

# The European Union and Drugs: Trafficking, consumption and strategies

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After two decades (the 70's and 80's) of exclusive national efforts, the European Union attempted to structure its approach to illicit drugs, to curb heroin consumption and the AIDS-epidemic (a direct consequence of unsafe heroin injection among drug users) throughout the 90's. The need to elaborate a common response emerged in the context of the establishment of the Single Market in 1993. Ten years later, the European Union must ask itself, in the context of the accession of 10 new Member States, if it is now in a better position to face an unstable and changing drug situation.

## **1. The global drug phenomenon**

*A multifaceted scourge at world and European level*

Already during the 1980s it became obvious that drugs were becoming one of the major global challenges mankind would have to face towards the end of the 20<sup>th</sup> Century. It was a global issue in both senses of the word: global, because it had now reached world dimension and scale (income



from drug trafficking was estimated to be as high as \$400 billion a year<sup>1</sup>); global also, because it was recognised as a multifaceted scourge, which included medical and social aspects, legal and law enforcement aspects, as well as transnational elements such as manufacturing, trafficking and consuming of not only a whole range of natural drugs, but also, increasingly, of so-called “designer” drugs, according to new patterns and new trends emerging mainly in the developed countries (USA and Europe).

To meet this challenge, the United Nations elaborated in 1987 a global strategy called: *Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control*.

This approach has been consistently confirmed and strengthened by the international community since then, and particularly at the United Nations Special Session on Drugs, in New York, in June 1998.

The goal and the main components of any strategy against drugs were based on the following principles:

- The principle of shared responsibility
- The principle of balanced and integrated approach
- The existence of a structured national strategy
- The existence of a comprehensive coordination system

## **2. THE GLOBAL DRUG SITUATION**

*1 in 5 have used cannabis, and treatment demand grows*

At least one in five (20%) adult Europeans have used cannabis at least once in their lifetime. Figures for young people aged between 15 and 34 are generally even higher, up to 44% – Spain (35%), France (40%), the UK (42%) and Denmark (44%).

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<sup>1</sup> Ten years later, in 2003, the United Nations' estimate is \$600 billion.

The prevalence of recent use (last 12 months) is the highest among the 15-25 year-olds (over 20% in Germany, Spain, France, Ireland and the UK).

A new concern is that a small but significant group is now using cannabis regularly and intensively.

Europe remains the world's biggest market for cannabis resin (hashish), accounting for some three-quarters of global seizures. Herbal cannabis (marijuana) grown in the European Union (EU) is also increasingly available. Evidence indicates that the average potency of cannabis in the EU (the amount of the psychoactive ingredient tetra-hydro-cannabinol [THC] it contains) has risen and now ranges from around 5 to 10% for both resin and herbal varieties. But some samples are considerably stronger, with a THC content of up to 30%.

#### *Amphetamines and ecstasy – EU a key area for production and use*

Europe remains a key area for the production and use of amphetamines and ecstasy. After cannabis, these are the second most commonly used illicit drugs, with lifetime adult consumption ranging from 0.5 to 5%.

Although ecstasy use continues to be highly prevalent among Europe's urban youth – and studies show very high use in some groups, such as partygoers – a marked increase is not seen generally in the wider population.

Amphetamines account for around one-third of people treated for drug problems in Finland and Sweden and 9% in Germany – but elsewhere in the EU they account for typically less than 1%.

Both amphetamine and ecstasy seizures rose substantially in the EU in the last decade, although such seizures now seem more stable.

#### *Cocaine – widespread EU concern*

Almost all countries express new concerns about rising cocaine use. Surveys suggest it is rising in the UK and, to a lesser extent, in Denmark, Germany, Spain and the Netherlands. Data for the period 2000–2002 show that lifetime experience ranges from 1 to 9% of those aged 15 to 34.



The total number of cocaine seizures in the EU has risen steadily since the 1980s with a marked increase noted in 2001. Street prices have stabilised or decreased in all countries in recent years.

Cocaine purity remains generally stable in every Member State, although increases were reported in 2001 by Denmark, Germany, Portugal and the UK.

Drug treatment attendance for cocaine use is reported as relatively high in the Netherlands (30%) and Spain (19%) but, less so in Germany, Italy, Luxembourg and the UK (6–7%), possibly reflecting differences in availability of cocaine treatment. European prevalence of crack (or base) cocaine remains low but still in progression.

#### *Half of the countries report rise in problem drug use estimates*

In most countries, problem drug use is characterised by chronic opiate use. National estimates of problem drug use vary from 2 to 10 cases per 1 000 adults: some 1 to 1.5 million Europeans. The highest rates are reported in Italy, Luxembourg, Portugal and the UK (6 to 10 cases per 1 000 adults). Rates are lowest in Germany, the Netherlands and Austria (3 cases per 1 000 adults).

About 60% of the estimated problem drug users are active injectors (some 600 000 to 900 000).

#### *Disease prevention still critically important*

HIV prevalence among injecting drug users (IDUs) varies considerably EU-wide: from around 1% in the UK to over 30% in Spain. In a number of countries, local rates of over 25% are found in a variety of settings.

Although national HIV prevalence data remain mostly stable, they can mask considerable variations locally and among certain groups. HIV increases among IDUs have been reported in the last few years from some regions or cities in Spain, Ireland, Italy, the Netherlands, Austria, Portugal, Finland and the UK.

The long-term costs of hepatitis C infection, both in terms of health-care spending and personal suffering, are likely to be considerable. Prevalence rates among current and former injectors are extremely high in all countries, at 40 to 90%.

### *Most overdose victims are young*

In the last decade, between 7 000 and 9 000 drug-related deaths were reported every year in the EU and Norway and the trend is upwards, with most affected in their 20s and 30s. In almost all countries, opiates are present in most cases of death (over 80%), often combined with other substances such as alcohol, benzodiazepines or cocaine. Simultaneous use of alcohol or depressants is a particular risk in heroin overdoses.

Polyuse and polyaddiction have been recently developed in a spectacular way, and posing new and increased challenges to public health.

### *Responses to the drug challenge – Strategic and legal responses gather pace*

Countries continue to modify legislation to facilitate the treatment and rehabilitation of drug users and addicts (e.g. Germany, Greece, Luxembourg and Finland). Systems to monitor drug trafficking and users have also been strengthened against a general background of increased European security concern.

Over the past years, some EU Member States (Denmark, Ireland, the Netherlands and the UK) have introduced legislative provisions to minimise the social impact of drug use through stricter controls of public- order offences and nuisance.

### *Substitution treatment up one-third in last five years*

The last five years have seen a 34% increase in the availability of substitution treatment in the EU and Norway. Over 400 000 people now receive substitution treatment in the 16 countries. Over 60% (around 250 000) of these treatment places are found in Spain, France and Italy. The biggest rise in treatment has been in countries with low initial provision (e.g. Greece, Ireland, Portugal, Finland and Norway).

Methadone is by far the most common treatment substance, but buprenorphine is increasingly used. Prescription of heroin is practised in the UK, is under scientific trials in Germany and the Netherlands and is in its preliminary stages in Spain.



### *Harm reduction is now widely established*

The prevention and reduction of health-related harm associated with drug dependence has become an integral part of the response to drugs across Europe.

Syringe exchange to prevent the spread of infectious disease through injecting drug use is now well established and widely available in the EU and Norway, although coverage is limited in Greece and Sweden. On the whole, access to sterile equipment has further improved in the past five years. Only in Spain are syringe exchange services implemented systematically in prisons.

Another important new development Europe-wide is the provision of medical care to drug users through low-threshold services, targeting those that are homeless or leading otherwise unstable lives.

### *Prevention in schools – quality is a priority*

School-based prevention is still at the core of activities directed at young people, usually from pre-teenage. Although there is much evidence of effective prevention in schools, its practice is less than state-of-the-art in most countries.

## **3. EUROPE AT THE CROSSROADS OF DRUGS ROUTES**

Europe is a particular target of drugs trafficking from the East (mainly opium from Afghanistan), from the West (cocaine from Colombia, Peru and Bolivia), and from the South (cannabis resin from Morocco and North Africa). The production and trafficking of drugs from these source countries are a particularly acute expression of the North-South divide and of the development gaps between these regions.

The opium produced in Afghanistan is processed into **heroin** on the spot, and also in neighbouring countries or countries located on the routes leading to Europe, for instance, Turkey. These routes are essentially the Balkan Route, which in fact passes through Turkey, and the Silk Route, which crosses Central Asia, the Caspian Sea and the Russian Federation, entering Europe via Poland and the Baltic countries.

In 2002, three-quarters of global production of illicit opium took place in Afghanistan (76%), with the

last quarter coming mainly from Southeast Asia (Myanmar: 18%, and Laos: 3%). It is estimated that up to 90% of production is destined for Europe. In other words, the spectacular rise in opium production in Afghanistan in recent years (4 565 T. in 1999, 3 276 T. in 2000, 185 T. in 2001, 3 400 T. in 2002, 3 600 T. in 2003 and 4 200 T. in 2004) is capable of meeting demand that has become more or less stabilised in the 15 Member States of Europe, but which is increasing rapidly in certain new Member States, and even more in Eastern European countries led by the Russian Federation, as well as in Ukraine and Belarus.

This development has also resulted in an increase all along the route in a demand, which can be satisfied, for heroin. It is estimated that Russia now has at least 2 500 000 problem opiate-injected consumers, compared with 2 100 000 in the enlarged European Union.

In these new consumer countries, as in Western Europe in the 1970s and 1980s, this phenomenon is accompanied by a veritable upsurge in HIV: from 10 000 cases reported in Russia in 1998, the figure rose to almost 150 000 in 2003, approximately 70% of the new infections officially recorded (roughly 230 000). However, the United Nations estimates that the number of actual cases of infection is 1 500 000 out of a population of 144 million, in other words ten times more.

Recent trends regarding **cocaine** concern an increase in consumption in Europe (even though this is still not as significant as in the United States), as can be seen from seizures and requests for treatment.

The cocaine consumed in Europe comes from three Latin American countries, whose potential production in terms of consumable cocaine was, in 2002, 580 T for Colombia, 160 T for Peru and 60 T for Bolivia, in other words a total of 800 T. While seizures of cocaine in the United States, the main consumer of this substance, tended to drop slightly between 1985 and 2001 (97.8% of the total in 1985, 92.8% in 1995, 82.7% in 2001), the trend was the opposite in Europe: 2.1% of the total in 1985, 7% in 1995, and 16.5% in 2001. Spain is also one of the countries in which the largest amounts of cocaine have been seized, with 9% of the world total in 2001 (33.7 T), behind Colombia, 20% (73.9 T) and the United States, 29% (106.2 T).

The main source of supply of **cannabis resin** is by far Morocco, followed by Afghanistan, Pakistan, Central Asia, Russia and Lebanon. Here, too, Spain is the world leader as far as seizures are



concerned, with 57% in 2001 (54.2 T), far ahead of Pakistan, 8% (75.2 T), Morocco, 7% (61.4 T), France, 7% (58.2 T), the United Kingdom, 5% (48.3 T) and Iran, 5% (46.1 T).

Europe has a high level of production of **amphetamines and synthetic drugs**, especially in Italy, Spain, France, Germany, the Netherlands and Finland, frequently for local use, in the three Baltic countries, and in Slovakia, Bulgaria, Hungary, Slovenia, the Czech Republic and, last but not least, the Russian Federation.

During the period 1991-2001, 58% of clandestine amphetamine-producing laboratories were found in Europe, 25% in North America and 17% in the rest of the world. This leading position is a clear indication of the relative importance of Europe as an amphetamine-producing region. As it produces relatively more than it consumes compared with other regions, it has therefore become a net exporter of these substances to the rest of the world.

In short, the general situation of Europe as regards drugs is therefore worrying since it is characterised by **heroin consumption which is becoming stabilised** in the West (the only real positive sign), but which is rising in the East, together with increasing production; **increasing cocaine consumption** (with stable production), but which is tending to drop in the United States which was, until now, by far the main consumer; and an increase and widespread use of **cannabis**, also with sustained production, particularly in Morocco.

In addition, there is the increase in **consumption of synthetic drugs**, mainly produced in Europe itself, as well as **polyconsumption** of a combination of some or all illicit drugs with legal drugs: alcohol, tobacco, medical products, etc. Objectively speaking, civil society is therefore entitled to expect and to demand of European governments that they reinforce the tools and methods used to combat every facet of this problem, and to ensure a considerable improvement in results, particularly since the main victims are recruited primarily among the young.

#### **4. CHALLENGING THE 5th ENLARGEMENT**

Up until the beginning of the 1990s, the countries of Central and Eastern Europe were almost exclusively regarded as transit countries between the areas of opium and heroin production, in Southeast Asia and Central Asia, and in Western Europe.

But these former buffer states have themselves quickly become the targets of drug traffickers, and consumption is tending to rise, and even rocket in some of them.

**Heroin** has tended to be replaced by substances that were in the past home-made locally, such as methylamphetamine (methamphetamine) in the Czech Republic, and “kompot” in Poland, which has obliged local producers and traffickers to seek alternative outlets in neighbouring countries. At the same time, heroin use has gradually spread from urban to rural areas.

At the beginning of the 2000s, heroin had become the main drug in most countries. The preferred method of consumption – reproducing behaviour in Western Europe a decade or two beforehand – is intravenous injection, practised by 80% to 90% of opiate users.

Problem drug use has thus reached a high level in the Baltic countries, above the Community average (over 1% among 15-64 year-olds), more or less equal to the Community average in Hungary, the Czech Republic, Bulgaria, Malta, Slovenia (more or less 0.5% of 15-64 year-olds), and lower than the EU average in the case of Poland only (0.25% of 15-64 year-olds).

While **cocaine** consumption is rare in these countries, the Western model of a rapid rise in experimental and recreational consumption of **cannabis**, and the use of **synthetic drugs** during festive occasions in youth culture (raves, discotheques, techno weekends, etc.) are occurring in the new Member States and candidate countries. It is accompanied by a very high incidence of risk behaviour. While HIV infection is generally at a quite low level, it is rising rapidly, even to an alarming extent among intravenous drug users, particularly in Estonia.

This development is all the more worrying in that policies, measures and tools to combat drugs are often fragile or even in their infancy, and facilities for receiving drug users and treating them are being set up with difficulty and only slowly, despite the committed cooperation of the EU for some years, particularly under the PHARE programme. However this cooperation is largely focusing on the criminal aspects. In 2000, for the entire population of the CEEC (excluding Turkey) amounting to some 100 million inhabitants, there were only 6 000 places available for substitution therapy, mainly using methadone and buprenorphine. This figure should be compared with the 300 000 places available for a population of 380 million in the 15 EU Member States (this figure has in fact risen to 400 000 in the meantime).



## **5. THE SINGLE MARKET AND DRUGS**

### *Drugs and the free movement of people, goods, services and capital in the European Community*

The establishment of a common market was already the main goal of the Treaty of Rome. After two enlargements of the European Community (in 1973 with Denmark, the United Kingdom and Ireland, and in 1981 with Greece) and considering a series of remaining obstacles towards a Single Market, Jacques Delors proposed in 1983 a White Paper on the completion of the Internal Market. The Single European Act, adopted in 1986 (year of the entry into the Community of Spain and Portugal) by the Heads of State, defines clearly the Internal Market as “an area without internal frontiers in which the free movement of goods, persons, services and capital is ensured in accordance with the provisions of this Treaty.” Based on an extensive list of obstacles to be removed according to a precise schedule, the Internal Market finally became a reality on 1 January 1993.

By removing borders, reducing customs costs, stimulating intra-Community trade and intra-Community movement, the completion of the Single Market has meant a decisive step towards European prosperity and welfare.

In relation to illicit drugs, however, this step meant also more flexibility and freedom for traffickers and criminals (free movement of people), for the diversion of legal chemicals (“precursors”) used for the manufacturing of illicit drugs inside and outside the European Community (free movement of goods), and for laundering and recycling illicit assets gained from the trade of drugs (free movement of capital).

Therefore, in order not to threaten the establishment and the functioning of the Single Market, it appeared to be inevitable to articulate a well designed counterattack against those three fronts, which actually constitute the hard core of the “global drug phenomenon”. Such a comprehensive response, however, was hampered by the lack of a real single competence anchored in the Treaty of Rome, to tackle the drug problem at European level in a comprehensive and well-coordinated way.

However, during the 1990s, numerous legislative and operational initiatives were taken at European level on these different aspects of the problem: fight against the diversion of chemical precursors; fight against money laundering and North-South cooperation....

President Mitterrand took the initiative in 1989 to write a letter to the other 11 Heads of State and to the President of the Commission, calling explicitly for a coordinated strategy on drugs at the European level, including the establishment of a European Drugs Monitoring Centre.

Proposals of President Mitterrand in his letter of 9 October 1989 were as follows:

- Implementation of a common diagnosis of drug addiction in Europe with the creation of an observatory in the long term;
- Convergence of policies with regard to drug addiction, especially prevention;
- Strengthening of controls at outer borders and development of coordination among the 12 Member States, involving all services responsible for public security;
- Coordination of policies among the 12 with regard to producer and transit countries and especially agreement at the demands for cooperation from these countries;
- Designation in each of the countries, as well as by the Commission, of a person with the authority to synthesise and reflect on the entirety of our preoccupations in the fight against drugs.

Starting from there, the CELAD (European Committee to Combat Drugs), a coordination body of national drugs coordinators, was quickly established, the first global European Action Plan on Drugs was elaborated and finally approved by the European Summit in Rome in 1990, and the Commission was asked to launch the preparatory work (feasibility study) for the setting up of the European Drugs Monitoring Centre, as well as its European-wide network of scientifically based national information systems and data collection centres, the so-called REITOX-network.

The EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) is currently one of over 15 established decentralised EU agencies and was created in 1993<sup>2</sup>. It became fully operational in 1995, and collects, analyses and disseminates information on the drug phenomenon in Europe.

The Centre's founding regulation states that it should work exclusively in the field of objective, reliable and comparable information at European level on the problem of drugs and drug addiction.

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<sup>2</sup> European Council regulation (CEE) n° 302/93, 8 February 1993.



The aim in creating such a Centre was to facilitate informed decision-making. By endowing the European Union with such a tool, the legislator's aim was to contribute, through the EMCDDA, to making available to the Community and the Member States an overview of the phenomenon of drugs and of drug addiction that would be likely to support reflection and the decision-making process by the authorities responsible for drug policies.

Despite the lack of a specific juridical basis on drugs in the treaty, the Community adopted in 1990<sup>3</sup>, 1992<sup>4</sup>, 1993<sup>5</sup>, respectively 3 legal instruments concerning the diversion of chemical precursors and money laundering. These instruments aim to give early warning of the practices or fraudulent transactions and install effective cooperation between the economic and financial actors and the public administration.

## **6. TACKLING THE DRUG PROBLEM AFTER THE MAASTRICHT TREATY**

### **a) The Maastricht Treaty and drugs**

#### *An emerging competence of the European Union*

The Treaty on European Union represents a major step forward in the fight against drugs. It extended the Community's scope for action in the field of drugs: drugs and drug addiction as a public health priority, 1<sup>st</sup> pillar, as well as the scope for cooperation between the Member States: drug trafficking and drug-related crime, a priority for cooperation in the field of justice and home affairs, 3<sup>rd</sup> pillar, and in the field of Foreign and Security Policy: drugs producing and trafficking, a priority for cooperation with the third (producer and transit) countries, 2<sup>nd</sup> pillar.

Since the end of the 1980s, the European Community had stimulated the cooperation among Member States in the area of **public health**. Encouraged by the European Parliament, budgets were allocated to support specific projects of exchange and cooperation at European level in the area of prevention of drug use. In 1992, at the initiative of the European Committee to Combat Drugs (CELAD), the

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<sup>3</sup> Council regulation (CEE) n° 3677 / 90.

<sup>4</sup> Directive (CEE) n° 109 / 92.

<sup>5</sup> Directive (CEE) n° 91/ 308.

European Commission coordinated across the Community its first major prevention campaign. Its primary success was to have led health and social authorities in the Member States to work together for the first time in this domain. Two other European campaigns of this sort were also organised during the 1990s. The allocation by the Maastricht Treaty of Community competence in the field of public health, which excludes, however the harmonisation of legislation, allowed for an expansion and diversification in this area, among others through the implementation of a whole range of specific actions. The Community action programme for the prevention of drug addiction (1996-2000) largely facilitated the creation of networks at EU level of practitioners and professionals in the field of demand reduction.

This legal framework opened up new possibilities, and among them, the creation of **Europol, the European Police Office**. Europol was created in 1994 to improve the effectiveness and cooperation of the competent authorities in the Member States in preventing and combating terrorism, unlawful drug trafficking and other serious forms of international (organised) crime.

Indeed it originally started life as the sole drugs law enforcement European Office: the so-called “Europol drug unit”.

Another legal instrument that has been adopted during this period and which aims at combating the drug phenomenon is the **Joint Action on the approximation of drug legislation** (17 December 1996)<sup>6</sup>.

The objective of this Joint Action was to strengthen cooperation among the Member States in combating drug addiction and drug trafficking through the approximation of their laws and practices. Some of the aims of the Joint Action have been implemented since 1997, for example :

- *approximate laws to combat illegal drug trafficking and ensuring that penalties imposed are among the most severe available for crimes of comparable gravity;*
- *to ensure closer cooperation among European police, customs services and judicial authorities;*
- *the collaboration in order to promote a rapid information system regarding synthetic drugs.*

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<sup>6</sup>JOINT ACTION 96/750/JHA of 17 December 1996 adopted by the Council on the basis of Article K.3 of the Treaty on European Union concerning the approximation of the laws and practices of the Member States of the European Union to combat drug addiction and to prevent and combat illegal drug trafficking OJ n° L 342 of 31/12/1996, p. 6



This very last objective was implemented in June 1997 with the adoption of the **Joint Action on new synthetic drugs**<sup>7</sup>. It founded a European-wide early warning system for the rapid exchange of information on new synthetic drugs and the scientific assessment of their health and social risks in order to facilitate the application of control measures in all Member States. In order to facilitate, if the case arises, the homogenous application of control measures in all the Members States, several substances have been placed under control by the Council of Ministers at the end of the process

### **b) The Amsterdam Treaty and drugs**

#### *The Area of Freedom, Security and Justice and the EU-Strategy on Drugs*

The Treaty of Amsterdam has represented a new step forward in the fight against drugs. It has introduced the objective of providing citizens with a high level of safety within an **“Area of freedom, security and justice”**. The fight against drugs is an inseparable objective of this area and the Treaty refers again to the possibility to introduce prevention measures (Article 152 TEC) and the setting up of reinforced cooperation on the fight against illicit drug trafficking (Title VI).

The European Council held a special meeting on 15 and 16 October 1999 in Tampere, Finland, on the creation of an area of freedom, security and justice in the EU. In the conclusions of this summit, the European Council considered that efforts to agree on common definitions, incriminations and sanctions should be focused in the first instance on a limited number of sectors of particular relevance, such as drugs trafficking. This objective has now been reached: the framework decision to harmonise minimum sanctions against drug trafficking has been finally adopted by the Council of Ministers in November 2003<sup>8</sup>. This framework decision invites countries to ensure that *“offences... are punishable by criminal penalties of a maximum of at least between 1 and 3 years of imprisonment”* (Art. 4.1 penalties), or *between 5 and 10 years of imprisonment when (a) the offence involves large quantities of drugs or (b) the offence... involves those drugs which cause the most harm to health...* (Art. 4.2 penalties).

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<sup>7</sup> JOINT ACTION 97/396/JHA of 16 June 1997 adopted by the Council on the basis of Article K.3 of the Treaty on European Union, concerning information exchange, risk assessment and control of new synthetic drugs; OJ n° L 167 of 25/06/1997, p. 1

<sup>8</sup> COM/2001/0259]

Following the European Summit in Tampere, during which the European Council also underlined the importance of addressing the drugs problem in a comprehensive manner, the **EU Strategy (2000-2004)** was adopted in Helsinki in 1999, and the subsequent **EU Action Plan on Drugs (2000-2004)** in Santa Maria da Feira, Portugal, in 2000.

The EU strategy and the EU action plan call both for a multidisciplinary and integrated approach to drugs, including drug demand and supply reduction as equivalent parts of a well-balanced strategy.

### **The EU strategy sets out 6 main targets, which are**

- to reduce significantly over five years the prevalence of drug use, as well as new recruitment to it, particularly among young users under 18 years of age;
- to reduce substantially over five years the incidence of drug-related health damage (HIV, hepatitis, TBC, etc.) and the number of drug-related deaths;
- to increase substantially the number of successfully treated addicts;
- to reduce substantially over five years the availability of illicit drugs;
- to reduce substantially over five years the number of drug-related crimes; and
- to reduce substantially over five years money-laundering and the illicit trafficking of precursors.

Beyond these general goals, the EU action plan on drugs includes elements concerning all aspects of the problem and underlines the importance of a process based on scientific information, coordination and evaluation, as crucial elements of the success of measures taken by the EU to tackle the problem.

Basically, the new **EU Drugs Strategy (2005-2012)** adopted by the European Council on 17 December 2004 reflects more continuity than innovation, compared with its predecessor (2000-2004). In particular, one can regret that the remarkable technical tools of evaluation prepared by the EMCDDA were not used to the full. No concrete measurable targets have been introduced into the new strategy (and the subsequent Action Plan) and so, the declaratory character of the strategy will remain unchanged for the next period, and its efficiency will not be therefore qualitatively improved. There is still a long way to go to meet convincingly the challenges posed by the situation of drugs on the ground and in the society of an enlarged European Union with almost half a billion inhabitants.



## **7. EUROPE AND DRUGS BY THE TIME OF THE EUROPEAN CONSTITUTION**

The 5<sup>th</sup> enlargement of the European Union has brought in ten new countries in which, as we have seen, drug consumption is rapidly growing. Moreover, new geo-political dangers are threatening not only the 25 EU Member States, but also the candidates (including Bulgaria, Romania and Turkey), and even more, all the countries located along the various routes between Europe and Asia, in particular Afghanistan, and its opium production. The level of opium production must really be taken seriously by Europeans, particularly since, given the current phase of the reconstruction of Afghanistan, poppy-growing and development appear to be largely beyond the control of the authorities in Kabul. In the light of this, the dramatic developments in terms of trafficking and consumption to, through and from Central Asia and the Caucasus, Russia and Ukraine, must be regarded as a time-bomb for the weakest and most vulnerable in Central and Eastern Europe, and also for the current European Union members, and should therefore be the subject of closer cooperation and partnership action, in a spirit of resolute determination. Russia and its 2 500 000 problem consumers cannot be regarded for long as a distant problem alien to the EU, since from 1 May 2004, the common border with this country is over 2 000 km long. In the enlarged European Union of the 2000s, drugs will constitute a high and persistent risk for society and individuals.

Faced with this formidable challenge, the European Union still has only disparate, fragmented and weak powers, which are under-used because of a lack of sufficient political will. Over the past 10-15 years, however, the current Member States have gradually developed converging policies and strategies, and in some cases even common approaches.

The European Union Action Plan on Drugs, to be adopted in the first half of 2005, still does not have a straightforward, clear and solid legal basis, and coordination within the Union of sectoral priorities and budgets is often only symbolic, whereas each year some EUR 100 million are allocated to various programmes and projects relating to drugs.

A particular regret in this respect, mentioned by the European Parliament in 1999 in its report on the 1999-2004 Action Plan, is:

- the lack of real participation by civil society in the process of drafting, implementing and evaluating the Action Plan;

- the lack of a powerful programme to boost European research into drugs;
- the fragmentation and incoherence of the projects and management of available human and financial resources.

The only way of making the qualitative leap required by this challenge was to establish a suitable legal basis in the future Constitution on the European Union, as proposed by Mr Lamassoure during the work of the European Convention. An “introductory” article laying down the principles of coordination and of serious, scientifically-founded information and evaluation of the fight against drugs in Europe, in the context of power-sharing by the European Union and the Member States, would have had a positive and real impact on the convergence of national approaches to this major societal phenomenon of drugs and drug addiction. Unfortunately, the draft constitutional treaty now proposed to the peoples of Europe for approval does not include any new provision on drugs

On this strategic matter as on others, the construction of the social component of the European Union and of the Single Market is still lagging behind, therefore requiring stronger involvement and mobilisation from the civil society in the years to come.