European Monitoring Centre for Drugs and Drug Addiction

2010 NATIONAL REPORT (2009 data) TO the EMCDDA by REITOX National Focal Point

ESTONIA
New developments, trends and in-depth information on selected issues

REITOX

REPORT ON DRUG SITUATION IN ESTONIA IN 2010 (2009 data)

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Abbreviations

AIDS - Acquired Immunodeficiency Syndrome
EDMC - Estonian Drug Monitoring Centre
EFSI - Estonian Forensic Science Institute
ESPAD - European School Survey Project on Alcohol and Other Drugs
EWS - Early Warning System
GBL - Gamma-Butyrolactone
GHB - Gammahydroxybutyrate
HIV - Human Immunodeficiency Virus
IDUs - Injecting Drug Users
IISS - International and Social Studies
ISCD - Information System of Infectious Diseases
MER - Ministry of Education and Research
NDTD - National Drug Treatment Database
NIHD - National Institute for Health Development
NSPDA - The National Strategy for Prevention of Drug Addiction until 2012
STD - Sexually Transmitted Diseases
TB - Tuberculosis
TDI - The Treatment Demand Indicator
UNODC - United Nation Office on Drugs and Crime

Contents

Summary

Drug policy: legislation, strategies and economic analysis

The National Strategy for Prevention of Drug Addiction until 2012 (NSPDA) is still the source document for combating drug addiction in Estonia. In 2009, the process for updating the NSPDA was started and the action plan for the NSPDA for the period of 2009–2012 was prepared.

No essential changes were introduced into the institutional framework related to the area of drug addiction compared to 2008. The only change worth mentioning was the establishment of two new administrative agencies by merging several existing agencies. The Health Board was formed by merging of the Health Care Board, the Health Protection Inspectorate and the Chemicals Notification Board, and the Police and the Border Guard Board was formed by merging of the Police Board, the Central Criminal Police, the Personal Protection Service, the Border Guard Administration and the Citizenship and Migration Board. Both agencies formed have operated from 1 January 2010.

Regarding legislation related to narcotic substances, eight substances were added to List I of narcotic drugs and psychotropic substances in 2009. The following substances were added to the List: mephedrone, JWH-073, JWH-018, CP 47497, CP 47497-C6-homologue, CP 47497-C8-homologue, CP 47497-C9-homologue, HU-210. Regarding legislation on drug-related crime, the Ministry of Justice was engaged in preparation of a draft legislation of alternative punishments to drug addicts that was sent to be circulated for approval. According to the plans, alternative punishment would be applied to drug addicts who have an actual penalty ranging from six months to two years and who agree to undergo treatment. In the legislation covering drug-related infectious diseases, a framework was established in 2009 for communicating information regarding risk factors of incidence and contraction of AIDS and HIV infection, providing future opportunities for obtaining information by risk groups.

Due to the economic crisis, the budget for the NSPDA was cut by 44% compared to the previous year (2008 – EUR 2,507,153, 2009 – EUR 1 408 873). The decrease was most drastic in the area of primary prevention, resulting in cancelling of information campaigns and preventive activities targeted to the society. Cuts in the budget for the NSPDA did not allow expanding treatment and rehabilitation services for drug addicts. Two of the main harm reduction services for drug addicts – syringe exchange and methadone substitution treatment were financed from the National Strategy of HIV/AIDS Prevention. Total

budgetary funds of National Strategy of HIV/AIDS Prevention in 2009 for prevention of HIV amounted to EUR 11,858,162 in 2009.

Drug use in the general population and specific targeted groups

We are not providing any recent data regarding drug use in general population and school population in this report. The survey among the Estonian population conducted in 2008 was thoroughly examined in the previous report where we referred to the trends causing concerns: the proportion having used drugs during their lifetime in the population has increased and the use of drugs is the heaviest in the age group of 25–34. Cannabis products, ecstasy and amphetamine are among the most wide-spread drugs among the population, while the increase in the use of stimulants among females was indicated separately.

Prevention

Due to the budget cuts introduced in 2009, no prevention campaigns and regional prevention activities were implemented. Most of the universal prevention in 2009 was based on the development of information materials and guidelines, training of instructors and provision of drug-related information through information portal www.narko.ee.
Unfortunately, we still cannot speak of drug prevention lessons in the general education system provided on common basis and study aids in the reporting period. Nevertheless, the subject syllabus in human studies completed in 2009 by the Ministry of Education and Research (MER), approved in 2010 based on the study materials of social coping skills developed during previous years, is indeed a positive trend. Proceeding from the professional standards, subject teachers acquire the teaching material within the framework of national in-service training of teachers. Drug prevention and prevention of risk behaviour are addressed in the lessons of human studies from form 2 to form 12.

Problem drug use

A new survey aiming at evaluation of the proportion and prevalence of the population group of injecting drug users (IDUs) by applying the capture-recapture method in the period of 2005−2009, will be conducted by the National Institute for Health Development (NIHD) and Department of Public Health, Tartu University in 2010. The results of this study will be published in 2011.

Drug-related treatment

Among the drug treatment services, methadone substitution treatment and also to a small extent detoxification treatment and rehabilitation services were available in 2009. Various drug treatment services are financed through the National HIV and AIDS Strategy, NSPDA and Tallinn Board of Social Welfare and Health Care. As of the end of 2009, a total of 660 adult drug addicts received substitution treatment funded from the National HIV and AIDS Strategy. Besides substitution treatment, the detoxification of 32 persons was funded in 2009 from the NSPDA and rehabilitation services for 181 persons was funded from the City of Tallinn and NSPDA. Besides adult addicts, the City of Tallinn also financed the addiction treatment of 117 minors.

Pursuant to the data of the National Drug Treatment Database (NDTD), the number of persons who applied for drug treatment in 2009 was 687; most of them were males, aged 20–34. 97% of those applying for drug treatment had a diagnosis of mental and behavioural disorders resulting from drug use, for the overwhelming majority (70%) methadone was prescribed as the main medication. Most of the persons applying for drug treatment received outpatient care, 70% received substitution treatment and 13% detoxification treatment. A total of 71% of the opiate addicts applying for treatment used fentanyl analogues (fentanyl and 3-methylfentanyl) as the main drug before applying for treatment, and 21% used heroine. 76% of the persons applying for treatment in 2009 had earlier experiences with drug treatment. Half of the persons having applied for drug treatment lived in Tallinn, 39% in Ida-Viru county. Compared to 2008, the proportion of the unemployed has soared among the persons applying for drug treatment.

Health correlates and consequences

In 2009, the total number of new HIV cases recorded was 411, 69% of them were male. Compared to 2008, the number of persons infected with HIV decreased by 134 persons. In 2009, also the number of persons having contracting acute viral hepatitis B fell abruptly from 53 cases in 2008 to 29 cases in 2009. 67 persons contracted viral hepatitis C in 2009. Regarding all three drug-related infectious diseases, the fact that the transmission route is known only for one-third of the cases, causes concern.

All of those having contracted tuberculosis (TB) in 2009 (n=378) 9.5%, (36 persons), were HIV-positive. Totally 24 (66.7%) of the 36 HIV-positive persons having contracted TB (33 first cases and 3 relapses), used or had used drugs.

The data of the Estonian Causes of Death Registry of the NIHD state that the total number of drug-related deaths was 133 in 2009, most of them were males. The average age of the

persons having died as a result of drug use was 29. According to the data of the Estonian Forensic Science Institute, the majority of the poisoning deaths related to the use of narcotic and psychotropic substances in 2009 and also in previous years were related to the accidental poisoning with 3-methylfentanyl.

Responses to health correlates and consequences

Considering the size of the IDUs group and prevalence of drug-related infectious diseases, securing the sustainability of harm reduction services (incl. increasing the volume of services and improvement of availability, integration of new services) in the future is of key importance. In the reporting period, the activities in the given area were mainly focused on the prevention and treatment of infectious diseases. In 2009, there were 36 syringe exchange points in 17 cities/settlements in Estonia, 13 of them were stationary and 23 field-work syringe exchange points. In total, 2 277 509 syringes were distributed to IDUs in 2009.

Drug-related crime, prevention of drug-related crime and prison

In 2009, drug-related crime comprised 2% of all recorded crimes. In total, 1042 drug-related crimes (Penal Code, §§ 183−190) were recorded in 2009, which is one-third (31%) less than in 2008. Of all drug-related crimes recorded in 2009, cases of unlawful handling of large quantities of narcotic drugs or psychotropic substances and provision of large quantities of narcotic drugs (§ 184) comprised 76% (n=789).
According to the estimations of the Ministry of Justice, there were 870 drug addicts in prisons (one-fourth of the total number of convicts), incl. ca 430 opiate addicts. 147 convicts underwent detoxification treatment due to use of non-opiate drugs in 2009, which exceeds the initial targets by 47 persons. Opportunities for opiate substitution treatment are still extremely limited in prisons. Only 12 convicts received substitution treatment in prisons in 2009. Drug-free departments are available in three prisons in Estonia, with 96 places.

Drug market

In 2009, the amounts of narcotic substances confiscated mostly exceeded the respective indicators of 2008 in the majority of substances. The amounts of amphetamine (56 kg), cocaine (5 kg), heroine (4 kg) and GHB (25 kg) increased considerably. In 2009, the increase in the seized amounts of GHB and the increasing GBL detection in postal packets were the major sources of concern. Also the amounts of fentanyl and analogues widely

used by the Estonian IDUs confiscated in 2009 almost doubled. The price of 1 gram of fentanyl in the reporting period remained between 64 and 69 euro. The price of amphetamine, on the other hand, exceeded 3 euro despite a decline in the purity of amphetamine. The cocaine price that dropped a little in 2009 coincided with the decline in the purity of the substance. The price of cannabis products remained at the same level (EUR 19), but the amounts of cannabis products seized during the reporting period dropped significantly.

Section A: New developments and trends

Chapter 1. Drug policy: legislation, strategies and economic analyses

The information provided in this Chapter is based on the reporting of the NSPDA 2012 and on the revision of drug-related legislation published in the database of the Electronic State Gazette. The implementation of the NSPDA is coordinated by the Ministry of Social Affairs; in addition to the Ministry of Social Affairs, the following institutions are involved in the performance of the NSPDA: NIHD, MER, Ministry of Justice, Ministry of Internal Affairs and Tax and Customs Board, which is in the area of administration of the Ministry of Finance. The reduction of demand and supply is annually financed on the basis of the Action Plan of NSPDA approved by the Minister of Social Affairs.
In 2009, the resources of the drug addiction prevention strategy decreased due to cuts in public expenditures made because of the economic crisis. If in 2008, EUR 2, 507, 153 was allocated for the implementation of the drug addiction prevention strategy, the funds allocated in 2009 amounted only to EUR 1 408 873 (Report on the performance of the NSPDA and its action plan, 2010).

1.1 Legal framework

Eight new substances were added to List I of narcotic drugs and psychotropic substances

Preparation and approval of the lists of narcotic and psychotropic substances is governed in Estonia by the Act on Narcotic Drugs and Psychotropic Substances and Precursors thereof (RT I 1997, 52, 834). In 2009, in total eight substances were added to List I of

narcotic drugs and psychotropic substances. Regulation No. 73 'Conditions and Procedure for Handling of Narcotic Drugs and Psychotropic Substances for Medical and Research Purposes, and Conditions and Procedure for Recording and Reporting in that Area and Lists of Narcotic Drugs and Psychotropic Substances' (Appendix to the State Gazette 2005, 57, 807; 2008, 61, 875) of the Minister of Social Affairs dated from 18 May 2005 was amended by Regulation No. 87 of the Minister of Social Affairs dated from 27 November 2009 (Appendix to the State Gazette, 08.12.2009, 89, 1308), whereby the List I of narcotic drugs and psychotropic substances was supplemented by 4-methylmethcathinone (mephedrone, 4-MMC) and JWH-073 JWH-073 Naphthalen-1-yl-(1-butylindol-3-yl) methanone. By Regulation No. 71 of the Minister of Social Affairs dated from 10 July 2009 (Appendix to the State Gazette, 21.07.2009, 59, 872), Regulation No. 73 of the Minister of Social Affairs dated from 18 May 2005 was amended, based whereupon the List I of narcotic drugs and psychotropic substances was supplemented by JWH-018 Naphthalen-1-yl-(1-pentylindol-3-yl)methanon, CP 47497 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]phenol, CP 47497-C6-homologe 5-(1,1-dimethylhexyl)-2-[(1R,3S)-3-hydroxycyclohexyl]phenol, CP 47497-C8-homologe 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]phenol, CP 47497-C9-homologe 5-(1,1-dimethylnonyl)-2-[(1R,3S)-3-hydroxycyclohexyl]phenol, HU-210 (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol.

Collecting of data on HIV-infection cases based on the risk groups

On 1 October 2009, Regulation No. 134 'Procedure for Presentation of Information about Infectious Diseases and Occurrence of Infectious Diseases and Risk Factors of Illness and Composition of Presented Data with Personal Data Identifying the Data Subject' (eRT, 27.07.2009, 41, 279) of the Government of the Republic dated from 23 July 2009 entered into force. The Regulation establishes a new procedure for presentation of information about infectious diseases, occurrence of infectious diseases and the risk factors of illness, and stipulates the composition of presented data. Additionally, a list of infectious diseases was determined, on which, when suspected or diagnosed, information must be presented including personal data that identify the data subject. Thus, as of 1 October 2009, doctors who have diagnosed a infectious disease have to send a digital notice to the Health Protection Inspectorate through the Information System of Infectious Diseases (ISCD) within 24 hours of making the final diagnosis of AIDS or HIV infection. [1]. After the Regulation has come into force, no HIV notice is filled in on the first cases of the illness that have been anonymously registered in AIDS counselling rooms.

[1] Starting from 01/01/2010 these data are collected by the Health Board that was formed by merging the Health Care Board, Health Protection Inspectorate and Chemicals Notification Board.

By Regulation No. 133 of the Government of the Republic dated 23 from July 2009 (eRT, 27.07.2009, 41, 278) the Statutes of the Estonian Infectious Diseases Registry was approved. Pursuant to the Statutes of the Infectious Diseases Registry, the Ministry of Social Affairs is the chief processor of the registry, and the Health Protection Inspectorate is its authorised processor (the Health Board as of 01.01.2010). Due to the aforementioned new electronic HIV notice, reliable data about people belonging to the risk group of people infected with HIV, and the transmission routes can be collected in the Infectious Diseases Registry.

Creation of legal bases for application of treatment of addiction as alternative punishment

The Ministry of Justice has sent the draft regulation for the amendment of the Penal Code, the Criminal Procedure Code, the Punishment Register Act and the Probation Supervision Act to be circulated for approval, whereby treatment of addiction is intended to be applied to drug addicts as an alternative punishment. The objective of the draft is to apply treatment of addiction to persons addicted to narcotic drugs and having committed a crime and such treatment will be financed from the state budget funds. Also, the draft is aimed at creating options for terminating criminal proceedings if a person voluntarily agrees to be sent for treatment of addiction.

The treatment of addiction of drug addicts as an alternative punishment was planned to apply only in the cases when a person has been actually sentenced to six-month to two-year imprisonment as a punishment, and the sentenced person agrees with that imprisonment to be replaced. Pursuant to the draft, the duration of the alternative punishment, i.e. treatment of addiction, is twelve months minimum and three years maximum. During the treatment, the sentenced person has to comply with supervision requirements and perform the obligations imposed on him/her, the performance of which shall be supervised by a probation supervisor. Thus, the duration of treatment of addiction imposed as an alternative punishment to replace imprisonment can be longer than the duration of actual imprisonment. In such case, a person is ensured a smaller restriction of freedom combined with the application of treatment at the state's expense (explanatory memo of the Ministry of Justice, 2010).

Early Warning System (EWS)

Within the framework of development of the EWS, legal bases for the exchange of confidential information were being developed in 2009. The issue was raised in the

Committee on Prevention of Drug Addiction of the Government of the Republic, where it was found that for better operation of the EWS, it is reasonable to develop a legal basis for improved coordination of information exchange between the agencies. The development of legislation was postponed to 2010.

1.2 National action plan, strategy, evaluation and coordination

The Ministry of Social Affairs coordinates the implementation of the NSPDA until 2012, and it also manages the activity of the Committee for Prevention of Drug Addiction of the Government of the Republic. In addition to the Ministry of Social Affairs, the following institutions are involved in the performance of the NSPDA: NIHD, MER, Ministry of Justice, Ministry of Internal Affairs and Tax and Customs Board, which is in the area of administration of the Ministry of Finance.

In 2009, the Ministry of Social Affairs, through various working groups, was engaged in the preparation of the action plan of the strategy for the prevention of drug addiction for 2009–2012. However, the new action plan was not submitted to the Government for approval in 2009. Six working groups formed by the Ministry of Social Affairs were engaged in the development of the action plan: prevention, harm reduction, drug treatment and rehabilitation, reduction of supply, monitoring and evaluation, and drugs in prison. Based on the areas of the working groups, the developed action plan comprises six parts. The only difference in the parts of the action plans for the previous years is that the Chapter considering monitoring and evaluation was renamed 'Monitoring, evaluation and scientific research'. In addition to the preparation of the action plan, the updating of the national strategy for the prevention of drug addiction was also started in 2009.

Formation of the Health Board, and Police and Border Guard Board

The major changes in the institutional framework in 2009 were the formation of the Health Board and Police and Border Guard Board. Both establishments were formed by way of merger of different institutions. The Health Board was formed by merging the Health Care Board, Health Protection Inspectorate and Chemicals Notification Centre (eRT, 21.10.009, 49, 331). The new agency started operation on 1 January 2010. The Health Board is a government agency functioning in the area of government of the Ministry of Social Affairs; its areas of activity include healthcare, monitoring, prevention and control of infectious diseases, environmental health, chemical and medical equipment safety (Appendix to the State Gazette, 12.11.2009, 84, 1235). The Police and Border Guard Board was formed by

merging the Police Board, Central Criminal Police, Personal Protection Service, Border Guard Administration and Citizenship and Migration Board (Appendix to the State Gazette, 29.12.2009, 99, 1476). Similarly to the Health Board, the Police and Border Guard Board started operation from 1 January 2010.

1.3 Economic analysis

In 2009, EUR 14,088,73 were allocated for the implementation of the action plan of the NSPDA (Report on the performance of the NSPDA and its action plan, 2010). Compared to 2008, the total expenses of the strategy for the prevention of drug addiction in 2009 decreased by 44% (in 2008, they amounted to EUR 2,507,153). Such budget cut was due to economic crisis. By areas of activity, the actual expenses of the NSPDA decreased in the area of supply as well as demand (Table 1). In brief, it can be said that in 2009 the resources of the area of administration of the Ministry of Internal Affairs decreased more than four times, and the resources of the Tax and Customs Board two times. Compared to 2008, the expenses of the Ministry of Justice for the prevention of drug addiction in prisons dropped nearly eight times.

Table 1. Use of resources of the NSPDA in 2007–2009 (EUR).

	2007	2008	2009
Reducing demand			
Ministry of Social Affairs (the NIHD, EDMC, Social Welfare Department of the Ministry of Social Affairs)	1,169176	1,537,228	1,137,235
Ministry of Education and Research	*	*	24,455
Reducing supply			
Ministry of Justice	123,627	184,183	23,333
Ministry of Internal Affairs (incl. Police Board)	27,546	639,116	151,790
Ministry of Finance (Tax and Customs Board)	990,311	146,626	72,060
TOTAL demand and supply	2,310,660	2,507,153	1,408,873

Source: 2009 Report of the action plan of the NSPDA.

* It is impossible to indicate the expenses of the activities of the Ministry of Education and Research separately for 2007 and 2008.

In 2009, resources in the area of primary prevention were considerably reduced in the area of demand reduction, where no notification activity aimed at the general population or local preventive activities were carried out (see Chapter 3). Due to the budget cuts, the scope of treatment and rehabilitation services provided to drug addicts did not increase either. In

total, 81% of the funds used within the framework of the NSPDA were spent for the activities of the area of demand reduction in the area of administration of the Ministry of Social Affairs (prevention, treatment and rehabilitation, harm reduction, monitoring and evaluation) (Table 1).

The area of harm reduction (syringe exchange, substitution treatment with methadone and distribution of condoms) was financed from the funds of HIV/AIDS national strategy. In 2009, the national HIV and AIDS strategy was financed with a total of EUR 11,858,162; of this amount, the biggest expenditure constituted the purchase of antiretroviral medicinal products (EUR 5,138,497). As a result of the cuts in the state budget made due to economic crisis, the budget of HIV/AIDS preventive activities performed by the National Institute for Health Development also noticeably decreased in 2009. While in 2008, EUR 3,079,830 was spent on HIV prevention in different groups at risk, in 2009, this amount dropped to EUR 2,423,478 (Table 2).

Table 2. Funds allocated for HIV/AIDS prevention in 2007–2009 (EUR)

	2007	**2008**	**2009**
HIV/AIDS prevention	2,431,409	3,079,830	2,423,478
ARV treatment	1,269,792	5,176,844	5,138,497

2009 Report of the National HIV and AIDS strategy.

*in 2004-2007 the purchase of ARV medicinal products was financed from GFATM funds.

*in 2008 and 2009, the purchase of ARV medicinal products was financed from the budget of the Ministry of Social Affairs.

To reduce supply (Ministry of Internal Affairs and Ministry of Finance), 16% of the NSPDA funds were used (EUR 223,851). The Ministry of Internal Affairs and its sub-offices are responsible for the area of supply reduction in Estonia. The sub-office of the Ministry of Finance, the Tax and Customs Board, is engaged in the detection, control and prevention of cross-border drug crimes in Estonia. In 2009, Tax and Customs Board used a total of EUR 72,060 for anti-drug activities. In conclusion it can be said that reduction of supply is a routine activity of the institutions related to this area, where it is frequently complicated to differentiate expenses for anti-drug activities in particular, and therefore not all respective expenses have been specified in the NSPDA report either. As to anti-drug activities, the main focus in 2009 was on the detection and apprehension of street dealers with large turnovers, their suppliers and large criminal groups engaged in drug-related crimes. A continually major target was also ascertaining and confiscating of income from drug-related criminal activities.

Chapter 2. Drug use in the general population and specific targeted groups

No recent surveys of drug use in the general population and among school students have been carried out during the reporting period. The next ESPAD[2] survey will be conducted among Estonian school students aged 15–16 in 2011. The population survey studying the use of narcotic drugs, alcohol and tobacco by the general population will be conducted in Estonia in 2013. The Institute of International and Social Studies of the Tallinn University has been conducting both surveys for years.

In 2009, the Institute of International and Social Studies (IISS) of the Tallinn University conducted a qualitative survey 'Use of drugs and related risk behaviour amount young people visiting Tallinn nightclubs'. The aim of the survey was to identify drug-use practices in nightclubs and related risk behaviour. Within the framework of the survey, a total of 26 respondents were questioned, of which 19 were young people aged 18–30 using drugs, who visit Tallinn recreational settings, and seven key persons working in recreational establishments (incl. security guards, club managers, DJs).

2.1 Drug use in the general population

In the previous report, we provided detailed drug-use related results of the population survey "Estonia 2008" conducted in 2008 (population aged 15–69). The next population survey will be carried out in 2013. Similarly to the previous years, this survey will be conducted by post, and the representative sample will be formed on the basis of the Population Register.

2.2. Drug use in the school and youth population

More recent data about drug use among school students are not provided in this report. The results of ESPAD survey conducted in 2007 were provided in the report for 2008. The next ESPAD survey among school students will be carried out in 2011. The preparation of this survey in 2010 and conducting in 2011 is financed from the resources of the action plan of the NSPDA.

[2] European School Survey Project on Alcohol and Other Drugs (ESPAD)

2.3. Drug use among specific groups and settings at the national and local levels

In 2009, the Tallinn University together with the Institute of IISS conducted a qualitative survey on the use of drugs and related risk behaviour in nightclubs and party settings. The results of the survey 'Use of drugs and related risk behaviour among young people visiting Tallinn nightclubs' was published in 2010. The aim of the survey was to identify drug-use practices in nightclubs and the related risk behaviour. Within the framework of the study, 26 semi-structured individual interviews were held, of these 19 interviews were conducted with drug users (W=4, M=15) (16 Estonian language speakers and 3 Russian language speakers) and 7 with key persons (incl. security guards, club managers, DJs). The selection of interviewees was based on the following preconditions: age starting from 18 years of age, use of any stimulants (amphetamine, ecstasy) in the past three months, and visiting Tallinn nightclubs. Additionally, the survey group performed description observations of nine Tallinn clubs during three months (the clubs were Prive, Parlament, Spider, Seduction, Venus, Hollywood, From Dusk Till Dawn, EKKM, Korter) with the aim of obtaining an overview of the survey environment.

The survey results cannot be generalised and extended to the entire specific group of drug users in Tallinn recreational settings. However, the survey results provide an overview of drug use and related risk behaviour pattern variance in respect of this specific group, providing valuable information for prevention.

The survey demonstrated that stimulants are used in Tallinn clubs, and simultaneous use of several drugs is widely spread. Typically, stimulants of one type are used simultaneously; of these, cocaine and ecstasy as well as amphetamine and alcohol are used together most commonly. Simultaneous use of ecstasy and amphetamine is related to a negative experience, and according to respondents, they rather avoid using them together. Amphetamine is considered to be an alcohol neutraliser that helps to stay "sober" and better control one's behaviour. According to respondents, drugs are rather not used openly in clubs, and this is mainly because clubs themselves knowingly try to avoid the reputation of the so-called drug club. The results reveal a pattern that the more elite the club, the less drugs are used there. To ensure safety in the clubs, security guards are usually trained to identify persons intoxicated by drugs, and the restrooms in the clubs are closely watched. Summoning of the police is not deemed reasonable since the appearance of the police in nightclubs would damage their reputation.

Stimulant users define risk behaviour as the use of drugs outside the club environment and intrusion of drugs into ordinary life. Low quality of drugs is considered to be a major health hazard (cases of intoxication and overdose), and it is also seen as a "waste of money" since "the goods do not meet the requirements and do not create the expected effect". The

impact of drug use on health is associated with "low quality drugs" or drugs of a certain type (e.g., GHB, with which "flaking out" is associated), and not with the general harmful effect of drugs. As to overdose, it is mainly ecstasy and GHB that are associated with it, and according to respondents, these substances are also used with greater caution.

It was stated in the survey that users of drugs in recreational settings are unaware of overdose or its prevention options. When experimenting with new drugs, the risks are minimised by taking a drug in small quantities at first.

Although the young people participating in the survey were to some extent aware of the risks related to drugs and of their prevention, some respondents considered the use of drugs to be safer than the use of alcohol. A short-term health hazard is seen as an inevitable consequence of the use of stimulants and alcohol.

Generally, risky sex behaviour and unwanted sexual intercourse is also associated with drug use. The survey demonstrated that users of stimulants in recreational settings do not associate drug use with risky sexual behaviour (incl. unwanted sexual intercourse). Risky sex behaviour is rather associated with excessive consumption of alcohol.

Recreational drug users do not associate violent and aggressive behaviour with the use of stimulants. In their opinion, it is rather alcohol that makes people violent and irritant. The persons who were studied found that with regard to stimulants, inadequate behaviour can be to a certain extent caused by amphetamine and GHB. The survey showed that the biggest threat for the public is risky traffic behaviour of stimulant users. Namely, it is the understanding of recreational drug users that stimulants increase driver's observation ability, and since the police do not establish drug intoxication, driving under the influence of drugs is considered normal.

Chapter 3. Prevention

The primary prevention of drug addiction is coordinated and carried out similarly to the previous years by the MER and the NIHD, which is in the area of administration of the Ministry of Social Affairs. The basic area of responsibility of MER is prevention in the education system and creation of leisure options for school students; the task of the NIHD is the preparation of methodical materials and guidelines in the area of prevention, training of specialists and necessary notification of the population. In the previous years, it was also the task of the NIHD to perform primary prevention at the county level, but due to the cuts in the budget, drug addiction and HIV prevention action plans have not been financed since

2009. Due to the reduction of funds, the notification campaigns and conferences/events aimed at the prevention of drug addiction were not held either.
This Chapter is particularly based on the report of activities of the NSPDA of 2009. The Chapter does not consider potential county-specific drug addiction prevention events performed at the county level and financed by the county.

3.1 Universal prevention

Prevention in school

In 2009, the MER was actively engaged in the renewal of the 'National curriculum of basic schools and upper secondary schools". The curriculum renewed in January 2010 was also approved by the Government of the Republic. In the new national curriculum, information on drug prevention (legal as well as illicit drugs) has been included in the subject syllabi of human studies, where the topic will be treated in all three school stages from form 2 to form 12, taking into account the age and needs of the students. The final term of implementation of the study programme is set for the beginning of the academic year 2013/2014. Due to updating of the study programmes, the required subject text books and other aids will also be updated by that date.

Organisation of leisure

By offering leisure options to young people it is possible to prevent the first trying of drugs since young people will be offered development and participation opportunities. Therefore, national funds have been channelled to recreational activities, public youth centres, camp activities and development of information services for the youth. Over the years, also the participation of children from low-income families in recreational activities has been financed. In total, as of 2010, there were 318 hobby schools in Estonia with over 40,000 young people participating. Over 240 public youth centres are functioning at local governments, and during summer youth and project camps are provided to nearly 34,000 youngsters.

Methodical materials and guidelines

During the accounting period, guidelines of youth workers for the organisation of drug prevention were being developed at the NIHD. The project was started in 2009, and the

handbook should be completed by the end of 2010. Essentially, this is material intended for specialists engaged in the organisation of leisure of young people. From this handbook, youth workers should obtain health-related knowledge and guidelines how to shape attitudes, values, skills and pass the knowledge to young people through active study, group work and individual approach.

In addition to the handbook, the development of drug prevention related counselling service description was also started in 2009. In the initial version of service description, the focus is in particular on advising in the area of communication with young people, identification of groups at risk, different counselling objectives based on the clientele and specific groups. Also, the components of a counselling service, likewise the essence of counselling, are explained in the service description. The service description is intended for social workers working with the youth, youth workers, psychologists, education system employees, advisers and health care professionals. The service description will also be completed in 2010. It is planned to translate the service description into the Russian language as well.

Training

In the activities of the MER, the following training sessions were organised for the specialists working with the youth in 2009 within the framework of the programme of the European Social Fund 'Development of youth work quality': 'Prevention of non-inclusion of the young', 'How to notice the use of addictive substances among young people' and 'Youth work with children needing attention'. Also, the Estonian Youth Work Centre presented different options of addiction rehabilitation services for the young to the juvenile committee workers/secretaries.

In 2009, the NIHD conducted three training sessions on social coping skills for teachers who teach children according to simplified study programmes. 68 teachers participated in the training, and the training sessions were held in Estonian as well as in Russian (Tartu, Valga, Tallinn). The training was based on the teacher's book of teaching social coping skills, which was developed for stage of study I (forms 1 to 5) in 2007 and which is intended for teaching according to a simplified study programme. The teacher's book is available both in the Estonian and Russian languages. The teacher's book according to a simplified study programme first provides an overview of drug use among Estonian youth, describes the reasons for drug use, prevention of drug use in schools and how to cope with this problem, besides, it also gives a summary of different drugs and their impact on people. The book provides various active work opportunities to the teacher, which should increase students' social coping skills.

In addition to specialist training, MER also dealt with the network of peer-to-peer training providers in 2009. During 2007–2009, 200 peer-to-peer training providers were trained, and as of 2010, 60 training providers participate in the activity of the network. Through prevention events, nearly 1200 young people were communicated in 2007–2009.

Distribution of information

The main drug-related information providing means in 2009 was still the website www.narko.ee. Over the years, the web environment of www.narko.ee has been continuously updated and questions/queries of visitors have been answered. In 2009, a total of EUR 4221 was spent for the administration of the website. Information and information materials were also distributed in different youth centres and at youth events ("Teeviit", "Terve elu kompass", etc.).

From new information materials, a brochure intended for parents was prepared in 2009, called "What are drugs and how they affect our life". The given information materials contain the main facts about drugs and the reasons for their use, recommendations how to talk to a child about drugs and what advice to give. Besides, the brochure specified main widely spread drugs for parents, the description of these drugs and effects and consequences of their use. In 2009 this information material was prepared, designed and translated into the Russian language; the material was also printed at the beginning of 2010.

In addition to the NIHD's information materials and information distribution options, 18 youth information and counselling centres provide the necessary information to adolescents. The notification service covers all counties and centres where in cooperation with different partners young people are provided information about prevention, counselling, different programmes and projects, as well as about agencies offering testing and advice, their working hours, etc.

3.2 Selective prevention in at- risk groups and settings

In 2007–2009, the annual average of adolescents sent to the juvenile committee whose offence was linked to the use of substances prohibited for minors by law was 250. The given prohibited substances include tobacco, alcohol and drugs. In 2009. a total of 278 young people were sent to the juvenile committee in relation to the use of substances prohibited for the young. Young people with the addiction problem are sent from the committee to counselling, treatment (psychiatrist) or rehabilitation as needed.

As of 2009, there were two specialised schools in Estonia, whose students in majority had tried different addictive substances. In more serious cases, there are already established drug addicts in the specialised schools. In both Kaagvere as well as Tapa specialised school, the students' study programmes include addiction related prevention, and in addition to studies, students are also taught health behaviour and coping skills. In the case of specialised schools, it is also important that prohibited substances do not enter the school territory. In order to restrict the bringing of addictive substances to the school territory, provisions are planned to be included in the draft Act of Sanctions for Minors, which would grant clearer rights to schools teaching students with behavioural problems regarding the confiscation of addictive substances possessed by a minor.

3.3 Indicated prevention

No recent data are available for the reporting period.

3.4 National and local media campaigns

Due to the budget cuts no national or local drug addiction prevention campaign was held in 2009.

Chapter 4. Problem drug use

The last survey on the proportion of the population group of injecting drug users and their prevalence among the population dates back to 2005 when *capture-recapture method was* applied. According to the estimation of the survey completed in the cooperation of the Department of Public Health, Tartu University and the NIHD, the number of injecting drug users as of 2004 was 13,886 (95% confidence interval CI=8,132−34,443) IDUs aged 15−44. The rate of prevalence of IDUs among the population in the relevant age group was 2.4% (95% CI=1.9−5.9%). The survey revealed that the prevalence of IDUs was higher in Harju county (incl. in Tallinn) (4.3%) and Ida-Viru county (3.5%) while it was considerably lower in other regions (0.5%) (Uusküla et al., 2007). The outcome of this survey has been applied for designing the services scheduled for the IDUs (treatment, rehabilitation, (syringe exchange etc.) as well as assessing coverage of services.

A new survey on the proportion of the population group of injecting drug users and their prevalence among the population will be carried out in 2010. The survey will be conducted by the Department of Public Health, Tartu University and Estonian Drug Monitoring Centre (EDMC) of the NIHD. It is important to note in regard of the new survey that the dynamics of the size of the population group of IDUs as well as prevalence of IDUs among the total population of Estonia in 2005–2009 will be estimated applying *capture-recapture* method. The results of this study will be published in 2011.

Chapter 5. Drug-related treatment: treatment demand and treatment availability

The data revealed in this Chapter build on the 2009 reports of the action plans of the National Strategy for HIV/AIDS and NSPDA. The *Treatment Demand Indicator* (TDI) data presented in this chapter comes from the NDTD of the NIHD. The EMCDDA TDI shows the number of persons applying for treatment during the year 2009 (from 1 January to 31 December), it does not reflect the number of persons already undergoing treatment during this period. The Ministry of Social Affairs is the chief processor of the NDTD, and the NIHD is the authorised processor. Persons who have applied to a health care provider with a psychiatric licence, received the diagnosis of F11–F16; F18–F19 from their doctor and receive treatment for the addiction, are entered in the NDTD. NDTD is a web-based dataset (data are entered in the database via Internet). The data provider must be equipped with the valid ID card and an ID card reader for being able to enter the data.
It should also be mentioned that the number of persons applying for treatment entered in the NDTD differs from the number of persons having received treatment based on the reports of national strategies, as the NDTD has not achieved the comprehensive range in all treatment institutions offering drug treatment during its first years of operation.

5.1 Strategy, policy

No changes in legislation regarding drug treatment took place in 2009. Major changes are expected only in 2011 when requirements for the drug treatment and rehabilitation services will be developed on the initiative of the Ministry of Social Affairs on the legislative field. Work was commenced already in 2010 and by the end of the year the first draft regulation

should be completed providing for a more clear-cut legal framework for treatment and rehabilitation.

During the reporting period, the improvement of the activities related to methadone substitution treatment became an important priority in the field of treatment through better work organisation in the treatment centre and improvement of treatment quality. The level of details of the service descriptions was improved in order to improve the work organisation and treatment quality and training was arranged for the employees of the treatment centres.

The area of addiction treatment was among the few which did not suffer from the budget cut in 2009. Still, the fact that funding remained on the same level still restricted the increase of the volume of services and provision of new required services.

5.2 Treatment systems

In Estonia, treatment for drug addicts is provided by health care providers with psychiatric licence. An accurate overview of the treatment services targeted at the drug addicts is not available, as not all service providers are included in the national reports and not all notices of treatment cases are entered in the NDTD. In 2009, NIHD signed methadone substitution treatment contracts with five service providers who provided services in seven treatment centres. Besides state funding, the city of Tallinn also signed a contract with two service providers. However, the majority of health care institutions providing addiction treatment engage only in outpatient care (five of the six national service providers). Only Wismari Hospital provides in-patient treatment funded by patients themselves. One of the treatment institutions funded by Tallinn offers only out-patient treatment, the other centre, targeted to minors, provides out-patient and in-patient treatment.

In Estonia drug treatment is funded from different sources; in 2009, Estonian National Strategy for HIV/AIDS 2006–2015 and NSPDA to 2012 and funds from local governments were used. Also, a person can seek treatment, funding it by his/her own means. Drug treatment is not included in the list of health care services funded by the National Health Insurance Fund.

5.2.1. Substitution treatment

As of 2008, methadone substitution treatment was mainly financed from the budget of national HIV/AIDS prevention strategy. EUR 465,097 was used for provision of treatment

and EUR 81,230 was spent on acquisition of methadone and other needed medical devices.

2009 saw an insignificant increase in the clients receiving methadone substitution treatment funded from the means of HIV/AIDS prevention strategy. The number of addicts receiving treatment from the budget of HIV/AIDS strategy was 1008 in 2008, while the respective number increased to 1012 in 2009. As of the end of the year, the number of clients on methadone substitution treatment was 660 (in the end of 2008, the respective number was 649) (Table 3). More than one-third of the opiate addicts receiving substitution treatment stopped the treatment (352 addicts in total). The average daily methadone quantity varied a lot by various treatment centres. The yearly comparison reveals that the average amount of methadone has increased year by year. While in 2005, the average amount over all centres amounted to 37 mg, it had increased to 59.4 g by 2009. In 2009, the average amount of methadone varied between 23 ml and 84 ml (Table 3).The number of appointments with psychiatrist has also increased in all centres, the number varying also by the centres.

Table 3 Availability of methadone substitution treatment funded from state budget for injecting drug users in 2009

Health care institution	Number of clients per year	Number of persons stopping the programme	Average amount of methadone per client (mg)	Monthly number of psychiatric appointments per client.
OÜ Aasa Kliinik	59	29	84	2.0
OÜ Corrigo	259	137	75	1.3
OÜ Narva Sõltuvusravi Keskus	133	81	55	1.3
OÜ Elulootus	129	59	23	1.7.
Wismari Haigla AS*	80	46	60	2.2
Total	660	352	59.4	1.7

Source: National HIV and AIDS prevention strategy, report for 2009.

** NIHD signed a contract with Wismari Hospital in 2009 for providing substitution treatment to a determined number of clients.*

Besides state funds, methadone substitution treatment was funded by the City of Tallinn in 2009. The Unit of Addiction Treatment of Psychiatric Department of the West-Tallinn Central Hospital offering out-patient substitution treatment to adult addicts received EUR 178,953 through the Tallinn Social Welfare and Health Care Department. In 2009, 103 persons received treatment (West-Tallinn Central Hospital 2009, personal communication).

5.2.2 Detoxification treatment

Detoxification treatment of 32 addicts in the amount of EUR 72,820 was financed from state budget allocations to the NSPDA in 2009 through OÜ Hospital in Kohtla–Järve. Due to the shortage of funds, the contract with OÜ Hospital lasted until 15 May 2009.
In 2009, detoxification was also carried out in Wismari Hospital and West-Tallinn Central Hospital. National reporting system does not allow for establishing accurate number of addicts having been detoxicated (substitution and detoxification are not distinguished), but the number of clients of different types of treatment can be established in the NDTD (see Table 8).
Besides the treatment of adults, the City of Tallinn also financed drug treatment of children and adolescents in 2009. Addiction Disorders Department of the Tallinn Children's Hospital received EUR 76,694 in total for that aim. In the period of 01.01.09–31.12.09, 117 patients received in-patient treatment and the number of psychiatric appointments for out-patients was 613 during the year. The City of Tallinn allocated additional EUR 12,782 for the out-patient psychotherapy of the patients aged up to 18 with behavioural and addiction disorders (group and family therapy). Tallinn Children's Hospital also received funds from the budget of the NSPDA in the amount of EUR 46,016, financing was earmarked for the psychological therapy of the units of children and adolescents in Tallinn Children's Hospital that is not included in the price list of National Health Insurance Fund through still necessary for efficient treatment.

5.2.3 Rehabilitation

As of the end of 2009, 83 clients received rehabilitation service from the funds of the NSPDA, and rehabilitation service for another 98 was jointly financed by the NSPDA and the City of Tallinn. More than 6 hundred thousand EUR from the means of the NSPDA was spent on offering rehabilitation service (including rehabilitation of children and adolescents in Jõhvi Rehabilitation Centre for Children and Adolescents) (Table 4). Most of the rehabilitation services focused at adult men, but also rehabilitation services focused at minors of both sexes (OÜ Corrigo Jõhvi Laste ja Noorukite Rehabilitatsioonikeskus) were provided. Despite the type of rehabilitation service the aim was to offer psychosocial support and counselling to clients and providing them with the skills needed for integration into the everyday life (discipline, study and work habits). Rehabilitation service starts after the detoxification of an addict from drugs as well as substitution drugs.

Table 4 Rehabilitation services of addicts in 2009.

	Financial resources allocated (EUR)	Number of clients as of year's end, 2009	Number of clients who commenced 2009 programme	Number of clients who stopped programme in 2009	Number of clients completing the 2009 programme
MTÜ AIDSi Tugikeskus*(day care centre)	21,288	89	165	71	61
MTÜ AIDSi Tugikeskus (commune)*	26,452	9	9	6	0
MTÜ Narva Narkomaanide ja Alkohoolikute Rehabilitatsiooni Keskus „Sind ei jäeta üksi" (commune)	74,630	12	22	4	16
SA Sillamäe Narkorehabilitatsioonikeskus (in-patient rehab centre)	249,810	26	35	12	26
OÜ Corrigo (in-patient rehab centre for minors)	215,617	15	22	13	21
MTÜ Eesti Abikeskused day care centre for addicts with dual diagnose	91,080	11	5	13	1
Total	678,877	181	280	136	129

Source: NSPDA Action plan report for 2009

*Financed for half a year. The City of Tallinn financed for the second half year.

Survey for mapping rehab centres in Estonia

In 2009, the NIHD conducted a survey "Mapping the rehab centres financed from state budget targeted to addicts and client satisfaction with the service" (NIHD, 2009). The aim of this survey was to get as specific overview as possible of the rehab centres financed from state budget targeted to Estonian addicts, and to complement it with the service-related insights and expectations of the clients. The need for mapping became evident due to the fact that rehabilitation targeted to addicts is understood very differently nationally and internationally. Based on the survey data and background documents, rehabilitation service targeted to addicts in Estonia both in treatment communes and day care centres will be provided. To sum it up, there are two providers of rehabilitation services with specific approach, one targeted to minors and the other to drug addicts with psychiatric diagnoses. The four remaining service providers can be divided as follows: two treatment communes, one day-time rehabilitation support facility and one in-patient treatment/rehab institution. All four last-mentioned rehabilitation services were based on the 12 steps program.

The main problems and recommendations for provision of rehabilitation services to drug addicts were the following:

- There is no legislative basis for the rehabilitation services in Estonia;
- The main documents governing the rehabilitation services, i.e. annexes to the contracts for service provision differ by the various centres in content and structure, although the service provided is principally the same;
- The services offered in the rehab centres, their volume, and workload of the specialists / professionals providing the respective service in the given centre should be given a critical look;
- It is complicated to establish the specific principle of follow-up treatment in the rehab centres (different understanding regarding the types of treatment and mix of various methods);
- The clients lack specific understanding of the service offered and the structure of the treatment / rehabilitation service;
- According to the words of the clients, there are too few professional services around the rehabilitation, and excessive stress on working;
- Vocational programmes (woodwork, welding, cooking, landscaping etc. should be established at the rehabilitation centres). This need arises from the low educational level and work experience of the addicts that complicates their coping in the society after rehabilitation;
- Many clients would need so-called post-rehabilitation service including further psychological and social support.

To sum it up, the survey gives grounds to consider making treatment/rehab options available for the addicts from the resources of the NSPDA as a positive achievement. The large majority of the clients of the in-patient and day care centres are satisfied with the services offered to them and according to their estimation, they have benefited from this service both in terms of health and psychological condition.

5.3 Characteristics of treated clients

Total 11 treatment institutions (2 prisons) submitted notices to the NDTD from January 1st to December 31st 2009. A total of 962 notices were submitted, 696 of them were about start of treatment and 266 about completion of treatment. 838 notices were left in the database after it was cleaned from starting the treatment notices that had been entered twice and completion of treatment notices that had been entered into the database without

starting treatment notices (treatment had started before 1 January 2009). 687 of these notices were starting the treatment notices and 151 completion of treatment notices.

The majority of persons seeking treatment in Estonia are young males. The average age of these persons in 2008 was 27.2 and in 2009, 28.5 years. In 2008 and 2009, two-thirds (66% and 65% respectively) of all persons seeking treatments were in the age group of 25−34. In both years under examination, nearly half (49%) of the persons having applied for the drug treatment for the first time were aged 25−34 (Table 5). Based on the data set, it can be said that women apply for treatment in the younger age compared to men. In 2009, over half of all women, as well as of the women who applied for treatment for the first time, were younger than 25 (52% and 61% respectively). The proportion of men younger than 25 applying for treatment was 21% ja 39% respectively. Compared to the previous year, the proportion of female addicts younger than 25 decreased somewhat in 2009. To sum it up, the age of the persons applying for treatment has somewhat increased.

Table 5. Gender and age distribution of all persons applying for treatment, as well as those applying for the first time

	All clients						**First-time clients**					
			2008						**2008**			
	Male		**Female**		**Total**		**Male**		**Female**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
<25	100	21.0	74	52.1	174	28.2	50	39.4	30	61.2	80	45.5
25-34	341	71.6	67	47.2	408	66.0	68	53.5	19	38.8	87	49.4
34<	35	7.4	1	0.7	36	5.8	9	7.1	0	0.0	9	5.1
Total	476	100	142	100	618	100	127	100	49	100	176	100
Average age	27.9		24.6		27.2		25.8		23.1		25.0	
			2009						**2009**			
	Male		**Female**		**Total**		**Male**		**Female**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
<25	104	19.7	58	36.3	162	23.6	36	31.0	24	54.5	60	37.5
25-34	355	67.4	93	58.1	448	65.2	60	51.7	19	43.2	79	49.4
34<	68	12.9	9	5.6	77	11.2	20	17.2	1	2.3	21	13.1
Total	527	100	160	100	687	100	116	100	44	100	160	100
Average age	29.0		26.6		28.5		27.9		23.4		26.7	

Source: NDTD, NIHD; EMCDDA standard table No. 34.

According to the data of NDTD, the majority of the persons having applied for treatment lived in two regions in Estonia – in Tallinn and in Ida-Viru county (Table 6). These are also the regions where the number of IDUs is the highest and prevalence in population higher (Uusküla et al, 2007) (See Chapter 4). Besides that, the majority of the new HIV cases are

recorded in Tallinn and Ida-Viru county (see Subchapter 6.1). Compared to 2008, the proportion of applicants has increased in Tallinn (39% in 2008, 50% in 2009).

Table 6. Place of residents of persons seeking treatment *(all treatment)* 2008–2009.

	2008					
	Male		**Female**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**
Tallinn	168	35.5	70	49.3	238	38.7
Harju county	17	3.6	16	11.3	33	5.4
Ida-Viru county	284	60.0	54	38.0	338	55.0
Other	4	0.8	2	1.4	6	1.0
Subtotal	473	100	142	100	615	100
Unknown/n/a	3		0		3	
total	476		142		618	
	2009					
	Male		**Female**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**
Tallinn	261	49.8	79	49.7	340	49.8
Harju county	28	5.3	16	10.1	44	6.4
Ida-Viru county	208	39.7	60	37.7	268	39.2
Other	27	5.2	4	2.5	31	4.5
Subtotal	524	100	159	100	683	100
Unknown/N/a	3		1		4	
total	527		160		687	

Source: NDTD, NIHD; EMCDDA standard table No. 34.

Fentanyl produced in illegal drug labs has been for years the most wide-spread injected drug on the drug market in Estonia (Talu et al., 2010). Both in 2008 and 2009, the majority of all applicants for treatments used fentanyl or 3-methylfentanyl as the first drug. In 2009, the proportion of drug addicts that applied for treatment and had used fentanyl or 3-methylfentanyl as the first drug, increased substantially (70% of all applicants and 83% of the first cases) (Table 7). Despite the lack of heroin on the drug market in Estonia (See Chapter 10), 24% of the persons applying for drug treatment used thisnarcotic drug in 2008, and 21% in 2009. The proportion of treatment seeking addicts who used amphetamine, cannabis and cocaine as the main drug was small. At the same time, in 2009, the proportion of the users of amphetamine as the first drug among the first-time applicants was a bit higher than in 2008.

Table 7 The main drug used, 2008–2009.

	2008				
	All clients		First clients		Unknown
	n	%	n	%	n
Heroin	148	23.9	13	7.4	22
Methadone	11	1.8	2	1.1	0
Fentanyl/3-methylfentanyl	349	56.5	106	60.2	1
Cocaine	0		0		0
Amphetamine	10	1.6	7	4.0	0
Cannabis	8	1.3	6	3.4	0
Other	92	14.9	42	23.9	5
Total	618		176		28
	2009				
	All clients		First clients		Unknown
	n	%	n	%	n
Heroin	146	21.3	5	3.1.	17
Methadone	3	0.4	0		0
Fentanyl/3-methylfentanyl	485	70.6	132	82.5	11
Cocaine	1	0.1	0		0
Amphetamine	15	2.2	10	6.3	0
Cannabis	6	0.9	6	3.8	0
Other	31	4.5	7	4.4	1
Total	687		160		29

Source: NDTD, NIHD; EMCDDA standard table No.34.

Compared to 2008, proportion of the addicts receiving substitution treatment underwent a steep rise (Table 8). For the majority of those having applied for treatment in 2009, methadone was prescribed (70%) (74% in 2008). The majority of the applicants for treatments received outpatient care (Table 9).

Table 8. Type of treatment prescribed to the persons having applied for drug addiction treatment in 2008–2009.

	2008					
	Male		Female		Total	
	n	%	n	%	n	%
Substitution treatment*	256	53.8	64	45.1	320	51.8
Detoxification treatment	103	21.6	53	37.3	156	25.2
Other**	117	24.6	25	17.6	142	23.0
total	476		142		618	
	2009					
	Male		Female		Total	
	n	%	n	%	n	%
Substitution treatment*	366	69.4	111	69.4	477	69.4
Detoxification treatment	67	12.7	20	12.5	87	12.7
Other**	94	17.8	29	18.1	123	17.9
total	527		160		687	

Source: NDTD, NIHD; EMCDDA standard table No.. 34.

*In 2008, the variable of maintenance treatment was not applied, it was added to the variables of the DTD in 2009. In analysing the data, the variable was included to substitution treatment.

**Alleviation of the symptoms classified under "other", and medication-free treatment

Table 9. Type of drug treatment by age and gender, 2008– 2009

	2008					
	Male		Female		Total	
	n	%	n	%	n	%
Out-patient treatment	462	97.1	135	95.1	597	96.6
In-patient treatment	14	2.9.	7	4.9	21	3.4
Subtotal	476	100	142	100	618	100
Total	476		142		618	
	2009					
	Male		Female		Total	
	n	%	n	%	n	%
Out-patient treatment	517	98.1	152	95.0	669	97.4
In-patient treatment	10	1.9	8	5.0	18	2.6
Subtotal	527	100	160	100	687	100
Total	527	76.7	160	23.3	687	100

Source: NDTD, NIHD; EMCDDA standard table No. 34.

Most of the persons seeking drug addiction treatment have also been subject to drug treatment earlier. Compared to the previous year, the proportion of those having received drug addiction treatment previously increased slightly (from 70% in 2008 to 76% in 2009) (Table 10). In 2009, nearly one-fourth (24%), and 29% in 2008 were treated for drugs for the first time.

Table 10. Persons having applied for the treatment for the first time and being treated earlier by gender, 2008–2009.

	2008					
	Male		Female		Total	
	n	%	n	%	n	%
First treatment	127	28.1	49	35.5	176	29.8
Previous treatment	325	71.9	89	64.5	414	70.2
Subtotal	452	100	138	100	590	100
Unknown	24		4		28	
Total	476		142		618	
	2009					
	Male		Female		Total	
	n	%	n	%	n	%
First treatment	116	23.1	44	28.2	160	24.3
Previous treatment	386	76.9	112	71.8	498	75.7
Subtotal	502	100	156	100	658	100
Unknown	25		4		29	
Total	527	76.7	160	23.3	687	100

Source: NDTD, NIHD; EMCDDA standard table No. 3

Table 11. Engagement of the applicants for drug treatment in labour market *(all treatment*) 2008–2009.

	2008					
	Male		Female		Total	
	n	%	n	%	n	%
Employed	226	47.8	36	25.4	262	42.6
Pupil/student	14	3.0	8	5.6	22	3.6
Unemployed	180	38.1	85	59.9	265	43.1
Dependent	48	10.1	6	4.2	54	8.8
Other	5	1.1	7	4.9	12	2.0
Subtotal	473	100	142	100	615	100
Unknown	3		0		3	
Total	476	77.0	142	23.0	618	100
	2009					
	Male		Female		Total	
	n	%	n	%	n	%
Employed	129	24.5	36	22.5	165	24.0
Pupil/student	15	2.8	9	5.6	24	3.5
Unemployed	329	62.4	92	57.5	421	61.3
Dependent*	45	8.5	19	11.9	64	9.3
Other**	9	1.7	4	2.5	13	1.9
Subtotal	527	100	160	100	687	100
Unknown						
Total	527	76.7	160	23.3	687	100

Source: NDTD, NIHD; EMCDDA standard table No. 34.

*"Dependent" includes home-makers, retired, persons receiving pension for incapacity for work

** "Other" includes convicts and conscripts

Compared to 2008, the proportion of the unemployed has soared among the persons applying for treatment. While in 2008, the proportion of the unemployed among the beneficiaries of drug treatment was 43%, it was 61% in 2009 (Table 11).

In both years under examination, over half of the drug addicts treated had basic education and a bit more than 40% had secondary education (Table 12).

Table 12. Education of the persons applying for drug treatment *(all treatment)* 2008–2009.

	2008					
	Male		**Female**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**
Primary education	10	2.1	7	4.9	17	2.8
Basic education	239	50.3	84	59.2	323	52.4
Secondary education	219	46.1	48	33.8	267	43.3
Higher education	7	1.5	3	2.1	10	1.6
Subtotal	475	100	142	100	617	100
Unknown	1				1	
Total	476		142		618	
	2009					
	Male		**Female**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**
Primary education	9	1.7	6	3.8	15	2.2
Basic education	275	52.2	89	56.0	364	53.1
Secondary education	240	45.5	62	39.0	302	44.0
Higher education	3	0.6	2	1.3	5	0.7
Subtotal	527	100	159	100	686	100
Unknown			1		1	
Total	527		160		687	

Source: NDTD, NIHD; EMCDDA standard table No. 34.

Similar to 2008, also in 2009 the majority of the persons applying for treatment were Russians (84% in 2008, 82% in 2009) (Table 13). Estonians comprised more than one-tenth of the patients applying for drug addiction treatment.

Table 13. Nationality of persons applying for drug treatment (*all treatment*) by gender, 2008–2009.

	2008					
	Male		Female		Total	
	n	%	n	%	n	%
Estonian	52	10.9	21	14.8	73	11.8
Russian	398	83.6	119	83.8	517	83.7
Other	26	5.5	2	1.4.	28	4.5
Subtotal	476	100	142	100	618	100
Unknown	0		0		0	
Total	476	77.0	142	23.0	618	100
	2009					
	Male		Female		Total	
	n	%	n	%	n	%
Estonian	60	11.4	19	11.9	79	11.5
Russian	430	81.6	132	82.5	562	81.8
Other	37	7.0	9	5.6	46	6.7
Subtotal	527	100	160	100	687	100
Unknown	0		0		0	
Total	527		160		687	

Source: NDTD, NIHD; EMCDDA standard table No. 34.

Compared to 2008, the proportion of those injecting during the last 30 days (i.e. active IDUs) (85% in 2008 and 68% in 2009) (Table 14) dropped considerably.

Table 14. Injecting status of persons applying for drug treatment *(all treatment)* by gender, 2008–2009.

	Male		Female		Total	
	n	%	n	%	n	%
Ever injected, but not presently	43	9.6	20	14.7	63	10.8
Injected during the last 30 days.	383	85.3	113	83.1	496	84.8
Never injected	23	5.1	3	2.2	26	4.4
Subtotal	449	100	136	100	585	100
Unknown	27		6		33	
Total	476		142		618	
	2009					
	Male		Female		Total	
	n	%	n	%	n	%
Ever injected, but not presently	131	26.0	50	32.1	181	27.5
Injected during the last 30 days.	348	69.2	99	63.5	447	67.8
Never injected	24	4.8	7	4.5	31	4.7
Subtotal	503	100	156	100	659	100
Unknown/n/a	24		4		28	
Total	527		160		687	

Source: NDTD, NIHD; EMCDDA standard table No. 34.

Speaking of the risky injection behaviour of the drug addicts having sought treatment, nearly 60% of them have shared a syringe during their lifetime (Table 15). It is worth

mentioning that syringe sharing is a more widespread practice among women. This refers to the need to apply necessary intervention regarding this target group.

Table 15. Syringe sharing among applicants for drug treatment *(all treatment)* by gender and age, 2008–2009.

	2008					
	Male		Female		Total	
	n	%	n	%	n	%
Shared the syringe, but not during the last 30 days	249	57.1	88	66.2	337	59.2
Shared the syringe during the last 30 days	11	2.5	6	4.5	17	3.0
Never shared a syringe	176	40.4	39	29.3	215	37.8
Subtotal	436	100	133	100	569	100
Unknown	40		9		49	
Total	476		142		618	
	2009					
	Male		Female		Total	
	n	%	n	%	n	%
Shared the syringe, but not during the last 30 days	274	56.7	91	61.5	365	57.8
Shared the syringe during the last 30 days	29	6.0	13	8.8	42	6.7
Never shared a syringe	180	37.3	44	29.7	224	35.5
Subtotal	483	100	148	100	631	100
Unknown	44		12		56	
Total	527	76.7	160	23.3	687	100

Source: NDTD, NIHD, 2010.

5.4 Trends of clients in treatment

No recent data are available for the reporting period.

Chapter 6. Health correlates and consequences

The data on AIDS and HIV-infection and the risk factors of contraction have been obtained from the Health Board. In this Chapter, we present the incidence of B and C viral hepatitis, the new cases of HIV and the risk factors for contraction, based on the data received from the Health Board. For collecting data on the cases of viral hepatitis B and C, EMCDDA standard table 9, part 4 was used. The data regarding IDUs infected with HIV have also been obtained from the Health Board. The data regarding cases of HIV infection and

transmission routes are submitted to the Health Board by the physicians who diagnose the first case of HIV infection and AIDS.
The definition of drug-related deaths in Estonia coincides with the definition applied by the EMCDDA (option B). The Causes of Death Registry in the NIHD is personal. Checking of data and double cases is part of the daily tasks of the Registry. The Registry covers all deaths of inhabitants of Estonia recorded in Estonia and foreign missions of Estonia. The Causes of Death Registry uses the International Classification of Diseases (ICD-10) in coding of the death data.
The data on incidence of TB comes from the Tuberculosis Registry of the NIHD. The data on the persons with dual diagnosis of HIV+/TB has been obtained by means of personal communication with the TB register.

6.1 Drug-related infectious diseases

HIV and AIDS

The total number of HIV infections ever diagnosed in Estonia is 7320 and AIDS has been diagnosed 290 times (as of 31.12.2010) (Health Board, 2010). In 2009, the Health Board recorded 134 fewer persons infected with HIV than in the previous year (545 cases in 2008, 411 cases in 2009) (Table 16). In 2009, 69% of the persons infected with HIV were males (M=242, F=168). The majority of the new cases of HIV in 2009 in Estonia were diagnosed in Harju county (n=193) (150 in Tallinn) and Ida-Viru county (n= 189).
The fact that the transmission route is known only for less than one-third of the new cases of HIV infection (27.3%) causes concern. The overwhelming majority (75%) of the persons infected with HIV, in case of whom the transmission route is known, are IDUs (Table 16).

Table 16. The number of newly diagnosed cases of HIV infections in Estonia, 1998−2009 (incl. the number and proportion of IDUs of all cases of known transmission routes).

	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Total number of persons infected with HIV	10	9	390	1474	899	840	743	621	668	633	545	411
Incl. the number of persons infected with HIV, with a known transmission route of infection (total)	10	9	390	1474	899	359	261	204	195	117	47	112
The number of IDUs infected with HIV with a known transmission route	0	0	354	1340	702	356	254	200	191	115	36	84
The proportion of IDUs of all cases with a known transmission route (%)	0.0	0.0	90.8	90.9	78.1	99.2	97.3	98.0	97.9	98.3	76.6	75.0

Source: Health Board, 2010.

Cases of hepatitis B and C

The data received from the Health Board reveal that in the period 2002–2008, the number of persons catching acute hepatitis B dropped drastically. Compared to 2001, when acute hepatitis B was recorded for 449 persons, the number dropped by ten times in 2007 (n=44). 2008 saw a remarkable increase in the number of persons having contracted acute hepatitis B, but in 2009, the number dropped again rapidly (from 53 cases in 2008 to 29 cases in 2009) (Table 17). There is a reason to believe that the drastic drop in infection with hepatitis B was considerably facilitated by the widespread vaccination against viral hepatitis B on the basis of the National Immunization Programme (Chapter 7).

Also in 2009, concern is caused by the fact that upon recording of cases of viral hepatitis B, the manner of catching infection was known only in nearly one-fourth of the cases – only seven persons of 29 people with acute cases of viral hepatitis B were aware of the transmission route, 57% (n=4) of them were IDUs (Health Board, 2010).

Table 17. Infection with acute viral hepatitis B 1999–2009.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total number of persons infected with acute viral hepatitis B	280	437	449	244	173	127	78	45	44	53	29
Number of persons infected with acute viral hepatitis B with a known transmission route	175	247	300	150	97	68	3	21	19	17	7
Number of IDUs infected with acute viral hepatitis B with a known transmission route	141	219	257	106	68	48	21	9	10	10	4
The proportion of IDUs infected with acute viral hepatitis B of all cases with a known transmission route	80.6	88.7	85.7	70.7	70.1	70.6	61.8	42.9	52.6	58.8	57.1

Source: Health Board, 2010, Standard table 9, part 4.

Data of the Health Board shows that in 2009, 67 persons in total were infected with viral hepatitis C, that is 3 cases more than in 2008 (Table 18). The presumable manner of contracting was known in the case of 24 persons of the 67 who had contracted viral hepatitis C. 67% of those having contracted viral hepatitis C and whose transmission route was known were IDUs.

It should also be kept in mind when interpreting the data on viral hepatitis B and C that the proportion of cases where the information regarding the risk factors of the presumable infection is not known is relatively high (Table 18).

Table 18. Infection with acute viral hepatitis C, 1999–2009.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total number of persons infected with viral hepatitis C	244	365	306	199	154	124	81	57	36	64	67
incl. the number of persons infected with viral hepatitis C with a known transmission route (total)	146	198	193	131	96	76	44	29	16	30	24
The number of IDUs infected with viral hepatitis C with a known transmission route	134	178	162	98	75	54	36	16	10	15	16
The proportion of IDUs infected with viral hepatitis C with a known transmission route	91.8	89.9	83.9	74.8	78.1	71	81.8	55.1	62.5	50	66.7

Source: Health Board, 2010, Standard table 9, part 4.

TB infection

On the basis of the Tuberculosis Registry of the NIHD, TB was recorded for 378 persons in total (329 first cases and 49 relapses) in 2009. 63 patients were diagnosed with multi-drug resistant TB. 16.4% of all first TB cases were multi-drug resistant (Report for 2009 of the National Tuberculosis Prevention Programme. 2010). In 2009, the number of HIV-positive patients having contracted TB was 36 (33 first cases and 3 relapses), comprising 9.5% of all diagnosed cases of TB (Table 19) (TB Registry, 2010). 24 (67%) of the 36 HIV-positive patients having contracted TB used narcotic substances (Viiklepp, personal communication 2010). The data in Table 19 regarding persons with HIV+/TB co-infection are based on the joint consultation meetings on HIV+/TB where respective cases were discussed by pulmonologists and infectionists (Viiklepp, personal communication 2010).

Table 19. Cases of TB /HIV co-infection, 2002–2009.

	2002	2003	2004	2005	2006	2007	2008	2009
TB/HIV+ (first cases and relapses)	17	15	22	33	39	47	37	36
TB/HIV+ first cases	17	12	20	30	3	40	33	33
Detected during preventive checks	1	1	4	9	9	9	2	5
Detected during preventive checks (%)	5.9	6.7	18.2	27.3	23.1	19.1	5.4	13.9
Multiresistent TB	3	2	2	6	4	11	9	4
Multiresistent TB (%)	23.1	15.4	10.0	18.2	13.8	26.2	30.0	17.4
Used narcotic substances*	-	-	-	-	-	16	24	24
Used narcotic substances (%)	-	-	-	-	-	34.0	64.9	66.7

Source: TB Registry, NIHD 2010

** Recording of drug use was started in 2007.*

Compared to 2008, 2009 saw an increase in the proportion of TB cases detected during preventive checks among the persons with HIV and TB co-infection (Table 19). All cases were diagnosed in the Central Hospital of Prisons.

6.2 Other drug-related health correlates and consequences

Data regarding first aid provided for overdoses in Estonia are limited to Tallinn. Compared to 2007 and 2008, the number of cases when Tallinn Emergency Service provided first-aid for overdosed drug users increased in 2009 (1308, 1225 and 1399 cases respectively) (Tallinn Emergency Service, 2010).

Data regarding wound botulism, tetanus and other communicative diseases among IDUs are not available. This issue has not been studied within the framework of various surveys of IDUs and therefore the incidence of other infectious diseases in the group under examination cannot be established either.

6.3 Drug-related deaths and mortality of drug users

In 2009, the number of recorded deaths increased by nearly twofold compared to 2008. In 2009, 133 persons died as a result of drugs (in 2008, the respective number was 67). The overwhelming majority of the persons died from drug-related causes were male (M=120, F=13) (Table 20). In most cases (n=99) the cause of death, as also in 2008, was accidental poisoning from drugs or psychodysleptikums not classified elsewhere and their effect (X42). The data of the Estonian Forensic Science Institute shows that most of the drug-related poisoning deaths were related to the use of 3-methyfentanyl (Estonian Forensic Science Institute (EFSI), personal communication 2010).

Table 20. Drug-related deaths in 2009.

Underlying cause of death	Substance*	Males	Females	Total
F112 Opiate dependence		1	0	1
X42 Accidental poisoning	T40.0	1	0	1
	T40.2	2	0	2
	T40.3	2	1	3
	T40.4	14	0	14
	T40.6	88	11	99
	T40.9	3	0	3
X62 Intentional self-poisoning	T40.2	1	0	1
	T40.9	1	0	1
Y12 Poisoning of undetermined intent	T40.4	1	0	1
	T40.6	6	1	7
Total		120	13	133

Source: Causes of Death Registry, NIHD; 2010, EMCDDA Standard Table 5.

*Opium (T40.0), other opioids (T40.2), methadone (T40.3), other synthetic narcotics (T40.4), other and unspecified narcotics (T40.6), other and unspecified psychodysleptics (T40.9).

The majority of the persons who died due to drug use were aged 20–34 at the moment of death (n=117) and male (n=106). In 2009, the average age of victims dying of drug poisoning at the time of death was 29.2 years (Table 21).

Table 21. Drug poisoning deaths in 2009 by gender and age groups.

	Male	Female	Total
<15			0
15–19	3	0	3
20–24	18	5	23
25–29	50	4	54
30–34	38	2	40
35–39	5	0	5
40–44	3	0	3
45–49	1	1	2
50–54	1	0	1
55–59	1	1	2
60–64	0	0	0
>=65	0	0	0
Total			133

Source: Causes of Death Registry, NIHD; 2010, EMCDDA Standard Table 5.

Most of the persons having died of drug-related causes were Russians (n=92) living mostly in Tallinn and Harju county (n=91) and Ida-Viru county (n=35). In these regions, the number of IDUs and their prevalence in the population is the highest (See Chapter 4).

Over the years, the total number of persons having died due to drug use in the period of 1999–2009 is 643, the majority of them were male (n=573), 80% of them in the age group of 20–34 (Tables 22 and 23).

Table 22. Drug-related deaths by gender, 1999–2006 and 2008–2009.

	1999	2000	2001	2002	2003	2004	2005	2006*	2008	2009	Total
Males	18	25	39	81	31	88	52	59	60	120	573
Females	4	6	6	5	5	10	5	9	7	13	70
Total	22	31	45	86	36	98	57	68	67	133	643
Average age	29	27.8	25.3	24	28.2	26	26	25.6	29	29.2	

Source: Causes of Death Registry, NIHD; 2010, EMCDDA Standard Table 6.

*Explanation: Data of drug-related deaths in 2007 is not available.

Table 23. Age distribution of drug-related deaths 1999-2006 and 2008-2009.

	1999	2000	2001	2002	2003	2004	2005	2006*	2008	2009	Total
<15	0	0	1	0	0	1	0	0	0	0	2
15−19	5	2	7	18	6	11	5	6	0	3	63
20−24	8	13	18	39	10	36	21	24	14	23	206
25−29	3	8	10	16	9	24	22	25	27	54	198
30−34	1	4	3	8	3	18	4	10	18	40	109
35−39	0	1	4	3	3	3	3	1	3	5	26
40−44	1	0	1	0	1	3	1	2	3	3	15
45−49	1	2	0	1	3	1	1	0	1	2	12
50−54	1	0	1	1	0	0	0	0	0	1	4
55−59	1	0	0	0	0	1	0	0	1	2	5
60−64	0	0	0	0	1	0	0	0	0	0	1
>=65	1	1	0	0	0	0	0	0	0	0	2
Missing cases	0	0	0	0	0	0	0	0	0	0	0
Total	22	31	45	86	36	98	57	68	67	133	643

Source: Causes of Death Registry, NIHD; 2010, EMCDDA Standard Table 6.

*Explanation: Data of drug-related deaths in 2007 is not available.

As already mentioned above, the data related to the narcotic/psychotropic substance having caused the death is currently not available in the Estonian Causes of Death Registry. Namely, not all poisoning deaths recorded by the EFSI and most of the results of toxicology analyses are not reflected in the data set of the Causes of Death Registry. Thanks to the improvement of cooperation between the Estonian Causes of Death Registry and the EFSI, major progress has been achieved in improving the quality of the causes of drug-related deaths recorded in 2010. In order to achieve data quality, the Estonian Causes of Death Registry shall ensure recording of all drug-related deaths; for that they must have at their disposal entries regarding causes of deaths that are as precise and complete as possible (incl. by substances). In 2010, the Estonian Causes of Death Registry of the NIHD in cooperation with Estonian Monitoring Centre for Drugs and the EFSI will conduct quality control of drug-related deaths. The aim of the survey is to ascertain the shortcomings in the completeness of recording of the drug-related deaths and preciseness in the Estonian Causes of Death Registry in the period of 1999−2009. In the process of the quality survey of the drug-related death data, the data of drug-related deaths entered in the NIHD Estonian Causes of Death Registry in the period of 1999─2009 will be compared with the results of autopsies of the EFSI on persons having died of drug poisoning. The survey results will be included in the report prepared for the EMCDDA in 2011.

Chapter 7. Responses to health correlates and consequences

In this chapter, cross-sectional surveys conducted among IDUs conducted by the NIHD and the Department of Public Health, University of Tartu, are used as background information. The part of the Report addressing the prevention of drug-related accidents and decrease of drug-related deaths builds on the data of the Estonian Forensic Science Institute, the NIHD and the State Agency of Medicine. Data on hepatitis B and C come from the Health Board. The NIHD reports and data of West-Tallinn Central Hospital have been used regarding prevention and treatment of drug-related infectious diseases. The TB Registry of the NIHD is the source of data regarding treatment of drug addicts and HIV-positive TB patients and the respective results.

Information regarding hepatitis B and C is available at the web page administered by the Estonian Association of Infectionists http://www.vaktsiin.ee and the web page of the Estonian Association of Gastroenterology at http://www.hepatiit.net. The data regarding vaccination against hepatitis B come from the Health Board. Separate data regarding vaccination of drug addicts against hepatitis B is not available. No separate strategy exists in Estonia for prevention of hepatitis B and C.

7.1 Prevention of drug-related emergencies and reduction of drug-related deaths

Despite the large number of overdoses and drug-related poisoning deaths, no specific intervention measures for prevention of drug-related overdoses and drug-related deaths targeted to IDUs and drug-users has been applied to date. The only activity aimed at prevention of drug-related deaths and overdoses during the reporting period is the oral information provided to the target group within the framework of harm reduction service (syringe exchange, substitution treatment) regarding the prevention of overdoses and the information available at the NIHD web page for prevention of drug use http://www.narko.ee on first aid for overdoses. These activities are not consistent and do not include the whole target group.

In 2009, the need for training of drug addicts has been on the agenda, including the so-called safe injecting practices and peer assistance in case of overdose. The possibility of teaching drug addicts how to provide first aid with Naloxone to the peers in the case of overdose, has also been discussed. At this moment, Naloxone is used only in accident and emergency medicine in Estonia, as it has no marketing authorisation in Estonia. Therefore, Nalaxone injection solution is also imported into Estonia pursuant to § 21 (7) of the Medicinal Products Act. This section means that this medicinal product can be imported into Estonia

pursuant to instructions of emergency medical care only upon application by the Estonian Association of Emergency Physicians (State Agency of Medicines, personal communication 2010).

7.2 Prevention and treatment of drug-related infectious diseases

Background information

The cross-sectional studies conducted earlier among the IDUs on the risk behaviour and prevalence of HIV show that 40−90% of the IDUs are HIV-seropositive (Platt et al, 2006; Wilson et al., 2006; Uusküla et al, 2006; Talu et al, 2010, Abel-Ollo et al, 2010). Also, the level of first cases of HIV is quite high among the Estonian IDUs (>20/100 per man-year) (Uusküla et al., 2007). However, it is known that Estonian HIV-positive IDUs who are aware of their serostatus, practice more risky injecting behaviour compared to the IDUs who are not aware of their serostatus (Abel-Ollo et al, 2010). Such finding refers to the need to plan for the interventions needed by the HIV-positive IDUs to reduce their risk behaviour. It has been established that if the prevalence of HIV increases to 10−20% among IDUs, even moderate risk behaviour in the risk group can cause a considerable increase in the contraction of HIV (Des Jarlais et al. 2000). As the prevalence of HIV is considerably higher among the IDUs in Estonia, it is important that relevant harm reduction and other services are offered in the sufficient amount.

Harm reduction services targeted to IDUs

In total, EUR 2,438,558 were used for prevention of HIV/AIDS in 2009, EUR 85322 were used by the Ministry of Social Affairs for acquiring methadone. In 2009, there were 36 syringe exchange points in 17 cities/settlements in Estonia, 13 of them were stationary and 23 field-work syringe exchange points. During the reporting period, 7,300 clients visited the syringe exchange points, 3400 of them being first-time visitos. In total, syringe exchange points were visited 180,000 times in 2009; 2,277,509 needles, 699,171 condoms and more than 110,000 information leaflets were distributed.

The amounts of syringes exchanged have increased over the years. More than half (66%) of the syringes were distributed in Ida-Viru county, 34% in Tallinn and 0.3% elsewhere in Estonia (Table 24).

Table 24. Harm reduction services in Estonia 2003−2009.

		2003	2004	2005	2006	2007	2008	2009
Tallinn and Harju county	Syringes distributed	18,010	129,093	230,409	443,961	600,021	734,954	774,782
	Condoms distributed	16,427	76,004	83,975	134,837	158,164	156,735	131,162
	Substitution treatment places	-	46	103	183	200	191	209
Ida-Virumaa	Syringes distributed	265,153	390,660	635,043	1,163,028	1,404,905	1,293,497	1,495,788
	Condoms distributed	135,444	231,429	301,415	396,665	573,245	527, 999	503,062
	Substitution treatment places	-	207	296	419	473	458	451
Rest of Estonia	Syringes distributed	-	-	-	9246	1025	4924	6939
	Condoms distributed	-	-	-	5662	21,548	70,140	64,947
	Substitution treatment places	-	-	-	-	-	-	-
Total (whole Estonia)	Syringes distributed	283,163	519,753	865,452	1,616,235	2,005,951	2,033,375	2,277,509
	Condoms distributed	151,871	307,433	385,390	537,164	752,957	754,874	699,171
	Substitution treatment places	-	253	399	602	673	649	660

Source: NIHD, 2010.

*The table contains only the services that are financed by the NIHD. The actual number of substitution treatment places in Estonia is higher as here the data of West Tallinn and Tallinn Wismari Hospital are not provided. As to the substitution treatment facilities, only the occupied places are provided.

*Data regarding substitution treatment in Ida-Viru county in 2003 is not available.

Prevention and treatment of TB

The general aim of National Tuberculosis Prevention Programme for 2008-2012“ is to reduce the new TB cases to 20 new cases per 100,000 inhabitants by the year 2012. During the last three years, success has been achieved in considerable reduction of new cases of TB (2007 – 30.4, 2008 – 26.3 and 2009 – 24.8 (initial data) new cases per 100,000 inhabitants) (NIHD, National Tuberculosis Prevention Programme for 2008-2012, Report for 2009, 2010). It is indicated in the report that in order to achieve the aims of the National Tuberculosis Prevention Programme, the infection with TB of the HIV positive persons must be reduced and the spread of the multi resistant form of illness must be restricted in Estonia. In 2009, the concept for the HIV positive drug addicts with TB for

monitoring their health status and treatment was developed within the framework of the TB programme.

Treatment of TB

In 2009, 90% of the persons having contracted TB were tested for HIV.
70% of the patients with TB/HIV+ coinfection (21 of 36) recovered and 10% stopped treatment. 6 persons having TB and HIV+ co-infection died in 2009 (Table 25).

Table 25. Treatment results of patients with TB/HIV+ co-infection in 2002–2009, as of 1 September 2010.

	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
TB/HIV+ first cases and relapses	17	13	22	33	38	47	37	36
Died before TB treatment started or during the first month of the treatment	1	1	4	5	8	9	8	6
Died before TB treatment started or during the first month of the treatment (%)	5.9	7.7	18.2	15.2	21.1	19.1	21.6	16.7
Started treatment of TB	16	15	18	27	31	38	29	30
Recovered from TB	9	8	11	20	20	25	24	21
Recovered from TB (%)	56.3	53.3	61.1	74.1	64.5	65.8	82.8	70.0

Source: TB Registry, 2010.

Prevention of hepatitis B and C

There are no specific preventive activities informing the IDUs about prevention of viral hepatitis B and C in Estonia. Appropriate information regarding contraction of hepatitis B and C reaches IDUs mostly via the harm reduction services (syringe exchange points and low threshold centres). The web page http://www.hepatiit.net administered by the Estonian Association of Gastroenterology and the web page http://www.vaktsiin.ee administered by the Estonian Association of Infectionists have been established for educating general population in viral hepatitis A, B and C, providing information on factors influencing infection and vaccinations.

Vaccination against hepatitis B

In 2009, the total number of patients vaccinated against viral hepatitis B was 39, 607; 35,964 of them were in the age group of 0–14 (data of the Health Board). In addition, 336 adolescents aged 15─17 and 3,307 adults were vaccinated against viral hepatitis B (the Health Board, Prevalence of Infectious Diseases in Estonia in 2009, 2010).

Pursuant to the National Immunization Programme, infants and children 13 years of age not immunized in infancy are vaccinated in Estonia against hepatitis B. Infant immunization against hepatitis B is arranged by neonatologists and family physicians. Vaccination of 13 year-olds is arranged by school physicians. Vaccination is also advisable for all health care professionals, rescue service employees, police officers, prison officers and members of the Defence Forces who come into contact with blood and persons suffering from B-hepatitis due to their work. Other people exposed to aggravated risk professionally are vaccinated at the cost of the employer or by the person himself.

In Estonia, family members and sexual partners of persons suffering from acute or chronic HBV infection, drug addicts, prostitutes, men having sex with men and patients receiving donor blood and blood products (incl. dialysis patients) are recommended to vaccinate against B hepatitis at their own cost. Vaccination of drug addicts against hepatitis B is allowed simultaneously with testing, rapid immunization is allowed.

Other support services to IDUs

Case management

Case management system has not been fully developed in Estonia, being rather an activity based on the initiative of the workers in the field of harm reduction and treatment services. In 2009, case management system was also financed from the NSPDA (150,000 EEK) in addition to HIV and AIDS strategy. In 2009, case management service financed within the framework of the NSPDA was offered to the IDUs who were subject to resident methadone substitution treatment whose children need health care and social services. In total, 25 families with dependency problems received assistance. Still, examining the size of the IDUs group and prevalence of HIV, the development of case management becomes gradually more important. The main aim of case management is to link the dependent persons with the services and benefits needed by them based on their individual needs.

Pregnant addicts

In 2009.a project was conducted in West-Tallinn Central Hospital providing pregnant opiate addicts substitution treatment buprenorphine, HIV analyses and ARV treatment,

psychological/psychiatric services and group therapy. Pregnant opiate addicts were granted use of public transport free of charge for reaching treatment centres in Tallinn and if necessary, social assistance within the project framework. In 2009, 198 infants received breast milk substitute for vertical prevention of HIV infection free of charge (HIV/AIDS report, 2010).

AIDS counselling centres

In 2009, eight AIDS counselling centres were operating in Estonia, conducting anonymous testing of nearly 7000 persons of whom 217 proved to be HIV-positive,105 of the latter were IDUs. The costs of HIV verification tests and transport of tests from first lab to reference lab were funded from national sources.

Anonymous diagnostics and treatment of STD

In Jõhvi and Narva, IDUs and their sexual partners were offered anonymous diagnostics and treatment of sexually transmitted diseases (STD) free of charge. During 2009, there were 2,000 visits to these centres and STD treatment services were provided free of charge to 750 persons.

7.3 Responses to other health correlates among drug users

Data for the respective area are not available.

Chapter 8. Social correlates and social reintegration

During the reporting period, no surveys on drug use have been conducted among the socially vulnerable groups. The drug addicts do not have a separate service for addressing issues related to their accommodation, training/education and employment. Such areas are addressed in Estonia by the agencies offering rehabilitation service designed for drug addicts (both in-patient as well as day centres). To be more exact, a social worker at the centre attends social problems and employment issues besides rehabilitation services. Besides specific rehabilitation services targeted to addicts, separate service for the reintegration into the society is also available for the persons released from prison. An

addict having served a prison sentence can use all ordinary rehabilitation services after release.

Chapter 9. Drug-related crime, prevention of drug-related crime, and prison

Introduction

Data on drug-related crimes and misdemeanours have been obtained from the Ministry of Justice, EMCDDA standard table No. 11 was used for data collection. Data on drug-related crime is derived from the National Register of Criminal Procedure (RT I 2001, 22, 121). The aim of this national register is to provide an overview of criminal procedures, to link criminal procedures commenced and terminated in the Republic of Estonia and facilitate preparation of statistical reports of crimes and criminal procedures. This register does not contain any data on the use of drugs of the persons having committed drug-related crimes (Penal Code § 183−190), and therefore it is impossible to establish correct data on the connection of persons having committed drug-related crimes to drug use. It is also impossible to present data by narcotic substances uses in case of misdemeanours related to owning or using small quantities of drugs (§ 15¹). A more detailed description of the additional data in the register is available in the EMCDDA Report 2009.
Information regarding engagement in drugs in prison environment comes from the reports of the NSPDA and reports of the NSPDA of 2009 and Ministry of Justice. The report does not present any new data regarding drug use in prison. A new survey in prisons is planned in 2011 by National Institute for Health Development.

9.1 Drug-related crime

In 2009, drug-related crime comprised 2% of all crimes. In total, 1042 drug-related crimes (Penal Code, § 183−190) were recorded in 2009, which is one-third (31%) less than in 2008 when the total number of drug-related crimes recorded amounted to 1558 (Table 26).
Of all drug-related crimes recorded in 2009, 76% (n=789) were related to unlawful handling of large quantities of narcotic drugs or psychotropic substances and provision of large quantities of narcotic drugs (§ 184). In 2009, charges of large-scale drug trafficking were brought against 25 organised criminal groups including 86 persons in total. Arrests of smugglers of drugs abroad from Estonia have become more frequent.

Crimes related to unlawful handling of small quantities of narcotic drugs or psychotropic substances (§ 183) comprised 15% (n=153) of all recorded drug-related crimes and in addition, 100 other drug-related crimes (§§ 185−190) were recorded.

Table 26. Recorded drug-related crimes in 2007–2009.

Type of criminal offence	**Penal Code §**	**2007**	**2008**	**2009**
Unlawful handling of small quantities of narcotic drugs or psychotropic substances	§ 183	297	301	153
Unlawful handling of large quantities of narcotic drugs or psychotropic substances	§ 184	1048	1143	789
Passing on of narcotic drugs or psychotropic substances to minors	§ 185	79	65	63
Inducing person to engage in illegal use of narcotic drugs or psychotropic substances	§ 186	0	0	0
Inducing minors to use narcotic drugs	§ 187	3	6	0
Illegal cultivation of opium poppy, cannabis or coca shrubs	§ 188	19	37	32
Preparation for distribution of narcotic drugs or psychotropic substances	§ 189	2	6	4
Violation of requirements for handling narcotic drugs or psychotropic substances or precursors thereof or of requirements for related recording keeping or reporting	§ 190	1		1
Total		1449	1558	1042

Source: Ministry of Justice, 2010.

In 2009, 3205 misdemeanours related to owning or use of small quantities of narcotic drugs (Narcotic Drugs and Psychotropic Substances Act § 15¹), that is almost half (48%) or 2908 cases less than in 2008 when the total number of drug-related misdemeanours recorded amounted to 6113 (Table 27).

Minors comprised 6.1% of all persons having committed misdemeanours related to owning or use of small quantities of narcotic drugs (§ 15¹) (196 persons).

The drop in the number of misdemeanours and crimes related to drugs is related to the fact that apprehension and bringing to justice of criminal groups engaged in trafficking large quantities of drugs have been a priority in the fight against drug-related crime during the last years, and in the situation were resources are rather limited the potential of the police to deal with less dangerous crime has been reduced to a certain extent (see also Subchapter 1.3).

Table 27. Drug-related misdemeanours and criminal offences, and the number of persons having committed drug-related crimes in 2006-2009

	2006	2007	2008	2009
Drug-related misdemeanours (use or possession of a small amount for personal use) *	4906	5991	6113	3205
Drug-related dealing/trafficking/production **	893	1345	1444	942
Other drug-related crimes ***	88	104	114	100
All drug-related offences (misdemeanours and crimes)	5887	7440	7671	4247
Persons charged for criminal offences	844	613	881	847

Source: Ministry of Justice, 2010, EMCDDA standard table No. 11.

Explanatory Statement:

* Narcotic Drugs and Psychotropic Substances Act § 15[1]

** Penal Code § 183 and § 184

*** Penal Code §§ 185–190

The number of recorded drug-related offences was the highest in Tallinn and other major cities in 2009. 43% of all drug-related offences were recorded in Harju county (n=449), the majority of them in Tallinn (n=396). 17% (n=180) of all drug-related offences were recorded in Tartu county, majority of them in Tartu (n=171). 17% of all drug-related offences were recorded in Ida-Viru county (n=176), the majority of them in Narva (n=132). Of all drug-related offences 6% (n=61, 60 in Valga) were recorded in Valga county and 5% in Pärnu county (n=56, 46 in Pärnu).

46% (359) of the offences related to unlawful handling of large quantities of narcotic drugs were recorded in Tallinn and Harju county, 19% (149) in Ida-Viru county, 17% (135) in Tartu county and 6% (49) in Valga county.

9.2. Prevention of drug-related crime

Data on the area is not available.

9.3 Interventions in the criminal justice system

There is no legislation for application of alternative punishment in Estonia. In 2009, the draft alternative punishment application was prepared in the Ministry of Justice (see Chapter 1.2).

9.4 Drug use and problematic drug use in prison

Recent data regarding drug use among the imprisoned persons is not available. The last survey of knowledge, attitudes and behaviours related to HIV and drug addiction was conducted by the NIHD in 2008, we provided a thorough examination of the results in our previous report to the EMCDDA. The survey results revealed that the convicts use drugs also in the custodial institutions (28%), half of them injected drugs and nearly one-fifth shared injection materials in the prison environment (Lõhmus & Trummal, 2009).

The survey results refer to the need to apply harm reduction services suitable for the prison system and further increase the efficiency of the activities aimed at prevention of smuggling of drugs into the prisons. According to initial plans, the next survey on the knowledge, attitudes and behaviour related to HIV and drug addiction among the convicts shall be conducted in 2011.

9.5 Responses to drug-related health issues in prison

Prevention of HIV/AIDS and drug addiction in the Estonian prisons is based on the National HIV/AIDS Strategy for 2006–2015 and NSPDA for 2004–2010.

Drug-free departments and drug treatment in prisons

There are drug-free departments in three prisons, comprising 96 places in total: Tartu Prison (44 places), Viru Prison (40 places, 20 for adolescent and 20 places for adult convicts) and Harku Prison (8 places). In the prisons, rehabilitation of addicts is based on social programmes. There is a special performance unit in Tartu Prison designed to take care of the drug addicts and a rehab department offering pre-release support to drug addicts having undergone drug treatment it is planned to be established there.

According to the estimations of the Ministry of Justice, there were 870 drug addicts in prisons (one-fourth of the total number of convicts), incl. ca 430 opiate addicts. 147 convicts underwent detoxification treatment due to use of non-opiate drugs in 2009, which exceeds the initial targets by 47 persons.

Opportunities for opiate substitution treatment are still extremely limited in prisons. This is partly the result of stopping treatment already in the houses of detention, where substitution treatment is not available to date. Stopping of treatment in houses of detention is the reason why up to now, the number of opiate addicts in Estonian prisons having substitution treatment is relatively low. Data of the Ministry of Justice shows that 12 persons received

substitution treatment in prisons in 2009 (2 persons in 2008). Resources required for drug addiction treatment come from general medical expenses of prisons. According to plans, from 2010, methadone substitution treatment will be offered in houses of detention as well, possibly significantly increasing the number of convicts needing substitution treatment in prisons. Pursuant to initial plans, substitution treatment can be provided to 25 convicts held in detention houses, who participated in the substitution treatment programme before detention.

Training for prison personnel and probation supervisors

In order to improve the quality of the services designed for imprisoned drug addicts, 57 prison officials/probation supervisors were trained in 2009 in the field of motivating counselling and 77 prison officials attended a 2-day training in the basic knowledge regarding drugs. All trainings fro the prison personnel were funded by the United Nation Office on Drugs and Crime (UNODC) project “HIV prevention and maintenance among IDUs and detention institutions in Estonia, Latvia and Lithuania”. The dog kennel of Murru Prison conducted refreshment training for 12 guards/dog handlers in 2009.

9.6 Reintegration of drug users after release from prison

Data on the reintegration of drug users after release from prison is not available in Estonia. Tartu Prison is specialised in working with drug addicts, and rehabilitation department offering support services and pre-release support for the addicts having undergone drug treatment is being established there.

Chapter 10. Drug Markets

Most of the data contained in this Chapter have been collected on the basis of EMCDDA standard tables 13, 14 and 16. Data regarding amounts of the narcotic substances and their purity were provided by the Estonian Forensic Science Institute which is the central institution conducting expert analyses of narcotic substances for law enforcement agencies in Estonia. Data regarding drug prices comes from the Estonian Police and Border Guard Board, and reflect the expert estimations based on surveillance activities. Prices for 2010

cover Estonia in total and are not limited to Tallinn. Data on drug transit have been obtained from the Tax and Customs Board.

10.1 Availability and supply

During the last three years, the number of detected cross-border drug crimes has increased year by year. In 2009, the Tax and Customs Board established 126 cases of tax crimes and the total amount of narcotic substances detained was 59.6 kg.
Below the data regarding transit of various narcotic substances is provided.

- Amphetamine and ecstasy (transit through Estonia as well as drugs produced in Estonia) are mainly smuggled to the Nordic countries. A new trend has become evident in amphetamine smuggling, where pure amphetamine is brought to Estonia from Russia. Production of amphetamine in Russia is rather the result of availability of the raw material, although it cannot be said that delivery of primary material from Russia to Estonia has ceased altogether.
- Marijuana and hashish are delivered mainly from Western Europe. Smaller quantities, intended mainly for personal use, are delivered to Estonia in postal parcels and among the personal belongings of travellers. Compared to 2008, the detection of hemp seeds and mycelium/spores of mushrooms in postal parcels remained on the same level in 2009. In 2008, hemp seeds and mycelium/spores were detected in mail in 34 times, in 2009, the detection rate was the same..
- Cocaine is mainly smuggled using the so called internal carriers so that the control over the courier and the goods would be stronger and risk smaller. Cocaine seized from the persons arrested by the Tax and Customs Board comes from the countries of Latin America and Africa. The amounts are not very large, but still quite remarkable (up to 2 kg). Both air and maritime transport are used and considering the fact that there are no direct flights from Estonia to Latin America and Africa, intermediate stops in Spain, England and Holland are used.

Of the more recent developments in narcotic substances, *khat* was found in 2009, which had emerged as a new trend only in 2008. These are leaves of the *Khat* plant native to Africa and attempts are made to smuggle from Great Britain to the Nordic countries via Estonia.
Also a new trend, import of plant drugs to Estonia was evidenced in 2009. In the first half-year the import and export of new hallucinogenic plant drugs (most wide-spread clichés Skunk, Spice Gold, Druids Fantasy, Spike99 Ultra, Bliss Extra) began to spread. But in the

2nd half-year of 2009, the mail orders almost stopped. The reason was the amendment introduced by the Ministry of Social Affairs in summer, including these plant drugs into the list of narcotic and psychotropic substances (see Chapter 1.1).

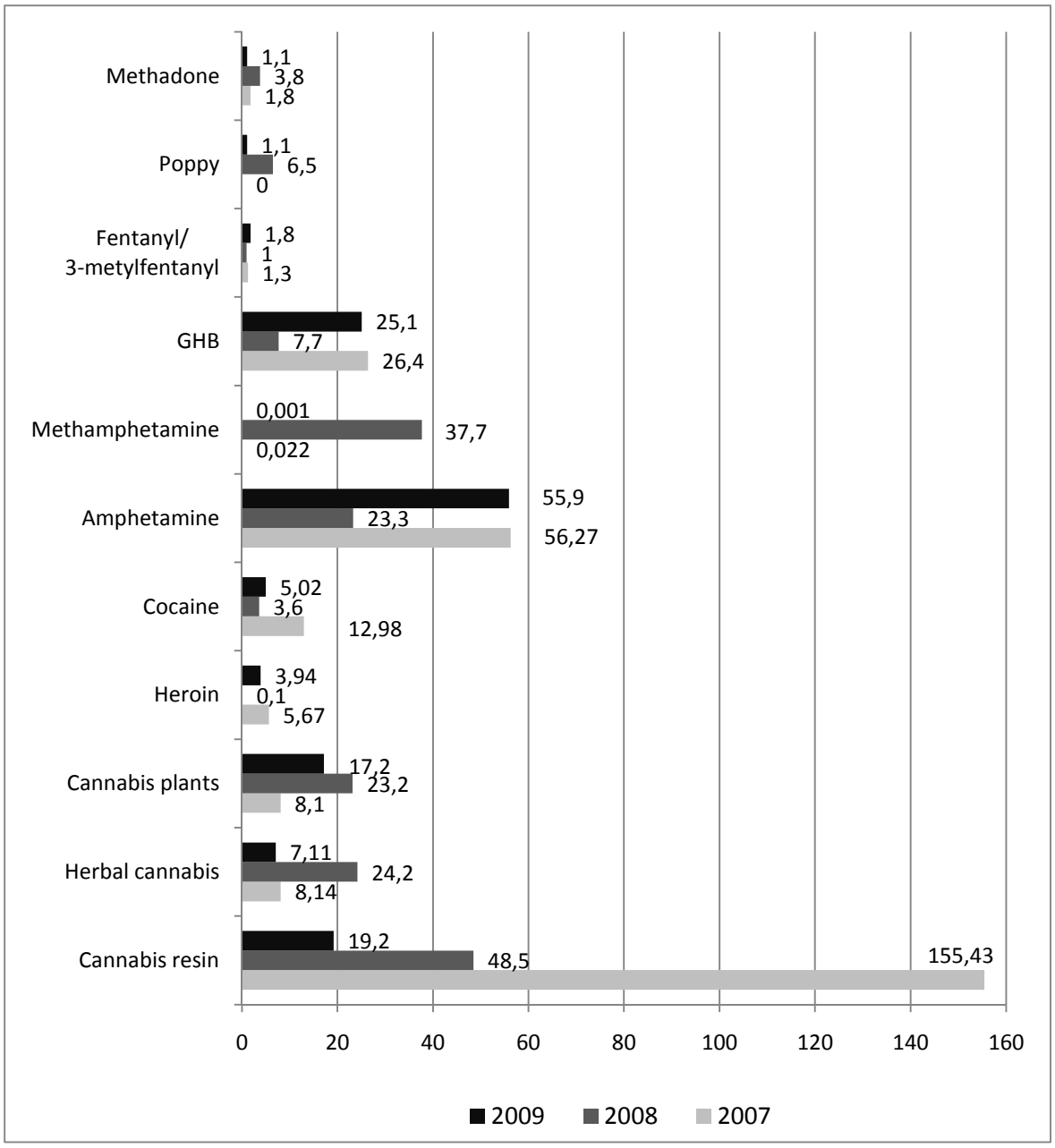
10.2 Seizures

Compared to 2008, there was an increase in the amounts of most of the narcotic substances confiscated in 2009. The only exceptions in 2009 constituted the number of confiscated cannabis substances and ecstasy-like pills, which showed a noticeable downtrend. Of cannabis substances, the confiscated amounts of hashish and marijuana dropped several times compared to 2008 (the confiscated amounts of hashish were 29.3 kg and marijuana 17.09 kg smaller compared to 2008). Similarly, the number of confiscated ecstasy-like pills has shown a continuous downtrend during three years. If in 2007, 32,256 pills were confiscated and in 2008, this number was 19,465. In 2009, the total amount of confiscated pills constituted 13,574.

However, contrary to this, the confiscated amounts of heroin, cocaine, amphetamine and GHB increased radically (Figure 1). The total amount of amphetamine confiscated in 2009 was 55.9 kg, which was over 50% per cent more than in 2008 (similar to the amount confiscated in 2007). Different law enforcement authorities confiscated 5 kg of cocaine and 25 kg of GHB in total. In addition to GHB, large amounts of primary material of GHB – GBL – were detected (27.7 kg). Compared to the previous years, it was the number of GBL detections made in the course of checking mail and courier post that considerably increased in 2009.

However, the amounts of confiscated poppy and opium poppy, as well as methadone dropped drastically. The comparison of the amount of 3-methylfentanyl confiscated in 2009 to the amount confiscated in 2008 shows a nearly two-times growth as well.

Figure 1. Amounts of confiscated narcotic substances in 2007-2009 (kg)



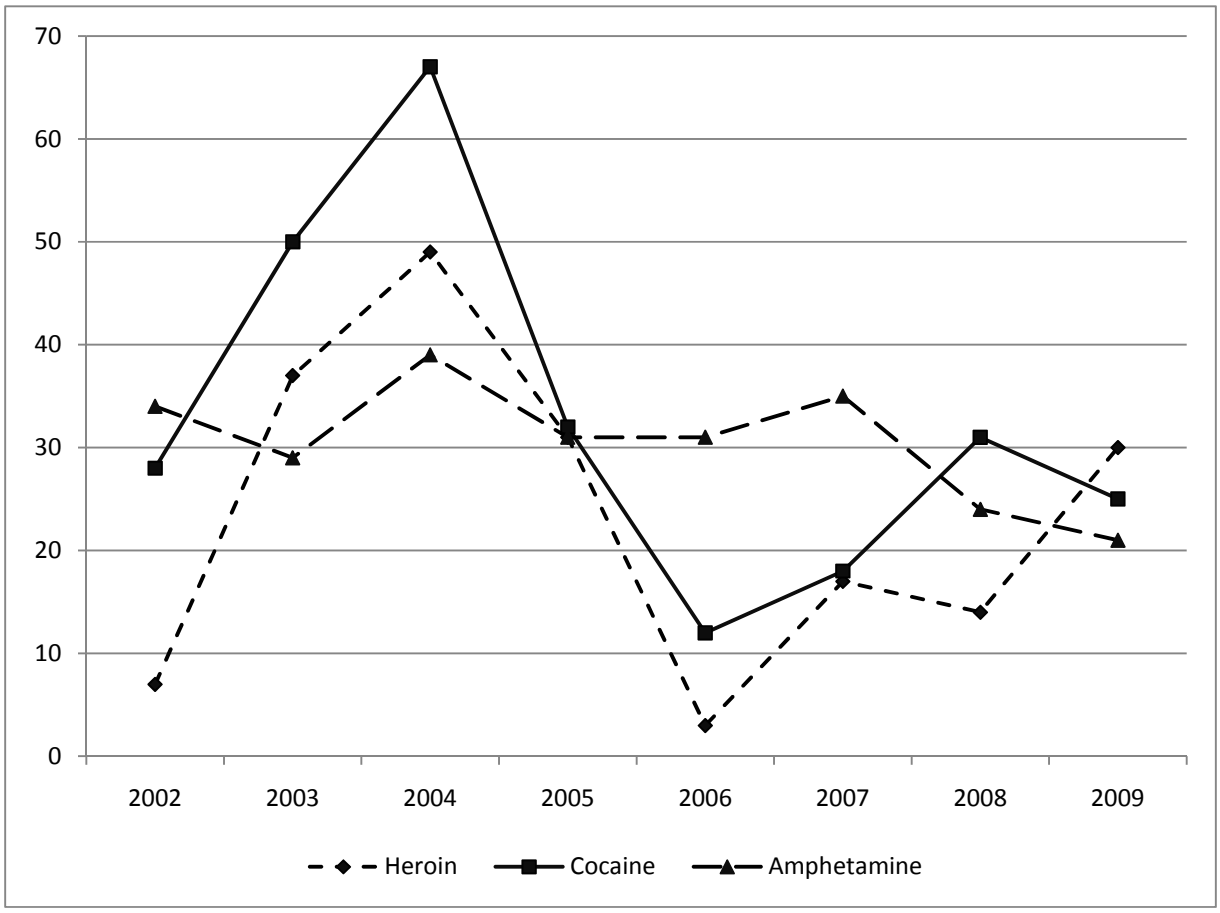
Source: EFSI, 2010.

If in 2008, the most often confiscated substance of opiates was 3-methylfentanyl, in 2009 it was again replaced by heroin. In 2009, 3.94 kg of heroin and 1.8 kg of 3-methylfentanyl were confiscated. The comparison of the amount of 3-methylfentanyl confiscated in 2009 to the amount confiscated in 2008 shows an almost double growth trend as well.

10.3 Price and purity

In 2009, we could claim that heroin has disappeared from the local Estonian market. Although you can find some heroin among the confiscated substances, this is not the case of the substance aimed at the Estonian drug market but it probably passes the territory of Estonia for transit purposes. Local injecting drug addicts prefer fentanyl analogues of various strength levels, such as "China White", "White Persian" and "Afghan". Instead of the heroin price, the police provides an estimated price for one gram of fentanyl analogues (fentanyl/3-methylfentanyl), which is within the range of 63.90–95.80 EUR. In the case of heroin we can only speak of purity of the confiscated heroin, which has increased compared to 2008. If the prevalent purity of the confiscated heroin was 14% in 2008, in 2009 it was 30% already (Figure 2). Contrary to the growth in the heroin purity in 2009, the purity of amphetamine and cocaine dropped. The prevalent purity of amphetamine was 21% in 2009 (24% in 2008), and the purity of cocaine 25% (31% in 2008). Although the purity of amphetamine has dropped compared to the previous year, its estimated street price has grown. The most common price of amphetamine was 15.9 EUR, which is 3.15 EUR more than in 2008. The price of amphetamine varied from 12.8 to 19.2 EUR. Of the stimulants, the price of ecstasy pills also grew in 2009. While in 2008, the price of an ecstasy pill varied within the range of 4–8 EUR, in 2009 it was between 5.10 and 7.90 EUR. In 2009, the most common pill price was 6.40 EUR. Cocaine purity was demonstrating an upward trend over the past years but dropped in 2009, which also corresponds to the drop in the price of the substance. While in 2008, the most common street price of one gram was 102 EUR, in 2009 it was 76.7 EUR, varying within the range of 57.50 and 115 EUR. The price of cannabis substances remained at the level of 2008. Hashish and marijuana are in the same price class since hashish is not very popular in the Estonian drug market. The price of hashish as well as of marijuana was around 19.20 EUR.

Figure 2. Prevalent purity of amphetamine, cocaine and heroin in 2002–2009 (mode).



Source: EMCDDA standard table 14, EFSI 2010.

Part B Selected Issues

Chapter 11. History, methods and implementation of national treatment guidelines

11.1 History and overall framework

The public became aware of the drug addiction problem just after Estonia regained independence in the middle of the 90s. The first strategic document of combating drug addiction in Estonia was adopted by the Government of the Republic in 1997, when "Alcoholism and drug addiction prevention programme for 1997–2007" was approved. The Ministry of Social Affairs of Estonia was responsible for the implementation of the Programme. In 1998, an advisory committee was formed for the Programme, with the official name the Council of National Programme for Prevention of Alcoholism and Drug Addiction, the objective of which was to supervise and coordinate the Programme for Prevention of Alcoholism and Drug Addiction. Each year the Council defined the priority areas for the following year. In 1999–2000 one of the priority areas was treatment of drug addiction and creation of new treatment/rehabilitation facilities. The Ministry of Social Affairs did not implement the Programme for Prevention of Alcoholism and Drug Addition itself, but it was the Estonian Foundation for Drug Prevention that was engaged in the process (National Report 2001). The first drug addiction treatment guidelines were prepared in 2001 under the leadership of the Estonian Foundation for Drug Prevention in cooperation with the Pompidou Group of the European Council. Leading psychiatrists and psychologists of Estonia were involved in the development of the guidelines for drug addiction treatment. Altogether, eight psychiatrists and three renowned psychologists were engaged in the preparation of the guidelines for drug addiction treatment. Besides, Martien Kooyman M.D., Ph.D., expert of the Pompidou Group, was involved in the development of the guidelines. The primary source materials for the guidelines for drug addiction treatment were the guidelines of Great Britain "Drug misuse and dependence – guidelines on clinical management". At that time, the preparation of the guidelines for drug addiction treatment was conditioned by a continuously growing need to treat drug addiction in the country and by the wish to harmonise the principles of drug addiction treatment provided. The first drug addiction treatment guidelines primarily focused on the general topics of addiction, and the issue of treatment of opiate addiction in particular formed an insignificant part of the guidelines. The treatment guidelines developed in 2001 were approved by the Estonian

Psychiatric Association only in 2005. Since the approved guidelines failed to pay adequate attention to the treatment of opiate addiction that was particularly a problem in Estonia, the existing treatment guidelines were started to be modified in 2006. In 2006–2007, the NIHD[3] in cooperation with the Estonian Psychiatric Association was primarily engaged in the development of the new guidelines for opiate addiction treatment supplementing the old treatment guidelines. The initial guidelines completed in 2001 mainly focused on stopping using drugs particularly by way of detoxification. The aim of detoxification was set at immediate or step-by-step termination of taking drugs and alleviating or avoiding acute detoxification symptoms within a maximum of six months. An annex to the guidelines of drug addiction treatment, supplementing and specifying the existing guidelines approved by the Estonian Psychiatric Association Society in 2007, in addition to detoxification also provides for the so-called maintenance treatment with substitution medicinal products. The new treatment guidelines developed were also updated in the part of more exact dosing of medicinal products.

Since 2008, the NIHD, in cooperation with the Estonian Psychiatric Association, has been engaged in the development of new guidelines for drug addiction treatment, which should be completed by the end of 2010.

11.2 Existing guidelines: narrative description of existing guidelines

As mentioned above, specialists engaged in the treatment of drug addiction in Estonia have been using two consensus documents over the years: guidelines for drug addiction treatment (2001) and guidelines of opiate addiction treatment (2007). The given documents are intended for use by all specialists who are concerned with drug addiction treatment. The first treatment guidelines developed in 2001 cover drug addiction treatment in a wider sense and focus just on detoxification, while the 2007 version is solely centred on opiate addicts, offering the following treatment types:

- *detoxification with substitution medicinal products* is a treatment of opiate addiction lasting a maximum of one month, during which substitution medicinal products are used;
- *substitution treatment* is a treatment of opiate addicts involving psychosocial rehabilitation, where substitution medicinal products are used and which lasts over one month;
- *supporting maintenance treatment* is a treatment of opiate addicts, where substitution medicinal products are used and which lasts over one month; the main

[3] Since 2003, the NIHD has been implementing the national strategy for prevention of drug addiction in the area of administration of the Ministry of Social Affairs.

objective of this treatment is harm reduction and improvement of the patient's life quality. Supporting maintenance treatment does not set the objective of getting rid of addiction or recovery of the patient's ability to work. Supporting maintenance treatment should be started only in the case of patients who could not be made to stop using drugs and whose treatment motivation could not be increased either during repeated detoxification episodes or during substitution treatment that had lasted for at least 6 months; who are HIV positive and in whose case due to maintenance treatment it will be obviously possible to avoid the spreading of infectious diseases and other health problems and whose life quality can be improved this way.

- *rehabilitation of opiate-addicted patient* is rehabilitation of drug addicts carried out either in day care centres or rehabilitation communes (Guidelines for opiate addiction treatment 2007). As an explanation, such rehabilitation treatment aimed at drug addicts in Estonia is defined as rehabilitation. Elsewhere in the world, such service is frequently called follow-up treatment or such services are just considered as drug addiction treatment without medicines. The guidelines set out that rehabilitation in the narrow sense of this word starts only after the addict has stopped using drugs and has undergone substitution treatment. Rehabilitation does not provide for connection with the provider of treatment service.

New guidelines for opiate addiction treatment that will be completed by the end of 2010 are more clinical and detailed than the previous ones and also include the description of the combined effect of different medicinal products. The development of the new guidelines for opiate addiction treatment was mainly based on the WHO's treatment guidelines "Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence" and in Lithuania on the treatment guidelines "Addictive disorders treatment for opioid users with Methadone (2009)".

11.3 Implementation process

Two guidelines for drug addiction treatment that have been in use in Estonia to date are advisory consensus documents, which have been approved by the specialists association, namely the Estonian Psychiatric Association. Similarly to the guidelines of drug addiction treatment, all treatment guidelines in Estonia are approved by specialists associations. It is unknown how many specialists engaged in drug addiction treatment proceed from these guidelines. The topic related to the guidelines for drug addiction treatment were in some respects discussed in "Research of evaluation of methadone substitution treatment quality

and need for services in Estonia" financed by UNODC in 2008 and in the research of mapping publicly financed rehabilitation centres aimed at drug addicts and client satisfaction with the service. In the research report treating methadone substitution treatment, a conclusion was made that providers of substitution treatment lack unambiguous guidelines that can be used in practice. To be more precise, the research found that there is no uniform understanding of the nature of substitution treatment and its objectives (Abel-Ollo et al., 2008). Also, there are references in the rehabilitation services research report that not all service providers currently proceed from the advisory guidelines for opiate addiction treatment or these guidelines are considered insufficient (NIHD, 2009). Such findings indicate that treatment guidelines are not uniformly used and unambiguously understood by specialists, and the improvement of treatment quality and wider use of the guidelines should be emphasised in the treatment guidelines. As a particular solution, the specialists participating in the UNODC research proposed the development of national drug addiction treatment standards and determination of the uniform treatment structure and development trends. Also, the rehabilitation centre evaluation report provides, as a future perspective, for the development of service descriptions that would be uniform and specific as to their structure. As one of the solutions, the UNODC evaluation research also recommends approving the guidelines for opiate addiction treatment, which will be completed in 2010, at a high level in order to avoid their becoming of advisory nature, which are not followed by all the specialists of the area.

11.4 Comparision with the WHO guidelines

Table 28. Comparison of Estonian treatment guidelines with the WHO standards

	Name of Assessors: KATRI ABEL-OLLO	Yes	No	Not Applicable specify	No answer
1.	**Choice of treatment**				
1.2	For the pharmacological treatment of opioid dependence, clinicians should offer opioid withdrawal, opioid agonist maintenance and opioid antagonist (naltrexone) treatment, but most patients should be advised to use opioid agonist maintenance treatment. Do the present guidelines include this recommendation?	**X**	□	□	□
1.3.	For opioid-dependent patients not commencing opioid agonist maintenance treatment, consider antagonist pharmacotherapy using naltrexone following the completion of opioid withdrawal. Do the present guidelines include this recommendation?	□	**X**	□	□

2	**Opioid agonist maintenance treatment**	□	□	□	□
2.1	For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine. Do the present guidelines include this recommendation?		**X**		
2.2	During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30mg. Do the present guidelines include this recommendation?	**X**	□	□	□
2.3.	On average, methadone maintenance doses should be in the range of 60–120 mg per day. Do the present guidelines include this recommendation?	**X**	□	□	□
2.4	Average buprenorphine maintenance doses should be at least 8 mg per day. Do the present guidelines include this recommendation?	**X**	□	□	□
2.5	Methadone and buprenorphine doses should be directly supervised in the early phase of treatment. Do the present guidelines include this recommendation?	**X**	□	□	□
2.6	Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review. Do the present guidelines include this recommendation?	**X**	□	□	□
2.7.	Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence. Do the present guidelines include this recommendation?	**X**	□	□	□

3	**Management of opioid withdrawal**	Yes	No	Not Applicable specify	No answer
3.1.	For the management of opioid withdrawal, tapered doses of opioid agonists should generally be used, although alpha-2 adrenergic agonists may also be used. Do the present guidelines include this recommendation?	**X**	□	□	□
3.2.	Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal. Do the present guidelines include this recommendation?	□	**X**	□	□
3.3	Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal. Do the present guidelines include this recommendation?	□	**X**	□	□
3.4	Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence. Do the present guidelines include this recommendation?	**X**			

4	**Pregnancy**				
4.1	Opioid agonist maintenance treatment should be used for the treatment of opioid dependence in pregnancy. Do the present guidelines include this recommendation?	□	**X**	□	□
4.2	Methadone maintenance should be used in pregnancy in preference to buprenorphine maintenance for the treatment of opioid dependence; although there is less evidence about the safety of buprenorphine, it might also be offered. Do the present guidelines include this recommendation?	□	**X**	□	□

WHO guidelines coherence: only to be applied to guidelines applied for guidelines on closed settings

Drug treatment guidelines for the so-called closed settings are missing in Estonia

		Yes	No	Not Applicable specify	No answer
1.	Do the present guidelines agree with the "Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings"?	□	□	□	**X**

Chapter 12. Cost of drug-related treatment: a comparative analysis

It must be mentioned by way of introduction that surveys on the cost or drug treatment or economic evaluation of drug treatment have not been conducted in Estonia.

12.1 Funding sources

Drug treatment is not included in the list of health care services funded by the Estonian Health Insurance Fund, but the Fund reimburses costs for the psychiatric treatment services for a person insured by the Health Insurance Fund to the medical institution on the basis of the limits established by the Government of the Republic in the list of Health care services of the Estonian Health Insurance Fund in accordance with the agreement signed by the Estonian Health Insurance Fund and the medical institution.

The majority of the drug treatment is financed directly from the state budget through the NSPDA until 2012 and National HIV and AIDS Strategy for 2006–2015. The first program is used for covering most of the costs related to detoxification treatment and rehabilitation, the other covers the costs required for methadone substitution treatment. Besides the state budget, the City of Tallinn has also funded the treatment service or its components. In addition to funds allocated from national sources and by the City of Tallinn, an addict can pay for the treatment service himself/herself.

Examination of the funds allocated from national strategies and the budget of Tallinn for drug treatment reveals the fact that during the last years funding of drug treatment has increased to some extent (Table 29).

Table 29. National and local funding (EUR), 2005–2009.

	2005	2006	2007	2008	2009
National funding*	392,793	458,642	356,689	476,132	619,147
Known local funding (only Tallinn)	228,676	95,867	6127	298,798	268,429
Total	621,469	554,509	362,816	774,930	887,576

Data: NSPDA, HIV/AIDS Strategy and Tallinn Social Welfare and Health Care Department 2010.

* National funding are means provided through HIV/AIDS Strategy and National Strategy for Prevention of Drug Addiction.

National resources have been used for financing of 5–6 major providers of treatment services in two regions in Estonia – in Tallinn and in Ida-Viru county. In other regions in Estonia, treatment service supported from the state budget is not available. Each year the average number of treatment places funded within the framework of the HIV/AIDS strategy and NSPDA has been 600. While in the period of 2005–2007, besides state budget, significant share of the funds for treatment was provided by the Global Fund source (under the strategic objective “reduction of risk behaviour among IDUs”).

For further information regarding substitution treatment and detoxification treatment, see the Chapters 5 and 7 of this Report.

12.2 Cost studies

No cost studies of addiction treatment have been conducted in Estonia.

12.3 Full economic evaluation

Economic evaluation of drug treatment has not been conducted in Estonia.

Part C: Annexes

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List of legislations in Estonian

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Nakkushaiguste ja nakkushaiguskahtluse esinemise ning haigestumise ohutegurite kohta teabe edastamise kord ja edastatavate andmete koosseis koos andmesubjekti identifitseerivate isikuandmetega. Vabariigi Valitsuse 23. juuli 2009. a määrus nr 134. RTI, 27/07/09, 41, 279, http://www.riigiteataja.ee/ert/act.jsp?id=13208994

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List of EMCDDA standard tables, 2010

Standard Table 05: Acute/direct drug related deaths

Standard Table 06: Evolution of acute/direct drug related deaths

Standard Table 09: Prevalence of hepatitis B/C and HIV infection among injecting drug users

Standard table 10: Syringe availability

Standard Table 11: Arrests/Reports for drug law offences

Standard Table 13: Number and quantity of seizures of illicit drugs

Standard Table 14: Purity at street level of illicit drugs

Standard Table 15: Composition of tablets sold as illicit drugs

Standard Table 16: Price at street level of illicit drugs

Standard table 24. Access to treatment

Standard table 34. TDI data

List of tables and figures

Tables:

Figures: