



European Monitoring Centre  
for Drugs and Drug Addiction

Estonian National  
Focal Point



# **ESTONIA**

## **DRUG SITUATION**

**2004 NATIONAL REPORT TO THE EMCDDA**

**by the Reitox National Focal Point**

**New Developments, Trends and In-depth Information on  
Selected Issues**

**REITOX**

## REPORT ON THE DRUG SITUATION IN ESTONIA 2004

Ave Talu<sup>1</sup>  
Katri Abel<sup>1</sup>  
Andri Ahven<sup>2</sup>  
Anu Neuman<sup>3</sup>  
Liina Laastik<sup>1</sup>

<sup>1</sup> National Institute for Health Development, Research Centre, Estonian Drug Monitoring Centre  
/Estonian National Focal Point/

<sup>2</sup> Ministry of Internal Affairs

<sup>3</sup> Estonian Forensic Service Centre

2004

copyright © NIHD, Estonian Drug Monitoring Centre /Estonian National Focal Point

National Institute for Health Development 2004

Research Centre, Estonian Drug Monitoring Centre / Estonian NFP)

Hiiu 42

Tallinn 11619

ESTONIA

Phone +372 659 3997

Fax +372 659 3998

e-mail: ave.talu@tai.ee

e-mail: katri.abel@tai.ee

website <http://eusk.tai.ee>

<http://www.tai.ee>

ISSN 1736-1338

ISBN 9985-9519-6-4

The contents of this report do not necessarily reflect the official opinion of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The responsibility for opinions expressed in single chapters rests solely with their authors. This report was co-financed by the European Monitoring Centre for Drugs and Drug Addiction (Grant Agreement No CT.2004.RTX.309).

Layout and printing in AS Spin Press.

## Table of Contents

<b>Acknowledgements and introductory note</b> .....	5
<b>Summary</b> .....	6
• Summary of the main findings including selected issues	
• Main developments and recent trends	
• Analyses and interpretations of developments and trends	
• Consistency between indicators	
<b>PART A - New Developments and Trends</b>	
<b>1. National Policies and context</b> .....	8
• Legal framework .....	8
• Institutional framework.....	10
• Budget and public expenditure.....	12
• Social and cultural context .....	14
<b>2. Drug Use in the Population</b> .....	17
• Drug use in the general population.....	17
• Drug use in the school and youth population .....	18
• Drug use among specific groups.....	21
• Attitudes to drugs and drug users.....	21
<b>3. Prevention</b> .....	22
• Universal prevention (family, school, community) .....	22
• Selective/indicated prevention (risk groups, risk families, recreational settings) .....	23
<b>4. Problem drug use</b> .....	24
<b>5. Drug-Related Treatment</b> .....	25
• Treatment system .....	25
• Drug-free treatment .....	27
• Medically assisted treatment .....	27
<b>6) Health Correlates and Consequences</b> .....	31
• Drug-related deaths and mortality of drug users.....	31
• Drug-related infectious diseases .....	31
• Psychiatric co-morbidity (dual diagnosis).....	34
• Other drug-related health correlates and consequences .....	34

<b>7. Responses to Health Correlates and Consequences .....</b>	<b>35</b>
• Prevention of drug-related deaths .....	35
• Prevention and treatment of drug-related diseases .....	35
• Interventions related to psychiatric co-morbidity .....	39
• Interventions related to other health correlates and consequences .....	39
<b>8. Social Correlates and Consequences.....</b>	<b>40</b>
• Social exclusion.....	40
• Drug-related crime.....	42
• Drug use in prison.....	43
• Social costs.....	44
<b>9. Responses to social correlates and consequences .....</b>	<b>45</b>
• Social reintegration.....	45
• Prevention of drug-related crime .....	45
<b>10. Drug Markets .....</b>	<b>49</b>
• Availability and supply .....	49
• Seizures .....	49
• Price/purity.....	51
 <b>PART B - Selected issues</b>	
<b>11. Buprenorphine, treatment, misuse, and prescription practices .....</b>	<b>52</b>
<b>12. Alternatives to prison targeting to drug using offenders .....</b>	<b>54</b>
<b>13. Public nuisance: definitions, trends in policies, legal issues and intervention strategies.....</b>	<b>54</b>

## Acknowledgements and introductory note

*2004 National Report to the EMCDDA. Estonia. New Developments, Trends and In-depth Information on Selected Issues* is the fourth report on drug situation in Estonia drafted by the Estonian Drug Monitoring Centre (EDMC). The EDMC based at the National Institute for Health Development (NIHD) has been appointed as the Estonian REITOX National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

This report provides an overview of the drug situation in Estonia in 2003 and describes the new developments and trends in the drug situation, responses and policy developments and gives in-depth information on selected issues.

This report together with the reports from other EU member states submitted to the EDMC will be used in the drafting of the annual report of the EMCDDA. Information provided in this report is based on the data collected by the Estonian REITOX NFP from different sources. In addition, the report includes data of epidemiological standard tables (ST) and structured questionnaires (SQ) annually submitted to the EMCDDA.

We are very grateful to our collaborators Ms Monika Sarapuu, Ms Ene Katkosilt, Ms Elo Liebert (Ministry

of Justice), Mr Andres Lehtmets (Opiate Addicts' Substitution and Detoxification Treatment Unit of West Tallinn Central Hospital Psychiatric Centre), Ms Urve Miidla and Ms Tiina Kase (Estonian Police Board), Ms Merike Kull (University of Tartu), Ms Marika Inno (Health Insurance Fund), Mr Kuulo Kutsar (Health Protection Inspectorate), Ms Liilia Lõhmus, Ms Kristi Rüütel, Ms Iveta Tomera, Ms Anu Harjo, Ms Aire Trummal and Ms Riina Enke (National Institute for Health Development), Ms Niina Derman and Ms Leeni Hansson (Institute of International and Social Studies) Ms Ene Orumaa (Schering-Plough) and Mr Gleb Denissov (Statistical Office of Estonia) who have provided us with background information and useful comments.

Special thanks to our proofreader Ms Anneli Saluste.

The website of the Estonian Drug Monitoring Centre is available at <http://eusk.tai.ee> or on the website of the National Institute for Health Development at <http://www.tai.ee> (see Research Centre).

## Summary

This report provides an overview of the political and legal framework, epidemiological situation and demand reduction interventions in the field of drugs in Estonia in 2003.

Lack of data on some important field makes it very difficult to draw conclusions on the drug situation in Estonia in 2003, however it is possible to describe the situation and changes in the drug field on the basis of the existing data. This summary gives a short overview of the changes in the reporting period.

In 2003 a number of changes were introduced in the legal framework. Amendments to the Penal Code providing more strict penalties with respect to most of the crimes associated with narcotic drugs or psychotropic substances were approved by the government in 2004. In 2003 the Ministry of Social Affairs outlined the Draft Narcotic Drugs and Psychotropic Substances Act Amendment Act. It will be submitted to the Riigikogu (Estonian Parliament) for approval next year (see the Chapter on national policies and context). National Strategy on the Prevention on Drug Dependency 2004-2012 was adopted in Estonia on April 22, 2004. The strategy includes six fields of activity - prevention, treatment-rehabilitation, harm reduction, supply reduction, drugs in prison, monitoring of drug situation and evaluation. Tallinn City Government has approved the Action Plan 2003-2008 for the Prevention of Drugs and HIV/AIDS in Tallinn. With regard to licit drugs the coalition parties have agreed to impose strict fines on persons selling alcohol and cigarettes to minors, limit alcohol and tobacco advertising and establish stricter limits on the availability of alcohol. More in-depth description of the changes in the area of drug legislation and institutional framework is given in the chapter on national policies and context.

With respect to providing an overview of the situation of drug treatment the biggest problem is lack of treatment data. Establishment of the epidemiological data collection system to get information on treatment demand has been recognised as one of the priorities in this area. The number of treatment institutions providing treatment for drug addicts has increased to some extent and the situation is likely to improve in the coming years. However, without appropriate rehabilitation programmes it is complicated to help drug addicts to stay drug-free, especially those having lost contacts with their family and friends.

Substitution treatment has been recently introduced in Estonia. The first substitution treatment programme with methadone was launched in 2003 in the substitution and detoxification treatment unit of the West Tallinn Central Hospital.

The latest development in terms of treatment is provision of drug addicts with access to buprenorphine treatment since 2003 and expansion of availability of methadone treatment in Tallinn (see Chapter 5 on drug-related treatment). More detailed overview of buprenorphine treatment in Estonia is given in Chapter 11 on selected issues (see Buprenorphine, treatment, misuse and prescription practises).

Data on drug-related mortality was not available in 2003 because of changes in legal framework described in chapter 6 on health correlates and consequences. Hopefully data on drug-related deaths can be presented in our next report.

Spread of drug-related infectious diseases (HIV and hepatitis C, B) showed a decreasing sign in Estonia. Prevention of drug-related infectious diseases in high-risk groups in Estonia (incl IDUs) improved in 2003 when compared to the previous reporting period. Increase in the scope of vaccination against hepatitis B can be described as a positive trend. In 2003 Estonia started to vaccinate all newborns against HBV within the framework of the national immunization programme. The number of HIV tests made annually increased during the period of 2000-2003. Also, the quantity and quality of syringe exchange points improved.

In 2003 counselling services became more available to the target group (see Prevention and treatment of drug-related infectious diseases). Reduction of incidents of HIV infection among the prison population was of utmost importance in the reporting period. Laboratories for primary HIV testing were set up in 7 prisons and pre- and post-test counselling service improved in terms of quantity as well as quality in the reporting year. More in-depth overview of this issue is given in chapter 9.

Social problems in Estonia were similar to those of the previous reporting year characterized by high rate of unemployment of young people. Also, the number of school drop-outs as well as drug-related crimes increased and drug use in prison was widely spread in 2003.

Drug use among the prison population has not been well studied in Estonia as stated in chapter 8.

Data gathered from the Ministry of Justice on the basis of standardised tables sheds some light on drug use among prison population indicating high level of lifetime drug use, particularly intravenous drug use among inmates.

According to the data the most widely used drugs among prison inmates were heroine, amphetamine and cannabis. Drug use in prison varies by type of substance (0,5% to 2%).

Data on drug use in prison presented in chapter 8 must be treated carefully due to the limitations with respect to obtaining data of good quality. Current data does not enable us to detect the actual size of prison population using drugs in prison correctly.

The new Drug Strategy on the Prevention of Drug Dependency envisages development of operative control system in prisons to prevent drugs from entering prisons and provision of conditions for systematic treatment and rehabilitation in prisons.

Chapter 9 on responses and social correlates and consequences gives an overview of a wide range of

activities carried out in Estonian prisons within the framework of resocialisation process to tackle the spread of HIV/AIDS and drugs. In 2003 assistance provided for drug users in prisons was also focusing on drug treatment. Drug treatment in prison is poorly developed. In 2003 there was only one treatment unit operating on the basis of the Prisons Central Hospital providing short-term detoxification treatment with methadone.

Data on seizures show that the confiscated amount of cannabis and amphetamines increased in 2003. The use of heroin and fentanyl decreased, at the same time methylfentanyl gained popularity. In 2003 the purity and price of heroin increased when compared to the previous year.

Chapter 13 "Public nuisance: definitions, trends in policies, legal issues and intervention strategies" presents a study on security conducted among school students of the 8th grade in schools of six districts of Tallinn as well as their parents. (Kruusvall *et al* 2004).

## 1. National policies and context

During the reporting period a number of changes in the legal and institutional framework were introduced in the drug field in Estonia. In April 2004 the government approved the Draft Narcotic Drugs and Psychotropic Substances Act (NDPSA) Amendment Act and the minister of Social Affairs submitted the draft law to the Riigikogu for approval. Also, the government unanimously approved the National Strategy on the Prevention on Drug Dependency 2004-2012. Amendments to the Penal Code providing more strict penalties with respect to most of the crimes associated with narcotic drugs or psychotropic substances. The Government Coalition Agreement for the years 2003-2007 introduces several tasks related to the fight against the drug problem.

Major changes in the institutional framework took place in the reporting year. On May 1, 2003 the National Institute for Health Development (NIHD) was appointed to be the institution responsible for the activities in the field of drug demand reduction as well as for the delivery of the ADAPP and national HIV programmes.

In terms of finances the areas of drug demand reduction and supply reduction were still under financed although drug use had become a problem of increasing concern in the country.

In general, the drug problem became more visible for the general public in the reporting period. Targeted initiatives were taken by the government to fight against the misuse of drugs through a focus on supply reduction, prevention, harm reduction and treatment.

### • Legal framework

*(See National Report 2002 1.2 and 1.3 and 2003 Chapter 1.2)*

On April 29, 2004 the government approved the Draft Narcotic Drugs and Psychotropic Substances Act (NDPSA) Amendment Act. The Draft Act includes the following amendments:

- Harmonizing of the provisions of the NDPSA with other relevant Estonian legal acts in force.
- Stipulation of the provisions restricting the handling of narcotic drugs and psychotropic substances and precursors in the Draft NDPS Amendment Act. Previously restrictions were regulated by different regulations.
- Introduction of additional restrictions to the handling of illegal narcotic drugs and psycho-

tropic substances and increasing the scope of surveillance to prevent availability and circulation of illicit narcotic drugs and psychotropic substances.

- Setting up a basis for the collection of objective and reliable epidemiological and statistical data on drugs and drug addiction and consequences thereof.

The Draft Narcotic Drugs and Psychotropic Substances Act Amendment Act will be submitted to the Estonian Parliament - Riigikogu. Amendments to the NDPSA provide the Estonian Drug Monitoring Centre with the right to collect data on drugs and drug addiction and set up a drug treatment registry.

On 22 of April 2004 the government unanimously approved the National Strategy on the Prevention on Drug Dependency 2004-2012. Pursuant to the decision the strategy is implemented by relevant ministries and the budgets are established according to the needs of the strategy. The Minister of Social Affairs informs the government on the progress of the implementation of the NSPDD. The strategy provides an integrated approach to both demand and drug supply. The strategy includes six fields of activity - prevention, treatment-rehabilitation, harm reduction, supply reduction, drugs in prison and monitoring of drug situation and evaluation. The NSPDD includes an action plan for four years (2004-2008) (see also Estonian Drug Situation 2003 Part I).

As a result of the decision to approve the NSPDP the Alcoholism and Drug Abuse Prevention Programme 1997-2007 will not be valid from the year 2005.

The Government Coalition Agreement concluded between the Union for the Republic - Res Publica, Estonian Reform Party and the Estonian Peoples Union for the period of 2003-2007 provides several activities related to the fight against illicit and licit drugs to be carried out by the Coalition parties.

According to the Coalition Agreement the political parties have agreed to propose amendments to the Penal Code to introduce stricter penalties with respect to drug-related crimes (drug dealing) up to life imprisonment.

Amendments to the Penal Code entered into force at the beginning of 2004 providing stricter penalties with respect to most of the crimes associated with narcotic drugs or psychotropic substances (drug-related crimes), particularly in case of serious circumstances (unlawful handling of large quantities of narcotic drugs or psychotropic sub-

stances, if the same act is committed by a group, a criminal organization or a person who has committed a criminal offence related to narcotic drugs or psychotropic substances or for the purpose of large proprietary gain), as well as in case of inducing minors to illegally consume narcotic drugs or psychotropic substances or other narcotic substances. If a drug-related crime has been committed in relation to serious circumstances it is punishable by over ten years' imprisonment (up to 15 years' imprisonment, in some cases up to 20 years' or lifetime imprisonment). At the same time, the lower limit of the punishment in case of an offence without related serious circumstances was not raised. As a conclusion, we may say that the range of the category of punishment has been considerably expanded.

Regarding licit drugs the coalition parties have agreed to impose strict fines on persons selling alcohol and cigarettes to minors, restrict the advertising of alcohol and tobacco and place stricter limits on the availability of alcohol. The Coalition Agreement also envisages regular campaigns to be carried out to introduce the harmful effects of alcohol, drugs and tobacco in Estonia.<sup>1</sup>

In order to improve the procedure for the prescription of medicinal products containing buprenorphine and avoid illegal use of the named medicinal product, additional restrictive measures were adopted in 2004 by the decree of the Minister of Social Affairs No 90, 20 July 2004 (see Part B, Chapter 11).

According to the Imprisonment Act (State Gazette I 2000, 58, 376) the main goal of the imprisonment is to guide the prisoner to law-abiding life and protect the legal order. The Imprisonment Act emphasizes the establishment of the resocialisation system of convicted persons, which has been one of the priority areas in the few past years now. The Health Services Organization Act (State Gazette I 2001, 50, 284) passed 9 May 2002, entered into force 1 January 2002 providing the organization of and the requirements for the provision of health services and the procedure for the management, financing and supervision of health care applies to the organization of the provision of health services in prisons; the details of the procedure are provided in the Imprisonment Act. As we stated in the National Report on the Drug Situation in Estonia 2003, the Health Care system in prison is a part of the national Health Care System, financed by the state budget through the Ministry of Justice (see National Report on Drug Situation 2003). All

prisoners entering prison pass medical examination and they have access to ambulatory medical care and in-patient special medical care in medical departments of prisons, however, access to drug treatment in prison is very limited (see Chapter 8).

A memorandum of understanding was signed between relevant institutions of the Republic of Estonia and the United Kingdom and Northern Ireland on January 29, 2003 to prevent illicit trafficking of drugs, organized crime, illegal immigration, international terrorism and other crimes.

The HIV and AIDS epidemic in Estonia has been a major concern of the authorities responsible for the public health policy in the last few years. Therefore, the government policy on HIV and AIDS and other drug-related infectious diseases form an integrated part of the national drug policy. The national health care programme National HIV/AIDS Prevention Programme 2002-2006 was approved by decree No 33-k 16 of 3 January 2002 of the Government of Estonia to fight more efficiently against the HIV and AIDS epidemic (State Gazette, 23.01.2002, 13, 73). According to the decree of the government the Minister of Social Affairs has to submit an action plan for each budgetary year as well as an analysis of the results of the previous reporting period of the programme. The Minister of Social Affairs is obliged to involve local governments in the implementation of the national HIV/AIDS programme. The Minister of Education, Minister of Justice, Minister of Internal Affairs, and Minister of Defence are obliged to develop activity plans for their areas of government.

The Government has taken an obligation to allocate finances from the state budget for the implementation of the tasks provided in the national HIV/AIDS programme in accordance with the financial resources incorporated in the state budget.

The National HIV/AIDS Programme provides two main goals - to stop the spread of HIV and AIDS and to ensure the PLWHAs access to high quality antiviral treatment and other health care and social services.

The main objectives of the programme are the following:

- significant increase in the awareness of the youth of the prevention of HIV/AIDS and other STD;
- reduction of HIV prevalence among individuals belonging to the risk group by taking verification-based preventive measures;
- protection of the population against HIV infection through the provision of safe donor blood, tissues and organs;

<sup>1</sup> See [http://www.riik.ee/en/valitsus/3r\\_kalitsioon\\_eng.html#\\_Toc39046952](http://www.riik.ee/en/valitsus/3r_kalitsioon_eng.html#_Toc39046952)

- ensuring availability of counselling and HIV-testing to all interested persons;
- involvement of the majority of people with HIV in HIV/AIDS in prevention, care, and preventive treatment; development and implementation of HIV/AIDS prevention programmes 2002-2006 by the ministries and local governments;
- arrangement of epidemiological monitoring and analysis of the spread of HIV infection and evaluation of the efficiency of HIV/AIDS prevention action plans of local governments.

The National HIV/AIDS Prevention Programme 2002-2006 defines the HIV and AIDS risk groups in Estonia as follows: youth, mainly adolescents involved in risk behaviour; IDUs, prostitutes, sexual partners of IDUs, homosexuals, bisexuals and men involved in risk behaviour; persons suffering from sexually transmitted diseases; detainees and prisoners; pregnant women; persons having potential contact with blood in their line of work (health care and social workers, police officers, security service employees, prison officials, teachers, persons involved in first aid and rescue activities).

The National HIV/AIDS Prevention programme includes principles of effectiveness, responsibility, transparency, research, evidence-based and targeted activities, comprehensiveness, administration and respect for human rights, co-ordination and partnership.

Tallinn City Government adopted the Action Plan for the Prevention of Drugs and HIV/AIDS in Tallinn for the years 2003-2007 (order of Tallinn City Government No 16, 20 February 2003). In the reporting period Tallinn City Government supported drug and HIV/AIDS Prevention Programmes, drug monitoring, treatment and rehabilitation, syringe exchange points, outreach work, peer education and distribution of prevention materials etc (see Also Chapter 1. Budget and public expenditure; Chapter 5. Medically assisted treatment; Chapter 7. Prevention and treatment of drug-related infectious diseases).

#### • Institutional framework, strategies and policies

On May 1, 2003 the National Institute for Health Development (NIHD) was appointed to be the institution responsible for the activities in the field of drug demand reduction. NIHD is a research and development institution in the area of government of the Ministry of Social Affairs.

NIHD consists of three centres - a research centre, health development centre and training centre. The

Research Centre is responsible for research and monitoring activities. The role of the Development Centre is planning of health policy, development, coordination and implementation of strategies and development plans, participation in national initiatives and projects, elaboration of standards and guidelines, prevention of addiction problems and HIV and AIDS, provision of local organisations with support and development of study materials. NIHD is also responsible for carrying out projects financed by the Estonian Health Insurance Fund and participating in international projects and networks.

The Estonian government entered into a contract with the Global Fund to Fight AIDS, Malaria and Tuberculosis (GFFAMT) for the allocation of USD 3,908,952 to carry out an ambitious and result-focused programme for combating the HIV epidemic. The NIHD is responsible for the delivery of the programme in Estonia.

The goal of the 4-year programme is to stop the progressive spread of HIV and AIDS by the year 2007. Seven objectives focusing on four main areas of concern have been defined to meet the overall goal of the programme.

Practical steps to be taken in the field of prevention work with young people, targeted interventions, provision of support for PLWHAs and capacity building activities to meet the following objectives:

- reduction in risk behaviour among young people;
- reduction in risk behaviour among injecting drug users;
- reduction of risk faced by sex workers and reduction of vertical transmission of HIV;
- prevention of HIV transmission in prisons;
- reduction in risk behaviour among men who have sex with men;
- improvement of the quality of life of infected people;
- improved institutional capacity of the agencies involved in the fight against HIV.

In 2003 the Ministry of Social Affairs (MSoA) was responsible for the overall administration, guidance and co-ordination of HIV prevention activities on the national level. Responsibility for the implementation of national HIV/AIDS prevention programme has been transferred a few times during the period of 1997-2003. The AIDS Prevention Centre was responsible for the management

and implementation of the National HIV/AIDS Prevention programme in Estonia in the period of 1997-2002. In 2002 the Estonian Health Education Centre was the authority responsible for the implementation of the above mentioned national programme and after the establishment of the National Institute for Health Development (NIHD) on 1 May 2003 the latter was appointed as the institution responsible for the co-ordination of all national health programmes including National HIV/AIDS Prevention Programme for 2002-2006 and the National Alcoholism and Drug Prevention Programme for the years 1997-2007 managed by the Ministry of Social Affairs <sup>2</sup>. In October 2003 the NIHD and the Global Fund to fight AIDS, Malaria and Tuberculosis (GFFAMT) entered into the Grant Agreement providing the NIHD responsibility for the implementation of the National HIV/AIDS Prevention Programme funded by the GFFAMT.

An evaluation study on HIV/AIDS prevention in Estonia 2003 shows that establishment of the NIHD has created better conditions for the organization and co-ordination of HIV/AIDS prevention activities in the reporting year when compared to 2002. The roles of different organisations were clearly defined: the Ministry of Social Affairs and NIHD were responsible for the development and financing of prevention whereas contracts were concluded with the partners of the NIHD for the implementation of the programmes. However, the issue of organization of efficient co-operation, communication and sharing of experiences between all actors involved on the national level is still one of the main problems to be solved (Kruuda et al. 2004). According to the recommendations of the above mentioned study a system for the communication of experiences and information between NGOs has to be set up by the NIHD.

The findings of the study analysing co-operation and capacity building in the context of HIV and AIDS carried out by Voigländer and Abel in 2003 suggested that in 2003 some of the objectives of the programme were poorly targeted at such as co-ordination of activities on different levels and parties, development of partnership and science-based activities (Voigländer et al. 2004).

Findings of the study External Evaluation of System-Wide Cooperation and Capacity-Building within the Framework of the Estonian HIV/AIDS Prevention System suggest that cooperation be-

tween different institutions does not function efficiently in Estonia. Hence it can be concluded that an organization should not focus only on vertical co-operation but open up to co-operation possibilities and give partnership a higher priority (Voigländer et al. 2004).

The study suggested that there was a need for closer cooperation between NGOs and state authorities to explore HIV/AIDS issues on different levels. Authors of the study suggested to set up a national HIV/AIDS forum to promote professional relationships between different players. State authorities have to concentrate on capacity building of the NGOs and provide appropriate assistance for the enhancement of the capacity of NGOs (Voigländer et al. 2004).

Shortly after the establishment of the NIHD in 2003 cooperation and capacity building in the field of HIV/AIDS showed visible signs of improvement (see Chapter 7).

Most current study on the evaluation of HIV/AIDS prevention carried out in 2004 by the centre of policy studies PRAXIS examined another crucial aspect of co-operation - leadership and management (Kruuda et al. 2004). The authors of the study showed that certain issues having been raised by the WHO/EURO Mission with respect to the evaluation of the HIV/AIDS Programme in Estonia had not been concentrated on such as leadership, distribution and scope of liability. The authors of the study emphasised that the main weakness of the MoSA preventing the ministry from successful implementation of the NHAPP was inability to ensure meeting of the responsibilities of other co-operation partners of the programme. Also, the NIHD - a research and development institution working under the area of government of the MoSA had not got the authority to affect other co-operation partners of the programme, particularly the ministries involved with respect to the planning of the prevention work and allocation of resources for HIV prevention (Kruuda et al, 2004) <sup>3</sup>. The study suggested that the role of the advisory committee - the Country Coordination Mechanism (CCM) - set up on the initiative of the MSoA to prepare a proposal to the GFFAMT was not clearly defined and need-

<sup>2</sup> According to the National HIV/AIDS Prevention Programme 2002-2006 the National Alcoholism and Drug Prevention Programme for the years 1997-2007 is a co-operation partner of the national HIV/AIDS Prevention Programme.

<sup>3</sup> 5 ministries (Ministry of Social Affairs, Ministry of Education, Ministry of Internal Affairs, Ministry of Defense and Ministry of Justice) local governments have agreed to cooperate within the framework of the national programme. Also, the Ministry of Foreign Affairs and Ministry of Culture and three health programmes support the implementation of the HIV/AIDS Prevention Programme 2002-2006 (incl. Research and Development Programme of Targeted Public Health related Activities for the year 1999-2009" etc).

ed to be revised. In order to improve HIV/AIDS prevention in Estonia the authors of the study recommended to allocate an adequate amount of resources for HIV/AIDS prevention programme and the National Drug Prevention Strategy to insure meeting of the goals and objectives defined by the government in the national programme and strategy.

#### • Budget and public expenditure

The level of state spending on drug-related activities is difficult to estimate as data on some areas of activities are not readily available. It is difficult to arrive at an accurate estimate of costs associated specifically with supply and demand reduction, treatment, universal, selective prevention and rehabilitation.

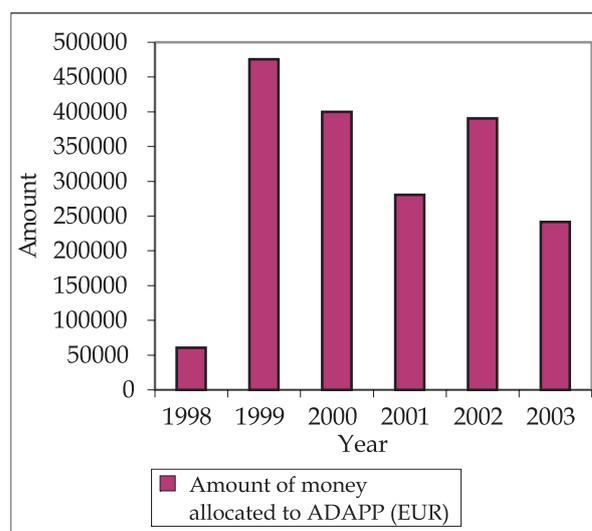
National expenditure estimates are available in relation to the ADAPP broken down by activities in Table 1. In 2003 total of EUR 241,341 was allocated to the ADAPP. In comparison with the year 2002 less resources were spent on drug-related issues. As we can see from Figure 1 financing of the drug prevention was unstable.

**Table 1.** ADAPP funds of the financial year 2003 (EUR) broken down by activities.

Activity	Funds allocated (EUR)
Development of local prevention activities	82,692
Prevention projects at local level	60,897
Training materials	1,090 4,869
Drug prevention in special schools, vocational schools and sanatorium schools.	30,769
Development of support network to fight against alcohol	6,154
Coordination and development of treatment and rehabilitation activities	1,603
Funding of treatment and rehabilitation services	47,890
Organizing a conference on drugs and alcohol	5,377
<b>TOTAL</b>	<b>241,341</b>

Source: *Estonian Alcohol and Drug Abuse Prevention Programme 2004*.

**Figure 1.** Budget for ADAPP (EUR).



Source: *Estonian Alcohol and Drug Abuse Prevention Programme 2004*.

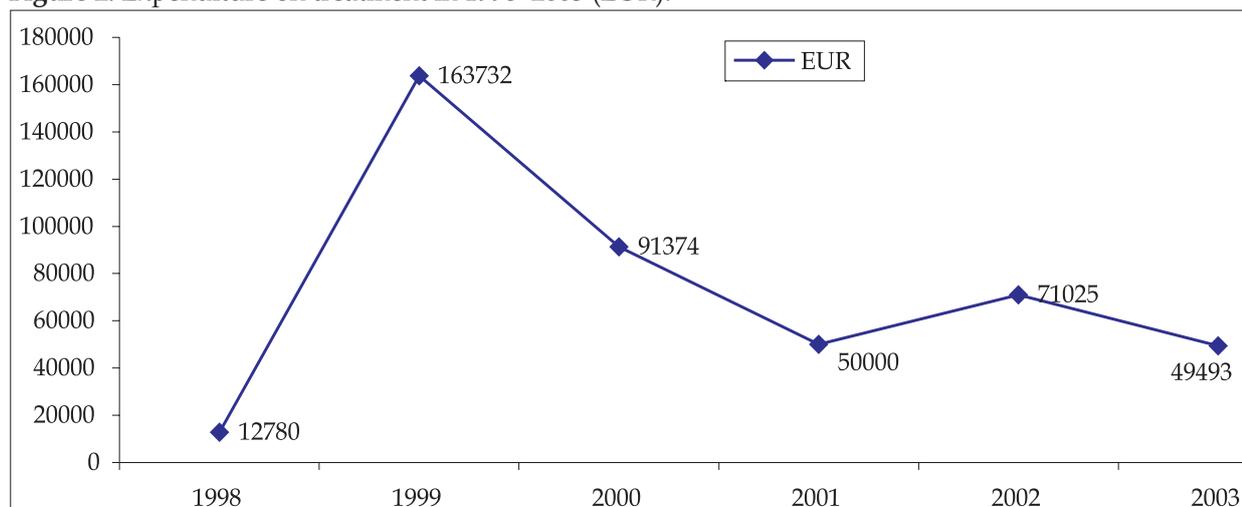
EUR 429,580 was allocated for the prevention projects in the field of drugs and HIV in Tallinn by the Health Care and Social Work Department of Tallinn City Government in 2003. Breakdown of HIV and drug prevention activities by HIV and drug prevention shows that annual expenditure on drug prevention amounted to EUR 363,295.

Estonian Health Insurance Fund financed prevention projects on addictive substances. Two of the financed projects with the expenditure of EUR 12,821 concentrated on the prevention of illegal drug use. Other projects focused on alcohol and tobacco prevention. Also, projects in the field of mental health, sexual education and health promotion included activities regarding drug misuse.

The Government provided the Estonian Police with EUR 45,622 EUR for crime prevention from the budget of national strategy of crime prevention. The activities included drug-related issues (see Chapter 9).

Breakdown of expenditure in the area of treatment for the period 1998 – 2003 has been provided. According to the most recent data available on treatment demand (from the year 2001) the number of persons seeking treatment has rapidly increased over the past few years, whereby the public expenditures for drug treatment allocated from the national drug prevention programme for the same period have decreased over the last few years.

In 1999 the government allocated total of EUR 163,732 for treatment, thus, comparison of the financial year 2003 with the year 1999 shows that funds allocated for drug treatment had decreased 3.3 times in 2003 (see Figure 2).

**Figure 2.** Expenditure on treatment in 1998–2003 (EUR).

Source: *Financial Report on the ADAPP budget 2004*, NIHD.

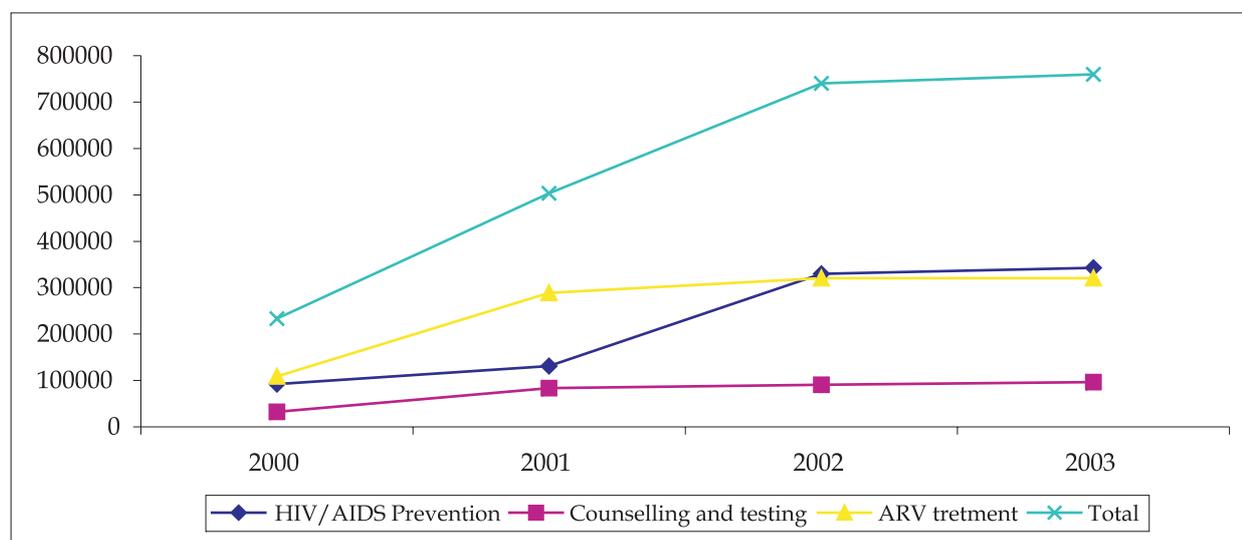
However, the question how much we need for drug treatment remains open as the expenditure estimates are not available for several areas of activity (see Chapter 5). We do not have data on the cost of treatment of drug addicts not covered with health insurance, treatment demand and prevalence of problem drug use etc.

According to the decree No 33-k of 16 January 2002 of the Government of the Republic on the approval of the national health care programme "National HIV/AIDS Prevention Programme for 2002–2006" the Ministry of Social Affairs submits an action plan of the programme for every budgetary year indicating the cost of relevant activities and sources of financing as well as providing an analysis of the results achieved in the previous year (State Gazette 2002, 13, 173). Funding of HIV/AIDS preven-

tion was rather sporadic, whereby funds released by the Government within the framework of the National HIV/AIDS programme were scarce and insufficient for effective prevention work (Kruuda et al. 2003; Report of the WHO/EURO Mission to Estonia, 2002).

According to the National HIV/AIDS Prevention Programme for 2002–2006 the estimated expenditure for the implementation of the programme is EUR 1,035,256.4 (EEK 16,150,000) for the year 2003, in reality 26.6% less financial resources were allocated for carrying out the programme.

However, annual expenditure provided by the Government for meeting the objectives of the national HIV/AIDS programme increased 3.3 times compared to the year 2000 (see Figure 3).

**Figure 3.** Funds allocated for HIV/AIDS prevention on national level.

Source: *National HIV/AIDS Prevention Programme*, NIHD.

According to the study "Evaluation of the HIV/AIDS Prevention in 2003" (Kruuda et al. 2004) HIV/AIDS prevention suffers from insufficient financing meaning that not all activities provided in the National HIV/AIDS Prevention Programme cannot be carried out to the needed extent. According to the recommendations of the authors of the study it would be reasonable to spend the limited resources of the budget on carrying out the activities focusing on the most critical aspects of HIV prevention rather than trying to do everything without setting any priorities. The study demonstrated that setting of priorities had contributed to more efficient implementation of activities and use of resources over the past years. Clearly defined objectives had facilitated decision-making with respect to prevention.

### • Social and cultural context

#### Public attitude to drug issues

Public perception of drug issues was reflected in media. The results of a survey on comparing the representation of drug addiction in media with the perception of drug-related issues of the public received on the basis of statistics, polls and other sources of information showed that representation of drug addiction in media is quite similar to that of the statistics, polls and other sources of information (Laastik 2004 a,b). We may conclude that media representation has become socially more responsible. Media plays the role of a provider of information about these issues quite successfully and keeps the topic of drug addiction on the agenda of the discussions of the general public.

There have been changes in the representation of the issue of drug addiction in media over the past years – currently the issue is being reflected as a matter of concern of the general public not only the problem of a marginal group, thus creating favourable prerequisites for raising the awareness of the public and developing informed attitude of the society of drug issues (Laastik 2004 b).

In 2003 drug-related crime was the most important issue of concern for the general public. Drug-related crime was also tackled from the point of view of the economic sector. Media depicted successful confiscations of large quantities of drugs and discoveries of large drug laboratories. In most cases powerful action of the police in the area of supply reduction was focused on in media (ibid. 2004).

In the reporting period changes in the attitude of the public were evident – the drug-addict was considered to be a person dangerous to the society,

however, the public was mainly focusing on the reasons for drug addiction and the harm caused to the society by the activities of drug dealers. According to the public opinion responsibility for the reasons for drug addiction had to be divided between drug dealers and the society. The drug addict was a looser caught somewhere between drug dealers and the society. The stereotype of a drug addict has not changed in media, however, the awareness of the general public of drug-issues has increased (ibid. 2004).

Representations of drug users in media varied according to the way of use of drugs. In media injecting drug (heroin) addicts were portrayed as particularly dangerous, also, users of synthetic substances in recreational setting were described as drug users. Media tried to break the stereotype of a drug addict as a non-Estonian heroin user from Ida-Viru county.

None of the open discussions or articles on drugs in media described any of the drugs as a safe drug. At the end of 1990-ies discussions about the legalisation of cannabis were held, however, today all narcotic substances are considered harmful and a positive opinion about or attitude to drugs is not being created through media any longer.

Secondly, the issue of drugs in media was very closely related to extensive spread of the HIV infection and AIDS. Today the myth of HIV infection and AIDS being the diseases of only injecting drug addicts is not being created any longer. Instead, the population is well aware of the disease spreading among the general population. The number of articles on raising the awareness of the public has increased. Greater societal awareness of the general population of the dangers and prevalence of drug misuse has resulted in understanding the necessity for the development of harm reduction policy, at the same time, the number of articles expressing opinions about the need for the elaboration of such policy has decreased. According to the media and public opinion it is not possible to get rid of drug addiction, Therefore, the number of articles on contradictory opinions of the public declined in the reporting period (ibid 2004).

#### Debates and initiatives in parliament and civil society

On September 23, 2003 the Riigikogu made a decision on setting up the Riigikogu Problem Committee on HIV, AIDS and drugs on issues of concern to increase the effectiveness of HIV, AIDS and drug addiction prevention activities. The purpose for initiating the development of the draft resolution

was a need for drawing the attention of the state to the issues of HIV/AIDS and drug addiction. In 2003 the the Riigikogu Problem Committee called a meeting of the representatives of different ministries responsible for drug prevention activities to discuss the problems, possibilities and visions of different state agencies in this area of concern.

The Ministry of Social Affairs paid great attention to the organisational structures and principles of prevention work <sup>4</sup>. Also, budgetary issues were discussed at the meeting of the ministries. The ministries decided to unite relevant resources of the budgets of different ministries to contribute more efficiently to the financing of programmes on drug-related issues <sup>5</sup>. The Ministry of Education and Science gave an overview of the relevant work of its agencies, possibilities of the youth work and problems concerning dissemination of information among the institutions working in the field of youth work <sup>6</sup>. According to the minutes of the Riigikogu Problem Committee the biggest concerns of the Ministry of Interior were drug addiction and prostitution, as well as the health of the police and officers of the rescue board with respect to the working environment.

In addition to drug-related issues the issue of Estonia as a country producing synthetic drugs (amphetamine) and a location of extensive dissemination of legal drugs were discussed at the meetings of the ministries <sup>7</sup>.

In the area of administration of the Ministry of Justice the main objective of drug-related activities was to prevent the spread of HIV-infection in prisons and ensure treatment for the infected. In 2003 measures taken to fight against the spread of HIV included anonymous and voluntary testing, counselling, creating a safe working environment for

prison officers and a safe environment for inmates, raising the awareness of prison officers and educational staff through the creation of an efficient monitoring system <sup>8</sup>.

The commission adopted a long-term action plan in January 19, 2004 after the revision of the work and activities of the Ministry of Social Affairs, Ministry of Education and Science, Ministry of Interior, Ministry of Justice in the field of HIV/AIDS. The commission planned to make visits across the country to get an idea of the problems in everyday drug-related work of non-governmental organisations to more efficiently contribute to the solving of drug-related problems <sup>9</sup>.

### Media representations

The number of articles on drug-related issues has increased year by year. More opinion pieces and leading articles have been published whereas cover page news have decreased over the past years. In most cases drug-related issues have been represented in media in the form of news supported by opinion pieces from experts and specialists providing the general public with information on drug misuse.

The drug news was mostly related with drug-related crime, drug trafficking, seizures, disposal of illegal laboratories and fines. In 2002 the topic of fine limits for drug-related offence was actual. In 2003 the maximum limits for fines for drug-related offences were increased in Estonia.

Changes in the priorities of the police were also reflected in media by means of opinion pieces written by experts and specialists. Instead of regular drug addicts the police was focusing on drug dealers and drug trafficking.

In 2003 discussions about the issue of responsibility for drug addiction were covered in media. Drug addicts were depicted as persons with mental and psychological disorders. According to the common understanding it was the drug addict who had to take responsibility for his/her own actions.

<sup>4</sup> Minutes of the meeting No 2 of the Riigikogu Problem Committee set up for enhancing the efficiency of HIV, AIDS and drug addiction - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042610001&login=proov&password=&system=ems&server=ragne1>

<sup>5</sup> Minutes of the meeting No 3 of the commission of issues of concern set up for enhancing the efficiency of HIV, AIDS and drug addiction - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042610002&login=proov&password=&system=ems&server=ragne1>

<sup>6</sup> Minutes of the meeting No 4 of the commission of issues of concern set up for enhancing the efficiency of HIV, AIDS and drug addiction - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042740008&login=proov&password=&system=ems&server=ragne1>

<sup>7</sup> Minutes of the meeting No 5 of the commission of issues of concern set up for enhancing the efficiency of HIV, AIDS and drug addiction - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042610003&login=proov&password=&system=ems&server=ragne1>

<sup>8</sup> Minutes of the meeting No 6 of the commission of issues of concern set up for enhancing the efficiency of HIV, AIDS and drug addiction - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042740010&login=proov&password=&system=ems&server=ragne1>

<sup>9</sup> Minutes of the meeting No 8 of the commission of issues of concern set up for enhancing the efficiency of HIV, AIDS and drug addiction - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042610004&login=proov&password=&system=ems&server=ragne1>

Articles written about ecstasy can be divided into four types: articles about the use of ecstasy in night clubs, ecstasy of cheap price and good availability, production and confiscation of ecstasy, import and export of ecstasy, i.e international drug trafficking.

In terms of opiates heroin was discussed in relation to its expensive price and illicit trafficking. Poppy was considered to be the drug of poor drug addicts because it was cheap and easily accessible. Cocaine was not much talked about, only in the context of foreign pop stars. Cocaine was thought to be a very expensive drug and used only by certain groups. Also, cocaine was associated with drug couriers and illicit trafficking (ibid. 2004).

In the reporting period treatment of drug addicts was one of the issues reviewed in media - various possibilities of drug treatment were introduced. Also, reporting of drug issues in media included opinion pieces about drug dealers with respect to the children` safety around schools and kindergartens.

In media drug addiction was mainly related with the spread of HIV and AIDS in Estonia, thus, the articles about HIV covered drug problems as well. In 2003 media drew the attention of the general public to the fact that HIV was not just a problem of injecting drug users but a sexually transmitted disease. A number of opinion pieces were issued to raise the public awareness of HIV.

## 2. Drug use in the Population

Population survey 2003 and ESPAD survey 2003 indicated a marked increase in illicit drug use compared with previous surveys. The study "Knowledge, attitudes and behaviour related to HIV/AIDS among Estonian youth" (Lõhmus *et al* 2003) showed that illicit drug use had gained more popularity among schoolchildren and young people. According to the study 6.4% of schoolchildren aged 14-15, 13.4% of 16-18 year school students, 17.3% of young people aged 19-24 and 12.7% of 25-29 year olds had used drugs at least once during their lifetime. The share of those who had used drugs repeatedly was considerably higher amongst 16-18 and 19-24 year olds – 17.3% and 18.5%, respectively. Comparison of the results of the population survey 1998 with that of the 2003 showed that the lifetime prevalence of any illicit drug of 18-24 year olds had increased from 9,4% among females and 24,7% among men to 31,2% among females and 57,7% among men. The ESPAD survey revealed similar trend - experiencing with illicit drugs had become a part of the life style for many students. The amount of students having had tried some illegal drug had increased with every consecutive ESPAD study (15% in 1999 and 24% in 2003).

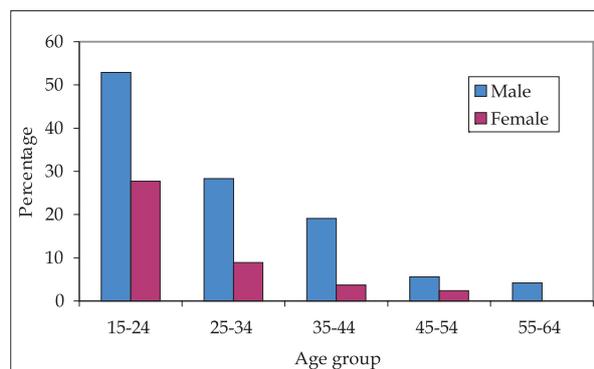
### • Drug use in the general population

In 2003 a questionnaire based on the formats of EMCDDA was included in the population survey as a separate bloc. A set of core items was selected from the "European Model Questionnaire" and integrated into the health section of the population survey. The target group of population survey 2003 was expanded to the age group of 15-69 year olds. The age group 15-17 year olds was added to the questionnaire to have more valuable information from the younger population.

According to the Estonian population survey 2003 lifetime prevalence of illegal drugs amongst 15-64 year olds was 15,4% and 28,4% in the age group of young adults (15-34). The share of younger people of those who had at least once experienced with drugs was considerably higher than lifetime prevalence of older population.

Figure 4 shows lifetime prevalence by age groups and gender in 2003. Figure 4 and Tables 2 and 3 demonstrate significant difference in lifetime prevalence for male and female.

**Figure 4.** Lifetime prevalence of illegal drug use by age groups and gender in 2003.



Source: Population survey 2003., Standard table No 01, 2004.

Comparison of the results of the population survey 2003 with the previous population survey conducted in 1998 indicates increase in lifetime prevalence of the use of illicit drugs. As a result of the revision of the age groups and methodology it is difficult to compare the 2003 population survey to the previous survey based on the EMCDDA standard table. However, the findings of the population survey can be compared on the basis of the IISS data. In 1998 lifetime prevalence of illicit drugs among 18-24 year olds was 9,4% among females and 24,7% among men whereas in 2003 lifetime prevalence was 31,2% for females and 57,7% for males.

The results of "Estonia 1998" showed higher lifetime prevalence for non-Estonians than Estonians whereas the 2003 survey demonstrated no such difference. 20% of non-Estonian men and 20% of Estonian men and 8% of Estonian and non-Estonian women had tried illegal drugs (Hansson 2004).

Also, the difference between cities and rural settlements is disappearing. In Tallinn the share of respondents who had at least once tried illegal drugs was 18% whereas in rural areas the respective share was 12-13% (Hansson 2004).

The share of respondents being offered drugs was the same or a little bigger than the share respondents having been experienced with drugs. The share of respondents in the 18-24 age group having been offered drugs was 55% which is equivalent to the share of 18-24 year olds having been experiencing with drugs (Hansson 2004).

The age of the youngest drug users was similar to that of the previous population survey. More than two thirds had begun with cannabis, followed by amphetamine (12%) and ecstasy (5-6%). Almost half of (49%) the respondents who had ever tried some illegal drugs had done it between the age of 14 and 18 (Hansson 2004).

Data of the Estonian population survey provide us with a possibility to observe the use of different types of illegal substances among the population. Regarding different substances the last 12-months prevalence and 30 days prevalence remained to be the highest with respect to cannabis followed by ecstasy and amphetamines. The last 12 months prevalence of cannabis among 15-64 year olds was 4,6% and 18,2% among the 15-24 year olds. The last 12 months prevalence of ecstasy was 1,7% among 15-64 years olds and 6,1% among 15-24 year olds. In terms of gender the prevalence of last 30 days in case of amphetamines in the age group 25-34 was higher for females. Also the prevalence of last 12 months amphetamine use among 25-34 years old females was higher than among men of the same age. Considerable differences appeared with the use of sedatives and tranquilizers where females had a higher prevalence than men. The only exception was the last 30 days prevalence in the age group of 15-24 (see Table 2).

**Table 2.** Use of illicit drugs among population aged 15-64, %.

DRUGS	Last 12-months prevalence (%)			Last 30 days prevalence (%)		
	15-64			15-64		
	M	F	T	M	F	T
Cannabis	7,5	0,3	4,6	2,4	0,6	1,4
Heroin	0	0	0	0,1	0	0,1
Cocaine (total including crack)	1,2	0,1	0,6	0	0	0
Amphetamines	2,2	0,5	1,3	0,3	0,4	0,3
Ecstasy	2,8	0,7	1,7	0,6	0,2	0,4
LSD	0,7	0	0,3	0	0	0
Sedatives and/or tranquilizers	12,9	26,2	20,4	8,2	15,1	12,1

Source: Population survey 2003 (IISS), EMCDDA standard table 01, 2004.

**Table 3.** Use of illicit drugs among population aged 15-34, %.

DRUGS	Last 12month						Last 30 days prevalence (%)					
	15-24			25-34			15-24			25-34		
	M	F	T	M	F	T	M	F	T	M	F	T
Cannabis	25,5	11,3	18,2	3,1	0,5	1,6	9,3	3,0	6,1	0,8	0	0,3
Heroin	0	0	0	0	0	0	0,6	0	0,3	0	0	0
Cocaine (total, including crack)	3,1	0,6	1,8	1,6	0	0,6	0	0	0	0	0	0
Amphetamines	9,3	1,8	5,5	0	0,5	0,3	1,2	1,1	1,2	0	0,5	0,3
Ecstasy	10,6	1,8	6,1	0,8	1,6	1,3	2,5	0,6	1,5	0	0,5	0,3
LSD	3,1	0	1,5	0	0	0	0	0	0	0	0	0
Sedatives and/or tranquilizers	11,5	16,8	14,2	4,8	19,0	13,3	8,1	7,7	7,9	3,9	9,5	7,3

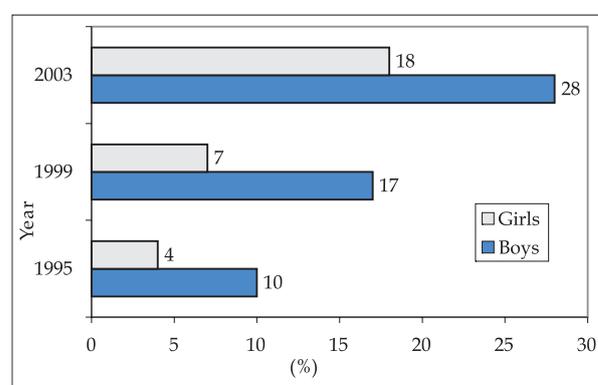
Source: Population survey 2003 (IISS), EMCDDA standard table 01, 2004.

### • Drug use in the school and youth population

According to the ESPAD 2003 survey experimenting with illegal drugs has become a lifestyle for an increasing number of school students. Each survey shows an increased share of school students having experimented with an illegal drug: 7% in 1995, 15% in 1999 and 24% in 2003.

This change has affected cannabis use a great deal – in 2003 the share of school students experimenting with cannabis had grown twice compared to the year 1999, accounting for one fourth of the total number of school students (see Figure 5).

**Figure 5.** Lifetime prevalence for taking cannabis.



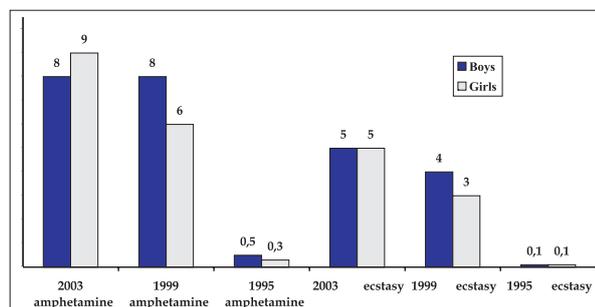
Source: ESPAD surveys 1995-2003.

The number of cannabis users had doubled, also, cannabis was the first drug of lifetime experience for 3/5 of the youth having experienced with drugs.

Cannabis was most often – more often than at the time of the previous survey – purchased at the dealer's place (30% of the school students were provided with information about the purchasing places.)

Half of the school students having experimented with cannabis considered cannabis to be easily accessible. Also, marijuana or hashish was bought from friends or with the help of friends. The share of school students with lifetime prevalence for ecstasy and the share of those having experienced with amphetamine of the total number of school students has grown considerably. Higher level of cannabis use among males than among females can be observed (see Figure 5), however, there were no gender differences in the use of ecstasy (see Figure 6). The use of amphetamine was slightly higher among girls than boys.

**Figure 6.** Share of school students with lifetime prevalence for amphetamine or ecstasy.



Source: ESPAD surveys 1995-2003.

The results of the survey 2003 show that school students experimenting with drugs both legal and illegal were younger than the school students having reported use of drugs in previous studies. One sixth of the schoolchildren having tried an illegal drug, in most cases either cannabis or amphetamine, were twelve or younger.

Regarding drug use in different regions similar tendencies can be observed - drugs are used most of all in Tallinn and Ida-Viru County. Increase in the scope of drug use has resulted in availability of drugs throughout Estonia. Currently illegal drugs, mainly cannabis, are also used in rural areas. Young people are experimenting with illegal drugs mostly in regions which are also known as areas of legal drug use.

Results of the survey show higher levels of drug use among Russian-speaking school students.

10% of the students used cannabis in Russian schools in 1995, 19% in 1999 and 35% in 2003 whereas 3%, 7% and 17% of the school students in Estonian schools, respectively. The proportion of school students experimenting with amphetamine has increased in Russian schools - 9% in 1999 and 14% in 2003, in Estonian schools the share of amphetamine users has decreased to some extent - 5% in 1999 and 4% in 2003.

The location of schools plays a certain role in the described trend - Russian-speaking schools are mainly located in Tallinn and Ida-Viru County where illegal drugs are more widely spread and easily accessible than in other regions in Estonia. Also, Russian-speaking young people have less possibilities for leisure and their economic and social situation is below average.

In 2003 the National Institute for Health Development conducted a study "Knowledge, attitudes and behaviour related to HIV/AIDS among Estonian youth" (Lõhmus et al. 2003). The study involved

the Estonian youth and children aged 10-29 (students of grades 4 to 12 aged 10-8 and young people aged 19-29).<sup>10</sup>

The main goal of the study was to get a better overview of the level of knowledge of the Estonian youth of the issues of HIV and AIDS, the scope of risk behaviour related to the possibilities of getting infected with HIV (including other type of risk behaviour such as licit and illicit drug use), attitudes and stigma related to HIV problems and information sources, sources where information on HIV and AIDS-related issues was obtained or was expected to obtain. When describing prevalence of drug use, we were focusing here only on illicit drug use. The sample consisted of two age groups (schoolchildren aged 16-18 and young people aged 19-24) involving about one third of the young people having used drugs at least once during their lifetime and approximately one fifth of those having used drugs repeatedly. The study demonstrated that the relative importance of the children having had contacts with drugs was low in the younger age group. The study showed that a slightly more than 2% of children aged 10-13 (n=37) had tried some narcotic drugs and most of those having used some illegal drugs had used them once (n=25).

The share of respondents who reported that they had not used any drugs was bigger among children aged 14-15 (86.6%) and among young people aged 25-29 (76.4%) and lower in the age group of 16-18 year olds and 19-24 year old young people - 69.3% and 64.2% respectively. According to the study 5% of schoolchildren aged 14-15 and young people aged 19-24, 10% of schoolchildren aged

<sup>10</sup> Total sample size was 6499 children and young people aged 10-29 (incl 4182 children aged 10-18 and 2433 young people aged 19-29). The sample involved total of 44 schools.

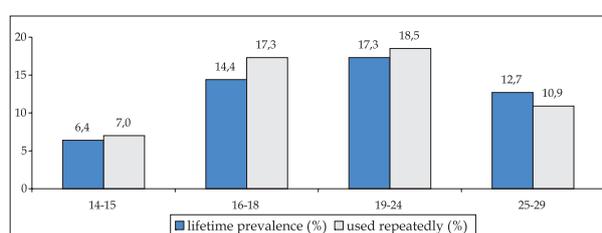
The study tools considered the age of the respondents. The study tools consisted of separate questionnaires for persons aged 10-13, 14-18 and 19-29. Mainly multiple choice questions were used, more detailed questions about sexual life were excluded from the questionnaire of the first age group and questions on family life differed in the questionnaires of the schoolchildren and the ones aged 19-29. Self-administered questionnaires were completed in classroom and questioning of the young people aged 19-29 was carried out via mail.

For the purpose of defining the sample Estonia was divided into 4 districts and schools were divided into 3 groups: Estonian-based city schools, Russian-based city schools and schools in rural areas. The uniform sequence selection was used for selecting schools in 12 established layers. The stratified random sample was separately established of young people aged 19-29 in each county.

The main limitation of the study was that the study instrument did not consist of questions on drug use by substances, because the aim of the study was to get a better overview of the knowledge, attitude and behaviour of schoolchildren and young people aged 10-29 of HIV and AIDS.

16–18 and 2% of the ones aged 25–29 had been offered drugs. The study indicated that 6.4% of schoolchildren aged 14–15, 13.4% of schoolchildren aged 16–18, 17.3% of young people aged 19–24 and 12.7% of 25–29 year olds had used drugs at least once in their lifetime. The share of those who had used drugs repeatedly was considerably higher in the age group of 16–18 and 19–24 old young people – 17.3% and 18.5%, respectively (see Figure 7).

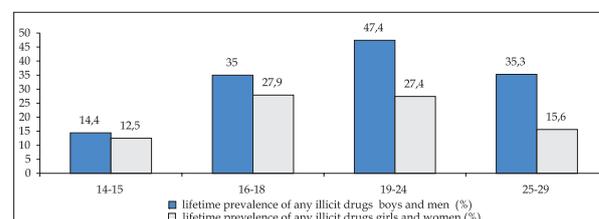
**Figure 7.** Lifetime prevalence and repeated use of illicit drugs among schoolchildren aged 14–18 and young people aged 19–24.



Source: Lõhmus et al, 2003.

Other studies having been conducted in Estonia indicate that generally the share of men using drugs is bigger than the share of women using drugs (ESPAD 1995, 1999, 2003; Population surveys Norbalt 1994, Estonia 1998, Estonia 2003). The same trend was observed in the study conducted by Lõhmus, Trummal and Harro in 2003. According to the study results 47.4% of young men aged 19–24, 35.3% of young men aged 25–29 and 35% of male school students aged 16–18 had tried drugs at least once (see Figure 8). In terms of gender, the study showed no statistically significant difference amongst 14 and 15 year old school students, in 2 older age groups the proportion of young men that had used drugs was 20% higher than that for young women. Also young men had started to use narcotic substances earlier – the average age of boys having started smoking drugs was 14.7 and the average age of girls that had started using drugs was 15.3. The proportion of female respondents reporting to have used drugs at least once was higher amongst female schoolchildren aged 16–18 and young female respondents aged 19–24 – 27.9 and 27.4%, respectively.

**Figure 8.** Breakdown of lifetime prevalence of illicit drugs amongst schoolchildren aged 14–18 and young people aged 19–29 by gender.



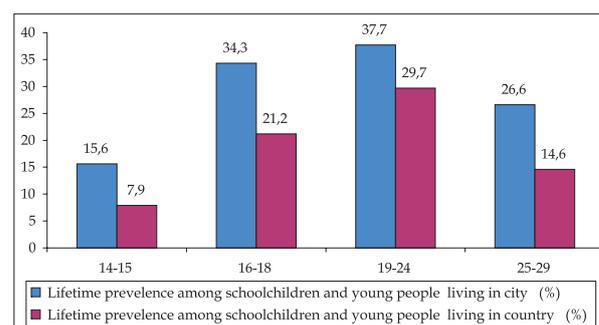
Source: Lõhmus et al, 2003.

Analysis of the data showed that the proportion of non-Estonian schoolchildren and young people having reported lifetime prevalence of drug use was higher than that for Estonians. No statistically significant difference was observed amongst 14–15 year olds. The proportion of non-Estonians having reported lifetime prevalence of drug use in other age groups was one tenth higher than that for Estonians. The number of non-Estonians having repeatedly tried drugs was also bigger compared to Estonians.

A study conducted by Lõhmus, Trummal and Harro in 2003 showed that the prevalence of illicit drug use among young people living in urban areas was much higher comparing to those living in the country (see Figure 9).

As it was named earlier the study was conducted with the aim of giving a better overview of the knowledge of HIV and AIDS, attitudes and risk behaviour of Estonian youth aged 10–29. Because of methodological limitations – respondents were not asked to report illicit drug use and patterns of drug use by type of substance – we can only conclude that smoking is the most common way of using drugs among young people, especially among 14–18 year olds. Difference in the method of drug use could be observed in age groups 19–24 and 25–29 – 48% of young adults aged 19–24 and 35% of 25–29 year olds smoked drugs.

**Figure 9.** Breakdown of lifetime prevalence of illicit drugs among schoolchildren aged 14–18 and young people aged 19–20 by type of residence (%).



Source: Lõhmus et al, 2003.

As to the differences in gender for using drugs it was observed that the share of young women that had used drugs in the form of tablets was higher than that for young men (36% and 25% respectively). As to nationalities some differences occurred in the method of using drugs – the use of drugs by way of smoking was more common among non-Estonians than Estonians in all age groups, however, the difference was insignificant among 16–18 year olds.

The main difference in the method of drug use can be observed in age groups 25–29 – 54% of non-Estonians compared to 28% of Estonians had tried or used drugs by way of smoking.

As it was mentioned earlier, we need to take into account methodological limitations of the study instruments when interpreting the results of the study regarding the patterns of use – respondents were not asked to report on patterns of drug use by type of substance. The study indicated that 5% of the sample had injected drugs, however, data on injected drugs by substance were not available.

There was some information on non-Estonian IDUs in Ida-Viru County using amphetamine by means of injecting (Magerova, personal correspondence 2004). Such information emphasizes that there is a need for including questions on drug use and patterns of use by type of substances in the study tools.

- **Drug use among specific groups**

No new information available

- **Attitudes to drugs and drug users**

Based on the population survey 2003 which included questions on attitudes to drug addicts we can say that in general a drug addict was considered to be a person with a medical condition (42%) rather than a criminal or both of them (36%). Only 7% of the respondents considered a drug addict to be a

criminal and 12% did not have an opinion of their own. According to age groups certain differences in opinion can be observed – older people thought drug addicts to be criminals rather than persons with a medical condition.

In terms of risk more than half of the respondents in age group 18–64 considered use of marijuana and ecstasy a big risk, two thirds of the respondents believed that trying cocaine was a big risk and three quarters of the respondents thought experiencing with heroin was a considerable risk. Major part of the population considered use of illicit drugs to be a big risk. Comparison of the results of the survey 2003 with the data of the population survey 1998 revealed that in 2003 less people considered the use of cannabis a big risk than in the previous survey.

The attitude towards other illegal substances has become more critical and compared to the previous survey the proportion of the population considering experiencing with heavy illegal drugs to be a significant risk to the health of people has considerably increased (Hansson 2004).

According to the survey on drug use in the schools of Tallinn carried out in 2003 nearly a quarter (23%) of the school population considered drug users normal people who used drugs for the fun of it (Kruusvall *et al* 2004). 39% of the school population considered drug users as sick people who had acquired addiction to drugs. The same amount of the school population (39%) found that drug users were dangerous to other citizens – they were likely to bother or attack other people, steal from them or rob them. Positive attitude was related to the actual consumption of drugs. 30% of the schoolchildren considering the use of drugs as a means of recreation were actual drug users, which was twice as much as the average proportion of drug users of the total amount of schoolchildren. Only 11–12% of schoolchildren with negative attitude to drug use had tried drugs (Kruusvall *et al* 2004).

### 3. Prevention

No significant changes have occurred in the prevention system during the reporting period. Prevention work was still mainly based on project work carried out within the framework of and according to the guidelines of Alcoholism and Drug Abuse Prevention Programme 1997-2007. In April 2004 the Estonian Government adopted National Strategy on Prevention of Drug Dependency 2004-2012 providing drug prevention according to the definition of J.van der Stel. According to the definition drug prevention is divided into three categories. Primary prevention is defined as intervention before the health damage where the emphasis is laid on removing the cause for initiating drug use. Secondary prevention is intervention in case of a developing health problem but not yet a clinical intervention. The aim of the third prevention is to avoid a new case by restricting clinically diagnosed or obvious behavioural disorders as soon as possible (J.van der Stel 2001).

Division into universal and selective prevention has been made by the EDMC on the basis of the EMCDDA definitions.

#### • Universal prevention

Since the year 2002 prevention work has been carried out as a part of school curriculum (see Chapter 9.1 of the National Report on Drug Situation in Estonia 2002). At the moment (2004) there are 3 study books on social skills available covering the first, second and third level. Total of 1600 teachers (see Table 4) have been trained to use the social skills study book ( Kull, personal correspondence 2004). The UNDCP, Estonian Health Insurance Fund, Ministry of Education and Science and NIHD finance trainings and provision with study books.

**Table 4.** Number of teachers trained according to the UNDCP study book on social skills.

I level teachers	600
II level teachers	550
III level teachers	150 (ongoing process)
Teachers of Russian schools	150
Open university	200
TOTAL	1600

Source: Merike Kull, 2004.

Trainings on the use of social skills study book by teachers in their everyday practice have been initiated and hopefully data on the results of the trainings will be available in the next reporting period. According to the reports on the use of the system the results of the first level study were good - teach-

ers had used the study book as well as the knowledge in their work.

Alcoholism and Drug Abuse Prevention Programme 1997-2007 has allocated funds for the implementation of the prevention projects at local level and financed drug prevention councils in every county. In 2003 the ADAPP financed 49 prevention projects with the total amount of **EUR 60,897** and allocated **EUR 82,692** for the work of local drug prevention councils. Prevention projects included several activities of which alternative activities, group work and lectures were most common (see Table 5). Resources for carrying out prevention work were mostly applied for by local governments and NGOs.

**Table 5.** Activities financed by the ADAPP in 2003.

Activity	Number of projects
Alternative activities (sports events, adventure games, camps, excursions, trips)	37
Group work, lectures (development of social skills)	26
Health campaign, health day	8
Activities for parents	7
Training of tutors, teachers	7
Round table discussions	6
Training of support students and teachers	5
Information materials, study materials	5
Counselling, therapy	4
Questionnaires, studies and situation analyses	3
Foundation of youth centre	2

\* Several activities were included in one project.

Source: National Institute for Health Development, 2004.

**Table 6.** Institutions having carried prevention projects.

Applicant	Number
Local government	16
NGO	14
Social Centre, Children Centre, Hobby Centre	6
Primary school, secondary school	6
City government	2
Hospital	1
Police	1
Foundation	1
Union of Children Protection	1
Church	1
Total	49

Source: National Institute for Health Development, 2004.

Prevention projects in the field of drugs and HIV in Tallinn (see Chapter 1 on budget and public expenditure) included activities targeted at children of risk groups, group work, alternative activities,

counselling, work of the youth centre, establishment of support network, risk behaviour, security study in schools of Tallinn, a documentary film about the risks facing minors, trainings for tutors and teachers on drug prevention, radio show concerning drug-related issues "Islands in the Ocean", drug conference and exhibition "Afflictive freedom".

The Estonian Health Insurance Fund financed two prevention projects (see the Chapter 1 on budget and expenditures) on illicit drugs: co-financing of a project on social skills training at schools (see the beginning of the Chapter) and a project on the establishment of a network of professionals and decision-makers to carry out regular activities for teenagers and their parents. The second part of the latter project was focusing on training of specialists and trainers providing health and subsistence-related services for children. Other projects financed by the Estonian Health Insurance Fund related to drug prevention included activities on mental health, sexual education, counselling and health promotion in local municipalities. Projects financed by the Estonian Health Insurance Fund were evaluated according to the method of random sample.

An initiative of Tallinn Rugby Club Youth Team promoting mental, moral and physical development of its members and focusing on core values like honesty, loyalty and commitment is also worth mentioning. The aim of the activities was promotion of a healthy lifestyle and drug free community ([www.rugby.ee](http://www.rugby.ee)).

### • **Selective prevention**

Principles of the National Strategy on the Prevention on Drug Dependency (NSPDD) 2004-2012 include activities focusing on children of risk groups: street children, children of poor families, children of families with drug and alcohol addiction problems. In 2004 ADAPP financed 8 projects related to children of most vulnerable groups and their parents.

Also, the Health Care and Social Work Department of Tallinn City Government and the Estonian Health Insurance Fund financed projects targeted at children of risk groups.

Selective prevention was mostly carried out in three special schools in Estonia. The ADDAPP allocated **EUR 30,769** for the prevention work in special schools and trainings of teachers. The main activities in those three schools included delivery of know-how and enhancement of drug prevention skills of students and parents and provision of possibilities for alternative activities. The goal was to create conditions and motivation for drug-free life and develop the personality of young people. Counselling, organization of treatment and rehabilitation were also carried out within the framework of the project. Provision of the pedagogical personnel with theoretical knowledge and practical skills in the area social affairs was also included in the projects carried out in special school.

#### 4. Problem drug use

Currently new information is not available. At the beginning of 2005 a prevalence study on HIV infection among IDUs will be carried out which enables us to make conclusions about the number of IDUs in Estonia and the prevalence of HIV among intravenous drug users. The study involves 350 IDUs from three most problematic cities in terms of drug use in Estonia (Tallinn, Kohtla-Järve, Narva). The sample is formed according to the snowball method and the interview is used as the tool for data collection. The questionnaire has been compiled

by the University of London, Imperial Collage of Science, Technology and Medicine and covers questions on demographical data, drug use, injection, needle exchange, contacts with police, prison, sexual behaviour, sex work, HIV testing and drug treatment. Every respondent is obligated to give a blood test to find out the possible HIV infection. The study is financed by the Global Fund and carried out in co-operation with the Imperial Collage of Science, Tecnology and Medicine.

## 5. Drug-related treatment

New national drug strategy "National Strategy on the Prevention of Drug Dependency 2004–2012" identifies treatment as one of the six main key areas until the year 2012 and is targeted at the development of contemporary, professional and efficient treatment for drug-addicted children and adults as well as improvement of the quality of treatment and expansion of drug treatment services across Estonia. According to the new Drug Strategy on the Prevention of Drug Dependency the main goal of the treatment is to achieve stable and long-term remission and develop preconditions for complete social reintegration (NSPDD 2004).

The strategy document defines treatment of drug addiction as a coordinated network of services with different treatment objectives aimed at various target groups. Treatment includes 4 stages: establishment of the first contact with the treatment centre, withdrawal, substitution treatment, rehabilitation and aftercare.

The main targets of drug treatment for the year 2008 established by the national drug policy document include, among others, improved availability of drug treatment. New specialized treatment centres and other institutions providing detoxification services in problematic regions will be established aiming at offering support to persons in the treatment and rehabilitation process, expanding the programmes of substitution treatment and increasing the quality of drug treatment services through the training of practising medical staff.

Drug addiction treatment is not the first national priority, however, support from the GFFATM Programme managed and supervised by the NIHD and Tallinn City Government has improved the availability of substitution treatment with methadone and drug addicts living in Tallinn have been provided with substitution treatment since 2003. The number of persons in methadone treatment is continuously increasing. In the same year Estonia introduced the use of buprenorphine as an alternative form of opiate-maintenance and substitution treatment (see Part B - Selected Issues on Buprenorphine, treatment, misuse and prescription practises).

Establishment of epidemiological data collection system for obtaining data on treatment demand has been recognised as one of the priority areas. The new National Strategy defines establishment of a nationwide Drug Treatment Registry to provide policy and decision-makers with high quality data on the number and characteristics of people seeking treatment for their drug problems. Most

likely the Government will approve the NDPSA in the second half of 2004. According to the draft "Development Plan of the Health Registries" the Treatment Demand Registry will be established at the beginning of the year 2005 (Ministry of Social Affairs 2004).

It is difficult to draw any conclusions on drug treatment in Estonia because of lack of data, especially data on treatment demand. This chapter gives an overview of the current situation in the field of drug treatment presenting data gathered from different sources.

### • Treatment system

With respect to drug treatment currently only a limited number of psychiatric hospitals having obtained a psychiatric activity license provide treatment services for drug addicts.<sup>12</sup>

However, the situation is likely to improve in the coming years. According to the "National Strategy on the Prevention of Drug Dependency 2004–2012" community-based specialized treatment centres will be set up as institutions providing more efficient drug treatment services. The new Drug Strategy foresees the establishment of 3 specialised treatment centres in Harju and Ida-Viru County and South-Estonia to provide adult drug addicts with specialized treatment and rehabilitation services. Centres for the provision of children with detoxification and rehabilitation services will be set up (NSPDD 2004).

Data gathered from the Health Insurance Fund in 2004 about persons receiving treatment for their mental and behavioural disorders caused by the use of illegal drugs sheds some light on the use of drug treatment services and the cost of treatment of insured drug addicts. Data provided by the Health Insurance Fund showed clearly that family doctors played a minor role in the treatment of drug addicts in the period of 2000–2004 as the vast majority of persons receiving treatment for their mental and behavioural disorders caused by the use of illegal drugs were recorded by psychiatrists.

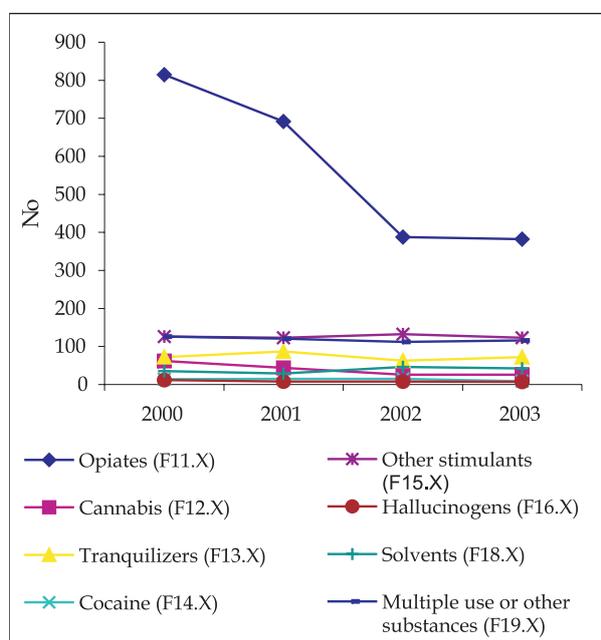
Data gathered from the Health Insurance Fund indicated that the number of persons receiving drug treatment for MBD caused by the use of heroine decreased in 2003. The number of persons admitted to treatment for MBD in 2003 fell considerably, almost 2,21 times when compared to the

<sup>12</sup> There are total of 13 specialized psychiatric hospitals having been granted an activity license to provide drug treatment services for drug addicts.

year 2002 (see Figure 10). It is difficult to explain such tendency because of insufficient data. Data was not available on the number and characteristics of those drug addicts who were not covered by medical insurance. Access of this group of drug addicts to the treatment was restricted. Significant decrease in the number of drug addicts receiving drug treatment can be explained by the fact that a vast majority of problematic drug users (eg heroine users) are unemployed and therefore, they are not covered by medical insurance. The same reason for unavailability of data on treatment demand was given in the previous report (see National Report on Drug Situation in 2002).

On the other hand, decline in the number of drug addicts admitted to treatment can be related to overall limited access to drug treatment, lack of rehabilitation system etc. However, comprehensive conclusions cannot be made because of the above named reasons. The number of drug addicts using other type of stimulants has remained quite stable falling from 126 in 2000 to 123 in 2001, rising to 132 in 2002 and falling again to 123 in 2003.

**Figure 10.** Number of persons covered by health insurance receiving treatment due to their mental and behavioural disorders caused by the use of illegal drugs 2000–2003.



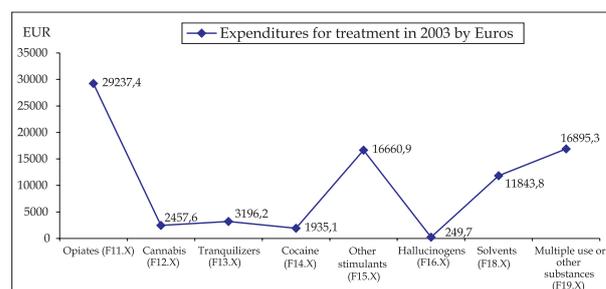
Source: Health Insurance Fund, 2004.

Figure 11 on the cost of drug treatment of the people covered by health insurance in 2003 indicates that the cost of treatment of those drug addicts admitted to drug treatment for their mental and behavioural problems caused by the use of heroine, other stimulants and multiple use of other sub-

stances is the highest. It is not surprising as most drug addicts seeking treatment for drug addiction belong to one of the above-mentioned 3 groups of drug users (see Figure 10 and Figure 11).

Data on the cost of drug treatment of heroine addicts covered by health insurance provided by the HIF in the period of 2000–2003 shows a clear falling trend.

**Figure 11.** Breakdown of the cost of treatment of persons covered by health insurance by type of mental and behavioural disorders caused by the use of illegal drugs in 2003 by EUR.



Source: Health Insurance Fund, 2004.

On the other hand the number of drug addicts with health insurance admitted to drug treatment due to MBD caused by the use of heroine has fallen 2.13 times in 2003 when compared to the year 2000. Data provided by the HIF demonstrate that the number of invoices submitted to the HIF for covering the costs of treatment of heroine addicts with medical insurance indicates that the number of invoices has fallen significantly during the period of 2000–2003 (see Figure 12).

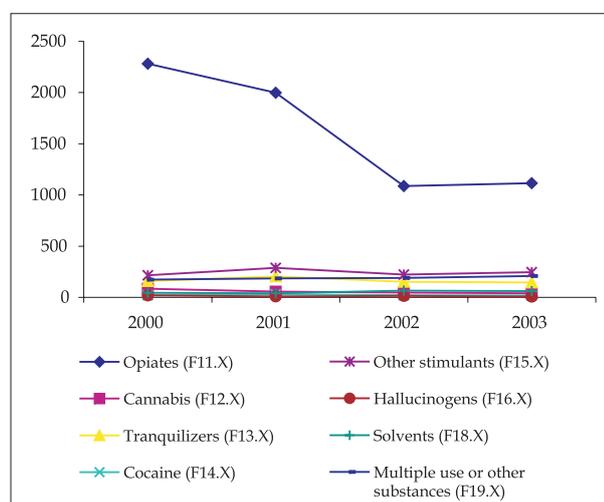
The cost of treatment of drug users admitted to treatment for MBS caused by the use of other stimulants rose considerably. At the same time, the number of drug addicts admitted to treatment in the observed period remained almost stable falling slightly from 126 in 2000 to 123 in 2001 and rising to 132 in 2002 and falling again to 123 in 2003 (see Figure 10).

On the whole, limited data enables us to make assumptions rather than draw reliable conclusions.

The number of treatment institutions providing treatment for drug addicts has increased to some extent, however the current treatment system is not capable of meeting the increasing demand for treatment for various reasons. Among other reasons the main problem is unavailability of resources necessary for the financing of drug treatment. According to the conclusions of the WHO mission report and PRAXIS evaluation report current funding is unstable, short-time, inadequate and sporadic and funds allocated to individual projects are very

small, which means that treatment programmes are financially unsustainable (see Chapter 1).

**Figure 12.** Breakdown of drug treatment invoices by type of mental and behavioural disorders caused by the use of illegal drugs 2000-2003 by EUR.



Source: Health Insurance Fund, 2004.

In 2003 Tallinn City Government approved the Action Plan 2003–2007 for the Prevention of Drugs and HIV/AIDS in Tallinn and initiated provision of support to drug treatment in Tallinn in March 2003. Action Plan 2003–2007 for the Prevention of Drugs and HIV/AIDS in Tallinn includes budget estimation for the implementation of the action plan. The budget estimation of the action plan provides funding for drug addiction treatment in the amount of EUR 230,769.2 (EEK 3.6 million) and EUR 173,976.9 (EEK 2.7 million) for rehabilitation. Tallinn City Government allocated four times more resources for the prevention of drug addiction and HIV/AIDS in Tallinn than the government for the same activities on the national level in 2003.

NIHD allocated EUR 49,834.8 to support the implementation of seven treatment and rehabilitation projects within the framework of the ADAPP in 2003 whereas Tallinn City Government provided funding for 4 treatment and rehabilitation projects in the amount of EUR 265,384.6 in the same year (see Tables 7 and 8).

It is clear that approval of the Drugs and HIV/AIDS Prevention Action Plan 2003–2007 will have a great impact on the provision of treatment services for drug addicts in terms of availability. Tallinn City Government supported the drug treatment unit of children with drug addiction of the Tallinn Children's Hospital with amount of EUR 102,564.1 (EEK 1,600,000) to provide withdrawal treatment for 90–100 children and adolescents living in Tallinn and allocated total of EUR 21,794.8

(EEK 340,000) to support the Children's Hospital in the implementation of a pilot project on buprenorphine treatment of children and adolescents and their social rehabilitation (see Chapter 11 of part B).

As a result of negative public opinion of drug addicts resistance of some local communities to set up a specialized drug treatment centre in their area has been met. Tartu City Government has made a decision on not supporting the establishment of a treatment and rehabilitation centre in Tartu. In the second half of 2003 the Ministry of Social Affairs made a decision to use the funds projected on setting up a rehabilitation centre in Tartu for the establishment of a rehabilitation centre in Sillamäe (Ida-Viru County).

### • Drug-free treatment

As in many other countries in Europe, drug free treatment services are abstinence based and have relapse prevention as their main goal. However, it is complicated to achieve this goal because of various reasons eg limited access to rehabilitation services. Patients having successfully completed drug-free or other forms of drug treatment and being motivated to return to a drug-free lifestyle have extremely limited possibilities to accomplish relapse prevention. The absence of reliable management information is a barrier for the provision of a comprehensive picture on inpatient and outpatient drug-free treatment in Estonia. Several approaches have been used in drug-free treatment such as cognitive behavioural, 12-step addiction counselling, family therapy and other methods. However, without appropriate rehabilitation programmes and providing a safe living environment supported by staff and peers it is complicated or even impossible to help drug addicts having lost contacts with their family and friends and having no income to avoid relapses and maintain their drug-free status. According to the new National Strategy on the Prevention of Drug Dependence 2004-2012, Estonia will establish a twenty-four-hour rehabilitation institution to support drug addicts to maintain drug-free status and integrate into the society. Considerable investments are needed for the implementation of this project (NSPDD 2004).

### • Medically-assisted treatment

Medically-assisted treatment has not been provided for a long time in Estonia. Withdrawal treatment is available as inpatient treatment in psychiatric units of general hospitals or provided by the psy-

chiatric hospitals, specialized treatment centres or non-governmental organizations. Various methods and schemes used in withdrawal treatment will be elaborated later in this chapter. The first methadone detoxification treatment programme was launched in 1998 in inpatient treatment centres. Adult opiate addicts have been provided with health care services in the form of rapid detoxification in Estonia since 2001 (see previous National Reports). The absence of reliable data prevents us from giving a comprehensive overview of medically-assisted treatment in Estonia. Access to medically-assisted in- and outpatient drug treatment is currently limited, particularly for those drug addicts not covered by health insurance.

Reasons for limited access to rehabilitation services are various: insufficient number of units providing medically-assisted treatment and under-financing of these institutions (see Tables 7 and 8).

Experts on treatment having contributed to the compiling of previous National Reports on Drug situation and NSPDD have indicated that the number of drug treatment units, availability and quality of treatment often do not correspond to the actual needs of drug addicts. As we have already stated in the overview of drug-free treatment, it would be much easier to maintain the drug-free status of a client if the client having successfully completed drug treatment and being motivated to stay drug-free can be provided with access to a rehabilitation programme.

The first substitution treatment programme with methadone was launched in West Tallinn Central Hospital in 2003 and currently this hospital is the only specialized treatment institution providing clients with methadone substitution programmes (see National Report 2003).

However, substitution treatment is not widely available in Estonia. Reasons for the limited availability of substitution programmes are various (eg resistance to this particular form of treatment, lack of financial resources etc). However, the New

Drug Strategy for Prevention of Drug Dependency recognises substitution treatment as an acceptable form of treatment and provides development and implementation of substitution treatment programmes in Estonia.

In 2003 Estonia continued to provide opiate addicts with a small-scale methadone substitution programme in the Substitution and Detoxification treatment unit of the West Tallinn Central Hospital Psychiatric Centre. On the basis of Tallinn Children's Hospital a pilot project on substitution treatment using buprenorphine for the substitution of opiates was carried out (see Chapter 12 on buprenorphine treatment, misuse and prescription practices). Both above-mentioned substitution treatment projects were funded by Tallinn Social Welfare and Health Care Department (TSWHCD).

Breakdown of expenditures in the area of drug treatment in 2003 shows that Tallinn City Government allocated notably bigger funds for drug treatment than the government. In 2003 TSWHCD allocated total of EUR 265,384 within the framework of the *Action Plan 2003–2007 for the Prevention of Spread of Drugs and HIV/AIDS in Tallinn* for the financing of treatment of drug addicts which was 5,3 times more than the financial resources allocated for treatment within the framework of the National Alcohol and Drug Prevention Program in the same year<sup>13</sup> (see tables 7 and 8). In 2003 TSWHCD allocated EUR 21,794.9 on the first project on substitution treatment using buprenorphine for the substitution of opiates in Estonia carried out on the basis of Tallinn Children's Hospital and allocated EUR 128, 205.1 for methadone substitution and detoxification project carried out on the basis of the Opiate Addicts' Substitution and Detoxification Treatment Unit of West Tallinn Central Hospital Psychiatric Centre.

---

<sup>13</sup> Includes projects granted resources from the project fund in the amount of EUR 137,179.5.

**Table 7.** Breakdown of expenditures of the ADAPP in the area of treatment in 2003, EUR.

No of project	Name of the project	Financer	EUR
1.	Methadone treatment of clients with opiate addiction in Narva city	NIHD from ADAPP budget	EUR 11,661.7
2.	Development of rehabilitation centre at Loksa	NIHD from ADAPP budget	EUR 6,025.6
3.	Drafting of the basic document for the regulation of treatment and rehabilitation	NIHD from ADAPP budget	EUR 1,303.8
4.	Analysis of the activities of current treatment and rehabilitation centres	NIHD from ADAPP budget	EUR 641
5.	Support to outpatient treatment unit in Jõhvi Hospital in Ida- Viru County	NIHD from ADAPP budget	EUR 6,282
6.	Provision of rehabilitation services for opiate dependent clients by NGO "You will not be left alone"	NIHD from ADAPP budget	EUR 6,025.6
7.	Provision of rehabilitation services for opiate dependent clients in Lääne - Viru County, Vihmari Rehabilitation Centre	NIHD from ADAPP budget	EUR 5,471.6
8.	Methadone treatment for opiate dependent clients in Jõhvi, Ida - Viru County	NIHD from ADAPP budget	EUR 6,308.6
9.	Development of drug testing	NIHD from ADAPP budget	EUR 6,114.9
<b>TOTAL</b>	<b>All treatment projects</b>	<b>NIHD from ADAPP budget</b>	<b>EUR 49,834.8</b>

Source: National Institute for Health Development, 2004.

**Table 8.** Breakdown of expenditures of the ADAPP in the area of treatment in 2003, EUR.

No of project	Name of the project	Financer	EUR
1.	Support to treatment unit of children with drug addiction of Tallinn Children's Hospital	Tallinn City Government	EUR 102,564.1
2.	Social rehabilitation of young drug addicts and provision of substitution treatment with buprenorphine to improve the state of health of drug addicts	Tallinn City Government	EUR 21,794.9
3.	Provision of IDUs with withdrawal treatment in West Tallinn Central Hospital	Tallinn City Government	EUR 12,820.5
4.	Opiate addicts` substitution and detoxification treatment unit of West Tallinn Central Hospital Psychiatric Centre	Tallinn City Government	EUR 128,205,1
<b>TOTAL</b>	<b>All treatment projects</b>	<b>Tallinn City Government</b>	<b>EUR 265,384.6</b>

Source: Tallinn Social Welfare and Health Care Department, 2004.

### Substitution treatment

According to the new Drug Strategy opiate addicts unable to abstain from drug use upon the completion of detoxification are provided with access to pharmaceutical treatment with substitute opiates with the purpose of gaining stable mental and physical health (NSPDD 2004).

Criteria for admission to substitution treatment are the following: aged over 18 years, over 5-year history of opiate use, several unsuccessful treatment episodes, HIV and other somatic illnesses, ability to comply with the treatment programme.

Criminal background is also considered to be one of the criteria for admission to substitution treatment programme. In 2003 West Tallinn Central Hospital provided substitution treatment for 60 clients on project basis in two locations. According to the data of West Tallinn Central Hospital 76% of the total of 55 clients enrolled for the programme were under 29 years of age, 20% of the clients participating in the substitution treatment programme were female, 58% were PLWHAs and 67% had hepatitis B or C. The majority of clients had given up taking illegal drugs prior to the participation in the treat-

ment programme (Lehtmets 2004). Preliminary assessment of the treatment outcome showed that substitution treatment programme had a positive impact in terms of social reintegration – social and family relations of persons participating in the treatment programme improved. The current situation is that of these 55 clients participating in the substitution treatment 18 have entered successfully into the labour market, 7 are actively looking for work and 1 is studying. 34% of the clients dropped out of the programme for various reasons such as non-compliance with treatment programme, termination of treatment contract, imprisonment and transfer of clients to another treatment programme (Lehtmets 2004).

Imprisonment of persons successfully participating in the substitution treatment programme has raised two important questions for policy-makers to be discussed: need for alternatives to imprisonment of drug users and need for the introduction of treatment programmes in prison.

## 6. Health Correlates and Consequences

The quality of data in the area of health correlates and consequences has to be improved. One of the reasons for the lack of data is the introduction of new provisions in Estonian legal acts prohibiting collection of personal data. Another reason is that the new data collection system has not been established yet to enable data to be collected as required. In 2003 it was not possible to provide data on drug-related deaths and mortality of drug users any longer. The number of newly diagnosed cases of HIV infections recorded according to the current data collection system in 2003 shows a slight falling trend. The fact is that HIV infection is not only the problem of IDUs, it also spreads sexually in Estonia. This trend makes the monitoring of HIV infection more difficult. Also, a decreasing trend was observed in case of hepatitis B and hepatitis C in 2003.

### • Drug-related deaths and mortality of drug users

The Statistical Office of Estonia responsible for keeping the mortality register collects information on causes of deaths (eg causes of drug-related deaths) in Estonia and provides annual statistics on drug-related deaths<sup>14 15</sup>.

As we stated in our previous national report on drug situation in Estonia there was a remarkable increase in the number of drug-related deaths reported in the period of 1997–2002 (see National Report 2003). In terms of gender males contributed to the majority of drug-related deaths, in terms of age 20-24 year olds accounted for less than half of all drug-related cases. Unfortunately, new data on drug-related deaths were not available in the reporting period.

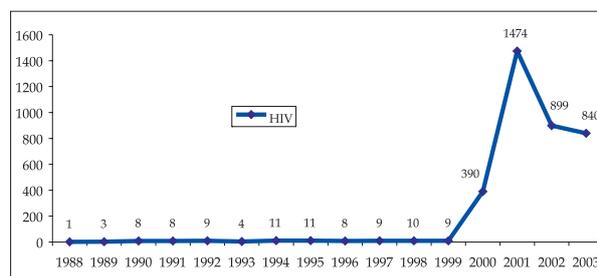
Recently changes were introduced in the system of collection of statistical data. New Personal Data Protection Act entered into force 1 October 2003 prohibiting the Statistical Office of Estonia to process personal data. Collection of information on medical death certificates as well as any other information concerning personal data is strictly

regulated<sup>16</sup>. In May 2004 the Riigikogu passed the Official Statistics Act Amending Act to enable the Statistical Office of Estonia to collect private personal data. However, details of the technical aspects of data protection measures to be taken by the Statistical Office of Estonia.

### • Drug-related infectious diseases

Health Protection Inspectorate is responsible for the provision of the Estonian National Focal Point with surveillance data on HIV/AIDS. According to the data the number of newly diagnosed HIV infections shows a slight falling trend<sup>17</sup>. The number of newly registered HIV infections decreased from 1474 in 2001 to 899 in 2002 (see also Chapter 3.3 of the National Report, 2003). In 2003 the number of newly registered HIV infections continued to decrease – 840 new HIV infections were diagnosed out of 119,296 persons screened for the infection (66,016 males and 53,280 females), which is 59 cases less than previous year (see Figure 13).

**Figure 13.** Number of newly registered HIV infections in 1998–2003.



Source: Health Protection Inspectorate, 2004.

As at December 31, 2003, total of 3699 HIV positives lived in Estonia, 3621 of which had Estonia as a permanent place of residence.

In terms of different regions, the number of newly diagnosed cases of HIV was the highest in Ida-Viru County and Tallinn, but the relative importance of Ida-Viru County shows a falling trend (see Figure 14). According to the data provided by the Health Protection Inspectorate, the relative importance of other regions is low compared to Tallinn and Ida-Virumaa, however, the proportion of other re-

<sup>14</sup> Information is coded and entered into the electronic database. Currently four-digit ICD codes are used to store the medical information; a separate position is reserved for injury codes.

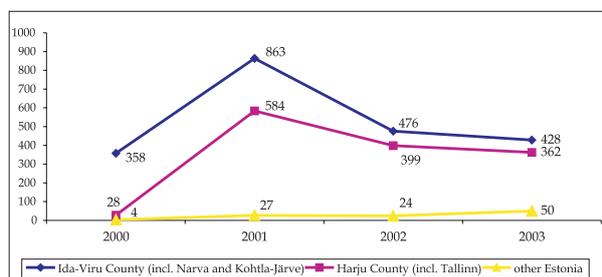
<sup>15</sup> According to an expert opinion the most difficult problem related to the quality of DRD data was lack of funds for forensic investigation, as a result, the proportion of cases with unknown toxicology was high. In 2002 the number of drug-related cases with known toxicology fell considerably when comparing to the previous year.

<sup>16</sup> The main agencies conducting official statistical surveys may process personal data only for purposes and under conditions specified in the Personal Data Protection Act.

<sup>17</sup> Persons screened for the infection: drug users, people with venereal diseases, pregnancy terminated with abortion, person having had sex with a HIV seropositive person, donors of blood and organs, pregnant women, conscripts, detainees, persons screened because of clinical indication, anonymously tested persons, health care workers, people screened for prophylactical reasons.

gions of all cases of HIV infection registered across Estonia has grown. In 2000 only 1% of HIV infections were registered in other regions of Estonia whereas in 2003 the respective rate increased up to 6%. In Ida-Virumaa the proportion of newly diagnosed HIV infections of the total number of cases registered across Estonia decreased from 92% in 2000 to 51% in 2003. In contrast to Ida-Virumaa, the rate of newly diagnosed cases of HIV infections in Tallinn increased from 6% in 2000 to 36% in 2001 and to 42% in 2002 and fell to 38% in 2003.

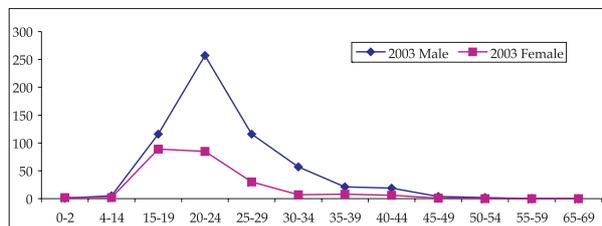
**Figure 14.** Breakdown of newly diagnosed cases of HIV infection by regions of Estonia in 2000–2003.



Source: Health Protection Inspectorate, 2004.

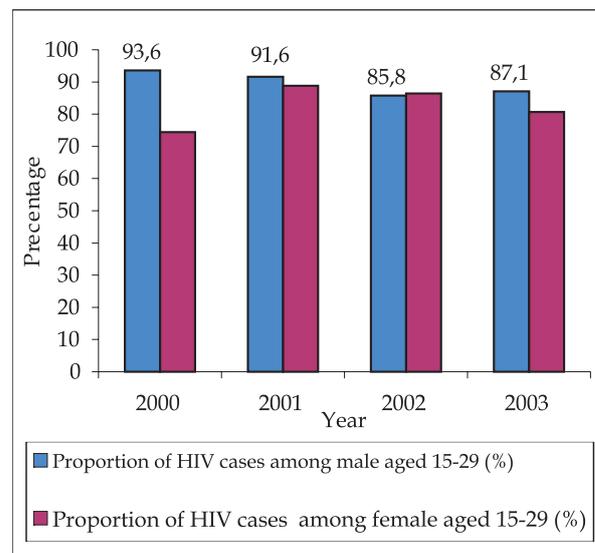
Similar to previous years the majority of newly diagnosed cases of HIV infection were registered among males (see Figure 15). However, the proportion of males among HIV infected persons decreased in 2003 (see Chapter 3.3. of report 2002). In 2000 80% of all diagnosed cases of HIV infection were registered among male, in 2002 the proportion of male HIV infected fell to 70%. In 2003 male HIV infected accounted for 72.1% of all newly registered cases of HIV.

**Figure 15.** Number of new cases of HIV infection by age and gender in 2003.



Source: Health Protection Inspectorate, 2004.

**Figure 16.** The share of newly registered HIV cases among 15–29 year-olds by gender (%).



Source: Health Protection Inspectorate, 2004.

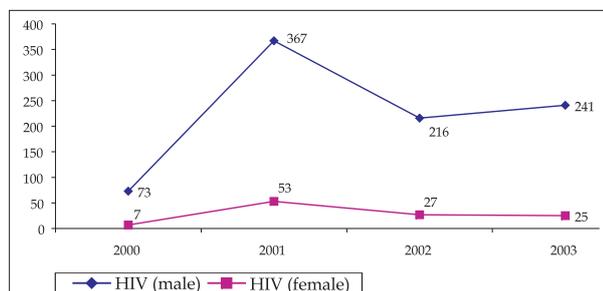
The share of young HIV infected aged 15–29 registered over the past 4 years is still high (see Figure 16<sup>18</sup>). The proportion of 15–29 year old female HIV infected has slightly decreased when compared to previous 2 years (2001–2002). The proportion of young males aged 15–29 having been tested as HIV infected of all tested males was very high in 2000 (93,6%). The following years showed a slight decrease, whereas in 2003 the proportion of male of the total number of HIV infected increased again. According to the data on HIV infection provided by the Reference Laboratory of West Tallinn Central Hospital 266 detainees out of 5009 were tested as HIV infected in 2003 contributing to 31,6% of all newly diagnosed HIV infections registered that year.

In 2003 women aged 15–29 accounted for 80,7% of all newly diagnosed HIV cases registered among females and men aged 15–29 accounted for 87,1% of all newly registered HIV cases registered among males (see Figure 16).

In 2002 the prison population contributed to 27% of all newly registered cases (see Figure 17) (see Chapter 3.3 of the National Report. Estonia. Drug Situation 2003). In 2003 there was a discernable trend in prevalence by gender – the majority of HIV infected prisoners were male. The number of HIV infected female prisoners decreased when compared to previous years, however, in contrast to this trend the number of HIV infected male prisoners increased in 2003 when compared to the year 2002.

<sup>18</sup> Over the last few years the quality of statistics has improved – the level of missing values is lower when compared to the previous years.

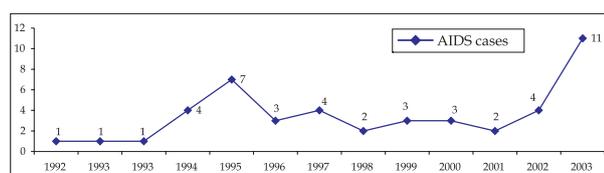
**Figure 17.** Breakdown of newly registered HIV cases in prison by age and gender, 2000-2003.



Source: Foundation West-Tallinn Central Hospital, Reference Laboratory of HIV Infection, 2000-2003.

During the period of 1992-2003 total of 43 cases of AIDS were registered. As at December 31, 2003 16 PLWHAs lived in Estonia (Figure 18) According to the data gathered by the HPI, the number of registered cases of AIDS was the highest in 2003 - 10 cases of AIDS were registered. 4 people with AIDS died in 2003.

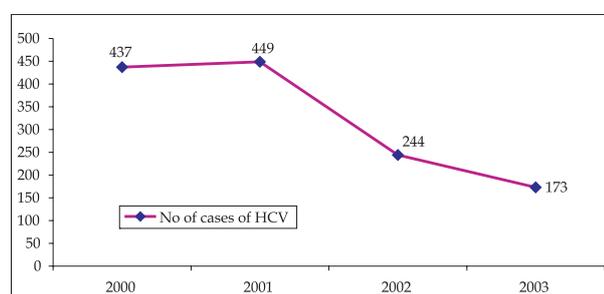
**Figure 18.** Number of cases of AIDS in 1992-2003.



Source: Health Protection Inspectorate, 2004.

According to the data gathered by the Health Protection Inspectorate the number of registered hepatitis B and C cases has decreased over the past years (Figures 19 and 20).

**Figure 19.** Number of registered cases of hepatitis B in 2000-2001.



Source: Health Protection Inspectorate, 2004.

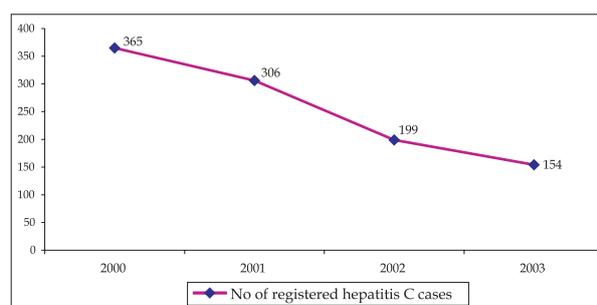
In 2003 total of 173 cases of HBV (the incidence rate per 100,000 inhabitants is 32.8) were recorded in Estonia of which male accounted for 72.8% (126 cases) and women 27.7% (47 cases). The incidence rate decreased 1.4 times when compared to the data of the previous reporting period (see National Report, 2003). 39.3% of the persons tested positive for HCV were IDUs. A vast majority of persons

tested positive for HBV were young people - 38.7% of persons with diagnosed HBV were 20-29, 22.5% 15-19 and 18.5% 30-39 years old. More than half of the HBV infected persons originated from non-working population groups<sup>19</sup>.

Total of 52 co-infections (HBV+HCV) were recorded in 2003 of which 25 in Tallinn, 18 in Ida-Viru County, 8 in Narva and 1 in Pärnu County. 131 persons with HBV were hospitalised accounting for 75.7% of all registered cases. Risk factors of hepatitis B infection identified in medical records were the following: blood transfusion (2 persons in Saare County), medical procedures (1 person in Tallinn, 7 in Harju County, 1 in Ida-Viru and Tartu County, intravenous use of drugs (total of 68 cases: 27 in Tallinn; 4 in Harju County, 18 in Ida -Viru County, 16 in Narva County, 3 in Tartu County), sexual intercourse (total of 10 cases of which 4 in Tallinn, 2 in Harju County, 3 in Ida-Viru County, 1 in Saare County), tattooing (in 5 cases - all registered among prison inmates). The risk factor was not specified with respect to 76 cases.

Total of 154 cases of HCV were registered in Estonia in 2003 accounting for 77.3% of the cases registered in 2002. 48.7% of the persons tested positive for HCV were IDUs. 92 people were hospitalized and no lethal cases were recorded in the reporting period.

**Figure 20.** Number of registered hepatitis C infections in 2000- 2001.



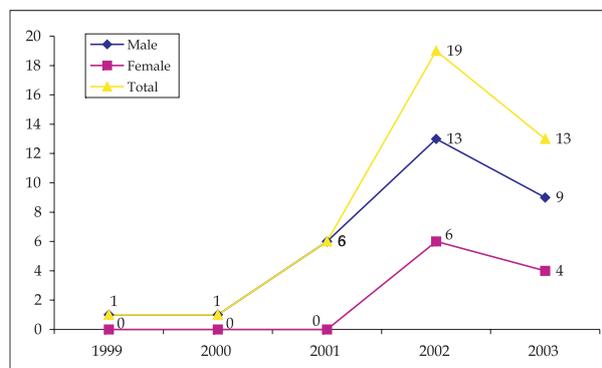
Source: Health Protection Inspectorate, 2004.

Risk factors of hepatitis B infection identified in medical records were the following: medical procedures (4 cases), work with blood (3 cases), intravenous use of drugs (75 cases: 40 in Tallinn; 4 in Harju County, 20 in Ida-Viru County, 10 in Narva County, 1 in Lääne-Viru County), sexual intercourse (10 cases: 6 in Tallinn, 3 in Harju County, 1 in Ida-Viru County), tattooing (5 cases, all of them were detainees). In 58 cases of HCV risk factors were not specified.

<sup>19</sup> Non-working population groups are old-aged people, unemployed, detainees, homeless, women on maturity leave, people incapable of working, care-home residents etc.

The number of cases of tuberculosis (TB) among HIV infected increased up to 19 cases in 2002. Since 2002 all cases of TB have been registered with respect to HIV infected men.

**Figure 21.** The number of TB cases among HIV infected persons 1999-2003.



Source Estonian Tuberculosis Registry, 1999-2003.

According to the statistics of the Tuberculosis Registry total of 13 cases of tuberculosis (TB) among HIV infected persons were registered in 2003 (see Figure 21). HIV infected males accounted for 9 and HIV infected female for 4 cases of TB.

- **Psychiatric co-morbidity (dual diagnosis)**

No new information available.

- **Other drug-related health correlates and consequences**

No new information available.

## 7. Responses to Health Correlates and Consequences

Rapid spread of HIV was recognised as a serious health problem in 2002. An important development in this field is related to a change in the structure of co-ordination. Since 1 May 2003 the NIHD has been responsible for the implementation of National HIV/AIDS prevention Programme for 2002-2007 and other health programmes.

Positive changes in the prevention of drug-related infectious diseases suggest that prevention of drug-related infectious diseases in high-risk groups in Estonia (incl. IDUs) has improved when compared to the previous reporting period. Despite limited resources available Estonia has made great efforts to achieve the main goals of the National HIV/AIDS prevention Programme for 2002-2007 – to stop progressive spread of HIV/AIDS and to ensure PLHAs access to high quality ARV treatment, other health care and social services. There have been considerable improvements in terms of funding of prevention of HIV – at the end of 2003 the Programme Grant Agreement between the Global Fund to Fight AIDS, Tuberculosis and Malaria and the NIHD was concluded to respond to the spread of HIV in Estonia. Within the framework of the GFATM programme practical steps will be taken to stop progressive spread of HIV and AIDS by the year 2007. Tallinn City Government approved the Action Plan 2003 – 2007 for the Prevention of Drugs and HIV/AIDS in Tallinn entering into force on March 1, 2003. The programme defines clear goals and performance indicators for monitoring the progress of project activities and sources of funding drugs, HIV and AIDS prevention.

In 2003 the number and geographical coverage of Needle Exchange Points in Estonia increased. Also, the working hours of NEPs were prolonged. In the reporting period monitoring and evaluation improved significantly as monitoring and evaluation have been recently recognised as important and necessary parts of project implementation. In order to get a better overview of the visitors and services of needle exchange, a pilot study was carried out by the NIHD on the visitors of Needle Exchange Points (Lõhmus *et al* 2004), the results of the study have been included to this report. The GFATM Programme for scaling the responses to HIV in Estonia managed by the NIHD introduces monitoring and evaluation indicators developed for the monitoring of the progress of the programme.

In the reporting period the vaccination for HBV improved, however, the coverage is still far from ideal. In 2003 vaccination of all newborn babies

was initiated in Estonia. Also, the coverage and quality of anonymous HIV counselling and testing and syringe exchange improved.

- **Prevention of drug-related deaths**

No new information available

- **Prevention and treatment of drug-related infectious diseases**

Prevention of drug-related infectious diseases was carried out according to the national health programme “National HIV/AIDS Programme for 2002-2006”<sup>20</sup>. The National HIV/AIDS Programme defines two overall objectives – to stop progressive spread of HIV/AIDS and ensure availability of high quality ARV treatment, other health care and social services for PLWHAs (Programme document, 2002). The main activities in the field of HIV/AIDS prevention provided in the national HIV/AIDS Programme are the following: rising the awareness of risk groups, general population and schoolchildren of the health behaviour; provision of voluntary counselling and HIV testing for all interested persons; reduction of prejudices of the general public of people with alternative sexual orientation and fighting against discrimination of the latter; ensuring the safety of donor blood. The programme provides activities for achieving the defined milestones in the field of harm reduction such as improvement of availability of condoms, methadone treatment, distribution of sterile syringes for IDUs within the framework of syringe exchange programmes, provision of counselling and HIV testing for people of risk groups (incl PLWHAs and their partners), tackling the HIV epidemic, which started in Estonia among IDUs in 2000 and was recognised as a serious health problem in 2002.

In order to attend to these issues the Prime Minister called a meeting of the main decision-makers from the ministries and NGOs working in the field of HIV prevention to discuss measures to be taken for efficient management of HIV-related issues having become of increasing concern for Estonia. In 2002 additional funds of EUR 173,076.9 (2.7 mil-

<sup>20</sup> HIV/AIDS Prevention Programme for 2002 – 2006 includes the following risk groups: youth, mainly adolescents with risk behaviour, IDUs, prostitutes, sexual partners of IDUs and prostitutes, homosexuals, bisexuals and men involved in risk behaviour, persons suffering from other STDs, detainees and prisoners, pregnant women, persons subject to potential contact with blood at work such as health care and social workers, police officers, security services employees, prison officials, teachers, persons involved in first aid and rescue services.

lion Estonian kroons) were allocated from the state supplementary budget for the HIV/AIDS prevention programme. In 2003 the government allocated resources for HIV prevention from the supplementary fund. In the second half of 2003 EUR 128,205.1 (2 million Estonian kroons) were allocated for the HIV/AIDS prevention work (see Chapter 1).

In 2003, the NIHD as the Estonian contractual partner to the Global Fund to Fight AIDS, Malaria and Tuberculosis (GFFAMT) and the GFFAMT entered into an agreement on the implementation of the programme "National partnership to increase the scale of Estonia's response to a concentrated and rapidly developing HIV/AIDS epidemic". The agreement obliges the NIHD to implement the 4-year programme aiming at stopping progressive spread of HIV/AIDS by the year 2007 which will be achieved by focusing on the meeting of 7 objectives within 4 main areas. The target groups of the programme are young people aged 10-24, IDUs, female sex workers, prisoners, men who have sex with men (MSM) and PLWHAs<sup>21</sup>.

The objectives of the programme are the following: reduction of risk behaviour of young people, IDU's, MSM, reduction of risk for sex workers and reduction of vertical transmission of HIV, prevention of HIV transmission in prisons, improvement of the quality of life of HIV-infected people, improvement of institutional capacity of the agencies involved in the fight against HIV.

The programme covers the following areas of activity: prevention work with young people, targeted interventions, support for PLWHAs and capacity building.

A project on the research on and training of peer educators in the field of HIV and drug use was financed within the framework of sexual education projects by the Estonian Health Insurance Fund. Altogether 75 children with drug dependence were tested and interviewed and 80 parents and teachers were consulted.

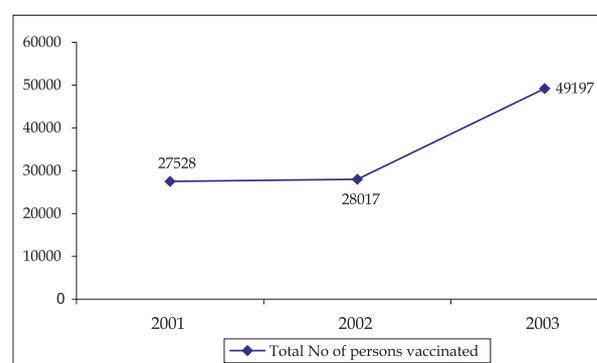
Also, training of students on peer education was carried out within the project. 25 university students were trained to become peer educators and

peer educators delivered prevention seminars for 731 school students. Within the framework of this project a working group was set up to initiate the establishment of a treatment and counselling centre for children with addiction problems in South Estonia.

### Vaccination

At present free HBV vaccination is provided only for certain population groups in Estonia. However, vaccination shows a positive trend – the number of persons vaccinated against HBV increased 1.75 times in 2003 when compared to the previous reporting period (see Figure 22).

**Figure 22.** Total No of persons vaccinated for HBV in 2001-2003.



Source: Health Protection Inspectorate, 2004.

In the second half of 2003 Estonia started to vaccinate all newborns against HBV within the framework of the national immunization programme. The vaccine coverage is good among 14-year old children – 95% of them are fully immune to HBV. More than a quarter of children aged from 7 months to 14 years are fully immune to HBV. In general the level of immunity is better in Tallinn (36.7%), Narva (31.2%) and Ida-Virumaa (30.1%) compared to other regions.

According to the data provided by the Health Protection Inspectorate in 2003 total of 49,197 persons were vaccinated against HBV of which 45,205 were children aged 0-14, 161 schoolchildren aged 15-17 and 3,831 adults. Altogether 51 persons were revaccinated of which 50 were adults and 1 was adolescent aged 15 –17.

### Counselling and testing

In Estonia HIV testing is voluntary and it is permissible only in case a person has given consent for testing. HIV test is obligatory only for foreigners who seek for residence permit. Testing of blood and organs is obligatory to ensure the safety of donor blood, tissues and organs. According to the decree

<sup>21</sup> Within the framework of the GFFAMT programme the NIHD funds the following activities: counselling, methadone treatment, syringe exchange, rehabilitation for drug addicts, media campaigns establishment of drop-in centre for sex workers, counselling of sex workers, pre- and post-testing counselling in prison, prevention of the spread of HIV among men having sex with men, establishment of gay's and lesbian's information centre, creation of support groups for HIV positives, raising the knowledge of schoolchildren of HIV, training of 18-24 year old vocational schools students, special school students and conscripts, training of youth organizations, ARV treatment).

of the Minister of Social Affairs No 118, October 31, 2003 HIV testing of pregnant women during the routine medical examination was initiated in Estonia. Conscripts are recommended to get tested for HIV on voluntary bases. Testing is obligatory for the conscripts participating in the International Mission. All detainees can voluntarily get tested for HIV within the framework of routine medical examination in the period of preliminary investigation.

All prisoners can apply to the prison medical department for HIV testing. Testing will be carried out provided the person under custody has given a voluntary written consent for testing (see Chapter 8 on drug use in prison).

The cost of HIV testing of persons without health insurance is covered by funds from various sources such as GFFAMT, National HIV/AIDS Prevention Programme. Also, Tallinn City Council has allocated funds for HIV testing of people without health insurance (see Chapter 1 on budget and public expenditures).

Statistical data provided by Merimetsa Reference Laboratory indicate that the number of HIV tests made annually has increased during the period of 2000-2003 (see Figure 23). The number of blood tests has increased over the past years - 64,794 blood tests were made in 2000, 94,214 in 2001, 99,190 in 2002 and reached to 119,296 tests in 2003.

The number of tests made annually to control the blood donors and donors of organs has increased 1.4 times. The number of HIV tests has increased as a result of considerable increase in the number of people of risk groups having been tested for HIV - in 2003 the number of pregnant women tested for HIV almost doubled and the number of tested convicted persons increased 4.8 times when comparing to the year 2000 (see Chapter 8, drug use in prison).

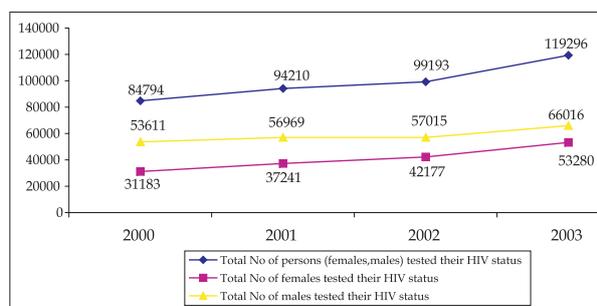
The initiative of the AIDS Prevention Centre - provision of information, counselling and testing services for all interested persons, as well as risk groups was followed by AIDS Prevention Centres in other regions of Estonia.

There are 6 AIDS Prevention Centres in Estonia - 2 in Tallinn, 1 in Narva, Tartu, Pärnu and Puru offering anonymous and free testing for HIV (including pre- and post- testing counselling)<sup>22</sup>.

<sup>22</sup> AIDS counselling centres use a unique code system and the results of HIV test are given to the person on the basis of his/her personal code. There are 3 counselling centres in Tallinn, 16 centres across Estonia. Jõgeva, Hiiu, Lääne-Viru County have not got a counselling center.

According to the statistical data of Merimetsa Reference Laboratory the number of clients tested for HIV in AIDS Prevention Centres was 5,223 in 2000 increasing to 6,235 and 6,507 in 2001 and 2002, respectively and decreasing drastically to 5,223 in 2003.

**Figure 23.** Number of HIV tests in 2000-2003.



Source: Tallinn Merimetsa Hospital, 2000-2003.

Decrease in the number of people tested for HIV in 2003 can be explained by external factors (restructuring of the old system etc). An important task of the AIDS prevention centres is provision of information and advice on STDs and other serious risks related to drug use such as drug overdoses etc.

AIDS prevention centres provides information on testing orally or in writing (distribution of leaflets in the Estonian and/or in Russian language) in the Estonian and Russian languages. All clients who get testing for HIV are provided with counselling before testing and after getting the test results. Service provision includes detainees and prisoners (see Chapter 8).

16 youth counselling centres managed by the Estonian Family Planning Association (carrying out activities with the purpose of enhancing reproductive health of young people) provide free testing and counselling services for young people under the age of 18.

### Syringe exchange

Syringe exchange is targeted at IDUs to reduce health risks related to drug use, spread of drug-related infectious diseases, particularly HIV and hepatitis B, C, as well as reduce the risk of overdoses.

During the period of 1997-2003 syringe exchange has improved not only in terms of quantity but also quality. As at 31 December 2003 19 syringe exchange points (SEPs) were operating in Estonia of which 11 were stationary SEPs, 4 mobile and 4 detached outreach SEPs (NIHD 2003). However,

SEPs were operating mostly in big cities, and the service was not available in rural areas<sup>23</sup>.

In 2002 the spread of HIV/AIDS was recognised by the Government as a serious health problem and in 2003 the Government started to fund syringe exchange within the framework of National HIV/AIDS Prevention Programme. Earlier most SEPs had been funded by foreign organisations and funds, since 2001 the state has allocated resources for syringe exchange points on project basis through the Gambling Foundation (see National Report 2001, 2002 and 2003).

According to the estimation of the NIHD total of 24,877 persons visiting SEPs were provided with counselling, 283,572 syringes, 154,312 condoms and 32,352 copies of information material were distributed free of charge in Estonia within the framework of the National HIV/AIDS Prevention Programme by 4 main service providers in this field - AIDS Support Centre, NGO "Convictus Estonia", Narva rehabilitation centre for drug addicts and alcoholics "You will not be Left Alone", NGO "We Will Help You" and Tapa Prevention and Counselling Centre (NIHD 2004).

According to the NIHD estimation 64,662 syringes out of 283,572 distributed syringes were returned. Returning of used syringes is a recommendation, not an obligation. It is most likely the reason for such big difference between distributed and returned syringes. However, in order to reduce the risk behaviour of clients and encourage the use of clean syringes, targeting particularly at those who had recently started to use the services of SEP, it was recommended to provide the clients with clean syringes even in case he/she had not returned the used ones.

In 2003 the NIHD supported publication of different information materials in the Estonian and Russian language on HIV, Hepatitis B, C and other STDs, safer injecting and safer sex practice and reduction of incidents of death as a result of overdoses targeted at IDUs and visitors of AIDS Prevention and Counselling centres (NIHD 2004 Report on HIV/AIDS programme)<sup>24</sup>.

---

<sup>23</sup> According to the data of NIHD all SEPs were managed by 4 NGOs - AIDS Support Centre (3 SEPs), "Convictus Estonia" (2 SEPs), "We will Help You" (4 SEPs) and Narva Rehabilitation Centre for Drug Addicts and Alcoholics "You will not be Left Alone" (10 SEPs).

<sup>24</sup> 5 publications out of 8 - "Contact Information", "Safety and Disinfections of Needles", "Overdosing", "A Woman and HIV" and "Safe sex" were co-funded by the Ministry of Foreign Affairs of Finland. NIHD supported publication of the following information materials "HIV infection and AIDS", "Safe sex" and "STDs and prevention of STDs".

In order to increase the quality of services provided by SEPs, the NIHD drafted the guidelines "Counselling of IDUs and Exchange of Syringes" in 2003. Also, the NIHD organised 2 trainings for the staff of SEPs with the purpose of increasing the knowledge of the staff and introducing the monitoring system of syringe exchange.

A media campaign was carried out by the NGO "Future" to promote use of condoms among young people aged 15-24. The campaign included TV, outdoor media and a poster. The media campaign was funded by the National HIV/AIDS Programme.

In the reporting year the NIHD supported total of 26 prevention events in school, 30 prevention events outside school, 31 interactive trainings targeted at young people aged 13-18, 3 trainings targeted at students of special schools and 2 trainings for teachers of special schools within the framework of national HIV/AIDS Prevention Programme (NIHD 2003).

Within the framework of national HIV/AIDS Prevention Programme, NGO "Convictus" and NGO "You will not be left alone" set up a client registration system using unique client registration codes. The idea was to get a better overview of clients visiting needle exchange points, the clients' profile, their risk behaviour etc and introduce the system to other SEPs. In 2003 the NIHD initiated a pilot project on establishing a national syringe exchange monitoring system.

The pilot study "Risk Behaviour and Knowledge of Visitors of Needle Exchange Points on HIV/AIDS transmission" is the best source of information about the characteristics of visitors of SEPs and their risk behaviour and knowledge on HIV transmission (Lõhmus et al. 2004)<sup>25</sup>. The study sample (n=2030) was a group of relatively young visitors (the mean age of primary visitors was 22.6 and repeated visitors 22.8). More than half of primary visitors (PVs) of SEPs (50.5%) of which 81% were male were 20-24 years old; nearly a quarter of PVs of SFPs (24.3%) of which 70% were male were 19 years old and younger; a quarter of the visitors of which 89% were male were 25-years old and older. Four fifth of IDUs visiting SEPs were male, repeated visitors accounted for 86.7% of the sample, 83.5% of the sample visited SEPs for the first time and more than half of the sample did not work or study.

---

<sup>25</sup> The sample size was 2,030 visitors of SEPs (incl. 1,880 primary and 350 repeated visitors). Criteria for the inclusion in the study included an ability to understand the purpose of the study and answer to the questions. A person having visited NEP at least once was defined as a repeated client.

The study showed that 3% of the visitors (PVs) of SEPs had been injecting drugs for more than 10 years, 45% 2-4 years, 20% 5-10 years, 13% had been injecting less than a year and 19% 1 to 2 years. However, more than half of repeated visitors (RVs) of SEPs had been injecting amphetamine (50%), followed by visitors injecting poppy liquid (39.9%) and heroine (34.1%).

Visitors of SEPs in Tallinn injected mostly heroine (68.7%), followed by visitors injecting amphetamine (45.5%) and poppy liquid while visitors of SEPs in Ida-Viru County tended to inject amphetamine (53%) and poppy liquid (43.8%) followed by visitors injecting heroin (29.3%).

60.9% of primary visitors and 63.7% of repeated visitors reported not sharing syringe in the last month. 50.5% of RVs and 46.6% of PVs of SEPs reported to have used condom when having had sex the previous month. More than 60% of the re-

spondents (PVs and RVs) reported having used a condom during last sexual intercourse.

On the basis of the study it was concluded that 59.5% of PVs and 63.7% of RVs visiting SEPs had accurate knowledge of HIV transmission, however, significant difference in gender was identified – the level of knowledge on HIV transmission was higher among male than female.

- **Interventions related to psychiatric co-morbidity**

No new information available

- **Interventions related to other health correlates and consequences**

No new information available

## 8. Social Correlates and Consequences

Social problems appear to have remained the same as in the previous reporting period. Positive trend was observed with respect to the unemployment rate falling to the lowest level of the five past years. At the same time the unemployment rate of young people increased in 2003 exceeding 20%. Social problems in Estonia include homelessness, financial problems of families with children and a big number of school dropouts. In 2003 2,9% of gymnasium students left school. Differences in the living standard of different regions in Estonia have resulted in appearing poorly developed communities where drug use and other criminal activities are common. In 2003 the total number of registered drug offences (crimes and misdemeanours) increased by 34% compared to the year 2002.

On the basis of data of the Standard Table (ST) No 12 provided by the Ministry of Justice in 2004, we can conclude that the level of drug use amongst prison population was high. Out of 992 persons recorded as drug users in the personal medical record, 68% had used heroine, 39% amphetamine and 17% cannabis during their lifetime.

### • Social Exclusion

#### Homelessness

According to the data of the population and dwelling census there were only 369 homeless persons in Estonia in 2003. Although the principles and definitions used in the questionnaire were in conformity with EUROSTAT the data on the number of homeless people are not reliable (Kõre 2003).

According to the expert opinion of social workers the total number of homeless people was approximately 3,000-3,500 people, i.e 0,25-0,3% of the total population.

According to the estimation of the Ministry of Economy and Communications and the Ministry of Social Affairs there were 5,000 homeless people which accounted for 0,4% of the population of Estonia.

A survey on the clients of shelter homes characterized homeless people as follows:

- in terms of gender 3/4-4/5 were men;
- they were single people who had lost their family, relatives and friends;
- all working age groups were represented (18-65), women of the age 40-50 and men of the age 50-60 contributed to the majority in this group;

- in terms of language the proportion of Estonian and Russian-speaking homeless people in shelter homes was similar to that in the relevant town;
- 90% of homeless people were local people; the rest came from neighbouring communities. In Tallinn 1/3 of homeless people were immigrants;
- 2/3 of the clients of shelter homes had been homeless for a long time (over 6 months).

Although exact data were not available we can say that the number of homeless people in Estonia is increasing year by year. It can be concluded from the increasing number of emergency calls to the emergency medical care in Tallinn.

Number of calls to the emergency medical care with respect to homeless people

- 1999 - 353
- 2000 -365
- 2001 - 619
- 2002 - 951
- 2003 -1041

*Source: Tallinn Emergency Medical Care, 2004.*

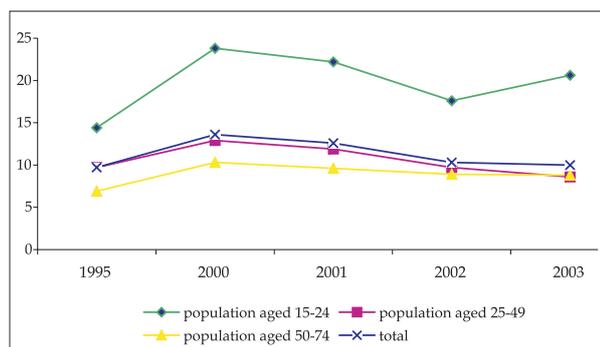
#### Unemployment

The unemployment rate was the highest in the year 2000 (13,6%), it has decreased over the last years. In 2003 the unemployment rate was the lowest of the past five years dropping to 10%. Over the years the unemployment rate of men has been higher than that of women. The gap between the unemployment rate of males and females is decreasing. In 2003 the unemployment rate of men was 10,2%, and the rate of women 9,9%. However, the unemployment rate of men decreased whereas the unemployment rate of women increased in the reporting period.

Within the period of 1998-2000 the unemployment rate of 15-24-year-olds increased more than the unemployment rate of people of older age groups. In 2001-2002 the unemployment rate of the youth decreased, however, it exceeded 20% in 2003.

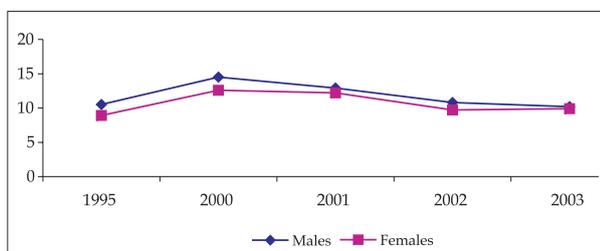
Unemployment is a bigger problem of men of older age groups than of women of the same age group. In case of young people it has been vice versa since the year 2001. In 2003 the unemployment rate of males aged 15-24 was 16,9% and females 26%.

**Figure 24.** Unemployment rate by age group, 1995, 2000-2003.



Source: Statistical Office of Estonia, 2004.

**Figure 25.** Unemployment rate by gender, 1995, 2000-2003.



Source: Estonian Statistical Office, 2004.

Differences in the unemployment rate by counties have increased since 2000. In 2003 the difference was two-fold, extending from 5% in Rapla county and 5,3% in Tartu county to 18,2% in Ida-Viru county.

Differences in the unemployment rate were also observed in terms of the level of education. The lower the level of education, the worse the prospects of finding work. In 2003 unemployed young people with basic education accounted for 16.9% of the total number of unemployed. The rate of unemployment was the lowest among the population of tertiary level of education - 5,8%, however, it had increased compared to the previous years (Statistical Office of Estonia 2004).

### School drop-outs

A considerable number of drop-outs in schools of general and vocational education is of big concern. In 2002/2003 there were 986 drop-outs among schoolchildren of grades 7-9 of diurnal general educational schools accounting for 1,5 % of the total number of schoolchildren. 1,022 schoolchildren i.e 2.9% of the total school population dropped out of upper grades of general educational schools. The share of drop-outs of the total number of school students was even bigger in schools providing vo-

ational education after basic education. In 2003 2,860 schoolchildren dropped out meaning that every sixth school student did not finish school. Dropping out does not exclude further continuation of studies, however, the share of 15-24-year olds without secondary education increased to 52% in 2003, which is a matter of great concern. Thus, in Estonia a process of the division of the population into different strata according to the level of education can be observed.

Also, the number of young people of the school-leaving age without secondary education (as well as basic education) is increasing. At the same time, the number of young people obtaining higher education is growing.

20,000 people without basic education aged 17-49 live in Estonia. Three fourth of school drop-outs is boys. Passing the minimum school-leaving age and ending up in a place of preliminary confinement are the most frequent reasons for dropping out of school (Statistical Office of Estonia 2004).

### Economic issues

The living standard of households with children is still the lowest. In 2003 the income of households with three and more children was the smallest contributing to only 67% of the average income in Estonia. Also, the income of a household with one adult and two children was less than 2,000 kroons (EUR 128,2) per month.

To compare with, the average net income of a household of a working-age couple or a single working-age person is over 4,000 kroons (256,4 euros). Comparison of different groups of the population on the basis of the poverty rate indicates that in Estonia half of the unemployed, one fifth of the retired and one tenth of paid workers live under the poverty line (Statistical Office of Estonia 2004).

### Social network

In 2003 a survey among the schoolchildren of the 8th grade in Tallinn was carried out by Tallinn Pedagogical University. The survey gave a thorough overview of the factors having an effect on the inclusion of schoolchildren using drugs in a risk group.

The survey revealed that 46% of the Estonian young people define themselves as members of a group or gang. Membership in a group/gang had a significant effect on the inclusion of a person in a risk group, including a group of drug users. Only 2/5 of the schoolchildren not using drugs were members of a group or gang, two thirds of those having used drugs once and 70-80% of those

having used drugs repeatedly. Also, pupils using drugs communicated more often with gangs having carried out illegal activities. Schoolchildren communicating with older school student as well as adults, youth of opposite sex and youth of other nationality were more prone to repeated drug use than those not having the described groups as communication partners.

The survey demonstrated that the more possibilities for leisure available, the less drug users in the group and vice versa – the less possibilities for interesting leisure the more users of drugs. It can be either lack of leisure facilities or just lack of facilities satisfying the specific needs of a young person; nevertheless, it is the feeling of dissatisfaction, which is often a cause for drug use. The latter in turn creates a feeling of dissatisfaction.

The survey revealed that the worse the relations with mother and father, the bigger the probability of trying drugs. The survey showed that if the parents of a young person were aware of the whereabouts and activities of their child, he/she was less likely a drug user. Less than 10% of the young being aware of their parents' interest in their activities were drug users. More than one third of those believing their parents knew nothing about their activities had tried drugs.

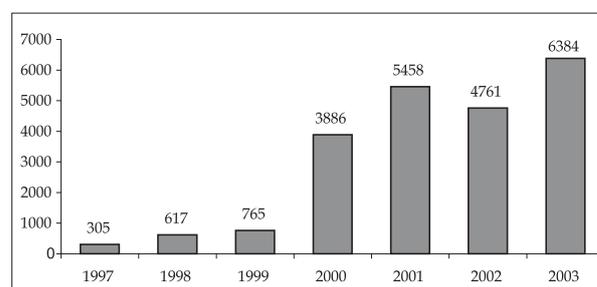
The survey indicated that there was connection between drug addiction and the frequency of missing classes without any good reason. The more narcotic substances were used the more frequently classes were missed. Use of drugs and missing of classes without good reasons were very closely related: alternative activities (to attending classes) were accompanied by more frequent use of drugs; the use of narcotic drugs was one of the reasons for missing classes at school (Kruusvall et al. 2004).

## • Drug-related crime

### Drug offences

The total number of drug offences registered by the police increased from 4,761 in 2002 to 6,384 in 2003 (increase was 34%) (see Figure 26). Those numbers include both crimes (criminal offences: drug possession with intent to supply, drug trafficking, etc) and misdemeanours (drug abuse or possession of a small amount for personal use). Criminal offences accounted for 18% of all drug offences in 2003 (see Table 9).

**Figure 26.** Total number of drug offences registered by the police (crimes and administrative offences or misdemeanours), 1997-2003.



Source: Police Board, 2004.

**Table 9.** Number of drug crimes (main types) registered by the police, 2003.

§183. Unlawful handling of small quantities of narcotic drugs or psychotropic substances	470
§184. Unlawful handling of large quantities of narcotic drugs or psychotropic substances	443
§185. Provision of narcotic drugs or psychotropic substances to persons of less than 18 years of age	35
§186. Inducing a person to engage in illegal use of narcotic drugs or psychotropic substances	5
§187. Inducing minors to illegally consume narcotic drugs or psychotropic substances or other narcotic substances	9
§188. Illegal cultivation of opium poppy, cannabis or coca shrubs	32

Source: Police Board, 2004.

In 2003, about 70% of all drug offences were registered in Tallinn and 17% in Ida-Viru County (including Narva). The police apprehended 3,182 persons who were under the influence of drugs (46% more than in 2002, the increase can be explained by more active police work, particularly in Tallinn). Combating drug offences, especially drug trafficking, has been one of the priority tasks of the police since 2000.

### Drug-related crimes

Drug abusers are committing a significant proportion of property crimes (especially thefts from cars, shoplifting, pick-pocketing, robberies). According to the police statistics, 35% of cleared property crimes were committed by persons who had been charged for committing a drug offence in last three years (see Table 10).

**Table 10.** The share of criminal offences committed by offenders with a history of drug offence\*, 2003 (% of cleared offences of respective type of crime).

Type of crime	%
Property crimes	35
thefts	39
domestic burglaries	34
thefts from cars	51
thefts from shops, supermarkets etc (shoplifting)	45
Crimes against person	14
Crimes against public order	16
Drug crimes	98
ALL CRIMES	30

\* Persons who had been charged for any kind of drug offence in 2001-2003.

Source: Police Board, 2004.

The number of detected drivers under the influence of illicit drugs has been relatively small: during the period from September 2002 to June 2003 (10 months) 77 such drivers were detected by the police.

#### • Drug use in prison

In Estonia there are total of 9 prisons of which 8 prisons are of closed type and 1 is an open prison. As at 1 January 2004 there were 4,567 persons in custody in prisons of which 3,221 were convicted prisoners and 1,355 pre-trial prisoners (Estonia Prison System Yearbook, 2004). Drug use among the prison population has not been well studied in Estonia for various reasons; therefore, it is difficult to give a comprehensive overview of the use of illicit drugs among prison inmates. The most recent study on drug use among the prison population dates back to 1998 (see National Report 2001).

On the basis of the data of the Standard Table (ST) No 12 provided by the Ministry of Justice in 2004 we can conclude that the level of drug use amongst prison population was high. Data presented in this chapter are not data from any survey but routine statistics collected by the Ministry of Justice from prisons. Data of the Standard Table 12 shows that heroine, amphetamine and cannabis were the most widely used drugs among prison inmates in 2003. According to the data on patterns of use 68% of the 992 persons recorded as drug users in the personal medical record had used heroine, 39% ampheta-

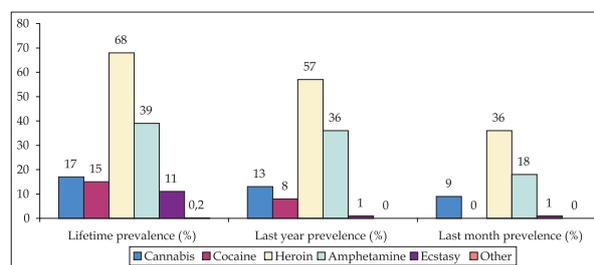
mine and 17% cannabis during their lifetime (see Figure 27)<sup>26 27</sup>.

According to the data the level of drug use in prison is much lower, last months prevalence varies from 0.2 % of heroine use to 1% of cannabis use and 2% of amphetamine use. Also, the data revealed that 57% of convicts used heroine, 36% amphetamine, 13% cannabis and 8% ecstasy last year. It should be noted that due to the deficiencies in the provision of data these numbers should be interpreted carefully.

According to the data of the Ministry of Justice, data on last month prevalence of drug use show high level of drug use in 2003 - 36% of convicts used heroine, 18% amphetamine and 9% cannabis.

However, data on last month prevalence should be treated with certain reservation as some of the persons held in custody (eg persons convicted recently have easier access to drugs having reported last month drug use had probably used drugs before imprisonment but the size of this group is unknown, etc).

**Figure 27.** Use of illicit drugs among prison population in 2003.



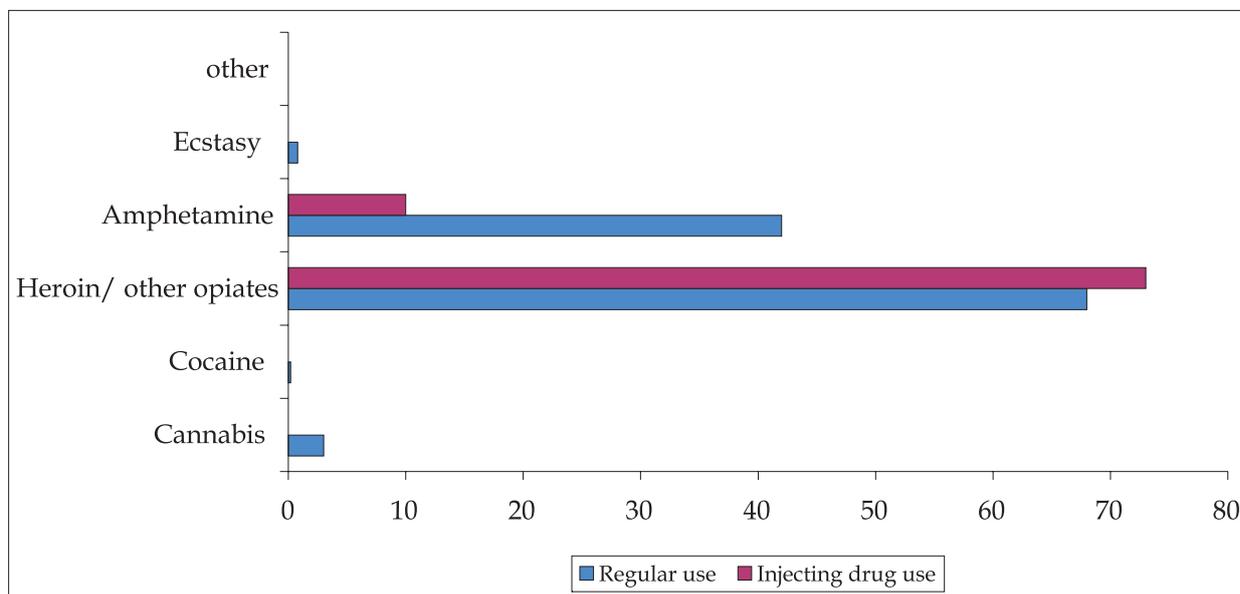
Source: Ministry of Justice, 2004.

68% of heroine users, 42% of amphetamine users 3% of cannabis users reported to be regular drug users. Data shows that the rate of IDUs among prison population was remarkably high - 73% of the prisoners recorded as a drug users in prison reported to have injected heroine and 10% amphetamine (see Figure 28). High level of drug use (eg high level of intravenous) among prison population indicates that there is an urgent need for the development and implementation of services aiming at the reduction of drug use and HIV prevalence and the prevalence of other STDs among inmates (see Chapter 9 of the National Report on Drug Situation 2004).

<sup>26</sup> Total sample size was 3,945 convicted persons (2003), according to the data provided in their personal medical records 992 reported to be drug users.

<sup>27</sup> Definition according to the ST 12, defined by the Ministry of Justice: a convicted person is a drug user if he/she has reported so and/or has given positive urine sample etc and it is recorded in his/her personal medical record.

**Figure 28.** Breakdown of regular and intravenous drug use among the prison population by type of substance in 2003.



Source: Ministry of Justice, 2004.

- **Social costs**

No new information available.

## 9. Responses to Social correlates and Consequences

In 2003 the conception of social reintegration was developed according to the National Strategy on drug dependency 2004-2012.

Very few activities were carried out in the field of social reintegration. In 2004 amendments to the Social Protection of the Unemployed Act and Social Welfare Act were initiated to promote reintegration of former drug addicts into the society.

The National Strategy for Crime Prevention until the Year 2005 provides the main principles of the prevention of drug-related crimes. The National Strategy for Crime Prevention is carried out by Ministry of Justice, Ministry of Internal Affairs, Ministry of Social Affairs and Estonian Ministry of education on Research.

Drug prevention in prisons is carried out within the framework of resocialisation process. In the past years on the initiative and management of the Ministry of Justice all prisons have made a big efforts to develop an effective resocialisation system involving other institutions such as NGOs and voluntary workers.

### • Social Reintegration

Meeting the long-term objective of the National Strategy on the Prevention on Drug Dependency 2004-2012 will ensure access to rehabilitation services for all former drug addicts having successfully completed treatment and/or seeking rehabilitation. The objective of rehabilitation is full social integration and acquisition of a drug free lifestyle. Reintegration involves participation in a 2-6-month programme following the therapeutic community enabling the patients to reintegrate in the society and adjust to normal conditions (supported apartment, supported jobs). The reintegration programme is the final stage of the community rehabilitation.

According to the principles of the NSPDD the purpose of a social rehabilitation centre is to focus on achieving complete social reintegration, either socializing or resocializing former drug addicts abstained from drug use, creating possibilities for the completion of education, acquiring professional skills and finding work.

In 2004 the Board of Riigikogu decided to bring in the legislative proceedings the draft Social Protection of the Unemployed Act and Social Welfare Act Amendment Act initiated by the HIV, AIDS and Drug Prevention Commission. The pur-

pose of the amendments was to promote reintegration of former drug addicts and persons who wanted to live a drug-free life. The government did not approve the amendments to the act. The government supported the general idea of making the above-mentioned amendments, however, according to the proposal of the government drug treatment and rehabilitation had to be defined and guidelines for the institutions offering rehabilitation services to drug addicts elaborated. Also, national budget for drug treatment and rehabilitation had to be revised increasing the amount of resources for the provision of rehabilitation services.

Draft Social Protection of the Unemployed Act Amendment Act provides drug addicts presenting for treatment and rehabilitation for drug addiction with labour market services and unemployment benefits. The draft Social Welfare Act Amendment Act is aiming at the provision of former drug addicts with access to social services such as counselling, social apartments and social benefits to enable them to exercise their right to social security. The purpose of the amendments is to lower the risk of relapse of former drug users. (Riigikogu Press Service 2004).

### • Prevention of Drug-related Crime

11 July 2000 the Estonian Government approved the *National Strategy for Crime Prevention until the Year 2005 (NSCP)*. The goals of the strategy are more efficient inclusion of the public in crime prevention, more efficient protection of property, increased safety on streets and in public places, decrease in criminal offence and crimes committed by young people (including drug prevention), better availability of assistance to victims and prevention of repeated crimes.

The main tasks related to drug use are to expand the possibilities for the young people to spend their free time, contribute to the creation of youth centres, carry out alcohol and drug prevention activities among young people, distribute study and information materials and carry out media campaigns.

Within the framework of health protection teachers need to be provided with information on drug prevention, violent and deviate behaviour. Teachers, trainers, instructors and psychologists should be provided with socio-educational training. One task of NSCP is grant access to treatment and rehabilitation centres for school children having become dependant on psychoactive substances to prevent them from dropping out of school.

The budget of the Estonian Police for carrying out crime prevention activities within the framework of the national strategy for crime prevention was EUR 81,570 of which EUR 45,622 was allocated for prevention projects. In 2003 the police was mainly responsible for the dissemination of information among the general public. Also, recreational activities in different counties and camps for children of most vulnerable groups were organized in Harju, Saare and Võru counties. Special attention was paid to increasing the possibilities for alternative activities in problem areas such as Ida-Virumaa. Also, lectures on different aspects of drug-related violence and risks were given to parents, teachers and children. The police carried out activities in co-operation with local municipalities to contribute to the meeting of the objectives of the drug and alcohol prevention policy.

Prevention work focusing on the functions of the police was based on *the guidelines for criminal prevention of the police*. According to clause 17 of the document the police have to participate in local drug prevention campaigns, explain the threats of using and purchasing drugs, as well as the consequences of drug trafficking. The police are responsible for finding out the meeting places of drug addicts and dealers and take action to prevent illegal activities in public places.

#### **Assistance to Drug users in Prisons**

High level of drug use, particularly high proportion of injecting drug users of prison inmates, high level of prevalence of HIV and hepatitis B and C have been the main concerns of the state over last few years. Reduction of incidents of HIV, hepatitis B and hepatitis C among persons held in custody was focused on in the last reporting period. The situation in terms of prevention of spread of HIV and drug use improved in 2003 when compared to the previous reporting period.

Drug use in prison is defined as one of the key areas of the new Estonian drug strategy "*National Strategy on the Prevention of Drug Dependency 2004–2012*". The new Drug Strategy envisages development of operative control system in prisons to stop entering of drugs in prison and provision of conditions for systematic treatment and rehabilitation in prison (NSPDD 2004). According to the New Drug Strategy drug prevention is one of the priority areas of activity. Prison directors are responsible for the implementation of drug prevention in prison. Prison Department of the Ministry of Justice is responsible for the supervision of drug prevention work in prisons.

The fourth objective defined in the GFFATM programme managed by the NIHD is to prevent HIV transmission in prisons by means of increasing access of inmates to counselling and voluntary testing (eg improve the quality of pre- and post-test counselling in prisons) and distribution of condoms. NIHD initiated the provision of HIV-positive inmates with group counselling services within the framework of the GFFATM Programme.

As it was referred to in Chapter 1, the Punishment Implementation Division is responsible for the collection and registration of statistical data on prisoners and persons being detained as well as keeping records (see Chapter 1). In 2003 the division was actively involved in improving routine data collection on drug use and other risk behaviour in prison. In the reporting year the Punishment Implementation Division of the Ministry of Justice in close co-operation with the Estonian Drug Monitoring Centre explored possibilities for developing a routine data collection system on the basis of the Registry of Prisoners to get better overview on drug use among the prison population and provide data of good quality on drug use among prison population. As a result, new core variables were selected to evaluate drug use among the prison population in 2003. The Ministry of Justice made a decision to integrate these core variables into the list of data of the Prison Registry. However, the Ministry of Justice and the EDMC acknowledged that problems regarding the quality of data might be encountered as the inmates have good reasons for hiding their drug use.

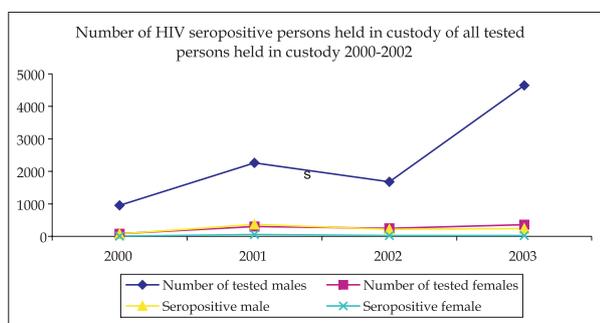
The HIV/AIDS epidemic which started among drug users in Estonian prisons in 2000 has been focused on over the past few years. The Ministry of Justice has acknowledged that reduction of prevalence of drug use can only be obtained through the development of the prison system.

In order to make drug prevention more effective the Ministry of Justice employed a drug prevention advisor to work for the Punishment Implementation Division as a person responsible for the supervision of drug prevention work, monitoring of the drug situation and responses in prison system.

According to the data provided by Merimetsa Reference Laboratory of West-Tallinn Central Hospital total of 5009 (M=4649; F=360) primary tests were made in prison of which 266 were seropositive (M=241, F=25) (see Figure 29). The figure indicates that the number of primary HIV tests increased 2.6 times showing significant improvement in terms of availability of testing in prisons in the reporting period. On one hand the improvement is

related to the establishment of new testing cabinets in prisons, on the other hand it shows increase in the awareness of prisoners of the possibilities and necessity of HIV testing.

**Figure 29.** The number of HIV seropositive tests in Prisons, 2000 - 2004.

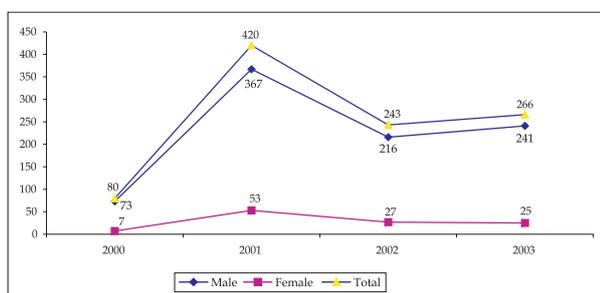


Source: Health Protection Inspectorate, 2000-2004.

Figures provided by the Merimetsa Reference Laboratory of West-Tallinn Central Hospital in 2003 confirmed that the number of new cases of HIV infection in prison had increased. In 2003 total of 266 cases of HIV infection were registered among the prison population contributing to one third of all newly registered HIV cases of that year (see Chapter 6). According to the data of Merimetsa Reference Laboratory of West-Tallinn Central Hospital, the number of prisoners reported to be seropositive increased in the reporting period.

Analysis of newly diagnosed HIV infections by age and gender showed that the majority of HIV infected were man. In 2003 women accounted for only 9.3% of all new cases of HIV infection registered in the prison system (see Figure 30).

**Figure 30.** Number of new cases of HIV infection by age and gender in 2000-2003.



Source: Merimetsa Reference Laboratory, 2003.

High level of drug use and significant number of IDUs among prisoners resulting in the spread of HIV-infection and hepatitis B and C among inmates called for an immediate intervention. This chapter gives an overview of the wide range of activities taken in Estonian prisons to tackle with the spread of HIV/AIDS and drugs in the reporting

period. The most important development in terms of responses targeting at drug users in criminal justice settings in 2003 was improvement of co-operation between the Ministry of Justice, NIHD and NGO. As indicated in the previous report, several NGOs such as the Anti-AIDS Association, AIDS prevention Centre, Social Rehabilitation Centre etc were very active in prevention work in prisons providing training on prevention of HIV, AIDS and STDs, distributing materials on drug misuse among prison inmates. In 2003 the NIHD funded a large number of HIV/AIDS projects in prisons. The National Institute for Health Development allocated total of EUR 6,919.5 (EEK 107,944) for carrying out a training programme of drug trainers in prisons. 23 trainees from 9 prisons were provided with training in the reporting year.

An international seminar "Drug use in Prison" was carried out within the framework of the training programme of drug instructors targeting at a wider audience in 9-10 October 2003. The main topic of the seminar was supply and demand reduction in prison.

Medical personnel of prisons having been trained according to the World Health Organization Programme provide prison inmates with counselling.

As a rule all offenders pass initial medical examination (incl testing for HIV and hepatitis) in Tartu, Tallinn or Maardu Prison when entering prison. In 2003 laboratories for primary HIV testing were established in 7 prisons (prison yearbook 2003). Pre- and post-test counselling service improved in terms of quantity as well as quality in the reporting year. Also, as mentioned earlier in this report access to counselling and testing improved significantly (see Chapter 7).

As at January 2004 the NIHD started to support provision of group counselling for HIV-positives in prisons within the framework of GFFAMT. The main service provider was the NGO Convictus offering psychosocial help and consultation for HIV-positive drug addicts in Estonia. NGO Convictus started to provide HIV positive prisoners with group counselling in Murru Prison already in 2002. NGO Convictus will offer counselling for inmates in Tallinn prison, Tartu prison, Harku prison, Ämari prison, Viljandi prison and Pärnu prison in 2004. Resources for the provision of HIV-positive prisoners with counselling are allocated by the NIHD within the framework of the GFFAMT Programme.

In 2003 assistance for drug users in prisons was also focusing on drug treatment. Drug treatment

in prison is poorly developed and it is necessary to pay more attention to this field of activity. There is only one treatment unit providing short-term detoxification treatment with methadone for about 15 drug addicts. The treatment unit is operating on the basis of the Prisons Central Hospital. Data on prevalence of drug use in prison in 2003 presented in Chapter 8 of this report indicated high level of drug use (eg high level of intravenous drug use) among the prison population suggesting there was an urgent need for improving and expanding drug

treatment services in prison settings. The number of drug-free departments in prisons did not increase in 2003. Thus, there was only one drug-free unit in Viljandi Prison. It has been planned to develop provision of detoxification treatment in prisons and implement substitution treatment programmes within the framework of the new Drug Strategy in the nearest future. The new Drug Strategy provides establishment of drug-free departments in other prisons.

## 10. Drug Markets

In 2003, synthetic drugs remained to be the most common drugs in terms of the number of seizures, followed by cannabis and opiates. Consumption of heroin decreased, at the same time fentanyl and home made poppy products gained more popularity. In 2002 heroin quantities were down considerably due to the decrease in the quality, however, during the reporting period the quality of heroin increased affecting the price of heroin. In 2003 many clandestine laboratories and local cannabis producers were discovered.

### • Availability and Supply

Four clandestine laboratories manufacturing synthetic drugs (mainly amphetamines) were discovered, including two large laboratories targeting the production primarily at foreign markets. Manufacturing of amphetamine had partly been transferred to Finland: liquid amphetamine was probably manufactured in Estonia, but very likely the final product (powder) was produced in Finland.

The use of heroin and fentanyl decreased in 2003, at the same time methylfentanyl gained popularity. Home-made poppy products as substitutes to heroin became more widespread again and illicit poppy cultivation created problems in some regions of the Eastern part of Estonia.

Hashish become more popular, also, production of cannabis herb in local plantations increased substantially in the reporting year as a result of the development of cultivation technology. In 2003, the police registered 32 cases of illicit cultivation of cannabis (of which 19 had least 6 plants). The production was targeted at local markets. Lately a new trend has developed – producers of cannabis plants use the state-owned land for the cultivation of cannabis to escape from criminal liability.

Cocaine import from Central America and Spain increased substantially in 2003. At the same time, the 'wholesale' price of cocaine fell to the level of USD 28.00 per gram of cocaine.

GHB remained rather popular in 2003, although the number of seizures and seized amounts decreased in comparison with the previous year.

The authorities confiscated several mail deliveries. Postal service was used to send spawn. This fact

indicates that hallucinogens were also rather popular.

In 2003, drug trafficking through and from Estonia had similar pattern than in previous years. Synthetic drugs were smuggled most actively. The majority of synthetic drugs produced in Estonia was targeted at Nordic countries. Locally produced cannabis herb (marijuana) was mainly sold on local markets.

According to the UNA 2003 data the main routes of illicit trafficking of drugs through or from Estonia in 2003 were the following:

- amphetamine from Estonia (local production), or from other countries (Lithuania, the Netherlands) via Estonia to Nordic countries;
- ecstasy from the Netherlands and Belgium via Estonia to Nordic countries and Russia, or from Estonia (local production) to Nordic countries;
- hashish from Spain via Estonia to Nordic countries;
- heroin from Central Asia via Russia and Estonia to Nordic countries;
- fentanyl from Russia via Estonia to Nordic countries;
- cocaine from Central America and Spain via Estonia to Russia and Nordic countries.

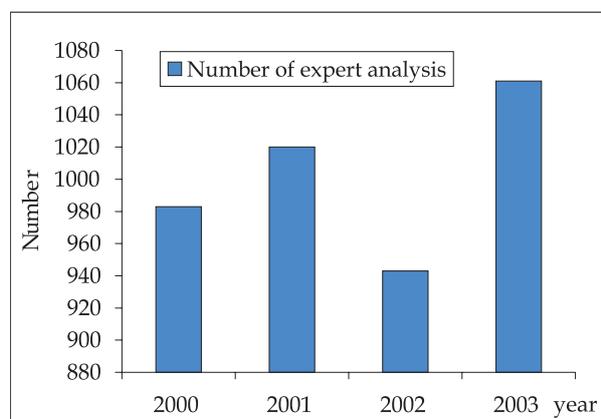
According to expert estimates transit may account for about 70% of all drug trafficking. Smuggling of synthetic drugs to Russia has increased in recent years as a result of increased prices on Russian markets. Estonian criminal groups are also participating in smuggling of marijuana and hashish from Spain directly to Nordic countries.

### • Seizures

According to the Narcotic Drugs and Psychotropic Substances Act the Estonian Forensic Service Centre is responsible for the final identification of the substances.

The Estonian Forensic Service Centre has made expert analysis of narcotic drugs within the period of 2000-2003, approximately 1000 expert analysis per year (943 – 1061) (see Figure 31).

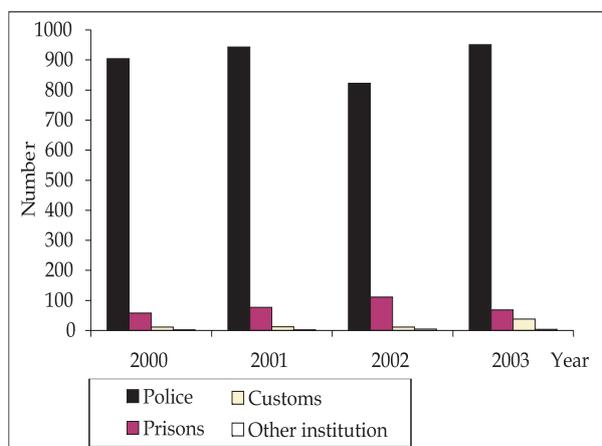
**Figure 31.** Total number of expert analysis of narcotic drugs and psychotropic substances in 2000-2003.



Source: Estonian Forensic Service Centre.

In 2003 the Estonian Forensic Service Centre made 1,061 expert analysis of narcotic drugs of which ca 90% were made by the resolution of the Police, ca 6% were ordered by the Prison Board and ca 4% by the resolution of the Customs Board (Figure 32).

**Figure 32.** Number of expert analysis of narcotic drugs made by the resolution of different agencies in 2000-2003.



Source: Estonian Forensic Service Centre.

In 2003 Tallinn Police Prefecture issued the largest number of resolutions for expert analysis of narcotic drugs - 54% (510 expert analysis), Central Criminal Police 11% (100 expert analysis), Narva Police Prefecture 8% (75 expert analysis) and Ida-Viru Police Prefecture 6% of the total number of expert analysis (53) issued by the Police.

In Estonia the most commonly used illicit drugs can be divided into three main groups - amphetamine type stimulants (ATS), cannabis products and opiates.

In 2003 amphetamine type stimulants accounted for the biggest number of the substances submitted for

the analysis in the Forensic Service Centre - stimulants occurred 616<sup>28</sup> times in the expert analysis of narcotic drugs - 426 seizures of amphetamine, 184 seizures of ecstasy (MDMA) (Figure 3). Total of 109,3 kg of amphetamine was confiscated which was over three times more than in 2002 (34,06 kg). One-time confiscation (96,7 kg) accounted for the majority of seizures, seizure of amphetamine produced according to Leuckard method in an illegal laboratory in Järva county contributed to the major share of the seized amphetamine.

The number of seized tablets (20,770 tablets) is 1,7 times bigger than in 2002 (12,019 tablets). Such big quantity of tablets can be explained by the discovery of a laboratory in Tallinn producing ecstasy (MDMA) tablets. 10,000 tablets and 153 kg of precursor PMK were seized. The amount of the latter was big enough to produce approximately 800,000 to 2 million ecstasy tablets (depending on the amount of MDMA in the tablets). In addition to the named laboratory another illegal laboratory was found in Lääne-Viru county in summer 2003 after having caught fire. It had probably produced the precursor (PMK) of ecstasy (MDMA).

438<sup>29</sup> seizures involving cannabis and products made from cannabis were carried out. 149 seizures of cannabis plants, 110 seizures of marihuana and 90 seizures of hashish were made in 2003. 12 illicit cultivation sites of cannabis of the size of more than 10 plants were discovered. The biggest cultivation sites had 262 plants. The quantity of confiscated cannabis was 41,5 kg accounting for half of the seized amount of cannabis in 2002. 32 kg was the biggest quantity of hashish seized at a time.

The third group of seized drugs was opiates - heroin, poppy and products made from poppy, methylphenanyl, morphine, opium and fentanyl. 331 seizures of opiates were carried out in 2003. Heroin accounted for the majority of seizures of opiates - 111 times, also, 93 seizures of methylphenanyl and 57 seizures of poppy plants or the parts thereof were carried out.

The number of expert analysis of heroin has been decreasing when compared to the year 2001: in 2001 - 295 expert analysis, 2002 - 86 expert analysis, 2003 - 111 expert analysis. Also, the quantity of confiscated drugs has dropped to 140 g compared to 1.163 kg and 3.78 kg in 2001 and 2002 respectively. Poor quality of heroine (the content of pure

<sup>28</sup> Number of occurrence does not include traces of the substance.

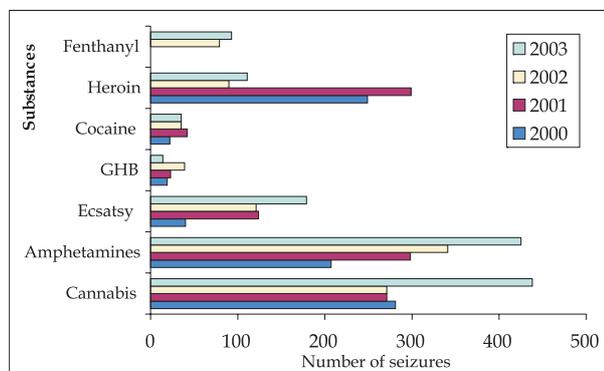
<sup>29</sup> Number of occurrence does not include traces of the substance.

heroin of 78% of confiscated heroine doses was only 10%) was compensated for by placing two new synthetic opiates on the market which were known as white Chinese, white Persian or synthetic heroin among drug users. In most cases the drugs sold under such names appeared to be either fentanyl or metylphenantyl. In 2002 fentanyl accounted for the majority of the seizures of the drugs of this group (68 expert analysis), seizures of metylphenantyl were rare (11 expert analysis) (see Figure 33). In 2003, on the other hand, seizures of metylphenantyl were frequent on our drug market (93 expert analysis), being equal to the number of seizures of heroin (111 expert analysis) whereas seizures of fentanyl were not made.

In addition to the above named three substance groups 35 expert analysis of cocaine of 30,5 kg were made. The number of seizures of cocaine was the same as in 2002, however, a significant quantity of cocaine (30,5 kg) was seized at a time.

The number of seizures of Gamma Hydroxybutyrate dropped considerably in comparison with the previous year – only 14 seizures, in the quantity of 9,91 kg compared to 39 seizures and 24,66 kg in 2002.

**Figure 33.** Number of seizures of some type of narcotic drugs in 2000-2003.



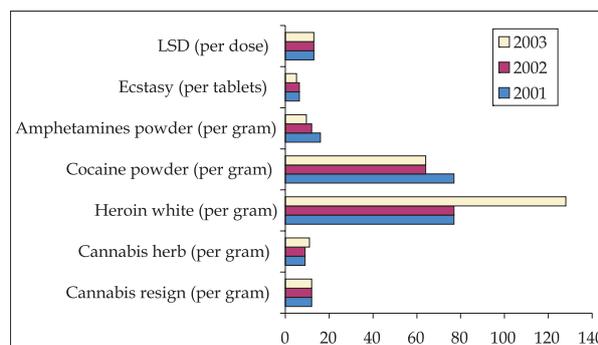
Source: Estonian Forensic Service Centre, 2004.

### • Price and purity

The price of heroin increased from 77 euros per gram in 2002 to 128 euros per gram in 2003 (the price varied from EUR 77 to EUR 141 per gram), while the price of Cannabis resign and LSD remained on the same level as in past 3 years. Surprisingly the price per gram of heroine was even higher than that of cocaine. Figure 34 shows that seizures of heroine decreased. According to the specialist opinion the reason for an increase in the price of heroine was limited availability of heroine on the market, also, the purity of heroine was higher. In 2002 the purity of heroine decreased remarkably and fenta-

nyl gained popularity on the Estonian drug market. In 2003 the purity of heroine increased again to 37 on average varying from 0.2 to 63. According to another expert opinion the price and purity of heroine were related to the changes in Middle East and TALIBAN.

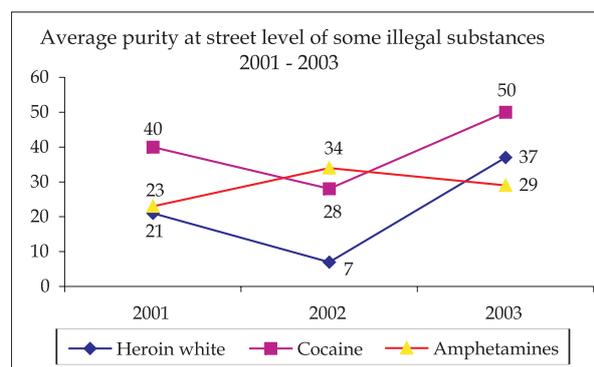
**Figure 34.** Street prices of some illegal substances in EUROS.



Source: Tallinn Police, 2004.

Contrary to amphetamines the purity of cocaine increased during the reporting period (see Figure 35). Amphetamine gained more popularity and to some extent replaced heroine. The 'wholesale' price of amphetamine remained at the same level for several years (1923–2243 EUR/kg) and its purity increased. At street level, the price of amphetamine dropped from 200 EEK/g to the 6,4 EUR/g in Ida-Viru County. The price of locally produced ecstasy was about 0,8–0,96 EUR/tablet for large amounts and 1,2–1,9 EUR/tablet for small amounts.

**Figure 35.** Average purity at street level of some illegal substances 2001-2003.



Source: Estonian Forensic Service Centre, 2004.

## PART B - Selected issues

### 11. Buprenorphine, treatment, misuse, and prescription practices

#### Description of new developments

Buprenorphine has been used in Estonia as an alternative form of opiate-maintenance and substitution treatment since the year 2003. On December 6, 2002 the State Agency of Medicines granted a Pharmaceutical Company Schering-Plough a licence for selling Subutex sublingual tablets 0,4 mg, 2 mg and 8 mg N7, however, the licence for the prescription of Subutex became valid on March 12, 2003 (State Agency of Medicines, 2004).

According to the decree of the Minister of Social Affairs No 90, 20 July 2004, amendments were made to the decree No 138 of the Minister of Social Affairs, 26 November 2002 "Regulation of prescribing and dispensing of pharmaceuticals and the form of prescription". Also, regulation of the Minister of Social Affairs No 39, 4 November 1997, "Procedure for handling of narcotic drugs, psychotropic substances and substances subject to special recording for medicinal and scientific purposes and approval of the procedure for related recording and reporting and the schedule of precursors.

Prior to the introduction of changes in the legal act Buprenorphine was classified under Schedule III of the Narcotic Drugs and Psychotropic Substances Act, whereas the doses were not limited by the prescription. As at July 2003, Buprenorphine and Flunitrazepam are classified under Schedule I According to the decree of the Minister of Social Affairs No 90, 20 July 2004 limits to the doses of Flunitrazepam and Buprenorphine prescribed for a single person have been introduced. The Estonian Association of Psychiatrists has supported the establishment of additional restrictions for the prescription of pharmaceuticals containing Buprenorphine. According to their proposal the maximum permitted quantity dispensed to a person on the basis of a prescription is "0,112 grams" instead of "1 original". Instead of 50 tablets it is possible to prescribe 30 tablets of Flunitrazepam (1 original) and Buprenorphine. Data provided by the State Agency of Medicines shows that as a result of this change prescribing of Rohypnole decreased and prescribing of Subutex increased in the reporting period (see misuse of buprenorphine in the chapter on selected Issues). According to the decree of the Minister of Social Affairs No 90, 20 July 2004, only psychiatrists providing psychiatric

services in in-patient psychiatric hospitals can prescribe Buprenorphine<sup>30</sup>.

Pharmaceuticals containing Buprenorphine can be prescribed only in case an opioid dependent drug user participates in outpatient drug treatment in a psychiatric hospital for at least 5 days.

#### Treatment with buprenorphine

According to the new Drug Strategy substitution treatment is considered an important measure for targeting the problems of drug users (National Drug Strategy 2004–2012)<sup>31</sup>.

As it was mentioned earlier in this chapter Buprenorphine has been suggested for the treatment of heroine dependence since 2003, however, as data on drug treatment is not available, it is hard to estimate to what extent Buprenorphine treatment has been used in Estonia. There are some indications that use of Buprenorphine in the treatment of heroin dependence has increased in Estonia. Statistical data provided to the EDMC by the State Agency of Medicines showed that in 2003 total of 5,107 original Subutex sublingual tablets were prescribed of which 1754 originals of 2 mg N7 and 3350 originals of 8mg N7 Subutex sublingual tablets. Also, that fact that in the first half year of 2004 total of 9,739 original Subutex sublingual tablets were prescribed of which 972 originals of 2 mg N7 and 8767 originals of 8mg N7 (State Agency of Medicines, 2004) indicates that the use of Buprenorphine has increased compared to the previous year.

Statistical data on Buprenorphine treatment as well as on the number of patients receiving buprenorphine substitution treatment are not available; therefore, it is not possible to provide comparison of the characteristics of the patients receiving buprenorphine substitution treatment in Estonia to those receiving methadone treatment.

As it was mentioned earlier, according to the amendments to the decree of the Minister of Social Affairs, Buprenorphine substitution treatment can only be provided by a psychiatrist in-patience psychiatric hospitals since July 2004 (see above).

<sup>30</sup> In Estonia there are total of 13 out-patient hospitals granted with an activity license for the provision of out-patience psychiatric services (Wismari Hospital, Foundation North - Estonia Regional Hospital, Foundation Ahtme Hospital, Põlva Hospital, Jõgeva Hospital, Kuressaare Hospital, Narva Hospital, Rapla County Hospital, Läänemaa Hospital, Pärnu Hospital, Tartu University Hospital, Viljandi Hospital, South Estonian Hospital).

<sup>31</sup> Estonia is using the same definition of problem drug use as the EMCDDA (injecting drug use or long duration/ regular use of opiates, cocaine or amphetamines).

Therefore, it is possible to provide only preliminary results of one small-scale treatment programme with a duration of 11 months targeted at heroin-dependant children and young people aged 15-24, which was carried out in Tallinn Children's Hospital in Estonia <sup>32</sup>. The treatment programme was financed by Tallinn City Government. Criteria for the admission to the treatment programme were the following: opioid dependent IDU at the age of 15-24 able to participate in the drug treatment programme, history of use of opiates for at least 5 years, other somatic diseases such as hepatitis B, C, HIV and a criminal record (Lehtmets 2004).

Patients aged 15-24 (n=13 of which 5 were 15-18 year olds and 8 19-24 year olds) meeting the criteria of opiate dependence were allocated a daily Buprenorphine dose from 10 mg to 0,4 mg. The treatment commission including a psychiatrist, family doctor, social worker and psychologist selected all the patients. The patients were provided with individual counselling by a psychiatrist on weekly basis and social counselling by a social worker 1-2 times a week. The patients submitted random urine samples for analysis to detect illicit drug use. As at 31 December 2003, 10 patients were transferred to Buprenorphine maintenance programme and 3 patients participated in the Buprenorphine substitution programme. According to the preliminary results by the end of the second phase of the pilot buprenorphine treatment programme in 2004, 4 patients had discontinued the treatment programme for the following reasons: parent's resistance, lack of motivation and support from family, 1 patient was imprisoned for a criminal offence committed prior to the treatment programme and 1 patient was not able to comply with the procedures of the drug treatment programme (Harjo 2004 b). It is difficult to draw any conclusions based on the preliminary results of the treatment programme. However, the preliminary results of the study indicated that Buprenorphine treatment in combination with psychological counselling, application of methods of social work (e.g counselling) and involvement of parents in the treatment process are very efficient and should be used in the treatment of heroin dependent patients. The preliminary results of the Buprenorphine-assisted treatment showed improvement in the quality of life of patients - 2 patients started to study at school, 1 client went on maternity leave. The majority of parents participated actively in the programme.

So far only a few trainings on Buprenorphine-assisted treatment have taken place in Estonia. In 2003 Schering-Plough organized a training on treatment with Buprenorphine for psychiatrists to introduce a new approach in the treatment of opioid dependence in Estonia and provide information on Subutex and its pharmacology; Trainings will continue next year. The training programme of Schering-Plough covers the following topics: transition from methadone to Buprenorphine precipitated withdrawal, transition from heroine to Subutex, treatment of opioid - dependent clients and substitution treatment, effective substitution treatment with Subutex etc.

### Misuse of Buprenorphine

It is difficult to estimate the extent of misuse of Buprenorphine in Estonia as data on Buprenorphine misuse has not been provided by general population surveys or specific studies. Also, centralized treatment data on clients receiving Buprenorphine treatment are not available. However, a number of hospitals providing drug treatment started to prescribe a partial opiate - receptor agonist buprenorphine in 2003. As a result, it was necessary to impose additional restrictions for the prescribing and dispensing of pharmaceuticals containing Buprenorphine. Additional restrictions for the prescribing of Buprenorphine have been introduced to limit the export of the substance, mainly to Finland, as well as avoid illegal misuse of the above-mentioned pharmaceuticals containing Buprenorphine. In 2003 the Ministry of Social Affairs and Health of Finland appealed to the Ministry of Social Affairs of Estonia with an official note. The Finnish authorities referred to the problem of Subutex misuse with respect to Finnish Citizens who regularly brought Buprenorphine from Estonia. The Finnish Government stressed the need for closer cooperation with Estonian authorities to introduce measures for more efficient control of the import of Subutex (letter of 7 May 2003; letter of 29 December 2003).

Inspectors of the State Agency of Medicines and Health Care Board confirmed the misuse of pharmaceuticals containing Buprenorphine.

In 2003 the Ministry of Social Affairs of Estonia made considerable efforts to get the use of Subutex under control. Restrictions with regard to prescribing and dispensing of Subutex were introduced and the Ministry of Social Affairs and Health of Finland was officially informed of the measures taken (4 June 2003 No 1-7/2537).

<sup>32</sup> See <http://www.stamet.ee/img/user/toetused%20tervish.projektid.doc>

## 12. Alternatives to prison targeting at drug using offenders

No new information available

## 13. Public nuisance: definitions, trends in policies, legal issues and intervention strategies

The term public nuisance has not been correctly defined in Estonia. According to our interpretation “public nuisance” means endangering the security of a community and opinion of the general public about the danger posed by drug addiction.

A study involving questions about security was conducted among school students of the 8<sup>th</sup> grade in schools of six districts of Tallinn. The study was

carried out in cooperation with the *Health Care and Social Work Department of Tallinn City Government and the Department of Sociology of Tallinn Pedagogical University*. Parents and schoolchildren participated in the survey. 49% of the parents considered their child to be threatened by drug addicts near their home and 49% of the parents considered the neighbourhood of the school and the school itself threatening for their child in terms of drug addiction. Although the level of danger from drug addicts near school and home was the same, danger from drug addicts near school had a higher ranking. Robbery was named as the most threatening factor near school and drug addiction was the second in ranking (Kruusvall *et al* 2004).

## REFERENCES

- Alkoholismi ja narkomaania ennetamise riikliku programmi 2003. aasta aruanne. Tervise Arengu Instituut. Seletuskiri (2004).
- Alkoholismi ja narkomaania ennetamise riikliku programmi 2003. aasta aruanne.
- Allaste A.-A. (toim) 2004. *Trendid koolinoorte uimastitaroitamises*. Tallinn: TPÜ kirjastus.
- Aruanne (2004). Tallinna Sotsiaal- ja Tervishoiuamet (avaldamata).
- Eesti statistika aastaraamat. Statistical Yearbook of Estonia. 2004. Statistikaamet. Statistical Office of Estonia.
- ESPAD 1997. *The 1995 ESPAD Report. Alcohol and other Drug Use among Students in 26 European Countries*. Stockholm, The Swedish Council for Information on Alcohol and other Drugs, CAN.
- ESPAD 2000. *The 1999 ESPAD Report. Alcohol and other Drug Use among Students in 30 European Countries*. Stockholm. The Swedish Council for Information on Alcohol and other Drugs, CAN.
- Eesti vanglasüsteemi aastaraamat 2003. (2003). Justiitsministeerium.
- Global Fund to Fight AIDS, Tuberculosis and Malaria. Main goals and accomplishments of activities. (2004. NIHD. Unpublished).
- Hansson L. Valikud ja võimalused. Argielu Eestis aastatel 1993-2003. TPÜ kirjastus. Tallinn 2004.
- Harjo, A. Ettekanne Shering-Plough Subutex koolitusel, Tallinn, 21. oktoober 2004.
- Harjo, A. Tallinna linna noorte opioidsoõltlaste buprenorfiini – asendus/võõrutusravi. Ettekanne 9. november 2004.
- Health Insurance Fund, 2004. Statistical Data on MBD caused by the use of illegal drugs (ICD-10) *Data ordered from Health Insurance Fund by Estonian Drug Monitoring Centre*.
- HIV/AIDSi ennetamise programmi aastateks 2002–2006 (RT 2002, 13, 173).
- HIV/AIDSi ennetamise programmi aastateks 2002–2006 sisuline ja rahaline aruanne 2003. aastaks plaanitud tegevuste lõikes. Tervise Arengu Instituut (2004).
- HIV/AIDSi ennetus Eestis (2004). (Ülevaade, avaldamata).
- HIV nakkuse uuring 2002-2003. Merimetsa Reference Laboratory of West-Tallinn Central Hospital.
- Kruusvall J, Tomson L. Tallinna kuue linnaosa koolide 8. klasside õpilaste turvalisuse ja riskikäitumise uuringu tulemused. Tallinn 2004. Tallinna Sotsiaal- ja Tervishoiuamet ja Tallinna Pedagoogikaülikooli sotsioloogia osakond.
- Kõre J. Kodutus ja sotsiaaltöö - Eesti lahendused. Sotsiaaltöö. 2003, 1.
- Laastik, L 2004. (a) Narkomaania representatsioonid Eesti suuremates päevalehtedes 2002. aastal. Avaldamata. (<http://eusk.tai.ee>)
- Laastik, L 2004. (b) Narkomaania representatsioonid Eesti suuremates päevalehtedes 2003. aastal. Avaldamata.
- Lehtmets A, 2004 presentation: Methadone substitution treatment in Estonia. Hotel Central 28.04.04
- Lõhmus L, Trummal A, Harro M. (a) Knowledge, attitudes and behaviour related to HIV / AIDS among Estonian youth. Tallinn. 2003 (unpublished).
- Lõhmus, L, Trummal, A., (b) (2004). Süstlavahetuspunktide külastajate riskikäitumine ja teadmised HIV levikutest: esmas- ja korduvkülastajate analüüs (unpublished report on syringe exchange).
- Ministry of Social Affairs and Health of Finland (2004). Copy of the letter of 7 May 2003 to the Ministry of Social Affairs of Estonia.

Ministry of Social Affairs and Health of Finland (2004). Copy of the letter dated 29 December 2003 to the Ministry of Social Affairs of Estonia.

Ministry of Social Affairs of Estonia (2004). Copy of the letter No 1-7/2537 to the Ministry of Social Affairs and Health of Finland, 4 June 2003.

National Report on Drug Situation (2003). National Institute for Health Development. Estonian Drug Monitoring Centre. Tallinn 2003.

National Report on Drug Situation (2002). Institute of Experimental and Clinical Medicine Estonian Drug Monitoring Centre. Tallinn 2003.

Narkomaania ja alkoholismi programmi tegevusaruanne 2003. (2004). NIHD (unpublished).

Sarapuu, M. (2003) Drug Prevention and Problems in Estonian prison system. Connections. Issue 15, May 2004.

Tallinna Sotsiaal- ja Tervishoiuameti uimasti ja AIDSi ennetusalaseks tegevuseks eraldatud toetused 2003. 11 mail 2004 toimunud teabepäeva materjalid (unpublished).

Vares T, Raal R., Tammaru, T, Kuivjõgi, K. Tervisevaldkonna Registrite Arengukava (2004). Tallinn

Voigtländer S, Abel K, (2004) External Evaluation of System Wide Cooperation and Capacity-Building within the framework of the Estonian HIV/AIDS Prevention System (unpublished).

#### Internet sources:

AS Lääne- Tallinna Keskhaigla Psühhiaatriakesuse opiaatsõltlaste asendus- ja võõrutusravi üksus <http://www.ltkh.ee/index.php?id=782>

Amended by the Riigikogu on 14 April 2004, entered into force 1 May 2004

Health Services Organisation Act. State Gazette I 2001, 50, 284

[http://www.legaltext.ee/et/andmebaas/ava.asp?tyyp=SITE\\_ALL&ptyyp=I&m=000&query=Health+Services+Organisation+Act+&nups.x=9&nups.y=16](http://www.legaltext.ee/et/andmebaas/ava.asp?tyyp=SITE_ALL&ptyyp=I&m=000&query=Health+Services+Organisation+Act+&nups.x=9&nups.y=16)

[http://www.riik.ee/en/valitsus/3r\\_kalitsioon\\_eng.html#\\_Toc39046952](http://www.riik.ee/en/valitsus/3r_kalitsioon_eng.html#_Toc39046952)

Imprisonment Act. State Gazette I 2000, 58, 376)

[http://www.legaltext.ee/et/andmebaas/ava.asp?tyyp=SITE\\_ALL&ptyyp=I&m=000&query=Health+Services+Organisation+Act+&nups.x=9&nups.y=16](http://www.legaltext.ee/et/andmebaas/ava.asp?tyyp=SITE_ALL&ptyyp=I&m=000&query=Health+Services+Organisation+Act+&nups.x=9&nups.y=16)

Kruuda R, Jesse M, Viik K(2004), "HIV/AIDSi ennetustegevuse hindamine Eestis 2004". PRAXISE Toimetised 16/2004.

[http://www.praxis.ee/data/toimetised\\_16\\_2004\\_templatis0.pdf](http://www.praxis.ee/data/toimetised_16_2004_templatis0.pdf)

National Strategy on the Prevention on Drug Dependency 2004-2012.

<http://www.sm.ee/est/pages/index.html>

MTÜ Convictus kodulehekülg <http://www.convictus.ee>

Official Statistics Act (State Gazette I 2004,30,204)

[http://estlex.ee/estlex/kehtivad/AktDisplay.jsp?id=22252&akt\\_id=22252](http://estlex.ee/estlex/kehtivad/AktDisplay.jsp?id=22252&akt_id=22252)

Personal Data Protection Act (State Gazette I 2003, 26, 158)

[http://www.legaltext.ee/et/andmebaas/ava.asp?tyyp=SITE\\_ALL&ptyyp=I&m=000&query=personal+data+protection+act](http://www.legaltext.ee/et/andmebaas/ava.asp?tyyp=SITE_ALL&ptyyp=I&m=000&query=personal+data+protection+act)

Riigikogu probleemkomisjoni HIV, AIDSi ja narkomaania ennetustegevuse tõhustamiseks istungi protokoll nr. 2 - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042610001&login=proov&password=&system=ems&server=ragne1>

Riigikogu probleemkomisjoni HIV, AIDSi ja narkomaania ennetustegevuse tõhustamiseks istungi protokoll nr. 3 - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042610002&login=proov&passwd=&system=ems&server=ragne1>

Riigikogu probleemkomisjoni HIV, AIDSi ja narkomaania ennetustegevuse tõhustamiseks istungi protokoll nr. 5 - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042610003&login=proov&passwd=&system=ems&server=ragne1>

Riigikogu probleemkomisjoni HIV, AIDSi ja narkomaania ennetustegevuse tõhustamiseks istungi protokoll nr. 4 - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042740008&login=proov&passwd=&system=ems&server=ragne1>

Riigikogu probleemkomisjoni HIV, AIDSi ja narkomaania ennetustegevuse tõhustamiseks istungi protokoll nr. 6 - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042740010&login=proov&passwd=&system=ems&server=ragne1>

Riigikogu probleemkomisjoni HIV, AIDSi ja narkomaania ennetustegevuse tõhustamiseks istungi protokoll nr. 8 - <http://web.riigikogu.ee/ems/saros-bin/mgetdoc?itemid=042610004&login=proov&passwd=&system=ems&server=ragne1>

Tallinn Social Welfare and Health Care Department [http://www.tallinn.ee/eng/departments/social\\_welfare\\_and\\_health\\_care\\_department](http://www.tallinn.ee/eng/departments/social_welfare_and_health_care_department)

Tallinn Rugby Club Youth Team <http://www.rugby.ee>

Uimastite ja HIV/AIDSi leviku ennetamise tegevuskava Tallinnas aastateks 2003-2007 <http://tallinn.andmevara.ee/oa/page.Tavakasutaja?c=1.1.1.1&id=91729>

Ülevaade Tallinna Sotsiaal-ja Tervishoiuameti poolt 2003.a. finantseeritud narkomaania ja HIV/AIDSi ennetusprojektidest

<http://www.stamet.ee/img/user/toetused%20tervish.projektid.doc>

## TABLES AND FIGURES

<b>Table 1.</b> Breakdown of ADAPP funds of the financial year 2003 (EUR) by activities (Source: Estonian Alcohol and Drug Abuse Prevention Programme 2004). .....	12
<b>Table 2.</b> Use of illicit drugs among population aged 15-64, % (Source: Population survey 2003, standard table 01 2004). .....	18
<b>Table 3.</b> Use of illicit drugs among population aged 15-34, % (Source: Population survey 2003, standard table 01 2004). .....	18
<b>Table 4.</b> Number of teachers trained according to the UNDCP study book on social skills (Source: Merike Kull 2004). .....	22
<b>Table 5.</b> Activities financed by the ADAPP in 2003 (Source: Estonian Institute for Health Development 2004). .....	22
<b>Table 6.</b> Institutions having carried out prevention projects. (Source: Estonian Institute for Health Development 2004). .....	22
<b>Table 7.</b> Breakdown of expenditures of the ADAPP in the area of treatment in 2003, EUR (Source: National Institute for Health Development 2004). .....	29
<b>Table 8.</b> Breakdown of expenditures of the ADAPP in the area of treatment in 2003, EUR (Source 1: Tallinn Social Welfare and Health Care Department, 2004, Source 2: grants allocated for drug and HIV/AIDS prevention activities by Tallinn Social and Health Care Board in 2003). .....	29
<b>Table 9.</b> Number of drug-related crimes (main types) registered by the police, 2003 (Source: Police Board 2004). .....	42
<b>Table 10.</b> The share of criminal offences committed by offenders with a history of drug offence*, 2003 (% of cleared offences of respective type of crime) (Source: Police Board 2004). .....	43

<b>Figure 1.</b> Budget for ADAPP (EUR). (Source: Estonian Alcohol and Drug Abuse Prevention Programme 2004). .....	12
<b>Figure 2.</b> Expenditure on treatment 1998–2003 (EUR). (Source: Financial Report on the ADAPP budget 2004). .....	13
<b>Figure 3.</b> Funds allocated for HIV/AIDS prevention on national level (Source: National HIV/AIDS Prevention Programme). .....	13
<b>Figure 4.</b> Lifetime prevalence of drug use by age groups and gender in 2003. (Source: Population survey 2003, standard table 01 2004). .....	17
<b>Figure 5.</b> Lifetime prevalence of cannabis use. (Source: ESPAD survey 2003). .....	18
<b>Figure 6.</b> Share of school students with lifetime prevalence of use of amphetamine or ecstasy. (Source: ESPAD survey 2003). .....	19
<b>Figure 7.</b> Lifetime prevalence and repeated use of illicit drugs among schoolchildren aged 14-8 and young people aged 19–24. (Lõhmus et al. 2003). .....	20
<b>Figure 8.</b> Lifetime prevalence of drug use among schoolchildren aged 14–18 and young people aged 19–29 by gender. (Source: Lõhmus et al, 2003). .....	20
<b>Figure 9.</b> Lifetime prevalence of illicit drug use among schoolchildren aged 14–18 and young people aged 19-20 by type of residence (%). (Source: Lõhmus et al, 2003). .....	20
<b>Figure 10.</b> Number of persons covered by health insurance receiving treatment due to their mental and behavioural disorders caused by the use of illegal drugs 2000–2003 (Source: Health Insurance Fund, 2004). .....	26
<b>Figure 11.</b> Breakdown of the cost of treatment of persons covered by health insurance by type of mental and behavioural disorders caused by the use of illegal drugs in 2003 by EUR. (Source: Health Insurance Fund 2004). .....	26
<b>Figure 12.</b> Breakdown of drug treatment invoices by type of mental and behavioural disorders caused by the use of illegal drugs 2000-2003 by EUR (Source: Health Insurance Fund 2004). .....	27
<b>Figure 13.</b> Number of newly registered HIV infections 1998–2003. (Source: Health Protection Inspectorate 2004). .....	31
<b>Figure 14.</b> Breakdown of newly diagnosed cases of HIV infection by regions of Estonia in 2000–2003. (Source: Health Protection Inspectorate 2004). .....	32
<b>Figure 15.</b> Breakdown of newly diagnosed cases of HIV infection by age and gender in 2003. (Source: Health Protection Inspectorate 2004). .....	32
<b>Figure 16.</b> Breakdown of newly diagnosed cases of HIV infection among 15–29 year olds by gender (%). (Source: Health Protection Inspectorate 2004). .....	32
<b>Figure 17.</b> Breakdown of newly diagnosed cases of HIV infection by age and gender in prison 2000–2003. Source: Foundation West – Tallinn Central Hospital, Reference Laboratory of HIV Infection. .	33
<b>Figure 18.</b> Breakdown of newly diagnosed cases of AIDS in 1992–2003. (Source: Health Protection Inspectorate 2004). .....	33
<b>Figure 19.</b> Breakdown of newly diagnosed cases of hepatitis B infection in 2000–2001. (Source: Health Protection Inspectorate 2004). .....	33
<b>Figure 20.</b> Breakdown of newly diagnosed cases of hepatitis C infection in 2000- 2001. (Source: Health Protection Inspectorate 2004). .....	33
<b>Figure 21.</b> Breakdown of TB cases among HIV infected persons 1999–2003. (Source: Tuberculosis Registry, 1999-2003). .....	34
<b>Figure 22.</b> Number of persons vaccinated for HBV in 2001-2003. (Source: Health Protection Inspectorate, 2004.). .....	36
<b>Figure 23.</b> Number of HIV tests 2000–2003. (Source: Tallinn Merimetsa Hospital, 2000-2003). .....	37

<b>Figure 24.</b> Unemployment rate by age group, 1995, 2000-2003.(Source: Statistical Office of Estonia 2004). .....	41
<b>Figure 25.</b> Unemployment rate by gender, 1995, 2000-2003 (Source: Statistical Office of Estonia 2004). ...	41
<b>Figure 26.</b> Number of drug offences registered by the police (crimes and administrative offences or misdemeanours), 1997-2003. (Source: Police Board 2004). .....	42
<b>Figure 27.</b> Use of illicit drugs prior imprisonment in 2003. (Source: Ministry of Justice 2004).....	43
<b>Figure 28.</b> Regular and intravenous drug use among the prison population by type of substance in 2003. (Source: Ministry of Justice, 2003).....	44
<b>Figure 29.</b> Number of HIV seropositive tests in prisons, 2000 – 2004 (Source: Health Protection Inspectorate, 2000-2004).....	47
<b>Figure 30.</b> Breakdown of new cases of HIV infection by age and gender in 2000 – 2003. (Source: Merimetsa Reference Laboratory, 2003). .....	47
<b>Figure 31.</b> Number of expert analysis of narcotic drugs and psychotropic substances in 2000-2003. (Source: Estonian Forensic Service Centre 2004). .....	50
<b>Figure 32.</b> Number of expert analysis of narcotic drugs made by the resolution of different agencies in the 2000-2003. (Source: Estonian Forensic Service Centre 2004).....	50
<b>Figure 33.</b> Number of seizures of some type of narcotic drugs in 2000-2003. (Source: Estonian Forensic Service Centre 2004).....	51
<b>Figure 34.</b> Street prices of some illegal substances in EUROS (Source: Tallinn Police 2004).....	51
<b>Figure 35.</b> Average purity at street level of some illegal substances 2001-2003. (Source: Estonian Forensic Service Centre 2004).....	51

---

## LIST OF ABBREVIATIONS

ADAPP - Alcoholism and Drug Abuse Prevention Programme  
AIDS - Acquired Immunodeficiency Syndrome  
AISC - AIDS Information and Support Centre  
ARV - Anti-retrovirus  
ATS - Amphetamine type stimulants  
EDMC - Estonian Drug Monitoring Centre  
EMCDDA - European Monitoring Centre for Drugs and Drug Addiction  
ESPAD - European School Survey on Alcohol and Other Drugs  
FINESTO - Finnish Task Force of the Estonian and Finnish Police  
GHB - Cammahydroxybutyrate  
HAV - Hepatitis A Virus  
HBV - Hepatitis B Virus  
HCV - Hepatitis C Virus  
HIV - Human Immunodeficiency Virus  
IDU - Injecting Drug User  
IISS - Institute of International and Social Studies  
MBD - Mental and Behavioural Disorders  
MDA - 3,4 Methylenedioxyamphetamine  
MDEA - 3,4 Methylenedioxyethylamphetamine  
MDMA - 3, 4 Methylenedioxymethamphetamine  
MSM - men having sex with men  
MsoA - Ministry of Social Affairs  
NDPSA - Narcotic Drugs and Psychotropic Substances Act  
NSCP - National Strategy for Crime Prevention  
NSPDD - National Strategy on the Prevention on Drug Dependency 2002-2012  
PC - Penal Code  
PLWHA - People living with HIV and AIDS  
RV - Repeated Visitor  
PV - Primary Visitor  
SEP - Syringe Exchange Point  
STI - Sexually Transmitted Infectious  
TB - Tuberculosis  
TDI - Treatment demand indicator  
TSWHCD - Tallinn Social Welfare and Health Care Department (TSWHCD)  
UNDCP - United Nations Drug Control Programme  
WHO - World Health Organization