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**REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND
THE COUNCIL**

on progress in the EU's 2013-2020 Drugs Strategy and 2013-2016 Action Plan on Drugs

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1. Introduction and Context

Illicit drugs are a complex social problem, which affects the lives of millions of people. While consumption of drugs such as heroin or cocaine has gone down in the past few years, new psychoactive substances are increasingly accessible on the open market and/or online, posing serious health threats.

The human and social costs of drugs addiction are very high. They generate costs for public health (on drug prevention and treatment, healthcare and hospital treatment), public safety, the environment and labour productivity.

At least 78.9 million Europeans reported having used cannabis at least once in their lifetime, while cocaine and amphetamines have been tried by 15.6 and 12 million people respectively. In addition, 1.3 million adults are problem opioid users and 3.4% of all deaths of Europeans aged between 15 and 39 are from drug overdoses. According to latest estimates, 1.700 individuals died in the EU of HIV/AIDS attributable to drug use in 2010¹. In 2013, 1 446 cases of HIV attributable to injecting drug use were newly reported in the EU². In 2014, 101 new psychoactive substances were detected, 22% more than in 2013.

The European Agenda on Security³ acknowledges Europol's assessment that the market for **illicit drugs is the most dynamic criminal market**. Drug trafficking and drug production remain among the most profitable criminal activities for organised crime groups active in the EU. The value of the European opiates market has been estimated at approximately EUR 12 billion⁴, while the estimated use of cannabis, the most popular drug in the EU, amounts to 2 000 tonnes. Cocaine is the second most widely used drug in the EU: in 2013 EU Member States seized more than 61 tonnes of it⁵. In addition, the internet has emerged in the last couple of years as an online marketplace for drugs⁶.

In 2013 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) improved its reporting on the situation on drugs in Europe. Also, in 2013 the EMCDDA and Europol issued the first EU drug markets report at the European Commission's request. The two EU agencies will publish a second edition in early 2016.

Drugs are a global problem. It is estimated that a total of 264 million people between the ages of 15 and 64 used an illicit drug in 2013. Some 27 million people suffer from drug use disorders or drug dependence. Almost half (12.19 million) of these inject drugs, and an estimated 1.65 million of those who inject drugs were living with HIV in 2013⁷.

In April 2016 the **United Nation's General Assembly will hold a Special Session (UNGASS) on drugs** that will look at how to improve global drugs policies while strengthening public health and human rights aspects as part of the UN Conventions on drugs⁸. This will be a turning point for the

¹ EMCDDA European Drug Report 2015

² EMCDDA reporting

³ COM (2015) 185

⁴ General Report on Europol's activities in 2014

⁵ Interim SOCTA 2015: An Update on Serious and Organised Crime in the EU, Europol, March 2015

⁶ EMCDDA and Europol joint report: EU Drugs Market Report: a strategic analysis, 2013

⁷ United Nations Office on Drugs and Crime (UNODC), World Drug report 2015

⁸ The 1961 Single Convention on Narcotic Drugs; the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

international community in determining the future of drugs policy. The EU's voice will count in this context.

The **EU's 2013-2020 Drugs Strategy**⁹ and the **2013-2016 Action Plan on Drugs**¹⁰ set out the EU's political framework and priorities on drugs policy. The strategy provides a single and evidence-based framework for tackling drugs inside and outside the EU. It aims to contribute to reducing both demand and supply for drugs within the EU, and to reducing the health and social risks and harm caused by drugs. The Strategy has three cross-cutting themes: (a) coordination, (b) international cooperation and (c) research, information, monitoring and evaluation.

This Report presents the **main progress** the EU achieved in 2013 and 2014 in implementing its 2013-2020 Strategy and 2013-2016 Action Plan on Drugs. Detailed findings are presented in the annexed Commission staff working document.

2. Method

The EU Action Plan on Drugs identifies who is responsible for implementing its actions and sets deadlines for each of them. This review, which covers 2013 and 2014, is based on contributions from the EMCDDA, Europol, Eurojust (the European Union's Judicial Cooperation Unit) and CEPOL (the European Police College). Contributions were also received from the European External Action Service and the Council Presidency.¹¹ The Commission also conducted a survey among EU countries¹² and civil society organisations with an interest in drugs policy¹³. This report focuses on the outputs of EU's Drugs Strategy and Action Plan.

3. Reducing drug demand

Prevention

According to a 2014 Eurobarometer survey on youth and drugs¹⁴, drug experimentation often starts during school years: it is estimated that one in four 15 and 16 year-olds have used an illicit drug¹⁵. **Awareness raising and counselling** remain the most common prevention activities used to reach young people thought to be at risk for substance abuse, such as school students with academic and social problems¹⁶. In 2013, less than half of all EU countries reported to the EMCDDA that they had fully implemented school drug policies. However, **general information campaigns** in schools about substance abuse are reported to be widely available in the EU¹⁷. Most EU countries reported having had specific programmes and/or measures aimed at **delaying the first use of illicit drugs** in the period 2013-2014.

⁹ OJ C 402, 29.12.2012, p. 1

¹⁰ OJ C 351, 30.11.2013, p. 1

¹¹ Including on the results of a survey conducted in April 2015 by the Council Presidency among Member States on the issue of misuse of and dependence on medicines. Although the survey is not part of the 2013-2014 timeframe, its results are used in this report because they show the state of play in the Member States in relation to actions 4 and 50 of the EU Action Plan on Drugs. This state of play is relevant also for the period 2013-2014.

¹² All Member States responded to the survey

¹³ Organisations from France, Greece, Hungary, Italy, Lithuania, Luxembourg, Netherlands, Portugal, Spain, Slovenia and Sweden responded to the questionnaire. Some of these organisations are network/umbrella organisations that represent several other organisations from the same country or from others, active in this field.

¹⁴ 2014 Flash Eurobarometer 401 "Young people and drugs"

¹⁵ <http://www.emcdda.europa.eu/data/2014>

¹⁶ EMCDDA reporting

¹⁷ Substance abuse includes alcohol, tobacco and drugs. Information provided by the EMCDDA

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The Mondorf Group, a collaborative group including Luxembourg and its border regions from France, Germany and Belgium, organized prevention activities by combining a non-drug-centred approach with intercultural components and has been organising leisure activities for youngsters based on the concept of ‘adventure pedagogy’. The activities primarily aim to provide the opportunity to youngsters to experience group dynamics, conflict management, limit and risk assessment as well as the feeling of solidarity within a group of socially and culturally different people.

Most EU countries, including civil society, reported having run **awareness initiatives** on the risks and consequences of using illicit drugs and other new psychoactive substances.

All EU countries reported having **implemented prevention measures**. Many EU Member States run universal prevention programmes and a few of them report on implementing selective¹⁸ and indicated¹⁹ prevention programmes. Half of the EU Member States reported implementing anti-drugs campaigns in recreational settings such as music festivals, parties, night-life and club venues. A majority of EU countries stated that the availability of prevention measures has improved or remained stable in 2013 and 2014. Some civil society representatives however, pointed to a fall in public spending in this area due to budgetary constraints.

Misuse of and dependence from prescribed medicines

The **misuse of and dependence on prescribed medicines in the EU deserves further work and analysis**. Benzodiazepines²⁰ are often misused by high-risk opioid users and are associated with morbidity and mortality in this group.²¹ It is thought that opioid analgesics and anaesthetics²², medicines primarily prescribed for their psychoactive effects and as a substitute medication to treat addiction, are likely to be misused. However, only very limited data is available in the EU countries to obtain a complete estimate of misuse, happening in various contexts, in the whole of the EU. Therefore, the scale of the problem and the response within the EU need to be further refined in order to decide on the actions to take in the future.

Treatment

In 2013 and 2014 **integrated treatment services**²³ with good coverage **were available in all EU Member States**. Half of the EU countries considered that there was no major change in the availability of treatment services in 2013-2014 in their country; most of the rest of the EU countries considered that this availability increased. On the other hand, some civil society representatives claim that the availability of treatment services fell due to budget cuts.

In 2013-2014 a wide range of **comprehensive and integrated treatment services** existed in EU countries. Half of the EU Member States reported that these treatments did not diversify in 2013 and 2014 compared with previous years.

¹⁸ "Selective prevention" strategies target subsets of the total population that are deemed to be at risk of substance abuse by virtue of their membership of a particular population segment, for example young offenders, school drop-outs, or students who are failing academically. Risk groups may be identified on the basis of social, demographic or environmental risk factors known to be associated with substance abuse, and targeted subgroups may be defined by age, gender, family history or place of residence such as deprived neighbourhoods or those with high drug-use or trafficking.

¹⁹ "Indicated prevention" addresses vulnerable individuals and helps them in dealing and coping with the individual personality traits that make them more vulnerable to escalating drug use.

²⁰ Benzodiazepines are a group of widely prescribed medicines with a range of clinical uses, including treatment of anxiety and insomnia and the management of alcohol withdrawal. Examples of such medicines are: diazepam, clonazepam, alprazolam and oxazepam

²¹ [The misuse of benzodiazepines among high-risk opioid users in Europe. Report by EMCDDA, 2015](#)

²² Prescribed and over-the-counter, if applicable

²³ As per action 5 of the EU Action Plan on Drugs. More details are also available in the accompanying Commission staff working document

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Drug treatment in England is very accessible. The latest treatment data (for 2013-14) shows that 98% of people referred to treatment started it in less than three weeks. Waiting times are low – around three days to enter treatment. Improvements to the treatment system over a decade, has resulted in the waiting time falling from two months in 2001 to just three days in 2013-14.

Most drug treatment in Europe is provided in **outpatient settings**²⁴. One tenth of drug treatment is provided to patients admitted to hospital or specialised centres.²⁵

Rehabilitation/recovery services evolved in 2013 and 2014 but almost half of the EU countries reported no expansion in such services. Likewise, many civil society representatives reported that there was no expansion in rehabilitation/recovery services in their countries in 2013 and 2014.

Risk and harm reduction

By 2013 all EU countries had adopted public health policy objectives to prevent and reduce health-related harm associated with drug dependence²⁶. Most EU countries reported having taken specific action in 2013 and 2014 to ensure availability of and access to evidence-based **risk and harm reduction measures**.

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In Cyprus, a low-threshold programme²⁷ established in 2013 implemented the first ‘snowball’ programme on a pilot basis in 2014. Former or current Injection Drugs Users (IDUs) were recruited and took part in a training which included information on HIV/AIDS, Hepatitis, Tuberculosis, First aid techniques, Safer Sex and Safer Drug Use. After the training each participant recruited three other IDUs and shared knowledge obtained during the training as well as collected data on high risk drug use behaviour using a questionnaire.

All EU countries have in place opioid substitution treatment (OST) and needle and syringe programmes as core measures to prevent and control infections among people who inject drugs and the coverage of the two programmes increased considerably. However, in 2013, needle and syringe programmes were far from full coverage in all countries and especially in prisons²⁸. Several countries also reported reductions in harm reduction services in recent years, and some countries have only limited provisions of these services.²⁹

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In the Czech Republic, accessibility of substitution treatment is limited. Methadone is free of charge for patients, but available just in approximately 10 specialised centres. The majority of OST patients are on buprenorphine, which, however, in practice is not covered by health insurance and majority of

²⁴ An outpatient is a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment. Data reported by the EMCDDA

²⁵ This is the case because in many countries specialised centres can prescribe opioid substitution treatment. Information reported by the EMCDDA

²⁶ According to the [Report on the current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm, associated with drug dependence, in the EU and candidate countries](#), Gesundheit Oesterreich & Sogeti, 2013

²⁷ Low-threshold" programmes are programmes that make minimal demands on the patient, offering services without attempting to control their intake of drugs, and providing counselling only if requested

²⁸ Ibid footnote 26

²⁹ EMCDDA reporting

patients have to pay very high price for their medication (approximately half of average monthly salary per month). This drives the black market in buprenorphine.

A few countries provide supervised **drug consumption facilities**³⁰ and some EU countries also provide take-home naloxone programmes³¹.

Although progress has been made in recent years, drug use resulting in overdoses or drug-related diseases, accidents, violence and suicide remains one of the major causes of avoidable mortality in young people in the EU. **The EU estimated number of deaths from drug overdoses only was a minimum of 5.800 in 2013**³². Since 2003 most countries have been unable to reduce the number of deaths from overdoses. However, it is worth noting that overall, the coverage and availability of harm reduction measures in the EU appears to be associated with declines in levels of reported drug overdose. HIV infections among injecting drug users decreased in 2013. However, infection rates for hepatitis C were still high in many countries³³.

Drug use in prisons

Substance use is higher among prisoners than among the general population. In 2013 and 2014, most EU countries had healthcare policies in place for drug users during imprisonment. More than half of these countries also plan to increase existing measures by the end of 2016 and a majority of those who do not currently implement such measures, plan to start doing so by the same date.

In 2013 and 2014, prison and community-based services provided continuity of care for drug users in more than half of the EU Member States with particular emphasis on avoiding drug overdoses³⁴.

In 2013, opioid substitution treatment was reported to be available in prisons in a large majority of EU countries³⁵. However, in some countries treatment in prison was limited to persons that already had a prescription before they were incarcerated.

Only some countries had **specific funding in place for drug demand reduction** activities in 2013 and 2014. Often the budget for such activities is incorporated into related areas such as healthcare, education and welfare.

4. Reducing drug supply

Europol reports that drug trafficking was the major crime area in 2013 and 2014 in terms of cases initiated and information flow. An estimated 230 000 drug supply offences were reported in 2013, 57% of which related to cannabis³⁶. More than 1 600 new drug-related cases were launched in 2014 in the EU targeting organised crime groups trafficking cocaine, heroin, synthetic drugs and cannabis³⁷.

In 2014, **101 new psychoactive substances** were reported for the first time in the EU, compared with 41 in 2010. More than 450 are currently being monitored by the EMCDDA. In 2013, 33 000 seizures

³⁰ Questionnaire responses supplemented with data from the EMCDDA report "[Perspectives on drugs. Drug consumption rooms: an overview of provision and evidence](#)", 2015

³¹ Naloxone is a drug used to counter the effects of opioids especially in overdoses. EMCDDA reports that some naloxone programmes are small and time limited. In one country naloxone distribution programmes are provided for high-risk users in the community and to inmates upon release from prison.

³² EMCDDA reporting

³³ EMCDDA Drugs report 2015

³⁴ Although in some countries this is true only in some prisons

³⁵ According to the EMCDDA

³⁶ EMCDDA reporting

³⁷ Europol reporting

of new psychoactive substances were made, amounting to more than 2.3 tonnes. The production of such substances, including tableting, packaging and labelling, is increasingly taking place inside the EU³⁸, but they are also brought into Europe from non-EU countries. EU Member States report that China was the main source of new psychoactive substances delivered to Europe in 2014.

In 2013 and 2014, the EMCDDA issued 182 formal notifications on new psychoactive substances and 32 public health alerts and advisories to the Early Warning System Network. Many of these concerned serious adverse events, particularly deaths, and/or hazards that had the potential to cause serious harm. In this period, the EMCDDA and Europol conducted seven risk assessments on new psychoactive substances posing health concerns. On this basis³⁹ the Commission submitted proposals to the Council to make two substances subject to EU-wide controls in 2013, with a further six following in 2014⁴⁰. All the Commission's proposals were adopted by the Council, following a positive opinion given by the European Parliament.⁴¹

Given the magnitude of the threat from new psychoactive substances, the Council and the European Parliament needed to decide on a new, faster and more effective system to tackle the threats. In September 2013 **the Commission adopted a legislative package**⁴² to meet these objectives. Since then the package has been subject to discussions by the co-legislators.

In 2013 and 2014 the EMCDDA worked with EU countries to obtain accurate, reliable, comparable and high-quality **data across the EU on drugs supply**. This will allow assessing the situation and the effectiveness of policies targeting supply reduction. Data will be collected on a pilot basis in 2015.

The number of cases of drug trafficking referred to Eurojust increased only slightly in 2014 compared with the previous year. A project run by Eurojust on drug trafficking in 2014 found that differences in substantive and procedural rules in the EU countries were **a major obstacle in investigations of drug trafficking** and in identifying, tracing and recovering of assets stemming from cross-border organised criminal activities. The project also found that freezing and confiscation orders were very little used in drug trafficking cases⁴³. In 2013 and 2014 a majority of EU countries put in place initiatives to counter cross-border trafficking and improve security with other Member States.

In 2013 and 2014 CEPOL organised training on drugs and drug-related issues for close to **1 300 participants** from EU countries, associated countries, candidate countries and EU agencies. Just over half of the EU countries reported **good cooperation** on drug-related issues between law enforcement

³⁸ Ibid. footnote 4

³⁹ An eighth risk assessment (on 4-methylamphetamine) was conducted by EMCDDA and Europol in 2012

⁴⁰ Council Implementing Decision (EU) 2015/1876 of 8 October 2015 on subjecting 5-(2-aminopropyl)indole to control measures; Council Implementing Decision (EU) 2015/1874 of 8 October 2015 on subjecting 4-methylamphetamine to control measures; Council Implementing Decision (EU) 2015/1875 of 8 October 2015 on subjecting 4-iodo-2,5-dimethoxy-N-(2-methoxybenzyl)phenethylamine (25I-NBOMe), 3,4-dichloro-N-[[1-(dimethylamino)cyclohexyl]methyl]benzamide (AH-7921), 3,4-methylenedioxypropylvalerone (MDPV) and 2-(3-methoxyphenyl)-2-(ethylamino)cyclohexanone (methoxetamine) to control measures; Council Implementing Decision (EU) 2015/1873 of 8 October 2015 on subjecting 4-methyl-5-(4-methylphenyl)-4,5-dihydrooxazol-2-amine (4,4'-DMAR) and 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine (MT-45) to control measures

⁴¹ The European Court of Justice's Judgment of 16.04.2015 in cases C-317/13 and C-679/13 required that the European Parliament is consulted before the adoption of the Council Decisions to ban new psychoactive substances. Therefore, all Council Decisions adopted or pending adoption before the ECJ's judgment had to be adopted again by the Council, following the consultation of the European Parliament. This happened in October 2015.

⁴² The package comprises: the Proposal for a Regulation of the European Parliament and of the Council on new psychoactive substances and the Proposal for a Directive of the European Parliament and of the Council amending Council Framework Decision 2004/757/JHA of 25 October 2004 laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking, as regards the definition of drug

⁴³ Based on Council Framework Decision 2006/783/JHA of 6 October 2006 on the application of the principle of mutual recognition to confiscation orders (OJ L 328, 24.11.2006, p. 59) and Council Framework Decision 2003/577/JHA of 22 July 2003 on the execution in the European Union of orders freezing property or evidence (OJ L 196, 02/08/2003 p. 45)

units and relevant bodies⁴⁴, although not all of them have memoranda of understanding in force to formalise cooperation.

In 2013 there were a total of **846 cases of seizures and stopped shipments of drug precursors intended for illicit use**; in 2014 there were **628 cases**⁴⁵.

Several EU countries pool their enforcement capabilities in the Maritime Analysis and Operations Centre (Narcotics) (MAOC-N) in order to intercept drug shipments in the Atlantic Ocean in particular. Since its establishment, the Centre has coordinated the interdiction of over **120 vessels** and seizure of over **100 tonnes of cocaine** and **300 tonnes of cannabis** with a retail commercial value in the EU of **EUR 8 billion**. The Centre's activities are also supported by EU funding.

In 2013 and 2014 the legal system in most EU countries provided for **alternatives to coercive sanctions for drug-using offenders**. Almost all those EU countries provided for treatment and rehabilitation, while half provided for education, aftercare and social integration.

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In Portugal, a law, in place since July 2001, decriminalized illicit drug use and related acts, but maintains drug use as an illicit behaviour. It is a crime to possess drugs in a quantity greater than the average for the individual consumption during a period of 10 days. However, a person caught in possession of an inferior quantity, without any suspicion of being involved in drug trafficking, will be evaluated by a local Commission for Dissuasion of Drug Addiction, composed of a lawyer, a doctor and a social worker. Administrative sanctions can be applied, but the main objective is to facilitate access to treatment and the return to life in health and in society. These Commissions act as a “second line” of preventive interventions, evaluating the personal circumstances of drug users referred by police and directing them to the appropriate responses.

Another challenge is the emergence of the internet as an online marketplace for drugs. **More than half of the EU countries specifically targeted drug-related crime over the internet**, with a number of them targeting websites used to sell synthetic drugs. Eurojust and Europol also reported carrying out several actions targeting drug-related crimes over the internet.

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In Germany the Federal Criminal Police Office (BKA) detected an increase of narcotic-selling of all kinds via the Internet. The main focus lies within synthetic drugs. In addition the trade with drugs shifts increasingly from the Clear web in the so-called Darknet. Therefore anonymization and encoding occur, which makes the identification of administrators, vendors and customers very difficult. Furthermore the usage of virtual currencies, such as Bitcoin, offers even more anonymity for the users. On account of this very increasing phenomenon BKA has installed a working group “drug trafficking via the internet” since November 15th, 2014. The working group currently consists of 2.5 staff members.

Only some countries had **specific funding in place in 2013 and 2014 for drug supply reduction** activities. Usually the budget for such activities is incorporated into related areas such as the general criminal police budget.

⁴⁴ Such as airlines, air express couriers, shipping companies, harbour authorities, and chemical companies

⁴⁵ EU database on drug precursors

5. Coordination

Responding effectively to the **cross-sector nature of the drugs problem requires coordination** between the different policy areas at EU and national level in the EU Member States.

The Council has a specific working party to deal with drugs issues across the board. Within this group, Council presidencies have been pursuing an agenda that follows closely the EU Drugs Action Plan. However, a few EU countries felt that not all actions were being addressed on a systematic basis. The Council's rotating presidencies have also made efforts to establish closer links and information sharing with the other working parties dealing with law enforcement.

Almost all EU Member States say that they coordinate their **positions in the EU Council Working Parties on drug-related issues** with all relevant parties at national level.

In 2013, apart from one country which has a regional-based approach, all EU countries had national **drugs strategies** in place. While a majority of the strategies were specifically focused on illicit drugs, in some EU countries drugs are included in broader addiction policies that include tobacco, alcohol and sometimes, other addictive behaviours. In recent years, an increasing number of countries have performed a final evaluation of their drug strategy or action plan⁴⁶. All EU Member States reported that **civil society organisations**⁴⁷ were involved in the development, monitoring and/or evaluation of their national drugs policy in 2013-2014.

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In Slovakia, NGOs have their representative (governmental deputy) in the main coordination body that is the Council of the Slovak Republic Government for Drug Policy) that is entitled to invite representatives to the Council meetings and particular agenda items discussion. In addition, during preparation of new strategic documents (strategy, action plans), representatives of NGOs are requested to submit their ideas, either via the governmental deputy, or directly. They have also legal competence to provide their remarks and suggestions within the documents' approval procedure. Their remarks and suggestions have to be discussed and the most reasonable have to be taken into account; any discrepancy should be avoided, otherwise the approval procedure can be stopped.

A majority of the civil society representatives confirmed having been involved in the development, monitoring and or evaluation of their country's drug policy in 2013-2014, although some also said that there was **no structured dialogue** in place for this. While many of the civil society representatives considered that the kind of cooperation they had at national level was useful, a few mentioned that there was no role for civil society in shaping drugs policies in their countries. At EU level structured dialogue exists between the Commission and civil society through the Civil Society Forum on Drugs, which provides advice to support policy formulation and implementation.

Civil society representatives considered that **insufficient resources** were allocated at national level to fulfil the priorities of the EU Drugs Strategy in 2013 and 2014. Many NGOs also reported budget reductions.

⁴⁶ EMCDDA reporting

⁴⁷ Namely professional drug service providers; non-governmental organisations active in the field of drugs policy; non-governmental organisations representing the interests of individual stakeholders in the field of drugs (drug users/family members etc.); the scientific community

Evidence of drug-related public expenditure at national level remains sparse. For the 19 countries that have produced estimates in the past 10 years, expenditure is estimated at between 0.01% and 0.5% of GDP, with healthcare representing between 24% and 73% of all drug-related expenditure⁴⁸.

6. International cooperation

At international level, an important goal enshrined in the EU Drugs Strategy is for the EU to speak with one voice in the international arena and with partner countries. In 2013 and 2014 the EU largely managed to present a coordinated position in international meetings. Although steps have been taken to achieve greater EU synchronisation in United Nations (UN) institutions, better coordination between delegations to the UN in Vienna and the Council's Horizontal Group on Drugs in Brussels is needed.

EU positions were prepared for meetings at the UN or in other international fora dealing with drug-related matters. A common EU position is being prepared for UNGASS 2016.

The EU has a **longstanding cooperation with non-EU countries** such as the US, countries in Latin America, the Caribbean, central Asia and the Western Balkans, Russia and the European Neighbourhood countries, with which it holds regular expert meetings on drugs. It also has specific agreements on cooperation regarding drug precursor control with 11 countries such as China, US and Mexico. Within these agreements experts meetings take place on a regular basis, mostly annually.

In 2013 and 2014 cooperation with **European Neighbourhood countries and Russia** had focused on drug supply reduction but cooperation was less dynamic than in the past. This was most likely also due to the challenging security situation along Europe's eastern border. The emergence in the **enlargement countries** of national drug strategies in line with the EU Drug Strategy and Action Plans represents significant progress⁴⁹. The **EU-CELAC**⁵⁰ coordination and cooperation mechanism on drugs and the joint follow-up group on precursors⁵¹ held meetings focusing on tackling the world's drug problem. The EU policy on drugs in the Latin American region is also supported by a number of regional and bilateral cooperation projects⁵². Dialogues between the **EU and US** focused on topics such as: dealing with new psychoactive substances, abuse of prescribed medicines and preparation for UNGASS 2016.

The approach taken by the EU's external cooperation programmes on drugs aims to tackle drug supply and demand in a balanced way, while also promoting and protecting human rights.

Some of the major drug-related projects the EU funded in 2013 and 2014 included:

- COPOLAD, a regional cooperation programme on drugs policies with Latin America⁵³;
- the Cocaine Route Programme⁵⁴ active in 38 countries in West Africa, Latin America and the Caribbean;

⁴⁸ EMCDDA reporting

⁴⁹ In 2013-2014 new/updated strategies were adopted in Turkey, Montenegro, the former Yugoslavia Republic of Macedonia and Serbia.

⁵⁰ Community of Latin American and Caribbean States

⁵¹ The EU has seven specific agreements on drug precursors control in Latin America with Bolivia, Chile, Columbia, Ecuador, Mexico, Peru and Venezuela

⁵² i.e. in Bolivia, Peru, Brazil, Ecuador, Columbia

⁵³ COPOLAD, launched in 2010, has been financed entirely by the EU, with a total budget of EUR 6.5 million. In 2014, COPOLAD was extended (to cover 2016-2019). In the second phase, the EU contribution will be EUR 10 million. The grant contract to implement COPOLAD was awarded to a Spanish-led consortium including partners from Europe, Latin America, associate entities from Costa Rica, Poland, Ecuador, Mexico and Romania, CICAD (Inter-American Drugs Abuse Control Commission), IDPC (International Drug Policy Consortium), EMCDDA (European Monitoring Centre for Drugs and Drug Addiction), PAHO (Pan American Health Organisation) and RIOD (Red Iberoamericana de ONGs que trabajan en Drogodependencias) https://ec.europa.eu/europeaid/regions/latin-america/copolad-cooperation-programme-between-latin-america-and-european-union-drugs_en

⁵⁴ <http://www.cocaineroute.eu/>

- the Heroin Route Programme⁵⁵
- the Central Asia Drug Action Programme (CADAP)⁵⁶
- BOMCA 8⁵⁷, also active in central Asia.

The EU is also developing cooperation with West Africa where it is providing support for implementing the ECOWAS⁵⁸ regional action plan on illicit drug trafficking, related organised crime and drug abuse.

The EU is a longstanding supporter of projects and programmes of the United Nations Office on Drugs and Crime (UNODC). The EU finances several projects and programmes in the global fight against drug trafficking providing a total funding of EUR 73 million.

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The cooperation between the EU and Latin America is also defined by COPOLAD, a regional cooperation programme on drugs policies aims at improving the balance, coherence and impact of drugs policies in Latin America as well as the EU-CELAC coordination and cooperation mechanism on drugs. Specifically, it aims at strengthening capacities and encouraging the different stages of drugs policies development process in Latin American countries. According to Latin America national Drugs agencies, COPOLAD has helped to enhance changes in the way drugs policies are perceived, it has help to change paradigms, it has helped to emphasize the need for: A balanced approach between drug demand reduction and drug supply reduction; evidence based-policies; policies based on Human Rights and Public Health principles; consider Gender issues; introduced acceptability for Harm Reduction approaches, which were massively rejected before.

Alternative development aims at giving farmers an economically viable, legal alternative to growing drug crops. Only a few EU countries reported funding such programmes in regions where illicit crop cultivation was taking place or which were at risk of illicit crop cultivation in 2013 and 2014⁵⁹.

In 2013-2014 less than half of the EU countries were involved in helping non-EU countries, including civil society in those countries, to develop and implement **risk and harm reduction initiatives**⁶⁰.

A few EU countries funded projects and/or programmes that tackled **drug-related organised crime** in non-EU countries in 2013-2014⁶¹.

In 2013 and 2014 half of all EU Member States entered into **bilateral agreements, cooperation strategies and/or action plans that included cooperation on drugs with non-EU countries** (mainly with Russia, the Western Balkans, the Middle East and Latin America). The most common types of bilateral cooperation agreements were those that covered coordination, drug demand reduction, drug supply reduction, information, evaluation, research and monitoring and those that covered drug supply reduction only.

7. Information, research, monitoring and evaluation

⁵⁵ <https://www.fight-trafficking.eu/>

⁵⁶ The EU consortium is led by Germany. The central Asian countries covered are: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. The EU allocated EUR 20.7 million to the programme for 2001-13.

⁵⁷ Border Management Programme in central Asia. The EU allocated EUR 33.6 million to BOMCA for 2003-14. One component focused on strengthening counter-drug capacities in agencies working at borders

⁵⁸ Economic Community of West African States

⁵⁹ The main beneficiaries were Afghanistan, Myanmar, Laos, Bolivia, Columbia, Peru, and Ecuador.

⁶⁰ The main beneficiaries were Latin America, central and south-east Asia, African countries, the Western Balkans, the southern Mediterranean and eastern European countries.

⁶¹ The main beneficiaries were the African countries, the Caribbean, South America, the Western Balkans, central Asia and eastern Europe.

In 2013 and 2014, the Commission provided close to EUR 10 million in funding for two drug-related projects under the Socioeconomic Sciences and Humanities programme of the Seventh Framework Programme for Research (FP7). The projects were: Addictions and Lifestyles in Contemporary Europe (ALICE RAP) and the European Research Area Network on Illicit Drugs (ERANID). The overall FP7 support to research on illicit drug amounts to some EUR 60 million, including also studies on: injecting drug users in hepatitis cohorts and HIV-infected pregnant women; innovative treatment options; and improvement of detection technologies for illicit drugs.

Finally, the Commission also provided more than EUR 1.5 million in funding from other financial programmes⁶² to research-related projects in the area of drugs.

In 2013-2014 new key research was carried out in EU countries mainly on drug demand reduction and on blood borne diseases associated with drug use. The next most popular research topics were poly-drug use and the misuse of prescribed controlled medicines; drug problems among prisoners and the availability and coverage of drug demand reduction interventions and services in prison settings. In a few countries, research was being carried out into drug supply reduction and psychiatric and physical co-morbidity.

In 2013 and 2014 almost all EU countries initiated/implemented initiatives to **train professionals**⁶³ in aspects of drug demand reduction and drug supply reduction. Half also initiated or implemented initiatives to train professionals in data collection and reporting on drug demand reduction and drug supply reduction. Some civil society organisations were also involved in training initiatives at national or EU level.

8. Conclusions

Illicit drugs are a complex social problem with very high **human and social costs**. Drug trafficking is one of the most profitable activities for organised crime. For a number of years, the EU has in place a policy that seeks to strike a balance between reducing drug demand and drug supply. This EU model is recognised as valid by many stakeholders and by non-EU countries.

The EU should build on existing relations and dialogues with non-EU countries to give a **new impetus to cooperation on tackling drugs**. If the EU wants its balanced approach to the drugs problem to be adopted around the world, it will need enhanced and targeted cooperation with non-EU countries and with regional and international organisations. EU's engagement and support will help non-EU countries tackle their drugs problems while at the same time helping with reducing the drugs supply to the EU.

New risks emerge regularly. One of these risks is the **rise of new psychoactive substances**. It is now imperative that the European Parliament and the Council reach agreement to put in place a robust and effective system to address the threats posed by new psychoactive substances across the EU. At the same time, efforts are necessary to enhance the capacity to schedule dangerous substances at international level in cooperation with the World Health Organisation.

⁶² The Prevention of and Fight against Crime Programme (ISEC), the Drug Prevention and Information Programme (DPIP) and the Justice Programme funded the following projects: LEADER on enhancing economic analyses of illicit drugs (Clinic Biomedical Research Foundation, Barcelona), Hepatitis C treatment and prevention research (University of Bristol), CASSANDRA research on new psychoactive substances supply chain and diffusion (King's College London), PREDICT – Predicting risk of emerging drugs with in silico and clinical toxicology (Maastricht University).

⁶³ Including healthcare professionals, NGOs, police officers, diplomats, teachers and educators, social workers, researchers and policy-makers, risk analysts, managers of psychosocial rehabilitation programmes, customs officers and customs dogs, judges, attorneys, prison administration

Another challenging development is the emergence of the **internet as a marketplace for drugs**. The EU and the international community need to address this aspect of the drug problem proactively, working together with law enforcement, industry, civil society and other partners to find effective ways to prevent drug trafficking online.

Cannabis is widely used and trafficked in the EU and the recent emergence of synthetic cannabinoid products has added a new dimension to this market. Cannabis is also the subject of intense debate at international level and in Europe, as new legislative developments are being implemented in non-EU countries allowing its use for recreational purposes. It is likely that this debate will continue and raise increased attention in the future.

Although information about **public spending on drug-related policies** in the EU is sparse, there is little doubt that the economic crisis has had an impact on how EU countries are tackling the issue. According to the EMCDDA several EU Member States have reported scaling back their harm reduction services and/or having only low-scale measures in place. In addition, civil society organisations have drawn attention to reductions in national budgets for drug prevention and treatment.

Research efforts in the drugs area will be pursued at EU level. Horizon 2020, the EU Framework Programme for Research and Innovation (2014-2020) and the Justice Programme (2014-2020) will be the main instruments to foster EU research in this area.

The 2016 **United Nation's General Assembly Special Session (UNGASS)** on drugs will be a milestone in the further development of a policy that affects the lives of millions of people worldwide. The model that the EU will promote at UNGASS is an integrated and balanced approach, based on scientific evidence. The EU will also use the event to call for a more humane and public health orientated drug policy at international level. It is of paramount importance that the EU speaks with one voice at UNGASS.

As provided for in the EU Drugs Strategy, in 2016 the European Commission will conduct a **comprehensive evaluation** of its drugs strategy and action plan. The evaluation will look at the impact of the implementation of the EU Drugs Strategy both inside and outside the EU. Based on its results the Commission will decide whether to put forward a proposal for a new 2017-2020 Action Plan.