European Monitoring Centre for Drugs and Drug Addiction

2011 NATIONAL REPORT to the EMCDDA (using 2010's data), by the Reitox National Focal Point

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

REITOX

REPORT ON THE DRUG SITUATION IN ESTONIA IN 2011 (according to 2010's data)

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List of abbreviations

AIDS - Acquired Immunodeficiency Syndrome (HIV - see below)
CI - confidence interval
EFSI - Estonian Forensic Science Institute
EMCDDA - European Monitoring Centre for Drugs and Drug Addiction
EMER - Estonian Ministry of Education and Research
ESF - European Social Fund
ESPAD - European School Survey Project on Alcohol and Other Drugs
GBL - Gamma-butyrolactone
GCDP - Government Commission on Drug Prevention
GHB - Gamma-hydroxybutyrate
HIV - Human Immunodeficiency Virus
AIDS - Acquired Immunodeficiency Syndrome
IISS - Institute of International and Social Studies
IDU - Injecting drug user
NSPDD - National Strategy for the Prevention of Drug Dependency
NDTD - National Drug Treatment Database
RDS - Respondent-driven sampling
STI - Sexually transmitted infection
TB - Tuberculosis
TCB - Tax and Customs Board
UNODC - United Nations Office for Drugs and Crime
WHO - World Health Organisation

Contents

Summary

Drug policy, legal framework and economic analysis

The underlying documents for activities against drug dependency in Estonia are the National Strategy for the Prevention of Drug Dependency until 2012 (NSPDD) and its action plan for 2011-2012. Compared to 2009, there were no fundamental differences in the institutions where the implementation of this programme was concerned. On the other hand, the action plan for 2011-2012 of the National Strategy for the Prevention of Drug Dependency until 2012 was approved by Order No 89, dated 03.03.2011, by the Government of the Republic (State Gazette III, 07.03.2011, 4).

Methylone, methedrone and PDVP (see Chapter 1.1) were added to the schedule of narcotic drugs and psychotropic substances as new substances. There were no other major legislative changes in 2010. However, a new legal basis for the application of drug addiction treatment as an alternative sentence for drug addicts was established, and the procedure for the preparation and surveillance of the application of treatment was also laid down.

Compared to the previous year, the budget for the National Strategy for the Prevention of Drug Dependency until 2012 decreased by 3% (see Chapter 1.3). In 2010 the budget for the strategy was 1,368,572 euros. It is necessary to add an explanatory note to clarify the fact that, unlike with previous years, the expenses of the Ministry of the Interior and the division of the Police and Border Guard Boards (PBG) that is involved in the ministry's administrative area, as well as that of the Estonian Ministry of Education and Research (EMER), are not reflected in the NSPDD's expenses. Both the expenses of the administrative areas of the EMER and the Ministry of the Interior are reflected in their expenses for principal activities and cannot be distinguished where the field of drugs is concerned. Three main interventions were financed amongst the available harm reduction services that are being targeted at drug addicts, these being syringe and needle exchange, substitution treatment with methadone, and condom provision, and as in previous years, these funds came from the HIV/AIDS National Strategy.

Drug Use in the general population and among specific groups

There is no recent information available on drug use amongst the general population and students that can be reported in the period covered here. The new ESPAD[1] amongst

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

students aged between fifteen and sixteen will be completed by the end of 2011 and a population survey which focuses, inter alia, on the use of drugs, alcohol and tobacco products in the population will be conducted in 2013.

A new account in this report is for the initial results of a survey on the risk behaviour displayed by injecting drug users (IDUs) and the spread of infectious diseases that was conducted in Narva in 2010. In summary, 75% of IDUs in Narva were male and half of them were below the age of thirty (22% were below the age of 24 and 31% were between 25 and 29 years old). According to the survey we can argue that the IDUs in Narva had a relatively long injection experience; nearly 40% of examinees had been injecting for more than ten years. The proportion of examinees whose injecting career was less than two years amounted to 19%.

Amphetamine was the main drug being injected for 17% of the IDUs in Narva. The majority of the IDUs (67%) injected once a week or less frequently, while 12% were daily injectors. A local pharmacy was the main point of access for new syringes for 50% of Narvas IDUs and a syringe exchange point accounted for a further 38%. According to the words of those who had shared a syringe, 20% of Narva's IDUs had used a common syringe in the last four weeks. The most frequent reasons for using a common syringe were the absence of a clean syringe (85%) and cleaning the syringe prior reusing it (37%). The spread of HIV amongst Narva's IDUs was 44%, hepatitis C was at 64%, and hepatitis B was at 5%.

Prevention

Primary prevention falls under the National Strategy for the Prevention of Drug Dependency, which is administered by the Ministry of Social Affairs. The National Institute for Health Development and the Estonian Ministry of Education and Research are the main bodies to implement primary prevention at the national level. The main prevention activities in 2010 involved providing society with information and preparing methodological materials. The dissemination of information to young people was carried out by means of issuing various leaflets, holding consultations, and publishing a web site - narko.ee - that provides information on drugs and their use. The major project for primary prevention in 2010 was the production of a twenty-minute educational film devoted to four different drugs. The film is teaching material for schools and its objective is to show the dangers that are related to experimenting with drugs and to decrease the desire among young people to try drugs in the first place. Specifically, the film discusses GHB (gamma-hydroxybutyrate), speed and cannabis (see Chapter 3).

No special drug prevention that was targeted at specific target groups was carried out during the reporting period in Estonia. The drug prevention programme that was carried out

in special schools mainly included the provision of information on addiction and activities supporting the development of social skills. In special schools, drug prevention was carried out as part of educational activities.

Problem drug use

In cooperation with the National Institute for Health Development and the Department of Public Health of the University of Tartu, a survey was carried out in 2010 which aimed to evaluate the size and prevalence of injecting drug users in the population as a whole during the period between 2005-2009 using the capture-recapture methodology. The results of this survey are being processed and will be reflected in the 2011 report.

Drug-related treatment

The provision of drug-related treatment in Estonian is still centred on methadone substitution treatment. Although, according to the results of the recent survey, the proportion of addicts using amphetamine has rapidly increased, services aimed at that target group are still insufficient. There are seven centres in Estonia that provide opiate substitution treatment at a national level. A total of 662 patients were receiving substitution treatment as of the end of 2010. The NSPDD reporting format does not distinguish between patients having treatment for addiction and those undergoing substitution treatment. However, on the basis of the National Drug Treatment Database (NDTD), we can argue that 65 patients underwent treatment for addiction in 2010. A total of 72 people were receiving rehabilitation as of 2010. There were six centres altogether that were providing rehabilitation. There are some differences between the statistics from national reporting and those from the National Drug Treatment Database, as the registry has not completely started yet. According to the National Treatment Database, 687 people came in for treatment in 2010 and 77% of them were male. Of all of those who came in for treatment in 2010, 27% were first time patients and the rest were had earlier experiences with drug treatment. More than half of those who came in for treatment belonged to the 25-34 age group. A total of 98% of patients received outpatient drug treatment as the opportunities to undergo in-patient treatment are very limited in Estonia. Nearly 90% of those who came in for treatment mentioned opiates as their primary drug (3-methylfentanyl was the primary drug for 71% of them).

Health correlations and consequences

A total of 7,692 people have cumulatively been diagnosed with HIV (Z21) (7,320 people in 2009 respectively), and 315 people with HIV disease (AIDS) (B20-B24) as at 31 December 2010. In 2010, altogether 372 new cases of HIV were registered (Health Board 2011). According to the tuberculosis registry of the National Institute for Health Development, 10% of all people who had become ill with tuberculosis had the dual diagnosis of HIV and TB.

A total of 23 people were recorded as having viral hepatitis B (B16) in 2010. The number of recorded viral hepatitis B cases has been continually decreasing since 2002, when 75 new cases were recorded, whereas in 2009 a total of 29 new cases of viral hepatitis B were registered. Presumably, the National Immunisation Programme has had an impact on the decrease in cases of viral hepatitis B. In addition to the decrease in the numbers of hepatitis B, the number of new cases of hepatitis C has also dropped. A total of 34 new cases of hepatitis C were recorded in Estonia in 2010, which is 33 cases less than in 2009 (see Chapter 6.1).

Recording the transmission route is still a problem both for cases of HIV and for hepatitis B and C. The transmission route is clear for only 6% of all new cases of hepatitis C and 35% of cases of HIV infection.

According to data from the Estonian Causes of Death Registry, which operates at the National Institute for Health Development, a total of 101 people died as a consequence of drug use in Estonia in 2010 (96 cases have been confirmed by toxicological test), which is a significantly smaller number than that of 2009 when, altogether, 133 people died as a result of drug poisoning. The average age of people who have died due to drug use was 29 years, and 84% of persons who died from drug use were between 20 and 34 years old when they died. Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified (X 42) was the recorded cause of death for 90% of registered drug-related deaths. According to data from the Estonian Forensic Science Institute, the majority of fatal poisoning deaths was connected to the use of 3-methylfentanyl.

Responses to health correlations and consequences

The main harm reduction services that are aimed at injecting drug users is that for methadone substitution treatment and the syringe exchange programmes. Nine organisations provided a syringe exchange service in 2010 and a total of 36 syringe exchange points were in operation (thirteen of these were stationary). A total of 2,800 first time visitors and nearly 7,500 repeat visitors came to the syringe exchange points.

Regardless the large number of drug-related deaths among injecting drug users, Estonia does not have a comprehensive programme for addressing overdoses. There are no special preventive measures to tackle hepatitis B and C among injecting drug users either. Persons belonging to risk groups are ensured health care and social services that prevent the contraction of tuberculosis. At the same time, regular prophylactic examinations are carried out for the early detection of illness among persons infected with HIV and persons who belong to risk groups and who have no health insurance. In the course of these activities, information materials are also distributed.

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

In 2010, a total of 901 drug-related crimes were recorded (Sections 183-190 of the Penal Code) (see Chapter 9.2). This is a significantly smaller number than that of 2009, when a total of 1,042 drug-related crimes were recorded. As in the previous year, drug-related crime formed 2% of all recorded crime. A total of 78% (i.e. 699) of all recorded drug-related crime was connected to the illegal handling and mediation of large quantities of narcotic drugs and psychotropic substances (Section 184). In 2010, the majority of drug-related crime was recorded in Harju County, which includes Tallinn, and Ida-Viru County, for which the vast majority were recorded in two cities, Narva and Kohtla-Järve.

As of the end of 2010, according to the assessment by the Ministry of Justice, there were 877 drug addicts being held in prison, 247 of whom were addicted to opiates. In 2009, there were 870 drug addicts in prison, with an estimated 430 of them addicted to opiates. The options for opiate substitution treatment are still limited in prisons. A total of 59 imprisoned persons received methadone treatment for addiction and 64 received substitution treatment in 2010. A positive development is that special rehabilitation departments for reintegrating drug addicts into society have been established in Estonian prisons. There are departments for this in three prisons altogether.

Drug markets

In comparison with 2009, quantities had decreased for most of the narcotic substances confiscated in 2010. The record growth in the quantities of cocaine confiscated can be considered an exception to this trend. The confiscated amounts have also increased in the case of methamphetamine (to 0.5kg); the number of confiscations of this drug increased from three to 36 cases. The quantities of all opiates confiscated decreased in 2010. However, the confiscation of GHB and GBL remained at a high level.

Observing the period of 2002-2010 overall, it can be noted that the general purity of narcotic substances has been relatively low. The purity of cocaine and amphetamine has been continually decreasing over the last three reported years. In terms of purity, only cannabis products can be regarded as an exemption as their purity has slightly increased in comparison with 2009. The price of cannabis products has remained at almost at the same level as in 2009.

In 2010 a small quantity of heroine reached the drug market in Tallinn. The estimated street price of heroine gram varied between 96 and 192 euros. The most commonly-used opiate in Estonia is still fentanyl for which the street price was 240-300 euros per gram depending on the strength of the substance. Compared to 2009, the price of amphetamine has remained more or less the same.

The methods used in the illicit traffic of narcotic substances or the precursors thereof, and the trends for this kind of activity, have generally remained the same. Heroine and fentanyl come to Estonia from eastern regions. The local production of amphetamine has decreased and this narcotic substance is now imported mainly from the Netherlands via Germany, Denmark and Sweden. Also, hashish comes to Estonia from the Netherlands. As a transit country, Estonia has become notorious for trafficking large quantities of cocaine in the case of which cocaine moves from South American and African countries to Europe via Estonia.

Part A: New developments and trends

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

The Ministry of Social Affairs is still coordinating the National Strategy for the Prevention of Drug Dependency until 2012 (NSPDD) and its implementation. As this is a multi-sector strategy, other ministries and agencies are also taking part in carrying out the strategy's action plan . The budget for the NSPDD in 2010 is relatively similar to that of 2009 as there was a decrease of only 3%. The total budget of the NSPDD for 2010 was 1,408,873 euros. A larger reduction in the budget of the NSPDD was made in 2009 when the budget was reduced by 44% when compared to 2008. In the field of legislation, new substances were entered into the schedule of narcotic drugs and psychotropic substances in 2010 and the legal basis for applying drug treatment as alternative punishment was established.
In the preparation of this chapter, reports by the National Strategy for the Prevention of Drug Dependency until 2012 and the action plan that is related to this have been used. In the chapter covering the legal framework, drug-related legal acts published in the database of the electronic State Gazette have been used.

1.1 Legal framework

In 2010, three new substances were added to the schedule of narcotic drugs and psychotropic substances.
In 2010, Schedule I of Narcotic Drugs and Psychotropic Substances gained three new substances. Regulation No. 73 by the Minister of Social Affairs, dated 18 May 2005: "The procedure for handling narcotic drugs, psychotropic substances and substances that are subject to special recording for medicinal and scientific purposes, and the procedure for related recording and reporting, and the schedules of narcotic drugs and psychotropic substances" (Appendix to the State Gazette 2005, 57, 807; 2008, 61, 875), was amended. The drugs, 4-methoxymethcathinone (methedrone, bk-PMMA, PMMC), 3.4-methylene-dioxymethcathinone (methylone, bk-MDMA), and methylenedioxypyrovalerone (MDPV), were added to Schedule I of Narcotic Drugs and Psychotropic Substances based on the Regulation No. 75 by the Minister of Social Affairs, dated 18 November 2010.

Legal bases were established for applying treatment for addiction as an alternative punishment for drug addicts

On 27 January 2011, Parliament adopted the following: “The Penal Code, Law of Criminal Procedure, Mental Health Act, Punishment Register Act, Probation Supervision Act and Healthcare Services Organisation Act Amendment Act” (State Gazette I, 23,2,2011, 2). The Act entered into force on 25.04.2011, establishing a basis for the application of treatment for addiction as an alternative punishment to imprisonment for drug addicts. Pursuant to the Act it is possible to replace a sentence of imprisonment for a drug addict for the crimes they have committed, replacing it with a course of drug treatment. It is only possible to apply a course of drug treatment where the person has been sentenced to a term of between six months to two years of real imprisonment and individuals who have been so sentenced agree on the replacement of imprisonment with the course of drug treatment. Pursuant to the Act it is possible to obligate the person, with their consent and upon conditional or conditional early release, to undergo treatment for addiction (in the form of drug treatment). The preparation for applying treatment that is imposed on a sentenced offender and sending the person to a health care services provider who will provide drug treatment falls into the competence of the relevant local Probation Supervision Department. The minimum duration of treatment for addiction applied as alternative punishment is eighteen months and the maximum length is three years. In some cases the duration of alternative punishment can be longer than the period of real imprisonment to which a person may be sentenced; in such cases fewer restrictions on individual’s freedom will be ensured (Explanatory -Letter by the Ministry of Justice, 2010).

On 25.06.2011, Regulation No. 33 by the Minister of Justice, dated 17.06.2011: “Procedure for the preparation and implementation and supervision of drug treatment and treatment for addiction applied upon conditional probation or conditional early release” (State Gazette I, 22.06.2011, 7). Thanks to this regulation, the Minister of Justice laid down the procedure for the preparation, implementation and supervision for the application of treatment. During drug treatment that is applied to a sentenced person as an alternative punishment, the person concerned must obey all supervisory requirements imposed on them while they are under supervision. The regulation determines when a sentenced person must visit their probation officer, when the probation officer sends the sentenced person to the institution that is applying treatment, how the probation officer shall be informed of any violation of the treatment regime by the sentenced person, and how the officer shall response to any such situation.

The procedure for the preparation of drug treatment that is applied upon the granting of conditional probation or conditional early release, and the procedure for the performance of the treatment regime and supervision thereof, was also laid down by the regulation.

The action plan for the National Strategy for the Prevention of Drug Dependency for 2011-2012 has been approved

The action plan for 2011-2012 of the National Strategy for the Prevention of Drug Dependency until 2012 was approved by Order No. 89, dated 03.03.2011, by the Government of the Republic (State Gazette III, 07.03.2011, 4).

1.2 National action plan, strategy, evaluation and coordination

In Estonia, the implementation of the National Strategy for the Prevention of Drug Dependency until 2012, as well as the work of the Government Commission on Drug Prevention (GCDP), is being continually coordinated by the Ministry of Social Affairs. As the NSPDD is a multi-sector strategy, involvement is also taken by the National Institute for Health Development (prevention, treatment, rehabilitation, monitoring and assessment), the Estonian Ministry of Education and Research (prevention among schoolchildren and students), the Ministry of Justice (the prevention of drug use and combating drug-related crimes in prisons), the Estonian Ministry of the Interior and Police and Boarder Guard Board (combating drug-related crimes), in the latter's administrative area, as well as the Estonian Tax and Customs Board (the cross-border investigation of drug-related crimes as well as combating and prevention these) in the administrative area of the Ministry of Finance.

There were no changes in the field of assessing the NSPDD in 2010. During the period of the validity of the NSPDD, the strategy has not been assessed whatsoever. Compared to the previous action plan, the title of the chapter for the monitoring and assessment of the National Strategy for the Prevention of Drug Dependency 2009-2012 that was approved by the Government was amended, and in the new operational programme the chapter is titled: "Monitoring, quality management, assessment and scientific research".

1.3 Economic analysis

In 2010 a total of 1,368,572 euros were allocated by the state for implementing the operational programme of the NSPDD, which is 3% less than in 2009 (2011 NSPDD Report). However, compared to the funding for the NSPDD in 2008, the budget for 2010 is 54% smaller (2,507,153 euros in 2008) (Table 1). Nevertheless, the changes in the NSPDD budget do not provide a basis for any valid conclusions as the expenses for activities in the field of drugs that are incurred by the Estonian Ministry of Education and Research as well

as those of the Ministry of the Interior and the Police and Border Guard Board in the administrative area thereof are not reflected in that report. These activities are carried out in the framework of principal activities and therefore cannot be specifically pointed out as being expenses in the field of drug addiction. As regards the expenses of supply reduction it should be taken into consideration that, similarly to 2010, the expenses for operational costs that were incurred in operational duties for this field (i.e. the real expenses of combating drug-related crimes) were also not reflected in the budget of the NDPDD in the previous years.

Table 1. Overview of the use of resources for the National Strategy for the Prevention of Drug Dependency in 2007-2010 (euros).

	2007	**2008**	**2009**	**2010**
Demand reduction				
Ministry of Social Affairs (NIHD, Estonian Drug Monitoring Centre (EDMC), Social Welfare Department of the Ministry of Social Affairs)	1,169,176	1,537,228	1,137,235	1,042,874
Ministry of Education and Research	*	*	24,455	*
Supply reduction				
Ministry of Justice	123,627	184,183	23,333	20,280
Ministry of the Interior (incl. Police and Border Guard Board) **	27,546	639,116	151,790	*
Ministry of Finance (Tax and Customs Board)	990,311	146,626	72,060	305,418
TOTAL demand and supply	**2,310,660**	**2,507,153**	**1,408,873**	**1,368,572**

Source: National Strategy for the Prevention of Drug Dependency until 2012, 2010 Report.
* The activities are financed by principal activities, so therefore it is not possible to point them out in the budget for the NDPDD.

Amongs expenses borne in 2007 and 2008, the expenses that were incurred by the Ministry of Interior and its agency (the Police and Border Guard Board) have been reflected. Amongst expenses for 2010 which were incurred through the implementation of the NSPDD, those expenses incurred by the Ministry of the Interior and Police and Border Guard Board have been presented.

Both the Ministry of the Interior and its subsidiary agencies, as well as the Tax and Customs Board (TCB) (the agency of the Ministry of Finance) carried out activities in the framework of the NSPDD. The latter, the TCB, is engaged in detecting, combating and preventing drug-related crimes. The TCB's expenses increased significantly in 2010. While the TCB used a total of 72,060 euros for anti-drug activities in the framework of the NSPDD

in 2009, in 2010 the amount was 305,418 euros. The majority of this amount (255,647 euros) was spent on the installation of a number identification system point. The remaining amount was spent on the preparation of the risk assessment for crimes belonging to the practical work of the TCB, national and international joint operations, and seminars, and to support the work of the TCB's liaison officer at Europol. Although the expenses for the Police and Border Guard Board are not reflected in the NSPDD reporting, criminal proceeds were confiscated to the amount of 511,293 euros in the framework of this authority's principal activity - combating drug-related crimes. Also, five joint operations were participated in, along with the Tax and Customs Board, and three organised criminal groups dealing with drug-related crime were detected during those operations; one of the groups was involved in drug trafficking between Estonia and Russia. The Police and Border Guard Board carried out four joint operations and the Tax and Customs Board seventeen.

In 2010 there were no information campaigns targeted at the general population, and regional prevention activities were not funded either. More information on prevention can be found in Chapter 3.

The field of harm reduction (i.e. syringe exchanges, methadone substitution treatment, and distributing condoms) was funded by the resources of the National HIV/AIDS Prevention Strategy. In 2010 the National HIV/AIDS Prevention Strategy was allocated 12,332,844 euros, and 51% of this was spent on medication for anti-retrovirus (ARV) treatment. 2,392,202 euros were spent in the field of harm reduction in 2010 (Table 2).

Table 2. Financing harm reduction related to HIV/AIDS and ARV treatment in 2007−2010 (EUR).

	2007	**2008**	**2009**	**2010**
HIV/AIDS prevention (activities of the Ministry of Social Affairs and NIHD)	2,431,409	3,079,830	2,423,478	2,392,202
ARV treatment	1,269,792	5,176,844	5,138,497	6,269,110

National HIV/AIDS Prevention Strategy - Report 2009.

* In 2004-2007 the purchase of medicines for ARV treatment was financed by the resources of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).
In 2008 and 2009 ARV treatment was financed from the budget of the Ministry of Social Affairs.

In the framework of HIV/AIDS prevention a total of 1,504,709 euros, which makes up 63% of the total appropriation for HIV/AIDS prevention, were spent on two substantial services - syringe exchange and methadone substitution treatment - which was targeted at injecting drug users. The syringe exchange service that was provided by a total of nine organisations through 36 syringe exchange points received a total of 917,682 euros (see Chapter 7.3). In 2010 there were seven institutions in nine different locations providing methadone substitution treatment in the framework of the National HIV/AIDS Prevention

Strategy; together with the obtainment of methadone 587,026 euros were spent on methadone substitution treatment.

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

There is no new information regarding drug use in the general population and among students to be covered in the reporting period. The next ESPAD[2] survey amongst fifteen to sixteen year-old Estonian students will be completed by the end of 2011. The next population survey that studies, inter alia, the use of drugs, alcohol and tobacco products in the general population will be carried out in Estonia in 2013. Both surveys have been conducted by the Institute of International and Social Studies at Tallinn University.
In 2010 the National Institute for Health Development carried out a survey of risk behaviour in injecting drug users and the spread of infectious diseases (HIV, HBV, HCV) among them in the city of Narva. The findings of the 2010 survey are not yet officially available. However, a short overview of the profile of an injecting drug addict in Narva will be given in this report.

2.1 Drug use in the general population

The next population survey will be carried out in 2013. As with previous years, the survey will be carried out by post and a representative sample will be created on the basis of the population register.

2.2 Drug use in the school and youth population

The next ESPAD study on students will be completed by the end of 2011.

[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

Injecting drug users (IDU)

Since 2005, surveys have been carried out that cover risk behaviours shown by IDUs and the spread of infectious diseases. These surveys have taken place in the Estonian cities of Tallinn (2005, 2007, 2009), Kohtla-Järve (2005, 2007), and Narva (2010). All of the foregoing studies have been carried out using respondent-driven sampling (RDS) (Heckathorn 1997). On the basis of the studies completed so far it can be summarised that the majority of IDUs in Estonia are men, they are below the age of thirty, and that they speak Russian. The average injection career has lengthened over the years, from six years (in 2005) to ten years (in 2009). The main drugs being injected have been fentanyl and amphetamine in Tallinn, poppy liquid in Kohtla-Järve, and amphetamine and fentanyl in Narva. Using various drugs simultaneously (polydrug use) has been a common practice with IDUs throughout the years (Rüütel et al., 2011). In this report a short overview will be given of the survey that was carried out in Narva in 2010.

According to the 2010 Narva Survey, it can be argued that 75% IDUs were male, whereas 22% of them were also under the age of 24 (Table 3). According to the survey it can be said that the IDUs in Narva have had a relatively long injection career; nearly 40% of respondents had been injecting for more than ten years. Just 19% of those IDUs had an injecting career that was less than two years.

Table 3. Main socio-demographic characteristics of injecting drug users - Narva 2010.

Characteristic	**n**	**%**	**EPP 95%CI***
Sex			
Male	265	75.4	68.4−81.8
Age			
24 and younger	66	21.6	15.1−29.1
25-29	111	30.8	23.3−38.8
30-34	98	25.6	19.3−32.8
35 and older	76	22.0	15.7−28.1
Language			
Russian	324	92.7	88.5−95.9
Education			
Basic education	138	34.1	26.5−41.6
Secondary education	54	19.7	13.5−26.6
Vocational education	134	39.2	31.8−46.7

Source: NIHD 2011.

*CI – Confidence Interval

Amphetamine was the main drug being injected for 71% of the IDUs in Narva. The majority of the IDUs (67%) injected once a week or less often, while 12% were daily injectors. The pharmacy was the main source for new syringes for 50% of Narva's IDUs, with the syringe exchange point accounting for a further 38% of them. According to accounts by those who had shared a syringe, 20% of Narva's IDUs had used a common syringe in the last four weeks. The most frequent reasons for using a common syringe were the absence of a clean syringe (85%), and cleaning the syringe prior reusing it (37%). The spread of HIV among Narva's IDUs was at 44%, hepatitis C at 64%, and hepatitis B at 5%.

Chapter 3. Prevention

Primary prevention falls under the National Strategy for the Prevention of Drug Dependency, administered by the Ministry of Social Affairs. The National Institute for Health Development and the Estonian Ministry of Education and Research are the main bodies to implement primary prevention at a national level. Information collection in the field of prevention is handled through the reporting of the national strategy. The main prevention activities were providing the society with information and preparing methodological materials for specialists. No selective drug prevention efforts that were targeted at specific target groups were carried out during the reporting period in Estonia.

3.1 Universal prevention

Drug prevention in general education schools

The priority of the Estonian Ministry of Education and Research for 2010 was developing and testing an early detection and intervention model in cooperation with UNICEF and the Ministry of Justice. The main purpose of the model is to detect problematic children in the school system early on, and provide then them with adequate help. Development of the models continues into 2011.

The situation with the classes provided in the framework for the school programme was similar to that of the previous reporting period. In 2009 the national curriculum was updated by adding drug prevention classes to the subject syllabus for personal education. The final implementation date for the application of the subject syllabus has been set for the beginning of the school year 2013/2014. The updating of subject syllabuses requires educational materials to be updated as well. In order to have some input into the refreshing of existing teaching books where these are related to drug prevention, a study on the current state of teaching about drug prevention and the obstacles involved was carried out

in 2010 and 2011. Specifically, there was a desire to find out what supports drug-related education in the school study process and what problems there are in covering these substances. One of the objectives was to find out what kind of teaching materials, guidelines and training teachers would expect in order to forward these topics successfully. In addition to drug prevention, the communication of sex education materials was also observed. However, this area is not reflected in this report. The target group of the study included people who are involved in communicating drug prevention materials in the school environment. Specifically, these were personal education teachers in both Estonian and Russian schools, so-called support staff assisting in teaching drug prevention (eg. psychologists, social workers, school nurses), and school management bodies[3]. Data was collected by means of focus group interviews.

Teachers' assessment of teaching materials

In this sub-chapter an initial, brief summary will be given of the study that commenced in 2010 and was completed in 2011, which was intended to map out the current state of the teaching of drug prevention and any obstacles to that teaching that might exist. Specifically, the assessment given to textbooks currently being used in personal education classes will be described in short.

The existing teacher book on drug prevention, "Social coping skills", was assessed as being good and applicable to the subject. The teachers liked the book's worksheets the most. The common opinion among teachers was that the teacher book was out of date in respect to certain topics (such as statistics, regulations and new substances) and would need to be updated. The teachers would prefer that there were more situation-related tasks and illustrative materials. The majority of the teachers use group work, role playing and creative work as the teaching method for their classes.

Something that was mentioned was that the possibility to borrow the book from a library was not enough to carry out a proper lesson and using the teaching material in question adequately would require a proper training cycle. The teachers expect the material to provide them with a framework that determines teaching volumes for drug-related topics for each grade and guidelines as to how to communicate these topics. Apart from this, recommended links and literature were expected as it was a complicated matter for teachers to assess the quality and reliability of materials that they had to search for on their own. New textbooks that are being developed are expected to be more child-friendly, use

[3] The sample was created keeping in mind the aim of building an overview of as varied an array of schools and teachers as possible. The criteria for selection onto focus groups were as follows: both Estonian-speaking and Russian-speaking personal education teachers with different lengths of employment (less than three years and over three years), from different regions (cities and rural areas), from schools containing different volumes of students, membership of personal education subject associations (yes/no), and professional training (in personal education) (yes/no). A total of eleven focus groups were formed in different regions.

simpler language, include more hands-on tasks, and contain fewer long passages of text and more pictures. Russian teachers specifically pointed out that in the personal education textbook there could be questions in each chapter that would help to spotlight the most important issues. The tasks in the textbook or workbook could interrelate more with real life. Teaching materials should underline the importance of a code of behaviour and moral values.

As for updating the book, there was a wish that the book could be accompanied by video materials, such as DVDs, as some teachers are using videos from YouTube at present. In general, teachers missed up-to-date educational films and exemplary materials. Specifically, they would like to show short film clips (of up to twenty minutes) describing a lifelike situation, relevant hazards and behaviour that would provide the basis for a discussion with students. Such films could contain a rather positive undertone (humane, kind), and not be too shocking, but could still provide food for thought.

On the basis of these results, it has been planned that the teaching materials for drug prevention will be updated by 2014.

Information dissemination and communication

In 2010, a twenty-minute educational film was produced which targeted four different narcotic drugs. The film is a teaching material for schools and its objective is to show the dangers related to experimenting with drugs and to decrease the desire to try drugs among young people. Specifically, the film discusses GHB (gamma-hydroxybutyrate), speed and cannabis. All scenes are based on real life situations for straightforward, ordinary young people and different drugs are associated with their negative side effects. Cannabis has been associated with the onset of schizophrenia, ecstasy with overdosing and the related consequences, the "*bottle-cap drink*" (GHB) -with sexual exploitation and poor behaviour in public, and finally *speed* (amphetamine) with abrupt and groundless violence and aggressiveness. In addition to educational films, information material for teachers will also be produced in 2011, showing how to use these films. A supplementary pamphlet for each of the films for students will be produced as well. The films and guidance materials will be available both in Estonian and Russian.

Apart from the educational film, information materials were created in 2010 that were targeted at young people, which discussed the assessments given by specialists who work with youths on the most important problems young people face. As a result of a survey the following materials were produced: "No to stress, loneliness and grief", "Assert yourself!", "Find a balance for your thoughts", "Don't hide from problems, solve them!", and "Rate yourself fairly!". The target group for the publications are youngsters between the ages of fourteen to sixteen. The purpose of the information materials is to provide knowledge about

various skills that are available for preserving mental health and advice as to how to develop these skills. The publications discuss how to preserve mental health, how to assert oneself, how to think in a comprehensive way, how to solve problems, and how to raise one's self-esteem. The publications have been intended to be distributed in schools, in youth centres, at youth events, etc. Each of the information materials were published in numbers of 10,000 copies in Estonian and 3,000 copies in Russian. The distributors of the materials were county health promoters, and schools and youth centres were the target group.

Information on drugs and various contact details related to this file are always available on the web site at narko.ee, which is administered by the National Institute for Health Development. However, the website was not further developed or updated in 2010. Publicity work on drug prevention was carried out at large-scale youth events ("Teeviit").

The Estonian Ministry of Education and Research financed youth information and counselling centres (a total of nineteen centres) in 2010. There are information centres in all fifteen counties and through them information about the necessary counselling options is available to young people, as is information on health promotion and drug prevention projects that are currently available. The centres cooperate with schools and open youth centres at a local level. A web site at www.nip.ee, which offers addiction-related information in addition to other information that is necessary for young people, is available to youths all over Estonia.

Methodological materials and training courses for youth workers

The publication of guidance materials that are targeted at youth workers and which had remained unfinished in 2009 was completed in 2010. A training cycle entitled "In-service training for group leaders for working with children and youngsters", which was targeted at youth workers continued. The training comprises several parts. The first part, which is for specialists working with children with dependency problems in which trainees acquired knowledge about the leading group processes in the work with young people, was conducted in 2009 (totalling 96 academic hours). The second part of the training course (covering 112 academic hours) was conducted in 2010. The wider objective of the training course was to provide skills for using simpler creative techniques and aids that can be applied both in working individually and with a small group. A total of eighteen specialists were trained. The training programme continues in 2011.

Training young people and youth projects

A pilot counselling service project targeted at youths can be talked about in the framework for prevention which is related directly to young people. A corresponding description of

service was prepared for the project both in Estonian and Russian in 2009. More than a hundred young people were trained within the pilot project. The activity was carried out in the form of eight group training sessions and 21 individual consultations. Different topics, such as the harm to individuals and society resulting from drugs, violating the norms, peer pressure, and options for gaining help, were discussed during the training session. The performers in the pilot project pointed out the need for broadening the activities to include parents, as the whole family should be engaged in solving several problems that youths face as well as in preventing them. The project was carried out in the city of Jõhvi (by OÜ Corrigo). Initially, the project was designed to be conducted in Tallinn, but due to the lack of necessary human resources this did not happen. However, there is a continuous demand for these activities.

In addition, there is a game entitled I.S.E. which can be held up as being one of the drug-related youth projects of 2010. The National Institute for Health Development was partially related to the development of the game through the process of assessing student work. The other judges of student work were the representatives of youth organisations. Also involved in the I.S.E. game were the Estonian Temperance Union (AVE), the Youth Assembly of the Estonian Union of Child Welfare, the Estonian Youth Association, the Juvente Youth Community, and Tartu University.

The game itself was targeted at seventh and eighth grade students (in teams of four players) and lasted for eight weeks. The game began on 11 October 2010 and finished in December with a camp for selected teams. The game constituted seven tasks given to the competitors via the internet. Presenting or solving the tasks required the use of creative techniques and an original approach. The tasks were built on the following topics: healthy leisure activities, healthy choices and lifestyle, mapping drug use and smoking amongst both the competitors and their acquaintances, presenting ideas for drug prevention in the local neighbourhood and implementation options for managing this, deciphering the skills behind self-assertion and saying “No” through lifelike examples and a discussion about typical misconceptions related to drug use and smoking. The winner of the game was awarded a prize.

3.2 Selective prevention

A total of 2,727 juvenile delinquency cases were discussed in Juvenile Committees in 2010, whereas 166 cases (5%) were connected to the use of an illegal substance. In 2010, a total of 63 minors were sent by Juvenile Committees to schools for students who need special treatment due to behavioural problems. As at the end of 2010 there were eighty

students studying at specialised schools (56 in Tapa and 24 in Kaagvere) which is a third less when compared to the same time four years ago.
The drug prevention work that was carried out in specialised schools mainly included the provision of information on addiction and activities supporting the development of social skills. Drug prevention work was performed within general education activities. In addition to the renewed curriculum, a project for specialised schools continued in 2010 entitled "Reintegrating into the society students who need special treatment due to behavioural problems", which supports students in the acquisition of good health behavioural and coping skills.

3.3 Indicated prevention

No data available for the reporting period.

3.4 National campaigns

No data available for the reporting period.

Chapter 4. Problem drug use

The previous study using the capture-recapture method on the assessment of the size of the population group for injecting drug users and the prevalence of this group throughout the general population was completed in 2005 in cooperation with the Department of Public Health, the University of Tartu, and the National Institute for Health Development. There is no newer study available and therefore the results of the 2005 survey are used as the basis for planning services that are targeted at injecting drug users. The more detailed results from the said study have been presented in our previous reports. It can be summarised that on the basis of the results from 2004 the size of the 15 to 44 year-old population group of injecting drug users was estimated to be 13,886 (95% confidence interval (CI) 8,132-34,443), and the prevalence of IDUs in the population from this age group was 2.4% (95% CI 1.9% - 5.9%) (Uusküla et al, 2007) (Chapter 7.3).
A more up-to-date assessment of the size and prevalence of the IDU population will be completed in 2011 and will be presented in the report for the following year. The study is

being carried out by the National Institute for Health Development and the Department of Public Health, at the University of Tartu.

The study was commenced in 2010 and, unlike the previous study that was based only on the information from 2004, this time the dynamics of the population group of injecting drug users and their prevalence in the general population is observed over the period between 2005-2009. The capture-recapture method is used and extracts from three administrative databases are involved in conducting the study. One of the sources for the study is the Estonian Causes of Death Registry. The completion of the study has been delayed by the fact that the Estonian Causes of Death Registry needed a study on the quality of recording drug-related deaths before it could conduct the aforementioned study. This study on the Estonian Causes of Death Registry was completed at the beginning of 2011.

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

The data presented in Sub-chapters 5.1 and 5.2 originate from two principal sources: 2010 annual reports from the National Strategy for the Prevention of Drug Dependency until 2010 and the National HIV/AIDS Prevention Strategy for 2006-2015. A report specifying the distribution of expenses and activities of the action plan of both national strategies in the form of a table has been used: the HIV/AIDS Prevention Strategy Report 2010, and the 2010 Report by the National Strategy for the Prevention of Drug Dependency until 2010.

In Chapter 5.3, data from the Drug Treatment Database of the National Institute for Health Development is presented, giving an overview of socio-demographic and treatment-related information on persons who underwent drug treatment over the previous two years (in 2010 and 2011). The Drug Treatment Database, which uses an internet-based data collection system, has been operating since 2008 and persons who have undergone drug treatment and who have been diagnosed with F11-F16.9 and F18-F19.9 by their attending physician have been recorded in the database. When interpreting the information presented in this chapter it should be taken into consideration that, due to the different registration systems, the number of persons registered as receiving treatment in the drug treatment database differs from the number of persons registered as receiving treatment in the reports of the national strategies (the HIV/AIDS prevention strategy and the drug addiction prevention strategy) in the period between 01.01.2010 and 31.12.2010. In addition, the medical departments of prisons submit their data to the Drug Treatment Database while the reporting of the HIV/AIDS strategy reflects the total number of persons who have received

treatment in treatment centres that are financed by the National Institute for Health Development during the year and as of the end of the year.

5.1 Strategy, policy

In the first half-year of 2011, substantial legislative amendments were made in the organisation for conducting drug treatment which established a legal basis for the application of drug treatment as an alternative punishment to imprisonment. This legislation and a relevant regulation have been discussed in more detail in Sub-chapter 1.1. Under the leadership of the Ministry of Social Affairs, a draft regulation was prepared in 2011 by which it is planned that the requirements of drug treatment and rehabilitation services will be laid down in the context of alternative treatment.

In the reporting period the mapping of services that are targeted at minor drug addicts became a substantial priority in the field of treatment. The purpose of the mapping was to discover the current volume of services, the actual need for services, and any problem areas. In the framework of the mapping a focus group and individual interviews were conducted in 2010-2011 with service providers and workers at institutions that encounter minor drug addicts. It can be argued on the basis of the findings of the study that more facilities should be established both in Tallinn and Ida-Viru County in order to treat minor drug addicts. In southern Estonia there is a need for juvenile rehabilitation facilities which the region lacks at the moment. The study highlighted the cooperation between different institutions and the issues related to the further education of children that stay at in-patient treatment centres as problem areas. The lack of personnel working with children who have received special training in the field of addiction is considered to be one of the major problems in the development of services. Over the coming years it is essential to educate new specialists and to motivate the personnel of existing health care and social welfare institutions to specialise in the target group of juvenile addicts. Another problem is the low supply of outpatient counselling and family therapy opportunities that are targeted at minors in Estonia. As a rule, in the case of juvenile drug addicts there are other mental and behavioural disorders involved in addition to addiction problems. Therefore a capable mental health centre that specialises in juvenile problems should be established in order to address the problems of minors in a complex way (Abel-Ollo et al, 2011).

5.2 Treatment system

In Estonia, drug treatment is provided by licensed mental health care service providers. Drug treatment is financed from different sources. In 2010 the resources of the National HIV/AIDS Prevention Strategy for 2006-2015, the National Strategy for the Prevention of Drug Dependency until 2012, and larger local government authorities were used for this purpose. It is also possible for customers to receive treatment at their own expense. The Estonian Health Insurance Fund does not specifically finance drug treatment. As in 2009, drug treatment was one of the few fields that did not experience a reduction in funding in 2010. As funding remained at the same level, it set limits on the increase of service volumes and the development of new and necessary services, including treatment services for amphetamine addicts. At the moment, the majority of people who come to receive treatment are addicted to opiates. This situation has been caused by the fact that the vast majority of treatment providers are engaged in providing opiates substitution treatment and the provision of other types of treatment is limited. However, taking into account the recent survey data, a growing need for the establishment of treatment facilities for amphetamine consumers can be seen. The cross-section surveys that were carried out amongst injecting drug users in Estonia show more specifically that between 13-71% of drug addicts surveyed used amphetamine as the principal drug in the previous four weeks (*Uusküla et al, 2006, Uusküla et al, 2007, Uusküla et al, 2005, Lõhmus et al, 2007, Uusküla 2010, NIHD 2010, Lõhmus et al, 2011) (Table 4).*

Table 4. The proportion of drug addicts injecting amphetamine as their principal drug according to the results of cross-section studies.

Year	Region	Average age of study participants / age range	Amphetamine as the principal injected drug (in the last 4 weeks) (%)
2004	Tallinn	22 (18-49) [1]	30
2005	Tallinn / Kohtla-Järve	24 (15-43) [1]	19
2007	Tallinn	27 (17-54) [2]	26
2007	Kohtla-Järve	27 (17-48) [2]	13
2009	Tallinn	27 (16-46)	28
2010	Narva	29 (18-60)	71

Source: Uusküla et al, 2006, Uusküla et al, 2007, Uusküla et al, 2005, Lõhmus et al, 2007, Uusküla 2010, NIHD 2010, Lõhmus et al, 2011.
[1] in the last 90 days
[2] in the last 28 days

The majority of health care institutions that provide treatment for addiction in Estonia solely provide outpatient treatment (involving five national service providers out of six). In-patient

treatment service for drug addicts is provided only at Wismari Hospital and the patients have to pay for it themselves. One medical institution that is funded by Tallinn City Government (the Opiate Addicts Substitution and Detoxification Treatment Unit at West Tallinn Central Hospital) provides outpatient treatment, and another institution (Tallinn Children's Hospital), is targeted at children, providing both outpatient and in-patient treatment.

5.2.1 Substitution treatment

As in 2009, methadone substitution treatment was again financed from the budget of the National HIV/AIDS Prevention Strategy in 2010. A total of 587,026 euros, which exceeds the amount spent in 2009 by 127,824 euros, were used for providing treatment service. Of the amount of 1,578,026 euros, a total of 7,899 euros were spent on purchasing methadone and other necessary medical aids. In 2010 the National Institute for Health Development entered into a one year contract with the aim of providing methadone substitution treatment with five service providers which provided the service in seven different treatment centres (Table 5). In addition, short-term contracts were entered into with West Tallinn Central Hospital in order to provide HIV-positive individuals with opiate substitution treatment and drug addicts with outpatient day care.

The number of clients who have received methadone substitution treatment has slightly increased over the last three years. While 1,008 drug addicts received substitution treatment during 2008 and 1,012 drug addicts received it in 2009, in 2010 the number of addicts treated was 1,064. As at the end of the year the number of clients undergoing treatment was 662 (at the end of 2009 there were 660 drug addicts being treated). A total of 321 clients discontinued their participation in the treatment programme and eighty clients completed the treatment programme successfully (Table 5).

The average daily dose of methadone given to clients varied between 44mg and 67mg in different medical centres. It can be observed that over the years the average dose of methadone has increased year by year. While in 2005 the average dose for all centres was 37mg, by 2010 it had increased to 59mg. In 2009 the average dose of methadone varied between 23mg and 84mg. The minimum and maximum dose given in a centre could differ by up to a hundred times. (Table 6)

Table 5. State-funded methadone substitution treatment programme for injecting drug users in 2010.

Health care institution	No of clients at the end of 2010 (n)	Joined the treatment (n)	Successfully completed the treatment (n)	Discontinued the treatment (n)
OÜ Tervisekeskus Elulootus	165	126	19	71
Wismari haigla AS* (Wismari hospital)	80	60	0	60
OÜ Sõltuvuste Ravikeskus	116	62	33	52
AS Lääne-Tallinna Nakkuskeskus (West Tallinn Infection Centre) (26.04.2011-31.12.2011)	15	18	0	3
AS Lääne-Tallinna Keskhaigla Psühhiaatriakeskus (West Tallinn Central Hospital Psychiatric Centre)	15	15	0	0
OÜ Corrigo	214	98	28	107
OÜ Aasa kliinik	57	28	0	28
Total	**662**	**407**	**80**	**321**

Source: National HIV/AIDS Prevention Strategy - 2010 Report.

* The NIHD entered into a public contract with Wismari Hospital in 2010 to provide substitution treatment for a specified number of clients (up to eighty clients a month).

In addition to state funding, the city of Tallinn also financed methadone substitution treatment in 2010. The Social Welfare and Health Care Department of Tallinn funded the work of the West Tallinn Central Hospital addiction treatment unit, which provides outpatient substitution treatment for adult drug addicts, by 134,615 euros; compared to 2009, the amount allocated by the city has decreased by 44,738 euros. A total of 81 persons received treatment in West Tallinn Central Hospital in 2010, while three started receiving treatment during the reporting year, one completed the treatment successfully, and 21 discontinued the treatment (West Tallinn Central Hospital 2010, personal communication).

Table 6. Doses of methadone dispensed in state-funded methadone substitution treatment centres (mg) in 2010.

Health care institution	Total amount	Average dose per client	Minimum dose	Maximum dose
OÜ Elulootus	2,715,300	44	5	180
Wismari haigla AS* (Wismari hospital)	1,755,417	67	8	170
OÜ Sõltuvuste ravikeskus	1,891,237	46	2	140
OÜ Corrigo	4,613,213	64	3	300
OÜ Aasa kliinik	1,567,814	77	3	300
Total	**12,542,981**	**59.5**	**2**	**300**

Source: National HIV/AIDS Prevention Strategy - 2010 Report.

5.2.2 Detoxification treatment

According to the Drug Treatment Database, detoxification treatment was provided for a total of 65 people through seven medical centres (including two prisons) in 2010. The plan was to provide short-term treatment for ten patients in 2010 for addiction based on non-opiate medicines through the use of the financial resources of the NSPDD but, due to a lack of human resources, the programme was postponed until next year. In the reporting for the NSPDD it is not possible to point out the exact number of addicts who received treatment for addiction as substitution treatment and detoxification treatment are not distinguished in the reporting.

In addition to treatment for addiction for adults, the city of Tallinn funded treatment for addiction for children and youngsters as well. The Children and Youth Addiction Treatment Department of Tallinn Children's Hospital was allocated a total of 26,076 euros for this purpose. During the period between 01.01.2009-31.12.2010, 110 patients were under in-patient treatment, and fifteen of them were diagnosed with an addiction to narcotic substances. Apart from this, the city of Tallinn allocated an additional 9,587 euros for outpatient psychotherapy for patients under the age of eighteen with behavioural and dependence disorders (group and family therapy). Tallinn Children's Hospital was allocated 49,069 euros from the budget of the NSPDD for funding the schooling and education of the Adolescent Drug Treatment Unit of Tallinn Children's Hospital, which is excluded from the price list of the Estonian Health Insurance Fund but is still necessary for conducting any successful treatment.

5.2.3 Rehabilitation

A total of 559,564 euros were allocated from the financial resources of the NSPDD for providing rehabilitation services in 2010. Apart from this, an additional 91,478 euros were allocated for providing support services for drug addicts with dual diagnoses, and 8,318 euros was allocated for the children of addicts. Compared to 2009 the amount allocated to rehabilitation decreased by slightly more than 25,565 euros. A total of five rehabilitation centres were allocated resources for providing rehabilitation services from public funds. Three rehabilitation centres financed by public funds provided services only to adult clients, while one provided services to children and one state-funded centre was targeted at providing counselling and support services for addicts with dual diagnoses. In addition to financing by the NSPDD, a contract to provide rehabilitation services by the financial resources of European Social Fund (ESF) was entered into with OÜ Comenius. In November 2010 the provision of rehabilitation service for female addicts was started up, and as of the end of the year nine women were engaged in the service. As of the end of 2010 the rehabilitation service for 63 clients was financed by the financial resources of the NSPDD and another nine clients were provided with the service by the joint funding of the NSPDD and the City of Tallinn (Table 7).

The majority of the rehabilitation services were targeted at adult men; however, the rehabilitation service, which focused on minors of both sexes, was funded as well (OÜ Corrigo's Jõhvi Rehabilitation Centre for Children and Adolescents). Regardless the type of rehabilitation service, the aim was to provide clients with psycho-social support and counselling and to teach them the skills necessary to return to normal life.

Table 7. Rehabilitation services for drug addicts in 2010.

Health care institution	Allocated financial resources (EUR)	Number of clients at the end of 2010	Persons who have joined (n)	Successfully completed (n)	Discontinued the programme (n)
MTÜ AIDSi Tugikeskus (NGO AIDS Support Centre)	26,513	0	7	3	4
City of Tallinn to MTÜ AIDSi Tugikeskus (NGO AIDS Support Centre)	-	9	6	0	10
MTÜ Narva Narkomaanide ja Alkohoolikute Rehabilitatsiooni Keskus “Sind ei jäeta üksi” (NGO Narva Rehabilitation Centre for Addicts and Alcoholics: “You will not be left alone") (commune)	73,053	12	30	12	18
SA Sillamäe Narkorehabilitatsiooni-keskus (Sillamäe Foundation Drug Rehabilitation Centre) (in-patient)	250,233	24	65	30	37
OÜ Corrigo (in-patient treatment centre for minors)	209,766	18	31	14	14
MTÜ Eesti Abikeskused Kaksikdiagnoosiga sõltlaste päevakeskus (NGO Estonian Help Centres: Day Centre for Addicts with Dual Diagnosis)	91,478	9	6	10	0
Total	**651,043**	**72**	**145**	**69**	**83**

Source: 2010 Report for the NSPDD Action Plan.
* NGO AIDS Support Centre was only funded in the first half of the year.

5.3 Characteristics of treated clients

A total of 1,157 notifications regarding the commencement and completion of treatment were sent to the Drug Treatment Database during 2010. The number of notifications has increased compared to 2009, when there were 838 notifications in total.

According to patient self-report, nearly 27% of those who sought treatment in 2010 and 23% of those who sought it in 2009 received treatment for the first time; the majority had received treatment at some point in the past. Mainly persons seeking treatment are males (77%), the proportion of females remained at less than a quarter of the total (Table 8).

Table 8. Distribution of persons who came in for treatment for the first time and repeatedly, by sex, 2009-2010.

	2009						2010					
	Male		Female		Total		Male		Female		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
In treatment for the first time	115	16.7	42	6.1	157	22.9	131	19.7	45	6.8	176	26.5
Treated before	388	56.5	114	16.6	502	73.1	373	56.1	105	15.8	478	71.9
No data available	24	3.5	4	0.6	28	4.1	10	1.5	1	0.2	11	1.7
Total	**527**	**76.7**	**160**	**23.3**	**687**	**100**	**514**	**77.3**	**151**	**22.7**	**665**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.

Over the last two years there have been no significant changes in the age composition of persons who came in for treatment; more than half of them (65% in 2009 and 66% in 2010) were between 25-34 years (Table 9). The average age of those who started to receive treatment was nearly 29 years, while the youngest person who came in for treatment was 13 and the oldest one was 56. The average age of people coming for treatment is 26 years.

Table 9. Distribution of persons who came in for treatment by age on the basis of treatment status in 2009-2010.

	2009				2010			
	All persons who came in for treatment		In treatment for the first time		All persons who came in for treatment		In treatment for the first time	
	n	%	n	%	n	%	n	%
<24	162	23.6	60	37.5	140	21.1	71	40.3
25-34	448	65.2	79	49.4	440	66.2	85	48.3
35<	77	11.2	21	13.1	85	12.8	20	11.4
Total	687	100	160	100	665	100	176	100
Average age (95% CI)	28.4 (28.1-28.8)		26.6 (25.5-27.8)		28.8 (28.5-29.1)		26.35 (25.4-27.4)	

Source: Drug Treatment Database 2010 for the National Institute for Health Development.

It became evident that women came in for treatment at a younger age than men. Among all the people who came in for treatment in 2010, the average age of female was 27 years (95% CI 25.9-27.3) and 29 years in the case of male (95% CI 29.0-29.8), and among those who came in for treatment for the first time the average age of female was 23 years (95% CI 21.6-25.2) and 27 years in the case of male (95% CI 26.2-28.5). There were 3% of

minors (under the age of eighteen) among all those people who came in for drug treatment, while the proportion of minors amongst first time patients was 9%.

The majority of persons who received drug treatment were Russians (over 80% of the total); the proportion of Estonians remained under 15% (Table 10). More than half the persons who came in for treatment were living in Tallinn and Harju County and nearly 35% were from Ida-Viru County, where the spread of injecting drug users is at its highest-known rate (Table 11). The majority of drug treatment patients were unemployed persons - only 24% in 2009 and 19% in 2010 were engaged in regular work (Table 12). A total of 1% were serving a prison sentence at the time they came in for treatment in 2009, and this rose to 2% in 2010.

Table 10. Distribution of drug treatment patients by nationality on the basis of treatment status in 2009-2010.

	2009				**2010**			
	All persons who came in for treatment		**In treatment for the first time**		**All persons who came in for treatment**		**In treatment for the first time**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Estonian	79	11.5	23	29.1	95	14.3	35	19.9
Russian	562	81.8	127	22.6	543	81.7	132	75.0
Other	46	6.7	10	21.7	27	4.1	9	5.1
Total	**687**	**100**	**160**	**100**	**665**	**100**	**176**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.

Table 11. Distribution of drug treatment patients by place of residence on the basis of treatment status in 2009-2010.

	2009				**2010**			
	All persons who came in for treatment		**In treatment for the first time**		**All persons who came in for treatment**		**In treatment for the first time**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Tallinn/ Harju County	384	55.9	124	77.5	415	62.4	134	76.1
Ida-Viru County	268	39.0	23	14.4	228	34.3	32	18.2
Other	31	4.5	11	6.9	22	3.3	10	5.7
No data available /data missing	4	0.6	2	1.2	-		-	
Total	**687**	**100**	**160**	**100**	**665**	**100**	**176**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.

Table 12. Employment status of patients undergoing drug treatment in 2009-2010.

	2009				2010			
	All persons who came in for treatment		In treatment for the first time		All persons who came in for treatment		In treatment for the first time	
	n	%	n	%	n	%	n	%
Employed (regular work)	165	24.0	35	21.9	123	18.5	35	19.9
Unemployed	421	61.3	95	59.4	388	58.3	104	59.1
Schoolchild/student	24	3.5	20	12.5	33	5.0	21	11.9
Dependant*	65	9.5	7	4.3	107	16.1	12	6.8
Other**	12	1.7	3	1.9	14	2.1	4	2.3
Total	**687**	**100**	**160**	**100**	**665**	**100**	**176**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.
* 'Dependant' means a housewife or husband, a pensioner, or a person receiving a pension for an incapacity to work.
** 'Other' means imprisoned persons and conscripts.

In both reference years slightly more than half the persons who came in for treatment had a basic education and nearly 45% had upper-secondary education. One person who came in for treatment in 2010 had never attended school according to the patient`s self-report (Table 13).

The majority of the persons who came in for treatment - 97% in 2009 and 98% in 2010 - received outpatient treatment as the number of beds for in-patient drug treatments is limited in Estonia and the number of persons who had been admitted to hospital was negligible (eighteen in 2009 and fourteen in 2010). A large proportion of drug treatment patients were in substitution treatment; 13% of all drug treatment patients in 2009 and 10% in 2010 received detoxification treatment for addiction (Table 14). Other types of treatment (non-drug treatment and the relief of symptoms) were applied to 18% and 14% of patients in 2009 and 2010 respectively.

Table 13. Distribution of drug treatment patients by education on the basis of treatment status in 2009-2010.

	2009				2010			
	All persons who came in for treatment		In treatment for the first time		All persons who came in for treatment		In treatment for the first time	
	n	%	n	%	n	%	n	%
Never attended school	-	-	-	-	1	0.2	1	0.6
Primary education	15	2.2	8	5.0	18	2.7	5	2.8
Basic education	364	53.0	103	64.4	343	51.6	103	58.5
Secondary education**	302	44.0	48	30.0	298	44.8	66	37.5
Higher education	5	0.7	1	0.6	4	0.6	1	0.6
No data available/ data missing	1	0.1	-	-	1	0.2	-	-
Total	**687**	**100**	**160**	**100**	**665**	**100**	**176**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.
* Vocational education acquired on the basis of primary and basic school which does not involve the acquisition of upper-secondary education belongs to basic education.
** Vocational education acquired on the basis of upper secondary education (without the level of professional higher education) and vocational education on the basis of basic school which provides upper secondary education belongs to upper secondary education.

Table 14. Types of treatment on the basis of treatment status in 2009-2010.

	2009				2010			
	All persons who came in for treatment		In treatment for the first time		All persons who came in for treatment		In treatment for the first time	
	n	%	n	%	n	%	n	%
Substitution treatment	477	69.4	104	65.0	504	75.8	121	68.8
Treatment for addiction	87	12.7	35	21.9	65	9.8	25	14.2
Other*	123	17.9	21	13.1	96	14.4	30	17.0
Total	**687**	**100**	**160**	**100**	**665**	**100**	**176**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.
* The relief of symptoms and non-drug treatment

Compared to 2009, the proportion of fentanyl/3-methylfentanyl users increased in 2010; while 71% used fentanyl/3-methylfentanyl as their primary drug in 2009, in 2010 the figure rose to 84%. At the same time, the proportion of addicts who used heroine as their primary drug decreased from 21% in 2009 to 6% in 2010. In general, more than 90% of the people who came in for treatment were using opiates as their primary substance, which partially results from the fact that there are only a few opportunities available for drug addicts to

receive treatment for other narcotic substances in Estonia and therefore a smaller number of them come for treatment. In significantly fewer cases, cocaine, cannabis and amphetamine were mentioned as the primary drug. While the proportion of those who used amphetamine as the primary drug out of all drug treatment patients was relatively small; the percentage of these had increased amongst first time patients, being set at 6% and 11% in 2009 and 2010 respectively (Table 15).

Table 15. Primary drug on the basis of treatment status 2009-2010.

	2009				2010			
	All persons who came in for treatment		In treatment for the first time		All persons who came in for treatment		In treatment for the first time	
	n	%	n	%	n	%	n	%
Heroin	146	21.3	5	3.1	38	5.7	4	2.3
Methadone	3	0.4	0	0.0	9	1.4	3	1.7
Fentanyl/TMF	485	70.6	132	82.5	559	84.1	141	80.1
Cocaine	1	0.1	0	0.0	28	4.2	0	0.0
Amphetamine	15	2.2	10	6.3	3	0.5	19	10.8
Cannabis	6	0.9	6	3.8	0	0.0	3	1.7
Other	31	4.5	7	4.4	28	4.2	6	3.4
Total	**687**	**100**	**160**	**100**	**665**	**100**	**176**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.

The majority of drug treatment patients used their primary drug by injecting it (91% in 2009 and 85% in 2010), while only 6% in 2009 and 12% in 2010 used the primary drug by smoking or inhaling it and the rest used it orally or in some other manner. More than 80% used their primary drug on a daily basis and fewer than 10% claimed to use it at least once a week. Nearly a quarter of patients used other addictive substances in addition to the primary drug. The most frequently-mentioned drugs were fentanyl/3-methylfentanyl, amphetamine, cannabis and alcohol. More than half of drug treatment patients were active injecting drug users - in other words, they had injected themselves in the last thirty days - although the proportion of them decreased somewhat in 2010 (65% in 2009 and 54% in 2010). (Table 16)

Table 16. Injection status on the basis of treatment status in 2009-2010.

	2009				2010			
	All persons who came in for treatment		In treatment for the first time		All persons who came in for treatment		In treatment for the first time	
	n	%	n	%	n	%	n	%
Injected at some point in the past but not now	181	26.3	36	22.5	237	35.6	64	36.4
Injected within the last 30 days	447	65.1	102	63.8	362	54.4	87	49.4
Never injected	31	4.5	21	13.1	44	6.6	24	13.6
No data available/data missing	28	4.1	1	0.6	22	3.3	1	0.6
Total	**687**	**100**	**160**	**100**	**665**	**100**	**176**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.

As for the risk behaviour of injecting drug users, there were no significant changes in 2010; as in 2009, nearly 60% of drug addicts under treatment had shared a syringe according to their own words (Table 17).

Table 17. Distribution of syringe sharing on the basis of treatment status in 2009-2010.

	2009				2010			
	All persons who came in for treatment		In treatment for the first time		All persons who came in for treatment		In treatment for the first time	
	n	%	n	%	n	%	n	%
Shared a syringe but not within the last 30 days	365	53.1	75	46.9	387	58.2	85	48.3
Shared a syringe within the last 30 days	42	6.1	9	5.6	14	2.1	9	5.1
Never shared a syringe	224	32.6	72	45.0	214	32.2	76	43.2
No data available	56	8.2	4	2.5	50	7.5	6	3.4
Total	**687**	**100**	**160**	**100**	**665**	**100**	**176**	**100**

Source: Drug Treatment Database 2010 for the National Institute for Health Development.

Early treatment termination due to the patient's failure to appear for treatment is a problem in terms of the success of drug treatment; in 67% of cases in 2009 and in 63% of cases in 2010 this was recorded as the reason for early treatment termination. Other reasons for early treatment termination were the patient being taken into custody, the termination of the patient's own initative by agreement with the attending physician, their being sent to

another doctor, or their being recovered. The so-called recovery of a drug treatment patient was noted down as the reason for the termination of treatment in 4% of cases in 2009 and in 3% of all cases in 2010.

Chapter 6. Health correlates and consequences

In Estonia the Health Board that operates in the administrative area of the Ministry of Social Affairs is engaged in the field of the prevention, monitoring and combating of infectious diseases, as well as the epidemiological risk analysis and risk assessment thereof. In this chapter we introduce the information that was received from the Health Board on cases of acute hepatitis B and C and new cases of HIV infection (Z21) and HIV disease (B20-B24) that were recorded amongst injecting drug users. It is still worrying that the transmission route of infection remains unknown in a vast majority of cases. The EMCDDA Standard Table No. 9, Part 4, was used in collecting the data received from the Health Board in 2010 on infections with hepatitis B and C. The data on injected drug addicts who have become infected with HIV originate from the Health Board as well. The infectionists who first diagnose a person with HIV infection and HIV disease submit information to the Health Board on cases of HIV infection and the risk factors of becoming infected.

The information on drug-related deaths has been received from the person-based Estonian Causes of Death Registry of the National Institute for Heath Development. The definition of drug-related deaths is the same as that used by the EMCDDA (Selection B). The registry covers all deaths of Estonian residents recorded in Estonia and by Estonian foreign missions. The Estonian Causes of Death Registry uses the International Classification of Diseases (ICD-10) for coding information regarding deaths.

In this report we present information from the Estonian Tuberculosis Registry of the National Institute for Health Development regarding the spread of tuberculosis among drug addicts as well as on HIV positives with tuberculosis.

6.1 Drug-related infectious diseases

HIV and AIDS

As of 31 December 2010, in Estonia a total of 7,692 people have been cumulatively diagnosed with HIV (Z21) (7,320 people in 2009), the majority of them were registered in Tallinn (a total of 2,876), Narva (n=2,062) and Ida-Viru County (n=2,025). As of

21.12.2010, a total of 315 persons have been diagnosed with HIV disease (AIDS) (B20-B24) (Health Board 2011).

In 2010 the Health Board registered 39 HIV-infected persons less than in 2009 (411 in 2009 and 372 in 2010) (Table 18). The vast majority of new HIV cases diagnosed in 2010 were recorded in Harju County and Ida-Viru County. The number of new HIV cases has decreased year by year, probably thanks to well organised prevention work. However, it is worrying that the transmission route of infection is only known in more than one third of all new HIV cases (35%). Almost half (48%) of persons infected with HIV for whom the transmission route is known are injecting drug addicts (Table 18).

Table 18. Number of persons diagnosed with HIV in Estonia in 1998-2010 (including the number of injecting drug users and the proportion thereof in all cases with a known transmission route).

	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Total number of persons infected with HIV	10	9	390	1,474	899	840	743	621	668	633	545	411	372
Including the number of persons infected with HIV with a known transmission route	10	9	390	1,474	899	359	261	204	195	117	47	112	130
Number of injecting IDUs of all HIV-infected persons with a known transmission route	0	0	354	1,340	702	356	254	200	191	115	36	84	62
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	47.7

Source: Health Board 2011.

Cross-section surveys using respondent-driven sampling conducted in recent years show that the spread of HIV among Estonian IDUs is high - more than 50% of injecting drug users are HIV-infected (54% in 2005, 55% in 2007, 51% in 2009) (Uusküla et al, 2011). However, a positive sign is the fact that the spread of HIV has decreased among new IDUs, which has probably been contributed to by the expanded provision of harm reduction services (see Chapter 7).

Cases of acute hepatitis B and C

According to the Health Board the number of persons who have contracted hepatitis B (B16) decreased from 29 cases in 2009 to 23 cases in 2010 (Health Board 2011). While a total of 437 persons contracted acute hepatitis B in 2000 and 449 persons in 2001, the number of cases of acute hepatitis has decreased remarkably year by year since 2002 (Table 19). It is very likely that the vaccination against hepatitis B that was conducted on the basis of the national immunisation programme has contributed to the decrease in cases of hepatitis B in Estonia.

The fact that information on the transmission route of hepatitis B has been known in only a few cases has been a problem for years - only 13 (10 of these (77%) were IDUs) of 23 persons who contracted acute hepatitis B were aware of the possible transmission route of their infection (Health Board 2010).

A total of 34 new cases of hepatitis C were registered in Estonia in 2010, which is 33 cases less than in 2009. The alleged transmission route was known only in two cases, and both of these were injecting drug users. When inspecting the information, both in regard to the cases of acute hepatitis B and C, one should keep in mind that the proportion of cases in which no information is available on the possible transmission route of infection is relatively high (Table 20).

Table 19. Cases of acute hepatitis B in 2000-2010.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of cases of acute hepatitis B	437	449	244	173	127	78	45	44	53	29	23
Number of acute hepatitis B cases with a known transmission route	247	300	150	97	68	34	21	19	17	7	13
Number of IDU cases of acute hepatitis B with a known transmission route	219	257	106	68	48	21	9	10	10	4	10
Proportion of IDUs in all cases of acute hepatitis B with a known transmission route (%)	88.7	85.7	70.7	70.1	70.6	61.8	42.9	52.6	58.8	57.1	76.9

Source: Health Board 2011, Standard Table 9, Part 4.

Table 20. Cases of acute hepatitis C in 1999-2010.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of cases of acute hepatitis C	244	365	306	199	154	124	81	57	36	64	67	34
Number of acute hepatitis C with a known transmission route	146	198	193	131	96	76	44	29	16	30	24	2
Number of IDU cases of acute hepatitis C with a known transmission route	134	178	162	98	75	54	36	16	10	15	16	2
Proportion of IDUs in all cases of acute hepatitis C with a known transmission route (%)	91.8	89.9	83.9	74.8	78.1	71.0	81.8	55.1	62.5	50.0	66.7	100

Source: Health Board 2011, Standard Table 9, Part 4.

6.2 Tuberculosis (TB) infection

The data from the National Institute for Health Development's the Estonian Tuberculosis Registry shows that 10% of all persons infected with tuberculosis (a total of 306, 253 of whom were initial TB cases and 53 were relapse cases) had TB and HIV dual infection (National Strategy for Tuberculosis Control 2008-2012, 2010 Report & 2011 Report) (Table 21). As can be seen in Table 21, the proportion of cases of TB and HIV dual infection that have been detected by means of prophylactic tests has increased from 14% in 2009 to 23% in 2010. A total of 19% of cases with TB and HIV dual infection that were recorded in 2010 carried multidrug-resistant pathogens. More than half (55%) of all persons infected with TB and HIV dual infection were drug users (Viiklepp, personal communication, 2011).

Table 21. Tuberculosis and HIV dual infection incidences in 2002-2010.

	2002	**2003**	**2004**	**2005**	**2006**	**2007***	**2008**	**2009**	**2010**
Persons with TB and HIV dual infection (initial cases and relapsed cases)	17	15	22	33	39	47	37	36	31
Including TB/HIV+ initial cases (n)	17	12	20	30	34	40	33	33	29
Including prophylactically detected (n)	1	1	4	9	9	9	2	5	7
Prophylactically detected (%)	5.9	6.7	18.2	27.3	23.1	19.1	5.4	13.9	22.6
Including multi-resistant tuberculosis (n)	3	2	2	6	4	11	9	4	6
Multi-resistant tuberculosis (%)	23.1	15.4	10.0	18.2	13.8	26.2	30.0	17.4	19.4
Including drug users* (n)	-	-	-	-	-	16	24	24	17
Drug users (%)	-	-	-	-	-	34.0	64.9	66.7	54.8

Source: Tuberculosis Database, *NIHD 2011* (Viiklepp, personal communication, 2011*).*
*The use of drugs has been registered since 2007.

6.3 Other drug-related health correlates and consequences

Information on cases of the provision of emergency health care following drug overdoses is available only for Tallinn. In comparison with previous years, the number of drug overdoses decreased dramatically in 2010. According to Tallinn Ambulance Service, drug addicts were provided with emergency health care due to an overdose on 930 occasions altogether in 2010. In 2009, emergency health care was provided on 1,399 occasions due to an

overdose. A total of 75 out of 930 drug addicts who received first aid due to an overdose needed to be hospitalised and in 53 cases narcotic poisoning was considered to be the cause of death (TEMS 2011).

There is no information available on incidents of wound-related botulism, tetanus and other infectious diseases among injecting drug users. This matter has not been covered within cross-sectional studies carried out among injecting drug users either.

6.4 Drug-related deaths and mortality of drug users

A total of 101 people died due to using drugs in Estonia in 2010 (this was 133 people in 2009). The majority of persons who died of accidental poisoning were males (89 men, twelve women) (Table 22).

According to the data from 2010, 77% of persons who died due to using drugs were Russians (78 cases), 71% of them had lived in Harju County (72 of them, including 57 who lived in Tallinn), and 24% lived in Ida-Viru County (24 of them, eight of whom had lived in Narva and a further fifteen who had lived in Kohtla-Järve). A total of 95% of drug-related deaths were registered in these two counties. The large number of drug-related poisoning deaths in Harju County (including the City of Tallinn) and Ida-Viru County can be explained by the fact that compared to other areas, the prevalence of injecting drug users is at its highest in these regions (see Chapter 4).

The table below also shows that in 2010 the cause of death for the majority of persons who died due to using drugs (91 of them in total) was accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified. According to the assessment by the Estonian Forensic Science Institute, the majority of them died through using 3-methylfentanyl (Estonian Forensic Science Institute, personal communication, 2011). The quality of data improved significantly in 2010 and there were only five cases with an unknown substance as the cause of poisoning. A large proportion of drug-related deaths (81 in all) were caused by other synthetic narcotics T40.4 (3-methylfentanyl).

Table 22. Distribution of drug-related deaths by sex 2009-2010.

		2009			2010		
Original cause	**Subs-tance***	**M**	**F**	**Total**	**M**	**F**	**Total**
F112 Addiction to opioids		1	0	1			
X41 Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	T43.6				7	1	8
X42 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	T40.0	1	0	1			
	T40.2	2	0	2	1	1	2
	T40.3	2	1	3	3	1	4
	T40.4	14	0	14	71	9	80
	T40.6	88	11	99	5		5
	T40.9	3	0	3			
X62 Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	T40.2	1	0	1			
	T40.9	1	0	1			
Y12 Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent	T40.3				1		1
	T404	1	0	1	1		1
	T40,6	6	1	7			
Total		**120**	**13**	**133**	**89**	**12**	**101**

Source: Estonian Causes of Death Registry, National Institute for Health Development 2010, EMCDDA Standard Table 5.

* opium (T40.0), other opiates (T40.2), methadone (T40.3), other synthetic drugs (T40.4), other and unspecified drugs (T40.6), other and unspecified psychodyslepticums (T40.9), and psychostimulants with the potential to be abused (T43.6).

A large proportion of persons who died (84%, or a total of 85 persons) due to using drugs in 2010 were between 20-34 years old (Table 23).

Between 1999 and 2010, a total of 825 people died as a result of using drugs, and 89% of them were males (a total of 736 cases). The average age of deceased individuals who died as a consequence of an accidental drug poisoning was 29 years in 2010 (Table 24). In 1999-2010 more than four-fifths (81%) of persons who died as a consequence of drug use were between 20-34 years old when they died (Table 25).

Table 23. Distribution of drug-related fatal poisonings by gender and age groups in 2009-2010.

Age	2009			2010		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
<15	0	0	0	0	0	0
15-19	3	0	3	1	0	1
20-24	18	5	23	14	3	17
25-29	50	4	54	37	6	43
30-34	38	2	40	22	3	25
35-39	5	0	5	11	0	11
40-44	3	0	3	4	0	0
45-49	1	1	2	0	0	0
50-54	1	0	1	0	0	0
55-59	1	1	2	0	0	0
60-64	0	0	0	0	0	0
>=65	0	0	0	0	0	0
Total	**120**	**13**	**133**	**89**	**12**	**101**

Source: Estonian Causes of Death Registry, National Institute for Health Development 2010, EMCDDA Standard Table 5.

Thanks to good cooperation from the Estonian Causes of Death Registry, which operates at the National Institute for Health Development, and the Estonian Forensic Science Institute (EFSI), the recording of drug poisoning deaths has significantly improved in recent years. The Estonian Causes of Death Registry, which operates at the National Institute for Health Development, conducted a survey of the quality of data being recorded in relation to drug-related deaths in cooperation with the Estonian Drug Monitoring Centre and EFSI; in the framework of the survey, information on drug-related deaths for deceased individuals that was recorded in the Estonian Causes of Death Registry between 2000 and 2009 were juxtaposed and compared with the autopsy findings of the EFSI that were recorded for persons who had died of drug poisoning. The survey was completed in 2011 and its results will be covered in the 2012 report.

Table 24. Distribution of drug-related deaths by gender for deceased individuals in 1999-2010.

	1999	2000	2001	2002	2003	2004	2005	2006*	2007	2008	2009	2010	Total
Male	18	25	39	81	31	88	52	59	74	60	120	89	736
Female	4	6	6	5	5	10	5	9	7	7	13	12	89
Total	**22**	**31**	**45**	**86**	**36**	**98**	**57**	**68**	**81**	**67**	**133**	**101**	**825**
Average age	29	28	25	24	28	26	26	26	28	29	29	29	

Source: Estonian Causes of Death Registry, 1999, *National Institute for Health Development 2011, EMCDDA Standard Table 6.*

Table 25. Distribution of drug-related deaths by age in 1999-2010.

	1999	2000	2001	2002	2003	2004	2005	2006*	2007	2008	2009	2010	Total
<15	0	0	1	0	0	1	0	0	0	0	0	0	2
15−19	5	2	7	18	6	11	5	6	2	0	3	1	66
20−24	8	13	18	39	10	36	21	24	22	14	23	17	245
25−29	3	8	10	16	9	24	22	25	34	27	54	43	275
30−34	1	4	3	8	3	18	4	10	13	18	40	25	147
35−39	0	1	4	3	3	3	3	1	6	3	5	11	43
40−44	1	0	1	0	1	3	1	2	1	3	3	4	20
45−49	1	2	0	1	3	1	1	0	2	1	2	0	14
50−54	1	0	1	1	0	0	0	0	1	0	1	0	5
55−59	1	0	0	0	0	1	0	0	0	1	2	0	5
60−64	0	0	0	0	1	0	0	0	0	0	0	0	1
>=65	1	1	0	0	0	0	0	0	0	0	0	0	2
Missing cases	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**22**	**31**	**45**	**86**	**36**	**98**	**57**	**68**	**81**	**67**	**133**	**101**	**825**

Source: Estonian Causes of Death Registry, National Institute for Health Development 2011, EMCDDA Standard Table 6.

Chapter 7. Responses to health correlates and consequences

Reporting of the National Institute for Health Development was used in connection with the prevention and treatment of drug-related infectious diseases. Information concerning the estimated spread of injecting drug users was received from research carried out by the National Institute for Health Development and Tartu University–Department of Public Health. Information concerning the treatment of drug addicts and HIV-infected tuberculosis patients, and the results of such treatment, has been received from the Estonian Tuberculosis Registry, maintained by the National Institute for Health Development. Information concerning hepatitis B and C was received from the Health Board. Information concerning vaccinations is available on various web sites, such as http://www.vaktsineeriee/ and http://www.vaktsiin.ee/. There is no special strategy in Estonia to prevent hepatitis B and C.

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

Regardless of the large number of drug-related deaths and overdoses among injecting drug users (see Chapters 6.4 and 6.5), a large-scale programme to prevent drug-related poisoning deaths and overdoses has not been implemented on this target group in Estonia so far. Illegally produced fentanyl and 3-methyfentanyl seem to be the most widespread substances among injecting drug users in Estonia (see Chapter 5.3), and fentanyl use causes a large number of overdoses. According to the survey on risk behaviour of injecting drug users and the cross-sectional survey on the spread of HIV that was conducted in Tallinn in 2009, 60% of respondents have experienced an overdose (according to unpublished data). The action plan by the national drug use prevention strategy includes training for injecting drug users, with the objective of providing knowledge about how to help your companion and cope properly with an overdose, and how to find opportunities for drug users to provide first aid with Naloxone. Unfortunately these training courses have not been initiated. Naloxone is still only used in Estonia in emergency care, as this medication has no authorisation to be marketed and for now it can only be used by emergency medical staff.

7.2 Prevention and treatment of drug-related infectious diseases

The spread of HIV among injecting drug users in Estonia has somewhat stabilised as the most recent cross-sectional surveys show that more than 50% of injecting drug users studied were infected with HIV (54% in 2005, 55% in 2007, and 51**%** in 2009). At the same time, a positive finding is that the proportion of HIV-positives has fallen somewhat among new injecting drug users (34% in 2005, 39% in 2007, and 16% in 2009) (Uusküla et al, 2011). Due to this, there is still a need for harm reduction services and interventions that can influence risk behaviour. The main measures to prevent drug-related infectious diseases in Estonia are the harm reduction services for injecting drug users that have been described in Sub-chapter 7.3. The following paragraphs provide an overview of the prevention and treatment of hepatitis B and C, and tuberculosis.

Prevention and treatment of hepatitis B and C

There are no special prevention programmes in Estonia that target injecting drug users in order to prevent hepatitis B and C. Prevention activities are carried out to some extent through the consultancy service in syringe exchange points and low threshold centres.

In 2010, a total of 28,392 persons were vaccinated against viral hepatitis B, with 26,695 of them falling into the fourteen-and-under age group, with 88 youths between the ages of 15-17, and 1,609 adults (Health Board, Infectious diseases in Estonia in 2010, 2011). According to the Estonian immunisation schedule, infants are vaccinated against hepatitis B along with those thirteen year-olds who were not vaccinated during infancy. In 2010, 3,267 persons were tested for hepatitis B and 3,341 for hepatitis C (NIHD reporting).

Prevention and treatment of tuberculosis

The prevention and treatment of tuberculosis in Estonia is carried out on the basis of the National Tuberculosis Prevention Strategy 2008-2012, approved by the Government of the Republic. The general objective of the programme is to reduce initial TB illness to 20 cases per 100,000 inhabitants by 2012. In 2010, a total of 340,241 euros were allocated to help achieve the objectives of the tuberculosis prevention programme. Health care and social services to prevent tuberculosis infection are ensured for anyone who belongs to the risk groups, including HIV-positives, and the topic of tuberculosis has been integrated into appropriate in-service training programmes for health care professionals and social workers. At the same time, regular prophylactic surveys are being conducted among HIV-infected persons and anyone without health insurance who belongs to the risk groups for the early discovery of the disease, during which the information materials are distributed (600 publications were distributed in 2010). The study that was conducted among injecting drug users in Estonia revealed that only one third of those persons who attend drug

treatment on daily basis (several of whom are HIV-positives) and regularly visit a clinic for infectious diseases have had their lungs X-rayed during the past year (Rüütel et al, 2011). These results show the need to implement tuberculosis screening more actively in cases involving methadone treatment patients.

Table 26 presents the treatment outcome for patients with the co-infection of tuberculosis and HIV. In order to ensure the continuity of the tuberculosis treatment, the treatment system, which is directly controlled, is implemented in hospitals and in cases of ambulatory care. In addition, there is the option of offering substitution treatment for opiate addicts in Ida-Viru Central Hospital and plans are in place to initiate similar substitution treatment for West Tallinn Central Hospital (in Tallinn) in 2011. Also, since May 2010, individuals who are released from prison have had the opportunity to continue their tuberculosis treatment, either in the Kose Department of the North Estonia Medical Centre or by means of ambulatory tuberculosis treatment.

Table 26. Treatment results for patients with a co-infection of TB/HIV in 2002-2010, as of 25 August 2011.

	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
TB/HIV + initial and recurrence	17	13	22	33	38	47	37	36	31
Died before TB treatment or during first month of treatment	1	1	4	5	8	9	8	6	5
Died before TB treatment or during first month of treatment (%)	6	8	18	15	21	19	22	17	16
Started tuberculosis treatment	16	15	18	27	31	38	29	30	26
Recovered from TB	9	8	11	20	20	25	25	22	-*
Recovered from TB (%)	56	53	61	74	65	66	86	73	-*

Source: NIHD TB Registry, 2011.

* The treatment results for 2010 are not final as the treatment of MDR-TB cases lasts for more than two years and several patients are still undergoing treatment.

7.3 Harm reduction services for injecting drug users

In 2010, a total of 2,528,011 euros was spent on HIV/AIDS prevention. The main harm reduction services for injecting drug users in Estonia are the methadone treatment and syringe exchange programmes. Nine institutions provide syringe exchange and counselling services and, in 2010, there were a total of 36 syringe exchange points, thirteen of which were stationary centres. These centres were visited by 2,800 first-time visitors and approximately 7,500 repeat customers. There were approximately 173,000 visits to syringe

exchange points, and a total of 2,403,480 syringes, 583,980 condoms and 106,029 information materials were distributed during those visits. Approximately two thirds (66%) of the syringes were distributed in Ida-Viru County, one third (33%) in Tallinn, and 0.5% in the rest of Estonia (Table 27). If we base the calculations on the information gained from the evaluation survey conducted in Estonia on the size of the population group of injecting drug users, then during 2010, the number of syringes distributed in Tallinn and Harju County was approximately 80 per drug user, and in Ida-Viru County it was 633 syringes per drug user. The recently published survey on the influence of the syringe exchange programmes on the prevalence of HIV proposes an objective of at least seventy syringes per drug user per year, which should remarkably restrain the spread of HIV (Uusküla et al, 2011). When comparing these figures with data from countries that are known to be the most advanced in the world when it comes to HIV prevention among injecting drug users, such as Norway and Australia, where 300 and 200 syringes, respectively, are distributed per injecting drug user, the figure of 600 syringes distributed per injecting drug user in Ida-Viru County is an impressive precedent, and this data needs a more thorough inspection. This is first and foremost due to the fact that the cross-section survey that was conducted by the National Institute for Health Development on the basis of a respondent-driven sampling method in Narva in 2010 showed that 71% of those people who were studied injected amphetamine and more than 60% of them injected drugs once a week (NIHD, 2011). Handling the topic of scope and quality more thoroughly is a practical idea when it comes to the harm reduction service, when there has been a more recent evaluation of the size of the population group of injecting drug users, something that was conducted in 2010, and when information from the survey on the risk behaviour of injecting drug users and the prevalence of HIV in Narva have been more thoroughly analysed. The results of the aforementioned survey would help to determine the need for and scope of the services more precisely.

Table 27. Harm reduction services financed by the National Institute for Health Development (2003-2010).

	Size of the population group for injecting drug users (95% CI)*	Prevalence of injecting drug users in the population (95% CI)*	Harm reduction services	2003	2004	2005	2006	2007	2008	2009	2010
Tallinn / Harju County	10,025 (5,871−24,866)	4.3% (2.5−10.6%)	No. of syringes distributed	18,010	129,093	230,409	443,961	600,021	734,954	774,782	798,087
			No. of condoms distributed	16,427	76,004	83,975	134,837	158,164	156,735	131,162	106,590
			Substitution treatment	-	46	103	183	200	191	209	245
Ida-Viru County	2,517 (1,474−6,242)	3.5% (2.0−8.6%)	No. of syringes distributed	265,153	390,660	635,043	1,163,028	1,404,905	1,293,497	1,495,788	1,592,989
			No. of condoms distributed	135,444	231,429	301,415	396,665	573,245	527,999	503,062	425,684
			Substitution treatment	-	207	296	419	473	458	451	387
Other regions in Estonia	1,344 (787−3,334)	0.5% (0.3−1.2%)	No. of syringes distributed	-	-	-	9,246	1,025	4,924	6,939	12,402
			No. of condoms distributed	-	-	-	5662	21,548	70,140	64,947	51,709
			Substitution treatment	-	-	-	-	-	-	-	-
Total	13,886 (8,132−34,443)	2.4% (1.4−5.9%)	No. of syringes distributed	283,163	519,753	865,452	1,616,235	2,005,951	2,033,375	2,277,509	2,403,480
			No. of condoms distributed	151,871	307,433	385,390	537,164	752,957	754,874	699,171	583,980
			Substitution treatment	-	253	399	602	673	649	660	632

Source: .Murd, NIHD, 2011

* The number of injecting drug users and the prevalence amongst the population in the 15-44 age group (Uusküla et al, 2007). The capture-recapture method was used to evaluate the number and/or spread of the population group for injecting drug users and the survey used data from three administrative databases for 2004. The results of the survey on the size and prevalence of the injecting drug users in the population that was conducted in 2010-2011 and which was based on the same method were not available at the time of the compilation of this report.

Explanations: The Table presents only those services financed by the NIHD during the period 2003-2010. In cases where substitution treatment was carried out, only occupied places are presented as of the end of the year. There was no information available concerning substitution treatment in Ida-Viru County in 2003. The number of places for substitution treatment was larger in Estonia as this service is also provide by the treatment centre for opiate addicts at the West Tallinn Central Hospital and at Tallinn Wismar Hospital. This table presents only those services that are financed by the NIHD. The NIHD financed substitution treatment at Tallinn Wismar Hospital in 2006-2010 and in the treatment centre for opiate addicts at the West Tallinn Central Hospital in 2007.

7.4 Other support services for injecting drug users

Case management

There are case management teams for HIV-positive persons in three out-patient departments for the health care institutions of infectious diseases (in Tallinn, Narva and Kohtla-Järve), which had 1,367 first-time visitors and 11,378 visits in total. The team includes nurses and social workers and it concentrates on solving health issues and social problems. In addition to this, addicts with a dual diagnosis have the opportunity to receive counselling and support services at MTÜ Eesti Abikeskus, which is the only institution that has specialised in improving coping levels for persons with severe mental disorders and drug addiction. There were nineteen customers at the centre during one year. Also, a contract with six professional counsellors was concluded in 2010 so that persons with addiction disorders would be provided with personal and group counselling services. The provision of such services was initiated in October 2010 and a total of 384 persons with addiction problems have received this service.

Pregnant drug addicts

In 2010, the project to treat pregnant women who have an opiate addiction was continued at the West Tallinn Central Hospital; fifteen women participated in this project, of whom four were successful and six abandoned the project. In order to prevent the vertical transmission of HIV-infection, babies that were born to HIV-positive women had the opportunity to receive a breast milk substitute for free until they reached twelve months; in 2010, 194 infants received free breast milk substitute.

HIV counselling and testing

During the reporting period, there were eight counselling rooms in Estonia in which 11,107 visitors were counselled and 10,941 persons were tested for HIV. A total of 153 HIV-infected persons were diagnosed, of whom 66 had injected drugs during their lifetime (43%). All expenses incurred within the country concerning verification tests and the transportation of analyses from initial labs to reference lab were covered by the finances of the national HIV/AIDS strategy.

Anonymous diagnostics and treatment of sexually transmitted infections

In 2010, the provision of free and anonymous diagnostics and treatment services for sexually transmitted infections (STI) which targeted injecting drug users and their sexual partners was continued in Jõhvi and Narva. There were 1,656 visits during the year and 757 treatment cases were registered.

Chapter 8. Social correlates and social reintegration

Drug use in socially vulnerable groups was not studied in 2010. So far we have not implemented any special service to handle the problems of drug users where dwellings, training or education, and employment are concerned. Such services are arranged by the rehabilitation centres for drug users in the framework of their daily work. Drug users who were released from prison have an opportunity to participate in the social reintegration programme. Addiction rehabilitation departments have been created in Estonian prisons to reintegrate drug users. Activities in this area will be discussed more thoroughly in Sub-chapter 9.3.

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

9.1 Introduction

The information connected with drug-related crimes and misdemeanours that is presented in this chapter is derived from EMCDDA Standard Table No. 11, which has been compiled by the Ministry of Justice. Information from the Ministry of Justice concerning drug-related crimes and misdemeanours is derived from the National Registry of Criminal Procedures. Unfortunately, the National Registry of Criminal Procedures does not contain information on drug use in persons who have committed drug-related crimes, and therefore we cannot present any data here on the connection between drug use and persons who have committed drug-related crimes. Additionally, in the case of misdemeanours that are connected with drug possession and usage in small amounts (Subsection 15(1)), it is not possible to gain an overview of the cross-section for specific drugs.

Information on the services provided for drug users, and especially for injecting drug users, is derived from reports by the National Strategy for Drug Addiction Prevention and the national HIV/AIDS Prevention Strategy, and also from the Ministry of Justice.

9.2 Drug-related crime

In 2010, the total number of registered drug-related crimes was 901 (Sections 183 to 190 of the Penal Code), which is 11% less than last year when the total number of registered drug-related crimes was 1,041 (Table 28).

A total of 78% (699 individual cases) of all registered drug-related crimes in 2010 were crimes related to the unlawful handling of large quantities of narcotic drugs or psychotropic substances and provision of large quantities of narcotic drugs (§ 184).

In 2009, charges were brought against 25 organised criminal groups (totalling 86 persons) which had been conducting large-scale drug trafficking operations.

Estonian drug traffickers are more often caught in foreign countries. A total of 15% of registered drug-related crimes in 2010 were crimes related to the unlawful handling of small quantities of narcotic and psychotropic substances (§ 183).

In 2010, a total of 2,410 misdemeanours related to owning or use of small quantities of narcotic drugs were registered (§ $15^1$of the Act on Narcotic Drugs and Psychotropic Substances and Precursors thereof) (Table 29). A total of 6% of all persons who committed such misdemeanours were minors (125 persons).

The registration of the number of drug-related misdemeanours and crimes has been influenced by the resources of law enforcement agencies, as well as by the setting of priorities due to the availability of resources. The main attention during the last few years has been on catching criminal groups that are trafficking large quantities of drugs. The statistics for crimes related to large quantities of drugs have been influenced to some extent by the fact that cases that were registered earlier as several crimes are now being registered as one follow-up crime[4].

[4] Crime in Estonia in 2010. Ministry of Justice. Tallinn, 2011. Page 13

Table 28. Registered drug-related crimes in 2007-2010.

Type of criminal offence	Penal Code	2007	2008	2009	2010
Unlawful handling of small quantities of narcotic drugs or psychotropic substances	§ 183	297	301	153	138
Unlawful handling of large quantities of narcotic drugs or psychotropic substances	§ 184	1048	1143	789	699
Narcotic drugs or psychotropic substances being passed on to minors (under 18 years)	§ 185	79	65	63	26
Inducing person to engage in the illegal use of narcotic drugs or psychotropic substances	§ 186	0	0	0	0
Inducing minors to engage in the illegal use of narcotic drugs	§ 187	3	6	0	0
Illegal cultivation of opium poppies, cannabis or coca shrubs	§ 188	19	37	32	32
The preparation for distribution of narcotic drugs or psychotropic substances	§ 189	2	6	4	6
Violations of requirements for handling narcotic drugs or psychotropic substances or precursors	§ 190	1	0	1	0
Total		**1449**	**1558**	**1042**	**901**

Source: Ministry of Justice, 2011.

Table 29. Number of drug-related misdemeanours and criminal offences, and the number of persons having committed drug-related crimes in 2007-2010.[5]

	2007	2008	2009	2010
Drug-related misdemeanours (possession or usage of small quantities of substance for personal use)*	5,991	6,113	3,205	2,140
Drug-related distribution/trafficking/production of drugs**	566	805	798	764
Other drug-related crimes ***	36	76	49	64

Source: Ministry of Justice, 2011.
* § 15(1) of the Act on Narcotic Drugs and Psychotropic Substances and Precursors
** Penal Code §183-184 of the Penal Code
*** Penal Code §185-190 of the Penal Code

In 2010, the court convicted 52 persons pursuant to § 183 of the Penal Code, and 408 persons pursuant to Section (§) 184 of the Penal Code (in 2009, this figures were 95 and 461 persons, respectively). A total of 43 persons were convicted of other drug-related crimes (this was 47 persons in 2009). A total of 87% of convicted offenders were men and 13% were women; the average age at the time at which the decision was made was 31 years.

[5] Persons connected to possible criminal offences: prosecuted persons and persons in the case of whom criminal proceedings were terminated due to proportionality considerations pursuant to Sections 201 to 205 of the Code of Criminal Proceedings.

More drug-related crimes were registered in Harju County and Ida-Viru County than anywhere else (Harju County had 461 of them, or 51% of all drug-related crimes, and of those, 419 were in Tallinn, while Ida-Viru County had 158 cases, of which 78 were in Narva and 41 in Kohtla-Järve). Both regions have a higher prevalence of injecting drug users in the population (see Chapter 4) and a major proportion of harm reduction services for injecting drug users are directed to those regions (see Chapters 1.3 and 7.3). A total of 12% of drug-related crimes were registered in Tartu County (107 cases, of which 102 were in Tartu), and 5% were registered for Pärnu County (76 cases, all in Pärnu). A total of 51% of crimes related to the handling of large quantities of narcotic substances or psychotropic substances (§ 184 of the Penal Code) were registered in Harju County (359 cases, of which 326 were in Tallinn) and 19% in Ida-Viru County (131 cases).

9.3 Drug use in prison

There is no recent information regarding drug use and the risk behaviour of convicted offenders during the period being reported. The last survey on knowledge, attitudes and behaviour related to HIV and drug addiction among convicted offenders was conducted by the National Institute for Health Development in 2008. A repeat survey will be conducted in cooperation with the National Institute for Health Development and the Ministry of Justice in autumn 2011. In addition to knowledge, attitudes and behaviour related to HIV and drug addiction, the survey to be conducted in 2011 will provide information about the services provided in the prison system and prevention measures that could be implemented.

In comparison with previous years, the number of searches carried out in prisons to check for drugs has increased. While in 2008, nineteen searches were performed, in 2009 and 2010 searches were performed in 22 and 27 cases, respectively. In comparison with 2009, the testing of prison inmates for the use of narcotic substances has reduced. In 2010, prison inmates were tested in 2,704 cases, but in 2009, they were tested in 3,107 cases. In 2010, a total of 7% of tests performed on prison inmates turned out to be positive, but some of these tests were positive due to the fact that the inmates were using medicines that contain narcotic or psychotropic substances that had been prescribed by a doctor (four cases in 205 positive tests).

Some information about drug use has been received from the testing of imprisoned persons for drug use. As a result of the testing of prison inmates for drug use in 2009, a total of 4% of the tests performed on the inmates (119 in total) were positive. In 2010, drugs were discovered in prisons in 35 cases. Looking further back, drugs were discovered in prisons in 281 cases in 2007, 99 cases in 2008, and 31 cases in 2009. The volume of

drugs discovered in the possession of prison inmates has very likely reduced due to the introduction of cell-type prisons and the increase in searches also has an important role to play.

9.4 Responses to drug use-related health issues in prisons

The basis for prevention work on drug addiction and HIV/AIDS in Estonian prisons is laid down by the “National Strategy for Drug Prevention up to the year 2012”, and the “National HIV/AIDS Strategy 2006-2015”. Handling of drug use-related health issues in prisons is more precisely described in the Selected Issue (Chapter No. 11) of this report.

Drug-free departments and drug addiction treatment in prisons

Special addiction rehabilitation departments have been created in Estonian prisons to reintegrate drug addicts into society. Addiction rehabilitation departments have been created in three prisons: Tartu Prison (174 places in the medical unit in total), Viru Prison (20 places for youths and twenty places for adults), and Harku Prison (eight places). In comparison with 2009, the number of addiction rehabilitation departments has significantly increased. The increase is due to Tartu Prison, in which there has been a post-rehabilitation department with 44 places since 2010. The department’s objective is to provide support for drug addicts before their release. The rehabilitation of addicts in prisons is carried out on the basis of social programmes. The necessary resources for drug addiction treatment are provided by the prison’s general medical expenses.

According to the Ministry of Justice, there were 877 drug users in prisons as of the end of 2010 (there were 870 in 2009), which made up approximately a quarter of the total number of prison inmates, and 247 of them were opiate addicts (this was at 430 in 2009). The opportunities for receiving opiate substitution treatment in prisons are still very limited. In 2010, a total of 59 persons received methadone aversion treatment and 64 persons received substitution treatment. At an earlier date there was a fairly large problem with discontinuity of substitution treatment for drug users by the time they reached a house of detention, but this situation has improved because, since 2010, these persons have the chance of continuing methadone substitution treatment that they have already started when they enter to a detention house of the Viru Prison.

Training for prison staff and probation supervisors

Major steps have been taken to improve the quality of services for imprisoned drug users in 2007-2010. In 2010, the objective was set to train prison staff and probation supervisors in the field of motivational interviewing. A total of 93 officials altogether received this 24-hour training course which is the basis for the prison's reintegration work. In addition, there were thirty-hour detoxification programme training programmes for chaplains in 2010, and sixteen chaplains participated in these training programmes. Also, there were opiate addiction treatment training programmes for prison staff in which 26 employees in total participated and six persons participated in drug instructor training sessions.

9.5 Reintegration of drug users after release from prison

There is no recent data available for this reporting period.

Chapter 10. Drug markets

The information presented in the chapter about changes in illegal drug markets has been collated from EMCDDA Standard Tables No. 13, No. 14 and No. 16. Information concerning the volumes of narcotic substances and their purity levels is received from the Estonian Forensic Science Institute. The overview on prices for drugs is supplied based on the surveillance-based expert assessment from the Estonian Police and Border Guard Board. Previously, information had only been presented for Tallinn where drug prices were concerned, but since 2010 this information has covered the whole of Estonia. The information presented in the drug transit section of the report was supplied by the Estonian Tax and Customs Board.

10.1 Availability and supply

In 2010, the Estonian Tax and Customs Board discovered 152 cases of the illicit traffic and possession of narcotic substances or precursors thereof. Approximately 115kg of drugs were discovered in total, which is 56kg more than a year before.

Criminal proceedings were completed for 89 drug-related crimes, and 128,205 euros in cash and several apartments and premises were seized during these proceedings.

The methods used and trends in the illicit traffic of narcotic substances or their precursors have generally remained the same. The illicit traffic of narcotic substances, ie. heroin and “China White”, has activated in the Eastern region, something that has also appeared in the increase of sales of heroin and fentanyl. Small amounts of strong narcotic substances are smuggled into Estonia in body cavities.

Instead of producing amphetamine themselves, Estonian criminals prefer to smuggle in this substance from the Netherlands, via Germany, Denmark and Sweden, using both rail and maritime transport. Amphetamine is smuggled to Estonia from other countries as the quality of imported amphetamine is better, the price is more competitive, and the risks are lower than when it is produced in Estonia. Estonia is still the main transit country for transporting amphetamine to Finland.

Several Estonian criminal groups smuggle large quantities of hashish and amphetamine from the Netherlands to Estonia both for the Estonian market and to forward these shipments to the Scandinavian countries and Russia. They mainly arrive in Estonia by land, using bus and rail transport as well as rented vehicles.

The illicit traffic of large quantities of cocaine from the South-American and African countries to Europe takes place through Estonia. Traffickers count on the inability of Estonian Customs officials to discover well-hidden narcotic substances (which are melted in with various products, or are impregnated into other products). Transporting goods from Estonia to Europe is much more risk-free than transporting them directly from South-America to any larger European country (NERS 2010 report).

10.2 Seizures

The largest volumes of confiscated drugs in 2010 were cocaine (218kg), amphetamine (48kg), and various cannabis products. In comparison with 2009, the confiscated volumes for most narcotic substances were smaller in 2010 (Table 30).

Table 30. Amounts of confiscated narcotic substances in 2007-2010 (kg).

	2007	2008	2009	2010
Cannabis resin (hashish)	155.4	48.5	19.2	14.5
Herbal cannabis, marijuana	8.1	24.2	7.1	14.8
Cannabis plants	8.1	23.2	17.2	10.8
Heroin	5.7	0.1	3.9	0.004
Cocaine	13.0	3.6	5.0	217.7
Amphetamine	56.3	23.3	55.9	47.7
Methamphetamine	0.02	37.7	0.001	0.5
GHB	26.4	7.7	25.1	16.1
Fentanyl / 3-methylfentanyl	1.3	1	1.8	0.5
Poppy / opium poppy	0	6.5	1.1	-
Methadone	1.8	3.8	1.1	1.5

Source: Estonian Forensic Science Institute 2011.

A significant increase in confiscated amount of cocaine in 2010 could be regarded as an exception (5kg in 2009 versus 218kg 2010). In October 2010, the Estonian Tax and Customs Board discovered a huge amount of cocaine in the context of Estonia (47.8kg); the drugs were smuggled to Estonia from Venezuela. Cocaine was confiscated in 25 cases in 2010. The confiscated amounts have also increased in the case of methamphetamine (0.5kg); the number of confiscations of this drug increased from three to 36 cases. According to the Police Board, it can be observed that methamphetamine is also about to reach other regions of Estonia in addition to Tallinn.

Confiscated quantities of all opiates decreased in 2010. The specialists think that the smaller amounts are due to the economic depression and a fear of getting caught, and therefore smaller amounts of drugs are handled each time (NERS 2010 report).

Although confiscated amounts of GHB were a little lower in 2010, the use of GHB and its precursor, GBL, is problematic in Estonia. According to the Estonian Forensic Science Institute, confiscated amounts of GHB and GBL in 2010 were at 16kg and 18kg, respectively. GHB is a controlled narcotic and psychotropic substance in Estonia but GBL, which has the same effect, is not. GBL is an industrial chemical that has no limits on its usage in Estonian legislation and the customary handling of this substance is legal in Estonia.

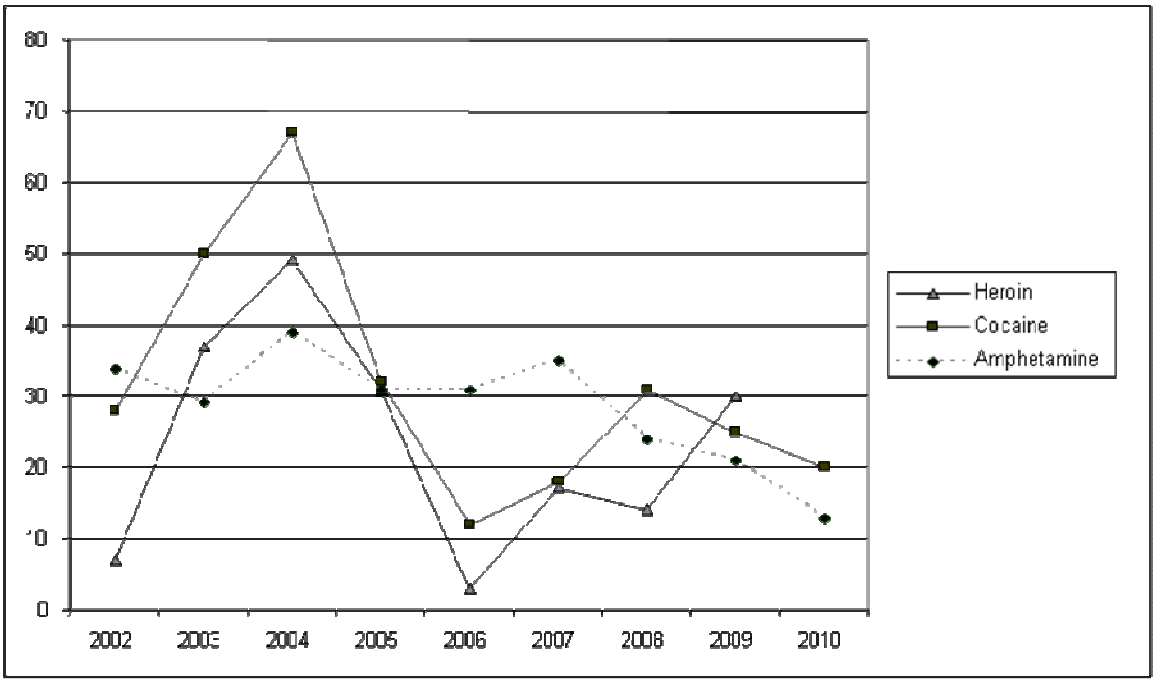
10.3 Price and purity

When looking at the 2002-2010 period, one thing that can be seen is that since 2004 the general purity of narcotic substances has been relatively low (Figure 1). The purity of cocaine and amphetamine has been continually decreasing in the last three reported years. In terms of purity, only cannabis products can be regarded as an exception as their purity levels have slightly increased in comparison with 2009. In 2009, the mean THC concentration in hashish was 4% but in 2010 it was 5.7% (typical THC concentration is between 2% to 20%). The purity of marijuana also increased in 2010. In 2009, the mean THC concentration in marijuana was 8% but in 2010 it was 10%. The price of cannabis products has remained at almost the same level as in 2009. In 2010, hashish was a little cheaper than marijuana (between 16-19 euros per gram). The price for the latter was between 16-22 euros per gram.

In 2010, small amounts of heroin reached the drug market in Tallinn. The estimated street price of heroin varied between 96 and 192 euros per gram. In terms of purity, heroin is a very impure substance. The minimum purity level for heroin was 0.2% while the maximum purity level was 5% of pure substance for every single gram of heroin. In 2009, the purity levels for heroine were between 7% and 59%. The most popular opiate in Estonia is still fentanyl, which in 2010 had a street price of between 240-300 euros per gram depending on the strength of the substance. The purity of amphetamine and cocaine has decreased in comparison with the previous reporting period. In 2009, the most common purity level for confiscated amphetamine was 21%, but in 2010 it was 13%. In 2010, methamphetamine was also confiscated, for which the most common purity level was 27%. Small amounts of Ecstasy pills were confiscated in 2010; the pills contained an average of 64 mg of pure substance (in 2009, the highest level of purity was 77 mg of pure substance per pill). The price of amphetamine has remained at a similar level as in 2009 (12.8-19.2 euros in 2009 versus 13-19 euros in 2010 per gram). The price of Ecstasy pills has dropped in the reported period to 4-6 euros per pill (in 2009 it was 5.1-7.9 euros per pill).

As with the purity levels for amphetamine, the most common purity level for cocaine has dropped in 2010 (25% in 2009 versus 20% in 2010). The price of cocaine has increased most significantly in comparison, with amounts of 57-115 euros per gram in 2009 (64-128 euros per gram in 2010).

Figure 1. Prevalent purity of amphetamine, cocaine and heroin in 2002-2010 (mode)*.



Source: EMCDDA Standard Table No. 14, Estonian Forensic Science Institute 2011.
* The amount of heroin confiscated in 2010 was too small to calculate the mode.

Part B: Selected Issues

Chapter 11. Drug related health policies and services in prison

11.1 Prison system and prison population: contextual information

Various sources have been used in this chapter. First of all, we have received data from the Ministry of Justice concerning the prison system, the health of convicted offenders, and intervention programmes that have been implemented. Also, we have data from the reports of 2010 from the national drug addiction and HIV/AIDS prevention strategies, and from studies on knowledge, attitudes and behaviour related to HIV/AIDS and drug addiction that were conducted amongst convicted offenders (2004, 2006 and 2008). Interventions for drug users in prisons are offered through the drug addiction and HIV/AIDS prevention strategies. The objectives where they are connected with prisons are presented in Chapter 4: “Drugs in prison”, in the drug addiction strategy.

11.2 Organization of prison health policies and service delivery

There are four prisons in Estonia: at Tartu, Tallinn, Viru, and Murru prisons. The last of these, Murru Prison, was formed on 15 January 2011 when two separate custodial institutions, Murru Prison and Harku Prison, were incorporated. Harku and Murru prison is at the same time also the last dormitory-type prison in Estonia. Tallinn, Tartu and Viru prisons are cell-type custodial institutions. According to the Ministry of Justice, there were 2,719 convicted offenders and 836 persons on remand (3,555 persons in total) in Estonian prisons as of 31 December 2009. A total of 145 of these were women and 34 were minors. In 2010, there were somewhat fewer persons in prisons. As of 31 December 2010, there were 2,649 convicted prisoners and 744 arrested persons (3,393 persons in total) in Estonian prisons (including 150 women and 23 minors).

Although the number of people who have been imprisoned has decreased every year, Estonian prisons are still overcrowded (Table 31). As of 31 December 2008, there were 279.6 imprisoned persons in Estonian prisons per 100,000 of the country’s inhabitants, which is also the highest indicator in comparison with member states of the European Union (Council of Europe, SPACE I, 2008). The adjusted prison population rate per 100,000 persons is 263.4 imprisoned persons per 100,000 inhabitants (Council of Europe,

SPACE I 2008). The average age of imprisoned persons was 33 years in 2008. According to the same source, the proportion of minors being detained was 1.4%.

Table 31. Number of imprisoned persons per 100,000 of the country's inhabitants.

	2000	2001	2002	2003	2004	2005	2006	2007	2008
No. of imprisoned persons per 100,000 inhabitants	328.0	350.0	340.9	353.8	337.9	327.4	321.6	262.6	279.6
No. of imprisoned persons	4.655	4.777	4.775	4.443	4.417	4.450	4.349	3.566	3.467

Source: The Quaker Council for European Affairs, 2011.

11.2.1 Prison health

The same health care services are ensured for convicted offenders and imprisoned persons as for the rest of the population. All medical departments in the prisons provide general ambulatory medical care and dental treatment to prisoners. Stationary specialised medical care is provided in the hospital of Tallinn Prison. Where an imprisoned person needs some kind of health care service that is not provided by the prison's medical department or hospital, treatment is provided in a civil hospital.

Regulation No. 330 of the Government of the Republic, dated 19 December 2003, on the amount, conditions and procedure for the funding of health care services provided on the basis of the Imprisonment Act and the acquisition of medicinal products and medical supplies required for the provision thereof from the state budget determines the health care services that are provided for imprisoned persons, persons who are being held in detention, and arrested persons, and the medicinal products and medical supplies required for the provision thereof. Appendix 1 of this Regulation clearly provides for the list of health care services, and the provision for this is funded from the state budget.

Regulation No. 115 of the Minister of Social Affairs, dated 30 October 2003: "The procedure for administering compulsory radiographic examinations on persons who are being held in detention, persons who are being held in custody, and prisoners, and the procedure for prison officers, guards and health care professionals who are in direct contact with them", establishes the procedure for administering compulsory radiographic examinations on persons who are being held in detention, persons who are being held in custody, and prisoners in a prison or house of detention and for prison officers, guards and health care professionals who are in direct contact with them.

The provision of health care and social services in the prison system is funded from the state budget via the Ministry of Justice. Medicine that is necessary for the treatment of

imprisoned persons is obtained from the prison's common pharmacy. The procurement of antiretroviral drugs is organized by the Ministry of Social Affairs and the costs are covered by the Ministry of Justice.

11.2.2 Drug-related health policies targeting prisoners

Hereinafter, we provide an overview of the objectives and sub-objectives of drug use and HIV/AIDS prevention work that targets prisoners in the framework of two national strategies: "National Strategy for Drug Prevention up to the year 2012", and "National HIV/AIDS Strategy 2006-2015". Detoxification treatment and training sessions for imprisoned persons are financed from the resources of the drug prevention strategy, and the testing of prisoners for HIV, viral hepatitis B and C, substitution treatment, anti-retroviral (ARV) treatment, and other services (including harm reduction services in the prison system) are financed from the means of the HIV/AIDS strategy.

11.2.2.1 Objectives set for prevention work in custodial institutions in the national drug prevention and HIV/AIDS strategies

The principles of the drug prevention strategy note that drug prevention in prisons is a part of the work being carried out for the social reintegration of imprisoned persons. Cooperation between different structural units in prisons for the social reintegration of imprisoned persons and a well-functioning cooperation between prisons and the partners of the prison system are considered to be important in prevention work in prisons. According to the principles of the drug prevention strategy, drug prevention is part of the main activities of prisons and the directors of prisons are responsible for the functioning of this activity. The realisation of the objectives mentioned in the drug prevention strategy is financed from the prisons' budgets. The main objective of prevention work that is carried out among convicted offenders in prisons is the creation of a functioning control system to prevent the entry of drugs into prisons. In addition to the aforementioned, there is another objective in the form of ensuring the appropriate opportunities in prisons to treat and rehabilitate drug addicts. In-service training sessions for prison staff are planned in order to help develop both of these activities. The sub-objective of the strategy is to create so-called drug-free departments.

The contractual relationships between imprisoned persons and the prison administration in the drug-free departments of prisons were considered to be important in order to motivate

imprisoned persons to avoid using drugs in prison. With this contract an imprisoned person takes on the responsibility not to use drugs and the prison takes on the responsibility to ensure agreed additional benefits for imprisoned persons in relation to this in the framework of its competence. Drug prevention, treatment and rehabilitation are all part of the social reintegration work for imprisoned persons, and prison chaplains and non-governmental organizations outside prison are also involved in these activities.

HIV/AIDS prevention work in prisons is based on the national HIV/AIDS strategy 2006-2015 and on its action plan. The HIV/AIDS prevention strategy is concerned with the HIV/AIDS prevention work in Part 5.1.5: “HIV and AIDS prevention work among imprisoned persons”. The strategy presents the following principles which, in brief, are as follows:

- A custodial institution is an important place from the point of view of HIV/AIDS prevention
- Health care services that are available outside prison must be also available in prisons (including detoxification and substitution treatment)
- Punishment policy is taken into account when offering harm reduction services
- Upon ensuring social and health care services their continuity through case management is ensured
- The offering of drug addiction treatment is arranged in a house of detention in cooperation with the centres that offer appropriate treatment and where the patient, who is now in a custodial institution, used the same health care service before imprisonment and where the same centre will provide custodial institution with the medication that is necessary to continue treatment
- The psychosocial support service offered in the support group must be available for HIV-positive prisoners in the custodial institution

The main objective set for custodial institutions in the HIV/AIDS strategy is that as a result of the prevention work there will not be any HIV infection transmissions inside prison.

In order to achieve this objective, the availability of harm reduction services for imprisoned injecting drug users must be ensured. At the same time the strategy says clearly that there is no syringe exchange in prisons. It is planned that the availability of high-quality counselling will increase, along with the diagnostics and treatment of HIV and other sexually transmitted infections in the framework of this strategy. The strategy mentions that imprisoned persons must have access to condoms, lubricants, disinfectants and other necessary means. Ensuring a safe working environment for all staff in a prison where they are in direct contact with imprisoned persons is considered to be important. The strategy also considers important the organisation of training sessions for prison staff in regard to the ways HIV can be transmitted and prevented, how the use of in-prison violence can be

avoided, and how to respect the rights, dignity and welfare of imprisoned persons. In addition to staff training sessions, the strategy also considers important the organisation of training sessions for imprisoned persons in regard to the prevention of the spread of HIV, to distribute information materials to them, and to carry out interviews either individually or in group sessions. In addition to the aforementioned, it is also considered necessary to ensure the provision of health care services, psychological and legal counselling, social counselling and welfare services for imprisoned persons who are HIV-infected and for imprisoned persons who suffer from HIV disease (AIDS).

11.2.3 Health care services in prison

Radiographic examinations are performed on persons who are being held in detention, persons who are being held in custody, and imprisoned persons during the first medical examination which occurs within ten working days of the arrival of an individual at the relevant house of detention. A compulsory radiographic examination is performed on persons who are being held in detention and imprisoned persons at least once a year. Persons who are in a house of detention and are showing the symptoms of tuberculosis, or persons who are known to be suffering from active tuberculosis, are immediately isolated from other inmates and are sent to the Tallinn Prison hospital to be treated.

In addition to the compulsory radiographic examination that is performed during the first medical examination, prisoners who have arrived in prison are also tested for HIV and viral hepatitis B and C, and any necessary treatment is designated, if needed. Voluntary HIV testing and/or counselling is available in all prisons and is carried out by health care professionals who have undergone the appropriate training. Imprisoned persons are tested for HIV only with their consent and the testing is confidential. When tested, the imprisoned person always receives pre-test and post-test counselling. Imprisoned persons who are HIV-positive are accommodated in the custodial institution pursuant to general procedure, i.e. an HIV-positive person is not isolated from fellow prisoners. Depending on the health status of HIV-positive persons, and in cases where it is required, further examinations and ARV treatment are designated for them and are organised by the medical department of prisons. There are free condoms and disinfectants available for prisoners in the medical departments of prisons. So far the syringe and needle exchange service has not been initiated in prisons. Thanks to good prevention work nobody has become infected with HIV in the prison environment.

11.3 Provision of drug-related health care services in prison

Imprisonment has been divided into three phases: admission, the main phase, and release. A medical examination is performed on a convicted offender in the admission phase, which we already discussed in the previous sub-chapter. In this sub-chapter we discuss the prevention work, treatment, rehabilitation and harm reduction that is carried out when targeting imprisoned persons.

11.3.1 Prevention, treatment, rehabilitation and harm reduction

The objective of the admission phase (during which the first medical examination is performed on imprisoned persons) is also to compile a social reintegration programme. Measures proposed in the treatment programme are realised in the main phase. The task of the release phase is to prepare prisoners for life after being released from prison. In order to ensure that the prisoner adapts back into society without any problems after being released, important preparations are made beforehand, the most important of which is the relocation of the prisoner to a minimum security prison and offering them social assistance. Social workers help prisoners to establish contacts with their families and social welfare institutions, and informs the local authorities of the place of residence of the person after they have been released. In cases where a prisoner is released on parole the probation supervisor is also involved. The objective of the work done with convicted offenders during the whole process of imprisonment is to prepare these persons for release. Once they have been released, a savings fund that has been created for the prisoner upon the occasion of their release is paid out to them.

The health status of the imprisoned person is assessed during the first medical examination. During this medical examination, in cases where it is required, a radiographic examination is performed on the imprisoned person and the prisoner is tested for HIV and viral hepatitis B and C. Generally, persons with a drug addiction have already been noted in any house of detention, and they can freely continue any drug addiction treatment that they have previously started in the house of detention, if they so wish.

HIV testing is done in all prisons and it always includes pre-testing and post-testing counselling. Testing is performed when an individual arrives in prison, one year after previous testing or more frequently where medical necessity demands. HIV testing in prisons is voluntary and pre-test and post-test counselling is very important. Testing on imprisoned persons for HIV and pre-test and post-test counselling is organised and kept on record by the prison’s medical department.

Testing for viral hepatitis B and C is carried out in prison only on imprisoned persons who belong to risk groups (injecting drug users, persons who are HIV-positive, etc), or if the physician arranges such testing for medical reasons. Similarly to HIV testing, testing for viral hepatitis B and C in prison is also voluntary. Testing imprisoned persons for viral hepatitis B and C and pre-testing and post-testing is organised by the prison's medical department.

According to the Ministry of Justice, the number of imprisoned persons who are HIV-positive was 493 in 2008 (14% of the total population) but the number of HIV-positive prisoners in 2009 increased to 575, or 15% of all imprisoned persons.

In comparison with 2009, the number of imprisoned persons who have been tested for HIV has dropped in 2010 (Table 32). This is probably due to the fact that a lot of prisoners in prison have already been tested for HIV. The survey, which was conducted among imprisoned persons in 2004, 2006 and 2008, shows that most imprisoned persons are aware that they can be tested for HIV by the prison medical officer (Table 35).

Table 32. Numbers of persons tested for HIV in prisons in 2009 and 2010.

Prison	**2009**	**2010**
Tartu	1,865	1,318
Tallinn	1,590	1,575
Viru	905	974
Harku and Murru	1,863	513
Total	**6,223**	**4,380**

Source: Ministry of Justice, 2011.

In comparison with 2009, the number of persons tested for viral hepatitis B and C has significantly increased in 2010 (Table 33).

Table 33. The number of imprisoned persons tested for viral hepatitis B and C in 2009 and 2010 in different prisons.

	Viral hepatitis B		**Viral hepatitis C**	
Prison	**2009**	**2010**	**2009**	**2010**
Tartu	220	380	105	44
Tallinn	26	300	26	30
Viru	135	241	115	182
Harku and Murru	20	46	16	46
Total	**401**	**967**	**262**	**302**

Source: Ministry of Justice, 2011.

According to the Ministry of Justice, 453 imprisoned persons were tested for viral hepatitis B in 2008, 219 imprisoned persons in 2009, and 746 imprisoned persons in 2010. The

officials were vaccinated according to plan in 296 cases. The imprisoned persons are vaccinated against viral hepatitis B if they belong to the risk group, if they have not refused vaccination, if they have not suffered from hepatitis B before, if they have not been vaccinated before, and if they have no allergy against any of the vaccine's components. The vaccination is also ensured for prison officers. The diagnosis for and treatment of chronic viral hepatitis B is performed according to the treatment guide and budgetary allowances.

In Table 34 we can see that there was a total of 870 imprisoned persons in prisons in 2009 (forming 24.5% of all imprisoned persons) and 877 imprisoned persons in 2010 (24.5% of all imprisoned persons) who had been diagnosed with having drug use-related mental or behavioural disorders.

Table 34. Number of drug addicted imprisoned persons by prisons in 2009 and 2010.

Prison	**2009**	**2010**
Tartu	313	268
Tallinn	147	216
Viru	305	303
Harku and Murru	105	90
Total	**870**	**877**

Source: Ministry of Justice, 2011.

The table below (Table 35) delivers an overview of the studies that were conducted amongst convicted offenders in 2004, 2006 and 2008.[6] These studies were conducted with the cooperation of the National Institute for Health Development and the Ministry of Justice. The objective of the study was to build up an overview of knowledge in regard to convicted

[6] The survey was conducted amongst convicted offenders who are serving a custodial sentence in custodial institutions that are located in Estonia. The questioners were employees of the medical or social departments who work in prisons and the questionnaires were filled in by the examinees themselves in writing. Participation in the survey was voluntary and anonymous. Where the questions are concerned, one has to bear in mind that the convicted persons were not tested for HIV or drug use.
In 2004, a total of 421 completed questionnaires were received back from the planned sample (out of a total of 917), of which all of them, 421 questionnaires, qualified for analysis (amounting to 45.9% of all convicted offenders in prisons). In 2006, a total of 834 completed questionnaires were received back from the initial sample (a total of 974), of which 807 or 82.9% of the initial sample qualified for analysis (26,0% of all convicted offenders in prison).
In 2008, a total of 775 completed questionnaires were received back from the initial sample (a total of 881), of which 750 or 85.1% of the initial sample qualified for analysis (42.8% of all convicted offenders in prison). * The median age was shown in the report for the survey of 2008 and it was eighteen years.
** Those who had used drugs in prison and answered that they had done so by injecting remained in analysis.
*** Those who had used drugs in prison and had used them in the past four weeks remained in analysis.
**** More than one variant fitted the answer
The report for the survey was conducted amongst convicted offenders in 2004. It showed LSD (7.3%) and ketamine (3.1%) to be amongst the drugs used during a prison stay. Fentanyl was not added to the list of drugs in the questionnaire.

offenders when it comes to the spread of HIV, drug use in a prison environment, the misconceptions and stigmas concerning the subject of HIV/AIDS, and the scope of risk behaviour in prison that is connected with drug use and the spread of HIV.

Table 35. Drug use among convicted offenders on the basis of the studies conducted in 2004, 2006 and 2008.

	2004 (n=421) %	**2006 (n=779) %**	**2008 (n=750) %**
The proportion of examinees who are of the opinion that their fellow prisoners are currently using drugs	50	33	39
Drug use during a lifetime	56	58	58
Average age to start using drugs	18.7	19.5	18 *
Persons reporting drug use in prison*	34	29	28
Injecting drugs in prison (% received from persons used drugs in prison)**	54.1	62.7	55.0
Drug use in prison in the last four weeks***	-	43	27
Drugs that were used in prison according to claims by examinees			
marijuana/hashish	72.7	78.1	67.9
amphetamine	72.7	77.3	65.8
ecstasy	23.7	34.5	36.7
cocaine	11.2	23.0	21.1
poppy liquid	15.6	35.4	22.0
fentanyl ****	-	43.8	41.8
GHB	5.2	20.1	9.7
heroine	30.9	40.1	30.8
Convicted offenders who had injected in prison and who had shared injecting equipment at least once in the last four weeks	-	59	17
Testing for HIV in prison	81	71.7	82

Source: NIHD: "Knowledge, attitudes and behaviour related to HIV/AIDS and drug addiction among convicted offenders (2004, 2006, 2008)".

The survey that was conducted among convicted offenders in 2004, 2006 and 2008 showed that approximately 60% of the subjects who took part in the study had used some kind of drug during their lives. The average age for starting to use drugs was 18.7 in 2004 and 19.5 in 2006. The report for the survey that was conducted in 2008 does not show an average age but the median age for starting to use drugs was eighteen years. The survey shows that the proportion of persons using drugs in prison has dropped from 34% in 2004

to 28% in 2008. More than half of convicted offenders who were studied in 2004 and 2008 who had used drugs in prison had done so by injecting. In 2006, approximately two thirds of convicted offenders who claimed that they had used drugs in prison had done so by injecting. In comparison with the survey that was conducted in 2006, the number of these drug users who, during the four weeks before the interview, had shared injecting equipment at least once (shared a mixing vessel, a filter or cotton, a water vessel, a syringe or needle, or a filling from another syringe) has significantly dropped in 2008 - from 59% in 2006 to 17% in 2008. At the same time it is worrying that approximately one in five people who inject in prison has shared a syringe and/or injecting paraphernalia.

According to the results of the three studies that were conducted among convicted offenders, the most widely used drugs in prison in the past four weeks were cannabis products (marijuana and hashish) and amphetamine and, on the basis of two previous studes, the most widely used of the opiates was synthetic opiate fentanyl, which has a street name of China White or Persian White. One has to bear in mind that in the case of the survey from 2004, fentanyl was not included in the list of drugs in the questionnaire.

Methadone drug addiction treatment (detoxfication and substitution treatment) has been offered to drug users in prisons since 2008. Initially the scope of this service was very limited. In 2009, a total of four imprisoned persons were on detoxfication treatment and eight imprisoned persons had substitution treatment with methadone. In 2010, this figure shot up to 59 imprisoned persons who had detoxification treatment with methadone and 64 who had methadone substitution treatment. The number of the persons who had detoxification and substitution treatment increased in 2010, mostly because it was possible to continue a treatment that had been discontinued as a matter of free choice in houses of detention. The UNODC project had a significant role to play in the development of drug addiction treatment in houses of detention.

So-called addiction rehabilitation departments play an important role in the social reintegration process of imprisoned drug addicts. There are 174 places in the addiction rehabilitation department at Tartu Prison. There are also addiction rehabilitation departments in Viru Prison (twenty places for youths and a further twenty for adults) and in Harku Prison (a total of eight places).

In comparison with 2009, the number of persons who have received anti-retroviral treatment (ARV treatment) has significantly increased (Table 36). In 2009, a total of 195 imprisoned persons received ARV treatment (5.5% of all imprisoned persons), but in 2010 the figure rose to 230 imprisoned persons who were receiving the same treatment (6.8% of all imprisoned persons). ARV treatment is organised by the medical departments of the prisons.

Table 36. Number of convicted offenders who received anti-retroviral (ARV) treatment in 2009 and 2010, by prison.

Prison	2009	2010
Tartu	55	63
Tallinn	51	76
Viru	63	58
Harku and Murru	26	33
Total	**195**	**230**

Source: Ministry of Justice, 2011.

The support group service for HIV-positive prisoners in prisons is maintained by NGO Convictus. A support service in the form of group work is also provided for imprisoned persons who are HIV-positive or drug users. There were 467 support group meetings in 2008, 720 in 2009, and another 720 in 2010.

The systematic prevention of overdoses has not been organised in prisons so far. At the same time the study on convicted offenders showed the need to implement intervention in order to prevent overdoses, as the study revealed that more than 40% of convicted offenders had used fentanyl. But the use of these drugs is connected with overdoses and drug-related deaths (Chapter 6.3). At the moment the main measures to prevent overdoses in prison are the collection and analysis of information and the planning and implementation of surveillance methods. The objective of these activities is to determine just who the drug users are and to bring imprisoned persons who are connected with drug trafficking to justice.

Testing imprisoned persons for drug use

We considered testing for drugs use in Chapter 9.3. In 2009, imprisoned persons were tested for drug use in 3,107 cases. In 2010, they were tested in 2,704 cases.

11.4 Quality of services

There is no information available concerning the quality of health care services that are provided to drug addicts and users in prisons. Health care services are provided, diseases are diagnosed and treatment is implemented pursuant to the treatment guides valid in Estonia. There is a practical guide for drug addiction and HIV/AIDS prevention work in prisons. HIV prevention work carried out in Tartu Prison was awarded the Best Practice Prize by the World Health Organisation in 2007.

Training courses for prison staff that covers drugs, HIV and hepatitis B and C are organised on a regular basis.

In 2010, a total of sixteen prison chaplains participated in drug rehabilitation training, 93 prison employees and probation supervisors participated in motivation counselling training, and 24 prison employees participated in opiate addiction treatment training (Chapter 9.4).

In 2011, a total of 22 prison medical practitioners participated in HIV training that was organised by the National Institute for Health Development and UNODC, and which was concerned with the pre-test and post-test counselling of testing for HIV, ARV treatment and topics connected to it (including the medication used, treatment schemes, pregnancy and ARV treatment). At the same time, prison officials were able to conduct study visits to foreign countries where the main topics had been the work done with drug users and HIV-positive persons.

11.5 Discussion, methodological limitations and information gaps

As was mentioned previously, the health care services for imprisoned persons who are in the prison system are ensured on the same basis as for the rest of the population. The only difference is in the syringe exchange program which is not available for injecting drug users in prison. Also, overdose prevention for injecting drug users is not dealt with in prison, but the provision of this service is also limited in the outside world.

Both the drug use strategy and the HIV/AIDS prevention strategy include activities that are targeted specifically at imprisoned persons and these activities are financed through the state budget. Detoxficaton treatment, testing for HIV and viral hepatitis B and C, substitution treatment, and antiretroviral therapy are the activities that are available for drug users. Although all these services are provided in prisons in certain scopes, there is no information available about the profile of clients and more precise information about the essence of the services that are being provided is also missing. As the target group of drug users in prison has not been directly examined, we do not have exact data on the background of imprisoned drug users. Therefore we cannot say what kind of drugs are mainly being used in our prisons (according to the main drug used). The only survey data that comes from prisons and which covers drug use is contained in the study entitled “Knowledge, attitudes and behaviour related to HIV/AIDS and drug addiction among convicted offenders”, which is conducted every two years. In its essence this study gives us information about the drug use of imprisoned persons according to their own self report.

In conclusion, a major part of the information that covers what is going on in prisons is received from the annual reports by the Ministry of Justice and from inter-agency communications.

Chapter 12. Drugs users with children (addicted parents, parenting, child care and related issues)

12.1 Size of the problem

No surveys have been conducted in Estonia that would enable an assessment of the number of drug-using pregnant women or drug addicted parents, and neither has any related information been gathered together. It is known from the study that was conducted in Tallinn in 2009 among injecting drug users (IDUs) that 32% of IDUs have one or more children, and approximately 60% of women had at least one child. A similar survey that was conducted in Narva in 2010 revealed that 55% of injecting drug users had one or more children (48% of men and 70% of women), and 6% of men and 28% of women lived together with their own or their co-habiter's child. The drug treatment database reveals that in 2010, 15% of men and 24% of women who had attended a drug treatment programme lived together with children.

12.2 Policy and legal framework

Currently there are no special programmes or interventions for drug addict parents or their children. Drug users, including those who are released from prison, belong to a risk group and their problems are dealt with by social welfare (similarly to other persons who are in need of assistance).

12.3 Responses

In 2009, West Tallinn Central Hospital initiated an on-going drug treatment project for pregnant opiate addicts, which provides free opiate addiction treatment with buprenorphine, pregnancy surveillance, testing for and the treatment of infectious diseases (where required), and the supply of social support and rehabilitation. Surveys focussing on

injecting drug users reveal that more than half of injecting drug user are unemployed and therefore they are without health insurance. The state ensures health insurance for pregnant women who don't have any of their own from the twelfth week of pregnancy and after the child is born, and these women have the right to health insurance until the child is three years old.

It is known that nearly half of IDUs are HIV positive; in 2008 there was a figure of 1% of HIV positives out of all pregnant women and almost 4% of the children who were borne to HIV positive mothers were diagnosed with HIV. In order to prevent the vertical transmission of HIV infection, the infants of HIV positive women who go into labour have the opportunity to obtain a breast milk substitute for free until the child reaches the age of twelve months.

Part C: Annexes

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