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DRUG USE AND RELATED PROBLEMS AMONG
VERY YOUNG PEOPLE (UNDER 15 YEARS OLD)



European Monitoring Centre
for Drugs and Drug Addiction

SELENES ACTS USED DETAILED

DRUG USE AND RELATED PROBLEMS AMONG VERY
YOUNG PEOPLE (UNDER 15 YEARS OLD)

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Reitox national focal points

Reitox is the European information network on drugs and drug addiction. The network comprises national focal points in the EU Member States, Norway, the candidate countries and at the European Commission. Under the responsibility of their governments, the focal points are the national authorities providing drug information to the EMCDDA.

The contact details of the national focal points may be found at <http://www.emcdda.europa.eu/?nnodeid=1596>



Introductory note

Three in-depth reviews of topical interest are published as 'Selected issues' in conjunction with the annual report each year. These selected issues are based on information provided to the EMCDDA by the EU Member States and candidate countries and Norway (participating in the work of the EMCDDA since 2001) as part of the national reporting process.

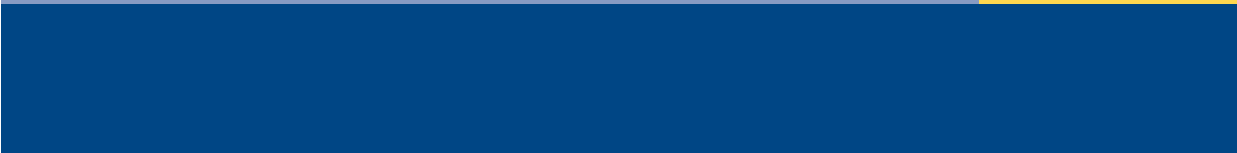
The three issues selected for 2007 are:

- Drugs and driving;
- Drug use and related problems among very young people (under 15 years old);
- Cocaine and crack cocaine: a growing public health issue.

Online versions of the 2007 selected issues (in English) and summaries (in 23 languages) are available at:
<http://issues07.emcdda.europa.eu>

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

The 2007 *Annual report on the state of the drugs problem in Europe* is available in 23 languages and may be found at <http://annualreport.emcdda.europa.eu>



Drug use and related problems among very young people (under 15 years old)

Introduction

The available information at European level (see 'Methodology') suggests that illicit drug use among very young people is confined to a small minority who experiment with drugs at a very early age. Regular use among the very young is rarer still — as is partly reflected in the European data on people attending drug treatment. Among those who start using substances at a very young age, evidence suggests that early experimentation with psychoactive substances, including alcohol and tobacco, is associated with an increased risk of developing drug problems later in life. Regular drug use among the under-15s is most often found among a highly problematic group of the population, in whom drug use is combined with other concurrent or preceding psychological and social disorders and might

Methodology

Information on substance use and drug-related problems among very young people is scarce and is often not harmonised at European level. Frequently, national or local research on drug use among young people is based on different age groups or specially targeted populations.

The EMCDDA collects data on young people under 15 years in three epidemiological indicators: the general school population indicator; the treatment demand indicator; and the drug-related deaths indicator. Information on the age at first drug use in the general school student population is available from almost all EU Member States for the 15–16-year-old age group, largely through ESPAD (Hibell et al., 2004), and 12 countries report the prevalence of psychoactive substance use among school students under the age of 15. Prevalence estimates of drug use among under-15s are very low, are based on relatively small numbers and, therefore, must be viewed with caution. The 2006 Reitox national reports included a specific analysis of drug treatment clients under 15 years in seven volunteer countries, with a breakdown by year of age from 10 to 14 years. The reference age group is not always restricted to young people under the age of 15 (e.g. school information on high-risk groups and correlates) to allow comparisons with the situation in other age groups.

often be a marker of social problems or of an underlying neurobehavioural pathway (Clark et al., 2005).

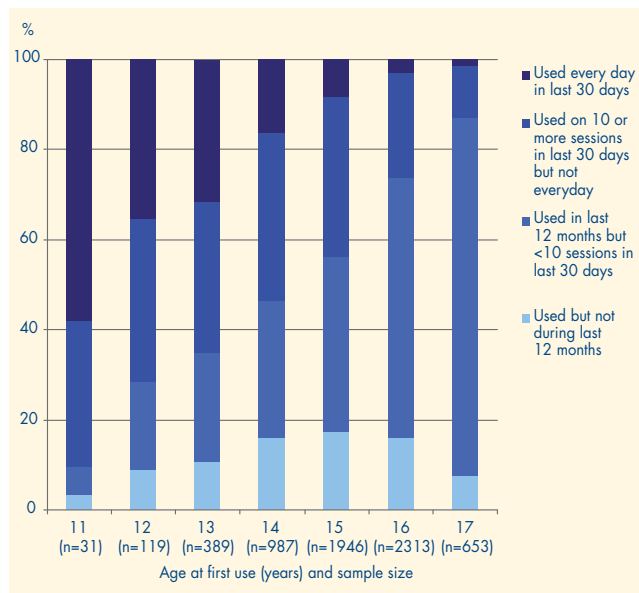
Responses targeted at substance use by very young people usually focus on both licit and illicit substances and, in addition to tackling the problems relating to substance use, seek to bring about early treatment of concomitant psychological or social disorders. This approach is also reflected in European and national legislation and strategies. Interventions aimed at very young people range from universal approaches to early intervention, when substance use is already suspected. Drug treatment targeted at drug-using young people is rare, but most European countries have identified the need for such programmes.

Legal regulations are especially important in protecting children and adolescents from drugs and ensuring that they have easy access to help and support. Education plays a crucial role in this respect, and the responsibility for this may be assumed by authorities if it cannot be fulfilled by parents. In this selected issue, information from Europe on the prevalence and patterns of substance use among very young people and on available responses in terms of legislation, prevention and treatment is presented.

Prevalence and patterns of alcohol, tobacco and illicit drug use

Estimates of substance use among children under 15 years are commonly based on school surveys. While few very young people take drugs, and drug dependence by the age of 15 is extremely rare, experimental substance use among very young people is widely recognised as a predictor of future dependence and other drug problems (Gfroerer et al., 2002). For example, a large representative survey of 17-year-olds in France found that two thirds of respondents who smoked cannabis for the first time before the age of 12 were daily cannabis users by the time they were 17, whereas those who did not start smoking cannabis until the age of 16–17 were mostly occasional smokers (Figure 1). While the time elapsed since first use may play a part, evidence from adult surveys suggests that first cannabis use at a young age is a stronger marker for daily use than the duration of time since first use.

Figure 1: Distribution of frequency of cannabis use sessions (percentage) according to age at first use among a French ESCAPAD sample of adolescents largely aged 17 years



NB: Overall sample survey size is 6 438.
Among the respondents, 80 % were aged 17 and 20 % were aged 18.
Source: Reitox French national report.

Alcohol and tobacco

Alcohol and tobacco use by under-15s has been found to correlate with subsequent use of illicit drugs, although the nature of the drugs–alcohol–tobacco relationship is complex and inextricably linked to other aspects of youth culture in each country, as well as to drug availability, social norms, fashions and the influence of the leisure industry. In 2003, ESPAD school surveys found that the prevalence of daily smoking by the age of 13 ranges from 7 % to 14 % in most European countries, but is higher in Germany (18 %) and Estonia (17 %) and lower in Turkey (3 %) and Greece (4 %) (1). In over half of the countries, the prevalence is higher in boys than in girls, but in 12 countries prevalence among girls equals or exceeds that among boys.

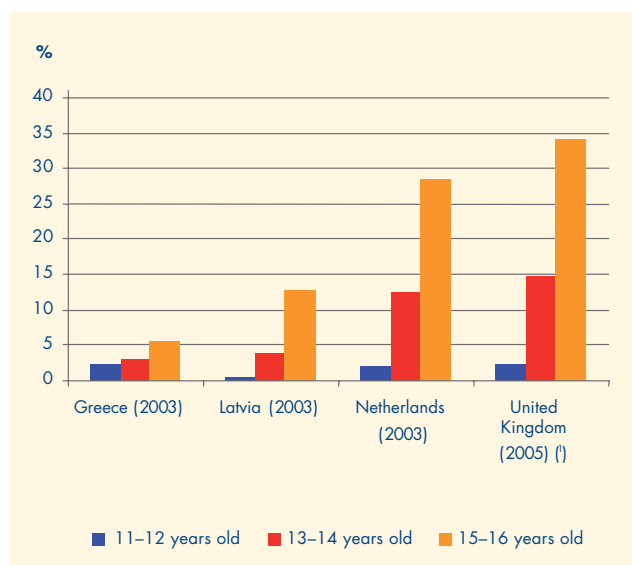
The proportions of students that report having been drunk at the age of 13 or younger also varies substantially between countries. Figures for drunkenness by the age of 13 or younger are highest in Denmark, Estonia, the United Kingdom and Finland (33–36 %) and lowest in Turkey and Cyprus (5 % and 7 % respectively). In the majority of countries, more boys than girls report having experienced drunkenness by the age of 13, but the rates are similar in boys and girls in Ireland, Malta, Austria, Finland, the United Kingdom and Norway.

Drug use

The illicit substance most commonly used by young people under 15 years is cannabis; use of inhalants (2) is higher than that of any illicit drug other than cannabis. Countries that record drug use data for younger age groups report strong increases in the ever-in-lifetime prevalence of cannabis use during the early teenage years — the phase in life when experimentation with drugs is most likely to occur. Differences between age groups are much greater than differences between the sexes. In all countries, a large increase in prevalence occurs between the ages of 11–12 and 15–16: in Greece this increase is twofold while in England it is 15-fold (Figure 2).

ESPAD school surveys reveal that the prevalence of first cannabis use by the age of 13 is 0–4 % in Bulgaria, Estonia, Greece, Italy, Latvia, Lithuania, Cyprus, Hungary, Malta, Poland, Portugal, Romania, Finland, Sweden, Norway and Turkey and 5 % – 8 % in all other countries except the United Kingdom, where the figure is 13 %. Since 1995, the largest increases in initiation to cannabis use at this young age (increases of 4 % or more) have occurred in newer Member States (the Czech Republic, Estonia, Slovenia and Slovakia) (Figure 3). Only the Netherlands and the United Kingdom report a decrease (of 1 %) in early cannabis use between 1995 and 2003. In all other countries early cannabis use was either stable or showed a small upward trend (one or

Figure 2: Ever-in-lifetime use of cannabis among very young people in four EU Member States, according to age



(1) Data for the United Kingdom cover only England. The oldest age group in this data are 15-year-olds.

NB: Year of survey in brackets.
Source: Reitox and ESPAD.

(1) ESPAD data for Germany cover only six *Länder* and for Turkey only six cities.

(2) Products that are commonly inhaled such as gas fuels (e.g. cigarette lighter fuel and bottled gas), aerosols (e.g. antiperspirants and pain-relief sprays), glues and solvents (e.g. contact adhesives and cleaning fluids) and amyl nitrate.

Figure 3: Changes between 1995 and 2003 in recalled use of cannabis at or before the age of 13 (percentage points) as reported by 15- to 16-year-old school students



NB: Caution is required regarding small percentages and changes: percentage changes are rounded off to the nearest percentage point. For Bulgaria and Cyprus, changes are calculated from 1999 to 2003 rather than 1995 to 2003.

Source: ESPAD.

two percentage points), mirroring the changes in prevalence in general during these years.

With regard to the use of inhalants, in countries that survey under-15s there appears to be little or no increase in prevalence after the age of 11–12 years, unlike cannabis, which suggests that experimentation with inhalants may peak before the age of 15.

Prevalence estimates for other types of drug use are considerably lower than those for cannabis and inhalants, as is the case among older school students. Ever-in-lifetime use of ecstasy, amphetamines, cocaine or heroin rarely rises above 2 % by the under-15s in the reported school surveys.

Drug-related consequences among very young people: under-15s entering treatment for drug use and other problems

Only a very small number of under-15s enter treatment because of use of illicit substances. In 2005, 17 EU Member States and Turkey reported around 3 300 clients under 15 years old entering drug treatment, which represents around 1 % of all drug clients (3). In most European countries, less than 1 % of drug clients are under 15 years old and in seven countries the proportion is between 1 % and 2 %. Only Romania has a higher rate, with 3 % of drug clients under 15 years old, but total figures are low in this case.

In general, reported figures are low. Several possible reasons for this can be proposed.

- Prevalence of drug use among very young people is generally low.
- Even if young people use drugs, drug use has not yet developed into problematic drug use.
- The availability of treatment centres targeted to very young people is low.
- Access to treatment is difficult, especially for marginalised groups.
- Some children with drug-use problems as well as other concomitant problems might be captured in social services registers although their drug problems remain unrecorded.
- Data regarding drug use among children may be under-reported for privacy and anonymity reasons.

Even taking into account the fact that the number of people treated for drug problems in this age group may be underestimated for several reasons, the European total is very small. However, this group is often highly problematic, as people in this category may be using drugs to cope with social and psychological problems (Cullen, 2006).

(3) See Table TDI-27 in the 2007 statistical bulletin.

Between 1999 and 2005, the number of under-15s reported entering drug treatment in Europe increased substantially (from around 1 000 to an estimated 3 300) ⁽⁴⁾. However, as this increase was largely due to a sharp rise in treatment demands in the United Kingdom, the data cannot be taken as an indication of an overall upward trend among this age group in Europe.

Most data on drug treatment clients under 15 years old concern outpatient treatment centres; therefore, the following description of their profile will focus on outpatient clients.

The large majority of under-15s who enter treatment do so for primary cannabis use, and to a lesser extent for use of inhalants; only a very small proportion of young drug clients use opioids or other substances as their primary drug ⁽⁵⁾. Countries reporting a non-trivial number of clients under 15 years old in treatment for drug use are Germany, Ireland, Spain, France, Italy and the United Kingdom; and Germany, Italy and the United Kingdom report some opioid users among clients under 15 years ⁽⁶⁾. The gender distribution among drug clients shows a higher proportion of girls in the youngest age group: there are 2.5 boys for every girl among clients under 15 years old, while among clients over 19 years old the gender ratio is 4.1 to 1 ⁽⁷⁾. This might be related to several factors: the narrowing gap between males and females in social behaviours, including drug use; the fact that young girls may be introduced to drug use by an older male partner; the delayed psychosocial development among boys compared with girls; the role played by psychiatric co-morbidity or preceding disorders earlier in childhood. Research indicates that, at this age, gender differences in the prevalence of behavioural disorders such as attention deficit (hyperactivity) disorder (AD(H)D) or conduct disorders (CD) are less pronounced than gender differences in the prevalence of substance abuse (Fegert, 2006). However, because of the limited research that has been conducted in this area, the low figures reported in treatment and the methodological limitations in the drug treatment data, interpretations should be made with caution ⁽⁸⁾.

In 2006, an additional data collection on under-15s entering drug treatment was conducted in Bulgaria, Germany, Ireland, Latvia, Slovakia, the United Kingdom and Turkey ⁽⁹⁾. In these countries, a total of 2 739 children were reported to have entered treatment in 2005. Most cases occurred in the United Kingdom (80 %) and, to a lesser extent, in Germany

(14 %); the other countries contributed with only few cases. The limited case numbers in the selected countries do not allow firm conclusions to be drawn.

Very young drug users enter treatment mainly following referral by court, family or social services. Social services play an important role in treatment referrals among the youngest clients, who may be subject to highly problematic family and social conditions and come into contact with other social or health services for reasons other than drug use (e.g. family and school problems, delinquency).

Other consequences of drug use, such as infectious diseases ⁽¹⁰⁾ and drug-related deaths, seem to be very rare in the youngest drug users, partly because of their short drug career. In 2005, 18 drug-related deaths among children under the age of 15 were reported, which represents 0.2 % of the total number of drug-related deaths in Europe ⁽¹¹⁾. Although it is possible that some drug-related deaths in this age group are not reported as such, the low numbers, even in countries where it can be assumed that reporting of drug deaths is very thorough, support the general finding.

High-risk groups and correlates

Individual analyses conducted on several surveys, including school surveys, in a variety of countries have identified groups at high risk of early drug use and vulnerability factors that are correlated with higher levels of drug taking. Factors associated with drug use at an early age often co-occur; children at risk of early drug taking are frequently in a complex problematic condition, experiencing family, school and other social and psychological problems (Prinz et al., 2000). Some of the main vulnerability factors are reported below, along with possible effects of early drug use.

Family

Children whose parents or other family members use psychoactive substances are known to be at higher risk of early drug use because of problems in the social and psychological family functioning or because of the neurobiological consequences of maternal substance use during pregnancy on child development (Bancroft et al., 2004; Obot et al., 2001; Repetti et al., 2002). Alcohol use in the family is also strongly associated with a high risk of drug use among children

⁽⁴⁾ See Table TDI-30 (part i) in the 2007 statistical bulletin.

⁽⁵⁾ See Table TDI-10 in the 2007 statistical bulletin.

⁽⁶⁾ See Tables TDI-103 and TDI-122 in the 2007 statistical bulletin.

⁽⁷⁾ See Table TDI-29 in the 2007 statistical bulletin.

⁽⁸⁾ See report on data coverage at <http://www.emcdda.europa.eu/?nnodeid=1420>

⁽⁹⁾ See Tables TDI-123, TDI-124 and TDI-125 in the 2007 statistical bulletin.

⁽¹⁰⁾ Data on the prevalence of drug-related infectious diseases are not available for this age group.

⁽¹¹⁾ See Table DRD-1 in the 2007 statistical bulletin.

(Clark et al., 2005). At European level, data available on the number of drug treatment clients living with children (alone or with a partner) indicate that a total of 27 908 outpatient and inpatient drug clients (14.3 % of all clients) live with their children; of these, 5 % live alone with one or more children. In some cases, children are living with more than one drug user. Research conducted in the United Kingdom found that at the age of 15, young people whose parents had used drugs during the previous year were more than twice as likely to have used drugs themselves than were those whose parents had not used drugs. Sibling drug users may also have a negative role on children's behaviour: research in several countries reports that among children with drug-using siblings the rates of drug use are much higher than among children with siblings not using drugs. Being in a single-parent family (Denmark), parents not knowing where children are in the evening (Denmark, the Netherlands) and children going out every evening (Greece) are indicated as risk factors for or associated with early drug use. Children from families with low educational level, unemployment or precarious labour conditions and low affluence may have a higher risk of drug use (Prince's Trust, 2004); however, a U-shaped curve shows that both high and low family incomes are related to high drug prevalence. Violence, sexual abuse, especially among girls, and criminal behaviour in families are other risk factors for early drug use (Fegert, 2006).

School

Research carried out on the relation between school performance and early drug use has shown an association between the risk of drug use and early school leaving, school truancy, poor school performance and expulsion or exclusion from school. Data from the Scottish school survey show that 56 % of children who have truanted school in the last year have tried drugs in the last year compared with 28 % of non-truants.

The association seems to be even stronger for exclusion from school: 36 % of children who have been excluded from school have used drugs in the last 12 months compared with 8 % of children who have never been excluded.

Ethnic minorities and other socially excluded groups

Though harmonised data are lacking at European level regarding the relation between drug use and membership of ethnic minority groups, some countries report a higher involvement in drug use among children from some ethnic minorities. In Italy, the prevalence of foreign drug users passing through the juvenile justice services, and of foreigners referred for drug-related crimes, is higher among the under-15s than among older age groups.

Children from socially and culturally marginalised or disadvantaged groups, for example from some Roma communities in Slovakia, are reported to start alcohol, tobacco and drug use at a very early age. Analysis of the 2005 school survey for England found that pupils of mixed ethnicity were more likely than any other group to have taken drugs in the last year, and Asian pupils were least likely to have done so. A Home Office study (2001) found that homeless and street children have higher rates of drug use at an early age.

Youth offenders and children in care

Several research reports show an association between drug use and criminal activities or norm-breaking among very young people. Young people involved in crime and children in care have been indicated as high-risk groups for using drugs in some Member States (the Netherlands, the United Kingdom).

Co-morbidity, markers or predictors: the role of behavioural disorders

Attention deficit (hyperactivity) disorder (AD(H)D) is estimated to affect 3–5 % of all children. Low neuronal activity in noradrenergic and dopamine pathways in specific brain areas explains patients' pronounced difficulties in filtering incoming (cognitive and emotional) stimuli for relevance and thus their inability to maintain attention, focus and affect regulation. Hyperactivity is an additional, but not essential, symptom. AD(H)D has very strong impact on an individual's psychological development, education, relationships and family; however, the lack of specific instruments and direct markers makes it difficult to make a firm diagnosis. Professionals in some Member States object that AD(H)D should be considered not a disease entity per se, but rather a final common behavioural pathway for a variety of emotional, psychological and/or learning problems. Furthermore, among the public the perception of recent increases in

the prescription of amphetamine derivatives such as methylphenidate has raised concerns. Pharmacotherapy with these stimulants normalises the neuronal systems for attention and focus and is part of — though not the only — standard treatment for AD(H)D. Proper diagnosis and pharmacotherapy are protective against the later development of drug problems, but the diversion of prescribed stimulants for non-medical use might be a growing problem (Poulin, 2007).

In ICD-10, conduct disorders (CD) are characterised by a repetitive and persistent pattern of dissocial, aggressive or defiant conduct. Such behaviour, when at its most extreme for the individual, may amount to major violations of age-appropriate social expectations, and is therefore more severe than ordinary childish misbehaviour or adolescent rebelliousness. As it implies an enduring pattern of behaviour, isolated dissocial or criminal acts are not in themselves grounds for the diagnosis.

Psychological problems: AD(H)D, conduct and mental disorders

Children affected by attention deficit (hyperactivity) disorder (AD(H)D) and conduct disorder (CD) are increasingly reported as a high-risk group for drug use. Recently, this problem has attracted increasing attention (see box on co-morbidity). There is known correlation between drug use, especially cannabis use, and early forms of schizophrenia as well as other psychological disorders. Cannabis use is widespread among young psychiatric patients, and is interpreted by some as a type of inadequate self-medication (Witton, 2007).

Responses

Prevention

Responses in Member States to substance use among the very young vary on a continuum between predominantly universal approaches, i.e. the provision of classical prevention programmes (Griffin et al., 2003) in schools and communities without any risk assessment, and — at the other extreme — approaches to be implemented only when substance use is already suspected (early intervention). The former prevail in, for instance, Ireland and the Baltic States, the latter in France.

Most Member States report the use of risk-factor-led approaches in the middle of the continuum. These approaches aim to tailor prevention responses to the high-risk groups described in the preceding sections, i.e. families at risk through drug use, economic situation, members of certain ethnic groups, those with conduct and mental disorders and those living in deprived neighbourhoods (see Chapter 2 in the 2007 annual report).

The delivery of these interventions is mostly through existing social or health services or through 'come structures' (e.g. family and youth counselling centres in Germany, Greece and France). The effectiveness and, especially, the efficiency of these interventions has not been proven. Protocol-like detailed programmes that would allow scientific evaluation of contents, results and intensity of interventions are very rare in this field.

Global strategy responses

Some Member States already address the question of very young people in their drugs and other strategies by defining priority target groups and services to be delivered. For instance in Ireland, homeless young people receive comprehensive assessment in emergency care, specialised accommodation and family support provision. The Irish and United Kingdom (e.g. Every Child Matters) strategies focus on the harmonisation of child-related policy in areas

such as early childhood care and education, youth justice, child welfare and protection, children and young people's participation, research on children and young people and cross-cutting initiatives for children. It is argued that factors that contribute to disadvantage in general (McArdle et al., 2006) — for example poverty, unemployment, drug and alcohol abuse, violence, inadequate and sub-standard housing — must be tackled in parallel with educational disadvantage per se and in an integrated way, along with a lifelong approach to mental health.

The strategies propose early assessment of vulnerable children in key risk groups in primary care, care management and appointment of lead professionals for those who need support and intervention, and integrated information systems to help agencies work together to track interventions with individual children and young people.

Generic services

An important role in this field is played by prevention centres (Greece, Cyprus), youth welfare (Germany) or public health (Ireland, Cyprus, Hungary) agencies or teams whose task is to support parents in raising their children or to intervene when parents are no longer able to fulfil their parental duties. Weighing up the rights of the parents and welfare of the child, State authorities exercise restraint if parents do not agree with external intervention. In addition, school-based services (reported by 16 Member States as being regularly or frequently available) can detect, support and refer children with psychosocial, behavioural or academic problems, often according to established protocols. In Greece, juvenile protection associations operating in courts of first instance help adolescents who display antisocial behaviour or are in danger of becoming involved in crime because of an absent or inappropriate family environment or other unfavourable social conditions. An additional resource and conceptual leap for this approach seems to be the merging of addiction care with (child) mental healthcare, as in Germany and recently in the Netherlands. Especially with regard to young people, this trend to interweave addiction care and mental healthcare has the great advantage that addiction problems are now generally treated within a wider mental health and social context.

Despite the relatively high prevalence of inhalant use among under-15s, the dangers of inhalant/volatile substance abuse by young people in the EU have received far less attention than illicit drugs and alcohol. In the United Kingdom, a television advertising campaign launched in the 1990s and specifically aimed at volatile substance abuse was hailed a success following subsequent decreases in recorded deaths among young people. However, the success has been questioned as the decrease was also noted in regions where there had been no broadcasts (Orr and Shewan, 2006).

Standardised programmes for selective and indicated prevention

High-risk families are not simply low-income families: one risk factor consistently mentioned in national studies (Denmark, the Netherlands, Sweden, the United Kingdom) is parents' level of knowledge of their children's whereabouts in their leisure time and about their friends.

Parenting is therefore a core component of prevention programme protocols, and some countries (Spain, Ireland, Romania, Norway) are implementing selective prevention programmes for families at risk, as well as parents in substitution treatment (Spain). These programmes focus on the development of educational skills, rule setting and parent-child relationships and are frequently evaluated with good results.

Programme-based approaches to the parenting of children with behavioural problems are effective in compensating for part of the problem trajectory (Reyno and McGrath, 2006; Stephenson and Helme, 2006). In Galicia in Spain, evaluation of a programme for the teachers and parents of children between the ages of 8 and 10 with disruptive behavioural problems in the classroom (impulsiveness, aggressiveness, attention problems, hyperactivity) is under way.

Several intervention programmes for children with diagnosed behavioural disorders have been published (Miller et al., 2002; Thompson et al., 1997; Zonneville-Bender et al., 2007). The Dutch prevention programme 'Match' targets children aged between 4 and 14 years who show risk factors such as early and persistent antisocial behaviour, alienation and rebelliousness. This programme matches a child at risk to a volunteer adult who has been trained to support the child during leisure activities within a relationship based on mutual trust. To participate in 'Match' it is required that the child at risk is not yet involved in an environment of heavy drug use.

Focus on AD(H)D

The recognition that attention deficit (hyperactivity) disorder (AD(H)D) and conduct disorder increases the risk of children developing a substance use disorder has prompted efforts in Member States such as Germany, the Netherlands, Slovakia and Sweden to improve and professionalise early detection in primary care and schools, to achieve proper diagnosis and to provide well-balanced treatment (between psycho- and pharmacotherapy) of these disorders. In the Netherlands, evidence-based multidisciplinary guidelines have been established to diagnose and treat AD(H)D among children and young people, and a specialised protocol has been established to screen for, diagnose and treat AD(H)D among clients in drug treatment. This reflects the concern in Europe about the increasing prescriptions for methylphenidate for children by non-specialists.

Treatment for very young people using drugs

Early intervention

Generally, there is no comprehensive risk factor assessment that focuses on early detection of drug use. In some Member States (Germany, Greece, the Netherlands), specialised facilities offer counselling and care for children and teenagers with drug problems although coverage is limited. Many facilities combine inpatient and outpatient measures and include important elements from both addiction therapy and youth welfare.

Treatment

Little information is available on drug treatment targeted to drug-using children. Although only one third of European countries report the existence of drug treatment centres for children or young people (Germany, Greece, Luxembourg, Cyprus, the Netherlands, Austria, Portugal, Romania), in most countries specific programmes or interventions for drug-using children are available. Treatment centres or programmes specifically targeted to child drug users are found in several settings: prevention centres or programmes (e.g. Cyprus, Austria); treatment services for adult drug users focusing on a specific substance (e.g. cannabis clinics in France, programmes on volatile substances in the United Kingdom); programmes for drug-using children in child psychiatric clinics (e.g. Hungary); or in institutions for problematic children, such as State care, reformatories, institutions for problematic or sentenced children (e.g. the United Kingdom). In the United Kingdom, a national framework has been developed to address volatile substance abuse.

Owing to scarce treatment availability, some children encountering problems related to drug use enter treatment in the general drug treatment services for the adult population. However, direct contact with adult drug users consuming heroin, cocaine and other drugs may have a negative influence on the behaviour of these children. For that reason, several countries have identified a need to establish drug services specifically for very young people.

The most common treatment approaches for drug-using children are based on individual care plans, in which health, social and educational services collaborate to produce an integrated intervention. Family involvement is another fundamental element in the treatment of children, and may include therapeutic sessions and social work with the family. Cognitive behavioural therapy and motivational support are common approaches in interventions for drug-using children.

Legislation and regulations

It is known that use of tobacco and alcohol (age of onset, intensity of use, social perception and attitudes) has a major influence on initiation of illicit drugs use. In most Member

States, this connection is taken into account in public health policies. From this perspective, measures to prevent the early use of licit substances are viewed also as prevention against illicit use. Controlling the access of children and adolescents to licit psychoactive substances provides strong protection against the harm caused by these substances. This is particularly important in this group, as they are still in a phase of biological development when effects, e.g. on the neural system, could be more harmful than later. In addition, there is some evidence that delaying the onset of drug use leads to a reduction in any drug use at a later age.

The main approach in this area is to allow purchase or consumption of tobacco or alcohol only after a certain age or to limit access to places of leisure-time activities (pubs, discos) by imposing age limits.

National legislation differs widely across the Member States, and numerous measures have been used in attempts to reduce alcohol- and tobacco-related problems among very young people. For instance, some countries prohibit the employment of minors in some jobs that deal with alcohol or tobacco. This is the case in Estonia and Latvia. In Estonia, adults are also prohibited from buying tobacco and alcoholic beverages and offering them to minors. Estonia also reports that minors do not have the right to send or receive alcoholic beverages in postal consignments.

However, the most common strategy reported by Member States is the setting of a legal minimum age for purchase or consumption. Other legal measures targeting young people reported by Member States include a ban or restriction of purchase or consumption in specific public places, an increase in taxes related to these substances and restrictions on the advertising of such products.

Age requirements and other restrictions for purchase and consumption of alcoholic beverages or tobacco

Only Cyprus reports any specific legislative instruments or regulations specifically targeting minors under 15 years concerning the consumption or purchase of alcohol and tobacco, although even there the laws exhibit discrepancies, the age limit on the purchase of alcoholic drinks being variously specified as 14, 17 or 18 years.

In Europe overall, the age limit for buying or consuming alcoholic beverages varies from 14 to 20 years and that for buying or consuming tobacco products ranges from 16 to 18 years. However, there are sometimes exceptions even within the same country. Greece, for example, reports a different age limit for on-premises sales than for off-premises sales: the legal age for drinking alcoholic beverages on premises of direct consumption is 17 years, while there are no age restrictions on off-premises drinking or on the

purchase of alcohol. In Sweden, the legal age for buying low-strength beer (in the 2.25–3.5 % alcohol range — the strongest alcoholic beverage sold outside the retail monopoly in Sweden) is 18 years but the age limit for buying alcohol at monopoly stores is 20 years.

In some countries, age limits differ for different beverages. For example, in Germany and the Netherlands, the age limit for the purchase of mild alcoholic drinks such as beer is 16 whereas for stronger alcoholic drinks such as wine and spirits it is 18. In contrast, the Czech Republic, for instance, does not distinguish between different beverages and the legal age for the purchase of any alcoholic beverage and tobacco products is 18 years.

In the Czech Republic, Estonia, France, Hungary, the Netherlands and Portugal, retailers may ask for proof of age. In Hungary, for example, if evidence of the buyer's age is inadequate, the sale of tobacco products or alcoholic beverages must be denied. In France, decree No 949 of 6 September 2004 states that the vendor has the right to ask for a form of identity to prevent the sale of tobacco to minors under the age of 16. In Sweden, by comparison, staff must ask anyone who looks younger than 25 to show proof of age at the stores of the Swedish alcohol retailing monopoly (Systembolaget).

In addition to checking the age of the buyer, in places where tobacco products are sold in the Czech Republic, the retailer is obliged to place a clearly visible sign stating that these products cannot be sold to persons under 18 years. Also in the Czech Republic, it is forbidden to place vending machines selling tobacco products or alcohol in places where it is not possible to restrict their sale to persons over 18 years. In Romania, Law 125/2001 forbids the sale to minors of alcohol and tobacco products in automatic vending machines.

In several Member States, nationwide provisions may be enhanced by more stringent regulation at regional and/or local level. In the Czech Republic, other restrictions on the sales, serving and consumption of alcohol can be laid down by an ordinance issued by a municipality with its own powers. In Slovakia, the State retail inspectorate is responsible for supervising the enforcement of the ban on the sale of tobacco and alcohol to young people under the age of 18.

In the Czech Republic, responsibility for the implementation of these restrictions lies with the municipal police and a municipality with delegated powers. This is also the case in Sweden, where local authorities and the police are in charge of monitoring compliance with legislation on the sale of tobacco and alcohol. In the Netherlands, compliance

with the tobacco law by youngsters aged 13–15 is assessed regularly.

In Sweden, for example, staff found selling alcohol and tobacco to minors can be fined or sent to prison for a maximum of six months and the owner may also be prohibited, under penalty of a fine, from selling tobacco or beer for a given period of time. In the Czech Republic, failure to implement the ban on sales of tobacco and alcohol is punishable by a fine of between CZK 50 000 in the case of a physical entity and CZK 500 000 in the case a legal entity⁽¹²⁾. In Portugal, the sale of tobacco or alcohol to young people (under 16) is an administrative offence punishable by a fine, with the illegal sale of tobacco subject to a fine of EUR 1 900 to EUR 3 740 (for an individual) and EUR 30 000 to EUR 44 000 (for a company) and corresponding fines of EUR 498–30 740 and EUR 2 493–29 927 for the illegal sale of alcohol. In Cyprus, the supply of tobacco to a person under 18 constitutes a criminal offence⁽¹³⁾.

In Latvia, a person inducing a child to use alcoholic beverages or to smoke shall be held liable as prescribed by the law, and the giving of such products to minors is considered as inducing the child to use them and will be punished the same way.

The protected zone

Besides setting minimum legal age limits for the purchase and consumption of alcoholic beverages and tobacco, in most countries regulations ban or restrict smoking or drinking, or sometimes purchasing, alcoholic beverages in major public places such as educational facilities (e.g. in canteens, bars and restaurants in Portuguese schools) or during sports events (alcohol in France, alcohol and tobacco in the Czech Republic) often frequented by the young.

In Hungary, advertising of alcoholic beverages is prohibited in institutions of public education, in health institutions and within a distance of 200 metres from their entrance (Act LVIII of 1997 on business advertising activity). Romanian legislation (Law No 148/2000) prohibits the advertisement of alcohol in youth publications, learning units and public halls.

Regarding the legal provisions in national legislation that address minors as users, Member States fall into two main groups: those where very young people do not appear in court and those where they do.

Increase in taxes

Member States⁽¹⁴⁾ also use tax increases to reduce the attractiveness of tobacco or alcohol consumption. For example, in Luxembourg, the government has raised an additional tax on the designer drink market, which particularly targets youngsters, and in France tax penalties are levied on pre-mixed alcoholic beverages specifically designed for the young. In Germany in 2004, a tax was imposed on tobacco and the price of 'alcopops' was increased by about 80 cents in order to render these products financially less attractive to young people.

European Union action on use of tobacco and alcohol by very young people

The European Union has competence and responsibility to address public health problems such as harmful and hazardous alcohol and tobacco use by complementing national actions in this field, as stated in Article 152 of the EC Treaty.

In 2001, the Council adopted a recommendation on the drinking of alcohol by young people, in particular children and adolescents, which invites the Commission to follow up, assess and monitor developments and the measures taken, and to report on the need for further actions. In its conclusions of 5 June 2001, the Council invited the Commission to put forward proposals for a comprehensive Community strategy aimed at reducing alcohol-related harm to complement national policies. The Council conclusions on alcohol and young people of June 2004 reiterated this invitation. Most Member States have taken actions to reduce alcohol-related harm, and many of them have extensive policies in this field.

Concerning tobacco, in December 2002, the Council adopted a recommendation on the prevention of smoking and on initiatives to improve tobacco control with the aim of encouraging Member States to improve tobacco control with particular emphasis on stepping up the prevention of smoking among children and adolescents.

Besides this non-binding legal instrument, the European Parliament and the Council also adopted, in May 2003, a directive intended to prohibit tobacco advertising at EU level. The directive is founded not on the article related to public health (Article 152) but on the article related to the internal market.

In addition to legislative action, two anti-tobacco campaigns in the media have also aimed at highlighting the hazards of passive smoking and at promoting tobacco-free lifestyles, particularly among young people.

⁽¹²⁾ In the Czech Republic, the sale, serving or any manner of facilitation of the consumption of alcohol to a person aged under 18 can also be prosecuted according to 200/1990 Coll. on Misdemeanours (punishable with a fine of up to CZK 3 000 or up to CZK 5 000 and prohibition of activities for up to one year).

⁽¹³⁾ This provision is included in both the protection of health law and the law on children, for minors under the age of 14.

⁽¹⁴⁾ The communication from the Commission on 'An EU strategy to support Member States in reducing alcohol-related harm' (COM (2006) 625 final, 24.10.2006) reports that Denmark, Germany, Ireland, France and Luxembourg have imposed a special tax or compulsory labelling for products such as 'alcopops'.

Illicit substances

A first analysis was made in October 2003 on the legal provisions in national legislations that address the issue of drugs among very young people ⁽¹⁵⁾. The objective here is to examine recent changes in legal approaches regarding drug use among minors.

Almost all drug action plans or strategies of Member States target young people in prevention, and in some cases also in treatment provisions (EMCDDA, 2006). In addition, some countries, such as Portugal, report specific provisions in their strategic document directed at very young people. Some countries have also provided interesting information related to the situation in which the minor is the 'victim', i.e. when exposed to drugs by an adult. In the Czech Republic, for example, the penal code protects minors against illicit drugs and allows for stricter sanctions if the drug offence was committed against a person aged under 15 or 18. Similarly, in the Czech Republic and Estonia (2004 national report), inciting or promoting the use of illicit drugs by young people attracts a high penalty. In Slovakia, any incitement to abuse any addictive substance constitutes a criminal offence.

The sale of illicit drugs around schools or locations usually attended by young people is also punished severely. This is the case, for example, in Denmark, where an amendment to the Euphoricants Act in 2004 deems it a significantly aggravating circumstance if drugs are sold or offered free of charge with the view to subsequent sale in restaurants, discotheques or similar places typically attended by children or young people.

In England and Wales, two pieces of legislation affect the availability of inhalants to young people. The first of these is the Intoxicating Substances (Supply) Act 1985. This makes it illegal for retailers to sell volatile substances to anyone under the age of 18 if there is reason to believe that they will use it for inhalation and intoxication purposes. This legislation does not, however, specify which products should be restricted and few cases have been brought to court. In 1999, the supply or sale of cigarette lighter refills to people under the age of 18 was specifically banned under the Cigarette Lighter Refills (Safety) Regulations. Measures to restrict availability are also in place in Scotland and further legislation in the United Kingdom addresses solvent availability for all ages. In recent years, the British Aerosol Manufacturers' Association (BAMA) has promoted the use of a warning on many commonly abused products (Orr and Shewan, 2006). In Romania, prison sentences were increased in 2005 for offences related to the supply of a toxic chemical inhalant to a minor to use for intoxication purposes.

In Cyprus, under the Child and Family Programme offered by the social welfare services, drug offenders under the age of 14, not involved in a serious crime, do not appear in court and their case is managed by the social welfare services.

Similarly, in Denmark, it is not the courts which decide the outcome for very young drug offenders. The municipality is responsible for examining the case and taking into account the overall social support being provided, as well as for drawing up an action plan for the entire intervention process, including treatment for drug use. In special cases (young people under 18 who have serious social and behavioural problems due to drug abuse), the county is obliged to offer drug addiction treatment. In Hungary, juvenile offences committed by children under 14 years cannot be punished and the child welfare services and the court of guardians are notified by the investigating authority immediately.

In the Member States which reported that very young people appear in court, there is very often a strong bias towards educational or treatment measures.

In the Czech Republic, for instance, children under 15 years are not criminally responsible and a special court for juveniles may impose either supervision by a probation officer, a therapeutic, psychological or other suitable educational programme in an educational care centre, or protective education.

The diversion of young offenders from prosecution is also a key element in Ireland and Greece. In Ireland, under the Children Act 2001, judges are required to seek pre-sentencing reports from the Probation and Welfare Service in all cases involving under-18-year-olds where the judge is considering a custodial sentence or community sanction. In Greece, offenders aged 8–13 years are not prosecuted but instead are subject to reformatory or therapeutic measures. Once the minor enters his/her 14th year, the court can impose imprisonment in a special prison for young persons (Law 3189/2003). Therapeutic measures are imposed if the minor uses drugs, following a psychiatric report and laboratory results.

In Luxembourg, the public prosecutor decides whether to close or to prosecute a drug-related case involving a minor. A minor can be prescribed compulsory treatment before his or her case is brought to court. On the other hand, the juvenile court can order educational assistance, out-of-home placements, treatment or social work supervised by the central service for social assistance. Médecins sans frontières'

⁽¹⁵⁾ <http://eldd.emcdda.europa.eu/?nnodeid=5175>

youth solidarity project works closely with the juvenile court to care for young drug law offenders.

In Slovakia, the new penal law ⁽¹⁶⁾ incorporates special provisions for minors, which cannot be used for a person older than 18 (depending, for example, on the severity of the act, imposition of penalties, probation upon sentencing).

In the same way in Spain, Organic Law 5/2000, 12 January, regulates the criminal liability of minors. Juvenile courts assume the responsibility of passing judgment, and minors aged 14–18 shall be criminally liable when they have committed crimes or offences considered as such in the penal code. However, for the youngest drug offender, should the need arise, therapeutic measures laid down in the law can be applied.

Conclusions

While the majority of under-15s have not used licit or illicit substances, and substance dependence is very rare in this age group, use at a very early age is recognised as a predictor of later drug dependence and other problems and as an indicator and crucial element of a difficult family and social situation for those concerned.

The prevalence of daily tobacco smoking at the age of 13 varies in European countries from 7 % to 14 % and for having been drunk from 5 % to 36 %. The prevalence of illicit drug use at that age is lower. In almost all European countries, lifetime prevalence of cannabis use among under-15s is between 0 % and 8 %, though in the United Kingdom it rises to 13 %. Most countries report either a stable or an increasing prevalence of cannabis use among very young people. The prevalence of the use of inhalants is lower, and for other substances lower still.

Problematic drug use is rarely found among very young people; in Europe only 1 % of treatment clients are younger than 15. While the numbers involved are low (about 4 000 in 2005), a sizable increase in very young clients entering treatment for drug use is reported from 1999 to 2005. An increase in the numbers of young people entering treatment is in itself a reason for the establishment of drug treatment services specifically for children, and that could result in further increases in the numbers of children in drug treatment. Often children enter drug treatment referred by families and by social services or by the criminal justice system;

the primary drugs are mainly cannabis or inhalants; only in a few cases are opioids the primary drug. The proportion of girls among the very young client group is higher than in the older age group. Possible reasons include a greater similarity of behaviour in boys and girls in this age group or a more equal gender distribution of co-morbid disorders at this age or delayed psychosocial development of boys compared with girls.

The few regular drug users among very young people are often part of a highly problematic group of the population, in which drugs are just one among other factors. Child drug users often come from problematic families and socially excluded groups; a negative relationship with school also seems to be associated with a high risk of drug taking among children. Increasing attention is currently being paid to the relation between AD(H)D, conduct disorders and other psychological disorders and drug use among very young people.

Responses targeted at child drug users mainly focus on prevention strategies, ranging from universal approaches to early intervention when substance use is already suspected. More attention has recently been given to the treatment of behavioural disorders in a global way. European and national legislation on substance use among young people focuses on restrictions on the purchase of licit substances (tobacco and alcohol) and on social interventions in the case of drug-using children committing crimes. In countries where children committing crimes are sent to court, treatment is often proposed as an alternative to punishment. Many of the children entering drug treatment are referred to it by the criminal justice system. Specialised treatment for drug-using children is still rare, but more targeted structures have been created recently, allowing better responses to the specific needs of very young people.

In general, interventions for children tend to focus not on drug use, but on a broader perspective in which the social context, in particular family and school, is a fundamental component. Preference is also given to integrated approaches in which drug treatment is coordinated with health, education and social services; the justice system may also be involved in ensuring compliance. The interventions aim to prevent an early initiation to substance use, which might lead to later regular use, or target a risk group within the population, tackling drug problems together with other problems.

⁽¹⁶⁾ The new Slovak penal code reduced the age of criminal responsibility by one year, meaning that a person having reached the 14th year of his/her age and not having exceeded the 18th year is considered as a juvenile.

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