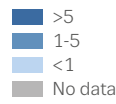
Price and purity of 'brown heroin': national mean values — minimum, maximum and interquartile range. Countries covered vary by indicator.

FIGURE 26

NUMBER OF HEROIN SEIZURES AND QUANTITY SEIZED: TRENDS AND 2018 OR MOST RECENT YEAR



Number of heroin seizures (thousands)



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

Quantity of heroin seized (tonnes)

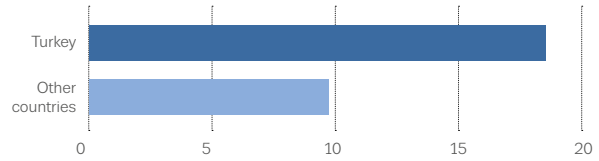


TABLE 2

SEIZURES OF OPIOIDS OTHER THAN HEROIN IN 2018

	Number	Quantity				Number of countries
		Kilograms	Litres	Tablets	Patches	
Methadone	1 650	130.9	26.4	34 500		20
Buprenorphine	3 220	0.2		106 500		18
Tramadol	5 520	0.7		1 112 300		14
Fentanyl derivatives	930	6.2	0.1	19 800	587	13
Morphine	1 110	354.1	0.2	12 400		12
Opium	550	781.2				15
Codeine	510	0.3		28 400		12
Dihydrocodeine	7			500		3
Oxycodone	650	<0.1		15 200		8

High-risk opioid use: continued decline of first-time heroin treatment entries

The prevalence of high-risk opioid use among adults (15-64) is estimated at 0.4 % of the EU population, equivalent to 1.3 million high-risk opioid users in 2018. At national level, prevalence estimates of high-risk opioid use range from less than 1 to more than 8 users per 1 000 population aged 15-64 (Figure 27). The five most populous countries in the European Union (Germany, Spain, France, Italy, United Kingdom), account for three quarters (75 %) of this estimate.

In 2018 use of opioids was reported as the main reason for entering specialised drug treatment by 143 000 clients, or 34 % of all those entering drug treatment in Europe. Of these, more than 27 000 were first-time entrants. Primary heroin users accounted for 77 % (almost 20 000 clients) of first-time primary opioid users entering treatment, a drop of 2 200 clients or 10 % compared with the previous year.

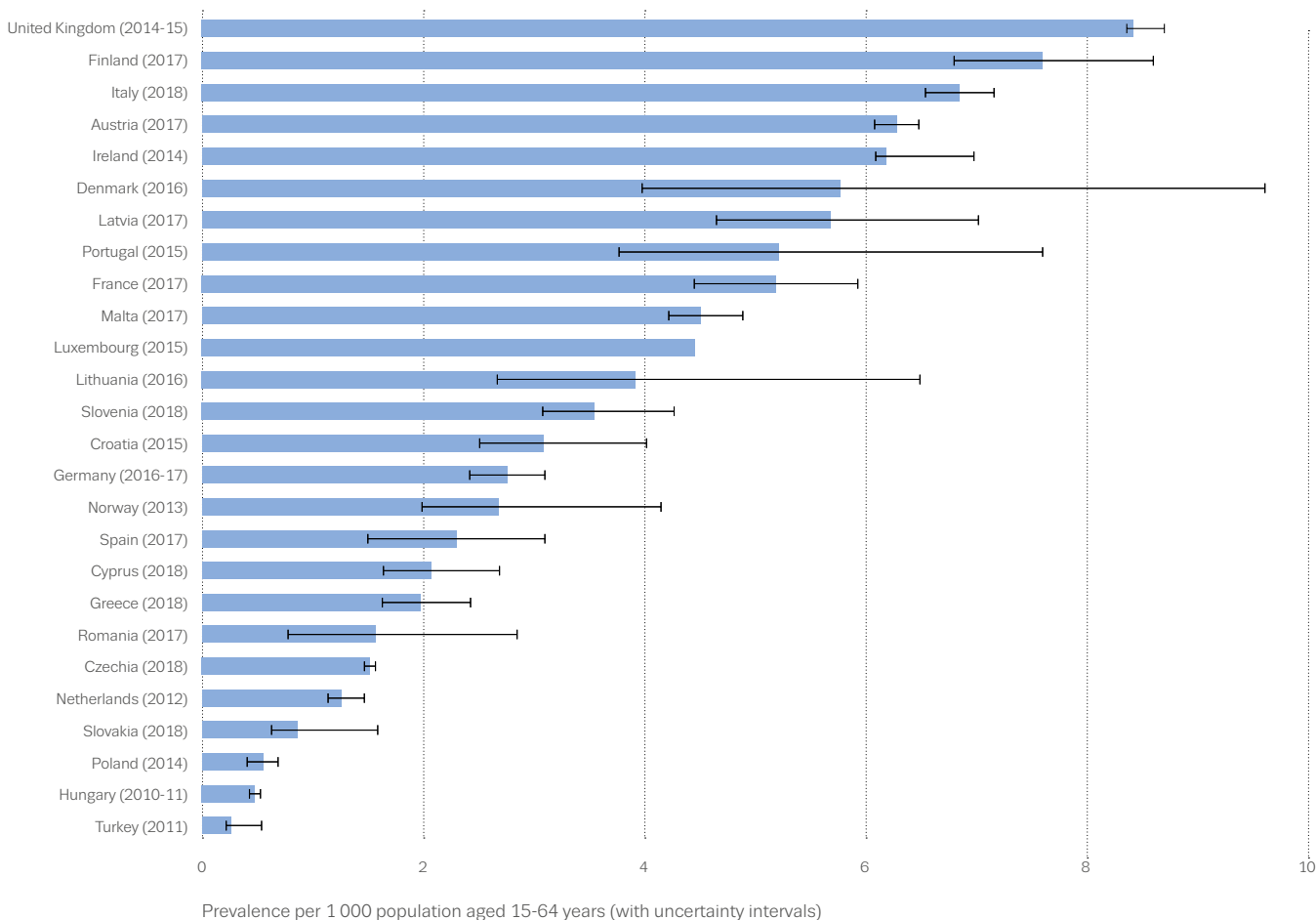
According to the available trend data, the number of first-time heroin clients has fallen by more than half from a peak observed in 2007. Between 2017 and 2018 the number of first-time treatment entrants for primary heroin use decreased in 18 countries out of the 29 with available data.

Synthetic opioids: national variation in substances used

Opioids other than heroin reported by treatment entrants include misused methadone, buprenorphine, fentanyl, codeine, morphine, tramadol and oxycodone. Overall, non-heroin opioids account for 16 % of all clients citing an opioid as their main problem drug. In some countries, non-heroin opioids represent the most common form of opioid use among entrants to specialised treatment. Twenty European countries reported that more than 10 % of all opioid

FIGURE 27

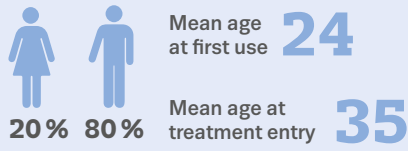
PREVALENCE OF HIGH-RISK OPIOID USE PER 1 000 POPULATION AGED 15-64 YEARS, BY COUNTRY (MOST RECENT STUDIES)



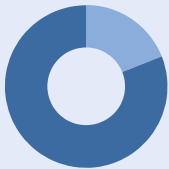
HEROIN

Heroin users entering treatment

Characteristics

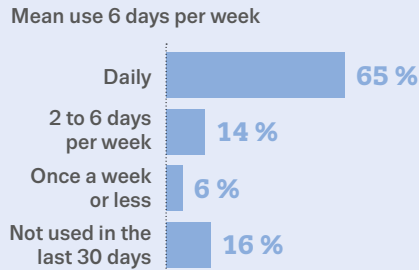


20 400
 First-time entrants 19%

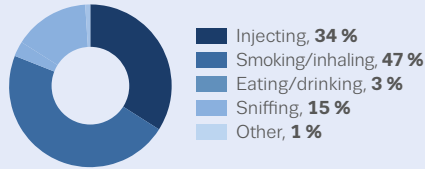


86 400
 Previously treated entrants 81%

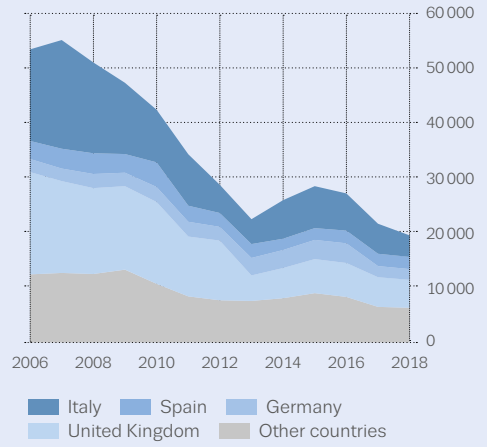
Frequency of use in the last month



Route of administration



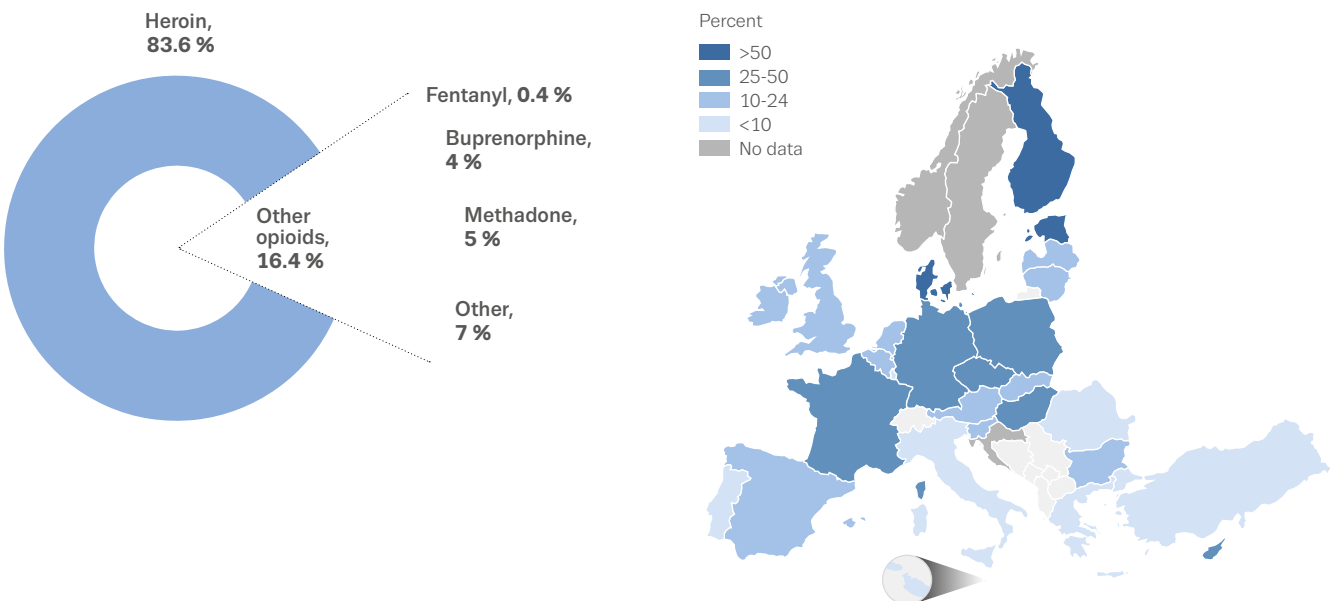
Trends in first-time entrants



Apart from trends, data are for all treatment entrants with heroin as primary drug. Data for Germany are for entrants with 'opioids' as primary drug. Trends in first-time entrants are based on 24 countries. Only countries with data for at least 11 of the 13 years are included in the trends graph. Missing values are interpolated from adjacent years. Due to changes in the flow of data at national level, data since 2014 for Italy are not comparable with earlier years. United Kingdom data for 2018 do not include Northern Ireland.

FIGURE 28

TREATMENT ENTRANTS CITING OPIOIDS AS PRIMARY DRUG: BY TYPE OF OPIOID (LEFT) AND PERCENTAGE REPORTING OPIOIDS OTHER THAN HEROIN (RIGHT)



clients entering specialised services in 2018 presented for problems primarily related to opioids other than heroin (Figure 28). In Estonia, the majority of treatment entrants reporting an opioid as their primary drug were using fentanyl, while buprenorphine was the most cited primary opioid among treatment entrants in Finland. Buprenorphine misuse is reported by around 24 % of opioid clients in Czechia, with the misuse of methadone being reported by 23 % of opioid clients in Germany and 22 % in Denmark. Non-heroin opioids also account for a large share of opioid treatment clients in Poland, where 27 % of opioid clients report 'kompot' — heroin made from poppy straw — and in Cyprus, where 39 % report oxycodone. It should be noted that those entering treatment for problems relating to new psychoactive substances with opioid-like effects may be reported under the general heading of opioids.

Health and social response options to problems related to use of opioids

- Pharmacological interventions, such as opioid substitution treatment, usually with methadone or buprenorphine. Heroin-assisted treatment may be useful for people who have not responded to other forms of opioid substitution treatment.
- Behavioural and psychosocial interventions to address psychological and social aspects of drug use include brief interventions, structured psychological therapies, motivational interventions, contingency management and behavioural couples therapy. They are often used in conjunction with pharmacological interventions.
- Residential rehabilitation involves living in a treatment facility and following a structured, care-planned programme of medical, therapeutic and other activities. This approach is suitable for clients with medium or high levels of need.
- Self-help and mutual aid groups teach cognitive, behavioural and self-management techniques without formal professional guidance.
- Recovery/reintegration support services, for example, offer employment and housing support.
- Effective long-term treatment of opioid dependence often requires multiple treatment episodes and combinations of responses. Harm reduction interventions, mental health and other services, addressing co-occurring mental and physical health problems, will also be important.

These and other responses are further explained in the EMCDDA's [*Health and Social Responses to Drug Problems: A European Guide*](#) supported by the online [Best Practice Portal](#).



Injecting drug use is more commonly associated with opioids, although in a few countries the injecting of stimulants such as amphetamines or cocaine is more prevalent. In this section, national studies on the prevalence of injecting drug use and data from specialised drug treatment centres are complemented by findings from a multicentre European study on drug residues in used syringes.

Injecting drug use continues to decline among new heroin clients

Only 16 countries have estimates of the prevalence of injecting drug use since 2012, where they range from less than 1 to more than 10 cases per 1 000 population aged 15-64. Opioids are reported as the main injected drugs in the majority (14) of these countries (Figure 29).

Among first-time clients entering specialised drug treatment in 2018 with heroin as their primary drug, 24 % reported injecting as their main route of administration, down from 43 % in 2006. In this group, levels of injecting vary between countries, from 9 % in Spain and Portugal to 90 % or more in Latvia. Injecting is reported as the main route of administration by less than 1 % of first-time cocaine clients and 21 % of first-time amphetamines clients. The overall picture for amphetamines, however, is influenced by Czechia, which accounts for more than 50 % of new amphetamines clients injecting the drug in Europe. Considering the three main injected drugs together, injecting as the main route of administration among first-time entrants to treatment in Europe has declined from 26 % in 2006 to 10 % in 2018 (Figure 30).

FIGURE 29

INJECTING DRUG USE: MOST RECENT ESTIMATES OF PREVALENCE OF INJECTING ANY DRUG IN THE LAST YEAR AND MAIN DRUG INJECTED

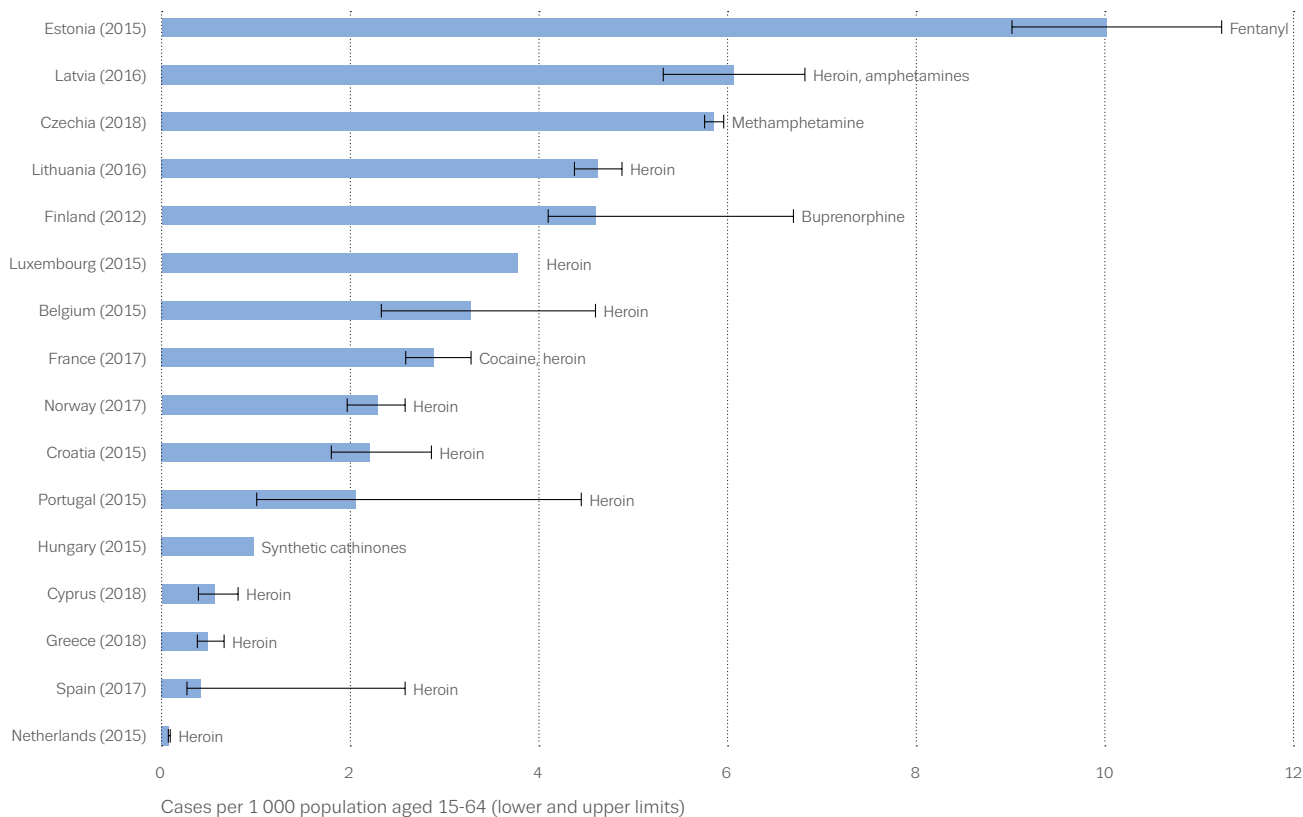
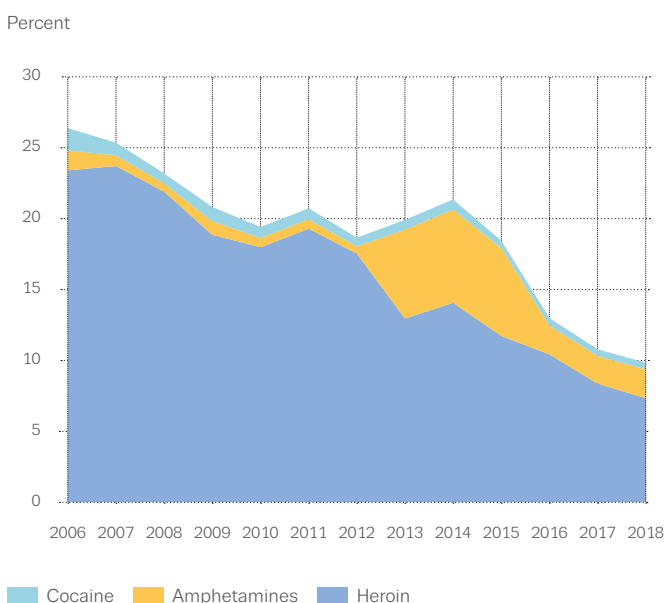


FIGURE 30

INJECTING AMONG FIRST-TIME TREATMENT ENTRANTS WITH HEROIN, COCAINE OR AMPHETAMINES AS PRIMARY DRUG: PERCENTAGE REPORTING INJECTING AS MAIN ROUTE OF ADMINISTRATION



Insights from syringe residue data: stimulant drugs commonly found

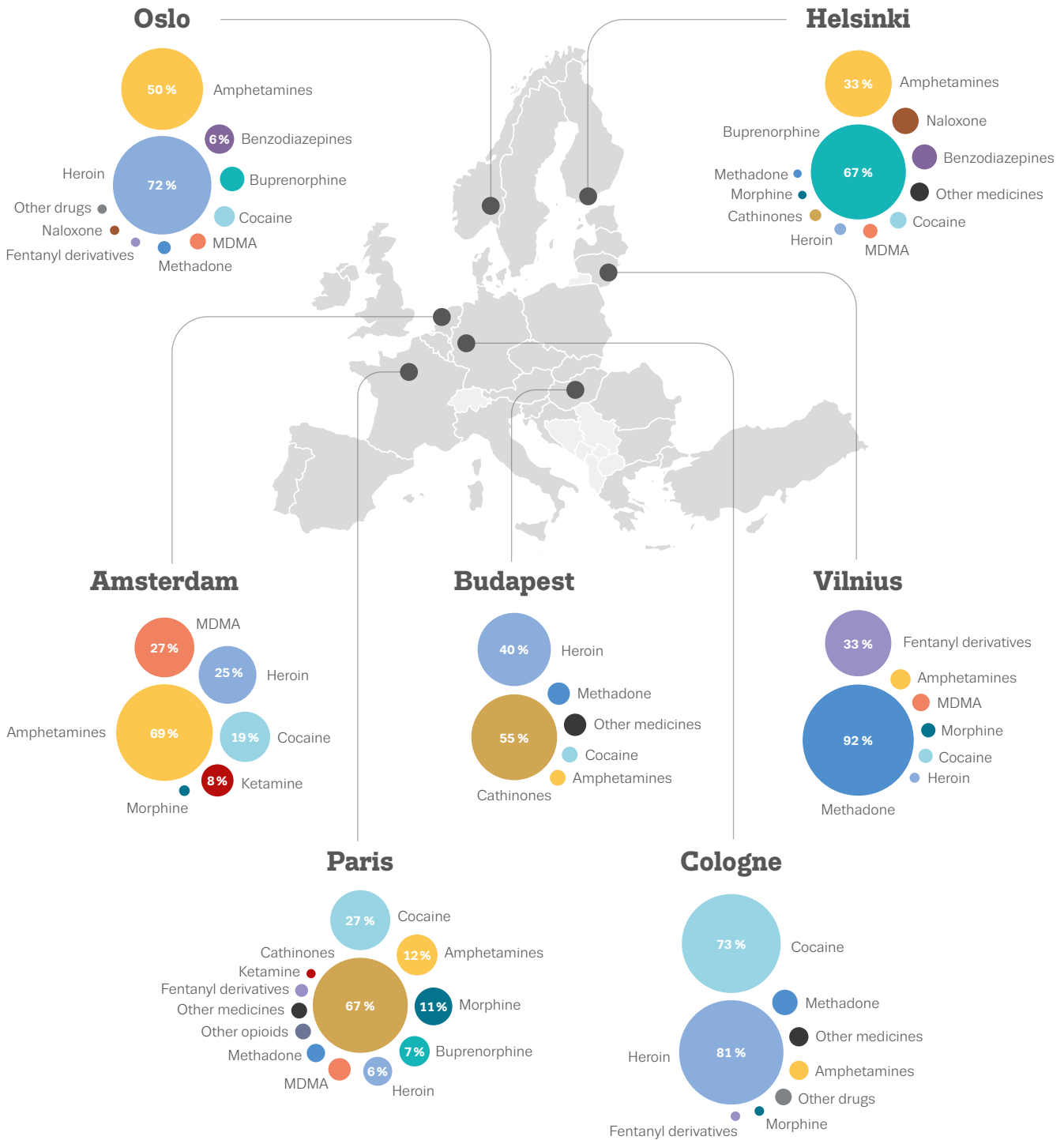
Data from drug treatment and high-risk drug use estimates can be complemented by findings from the European Syringe Collection and Analysis Project Enterprise (ESCAPE) network, which collates information on injected substances by analysing the residual content of used syringes. In 2019 syringes were collected from the bins of street automatic injection kit dispensers and at harm reduction services in Amsterdam, Budapest, Cologne, Helsinki, Oslo, Paris and Vilnius. The contents of 1 180 used syringes were tested in seven laboratories.

A high proportion of the syringes in six of the cities contained stimulants, with cocaine, amphetamines and synthetic cathinones often found (Figure 31); the exception was Vilnius, where only opioids (methadone or carfentanyl) were found in the majority of syringes. A third of the syringes contained two or more drugs; the most frequent combination being a mix of stimulant and opioid.



FIGURE 31

DRUG RESIDUES IN USED SYRINGES IN SELECTED EUROPEAN CITIES, 2019



Circle area is proportional to percentage of syringes in each location in which a substance was detected. More than one substance may be detected in a single syringe. Study conducted in 2019. Source: European Syringe Collection and Analysis Project Enterprise (ESCAPE) network.



Hospital emergency data can provide an insight into acute drug-related harms and the public health impact of the use of drugs in Europe. Data on drug-related presentations to emergency departments collected by a number of countries allow some national-level analysis. A broader, albeit non-representative, European picture is afforded by the work of the Euro-DEN Plus network.

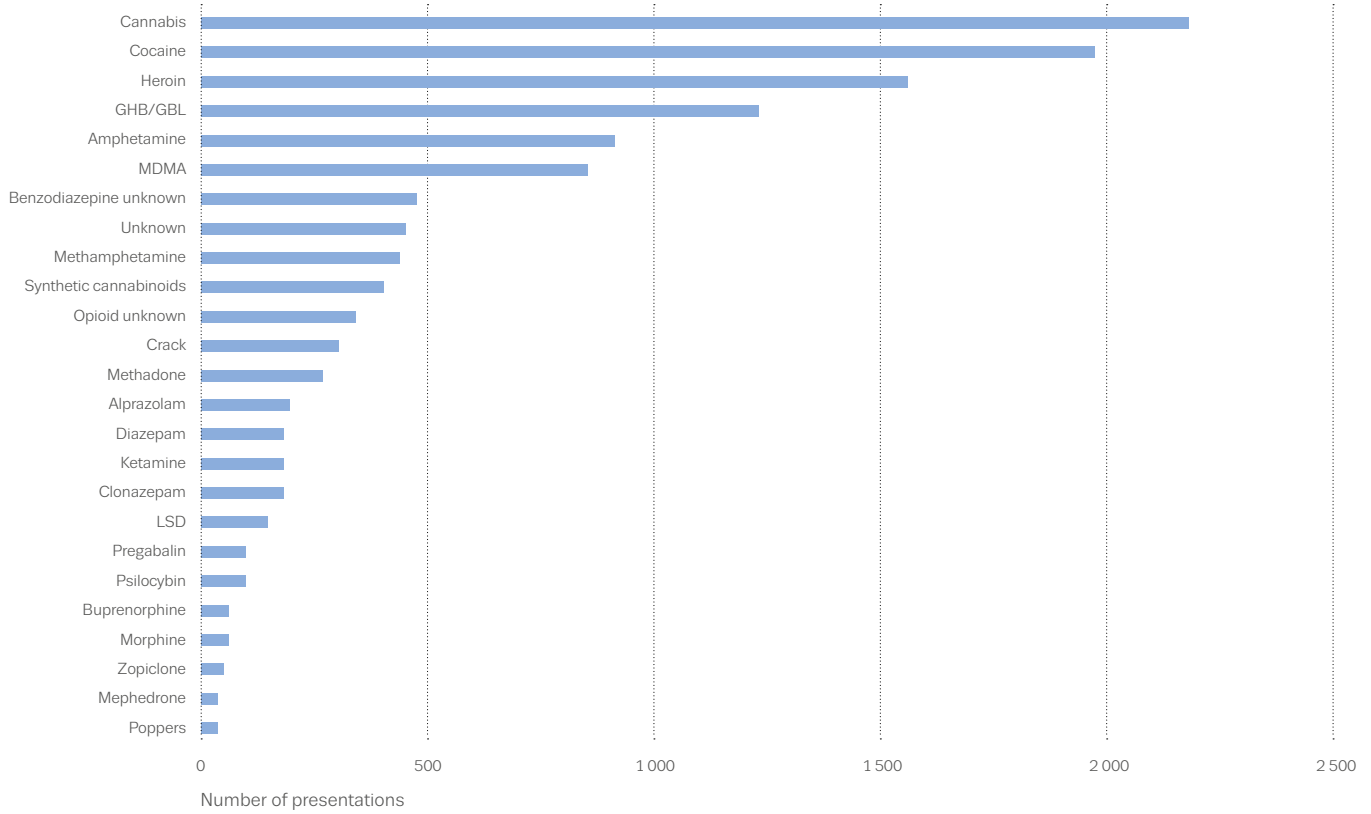
Established drugs increase in emergency presentations

Hospital emergency data can provide an insight into acute drug-related harms and the public health impact of the use of drugs in Europe. Only a small number of countries, such as Czechia, Denmark, Spain, France and the Netherlands, report data on acute drug emergencies. Among these, the Netherlands has a multi-source monitoring system in place, which captures data from different medical services in eight regions plus first aid services operating at large-scale events at the national level. Data reported here is mainly from a sentinel station system without national coverage. The most common drugs involved in acute emergencies reported from this network of emergency centers in 2018 were MDMA (46 %), cannabis (25 %), GHB (23 %), cocaine powder (16 %), ketamine (10 %) and the new psychoactive substance 4-fluoroamphetamine (4-FA, 5 %). In 2018 the proportion of both MDMA and ketamine-related presentations increased, while the proportion of presentations related to 4-FA, controlled in 2017, decreased.

In Denmark, drug-related acute emergencies have shown an increasing trend, from 1 618 in 2009 to 2 618 in 2018, with the overall increase primarily due to cases involving non-heroin opioids and stimulants. The number of emergencies related to heroin declined over the period, from 195 in 2010 to 130 in 2018. More recently, acute emergencies involving cocaine increased from 341 cases in 2016 to 523 in 2018. Due to under-reporting, these are likely to be minimum figures.

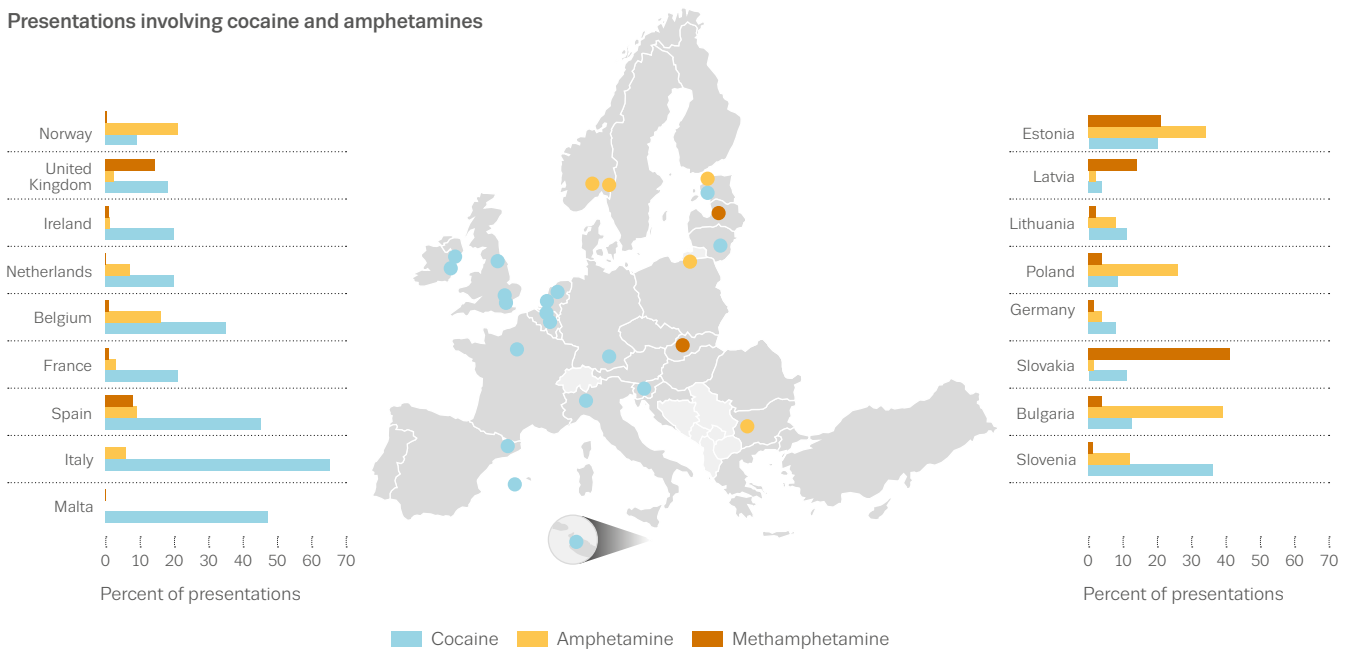
FIGURE 32

TOP 25 DRUGS RECORDED IN EMERGENCY PRESENTATIONS FROM A NETWORK OF SENTINEL HOSPITALS IN 2018 (TOP) AND FREQUENCIES OF COCAINE AND AMPHETAMINES PRESENTATIONS (PERCENTAGE OF PRESENTATIONS), AGGREGATED BY COUNTRY (BOTTOM)



Results of 9 134 presentations in 27 sentinel hospitals in 19 European countries.

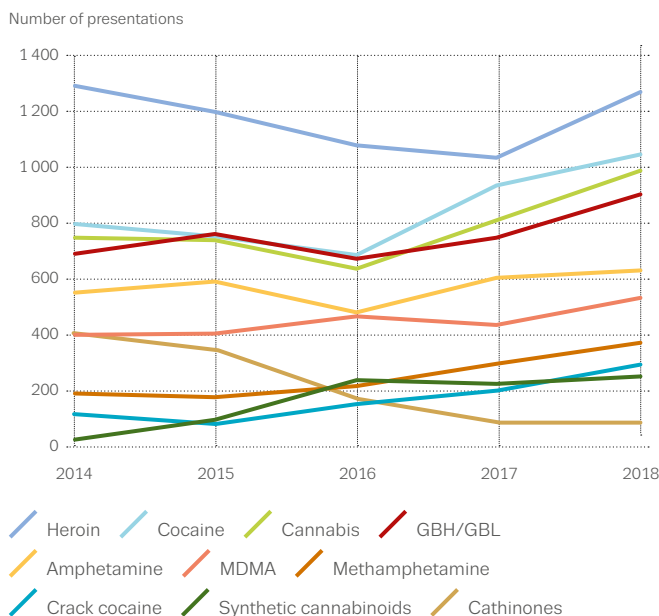
Presentations involving cocaine and amphetamines



Only countries with more than 50 cocaine and amphetamines presentations are included in the stimulants graphic. Coloured circles indicate the stimulant drug most often involved in presentations to the individual hospitals: Belgium (Antwerp and Ghent), Bulgaria (Sofia), Germany (Munich), Estonia (Parnu and Tallinn), Ireland (Drogheda and Dublin), Spain (Barcelona and Mallorca), France (Paris), Italy (Monza), Latvia (Riga), Lithuania (Vilnius), Malta (Msida), Netherlands (Amsterdam and Utrecht), Poland (Gdansk), Slovenia (Ljubljana), Slovakia (Bratislava), United Kingdom (London, 2; York) and Norway (Oslo, 2).
 Source: European Drug Emergencies Network (Euro-DEN Plus).

FIGURE 33

TRENDS IN THE NUMBER OF PRESENTATIONS RELATED TO SELECTED DRUGS TO THE 14 SENTINEL HOSPITALS THAT REPORTED DATA FOR 2014-18



Data from the 14 Euro-DEN Plus sentinel hospitals reporting in each year from 2014 to 2018.
Source: European Drug Emergencies Network (Euro-DEN Plus).

Drug-related acute toxicity presentations to 27 (sentinel) hospitals in 19 European countries are monitored by the European Drug Emergencies Network (Euro-DEN Plus). While the presentations seen in the sentinel hospitals may not reflect the national picture and this is not a representative data set, it does provide insight on trends in drug-related emergency presentations. In 2018 the hospitals recorded 9 134 presentations, most of whom were male (77 %). Almost three quarters of the presentations were brought to hospital by ambulance, with the majority (80 %) discharged within 12 hours. A small proportion needed to be admitted to critical care (6 %) or to a psychiatric ward (4 %). Some drugs were more associated than others with admission to critical care, such as GHB/GBL (16 %), methamphetamine (8 %) and MDMA (8 %). Among the sample, 30 in-hospital deaths were recorded, of which 13 involved cocaine, 9 heroin and 11 other opioids. Most cases involved more than one drug.

Cannabis was the drug most commonly involved in presentations in 2018, followed by cocaine and heroin (Figure 32). Seventeen percent of the drugs reported were prescription or over-the-counter medicines (most commonly benzodiazepines and opioids), 10 % were GHB/GBL, and 4 % were new psychoactive substances.

Differences in the drugs involved in emergency presentations between sites appear to reflect variations in hospital catchment area and local patterns of use. For example, emergencies involving amphetamines were most common in the north and east of Europe, whereas presentations related to cocaine were predominant in the south and west of Europe (Figure 32).

The overall trend for the 14 Euro-DEN centres that have reported data for 2014-18 shows a rebound in the number of presentations related to heroin — mainly in London — and increases for powder cocaine and crack cocaine, cannabis, GHB/GBL and methamphetamine (Figure 33). The largest increases over this period in the number of presentations related to cocaine powder were reported in the centres in the north and west of Europe: Oslo, London, Dublin, as well as Mallorca. Meanwhile, London, Paris, and to a lesser extent Dublin reported the largest increases in presentations related to crack cocaine. During the same period, there was an overall decrease in presentations related to synthetic cathinones and an increase in those related to synthetic cannabinoids. The four hospitals in London and Oslo account for over half of the presentations to the 14 centres that have reported data since 2014.



People who use drugs, particularly those who inject them, are at risk of contracting infections such as the hepatitis C virus (HCV) and the human immunodeficiency virus (HIV) through the sharing of drug use material. These infections typically cause chronic diseases that may result in severe health harms, including death. This section presents an overview of national data on new HIV diagnoses attributable to drug injecting along with serological data on HIV and HCV among national and sub-national samples of people who inject drugs.

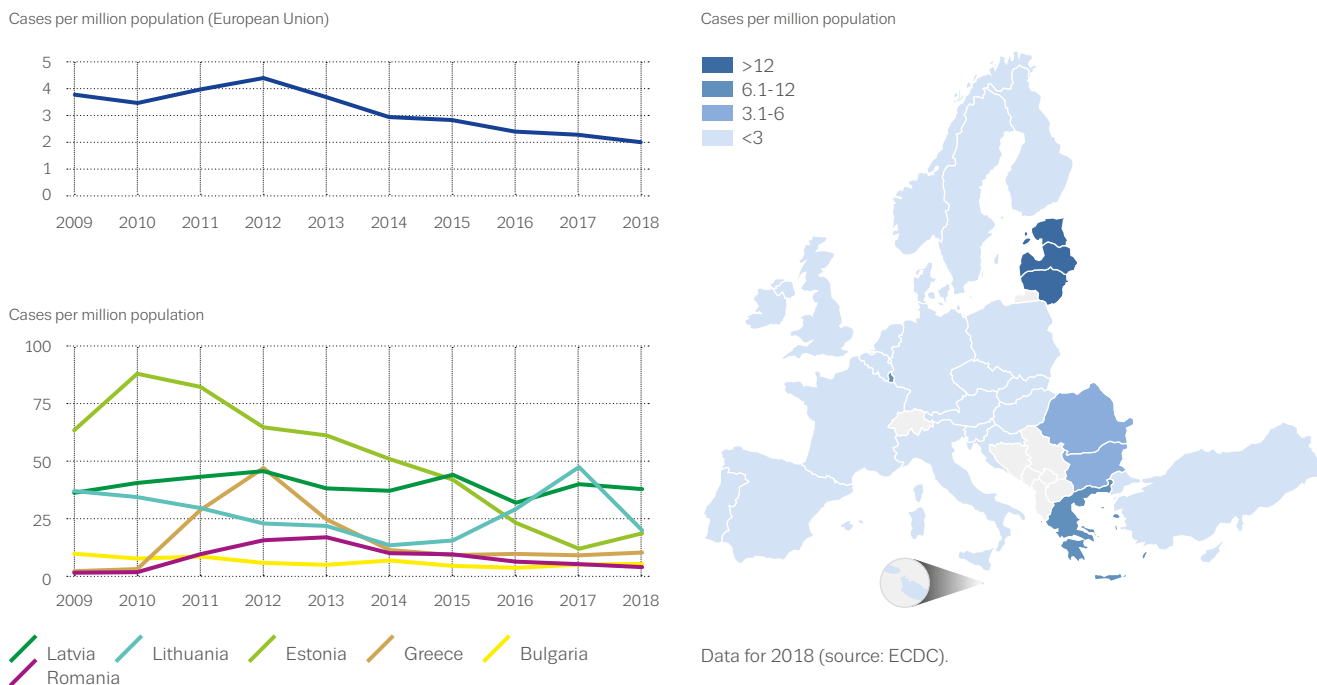
Stimulant injecting linked to local HIV outbreaks

In 2018 an estimated 966 new HIV diagnoses attributable to injecting drug use were notified in the European Union. This represents a 4.8 %-share of all new HIV diagnoses for which the route of transmission is known, a proportion that has remained low and stable for the last decade. Most of these cases were males (82 %), typically 35 years or older. Notifications of newly diagnosed HIV infections among people who inject drugs declined in most European countries between 2009 and 2018 (Figure 34). However, injecting drug use remains an important mode of transmission in some countries. In 2018, according to the data reported to the European Centre for Disease Prevention and Control, injecting drug use was linked to 40 % of newly diagnosed HIV cases in Lithuania and 35 % in Latvia. Seroprevalence studies — based on blood samples — among people who inject drugs, conducted in Estonia, Greece, Latvia, Lithuania, Poland and Romania in 2017-18, found that more than 10 % of those tested were HIV-positive.

Localised HIV outbreaks have been documented among marginalised populations of people who inject drugs in Dublin (2014-15), Luxembourg (2014-16), Munich (2015-16), Lithuania (2016-17), Cologne (2018) and Glasgow (2015-19). These outbreaks have been sometimes associated with injection of stimulants, such as cocaine and synthetic cathinones.

FIGURE 34

NEWLY DIAGNOSED HIV CASES RELATED TO INJECTING DRUG USE: OVERALL AND SELECTED TRENDS AND MOST RECENT DATA



Where the information was available, more than half of the new HIV diagnoses attributed to drug injecting in the European Union in 2018 were diagnosed late — that is, when the virus had already begun to damage the immune system — suggesting that opportunities for earlier intervention are being missed. Late HIV diagnosis is associated with delays in initiation of anti-retroviral therapy and increased morbidity and mortality. The policy of ‘test-and-treat’ for HIV, whereby anti-retroviral therapy is started directly after an HIV diagnosis, can result in a reduction of transmission and is especially important among groups with higher-risk behaviours, such as people who inject drugs. Early diagnosis and initiation of anti-retroviral therapy offers those infected a normal life expectancy. Where data are available, EU countries are behind Sustainable Development Goals targets on HIV treatment and viral suppression among people who inject drugs, indicating that better linkage to care and adherence support is needed.

In 2018, 12 % of newly reported AIDS cases in the European Union, for which the route of transmission was known, were attributed to injecting drug use. These 327 injection-related AIDS notifications represent less than a quarter of the number reported a decade ago.

HCV prevalence: national differences

Viral hepatitis, particularly infection caused by the hepatitis C virus (HCV), is highly prevalent among injecting drug users across Europe. For every 100 people infected with HCV, 55 to 85 will develop chronic infection. This has important long-term consequences, as chronic HCV infection, often worsened by heavy alcohol use, will lead to increasing numbers of deaths and cases of severe liver disease, including cirrhosis and cancer, among an ageing population of high-risk drug users.

The prevalence of antibodies to HCV among people who inject drugs, indicating present or past infection, is estimated from seroprevalence studies or routine diagnostic testing often offered in drug services. In 2017-18, HCV antibody prevalence in national samples of people who inject drugs varied from 16 % to 86 %, with 10 of the 16 countries with national data reporting rates in excess of 50 % (Figure 35).

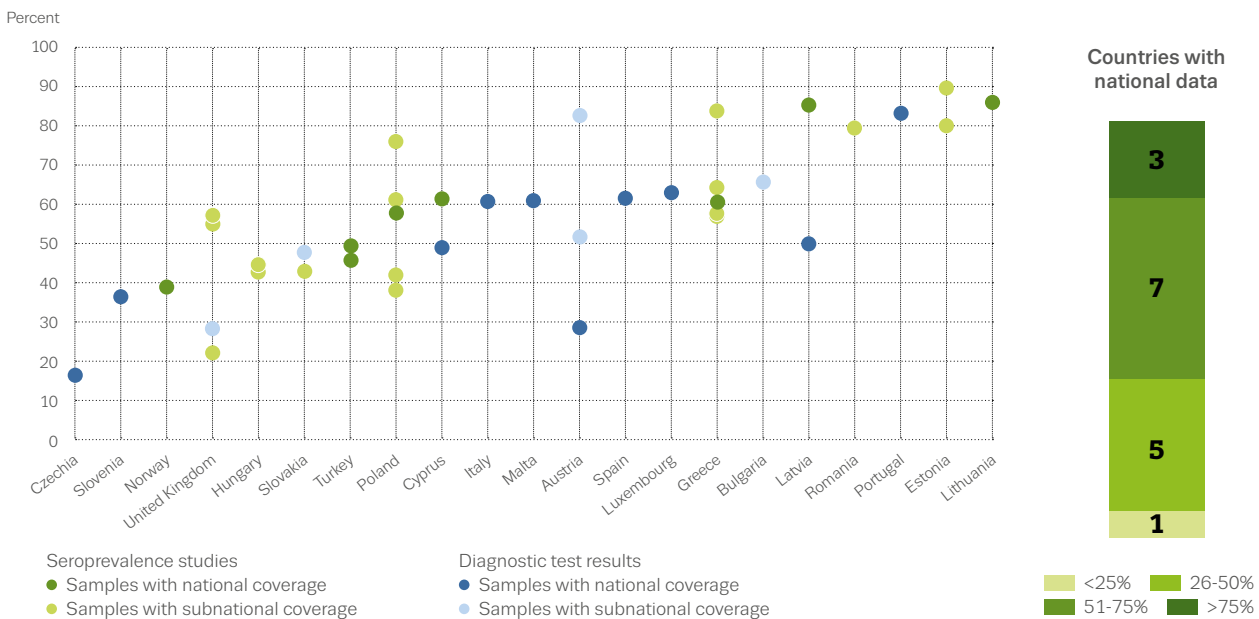
Patients who naturally clear the virus and those who are cured will, however, still test positive for HCV antibodies. In terms of burden of disease, it is important to identify individuals who remain chronically infected; they are at risk of cirrhosis and cancer, and can transmit the virus to others when sharing any injecting material that has been in contact with their blood. Among the countries reporting recent data on chronic infections among people who inject drugs, with a sample size equal to or greater than 100, the prevalence ranged from 27 % in the United Kingdom (England and Wales, 2018) to 55 % in Austria (Vienna, 2018).

Drug injection is a risk factor for other infectious diseases, and drug-related clusters of hepatitis A were reported in Czechia and Germany in 2016. In the United Kingdom, the number of notified group A Streptococcus and Staphylococcus aureus cases associated with injecting drug use has increased, and wound botulism cases continue to be reported in Europe.

Among people who inject drugs, hepatitis B virus (HBV) infection is less common than HCV infection, but still higher than in the general population, despite the availability of an effective vaccine. The presence of the HBV surface antigen indicates current infection, which may be acute or chronic. In the seven countries with national data for 2018, an average of 5.3 % (range: 0-17 %) of people who inject drugs were estimated to be currently infected with HBV.

FIGURE 35

HCV ANTIBODY PREVALENCE AMONG PEOPLE WHO INJECT DRUGS: SEROPREVALENCE STUDIES AND DIAGNOSTIC TEST RESULTS WITH NATIONAL AND SUBNATIONAL COVERAGE, 2017-18





DRUG-RELATED DEATHS AND MORTALITY

Drug use is a recognised cause of avoidable mortality among European adults. This section presents the most recent data on deaths attributed to acute drug toxicity (overdoses), a major contributor to the overall number of deaths related to drug use. The analysis covers both the overall numbers of deaths and the mortality rates. Trends in deaths related to heroin and cocaine are given a special focus.

Overdose: a frequent cause of death among high-risk drug users

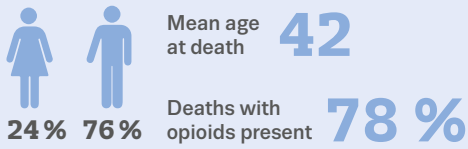
Drug use is a recognised cause of avoidable mortality among European adults. Overall, in Europe, people who use opioids are between 5 and 10 times more likely to die than their peers of the same age and gender. Overdose is one of the most frequent causes of deaths among people with drug problems. However, other causes of death indirectly related to drug use, such as HIV/AIDS and viral hepatitis, accidental injuries, violence including homicide and suicide, are also important causes of mortality in this group. Chronic pulmonary and liver conditions as well as cardiovascular problems are frequent and now account for an increased share of deaths among older and chronic drug users, who have long-term cycles of use, treatment, abstinence and relapse.

Overdose data, especially the European cumulative total, must be interpreted with caution. Among the reasons for this are systematic under-reporting in some countries, differences in the ways toxicological examinations are conducted and registration processes that can result in reporting delays. Annual estimates therefore represent a provisional minimum value.

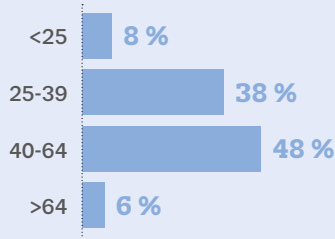
It is estimated that at least 8 300 overdose deaths involving illicit drugs, primarily opioids, occurred in the European Union in 2018, representing a stable situation compared

DRUG-INDUCED DEATHS

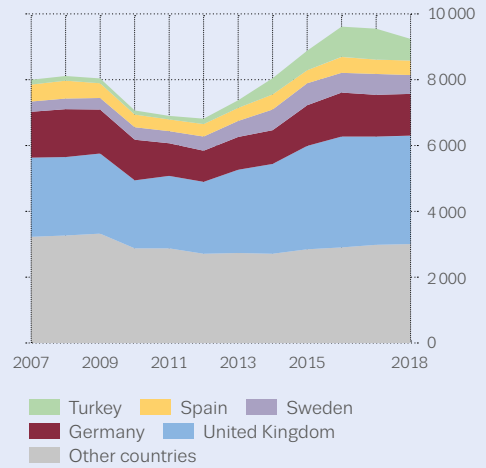
Characteristics



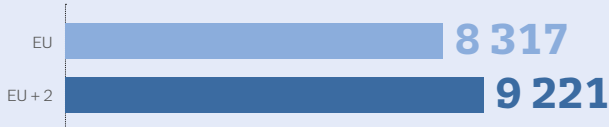
Age at death



Trends in overdose deaths



Number of deaths



Data refer to EU Member States, Turkey and Norway (EU + 2). Where 2018 data are not available, 2017 or otherwise most recent data are used. The latest data for the United Kingdom do not include Northern Ireland.

with 2017. This total rises to an estimated 9 200 deaths if Norway and Turkey are included, representing a slight decrease in relation to the revised estimate of 9 500 in 2017. The European analysis, however, is provisional and probably understates the actual number of deaths that occurred in 2018.

As in previous years, the United Kingdom (a third) and Germany together account for half of all reported overdose deaths in the European Union, Norway and Turkey. This figure needs to be interpreted in the context of both the size of the at-risk populations in these countries and under-reporting in some other countries.

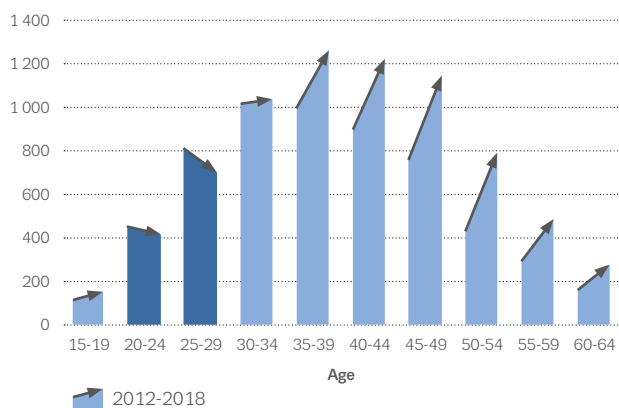
Three quarters of those dying from overdose are male (76 %). The mean age of those who died in Europe continued to increase, reaching 41.7 years in 2018. This reflects the ageing nature of a large part of Europe’s opioid-using population, mainly in western Europe, who are at greatest risk of drug overdose death. In some countries, a proportion of opioid cases may be related to deaths involving opioids in the context of long-term pain management.

Decreases in the numbers of deaths have been reported in Sweden, Estonia and Turkey. The declines in Estonia and Sweden are potentially related to decreased availability of fentanyl derivatives and a scaling-up of interventions, particularly the provision of take-home naloxone. The decline in overdose deaths in Turkey may be related to a number of factors, possibly including an increase in the coverage and effectiveness of the interventions available.

Between 2012 and 2018 overdose deaths in the European Union increased in all age categories with the exception of those aged 20-29 (Figure 36). Deaths among the 50-plus age groups increased by 75 % overall, while deaths among younger age groups have generally been stable. Analysis of fatal overdoses reported by Turkey in 2018 shows a younger profile than the European Union average, with a mean age of 32.5 years (Figure 37).

FIGURE 36

NUMBER OF DRUG-INDUCED DEATHS REPORTED IN THE EUROPEAN UNION IN 2012 AND 2018, OR MOST RECENT YEAR, BY AGE BAND



Drug-induced mortality: northern Europe sees above-average rates

The mortality rate due to overdoses in Europe in 2018 is estimated at 22.3 deaths per million population aged 15-64. The rate among males (35.1 cases per million males) is almost four times that among females (9.5 cases per million females). Males aged 35-44 are the most affected, with a mortality rate of 53.7 deaths per million, more than double the average seen for all ages, and more than three times the highest mortality rate in females (13.9 deaths per million females aged 35-44 years).

National mortality rates and trends vary considerably and are influenced by factors such as prevalence and patterns of drug use, particularly injecting opioid use; risk and protective factors, such as the availability of treatment; and national practices of reporting, recording information and coding of overdose cases, including variable levels of under-reporting, in national mortality databases. Comparisons between countries should be made bearing in mind the national contexts and the limitations of some data. According to the latest data available, rates of over 40 deaths per million

FIGURE 37

AGE DISTRIBUTION OF DRUG-INDUCED DEATHS REPORTED IN 2018, OR MOST RECENT YEAR

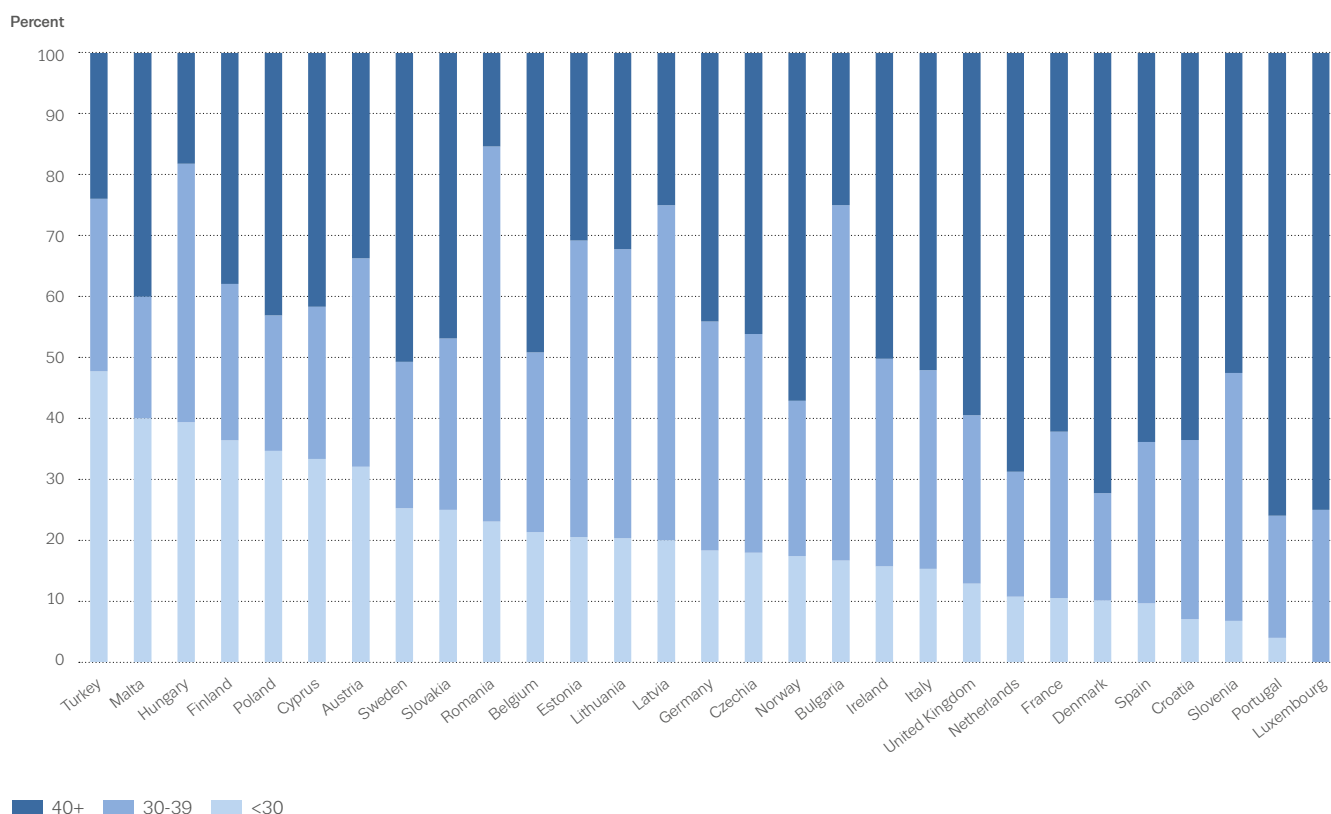
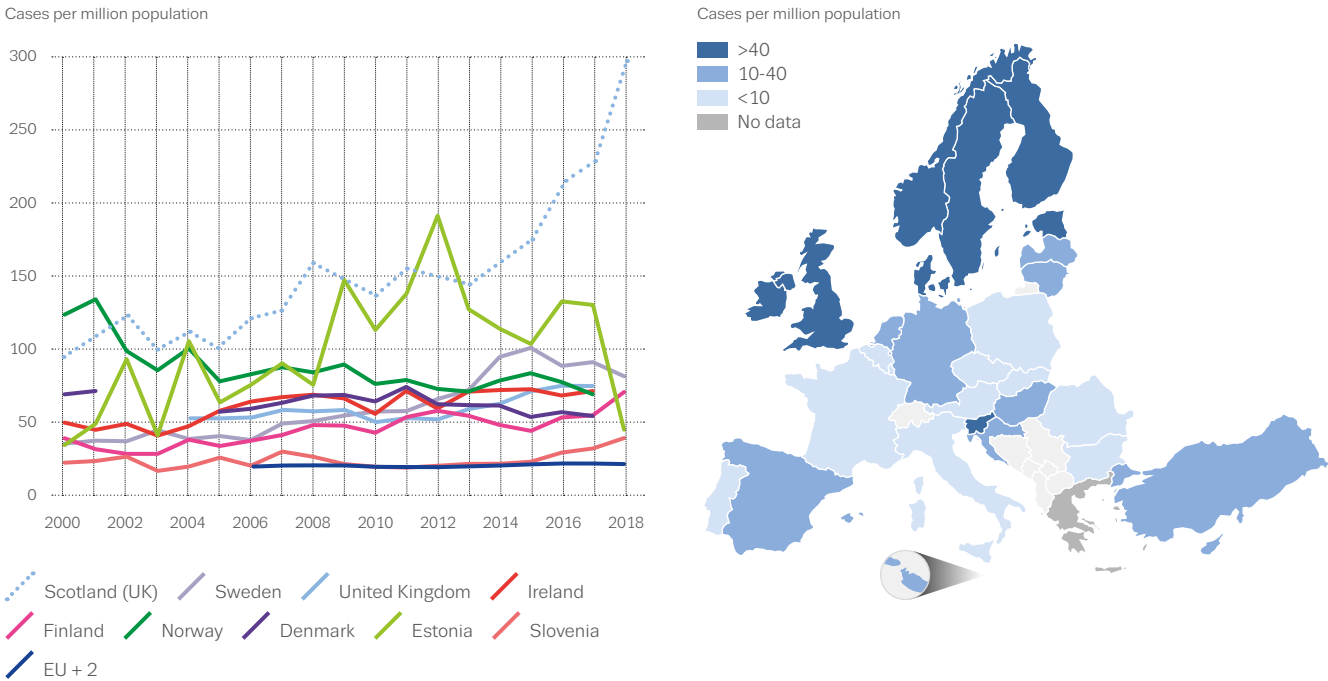


FIGURE 38

DRUG-INDUCED MORTALITY RATES AMONG ADULTS (15-64): SELECTED TRENDS AND MOST RECENT DATA



Trends in the eight countries reporting the highest rates in 2018 or 2017 and overall European trend. UK data for 2017 do not include Northern Ireland. EU + 2 refers to EU Member States, Turkey and Norway. Due to methodological differences and potential under-reporting in some countries, comparisons between countries may not be valid.

population were reported in eight northern European countries, with the highest rates reported in Sweden (81.5 per million in 2018) and the United Kingdom (excluding Northern Ireland) (76.2 per million in 2017) (Figure 38). Scotland, in the United Kingdom, had the highest mortality rate in 2018, with 295 deaths per million adult population aged 15-64.

Trends in heroin and cocaine-related deaths

Opioids, mainly heroin or its metabolites, often in combination with other substances, are present in the majority of fatal overdoses reported in Europe. Opioid-related deaths particularly predominate in the north of Europe — Austria, Denmark, Estonia, Finland, Ireland, Luxembourg, Norway, Sweden and the United Kingdom — and also in Bulgaria, Croatia and Romania, where around 9 out of 10 overdose deaths involved some form of opioid.

The number of heroin deaths increased in Portugal (29 deaths, a 93 % increase). As in 2017 Germany (405 deaths in 2018, a 1 % decrease), Italy (155 deaths in 2018, a 5 % increase) and Turkey (205 deaths in 2018, a 3 % decrease) reported large numbers of heroin-related deaths in 2018. Sweden reported 98 heroin deaths in 2018. Austria reported an increase in deaths with morphine or heroin in the toxicology, from 77 in 2017 to 113 in 2018.

Opioids other than heroin are also regularly mentioned in post mortem toxicology reports. These substances, primarily methadone, but also buprenorphine (Finland), fentanyl and its derivatives and tramadol, are associated with a substantial share of overdose deaths in some countries. Where post mortem toxicology is available on the presence of either fentanyl or fentanyl derivatives in fatal overdoses, declines have generally been observed in the most recent data. Countries reporting a decline include Germany (from 157 deaths in 2017 to 59 in 2018), Estonia (from 86 in 2017 to 12 in 2018) and Sweden (from 131 in 2017 to 30 in 2018). Deaths linked to either fentanyl or fentanyl derivatives were stable in the United Kingdom (England and Wales; 106 deaths registered in 2017 and 105 in 2018), while Finland reported an increase from 7 in 2017 to 14 in 2018.

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. They are often found in combination with other substances. Similar to previous years, cocaine was present in more than half (53 %) of the drug-induced deaths reported in 2018 in Spain. Where data are available, an increase in cocaine-related deaths was reported in 2018 compared with 2017 in Germany, Italy, Austria and Portugal. Similar year on year comparisons of the number of cocaine deaths cannot be made for France, Ireland and the United Kingdom. In these countries, the share of deaths related to the drug has increased in the most recent data; between 2016 and 2017 in France and Ireland and among deaths registered in 2018 in the United Kingdom.

Health and social response options

Deaths

- These mainly focus on preventing the occurrence of overdoses and on improving the survival of those who overdose.
- Enrolling and retaining problem opioid users in OST and ensuring continuity between treatment in prisons and the community and at other transition points.
- Promoting overdose awareness, particularly around key risk periods and other risk factors, such as concurrent alcohol or benzodiazepine use.
- Ensuring opioid antagonist (naloxone) availability and promoting appropriate use by professionals responding to or intervening in drug overdoses.
- Education and training of drug users, peers and family members to identify overdoses and intervene with take-home naloxone while waiting for the ambulance to arrive.
- Provision of drug consumption rooms to support safer injecting.

Infectious diseases

- Providing opioid substitution treatment and other effective drug dependence treatment to people who inject drugs.
- Needle and syringe programmes providing sterile injection equipment to injectors.
- Vaccination against hepatitis A and B, tetanus and influenza, and also pneumococcal vaccine for HIV-positive individuals.
- Routine testing for HIV, HCV (HBV for unvaccinated) and other infections including tuberculosis.
- This needs to be linked to referral and treatment provision for those found to be infected, including the new direct-acting antiviral treatments for HCV that are now available.
- Health promotion focused on safer injecting behaviour; sexual health, including condom use; and disease prevention, testing and treatment.
- Developing proactive, multi-component approaches that are adapted to user needs and local conditions.

These and other responses are further explained in the EMCDDA's *Health and Social Responses to Drug Problems: A European Guide* supported by the online [Best Practice Portal](#).



ANNEX

National data for estimates of drug use prevalence including problem opioid use, substitution treatment, total number in 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 2020](#), where notes and meta-data are available. The years to which data refer are indicated.




TABLE A1

OPIOIDS

Country	Problem 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)			
	Year of estimate	cases per 1 000	All entrants	First-time entrants	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants	count
			% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	
Belgium	–	–	21.1 (2 322)	6.6 (269)	30.4 (1 969)	13.7 (287)	11.4 (28)	13.8 (245)	16 179
Bulgaria	–	–	83.1 (987)	52.2 (144)	91.7 (705)	74.2 (710)	67.7 (88)	73.8 (516)	3 181
Czechia	2018	1.5-1.6	17.2 (751)	9.9 (188)	22.9 (525)	61.8 (443)	60.2 (112)	62.4 (311)	5 000
Denmark	2016	4.0-9.6	11 (565)	6.3 (151)	15.6 (404)	15 (85)	2.6 (4)	19.8 (80)	6 600
Germany	2016-17	2.4-3.1	17.3 (6 977)	8.5 (1 972)	–	22.3 (1 067)	17.6 (246)	–	79 400
Estonia	–	–	93.4 (271)	87.4 (76)	95.5 (150)	69.3 (187)	72 (54)	80.7 (121)	1 052
Ireland	2014	6.1-7.0	42.2 (4 178)	18.1 (718)	60.2 (3 312)	29.7 (1 202)	19.7 (141)	32.2 (1 032)	10 332
Greece	2018	1.6-2.4	55.1 (2 036)	32.5 (494)	70.2 (1 485)	26.5 (526)	19.5 (95)	29.1 (424)	9 162
Spain	2017	1.5-3.1	24.9 (11 632)	12 (2 850)	39.4 (8 404)	15.8 (1 816)	8.4 (240)	17.5 (1 457)	59 857
France	2017	4.5-5.9	24.8 (11 935)	11.4 (1 509)	39.7 (7 519)	17.4 (1 774)	10.2 (139)	20 (1 304)	178 665
Croatia	2015	2.5-4.0	–	21.2 (203)	–	–	30.9 (56)	–	4 792
Italy	2018	6.5-7.2	42.6 (16 445)	26.4 (4 256)	54.1 (12 189)	45.9 (6 252)	32 (1 050)	50.4 (5 202)	75 711
Cyprus	2018	1.6-2.7	24.4 (272)	13.3 (72)	38.6 (187)	36.3 (94)	44.1 (30)	34.1 (61)	257
Latvia	2017	4.7-7.0	49.4 (399)	28.7 (123)	72.8 (276)	82.8 (323)	73.8 (90)	86.9 (233)	690
Lithuania	2016	2.7-6.5	82.4 (1 075)	50.7 (105)	89.1 (961)	83.3 (895)	77.1 (81)	84 (807)	1 275
Luxembourg	2015	4.5	51.6 (158)	35.4 (29)	59.6 (115)	46 (64)	34.8 (8)	48.5 (50)	1 142
Hungary	2010-11	0.4-0.5	2.6 (121)	1.2 (43)	6.7 (63)	34.7 (35)	7.9 (3)	52.6 (30)	650
Malta	2017	4.2-4.9	56.3 (1 067)	19.5 (76)	65.8 (991)	54.2 (578)	30.3 (23)	56 (555)	729
Netherlands (¹)	2012	1.1-1.5	11.5 (1 262)	6.2 (402)	19.3 (860)	6.1 (39)	7.6 (13)	5.6 (26)	5 241
Austria	2017	6.1-6.5	47.5 (1 966)	29.8 (548)	61.6 (1 418)	34.7 (553)	21.1 (90)	39.6 (463)	19 216
Poland	2014	0.4-0.7	15.7 (1 035)	6.2 (201)	25.7 (822)	53.5 (545)	36.7 (73)	58 (469)	2 797
Portugal	2015	3.8-7.6	37.1 (1 214)	20.8 (379)	57.7 (835)	11 (127)	5.8 (21)	13.4 (106)	17 246
Romania	2017	0.8-2.9	24.6 (1 048)	10.8 (314)	54 (734)	83.4 (859)	80.8 (253)	84.5 (606)	1 772
Slovenia	2018	3.1-4.3	79.5 (174)	44.9 (22)	89.3 (151)	39.1 (68)	13.6 (3)	42.4 (64)	3 301
Slovakia	2018	0.6-1.6	26.5 (805)	9.3 (115)	39.6 (676)	71.4 (566)	66.1 (74)	72.7 (487)	620
Finland	2017	6.9-8.6	48.5 (328)	35.5 (86)	55.8 (242)	77.3 (252)	75.6 (65)	77.9 (187)	3 329
Sweden (²)	–	–	23.6 (10 005)	16.1 (2 259)	27.7 (7 363)	–	–	–	4 014

Country	Problem 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
United Kingdom ^(?)	2014-15	8.3-8.7	49.7 (55 687)	21.9 (7 502)	62.1 (48 081)	30.7 (11 553)	15.6 (646)	32.7 (10 884)	147 568
Turkey	2011	0.2-0.5	63 (7 141)	47.2 (2 446)	76.3 (4 695)	24.1 (1 719)	14.1 (346)	29.2 (1 373)	12 500
Norway ⁽⁴⁾	2013	2.0-4.1	17 (1 010)	11.4 (309)	21.6 (701)	–	–	–	7 762
European Union	–	–	33.1 (134 715)	15.4 (25 106)	48.7 (100 437)	31.6 (30 960)	21.5 (3 726)	34.6 (25 720)	659 778
EU, Turkey and Norway	–	–	33.7 (142 866)	16.3 (27 861)	49.1 (105 833)	31.1 (32 619)	20.6 (4 072)	34.3 (27 093)	680 040

Data on entrants into treatment are for 2018 or most recent year available: Estonia, 2016; Croatia, Latvia and Spain, 2017; Netherlands, 2015.

Data on clients in substitution treatment are for 2018 or most recent year available: Luxembourg, 2017; Croatia, Denmark, France, Slovakia and Spain, 2016; Netherlands and Finland, 2015; Turkey, 2011. The number for Sweden does not represent all clients.

⁽¹⁾ Data for the number of clients in substitution treatment is not complete.

⁽²⁾ Data for clients entering treatment refer to hospital-based care and specialised outpatient care facilities. Data shown are not fully representative of the national picture.

⁽³⁾ The high-risk opioid use estimate and the entrants into treatment data do not include Northern Ireland. Clients in substitution treatment relates to England and Wales.

⁽⁴⁾ The percentage of clients in treatment for opioid-related problems is a minimum value, not accounting for opioid clients registered as polydrug users.

TABLE A2

COCAINE

Country	Year of survey	Prevalence estimates		Entrants into treatment during the year					
		General population		Cocaine clients as % of treatment entrants			% cocaine clients injecting (main route of administration)		
		Lifetime, adults (15-64) %	Last 12 months, young adults (15-34) %	All entrants	First-time entrants	Previously treated entrants	All clients	First-time entrants	Previously treated entrants
				% (count)	% (count)	% (count)	% (count)	% (count)	% (count)
Belgium	2018	–	2.9	25.4 (2 804)	25.3 (1 037)	24.7 (1 600)	3.8 (97)	1.1 (11)	5.4 (77)
Bulgaria	2016	0.9	0.5	3.5 (41)	7.6 (21)	2.6 (20)	0 (0)	0 (0)	0 (0)
Czechia	2018	1.3	0.2	0.9 (38)	1 (19)	0.8 (18)	10.8 (4)	10.5 (2)	11.1 (2)
Denmark	2017	6.4	3.9	18.9 (971)	21.3 (511)	16.7 (432)	1.7 (16)	0.2 (1)	3.6 (15)
Germany	2018	4.1	2.4	6.5 (2 598)	6.6 (1 533)	–	2 (36)	1.7 (18)	–
Estonia	2018	5.0	2.8	0.3 (1)	1.1 (1)	–	–	–	–
Ireland	2015	7.8	2.9	22.1 (2 186)	31.1 (1 231)	15.9 (878)	0.8 (17)	0.5 (6)	1 (9)
Greece	2015	1.3	0.6	11.6 (429)	15.3 (233)	9.2 (194)	8.5 (36)	3.1 (7)	15 (29)
Spain	2017	10.3	2.8	43.1 (20 168)	43.8 (10 393)	42.3 (9 025)	0.9 (179)	0.3 (36)	1.5 (138)
France	2017	5.6	3.2	10.8 (5 182)	9.8 (1 300)	12.5 (2 368)	8.2 (382)	2.7 (33)	12.2 (264)
Croatia	2015	2.7	1.6	–	3.2 (31)	–	–	3.2 (1)	–
Italy	2017	6.9	1.7	32.7 (12 641)	37.3 (6 014)	29.4 (6 627)	2.6 (294)	1.5 (79)	3.6 (215)
Cyprus	2016	1.4	0.4	17.8 (199)	15.9 (86)	20.2 (98)	2.6 (5)	2.4 (2)	3.1 (3)
Latvia	2015	1.5	1.2	0.5 (4)	0.7 (3)	0.3 (1)	0 (0)	0 (0)	0 (0)
Lithuania	2016	0.7	0.3	1.1 (15)	3.4 (7)	0.6 (7)	6.7 (1)	0 (0)	14.3 (1)
Luxembourg	2014	2.5	0.6	20.6 (63)	23.2 (19)	17.6 (34)	51.9 (27)	38.9 (7)	58.3 (14)
Hungary	2015	1.2	0.9	3 (143)	3.2 (113)	2.7 (25)	2.2 (3)	2.7 (3)	0 (0)
Malta	2013	0.5	–	26.8 (508)	49 (191)	21 (317)	16.5 (84)	3.7 (7)	24.3 (77)
Netherlands	2018	6.5	3.9	24.3 (2 675)	20.8 (1 357)	29.6 (1 318)	0.4 (5)	0.1 (1)	0.6 (4)
Austria	2015	3.0	0.4	10.7 (443)	11.4 (210)	10.1 (233)	9.5 (41)	3.9 (8)	14.5 (33)
Poland	2018	0.7	0.5	2.6 (173)	2.2 (72)	3.1 (99)	1.2 (2)	1.4 (1)	1.1 (1)
Portugal	2016	1.2	0.3	19.9 (650)	21.8 (397)	17.5 (253)	2.4 (15)	1 (4)	4.6 (11)
Romania	2016	0.7	0.2	1.5 (64)	1.9 (55)	0.7 (9)	1.6 (1)	0 (0)	11.1 (1)
Slovenia	2018	2.7	1.8	7.3 (16)	18.4 (9)	4.1 (7)	25 (4)	0 (0)	57.1 (4)
Slovakia	2015	0.7	0.3	0.9 (28)	1.5 (18)	0.5 (9)	–	–	–
Finland	2018	3.2	1.5	0.4 (3)	0.8 (2)	0.2 (1)	0 (0)	0 (0)	0 (0)
Sweden (¹)	2017	–	2.5	1.7 (715)	3 (424)	0.7 (190)	–	–	–
United Kingdom (²)	2018	10.1	5.3	19.4 (21 750)	25.4 (8 712)	16.8 (12 981)	1.7 (257)	0.4 (24)	2.7 (226)
Turkey	2017	0.2	0.1	2.9 (328)	3.2 (166)	2.6 (162)	0 (0)	–	0 (0)
Norway	2018	5.1	2.3	1.9 (112)	2.8 (75)	1.1 (37)	–	–	–

Country	Year of survey	Prevalence estimates		Entrants into treatment during the year					
		General population		Cocaine clients as % of treatment entrants			% cocaine clients injecting (main route of administration)		
		Lifetime, adults (15-64) %	Last 12 months, young adults (15-34) %	All entrants	First-time entrants	Previously treated entrants	All clients	First-time entrants	Previously treated entrants
				% (count)	% (count)	% (count)	% (count)	% (count)	% (count)
European Union	–	5.4	2.4	18.3 (74 508)	20.9 (33 999)	17.8 (36 744)	2.4 (1 506)	0.9 (251)	3.7 (1 124)
EU, Turkey and Norway	–	–	–	17.7 (74 948)	20 (34 240)	17.1 (36 943)	2.4 (1 506)	0.9 (251)	3.7 (1 124)

Prevalence estimates for the general population: United Kingdom estimates refer to England and Wales only. Age ranges are 18-64 and 18-34 for France, Germany, Greece and Hungary; 16-64 and 16-34 for Denmark, Estonia, United Kingdom and Norway; 18-65 for Malta; 17-34 for Sweden.

Data on entrants into treatment are for 2018 or most recent year available: Estonia, 2016; Croatia, Latvia and Spain, 2017; Netherlands, 2015.

(¹) Data for clients entering treatment refer to hospital-based care and specialised outpatient care facilities. Data shown are not fully representative of the national picture.

(²) Entrants into treatment do not include Northern Ireland.

TABLE A3

AMPHETAMINES

Country	Year of survey	Prevalence estimates		Entrants into treatment during the year					
		General population		Amphetamines clients as % of treatment entrants			% amphetamines clients injecting (main route of administration)		
		Lifetime, adults (15-64)	Last 12 months, young adults (15-34)	All entrants	First-time entrants	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants
		% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)
Belgium	2018	–	0.8	9.2 (1 015)	7 (285)	10.9 (706)	14.6 (125)	10.1 (24)	16.4 (100)
Bulgaria	2016	1.5	1.8	7.1 (84)	20.3 (56)	3.3 (25)	1.2 (1)	0 (0)	0 (0)
Czechia	2018	2	0.5	50.1 (2 185)	53.8 (1 018)	46.9 (1 074)	62.5 (1 315)	57 (569)	68 (707)
Denmark	2017	7.0	1.4	6.1 (312)	5 (121)	7.1 (183)	3 (9)	2.5 (3)	3.5 (6)
Germany	2018	4.1	2.9	16.2 (6 511)	14.5 (3 387)	–	1.9 (79)	1.5 (33)	–
Estonia	2018	6.1	2.1	3.8 (11)	6.9 (6)	2.5 (4)	50 (5)	66.7 (4)	33.3 (1)
Ireland	2015	4.1	0.6	0.6 (56)	0.9 (34)	0.3 (18)	7.4 (4)	5.9 (2)	11.1 (2)
Greece	–	–	–	1.1 (41)	1.1 (16)	1.2 (25)	12.2 (5)	6.2 (1)	16 (4)
Spain	2017	4	0.9	1.5 (689)	1.7 (410)	1.2 (252)	1.2 (8)	1.5 (6)	0.8 (2)
France	2017	2.2	0.6	0.5 (220)	0.4 (50)	0.4 (80)	11.6 (20)	18.6 (8)	4.2 (3)
Croatia	2015	3.5	2.3	–	3.4 (33)	–	–	0 (0)	–
Italy	2017	2.4	0.3	0.3 (102)	0.4 (67)	0.2 (35)	4.5 (4)	5.1 (3)	3.4 (1)
Cyprus	2016	0.5	0.1	6.6 (74)	5.7 (31)	8.5 (41)	7 (5)	10 (3)	5 (2)
Latvia	2015	1.9	0.7	17.5 (141)	22.9 (98)	11.3 (43)	64.1 (84)	54.9 (50)	85 (34)
Lithuania	2016	1.2	0.5	2.8 (36)	9.2 (19)	1.3 (14)	16.7 (6)	15.8 (3)	21.4 (3)
Luxembourg	2014	1.6	0.1	0.3 (1)	–	–	–	–	–
Hungary	2015	1.7	1.4	11.4 (538)	11.2 (394)	13 (122)	5.5 (29)	3.1 (12)	12.4 (15)
Malta	2013	0.3	–	0.3 (6)	–	0.4 (6)	50 (3)	–	50 (3)
Netherlands	2018	5.6	2.7	7.4 (817)	7.5 (487)	7.4 (330)	1.3 (4)	1 (2)	1.9 (2)
Austria	2015	2.2	0.9	5.6 (232)	7.1 (131)	4.4 (101)	1.4 (3)	0.8 (1)	2.1 (2)
Poland	2018	2.4	1.4	30.4 (1 998)	33 (1 074)	27.7 (885)	2.3 (45)	1.3 (14)	3.5 (30)
Portugal	2016	0.4	0.0	0.2 (5)	0.2 (3)	0.1 (2)	20 (1)	33.3 (1)	0 (0)
Romania	2016	0.3	0.1	0.5 (23)	0.7 (19)	0.3 (4)	0 (0)	0 (0)	0 (0)
Slovenia	2018	2.3	1.1	0.9 (2)	0 (0)	1.2 (2)	50 (1)	0 (0)	50 (1)
Slovakia	2015	1.4	0.8	40.8 (1 241)	48.9 (602)	34.8 (594)	28.1 (331)	26.8 (158)	30.5 (170)
Finland	2018	4.7	3.0	20.3 (137)	17.8 (43)	21.7 (94)	73.5 (100)	54.8 (23)	81.9 (77)
Sweden ⁽¹⁾	2017	–	1.2	6.6 (2 778)	7.5 (1 055)	4.8 (1 278)	–	–	–
United Kingdom ⁽²⁾	2018	8.6	1.0	2.1 (2 305)	2.6 (880)	1.8 (1 416)	17.6 (262)	11.1 (60)	21.4 (201)
Turkey	2017	0.0	–	7.8 (886)	12.2 (631)	4.1 (255)	0.1 (1)	–	0.4 (1)

Country	Year of survey	Prevalence estimates		Entrants into treatment during the year					
		General population		Amphetamines clients as % of treatment entrants			% amphetamines clients injecting (main route of administration)		
		Lifetime, adults (15-64)	Last 12 months, young adults (15-34)	All entrants	First-time entrants	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants
		% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)
Norway	2018	3.5	0.9	12.9 (770)	10.3 (280)	15.1 (490)	–	–	–
European Union	–	3.7	1.2	5.3 (21 560)	6.3 (10 319)	3.6 (7 334)	17.2 (2 449)	13.3 (980)	26.6 (1 366)
EU, Turkey and Norway	–	–	–	5.5 (23 216)	6.6 (11 230)	3.7 (8 079)	16.2 (2 450)	12.3 (980)	25.4 (1 367)

Prevalence estimates for the general population: United Kingdom estimates refer to England and Wales only. Age ranges are 18-64 and 18-34 for France, Germany and Hungary; 16-64 and 16-34 for Denmark, Estonia, United Kingdom and Norway; 18-65 for Malta; 17-34 for Sweden.

Data on entrants into treatment are for 2018 or most recent year available: Estonia, 2016; Croatia, Latvia and Spain, 2017; Netherlands, 2015.

Data for Germany, Sweden and Norway refer to users of 'stimulants other than cocaine'.

(¹) Data for clients entering treatment refer to hospital-based care and specialised outpatient care facilities. Data shown are not fully representative of the national picture.

(²) Entrants into treatment do not include Northern Ireland.

TABLE A4

MDMA

Country	Year of survey	Prevalence estimates		MDMA clients as % of treatment entrants		
		General population		All entrants	First-time entrants	Previously treated entrants
		Lifetime, adults (15-64)	Last 12 months, young adults (15-34)			
		%	%	% (count)	% (count)	% (count)
Belgium	2018	–	2.5	0.6 (62)	1 (43)	0.2 (16)
Bulgaria	2016	2.1	3.1	0.2 (2)	0.7 (2)	0 (0)
Czechia	2018	5.3	1.6	0.7 (30)	0.7 (14)	0.7 (15)
Denmark	2017	3.2	1.5	–	–	–
Germany	2018	3.9	2.8	–	–	–
Estonia	2018	5.4	2.5	0.3 (1)	–	0.6 (1)
Ireland	2015	9.2	4.4	0.3 (32)	0.5 (18)	0.2 (12)
Greece	2015	0.6	0.4	0.2 (6)	0.3 (4)	0.1 (2)
Spain	2017	3.6	1.2	0.1 (68)	0.2 (56)	0 (10)
France	2017	3.9	1.3	0.3 (168)	0.5 (62)	0.2 (46)
Croatia	2015	3.0	1.4	–	0.8 (8)	–
Italy	2017	2.7	0.8	0.1 (56)	0.1 (24)	0.1 (32)
Cyprus	2016	1.1	0.3	0.2 (2)	0.2 (1)	0.2 (1)
Latvia	2015	2.4	0.8	0.4 (3)	0.2 (1)	0.5 (2)
Lithuania	2016	1.7	1.0	0.5 (6)	1 (2)	0.4 (4)
Luxembourg	2014	1.9	0.4	0.3 (1)	–	0.5 (1)
Hungary	2015	4.0	2.1	2.3 (110)	2.1 (75)	3.3 (31)
Malta	2013	0.7	–	0.9 (17)	–	1.1 (17)
Netherlands	2018	10.3	6.9	0.7 (80)	1 (67)	0.3 (13)
Austria	2015	2.9	1.1	1 (42)	1.3 (24)	0.8 (18)
Poland	2018	1.0	0.5	0.3 (23)	0.6 (18)	0.2 (5)
Portugal	2016	0.7	0.2	0.2 (7)	0.3 (6)	0.1 (1)
Romania	2016	0.5	0.2	1.3 (55)	1.8 (52)	0.2 (3)
Slovenia	2018	2.9	1.3	0.5 (1)	2 (1)	0 (0)
Slovakia	2015	3.1	1.2	0.4 (13)	0.6 (8)	0.2 (4)
Finland	2018	5.0	2.6	0 (0)	0 (0)	0 (0)
Sweden	2017	–	2.0	–	–	–
United Kingdom ⁽¹⁾	2018	9.1	3.1	0.5 (555)	1.2 (396)	0.2 (156)
Turkey	2017	0.4	0.2	1.5 (172)	2.3 (118)	0.9 (54)
Norway	2018	3.6	1.7	–	–	–
European Union	–	4.1	1.9	0.3 (1 340)	0.5 (882)	0.2 (390)
EU, Turkey and Norway	–	–	–	0.4 (1 512)	0.6 (1 000)	0.2 (444)

Prevalence estimates for the general population: United Kingdom estimates refer to England and Wales only. Age ranges are 18-64 and 18-34 for France, Germany, Greece and Hungary; 16-64 and 16-34 for Denmark, Estonia, United Kingdom and Norway; 18-65 for Malta; 17-34 for Sweden.

Data on entrants into treatment are for 2018 or most recent year available: Estonia, 2016; Croatia, Latvia and Spain, 2017; Netherlands, 2015.

(¹) Entrants into treatment do not include Northern Ireland.

TABLE A5

CANNABIS

Country	Year of survey	Prevalence estimates		Entrants into treatment during the year		
		General population		Cannabis clients as % of treatment entrants		
		Lifetime, adults (15-64)	Last 12 months, young adults (15-34)	All entrants	First-time entrants	Previously treated entrants
		%	%	% (count)	% (count)	% (count)
Belgium	2018	22.6	13.6	34.6 (3 808)	51 (2 090)	24.4 (1 579)
Bulgaria	2016	8.3	10.3	2.2 (26)	4.3 (12)	1.7 (13)
Czechia	2018	26.2	16.6	25 (1 092)	29.1 (551)	21.9 (502)
Denmark	2017	38.4	15.4	60.6 (3 109)	64.1 (1 540)	57.2 (1 482)
Germany	2018	28.2	16.9	57.9 (23 301)	68.3 (15 895)	–
Estonia	2018	24.5	16.6	1 (3)	2.3 (2)	0.6 (1)
Ireland	2015	27.9	13.8	23 (2 276)	38 (1 503)	11.6 (637)
Greece	2015	11.0	4.5	28.1 (1 038)	47.7 (725)	14.6 (308)
Spain	2017	35.2	18.3	27.6 (12 932)	38.4 (9 122)	15.5 (3 314)
France	2017	44.8	21.8	59.8 (28 818)	74.4 (9 868)	42.9 (8 124)
Croatia	2015	19.4	16.0	–	62.9 (602)	–
Italy	2017	32.7	20.9	22 (8 514)	32.4 (5 217)	14.6 (3 297)
Cyprus	2016	12.1	4.3	50.7 (566)	64.8 (351)	32 (155)
Latvia	2015	9.8	10.0	24 (194)	36 (154)	10.6 (40)
Lithuania	2016	10.8	6.0	5.1 (66)	19.3 (40)	2.2 (24)
Luxembourg	2014	23.3	9.8	25.8 (79)	39 (32)	21.2 (41)
Hungary	2015	7.4	3.5	67.4 (3 174)	72.4 (2 539)	48.9 (458)
Malta	2013	4.3	–	13.2 (251)	26.9 (105)	9.7 (146)
Netherlands	2018	28.6	17.1	47.3 (5 202)	55.5 (3 625)	35.4 (1 577)
Austria	2015	23.6	14.1	33 (1 367)	48.6 (895)	20.5 (472)
Poland	2018	12.1	7.8	31.5 (2 074)	39.5 (1 286)	23.2 (743)
Portugal	2016	11.0	8.0	40 (1 309)	53.7 (980)	22.8 (329)
Romania	2016	5.8	5.8	54.4 (2 320)	68.9 (2 003)	23.3 (317)
Slovenia	2018	20.7	12.3	6.8 (15)	26.5 (13)	1.2 (2)
Slovakia	2015	15.8	9.3	21.2 (643)	31.2 (384)	13.8 (235)
Finland	2018	25.6	15.5	18.3 (124)	32.2 (78)	10.6 (46)
Sweden (¹)	2018	16.7	7.9	10.7 (4 537)	14.4 (2 029)	7.1 (1 875)
United Kingdom (²)	2018	29.0	13.4	22.4 (25 103)	42.7 (14 647)	13.4 (10 375)
Turkey	2017	2.7	1.8	8.3 (941)	12.9 (668)	4.4 (273)
Norway	2018	23.6	9.6	30.1 (1 795)	39.4 (1 071)	22.3 (724)
European Union	–	27.2	15.0	32.4 (131 941)	46.8 (76 288)	17.5 (36 092)
EU, Turkey and Norway	–	–	–	31.7 (134 677)	45.7 (78 027)	17.2 (37 089)

Prevalence estimates for the general population: United Kingdom estimates refer to England and Wales only. Age ranges are 18-64 and 18-34 for France, Germany, Greece and Hungary; 16-64 and 16-34 for Denmark, Estonia, Sweden, United Kingdom and Norway; 18-65 for Malta.

Data on entrants into treatment are for 2018 or most recent year available: Estonia, 2016; Croatia, Latvia and Spain, 2017; Netherlands, 2015.

(¹) Data for clients entering treatment refer to hospital-based care and specialised outpatient care facilities. Data shown are not fully representative of the national picture.

(²) Entrants into treatment do not include Northern Ireland.

TABLE A6

OTHER INDICATORS

Country	Year	Drug-induced deaths		HIV diagnoses related to injecting drug use (ECDC)	Injecting drug use estimate		Syringes distributed through specialised programmes
		All ages	Aged 15-64		Year of estimate	Cases per 1 000 population	Count
		Count	Cases per million population (count)	Cases per million population (count)			
Belgium	2014	61	8 (60)	1.1 (12)	2015	2.3-4.6	1 228 681
Bulgaria	2018	24	5 (21)	5.0 (35)	–	–	25 151
Czechia	2018	39	5 (36)	0.8 (8)	2018	5.8-6.0	6 932 269
Denmark	2017	238	52 (191)	1.0 (6)	–	–	–
Germany ⁽¹⁾	2018	1 276	21 (1 120)	1.7 (140)	–	–	–
Estonia	2018	39	43 (36)	18.2 (24)	2015	9.0-11.3	1 680 531
Ireland	2017	235	72 (227)	2.7 (13)	–	–	488 755
Greece	2017	62	– (–)	9.9 (106)	2018	0.4-0.7	245 860
Spain ⁽²⁾	2017	437	14 (437)	1.6 (74)	2017	0.3-2.6	1 603 551
France ⁽³⁾	2016	465	9 (391)	0.9 (61)	2017	2.6-3.3	11 998 221
Croatia ⁽²⁾	2018	85	30 (80)	0.0 (0)	2015	1.8-2.9	244 299
Italy	2018	334	9 (332)	1.8 (106)	–	–	–
Cyprus	2018	12	20 (12)	1.2 (1)	2018	0.4-0.8	243
Latvia	2018	20	16 (20)	37.7 (73)	2016	5.3-6.8	951 063
Lithuania	2018	59	32 (59)	19.6 (55)	2016	4.4-4.9	241 953
Luxembourg	2018	4	10 (4)	6.6 (4)	2015	3.8	492 704
Hungary	2018	33	4 (28)	0.1 (1)	2015	1.0	83 341
Malta	2017	5	16 (5)	0.0 (0)	–	–	275 969
Netherlands	2018	224	18 (206)	0.1 (2)	2015	0.07-0.09	–
Austria	2018	184	31 (184)	1.4 (12)	–	–	6 234 094
Poland	2017	202	7 (168)	0.5 (20)	–	–	129 681
Portugal	2017	51	6 (43)	2.0 (21)	2015	1.0-4.5	1 300 134
Romania ⁽⁴⁾	2018	26	2 (26)	3.5 (68)	–	–	896 397
Slovenia	2018	59	41 (55)	0.0 (0)	–	–	591 080
Slovakia	2018	32	8 (30)	0.2 (1)	–	–	425 880
Finland	2018	261	72 (248)	1.1 (6)	2012	4.1-6.7	5 992 811
Sweden	2018	566	81 (515)	2.3 (23)	–	–	607 195
United Kingdom ⁽⁵⁾	2017	3 284	76 (3 126)	1.4 (94)	–	–	–
Turkey	2018	657	12 (637)	0.3 (24)	–	–	–
Norway	2017	247	66 (229)	1.1 (6)	2017	2.0-2.6	3 000 000
European Union	–	8 317	23.7 (7 660)	1.9 (966)	–	–	–
EU, Turkey and Norway	–	9 221	22.3 (8 526)	1.7 (996)	–	–	–

In some cases, the age band is not specified, and these cases were not included in the calculations of mortality rate referring to the population aged 15-64:

Portugal (1), Greece (62) and Turkey (14).

(1) For 'Drug-induced deaths (aged 15-64)', the data for 2017 were used (147 cases without information on age).

(2) Syringes distributed through specialised programmes refer to 2017.

(3) Syringes distributed through specialised programmes refer to 2016.

(4) Drug-induced deaths data with sub-national coverage: 3 counties out of 42 recorded DRD cases (Bucharest, Arad and Ilfov).

(5) Drug-induced deaths data do not include Northern Ireland. Syringe data: England, no data; Wales 2 658 586; Scotland 4 401 387 and Northern Ireland 337 390 both in 2017.

TABLE A7

SEIZURES

Country	Heroin		Cocaine		Amphetamines		MDMA, MDA, MDEA		
	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	4 537	1 762	53 032	5 646	75	3 109	225 908	(587)	2 462
Bulgaria	1 033	43	22	29	91	94	5 054	(320)	45
Czechia	1	110	24	297	108	2 053	32 591	(9)	577
Denmark	38	427	151	4 786	379	2 080	18 320	(4)	722
Germany	298	–	8 166	–	1 784	–	693 668	(–)	–
Estonia	<0.1	7	4	164	22	472	–	(8)	275
Ireland	–	313	–	608	–	90	–	(–)	304
Greece	207	2 388	166	766	782	12	62 762	(5)	82
Spain	251	8 058	48 453	45 583	413	4 725	337 904	(293)	4 084
France	1 115	4 103	16 357	12 578	334	615	1 783 480	(–)	1 048
Croatia	5	146	109	455	37	981	–	(12)	642
Italy	975	2 236	3 623	7 995	18	177	23 176	(21)	297
Cyprus	<0.1	9	5	129	1	105	939	(0)	15
Latvia	<0.1	40	5	91	55	487	14 967	(3)	352
Lithuania	3	157	14	99	43	318	–	(17)	167
Luxembourg	3	75	347	215	1.9	11	1 564	(–)	20
Hungary	35	49	25	303	22	1 153	43 984	(1)	792
Malta	5	20	188	166	0.004	1	369	(0)	83
Netherlands (¹)	354	–	40 134	–	7	–	–	(472)	–
Austria	76	1 115	75	1 810	85	1 759	83 037	(12)	1 174
Poland	9	3	277	2	1 354	34	218 442	(408)	–
Portugal	27	225	5 541	501	0.4	52	4 145	(19)	186
Romania	5	264	35	358	3	165	53 072	(1)	819
Slovenia	11	286	12	277	6	242	–	(–)	63
Slovakia	0.6	41	1	32	4	661	–	(–)	74
Finland	0.1	76	10	340	203	2 456	219 352	(–)	839
Sweden	75	780	544	3 995	1 052	6 974	147 792	(22)	2 171
United Kingdom	617	10 868	3 469	19 451	1 668	3 682	713 896	(1)	3 630
Turkey	18 531	18 298	1 509	3 519	6 273	15 528	8 409 892	(–)	9 758
Norway	50	781	98	1 862	418	6 711	60 400	(11)	1 366
European Union	9 681	36 610	180 787	110 196	8 549	46 349	4 684 422	(2 217)	24 443
EU, Turkey and Norway	28 262	55 689	182 394	115 577	15 240	68 588	13 154 714	(2 228)	35 567

All data are for 2018 or most recent year.

(¹) Data on number and quantity of seizures do not include all relevant law enforcement units and should be considered partial, minimum figures.

Cocaine seizures represent the majority of large seizures

TABLE A7

SEIZURES

Country	Cannabis resin		Herbal cannabis		Cannabis plants		
	Quantity seized	Number of seizures	Quantity seized	Number of seizures	Quantity seized		Number of seizures
	kg	count	kg	count	plants	(kg)	count
Belgium	108	6 889	17 290	28 801	422 261	(-)	1 006
Bulgaria	2	21	986	85	24 244	(108 509)	147
Czechia	3	189	948	5 779	28 334	(-)	441
Denmark	8 956	18 715	293	1 803	17 840	(272)	480
Germany	1 295	-	7 731	-	101 598	(-)	-
Estonia	110	48	72	707	-	(20)	40
Ireland	-	176	-	1 352	-	(-)	112
Greece	7 388	291	12 812	9 198	50 597	(-)	635
Spain	436 963	167 530	37 220	143 087	981 148	(-)	2 986
France	85 400	76 227	29 800	30 175	138 564	(-)	462
Croatia	50	326	4 687	7 388	3 614	(-)	132
Italy	78 522	9 661	39 178	10 432	430 277	(-)	1 262
Cyprus	1	28	319	997	301	(-)	21
Latvia	133	57	41	866	-	(108)	46
Lithuania	389	75	168	606	-	(-)	-
Luxembourg	181	434	35	647	34	(-)	9
Hungary	20	164	868	3 492	4 769	(-)	167
Malta	17 366	22	594.6	171	2	(-)	2
Netherlands ⁽¹⁾	7 288	-	3 002	-	516 418	(-)	-
Austria	111	1 077	1 382	16 029	24 571	(-)	565
Poland	8 316	26	4 260	149	118 781	(-)	10
Portugal	4 170	1 774	138	300	8 706	(-)	139
Romania	8	200	266	3 354	-	(28)	87
Slovenia	20	107	838	3 768	13 594	(-)	218
Slovakia	1	26	144	1 115	2 299	(-)	31
Finland	54	280	344	1 040	13 085	(-)	1 073
Sweden	2 709	16 280	960	7 166	-	(-)	-
United Kingdom	8 470	11 876	29 533	101 744	372 207	(-)	8 382
Turkey	31 473	13 798	49 232	51 374	-	(-)	2 812
Norway	2 658	6 771	354	3 908	-	(-)	-
European Union	668 032	318 273	193 909	411 873	3 273 244	(108 935)	20 660
EU, Turkey and Norway	702 163	338 842	243 495	467 155	3 273 244	(108 935)	23 472

All data are for 2018 or most recent year.

(¹) Data on number and quantity of seizures do not include all relevant law enforcement units and should be considered partial, minimum figures.



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