

Assessment of the implementation of the EU Drugs Strategy 2005–2012 and its Action Plans

Deirdre May Culley, Jiri Skoupy, Jennifer Rubin,
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TECHNICAL REPORT

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Prepared for the European Commission Directorate General for Justice

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Preface

The cornerstone of the European approach to drugs policy in the period 2005–2012 has been the EU Drugs Strategy and its associated Action Plans. They together comprise two policy areas of supply reduction and demand reduction, with three cross-cutting themes, international cooperation, coordination and information, evaluation and research.

With the current Strategy expiring in 2012, the European Commission has commissioned an evaluation of its implementation, relevance and influence. This document reports on the findings of the evaluation, analysing the added value of the current Strategy and its Action Plans (2005–2008 and 2009–2012) in Member States and at EU level. The study employed a targeted document review and three main data collection techniques: key informant interviews, an online survey, and more in-depth assessment of six specific objectives in seven Member States and at EU level. Additionally, where possible, we contextualise these findings against a backdrop of trend reports from EMCDDA and Europol.

This evaluation does not aim to investigate the effectiveness or wider outcomes of specific interventions on the EU drugs situation. It is unrealistic to make causal inferences in relation to the EU Drugs Strategy given the breadth and complexity of the field, the wide scope of the assessment across the EU, and the many external variables operating at local, national and cross- or supra-national levels. Nonetheless, the report aims to provide insights into the added value of a cross-cutting Strategy for the EU, Member States and third countries, and provides recommendations for a potential successor strategy.

This report should be of interest to EU and national level policymakers, researchers and practitioners working in the field of drugs and drugs policy.

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Executive summary

The EU Drugs Strategy 2005–2012 was the outcome of a political process of negotiations between Member States and EU institutions. It builds on a rich tradition of programmes and initiatives in drugs policy at EU level since the late 1980s. These have had a bearing on the drugs situation in the EU, and have set the tone, to differing extents, for how the Strategy was developed, implemented and perceived.

As the Strategy comes to an end in 2012 and a decision will need to be taken about its successor, the European Commission commissioned an evaluation of the Strategy and its Action Plans (2005–2008 and 2009–2012). This evaluation focuses on the added value of these documents for drugs policy in Member States and third countries. As the competencies for drugs policy (including its public health, criminal justice, enforcement, and customs components) remain primarily at Member State level, the EU Drugs Strategy is expected to add value over national drugs strategies. Therefore, we provide an assessment of the relevance and influence of the current Strategy and the implementation of the Action Plans in Member States and at EU level. This summary first sets out our study's main findings: first overall findings about the Strategy as a document and a process; second, across each of the two policy areas, demand reduction and supply reduction; and third, across the three cross-cutting themes of the Strategy, coordination; international cooperation; and information, research and evaluation. Finally, the summary provides a brief overview of the evaluation questions and responses arrived at in the course of the study.

Findings on the Strategy document and process of development

An extensive development process and a coherent, well-structured but lengthy document

The process of developing the Strategy was, overall, effective and collaborative, and contributed to consensus building between Member States with often differing perspectives on drugs policy. A small number of issues proved contentious and led to intense debate and negotiation. However, discussion, debate and negotiation ultimately resulted in a Strategy with widespread acceptance among stakeholders.

The Strategy and Action Plans appear logical and coherent. While there has been some ambiguity in the use of certain terminology, the objectives and priorities in the Strategy are clearly linked to the actions identified in the Action Plans. Each of the two policy fields and three cross-cutting themes contain a number of specific objectives, and each objective is addressed by a series of actions. These actions are generally specific, measurable, attainable, relevant, and timely (SMART), although many of the performance indicators

are very process driven (as opposed to outcome driven). The analysis suggests there are a few points that could be addressed to further improve internal logic and coherence.

While the Strategy's internal structure and coherence are strengths, its comprehensiveness may be at the expense of the Strategy's focus and ability to prioritise. The 158 actions identified in the two Action Plans read more like a comprehensive 'wish list' of potential activities, rather than focusing on a limited number of interventions or priorities. Related to this comprehensiveness the documents' length and wide range may partly explain the lack of familiarity with the content of the Strategy and Action Plans found amongst many of the drugs policymakers at EU and Member State level.

The Strategy is divided into two policy fields – supply reduction and harm reduction - and three cross-cutting themes: coordination; international cooperation; and information, research and evaluation. Each of these themes is analysed individually below.

Findings on Demand reduction

There are a number of clear successes in the area of demand reduction consistent with the objectives in the Strategy.

Data on the prevalence of illicit drug consumption do not reveal a clear downward trend as sought in the EU Drugs Strategy. There are signs of decreasing cannabis consumption, for example, in traditionally high prevalence countries, but these are thought to reflect recreational users as opposed to intensive users. Cocaine consumption had experienced significant increases in some countries during the early 2000s, but recent data suggest stabilisation and even slight decrease subsequently. Opioid use still accounts for the lion's share of drug-related morbidity and mortality, but the population of opioid users is ageing and drug injecting has decreased. Finally, recent data indicate an increase in the number and availability of new unregulated substances, or 'legal highs'. These trends suggest there are a number of clear successes in the area of demand reduction that are consistent with the objectives in the Strategy. However, there is little evidence as to whether or not these successes can be attributed, directly or exclusively, to the implementation of the Strategy and its Action Plans – with the potential exception of some harm reduction interventions.

The relevance of demand reduction objectives and actions lies in their wide scope.

The Strategy's relevance in the area of demand reduction is in part attributable to its breadth. The breadth of demand reduction policies and programmes allows Member States with varied drugs policy regimes to emphasise different aspects of the 'balanced approach'. The importance of this breadth was noted in relation to newly acceded Member States where such policies have recently been implemented as a result of EU accession.

Prevention and treatment objectives have been influential at Member State level.

In line with the recommendations in the Action Plans, a moderate shift can be observed from universal prevention which targets the entire population, towards more focused models whose efficacy is more robustly grounded in scientific evidence. However, these more effective models of prevention are not given priority in all Member States. The Strategy's emphasis on improving access to treatment translates into official policy documents in individual Member States. The Strategy has been influential, enabling a forum and open debate about the scientific reliability of demand reduction measures, and a discussion around data collection and best practice.

There is some evidence for the positive impact of harm reduction measures.

The provision of harm reduction programmes across all Member States is frequently cited as evidence of the influence and implementation of the Strategy, as well as a prominent area of added value. Harm reduction has also been firmly embedded in numerous national drugs strategies, and several governments have launched related national plans and legislation in support of the harm reduction objective. There remain, however, significant differences in levels of implementation, and notable controversy in relation to which harm reduction approaches should be pursued and included as part of the balanced approach. Nonetheless, there are indications that some of these measures have had a positive impact on drug-related mortality and morbidity in the EU.

There is a need to consider drug use in a broader policy framework of addiction and licit drugs.

While there has been a trend towards considering drugs supply in a broader context of EU policy on organised crime and security (see below), this ‘horizontal integration’ has not taken place on the demand side. There is a desire among many stakeholders to consider drug consumption in a broader policy framework of (poly)consumption of licit and illicit substances (including ‘legal highs’, alcohol, tobacco and other addictive behaviour). Indeed this need was noted in the evaluation of the 2005–2008 Action Plan. Furthermore, and as detailed below, new phenomena such as legal highs now pose emerging health and research challenges. Some commentators note the need to adopt a wider conceptual framework for treating addiction and substance use. Progress in these areas has been limited, and a more comprehensive approach to treating licit and illicit problem drug use, as well as addiction, continues to pose a significant challenge.

Findings on Supply reduction

There are few visible indications that trends on the supply side are moving in a desirable direction.

Europol notes a trend towards diversification of drug supply, with trafficking increasingly dominated by groups dealing in more than one product in an effort to maximise their profits. If there are trends in supply reduction, there is no available evidence that the change can be attributed to the Strategy or its Action Plans. Despite EU progress, there remain difficulties in evaluating supply reduction interventions.

Joint operations in the field of supply reduction have yielded good results.

The examples of Maritime Analysis and Operations Centre- Narcotics (MAOC-N) and Anti-Drug Coordination Centre for the Mediterranean Sea (CECLAD-M) are illustrative of the Strategy and Action Plans objectives on EU law enforcement cooperation and intelligence projects. These joint operations set up to tackle illicit drug trafficking were carried out by Member States and coordinated by Europol, and have been credited with some success.

There are some indications that the control of precursors diverted from the licit economy to manufacture illicit drugs has proved effective in disrupting production. However, these disruptions are short term since manufacturers are adaptable and replace precursors with other licit substances that can be more difficult to detect and more difficult to regulate.

Supply reduction initiatives now face new challenges from 'legal highs'.

Unregulated synthetic products simulating illicit drugs are developed, marketed and distributed quickly and effectively. The speed at which manufacturers can adapt to new regulations and develop alternative products poses new regulatory and law enforcement challenges.

There remain serious limitations to measuring effectiveness of supply reduction initiatives and understanding 'what works'.

Some recent efforts have been made in this field, but these efforts need to be built upon and sustained to ensure supply reduction is based on learning about what has and has not been effective and where.

The supply reduction objectives described in the Strategy and Action Plans are relevant to addressing the drugs challenges faced in the EU.

The emphasis in the Strategy on achieving coordination and cooperation is broadly welcomed by stakeholders at Member State and EU level, including in the field of supply reduction. However, that does not necessarily mean that these objectives have influenced the existence of such priorities or activities within Member States and third countries. Member States are making use of current mechanisms and practices provided in the Strategy. However, implementation of supply reduction measures is largely a matter of national legislation, and for many Member States pre-dated the Strategy. Many of the practices, for example around judicial cooperation, preceded the Strategy, particularly in older Member States. The Strategy is thought to have been more relevant and influential in newer Member States, candidate and accession countries - it has provided a model for countries with less developed approaches and mechanisms in the field of supply reduction.

The reason for the broad support of supply reduction objectives in the Strategy may partly be based on growing emphasis on international cooperation in tackling organised crime. The trend towards 'securitisation' of drugs in Member States has entailed an embedding of supply reduction measures within security agendas at EU and Member State level.

Findings on Coordination

The Strategy seems to have been relatively effective in its contribution to a more collaborative and informed drafting of national drugs policies.

Member States have increasingly adopted drugs policy documents and strategies in the period covered by the Strategy. Almost all Member States have a recent and/or updated drugs policy document and almost half of the Member States have action plans in place (EMCDDA, 2010). Most countries have adopted the EU model of a strategy with defined challenges, objectives, actions and metrics for measuring performance. Some Member States have actively synchronised their national policy documents with the Strategy. Although national strategies generally note the need for international or European coordination of drugs policies, there is little explicit reference to the EU Drugs Strategy or evidence of active implementation of its actions.

The Horizontal Drugs Group (HDG) is viewed as unique and innovative, embodying the balanced approach of the EU Drugs Strategy.

This view was especially strongly expressed by representatives of new Member States. They largely agree that the HDG has prepared a clear and coherent drugs policy for adoption by the Council, has succeeded in functioning as the main coordinating body on drugs policy

at EU level, and has improved communication within the Council on drug-related matters. The key added value of the HDG is viewed as its role as a forum for information exchange between Member States, allowing for attendant networking and international learning.

A number of challenges to the functioning of the HDG exist

The rotating presidencies may have some impact on the effectiveness and efficiency of HDG meetings. Continuity and follow-up between presidencies can be difficult, and the effectiveness of the HDG seems to correlate with the presidencies' capacity and clout. Presidencies of larger Member States or a longer track record in drugs policy tend to have more leverage.

Some concerns exist about the balance between supply and demand reduction in the HDG.

Law enforcement activities in drugs policy have gained importance in the EU internal security agenda. This may have caused the HDG to begin to reduce or lose some of its coordinating role in the area of supply reduction, posing a potential threat to the balanced approach. The Council's Standing Committee on Operational Cooperation on Internal Security (COSI) has become more active in coordinating supply reduction initiatives. This can partly be explained by the political traction of the internal security agenda. The action-oriented approach of COSI, focusing on short-term implementation cycles ('the policy cycle') to prioritise actions, is perceived as effective. However, the COSI is a recently-established structure, and detailed assessment of its effectiveness will take time.

Findings on International cooperation

The objectives included under international cooperation are considered crucial to the added value of the EU Strategy.

Drug markets do not respect national boundaries and therefore cooperation with non-EU countries is crucial for addressing drugs challenges in EU Member States.

International cooperation is considered to be particularly important with respect to integrating candidate and new accession countries into the EU acquis.

As part of the roadmap to accession, the EU has worked extensively with candidate and accession countries on issues revolving around institution and capacity building, data collection, the tackling of trafficking and demand reduction. Candidate countries have been increasingly involved in the work of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), focusing on setting up their own drug monitoring infrastructure, and have participated in the efforts of Europol and Eurojust.

The Strategy has enabled the EU to 'speak with one voice' at international fora.

The HDG has been particularly instrumental in achieving consensus regarding issues on the agenda at the Commission on Narcotic Drugs of the United Nations Office on Drug and Crime (CND), for instance. In doing so, the EU appears to have more leverage on the international stage. However, there is a perception that more can be done to build on existing achievements in raising the profile of the EU's approach internationally. Furthermore, the very breadth of contexts and approaches that the EU Drugs Strategy must encompass in order to 'speak with one voice' at times undermines its ability to be specific and unambiguous. This may to some extent undermine the relevance of the Strategy as well as its influence. Its influence and implementation have both been to some

extent limited by the fact that there is not complete consensus in all areas and objectives, thereby posing a challenge to its unified voice even with the current breadth.

Notable successes in implementation in relation to third countries can be highlighted.

Successes include the achievement of several important bilateral agreements, though a note of caution was raised about the possibility of duplicating effort with some international bodies in this area. However, evidence collected from EU delegations in third countries revealed variable levels of knowledge of the EU Drugs Strategy – with examples of both detailed knowledge of the Strategy by some and lack of familiarity by others.

There are examples of a direct influence and alignment between the Strategy and national strategies in third countries.

The principles in the Strategy –an evidence-based approach balancing demand reduction with supply reduction – appear to be widely respected in third countries. In many cases these principles are reflected in national policies, policy dialogue and external assistance. In some cases, priorities and actions from the EU Drugs Strategy appear to have been directly relied upon and brought to bear; in other instances, national strategies are reported to be in line with, but not directly influenced by, the Strategy.

Findings on Information, Research and Evaluation

Notable progress has been made regarding implementation in this area.

The results of the evaluation suggest that notable progress has been made regarding the implementation of the Strategy objectives for information, research and evaluation. In particular, research commissioned by Member States and the EC in the area of illicit drugs has increased, addressing a number of priority areas. Comparative analysis conducted for the EC on research into illicit drugs in the EU (Bühringer et al., 2009) identified over 250 research projects, more than 30 of which were EU-funded. Although many of these studies are ongoing (with results pending and impacts and outcomes taking time to materialise), they have contributed to the Strategy objective of creating ‘better understanding of the drugs problem and the development of an optimal response to it through a measurable and sustainable improvement in the knowledge base and knowledge infrastructure’ (European Council, 2004, p. 19).

This area enjoys broad support from stakeholders at Member State and EU level.

The objectives included under this priority are considered to be central to the Strategy’s ability to contribute to a better understanding of drugs challenges, to monitoring of changes and to learning and implementation of this learning. A focus on this area enjoys broad support from stakeholders at Member State and EU level as well as in third countries. It is of particular importance to newer Member States and candidate countries that can be in need of assistance with developing their capabilities in this field.

The Strategy itself and the Action Plans are regarded as influential in relation to drugs policies at the level of individual Member States, particularly in that the focus on information, research and evaluation is seen as motivating Member States to improve and harmonise data collection efforts and increase research collaboration with other Member States. The sum of a transnational evidence base is greater than its parts, as markets operate internationally: findings and lessons may be needed from and translated to other regions.

The EMCDDA is frequently highlighted for its pivotal role as a channel of influence and support in this area within and outside the EU.

The EMCDDA has facilitated, shaped and supported efforts in this area across the EU, and especially for new Member States and accession countries. Member States are coordinating and sharing information and best practice, disseminating research through the activities of the EMCDDA. The EU has received international praise for its world-class data collection infrastructure.

Some disparities in quality and availability of data remain.

While notable progress against these objectives has been made, issues and challenges persist, and two challenges stand out. First, there is ongoing uncertainty over availability and continuity of funding, despite EU level progress such as the Framework Programme funding. Second, despite considerable progress in data harmonisation, quality and availability of data still varies across the Member States. Further, disparities remain between quality and availability of supply-side data on the one hand and that of demand-side data on the other. These differences may be partly explained by the less transparent and available supply reduction knowledge base associated with the classified nature of much law enforcement intelligence.

Summary of responses to the evaluation questions

To what extent have the objectives and priorities of the EU Drugs Strategy 2005-2012 been implemented and what are the main outputs?

- There has been some progress on virtually every objective and priority included in the Strategy, even though the degree to which these have been implemented varies significantly.
- Data collection exercises have revealed an overall perception that the situation in areas that were the focus of the Strategy has improved since its adoption.
- Implementation of the Strategy's objectives has followed its core principle of a balanced approach to drugs policy. This has been exemplified by the fact that progress in the area of demand reduction (such as greater availability of harm reduction programmes) was achieved in tandem with supply reduction objectives (such as greater uptake of existing instruments for law enforcement cooperation).

To what extent has the EU Drugs Strategy 2005-2012 and its Action Plans had an impact on Member States' national (or regional) drugs strategies and action plans?

- The Strategy has contributed to a convergence in the way individual Member States formulate and adopt their own national drugs policies and strategies.
- National strategies and action plans have become more in line with the EU document. They often refer to the Strategy as their model, are similarly structured, or are synchronised with it.
- Evaluation of national strategies and other policy documents has become a more firmly embedded practice.

What indirect impacts has the EU Drugs Strategy had on third countries' or international organisations' policies on drugs?

- The Strategy has enabled the EU to better 'speak with one voice' at international fora and in international organisations.
- At the international level, it has promoted a clearly recognisable and acknowledged 'EU model' of tackling drug related challenges.
- The Strategy has served as a source of guidance for candidate countries as part of the EU acquis and for other countries in the process of formulating their own drugs policies.

How has the drugs situation in the EU changed since 2005?

- There appears to have been little change in the overall demand for and availability of illicit drugs in the EU, though trends and patterns of supply and demand have evolved, posing new research and policy challenges.
- There has been a significant decline in the number of newly reported HIV infections since 2005. This has been attributed to a decline in injecting drug use prevalence and risky behaviours, indicating that certain interventions could have been effective.
- Drug-induced deaths, most of which relate to problem opioid use, remain at historically high levels, though the age of victims is increasing, indicating that an older generation of users is not being replaced.

To what extent can these changes be associated with the development and implementation of the EU Drugs Strategy and its Action Plans?

- We do not have evidence for what would have happened to supply and demand for illicit drugs in the EU in the absence of the Strategy. There is no overwhelming evidence that the Strategy has or has not had an impact on the drugs situation in the EU.
- In relation to supply reduction, data from the EMCDDA and Europol does not indicate any significant improvements in the drugs situation.
- In relation to demand reduction, available data does show some positive changes. For example, there appears to be an increase in provision of treatment (particularly opioid substitution). This direction of change is certainly in line with the objectives of the EU Drugs Strategy, even though there is no evidence upon which to decide whether the Strategy has had an influence.
- There are, however, also less positive trends in demand reduction – for example increases in poly drug use – which are not in line with the objectives of the Strategy.

What is the added value of the EU Drugs Strategy 2005-2012 and its Action Plans for addressing illicit drugs in the EU?

- The Strategy has provided added value to individual Member States and their strategies by offering a platform for consensus building and coordination in relation to a horizontal and increasingly international issue.

- The Strategy has facilitated information exchange and the sharing of best practices across Member States.
- It has also promoted a debate about the scientific reliability of drugs policy strategies and interventions, and contributed to support for an evidence-based approach to drugs policy.

What conclusions and lessons can be drawn for the new EU drugs strategy post-2012 and its action plans?

- The EU can and has added value with its Strategy in many ways, including enhancing the ‘voice’ of the EU in international fora and in relation to third countries, providing clear guidance for candidate countries, and providing coordination within the EU.
- To maximise its impact, it may be useful to present the document in a more compact version with shorter timeframe, by better embedding it in existing EU policy processes.
- The Strategy has played an important role in promoting the use of evidence for policy. Its successor should continue to do so, as there remain instances of insufficient evidence for the effectiveness or ineffectiveness of specific measures.
- While this report has found the HDG central to the coordination of EU drugs policy along the lines of the Strategy, several challenges persist that should be addressed. These include, but are not limited to, continuity between presidencies, consistency of focus on the balanced approach, and the role of other EU-level initiatives and bodies.

This summary has set out the main findings of the study. The following chapters provide much more detailed information on the methods and findings of the project, and are followed in the final chapter by concluding recommendations for a future EU drugs strategy.

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Glossary

ALICE RAP	Addictions and Lifestyles in Contemporary Europe – Reframing Addictions
CECLAD-M	Anti-Drug Coordination Centre for the Mediterranean Sea
COREPER	Committee of Permanent Representatives
CND	Commission on Narcotic Drugs of the United Nations Office on Drug and Crime
COSI	Standing Committee on Operational Cooperation on Internal Security
DCI	Development Cooperation Instrument
DG DEVCO	Directorate-General for Development and Cooperation – EuropeAid, European Commission
DG ENLARG	Directorate -General for Enlargement, European Commission
DG ENTR	Directorate-General for Enterprise and Industry, European Commission
DG HOME	Directorate-General for Home Affairs, European Commission
DG JUST	Directorate-General for Justice, European Commission
DG MOVE	Directorate-General for Mobility and Transport, European Commission
DG SANCO	Directorate-General for Health and Consumers, European Commission
DG TAXUD	Directorate-General for Taxation and Customs Union, European Commission
DG RTD	Directorate-General for Research and Innovation, European Commission
ECDC	European Centre for Disease Prevention and Control
ECJ	European Court of Justice
EEAS	European External Action Service
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction

ERA-NET	European Research Area Network
ESDP	Expertise Centre on Synthetic Drugs and Precursors (the Netherlands)
Eurojust	European Union Judicial Cooperation Unit
Europol	European Police Office
EWS	Early Warning System
FDCS	Federal Drug Control Service (Russia)
HDG	Horizontal Drugs Group of the Council of the European Union
INCB	International Narcotics Control Board
ISG	Inter-Service Group on Drugs
JIT	Joint Investigation Team
LAC	Latin America and the Caribbean
LEDETs	Law Enforcement Detachments
MAOC-N	Maritime Analysis and Operations Centre – Narcotics
NCA	National Crime Agency (UK)
NTA	National Treatment Agency (UK)
OCTA	Organised Crime Threat Assessment
OCRTIS	Central Office Against Illegal Narcotics Trafficking (France)
OFDT	Observatory on Drugs and Addictions (France)
OLAF	European Anti-Fraud Office
OST	Opioid Substitution Treatment
REITOX	European Information Network on Drugs and Drug Addiction
SOCA	Serious Organised Crime Agency (UK)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WCO	World Customs Organization
WHO	World Health Organization

The period covered by the EU Drugs Strategy 2005–2012 is drawing to a close. As with preceding strategies, the EU has sought to evaluate the current Strategy and its Action Plans. The aim is to learn about the drivers and obstacles to implementation, to assess the Strategy’s relevance to and influence on Member States, the EU, and global drugs policy, and to establish an evidence base for potential future initiatives. This document presents the results from the independent, external assessment of the current Strategy and its Actions Plans, in the context of the drugs situation in the EU since 2005.

1.1 **Scope and objectives**

This evaluation focuses on the added value of the EU Drugs Strategy 2005–2012 and its Action Plans (2005–2008 and 2009–2012) for drugs policy in Member States and third countries. As the realms of drugs policy (including its public health, criminal justice, enforcement and customs components) are primarily Member States’ prerogatives, the EU Drugs Strategy is expected to add value to national-level drugs policy. It is therefore necessary to evaluate the relevance and influence of the current Drugs Strategy and the implementation of the Action Plans in Member States and at EU level.

In the context of this report, we define the concepts of relevance, influence and implementation as follows:

- **Relevance:** the extent to which priorities and objectives in the EU Drugs Strategy and actions in the Action Plans address the challenges of the drugs situation or drugs policy in Member States.
- **Influence:** the extent to which actors (e.g. policymakers or stakeholders in Member States, accession, candidate or third countries) have taken action or changed behaviour as a consequence of the EU Drugs Strategy and/or Action Plans.
- **Implementation:** the extent to which the actions formulated in the Action Plans have been implemented, as well as drivers of and inhibitors of this implementation.

In view of the number of variables at play and the difficulties associated with establishing causality between the implementation of the Strategy and drugs trends, this evaluation first seeks to identify the added value of the Strategy, as well as its relevance, influence and

implementation. It then aims to triangulate these findings with data on drugs trends and examples of initiatives to respond to the evaluation questions.

The specific objectives of the evaluation are presented below in Box 1.1. These objectives were specified by the Commission, and were set out in the Terms of Reference for this study.

Box 1.1: Objectives and evaluation questions

Objective 1: To assess to what extent the objectives and priorities of the EU Drugs Strategy 2005-2012 have been implemented at both national and EU level

To what extent have the objectives and priorities of the EU Drugs Strategy 2005-2012 been implemented and what are the main outputs?

Objective 2: To examine the extent to which the EU Drugs Strategy and its Action Plans have influenced Member States' drugs policy and legislation

A) To what extent have the EU Drugs Strategy 2005-2012 and its Action Plans had an impact on Member States' national (or regional) drugs strategies and action plans?

B) What indirect impacts did the EU Drugs Strategy have on the drugs policies of third countries and international organisations?

Objective 3: To assess to what extent the implementation of the EU Drugs Strategy 2005-2012 and its Action Plans has had an impact on the drugs situation in the EU and on the responses prepared to tackle the drugs problem

A) How has the drugs situation in the EU changed since 2005?

B) To what extent can these changes be associated with the development and implementation of the EU Drugs Strategy and its Action Plans?

C) What is the added value of the EU Drugs Strategy 2005-2012 and its Action Plans for addressing illicit drugs in the EU?

Objective 4: To identify key aspects and recommendations that may be of importance for the formulation and implementation of the new EU Drugs Strategy and its Action Plans

What conclusions and lessons can be drawn for the new EU drugs strategy post-2012 and its action plans?

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol have both made available their reports on trends and developments in drug use and responses in Europe, and trends in drugs trafficking respectively. These analyses contextualise the findings of this evaluation and provide an indication whether and to what extent the EU drugs situation has improved or deteriorated. Establishing the causal effects of the Strategy on drugs trends is beyond the scope of this study. As documented extensively in the academic literature on drugs policy, evaluating the impact of policy interventions is particularly problematic in this area due to problems of attribution, endogeneity, measurement, and data (see for example, Disley *et al.*, 2010, p. 84).

In view of these difficulties, this study relies primarily on expert knowledge, stakeholder views and a review of available documentation. There are various limitations to using these consultative techniques, and these should be considered when interpreting the results of this evaluation. However, given the variety of data collection methods, a combination of breadth and depth, and the sheer number of different inputs (from more than 250 individuals and organisations), we feel confident that together they contribute to a useful

assessment of the relevance, influence and implementation of the EU Drugs Strategy 2005–2012.

1.2 Data collection and methodologies

As noted above, the aim of this evaluation is to assess the relevance, influence and implementation of the EU Drugs Strategy and its Action Plans. This is a complex exercise because of the many levels at which the objectives of the Drugs Strategy operate: at EU level, towards Member States, towards accession or candidate countries, and towards third countries and international fora.

In order to obtain insights into the relevance, influence and implementation of the Strategy and its Action Plans at these various levels we conducted several data collection processes. These are summarised in Table 1.1 and described in detail below.

Table 1.1: Overview of data collection approaches in this evaluation

Data collection method	Description
Document review	<ul style="list-style-type: none"> Targeted review of documents to understand the context and development of the Strategy and Action Plans as well as drug trends over the course of the Strategy's timeframe
Key informant interviews	<ul style="list-style-type: none"> 22 interviews with key informants Individuals who were influential in development of the Strategy Representatives from third countries, candidate countries and international organisations
Online survey	<ul style="list-style-type: none"> 26 Member States Included respondents from health, law enforcement and criminal justice respondents Evaluation questions on all 28 of the Drugs Strategy's objectives
In-depth interviews	<ul style="list-style-type: none"> 41 interviews 33 with representatives from 7 Member States (included interviewees from health, law enforcement and research backgrounds) 8 with EU representatives from different Directorate Generals and institutions
EEAS survey	<ul style="list-style-type: none"> Survey administered by the EEAS and DG Justice 44 delegations invited to respond, 29 responses
Expert workshop	<ul style="list-style-type: none"> Day-long event involving study team and three members of the study's expert advisory panel

Our approach began by developing a background understanding of the context and development of the Strategy and Action Plans through a targeted document review and a series of 22 key informant interviews. These also provided insights into the external perceptions of the Strategy, as well as the perceptions of individuals involved in the development of the Strategy itself. We then sought to obtain an EU-wide overview of perceptions on the relevance, influence and implementation of the Strategy and Action Plans through an online survey, which was undertaken by Ipsos MORI's Social Research Institute. Experts and policymakers in the fields of health, law enforcement, research and external affairs from 26 of the 27 Member States participated. The survey asked questions on all 28 objectives of the Strategy.

We then sought to clarify and challenge the findings from the survey with a more detailed understanding of the relevance, influence and implementation of the Strategy and Action

Plans by conducting 41 in-depth interviews. These focused on a variety of objectives in a selection of Member States as well as at EU level. Member State-level in-depth interviews were carried out by Ispos MORI, whilst the EU-level interviews were undertaken by the evaluation team. All interviews followed protocols developed by RAND Europe in consultation with the Steering Committee.¹ Given the importance of understanding the role of the Strategy and Action Plans in third countries, these findings were further supplemented by the results of a survey administered by the European External Action Service (EEAS) and DG Justice of 29 EU delegations around the world to obtain their views on the Drugs Strategy's role in external relations with countries in which they operate.²

Finally, the research team held a day-long expert workshop on 7 December 2011 in Cambridge, made up of European experts in the field of drugs and on EU drugs policy. The aim of the workshop was to present, challenge, and synthesise findings, the outcome of which has informed various sections of the report.

1.2.1 Targeted review of documents

A large number of documents relating to the development of the current Strategy and assessments of previous EU drugs policy were reviewed.

These documents formed the backbone of the study, in that they provided:

- A comparison of how the various aspects of the drugs situation in the EU have evolved since 2005
- Indications of the relevance, influence and implementation of the Strategy
- A clear view of the process and timeline of the development of the Strategy and its Action Plans, and the drugs situation in the EU.

This review included EU and UN treaties, and EU policy documents, such as:

- The EU Drugs Strategies and Action Plans themselves
- Commission and Council communications and working documents
- Previous evaluations, progress reports and impact assessments
- National green papers and reports
- EU legislation in the field of drugs

¹ The Evaluation Steering Committee (separate from our expert advisory panel) consisted of representatives from: EEAS, EMCDDA, DG ENLARG, DG DEVCO, DG ENTR, DG HOME, DG MOVE, OLAF, EU RTD, DG SANCO, DG TAXUD, DG JUST

² In addition to the data collection approaches carried out as part of the evaluation, we were asked to commission a consultation of a limited sample of stakeholders provided by the Commission, soliciting their views on the current Strategy and suggestions for the future of EU drugs policy. The responses to this consultation have been reviewed to provide an understanding of the stakeholder context. A description of its results, approach and sample will be presented in a separate report. In 2012 the European Commission will launch an open consultation to inform the decision-making process following this evaluation, asking the public its views on the best ways to tackle the demand for and supply of drugs, as well as the phenomenon of new psychoactive substances

- Documents on funding programmes in the field of drugs
- EMCDDA reports
- Europol Organised Crime Threat Assessments (OCTAs)
- Further documents provided by the EMCDDA and Europol.

The evaluation team also received numerous documents from the commissioning team to help contextualise the development of the Strategy. These included meeting minutes, e-mails, Strategy drafts, impact assessments, information and evaluations of the different EU agencies, civil society consultation, and questionnaires related to implementation. A list of documents consulted can be found in Appendix H.

1.2.2 Key informant interviews

The evaluation team conducted, transcribed and analysed key informant interviews with 22 individuals. The interviews were conducted in the early stages of the research with the aim of gaining a better understanding of the added value of the Strategy, the context and specifics of its development, as well as more broadly how the EU's 'balanced approach' was perceived internationally. The interviewees included:

- Policymakers involved in the development of the EU Drugs Strategy and Action Plans
- EU-level policymakers closely involved in EU drugs policy
- Representatives from accession and third countries who could provide an external view of the role of the Strategy. These included country representatives to the UN (US, Australia, Russia, Argentina) and candidate country national representatives (Croatia and FYR Macedonia).

Nine interviews were conducted face-to-face and thirteen were conducted by telephone. The evaluation team developed two protocols for these interviews (for the external dimension and candidate countries) in consultation with the commissioning team and RAND Europe's expert panel (the protocols are included in Appendix B). These interviews were professionally transcribed and coded using software for qualitative research (NVivo).

These interviews served multiple purposes:

- They provided relevant background to the evaluation, the EU Drugs Strategy and EU drugs policy in general
- They informed the sections of this report on the development of the Strategy
- They informed the sections of this report on the internal coherence of the Strategy
- They provided an early indication of objectives to consider for further investigation in the exemplar objectives (see section 1.2.4)
- They provided an early indication of the perceptions of the Strategy's added value
- They informed findings on international cooperation.

1.2.3 Online survey

To provide an overview of the relevance, influence and implementation of the Drugs Strategy and its Action plans in Member States, we contracted Ipsos MORI's Social Research Institute to conduct an EU-wide online survey covering the 28 objectives in the Strategy. Contacts for potential respondents were provided by the delegations in the Horizontal Working Party on Drugs (HDG). Respondents were selected from government institutions, NGOs and academia to provide input from across the fields of health, law enforcement, research and external affairs. In total 183 responded of a total 279 invited (65 percent), representing 26 of the 27 Member States. The survey was structured so that respondents answered questions on their area(s) of expertise or involvement. It aimed to provide an overview of the relevance, influence and implementation of the Strategy across all Member States, and to highlight areas, such as added value or challenges, for further inquiry. The findings from the survey are used in relevant sections of this evaluation.

These findings were also used to identify a selection of countries from which to conduct a more in-depth assessment of the relevance, influence and implementation of the Strategy and Action Plans for a smaller number of selected objectives.

The questionnaire for the online survey is included in Appendix F.

1.2.4 Selection of exemplar objectives for in-depth analysis

As noted above, the study aims to build on the online survey and 'dig deeper' into specific areas of interest to explore the relevance, influence and implementation of the Strategy. This was carried out by means of 'exemplar objectives', which were researched by means of in-depth interviews in seven Member States and at EU level. The exemplar objectives were selected in consultation with the Commission and the independent expert panel. We included at least one objective from each of the five main areas of the Strategy (the two pillars and three cross-cutting themes described in Section 3.3). Table 1.2 lists the exemplar objectives chosen.

Table 1.2: Selected exemplar objectives for detailed analysis

Reference in the Strategy	Objective
Objective 18	EU-level coordination of drugs policy through the HDG
Objective 25.3	Improving access to targeted and diversified treatment
Objective 25.4	Improving access to services for prevention/treatment of HIV/AIDS
Objective 31.1	Improving the EU knowledge infrastructure in the field of drugs and consolidating drug information systems
Objective 30.1	Coordinated action in international organisations
Objective 27.4	Enhancing law enforcement, criminal investigation and forensic science cooperation

1.2.5 Country selection to inform in-depth analysis of exemplar objectives

The evaluation team, in consultation with the Steering Committee, developed criteria to help select a number of Member States. These Member States would provide the vehicle for researching the exemplar objectives and acquiring a more granular understanding of the added value, relevance, influence and implementation of the Strategy.

- As a starting point it was agreed that the selection should include Member States that joined the EU prior to 2004 (old) and those that joined in 2004 or 2007 (new).
- It was agreed that the selection should include both larger and smaller Member States in terms of population size. The threshold level for a ‘large’ country was placed at the EU mean population of 18.6 million.
- Additionally, it was agreed the selection should include a country with a federal structure, to reflect that responsibility for drugs policy is more localised in some countries. We chose to select Spain, a country among the larger, older Member States.

These initial criteria yielded a large number of possible combinations, so an additional set of considerations were used to select a sample of countries that provides sufficient variation in dimensions important for the evaluation of the EU Drugs Strategy and its Action Plans. These included:

- Prevalence of substance use
- Type of drugs policy regime
- Position in the drug supply chain (i.e. primarily production, transit or consumption).

In addition to the chosen Member States, we also decided to include the EU as a geopolitical entity for in-depth analysis. This was because a number of objectives from the Strategy, and actions from the Action Plans, relate to activities to be carried out by EU institutions (notably those involving international cooperation). The relevance, influence and implementation of those specific objectives and actions are best assessed at EU level.

Box 1.2 presents the final selection of Member States. We acknowledge that, in principle, our criteria and considerations could have resulted in a different selection.

Box 1.2: Geopolitical entities selected for in-depth analysis

- Czech Republic
- Netherlands
- Sweden
- France
- United Kingdom
- Spain
- Romania
- EU

Background information was collected for each of the Member States selected for in-depth analysis. This information is set out in Appendix G.

1.2.6 In-depth interviews

Forty one in-depth interviews were conducted with experts, policymakers and others involved in drugs policy at EU and Member State level. These were conducted in the seven chosen Member States and the EU, and covered the six selected exemplar objectives for in-

depth analysis listed in Table 1.2. Member State interviews were conducted by Ipsos MORI; EU-level interviews were conducted by RAND Europe.

An interview protocol covering these selected objectives and focusing on the Strategy's relevance, influence and implementation was developed in consultation with the commissioning team, and was then piloted with a member of our expert panel. In addition, a second protocol, with a focus on coordination and international cooperation, was developed for the EU-level interviews (see Appendix C).

Thirty three interviews were conducted (by Ipsos MORI) in the selected Member States and eight were conducted with EU-level policymakers (by researchers from RAND Europe). Interviewees were identified through the online survey (respondents were asked if they would like to participate in further research), and supplemented with additional searches by the evaluation team. Interviews were transcribed before being analysed. Ipsos MORI analysed Member State interviews, and presented this analysis in a report. Findings from the Member State in-depth interviews, presented in later chapters of this document, are taken from that Ipsos MORI report.

1.2.7 **EEAS survey**

In view of the wide array of actors and activities involved in international cooperation, the evaluation team and Steering Committee agreed it would be helpful to expand information gathering relevant to the international cooperation elements of the EU Drugs Strategy. In order to do so, we used the results of a survey commissioned by the European External Action Service (EEAS) and DG Justice, which included a number of EU delegations around the world. The questions solicited input on how drugs policy informed bilateral relations and the extent to which the EU Drugs Strategy informed policy, programmes and interventions. RAND Europe helped formulate the questions and analyse responses, but the survey administration and the recruitment of respondents was carried out by the Commission. The questions and an analysis of the responses can be found in Appendices D and E of this report.

1.2.8 **Expert workshop**

Throughout the project the research team benefited from the input of three experts on the expert advisory panel:

- Franz Trautmann, Netherlands – Head Unit International Affairs, Trimbos Instituut
- Jean-Michel Costes, France – former Director of French Monitoring Centre for Drugs and Drug Addiction (OFDT)
- Tomas Zabransky, Czech Republic – Head of Research and Development Programs at the Center for Addictology at Charles University

These experts commented on interview protocols and deliverables throughout the project, and their contribution culminated in a one-day expert workshop with the research team. In the workshop the RAND research team presented the main findings and the sources of evidence from which these were drawn. The presentation was interactive, facilitating and encouraging discussion and challenging of findings. While discussion with the expert panel provided nuances and added to conclusions, overall the findings were deemed by the

expert panel to be of interest and useful for the development of future strategies, and were seen to be valid on the basis of the knowledge and experience of the expert panel.

1.2.9 The use of vignettes

In addition to the main data collection activities described above we also use examples or ‘vignettes’ in this report. These provide further information about particular programmes, interventions or activities mentioned to us in the course of the other data collection activities. The evaluation team gathered additional information on these in order to illustrate the implementation of ideas or approaches endorsed by the EU Drugs Strategy. These vignettes are *not* provided as evidence that the Drugs Strategy has caused a particular programme to be implemented or that the Strategy has led to changes in the drugs situation. Rather, the vignettes demonstrate how the kinds of approaches and activities advocated in the Strategy and Action plans can be put into practice, and how, in some instances, it appears they can be effective in achieving the Strategy’s objectives.

1.3 Structure of the report

This evaluation reports on the results, findings and conclusions of the research activities described above. It is divided in to three parts:

Part 1 (Chapters 2 and 3) presents the context of drugs policy at different governmental levels and introduces the EU Drugs Strategy and its history. Chapter 2 illustrates the background of trends and developments in the drugs situation in the EU and provides the context of drugs policy at different governmental levels. Chapter 3 introduces the EU Drugs Strategy and its history with particular attention to the process leading up to the adoption of the 2005–2012 Strategy. It also presents findings on the Strategy’s internal logic and coherence.

Part 2 (Chapters 4 to 8) presents the assessment of the relevance, influence and implementation of the two policy fields and three cross-cutting themes of the Strategy: demand reduction (Chapter 4); supply reduction (Chapter 5); coordination (Chapter 6); international cooperation (Chapter 7); and information, research and evaluation (Chapter 8). The structure of each of those chapters focuses on the findings for the three main evaluation criteria: relevance, influence and implementation.³ For the two ‘vertical’ pillars of the Strategy – Demand reduction and Supply reduction – we have included sections on the trends in the European drugs situation in these areas.

Part 3 (Chapters 9 and 10) draws together conclusions and lessons from this evaluation by addressing each of the guiding study questions. The final chapter formulates a set of recommendations for the future of EU drugs policy and a potential successor to the EU Drugs Strategy 2005–2012.

³ It must be noted that in some cases it is difficult to strictly separate the findings for these three criteria

PART 1: THE EU DRUGS STRATEGY AND ITS CONTEXT

2.1 **Tackling illicit drug markets**

There are a multitude of approaches aimed at tackling the challenges of illicit drugs. These target different dimensions of problems relating to drugs, with varied (and sometimes unintended) consequences and levels of effectiveness. It is possible to conceive of a taxonomy of drugs policies. These different policies can target and impact on different aspects of society, such as health, safety and public order, the criminal justice system, and social and economic functioning, and they can do so in different ways. Policies can be devised in terms of the harms they seek to minimise, the sources they seek to affect, or those who bear the burden of the harms incurred (MacCon and Reuter, 2001).

National and international approaches to tackling the challenges of illicit drugs tend to be mixed. Firstly, governments and international organisations deploy a range of measures aimed at targeting the *supply* of illicit drugs, through law enforcement interventions, seizures, precursor interdictions, and destruction of production facilities and crops. Secondly, there are measures that are intended to reduce the *demand* for illicit drugs, by targeting users or potential users directly; these include education and information provision through a variety of different media (radio, television, Internet, posters, etc.), early interventions with at-risk groups, treatment and possession bans. Finally, there are interventions geared at reducing harms such as ill health and morbidity, for example through needle exchange programs or substitution treatment.

2.2 **Drugs policy in the EU**

Drugs policy at the EU level requires coordination at institutional levels between the Council and the European Commission. The European Commission functions as the main executive body at EU level and is responsible for EU level actions. These are implemented through policy initiatives, funding and coordination – and are implemented with the relevant national and international structures as well as civil society. The main EU technical and operational agencies with a remit in the drugs field are the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Europol (the European Police Office) and Eurojust (the European agency for judicial cooperation). The EMCDDA plays an important role as an information hub, gathering comparable data and publishing reports on the drugs situation in the EU. It further acts as coordinator of the European Information Network on Drugs and Drug Addiction (REITOX), a practical instrument for the collection and exchange of data and information on drugs and drug

addiction between 31 members (27 Member States, Norway, Turkey, Croatia and the EC). Europol⁴ also plays an important role in terms of law enforcement coordination and expertise. It facilitates and supports cross-border investigations and operations, provides information on drug trafficking, and acts as a central institute from which Member States can draw expertise. Europol also publishes reports that are disseminated to EU policymakers and the law enforcement community in the 27 Member States. Finally, Eurojust is the body that facilitates coordination of action for investigations and prosecutions between competent authorities in Member States

Internationally, the United Nations Office on Drugs and Crime (UNODC) plays a key role in coordinating action and assisting member nations in addressing the challenges associated with illicit drugs, drawing on key legal instruments that form the basis of international cooperation in the field, namely, the UN Single Convention on Narcotic Drugs of 1961 (as amended by the 1972 Protocol), the Convention on Psychotropic Substances of 1971, and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. The UN Commission on Narcotic Drugs (CND) is the main body dealing with this area in the UN system, with specific mandates pertaining to the Drug Control Conventions and as governing body of UNODC.

In Europe, drugs policy remains a Member State prerogative. The Strategy provides an ‘outline’ of the EU balanced approach, and its Action Plans a means of implementing this approach. National drug strategies and the means through which these are implemented are designed at the national level. The EMCDDA reports that virtually every EU Member State has adopted a national drug strategy, ‘usually supported by an action plan, which has concrete targets and is time-based’ (EMCDDA, 2010, p. 13) (see Box 2.1).

Box 2.1: Examples of national drugs strategies

Spain published its first National Action Plan on Drugs in 1985, led by the Ministry of Health and Consumer Affairs, which included an inter-ministerial group composed of representatives of the ministries of Health, External Affairs, Home Affairs, Justice, Education and Science, and others (Delegación del Gobierno para el Plan Nacional sobre Drogas, 1985)

The **United Kingdom’s** first national drug strategy was published in 1995, has since been revised, and is now updated and reviewed periodically. The strategy is led by the UK Home Office.

In contrast, the **Czech Republic** established a national drug strategy in 2005, focusing not only on illicit substances, but also on alcohol and prescription drugs. The strategy is evaluated every two years (Government Council for Drug Policy Coordination Czech Republic, 2010).

Regarding illicit drugs, the EU has certain competencies in the fields of:

- Judicial, police and customs cooperation (Title VI TEU, Articles 29 to 34)
- Internal market/external trade in precursors (Article 114 TFEU, formerly Art. 95 TEC; Art. 207 TFEU)
- Complementary measures in the field of public health, including reducing drugs-related health damage, and information and prevention (Article 168 TFEU)

⁴ Please note that work is currently underway to map out Europol’s involvement in EU drugs policy and the EU Drugs Strategy 2005-2012

- Adopting minimum rules concerning the definition of criminal offences and sanctions on serious organised crime, including illicit drugs trafficking (Article 83 TFEU).

Thus, while drugs policy may be formulated at the Member State level and drug legislation is primarily a matter of national competence, there are a number of areas which fall within the realm of wider EU competence. These include the control of the trade in drug precursors,⁵ the prevention of money laundering, the establishment of minimum provisions for penalties for illicit drug trafficking, and information exchange, risk assessment and control of new psychoactive substances (European Commission, 2008b).

Coordination of drugs policy between Member States takes place primarily at the Horizontal Working Party on Drugs (HDG), a Council working party set up in 1997 and reporting to the Committee of Permanent Representatives to the European Union⁶ (COREPER). Chaired by the rotating EU presidencies and organised with the support of the Council secretariat, the HDG is composed of delegations from the 27 Member States, the European Commission (DG Justice is the lead DG; other DGs involved when appropriate), the EMCDDA and Europol. Since the ratification of the Lisbon Treaty the European External Action Service (EEAS) has had a seat. The HDG prepares statements on EU drugs policy, such as those communicated at the CND, and holds informal dialogues with third countries.

In the case of EU legislation, the presidency is in charge of preparing the working documents, which are piloted in the relevant working party before being adopted by the Council, or as in the case of the EU Drugs Strategy, the European Council.⁷

Specific elements relating to illicit drugs policy may also be discussed by other Council working bodies, such as the Customs Working Party in relation to the control of drug precursors, or the Standing Committee on Operational Cooperation on Internal Security (COSI). COSI was set up in 2010 with a mandate to 'facilitate, promote and strengthen the coordination of EU States' operational actions in the field of internal security' (European Council, 2010). As its responsibilities include facilitating effective operational cooperation and coordination around organised crime and other threats to EU internal security, it takes a related role in the coordination of cross-border supply reduction actions, as these are often linked to organised crime.

The EU also complements national efforts to combat illicit drugs by means of funding programmes that provide grants for cross-border projects (European Commission, 2011). Currently, the Drugs Prevention and Information Programme (2007–2013) is in place,

⁵ Drug precursors are compounds that are required in the synthesis or extraction processes of drug production, becoming incorporated into the final drug molecule

⁶ COREPER is composed of Member State heads of mission to the EU. Its role is to prepare the agenda for ministerial meetings, and to oversee and coordinate the work of committees and working parties

⁷ After the presidency pilots the document in the working party it is sent to COREPER. COREPER can in turn either submit the legislation without discussion - in which case it would be referred to as ROMAN I item, to be adopted by the Council - or refer the document back to the HDG to resolve any outstanding specific or political questions. This process can occur several times before the legislation is ultimately adopted by the Council.

which will provide €21.35 million to fund transnational projects aimed at preventing drug use, as well as reducing drug use, dependence and harms. This is the only programme at EU level specifically referring to the implementation of the EU Drugs Strategy and solely dedicated to funding projects in the field of drugs. However, other programmes provide some funding to projects that support research in the field of drugs, for example:

- The Prevention of and Fight Against Crime Programme
- The Health Programme
- The Seventh Framework Programme of the European Community for Research, Technological Development and Demonstration (2007–2013).

2.3 Drugs policy and the Lisbon Treaty

The EU approach has been reinforced by the ratification of the Lisbon Treaty in 2009. Although there were no specific clauses relating to drug issues *sensu stricto*, the Lisbon Treaty has introduced a number of changes in the area of freedom, security, justice and public health that have implications for drugs policy. For example, in addition to changes in legislative instruments and procedures, the European Court of Justice (ECJ) is to have full jurisdiction in the areas of judicial cooperation in criminal matters and police cooperation.⁸ The EU can now also adopt measures regarding the way in which Member States conduct evaluations in the policy areas relevant to DG Justice, which include drugs (Article 70 TFEU).

In the field of criminal justice, the Lisbon Treaty identifies drug trafficking as one of the EU's 'Eurocrimes', allowing for the establishment of minimum rules concerning the definition of criminal offences in the areas of particularly serious crime with a cross-border dimension, which includes illicit drug trafficking (Article 83(1) TFEU).

The Lisbon Treaty also provides for the possibility of creating a European Prosecutor's Office, which means that long-term, cross-border drug trafficking offences could be prosecuted at the EU level (Article 86 par. 4 TFEU). In the field of public health, the Treaty allows the EU to complement Member State actions in reducing drug-related health damage (Article 168(1) TFEU), as well as strengthen coordination in terms of establishing common 'guidelines and indicators', exchanging 'best practice' and performing 'periodic monitoring and evaluation', thus reinforcing the European Commission's options to launch initiatives in the field of public health and drug demand reduction, complementing those of Member States as well as the EMCDDA's mission in the field of data collection, exchange of information and best practices (Article 168 par. 2 TFEU). The Treaty also enables the European Parliament and the Council to adopt certain incentive

⁸ The ECJ can monitor the implementation of national legislation through infringement procedures and preliminary rulings, but has no jurisdiction to 'review the validity or proportionality of operations carried out by the police or other law-enforcement services of a Member State or the exercise of the responsibilities incumbent upon Member States with regard to the maintenance of law and order and the safeguarding of internal security' (Article 276 TFEU). Furthermore, certain limitations have been continued in regard to the right to suspend ordinary legislative procedure if requested by the Council (Article 83 paragraph 3 TFEU), as well as shared right of initiative EC/MS (Article 83 paragraph 3 TFEU)

measures to ‘combat the major cross-border health scourges’ (Article 168 par. 5 TFEU). Finally, the Lisbon Treaty provides for the creation of the European External Action Service (EEAS), an institution mandated to deal with EU’s external relations, who will take charge of certain aspects of EU drugs policy relating to international cooperation.

Key Findings

- The EU Drugs Strategy builds on a number of programmes, organisations, agencies, experiences and data established since the late 1980s
- These have had a bearing on the drugs situation in the EU, and have set the tone, to differing extents, for how the Strategy has been developed, implemented and perceived.
- The multiplicity of initiatives at national, EU and international level that bear on the field of illicit drugs hampers efforts to attribute changes in the drug situation to the Strategy.
- The process of developing the Strategy was, overall, effective and collaborative. It contributed to consensus building between Member States with differing perspectives on drugs policy.
- A small number of issues, most notably around harm reduction approaches to addressing illicit drug demand, proved contentious and led to intense debate and negotiation. These conflicts were ultimately resolved, resulting in a Strategy with widespread acceptance among stakeholders.
- Our analysis of the Strategy and Action Plans suggests that they are internally logical and coherent.
Experts consulted in key informant interviews highlighted some areas for improvement but agreed with this overall assessment
- This evaluation makes recommendations for ways in which the logic and coherence of future documents might be further improved. In some instances greater coherence may be achieved through specificity.
- In other instances a broader interpretation may be necessary to ensure the Strategy is flexible and inclusive enough to coordinate the range of Member States' drugs situations and perspectives.

3.1 Introduction

Having set out the context for EU drugs policy in the previous chapter, this chapter examines the following issues:

- The past experience that informed the development of the current Strategy
- The process through which the Strategy was developed
- The main issues of debate during the development of the Strategy
- The internal logic, structure and coherence of the Strategy.

The analysis in this chapter was informed by reviews of documents and materials, as well as interviews with key informants at EU, Member State, third country, candidate country and international level.

3.2 History of EU drugs policy

The EU Drugs Strategy 2005–2012 and its Action Plans were developed following years of experience with initiatives aimed at tackling drugs challenges. Intra-state cooperation with the aim of tackling drugs was first initiated at the international level, under the auspices of the United Nations, setting the scene for EU coordination (United Nations, 1961, 1971, 1988). The Strategy is therefore embedded in a wider, longstanding context and approach to tackling drugs in the EU. It is built on, and reflected in, a number of different programmes, organisations, agencies, experiences and data that have been progressively assimilated since the late 1980s. In fact, a number of initiatives took place prior to, and are ongoing concurrently with, the Strategy. These various initiatives have had a bearing on the drugs situation in the EU, and have set the tone, to differing extents, for how the Strategy has been developed, implemented and perceived. In view of this complex context, it is useful to trace some of these initiatives back to the early development of the EU framework for drugs policy and to develop a timeline for EU activity in this field. Key steps and actions included:

- The European Plan to combat drugs 1990
- The European Plan to combat drugs 1992
- The creation of the EMCDDA in 1993
- The EU Action Plan to combat drugs 1995–1999
- The establishment of the Drugs Unit of Europol in 1994
- EU Action Plan to combat drugs (1995–1999)
- The release of various Commission communications on illicit drugs
- The publication of the EU Drugs Strategy and Action Plan (2000–2004).

The timeline displayed in Figure 3.1 shows key programmes, initiatives and treaties that have been developed and implemented since 1993. These include, for example:

- Council decisions and regulation (e.g. on precursors).
- Council recommendations (e.g. European Council, 2003).
- Programmes (such as the Stockholm and Hague Programmes).
- Funding programmes (such as EU (public) health programmes, the Drug Prevention and Information Programme, and the research and development framework programme).
- Implementation plans.
- Establishment of institutions with specific tasks in the field of drugs (such as EMCDDA and [the Drug Unit at] Europol), and agencies dealing with drug-

related issues such as Eurojust (judicial cooperation) and the ECDC (drug-related infectious diseases).

- Other relevant initiatives that have a wider focus (such as the EU Internal Security Strategy and the recently introduced EU Policy Cycle for organised and serious international crime).

The current Strategy is therefore explicitly framed as an integral part of the EC's efforts to promote the EU as an area of justice, freedom and security. Indeed, drugs policy has been a central component of both The Hague (2005–2010) and Stockholm programmes (2010–2014), in which the EU Drugs Strategy is relied upon as a key policy tool in bringing about these programmes' objectives. Furthermore, the Stockholm Programme, in addition to setting out a number of actions addressing illicit drugs, specifically highlights evaluating the current Drugs Strategy and Action Plans as one of its activities.⁹ The Drug Prevention and Information Programme 2007–2013, which funds small projects as well as more substantial developmental projects and studies (€100,000–600,000) with the aim of exchanging best practice in the field of drugs prevention, was established to implement targets identified by the EU Drugs Strategy and Action Plans by supporting projects aimed at preventing drug use.

Even if not mentioned explicitly in the Strategy, many if not all of the activities and initiatives in the timeline relate to and may indirectly reinforce the aims of the Drugs Strategy – and vice versa. For example, the specific programme 'Criminal Justice', part of the General Programme on Fundamental Rights and Justice 2007–2013 (Council of the European Union, 2007), aims to improve the contacts and exchange of information and best practices between legal, judicial and administrative authorities and the legal professions, which is also an element of the Drugs Strategy. Similarly, the two subsequent Programmes of Community Action in the Field of Health support certain activities aimed at drug demand reduction, a central area of focus for the Strategy (European Parliament and European Council, 2002). The Drug Prevention Information Programme supports law enforcement networks and funds studies on the global drugs market, thus addressing issues of illicit drug supply, another key focus of the Strategy (European Council, 2007a).

The EU has developed a distinct approach to combating drugs challenges since the 1980s. This has developed over time, building on greater Member State integration and the expansion of EU competencies, greater and more reliable data and information collected by the EMCDDA, and greater exchange of information between Member States (via REITOX, the Drug Prevention and Information Programme, etc.). The approach also provides for the support of Member State efforts by the European Commission, who play a facilitating and supporting role, through taking of policy initiatives, and funding of studies, research, projects, etc.

⁹ Please note that work is currently underway to map out the relationship between the EU Drugs Strategy 2005–2012 and the Stockholm programme

Year	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014		
Presidencies	DK-BE	HE-GR	FR-ES	IT-IRL	NL-LUX	UK-AU	GR-FIN	PT-FR	SW-BE	ES-DK	HE-IT	IRL-NL	LUX-UK	AU-FIN	GR-PT	SL-FR	CZ-SW	ES-BE	HU-PL	DK-CY	IRL-LIT			
Organisations/ forums	EMCDDA	Drug Unit Europol			Joint Action Info exchange on synthetic drugs						REITOX			European Civil Society Forum on Drugs						European Drug Alliance launched				
Strategies			EU ACTION PLAN ON DRUGS					EU DRUGS STRATEGY					EU DRUGS STRATEGY											
Action Plans								EU Action Plan on Drugs					First Action Plan			Second Action Plan								
Treaties	Treaty of Maastricht				Treaty of Amsterdam						Treaty of Nice							Lisbon Treaty						
Programmes											1st Programme of Community Action in Public Health													
												HAGUE PROGRAMME												
													DRUG PREVENTION AND INFORMATION PROGRAMME											
														GENERAL PROGRAMME ON FUNDAMENTAL RIGHTS AND JUSTICE										
														SECURITY AND SAFEGUARDING LIBERTIES PROGRAMME										
														7th Framework Programme for Research Technical Development and Demonstration Activities										
																		2nd Programme of Community Action in Public Health						
																				STOCKHOLM PROGRAMME				

Figure 3.1: Timeline of key programmes, initiatives and treaties related to drugs policy in the EU since 1993

3.3 The EU Drugs Strategy 2005–2012

The EU Drugs Strategy and Action Plans employ a combination of approaches to tackling drugs, together referred to as the ‘balanced approach’. The Strategy has two policy areas – supply reduction and demand reduction – and three cross-cutting themes – coordination, international cooperation, and information, research and evaluation (see Figure 3.2 below)

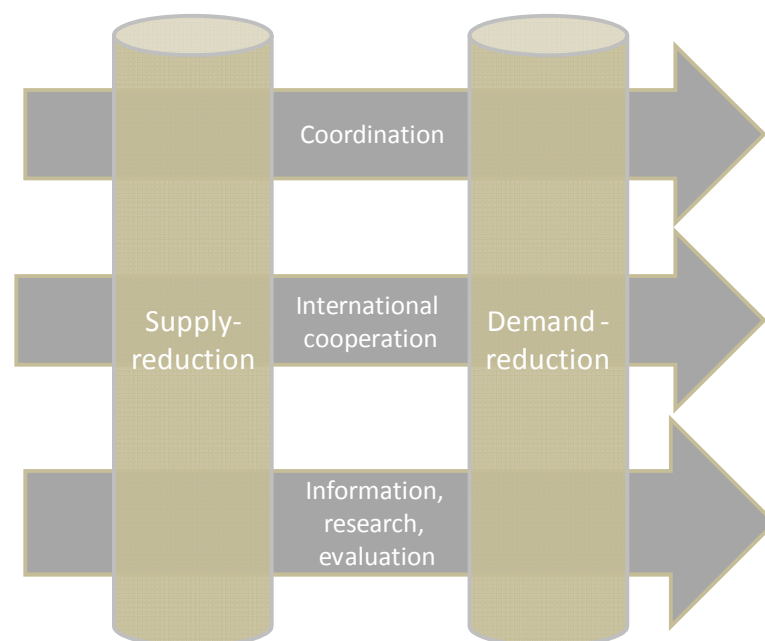


Figure 3.2: Structure of the EU Drugs Strategy

In the Strategy, adopted by the Council in November 2004, two general aims in regard to drugs were identified:

- To contribute to ‘the attainment of a high level of health protection, well-being and social cohesion by complementing the Member States’ actions in preventing and reducing drug use, dependence and drug-related harms to health and society.’
- To ‘ensure a high level of security for the general public by taking action against drugs production, cross-border trafficking in drugs and diversion of precursors, and by intensifying preventive action against drug-related crime, through effective cooperation embedded in a joint approach.’

The Strategy identifies a number of priorities. In relation to demand reduction, these include improving access to and the effectiveness of prevention programmes, improving access to early intervention programmes, and providing access to a range of treatment options. With regards to supply reduction, among the priorities are strengthening and intensifying effective law enforcement cooperation between Member States, making best use of existing legislation, legal instruments and frameworks, and preventing and punishing the illicit import and export of narcotic drugs and psychotropic substances. In relation to the cross-cutting themes, priorities include coordinated, effective and more visible action by the EU in international organisations in order to enhance and promote a

balanced approach to the drugs problem, and the improvement of EU knowledge infrastructure in the drug field.

3.4 **The 2005–2008 and 2009–2012 Action Plans**

The practical implementation of the EU Drugs Strategy has been facilitated through Action Plans, one covering the period 2005–2008 and one for 2009–2012. Based on and following the structure of the Strategy, they describe specific interventions and actions, specify concrete results, and set out a timetable for the proposed actions (European Commission, 2005, p. 3). It is anticipated in the Introduction to the EU Drugs Strategy that the Action Plans should be flexible and able to be adjusted to take account of ‘any significant change in the EU drugs situation’ that emerges during the period in which the Action Plan is operational (European Council, 2004, p. 6). As such, the Action Plans are described by the Commission as a ‘dynamic policy instrument’ rather than a static list of political objectives (European Commission, 2005, p. 3).

The Drugs Strategy also specifies criteria to guide how actions are selected for inclusion in the Action Plans. These include that actions should add value and should be measurable, have a specified timeframe and responsibility assigned for executing them, and contribute directly to the goals of the Strategy.

3.5 **The process of developing the EU Drugs Strategy**

It is in the context of the activities and initiatives described earlier in this Chapter that the EU Drugs Strategy 2005–2012 was developed. According to a number of interviewees who participated in the early stages of the development of the Strategy, one of the first formal steps in the drafting process took place in May 2004, with a conference in Dublin organised by the Irish presidency of the EU in collaboration with the Dutch EU presidency and the Dutch Ministry of Health, entitled ‘The Way Forward’. The conference aimed to provide a forum for discussion about the future EU Drugs Strategy 2005–2012, to follow on from the Second Strategy, which was coming to a close at the end of 2004 (Council of the European Union, 2004). The Netherlands, Ireland, Luxembourg and UK acted as an organising committee for the conference. In the course of our interview discussions some respondents who knew about the conference explained that its specific purpose was to:

- Contribute to the development of the EU Drugs Strategy
- Facilitate the exchange of ideas between the EU, Member States and ten accession countries, and EU institutions and bodies.

According to interviewees, the conference focused on the added value of the Strategy and the areas where a joint approach could lead to better results in tackling illicit drugs in the EU (rather than what individual national policies could accomplish by themselves). To this end, the workshops during the conference aimed at agreeing on initial choices from the proposed priorities for each of the thematic fields, and to cross-check priorities in different fields against each other.

The process of developing and coordinating the drafting of the Strategy, which took approximately one year, was spearheaded by the Irish and Dutch governments (who held the first and second EU presidencies respectively during 2004), as illustrated in Figure 3.3. These two Member States worked in close cooperation with the governments of the UK and Luxembourg, who held the two presidencies immediately following the Dutch in 2005. While not the direct responsibility of the European Commission, Commission staff provided legal, technical and political assistance to the presidencies leading the process. The Horizontal Working Party on Drugs (HDG), as well as Member States individually, also provided input and support. In addition to the 2004 conference, other formal inputs into the Strategy's development included:

- The final evaluation of the 2000–2004 Strategy and Action Plan
- Input from the HDG
- Council opinions
- A consultation document developed by the Dutch government with a view to securing Council agreement to a new strategy during its presidency
- EMCDDA reports and publications.

In addition to these inputs, other documents fed into the process in various ways. Member States, the EMCDDA and Europol, for instance, brought forward contributions and comments to the HDG. One example is a paper expressing the UK government's views on the development of the Strategy. This paper expressed the need for:

- A closer focus on the delivery of concrete actions that demonstrate that the EU is adding practical value to Member States, bilateral and multilateral work.
- A clear statement in the Strategy of how the EU can best add value – through practical cooperation as well as exchange of information and best practice in supply reduction at all levels, but only through exchange of information and best practice in demand reduction.
- Clarification and making more effective the role of the HDG.
- Finding a way the HDG can work effectively with its enlarged membership (as a result of accession of new Member States).

Evidence from research in the field of illicit drugs policy and practice was also drawn on during the process. One interviewee explained that such evidence was used more to draw up the demand reduction sections of the Strategy than the supply reduction sections. This, the interviewee argued, was a result of the (at least perceived) better quality of the evidence on what works in tackling demand. For example, the Strategy was informed by evidence as to the effectiveness of prevention measures and addiction treatment (including substitution therapy). In contrast, evidence on tackling the supply of illicit drugs was perceived to be less robust, and there was a lack of agreement on what constitutes appropriate indicators of illicit drug supply and drug supply reduction.

The European Drugs Strategy 2005–2012 was finally endorsed by the Council in December 2004. The Commission then brought forward the two consecutive four-year

Action Plans, for the periods 2004–2008 and 2009–2012. The first of these was endorsed by the Council in July 2005, the second in September 2008 (European Commission, 2008c).

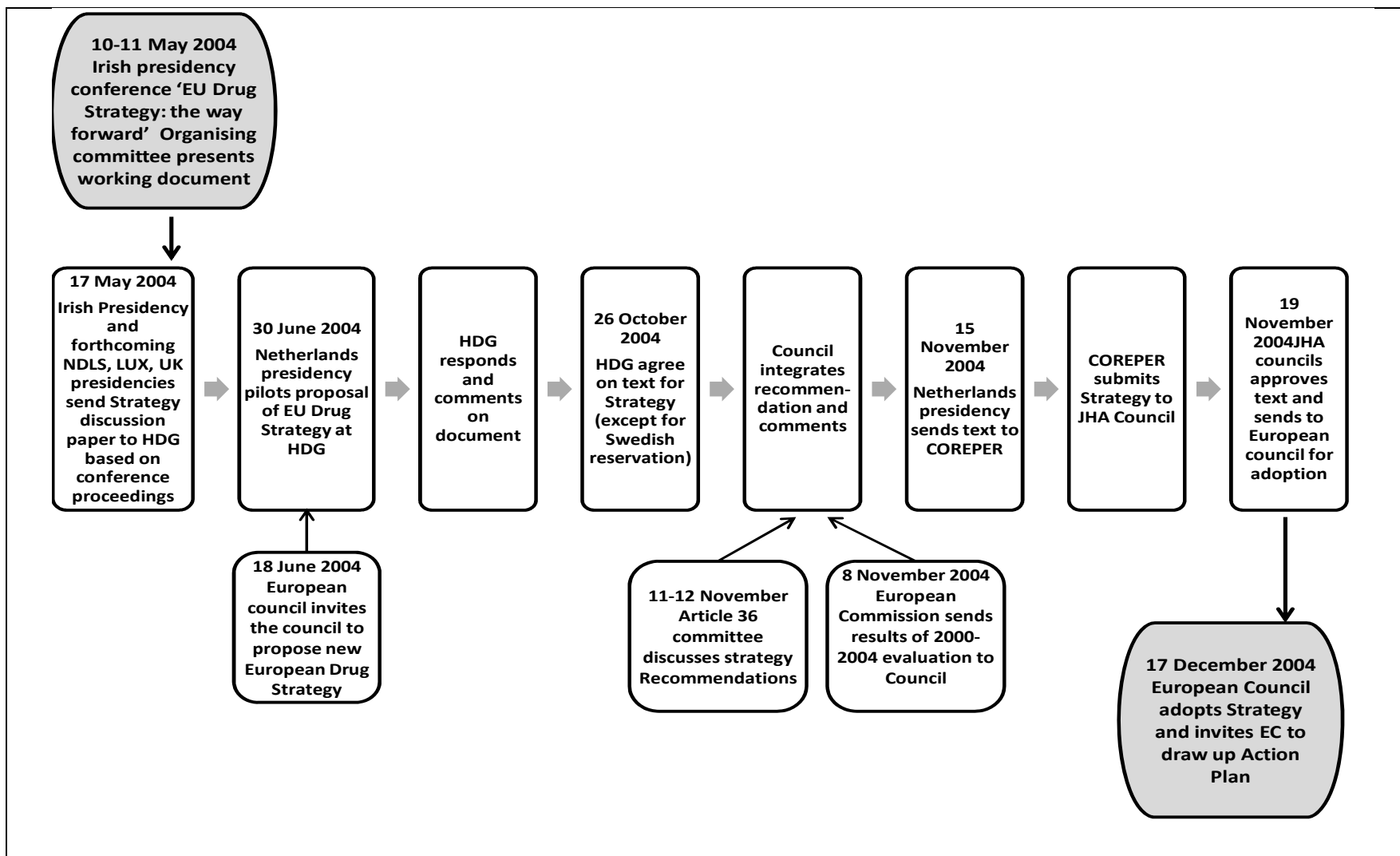


Figure 3.3: The process of developing the EU Drugs Strategy

3.6 **Substantive points of debate during development of the Strategy**

The Strategy was negotiated by Member States, with a need to acknowledge and reconcile different legal, regulatory and cultural approaches to tackling the drugs problem. The inclusion of the term ‘harm reduction’ proved to be a point of debate during this negotiation.

‘Harm reduction’ typically refers to interventions, programmes and policies that aim to ‘reduce the health, social and economic harms of drug use to individuals, communities and societies’ (EMCDDA, 2010, p.19).¹⁰ Three key informant interviewees noted that a small number of countries with policies more akin to ‘zero tolerance’ to drugs found it difficult to agree to the inclusion of what could be perceived as a more permissive approach, objecting to the inclusion of the concept and terminology of ‘harm reduction’ in the Strategy. The consensus that emerged from this negotiation ensured that all Member States were on board. Certain references to harm reduction were included in the Strategy¹¹ (and in both the 2005-2008 and 2009-2012 Action Plans).¹²

3.7 **Internal logic and coherence of the Strategy**

Given the centrality of the EU Drugs Strategy to European and international understanding of the EU approach, the research team was tasked with assessing the document’s internal logic. In order to do so, we interrogated the Strategy’s structure, clarity and internal coherence, and the relationship between the Strategy and its Action Plans. In such an assessment of the internal logic and coherence of an initiative or program, it was important to consider what its aims are, how, and how clearly, it

¹⁰ Typically, harm reduction interventions include needle and syringe programmes, opioid substitution treatment, and counselling services. They can also include heroin prescription treatment, drug testing kits in recreational settings, and drug consumption rooms. See European Council (2003) for a breakdown of ‘standard’ interventions, reflecting the 2005/2006 situation

¹¹ The current Strategy contains a few mentions of the specific term ‘harm reduction’ or similar:

‘The EU aims at a contribution to the attainment of a high level of health protection, well-being and social cohesion by complementing the Member States’ action in preventing and reducing drug use, dependence and drug-related harms to health and society’ (p.5);

‘Measurable reduction of the use of drugs, of dependence and of drug-related health and social risks through the development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures within the EU Member States’ (p.10);

‘Such a demand reduction system implies the following measures using all the options available according to the latest state of scientific knowledge: ... reducing drug-related health and social damage...’ (p.10);

‘In the area of demand reduction the following priorities have been identified: ... improving access to services for the prevention and treatment of HIV/AIDS, hepatitis, other infections, diseases and drug-related health and social damage’ (p.11).

We note that preventing and reducing health damage related to drugs is now an official area of complementary action in Art 168(1) of the Lisbon Treaty.

¹² For example, Actions 8 and 9 of the 2009–2012 Action Plan, p.13.

articulates its aims, and whether the specified objectives and actions are aligned with the overall aims.

The following assessment is also informed by the views and perceptions of key informant and in-depth interviewees. In particular, we explored interviewees' opinions on the structure, logic and consistency of the documents.

Overall coherence, structure and internal logic

Overall, the Strategy and Action Plans appear to exhibit internal logic and coherence in that all three documents have the explicit objective of addressing the drugs challenges in the EU, and all the actions and priorities they mention address at least one of the two policy fields or three cross-cutting themes.¹³

The documents also contain a wide range of different types of information, statements and aspirations that reflect the differences in timing and authorship of each text. However, the texts of the Strategy and Action Plans all:

- Clearly spell out the overall goals of the EU approach to tackling drugs: a reduction in drug problems through a number of mechanisms (supply and demand reduction policies, improved international cooperation towards these policies, improved information to support these policies, improved coordination of these policies).
- Provide advice to and encourage Member States to pursue certain avenues with regards to drugs policy based on their national competences (i.e. the documents aim to foster the use of approaches that are evidenced-based and/or appropriate to tackle the drugs problem according to EU stakeholders).
- Set out objectives for EU-level action (i.e. action for which the EU institutions are primarily responsible).
- Provide coordination of and lend coherence to the Drugs Strategy at EU level, as well as allowing for coordinated action in areas in which one Member State may not effectively or efficiently act alone (e.g. tackling transnational drug trafficking).

Four key informant interviewees commented on the internal coherence of the Strategy, and all were of the view that the Strategy is an internally coherent, clear and well-structured document. They also noted that the Strategy is less detailed and specific in certain sections, but acknowledged that Strategy documents of this type, built through collaboration, based on the consensus of a large number of stakeholders, and oriented towards coordination, may be expected to be limited in their ability to be detailed and

¹³ The Strategy sets out its aims as follows: '[the new Drugs Strategy] aims to protect and improve the well-being of society and of the individual, to protect public health, to offer a high level of security for the general public, and to take a balanced, integrated approach to the drugs problem' (European Council, 2004, p.2) p.2). 'The aim of this European Union Strategy is to add value to national strategies while respecting the principles of subsidiarity and proportionality set out in the Treaties. This Strategy stresses that Member States should consider the impact of their national strategies on other Member States, the ways national strategies of different Member States can be mutually supportive, and the contributions such strategies can make towards achieving the objectives of this European Union Strategy. It is also intended to allow scope for local, regional, national and transnational dynamics and potentialities and to make optimal use of the resources available.' (Preface, p.3).

specific in all areas (as an interviewee on drugs policy at the Member State level put it: ‘It’s hard to have something concrete... with [a document] like this’). There did not appear to be systematic differences in the views of different types of interviewees (such as third country experts, Member State practitioners and EU-level officials) on this aspect of the Strategy and Action Plans.

The Strategy and Action Plans as separate documents

The Strategy covers an eight-year time period, during which important changes to the drugs situation or policy priorities may have evolved and changed. As a result, the two Action Plans are now useful tools, being somewhat more responsive to the changing environment. Also, the Strategy constitutes a higher-level, priority- and direction-setting document, whereas the Action Plans provide policymakers with more specific, concrete initiatives to consider.

Interviewees, however, varied in their views on whether the Strategy and Action Plans worked effectively as a single set of interlinked documents. The majority of interviewees preferred the interlinked format, though some felt it could be further improved. Only one interviewee favoured a single integrated document. One interviewee, working at the EU level, stated that the Strategy document has a ‘good structure’. He also remarked that, should there be another Strategy, he would not change the basic two-pillar structure and underlying emphasis on collaboration and research. However, he felt that ‘[w]hat has not been entirely clear is the division between the Strategy and Action Plans. More clarity [on this] is needed’. Another interviewee, from a third country, observed that the Strategy ‘could be streamlined, so that you actually include [the Action Plans] in one document, [which] would be helpful’.

A third interviewee, working at the EU level on drugs issues, explained that he was not ‘100 percent sure if we need an action plan, but if [there are] action plans... they should be at a higher level and should not have ... hundreds of actions’.

Four interviewees felt differently. One of these, working at the EU level, felt that:

The Strategy and Action Plans work well together; they’re linked by their structure and main objectives. There is consistency and coherence between the three documents. There may be some inconsistencies because of revisions from different countries and stakeholders who contribute, but overall it’s ok.

Length

Three interviewees commented on the length of the Strategy and Action Plan documents. One, active in the drugs field at European level, stated that the Strategy and Action Plans constitute ‘very long wish-lists of actions, indicators to measure [progress] and so forth... which makes it a bit difficult to follow sometimes’. He then went on to add that this is true of national-level strategies as well as other policy documents of this kind at both EU and Member State level: ‘As every political document, it’s a bit of many things. But it achieves the type of basic guidance expected of this kind of document’. In a similar vein, an interviewee working at the Member State level but involved in EU-level discussions on drugs, stated that:

The Strategy, being too big and unwieldy, has the risk that people won’t take it seriously enough; officials will look at it and say ‘I can’t be bothered with this’... It is not easy to incorporate feedback from 50-odd people and stick to a simple document.

A third interviewee noted that the documents are too long and the objectives and action plans too broad, making it ‘more a wish list than a set of priorities’. These concerns about the length of the documents are important: if they are not perceived as accessible, this could limit their relevance and impact. However, the documents do need to be understood as the outcome of negotiations involving numerous actors all of whom contributed to its drafting. Furthermore, the EU Drugs Strategy is of a similar length to most individual Member State strategies.

Comparison with previous strategies

A few interviewees compared the current Strategy with previous ones, arguing that the former represents an improvement and offers greater clarity. For instance, referring to the ‘balanced approach’ and other cornerstones of the EU’s drugs policy, one interviewee who was involved in the development of the Strategy at the EU level stated:

[Policies] had not been set out as clearly... in previous strategies. Previous strategies had been more, I would say more [of a] political wish list. What you get here is a more structured document... and it is more balanced and it makes sure to be consensual enough for let’s say the more prohibitionist-minded Member States to be able to live with it.

An EU-level drugs policy expert, however, explained that during the development of the current Strategy there had been a push from the Commission to make it and the Action Plans much more concrete than previous ones. This was driven by concerns that the previous strategy and the action plan that accompanied it were too vague to enable monitoring and evaluation of the extent to which actions were being implemented. This interviewee said: ‘The idea was to make things as concrete as possible [so] that you can evaluate implementation. I’m not so sure that we are really better off with this Action Plan as regards evaluation of the implementation... I’m not sure if we need an action plan. There might be some sense in putting some strategic elements more into concrete terms in the [style] of an action plan but... not go into this detail.’

Terminology and language

Some broad terminology is used in the Strategy, for example, the term ‘harm reduction’. Different views were expressed about this by interviewees; whilst the flexibility of such terms is seen by some as necessary to facilitate consensus building, others highlighted that the lack of specificity can present challenges in practice. For example, about a quarter of the key informants commented on the fact that different stakeholders may interpret ‘harm reduction’ differently. One interviewee, who works on drugs policy at the national government level in a Member State noted:

The Strategy represents the European consensus. The problem is that it comprises terms whose meaning varies considerably depending on the actor. It seems difficult to talk about harm reduction in the context of the Strategy when one has no way of knowing what is meant by harm reduction, for some it could be substitution, others needle exchange programs, others medicalised heroin prescriptions or shoot-up clinics.

Typical of comments from these interviewees, a drugs expert from a Member State commented: ‘In general [the Strategy and Action Plans] are consistent, although of course they can be improved’. He then added: ‘It’s a common problem with these documents

[that] there is a specific type of [EU] language that needs to be used, but it's still clearly written'.

A second limitation regarding language and terminology concerns the 'assessment tool/indicators' presented in the Action Plans. Those presented in the first Action Plan, and to a lesser extent in the second Action Plan, can be better characterised as 'reporting requirements' rather than as explicit indicators. It is not clear how the Action Plans define 'assessment tool', although a reading of the text would indicate that it refers to reporting requirements for the different activities. The Strategy's emphasis on 'measurable and realistic results' for the actions in the Action Plan is commendable, but could be strengthened with the provision of actual indicators.

For instance, in the first Action Plan (2005–2008), one action specifies that Member States are to 'give the opportunity to civil society to present their opinion'. The corresponding assessment tool/indicator specified for this action is 'Member States report to the HDG by 2008' (European Council, 2005).¹⁴ The lack of measurability of this action is evidenced by the fact that it was noted that 'the achievement of this objective cannot be assessed' in the evaluation of the Action Plan (European Commission, 2008b). The evaluation also stated that:

The Action Plan 2005–2008 provides a mix of output, outcome and impact indicators but in a considerable number of cases, no indicators are provided at all but only assessment tools/data sources (European Commission, 2008b, p. 14).

The second Action Plan (2009–2012) took a modified approach, separating Indicators from assessment tools resulting in more clarity than in the first Action Plan. For instance, the proposed indicators for Action 1 (Member State and EU institutions to effectively coordinate drugs policy to reflect the objectives of the EU Drugs Strategy 2005–2012 and this Action Plan) were:

- Objectives of the EU Drugs Strategy and Action Plans included in national policies.
- Drugs policy at EU level reflects the objectives of the Drugs Strategy.

Specificity of Action Plan objectives

While not affecting the logic or coherence fundamentally, the Strategy states that actions should have 'measurable and realistic results', be 'cost-effective' and 'contribute directly to the achievement of at least one of the goals or priorities set out by the Strategy' (European Council, 2004. P. 7). However, this is not always done, as, for example, in the following actions:

- Member States to involve civil society at all appropriate levels of drugs policy (in both Action Plans).

¹⁴ It is worth noting that while the Action Plans themselves do not suggest sufficient indicators to monitor the progress of the proposed actions, the European Commission has in recent years undertaken research towards developing a set of indicators of drug supply and demand (Kilmer and Hoorens, 2010)

- ‘The EU to focus on coordinated and joint efforts between the Member States and regions most highly exposed to particular drug production/trafficking phenomena, in cooperation with Europol as appropriate’ (action 36, second Action Plan).
- ‘To ensure that EU relations with third countries reflect the objectives of the EU Drugs Strategy and Action Plans’ (action 45, second Action Plan).

The final evaluation of the first Action Plan stated that:

‘A considerable number of general objectives are often vaguely formulated, while specific objectives are not specific enough to prevent broad interpretation of what is meant and which activities are covered’. This was improved in the second Action Plan, which makes some strides towards greater specificity (European Commission, 2008b, p. 14).

PART 2 ASSESSMENT OF THE EU DRUGS STRATEGY

Key findings

- Demand reduction has been identified as an area of key added value, with a noted shift away from policy based on ideology towards evidenced-based interventions.
- Demand reduction objectives are perceived as relevant and their wide scope is appreciated by Member States as it allows discretion in the types of policies and programmes adopted.
- The relevance of the objectives was particularly noted in new Member States who have recently implemented such policies following EU accession.
- Coordination through the HDG has enabled a forum and open debate about the scientific basis of demand reduction measures, and a discussion around data collection and best practice.
- Objectives on harm reduction have now been implemented across all 27 Member States, though there remain important differences in levels of implementation.
- The Strategy outlines the use of legal psychoactive substances, such as tobacco, alcohol and medicines, as important areas of focus that could be further developed.
- New phenomena such as ‘legal highs’ pose emerging health and research challenges.

4.1 Context

Demand reduction is one of the two core policy areas of the EU Drugs Strategy’s balanced approach. It incorporates a number of objectives that aim to tackle the drugs problem by curbing the demand for and consumption of drugs. The means of achieving this result is outlined in the Strategy and Action Plans through the implementation of interventions focused on education, prevention, treatment and rehabilitation by Member States. The Strategy and Action Plans also include harm reduction measures, which aim to reduce drug-related health and social damage, and minimise the harms caused from drug consumption. The EMCDDA, based in Lisbon, is a central facilitator in the realisation of the Strategy’s demand reduction objectives. The agency’s core mission is to provide a solid evidence base for drugs policy formulation in the EU, to collect and analyse EU data on emerging drug trends, and offer advice to Member States on best practice in the drugs field.

4.2 Drug demand trends, 2005–2012

Data on the demand for and consumption of illicit drugs are provided by the EMCDDA (recent data are set out in Box 4.1, below). The EMCDDA systematically collects such data through its network of REITOX national focal points. Significant efforts have been put in to ensuring

Member States and others collect data in a systematic manner and using common indicators, so as to enable cross country comparisons. The EMCDDA analyses the data and publishes yearly statistical reports on the drug situation in Europe, as well as other reports on various aspects of drugs challenges. The EMCDDA has prepared a special statistical report on drug trends in the EU from 2005 to 2012, to coincide with the evaluation of the Strategy.

Box 4.1 Trends in use

Cannabis

Cannabis remains the most widely used illicit drug in Europe. Prevalence rates have stabilised since the early 1990s, and even decreased in some countries with traditionally high prevalence. However, these reductions are thought to reflect recreational users rather than intensive users. Treatment demand for cannabis-related issues increased over the course of the Strategy, with the numbers of new clients entering treatment for primary cannabis use increasing by over 40 percent between 2004 and 2009 (EMDCCA, 2011).

Cocaine

Cocaine is the second most commonly used illicit drug in Europe. However, there is great variation in prevalence between Member States, with high levels of use recorded in a restricted number of old Member States, mainly in the north of the continent. After significant increases in cocaine use during the early 2000s, most notably in Spain and the UK, recent research suggests a stabilisation and even slight decrease in use (EMCDDA, 2011b, p.4).

Synthetic drugs and other hallucinogens

Amphetamine use has remained relatively low and stable in the majority of Member States over the last decade, and some countries have even reported a decrease. Prevalence of methamphetamine use has remained stable in the Czech Republic and in Slovakia though the substance is found on the drug markets of a number of mostly northern Member States, where it appears to have partially replaced amphetamine. The overall use of hallucinogenic drugs, GHB and ketamine has remained generally low, whilst the use of LSD and hallucinogenic mushrooms appears to have been largely stable in the 2004 to 2010 period (EMCDDA, 2011b, p.4)

Opioids

Heroin remains the main opioid used in the EU, with few exceptions. Extrapolated data indicates that the number of problem opioid users has remained stable over the course of the Strategy. Despite progressive trends in prevention, treatment and harm reduction, drug-induced deaths remain at historically high levels, and still accounts for the greatest share of morbidity and mortality related to drug use in Europe (EMCDDA, 2011a). Overdose deaths only represent around half of the estimated mortality found among problem drug users who are also at a higher risk of death caused by disease (in particular, conditions associated with blood-borne infections), suicide, trauma and violence (EMCDDA, 2011b). The age of opioid overdose victims increased over the period. However, reported numbers of new users has decreased and is relatively low in most countries (EMCDDA, 2011b). This suggests that the older generation of problem opioid users is not being replaced.

Source: (EMCDDA, 2011b).

Trends in drug-related harm

The EMCDDA notes that newly reported infections with HIV have declined since the adoption of the Strategy. This is possibly as a result of a decline in the prevalence of injecting drug use and a decline in risky behaviours. Despite this decline in newly reported infections, the EMCDDA reports no change in HIV prevalence in samples of injecting drug users in the majority of Member States over the course of the Strategy. There have, however, been counter-trends, such as increasing HIV rates in a small number of new Member States and the recent 2011 HIV outbreak in Greece.

Contrary to HIV whose prevalence is comparatively low, Hepatitis C Virus (HCV) infection is highly prevalent among injecting drug users in most EU Member States. High prevalence of

HCV is also found in young and new injecting drug users, suggesting transmission often occurs early in an individual's injecting career. Notification data suggest that a considerable part of all HCV cases in Europe is attributable to injecting drug use. In the period 2004–09/10 in the EU countries where it was possible to establish trends, some modest decline in HCV incidence is reported (EMCDDA, 2011b).

Trends in consumption patterns have evolved over the lifetime of the 2005-2012 EU Drugs Strategy, and pose new policy challenges. Polydrug use is today the dominant pattern of drug use in the European Union (EMCDDA, 2011b). This involves the consumption of multiple illicit drugs in combination with each other, or alongside alcohol or non-controlled psychoactive substances or medicines. This pattern poses a significant challenge for Member States in terms of providing comprehensive and specific policy interventions, for example, by adapting treatment services to provide for polydrug use.

A further trend has been the emergence of new non-controlled psychoactive substances. A record number of 41 new such substances were recorded by the EMCDDA in 2010 (EMCDDA, 2011b). The sheer number of new psychoactive substances on the market poses important research and policy challenges in terms of gathering data and increasing understanding of the impact of such substances, and in terms of adopting appropriate mechanisms for identification and formulating adequate responses.

4.3 Relevance

Demand reduction objectives are perceived as relevant and established in Member States

Online survey respondents felt that the Strategy's objectives in the area of demand reduction were important and relevant to addressing the drug situation in their own Member States. Respondents were asked questions about three demand reduction objectives from the Strategy (about the effectiveness of prevention programmes, access to targeted and diversified treatment programmes, and the accessibility of services for the prevention and treatment of drug-related health and social damage). Ninety five percent of survey respondents said these objectives were either 'very important' or 'fairly important'.

The number of people that chose to answer the question on harm reduction was lower (n=36) than the other two questions (n=57 and n=54 respectively). Interestingly, all respondents from the sphere of supply reduction felt that improvements in the overall situation regarding the effectiveness of prevention were important (n=3), whereas a third of respondents from the demand reduction sector felt either that they were fairly important (30 percent) or not very important (3 percent, n=30). A similar split among respondents from the demand reduction field was revealed with respect to the harm reduction objective, where 63 percent found it very important while 32 percent (n=19) viewed it as fairly important. Regarding access to diversified treatment, respondents from new Member States assigned slightly higher relevance to this objective, with 78 percent (n=23) considering it very important, compared to 55 percent (n=31) of respondents from old Member States. When asked about these objectives in relation to the next EU Drugs Strategy, 100 percent of respondents felt that it was important to include these three demand reduction objectives in its framework.

Indeed, the in-depth Member State-level interviews corroborated these views, though at the same time providing some more textured insights. Whilst interviewees described a range of targeted

and diversified treatment programmes available in their Member States, most felt that their approaches were broadly aligned with the EU Strategy. Respondents from old Member States reported a good spread in terms of diversity of programmes and were, with some exceptions, supportive of the approach adopted in their respective Member States. Interviewees from new Member States also emphasised the relevance of the objectives. Some interviewees from Romania noted areas of progress, such as diversity and access, as well as areas for improvement, such as substitution treatment. Interviewees from the Czech Republic particularly felt that the balanced approach was relevant and in line with policies already pursued in their Member State.

The relevance of harm reduction was challenged by some Member States

For example, in France, experts' views towards targeted and diversified treatment programme were mixed. Although views were generally positive, reflecting on a broad range of available treatments, one expert questioned the balance of available options, feeling there was 'too much' of a focus on substitution treatment and not enough on psychosocial treatment. One EU-level official who emphasised the relevance of drugs policy in relation to health policy in the EU, noted some continued sensitivity about and objections to some aspects of harm reduction in certain Member States.

New challenges have emerged for EU drugs policy

Several interviewees also commented on the phenomenon of 'legal highs'. The need to address the phenomenon at an EU level was noted as relevant, but some interviewees felt that the Strategy could be more active in terms of the measures adopted to address this new challenge. For example, one interviewee noted that:

(Initiatives) from the European Commission have been 'vague' and 'aspirational' ... they need to be more concrete and direct. The current actions are not equipped to deal with new legal highs.

This point was further elaborated in regard to tobacco, alcohol and other licit drugs. It was argued that there is a need to understand the broader phenomenon of addiction and adopt a wider overarching framework to address it.

Overall, Member States described very different drug treatment 'markets' and demand reduction 'regimes' in their Member States, which emphasised the broad scope of demand reduction objectives in the Strategy. Certain comments noted above highlight the divergence in views on the most appropriate demand reduction approach and on the desirability of certain harm reduction measures, which helps explain the great variety in demand reduction policies. The inclusion of licit psychoactive substances and addressing the broader phenomenon of addiction were further noted as ongoing challenges in the area of demand reduction.

4.4 Influence

Contrary to findings on other dimensions of the Strategy presented in this assessment, results from the online survey and the interviews indicate that overall the EU Drugs Strategy is not perceived as influential in the provision of demand reduction policies in old Member States. However, this is not the case for the specific area of harm reduction within demand reduction, where respondents from the online survey as well as interviewees from all Member States felt the Strategy had indeed been influential.

The Strategy was perceived as more influential in demand reduction policies and approaches in new versus old Member States

Of the respondents answering questions on prevention in drug demand reduction, 60 percent felt the Strategy had not been influential (n=27). This was also the case for those answering the question on targeted and diversified treatment, where 53 percent of respondents felt the Strategy had not had an influence (n=43). In relation to the question on harm reduction, however, a slight majority of 53 percent felt the Strategy had had an influence on services for the prevention and treatment of drug-related health and social problems (n=25).

The survey, however, exposed a notable divergence between responses from old and new Member States in their assessment of the Strategy's influence, with respondents from new Member States on the whole being more positive about the influence of the Strategy. Respondents from new Member States largely found the Strategy more influential in relation to demand reduction objectives (61 percent for those answering on access to targeted treatment (n=18), 86 percent on harm reduction (n=7), and 50 percent on prevention (n=10) found it influential), whereas respondents from old Member States were sceptical in all three instances. At the same time, 63 percent of respondents (n=79) felt that harm reduction programmes had become more recognised in public health policy at the national level: again, respondents from new Member States were more likely to express this opinion than old Member States. In addition, those working in demand reduction treatment (80 percent, n=5) or supply reduction law enforcement (75 percent, n=4) were more likely than respondents in other sectors to feel this way. There were several countries where 100 percent of respondents thought harm reduction programmes had become more recognised, the majority from new Member States (Bulgaria, Cyprus, Finland, Ireland, Latvia, Poland, Portugal and Romania).

The in-depth interviews at Member State-level supported the results from the online survey. Two interviewees from older Member States felt that the Strategy and its Action Plans had less influence in their countries, because demand reduction policies were already well established when the Strategy was adopted. One UK expert commented that:

the EU strategy has had less impact/influence in the UK as the UK has very thoroughly thought through policies on demand reduction

The view within the Czech Republic was that demand reduction treatment has not been obviously influenced by the EU strategy, being in place since the 1990's with little notable change to the national strategy that they would attribute to the EU Strategy. However, a common theme from interviews with old Member States was a recognition that although they did not feel the approach to demand reduction had been influenced by the EU Drugs Strategy in their Member States, they felt it had significant influence and impact in new Member States. As an interviewee from the Netherlands noted:

I am not sure it has had any impact in the Netherlands, this would be different in maybe Slovenia or Slovakia, for example, who had not had a long history in drug problems so used the Strategy as a basis for formulating drug demand policy.

The Strategy was perceived as influential in the provision of harm reduction measures

Interviewees from new Member States that have traditionally not endorsed harm reduction approaches noted the influence of the Strategy in this domain. Indeed, a Swedish interviewee noted that:

Because they [new Member State governments] have taken notice of the Strategy (and results from EMCDDA) it was being viewed as more important to have a balanced approach. In the past, anyone who advocated harm reduction approaches was viewed as pro drugs but this is changing – partly due to the Strategy.

The influence of the Strategy on the provision of harm reduction measures was also highlighted by an EU official, who commented on the fact that despite the high level of controversy surrounding harm reduction, and opposition in certain Member States, it has now been adopted across all Member States, albeit to varying degrees. As an example, Table 4.1 shows the very significant increases in the number of treatment facilities in the Czech Republic since 2006. Box 4.2 provides a detailed example of the provision of one particular harm reduction measure: opioid substitution treatment.

Table 4.1: Evolution of the number of registered facilities and reported clients in substitution treatment in the Czech Republic (2001–2009)

Year	Number of facilities		Number of clients treated		
	Registered	Active	Total	Of this number Methadone	Buprenorphine
2001	8	8	533	510	23
2002	8	8	560	511	49
2003	8	8	789	520	269
2004	8	8	866	546	320
2005	9	9	825	571	254
2006	12	12	938	586	352
2007	14	13	1,038	605	433
2008	38	24	1,356	689	667
2009	72	34	1,555	686	869

Source: Mravcik *et al.*, 2010, p. 51

Note: The responsible registration body is the National Register of Users of Medically Indicated Substitution Substances

Box 4.2: Vignette: demand reduction – opioid substitution treatment

Opioid substitution treatment (OST) represents one of the main modalities used for drug problem treatment in Europe, alongside detoxification programmes and psychosocial interventions. According to the EMCDDA, roughly two thirds of all cases of drug treatment are related to opioid substitution (EMCDDA, 2011b, p.53).

The EU Drugs Strategy stated that one of its priorities in the area of demand reduction was ‘improving access to targeted and diversified treatment programmes’ and stressed that ‘the standard of effectiveness of treatment programmes should be continuously evaluated’ (European Council, 2004, p. 3). This priority was echoed in the first Action Plan, which called, among other actions, for ‘evidence based treatment options covering a variety of psychosocial and pharmacological approaches to be available and correspond to demand for treatment’ and for ‘development of know-how on drug treatment while continuing to develop and support the exchange of best practices in this field’ (European Council, 2005, p. 6). On a similar note, the second Action Plan aimed to ‘increase the effectiveness and spread of evidence based drug treatment options’ and to ‘develop an EU consensus on minimum quality standards and bench-marks’ (European Council, 2008, p. 12-13).

By the time of the adoption of the Strategy, OST had established itself as a common treatment practice. In 2005, it was already available in 26 of the current Member States, with Cyprus becoming the last country to offer the service in 2007. Rather than a rise in the number of countries offering OST, the EU Drugs Strategy saw an increase in the number of substances used in substitution treatment. Methadone remains by far the most frequent substance used, accounting for 70–75 percent of all cases, even though this represents a slight decrease from about 80 percent in 2004. It is available in all EU countries except for Cyprus, which opted for buprenorphine as a form of treatment. However, methadone is now far from the only option for treatment seekers. In addition to Cyprus, buprenorphine maintenance was added to their range of medications by five other EU Member States, and twelve countries introduced buprenorphine naloxone combination tablets. As a result, buprenorphine-based treatment is now available in all EU Member States. Furthermore, over the course of the Strategy, slow-release morphine was adopted by Bulgaria, Luxembourg, Slovenia and Slovakia, and Denmark and Belgium (on a trial basis) joined the ranks of countries offering supervised heroin-assisted treatment (EMCDDA, 2011b, p.54).

In terms of demand for this type of treatment, the number of those treated by opioid substitution appears to have increased since the adoption of the Strategy. According to the EMCDDA, the number of clients is estimated to have risen by a quarter between 2005 and 2009, reaching around 685,000 cases. Interestingly, the demand for OST is disproportionately large in the old Member States, who account for well over 90 percent of all European cases. While demand for OST in new Member States almost tripled in the years 2003-2009, their share in 2009 still accounted for less than 3 percent of the EU total (despite having roughly 20 percent of the total EU population). Furthermore, there was strong variation within the group of new Member States. Some countries such as Estonia, Bulgaria or Latvia reported manifold increases and other countries such as Slovakia, Hungary or Romania saw very small, if any, increases (EMCDDA, 2011a, p. 77).

The case of the Czech Republic offers an illustrative example of a new Member State that has undergone an increase in opioid substitution treatment availability and its uptake, both of which have coincided with the course of the EU Drugs Strategy. Table 4.1 summarises the main indicators of the extent of OST provision in the country. It should be noted that the client figures in the chart represent reported cases only; estimates of the country’s total number of substitution treatment clients are around or slightly above 3,000 people (Mravcik *et al.*, 2010, p. 52).

The Strategy is perceived as improving discussion, debate and interest in demand reduction evidence

One interviewee commented specifically on the value of sharing best practice with other Member States and gave an example of this being of direct benefit in their own Member State; one interviewee credited the Strategy with providing a more open debate on demand reduction measures, with the development of a common language, and a strong emphasis and reliance on evidence for the development of policy in the area.

Box 4.3 provides a specific example of a demand reduction programme – ‘FreD goes net’ which was rolled out in several Member States following positive findings from research into its effectiveness.

Box 4.3: Vignette: developing and disseminating knowledge-based interventions – ‘FreD goes net’

Selective prevention is a type of prevention that is provided for a specific target group that displays a particularly high risk of progressing from drug use to abuse and/or addiction. FreD is a selective prevention programme originally developed and trialled in Germany, and later extended to 16 other Member States. The pilot project was started in 2000 under the scientific supervision of the Society for Research and Counselling in Health and Social Affairs (Gesellschaft fuer Forschung und Beratung im Gesundheits- und Sozialbereich, FOGS) in Cologne. The core focus of this programme is early detection and early intervention for youths. FreD was designed to reach young drug users (14–20 years old) after their first contact with the police. The programme targets adolescents who do not meet the DSM-IV¹⁵ or ICD-10¹⁶ criteria for dependence at the moment of their first offence, but who are nevertheless at risk of falling into addiction.

Evaluation of the FreD programme revealed positive results, including the reduction of illicit use of substances by programme participants and enhanced risk assessment. Following these positive evaluation findings, FreD was extended to other European countries under the name ‘FreD goes net’. It was implemented in a total of 16 countries (Austria, Belgium, Cyprus, Denmark, Germany, Ireland, Iceland, Latvia, Lithuania, Luxembourg, Poland, Romania, Sweden, Slovakia, Slovenia and the Netherlands) from 2007 until 2010.

The transfer of the German model to other countries engendered some improvements in the general framework of the intervention. The target group was expanded to include young people who display behavioural problems related to alcohol. With this development, adolescents can be identified through a referral mechanism at school or within the workplace, as well as the police and judicial system. On a structural level, ‘FreD goes net’ implies the establishment of cooperation networks between drug counselling services and the above mentioned settings (police/judiciary, the school and the workplace of the adolescent).

The cornerstone of the programme is to promote reflection and to motivate a change in behaviour. Information on the legal aspects of drug use and on the implications of risky consumption is given, as well as more practical advice on how to quit or limit problematic consumption.

‘FreD goes net’ illustrates the approach recommended in the EU Drugs Strategy in terms of developing knowledge-based interventions and exchanging and disseminating research results and experiences. ‘FreD goes net’ is one of the few selective prevention programmes that has undergone a process of evaluation leading to wider roll out, with amendments made to the programme on the basis of research findings and the new country contexts in which it was implemented.

4.5 Implementation

Overall drug demand objectives were perceived as having been implemented in Member States. It is worth noting that reasons cited for this progress included the point that demand reduction policies were already being adopted prior to the adoption of the Strategy, but also that objectives from the Strategy were seen to have been formulated based on ‘what works’. Harm reduction measures in particular were perceived as having been implemented in Member States as a consequence of the Strategy, including in those Member States whose drugs policy regimes did not otherwise provide for such an approach.

¹⁵ American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth edition.

¹⁶ World Health Organization International Classification of Diseases, version 10.

Respondents felt that access to treatment programmes improved over the course of the Strategy. In comparison, only a slightly smaller proportion of respondents who chose to answer questions related to access to harm reduction services felt these services had improved (64 percent, n=36). On the other hand, respondents who chose to answer questions on prevention programmes were more likely to feel that the effectiveness of prevention programmes had stayed the same (47 percent of the 57 respondents), rather than improved (35 percent). There remain, however, important challenges to the implementation of demand reduction objectives. These include the considerable variation in the implementation of harm reduction measures relating to differing national priorities and approaches, difficulties in coordination and implementation at the national level, and the funding of demand reduction programmes in an economic downturn.

Table 4.2: Findings from online survey – how demand reduction has changed since 2005

Demand reduction objective	Improved	Stayed the same	Got worse	Don't know	Sample size
Effectiveness of universal prevention	42%	49%	5%	4%	57
Effectiveness of selective prevention	44%	46%	5%	5%	57
Effectiveness of indicated prevention	42%	40%	7%	11%	57
Overall effectiveness of prevention	35%	47%	12%	5%	57
Access to targeted and diversified treatment programmes	70%	22%	9%	0%	54
Access to services for the prevention and treatment of drug-related health and social damage	64%	28%	6%	3%	36
Evaluation of the effectiveness of treatment programmes	53%	32%	4%	11%	79

4.5.1 Treatment

The Strategy and Action Plans aim to improve targeted and diversified treatment programmes, including integrated psychosocial and pharmacological care.

According to the EMCDDA (2011b, p.8) the main drug treatment modalities in the EU are psychosocial interventions, opioid substitution and detoxification. The treatment of stimulant and cannabis users is predominantly based on psychosocial interventions, whilst most treatment for opioid dependence consists of a combination of pharmacological treatment with psycho-social assistance. The EMCDDA (2011b, p.9) reports that availability and access to drug treatment facilities has generally increased since 2005, with an estimated one million treatments delivered in 2009, two thirds of which related to opioid substitution treatment.

The evaluation of the first Action Plan further recommended providing treatment for non-traditional types of problematic use, such as cannabis or amphetamines (European Commission, 2008b). Currently, data suggest that the availability of specialised treatment remains low in most

Member States¹⁷ (EMCDDA, 2011b, p.56). Half of the Member States provided specialised treatment for cannabis users in 2008, and 11 for cocaine and crack cocaine. Specialised treatment programmes for amphetamine users increased from being reported in 3 Member States in 2004 to 9 in 2009.

Access to treatment perceived as having improved

When asked about their perception of changes since 2005, 70 percent of survey respondents who chose to answer questions on access to targeted and diversified treatment programmes (n=54) felt access had improved (see Table 4.2). While all respondents from the supply reduction sector (n=3) thought access to treatment programmes had improved, 24 percent of respondents from demand reduction (n=29) felt access had stayed the same and 10 percent of them felt it had got worse.

4.5.2 Prevention

The Strategy (objective 25.1) and Action Plans aim to improve the access to and effectiveness of prevention programmes, with special focus on the prevention needs of specific groups, as well as family- and community-based prevention. Such targeted interventions are grounded in more robust scientific evidence. Indeed, the EMCDDA noted a moderate shift over the course of the Strategy from universal prevention towards more focused models. However, certain interventions with little evidence of effectiveness, such as school-based universal prevention, continued to be provided (EMCDDA, 2011b, p.52). Compared to 2005, Member State drugs policies were more likely to mention vulnerable groups in 2010. This indicates a growing awareness of evidence-based prevention, though this does not seem to have been accompanied by greater investment in such targeted prevention programmes. Indeed, the EMCDDA has concluded that ‘the objective does not appear to have been significantly achieved’ (EMCDDA, 2011b, p.8).

Member States are positive about effectiveness of prevention programmes

Interestingly, online survey respondents felt more positive about the effectiveness of individual types of prevention than about the overall effectiveness of prevention programmes.

As Table 4.2 indicates, the proportion of respondents who felt that the effectiveness of all three types of programmes (universal, selective, targeted) had improved was roughly similar to that of respondents who felt it had stayed the same. However, when asked about effectiveness of prevention programmes overall, only 35 percent of respondents (n=57) felt the situation had improved, as opposed to 47 percent who felt it had stayed the same. The breakdown of types of prevention programmes also revealed a difference between old and new Member States. A larger proportion of respondents from new Member States (50 percent n=22) felt that the effectiveness of universal prevention had improved, compared to only 37 percent (n=35) of respondents from old Member States. By contrast, respondents from old Member States were clearly more optimistic about selective (51 percent n=35, compared to 32 percent n=22) and indicated prevention programmes (49 percent n=35, compared to 32 percent n=22) than their new Member States counterparts. This is particularly interesting when one considers, as noted above, the underlying evidence basis of different prevention programmes, and the general shift toward more focused interventions.

¹⁷ This could be explained by variable prevalence rates in different countries for certain substances, such as cannabis or cocaine

Harm reduction measures implemented in all 27 Member States

Harm reduction measures, which proved controversial when the Strategy was negotiated, have now become more common. The EMCDDA notes that these are now available in all Member States, and have been integrated into healthcare and social services (EMCDDA, 2011b, p.9). Substitution treatments, such as methadone programmes, needle exchanges and other harm reduction provisions are now less controversial and more widespread than at the time of the Strategy’s adoption. The range of opioid substitution treatment mediations, which is available in all 27 Member States has expanded since 2005. The number of opioid substitution clients increased significantly over the course of the Strategy, by some 25 percent across the EU and even more significantly in new Member States. Quality guidelines and standards for drug interventions and programme implementation in the field of drugs have been developed in most Member States.¹⁸

There remain, however, differences in implementation and availability of harm reduction programmes, especially with regards to ‘second line’ and ‘highly targeted’ interventions¹⁹ (EMCDDA, 2011b, p.53). This evidence of increased prevalence of harm reduction measures can be viewed alongside available data on the effectiveness of such measures. In a meta review of existing studies and data, EMCDDA researchers found evidence in support of a variety of harm reduction interventions. A high-level summary of their conclusions is set out in Table 4.3.

Table 4.3: Overview of the EMCDDA meta review of the effectiveness of harm reduction measures

Treatment type	Opioid substitution treatment (OST)	Needle and syringe programmes (NSP)	Peer naloxone distribution (PND)
Outcome measure			
HIV transmission	Sufficient evidence that OST reduces HIV transmission	Tentative evidence that NSP reduces HIV transmission	Insufficient evidence that PND reduces HIV transmission
Hepatitis C (HVC) transmission	Tentative evidence that OST has limited effectiveness in reducing HVC transmission	Insufficient evidence about effectiveness in reducing HVC transmission	Insufficient evidence about effectiveness in reducing HVC transmission
Self-reported injecting risk behaviours	Sufficient evidence that OST reduces risk behaviours	Sufficient evidence that NSP reduces risk behaviours	Sufficient evidence that PND reduces risk behaviours
Overdose mortality	Sufficient evidence that OST reduces overdose mortality	Insufficient evidence about effect on overdose deaths	

Source: Kimber *et al.*, 2010

Political will of Member State national governments is a determining factor in implementation

A number of national-level barriers to implementation were also noted during the interviews with both new and old Member States. Some interviewees felt that a lack of national coordination and effective ‘ownership’ of certain demand reduction objectives was a barrier to effective implementation. In particular, an example was given in the UK of a lack of ‘ownership’ of prevention work. A UK interviewee felt that whilst the National Treatment Agency (NTA) had taken responsibility for coordination of treatment, there was no similar coordinating body in the UK for prevention work, and that efforts in this area are more piecemeal. Another barrier

¹⁸ 24 Member States have adopted guidelines for interventions, and 19 for programme implementation

¹⁹ Such as heroin-assisted treatment, drug consumption rooms, or prison needle exchange programmes

mentioned by several interviewees was lack of funding. Interviewees acknowledged the current economic crisis and were concerned this may lead to a cut in funds.

Key findings

- The Strategy and Action Plans are perceived as relevant to addressing the drug supply challenges faced in the EU.
- The importance of objectives on coordination and cooperation are especially highlighted.
- The Strategy enabled long-standing efforts, initiatives, and practices in the field of supply reduction to be extended to all 27 Member States.
- The added value of the Strategy appears greatest in new Member States that did not have pre-existing, developed policies in the area of supply reduction.
- Supply reduction efforts are often embedded within wider security agenda.
- EU legislation in the area of precursor control is seen as effective.
- Member States are increasing judicial coordination and using existing tools such as extradition processes.
- The lack of reliable metrics to measure the impact of supply reduction efforts continues to pose a challenge in the monitoring of effectiveness.

5.1 Context

Efforts to reduce the supply of illicit drugs to markets target the national and transnational dimensions of drugs challenges. With production being carried out within and outside the EU and illicit drugs being trafficked across borders to reach destination markets, supply reduction relies on high levels of coordination in terms of policy formulation, information sharing and joint operations. Supply reduction efforts at the EU level can be classified into three broad categories: law enforcement operations (including seizures, arrests, etc.), the diversion of precursors used to produce illicit drugs (Council Regulation (EC) No 111/2005; Regulation (EC) 273/2004), and approximation of criminal justice tools such as criminal laws and penalties related to drug production and trafficking (Framework Decision 2004/757/JHA).

At the EU level, the diversion of precursors is the key area of drugs policy in which the EU legislates, with a common licensing system for Member States and third country trading partners, and specific customs controls and procedures. Efforts towards realising supply reduction objectives are further enhanced by coordination of initiatives and joint operations between Member States within the framework of the Action Plans, supported by Europol and Eurojust. Europol coordinates and publishes information on organised crime in the EU, including trends in criminal networks and illicit markets, the diversification of trafficking routes and emerging new challenges in the field. It also acts as a coordinator and facilitator supporting cross-border

investigations and operations in the EU. Eurojust provides judicial expertise and helps coordinate investigations and prosecutions between Member States.

5.2 Drug supply trends, 2005–2012

Despite recent research efforts, identifying trends and improvements in the area of supply reduction ‘remains difficult’ (European Commission, 2007, p. 6). This is largely due to the covert nature of operations and the challenges of measuring illicit trade, which is not captured by official statistics in the way that trade in licit goods can be (through customs, VAT, etc.). The methodologies that have been devised are very resource intensive, and rely on confidential information and intelligence gathering, which are not readily available in the public domain. Furthermore, areas of data collection that are predominantly carried out at the national level, such as registration of drug seizures, have not yet been standardised across Member States (European Commission, 2008b, p. 32). As the EMCDDA notes, the data are often restricted in scope, reflect local or national priorities and/or focus on highly specific issues. As a result, it is at times difficult to provide an analysis at the European level (EMCDDA, 2011b, p.30). Another insight into the progress of supply reduction objectives is the success of joint operations carried over the course of the Strategy, and within the context of the two Action Plans. Such Joint operations could indicate how actions are implemented. However, the sensitivity surrounding these initiatives means it is not possible to systematically analyse the different ways in which joint operations are carried out and the extent to which they are successful.

Acknowledging these difficulties and limitations, the following sections provide an overview of the available information on trends in supply reduction from 2005 to 2012. They are based on data from seizures and drug offences collected by the EMCDDA as part of the statistical report published to coincide with this evaluation, as well as on information published by Europol as part of its 2011 Organised Crime Threat Assessments (OCTAs).

Cannabis

Overall, the number of seizures and the quantities of cannabis herb, resin and plants seized increased during the 2004–2009 period. There was a significant increase in the number of seizures of cannabis plant and herb, both of which more than doubled. Quantities of cannabis resin, on the other hand, decreased marginally (EMCDDA, 2011b, p.30). The EMCDDA notes that the size and diversity of the cannabis market, as well as the fact that cannabis is produced domestically as well as abroad, makes it difficult to draw a clear picture of trends in supply to the EU.

Cocaine

Based on available information on seizures, purity and prices, the EMCDDA reports no consistent picture for trends in the supply of cocaine in the European Union. There is no clear relationship between the number of cocaine seizures and aggregate quantities seized, and no clear relationship between purity and price. This lack of clarity makes it difficult to draw any conclusions in relation to the supply of cocaine to the EU (EMCDDA, 2011b, p.31). Certain initiatives, such as the establishment of the Maritime Analysis and Operations Centre – Narcotics (MAOC-N), have made concerted and targeted efforts toward curbing the supply of cocaine to the EU, and with some success. MAOC-N, which is based in Lisbon, was set up in 2007 as an

intergovernmental working group comprising seven Member States²⁰ to enhance criminal intelligence and coordinate police action on the high seas to intercept illicit drugs, especially cocaine and cannabis (EMCDDA). MAOC-N seized in excess of 40 tons of cocaine in its first year of operation (UK House of Commons Home Affairs Select Committee, 2010), which supply reduction experts believe would have had an impact on availability in the EU. There are some indications, however, that the supply of cocaine seems to have diversified and become more sophisticated, with the appearance of new trafficking routes and methods, as well as the discovery of 'secondary extraction labs' uncovered in the EU (EMCDDA, 2011b, p.32).

Synthetic drugs

Europe continues to be a major producer of amphetamines supplying both the EU market and further afield, though there is evidence of increasing production outside Europe competing for the Middle Eastern markets (EMCDDA, 2011b, p.6). Available data indicate overall stability in supply of the drug, though purity levels declined in certain Member States. There is also evidence that, after 2004, the amphetamine precursor BMK was no longer being sourced from China, but from the Russian Federation. Some noteworthy changes were recorded in the supply of methamphetamine between 2004 and 2009. Traditionally consumed in a restricted number of old Member States, significant quantities of the drug were seized in the Baltic Sea and Norway (EMCDDA, 2011b, p.34). The EMCDDA reports that the number of ecstasy seizures in the EU remained stable between 2004 and 2006, but has subsequently declined. Trends in price data do not show a decline in ecstasy availability in Europe, and indicate that ecstasy is now considerably cheaper than it was in the 1990s. Furthermore, there has also been a change in the content of illicit drug tablets, from MDMA being a primary ingredient to a diversification of psychoactive substances. There is evidence that production difficulties have led manufacturers to replace MDMA with other substances in tablets sold as ecstasy. The EMCDDA notes that the most likely explanation for this trend in the decline in the availability of MDMA is a shortage of PMK, traditionally one of the main precursor chemicals used to manufacture ecstasy in Europe. This trend may have reversed since 2010, however, indicating that supply networks seem to have responded by adapting their production techniques and finding alternatives to PMK to produce MDMA.

Heroin

The supply of heroin to EU markets has been stable over the course of the current Strategy. The EMCDDA notes a significant increase in the number of seizures, but with stable quantities seized. In terms of availability, a recent trend worthy of note is the apparent 2010 'heroin drought' in the UK and Ireland. Several explanations have been put forward relating to shocks in production, effective law enforcement interventions, successful diversion of precursors, and diversion of the drug to other markets. However, such a shock in supply does not seem to have affected other Member State markets.

Legal highs

The EMCDDA notes an increase in the number of new unregulated substances, also known as 'legal highs'. These substances are synthetic analogues of major drug groups and are marketed online or sold in specialised shops. The size of the phenomenon is evidenced by the record number of new substances that have been reported to the European Early Warning System (EWS) in the past six years (EMCDDA, 2011b). These new substances pose new regulatory and

²⁰ Spain, France, Ireland, Italy, the Netherlands, Portugal and the UK

research challenges. Whilst 'legal highs' have thus far emulated drugs traditionally consumed in a recreational setting, the 2009–2010 EWS reported trends that might suggest that manufacturers are shifting their efforts towards emulating substances consumed by problem drug users (EMCDDA, 2011b).

5.2.1 Data on drug law offences

Other routinely available data in the area of supply reduction are reports of offences against national drug laws, which account for a significant proportion of law enforcement and criminal justice resources. These include offences such as drug use, possession, cultivation, production, importation and trafficking, but also other related offences such as illicit manufacture/trafficking of precursors or money laundering. The data are a direct indicator of law enforcement and judicial activity and interventions, and only an indirect measure of drug use and drug trafficking (EMCDDA, 2011b). In terms of the latter, the data are imprecise, as they measure only those activities that have been picked up by law enforcement. Furthermore, variation between Member States in terms of reporting, classifying and recording offences, as well as differing legislation, requirements and funding of interventions, make cross-Member State comparisons difficult (EMCDDA, 2011b).

An EU index compiled with data from 21 Member States²¹ shows that reported drug offences increased by an estimated 21 percent between 2004 and 2009. Drug-related supply offences increased by 7 percent over the same period, although the EMCDDA report that these have remained stable since 2007. The number of ecstasy-related offences decreased most significantly, while the number of recorded cannabis and heroin offences remained stable. Marginal increases were recorded for amphetamines and cocaine (EMCDDA, 2011b, p.38).

5.2.2 Drug supply trends: diversification of illicit markets and cooperation of criminal groups

According to Europol, there has been a discernible trend towards diversification of drug supply. Drug trafficking has become increasingly dominated by groups dealing in more than one product in an effort to maximise their profits. Simultaneously, some groups have resorted to other forms of criminal activity in order to secure a source of funding for their drug trafficking operations and to better position themselves to face fluctuations in drug supply and demand (Europol, 2011, p. 7).

Europol has also reported on the enhanced cooperation among groups involved in drug trafficking and related criminal activities across the European Union. This development is accompanied by the emergence of a barter market, which has contributed to the growth of an informal economy, rendering organised crime networks harder to detect (Europol, 2011, p. 8). A corollary of this enhanced cooperation has been increased flexibility of drug networks, especially in the way trafficking routes are organised.

Regionally speaking, Europol has highlighted three high-profile areas. The North West hub (with the Netherlands at its centre) continues to be the main distribution centre for cocaine in the European Union, largely due to its proximity to principal markets. The Western Balkans has further expanded its role as a logistical hub and transit centre for drug shipments to and from the European Union. And finally, West Africa has retained its prominent position on the agenda of law enforcement agencies, predominantly due to its role as a transit hub in the cocaine supply chain and because of possible links to terrorist groups (Europol, 2011, p. 11).

²¹ Representing 95 percent of the population aged 16–64 in the European Union

In terms of evolving trends in the supply of drugs, the Internet has come to play a more significant role as a facilitator of drug production, marketing, trafficking and distribution. This development has been consistently flagged up by relevant bodies and authorities, including the European Commission (EMCDDA, 2011b, p.7; EMDCCA, 2011, p. 7; European Commission, 2010b, p. 5; Europol, 2011, p. 11).

5.3 Relevance

Supply reduction objectives tend to be seen as relevant by Member States

In order to assess the relevance of the Strategy's supply reduction objectives, respondents participating in the online survey were asked a number of questions on the importance of improving efforts towards these objectives in order to address the drugs situation in their Member States. Respondents were further asked about the extent to which these objectives should be included in a future EU drugs strategy.

Overall, of the respondents that chose to answer the questions on supply reduction, a significant majority felt that these objectives were important. Broken down by individual objective, the findings from the survey indicate that: 95 percent of respondents (n=20) felt that improving law enforcement efforts directed at non-EU countries was important; 96 percent of respondents felt cooperation between Member States that have common interests and/or the same drug-related problems was important (n=24); 96 percent felt that fully utilising existing instruments and frameworks was important (n=26), as did 95 percent of those that answered the question on improving law enforcement at EU level (n=43). In the last group, respondents from new Member States assigned slightly greater importance to this objective – 55 percent (n=22) felt this was very important, compared to 43 percent (n=21) in old Member States. With regards to fully aligning the national prosecution policies of Member States, a slightly lower proportion of respondents, 81 percent, felt that this was important (n=27).

When asked about a potential future strategy, 100 percent of respondents felt that objectives on intensifying law enforcement efforts directed at non-EU countries (n=43) and enhancing cooperation between Member States that have common interests and/or the same drug-related problem (n=36) should be included. It is noted that more respondents agreed these objectives should be included in a future strategy than thought they were important, which indicates that respondents felt these objectives were, and would continue to be, relevant to addressing the drugs situation in their Member States. 93 percent of respondents reported that it would be important to include objectives on strengthening law enforcement cooperation at the EU level (n=27), and 88 percent thought it would be important to further develop EU-level law enforcement instruments (n=24). A marginally lower proportion, 81 percent felt it would be important for a future strategy to provide for the aligning of national prosecution policies (n=20).

The Member State-level in-depth interviews indicated that supply reduction is seen as an area of drugs policy that relies very heavily on effective pan-European cooperation and coordination, facilitated by the EU Drugs Strategy. Indeed, participants were keen to stress the need for Member States to work very closely together in the fight against illicit drugs moving into and around the EU.

Supply reduction objectives reflect established processes

A number of Member State-level interviewees noted that the Strategy reflects the processes and approaches adopted by older EU nations, such as the UK, France and the Netherlands.²² With respect to the enhancement of law enforcement cooperation (objective 27.4) some argued that it is vital that a common EU approach on supply reduction continues to reflect established mechanisms and actions. A UK interviewee stated that:

The EU Strategy has not directly influenced the UK strategy, however it is a document that overlays things that we are already doing.

Related to this, a point raised by two-EU-level interviewees, as well as some Member State interviewees, was that at the time of drafting the Strategy it was ensured that some existing practices were incorporated into the Action Plans (e.g. asset confiscation, chemical identification of drugs). It was argued that the Strategy incorporates supply reduction mechanisms and practices that were already in place, more formally embedding these in an EU-wide agreement. Indeed a number of interviewees from older Member States highlighted the influence of the Strategy on newer Member States, where the approach to supply reduction was felt to be less developed. Interviewees felt that the Strategy enables new Member States to follow an ‘established’ approach and align their developing policies and strategies to those of the EU as a whole.

5.4 Influence

Influence of the Strategy on supply reduction is difficult to ascertain

In the survey, only a small number of respondents answered questions relating to the influence of the Strategy on supply reduction policies, and these small sample sizes mean that this assessment cannot report on the individual objectives. To the extent that responses can be aggregated, a majority felt that the Strategy had indeed been influential. Of those who felt the situation had improved since 2005, a higher proportion of respondents felt the Strategy had been influential in improving supply reduction initiatives (n=68) than those who thought it had not been influential (n=25). Of those respondents who felt the situation had got worse since 2005 (n=2), neither felt that the Strategy had been influential in this. Therefore, although the sample for the online survey broken down by individual question would be too small to report specific findings on the influence of individual supply reduction objectives, the overall picture from the survey appears positive.

The interviews provide more textured views on supply reduction. EU-level interviewees tended to be more sceptical about the influence of the Strategy, whereas Member State interviewees, whilst acknowledging the influence of national-level factors, noted a number of areas where progress had been made in relation to objectives set out in the Strategy.

The perception is that there has been progress in implementing supply reduction objectives but there is caution in attributing causality to the Strategy

Interviewees acknowledged that there had been progress in the development of supply reduction policies, but were divided with some attributing this to the Strategy, and others suggesting that these changes had come about more directly as a result of internal national policy. It was argued

²² This was noted in both in-depth interviews in the seven Member States and at EU level, as well as in key informant interviews

that effective cooperation had been well established before the introduction of the Strategy – and that improvements seen in recent years could therefore not necessarily be attributed to it. One of these areas of improvement was noted when interviewees were asked about judicial cooperation in the area of drug trafficking and law enforcement, at which point Member State-level interviewees reported progress, specifically in terms of smoother arrest and extradition procedures. In particular, the European Arrest Warrant was felt to have had a very positive impact. Member State interviewees also felt that Member States were increasingly coordinated in general, through the HDG and engagement with other mechanisms, and that this meant that judicial processes were also becoming more integrated. Certain Member State interviewees further noted changes in prosecution policies, which were seen as increasingly pro-prosecution and punitive. However, even these respondents remained ambiguous about the extent to which this could be attributed to the Strategy.

From a Member State perspective interviewees reported progress in law enforcement cooperation directed at non-EU countries, though they were not able to say whether this could be attributed to the Strategy. Member State interviewees discussed the importance of EU coordination and cooperation with countries bordering the EU and other countries that are key links in the supply chain. To this end, interviewees described efforts and activities that had been conducted in their Member State. There was acknowledgement that in some cases Member States with strong sovereign ties to or links with certain third countries could be better placed to exert influence than the EU. Indeed, the point that progress in international cooperation may be more related to Member State initiatives than the Strategy was further elaborated by an EU official who argued that:

[Cooperation directed at non-EU countries] is very much based on national initiative[s]... it is very much inter-governmental...the Council [can] ... point to good practice and so on, but you very much depend on Member States.

Certain EU-level interviewees were equally unsure about attributing causality, with one interviewee noting that:

There is an impact in [the] sense of what happens in Member States is in relation to what is in the Strategy. But a good question is what comes first. Is the Strategy reflected [in national policy] or is it a simple reflection of a sort of broad consensus?

Supply reduction actions are based on legislation

The EU drug precursors legislation has been adopted as an independent piece of legislation, based on Article 114 TFEU (formerly Art. 95 TEC). Even though in line with the last Drugs Strategy, its existence is not dependent on a new strategy, as this EU-level expert commented:

If... a new EU Drugs Strategy [was not adopted], let's say the current one would just fail and it would be nothing. I mean our legislation would probably remain the same... But again it's not a Strategy which changed things but rather the legislation which was adopted on EU level in 2004/2005. It came into force in 2005.

5.5 Implementation

As explained in the previous section on the influence of supply reduction objectives on Member States and EU approaches and actions, many of the mechanisms and tools provided in the Strategy were already in place prior to its adoption. To the extent that some initiatives already

existed and that some others have been adopted, supply reduction objectives are being implemented. Yet there remain challenges and areas for improvement.

A range of EU agencies and instruments are implementing supply reduction objectives

EU Member States have implemented the Strategy to the extent that they have been 'using existing instruments and frameworks' to reduce drugs supply, as stated in objective 27.2. According to the 2007 Progress Report, Member States have made use of an array of bodies and instruments developed to foster cooperation in the supply reduction area. These have included, among others, Europol, Eurojust, Joint Investigation Teams (JITs), Joint Customs Operations and the European Joint Unit on Precursors. However, it has been repeatedly noted that the use of these platforms could be further developed and strengthened (European Commission, 2007, p. 4; 2008b, p. 32).

According to the online survey, 88 percent of respondents who chose to answer questions on EU law enforcement cooperation (n=43) felt that cooperation at the EU level had improved since 2005 (see Table 5.1). A high proportion of respondents also felt that cooperation had improved among Member States with common interests and/or the same problems since 2005 (79 percent, n=24). Out of these, all respondents from new Member States (n=8) were positive about the trend since 2005, whereas 25 percent (n=16) of respondents from old Member States felt the situation had stayed the same. Fewer respondents who chose to answer questions on existing law enforcement cooperation instruments at EU level felt utilisation of these instruments had improved since 2005 (18/26, 72 percent). A similar proportion (13/20, 65 percent) felt enhancing law enforcement efforts directed at non-EU countries had improved. In contrast, an equal proportion of respondents felt there was greater consistency in national prosecuting policies as the proportion of respondents who felt this consistency had stayed the same (11/27, 40 percent).

In terms of individual law enforcement cooperation instruments, the highest proportion of respondents felt that EU legislation on drug precursors for intra-EU trade had improved (18/26, 72 percent).

Just under two thirds of respondents who answered these questions felt the EU legislation on the monitoring of trade between the EU and third countries had also improved (17/26, 65 percent). JITs and Europol were also viewed favourably with a relatively high proportion of respondents feeling these instruments had improved (16/26, 61 percent and 15/26, 57 percent respectively). In regard to other instruments, it is likely that respondents were less familiar or had less involvement with them, as a relatively high proportion of respondents answered 'don't know' when asked if the utilisation of these instruments had changed since 2005.

Table 5.1: Findings from the online survey – how supply reduction has changed since 2005

Supply reduction objective	Improved	Stayed the same	Got worse	Don't know	Sample size
Law enforcement cooperation to counter drug production and trafficking at EU level	88%	5%	0%	7%	43
Utilisation of Framework Decision laying down minimum provisions on the constituent elements of criminal acts and penalties in drug trafficking (2004/757/JHA)	19%	46%	0%	35%	26
Utilisation of the EU legislation on drug precursors for intra-EU trade (Regulations 273/2004 & 1277/2005)	69%	15%	0%	15%	26
Utilisation of the EU legislation on drug precursors laying down rules on the monitoring of trade between the EU and third countries	65%	19%	0%	15%	26
Utilisation of JITs	62%	15%	0%	23%	26
Utilisation of Joint Customs Cooperation	38%	15%	0%	46%	26
Utilisation of European Arrest Warrant	46%	19%	0%	35%	26
Utilisation of Financial Intelligence Unit (Europol)	23%	27%	0%	50%	26
Utilisation of EU legislation in the field of Asset Confiscation	31%	27%	0%	42%	26
Utilisation of Europol	58%	23%	0%	19%	26
Utilisation of Eurojust	42%	23%	0%	35%	26
Overall use of existing instruments	69%	12%	4%	15%	26
Consistency of national prosecuting policies	41%	41%	4%	15%	27
Cooperation between EU Member States that have common interests and/or the same drug-related problems	79%	17%	0%	4%	24
Law enforcement efforts directed at non-EU countries	65%	30%	0%	5%	20

Interviewees were unanimous in the view that the effective sharing of information and intelligence across country borders was the most important facilitator in effective supply reduction. In this regard, the Strategy was credited with having fostered frameworks and mechanisms to facilitate the sharing of intelligence, especially in relation to Europol and the HDG, which were both considered to be very effective mechanisms for joint working across the EU. One UK interviewee discussed Operation Captura, a Crimestoppers initiative with a focus on tracking down wanted UK criminals currently residing in Spain. The Strategy was felt to have had a very positive impact facilitating this cooperation – and the initiative itself was felt to have been very successful, helping to capture 43 of the ‘Top 60’ over the past three years. Furthermore, an EU-level interviewee highlighted the role of Europol in the implementation of Action Plan objectives:

When it comes to the action plan, definitely Europol has been playing a key role and a role that has been increasing both in quantity and quality....

There have also been efforts to implement ‘regional or thematic cooperation’, as outlined in the Strategy (European Council, 2004, p.12). For instance MAOC-N (described in Box 5.1, below), CECLAD-M - which fights drug flows in the Mediterranean, and the Baltic Sea Task Force which addresses the drug supply problem in the Baltic region (European Commission, 2008b, p. 31). However, the 2010 Action Plan Progress Review noted the challenges involved in

responding to drug trafficking networks, and their ability to adapt and circumvent barriers as they are put up (European Commission, 2010b, p. 6).

Box 5.1: Vignette: supply reduction policies – MAOC-N

MAOC-N is an intergovernmental working group or taskforce based in Lisbon, set up in 2007 to tackle maritime drug smuggling in Europe. It comprises seven Member States: Spain, France, Ireland, Italy, the Netherlands, Portugal and the UK. According to the EMCDDA, its mission is to ‘enhance criminal intelligence and coordinate police action on the high seas, with a view to intercepting vessels carrying cocaine and cannabis.’ (EMCDDA)

MAOC-N and other similar initiatives (such as CECLAD-M) reflect the Strategy’s objectives in the field of supply reduction. The Strategy, among other priorities, calls for ‘strengthening EU law enforcement cooperation on both strategic levels and crime prevention levels’ and for ‘prevention and punishment of the illicit import and export of narcotic drugs and psychotropic substances’ (European Council, 2004, p. 13-14). At the level of concrete actions, the first Action Plan envisaged implementation of ‘law enforcement intelligence projects to improve both the intelligence picture and interventions made’ that would ‘include at least 2 Member States and should be focused on drug production, illicit cross-border trafficking and criminal networks engaged in those activities.’ The plan also called for the strengthening of EU external borders to ‘stem the flow of drugs from third countries’(European Council, 2005, pp.7-8)

The second Action Plan made an explicit reference to MAOC-N as an example of a regional security platform within the framework of its objective to ‘respond rapidly and effectively at operational, policy and political levels to emerging threats (e.g. emerging drugs, new routes)’ (European Council, 2008, p.17).

Conceived originally as an intergovernmental agreement, MAOC-N brings together law enforcement and military personnel representing participating Member States. It is in tight cooperation with national intelligence bodies such as the British Serious Organised Crime Agency (SOCA) or the French Central Office against Illegal Narcotics Trafficking (OCRTIS), on whose products it relies and acts. Furthermore, it exchanges information and coordinates closely with Europol, whose representatives sit on MAOC-N management board meetings. It has also reached out beyond the European Union in search of partner countries and organisations. For instance, officers from the US Joint Inter Agency Task Force have been posted to MAOC-N as observers and US Navy ships have participated in MAOC-N operations (UK House of Commons Home Affairs Select Committee, 2010, Annex A). Similarly, the Russian Federal Drug Control Service (FDCS) has established contacts with MAOC-N with the view to share experience and cooperate, particularly in regard to the Black Sea region (European Commission, 2008a, p. 125). For the execution of its operations and subsequent prosecutions, MAOC-N also frequently relies on partner countries, such as Cape Verde, and their willingness to make assets and Law Enforcement Detachments (LEDets) available.

In terms of impact, a 2009 independent evaluation of MAOC-N concluded that cooperation within its framework was fast and flexible and that its functioning was a success story. MAOC-N’s activities have resulted in the seizure of over 65 tonnes of cocaine and over 47 tonnes of cannabis (European Council, 2011, p. 2). According to a report by the US-based Institute for Foreign Policy Analysis, the secret of its success lies primarily in its bureaucratically light structure and its culture of evaluation and constant improvement (Institute for Foreign Policy Analysis, 2010). However, the number of seizures carried out by MAOC-N appears to have diminished in recent years. This suggests that criminal and trafficking networks have been able to establish new trafficking routes, for instance via eastern Europe, to circumvent existing law enforcement platforms and interdiction patterns (European Commission, 2010a).

Member States are aligning policy and legislation with the Strategy

The interviews indicated that whilst there were clear differences across the EU, significant progress had been made to align policy relating to supply reduction, which would indicate the implementation or homogenisation of policies towards a common EU approach. This, as noted in the previous section, was especially the case for new Member States adopting approaches outlined in the Strategy that had already been pursued and implemented in older Member States. To illustrate this point, a number of examples of moves towards alignment were provided, such as the creation of central agencies (including the National Anti-Drug Agency in Romania and

creation of the National Crime Agency (NCA) from the current Serious and Organised Crime Agency (SOCA) in the UK).

There is a lack of progress in developing supply reduction indicators

As the final evaluation of the 2005–2008 Action Plan highlights, progress in data collection and its reliability, and the availability and comparability of supply reduction and law enforcement indicators remains very limited (European Council, 2005, p. 47). This is despite a number of initiatives undertaken by the Commission. These include, for example, commissioning research on drug supply reduction efforts in the EU (Kilmer and Hoorens, 2010) and organising a conference, with the EMCDDA, on drug supply indicators in Brussels (October 2010).

The lack of reliable metrics and the perceived dearth of research in the field of supply reduction were noted by interviewees. This lack of progress in the ability to ‘measure improvement’ or otherwise against the Strategy’s aims is an important limitation to understanding and assessing implementation of supply reduction objectives and to learning from these in order to attain the Strategy’s ultimate aims in the field.

Control of drug precursors is regulated at EU level but challenges remain for Member States

As noted above, an important part of the EU’s supply reduction strategy involves the control of the licit trade in drug precursors, in order to prevent their diversion by traffickers towards the production of illegal drugs. The EU legislation on drug precursors²³ could be considered to be one of the most fully implemented aspects of the Strategy. A specific example is explored further in Box 5.2, below.

The Commission has carried out an assessment of the implementation and effectiveness of drug precursor legislation (European Commission, 2009b)²⁴ and has concluded that it is essentially functioning well. Work is continuously underway towards a more effective coordination mechanism both internally, as noted in Chapter 6, and in cooperation with third countries, as noted in Chapter 7.

However, the evaluation has also found some weaknesses in the drug precursors legislation and there remain challenges in its implementation at national level. The Commission intends to propose an amendment to the EU drug precursors legislation in order to address the identified weaknesses.

More generally in the area of supply reduction, both the evaluation of the first Action Plan and the 2010 Progress Report note that efforts in this area are often hampered by a lack of priority and by existing differences between the legislation of individual Member States (European Commission, 2004, p. 36; 2010b, p. 6). Indeed, this challenge was raised in the Member State-level interviews, with a UK interviewee arguing that:

Juggling priorities is a challenge. The priority in terms of drugs has to be class As in the UK – that is our bottom line. As a result we cannot always fulfil our obligations to tackling the movement of drug precursor chemicals into and out of the UK.

²³ Council Regulation (EC) No 111/2005; Regulation (EC) No 273/2004; Commission Regulation (EC) No 1277/2005

²⁴ In reaction to the Commission’s Report, the Council adopted conclusions inviting the Commission to propose legislative amendments (Council conclusions on the functioning and implementation of the EU drug precursor legislation – 3016th Competitiveness Council meeting Brussels, 25 May 2010)

Box 5.2: Vignette: policies for supply reduction – PMK

EU legislation aims to prevent diversion of precursors used for the manufacture of illicit drugs from the licit economy. Regulation (EC) No 111/2005 regulating trade in precursors with third countries and Regulation (EC) No 273/2004 regarding their intra-EU movement both implement the recommendations of Article 12 of the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Both regulations have been adopted on the basis of Article 114 TFEU (formerly Art. 95 TEC) in the framework of EU competence for approximation of national laws.

The existence of EU legislation on precursors is not dependent on the EU Drugs Strategy 2005–2012, but it is in line with it, as well as with the previous Strategy.

Implementation of the two regulations is governed by Commission Regulation (EC) No 1277/2005 as amended by Commission Regulation (EC) No 297/2009. This defines procedures and documentation requirements for: licensing operators; monitoring international trade through pre-export and pre-import notifications; and demonstrating the licit purposes of transshipment operations.

Control of precursors is implemented in all Member States by means of a common licensing system for EU and third country trading partners, with a special emphasis on customs procedures and controls. Requirements for identifying and tracking the traded precursors are proportional to their sensitivity, and they are assigned to one of three categories (in line with the UN convention). The Commission monitors implementation of the European legislation on precursors (European Commission, 2009b) and publishes annual data on seizures.

The EU has concluded bilateral agreements with some of its major trading partners, enhancing trade monitoring and mutual administrative assistance for preventing precursor diversion. Over the course of the EU Drugs Strategy, in 2009, the European Commission concluded a bilateral agreement on preventing diversion of chemical precursors with China, a major source of PMK for the EU market. The European Commission is currently in the process of negotiating a similar agreement with Russia.

In the framework of the Strategy, the HDG and the Customs Joint Working group share responsibility for enhancing cooperation in national supply reduction policies, which includes precursor control. The EU has acted to extend the knowledge base through the exchange of best practices among Member States, e-learning courses, seminars and expert round tables for discussing specific issues regarding synthetic drug precursors for making amphetamine or ecstasy (BMK, PMK), both under the Strategy and the Customs 2013 Programme.

PMK ('3,4-Methylenedioxyphenyl-2-propanone' or 'piperonyl methyl ketone') is the main precursor used for MDMA production. There were eight seizures (totalling 6,645 litres) of PMK between 2005 and 2010. Following the above-mentioned measures to limit the diversion of PMK, amounts seized decreased significantly after 2006 (see Table 5.2).

In the same period – since 2006 – there was a downward trend in the levels of ecstasy seizures, despite most countries reporting stable or only slightly decreasing trends in prevalence among users. Also at the same time, two distinct changes in the ecstasy market were observed: replacement of MDMA in end-user products and replacement of PMK with other precursors in MDMA production. Reports indicate an increasing diversification of active substances used in ecstasy tablets (EMCDDA, 2011b, p.33).

This period coincided with an increase in the interception of alternative precursors. The coincidence could suggest that manufacturers might have replaced PMK with alternative substances, such as the chemical safrole, as their base for producing the MDMA used in ecstasy (EMCDDA, 2011b, p.34). Some 1,050 litres of safrole and safrole-rich oils were seized in 2009/10, mostly in Lithuania, while in Latvia 1,851 litres of safrole were confiscated.

Unlike PMK, which is controlled under the 1988 UN Convention and has limited licit uses, safrole-rich oils, which can be transformed into safrole and PMK, have many licit uses and are not subject to control. This makes it difficult to estimate trends of substitution between these oils and PMK.

Overall, there does not appear to be a clear or observable impact of actions taken under the drug precursors legislation on availability and prevalence of ecstasy use in the EU.

Table 5.2: Seizures of PMK, Safrole and Ecstasy, 2005–2010

Year	PMK Seizures 2005–2010		Safrole Seizures 2005–2010		Ecstasy seizures 2005–2010	
	Amount of PMK (litres)	Number of Seizures	Amount of Safrole (litres)	Number of seizures	Amount of ecstasy (pills)	Number of seizures
2005	5417	4	33	14	13069721	19308
2006	1438	2	7	1	15830129	19795
2007	20	1	8	3	15124449	18487
2008	0	0	1901	2	3744037	14715
2009	40	1	954	4	1893173	8383
2010	0	0	85	2	n/a	n/a
Total	6645	8	2988	26		

Source: EMCDDA, 2011a; European Commission, 2008d; International Narcotics Control Board, 2011.

The impact of the Strategy's supply reduction pillar on synthetic substances

Alongside reports of the challenges of addressing drug precursors at the national level, our interviewees did note some positive action and activity in relation to the impact of the EU Strategy on the manufacture and supply of synthetic drugs. Some interviewees felt that the EU has been a very effective coordinator and facilitator of joint working between Member States, and that progress is being made. In particular, the Netherlands, Czech Republic and Germany are felt to be especially active on this issue, with the Dutch Expertise Centre on Synthetic Drugs and Precursors (ESDP) viewed as a crucial organisation. However, French interviewees noted that there had been no reduction in the manufacture of synthetic substances, and also indicated that production may have increased over the period:

We have seen no reduction as they are very easy to manufacture and very difficult to seize.

There was also a view expressed in France that Member States are not well equipped to deal with synthetic substances, and that it is difficult to get a good idea of usage and prevalence as the numbers are small. There was also reported to be a challenge in collecting accurate data in this area:

Denominations for these drugs are unclear and changing so it is impossible to capture [usage] through national surveys.

In the UK, there was a sense that no noticeable reduction in the supply of synthetic substances had been achieved, though there has been a more active focus in this area in recent years. These drugs are now considered to be becoming more of a priority in the UK, though it was felt that there remains a need for the focus on synthetic substances to reach parity with efforts towards cocaine and heroin supply reduction.

Key findings

- The Strategy has been effective in providing guidelines for Member States to draft their national drugs policies.
- The HDG has succeeded in functioning as the main coordinating body on drugs policy at the EU level, and has improved communication within the Council on drug-related matters.
- The HDG adds particular value with regard to information exchange between Member States, with indirect positive effects such as networking and international learning.
- New Member States attribute greater value to the work of the HDG as a coordinating body, as opposed to old Member States that have bilateral and multilateral coordination mechanisms that predate the Strategy.
- The effectiveness of the HDG is in part dependent on the clout and capacity of the presidency. Presidencies of larger Member States or those with a longer track record in drugs policy tend to have more leverage.
- The coordinating role of the HDG in the area of supply reduction is becoming more complicated, as law enforcement activities in drugs policy have also become a priority in the EU internal security agenda. COSI has become more active in coordinating some initiatives in the field of drug supply reduction

6.1 Context

EU drugs policy is formulated within the current legal framework of the EU treaties, and according to the principles of subsidiarity and proportionality (European Council, 2004). In line with the machinery of all EU policy coordination, drugs policy requires coordination at the national level, to feed into a coordinating mechanism at the European-level, which in turn coordinates with a number of institutions internationally. To the extent that this process can be described as vertical, the cross-cutting nature of drugs policy further requires horizontal coordination between policy areas, extending through health, service provision, law enforcement, customs, criminal justice, education and external affairs. This horizontal coordination occurs at both national level, grouping various ministries and bodies, as well as at European level, bringing together relevant DGs, institutions and agencies.

By way of further context, Box 6.1 sets out information on the way that the EU Drugs Strategy has influenced national drugs strategies.

Box 6.1: Vignette: the influence of the EU Drugs Strategy on national drugs strategies

Over the course of the period covered by the EU Drugs Strategy 2005–2012, the process of formulating drugs policy and legislation at the level of Member States and aligning it with the EU Strategy and its Action Plans has been strengthened and accelerated, as called for by the very first objective of the 2005–2008 Action Plan. Indeed, the evaluation of that Action Plan notes that all EU Member States have a recent and/or updated drugs policy document (European Commission, 2008b, p. 17).

In 2004, 24 of 27 Member States had a national drugs policy document, and this number increased to 26 in 2008 after Italy and Malta implemented national strategies. 23 Member States adopted at least one new drugs policy document between 2005 and 2010, and around 45 new drug strategies entered into force during this period, compared to 35 in the preceding six-year period (EMCDDA, 2011a). This confirms a trend noted by the 2007 Progress Report (European Commission, 2007), which observed that while less than half (7 out of 15) of EU Member States had a national drugs policy document in 1995, almost all of them had one in 2007. The acceleration in the development of drugs policy documents is even more evident in the emergence of action plans as a complement to national drug strategies. In 2000, only one Member State had both a strategy and an action plan, and this had grown to 11 in 2007 (European Commission, 2007, p. 13).

Consequently, most of the 30 countries monitored by the EMCDDA currently have a drugs policy document less than 3 years old (EMCDDA, 2011a, p. 21). The most recent additions include strategies in the Czech Republic, Luxembourg, Sweden and the United Kingdom, action plans in the Czech Republic, Denmark, Italy, Luxembourg, Portugal, Romania and Turkey, and drugs programmes in Latvia and Lithuania. What is more, out of these, three countries – Portugal, Romania and Turkey – have actively synchronised their national policy documents with the EU Drugs Strategy. Most countries have adopted the EU model of a strategy with defined problems and objectives, actions and metrics for measuring performance (EMCDDA, 2011a, p. 13). The vast majority of policy documents at the national level focus on illicit drugs; however, there exist a few exceptions, such as Sweden, which has a combined strategy on drugs and alcohol and/or tobacco (EMCDDA, 2011a, p. 21).

What is more, the content of national policy documents appears to have been influenced by the EU Drugs Strategy. According to a survey conducted by the Commission for its mid-term review, the 2009–2012 Action Plan provided guidance for 12 out of 24 Member States in the development of their national strategies. In addition, 10 Member States indicated that the Action Plan had been discussed and evaluated against the background of their existing national policy (European Commission, 2010a, annex p. 4). In several cases, the influence of the EU Strategy has permeated into the language of national policy documents, as exemplified by, for instance, the current Czech, Romanian and Spanish strategies, all of which make explicit references to the EU document.

In terms of infrastructure for the execution and coordination of drugs policy at the national level, there appears to have been convergence between individual Member States, along the lines of the objectives of the 2009–2012 Action Plan. All EU Member States have in place a drug coordinating mechanism that usually consists of three components: a strategic entity such as an inter-ministerial board or a commission tasked with defining the strategic framework, an operative body to oversee and implement national drugs policies, and regional and/or municipal bodies tasked with coordination at the local level (European Commission, 2010a, annex p. 4). In addition, the Strategy's call for greater involvement of civil society in drugs policies at the national level has become increasingly reflected in individual Member States. Indeed, in a survey conducted for the mid-term assessment of the 2009–2012 Action Plan, 23 out of 24 countries indicated that civil society was involved in their drugs policy.

6.2 Relevance and influence

Later chapters in this report contain separate discussions on the relevance and influence of each objective. In this chapter, however, we present findings on the relevance and influence of the EU Drugs Strategy on EU drugs coordination within the same section. The rationale behind this approach lies in the fact that relevance is here defined as the extent to which priorities and objectives in the EU Drugs Strategy and actions in the Action Plans address the challenges in the drugs situation or drugs policy in the Member States. To this end, the relevance of the

Strategy and Action Plans also identifies the extent to which the Strategy and Action Plans influence the way drugs policy is coordinated in the EU.

Responses from the online survey and a clear majority of the Member State and a minority of EU-level interviews were positive on EU-level coordination and the role of the HDG. As will be detailed below, however, other interviewees provided a more nuanced perspective on the relevance of the HDG in regard to coordinating supply reduction policy and action.

Online survey indicates the HDG is viewed positively

The online survey revealed largely positive attitudes from Member State representatives towards the HDG, although it should be noted that the degree of involvement in the HDG varied among respondents. Ten per cent of respondents did not know what the HDG was and around a quarter (24 percent, n=183) had no involvement with the HDG, with those working in the NGO sector being among those most likely to neither know what the HDG is (40 percent) nor to have any involvement with the group (40 percent, n=15). Overall, however, the large majority of survey respondents who completed questions on the coordination of drugs policy (n=53) agreed that the HDG ‘prepared a clear and coherent drugs policy for adoption by the Council’ (83 percent), ‘succeeded in functioning as the main coordinating body on drugs policy at the EU level’ (81 percent), and ‘improved communication within the Council on drug-related matters’ (81 percent). Interestingly, survey respondents from new Member States (i.e. those who joined the EU after 2004) showed a generally greater degree of readiness to agree with positive statements about the HDG than their counterparts from older Member States. In the case of the three statements above, the difference amounted to more than 20 percentage points.

A similar trend between old and new Member States emerged when respondents were asked how well the HDG has been kept informed by other actors, such as the EMCDDA, Member States participating in the HDG, the European Commission or Europol. It should be stressed, however, that despite the noted difference, the overall opinion was that the HDG was kept informed in all four aforementioned cases (83 percent, 77 percent, 74 percent and 62 percent, respectively, n=53). Indeed, this finding was supported by the interviews with a key informant from the EMCDDA who noted the relevance of the Strategy in regard to coordinating agencies, stating that:

Work between agencies is working quite well, between EMCDDA and Europol, though they have very different mandates, when they can work together they work.... [The] EMCDDA coordinates a lot with the Commission. It’s also a small world; people talk together a lot about all these issues.

Added value of the HDG as a forum for discussion

The positive views of the HDG from the online survey were further elaborated during the Member State in-depth interviews, which provided a more detailed perspective on why coordination is relevant and effective. For example, a Dutch interviewee noted the uniqueness of the group: ‘It is a coordinating body – there isn’t another like it’. A number of interviewees highlighted the importance of bringing people together to discuss drugs policy. A Swedish interviewee highlighted the benefit of meeting European counterparts, noting that the HDG allowed him get to know his counterparts in other Member States. Interestingly, a similar point was formulated by a UNODC key informant, who, whilst acknowledging the difficulties associated with dealing with many different actors, noted the benefits of EU coordination in terms of shared learning. Another key informant highlighted the scope of the exercise, giving

the example of the coordination of supply reduction, where policy is the prerogative of multiple ministries (such as defence, finance, ministry of the interior, exterior, etc.), all of whose views get brought to the table.

Internal and external coordinating mechanisms challenge the HDG's efficiency and relevance

Despite these positive views on coordination, the relevance and the role of the HDG was challenged in a number of interviews. First of all, three EU level experts noted that the effectiveness of the HDG seems to be highly dependent on the clout and capacity of the presidency, as well as the capabilities of the chairman. Furthermore, four EU-level experts noted the role of the HDG is perceived as more prominent in coordinating demand reduction than supply reduction.

However, to contextualise these interviewees' comments we note that the evidence base for the effectiveness of policies in demand reduction tends to be stronger and/or more transparent or publicly available than in supply reduction, therefore a horizontal coordinating body such as the HDG might be expected to have more or wider leverage in drawing on this evidence in the field of demand reduction. Further, we note that Council working groups and committees other than the HGD, such as COSI, have taken initiatives in the area of drugs supply (European Commission, 2010b, p. 5).

The 2007 Progress Report (before COSI was established) found that HDG presidencies were liaising well with other working parties with an interest in drug-related matters (European Commission, 2007, p.16), which speaks to the embedding of drugs policy within the wider security agenda. Three EU-level experts noted that there is a potential risk to the sustainability of the balanced approach if coordination of drug supply reduction efforts becomes incorporated in the security agenda.

6.3 Implementation

Objectives and actions relating to the coordination of drugs policy at the EU level have been implemented to the extent that the HDG operates as a coordinating body in the field of drugs, as evidenced by views in the survey and some of the interviews. Indeed, the HDG's ability to coordinate positions and enable the EU to 'speak with one voice' at international fora was highlighted by interviewees. There remain, however, ongoing challenges and serious limitations to the HDG effectively coordinating EU drugs policy. As noted above and detailed below, these include the difficulty of coordinating common positions, the structure of the HDG and dependency on the presidency, and the apparent or possible gradual shift of supply reduction policy away from the HDG.

The Commission plays an important role in HDG coordination and organisation

A majority of Member State interviewees and three EU-level interviewees perceived the HDG to be a powerful group, mainly because it acts as both a practical Council group with legislative initiatives and priorities and a coordination group responsible for exchange of best practice between Member States. The official added that internal preparation and coordination of the HDG meetings by the European Commission is strongly enhanced by the work of its Inter-Service Group on Drugs (ISG) which is responsible for internal coordination of the Commission in preparation of the HDG. The official suggested that ISG input might be further developed and that the European Commission might be more proactive in introducing items on the agenda of the HDG. However, to contextualise these comments, it is noted both

that there are legal limits to the mandate of the Commission, and that the Commission does already take some initiatives for the HDG (for example, communications and projects).

Member State differences pose an important challenge to adopting common positions

An ongoing challenge for the HDG, inherent in the nature of coordination, is reaching agreement and adopting common positions. Four EU-level experts and one Member State interviewee noted that effective coordination was hampered by the size of the EU and hence HDG membership – stressing that northern, southern and central countries all have ‘totally different’ needs, as well as cultures and approaches to drugs policy, which makes for a complicated political discussion. Indeed, these differences between Member States were recognised as one of the persistent challenges in the 2010 Action Plan Progress Report (European Commission, 2010b, p. 4). These same difficulties were demonstrated during the negotiations of the new UN Political Declaration and Plan of Action on drugs, when unanimous support among EU Member States for including a reference to ‘harm reduction’ in the text of the document was not attained. Indeed, this point was also made in relation to project/policy implementation.

The rotating chair and representation of the HDG is perceived to hamper its effectiveness

As noted above, mechanisms relating to the rotation of the chair of the HDG have been perceived as a key challenge to its effectiveness. The 2007 Progress Report suggests that the HDG presidencies have largely respected and followed the Action Plans in their agenda-setting efforts. This view, however, was not supported by the current study’s other sources. Three EU-level interviewees noted that the effectiveness of the HDG strongly depends on the capacity of the presidency, as well as the capabilities of the chairman, a point reinforced by the Member State and EU-level interviewees. Indeed, the Member State interviewees identified the presidency as a barrier to implementation, feeling that the process of implementing the Strategy and its Action Plans depended on the rotating chair and the priorities and drives of the presidency at the time.

On a related note, room for improvement in the HDG’s work has been observed in terms of making better use of the meetings of national drug coordinators (European Commission, 2008b, p. 19). The point was made by a Member State expert that HDG meetings were too frequent for the appropriate delegates to attend, and consequentially membership of the HDG was sometimes lacking in terms of expertise (to contribute substantively to the debate) and seniority (to partake in decisions).

Supply reduction coordination is splitting away from the HDG

The most serious challenge, however, may lie in a gradual split in the coordination of supply and demand reduction. Three EU-level experts argued that this was happening, one of them noting:

On supply reduction it is the COSI for the moment. On demand reduction it is the [HDG].

Another of these interviewees provided an explanation for this perceived shift, arguing that COSI was very result-oriented, as opposed to the HDG, which was not regarded as particularly effective:

COSI is very practical, very operational oriented and it wants to achieve results with timelines and it is very focused on the concrete aspect. Something very different than we could see with HDG, for example, which has a very much more I would say foggy approach to things.

This official explained that COSI was seen as the preferred go-to platform for issues of law enforcement due to its action-oriented approach:

The law enforcement community is not very interested in what is going on [in the] HDG ... because in HDG there is a lot about information... COSI is very targeted: 'this is a situation ...and this is a proposal to tackle it'.

Interviewees thought that the policy cycle used by COSI has the benefits of being both focused and evidence-based. Broadly, the COSI process begins with the identification of relevant evidence, on the basis of which a small number of objectives are set along with actions to address them. The policy cycle lasts for two years.

The extent to which objectives and actions related to implementation have been carried through is mixed. On the one hand, the survey and other information sources have indicated that many view the HDG as an effective and necessary coordinating body in the field of drugs policy. The benefits associated with drawing together different agencies and policy areas have been highlighted, as has the wide scope of HDG activities, and its mixed functions as Council working group and forum for exchanging best practice. On the other hand, the HDG's relevance, importance and authority in the area of supply reduction, and the increase in prominence of other coordinating bodies such as COSI has called into question the HDG's role in coordinating and promoting the balanced approach, as outlined in the Strategy.

Key findings

- International cooperation is a key area where the EU adds value to Member State efforts to coordinate policy and address drugs challenges, with the EU Drugs Strategy and Action Plans acting as an important basis for EU action in the field.
- The Strategy is an important basis for international cooperation in the field of drugs with third countries, candidate and potential candidate countries, as well as international organisations.
- The Strategy is credited with improving the influence and visibility of the EU on the international stage. This improvement was explained in terms of the EU 'speaking with one voice', and in terms of the impact of the EU funding various projects and initiatives.
- Knowledge of the Strategy amongst External Action Service delegations in third countries is variable. Whilst some had a detailed understanding of the Strategy, others – even those having responsibilities in the area of drugs policy – had limited knowledge.
- Few tangible examples of international cooperation brought about directly by the Strategy were provided by EU delegations in third countries – even though the inclusion of these objectives was strongly supported.
- EU influence in international fora relies on consensus and the ability to project a unified approach. This inevitably engenders vulnerabilities linked to the EU's ability to negotiate and maintain a common position between 27 Member States.
- The EU may increasingly have to compete for influence in the field of drugs policy with state actors who are becoming more prominent in the field of drugs, such as Russia and increasingly, Latin America.
- The EU has been pursuing the Strategy's objectives of promoting the 'balanced approach' in international fora, ensuring demand reduction efforts are adopted in tandem with supply reduction efforts.
- There are practical benefits to having an EU Drugs Strategy as it provides a guide to EU policy in the field of drugs, to which delegates in international fora or third countries can refer.
- The EU 'model' for tackling drugs as defined in the Strategy is being adopted by other countries. The model is being adopted by candidate countries as an integral part of adopting the EU acquis, but also further afield by third countries, thus increasing the EU's influence in the field of drugs.

7.1 Context

International cooperation is a vital element of the EU Drugs Strategy. The drugs market is global, with drugs produced outside the EU and trafficked in, and vice-versa. Thus the objectives of the Strategy cannot be achieved by measures taken in Europe alone. For example, the EMCDDA reports that amphetamine produced in Europe is exported to the Middle East and the Arabian Peninsula (EMCDDA, 2011b). Cocaine is imported from areas including Colombia and Mexico, with countries such as the Dominican Republic acting as transit points (Europol, 2011).

There are three levels to international cooperation with respect to EU drugs policy, and thus three areas in which the Strategy might have an impact:

- International organisations and fora, such as the WHO or the UNODC.
- Europe's enlargement policy relating to acceding countries (Croatia), potential candidates (Serbia, Bosnia), candidate countries (Turkey, FYRO Montenegro, Macedonia, Iceland).
- Europe's enlargement policy relating to neighbourhood countries (e.g. Ukraine and Russia (ENPI assimilated) or southern Mediterranean countries) and third countries (e.g. United States, Afghanistan, etc.).

These three dimensions and the broad scope of the external dimension of the Strategy are reflected in the multiple actors involved in its implementation. As international cooperation in the field of drugs is to a large extent conducted at the EU level, it is carried out by the EEAS and the EC. The Directorate-Generals of the EC involved include Development and Cooperation, Justice, Enlargement, Health and Consumers, Home Affairs, and Taxation and Customs Union.

The context of EU external relations has changed significantly since the adoption of the Strategy in 2005: two new Member States (Bulgaria and Romania) have joined the European Union, a number of countries have applied for EU membership, and others in the West Balkans have become 'potential candidate countries'. The organisation and structure of the EU's external relations have also been reorganised with ratification of the Lisbon treaty and the introduction of the EEAS.

7.2 Relevance

Overall, respondents to the online survey agreed that improving international cooperation is an important objective for addressing the drugs challenges in their Member States, even though there were notable differences depending on the international cooperation objective in question. Improving the cooperation between EU and third countries, and EU efforts to encourage candidate and potential candidate countries to adopt the EU acquis, were perceived as 'very important' by 70 percent (n=33) and 77 percent (n=22) of respondents, respectively.

Respondents from new Member States felt somewhat more strongly about the perceived importance of cooperation with third countries – 83 percent (n=12) found it 'very important,' compared to 62 percent (n=21) of their counterparts from old Member States. In contrast, only 43 percent of respondents viewed coordination of EU action with international organisations as 'very important' and nearly 20 percent (n=37) of respondents felt it was 'not

very important'. The largest proportion of respondents who felt this objective was 'not very important' – 33 percent (n=18) – was amongst those who stated 'coordination of drugs policy' was the focus of their role.

The perceived importance of international cooperation is apparent in respondents' views on its inclusion in the next EU drugs strategy. All respondents felt that it was important for cooperation between the EU and third countries to be included in any future document (20 out of 33 found this very important; 13 out of 33 fairly important). Respondents were similarly positive about including an objective on encouraging (potential) candidate countries to adopt the EU acquis. Interestingly, the inclusion in a future strategy of objectives on coordination of EU action with international organisations was equally strongly supported despite the fact that the lowest proportion of respondents (in comparison with the other objectives) found this objective important to address the drug problem in their Member State.

Findings from the in-depth interviews indicate that interviewees similarly thought that international cooperation objectives were relevant to Member States. Interviewees were acutely aware that the tackling of drugs challenges does not begin and end at EU borders. Indeed, interviewees were keen to see the EU continuing to build on its increased visibility and influence on the international stage. Many agreed that it is very important for the EU to work towards a cohesive approach to engaging 'as one' with the rest of the world on the international stage.

Finally, analysis of responses to the survey of EU delegations (see Appendix E for further information) indicates that individuals working in third countries find the inclusion of objectives relating to international cooperation to be very relevant. This was mainly for the reason that organised crime does not respect national borders and thus needs an international response. Additionally, respondents mentioned country-specific factors that made dealing with drugs challenging, and which made international cooperation (and support from the EU) particularly relevant. Some delegates mentioned less instrumental reasons for the relevance of international cooperation – namely, that cooperation in the field of drugs could improve living conditions or internal security in third countries.

When asked about the areas of drugs policy most relevant to the country in which they were based, the topics most commonly mentioned by EU delegations related to the trafficking and transit of drugs, and steps to ensure that people in third countries, whose livelihoods depend on the cultivation of drugs, were helped to secure alternative sources of income. An example of alternative development policies in Latin America is provided in Box 7.1, and Box 7.2 sets out information on EU spending on assistance to third countries, showing that alternative development received the largest proportion of funding.

Box 7.1: Vignette: international cooperation – alternative development in Latin America

The concept of alternative development is explicitly endorsed by the EU Drugs Strategy, which affirms that the 'global nature of the drugs problem... calls for a comprehensive effort that includes law enforcement, eradication, demand reduction and alternative livelihoods and alternative development initiatives backed by local communities' (European Commission, 2004, p. 17). It was also included in the second Action Plan, which had as one of its objectives to 'promote and implement the EU approach to alternative development in cooperation with third countries, taking into account human rights, human security and specific framework conditions' (European Council, 2008, p. 21).

The basis for the implementation of the Strategy's objective was formulated in 2006 in a document drafted by the HDG outlining the EU approach to alternative development (Council of the European Union, 2006). Among other principles, the document reiterated that 'EU concerns against forced eradication are not ideological, but rather pragmatic and evidence-based', and reaffirmed the basis of the Strategy's international cooperation objectives, i.e. 'the European view of the need to systematically combine supply reduction and demand reduction measures' (Council of the European Union, 2006). The EU approach was further elaborated in a subsequent EU Presidency Paper for the UNODC (UNODC, 2008).

According to the Action Plan, responsibility for implementing the alternative development objective was to be shared between the Commission and individual Member States. Yet it appears the Commission has been the dominant actor in the implementation process. Indeed, in a survey conducted in preparation for the evaluation of the 2009–2012 Action Plan, four Member States (Belgium, France, Italy and the UK) reported that alternative development was a part of their broader development policy, while no information was available from the remaining Member States. This suggests that the primary vehicle for the EU's alternative development programmes has been EU funding programmes at the EU level (European Commission, 2010a, p.43).

In the case of Latin America, the framework for cooperation between the EU and the region is provided by the EU-LAC Cooperation and Coordination Mechanism on Drugs, prepared by the EU-LAC Technical Committee on Drugs, and by the Development Coordination Instrument, which represents the main legal instrument governing European cooperation with Latin America. As for policy documents guiding cooperation on drugs, both parties agreed in 1999 on an Action Plan on Drugs for Latin America (European Council, 1999), which was revised under the current EU Drugs Strategy in 2007 by the Port of Spain Declaration (European Council, 2007b). This reiterated the commitment to a balanced approach and identified as one of its priority areas 'to promote and finance initiatives on alternative development' (European Council, 2007b, p.5).

Within this framework, the European Union supported a host of projects that either focus on alternative development or have a component that revolves around the concept of alternative development. To name a few examples from the Andean region, the Commission has funded alternative development programmes in the Bolivian regions of Chapare and Yungas and has contributed to the country's National Alternative Development Fund (International Crisis Group, 2008, p.13). In Colombia, the European Commission has been involved in projects such as Laboratorio de PAZ (€92m), Regional development for peace and stability (€26m), and Regional development for peace and stability II (€8.4m, half of which was earmarked for alternative development). Peru has been the largest recipient of EU alternative assistance, targeting problematic areas such as Pozuzo, Palcazu, Pasco and Huanucoa (International Crisis Group, 2008, p.14). Similarly, a €6 million project in Peru has aimed to strengthen good governance and social inclusion, and included support to the Peruvian anti-drug agency (European Commission, 2010a, p.42).

In terms of possible impact, according to the Organisation for American States, coca cultivation detected in the main producer countries (Bolivia, Colombia, Peru) totalled 181,488 hectares in 2007, and 158,825 hectares in 2009, an overall decrease of 12 percent. It should be noted, though, that there was a notable increase in coca production prior to 2007, so the values for 2009 are roughly on par with those for 2006 (Organisation of America States, 2011, p.18). Furthermore, there appears to have been a slight increase in the uptake of alternative development in countries throughout the LAC region, as 11 countries reported to the OAS they had been implementing alternative development programmes or activities in 2006–2009, compared to 8 countries in 2004–2005 (Organisation of America States, 2011, p.22). However, the newest additions were recruited from outside the group of Andean countries, which attract a predominant share of the EU's assistance.

7.3 Influence

The Strategy facilitates international cooperation and increases EU influence on the world stage

Online survey results indicated that a large majority of those who felt that EU international cooperation and visibility had improved attributed this to the EU Drugs Strategy (55 respondents shared this opinion, while 15 respondents did not find the Strategy to have had an impact).

The online survey also indicated that respondents recognise the role of the Strategy and Action Plans in improving the effectiveness of international cooperation. Respondents listed the Strategy among the top three perceived facilitators for the achievement of all of the objectives in the field of international cooperation. Similarly, lack of inclusion of the Strategy's objectives on international cooperation in national drug strategies was seen as one of the most important barriers to improved effectiveness by the survey respondents. On the other hand, responses to the survey of EU delegations indicate that detailed knowledge of the Strategy was patchy, even among respondents whose role specifically related to drugs issues. Delegates from one third country reported that they had not received any training in the Strategy – which raises questions about the influence of the Strategy on their day-to-day work.

Yet a positive perception of the Strategy's influence generally resonated throughout the in-depth interviews. Several interviewees reported a belief that the Strategy had a 'huge influence' on the EU's work with international organisations. This was primarily seen through two main avenues – firstly through the political path of 'speaking with one voice', and secondly through the impact of EU funding. A common sentiment expressed by interviewees was that simply having a Strategy set down in one document was enough to improve relations with international organisations because it provided something to guide representatives during debates and negotiations. As one EU official noted, the Strategy has allowed the European Union to be more independent and present on the international scene.

As a result, there was a sense among a majority of Member State interviewees that the EU has a strong international influence in the area of drugs policy, particularly within organisations such as the World Customs Organisation and the CND. The close relationship between the EU and UNODC was noted by some, while other examples included the WHO's recognition of the use of methadone as a treatment, and work on novel psychoactive drugs. Similarly, the EU's activities were seen as adding value to the work of organisations such as the Pompidou Group, whilst also ensuring that a focus on European issues is maintained.

The Strategy defines the EU model, which is being adopted by other countries

According to one EU official, the added value of the EU Drugs Strategy lies in its definition of a model that is universally recognised and adopted by other countries. This point was especially made in regard to candidate and potential candidate countries. Another interviewee saw the added value of the Strategy in that many third countries have radically changed their views and approaches in tackling drugs challenges, emphasising that some, such as Ukraine, are building their national strategies and policy documents based on the European model.

To explore further the value of the Strategy to third countries, we can turn to the survey of EU delegations. This reveals mixed responses about the extent to which the Strategy has been influential in third countries. Around half of respondents said that there was no influence on national strategies (or that they did not know of any). The other half either identified ways in

which the Strategy had directly influenced the content of national strategies, or identified ways in which national strategies reflected the Strategy's content. Here it appears that respondents had different interpretations of 'influential'. Some judged the Strategy as influential on the grounds that there were similar principles in the national strategies. Others tried to identify possible causal links between the content of the Strategy and Action Plans and the national strategies of the countries to which they were posted. One example of the latter included holding a round-table discussion on the EU Drugs Strategy around the time the national strategy was written,

EU reliance on consensus means international cooperation is vulnerable to the risk of Member States removing support

The in-depth interviews highlighted the difficulties linked to achieving and maintaining consensus, which can be breached if one of 27 Member States withholds support on a particular issue. As EU influence relies on consensus, it is inevitably vulnerable to competing demands and priorities from Member States and the risk of them removing support. This can be the source of some difficulty and frustration in international organisations, although this is not limited to the field of drugs. An example of this can be found in the negotiations that surrounded a new UN Political Declaration and Plan of Action on drugs, when two EU Member States withdrew their support for including the term 'harm reduction' in the final document, thus illustrating the lack of unanimity (European Commission, 2010b, p. 7).

7.4 Implementation

EU cooperation with international organisations has improved

The results of the online survey show that nearly three quarters of respondents who chose to answer questions on coordinating effective action by the European Union in international organisations felt that, overall, EU cooperation had improved since 2005 (27 out of 37) (see Table 7.1). Only three respondents felt that the EU's levels of international cooperation in the field of tackling illicit drugs had stayed the same and only one thought that it had got worse.

Survey respondents were most positive about the visibility of the EU within the CND (20 out of 37 respondents thought this had improved) and about EU cooperation with the UNODC and the coordination of EU positions at the CND (19 out of 37 respondents thought these had improved). By contrast, respondents were much less likely to have favourable views on the progress of EU cooperation with the WHO and UNAIDS, even though this can be largely attributed to the apparent relative unfamiliarity of respondents with these organisations ('don't know' accounted for 16 and 17 out of 37 respondents, respectively).

Table 7.1: Findings from the online survey – how international cooperation has changed

International cooperation objective	Improved	Stayed the same	Got worse	Don't know	Sample size
Effectiveness of EU cooperation within the CND	49%	30%	11%	11%	37
Visibility of EU actions within the CND	54%	27%	5%	14%	37
Coordination of EU positions at the CND	51%	22%	16%	11%	37
EU cooperation within the Council of Europe (Pompidou Group)	35%	24%	14%	27%	37
EU cooperation within the Dublin Group	30%	27%	8%	35%	37
EU cooperation with the INCB in the field of drug precursors	32%	35%	0%	32%	37
EU cooperation with UNODC in the field of drugs	51%	32%	0%	16%	37
EU cooperation with the WHO in the field of drugs	22%	35%	0%	43%	37
EU cooperation with UNAIDS in the field of drugs	19%	35%	0%	46%	37
Overall EU cooperation and visibility within and towards international organisations since 2005	73%	8%	3%	16%	37
Efforts made by the EU to encourage candidate countries and potential candidate countries to adopt the EU acquis	64%	23%	0%	14%	22
Law enforcement cooperation between the EU and third countries	73%	12%	0%	15%	33
Other cooperation in supply reduction between the EU and third countries	58%	15%	0%	27%	33
Harm reduction cooperation between the EU and third countries	21%	18%	6%	55%	33
Other cooperation in the field of demand reduction between the EU and third countries	36%	12%	6%	45%	33
Cooperation on alternative development between the EU and third countries	15%	30%	6%	48%	33
Cooperation on precursor control between the EU and third countries	73%	12%	0%	15%	33
Cooperation on institution and capacity building between the EU and third countries	55%	24%	0%	21%	33
Overall cooperation between the EU and third countries	67%	24%	0%	9%	33

Promotion of the Strategy's balanced approach has been an underlying principle of the EU's international cooperation efforts

Frequent references were made to the fact that EU representatives and those in EU positions at various international fora try to ensure demand reduction issues are addressed in tandem with supply reduction efforts (European Commission, 2007, p. 59).

One way to illustrate the EU's balanced approach in international cooperation is to look at the nature and range of projects and activities that the Commission has funded in third countries - Box 7.2 sets out some examples (we have no evidence that this spending was due to the EU Drugs Strategy, but it demonstrates how the objectives of the Strategy might be put into practice).

Further support for the view that the EU is advancing a balanced approach can be found in responses to the EEAS survey about the 'impact' of the Strategy and Action Plans on national policies, policy dialogue and external assistance. Respondents reported that the balanced approach is widely reflected in all of these domains. In some instances, the priorities and actions as set out in the Strategy appear to have been directly relied upon and brought to bear. More often, though, it might be more appropriate to sum up the responses as confirming that there is coherence between the work of the EU delegations in drugs issues, and the Strategy and Action Plans.

Box 7.2: Some examples of Commission-funded projects in third countries

Central Asia Drug Programme (CADAP 5)

- The fifth phase of this Programme funded in 2008.
- Budget of €5 million approved under the Development Cooperation Instrument (DCI).
- Consolidates the previous phases and supports new areas in the field of drug demand reduction.

Border Management Programme in Central Asia (BOMCA) – law enforcement

- Capacity-building measures in Central Asia.
- Countries continue to be supported: eighth phase was approved in 2009.

Cocaine trafficking routes

- Support for Venezuelan anti-drug agency: €3.3 million project under the DCI.
- Bilateral anti-drug actions financed by the Commission in the three cocaine-producing countries (Colombia, Peru and Bolivia).

For the new trafficking route of West Africa

- €2 million project under the 9th European Development Fund.
- Aims to strengthen drug law enforcement capacities in Guinea-Bissau.

Cooperation Programme between Latin America and the European Union on Drugs Policies (COPOLAD)

- New regional programme launched 2009.
- €6 million for drugs policies.
- Approved and funded by the DCI under the Regional Indicative Programme for Latin America.
- Based on a balanced approach to drug demand and supply reduction and aims to support concrete anti-drug cooperation activities complementing the coordination efforts under the EU-LAC Mechanism.

PRELAC project

- Trans-regional level.
- Commission approved under the Instrument for Stability (IfS).
- Started in 2008.
- Aims to help prevent the diversion of drugs precursors in the Latin American and Caribbean region.

Source: European Commission, 2010a, p. 38-41

A similar conclusion, albeit somewhat muted, was presented in an EU-funded qualitative evaluation of selected EU drug-related projects in third countries since 2005. To some extent, the evaluation supports the view that a balanced approach is promoted, stating that EC funded projects appeared to address all priority areas of the EU Drugs Strategy and that the projects showed a significant level of coherence with regard to the policies and aims espoused by the

EU Drugs Strategy and Action Plan. The wide variety and impact of the projects was seen as a demonstration of the success of the EC in promoting the EU balanced approach to drug control, since some beneficiary countries adopted measures aiming to reduce demand for drugs as an integral part of their initial exclusively drug supply reduction policies (Amiot and Radimecky, 2010, p. v). However, the evaluation noted a trend for fewer drug demand reduction projects, or projects with a drug demand reduction component, being implemented in third countries by the EC, and recommended that:

Future EC funded projects pay more attention and provide more support to the enhancement of existing drug demand and harm reduction measures and services, or to the development of demand and harm reduction strategies and services in beneficiary countries where they do not yet exist (Amiot and Radimecky, 2010, p.25).

However, we note that the final evaluation of the first Action Plan revealed an imbalance in the composition of EU funding. Most resources were provided for alternative development (66 percent), institution building (17 percent, mostly law enforcement), and supply reduction and law enforcement cooperation (11.4 percent), while demand reduction, including harm reduction, accounted for only 5 percent of the total (European Commission, 2008b, p.41). Box 7.3 sets out data published by the Commission in 2007 about assistance to third countries.²⁵

Box 7.3: EU assistance to third countries in the area of drugs

At the end of 2007, the Commission published an update on EU assistance to third countries. EU international cooperation projects in the area of drugs accounted for over €760 million in 2005, making the EU one of the strongest players in the global effort against drugs.

Funding was provided for:

- Alternative development (66 percent)
- Institution building (17 percent, mostly law enforcement)
- Supply reduction and law enforcement cooperation (11.4 percent)
- Demand reduction, including harm reduction (5 percent).

Of the total spending, two thirds was allocated to activities in Afghanistan (€452 million) and almost one third to the three main coca growing countries, Colombia, Bolivia and Peru (€220 million). The remainder was spread throughout the rest of the world, particularly in the Mediterranean/Balkan region, South East Asia, the South Caucasus and Central Asia.

More than half of the EU Member States plus the European Commission were involved in international cooperation projects in the area of drugs.

Thus there was a considerable amount of funding provided by the Commission to drug related assistance projects in third countries up until the end of 2006.

The new EC external funding instruments for project funding in 2007 and 2008 do not have a thematic budget line for drugs. The consequences of this have not been assessed so far (European Commission, 2008b, p. 41).

Lastly, we note evidence of the predominance of supply reduction in bilateral agreements concluded by individual Member States with third countries which address cooperation in the field of drugs. This was noted as a challenge in the 2010 Progress Review of the second Action

²⁵ These were the most recent data identified. Additionally, as the final evaluation of the first Action Plan noted, the EC is also a major donor to the UNODC's Drugs Programme - as are a majority of EU Member States (European Commission, 2010a, p.46).

Plan. The review lauded the fact that a majority of Member States had reached such agreements but noted a concern that:

Over the last two years the external policy on drugs has sometimes focused too much on security. Bilateral agreements concluded by EU Member States with non-EU countries concentrated mostly on cooperation on supply reduction (European Commission, 2010b, p.4).

The growing influence of other international actors challenges EU influence

Interviewees expressed concern over the future prospects of the EU's role in international organisations. One interviewee from the Netherlands believed that the increasing influence that the EU has experienced in recent years is beginning to level off, in part due to the declining relative importance of drugs policy compared with other areas such as terrorism. This was a sentiment echoed by interviewees in the Czech Republic, who felt that the influence of the EU in this area was declining. Other countries and state actors such as the USA, certain Latin American countries and Russia are felt to be growing in influence relative to the EU. This is partly attributed to the EU's dependence on consensus, which, it was argued, is becoming increasingly difficult to maintain with the Union growing in size and accounting for multiple political contexts.

There is no evidence that international cooperation objectives have been systematically implemented in third countries

EU delegations were asked whether the objectives and actions of the Strategy and Action Plans in the areas of international cooperation had been implemented in the countries in which they were based. Only two respondents identified a direct link between cooperation activities and the Strategy and Action Plans. Others said there had been some implementation of cooperation activities, but their responses did not indicate explicit links between these activities and the Strategy. Linking to what has been said above about other influential actors in the field of international cooperation, responses from EU delegations suggest that work with the EMCDDA and other activities in the field of justice and security were also prompts for cooperation, independent of the Strategy.

Finally, it is noted that those respondents to the EEAS survey who did identify examples of international cooperation with third countries also noted scope for improvement, for example, by developing a more consistent policy dialogue with the EU.

Key findings

- The promotion of research and exchange of accurate and policy-relevant information were valued by Member States and in particular by new Member States, some of whom used the Strategy as a model for drafting national policies and strategies in relation to data collection.
- The EU Drugs Strategy is viewed as influential and impactful in prompting Member States to improve and harmonise data collection efforts, develop evidence-based policy and increase research collaboration.
- The EMCDDA is frequently praised for playing a key role as a facilitator, shaper and supporter of efforts in this area across the EU, and especially for new and accession countries.
- There has been an increase in the knowledge base on drugs in the EU, particularly in relation to harm reduction. The number of evaluations in the EU has increased, and the Commission has funded many research projects in this field. There is concern about future research funding in the current financial climate.
- There is scope for a greater focus to similarly expand the knowledge base and improve data and indicators on supply reduction.
- Some issues persist relating to the quality and availability of comparative data, and obtaining information on new and emerging drugs.

8.1 Context

The Strategy sets out a number of priorities including improving the knowledge infrastructure and disseminating findings at EU and Member State level. It also stresses the importance of evaluation in relation to EU actions and activities (European Council, 2005, p. 20). Indeed, an important aspect of EU drugs policy has been the creation of a sound evidence base through the development of new indicators and the homogenisation and systematic collection of data on drugs in the EU. These objectives are therefore rooted in a longstanding effort to increase knowledge of drugs challenges and their impact on society, as well as the establishment of ‘what works’ in drug demand interventions (including prevention, treatment, harm reduction and social integration).

8.2 Relevance

Findings from this evaluation indicate that information, research and evaluation objectives were perceived as relevant to addressing the drugs situation in Member States. This was notably the case for new Member States, whose data collection was not yet as developed as older Member States.

Inclusion of information, research and evaluation as one focus of the Strategy and Action Plans is seen as relevant

All the inputs collected for this evaluation indicated that information, research and evaluation are regarded as a relevant component of the EU Drugs Strategy and its Action Plans, in that they are indeed addressing a need in this area. Online survey respondents in Member States clearly viewed improving all objectives as important for addressing the drugs situation in their Member States. 97 percent of respondents felt that it was important to improve promotion of research (n=86); the same proportion of respondents also deemed it important to improve the exchange of accurate and policy-relevant information. In both cases, respondents from a demand reduction background felt slightly more frequently than their supply reduction counterparts that the objectives in question were 'very important' (79 percent and 76 percent, n=29, compared to 67 percent and 53 percent, n=15, respectively).

Furthermore, survey respondents felt equally strongly when asked about the importance of including research and evaluation objectives in the next EU drugs strategy. 97 percent felt it was important to include the objective of promoting research (n=86) and 92 percent reported that it was important to include the exchange of accurate and policy-relevant information (n=86).

These views were also reflected in the in-depth interviews conducted to provide a more textured view on these issues in a selection of Member States. The Member State- and EU-level interviewees who participated in this part of the study stressed the importance and value of clear, robust and comparable data and information. Moreover, most interviewees felt that the focus on expanding the evidence and knowledge base across the EU has been an integral part of the success and influence of the Strategy as a whole.

Data collection provision is of particular relevance to new Member States

For those interviewees from newer Member States, the issue of information, research and evaluation was perceived as being of particular relevance. Adhering to EU guidance on drug data collection was an integral part of the roadmap for accession to the EU,²⁶ and as such, the Strategy was relevant because of this binding nature. Newer Member States were generally keen to learn as much as possible from some of the frontrunner countries that are considered to be very effective and successful at collecting data on a range of key areas at the national level. As such, newer Member States placed a great deal of emphasis on the value of accurate data to help them understand the impact of policy decisions and in particular on the efficacy or otherwise of various initiatives. The particular relevance of the Strategy for newer Member States and acceding countries was also stressed by drugs policy experts, as the Strategy often served as a close model and reference point for newly drafted policy documents. Interestingly, one EU-level interviewee

²⁶ For the Member States of the 2004 accession wave, it was the previous Strategy that should be credited with this relevance. Whilst Romania and Bulgaria joined in 2007, the process of adherence to data collection mechanisms in the area of drugs started years prior to accession. Currently, this aspect is particularly relevant for the current accession countries: Croatia, Iceland, FYR Macedonia, Montenegro and Turkey

noted that currently the Strategy omits the global dimension of research cooperation, which could be, if included, very beneficial to efforts to promote the balanced European model and to increase the EU's clout and build international trust.

8.3 Influence

The EU Drugs Strategy is generally seen as influential, especially in providing focus and direction for data collection

Across the range of objectives relating to information, research and evaluation, the online survey revealed a clear, positive view of the Strategy's influence. Among survey respondents who felt the area of information, research and evaluation had improved since 2005, the proportion of those who viewed the EU Strategy as influential in this aspect was significantly greater (n=80) than those who did not find it influential (n=21). While it is worth noting that nine respondents reported that the situation in the field of information, research and evaluation had worsened, it is also noteworthy that they did not feel the Strategy was responsible for that change.

Survey respondents also appreciated the impact of the inclusion of the Strategy's objectives in national drug strategies and policy documents at the level of individual Member States. When asked to identify the most important barriers and facilitators to improving effectiveness in the field of information, research and evaluation, 'inclusion in national strategies' was regarded as an important facilitator to promote research; 72 percent of respondents felt this was important (n=86) and nearly half of the respondents (48 percent) felt it was an important driver of improving information exchange (n=86). In line with these views, survey respondents identified lack of inclusion in national strategies as the third most important barrier to improved effectiveness for both research promotion and information exchange – 35 percent and 31 percent respectively (n=86).

An equally favourable view emerged from in-depth interviews conducted with experts at the EU and Member State-level. Respondents were very positive about the focus the Strategy has brought to the collection of data that facilitate more reliable comparison across Member States. A representative of the EMCDDA stated that the Strategy and its Action Plans were clearly instrumental in solidifying the emphasis on evidence-based policies and were influential in supporting efforts to collect better data across all Member States:

I think the Strategy and the action plans were extremely helpful... It's not binding but nevertheless it was agreed unanimously by our Member States and that is, I think, one of the big values of the exercise. I think all these discussions about evidence-based policies and need for evidence... has helped us to get more and better data... So it was very much, for us, a tool in motivating Member States.

At the same time, some Member State-level interviewees did not know if the EU Strategy or Action Plans have influenced data collection across older Member States. For example, in the UK, experts referred to long-established national surveys, such as the British Crime Survey (which provides trend data stretching back nearly 30 years and includes questions on self-reported usage of drugs). Similarly, Swedish experts felt that they have a long history in data collection, although they did feel that the Strategy has encouraged Member States to collect the data needed for comparison with each other.

These views may reflect the fact that efforts toward the homogenisation and expansion of data collection started with the establishment of the EMCDDA in 1995, and therefore the situation today is the result of over 15 years of efforts, supported by various strategies. In this context, interviewees may not have experienced recent changes in data collection in their Member State and therefore may be less inclined to attribute national data collection to the Strategy.

The EMCDDA is considered crucial for improving data collection, research and information sharing

Across all data collection exercises conducted for this evaluation, the role of EMCDDA was frequently identified as an important aspect of the Strategy's influence. When asked to identify the most important facilitators to improving effectiveness in the field of exchange of accurate and policy-relevant information, 58 percent of survey respondents identified 'information provided by the EMCDDA' as one of the most important factors (n=86).

In Member State in-depth interviews, the EMCDDA was felt to be making very positive strides towards ensuring a more consistent and coherent approach to data collection and quality, and it was regularly praised in this respect, as well as being valued for providing guidance and advice on conducting research and ensuring consistency in data collection. Respondents acknowledged that the EMCDDA has a challenging task in 'persuading' Member States to pursue a more uniform approach to data collection; it has to use a 'carrot' rather than a 'stick' approach in its dealings with Member States. However, respondents did feel that on the whole the EMCDDA was succeeding in this endeavour. A French expert noted:

The EMCDDA have developed a system of European indicators, which are really useful. They provide guidance in terms of comparability, robustness and transparency of methodology – it's been great to have comparable measures.

The Strategy has contributed to the expansion of the EU knowledge base on drugs

In relation to research promotion, interviewees agreed that the EU knowledge base has expanded over recent years. Interviewees were appreciative of the increased focus on research into harm and demand reduction and felt that this was an area that has developed significantly in recent years. One Swedish interviewee felt that the Strategy, and in particular the Action Plans, have been instrumental in this expansion:

Research is increasingly important at the European level, particularly given the reduction in individual Member States' budgets. The action plans have been very positive in encouraging research links with other countries.

However, it is not clear that the improvement can be attributed to the Strategy alone – it is not known what would have happened in its absence. An EU-level interviewee agreed that the knowledge base and research in Europe has improved in recent years, but was cautious in attributing causality on the basis that certain countries are far ahead in terms of research, and these countries have been carrying out such research for a long time, prior to the establishment of the Strategy. Additionally, there were a number of comments about the lack of similar focus on developing and expanding the knowledge base around supply reduction.

Evaluation has improved significantly in recent years

The EU Drugs Strategy calls for regular and ongoing evaluation not only of the Strategy and Action Plans themselves, but also of national drugs strategies in Member States. An EU-level interviewee felt that evaluation in the field of drugs policy had improved significantly and that the

Strategy and Action Plans had been influential in that process, primarily by putting evaluation on the drugs policy agenda. An interviewee from the EMCDDA said:

I think what is improving in the field is the evaluation of a certain type of actions. You know, an area of evaluation that was almost not existing until a few years ago is prevention... this has changed a lot and we have been seeing increasing quality, increasing evidence that things are working there... and if you see the national strategies in the EU you see that many, many of them have an in-built evaluation component. This was not the case in the old ones.

8.4 Implementation

Member States and the EU are carrying out more research and more evaluations

According to a 2008 EMCDDA report on the state of drug-related research in Europe, there has been significant overall progress in the area of drug-related research and research promotion. Between 2008 and 2010 the annual number of studies cited in the REITOX annual reports increased from 350 to 750. Most Member States have organisations that carry out research on drugs and coordinate funding (EMCDDA, 2008, p. 26). Europe currently has no inventory of drug-related research conducted at the national level (EMCDDA, 2011a, p. 25). The European Commission has, however, commissioned a comparative analysis on research into illicit drugs in the EU (Bühringer et al., 2009) that identified over 250 research projects, more than 30 of which were EU-funded. The EU also facilitated research coordination and cooperation through such schemes such as the European Research Area Network (ERA-NET).

European Commission funding of drugs research

The Commission has multiplied efforts in the drugs research field, publishing numerous working papers on the subject, for example on how to strengthen EU research capacity on illicit drugs and on new drugs challenges such as psychoactive substances (European Commission, 2009a), as well as organising conferences such as the October 2010 conference on drug supply indicators and the September 2009 conference entitled 'Bridging the research gap in the field of illicit drugs in the EU'.

The Commission funds research on illicit drugs through a number of programmes: the Drugs Prevention and Information Programme (2007–2013), the Prevention of and Fight Against Crime Programme, the Health Programme, and fundamental research on drugs through the Seventh Framework Programme (FP7) of the European Community for Research, Technological Development and Demonstration (2007–2013). The Commission is currently co-financing a five-year project aimed at deepening knowledge of addiction, entitled ALICE RAP (Addiction and Lifestyles in Contemporary Europe – Reframing Addictions Project) and further explained in Box 8.1.

The EMCDDA identifies positive trends in relation to policy evaluation, which have become firmly embedded in national drugs policies and documents across the EU. At the same time, the trend report noted there is further room for improvement, especially in the following areas: 1) developing new theoretical models of evaluation, 2) conducting more frequent cross-country comparisons, and 3) harmonising relevant concepts and definitions across Member States (EMCDDA, 2011a).

Findings from the online survey are broadly in line with these trend assessments. The survey results indicated that just over half of respondents (51 percent, n=86) felt promotion of research

had improved over the course of the past seven years, as opposed to 12 percent who felt it had got worse (see Table 8.1). A much larger proportion of respondents from the demand reduction sector shared the optimistic perspective – 72 percent (n=29) felt promotion of research had improved compared to only 33 percent (n=15) of their counterparts from the supply reduction sector. The overall picture was more optimistic as far as exchange of accurate and policy-relevant information was concerned, with 69 percent of respondents finding it had improved (n=86), as opposed to only 1 percent who felt it had got worse. Similarly to the previous objective, the share of demand reduction respondents who felt there had been improvements since 2005 was notably larger (79 percent, n=29) than that of their supply reduction counterparts (40 percent, n=15).

Table 8.1: Findings from the online survey – how information, research and evaluation have changed

Information, research and evaluation objective	Improved	Stayed the same	Got worse	Don't know	Sample size
Promotion of research in the field of illicit drugs	51%	29%	12%	8%	86
Exchange of accurate and policy-relevant information in the field of illicit drugs	69%	21%	1%	9%	86

Respondents in the in-depth interviews also shared an overall positive view on developments in the information, research and evaluation field since 2005, especially at the EU level. On the whole, they were very positive about the progress made in enabling and facilitating the commissioning of larger pan-European studies to expand the evidence and knowledge base, in particular through improved access to EC funding. For instance, the planned set-up of ERA-NET was described as a very positive step forward, bringing together researchers to design, commission and run pan-European research.

Box 8.1: Vignette: addictions research in the EU – ALICE RAP

The EU Drugs Strategy aims to develop a better understanding of the drugs problem and a measurable and sustainable improvement in the knowledge base. The related priorities are improvement of the knowledge infrastructure, conducting research, and disseminating findings at the EU and Member State level.

ALICE RAP is a Europe-wide multidisciplinary research project, uniting 107 researchers from 43 research institutes in 29 different scientific disciplines. The five-year project co-funded by the European Commission under the FP7 Socio-economic Sciences and Humanities component started in 2011 with a budget of €10.17 million. Its work is divided into seven areas and 21 work packages, bringing together historical, economical and biomedical analysis. Researchers will contribute a total of 1,000 months of work conducting studies under the headings of Ownership, Determinants, Business and Governance of addictions, as well as a module dedicated to youth. The program is complemented by work packages dedicated to program coordination and integration.

ALICE RAP contributes to objectives in the EU Drugs Strategy to extend the knowledge base by critically examining and analysing existing fragmented research and conducting and disseminating findings of multidisciplinary, integrated studies on the socio-economic aspects of addictions. Its focus includes, but is not limited to drugs. Certain planned outputs, such as a webpage and wiki portal on addiction, will contribute to the European knowledge infrastructure.

The findings of the study will be published in one or more thematic reports focusing on scientific evidence as well as current and alternative policy solutions. Dissemination activities will include expert workshops and decisionmaker round tables designed to bring together scientists, stakeholders and policymakers.

All studies are envisaged to inform a redesign of effective addictions governance and a reframing of the concept of addiction. At the same time, one of the prospective benefits of the research is providing a stimulus to the public and political debate at national and EU levels while facilitating dialogue between science, policy and media.

Source: ALICE RAP

Greater dissemination of research findings

As part of the overall positive trend in drug-related research, the EMCDDA noted that channels for dissemination and sharing of research findings have become more numerous, as evidenced for instance by the growth of the number of relevant peer-reviewed journals (EMCDDA, 2008, p. 28). The downside of this development is that it may have become more difficult for less informed audiences to identify quality research among the expanded array of sources. Interviewees felt that the EMCDDA itself plays a crucial role in this respect, with their annual reports and ‘monographs’ being frequently cited as providing reliable, ‘up-to-date’ information for professionals working in drugs policy.

Despite the above-noted achievements, important challenges remain in the domain of drug-related research and evaluation. Most significantly, the quality and size of drug-related research varies substantially between individual Member States. While some enjoy a very robust research base and have developed numerous drug-specific research programmes, other Member States’ research capacity remains underdeveloped (European Commission, 2009a, p. 4). The same applies to the aforementioned growth in the number of dissemination platforms, which has been limited to a relatively narrow group of (predominantly old) Member States.

Uncertainty over funding due to affect drug related research

While there appears to have been significant progress in the prioritisation of information, research and evaluation, funding remains a persistent challenge for conducting drug-related research. The recent economic downturn has further exacerbated the issue, which is evident in reports on financing difficulties in the REITOX network, highlighted in the final evaluation of the 2005–2008 Action Plan (European Commission, 2008b, p. 45). The Progress Review of the 2009–

2012 Action Plan observed that the economic downturn had dented budgets allocated to drug research and evaluation at the national level, identifying this development as one of the key challenges to be addressed (European Commission, 2010b, p. 4).

Online survey respondents echoed this issue of funding. Allocation of financial resources was considered an important facilitator for research promotion (69 percent) and information sharing (52 percent). Moreover, respondents felt that lack of financial resources was the most important barrier to improve effectiveness in both research promotion (79 percent) and information exchange (58 percent).

Similarly, in-depth interviewees reiterated their concerns that the current economic climate may result in a scaling down of budget and funding available for data collection at the EU level, which they felt would negatively impact on the growing knowledge base. And while in general the interviewees noted some progress in terms of improved access to EC funding, a number raised concerns about the level of bureaucracy and administration that is needed to apply for European Commission research grants and funding. Many stated that this level of bureaucracy and administration limited access, in particular for smaller research organisations, and academics felt they did not have suitable resources to put into applying for funding.

One EU-level interviewee echoed the assessment of the final evaluation of the 2005–2008 Action Plan, which concluded that the number of research projects available through the Seventh Framework Programme of the European Community for Research, Technological Development and Innovation is rather limited (European Commission, 2008b, p.47).

Supply reduction data and indicators remain a challenge

As the discussion above suggests, there has been progress in data collection in recent years. Yet challenges remain. As the final evaluation of the 2005–2008 Action Plan summarised, progress in data collection and data reliability, availability and comparability has been somewhat hampered by the fact that not all recommended indicators, most notably in the domain of supply reduction and law enforcement, are pursued (European Commission, 2008b, p.47). Member State in-depth interviewees shared this view. As described above, they noted the increased focus on research into harm and demand reduction and commented on what they perceived to be a lack of similar focus on developing and expanding the knowledge base around supply reduction. This may in part be explained by the fact that supply reduction indicators were more recently introduced as an area of focus (in the 2009–2012 Action Plan). Efforts have since been made to develop supply reduction indicators, notably at the EU level,²⁷ but the complexity and recentness of the exercise mean that research is still in its early days.

When discussing possible reasons for this perceived disparity between demand and supply reduction data, one EU-level official suggested a historical explanation based on the fact that at the time of drafting the Strategy, data collection, namely via EMCDDA, was foreseen as mainly focusing on the health-related dimension of the drug problem. Furthermore, indicator development, data collection and monitoring on the supply side are potentially very resource-

²⁷ For instance, the European Commission DG JLS (now DG Justice) commissioned a study, now published, on the development of indicators to measure the effectiveness of strategies aimed at drug supply reduction and tackling drug-related crime (Kilmer and Hoorens, 2010). Other initiatives include publishing working papers on related subjects, for example on how to strengthen EU research capacity on illicit drugs (European Commission, 2009a), as well as organising conferences such as the October 2010 conference on drug supply indicators or the September 2009 conference entitled 'Bridging the research gap in the field of illicit drugs in the EU'

intensive, and limited by the nature of the exercise as supply reduction efforts rely on intelligence and other information not readily available in the public domain.

PART 3: SYNTHESIS

In this chapter we synthesise the data presented, bringing together the findings in relation to each of the questions formulated at the outset of this evaluation. These questions address our four main objectives:

1. To assess to what extent the objectives and priorities of the EU Drugs Strategy 2005–2012 have been implemented at both EU and national level.
2. To examine the extent to which the Strategy and its Action Plans have influenced Member States' drugs policy and legislation.
3. To assess to what extent the implementation of the Strategy and its Action Plans has had an impact on the drugs situation in the EU and on the responses prepared to tackle the drugs problem.
4. To identify key aspects and recommendations that may be of importance for the formulation and implementation of the new EU drugs strategy and its action plans.

Objective 1: To assess to what extent have the objectives and priorities of the EU Drugs Strategy 2005–2012 been implemented at both EU and national level

The objectives and priorities of the EU Drugs Strategy have been implemented to various degrees across both pillars and all three cross-cutting themes.

With respect to **demand reduction**, this evaluation suggests that over the past eight years there has been progress in areas identified as priorities in the Strategy and its Action Plans. For instance, there has been a moderate shift towards more targeted approaches and models in prevention programmes and harm reduction has become a public health objective across all Member States. However, as the findings in Chapter 4 suggest, there remain persistent challenges as far as demand reduction implementation is concerned. These challenges include differing levels of implementation of harm reduction measures in different Member States and the risk that demand reduction programmes will not secure funding during an economic downturn.

As far as **coordination** is concerned, the HDG has functioned as the main coordinating body at the EU level and has greatly facilitated information exchange between EU Member States. On top of internal coordination within the EU, the HDG has also contributed to the formation of common positions on the external elements of the EU's drugs policy. However, as discussed in Chapter 6, the implementation of coordination objectives has been somewhat hampered by the challenges relating to the role and functioning of the

HDG, such as coordination with the COSI or dependence on the capacity of the presidency.

In the field of **supply reduction** there have been numerous instances of successful implementation of the Strategy's objectives and priorities. Most importantly, Member States have taken advantage of (and have shown initiative in building) instruments, bodies and frameworks designed to reduce drug supply, such as Europol, Eurojust, Joint Investigation Teams, Joint Customs Operations, MAOC-N, the European Joint Unit on Precursors, and the European Expert Group on Cannabis. Moreover, efforts in law enforcement have been accompanied by increased judicial and forensic cooperation between Member States. The Strategy's objective to intensify law enforcement efforts directed at non-EU countries has particularly been taken up by Member States, as regional initiatives such as CECLAD-M or MAOC-N attest. But, as Chapter 5 highlights, despite some visible progress in this area, measurability remains a challenge, largely stemming from a lack of reliable metrics and from underdeveloped indicators. Furthermore, implementation of supply reduction objectives is to a great extent a matter of national legislation. While there has been some progress in harmonising national priorities and laws relating to supply reduction, this process remains far from complete.

In relation to **international cooperation**, the EU has actively promoted a balanced approach to the drugs problem and improved its visibility as an actor at the international level, in line with the Strategy's objectives and priorities. In particular, extensive work has been undertaken in the area of cooperation with candidate, potential candidate, and neighbourhood countries, especially on issues revolving around institution and capacity building, tackling trafficking and demand reduction. And yet, as Chapter 7 explains, the EU's external relations and presence on the international stage have occasionally suffered from a lack of consensus, and the EU has had to face a growing challenge from other international actors.

Finally, the Strategy's objectives and priorities in the field of **information, research and evaluation** have clearly been implemented in that there has been a notable increase in the body of research and collaboration on drug-related topics over the course of the past eight years, along with an increase in channels for its dissemination. Also, collection of drug-related indicators has broadened in scope and moved towards greater availability and comparability, particularly in the area of demand reduction. Furthermore, policy evaluation has become more firmly embedded in national policies and documents. However, as with other areas and as discussed in Chapter 8, there remain challenges to be addressed, especially in relation to information on supply reduction, consistency of data collection, and the continued funding of drug-related research.

Overall, it can be concluded that there has been discernible progress on every objective included in the Strategy, albeit to varying degrees. Often, the degree to which individual objectives have been implemented depends on a particular Member State, its resources, policy preferences and other specific circumstances. Importantly, this development was anticipated at the time of the adoption of the Strategy itself, since the document was 'intended to allow scope for local, regional, national and transnational dynamics and potentialities and to make optimal use of the resources available' (European Council, 2004, p. 3).

Objective 2: To examine the extent to which the Strategy and its Action Plans have influenced Member States' drugs policy and legislation

A: To what extent have the Strategy and its Action Plans had an impact on Member States' national (or regional) drugs strategies and action plans?

The EU Drugs Strategy has had a discernible impact on the process of drugs policy formulation and adoption in individual Member States. The number of countries that have adopted their own national drugs strategy has increased over the lifetime of the EU Strategy. On a related note, the process of evaluating, revising and updating national drugs policy documents has become a more firmly embedded and common practice. An increasingly large proportion of Member States have complemented their national strategies with associated action plans, along the lines of the European example.

The content and structure of policy documents at the national level appear to have converged with the EU Strategy. For instance, most countries have embraced the Strategy's model of objectives, actions and performance metrics, several countries have actively synchronised their strategies with the EU's, and, most importantly, a majority of countries have reported that the Strategy has served either as a source of guidance or as a reference point for their national policy documents.

B: What indirect impacts has the Strategy had on third countries' or international organisations' policies on drugs?

As argued in Section 7.4, the EU Drugs Strategy has played an instrumental role in the EU's work with **international organisations**. It has served as a guiding reference for EU representatives and delegates, both in international fora and in third countries, and has contributed to greater coherence in the EU's external relations on drug-related issues. In fact, the very existence of a pan-European document has enabled the EU to 'speak with one voice' and raise its profile as an actor on the international scene, advancing its own approach. As such, the EU has been better positioned to influence the policies of international organisations such as the WCO, the UNODC and the WHO. At the same time, the EU's ability to impact on international organisations' policies depends on its capacity to maintain consensus and unity among its Member States, which has proved more challenging during the later years of the Strategy's operation.

The impact of the Strategy also manifests in the EU's dealings with **candidate, potential candidate, and third countries**. For candidate and potential candidate countries, the Strategy's balanced approach has been a part of the EU acquis they are expected to adopt prior to accession. In addition, the Strategy has served as a source of guidance for other countries drafting or reframing their national strategies. Romania is an example of a former candidate country whose national drugs strategy is closely aligned with that of the EU, while Ukraine can serve as an example of a country that has been reframing its national drugs policy along the lines of the EU model. Furthermore, with regard to relations with third countries, the Strategy's impact can be seen in efforts to promote the adoption of demand reduction efforts in tandem with supply reduction initiatives. This has translated, for instance, into consistent support for and increased uptake of alternative development programmes, particularly in bilateral relations with Latin America. However the Strategy's impact has been limited by the fact that most partner countries continue to prioritise supply reduction measures over those targeting demand reduction.

Objective 3: To assess to what extent the implementation of the Strategy and its Action Plans has had an impact on the drugs situation in the EU and on the responses prepared to tackle the drugs problem

A: How has the drugs situation in the EU changed since 2005?

Since 2005, there appears to have been little change in the demand for and availability of drugs in the EU. Drug-induced deaths remain at historically high levels.

Overall, prevalence rates of most illicit drugs have remained stable over the course of the Strategy. Some Member States with traditionally high prevalence rates of certain substances, such as cannabis or cocaine, recorded small decreases. Notable trends in demand include the emergence of polydrug use, as well as the development of new markets for certain substances (for example methamphetamine availability in certain northern Member States and seizures in Norway and the Baltic Sea).

Trends in the supply and availability of illicit drugs paint a more mixed picture. Cannabis seizures have increased while production has diversified, with domestic production competing with foreign imports. Information on cocaine seizures, purity and price offers few clues on the dynamics of the cocaine market in the EU, whilst trends in heroin seizures do not explain the significant shortages in certain markets. There are indications that precursor control legislation has disrupted the ecstasy market, although this disruption may only be temporary.

Heroin remains the main opioid used in the EU. Extrapolated data indicate that the number of problem opioid users has remained stable over the course of the Strategy, and that heroin still accounts for the greatest share of drug-related morbidity and mortality in the EU. However, there are indications that the current, ageing generation of opioid users is not being replaced. The supply of heroin to EU markets appears to have remained stable over the course of the Strategy. The EMCDDA notes a significant increase in the number of seizures, but with stable quantities seized. In terms of availability, a recent trend of note is the apparent 2010 'heroin drought' in the UK and Ireland. Several explanations for this have been suggested, including shocks in production, the effect of law enforcement interventions, the successful diversion of precursors, and the diversion of the drug to other markets.

The rate of newly reported HIV infections has declined over the last couple of years, whilst HIV prevalence in samples of injecting drug users has remained low and stable in most Member States. This trend has been attributed to a decline in injecting drug use prevalence and risky behaviours. There have, however, been counter-trends, such as increasing HIV rates in a small number of new Member States and the recent 2011 HIV outbreak in Greece.

B: To what extent can these changes be associated with the development and implementation of the Strategy and its Action Plans?

There is no evidence that the EU drugs situation has unequivocally improved over the period of the EU Drugs Strategy. As outlined above in relation to objective 3A, the trends over this period are complex, with some indicators moving in a positive direction and others suggesting worsening trends. Even without such complexity, it would be difficult (if not impossible) to attribute causation between drugs policies and the drugs situation in the

EU. Many factors, operating at local, national and cross- or supra-national levels, influence the drugs landscape.

Thus in answering objective 3B we do not claim evidence of causal relationships. Rather, we highlight some specific examples where the data collected during the course of this evaluation suggest a potential impact of the Strategy or a development in line with the objectives of the Strategy. The following examples of success in demand reduction are consistent with the objectives in the Strategy:

- There are signs of decreasing cannabis consumption in traditionally high prevalence countries (probably among recreational users).
- There has been a stabilisation and even slight decrease in cocaine consumption.
- The population of opioid users is ageing, which suggests that the older generation of problem users is not being replaced.
- The number of newly reported HIV infections has decreased.
- Availability and access to drug treatment has increased.
- Precursor control legislation is temporarily disrupting the ecstasy market.
- Alternative development programmes are being implemented in third countries.

The provision of harm reduction programmes across all Member States is frequently cited as evidence of the influence and implementation of the Strategy. A specific example is an increase in the number of individuals treated by opioid substitution programmes since the adoption of the Strategy (although there is significant variation between Member States). This increase can be viewed in light of evidence that substitution programmes have been shown to reduce HIV-related infections, overdose mortality and self-reported injecting risk behaviours (Kimber et al., 2010). Of course, there are counter-trends: Hepatitis C infection remains high among young and new injecting drug users and drug-induced deaths remain at historically high levels.

There is no convincing evidence from the information available that the Strategy or its Action Plans have had an impact upon supply-side trends. There are few visible indications that the trends on the supply side are moving in a desirable direction. Europol notes a trend towards diversification of drug supply, with trafficking increasingly dominated by groups dealing in more than one product. Other data, for example on drug arrests and seizures, are not considered a reliable indicator for the size of drugs markets. There remain difficulties in evaluating supply reduction interventions.

In relation to international development there are some signs, albeit modest, that projects supported by the EU and implemented in Latin America are having an impact. An example discussed in this report is the impact of alternative development programmes on coca cultivation, which stabilised and even dropped a little following increases in previous years. There has also been a slight increase in the numbers of countries implementing alternative development projects.

C: What is the added value of the Strategy and its Action Plans for addressing illicit drugs in the EU?

This evaluation has shown that a drugs strategy at EU level can add considerable value to national drugs strategies. Firstly, drug markets operate internationally, and tackling them requires international coordination and cooperation between Member States and between the EU and third countries (particularly when targeting supply). Such coordination and external cooperation are important elements of the Strategy. Secondly, mutual learning and exchange of best practices avoids having to reinvent the wheel. The Strategy has considerable potential as a means of sharing evidence on the effectiveness or ineffectiveness of specific interventions or initiatives, promoting the implementation of evidence-based interventions, and launching joint initiatives.

Finally, the sum of activities at Member State level is greater than its parts, particularly in relation to information and knowledge development. Not only do Member States with less well-developed monitoring and information infrastructures learn from others, the front runners also benefit from comprehensive coverage and data harmonisation. Examples of EU-level activities which generate this added value include: information sharing as facilitated by Europol; alternative development programmes that help tackle drugs challenges in unstable countries; coordination of intra-EU cooperation in joint investigations; other cross-border judicial and law enforcement initiatives; and an emphasis on border practices that can help reduce the movement of both precursors and illicit drugs.

Notwithstanding the specific objectives or actions formulated in the Strategy and Action Plans, the intrinsic value of the Strategy has been its key success. It has provided a forum and a decisionmaking process for consensus building, developed a shared language and understanding and provided a platform for information sharing and mutual learning.

This has not only been shown to be important within the borders of the EU; the EU model for drugs policy is internationally acclaimed and respected. A common approach to drugs policy, set out in the Strategy, improves the EU's effectiveness, raises its leverage on the international stage and has helped to raise the profile of the EU model in international fora and in relation to third countries.

The Strategy has also been influential as it has enabled an open debate about the scientific reliability of drugs policy strategies, particularly demand reduction measures. It has promoted a culture of harmonised data collection and evidence-based best practices. The Strategy has facilitated debate around the effectiveness of interventions, even of those that are considered controversial in some contexts. For example, certain harm reduction measures are perceived to have been effective, with the example of the decrease in newly reported HIV infections over the past decade being cited.

Objective 4: To identify key aspects and recommendations that may be of importance for the formulation and implementation of the new post-2012 EU drugs strategy and its action plans

What conclusions and lessons can be drawn for the new EU drugs strategy post-2012 and its action plans?

On the basis of the findings stemming from the various data collection approaches, and following from the conclusions in relation to objective 1, 2 and 3 a number of

recommendations can be drawn to inform future EU drugs policy; these are outlined in Chapter 10.

This chapter sets out nine recommendations from this evaluation. These recommendations flow from the conclusions set out in Chapter 9. In turn, the conclusions, and these recommendations, arise from analysis of the data collected throughout the study. These recommendations are intended to inform the development of a future drugs strategy at EU level. The recommendations seek to identify areas of added value that should be continued and areas of improvement that, if addressed, could help mitigate current limitations and/or help anticipate future challenges.

1. **The EU should undertake the development and implementation of a future EU drugs strategy.** The EU could benefit from a future strategy which provides a coordinated regional framework. It can provide fora and a focus for discussion, debate, learning and consensus building. It can increase coherence, pool resources and help develop knowledge and understanding. The EU can and should continue to bring together the many and varied perspectives with different levels of resources, capabilities and approaches in order to learn from and challenge one another, and to build common positions through doing so.
2. **In order to maintain the balanced approach, the HDG could further align its activities with other EU initiatives touching upon drugs policy, and with COSI in particular.** The HDG's mandate - the coordination of EU drugs policy - could be reinforced. To ensure that the HDG continues to coordinate a balanced approach, rather than moving towards a situation in which different bodies focus on one or other pillar, further alignment with other EU initiatives such as COSI's policy cycle could help maintain balance and enhance effectiveness. While the HDG continues to be viewed as the main forum for discussion regarding the demand reduction pillar, COSI has increasingly gained prominence and traction, in part for its perceived 'action-oriented approach' in the field of supply reduction. This may be because supply reduction efforts inherently require coordination of a more operational nature, and because tackling illicit drugs as one aspect of transnational organised crime has been increasingly incorporated into the wider security agendas of the EU and elsewhere.
3. **Some logistical and structural changes in the HDG could create greater efficiency, coherence and effectiveness in the coordination of drugs policies at EU level.** There is a balance to be struck in meeting frequently enough to proactively coordinate and propose action in this field, without demanding time commitments that may impede the senior and expert participation necessary for

effectiveness. While subsidiarity allows for differential implementation and prioritisation, it may be useful to support the development of country blocks or regional working groups. These would form around shared interests with respect to tackling production, transit or consumption (or various combinations of these) or particular approaches (such as a greater focus on supply reduction and law enforcement versus more attention on harm reduction). This could enable Member States to pursue greater flexibility in their own approaches, yet to learn from, observe and participate in others where possible. Finally, structural changes could be considered to remedy the inconsistencies brought about by the reliance on the clout and capacity of the presidencies of the HDG.

4. **Information, research and evaluation in the field of illicit drugs should continue to be supported as a strong example of where working together can add value to many Member States and aspiring Member States, as well as third countries and international bodies.** The development of approaches and infrastructures to gather, report and coordinate information, as has happened over previous strategies, can be regarded as a considerable achievement in its own right. It is especially beneficial for new Member States, candidate countries, potential candidate countries and third countries with undeveloped policies in the field.
5. **International cooperation should continue to be a strong theme for any future EU drugs strategy, which should build on the existing international reputation of the EU in this field and continue to promote a balanced approach.** The EU Drugs Strategy has helped to raise the international profile of an EU model for drugs policy employing a balanced approach. In doing so, the Strategy supports those who act as EU delegations to international fora related to illicit drugs. International cooperation centred on the EU Drugs Strategy is influential for candidate and accession countries seeking to understand drugs policy, build capacity, develop data infrastructure, and otherwise engage with the EU acquis in this field. This support for delegates at international organisations and the influence and infrastructure for candidate and accession countries should continue to be developed and prioritised in a future Strategy.
6. **EU drugs strategy should continue to play an important role in helping to understand the effectiveness of interventions and approaches to reducing demand for illicit drugs, and therefore can help in prioritising actions to this end.** The Strategy has been influential in providing a forum and open debate about the scientific reliability of drugs policy strategies, particularly measures in demand reduction. It has promoted a culture of harmonised data collection and evidence-based best practices. This forum and debate around scientific evidence in the field of illicit drugs is an important function and should be seen as a significant aspect of any future EU drugs strategy.
7. **More emphasis needs to be placed on the deployment of effective measures in the field of drug supply reduction.** While important progress is being made in this domain, further efforts are required to expand the evidence base on supply of drugs to national and local drug markets, and even more on the impact of different interventions on supply to those markets.

8. **More progress can and should be made to develop integrated policy approaches across licit and illicit substances (including legal highs) and across different forms of addiction.** Concern about the emerging health and social risks posed by legal highs run alongside calls to develop a framework that acknowledges the harms generated by alcohol, cigarettes and other substances, as well as illicit drugs. While several of the relevant areas will not be amenable to EU level regulation, research and learning may still be usefully generated about the legal and illegal markets across a range of substances that need to be better understood. The impact of policy interventions such as regulation, pricing instruments and behavioural interventions might also have applicability across types of addictions. There is a growing body of work in these areas and it will be important for future strategies to harness this emerging knowledge base to inform the collection and reporting of information and the prioritisation of actions to tackle related challenges.
9. **A future strategy may benefit from being presented as one integrated document that includes objectives and suggested, prioritised actions, and covers a shorter period of time.** The Strategy and the two Action Plans form a set of coherent and internally logical documents; however, the Strategy is primarily known to those who are routinely and consistently involved with it. A shorter-term strategy aiming to cover fewer years, and with a reduced number of focused priorities and clearly associated integrated actions may be one route to increase accessibility, widen knowledge and potentially increase impact.

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APPENDICES

Appendix A: Interview protocol – EU and international level key informant interviews

Introduction to the study and the interview

By the end of 2011, the European Commission will propose a new drug strategy. We, RAND Europe, have been commissioned by the EU to conduct an independent, external evaluation of the current Strategy and its Action Plans prior to the development of the new strategy.

As part of the study, we are meeting with key experts and those involved in the development of the process and implementation of the Strategy and Action Plans to obtain their insights. These discussions will also inform the selection of a small sample of priority objectives from the Strategy, to pursue in more depth as case studies.

Part 1: About the respondent

- Please tell us about your **current position**
- Please tell us about **your involvement** with the development of Strategy and/or Action Plans

Part 2: The Strategy and Action Plans

- In your opinion, is there a need for the EU to play a role in drugs policy?
- What would you say are the **overall aims** of the 2005-2012 Drugs Strategy and Action Plans?
- And how would you **describe overall** – effective, ineffective, necessary, redundant etc?
- If you are familiar with previous EU drugs strategies, what do you consider to be the main difference(s), if any, with the current EU Drugs Strategy?
- What is your view on the “balanced approach” idea (i.e. both demand and supply reduction)? Did the strategy succeed in this approach?
 - What do you think are the **implications**, if any, of the balanced approach for the **strategy's added value**, weaknesses and strengths?
 - If need to be prompted: what does it mean for the strategy that the **EU has no competence in the area of public health**?
 - If need to be prompted: what does it mean for the strategy that the **MSs were already doing much on the supply side**, and the

EU already had some competence in it, like with precursors and setting minimum penalties for trafficking offences?

- What is your **view on the logical structure** of the Strategy and its Action Plans (i.e. 6 areas – Priorities – Objectives – Actions)?

Part 3: Development of the Strategy and Action Plan

- Could you tell us about the **process that led to the publication** of the Strategy and Action Plans?
 - Who were the **stakeholders** or perspectives (such as health, criminal justice, etc) involved?
 - How did you perceive the involvement of the different Presidencies?
 - And how would you say the views of **different countries** came to play in the development of the strategy?
 - Do you think the proposal (at the time) and/or the ultimate Strategy text reflect some of the **specific interests of particular Member States**?
 - How was the **process** of formulating the Strategy and Action Plans structured?
 - Was it **formal/informal/somewhere in between**? Did national politics influence the process of adoption of the Strategy (e.g. turf wars between Ministries)? If so, how?
 - Was there **overall consensus or much disagreement** and/or debate in the development of approach and priorities?
 - And how has this played out in practice?
 - What were the **key stages or pivotal points in the development**?
 - Were there any **procedural bottlenecks/challenges**? How were these resolved?
 - Were these **conflicts or tensions** surprising and/or new or did they exist before this process?
 - Were there any particular points of **consensus or agreement**?
 - Were these **surprising or pre-existing** before the process?
 - What would you say were the key **influences on the content** of the Strategy and Action Plans
 - E.g. Existing evidence, evaluations of previous Strategy, individual people's expertise, specific countries' input, particular departmental interests/priorities e.g. health, cjs, etc?
 - How would you **characterise the process** of development of the Strategy (effective, ineffective, carefully considered, too slow, too hasty)?

- Where there any key developments that affected the formulation and adoption of the 2008-2012 Action Plan?
 - Is it still consistent with the previous Action Plan & overall Strategy?

Part 4: Selection of objectives to focus on in more detail

- **Which objectives would be particularly interesting** to study in more detail
 - And why?
- What is your assessment of the way in which these objectives have been **implemented** in the EU?
 - And why
- What have been the **outcomes of the implementation of these objectives**, at the EU and/or MS level?
- What in your view has **contributed** to the **successes and failures** of implementation?
- In your view, what does (or what would) the **successful implementation of these objectives require** (at EU and/or MS level)?

General questions about implementation of the Strategy and Action Plans

- Beyond these few main objectives looking at the Strategy and Action Plans as a whole, what would be your **overall assessment of the implementation** of the Drugs Strategy 2005-2012 and Action Plans?
- Have there been **any Drug Strategy priorities** or areas of implementation that have been **especially successful**?
 - Could you describe?
- Have there been any priorities or areas which have experienced greater **difficulties in implementation**?
 - Could you describe?
- What would you say have been the **greatest facilitators to implementation**, both at MS and EU level?
- What would you say have been the **greatest barriers to implementation**, both at MS and EU level?
- Is there a **difference between how New Member States and EU-15** countries accepted and/or implemented the Strategy?
- Have there been **developments or events since adoption that affected implementation** of the Strategy?

Questions about intra-institutional and inter-agency coordination and cooperation mechanisms at EU level

- What would you say are the **institutions and agencies at EU level which play a role** in implementation?
- Are there **particular mechanisms for coordination and/or cooperation** in place between and within these bodies?
 - If so, **how effective would you say these mechanisms are** in facilitating implementation?
 - And why – could you give some examples?
- What would you say are the main **barriers to effective coordination and cooperation**?
- And the **main facilitators**, opportunities or strengths?
- Are there **overlapping or even competing drug policy or strategy initiatives**, institutions or platforms that may undermine the role of the strategy?

Questions about funding to support the implementation of the Strategy and Action Plans

- What **types of funding are available** at the EU and/or international level to support the implementation of the Strategy and Action Plans?
- What are the **bodies responsible for this funding**?
- How is funding to support implementation **allocated**?
- What would you say about the **adequacy and sufficiency** of the funding?
- And of the **mechanisms** by which it is allocated?

Questions about relevance and influence (added-value) and impacts

- In **which of the 6 priority areas** (more than one possible) of the Strategy **does the EU have the biggest potential added value** over those of Member States? Explain.
- Did the **Strategy realise this potential**? Explain.
- Are there any **other areas** (not included in the Strategy) that could have the potential **to present added value** in your opinion?
- Do you think the Strategy **holds equal relevance in all MS**?
 - And does this have any impact on implementation?
- Did the Strategy **contribute to its overall objective** of improving the EU drugs situation in all of its priority areas?
- Is there **evidence for a causal relation between implementation strategy and such improvements**?

Appendix B: Interview protocol - EU level in-depth interviews

Introduction to the study and the interview

By the end of 2011, the EU Drugs Strategy 2005-2012 and its current Action Plan 2009-2012 will draw to a close. We, RAND Europe, have been commissioned to conduct an independent, external evaluation of the Strategy, and its two corresponding Action Plans (2005-2009 and 2009-2012).

As part of this study, we are conducting a number of in-depth interviews to gain further insights on specific objectives of the Strategy. These in-depth interviews are to be carried out in 7 Member States (Czech Republic, the Netherlands, France, UK, Romania, Spain, and Sweden) and with stakeholders from the various EU institutions.

Section 1: Interviewee introduction

1. Could you start by describing your current role and responsibilities?
2. How long have you been in your current role?
3. How does your role relate to the area of drugs policy?
4. Are you familiar with the EU Drug Strategy? How do the EU Drugs Strategy and Action Plans relate to your role?

Section 2: Introductory questions about value-added elements of the EU Drugs Strategy and its Action Plans

5. Can you tell me more about your involvement with the Strategy and Action Plans?
 - Specifically – were you involved in their development? Their negotiation? Their implementation? Please explain
6. Overall, in your view, do you think the EU Drugs Strategy and Action Plans add value?
 - If so, where are they adding value? If not, why not?
7. In your view, have there been any significant changes to the approach taken to drugs policy since 2005? **IF YES** - Could you outline the main changes? **IF NO** – Why do you think that things have remained the same?

Now I would like to ask you a few questions about some specific areas of the EU drugs strategy and action plans – in line with the areas you previously prioritised.

SECTION 3: CO-ORDINATION

Objective 18) EU-level coordination of drugs policy through the Horizontal Drugs Group (HDG)

FOR INFORMATION: The Drugs Strategy says that the HDG should: Monitor and chase up activities in all the other bodies of the EU that are relevant to the drug strategy; help to avoid duplication of drugs work between itself and other bodies; signal gaps; suggest, where needed, the launching of initiatives.

Main questions

8. What do you think are the most important elements for the co-ordination of drugs policy at the EU-level?
9. Are you, or have you been, involved in coordinating activities through the HDG, or COSI for example?
 - Type of involvement? What was your experience?
10. What would you say is the main role of the HDG, and to what extent does it fulfil this role?
11. How effective do you feel the HDG has been at coordinating drugs policy at the EU level? Please explain your answer.
12. (For EC staff) How useful are ISSG preparatory meetings in preparing the Commission's position at the HDG? How could this be improved?
13. Have EU coordination mechanisms facilitated the adoption of a common position and/or integrated approach internationally? And if so, which ones?
14. How and why has the role of the HDG evolved over the 2005-2012 period? What have been the implications of this evolution?
15. How does drugs policy relate to the COSI's activities, and what role does the COSI play in drugs policy? What are the implications of this?
16. What are the main drivers and challenges to successfully coordinating drugs policy at the EU level?
17. How reliable and effective are information and reporting mechanisms on the implementation of Action Plan actions and Drugs Strategy objectives?
18. What are the main issues you encounter in the implementation of Action Plan actions and Drugs Strategy objectives?

Closing questions

19. Is there anything else you'd like to comment on as regards the coordination of EU drug policy?
20. What role do you see the HDG and the COSI respectively adopting going forward?

SECTION 4 INTERNATIONAL CO-OPERATION

Objective 30.1) Co-ordinated, effective and more visible action by the EU in international organisations and fora enhancing and promoting a balanced approach

Main questions

21. In your opinion, how much influence or impact in the field of drugs does the EU hold with international organisations such as the CND, Council of Europe (Pompidou Group), The Dublin Group, UNODC, WHO, UNAIDS?
 - Has there been any change in the level of influence in recent years? Since 2005, 2009?
 - Are there better relations with some organisations than others? If so, why? What are the drivers? Can you provide any examples of influence or impact?
22. How much influence, if any, do you feel the EU Drugs Strategy has had on the EU's influence in the field of drugs in the international arena?
 - How? Why? Can you provide any specific examples or instances?
 - How is/has the EU's balanced approach received in the international area?
23. The Action Plans have set out some specific actions in relation to international cooperation. Do you think these actions are useful/relevant for advancing the EU's goals in the area of international cooperation on drugs?
24. Which actions have been useful/ had an impact? Which actions have been redundant? What do you see are the main barriers and drivers of these?
25. The strategy aims to systematically include EU drug policy concerns in relations with third countries and regions, and within the broader development and security agenda. To what extent, if at all, have you seen development in this area?

Closing questions

26. Are there any ways in which the provisions of the Strategy relating to international cooperation could be improved?
27. Is there anything else you'd like to comment on in relation to international cooperation?

SECTION 5 Final questions

28. How have the EU Drugs Strategy and Action Plans impacted on the manner in which the EU institutions approach and carry out policy in general and drugs policy in particular?
29. What would you say are the Strategy and Action Plans' main successes?
30. What would you say are the Strategy and Action Plan's main shortcomings?
31. Are there any issues which you would like to be taken into account in drafting a future Drugs Strategy?
32. Anything else of importance?

Explain next steps - thank and close

Appendix C: Interview protocol – Member State level in-depth interviews

The protocol set out in this appendix was the basis for interviews in the Czech Republic, France, The Netherlands, Romania, Spain, Sweden and the UK.

For each country, specific probes were added drawing on the findings from the online questionnaire. In the version of the protocol included in this appendix, we have included probes used for interviews in the Czech Republic.

Interviewer introduction APPROX 5 MINUTES

- Introduce self
- Introduce Ipsos MORI Social Research Institute and mention that the evaluation is a collaboration with RAND Europe (independent not-for-profit research organisation)
- Timings c. 45 minutes.

Explain aim of the interview

- The European Commission commissioned RAND Europe and Ipsos MORI SRI to conduct an independent, external evaluation of the 2005-2012 EU Drugs Strategy and Actions Plans.
- As part of the evaluation we invited relevant experts and practitioners from each of the EU 27 to complete an online survey about all the objectives in the strategy. In total, 183 questionnaires (66% response rate) were completed in May 2011 across 26 member states.
- Subsequently, we have selected several case study objectives for more in-depth analysis, and we would like to gather your views on these during this interview.
- **Stress:** This evaluation aims to assess the relevance and influence of the EU Drug Strategy and does not aim to evaluate the national drug policies and/or situations of MS.

Confidentiality and recording

- **Confidentiality:** explain to interviewee that any information provided will not be attributed to them or their organisation without their permission.
- **Ask permission to record:** transcribe for quotes, allows interviewer not to write detailed notes, no attribution without permission.

SECTION 1: Interviewee introduction APPROX 5 MINUTES

1. Could you start by describing your current role and responsibilities?
2. How long have you been in your current role?
3. And how long have you worked in the area of drugs policy?
4. Does [INSERT COUNTRY NAME] have a national drugs strategy?
 - **IF NO** – How would you describe the approach to drugs policy in your MS? To what extent are you familiar with this strategy/approach?
5. Are you familiar with the EU Drug Strategy?
 - **COUNTRY-SPECIFIC PROBE FROM ONLINE SURVEY** (e.g In the online survey, just one out of five of Czech respondents stated that they had read the strategy. What do you think about this figure? Do you think that those working in the drugs field in Czech are likely to be familiar with detail of the EU Strategy?)
 - And are you familiar with the Action Plans?
 - **PROBE** for each - how familiar would you say you are, e.g. know a lot, or just a little?
 - **READ OUT** - The EU Drug Strategy has five key overarching aims; these are
 - Co-ordination of drug policy;
 - Drug demand reduction;
 - Drug supply reduction;
 - Co-operation with international organisations; and
 - Information, research and evaluation
6. Which of these areas would you say you are most involved in?

IF ONE MENTIONED – INSERT IN PRIMARY ROLE (1) IN THE TABLE BELOW, IF TWO MENTIONED – ASK THEM TO STATE THE PRIMARY ROLE AND SEPARATE ACCORDINGLY IN THE TABLE BELOW.

IF MORE THAN TWO MENTIONED – ASK THEM TO PRIORITISE THE TOP TWO FOR PURPOSES OF MORE DETAILED QUESTIONING, AND MARK THE TOP TWO IN THE TABLE BELOW. IF MORE THAN TWO MENTIONED AND RESPONDENT HAS INDICATED THEY ARE ABLE TO SPEAK FOR AN EXTENDED PERIOD – THEN NOTE DOWN THIRD PRIORITY AREA TO FOCUS ON.

Aim	Primary role (1)	Primary role (2)	Primary role (3)
Co-ordination of drug policy			
Drug demand reduction			
Drug supply reduction			
Co-operation with international organisations			
Information, research and evaluation			

SECTION 2: Introductory questions about value-added elements of the EU Drugs Strategy and its Action Plans

(if they say they are familiar with them) APPROX 5 MINUTES

7. **IF RESPONDENT HAS WORKED WITH OR USED THE EU DRUGS STRATEGY AND ACTION PLANS:** Can you tell me more about your involvement with the Strategy and APs?
- Specifically – were you involved in their development? And have you worked with them as part of your job?
8. Overall, in your view, do you think the EU Drugs Strategy and Action Plans add value?
- If so, where are they adding value? If not, why not?
 - **PROBE AROUND** – adding value in providing guidance in formulating national drugs policy, adding value in co-ordination of drugs policy, adding value to co-operation of international organisations, adding value as a model or approach to refer to support arguments for certain approaches and actions
9. Does your national strategy [*or approach to drugs policy*] refer to, or draw on, the EU Drugs Strategy and its Action Plans?
- If so, how? If not, why not?
 - **COUNTRY-SPECIFIC PROBE FROM ONLINE SURVEY** (e.g In the online survey, all Czech respondents stated that the EU Drugs Strategy was explicitly mentioned in the national drugs strategy. Does that tally with your view?)
10. And to what extent do you think your national strategy/approach is consistent with the EU strategy?
- In what areas, if any, are drug policies in your country and the Drugs Strategy most aligned? In what areas do they differ most?
 - **COUNTRY-SPECIFIC PROBE FROM ONLINE SURVEY** (e.g Two out of five Czech respondents to the online survey felt that drugs policy in the Czech Republic placed an equal focus on drug supply and drug demand reduction. How do you feel about the way this is aligned to the EU strategy?)
11. Have there been any significant changes to the approach taken to drugs policy since 2005? **IF YES** - Could you outline the main changes? **IF NO** – Why do you think that things have remained the same?

Now I would like to ask you a few questions about some specific areas of the EU drugs strategy and action plans – in line with the areas you previously prioritised.

SECTION 3: CO-ORDINATION

Objective 18) EU-level coordination of drugs policy through the Horizontal Drugs Group (HDG)

Firstly, I would like to ask you some questions on the EU level co-ordination of drugs policy.

3.1 Main 'top-tier' questions to ask of everyone (approx. 5 mins)

12. What do you think are the most important things which need to happen at the EU-level and between the EU and MS to co-ordinate drugs policy?
13. Are you involved with the HDG or MS-level coordinating activities?
 - Type of involvement? What was your experience of involvement?
14. And how familiar are you with the role of the HDG in coordinating actions against illicit drugs at EU-level and/or coordination actions taken against drugs at MS-level?
15. What would you say is the main role of the HDG?

FOR INFORMATION: *The Drugs Strategy says that the HDG should: Monitor and chase up activities in all the other bodies of the EU that are relevant to the drug strategy' help to avoid duplication of drugs work between itself and other bodies; signal gaps; suggest, where needed, the launching of initiatives*

16. Findings from the online survey show that 81% of respondents (that chose to answer questions on co-ordination) felt that the HDG had succeeded in functioning as the main co-ordination body on drugs policy at EU-level. What do you think about these findings? Surprised/unsurprised? How effective do you feel they have been in this role?
17. What are the main drivers to the HDG successfully coordinating drugs policy at the EU level?
18. What are the main challenges to the HDG successfully coordinating drugs policy at the EU level?
19. Sixty four per cent of the respondents in the online survey (choosing to answer questions on co-ordination) felt that the HDG had been proactive in identifying gaps not being addressed in drugs policy. How do you feel about these findings? Are you aware of any policy gaps identified by the HDG?
 - Which ones? Were they important/not important? Is this role of the HDG important/ not important? Why
20. And are you aware of any new trends identified by the HDG?
 - Which ones? Were they important/not important? Is this role of the HDG important/ not important? Why
21. And are you aware of new initiatives launched by the HDG?

- Which ones? What did you think about these initiatives/ policies? Important/unimportant? Clear/unclear? Relevant to your MS? How do you think they could be improved?

IF INTERVIEWEE IS A SPECIALIST/HAS PRIORITISED THIS AIM THEN CARRY ON WITH THE FOLLOWING SECTIONS – OTHERWISE MOVE TO SECTION 4: DEMAND REDUCTION

3.2 Specialist questions to ask of those prioritising this aim (approx. 10 mins)

22. How effective has the EU Drug Strategy and its Action Plans been at helping co-ordination of drugs policy at EU level? (for example, adopting EU common positions?)
- Why/why not? Can you provide examples?
23. How effective has the EU Drug Strategy and Action Plans been at helping coordination of drugs policy at the national level?
- How would you describe the situation in [INSERT COUNTRY] – is drugs policy joined-up at the national level or do things operate in a more localised setting?
 - How can things be improved here?
 - Can you give any firm examples?
24. How much does civil society participate in drugs policy? (e.g. public bodies, commercial enterprises, schools, NGO's)
- Why do you say that? Can you give any firm examples?
 - How does this happen, if at all, in [INSERT COUNTRY]? Is this stated in the National Strategy?
 - Has there been any change to civil society participation since 2005? If so what have you seen? To what extent would you attribute these changes, if at all, to the DS or APs?
 - How can better participation be encouraged here?
25. Has EU coordination been strengthened in the multilateral context – i.e. across different organisations such as UNODC, CND, WHO, Interpol? How and why do you think that?
- What do you feel has caused this strengthened coordination?
 - Is an integrated and balanced approach being promoted?
 - Why do you say that? Can you give any firm examples?
 - How might this situation be improved?

3.3 Closing questions

26. Is the HDG addressing a) the 2005-2008 action plan and b) the 2009-2012 action plans related to the strategy?

- Can you give any firm examples?

- For example – *“the Presidency is to convene meetings of the national drugs coordinators or their equivalents on a regular basis to advance coordination on specific and urgent issues requiring action. The coordinators are to be invited to contribute to the Council’s annual examination of the state of the drugs problem”* - Has this been happening?

27. In your view, should the HDG be more active in co-ordinating and developing new policies?

- Have you got any examples of when it has not been active enough, or when it has been positively active?
- In your view are there particular areas on which the HDG should be focusing – and is it or is it not doing so?

28. Is there anything else you’d like to comment on as regards the coordination of EU drug policy through the HDG?

SECTION 4: DEMAND REDUCTION

4.1 Main ‘top-tier’ questions to ask of everyone (approx. 5 mins)

I would like to ask you some questions about targeted and diversified treatment programmes in [the member state] – including both psychosocial and pharmacological care.

29. What type of targeted and diversified treatment programmes do you feel are prioritised in [member state]? [For example, detoxification? Drug free treatment? Substitution treatment? Psycho-social treatment?]

- Why do you think that is?

30. What are your views about the diversity of the treatment programmes offered in [the member state]?

- Too much/too little/about right? Why?

31. How easy is it for drug users to access the available treatment programmes?

- **IF NOT** - Why not? What are the challenges/barriers here?

32. To what extent do you feel the treatment of health problems resulting from the use of psychoactive substances are a part of national health policies?

- Why/why not?

33. Do you feel there have been any notable changes in treatment programmes over the period since 2005? What are they? What has brought about these changes?

34. In the online survey, an equal proportion of respondents who felt demand reduction services had improved felt that the strategy had been influential in this improvement as those that did not (39 vs 38). Why do you think that is the case?

We’d be interested to find out whether and why some parts of the EU Drugs Strategy have been implemented more or less than others.

35. Thinking about diversified and targeted treatment programmes in your country, to what extent did [the member state] align with approaches included in the EU Drugs Strategy and set out in the associated action plans for 2005-2008? 2009-2012?
- Why/why not?
 - How, if at all, did [member state] follow the guidance on how accessible these programmes should be?
 - How diverse? Is there consistent coverage across your MS? PROBE FOR geographical coverage and range of services

4.2 Specialist questions to ask of those prioritising this aim (approx. 10 mins)

Objective 25.3) Improving access to targeted and diversified treatment (including integrated psychosocial and pharmacological care

FOR INFORMATION: Treatment programmes include: Detoxification (to end the physical dependence to a drug); Drug-free treatment (patients do not receive psychoactive medicines and are substance free); Substitution treatment (in which e.g. heroin is replaced by methadone/buprenorphine, on medical prescription and under supervision, Intended to stabilise dependent users, and improve quality of life); Psycho-social treatment (Intended to reduce and/ or terminate the psychological dependence, This includes various types of therapy, often in combination with other treatment types)

36. Both of the action plans associated with the 2005-2012 EU Drugs strategy set out some specific actions in relation to treatment programmes. How familiar are you with these Actions? From which action plan? (2005-2008, 2009-2012)
37. If possible, could you give a broad indication of whether or not the Actions have been implemented in your MS?

Please remember we are evaluating the effectiveness, implementation and relevance of the EU drugs strategy, rather than MS compliance with it

- Which have been implemented? When were things implemented?
 - And which not? **FOR EACH NOT IMPLEMENTED ASK:**
 - Are there any particular challenges/barriers to implementing this action that you can raise?
 - How might [MS] implement this Action moving forward – what assistance, if any, is needed?
38. Overall, how do you feel the Strategy (and its associated action plans) have enhanced the effectiveness of drug treatment and rehabilitation?
- PROBE for improving the availability, accessibility and/or quality of services in [the member state]? Targeting services (In particular taking into account specific needs of drug users according to gender, cultural background, age etc?)
 - In what ways? Can you give specific examples? Would I find reference to this in the National Strategy?

- Has this been evaluated? Would it be possible to access an evaluation report?
39. Since 2005, what improvements, if any, have there been in the provision of treatment and preventative work in prisons in [the member state]?
- In what ways? Can you give specific examples? Would I find this in the National Strategy? Has this been evaluated? Would it be possible to access an evaluation report?
 - How, if at all, would you say that the strategy and its associated action plans influenced this?

Objective 25.4) Improving access to services for the prevention and treatment of HIV/AIDS, hepatitis, other infections, diseases and drug related health and social damage (harm reduction services).

40. What do you understand by the term harm reduction?

FOR INFORMATION: approaches that prioritise a focus on reducing the harms from drug use rather than the drug use itself: can include information, education & counselling; Reaching out to drug users by bringing them in contact with health and social services, by offering housing; Needle & syringe exchange ; Paraphernalia distribution, testing & screening for diseases, vaccination; Substitution treatment (the substitution substance is of constant 'potency' and quality, and often administered under medical supervision); Medical response to overdose (antagonist drugs); Heroin prescription (for long-term, chronic dependent drug users); Drug consumption rooms (drug users use drugs under supervision, avoiding 'open drug scenes'); Pill testing (superficial test of content of synthetic drugs).

41. How, if at all, has the strategy and/or its Action Plans influenced change in the accessibility of harm reduction services, for example those seeking to reduce the spread of HIV/AIDS, hepatitis C and other drug-related blood-borne infectious diseases?
42. Have there been any other influences on harm reduction services in your MS? What are these?
- What impact have they had?
43. In your opinion, has the existence of the EU drugs strategy and associated action plans helped to reduce the number of drug-related deaths in the EU?
- Why/why not? Do you have any specific examples? Has this been evaluated in your [MS]?

4.3 Closing questions

44. In what way(s) could the Strategy and/or AP's be more relevant or useful in relation to harm reduction in your member state?
- What would you suggest the DS or AP's focus on to help your MS further?
45. In the online survey, 50/81 respondents felt harm reduction policy was more recognised in national health public policy since 2005. Thirty out of 50 of these respondents felt the EU Drugs Strategy was influential in this change. How do you feel about this? Influential/not influential? Why do you think these respondents felt like this?

46. Is there anything else you'd like to comment on in relation to the Strategy and Action Plans' aims of improving access to harm reduction programmes?
47. We'd be interested to find out whether and why some parts of the EU Drugs Strategy have been implemented more or less than others. To what extent are harm reduction programmes in your MS aligned with the EU drugs strategy.
- Why/why not?
48. Thinking about harm reduction services in your country, to what extent did [the member state] follow guidance provided in the EU Drugs Strategy? The associated action plans for 2005-2008? 2009-2012?
49. Is there anything else you'd like to comment on in relation to harm reduction programmes

SECTION 5 SUPPLY REDUCTION

Objective 27.4) Enhancing law enforcement, criminal investigation and forensic science cooperation

I would like to ask you some questions about enhancing law enforcement, criminal investigation and forensic science cooperation in your MS.

5.1 Main 'top-tier' questions to ask of everyone (approx. 5 mins)

50. To what extent do you feel [MS's] approach to supply reduction is influenced by the EU strategy? In what ways?
51. Have you noticed any change to the approach taken to supply reduction in [your MS] over the period since 2005?
- What has changed?
 - What would you attribute these changes to? PROBE – internal action on manufacturing, reduction of trafficking etc?
52. In the online survey, a higher proportion of respondents who felt supply reduction programmes and services had improved since 2005 felt the strategy had been influential in this change (n=68) than those who thought it had not been influential (n=25). How do you feel about these findings? Why do you think respondents felt like this?

FOR INFORMATION: examples of supply reduction include: improvement of law enforcement cooperation and exchange; Improvement of judicial coordination and cooperation; Rapid response to emerging threats; Reduction of manufacturing and supply of drugs; Reduction of diversion and/or trafficking of drug precursors

5.2 Specialist questions to ask of those prioritising this aim (approx. 10 mins)

53. The Action Plan sets out some specific actions in relation to supply reduction. If possible, could you give a broad indication about whether or not you feel these actions have been implemented in your MS since 2005?

Please remember we are evaluating the effectiveness, implementation and relevance of the EU drugs strategy, rather than MS compliance with it

- Which have been implemented? **FOR EACH – PROBE ON:**
 - when were they implemented?
 - Before or after 2005?
 - And what role do you think the DS and/or AP's play in maintaining these actions?
 - And which have not been implemented? **FOR EACH NOT IMPLEMENTED ASK:**
 - Are there any particular challenges/barriers to implementing this action that you can identify?
 - How might [MS] implement this Action moving forward – what assistance, if any, is needed?
54. Have the aims and objectives of the strategy and APs helped to enhance effective law enforcement cooperation in the EU to counter drug production and trafficking?
- In what ways? Can you give specific examples? Would I find this in the National Strategy?
 - Has this been evaluated? Would it be possible to access an evaluation report?
55. The strategy also aims to enhance effective judicial cooperation in the area of combating drug trafficking and law enforcement as regards production, trafficking of drugs and/or precursors, and money laundering related to this traffic. To what extent, if at all, have you seen progress in this area since 2005 (or since when)?
- In what ways? Can you give specific examples? Would I find this in the National Strategy?
 - Has this been evaluated? Would it be possible to access an evaluation report?
56. Have you seen any reduction in the manufacture and supply of synthetic drugs? Is that at the EU or the national level?
- In what ways? Can you give specific examples or evidence for this?
 - Has this been evaluated? Would it be possible to access an evaluation report?
 - To what extent would you attribute this to the DS and/or AP's that have been in place since 2005?

5.3 Closing questions

57. Given the situation in your MS – is there anything else you would like to see from the DS and/or AP's to further aid supply reduction?

58. Is there anything else you'd like to comment on in relation to supply reduction?

SECTION 6 INTERNATIONAL CO-OPERATION

Objective 30.1) Co-ordinated, effective and more visible action by the EU in international organisations and fora enhancing and promoting a balanced approach

I would like to ask you some questions in relation to international co-operation

6.1 Main 'top-tier' questions to ask of everyone (approx. 5 mins)

59. In your opinion, how much influence or impact in the field of drugs does the EU hold with international organisations such as the CND, Council of Europe (Pompidou Group), The Dublin Group, UNODC, WHO, UNAIDS?
- Has there been any change in the level of influence in recent years? **PROBE** since 2005, 2009?
 - Are there better relations with some organisations than others? If so, why? What are the drivers? Can you provide any examples of influence or impact?
60. How much influence, if any, do you feel the EU Drugs Strategy has had on expanding the EU's influence in the field of drugs in the international arena?
- How? Why? Can you provide any specific examples or instances?
61. In the online survey, a higher proportion of respondents who felt EU co-operation and visibility within and towards international organisations had improved since 2005, felt the strategy had been influential in this change (n=55) than those who thought it had not been influential (n=15). How do you feel about these findings? Why do you think respondents felt like this?

6.2 Specialist questions to ask of those prioritising this aim (approx. 10 mins)

62. The Action Plan sets out some specific actions in relation to international cooperation. If possible, could you give a broad indication about whether or not you feel these actions have been addressed by your MS?

Please remember we are evaluating the effectiveness, implementation and relevance of the EU drugs strategy, rather than MS compliance with it

63. Which have been addressed? And which not? **FOR EACH NOT ADDRESSED ASK:**
- Are there any particular challenges/barriers to addressing this action that you can see?
 - How might this Action be addressed moving forward – what assistance, if any, is needed?
64. The strategy also aims to systematically include EU drug policy concerns in relations with third countries and regions where appropriate and within the broader development and security agenda. To what extent, if at all, have you seen development in this area?
- In what ways? Can you give specific examples? Would I find this in the National Strategy?
 - Has this been evaluated? Would it be possible to access an evaluation report?

6.3 Closing questions

65. Are there any ways in which the provisions of the Strategy relating to international cooperation could be improved?

66. Is there anything else you'd like to comment on in relation to international cooperation?

SECTION 7 INFORMATION, RESEARCH AND EVALUATION

Objective 31.1) Improving the EU knowledge infrastructure in the field of drugs and consolidating the drug information systems

I would like to ask you some questions about improving the knowledge base in the field of drugs and consolidating the drug information systems in the EU.

7.1 Main 'top-tier' questions to ask of everyone (approx. 5 mins)

67. Could you provide a brief overview of the policy-relevant data collected in your member state about drugs?

- For example, about treatment demand, problem drug use, rehabilitation and reintegration, drug demand reduction?
- What are the main strengths and weaknesses of the data collected? [accuracy, breadth etc]

68. How much influence do you feel the Strategy has had on the data collected in your MS?

- Please provide examples of any ways in which the Strategy has had influence. PROBE – how have things changed since 2005? Have AP's had an impact on how information is collected and used?

69. In the online survey, a higher proportion of respondents who felt information, research and evaluation had improved since 2005, felt the strategy had been influential in this change (n=80) than those who thought it had not been influential (n=21). How do you feel about these findings? Why do you think respondents felt like this?

70. In your experience, has the exchange of policy-relevant information in the field of illicit drugs by the EMCDDA been useful for your MS?

- Has this always been the case or have there been changes/developments in recent years? IF SO – when, and why? PROBE SINCE 2005, 2009
- In what ways does it help drug policy in your country? And in other countries?

7.2 Specialist questions to ask of those prioritising this aim (approx. 10 mins)

71. Are you aware of any EU initiatives in relation to information, research and evaluation?

- Are these relevant to your MS? Why do you say that?

72. The Action Plan sets out some specific actions in relation to expanding the knowledge base in the field of drugs. If possible, could you give a broad indication about whether or not you feel these actions have been implemented in your MS?

Please remember we are evaluating the effectiveness, implementation and relevance of the EU drugs strategy, rather than MS compliance with it

- Which have been implemented? When would you say this was?
 - And which not? **FOR EACH NOT IMPLEMENTED ASK:**
 - Are there any particular challenges/barriers to implementing this action that you can raise?
 - How might [MS] implement this Action moving forward – what assistance, if any, is needed?
73. The strategy has an aim to “expand the knowledge base in the field of drugs by promoting research”. How have things fared in this regard?
- **IF IMPROVEMENT NOTED** – To what extent would you attribute this change to the DS and AP’s? Have there been any other influences?
 - In what ways? Can you give specific examples? Would I find this in the National Strategy?
 - Has this been evaluated? Would it be possible to access an evaluation report?

7.3 Closing questions

74. Are there any ways in which the provisions of the Strategy relating to information, research and evaluation could be improved?
- What would you change? Why?
75. Is there anything else you’d like to comment on in relation to information, research and evaluation?

SECTION 8: CONCLUSION APPROX. 5 MINS

76. Is there anything else about the implementation, influence and relevance of the EU Drugs Strategy, which you think we should be aware of?
77. Are there any issues which you would like to be taken into account in drafting a future Drugs Strategy?
78. Anything else of importance?

Explain next steps - thank and close

Appendix D: Questions in the EEAS Survey

1. To what extent is cooperation in the field of illicit drugs (law enforcement cooperation, prevention, treatment, harm reduction, data collection, precursors, alternative development, etc) with your country part of the EU policy dialogue and/or external assistance? If cooperation in the drugs area is covered by the NIP/RIP, which are its objectives and amounts?
2. Were you involved in any recent evaluation of drug programmes and/ or projects and if so, what were/are key findings?
3. To what extent are you familiar with the principles, objectives and actions of the EU Drug Strategy 2005-2012 and its implementing EU Drugs Action Plans (2005-2008, 2009-2012)?
4. To what extent do you think EU cooperation in the field of illicit drugs vis-à-vis the country you are assigned to reflects the EU approach to illicit drug policy as laid down in the EU Drugs Strategy and/ or its Drug Action Plans?
 - In particular, have these policy documents and/or their principles been reflected in the programming documents of your country/region?
 - Have they been used in the policy dialogue with the country?
 - Did they have an impact on the preparation and implementation of the external assistance programmes, notably in terms of scope and objectives?
5. Do you think the EU Drugs Strategy has been influential in the formulation of the national drugs strategy of the country you are assigned to (e. g. by fostering principles such as a balanced and integrated approach or as an example of best practice)?
6. To what extent do you believe the objectives and actions of the EU Drugs Strategy/Action Plans – notably of the chapter on international cooperation – have been implemented?
7. How important do you think it is that international cooperation in the field of illicit drugs is part of an overall EU Drugs Policy?
8. Which areas of drug policy do you think would be relevant and/or important for EU assistance and cooperation considering the needs and priorities in the field of illicit drugs vis-à-vis the country/region you are assigned to?

9. Are there any recent trends or developments regarding the situation of illicit drugs in the country you are assigned to and/ or in the region you think may be of future relevance for international cooperation of the EU in the field of drugs?
10. Do you think there is scope for the Commission/ EEAS to improve the information flow on objectives, trends and developments on EU illicit drug policy towards the EU delegations in third countries?
11. Can you provide concrete suggestions that may support the objective to increase the impact of EU interventions in this field in the future?

Appendix E: Findings from EEAS survey

Influence, relevance and implementation of the EU Drug Strategy – the perspective of EU delegations

A survey was sent to EU delegations including 11 questions (see Box a). Information relevant to the research objectives for the assessment of the implementation, relevance and influence of the EU Drugs Strategy and Action Plans 2005-2012, especially with respect to international cooperation, was extracted from these survey responses and analysed, with the sample and findings described below.

Box a: Questions in EEAS survey

1. To what extent is cooperation in the field of illicit drugs (law enforcement cooperation, prevention, treatment, harm reduction, data collection, precursors, alternative development, etc) with your country part of the EU policy dialogue and/or external assistance? If cooperation in the drugs area is covered by the NIP/RIP, which are its objectives and amounts?
2. Were you involved in any recent evaluation of drug programmes and/ or projects and if so, what were/are key findings?
3. To what extent are you familiar with the principles, objectives and actions of the EU Drugs Strategy 2005-2012 and its implementing EU Drugs Action Plans (2005-2008, 2009-2012)?
4. To what extent do you think EU cooperation in the field of illicit drugs vis-à-vis the country you are assigned to reflects the EU approach to illicit drug policy as laid down in the EU Drugs Strategy and/ or its Drug Action Plans?
 - In particular, have these policy documents and/or their principles been reflected in the programming documents of your country/region?
 - Have they been used in the policy dialogue with the country?
 - Did they have an impact on the preparation and implementation of the external assistance programmes, notably in terms of scope and objectives?
5. Do you think the EU Drugs Strategy has been influential in the formulation of the national drugs strategy of the country you are assigned to (e. g. by fostering principles such as a balanced and integrated approach or as an example of best practice)?
6. To what extent do you believe the objectives and actions of the EU Drugs Strategy/Action Plans – notably of the chapter on international cooperation – have been implemented?
7. How important do you think it is that international cooperation in the field of illicit drugs is part of an overall EU Drugs Policy?
8. Which areas of drug policy do you think would be relevant and/or important for EU assistance and cooperation considering the needs and priorities in the field of illicit drugs vis-à-vis the country/region you are assigned to?
9. Are there any recent trends or developments regarding the situation of illicit drugs in the country you are assigned to and/ or in the region you think may be of future relevance for international cooperation of the EU in the field of drugs?
10. Do you think there is scope for the Commission/ EEAS to improve the information flow on objectives, trends and developments on EU illicit drug policy towards the EU delegations in third countries?
11. Can you provide concrete suggestions that may support the objective to increase the impact of EU interventions in this field in the future?

Respondents to the EEAS survey

Responses were received from 30 delegates. As shown in Figure a 11 respondents specifically mentioned that drugs issues were part of the policy area for which they were responsible, seven said they worked in the field of home affairs or security, four mentioned regional or development cooperation as their focus. The remaining 11 said their responsibilities did not relate to drugs (their roles included, for example, governance, economic development, and water policy). Respondents varied in the length of time in which they had been in post. The majority (23) had taken up their post in or since 2008. Eight had been in post before then (one person did not respond about length in post).

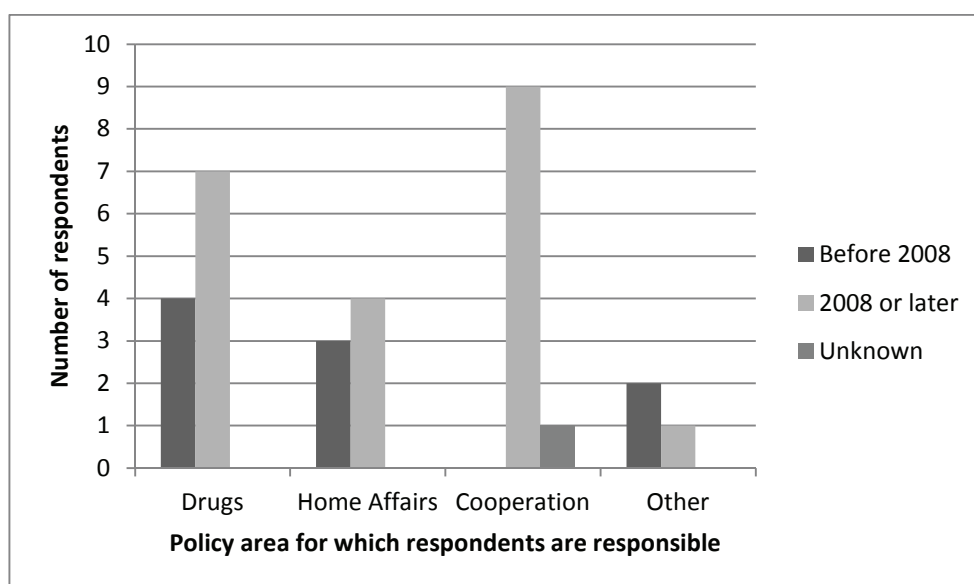


Figure a : Policy areas for which EEAS survey respondents are responsible

Knowledge of the Strategy

Respondents were asked: ‘to what extent are you familiar with the principles, objectives and actions of the EU Drug Strategy 2005-2012 and its implementing EU Drugs Action Plans (2005-2008, 2009-2012)?’

Twenty-seven respondents answered this question. Eight¹ said that they were not familiar with the EU Drug Strategy or Action Plan (of those, two had described their role as specifically involving the policy area of drugs.) One (Gambia) had heard about the Strategy for the first time as a result of this survey.

Of the 18 who had heard of the EU Drug Strategy and Action Plans, six did not report an in-depth knowledge² (one of these respondents had described their role as involving drugs issues). For example, one responded:

Being not directly involved in the management of the drugs-related projects, the main objectives and principles of the EU Drug Strategy were presented by the EU CADAP³ interviewees during the seminar ... (Kazakhstan)

Another responded:

The EU Delegation is familiar with the broad principles of the strategy, as they were presented during the sub-committee, but not with the details. The strategy has not been used as a real tool. However, the approach adopted in our cooperation is fully relevant with the strategy (Morocco)

Twelve respondents from -ten countries reported a more detailed knowledge of the EU Drugs Strategy and Action Plans⁴, for example demonstrating knowledge of content and

¹ Armenia, Chile, Israel, Jordan, Jamaica, Laos, Peru x1, Tajikistan

² Azerbaijan, Bosnia and Herzegovina, Kazakhstan, Kosovo, Morocco, Ukraine,

³ Central Asia Drug Action Programme (CADAP)

provisions or indicating specific priorities which had been identified (Guyana). However, familiarity with the Drugs Strategy and Action Plans did not mean that they thought that it had been implemented, for example:

We are familiar with the EU Drugs Strategy [but] despite its importance at Latin-American regional level we do not implement it (or its actions plans) specifically (Argentina)

Principles, objectives and actions are known to us, as documents are available for consultation. However, no specific training has been carried out with the EU Delegation staff responsible for the subject (Brazil)

Overall, therefore, evidence from these responses indicates that detailed knowledge of the strategy was patchy, even among respondents whose role specifically related to drugs issues.

Influence of the drugs strategy

Delegations were asked: ‘Do you think the EU Drugs Strategy has been influential in the formulation of the national drugs strategy of the country you are assigned to (e. g. by fostering principles such as a balanced and integrated approach or as an example of best practice)?’ The aim was to understand whether the EU Drugs Strategy had been influential in particular in international cooperation activities.

Thirty respondents answered this question. Of these, six⁵ respondents said they did not know, and 11⁶ said it was not influential (giving no further explanation). One (Lebanon) said it was not yet influential, but that “the EU Drugs Strategy could represent a useful roadmap for the formulation of a national strategy...”

Five reported that the EU Drugs Strategy had been directly influential noting a range of influences including that:

- their national Drugs Strategy was ‘inspired by’ the EU Strategy (Bosnia and Herzegovina);
- the EU Drugs Strategy had ‘certainly been ‘influential’ in formulating the national strategy (although it wasn’t clear whether it had been implemented) (Kosovo)
- the national Drugs Strategy had been ‘designed in line’ with the EU Drugs Strategy (Macedonia)
- one respondent listed those elements of the national strategy which were in line with the EU Drugs Strategy (Montenegro)
- there had been a round-table on the EU Drugs Strategy at the time the national strategy was written – so it fed into discussions (the final draft of the national strategy was not available, so the delegate could not see how much from the EU Drugs Strategy had been included) (Kazakhstan)

⁴ Afghanistan, Argentina, Bolivia, Brazil x2, Colombia, Guyana, Kyrgyzstan, Paraguay, Peru x2, Senegal.

⁵ Brazil x2, Gambia, Kyrgyzstan, Laos, Ukraine

⁶ Argentina, Armenia, Jamaica, Jordan, Paraguay, Peru (x3), Tajikistan, Thailand/ Myanmar, Venezuela

Other respondents agreed the EU Drugs Strategy was influential, but made fewer direct links to the EU Drugs Strategy in their responses, for example:

- Three (Afghanistan, Bolivia, Morocco) said that there were no explicit references to the EU Drugs Strategy in national strategies but that they followed the EU approach (the delegate to one of these countries thought that was more an outcome of national debate than EU policy dialogue - Bolivia)
- Two said that a specific element of the EU Drugs Strategy was to be developed (establishing a national monitoring system in Israel and the 'cocaine route programme' in Senegal)
- Respondents in two countries could identify ways in which information about the EU Drugs Strategy was available at the time of drafting national strategies, and to that extent the EU Drugs Strategy was influential (Azerbaijan, Kazakhstan)

Overall, it appears that different respondents interpreted 'influential' in different ways. Some judged the Strategy as influential on the grounds that there were similar principles in the national strategies, others tried to identify some possible causal link between the content of the EU Drugs Strategy and Action Plan and the national strategies of the countries to which they were posted.

Implementation

Information about implementation was obtained from the question: 'To what extent do you believe the objectives and actions of the EU Drugs Strategy/Action Plans – notably of the chapter on international cooperation – have been implemented?'

Four⁷ respondents said they were unable to respond to this question – one of those mentioned that this was because it was difficult for respondents to understand what initiatives were ongoing:

According to my knowledge the coordination mechanism establishing a monitoring of EU drug related assistance given to the third countries has never fully been achieved (Senegal)

Five⁸ said there had been no implementation – only one of these suggested a reason for the lack of implementation: that local growing of coca was 'sensitive', and therefore the work of the EU delegation was 'discrete' (Bolivia).

Among those who identified some implementation, five mentioned 'mini Dublin Groups'⁹. Other respondents mentioned the following mechanisms through which cooperation in the field of drugs was facilitated:

- The Cooperation Programme between Latin America and the European Union on Anti-Drugs Policies COPOLAD (Argentina)

⁷ Chile, Kyrgyzstan, Laos, Senegal

⁸ Armenia, Bolivia, Jordan, Senegal, Tajikistan

⁹ Argentina, Colombia, Jamaica, Lebanon, Venezuela

- Stabilisation and Association (SAA) development relations with EMCDDA and Europol (Bosnia and Herzegovina)
- Southern Caucasus Anti-Drug (SCAD) Regional Assistance Programme, funded by the EU which was said to ‘promote strategies main objectives’ ((Azerbaijan and Kazakhstan)
- UNODC (Brazil and Lebanon)
- Security sector-related cooperation activities under European Neighbourhood Policy (ENP) action plan, aimed at increasing Lebanon's capability to improve border management and fight organised crime, including drug-trafficking.
- Pompidou Group (Lebanon)

Only two¹⁰ respondents made a direct link between cooperation activities and the EU Drugs Strategy and Action Plans. Others said there had been some implementation of cooperation activities, but their responses did not indicate explicit links between these cooperation activities and mechanisms and the EU Drugs Strategy.

Further, even where international cooperation was noted, respondents identified areas for improvement:

Little was done, however, via development cooperation instruments (see above), in terms of cooperation with Member States or discussing the issue of drugs as part CFSP¹¹ efforts (Azerbaijan)

It has been difficult to engage with [country] authorities in some of the EU-LAC¹² cooperation mechanisms, [in part because] the EU has seemed to lack a continuous and coherent policy dialogue with authorities (Venezuela)

However, the level of coordination within the country is still relatively low, which impacts on the overall success of these efforts (Bosnia and Herzegovina)

Overall, therefore, it is not possible to say from these responses whether there was an *association* between the existence of the EU Drugs Strategy and the implementation of international cooperation in the field of drugs. It seems that work with the EMCDDA and other activities in the field of justice and security were also prompts for cooperation, independently of the EU Drugs Strategy.

Relevance

Three questions in the survey are concerned with the relevance of the EU Drugs Strategy and Action Plans. The first is ‘How important do you think it is that international cooperation in the field of illicit drugs is part of an overall EU Drugs Policy?’

All those who responded to this question agreed it was important that international cooperation in the field of illicit drugs should be part of an overall EU Drugs Strategy. In some ways this is not surprising given the positions that they hold. However, several of the

¹⁰ Lebanon, Venezuela

¹¹ Common Foreign and Security Policy

¹² EU-Latin America and Caribbean Summit

respondents described clearly why they thought this was the case. The most commonly mentioned reason was that organised crime did not respect national borders, and the response must be similarly international. The next most commonly mentioned reason for the importance of international cooperation in this field was the impact on Europe¹³ – third countries were producers and transit countries through which drugs are brought into Europe. One delegate advised that as those countries currently identified as key transit routes were already getting considerable support from the EU, so it was important to be aware that traffickers would try to avoid those countries and to find alternative transit routes, and that in this respect the EU should ensure involvement early in those countries which could be seen as attractive alternatives by traffickers (Armenia).

Six respondents supplemented their responses by mentioning country-specific factors which made international cooperation important, for example highlighting the issues of large territory and lengthy borders (Brazil), increasing levels of drug cultivation within the country (Laos, Macedonia) and insufficient resources among national law enforcement agencies (Peru).

Some respondents mentioned less instrumental reasons for the importance of cooperation, for example noting that cooperation in the field of drugs would improve living conditions or internal security in a country:

The connections between drug trafficking and insecurity must also be taken into account, specifically with regard to the production and trafficking of drugs, which undermine security and may promote corruption, crime, terrorism and instability (Azerbaijan)

EU cooperation has been present under the overarching objective of overcoming the armed conflict, in local development and peace building projects (Colombia)

The second question respondents were asked concerning relevance is: ‘To what extent do you think EU cooperation in the field of illicit drugs vis-à-vis the country you are assigned to reflects the EU approach to illicit drug policy as laid down in the EU Drugs Strategy and/ or its Drugs Action Plans?’ This question had three parts, each of which is discussed in turn in this section:

Have these policy documents and/or their principles been reflected in the programming documents of your country/region?

Seven respondents¹⁴ thought that the principles of the EU Drugs Strategy and Action Plans were not reflected in national programming documents. The main reason given for this was that drugs issues were not a priority area for that country. Three respondents¹⁵ said that the principles were not yet reflected, but might be in the future, for example:

Anti-trafficking programmes have not yet been part of the EUD's cooperation ... We will take the EU Drugs Strategy and Action Plans into account when formulating the project identification fiche (Gambia)

¹³ Mentioned by Argentina, Armenia, Kyrgyzstan, Macedonia, Montenegro, Peru, Senegal, Tajikistan, Thailand/ Myanmar, Venezuela.

¹⁴ Azerbaijan, Chile, Laos x2, Morocco, Thailand/ Myanmar, Ukraine,

¹⁵ Gambia, Paraguay, Senegal

Two respondents¹⁶ reported that the EU Drugs Strategy and Action Plans were specifically mentioned, for example:

The current BOMCA¹⁷ and CADAP programmes for Central Asia directly refer to the EU Drug Strategy and Action Plan. Most of efforts and assistance at delegation level have been directed to achieving objectives 16,17, 18 and the corresponding actions 51,52,53, 54, 59 of the current EU Drug Action Plan 2009-2012 (Kyrgyzstan)

Eleven respondents¹⁸ said, to different extents, that the EU Drugs Strategy priorities were reflected in national policy documents but did not describe specific references to the EU Drugs Strategy. For example, one respondent said there was a ‘degree of coherence with EU Drugs policy and Action Plans’ (Bolivia). Others mentioned that the balanced approach was reflected nationally - for example:

The National Strategic Response to Drugs 2008-2012 of [country] is in line with the international policy framework (UN conventions, Council of Europe recommendations, the EU drug strategy, and EMCDDA recommendations) ... It is based on multidisciplinary, integrated and balanced approach, which consolidates measures and interventions directed towards drug supply reduction, as well as drug demand reduction (Montenegro)

Have they been used in the policy dialogue with the country?

Of the 22 respondents who answered, 13 said that the EU Drugs Strategy had played a part in policy dialogue¹⁹, and nine said that it did not.²⁰ Some examples of how it was used are reflected in these quotations include:

in particular introducing drugs issues in policy dialogue with government, research on drugs issues and increased contacts with Member States (Bolivia)

The EU Drugs Strategy and Action Plans along with the Action Plan on drugs between the EU and Central Asian States for 2009-2013 were consulted during the identification and formulation exercise of the new phase 6 of CADAP. The current CADAP implementation team is well acquainted with the basic principles and objectives of the documents (Kyrgyzstan)

One delegate made a distinction between being ‘used’ and ‘discussed’ – whereby by being discussed it was meant that there had been a presentation on the EU Drugs Strategy.

Did they have an impact on the preparation and implementation of the external assistance programmes, notably in terms of scope and objectives?

Twenty one respondents answered this question. A small number (five) reported that the EDUS and Action Plan did not have an impact on external assistance programmes²¹ and

¹⁶ Kyrgyzstan and Venezuela

¹⁷ Border Management Programme in Central Asia

¹⁸ Afghanistan, Bolivia, Brazil x2, Colombia, Guyana, Kosovo, Lebanon, Macedonia, Montenegro, Peru.

¹⁹ Bolivia, Bosnia and Herzegovina, Brazil, Kazakhstan, Kosovo, Kyrgyzstan, Laos x2, Lebanon, Macedonia, Montenegro, Morocco, Paraguay, Peru x2.

²⁰ Afghanistan, Azerbaijan, Chile, Colombia, Peru, Senegal, Thailand/ Myanmar, Ukraine, Venezuela.

²¹ Chile, Laos, Lebanon, Macedonia, Ukraine.

three respondents said that the EU Drugs Strategy and action plans were directly cited or used to draft programmes, ²² for example:

Yes, new identification fiche for SPSP²³ makes reference to EU drugs policy and policy dialogue and coordination with international partners are highlighted (Bolivia)

The majority – eleven respondents – replied that the EU Drugs Strategy and Action Plans had indirect impact.²⁴ This usually meant that external assistance, when it covered drugs issues, was in line with the principles of the EU Drugs Strategy:

The design and elaboration of the Drogastop-project reflected well the EU Drugs strategy 2005-2012, including elements of both supply and demand reduction, as well as drug monitoring (Venezuela)

Recent examples in this regard were the discussion during the EU-Central Asia Horizontal Group on drugs which took place in Brussels in April 2011. The main ... principles and objectives are also implicitly brought up during EU-CA cooperation committees, and notably the JHA subcommittees (Kyrgyzstan)

Overall, drawing on responses to these three sub-questions about the ‘impact’ of the EU Drugs Strategy and Action Plans on national policies, policy dialogue and external assistance it appears that the principles in the EU Drugs Strategy – of a balanced approach and using international cooperation – are widely reflected in all of these domains. In some instances, the priorities and actions as set out in the EU Drugs Strategy appear to have been directly relied upon and brought to bear. More often, though, it might be more appropriate to sum up the responses as confirming that there is coherence between the work of the EU delegations in drugs issues, and the EU Drugs Strategy and Action Plans.

The third question which could be helpful in assessing relevance is: ‘Which areas of drug policy do you think would be relevant and/or important for EU assistance and cooperation considering the needs and priorities in the field of illicit drugs vis-à-vis the country/region you are assigned to?’. Respondents from 25 countries responded to this question.²⁵ Two said that all areas were relevant (Kyrgyzstan, Ukraine), but most respondents listed a range of elements which they considered relevant. These are displayed in Table a, below.

²² Bolivia, Kazakhstan, Peru

²³ Sector Policy Support Programme

²⁴ Afghanistan, Azerbaijan, Colombia, Kosovo, Kyrgyzstan, Montenegro, Morocco, Paraguay, Senegal, Thailand/ Myanmar, Venezuela.

²⁵ Armenia, Chile, Israel, Jordan did not respond.

Table a: Analysis of responses as to areas of drug policy considered relevant and/or important for EU assistance and cooperation

Relevant areas	Number of respondents who mentioned it
Trafficking or transit	7
Alternative livelihoods and economic development in areas of production areas	7
Migration, customs and boarder issues	6
Money laundering, asset seizure or organised crime elements	5
Activities around awareness raising and media campaigns	5
Treatment	5
Development of institutions or support to civil society	5
Supply reduction (generally)	4
Data collection	4
Regional cooperation	4
Law enforcement cooperation	3
Training law enforcement and other criminal justice practitioners and sharing best practice	3
Conflict management	2
Production or precursors	2
Information sharing	2
Demand reduction (generally)	2
Harm reduction	1

The most common area related to the trafficking of drugs, or the transit of drugs, through the country where the delegate was posted. For example:

being one of the main transit countries on the Balkan heroine route, in order to reduce the transit of drugs...to EU countries, the EU should focus on its support to strengthening, via its projects, the ability of country's police, prosecutors, and judges to monitor, arrest, prosecute, and sanction narcotics traffickers

Second most common was steps to ensure that people in third countries, whose livelihoods depend on the cultivation of drugs, were helped to secure alternative sources of income, and that generally, those poor areas where cultivation was common were supported to develop economically in other ways:

Alternative livelihoods in opium growing areas are relevant and complementary to our overall objective of poverty reduction (Laos)

The issue of borders was also mentioned, for example:

A main concern for [my country] are its borders and the fact that it neighbours producer states ... and also states with weak institutions ... somewhat facilitate the entry of drugs... both for internal consumption and for further distribution to both Europe and Africa (Brazil)

Appendix F: Online questionnaire

This appendix sets out the text of the online questionnaire prepared by Ipsos-Mori.

The European Commission has contracted RAND Europe and the Ipsos Social Research Institute to conduct an independent, external evaluation of the 2005-2012 EU Drugs Strategy – adopted by the commission in 2004. The Strategy document as well as the Action Plans can be accessed through the following link:

http://ec.europa.eu/justice/policies/drugs/policies_drugs_intro_en.htm

The aims of this independent evaluation are:

- To assess barriers and facilitators to the implementation of objectives and priorities of the EU Drugs Strategy at EU and MS level
- To assess the relevance, added value and influence of the Strategy with respect to national drugs policy and legislation
- To assess possible impact on the drugs situation in the EU
- To identify key aspects and recommendations for future EU Drugs Strategies.

The evaluators are **not** evaluating Member States' compliance with the EU Drugs Strategy. Throughout the questionnaire, we have used the terminology referred to in the EU Drugs Strategy for consistency.

As part of this evaluation we would like to invite relevant experts and practitioners from each of the EU 27 member states to complete this on-line survey.

The questionnaire will take around 15 - 40 minutes to complete. We would be grateful if you could complete the survey by 26.05.11.

Individual answers will be treated anonymously, will remain confidential to the evaluation team and be used for research purposes only. Information collected in the on-line survey will be used to inform our evaluation and overall findings from the survey will be included in a final report to the Commission.

If you have any technical queries about the survey then please contact Amy Homes at the Ipsos Social Research Institute on +32 26 424 711 or email amy.homes@ipsos.com. If you have questions about the purpose of the survey or the phrasing used in the questionnaire you can get in touch with Deirdre Culley +44 1223 353 329 or email dculley@rand.org.

I. Information about respondents

Q1.1 Which country are you based in?

Several answers possible

1	<input type="checkbox"/>	Austria	19	<input type="checkbox"/>	Latvia
2	<input type="checkbox"/>	Belgium	20	<input type="checkbox"/>	Lithuania
3	<input type="checkbox"/>	Bulgaria	21	<input type="checkbox"/>	Luxemburg
4	<input type="checkbox"/>	Cyprus	22	<input type="checkbox"/>	Malta
5	<input type="checkbox"/>	Czech Republic	23	<input type="checkbox"/>	Netherlands
6	<input type="checkbox"/>	Denmark	24	<input type="checkbox"/>	Poland
7	<input type="checkbox"/>	Estonia	25	<input type="checkbox"/>	Portugal
8	<input type="checkbox"/>	Finland	26	<input type="checkbox"/>	Romania
9	<input type="checkbox"/>	France	27	<input type="checkbox"/>	Slovakia
10	<input type="checkbox"/>	Germany	28	<input type="checkbox"/>	Slovenia
11	<input type="checkbox"/>	Greece	29	<input type="checkbox"/>	Spain
12	<input type="checkbox"/>	Hungary	30	<input type="checkbox"/>	Sweden
13	<input type="checkbox"/>	Ireland	31	<input type="checkbox"/>	United Kingdom
14	<input type="checkbox"/>	Italy	32	<input type="checkbox"/>	Other (please specify)

Q1.2. How would you best describe your organisation?

Several answers possible

1	<input type="checkbox"/>	Law enforcement (police or national criminal intelligence/policing organisations)
2	<input type="checkbox"/>	Criminal justice (for example, courts/prisons/probation service)
3	<input type="checkbox"/>	Health services provider (including prevention, harm reduction and/ or addiction treatment)
4	<input type="checkbox"/>	Social or educational services
5	<input type="checkbox"/>	Border control/customs
6	<input type="checkbox"/>	National government (GO TO Q1.2A)
7	<input type="checkbox"/>	National drugs coordination
8	<input type="checkbox"/>	National liaison officers or national focal points (then if respondents tick this - have drop-downs to tick for Europol, Eurojust, EMCDDA)
9	<input type="checkbox"/>	Academic or/ research institute
10	<input type="checkbox"/>	NGO
11	<input type="checkbox"/>	Other (please specify)

Q1.2a. How would you best describe your national government institution?

Only one answer

1	<input type="checkbox"/>	Ministry of Home Affairs (or equivalent)
2	<input type="checkbox"/>	Ministry of Health (or equivalent)
3	<input type="checkbox"/>	Ministry of Justice (or equivalent)
4	<input type="checkbox"/>	Ministry of Social Affairs (or equivalent)
5	<input type="checkbox"/>	Ministry of Foreign Affairs (or equivalent)
5	<input type="checkbox"/>	Prime Ministers Office (or equivalent)/ Inter-ministerial office
4	<input type="checkbox"/>	Other (please specify)

ASK ALL

Q1.3. What is your current position?

Only one answer

1	<input type="checkbox"/>	Director-General or equivalent
2	<input type="checkbox"/>	Director or equivalent
3	<input type="checkbox"/>	Head of unit or equivalent
4	<input type="checkbox"/>	Other management position (managing less than 6 employees)
5	<input type="checkbox"/>	Desk officer (no management role)
6	<input type="checkbox"/>	Professional/ operational position (not working at desk)
7	<input type="checkbox"/>	Counsellor/ diplomat

ASK ALL

Q1.4. Are you the National Drugs Co-ordinator?

Only one answer

1	<input type="checkbox"/>	Yes
2	<input type="checkbox"/>	No

Q1.5. Which of the following areas of drug policy best describes the focus of your role?

Several answers possible

1	<input type="checkbox"/>	Co-ordination of drug policy
2	<input type="checkbox"/>	Drug demand reduction
3	<input type="checkbox"/>	Drug supply reduction
4	<input type="checkbox"/>	Co-operation with international organisations (e.g. UN) and non-EU countries
5	<input type="checkbox"/>	Information, research and evaluation

Q1.6. Please indicate your main policy level of responsibility:

Several answers possible

1	<input type="checkbox"/>	EU / International co-operation
2	<input type="checkbox"/>	National
3	<input type="checkbox"/>	Local, regional, or other sub-national
4	<input type="checkbox"/>	Other
5	<input type="checkbox"/>	Not applicable

Q1.7. How long have you been in your current job?

Only one answer

1	<input type="checkbox"/>	Less than one year
2	<input type="checkbox"/>	1 year to less than 3 years
3	<input type="checkbox"/>	3 years to less than 5 years
4	<input type="checkbox"/>	5 years or more

Q1.8. How long have you worked in the area of drugs policy and/ or practice?

Only one answer

1	<input type="checkbox"/>	Less than 3 years
2	<input type="checkbox"/>	3 year to less than 7 years
3	<input type="checkbox"/>	7 years to less than 10 years
4	<input type="checkbox"/>	10 years or more

II. Awareness and involvement with the EU Drugs strategy 2005-2012

Q2.1. Which of these statements is most applicable to you?

Several answers possible

1	<input type="checkbox"/>	I was involved in the negotiations at EU level to adopt the EU Drugs Strategy
2	<input type="checkbox"/>	I am involved in implementing objectives of the EU Drugs Strategy
3	<input type="checkbox"/>	I have read the EU Drugs Strategy
4	<input type="checkbox"/>	I have heard of the EU Drugs Strategy but have not read it
5	<input type="checkbox"/>	I have not heard of the EU Drugs Strategy GO TO Q2.3?

Q2.2. Have you participated in discussions or attended any meetings in relation to the adoption of the EU Drugs Strategy in [the member state]....?

Only one answer for each

		Yes	No
1	In your current job	<input type="checkbox"/>	<input type="checkbox"/>
2	In your previous job	<input type="checkbox"/>	<input type="checkbox"/>

Q2.3. To what extent are you familiar with the content of each of the following...?

Only one answer for each

	Very familiar	Fairly familiar	Not very familiar	Not familiar at all	Don't Know
1 The EU Drugs Strategy 2005-12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 The EU Drugs Action Plan for 2009-12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 The EU Drugs Action Plan for 2005-8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q2.4. How involved are you with the European Council's Horizontal Drugs Group?

Several answers possible

1	<input type="checkbox"/>	I do not know what the Horizontal Drugs Group is
2	<input type="checkbox"/>	I am/was a representative to the HDG
3	<input type="checkbox"/>	I have attended meetings of the HDG
4	<input type="checkbox"/>	Some of my colleagues are representatives to the HDG
5	<input type="checkbox"/>	I receive the mailings/ documents of the HDG on a regular basis
6	<input type="checkbox"/>	I am involved in another way (Specify)
7	<input type="checkbox"/>	I have no involvement in the HDG
8	<input type="checkbox"/>	I regularly participate in meetings with National Drugs Coordinators

III. Exploring views towards the EU Drugs Strategy 2005-2012

The key overarching areas of the Strategy are coordination, the policy areas of supply reduction and demand reduction, and the cross-cutting themes of international cooperation, and information, research and evaluation. In this section we would like to ask you some questions about these areas.

Q3.1. Please indicate in which of the following area(s) you could answer questions given your familiarity with and professional involvement in national and EU drugs policy:

Several answers possible

1	<input type="checkbox"/>	Co-ordination between EU Member States
2	<input type="checkbox"/>	Drug demand reduction
3	<input type="checkbox"/>	Drug supply reduction
4	<input type="checkbox"/>	Co-operation with international organisations (e.g. UN) and non-EU countries
5	<input type="checkbox"/>	Information, research and evaluation

Co-ordination

In this section we would like to ask questions about the area of Co-ordination in the EU Drugs Strategy, including the role of the Horizontal Drugs Group. The relevant objectives are outlined in paragraphs 18, 20 and 21 of the EU drugs strategy.

Q3.2. To what extent do you agree or disagree with each of the following statements about the Horizontal Drug Group? The HDG has...

One answer for each

		Strongly agree	Agree	Disagree	Strongly disagree	Don't Know
1	succeeded in functioning as the main coordination body on drugs policy at EU-level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	prepared clear and coherent drugs policy for adoption by the council	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	been effective in ensuring the implementation of the EU Drugs Strategy and Action Plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	effectively co-ordinated drugs policy at the EU level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	monitored, and where necessary, chased up drug-related activities in all other relevant bodies of the EU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	improved communication within the Council on drug-related matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	been proactive in identifying new gaps in and challenges to drugs policy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	been responsible for launching new initiatives in the field of drugs policy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	added value to coordination in EU drugs policy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	been effective in preparing EU common positions on the external relation elements of EU drugs policy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Been effective in preparing and coordinating EU positions towards the Commission on Narcotic Drugs (CND)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q3.3 The HDG needs to be kept informed of relevant developments at a national level and of activities carried out by other relevant Council working groups. In your opinion, how informed have the following actors, council working groups, EU institutions and EU agencies kept the HDG?

		Very informed	Fairly informed	Not very informed	Not at all informed	Don't Know
1	The member states participating in the HDG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	The Customs Cooperation Working Party	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	The Law Enforcement Working Party (former Police Cooperation Working Party)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	The Multidisciplinary Group on Organised Crime (MDG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	The Working Party on Public Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	The Standing Committee on Operational Cooperation on Internal Security (COSI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	The JAI-RELEX Working Party (JAIEX)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	The European Commission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	EMCDDA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Europol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Demand Reduction

In this section we would like to ask you some questions about the priority area of Demand Reduction outlined in paragraph 25 of the EU Drugs Strategy.

Q3.4 Please indicate in which of the following area(s) you could answer questions given your familiarity with and professional involvement in national and EU drugs policy:

Several answers possible

1	<input type="checkbox"/>	Prevention programmes
2	<input type="checkbox"/>	Targeted and diversified treatment programmes
3	<input type="checkbox"/>	The prevention and treatment of infections, diseases and related health and social damage
4	<input type="checkbox"/>	I do not want to answer any questions on Demand Reduction [move to the next section]

The next few questions focus on the effectiveness of drug prevention programmes (including early risk factors, detection, targeted prevention and family/community-based prevention). This objective is outlined in paragraph 25.1 of the EU drugs strategy.

Q3.5. In your opinion, how has the **effectiveness of the following drug prevention types** changed in [the member state] since 2005? Effective prevention concerns evaluated, evidence-based prevention programmes and interventions that have demonstrated significant positive outcomes in terms of achieving their objectives.

Only one answer

	Prevention type	It has improved	It has stayed the same	It has got worse	Don't know/ No opinion
1	Universal prevention (targeting overall populations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Selective prevention (targeting vulnerable groups)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Indicated prevention (targeting high risk individuals)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Overall situation regarding effectiveness of prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF 'it has improved' or 'it has got worse'

Q3.6 In your opinion, the overall situation regarding the **effectiveness of drug prevention programmes** has [improved/got worse] in [the member state]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.7. In your view which, if any, of the following are the main facilitators to improving the **effectiveness of drug prevention programmes**?

Several answers possible

1	<input type="checkbox"/>	Allocation of financial resources for improving the effectiveness of drug prevention programmes
2	<input type="checkbox"/>	Allocation of financial resources for the evaluation of drug prevention programmes
3	<input type="checkbox"/>	Inclusion of the aim to improve the effectiveness of drug prevention programmes in national strategies
4	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting the improvement of the effectiveness of drug prevention programmes
7	<input type="checkbox"/>	The effort and work of the HDG in promoting effective drug prevention programmes
8	<input type="checkbox"/>	Strong public support for improving the effectiveness of drug prevention programmes in [the member state]
9	<input type="checkbox"/>	Strong political support for improving the effectiveness of drug prevention programmes in [the member state]
10	<input type="checkbox"/>	Strong support for improving the effectiveness of drug prevention programmes by local and regional officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Strong support from professionals for improving the effectiveness of drug prevention programmes in [the member state]
12	<input type="checkbox"/>	New or existing evidence regarding the improvement of the effectiveness of drug prevention programmes from the scientific community
13	<input type="checkbox"/>	New trends in drug use calling for improvement of the effectiveness of drug prevention programmes in [the member state]
14	<input type="checkbox"/>	New information and/or data regarding the effectiveness of drug prevention programmes from the EMCDDA
15	<input type="checkbox"/>	Strong support by NGOs for improving the effectiveness drug prevention programmes in [the member state]
16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of improving the effectiveness of drug prevention programmes
17	<input type="checkbox"/>	Pressure from third countries and international organisations (such as CoE (Pompidou Group), UNODC, WHO, INCB) in support of improving the effectiveness of drug prevention programmes
18	<input type="checkbox"/>	International law or international conventions enabling the provision of improving the effectiveness of treatment programmes
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.8. In your view which, if any, of the following are the main barriers to improving the effectiveness of drug prevention programmes?

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources for improving the effectiveness of drug prevention programmes
2	<input type="checkbox"/>	Lack of financial resources for the evaluation of drug prevention programmes
3	<input type="checkbox"/>	Lack of inclusion of the aim to improve the effectiveness of drug prevention programmes in national strategies
4	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and Action Plans
5	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with the improvement of the effectiveness of drug prevention programmes
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting effective drug prevention programmes
8	<input type="checkbox"/>	Lack of public support for improving the effectiveness of drug prevention programmes in [the member state]
9	<input type="checkbox"/>	Lack of political support for improving the effectiveness of drug prevention programmes in [the member state]
10	<input type="checkbox"/>	Lack of support for improving the effectiveness of drug prevention programmes by local and regional officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of support from professionals for improving the effectiveness of drug prevention programmes in [the member state]
12	<input type="checkbox"/>	Lack of evidence regarding the improvement of the effectiveness of drug prevention programmes from the scientific community
13	<input type="checkbox"/>	Lack of new trends in drug use calling for the improvement of the effectiveness of drug prevention programmes in [the member state].
14	<input type="checkbox"/>	Lack of new information or data regarding the effectiveness of drug prevention programmes from the EMCDDA
15	<input type="checkbox"/>	Lack of support by NGOs for improving the effectiveness drug prevention programmes in [the member state]
16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of improving the effectiveness of drug prevention programmes
17	<input type="checkbox"/>	Pressure from third countries or international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in opposition of improving the effectiveness of drug prevention programmes
18	<input type="checkbox"/>	International law or international conventions in conflict with the provision of improving the effectiveness of treatment programmes
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.9 In your opinion, how important is it to improve the **effectiveness of each of the following types of prevention programmes** for addressing the drugs situation in [the member state]?

Only one answer per category

	Prevention type	Very important	Fairly important	Not very important	Not important at all	Don't Know
1	Improve universal prevention (targeting overall populations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Improve selective prevention (targeting vulnerable groups)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Improve indicated prevention (targeting high risk individuals)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Improve the overall situation regarding effectiveness of prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q3.10 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives on improving the **effectiveness of drug prevention programmes?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

The next few questions focus on access to targeted and diversified treatment programmes, including integrated psychosocial and pharmacological care in [the member state]. These programmes take into account specific needs of drug users according to gender, cultural background, age, etc. This objective is outlined in paragraph 25.3 of the EU drugs strategy.

Q3.11 In your opinion, how has **access to targeted and diversified treatment programmes** changed in [the member state] since 2005?

Only one answer

1	<input type="checkbox"/>	It has improved
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	It has got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse'

Q3.12 In your opinion, the **access to targeted and diversified treatment programmes** has [improved/got worse] in [the member state]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.13 In your view which, if any, of the following are the main facilitators to improving **access to targeted and diversified treatment programmes**?

Several answers possible

1	<input type="checkbox"/>	Allocation of financial resources to improve access to targeted and diversified treatment programmes
2	<input type="checkbox"/>	Allocation of financial resources for the evaluation of access to targeted and diversified treatment programmes
3	<input type="checkbox"/>	Inclusion of improving access to targeted and diversified treatment programmes in national strategies
4	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting the improvement of access to targeted and diversified treatment programmes
7	<input type="checkbox"/>	The effort and work of the HDG in promoting improving access to targeted and diversified treatment programmes
8	<input type="checkbox"/>	Strong public support for improving access to targeted and diversified treatment programmes in [the member state]
9	<input type="checkbox"/>	Strong political support for improving access to targeted and diversified treatment programmes in [the member state]
10	<input type="checkbox"/>	Strong support for improving access to targeted and diversified treatment programmes by local and regional officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Strong support from professionals for improving access to targeted and diversified treatment programmes in [the member state]
12	<input type="checkbox"/>	New or existing evidence regarding the effectiveness of targeted and diversified treatment programmes from the scientific community
13	<input type="checkbox"/>	New client needs for targeted and diversified treatment programmes in [the member state]
14	<input type="checkbox"/>	New information and/or data regarding the effectiveness of targeted and diversified treatment programmes from the EMCDDA
15	<input type="checkbox"/>	Strong support by NGOs for improving access to targeted and diversified treatment programmes in [the member state]
16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of improving access to targeted and diversified treatment programmes
17	<input type="checkbox"/>	Pressure from third countries and international organisations (such as CoE (Pompidou Group), UNODC, WHO, INCB) in support of improving access to targeted and diversified treatment programmes
18	<input type="checkbox"/>	International law or international conventions enabling the provision of improving access to targeted and diversified treatment programmes
19	<input type="checkbox"/>	Don't know

20	<input type="checkbox"/>	Other (please comment)
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Q3.14. In your view which, if any, of the following are the main barriers to improving **access to targeted and diversified treatment programmes**?

1	<input type="checkbox"/>	Lack of financial resources for improving targeted and diversified treatment programmes
2	<input type="checkbox"/>	Lack of financial resources for the evaluation of access to targeted and diversified treatment programmes
3	<input type="checkbox"/>	Lack of inclusion of improving access to targeted and diversified treatment programmes in national strategies
4	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and Action Plans
5	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with the provision of improving access to targeted and diversified treatment programmes
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting improving access to targeted and diversified treatment programmes
8	<input type="checkbox"/>	Lack of public support for improving access to targeted and diversified treatment programmes in [the member state]
9	<input type="checkbox"/>	Lack of political support for improving access to targeted and diversified treatment programmes in [the member state]
10	<input type="checkbox"/>	Lack of support for improving access to targeted and diversified treatment programmes by local and regional officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of support from professionals for improving access to targeted and diversified treatment programmes in [the member state]
12	<input type="checkbox"/>	Lack of evidence regarding effectiveness of, or evidence attesting to the ineffectiveness of, targeted and diversified treatment programmes from the scientific community
13	<input type="checkbox"/>	Lack of client needs for targeted and diversified treatment programmes in [the member state].
14	<input type="checkbox"/>	Lack of new information or data regarding the effectiveness of targeted and diversified treatment programmes from the EMCDDA
15	<input type="checkbox"/>	Lack of support by NGOs for improving the access to targeted and diversified treatment programmes in [the member state]
16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of improving access to targeted and diversified treatment programmes
17	<input type="checkbox"/>	Pressure from third countries or international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in opposition of improving access to targeted and diversified treatment programmes
18	<input type="checkbox"/>	International law or international conventions in conflict with the provision of improving access to targeted and diversified treatment programmes
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.15 How important is it to improve **access to targeted and diversified treatment programmes** for addressing the drugs situation in [the member state]?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.16 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives on improving **access to targeted and diversified treatment programmes?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

The next few questions focus on the availability of services for prevention and treatment of infections, diseases and related health and social damage in [the member state]. This includes prevention of HIV/AIDS and hepatitis. In the remainder of this section, these programmes are referred to as "services for the prevention and treatment of drug related health and social damage." This objective is outlined in paragraph 25.4 of the EU drugs strategy.

Q3.17 In your opinion, how has **access to services for the prevention and treatment of drug related health and social damage** changed in [the member state] since 2005?

Only one answer

1	<input type="checkbox"/>	It has improved
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	It has got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse'

Q3.18 In your opinion, the **access to services for the prevention and treatment of drug related health and social damage** has [improved/got worse] in [the member state]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.19 In your view which, if any, of the following are the main facilitators to improving **access to services for the prevention and treatment of drug related health and social damage (harm reduction)** in [the member state]?

1	<input type="checkbox"/>	Allocation of financial resources for improving access to harm reduction services
2	<input type="checkbox"/>	Allocation of financial resources for the evaluation of access to harm reduction services
3	<input type="checkbox"/>	Inclusion of improving access to harm reduction services in national strategies
4	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting the improvement of access to harm reduction services
7	<input type="checkbox"/>	The effort and work of the HDG in promoting improving access to harm reduction services
8	<input type="checkbox"/>	Strong public support for improving access to harm reduction services in [the member state]
9	<input type="checkbox"/>	Strong political support for improving access to harm reduction services in [the member state]
10	<input type="checkbox"/>	Strong support for improving access to harm reduction services by local and regional officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Strong support from professionals for improving access to harm reduction services in [the member state]
12	<input type="checkbox"/>	New or existing evidence regarding the effectiveness of harm reduction services from the scientific community
13	<input type="checkbox"/>	New client needs for harm reduction services in [the member state]
14	<input type="checkbox"/>	New information and/or data regarding the effectiveness of harm reduction services from the EMCDDA
15	<input type="checkbox"/>	Strong support by NGOs for improving the access to harm reduction services in [the member state]
16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of improving access to harm reduction services
17	<input type="checkbox"/>	Pressure from third countries and international organisations (such as CoE (Pompidou Group), UNODC, WHO, INCB) in support of improving access to harm reduction services
18	<input type="checkbox"/>	International law or international conventions enabling the provision of improving access to harm reduction services
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.20 In your view which, if any, of the following are the main barriers to improving **access to services for the prevention and treatment of drug related health and social damage** in [the member state]?

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources to improve access to harm reduction services
2	<input type="checkbox"/>	Lack of financial resources for the evaluation of access to harm reduction services
3	<input type="checkbox"/>	Lack of inclusion of improving access to harm reduction services in national strategies
4	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and Action Plans
5	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with the provision of improving access to harm reduction services
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting improving access to harm reduction services
8	<input type="checkbox"/>	Lack of public support for improving access to harm reduction services in [the member state]
9	<input type="checkbox"/>	Lack of political support for improving access to harm reduction services in [the member state]
10	<input type="checkbox"/>	Lack of support for improving access to harm reduction services by local and regional officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of support from professionals for improving access to harm reduction services in [the member state]
12	<input type="checkbox"/>	Lack of evidence regarding effectiveness or evidence attesting to the ineffectiveness of harm reduction services from the scientific community
13	<input type="checkbox"/>	Lack of client needs for harm reduction services in [the member state].
14	<input type="checkbox"/>	Lack of new information or data regarding the effectiveness of harm reduction services from the EMCDDA
15	<input type="checkbox"/>	Lack of support by NGOs for improving access to harm reduction services in [the member state]
16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of improving access to harm reduction services
17	<input type="checkbox"/>	Pressure from third countries or international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in opposition of improving access to harm reduction services
18	<input type="checkbox"/>	International law or international conventions in conflict with the provision of improving access to harm reduction services
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.21 How important is it to improve **access to services for the prevention and treatment of drug related health and social damage** for addressing the drugs situation in the [member state]?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.22 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives that help improve the **accessibility of services for the prevention and treatment of drug related health and social damage?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

ASK ALL WHO ANSWERED 1, 2 or 3 IN Q3.4.

Q3.23 In your opinion, how has **the evaluation of the effectiveness of treatment programmes** changed in [the member state] (if at all) since 2005?

Only one answer

1	<input type="checkbox"/>	It has improved
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	It has got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse'

Q3.24 In your opinion, the **evaluation of the effectiveness of treatment programmes** has [improved/got worse] in [the member state]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.25. In your opinion, to what extent have programmes aimed at addressing health-related problems associated with drug use (such as HIV/ AIDS, hepatitis C and other blood borne diseases) become an official part of national public health policies in [the member state] since 2005?

Only one answer

1	<input type="checkbox"/>	Harm reduction programmes have become more recognised in national public health policy
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	Harm reduction programmes used to be more recognised in national public health policies than they are now
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse'

Q3.26; In your opinion, the **integration of drug-related health problems into national health policies** has [improved/got worse] in [the member state]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

IF ANSWER 3 IN Q3.1.

Supply Reduction

Q3.27 *In this section we would like to ask questions about the priority area of Supply Reduction outlined in paragraph 27 of the EU Drugs Strategy. Please indicate in which of the following area(s) you could answer questions given your familiarity with and professional involvement in national and EU drugs policy:*

Several answers possible

1	<input type="checkbox"/>	EU law enforcement co-operation to counter production and trafficking of drugs and precursors
2	<input type="checkbox"/>	The utilisation of existing law enforcement cooperation instruments at EU level
3	<input type="checkbox"/>	The prevention and punishment of the illicit import and export of narcotic drugs and psychotropic substances
4	<input type="checkbox"/>	Enhancing law enforcement, criminal investigation and forensic science co-operation between EU member states that have common interests and/or face the same drug-related problems
5	<input type="checkbox"/>	Intensifying law enforcement efforts towards non-EU countries
6	<input type="checkbox"/>	I do not want to answer any questions on Supply Reduction [move to the next section]

IF ANSWER 1 IN Q3.27.

The next few questions focus on strengthening EU law enforcement co-operation to counter drug production and trafficking (including exchange of best practices, mainstreaming and strategic/operative analyses, sharing intelligence and Joint Investigation Teams). This objective is outlined in paragraph 27.1 of the EU drugs strategy.

Q3.28. In your opinion, since 2005, how has **law enforcement co-operation to counter drug production and trafficking at EU level** changed?

Only one answer

1	<input type="checkbox"/>	It has improved
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	It has got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse'

Q3.29 In your opinion, **EU law enforcement co-operation at an EU level** has [improved/got worse]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.30 In your view which, if any, of the following are the main facilitators to improving **EU law enforcement co-operation at an EU level**?

1	<input type="checkbox"/>	Allocation of financial resources for EU-level law enforcement co-operation
2	<input type="checkbox"/>	Inclusion of EU-level law enforcement co-operation in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting the implementation of EU-level law enforcement co-operation
6	<input type="checkbox"/>	The effort and work of the HDG in promoting EU-level law enforcement co-operation
7	<input type="checkbox"/>	Strong public support for EU-level law enforcement co-operation in [the member state]
8	<input type="checkbox"/>	Strong political support for EU-level law enforcement co-operation in [the member state]
9	<input type="checkbox"/>	Strong support for EU-level law enforcement co-operation by diplomats/ officials/ civil servants in [the member state]
10	<input type="checkbox"/>	Support for EU-level law enforcement co-operation by law enforcement bodies in [member state]
11	<input type="checkbox"/>	Strong support by Europol for EU-level law enforcement co-operation at national level
12	<input type="checkbox"/>	Strong support by Eurojust for EU-level law enforcement co-operation at national level
13	<input type="checkbox"/>	New trends in drug-related organised crime that require EU level cooperation
14	<input type="checkbox"/>	The leadership and/or effort of law enforcement bodies in [member state]
15	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of EU-level law enforcement co-operation
16	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in support of EU-level law enforcement co-operation
17	<input type="checkbox"/>	International law or international conventions enabling EU-level law enforcement co-operation
18	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) in support of EU-level law enforcement co-operation
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.31 In your view which, if any, of the following are the main barriers to improving EU law enforcement co-operation at an EU level?

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources for EU-level law enforcement co-operation
2	<input type="checkbox"/>	Lack of inclusion of EU-level law enforcement co-operation in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) conflicting with EU-level law enforcement co-operation
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with EU-level law enforcement co-operation
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting EU-level law enforcement co-operation
8	<input type="checkbox"/>	Lack of public support for EU-level law enforcement co-operation in [the member state]
9	<input type="checkbox"/>	Lack of political support for EU-level law enforcement co-operation in [the member state]
10	<input type="checkbox"/>	Lack of support for EU-level law enforcement co-operation by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of support for EU-level law enforcement co-operation by law enforcement bodies in [member state]
12	<input type="checkbox"/>	Lack of support by Europol for EU-level law enforcement co-operation at national level
13	<input type="checkbox"/>	Lack of support by Eurojust for EU-level law enforcement co-operation at national level
14	<input type="checkbox"/>	Lack of leadership and/or effort of law enforcement bodies in [member state]
15	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of EU-level law enforcement co-operation
16	<input type="checkbox"/>	Pressure from third countries or international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in opposition of EU-level law enforcement co-operation
17	<input type="checkbox"/>	International law or international conventions in conflict with EU-level law enforcement co-operation
18	<input type="checkbox"/>	Don't know
19	<input type="checkbox"/>	Other (please comment)

Q3.32 How important is it to improve **law enforcement co-operation at EU level** for addressing the drugs situation in [the member state]?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.33 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives on **strengthening law enforcement cooperation at an EU level?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

IF ANSWER 2 IN Q3.27.

The next few questions focus on intensifying effective law enforcement cooperation between Member States using existing instruments and frameworks. This focuses on member states utilising existing law enforcement instruments that exist at EU level to support law enforcement cooperation. This objective is outlined in paragraph 27.2 of the EU drugs strategy.

Q3.34 In your opinion, since 2005, how has the **utilisation** of the following **existing law enforcement cooperation instruments at EU level** changed?

Only one answer per instrument

	Law enforcement cooperation instrument	It has improved	It has stayed the same	It has got worse	Don't know/ No opinion
1	Framework Decision laying down minimum provisions on the constituent elements of criminal acts and penalties in drug trafficking (2004/757/JHA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	The EU legislation on drug precursors for intra-EU trade (Regulations 273/2004 & 1277/ 2005)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	The EU legislation on drug precursors laying down rules on the monitoring of trade between the EU and third countries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Joint Investigation Teams (JIT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Joint Customs Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	European Arrest Warrant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Financial Intelligence Unit (Europol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	EU legislation in the field of Asset Confiscation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Europol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Eurojust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	The overall use of these existing instruments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF OVERALL USE OF THESE INSTRUMENTS ‘it has improved’ or ‘it has got worse’ – (ANSWER 1 or 3 IN Q3.34/9)

Q3.35 In your opinion, **the utilisation of existing EU level law enforcement instruments** has [improved/got worse]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.35 How important is it to fully **utilise existing EU level law enforcement instruments** for tackling drug-related organised crime in [member state]?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.36 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives **to further develop EU level law enforcement instruments**?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

IF ANSWER 3 IN Q3.27.

The next few questions focus on the prevention and punishment of the illicit import and export of narcotic drugs and psychotropic substances, including towards the territories of other member states. This focuses on member states making efforts towards consistency of the standards of prosecution practices across the EU. This objective is outlined in paragraph 27.3 of the EU drugs strategy.

Q3.37 In your opinion, since 2005, how has the **consistency of national prosecuting policies** changed?

Only one answer

1	<input type="checkbox"/>	It has improved
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	It has got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse' – ANSWER 1 & 3 IN Q3.37

Q3.38 In your opinion, **consistency of national prosecuting policies** has [improved/got worse]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.39 How important is it to **align member states national prosecution policies** for addressing the drugs situation in the [member state]?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.40 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives **on the punishment of the illicit importation and exportation of drugs** and the alignment of member states national prosecution policies?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

IF ANSWER 4 IN Q3.27.

The next few questions focus on enhancing law enforcement, criminal investigation and forensic science co-operation between EU member states that have common interests and/or face the same drug-related problems (for example, diversion of precursors, cocaine/heroin/cannabis smuggling, production of synthetic drugs, criminal investigation and forensic science issues).

This may involve member states joining together on a project basis in search of solutions (for example, forming joint investigation teams, setting up intelligence exchange networks such as MAOC-N, training, seminars or conferences.) This objective is outlined in paragraph 27.4 of the EU drugs strategy.

Q3.41 In your opinion, since 2005, how has **co-operation between EU member states that have common interests and/or the same drug related problems** changed?

Only one answer

1	<input type="checkbox"/>	It has improved
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	It has got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse' – ANSWER 1 or 3 IN Q3.41

Q3.42 In your opinion, **co-operation between EU member states that have common interests and/or the same drug related problems** has [improved/got worse]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.43 In your view which, if any, of the following are the main facilitators to improving **co-operation between EU member states that have common interests and/or the same drug related problems**?

1	<input type="checkbox"/>	Allocation of financial resources for co-operation between groups of EU Member States
2	<input type="checkbox"/>	Inclusion of co-operation between groups of EU Member States in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting the implementation of co-operation between groups of EU Member States
6	<input type="checkbox"/>	The effort and work of the HDG in promoting co-operation between groups of EU Member States
7	<input type="checkbox"/>	Strong public support for co-operation between groups of EU Member States in [the member state]
8	<input type="checkbox"/>	Strong political support for co-operation between groups of EU Member States in [the member state]
10	<input type="checkbox"/>	Strong support for co-operation between groups of EU Member States by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Support for co-operation between groups of EU Member States by law enforcement bodies in [member state]
12	<input type="checkbox"/>	Strong support by Europol for co-operation between groups of EU Member States at national level
13	<input type="checkbox"/>	Strong support by Eurojust for co-operation between groups of EU Member States at national level
14	<input type="checkbox"/>	New trends in drug-related organised crime that require EU level cooperation
15	<input type="checkbox"/>	The leadership and/or effort of law enforcement bodies in [member state]

16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of co-operation between groups of EU Member States
17	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in support of co-operation between groups of EU Member States
18	<input type="checkbox"/>	International law or international conventions enabling co-operation between groups of EU Member States
18	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) in support of co-operation between groups of EU Member States
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.44 In your view which, if any, of the following are the main barriers to improving **co-operation between EU member states that have common interests and/or the same drug related problems?**

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources for co-operation between groups of EU Member States
2	<input type="checkbox"/>	Lack of inclusion of co-operation between groups of EU Member States in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) conflicting with co-operation between groups of EU Member States
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with co-operation between groups of EU Member States
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting co-operation between groups of EU Member States
8	<input type="checkbox"/>	Lack of public support for co-operation between groups of EU Member States in [the member state]
9	<input type="checkbox"/>	Lack of political support for co-operation between groups of EU Member States in [the member state]
10	<input type="checkbox"/>	Lack of support for co-operation between groups of EU Member States by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of support for co-operation between groups of EU Member States by law enforcement bodies in [member state]
12	<input type="checkbox"/>	Lack of support by Europol for co-operation between groups of EU Member States at national level
13	<input type="checkbox"/>	Lack of support by Eurojust for co-operation between groups of EU Member States at national level
14	<input type="checkbox"/>	Lack of new trends in drug-related organised crime that requires EU level cooperation
15	<input type="checkbox"/>	Lack of leadership and/or effort of law enforcement bodies in [member state]
16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of co-operation between groups of EU Member States
17	<input type="checkbox"/>	Pressure from third countries or international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in opposition of co-operation between groups of EU Member States
18	<input type="checkbox"/>	International law or international conventions in conflict with co-operation between groups of EU Member States
19	<input type="checkbox"/>	Don't know

20	<input type="checkbox"/>	Other (please comment)
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Q3.45 How important is it to improve **co-operation between EU member states that have common interests and/or the same drug related problems** for addressing the drugs situation in the [member state]?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.46 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives **enhancing co-operation between EU member states that have common interests and/or the same drug related problems?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

IF ANSWER 5 IN Q3.27.

The next few questions focus on intensifying law enforcement efforts directed at non-EU countries (especially producer countries and regions along trafficking routes). This may involve law enforcement and customs authorities improving the checks on their respective territories; national controls complementing the measures taken at the external borders of the EU and/or increased partnership working between customs and other law enforcement services working together across member states. This objective is outlined in paragraph 27.5 of the EU drugs strategy.

Q3.47 In your opinion, since 2005, how have **law enforcement efforts directed at non-EU countries** changed in general?

Only one answer

1	<input type="checkbox"/>	They have improved
2	<input type="checkbox"/>	They have stayed the same
3	<input type="checkbox"/>	They have got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse' – ANSWER 1 or 3 IN Q3.47

Q3.48; In your opinion, **law enforcement efforts directed at non-EU countries** have [improved/got worse]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.49 In your view which, if any, of the following are the main facilitators to improving **law enforcement efforts directed at non-EU countries**?

1	<input type="checkbox"/>	Allocation of financial resources for law enforcement efforts directed at non-EU countries
2	<input type="checkbox"/>	Inclusion of law enforcement efforts directed at non-EU countries in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	EU legislation in the field of drug precursors monitoring the trade between the EU and third countries
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting the implementation of law enforcement efforts directed at non-EU countries
7	<input type="checkbox"/>	The effort and work of the HDG in promoting law enforcement efforts directed at non-EU countries
8	<input type="checkbox"/>	Strong public support for law enforcement efforts directed at non-EU countries in [the member state]
9	<input type="checkbox"/>	Strong political support for law enforcement efforts directed at non-EU countries in [the member state]
10	<input type="checkbox"/>	Strong support for law enforcement efforts directed at non-EU countries by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Support for law enforcement efforts directed at non-EU countries by law enforcement bodies in [member state]
12	<input type="checkbox"/>	Strong support by Europol for law enforcement efforts directed at non-EU countries at national level
13	<input type="checkbox"/>	Strong support by Eurojust for law enforcement efforts directed at non-EU countries at national level
14	<input type="checkbox"/>	New trends in drug-related organised crime that require EU level cooperation
15	<input type="checkbox"/>	The leadership and/or effort of law enforcement bodies in [member state]
16	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of law enforcement efforts directed at non-EU countries
17	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in support of law enforcement efforts directed at non-EU countries
18	<input type="checkbox"/>	International law or international conventions enabling law enforcement efforts directed at non-EU countries
19	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) in support of law enforcement efforts directed at non-EU countries
20	<input type="checkbox"/>	Don't know

21	<input type="checkbox"/>	Other (please comment)
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Q3.50 In your view which, if any, of the following are the main barriers to improving **law enforcement efforts directed at non-EU countries**?

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources for law enforcement efforts directed at non-EU countries
2	<input type="checkbox"/>	Lack of inclusion of law enforcement efforts directed at non-EU countries in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	EU legislation in the field of drug precursors monitoring the trade between the EU and third countries
6	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) conflicting with law enforcement efforts directed at non-EU countries
7	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with law enforcement efforts directed at non-EU countries
8	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting law enforcement efforts directed at non-EU countries
9	<input type="checkbox"/>	Lack of public support for law enforcement efforts directed at non-EU countries in [the member state]
10	<input type="checkbox"/>	Lack of political support for law enforcement efforts directed at non-EU countries in [the member state]
11	<input type="checkbox"/>	Lack of support for law enforcement efforts directed at non-EU countries by diplomats/ officials/ civil servants in [the member state]
12	<input type="checkbox"/>	Lack of support for law enforcement efforts directed at non-EU countries by law enforcement bodies in [member state]
13	<input type="checkbox"/>	Lack of support by Europol for law enforcement efforts directed at non-EU countries at national level
14	<input type="checkbox"/>	Lack of support by Eurojust for law enforcement efforts directed at non-EU countries at national level
15	<input type="checkbox"/>	Lack of new trends in drug-related organised crime that requires EU level cooperation
16	<input type="checkbox"/>	Lack of leadership and/or effort of law enforcement bodies in [member state]
17	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of law enforcement efforts directed at non-EU countries
18	<input type="checkbox"/>	Pressure from third countries or international organisations (such as UNODC, INCB, Dublin Group, Pompidou Group) in opposition of law enforcement efforts directed at non-EU countries
19	<input type="checkbox"/>	International law or international conventions in conflict with law enforcement efforts directed at non-EU countries
20	<input type="checkbox"/>	Don't know
21	<input type="checkbox"/>	Other (please comment)

Q3.51 How important is it to improve **law enforcement efforts directed at non-EU countries (especially drug producer countries and regions along drug trafficking routes)** for addressing the drugs situation in [the member state]?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.52 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives **on intensifying law enforcement efforts directed at non-EU countries?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

IF ANSWER 4 IN Q3.1.

International cooperation

In this section we would like to ask questions about the priority area of International Cooperation, outlined in paragraph 30 of the EU Drugs Strategy.

Q3.53 Please indicate in which of the following area(s) you could answer questions given your familiarity with and professional involvement in national and EU drugs policy:

Several answers possible

1	<input type="checkbox"/>	Co-ordinating effective action by the Union in international organisations - in particular the Commission on Narcotic Drugs (CND)
2	<input type="checkbox"/>	Special efforts to encourage candidate countries and potential candidate countries to adopt the EU drugs acquis and participate in existing structures such as EMCDDA, Europol and Eurojust
3	<input type="checkbox"/>	Assisting third countries and key drug producing and transit countries to be more effective in both drugs demand and drugs supply reduction
4	<input type="checkbox"/>	I do not want to answer any questions on International Co-ordination [move to the next section]

IF ANSWER 1 IN Q3.53.

The next few questions focus on co-ordinating effective and visible action by the Union in international organisations such as the Council of Europe, UNODC, the Dublin Group, the Who and UNAIDS, as well as relations with third countries. This objective is outlined in paragraph 30.1 of the EU drugs strategy.

Q3.54 In your opinion, how has **EU action with the following international organisations** changed since 2005?

Only one answer

	International organisation	It has improved	It has stayed the same	It has got worse	Don't know/ No opinion
1	Effectiveness of EU cooperation within the CND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Visibility of actions of the EU within the CND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Coordination of EU positions during the CND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	EU Cooperation within the Council of Europe (Pompidou Group)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	EU Cooperation within the Dublin Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	EU Cooperation with the INCB in the field of drug precursors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	EU Cooperation with UNODC in the field of drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	EU Cooperation with the WHO in the field of drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	EU Cooperation with UNAIDS in the field of drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Overall EU cooperation and visibility within and towards international organisations since 2005	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF 'it has improved' or 'it has got worse' – ANSWER 1 or 3 IN Q3.54/9

Q3.55 In your opinion, **effective coordination of EU action with international organisations** has [improved/got worse]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.56 In your view which, if any, of the following are the main facilitators to improving **effective coordination of EU action with international organisations?**

1	<input type="checkbox"/>	Allocation of financial resources for EU coordination of action with international organisations
2	<input type="checkbox"/>	Inclusion of EU coordination of action with international organisations in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) towards EU coordination of action with international organisations
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting EU coordination of action with international organisations
7	<input type="checkbox"/>	The effort and work of the HDG to promote EU coordination of action with international organisations
8	<input type="checkbox"/>	Strong public support for EU coordination of action with international organisations in [the member state]
9	<input type="checkbox"/>	Strong political support for EU coordination of action with international organisations in [the member state]
10	<input type="checkbox"/>	Strong support for EU coordination of action with international organisations by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Strong support by NGOs for EU coordination of action with international organisations in [the member state]
12	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of EU coordination of action with international organisations
13	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, WHO, UNAIDS) in support of EU coordination of action with international organisations
14	<input type="checkbox"/>	International law or international conventions enabling EU coordination of action with international organisations
15	<input type="checkbox"/>	Co-operation agreements between the EU and third countries in areas other than drug policy
16	<input type="checkbox"/>	Don't know
17	<input type="checkbox"/>	Other (please comment)

Q3.57 In your view which, if any, of the following are the main barriers to improving effective coordination of EU action with international organisations?

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources for EU coordination of action with international organisations
2	<input type="checkbox"/>	Lack of inclusion of EU coordination of action with international organisations in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) conflicting with EU coordination of action with international organisations
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with EU coordination of action with international organisations
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting EU coordination of action with international organisations
8	<input type="checkbox"/>	Lack of public support for EU coordination of action with international organisations in [the member state]

9	<input type="checkbox"/>	Lack of political support for EU coordination of action with international organisations in [the member state]
10	<input type="checkbox"/>	Lack of support for EU coordination of action with international organisations by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of support by NGOs for EU coordination of action with international organisations in [the member state]
12	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of EU coordination of action with international organisations
13	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, WHO, UNAIDS) in opposition of EU coordination of action with international organisations
14	<input type="checkbox"/>	International law or international conventions enabling EU coordination of action with international organisations
15	<input type="checkbox"/>	Lack of co-operation agreements between the EU and third countries in areas other than drug policy
16	<input type="checkbox"/>	Don't know
17	<input type="checkbox"/>	Other (please comment)

Q3.58 How important is it to improve **coordination of EU action with international organisations** for addressing the drugs situation in [the member state]?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.59 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives improving **EU action with international organisations**?

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

IF ANSWER 2 IN Q3.53.

The next few questions focus on special efforts to encourage candidate countries and potential candidate countries to adopt the EU drugs acquis and participate in existing structures such as EMCDDA, Europol and Eurojust. This objective is outlined in paragraph 30.2 of the EU drugs strategy.

Q3.60 In your opinion, how have the **efforts made by the EU to encourage candidate countries and potential candidate countries to adopt the EU acquis** changed since 2005?

Only one answer

1	<input type="checkbox"/>	They have improved
2	<input type="checkbox"/>	They have stayed the same
3	<input type="checkbox"/>	They have got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse' – ANSWER 1 or 3 IN Q60

Q3.61 In your opinion, the **efforts made by the EU to encourage candidate countries and potential candidate countries to adopt the EU acquis** has [improved/got worse] since 2005. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.62 In your view which, if any, of the following are the main facilitators to improving the **efforts made by the EU to encourage candidate countries and potential candidate countries to adopt the EU acquis?**

Several answers possible

1	<input type="checkbox"/>	Allocation of financial resources for such efforts towards Candidate and Potential Candidate countries
2	<input type="checkbox"/>	Inclusion of such efforts towards Candidate and Potential Candidate countries in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) towards such efforts with Candidate and Potential Candidate countries
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting such efforts towards (potential) candidate countries
7	<input type="checkbox"/>	The effort and work of the HDG to promote such efforts towards (potential) candidate countries
8	<input type="checkbox"/>	Strong public support for such efforts towards (potential) candidate countries in [the member state]
9	<input type="checkbox"/>	Strong political support for such efforts towards (potential) candidate countries in [the member state]
10	<input type="checkbox"/>	Strong support for such efforts towards (potential) candidate countries by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Strong political support for such efforts from Candidate and Potential Candidate Countries
12	<input type="checkbox"/>	Strong financial support for such efforts from Candidate and Potential Candidate Countries
13	<input type="checkbox"/>	The institutional capacity and capability in Candidate and Potential Candidate Countries to accommodate the requirements needed for adoption of the EU acquis
13	<input type="checkbox"/>	Strong support by NGOs for such efforts towards (potential) candidate countries in [the member state]
14	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of such efforts towards (potential) candidate countries
15	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, WHO, UNAIDS) in support of such efforts towards (potential) candidate countries
16	<input type="checkbox"/>	International law or international conventions enabling such efforts towards (potential) candidate countries
17	<input type="checkbox"/>	Don't know
18	<input type="checkbox"/>	Other (please comment)

Q3.63 In your view which, if any, of the following are the main barriers to improving efforts made by the EU to encourage candidate countries and potential candidate countries to adopt the EU acquis?

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources for such efforts towards Candidate and Potential Candidate countries
2	<input type="checkbox"/>	Lack of inclusion of such efforts towards Candidate and Potential Candidate countries in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) conflicting with such efforts towards Candidate and Potential Candidate countries
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with such efforts towards (potential) candidate countries
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting such efforts towards Candidate and Potential Candidate countries
8	<input type="checkbox"/>	Lack of public support for such efforts towards (potential) candidate countries in [the member state]
9	<input type="checkbox"/>	Lack of political support for such efforts towards (potential) candidate countries in [the member state]
10	<input type="checkbox"/>	Lack of support for such efforts towards (potential) candidate countries by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of support for such efforts towards (potential) candidate countries from Candidate and Potential Candidate Countries
12	<input type="checkbox"/>	Limited capacity in Candidate and Potential Candidate Countries to accommodate the requirements needed for adoption of the EU acquis
13	<input type="checkbox"/>	Lack of support by NGOs for such efforts towards (potential) candidate countries in [the member state]
14	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of such efforts towards (potential) candidate countries
15	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, WHO, UNAIDS) in opposition of such efforts towards (potential) candidate countries
16	<input type="checkbox"/>	International law or international conventions enabling such efforts towards (potential) candidate countries
17	<input type="checkbox"/>	Don't know
18	<input type="checkbox"/>	Other (please comment)

Q3.64 How important is it to improve **efforts made by the EU to encourage candidate countries and potential candidate countries to adopt the EU acquis?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.65 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives on improving **efforts by the EU to encourage candidate countries and potential candidate countries to adopt the EU acquis?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

IF ANSWER 3 IN Q3.53.

The next few questions focus on efforts made by the EU to assist third countries and key drug producing and transit countries to be more effective in reducing drug demand and drug supply. This objective is outlined in paragraph 30.3 of the EU drugs strategy. Cooperation may entail activities and technical cooperation supported through the EU funding instruments (e.g. TACIS/ ENP/ Instrument for Stability/ SCAD/ CADAP, etc) and bi- and multilateral cooperation projects.

Q3.66 In your opinion, how have **the co-operation between the EU and third countries** changed since 2005?

Only one answer per area

	Area of international cooperation	It has improved	It has stayed the same	It has got worse	Don't know/ No opinion
1	Law enforcement cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Other cooperation in supply reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Harm reduction cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Other cooperation in field of demand reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Cooperation on alternative development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Cooperation on precursor control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Cooperation on institution and capacity building	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Overall cooperation between the EU and third countries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF 'it has improved' or 'it has got worse' – ANSWER 1 or 3 IN Q3.66/8

Q3.67 In your opinion, **the co-operation between the EU and third countries** have [improved/got worse] since 2005. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.68 In your view which, if any, of the following are the main facilitators to improving **co-operation between the EU and third countries?**

Several answers possible

1	<input type="checkbox"/>	Allocation of financial resources at EU level for co-operation between the EU and third countries
2	<input type="checkbox"/>	Inclusion of co-operation between the EU and third countries in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) towards co-operation between the EU and third countries
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy supporting co-operation between the EU and third countries
7	<input type="checkbox"/>	The effort and work of the HDG to promote co-operation between the EU and third countries
8	<input type="checkbox"/>	Strong public support for co-operation between the EU and third countries in [the member state]
9	<input type="checkbox"/>	Strong political support for co-operation between the EU and third countries in [the member state]
10	<input type="checkbox"/>	Strong support for co-operation between the EU and third countries by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Strong support by NGOs for co-operation between the EU and third countries in [the member state]
12	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of co-operation between the EU and third countries
13	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, WHO, UNAIDS) in support of co-operation between the EU and third countries
14	<input type="checkbox"/>	International law or international conventions enabling co-operation between the EU and third countries
15	<input type="checkbox"/>	Co-operation between the EU and third countries in areas other than drug policy
16	<input type="checkbox"/>	Don't know
17	<input type="checkbox"/>	Other (please comment)

Q3.69 In your view which, if any, of the following are the main barriers to improving **co-operation between the EU and third countries?**

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources at EU level for co-operation between the EU and third countries
2	<input type="checkbox"/>	Lack of inclusion of co-operation between the EU and third countries in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Non-EU initiatives and programmes (e.g. bilateral collaboration with third countries) conflicting with co-operation between the EU and third countries
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy conflicting with co-operation between the EU and third countries
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting co-operation between the EU and third countries

8	<input type="checkbox"/>	Lack of public support for co-operation between the EU and third countries in [the member state]
9	<input type="checkbox"/>	Lack of political support for co-operation between the EU and third countries in [the member state]
10	<input type="checkbox"/>	Lack of support for co-operation between the EU and third countries by diplomats/ officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of support by NGOs for co-operation between the EU and third countries in [the member state]
12	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of co-operation agreements between the EU and third countries
13	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, INCB, WHO, UNAIDS) in opposition of co-operation between the EU and third countries
14	<input type="checkbox"/>	International law or international conventions enabling co-operation between the EU and third countries
15	<input type="checkbox"/>	Lack of co-operation between the EU and third countries in areas other than drug policy
16	<input type="checkbox"/>	Don't know
17	<input type="checkbox"/>	Other (please comment)

Q3.70 How important is it to improve **co-operation between the EU and third countries?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.71 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives on **drug-related co-operation between the EU and third countries?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

IF ANSWER 5 IN Q3.1.

Information, research and evaluation

In this section we would like to ask questions about the priority area of information and research in the field of drugs, outlined in 31 of the EU Drugs Strategy.

The next few questions focus on expanding the knowledge base in the field of drugs by promoting research. This would involve including drug-related priority themes in the EU Research Framework Programme as well as in national research programmes, creating networks of excellence in drugs research, and in particular, and making full use of the research capacity of the Pompidou Group at the Council of Europe.

Q3.72 In your opinion, has **the promotion of research in the field of drugs** changed since 2005 in (the member state)?

Only one answer

1	<input type="checkbox"/>	It has improved
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	It has got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse' – ANSWER 1 or 3 IN Q3.72

Q3.73 In your opinion, **the promotion of research in the field of drugs** has [improved/got worse] since 2005 in [the member state]. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.74 In your view which, if any, of the following are the main facilitators to expanding **the knowledge base in the field of drugs by promoting research?**

1	<input type="checkbox"/>	Allocation of financial resources for research in the field of drugs at the member state level
2	<input type="checkbox"/>	Inclusion of research in the field of drugs in national strategies
3	<input type="checkbox"/>	EU level research initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Initiatives and programmes for research in the field of drugs conducted/or funded outside the EU
6	<input type="checkbox"/>	EU research initiatives, policies or programmes in areas other than drugs policy
7	<input type="checkbox"/>	The effort and work of the HDG to promote research in the field of drugs
8	<input type="checkbox"/>	Strong public support for research in the field of drugs in [the member state]
9	<input type="checkbox"/>	Strong political support for research in the field of drugs in [the member state]
10	<input type="checkbox"/>	Strong support for research in the field of drugs by officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Policy initiatives initiated by the European Commission supporting research in the field of drugs
12	<input type="checkbox"/>	Research initiatives funded by the European Commission supporting research in the field of drugs
13	<input type="checkbox"/>	Allocation of financial resources for research in the field of drugs at the EU level
14	<input type="checkbox"/>	Information regarding research cooperation at an EU level in the field of drugs from the EMCDDA
15	<input type="checkbox"/>	Investment in consistent and coherent data collection efforts contributing to research efforts at national and EU level
16	<input type="checkbox"/>	Strong support by NGOs for research in the field of drugs in [the member state]
17	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of research in the field of drugs
18	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, Council of Europe, WHO or UNAIDS) in support of research in the field of drugs
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.75 In your view which, if any, of the following are the main barriers to expanding **the knowledge base in the field of drugs by promoting research?**

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources for research in the field of drugs at the member state level
2	<input type="checkbox"/>	Lack of inclusion of research in the field of drugs in national strategies
3	<input type="checkbox"/>	EU level research initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Lack of initiatives and programmes for research in the field of drugs conducted/funded outside the EU
6	<input type="checkbox"/>	EU research initiatives, policies or programmes in areas other than drugs policy
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting research in the field of drugs
8	<input type="checkbox"/>	Lack of public support for research in the field of drugs in [the member state]
9	<input type="checkbox"/>	Lack of political support for research in the field of drugs in [the member state]
10	<input type="checkbox"/>	Lack of support for research in the field of drugs by officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of policy initiatives initiated by the European Commission supporting research in the field of drugs
12	<input type="checkbox"/>	Lack of research initiatives funded by the European Commission supporting research in the field of drugs
13	<input type="checkbox"/>	Lack of financial resources for research in the field of drugs at the EU level
14	<input type="checkbox"/>	Lack of information regarding research in the field of drugs from the EMCDDA
15	<input type="checkbox"/>	Lack of investment in consistent and coherent data collection efforts contributing to research efforts at national and EU level
16	<input type="checkbox"/>	Lack of support by NGOs for research in the field of drugs in [the member state]
17	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of research in the field of drugs
18	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, Council of Europe, WHO or UNAIDS) in opposition of research in the field of drugs
19	<input type="checkbox"/>	Don't know
20	<input type="checkbox"/>	Other (please comment)

Q3.76 How important is it to expand **the knowledge base in the field of drugs by promoting research?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.77 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives of **expanding the knowledge base in the field of drugs by promoting research?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

The next few questions focus on the exchange of accurate and policy relevant information in the field of illicit drugs. This includes providing reliable data related to the key epidemiological indicators on the drug situation at EU level and on emerging trends and patterns of drug use and drug markets. Much of this information exchange takes place through the EMCDDA and its network of National Focal Points (NFP).

Q3.78 In your opinion, how has **exchange of accurate and policy-relevant information in the field of illicit drugs** changed since 2005?

Only one answer

1	<input type="checkbox"/>	It has improved
2	<input type="checkbox"/>	It has stayed the same
3	<input type="checkbox"/>	It has got worse
4	<input type="checkbox"/>	Don't know/ No opinion

IF 'it has improved' or 'it has got worse' – ANSWER 1 or 3 IN Q3.78

Q3.79 In your opinion, the **exchange of accurate and policy-relevant information in the field of illicit drugs** has [improved/got worse] since 2005. To what extent do you feel the EU Drugs Strategy has influenced this change?

Only one answer

1	<input type="checkbox"/>	The strategy and its action plans were very influential
2	<input type="checkbox"/>	The strategy and its action plans were fairly influential
3	<input type="checkbox"/>	The strategy and its action plans were not very influential
4	<input type="checkbox"/>	The strategy and its action plans were not at all influential
5	<input type="checkbox"/>	Don't Know/ No opinion

Q3.80 In your view which, if any, of the following are the main facilitators to improving the **exchange of accurate and policy-relevant information in the field of illicit drugs**?

1	<input type="checkbox"/>	Allocation of financial resources for exchange of accurate and policy-relevant information in the field of illicit drugs at the member state level
2	<input type="checkbox"/>	Inclusion of exchange of accurate and policy-relevant information in the field of illicit drugs in national strategies
3	<input type="checkbox"/>	EU level research initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Initiatives and programmes for exchange of accurate and policy-relevant information in the field of illicit drugs conducted/funded outside the EU
6	<input type="checkbox"/>	EU initiatives, policies or programmes in areas other than drugs policy
7	<input type="checkbox"/>	The effort and work of the HDG to promote exchange of accurate and policy-relevant information in the field of illicit drugs
8	<input type="checkbox"/>	Strong public support for exchange of accurate and policy-relevant information in the field of illicit drugs in [the member state]
9	<input type="checkbox"/>	Strong political support for exchange of accurate and policy-relevant information in the field of illicit drugs in [the member state]
10	<input type="checkbox"/>	Strong support for exchange of accurate and policy-relevant information in the field of illicit drugs by officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Policy initiatives initiated by the European Commission supporting exchange of accurate and policy-relevant information in the field of illicit drugs
12	<input type="checkbox"/>	Research initiatives funded by the European Commission supporting exchange of accurate and policy-relevant information in the field of illicit drugs
13	<input type="checkbox"/>	Allocation of financial resources for exchange of accurate and policy-relevant information in the field of illicit drugs at the EU level
14	<input type="checkbox"/>	Information regarding the exchange of accurate and policy-relevant information in the field of illicit drugs at the EU level from the EMCDDA
15	<input type="checkbox"/>	Allocation of adequate resources for the Reitox National Focal Point at national level
16	<input type="checkbox"/>	Investment in exchange of accurate and policy-relevant information in the field of illicit drugs at national level to support the work of the Reitox National Focal Point and the EMCDDA
17	<input type="checkbox"/>	Strong support by NGOs for exchange of accurate and policy-relevant information in the field of illicit drugs in [the member state]
18	<input type="checkbox"/>	Pressure from specific (groups of) Member States in support of exchange of accurate and policy-relevant information in the field of illicit drugs
19	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, Council of Europe, WHO or UNAIDS) in support of exchange of accurate and policy-relevant information in the field of illicit drugs
20	<input type="checkbox"/>	Don't know
21	<input type="checkbox"/>	Other (please comment)

Q3.81 In your view which, if any, of the following are the main barriers to improving the exchange of accurate and policy-relevant information in the field of illicit drugs?

Several answers possible

1	<input type="checkbox"/>	Lack of financial resources for exchange of accurate and policy-relevant information in the field of illicit drugs at the member state level
2	<input type="checkbox"/>	Lack of inclusion of exchange of accurate and policy-relevant information in the field of illicit drugs in national strategies
3	<input type="checkbox"/>	EU level initiatives other than those under the EU Drugs Strategy 2005 -12 and its Action Plans
4	<input type="checkbox"/>	The EU Drugs Strategy 2005 -12 and its Action Plans
5	<input type="checkbox"/>	Lack of initiatives and programmes for exchange of accurate and policy-relevant information in the field of illicit drugs conducted/funded outside the EU
6	<input type="checkbox"/>	EU research initiatives, policies or programmes in areas other than drugs policy
7	<input type="checkbox"/>	Lack of prioritisation in the work of the HDG in promoting exchange of accurate and policy-relevant information in the field of illicit drugs
8	<input type="checkbox"/>	Lack of public support for exchange of accurate and policy-relevant information in the field of illicit drugs in [the member state]
9	<input type="checkbox"/>	Lack of political support for exchange of accurate and policy-relevant information in the field of illicit drugs in [the member state]
10	<input type="checkbox"/>	Lack of support for exchange of accurate and policy-relevant information in the field of illicit drugs by officials/ civil servants in [the member state]
11	<input type="checkbox"/>	Lack of policy initiatives initiated by the European Commission supporting exchange of accurate and policy-relevant information in the field of illicit drugs
12	<input type="checkbox"/>	Lack of research initiatives funded by the European Commission supporting exchange of accurate and policy-relevant information in the field of illicit drugs
13	<input type="checkbox"/>	Lack of financial resources for exchange of accurate and policy-relevant information in the field of illicit drugs at the EU level
14	<input type="checkbox"/>	Lack of information regarding exchange of accurate and policy-relevant information in the field of illicit drugs from the EMCDDA
15	<input type="checkbox"/>	Lack of allocation of adequate resources for the Reitox National Focal Point at national level
16	<input type="checkbox"/>	Lack of investment in consistent and coherent data collection efforts at national level to support the work of the Reitox National Focal Point and the EMCDDA
17	<input type="checkbox"/>	Lack of support by NGOs for exchange of accurate and policy-relevant information in the field of illicit drugs in [the member state]
18	<input type="checkbox"/>	Pressure from specific (groups of) Member States in opposition of exchange of accurate and policy-relevant information in the field of illicit drugs
19	<input type="checkbox"/>	Pressure from third countries and international organisations (such as UNODC, Council of Europe, WHO or UNAIDS) in opposition of exchange of accurate and policy-relevant information in the field of illicit drugs
20	<input type="checkbox"/>	Don't know
21	<input type="checkbox"/>	Other (please comment)

Q3.82 How important is it to improve the **exchange of accurate and policy-relevant information in the field of illicit drugs?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

Q3.83 In your opinion, how important do you think it is that the next EU Drugs Strategy should include objectives **on the exchange of accurate and policy-relevant information in the field of illicit drugs?**

Only one answer

1	<input type="checkbox"/>	Very important
2	<input type="checkbox"/>	Fairly important
3	<input type="checkbox"/>	Not very important
4	<input type="checkbox"/>	Not important at all
5	<input type="checkbox"/>	Don't Know

ASK ALL.

IV. General questions on [the member state's] national strategy and the EU Drugs Strategy

This final section includes questions on [the member state's] national drug strategy as well as some more general questions to explore your views towards the EU Drugs Strategy.

ASK ALL.

Q4.1 Would you say the current national strategy in [the member state] places more of a focus on...?

Only one answer

1	<input type="checkbox"/>	Drug demand reduction
2	<input type="checkbox"/>	Drug supply reduction
3	<input type="checkbox"/>	Equal emphasis
4	<input type="checkbox"/>	Do not know

Q4.2 Does [the member state]'s national drug strategy make explicit reference to the EU Drugs Strategy?

Only one answer

1	<input type="checkbox"/>	Yes
2	<input type="checkbox"/>	No
5	<input type="checkbox"/>	Don't know

Q4.3 How important a role do you think the EU currently plays in each of these areas?

Only one answer for each

		Very important	Fairly important	Not very important	Not important at all	Don't Know
1	Improving EU co-ordination, co-operation and raising public awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Improving effectiveness of drug demand reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Improving effectiveness of drug supply reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Improving international co-operation (potential) candidate countries and third countries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Improving aspects related to information, research and evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q4.4 How important a role do you think the EU should play in each of these areas?

Only one answer for each

		Very important	Fairly important	Not very important	Not important at all	Don't Know
1	Improving EU co-ordination, co-operation and raising public awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Improving effectiveness of drug demand reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Improving effectiveness of drug supply reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Improving international co-operation (potential) candidate countries and third countries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Improving aspects related to information, research and evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q4.5 *The section stage of the evaluation will involve the selection of several case study countries where in depth interviews will be conducted with relevant experts and practitioners.*

If your member state is selected as a case study country, are you willing to be recontacted by Ipsos for the next stage of the research?

Only one answer

1	<input type="checkbox"/>	Yes
2	<input type="checkbox"/>	No

Appendix G: Case study objectives for implementation: data summary tables

Case study objective 18	
Priority defined in Drugs Strategy	EU-level coordination of drugs policy through the HDG
Defined in Action Plan	Objective 2: Ensure effective coordination at EU level; Action 2: The Council's Horizontal Drugs Group (HDG), as the working group with leading and steering responsibility for drugs in the Council, should pro-actively coordinate EU drug policy. The HDG should identify specific areas of work in other Council working groups and work towards effective coordination
Recommendation in AP Evaluation	The evaluation concluded that the HDG was indeed the main drug coordinating body at the EU-level. It noted, nevertheless, that its work can be improved by clearer agenda-setting efforts and by improving communication across policy fields. To that end, the evaluation recommended enhancing the role of National Drug Coordinators and bringing it into line with the work of the HDG. On a related note, it suggested that it be assessed to what degree Member States' policies are consistent with the EU Action Plan (EC 2008b, p.87).
Evidence of Implementation	
EU level (EMCDDA, Progress Report)	The 2010 Progress Review largely echoed the findings of the Action Plan evaluation two years earlier. It found the HDG to be the main EU-level coordinating body and observed that occasional uncertainties arise regarding its role, particularly as a result of the involvement of other Council working parties.
MS level (National Strategy)	National strategies and policy documents of the case study countries generally mention the need for international or European coordination of drug policies and on occasions refer to the EU Drugs Strategy in that aspect; however, as a rule of thumb, there is no reference to the HDG. An exception is the French Strategy, which suggests raising the HDG's profile: "Seize the opportunity of the French presidency and the renegotiation of the European Union drug action plan, in close collaboration with the Czech and Swedish presidencies that will succeed to France, to reinforce intra-European coordination and the status of the horizontal drug Group." (FRA, p.78) Also, the Spanish national plan for combating cocaine 2007-2010 (Programa de Actuacion Frente a la Cocaina) lists the HDG as an example of a body suitable for coordination and cooperation: ""El problema de las drogas no se centra en un país ni en un grupo de países, y ningún Gobierno puede pretender hacer frente por sí mismo a este problema. Son múltiples los foros internacionales, como la Organización de Naciones Unidas para la Droga y el Delito (ONUDD), el Grupo Horizontal Drogas de la Unión Europea, o el Grupo Pompidou del Consejo de Europa, donde se puede cooperar para enfrentarlo." (p.21)
MS level (Other national documents, our data)	National Focal Points and national evaluations report on occasional instances of successful coordination efforts within the EU. However, as above, the HDG is not usually included. An exception to this trend is, for instance, the Czech Focal Point, which observed and reported on the work of Czech officials in the HDG during the Czech Council presidency in 2009.

Case study objective 25.3	
Priority defined in Drugs Strategy	Improving access to targeted and diversified treatment
Defined in Action Plan	Objective 7: Enhance the effectiveness of drug treatment and rehabilitation by improving the availability, accessibility and quality of services; Objective 8: Enhance the quality and effectiveness of drug demand reduction activities, taking account of specific needs of drug users according to gender, cultural background, age, etc.
Recommendation in AP Evaluation	Final evaluation of the 2005-2008 Action Plan concluded that in general, EU Member States offered a variety of treatment programmes, including drug-free treatment, psychosocial treatment and substitution treatment, and were increasingly adopting guidelines for them. At the same time, evaluation recommended devoting more attention to non-traditional problem drug use, which might require different treatment programmes (EC 2008b, p.87).
Evidence of Implementation	
EU level (EMCDDA, Progress Report)	According to the EMCDDA 2011 Trend report, availability of and access to drug treatment has improved in recent years (EMCDDA 2011, p. 53). Indeed, the EMCDDA notes that there seems to have been a moderate shift during the 2004 to 2009 period, from the use of universal prevention targeting the whole population towards more focused models. Nevertheless, they note, universal prevention approaches still tend to be characterised by interventions which may stimulate public attention and influence debates, but that are not grounded in scientific evidence that they can prevent drug use. In spite of an increased interest in selective prevention approaches by Member States this does not yet appear to have been translated into a significant increase in investment in interventions targeting the most vulnerable groups. Indicated prevention interventions are beginning to gain ground in a few European countries, although the potential for this kind of approach to reduce the impact of neuro-behavioural factors relevant to drug taking behaviours is still largely unexplored. It is therefore hard to avoid the conclusion that, despite some positive examples of innovative programmes, the data available suggest that the objective of encouraging a greater uptake of prevention approaches with a stronger evidence base for effectiveness does not appear to have been significantly achieved (EMCDDA 2005-2012).
MS level (National Strategy)	The EU Drugs Strategy exemplar objective translates invariably into official policy documents in individual Member States. To illustrate, the French Strategy calls, among others, for “increases in capacities for the accommodation of dependent persons, through a partnership between addiction care, welfare and prevention centres and the social accommodation system, and also through the development of new therapeutic communities.” Similarly, the European objective 25.3 is an inherent part of the Romanian Strategy, which aims to give “the drug users’ access to harm reduction services, by promoting and developing adequate programmes and policies necessary in the medical care system, outside it and in the penitentiary system.”
MS level (Other national documents, Our data)	Reports at the national level reveal a slightly more mixed picture. Both the Czech Focal Point and an evaluation of the 2005-2008 Czech Drugs Strategy noted a wider array of treatment services available to drug users, but lamented a decrease in the number of healthcare facilities. In the Netherlands, the national Focal Point reported on improvements in care in selected areas such as chronic complex addictions, cocaine problems and online therapy. At the same time, it stated that the number of organisations for addiction care had been reduced significantly. Similarly, the Swedish Focal Point observed that the number of treatment centres reporting to the system had increased but concluded that financial and organisational issues pose such a major problem “that many patients are not offered the help they desire and need.” (SWE Reitox, p.9)

Case study objective 25.4	
Priority defined in Drugs Strategy	Improving access to services for the prevention and treatment of infectious diseases and drug-related health and social damage.
Defined in Action Plan	Objective 10: Ensure access to harm reduction services, in order to reduce the spread of HIV/AIDS, hepatitis C and other drug-related blood-borne infectious diseases and to reduce the number of drug-related deaths in the EU.
Recommendation in AP Evaluation	The Final evaluation stated that major progress had been achieved in the field of harm reduction. All EU Member States defined the prevention and reduction of drug-related harm as a public health objective at national level. The most prevalent interventions were needle and syringe exchange programmes, combined with health education and advice, outreach workers and opioid substitution treatment combined with psycho-social assistance. However, it noted that availability and accessibility of these programmes was variable among the Member States. As part of its recommendations, the evaluation invited Member States to invest more efforts in reducing avoidable drug-related infectious diseases and deaths, namely by investing in prison health care and after care and by rolling out harm reduction interventions (EC 2008b, p. 88).
Evidence of Implementation	
EU level (EMCDDA, Progress Report)	As the EMCDDA trend report noted, there has been significant progress in the field of harm reduction in recent years. While notable policy differences continue to exist between Member States, especially in regard to highly targeted interventions such as drug consumption rooms, there has been a discernible consolidation of harm reduction policies and interventions. As a result, core provisions such as substitution treatment are rarely viewed as controversial (EMCDDA 2011, p. 56-57). The 2010 Action Plan progress review reaches broadly the same conclusion, even though it adds two important qualifications. First, quality and scope of harm reduction measures differ between individual Member States. Second, there is very little information available on the availability and nature of social reintegration programmes (EC 2010, p. 5-6)
MS level (National Strategy)	Harm reduction has been firmly embedded in numerous national drugs strategies. It is one of four cornerstones of the Czech Strategy, which aims "to minimise the adverse health and social consequences of drug use for both society and current drug users." (CZE, p. 13) Care, social integration and harm reduction is one of five major themes in the French Strategy, seeking "to intensify and diversify the health and social care of drug users, by targeting exposed and vulnerable populations." (FRA, p. 12). The EU Objective 25.4 is particularly visible in the Romanian Strategy, which lists the following among its overall objectives: "Ensuring universal access of drug users and dependant drug users to the integrated programmes of medical, psychological and social assistance, by developing adequate programmes and policies for the general population, drug users and dependant drug users in the medical care system, outside it and in penitentiaries, with a view to the drug users' social reintegration and reinsertion." (ROM, p.8). Risk and harm reduction also features prominently in the Spanish Strategy: "The key objectives for interventions in this field should be: avoiding experimental and sporadic uses becoming continuous and, above all, reducing or limiting the harm caused to the health of people who use drugs and, in general terms, the undesirable socio-health effects linked to use."(SPA, p.63). The theme of social damage is also picked up in the Spanish Action Plan: "To foster the development and setting up action of new programs that favour the social and work integration of drug dependents in the process of reinsertion with diverse measures." (SPA AP, p.10). The UK Strategy, while not containing a specific section devoted to this objective, offers the following justification for its importance: "We know that drug treatment can be very effective in preventing wider damage to the community such as high volume acquisitive crime, and together with initiatives like needle exchange schemes, can reduce the harms caused by dependence such as the spread of blood-borne viruses like HIV." (UK,

	p.6)
MS level (Other national documents, our data)	<p>Several governments have launched/introduced related national plans and legislation in support of the harm reduction objective. These include England (Hepatitis C Action Plan, 2004), Scotland (2005 strategy and action plan to reduce DRDs, Hepatitis C Action Plan for Scotland, 2006 and 2008). (Scottish Government 2008c), Northern Ireland (An Action Plan for the Prevention, Management and Control of Hepatitis C, 2007), Wales (Blood-borne Viral Hepatitis Action Plan for Wales 2010-2015, 2010), France (National hepatitis B and C plan 2009-2012), Sweden (Act on Exchange of Syringes and Needles, 2006), the Netherlands (Hepatitis C information campaign, 2009; Hepatitis B vaccination campaign, 2010). Member States have reported other improvements in implementing this objective. The Czech Focal Point observed that expenditures on treatment, harm reduction and aftercare have risen as a share of total drug-related expenditures in recent years. (CZE Reitox, p. 22). Similarly, an evaluation of the Spanish 2000-2008 Drugs Strategy concluded that "the quality of treatment and harm reduction programmes has shown a positive trend: both the services and the programmes have been diversified and match the needs of the people served better." At the same time, case study Member States have also experienced persistent problems. For instance, the evaluation of the Spanish Strategy noted that the uptake of social reintegration programmes remained low. The Romanian Focal Point expressed concerns about the continuity of funding for harm reduction measures as significant support from abroad and international organisations was set to expire. Also, the French Focal Point found the existing offer of residential treatment schemes for drug users "inadequate" (FRA Reitox, p. 105)</p>

Case study objective 27.4	
Priority defined in Drugs Strategy	Enhancing law enforcement, criminal investigation and forensic science cooperation between EU member states, within an EU framework.
Defined in Action Plan	Objective 11: Enhance effective law enforcement cooperation in the EU to counter drug production and trafficking; Objective 12: Enhance effective judicial cooperation in the area of combating drug trafficking and law enforcement as regards production, trafficking of drugs and/or precursors, and money laundering related to this traffic.
Recommendation in AP Evaluation	The Evaluation concluded that law enforcement cooperation between Member States had improved, despite the fact that existing instruments were not being used to their full extent. Consequently, as for recommendations for the future, the evaluation urged Member States to make better use of existing cooperation infrastructure. (EC 2008b, p.88)
Evidence of Implementation	
EU level (EMCDDA, Progress Report)	The 2010 Action Plan Progress Review concludes that there had been notable improvement in the area of law enforcement and criminal investigation and forensic science cooperation between individual Member States. An illustrative example thereof are three ongoing COSPOL projects on cocaine (COLA), heroin (MUSTARD) and synthetics (SYNERGY). The review also cited an increase in the number of cases submitted to Eurojust as an indicator of the positive trend. (EC 2010, p. 6). On a similar note, the EMCDDA noted the success of several interdiction efforts, such as the MAOC-N and Regional Intelligence Exchange Centres in West Africa (EMCDDA 2011, p. 32).
MS level (National Strategy)	The objective to cooperate with EU partners in the area of supply reduction has been reflected in national drug strategies across the European Union. For instance, the French Strategy suggests that "resolute action in France and across Europe should make a long term reduction to the drug supply, particularly by allowing police forces and the armed forces to cooperate on drug routes" (FRA, p. 11) and the Romanian one includes, among others, the following objectives: "intensifying the operative actions of international cooperation aimed at identifying and annihilating the international drug trafficking rings involved in criminal activities in the country; intensifying identification activities of new synthetic drugs and, to this end, expanding national and international interagency cooperation; developing the international cooperation in order to prevent the diversion of narcotic and psychotropic substances and of precursors ..." (ROM, p.11). Even national policy documents that do not state this objective explicitly appear to implicitly embrace it, albeit in reference to an international, rather than European context. For instance, even though the Swedish Strategy does not discuss the international dimension in its chapter on supply reduction, it recognises that "the transboundary character of serious organised crime requires close cooperation between relevant agencies both in Sweden and beyond, as well as active participation in joint international efforts." (SWE, p. 16)
MS level (Other national documents, our data)	In regard to the implementation of the objective, few Member States and their Focal Points report on international cooperation efforts as a specific part of their supply reduction efforts. To illustrate, the evaluation of the Czech 2005-2009 Strategy concluded that the pillar of supply reduction was one of the most successful ones in terms of met objectives, but did not comment on its international dimension. (CZE Eval, p.11). France is a notable exception in this aspect, presumably due to the high degree of involvement in cross-border law enforcement initiatives. A report of the French Focal Point highlighted numerous instances of progress towards the EU objective 27.4, such as an agreement to create an operational centre for analysis of maritime narcotics information, an agreement between France and the Interpol, renewing the presence of these international organisations in France, the use of common investigation teams to combat cross-border crime, the establishment of the Mediterranean anti-drugs co-ordination centre also came into service in 2009, or the opening of two European liaison officer platforms to exchange information on international narcotics trafficking. (FRA, Reitox, p.22)

Case study objective 30.1	
Priority defined in Drugs Strategy	Action by the Union in international organisations and fora enhancing and promoting a balanced approach.
Defined in Action Plan	Objective 18: Strengthen EU coordination in the multilateral context and promote an integrated and balanced approach.
Recommendation in AP Evaluation	The final evaluation contended that the EU's balanced approach is seen as an example of good practice for third countries at international fora and has served as a model for Candidate Countries, Stabilisation and Association Process countries, as well as many European Neighbourhood Policy Countries in developing their national drug strategies and action plans. On a related note, increasing attention, albeit starting from a very low level, is being devoted to funding projects in the field of demand reduction in third countries to address drug use as well as drug trafficking and drug production. However, the evaluation noted that the policy outcomes of these activities had not been assessed. As a recommendation, the evaluation suggested promoting the balanced approach even more strongly, partly by "identifying complementarities and coherence between the funding instruments at EU level and national level through explicit policy priorities during the present funding period and in preparing for the next funding period from 2013 onwards." (EC 2008b, p. 89)
Evidence of Implementation	
MS level (National Strategy)	Almost all of case study countries (with the exception of the UK) devote a sizable section to international cooperation in their national drug strategies. However, these sections do not generally discuss action by the European Union at the international level. A notable exception is the Spanish document which makes an explicit reference to the EU Drugs Strategy along with its emphasis on the balanced approach and affirms that "the [Spanish] National Drug Strategy 2009-2016 will be closely linked to the actions arising from the European Strategy and contained in the Action Plan for 2009- 2012 in order to develop and promote Spanish initiatives presented in the European Union." (SPA, p.81). The Romanian Strategy mentions the balanced approach in its statement of principles, but not necessarily in connection to EU's activities: "The principle of the global, unitary, multidisciplinary and balanced approach. The measures for the drugs demand and supply reduction must be in line with the international outlook in countering the drug phenomenon." The Czech Strategy also refers to the EU's balanced approach; however, this is done to emphasize that the Czech Strategy has embraced it rather than in relation to its promotion at international fora.

Case study objective 31.1	
Priority defined in Drugs Strategy	Improving the EU knowledge infrastructure in the field of drugs and consolidating the drug information systems and tools.
Defined in Action Plan	Objective 21: Expand the knowledge base in the field of drugs by promoting research; Objective 23: Further develop instruments to monitor the drug situation and the effectiveness of responses to it
Recommendation in AP Evaluation	The evaluation concluded that there had been notable improvements in the area of information collection, especially in regard to data reliability, comparability and availability. Further, the evaluation noted improvement in the implementation of key indicators by individual Member States in the area of demand reduction. However, supply reduction data remained an issue, with information not available, and/or consistent and/or comparable. As a result, the evaluation recommended Member States to devote more attention to implementation of common data collection standards and methodologies at the level of the Member States. (EC 2008b, p.85)
Evidence of Implementation	
MS level (National Strategy)	Majority of case study countries have embedded the EU objective in their national strategies. For example, the French Strategy highlighted the importance of "sharing research across Europe" (FRA, p.11). The Dutch White Paper stated that "the EU has set up a number of initiatives aimed at reaching a better understanding of the extent of and changes in drugs use in Europe, and the European Monitoring Centre for Drugs and Drug Addiction has been set up in Lisbon ... The Netherlands government attaches great value to the production of improved and comparable statistics and research data on drug use." (NED, p.55) Even more explicitly, the Spanish Strategy referred directly to the EU Drugs Strategy and declared as its objective "encouragement for the participation and cooperation with international institutions and bodies which undertake research in the field of drug addictions (the European Monitoring Center for Drugs and Drug Addiction, the Council of Europe etc.)" (SPA, p.75). The Swedish Strategy, despite not having a section on research, introduced a section on follow-up and evaluation. There, one small reference to European coordination/standardization efforts is made: "A system for reporting in accordance with EU and international agreements is also to be put in place." (SWE, p.37) On the other hand, the UK Strategy contains a section on identifying best practices and evaluation with no reference to the international/European level.
MS level (Other national documents, our data)	International research and data collection collaboration does not feature prominently in Focal Points reports or national policy evaluations. To offer at least a few examples, the Romanian Focal Point highlighted the participation of the Romanian Anti-Drug Agency as a main partner in a European project for the formulation and implementation of quality standards for prevention programmes (ROM Reitox, p. 22) and the Dutch Focal Point noted the role of the Trimbos Institute as part of the International Collaboration on ADHD and Substance Abuse (ICASA). (NED Reitox, p.99)

Appendix H: List of documents consulted

Bühringer, G. et al. (2009) “Comparative Analysis of Research into Illicit Drugs in the European Union,” study commissioned by the Directorate-General for Justice, Freedom and Security of the European Commission (JLS/2007/C4/006), Institut für Therapie Forschung.

Commission Regulation (EC) No 1277/2005 of 27 July 2005 laying down implementing rules for Regulation (EC) No 273/2004 of the European Parliament and of the Council on drug precursors and for Council Regulation (EC) No 111/2005 laying down rules for the monitoring of trade between the Community and third countries in drug precursors, OJ L 202, August 3, 2005, pp. 7-33.

Consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union, OJ C 115, May 9, 2008, pp.1-388.

Costes, J. et al. (2010) “France: New Developments, Trends and In-depth Information on Selected Issues,” 2009 National Report to the EMCDDA. Paris: Reitox National Focal Point, July 2010.

Council Decision 2005/387/JHA of 10 May 2005 on the information exchange, risk assessment and control of new psychoactive substances, OJ L 127, May 20, 2005, pp.32-37.

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