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Drug and alcohol use among young people

EMCDDA 2003 selected issue

In EMCDDA 2003 Annual report on the state of the drugs problem in the European Union and Norway

Chapter 3

Selected issues

This chapter highlights three specific issues relating to the drug problem in Europe: drug and alcohol use among young people; social exclusion and reintegration; and public expenditure in the area of drug-demand reduction.

Drug and alcohol use among young people

Young people are often at the leading edge of social change, and upward trends in alcohol and illicit drug use by young people constitute an important social development in the EU. The inclusion of alcohol in this section of the report is new and arose out of concerns about complex patterns of substance use and associated dependency, health damage and criminal behaviour. These patterns of psychoactive substance use present a particular challenge for policy-makers to develop an appropriately wide and timely range of responses for effective action.

The EU has set itself a target to reduce significantly, over a period of five years, the prevalence of illicit drug use, as well as recruitment to it, particularly among young people under 18 years of age, and to develop innovative approaches to prevention (COR 32).

Material consulted in the writing of this chapter includes the Reitox national reports and population survey data. Comparable data on young people are largely based on the European school survey project (ESPAD) reports from 1995 and 1999 (ESPAD, 1999), which covered 15- to 16-year-old school students and in which nine Member States participated. The data from the Netherlands in ESPAD surveys are not strictly comparable with those from other participating Member States. Published research, grey literature⁽¹⁵⁴⁾ and government publications on drugs and alcohol use by young people (particularly from France and the United Kingdom) have also been used for reference.

Prevalence, attitudes and trends

Prevalence

Excluding tobacco and caffeine, alcohol is the psychoactive substance used most by young people across the EU. The proportion of 15- to 16-year-old students who have been

drunk at some time in their lives ranges from 36 % in Portugal to 89 % in Denmark⁽¹⁵⁵⁾ (Figure 19)⁽¹⁵⁶⁾. The majority of young people in the EU have never used illicit drugs but, among those who have, cannabis is the most commonly used drug, followed by inhalants/solvents⁽¹⁵⁷⁾. According to the 1999 ESPAD survey in Greece and Sweden, lifetime experience of inhalants/solvent use is as high as or higher than lifetime experience of cannabis use among 15- to 16-year-old students⁽¹⁵⁸⁾.

National school surveys do not measure problem substance use among young people, but they are a very useful source for assessing experimental drug use and attitudes among young people. On the basis of Reitox reports and 1999 ESPAD data, lifetime prevalence of cannabis use was lowest in Portugal (8 %), Sweden (8 %), Greece (9 %) and Finland (10 %). Lifetime prevalence was highest in France (35 %), the United Kingdom (35 %) and Ireland (32 %), followed by Spain (30 %). School survey sample sizes may be found in Statistical Table 3⁽¹⁵⁹⁾. Strict comparability of data in this table is limited as not all Member States used the same school survey methods.

Among 15- to 16-year-old students, in general, lifetime prevalence of use of cannabis, inhalants, tranquillisers and sedatives (without a doctor's prescription) is higher than use of stimulant and hallucinogenic drugs. School students experimenting with cocaine and heroin are relatively rare throughout the EU, with lifetime use of these drugs ranging from 0 % to 4 % (Statistical Table 3).

Most young people who have tried cannabis will have some experience of alcohol and tobacco. Young people who use ecstasy, amphetamines, cocaine and hallucinogens tend to form a separate cluster and belong to specific social groups. Relationships in consumption of different drugs are shown in Table 15 OL (online version) based on Spanish school survey data (Observatorio Español sobre Drogas, 2002)⁽¹⁶⁰⁾. A major challenge is to respond to the

⁽¹⁵⁴⁾ Defined as 'a document which has not been published in a peer-reviewed journal'. For more information see QED Network Journal (<http://qed.emcdda.eu.int/journal/bulletin27.shtml>).

⁽¹⁵⁵⁾ Based on responses to having been 'drunk from drinking alcoholic beverages'.

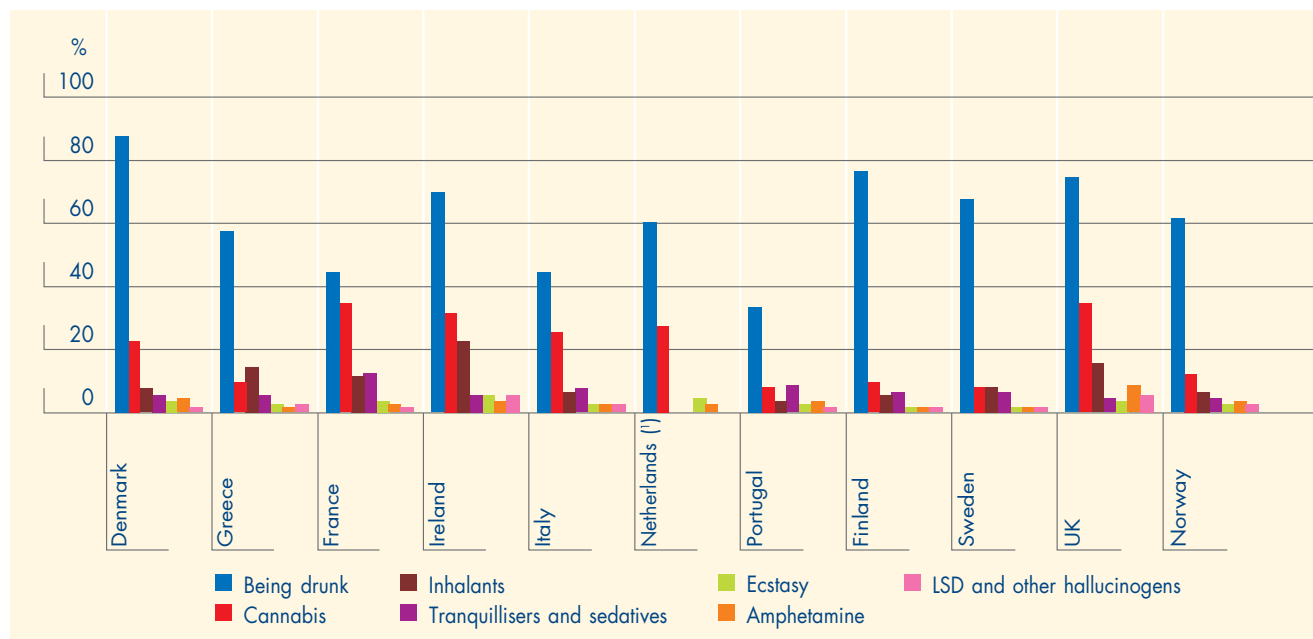
⁽¹⁵⁶⁾ Figure 42 OL: Comparison of 'binge' drinking with cannabis use in last 30 days.

⁽¹⁵⁷⁾ Based on responses to 'sniffed a substance (glue, aerosols, etc.) to get high'.

⁽¹⁵⁸⁾ Statistical Table 3: School surveys — lifetime prevalence among students, 15–16 years of age (online version).

⁽¹⁵⁹⁾ Statistical Table 3: School surveys — lifetime prevalence among students, 15–16 years of age (online version).

⁽¹⁶⁰⁾ See Table 15 OL: Relationship of consumption of different substances among Spanish school students (14–18 years) (online version).

Figure 19: Lifetime prevalence of being drunk and illicit substance use (15- to 16-year-old students)

(1) Limited comparability.

Source: ESPAD school survey project (1999).

complexities and idiosyncrasies of different patterns of drug use (Calafat et al., 1999; Parker and Eggington, 2002; Smit et al., 2002).

A higher level of drug use among males than among females is more marked in adult populations than in school students. However, among school students, gender differences are greatest in Greece, France, Italy and Portugal. One exception is that the use of tranquillisers and sedatives without a doctor's prescription and of alcohol together with 'pills' is generally higher among girls.

Variations in prevalence also occur between regions within Member States. In Germany, the gap between east and west is closing faster in students than in adults. Other aspects of drug prevalence, such as the spread of cannabis into rural areas, are the same as those observed in older populations.

Attitudes

Attitudes towards different drugs can help predict future prevalence of drug use. In 1999, disapproval of getting drunk once a week varied widely, from relatively low in Denmark (32 %) to high in Italy (80 %). Disapproval of cannabis experimentation was less variable and was lowest in France (42 %) and highest in Portugal (79 %) and Sweden (78 %) ⁽¹⁶¹⁾. Attitudes help to predict trends, but other factors are also involved. In all Member States, disapproval and perceptions about 'great risks' attached to

experimenting with drugs such as ecstasy, cocaine and heroin were generally very high among 15- to 16-year-old school students. Disapproval of trying ecstasy ranged from 71 % in Greece to 90 % in Denmark.

Trends

Concern is growing about increased levels of drunkenness and 'binge' use of alcohol for recreational purposes ⁽¹⁶²⁾. Between 1995 and 1999, marked increases in lifetime experience of being drunk occurred in Greece and Norway (Figure 20). Strictly comparable data for alcohol use are not available for Member States that do not participate in the ESPAD surveys, but trend data from both Germany (1973–2001) and Spain (1994–2000) show recent decreases in alcohol consumption by young people (Bundeszentrale für Gesundheitliche Aufklärung, 2002; Observatorio Español sobre Drogas, 2002). However, it is possible for overall consumption to decrease while patterns of 'binge' drinking increase.

During the 1990s, lifetime prevalence of cannabis use increased to such a level that it could be described as widespread in a number of Member States. However, by 1999, the use of cannabis among young people in Ireland, the Netherlands and the United Kingdom had decreased. This may indicate that prevalence has reached saturation in these countries, with a trend towards stabilisation at levels of around 30 %.

⁽¹⁶¹⁾ See Figure 43 OL: Percentage of 15- to 16-year-old students who disapprove of getting drunk compared with trying cannabis and ecstasy (online version).

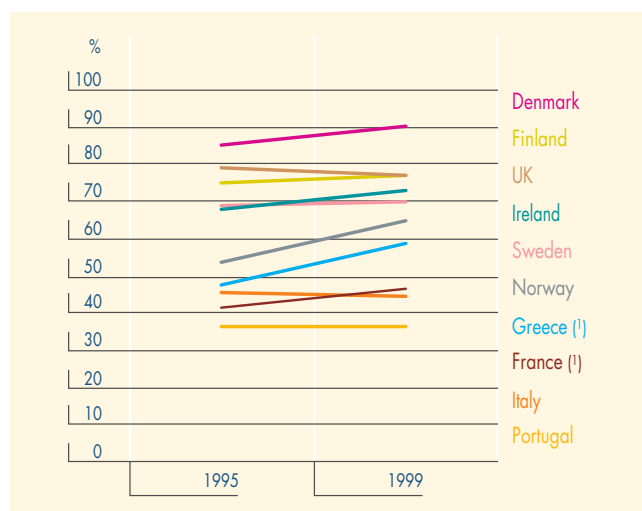
⁽¹⁶²⁾ Figure 44 OL: Changes in drinking five or more drinks in a row during past 30 days.

There are also indications of stabilisation of lifetime use of ecstasy at very much lower levels than for cannabis. In the case of the United Kingdom, decreased lifetime prevalence of both cannabis and ecstasy was accompanied by a decrease in perceived availability ⁽¹⁶³⁾ ⁽¹⁶⁴⁾ and an increase in disapproval ⁽¹⁶⁵⁾. In 1999, the proportion of students who perceived that the risk associated with trying ecstasy once or twice was great was highest in the two Member States (Ireland and the United Kingdom) in which lifetime prevalence of ecstasy was also highest ⁽¹⁶⁶⁾ and where much media coverage was given to a relatively small number of ecstasy-related deaths. Media coverage, together with an increasingly negative image, appears to have influenced the downward prevalence of ecstasy use in these two Member States.

Young people judge each other on the basis of image, style and possession of status symbols. Such symbols, which may include drugs, change constantly. Currently held negative images of heroin users and the ready accessibility of other drugs are important factors in current drug choices (FitzGerald et al., 2003). A recent analysis of drug lyrics in English-language popular music since the 1960s has shown that musicians today are more likely than in the past to decry the harm that cannabis does ⁽¹⁶⁷⁾ (Markert, 2001).

Figure 20: Lifetime prevalence for (A) being drunk, (B) taking cannabis and (C) taking ecstasy (15- to 16-year-old students)

Figure 20 (A): Being drunk



(!) The data for France and Greece for 1995 are based on surveys in 1993.
Source: ESPAD school survey project (1995 and 1999).

The results of a recent survey of 878 young people up to the age of 19 conducted in 10 EU cities signal a possible tendency in urban mainstream culture towards decreasing amphetamine and ecstasy use and increasing cocaine use. This sample was not sufficiently representative or large enough to draw definitive conclusions. This study also found that respondents spend more money on alcohol than on drugs or any other single category of recreational consumption, such as admission to discos, clubs or cinemas, mobile phones and tobacco (Calafat et al., 2003) ⁽¹⁶⁸⁾.

Figure 20 (B): Taking cannabis

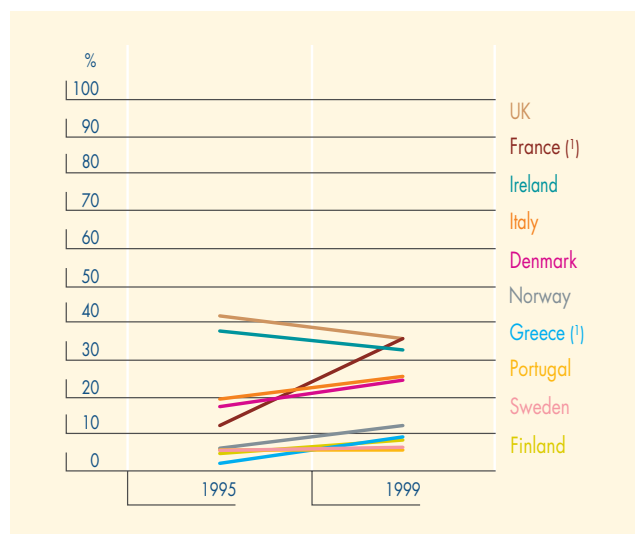
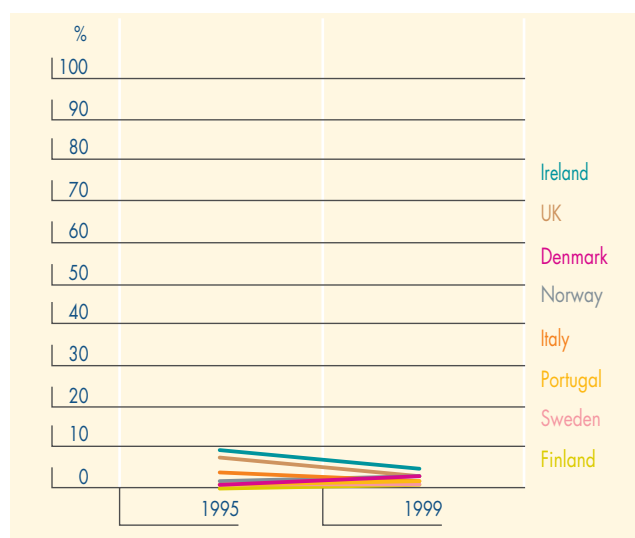


Figure 20 (C): Taking ecstasy



⁽¹⁶³⁾ Based on responses that the drug would be 'very easy' or 'fairly easy' to obtain if wanted.

⁽¹⁶⁴⁾ Figure 45 OL: Changes in the perceived availability of (A) cannabis and (B) ecstasy (online version).

⁽¹⁶⁵⁾ Figure 46 OL: Change in the percentage of 15- to 16-year-olds who disapprove of (A) getting drunk once a week or (B) trying cannabis once or twice or (C) trying ecstasy once or twice (online version).

⁽¹⁶⁶⁾ Figure 47 OL: Percentage of 15- to 16-year-old students who perceive a 'great risk' associated with using ecstasy once or twice and lifetime prevalence of ecstasy use (online version).

⁽¹⁶⁷⁾ Figure 48 OL: Percentage of positive images in contemporary popular music, 1960s to 1990s (online version).

⁽¹⁶⁸⁾ Figure 49 OL: Euro spent each weekend by 13- to 19-year-olds in 10 EU cities in 2001–02 (online version).

Almost all of the EU Member States (Belgium, Denmark, Germany, Spain, France, Luxembourg, Italy, the Netherlands, Austria, Portugal and the United Kingdom) report rising concerns about a possible increased cocaine and base/crack market for young problem drug users. Further information about trends in availability can be found on p. 36.

Initiation, patterns and risk factors

In general, the likelihood of young people aged 12–18 years getting drunk or being offered cannabis, or any other illegal drug, as well as their willingness to try drugs, increases sharply with age. This is illustrated here by data from the French Escapad survey (Beck, 2001). Figure 21 A shows that, among boys aged 13 and 14, the proportion who had lifetime experience of being drunk was 15.9 % and the proportion who had experimented with cannabis was 13.8 %. Among 17- to 18-year-olds it had increased to 64.5 % and 55.7 % respectively.

In a recent EU young population survey, ‘curiosity’ was given as the main reason for trying drugs (EORG, 2002). Of those who experiment with drugs, the majority do not continue to use them on a regular basis. In a small but significant minority, use escalates to intensive levels. This is illustrated in Figure 21 B, which shows the distribution of cannabis use among the general population of 18-year-olds in France. General population surveys show that lifetime experience of illicit drug use is significantly higher than recent or current use ⁽¹⁶⁹⁾. Comparable information on patterns of use among regular drug users is less developed than in the field of alcohol research. This limits understanding about the patterns of drug use and, consequently, the development of effective responses. Definitions of ‘problem cannabis use’ are being explored in some Member States, and it has been suggested that people who have used cannabis on 20 or more occasions during the past month are most at risk of developing a problematic pattern of use (Beck, 2001; Dutch national report). By this definition, one out of every five people in the Netherlands who have used cannabis during the past month can be classified as ‘at risk’. According to Figure 21 B, in France 13.3 % of 18-year-old men, compared with only 3.6 % of 18-year-old women, fall into the ‘at-risk’ category.

One major concern about experimental use of cannabis is related to the ‘gateway effect’ ⁽¹⁷⁰⁾. However, the association between cannabis use and other illegal substances is complex and not reducible to a simple causal model. An alternative ‘common factor’ model demonstrates how correlations between the use of cannabis and hard drugs

Figure 21: Cannabis use among 17- to 18-year-olds in 2001. (A) Age at initiation of use. (B) Level of use.

Figure 21 (A): Age of initiation to being drunk and cannabis use among 17- to 18-year-old boys in France in 2001

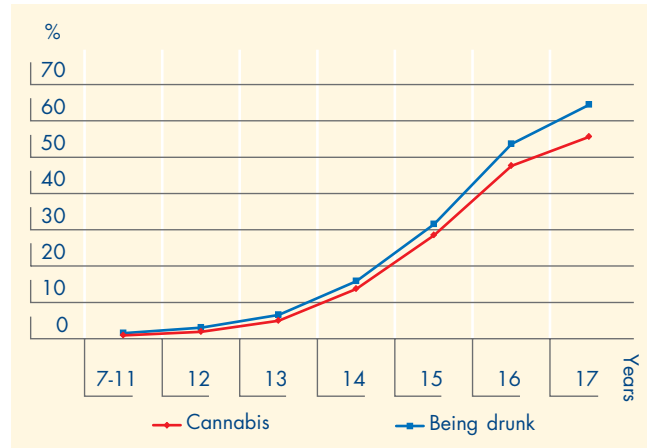
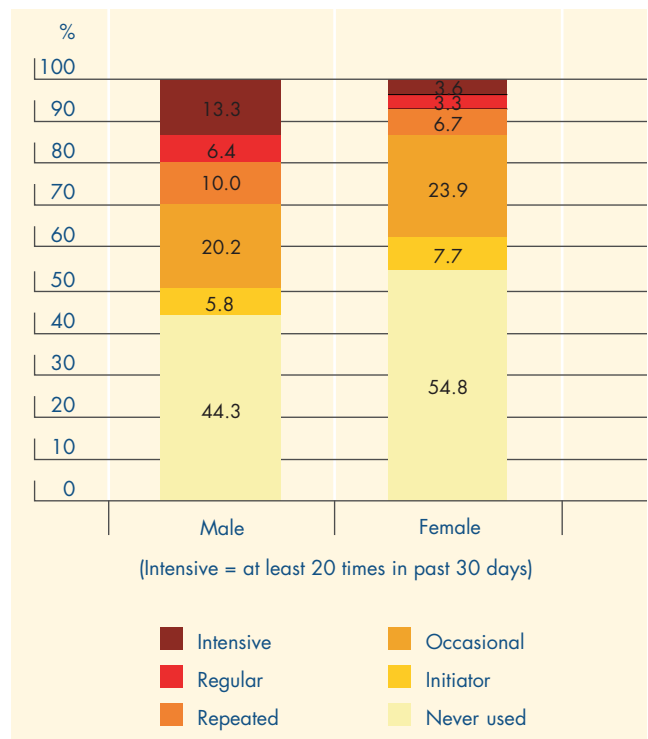


Figure 21 (B): Level of cannabis use at the age of 17-18 in France in 2001



Sources: Escapad (2001), OFDT. National representative sample.

are due to a range of common risk factors, including vulnerability and access to drugs and propensity to use drugs. Findings from cohort studies show that illicit drug use is rarely the first sign of trouble for adolescents. Alcohol use, antisocial behaviour, truancy and crime often occur at

⁽¹⁶⁹⁾ See Figure 1 OL: Patterns of cannabis use among the general population — lifetime experience versus current use (last 30 days), National (drug use) prevalence survey 2001 (the Netherlands).

⁽¹⁷⁰⁾ This is based on the hypothesis that use of cannabis per se increases risk of initiating hard drugs.

a younger age than cannabis use ⁽¹⁷¹⁾. Adolescents rarely use illicit substances without concomitant exposure to other illicit users and believe that the potential benefits of use outweigh the potential costs (Engineer et al., 2003). Evidence for the ‘gateway effect’ may be explained by cannabis bringing users into contact with an illicit market, increasing access to other illegal drugs and providing a platform of acceptability for using other illicit drugs (Grant and Dawson, 1997; Petraitis et al., 1998; Adalbjarnardottir and Rafnsson, 2002; Brook et al., 2002; Morral et al., 2002; Parker and Eggington, 2002; Pudney, 2002; Shillington and Clapp, 2002).

In the Netherlands, a youth survey conducted in 1999 found that the majority of young cannabis users purchased cannabis from friends (46 %) and from coffee shops (37 %) (De Zwart et al., 2000).

Identifying a range of risk factors that influence both the initiation and escalation of drug use in an extremely heterogeneous adolescent population is an approach that has begun to gain currency. These factors span a continuum from individual to community to macroenvironmental factors and are probably different for recreational and problem drug use.

Risk factors

Targeted surveys have shown that particular groups of young people have much higher levels of drug use than those found in the general national population. These are often young people who have been excluded from school or truanted, committed a crime, been homeless or run away from home, and those whose siblings are drug users (Lloyd, 1998; Swadi, 1999; Goulden and Sondhi, 2001; Hammersley et al., 2003). The United Kingdom youth lifestyles survey 1998/1999 found that prevalence of drug use was significantly higher among these vulnerable groups ⁽¹⁷²⁾. The size of these vulnerable groups at national level suggests that current school-based surveys are underestimating drug prevalence by failing to identify the populations of high-risk adolescents not found in the school environment. Comparable EU data on ‘vulnerable groups’ of young people at present are scarce. Young people who go out at night to particular dance music settings constitute another vulnerable group. The links between specific youth cultures and drugs are well documented, most recently in relation to the diffusion of ecstasy (MDMA) use (Griffiths et al., 1997; Springer et al., 1999). In techno dance settings, lifetime prevalence of ecstasy use ranges from 12.5 % (Athens) to 85 % (London), compared with a lifetime prevalence of 1 % (Greece) and 8 % (United Kingdom)

among the general young adult populations (EMCDDA, 2002a).

Community

In recent years, increased attention has been given to social, economic and cultural determinants including physical environment (Spooner et al. 2001; Lupton et al., 2002). Drug problems are often concentrated in particular geographical areas and housing locations. For example, the Irish national report cites that children in focus groups recounted routine encounters with drug users and made casual reference to the presence of drug paraphernalia on stairs and balconies. Parents living there expressed extreme anxiety about their children’s high level of exposure to drugs (O’Higgins, 1999).

Deaths and hospital emergencies

Drug- and alcohol-related deaths among the under-20s are relatively rare. However, during the 1990s, the number of drug-related deaths among young people in the EU overall rose steadily. A total of 3 103 deaths among young people were recorded in the EU between 1990 and 2000 ⁽¹⁷³⁾. The comparable loss of years for the death of a young person is higher than for an older person when years of life expectancy lost ⁽¹⁷⁴⁾ are calculated. Detailed information on drug-related deaths can be found on pp. 28–32. The United Kingdom is the only Member State that reports on deaths specifically related to inhalation of volatile substances. Over a period of 18 years, there were 1 707 deaths specifically related to this phenomenon. The majority of these deaths occurred in people between the ages of 15 and 19 (Field-Smith et al., 2002). Despite the media attention given to ecstasy-related deaths, inhalants probably constitute a greater health risk to adolescents than other forms of drug use.

There are no routinely collected EU data on drug-related hospital emergencies because of the hidden nature of illicit drug use, combined use of alcohol and other drugs and lack of toxicological analyses (Tait et al., 2002). The limited data that are available suggest that alcohol is a greater burden on the health services in some Member States than illicit drug use. WHO estimates that in developed countries alcohol accounts for 10–11 % of all illness and death each year (Rehn et al., 2001). For example, a Danish survey of young people in 2001 found that fewer 17-year-olds had reported hospital attendance for drug-related problems than for alcohol-related problems (Danish national report). In Ireland, a regional study of hospital case notes over a three-month period found that almost all of the 55 hospital

⁽¹⁷¹⁾ Figure 50 OL: Percentage of 15- to 16-year-old students who have been drunk or tried cannabis aged 13 or younger (online version).

⁽¹⁷²⁾ Figure 51 OL: Comparison of drug use by vulnerable group (online version).

⁽¹⁷³⁾ Figure 52 OL: Acute drug-related deaths reported in the EU among young people up to the age of 19 (online version).

⁽¹⁷⁴⁾ The current EU average life expectancy is 75 years for men and 80 for women.

admissions among young people aged 10–18 were related to alcohol alone or deliberate self-poisonings (Mid-Western Health Board, 2002; reported in the Irish national report).

Legal responses and recommendations

In almost all Member States, availability of alcohol is controlled by means of State monopoly or a licensing system. Attempts to control the availability of alcohol to young people have been made in most EU Member States by applying age restrictions (usually either 16 or 18 years) to off-premises and on-premises sales of alcohol. Portugal introduced its age restrictions relatively recently, in January 2002. Alcohol advertising restrictions vary from complete bans to voluntary advertising codes or no restrictions (Rehn et al., 2001; Bye, 2002). In the United Kingdom, the sale of cigarette lighter refills to under-18s was restricted by the 1999 Cigarette Lighter Refill (Safety) Regulations (Field-Smith et al., 2002). A decrease in deaths is thought to have been achieved as a result of this legislation together with information campaigns targeted at parents. There are some variations in legislation, and little is known about practice. An example of a new initiative to address issues of practice is to be found in Germany, which has recently introduced the 'Apple juice' law, which requires bars to offer at least one non-alcoholic drink cheaper than the cheapest alcohol (German and Dutch national reports). In the United Kingdom, a new scheme is being launched by retailers, with the support of government, to provide a special 'pass' for young customers to help enforce age restrictions on the purchase of alcohol and volatile substances (BBC News).

In recent years, the Netherlands has increased controls over coffee shops and coffee shops selling cannabis near schools have been closed. Under-18s are not permitted to purchase cannabis. Advertising of cannabis products is prohibited, and in recent years the tighter control of coffee shops has significantly reduced the number of customers under 18 years old (Dutch national report). In Copenhagen, Denmark, police have closed down approximately 50 cannabis clubs since an act to prohibit visitors in certain premises came into effect (Danish national report).

In Ireland and the United Kingdom, initiatives have been taken recently to reduce problems linked with drugs and alcohol in young people. For example, the Children's Bill (1999) in Ireland places responsibility on parents to control children. Penalties for parents include treatment for their own substance abuse and training in parenting skills. Children considered to be out of control may be subject to

night-time curfews. Also, in Ireland, two national public order initiatives are operated by the police. Operation Oíche focuses on under-age drinking, illicit drug use and under-age alcohol sales and Operation Encounter concentrates on antisocial conduct on the streets as well as in licensed premises, nightclubs and fast food outlets. For further details about legal responses, see p. 42.

A broad continuum of needs and responses

A major EU objective for addressing drugs and alcohol misuse is to make appropriate interventions in order to have the most effective impact. The main focus is on five broad, sometimes overlapping, target groups for intervention strategies: (1) school-age young people; (2) young experimental and recreational drug users; (3) young people in socially deprived areas; (4) young offenders; and (5) young people with a need for drug treatment⁽¹⁷⁵⁾.

School-age young people

Prevention in schools is a widely used response for this target. Details can be found on p. 45.

At a school policy level, several Member States have issued recommendations on how to react to drug incidents and drug-using students. In France, there is a strong focus on 'Reference points for the prevention of at-risk behaviour in schools' and the resolution of problems through targeted counselling. There is a major focus on professional training for school staff in order to handle deviant youth behaviour. In Austria and Germany, the STEP-by-STEP programmes⁽¹⁷⁶⁾ help schoolteachers to identify and intervene with drug-using pupils. In Norway, a handbook for this purpose has been launched.

The United Kingdom Drug Prevention Advisory Service evaluated a drug-prevention programme aimed at young people excluded from school and concluded that drugs programmes are clearly needed, but that brief periods of drugs education are inadequate. Many young people targeted by the programme were already taking drugs, implying that programmes should be implemented at a younger age, and should clearly identify and deal with problems. The new Portuguese national framework for prevention anticipates allocating EUR 400 000 for alternative school curricula and early professional training for school drop-outs. Almost all Spanish autonomous communities have such programmes in place. In Greece, early interventions are aimed at adolescent drug users and their families (family therapy), as well as at adolescents who have problems with the law.

⁽¹⁷⁵⁾ Figure 53 OL: Selective prevention — targets of intervention (online version).

⁽¹⁷⁶⁾ See EDDRA http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=36.

Young experimental and recreational drug users in the community

The potential harm caused by alcohol and illicit drug use in the lives of a small but significant proportion of the young population is increasingly recognised. A major target for more effective action are vulnerable groups of young people who consume alcohol and experiment with drugs for recreational purposes while being unaware of, or unable to control, the risks associated with their patterns of substance use (overdosing, accidents, criminal behaviours, violence, loss of capacity to study or work, sexually transmitted infections and longer-term health damage to liver/brain, etc.) (Boys et al., 1999; Parker and Egginton, 2002).

Concern about changing patterns of use of alcohol and drugs for recreational purposes is growing in the EU, and particularly about the health risks for women. Recreational facilities such as bars, discos, sport clubs and youth clubs would seem to be suitable settings for drug prevention as they guarantee contact with a large number of young people, many of whom use drugs or are at risk of doing so⁽¹⁷⁷⁾. There is an urgent need for methodological documentation and thorough evaluation of interventions in this setting.

In France, by 2001, at least 30 % of *départements* were taking preventative actions or providing first aid at dance events. In one regional health board area in Ireland, nightclub staff and clubbers are targeted by 'The sound decisions' project⁽¹⁷⁸⁾. However, in Luxembourg, no legal framework exists for drug agencies' interventions in nightclubs.

Train-the-trainer courses in first aid for drugs incidents in recreational settings are organised in the Netherlands.

The Dutch 'Going out and drugs' initiative includes interventions for different settings outside school where youngsters use drugs, such as coffee shops, discos, parties and clubs, and places where major musical events are organised.

Several projects approach drug users within the music scene to minimise the risks of consuming legal and illegal drugs. Sometimes, project staff drive to different events in a mobile home, providing a quiet atmosphere for informal counselling. Special hotlines or web sites⁽¹⁷⁹⁾ can be additional features.

An overview and analysis of examples of prevention in party settings has been carried out on the projects in

EDDRA⁽¹⁸⁰⁾. An overview of current projects and policies is provided in a series of online tables⁽¹⁸¹⁾.

Specific on-the-spot counselling services and on-site pill testing at rave events are — according to a recent Commission-funded study — effective in reaching those young people who, although they take drugs regularly, do not think of themselves as drug users and would not contact established drug help services. The study also found that pill testing does not counteract abstinence-oriented prevention interventions⁽¹⁸²⁾. In Austria and Spain, these services have now expanded, while in the Netherlands they are restricted to services with high standards of methodological accuracy.

Another set of interventions involves peers, self-help groups and alternatives to drugs use such as information and psychosocial support as well as involvement in cultural or sports activities (e.g. in summer camps in Greece). In Spain, alternative leisure programmes have for some years been available throughout the country.

In Norway, Sweden and Denmark, 'The night ravens' are volunteer adults who patrol the city centre streets during weekend evenings and nights. Their mission is to be visible and available to young people. The idea is that their presence will reduce the likelihood of violence and harm.

Young people in socially deprived neighbourhoods

In Sweden, the Drugs Commission conducted a review of the research literature on preventative responses (Narkotikakommissionen, 2000), and concluded that three types of initiative are needed: specific initiatives targeting the poorest people; general initiatives to improve public health; and initiatives aimed at helping vulnerable families.

Ireland, Portugal and the United Kingdom are the only Member States that identify particular areas with a view to providing special programmes in these areas. Ireland's Young People's Facilities and Services Fund (YPFSF) aims to attract 'at-risk' young people in disadvantaged areas into facilities and activities that divert them from the dangers of substance abuse. In the United Kingdom, Positive Futures is operating in 57 deprived areas to divert vulnerable young people from drugs and crime through involvement in sport. The initial results are encouraging, showing reductions in criminal activity and truancy and improved community awareness. Health action zones (HAZs) are multi-agency partnerships located in some of the most deprived areas in England, and their aim is to tackle health inequalities through healthcare and social care modernisation

⁽¹⁷⁷⁾ Figure 54 OL: Target group prevention in recreational settings (online version).

⁽¹⁷⁸⁾ See http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=356.

⁽¹⁷⁹⁾ See <http://www.emcdda.eu.int/responses/infosites.shtml>.

⁽¹⁸⁰⁾ See http://eddra.emcdda.eu.int:8008/FurtherReading/eddra_party_settings.pdf.

⁽¹⁸¹⁾ Table 16 OL: Main quantitative parameters of prevention in recreational settings; Table 17 OL: Outreach work/prevention in recreational settings; and Table 18 OL: Overview of policies and frameworks for outreach work/prevention in recreational settings (online version).

⁽¹⁸²⁾ See http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2828.

programmes to cover a wide spectrum of vulnerable young people thought to be a risk of misusing drugs (130 projects and initiatives in the 26 HAZs). Connexions is a United Kingdom support and advice service for young people aged 13–19 that incorporates the identification of young people at risk and makes referrals to specialist drug services. Twenty-seven partnerships were operational in 2002, with another 20 expected to be introduced by 2003.

In the United Kingdom, all drug action teams (DATs) conducted a young people's needs assessment in 2001 and are required, through young people substance misuse plans (YPSMPs), to plan services for young people from universal prevention services through to substance misuse treatment services, which are based on local need.

In Austria, mobile centres targeting young people in the streets are working in close cooperation with other relevant help organisations to provide assistance to drug-using adolescents and young adults at an early stage. It is anticipated that the geographical coverage of these centres will increase in future ⁽¹⁸³⁾.

In Finland, Walkers youth cafés ⁽¹⁸⁴⁾ provide early intervention and currently operate in 24 localities. An important role is played by trained adult volunteers supported by youth work professionals. An effort has been made to develop the youth cafés into safe meeting places. Similarly, in one regional health board area in Ireland a health advice café, which aims to provide a combined prevention and direct access health service for young people, is in place.

In Norway, most large municipalities have outreach services. Their objectives include various preventative interventions aimed at older children and young people as well as counselling and referral to the support and treatment services.

Young offenders

Some Member States provide targeted support, training and outreach programmes for at-risk young people such as young offenders. A major impact of some of these initiatives has been to reduce the number of young people receiving criminal sentences.

Interventions provide alternatives to law-enforcement and punishment strategies, with the aim of reducing or preventing young people falling into a life of crime, with irreversible consequences. In the United Kingdom, youth offending teams (YOTs) include drug workers who assess young offenders for drug abuse and, where appropriate, offer interventions to prevent further abuse. The

Luxembourg MSF Youth Solidarity project operates on a similar basis in direct collaboration with youth magistrates and competent law-enforcement actors.

The FRED project in Germany aims at early interventions with first notified drug users ⁽¹⁸⁵⁾. Finnish law-enforcement projects operate under the same principles.

Young people with a need for treatment services

Demand for drug treatment is a significant indicator of drug dependency and severe need. In 2001 in the EU, young people up to the age of 19 accounted for just under 10 % of the total reported specialist drug-treatment demand. Over half of these young people were receiving treatment for cannabis as their main drug of use. Nearly a quarter were being treated for opiate problems, and the remainder were evenly divided between treatment for use of cocaine and other stimulant drugs. However, there are national variations; for example, Ireland treats a larger proportion of young people than any other country in the EU. Treatment for under-18s is complicated by issues of parental consent and concerns about prescribing substitution drugs in the absence of adequate research into the effects of such drugs in this age group. Most young people in treatment with severe drug problems attend ordinary treatment settings.

Specialised treatment services have been developed in some countries. For example, in the Netherlands, there is a small-scale clinic targeting 13- to 18-year-olds. In Finland, special emphasis is on a sustained and intensive psychosocial treatment continuum, with necessary institutional treatment. Based on 1999 information, there were six treatment units for young substance abusers, with a total of 40 beds. In addition, reform schools had three units specialising in drug treatment, with a total of 23 beds. In Luxembourg, there is one specialist centre, 43 % of whose clients are under the age of 16 years. In Greece, early interventions are aimed at adolescent drug users and their families (family therapy), as well as at adolescents who have problems with the law.

In Sweden, young people aged between 12 and 21 who have serious psychosocial problems, often in association with elements of criminal behaviour and psychoactive substance use, can be placed in institutional care without their consent. Methods of treatment include environmental therapy, functional family therapy, cognitive behavioural therapy and, for substance abuse, the 12-step method. Young offenders will, as an alternative to prison, be taken care of according to the Care of Young Persons (Special Provisions) Act in closed institutional youth care

⁽¹⁸³⁾ See Auftrieb in http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2086.

⁽¹⁸⁴⁾ See <http://www.aseanlapset.fi/walkers-nuorisokahvilat/walkers-kahvilat-suomessa/>.

⁽¹⁸⁵⁾ See EDDRA http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2091.

treatment ⁽¹⁸⁶⁾. For further information about treatment responses see p. 49.

Social exclusion and reintegration

Definitions and concepts

According to the last survey on 'social precarity and integration' ⁽¹⁸⁷⁾, the proportion of the European population at risk of poverty and social exclusion in Europe varies from 9 % to 22 % (European Council, 2001). People are considered to be socially excluded if they 'are prevented from participating fully in economic, social and civil life and/or when their access to income and other resources (personal, family and cultural) is so inadequate as to exclude them from enjoying a standard of living that is regarded as acceptable by the society in which they live' (Gallie and Paugam, 2002).

Social exclusion can thus be defined as a combination of lack of economic resources, social isolation, and limited access to social and civil rights; it is a relative concept within any particular society (CEIES, 1999) and represents a progressive accumulation of social and economic factors over time. Factors that could contribute to social exclusion are problems related to labour, educational and living standards, health, nationality, drug abuse, gender difference and violence (European Council, 2001; National reports, 2002).

Drug use could be viewed as either a consequence or a cause of social exclusion (Carpentier, 2002): drug use can cause a deterioration of living conditions, but, on the other hand, processes of social marginalisation can be a reason for starting drug use. Nevertheless, the relation between drug abuse and social exclusion is not necessarily a causal one, because social exclusion 'does not apply to all drug consumers' (Tomas, 2001).

Taking into account this complexity, it is possible both to analyse drug use among socially excluded populations and study social exclusion among drug addicts (Figure 22).

Drug-use patterns and consequences observed among socially excluded populations

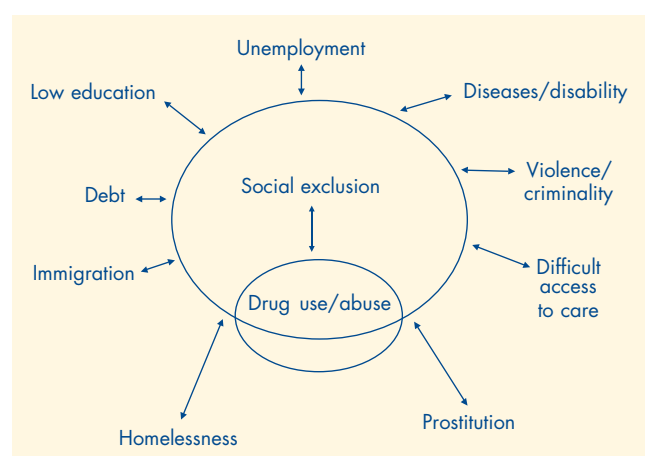
In the literature and research, the following populations are usually considered to be at risk for social exclusion: prisoners, immigrants ⁽¹⁸⁸⁾, the homeless, sex workers and vulnerable young people. Bias and methodological

limitations in the presented information on drug use and patterns of use among socially excluded groups have to be considered, because of the lack of information sources and comparable data across Europe.

The association between being prisoner and using drugs has been shown to be quite strong (see also p. 34). A large proportion of prisoners are drug users before being imprisoned, and the reason for their incarceration is often associated with drug use. However, some people follow the opposite course, becoming drug users only after being incarcerated for committing crimes. Studies suggest that between 3 % and 26 % of drug users in European prisons start taking drugs in prison and between 0.4 % and 21 % of incarcerated IDUs first inject while in prison. Drug use within prison is very common: up to 54 % of inmates report using drugs while incarcerated, and up to 34 % report injecting in prison (Stoever, 2001; EMCDDA, 2002a).

The relation between 'black and minority ethnic groups' and drug use is less clear, as little information is available. There is no scientific evidence to suggest that drug use is higher among immigrants than in the general population. However, some studies in specific ethnic minority groups have found a higher proportion of problematic drug users among those groups than among the general population, such as among the Ingrian in Finland (1–2 % of whom are estimated to be drug users, especially heroin users), Kurds in Germany, Gypsies in Spain and several ethnic groups in the Netherlands (Vrieling et al., 2000) ⁽¹⁸⁹⁾. The reasons for this could be a combination of socially disadvantageous factors, such as poor command of the local language,

Figure 22: Relationship between social exclusion and drug use



⁽¹⁸⁶⁾ See <http://www.stat-inst.se/article.asp?articleID=87>.

⁽¹⁸⁷⁾ Eurobarometer survey 56.1 (http://europa.eu.int/comm/employment_social/soc-prot/soc-incl/eurobarometer_en.pdf).

⁽¹⁸⁸⁾ According to the EMCDDA (2002b), immigrants are defined as 'black and minority ethnic groups' and include immigrant populations from diverse communities living in EU countries.

⁽¹⁸⁹⁾ Table 19 OL: Distribution of primary addiction problems (alcohol, heroin, cocaine, cannabis and gambling) in the Netherlands among immigrants and native Dutch (online version).