

**Institute of Experimental and Clinical Medicine  
Estonian Drug Monitoring Centre  
Estonian National Focal Point**

# **ESTONIA DRUG SITUATION 2002**

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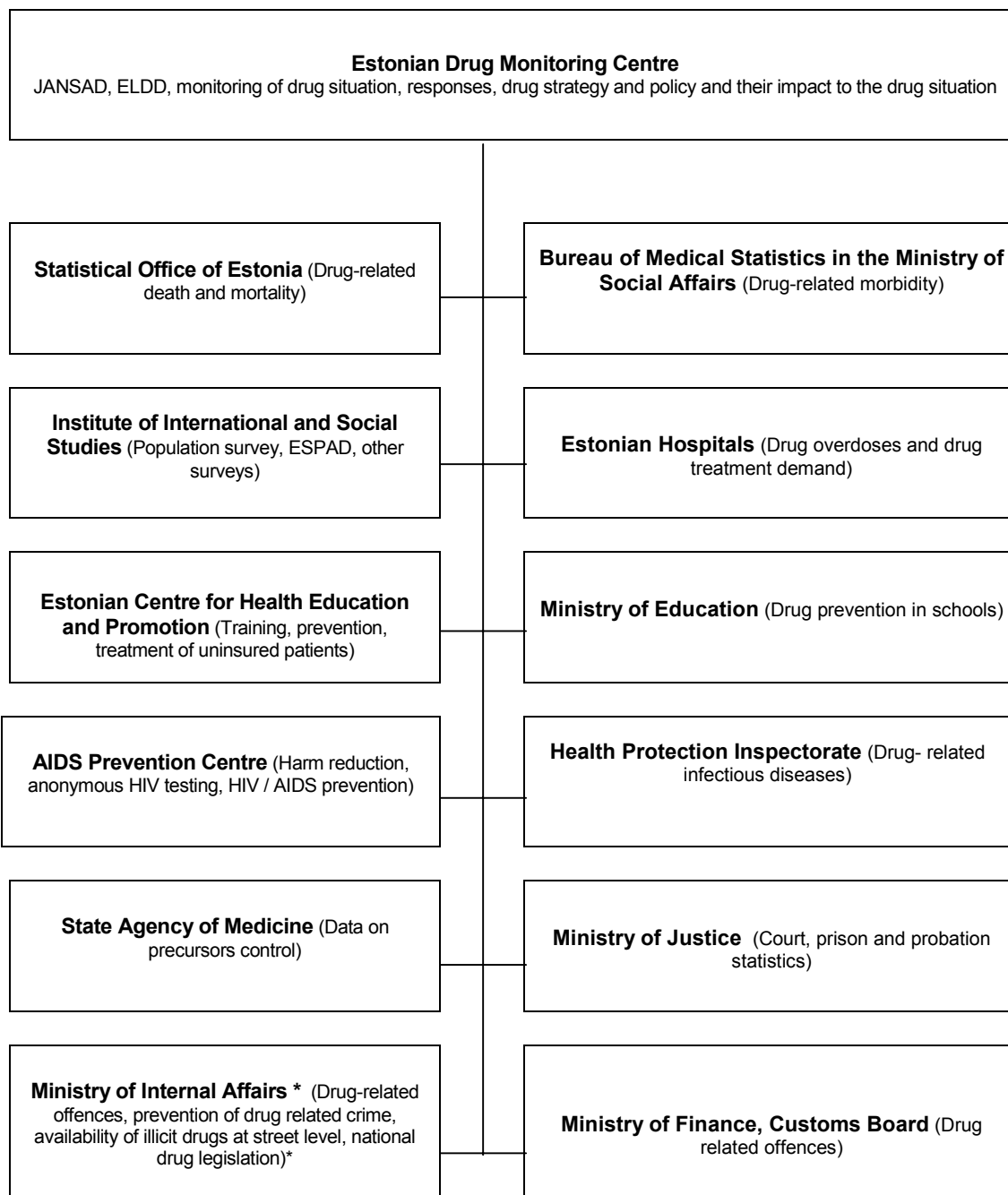
## **SUMMARY**

The National Report on the Drug Situation in Estonia has been drafted by the Estonian Drug Monitoring Centre for the submission to the Ministry of Social Affairs of Estonia and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). All National Focal Points of the Central and Eastern Europe (CEEC) countries are subject to reporting responsibility and have been submitting an annual report since 2001. The present report is the second report, which gives an overview of the drug situation in Estonia in 2001. The structure of the report is based on the EMCDDA "Guidelines 2002 for National Reports", which are the same for all EU and CEEC countries National Focal Points. This report provides an outline of the political and legal framework, epidemiological situation and demand reduction interventions in Estonia in 2001.

The data presented in the report is key information to be used by the Ministry of Social Affairs of Estonia and the European Monitoring Centre for Drugs and Drug Addiction. Every year the EMCDDA outlines specific key issues national reports have to focus on; demand reduction expenditures in 1999, drug use among young people aged 12-18, social exclusion and re-integration have been defined as key issues in 2002.

### **Situation of drug information**

From May 2001 the Estonian Drug Monitoring Centre (EDMC) has been responsible for the collection and analysis of epidemiological and statistical data in the drug field. EDMC was established in the Institute of Experimental and Clinical Medicine (IECM) and is functioning as the National Focal Point (NFP) for the EMCDDA. The EDMC is collecting information from different institutions related to the drug field. The main information channels are the same as in the previous reporting period (Figure 1).

**Figure 1.** Collaborates of the Estonian Drug Monitoring Centre in 2002

\* Subordinated institutions of the Ministry of Internal Affairs are the following: the Police Board, Department of Information and Analysis, Drug Unit of National Criminal Investigation Department, the Board of Boarder Guard, Estonian Forensic Service Centre.

The report is based on the data collected by the National Focal Point from the information channels specified afore (Figure 1.). We are very grateful to our collaborators Ms. Ene Orumaa, Ms. Aire Trummal and Ms. Liilia Lõhmus (Estonian Centre for Health Education and Promtion), Mr. Kuulo Kutsar (Health Protection Inspectorate, expert of drug-related infectious diseases), Ms. Nelli Kalikova (AIDS Prevention Centre), Ms. Ene Palo and Ms. Heldi Thomson (Ministry of Social Affairs of Estonia, Medical Statistics Bureau), Ms. Anu Neuman and Mr. Peep Rausberg (Estonian Forensic Service Centre), Mr. Rait Kuuse, Ms. Katrin Mänd, Ms. Elo Liebert, Ms. Marika Truumure (Ministry of Justice) who have provided us with background information and useful comments and/or contributed to the drafting of these chapters.

**PART 1: NATIONAL STRATEGIES: INSTITUTIONAL AND LEGAL FRAMEWORK****1. Developments in drug policy and response****1.1 Political framework of the drug field**

The Estonian Centre for Health Education and Promotion has been responsible for the implementation of the Estonian Alcohol and Drug Abuse Prevention Programme 1997-2007 (ADAPP) since 2000. The main priorities of the ADAPP are drug prevention, monitoring and data collection and fight against drug-related crime. The Ministry of Social Affairs in close cooperation with the Phare Twinning project initiated drafting of a new multi-disciplinary national strategy in September 2001 to enhance the development of the national strategy and insure the correspondence of the strategy to the EU *acquis*. The Ministry of Social Affairs of Estonia and Ministry for Labour, Health and Social Affairs and Ministry of Interior of Schleswig-Holstein, Germany, entered into a contract with the purpose of contributing to the development of the administrative capacity in the field of supply and demand reduction. New multi-disciplinary national strategy focusing on the co-operation between all relevant institutions to fight against drugs will be completed by the end of the year 2002. The strategy will be then submitted to the Government for approval.

**1.2 Legal framework**

Estonia has ratified the main international drug control conventions:

The United Nations Single Convention on Narcotic Drugs (1961);

The United Nations Convention on Psychotropic Substances (1971);

The United Nations Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances (1988);

The Council of European Convention on Laundering, Search, Seizure and Confiscation of the Proceeds from Crime (1990).

Estonia is signatory to Riga Declaration on Money Laundering (1996).



The provisions of the above named conventions and their supplementary schedules on narcotic drugs, psychotropic substances and precursors have been integrated into the Estonian drug legislation.

Estonia has adopted following drug-related legal acts:

Narcotic Drugs and Psychotropic Substances Act (NDPSA) (1997);  
Administrative Code and the Criminal Code (CC) – (valid until August 31, 2002 (incl.);  
Penal Code (entered into force on September 1, 2002);  
Mental Health Act (1997);  
Money Laundering Prevention Act (1998);  
Forensic Examination Act (2002);  
Public Health Act (1995; lastly amended in 2002).

The Forensic Examination Act provides legal basis for setting up a Chemistry and Biology Department in the Forensic Service Centre with the purpose of conducting forensic examinations of substances, and a Technical Department to carry out forensic examinations of the technical aspects of drug manufacturing.

### **1.3 Implementation of legal acts**

New Penal Code was approved by Riigikogu in June 2001 and entered into force on September 1, 2002. It replaced the Criminal Code and a part of the Administrative Code. The Administrative Code was repealed and its provisions were transferred into or replaced by other legal acts.

The Penal Code, which entered into force on September 1, 2002, stipulates that repeated use of illicit drugs or possession of a small amount of illicit drugs for personal use (except the use of drugs in prison and a house of detention) is decriminalized, i.e. excluded from the criminal law. Criminal punishments (fine, arrest or imprisonment) no longer exist in terms of drug offence, and the only sanctions available are either an administrative fine or an administrative arrest. The sanctions for drug offences provided in the Administrative Code were integrated into the Narcotic Drugs and Psychotropic Substances Act (NDPSA).

§53 of the new Penal Code contains a section providing that if a person has been convicted of a criminal offence and imposed imprisonment of more than three years the convicted offender may be imposed a supplementary punishment according to which the convicted offender has to pay an amount up to the extent of the total value of all his/her assets. This section is applicable, *inter alia*, in case of unlawful handling of large quantities of drugs (§184), and provision of premises for the purposes of unlawful activities, including consumption of narcotic drugs (§268), as well as in case of membership or recruitment of organized criminal groups (§255 and § 256).

Regulation of the Minister of Social Affairs No 20 of 18<sup>th</sup> March 1998 on Detoxification and Substitution Treatment of Drugs Addicts in Different Health Care Phases, which provided the procedure for methadone detoxification treatment and regulated long-term substitution treatment with medicaments that contain opiates, was repealed in 2002. The Ministry of Social Affairs acknowledged that the majority of the medical institutions were unable to meet the unrealistically high criteria set by the Ministry for the provision of substitution treatment. At present substitution treatment is not regulated.

#### **1.4. Developments in the attitude of the general public**

No data available.

#### **1.5 Budget and funding arrangements**

The Ministry of Social Affairs financed the Alcoholism and Drug Abuse Prevention Programme in 2001. The financial resources allocated for the Estonian Foundation for Prevention of Drug Addiction (EFPDA) within the annual budget of the ADAPP in 2001 were smaller compared to the resources of 2000. In 2000 the EFPDA was allocated EUR 399 719 compared to EUR 280 417 in 2001 (Ref. National Report on Drug Situation in Estonia 2001, Chapter 1.4). Table 1. Provides the use of the appropriations of the ADAPP allocated for the financial year 2001 by EUR.

**Table 1.** The use of the appropriations of the ADAPP allocated for the financial year 2001 by EUR.

	EUR
Prevention projects	99 359
Development projects of treatment and rehabilitation	91 026
Treatment and rehabilitation	50 000
Coordination of the Drug Information Centre	16 026
Organising of a drug conference	4 808
Drug prevention in prisons	12 788
First treatment database	6 410
	<b>280 417</b>

See also Chapter 14. Demand reduction expenditures in 1999.

**PART II****EPIDEMIOLOGICAL SITUATION****2.1 Main developments and emerging trends**

The preliminary data of next population survey and ESPAD will be available in 2004 (Chapter 2.2 of the National Report on Drug Situation in 2001).

To date only few studies on special risk groups have been conducted. A study “Ecstasy and Young People” (2001) carried out by the World Health Organization (WHO) involved the sample group of ecstasy users showed that ecstasy users were mostly students and schoolchildren living with their parents<sup>1</sup>. According to the study young people start to use ecstasy at an early age and consume it mainly at the weekends. During the last 3 months about one sixth of the sample group used ecstasy once a week; about one third of the sample group 2-3 times a month. The results of the study revealed that young people who used ecstasy were most likely polydrug users – they used various drug combinations including some of the following substances: alcohol, cannabis, amphetamine, GHB, cocaine and ketamine. An important finding was that half of the respondents in the sample group fulfilled the criteria of dependency, but their access to information, counselling and other measures, such as counselling and treatment was very limited. The results of the study showed that those young people were exposed to a lot of harm due to their (poly)drug use. The high dependence rate suggests that there is an urgent need for setting up a service system (treatment, counselling etc) for synthetic drug users (Talu, 2001).

There is a clear indication that synthetic drugs will become a problem in younger age groups (See also Chapter 2.2 Report 2001), thus, appropriate prevention measures have to be taken immediately to respond to the problem. At the moment specific prevention or intervention programmes targeted at young people using drugs in recreational settings are not available (Sub-chapter 10.1).

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<sup>1</sup> A study, “Ecstasy and Young People” was conducted within the framework of WHO Global Research Programme on Amphetamine Type Stimulants (ATS) in 2001 to examine Ecstasy use among young people aged 16-25. Total sample size was 100.

A study “Children and Adolescents Involved in Drug Use and Trafficking: A Rapid Assessment” (Kalikova, Kurbatova, Talu 2002) revealed that the majority of interviewed children who were involved in drug trafficking were drug users themselves experimenting with the substances they were selling. A high proportion of the sample group contributed to school dropouts. Though some of them lived on the streets, most of them have permanent places of residence and live with one or both parents. The families’ financial status varied from wealthy to very poor, which, on the basis of this study, allows for the statement that the family’s financial situation does not substantially influence child’s involvement in drug trafficking and prostitution in the targeted communities.

This study shows that children tend to start trafficking at the same time they start using drugs, between the ages of 13 and 16. Once the child or adolescent gets involved in drug distribution or prostitution, s/he may stay connected until s/he reaches adulthood and beyond.

The most widespread reasons for children getting involved in drug trafficking are the influence of close friend and peers who are already involved, the desire to become rich, the lack of other income and the need for free drugs.

### 3. Health Consequences

#### 3.1 Drug treatment demand

In Estonia drug addiction is treated on a voluntary basis pursuant to the procedure prescribed in the Mental Health Act (1997).

Only few methods of treatment for drug addicts are available: detoxification with methadone, drug-free therapy, counselling and support. According to the treatment demand data collected by the Estonian Foundation for Prevention of Drug Addiction (EFPDA) short-term detoxification with methadone is still the most widely used treatment method: more than 80 % of the patients have been provided with access to detoxification. Availability of treatment – out-patient as well as in-patient treatment facilities – has not been assessed by scientific methods, but the problem is obvious. According to the estimation of medical doctors and the treatment demand indicator a considerable number of drug addicts are seeking treatment for their drug use. The role of general practitioners (GPs) is insignificant. The role of NGOs and low-threshold services in the treatment and rehabilitation system of drug addicts is crucial (Drug Situation in Estonia 2001, 2002).

According to the data of the Database of First Treatment Demand, the number of persons who have sought treatment for their drug problems has grown very rapidly over the past years<sup>2</sup>. In 1999 812 and in 2000 1431 persons were seeking drug treatment, while in 2001 the number of persons seeking treatment was already 2034. The rate of new cases among total number of drug addicts seeking treatment shows a growing tendency and was very high already in 2001 (59%). The use of injected heroine or home-made poppy products is the biggest problem among Russian-speaking population. The majority of clients who applied for treatment for their drug problems in 2000 were from Tallinn (54.4 %), followed by Narva (29.3 %) and Kohtla-Järve (9.7 %). The situation changed slightly by 2001, when the share of treated persons increased to a certain extent in Tallinn (to 57.7 %) and fell in Narva (18.3 %) and Kohtla –Järve (7.8 %).

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<sup>2</sup> Data on Treatment Demand in Estonia, collected by the Estonia Foundation for Prevention of Drug Addiction, cover only special treatment facilities, and do not cover GP's. TDD collection was supported from ADAPP budget in 2001.

Socio-demographic characteristics of the clients reveal that most of the treated drug users are relatively young, a considerable proportion of them are 15 to 24 years old. It is remarkable that in 2000 less than half of the treated drug users were 20-24 years old (37.1 %), followed by 15-19-year old young people (35.7%). By 2001 the share of 20–24-year old adolescents had increased (39%) and the share of 15–19-year olds had decreased a little (32%). In 2001, similarly to the previous year, mostly the Russian-speaking population applied for treatment (80% in 1999, 83% in 2000; 82% in 2001). Only a small proportion of treated persons were Estonians. The share of non-citizen clients decreased from 28.3% in 1999 to 19.3% in 2000 and increased again to 26% in 2001. The unemployment rate among the clients was highest in 1999 (53.7%), it fell slightly in 2000 (50.8%) and increased a little again in 2001 (51.7%).

Opiates are the illegal substances still most commonly used among persons seeking treatment. Increasing treatment demand of opiate users and long waiting-lists indicate that there is an urgent need for the development and modification of the current treatment system and establishment of an effective rehabilitation system. The share of patients seeking treatment for stimulants use decreased from 11.8% in 1999 to 6.8% in 2000 and increased substantially to 18.4 % in 2001. Other indicators (drug-related crime, data on seizures, results of studies) confirm the hypothesis that stimulants, particularly amphetamines, are a growing problem in Estonia and the share of patients seeking treatment for their stimulants use will increase rapidly in the nearest future. An appropriate treatment system has to be set up to respond to such need. Within the next years quality assessment of treatment services for drug users must become an inseparable part of treatment management in order to improve the planning and to expand the methods of treatment and provide opiate and other drug users in particular with better services.

The share of clients having used the same syringe over the last month increased from 7.9% in 1999 to 22.4% in 2000 and was the highest in 2001 (26.5 %). High proportion of current injecting drug-users (78.6 % in 1999; 84.4 % in 2000; 83.8 % in 2001) suggests that more attention has to be paid to the implementation of appropriate harm reduction measures. Support to and development of present low-threshold and rehabilitation service providers should be a priority. Revision and assessment of the treatment system must be carried out.

Assessment of the provision of drug treatment services is a prerequisite for the introduction of changes in the treatment system.



**Table 2.** Characteristics of treated clients 1999- 2001.

Characteristics	1999 (%)	2000 (%)	2001 (%)
<b>Nationality</b>			
Russians	80.3	82.6	81.6
Estonians	13.8	11.3	12
Russians (male clients)	80	83	82
Russians (female clients)	81.9	79.3	79.6
<b>Treated clients by citizenship</b>			
Estonian citizens	35	39.4	40.7
Russian citizens	6	8.7	9.2
Clients without citizenship	19.3	28.3	26
<b>Age</b>			
15- 19 years old	30	35.7	32
20- 24 years old	39	37.1	39
<b>Treated clients by place of residence</b>			
Clients from Tallinn	63.5	54.4	57.7
Clients from Narva	7.1	20.3	18.4
Clients from Kohtla – Järve	12.8	9.7	7.8
<b>Labour status</b>			
Unemployed	53.7	50.8	51.7
Regular employment	20.9	24.2	28.8
<b>Drug-related information</b>			
Heroin as the primary drug (incl. home-made poppy products, morphine, unspecified opioids)	53.8	69.9	53.8
Stimulants as primary drugs	11.8	6.8	18.6
Previously treated	39.2	42.2	48.5
Use of the same syringe last month	7.9	22.4	26.5
Current injecting	78.6	84.4	83.8
Lifetime injecting	57.1	53.8	53.8

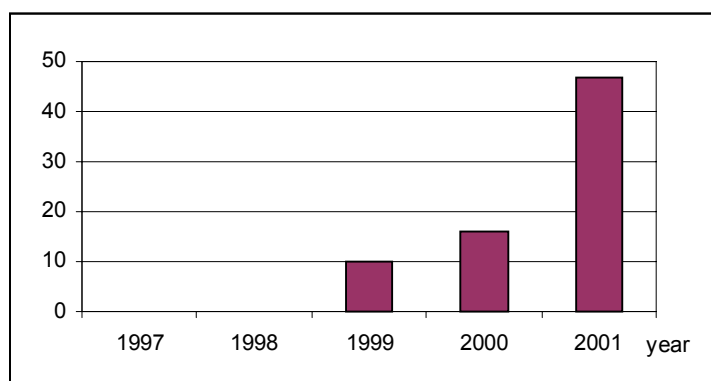
Source: Database of First Treatment Demand 1990- 2001

### 3.2 Drug-related mortality

Significant improvement of the quality of data denotes the most important development of this field in 2001. The share of cases with known toxicology grew from 16% in 2000 to 47% in 2001. This is primarily the result of structural changes in the forensic system: the Bureau of Forensic Medicine became a government agency of the Ministry of Justice and an increased amount of funds were allocated for forensic investigations. On the other hand, the Statistical Office replaced the three-character ICD-10 codes used in 1997-2000 with four-character ICD-10 codes. Thus, two key institutions have improved their work in terms of statistics on drug-related deaths. However the quality of the data on drug – related death still depends on further improvements in forensic examination practice and notification procedure.

In 2001 the number of cases of drug-related deaths in combination with other factors decreased compared to the year 2000, e.g. in 2000 there were 13 cases in combination with F11 (Mental and behavioral disorders due to opioids use), 8 cases of accidental drug poisonings with unspecified narcotic drug (X42-T40); in 2001 only two cases of drug-related deaths in combination with F11 were registered, one of them accidental poisoning with opium (X42-T40). The combination of X42-T40 and F11 on a death certificate means suspected overdose, used in cases when it is not possible to carry out a toxicological test because of insufficient funds or for other reasons. Issuing of such certificates in a reduced number is a positive sign.

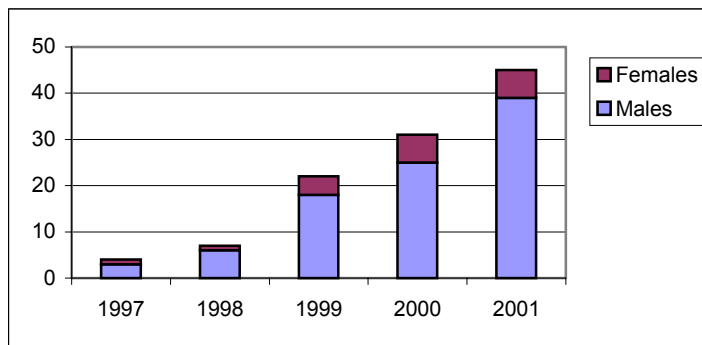
**Figure 2.** Number of direct drug-related deaths with known toxicology, 1997-2001.



Source: Estonian Statistical Office, 2002

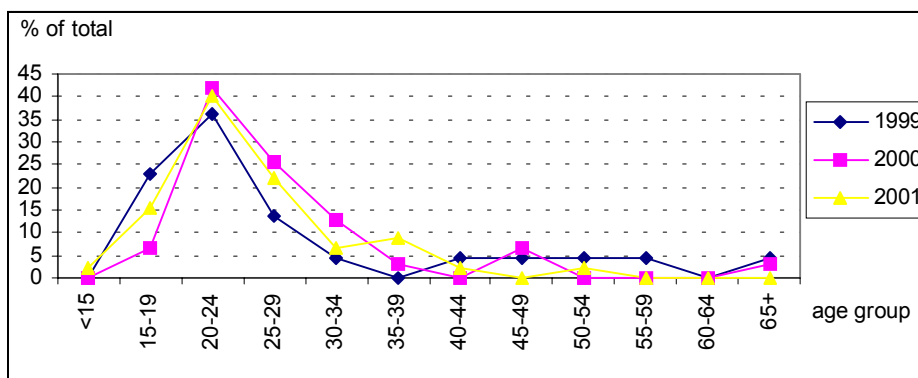
The number of direct drug-related deaths grew from 31 in 2000 to 45 in 2001, absolute numbers are rather insignificant, but the trend is disturbing (Figure 3). It is worth mentioning that the share of females has not changed, the growth has been achieved at the expense of males. The share of males has increased up to 87%. Age distribution of drug-related deaths has not changed much: most cases of death account for the age groups 15-34, the biggest amount of cases contribute to the age group 20-24 (Figure 4).

**Figure 3.** Number of direct drug-related deaths by gender, 1997-2001.



Source: Estonian Statistical Office, 2002

**Figure 4.** Proportion of drug-related deaths by age groups, 1999 – 2001.

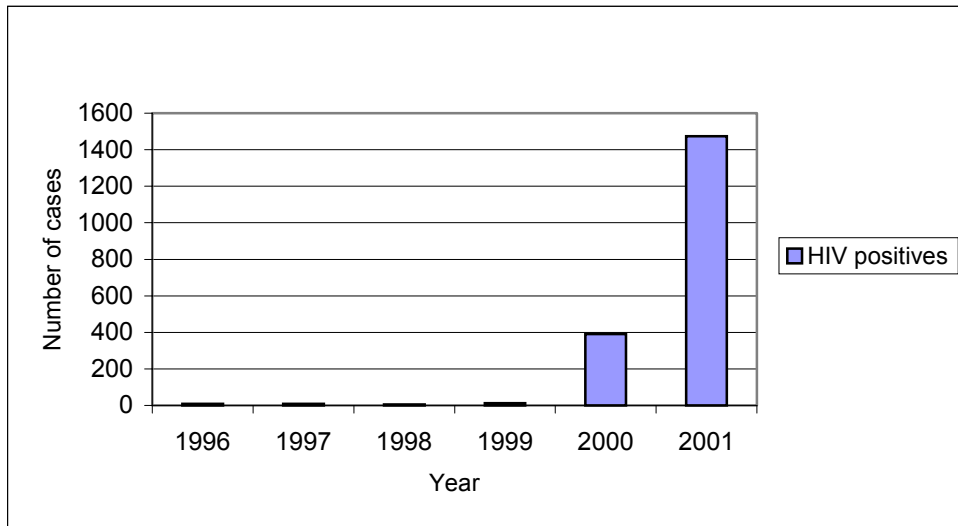


Source: Estonian Statistical Office, 2002

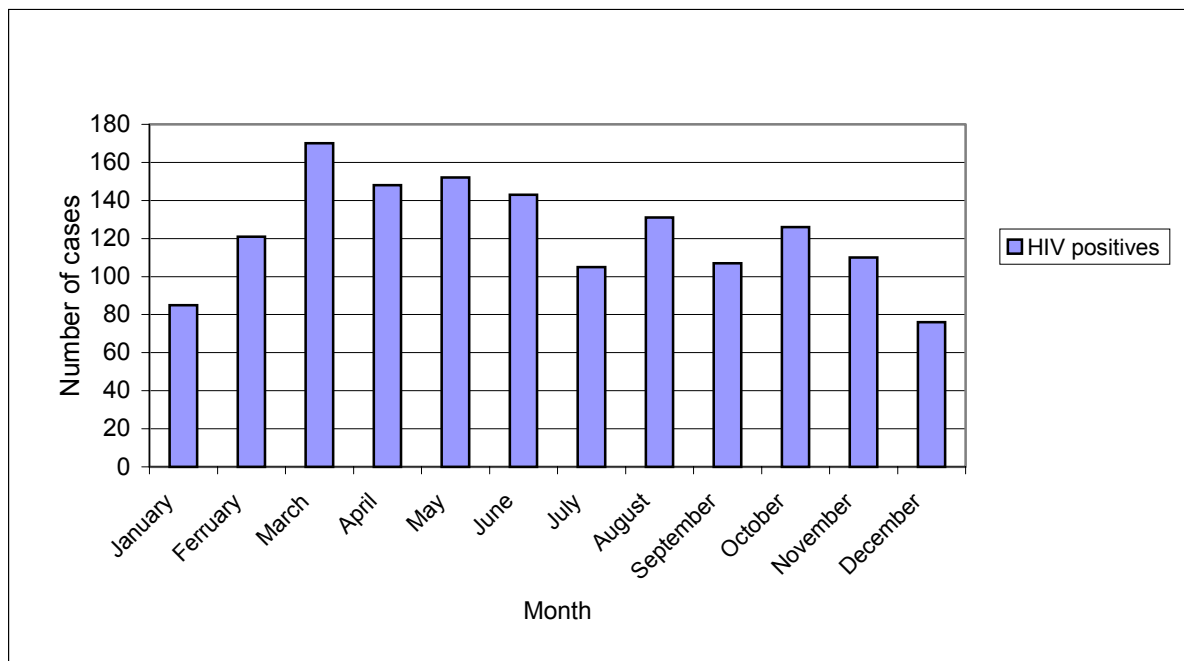
### 3.3 Drug-related infectious diseases

Drug-related infectious diseases have transmitted very rapidly over the last years in Estonia. The population of Estonia was shocked when 390 new HIV positive cases were reported in 2000. Due to the rapid growth of HIV incidence the Estonian Ministry of Social Affairs classified the situation as concentrated HIV/AIDS epidemic according to the UNAIDS/ WHO classification in February 2001. In 2001 the number of HIV cases increased further, the data of the Health Protection Inspectorate was complemented by 1474 newly diagnosed HIV cases (Figure 5), of which 382 were detainees. The incidence rate of *newly diagnosed HIV infections* was 107,8 cases per 100,000 of the population. The number of male and female people living with HIV/AIDS (PLWHA) was 1132 and 342, respectively. 2 cases of AIDS (both male) were registered in 2001. As at December 31, 2001 there were 1898 newly diagnosed HIV infections in Estonia altogether, 7 AIDS cases included. The distribution of newly diagnosed HIV infections by months is shown in Figure 6. The most critical areas in Estonia were Tallinn (528 cases), Narva (409 cases) and Ida-Virumaa county (454 cases). Table 3 gives the breakdown of HIV infections by age groups in 2001.

No baseline studies or surveys on HIV prevalence have been carried out. In 2001 in total 4892 persons have been tested in anonymous cabinets. The number of tested drug addicts in anonymous cabinets was 1022. Incidence rate of HIV-positive among tested drug addicts was 41% (423/1022). Incidence rate of drug addicts among HIV positives was 91% (423/465).

**Figure 5.** Number of newly diagnosed HIV infections in 1996-2001.

Source: Health Protection Inspectorate, 2002

**Figure 6.** Number of newly diagnosed HIV infections by month in 2001.

Source: Health Protection Inspectorate, 2002

**Table 3.** Number of newly diagnosed HIV infections by age group and gender in 2001.

Age	Men	Women
0	0	3
10-14	24	7
15-19	351	177
20-24	474	119
25-29	176	22
30-34	55	9
35-39	24	6
40-44	14	4
45-49	2	0
50-54	2	0
Unspecified quantity	5	0
All	1127	374

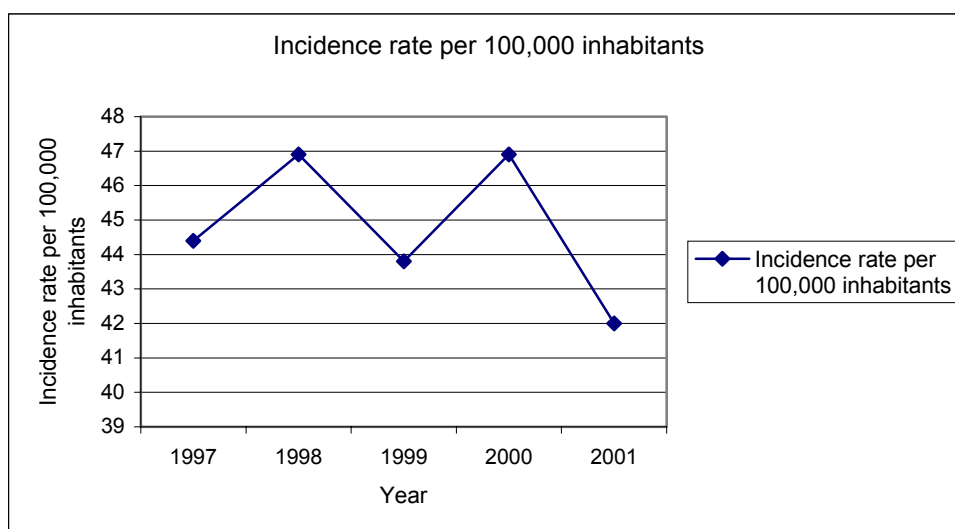
*Source: Health Protection Inspectorate, 2002*

The rate of hepatitis B has also increased over the reporting period. 449 cases of hepatitis B were registered in 2001. The estimated incidence rate of hepatitis B was 32,8 cases per 100,000 inhabitants. The number of males and females infected with hepatitis B was 306 and 143, respectively.

The risk factors of hepatitis B infection were identified by means of questioning 300 infected people. The following risk factors were specified: intravenous use of drugs with needle sharing (257 answers), sexual intercourse (23 answers), medical procedures (13 answers), blood transfer (4 answers) and tattooing (3 answers). 3,777 infected persons were hospitalised, 27,528 people were vaccinated (25,628 children, 102 youngsters, 1,798 adults) in 2001.

The prevalence of hepatitis C infection has shown a decreasing tendency, 350 cases of hepatitis C infection were reported in 2000 and 306 cases in 2001. The estimated incidence rate of hepatitis C infection was 22,5 cases per 100,000 inhabitants. The number of males and females infected with the hepatitis C virus was 220 and 86, respectively. The following risk factors of hepatitis C infection have been identified: needle sharing, sexual intercourse and tattooing. 203 infected persons needed hospitalisation.

With regard to tuberculosis the situation became worse in 1993 when morbidity increased by 32% compared to 1992. In 1994 the increase continued, 34,3 new cases of tuberculosis per 100,000 inhabitants were diagnosed. In 1995 the situation stabilised to some extent, the estimated rate of morbidity being 34,4/100,000. At the same time, incidence of tuberculosis among children and juveniles increased. In 1992 and 1993 4 children fell ill with tuberculosis, in 1994 9 children and in 1995 the respective number was already 18. Tuberculosis infection in Estonia is often characterized by secretion of tuberculosis generators and the occurrence of caverns in lungs, 75% and 66% of new cases respectively. Figure 7 demonstrates the incidence rate of active tuberculosis per 100,000 inhabitants over the past years.

**Figure 7.** Incidence rate of tuberculosis per 100,000 inhabitants in 1997-2001.

Source: *Estonian Statistical Yearbook 2001*

Rise in morbidity and deteriorating epidemiological situation are closely related to socio-economic changes in the society. As a result of the implementation of health care reforms and rearrangement of the inpatient and outpatient treatment system, people with low incomes and without insurance have been deprived of the possibility of getting treatment in inpatient institutions. Also, the current number of beds does not enable to arrange rehabilitation of patients. Thus, a certain social group in the community is deprived of social benefits and will not be admitted to treatment in hospitals (care homes), the more so, an appropriate law providing mandatory hospitalisation and treatment of persons with infectious diseases being dangerous to the rest of the community, does not exist (Programme on Tuberculosis Treatment in Estonia 1998-2003).

As to the relationship between tuberculosis and the drug problem, only data on patients infected with HIV and tuberculosis are available. HIV infection is one of the most important TB risk factors in the world. Currently higher morbidity of TB among HIV positives has not been observed in Estonia. As a result of the increase in the number of persons with tuberculosis infection in the last years we can expect an increase of TB infected people among HIV positives. Total of 17 such cases have been recorded in the TB registry (30.04.2002).



HIV infected males accounted for 15 cases of tuberculosis and HIV infected females for 2 cases of tuberculosis in the age group of 18-55. The mean age of the patients was 32,5 years.

1997 - 1 case

1999 - 1 case

2000 -1 case

2001 - 7 cases

2002 (I quarter) - 7 cases.

Distribution of reported HIV/TB cases by place of residence: Tallinn 5, Harjumaa 2, Ida-Virumaa 5 and Central Prison Hospital 5 cases.

At the moment 8 patients are under treatment, 2 have deceased, 3 terminated their treatment on their own will (Tuberculosis incidence in Estonia, 2000).

### 3.4 Other drug-related morbidity

The Medical Statistics Bureau (MSB) of the Ministry of Social Affairs is responsible for the collection of the data on mental and behavioural disorders (MBD) caused by psychoactive substances<sup>3</sup>. In general, the rate of MBDs caused by the use of psychoactive substances has fallen slightly compared with the previous year, but the number has increased 1.56 times compared with the situation in 1995 (Table 4).

**Table 4.** Number of mental and behavioural disorders caused by the use of psychoactive substances in 1995 – 2001.

Substance / ICD-10	1995	1996	1997	1998	1999	2000	2001
Alcohol (F 10.X)	8219	8974	9524	9524	9325	9920	10533
Opiates (F 11.X)	264	542	769	878	1804	3149	2421
Cannabis (F 12.X)	10	27	21	23	30	74	45
Tranquillizers (F 13.X)	64	64	114	80	57	146	68
Cocaine (F 14.X)	-	-	13	23	23	26	19
Other stimulants (F 15.X)	5	12	44	93	152	151	162
Hallucinogens (F 16.X)	1	2	2	13	7	44	4
Tobacco (F 16.X)	11	18	16	59	20	32	28
Solvents (F 18.X)	15	44	35	25	64	42	28
Other (F 19.X)	7	64	61	57	66	138	116
Total (F 10.X-F 19.X)	8596	9747	10599	10775	11548	13 722	13424

Source: Medical Statistics Bureau 1994 – 2001

- F 10.X Mental and behavioural disorders caused by the use of alcohol.
- F 11.X Mental and behavioural disorders caused by the use of opiate.
- F 12.X Mental and behavioural disorders caused by the use of cannabis.
- F 13.X Mental and behavioural disorders caused by the use of tranquilizer.
- F 14.X Mental and behavioural disorders caused by the use of cocaine.
- F 15.X Mental and behavioural disorders caused by the use of other stimulants.
- F 16.X Mental and behavioural disorders caused by the use of hallucinogens.
- F 17.X Mental and behavioural disorders caused by the use of tobacco.
- F 18.X Mental and behavioural disorders caused by the use of solvents.
- F 19.X Mental and behavioural disorders caused by multiple use of psychoactive substances.

<sup>3</sup> The statistical data on mental and behavioural disorders (MBD) as a result of drug use is aggregated data collected by the Medical Statistics Bureau (MSB) on the basis of ICD-10 about outpatient clients and clients under psychiatric care (codes F11–16 and F18–19) separately by the clinical status. Double counting might be quite frequent, depending on the number of visits of the same client to different psychiatrists and the number of consultations.

The number of registered mental and behavioural disorders caused by the use of opiates (F 11.X), cannabis (F 12.X), tranquilliser (F 13.X), cocaine (F 14.X), hallucinogens (F 16.X), solvents (F 18.X) has decreased compared with the previous year. At the same time the, the total number of cases of MBDs due to other stimulants (F 15.X) has increased. Comparing the year 1995 with the year 2001, a considerable increase in the cases of MBD can be observed due to the use of other stimulants and multiple use of psychoactive substances – 32,4 and 18,9 times, respectively.

The majority of the cases of MBDs caused by the use of psychoactive substances were diagnosed as an addiction or misuse (See table 5). 65.7% of the cases of MBD caused by opiate use, 45.1% of cases of MBD caused by stimulants use, and 86.8% of the cases of MBD caused by tranquilliser use were diagnosed as an addiction. The proportion of MBD due to the use of stimulants has increased very rapidly over the last years, most likely because of the growing popularity of the use of stimulants in recreational settings (See also Chapter 2.1).

**Table 5.** Number of mental and behavioural disorders caused by the use of psychoactive substances in 2001.

ICD-10	Intoxication	Misuse	Addiction	Condition of estrangement	Delirium of estrangement	Other psychosis	Other Permanent interference	<b>Total</b>
F 10.X	131	1218	4883	2857	433	620	391	<b>10533</b>
F 11.X	9	36	1590	780	2	2	2	<b>2421</b>
F 12.X	1	28	10	1		5		<b>45</b>
F 13.X		4	59	5				<b>68</b>
F 14.X		11	8					<b>19</b>
F 15.X	9	37	73	23	1	12	7	<b>162</b>
F 16.X	1		2			1		<b>4</b>
F 18.X	4	8	8	1			7	<b>28</b>
F 19.X	12	50	38	2	5	7	2	<b>116</b>
<b>Total</b>	<b>167</b>	<b>1392</b>	<b>6698</b>	<b>3670</b>	<b>441</b>	<b>647</b>	<b>409</b>	<b>13424</b>

Source: Medical Statistics Bureau 2002

#### **4. Social and legal implications and consequences**

##### **Social background**

According to the censuses the population size decreased by 12.5 % within the period of 1989 to 2000. As at January 1, 2002 the population size of Estonia was 1,361,242. At the beginning of 2002, the estimated population size in Tallinn, the capital of Estonia was 398,434 and 177,471 in Ida – Virumaa county (incl. Narva and Kohtla–Järve) (Estonian Statistical Office 2002).

The birth rate has sharply decreased over the past decade. Since 1991, the rate of mortality has been higher than the rate of birth; consequently, the size of population has decreased due to negative natural population growth by approximately 54,000 people, i.e. 3.4 %. In 2001 the rate of birth was 1,34, which was less than the average in Europe (WHO, 2001). The birth rate has shown a slight decrease compared to the previous year (9,3 births per 1,000 inhabitants in 2001). Total of 12,629 children were born in 2001, which was 439 children less than a year earlier. 18,516 deaths were registered in Estonia in 2001.

The share of illegitimate births has been continuously increasing. In 2001 56.2% of children were born outside marriage, which is 1.7% more than in 2000, being a reflection of the situation where cohabitation is preferred to marriage (The Statistical Yearbook of Estonia, 2002). 5,647 marriages and 4,312 divorces were registered in Estonia in 2001.

Due to a small number of births and the age structure of the population having developed over the previous years, the proportion of young people has decreased and the share of old people among the population has increased. At the beginning of 2002, 18.7% of the population was less than 16 years and 15.5% were over 64 years old. In 2001 these indicators were 19.3% and 15.2%, respectively. According to the data of the population censuses in 1989 and 2000 the ethnic composition has not changed significantly. In the year 2000 6790 Estonians were registered per 10,000 inhabitants, followed by 2,564 Russians per 10,000 inhabitants, 212 Ukrainians per 10,000 inhabitants and 126 Belarussians per 10,000 inhabitants (Yearbook of Estonian Statistical Office, 2002).

#### 4.1 Social problems

Social problems in Estonia have not changed over the reporting period (see previous report 2001, chapter 4.1). However, the employment situation shows some signs of improvement. The falling trend in the number of the labour force, characteristic of the nineties, stopped in 2000. When compared with 1999, the number of labour force (sum of the employed and unemployed) increased slightly. The unemployment rate started to increase at the end of 1998 due to the economic crisis in Russia and reached its peak (13,5%) in 2000. In 2001 the unemployment rate decreased to 12,6%, which is the most significant decline in unemployment since Estonia regained independence (Estonian Statistical Yearbook, 2002). The rate of unemployment varies from region to region; the most problematic region is still North-Eastern Estonia, where the unemployment rate is 18%.

According to the data of the Estonian Statistical Office, the unemployment rate among young people, aged 15 – 24, has increased most over the last years and reached 23.8% in 2000. The employment rate of the young population fell to 22.2% in 2001. The reason for the high unemployment rate of the young is connected with education. The current education system does not meet the demands of the labour market, the vocational and higher education reform has not given remarkable results yet (Statistical Yearbook of Estonia, 2002).

The share of the Estonian population having obtained formal education is notably high. In all age groups of the working population the proportion of persons having obtained only primary or basic education is more than two times lower than the average level of the European Union. The prospects of people with primary or basic education for finding employment do not differ much by ethnic groups. However, the youngest age group (15-24) is clearly in the least favourable situation. The rate of dropout from basic schools is currently quite high: during the school year 1998/99 nearly 1400 young persons terminated their studies at basic school (Annus et al. 2000).

Since the figure has remained stable, at around 1300- 1400 over the last five years, it has in fact a cumulative impact, i.e. each year the number of young people without basic education increases by more than 1000. Until recently, basic school dropouts

had no place in the education system. They could not get even minimum vocational training, because the previous Vocational Educational Institutions Act restricted access of persons without basic or even secondary education to such schools. On June 13, 2001, the Riigikogu adopted an amendment to the law, providing young people, up to 25 years of age, not having obtained basic education, with access to preliminary vocational training. Such young people can now acquire basic education in parallel with vocational education. Since 2001 180 young people without basic education have been provided with an opportunity to obtain preliminary vocational training, but this is probably not enough since the age group of 17-25 currently includes more than 20,000 young people without basic education. At the same time, it is not certain whether this would solve the employment problem, as the young people with lower educational level have increasing difficulties in breaking out of the vicious circle – as the educational level of those of the same age is improving, which means that the young population with lower educational level will still experience problems with entering the labour market or pursuing their education.

The most problematic area in Estonia is still Narva, which is the fourth largest Estonian city. As of May 2000 the population of Narva was 71,370, Estonians account for 4% of the population of Narva. The most important areas of activity have traditionally been associated with industry. In the last years several large enterprises have been totally or partially shut down. Inhabitants of Narva are of the opinion that unemployment and poverty are mostly caused by worker layoffs and low salaries, rather than shutting down local enterprises.

The language spoken in the named region is mostly Russian; it is also spoken well by the Estonians living there. Russian-speaking residents of Narva, however, have rather poor Estonian language skills. Compared with non-ethnic Estonians residing in Tallinn, the Estonian language skills of those living in Narva are much worse. While nearly half of the Russian-speaking inhabitants of Tallinn are of the opinion that they are able to communicate in Estonian at a good or average level and only 16% cannot communicate in Estonian at all. In Narva and Sillamäe 66% of the adults are not able to communicate in Estonian and only 13% claim that they speak good or average Estonian (Proos 2000: 37).

In general, the economic situation in Ida-Virumaa is very difficult, both subjective evaluations and objective indicators give evidence of poverty. In 2000 the average net income per family member in Estonia was 2,183 kroons (EUR 139.9). While in Tallinn, for example, the average income per family member was 2,744 kroons (EUR 175.9) and 2,860 kroons (EUR 183.3) in Harju county, in Ida-Viru county it was only 1,630 kroons (EUR 104.5). Accordingly, the average income in Ida-Viru county accounted for 75% of the average income per family member in Estonia, which is a little less than in the previous year (Estonian Human Development Report 2001).



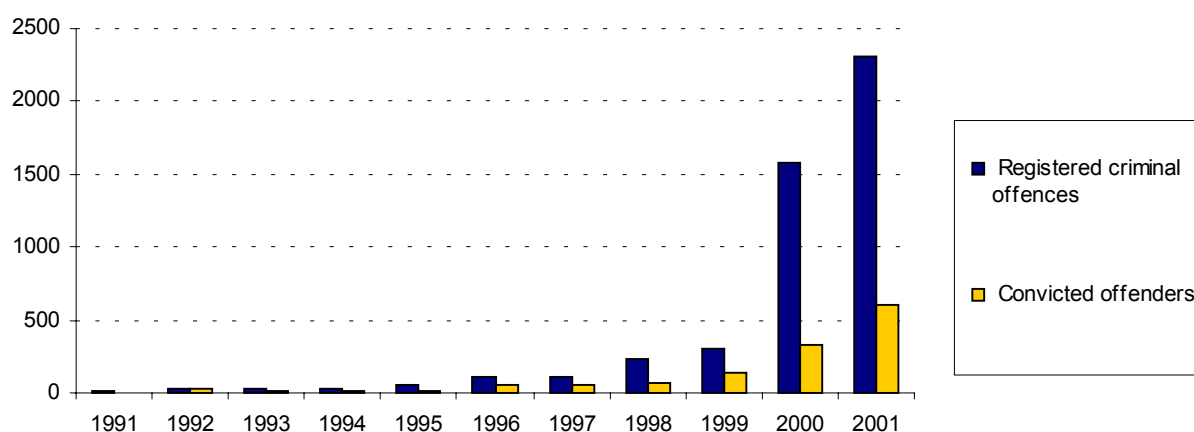
## 4.2 Drug -related crimes

Over the last few years, the number of registered drug offences (both criminal and administrative offences) has increased rapidly. The number of criminal offences (multiple drug abuse, drug possession with intent to supply, drug trafficking, etc.) registered by the police increased from 297 in 1999 to 2301 in 2001 (Figure 8). The number of detected administrative offences (illegal possession of small quantities of narcotic drugs or unauthorized use of narcotic drugs – first offence only) increased from 468 in 1999 to 3157 in 2001. The share of drug-related criminal offences of the total of police registered criminal offences increased from 0.6% in 1999 to 3,9% in 2001.

During the year 2001, total of 5458 drug offences (criminal as well as administrative offences) were registered that exceeded more than seven times the respective figure in 1999 (765 offences). About 57% of all drug offences were registered in Tallinn and 27% in Ida-Viru county (including Narva). Significant increase in the number of drug offences reflects to a certain degree an increased capability of the police in tackling drug crime. However, the actual drug use and drug trafficking have also increased substantially.

Combating drug offences, especially drug trafficking, has been one of the priority tasks of the police since 2000. Specialized drug divisions have been established in all police prefectures and the number of full-time drug officers has been increased. Since 2000, training for more than 800 police officers has been carried out. Their improved knowledge on drugs has been one of the essential factors that has resulted in an increase in the number of detected drug offences. The increase has been most significant in Tallinn, Narva and Ida-Viru Police Prefectures, especially with regard to offences related to illegal possession of small quantities of narcotic drugs or unauthorized use of narcotic drugs – including both administrative and criminal offences (Administrative Code §158 and Criminal Code §202<sup>5</sup>). Registration of such offences has also increased in the majority of other regions, particularly in Tartu, Harju, Viljandi, Pärnu and Lääne-Viru Police Prefectures.

**Figure 8.** Police registered drug-related criminal offences and convicted offenders, 1991-2001.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Registered criminal offences	20	24	27	33	51	115	114	235	297	1581	2301
Convicted drug offenders <sup>4</sup>	4	23	7	10	15	59	54	65	144	324	606

Sources: Police Board (data on registered crime offences), Ministry of Justice (data on convicted drug offenders) 2002

**Table 6.** Police registered drug-related administrative offences\*, 1997-2001.

	1997	1998	1999	2000	2001
Registered administrative offences <sup>5</sup>	191	382	468	2305	3157

Source: Police Board 2002

In 2001, drug-related criminal offences associated with the use or possession of narcotic drugs without the intent of trafficking (Criminal Code §202<sup>5</sup> and §210<sup>1</sup>) accounted for about 71% of all police registered drug crimes (Table 9). Possession

<sup>4</sup> Unlawful acquisition or storage of small quantities of narcotic drugs or psychotropic substances, or use of narcotic drugs or psychotropic substances without doctor's recommendation (first offence; second similar offence during the last 12 months is punishable according to the Criminal Code § 2025)

with intent to supply and drug-trafficking offences (Criminal Code §210<sup>2</sup>) accounted for 27% of registered drug-related criminal offences.

**Table 7.** Police registered drug-related criminal offences by types of offences, 2000-2001.

Criminal Code paragraph	2000	2001
§ 202 <sup>2</sup> . Inducing minors to use narcotic drugs or psychotropic substances	7	14
§ 202 <sup>3</sup> . Inducing a person to use narcotic drugs or psychotropic substances	1	5
§ 202 <sup>5</sup> . Unlawful acquisition or storage of [small quantities]* of narcotic drugs or psychotropic substances, or use of narcotic drugs or psychotropic substances without doctor's recommendation (first offence; second similar offence during the last 12 months is punishable according to the Criminal Code § 202 <sup>5</sup> ).	1096	1556
§ 209 <sup>2</sup> . Violation of requirements for manufacture, production, acquisition, storage, recording, issue, transport or delivery of narcotic drugs or psychotropic substances	1	1
§ 210 <sup>1</sup> . Illegal manufacture, [acquisition, storage,]* [reprocessing,]** transport or delivery of narcotic drugs or psychotropic substances without intent of trafficking	161	72
§ 210 <sup>2</sup> . Illegal manufacture, [reprocessing,]** acquisition, storage, transport, [or]** delivery [or trafficking]* of narcotic drugs or psychotropic substances [with intent of trafficking]**	306	628
§ 210 <sup>3</sup> . Theft or robbery of narcotic drugs or psychotropic substances	2	2
§ 210 <sup>4</sup> . Illegal sowing or growing of opium poppy, cannabis [or coca**]	7	22
TOTAL	1581	2301

\* Was in force until 10.03.2001

\*\* Entered into force 10.03.2001

\*\*\* Entered into force 17.04.2000

Source: Police Board 2002

#### 4.2.1 Characteristics of drug offenders

The number of men charged for drug-related criminal offences increased from 157 in 1999 to 863 in 2001, and the number of females from 37 in 1999 to 156 in 2001. In 2001, total of 1019 persons were charged for drug-related criminal offences, and the share of females contributed to 15%. Data on gender of the persons arrested for administrative offences are not available.

In 2001, there were 184 (18%) Estonians and 835 non-Estonians (82%) among the drug offenders charged for criminal offences. The share of Estonians of all offenders has declined after 1997 (39%). In 2001, 513 (50%) drug offenders did not have permanent citizenship, 424 (42%) were Estonian citizens, 72 (7%) Russian citizens, 4 Ukrainian citizens, 2 persons from other CIS countries, 2 Lithuanian citizens, and 1 Finnish citizen. During the last years the total number of drug offenders has substantially increased in all main population groups (Estonians and non-Estonians; Estonian citizens, persons without citizenship and foreign citizens).

**Table 8.** Number of definitively sentenced persons by types of drug crimes, 2000-2001.

Criminal Code paragraph*	2000	2001
§ 202 <sup>2</sup> . Inducing minors to use narcotic drugs or psychotropic substances	0	0
§ 202 <sup>3</sup> . Inducing a person to use narcotic drugs or psychotropic substances	2	2
§ 202 <sup>5</sup> . Unlawful acquisition or storage of [small quantities]* of narcotic drugs or psychotropic substances, or use of narcotic drugs or psychotropic substances without doctor's recommendation	203	370
§ 209 <sup>2</sup> . Violation of requirements for manufacture, production, acquisition, storage, recording, issue, transport or delivery of narcotic drugs or psychotropic substances	0	1
§ 210 <sup>1</sup> . Illegal manufacture, [acquisition, storage,]* [reprocessing,]** transport or delivery of narcotic drugs or psychotropic substances without intent of trafficking	50	49
§ 210 <sup>2</sup> . Illegal manufacture, [reprocessing,]** acquisition, storage, transport, [or]** delivery [or trafficking]* of narcotic drugs or psychotropic substances [with intent of trafficking]**	65	183
§ 210 <sup>3</sup> . Theft or robbery of narcotic drugs or psychotropic substances	0	0
§ 210 <sup>4</sup> . Illegal sowing or growing of opium poppy, cannabis [or coca**]	4	3
TOTAL	324	608

\* Was in force until 10.03.2001

\*\* Entered into force 10.03.2001

\*\*\* Entered into force 17.04.2000

Source: Ministry of Justice 2002

#### 4.2.2 Drug trafficking

Drug trafficking through and from Estonia has increased since the late 1990-ies. Smuggling of heroin and synthetic drugs has increased most significantly. Local production of cannabis herb (marijuana) has also increased in recent years. The majority of locally produced illicit synthetic drugs are targeted at Nordic countries. At the same time, smuggling of cannabis resin (hashish) through Estonia has decreased, as Estonia is not situated at the main smuggling routes.

The main routes of illicit trafficking of drugs through or from Estonia in the recent years have been the following:

- opium (raw and prepared) from Central Asia via Russia or Latvia and Estonia to Finland and other Nordic countries;
- heroin from Central Asia via Russia and Estonia to Finland and other Nordic countries;
- amphetamine and methamphetamine from Poland via Latvia and Estonia to Finland and other Nordic countries;
- ecstasy from the Netherlands and Belgium via Estonia to Nordic countries and Russia, or from Estonia (local production) to Nordic countries and Russia;
- cocaine from South and Central America via Estonia to Russia or Nordic countries.

Estonian criminal groups have also participated in smuggling of marijuana and hashish from Spain via Western Europe to Nordic countries. A new route of smuggling drugs has appeared: there have been cases of smuggling raw opium from Central Asia and marijuana from Africa through Estonia to the United Kingdom.

#### **4.2.3 Drug-related crimes**

Drug abusers commit a significant proportion of thefts and robberies in order to get money for buying drugs. The statistics of Tallinn Police Prefecture show that about 25% of all cleared crimes in 2000 were committed by offenders who had been sentenced for at least one administrative drug offence (i.e. drug abuse or possession of a small amount of drug) in the past. According to some estimates the actual share of offences committed by drug abusers may even account for 40-50% of all thefts and robberies. The most common types of crimes committed by drug abusers are street crimes (thefts from cars, pick-pocketing, robberies) and shoplifting.

### **4.3 Social and economic costs of drug consumption**

Studies on social and economic costs of drug consumption have not been conducted in Estonia.

## **5. Drug market**

### **5.1 Availability and supply**

The most common drugs until 1997-1998 were home-made poppy products and cannabis (marihuana). Heroin appeared on the market at the end of 1997, and became quickly widespread. Simultaneously, the popularity of home-made poppy products has been declining since 1999. Supply (both import and local production) of amphetamine-type synthetic drugs has increased substantially since the late 1990s. Availability of GHB has increased since 2000.

In 2001, as a result of the decrease in heroin quality (purity) due to the situation in Afghanistan, the total amount of heroin smuggled into Estonia increased. At the same time, due to the difficulties in obtaining heroin and its poor quality (for example, portions of less than 10% of purity have been found), some heroin addicts have started to use home-made poppy products again.

The number of detected cannabis plants and the share of cannabis herb (marihuana) produced in local plantations increased substantially in 2001. 13 cannabis plantations were found in 9 counties out of 15. According to the police assessment, the major part of locally produced cannabis (marihuana) is consumed in Estonia. Amphetamine and ecstasy continued to gain popularity among drug abusers in 2001.

## 5.2 Seizures

According to the statistical data of the Estonian Forensic Service Centre, the number of drug seizures and quantity of seized drugs have increased since mid-1990s in terms of all major drug types - opiates, cannabis and amphetamine- type stimulants (see Table 9 and Figure 9). The most important seized drugs in 1997-2001 were opiates (home-made poppy products, heroin, methadone, morphine), followed by cannabis (mainly marihuana) and synthetic stimulant drugs (amphetamines, metaamphetamine, ecstasy group).

**Table 9.** Number of drug analyses carried out in the Estonian Forensic Service Centre, 1994-2000.

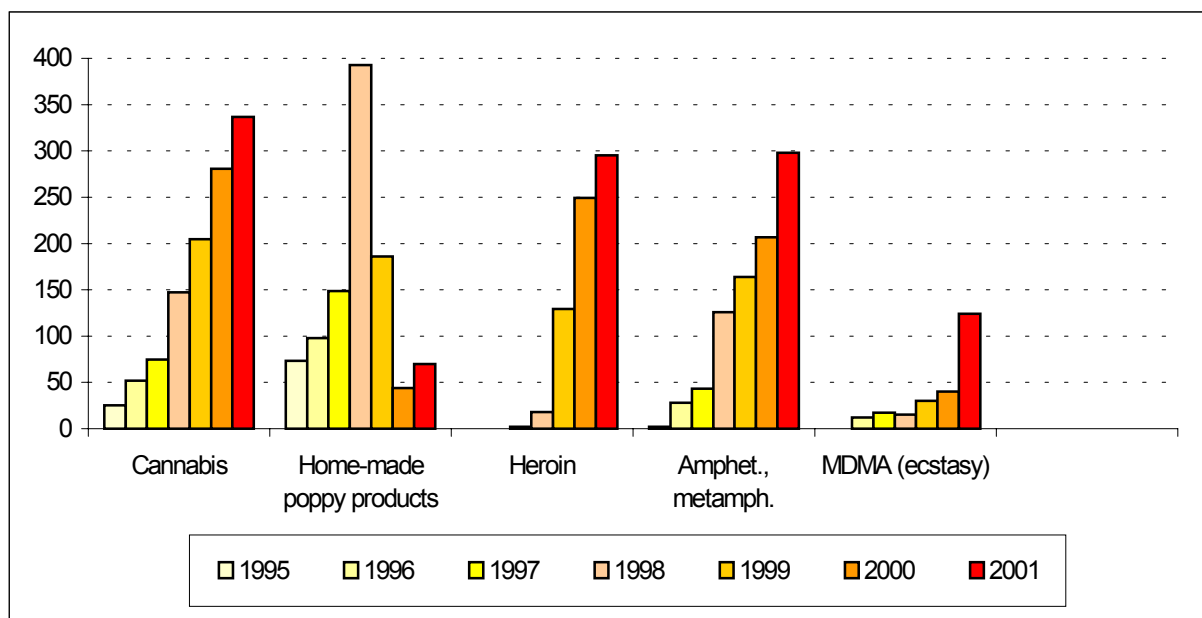
	1994	1995	1996	1997	1998	1999	2000	2001
TOTAL number of drug cases	75	148	248	346	605	677	983	1020
analyses with a positive result	75	113	209	275	538	565	741	807
<i>of which:</i>								
- Home-made poppy products	22	73	98	149	393	186	44	70
- Heroin				2	18	129	249	295
- Morphine				3	4		4	7
- Methadone					5	10	12	6
- Cannabis	28	25	52	75	147	205	281	337
- Amphetamine		2	28	42	111	123	181	297
- Metamphetamine				1	15	41	26	1
- MDMA (ecstasy)			12	17	15	30	40	124
- LSD			1			2	3	2
- Benzodiazepines		1	4	24	34	35	54	45
- GHB					1	5	19	23

Source: Estonian Forensic Service Centre 2002

Heroin seizures accounted for the most significant increase in terms of drug seizures within the period of 1997-2001. Also, the number of cannabis, amphetamine and ecstasy seizures has increased several times. The number of GHB seizures increased rapidly in 2000-2001.

A decline in the number of seizures of home -made poppy products was observed in 1999-2000, but an increase took place again in 2001. The number of methamphetamine seizures has decreased since 2000.



**Figure 9.** Number of seizures for main types of drugs, 1995-2001

Source: Estonian Forensic Service Centre 2002

In recent years, the quantity of seized drugs has increased considerably with respect to the majority of drugs.

Compared to the year 2000, 2.7 times more heroin was seized in 2001 (because of low purity, the seized quantity of pure heroine increased only 28%). In the same period, the amount of seized ecstasy group increased 4 times and the amount of seized amphetamine and methamphetamine decreased about 5%. The quantity of seized cannabis (mostly marihuana and cannabis plants) increased 3,1 times. 12 times more (in quantity) GHB was seized in 2001 than in 2000. Quantities of the main types of seized drugs are shown in the table 10.

In 2001 no clandestine laboratories for producing synthetic drugs were found by the police.

**Table 10.** The quantity of the main types of drugs seized in 1998- 2001.

Year		1998	1999	2000	2001
Type	Unit of measure				
Cannabis (total)	kg	28,106	44,633	82,050	259,833
Heroin	kg	0,091	0,518	0,438	1,169
Amphetamines	kg	1,881	10,811	26,692	25,315
Ecstasy	Tablets (kg)	2623 (0,55)	1770 (0,624)	1326 (0,421)	3759 (1,714)

Source: Estonian Forensic Service Centre 2002

The biggest seizures of some types of drugs in 2001 were;

amphetamine – 10,932 kg

ecstasy (MDMA) – 0,756 kg

cannabis plants – 31,25 kg

marihuana (cannabis herb) – 8,441 kg

heroin – 0,294 kg

poppy plants – 11,154 kg

poppy staw – 4,880 kg

GHB – 11,590 kg

### 5.3 Price, purity

The estimated prices provided by the Central Criminal Police are given in table 11. During the reporting period the price of drugs increased. The only exception is amphetamine type powders, the price of which decreased.

**Table 11.** Street prices of illegal substances in EUROS in 2000-2001

Size of sample	2000			2001		
	Min	Max	Average	Min	Max	Average
Cannabis resin (per gram)	7,98	9,58	8,87	12,78	15,97	14,38
Cannabis leaves (per gram)	4,47	9,58	7,02	8,31	9,58	8,95
Heroin white (per gram)	63,91	76,69	70,3	51,12	95,85	73,48
Cocaine powder (per gram)	51,13	76,69	63,91	76,68	95,85	86,26
Amphetamines powder (per gram)	12,78	15,97	14,37	6,39	12,78	9,58
Ecstasy group (per tablet)	4,47	7,98	6,22	5,75	7,67	6,39
LSD (per dose)	–	6,39	6,39	12,78	15,97	14,38

Source: Central Criminal Police 2002

The purity of seized substances is different, however, on the basis of the statistical data of the Forensic Service Centre it can be stated that in general the purity of substances decreased in 2001 (Table 12).

**Table 12.** The purity of tested substances (%), 1999- 2001

	1999			2000			2001		
	Min	Max	Average	Min	Max	Average	Min	Max	Average
Heroin	16	100	45	1	100	58	3	100	21
Cocaine	20	100	47	26	99	60	8,5	83	40
Amphetamines	11	100	60	10	100	28	2	100	23

Source: Estonian Forensic Service Centre 2002

## 6. Trends per drug

In Estonia population survey data on the year 2001 is not available and we cannot make any conclusions regarding the prevalence of the use of certain types of drugs among the general population.

Trends of drug use in the Estonian society can only be observed on the basis of the data on drug seizures, quantities of drugs, crime statistics, qualitative studies and treatment demand database.

The last population survey dates back to 1998 and cannot form the basis for the identification of trends of 2001, but already the results of the ESPAD Survey 1999 indicated that amphetamine- type synthetic drugs are gaining popularity in Estonia (See Chapter 15).

According to the Database of the First Drug Treatment Demand the proportion of patients having sought treatment for stimulants use has increased by 63% in the reporting period. Other indicators (drug-related crime, number of seizures, study results) confirm that stimulants are a growing problem in Estonia.

## **7 Discussion**

### **7.1 Consistency between indicators**

Due to the lack of updated population survey data, it is difficult to make data based decisions. Consistency between the indicators of drug treatment demand, drug-related deaths and infectious diseases is apparent. The data of drug treatment demand suggest that there is an urgent need for the establishment of an appropriate treatment and rehabilitation system. Opiates are the main reason for seeking treatment and there is a need for the development of treatment possibilities. The proportion of clients having used the same syringe increased in 2001 (See Chapter 3.1). As to drug-related infectious diseases the situation has got worse compared to the previous years. According to the data of the Health Protection Inspectorate data the newly diagnosed HIV infections reported in 2001 were almost 74% higher than the previous year. According to the data of anonymous AIDS cabinets the incidence rate of drug addicts among newly diagnosed HIV infections was 91% (See Chapter 3.3). In terms of mortality the number of direct drug-related deaths grew from 31 in 2000 to 45 in 2001.

Consistency of indicators is apparent, however, new population survey data and prevalence study to estimate the number of problematic drug users in Estonia are needed.

## **7.2 Methodological limitations and data quality**

The main limitations with respect to the methodology are related to lack of data sources, different methods of data recording and lack of concrete definitions on the national level and qualitative data, especially on intervention issues. Appropriate definitions and concepts have not been agreed upon on the national level yet. The new National Drug Strategy for the year 2003-2012 will include agreed definitions, thus, they will be available in the next report.

There have been some changes in the quality of drug data in Estonia since the last reporting period, however, in some cases updated data is not available about the year 2001, data of the next population survey as well as the ESPAD Survey will be available in 2004.

The quality of data with respect to drug-related deaths has improved. The Statistical Office has switched from three-character ICD-10 codes used in 1997-2000 to four-character ICD-10 codes to adhere to the EMCDDA guidelines with regard to reporting the level of mortality and indicating the causes of death.

Reliable information on HIV / AIDS prevalence in Estonia is not available, especially with respect to IDU-s. Anonymous reporting can only give information on diagnosed infectious diseases by age groups and gender also the registration system enables to identify injecting drug use. In 2001 a discussion regarding the improvement of the current reporting system of infectious diseases was held. As a result of acquiring a new Programme of HIV / AIDS, the Surveillance System of HIV / AIDS and other STD should be improved at the beginning of 2003, Estonia will have appropriate data available by risk groups on drug treatment, needle exchange, STD clinics, pregnant women screening, hospitals and arrests.

Harm reduction data and data on the drug use in prisons is neither collected systematically nor according to any defined method.

Data on drug use in prison is available about one prison only, but is doubtful because of the lack of data recording method. In order to improve registration system in prisons some efforts should be made to set up clear concepts and definitions.

## **PART 3**

### **DEMAND REDUCTION INTERVENTIONS**

#### **8 Strategies in demand reduction at national level**

##### **8.1 Major strategies and activities**

The main activity regarding demand reduction on the national level was setting up county drug councils. In July 2001 the Estonian Centre for Health Education and Promotion (ECHEP) entered into contracts with all 15 counties with the purpose of setting up drug councils. The aim of the established drug councils is to improve prevention activities on the local level. County drug councils should be able to collect more detailed information about local needs within next few years and thus, act more operatively. As at autumn 2001 all county councils were established, their responsibilities defined and county drug prevention development plans composed.

##### **8.2 Approaches and new developments**

In 2001 the focus was on improvement of the quality of drug prevention and availability of drug treatment. Within the framework of prevention work in schools and counties seminars were organised to improve the knowledge and skills in setting targets and initiating activities to meet the overall goals of the prevention work.

With respect to increasing the access to drug treatment, the purpose was to improve the availability of drug treatment to both, insured and uninsured patients, and improve the overall quality and coverage of drug treatment. Several trainings were carried out (see Chapter 9.4) with the aim of improving the efficiency of drug prevention activities.

In 2001 assessment of the ADAPP was undertaken. The purpose of the assessment was to improve the quality and efficiency of the programme as well as develop the quality criteria of the programme. Within the framework of this assessment procedure, five subordinate projects of the ADAPP were assessed.

## **9. Prevention**

Prevention work was carried out in the form of project work in Estonia in 2001. The aim of the prevention projects was drafting of prevention plans and cooperation plans, development of prevention networks and arrangement of secondary prevention in risk groups. Almost 10,000 young people, parents and teachers took part in the prevention work in Estonia in 2001. 15 prevention projects were submitted to ADAPP by NGO-s from 6 counties of Estonia, 7 by county governments and local governments and 10 projects by schools. One project was implemented in the form of a TV program, which focused on the impact of drug use on the behaviour of an individual as well as on everyday habits of the risk groups of the young population. Expenditures of the prevention work are shown in Chapter 14.

### **9.1 School programmes**

There are 700 municipal and 100 state schools in Estonia.

From the year 2002 prevention work is carried out as a part of the school curriculum in Estonia. In the last report it was mentioned that Estonian experts in cooperation with the UNDCP were developing study materials of the drug prevention programme to be included in the curricula of the grades 4-6. The programme was tested in 2001 and included in the school curriculum in 2002. The main methods of the study material comprise active learning and acquisition of social skills. The material of the programme is divided into eight parts among which are prevalence of drug use among the young population, prevention of drug use in schools, drugs in school, drugs and levels of drug addiction, active learning. Drug prevention lessons take place as a part of human and health study.



Prevention work in schools is also carried out within the framework of prevention projects. 4 school projects out of ten were undertaken in primary schools, 1 was conducted in an elementary school, 3 in special schools, 1 in a gymnasium and 1 in a vocational school. Those projects were mostly aiming at performance of alternative activities and acquisition of social skills and theoretical knowledge (in the form of seminars, lectures and training) about drugs. Students of Tapa special school were provided with individual counselling.

Also, the projects of local governments and NGOs were focusing on prevention work in schools involving trainings and seminars for students and teachers (Table 13).

### **9.2 Youth programmes outside school**

A few projects of the total of 33 prevention projects involved out-of-school activities targeted mostly at youngsters and involving such alternative activities as organising camps or trips or sports events. All programmes implemented outside schools covered also active learning, which was carried out by means of seminars or lectures (Table 13.). (See also Chapter 10.1 Harm reduction).

### **9.3 Family and childhood**

In 2001 drug prevention projects hardly took in the family and the child. A couple of projects included a few lectures for parents. In Paide some prevention activities were targeted at children aged 5-6 (Table13).

**Table 13.** Projects implemented in 2001.

No	Applicant	Activity
1	Ida-Viru county, Rehabilitation Centre <i>You will not Be Left Alone</i>	Prophylactic training for school children aged 12-17.
2	Tartu, Konguta Elementary School	Active learning providing with knowledge about drug addiction and prevention.
3	Lääne-Viru county, City Government of Kunda	Informative lectures, seminars and training about drug addiction.
4	Põltsamaa, Young Union <i>JUVENTUS</i>	Questionnaire about prevalence of drugs, tobacco and alcohol and knowledge of AIDS. Development of leisure activities to respond to drug use.
5	Põlva county, Kanepi Gymnasium	Leisure activities for students.
6	Saare county, Tornimäe Primary School	Questionnaire to evaluate the situation with respect to the response to drug use; development of alternative activities and trainings.
7	Tallinn, Estonian TV	A TV program about the impact of drug use on individual behaviour.
8	Rapla county, Vana- Vigala Technical and Production School	Study camp in Hobulaid, a drug prevention week for students, incl. an essay-writing contest.
9	Viljandi, Puiatu Special School	Outside school activities for students, an essay-writing and painting contest to help to give meaning and motivation to life, provide possibilities for the development of necessary skills for leading a life free from drugs and criminal offence.
10	Tartu, Kaagvere Special School	Prevention of addiction. A follow-up program for the continuation of activities of the previous year.
11	Rapla County Government	Leisure activities, improvement of training and counselling possibilities.
12	Võrumaa, Estonian Health Promotion Union, Võru Department	Group work in schools (grades 4-9) facilitated by a counsellor having undergone special training. Training in counselling for students; printing of information material.
13	Lääne-Viru county,	Organisation of a camp (8 shifts) including lectures and

	NGO Rutja Vocational Centre	group work.
14	Narva City Government	Setting up and launching of a prophylaxis centre of drug addiction.
15	Hiiu county, Hiiumaa Municipality	Sniffing dog raids, organisation of an international seminar, trainings and a performance.
16	Ida-Viru county, NGO Regional Centre of Drug Addiction Prevention.	Sports and work camps; establishment of sports clubs in the housing area.
17	Võru county, Mõniste Primary School	Provision of theoretical knowledge and organisation of leisure activities.
18	Harju county, Harku municipality government	Provision of children and teachers of the educational institutions of the local municipality with possibilities for active learning. Development of possibilities for leisure activities in the local municipality.
19	Järva county, Paide City Government	Trainings for children aged 5-6, young people aged 7-29 and teachers. Questionnaires, a drug tent and a sniffing dog.
20	Valga county, Patküla Primary School	Implementation of a training and counselling programme involving three local schools.
21	Viljandi, Settlement Foundation <i>Trust</i>	Prevention classes in Viljandi schools, grades 3 and 7. Trainings for parents.
22	Lääne- Viru county, Simuna Ladies` Club	Round table meetings and publishing of information material.
23	Lääne county, Haapsalu City Government	A work and leisure camp (7 shifts) for city youngsters aged 8-16.
24	Ida-Viru county, Kohtla Primary School	Interactive learning, organising of trips, excursions and performances.
25	Tartu, NGO <i>Owl</i>	Organizing a camp for 20 children aged 10-15.
26	Tartu, Tartu Children Support Centre	A four-day camp for 50 children from risk families and their support persons.
27	Saare County Government	Setting up a system of sending problem letters, organisation of a party to youngsters, organisation of an international seminar, trainings and other seminars.
28	Harjumaa, Social Centre of Keila	Organisation of a campaign week including an audiovisual contest, forum, lectures and movies.
29	Viljandi, NGO <i>Develop of Karksi</i>	Organising of trainings, health weeks and information days for prevention workers.
30	Tallinn, Union of Gymnastic Teachers	6-day international prevention course for teachers of gymnastics from Estonia and Finland.
31	Tallinn, Probation Supervision Department of Tallinn City Court	7-day camp involving lectures, group work and individual counselling. The target group of this camp is youngsters having committed a misdemeanour.
32	Lääne-Virumaa, Tapa	Individual counselling, seminars, a camp for drug

	Special School	abusers and information days for parents.
33	Harjumaa, NGO <i>Persona</i>	Leisure activities

Source: *Estonian Centre for Health Education Centre 2002*

## 9.4 Other programmes

### Trainings

The Estonian Centre for Health Education and Promotion launched several trainings and seminars in the year 2001.

- In-service training in drug prevention for the teachers of general and vocational schools. The purpose of the training was to improve the knowledge of teachers and administration of prevention work. Another aim of the training was to compile prevention material for the teachers of vocation schools. Total of 365 teachers participated in 7 seminars, which were organised within the framework of trainings in 35 schools.
- Two complex drug prevention trainings were carried out within the framework of the establishment of prevention network in local municipalities in Ida- Viru and Järva counties. The purpose of the trainings was development of a training model for the prevention work in local settings. Total of 376 persons from Järva and Ida- Viru county participated in three-stage trainings in both counties. The seminars concentrated on the collection of information on the availability of drugs and the current situation regarding drugs, prevention methods and trainings needs of the areas where the trainings were about to take place. Also, information on activities necessary for efficient functioning of the network and the principles of networking was disseminated.
- Drug prevention training for social workers and health care professionals. The purpose of the training was to improve prevention work skills of health care professionals (see Chapter 9.4). Total of 53 social workers, 72 health care professionals, 9 child welfare workers, 51 municipality workers, 30 local government workers, 2 journalists, 6 representatives of the church and 37 managers of different institutions participated in the training.
- Drug prevention training in prison. Training in drug intoxication diagnostics was carried out in prison. Total of 282 prison workers participated in the training. According to the report on the training 240 participants completed the training successfully.

- Drug prevention trainings for police officers. Total of 28 police officers from local governments were participating in the trainings.
- Drug prevention trainings for the representatives of mass media. The purpose of the training was to initiate discussions about drug issues in media. Trainings focused on the problem of presenting drug issues in the media in the correct way. Trainings took part in the form of seminars in Tartu and Tallinn.
- Drug prevention training for project managers. The purpose of the training was to improve the quality of projects. It was a two-stage training, 14 participants took part in the first part of the training and 17 in the second part of the training; 10 of them participated in both seminars. The main subject was assessment of the efficiency of projects.

### **Internet**

Up to 2001 a special drug information website providing information on drug issues and promoting drug prevention did not exist. According to the international study "Global E commerce Report 2002" Estonia is one of the most rapidly developing information society in the Central and Eastern Europe, in 2001 33% and in 2002 39% of the whole population in Estonia used the Internet. According to the study about 81% of the population under 20 years of age and 68 % of people aged 20 – 29 are internet users, thus, it is evident that there is a great need for launching an Internet website giving adequate drug-related information targeted at wider public, parents, families and professionals of the drug field. Also, the website should include other important topics such as implementation of the national strategy and drug information action plan, monitoring of drug situation, drug policy, responses to drug use on the national as well as local level and innovative drug programmes targeted, first and foremost, at young people.

At the moment the accessible Internet websites include limited amount of information on drugs, non-governmental and governmental services regarding alcohol and drug use, however, websites targeted at specific target groups, such as a young people, are not available. Also, specific information about the effects and consequences of drug and alcohol (chronic) use, dependency and harm reduction measures, is not available on the Internet. The website of the Estonian Centre for Health Education and Promotion (<http://www.tervis.ee/>) provides an overview of the Alcohol and Drug Abuse Prevention Programme.

The publication of the Ministry of Internal Affairs of Estonia "Drugs in Estonia: Legislation and Statistics on Drug-related Offences" is available on their website (<http://www.sisemin.gov.ee/sisejulgeolek/ylevaated.html>).

The homepage of the Estonian AIDS Prevention Centre provides access to their publication, which provides information about drugs, addiction and possible contacts of help. (<http://www.aids.ee/est/narkomaania/narkomaania.html>).

Also, counties provide information on drug-related issues on the local level. Põlva county ([http://tervis.polvamaa.ee/narko\\_areng.html](http://tervis.polvamaa.ee/narko_areng.html)) and Hiiu county (<http://www.mv.hiiumaa.ee/info/narko.html>) are among the few counties having made drug information available on the Internet. Despite all, it is obvious that provision of drug information should be more systematic. Efforts should be made to improve the coverage as well as quality of information provided via Internet

## **10. Reduction of drug-related harm**

It is not possible to give a comprehensive quantitative overview of drug-related harm reduction in Estonia. The history of harm reduction in Estonia is very short and experience is limited. Outreach work has not been defined in the ADAPP and in the National HIV/AIDS Prevention Programme as an activity performed with the purpose of reducing drug-related harm. The most common method of funding harm reduction activities has been direct state funding. Since 2001 certain local authorities have also been providing finances for certain outreach projects. Financial, legal and human resources for the performance of harm reduction activities targeted at IDU-s are still insufficient (Chapter 14). Harm reduction used to play a minor role in the national drug strategy and policy, however, the importance of harm reduction has increased as a result of rapid transmission of HIV/AIDS since 2000, consequently, and the activities have been focusing on the IDU-s. In the year 2000, when the HIV infection was transmitting very extensively - about 90% of the incidents of HIV were related with IDU-s (Estonian National Report 2001) - the Government started to pay more attention to the implementation of harm reduction measures and allocated more funds to needle exchange, HIV testing and distribution of condoms.

It was decided that harm reduction must form an integral part of the new comprehensive multi- disciplinary national drug strategy, which was being drafted by the Ministry of Social Affairs and Ministry of Internal Affairs in close co- operation with the Phare – Twinning Project.

The Ministry of Social Affairs coordinated the National HIV/AIDS/STDs Prevention Programme up to 2001 and continues to do so. The Programme Council for the Fight Against HIV/AIDS was established in 1998 and consisted of representatives of various ministries, government agencies and NGOs. The Council is responsible for the implementation of the National HIV/AIDS Prevention Programme; it coordinates the activities of different sectors and ministries and monitors the fulfilment of the time-schedule and the management of finances.



At the beginning of 1990's only some NGOs were active in the field of harm reduction. The AIDS Prevention Centre (APC)<sup>5</sup> was established in May 1996 as a non-profit government agency. Since 2000 the APC has been the most powerful institution on national level responsible for the implementation of the National HIV/AIDS Prevention Programme. The APC is responsible for the implementation of the projects and tasks initiated within the framework of the National HIV/AIDS Prevention Programme and coordination of the cooperation between government agencies and NGOs.

The number of full-time employees in the APC has increased from 9 to 10, including: a managing director, five project managers, a social worker and three specialists of the anonymous testing sites located in Tallinn, Tartu and Narva. Another anonymous cabinet was set up in Pärnu in 2001.

Also, 20 – 30 voluntary workers belong to the APC team: office volunteers assist the office staff and outreach volunteers work in the streets, distribute information material etc. Distribution of roles between different organizations is shown in Table 14.

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<sup>5</sup> Since 2000 the Health Protection Inspectorate governs the APC, which is a government agency responsible for the surveillance system.

**Table 14.** Distribution of roles between different organizations in 2001.

Institutions	Address	Main tasks
Ministry of Social Affairs	Gonsiori 29, 15027 Tallinn E-mail: <a href="mailto:smin@sm.ee">smin@sm.ee</a> Tel: +372 626 9700 Fax: +372- 699 2209	1. Coordination of the National HIV / AIDS Prevention Programme; 2. Coordination of the National Alcohol and Drug Abuse Prevention Programme.
Estonian AIDS Prevention Centre (APC)	1. Main office: Narva 48, Tallinn 10150 Phone: (372) 6273 500; Fax: (372) 6273 510 <a href="http://www.aids.ee">http://www.aids.ee</a> E - mail: <a href="mailto:aek@aid.ee">aek@aid.ee</a>  2. Tiigi 1-1, Tartu, 51004 Phone: +372-7427611  3. Karja 6, Narva, 20306 Phone: +372-3548344	1. Planning and implementation of HIV/AIDS prevention measures in Estonia; 2. Preparation and provision of information and information material (seminars, lectures, discussions, etc); 3. Provision of health teachers with uniform programmes of HIV, safer sex and drug abuse, and carrying out respective seminars; 3. Anonymous testing in Tallinn, Tartu, Narva and Pärnu; 4. Organisation and implementation of campaigns, charity concerts and World AIDS Days; 5. Collection and dissemination of data about HIV/AIDS/STDs, both locally and internationally; 6. Analysis of the data on HIV/AIDS/STDs and making estimates for the future; 7. Provision of media with updated information; 8. Conducting research and studies about the behaviour of the Estonian and Russian youth with the purpose of making informed decisions within the framework of other appropriate projects.
AIDS Support and Information Centre	1. Erika 5a, 10416, Tallinn Phone +372-6603636 E-mail: <a href="mailto:tugikeskus@hotmail.com">tugikeskus@hotmail.com</a> 2. IDU Subsidiary in Tallinn Kopli 32, 10412 Tallinn Phone/fax +372 6413165 e-mail: <a href="mailto:tugikeskus@hotmail.com">tugikeskus@hotmail.com</a> 3. IDU Subsidiary in Tartu Phone: +372-7627611 4. IDU Subsidiary in Narva Phone: +372-5542814	1. HIV/AIDS prevention work targeted at risk groups (sex workers, marginalized youth, IDUs); 2. Methadone treatment programme; 3. Needle exchange programme.
Ministry of Education	Tartu, Munga 18, 50088. E- mail: <a href="mailto:hm@hm.ee">hm@hm.ee</a> Tel: +372+0735022	1. Improvement of the efficiency of sexual education within the framework of school curricula and trainings for health education

		teachers.
Estonian Health Education Centre	Rüütli 24, 10130, Tallinn Phone: (+372) 627 9280 Fax: (+372) 627 9281  E- mail: <a href="http://www.tervis.ee">http://www.tervis.ee</a>	1. Implementation and coordination of the ADAPP, National HIV/AIDS Prevention Programme on the national level; 2. Dissemination of information on local level; 2. Dissemination of information between different organisations on national and international level.
Estonian Anti-AIDS Association	Paldiski 62, 11617, Tallinn Phone: + 3726514360 Fax: + 372-6706814 E- mail: <a href="mailto:dr.priimagi@hotmail.ee">dr.priimagi@hotmail.ee</a> ; <a href="mailto:viroloogia@hotmail.ee">viroloogia@hotmail.ee</a>	1. Dissemination of information on HIV/AIDS among the youth; 2. Distribution of prevention material; 3. Organisation of lectures and seminars.
Estonian HIV-Positives Society, ESPO	Tallinn, Narva 48, 10412 E-mail: Phone +372 627 3505 Fax: +372 627 3510 E-mail: <a href="mailto:esposociety@hotmail.com">esposociety@hotmail.com</a>	1. Psycho-social support to PLWHA, as well as to their relatives (self – help groups); 2. Setting up self-help groups for PLWHA, participation of such groups in prevention work (lectures, outreach work, volunteers, etc.).
Parents against Drugs	Kahu 4, Tallinn, 13619 Phone: +372-6328814; +372-328819	1. Dissemination of information; 2. Implementation of measures to ensure development and application of innovative methods in drug abuse prevention by government agencies; 3. Counselling of the parents of drug users.
"Living for Tomorrow"	Narva mnt. 48, Tallinn 10150, Estonia Tel. (+372) 6273 500, (+372) 52 87376 E-mail: <a href="mailto:aek@aids.ee">aek@aids.ee</a>	1. Prevention of the transmission of HIV/AIDS using gender approach; 2. Carrying out youth programmes targeted at Estonian and Russian adolescents.
Estonian Union Against Sexually Transmitted Infectious Diseases	Ujula 76, 51008, Tartu Phone: +372-5058949	1. Cooperation of specialists of various fields interested in changing the existing outdated stereotypes in diagnosing, treatment and prevention of infectious diseases.

In 2001 the Ministry of Social Affairs established a working group with the purpose of drafting an updated National HIV/AIDS Prevention Programme for 2002 – 2006 and find the best solutions for the increasing HIV/AIDS problems in Estonia. The main objectives of the national programme are to increase the awareness of the risk groups, especially the young population, of HIV/AIDS and other STD and prevention methods, to ensure access of all interested persons to counselling and HIV testing and HIV/AIDS prevention activities, provide HIV infected persons with possibilities for treatment. It was decided that the surveillance system set up for the monitoring and analysis of the transmission of HIV would be reviewed and updated and a more effective system for the assessment of the efficiency of the HIV/AIDS Prevention Programmes would be established.

The key objective of harm reduction is to minimize drug-related harm to the society as well as to the individual by means of ensuring application of appropriate prevention measures, provision of counselling and HIV testing to risk groups. Previous harm reduction policy was mostly oriented towards the “hidden” groups of the population. The main target group of the programme were IDU-s, as well as other vulnerable groups such as young people, mainly adolescents with risk behaviour, prostitutes and homosexuals. Later on, in 2001, the risk group was extended as the surveillance data indicated that only a small proportion of HIV infected were IDU-s (Chapter 3.3). The new target groups included bisexuals and men with risk behaviour, persons suffering from sexually transmitted diseases and pregnant women etc. Due to extensive transmission of HIV among the prison population since 2000, detainees and prisoners were also defined as a risk group.

**Expenditures allocated to reduction of drug related harm**

In 2001 the total budget for HIV/AIDS Prevention Programme was 4,850,000 EEK (EUR 310 897.4). The AIDS Prevention Centre is mainly financed from the state budget. In addition, the APC has applied for and received several international grants, which have been used for the financing of specific projects, e.g. harm reduction projects targeted at injecting drug users, projects on the prevention of HIV/AIDS/STDs among sex-workers, the project on the inclusion of drug prevention in the school curriculum, a couple of publications etc

In 2001 EEK 2 million (EUR 128 205.1) was allocated for the combined antiretroviral therapy with 3 medicaments for 31 patients already receiving treatment, which covered the expenses of the medicaments for 7.5 months. In the second half-year the AIDS Prevention Centre was allocated an additional EEK 700,000 (EUR 44 871.8) from the state budget, providing a possibility for continuing the treatment of the patients with 2 medicaments up to the end of the year. According to the calculations total of EEK 4,530,000 (EUR 290 3845.6) is needed to cover the expenses of combined treatment of 31 patients with 3 medicaments and until 10 new patients treatment. EEK 800,000 (EUR 51282.05) were allocated from the state budget for the testing of HIV, including EEK 150,000 (EUR 9615.4) was allocated for anonymous testing, which has turned out to be a very effective method. In 2000 total of 3582 HIV tests were made in the anonymous cabinets of the AIDS Prevention Centre in Tallinn, Tartu, Narva and Pärnu. The cost of a test (includes routine testing for syphilis) is EEK 50 (EUR 3.2). According to the estimations the number of HIV tests could increase to 4982 in 2001.

### **10. 1 Description of interventions**

It is difficult to define outreach work, as a nationally accepted definition of outreach work has not been provided. Different types of activities, which can be identified as outreach work, have been carried out. Unfortunately, information on outreach interventions is not available in a structured, systematic and standardized form. Involvement of volunteers has been important for the maintaining of contact with IDU-s and other risk groups, as there is shortage of full – time professional staff. The most widely used model in the field of harm reduction has been the Catching Clients Model. The staff of the needle exchange points and the volunteers have been actively seeking contact with IDU-s, to encourage the target group to contact with needle exchange and condom distribution points, treatment and rehabilitation institutions and NGO's working in this filed. The use of the Public Health Model was initiated as a result of extensive transmission of HIV in Estonia in 1994. The main aim of the model was to reduce drug-related harm through safer drug use (needle exchange) and safer sex (condom distribution). The APC is responsible for the prevention of infectious diseases by means of implementation of agreed preventive measures and for the application of comprehensive HIV/AIDS and other STD prevention measures on the national level as well as for the coordination of prevention work on the local level. APC carried out the media campaign in 2001.

Common agreement on the methods of outreach work in recreational settings has not been reached on the national level. In 2000 the EFPDA published leaflets on the safe use of drugs in recreational setting targeting the information at recreational drug users. The leaflets were criticized and in 2001 similar projects were not initiated.

In 2000 the EFPDA prepared a campaign targeted at drug users in recreational setting. The campaign was aiming at 3 main aspects. The main aim of the campaign was to avoid overdoses and give adequate information about club drugs such as amphetamine, ecstasy and cannabis. Another objective was to provide information about the adverse impacts of drug use and special attention was paid to female club-goers. Prevention of overdoses was the main purpose of the project launched by the EFPDA. Dissemination of information material in clubs to prevent young people from taking overdoses has been the main activity in this field. Data on trainings in safe drug use are not available.

APC is the main organization carrying out a peer-to-peer outreach project (*Living for Tomorrow*).

## **10.2 Standards and evaluation**

No data available.



## 11. Treatment

Estonia has been reforming the health care system for more than 10 years. Planning and management of health care services is the responsibility of the Ministry of Social Affairs of Estonia. The first two significant reforms were carried out within the period of 1992-1994 aiming at decentralisation of planning and provision of health care services and revision of the financing of health insurance system. A licensing system for hospitals was established in 1994. The third reform was initiated in 1997 to develop a system of family practitioners and public health services. The latest reform aimed at improving the quality of hospital services by centralising acute inpatient care and making use of the latest technological developments in medicine, as well as creating a modern and comprehensive system of supportive health care.

The Health Insurance Act adopted in 1992, established a basis for the financing of national health care system, which covers ca 95% of the general population. Organization of public health system is legally regulated by the Public Health Act, approved by the Riigikogu in 1995. The latest amendments to the Public Health Act entered into force in 2002. The Public Health Act provides a legal basis for the National Alcohol and Drug Abuse Prevention Programme 1997 - 2007, National HIV/AIDS Prevention Programme 2001 and later on National HIV/AIDS Prevention Programme 2002-2006 etc.

Financing of services is co-ordinated by the health insurance system. Health insurance is a state-guaranteed system for the payment of the costs related to preserving the health of residents of Estonia, the costs related to their temporary incapacity for work and their medical treatment as a result of illness or injury, and benefits in the event of pregnancy and childbirth, also care allowance for caring of a sick dependant, and compensation for the cost of pharmaceuticals for some categories of insured persons<sup>6</sup>.

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<sup>6</sup> Those persons not covered by compulsory or voluntary health insurance must pay medical expenses themselves. State budget resources have been allocated for those with financial needs to cover the expenses of emergency medical care. These resources are distributed through local authorities and they pay for the medical services provided to those in need on the basis of guarantee letters.

### **11.1 Drug – free treatment and health care on national level**

Treatment of drug addicts is a part of psychiatric care, regulated by the Mental Health Act (Chapter 3.1). In most cases, treatment of drug addicts takes place in inpatient psychiatric treatment institutions, which also provide treatment for other kind of psychiatric disorders. There are only a few specialised hospitals / departments specialised in treatment of drug addiction.

Treatment of uninsured patients is covered by the Health Insurance Fund and directly from the budget of ADAPP.

In the background of an increasing demand for drug treatment, availability of treatment facilities is limited (Jänes, 2001). Assessment of the current treatment system and services for drug addicts is the prerequisite for the revision of the drug treatment system.

According to the data provided by medical doctors, there is a long waiting list of persons seeking treatment for drug problems, but access to treatment services is limited. Drug treatment facilities are divided into two main categories: in-patient and out-patient treatment institutions. Psychiatric care hospitals provide drug addicts with all basic types of treatment: detoxification with methadone, medicines– free therapy, counselling and support. However, substitution treatment is not available. Short – term detoxification with methadone is still most widely used treatment method for opiate addicts: more than four fifth of the treated patients have received detoxification. Drug free treatment has not been systematically recorded in Estonia, thus, according to treatment demand data only a very low proportion of drug addicts have received drug – free treatment.

Only a limited number of in- and out-patient treatment centres (some of them are NGOs), provide drug – free treatment: NGO A- Kliinik in Tartu, Narva Hospital, the policlinic of Ahtme Hospital, Ahtme Hospital, department of psychiatrics in Pärnu Hospital. Some of the other NGOs active in this field are SA Anti Liew & Hingehooldus and NGO “Sind ei jäeta üksi” in Narva. Several treatment centres in Ida – Virumaa use the Minnesota model of treatment.

Establishment of a new treatment centre in Tartu and rehabilitation centres in Sillamäe and Loksa were initiated in 2001. Training of the staff started in autumn 2001 in close cooperation with the Phare Twinning Programme team. Sillamäe and Loksa Rehabilitation Centres should be fully operational by the end of 2002. Tartu Rehabilitation Centre is expected to launch its activities in the middle of the year 2003.

Estonian experts drafted "Guidelines for Drug Treatment" within the framework of the Council of Europe Pompidou Group Drug Demand Reduction Staff Training Project (DRSTP II). The above-mentioned guidelines were approved and published by the Estonian Psychiatric Association.

Data on the evaluation of treatment and rehabilitation services is not available.

### **11.2. Substitution and maintenance programmes**

In Estonia short – term methadone treatment is the only widely used method. Methadone treatment is not allowed in case of person under 18. Short – term detoxification is provided in most psychiatric hospitals and in a few NGOs. The AIDS Support and Information Centre in Tallinn (Erika 5a) was the first NGO, which started to provide short – term methadone detoxification. The Centre treated heroin addicts for more than 4 years also using volunteers in their everyday work.

Similar kind of treatment was provided in Narva (Karja 6a), at the Rehabilitation Centre for Drug Addicts and Alcoholics.

The AIDS Support and Information Centre also launched a reintegration programme for persons who were participating in the programme of the Rehabilitation Centre, located in Ida – Viru county. There are only 8 treatment slots in the Rehabilitation Centre and regarding to that small number of patients was possible for the patients to participate in the Estonian language and driver's courses in Rakvere. The AIDS Support and Information Centre and the parents of the patients of the Rehabilitation Centre covered the expenses of the courses. Also, the centre organised a parents' support group, which used to have meetings in Tallinn (Karu St 4).

### **11.3 After – care and reintegration**

After – care and rehabilitation is a responsibility of local government as described by the Social Welfare Act (1995). After –care and the building of the network around the clients is rather poorly developed in Estonia. Currently only few NGOs – the AIDS Support and Information Centre, Rehabilitation Centre in Narva for Drug Addicts and Alcoholics have launched a reintegration programme for persons who were participating in the rehabilitation programmes. The programme is directed to former drug addicts and the main goal is to integrate them into normal every day life.

## **12. Interventions concerning the system of criminal justice**

Prisons are government agencies governed by the Ministry of Justice. The main task of the Prison Department of the Ministry of Justice is to organize the work of prisons, places of preliminary detention and extradition camps, as well as supervision, execution of pre – trial investigation of prison crimes and surveillance work. In 2000 the Ministry of Justice elaborated a development plan of the prison system until the year 2003. As the first step in reforming the prison system, the administration and control of prisons were brought under the direct responsibility of the Ministry of Justice.

The Imprisonment Act (RT I 2000, 58, 376) stipulates the procedure for and organization of deprivation of liberty, arrest and administrative arrest and preliminary detention as well as the definition and conditions of prison service. The Imprisonment Act provides regulations for 2 types of prisons in Estonia – closed and open type prisons. The Imprisonment Act emphasizes the establishment of the resocialisation system of prisoners aimed at successful social adaptation of convicts. In Estonia there are total of 9 prisons (4 prisons are of closed type, 3 of semi – closed and 2 institutions for young offenders).

The Probation Supervision Act stipulates conditions for alternative measures of imprisonment (Sub-chapter 12.2).

The Minors Sanctions Act entered into force in September 1998 and act provides a possibility to implement alternative sanctions in case of a minor offender.

According to the Health Service Act (01.01.2002) the Health Care system in prison is a part of the national Health Care System, financed by the state budget. All persons are subject to routine health control.

Access to psychological support is guaranteed in every prison and at the moment there are 21 psychologists working in different detention facilities. In addition, it has been planned to train 12 psychologist and social workers within the framework of the Phare project “Crime Prevention”; in 2003 a programme “Motivational Interviewing” will be launched. A health unit and social work unit have been set up in all Estonian prisons. The size of health and social teams is different depending on the capacity of a prison.

The Social Welfare Act (1995, RT 21, 323, 723 – 736) regulates the provision of social assistance to different risk groups with special needs. Social services are provided and other support measures are taken to assist persons with special social needs such as children, disabled persons, and the elderly, persons released from penal institutions and other persons in need.

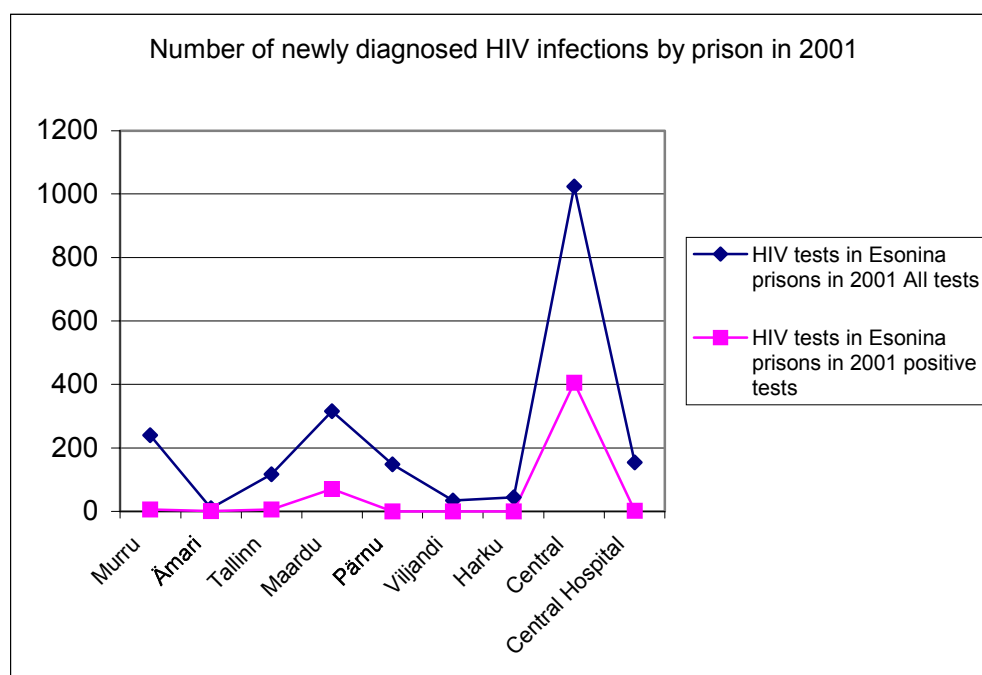
### 12. 1 Assistance for drug users in prison

New developments in the field of intervention are focused on IDU-s and rapid transmission of HIV / AIDS and other STDs in prison since 2001.

In 2001 total of 2087 inmates were tested in all prisons, 485 from which were HIV positives (about 23% of all tested persons).

The transmission of HIV did not follow the same pattern in all prisons (Figure 10).

**Figure 10.** Number of newly diagnosed HIV infections by prisons in 2001.



Source: Ministry of Justice, 2002

Almost all cases of newly diagnosed HIV infections were related to intravenous drug use prior to imprisonment and only 2 persons had got the infection in prison.

According to the ADAPP the establishment of a drug-free programme in juvenile prison was a task of the Ministry of Justice for the 3<sup>rd</sup> quarter of 1998. The number of drug – free departments in the prison system has not increased compared to 1999, when the first separate drug- free department were established in Viljandi Prison<sup>7</sup>. At the moment a drug – free department is being set up in Harku Prison. The costs related to the establishment of such department, including renovation of the rooms, are covered from the ADAPP budget. Short- and long – term programmes have been prepared for the inmates with addiction problems, as well as for prisoners not using drugs, to protect them from the influence of drug-using inmates. Establishment of the drug free unit enabled the prison officers and doctors to identify the inmates with a dependency problem and provide them with assistance, as well as exercise more efficient control over them. Inmates stay in the drug – free department on a voluntary basis. An inmate has to sign a contract providing that he/she agrees to stay in a drug – free department and accepts the conditions therein (e.g. to give regularly a urine sample).

The first measures in the Estonian prison system to reduce the risks related to HIV/AIDS and other STDs were undertaken in 2000. The directive of the Minister of Justice on the Guidelines for the Identification of Potentially HIV Infected and the Treatment of HIV Infected Imprisoned Persons entered into force on December 13, 2000. According to the directive of the Minister all HIV infected inmates are separated from other inmates. In October 2001 a separate department was established in the Central Prison for the HIV infected imprisoned persons.

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<sup>7</sup> Since December 1, 2001 there are 100 places for 13 – 21- year-old convicted minors and adolescents in Viljandi Prison.

The AIDS Prevention Centre (APC) is one of the main institutions responsible for the prevention of HIV and other STD's in prisons in Estonia. In 2000 the Ministry of Justice published a brochure "A Prison Officer and Risks" targeted at the prison staff. In close cooperation with the AIDS Prevention Centre Ministry of Justice translated and published the booklet "Protect Yourself" aimed at imprisoned persons. In August 2001 the Government allocated EEK 250,000 (EUR 16025.6) for HIV testing in prisons. In December 2001 440 prisons officers were vaccinated against hepatitis B. Voluntary HIV testing has been available in all prisons since October 2001.

In January 2001 the Open Society Foundation allocated EEK 549,100 (EUR 35198.7) to the AIDS Information and Support Centre for the implementation of the HIV prevention programme in prisons. The main aim of the programme was to prevent transmission of HIV among inmates, provide inmates with information about the adverse effects of unprotected sex and used needles, to raise the knowledge of the prisons medical staff, officers and inmates of drug-related issues. In addition, the project supported distribution of condoms among prison inmates. Currently needle exchange projects have not been carried out in Estonian prisons.

Within the framework of the programme total of 660 prison officers and 4000 inmates were provided with training. 3 medical doctors of the Central Prison participated in the work of the project.

In addition to the establishment of a surveillance system of HIV infection, similar system must be set up with respect to hepatitis. Provision of the prison personnel, especially the medical staff, social workers and psychologists with regular appropriate training is of utmost importance in terms of ensuring adequate attendance of the problems of drug use and drug-related infectious diseases in prisons.



## **12.2 Alternatives to prison for drug dependent offenders**

According to the Probation Supervision Act (RT I 1998, 4, 62) in probation supervision, the behavior of probationers and their performance of obligations imposed on them by a court are monitored and probationers are assisted in social adjustment with a view to deterring them from committing criminal offences.

The Probation and Crime Prevention Divisions in the Ministry of Justice deal with issues related to the administration of the probation system and co-ordination between probation departments of courts of the first instance, as well as crime prevention issues. 13 probation supervision departments have been set up in county and city courts all over the Estonia. Probation officers are appointed to office on the basis of public competitions.

The Act provides strict criteria with respect to the access of an offender to alternative measures.

According to the study "The Need of Probationers for Social Services and the Possibilities for Meeting Such Needs" there is an urgent need for the development of treatment and rehabilitation services for drug addicted persons (the score of the importance was 6.9 in the 10 point scale system). The need for solving problems with respect to drug treatment and rehabilitation is very high in Ida-Viru, Järva, Põlva and Pärnu counties, services for drug addicts are not available in 2 counties. Also, a need for the development of a drug treatment and rehabilitation system for persons under probation in all Estonian regions has been identified. Rehabilitation services are in most cases provided by NGO-s (Ojasoon 2001).

One of the biggest problems in Estonia is repeated crime – in 2001 75% of the detainees were in prison for the second time or had been in prison several times already. This explains the difficulty in resocialisation of detainees in the society (The Yearbook of Prison System 221 / 2002, 221).

### **12. 3 Evaluation and training**

In 2001 prison workers were regularly trained in drug-related issues within the framework of the subproject of the ADAPP “Evaluating the Scope of Drug Use in Prisons” (Chapter 9.4). The Ministry of Justice organised additional training targeted at inmates working together with inmates living with HIV/AIDS. In May 2001 the NGO Social Rehabilitation Centre carried out a project “Sexual Health Programme”. The main aim of the programme was to raise the knowledge of inmates on HIV/AIDS and other STDs and to increase tolerance towards inmates living with HIV/ AIDS. In October 2001 a training for the medical staff of prisons was carried out in close cooperation with Swedish partners. The training was organized by Stockholm Kronberg Prison and implemented by the doctors of Huddinge University Clinic. Four doctors from the Central Prison participated in those trainings. In 2000 the Ministry of Justice organized training for 110 probation officers in the form of a summer school. In 2001 the Ministry of Justice did not organize any special training concerning probation, however, training courses for total of 95 crime probation officers were carried out within the framework of a Twinning project between the Netherlands and Estonia. Probation departments organized courses for 44 probation officers.

Results of the project evaluation were not available in 2001 yet.

### **13. Quality Assurance**

The Estonian Drug Monitoring Centre (EDMC) is responsible for the establishment and maintenance of the drug information network with the aim of providing the EMCDDA and policy and decision-makers and public organisations with adequate drug – related information comparable at the European level. The Minister of Social Affairs has nominated legal correspondents and experts for the EMCDDA. The following legal correspondents have been appointed: a correspondent of the European Legal Database on Drugs, a legal correspondent of the Joint Action on New Synthetic Drugs and experts of four key-indicators: drug-related death and mortality, drug use in general population, drug-related infectious diseases and demand for drug treatment. The legal experts of four key-indicators have received training and are harmonizing the indicators with the European key-indicators according to the EMCDDA guidelines. Improvements have already been made with regard to drug-related deaths (Chapter 7.2). In some cases, however, appropriate information sources are still not available and access to the necessary data on the national level is extremely limited. Also, problems are encountered with geographical coverage of the data. In some cases good databases are available on institutional level but similar data on the national level does not exist, therefore, comprehensive overview of the situation cannot be provided. Development of Drug Information Network is still one of the most important priorities in Estonia. Identification of appropriate data sources to ensure improvement of the collection of necessary data on key issues on the national level is the most urgent task to be performed.

**PART 4****KEY ISSUES****14. Demand reduction expenditures in 1999**

It is very difficult to get a reliable overview of the expenditures for prevention. The only overview of expenditures on drug demand reduction on the national level has been made available by the ADAPP governed by the Ministry of Social Affairs. In 1999 the EFPDA was responsible for carrying out prevention activities on the national level and was allocated total of EEK 1,896,452 (EUR 121,567) for the organisation of prevention work targeted at youth and children. In 1999 most of the demand reduction activities carried out by NGOs and other institutions in Estonia were financed from the state budget and the national government budget.

Finances allocated for demand reduction activities in 2000 were more substantial. The EFPDA received total of EEK 3,361,755 (EUR 215,497) for prevention activities from the state budget. EEK 1,400,000 (EUR 89,743) were allocated for the prevention work targeted at the young population, EEK 1,611,755 (EUR 103,318) for the prevention work carried out in local governments and EEK 350,000 (EUR 22 435) for the prevention work in prison. In terms of international projects, information is available only about one project "Exchanging the Experience and Knowledge in Substance Abuse Prevention" carried out in 2000 by the EFPDA and supported by the Nordic Council of Ministers Grant Scheme with the total budget of EUR 25 575.

In 2001 the EFPDA was allocated total of EEK 1,555,000 (EUR 99,679,5) from the budget of the Alcohol and Drug Abuse Prevention Programme to carry out prevention projects in Estonia. Also, EFPDA was allocated EEK 199,500 (EUR 12,788,5) for prevention projects to be implemented in Estonian prisons. In 2001 40 % of the total budget of the EFPDA was used for carrying out projects aimed at the prevention of drug addiction in Estonia.

### 15. Drug use among young people aged 12-18

The ESPAD 1999 is the only reliable study, which gives information about drug use among the age group of 12-18 in Estonia. The sample of the ESPAD consisted only of the age group of 15-16. In the year 2003 studies on school children will be carried out, hopefully the studies will give more information about the prevalence of drug use among children.

At the moment, only the ESPAD 1999 study is available. According to the study, a higher proportion of students reported recent prevalence of alcohol use in Estonia in 1999, compared to the average of other ESPAD countries (89% and 83%, respectively). According to the ESPAD survey in 1999 (ESPAD report 2000) the proportion of students who reported lifetime experience of smoking was slightly higher in Estonia than the average of the European countries (74% and 69%, respectively). The number of students who reported lifetime experience of illegal drug use had doubled by 1999 compared to the results of the ESPAD survey 95 (12% and 23%, respectively). The number of students reporting lifetime experience of ecstasy, amphetamine and cannabis use had also increased as shown in the table 16.

**Table 15.** Lifetime prevalence of drug use among students in 1995 and 1999.

	1995	1999
Amphetamines	0,4%	6,8%
Ecstasy	0,1%	3,0%
Cannabis	7,2%	12,7%

*Source: ESPAD Survey 1995 and 1999*

Some information with regard to drug use among children is provided in the UNICEF opinion survey "Young Voices" which gives the opinion of children and young people. It is a scientific, quantitative opinion survey conducted in 35 countries using the same methodology and questionnaire. Children subject to interviews were selected according to their age (9-17), gender, geographical region and area of the country they lived in.

Total of 400 children aged 9-17 were interviewed in Estonia in 2000- 2001. Two questions of that survey were about illicit drugs, which provided us with some information about the prevalence of illicit drugs. The answers to the questions about lifetime experience of drug use and addiction provided by the sample group about their friends and acquaintances gave an idea of the drug situation among the school population in Estonia. 76% of the respondents reported that their friends or acquaintances had tried tobacco, 63% reported lifetime experience of alcohol use, 14% reported sniffing of harmful substances and 17% reported lifetime prevalence of the use of illegal substances. The situation was different concerning children and youngsters. 93% of the youngsters (14-17) and 61% of the children (9-13) reported having lifetime experience of the use of tobacco. The same applied to lifetime experience of the use of alcohol and illegal substances: 87% of youngsters and 43% of children had tried alcohol and 35% of youngsters and 10% of children had tried illegal substances. The question about friends or acquaintances addicted to harmful substances gave the following results: 39% reported addiction to tobacco, 10% addiction to alcohol, 3% addiction to sniffing harmful substances and 4% reported addiction to illegal substances. The share of youngsters addicted to harmful substances was higher than the share of addicted children aged 9-13 (Young Voices 2001).

In 2001 a survey on schoolchildren within the framework of the project "Drug Prevention in Schools of Tallinn" was conducted. The target group was students of the 5<sup>th</sup>, 7<sup>th</sup> and 9<sup>th</sup> grade and the purpose was to identify the prevalence of drug use and attitudes towards drugs among schoolchildren. Another purpose was to analyse the relation between health and environment. This survey was carried out at the end of 2001 and at the beginning of 2002 thus, the results will be available in the next report.

## **16. Social exclusion and re-integration**

### **16.1 Definitions and concepts**

Social exclusion is seen as disappearance of social cohesion and it finds expression in the disability of the population to use available resources and to adapt to the changes in the society. The consequences of social exclusion include drastic decrease in the involvement in community activities, disablement, increase of disappointment in and withdrawal from community life. Social exclusion and concurrent alienation is caused by the decrease in income, loss of employment a person's dissatisfaction with his or her economic and social situation. Social exclusion as a social problem is characterized by subjective and objective conditionality. Objective causes may include rapid and multidimensional changes in the society and changes in the social security system; subjective causes are related to the difficulties of a human being to adapt to those changes (Estonian Human Development report 1997).

The relationship between social exclusion and drug use has not been considered an issue of importance in Estonia. Conferences have been organised and several discussions conducted on social exclusion, however, they have not been related to drug use issues.

Theoretically we know that poverty generates social exclusion, which is a favourable ground for drug addiction on the other hand, drug addiction is one of the prerequisites for social exclusion. Also, we can assume that this is the case with respect to heroine users in certain regions. At the same time, another type of drug use can be identified – recreational drug use in big cities, especially the use of synthetic drugs. Hence the need for the differentiation of drug addicts and recreational drug users. Today, recreational users obviously form the largest group of drug users. They are people who lead a normal everyday life and use drugs mostly at the weekends or even less frequently. Another important difference between recreational drug users and addicts is related to the disapproval of the community. In case of recreational drug users, such weekend habit is usually unknown to most of the people they communicate with during weekdays.

Addicts, especially heroin addicts, are not able to hide their drug use for a long time and thus, become subject to condemnation by the community. They lose contacts with people who are not drug users and spend most of their time in a group where drug use is the main activity (Allaste, Lagerspetz 2002).

Some information about the background of drug addicts could be found in two surveys, one was conducted in Narva in 2000 and the other in Ida-Viru county and Tallinn in 2002. The survey about drug use and risk behaviour of young non-Estonians conducted in Narva in 2000 was referred to in the last Estonian National Report (page 59), the second survey was an ILO (International Labour Organization) survey on "Children and Adolescents Involved in Drug Use and Drug Trafficking: a Rapid Assessment".

Those surveys are not directly connected with social exclusion and drug use issues, however, we can draw some conclusions. The factors that might in certain circumstances cause social exclusion are the following: nationality (minorities), education (lack of education), poverty and unemployment, which, at the same time are often related to drug use.

The Narva survey indicates that Russian-speaking population, the minority in Estonia, especially non-citizens not provided with social benefits, consider themselves as being in an unfavourable condition with respect to employment. A number of young people of Narva feel that they are treated unfairly and they have been deprived of benefits they must be subject to, thus, it has developed bitterness and disappointment in life, causing, in turn, a considerable amount of problems. The biggest problem is the increase in the rate of criminal offences. A number of families live in poverty, i.e. their living standard is under the poverty limit, and they often choose to solve their problems by means of criminal activities (Allaste 2000).

ILO survey provides some information about the social background of young drug users. One important issue is educational background. Truancy and dropping out of school are just a few examples of the problematic behaviour of the young people in Estonia. Compared to the Soviet period, when school attendance was strictly monitored by the state, young people of today enjoy more liberties and opportunities to stay away from school. Secondary education used to be compulsory in Estonia, but today, only basic education or school attendance until the age of 16 has been made compulsory (Narusk 1997).



There are several reasons for truancy and dropping out. Most frequently, it is the “street children” who tend to drop out. A child can also drop out of school due to various social and economic problems, which may develop in the family. Sometimes the unemployment of parents and poor economic situation of the family make a child give up school and concentrate on earning money. Also, low salaries of parents may give a child the impression that education acquired at school does not necessarily guarantee good life. Out of 40 children interviewed during the above named survey, 16 answered negatively when asked if they attended school (Kalikova, Kurbatova, Talu 2002).

Children who drop out because they are not willing to study or because of economic hardship often spend their time in street gangs instead of going to school. In the streets some of them become drug addicts or thieves or they may get involved in other types of criminal activity (Tiit & Eglon 2000).

Based on a recent study carried out by the AIDS Prevention Centre, a drug user is often a 20-25-year-old Russian-speaking male from Ida-Viru county or Tallinn who has used drugs intravenously for a couple of years. The majority of long-term addicts never work; they earn their own living by committing crimes. 56% of the injecting drug users started to inject at the age of 14-20, the most vulnerable age in terms of drug addiction is 17. Although alcoholism and ethnic aspects are not interrelated, relevance of the ethnic aspect is obvious with respect to drug addicts in Estonia. 81,6% of drug addicts admitted to treatment in 2001 were Russians, Estonians accounted for 12% of treated patients (Chapter 3.1). According to the data of NGOs 98% of intravenous drug addicts are Russians (AIDS Prevention Centre). Narcotic drugs are mostly used in big cities, primarily in Tallinn and in three towns of Ida-Viru County. One 15-16-year-old student out of four in Kohtla-Järve has reported lifetime experience of illegal drug use. The same applies to the students in Sillamäe and Narva (Estonian National Human Development Report 2000). In Estonia socially excluded young people are exposed to the risk of drug use most of all. For instance, heroin is widely used in Ida-Viru county where the rate of unemployment is the highest and the standard of living the lowest (Estonian Statistical Office 2002).

To conclude with, we can state that drug use and social exclusion are most likely interrelated. Hopefully in the future we can present data on surveys about the interdependence of drug use from social exclusion in Estonia.

### **16.2 Drug use patterns and consequences observed among the socially excluded population**

No data available.

### **16.3 Relationship between social exclusion and drug use**

No data available.

### **16.4 Political issues and reintegration programmes**

The Estonian Ministry of Social Affairs is responsible for the social welfare system. The social security system of Estonia comprises pension insurance, health insurance, family benefits scheme, unemployment benefits, funeral grant and social benefits for disabled persons. However, the actual sums of money provided, as benefits are insufficient and have not increased significantly over the years. Therefore, the social security system is not able to prevent poverty and social exclusion.

Drug-related social reintegration programmes to prevent social exclusion have not been developed in Estonia. Only general information is available on social exclusion issues. Vulnerability and low competitiveness on the labour market are most commonly discussed aspects of social exclusion and drug addiction. On the basis of the aforementioned the following risk factors can be identified: lack of professional education or qualification, the status of a non-Estonian not knowing the state language, youngsters having dropped out of school and/or lost their work.

In the background of the named risk factors and reintegration of socially excluded persons it should be mentioned that language-study programmes are available for those not speaking the Estonian language (within the framework of integration programmes) and efforts have been made for the development of vocational education.

Implementation of the national programme “Integration in Estonian Society 2000-2007” continues. The priorities of the programme are linguistic-communicative, legal-political and socio-economic integration.

In autumn 2001, the second EU PHARE Programme “Social Integration in the Estonian Society and Language Teaching Programme for non-Estonian-speaking Population” for the years 2001-2003 was launched. The programme is the continuation of the first three-year EU PHARE programme of the Estonian language training, which was successfully completed at the end of 2000. The programme contributes to the achievement of the medium-term objectives set forth in the National Integration Programme, focusing specifically on the linguistic-communicative and social-economic spheres of integration.

In 2002 Norway, Finland, United Kingdom, Sweden and Estonia signed an agreement “Integrating Estonia 2002-2004” to support the integration-related activities in Estonia. The project activities are mainly targeted at the younger generation. The project provides support to the Estonian language training as well as aims at increasing the number of informal contacts between the Estonian- and Russian-speaking youth and enhancing the cooperation between the Estonian and Russian schools. It contributes to the strengthening of the linguistic and professional competitiveness of non-Estonians on the labour market and in vocational schools, involves non-Estonians in the Estonian media sector and increases the knowledge and motivation of non-Estonians in applying for citizenship.

The abovementioned projects as well as other on-going programmes such as Estonian-Canadian-Finnish joint project “Language Immersion as a Key to Integration” for the years 2000-2004 and support from the governments of the USA and the Netherlands are administrated by the Non-Estonian Integration Foundation (EU Progress Report, June 2002).

Measures and programmes targeted at the development of vocational education and training reflect the needs of the society. Most of the programmes were not of preventive character, the activities carried out by NGOs in the form of projects were mainly interventions targeted at street children, mistreated children and dropouts. The aim of the projects was to provide rehabilitation to dropouts, school truants, wayward children, mistreated children and young people as well as the unemployed.

For example, one project implemented by an NGO was targeted at young men aged 17 and over without any vocational education. The aim of the project was to provide rehabilitation to young men, who were neither employed nor attending any courses, with the purpose of providing them with vocational skills and working habits, as well as motivation and perspectives concerning independent working life.

As far as juvenile crime prevention is specifically concerned, a National Crime Prevention Programme was initiated by the Ministry of Education in 1999. The main aims of the programme were restoration of the motivation of children for studying and decreasing the cases of truancy and dropouts by means of improving the connection between school and home.

The Ministry of Education in close cooperation with the Ministry of Social Affairs has launched a project on the establishment of vocational centres for the young people. The aim of the project is to monitor the activities of basic school graduates under 17 years of age and improve the vocational skills of the unemployed young people aged 17-25.

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### **Links**

Riigi Teataja (official website of legal acts in Estonian): <http://www.riigiteataja.ee> .

Estonian Legal Translation Centre (selected legal acts in English): <http://www.legaltext.ee> .

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## LIST OF ABBREVIATIONS

ADAPP - Alcoholism and Drug Abuse Prevention Programme for 1997-2007

AIDS - Acquired Immunodeficiency Syndrome

APC- AIDS Prevention Centre

CC - Criminal Code

CEEC – Central and Eastern - Europe Countries

ECHEP - Estonian Centre for Health Education and Promotion

EDMC – Estonian Drug Monitoring Centre

EFPDA- Estonian Foundation for Prevention of Drug Addiction

EMCCDA - European Monitoring Centre for Drugs and Drug Addiction

ESPAD - European School Survey Project on Alcohol and Other Drugs

GHB- Gammahydroxybutyrate

GP- General practitioners

HIV- Human Immunodeficiency Virus

IDU - Injecting Drug User

ILO- International Labour Organization

IECM - Institute of Experimental and Clinical Medicine

LSD - Lysergic acid diethylamide

MCDP - Ministers Committee on Drug Policy

MBD- Mental and behavioural disorders

MDA - 3,4 Methylenedioxyamphetamine

MDEA - 3,4 Methylenedioxyethylamphetamine

MDMA- 3, 4 Methylenedioxymethamphetamine

MSB- The Medical Statistics Bureau

NADPP - National Alcoholism and Drug Prevention Programme

NDPSA - Narcotic Drug and Psychotropic Substances Act

NFP - National Focal Point

PLWHA – People Living With HIV/AIDS

STD- Sexually Transmitted Diseases

TB- Tuberculosis

UNDCP - United Nations Drug Control Programme

UNICEF- United Nations Children’s Fund

WHO - World Health Organization