European Monitoring Centre
for Drugs and Drug Addiction

2007 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point

MALTA

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

REITOX
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SUMMARY

Chapter 1 – National Policies and Context

Legal framework

As has been reported in the previous national reports, the principal pieces of legislation dealing with substance abuse in Malta are the Medical and Kindred Professions Ordinance (Cap.31) concerning psychotropic drugs, and the Dangerous Drugs Ordinance (Cap.101) concerning narcotic drugs.

New Developments

A 2006 Bill entitled 'An act to amend the Code of Police Laws, (Cap.10)' provides for penalties for any person who sells to, or purchases alcohol on behalf of a minor or serves or supplies alcohol to a minor in any shop, street or public place. Likewise, a minor may not consume, procure or possess alcohol in any such places.

Legal Notice 135 of 2006 and Legal Notice 127 of 2007 amend the Medical and Kindred Professions Ordinance (Cap.31) and regulate the new psychoactive substances 1-benzylpiperazine (BZP) and 1-(3-chlorophenyl)piperazine (mCPP).

A first Draft National Drugs Policy (2007) has been drawn up and at the time of submission of this report, is going through its final re-drafting following a consultation period of some three months. In essence, this first drugs policy provides the framework through which a co-ordinated effort may be better achieved to reduce drug use in the first place, help those who started to use drugs and enable those who have succumbed to drug addiction to be better served.

Budget and Public Expenditure

Overall the total government funding involved is of the order of approximately 2.1 million Maltese lira per annum or some 5 million Euros. More funds this year have been allotted to the Ministry for the Family and Social Solidarity in order to put in place the new Drug and Alcohol Co-ordinating Unit.

Chapter 2 – Drug Use in the Population

Current trends show an increase in the prevalence of illicit drug use since the last general population survey conducted in 2001. A 2006 survey, conducted among 18-24 year old students in full time education, shows that 22% of students had ever smoked cannabis, with 7% admitting to current use. As regards lifetime use of other drugs, 12% of students had used anabolic steroids, 11% magic mushrooms, 10% tranquillisers, 7% inhalers, 6% cocaine and 5% ecstasy. A high lifetime prevalence of alcohol use (96%) and current alcohol use (79%) was also reported. Binge drinking was reported by 64% of current drinkers.

Chapter 3 – Prevention

Universal Prevention

School-based Prevention focuses on life skills such as self esteem, peer pressure and building confidence to be able to make sensible decisions regarding non-use of substances and learning skills to be able to refuse substances offered. School-based prevention programmes are provided by Sedqa, Caritas and the Education Division's Anti Substance Abuse Unit in Malta. Prevention in Gozo is organised by the OASI Foundation.

Family-based Prevention programmes generally tackle topics related to parenthood such as leadership styles, communication, child development and discussions on drug and alcohol abuse in an interactive environment.

Community-based Prevention programmes primarily target families and youth in different environmental settings such as local councils, youth organisations, religious societies, parishes and social and political clubs. Community and Church activities, drug awareness talks, exhibitions, concerts and drug-free marches are organised at specific times of the year and aimed at targeting the general public.

Workplace-based programmes are provided by Sedqa and Caritas. Caritas introduced their Employee Assistance Programme (EAP) in local industries in 1992. Sedqa' s Substance Abuse-Free Employee Programme (S.A.F.E.) was first implemented within Maltese enterprises in 1996.

Selective Prevention

Interventions are mainly school-based and focus on students with high levels of absenteeism and those at risk of dropping out of school early. Other interventions include some outreach work targeting youth from disadvantaged neighborhoods and making contacts at parties, events and venues where drugs are known to be available.

Indicated Prevention

The main target groups for indicated prevention are youth in vulnerable schools, juvenile inmates in prison settings, young offenders (via the arrest referral scheme and some outreach in prison) and individual interventions through immediate intervention services occurring mainly as a result of referrals to drug treatment agencies.

Chapter 4 – Problem Drug Use

This chapter focuses on the sociodemographic and drug-use characteristics of clients in treatment in 2006 in service providers in Malta, namely *sedqa*, Caritas, OASI, the Dual Diagnosis Unit (DDU) within Mount Carmel Psychiatric Hospital and the Substance Abuse Therapeutic Unit (SATU).

Prevalence and Incidence Estimates of Problem Drug Use

Since not all problem drug users will be in treatment it is necessary to estimate the number of such users in Malta. Prevalence estimates provide an indication of the total number of drug users, which can assist is service planning and resource allocation, public health surveillance and monitoring key targets. The estimated number of daily heroin users stood at 1606 (range 1541-1685). The rate per 1,000 population aged 15-64 was 5.4 (range 5.1-5.6) displaying relative stability since 2004.

Treatment Data

All Treated Clients 2006

The number of treated cases in Malta has increased from 1444 in 2003 to 1584 in 2006. The percentage of males to females has remained relatively stable over time. 14% of all treated clients were female in 2006. The largest group of clients are aged 20 to 29 years. 85% of clients were in treatment primarily because of their heroin use.

First Treated Clients 2006

The total number of first treated clients has increased from 256 in 2003 to 417 in 2006. Across the years most first treated clients are aged 15 to 19 followed by 20 to 24. In

2006 the percentage of first treated clients aged 15 to 24 declined compared to previous years whist the percentage of clients aged 25 and over increased. This is also reflected in the increase in mean age of first treated clients from 23 in 2003 to 25 in 2006

Chapter 5 – Drug-Related Treatment

Treatment Systems

In Malta, in 2006, there were five main drug-treatment providers. Three are managed and funded by the government: Sedqa, Agency Against Drug and Alcohol Abuse, which falls under the Ministry of Family and Social Solidarity; the prison-based unit SATU (Substance Abuse Therapeutic Unit), which falls under the Ministry for Justice and Home Affairs; and the DDU (Dual Diagnosis Unit) within Mount Carmel Psychiatric Hospital, which falls under the Ministry of Heath, the Elderly and Community Care. Caritas and OASI are voluntary treatment agencies, which receive partial support from the government.

Medically-Assisted Treatment

The provision of oral methadone is the most common form of medically-assisted treatment. Naltrexone has also been offered since 1996. As from July 2006 Buprenorhine became available in Malta and has increased the number of treatment modalities available to opioid dependent persons. Buprenorphine, which is only available through private purchase, is a substitution medicine.

Chapter 6 – Health Correlates and Consequences

Drug-Related Deaths and Mortality of Drug Users

The definition used in Malta for an acute drug-related death (DRD) is the same as that given by the EMCDDA, ‘deaths caused directly by the consumption of drugs, generally occurring shortly after the consumption of the substance’. In 2006 there were a total of 7 drug related deaths (mean age 28.6 years); 5 males and 2 females. The number of deaths due to opiates was 6 and the one death not due to opiates was as a result of a combination of cocaine and ecstasy. The numbers of DRDs in 2006 seems to be in line with what has been reported in the past 9 years with the number of annual deaths ranging from five to eight. Between 1994 and 2006 the DRDs occurring in the 15-34 years age groups accounted for around 7% of all deaths in this age cohort.

Drug-Related Infectious Diseases

A drug-related infectious disease (DRID) is defined as a disease contracted as a direct or indirect result of using drugs. According to the2005 and 2006 data obtained from testing for DRIDs at the Substance Misuse Outpatient Unit (SMOPU), the percentage for Hepatitis C infections remains stable and those for Hepatitis B and HIV very low. In 2005 and 2006, from those tested, no one tested positive for HIV. Similarly, notification data from the Disease Surveillance Unit shows that the main problem seems to revolve around the high numbers of Hepatitis C cases amongst drug users.

Non-Fatal Overdoses (NFODs)

In 2006 the total number of NFOD cases was 238 (unique individuals: 231). Between 2005 and 2006, a 36% increase of NFOD cases was reported. Most NFODs in 2006 involved medicinals, particularly psychotropic medication. Whereas in 2006, the numbers of NFODs due to medicinals increased only slightly from 2005, those resulting from illicit substances reached a dramatic high. This figure is more than double that reported in 2004 and 2005. During 2006, NFODs due to illicit drugs comprised 28% of all NFODs, compared to 15% in 2004 and 2005. Moreover, the data also shows that the overall reported increase of NFOD cases is due to a doubling in the numbers of male cases, from 67 in 2005 to 126 in 2006 for non-illicit substances and from 23 in 2005 to 59 in 2006 for illicit substances.

Chapter 7 – Responses to Health Correlates and Consequences

One of the main objectives of the Draft National Drugs Policy 2007 is that of achieving a high level of health protection and social cohesion by preventing and reducing drug related harm to health and society. The policy's actions in this sense, aim to provide the general public with the dangers of drug use, promote ongoing and public health campaigns.

Prevention of Drug Related Deaths

Most measures aimed at reducing the amount of drug related deaths are implemented by drug treatment agencies. These involve providing information and knowledge on drug

use and its dangers through groups and individual sessions, leaflets, flyers, billboards, outreach work, websites and through the media.

Interventions Related to Drug Related Infectious Diseases

Hepatitis C

Free blood screening as well as pre and post test counselling for Hepatitis C takes place at the Substance Misuse Outpatient Unit (SMOPU), prison (CCF) and the Genitourinary (GU) clinic within the department of health. Contact tracing is also affected by this unit as well as by the Department of Public Health's Disease Surveillance Unit (DSU), which, by law, is meant to receive all Hepatitis C notifications. Treatment for Hepatitis C includes Interferon treatment alone and Interferon/Ribavarin combination treatment.

HIV

Blood screening and pre and post test counselling is provided by SMOPU, CCF, the GU clinic and the XEFAQ service offered by Caritas. Unlike Hepatitis C, the prevalence of HIV amongst drug users appears to be low in Malta (no cases of HIV among drug users were notified in 2006). By law, since 2004, HIV has become a notifiable disease and the DSU is responsible for receiving these notifications and conducting contact tracing.

Hepatitis B Vaccine

Testing and vaccination for Hepatitis B is a free service provided by health centres to the general public. SMOPU provides a free and highly accessible screening and vaccination program to all drug users who are attending the clinic. Prison inmates are screened on admission for Hepatitis B. A vaccination program for inmates has been started in 2007. The prevalence of Hepatitis B amongst drug users is low in Malta (about 1.6%).

Needle and Syringe Availability

Since syringe distribution started in Malta in the 1980's, reaching national coverage in 1994, the number of syringes distributed yearly has risen steadily with an increase of 1.4% in 2005 compared to 2004, and of 2.5% in 2006 compared to 2005.

Chapter 8 – Social Correlates and Consequences

Arrest Data

Over a nine-year period, 2006 recorded the lowest arrest rate to date. Between 2004 and 2005 there was a decrease of 12% in the number of arrests and between 2005 and

2006 a decrease of 28%. Arrest data indicators are sensitive to law enforcement strategies, levels of police enforcement as well as the level of substance use problems. In 2006, from the 544 arrests for drug law offences, 76% were charged for possession, 15% for trafficking and 9% for a combination of trafficking and possession. Most charges for possession and trafficking were for cannabis and heroin. Adolescents aged 20 years and under, tend to be charged with possession of cannabis and ecstasy more than other types of drugs. Young adults, aged 20-34 years, on the other hand, are more commonly charged for possession of cannabis, heroin and cocaine. Young adults aged 20-34 years are more involved in trafficking multiple drugs than older adults aged 34 years and over. Young adults tend to traffic cannabis and ecstasy while older adults heroin.

Drug Use in Prison

During 2006, 493 persons (466 males and 27 females) were imprisoned after arrest or sentencing. 2006 prison routine inspections resulted in 51 drug seizures on prison grounds or in related health institutions and in the majority of cases heroin was suspected. During the duration of their prison sentence, inmates are randomly tested for drugs on a monthly basis. In 2006, from a total of 424 random drug tests conducted on 268 unique individuals, 22.6% tested positive for heroin and 5.6% for cannabis. No one tested positive for cocaine. Upon admission into SATU, CCF's Substance Abuse Therapeutic Unit, 13 from a total 27 admissions in 2006, tested positive for drugs, namely heroin (40%), followed by cocaine (11%). During the same year, 51 random drug tests were conducted, with 6% resulting positive for drugs.

Chapter 9 – Responses to Social Correlates and Consequences

Problem drug use is very often linked to deprivation and poverty, and drug users share a common experience with other socially deprived groups. They face exclusion from the labour market, often compounded by social instability, a criminal record, and dependence on state benefits. This chapter looks at ways of re integrating drug users back into society by training, education, housing, social assistance and employment.

Chapter 10 – Drug Markets

Availability and Supply

Cannabis and heroin remain the most popular drugs of abuse in Malta. Herbal cannabis is generally locally grown, while cannabis resin (hashish) was of Moroccan origin. Heroin

is imported primarily from North Africa and Turkey while cocaine, ecstasy and other amphetamines are smuggled into Malta mainly from European destinations particularly the Netherlands. Since 2005, Malta has also become a recipient for New Psychoactive Substances. In 2006, 1-benzylpiperazine (BZP) and 1-(3-chlorophenyl)piperazine (mCPP) tablets were detected in Malta. Before these seizures, both substances were not controlled; this situation was shortly rectified by means of two Legal Notices.

Seizures

There was a decrease of 27% in the amount of drug seizures effected by the Malta Police Force and the Customs Department between 2006 and 2005. Although the number of seizures for 2006 decreased in number when compared to 2004 and 2005, the quantities seized increased.

Drug Purity

All told, drug purity levels have remained relatively stable. Although the mean purity percentages may vary slightly from year to year, it is important to keep in mind that sample sizes also fluctuate from one year to the next, and this factor could influence the mean percentages. Additionally, one particular sample that has either very high or very low purity could also skew the overall mean of the reporting year

Drug Prices

The mean price at street level for different drugs in 2006 as reported by the inspectors of the Malta Drug Squad are lower than those reported in 2005. The limitations as regards drug prices are mainly due the fact that data is limited to one source (4 police inspectors) and not multiple sources that can be cross-compared. Additionally, at present, drug prices are collected only once yearly and this method is not extensive or reliable enough to ensure the integrity and reliability of the data.

Chapter 11 – Public expenditures

For the purpose of this chapter the term public expenditure refers to the value of goods and services bought by the administrative bodies of the state, in Malta's case these constitute the central government and its ministries. Thus for the purpose of this chapter, the Budget Document and the Ministerial End of Year Reports were used. Also, qualitative interviews were conducted with the Senior Probation Officer and the director of the Criminal Courts. Finally, a drug expenditure report was requested from various

ministerial departments. The Public Expenditure on Drugs for the year 2005 was estimated to be close to EUR 5 million.

Chapter 12 – Epidemiology Related to Vulnerable Groups

Drug experimentation is increasingly widespread; however levels of drug use and the risks of developing drug-related problems are much higher amongst vulnerable groups. Most young people who experiment with drugs or use them recreationally do not develop long-term serious drug problems; however, a small but significant minority of young people do develop serious drug-related health problems. Vulnerable groups include at risk children, youth and families, immigrants and persons with mental health problems.

Responses to Drug Problems Among Vulnerable Groups

The first National Drugs Policy 2007 (still in draft) indirectly mentions vulnerable groups under the heading 'Actions to reduce demand for drugs'. Specifically, Action 28 states: *"In terms of facilitating social integration Government, shall through the Ministry responsible for social policy … Strengthen the organization of primary and secondary prevention initiatives with a view to ensure that all target groups are effectively reached".*

Prevention and Treatment

In Malta, the main target groups for indicated prevention are youth in vulnerable schools, juvenile inmates in prison settings, young offenders through the arrest referral scheme and individual interventions through immediate intervention services occurring mainly as a result of referrals to drug treatment agencies.

Chapter 13 – Drug-related Research

Drug Related Research in National Policy

The section on research in the 2007 Draft National Drugs Policy is titled: Monitoring, Evaluation, Research, Information and Training. The policy recognises the need for adequate monitoring, collection and dissemination of information, periodical evaluation of policy measures and ongoing research and training. The National Focal Point (NFP) is recognised as an important body in this regard.

Main National Structures for Drug-related Research

The National Commission on the Abuse of Drugs, Alcohol and Other Dependencies (NCADAD), which sits in the Ministry for the Family and Social Solidarity (MFSS), is constituted by a multi-disciplinary forum of experts coming from fields that are crucial for the formulation of policies on various dependencies. The NCADAD coordinates the NFP, which ultimately is responsible for gathering the necessary information to enable the policy cycle and to monitor the drug situation and the responses as highlighted above. MFSS is the main Ministry responsible for the co-ordination of drug-related issues. Other related Ministries are: the Ministry for Justice and Home Affairs, the Ministry of Education, Youth and Employment and the Ministry of Health, the Elderly and Community Care. The main agencies and departments that conduct drug-related research are Sedqa the National Agency against Drug and Alcohol Abuse, the Department of Health Promotion, the Department of Public Health and the Department of Health Information. Within the University of Malta the main departments that conduct any form of research related to drugs are: the Department of Biomedical Studies within the Faculty of Medicine and Surgery, the Department of Psychology and the Department of Youth and Community Studies within the Faculty of Education.

Information flows

The NFP acts on behalf of, and reports to the NCADAD. The model for the operation of the NFP is based on the concept of the Integrated Drug Information System, as promoted by United Nations Office on Drugs and Crime (UNODC) and amended by the Pompidou Group in the context of its Local Monitor project, and the views on the organisation of supporting functions for drug policy, promoted by the Pompidou Group. Based on this model, the NFP is primarily perceived as a coordinating agent of national data providers and data users responsible for the organisation and maintenance of supporting functions for Maltese drug policy. Acknowledging this primary role of the NFP, its concrete tasks are defined in compliance with the demands of the EU Community Acquis. The role of the NFP involves coordinating its national information network in order to collect, verify and synthesise raw and/or aggregate data on an annual basis. The data is used to assess the drug situation in Malta and monitor trends over time.

PART A

NEW DEVELOPMENTS AND TRENDS

CHAPTER 1

NATIONAL POLICIES AND CONTEXT

1.1 Legal framework

As has been reported in the previous national reports, the principal pieces of legislation dealing with substance abuse in Malta are the **Medical and Kindred Professions Ordinance (Cap.31)** concerning psychotropic drugs, and the **Dangerous Drugs Ordinance (Cap.101)** concerning narcotic drugs.

The **Medical and Kindred Professions Ordinance** was enacted in 1901 and was amended several times subsequently to bring it into line with Malta's international obligations as these changed from time to time with the coming into force of new conventions in the field. This Ordinance deals principally with the regulation of the medical and para-medical professions but it is also concerned with the control of specified drugs and contains enabling provisions vesting the Minister with the power to make regulations to control the manufacture, exportation, importation, possession, distribution and sale of such drugs.

The Drugs (Control) Regulations (Legal Notice 22 of 1985) issued by virtue of the Medical and Kindred Professions Ordinance:

- regulate the manufacture, exportation, importation, possession, distribution, sale and improper use of the listed psychotropic drugs;
- regulate the issuing of prescriptions, by the respective medical professionals, containing of any such drugs and the dispensing of any such prescription; and
- provide for the keeping and producing for inspection of such books and the furnishing of such information by persons engaged in the manufacture, exportation, importation, sale or distribution of any such drug.

The **Dangerous Drugs Ordinance** was enacted in 1939 and has also been extensively amended. This is especially true in recent times when several amendments have been made in relatively quick succession in order to keep pace with developments in the

international arena both as regards investigative techniques as well as regards new avenues of mutual assistance measures between States in an attempt to put up a united international front against what is seen as a serious danger common to all States.

New Developments

A 2006 Bill entitled **'An act to amend the Code of Police Laws, (Cap.10)'** provides for penalties for any person who sells to, or purchases alcohol on behalf of a minor or serves or supplies alcohol to a minor in any shop, street or public place. Likewise, a minor may not consume, procure or possess alcohol in any such places. The Bill further provides for the introduction of a supervised working programme for an offender who is a minor consisting, among other provisions, in uncompensated community service work.

Legal Notice 135 of 2006 and **Legal Notice 127 of 2007** amend the Medical and Kindred Professions Ordinance (Cap.31) and regulate the new psychoactive substances 1-benzylpiperazine (BZP) and 1-(3-chlorophenyl)piperazine (mCPP).

1.2 Institutional framework, strategies and policies

A first Draft National Drugs Policy (2007) has been drawn up and at the time of submission of this report, is going through its final re-drafting following a consultation period of some three months. In essence, this first drugs policy provides the framework through which a co-ordinated effort may be better achieved to reduce drug use in the first place, help those who started to use drugs and enable those who have succumbed to drug addiction to be better served.

This policy is thus primarily directed towards service providers with a view to;

(a) improve the quality and, where necessary, increase the provision of drug-related services, and
(b) provide for a more co-ordinated mechanism through which the supply and demand for drugs are appropriately reduced as much as possible in the best interest of society.

The document per se is divided into nine sections and contains some 47 actions to be achieved that directly focus on the heart of the problem. In this short overview some of the actions are highlighted that provide the core basis of what this document is all about.

The policy opens with an **Introduction** that lays down the scope of the policy as well as the context, that is the current drug situation here in Malta and against this backdrop concludes with the primary objectives, that of ensuring a high level of security for the general public and a high level of health protection, well being and social cohesion. Some eight-policy targets conclude this section, two of which are of highest priority, the reduction in the availability of illicit drugs and a reduction in the use of such illicit drugs.

Following on from the introduction, the second section provides information on the institutional structures that deal with issues related to drug use as it is not at all apparent what these are and what they do. **Co-ordination of the National Drugs Policy** is pivotal if such is going to succeed and in this section it is suggested that the Ministry responsible for social policy hosts a new unit, namely a National Co-ordinating Unit for Drugs and Alcohol to ensure that this policy is implemented and monitored in the correct manner.

The third section introduces the **Legal and Judicial Framework** through which drug issues are currently framed. It also provides for the setting up of a Drugs Court that may streamline drug offence cases.

Section 4 deals with what is termed as **Supply Reduction** and the structures that have the main task of reducing the street availability of illicit drugs. In this section it is put forward that a National Law Enforcement Body is set up to strengthen the co-operation between the law enforcement bodies in their daily work to reduce street availability.

In addition to availability of drugs, this implies that there is a demand for them. Thus Section 5 deals with measures/actions related to **Demand Reduction**. Moreover, this section contains the most actions, nearly half, to prevent drug use in the first

place, reduce drug use in those who have started and for those who have succumbed, and actions aimed at treating addiction problems. In an effort to consolidate the efforts aimed at treatment of those who use drugs and those addicted to drugs a Central Intake Unit is to come into fruition.

It is tantamount that while implementing this policy, it is also continually monitored and evaluated. Ongoing research of the situation and the dissemination of information resulting from such efforts are also crucial. In this vein, section 6, **Monitoring, Evaluation, Research, Information and Training,** provides the basis for such. Consequently, the National Focal Point for Drugs and Drug Addiction will be incorporated into the new National Co-ordinating Unit for Drugs and Alcohol to enable it to do just that.

Section 7, **The International Perspective,** provides actions that enable Malta to fulfil its International obligations, namely those that relate to the UN, EU and the Pompidou Group, Council of Europe.

Penultimately, all this would not be possible without the necessary **Funding** as provided through the Ministry of Finance, who will endeavour to allocate more funds to drug related programmes and initiatives by supplementing current funding provisions with monies derived from assets confiscated under *The Prevention of Money Laundering Act* in relation to drug related offences.

Finally, in the last section, the **Conclusion,** it is made explicitly clear that if there is a need to introduce any other measures or actions in response to the changing situation the Ministry for the Family and Social Solidarity will take this responsibility on board whereas the new National Coordinating Unit for Drugs and Alcohol, within the said Ministry will be responsible for the implementation of this policy. Table 1.1 highlights the entities and organisations involved in the responses to drug use in Malta.

Entities and Organisations Involved in Responses to Drug Use in Malta

NATIONAL COORDINATING UNIT FOR DRUGS AND ALCOHOL (Co-ordinating Body)

Office of the Prime Minister	Ministry for the Family and Social Solidarity	Ministry of Health, the Elderly and Community Care	Ministry of Justice and Home Affairs	Ministry of Finance	Ministry for Investment, Industry and Information Technology	Ministry for Education Youth and Employment	Ministry for Gozo	Civil Society (Malta & Gozo)
Armed Forces of Malta	Foundation for Social Welfare Services	Foundation for Medical Services	Law Courts	Customs Department	Malta National Laboratory (including Forensic Laboratory)	Employment and Training Corporation	Social Work Unit	Voluntary Organis-ations
	National Commission on the Abuse of Drugs, Alcohol and other Depend-encies	Department for Institutional Health	Attorney General	Budget Office		Student Services Department - Safe Schools Programme	Gozo General Hospital	Social partners
	National Focal Point for Drugs & Drug Addiction	Department for Primary Health Care	Police Force			Curriculum Directorate	General Health Centre	Private hospitals and clinics
		Department for Public Health	Malta Security Service			Youth organisations	The Education Office	Parishes
		Health Information Department	Correctional Facilities				Gozo Local Councils	
		Health Promotion Department	Probation Services					
		Toxicology Laboratory	Pre-release Programmes including The Substance Abuse Therapeutic Unit (SATU)					
			Local Councils					

Table 1.1.

Source: Draft National Drugs Policy – July 2007

1.3 Budget and Public Expenditure

Overall the total government funding involved is of the order of approximately 2.1 million Maltese lira per annum or some 5 million Euros. More funds this year have been allotted to the Ministry for the Family and Social Solidarity in order to put in place the new Drug and Alcohol Co-ordinating Unit. In the main however, the division of funds has remained the same in that approximately 70% is allotted to Demand Reduction activities while the remaining 30% is for use in the Supply Reduction sector.

1.4 Social and Cultural Context

Again, public debate on drug issues mainly takes place on a regular basis in the columns of the daily and Sunday newspapers and on a number of occasions on Television programmes dedicated to current affairs. All arrests by police for drug possession and/or drug trafficking are reported in the daily tabloids. The outcomes of any court proceedings are also regularly reported in the news bulletins on television and the newspapers.

The President's Forum which brings together all service providers working in the sphere of illicit drug use provides the framework through which members are able to raise and discuss issues that relate to everyday practice.

The Parliamentary Committee for Social Affairs may, at any time, decide to discuss any drug related issues that may require amendments to existing legislation to be prepared for consideration by Parliament. In the discussions that ensue, the said committee may solicit the views of the public, members of public and private entities and NGO's involved in the field.

CHAPTER 2

DRUG USE IN THE POPULATION

2.1 Drug Use in the General Population

The latest data Malta has on the prevalence of drug use amongst the general population can be obtained from the 2001 General Population Survey on Licit and Illicit Drug Use (Korf et. al., 2001). This data has already been presented in Chapter 2 of the 2004 and 2005 National Drug Reports (see also Standard Table 1). Due to financial constraints, this survey has not been repeated. Plans are underway, however, to include a number of questions related to drug use (lifetime use, last year use, last month use and age of first use) in the Department of Health Information's 2008 National Health Interview Survey (NHIS), conducted amongst residents of the Maltese Islands aged 16 years and over. This data should provide us with updated 2008 estimates of the prevalence of illicit drug use amongst the general population of Malta.

2.2 Drug Use in the School and Youth Population

The results of the 2003 ESPAD study (European School Survey Project on Alcohol and other Drugs) were presented in Chapter 2 of the 2004 Malta National Drug Report. The results of the latest 2007 ESPAD study conducted by Sedqa the National Agency against Drug and Alcohol Abuse, have not yet been published.

Between February and March 2006, a Lifestyle Survey was conducted conjointly by the National Commission on the Abuse of Drugs, Alcohol and other Dependencies (NCADAD), the National Focal Point for Drugs and Drug Addiction (NFP) and Sedqa, amongst 18-24 year-old full time students attending post secondary and tertiary education in Malta and Gozo. The aims of this study were to obtain reliable and comparable information on the extent, patterns of use of different substances, and attitudes towards tobacco, alcohol and drug use amongst this cohort. The sample was randomly selected to include about 15% of the post-secondary student population and another 25% of the university population. The questionnaire used was a slightly modified version of the European Model Questionnaire (EMQ) and was self completed by all the

students (N=1,226; 39% male and 61% female[1]). Both electronic and hard copies of the questionnaires were used, depending on the facilities made available by the schools. The main results of this study are presented below (see also Standard Table 2).

Alcohol and Tobacco: Number of Users and Frequency of Use

Alcohol was the most commonly used substance amongst students, with 96% having consumed alcohol during their lifetime, 95% in the last year and 79% in the last 30 days[2]. Just over half of the students (54%) had smoked cigarettes, 42% of students smoked in the last year and 30% in the last 30 days (Figure 2.1). There is no difference in the use of alcohol and tobacco between males and females (Figure 2.2).

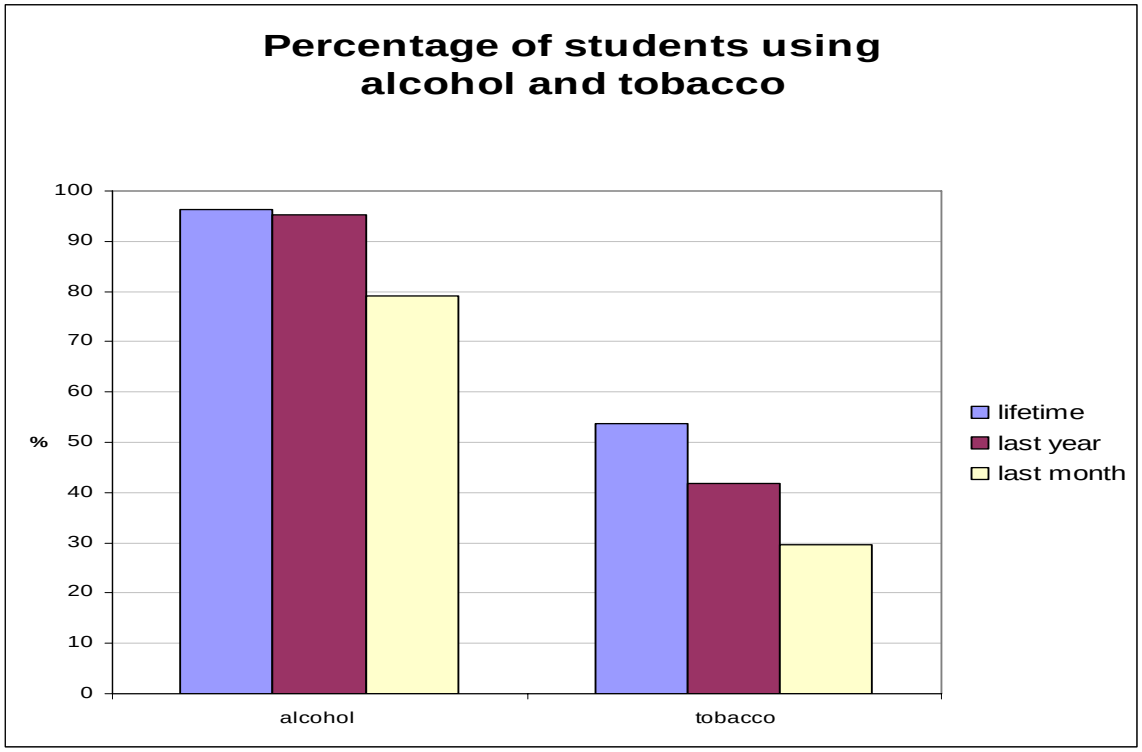


Figure 2.1

[1] The percentage of male and female students attending post-secondary and tertiary education is 43% and 57% respectively. Source: National Statistics Office.

[2] The last year and the last 30 days = prior to completion of the survey. The last 30 days is also referred to as 'current use'.

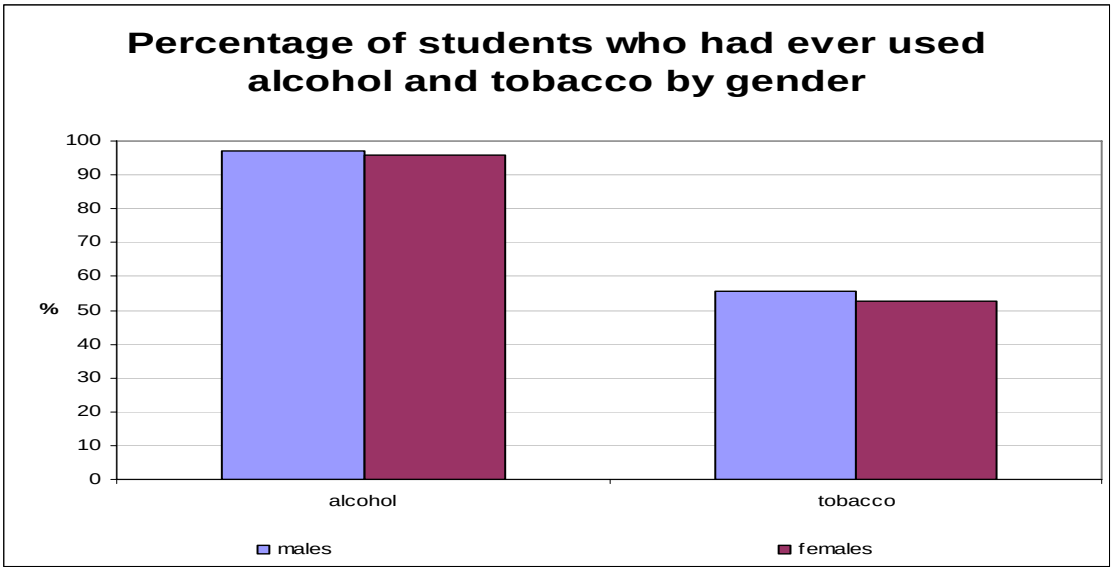


Figure 2. 2

Amongst the 79% of students who had consumed alcohol in the last 30 days, 10% had drunk twice a week or more (Figure 2.3). Binge drinking (here defined as consuming 6 glasses of an alcoholic drink on the same occasion) was reported by 64% of students, with 33% binge drinking at least once a week (Figure 2.4). Amongst the 30% of students who had smoked tobacco in the last 30 days, 61% smoked twice a week or more (Figure 2.3).

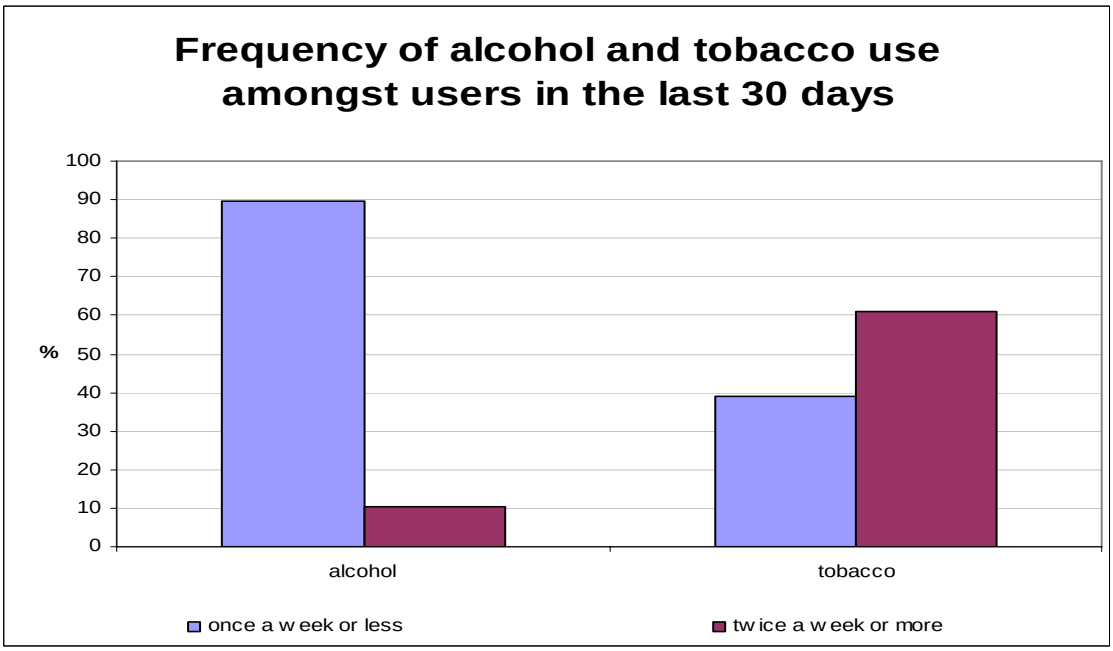


Figure 2.3

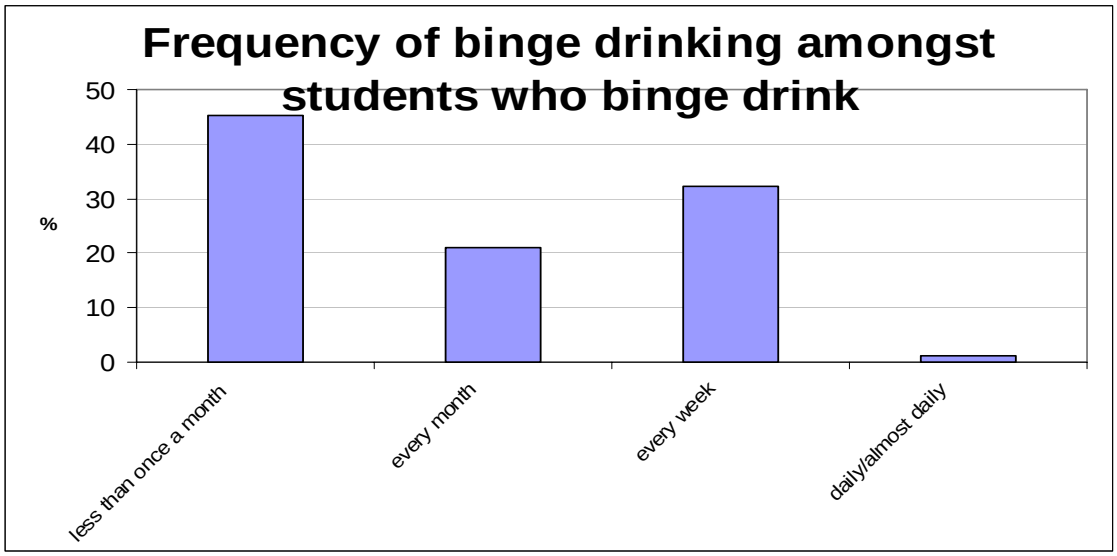


Figure 2.4

Other Substances: Number of Users and Frequency of Use

Cannabis was the most widely used illicit drug with 22% of students having ever used this substance. Some 16% of students had taken cannabis in the last year and 7% in the last 30 days. Following cannabis, the substances most commonly used were anabolic steroids[3] (12%), magic mushrooms[3] (11%) and tranquillisers (10%). Inhalants, cocaine and ecstasy were used by 7%, 6% and 5% of the sample, respectively (Figure 2.5). A greater proportion of males used each illicit substance. Tranquillsers on the other hand, were used by a slightly greater proportion of females than males (Figure 2.6).

[3]Students were not asked about their use of anabolic steroids or magic mushrooms in the last year and last 30 days.

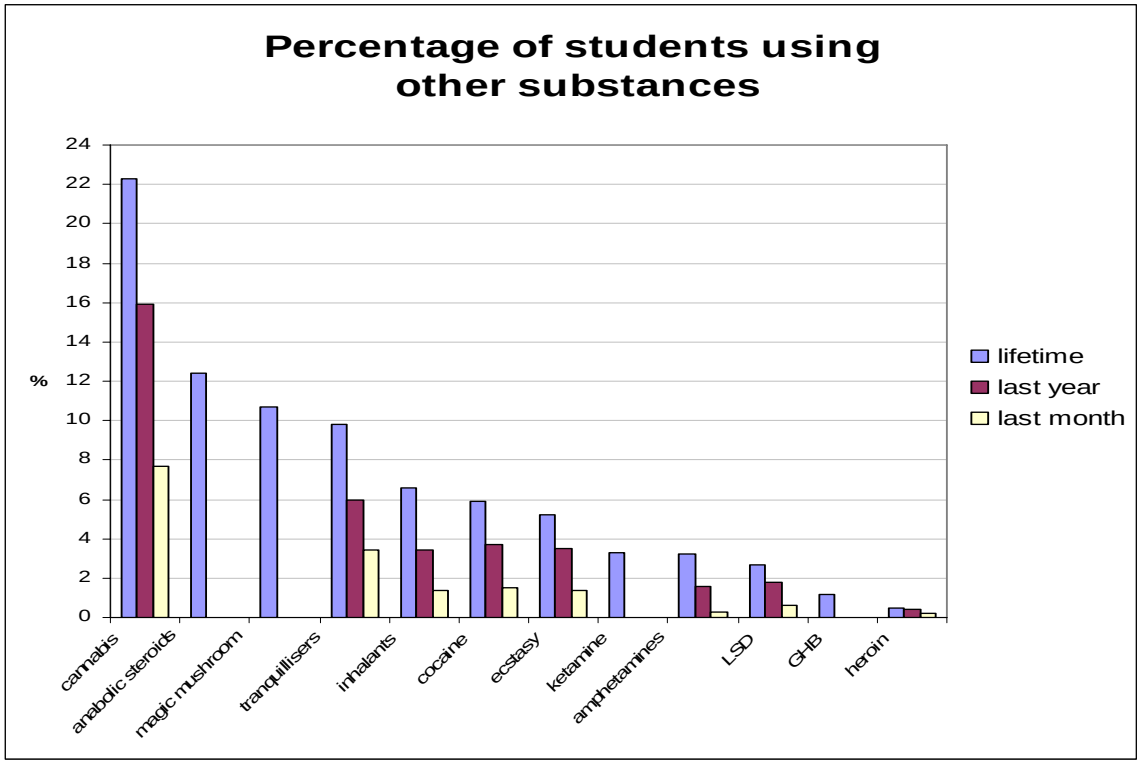


Figure 2.5

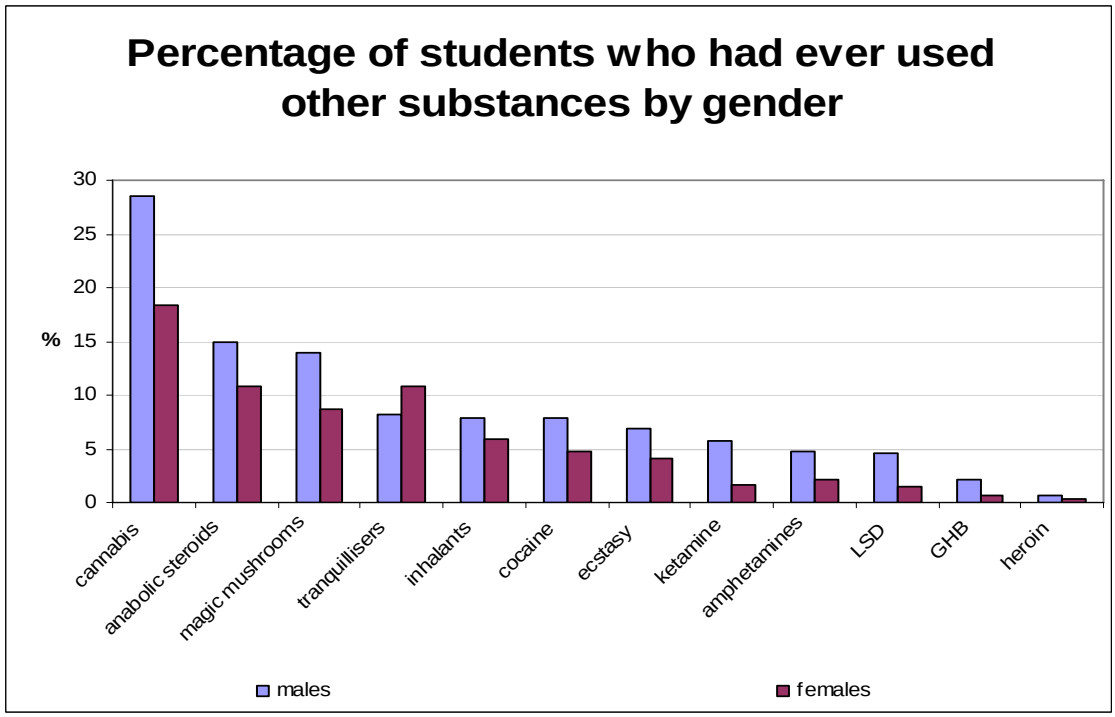


Figure 2.6

Most students who had used cocaine and ecstasy in the last 30 days, used once a week or less, with only 6% using twice a week or more (Figure 2.7). A higher percentage of students currently using cannabis (30%) and tranquillisers (51%) had taken the substance twice a week or more.

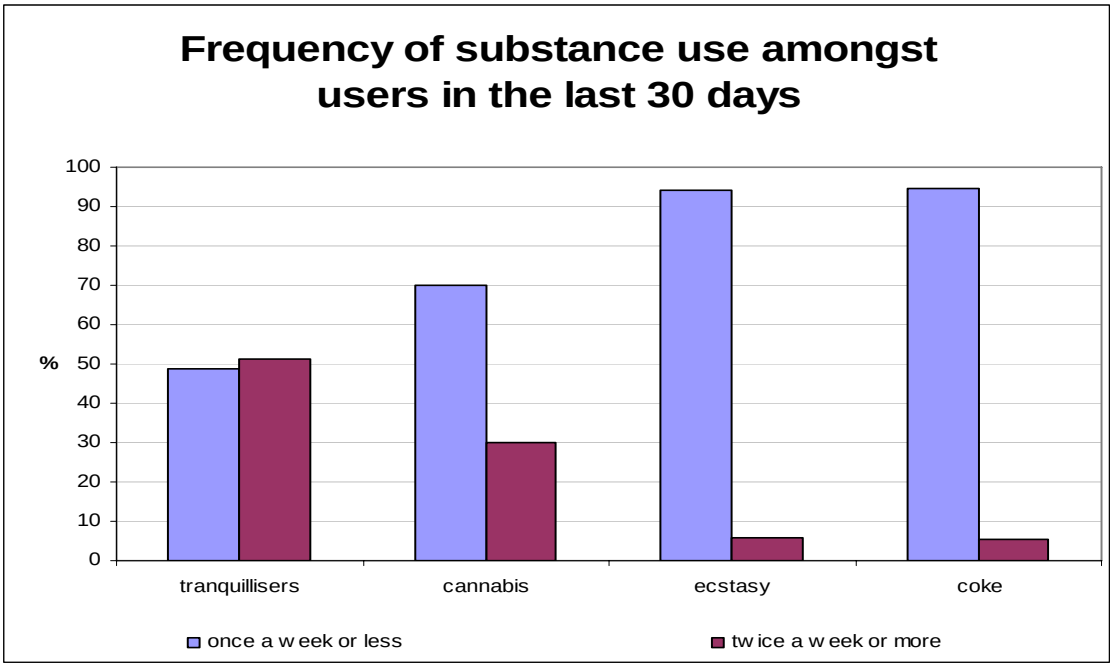


Figure 2.7

Age of First Use

Amongst students who drank alcohol, 67% reported that they first drunk an alcoholic beverage before the age of 16. 54% of smokers and 43% of inhalant users also reported first use of these respective substances before the age of 16. The majority of students who had used amphetamines, ecstasy, cannabis and cocaine, initiated use between the ages of 16 and 17. More than 25% of students who had used amphetamines, ecstasy, cannabis, cocaine, tranquillisers, LSD and heroin had done so for the first time when they were18 years or older (Figure 2.8).

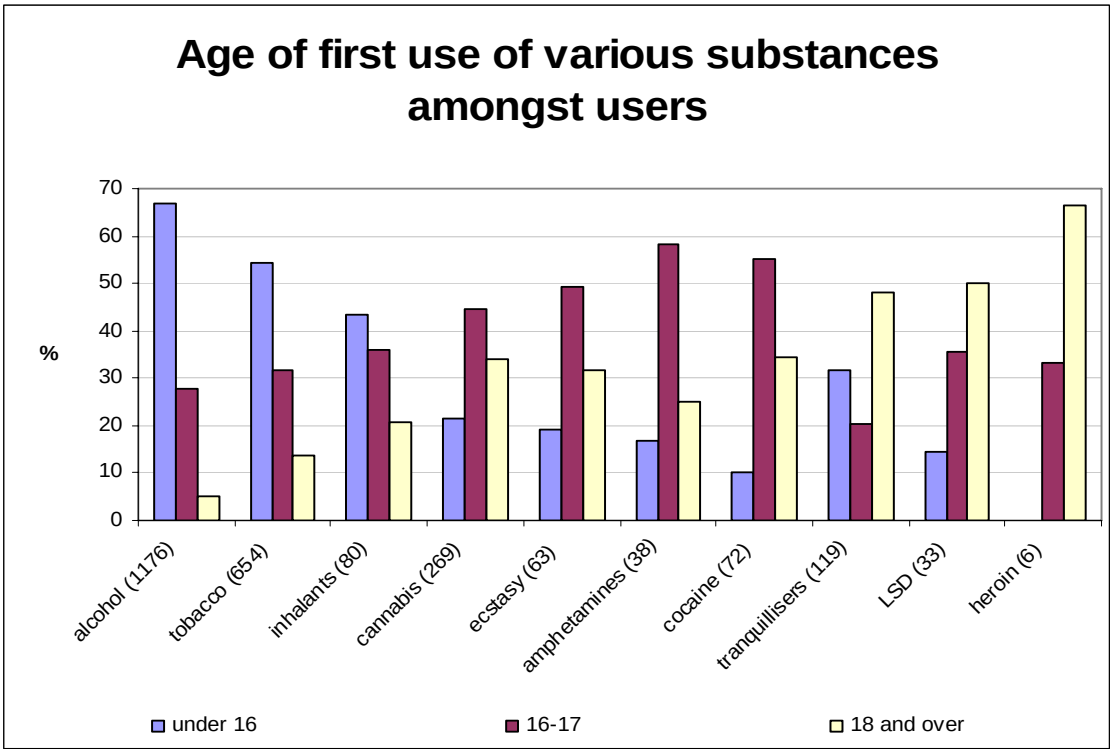


Figure 2.8

Attitudes to Drugs and Drug Users

This section covers ease of availability, perceptions and attitudes to certain drugs and drug use. Perception of availability was measured for cannabis, ecstasy, cocaine and heroin. Availability for cocaine and heroin is moderate to low, however that for ecstasy and especially cannabis is considerably higher (Figure 2.9).

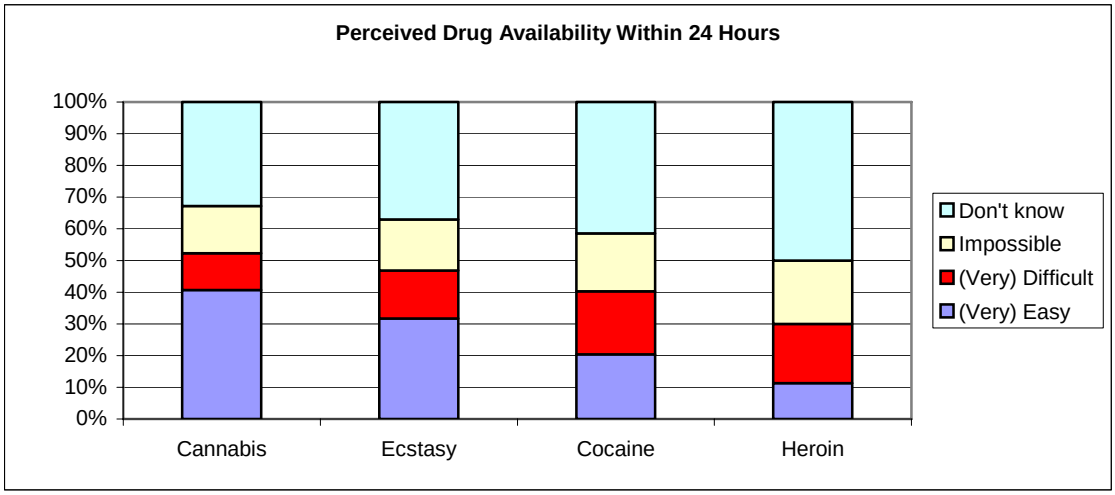


Figure 2.9

As regards risk perception, respondents see more risks in taking illicit drugs and smoking one or more packets of cigarettes a day than drinking 5 or more drinks in a row to the point of intoxication (Figure 2.10).

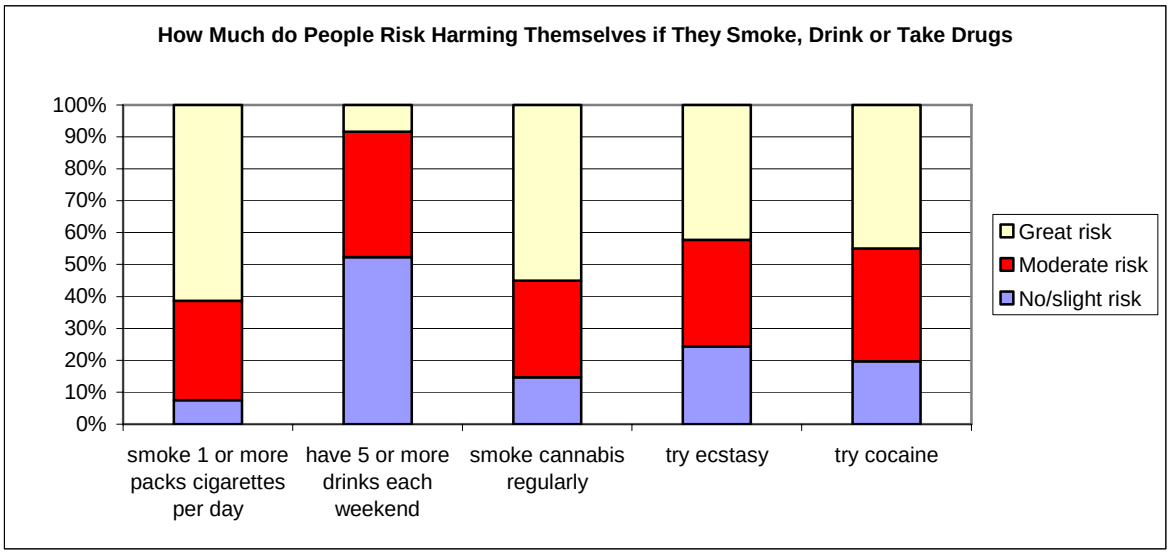


Figure 2.10

Most respondents are quite critical towards the abuse of substances with the majority saying that they disapproved of people smoking 10 or more cigarettes a day, drinking 5 or more drinks in succession and taking cannabis or ecstasy occasionally. More disapproval is attributed to having 5 or more drinks in succession than smoking cannabis occasionally (Figure 2.11).

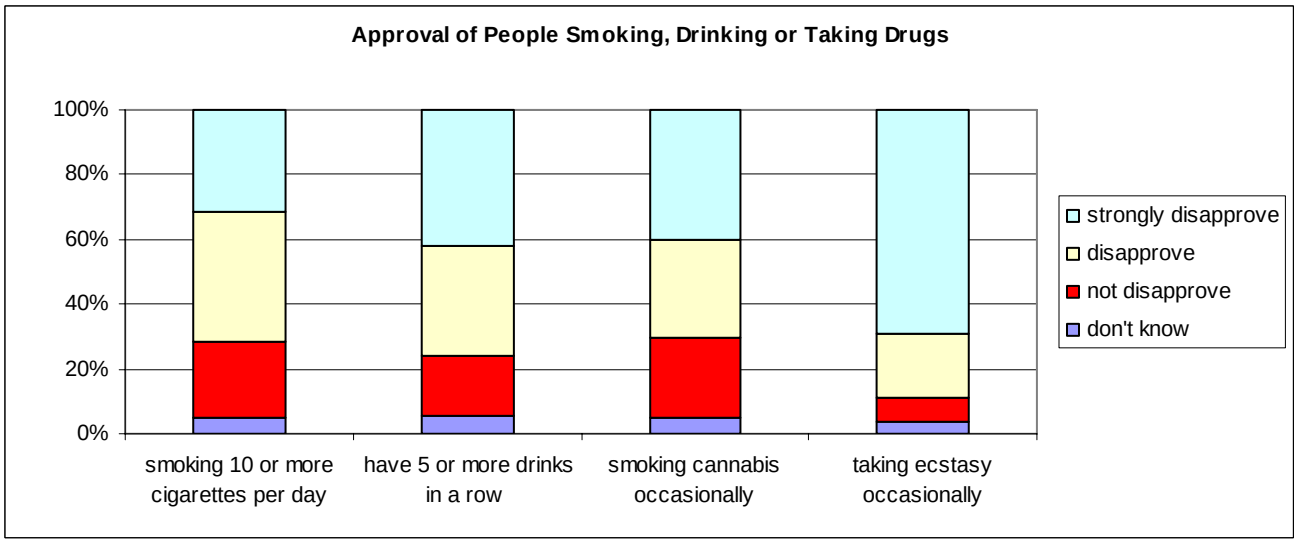


Figure 2.11

The vast majority of persons are of the opinion that people should not be permitted to take illicit drugs, especially heroin, cocaine and ecstasy (Figure 2.12).

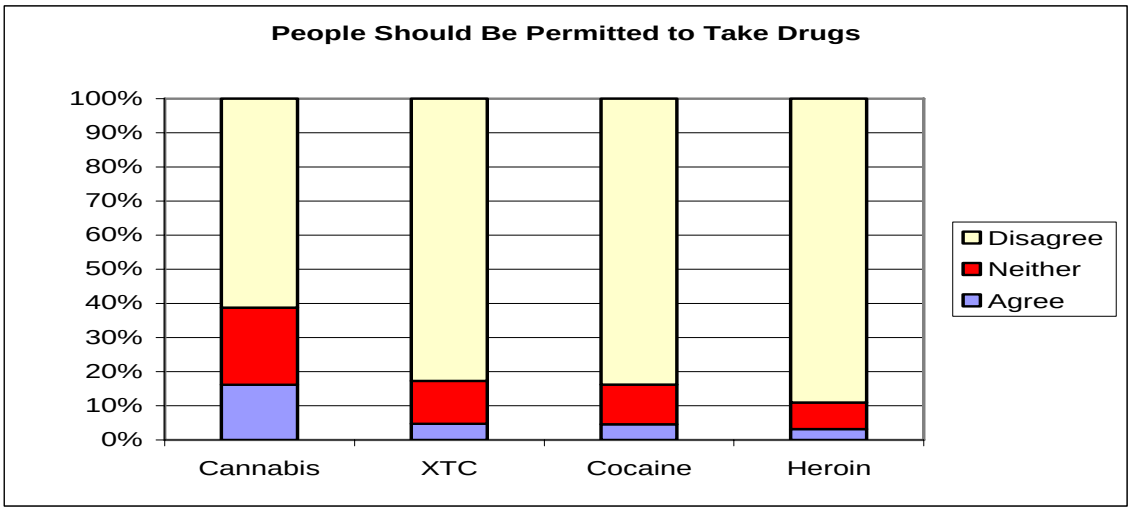


Figure 2.12

2.3 Drug Use Among Specific Groups

Between 1998 and 2002 a study was conducted that looked at the numbers of babies born to pregnant drug abusers (Savona Ventura, 2003). During the period under review, there were a total of 20086 maternities that resulted in 20375 births delivered at Karin Grech Maternity Unit of St. Luke's Hospital in Malta; 47 maternities (0.24%) occurred in women who admitted current (n=42) or past (n=5) heroin abuse. The socio-biological characteristics of these women were assessed and compared to similar parameters in the remaining pregnant population.

The women in this study who had a history of past or recent heroin abuse were younger in age than pregnant women in the general population (<25 years), and they also had significant social problems that arose from their drug habit. They came from socially deprived backgrounds, had a poor record of antenatal attendance and had frequent admissions to hospital. They were generally unmarried and thus had little family support to help them care for their child. They were often 'habituals' with the pregnancy resulting from prostitution. Their associated medical problems included Hepatitis C infection. There also appeared to be a statistically increased predisposition to pre-existing diabetes. There did not appear to be any statistically significant increased risks to the infant, apart from a greater predisposition to low birth weight and premature birth.

CHAPTER 3

PREVENTION

3.1 Universal Prevention

Universal prevention strategies address the entire population (national, local community, school, neighbourhood) with messages and programmes aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem (EMCDDA).

School-based Prevention

During 2006 there were no changes to the school prevention programmes described in previous reports (National Report on the Drug Situation 2004, 2005 and 2006). Prevention in schools continues to focus on life skills such as self esteem, peer pressure and building confidence to be able to make sensible decisions regarding non-use of substances and learning skills to be able to refuse substances offered. School-based prevention programmes are provided by Sedqa, Caritas and the Education Division's Anti Substance Abuse Unit in Malta. Prevention in Gozo is organised by the OASI Foundation.

School prevention programmes commence from primary level. Sedqa's Primary school team work with students, teachers and parents. This programme is delivered by the school teacher, accompanied by a booklet and lesson notes. Caritas commence prevention in schools in year 6 (ages 10-11) and focus on friendship and peer pressure with some introductions to tobacco and alcohol and the possible problems they can cause. OASI in Gozo introduce their prevention programmes in year 4 (7-8 year olds) with a programme called 'Truth'. As it's name suggests, this programmes stresses the importance of honesty. Year 5's receive a programme where drugs are mentioned and there is time available for the students to ask any questions they may have. OASI visit all primary schools in Gozo.

School programmes delivered to secondary schools are consistent with those described in previous reports (National Report on the Drug Situation 2004, 2005 and 2006). They

continue to focus on reinforcing non-use of tobacco, alcohol and drugs and teach knowledge, attitudes and life skills to minimise the experimenting with the various substances and hopefully, preventing the development of longer term harmful use of these substances.

Various factors contribute to harmful drug use and a better understanding of these will make programmes more relevant and meaningful to the target group. A more collaborative approach between the education and treatment systems will help reinforce desired behaviours by providing a supportive environment for school-based programmes. Education programmes are necessary in helping to achieve drug-free or safer drug use among young people; however these require more support and back-up of Policy, related services, healthy and safer environments and school-community partnerships in order to be more successful.

National Research in the area of school-based prevention programmes

The need to evaluate the existing prevention programmes in schools was addressed by the National Focal Point for Drugs and Drug Addiction (NFP) by establishing a Prevention Network in 2005 comprising representatives from the Education Division and the three drug agencies Sedqa, Caritas and OASI. This network has developed a study aimed at evaluating all school-based programmes implemented by the agencies amongst Form 3 students (aged 13/14 years). Besides measuring the impact of the prevention programmes amongst this age cohort, a secondary aim of the study is also that of measuring prevalence, knowledge and attitudes towards licit and illicit drug use amongst very young persons.

The questionnaire that was used for the study was a slightly modified version of the European School Survey Project on Alcohol and Other Drugs (ESPAD) questionnaire. It was piloted in May 2006 using 120 children from 6 different schools[1]. As a result of the pilot study the ESPAD questionnaire was found to be very long and a bit more complicated for the younger age students to comprehend, so the questions were streamlined and simplified to make it easier. The questionnaire was translated into Maltese to give the students the choice of which language to use to complete it.

[1] Total number of 13/14 year olds in school in 2006 = 5335; Total number of schools = 63

The actual study which commenced in November 2006, involved a pre-test/post-test design, using all schools in Malta and Gozo, matched according to selective criteria and randomly allocated to either the 'treatment group' (receiving prevention programme) or 'control group' (not receiving prevention programme). The pre-test questionnaire was administered to all Form 3 students in November 2006. This was followed by the implementation of the prevention programmes by the 4 different agencies[2] (for the treatment group only). In March 2007 the first post-test was administered. In November 2007 the second post-test will be administered. The results of this study should be published by the end of 2008.

Family-based Prevention

Universal family-based prevention programmes generally tackle topics related to parenthood such as leadership styles, communication, child development and discussions on drug and alcohol abuse in an interactive environment. Courses are delivered by trained facilitators, and often include the use of videos and written material.

Community-based Prevention - The General Public, Families and Youth

Community-based prevention programmes are implemented by the three main drug treatment agencies Sedqa, Caritas and OASI, and these primarily target families and youth in different environmental settings such as local councils, youth organisations, religious societies, parishes and social and political clubs. Community and Church activities, drug awareness talks, exhibitions, concerts and drug-free marches are organised at specific times of the year and aimed at targeting the general public.

Sedqa's community team promote drug prevention by distributing leaflets, booklets and posters to local council offices and Health Centres. The elderly are a vulnerable group prone to suffering from low self- esteem and loneliness and who can sometimes turn to alcohol abuse or medicines. The Sedqa team regularly visit Day Centres for the elderly and promote healthier lifestyles to minimise these problems.

Sedqa and Caritas in Malta as well as OASI in Gozo target youth in the community by organising alcohol-free alternative get-togethers and parties to encourage youth to socialise without alcohol. Live-in weekends and youth club activities are also organised.

[2] The four different agencies are Sedqa, Caritas, the Education Divison and Oasi in Gozo

Sedqa's community prevention allows dissemination of information via community leaders using various routes of printed material, media and talks. Sedqa's staff help youth groups by providing them with educational material, direct interventions and also monetary grants are sometimes made available to support specific causes.

Caritas's 'Diaconia Unit' co-ordinates actions at parish level. The unit's aims are mainly those of raising the awareness of the Christian community, uniting, strengthening and coordinating parish groups that are involved in social voluntary work and establishing on a parish level, new voluntary services for the welfare of the persons in need.

Community-based Prevention - Workplace-based programmes

Sedqa and Caritas both provide a service related to the provision of information on problems that could be encountered at the workplace due to drug and alcohol use.

Caritas introduced their Employee Assistance Programme (EAP) in local industries in 1992. The programme is tailor-made to the needs and culture of the respective company. Through EAP, Caritas helps employees and their families resolve job-effecting problems, irrespective of their position in the company.
It aims to create awareness among employees regarding substance misuse and other social problems that could affect their personal and social lifestyles and their work performance. It also helps the employees identify, assess and resolve their problems through timely interventions of professional support.

Sedqa' s Substance Abuse-Free Employee Programme (S.A.F.E.) was first implemented within Maltese enterprises in 1996. The programme is always implemented according to the companies needs, yet the general approach is as follows:
Phase 1: A nomadic stand is set up in a prominent place within the company, normally with one preventive message on either Alcohol or Drugs and Sedqa's 24-hour helpline number.
Phase 2: A four-session training programme on alcohol/drugs and their effects, stress management and approaching potential problem employees, is conducted for Management, Frontline Supervisors, and Foremen.
Phase 3: Informative sessions related to alcohol/drugs and their effects are conducted for employees.

Phase 4: A Company Drug and Alcohol Policy is formulated and a Focus Person appointed.

3.2 Selective Prevention

Selective prevention targets an entire subgroup regardless of the degree of risk of any individual within the group. Selective prevention is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population (EMCDDA).

During 2006 there were no new developments in selective prevention programmes since those reported in the National Report on the Drug Situation 2006. Interventions are mainly school-based and focus on students with high levels of absenteeism and those at risk of dropping out of school early. Other interventions include some outreach work targeting youth from disadvantaged neighborhoods and making contacts at parties, events and venues where drugs are known to be available.

New Development in Selective Prevention

Sedqa are developing a new programme called “Booster” which is due to commence by the end of 2007. The aims of this programme are to identify students who are experimenting with drugs and prevent early drug taking from developing into more intense abuse.

3.3 Indicated Prevention

The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programmes (EMCDDA).

In Malta, the main target groups for indicated prevention are youth in vulnerable schools, juvenile inmates in prison settings, young offenders (via the arrest referral scheme and some outreach in prison) and individual interventions through immediate intervention services occurring mainly as a result of referrals to drug treatment agencies.

New Development in Indicated Prevention

Budz, a joint venture between Appogg and Sedqa, is another new project due to commence by the end of 2007. It is an intensive, non-residential programme aimed at treating adolescent drug users aged between 13-18 years, who have instability and other problems in their lives such as prostitution, homelessness and severe truancy.

CHAPTER 4

PROBLEM DRUG USE

4.1 OVERVIEW

This chapter focuses on the sociodemographic and drug-use characteristics of persons attending all drug treatment service providers in Malta, namely Sedqa, Caritas, OASI, the Dual Diagnosis Unit (DDU) within Mount Carmel Psychiatric Hospital and SATU. Treatment refers to both medical and non-medical interventions. Data has been collected and collated by the National Focal Point (NFP) since 2003 therefore pertinent trends between 2003 and 2006 will also be highlighted.

Malta has a small population (circa 408,000) and a small number of treatment providers, which means that changes in operating procedures or variable definitions within one treatment provider, changes in the availability or accessibility of services or changes in target population of existing services, for example, can have a large impact on national data. With this in mind, in 2004 there were some variations in the definitions of key variables in one treatment unit. Data from 2004 is therefore not comparable with other years. This variation will have also resulted in under-reporting of clients in 2004. When looking at trends it should also be noted that since 2004 data from the newly opened DDU in Mt Carmel Hospital was also included in the core data set. This is a small unit with a relatively low number of clients and therefore its inclusion will not impact the figures greatly.

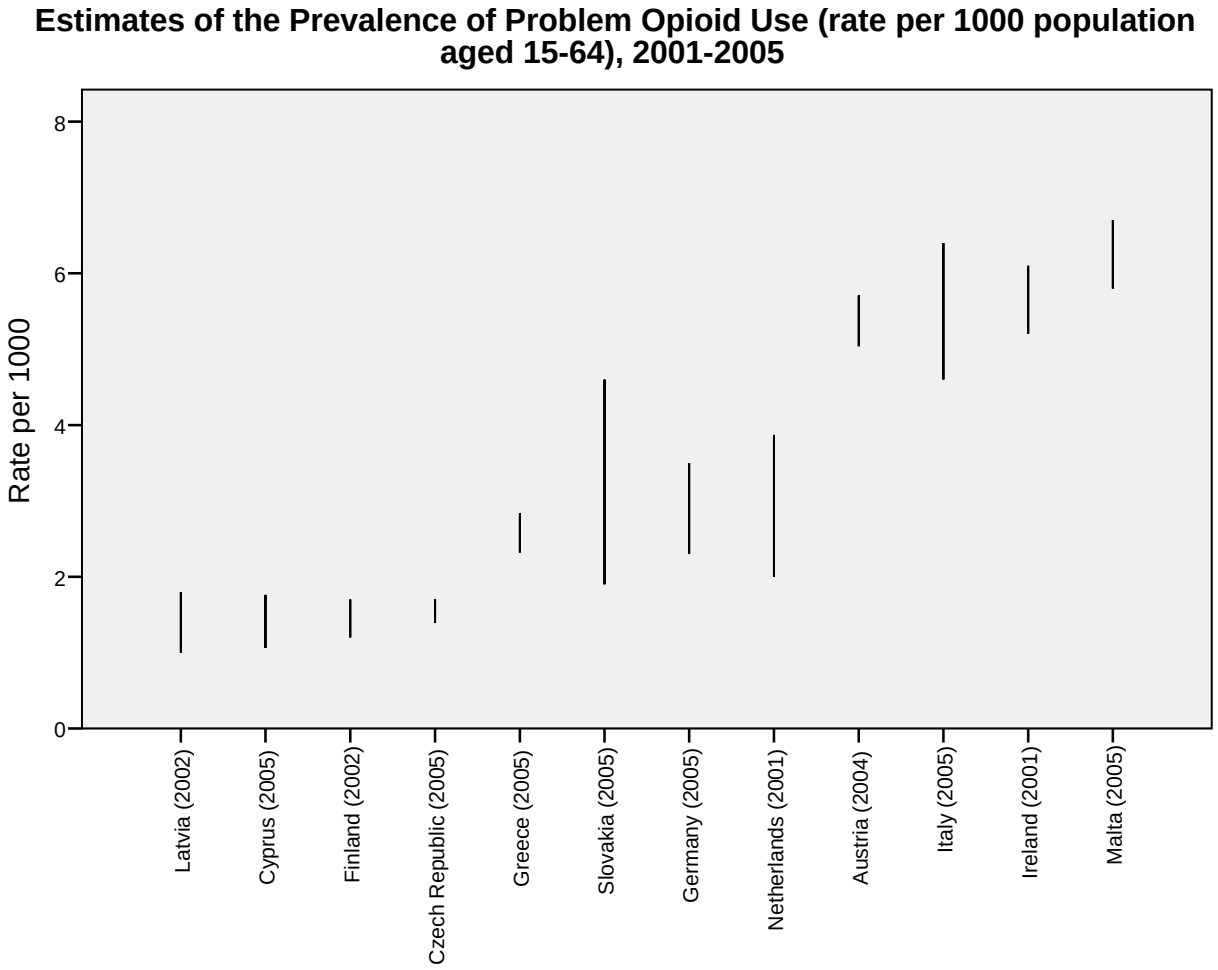
This chapter also examines the prevalence of problem drug use. Problem drug use is defined by the EMCDDA as 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines' (EMCDDA 2005). Drug users usually approach treatment services as a result of social, psychological, physical or legal problems. Not all clients in treatment would be categorised as problem drug users as defined by the EMCDDA, and not all drug users fitting this definition will be in treatment.

4.2 PREVALENCE AND INCIDENCE ESTIMATES OF PROBLEM DRUG USE

Since not all problem drug users will be in treatment it is necessary to estimate the number of such users in Malta. Prevalence estimates provide an indication of the total number of drug users, which can assist in service planning and resource allocation, public health surveillance and monitoring key targets (Hickman & Taylor, 2005). Since drug use is an illicit and often stigmatised activity, direct estimation methods such as population and household surveys will underestimate the prevalence of problem drug use. Indirect methods have therefore been devised to estimate such behaviour.

In Malta, a five-source capture-recapture method was adopted using data from Maltese daily heroin users attending the five treatment providers in 2006. This is consistent with the methodology employed by Malta in previous years and will allow comparisons to be made over time. Heroin users were included because treatment is predominately provided to heroin users (heroin is the primary drug of 85% of all clients). In 2006 only one client in Malta had reported using amphetamines and clients reporting cocaine use tend to be relatively low amongst the treated population in Malta (6%).

The estimated number of daily heroin users stood at 1606 (95% confidence interval 1541 to 1685). This estimate suggests that approximately 78% of daily heroin users attended treatment services in 2006. The rate per 1,000 population aged 15-64 was 5.4 (95% confidence interval 5.1 to 5.6), displaying relative stability since 2004. The estimated rates of opioid use in Malta are consistently amongst the highest in Europe (see Figure 4.1) and would be even higher if the EMCDDA's more inclusive definition had been used.



NB: The bars indicate an estimation uncertainty interval. Comparisons should be made with caution since target groups may vary slightly due to different estimation methods and data sources, and estimates are based on different years (year in parenthesis).

Figure 4.1.

Source: EMCDDA Annual Report 2007

Incidence can be defined as the number of individuals initiating a given behaviour (e.g. heroin use) per year. Retrospective incidence estimates can help in understanding the risk of heroin initiation over time and space and can be used to study aetiological factors for heroin use and evaluate interventions aimed at preventing heroin use among the population at risk (Rossi, 2002). No new incidence estimates have been obtained for 2006.

4.3 PROFILE OF CLIENTS IN TREATMENT

In some treatment agencies sociodemographic and drug use characteristics are only recorded at the point of first treatment contact, which for many clients will have been before 2006. Since the characteristics of individual clients of longer-term may have changed over time, only variables that are likely to have remained stable will be presented for all clients in treatment in 2006 (referred to as all treated clients). More detailed profiles of new clients first in treatment in 2006 (referred to as first treated clients) can be presented.

Number of Clients

The number of clients in Malta has increased from 1444 in 2003 to 1584 in 2006 (Table 4.1). Discounting 2004, (due to the data problems mentioned previously in the overview) the total number of first treated clients has increased from 252 (17% of all treated clients) in 2003 to 417 (22% of all treated clients) in 2006. This increase is likely a result of a true increase in drug use. The opening of the DDU would not have caused such an increase in individual clients.

Number (%) of Clients Treated for Drug Use in Malta by Status, 2003-2006

	2003		2004		2005		2006	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
All clients	1444	100	1525	100	1714	100	1848	100
Previously treated clients	1175	81	1358	89	1402	82	1431	77
First treated clients	252	17	167	11	312	18	417	23
Status unknown	17	1	0	0	0	0	0	0

Table 4.1.

Source: Merged Treatment Data Files 2003-2006

Gender

In 2006, 14% of all treated clients and 16% of first treated clients were female. The ratio of male to female clients amongst all treated and first treated clients has remained relatively stable between 2003 and 2006.

Age

In 2006, 82% of all treated clients were less than 35 years of age (See standard table 3). The most predominant age groups were 20 to 24 (26%) and 25 to 29 (26%) (Figure 4.2).

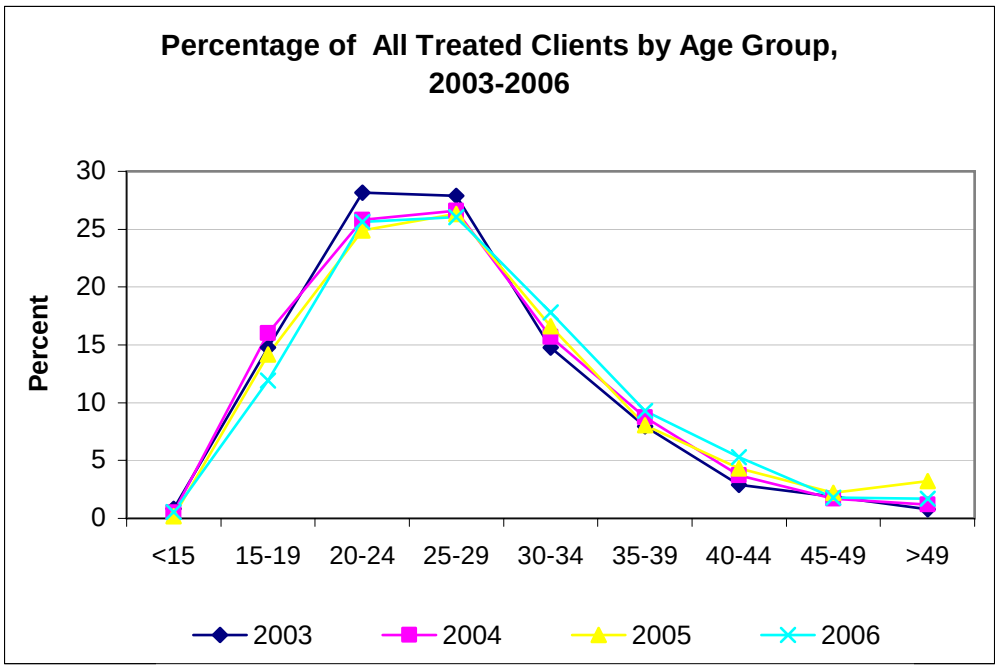


Figure 4.2

Source: Merged Treatment Data Files 2003-2006

Amongst first treated clients 88% were less than 35 years of age. The largest group were aged 15 to 19 (31%), followed by those aged 20-24 (26%) and 25 to 29 (17%) (Figure 4.3). All treated clients tend to be older than first treated clients since this group incorporates persons that have been in treatment for longer, in some cases, years. In addition, clients who used or are using heroin are likely to remain in treatment for longer

periods than clients using other substances, partly because of the availability of methadone maintenance treatment.

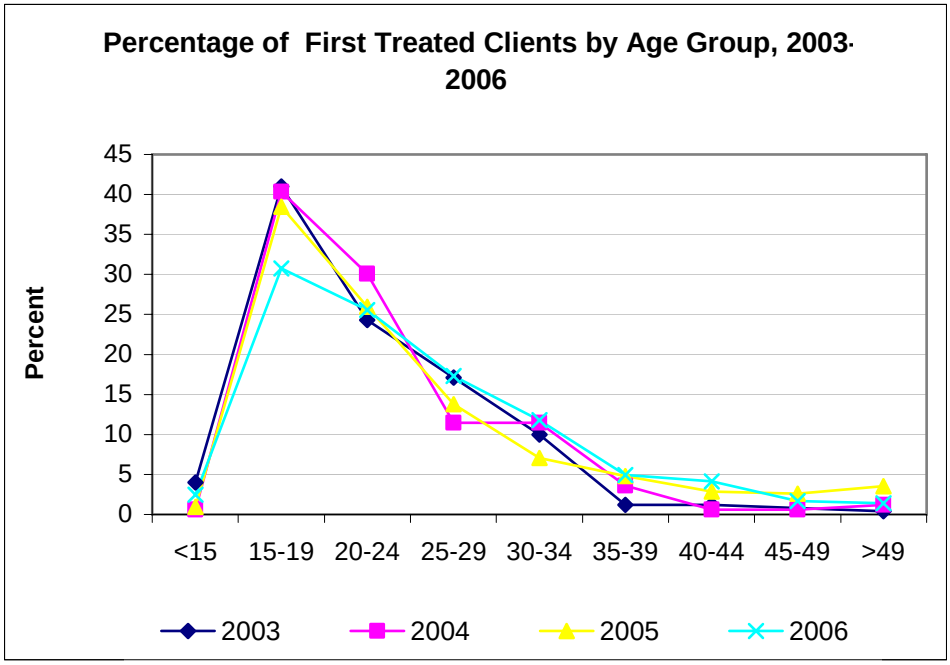


Figure 4.3

Source: Merged Treatment Data Files 2003-2006

There has been a decline in the percentage of all and new treated clients aged 15 to 19 between 2003 and 2006. In real terms the number of 15 to19 year olds has remained relatively stable while the number of older clients has increased.

Region

The highest rates of all treated clients residing in Malta per 10,000 population of 15 to 64 years were found in the Southern Harbour region (112.5), the Northern Harbour region and the South Eastern region (62.3) (Table 4.2). This is consistent with the fact that most syringes were distributed from health centres in the Southern and Northern Harbour regions of Malta (see Chapter 7). The highest rates of first treated clients were seen in the Southern Harbour (19.9) and Northern (12.8) regions, followed by the Northern Harbour region (12.2).

Rate of Persons in Treatment per 10,000 Population Aged 15-64 Years

	Southern Harbour	Northern Harbour	Northern	South Eastern	Western	Gozo	Total
Total population aged 15-64*	55179	82610	39844	41812	39722	20639	279805
All treated clients							
No. in treatment 2006	621	515	188	227	141	19	1711
Rate of persons in treatment per 10,000 of the regional pop. aged 15-64	112.54	62.34	47.18	54.29	35.50	9.21	61.15
First treated clients							
No. in treatment 2006	110	101	51	45	17	13	337
Rate of persons in treatment per 10,000 of the regional pop. aged 15-64	19.94	12.23	12.80	10.76	4.28	6.30	12.04

Table 4.2.

Source: Merged Treatment Data Files 2006

***based on 2005 National Census (ref) http://www.nso.gov.mt/docs/Census2005_Vol1.pdf**

Between 2003 and 2006 the percentage of all treated clients originally residing within each region is relatively stable. In 2006, most clients were from the Southern Harbour region (36%), followed by the Northern Harbour region (30%), the South Eastern Region (13%), the Northern Region (11%), the Western Region (8%) and Gozo (1%). Fluctuations over time are observed for first treated clients (see Figure 4.4). Between 2005 and 2006 there was an increase in the percentage of first treated clients coming from the Northern region (from 8% to 15%) and a decrease in the number from the Western region (from 11% to 5%). The percentage of clients deriving from Gozo, although low, doubled (from 2% to 4%).

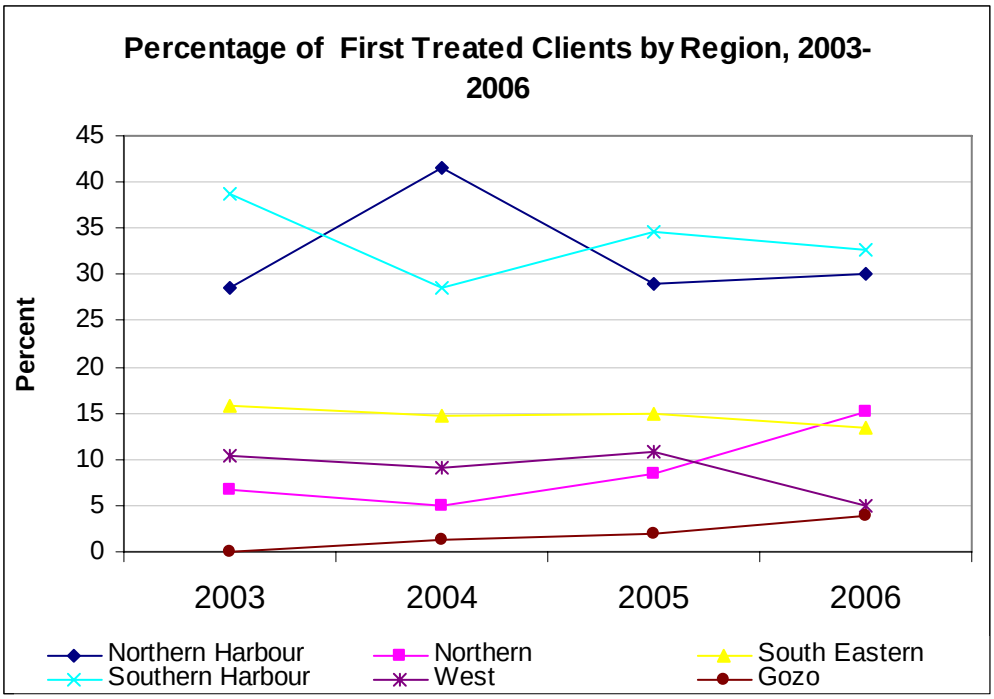


Figure 4.4

Source: Merged Treatment Data Files 2006

Figure 4.5 displays towns with the highest percentage share of clients in 2006. Amongst all treated clients a higher percentage of clients reside in Zabbar, Valletta and Qormi. Amongst first treated clients a higher percentage reside in St. Paul's Bay, Paola and Zabbar.

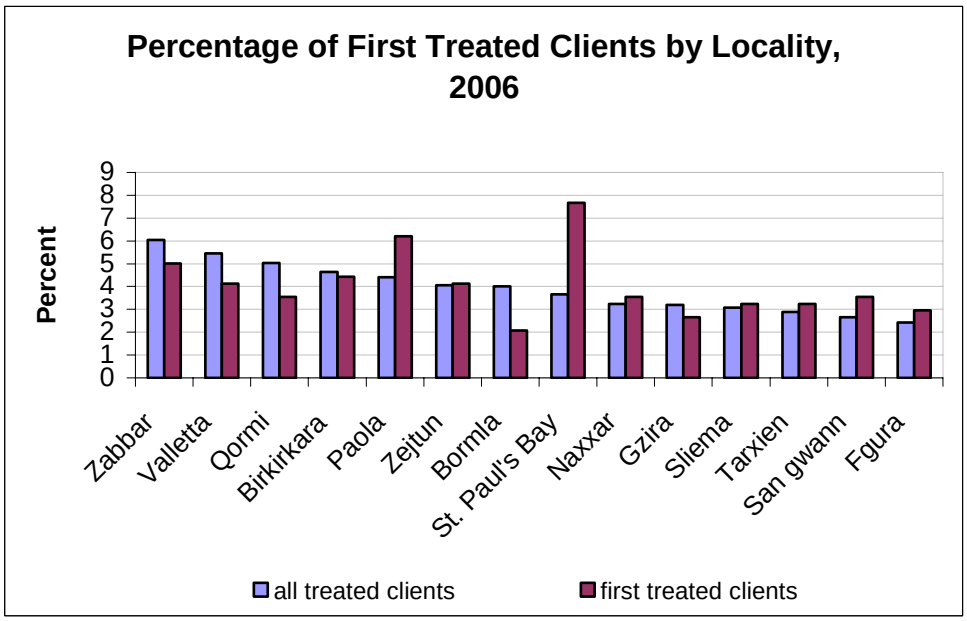


Figure 4.5

Source: Merged Treatment Data Files 2006

Much of the increase in the percentage of clients coming from the Northern region is due to an increase between 2003 and 2006 in the percentage of first treated clients residing in St. Paul's Bay (from 2% to 8%). This area has developed rapidly over the past few years. The increase in population alone will result in an increase in the percentage of clients residing in the locality. However, accommodation is also cheaper to purchase and rent when compared to many other localities. This may mean that persons already using drugs are moving into the area, or that factors relating to the need for cheaper housing, such as living in a single parent household (see Chapter 12, ESPAD results), are increasing the risk of problem drug use.

Nationality

The vast majority of all treated clients (96%) and first treated clients were Maltese (93%), with small increases between 2003 and 2006 seen in the percentage of first treated clients from EU (from 1% to 3%) and non-EU countries (from 3% to 4%).

Occupation

45% of first treated clients were employed, 45% were unemployed, the remaining 10% were classified as 'other' (this group includes students and homemakers). Excluding data from 2004, these figures have remained relatively stable between 2003 and 2006.

Primary Drug of Use

A primary drug is the drug that causes the client the most problems. In 2006 the primary drug amongst all treated clients was most frequently heroin (85%), followed by cannabis (7%), cocaine (6%), ecstasy (2%) and other drugs (1%).

Between 2003 and 2006, 2004 aside, there are small decreases in the percentage of first treated clients whose primary drug of use was heroin (from 69% to 64%) and cannabis (from 22% to 19%) and an increase in cocaine (8% to 12%) and ecstasy (1% to 5%) (Figure 4.6).

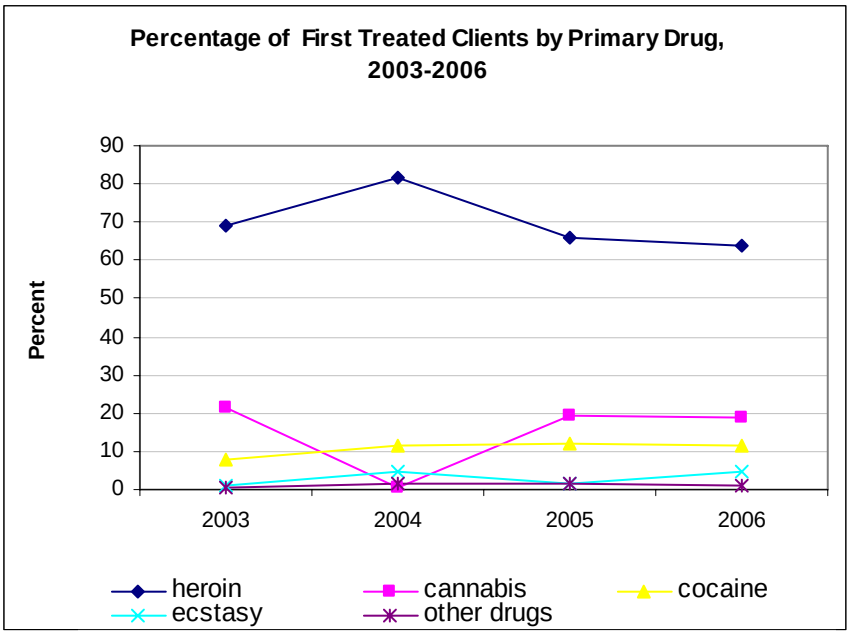


Figure 4.6

Source: Merged Treatment Data Files 2006

Current Injecting Status

In 2006, 51% of first treated clients were current injectors, an increase from 45% in 2003.

Frequency of Use of Primary Drug

In 2006 most first treated clients (76%) were daily users of their primary drug. Between 2003 and 2006 there was an overall increase in the percent of clients using twice a week or more (from 77% to 84%) (Figure 4.7).

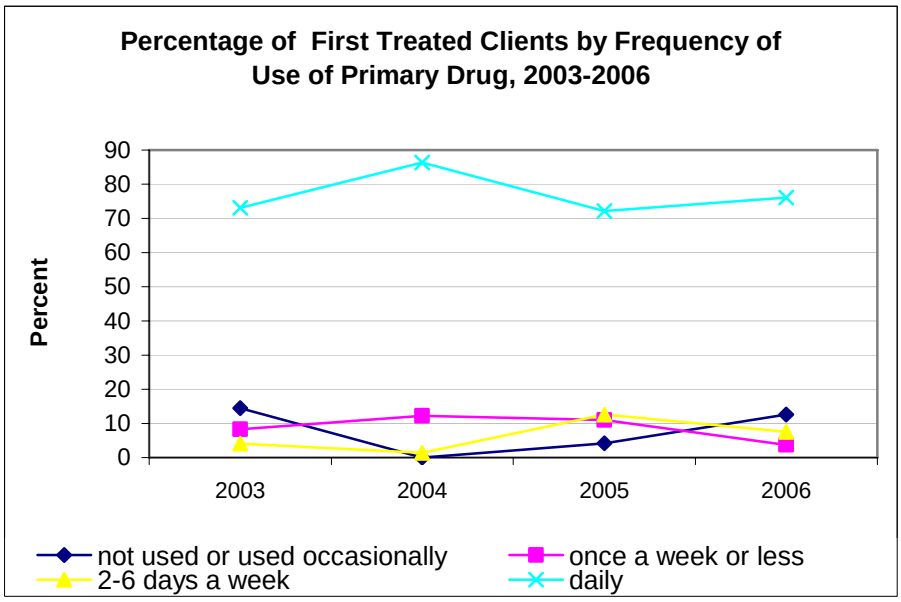


Figure 4.7

Source: Merged Treatment Data Files 2006

Profile of Cases by Primary Drug

Amongst all treated clients, a higher percentage of primary users of heroin are female (15%) when compared to primary users of cocaine (13%) or cannabis (11%). Primary users of heroin have a higher median age (26 years) compared to their counterparts (Table 4.3).

Gender and Age of All Treated Clients 2006 by Primary Drug

	share%	female%	median age
Heroin	87	15	26
cocaine	4	13	23
cannabis	8	11	21

Table 4.3.

Source: Merged Treatment Data Files 2006

Amongst first treated clients, a higher percentage of primary users of heroin, when compared to primary users of cocaine or cannabis, are female (20%), unemployed (52%), inject (64%) and use daily (88%). Primary users of cocaine have a higher median age (27.5 years) compared to primary users of heroin (23 years) and cannabis (20

years) and are more likely to sniff the drug (63%). Primary users of cannabis are least likely to be female (12%), unemployed (28%) and are more likely to smoke the drug (98%) and use the substance less frequently (Table 4.4).

Profile of First Treated Clients 2006 by Primary Drug

					route of administration			frequency of use			
	share%	female%	median age	unemployed%	Inject%	smoke/ inhale%	sniff%	daily%	2-6 days per week%	>once a week%	not used/ occasional%
heroin	64	20	23.0	52	64	25	9	88	4	4	4
cocaine	12	14	27.5	45	24	13	63	60	18	0	22
cannabis	19	12	20.0	28	0	98	0	57	8	2	33

Table 4.4
Source: Merged Treatment Data Files

4.4 MAIN CHARACTERISTICS AND PATTERNS OF USE FROM NON-TREATMENT SOURCES

There is no new information available from non-treatment sources.

4.5 DATA QUALITY: FUTURE IMPROVEMENTS

Since 2003, the first year that the NFP began operating and producing Malta's national report, data has been collected from the separate treatment providers in the form of an excel datasheet. Each treatment provider collects data in a disparate fashion, using different categories with different definitions and different coding systems. These data files are then harmonised into one SPSS file and codes and variables are standardised and cases of double counting checked for and duplicate cases excluded. In future, the quality of the data shall be further improved with the introduction of standard operating procedures within drug treatment providers and Sedqa's new case software management system in 2008.

CHAPTER 5

DRUG-RELATED TREATMENT

5.1 OVERVIEW

Drug treatment is defined by the EMCDDA (2007) as "*all structured interventions with specific pharmacological and/or psychosocial techniques aiming at reducing or abstaining from the use of illegal drugs*". Previous National Drug reports (2003, 2004, and 2005) have provided a comprehensive description of drug treatment systems. This chapter focuses on new developments and trends in drug-free treatment and pharmacologically-assisted treatments, which is provided on both an inpatient and outpatient basis in Malta.

5.2 TREATMENT SYSTEMS

In Malta there are five main drug treatment providers. Three are managed and funded by the government: Sedqa, Agency Against Drug and Alcohol Abuse, which falls under the Ministry of Family and Social Solidarity; the prison-based unit SATU (Substance Abuse Therapeutic Unit), which falls under the Ministry for Justice and Home Affairs; and the DDU (Dual Diagnosis Unit) within Mount Carmel Psychiatric Hospital, which falls under the Ministry of Heath, the Elderly and Community Care. Caritas and OASI are voluntary treatment agencies, which receive partial support from the government.

The DDU and SATU are single inpatient units providing services only to males. Sedqa, Caritas and OASI offer treatment from a number of units on both an inpatient and outpatient basis. OASI is the only treatment provider offering services in Gozo, Malta's sister Island. These five main treatment providers collaborate and can be viewed as somewhat interdependent. Clients may attend more than one treatment provider in parallel or subsequently and referrals between treatment providers occur. For example, only Sedqa's Substance Misuse Outpatient Unit, (SMOPU - formerly known as Detox) is licensed to dispense methadone in Malta and so clients from other treatment providers requiring pharmacologically assisted treatment will be referred to this Unit. (In Gozo methadone is dispensed from Craig Hospital).

At a national level 1848 individuals attended treatment services, with 380 (21%) attending more than one service provider in 2006. Most of this overlap occurred between Sedqa and Caritas. Over a longer period of time this overlap will be greater given the chronic nature of addiction, the resulting habitual use of treatment services and long term contact some clients have with treatment providers (in particular those following a methadone maintenance programme).

Initially when DDU first started to operate it was functioning as a crisis management unit to separate persons with a drug problem from the rest of the patients in the hospital. Recently it has started to function as a unit that diagnoses and treats persons who have both a psychiatric and a substance use problem. This has resulted in an increase in average length of stay, which is now approximately 3 weeks and a consequent decrease in the number of clients resident throughout the year.

5.3 DRUG FREE TREATMENT

In October 2006, Anew, a private treatment facility offering help for a range of problems including drug abuse, was opened in Gozo. The programme includes a stay in a residential setting, which can accommodate 24 clients at any one time. The rehabilitation centre employs a range of treatment approaches including psychotherapy, counselling, group work, reflexology, massage, and emphasis good nutrition. This facility targets clients, both Maltese and foreign, for whom privacy is of prime importance. To date, Anew, does not forward data to the National Focal Point.

5.4 PHARMACOLOGICALLY- ASSISTED TREATMENT

The provision of oral methadone is the most common form of medically assisted treatment. Naltrexone has also been offered since 1996. As from mid 2006 Buprenorphine became available in Malta, increasing the treatment options available to opioid dependent persons. Buprenorphine, a substitution medicine, is a partial agonist. In comparison to methadone it is considered to have milder withdrawal symptoms and to be safer in overdose (Ford et al. 2004). Buprenorphine can be prescribed by a medical

doctor at Sedqa or a GP and is only available through private purchase. In 2006, 141 persons were prescribed Buprenorphine by a medical doctor at Sedqa.

Outcomes of young people on methadone

Damato (unpublished dissertation, 2007) explored outcomes amongst 19 clients who had started treatment on methadone at Sedqa's SMOPU aged between 15 and 19, in 2003, and were still in treatment 24 months later. Nine clients had lost contact with SMOPU. From the analysis of secondary data and in-depth interviews it was found that many of the young people had eliminated or drastically reduced their intake of illegal drugs and experienced improved physical health. Eight clients report an improved familial situation. However, the majority of young persons noted unstable psychological health, with twelve clients still taking prescribed psychotropic medicine although their intake had reduced substantially. Both 'sharing' and unprotected sex with 'regular partners' was engaged in. Some participants had engaged in criminal behaviour, in addition to illicit drug use, and two thirds of the participants were unemployed.

5.5 SYSTEM OF INFORMATION DISSEMINATION AND QUALITY ASSURANCE

In 2006 there were no changes to the system of information dissemination or quality assurance.

CHAPTER 6

HEALTH CORRELATES AND CONSEQUENCES

The use and abuse of drugs is dangerous and can result in illness and even death. This chapter focuses on the health issues that often accompany drug use, such as overdoses, fatal and non-fatal, drug related infectious diseases and psychiatric co-morbidity.

6.1 Drug-related Deaths and Mortality of Drug Users

The definition used in Malta for an acute drug related death (DRD) is the same as that given by the EMCDDA, 'deaths caused directly by the consumption of drugs, generally occurring shortly after the consumption of the substance'.

The numbers of DRDs are routinely documented by the National Mortality Register (NMR) and the Police Special Register (PSR). The NMR only collects data on Maltese Nationals or Maltese residents, whereas the PSR collects data on all who die as a result of drugs, even if they are non-residents.

With reference to Standard Table 5 produced by the NMR, in 2006 there were a total of 7 drug related deaths (mean age 28.6 years), 5 were males (mean age 24.8 years) and 2 were females (mean age 38 years). The number of deaths due to opiates was 6 and the one death not due to opiates resulted from a combination of cocaine and ecstasy. The NMR data is deemed to be accurate with a very low chance of under-reporting.

The numbers of DRDs in 2006 seems to be in line with the numbers reported in the past 9 years, which range from five to eight (Figure 6.1).

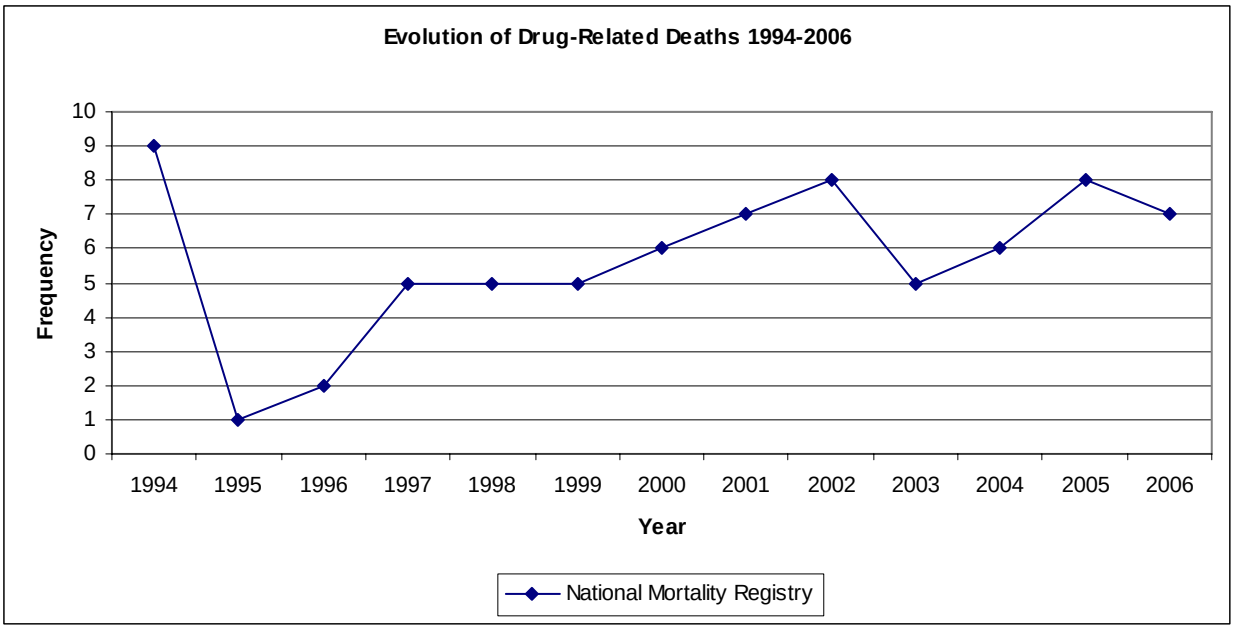


Figure 6.1

Source: National Mortality Registry 1994-2006

Between 1991 and 2006 the mean age has fluctuated from 24 years in 2001 to 38.2 years in 2003 (Figure 6.2). These fluctuations are mainly due to the small numbers in question and not necessarily indicative of increases or decreases in age *per se*. Between 1994 and 2006 the DRDs occurring in the 15-34 years age groups accounted for around 7% of all deaths in this age cohort.

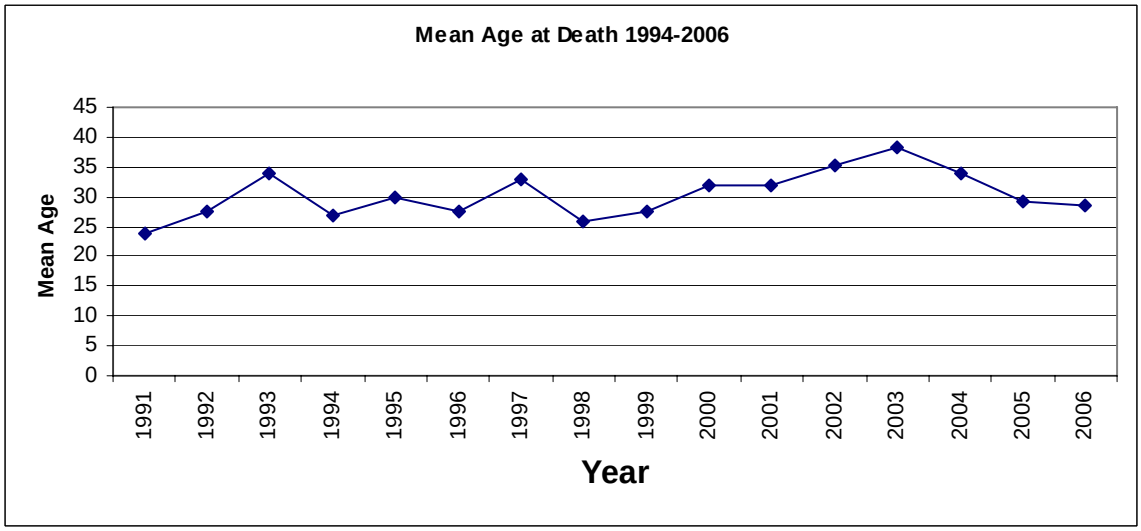


Figure 6.2

Source: National Mortality Registry 1991-2006

Recent progress in the collection of DRD data

During 2006, more detail on the multiple substances involved in DRDs were collected by the NMR and the Toxicology Unit for the years 2002-2005. This was done as a joint venture with the EMCDDA and other EU countries for the toxicological field trial. The results show that although a combination of substances do emerge[1], opiates remain the major problem (Figure 6.3.), and this is a reflection of the type of problem drug users seeing in Maltese drug treatment centres – heroin users who also abuse multiple substances.

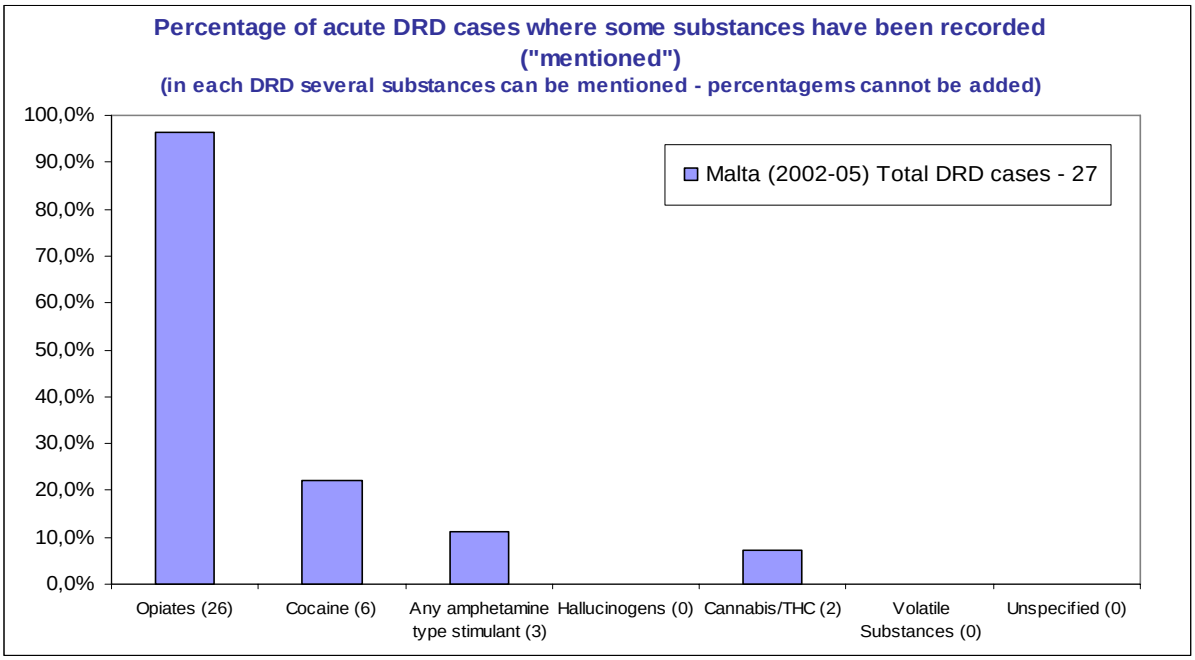


Figure 6.3
Source: Toxicology Field Trial 2006 – Department of Health Information and EMCDDA

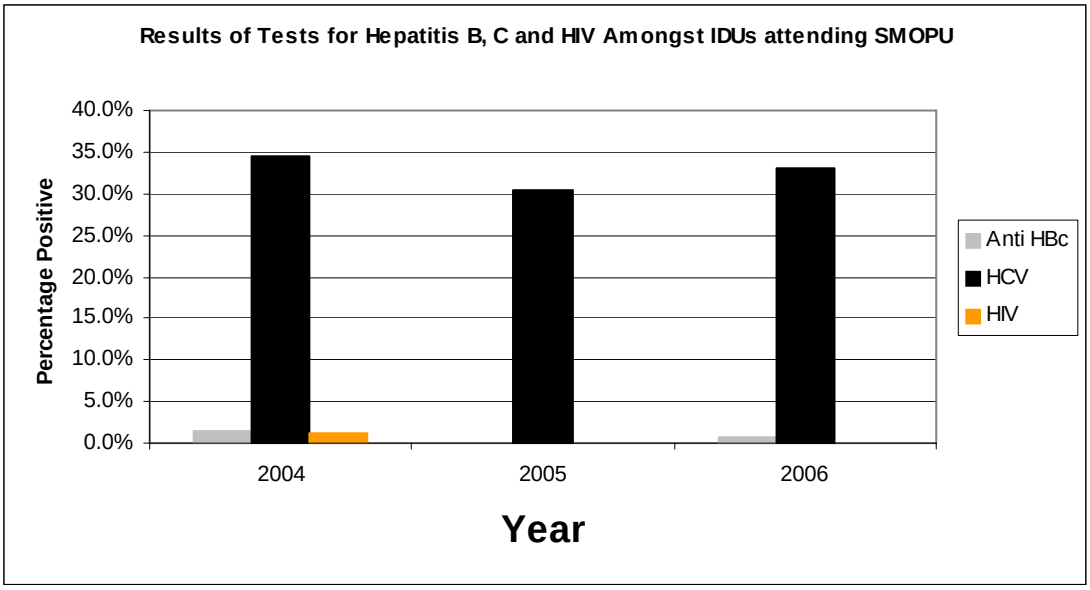
Cohort Study – Mortality of drug users over time

A cohort study among a defined group of drug users over the period 1995-2005 is being planned. The aim of this study is to link data from a heroin-using cohort (collected by the Detox centre (SMOPU) at Sedqa) with the NMR of the Department of Health Information. Information about causes of death will be collected. Other factors to be analysed include socio-economic variables as well as age at first use, frequency of use and route of administration.

[1] The way the data was calculated under-estimates and probably under-represents the importance of alcohol and its effect on the central nervous system. In the tables provided for this trial, alcohol is documented only if found alone with one substance of abuse and consequently may be largely under-reported.

6.2 Drug-related Infectious Diseases (DRIDs)

DRIDs are defined as diseases contracted as a direct or indirect result of using drugs. This section reports data on Hepatitis C (HCV), Hepatitis B (Anti HBc) and HIV amongst drug users. With reference to Standard Table 9, DRID data used to calculate the prevalence[2] of infectious diseases amongst drug users is collected from Sedqa the National Agency against Drug and Alcohol Abuse, who test drug users attending the Substance Misuse Outpatient Unit (SMOPU). The results of tests for the years 2004-2006 are presented in Figure 6.4. As in previous reporting years, only injecting drug users (IDU) registered with SMOPU in any given year are included in the data, and from those, only those tested in that year are included. The results may therefore be biased downwards. Figure 6.4 shows that the percentage for Hepatitis C infections remains stable and those for Hepatitis B and HIV very low. In 2005 and 2006, from those tested, no one tested positive for HIV.



DATA SOURCE SMOPU	IDUs Anti HBc	IDUs HCV	IDUs HIV
2004 Number Tested	142	180	77
2005 Number Tested	118	138	83
2006 Number Tested	151	151	175

Figure 6.4
Source: Sedqa Data Files 2004, 2005 and 2006

[2] Please see comments section in Standard Table 9 for limitations on this definition and data limitations.

Notification Data from the DSU

Last year the DSU reported infectious disease notifications for the first time. This year data from DSU is reported again, albeit with limitations. There may be problems of under-reporting as the previous year's report highlighted. Under reporting is thought to be extensive due to the large number of anonymous tests, and a lack of standard operating procedures for notifications[3]. Table 6.1 shows the percentages of drug-related notified cases of acute and chronic Hepatitis B and C amongst all notified cases with known route of transmission. The data shows that the main problem seems to revolve around the high numbers of Hepatitis C cases amongst drug users.

Notifications of Hepatitis B, Hepatitis C and HIV 2005 and 2006

YEAR	HCV ACUTE	HCV CHRONIC	HBV ACUTE	HBV CHRONIC
2005	25%	77%	0%	4%
No. of Notified Cases of Known Route of Transmission	2/8	33/43	0/12	2/47
2006	100%	79%	0%	14%
No. of Notified Cases of Known Route of Transmission	6/6	11/14	0/3	3/21

Table 6.1.

Source: DSU Notification Data 2005, 2006

6.3 Psychiatric co-morbidity (dual diagnosis)

A national clinical picture of persons with drug problems and psychiatric disorders (dual diagnosis) cannot be presented due to data collection limitations in this area. Drug treatment agencies do receive such clients and are increasingly concerned about the numbers of persons presenting with such problems. There are also 3 specialised units for the treatment of clients with dual diagnosis – The Dual Diagnosis Unit (DDU) at Mount Carmel Hospital, the Dual Diagnosis Outpatient Clinic at Sedqa's Substance Misuse Outpatient Unit (SMOPU) and the prison pre-release programme at the Substance Abuse Therapeutic Unit (SATU). Some data can only be presented for SATU:

Substance Abuse Therapeutic Unit (SATU)

Since 2004, SATU has catered primarily for those persons who are in prison, have a substance abuse problem and in addition suffer from dual diagnosis. During 2006, 23 persons were referred to SATU from CCF, compared to 15 in 2005. The average age of clients in 2006 was 41 years (range 20 years – 52 years) and most, 39%, were

[3] See Standard Table 9 for further details re: notification data limitations

diagnosed with Obsessive Compulsive Personality Disorder. Other diagnosed disorders amongst this client group included Obsessive Compulsive Disorder, Paranoid Personality Disorder, Narcissistic Personality Disorders, Antisocial Personality Disorder, Borderline Personality Disorder and Chronic Delusional states.

6.4 Other drug-related Health Correlates and Consequences

Non-Fatal Overdoses (NFODs)

NFOD data is obtained from the Police Drug Squad records. This data, although not without its limitations, remains the most comprehensive source available.

In 2006 the total number of NFOD cases was 238 (unique individuals: 231)[4] compared to 175 cases (unique individuals: 170) in 2005 and 216 cases (unique individuals: 205) in 2004. Between 2005 and 2006, a 36% increase of NFOD cases was reported.

Most NFODs in 2006 involved medicinals, particularly psychotropic medication (166 persons: 99 females, 67 males). Whereas in 2006, the numbers of NFODs due to medicinals increased only slightly from 2005, those resulting from illicit substances reached a dramatic high (n=65). This figure is more than double that reported in 2004 (n=28) and 2005 (n=27). During 2006, NFODs due to illicit drugs comprised 28% of all NFODs, compared to 15% in 2004 and 2005 (Figure 6.5).

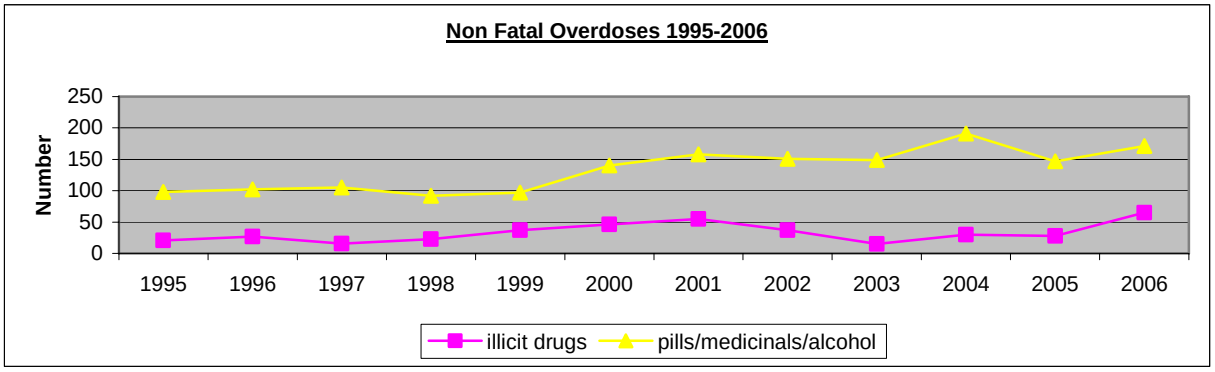


Figure 6.5.

Source: Police Drug Squad Records 2006

[4] Includes non-residents (tourists/foreigners)

Moreover, in 2006, there were more male (n=126) NFOD cases than females (n=105) compared to 2005 (67 males vs 103 females). This data shows that the overall reported increase of NFOD cases is due to a doubling in the numbers of male cases, from 67 in 2005 to 126 in 2006 for non-illicit substances and from 23 in 2005 to 59 in 2006 for illicit substances.

In 2006, similar to 2005 and 2004, a substantial percentage of NFODs occurred amongst young adults aged between 20 and 34 years (41.1%). The share of NFODs amongst 15-19 year olds increased between 2005 and 2006 from 12% to 16%. Females are more likely to overdose from some kind of prescription or over the counter drug (60%) as opposed to illicit substances (9%) whereas males, in contrast, are nearly as likely to overdose from medicinals (29%) as they are from illicit drugs (25%). NFODs due to illicit drugs peak amongst those in their younger years (mean age 26 years) whilst those for medicinals peak for an older cohort (mean age 37 years). NFOD records show that those cases involving illicit drugs were generally reported as accidental (28%) whereas those involving medicinals were more often reported as intentional or attempted suicide (72%). Few were the cases of accidental intake of medicinals, these usually involved the elderly (6%)

Non Fatal Overdose Data Summary and Conclusions

The numbers of NFODs due to medicinals are high. These are easily obtained and consequently, their abuse becomes a common occurrence. Teenagers (aged between 14 and 19), especially females, are overdosing at an equivalent rate to their middle-aged cohort (aged between 45 and 54). The numbers of males overdosing on illicit drugs has doubled between 2005 (24 persons) and 2006 (59 persons).

Although proposals have been made to establish a working group aimed to create a standard operating procedure to collect, harmonise and cross-compare NFOD data between different sources (namely Police and hospital Emergency), data collation in this regard still falls short. The general hospital does not have an NFOD database. Additionally, since a change in the law in 2003 no longer obliges doctors to report NFODs to the Police, the Police database may not contain all NFODs admitted to hospital. Finally, the word overdose in the case of drugs of abuse is possibly a

misnomer, as there is a chance that any person admitted to hospital where drugs of abuse are found on screening, is incorrectly labelled an overdose.

Pregnancies and Children Born to drug Users - Methadone Babies

Methadone babies are those newborns who need to undergo substitution therapy on methadone following heroin intake by their mother during the pregnancy. This therapy is absolutely necessary in order to protect the newborn from withdrawal symptoms. The newborn undergoes the same symptoms of muscle pain, sweating nausea etc. as a result of the mother's drug intake. SMOPU has been providing this substitution therapy and its subsequent after-care.

Following labour and birth, a child born to an addicted mother who took heroin during pregnancy, is taken to the postnatal ward. There the newborn is screened for withdrawal symptoms on a regular basis. Once these start, the newborn is taken to the Special Care Baby Unit (SCBU) and methadone treatment is administered. Once stabilisation occurs (withdrawals are controlled and a weaning off regime is established) the newborn is moved to a nursery. The above process takes from 2 - 3 weeks. Once moved to the nursery in post-natal ward, the newborn is weaned off methadone and sent to the Paediatric Ward. The above process takes from 4 – 6 weeks. All told, a newborn undergoing substitution therapy requires approximately 10 weeks in treatment after birth. A longer period may be required if complications occur. The data in Tale 6.2 shows that the number of mothers attending the Well Women Clinic, a service provided by SMOPU, has increased, as have the numbers of infant fatality.

Methadone Babies 2003-2006

Year	*Mothers attending SMOPU on Methadone*	*Mothers not attending SMOPU*	*Stillbirths/ miscarriages*	*Healthy babies on methadone*	*Babies born not requiring methadone*
2003	***8***	***3***	***1***	***7***	***3***
2004	***14***	***0***	***0***	***14***	***0***
2005	***13***	***0***	***2***	***10***	***2 (twins)***
2006	***16 (3 were still pregnant at the end of 2006)***	***0***	***4 (3 due to heroin use during pregnancy***	***9***	***0***

Table 6.2
Source: 2006 report from SMOPU's Well Woman Clinic

CHAPTER 7

RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

One of the main objectives of the Draft National Drugs Policy 2007 is that of achieving a high level of health protection and social cohesion by preventing and reducing drug related harm to health and society. The policy's actions in this sense, aim to provide the general public with information on the dangers of drug use, promote ongoing and public health campaigns. Additionally, the policy also states that it aims to, "through its different entities, ensure that effective education campaigns are conducted to further disseminate information, raise awareness and educate the public in general and vulnerable groups in particular about:

(a)the misuse/abuse of prescription and non-prescription medication and the physical, social, psychological and emotional effect that such misuse/abuse has on users, their significant others and the community at large;

(b)the various types of illicit drugs and their effect on users, on their significant others and on the community at large;

(c)the availability of professional services designed to promote the prevention of illicit drug use and misuse/ abuse of prescription and non-prescription medication and to facilitate the rehabilitation and reintegration/integration of drug users;

(d)the role that society should play to promote a healthy lifestyle, prevent the use of illicit drugs and misuse/abuse of prescription and non-prescription medication, facilitate the integration of rehabilitated drug misusers and help them avert relapse; and

(e)the benefits of suppressing the supply of and demand for drugs with a view to ideally eliminate the use of illicit drugs and misuse/abuse of prescription and nonprescription medication".

In terms of improving treatment, the Policy also states that Government, through the Ministries responsible for health and social policy shall:

"Analyse and seek to improve upon the various treatment options which shall not be limited to medical treatment but which shall also focus on psychological and social aspects….."

"Improve those harm reduction measures which shall be applied in the case of drug users where abstinence from illicit drug and prescription and non-prescription medication misuse/abuse is not immediately viable or realistically possible".

7.1 Prevention of Drug-Related Deaths

Most measures aimed at reducing the amount of drug-related deaths are implemented by drug treatment agencies. These involve providing information and knowledge on drug use and its dangers through groups and individual sessions, leaflets, flyers, billboards, outreach work, websites and through the media. There have been no new developments in preventative measures targeting the reduction of drug related deaths in the reporting year (see National Reports 2004, 2005, 2006).

7.2. Interventions Related to Drug-Related Infectious Diseases

Hepatitis C

Free blood screening as well as pre and post test counselling for Hepatitis C takes place at the Substance Misuse Outpatient Unit (SMOPU). Hepatitis C pre and post test counselling and testing is also offered to clients who are frequenting a drug residential programme. Other settings where testing takes place include prison (CCF), where all inmates are tested upon admission. The Genitourinary (GU) clinic within the department of health also provides a service for free testing of sexually transmitted diseases to the general public. Contact tracing is also affected by this unit as well as by the Department of Public Health's Disease Surveillance Unit (DSU), which, by law, is meant to receive all Hepatitis C notifications.

Treatment for Hepatitis C includes Interferon treatment alone and Interferon/Ribavarin combination treatment. Drug users who have contracted chronic Hepatitis C and who

are still using drugs are not eligible for treatment as the criteria for eligibility for treatment include drug abstinence and termination of methadone treatment for at least one year.

HIV

The prevention of HIV amongst drug users is similar to that of Hepatitis C. Blood screening and pre and post test counselling is provided by SMOPU, CCF, the GU clinic and the XEFAQ service offered by Caritas. Unlike Hepatitis C, the prevalence of HIV amongst drug users appears to be low in Malta (no cases of HIV among drug users were notified in 2006). By law, since 2004, HIV has become a notifiable disease and the DSU is responsible for receiving these notifications and conducting contact tracing.

Hepatitis B Vaccine

Testing and vaccination for Hepatitis B is a free service provided by health centres to the general public. SMOPU provides a free and highly accessible screening and vaccination program to all drug users who are attending the clinic. Prison inmates are screened on admission for Hepatitis B. A vaccination program for inmates has been started in 2007. The prevalence of Hepatitis B amongst drug users is low in Malta (about 1.6%).

Needle and Syringe Availability

Since syringe distribution started in Malta in the 1980's, reaching national coverage in 1994, the number of syringes distributed yearly has risen steadily (Figure 7.1.), with an increase of 1.4% in 2005 compared to 2004, and of 2.5% in 2006 compared to 2005. Most syringes were distributed from health centres in the Southern and Northern Harbour regions of Malta. One particular health centre in the Southern Harbour Region distributed 30% of all syringes. Although the syringe distribution programme works well, the needle-exchange practice that existed briefly and failed in 2002, was never re-implemented.

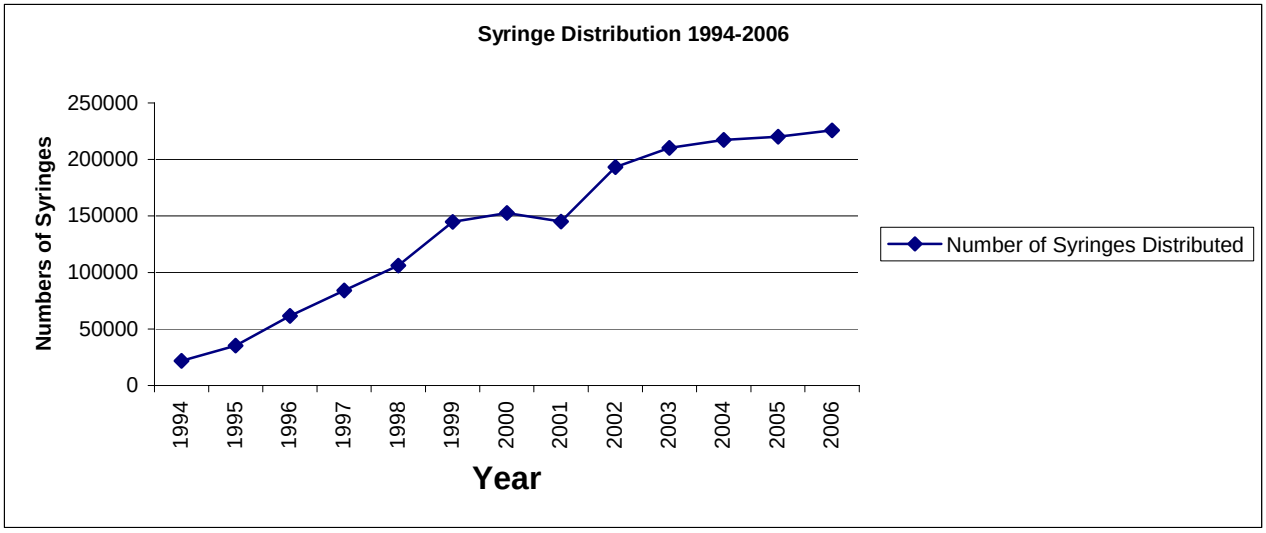


Figure 7.1
Source: Department of Primary Health Care Data 2004-2006

Detection and Treatment of Bacterial Infections Amongst Female Substance Abusers

The Well Women Clinic at SMOPU conducts routine smear tests amongst female substance abusers. In 2005, of the 30 tests conducted, 20 gave normal cytological findings. Of the remaining 10, 5 had bacterial infections, 4 had the Human Papilloma Virus (HPV) and 1 had Carcinoma in situ, stage iii. All patients were successfully treated. In 2006, 44 smear tests resulted in 8 indicating pre-cancerous and cancerous states requiring further treatment, whilst a further 15 required treatment for bacterial infections. In an average population of women one would normally expect to find abnormalities in 1 out of every 12 smear tests conducted. The results of these tests show that more than half of those tested as having some serious abnormalities. This is indicative of particular sexual health and related needs of the female substance misusing population.

7.3 Interventions related to Psychiatric Co-Morbidity (Dual Diagnosis)

The Dual Diagnosis Unit (DDU) at Mount Carmel Hospital serves to detoxify, stabilise and provide medication to dual diagnosis clients. Referrals to and from other drug treatment agencies are often made. The nursing staff provide patients with basic problem-solving interventions however therapeutic input is limited and further supervision and training in the areas of motivational interviewing, group work, individual and family therapy are needed. Most clients typically discharge themselves against

medical advice. Such persons are increasingly susceptible to drug overdose due to their concomitant use of illicit drugs and pills.

SMOPU offers a psychiatric service for clients with varying degrees of mental problems. The aim of this service which commenced in 2004 is stabilisation of drug use through substitution treatment and treatment of the psychiatric condition.

The standardisation of clients' intake assessments has enabled drug treatment agencies to detect more easily the signs of any co-morbid conditions. This has meant that agencies are now working more closely and in parallel with psychiatrists and psychologists in order to treat clients with psychiatric co-morbidity more effectively. Additionally, whereas in the past rehabilitation centres did not accept clients on psychotropic medication, in recent years a large number of clients entering rehabilitation are on medication, although rehabilitation centres still do not cater for clients who are psychotic or who are severely depressed.

In order for the needs of clients with psychiatric co-morbidity to be addressed more effectively, common definitions and tools need to be used across the different specialised drug treatment agencies. Also clear working protocols regarding the initial diagnosis, treatment plan and referral of clients to different services and agencies need to be established. Finally, training of staff members in the management of clients with dual diagnosis is essential if agencies are to be in line with best practice when intervening with this type of client group.

7.4 Interventions Concerning Pregnancies and Children Born to Drug Users.

Drug Therapeutic Communities (T.C.) accept pregnant women and offer them special care and monitoring throughout their pregnancy, in the form of intensive tailor-made psychological and medical support. Women who are eligible to join the T.C. but who cannot due to child care responsibilities are given intensive outpatient support in the form of more frequent individual sessions and long term therapy. The Caritas San Blas T.C. also offers a service whereby children of drug users can visit over the weekend. A flat within the T.C. is especially allocated for this service. A trained facilitator is also employed to assist the parent/s and child/ren.

On an outpatient basis, the Well Woman Clinic at SMOPU gives priority to pregnant drug users who are closely followed up on and monitored during their pregnancy. If the woman is still using drugs she is encouraged to undertake a methadone maintenance programme and advised to enter an inpatient treatment programme. Although detoxification from opioids prior to delivery is the ideal goal, this is not always possible or recommended. All pregnant drug users are encouraged to attend the antenatal clinic at St. Lukes Government Hospital that liaises constantly with the Well Woman Clinic. (See Chapter 6 for interventions related to newborns)

CHAPTER 8

SOCIAL CORRELATES AND CONSEQUENCES

8.1 Social Exclusion

Social exclusion or social isolation can be seen as either a cause or consequence of drug use. A National picture on the extent of social exclusion amongst drug users in Malta cannot be provided due to the extent of data limitations in this regard.

8.2 Drug-Related Crime

Police Arrest Data

Between 1998 and 2006 the number of arrests fluctuated only slightly reaching a peak in 1999 and then in 2004. Since 2005, the numbers have again started to decrease. Over a nine-year period, 2006 recorded the lowest arrest rates to date. Between 2004 and 2005 there was a decrease of 12% in the number of arrests and between 2005 and 2006 a decrease of 28% (Figure 8.1). The police anti-drug section is not able to explain why such a decrease has occurred, since over the year their efforts remained relatively high and unchanged. Arrest data indicators are sensitive to law enforcement strategies, levels of police enforcement as well as the level of substance use problems. As such, great care must be taken when interpreting changes in arrest rates. When tracking arrest data over a period of time, it is often impossible to determine if an increase or decrease in arrests is related to changes in police enforcement, community problems, community efforts to reduce use, or to some combination of the three.

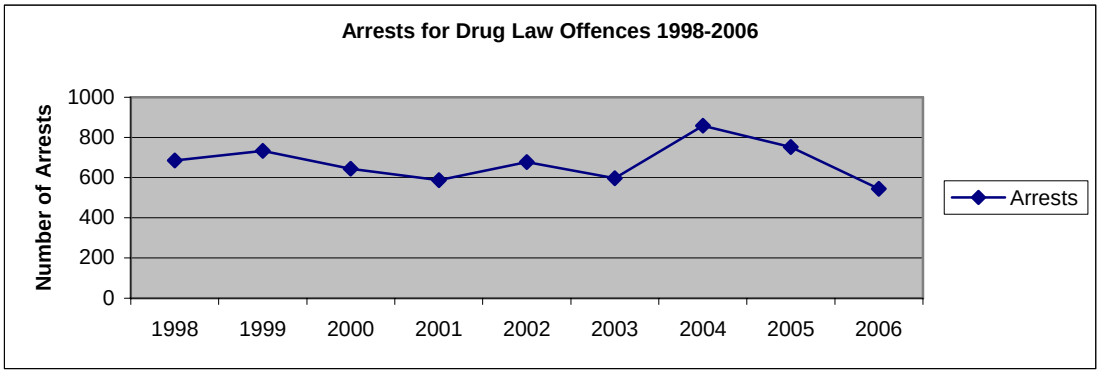


Figure 8.1.

Source: Police Arrests File 1998-2006

In 2006, the Malta Police Drug Squad made 544 arrests for drug law offences, of these, 445 persons were charged. 76% for possession, 15% for trafficking and 9% for a combination of trafficking and possession. Most charges for possession and trafficking were for cannabis and heroin (Figures 8.2 and 8.3)

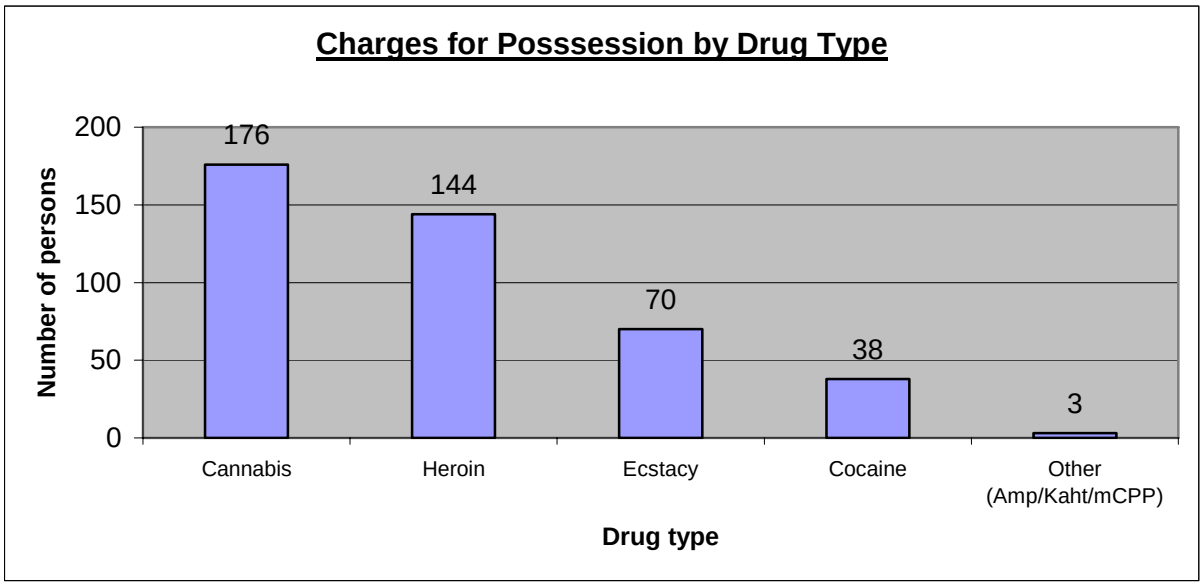


Figure 8.2.

Source: Police Arrests File 2006

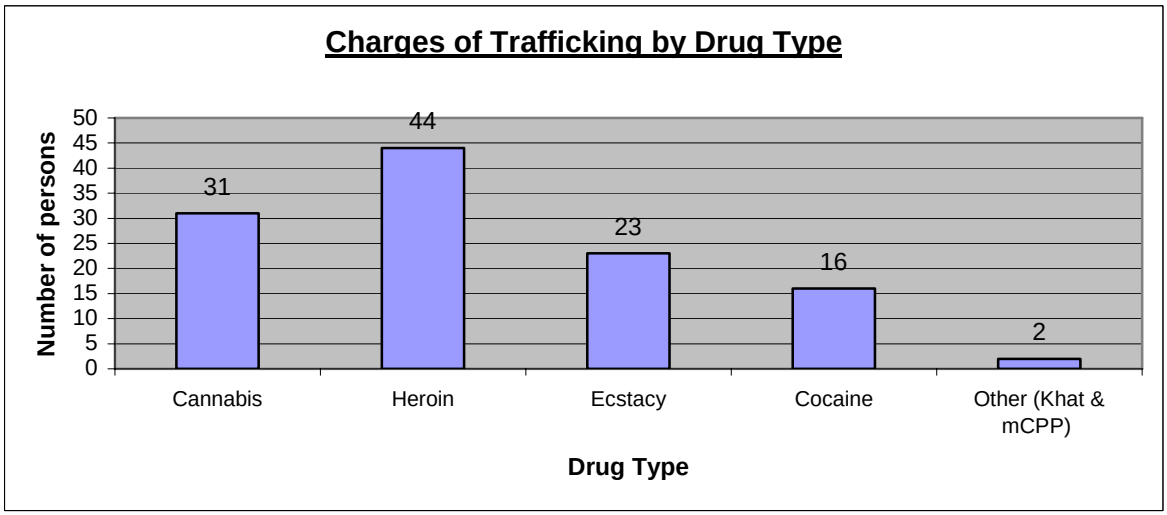


Figure 8.3

Source: Police Arrests File 2006

Demographic characteristics of arrestees charged with drug offences

Of all the 445 persons charged in 2006, 408 were male (91.7%) and 37 were female (8.3%). The majority (90.5%) were Maltese. Most persons charged with drug possession were aged between 15 and 30 years, whereas most persons charged with drug trafficking were aged between 20 and 34 years (Figure 8.4).

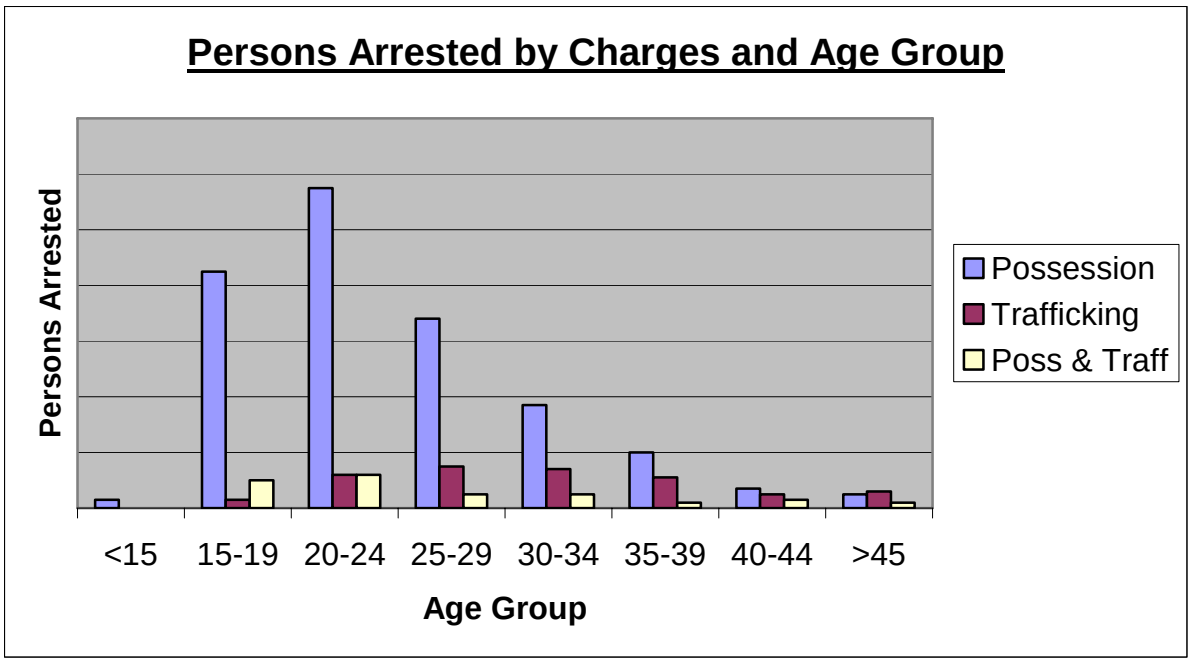


Figure 8.4

Source: Police Arrests File 2006

Adolescents aged 20 years and under, are more commonly charged with possession of cannabis and ecstasy. Young adults, aged 20-34 years, on the other hand, are more commonly charged for possession of cannabis, heroin and cocaine. In both adolescents and young adults, the data indicates that cannabis remains the drug of use for many years. In recent years, an increasing number of individuals have been charged with possession of multiple drugs. Young adults aged 20-34 years are more likely to be involved in trafficking multiple drugs than older adults aged 34 years and over. Young adults tend to traffic cannabis and ecstasy while older adults heroin. Furthermore, although the numbers are relatively low when compared to single possession and trafficking charges, there is a tendency for the younger cohorts, aged 15-24 years to be charged for possessing one type of drug while dealing in another. This seems to be typical of people at the very first stages of dependence, particularly heroin. Such

individuals are typically charged for possession of heroin while dealing for instance in cannabis or ecstasy.

Probation Services Data

During 2006, the Probation Services had 222 clients with a known drug problem, predominantly heroin (Figure 8.5). 89% of clients were male and the average age was 25.6 years.

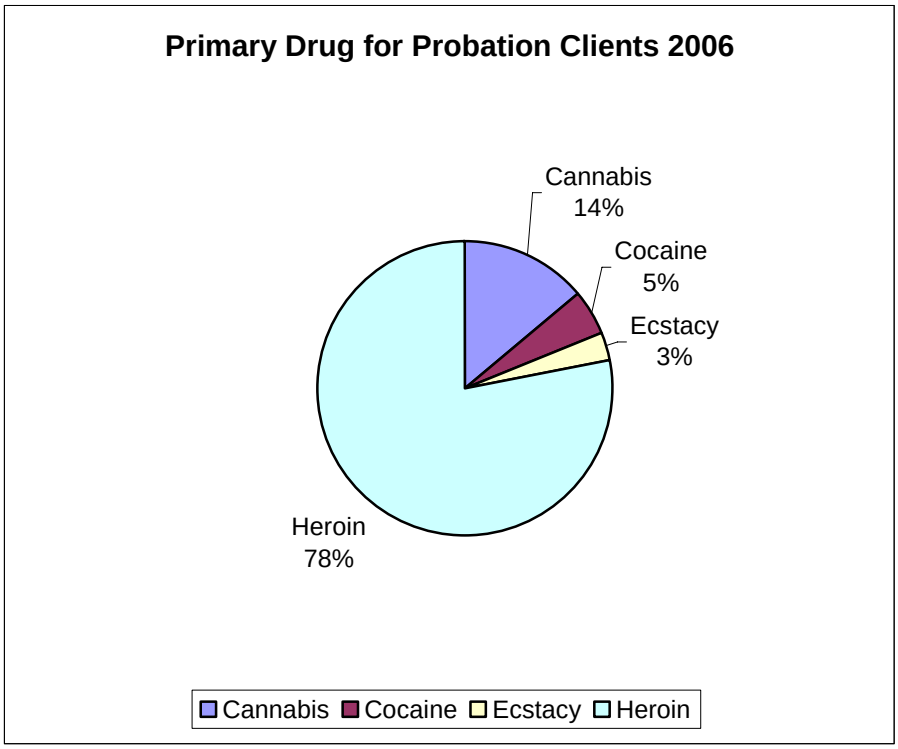


Figure 8.5

Source: Probation Data File 2006

Prison (CCF) Data

During 2006, 493 persons[1] (466 males and 27 females) were imprisoned after arrest or sentencing[2]. The mean age for males was 35.4 years, whereas that for females was 37.1 years. All inmates are tested for drugs upon admission and in 2006, 45% of inmates[3] tested positive for opiates, cocaine or cannabis.

[1] Unique Individuals
[2] Forty persons were imprisoned more than once during the year. To avoid identity duplication only the latest admission was recorded.
[3] Includes double counting

8.3 Drug Use in Prison

Prison routine inspections in 2006 resulted in 51 drug seizures on prison grounds or in related health institutions. 47 of these cases were prosecuted. 37 were inmates (34 males and 13 females) and 10 were visitors (9 female and 1 male). In the majority of cases (84%), heroin was suspected.

For the duration of their prison sentence, inmates are randomly tested for drugs on a monthly basis. In 2006, from a total of 424 random drug tests on 268 unique individuals[4], 23% tested positive for heroin and 6% for cannabis. No one tested positive for cocaine. Some prisoners were tested more than once and the number of positive results for multiple testing on the same individual ranged from two to six.

Upon admission into SATU, CCF's Substance Abuse Therapeutic Unit, from a total of 27 admissions in 2006, 13 tested positive for drugs, namely heroin (40%), followed by cocaine (11%). During the same year, 51 random drug tests were conducted, with 6% resulting positive for drugs.

8.4 Social Costs

There are no research studies available that look into the social costs related to drugs and drug use.

[4] The number of random drug tests administered in 2006 nearly doubled those conducted in 2005 (244 random drugs tests on 194 individuals) (NR2006)

CHAPTER 9

RESPONSES TO SOCIAL CORRELATES AND CONSEQUENCES

Problem drug use is very often linked to deprivation and poverty; drug users share a common experience with other socially deprived groups. They face exclusion from the labour market, often compounded by social instability, a criminal record and dependence on state benefits. Traditionally, social integration was seen as an intervention subsequent to the successful completion of a treatment process, but increasingly it is considered an intervention which might be applied at any stage of a treatment process.

9.1 Social Reintegration

Housing

''Good health, adequate housing and effective social welfare services all contribute towards a person's well being and promote his/her prospects for social inclusion.'' (National Report on Strategies for Social Protection and Social Inclusion 2006-2008). Malta has several strategies to assist the general population in adequate and affordable housing, which focus particularly on households with children: repair schemes, rent subsidies, shared ownership opportunities and 'Headstart'. Headstart, funded by EU money, has enabled youth leaving care homes to undergo an integrated holistic package of vocational guidance, relevant training, work placement and mentoring. This has given these youth a chance of work, a home and support to live in society.

Education (as a form of prevention to drug use amongst the general population)

Education opens up the options and is provided free in Malta to all students from age 5 until tertiary level. In the post secondary stage students are encouraged to continue their education by the provision of stipends, giving students a small sum of money per month, providing they continue to attend the course they are enrolled in. This extends to tertiary level as well. As stated in the National Report on Strategies for Social Protection and Social Inclusion 2006-2008, there is a move to reform education to a) effectively address early school leaving and b) reduce illiteracy rates; and enhance inclusive and quality education for all.

Training and Employment

The Employment and Training Corporation (ETC) offers various innovative programmes that enhance the employability prospects of unemployed people with some of these programmes specifically focusing on young people, namely, Job Club designed for school leavers who have low basic skills or no skills at all; and Supported Employment Schemes which are specifically designed for young people with special needs with a view to enhance their capabilities to facilitate their integration into the labour market.

A considerable amount of work related to the training and employment of drug users is also conducted between the ETC and the drug treatment agencies Sedqa and Caritas, Probation Services and Corradino Correctional Facility (CCF). The following schemes and agreements took place during 2006:

- Since 2002, there has been a financial cooperation agreement between ETC and Caritas whereby ETC pays Caritas a certain amount of money for every client that undergoes training with ETC and for every person placed in employment by Caritas. This financial agreement does not exceed LM12,000 (EUR27,884)[1] yearly.

- The Bridging the Gap Scheme is designed to support a person's transition period to employment. The scheme offers the trainee a period of work exposure as well as a weekly allowance of 80% of the minimum wage[2]. The ETC 2005-2006 annual report indicates that work exposure opportunities through this scheme showed a notable increase during 2005, with 20 persons utilising the scheme, 10 of which were prison inmates nearing the end of their prison sentence.

- Training programmes are also offered for inmates at CCF and these consist mainly of English and Maltese literacy classes, electrical engineering and basic woodwork. Also, an ongoing working relationship exists between ETC and the Substance Abuse Therapeutic Unit (SATU), CCF, Probation Services and

[1] LM1.00 = EUR2.32368.
[2] Minimum Wage = LM60.00 (EUR139.42) weekly.

Sedqa, which mainly involves references for work on behalf of ETC as well as the provision of training courses for clients.

- In mid-2006 a new board was established, the '(Ex-) Substance Abuse Monitoring Board'. This comprises representatives from ETC, Sedqa and the Department of Social Security. The aims of this board are to discuss, evaluate and monitor the employment status and employment prospects of particular clients and provide them with additional assistance if needed.

- During 2006, due to the European Union State Aid Regulations, the 1996 Employment Training Scheme (which encourages private sector employers to recruit the unemployed by providing them with a wage subsidy) was discontinued.

ETC data as of end 2005
Registered Unemployed with ETC: 7,379
Registered unemployed known substance abusers: 244
Registered unemployed 'social cases' (some substance abusers can fall under this category): 49

Substance abusers can also fall under the total registered unemployed cases, as most substance users do not state their status and therefore it is very likely that the numbers of registered unemployed substance abusers is much higher than the figure presented.

Basic Social Assistance
Malta has a free medical system through the provision of polyclinics and hospitals where any individual can request help for any health problem. There is a Social security system enabling people who are not employed to claim assistance from the state, which follows on to the provision of Pensions for the retired population.

9.2 Prevention of Drug-Related Crime

In order to try and curb drug-related crime in youth, there are a number of existing action plans such as Community Service orders and Combination Orders (community service

combined with probation). Another means of dealing with youth crime is using provisional orders of supervision. These fall under the auspices of community treatment and still require some development and upgrading to the ancillary services. The National Report on Strategies for Social Protection and Social Inclusion Policy however states that there is still a need for the ''Identification of risk categories among the youth population and to develop projects that deviate or deflect potential delinquent and criminal behaviour toward integrative behaviour''. The need to try and prevent youth from re-offending is also a main priority to reduce recidivism in re-offenders and effectively to prevent 'new' offenders from commencing a criminal career.

Assistance to prison drug users

Prison (CCF) houses a number of inmates who have been admitted with a drug addiction problem. As soon as a person is admitted to CCF a series of medical examinations and urine testing for drugs are conducted. Medication is administered if the person is withdrawing from drugs. The option of going to the Forensic Unit at Mount Carmel Hospital where a methadone-reduction programme is initiated is also available. The Medical Unit at CCF also liaises with the Substance Misuse Outpatient Unit (SMOPU) when a newly admitted inmate claims that he is undergoing methadone treatment there.

Whilst at CCF, inmates with a drug addiction problem are kept under constant check by the medical unit and tested regularly for drugs. Those whose urines test positive have their substitution medication discontinued as this could lead to serious medical complications. Psychiatric assistance is also offered.

Forensic psychologists and a social worker assess all newly admitted inmates and liaise with the team of doctors with regards to the inmate's psychosocial and rehabilitative needs. Contact with outside drug treatment agencies such as Sedqa and Caritas is ongoing, and key-workers from these agencies regularly visit persons at CCF who have been referred to them. The social worker also maintains regular contact with other agencies such as the social welfare service APPOGG, the Employment and Training Corporation (ETC) and the Housing Authority. Towards the end of their sentence, inmates can also benefit from work release, which is a privilege allowing them to work in

gainful employment during the last months of incarceration with the aim of further facilitating their reintegration into society.

Arrest Referral Scheme (ARS)

The ARS aimed at referring first time drug offenders (for minor offences) to drug treatment / monitoring programmes was launched in July 2005 and became fully operational in September of the same year.

Between July and December 2005, the Police referred 15 arrestees (13 males and 2 females). All arrestees were Maltese nationals. Their average age was 25.5 years (range 17 years – 34 years). Of a total of 212 persons arrested during the 5-month period in question, 15 persons were referred for treatment while 8 persons refused referral. In 2006, the police attempted referring 37 persons (4 females and 33 males) from a total of 530 arrestees. Of these, six were already known to drug treatment services (Sedqa and Caritas) whilst the rest were new clients. 19 arrestees (all male) refused referral. The average age of those arrestees who accepted referral (N=18) was 25 years (range 16 – 34 years).

Problems with the ARS

The time lapse between referral and contact by the agencies, often due to long waiting lists, may result in the arrestee losing interest. A substantial number of persons refuse referral. This highlights the need for further training in motivational interviewing techniques. A lack of co-operation on the part of parents of minors has also been noted by drug treatment agencies.

Urban Security Policies in the Prevention of Drug Related Crime

For the last four years, the Crime Investigation Department within the Malta Police Force have allocated different inspectors to different police districts, where they organise talks within various communities and local councils on security measures and ways to protect persons and property from incidents of theft/burglary. They are also invited on Television programs to supply such information. The Drug Squad Unit of the Malta Police Force offers presentations to schools on drug awareness topics and on how to approach the Police if children are offered drugs or know of someone who is committing criminal activities due to a drug habit.

CHAPTER 10

DRUG MARKETS

10.1 Availability and Supply

Cannabis is the most widely used illicit drug amongst the general population as seen from the results of various National Surveys (refer to Chapter 2 of National Reports 2004, 2005, 2006 and 2007) as well as from arrest data on possession charges (Chapter 8) and quantities of seizures effected (Chapter 10.2). As indicated in Chapters 4 and 8 heroin is also the primary drug for most people in treatment and on probation.

Previous National Drug Reports (2004, 2005 and 2006) highlighted the fact that herbal cannabis in Malta was generally locally grown, while cannabis resin (hashish) was of Moroccan origin. To date this remains unchanged. Heroin is imported primarily from North Africa and Turkey while cocaine, ecstasy and other amphetamines are smuggled into Malta mainly from European destinations, particularly the Netherlands.

Since 2005, Malta has also become a recipient for New Psychoactive Substances. In 2006, 1-benzylpiperazine (BZP) and 1-(3-chlorophenyl) piperazine (mCPP) tablets were detected in Malta. Prior to these seizures, both substances were not controlled; this situation was shortly rectified by means of independent Legal Notices[5]. Controlling for emerging New Psychoactive Substances, within a short period of time through the set up of it's Early Warning System (EWS) Network, comprising the National Focal Point for Drugs and Drug Addiction (NFP), the Crime Intelligence Analysis Unit (CIAU) the Drug Squad Unit, Europol Liaison Bureau and Europol National Unit of the Malta Police Force, Customs Department, the Toxicology Laboratory, the Forensic Laboratory, the Emergency Department at St. Luke's General Hospital and the Medicine's Authority, puts Malta in-line with EU propositions to control for emerging substances (Drugnet Europe, Issue 59, 2007).

[5] Under Chapter 31 – Medical and Kindred professions Ordinance of the Laws of Malta – BZP was controlled through Legal Notice 135 of the 16th of June 2006 and mCPP controlled through Legal Notice 127 of the 4th of March 2007.

To a lesser extent, yet still worth noting, 'new' trends, in terms of the herbal drug Khat, have started to emerge. This infusion seems to be a direct reflection of cultural, social or religious habits enjoyed by some of the African immigrants taking refuge in Malta.

10.2 Seizures

There was a decrease of 27% in the amount of drug seizures effected by the Malta Police Force and the Customs Department between 2006 (228 seizures) and 2005 (314 seizures) (Figure 10.1). This decease is synonymous with that observed for the number of drug arrests in 2006 (see Chapter 8 and Standard Table 11).

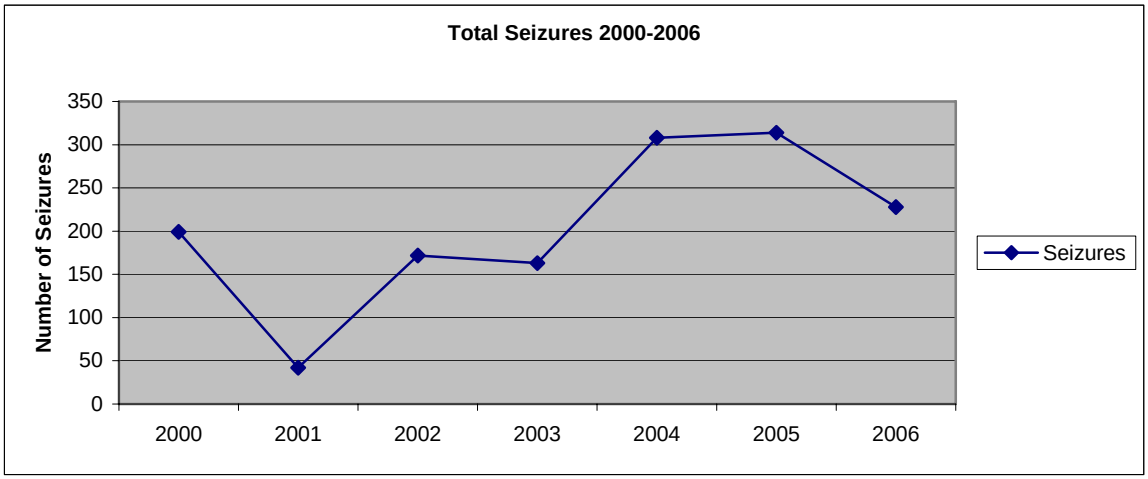


Figure 10.1

Source: Police Drug Squad Annual Reports 2000-2006

Although the number of seizures for 2006 decreased when compared to 2004 and 2005, the quantities seized increased. In 2006, there was a large seizure of over 50,500 tablets for mCPP and one for Khat (over 11 kilograms). The quantities of cannabis resin seizures amounted to nearly 45 kilograms - the largest since 2000, and those for ecstasy remained high with quantities of up to 16,000 tablets (refer to Table 10.1 and Standard Table 13).

The mCPP seizure and one large cannabis resin seizure of 30 kilograms took place at the country's seaport. Investigations revealed that mCPP was trafficked overland from Spain through Italy. It was impossible to determine the route for the resin seizure as the substance was detected floating at sea. Trafficking routes for cocaine by air (Malta

International Airport) were identified in two major seizures of nearly 1.5 kilograms each. These originated from Mexico through Amsterdam. In two separate cases, involving cocaine and cannabis grass and Khat respectively, substances were trafficked from Amsterdam. As regards ecstasy, the largest seizures (5,000 and 9,618 tablets) originated from the United Kingdom. Heroin trafficking primarily remained in the Northern African route, particularly Libya. BZP was only seized in street cases. In four separate cases, these totalled approximately 170 tablets and around 10 grams of powder. In five separate instances 39 cannabis plants (4 seizures) and 500 grams of amphetamine powder were seized.

Quantities of Drugs Seized 2000-2006

Drug Type	2000	2001	2002	2003	2004	2005	2006
Heroin (grams)	5912.0	2848.0	1218.0	5498.0	769.0	15487.2	1892.1
Cocaine (grams)	28.1	4549.0	4535.0	3716.0	152.0	6398.1	4269.0
Cannabis resin (grams)	3913.0	3636.0	8801.0	34429.0	33081.0	19662.8	44987.3
Cannabis grass (grams)	104.9	32.4	846.4	24532.8	2348.0	1886.6	2862.9
Cannabis seeds	4.0	3.0	43.0	48259.0	2281.0	0.0	0.0
Cannabis plants	22.0	20.0	12.0	125.0	293.0	3.0	39.0
LSD (microdots)	462.0	0.0	0.0	0.0	0.0	3.0	0.0
Ecstasy (tablets)	5191.5	2458.0	11011.5	8694.5	6071.0	17273.0	16479.0
Amphetamines (grams)	0.0	0.0	1.0	0.5	69.0	1000.0	0
mCPP (tablets)	0.0	0.0	0.0	0.0	0.0	0.0	50533.0
Khat (grams)	0.0	0.0	0.0	0.0	0.0	0.0	11812.3
BZP (tablets)	0.0	0.0	0.0	0.0	0.0	0.0	170.0
BZP (grams)	0.0	0.0	0.0	0.0	0.0	0.0	9.9

Table 10.1

Police Drug Squad Annual Reports 2000-2006

Table 10.2 shows that the majority of persons caught trafficking drugs were Maltese nationals (84.5%). Generally, most traffickers were drug addicts caught selling drugs to support their habit, only 7.3% were individuals whose main aim was profit making. The

highest numbers of cases for trafficking were for heroin, cannabis, ecstasy and cocaine respectively.

Traffickers by Nationality and Seizure Cases

Nationaltiy	Drug Type						
	Cannabis	Heroin	Cocaine	Amphetamines (mCPP)	Ecstasy	Khat	TOTAL
British	2	0	1	1	2	0	6
African National	1	0	0	0	0	0	1
French	2	0	0	0	0	0	2
Somali	0	0	0	0	0	1	1
Italian	1	0	0	0	0	0	1
Libyan	0	4	0	0	0	0	4
Maltese	25	40	12	0	21	0	98
Mexican	0	0	2	0	0	0	2
Colombian	0	0	1	0	0	0	1
TOTAL	31	44	16	1	23	1	116

Table 10.2

Source: Police Drug Squad Records 2006

10.3 Purity and Price

"Price and purity data, if properly collected, can be very powerful indicators for the identification of market trends. As supply changes in the short-run are usually stronger than changes on the demand, shifts in prices and purities are a good indicator for actual increases or declines of market supply. (UNODC 2007 World Drug Report)

Purity

All told, drug purity levels have remained relatively stable. Although the mean purity percentages may vary slightly from year to year, it is important to keep in mind that sample sizes also fluctuate from one year to the next, and this factor could influence the mean percentages. Additionally, one particular sample that has either very high or very

low purity could also skew the overall mean of the reporting year. Finally, small sample sizes, like those for cannabis herb (n=7 in 2005 and n=6 in 2006), for example, make it impossible to generalise results. Table 10.3 shows the mean purity at street level for different drugs for the years 2005 and 2006 (see also Standard Table 14). In 2006, during laboratory analysis of cocaine seizures, crack was also detected; its purity levels appear to be consistent with purity levels across other European and EU member states (EMCDDA, 2005).

Mean Purity at Street Level for Different Drugs 2005 and 2006

	2005		2006	
SUBSTANCE	sample size	purity/potency level(%)	sample size	purity/potency level(%)
Cannabis herb	7	5.5	6	8.5
Cannabis resin	136	10.3	196	9.2
Heroin	63	38.6	111	32.2
Cocaine	32	46.3	35	47
Ecstasy	72	22.3 (53.5mg)	151	20.1 (48.2mg)

Table 10.3
Source: Malta Forensic Science Laboratory Data 2005 and 2006

Price

Table 10.4 shows the mean price at street level for different drugs in 2006 as reported by the inspectors of the Malta Drug Squad (see also Standard Table 16). Overall, prices for all drugs (except amphetamines) are lower than those reported in 2005. The limitations as regards drug prices are mainly due the fact that data is limited to one source (reports by 4 police inspectors) and not multiple sources (e.g. reports by persons in treatment, probation officers through their clients,) that can be cross-compared. Additionally, at present, drug prices are collected only once yearly and this method is not extensive or reliable enough to ensure the integrity and reliability of the data. Finally, prices for cannabis, heroin and amphetamine are reported in amounts that are commonly sold at street level and only roughly 'translated' into weights per gram.

As an overall note, it is also important to acknowledge that the drug market is sensitive to changes occurring at social and law enforcement level and that these factors can affect prices, particularly where drug availability is concerned

Prices at Street Level for Different Drugs 2005 and 2006

	Mean Price(EUR) 2005	Mean Price(EUR) 2006
Cannabis resin (per gram)	9.79	6.41
Cannabis herb (per gram)	14.44	13
Heroin brown (per gram)	61.75	46
Cocaine powder (per gram)	87.61	76
Amphetamine powder (per gram)	69.91	70
'Ecstasy' (per tablet)	11.65	9.6

Table 10.4
Source: Malta Police Force 2001-2006

PART B

SELECTED ISSUES

CHAPTER 11

PUBLIC EXPENIDTURES

11.1 Introduction

This chapter has been written in response to the EU Drugs Action Plan 2005 – 2008, that requires,

> *among other actions, Member State to consider the development of compatible methodologies on drug-related public expenditure by 2008, and foresees a 'report based on this methodology' as an evaluation tool for this action.*

These methods are ultimately intended to provide policy makers with decision-making tools related to the level of resources allocated to particular drug-related services.

The EU recognises that each member state devotes a part of its budget to face the negative consequences of drug consumption and to combat trafficking and related crimes. Unfortunately EU Member States do not generally calculate 'drug budgets' as such and the figures permitting this calculation are sometimes non-existent and at times incomplete – the latter situation holds true for Malta. Additionally, most of the entities approached to help in the compilation of data for this chapter, stressed the importance of the provision of tools and uniform methodological guidelines, with which to be able to conduct this audit on a yearly basis. These are crucial in order to obtain a true National picture of public expenditures.

11.2 Definition of Public Expenditures and Limitations in Data Collection

For the purpose of this chapter the term **public expenditures** refers to the value of goods and services bought by the administrative bodies of the state; in Malta's case these constitute the central government and its ministries. It therefore excludes costs of indirect consequences (e.g. loss of income due to drug related illness) and non-

quantifiable costs (e.g. loss of welfare) as well as expenditures related to the acquisition of illicit drugs by the consumer. This document assesses the monetary but not the social impact (social costs) or loss of quality of life. Additionally, it does not calculate revenues created by the illegal drug market. Last but not least it is a calculation which at times is based on a rough estimate of public finances and not private expenditures or investments. The rough estimate was necessary in those cases where no labeled amount was made available as most departments had not actually carried out their calculations at the end of 2005 as this was not necessary at the time.

Methodology

The methodology applied refers to the concepts of **Cost of Illness (COI) Theory** rather than to the **Cost-Benefit Approach**.

Public drug expenditures are of two types:

- Expenditures that appear in public finance that are directly labeled as being related to drug problems – ***direct expenditures***
- General authorities who devote part of their resources to deal with the issues precipitated by drugs – ***indirect expenditures***

The main ***public expenditures data sources*** suggested by the EMCDDA are the:

- **Budget**
- **Functional Categories**
- **End of Year Reports**

By perusing the above-mentioned documents we would be able to at least trace back the ***labeled drug-related expenditures/direct expenditurse*** and ***non-labeled drug related expenditures/indirect expenditures*** and include **health** and **law enforcement** sectors as these would account for the bulk of government expenditures on drugs. Not all ***non-labeled drug-related expenditures*** are necessarily identified as such in national budgets or year-end reports. These may however be calculated by following a **top-down approach.**

Overall Expenditure x Attributable Proportion = Non-labeled Drug-related Expenditures

Thus for the purpose of this chapter, the following documents were used:

- The Budget
- Ministerial End of Year Reports

Also, qualitative interviews were conducted with the Senior Probation Officer and the director of the Criminal Courts. Finally, a drug expenditures report was requested from various ministerial departments. These included:

Office of the Prime Minister
Customs Division
Armed Forces of Malta

Ministry for Family and Social Solidarity
Sedqa National Agency Against Drugs and Alcohol
Caritas - NGO
OASI Foundation - NGO

Ministry for Justice and Home Affairs

State Prison Corradino Correctional Facility (CCF)

Prison Inmates Programmes

Probation Services

Malta Police Force
Courts of Malta

Ministry of Education Youth and Employment
Student Services Section of the Education Division

Ministry of Health, the Elderly and Community Care
Mt. Carmel Hospital's Dual Diagnosis Unit (DDU
Directorate of Primary Prevention

Ministry for Gozo

OASI Foundation

Gozo Hospital

11.3 Account of the Public Expenditures on Drugs

The amounts quoted hereunder in Table 11.1, were supplied by each Ministry and their related departments and refer to the year 2005.

Public Expenditures on Drugs 2005

MINISTRY	DEPARTMENT	EXPENDITURE (EUR)	
Office of the Prime Minister	Customs Division	274,704	
	Armed Forces of Malta	53,813	
		328,517	**SUB TOTAL**
Ministry for the Family and Social Solidarity	Sedqa	2,026,718	
	Caritas	349,434	
		116,504	
	OASI	139,805	
		2,632,461	**SUB TOTAL**
Ministry for Justice and Home Affairs	Corradino Correctional Facility and SATU	226,213	
	Drug Rehabilitation for Inmates (Caritas)	186,413	
	Probation Services	74,568	
	Police General Drug Expenditure	958,067	
	Judiciary Administration*	173,604	
		1,618,865	**SUB TOTAL**
Ministry of Education Youth and Employment	Student Services Section	4,659	
		4,659	**SUB TOTAL**
Ministry of Health the Elderly and Community Care	Mount Carmel Hospital's DDU	182,691	
	Directorate General of Health	12,618	
		195,309	**SUB TOTAL**
Ministry for Gozo	Donation to OASI Foundation	11,645	
	Gozo Hospital Short Stay Unit	53,810	
	Gozo Hospital Detox Unit	3,261	
	Gozo Hospital Methadone Dispensing	1,549	
		70,265	**SUB TOTAL**
		4,850,076	**GRAND TOTAL**

***Relates to the proportion of time dedicated by the judiciary to drug cases: including (i) simple cases where the sentence is less than 6 months (e.g. drug possession cases, n=368), (ii) compilation of evidence which is passed on to the Attorney General who in turn decides case level (n=426 cases) and (iii) Jury cases (n=6).**

Table 11.1

Source: Budget and Ministerial End of Year Reports 2005

CHAPTER 12

EPIDEMIOLOGY RELATED TO VULNERABLE GROUPS: PREVALENCE AND PATTERNS OF DRUG USE; RISKS, CORRELATES AND CONSEQUENCES

12. 1 Profile of Main Vulnerable Groups

Drug experimentation is increasingly widespread; however levels of drug use and the risks of developing drug-related problems are much higher amongst vulnerable groups. Most young people who experiment with drugs or use them recreationally do not develop long-term serious drug problems; however, a small but significant minority of young people do. This section will provide definitions for different vulnerable groups obtained from the target groups indicated in the 2006-2008 National Action Plan for Social Protection and Social Inclusion (Ministry for the Family and Social Solidarity). The needs of these vulnerable groups could be identified and addressed through selective/indicated prevention strategies aimed at strengthening protective factors and reducing risk factors.

Target Group 1: Children

Looked After Children	Children with Disability	Children of prostitutes
Children living in Large Families	Children Living with Lone Parents	Children of Prisoners / Ex-Prisoners
Children with Illness	Children with Illiteracy difficulties	School Drop Out Children
Under age employed	Children victims of paedophilia	Children in child care facilities
Children with emotional and mental health problems	Children living in a mental health institution	Children with Challenging and/or Delinquent Behaviour
Low Achievers	Children who are bullied	

Target Group 2: Families

Unemployed	Lone Parents	Ex-Prisoners/Prisoners
Domestic Violence	Mental Health	Disability
Victims of usury	Families in debt	Families as carers of mental health
Families as carers of elderly	Families as carers of terminally ill	Families as carers of disabled
Parents requiring parental skills	Parents who work abroad	Prostitution

Target Group 3: Immigrants

Unaccompanied Minors	Single Mothers	Single Women
Elderly Immigrants	Immigrants with Disability	Unemployed Immigrants
Immigrants (minors and adults) with mental health difficulties		

Target Group 4: Persons with Mental Health Problems

Unemployed	Single parents	Persons lacking social/coping skills
Persons without family support	Persons with mental health problems who are living in shelters because of homelessness	
Persons with mental health problems who are living in mental health institutions because of lack of community mental health services		

Target Group 5: Youth

Early school leavers	Unemployed youth	Youth with a disability
Youth living in jobless households	Homeless Youth	Youth in Prostitution
Youth who lack social skills	Youth with addiction difficulties	Youth leaving care
Youth with Illiteracy difficulties	Youth with criminal behaviour	Teenage parents
Youth living in a mental health institution	Youth with mental health difficulties	Youth living in inadequate accommodation
Youth from racial and ethnic origins	Youth living in violent environments	Youth with unstable home situations
Youth with Challenging and/or Delinquent Behaviour		

12.2 Results from Studies on Risk-Groups

Statistical Overview of the Situation of Children and Youths with Very Challenging Behaviour over the last 5 years (2000-2005)[1].

The aim of this study was to collect information over a 5-year period about children with very challenging behaviour. Very challenging behavior was defined in this study as: *"Behaviours of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which seriously limits the persons' access to ordinary settings, activities and experiences'.* In reality this project did not meet its objectives entirely as insufficient data made available, resulted in it being

[1] Office of the Commissioner for Children (2006) A Fair Deal: A study on Children and Young People with very Challenging Behaviour. Malta

impossible to provide a clear and definite picture of the current situation in Malta, and therefore results cannot be generalized to the whole Maltese population. Nevertheless the results do give a clear enough representation of children who accessed the services available[2] and provided the required information.

The study collected information from 811 children (25% female and 75% male)[3]. These represent around 1.5% of the total children population aged 18 years and under. Most problems in these children became acute from the age of 13 years, peaking at 17 years. Age 13 is usually when puberty starts and also when mental health problems begin manifesting themselves. Age 17 is when children finish their scholastic term and therefore this transitional period accompanied by social problems, lack of job availability, housing alternatives and structured environments previously represented by the educational establishment could heighten challenging behaviour.

44% of children used the services for a period of 1-3 years, 29% for a period of less than a year and 27% for more than 3 years. The study makes recommendations to maximise all efforts to implement programmes which are community-based as opposed to residential services, which should only be used as last resort measures. The study also highlights the need for proper data systems across all services offering support to children so that proper research studies may be undertaken and a better national view of the needs of this client population can be obtained, assessed and monitored over time.

12.3 Drug Use Among Vulnerable Groups

Selected Data from the 2003 ESPAD Study

Truancy

The ESPAD measures truancy by asking students how many days of school they skipped not due to illness. The 2003 data shows that 24% of students who skipped one day of school or more had admitted to using an illicit drug at least once in their lives.

[2] (i) Services catering directly for very challenging behaviour, (ii) Services which cater for children and may have offered services to children with very challenging behaivour, (iii) Services which do not cter for children but during the 5 years in question may have offered services to children with very challenging behaviour.

[3] The gender distribution shows high gender disparity. This result may be distorted as it does not follow general patterns and therefore the working group of this study questioned this.

Drug use by Siblings

13% of students who had siblings who drank alcohol admitted to ever using an illicit drug compared to 7% of students whose siblings did not drink alcohol. Additionally, 44% of students whose siblings smoked cannabis, admitted to using an illicit drug at least once in their lives compared to 10% of students whose siblings did not smoke cannabis.

Parental Supervision

The question of parental supervision in ESPAD is measured by asking students if their parents knew where they spent Saturday nights. 9% of students whose parents always or frequently knew where they spent Saturday nights admitted to ever using an illicit drug compared to 26% of students whose parents sometimes or usually did not know.

Single Parents

16% of students who admitted to using an illicit drug did not live with both natural parents compared to 11% of students who lived with both parents.

12.4 Vulnerable Groups Among the Treated Population

There is no National data available on vulnerable groups among the treated population.

12.5 Correlates and Consequence of Substance Use Among Vulnerable Groups

Arrest Data 2004-2006 – young persons

In 2004, 2005 and 2006 approximately 14% of arrests for drug law offences were youth under 18 years of age; around 12% of these were male. The three reporting years show no increases in the numbers of arrests amongst those aged less than 18 years.

Prison Data – young persons

The 2005 and 2006 prison (CCF) data shows that the percentage of those aged less than 18 years who were sentenced to imprisonment was 5% and 4% respectively. No females under 18 years of age were sentenced during these two reporting years.

12.6 Responses to Drug Problems Among Vulnerable Groups

Policy and Legal Development

The first Draft National Drugs Policy 2007 indirectly mentions vulnerable groups under the heading 'Actions to reduce demand for drugs'. Specifically, Action 28 states:

"In terms of facilitating social integration Government, shall through the Ministry responsible for social policy … Strengthen the organization of primary and secondary prevention initiatives with a view to ensure that all target groups are effectively reached".

Prevention and Treatment

In Malta, the main target groups for indicated prevention are youth in vulnerable schools, juvenile inmates in prison settings, young offenders through the arrest referral scheme and individual interventions through immediate intervention services occurring mainly as a result of referrals to drug treatment agencies. The current services available to target and treat specific vulnerable groups for drug-related problems are:

Sedqa programmes

Sedqa are in the process of developing a new programme called "Booster" which is due to commence by the end of 2007. The aims of this programme are to identify students who are experimenting with drugs and prevent early drug taking from developing into more intense abuse.

Budz, a joint venture between Appogg and Sedqa, is another new project due to commence by the end of 2007. It is an intensive, non-residential programme aimed at treating adolescent drug users aged between 13-18 years, who have instability and other problems in their lives such as prostitution, homelessness and severe truancy.

The Young Offenders Unit of Rehabilitation Services (YOURS)

YOURS, established in 1999, is a section annexed to the prison (CCF), which caters for males below 21 years of age. At the discretion of the concerned authorities, older youth can also be admitted to this section on the basis of factors associated with the inmate's personal security. YOURS caters for up to 36 inmates. Most offences include armed

robbery and hold-ups, drug possession / trafficking and criminal offences against a person's personal security like grievous bodily harm, fighting and attempted murder. The vast majority of young people are admitted to YOURS with a drug problem which may have led them to commit the criminal offences previously mentioned. The Head of YOURS states that its population is on the increase because the offences committed by these young people are serious and often entail imprisonment and although sentencing options may have been reverted, young people keep breaking the law repeatedly. Additionally, sometimes there are instances were even the court has a dilemma as to where to send these young offenders, as the option of sending them home is sometimes even more detrimental to them.

The Caritas Harm Reduction Shelter

The Harm Reduction Shelter came into operation in October 2004. Harm Reduction clients have a specific profile: they indulge in polydrug abuse, live chaotic lifestyles, and typically lack any sort of family support. Very few of these clients have stable housing, and tend to make arrangements for their night's shelter on a day-to-day basis, with friends and acquaintances. Many Harm Reduction clients tend to have an array of psychological and physical difficulties often suffer from malnutrition, untreated injuries and other ailments. Some of these clients do not manage to find shelter and are entirely homeless. At present, existing shelters for the homeless, such as Osanna Pia, Suriet il-Bniedem, and the YMCA do not accept persons with a drug addiction problem. Some of these clients have no alternative but to live and sleep in abandoned cars in fields and makeshift shelters. Many of the persons, whose drug-related death reaches the media and national attention, belong to this category of persons with drug addiction. The Caritas Harm Reduction Shelter primarily provides a loosely structured low-threshold programme for persons who are currently abusing drugs and alcohol, and who are not yet in a position to work towards total abstinence. Close contact is sustained with other professionals, such as probation officers, medical doctors, psychiatrists, and the Dual Diagnosis Unit. Clients who are homeless have the opportunity to take up temporary residence at the Shelter until more permanent accommodation can be arranged for them. They participate in a rather more structured day programme, which helps to stabilise their chaotic lifestyle whilst offering them psychotherapeutic support. Clients who manage to reduce their methadone intake to a specified level, and who are

motivated to become fully abstinent from drugs, are referred to another service within the agency, with a view to embarking on an inpatient Residential Programme.

Caritas Drop-In

Drop-in clients can make use of Caritas's services for a number of hours a day. During this time, they are able to come in, have a meal, and sit in the living area where they are engaged in conversation by the staff, and where they are supervised in their interactions with each other. They may watch television, read newspapers and are encouraged to discuss various news items of interest to them. They are offered therapeutic support, both individually as well as at a group level. Staff members work towards encouraging these clients to regain an interest in the world around them, to relearn a routine of personal hygiene and adequate diet, and to try and resolve family and housing issues.

The Dual Diagnosis Unit at Mount Carmel Hospital

The Dual Diagnosis Unit (DDU) at Mount Carmel Hospital caters for males only and came into operation in June 2004. The DDU targets patients with severe drug abuse problems combined with psychiatric disorders as defined by the ICD10. Due to the wide array of client motivational, behavioural, psychological and psychiatric conditions, no structural rehabilitative process can be undertaken. The primary focus of the unit is to assess and provide acute management of the psychiatric problem, stabilise the client by means of substitution or detoxification treatment and provide medium or long term treatment plans in liaison with drug treatment agencies. Currently, treatment is limited to 4 weeks, which may be extended to 6 weeks in the most exceptional circumstances, and only after approval by the Director of Psychiatry. Clients may discharge themselves against medical advice. Readmission takes place if the client returns within one week. If this time period elapses, clients are re-registered. Therapeutic activities take place on a daily basis and are organised either by the head nurse or by the occupational therapist. These take the form of supportive, educational and motivational interventions.

CHAPTER 13

DRUG-RELATED RESEARCH

13.1 Research Structures

Drug-related Research in National Policy

The section on research in the 2007 Draft National Drugs Policy is titled: Monitoring, Evaluation, Research, Information and Training. The policy recognizes the need for adequate monitoring, collection and dissemination of information, periodical evaluation of policy measures and ongoing research and training. The National Focal Point (NFP) is recognized as an important body in this regard. The actions to realise this policy target include:

- Consolidating and facilitating of the functioning of the National Focal Point for Drugs and Drug Addiction (NFP) by incorporating it into the proposed National Co-ordinating Unit for Drugs and Alcohol together with the provision of adequate legal status for the National Commission on the Abuse of Drugs Alcohol and other Dependencies (NCADAD).
- Monitoring the effectiveness of education, prevention, care and treatment, social integration and harm reduction programmes.
- Ensuring that all information drawn from research findings, training and evaluation initiatives concerning the use of illicit drugs and misuse/abuse of prescription and non-prescription medication is published.
- Encouraging ongoing research so as to facilitate the regular assessment of the drug situation, relative responses and the monitoring of trends over time in Malta.
- Formulating disciplinary and interdisciplinary courses for people coming from different professional backgrounds in drug addiction.

The Relationship between Research and Policy

As regards research, and its link to influencing policy, the (draft) Drugs Policy takes into account the following key element:

- The National Co-ordinating Unit for Drugs and Alcohol within the Ministry for social policy, once established, shall be responsible for the implementation and monitoring of the National Drugs Policy and promote the co-ordination and co-operation among stakeholders, namely relevant Ministries and Departments, voluntary and private organizations and the President's Forum[1].
- The National Co-ordinating Unit for Drugs and Alcohol, once established, shall also manage the NFP, which in turn shall be responsible for collecting, analyzing and distributing data on drug use, evaluating the impact of drug use and ensuring through it's monitoring, that policy measures are realised at all levels.

Main National Structures for Drug-related research

The National Commission on the Abuse of Drugs, Alcohol and Other Dependencies (NCADAD), which sits in the Ministry for the Family and Social Solidarity (MFSS), is constituted by a multi-disciplinary forum of experts coming from fields that are crucial for the formulation of policies on various dependencies. The aim of the NCADAD is to:

- identify, formulate and update policy proposals and standards of practice, for the Minister's consideration, on prevention, treatment and enforcement matters related to dependencies;
- provide the appropriate forum for discussion, exchange and dissemination of ideas and information pertinent to the various sectors;
- promote good practices in the field and, to this end, recommend national mechanisms for monitoring and safeguarding standards of practice;
- conduct surveys, studies and submit reports on the ongoing situation in relation to dependencies;
- facilitate and monitor the necessary co-ordination and participation between government entities and other concerned organisations in the implementing of measures, services or initiatives;

[1] The President's Drug Forum comprises representatives from the National Commission on the Abuse of Drugs, Alcohol and other Dependencies (NCADAD), Drug Treatment Agencies, the Malta Police Force and Probation Services

- act as a national forum for the collation and analysis of data, thereby securing a comprehensive and concerted dependency research strategy;
- perform such other functions as may be assigned to it by the Minister.

The NCADAD co-ordinates the NFP, which ultimately is responsible for gathering the necessary information to enable the policy cycle and to monitor the drug situation and the responses as highlighted above.

MFSS is the main Ministry responsible for the co-ordination of drug-related issues. Other related Ministries are: the Ministry for Justice and Home Affairs, the Ministry of Education, Youth and Employment and the Ministry of Health, the Elderly and Community Care.

The main agencies and departments that conduct drug-related research are: sedqa, the National Agency against Drug and Alcohol Abuse, the Department of Health Promotion, the Department of Public Health and the Department of Health Information.

Within the University of Malta the main departments that conduct any form of research related to drugs are: the Department of Biomedical Sciences within the Faculty of Medicine and Surgery, the Department of Psychology and the Department of Youth and Community Studies within the Faculty of Education

13.2 Main Recent Studies and Publications

Main Recent Studies Since 2000

The main research studies undertaken in the Malta, organised according to the most recent year of publication, are the following:

1. Name of Research Project:

Alcohol, Tobacco and Drug Use Amongst 18 - 24 Year Olds in Post-Secondary and Tertiary Education (2006)

Research Institution/s Responsible:

National Commission on the Abuse of Drugs Alcohol and other Dependencies

National Focal Point for Drugs and Drug Addiction

Sedqa National Agency Against Drugs and Alcohol

Funding: Approx EUR 5,800

Structured Abstract:

In 2006 the first ever study on the use of alcohol, tobacco and drugs amongst students in post-secondary and tertiary education in Malta was conducted. Between February and March, self-administered questionnaires were completed by 1,226 (39% male and 61% female) full-time, 18-24 year old students. Here we present the number of users and age of first use of alcohol, tobacco and other drugs.

Alcohol and tobacco

Alcohol is the most commonly used substance.

64% of students binge drink. .

30% of students are current smokers.

Other substances

22% of students had used cannabis.

12% had used anabolic steroids.

11% had used magic mushrooms

10% had used tranquillisers.

7% had used inhalants.

6% had used cocaine.

5% had used ecstasy.

Age of first use for the majority of users

Under 16 years – alcohol, tobacco, inhalants

16-17 years – cannabis, ecstasy, amphetamines, cocaine

18 years and over – tranquillisers, LSD, heroin

Reference:

National Commission on the Abuse of Drugs Alcohol and other Dependencies, National Focal Point for Drugs and Drug Addiction, Sedqa National Agency Against Drugs and Alcohol (2006). *Alcohol, Tobacco and Drug Use Amongst 18 - 24 Year Olds in Post-Secondary and Tertiary Education*. Ministry for the Family and Social Solidarity, Malta.

2. Name of Research Project:

European School Survey Project on Alcohol and Other Drugs (ESPAD) 1999, 2003, 2007 (not yet published).

Research Institution Responsible:

Sedqa National Agency Against Drugs and Alcohol

Funding: Approx EUR 7,900

Structured Abstract (extracted from synopsis of ESPAD 2003 written by Sharon Arpa)

The survey was conducted in the country as a whole, and the targeted cohort were students attending the last year in the secondary schools in Malta and Gozo. A total of 4198 students took part, but only those born in 1987 were chosen from this population. Therefore those selected and eligible for this study totalled to 3500 students (1555 boys and 1945 girls). The response rate for this study was of 83%.

Alcohol Use

As in the previous study, the greatest and most widespread abuse of substances studied was alcohol. Consumption of alcohol continued to be a frequent current occurrence among participants.

Tobacco Use

Although a drop in cigarettes smoking was reported by respondents when compared to previous studies (56.6%in 1999, 52% in 2003), tobacco is still experimented with by more than 1 of every 2 students. Furthermore, 10% (13.9% in 1999) reported this to have taken place by the age of 11.

Illicit Drug Use

By the age of 16 years, experimentation with illicit drugs is not uncommon as already evidenced in the 1995 and 1999 ESPAD studies. The so called “soft drugs” are often the first to be tried out. The most commonly used illicit drug emerged once again to be inhalants. There have been increases in the use of cannabis compared to the 1999 study. A significant drop was registered in relation to tranquilliser and sedative use. The experimentation with many other drugs is not high – but still remains a worrying threat. It was anticipated that there will be a significant increase in lifetime use of ecstasy, being the drug of the moment. Actually, a decrease was registered when compared to previous

studies. A drop from 2.3% in 1999 to 1.2% in 2003 of respondents admitting to have experimented with ecstasy was reported. The figures for other drugs include 1.3% for amphetamines, 0.8% abused cocaine and 1.2% anabolic steroids. Overall, 13.3% of boys and 9.1% of girls have reported in having experimented with illicit drugs at least once in their lifetime by the age of 16.

Reference

Arpa, S. (2005). *Student Survey in Secondary Schools*, Malta, National Report. Sedqa, National Agency Against Drugs and Alcohol, Malta.

3. Name of Research Project:

2003 Risk and Resiliency Research Project (longitudinal study – still ongoing)

Research Institution/s Responsible:

Sedqa National Agency Against Drugs and Alcohol.
Department of Youth and Community Studies at the University of Malta.

Funding: Approx EUR 8,700

Structured Abstract:

The Risk and Resiliency Research Project (RRRP) is a five year longitudinal project taking 2003/4 (students aged 12-13 years), as the baseline. Some very preliminary findings on alcohol and psychosocial variables are presented. Young people whose peers drink alcohol are more likely to have consumed alcohol in their lifetime, the last year and last month. Students who agreed that: alcohol goes against their principles, is bad for health, makes one lose control, leads to deviant behaviour, effects family life negatively and produces bad after-effects were less likely to have consumed alcohol in the last month. Respondents who expected alcohol to make them feel relaxed, feel happy and have a lot of fun were more likely to use alcohol in the last month. Respondents who expected alcohol use to get them in trouble with police, harm their health, make them do something they regret, and make them feel sick were less likely to use alcohol in the last month. Participants who approved of drinking alcohol occasionally and regularly were significantly more likely to have drunk alcohol in the last month when

compared to those who were ambivalent or who disagree with occasional drinking. Respondents who had used alcohol in the last month experienced more psychosocial stressors when compared to those who had not consumed alcohol in the last month.

Reference:

Clark, M., & Arpa, S, (2003). *Risk and Resiliency Research Project*. Sedqa, National Agency Against Drugs and Alcohol, Malta.

4. Name of Research Project:

Young People's Health in Context: International report from the HBSC 2001/02 survey.

Research Institution Responsible:

Department of Health Promotion.

Funding:Unknown

Structured Abstract:

This study, conducted among children aged 11 years, 13 years and 15 years shows that as regards tobacco use, a higher percentage of girls ages 13 years (girls 32.9%; boys 25.9%) and 15 years (girls 40.1%; boys 37.6%) have ever smoked cigarettes in their lives. Onset of use is higher for boys than girls as seen in the percentages of those smoking at 11 years (girls 5.1%; boys 8.7%). As regards alcohol, more boys than girls were reported to consume alcohol every week across all three age cohorts (11 year olds: girls 3.2%; boys 9.1%; 13-year olds: girls 18.1%; boys 21%; 15-year olds: girls 39.8%; boys 55.8%). Percentages for Maltese children were higher than the HBSC average. In terms of cannabis use, more 15-year old boys than girls reported to have ever used cannabis (girls 3.9%; boys 9.2%) and to have smoked cannabis in the last year (girls 4.4%; boys 7.6%). Percentages are well below the HBSC average.

Reference:

Currie C. et al (eds.) 2004. *Young People's Health in Context: International report from the HBSC 2001/02 survey*. WHO Policy Series: Health policy for children and adolescents Issue 4, WHO Regional Office for Europe, Copenhagen.

5. Name of Research Project:

Licit and Illicit Drug Use in Malta in 2001: A General Population Survey Among 18-65 Year Olds.

Research Institution Responsible:

National Commission on the Abuse of Drugs Alcohol and other Dependencies

Funding: Approx EUR 34,900

Structured Abstract:

This report presents the findings of a survey among a random sample of 1.755 people aged18-65 years in Malta. The response rate was 68.3%.

Alcohol, Tobacco and Licit Drug Use

Drinking alcohol is quite common and appears to increase with age. 56.2% are current drinkers. Most people had their first alcohol beverage during adolescence. People who started drinking alcohol tended to continue to do so for many years. Smoking tobacco is also quite common in Malta, but not as much as drinking alcohol. 31.9% are current smokers. Most smokers tried their first cigarette during early adolescence. The use of sedatives and tranquillisers is less common in Malta than drinking alcohol or smoking tobacco. 8.9% are currently taking these substances. Like in other countries, people start using sedatives and tranquilisers much later in life than alcohol and tobacco.

Illicit Drug Use

According to the survey conducted in 2001, the percentage of those who admitted to ever smoking cannabis was 3.5%. First use commonly took place during late adolescence, and almost exclusively in Malta. Similar to other European countries, the use of cannabis appears to be predominantly experimental. Admitting to the use of other illicit drugs was low with 1.2% saying they had ever tired ecstasy, amphetamines, cocaine, heroin and/or LSD. Most likely, the use of illicit drugs was underreported in the survey due to problems of perceived confidentiality.

Gambling

Over half of respondents gambled at least once in their life (56.9%). Playing lotto, lottery, super 5 and scratch cards were very clearly the most popular ways of gambling. Experimenting with gambling increased with age.

Gender and age

Drinking, smoking, using illicit drugs and gambling are more common among males than females. Like in other countries, females more often use sedatives and tranquillisers than males. Drinking is highest among 18-24 year olds and smoking is highest amongst 35-44 years. Use of sedatives and tranquillisers is highest amongst those age 55 years and over.

Reference:

Korf, D., Benschop, A., Bless, R., Rapinett, G., Abela, D., Muscat, R. (2001*). Licit and Illicit Drug Use in Malta in 2001: A General Population Survey Among 18-65 Year Olds.* National Commission on the Abuse of Drugs Alcohol and other Dependencies. Ministry for Social Policy, Valletta, Malta.

13.3 Collection and Dissemination of Results

Information flows

The National Focal Point (NFP) for Drugs and Drug Addiction acts on behalf of, and reports to the National Commission on the Abuse of Drugs, Alcohol and other Dependencies (NCADAD). The model for the operation of the NFP is based on the concept of the Integrated Drug Information System, as promoted by United Nations Office on Drugs and Crime (UNODC) and amended by the Pompidou Group in the context of its Local Monitoring project, and the views on the organisation of supporting functions for drug policy, promoted by the Pompidou Group. Based on this model, the NFP is primarily perceived as a coordinating agent of national data providers and data users responsible for the organisation and maintenance of supporting functions for Maltese drug policy. Acknowledging this primary role of the NFP, its concrete tasks are defined in compliance with the demands of the EU Community Acquis.

The role of the NFP involves coordinating its national information network in order to collect, verify and synthesise raw and/or aggregate data on an annual basis. The data is used to assess the drug situation in Malta and monitor trends over time. The data is

collected in the form of databases and/or data sheets provided by the network. This data is stored in the NFP's database and is also documented into various standard tables and structured questionnaires (provided by and submitted to the EMCDDA on an annual basis) and used to compile an annual report at the end of each year, providing a global and harmonised picture of the drug situation in Malta.

The dissemination of information between the NFP and its network (Figure 13.1), other related agencies and the public in general is of paramount importance. The role of the media and the link between the NFP and the media through the media relations officer within the MFSS is a crucial element in ensuring that that the data and information reaches the general public in an unbiased and impartial manner.

The data sources that form part of the NFP's network are:

1. Information Network

Treatment Centres, Health Departments, the Education Division, Drug Prevention Services, the Police and Customs, Forensic and Toxicology Laboratories, Probation Services, Prison and Prison Inmate Programmes. This network consists of data managers, data collectors and other informants about the drug situation and responses in Malta. The role of the network is to deliver and discuss data specifications, cross-checking of data and data collection methods and to develop common standards for data and data collection.

2. Interpretation Network

This network consists of operational managers of government and non-government departments, organisations and services in the field of drug intervention. The role of the network is to discuss data and trends and implications for intervention in context; to provide expert estimates when data are not available; to provide feedback from practice regarding implementation of drug policies and to advise on topics for future monitoring and evaluation. The Interpretation Network should be installed by the National Commission as a consultative forum of the NFP, with a specific task to discuss the draft Annual National Report of the NFP prior to submission to the National Commission.

3. Research Network

This network consists of researchers of the organisations represented in the Information and Interpretation Network as well as other researchers with expertise in analyses and evaluations regarding the drug situation in Malta. The function of the Research Network is to exchange experience, to assist the NFP in responding to questions or research demands of the Maltese Government, EMCDDA or the European Commission and to further develop national capacity in drug research. The network does not require a formal basis, as actual research projects of the NFP will be conducted on the basis of dedicated assignments or commissions. Members of the NFP networks can be assigned to represent the NFP in projects and activities in which the NFP participates.

The NFP NETWORK

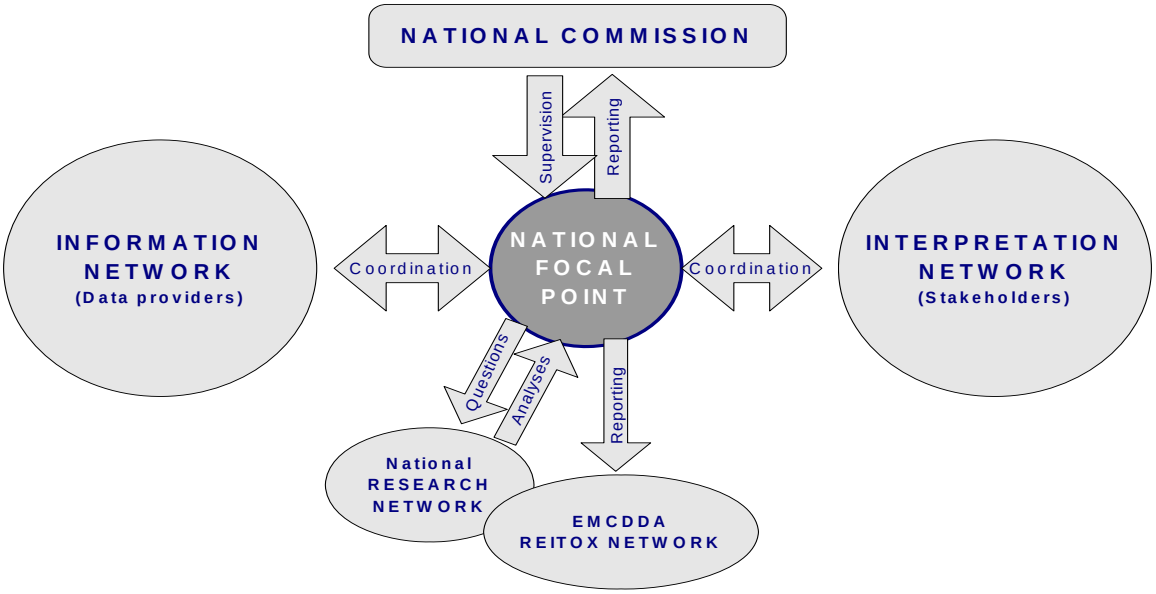


Figure 13.1

The main data collected by the NFP are treatment data, data on drug-related infectious diseases, fatal and non fatal overdoses, psychiatric co-morbidity and other health correlates, survey data to assess drug use in the general, school and youth population, data from agencies and departments implementing drug prevention programmes, arrest

and seizure data, prison data, probation services data, data on the price and purity of drugs and composition of tablets.

In order to fulfil its tasks, the NFP requires the structural and administrative support of the Ministry for the Family and Social Solidarity and related Ministries, namely the Ministry for Justice and Home Affairs, the Ministry of Health, the Elderly and Community Care and the Ministry of Education, Youth and Employment.

The NFP disseminates information by holding regular meetings on specific topics, with its different networks, through its mailing list (email and post), through the website of the Ministry for the Family and Social Solidarity and via the media.

National Scientific Journals

The main National research journals where papers related to drugs and drug use could be published in Malta are the following:

Journal of Maltese Education Research

This electronic journal provides established and emerging scholars and practitioners with a space for critical and empirical analysis of issues central to Maltese education policy, curriculum reform and pedagogy. The scope of this journal is not limited to schooling but is also extended to scholars and practitioners working in: pre-school education; adult and continuing education; vocational training; popular education; popular culture; education for leisure; museum education; media education; distance learning; open learning; education and the Maltese diaspora; education administration and management; education planning; and history of education. Papers published in this journal are written in English and reviewed by at least two independent referees.

The Malta Medical Journal

The Malta Medical Journal is the peer reviewed scientific publication of the Faculty of Medicine and Surgery at the University of Malta. The Journal aims to serve the needs of the medical community in the broadest sense by encouraging continuing professional development and furthermore enabling the publication of articles related in particular but not solely to the practice of Medicine in Malta. Papers are published in the English language.

Xjenza

This is the Journal of the Malta Chamber of Scientists and is published in hard copy and in electronic format. It is a peer-reviewed journal written by scientists for academics, industrialists and other scientists working in all branches of science and technology.

HUMANITAS - Journal of the Faculty of Arts

This journal publishes papers related to the study of the humanities. Papers related to social issues like inclusion and criminology may also be published here.

DISCERN

DISCERN is the multi-disciplinary Institute for Research on the Signs of the Times. It is run by and answerable to the Archdiocese of Malta and organises research, publishes various materials of a sociological nature, and often invites distinguished international guest speakers to lecture on particular social issues.

Other means of dissemination

Information related to drugs and drug use in Malta is disseminated by the NFP mainly via the following channels:

- Via a mailing list consisting of all agencies, departments, organizations etc related directly or indirectly to the area of drugs; the NFP regularly posts or emails national and international reports, newsletters or any work it receives or publishes, to relevant entities that form part of this mailing list.
- The website of the Ministry for the Family and Social Solidarity (www.msp.gov.mt) has a section dedicated to Addictive Behaviours and relevant reports and publications are uploaded here.
- Training seminars and meetings are organised with different stakeholders that form part of the NFP network and also with other entities that may be even indirectly related to the area of drugs, in order to exchange information and initiate or improve working collaborations.
- The media is used by the NFP as a means of information dissemination.

PART C

BIBLIOGRAPHY AND ANNEXES

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ANNEXES

Abbreviations

ARS	Arrest Referral Scheme
BZP	1-Benzylpiperazine
COI	Cost of Illness
DSU	Disease Surveillance Unit
EAP	Employee Assistance Programme
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMQ	European Model Questionnaire
ESPAD	European School Survey Project on Alcohol and Other Drugs
ETC	Employment Training Corporation
EWS	Early Warning System
CIAU	Crime Intelligence Analysis Unit
CCF	Corradino Correctional Facility
DDU	Dual Diagnosis Unit
DSU	Disease Surveillance Unit
EU	European Union
GU	Genitourinary
HBSC	Health and Behaviour in School Aged Children
HBV	Hepatitis B Virus
HIV	Human Immune Deficiency Virus
HPV	Human Papilloma Virus
ICD	International Classification of Diseases
IDU	Injecting Drug User
LSD	Lysergic Dyethylamide Acid
mCPP	Meta-chlorophenylpiperazine
NCADAD	National Commission on the Abuse of Drugs Alcohol and other Dependencies
NFOD	Non Fatal Overdose
NFP	National Focal Point for Drugs and Drug Addiction
NGO	Non Governmental Organisation
NHIS	National Health Interview Survey

NMR	National Mortality Register
OD	Overdose
PIP	Prison Inmates Programme
PSR	Police Special Register
SAFE	Substance Abuse-Free Employees
SATU	Substance Abuse Therapy Unit
SCBU	Special Care Baby Unit
SMOPU	Substance Misuse Outpatients Unit
TC	Therapeutic Community
TDI	Treatment Demand Indicator
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
YOURS	Young Offenders Unit of Rehabilitation Services

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