



European Monitoring Centre
for Drugs and Drug Addiction

**2014 NATIONAL REPORT
(2013 data) TO THE EMCDDA by the REITOX National
Focal Point**

**ESTONIA
New developments, trends**

REITOX

REPORT ON DRUG SITUATION IN ESTONIA IN 2014 (based on the data of 2013)

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2014

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The content of the report may not necessarily reflect the opinions of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Authors of the respective chapters are responsible for the views reflected. The preparation of this report was co-funded by the European Monitoring Centre for Drugs and Drug Addiction (grant contract identification number GA.14.RTX. 007.1.0).

Acknowledgements

We wish to thank our colleagues Aljona Kurbatova, Piret Viiklepp, Margit Kuus and Gleb Denissov from the National Institute for Health Development, whose relevant explanations contributed to the drafting of this report.

We thank sincerely the experts from the Police and Border Guard Board, Estonian Tax and Customs Board and from the Estonian Forensic Science Institute. We would also like to thank Andri Ahven and Maret Miljan from the Ministry of Justice.

Abbreviations

AIDS - Acquired Immune Deficiency Syndrome

ARV - Antiretrovirus

EKEI – Estonian Forensic Science Institute

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

ESPAD – European School Survey Project on Alcohol and Other Drugs

GBL – gamma-butyrolactone

GHB – gammahydroxybutyrate

HCV - hepatitis C virus

HIV – Human Immunodeficiency Virus

HTM - Ministry of Education and Research

KarS - Penal Code

MDMA - 3,4-methylenedioxy-N-methylamphetamine

MDR-TB – multidrug-resistant tuberculosis

MTA – Estonian Tax and Custom Board

NSPD – National Strategy for Prevention of Drug Addiction

NPALS - Act on Narcotic Drugs and Psychotropic Substances and Precursors thereof

PPA –Police and Border Guard Board

RDS – respondent driven sample

ICD - International Classification of Diseases

RTA - National Health Plan

SoM - Ministry of Social Affairs

STI - sexually transmitted infections

TAI - National Institute for Health Development

TB – tuberculosis

THC – Tetrahydrocannabinol

VV - Government of the Republic

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Summary

Drug policy: legislation strategies and economic analysis

The most important change in this reporting period was the approval of the White Paper on Estonian's drug prevention policy at the beginning of 2014. Although the official document for planning financial resources and activities continues to be the National Health Plan 2009–2020 and its implementation plan 2013–2016, the new document is an important vision document which sends a clear message that there is a need for a science-based drug policy which could be jointly implemented. Another important change occurred in the drug policy coordination mechanisms as the Drug Prevention Committee of the government obtained thematic working groups for the enhancement of cooperation. The working groups include service providers, representatives of the relevant ministries and drug coordinators of implementation agencies. Concerning legislation, eight new psychoactive substances were included in the list of narcotic drugs and psychotropic substances.

Drug-use in the general population and specific target groups

About one fifth of Estonian residents at the age of 18–74 reported that they had used narcotic substances at some point in their life, 8% of them had used them repeatedly. Drug use at some point in their life was three times more frequent among men than among women. Also, more young people reported to have used drugs at some point in their life (42% of 18–24 year-olds and 39% of 25–34 year-olds). Within the last year, 2% of Estonian residents at the age of 18–74 had used drugs. Cannabis was a drug used most often. That was followed by amphetamine, ecstasy, cocaine and hallucinogenic mushrooms (Police and Border Guard Board 2014).

A survey conducted among pupils indicated that 16% of pupils in the 6th, 8th and 12th forms had used narcotic drugs at some point in their life; most of them only once. The older the pupil the higher the percentage of drug users. The main narcotic substances used were cannabis products. However, magic mushrooms, new psychoactive substances, sedatives/tranquilisers without a doctor's prescription, amphetamine, ecstasy and cocaine were also mentioned (Police and Border Guard Board 2014).

Prevention

In universal prevention considerable progress was made in 2013. One of the important aspects was the process of compilation of the White Paper which lasted for a year and during which several important agreements were reached between the relevant parties of

the field of prevention and objectives for the year 2018 were set. Primary prevention plays an important role in the White Paper on Estonian's drug prevention policy. In addition to the drug prevention policy document, framework documents on the Estonian Alcohol and Tobacco Policy were also passed at the beginning of 2014. There were no significant changes in the drug prevention education taught in schools. The main focus in 2013 was the development of educational materials and guidelines of drug prevention for schools. A significant difference compared to the previous period was the focus on educating the parents on addictive drugs and the prevention of their children's addiction. Informational materials, a national media campaign and specific comprehensive projects were provided to educate parents. Also, several projects of universal as well as selective prevention for pupils and youth at risk were funded.

High Risk drug use

According to a survey on the risk behaviour and prevalence of infectious diseases among Tallinn IDUs' of 2013, the average age of IDUs was 32, and the respondents were mainly of Russian nationality. 79% of respondents started their drug use in ways other than injecting. On the average, respondents started to use drugs (except cannabis) at the age of 18. The first narcotic drugs used were usually amphetamine, ephedrine and ecstasy. The first injection occurred, on the average, at the age of 20. The respondents had been injecting, on the average, for 12 years (in the range of 0–33 years). Within the last four weeks, the main drugs injected were fentanyl and amphetamine. Within the last four weeks, 64% of respondents obtained clean syringes and/or needles mainly from a syringe exchange programme, 23% obtained them mainly from a pharmacy. More than half of the respondents in the survey had received drug treatment at some point in their life.

Drug-related treatment

The data on drug treatment originate from the RTA Implementation Plan Report of 2013 and from the Drug Addiction Treatment Database. In 2013, over 2.3 million euros were allocated for the provision of drug treatment and rehabilitation services, almost half of which was spent on methadone maintenance treatment and one third of which on the provision of adult rehabilitation service.

In 2013, 788 notices on treatment were sent to the Drug Addiction Treatment Database 434 of which were on the starting of treatment and 357 on the termination of treatment. One third of the people who sought treatment received treatment for the first time. Almost 60% of the people who sought treatment is of the age of 25–34 and 2/3 of the people who started treatment were male. Year by year the average age of the people who commence treatment has increased. In 2008 it was 27.0 and in 2013, 31.3 years. Most of the people

who sought treatment used fentanyl as their primary drug and received outpatient replacement therapy.

Health correlates and consequences

The number of new HIV cases per 100,000 residents was 24.3 cases (n=325) in 2013. According to the Health Board, the new cases included 22% of drug users. In 2013 all cases of HIV among drug users were diagnosed either in Tallinn or in Northeast Estonia. The prevalence of HIV among IDUs has been stable by regions within the last eight years: In Tallinn 55% (2007) and 58% (2013); in Kohtla-Järve 69% (2007) and 62% (2012), in Narva 52% (2010) and 51% (2014). The percentage of HIV-infected among people with TB has increased from 0.25% in 2000 to 11.4 in 2013. In total, 400 people with tuberculosis have been diagnosed within years, 30 of them in 2013.

Pursuant to the Estonian Causes of Death Registry, much less people have died as a result of drug use compared to the year before. 170 people died of such cause in 2012 but only 111 in 2013. The average age of the people who died was 32 and they were mainly men of Russian nationality who lived in the Harju or Ida-Viru County. Most of the drug-related deaths were related to fentanyl.

Responses to health correlates and consequences

The most important development in 2013 was the launch of the take home naloxone programme. The program educates IDUs and people close to them to recognize the overdose and administer naloxone to the person who has overdosed, and give first aid until the ambulance arrives. In total, 554 participants received training and 552 naloxone syringe sets were given out during the period of September 2013–June 2014. There were 72 repeated prescriptions.

Syringe exchange and counselling were provided by nine organisations in 2013 and there were 37 stations providing harm reduction services 13 of which were stationary and 24 of which field work stations. There were 153,745 visits to establishments providing harm reduction services in 2013. 849 new visitors and 6,677 repeat visitors with visitor's code were registered. In total, 2,183,933 syringes were given out in 2013.

Within the framework of the tuberculosis prevention programme, health care and social services preventing infection with tuberculosis are provided to HIV positive persons and other risk groups. In 3 of the 5 stationary tuberculosis wards, opioid addicts treated for tuberculosis have been provided with methadone maintenance treatment.

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

In 2013, in total of 1,019 drug-related crimes were registered which is somewhat more than in previous year. Of all drug-related crimes recorded in 2013, cases of unlawful handling of large quantities of narcotic drugs comprised 78%. Drug-related crime comprised 2.6% of all crimes. 3,519 misdemeanours related to drug use or possession of small quantities of drugs were registered in 2013.

870 persons with addiction diagnosis stayed in Estonian prisons in 2013, i.e. 28.8% of the total number of prisoners. Based on diagnoses, opioid addicts form the largest amount of all addicts, amounting to half of all drug addicts in prisons. Addicts are treated in prisons with non-opioid as well as opioid drugs. Methadone maintenance treatment is provided as replacement treatment.

Special departments of addiction rehabilitation have been established in Estonian prisons for social reintegration of drug addicts. The departments of addiction rehabilitation have been established in three prisons in total. The rehabilitation of the remaining addicts is based on social programmes.

Drug market

Estonia is not a manufacturer of drugs and most of the drugs are brought in. Cannabis comes from Holland; ecstasy, in addition to Holland, from Belgium and France; amphetamine from Holland, Lithuania and Russia; fentanyl, in liquid as well as solid form, from Russia. Estonia is a transit country for some narcotic drugs. Hashish moves through Estonia to Russia and cocaine to Scandinavia, Holland and Russia. The seized amounts of drugs included dramatic increases in cannabis products and amphetamine. The purity and price of drugs were quite stable compared to the previous year.

Approximately one-third of the 18–74-year-olds did not know how to evaluate the availability of narcotic substances. The remainder of the respondents assessed cannabis to be the most accessible (27%). Amphetamine, ecstasy and sedatives/tranquilizers were thought to be fairly or very easily accessible for 14–15% of the population. The younger the respondents, the more accessible cannabis was considered and the fewer respondents there were who were unable to assess the accessibility. The same age-related tendency occurred in questions regarding the availability of amphetamine and ecstasy (Police and Border Guard Board 2014).

Section A: New developments and trends

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

1.1 Introduction

The official document for planning financial resources and activities continues to be the National Health Plan 2009-2020 and its implementation plan 2013-2016. In addition to RTA, the Government of the Republic approved the White Paper on Drug Prevention Policy which is a vision document for drug policy which various parties shall take into account upon planning the activities of the field. The coordinating unit in the field of drug addiction is still the Drug Prevention Committee of the Government which includes, as of 2013, thematic working groups. The information necessary for the preparation of this chapter originates from the RTA Report of 2013, the White Paper and Annex 2 thereof and various legal acts available on the State Gazette.

1.2 Legal framework

In 2013 there were no significant changes in the legislation on drug addiction and no national guidelines forming the field were adopted within that period. The only relevant legislative change in 2013 was already included in the report of 2013. This was a change in the lists of narcotic drugs and psychotropic substances where, to the initial four lists, a fifth one was added (RT I, 05.03.2013, 1). The handling of substances listed in the fifth list is forbidden only if the purpose thereof is the causing of drug intoxication to a person. The amendment had to do with the need to add GBL and 1,4-BD to the list of narcotic drugs and psychotropic substances (<https://www.riigiteataja.ee/akt/105032013001>).

New substances were listed as narcotic drugs and psychotropic substances in 2013 as follows:

- 05.04.2013 GBL and 1,4-BD (www.riigiteataja.ee/akt/102042013004)
- 29.11.2013 Diviner's Sage (*Salvia divinorum*), Mitragyna Speciosa (*Kratom*), Salvinorin A, *mitragynine*, *7-hydroxy-mitragynine* (RTI,26.11.2013,4 www.riigiteataja.ee/akt/126112013004)
- 17.06.2013 4-methamphetamine (4-methylamphetamine, 4-MA)(www.riigiteataja.ee/akt/114062013001).

The Estonian lists of narcotic drugs and psychotropic substances are contained in Annex 1 of Regulation of the Minister of Social Affairs no. 73 of 18.05.2005 (https://www.riigiteataja.ee/aktilisa/1300/5201/4009/Narkootiliste%20ja%20psuhotroopsete%20ainete%20nimekirjad_lisa.pdf#).

1.3 National action plan, strategy, evaluation and coordination

As indicated in the last year's report, as of 2013, the source document of financial resources and planning of activities of reduction of drug addiction is the National Health Plan (RTA) 2009–2020 and the implementation plan thereof 2013–2016. As the RTA drug measure is quite general and the activities related to the field of drug addiction fail to form a systematic approach on how to address the drug addiction problem in Estonia, the White Paper on Drug Prevention Policy was prepared at the beginning of 2014. The document was prepared on the request of the Government Committee of Drug Prevention of Estonia and was approved by the Government of the Republic (VV) on 30.01.2014. To be more exact, VV approved the principles and policy recommendations for the reduction of drug-use contained on the White Paper on Drug-Use Reduction and the obligation to take them into account upon planning of actions of the National Health Plan 2009-2020 and other related plans in the field. The initial objectives of the White Paper have been established until the year 2018. The White Paper on Drug-Use Reduction in Estonia is available at: https://www.siseministeerium.ee/public/Valge_raamat.pdf.

The main objective of the White Paper on Drug Prevention Policy is to constantly reduce drug-use in Estonia and the public harm caused as a result thereof. In order to achieve this main objective, actions are carried out in three main directions of effect through six inter-agency cooperation systems and a separate monitoring system originating from these main directions of effect. The main activities planned for each system have been established in the detailed vision of activities of the White Paper until the year 2018, i.e. in Annex 2 of the White Paper.

The directions of effect of the White Paper and their sub-systems are the following:

I Direction of Effect: Decrease in the availability of drugs

System 1: The objective of the system of decreasing the supply of drugs is to combat the drug market and to decrease organised crime.

II Direction of Effect The prevention of the start of using drugs

System 2: Based on the universal prevention system, the demand for drugs shall be decreased. The objective of this sub-system is to ensure the necessary level of awareness and the rules disapproving drug-use in the society, including a drug-free developmental environment for the youth.

System 3: The objective of the early detection and intervention system is to detect the risk factors of drug-use as early as possible and to avoid the development of risks into an addiction by using appropriate interventions.

III Direction of Effect The helping of a drug-addict to get well

System 4: The objective of the harm reduction system is to decrease the prevalence of infectious diseases and the frequency of life-threatening overdoses among IDUs. Several civil society organisations provide help in the harm reduction system.

System 5: The objective of the addiction treatment and rehabilitation system is to provide treatment for drug addicts and thus decrease the demand for drugs. The system includes various services of drug treatment from stationary detoxification to various types of outpatient counselling.

System 6: The objective of the rehabilitation services' system is to prevent relapses after the end of treatment. In this system, the persons who have been released from drug treatment or prison are supported in resuming their independent lives by providing low-threshold education, supported jobs and support persons.

System 7: The monitoring system shall monitor the performance of all sub-systems and collect data on the efficiency of the interventions.

Upon establishment of objectives and choosing actions, the White Paper on Drug Prevention Policy of Estonia took into account scientific research on the nature of drug addiction and principles in conformity with the EU Drugs Strategy.

The drug prevention policy is still **coordinated** on the level of the Drug Prevention Committee of the Government (the basis for forming the Committee RT III, 10.04.2012, 11), in order to ensure constant cooperation between various areas and levels of government. The heads of the main organisations engaged in drug prevention and the reduction of drug supply and representatives of stakeholders meet four times a year in the Drug Prevention Committee. Four ministries - the Ministry of the Interior, the Ministry of Justice, the Ministry of Social Affairs and the Ministry of Education and Research - are represented on the highest level. The Minister of the Interior is in charge of the Drug Prevention Committee. As of 2013, the substantial coordination of the drug policy is carried out in the working group based on the sub-system of the White Paper consisting of service providers, representatives of the respective ministries and drug coordinators of implementing agencies. The work of working groups includes the discussing of joint priorities for the planning of the state budget, the resolution of current problems in cooperation, and the feedback received from working groups shall be forwarded to the ministers for the making

of management decisions. A representative of the monitoring system shall participate in all working groups and shall summarise the input which shall be forwarded to the Drug Prevention Committee of the Government to the management of the ministries for decision-making. Policy guidelines of the White Paper are monitored by the National Institute for Health Development as the performance indicators of the White Paper coincide, to a considerable extent, with the former national monitoring needs.

As one of the bottlenecks of carrying out the strategy of the previous period was insufficient coordination, it is important to ensure sufficient communication by working groups, constant sharing of the common vision and the following of the same performance indicators. Each working group has a leader that has been appointed permanently and the leaders of working groups, in turn, form a task force. The body discusses overlaps in and cooperation between systems and makes proposals to the government committee on specific guardianship and investment needs.

1.4 Economic analysis

Since as of 2013 reporting in the field of drugs is no longer a part of reporting on the National Drug Prevention Strategy 2012 (NERS), the costs of the field of drugs can no longer be compared to the costs of previous years. Drug prevention finances are mostly planned in the implementation plan of the National Health Plan 2013-2016 but the budget and division of activities thereof no longer reflects the detailed drug prevention costs of education and the field of reduction of supply. The costs of the field of drugs in education and the reduction of supply are included in the general amounts of general education and crime prevention.

In the previous year of 2012, EUR 2,322,755.43 was spent on the carrying out of NERS, in 2013 the total of **EUR 18, 28036** was spent directly on activities related to drug-use prevention (Measure 5). Initially EUR 2,496,058 was planned for the carrying out of Measure 5 of RTA which did not include the costs of activities of reduction of supply, however, in reality 73% of the planned amount was spent. The biggest difference between the planned and actual costs occurred in the Ministry of Justice where EUR 1,684 of the planned EUR 412,590 on alternative sentences was realised since alternative sentence was only imposed on one person.

From the funding of RTA, EUR 1,421,027 was allocated to the National Institute for Health Development of which 94% (EUR 1,331,845) was used. The under-execution has to do with the payment of some of the invoices in January 2014. Most of the activities of TAI included drug addiction therapy and rehabilitation. In total of EUR 127,073 was spent on the treatment of non-opioid drug addictions and the increasing of the quality thereof, EUR 1,156,141 was spent on rehabilitation services and EUR 39,922 on counselling. In addition

to drug measures Measure 7 of RTA also included: The activities in the field of drugs *the prevention of new cases of infection and the achieving of a constant downward trend in the prevalence of HIV/AIDS*. From Measure 7, in 2013, syringe exchange service and counselling were funded in the sum of EUR 1,124,021; the prevention of deaths caused by overdoses was funded in the sum of EUR 22,652 and methadone maintenance treatment of opiate addicts was funded in the sum of EUR 1,037,555. In addition to the state budget, the funds of the European Social Fund (ESF) were used in 2013 for the funding of activities of the National Drug Prevention Strategy. The activities focused on the development and provision of counselling services for people with addictive disorders. In total, ESF's funds in the sum of EUR 156,083 were used.

In 2013, the Ministry of the Interior funded activities of primary prevention of drug addiction in a larger amount. More than EUR 100,000 was allocated for universal and selective prevention projects for the use of addictive substances (see Chapter 3) and a comprehensive media campaign directed to parents was carried out (EUR 124,743). The Police and Border Guard Board financed projects of addictive subject prevention and increase in social skills in the total sum of EUR 44,366.

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

2.1 Introduction

Drug use among the population was surveyed by a poll organised by the Police and Border Guard Board. Almost one-fifth of the adult residents of Estonia reported that they have used drugs at least once in their life. The substance used more often is cannabis. Drug-use was the most common among younger men.

Pupils and class teachers were examined in the same survey. 16% of the students reported to have used drugs, cannabis the most often, at least once. Teachers were asked how big of a problem they consider drug-use to be among pupils and how they would act in such situations. Also, the preparedness of teachers for dealing with problems like these were researched.

2.2 Drug use in the general population

A survey requested by the Police and Border Guard Board "A Survey on Awareness of Risk Behaviour" conducted by AS Emor was carried out in 2013. The topics addressed in

the survey included addictive substance use, violence, prevention related to theft and traffic behaviour, matters concerning citizenship and identity documents and cooperation with the police. We will analyse the results concerning the use of addictive substances. The sample was formed of residents of Estonia at the age of 18–74, pupils of general education schools in 4th, 6th, 8th and 12th forms and teachers of these schools. Among adults, data was collected in the CATI method of phone interview (*Computer Assisted Telephone Interviewing*). The sample of the survey was formed of desk set as well as mobile phone users. 3,850 adults were included in the survey.

About one fifth (19%) of Estonian residents at the age of 18–74 reported that they had used narcotic substances at some point in their life, 8% of them had used them repeatedly. Drug use at some point in their life was three times more frequent among men than among women (29% vs 10%). Also, more young people reported to have used drugs at some point in their life (42% of 18–24 year-olds and 39% of 25–34 year-olds).

More than half of the respondents who reported to have used drugs did it more than 5 years ago and 40% did it within the last 5 years, including more than one-tenth of the respondents within the last year. Within the last year, 2% of Estonian residents at the age of 18–74 had used drugs. Cannabis was a drug used most often (16% of the respondents). That was followed by amphetamine (1.5%), ecstasy (1.1%), cocaine (0.8%) and hallucinogenic mushrooms (0.4%).

Upon assessment of the hazardousness of drug-use, regular use of ecstasy or amphetamine was considered the most hazardous, and a large number of respondents assessed it to be a high-risk activity. This was followed by regular cannabis smoking and the trying of ecstasy/amphetamine once or twice. 29% of respondents considered smoking cannabis once or twice an activity with a high risk level. Compared to men, women considered drug-use to be more of a high risk activity. By age groups, respondents at the age of 18–34 perceived the least risks related to drug-use.

Among other things, parents were asked about talking to their children about addictive substances. 72% responded that they have discussed topics on the use of cannabis, ecstasy and amphetamine. Less (52%) of the parents said that they have talked about the hazardousness of inhalants (e.g. glue, varnish, solvents). The younger the parents the more they have talked about the risks involved in drug-use.

2.3 Drug-use in the school and youth population

The results of the last European School Survey Project on Alcohol and Other Drugs (ESPAD) were provided in the report for 2012. The next ESPAD survey shall be carried out in 2015.

In the abovementioned survey on risk behaviour of the Police and Border Guard Board, pupils and their teachers were also examined. 3,853 pupils in 4th, 6th, 8th and 12th forms of Estonian general education schools were included in the survey. The pupils filled out their questionnaires either electronically in a computer class or on paper. The class teacher survey involved the same general education schools as the pupil survey. The teachers were sent an invitation to participate in the survey by email with a link to an electronic questionnaire. In total 352 class teachers completed the questionnaire.

The survey indicated that 16% of pupils in the 6th, 8th and 12th forms had used narcotic drugs at some point in their life; most of them only once. The older the pupil the higher the percentage of drug users, and in the 12th form it was four times higher than in the 8th form. Of students in the 6th form, 1% had been exposed to drugs and 3 respondents of this percentage reported repeated drug-use.

The main narcotic substances used were cannabis products. However, magic mushrooms and of new psychoactive substances Spice, PMMA, mCCP, BZP, etc., depressants/sedatives without a doctor's prescription, amphetamine, ecstasy and cocaine were also mentioned. In half of the cases narcotic drugs were obtained from an acquaintance or a friend for free and about one-fifth reported to have bought it from an acquaintance or a friend. Obtaining of buying drugs from a stranger were reported less.

Pupils were asked how forbidden or allowed the use of cannabis should be. Most of the pupils (84%) agreed that the use of cannabis should be forbidden for minors and 46% thought that it should also be forbidden for adults. The younger the pupils, the more strict their opinions on the admissibility of addictive substances. 85% of the pupils replied that they would refuse from the use of cannabis if offered to do so by a friend. Most of the pupils (93%) agreed that drug-use may bring about situations that are regretted later and they agreed (82%) that a large percentage of criminal offences are committed under the influence of alcohol or drugs. They were also aware (77%) that upon buying a narcotic substance, one cannot be sure how strong the substance is.

Pupils were also asked if they knew how to act in a situation where a friend that has used drugs does not feel well, i.e. he or she is having seizures and is unconscious. Almost one-third (31%) of the pupils indicated that they know for sure what to do and 19% did not know what to do. The rest were not sure about their skills.

It appeared from the survey carried out among class teachers that 94% of the teachers considered drug-use among pupils at their school a rather insignificant problem or no problem at all. Almost one-tenth (9%) reported that they have seen a pupil possess or use drugs or suspected a pupil thereof. In regard to inhalants, the same was reported by 4% of the teachers. The teachers who had noticed a pupil possess or use drugs or suspected a pupil thereof were asked what they had done in these situations. More than a half of them reported talking to another teacher or to the pupil associated with the situation. Addressing the management or a specialist at school and contacting the police were mentioned often. Generally, it was reported that there were no problems with the resolution of these situations. However, there were situations where pupils were reluctant to help resolve the case or where parents were not interested in cooperation. In some cases, there was a problem that since it was only a suspicion the school was unable to address the problem in fear of a wrongful accusation. Among other things, the lack of necessary staff was mentioned.

Less than half of the teachers were aware that upon suspicion of carrying of an illegal substance, a teacher has the right to request the pupil to open their bag or locker. More than 60% were aware that if a pupil brings tobacco products, alcohol or narcotic drugs to school, a teacher has the right to confiscate, i.e. store them. Interestingly, the less work experience the teacher had, the better were his or her knowledge. More than half (60%) assessed their knowledge and skills in addressing cases concerning the possession and use of narcotic substances to be insufficient.

2.4 Drug use among specific target groups and locations at the national and local levels

No special surveys have been carried out on drug-use in different target groups and in different locations.

Chapter 3. Prevention

3.1 Introduction

As of 2013, all national drug addiction prevention activities are a part of the comprehensive National Health Plan 2009-2020 (RTA) and form a plan measure therein. In RTA, drug addiction prevention activities are represented very generally. More specific objectives, directions and necessary activities are described in the White Paper on Drug Prevention Policy adopted at the beginning of 2014 and the vision of activities thereof, i.e. Annex 2. Prevention activities included in the White Paper and Annex 2 thereto have been agreed upon between various ministries and approved by the Cabinet Meeting so the carrying out thereof should be taken into account in the annual activity plans of RTA and their development plans concerning the field of drug addiction. The objectives of the White Paper shall be carried out by 2018. The objective of the prevention part of the White Paper is to form a guideline for the planning of RTA and other development plans of strategic documents.

One of the three directions of effect in the White Paper **mentioned in the document** is the prevention of commencement of drug use the purpose of which is to decrease drug-use in general and to prevent and postpone the commencement of drug use. Two systems have been provided under the direction of effect of drug-use prevention: **the primary or universal prevention system** directed to children and all residents who have not yet used drugs, and **the early detection and intervention system** which helps notice the symptoms of children or adults with the risk of drug addiction early and help these people before the experimentation with drugs has turned into an addiction.

The main objective of the **universal prevention system** of the White Paper is to provide systematic, continuous and sufficient prevention services that strengthen the protection factors of adult residents and children against drug addiction. The Ministry of Social Affairs, the Ministry of Education and Research, the Ministry of Culture, the Ministry of the Interior and the National Institute for Health Development with local governments are the cooperation partners in planning and funding the universal prevention system. The executors of activities are parents, child care and educational institutions, civil society organisations engaged in youth work and hobby education and local governments.

Sub-objectives of the universal prevention system are:

- Development of parental skills;

- Implementation of evidence-based universal interventions in child care and educational institutions;
- Ensuring of adults with sufficient information and norm formation

The main objective of the **early detection and intervention system** is to detect the risk factors of drug-use as early as possible and to avoid the development of risks into an addiction by using appropriate interventions. The cooperation partners in the early detection system are the Ministry of Social Affairs, the Ministry of Education and Research, the Ministry of the Interior and the Ministry of Justice and the executors are health care professionals, the police, child protection at the local level, support service specialists and social workers at schools.

Sub-objectives of the early detection and intervention system are:

- The development of the concept of the early detection and intervention system;
- The piloting and implementation of the services of early detection and intervention of drug addiction in the health care system;
- The piloting and implementation of the services of early detection and intervention of drug addiction at child care and educational institutions, in police work and the social and support services;

The prevention-related information of 2013 has been obtained from the management report of RTA of 2013, from the prevention report of the Police and Border Guard Board of 2013 and the prevention report of the Ministry of the Interior of 2013. The White Paper on Drug Prevention Policy has also been used.

3.2 Environmental prevention

There were no relevant amendments to the legislation concerning alcohol and tobacco. However, at the beginning of 2014 two important policy documents were approved by the Cabinet Meeting which should be considered in the activities of these fields.

First, in January of 2014 the Green Paper on Tobacco Police was approved which is based on Section 8 “Efficient combat with infectious diseases, alcoholism, tobacco and drug addiction that are destroying the society” of the Chapter “Healthy Estonia” of the Action Programme of the Government of the Republic 2011–2015.

The following specific steps were pointed out in the tobacco policy:

- Measures to ensure a smoke-free environment;
- Measures to reduce the attractiveness of tobacco products;
- Measures for the regulation of marketing of products that provide an alternative to tobacco products;

- Measures to prevent tobacco-use, publicity measures, treatment of tobacco addiction and
- counselling services for giving up tobacco products.
- Measures to restrict the illegal market and to develop the tax policy;
- Strengthening penalties for making tobacco products available to minors;
- Monitoring;

The Green Paper on Tobacco Policy is available here:

http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/tubakas_2014.pdf.

Also in February of 2014, the Government of the Republic also approved the Green Paper on Alcohol Policy. The Green Paper prescribes measures for the restriction of alcohol accessibility and promotion, for the reduction of harm caused by alcohol consumption and intoxication, for the local support of alcohol policy measures, for the enhancement of awareness and for the improvement of availability of treatment and counselling services.

The following specific measures were set forth in the alcohol policy for the reduction of excessive use and harm:

- Restriction of accessibility of alcohol;
- Restriction of promotion of alcoholic beverages;
- Price and tax policy;
- Prevention of distribution of illegal alcohol;
- Reduction of alcohol consumption and the harm caused by intoxication;
- Prevention of drunk driving;
- Activities of local governments on reduction of harm caused by alcohol;
- Enhancement of awareness;
- Treatment and counselling;
- Monitoring and assessment of alcohol consumption, health impact and the implementation and efficiency of the alcohol policy.

The Green Paper on Tobacco Policy is available here:

http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/tubakas_2014.pdf.

3.3 Universal prevention

The topic of drugs is still addressed through the subject syllabus of Health Education which is mandatory in all general education and vocational schools (2nd–12th form). The actual implementation of the study programme has not been fully efficient so far. The teaching of

the topic of drugs is still problematic due to outdated study materials as well as the accessibility of teacher training. Most of the teacher's books on drug prevention based on social coping skills for regular schools have been developed in the period of 2001–2004 (in 2007, a teacher's book on social coping skills was completed for teachers who teach pursuant to the simplified study programme in 1st to 5th forms) In 2013, the process of updating teacher's books for social coping skills was commenced. The leading experts of the field in Estonia prepared a new manuscript of a teacher's book on social coping skills for the stages of study I-III. The manuscript is basically edited and approximated and it shall be dealt with in 2014. In addition to teacher's books, as of 2012, teachers of Health Education have a drug-related educational film "Mõtteaine" [in English "Substance of Thought"] to help them teach the topic of drugs (see the report of 2013).

In 2013, the National Institute for Health Development also engaged in the preparation of guidance materials for recommendations on drug prevention and the resolution of drug-related situations prepared for schools. The guidance material provides advice on the comprehensive organisation of drug prevention at schools and is divided into five larger chapters: "Introduction to drug prevention", "Starting points on drug prevention at schools", "Possibilities of drug prevention at schools", "Organisation of drug prevention at schools" and "Drug-related situations and the resolution thereof". The annexes include explanatory practical auxiliary materials. The guidance material concerns the study programme of drug education in Health Education and based thereupon every school is able to supplement the existing school documents (the school's development plan, the school's statutes, the emergency management plan, etc.) or to prepare a drug prevention action plan suitable for their circumstances. The guidance material is suitable for basic schools and upper secondary schools, institutions of higher education, vocational schools, specialised schools and hobby schools. The guidelines are addressed to school managements and health councils (or other working group with such functions) as well as other school employees: teachers of extra-curricular activities, subject teachers, class teachers, school psychologists, health care professionals, social pedagogues or social workers and other persons related to school (parents, caregivers, the Board of Trustees). They may also be helpful for organisations working with schools, youth organisations, youth centres, parents/caregivers and the Juvenile Police.

The guidance materials were published in 2014 and are available here: <http://www.terviseinfo.ee/et/tervise-edendamine/koolis/olulised-abimaterjalid/uimastiennetus/uimastiennetusjuhend>.

Progress was made in **drug prevention addressed to parents** in 2013. As of the school year of 2012/2013, the National Institute for Health Development conducts in 5th forms of 34 schools the alcohol prevention programme “Efekt” [in English “Effect”] which is a prevention programme developed by the scientists of Örebro University in Sweden. The main objective of the programme is to postpone the age of first-time alcohol consumption and to decrease the consumption of alcohol among young people. Within the framework of the programme, six 30-minute meetings are organised at parent-teacher meetings within three years where trainers who have received special training tell parents about alcohol consumption among young people, the prevention thereof and the attitudes of parents towards youth alcohol consumption. Twice within a school year all parents receive newsletters containing information on addictive substances and other topics related to children. This is the first time where such approach is used for the reduction of alcohol consumption among young people.

The programme provides parents with knowledge on the effects and harm caused by alcohol and strengthens their skills on communicating with and setting rules for children. It is also important that parents agree among each other which rules to set for children. The “Efekt” programme was conducted for the first time among pupils in 7th to 9th forms and their parents in the period of 1999–2001. The assessments carried out during and after the programme indicated that the attitude of parents who received training was more strict compared to the ones not participating in the programme. Also, it was determined that the children whose parents participated in the training had lower results in getting drunk. The programme also had a positive effect on the anti-social behaviour of children. At first the programme is conducted in the network of health promoting schools of Estonia and should the results be positive, it will be carried out all over Estonia in the following years.

In 2013 the National Institute for Health Development started to develop a drug-related brochure for parents. The guidance materials for parents shall be available both in the Estonian and Russian languages. The column for parents on the web page [narko.ee](http://www.narko.ee) <http://www.narko.ee/lapsevanemale/> where parents obtain information on the nature of drugs, on how to talk to children about drugs and how recognise the first signs of drug-use has also been updated.

In addition to the parent column on [narko.ee](http://www.narko.ee), in 2013, the Ministry of the Interior created a web page for parents called “Tark vanem” [in English “Smart parent”] <http://www.tarkvanem.ee/>. The web page contains useful information for parents on how and when to talk to their children about addictive substances. The web page contains educational videos prepared especially for that project and reading suggestions. The web

page is also linked to a Facebook page. The development of the web page and the Facebook page was related to the larger awareness campaign for parents “Lapsevanem, ära maga maha õiget aega! Varakult suitsule ja alkoholile pandud piirid peavad paremini” [in English “Parents, do not miss the right time!”] [in English “Parents, do not miss the right time! Early restrictions on smoking and alcohol are more effective”] (see Paragraph 3.6).

The Healthy Estonia Foundation has been dealing with the education of parents on addictions at the workplace (<http://terve-eesti.ee/koolitused/alkohol/>). Trainings may be ordered by employers and they include the teaching of parenting skills to private persons as well as on a project-based manner Family Centre You and Me (<http://www.sinamina.ee/>).

In 2013, a qualitative survey based on focus groups and a quantitative (N=600) survey for mapping the awareness of parents on addictive behaviour were carried out. The quantitative survey concerned the ex ante and ex post appraisals of the “Tark vanem” [in English “Smart parent”] awareness campaign and the objective of the survey was to map the awareness, attitudes and concepts of parents regarding their role in the prevention of their children’s risk behaviour. There were in total 83 parents in the focus groups (12 focus groups) and their main objective was to examine in depth how the parents of children at the age of 5–17 perceive their role in the prevention of their children’s addictive behaviour and how the topic of drugs is addressed at home.

Universal drug prevention projects funded in 2013

In 2013, the Ministry of the Interior made a considerable contribution to the universal prevention. In addition to comprehensive education provided for parents all over the country, the Ministry of the Interior invested more than EUR 100,000 in several drug prevention projects. Under the objective of drug prevention, the Ministry of the Interior also funded the anti-school-bullying programme “KiVa” and, in 2013, started to develop and localise the sports programme “Kickz” developed in the UK the purpose of which is to involve children in the risk group in sports. The Ministry of the Interior funded the KiVa programme (SA Kiusamise Vastu [in English The Against Bullying Foundation]) in liaison with the Ministry of Education and Research in the total sum of EUR 30,719. The objective of KiVa was to implement an anti-bullying programme at Estonian schools which is based on the best international practice and is evidence-based. The Anti-Bullying School Programme has a considerable effect on the comprehensive prevention of risk behaviour. The Estonian KiVa programme is focused on the development of emotional and social skills of children and the understanding of the rules of group behaviour and relationships. The objective of the KiVa programme was to decrease the frequency of school bullying, the anxiety and depression of pupils, the dropping out of school and to increase pleasant

feelings towards going to school, academic achievement and to improve the relationships among pupils. In the framework of the Estonian pilot project, 20 schools participated in the basic part of the Anti-School-Bullying Programme in the school year of 2013/2014.

In addition to KiVa, chess studies of 20 schools (10 with Estonian and 10 with Russian language of instruction) were funded in the school year of 2013/2014. The activities were carried out by the NGO Kasparov Chess Foundation to which EUR 24,264 was allocated.

In total, about 1,000 children joined the project. In addition to the 20 schools, chess studies were also commenced in up to 12 schools who started the teaching chess in the school year of 2012/2013 (about 600). Chess studies were funded from the funds of drug prevention because one of the special features of chess is the obligation to follow correct rules of behaviour when playing. One cannot violate the rules because each violation may immediately lead to losing. This develops children's respect for rules and generally recognised rules of behaviour from an early age which contributes to the development of moral and ethical values and attitudes.

The third primary prevention project funded by the Ministry of the Interior was the social circus project carried out by Tsirkusestudio Folie NGO (EUR 21,630). Through various circus and acrobatics' techniques, the social and teamwork skills of 6–10-year-old children were developed. The project involved 10 schools and 180–250 pupils from these schools.

In addition to the Ministry of the Interior, the Police and Border Guard Board (PPA) funded several drug prevention projects in 2013. Most of the drug-use prevention was carried out by developing social skills and providing legal information. The prevention activities in PPA were carried out through various prefectures. On the territory of the East Prefecture, several prevention activities for 13–16-year-old pupils were carried out where the pupils were talked to by former drug addicts and athletes who aimed to direct children to healthy ways to spend their free time. Several sporting events and competitive activities were carried out within the project. Drug-related lectures were given to the youth of the North Prefecture and an inter-school drug-preventing orienteering competition was carried out. In two schools, round tables with teachers were held and pupil seminars were organised for the early detection of a drug problem at school. The youth were organised thematic days on drug-use and violation of laws. In South and West Prefectures there were several drug-related lectures at schools as well as youth centres.

Provision of information related to drug-addiction

The main web page providing information on drugs is still the narko.ee maintained by the National Institute of Health Development. In 2013, a banner campaign was carried out the objective of which was to increase the attendance of narko.ee. The campaign was directed

to parents and youth at the age of 14–18 who have had previous contact with drugs. The narko.ee environment was provided with the search functionality in 2013 so that the web page would be easier to use. Throughout the year, letters sent through the narko.ee web page were replied.

In counties and larger towns there are still information and counselling centres which provide young people with prevention-related information. The centres have visual information on the effects of addictive substances, basic means of self-protection and the contact information of counsellors in order to get help in case of a problem.

3.4 Selective prevention for risk groups

Similarly to previous years, drug counselling service for risk children was provided by SA Tallinna Lastehaigla and OÜ Corrigo in Jõhvi. OÜ Corrigo provided individual psychological counselling and family therapy for youth and parents. It also carried out 35 interactive drug prevention trainings within a year. In total, 625 young people participated in the trainings. SA Tallinna Lastehaigla carried out group therapy sessions for minors with addiction problems and for minors in the risk group and their parents. In addition 195 phone counselling sessions were carried out.

In the schools of the students needing special education conditions, drug prevention covers all pupils. Relevant programmes are implemented within the framework of the general education activities. The pupils mainly obtained information on addictions and training on social skills. All pupils of specialised schools were included in the prevention work.

In 2013 the Ministry of the Interior carried out a project competition for prevention projects directed to **high-risk youths** the purpose of which was to find social partners who are willing to carry out high-quality activity and prevention programmes for high-risk youths that develop their social and emotional skills and facilitate their participation in organisations and social life. Of the 13 projects presented, 3 were funded in the total sum of EUR 50,317. First of the chosen projects introduced extra-curricular developing activities on the basis of purposeful creative group work to high-risk children at schools. Purposeful creative group work is a manner of intervention where in a safe, encouraging, judgement-free, positive and supporting environment of peers artistic activities are used based on the rules agreed in the group to support self-expression in order to develop self-related and social skills. Purposeful creative group work was provided, in total, for 16 groups of pupils (on the average 6 pupils in a group). Four groups were formed of pupils of 1st to 4th forms (group work with the length of 45 minutes per session) and twelve groups (group work with the length of 90 minutes per session) were formed in cooperation with schools, local governments and the Juvenile Committee. The activities were carried out by NGO Pusa.

The second project chosen was directed to the development of social and emotional skills of the risk youth in the City of Narva and to the increase of their social activeness. Within the project, a preventive forum theatre programme was developed and carried out at the schools of Narva and at the Narva youth centres. During the project, results were assessed and the programme was developed in liaison with the Tartu university and the local government. The forum theatre method is focused on the stimulation of youth in protecting their rights and changing their own attitudes. One of the objectives of the project was to decrease risk factors related to drug-use, academic failure, impulsiveness, behavioural problems and the committing of offences. The immediate target group of the project was the youth at risk in the City of Narva at the age of 10–26. The forum theatre performed at each and every school and youth centre in Narva. The project was carried out in Narva (Ida-Viru County) because the drug-use statistics, the number of children sent to the Juvenile Committee and the number of children engaged in recreational activities indicate that this is a high-risk region. The project was carried out by NGO Vabatahtlike Ühendus SEBRA.

The third project involved the support of the Tallinn Child Support Centre where group assignments were carried out with the view to improve the social skills of high-risk youths, to prevent new criminal offences, to improve the impulse control of children which contributes to more successful social and psychological coping and law-abiding behaviour of the children and their families. The youths were directed to the project by a child protection official or, upon consent of a parent, by a psychologist/social worker. The project involved 100 clients (youths and their parents) who were not staying the Child Support Centre. Another target group is the parents of the children included in the project. Group assignments are based on the teaching of social skills. In addition to group assignments, parents are provided in-service training courses held four times per semester in Estonian as well as Russian. Trainings provide parents with courage and tips on interacting with their children, on how to handle matters of sexuality and how to and why discuss addiction problems. The increase in the competence and self-confidence of parents contributes to the development of more responsible behaviour of youths, the improvement of awareness on safe behaviours, relationships and the prevention of alcoholism and drug addiction. The project was supported in the amount of EUR 22,472.

3.5 Indicative prevention

Within the reporting period there was only one small-scale pilot project of the North Prefecture “Puhas Tulevik” [in English “Clean Future”] within which youths up to the age of 27 were directed, pursuant to the developed guidelines, upon their own consent, to a six-month programme developed by the city district government. The project focused on the

counselling of and the provision of support and help to minors. In 2013, 6 minors were directed to the programme. In addition to the project, PPA engaged in the small-scale development of sponsor service for people detained in houses of detention for a drug-related offence. The objective was to counsel them and to direct them to necessary services. In 2013, the project “Julge olla Sina ise” [in English “Dare to be yourself”] was carried out which provides a social programme for minors directed by the Juvenile Committee in three 6-day camps.

3.6 National media campaigns

In 2013, two drug-related media campaigns were carried out. The first and the bigger one was a parent involvement campaign for the prevention and reduction of children’s addiction behaviour funded by the Ministry of the Interior. The slogan of the campaign was “Lapsevanem, ära maha maga õiget aega! Varakult suitsule ja alkoholile seatud piirid peavad paremini” [in English “Parents, do not miss the right time! Early restrictions on smoking and alcohol are more effective”]. The campaign served the purpose of a drug prevention campaign, considering the fact that drug-use is usually preceded by the consumption of alcohol and tobacco. A parent with his or her eyes closed who misses the right time to talk to their child about addictions and to set early restrictions on the consumption of alcohol and tobacco products was featured in the campaign. The campaign was carried out in the period of 03.12.2013–26.01.2014 and focused on the parents of children at the age of 6–11. The campaign included televised and outdoors media, newspapers and magazines, social media and the internet. The video produced for television and social media is available here: <http://www.youtube.com/watch?v=ydE-yxJ4Qig>. In the framework of the campaign, a web page and a Facebook page www.tarkvanem.ee were developed. Outdoors advertising of the prevention campaign was displayed in bus stops, illuminated display stands, on the doors of shopping centres, and the purpose was to bring about discussions between a child and his or her parent. The advertisements displayed in illuminated display stands were provided with lenticular images where the main visual was at the level of a parent’s eyes and a bad bogeyman representing addictive substances was at the level of a child’s eyes. The approach was to make a child wonder who is the bogeyman.

The campaign received a massive response in media. That includes online and print media as well as TV and radio. The campaign caused a wider discussion in media which was supported by a properly chosen spokesperson and PR.



Picture of the campaign “Tark vanem”

Another drug addiction prevention clip promoted in media was prepared in the framework of the prevention project of the East Prefecture of the Police and Border Guard Board where pupils were given an opportunity to write a scenario for an anti-drug social advertisement. The winning scenario was the basis for a TV advertisement in Estonian and Russian reminding the hazards of drugs. The main message of the TV advertisement was to visualise the downward spiral brought about by drug-use and the slogan was “Loobu mõttest proovida. Sul on ainult üks elu”. [in English “Give up the thought of trying. You only have one life”].

The clips were shown on national television (ETV, ETV2) at the beginning of school 2.-15.09.2013, on Lites TV in the period of 1.09.-30.10.2013 and on the Russian TV channel NTV Mir during the month of August.

The clips are available here:

in Estonian: <http://youtu.be/BFUr10ZbNg8>

in Russian: <http://youtu.be/APvYUjIPPWw>

Chapter 4. High risk drug use

4.1 Introduction

In liaison with TAI and the University of Tartu Department of Public Health, surveys on IDUs' risk behaviour and prevalence of infectious diseases have been carried out in Estonia since 2003. The first surveys were conducted among clients of the syringe exchange programme. The method of respondent driven sampling (RDS) has been used since 2005. The results of previous surveys have been introduced in the previous reports. In this report we will provide an overview of the latest survey conducted in Tallinn.

4.2. Prevalence of and trends in HRDU

Until now, two surveys on the assessment the population group of IDUs have been carried out (Uusküla et al 2007; Uusküla et al 2013). Based on these surveys, the number of IDUs at the age of 15–44 has decreased from 13,886 persons in 2004 to 5,362 in 2009. The latest survey on the size of the population group of IDUs was introduced on the previous report.

4.3. Characteristics of high-risk drug-users

In the summer of 2013, a survey on risk behaviour and prevalence of infectious diseases was carried out among IDUs of Tallinn. 328 respondents were included in the survey, 77% of whom (n=252) were men and 23% of whom (n=76) were women. Their average age reached 32 years (in the range of 18-59 years of age). The respondents were mainly of Russian nationality (77%, n=253).

79% (n=257) of respondents started their drug use in ways other than injecting. On the average, respondents started to use drugs (except cannabis) at the age of 18 (in the range of 8–53 years of age). The first narcotic drugs used were usually amphetamine (57%, n=185), ephedrine (10%, n=33) and ecstasy (9%, n=28). The first injection occurred, on the average, at the age of 20 (in the range of 8–53 years of age). The respondents had been injecting, on the average, for 12 years (in the range of 0-33 years). Within the last four weeks, the main drugs injected were fentanyl (78%, n=257) and amphetamine (20%, n=67).

Within the last four weeks, 64% (n=210) of respondents obtained clean syringes and/or needles mainly from a syringe exchange programme, 23% (n=76) obtained them mainly from a pharmacy. More than half (54%, n=178) of the respondents in the survey had received drug addiction treatment at some point in their life. Within the last 6 months, 34% (n=112) had received treatment. During the survey, more than a quarter (27%, n=88) of participants in the survey were receiving drug addiction treatment, most of whom were on replacement or detoxification treatment.

94% (n=308) of the respondents had taken an HIV test before. Based on the blood tests taken in the survey, the prevalence of HIV was 58% (95%CI 52%–63%) (n=190). 88% (n=165) of the drug addicts that turned out to be HIV-positive were aware that they had HIV. Almost three quarters of the HIV positives (73%, n=120) had taken antiretroviral drugs before.

68% (n=224) had been in prison before, 37% (n=82) had injected drugs while in prison. 39% of them had done at the last time they were in prison. Upon injecting drugs while in prison at that last time, 58% (n=21) of respondents used a needle and/or a syringe that had been used before.

68% (n=224) of respondents had overdosed up to the point of losing consciousness before. Within the last 12 months, 27% (n=89) had overdosed.

Upon comparing the results of surveys carried out in Tallinn in various years (2005, 2007, 2009, 2013), it may be concluded that most of IDUs are men. However, the percentage of women has increased slightly from 17% in 2005 to 23% in 2013. Also, the average age of IDUs has increased from the age of 24 to the age of 32. Moreover, there have been changes in the substance being injected. When in the first surveys the most popular substances were heroin and poppy liquid, then in the past years the main substances injected are fentanyl and amphetamine. Upon comparing the first survey and the last survey carried out last year, the period of injection of respondents has extended, with the median respectively, 6 years and 12 years. Upon comparing the results conducted in various years, there is a decrease in the use of syringes and needles that have been previously used by another person from 54% to 23%. However, the prevalence of HIV has not changed among IDUs, it still being over 50%.

The survey report is available on the web page of TAI.

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

5.1 Introduction

The data presented in subchapters 5.1 and 5.2 of this chapter originate from the implementation plan report on 2013 of the National Health Plan 2009-2020 (RTA). The subchapter 5.3 presents data of the drug addiction treatment database of TAI, providing an overview of the social-demographic and treatment-related data of the persons having sought drug addiction treatment in the last two years (2012 and 2013). The drug addiction treatment database using internet-based data collection system has been operating since 2008 and includes the persons having sought drug addiction treatment and to whom their attending physician has placed the diagnosis F11–F16.9, F18–F19.9. In the interpretation of the data presented in the chapter, account should be taken of the fact that due to the difference of the registration systems the number of persons having sought treatment registered in the drug addiction treatment database from 1.01.2013 to 31.12.2011 differs from the number of treated persons shown in the RTA reports.

5.2 General description, availability and quality assurance

Strategy

The most significant change concerning drug addiction treatment and rehabilitation is the completion of the long-term National Strategy of Prevention of Drug Addiction (NERS) and the transfer the field of drugs from the domain of the Minister of Social Affairs to the domain of the Minister of the Interior. The source document of drug addiction, after NERS was completed, was the National Health Plan 2009-2020 (RTA) managed by the Ministry of Social Affairs.

As of 2013, the source document for the reduction of drug addiction is RTA and the implementation plan thereof for 2013–2016. Measure number 5 of the implementation plan's forth sub-objective "The physical activity of the population has increased, the diet is more balanced and there is a decrease in risk behaviour" is the prevention, reduction and of use of narcotic substances and the decrease of harm to health and the society caused

as a result thereof. In addition to NERS which was completed in 2012 but the activities of which are continued in RTA, the National Tuberculosis Prevention Strategy 2008-2012, the National Cardiovascular Disease Prevention Strategy 2005-2020 and the National HIV and AIDS Strategy 2006-2015 will also be integrated with RTA.

Treatment system

In Estonia, the health service providers possessing the activity licence of psychiatry deal with drug addiction treatment. Drug addiction treatment and rehabilitation is funded through the RTA implementation plan from the state budget and from the resources of larger local government. A client can also seek treatment at his/her own expense. Estonian Health Insurance Fund does not finance drug addiction treatment specifically.

In 2013, over 2.3 million euros were allocated for the provision of drug treatment and rehabilitation services. Almost half of that was spent on methadone maintenance treatment and one third on the provision of adult rehabilitation service.

Six out of seven Estonian national health care institutions providing addiction treatment are providing only outpatient treatment. A stationary treatment service for drug addicts is provided only by Wismari Hospital which, in addition to detoxification treatment funded by the patient, provides the service at RTA funding. Of the treatment facilities financed by the City of Tallinn, one (treatment centre of opiate addicts of Western Tallinn Central Hospital) is providing outpatient treatment and the other (Tallinn Children's Hospital, a centre targeted to children) outpatient as well as inpatient treatment.

Replacement treatment

In 2013, methadone maintenance treatment was funded through the RTA implementation plan from the state budget. EUR 1,037,504.75 were used for the provision of treatment service, which is 20% more than in 2012 and over 30% more than in 2011. In 2013 the Estonian National Institute for Health Development concluded year-long agreements for the provision of methadone substitution treatment with six service providers, who provided the service in eight different treatment centres (Table 5). In addition, opioid addiction replacement treatment was funded in the Jõhvi cell of the house of detention of the East Prefecture Police Department.

At the end of 2013, the number of clients receiving methadone maintenance treatment was 672 which is a bit less than in the previous years (717 at the end of 2011 and 687 at the end of 2012). The methadone maintenance programme was joined by 387 clients in 2013 which is 19 clients less than in 2012. The treatment programmed was completed successfully by 54 clients while in the previous year there were 90 clients who completed

the programme successfully. The number of the clients who dropped out of the treatment programme remained basically the same as in 2012, amounting to 347 in 2013 (in 2012, 346 clients dropped out) (Table 1).

Table 1. Methadone maintenance treatment funded from state budget for injecting drug users in 2013.

Name of a health care institution	Number of clients at the end of 2013	Number of persons having joined the treatment programme	Number of persons having completed the treatment programme successfully	Number of persons having terminated the programme
OÜ Tervisekeskus Elulootus	152	84	19	71
Wismari Hospital AS	100	41	4	59
OÜ Sõltuvuste Ravikeskus	122	105	24	73
AS Lääne-Tallinna Keskhaigla Psühhiaatriakeskus	50	35	0	23
AS Lääne-Tallinna Keskhaigla Psühhiaatriakeskus	15	4	1	2
OÜ Corrigo (Jõhvi+Kiviõli centres)	185	97	6	95
OÜ Aasa Kliinik	44	18	0	24
TÜ Psühhiaatriakliinik	4	3	0	0
Total	672	387	54	347

Source: RTA report 2013

Average daily quantity of methadone administered to the client varied in different centres from 40 mg to 66 mg. Average quantity of methadone administered to the clients has increased year by year: in 2005 it was 37 mg, in 2011 63 mg. However, it has decreased a little in the previous years - in 2012 57 mg and in 2013 55.5mg (Table 2).

Table 2. Quantities of methadone administered in nationally funded methadone substitution treatment centres in 2013 (mg).

Name of a health care institution	Total quantity of methadone used (mg)	Average dose per client	Minimum dose	Maximum dose
OÜ Tervisekeskus Elulootus	2,758,049	45	5	160
Wismari Hospital AS	2,366,709	65	2	175
OÜ Sõltuvuste Ravikeskus	2,145,637	50	2	185
OÜ Corrigo	3,373,176	62	2	320
OÜ Aasa Kliinik	1,016,557	65	5	190
AS LTKH psühhiaatriakeskus	282,003	51	5	130
AS LTHK nakkuskeskus	1,031,165	66	10	160
TÜ Psühhiaatriakliinik	41,032	40	23	70
Total	13014598	55.5	2	320

Source: RTA report 2013

Detoxification treatment

The contract for stationary detoxification treatment of adults was entered into in 2013 with AS Wismari Haigla in the amount of EUR 59,497. In the framework thereof, patients were provided with 1-month stationary treatment which was followed by the option of continuing with outpatient follow-up treatment. In 2013, the treatment was provided to 78 persons 64 of whom were reported to complete the treatment successfully.

Further EUR 55,583 were allocated to Tallinn Children's Hospital for the funding of the educational activities of the unit of children and adolescents of Tallinn Children's Hospital not included in the price list of the Estonian Health Insurance Fund, but which is necessary for the conduction of successful treatment. The service included 130 children and adolescents.

Also Tallinn City government had the contracts with Tallinn Children's Hospital for the funding of drug treatment and rehabilitation service until 18 year old children with addictive or behavioural disorders (26 075 EUR) and for the psychological counselling for the children and their parents in situation of crises (12 000 EUR).

Rehabilitation

In order to provide rehabilitation services for adults, EUR 722,023 was allocated from the funds of RTA which is 50% more than in 2012 (EUR 378,481 in 2012). The services were provided by Sillamäe Rehabilitation Centre for Drug Addicts Foundation and by Viljandi Hospital Foundation in total for 151 male and 34 female clients. Further EUR 88,634 were allocated from the same source for the provision of counselling and support services to addicts with dual diagnosis. The initial contract (until 31.10.2013) was entered into with NGO Estonian Advice Centre. As of 01.11.2013 the service was provided by the North Estonia Medical Centre. The service was also provided for 48 clients with double diagnosis. For the provision of rehabilitation services for minors, EUR 345,483 was allocated from the state budget which was EUR 142,805 less than in 2012. A contract for the provision of service was entered into with OÜ Corrigo, and within a year they provided services for 37 boys and 19 girls

Regardless of the type of rehabilitation service, the objective was to provide clients with psycho-social support and counselling and to teach them skills that help cope in real life (discipline, study and work habits).

5.3. Background information of clients that have sought treatment

In 2013, 788 notices were sent to the Drug Addiction Treatment Database (434 on the commencement of treatment and 375 on the termination of treatment).

In 2012, 28% of the persons seeking drug addiction treatment (29% in 2013) sought treatment for the first time (as told by the patients), while the majority were recurrent patients. Most of the persons seeking treatment were male (75.8%), the percentage of women was less than 25% (Table 3).

Table 3. Persons seeking treatment for the first time and recurrently in 2012–2013 by gender

	2012						2013					
	Male		Female		Total		Male		Female		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
First-time applicants	90	21.3	35	28.5	125	22.9	97	29.3	29	28.2	126	29.0
Recurrent treatment	307	72.6	84	68.3	391	71.6	220	66.5	68	66.0	288	66.4
Unknown	26	6.2	4	3.3	30	5.5	14	4.2	6	5.8	20	4.6
Total	423	77.5	123	22.5	546	100	331	76.3	103	23.7	434	100

Source: Drug Addiction Treatment Database, National Institute for Health Development, 2013

Pursuant to the data of the previous years, there is a change in the age structure of people seeking treatment compared to previous years (Table 4). While in 2010–2011 more than 65% of the people who commenced treatment were at the age of 25–34 and in 2012 62% where of the same age, then in 2013 there were 58% of people in this age group who sought treatment. However, compared to previous years, the number of 35-year-old people who commenced treatment had increased by a few percent. The youngest person who sought treatment was 13 and the oldest 56 years old. Minors (under 18 years of age) formed 5.1% of all persons seeking treatment and 16.7% of the persons seeking treatment for the first time.

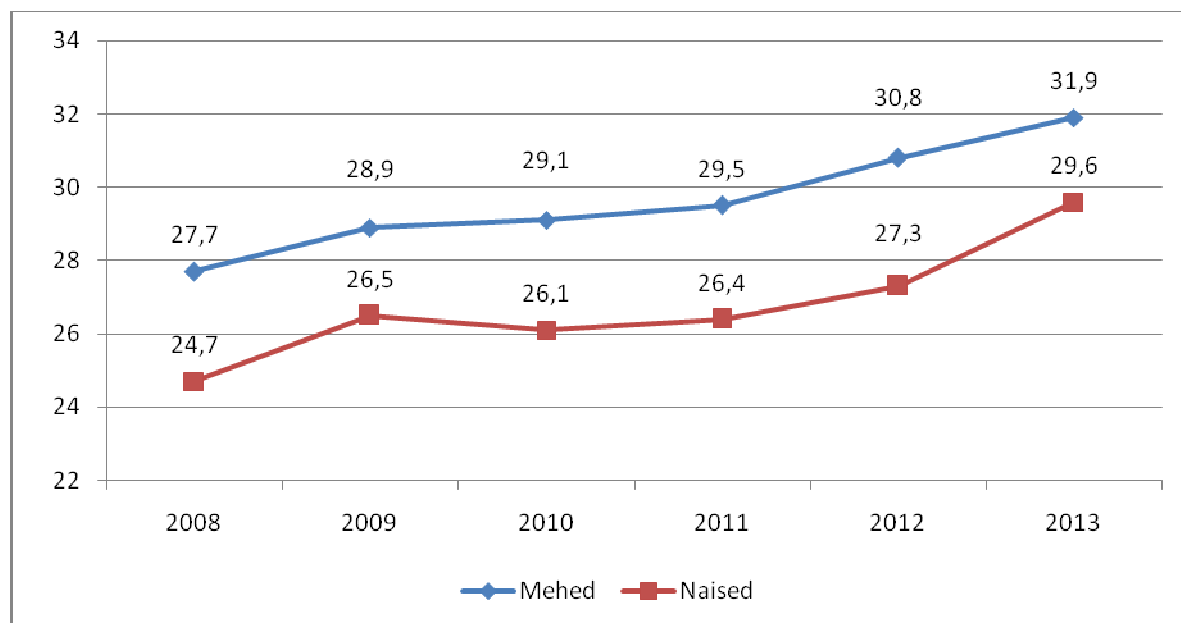
Table 4. Distribution of persons seeking treatment by age on the basis of treatment status in 2012–2013.

	2012				2013			
	All persons seeking treatment		First-time applicants		All persons seeking treatment		First-time applicants	
	n	%	n	%	n	%	n	%
<25	99	18.1	49	39.2	65	15.0	44	34.9
25–34	341	62.5	54	43.2	253	58.3	56	44.4
35<	106	19.4	22	17.6	116	26.7	26	20.6
Total	546	100	125	100	434	100	126	100

Source: Drug Addiction Treatment Database, National Institute for Health Development, 2013

Year by year the average age of the people who commence treatment has increased. In 2008 it was 27.0 and in 2013, 31.3 years. In 2013, the average age of people who seek treatment for the first time was 27.6 years. At the same time it was found that women seek treatment earlier than men. Among all persons seeking treatment in 2013 the average age of women was 29.6 years (95% CI 28.7–30.4) and men 31.9 years (95% CI 31.3–32.4) (Figure 1). Among first-time patients the average age of women was 24.1 years (95% CI 20.9–24.8) and men 28.6 years (95% CI 25.4–28.5).

Figure 1. The change in the average age of people who seek treatment in 2008–2013.



Source: Drug Addiction Treatment Database, National Institute for Health Development, 2013

Most of the persons receiving drug addiction treatment (over 80%), just like in the previous year, were Russians, the percentage of other nationalities was less than 10%. In 2013, the percentage of Estonians who sought treatment for the first time was somewhat larger amounting to almost 20%. Half 38% of all people who sought treatment lived in Tallinn and Harju County and 59% in Ida-Viru County. However, among the persons who sought treatment for the first time, the percentages of patients living in Tallinn or Harju County and the Ida-Viru Country were reversed - 59% of the people who sought treatment lived in Tallinn or Harju County while 38% lived in Ida-Viru County (Table 5).

Most of the persons receiving addiction treatment were unemployed, only 20% in 2011, 18% in 2012 and 15.7% in 2013 had a regular job. Imprisoned persons formed 7.7% of the persons seeking treatment in 2012 and 10% in 2013. In 2012 a little less than 50% of people seeking treatment had basic education, in 2013 there were 53% of patients that had basic education. In 2012, 47% and in 2013 42% had secondary education (Table 5).

Table 5. Socio-economic background of people who sought treatment in 2012–2013.

	2012				2013			
	All persons seeking treatment		First-time applicants		All persons seeking treatment		First-time applicants	
	n	%	n	%	n	%	n	%
Nationality								
Estonian	74	13.6	25	20.0	51	11.8	25	19.8
Russian	433	79.3	91	72.8	357	82.3	89	70.6
Other	39	7.1	9	7.2	26	6.0	12	9.5
Region of the place of residence								
Tallinn/Harju County	274	50.3	92	73.6	166	38.2	74	58.7
Ida-Viru County	255	46.7	26	20.8	254	58.7	48	38.2
Other	16	2.9	7	5.6	12	2.7	4	3.1
Unknown/n/a	1	0.1	0	0.0	2	0.5	0	0
Area of activity								
Employed (regular job)	100	18.3	29	23.2	68	15.7	22	17.5
Unemployed	291	53.3	64	51.2	206	47.5	63	50
Pupil/student	25	4.6	21	16.8	21	4.8	20	15.9
Dependent*	84	15.4	9	7.2	92	21.2	13	10.3
Other**	46	8.4	2	1.6	47	10.8	8	6.4
Education								
Without primary education	2	0.4	0	0.0	0	0.0	0	0.0
Primary education	25	4.6	12	9.6	14	3.2	6	4.8
Basic education*	249	45.6	55	44.0	232	53.5	77	61.1
Secondary education ****	253	46.3	57	45.6	185	42.6	43	34.1
Higher education	3	0.6	1	0.8	2	0.5	0	0.0
Unknown/n/a	14	2.5	0	0.0	1	0.2	0	0.0

Source: Drug Addiction Treatment Database, National Institute for Health Development, 2013.

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

** „Other“ includes prisoners and conscripts.

* Basic education includes also vocational education basing on primary and basic school not providing secondary education.

** Secondary education includes also vocational education basing on secondary education (without the level of applied higher education) and vocational education basing on basic school providing secondary education.

Most of the persons seeking treatment, 94%, received outpatient treatment, because the number of inpatient drug addiction treatment places is limited in Estonia and therefore the number of the persons receiving inpatient treatment was very low (in 2012 29 and in 2013 25 people). Many persons seeking treatment received replacement treatment, detoxification treatment was provided in 2012 to 7% and in 2013 to 3% of all persons seeking treatment (Table 6). Other treatment methods (non-medicament treatment and mitigation of symptoms) were provided in 2012 to 14% and in 2013 to 22% of the patients. 89% of patients received treatment for psychological and behavioural disorders caused by the use of opioids.

Table 6. Drug addiction treatment types on the basis of treatment status in 2012–2013.

	2012				2013			
	All persons seeking treatment		First-time applicants		All persons seeking treatment		First-time applicants	
	n	%	n	%	n	%	n	%
Replacement treatment	427	78.2	88	70.4	326	75.1	82	65.1
Detoxification treatment	38	7.0	6	4.8	13	3.0	5	4.0
Other*	81	14.8	31	24.8	95	21.9	39	30.9
Total	546	100	125	100	434	100	126	100.0

Source: Drug Addiction Treatment Database, National Institute for Health Development, 2013

**Mitigation of symptoms and non-medicament treatment.*

Within the previous years the number of fentanyl/3-methyl-fentanyl users seeking treatment has consistently gone up. In 2011, fentanyl/3-methylfentanyl was used as the primary drug by 76%, in 2012 by 79% and in 2013 by 81% of the patients. The number of people using heroin has decreased from 10% in 2011 to 3% in 2013. In general it can be said that more than 90% of the persons seeking drug addiction treatment used opiates as the main drug. Amphetamine or cannabis were reported as the primary drug a lot less (Table 7).

Table 7. Risk behaviour of people seeking treatment 2012–2013

	2012				2013			
	All persons seeking treatment		First-time applicants		All persons seeking treatment		First-time applicants	
	n	%	n	%	n	%	n	%
Primary addictive substance								
Heroin	29	5.3	0	0.0	14	3.2	3	2.4
Methadone	32	5.9	0	0.0	29	6.7	1	0.8
Fentanyl/3-methylfentanyl	432	79.1	104	83.2	353	81.3	96	76.2
Amphetamine	13	2.4	3	2.4	13	3.0	7	5.6
Cannabis	16	2.9	10	8.0	16	3.7	16	12.7
Other	24	4.4	8	6.4	9	2.1	3	2.4
Injection habit								
Has injected, but not presently	99	18.1	19	15.2	58	13.4	8	6.4
Injected during the last 30 days	350	64.1	74	59.2	304	70.1	93	73.8
Never injected	44	8.1	25	20.0	34	7.8	23	18.3
Unknown/n/a	53	9.7	7	5.6	38	8.7	2	1.6
Sharing of syringe								
Shared the syringe, but not during the last 30 days	268	49.1	48	38.4	259	59.7	64	50.8
Shared the syringe during the last 30 days	29	5.3	6	4.8	18	4.2	7	5.6
Never shared a syringe	173	31.7	62	49.6	93	21.4	42	33.3
Unknown	76	13.9	9	7.2	64	14.8	13	10.3

Source: Drug Addiction Treatment Database, National Institute for Health Development, 2013

Majority of the persons seeking treatment used their main drugs by injecting (76% in 2012 and 80% in 2013), only 15% in 2012 and 13% in 2013 used the main drug by smoking or inhaling, while the rest used it by oral or other administration. Almost 76% used their main drug daily and 15% said that they used the main drug at least once a week but not daily. One-third of respondents said that they used also other drugs in addition to the main drug; the most frequently mentioned drugs were amphetamine, cannabis, fentanyl/3-methylfentanyl. As opposed to previous years, no-one had pointed out alcohol as a secondary substance in 2013. This, however, does not mean that people who seek treatment do not consume alcohol but rather that alcohol is not considered an addictive substance worth mentioning. Low percentage of users of secondary drugs may be caused by the data collection method; namely, the questions about secondary drug can be left unanswered in the IT system of the database. Less than half of the persons seeking treatment were active injecting drug users. i.e. had injected themselves in last 30 days. While the percentage of active injectors decreased in 2010 and 2011, in 2013 it has increased to the level of 2009. (2009 - 65%, 2010 - 54%, 2011- 44%, 2012 - 64%, 2013 - 70% (Table 7).

No major changes have took place in 2013 in the risk behaviour of IDUs; approximately 60% treated addicts have admitted sharing of a syringe, while the percentage of persons having shared syringe in last 30 days has decreased (from 8% in 2011 to 4% in 2013) (Table 7).

Almost one-third of the patients who have terminated treatment, did it due to failure to appear to treatment. Compared to 2010 and 2011, the proportion of drop-outs has decreased (in 2010 in 63%, in 2011 in 53%, in 2012 in 36% and in 2013 in 29% of the cases). In addition to non-appearance the reasons for termination of treatment were following: imprisonment or release of the patient; voluntary leave agreed with the physician; referral to another attending physician or other reason (e.g. death of the patient). Recovery of drug addict receiving drug addiction treatment was noted as the reason for termination of treatment in 7% of the cases in 2012 and in almost 5% of the cases in 2013.

Chapter 6. Health correlates and consequences

6.1 Introduction

In Estonia case-by-case monitoring of infectious diseases (passive monitoring) is conducted by the Health Board (until 2010 by the National Inspectorate of Health Protection). This is based on Regulation of the Government of the Republic no. 134 (publication citation in the State Gazette RT I 2009, 41, 279)_which lists 56 infectious and parasite diseases and disease conditions in regard to which information shall be provided, including HIV (Z21), AIDS (B20-B24), virus hepatitises (B15-B19) and the primary sexually transmitted infections (STI) (syphilis, sexually transmitted chlamydia diseases and gonorrhoea). As of the implementation of the new Information System of Infectious Diseases in October 2009, all doctors (family doctors as well as medical specialists) who diagnose these infections and all laboratories shall be obliged to inform the Health Board thereof either online or by sending a notice on paper. HIV is the only infection information on which should be provided online.

Active monitoring of HIV is, first and foremost, conducted by the National Institute for Health Development by carrying out behavioural monitoring and prevalence surveys among the main risk groups in liaison with various research and implementation authorities. Behavioural data on IDUs is collected in the framework of surveys on knowledge, attitudes and behaviour (mostly cross-sectional data in three places - the capital city of Tallinn and in Kohtla-Järve and Narva in Ida-Viru County). In addition to notification of cases and cross-sectional surveys, some behavioural data and data on the prevalence of infections is collected from the clients of syringe exchange stations and among the provision of STI treatment services which are provided especially to IDUs and their partners (in two places in Ida-Viru County - in Jõhvi and Narva).

Information on cases of tuberculosis and treatment results thereof (including personal data) is collected by the National Tuberculosis Register maintained by the National Institute for Health Development.

Data about drug-related deaths originate from the database of causes of death. The authorised processor of this person-based register is the National Institute for Health Development and it includes death cases of Estonian residents registered in Estonia and foreign missions of Estonia. The database of causes of death uses the International Disease Classification (ICD-10) for encoding of death data. The definition of drug-related deaths is the same as used by EMCDDA (selection B).

6.2 Drug-related infectious diseases

Epidemiologic situation of the HIV infection

Although within the last decade, the number of new HIV cases have decreased considerably (by 56% in the period of 2004-2013), the number of new cases per 100,000 residents is still high (24.3 cases per 100,000 residents in 2013; n=325) and has not decreased in the last years (23.5 cases per 100,000 residents in 2012). In total, by the end of 2013, 8,702 HIV cases (5,866 men and 2,836 women, the percentage of women 33) had been registered in Estonia.

Almost 70% of all new HIV cases in 2000–2013 were among men. The percentage of men was especially high in the period of 2000–2001 but in the past years the percentage of woman has increased in all age groups which is caused by the decrease in the absolute number of infected men. Of all new cases of 2000, women formed 20%, in 2013, the percentage was 39. Within the past five years, the percentage of women in the age group of 15–24 years has been higher than the one of men's' (it was 63% in 2013).

Almost two-thirds of the new cases in 2013 were diagnosed among 30-year-olds and older. The percentage of 30-year-olds and older has increased year by year but the absolute numbers in the period of 2006–2013 were stabile (especially among men). At the beginning of the epidemic (2000–2001), 78% of the new cases were diagnosed in the age group of 15-24 (n=1,402). In 2013, there were only 14% of new cases among 15–24-year-olds (n=46).

There is a positive trend of decrease of HIV cases among children and adolescents. In 2013, HIV was diagnosed among 15-19-year-olds in 11 cases. This may be compared to 2001 which was the culmination of the epidemic. In 2001, 560 new HIV cases were discovered in this age group (in 2002, there was 306 cases). In the age group of 10-14, the last HIV case was diagnosed in 2010.

In 2013, most of the new cases were diagnosed in Northeast Estonia and Tallinn - respectively 38% (n=123; 81 cases per 100,000 residents) and 57% (n=185; 46 cases per 100,000 residents). The trend has remained stabile as of the beginning of the epidemic in 2000. Elsewhere in Estonia, in total of 17 new HIV cases were diagnosed in 2013 (2.2 cases per 100,000 residents) and the indicator has remained quite stable within the past years (4.7 per 100,000 in 2012)

According to the Health Board, the new cases in 2010 included 17% of drug users, in 2011 18%, in 2012 22% and in 2013 22% of drug users (in 2013 the manner of infection was undetermined for a quarter of all cases). In 2013, all cases of HIV among drug users were

diagnosed either in Tallinn or in Northeast Estonia, respectively 65% (n=47) and 35% of these cases (n=25). In anonymous HIV counselling and testing rooms (where in 2013 19% of all new cases were diagnosed) 30% of all new cases were people who had injected drugs (of new cases 37% of men and 18% of women).

Vertical transmission, i.e. from mother to child, has been constantly low - 0.5% of all new cases in the period of 1988-2013 (three cases in 2012 and two in 2013).

The number of AIDS cases per 100,000 residents in 2013 was 1.8 (n=24) and it has decreased in the past years (in 2011 2.9 cases and in 2012 2.7 cases per 100,000 residents).

HIV among IDUs

The prevalence of HIV among IDUs has been stable by regions within the last eight years (based on cross-sectional surveys using the method of respondent driven sampling):

- The prevalence of HIV in Tallinn in 2007 was 55% (350 participants) and 58% in 2013 (n=328) (Lõhmus 2008; Vorobjov 2014a).
- The prevalence of HIV in Kohtla-Järve in 2007 was 69% (n=350) and 62% in 2012 (n=599) (Lõhmus 2008; Vorobjov 2014b).
- The prevalence of HIV in Narva in 2010 was 52% (n=351) and 51% in 2014 (n=350) (Lõhmus 2011; unpublished data).

Viral hepatitis

The prevalence of acute and hepatitis B and C have been quite stable. The prevalence of acute hepatitis B has decreased from 1.2 cases (n=16) in 2011 to 0.8 cases (n=11) per 100,000 residents in 2013. The prevalence of acute hepatitis C has decreased from 1.3 cases (n=17) in 2011 to 2.1 cases (n=28) per 100,000 residents in 2013.

The cluster of hepatitis A in the second half of 2011 has subsided. In 2011 11.5 cases were diagnosed per 100,000 residents (n=154), in 2012 4.7 cases (n=63) and in 2013 0.4 cases were diagnosed per 100,000 residents (n=6). No linkage to injection drug addiction has been discovered. A more thorough overview of the cluster has been published in the Eurosurveillance (Dontchenko 2011).

Viral hepatitis among IDUs

In a cross sectional (RDS) survey among IDUs in Kohtla-Järve (n=599) in 2012 (Vorobjov 2014b):

- 75% of participants (n=477) tested positive for HCV antibodies.

- 4% of participants (n=25) tested positive for HbsAg which indicates either acute or chronic hepatitis B. 25% (n=149) tested positive for both anti-HBc IgG and anti-HBsAb (natural immunity caused by having been infected).

In a previous survey in the same region conducted in 2007, the prevalence of HCV antibodies was 76% and the prevalence of HbsAg was 1% (350 participants) (Lõhmus 2008).

In a similar study in Tallinn in 2013, the prevalence of HCV antibodies was 90% and the prevalence of HbsAg was 4% (328 participants) (Vorobjov 2014a).

Sexually transmitted infections and tuberculosis

The prevalence of the main sexually transmitted infections in Estonia has decreased in the past decade. In 2013, 10 cases of gonorrhoea, 3 cases of syphilis and 121 cases of sexually transmitted chlamydia were registered per 100,000 residents. The diseased included more women than men and the indicators are highest in the age group of 20-29 years. STI notices contain no information on the injection of drugs which is why there is no information on STI prevalence among IDUs.

Pursuant to the initial data of 2013, the first-time infection with TB was 17.5 per 100,000 residents. In 2013, in total of 287 TB cases were registered, including 225 first-time, 38 TB relapse and 24 recurrent cases 13.7% (36 cases) of first-time and relapse cases were multiresistant TB, 13.9% of them (5 cases) were extensively drug-resistant TB. The percentage of HIV-infected among people with TB has increased from 0.25% in 2000 to 11.4 in 2013. In total, 400 people with tuberculosis have been diagnosed within years, 30 of them in 2013.

Sexually transmitted infections and tuberculosis among IDUs

In a cross-sectional (RDS) survey among IDUs in Kohtla-Järve and Northeast Estonia (n=599) in 2012 2% of participants tested positive for syphilis (detection of anti-bodies) and 32% tested positive for HSV-2 antibodies (Vorobjov 2014b). In a previous survey in the same region conducted in 2007, the prevalence of syphilis was 9% (the method of RPR; 350 participants) (Lõhmus 2008).

In the case of STI services provided for IDUs and their sexual partners, the number of gonorrhoea cases has not increased. However, the number of trichomoniasis increased 2.5 times in 2012 compared to 2010 and 2011 and the number of chlamydia cases increased in the same period by one-third (TAI reports).

In the RDS survey conducted in 2012, 1.5% of participants (nine people of 595) reported that they have had tuberculosis before (Vorobjov 2014b). In a survey conducted in 2007 in the same region, none of the 350 participants had had tuberculosis before (Lõhmus 2008).

Other infectious diseases (abscesses, sepsis, endocarditis, tetanus, wound botulism)

In 2012 no cases of tetanus were registered and in 2013 one tetanus case was registered. There is no information on whether these patients injected drugs. No cases of botulism were registered in 2012-2013

Routine data is collected only on sepsis caused by *streptococcus pneumoniae* and *Haemophilus influenzae* but the risk factors of these patients (e.g. drug injection) are not known. The diagnosis of these conditions has been low in the last two years - about 1.5 cases per 100,000 residents for *Streptococcus pneumoniae* sepsis (n=20) and 0.1 cases for *Haemophilus influenzae* sepsis (n=1).

In cross-sectional studies conducted among IDUs, no data on abscesses, sepsis, endocarditis, etc. has been collected so there is no information on the extent of these problems.

HIV testing

In Estonia, every doctor (a family doctor as well as a medical specialist) may recommend and carry out HIV testing pursuant to clinical indications, risk assessment and the wishes of a patient. As of 2012 there are guidelines on outpatient and inpatient HIV testing prepared and approved by the Ministry of Social Affairs. Testing is recommended pursuant to clinical indications and the assessment of risk behaviour. In addition, HIV testing is recommended to all pregnant women. In the regions of HIV epidemic - the capital of the City of Tallinn and Northeast Estonia - HIV testing is recommended to all 16–49-year-olds.

HIV testing is carried out only in health care institutions (incl. family health centres and health care facilities of prisons). Non-medical workers are not allowed to perform HIV tests but they may engage in counselling.

In addition to testing in the general health care system (where health insurance is a precondition for free testing), there is a special network of anonymous HIV counselling and testing rooms funded by the state (previously referred to as anonymous AIDS rooms) where everyone, including non-citizens of Estonia, may have themselves tested for HIV and viral hepatitises anonymously and free of charge.

In 2013, more than 150,000 people (11.5% of the population; 114 people per 1,000 residents; 52 people per 1,000 residents, excluding blood donors and pregnant women) were tested.

IDUs can have themselves tested for HIV also at special STI service providers in Northeast Estonia (Narva and Jõhvi) and in replacement treatment centres. Syringe exchange stations (SVP) do not provide a regular HIV testing option but in Tallinn and Northeast Estonia local anonymous HIV counselling and testing rooms work with them by providing HIV testing at SVPs for couple of hours per week.

The most recent data indicates that HIV testing and awareness about one's HIV status has increased among IDUs.

- Thus, the percentage of people that have been tested for HIV in **Tallinn** has increased from 85% in 2007 to 94% in 2013, and the percentage of those who are aware of being HIV positive increased from 63% to 88% in the same period (Lõhmus 2008, Vorobjov 2014b).
- The percentage of people that have been tested for HIV in **Kohtla-Järve** has increased from 76% in 2007 to 90% in 2012, and the percentage of those who are aware of being HIV positive increased from 67% to 84% in the same period (Lõhmus 2008, Vorobjov 2014a).
- In **Narva** in 2010 - 52% are positive and 76% are aware of their being HIV positive.

6.3 Other drug-related health correlates and consequences

No data available for the reporting period

6.4 Drug-related deaths and mortality of drug users

According to the database of causes of death, 1229 persons in total died in Estonia in 1999–2013 as a result of drugs, most of whom (89%) were male (n=1089) (Table 9). In 2013, 59 persons less died as a result of drug-use than in 2012 but the number of deaths caused by drugs still exceeded one hundred (n=111). Just like in the past years, the people who died as a result of drugs were mostly male (84%). The average age of the people who died as a result of drugs in 2013 was 31.9 years and it has been gradually increasing within the past decade. It should be pointed out that the average age of women upon dying was somewhat higher (33.0 years) than the average age of men (31.7 years) (Table 8). In the period of 1999–2013 most (87%) of the persons who died due to drug-use were 20–34 years of age (Table 10).

Table 8. Drug-related intoxication deaths in 2013 by gender and age groups.

	2013		
	Male	Female	Total
<15	0	0	0
1519	0	0	0
2024	11		11
2529	25	7	32
3034	32	6	38
3539	16	3	19
4044	6		6
4549	1	1	2
5054	2	1	3
5559	0	0	0
6064	0	0	0
>=65	0	0	0
Total	93	18	111
Average age	31.7	33.0	31.9

Source: *Causes of Death Registry, National Institute for Health Development 2013, EMCDDA Standard Table 5.*

In 2013, 70.2% of the persons who died due to drug overdose were ethnic Russians (n=78) and 21.6% ethnic Estonians (n=24), 62% were from Harju County (n=69) and 29% from Ida-Viru County (n=32).

In 2012, 72% of the persons who died due to drug use were ethnic Russians (n=123) and 20.6% ethnic Estonians, 59% had lived in Harju County (n=101) and 30% in Ida-Viru County. High number of deaths resulting from drug intoxication in Harju County and Ida-Viru County can be explained with the fact that in both counties the number and prevalence of IDUs in total population is rather high (Uusküla et al., 2007).

In 2012, the main cause of death of most (n=100) persons having died in result of drug use was accidental intoxication with non-classified drugs or psychodysleptics and their effect (X42) (n=150 in 2012) (Table 11).

Data of drug-related intoxication deaths in 2013 originating from the database of causes of death and from the Estonian Forensic Science Institute (EFCI) are slightly different (they were also different in 2012). Pursuant to EFCI's data, 119 people died in 2013 as a result of drug intoxication (in 2012, the number of drug-related deaths presented by EFCI was 178) (EKEI, M.Tõnisson, personal communication 2014). The difference in the data of EFCI and the database of causes of death may arise from the fact that pursuant to EFCI's data, the death certificates regarding deaths caused by drug overdoses have been marked by doctors as intoxication by a pharmaceutical drug.

Table 9. Persons having died as a result of drug use in 1999-2013 by gender.

	1999	2000	2001	2002	2003	2004	2005	2006*	2007	2008	2009	2010	2011	2012	2013	Total
Male	18	25	39	81	31	88	52	59	74	60	120	89	108	152	93	1,089
Female	4	6	6	5	5	10	5	9	7	7	13	12	15	18	18	140
Total	22	31	45	86	36	98	57	68	81	67	133	101	123	170	111	1,229
Average age	29	28	25	24	28	26	26	26	28	29	29	29	30.1	31.1	31.9	

Source: The database of causes of death, Estonian National Institute for Health Development 2013, EMCDDA Standard Table 6

Table 10. Persons having died as a result of drug use in 1999–2013 by age.

	1999	2000	2001	2002	2003	2004	2005	2006*	2007	2008	2009	2010	2011	2012	2013	Total
<15	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	2
1519	5	2	7	18	6	11	5	6	2	0	3	1	2	2	0	70
2024	8	13	18	39	10	36	21	24	22	14	23	17	14	27	11	297
2529	3	8	10	16	9	24	22	25	34	27	54	43	41	48	32	396
3034	1	4	3	8	3	18	4	10	13	18	40	25	46	51	38	282
3539	0	1	4	3	3	3	3	1	6	3	5	11	14	20	19	96
4044	1	0	1	0	1	3	1	2	1	3	3	4	4	12	6	42
4549	1	2	0	1	3	1	1	0	2	1	2	0	0	8	2	24
5054	1	0	1	1	0	0	0	0	1	0	1	0	1	1	3	10
5559	1	0	0	0	0	1	0	0	0	1	2	0	0	1	0	6
6064	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	2
>=65	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Total	22	31	45	86	36	98	57	68	81	67	133	101	123	170	111	1,229

Source: The database of causes of death, Estonian National Institute for Health Development 2013, EMCDDA Standard Table 6

Table 11. Drug-related deaths by gender and death cause 2009–2013.

Initial cause	2009			2010			2011			2012			2013		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
F112 Opiate addiction	1	0	1												
X41 Accidental intoxication with anti-epileptics, sedative-hypnotic, anti-parkinsonism or n.e.i. psychotropic drugs and their effect				7	1	8	4		4	17	2	19	8	3	11
X42 Accidental intoxication with n.e.i. drugs or psychodysleptics [hallucinogens] and their effect	110	12	122	80	11	91	101	15	116	134	16	150	85	15	100
X62 Intentional self-intoxication with n.e.i. drugs or psychodysleptics [hallucinogens] and their effect	2	0	2												
Y11 Intoxication with unknown intention with antileptics, tranquilisers, sedatives, antiparkinsonism and other n.e.i. psychotropic drugs										1		1			
Y12 Intoxication with unknown intention with n.e.i. drugs or psychodysleptics [hallucinogens] and their effect	7	1	8	2		2	3		3						
Total	120	13	133	89	12	101	108	15	123	152	18	170	93	18	111

Source: The database of causes of death, Estonian National Institute for Health Development 2013, EMCDDA Standard Table 5

Chapter 7. Responses to health correlates and consequences

7.1 Introduction

The data presented in subchapters 7.2 and 7.3 of this chapter originate from the implementation plan report on 2013 of the National Health Plan 2009–2020 (RTA). Addition to that needle exchange points information system is used to give overview of needle exchange clients and for the Naloxone program the program reports and service description was used.

7.2 Prevention of drug related emergencies and reduction of drug related deaths

In September 2013, the take home naloxone program was launched in Estonia. The source document for the naloxone program in Estonia is the service description, approved with the directive of director of the National Institute for Health Development (approved on 20.06.2013), and the upgraded Public Health Development Plan for 2009–2020 and its operational program. The main purpose of the service is to reduce the number of fatal overdoses among IDUs due to the use of narcotic substances in Estonia. The program educates IDUs and people close to them to recognize the overdose and administer naloxone to the person who has overdosed, and give first aid until the ambulance arrives. The provision of the service is carried out in cooperation with the health care providers and organizations providing harm reduction services in the region.

A health care provider trained by the National Institute for Health Development educates and hands over a naloxone-filled syringe to IDUs and people close to them after they have completed the training. Naloxone only can be prescribed by a physician registered in register of health care professionals and the medication is only available in pharmacies stated by The National Institute for Health Development. The medicine is obtained on the basis of an order received from the physician and the medicine is kept track of. Harm reduction services advise and motivate customers to participate in the training and put together training groups. There are separate training sessions for people close to IDU. The description of services states how to carry out a training and how to put together training groups.

The knowledge acquired during the training is the following:

- Drugs and their effects, including interactions;

- How overdose occurs;
- Giving first aid to someone with who has overdoses (specific steps);
- How to use pre-filled naloxone syringes;
- The safe use of needles. Infectious diseases transmitted through injection;
- Maintaining the used naloxone syringe and bringing it back to the service provider.

All participants completing the training must demonstrate their acquired knowledge on the basis of a survey. The participation of each person shall be documented. A person who has completed the training must complete a retraining course every three years. Everything related to the providing of a service shall be documented according to the forms developed for that specific reason. For each used naloxone injection, questions on the circumstances the naloxone was used shall be answered and each case shall be discussed.

The inclusion of naloxone program criteria is:

- A personalised patient of at least 16 years of age with the risk of opioid overdose
- A representative appointed by the personalised patient
- Methadone substitution therapy service provider
- Health care providers working in the syringe exchange

During the courses, harm reduction services remind people about the need for calling an ambulance and hand out materials on "How to act in case of an overdose?" and "Naloxone. A lifesaver in the case of an opioid overdose" used by The National Institute for Health Development. The brochure gives step-by-step instructions on what to do with a person suffering from an overdose, emphasizing first aid, the need to call the ambulance and instructions for the naloxone injection. The brochure also contains a tutorial on how to turn the victim sideways. It also contains the most important facts on the effects of naloxone, what to do with a used naloxone syringe, and where to get a new one.

The drug used in the program in Estonia is the PRENOXAD INJECTION (naloxone hydrochloride 1mg/1ml solution for injection) and contains 2 ml naloxone hydrochloride 1 mg/ml.. One set costs approximately 28 euros.

The first report on the Naloxone pilot project is shown in Table12 below. In total, 554 participants received training and 552 naloxone syringe sets were given out during the period of September 2013 – June 2014. 72 repeated prescriptions were reported (one of them was reported as not intended for medical use). Most of the syringes were distributed to users of narcotic substances

Most of the syringes were distributed to users of narcotic substances. Naloxone programs are held in Harju and East-Viru Counties, where the problem of IDUs in Estonia is the greatest.

Table 12. Naloxone project report in September 2013-June 2014.

	2013 (Sep–Dec)			2014 (Jan–June)		
	Harju County	Ida-Viru County	TOTAL	Harju County	Ida-Viru County	TOTAL
TOTAL number of training courses:	13	7	20	37	39	76
TOTAL number of participants in the training:	56	33	89	223	242	465
<i>including drug users</i>	50	28	78	214	183	397
TOTAL number of persons who receiving Naloxone:	0	33	33	223	240	463
<i>including drug users</i>	50	28	78	214	181	395
Number of repeated naloxone prescriptions:	0	7	7	35	22	57

Source: *The National Institute for Health Development, 2014*

7.3 Prevention and treatment of drug related infectious diseases

The main harm reduction services for IDUs in Estonia are methadone maintenance treatment and syringe exchange programmes. Methadone maintenance treatment shall be discussed in Chapter 5 of this report.

Pursuant to the new service descriptions, the term “syringe exchange station” has been replaced with the term “establishments providing harm reduction service”. In 2013, there were 9 organisations providing syringe exchange and counselling services. There were 37 stations providing harm reduction services 13 of which were stationary and 24 of which field work stations. Also, as of 2013 there is a syringe exchange bus in Northeast Estonia.



Picture of the syringe exchange bus

There were 153,745 visits to establishments providing harm reduction services in 2013. 849 new visitors and 6,677 repeat visitors with visitor's code were registered. Within the last decade the number of visits to establishments providing harm reduction services has increased considerably. The number of visits started to grow in 2003 when, in addition to the state, the Global Fund to Fight Aids, Tuberculosis and Malaria (GF) also started to fund harm reduction services. After the end of GF, the state took over the funding of harm reduction services in full. With the financing of GF programme the number of new visitors at the centres started to increase which, however, has been decreasing in the past years. The latter may be caused by the fact that the population group of IDUs in Estonia is has started to age (for more information, see Chapter 4 of the report of 2013).

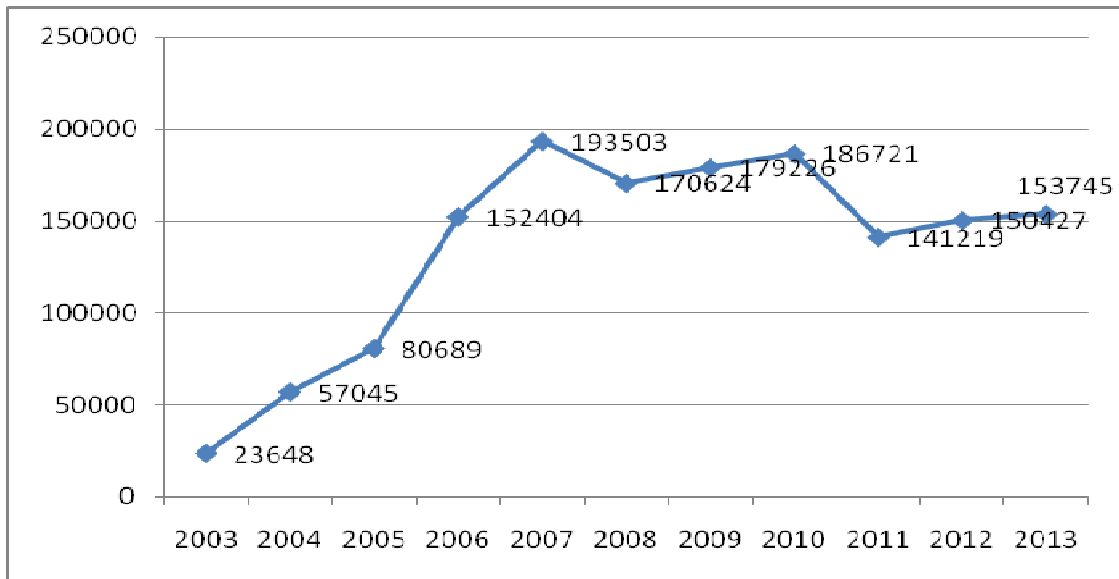


Figure 2. The number of visits to establishments providing harm reduction services in 2003–2013. *Source: National Institute for Health Development, 2014*

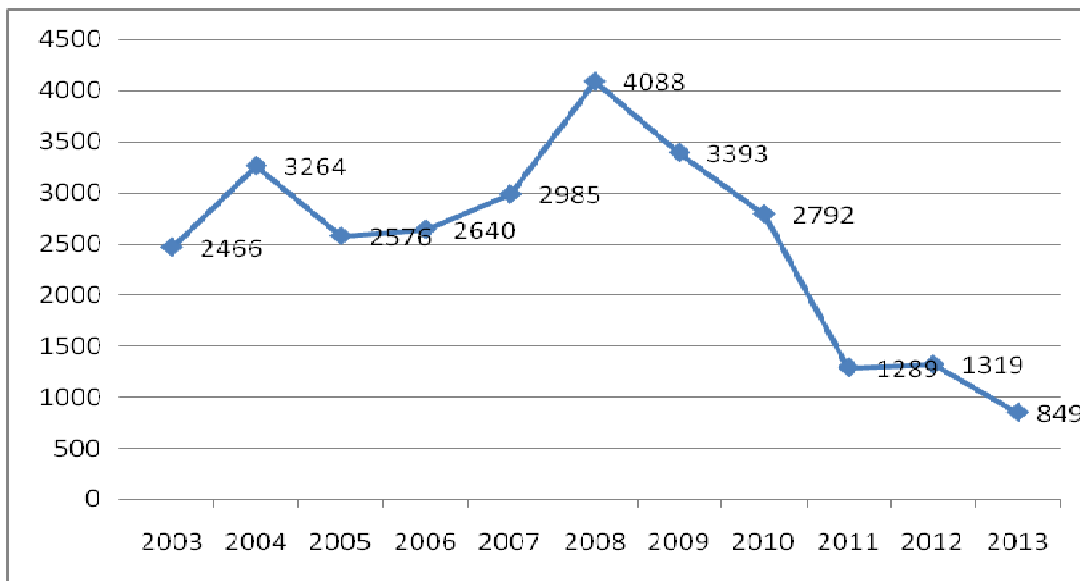


Figure 3. The number of visits to establishments providing harm reduction services in 2003–2013. *Source: National Institute for Health Development, 2014*

In total, 2,183,933 syringes were given out in 2013. Almost two-thirds of the syringes (66.8) were given out in Ida-Viru County, one-third (32.5%) in Tallinn and 0.7% elsewhere in Estonia. In Ida-Viru Country, on the average 12.1 syringes, in Tallinn/Harju County 19.2 syringes and elsewhere in Estonia 2.3 syringes were given away per visit. In 2013, about 64% of the syringes given out were brought back to the syringe exchange stations. Similarly to the increase of visits to the establishments providing harm reduction services as of 2003, the number of syringes given out has also increased from that time.

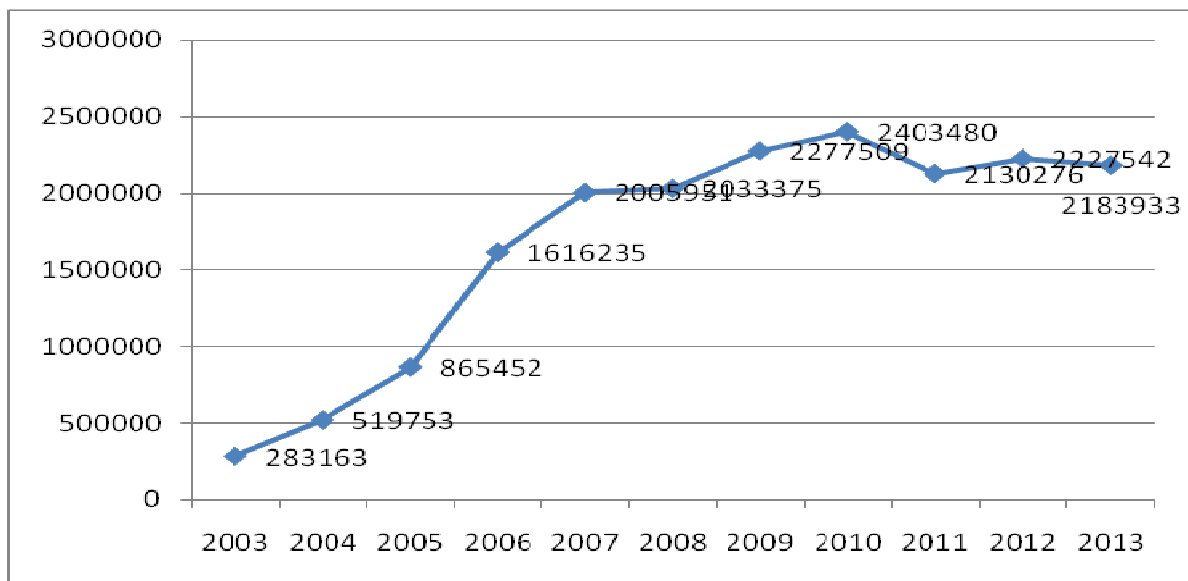


Figure 4. The number syringes given out by establishments providing harm reduction services in 2003–2013. *Source: National Institute for Health Development, 2014*

The average age of new visitors visiting establishments providing harm reduction services has increased over the years being 27.8 years in 2013 and 24 years in 2009. The average injection experience of new visitors was 5 years. 26% of the visitors had less than a year of injection experience. 52% of new visitors reported that fentanyl was the main substance injected within the past four weeks and 40% reported that substance to have been amphetamine. 21% of respondents had injected themselves within the past four weeks with a syringe that had previously been used by someone else.

7.4 Responses to other health correlates among drug users

HIV counselling and testing

In 2013, eleven establishments provided the services of anonymous and voluntary HIV counselling and testing in eleven towns. Within the year, 14,310 people were counselled and 14,237 people were tested (including 7,272 rapid HIV tests). 155 new HIV-infected people were discovered. The rapid HIV tests were provided for free by the US charity organisation AIDS Healthcare Foundation.

Anonymous STI diagnostics and treatment service

In 2013 the provision of free and anonymous diagnostics and treatment services of sexually transmitted infections (STI) for IDUs and their sexual partners in Jõhvi and Narva

was continued. In total, the number of people tested for STIs was 972. 142 of them tested positive for an STI and 47 tested positive for HIV.

Pregnant drug users

To pregnant women with an opiate addiction, drug addiction treatment has been provided at the existing places of treatment. In order to prevent vertical transmission of HIV, breast milk substitute is provided for HIV positive mothers in AS Lääne-Tallinna Keskhaigla, SA Ida-Viru Keskhaigla and in SA Narva Haigla in the process of provision of case management service until the infant becomes one year old. In 2013, formula was received by 187 infants.

Case management

For the provision of service, contracts were entered into with 3 health care institutions (in Tallinn, Narva, Kohtla-Järve) where a case management nurse was contacted by 326 first-time clients. The total number of contacts was 10,023. 349 clients contacted a social worker for the first time, while the number of recurrent contacts was 1,310. 102 clients contacted a psychologist for the first time, while the number of recurrent contacts was 731. Counselling and support services for addicts with a dual diagnosis was provided, until 31.10.2013, by MTÜ Eesti Abikeskused. As of 1.11.2013, support for the improvement of coping of people with severe psychological disorders and drug addiction is provided by SA Põhja-Eesti Regionaalhaigla Psühhiaatriakeskus. The change of a service provider was necessary due to the needs of the target group of the service. Within the year, the service was provided for 48 people.

In 2013 individual psychological counselling and family therapy for youth and parents was provided. Within the year, 31 interactive drug prevention trainings were carried out where 625 adolescents took part. Group therapy sessions for minors with addiction problems and for minors in the risk group and their parents were carried out. In addition, 195 phone counselling sessions were carried out.

Prevention and treatment of tuberculosis

In 2012, the National Tuberculosis Strategy for 2008-2012 was terminated. In 2013, the activities related to tuberculosis prevention were carried out on the basis of the National Health Plan 2009–2020.

In 2013, a draft of Amendment Act of Infectious Disease Prevention and Control Act was prepared which provides the elaboration of cooperation between the police and a health care service provider upon implementation of involuntary treatment to a person with an extremely dangerous infectious disease (including tuberculosis), if the place of residence of

the infectious person is unknown. The legislative proceeding of the draft continues in 2014. An agreement was reached with the Estonian National Social Insurance Board in 2013 on people with tuberculosis not receiving the benefit for incapacity for work for a period longer than 6 months in order to motivate the people who need treatment to follow the treatment regime.

The topics concerning tuberculosis have been integrated into the in-service training programmes of health care and social workers. In 2013, 16 trainings on tuberculosis were organised where 269 people participated among whom were nurses of directly observed treatment of tuberculosis, nurses monitoring the directly observed treatment of TB, lectures in medical institutions and lectures for people working with TB risk groups.

Within the framework of the tuberculosis prevention programme, health care and social services preventing infection with tuberculosis are provided to HIV positive persons and other risk groups. Regular preventive laboratory tests of HIV infected persons and persons of risk groups not covered by health insurance are performed for early detection of tuberculosis. Regular screening for tuberculosis is also performed for all residents of shelters and in prisons.

In three of the five stationary tuberculosis wards, opioid addicts treated for tuberculosis have been provided with methadone maintenance treatment. In one hospital there has been no need for methadone maintenance treatment and in one ward there is a methadone maintenance treatment centre in the same house as the tuberculosis ward so these patients are also ensured with methadone. In 2013, there were in total 24,326 outpatient TB OKR visits 196 of which had methadone maintenance treatment included.

Also, in order to reduce cases of termination of treatment among the persons released from prison, since May 2010 an agreement has been concluded with the Ministry of Justice that a prison shall transport the patients with infectious and/or multi-resistant tuberculosis, whose treatment has not yet been completed at the moment of release, to Kose tuberculosis facility of SA PERH or to an outpatient visit in order to continue the treatment.

There is a problem with outpatient treatment where methadone is accessible only in two rooms of directly observed treatment.

Table 13. Treatment results for people with TB/HIV co-infection in first-time and relapse cases of TB from 2003 to 23.09.2013.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
TB/HIV+ first-time cases and relapses	13	26	32	39	47	35	36	31	41	42	30
Died before TB treatment started or during the first month of treatment	0	4	7	7	9	7	7	5	6	6	5
Died before TB treatment started or during the first	-	15.4	21.9	18.4	19.1	20.0	19.4	16.1	14.6	14.3	16.7

month of treatment (%)											
Started treatment of TB	15	22	25	31	38	28	29	26	35	36	25
Recovered from TB	8	14	18	20	25	25	26	20	26	20	25
Recovered from TB (%)	53.3	63.6	72.0	64.5	65.8	83.3	89.7	76.9	74.3	-*	-*
Received ARV co-treatment						13	20	17	24	25	23
Refused or terminated ARV treatment						1	2	2	2	1	
Did not need ARV**						1	5	3	6	1	3
Data not available or did not receive ARV treatment						16	2	2	3	9	4

Source: TAI, TB register, 2014

**Treatment results of 2011 and 2012 are not yet completely clear, because the treatment of MDR-TB cases may last over 2 years and some patients are still receiving treatment.*

***Pursuant to the Estonian treatment guidelines, ARV will be started, when the number of CD4 cells is below 350*

****Data is collected since 2008 during TB/HIV + consultations.*

Chapter 8. Social indicators and social reintegration

In 2013 there were no specific surveys in social risk groups on drug-use. There are currently no special services in Estonia which would address the problems of drug addicts with places of residence and training/education.

Since 2010 there have been some directed activities regarding employment problems of drug addicts financed by the ESF program. In 2013 totally 1154 people with addiction problem received counselling on mental health and work efficiency issues, 17% of them were the close ones of drug addicts. The objective of the counselling service is the improve of persons mental health, work efficiency and quality of life trough the counselling, exchanging experiences and acquisition of problem solving skills. The major objective of the counselling is reintegration with labour market. Service is offered in 5 towns: Tallinn, Tartu, Jõhvi, Narva and Rakveres.

If possible, drug-users are provided with general social assistance services and possibilities. The organisation of these services to drug-users is conducted by centres dealing with drug addicts within their regular work. The social issues and employment is mainly handled by the social worker of a drug addiction treatment and rehabilitation centre. The only significant change in the reintegration in the reporting period is related to the White Paper. The White Paper contains an entire chapter (6 system) on the services of social reintegration which describes in detail all the needs of drug users in regard to social

reintegration. In addition to the vision of social reintegration, Annex 2 of the White Paper also includes an agreement on specific activities for 2014–2018 that should be created and provided for drug-users concerning social reintegration. The following separate activities have been set forth which shall be provided by no later than 2018:

- The development of the concept of the social reintegration system and the coordination thereof;
- The ensuring of counselling services to drug addicts who have gone through addiction treatment and/or rehabilitation in order to prevent relapses (group and individual counselling);
- The creation of equal opportunities for drug addicts upon entering the labour market;
- The existence of case management and sponsor services;
- The creation of opportunities for less competitive people in participation of trainings;
- Accommodation opportunities for addicts.

Behind the activities of Annex 2 there are persons responsible for certain activities and strategic documents which should be considered upon carrying out of the objectives in this period of time.

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

9.1. Introduction

The data presented in this chapter originate from the reports of the National Health Plan and the National HIV/AIDS Prevention Strategy and the Ministry of Justice.

9.2 Drug-related crime

In 2013, in total of 1,019 drug-related crimes were registered (under § 183-190 of the Penal Code) which is more than in 2012 but somewhat less than in previous years (Table 14). Of all drug-related crimes recorded in 2013, cases of unlawful handling of large quantities of narcotic drugs (§ 184) comprised 78% (n=795). Compared to 2012, the total number of drug-related crimes increased by 18%. Drug-related crime comprised 2.6% of all crimes.

In 2013, 3,519 misdemeanours concerning drug-use or possession of small quantities were registered (§ 15¹ of the Act on Narcotic Drugs and Psychotropic Substances and Precursors thereof) (Table 15).

The registration of drug-related offences is directly dependant on the performance and priorities of investigative bodies. As of 2005, the combating of organised drug crime has been one of the focal points and as a result more attention has been paid on offences concerning the handling of large quantities of drugs (§ 184) Pursuant to the anti-crime priorities specified in March of 2013 by the Ministry of Justice, the field requires focus, first and foremost, on strong drugs and drug-related offences concerning minors.

Table 14. Registered drug-related crimes in 2007–2013.

Type of offence (chapter, § of the Penal Code)		2007	2008	2009	2010	2011	2012	2013
§ 183	Unlawful handling of small quantities of narcotic drugs or psychotropic substances	297	301	153	138	91	92	100
§ 184	Unlawful handling of large quantities of narcotic drugs or psychotropic substances	1,048	1,143	789	699	745	702	795
	Total of 183-184	1,345	1,444	942	837	836	794	895
§ 185	Passing on of narcotic drugs or psychotropic substances to minors	79	65	63	26	24	29	61
§ 186	Inducing person to engage in illegal use of narcotic drugs or psychotropic substances							1
§ 187	Inducing minors to illegally consume narcotic drugs or psychotropic substances or other narcotic substances	3	6				4	5
§ 188	Illegal cultivation of opium poppy, cannabis or coca shrubs	19	37	32	32	45	27	55
§ 189	Preparation for distribution of narcotic drugs or psychotropic substances	2	6	4	6	8	12	2
§ 190	Violation of requirements for handling narcotic drugs or psychotropic substances or precursors thereof or of requirements for related record keeping or reporting	1		1				
	Total of 185-190	104	114	100	64	77	72	124

Table 15. Registered drug-related misdemeanours in 2007–2013.

	2007	2008	2009	2010	2011	2012	2013
Unlawful handling of narcotic drugs or psychotropic substances in small quantities (§ 15 ¹ of the Act on Narcotic Drugs and Psychotropic Substances and Precursors thereof)	5,991	6,113	3,205	2,140	2,908	3,750	3,519

Source: Ministry of Justice, 2014

In 2013, the court convicted 40 persons under § 183 of the Penal Code, 456 persons under § 184 and 65 persons in other offences (§ 185-189). In 2013, charges were brought against ten cross-border criminal organisations.

Of all counties, the most drug-related offences were registered in Harju County (53% of all drug-related offences), Ida-Viru County (16%), Tartu County (15%) and Pärnu County (5%). In 2013, of the persons suspected in drug-related offences, 87% were men and 13% women.

9.7 Drug use and problem drug use in prison

In the past years (in 2011 for the last time), no surveys have been carried out among convicts concerning knowledge and behaviours related to drug addiction, however, data collected by the Ministry of Justice can be used.

The discovery of forbidden items and substances and the prevention of these items occurring in the territory of prison are focused on in prisons on a daily basis. Regular check-ups have become more effective and the respective infrastructure has been improved. All prison rooms occupied by prisoners are searched at least once every two months. In addition, there are larger operations to discover forbidden substances, comprehensive video surveillance, each prisons has detection dogs with dog handlers, body scanners are used, packages received by mail are checked, security work has been enhanced and the use of medications for the intended purposes is checked regularly. In 2013, 18 proceedings were commenced in prisons under § 183, 184 (unlawful handling of small/large quantities of narcotic drugs and psychotropic substances by a prisoner, detainee or person held in custody) due to the discovery of narcotic drugs or suspected narcotic drugs. In six cases the proceedings were terminated because the substance turned out not to be a narcotic substance, the proceedings of the rest of the cases are pending. In 2012, 12 criminal matters were commenced on the same grounds. Within a year, nine criminal cases in proceeding were terminated due to lack of necessary elements of a criminal offence. Currently, in the new prisons the possibility of drugs reaching prisoners have been minimised.

In order to enhance the detection of drug use, prisoners are tested regularly, for a reason or randomly. Urine as well as saliva tests are used. In total, in 2013, 2,838 tests for the establishment of drug content were taken from bodily fluids of which 107 gave a preliminary positive result. 78.5% of preliminary positives were caused by the positive result of a medication prescribed by a doctor. The level of testing has considerably decreased compared to the results of 2012. This concerns especially Tartu Prison where 50% less tests were carried out than in 2012.

Under § 331 of the Penal Code (preparation, acquisition and possession of narcotic drugs or psychotropic substances by prisoner or person in detention or custody and consumption by prisoner or person in detention or custody of such drugs or substances without prescription), 19 criminal proceedings were commenced. Compared to 2012, the indicator has decreased as 36 criminal proceedings were commenced at that time. The decrease has been brought about by Tallinn Prison where the use of methadone without a doctor's prescription has mainly taken place which, however, is now being prevented with better results.

9.8 Responses to drug related health issues in prison

Drug and HIV/AIDS prevention in Estonian prisons is based on the National Health Plan 2009-2020 and the National HIV and AIDS Prevention Strategy 2006-2015.

Addiction rehabilitation departments and drug addiction treatment in prisons

870 persons with addiction diagnosis stayed in Estonian prisons in 2013, i.e. 28.8% of the total number of prisoners. Based on diagnoses, opioid addicts (ICD diagnosis F-11) form the largest amount of all addicts, amounting to half of all drug addicts in prisons.

Special departments of addiction rehabilitation have been established in Estonian prisons for social reintegration of drug addicts. The departments of addiction rehabilitation have been established in three prisons in total: In Tartu Prison (174 places in total), including 44 active rehabilitation places and 44 post-rehabilitation places), in Viru Prison (20 places for adolescents and 20 for adults) and in Harku Prison (8 places). The rehabilitation of the remaining addicts is based on social programmes.

Addicts are treated in prisons with non-opioid as well as opioid drugs. Methadone maintenance treatment is provided as replacement treatment. The methadone maintenance treatment started before prison is continued in prison and, if necessary, treatment is started. In 2013, non-opioid detoxification treatment was carried out in 89 cases, detoxification treatment with methadone was carried out in 29 and replacement treatment in 142 cases. The number of people receiving methadone maintenance treatment was 57 at the end of the first quarter, 62 at the end of the second quarter, 60 at the end of the third quarter but decreased to 51 by the end of the fourth quarter. Compared to 2012, the average per quarter number of people receiving replacement treatment is the same in 2013. However, considering the decrease in the number of prisoners, the percentage of patients has increased (at the beginning of 2013, there were 3,286 prisoners and at the end of the year 3,026 prisoners).

In order to prevent the treatment started before prison from being interrupted, the Ministry of Justice has ensured that methadone maintenance treatment continues at the Viru House of Detention.

Training for prison staff and probation supervisors

As of 2007, prison officials have been trained in various fields: Basic drug training, motivational counselling techniques, treatment of opioid addiction, in-service trainings for guards-dog handlers. In 2013, the training needs of prison staff were mapped and planned for the following periods.

At the same time, various trainings were organised in 2013 which were taken part by 131 prison officials. 8 officials took part in a drug-related training for dogs and dog handlers, 14 people took part in a lifestyle programme training and supervision. A motivational interviewing training had 50 participants. A drug-related training had 40 participants and there were 19 participants in a drug-related training for medical staff.

9.9 Reintegration of drug users after release from prison

As of 2012, an opportunity has been provided for undergoing a detoxification treatment as an alternative sentence upon release on parole. In 2012 as well as in 2013, the alternative sentence was implemented on one occasion, even though in both years the planned capacity was 15 persons.

The option of substituting imprisonment with detoxification treatment has been used rarely until now because imprisonment could only be substituted with detoxification treatment by persons who had no previous punishments. This restriction has been abolished by the amendment of 08.03.2014. § 69² (6) of the Penal Code was amended so that addiction treatment may be implemented on a person who has been previously sentenced to imprisonment. The small amount of service providers has also been an issue. Through a public procurement, the state only obtained one service provider for outpatient and one for inpatient services. Both were located in Ida-Viru County. In 2014 the circle of service providers has widened.

The Police and Border Guard Board is conducting a project in houses of detention for the development of sponsor service for people who have been detained for a drug-related offence. In 2013, houses of detention were visited for 40 times, 80 people were talked to and a contract was entered into with 51 persons.

Chapter 10. Drug market

10.1 Introduction

The data in the chapter covering the changes on the drug market have been compiled on the basis of the EMCDDA standard tables 13, 14 and 16. The data on the quantities and purity of confiscated narcotic substances were obtained from the Estonian Forensic Science Institute, which is a national central expert body. EFSI is a state agency managed by the Ministry of Justice and all biological and other materials forwarded to the expertise by the Estonian Police and Border Guard Board and the Estonian Tax and Customs Board are sent there. The overview on the drug prices is based on the expert assessment of the surveillance data from the Estonian Police and Border Guard Board. The presented data on drug transit were collected by the Estonian Tax and Customs Board. As all readers of this report do not have access to the EMCDDA standard tables, the main data from tables 13, 14 and 15 are stated in this chapter.

10.2 Internal and transnational drug transit

The majority of narcotic substances are imported into Estonia. The Estonian Tax and Customs Board provide information on the origin and transit of narcotic substances. The following are the descriptions of main narcotic substances, their origin and their method of import, when possible.

Marijuana continues to be the most popular narcotic substance in Estonia and a great many criminal groups are engaged in transporting marijuana from the Netherlands to Estonia. Marijuana is mainly delivered to Estonia by mainland using cars and trucks, but air and bus transportation are also used. Compared to the previous 5 kg delivery, the delivery quantities have increased and are now 10 kg or higher, and less importance is given to properly hiding narcotic substances. The main emphasis in hiding the substances is placed on fast delivery; in transportation by car, emphasis is placed on the fast and easiest way to getting substances out of the car and handing them over. There are many of those, who are trying to grow cannabis for their own use (mainly 1–20 plants), but also wholesale growers who are engaged in selling their produce. The large vendors still prefer to bring marijuana from the Netherlands. Along with marijuana, cocaine and hashish are also brought into Estonia from the Netherlands and Spain. As there is no market for hashish in Estonia, it is forwarded to Russia or Nordic Countries.

Hashish is transported from Spain via Estonia to Russia. In Estonia there is no market for the substance, but a part of the transit market belongs to criminals originating from Estonia. The newest and/or the most expensive cars (BMW, VW etc.) are used for transportation of

the substance and the quantities being transported at a time are approximately 100 kg. The substance is almost always hidden in the side member or special containers built under the ceiling of the car.

Air and maritime transport are used for transporting **cocaine** from South America to Europe; transit through West and Central African countries is also possible. The methods of hiding in smuggling cocaine to Europe have become very complex and today they can be hidden in plastic, ice bags, coffee or in any of other substance, thus reducing the risk of detection. Larger quantities of cocaine are moved through Estonia to Scandinavia, the Netherlands and Russia. The cocaine for street selling is brought to Estonia from Russia and the Netherlands. Smaller quantities of cocaine Estonia through postal services and individual couriers via Spain and the Netherlands.

Heroin is continually transported along the mainland via the Balkan route to Central and Eastern Europe hidden in vehicles, having no market in Estonia.

Fentanyl is delivered to Estonia in solid as well as in liquid form from Russia, including smaller quantities brought in by drug addicts for own use. During their travels to the Nordic countries, drug addicts have started bringing in fentanyl for their own use.

Ecstasy and its analogues mainly originate from the Netherlands, Belgium, France and Germany, where they are transported hidden in cars, but also via postal and courier services.

There are continuous attempts to produce **amphetamine** in Estonia, but many criminals prefer to bring it from the Netherlands, Russia and Lithuania. In November 2013, only one lab was discovered, where powder was prepared from liquid amphetamine originating from Russia. The trend of transporting amphetamine from Estonia to Finland is constant, whereby Estonia is a transit corridor between Lithuania and the Nordic Countries.

The centre of the production of **methamphetamine** is considered to be Lithuania, Poland and Russia. In the Estonian street trade this substance is uncommon.

Estonia is used as a transit country for smuggling **khat**: Somalis as well as disadvantaged Europeans use low-cost airlines from the Netherlands and England combined with ship transportation to carry khat via Estonia to Finland.

After adding **GBL** in the V list of narcotic and psychotropic substances, attempts to deliver it to Estonia via postal and courier services have decreased. However, this has not solved the problem conclusively as it is continuously possible to deliver this substance to Estonia via mainland. GHB is also boiled in Estonia.

Unfortunately, SUBUTEX (medicine of opioid substitution therapy) tablets are also gaining popularity, the volumes of which today are large and many Estonian criminals see it as a way of making money. The tablets are brought to Estonia solely from Belgium and France, and are delivered from Estonia to Finland. There is no market for these tablets in Estonia.

Air transportation as well as transportation by mainland is used for smuggling SUBUTEX tablets. In addition to Estonians and Finns, Albanians are also engaged in the smuggling of the tablets!

The tablets are hidden in cans or bottles, taped to the body or hidden in backpacks. Generally, the tablets are transported with the packaging to obtain maximum profit in Finland.

A continuing trend for **young people** is attempting to deliver narcotic substances into Estonia using postal and courier services. Mainly marijuana is ordered through the Internet for own use, but smaller quantities of other narcotics such as hashish, heroin, amphetamine and a variety of powders, both prohibited and permitted, in addition to pills and psilocybin-containing mushrooms are also ordered. Efforts of ordering larger quantities of narcotic substances intended for resale are through the Internet are also common. Other narcotic substances include: (1) psiloc(yb)in-containing mushrooms/mushroom spores, cathinone derivatives and synthetic cannabinoids are continuously ordered over the Internet as postal and courier items. Criminals in Estonia closely monitor the lists of narcotic and psychotropic substances; psychoactive substances that are not on these lists are then marketed on the streets.

10.3 Drug seizures

In the table 16 are presented amounts of confiscated narcotic substances in the period of 2008–2013. The confiscated quantities of cannabis products (176.6 kg vs. 36.5 kg) and amphetamine (25.4 kg vs. 14.2 kg) increased the most in 2013 compared to 2012. In 2013, cannabis products were confiscated in a total of 590 cases (in 2012, a total of 526 cases were reported). The confiscated quantities of other commonly used narcotic substances decreased in 2013. The biggest drop was recorded in the seized quantities of methamphetamine. Contrary to 2012, during which seized quantities of methamphetamine rose sharply to 27 kg, the confiscated quantity in 2013 was only 2.4 kg and methamphetamine was confiscated in 69 cases (110 cases in 2012). The seized quantities of ecstasy tablets decreased in 2013 compared 2012, respectively from 9210 to 3341 tablets. The seized quantities of cocaine decreased by half, a total of 1.79 kg of cocaine was seized in 2013.

Table 16. Amounts of confiscated narcotic substances in 2008–2013 (kg).

	2008	2009	2010	2011	2012	2013
Cannabis resin (hashish)	48.5	19.2	14.6	45.6	4.7	109.2
Cannabis leaf (marijuana)	24.2	7.1	14.8	53.5	25.1	51.2

Cannabis plants	23.2	17.2	10.8	29.3	6.6	16.21
Heroin	0.1	3.9	0.004	0.1	0.0004	0.0007
Cocaine	3.6	5.0	217.7	0.8	3.4	1.79
Amphetamine	23.3	55.9	47.7	41.6	14.2	25.44
Methamphetamine	37.7	0.001	0.5	1.5	27.1	2.44
GHB	7.7	25.1	16.1	13.5	28.9	23.2
Fentanyl/3-methylfentanyl	1	1.8	0.5	0.9	1.7	1.07

Source: EMCDDA standard table 13, Estonian Forensic Science Institute, 2014

Heroin remains undistributed in the Estonian drug market, being seized only on two occasions with a total of only 0.7 g of the substance. The most common opiate in Estonia is still fentanyl. 1.5 kg of fentanyl was seized in 2013, which is 700 g less than in 2012. However, the number of seizures of fentanyl compared to the previous reporting year rose from 258 to 276. In 2013, the priority of the police remained to capture street vendors who sell fentanyl. During that year, a series of extensive police operations were carried out, catching both street vendors as well as persons who were suspected of dealing large amounts of fentanyl. In the September of 2013, nearly half a kilo of fentanyl was seized from two larger middlemen, amounting up to 18 000 doses.

GHB seizures also decreased in 2013. A total of 23 kg of GHB was seized. Synthetic cannabinoids proved to be the most confiscated of new psychoactive substances in 2013 (a total of 33 cases and 325 g). New substances are not as big of a problem to Estonia as it is for neighbouring countries and other EU countries, but year after year, the growing interest in psychoactive substances as alternatives for commonly used narcotics ordered via internet can be seen. In 2013, a number of cathinones having a stimulatory effect like methylnon (204 g), α -PVP (233.4 g), mephedrone (10,3 g) (Table 17) were seized. All undermentioned new psychoactive substances have been added to the list of narcotic and psychotropic substances in Estonia and an ordinary person is not allowed to order/handle those substances.

Table 17. The new psychoactive substances confiscated in 2013.

The name of the substance	The number of expertises	Quantities of expertises (g)
PMMA, 2C-T-2, 2C-T-7	11	144.7 g
4FMP	2	21.9 g
Synthetic cannabinoids (Spice, etc.)	33	325.1 g
Mephedrone	1	10.3 g
Methylnon	4	204.2 g
MDPV	1	1.68 g

4-MEC	6	8.95 g
3-FMC	1	0.92 g
α-PVP	16	233.4 g
EP	19	27.3 g

Source: *Estonian Forensic Science Institute, 2014*

Because Estonia is not a large country in producing narcotic substances, there is no information on the confiscation of the precursors of narcotic substances.

10.4 The availability of drugs

In 2014, the study on the awareness of risk behaviour by the Police and Border Guard Board mapped the assessment of people aged 18–74 on the availability the narcotic substances. They were asked to assess how accessible cannabis products, amphetamine, ecstasy and sedatives or tranquilizers are for them without a doctor’s prescription. Approximately one-third of the respondents did not know how to evaluate the availability of narcotic substances. The remainder of the respondents assessed cannabis to be the most accessible, 27% of the population assessed cannabis products to be fairly or very easily accessible. Amphetamine, ecstasy and sedatives/tranquilizers were thought to be fairly or very easily available for 14-15% of the population (Figure 5)

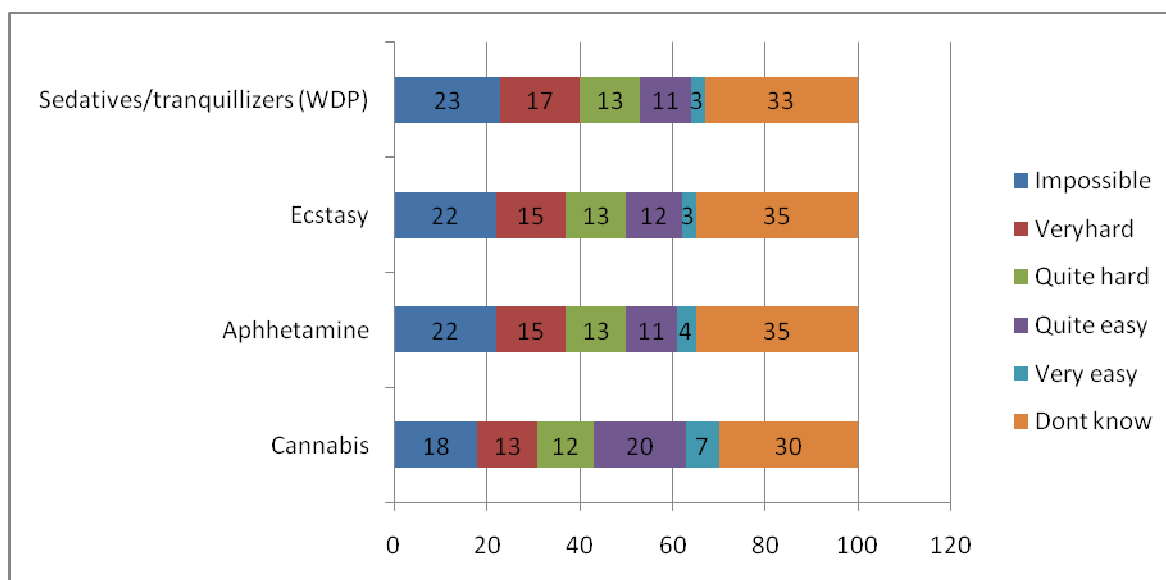


Figure 5. Assessments of the availability of the various drugs for themselves.

Source: *A study on the awareness of risk behaviour among the adult population by Police and Border Guard Board 2014.*

The younger the respondents, the more cannabis was considered as easily accessible, fewer were not able to assess the availability. The same age-related tendency occurred in questions regarding the availability of amphetamine and ecstasy. In the 18–24 and 25–34 age groups, about 40% considered cannabis products to be fairly or very easily accessible. 21% of the respondents in the 18–24 age group considered amphetamine and ecstasy to be fairly or very easily accessible. In the 25–34 age, the responses on the accessibility being fair or very easy was 16% for amphetamine and 17% for ecstasy. A study on the awareness of risk behaviour was conducted in 2014 among the students of grades 6, 8 and 12. Students, who had used drugs in their lifetime, were asked about where they got narcotic substances the previous time. Half of the students claimed they got them from an acquaintance or a friend for free and more than a fifth replied that a friend/acquaintance had sold them the substance. Only 4% claimed that a stranger gave them for free (Figure 6).

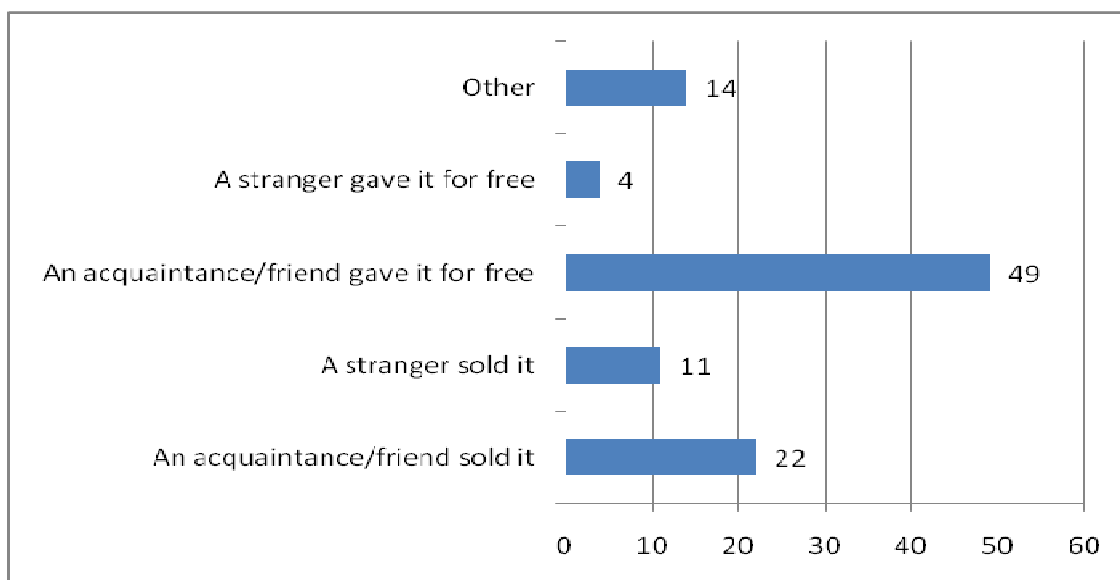


Figure 6. The way of obtaining drugs the previous time among the 6th, 8th, and 12th grade students, who have used drugs.

Source: "A study on the awareness of risk behaviour among students 2014."

Regarding the 2014 innovations of the syringe exchange information system, the next report can include evaluations of the syringe exchange point customers on the availability of narcotic substances by subjects. As of the second half of 2014, all customers visiting the syringe exchange centres at least once a year are obligated to answer a repeating visitor's electronic survey, which aims at mapping the assessments of various clients on the availability of narcotic substances and their estimated price. The survey is completed by a

worker of the syringe exchange centre by talking to the customer and the questionnaire is anonymous.

Drug prices and purity

The drug prices in the report are estimated based on the surveillance of the Estonian Police and Border Guard Board. It is the annual assessment, which takes into account the wholesale trade. As of 2014, due to the innovation of the needle exchange information system, it is possible to report the information from IDUs on street prices.

In 2013, according to the Estonian Police and Border Guard Board drug prices were almost on the same level with the prices in 2012. The only major increase in 2013 was the street price of hashish. When compared to the last reporting period, it can be said that drug prices have been relatively stable in the last three years.

Regarding the purity of majority of the drugs, stable or slightly increasing trends were reported in 2013.

In 2013, the most common THC content in cannabis products was 11 %, which is similar to the most widespread content in 2012 (typical THC content 2–20%). Although when looking at the arithmetic average of purity, the increase of the average THC content of hashish is noticeable (6% vs. 11.5%). The purity of marijuana in 2013 remained the same as in 2012, with the most common form of purity being 14% of the THC content of the material. Compared to 2012, the price of hashish doubled, meaning that the price of one gram in 2012 was EUR 7, increasing in 2013 to EUR 15. No significant changes were reported in the street prices of marijuana – the price of marijuana was EUR 20 for a gram in both 2012 and 2013.

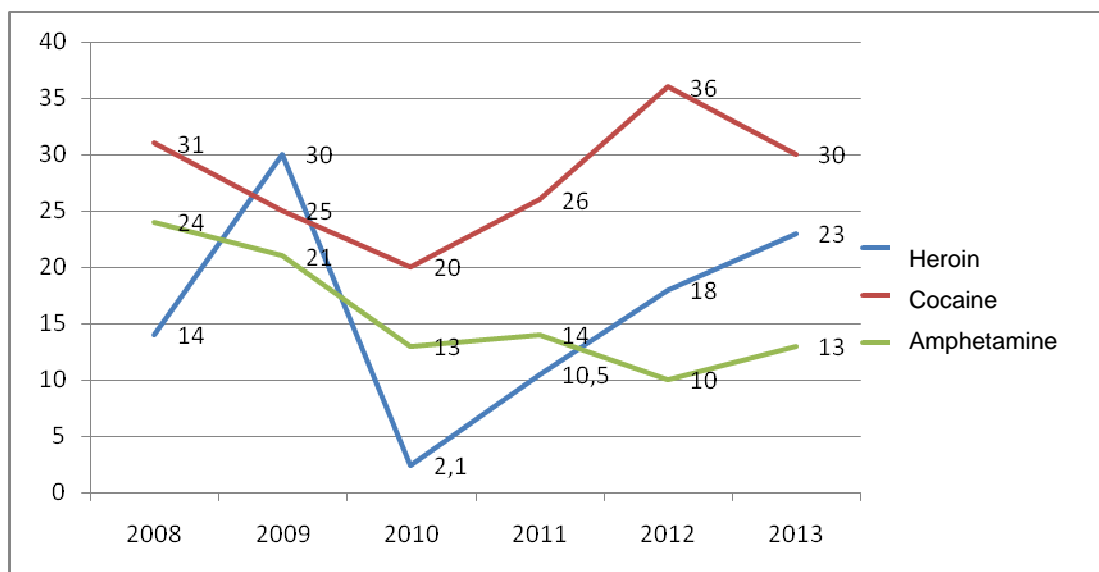


Figure 7. The purity of heroin, cocaine and amphetamine in 2008–2013.

Source: EMCDDA standard table 14, Estonian Forensic Science Institute 2014

Since the amounts of heroin are practically non-existent in the Estonian drug market, it is impossible for the police to assess the most common street price of heroin. The purity of heroin in a small seized quantity was 23% of pure substance, which is 5 percentage points higher than in 2012. Fentanyl remains the most widely used opioid in Estonia and the most common street price varies between EUR 10 and 15 per dose. The usual dose of fentanyl is 0.028–0.035 g. The purity of fentanyl has fallen a by some degree during the reporting period. When in 2012, the average purity level of fentanyl was 6.6% of pure substance per gram, then in 2013 it the respective number was 5.8% of pure substance per gram. The most common type of purity of fentanyl was 5.9% of pure substance per gram. One of the reasons for the decreasing number of deaths caused by drug use is believed to be the decreased quantity of pure substance in narcotics i.e. decreasing the degree of potency. Since fentanyl street vendors are a priority for the police, dealers are forced to meet the demand and therefore dilute the dose which, in turn, means fewer overdoses and deaths.

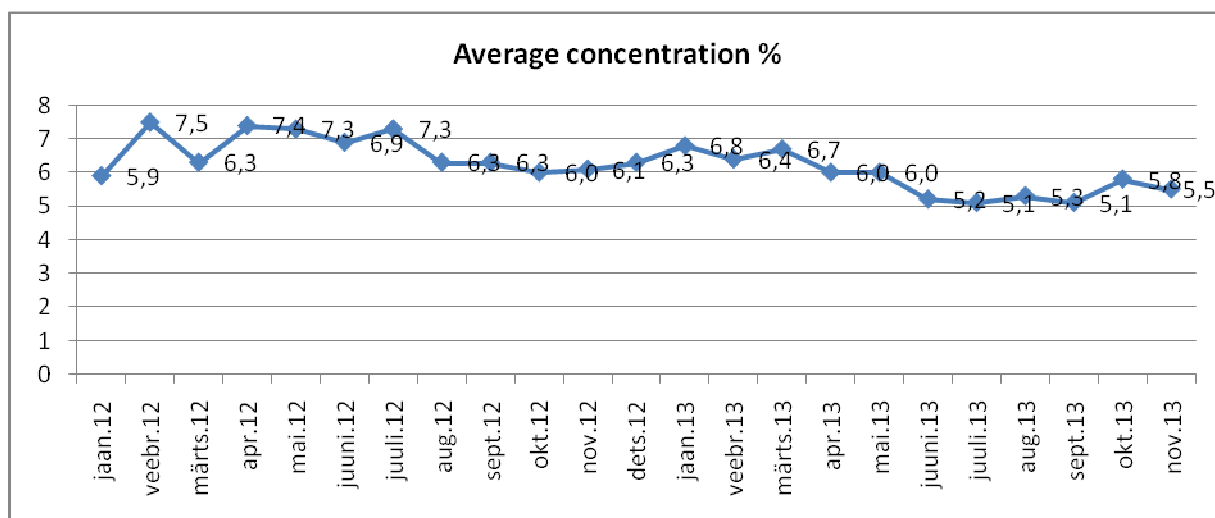


Figure 8. The average concentration of fentanyl in one gram of the substance (%) in period of Jan 2012–Nov 2013.

Source: Estonian Forensic Science Institute, 2014

The most common type of purity of cocaine per gram fell in 2013 from 36% to 30%; the arithmetic average of purity was also approximately 41%, which is 5 percentage points lower than in 2012. The street price of cocaine did not change in 2013 and was still between EUR 80–120. The most common purity of amphetamine in 2013 was a little bit higher than in 2012. The most common purity of amphetamine was 13% of pure substance per gram, which was 3 percentage points higher than in 2012. There was no change in the street price of amphetamine and the price still between EUR 10–20. The street price of methamphetamine is similar to the street price of amphetamine, but the purity of the substance is higher than in amphetamine. The average of pure substance per gram in

methamphetamine was 33% which, compared to the purity of methamphetamine in 2012, was 19 percentage points higher. The purity of ecstasy also rose during the reporting period, being 79 mg MDMA per tablet in 2012, but 91 mg MDMA per tablet in 2013. The price of an ecstasy tablet remained the same as in 2012, ranging between EUR 6 and 10. The most common purity level of GHB increased by some degree. When the most common purity level of GHB in 2013 was 57% of pure substance, then in 2012 the respective number was 51%. But when looking at the arithmetic average, the purity percentage of GHB did not change and remained at 47%. The price of GHB was a slightly higher compared to 2012, ranging between EUR 4 and 6 per dose (with a dose of 5 ml).

Part B

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<http://youtu.be/APvYUjIPPWw> (vene keelne)

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Used EMCDDA standard tables, 2014

Standard Table 05: Direct drug related deaths/Drug-induced deaths

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