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for Drugs and Drug Addiction

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SELECTED ISSUES

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Reitox national focal points

Reitox is the European information network on drugs and drug addiction. The network comprises national focal points in the EU Member States, Norway, the candidate countries 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 at: <http://www.emcdda.europa.eu/?nnodeid=1596>



Introductory note

This volume contains the selected issues of the annual report.

The annual report is based on information provided to the EMCDDA by the EU Member States and candidate countries and Norway (participating in the work of the EMCDDA since 2001) in the form of a national report.

The national reports of the Reitox focal points are available on the EMCDDA website (<http://www.emcdda.europa.eu/?nnodeid=435>).

An online version of the selected issues is available in English and may be found at <http://issues06.emcdda.europa.eu>

An online version of the annual report is available in 23 languages and may be found at <http://annualreport.emcdda.europa.eu>

The 2006 statistical bulletin (<http://stats06.emcdda.europa.eu>) provides the full set of source tables on which the statistical analysis is based. It also provides further detail on the methodology used.

Country data profiles (<http://datapfiles06.emcdda.europa.eu>) provide a top-level, graphical summary of key aspects of the drug situation for each country.

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Selected issue 1

European drug policies — extended beyond illicit drugs?

Introduction

It has been noted in several publications (e.g. EMCDDA, 2004; Zobel et al., 2004) that the scope of drug strategies in EU Member States, originally confined to illicit drugs, is increasingly being extended to encompass a variety of psychoactive substances and even behaviours that might engender some sort of addiction. For example, drug strategies in both France and Germany consider all drugs, both licit and illicit.

At EU level, although the EU drug strategy 2005–12, which was adopted at the end of 2004 by the Council of the European Union, and the EU drug action plan 2005–08, endorsed by the Council in June 2005, are directed at illicit drugs, both mention the combined use of illegal and legal psychoactive substances.

The EU drug strategy makes clear its expectations in the area of demand reduction: 'Drug demand reduction must take into account the health-related and social problems caused by the use of illegal psychoactive substances and poly-drug use in association with legal psychoactive substances such as tobacco, alcohol and medicines'. Furthermore, one of the more than 80 actions of the EU action plan 2005–08 states that Member States should ensure that 'comprehensive effective and evaluated prevention programmes on both licit and illicit psychoactive substances, as well as poly-drug use, are included in school curricula or are implemented as widely as possible'.

The previous EU drug strategy 2000–04 (¹), adopted in 1999, also made it very clear that prevention of drug abuse should address both licit and illicit drugs, emphasising the need for national preventative actions and strategies to address risk behaviour and addiction in general, and including not only illegal drugs but also alcohol, tobacco, medicines and substances used for doping in sports.

At the same time, both basic and clinical scientific research is increasingly addressing the issue of addiction and addictive behaviour, irrespective of substance, accompanied by increasing recognition of the need to match treatment options with clients' profiles and patterns of use. For

instance, Ehrenberg (1998) has pointed out that previous distinctions between the roles of alcohol, illicit drugs and psychotropic medicines are slowly vanishing: a growing body of research has identified that psychoactive substances are used for various reasons, irrespective of their legal status; for example, medicines may be used to 'get high', whereas heroin may be consumed to cope with psychiatric disorders or cocaine to improve sporting performance. According to Ehrenberg, framing the issue according to the legal status of drugs and their stereotypical functions/purposes (psychotropic medicines to care, illegal drugs to have fun or to escape from reality, legal drugs to socialise, etc.) is no longer relevant and more research is needed on the reasons for, and the public health impact of, the growing use of a wider range of psychoactive products, whether legal or illegal, in modern society.

It would appear, then, to be interesting to launch a more in-depth analysis of national drugs strategies or policies that aim to draw attention to all substances or to addictive behaviours.

This selected issue on policies extending beyond illicit substances aims to present a first insight into an emerging phenomenon. It has three objectives:

1. to clarify which countries in the EU have adopted a wider approach in their drug strategies/policies, beyond illicit drugs, in particular which areas (substances and/or disorders) have been addressed and by which measures and to what extent; special attention is given to the official aspects of drugs policies, analysing the drug strategies and/or action plans and their normative/cognitive framework;
2. to understand the rationale behind this broadening of scope of drug strategies/policies;
3. to identify the potential repercussions of an expanded drug strategy, at operational level, on drugs services, responsible bodies and their competences.

Twenty-five Member States, as well as Romania and Norway, responded to a request for information, providing a good insight into the current European situation.

¹ European Union drug strategy 2000–04. Cordroque 64 Rev 3 (12555/3/99), 1.12.1999.

As the dataset comprised national strategies and action plan documents, the absence of such documents at national federal level led to some problems. Italy, Malta and Austria are not considered in this report as they do not have a national drug strategy. However, to maximise the relevance of the analysis, references to the reports from these countries are included where relevant.

The in-depth analysis of the reports presented below reveals that, although illicit drugs strategies do not always refer explicitly to licit drugs or addictions, prevention programmes and, in some countries, treatment measures apply to both licit and illicit drugs, and usually give priority to children and young people.

Variation in European drug strategies

The national focal points (NFPs) in some countries report that there is an increasing body of opinion which believes that licit drugs should be included within the national drug strategy ^(?). However, the majority of these countries still clearly differentiate between licit and illicit drugs and continue to adopt separate strategies to address licit drugs. For the sake of brevity and clarity, in this selected issue all official documents, national drug strategies, action plans, national programmes, etc. will be referred to as 'national drug strategies' (see also EMCDDA and European Commission, 2002, pp. 11–13).

Three types of drugs strategies may be distinguished depending on the extent to which licit drugs are considered: (a) those that address fully both licit and illicit substances and refer to the concept of addiction; (b) those in which consideration of licit drugs is confined to the areas of prevention, treatment and drug coordination; and, finally,

(c) those that address illicit drugs exclusively, referring to licit drugs only in their public health policy.

Strategies explicitly addressing all substances

Eight countries (Belgium, the Czech Republic, Germany, Spain, France, Cyprus, Romania and Norway) out of 27 surveyed reported that their national drug strategies address all types of substances (Table 1). As Austria does not yet have a national strategy, only provincial drug strategies can be considered. However, as strategies in six of the nine Austrian provinces are oriented towards an extended range of substances, Austrian policy will be considered in this section. Reference will also be made to Northern Ireland, where alcohol and drug strategies — originally split into separate strategies in 1999 and 2000 — have recently been merged into an inter-agency local action plan and a plan 'New strategic direction for alcohol and drugs, 2006–11', which covers both drug and alcohol use as well as use of prescription-only medicines, over-the-counter medicines and volatile substances.

This phenomenon of extension of the scope of drug strategies is clear from the titles of the national drugs strategies, such as the 'Action plan to combat drug and alcohol-related problems' (Norway, 2002), 'Action plan on drugs and addiction' (Germany, 2003) and 'Government plan for the fight against illicit drugs, tobacco and alcohol 2004–08' (France, 2004), but it is also apparent in the general objectives of some strategies (e.g. in Belgium, the Czech Republic, Germany and Norway).

The general objective of the Belgian 'Federal drug policy note' is to advise against drugs, to reduce drug consumption and to reduce the number of new drug users through

Table 1: Substances or behaviours targeted in national drugs strategies

	Illicit drugs	Alcohol	Tobacco	Medicines	Other substances or addictions
Belgium	+	+	+	+	+
Czech Republic	+	+	+		
Germany	+	+	+	+	+
Spain	+	+	+	+	
France	+	+	+	+	+
Cyprus	+	+	+	+	
Romania	+	+	+	+	
Norway	+	+		+	

Sources: Reitox national focal points.

^(?) The majority of national drug strategies can be downloaded from the EMCDDA website (<http://www.emcdda.europa.eu/?nnodeid=1360>).

prevention, addressing both licit and illicit drugs. In the Czech Republic, three of the six specific objectives of the 2005–09 national strategy involve issues related to licit drugs: to halt the increasing experimental and occasional use of licit and illicit drugs, to stabilise or reduce the consumption of licit and illicit drugs in society, especially among adolescents, and to reduce the availability of licit and illicit drugs among the general population, and especially among adolescents, via more efficient implementation of existing legislative and institutional instruments. In Germany, the new strategy, 'Action plan on drugs and addiction', adopted in 2003, places addiction at the centre, and its general goals apply to both licit and illicit substances (specific targets include a reduction in tobacco consumption and the proportion of people who consume alcohol). One of the main strategic objectives of the Norwegian action plan is to prevent all types of substance abuse, particularly among children and young people. Finally, in Spain, one of the 10 aims of the drug strategy clearly takes into consideration all substances and, in France, the government plan outlines the principal strategies for dealing with each substance.

The licit substances referred to are almost always the same: all eight countries refer to alcohol, and all except Norway refer to tobacco. All except the Czech Republic and Spain refer to medicines. Upper Austria, Tyrol and Carinthia also include addiction not related to substances, such as gambling and eating disorders. Styria goes further and also encompasses behaviours that might result in addiction. But it is clear that these strategies or action plans are based on a comprehensive addiction concept; in Romania 'the strategy reflects the government's concept on the prevention of drug use and abuse'.

A broader scope combined with action plans on licit drugs

Some countries, in addition to having extended the scope of their national drug strategies, have specific alcohol and tobacco plans. Belgium has a federal anti-smoking plan (launched in 2004), and a national plan on alcohol should be drafted soon. In France, the 'National plan for the fight against cancer 2003–07' aims to reduce tobacco use. In the Czech Republic, one of the objectives of the health policy document *Health for all in the 21st century (Health 21)* includes specific references to alcohol, tobacco and illicit drugs.

The same direction but with different rationale

Interestingly, the analysis of the drug situation used to justify broadening the scope of drugs strategies varies between Member States, i.e. although the direction is the same, the rationale may be different. Belgium, for example, based its new approach on the recommendations of a parliamentary working group and the evaluation report on the follow-up of these recommendations. The starting point was that drug use

is a public health issue and that, from a health perspective, the distinction between licit and illicit drugs is irrelevant. The same reasons underlie the extension of drugs strategies in the Czech Republic and Spain: licit substances can cause addiction and thus constitute a major health and social problem.

Another major reason for widening the scope of drugs strategies is that the prevalence of smoking and alcohol consumption is high both among the adult population and among children and young people. The broadening of the national strategies to include licit substances that occurred in France in 1999 was based on scientific knowledge and in particular on recommendations included in reports published in 1994 and 1999. The approach is based upon a medico-scientific consensus that takes into account the causes and consequences of addictive behaviours regardless of the legal status of the substance involved. While acknowledging differences in the pharmacological effects and social roles of different substances, it places greater emphasis on common behaviours than on substances. In Germany, an important reason for including licit drugs in the drug strategy is the difficulty of differentiating between target groups owing to the increasing prevalence of polydrug use. In the case of Cyprus, excepting alcohol, which is a more complicated issue, the reason cited for this extension is harmonisation with the objectives and measures foreseen within the European Union's action plans.

In addition to a broadening of scope in the texts of drugs strategies, a practical change, in terms of the competences of the bodies in charge of the drug coordination within the governments of these countries, can also be observed.

Extending the responsibility of the entity in charge of coordination of drug policy

Most countries did not state whether or not alcohol, tobacco and gambling fall within the remits of the national drug coordination bodies. Nevertheless, it is possible to conclude that, in the case of the Member States whose strategies specifically address both licit and illicit substances, the entities responsible for coordinating drug policy are responsible for both types of substance. In Spain and Norway, for example, the ministries of health are responsible for coordination of the extended drug policy, and in Norway this requires the coordination of seven ministries that are directly involved in alcohol and drug policy. In France, the sphere of activity of the MILDT (Interministerial Mission for the Fight Against Drugs and Drug Addiction) has been extended to incorporate licit substances. One of the main objectives of France's 'Government plan for the fight against illicit drugs, tobacco and alcohol 2004–08' is the interministerial coordination of prevention, treatment and harm reduction.

The plan embraces action against tobacco, alcohol and illicit drugs and involves about 20 ministerial departments.

The new system in France also has consequences for the social and health systems, as well as at local level, where 'drugs and drug addiction project managers' are now expected to coordinate the actions of local services in all areas of the field of drugs. In Belgium, it is the responsibility of the federal authority to collect all information regarding health issues and to coordinate the measures taken, but whether this is undertaken by a specific body was not reported. In Germany, the drug commissioner of the federal government is responsible for the coordination of activities relating to addiction within the federal government. In some countries, the bodies responsible for drug coordination have been renamed. For example, in Austria in 2000, all nine provinces had drug coordinators and drug advisory boards. Six provinces now have 'addiction coordinators' and addiction advisory boards, while the remaining three provinces (Salzburg, Vienna and Vorarlberg) maintain the distinction between licit and illicit substances.

The above findings show that a new conceptual and strategic framework is slowly being implemented within some European countries that have extended the scope of their illicit drugs strategies to include licit drugs, addictions or behaviours.

In addition to these countries, a considerable number of other countries refer in their national drug strategies exclusively to illicit drugs, but with clear references and links to other substances. These are discussed below.

Drug strategies with links to licit drugs in the context of prevention and/or treatment

Strategies that address only illicit drugs but which include links to licit drugs in the context of prevention and/or treatment are reported in 11 Member States (Denmark, Estonia, Greece, Ireland, Lithuania, Luxembourg, Hungary, the Netherlands, Portugal, Slovakia and Finland) as well as in Northern Ireland and Scotland. In such drugs strategies, acknowledgement of the close links between licit and illicit drugs takes two broad forms: first, via specific provisions of the drug strategy in the area of prevention or treatment targeting both types of substances and, second, through links between the drug strategy and other strategies such as alcohol or tobacco strategies.

Links to the implementation of prevention and treatment programmes focusing on licit and illicit drugs

In Estonia, for example, the 'National strategy on prevention of drug dependency 2004–12' focuses on illicit drugs but also acknowledges the connection between licit and illicit drugs in that the first chapter, on primary prevention, focuses

on the relation between drug use and alcohol consumption. In Denmark, although the drug strategy 'Fight against drugs — action plan against drug use' is aimed specifically at illicit drugs, the management of drug prevention and of alcohol and tobacco problems are considered together, especially in discussion of young people as the target group.

In Greece, a link between licit and illicit drugs is made when discussing not only prevention, but also treatment and research. Although nine Member States link licit and illicit drugs in the field of prevention, only four (Denmark, Greece, Hungary and Slovakia) mention such a link in the context of treatment. In Luxembourg, the drug strategy states that efforts to be developed in the field of prevention and treatment should focus on the fight against drugs and drug addiction. The national anti-drug strategy 2005–09 gives clear priority to illicit drugs but recognises that polydrug use renders artificial the distinction between licit and illicit drugs as far as treatment and harm reduction are concerned.

To conclude, some national drugs strategies state that their prevention or treatment activities are aimed at both licit and illicit substances, while some Member States also have a specific action plan or strategy regarding alcohol and/or tobacco use that links to their drug strategy.

Links between illicit drugs strategies and licit drugs strategies

It is important to emphasise that most countries reported the existence of, in addition to a national strategy or policy document aimed at illicit drugs, some other action plan or strategy or general policy aimed at tobacco, alcohol or doping problems (Table 2). Some countries reported strong links between such supplementary policy documents and the main drug strategy, to the extent that they might be considered an indirect extension of the illicit drug policy documents.

In Ireland, 'Building on experience: national drug strategy 2001–08' refers mainly to illicit drugs, and in particular opiate misuse. However, there are links between the national drug strategy and national alcohol policy in terms of prevention approach. These links aim 'to ensure complementarity between the different measures being taken' in the field of prevention. In the 1995 Dutch policy document 'Continuity and changes', the final target is 'the prevention of health risks and negative social consequences'. In principle, the targets of illicit drugs policy are also valid for licit risk substances such as alcohol and tobacco, even if separate policy frameworks are operational for licit substances. In general, national policy documents do not focus specifically on the combined use of drugs or on poly-drug use.

Similarly, in Lithuania, although the national drug strategy includes no direct reference to licit drugs, one article links the

Table 2: Strategies existing in the countries

	National drug strategy	Tobacco strategy	Alcohol strategy	Doping strategy	Public health strategy
Belgium	+	+			
Czech Republic	+				+
Denmark	+	+		+	+
Germany	+	+	+		
Estonia	+	+			
Greece	+				
Spain	+	+	+	+	
France	+	+			+
Ireland	+		+		
Cyprus	+				
Latvia	+	+	+		+
Lithuania	+	+	+		+
Luxembourg	+				
Hungary	+				+
Netherlands	+	+	+		+
Poland	+		+		+
Portugal	+	+	+	+	+
Slovenia	+				
Slovakia	+	+	+		+
Finland	+		+		+
Sweden	+	+	+		+
United Kingdom	+	+	+		
Romania	+				
Norway	+				

Sources: Reitox national focal points.

NB: Italy, Malta and Austria are not considered here as they do not have national drug strategies.

drugs programme with other national programmes including the state alcohol control programme, the state tobacco control programme, the Lithuanian health programme and addictive disorders programmes.

Finally, in Northern Ireland, two specific links are visible. First, the drug strategy and the alcohol strategy are cross-referenced through the Northern Ireland drugs and alcohol campaign, a joint campaign enabling regional and local action plans to be developed. Second, in 2003, a regional drug and alcohol strategy coordinator was appointed in charge of the implementation and delivery of the combined drugs and alcohol strategies, leading to the

development of a new strategy in 2006, which combines drug and alcohol misuse.

The same authority in charge of different strategies

In those countries that have separate licit and illicit drug strategies, implementation of drugs policies, in terms of the coordination bodies responsible, falls into two main types: either the same ministry is in charge of both licit and illicit drugs strategies or separate ministries or departments are responsible for the different strategies.

In England and Scotland, it is now common for drug action teams to coordinate local action on alcohol as well, and

they are frequently designated drugs and alcohol action teams. Also in England, the substance misuse team at the Department of Health, working with the Home Office, is responsible for developing a framework to tackle the abuse of volatile substances. The two groups also worked together to develop an alcohol harm reduction strategy for England. In Estonia, the National Institute for Health Development (NIHD), established in May 2003, was appointed as the institution responsible for the implementation of all national health programmes under the direction of the Ministry of Social Affairs.

Countries that could also be included in the first group are Denmark, where the Ministry of the Interior and Health is responsible for illicit drugs, alcohol and tobacco measures (although doping issues are within the remit of the Ministry of Education), and Greece, where the Ministry of Health and Social Solidarity is responsible for the coordination of alcohol and tobacco policy although a separate body, ESKAN (the Hellenic National Council for Combating Doping), is the primary authority responsible for combating doping. In Finland also, drug, alcohol and tobacco policy are within the remit of the same ministry (Ministry of Social Affairs and Health) whereas anti-doping activities are the responsibility of the Ministry of Education. Finally, in the Netherlands, drugs policy is coordinated by the Ministry of Health, Welfare and Sport (VWS).

What is interesting about the above examples is that, even where there are separate strategies, a common drugs and alcohol coordinator is responsible for policy in both areas. Even if the national drug strategy is not extended to include licit drugs, the coordination bodies that deal with licit and illicit drugs are often the same.

Other countries report that the coordination and implementation of strategies regarding licit and illicit drugs are separated. In Ireland, two different departments are in charge of the implementation of the national drug strategy and the alcohol policy although the national drug strategy calls for complementarity between alcohol and drugs measures to be achieved by a close cooperation between the two departments. To this end, the national drug strategy team regularly meets the coordinators of the national alcohol policy and a member of the drugs team sits on the body charged with the coordination of the national alcohol policy.

Even where no formal extension of drug strategy exists, links between the different strategies, the implementation of joint prevention and treatment programmes and the existence of common coordination authorities are clear indicators of a trend to coordinate policies regarding licit and illicit substances.

Strategies addressing exclusively illicit drugs

In three EU Member States (Latvia, Poland and Sweden), the national drug strategies refer strictly to illicit drugs. These three documents contain no objective aimed at licit drugs, and no reference to licit drugs is made, even in the fields of prevention and treatment. Responses to the illicit drug problem and to the licit drug problem are developed separately: Sweden and Latvia have an alcohol strategy and a tobacco strategy or programme and Poland has an alcohol policy.

However, even within this third group, we can distinguish variations. In Poland, drugs and alcohol are clearly distinguished and are dealt with by two parallel administrative structures with separate laws; in addition, there are separate treatment systems and even different non-governmental organisations to handle these problems. However, at local level, preventive and informational activities, especially those aimed at children and young people, cover both alcohol and drug abuse.

In Latvia and Sweden, the situation is slightly different. In both cases the national drug strategy refers only to what would be considered illicit drugs, and alcohol, tobacco, gambling and other addictions are not mentioned in these documents. The objective of the Swedish drug policy is a drug-free society.

However, and importantly, in both cases there is a link between the national drug policy and the public health strategy, with the latter referring to objectives that address both licit and illicit substances. For example, one of the objectives of the Swedish public health strategy is 'reduced use of tobacco and alcohol, a society free from illicit drugs and doping and reduction in the harmful effects of excessive gambling'. The Latvian 'public health strategy', adopted in 2001, includes an objective that refers to the 'reduction of harm caused by alcohol, narcotic and psychotropic substances and tobacco'.

The above is an analysis of the texts of the national strategies or policy documents. However, there may also be evidence of extension of such strategies in the practical workings of the prevention and treatment systems in each country. The next section examines these systems for such evidence.

Broadening of the scope of the European drug policies in practice

An analysis of national drug strategies reveals the policy underlying the specific approach taken by Member States in relation to broadening the scope of their drug policy. However, all countries reported that traditional prevention programmes and activities are aimed at misuse of both licit and illicit drugs, and are increasingly associated with the

prevention of addictive behaviour, i.e. with addiction per se, rather than with specific substances.

In the following sections, a brief overview of current prevention and treatment interventions dealing with both licit and illicit substances will be followed by a review of the reasons for an alternative approach.

Prevention and treatment: what is actually happening in the field?

It is in the area of prevention that the aim of extending the scope of the national drugs policies to other substances is most often apparent. In the other areas, such as treatment, it is still very rare for provisions to target licit and illicit drugs together.

Prevention

The EU action plan on drugs 2000–04 ^(*) asked Member States and the Commission ‘to encourage the inclusion in school curricula of the prevention of licit and illicit drugs in schools and to set up programmes to assist parents’. In addition, the plan called on the Commission and Member States, as far as they are able, and when appropriate, to address risk behaviour, and addiction in general, related to the use not only of illicit drugs, but of alcohol, medicines, substances used for doping in sport and tobacco, with the aim of significantly reducing, over the next five years, the prevalence of drug use, as well as new recruitment to it, particularly among young people under 18.

The EU drug strategy 2005–12 sets an objective that ‘drug demand reduction measures must take into account the health-related and social problems caused by the use of illegal psychoactive substances and of polydrug use in association with legal psychoactive substances, such as tobacco, alcohol and medicines’. The EU drug action plan asks Member States to ensure that comprehensive effective and evaluated prevention programmes on both licit and illicit psychoactive substances, as well as polydrug use, are included in school curricula or are implemented as widely as possible.

In practice, universal prevention activities in all Member States address licit and illicit drugs together, and prevention interventions that focus exclusively on illicit drugs are very rare. The trend towards an extension of traditional prevention programmes and activities aimed at illegal drugs to cover licit substances such as alcohol and tobacco can be identified in the national drugs strategies of almost all EU countries. Prevention of drug use is increasingly associated with prevention of addictive behaviour involving a wide range of substances, both licit and illicit. The main objective is usually to prevent or delay initiation into the use of legal drugs,

because the early use of licit drugs is the most important risk factor associated with initiation into and problem use of illicit drugs in the future. Tobacco and alcohol use depend strongly on cultural factors such as the acceptability of use and availability of these drugs.

In Hungary, a general prevention programme is in place because, according to the national strategy, prevention of illicit drugs cannot be separated from school prevention of the use of licit drugs. A subprogramme of the public health programme, called ‘alcohol and drug prevention’, aims to combat and prevent alcohol and drug use and the associated health and social harms and complements prevention measures undertaken under the auspices of national drug strategy and national alcohol policy.

Complementarity between, and coordination of, the prevention of alcohol and tobacco use and the prevention of drug addiction are also envisaged in one article of the national drug prevention and drug control programme for 2004–08 in Lithuania, although the drug strategy refers only to illicit drugs. In Slovenia, licit drugs are included in educational preventive activities. In Spain, interventions cover illicit drugs, alcohol and tobacco. The main interventions foreseen are the provision of information about risks, the implementation of control measures governing the advertisement of alcoholic drinks and tobacco, and the development of programmes and protocols aimed at the early diagnosis of problems related to the use of tobacco, alcohol and illegal drugs. In France, the common prevention purpose is to prevent or delay experimentation with all potentially addictive substances, especially tobacco and alcohol.

In the Estonian drug strategy, the chapter on primary prevention focuses on the relation between drug use and alcohol consumption and emphasises the need for prevention activities. In Northern Ireland, although there are separate strategies for drugs and alcohol, prevention programmes aimed at schoolchildren and young adults cover medicines, alcohol, tobacco and solvents.

However, in most countries prevention programmes mainly involve interventions targeting illicit drugs and alcohol.

Treatment

In contrast to prevention programmes, the extension of treatment programmes to licit drugs use is only occasionally reported in the EU.

Many Member States refer to complementary measures to deal with substance abuse, which can encompass everything from drug prevention to treatment. For example, in Finland, the ‘Drugs policy action programme 2004–07’ mentions

(*) Cordrogue 32, 7.6.2000.

complementary measures and the need to bring together interventions in the field of licit drugs and alcohol: 'these types of action aim to support and rehabilitate young people with alcohol and drug problems'. In Ireland, treatment services for drug use and alcohol use are not officially linked, although in practice many drug services also treat clients with alcohol dependence. The reason for this is that one fifth of those treated for problem alcohol use also misuse drugs.

Many Italian regions have formulated an expansive approach to addictions as part of integrated public-private systems of a departmental nature. The addiction departments (or programmes) call for broad attention to addictions to legal and illegal substances and to non-pharmacological addictions and most of them include alcoholism services, others have set up therapeutic and rehabilitation programmes for tobacco smokers, and a few of them have set up strategies for addictions to prescription drugs.

Considering the context of non-pharmacological addictions, several addiction departments in Italy have developed therapeutic and rehabilitation strategies for bulimia and anorexia and others have also developed therapeutic and rehabilitation programmes for gamblers.

The most commonly reported development regarding treatment is the integration of treatment centres for licit and illicit drugs or the establishment of joint treatment centres. This trend is particularly visible in Belgium, Germany, Spain and France, countries which have extended the scope of their drug strategy to licit substances.

In France, since the triennial plan 1999–2001, which recognised the notion of harmful use and broadened its scope to licit substances, a general policy of care for drug users and addicts has been implemented and joint centres have been created. Centres for treatment, assistance and prevention of addiction have replaced outpatient alcoholism treatment centres and specialist centres for drug addicts and provide combined treatment for several types of addiction simultaneously or treatment for problems with alcohol or tobacco alone.

In Hungary, too, although the national drug strategy does not set out specific aims in relation to alcohol and tobacco use, in several aspects of prevention and treatment it is impossible to distinguish between alcohol use, smoking, inhalation of volatile substances and abuse of medicines. The national treatment network assists both drug and alcohol users. And this approach is not uncommon: in a recent EMCDDA study, in response to the question, 'Does the main bulk of drug-related treatment take place in settings for addicts in general or specifically problem drugs users?', 17 countries reported that treatment services were available to addicts in general, while 10 replied that treatment was

aimed specifically at problem drug users. In the same way, in Slovakia, the specific drug treatment facilities (centres for the treatment of drug dependency) treat those with alcohol problems as well as those with (illicit) drug problems. Finally, it should also be noted that in Sweden the same treatment system addresses both alcohol and illicit drug problems.

Reasons for extending prevention and treatment programmes to licit and illicit drugs

It is one of the best-known paradigms of drug prevention that the longer that initiation to tobacco and alcohol use can be delayed, the greater the reduction in later substance abuse problems. Therefore, all evidence-based universal prevention programmes targeting primary schoolchildren focus first on alcohol and tobacco, and sometimes only on alcohol and tobacco, while all international guidelines on prevention cite 'to target all substances' as an essential ingredient of evidence-based prevention strategies (Pentz, 2003).

The reasons for this are virtually the same in all countries and include changes in socioeconomic factors, new consumption patterns and emerging psychoactive substances. An epidemiological study conducted in Denmark in 2002 clearly suggested 'a clear correlation between extensive use of alcohol, experimental use of illicit drugs and smoking among a minor group of young people'.

There is also a common belief that addiction is a fundamental problem and a common concept of drug-related harm. Thus, for example, in Estonia, the previous drug strategy, which aimed to establish a drug-free society, has been replaced by a new approach that, while still referring only to illicit drugs, also aims at the reduction of drug-related harm.

In most countries, the extension of treatment programmes is the result of the increasing numbers of polydrug users. In Luxembourg, it is believed that 'the concept of polydrug use renders the distinction between illicit and licit drugs artificial as far as treatment and harm reduction are concerned'. This is also the case in Denmark, where a different legal framework exists for alcohol treatment and for the treatment of drug use. However, the most recent report on treatment, published in 2002, states that the most marginalised drug users are often polydrug users, and local practice has been developed in the direction of integrating alcohol and drugs treatment intervention (tobacco interventions are carried out under the auspices of other services). Denmark reports that the treatment of alcohol and drug abuse is a regional responsibility. Most counties have a joint organisation that handles the treatment of abusers, with no distinction being made between alcohol and/or drug problems.

Environment

In Luxembourg and Cyprus, the national approach towards addiction prevention focuses on the individual and his or her environment rather than on drugs and drug addictions. To be more precise, in Cyprus, the 'Action plan on drug demand reduction' considers three environmental aspects of alcohol and tobacco use: the working environment, the recreational environment and the school environment.

Environmental approaches are prevention measures that operate at the level of social and cultural norms. While universal prevention intervenes at a population level, selective prevention at (vulnerable) group level and indicated prevention at an individual level, environmental approaches operate at societal level, mostly by attempting to shape attitudes and values regarding legal drug consumption.

The importance of environmental measures for drug prevention is twofold.

Norms, normality and values regarding substance abuse in general

One of the main cognitive elements that condition adolescents' substance use behaviour is the perceived 'normality' of substance use in their reference population. Accordingly, one of the most efficient components of drug prevention programmes is challenging these normative beliefs (Hansen, 1992; Paglia and Room, 1999; Cuijpers, 2002). They focus on correcting — typically exaggerated — estimates of the drug use of peers and the perceived or presumed acceptance of the use of the substance among the social environment, specifically peers (Ajzen and Fishbein, 1980).

In this context, the perceived and publicly promoted acceptance of legal drugs plays a key role, and the impact of any universal prevention strategy is strongly jeopardised if its normative messages (i.e. self-control and a critical attitude towards substance use at large) are not underpinned by appropriate structural conditions in the social environment, e.g. attitudes and norms regarding (uncontrolled) use of legal substances.

Universal prevention efforts face a more challenging task in a society in which, for instance, binge drinking and smoking in public spaces are widely accepted and have positive value associations such as extroversion and fun (in the former case) and civil liberty (in the latter case). This weakens the credibility of prevention measures, because it appears to adolescents that disapproval of illicit drug use, and attempts to prevent it, stem only from legal concerns and not from a real social commitment to avoid harmful substance use.

Following this line of thinking, several countries (France, Finland, Sweden, Romania and Norway) include in their strategies on alcohol or tobacco their rationale for seeking to influence norms, culture and the social acceptance of legal substance abuse. Slovakia explicitly promotes non-smoking as 'normal' behaviour through competitions such as the 'Quit and win' competition, established in 1994. In addition, mass media campaigns in some Member States and by the EU aim to highlight the normality of non-use rather than targeting drug use behaviour. The same rationale was behind the issuing by the EU of the tobacco advertising directive 2003 (4).

It is clear that for schools the local normative setting has an important impact. As Butters (2004) puts it, 'the likelihood of adopting a certain behaviour may depend on the extent to which that behaviour already exists in a particular environment. Therefore, attending a school with a pervasive subculture and user networks may create an environment in which the temptation or pressure to use becomes overwhelming.' This illustrates why some Member States insist that all schools have in place drug policies (see 'New developments in prevention' in EMCDDA, 2005) that define procedures and rules about consumption, availability and trafficking of legal and illegal substances in and around school premises. These are also important environmental measures to support intervention at group or individual level.

Tobacco and alcohol as predictors for later drug problems

Early adolescent smoking and heavy alcohol use are among the most relevant problem behaviours in youth and strongly predict later drug and social problems (Gil et al., 2002; De Vries et al., 2003; Orlando et al., 2005; Paddock, 2005). Tobacco use in early adolescence prepares the ground for the use of other drugs, especially cannabis (Duncan et al., 1998; Vázquez and Becoña Iglesias, 2000; Oman et al., 2004), and seems to have a bigger impact on long-term substance use behaviour than does use of other drugs.

Control policies on legal drugs, aimed at affording a higher level of health protection, are in place in several Member States, but only Denmark, Germany, France, Italy, the Netherlands and Norway cite as an additional reason the explicit aim of reinforcing prevention of illicit drug use, based on the escalation and gateway theories. In other Member States where smoking bans are in place (Ireland, Scotland) or have been mooted (England), such a rationale is not publicly stated.

Obviously, it is not only policy — but also culture and tradition — that influence attitudes towards legal and illegal drugs and the related social behaviours, but the Irish, Italian and Nordic experiences indicate that the public

(4) European Union and Council Directive 2001/37/EC on the approximation of the laws, regulations and administrative provisions of Member States in relation to the production, presentation and sale of tobacco products.

understands and is willing to support such policies. Mass media campaigns can help in this respect. It has been shown that such campaigns raise awareness but do not change behaviour. As a result, they are helpful in supporting, underpinning and explaining this kind of environmental strategy to the population at large (Norwegian example in EDDRA), although they are of little benefit in convincing people not to take drugs. For example, several German *Länder* have sent letters to parents or held information events/parents' evenings about the dangers of 'alco-pops'.

The level of enforcement of anti-smoking policies in Member States correlates well with the level of adolescent smoking (Aspect Consortium, 2004). This underlines the importance of environmental prevention strategies, especially for the use of legal drugs. In several Member States, for instance, without implying causality, there seems to be a degree of correspondence between lenient anti-tobacco policies and a higher prevalence of tobacco smoking amongst young people, and it is interesting to observe that several countries with high rates of adolescent smoking and lenient tobacco policies also have a high rate of cannabis consumption.

Conclusions

Four main conclusions can be drawn. First, there is no single format of drug strategy in the European Union. Though some common features can be identified, the scope of drugs strategies — in the written documents at least — can vary greatly between Member States.

Second, and most importantly, while a broadening of the scope of drug strategies is not always highly visible,

strategic or institutional integration of licit and illicit drugs is increasingly common, even in those countries where the drug strategies refer only to illicit drugs. In this respect, Greece, Ireland, Luxembourg and also Northern Ireland all report the establishment of working groups or steering committees to examine the possibility of forming a combined strategy or of implementing an integrated policy against both licit and illicit drugs. Portugal is also considering a combined strategy for licit and illicit drugs in the area of treatment and rehabilitation (as is already the case regarding prevention).

A combined strategy is also apparent in countries which do not yet have a drug policy or strategy at present but which are working on one. For example, in Malta, the National Commission on the Abuse of Drugs, Alcohol and Other Dependencies (within the Ministry for the Family and Social Solidarity) met the policy development unit of the ministry in 2005 and outlined a drugs policy that includes illicit drugs and medicines. There will, however, be a separate policy for alcohol.

A third conclusion is that, although approaches vary greatly from country to country, there are some common features in strategies in which licit and illicit drugs are dealt with together. The majority relate to drug prevention. Some relate to drug treatment. In particular, programmes targeting young people are increasingly taking polydrug use into account.

Finally, the fourth conclusion is that, although domestic strategies may differ greatly between countries, a common trend can be seen across Europe: prevention programmes and, increasingly, treatment programmes and bodies are now taking into account both licit and illicit drugs.

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Selected issue 2

A gender perspective on drug use and responding to drug problems

Relevance of gender-specific information in the drug field at European and international level

This selected issue explores how gender influences not only patterns and levels of drug consumption in Europe, but also how responses to drug problems are planned and implemented. This is an issue of acknowledged importance, with gender issues at the core of some of the key objectives of the EU drug action plan 2005–08, which highlights the importance of providing accessible and good-quality drug services ⁽¹⁾. Concerns in this area are not new: over two decades ago, a first call was made to European policymakers to pay more attention to gender-specific issues, with particular focus on women's needs ⁽²⁾, and this theme has been taken up in a plethora of research papers and articles. It is now accepted that understanding gender differences in drug-related behaviours is a critical requirement for developing effective responses ⁽³⁾. Ensuring equality of access to services and sensitivity to gender-specific issues within services are two of the key themes for developing high-quality care in this area.

Clearly, the potential coverage of discussion on gender and drug use is considerable, and it is therefore necessary here to restrict attention to those aspects that are supported by gender-specific differences in data reported at a European level. The focus of this selected issue is on examining differences between men and women in relation to the prevalence of drug use, patterns of drug use and drug-related problems and exploring how these issues are reflected in gender-specific approaches to prevention, treatment and harm reduction. As with any comparative exercise at this level, there are limitations in the data available (see box on methodology). For example, the available epidemiological data do not always include a gender breakdown, and when data do exist, figures relating to women are sometimes low and difficult to interpret. It is also worth noting that

information on responses predominantly describes interventions designed for women because men are seldom explicitly targeted — despite increasing evidence that young males in particular may represent an important group for developing targeted, gender-specific interventions.

Gender differences in drug consumption and drug-related problems

Gender differences in prevalence and patterns of drug use by type of substance

In general in Europe, drug use is considerably more common among men than among women, especially when regular, intensive or problematic use is considered. That said, some national research studies suggest that, based on some consumption measure, the gender gap may be narrowing in a few countries, at least in the case of some types of drug use. The differences in the European data on male and female reported drug use are explored in detail below. However, parity, or near parity, of drug use among males and females is found only in lifetime prevalence among school students, and even then only in a minority, albeit a significant one, of countries.

Cannabis

In Europe, the vast majority of young people who have tried an illicit drug have used cannabis, but there are considerable differences between countries. Lifetime prevalence of cannabis use among all adults (aged 15–64) ranges from less than 2 % in Romania to more than 30 % in Denmark (Figure 1). Males outnumber females in lifetime experience of cannabis use in most of the countries surveyed.

Among school students aged 15–16 years who have ever in lifetime experience of cannabis use, males outnumber females in most countries (Hibell et al., 2004), but ratios are low and vary only a little across Europe, ranging from

⁽¹⁾ Details of this can be found at http://europa.eu/comm/employment_social/emplweb/news/news_en.cfm?id=136

⁽²⁾ At the 1984 Ministerial Conference of the Council of Europe Pompidou Group; policy recommendations on 'Women and drugs' were later adopted at a European conference.

⁽³⁾ The concept of bringing gender issues into mainstream society was clearly established as a global strategy for promoting gender equality in the platform for action adopted at the United Nations Fourth World Conference on Women, held in Beijing (China) in September 1995. The Beijing declaration states that if, gender perspectives are to be reflected in policies and programmes, then statistics related to individuals should be collected, compiled and analysed, and presented by sex and age to reflect problems, issues and questions related to women and men in society.

Methodology

Differences between males and females are presented as ratios of prevalence among males and females. Ratios higher than 1 indicate more males than females, for example a ratio of 2 indicates twice as many males as females. Ratios lower than 1 indicate more females than males, so a ratio of 0.5 will indicate twice as many females as males.

Typically, three observational time frames are used for studies of illicit drug consumption. 'Lifetime use' is of limited value in assessing current drug use among adults (although it is considered to be a reasonable indicator among schoolchildren), but it can provide insight into patterns of use. 'Last year use' and 'last month use' reflect the current situation more accurately, with the latter weighted more heavily towards people who use the drug frequently.

The ESPAD school surveys provide prevalence data on school students aged 15–16 years in most EU countries and are a

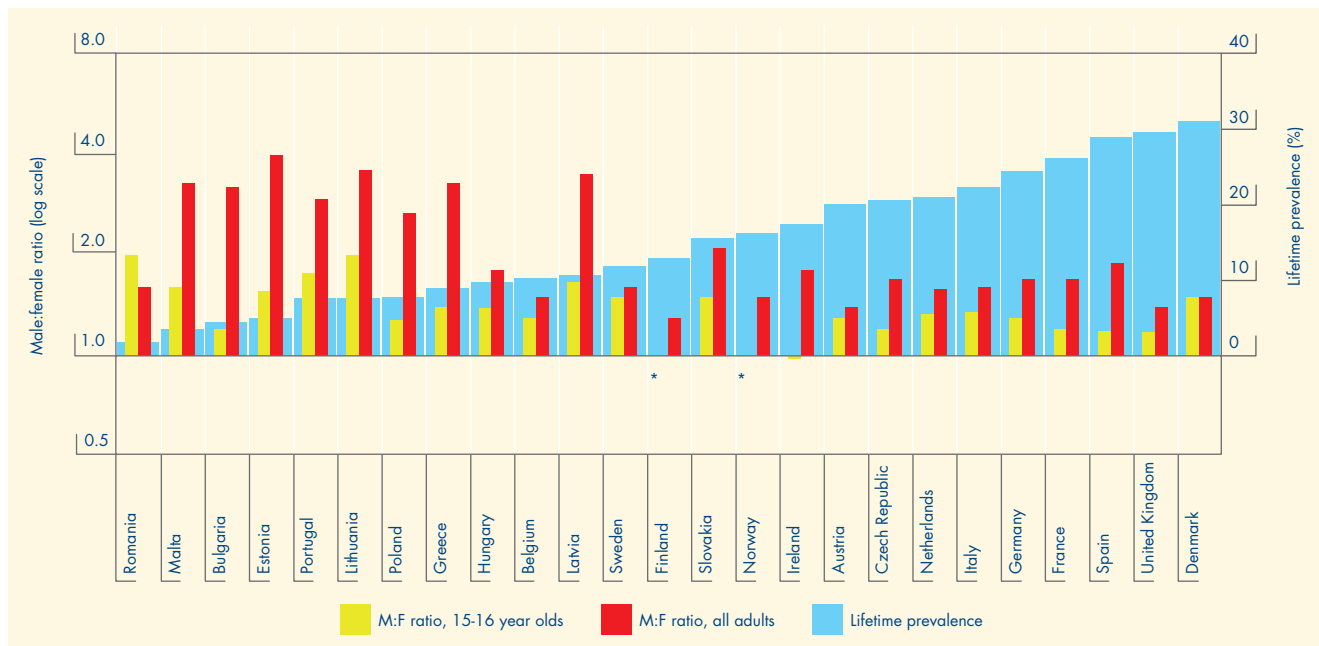
principal source of information for this group. Surveys conducted among other age groups are less homogeneous, and coverage and methods may vary. Full details of the available surveys and detailed notes on methodological issues can be found in the accompanying statistical bulletin. This analysis uses data from the 2003 ESPAD school survey.

Two different sources of treatment data are available. The total number of clients requesting treatment for drug use for the first time in one or more of five types of treatment centre (outpatient, inpatient, low-threshold agencies, general practitioners, treatment units in prison) provides a general overview and enables trends in gender differences among drug clients to be identified. Secondly, data regarding drug clients requesting treatment (including for the first time) in outpatient treatment centres are used to analyse patterns of drug use and to describe the socio-demographic characteristics of drug clients from a gender perspective. This analysis is based on data from the above sources collected in 2004.

1.0 (signifying equality) in Ireland, Finland and Norway to 1.8 in Portugal. In contrast, gender differences in lifetime experience of cannabis use among all adults are typically higher and show considerably more variation between countries. Adult male to female ratios range from 1.3 in Finland to 4.0 in Estonia. Generally, the adult gender difference tends to be less marked in countries with relatively

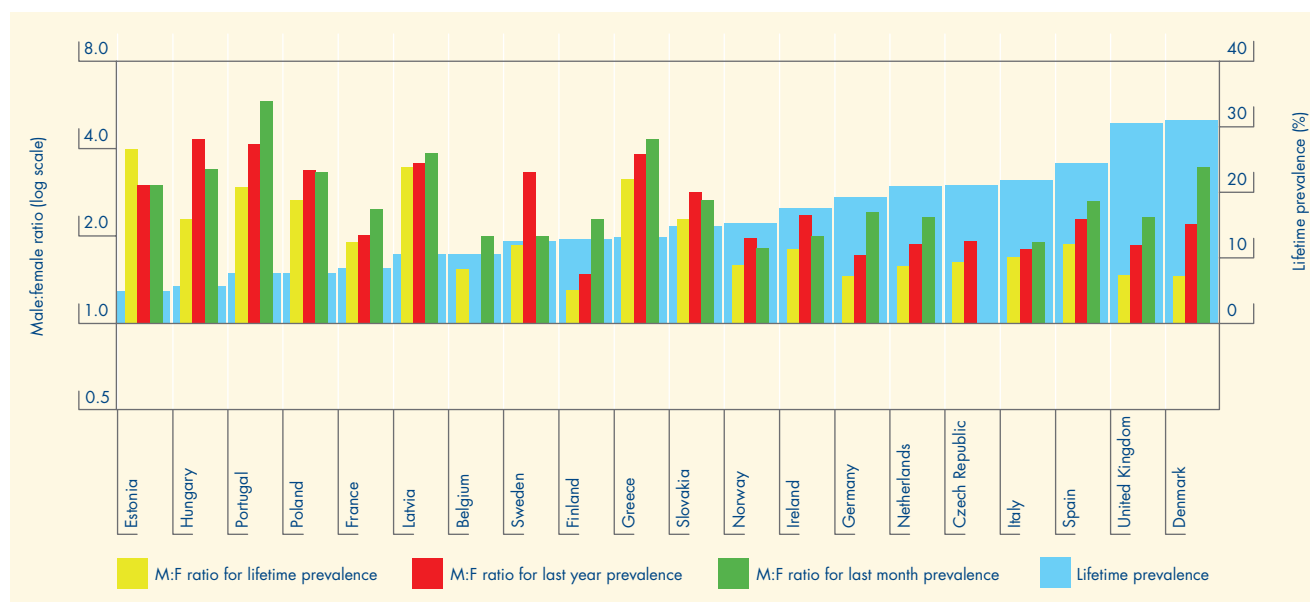
high prevalence rates than in countries with low prevalence rates, the latter group including most of the new EU Member States (but excluding the Czech Republic and Slovenia), together with Greece and Portugal. However, in Finland, Sweden, Romania and Norway, where lifetime prevalence levels are also relatively low, male–female differences are minimal (Figure 1).

Figure 1: Male to female ratios for ever in lifetime use of cannabis among 15- to 16-year-old students and all adults (15–64 years)



NB: *M/F ratios of 1 among students in Finland and Norway. Countries are ordered by increasing levels of lifetime prevalence among all adults (plotted on the right-hand axis). Male–female ratios are plotted on a logarithmic scale (left-hand axis). ESPAD figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia). Sources: 15- to 16-year-old students — ESPAD (2003 survey); all adults (15–64 years) — 2006 EMCDDA statistical bulletin.

Figure 2: Male to female ratios for ever in lifetime, last year and last month cannabis use among all adults (15–64 years)



NB: Countries are ordered by increasing levels of lifetime prevalence among all adults (plotted against the right-hand axis). Male–female ratios are plotted on a logarithmic scale (left-hand axis). Figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg–Western Pomerania and Thuringia). In Belgium, no data are available for last year prevalence. In the Czech Republic, no data are available for last month prevalence.
 Source: 2006 EMCDDA statistical bulletin.

Among adult drug users, male predominance increases as the observation time frame is shortened from lifetime through last year to last month. Gender ratios for lifetime experience range from 1.3 to 4.0, with last year prevalence ratios being slightly higher, ranging from 1.5 in Finland to 4.3 in Hungary. In the case of last month prevalence rates, gender ratios are even higher, ranging from 1.8 in Norway to 5.9 in Portugal. However, these figures must be interpreted with care as random variation may be high because of the low numbers reporting last year and last month use (Figure 2).

Among 15- to 16-year-old school students, gender differences are considerably more marked among those who report ‘frequent use’ of cannabis (40 or more times during a lifetime) than in the case of lifetime or last year prevalence. Among the frequent use group, the prevalence among male students can be twice, three times or even, in one country, four times higher than in female students. Again, some caution is needed in interpreting these results because of the relatively small numbers of students reporting frequent use (Figure 3).

The most marked continuous increases in lifetime experience of cannabis among both male and female school students have occurred since 1995 in the Czech Republic, Estonia, Slovenia and Slovakia and since 1999 in France. Although these increases generally run in parallel among males and females in both adult and school student populations, in 2003 the strong male predominance in lifetime prevalence

for cannabis use among students was reduced in several countries where prevalence levels are either high or increasing (Figure 4). For adults, however, this is not the case, at least in countries where cannabis trend data are available. During the last decade, there have been increases in last year prevalence rates for cannabis use in Germany, Spain, France and the United Kingdom, yet the gender differences remain constant.

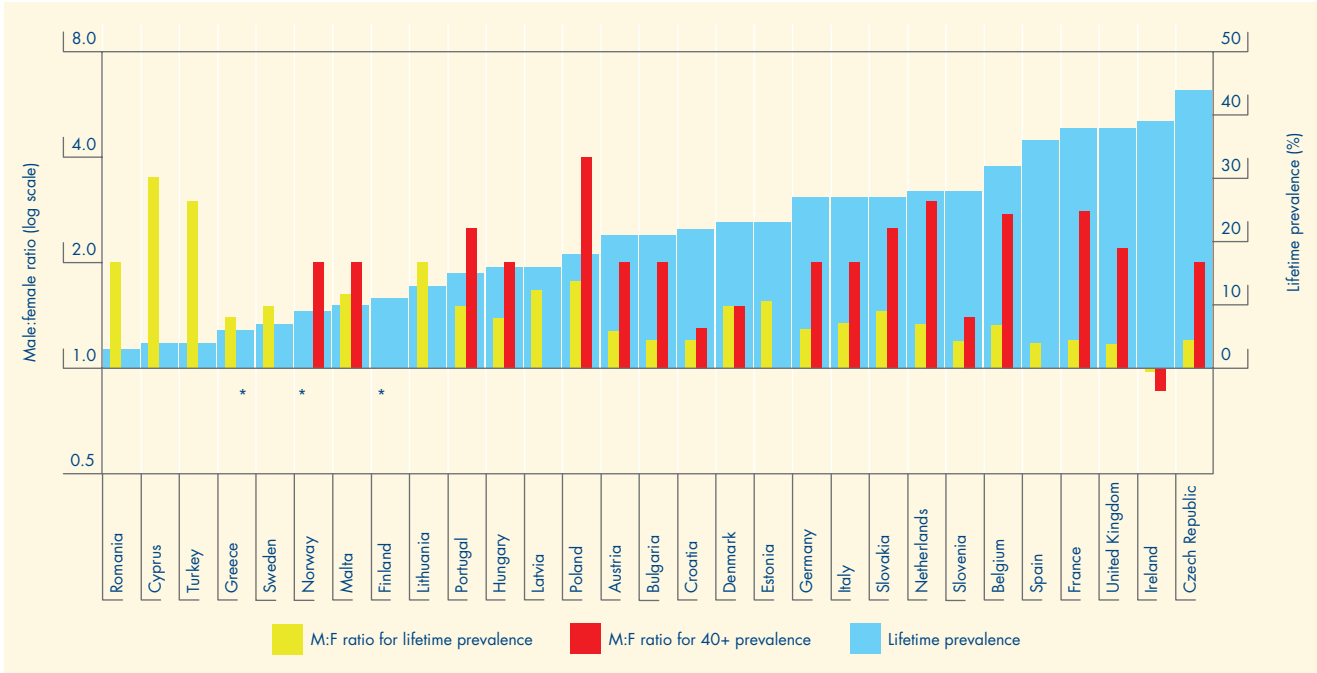
Ecstasy

Overall prevalence rates for ecstasy use are much lower than those for cannabis, although there is considerable variation between countries and between population subgroups. Reported rates for lifetime prevalence range from 0.1 % among all adult females (15–64 years) in Sweden to 17.3 % among young adult males (16–34 years) in the United Kingdom (4).

Gender ratios in lifetime prevalence of ecstasy use vary more widely between countries than in the case of cannabis. In over half of the EU countries reporting data, lifetime experience of ecstasy use is approximately the same in 15- to 16-year-old female students as in male students of the same age. In the remaining countries, ecstasy use is higher in male students than in females, with ratios varying from 1.3 in France to 2.0 in Denmark, Greece, Italy, the Netherlands and Sweden. Likewise, among adults (15–64 years) in most of the EU countries surveyed, lifetime experience of ecstasy is

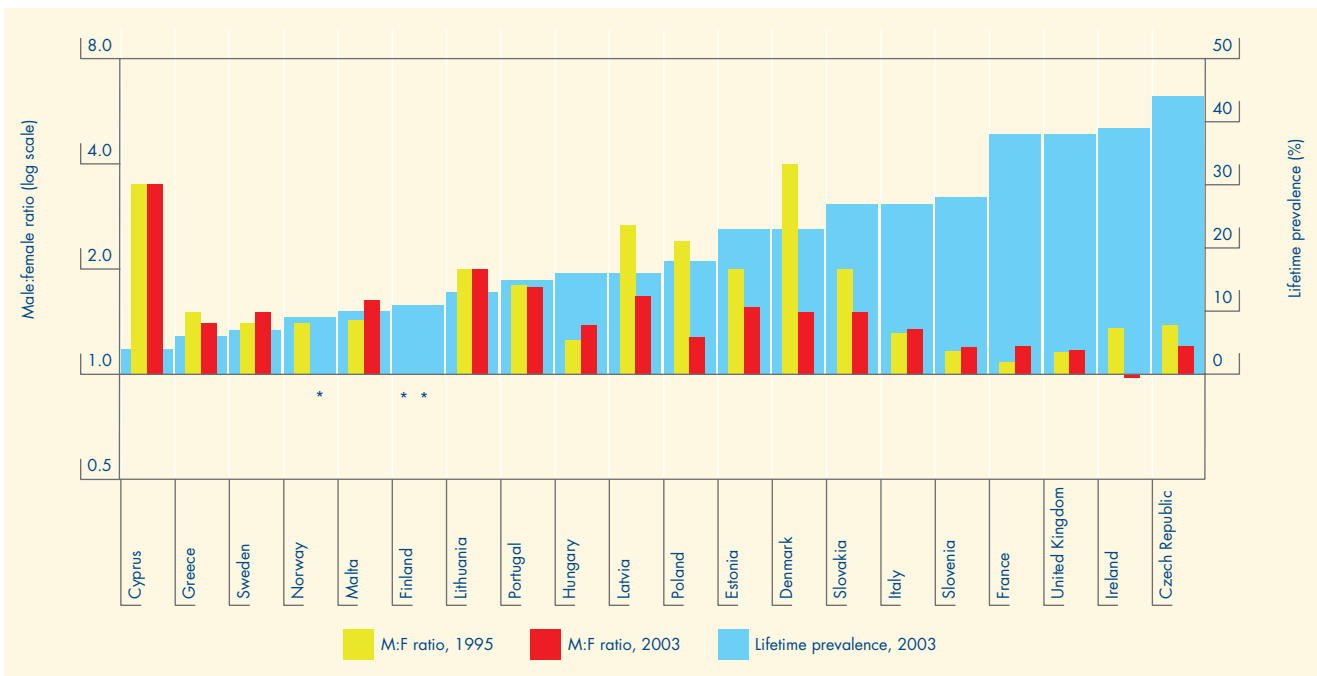
(4) See Tables GPS-8 and GPS-9 in the 2006 statistical bulletin.

Figure 3: Male to female ratios for ever in lifetime or repeated (40 + in lifetime) cannabis use among 15- to 16-year-old school students



NB: *M/F ratios of 1 for lifetime prevalence in Finland and Norway, and for 40+ prevalence for Greece. Countries are ordered by increasing levels of lifetime prevalence among all students (plotted on the right-hand axis). Male-female ratios are plotted on a logarithmic scale (left-hand axis). Figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia). In Spain, no data are available for 40 + times in lifetime use. In Cyprus, Sweden, Finland, Lithuania, Latvia and Estonia, ratios for 40 + prevalence could not be computed because of the existence of a zero prevalence. Source: ESPAD (2003).

Figure 4: Male to female ratios for ever in lifetime use of cannabis among 15- to 16-year-old school students in the 1995 or 2003 rounds of the ESPAD survey



NB: *M/F ratios of 1 for both years in Finland and for 2003 in Norway. Countries are ordered by increasing levels of prevalence in 2003 (plotted on the right-hand axis). Male-female ratios are plotted on a logarithmic scale (left-hand axis). Figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia). Source: ESPAD (1995 and 2003 surveys).

generally lower among females, with ratios ranging from 1.0 in Estonia to 6.0 in Poland (Figure 5). Thus, as for cannabis, gender ratios for lifetime prevalence progressively increase in higher age groups. However, overall prevalence rates for use of ecstasy are low, and therefore caution should be exercised in interpreting male to female ratios.

Since 1995, small but continuous increases in the lifetime use of ecstasy among school students have taken place in the Czech Republic, Estonia and Portugal. These have occurred largely in parallel among both male and female school students.

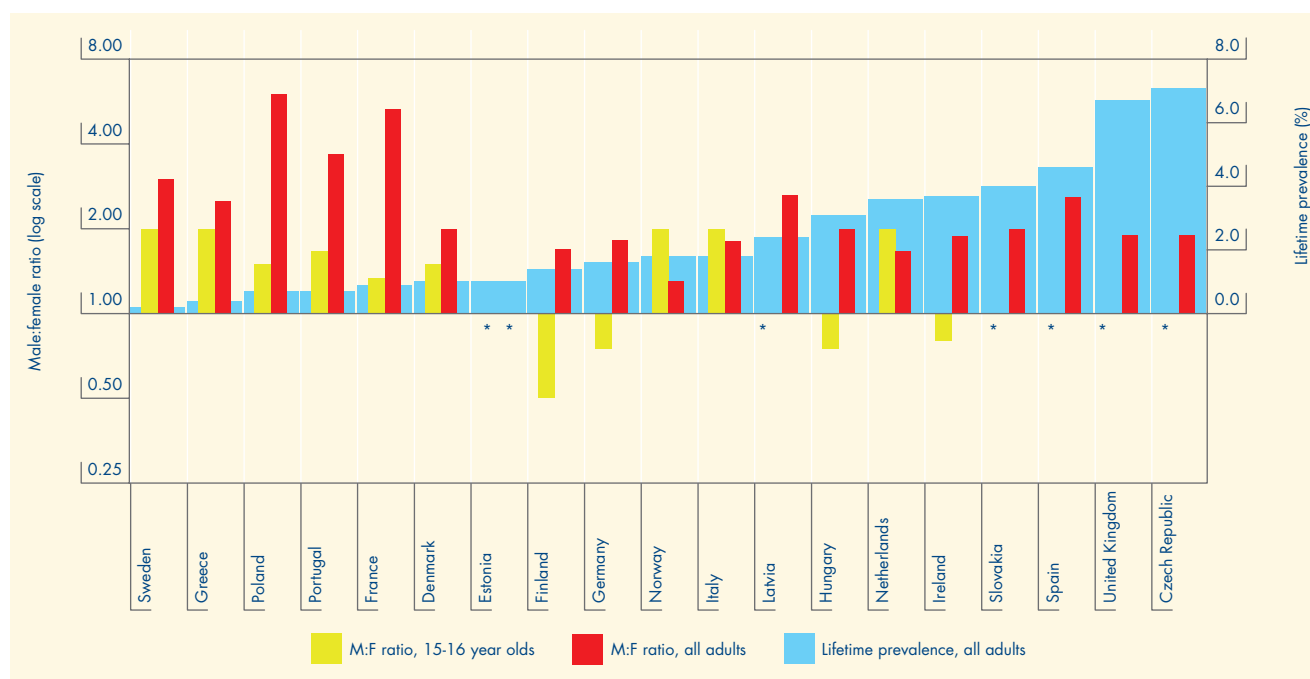
Cocaine

Overall prevalence rates for cocaine use are very low among school students, and among adults are lower than those for cannabis and ecstasy use, although considerable variation exists between countries. Reported lifetime prevalence rates among young adults aged 15–34 years range from 0.1 % of females and 1.2 % of males in Lithuania to 7.1 % of females and 14 % of males in the United Kingdom ⁽⁵⁾. Males outnumber females by a factor of two or more in most countries (Figure 6).

Tranquillisers and sedatives

Tranquillisers and sedatives can be used both as legally prescribed medicines and illegally without a doctor's prescription. Comparable data on gender differences for this type of behaviour are not available from adult population surveys. However, among school students (aged 15–16 years) surveyed in the EU Member States, candidate countries and Norway by ESPAD, lifetime prevalence of the use of tranquillisers or sedatives without a doctor's prescription was markedly higher in females than in males in all countries (Hibell et al., 2004), with the exception of three Member States (Cyprus, Ireland and the United Kingdom) and Bulgaria, Turkey and Norway. Lifetime prevalence ranges from 1–2 % of females in Cyprus, Ireland, Germany, Austria and the United Kingdom to 18 % of females in Lithuania and 22 % in Poland. In the United Kingdom, more males than females use these drugs, but prevalence estimates for the use of this type of illicit substance are very low and the difference has to be seen in this context (Figure 7). Nevertheless, concerns about increased use of tranquillisers and sedatives by males have been expressed ⁽⁶⁾.

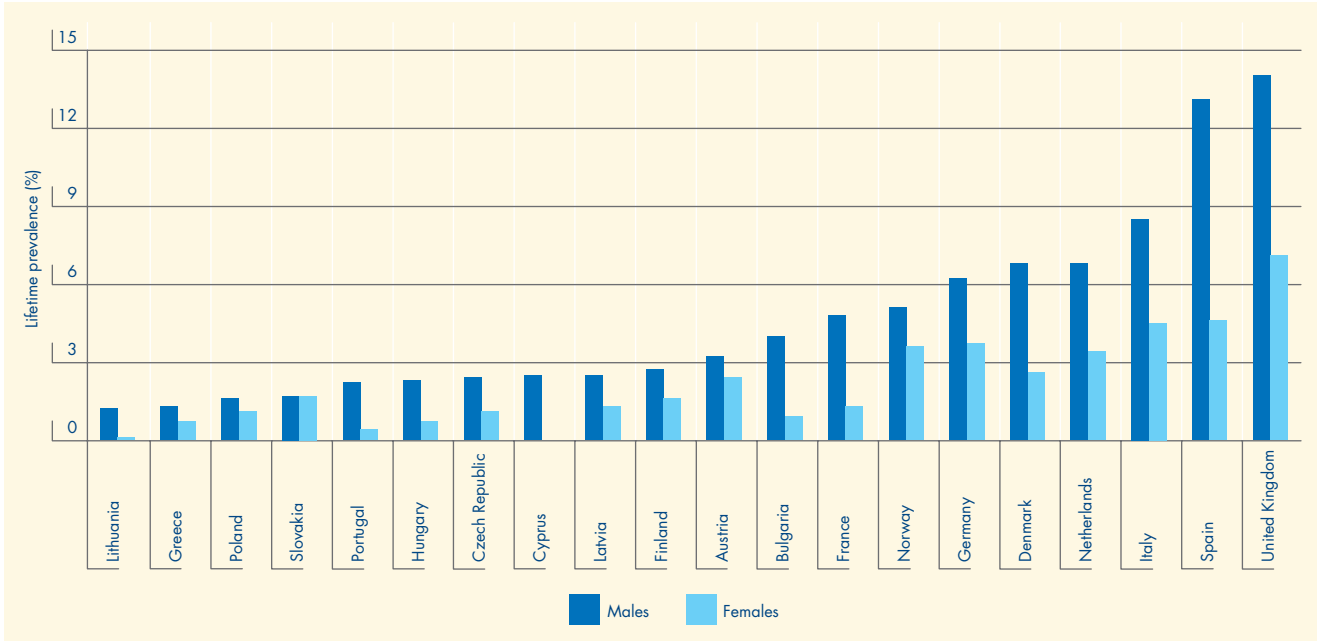
Figure 5: Male to female ratios for ever in lifetime use of ecstasy among 15-16-year-old school students and all adults (15–64 years)



NB: *M/F ratios of 1 for students in the Czech Republic, Spain, Estonia, Latvia, Slovakia and the United Kingdom and for all adults in Estonia. Countries are ordered by increasing levels of prevalence among all adults (plotted on the right-hand axis). Male-female ratios are plotted on a logarithmic scale (left-hand axis).
 ESPAD 2003 figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia).
 Sources: 15–16 year old students — ESPAD (2003); all adults (15–64 years) — 2006 EMCDDA statistical bulletin.

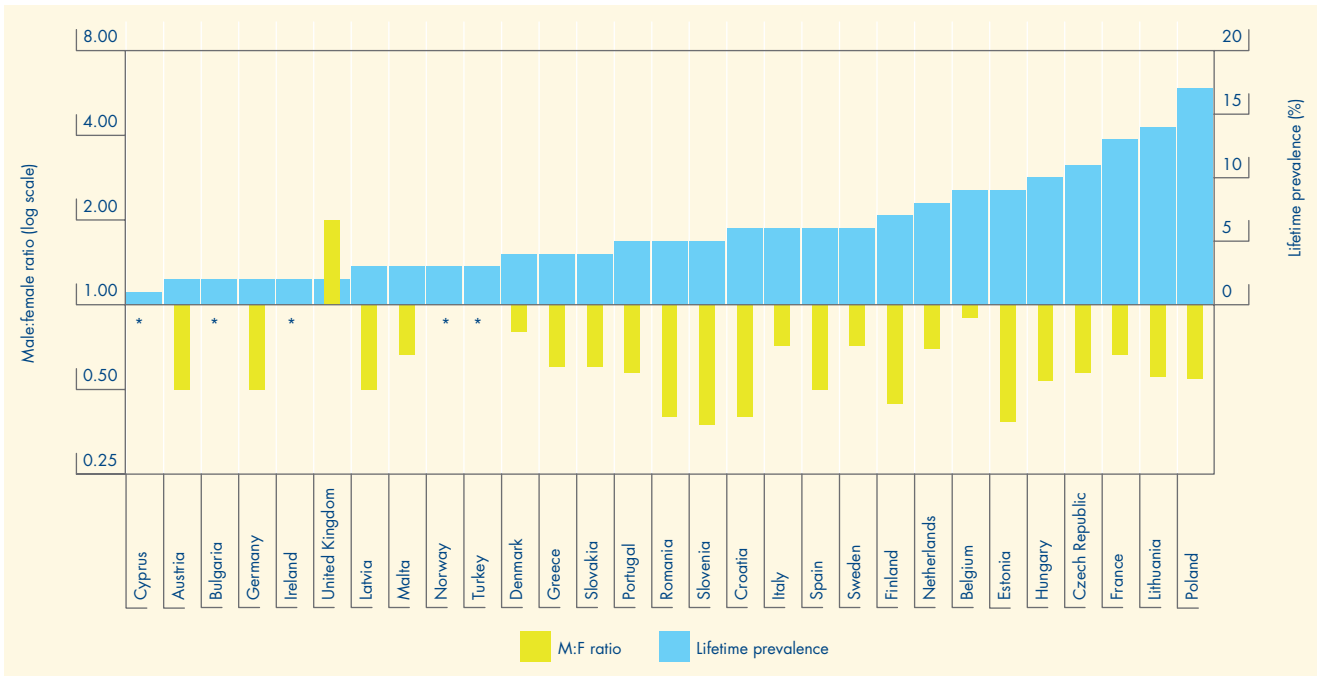
⁽⁵⁾ Tables GPS-8 and GPS-9 in the 2006 statistical bulletin.
⁽⁶⁾ German national drugs coordinator at www.dw-world.de/dw/article on 4 May 2006.

Figure 6: Prevalence of ever in lifetime use of cocaine among 15–34 year olds in the general population, by gender



Sources: Reitox national focal points.

Figure 7: Male to female ratios among 15–16 year old school students reporting ever in lifetime use of tranquillisers or sedatives without a doctor's prescription



NB: *M/F ratios of 1 in Ireland, Cyprus, Bulgaria, Turkey and Norway.
 Countries are ordered by increasing levels of prevalence among all students (plotted on the right-hand axis).
 Male–female ratios are plotted on a logarithmic scale (left-hand axis).
 Figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg–Western Pomerania and Thuringia).
 Source: ESPAD (2003).

Data from the different rounds of the ESPAD school survey suggest no marked trend in the prevalence of tranquillisers or sedative use. A substantial increase, among female students, was reported only from Estonia.

Alcohol

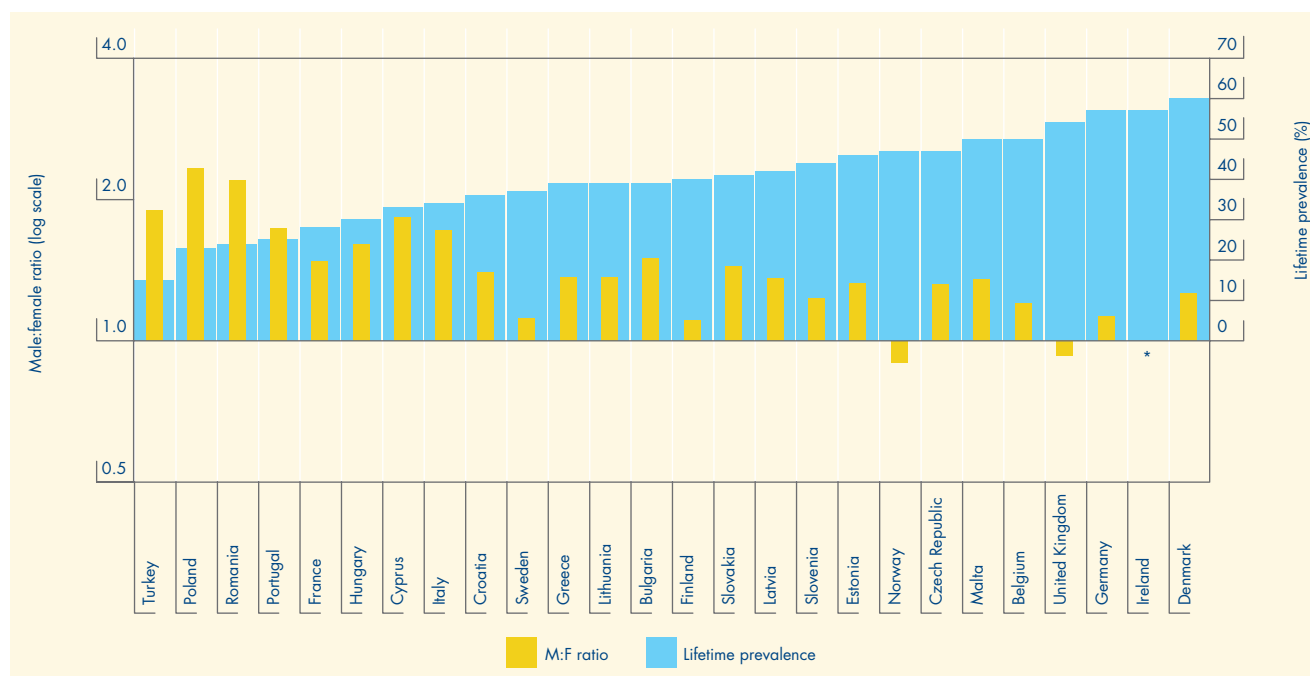
In most countries, the vast majority (90 % or more) of 15- to 16-year-old students have drunk alcohol at least once, and a relatively high proportion report having had five or more drinks in one session during the last month. Prevalence of this more intensive pattern of alcohol use (sometimes referred to as binge drinking) ranges from 10 % of females in Turkey to 67 % of males in Denmark. This measure of potential problem alcohol use among 15- to 16-year-old students is higher than lifetime use of cannabis in all countries reporting data, with the exception of France (Figures 3 and 8).

Among school students aged 15–16 years, experience of drinking five or more drinks in one session in the last month is higher in males than in females, except in three countries (Ireland, the United Kingdom and Norway). In general, male predominance is lower in those countries where the prevalence of binge drinking is highest. The gender differential of intensive alcohol use ranges from 1 (signifying equality) or under in Ireland, the United Kingdom and Norway to 2.3 in Poland, and is broadly similar to that for cannabis.

Polydrug use

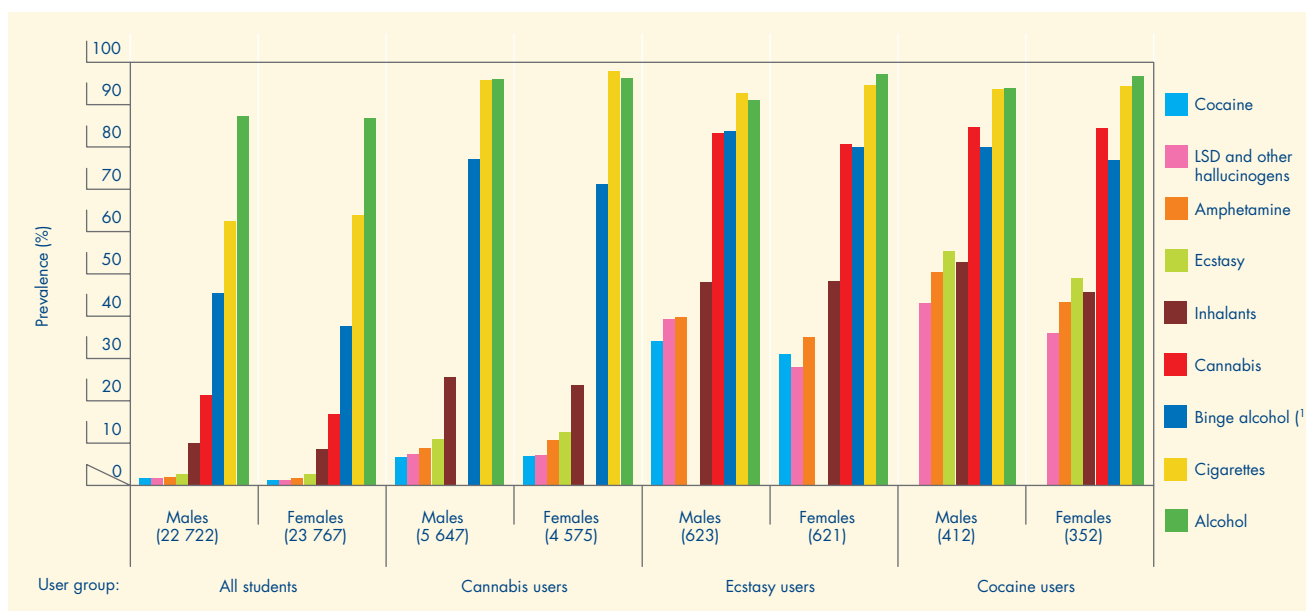
Analysis of data collected from the 15 European countries that participated in the 2003 ESPAD school survey shows that, in terms of patterns of substance use, gender differences are less marked than variations between different types of user groups. School students can be categorised into groups according to their lifetime experience of cannabis, ecstasy and cocaine, and these groups can then be compared with the general 15- to 16-year-old school student population (Figure 9). Compared with the general school student population, those with cannabis experience have a fourfold higher prevalence of other illegal substance use and a twofold higher prevalence of binge drinking. Among the group with ecstasy experience, the prevalence rates for use of cocaine and hallucinogenic drugs are more than 20 times higher than in the general school student population, and around five times higher than among those with cannabis experience. These data suggest that the more deviant/low-prevalence patterns of drug use among school students (ecstasy, amphetamine, hallucinogens, cocaine) cluster among a few individuals, and this pattern applies to both male and female students. It should be noted that lifetime use means ever having used each different drug and not necessarily use on the same occasion.

Figure 8: Male to female ratios for consumption of five or more drinks in one session during the last 30 days among 15- to 16-year-old students



NB: *M/F ratio of 1 in Ireland.
 Countries are ordered by increasing levels of prevalence of drinking five drinks in a row in the last month (plotted on the right-hand axis).
 Male–female ratios are plotted on a logarithmic scale (left-hand axis).
 Figures for Germany are based in six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia).
 Source: ESPAD 2003.

Figure 9: Gender and the use of psychoactive substances by different user groups — ever in lifetime prevalence of use of nine psychoactive substances among 15- to 16-year-old students in 15 European countries



(*) Binge drinking is defined as consuming five or more drinks in a row.
 NB: User groups are defined as those who have lifetime experience of the substance. Total numbers for the 15 ESPAD countries are given in brackets. Lifetime prevalence rates are the average for 15 countries (Germany, Greece, France, Italy, Lithuania, Hungary, Malta, the Netherlands, Slovenia, Slovakia, Finland, Sweden and the United Kingdom together with Norway and Croatia, where ESPAD experts provided individual drug use data).
 Source: ESPAD experts.

Conclusions

Underlying trends in gender can be ascertained only by taking a broad look at the considerable variation in the data for different countries and drugs. However, patterns are detectable; for example, gender equality in cannabis use and binge alcohol use increases with increasing prevalence of use, and generally prevalence rates are lower for serious illegal, recent or frequent drug use. The explanations may lie in lifestyle influences that are intrinsically related to gender or age, or in the ever-changing factors that determine the stages of developing drug fashions across Europe. Detailed analysis of differences in male and female drug use can yield important information about changing lifestyles in relation to patterns of drug use and about the potential efficacy of drug prevention and drug treatment services for different client groups. If young females are increasingly likely to experiment with drugs in the same manner as their male counterparts, the likely impact on future drug use trends must be determined. It is necessary to identify the different influences of each sex on overall trends in order to understand their direction and develop appropriate responses. Also, the markedly higher proportion of female to male students who have used tranquillisers or sedatives without a doctor’s prescription and possible increases in male use of these substances merit future research attention.

Gender differences in development of drug-related problems

Treated population

Males far outnumber females among drug treatment clients. As some research studies have suggested that there may be barriers to service uptake by women, an important question, but one that is difficult to answer, is the extent to which women are underrepresented in the treatment population compared with the population of those who could be considered in need of treatment. In 2004, data from all types of treatment centres from which data are available suggest that among drug clients asking for treatment for the first time males outnumber females by a ratio of 4 to 1 (ratios of 3.9 for new clients and 4.0 for all clients) (7) (8).

Gender ratios among drug clients vary greatly between countries but are generally higher in the southern European countries than in northern countries. In 2004, the highest proportions of female clients were in the Czech Republic, Finland and Sweden, and the lowest were in Italy, Cyprus and Turkey. These differences to some extent reflect differences between countries in data coverage, as well as differences in structural factors such as the organisation of treatment services and in cultural and social factors such as the distribution of clients according to primary drug for which they seek treatment.

(7) See Table TDI-41 in the 2006 statistical bulletin.

(8) Methodological limitations should be considered when reading the data because of the partial data coverage in some Member States and the low numbers often reported for female clients in the smaller countries.

From 1999 to 2004, the gender distribution among new drug clients seeking treatment did not change to any great extent; the proportion of males increased in eight countries, decreased in three countries and remained stable in the remaining 13 countries ⁽⁹⁾. Where increases in the gender ratio were observed, the principal reason is likely to be an increase in cannabis and cocaine users, who are mainly males, among first-time clients.

Data from outpatient treatment centres offer a more detailed picture of gender differences among drug treatment clients. In the treatment centres from which data were available, the gender ratio in 2004 was 3.6 for new drug clients and 4.3 for all clients ⁽¹⁰⁾.

Gender ratios vary according to the primary drug for which drug users present for treatment. Most of the care provided by drug treatment services is aimed at opioid, cocaine and cannabis users, among whom males far outnumber females. The male to female ratio among new clients is especially high for cannabis (6.0) and cocaine (5.8), but lower for opioids (3.5), amphetamines and ecstasy (2.1); the only drugs for which female clients outnumber males are hypnotics and sedatives (0.9), but the limitations of the low numbers of clients reported have to be taken into account ⁽¹¹⁾.

Most people, both men and women, attend drug treatment services on their own initiative as self-referrals; the only gender differences regarding referral routes relate to the criminal justice system and health or social services. Male clients are more likely than females to have been sent for treatment by police and the criminal justice system (22.2 % of males and 10.6 % of females), whereas female clients are more likely than males to come to treatment via health and social services (27 % of males and 36 % of females seek treatment through health or social services, general practitioners or other drug treatment centres) ⁽¹²⁾.

Among clients new to treatment, the women are usually younger than the men. New female drug clients requesting treatment for opioid and cocaine use are, on average, two years younger than males, while those requesting treatment for stimulants are an average of four years younger. Exceptions here are females asking for treatment for the use of hypnotics, sedatives or hallucinogens, who tend to be older than their male counterparts, although the numbers on which this conclusion is based are very low ⁽¹³⁾, and cannabis clients, among whom the average age of

both males and females is around 23 years. Overall, the proportion of female clients is higher in the younger age groups ⁽¹⁴⁾.

Among new drug clients in outpatient centres in the European countries that provide data, males and females report a similar age at onset of drug use; only among users of hypnotics and sedatives is the age at onset higher in females (29.2 years) than in males (25.1 years), but it should again be borne in mind that figures for clients being treated for use of hypnotics and sedatives are very low ⁽¹⁵⁾. If age at first entering drug treatment is lower among females, but age at first use is similar to that of males, as is the case for some drug types, then this suggests that females achieve earlier access to treatment than males do (this point is taken up in the next section).

Among new treatment clients, males more often report severe patterns of drug use than females: higher male to female ratios are found among new clients using drugs daily (for all drugs except cannabis and hypnotics) than among those using less frequently ⁽¹⁶⁾; and among new clients who use opioids the male to female ratio among injectors is higher than average ⁽¹⁷⁾.

Describing drug users seeking treatment provides important insights into gender ratios among those in treatment services, but the mechanisms that drive the treatment demand process must remain speculative without some type of careful comparison of drug users who come for treatment at a given point and those who do not. More analysis, including time trends, is required to better understand how gender impacts on drug treatment demand.

Non-treated population of problem drug users

Problem drug users who have no contact with treatment or other drug services constitute a 'hidden population', for which gender-related data are rarely available. Problem drug use (PDU) estimates that include both the treated and non-treated population are available by gender in only a few countries.

In Greece and Estonia (Uuskula et al., 2005), the available PDU estimates suggest a higher proportion of males among the non-treated population than among those in treatment. In contrast, in Finland, the proportion of males is higher in the observed treatment population than in the hidden population. However, as these are results from modelling studies that may

⁽⁹⁾ See Table TDI-6 in the 2006 statistical bulletin.

⁽¹⁰⁾ See Table TDI-21 in the 2006 statistical bulletin.

⁽¹¹⁾ See Table TDI-21 in the 2006 statistical bulletin.

⁽¹²⁾ See Table TDI-29 in the 2006 statistical bulletin.

⁽¹³⁾ See Table TDI-28 in the 2006 statistical bulletin.

⁽¹⁴⁾ See Table TDI-42 in the 2006 statistical bulletin.

⁽¹⁵⁾ See Table TDI-30 in the 2006 statistical bulletin.

⁽¹⁶⁾ See Figure TDI-8 in the 2006 statistical bulletin.

⁽¹⁷⁾ See Figure TDI-7 in the 2006 statistical bulletin.

depend on different assumptions, they should be interpreted with caution and the data do not provide us with any insight into the European picture as a whole. See Table 1 for a summary of the data from the three studies.

A study analysing 'latency period to treatment' (time between first use and first drug treatment) in three large European cities (Amsterdam, London, Rome) found that latency period was shorter in females than in males (EMCDDA, 2002). On average, among opioid users who request treatment, females request treatment 1.5–2 years earlier in their drug career than males. This difference was found in all three cities studied. After controlling for other variables that might have influenced the length of latency period (age, route of administration and ethnicity), gender remained significant in two of the three cities. The reasons for this are unclear, but it might be that female opioid users progress more rapidly to a level of problems that lead them to treatment, that they are directed to treatment by their social environment more rapidly than males or that other mechanisms lead them to seek treatment earlier.

Mortality and drug-related deaths

In all EU countries, most drug-related deaths ⁽¹⁸⁾ are male. The proportion of female drug-related deaths ranges between 7 % and 35 %. The lowest proportions are found in Greece, Italy, Cyprus, Portugal and Romania, and the highest proportions are in the Czech Republic (where most deaths are associated with prescribed medicines), Poland, Finland and the United Kingdom.

The lower proportions of females among cases of drug-related deaths correlate with the lower proportions of females among problem drug users (in particular opioid users). However, due to the scarcity of data, it is difficult to compare gender breakdown for drug-related death and gender breakdown of problem drug use in each country. In most countries, the proportion of males among drug-related deaths is higher than the proportion of males among treatment clients ⁽¹⁹⁾, but possible biases in the data make them difficult to interpret.

Notable differences have been detected between the genders in trends in drug-related deaths in the EU-15 Member States (for which the most complete set of data is available). Whereas the number of male deaths progressively increased from 1990 to 2000, followed by a clear decrease (30 % by 2003), the number of reported deaths among females remained relatively stable over the same period, ranging from 1 700 to 2 000 per year with only a 15 % decrease since 2000. This may imply that interventions (treatment and harm reduction) do not reach women to the same extent as men, or it may be an indication of differences in the prevalence of opioid use or in risk factors between the genders.

The mean age of male and female cases of drug-related death was similar in 12 countries. In seven countries, the mean age was higher among females, especially in Belgium, Ireland, Finland, the United Kingdom and Bulgaria. In contrast, in Cyprus, Latvia and Malta, the mean age was lower among females.

Among the EU population aged 15–39 years, the average rate of mortality caused by drug overdose in females is about nine per million, compared with 48 per million in males. However, gender differences in proportional mortality (the percentage of all deaths that can be attributed to any specific condition) due to drug overdose are lower (4 % for males against 2 % for females) because general mortality is lower among females. In Denmark, Luxembourg and Norway, drug-related deaths account for 8–10 % of mortality among females; in Austria, Slovenia, Sweden and the United Kingdom, this figure is between 4 % and 5 %.

In cohort studies of opioid users, mortality rates are usually higher for males. This could be because there is a higher proportion of injectors among males or because males are more likely to exhibit high-risk behaviour (for example, higher frequency of injection; use of higher dosages; polydrug use, in particular including alcohol; injecting alone) or to be in high-risk situations (e.g. incarceration). However, the excess mortality of female opioid users in comparison with the

Table 1. Male to female ratio among observed drug users and in estimates of the hidden population (capture–recapture method)

	Observed population	Male/female ratio — observed population	Hidden population	Male/female ratio — hidden population
Greece	3 770	5.3	15 429	6.6
Estonia	3 024	6.0	10 777	10.0
Finland	4 097	3.5	14 117	2.1

Sources: Greece: data from treatment agencies; Estonia: estimates injecting drug users obtained from the HIV reference laboratory, police arrests, overdoses and drug treatment; Finland: data from treatment, driving under the influence of drugs, criminal report file and a register of infectious diseases.

⁽¹⁸⁾ Drug-related deaths refer to those deaths caused directly by the consumption of one or more drugs. These deaths are known as 'overdoses', 'poisonings', 'drug-induced deaths' or 'acute drug deaths'.

⁽¹⁹⁾ See Figure TDI-9 in the 2006 statistical bulletin.

general female population is higher than the corresponding figure for males. The lower general mortality of young females in part explains why females who use opioids increase their risk of dying to a greater extent than males do.

Infectious diseases

A breakdown of the most recent available seroprevalence data by gender shows that female intravenous drug users (IDUs) are more vulnerable to HIV infections⁽²⁰⁾ and sexually transmitted infections (STIs) than are male IDUs. The likely reasons for such a gender difference include both social factors, e.g. female IDUs are much more likely to be involved in sex work than males are (Platt et al., 2005), and biological factors, such as women's higher risk of contracting genital infections owing to the much larger area of mucous membrane exposed. It is less clear whether women are at an increased risk of contracting these infections as a result of injecting; however, female IDUs are likely to be more often in a vulnerable position when attempting to protect themselves from infection within IDU partnerships and networks (Gollub et al., 1998).

Data available from Belgium, Estonia (2005), Spain (2002), France, Italy, Luxembourg, Austria, Poland and Portugal (all 2001) provide a total sample of 124 337 males and 20 640 females tested for HIV, mostly in drug treatment centres or other drug services. Overall HIV prevalence was 13.6 % among males and 21.5 % among females. Differences by country are marked, with the highest female preponderance being in Estonia, Spain, Italy, Luxembourg and Portugal; in contrast, in Belgium, HIV prevalence is higher among males. It is possible that these gender differences reflect different transmission patterns, for example differences in the relative contribution of sexual transmission, as mentioned above. On the other hand, variations in selection mechanisms resulting in spurious differences related to gender cannot be ruled out. For example, if female IDUs are tested more frequently than their male counterparts (e.g. as part of pregnancy care or screening for STIs) then infections among female IDUs may be detected more often.

In contrast to HIV, median seroprevalence for hepatitis C virus (HCV) is very similar in male and female IDUs: 58.1 % in males and 56.4 % respectively. It is known that sexual transmission of HCV is very difficult compared with transmission of HIV, and therefore infection among IDUs will probably almost exclusively be the result of sharing needles/syringes and other injecting paraphernalia. Thus, the contrasting findings for HIV and HCV suggest that the large gender difference in HIV seroprevalence is more likely due to differences in (exposure to) sexual risks in males and females

rather than to a gender difference in rates of detection of existing infections.

Social correlates and consequences

Drug-related crimes

In most reporting countries⁽²¹⁾, women commit between 9 % and 15 % of drug law offences; the figure is lower in the Czech Republic (4 %) and higher in Lithuania and Romania (25 % and 20 % respectively). Against a background of an increase in the number of drug law offences reported in Europe in recent years, the proportion of women among drug law offenders has grown.

Regarding the substances involved in drug offences, in Belgium, Luxembourg and the Netherlands, women are more likely than men to be reported for cocaine or heroin offences, and, in the United Kingdom, female offenders screened in the framework of the NEW-ADAM⁽²²⁾ research programme show higher rates of positive opioids tests. Among Italian juveniles passing through juvenile justice services, girls (4 % of all juveniles concerned) are more likely than boys to admit to polydrug use; cannabis is the main substance used by 81 % of boys and by 59 % of girls, whereas opioids are the main substance used by 27 % of girls but by only 7 % of boys.

When it comes to convictions for drug law offences, the proportion accounted for by women ranges from 4 % to 14 %. Some countries (Spain, Italy, Austria and Sweden) report that women are less likely to be convicted than men, but Germany, in contrast, reports the opposite: crimes committed by women more often lead to convictions because, compared with drug law offences committed by men, those committed by women are more often associated with other punishable acts.

Information on gender differences among prisoners sentenced for drug law offences is scarce. Nonetheless, a few countries (Belgium, the United Kingdom) report that women who commit drug offences are more likely than men to be incarcerated. In addition, Spain and Ireland both point out that, as the number of women involved in drug trafficking (mainly as drug couriers) increases, so does the number of women in prison, as well as the average length of their sentence.

Social conditions of problem drug users

The social characteristics of problem drug users vary by gender, often to some extent reflecting broader gender differences in the general population. Studies of women with drug problems suggest that, compared with their male counterparts, they may suffer disproportionately from a range

⁽²⁰⁾ See Figure INF-3 (Part v) in the 2006 statistical bulletin.

⁽²¹⁾ Belgium, the Czech Republic, Germany, Spain, France, Ireland, Italy, Latvia, Lithuania, Luxembourg, Hungary, Malta, the Netherlands, Austria, Portugal, Slovakia, Finland, Sweden, the United Kingdom, Romania and Norway.

⁽²²⁾ The New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) research programme interviews arrestees and examines voluntary urine tests to establish the prevalence of drug use.

of problems. Some evidence of this is found in data on drug treatment attendees.

Compared with male drug users in treatment, a higher proportion of female treatment clients are economically inactive (a group that includes housewives, pensioners and invalids); in addition, unemployment rates are more than 10 % higher among female drug users in treatment than among male drug clients ⁽²³⁾.

Living conditions also differ between female and male drug users: a high proportion of male drug treatment clients live in institutions, whereas a relatively high proportion of female clients live with children, either with or without a partner. In every country, women are relatively overrepresented among drug clients living with children: the gender ratio among the drug treatment population as a whole is 3.6, compared with a gender ratio among drug clients living with children of 1.1. Among drug users, as in the general population, women are the main providers of childcare ⁽²⁴⁾.

International comparisons between Europe and other regions

Men are more likely than women to use illicit drugs. This is the case in the European Union, as shown by EMCDDA data, and it appears to be a worldwide phenomenon. Despite the use of different reporting systems and research methods internationally, for the purpose of comparison, it is worthwhile looking at the gender differences in drug use that are reported in countries outside Europe.

In the USA, males are more likely than females to use, abuse and be dependent on alcohol or illicit drugs ⁽²⁵⁾. According to the 2003 SAMHSA National Survey on Drug Use and Health, 15.2 million females (12 %) and 19.8 million males (17 %) used an illicit drug during the last year. In the 2002 National Survey on Drug Use and Health, among the population aged 12 or older, 6.4 % of women compared with 10.3 % of men reported last month illicit substance use; and this male to female ratio of 1.6:1 has remained fairly constant throughout the 29-year history of the survey (NSDUH, 2004). In Canada, overall, men are nearly twice as likely as women to report use of any illicit drug. In the 2004 'Canada's alcohol and other drugs survey', 18.2 % of men and 10.2 % of women reported using cannabis in the last year (Adlaf et al., 2005). In Australia, the use of illicit substances is more common among men than among women (41.3 % versus 34.2 % in 2001), except in the youngest age group (UNODC, 2004).

Data from several other countries indicate that, throughout much of the world, drug use remains an overwhelmingly

male activity. In China, where reported drug use is still very low despite a large increase during the 1990s, the lifetime prevalence of illicit substance use was 0.57 % in women and 2.58 % in men. Rates of use over the previous 12 months were 0.48 % for women compared with 1.80 % for men. In a rapid assessment survey conducted in 14 cities in India during 2000–01, the mean proportion of the sample of substance abusers who were female was 7.9 %. A similar assessment of drug use carried out in the Islamic Republic of Iran in 1999 estimated that only 6 % of the 800 000–1 200 000 substance users were women. A study of heroin users in one Kenyan coastal town estimated the ratio of male to female heroin users to be 20 (UNODC, 2004).

However, there are also signs that substance use among women is increasing rapidly. Official statistics from Russia reveal that the annual number of women registering for the first time with a diagnosis of drug addiction increased 10-fold over the period 1993–99 in the Russian Federation as a whole and 16-fold in Moscow.

Data from the treatment sector show that, in some regions of the world, women represent between 10 % and 30 % of the treated population ⁽²⁶⁾.

Gender differences in drug use patterns can also be discerned, despite considerable differences in figures and methodology between regions; generally, men predominantly use cannabis, opioids and cocaine, whereas women more often use stimulants and pharmaceutical drugs. Among older women, the highest rates of pharmaceutical drug use are in North America and Europe. Numerous international studies report the same finding — that women are more likely to use and abuse prescribed psychoactive drugs such as painkillers, sleeping pills and tranquillisers (Cormier et al, 2004). Indications of an increase in female use of methamphetamine are reported in some countries (e.g. Canada).

Women who use drugs, especially heroin, are often involved in prostitution and are likely to engage in unsafe practices and to share injecting equipment. In the USA, 47 % of all women diagnosed with AIDS are injecting drug users, and a further 19 % report having sex with users who inject drugs (NIDA notes, 2000). The Australian Institute of Criminology reported that there is a strong link between women's drug use and crime, especially prostitution and property crime: the prevalence of drug use is high among sex workers and women who commit property crime but it is not known whether drug use leads to crime and prostitution or vice versa.

Gender appears to be an important variable affecting the link between personality and substance use (Adalbjarnardottir

⁽²³⁾ See Table TDI-40 in the 2006 statistical bulletin.

⁽²⁴⁾ See Table TDI-14 in the 2006 statistical bulletin.

⁽²⁵⁾ In the USA, unlike Europe, data on drug use concern both alcohol and illicit drugs.

⁽²⁶⁾ See results from the 2004 annual expert meeting on treatment demand indicator (<http://www.emcdda.europa.eu/?nnodeid=6437>).

and Rafnsson, 2001). Male drug users still outnumber females, except in the case of tranquillisers and sedatives, for which the opposite is true. Indications that the gap in illicit drug use between males and females is narrowing, especially among younger age groups, are reported from many regions worldwide. However, more consolidated research is needed internationally in order to elucidate the differences in patterns of drug use among males and females.

Gender-specific approaches in responses to drug use

Prevention: universal and selective prevention for boys and girls

In all Member States, gender-related prevention work remains uncommon. This is somewhat surprising as it is well known that girls and boys experience different developmental problems during adolescence and have different resources at their disposal to cope with these problems. Moreover, at least in the case of prevention, gender specificity usually equates to interventions for girls; only very rarely are specific prevention actions targeted at boys, despite their known higher risk of both using drugs and developing problems (Butters, 2004). Boys may in fact represent a good target for this sort of approach as they may be more susceptible to social influence (Szalay et al., 1996) and because they appear to have a higher threshold for seeking help (Schmidt, 2001). Although currently underdeveloped, gender-specific preventive interventions for boys therefore represent an important area for research and a potentially valuable area for service development.

Several studies provide evidence of the need to adopt a gender-specific approach in preventive intervention in terms of content, setting and practice. For example, Schinke (1994) found that interventions are more effective if their content takes account of gender: in the case of young men, effective interventions include improving social skills and, in particular, assertiveness in the social environment, whereas helpful techniques in young women focus on facilitating expression, reducing tension and teaching effective control techniques.

For effective prevention, the setting should also be different for women and men; according to reports from some Member States, women prefer settings that allow informal exchange and extroverted forms of expression, such as small workgroups. Reflection on personal experience and role images (including that of the trainer) are considered important, as is the gender of the contact person, which should be a woman for girls and a man for boys. Often, the

effects of the programmes are longer lasting (Lillehoj et al., 2004) and more pronounced for girls (www.eu-dap.org).

For young people at high risk, family supervision is a more consistent protective factor for girls than for boys (and helps to reduce opportunities for girls to use substances). Schools are more likely to provide self-help tools and protection against substance use for high-risk girls than for high-risk boys. And substance use among boys is affected more by risk conditions in their neighbourhood (Sale et al., 2005).

For girls, the programmes that are most effective in sustaining positive effects on substance use prevention after their completion focus on behaviourally orientated life skills. In contrast, methods of delivery that involve interaction with peers or adults are particularly effective in boys (Springer et al., 2004).

In practice, gender-specific prevention projects (in Germany, Austria and the Nordic countries) mostly take the form of separate workshops or seminars for girls and boys in order to encourage positive body image, identity development, self-reliance and action competence and to avoid the reiteration of gender stereotypes. Belgium and Denmark report that gender-specific projects are mostly found within the vocational education system, where social problems such as drug use are more frequent. In one Danish scheme 'many boys felt a sense of relief at being able to break down the barrier and talk about their own experiences, feeling that they were not the only ones with these problems. At the start of the project, the girls' relations with each other at the schools were, in most cases, rather delicate. ... but during the project a stronger sense of solidarity was created among the girls.' Several school programmes in Germany (Sign) and Austria (*Selbst sind de Kids, Eigenständig werden, I luag uf mi*) take gender-specific aspects into account. The German/Austrian project 'Step by step' ⁽²⁷⁾ also takes into account gender-specific differences, e.g. training teachers to recognise the early signs of drug use in boys and girls.

Ethnicity and gender are targeted together in interventions in Belgium, Luxembourg and the Netherlands. In Belgium, the 'Tuppercare' project targets women from the Turkish and Moroccan communities. Key women in the community host meetings of family members and friends at which prevention workers of the same ethnic origin can provide information about sensitive issues such as drug use. A joint Dutch-Luxembourgish peer-to-peer education project ('Chebbab' in Nijmegen) involving young Moroccan men ⁽²⁸⁾ in a socially vulnerable position has proved to be successful. Fifteen young Moroccan men provided peer education about cannabis use to other Moroccan young men. In 2004, the 'Chebbab' project resulted in the production of a manual for the peer education method entitled *Youth with*

⁽²⁷⁾ See <http://eddra.emcdda.europa.eu>

⁽²⁸⁾ A relatively high proportion of migrant young people in Dutch cities, men more than women, appear to belong to a socially vulnerable group with a multiplicity of problems, including drug problems.

a message (*Jeugd met een boodschap*) (Kroneman et al., 2003). However, three other pilot studies in the Netherlands involving Antilleans and Turks failed; because of the stigma attached to drugs in these cultures, non-using peers were unwilling to be associated with drugs.

Tobacco campaigns in Germany and in France use gender-specific target messages, e.g. the contradiction between seduction and the effects on beauty or between addiction and the quest for freedom.

In recreational settings in the Netherlands, gender appears to be a less significant factor affecting drug use than age and music preference (www.unitydrugs.nl). However, Calafat et al. (2003) highlight the moderating 'partying skills' of female party-goers and suggest that female consumption behaviour in recreational settings should be promoted as a model for prevention.

Gender-specific approaches to drug treatment

Treatment facilities are usually organised around the needs of opioid addicts, who are mainly men. Those treatment interventions that do have a gender-specific component are mainly targeted to women's needs and, in particular, to pregnant drug users or women with children. Thus, in practice, gender-specific treatment often means treatment targeted towards women drug users.

Most European countries report having at least one treatment unit or programme exclusively for women or for women with children. In recent years, the introduction of high-quality management at drugs agencies seems to have played a role in several countries in achieving a higher target group specialisation, although coverage of gender-specific service provision appears to be low and is often limited to major urban centres. The most common types of gender-specific intervention include case management approaches that facilitate the mediation of care for pregnant drug users, services that specifically address the mothers and fathers of small children and specially designed outreach projects targeted at sex workers.

Gender difference in treatment access, completion and outcome

The structural, social, cultural and personal barriers to treatment that women can face are summarised in the UNODC toolkit on substance abuse treatment and care for women, bringing together case studies and lessons learned (UNODC, 2004). The literature reviewed here shows that, among individuals with substance use problems, women are more likely than men to have a partner with a substance use problem; childcare responsibilities; severe problems at the beginning of treatment; trauma related to physical and sexual abuse; and concurrent psychiatric disorders.

Research on gender differences in the access, duration, completion and outcome of treatment suggests that generalisations on gender cannot easily be made (EMCDDA, 2005). In some analyses, women are reported to be more likely than men to access treatment; the reasons for this may be related to the existence of specific services offered to women or to the fact that women need treatment more than men if they are pregnant or if they have children. In other studies, women are reported to seek treatment proportionately less often than men because of the associated social stigma.

There is not enough information about gender differences in treatment duration, completion and outcome in Europe to draw any firm conclusions. For example, a German analysis of outpatient treatment data reports that men require a shorter treatment duration and have a better outcome, whereas, in Slovakia, among clients of a methadone programme, the success rate was higher for women than for men.

More research is needed to better understand gender differences in all treatment processes; the analysis should take into account differences in the clients' characteristics, their patterns of drug use and the differences between the types of treatment offered (for example outpatient/inpatient; medical/counselling).

Interventions for pregnant women

Outpatient and low-threshold facilities increasingly provide basic medical care as well as sexual healthcare, contraception advice, free infectious disease testing and treatment and pregnancy testing.

Pregnant drug users are defined as a priority group, and they are given preferential access to drug treatment. Integrated quality care for pregnant drug users is being increasingly provided across Europe. Staff support women in gaining access to a range of appropriate services. Case management and the mediation of care are critical components of accessibility and quality of services — objectives noted in the EU action plan.

In most countries, the preferred treatment for opioid-dependent pregnant women is substitution therapy, particularly if discontinued opioid use would be detrimental to the mother or child or if the mother is already in substitution treatment. Research concerning the substitution drug of choice is inconclusive (Lejeune et al., 2003; Jones et al., 2005; Fischer et al., 2006); however, there is consensus that substitution treatment is beneficial to both mother and child. In some countries, e.g. Belgium, France and Sweden, the primary aim of maternity care for drug users is usually abstinence.

Pregnant drug users receive priority treatment in Member States in order to meet their specific needs. The concern is to monitor these women regularly throughout pregnancy

and during the postnatal period in order to ensure that the health of the mother and child remains as good as possible and to support the mother and child relationship. Pregnant opioid addicts require individual counselling and therapy that is quick to implement. In Belgium, a case management approach is adopted. In Greece, a special unit has been created in Thessaloniki to cater for the needs of pregnant women who are turned down by other services. In Ireland, treatment centres refer pregnant clients to midwives to ensure a consistent care plan. In Sweden, maternity care centres have a very high coverage; they refer pregnant drug users to treatment, and studies have shown particularly positive treatment outcomes for pregnant addicts. Research has shown the benefits of centralising care in special units that have access to comprehensive information about the social and medical consequences of substance abuse.

Drug-using parents and child care

Although pregnant women are often the focus of attention, this service may not always continue when the child is born. In many countries, services have been developed mainly for mothers and their children and, in some cases, for families. ‘Vulnerable people — addicted mothers and their children’⁽²⁹⁾ is a European project with participation from Belgium, Germany, Greece, Italy and the Netherlands, assisting mothers and their children up to four years old. It has produced a manual which combines the experiences and methods applied by the project partners with recommendations and models for practical use. Courses and training in parenting skills are also available in France, Luxembourg and Portugal, and guidelines for the integrated assistance of pregnant drug users and those with children were developed in 2005 for the Venice region and presented to the other Italian regions as a model (Provoid project)⁽³⁰⁾.

Outpatient treatment centres, e.g. in the Czech Republic, Ireland, the Netherlands, Portugal and the United Kingdom, provide childcare and specific sessions on parenting skills together with drug treatment. In several countries, such as Belgium, the Czech Republic, France, Italy, Malta and Portugal, therapeutic communities have special provisions for mothers or parents with children. In Luxembourg, a collaboration network involving services for the psychomotor rehabilitation of children, family social services, homes for women and children, hospitals and schools has been set up.

Prison sentences are particularly difficult for drug-using mothers; often, their children are placed in foster homes, but several countries (the Czech Republic, Ireland, Hungary, Slovakia and Sweden) report that assistance is given to maintain the emotional bonds between mother and child. One prison in Belgium has a special unit for mothers with children up to two and a half years old. There is at least one prison in Portugal with a special unit for mothers with

children under four years old; in Slovakia, pregnant women and mothers of children less than one year old cannot serve a prison sentence.

Although there is usually a focus on motherhood — often in the absence of a stable partner — one Swedish study has looked at the importance of fatherhood for addicted men. Many of these fathers want to take part in raising their children, but the social authorities see them only as addicts, even though they consider the fathers to be important in their children’s lives.

Interventions in the criminal justice system

Although there are far fewer female than male prisoners, with women making up between 2 % and 8 % of the prison population in Europe, this is not to women’s advantage. Women prisoners are often placed in a unit that is annexed to a male prison, and there may often be a lack of services specifically targeted to women’s needs in areas such as medical services, treatment of drug dependency, work and training. This is reflected in the information available to the EMCDDA, with reports revealing that only four countries (France, Portugal, Slovakia and Sweden) have projects specifically for drug-using female prisoners.

Quartier Intermédiaire Sortantes

The Quartier Intermédiaire Sortantes is a pre-release unit for female prisoners with drug-use-related problems from three French prisons (Fleury-Mérogis, Versailles and Fresnes). Based at Fresnes, near Paris, it was established in 1997 and prepares prisoners with drug and/or alcohol problems who are in the last month of imprisonment for life after release. The day programme is voluntary and run jointly by internal and external staff, who provide information and advice on a variety of topics, including health issues (e.g. health promotion, healthcare, harm reduction/transmission of STDs, body awareness) and support networks (e.g. re-establishing links with family and children; agencies that offer support to sex workers) as well as training in the day-to-day skills required for life outside prison (household tasks, cooking, managing finances). The use of external experts in this programme is strongly geared to creating links that the women can use on their return to the community. The services provided at QIS are funded by the Direction Générale de la Santé and by the MILDT (Interdepartmental mission for the fight against drugs), and are currently under evaluation. Promising results were achieved during the first two years of operation: only 10 % of women who attended the programme, compared with 40–50 % of the rest of the prison population, returned to prison.

⁽²⁹⁾ <http://www.vulnerablepeople.org/>

⁽³⁰⁾ www.venetosociale.it

Harm reduction approaches to female problem drug users

There is a trend among low-threshold agencies to reorient their services and opening hours to respond better to the needs of female problem drug users. Specialised low-threshold agencies providing health promotion services to female problem drug users, and targeting sex workers in particular, are reported by Belgium, Germany, Greece, Luxembourg, the Netherlands and Finland. This work usually takes the form of street outreach services to provide information and advice, particularly about safer sex, but also to distribute sterile injecting equipment, condoms and lubricants and to make referrals to other health, social and treatment services. There is some provision, although much less, of such health promotion services to male sex workers, but these services are not usually targeted specifically at drug users.

Conclusions

There are marked differences between the genders in almost all aspects of the drug phenomenon. Males far outnumber females among drug users in all European countries and for most types of drugs. Similar findings are reported in other regions of the world, and in terms of numbers men remain the major consumers of both illicit drugs and services for those with licit drug problems.

Some indications of a narrowing gap between men and women in drug use have recently been reported, in particular among younger people in higher prevalence countries. However, a narrowing of the gender divide is not generally apparent in other data sets, and this remains an important area for further scrutiny and research. Certainly, it would be a worrying observation if women were beginning to adopt the same drug consumption patterns as men, as this would result in a considerable expansion of both the size of the European drug problem and the demand for services.

From the European data presented here, we can identify some overall patterns of differential participation in drug use between the genders. Southern countries tend to report higher male to female ratios than do countries in the north of Europe. The highest proportions of men are found among users of cannabis and cocaine, and the highest proportions of women among users of tranquillisers, sedatives and pharmaceutical drugs, and this is generally reflected in the data on the population in drug treatment.

Far more males than females die as a result of drug use. However, there are signs that the moderate overall decrease in drug-related deaths observed since 2000 is more marked among males than it is among females. The reasons for

this are unclear but there is clearly a need to ensure that intervention measures targeting drug overdose are sensitive to the needs of both genders.

Research evidence has suggested that barriers may exist to service uptake by women and that addressing childcare issues is an important element of developing women-friendly services. Women appear to be more likely to access treatment earlier in their drug-using career. Why this is the case remains unclear, although for some women pregnancy and motherhood can be strong motivators for entering treatment and reducing or quitting the use of drugs, again emphasising the importance of this issue in considering treatment opportunities for women.

The proportions of male and female drug users testing positive for hepatitis C are similar, although HIV seroprevalence is higher among female (20 %) than among male drug users (13 %). Females represent between 9 % and 15 % of drug law offenders in the European countries, but there are indications of an increased involvement of women in drug-related crimes in recent years. Social exclusion affects more women than men, with female drug users suffering from twofold discrimination both as drug users and as women.

Even though growing attention is being paid to specific gender needs in drug-related interventions, in practice, gender-specific prevention projects are the exception rather than the rule.

Gender-specific treatment is usually targeted at pregnant drug users and women with children. In most, but not all, European countries there is at least one treatment unit for women only. Drug users in prisons have access to gender-specific resources in only a few countries. Harm reduction agencies in several countries are implementing interventions that specifically target female drug users, especially in the context of their involvement in sex work and related individual and public health risks.

Although drug use has often been treated as a non-gender-specific issue, data show that prevalence of drug use, problem drug use and related health and social consequences differ greatly between the genders. Men and women characteristically have different histories of drug use, from initiation to exit. The reasons for those differences are complex and are related to a mix of social, physiological and personal factors.

Further research is clearly needed to describe and interpret the role of gender in drug use and its associated problems. As a starting point, policymakers, professionals and scientists must always take gender into consideration in the planning of research, analysis, interventions and policy in this field.

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Selected issue 3

Developments in drug use within recreational settings

Introduction

Background

Drug use and the recreational activities of young people have been linked ever since the concept of youth culture emerged in the 1960s. Research over the past two decades has shown that the prevalence of drug use in dance music settings is significantly greater than in the general population. It is such dance music settings that are the main focus of this selected issue.

The emergence of the electronic ⁽¹⁾ dance music scene in parts of Europe during the late 1980s and 1990s brought with it an increase in the availability and consumption of 'dance drugs' such as ecstasy (MDMA) and amphetamines. Initially this development was at the expense of alcohol sales as early electronic dance music events were characterised as alternatives to the mainstream licensed pubs and clubs of the time. However, the drinks manufacturing and marketing industries have tapped into the lucrative dance music market and contributed to its expansion, opening it up to different social groups, especially young women. New alcoholic drinks with distinctive designs are targeted at the youth market, leading to concerns about excessive alcohol consumption in these settings, particularly when taken in combination with illegal drugs.

In the European Union, high densities of dance music venues are found in cities where there are many young people with disposable income. Furthermore, the Schengen Agreement ⁽²⁾ has opened internal borders within the EU; this, together with cheap travel options both between and within EU countries, appears to have stimulated developments in the dance music industry (Tosman et al., 2001; Bellis et al., 2003; Hollands and Chatterton, 2003; Measham, 2004; Sumnall et al., 2004; Dutch national report, 2005; Salasuo, 2005; Nutt, 2006).

Scope

The range of potential targets for discussion on drug use in recreational settings is almost inexhaustible. To narrow the

scope of the selected issue and provide a practical focus, selection criteria were adopted for the settings and the drugs to be included.

Recreational settings

Research studies targeted at young people in the EU who attend dance music events consistently report much higher prevalence of drug use than are found in surveys of the general population. Drug prevalence levels reported from surveys conducted in a dance music setting inevitably vary according to the type of setting, the type of music played, the target group and also the year in which the survey was conducted. Dance music settings across the EU are increasingly heterogeneous, especially since the enlargement of 2004. A setting that may be characterised by a specific music style or client group at one point in time may change or cease to exist. For example, many of the very large dance venues popular in the 1990s and early 2000s have now closed down, while, during the same period, many new, smaller, clubs have opened and a wide range of small esoteric festivals has developed. In general, dance music culture is even more fragmented now than in the past.

The changes taking place in target settings, combined with the heterogeneity of the settings, presents difficulties for monitoring the situation and developing comparable drug surveys. Changes in music styles and clientele quickly render methods for comparing drug use in such settings obsolete. Because of this, drug surveys conducted in targeted recreational settings cannot form a representative sample of those who spend time in such varied settings. Moreover, comparisons between surveys can be made only with the utmost caution as the age and gender distribution of survey respondents as well as variations in the setting may partly explain observed differences.

Most of the drugs research conducted in this field has targeted two broad categories of recreational setting. One comprises large music festivals attracting thousands of visitors. The other comprises raves and dance parties as well

⁽¹⁾ Electronic music is a term for music created using computer systems and other electronic devices.

⁽²⁾ The Schengen Agreement is named after the town in Luxembourg where the agreement was signed in 1985, and is aimed at creating a European 'territory without internal borders'.

as smaller clubs, discotheques, lounges, dance bars and nightlife areas.

Several research studies have categorised drug prevalence in terms of association with specific genres of electronic music. Ecstasy is the substance most widely and generally associated with techno music. However, in Greece, it is also associated with trance music and in Hungary and Slovakia, techno music is also associated with amphetamines. Research in Germany and the Netherlands has identified cannabis as the predominant substance found in the reggae/hip-hop scene. However, cultural differences in music genres and their definitions limit the possibility for robust between-country comparisons.

In-depth qualitative research with drug users who spend time in dance music settings has identified and described drug taking in illegal, 'underground' or 'free party' settings and in private pre- and post-club settings (Polish and French national reports). However, research on drugs use in private and illegal settings is so limited that it must remain outside the scope of this selected issue.

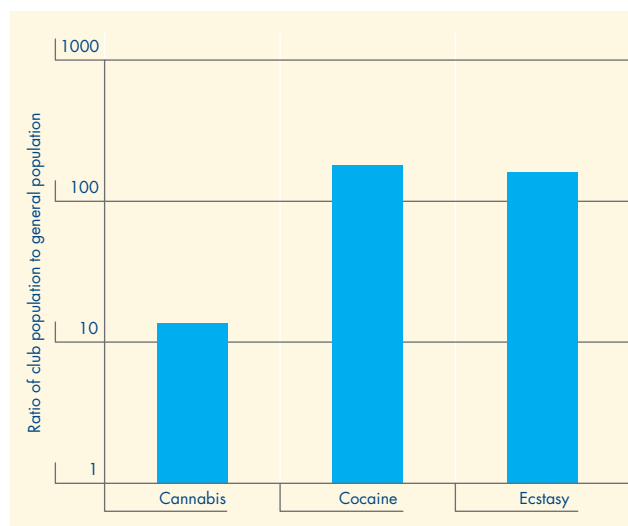
Internet

Another area for research related to settings for recreational drug use is the numerous Internet websites, forums and chat rooms that play an increasingly large part in the exchange of information about recreational drugs. Current estimates of Internet use hover around 650 million users⁽³⁾ and about 3.9 million hosts worldwide. Along with the rapid growth of the Internet, the opportunity for drug users and potential drug users across the EU to access the information needed to produce, cultivate, purchase or sell drug products or to exchange information on drug-using experiences has increased correspondingly.

Drugs

For the purpose of this selected issue, the prevalence and patterns of use of stimulant drugs — ecstasy, amphetamine and cocaine — will be explored. It is in dance music settings that most research on recreational drug use has been conducted and, according to the research literature, it is these drugs that are most associated with these settings. An example from France shows that cannabis users are over 10 times more likely to be found in dance music settings than in the general population, and ecstasy and cocaine users are over 100 times more likely to be found in such settings (Figure 1). For similar reasons, prevalence estimates for the use of hallucinogenic drugs (LSD and hallucinogenic, psilocybin-containing mushrooms), ketamine and GHB are also included in this selected issue.

Figure 1: Comparison of last month use of cannabis, cocaine and ecstasy among the electronic music club population in France and general population of young adults (15–24 years) (odds ratio)



NB: A ratio of 1 signifies equality. The odds ratio indicates the increased likelihood of finding drug users in the club population compared with the general population. Caution advised as the club surveys were conducted in 2004 and the general population surveys were conducted in 2000. Odds ratios may have been less if both types of survey were conducted during the same year.

Source: Reitox national reports.

Prevalence and patterns of drug use

Since 1998, 18 Member States have reported the results of research studies conducted in or associated with dance music settings. The methods used for conducting these surveys vary in a number of respects that should be kept in mind when making comparisons between countries and surveys. Sample sizes range from seven in-depth interviews with ecstasy users in Malta to 2 800 respondents in 43 different settings in France (Table 1). Types of setting also vary. Studies conducted to date have included large music festivals that attract up to 200 000 people as well as relatively small mainstream dance clubs. Geographical locations vary: some studies are city based (e.g. Amsterdam, Athens, Berlin, Bologna, Budapest, Madrid, Paris, Prague, Riga, Rome, Vienna, Vilnius, Vicenza) and some are regional (e.g. the French- and Flemish-speaking communities in Belgium, south-east England). Some EU Member States have attempted a form of national coverage of dance music settings (the Czech Republic, France, Hungary, the Netherlands, Austria and Sweden). In addition, a dance music magazine in the United Kingdom provides trend data based on a readership survey conducted annually since 2000 (*Mixmag* drugs survey).

⁽³⁾ <http://www.internetworldstats.com/stats.htm>

Table 1: Drug studies and surveys conducted in dance music settings in Europe that provide the data and information reported in this selected issue

Member State	Year survey conducted	Sample size	Brief description
Belgium	2000–04	1 000 per year (average)	38 rock festival events in French community in 2004
	2003	645	VAD trend study in party/club settings in Flemish community
	2001	n.a.	Two large events in Ghent
Czech Republic	1998	505	Techno party scene, Prague
	2003	1 652	Dance parties
Germany	1998	501	Techno party scene, Berlin
Greece	1998	305	Trance, house, rock and local music scenes in Athens
Spain	1998	500	Techno party scene, Madrid
France	2003	2 800	43 Parisian venues attended largely by homosexual men
	2004–05	1 496	GRVS/OFDI electronic music survey
Ireland	1990s	20	In-depth interviews with ecstasy users
	1990s	10	In-depth interviews with recreational cocaine users in private settings
Italy	2003	300	People in recreational settings in Rome and Vicenza
	2004	2 015	Very large festivals in Bologna, Imola and Arezzo
	2004	590	Street rave parade, average age 24
Latvia	2000	400	Riga
Lithuania	2000	290	Vilnius and Kaunas
Hungary	2003	1 059	Party scenes
	1999	1 507	Clubbers in Budapest and four other big cities
	1997	373	Discos, parties and club settings
Malta	2001	7	In-depth study of ecstasy users in Malta
	2002	16	Study of ecstasy users in Malta
Netherlands	1998–2005	Approx. 400	Amsterdam nightlife surveys
	2001–02	490	Rave parties in the Netherlands
	2003	431	Party scene in the Hague
	2003–05	n.a.	Expert 'grass root' panel
Austria	1998	505	Techno party scene, Vienna
	2001, 2003	838	ChEckiT
		110	Three dance music scenes (Drum'n bass, Freetekno and Goa)
Slovakia	2005	227	Participants at three large music festival (Pohoda, Hodokvas and Be Free)
Sweden	2004	n.a.	Interviews and observation at two major music festivals
	2004	129	Four comparable projects in club scene in large cities
United Kingdom	2000–05	834 (average)	Annual <i>Mixmag</i> surveys
	2000	760	Clubbers attending six mainstream clubs in south-east England, including one gay one
Norway	2004	n.a.	Research in Oslo

NB: n.a., data not available.
Methodology: Comparisons between surveys conducted in dance music settings should be made with the utmost caution as variations in the age and gender distribution of survey respondents and in survey methods, settings and countries may partly explain observed differences. The main purpose of presenting data from such surveys is to illustrate that, without exception, they all render higher prevalence estimates for drug use than those obtained from general population surveys among young adults (aged 15–34 years).

Sources: Reitox national reports.

Methodology

Site sampling, in which samples are taken from a location that is commonly visited by individuals displaying a target behaviour, is a technique used in the social sciences to generate samples that would be more costly or difficult to generate by other means. However, it should be noted that these samples cannot be regarded as representative in any statistical sense. Respondents are often self-nominated, and the representativeness of the individuals attending the event selected for study cannot be assumed. Comparability between samples from different sites is usually poor, and drawing comparisons between different site surveys must be done with caution. Factors to be borne in mind include the fact that the settings that are targeted by drug studies are those in which drug use is perceived to be high. In addition, different studies may employ different instruments and methods. Differences in age,

gender, income and other lifestyle-related variables complicate comparisons, as do social, cultural and geographical differences both between and within countries. Nonetheless, surveys conducted in dance music settings provide a useful window on a group that is often poorly visible in other data sources and confirm that levels of some types of drug use are high in these settings. Thus, they provide valuable information on a group that is clearly appropriate for informing the targeting and development of prevention and risk reduction initiatives. Furthermore, looking at behaviour over time in these sorts of targeted samples can provide important clues on general trends and new developments in drug use in recreational setting, even if conclusions need to drawn with caution and verified against other data sources. Magazine and Internet surveys are also used to understand a target behaviour. These surveys require similar cautions.

Despite the described variability in drugs research conducted in dance music settings in the EU, a common feature of all of the studies is that the reported prevalence levels for most forms of drug use are considerably higher than those reported in general population surveys.

and the United Kingdom reported rates of lifetime prevalence of cocaine use of over 60 %.

With regard to gender differences there is a progressive increase in male to female ratios for lifetime experience of drug use with increasing age. Gender ratios for lifetime

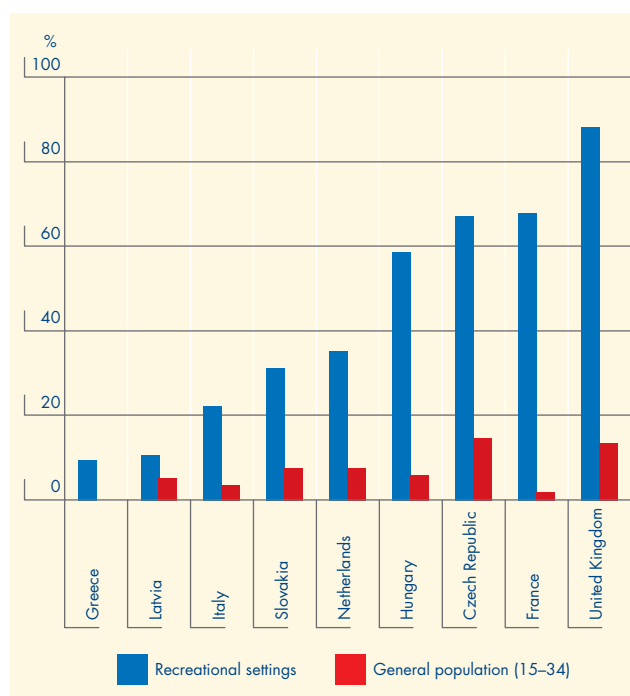
Lifetime prevalence estimates of 'club drugs'

Stimulant drugs

Figure 2 shows that ever in lifetime prevalence of ecstasy use among people surveyed in dance music settings in nine different countries ranged from 9 % in Athens in 1998 to 88 % of respondents of a dance music magazine survey conducted in the United Kingdom in 2003. Lifetime prevalence levels of ecstasy use of over 50 % have been reported in targeted surveys from the Czech Republic, France, Hungary, the Netherlands and the United Kingdom, compared with prevalence levels of 11 % or below reported in Greece and Latvia.

Lifetime prevalence of amphetamine use, surveyed in eight countries, ranged from 6 % in Athens to 74 % in the United Kingdom magazine survey. Figure 3 shows that the countries with the highest prevalence of amphetamine use are broadly the same as those with the highest prevalence rates for ecstasy. Chapter 4 of the EMCDDA 2006 annual report describes the general population trends for these two drugs, suggesting that ecstasy has gradually replaced amphetamine use in a number of EU Member States. Research in targeted settings indicates increases in the use of cocaine, and it has been suggested that, in the Netherlands, cocaine may be becoming a favoured drug for use in dance music settings. Among seven countries reporting the results of surveys targeted at dance music settings, lifetime prevalence of cocaine use ranged from 10 % in Athens to 75 % in the United Kingdom magazine survey (Figure 4). France, Italy

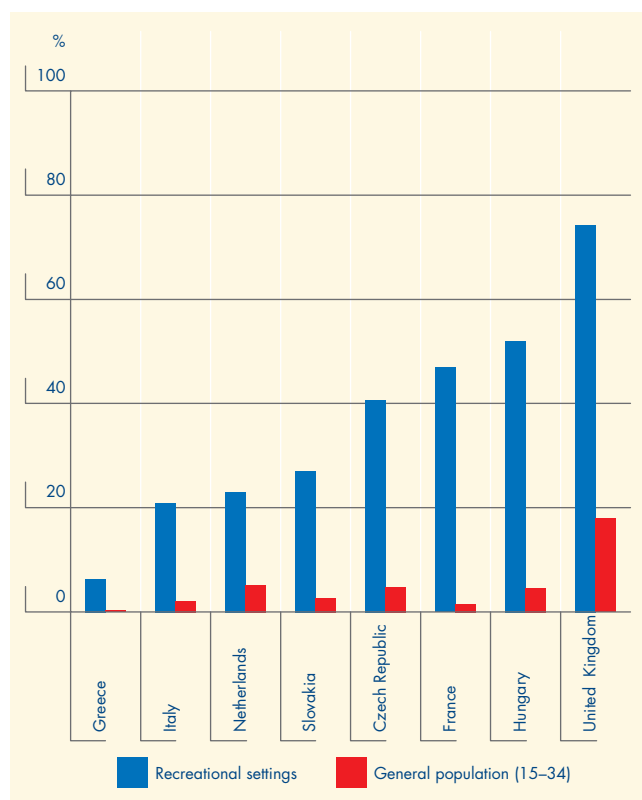
Figure 2: Prevalence of ever in lifetime use of ecstasy in surveys carried out in club settings and among the general population



NB: Estimates for recreational settings are based on non-probability samples using a variety of methods and sampling frames. Prevalence of drug use among the broader population of clubbers cannot be inferred from these samples. General population survey estimates based on young adults (15-34 years). Most surveys were conducted in 2003-04 except: Greek club survey in 1998, French general population survey in 2000 and Netherlands general population survey in 2001. See Table GPS-9 in the 2006 statistical bulletin for further information about the general population surveys.

Sources: Reitox national reports; Korf et al. (2004); McCambridge et al. (2003).

Figure 3: Prevalence of ever in lifetime use of amphetamines in surveys carried out in club settings and among the general population



NB: Estimates for recreational settings are based on non-probability samples using a variety of methods and sampling frames. Prevalence of drug use among the broader population of clubbers cannot be inferred from these samples. General population survey estimates based on young adults (15–34 years). Most surveys were conducted in 2003–04 except: Greek club survey in 1998, French general population survey in 2000 and Netherlands general population survey in 2001. See Table GPS-9 in the 2006 statistical bulletin for further information about the general population surveys.

Sources: Reitox national reports; Korf et al. (2004); McCambridge et al. (2003).

prevalence of ecstasy use increase from a range of 0.5–2.0 among 15- to 16-year-old school students to a range of 1.0–6.0 among all adults (see the selected issue on gender for further details). It has been suggested that the higher prevalence among female than among male school students found in some countries is the result of 15- to 16-year-old female school students socialising in dance music and other recreational settings with older males.

Hallucinogenic drugs

Prevalence estimates for ever in lifetime use of LSD of 45 % in the Czech Republic (Figure 5) and of lifetime use of magic mushrooms of 55 % in France (Figure 6) are the highest reported rates of use of hallucinogenic substances. In-depth studies with users show that regular use of hallucinogenic substances is relatively uncommon and significantly less prevalent than regular use of stimulant drugs.

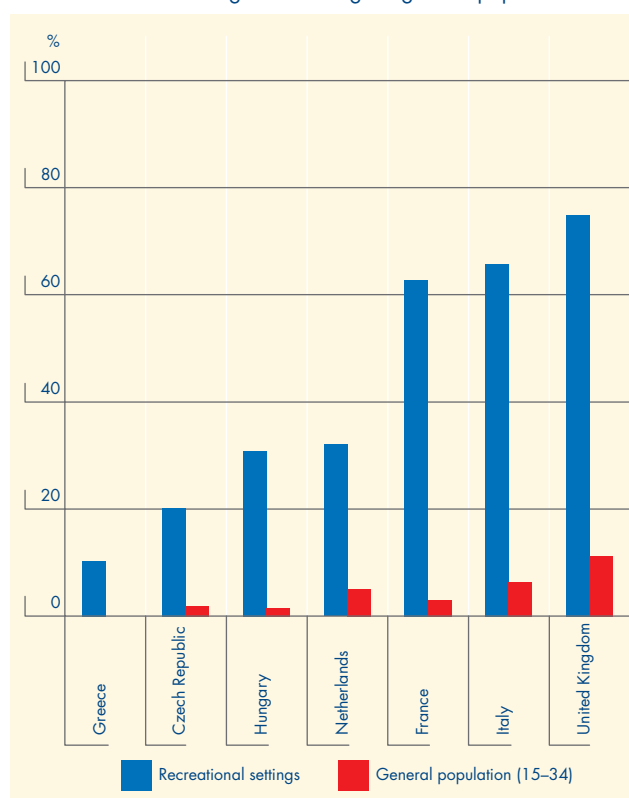
GHB and ketamine

Less widely used than ecstasy, GHB and ketamine are nevertheless substances whose use has increased during the

past five years, to the extent that estimates of their prevalence levels are significant in the dance music scene in some Member States. Dance music surveys in five countries have reported prevalence estimates for ever in lifetime use of GHB, ranging from 5.6 % in the United Kingdom to 17.4 % in the Netherlands. Seven countries provided data for lifetime ketamine use, ranging from 6.7 % in the Czech Republic to 20.9 % in Hungary (Table 2).

Differences between countries for lifetime prevalence of the use of ecstasy, amphetamines and LSD in recreational settings generally reflect the differences in prevalence reported by general population surveys. However, it should be noted that surveys targeted at dance music settings are not based on representative samples, and reported estimates of prevalence often vary between different surveys within the same country. For example, a survey conducted among 760 ‘clubbers’ in the south-east of England in six different nightclubs in 2000 reported 52 % lifetime prevalence for ecstasy use, whereas another survey conducted during the same year by a United Kingdom clubbers’ magazine (*Mixmag*) reported a lifetime prevalence of 96 % for ecstasy

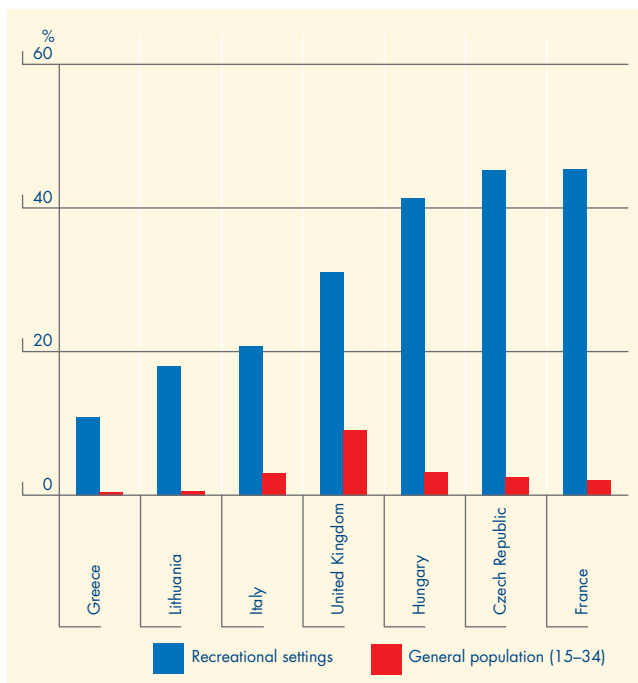
Figure 4: Prevalence of ever in lifetime use of cocaine in surveys carried out in club settings and among the general population



NB: Estimates for recreational settings are based on non-probability samples using a variety of methods and sampling frames. Prevalence of drug use among the broader population of clubbers cannot be inferred from these samples. General population survey estimates based on young adults (15–34 years). Most surveys were conducted in 2003–04, except: Greek club survey in 1998, French general population survey in 2000 and Netherlands general population survey in 2001. See Table GPS-9 in the 2006 statistical bulletin for further information about the general population surveys.

Sources: Reitox national reports; Korf et al. (2004); McCambridge et al. (2003).

Figure 5: Prevalence of ever in lifetime use of LSD in surveys carried out in club settings and among the general population



NB: Estimates for recreational settings are based on non-probability samples using a variety of methods and sampling frames. Prevalence of drug use among the broader population of clubbers cannot be inferred from these samples. General population survey estimates based on young adults (15-34 years). Most surveys were conducted in 2003-04 except: Greek club survey in 1998 and French general population survey in 2000. See Table GPS-9 in the 2006 statistical bulletin for further information about the general population surveys.

Sources: Reitox national reports; Korf et al. (2004); Deehan and Saville (2003).

use. Similarly, the south-east of England survey reported 46 % lifetime prevalence for cocaine use compared with 76 % in the *Mixmag* survey.

Last month prevalence of 'club drugs'

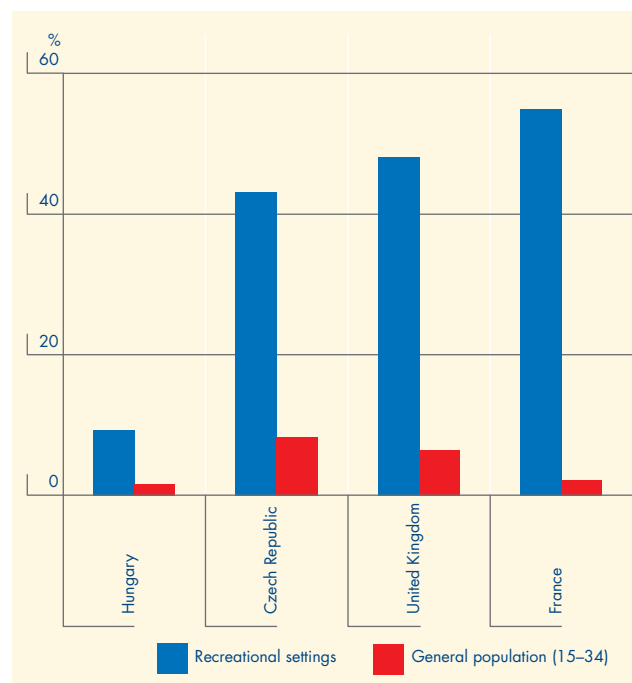
Last month prevalence is generally taken as a measure of current drug use and is considered a better indicator of potential problem drug use than lifetime prevalence, although between-country differences in both lifetime and last month prevalence generally follow similar patterns. Last month prevalence as a proportion of lifetime prevalence varies for different substances. For example, estimates of last month prevalence of ecstasy use reported in dance music surveys in five countries are close to half of those for lifetime prevalence, whereas last month prevalence of amphetamine use is considerably less than half of lifetime prevalence in most countries reporting dance music surveys (Figure 7). This appears to support suggestions that ecstasy is currently favoured over amphetamines in these types of settings. For more details about the use of these two substances, see Chapter 4 of the EMCDDA 2006 annual report. Data on last month prevalence of cocaine use, provided by six countries, reveal a more mixed picture (Figure 7).

Prevalence of crack cocaine use is, generally, very low in dance music settings, which tend to cater largely for socially integrated young people. The strong separation of the (mainstream) powder cocaine scene from the (marginalised and problem) crack cocaine scene is demonstrated in data from the recent United Kingdom *Mixmag* survey. According to the 2004 *Mixmag* survey, nearly half (47.5 %) of respondents had used powder cocaine during the month prior to the survey, compared with only 3.4 % who had used crack cocaine. Ireland reported that cocaine is more likely than ecstasy to be used in private.

Trends

Data on trends from research targeted at dance music club surveys are very limited and not as robust as those derived from general population surveys. However, these surveys serve to highlight and describe patterns and emerging trends in drug use that are needed for designing appropriate responses. Examples include the Austrian ChEckIT studies, which report a significant increase in the use of cannabis, ecstasy, cocaine, ketamine and magic mushrooms. Trend data in the French-speaking community in Belgium show no major changes except for a decrease in last month

Figure 6: Prevalence of ever in lifetime use of hallucinogenic mushrooms in surveys carried out in club settings and among the general population



NB: Estimates for recreational settings are based on non-probability samples using a variety of methods and sampling frames. Prevalence of drug use among the broader population of clubbers cannot be inferred from these samples. General population survey estimates based on young adults (15-34 years). Most surveys were conducted in 2003-04 except the French general population survey in 2000. See Table GPS-9 in the 2006 statistical bulletin for further information about the general population surveys.

Sources: Reitox national reports; EMCDDA (2006).

Table 2: Lifetime prevalence of use of GHB and ketamine in dance music surveys

	GHB, lifetime prevalence of use (%)	Ketamine, lifetime prevalence of use (%)
Belgium	13	n.a.
Czech Republic	6.7	6.7
France	n.a.	16.4
Italy	n.a.	10.8
Hungary	5.9	20.9
Netherlands	17.4	n.a.
United Kingdom	5.6	17.0

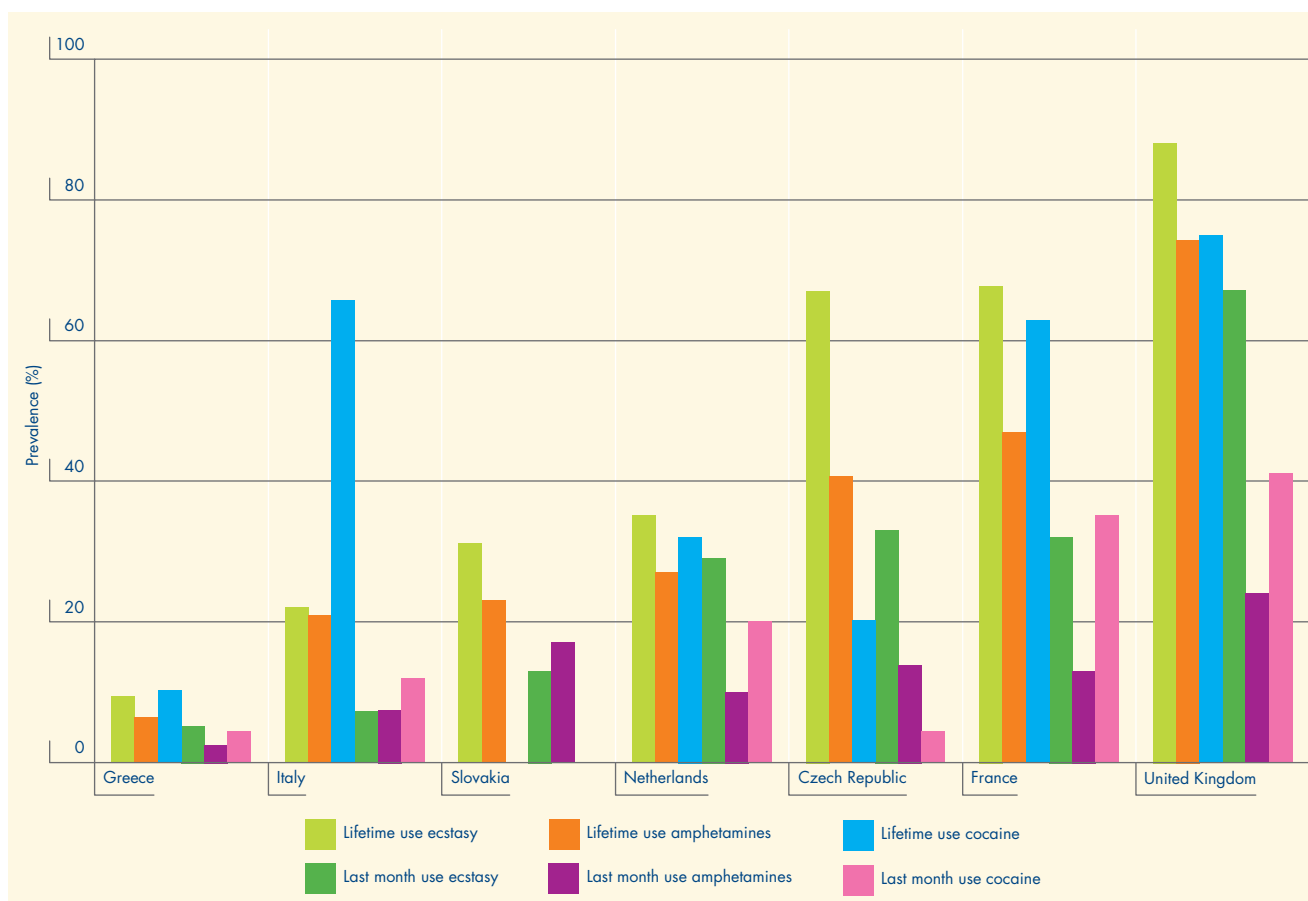
NB: n.a., data not available.
Sources: Reitox national reports.

prevalence of LSD use. Reports from Amsterdam suggest that last year and last month use of ecstasy and cocaine decreased by 20 % and 10 % respectively between 1998

and 2003 (Dutch national report). It is of note that the average amount of ecstasy used on each occasion also declined in this period, whereas the average amount of cocaine used on each occasion increased. Furthermore, a qualitative trend watch study in the Netherlands suggests that the popularity of cocaine has increased and its use has become normalised among some sectors of young people. Five-year trends reported by the annual United Kingdom *Mixmag* music magazine readership survey show that, despite an apparent reduction in the prevalence of ecstasy use during the last month, the proportion of heavy users (defined as taking usually more than four pills per session) more than doubled between 1999 and 2003 (McCambridge et al., 2005). Increasingly intense use of ecstasy and polydrug use by experienced ecstasy users is also reported in a United Kingdom Internet study (Scholey et al., 2004). Increased consumption of tablets in one session may be related to a reduction in price (see also 'Drug availability, purity and prices', p. 46).

The average quantity of cocaine consumed in one session, according to surveys carried out, was nearly half a gram in

Figure 7: Prevalence of ever in lifetime use and last month use of ecstasy, amphetamines and cocaine in dance music populations



NB: Estimates for recreational settings are based on non-probability samples using a variety of methods and sampling frames. Prevalence of drug use among the broader population of clubbers cannot be inferred from these samples.
Sources: Reitox national reports; Korf et al. (2004); McCambridge et al. (2003).

the United Kingdom in 2004 and over one third of a gram in the Netherlands in 2003.

Because there is much concern about the use of illegal drugs among young people in dance music settings, less media attention has been paid to alcohol. However, the consumption of alcohol in such settings, often in quantities considered hazardous to health (Parker et al., 1998), and in combination with stimulant drugs, is a growing cause for concern. For example, a recent editorial in the *Journal of Psychopharmacology* highlights the fact that alcohol contributes to 22 000 premature deaths per annum in the United Kingdom at a cost to society of EUR 27 billion (Nutt, 2006).

Risk factors for drug use in recreational settings

There is a social process that young people who take drugs must go through. The process generally begins with hearing positive reports about a drug and being able to observe other young people using it. After this the person may try the drug. If the experience is positive, drug use may be repeated. Certain attributes of the drug itself play a significant part in the process whereby young people start to take it in recreational dance music settings. These include how easy it is to try, how easy it is to observe others using it, what the relative advantages and risks are and how compatible its use is with other valued aspects of social life (e.g. people who smoke cigarettes are more likely to smoke cannabis than those who do not smoke cigarettes) (Golub and Johnson, 1996; Ferrence, 2001).

The significantly higher prevalence of drug use reported in targeted dance music club surveys compared with the general population suggests that dance music settings may constitute a risk to young people who spend time in them by exposing them to drugs. However, the higher than average prevalence of drug use in these settings should be interpreted with caution as interrelated factors such as age, marital status and other individual factors strongly influence prevalence. Work conducted in the United Kingdom on general population data identified age and gender as the factors that are most significantly associated with class A drug use in the previous year. Visiting nightclubs was next in terms of its association with drug use. The high prevalence of drug use found in dance music settings may simply be because clubbers tend to be young and single. In the Netherlands, use of ecstasy has been most closely linked to dance parties attracting younger age groups whereas cocaine has been linked to clubs attracting older age groups.

It is important to note that, for the majority of young people across the EU, drug use is still not necessarily an integral

element of dance music settings. For the majority it is the music, the social aspects and the use of alcohol that form the most integral experiences in these settings.

Another factor to consider in relation to the high prevalence estimates obtained from surveys in recreational music settings is that experimenting with drugs is often associated with brief periods in an individual's life. The findings of research conducted in Spain, Sweden and the United Kingdom suggest that young people holidaying abroad do not behave in the same way as they do at home. A United Kingdom survey conducted in Ibiza airport found that individuals who had never used illegal drugs at home started using them whilst on holiday in Ibiza (17.4 and 33.1 per 1 000 people were introduced to cocaine and ecstasy use, respectively, in Ibiza) (Bellis et al., 2003). Among those individuals who were already using drugs in the United Kingdom, frequency of use was significantly higher during the holiday period — 7 % reported using ecstasy on five or more nights per week while in the United Kingdom compared with 37 % while in Ibiza. Furthermore, Spain reported that recreational drug use was highest among the high concentrations of young people on the Mediterranean coast where there are many tourists. Swedish research found that, of the young people who had tried illegal drugs, 23 % did so for the first time while abroad. Sweden reports a shift in attitudes among young Swedish travellers towards a more permissive stance and a relaxing of restrictive values with travel. In addition, it is reported that party cruises, associated with high levels of drug use, have sprung up in Sweden.

A large body of research shows that drug use in general is linked to specific individual and social factors. In recreational settings, for example, a proportion of young people may be categorised as greater than average risk-takers, and it is those 'risk-takers' who are most likely to try different drugs (Austrian national report). Norway reported that homosexuals may be at greater risk than heterosexuals in regard to drug taking. A range of individual and social risks for developing problematic or intensive patterns of drug use have been identified (Bobes and Saiz, 2003), but these are outside the scope of this selected issue.

Drug availability, purity and prices

Drug use prevalence data from studies conducted in dance music settings are almost always based on self-reported use. However, young people in these settings often have no definitive way of knowing what the contents of tablets and powders are. A common concern about the use of drugs in dance music settings is the risk of a young person inadvertently purchasing and using a highly toxic substance which has been sold as ecstasy or cocaine, for example.

Chapters 4 and 5 of the EMCDDA annual report provide detailed EU information on the price and purity of ecstasy, amphetamines and cocaine. Generally, in Europe, most tablets sold as ecstasy contain MDMA or another ecstasy-like substance (MDEA, MDA), usually as the only psychoactive substance present. The MDMA content of ecstasy tablets varies greatly between batches. In 2004, the average content of active substance (MDMA) per ecstasy tablet was reported to range from 30 to 82 mg ⁽⁴⁾. In the United Kingdom, a system to address the purity of drugs used in dance music settings has been established. Substances that are discarded in 'amnesty bins' located at the entrances of clubs and music festivals have been analysed. Tablets containing only MDMA (ecstasy) were found to account for 94 % and 84 % of the total discarded tablets in London and Manchester respectively. The most common drugs found in powders in London and Manchester were cocaine (29 % and 40 % respectively), amphetamine (25 % and 26 %), ketamine (19 % and 20 %) and MDMA (19 % and 11 %) (Kenyon et al., 2005).

The Netherlands also has a system in place to monitor samples of drugs used in recreational settings (DIMS). Some alarming new ingredients have been reported as well as higher doses of psychoactive substances than in previous years. For example, atropine was found in several samples of cocaine; this discovery led to a large-scale warning.

A study conducted in dance music settings in Rome and Vicenza attempted to correlate self-reported drug consumption with that assessed by the analysis of hair samples. The results appeared to confirm the veracity of self-reported drug use.

The most recent available data on the price of drugs used in dance music settings indicate that, although prices for ecstasy (EUR 3 to EUR 25 per tablet), amphetamines (EUR 4 to EUR 64 per gram) and cocaine (EUR 41 to EUR 100 per gram) vary considerably across Europe, in each case the general trend in price is downward.

Role of the Internet

Increasing concern is being expressed about the role of the Internet in both the supply and promotion of drugs for use in dance music and other recreational settings (Maltese national report).

Up-to-date, systematic assessments of representative samples of drug-related websites are resource-intensive and scarce. An exception is the Psychonaut 2002 Project, involving nine EU Member States, which systematically searched the Internet for websites with contents related to different drugs of abuse, including recreational drugs. A total of 1 633 unique

websites were identified, of which 41.4 % were identified as 'private interest' (commercial or personal) websites, and which typically reported either self or others' accounts of experiences taking drugs and/or offered different items for sale (Schifano and Deluca, 2005).

The Internet allows for fast global contact with growing numbers of individuals and groups and has become a virtual setting for information exchange for many individuals who are interested in psychoactive drugs. The number of such sites is unknown. However, a simple search via the search engine Google allows easy identification of sites that offer information about recreational drug use. The most common Internet-mediated communication technologies used for such exchange are discussion forums (or web forums, message boards) and chat rooms.

Internet forums, chat rooms and websites

The basic characteristic of a forum is that it enables people to start discussion threads and reply to other people's threads. Someone posts a message which is visible to everyone, other people can read it and then they have the option of posting a reply which will also be visible to everyone; in this way, a discussion can develop without all users having to be online at the same time. Intrinsic to Internet forums and chat rooms are problems of identity and motive. The real characteristics and origin of the authors are unknown, and the motivations for posting such messages cannot be ascertained. For example, messages may be posted by drug prevention workers seeking to engage with drug users or by individuals with commercial interests.

Chat rooms are usually real-time interactive, text-based discussion systems delivered via a networked computer chat server. Forums and chat rooms concerned with legal and/or illegal drugs can be classified as anti- or pro-drugs. Anti-drug sites are frequently added features of online drug prevention sites or treatment-related forums and clearly state their objectives. For example, anti-drug chat rooms and forums often set up rules for posting messages such that the exchange is not used for the promotion of drug use and/or sale of drugs (e.g. www.drugcom.de). These rules are often enforced by forum administrators, who have the ability to edit, delete, move or otherwise modify any thread on the forum.

Pro-drug sites or sites that are not explicitly drug prevention sites are often linked to online retailers selling legal alternatives or sites promoting the legalisation of specific drugs and/or simply document users' exchanges. They provide a wide range of drug-related information, such as consumption techniques, drug recipes, user reports, overviews on the legal situation, etc. Forums or chat rooms

⁽⁴⁾ This range is based on data from a few countries only, namely Denmark, Germany, France, Luxembourg and the Netherlands.

often focus on a single drug or group of specific drugs (e.g. <http://boards.cannabis.com/>, <http://www.sjamaan.com/forum/default.asp>), or are primarily targeted at clubbers, who also have the opportunity to exchange drug-related information (e.g. <http://www.clubdogma.com>).

Marijuana appears to be the most common drug promoted on websites offering drug-related information exchange. However, information about stimulants and other drugs used in dance music settings, such as ecstasy, LSD and magic mushrooms, is also commonly exchanged via the Internet (e.g. <http://ecstasy.org>). The use of ecstasy is promoted, and many Internet sites and bulletin boards allow users to discuss their experiences. Club or party sites often provide descriptions of side-effects and safe use recommendations (e.g. http://www.aromadome.com/d-drugs.html_UK, <http://www.underave.net>).

Internet sales

The emergence of the Internet not only as a source of information and information exchange, but also as a source of illegal drugs and/or their compounds (Schifano et al., 2003), has been increasingly the subject of concern and discussion. In 2005, the International Narcotics Control Board (INCB) warned in its annual report of a growing hard-to-control threat posed by Internet drug sales (INCB, 2005). This includes Internet pharmacies illicitly selling pharmaceuticals containing internationally controlled narcotic drugs and psychotropic substances or precursors to them. In 2004, Sweden and Romania reported that the Internet was used as a source of illegal drugs.

The online market for legal substances claiming to have psychoactive properties is also expanding. Legal alternatives are sold by Internet-based companies often referred to as online smart shops. It appears that the majority are based in the Netherlands and the United Kingdom (EMCDDA, 2006) but there are sites based in other EU Member States (e.g. Denmark, Germany, France and Austria). They sell legal products frequently labelled as 'herbal highs' or 'legal highs'. Among these products are drugs such as 'herbal xtc' ⁽⁵⁾ and *Salvia divinorum* ⁽⁶⁾, *Amanita muscaria* (fly agaric), purple ohms capsules ⁽⁷⁾ and pep pills ⁽⁸⁾. Many of these products may pose serious health risks when taken by people with mental health problems or when mixed with other drugs or taken in high dosages.

Consequences of drug use

The absence of accurate and comparable systems for recording deaths and non-fatal emergencies related to the use of ecstasy, amphetamine, cocaine and other substances in dance music settings limits the data available in this area. However, there have been reports that provide insights into the negative effects of drug use in recreational settings. It is worth noting that, in the context of recreational settings, drug users generally form part of the socially integrated youth culture. Typically they are students or in full-time employment and they tend to make decisions about their drug use based on assessments of the risks and benefits in the light of perceptions about the dangers of different substances.

Health problems and non-fatal emergencies

The records of the Municipal Health Service in Amsterdam show that the number of non-fatal drug emergencies attributed to ecstasy, amphetamines and hallucinogenic drugs use account for only a small proportion of the total 3 404 drug emergencies during the five-year period from 2000 to 2004 (Figure 8). Comparable data are not available from other countries. In the United Kingdom, a study of 777 'nightclub cases' attending an accident and emergency (A & E) department in 2001 found that most of those attending had lacerations (39 %) or soft-tissue injuries (26 %). The most common illegal drug resulting in presentation to A & E was ecstasy. An association was noted between problem ecstasy use and weekend presentations at a large London A & E department, with young adults presenting with overstimulation, disturbed behaviour and increased temperature.

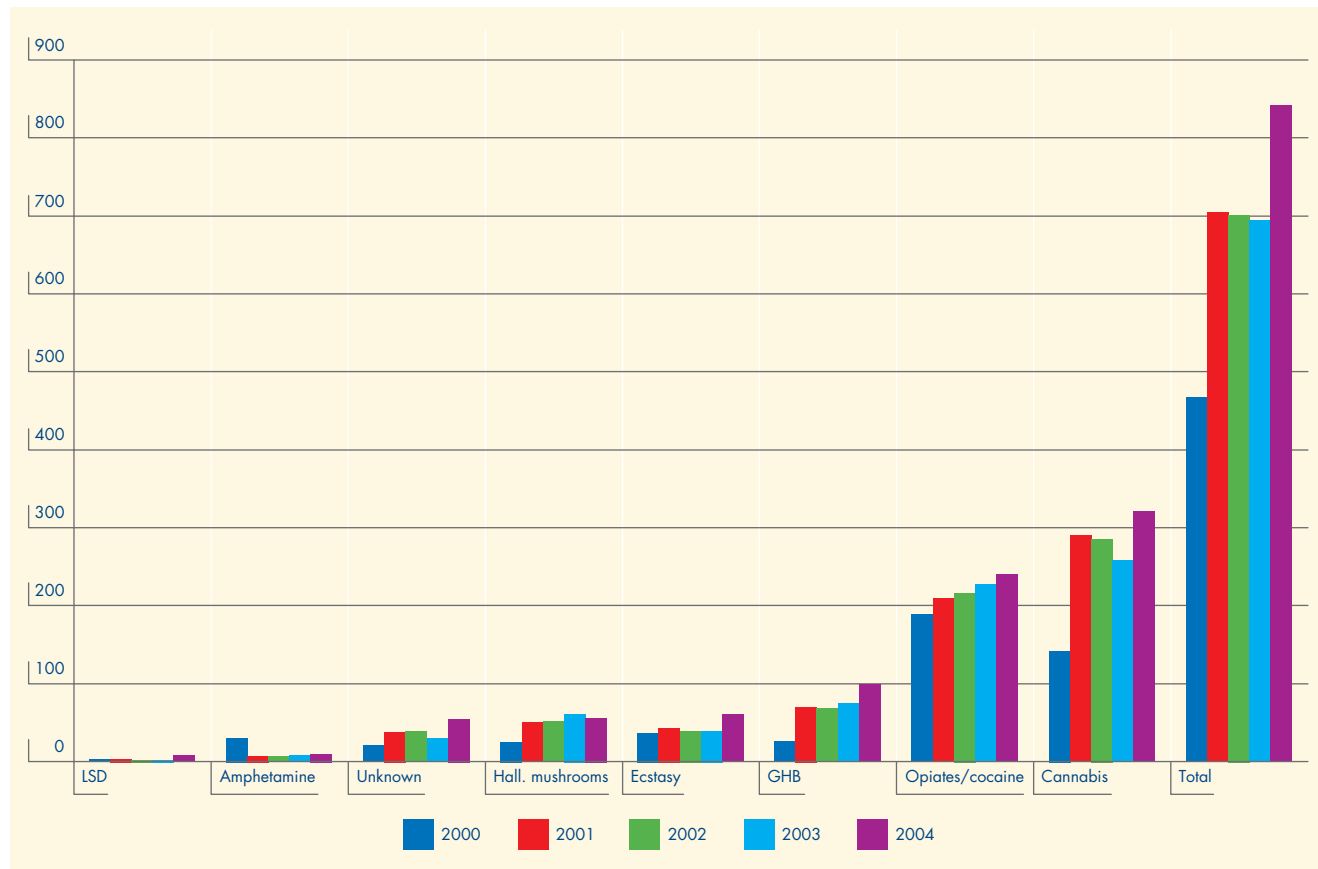
Data collected from 60 individuals admitted to an on-site medical station during a techno music event in Ghent, Belgium, attracting around 37 000 people show that vomiting and abdominal pain was the most common health problem (14 cases). There were nine cases of each of the following: coma, agitation/anxiety, syncope and alcohol inebriation (Figure 9). There is increasing concern about the health risks of cocaine use following the increases in recreational use observed in some countries among young people. Such risks include cardiovascular problems (arrhythmias, myocardial infarction, cerebral haemorrhages), particularly in users with predisposing conditions or other risk factors (hypertension, angiomas,

⁽⁵⁾ Possible ingredients of 'herbal xtc' products are ephedra alkaloids, *Sida cordifolia*, guarana, caffeine, Siberian ginseng, kola nut and andorn. Most of them are supposed to have a stimulating, energising effect.

⁽⁶⁾ *Salvia divinorum* is a sprawling perennial herb which grows wild only in the Sierra Mazatec region of Mexico. Its leaves contain the extremely potent substance salvinorin-A. It has a history of use as a divinatory psychedelic for oral use and has been widely available since the mid-1990s, primarily as a smoked herb.

⁽⁷⁾ Purple ohms capsules' main ingredient is *Argyria nervosa*, which contains lysergic acid amide (LSA).

⁽⁸⁾ Pep pills contain amino acid blend, citrus aurantium, black pepper extracts, piperine and piperazine blend. They attempt to replicate the rush of ecstasy.

Figure 8: Number of non-fatal emergencies due to drug use recorded by the Amsterdam municipal health service, 2000–04

NB: These emergencies involve both recreational drug users and problem drug users.
Source: Reitox national reports.

smoking), although these occurrences might pass unnoticed at present because of a lack of awareness. Cocaine is commonly consumed together with alcohol, a combination that may result in increased toxicity (Ghuran et al., 2001; Pennings et al., 2002).

Spain, Luxembourg, Hungary, Malta, the Netherlands, Slovenia, the United Kingdom and Norway reported that the health consequences of alcohol use were perceived as a significant problem. Data from the Netherlands in 2000 suggest that alcohol-related health incidents were on the increase. Some club surveys (Italy, United Kingdom *Mixmag*) have shown relatively high rates of psychological problems (such as depression, anxiety and sleep disturbances).

The effects of drugs such as ecstasy can be exacerbated in the club setting by continuous dancing, poor ventilation and overcrowding and insufficient water intake, all of which raise body temperature. Excessive water intake following ecstasy use can also create health problems. Regular overexposure to loud noise can damage hearing. Violence has also been associated with drug dealers in dance music settings, and

unsafe sexual behaviour can also be considered a risk in this environment (United Kingdom national report).

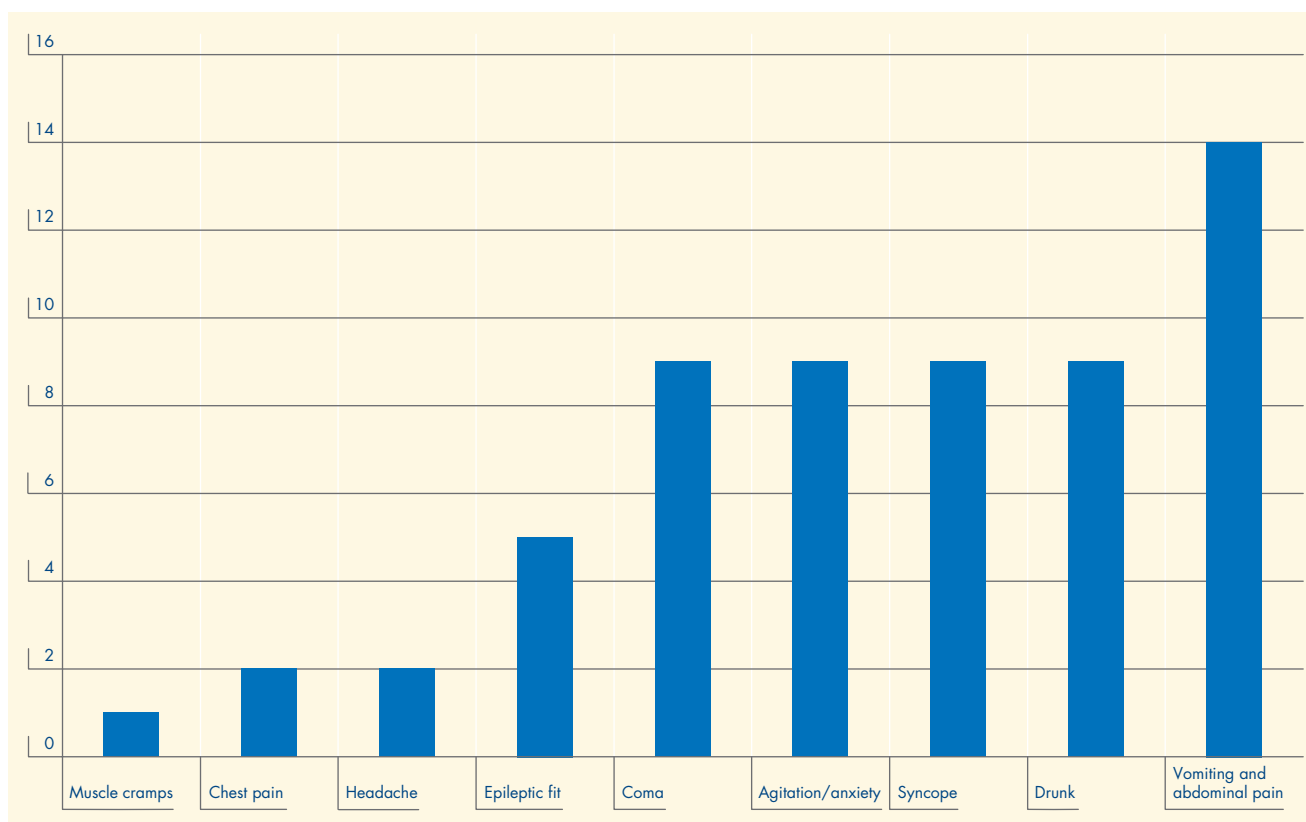
Deaths related to ecstasy, amphetamines and cocaine

Deaths related to ecstasy started to be reported in Europe during the 1990s as the drug became popular in dance music settings. This attracted considerable attention from the media as these deaths often occurred unexpectedly among socially integrated young people.

Data from the 2005 Reitox national reports suggest that deaths involving ecstasy remain relatively unusual compared with deaths from opioid use, although in some countries they are more common. In Europe as a whole, there were references to 77 ecstasy-related deaths, which should be considered a minimum estimate. Cases were reported by Denmark (2), Germany (20), France (4), Hungary (3) and the United Kingdom (48 cases with 'mentions' — 33 in England and Wales), where reporting is probably better than in other countries (*). In Spain, ecstasy was present in 2.5 % of fatal drug poisonings. Deaths related to amphetamine use are also infrequently reported.

(*). Depending on country, figures refer to 2003 or 2004.

Figure 9: Number of patients admitted to on-site clinics with drug-related problems at the 'I Love Techno' event in Ghent, Belgium, November, 2001 (37 000 attendees)



NB: The dominant drug involved was ecstasy in eight cases, GHB in seven and alcohol in three cases. When a combination was used, only the main drug was recorded.
 Source: Reitox national reports.

The issue of the risk associated with ecstasy use has been widely debated. Bearing in mind the margin of error in survey-based estimates of prevalence and the difficulties in reporting drug deaths, dividing the number of fatalities observed by the number of users per year ⁽¹⁰⁾ (people at potential risk) yields rates of five to eight cases and two to five cases per 100 000 users in the two countries for which this calculation can be made.

The European data that exist indicate that many deaths involving cocaine also involve opioids. However, cocaine may be an unrecorded contributor to deaths from cardiovascular problems (Pennings et al., 2002). Deaths and non-fatal emergencies related to the use of GHB and ketamine are very rare (see Chapter 4 in the 2006 annual report).

Overall, deaths and health problems attributable to the use of ecstasy, amphetamines and cocaine may be limited by the fact that a large proportion of people who use drugs in recreational settings do so in relative moderation for the purposes of recreation. In-depth interviews with individuals who use drugs in dance music settings indicate that this

group is interested and aware to some degree of the health and legal risks associated with their drug use. They adopt various strategies to minimise these risks. For example, they find out how to minimise the immediate physical health risks arising from the use of drugs and the excessive physical demands of clubbing. However, awareness and concern about alcohol-related problems and its long-term risks are less evident.

Further information about deaths and morbidity associated with drug use in general is available in Chapter 7 of the 2006 annual report.

Drug-facilitated sexual assault

In recent years, concern has also been expressed over the incidence of drug-facilitated sexual assault (DFSA) in dance music settings through the surreptitious administration of a psychoactive drug into drinks. However, obtaining forensic evidence of DFSA is problematic, and the complexity of this issue means that many cases may remain unreported. The most comprehensive United Kingdom study to be carried out to date reported that only 21 of 1 014 cases of alleged

⁽¹⁰⁾ Last year use in population surveys by population.

DFSA (2 %) were attributed to involuntary drug ingestion (Scott-Ham and Burton, 2005). This figure included three cases in which the drug was ecstasy, which may have been given to reduce inhibition rather than to induce sedation. No samples tested positive for flunitrazepam (Rohypnol), a drug often thought to be associated with such incidents. Nor is there much forensic evidence of GHB being used for this purpose. However, a small increase in dose of GHB can cause loss of physical control and consciousness. One study found that over 52 % of users experienced unconsciousness and 53 % experienced vomiting following use (Degenhardt et al., 2002).

Responses

This section deals with the response of the EU and its Member States, specifically in relation to legislation and preventative strategies to address new developments in drug use in recreational settings.

Legal responses at international and European level

Legal responses addressing drug use within recreational settings at international and European level are relatively limited and so we cannot refer to any statutory instruments that address this phenomenon. However, two resolutions adopted by the United Nations Commission on Narcotic Drugs and the Council of the European Union should be mentioned here.

First, in March 2001, recalling the new trends in drug use among young people, the Commission on Narcotic Drugs adopted Resolution 44/5⁽¹¹⁾ on the recreational and leisure use of drugs among young people. The first point of this resolution foresees the possibility of states requesting guidance and assistance from the United Nations international drug control programme in developing strategies and programmes for reducing illicit drug use, especially among young people in recreational settings. It 'also encourages states to develop information systems and prevention programmes aimed at raising public awareness of the risks associated with the new trends in illicit drug use among young people, in particular in recreational areas'.

Within the European Union, a resolution⁽¹²⁾ was adopted in 2002 by the Council and the representatives of the Member States. Addressing the prevention of recreational use of drugs, this instrument gives clear advice on the political priority of this topic, even if it does not create any obligations on national authorities in terms of competence.

From the point of view of policy, the new EU drug action plan 2005–08 clearly refers to drug use within recreational settings. It is up to the Member States to develop and improve prevention programmes for selected target groups and also specific settings, such as recreational settings⁽¹³⁾. The EMCDDA has been asked to provide data by 2008 on prevention projects in recreational settings.

Legal responses at national level

National strategies in the Czech Republic, Greece, Cyprus, Lithuania, Hungary and Slovakia refer to recreational drug use. The main actions mentioned are prevention, harm reduction activities and training. In some other countries, first steps are being taken to extend the legal framework regulating prevention and intervention to reduce harm to include recreational settings. For example, in Luxembourg, the action plan on drugs 2005–09 includes a needs assessment in the techno scene to help devise measures for reducing risk, damage and nuisance.

There is no legislation in the Member States specifically dedicated to prevention and harm reduction activities or to the control of drug use in recreational settings. General legislation covering recreational settings refers occasionally to drug use and seems to be the most common approach taken by many countries. Two countries reported that drugs legislation regulating use, possession or trafficking contains specific provisions for regulating drug use in areas usually frequented by young people.

Legislation regulating recreational settings

National reports distinguish two types of legislation: first, legislation regarding the organisation of an occasional festival, concert or rave party and, second, legislation addressing regular nightclubs and dance music establishments.

France is the only EU Member State that has reported a strict legal framework for occasional recreational events. The new Article 23-I of the law giving guidance and programming for daily security (LOPS) requires the organisers of rave parties to declare their plans to the prefect of the department concerned. The 2002-887 Order of 3 May 2002 specifies the submission mode and Article 3 al. 2 requests that the organisers of such gatherings indicate the provisions planned in order to reduce harm linked to the use of alcohol or drugs.

Many risk reduction strategies have developed in the techno party scene over the past decade and the Order issued on 14 April 2005 finally offered a legal status to these strategies. It details the national reference framework for risk reduction strategies for drug users, such as the distribution and

⁽¹¹⁾ CND Resolution 44/5 on the recreational and leisure use of drugs among young people, 29.3.2001.

⁽¹²⁾ Draft resolution of the Council and of the representatives of the Member States on the prevention of the recreational use of drugs. Cordroque 2 Rev 3, 15.4.2002.

⁽¹³⁾ Objective 9 of the EU drugs action plan 2005–08. OJ C 168, 8.7.2005, p. 1.

promotion of clean equipment, and directions to emergency care, general care, specialised care and social services.

In Belgium, there are no legal requirements to obtain a licence or authorisation before the organisation of a rave party. Furthermore, the latest directive on drugs states that, although use of cannabis is illegal, possession for personal use should not necessarily be prosecuted. However, in the case of a special event, such as a rave party, which could create public nuisance, the law gives local authorities the power to issue a specific directive that enables possession for personal use, normally associated with the lowest penalties, to be punished with a higher penalty.

In the Netherlands, policy is not confined to possible dangers of specific drug use. Municipal guidelines were developed, including rules, regulations, agreements and suggestions for the owners of establishments where parties are organised and proposing cooperation between stakeholders. However, it is interesting to note that, since September 2002, mayors have been legally permitted to allow preventive searching in situations that are considered to present a high risk to public safety, such as violence (weapons), but also drug-related nuisance and health risks.

Some Member States have reported specific guidelines regarding the organisation of such parties, even if they do not have legal provisions on this topic. In Norway, for example, pursuant to the Police Regulations, organisers of events are obliged to notify the police of the time, place and expected size of the event. The security plan for such gatherings often includes body searches before admission to confiscate illegal objects and drugs.

In the same way, in Finland, recreational drug use is controlled by police monitoring and raids. Police officers circulate among festival crowds with drug detector dogs, and control measures have also been targeted outside events.

In addition to this legislation on occasional rave parties, some Member States reported legal provisions on regular nightclubs or dance venues that include articles referring to drug use.

Taking into consideration these kinds of establishments, it is possible to distinguish two different types of legislation: (a) laws dealing with the prevention of drug use in recreational settings; and (b) laws dealing with the consequences of drug use within such establishments.

In order to prevent drug use in nightclubs or dance clubs, Irish legislation allows the prohibition of a person entering or being in the vicinity of licensed premises or a dance hall if he/she is the subject of an exclusion order. Such exclusion orders are imposed on persons convicted of a public order offence, such as intoxication (being under the influence of any alcoholic drink, drug or solvent or other substance).

With the same objective, the national strategies of Greece and Cyprus suggest that actions to prevent drug use should be developed. Ireland and the United Kingdom have a legal framework providing training and support for nightclub staff to optimise ways of addressing drug problems. As of April 2005, all door supervisors at bars and clubs must have a security industry authority licence, which means that they must have specific qualifications and must take part in a training course that covers drug awareness. From a non-legal point of view, but with the same aim of prevention, a training course in first aid to deal with drug accidents in recreational settings has been implemented in the Netherlands. Individuals who complete the course are able to train other people working in recreational settings. A handbook for coffee shop owners has also been produced to encourage prevention in coffee shops, and a plan, 'Nightlife and Drugs 1998–2001', has been formulated by the Trimbos Institute.

Some countries have specific national legal frameworks that regulate the licensing of recreational establishments and their eventual liability in case of drug use on their premises. The most common consequence is revocation of the licence.

In Ireland, for example, the Licensing (Combating Drug Abuse) Act 1997 provides for permanent disqualification from obtaining a licence for intoxicating liquor on conviction of a drugs offence. It also provides for the permanent revocation of such a licence on conviction of a drugs offence. Such revocation is also provided for in the case of sale of controlled drugs on the premises of the establishment. In that case, the licence holder will be disqualified for five years.

Similarly, in the United Kingdom, according to the Public Entertainments Licences (Drug Misuse) Act 1997, a licence may be refused or revoked if:

- (a) the local police commissioner states (and gives evidence) that there is a serious problem relating to the supply or use of controlled drugs at the premises, or any premises nearby controlled by the licence holder (such as a club car park); and
- (b) the licensing authority is satisfied that refusal to issue or renew the licence will significantly assist in dealing with the problem.

Norway also reported that, under the Alcohol Act, which includes regulatory provisions relating to the sale and serving of alcohol, an alcohol licence, delivered by municipal councils (licensing authorities), can be revoked if the repeated sale of drugs in the licensed premises is discovered.

The Spanish Organic Law 1/1992 Protection of Citizen Safety strictly prohibits the consumption and traffic of illicit narcotics and psychotropic substances in public venues or establishments, or a lack of diligence in enforcing this

prohibition by owners, managers or overseers of the establishment.

Finally, in Lithuania, no specific legal provision stipulates control and prevention of drug use in recreational settings but a proposed amendment to the draft revision of the Administrative Code stated that owners of recreational settings shall be prosecuted for taking no action to prevent and report distribution and use of narcotic and psychotropic substances within their establishments. The proposal was rejected.

In addition to licensing legislation that specifically addresses recreational settings, provisions relating to drug use in recreational settings can be found in national drug legislation. It is common for national legislation to include provisions regulating the sale or use of drugs near schools ⁽¹⁴⁾. However, only two Member States (Denmark and Malta) have provisions in their drugs legislation that consider use near recreational settings usually frequented by young people as an aggravating circumstance in a drug offence. In Denmark, a 2004 amendment to the Euphoricants Act makes it an aggravating circumstance to sell drugs (or to offer them free of charge) in restaurants or discotheques or at concerts and music festivals or similar places typically attended by children or young people. Similar provisions exist in Malta, where punishments are increased by one degree if the offence takes place within 100 metres of the perimeter of a school, youth club or any place frequented by young people.

Prevention

Drug prevention activities in recreational settings

For the purposes of this section on prevention activities, dance music settings are distinguished mainly by their size — large music festivals and smaller commercial recreational music settings (raves and clubs).

Large music festivals

The most frequently used responses to drug-taking in the context of large music festivals and dance events are targeted public information campaigns (Belgium, Denmark, Poland, Sweden, Norway) and the distribution of brochures on specific substances through mobile teams. Several Member States provide structural risk reduction measures such as water distribution and healthcare support delivered by first aid teams (Belgium, Denmark).

In several countries, information campaigns are selectively targeted at large festivals. These campaigns focus on information about overheating, the importance of peer group support and not dancing alone, first aid, the risks of combining drugs and the importance of drinking water (Partywise, Belgium). In some countries, campaigns strive to

encourage critical attitudes towards drug use, e.g. the Czech Republic, Denmark (see box), Germany, Hungary, Austria and Poland.

The delivery of other interventions, which are largely information based, at large events is usually carried out by trained peers at information stands. Brochures or leaflets/flyers about drugs and sexually transmitted diseases, as well as condoms, are provided. Typically, a number of different self-help, non-governmental or scene-based organisations provide interventions at these large events. These organisations acknowledge that drugs play a part in the festival scene and, while stating that the safest option is not to take drugs at all, they usually neither proscribe nor condone the use of illegal drugs (Belgium, the Czech Republic, Austria). Risk reduction materials are usually developed in styles that emulate youth cultures.

Volunteers who provide peer education at large festivals may occasionally be recreational drug users themselves or have used drugs in the past. In these cases, the objective is to be able to answer questions from young people about safe use and risk reduction, rather than to prevent drug use (Germany, the Netherlands). This approach has been criticised on the grounds that such volunteers tend to adopt rather pro-drug

An example from Denmark — Roskilde festival/ Festival danmark against drugs

In 2005, following earlier work at the Roskilde festivals in 2003 and 2004, a national campaign project subsidised by the National Board of Health was launched involving various festival planners. The campaign included an anti-drug statement in the Roskilde festival programme and on the website, a logo, Go-cards (electronic as well as printed), car streamers, badges, posters and fact folders on drugs. The campaign encouraged debate about drug use among the participants at the Roskilde festival. The anti-drug statement in the festival programme and in large screen spots before major concerts and in buses were some of the elements considered to have had maximum effect. Evaluations claim that the drug prevention messages at Roskilde festival reached 80 % of the participants, while 29 % discussed the campaign with their friends and 93 % agreed that it was a good idea. In addition, a new peer counselling prevention and harm reduction initiative entitled 'Are you experienced?', financed by the Ministry of Social Affairs and aimed at drug users at the Roskilde festival, was established in 2005. This was based in a graffiti-painted bus near the electronic music area, where former drug users provided counselling, information and practical support to young people.

For further details see EDDRA http://eddra.emcdda.europa.eu/pls/eddra/showQuest?Prog_ID=5156

⁽¹⁴⁾ See 'New national laws: young people' in the 2005 annual report for more information.

attitudes (Calafat et al., 2004). It has been recommended that the selection of peers for work in such settings should ensure that their attitudes and approaches match the specific aims of the intervention, for example to emphasise reducing drug use.

It has been suggested that a recent increase in small and fragmented private dance music events may be partly the result of the reaction of organisers who wish to avoid new regulations. For example, in France gatherings of fewer than 250 individuals do not have to be officially declared to a prefecture and have therefore become more common in some cities. Information about these events is usually disseminated through informal acquaintance networks. Consequently, gaining access to these events and communicating with the target groups is more difficult than it was in the past at larger and well-publicised events. New and different responses are required, which have resource implications as prevention efforts have to cover many more events but overall reach fewer people. An Austrian organisation (MDA Basecamp, Tyrol) recruits young people aged between 16 and 22 to work for the organisation at dance music events (taking photographs, distributing flyers) or in a youth centre and who participate in training courses in order to acquire additional youth work experience.

Commercial recreational music settings (raves and clubs)

Interventions in these smaller commercial music settings are now becoming increasingly common in the Czech Republic, Germany, France and Poland, where they often receive political support. Provision of information is the most common intervention in these settings, but other initiatives may include counselling and relaxation techniques.

Structural measures in recreational environments are also implemented, for example freely available cool drinking water, ventilated seating ('chill-out') areas and trained staff on site for medical emergencies. And in Germany, an initiative has been implemented to ensure that alcohol-free drinks are available at a lower price than alcoholic drinks.

Risk reduction interventions provide information about different substances, the consequences of their use and the best way to avoid problem use. In the absence of any criticism of drug use, they are sometimes viewed as implicitly condoning or accepting drug use as an integral aspect of youth culture (Portuguese national report).

Tourist locations

Interventions targeting concentrations of dance music settings in tourist locations have been reported by several countries (Belgium, Spain, the United Kingdom and Norway). Prevention activities in these locations usually involve the creation of websites, distribution of flyers, information campaigns and peer support. Some attempts have been

made to encourage professionals in the entertainment industry to work with local authorities. Environmental strategies and regulations in these settings appear to be rare.

Environmental strategies: clubs, restaurants and the leisure industry

In an increasing number of countries (Belgium, Denmark, Ireland, Italy, the Netherlands, Sweden, the United Kingdom and Norway) there appears to be an interest among municipalities in establishing closer contact with the relevant players in dance music and other recreational settings (local police force, restaurant owners, commercial dance music establishments).

Typically, municipalities target preventive activities at nightlife settings to limit the availability of drugs in recreational settings and reduce the health risks. The type and extent of intervention varies. Interventions range from a series of training courses offered to doormen and barmen to large-scale local development projects involving local players such as restaurant associations, police, licensing authorities, fire services, tax and customs authorities.

In some countries non-municipal formal working groups have been established, such as the German 'Healthy nightlife' and the Hungarian 'Safe entertainment venue programme'. These working groups are made up of representatives from drug counselling facilities, scene-based initiatives, government authorities and organisers of dance music events. The working groups serve as a forum for introducing minimum standards of drug prevention in dance music and other recreational settings. Minimum standards for nightlife venues regarding security and hygiene are the rule in Luxembourg and the United Kingdom, and these standards are controlled by specific health departments. As concern about alcohol-related problems grows, countries such as the Netherlands and the United Kingdom have started to relate prevention initiatives in recreational settings to alcohol. In the Netherlands it has been recommended that preventive strategies should place a stronger emphasis on alcohol in order to reduce the incidence of serious violence.

Safe clubbing guidelines, such as those developed in the United Kingdom (see box), are now being found in other countries. In Belgium, Partywise has produced a manual including safe clubbing guidelines and some information on creating a safe and healthy physical environment, for example by preventing overcrowding and overheating and ensuring free water supplies. The manual includes supplementary prevention messages concerning location, first aid and safety in road traffic as well as information relating to controlling the amount of drugs on the premises. The manual promotes a tailor-made alcohol and drug policy for club managers, organisers of music events, local

governments and youth workers with feasible prevention interventions (De Vriendt et al., 2005). Brussels has developed a similar manual, *Charte de Bien-Etre*.

Pill testing

On-site pill testing ⁽¹⁵⁾ is becoming less common in Europe than it was in the past. The main arguments against pill testing are that the cost–benefit ratio is poor and that, by permitting on-site pill testing, contradictory messages are being sent out about the risks related to both use and possession of controlled substances. The capacity of on-site tests to accurately detect harmful substances is limited, and for this reason testing in France was banned in April 2005. Czech non-governmental organisations were told in 2004 not to use subsidies, including staff wages, for qualitative testing of tablets containing synthetic drugs. In Belgium, where, since 1996, pill testing within a limited number of events had been allowed, the Minister for Justice forbade pill testing in 2002. However, in Belgium a new experimental project has been designed combining on-site and laboratory pill analysis, integrated within harm reduction activities. This will include an external evaluation.

Safer dancing guidelines

The 'Safer clubbing' guidelines ⁽¹⁾, jointly developed by organisers, club owners, users' organisations and prevention agencies, aim above all to create a safe physical environment. Health hazards in recreational settings more often arise from how events are organised rather than directly from drug use (e.g. intoxication or unexpected effects). Above all, overcrowding, poor ventilation, lack of affordable drinking water, violence and accidents from broken glass are addressed. But guidelines also deal with drug dealing and the training of door supervisors to organise searches and supervise toilet areas. Training in first aid and early detection of drug-induced problems is included. Sometimes, 'amnesty bins', where club attendees can drop objects (including drugs) before being searched, are put next to entrances. Recommendations for drug prevention by distributing information and outreach teams are included.

The guidelines include aspects related to local communities, for example promoting liaison with local agencies and police officers to organise safe transport and ensure that people can get home safely.

These guidelines are being largely applied in Belgium, northern Italy and the United Kingdom.

⁽¹⁾ 'Safer clubbing' guidelines are available at <http://www.clubhealth.org.uk>

Legal difficulties have presented another problem for on-site pill testing. The drug testing scheme drawn up by MDA Basecamp in the Tyrol in Austria under the name of 'fact' was not approved on legal grounds. However, in Austria, ChEckiIT! continues to test pills and in addition expanded its legal counselling services in 2005 so that a lawyer is now available for answering drug-related legal questions for one hour each week. From a toxicological perspective, justification for maintaining on-site pill testing is diminishing as the risk of pills being adulterated appears to be low. The contents of drug samples tested by the Dutch Drug Information and Monitoring System (DIMS) showed that, since 1998, pills sold as ecstasy have been reasonably 'pure', meaning that they contained mainly MDMA-like substances. However, the percentage of high-dose MDMA tablets has increased, and this system has made important contributions to alerts and early warning about new drugs.

The main argument in support of on-site pill testing is that it offers a valuable and effective means for establishing contact with recreational drug users in the dance setting (Benschop et al., 2002). In the Czech Republic, in 2003, more than 500 direct contacts with drug (especially ecstasy) users were established at the largest dance event in Brno. However, during the same event in the spring of 2005, only 65 people visited the tent (after pill testing restrictions were implemented), and close contact was established with only eight.

Websites

Prevention strategies have made use of the Internet to establish low-threshold contact with young people who take drugs or might be considering taking drugs. In many Member States, information and prevention is being provided through Internet websites to promote critical reflection among young people about their own consumption behaviour. These sites provide advice, for example about going out 'wisely', safe sex, road traffic risks, healthy diets, party tourism and legal issues (Belgium) ⁽¹⁶⁾.

Online support is also provided to help people reduce or stop drug taking or to refer them to other local help services. Increasingly, such Internet sites include interactive modules for the self-assessment of risk or dependence ⁽¹⁷⁾. In 2004, the German Internet portal www.drugcom.de received 25 % more hits than in the previous year. An analysis of visitors to the site showed that about two thirds of them were under 22 years of age, 75 % of them had experience with cannabis and about 50 % were currently using the substance. These figures demonstrate that an important target group can be reached via the Internet.

⁽¹⁵⁾ Pill testing is a widely used term for the chemical testing of drugs whether in the form of tablets, powders or liquids.

⁽¹⁶⁾ Links to some of these may be seen at <http://www.emcdda.europa.eu/?nnodeid=5575>

⁽¹⁷⁾ Belgium: www.partywise.be; Germany: www.drugcom.de; Austria: www.onlinedrogenberatung.at

Paradigm shift in prevention

There has been a paradigm shift in approaches to prevention towards increasing recognition of the key role that lifestyle fashions play in recreational nightlife settings and challenging drug-related normative beliefs. Environmental strategies that modify the availability of legal drugs and the settings where drugs are consumed have been shown to be more effective in preventing drug use than educative–persuasive measures alone (Paglia and Room, 1999).

First, there has been growing recognition that information-based approaches alone are not effective and that strict abstinence-oriented messages are not realistic in party settings. At the same time, the sort of harm reduction approaches employed to address some of the problems of chronic heroin addiction are not considered desirable or appropriate for young recreational drug users. Therefore, lifestyle fashions, beliefs and attitudes of young target groups and the symbolic aspects of drugs and drug use are being given more consideration than in the past (Kemmesies, 2000).

Some incipient environmental prevention strategies in this field are therefore trying to go further than simply providing safer environmental conditions for young people in recreational settings or reducing the availability of drugs. There is increasing recognition that prevention strategies could aim to influence young people's approaches towards having 'fun' without using drugs.

An Austrian prevention project emphasises moderation using values such as good preparation (before drug use), being in control (during) and reflection (see, for example, www.risflecting.at). Research by IREFREA on people who consume less or not at all in recreational settings shows that they are often female and the research postulates prevention goals that promote moderation and a more 'female' approach towards drug use (Calafat et al., 2003; see also the selected issue on gender).

Secondly, there have been new developments in the creation of working groups and the production of guidelines for environmental strategies. These are, to a certain extent, the first preventive responses that have engaged with and made demands on the entertainment and drinks manufacturing industries and brought together professional groups involved with recreational settings. The efficacy of these approaches has yet to be evaluated.

In some countries, no interventions in recreational settings have been reported, although sometimes those working in the recreation industry have expressed interest in participating in preventive interventions.

Conclusions

Research studies targeted at young people in the EU who attend dance music events consistently report much higher prevalence of drug use than that found in surveys of the general population. This appears to be the case in all of the countries where such surveys have been conducted — despite the heterogeneity and fragmentation of dance music settings and other methodological constraints that present challenges to issues of measurement and comparability.

The relatively high prevalence of drug use recorded by surveys conducted in dance music settings provides a clear target for initiatives in prevention and this has been recognised in the EU drug action plan 2005–08. Some recent national developments in dance music settings show that effective responses are no longer confined to measures aimed at informing and persuading individuals. Environmental and prevention strategies that aim to modify the availability of alcohol and tobacco, the settings where drugs are consumed and the drug-related normative beliefs held by young people all appear to have been effective in ameliorating the risks of drug use. However, so far only some countries have embraced these new approaches. Wider economic interests, new technology and lifestyle trends will continue to have significant influence on developments in recreational dance music settings.

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