European Monitoring Centre
for Drugs and Drug Addiction

2004 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point

MALTA

New Developments, Trends and In-depth
Information on selected issues

REITOX
Malta National Focal Point

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Introduction

This is the first National Report on the drug situation in Malta compiled by the newly founded National Focal Point for Drugs and Drug Addiction under the auspices of the National Commission on the Abuse of Drugs, Alcohol and Other Dependencies based in the Ministry for the Family and Social Solidarity.

The launch of the National Focal Point (NFP) was a direct consequence of the award of a "EU Twinning Grant" which has just been completed and which involved other factors, but integral to the whole project was that of a functioning NFP by the end of 2004.

As such, since its inception in June 2004, the NFP has been extremely active in putting together the Drug Information Network that is constituted of what may be termed the data providers. This has permitted the collection and collation of drug-related information at a National level to provide the necessary material for this report. In addition, the Interpretation network made up of the stakeholders or managers of the relative drug agencies has also been initiated and has provided a major input into this National Report.

The result of this initiative, a National Report, is that for the first time Malta will have a comprehensive picture of the drug situation. In turn, it also provides us with the evidence through which a National Drug Strategy may be elaborated in line with the new EU Drug Strategy that will come into force in 2005. Finally, it will also provide Malta' s contribution to describing the drug situation in the EU in what has come to be known as the EMCDDA's Annual Report on the State of the Drugs Problem in the European Union.

The collection and interpretation of data for the report is a result of the joint effort of experts in the field of drugs in Malta. In this regard, the NFP is grateful for the dedication and collaboration of both its information and interpretation network and would like to extend its gratitude to the external authors for their contributions. The NFP would also like to thank Mr Ruud Bless for his professional assistance throughout the whole process of writing up this report and the Data Protection support team for their assistance in setting up the inter-agency meeting that resulted in the merging of treatment data files for Chapter 4.

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Summary

This is the first National Report on the drug situation prepared by the National Focal Point for the Ministry for the Family and Social Solidarity and submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The report per se gives an overview of the current, that is at it stands at 2003, legal and institutional structures, epidemiological situation, demand and supply reduction activities related to the drug issue.

With these factors in mind the following encapsulate the content of this report:

- 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 National Commission on the Abuse of Drugs, Alcohol and other Dependencies, launched in 1999, has as its primary responsibility that of providing policy advise to Government on drug related issues. The National Commission per se sits in the Ministry for the Family and Social Solidarity, formerly the Ministry for Social Policy and is the lead Ministry in the area of drug policy.

- Discussions on drug policy that involve the said Ministry as well as the Ministry for Justice and Home Affairs, the Ministry of Health, the Ministry of Education and that of the Ministry for Investment take place under the umbrella of the Parliamentary Committee for Social Affairs.

- The National Focal Point for Drugs and Drug Addiction is operated by the National Commission and is primarily responsible for the collection and collation of drug-related information through its Data Information Network and Data Interpretation Network.

- Total Government funding involved in the drug field is approximately 1.5 million Maltese lira per annum or some 3.5 million Euros. In the main, that is 66%, is allotted to Demand Reduction activities while the other third for Supply Reduction activities.

- When referring to types of prevention, Malta still uses the terms ‘primary’ ‘secondary’ and ‘tertiary’. Primary prevention in Malta refers to measures targeting schools, the community, the workplace and the media and would thus fall under the EMCDDA category of ‘Universal Prevention. Secondary and tertiary prevention on the other hand, would include measures targeting high-risk groups (mainly in schools) and treatment in care centres respectively.

- Cannabis use amongst the general population aged 18-65 is around 5% whereas in the 15-16year old cohort it is double the amount, some 10%.

- Heroin use is of the order of 10 per 1,000 of the population, which for comparative purposes is similar to or higher than the leading 3 or 4 countries within the EU reporting such figures.

- The most pertinent aspect in relation to the prevalence estimates for the use of cannabis with other drugs such as heroin is that this amounts to just over twice as much whereas in most other European countries it is of the order of 5. This would seem to suggest that drug use is restricted to a particular cohort.

- Drug Treatment in Malta is divided into 4 main categories, namely, methadone substitution treatment, detoxification treatment, outpatient community service/day care and inpatient drug free rehabilitation programmes.

- Between 1991 and 2003 there were a total of 63 acute/direct drug related deaths. In 2003, the number of drug related deaths was 5. Between 1991 and 2003, the rate of drug related deaths per 1,000 of the population aged between 15-64 was 0.02. The cause of death in 95% of the cases was opiates. Due to a combination of factors generally associated with determining the actual cause of death when drugs are involved, such figures may be an underestimate.

- In 2003, almost all arrested persons were charged for possession of drugs: 74% only for possession and 22% for possession and trafficking, mostly related to cannabis or heroin. The number of arrests for drug-law offences since 1998 shows peaks in 1999 and 2002 and a slight drop in 2001 and 2003.

- Cannabis remains the most popular drug of abuse in Malta. The herbal form (grass) can be grown locally. Cannabis resin (hashish) on the other hand is imported from North Africa. Heroin is imported from Eastern Mediterranean countries and from North Africa, while cocaine and ecstasy are imported from other European Countries.

- Cannabis, followed by heroin remains the most common drug seized. Ecstasy seizures, however, have shown a marked increase since 2001.

- The prices for different narcotic substances are based on information obtained from the Police Drugs Squad. According to their information, street level prices for cannabis herb and resin have remained quite stable since 2001. Prices of heroin and cocaine have increased since 2001, whereas prices for ecstasy have dropped. The Police Annual Report Questionnaire 2003 reports no significant changes in drug purity across all drugs between 2003 and the previous year, however an increase in heroin purity and a decrease in ecstasy purity can be observed between 2001 and 2002/3.

Part A

New Developments and Trends

Chapter 1. National policies and context

1.1 Legal framework

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 **Dangerous Drugs Ordinance** was enacted in 1939 and has also been extensively amended. This is especially true in recent times when several amendments had to be 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. The Ordinance deals specifically with *opium, coca leaves, cannabis, cocaine, morphine* and other drugs. There are also regulations regarding raw opium and the internal control of drugs, which date back to 1939 with amendments made during the course of time.

The punishments for drug offences vary from pecuniary measures to life imprisonment, depending on the gravity of the offence. In serious cases, apart from long prison sentences and hefty fines, the courts will order the confiscation of the accused`s assets since it is presumed that those assets have been purchased from drug-related income. It is then up to the accused, if he so desires, to file a civil lawsuit to prove the contrary.

The third schedule of the Medical and Kindred Professions Ordinance provides a list of psychotropic drugs, for example MMDA more commonly known as ecstasy.

The Dangerous Drugs Ordinance deals with narcotic drugs. The drugs, namely *opium, coca leaves, cannabis, cocaine, morphine* are specifically mentioned in the substantive provisions. The first schedule of this Ordinance then provides a list of preparations containing any of the above-mentioned drugs.

The use of illegal substances is not, *per se*, recognised. However, the use of these substances, if proved in court, will lead to a conviction of possession or trafficking.

As regards possession, our laws recognise two kinds of possession; the so-called simple possession or possession for personal use, and the aggravated possession or possession under which circumstances it appears that the possession was not for the offender's exclusive use. This latter type of possession, given certain circumstances, carries a maximum punishment of life imprisonment.

The State gives priority to education on the harmful (many times deadly) effect of drugs, rehabilitation as well as prevention. When certain offences take place within 100 metres of the perimeter of a school, youth club or centre, or such other place where young people habitually meet, the normal punishment is increased in that these circumstances are deemed to be an aggravation of the offence.

It can be said that the state of addiction is legally recognised since our courts may order drug addicts to undergo treatment for their addiction by way of punishment.

Non-criminal sanctions are not contemplated by our laws. However, these laws provide certain non-custodial sanctions in minor cases.

The Maltese courts come down hard on drug traffickers. Unless exceptional circumstances are actually proved, our courts have shown little mercy to these offenders and it can be said that, together with criminals convicted for homicide, drug traffickers in Malta are the ones facing the stiffest punishments.

The Maltese courts have not shown much leniency in relation to drug-related offences, such as theft from vehicles, invariably stating that if such leniency were shown, they would be condoning more than one odious crime.

User-dealers are naturally not treated in the same way as dealers whose only scope is that of enrichment. However, once again, they also face harsh punishments. If it is proved that an accused person is not a drug abuser, although technically one cannot speak of aggravating circumstances, our courts have always dealt with such situations as if they were aggravating circumstances.

As regards leniency, the Attorney General has an important role to play. He must, possibly before the initiation of criminal proceedings, decide whether the offender is to be tried before the inferior courts or before the superior courts. The parameters of punishment vary accordingly. Suffice to say that the maximum punishment that may be awarded by the inferior courts is that of ten years imprisonment, whereas the superior courts may award a maximum punishment of life imprisonment.

According to the Maltese laws of criminal procedure, the Executive Police initiate all criminal proceedings. They have no obligation whatsoever to divert proceedings. However, they do have discretion not to prosecute if they feel that prosecution would not be in the best interest of justice. Given certain circumstances, the Attorney General also has discretion to discontinue criminal proceedings, provided that he informs the President of the Republic accordingly giving reasons for his decision.

Maltese law provides for forced treatment as part of the punishment for drug offences.

The Conduct Certificates Ordinance (Cap. 77) does provide remedies for a conviction relating to drug offences not to be registered. However, these types of offences are treated with utmost severity even in this regard.

The primary legislation that criminalises money laundering of proceeds of offences is the Prevention of Money Laundering Act (Cap. 373). This law was enacted in 1994. It originally dealt with very few predicate offences, mostly drug and drug-related offences. However, with the passage of time and in view of the fact that this

phenomenon has increased immensely, the list of predicate offences today includes a number of other crimes.

However, the Medical and Kindred Professions Ordinance and the Dangerous Drugs Ordinance also deal specifically with the offence of money laundering with numerous cross-references to the Prevention of Money Laundering Act. The same cannot be said of other predicate offences.

As regards confiscated money, this all goes to the State.

The notion of injection rooms is unknown to our legislation.

1.2 Institutional framework, strategies and policies

The first Maltese drug commission was set up in 1973. Though still in its infancy, the focus of this commission was that of setting up educational programmes against drug abuse. In 1993, the Minister for Social Development set up a working committee whose task was to evaluate the drug and alcohol treatment services in Malta. The evaluations carried out by this committee were presented in the Meli Report[1], which made recommendations that resulted in the formation of a new commission, K.A.D.A: The Commission Against Drug and Alcohol Abuse and the establishment, in 1994 of Sedqa, the government agency against drug and alcohol abuse. In 1999, the Commission was re-launched and renamed to The National Commission on the Abuse of Drugs, Alcohol and other Dependencies with the specific remit to advise Government on policy in the dependency field.

The National Commission per se sits in the Ministry for the Family and Social Solidarity, formerly the Ministry for Social Policy and is the lead Ministry in the area of drug policy. A Policy Directorate has recently been set up within the Ministry. Drug issues are amongst a number of policy areas that are now handled by the said directorate. Previously drug policy issues were being handled directly by the Ministry's Policy Co-ordinator in liaison with the National Commission on the Abuse of Drugs Alcohol and other Dependencies, which tenders its advice.

Discussions on drug policy that involve the said Ministry as well as the Ministry for Justice and Home Affairs, the Ministry of Health, the Ministry of Education and that of

[1] The Meli report, named after Magistrate Silvio Meli who chaired the working committee, was the main catalyst behind the restructuring of the drug and alcohol sector.

the Ministry for Investment take place under the umbrella of the Parliamentary Committee for Social Affairs.

In Malta five Ministries and within each, several departments or units, are also involved in the responses to the drug situation as detailed below (Table 1).

Ministry for the Family and Social Solidarity	Ministry of Health	Ministry of Justice and Home Affairs	Ministry of Finance	Ministry for Investment, Industry and Information Technology
National Drug Agency Sedqa	State Hospitals Dept. Public Health Dept. Health Information	Police Force Law Courts State prison (CCF) Pre-release Programmes including Substance Abuse Therapeutic Unit (SATU)	Customs Department	National Lab including Forensic Lab
Subsidised NGO's: Caritas Oasi				
National Commission on the Abuse of Drugs, Alcohol and other Dependencies				

Table 1.1. Ministries and departments involved in the responses to the drug situation

Subsidies to non-governmental organisations delivering services in the field of demand reduction are included in the budget of the Ministry for the Family and Social Solidarity. However, funds for the Pre-release Treatment Programme for imprisoned drug users are provided by the Ministry for Justice and Home affairs.

In the field of International co-operation with international bodies such as the United Nations, EU and Council of Europe, Malta is either represented by the Malta Police Force on behalf of the Ministry for Justice and Home Affairs or by the chair of the

National Commission on the Abuse of Drugs, Alcohol and other Dependencies on behalf of the Ministry for the Family and Social Solidarity.

1.3 Budget and public expenditure

Over the past ten years or so, the Maltese Government has become increasingly sensitive to the negative consequences of drug addiction. Drug use in the long term robs citizens of their dignity and character and erodes any ambition or hope. The social cost of this phenomenon, recognised by, health, criminal and economic dimensions, has thus also raised the stakes. Regularly, and for several years now, the state has invested resources, be they financial, human or capital, towards addressing drug addiction. The instigation of preventive and rehabilitative services, the inauguration of a specific section within the Police Force, the financial support towards NGOs within the drug addiction field, the reconstitution of the National Commission on the Abuse of Drugs, Alcohol and other Dependencies in 1999 and the completion of a national drug prevalence survey (2002) are but a selection of initiatives that have been currently undertaken in the field.

Total government funding involved is of the order of 1.5 million Maltese lira per annum or some 3.5 million Euros. In the main, that is 66% is allotted to Demand Reduction activities while the other third for Supply Reduction.

A significant proportion of funds allocated to Demand Reduction activities are channelled towards prevention activities (see Chapter 3), which have primarily been put in place by the Governments executive agency in the drug field, Sedqa. In addition, the NGO's Caritas and OASI also have a range of prevention programmes in place that address specific audiences such as school children, peers, parents, the community and the work place.

These programmes attempt to stop use before it starts as it is now known that if one prevents the use of drugs during adolescents there is less chance of their using drugs when adults. Moreover, the content of such programmes are focused on a healthy and responsible life style in addition to providing the basic factual information on the dangers of drug use.

In conjunction with such efforts to reduce use, the Government has attached equal importance to disrupting "supply" and thus the drug market (see Chapter 10) by

attacking the economic basis of the drug trade. “Street Availability” is a major determinant of drug use thus reducing such may be a powerful means through which to reduce overall use as well as facilitate users to enter treatment.

Treatment (see Chapter 5) is provided by both Sedqa and the NGO’s Caritas and OASI as well as the prison based unit SATU (Substance Abuse Therapeutic Unit). These agencies offer their services to persons with problems across all types of substances; however, it would appear from the data that the majority of clients are those whose primary drug of abuse is heroin.

1.4 Social and cultural context

Most people in Malta are aware of the major classes of illicit drugs due to the coverage in the media that incorporates both television and the press. From the last “Lifestyle” survey conducted in 2001, it was apparent that one in five know of another who has smoked cannabis and in addition the majority were not in favour of decriminalising cannabis use or for that matter any other drug.

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, or if not all, arrests made by the 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.

Moreover, the major issue discussed, both in public and amongst those involved in drug issues under the umbrella of the President’s Forum, was that of drug use among youth in relation to the justice system. It is evident that the public views such users in the main as “patients” and not “criminals” and thus providing the framework through which drug users could profit from coming to terms with the problem provided the central theme for discussion. The outcome of such public discussions have resulted in action by the President’s Forum in the form of an appraisal of the criminal justice system at present and recommendations such as the suggestion of alternative sentencing methods for substance abusers and the proposed the setting up of a separate system of jurisdiction for substance abusing offenders which would take into consideration both the offending as well as the substance abusing aspects of the crime. It was suggested that therapeutic and judicial elements form an

innovative (for the Maltese setting) entity, which would address both facets of the issue, treating substance abuse while administering justice, with the ultimate aim of curbing the abuse and diminishing criminal behaviour. These suggestions will shortly be discussed at the Parliamentary Committee for Social Affairs.

Chapter 2. Drug use in the Population

2.1 Drug use in the general population

The only and most recent general population survey was conducted in 2001 and an estimate of drug use in the population was again attained as part of a Health Survey conducted in 2002. The figures obtained as detailed below, would seem to substantiate the general conclusion that drug use in Malta is limited to a particular cohort.

General population surveys provide an overall perspective of substance use within the population as a whole. It must be stressed however that certain groups may be missed such as those in treatment and prison, and thus such information is normally obtained by focussing on these specific groups (see for e.g. Chapter 4 and Chapter 8).

Overall then the self-reported use of illicit drugs is much lower then most other European countries. It was estimated that 3.5% or some 10,000 of the Maltese population have at least tried cannabis once as shown in the figure below (Figure 2.1).

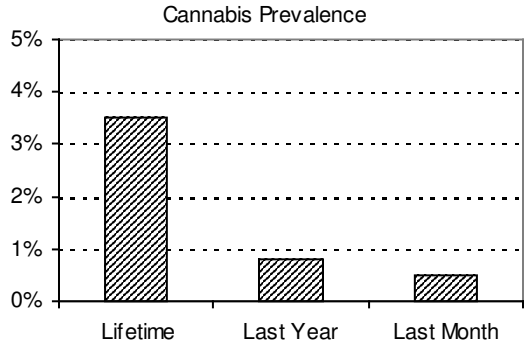

Figure 2.1. Prevalence of cannabis use in the general population
Source: Population survey 2001

This figure is somewhat increased if one takes the age group 18-24 where it rises to 4.9% or some 13,000 of Maltese youth. This is somewhat slightly lower than that achieved using school surveys as shown below (Figure 2.2).

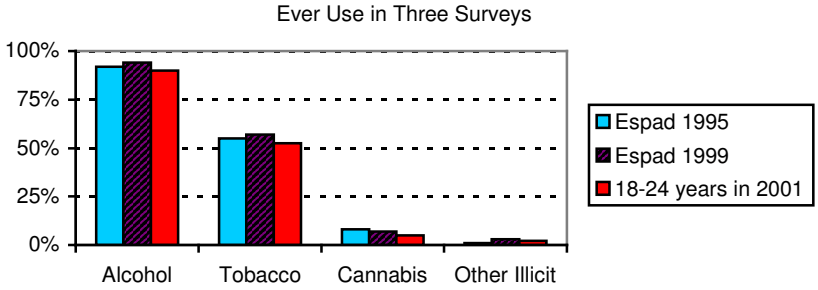

Figure 2. 2. Prevalence of substance use in the youth population
Source: Espad 1995, 1999; Population survey 2001

However, first use of cannabis appears to take place between the ages of 16 and 21 (Figure 2.3) which is in accordance from what is found in school surveys and in the majority of circumstances such use takes place here in Malta and not abroad.

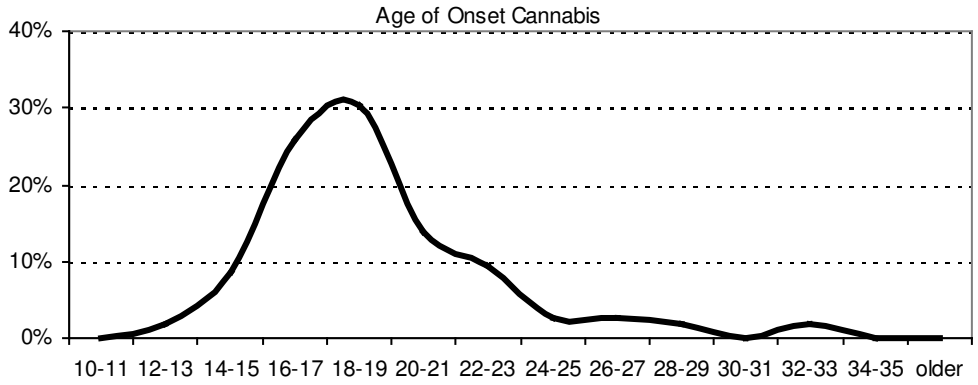

Figure 2.3. Age of onset of cannabis use in the general population
Source: Population survey 2001

Thus overall, experimentation with cannabis appears to be rather stable over the past years but it would appear to be on the increase in the 16 year old males as illustrated by school surveys (see next section). At present, ever use of cannabis by the 18-24 year olds and by those in their forties is similar but is absent in those who are in their fifties or over which is indicative of the fact that cannabis only appeared in Malta in the early 1970's (Figure 2.4).

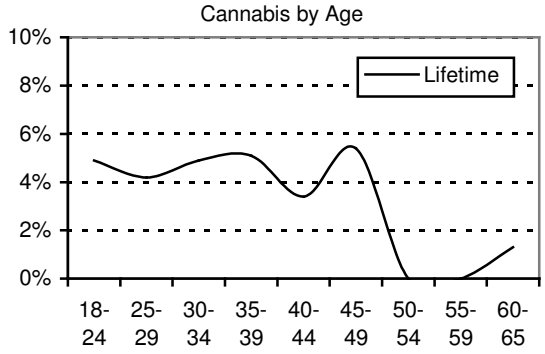

Figure 2.4. Cannabis use by age in the general population
Source: Population survey 2001

With regard to the use of other illicit substances such as ecstasy, LSD, amphetamines, cocaine and heroin, 1.2% of the population, or 3000 people have tried these drugs at least once (Figure 2.5).

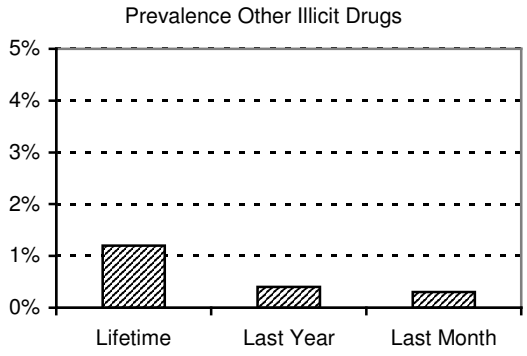

Figure 2.5. Prevalence of use of other illicit drugs in the general population
Source:Population survey 2001

The most pertinent aspect of these findings is the fact that when one compares the prevalence estimates for the use of cannabis with other drugs this amounts to just over twice as much, whereas in most other European countries it is of the order of 5 (Figure 2.6). This would seem to suggest that drug use is restricted to a particular cohort and is not widespread throughout the population.

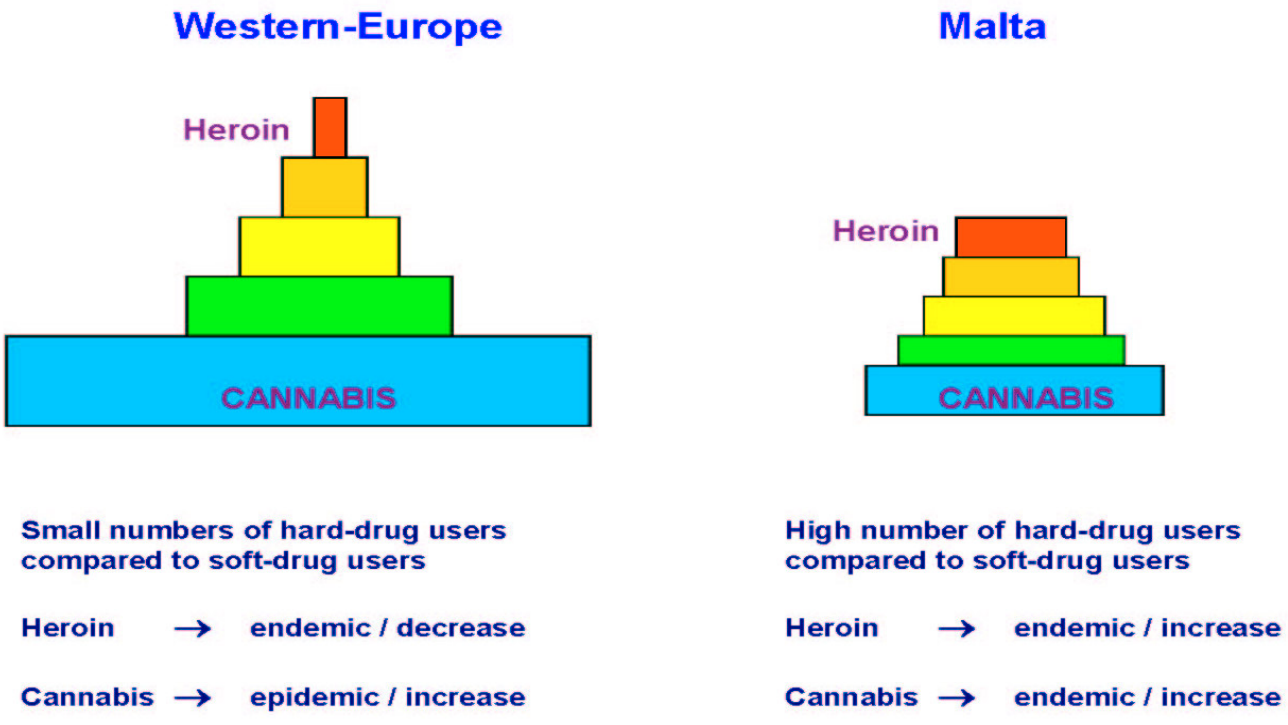

Figure 2.6. Comparisons with Western Europe for prevalence estimates of cannabis use with other illicit drugs
Source: Drug Service evaluation Study 2001

2.2 Drug use in the school and youth population

Malta over the years has conducted a number of school surveys to assess substance use, risk perceptions and attitudes to such in school aged children attending secondary school (age 11-16years old). The first survey conducted in 1991 by Caritas, known as the Pride survey among school aged children between the ages of 11-16 covered the total population of some 20,000. Moreover, the survey was repeated again in 1998 among a sample of some 1000 students. These efforts have been reinforced by the participation of Malta in the ongoing European School Survey Project on Alcohol and Other Drugs (ESPAD) since 1995. Overall some three European surveys have been conducted since 1995 that is a further one in 1999 and the last one in 2003, which was launched in December 2004. Moreover, Malta has also started to participate in the WHO study, Health and Behaviour in School Aged Children (HBSC) that covers children aged 11, 13 and 15years old. It primarily covers health but now includes questions related to drug use, namely cannabis in the 15-year-old age cohort. The last survey was conducted in 2001/2002 and is repeated every four years as is the ESPAD study but this in it self is vital as it provides information on drug use in the interim period between ESPAD studies and thus is now available every two years.

Drug use amongst the 15-16 year old cohort, namely those students attending form V, is mainly related to the use of cannabis as is in most European countries. However, cannabis use in this cohort has steadily increased since the first survey conducted in 1995 and the last in 2003 as shown below (Figure 2.7).

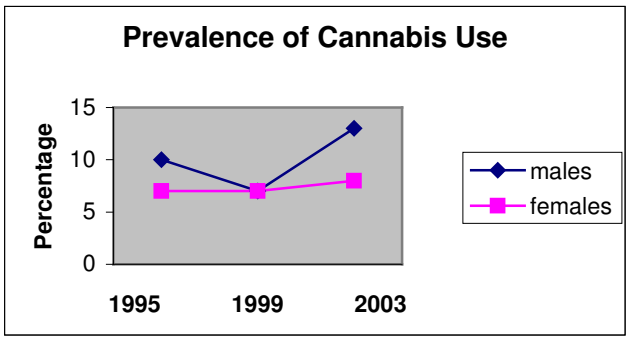

Figure 2.7. Prevalence of cannabis use amongst the 15-16 year old cohort
Source: ESPAD 1995, 1999, 2003

Use of cannabis over the last thirty days has also progressively increased over the three surveys in both the male and female cohort of 15-16 year olds in Malta as shown below (Figure 2.8).

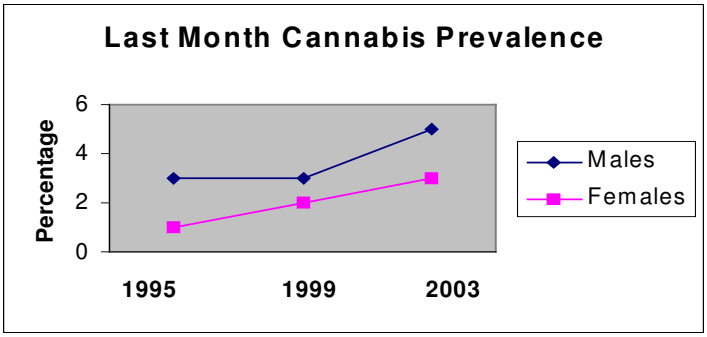

Figure 2.8. Prevalence of last month cannabis use amongst the 15-16 year old cohort
Source: ESPAD 1995, 1999, 2003

The modest increases in cannabis use over the three surveys be it lifetime use or use last month is further supported by the notion of the perception of 'ease of availability' which has increased substantially between 1995 and 2003 as depicted below (Figure 2.9).

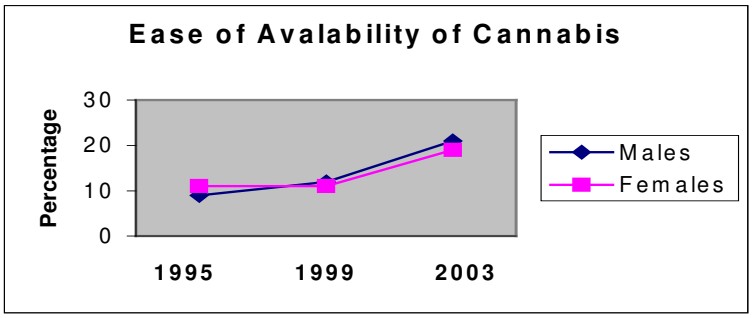

Figure 2.9. Perception of ease of availability of cannabis amongst 15-16 year olds
Source: ESPAD 1995,1999, 2003

Lifetime use of other drugs, that includes, ecstasy, amphetamines, cocaine and heroin in main, are much lower than that of cannabis. However, once again increases in use of such drugs can be observed over the period of study that is between 1995 and 2003 as shown below (Figure 2.10).

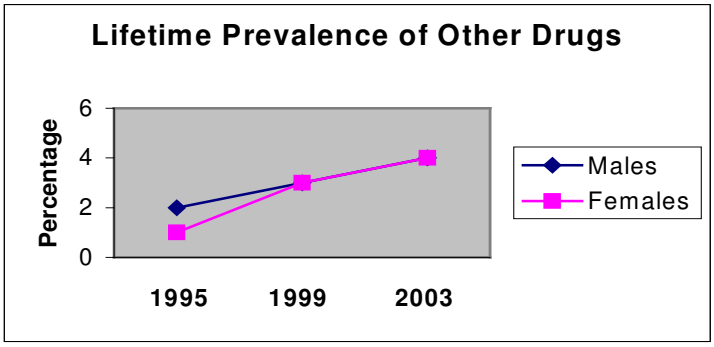

Figure 2.10. Lifetime prevalence of other drugs amongst 15-16 year olds
Source: ESPAD 1995, 1999, 2003

Moreover, the most popular choice of drug among this particular cohort are what may be termed as inhalants or those substances such as glues that are sniffed. The lifetime prevalence estimates for the use of such substances have remained high over the eight-year period in relation to our European counterparts but as such have not changed over the test period in question (Figure 2.11).

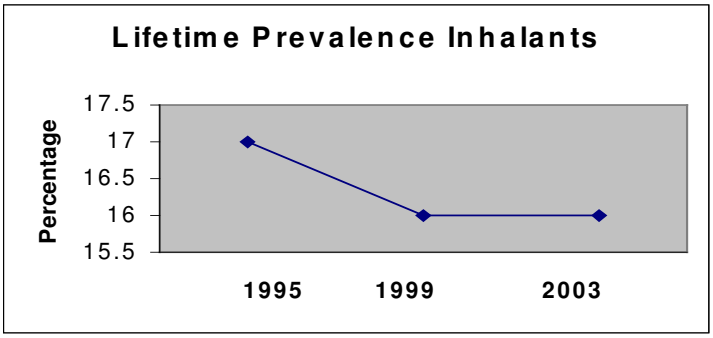

Figure 2.11. Lifetime prevalence of inhalants amongst 15-16 year olds
Source: ESPAD 1995, 1999, 2003

However, the perception of the ease of availability of inhalants has tripled between the first conduct of the survey in 1995 and the last one in 2003 (Figure 2.12).

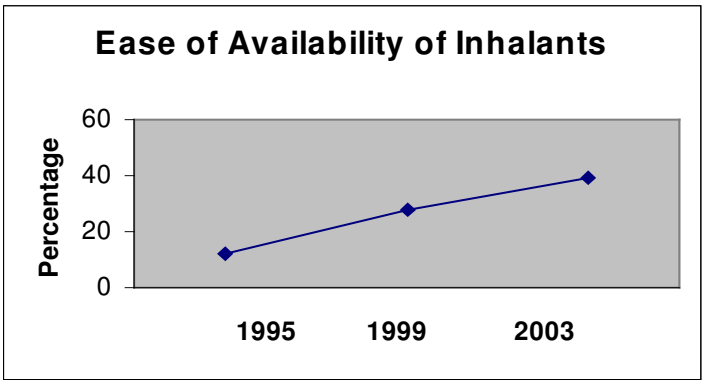

Figure 2.12. Ease of availability of inhalants amongst 15-16 year olds
Source: ESPAD 1995, 1999, 2003

Thus the use of cannabis and other drugs would appear to be on the increase among the 15-16 year old cohort and in some respect this is mirrored by the perception of the increase in the ease of availability of cannabis and the other drugs such as ecstasy.

2.3 Drug use among specific groups

The information on the use of drugs among specific cohorts mainly relates to studies conducted by University students in their final year of study and as such cannot be found in the literature as they mainly relate to local studies and are part of other initiatives.

Use of Ecstasy among partygoers namely those attending rave parties was first examined in 1999. Crockford (1999) used a snowball sample generated from the Community Service run by the National Drug Agency Sedqa and then conducted interviews to ascertain frequency of use amongst other things. From the information obtained, a questionnaire aimed at MDMA users was formulated and distributed by volunteers of the previous study. A total of 70 questionnaires were distributed. The response rate was 64% of which 34 respondents were males while 11 were females. The mean age for males was 22.5 years, whilst that of females was 21.5 years. Most respondents first encountered MDMA between the ages of 16 and 19. Almost half replied that they had been using MDMA for the past 3 to 5 years. The majority of respondents stated that they used between one and two MDMA tablets at each party. However, a third of the respondents claimed to use between 2 and 4 tablets each when they used MDMA. 62% of respondents claimed to use MDMA at least once a month. Although females tended to use less amounts of MDMA their frequency of use was much higher than that of males. A high use of alcohol together with MDMA was also noted. 71% of the respondents used other drugs together with MDMA. 12 claimed to use heroin in order to reduce the immediate side effects of MDMA.

Cassar (1999) also conducted a limited study into the use of ecstasy which involved a number of interviews with eight known ecstasy users, four females and four males, and another four females and four males non ecstasy users but who also attended raves as part of a more overall of study in the use of drugs in such settings.

Gatt (2002) looked at "Cognitive Deficits Associated with MDMA Use" using different categories of drug users via an opportunity sample. This study per se was conducted to determine whether cognitive performance in MDMA users was compromised, and if so, whether this decrement was specifically associated with their past exposure to MDMA and not other illicit drugs. When comparing both the MDMA groups with the marijuana control group, a significant difference resulted in the visual selective attention and sustained and divided attention tasks. The results also provided evidence of relationships between the degree of consumption of MDMA and the severity of the cognitive impairment. The findings support evidence that cognitive impairment correlates with the degree of MDMA exposure and not with the other illicit drugs consumed by the participants. This cognitive disturbance is likely to be related to the well-recognised neurotoxic potential of ecstasy.

Gauci (2002) addresses the issue of "Female Addiction" in particular to those in treatment as it has been estimated that this cohort accounts for 15% of the total in treatment (see Chapter 4). 12 female clients from one of 2 drug agencies, Sedqa and Caritas participated in the study that consisted of structured interviews. In essence, the study promotes awareness of the reality of female addiction in our society, it highlights inadequacies that directly or indirectly enforce their habit and introduces perspectives and methods of intervention that enable their rehabilitation.

"Young Women Heroin Users: their lives and experiences" was again the focus of study by Pisani (2001). Structured face-to-face interviews with 10 outpatient users of the Drug Agency Sedqa were done in order to attempt to explore the psychosocial dynamics of female heroin addiction. The study highlights the gender-specific aspects of heroin addiction, from young women's life before heroin, the onset of their drug use and the life they experience in the world of heroin. A common theme that emerges is the importance of relationships for the young women's sense of self. This study presents female heroin use within the context of Maltese Society. Society labels these women as prostitutes and not to be trusted. The women in this study express feelings of guilt and shame, knowledge of how they are regarded by society increases their self-contempt and impedes them from achieving a drug-free lifestyle. To conclude, this study suggests ways of improving the services offered to women heroin users.

2.4 Attitudes to drugs and drug users

This section covers familiarity, availability, susceptibility, risk perceptions and attitudes to drugs and drugs users as gleaned from the 2001 Lifestyle Survey. In all probability with the exception of availability these would appear to remain valid today as they were in 2001.

Familiarity

The vast majority of the population have heard of cannabis, ecstasy, cocaine and heroin. About three-quarters have heard of LSD and almost one half of the population have heard of amphetamines. About one out of every five Maltese personally know people who take cannabis. About one out of every ten personally know people who take ecstasy (XTC) and only some personally know people who take cocaine, heroin, LSD or amphetamines (Figure 2.13).

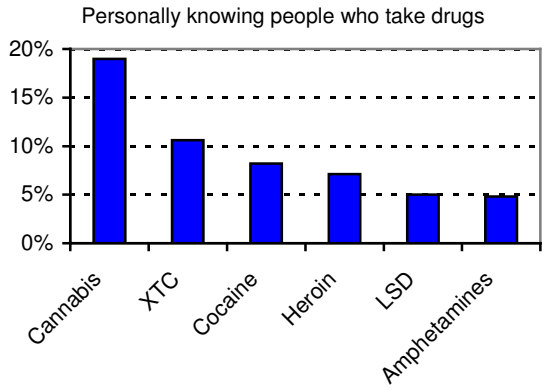

Figure 2.13. Percentage of people from the general populations survey who know people who take drugs
Source: Population survey 2001

Availability

Perception of availability was measured for five illicit drugs: cannabis, XTC, cocaine, heroin and amphetamines. Availability is moderate. Most people who have heard of these drugs, believe that it is not easy to get them within 24 hours. In fact, the majority believe that it is impossible for them or they can not answer the question (Figure 2.14). Most strikingly, there is no strong difference between cannabis and the other illicit drugs. On the other hand, most of those who ever tried drugs report that it is pretty easy to get them. Perception of availability is linked to experience.

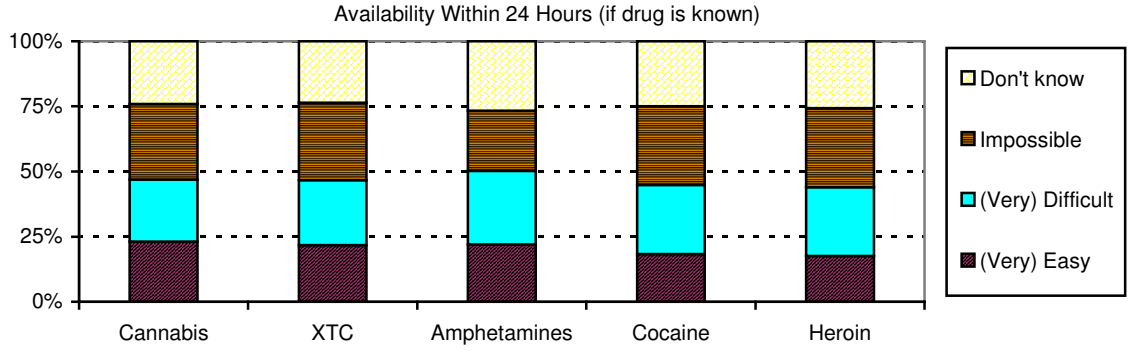

Figure 2.14. Perceived availability of drugs amongst the general population
Source: population survey 2001

Susceptibility

Susceptibility to illicit drug use appears to be very low. The vast majority of the population who know of the substances mentioned, say they would not try or take them when offered, e.g. at a party or in a pub. Further analysis shows that this is not only true of those who never used these substances. At least two thirds of those who did use them say they would not take them (again) when offered.

Risk perception and attitude

Respondents very clearly see more risks in taking illicit drugs then in drinking 5 or more glasses of alcohol every weekend and smoking tobacco heavily (Figure 2.15).

Figure 2.15. Perceived risk of taking drugs amongst the general population
Source: Population survey 2001

Most respondents approve of people drinking 5 or more glasses of alcohol every weekend. Overall, people in Malta appear to have a rather tolerant viewpoint with regard to alcohol. They are somewhat critical towards smoking tobacco, but in general they think that taking cannabis regularly or trying other illicit drugs once or twice is very harmful and they disapprove of people that try or take these substances (Figure 2.16).

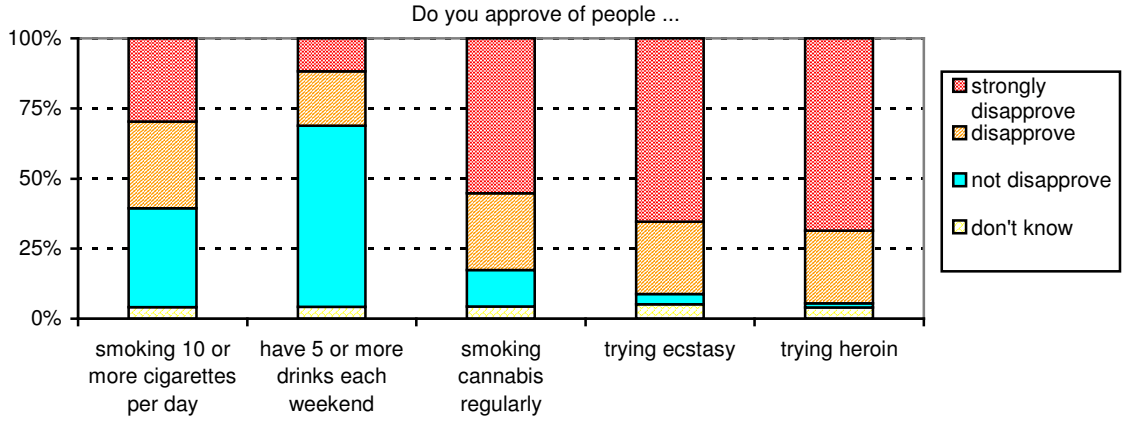

Figure 2.16. Attitudes toward licit and illicit substances amongst the general population
Source: population survey 2001

About 8% of respondents find that people should be permitted to take hashish or marihuana, slightly over 3% thinks so in the case of ecstasy or heroin. The vast majority is of the opinion that people should no be permitted to take drugs, heroin in particular (Figure 2.17).

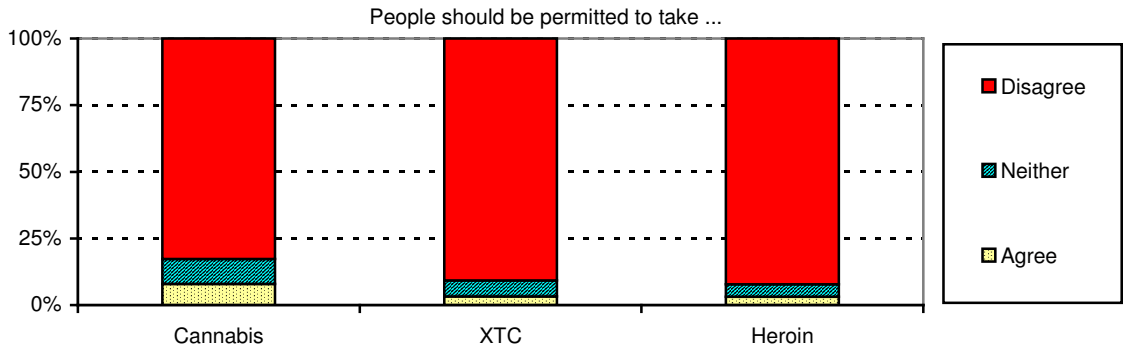

Figure 2.17. Attitudes amongst the general population towards allowing people to take drugs

Source: Population survey 2001

People in Malta perceive drug addicts more as patients and less as criminals. Over half of the respondents perceive them more as patients and about then 10% more as criminals. Others prefer to perceive them as both, or as neither patients nor criminals.

In **summary**, the vast majority of people in Malta know several illicit drugs, at least by name. However, most of them do not personally know people who use illicit drugs. When they do know people who use illicit drugs, this predominantly refers to cannabis and then XTC. Overall, respondents think much more positive about licit drugs, alcohol in particular, than about illicit drugs. Most people in Malta perceive drug addicts more as patients than as criminals.

Chapter 3. Prevention

Drug prevention in Malta is aimed at demand reduction. In 1994 the National Drug Agency Sedqa, was asked to develop and implement a national prevention strategy. This resulted in an extensive programme of activities targeting different groups in Maltese society.

The non-governmental organisations Caritas and Oasi have also developed a variety of prevention programmes. To date, however, there is no formal coordination of these programmes between the three agencies.

When referring to types of prevention, Malta still uses the terms 'primary', 'secondary' and 'tertiary'.

Primary prevention in Malta refers to activities targeting schools, the community and the workplace and corresponds to universal prevention.

Secondary prevention refers to activities targeting high-risk groups (mainly in schools), which are presented here as selective/indicative prevention.

Tertiary prevention corresponds to treatment or responses to health and social correlates and will be discussed in the chapters 5, 7 and 9.

3.1 Universal prevention

3.1 a School-based programmes

Since attitudes towards alcohol and other drugs are often shaped during pre-adolescent years (Bezzina, Clark and Borg, 1997), initiatives targeting this age group are the most extensive of all programmes. Schools are a milieu where many children and youth can be reached simultaneously; therefore they are an ideal setting for promoting healthy and value-based life styles among young people.

In Malta school-based prevention programmes range from Year 1[2] to Form 6 and aim to target students, teachers and parents. The majority of school-based prevention programmes are based on a curricular approach, involving the education system, which assists in the delivery of prevention messages. Drug, alcohol and tobacco topics are incorporated in the Personal and Social Development (PSD) curriculum in all Maltese schools.

An overview of the different prevention programmes currently being implemented by the agencies in primary[3] and secondary[4] schools in Malta is presented in table (Table 3.1)

[2] Year 1 to Year 6 Primary School = Ages 5- 10; Form 1 to Form 5 Secondary School = Ages 11-15; Form 6 = Ages 16 & 17.

[3] Primary Schools in Malta: N = 79; Pupils: N = 41,100.

[4] Secondary Schools in Malta N = 69; Pupils: N = 33,800 (Source: National Statistics Office)

Primary and Secondary Schools Prevention Activities 2003

PRIMARY SCHOOL PROGRAMS	Years	Agency	Delivery	Schools	Pupils Reached
TFAL (CHILDRENS PROGRAM)	2 - 6	SEDQA	Teachers & PSD	All	24,000 (books)
BABES	3	SEDQA	Prevention Staff	61	4,100
SKOLA SAJF (SUMMER SCHOOL)	4, 6	SEDQA	Prevention Staff	14	700
VULNERABLE schools		SEDQA	PSD/Teacher on loan	5	Not Known
FOCUS	6	CARITAS	Prevention Staff	7	630
TRUST/ASK SPRINGBOARD	4,5,6	OASI	Prevention Staff	All	1631
Other Programmes	Target Group	Agency	Delivery	Courses	No. Reached
Parental Skills	Parents	SEDQA	Facilitators	21	400
Babes Parents Programme	Parents	SEDQA	Prevention Staff	58	400
Zazu 'puppet' Visits	Students	SEDQA	Zazu	27 visits	Not Known
Exhibitions		SEDQA	N/A	35	Not Known
Teacher Training	Teachers	SEDQA	Prevention Staff	2	30
Parental skills facilitator training	Facilitators	SEDQA	Prevention Staff	3	13
Parental Skills	Parents	CARITAS	Facilitators	6	180
Drug Information Talks	Parents	CARITAS	Facilitators	Not Known	260
SECONDARY SCHOOL PROGRAMS	Years	Agency	Delivery	Schools	Pupils Reached
JEANS	1,2,4	SEDQA	PSD & Subject Teachers	All	10,400 books
FOCUS	3,4	CARITAS	Prevention Staff	6	108
STUDIO 4,5	4,5	OASI	Prevention Staff	Not Known	1580
VULNERABLE SCHOOLS	second + opport centres	SEDQA	PSD/Teacher on loan	4	1800
SECONDARY SCHOOLS PGM	1-3(selected schools)	SEDQA	Prevention Staff	28	565
Other Programmes	Target Group	Agency	Delivery	Courses	No. Reached
Parental Skills	parents	SEDQA	trained facilitators	37	572
Interpersonal skills	students	SEDQA	prevention staff	4	90
Prefects course	school prefects	SEDQA	prevention staff	13	150
Info & awareness seminars	students	SEDQA	prevention staff	28	565
Life force international	students	SEDQA	canadian musical grp	30	3900
Staff development programmes	teachers	SEDQA	prevention staff	4	125
Peer leadership course	students	SEDQA	prevention staff	6	150
Boys&Girls Secondary Schools course	students	SEDQA	Prevention Staff	105	1800
Parental Skills	parents	CARITAS	facilitators	8	240
Peer leadership course	students	CARITAS	facilitators	14	510
Drug Information Talks	parents	CARITAS	facilitators	5	350

Table 3.1 Overview of primary schools and secondary schools prevention programmes
Source: Caritas, Sedqa and Oasi prevention division reports 2003

3.1b Community-based Programmes

Community-based initiatives consist of projects that target the family, particular parents, youth and social environments, social, political and religious societies and clubs as well as local councils (Table 3.2). The aim of the community-based prevention is to strengthen leadership within community settings. The programmes include activities like alcohol-free parties for young people, exhibitions and stands with drug prevention and informative messages, drug awareness talks, drug free youth club activities and yearly drug free marches. Community-based prevention programmes also liaise with local councils and parishes in the organisation of training courses for young people and adults who would like to offer their services within their local community to parental skills courses, peer leadership courses and drug and alcohol information seminars.

Community-based Activities 2003

Activities	Target Group	Agency	Delivery	No. Activit	No. Reached
Parental Skills	parents	CARITAS	trained facilitators	10	320
Parental Skills	parents	OASI	trained facilitators	Not Known	299
Community/Church Activities	Gen. Public	SEDQA	trained facilitators	30	Not Known
Drug Awarenesss Seminars/Talks	Gen. Public	all agencies	trained facilitators	Not Known	Not Known
Alcohol Free Parties	teens	CARITAS		2	650
Exhibitions	youth/parents	SEDQA	Prevention staff	12	Not Known
OK Club	Pre teens	OASI	Prevention staff	12	146
Drug Free Marches	Gen. Public	CARITAS		Not Known	Not Applicable
Grants to comm-based initiatives	Gen. Public	SEDQA		13grants	Not Applicable
Live In Week Ends	Teens	OASI	Prevention staff	2	157
Summer Concert	Gen. Public	OASI	Prevention staff	1	Gen. Public
Youth of the Year Award	Gen. Public	OASI	Prevention staff	1	Gen. Public
Youth Club Activities	youth	CARITAS	trained facilitators	8	300

Table 3.2. Community-based prevention activities 2003
Source: Caritas, Sedqa and Oasi Prevention Division Reports 2003

3.1c Work-Based Programmes

The aim of work-based prevention programmes is to provide information to managers and employees on the problems associated with alcohol and drugs, to aid managers in identifying potential problems at an early stage and to assist organisations in developing policies to combat substance and alcohol abuse at the workplace. A study carried out in 190 local companies on managerial attitudes to drugs and alcohol in the workplace (Vella & Gauci, 1996) revealed that the majority of managers (91.7%) were in favour of training programmes that would increase workers' awareness about the effects of substances. 60% of managers, however, were uncertain as to whether their company would actually fund such activities or whether they would be keen for these activities to take place during working hours. Eight years down the line, work-place prevention programmes still encounter a certain ambivalence: prevention programmes are being offered, yet not many managers are willing to actually introduce and implement them in their organisations. Table 3.3 provides a summary of the activities conducted with regards to workplace-based prevention in 2003.

Work–Place Based Prevention Activities 2003

Programme	Target Group	Agency	Delivery	No. of Pgm's	No. Reached
SAFE	organisations	SEDQA	Prevention staff	18	Not Known
	managers	SEDQA	Prevention staff	21	456
	employees	SEDQA	Prevention staff	40	945
	managers	SEDQA	Prevention staff	6	Not Known
Employees Assistance Program	organisations	CARITAS	Prevention staff	2	120

Table 3.3. Work-Place based prevention activities 2003
Source: Caritas and Sedqa prevention division reports 2003

3.1d Media-based programmes

The Sedqa, Caritas and Oasi Prevention Divisions also make extensive use of the media to reinforce health-oriented attitudes. All three agencies participate in information and discussion programmes both on radio and TV and produce programmes in collaboration with the national and private radio and TV stations. Other activities include newspaper articles, the production of posters, leaflets and other material conveying prevention messages as well as Webpages[5] providing information on various drug and alcohol related topics and services.

3.2 Selective/indicated prevention

Selective prevention in Malta is carried out primarily in the form of special sessions for vulnerable schools and vulnerable age groups in selected schools or as a result of contact made to the service by a particular school. Also, additional interventions are carried out in the form of personal interventions with individuals, either as follow-up of programme-based (school, community, work-place) activities or as 'outreach' contacts at parties or locations frequented by youth or where drugs are known to be available. An overview of activities in 2003 is presented in table 3.4.

Secondary Prevention Activities 2003

Type of Intervention	Target group	Agency	No. Reached
Tailor made sessions for High Risk Schools	Secondary Schools	SEDQA	869
	Post Secondary Schools	SEDQA	1009
	Other Institutes	SEDQA	116
Individual Interventions	Students	SEDQA	271
Immediate Intervention Service	All	OASI	103

Table 3.4. Secondary prevention activities 2003
Source: Sedqa and Oasi Secondary Prevention Division reports 2003

3.3 Research and Data Analysis

The first school survey on attitudes towards drugs and alcohol was carried out in 1991. Caritas, with the assistance of Pride International, conducted two Maltese National surveys (1991, 1998) on the total population[6] of 11-17 year-olds attending schools in Malta and Gozo. The major findings of the 1991 study revealed that 4.7% of the school-aged population had used one or more illicit drug. Marijuana was the most popular drug; reported to have been used by 7.5% of the 17 year-old cohort in the past year (1993). The results of the 1998 follow-up study, which report an overall increase in experimental drug use from 1991, showed primarily that the onset of experimental drug use is around 14 years. Findings also show a high rate of inhalant use and this is concordant with the ESPAD findings. The Health Behaviour in School-age children study (HBSC) conducted in 2002, revealed similar findings with regards to the age cohort for experimental drug use (Pace Asciak et. al., 2003). Additionally, the results from the ESPAD (2003) reveal a moderate increase in cannabis use,

[5] Treatment Centres Web Pages: www.sedqa.org.mt www.caritasmalta.org www.oasi.org.mt

[6] Total Population of the 1991 survey = 20,815 students from schools in Malta and Gozo.
Total Population of the 1998 survey = 1,100 students representing 3% of the school population in Malta and Gozo.

more markedly so in males, in the 15-16-age cohort compared to the results from the 1999 study.

A 1997 study on 426 pupils (10% of the population that attend state schools), aged 9-11 years, to assess attitudes towards tobacco, alcohol and other substances, revealed that alcohol was already widely used and accepted among this age cohort. This finding was attributed to the Mediterranean cultural attitudes towards alcohol being served on almost all social and familial occasions (Calleja, 1997).

In 2003, a dual effort by SEDQA and the Youth Studies Programme at the University of Malta initiated a risk and resiliency longitudinal project conducted with adolescents (11 and 12 year-olds). One aim of this study is to investigate and highlight the risk and protective factors associated with substance use among Maltese adolescents in order to provide a local snapshot of unique risk factors associated with substance use and resiliency variables associated with its avoidance (Clark & Arpa, 2003). Another aim of this study is to provide local data to agencies and policy makers that will serve as part of the basis for reviewing and implementing new prevention programmes or strategies. This study is ongoing.

Research on the impact, effectiveness and efficiency of prevention activities in Malta has as yet not been carried out. Evaluations by the respective agencies in the form of satisfaction questionnaires following the completion of a specific programme, are administered and evaluated internally. To date, however, Malta does not have a global picture on the overall impact and reach of its prevention programmes, which would be obtained as a result of independent, co-ordinated and continuous monitoring and evaluation of such programmes and their target groups.

Chapter 4. Problem Drug Use

4.1 Prevalence and incidence estimates

The graph below (Figure 4.1) indicates that in 2003 there were approximately 1200 persons with heroin problems in treatment. 1000 of these are problem users based on the criterion of 'daily heroin use' at the time of their assessment in treatment. About 700 from this client population are in substitution treatment, taking methadone for a period of 3 months or longer.

Heroin/Problem Drug Users in Treatment

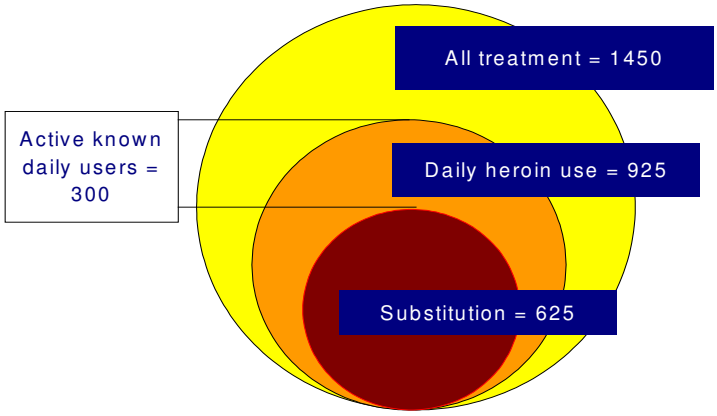

Figure 4.1. Problem drug users in treatment
Source: Merged treatment data files 2003

This picture does not provide us with enough information to reliably assess the hidden population of problem users. However, based on the assumption that clients in substitution treatment are 'non active' drug users, the known number of 'active' users results in a figure of around 300. Merged treatment and drug arrest data files however, reveal that clients in substitution treatment are also arrested for drug offences and therefore this raises doubts as to whether this client group can be appropriately called 'non-active' users.

The Treatment Demand Indicator data suggest that about 80% of heroin users inject. Among our assumed population of 300 'active' users we then would have some 250 injectors. Syringe data indicate that approximately 220,000 syringes were distributed in 2003. Therefore, if we assume, albeit speculatively, that an active user uses one syringe a day, then the syringe data indicate a population of some 600 active injectors.

If 250 of these are 'known clients' in treatment, there are consequently around 350 'unknown' injecting drug users. If the injecting pattern is the same among the 'unknown' population as it is among the 'known' client group, we should have almost 450 hidden daily heroin users. Combined with the 1000 daily users in treatment we then can estimate that there were some 1450 problem heroin users in Malta in 2003. The inclusion of occasional users (assuming the same distribution of daily and occasional users as in treatment) might raise this figure to around 1750.

Applying the Capture-Recapture Method (CRC) to the 2-sample set of treatment and police data yields a much higher estimate of 2750 and probably even higher if we limit the CRC to daily heroin users only. The quality of our treatment data however, makes it difficult to define a proper subset of "problem users". The police data on the

other hand, is not precise enough to single out regular heroin users. Therefore this results in a serious problem of homogeneity. Additionally, the number of overlaps between first treatment cases and arrestees, casts doubt on the independence of treatment and police samples.

All told, the fact that 2/3 of our estimate above is actually seen in treatment, the figure of 1450 problem drug users seems acceptable, especially if we consider that Malta has an easily accessible and centralised methadone provision.

In the Netherlands, a similar accessible methadone provision and rather accurate data to allow CRC, reveals a comparable picture: 19,000 people with opiates as a primary drug in treatment and an estimated opiate using population of 26-30,000 (2002 data), which means that some 65-75% of users are seen in treatment.

This comparison with the Netherlands also brings forth another issue. The Dutch population is about 40 times the population of Malta. If the Malta figures were to be applied to the Netherlands, the Dutch figures would rise to about 40,000 people in treatment (40 X 1000 daily users) resulting in an estimate of 70,000. This conclusion highlights the possibility that the Maltese figures may appear moderate in absolute numbers, however are relatively twice as high as the Dutch figures, indicating that heroin use is nevertheless a major problem for a small country like Malta.

4.2a Profile of clients in treatment by substance used

Apart from a quick census scan across all treatment centres in 2001, information about client profiles has so far only been published as monthly and annual frequency counts of individual characteristics of the clients of the national drug agency Sedqa. In 2004, the client data of all Maltese treatment centres were combined, with exclusion of double counting, into a harmonised file of the national treatment population of 2003 (see here Chapter 4.1).

With regards to many characteristics of clients that received treatment prior to 2003, it is not known however if the recorded data apply to the situation of a client in 2003 or to the situation as per first admission. For this reason, only general profiles of all clients in 2003 will be presented, whereas more detailed profiles will be given for new clients that have entered treatment for the first time in 2003. These profiles will be followed by some results of the quick census scan carried out in 2001.

In 2003, 1444 persons were registered for treatment. The graph below shows the age distribution of clients in treatment (Figure 4.2). The mean age of all clients in treatment at the end of 2003 was 28 years.

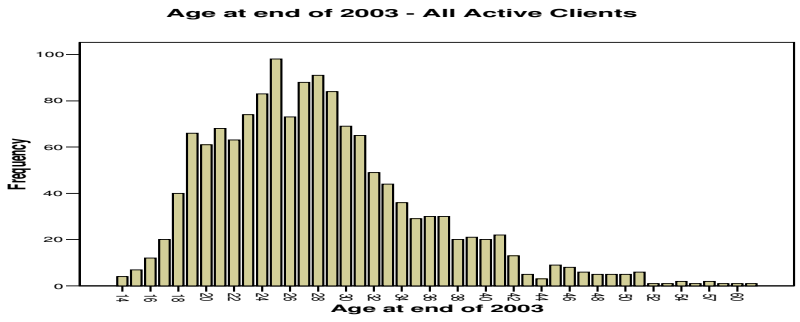

Figure 4.2. Age Distribution of clients in treatment in 2003
Source: Merged treatment Data Files 2003

Based on the premise that data on primary drug upon first admission was not overwritten, most clients in treatment are male (86%) with a heroin problem (85.7). 56.1% of clients are reported to have 'ever injected' in their lives. The percentage of treatment demand for cannabis and cocaine problems are 9% and 4% respectively. A small percentage of clients (1%) are in treatment for problems related to other substances like ecstasy and LSD (Figure 4.3).

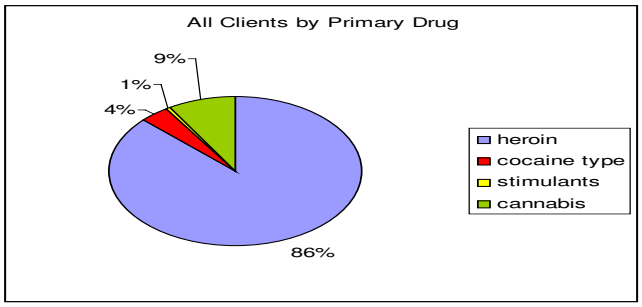

Figure 4.3. Primary drug of all clients in treatment in 2003
Source: Merged treatment Data Files 2003

The table below shows a profile of all clients according to primary drug (Table 4.1). The mean age of clients with a heroin and cocaine problem is around 5 years older than those with a cannabis problem. Most clients are male, however the percentage of female clients increases with the cannabis group.

Primary Drug	Age	Male	Female	Ever Injected
Heroin	28.5 yrs	85.7%	14.3%	63.3%
Cannabis	23 yrs	78.5%	21.5%	6.6%
Cocaine	28.2 yrs	87%	13%	22.2%

Table 4.1. Profile of all clients in treatment in 2003 according to primary drug
Source: Merged Treatment Data Files 2003

With regards to 'first ever treated' clients, a more detailed picture can be produced, due to the assumption that information at treatment entry would not have been overwritten within the same year. Comparisons between 'first ever treated' and 'all treated clients' cannot be made as data for 'all treated clients' may or may not have been systematically updated across the years, and it is unclear whether or not this is the case both within and across the agencies. Moreover, 'all treated clients in 2003' incorporates a large number of people who would have been in treatment for some time (Figure 4.4), and those who happened to have been in treatment in 2003, and this in itself is a biased selection of clients.

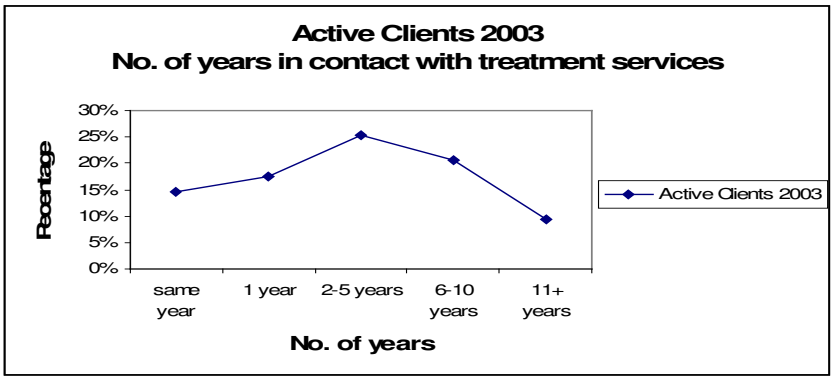

Figure 4.4. Average number of years in contact with treatment services (2003 clients)
Mean length of time spent in treatment = 7.9 years
Source: Merged Treatment Data Files 2003

17% of clients in treatment in 2003, were treated for the very first time (N=252), nearly half of the clients were self-referrals (Figure 4.5).

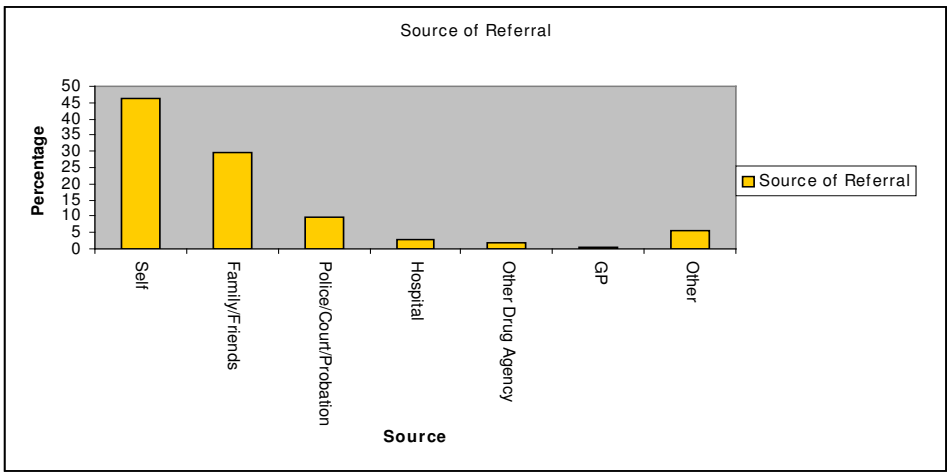

Figure 4.5. Main source of referral for new clients in treatment in 2003
Source: Merged treatment data Files 2003

The graph below gives a picture of the age distribution of 'first ever treated clients' (Figure 4.6); the mean age of clients was 23.5 years.

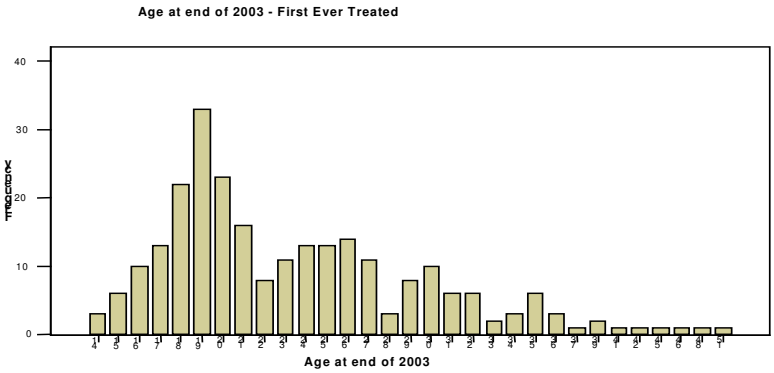

Figure 4.6. Age distribution of first ever treated clients in 2003
Source: Merged Treatment Data Files 2003

The majority of clients were male (82.9%) with a heroin problem (69%). The percentage of clients with a cannabis and cocaine problem was 22% and 8% respectively. 1% sought treatment for problems related to other drugs like ecstasy and LSD (Figure 4.7). 48.8% of clients across all drug types reported to have ever injected, and 56% were recorded as 'daily injectors'.

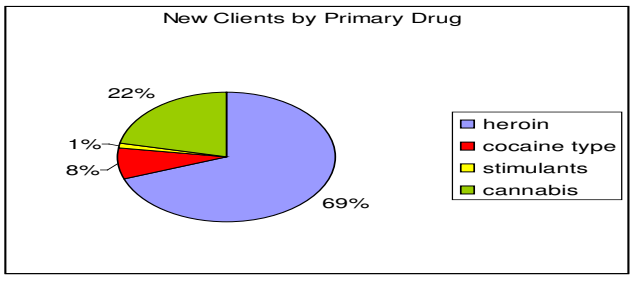

Figure 4.7. Primary drug for first ever treated clients 2003
Source: Merged Treatment Data Files 2003

65% (n= 163) of first treated clients were recorded as 'polydrug users' in the treatment files. The table below shows the percentage of multiple responses for secondary drug use[7] cross-tabulated with primary drug type (Table 4.2). Cannabis is the most common secondary drug used by both heroin and cocaine clients.

Multiple Response Table for Secondary Drug

Primary Drug	Number of Clients	Secondary Drug (%)					
		Heroin	Cocaine	Ecstasy	LSD	Cannabis	Other
Heroin	117		51.3	20.5	23.1	88	11.2
Cocaine	16	31.3		37.5	6.3	81.3	18.8
Cannabis	27	25.9	33.3	59.3	11.1		33.3

Table 4.2. Multiple response table for secondary drug – first ever treated clients 2003
Source: Merged Treatment Data Files 2003

The profiles for 'first ever treated clients' according to primary drug are presented in the table below (Table 4.3). In 2003, a higher percentage of females were seen in treatment for cannabis-related problems than for either heroin or cocaine. First treated cannabis and heroin clients are on average younger than cocaine clients. The average length of time that heroin clients use the drug before seeking treatment for the first time is around 4 years, as seen in the delay between age of first use of primary drug[8] and age first treatment demand. The vast majority of clients report having stable accommodation, and the majority (68.7%) live with parents. The majority of clients across all drug categories are employed (61%); however, nearly half of heroin clients are not (47.4%).

Profiles for First Ever Treated Clients in 2003

Category Primary Drug	Mean Age at end 2003	Age First Use Primary Drug	Male %	Female %	Ever Injected	Daily Use %	Route Of Administration	Unemployment %	Stable Accomodation	Source of Referral
Heroin	23.4 yrs	19 yrs	83.6	16.4	68.4	71	63% inject	47.4	90	52% self; 26% family/friends
Cannabis	22 yrs	15.6 yrs	75.5	24.5	5.7	28.3	100% smoke	20	87	30% self; 37% family/friends
Cocaine	26.5 yrs	19.9 yrs	100		15.8	21.1	68% sniff	15	94.7	36% self; 36% family/friends

Table 4.3. Profiles for first ever treated clients 2003
Source: Merged Treatment Data Files 2003

Drug taking behaviour for first ever treated clients differs across substances, with heroin clients showing the most problematic use (daily use 71% and 63% injectors). Nearly half of first treated heroin clients are 'currently injecting' drugs (48.5%).

4.2b Profile of clients in treatment by centre types

Treatment in Malta can be classified into 3 main types: Detox[9], Community and Rehabilitation[10] (a more detailed description of these can be found in Chapter 5).

The table (Table 4.4) gives a snap shot of client characteristics for first ever treated and all clients across the 3 treatment modalities in 2003. The majority of clients are seen in detox. Across other treatment settings, 29% of clients are seen in the community services and 20% are in rehabilitation programmes.

[7] Alcohol as a secondary drug is not recorded by treatment agencies
[8] Data for age first use primary drug excludes Caritas clients as this variable was not recorded in the data file
[9] The official name for the detox unit is Substance Misuse Outpatient Unit (SMOPU), but is commonly referred to as detox and therefore will be termed as such in this report
[10] Rehabilitation programmes include: 2 residential Therapeutic Communities, 1 day programme and 3 Prison Inmate Programmes

Snapshot of Client Characteristics Across Treatment Modalities

2003 FIRST EVER TREATED	Number	Male %	Female %	Mean Age Yrs	Age Median(Yrs)	Primary Drug Heroin (%)	Primary Drug Cannabis (%)	Primary Drug Cocaine (%)	Ever Injected (%)
Detox	82	86.6	13.4	23.9	22	98.8	1.2	-	62.2
Community	159	81.8	18.2	23	21	50.3	32.7	11.3	44.3
Rehabilitation	10	70	30	27.2	27	90	-	10	55.6
ALL 2003 Clients*	Number	Male %	Female %	Mean Age Yrs	Age Median(Yrs)	Primary Drug Heroin (%)	Primary Drug Cannabis (%)	Primary Drug Cocaine (%)	Ever Injected (%)
Detox	733	86.2	13.8	29.6	27	98.6	0.7	0.5	61
Community	422	81	19	25.2	24	61.4	19	8.4	53
Rehabilitation	286	86.4	13.6	28	28	88.8	4.5	3.5	71

Table 4.4. Snap shot of clients in treatment in 2003
Source: Merged Treatment Data Files 2003
*3 clients were not included in the table as it was unclear from the data files which treatment setting they belonged to

Heroin is by far the most prominent primary drug for those clients in rehabilitation and detox settings. Clients in community settings in 2003 on the other hand, are either heroin users (61%), or cannabis users (24%). A small percentage are cocaine users (10%) (Figure 4.8). This is also the setting that sees the youngest client group. The majority of clients in rehabilitation (71%), detox (61%) and community settings (53%) have 'ever injected' drugs.

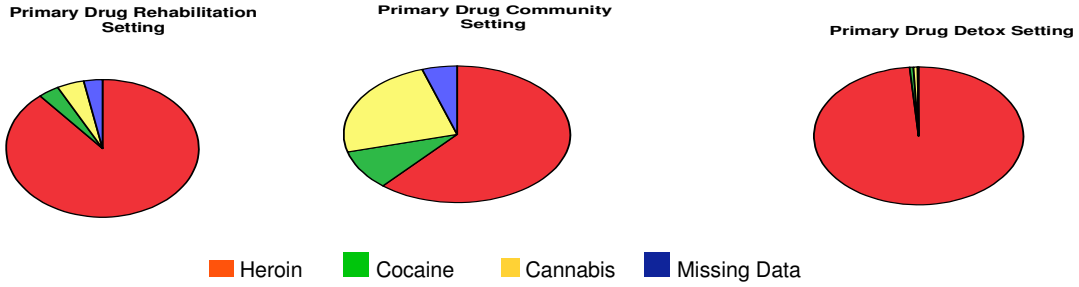

Figure 4.8. Profiles of types of drug users according to treatment setting
Source: Treatment Data Files 2003

The census scan carried out in October 2001 gave some indications, based on assessments by the care workers on the needs and capacity of clients in treatment at that time, to sustain in the Maltese society (Bless, 2001). Distinctions between clients by drug type were not made. The results of this scan should not be compared with the 2003 data from the merged treatment files. Results showed that just over half of the clients in treatment would be able to sustain relatively well in the Maltese society. Psychiatric and psychological treatment was unnecessary for 47% of clients however, for 31% it was needed somewhat urgently. Similarly, social assistance was not necessary for 47% of clients, however for 39% it was needed quite urgently (Table 4.5). Most clients, who urgently needed psychological/psychiatric treatment or social support, were willing to accept such treatment.

	Capacity to Sustain in Maltese Society (%)		Need for Psychological or Psychiatric Treatment (%)	Need for Social Assistance/Support (%)
Poor/Somewhat Poor	18.1	Urgent/Somewhat Urgent	31.7	39.6
Neither Good Nor Poor	24.1	Neither Urgent nor Unnecessary	20.5	17.7
Good/Relatively Good	57.8	Unnecessary/Somewhat Unnecessary	47.7	42.7

Table 4.5. Clients' capacity to sustain in Maltese society
Source: Census scan 2001

Chapter 5. Drug-Related Treatment

5.1 Treatment systems

Specialised drug treatment started in the first half of the 1980's when Caritas Malta asked the Coolemine Lodge Therapeutic Community of Ireland to assist in the setting up of a Rehabilitation Centre in Malta. In March 1985, after Maltese qualified staff returned from specialised training abroad, the very first Rehabilitation Day-Programme was launched.

Following an increased demand for treatment a meeting was held in September 1988 between Caritas and a group of professionals and business people who offered their voluntary help in the administration of a Residential Rehabilitation Centre. In June 1989 Caritas started the first long-term rehabilitation centre (San Blas).

Methadone treatment dates back to before 1985, when initially methadone was given on a weekly basis from the psychiatric unit, to a small number of drug users to take home. In 1987, the detox unit was set up at St. Lukes Hospital, where methadone was dispensed both for detoxification and substitution treatment. An inpatient detoxification clinic also existed within the unit. In 1994, the inpatient clinic moved to a building close by and became known as Dar L-Impenn. Initially, detoxification was carried out using methadone and catapress, and in June 1996 naltrexone was also introduced.

Drug treatment on the island of Gozo was initiated by Oasi in 1992 as an outpatient service and later extended to residential treatment.

Today the Maltese treatment system offers the following services (Table 5.1)

1. Detox - Methadone substitution treatment
2. Detox - In patient detoxification treatment
3. Outpatient Community Services
4. Rehabilitation programmes
5. Pre-release rehabilitation programmes in a prison setting

The types of treatment available in Malta are as indicated above and consequently the different treatment modalities and their descriptions shall be listed as per the above-mentioned categories. The EMCDDA definitions of **drug free treatment** and **medically assisted treatment** do not apply to the Maltese situation because only the detox unit provides medically-assisted treatment[11] (MAT) and all clients who require MAT from other services are referred to this unit for such treatment. This means that on the one hand the detox unit has its own domain of clients and on the other hand it offers an extended medically assisted service to community and rehabilitation treatment programmes across agencies. In principle therefore, clients who require MAT and are registered with other services or agencies would also be registered as detox clients.

[11] MAT= both substitution and other pharmalogical treatments (e.g. with antagonists) which is targeted at the drug use (and not anti-depressives and benzodiazepines)

Types of Services Offered by Maltese Treatment Agencies

Type of Treatment	Service Provider	Programmes	Treatment Model	Drug-free (Y/N)	N clients 2003	Total No. Clients
Rehabilitation	Caritas*	San Blas Programme	Bio-Psycho-Social	Y/N**	174	
		Prison Inmates Programme		Y	7	
Community		Outreach		N	140	
Community		Harm Reduction		N	34	
Community		Short/Long term Support		N	35	
						390
Rehabilitation	Oasi	Day Programme	12-Step & Minnesota	Y	15	
Community		Outreach		N	3	
Community		Outpatient		N	21	
						39
Rehabilitation	Sedqa	Residential	Bio-Psycho-Social	Y	76***	
Community		Outpatient		N	43	
Community		Outreach		N	146	
Detox		Withdrawal & Substitution		N	733	
						998
Rehabilitation	SATU	Prison Inmates Programme	Bio-Psycho-Social	Y	14	
						14
						1441

* 3 clients from Caritas not included in table as unclear from data files which programme they were frequenting in 2003

** Y/N due to the fact that for the first phase of treatment, clients are accepted into the programme on 20mg methadone and are supported in a rehabilitation setting through their detoxification period

*** The total number of clients in this category includes (a) clients from St. Maria Residential Rehab (b) clients undergoing inpatient detox at Dar L-Impenn. A distinction could not be made between clients in St. Maria Rehabilitation and clients undergoing inpatient detoxification at Dar L-Impenn due to both client groups being coded by the agency under the 'umbrella' definition 'Inpatient Treatment'

Table 5.1. Services offered by Maltese treatment agencies
Source: Treatment Data Files 2003

5.1a Detoxification Treatment

Detox in Malta comprises programmes in which opiate substitutes (usually methadone) are prescribed, either for detoxification in emergency cases, or as preparation for therapy and rehabilitation, or in the context of (long-term) substitution programmes.

Outpatient Services

There is only one outpatient service in Malta - the SEDQA Substance Misuse Out-Patients Unit (SMOPU or detox unit), located at St. Luke's Hospital with a dispensing agency at Craig hospital in Gozo. This service provides methadone on a detoxification or substitution basis in combination with withdrawal treatment, medical, psychiatric and psychosocial interventions.

In Patient Detoxification Services

Inpatient detox is provided by Sedqa and Mt. Carmel. Mount Carmel is a psychiatric hospital, however, it is also used for detoxification cases usually as part of a crisis intervention or for those patients who need immediate containment. The Sedqa Substance Misuse In-Patients Unit - '*Dar L-Impenn'*, provides withdrawal treatment in a safe and controlled environment, under 24-hour medical supervision. During their stay at the unit, patients are offered psychological and emotional support, information on how to reduce health risks associated with drug and alcohol abuse and individualised treatment plans devised on the basis of the patient's addiction. '*Dar L-Impenn'* is a stepping-stone for further treatment, either in the community or in a residential rehabilitation programme.

5.1b Community Based Services

Outpatient Therapy and Counselling

Caritas (Outreach Service), Sedqa (Gubbio House – *'Dar Gubbio')* and Oasi (Outreach/ First Contact Service) offer community-based outpatient services in the form of long or short-term support through social work, counselling, group therapy and psychological interventions to persons with a drug problem. Community services also prepare clients for long-term rehabilitation or refer clients to other services within or between agencies.

Support is also provided to family members and significant others through the agencies Family Services. Sedqa's community services include a programme called 'Stima' which provides support to individuals who are following a naltrexone medication programme.

Harm Reduction Programme

The Caritas Harm Reduction programme, which started in 1997 also forms part of the community service and consists of groups and individual sessions, for drug abusers who are not in a position to abstain from taking drugs. This programme focuses primarily on helping the individual to stabilise and decrease risk behaviour associated with drug use, stop criminal activity and address health-related, social and familial problems.

5.1c Drug Rehabilitation Programmes

Residential Programmes

The Caritas San Blas 2-year Programme and the Sedqa Santa Maria 18-month Programme are both long-term residential treatments. They offer a holistic, multi-disciplinary approach to therapy in a communal living environment, facilitating behaviour modification, exploration of the self and the adoption of a drug-free lifestyle to persons with severe and complex drug-related problems. Both programmes aim to guide the client towards abstinence. The San Blas Therapeutic Community (T.C.) is the only residential programme that accepts clients who are still in the process of detoxification[12] and follows them through residential, semi-residential, re-entry and after care. In 2004 the San Blas Programme extended its services to include a specially monitored section within San Blas, whereby residents' children can spend weekends at the T.C. The Sedqa Santa Maria Programme is also structured in four phases: welcome phase, formation phase, re-entry and after care. Since 1999 the St. Maria residential unit began accepting referrals from prison and in this sense adopts the same admission criteria for this client group as the other 2 prison inmate programmes: The Substance Abuse Therapeutic Unit (Satu) and the Caritas Prison Inmates Programme (P.I.P).

In Gozo, the Oasi foundation provides a 2-4 month short residential programme followed by Continued Care Sessions. The programme offers therapeutic groups, occupational therapy, life skills and leisure activities. Treatment is based on the Minnesota Model and the 12-step principles of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

[12] Clients must be on 20mg methadone or less to enter the T.C.

Prison Pre-release Residential Programmes

Prison inmates who are drug users and within the last two years of imprisonment are eligible to apply for a drug rehabilitation programme. There are 3 prison inmate programmes currently in operation: Caritas PIP, SATU of the Corradin Correctional Facility (CCF) and (a special section of) the Sedqa St. Maria Programme.

Day Programme

Day programmes are only offered by Oasi. The programme is a 5-8 month programme for clients who have good family support and reasonably stable life styles. This AA-based programme offers treatment in the form of group and individual therapy, life skills, leisure activities and occupational therapy.

5.2 Trends in Treatment Demand

The historical development of treatment demand can only be indicated by the detox data files, which consequently only include heroin clients. However, since the majority of clients in treatment are heroin users (85%) and methadone distribution is centralised, (51% of all clients in treatment are detox clients) this data incorporates a representative sample of the heroin population. The figure below shows that the number of 'all clients' continues to increase since the opening of the detox unit back in 1994, indicating continued contact of clients who have been in treatment for some time (Figure 5.1). Between 2000 and 2003, however, the figures stabilise and we see what appears to look like a 'saturation effect'. In the case for 'first treatment demand', we do not see a consistent or progressive increase over the years, except for peaks in 1996, 1997 and 2000.

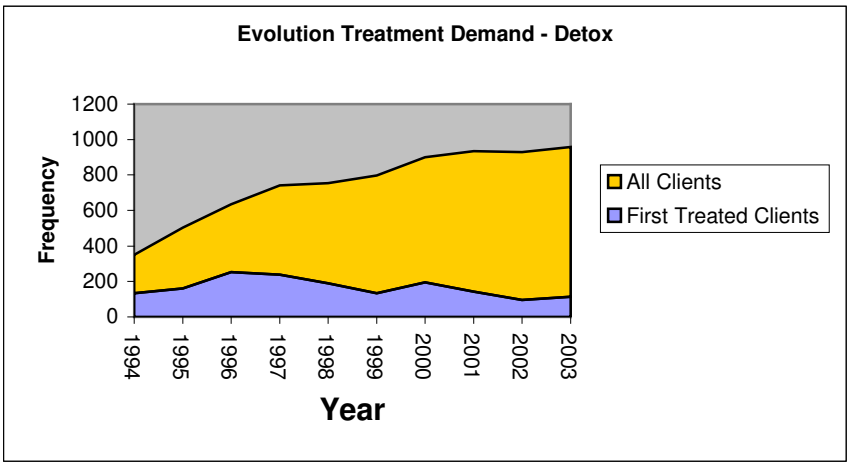

Figure 5.1. Evolution of treatment demand between 1994 and 2003
Source: Detox Unit reports 1994-2003

Chapter 6. Health correlates and Consequences

6.1 Drug related deaths and mortality of drug users

Information on drug related deaths is provided by two sources, the General Mortality Registry (GMR) and the Police Special Registry (PSR). The GMR in the Department of Health Information, also has a framework for co-operation with the EU and with Eurostat and thus all deaths are coded based on the ICD 10. The GMR's records are based on details from death certificates, which are also cross-checked with toxicology reports. The PSR's records are based on reports from inspectors, who receive toxicology reports from the doctor in charge of the case. As of 2004, the National Focal Point (NFP) has established a collaborative network between the two registries in order to cross-validate the data and to ensure that the 'National Definition' for reporting to the EMCDDA will be based on the GMR.

Acute/direct drug related deaths over the last 13 years have ranged from 1-9 yearly deaths by illicit drugs. (Figure 6.1). Between 1991 and 2003 there were a total of 63 acute/direct drug related deaths[13], (N of females = 4). The cause of death in 95% of cases was opiates. In 2003, the number of drug related deaths were 5. Between 1991 and 2003, the rate of drug related deaths per 1,000 of the population aged 15 - 64 was 0.02. Due to the combination of factors generally associated with drug related deaths, and the problems encountered by the different entities in determining the actual cause of death, this figure may be an underestimate.

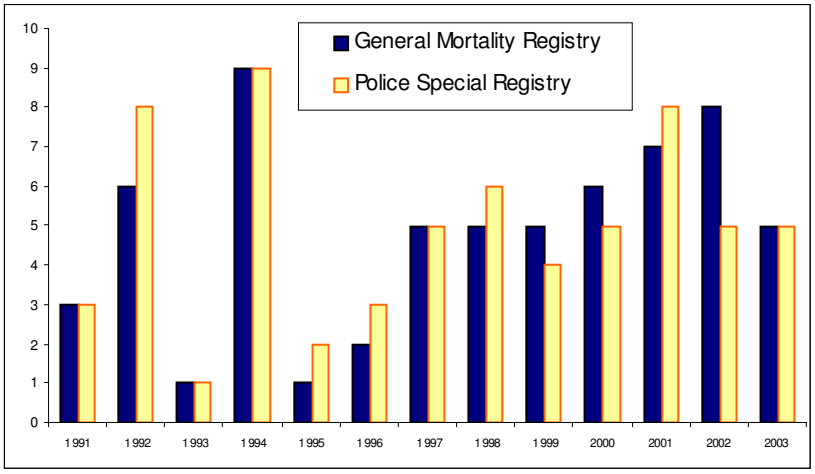

Figure 6.1. Evolution of drug related deaths 1991-2003
Source: Police Special Registry and General Mortality Registry

6.2 Drug related infectious diseases

The Disease Surveillance Unit (DSU) in the Department of Public Health is the national surveillance centre for communicable diseases in Malta. This unit was set up in 1990 and was then housed within the Health Services Information Unit. In 1993, the unit moved to the Department of Public Health and became responsible for the control and prevention of all communicable diseases. The unit is notified on acute Hepatitis B and C and AIDS cases. HIV only became notifiable in 2004.

The DSU receives notifications of positive cases from virology laboratories and prison (CCF). Notifications from the detox unit, where the majority of testing takes place, are not reported to the DSU. The only consistent reports received by the DSU

[13] Mean age: 30.2 years

are reports from CCF. Additionally, until 2004 only acute Hepatitis C cases were reported and therefore this automatically eliminates reporting for the majority of injecting drug user population, which generally do not carry an acute infection. As a result of these problems, data from the DSU cannot be used for this report. As of 2004, steps are being taken to enhance the collaboration and collection and reporting of data within the drug-related infectious diseases information network.

2003 data on infectious diseases obtained from CCF shows that from the total prison population in 2003, which was 475[14], 237 were tested. Of these, 1 tested positive for HIV, 5 tested positive for Hepatitis B and 68 (28.7%), tested positive for Hepatitis C.

Data from the detox unit on Hepatitis B and C shows that among all active clients in 2003 (N=733) who had 'ever been tested', 1.1% and 41% had tested positive for Hepatitis B and Hepatitis C respectively. This data does not provide us with either prevalence or incidence rates and as of 2004, preliminary procedures are underway to improve existing data sources for this key indicator.

Detox data on HIV and AIDS reveal that from all active clients who were ever tested (86%) there have been no known positive reported cases.

6.3 Psychiatric co-morbidity (dual diagnosis)

Co-morbidity has become a major clinical problem in recent years. Staff from various treatment centres in Malta have expressed their concerns about the high number of clients on long-term psychiatric medication admitted into treatment. Figures related to the number of clients on medication cannot however be reliably reported, as until 2003 information regarding medication was not consistently assessed upon admission. The data that exists regarding dual diagnosis is obtained from detox, where the psychiatrists who work there assess clients who exhibit traits and behaviour associated with a co-existing disorder. These clients are referred to the dual diagnosis clinic within the unit. According to detox records of 2003, a total of 78 new and 188 known clients[15] were diagnosed with some form of psychiatric co-morbidity. Additionally, as of 2004, a 6-bed inpatient dual diagnosis unit was set up within Mt. Carmel psychiatric hospital.

6.4 Other drug-related health correlates and consequences

Non-Fatal Overdoses

Data on non-fatal overdoses (OD's) is obtained from the Police Drug Squad records. The data collected over the last 9 years and presented in the graph (Figure 6.2) regards the annual number of non-fatal over-doses by heroin and illicit drugs, alcohol and pills. It may be appropriate to collect additional routine information on non-fatal OD's and also to set up an enhanced collaborative network of data collection between the emergency rooms at St. Luke's hospital, the Department of Health Information and the Police Drugs Squad. There were a total of 15 non-fatal OD's from illicit drugs in 2003. The number of non-fatal OD's from licit substances (alcohol and pills) was far higher, rising to 149. The total number of non-fatal O.D's (licit and illicit drugs) was 165; 96 were female. Trend data shows a progressive decrease in O.D's by illicit drugs and a levelling off of O.D's from alcohol and pills from 2001,

[14] 242 inmates have a know drug problem

[15] Total Number of clients at SMOPU in 2003 = 733

following the upward surge between 1998 and 2001. However, a longer term perspective is needed to conclude that there has in fact been a stabilising or decrease of non-fatal O.D's.

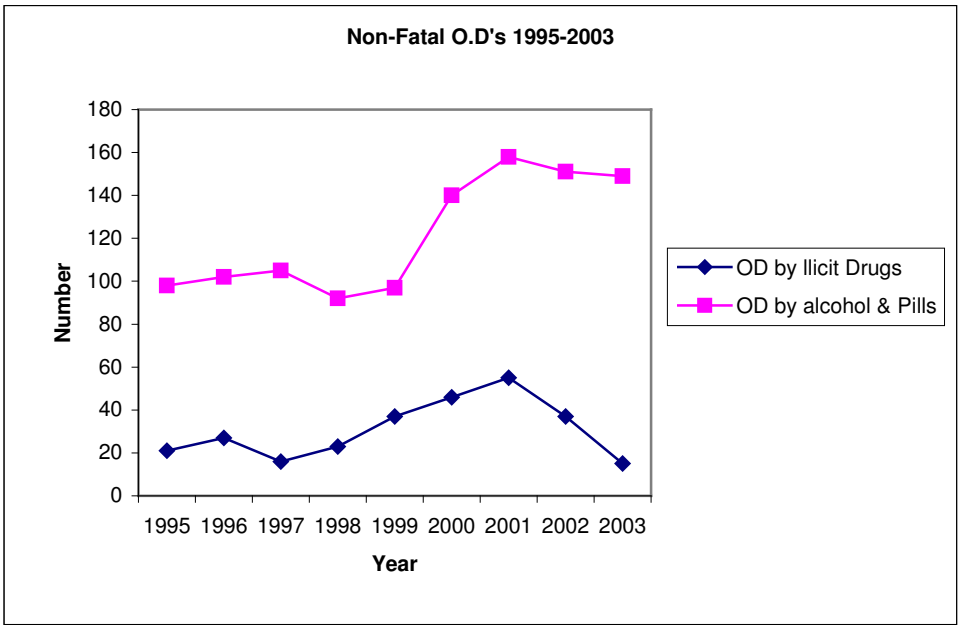

Figure 6.2. Evolution of Non Fatal OD's 1995-2003
Source: Police Drug Squad Records

Chapter 7. Responses to Health Correlates and Consequences

7.1 Prevention of drug-related deaths

Preventing drug misuse is in the long-term certainly the most effective way to prevent drug-related deaths. In Malta, informative messages on the dangers of taking drugs are given to children and youth in schools (starting from primary schools). Seminars are conducted, exhibitions take place in a variety of settings on a community level, billboards and media based preventative and informative messages are transmitted through special programmes on television and radio stations.

The message that drugs can kill both directly and indirectly (e.g. accidents as a result of intoxication; overheating in crowded nightclubs after taking ecstasy) is being sent out through the local drug agencies and even through health promotional activities from the Department of Health. Also, outreach work at rave parties takes place and front line workers like nurses from St. John's Ambulance and the Red Cross are present at all parties where drugs are known to be prevalent.

With regards to reducing the level of premature death among heroin users, treatment services provide information on the dangers of injecting drug use. Information on the dangers of injecting and sharing needles in the form of leaflets is available at all treatment centres. Also, groups tackling topics such as the risks involved in injecting drugs and the risks of overdosing following long-term abstinence are organised for clients frequenting a programme. Harm reduction programmes also provide information in this regard. The latter also offer crisis intervention assistance to users who are at risk of over dosing due to polysubstance use, mainly the combination of heroin and the abuse of prescribed psychiatric medication.

When considering the situation around the immediate event of an overdose and what may be done by someone who witnesses an overdose, a slightly more complicated picture emerges. Currently under debate in the Social Affairs Committee is the extent with which the law on drug trafficking, whereby two or more people sharing drugs can be charged on a possession or trafficking offence, is negatively affecting the chances of users accompanying an overdose victim to hospital, for fear of incrimination.

Treatment centres report the need for an enhanced supportive system with regards to clients who are suicidal and/or abusing psychiatric medication. In most cases these clients are referred to Mount Carmel, the psychiatric hospital.

7.2 Prevention and treatment of drug-related infectious diseases

Associated public health measures in the prevention of drug-related infectious diseases include providing access to clean injecting equipment; testing and counselling for infectious diseases; risk-awareness education for drug users and HBV vaccination.

Since 1994, free syringes have been distributed from all 8 Health Centres to promote harm reduction and reduce the risks of spreading of infectious diseases (Figure 7.1). The trend shows a progressive increase in syringe distribution over the last 9 years. In 2002, Sedqa launched a safe syringe disposal programme. This programme

however was discontinued after 1 year as it failed to attract the injecting drug user population.

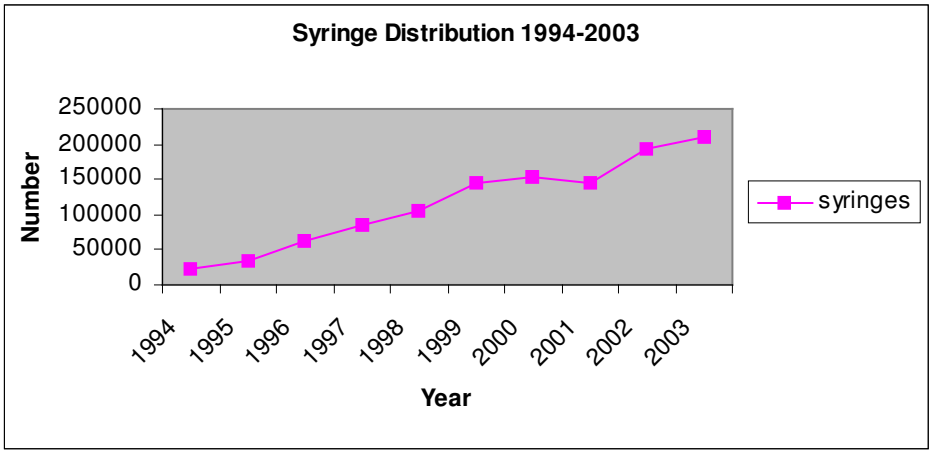

Figure 7.1. Syringe distribution trends between 1994 and 2003
Source: SEDQA Epidemiological Report 1994-2002; SEDQA Bi-Monthly Reports, 2003

Other harm reduction measures that have been implemented by treatment agencies include providing information to current clients on the risks involved in sharing needles, the possibilities for random testing, pre/post test counselling and dispersion of public health promotion material. One area that warrants further attention is that of looking into the sexual behaviour of injecting drug users and promoting safe-sex. Information obtained from staff at the various treatment agencies indicates that a large number of injecting drug users still engage in unsafe sex, however no documented evidence is as yet available.

7.3 Interventions related to psychiatric co-morbidity

Data on co-morbidity in Malta is still quite fragmented and incomplete. Workers in the field have attempted to adapt their existing resources to address the needs of this client group. However, further attention is needed in the form of setting up an expert group whereby certain issues such as defining the broad clinical definitions of psychiatric co-morbidity, its diagnoses and treatment can be discussed. Additionally data sources need to be updated in order to collect more consistent and reliable information. This would provide us with a clearer clinical picture, enhance the signalling of problems or developments that need to be addressed and allow for a more relevant and cost effective implementation of responses.

When considering this action, one must take into consideration the limited human resources in treatment services, when compared to the number of clients. If a common assessment measure were to be used across all types of treatment, one would have to consider the financial and human resources that would be needed in order to effectively embark on this action. This would entail training existing staff members or employing new staff members who are qualified to administer such an assessment. Additionally, treatment centres would have to adapt or extend their current services in order to address the needs of this client group appropriately.

7.4 Interventions related to other health correlates and consequences – non-fatal overdoses

To date there is no official programme aimed at preventing drug overdoses, however the substitution programme operating at detox, the information delivered to drug users in contact with treatment services, awareness created through public health material and the work done by first aid professionals who are on site at rave parties are all contributing factors towards minimising overdose risks.

Clearer data on non-fatal OD's in the form of setting up an information network between the Emergency Rooms, Dept. of Health Information and Police Drug Squad would contribute to enhanced evaluative measures and preventative interventions. The high number of O.D's from alcohol and pills also raises the issue of focusing on preventative measures in the area of abuse of alcohol and pills in combination with illicit drug use.

Chapter 8. Social Correlates and Consequences

8.1 Social Exclusion

A coherent picture on social exclusion cannot be presented. It is unclear from the different data files whether unemployment, housing, education and other social variables refer to a person's situation at entry or whether the information was updated to reflect a client's 'current situation'. Some data from treatment sources on social exclusion for 'first treated clients in 2003' is available and this is presented in chapter 4.2 of this report.

8.2 Drug related crime

Not only trafficking but also possession of any amount of illicit drugs is a criminal offence in Malta. As drug use implies the prior possession of drugs, in principle all active drug users run the risk of criminal charges.

In 2003 the Drug Squad of the Malta Police Force made 597 arrests of 528 persons on the suspicion of drug-law offences. In 395 cases, involving 367 persons, an arrest resulted in charges. Almost all arrested persons have been charged for possession of drugs: 74% only for possession and 22% for possession and trafficking[16], mostly related to cannabis or heroin (Figures 8.1, 8.2, 8.3).

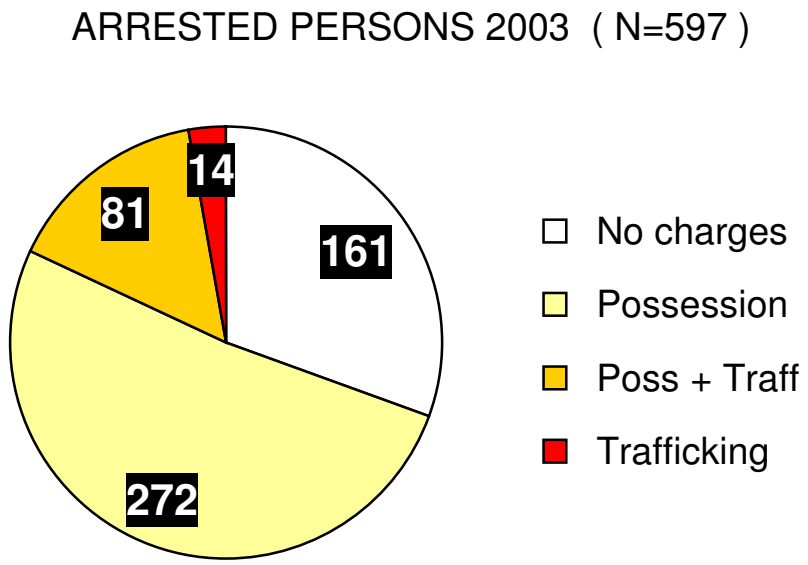

Figure 8.1. Arrested persons in 2003 by type of offence
Source: 2003 Police Data File

[16] Trafficking also includes conspiracy to traffic, possession with intent to traffic (e.g. sharing drugs) and cultivation (in Malta: cultivation of cannabis).

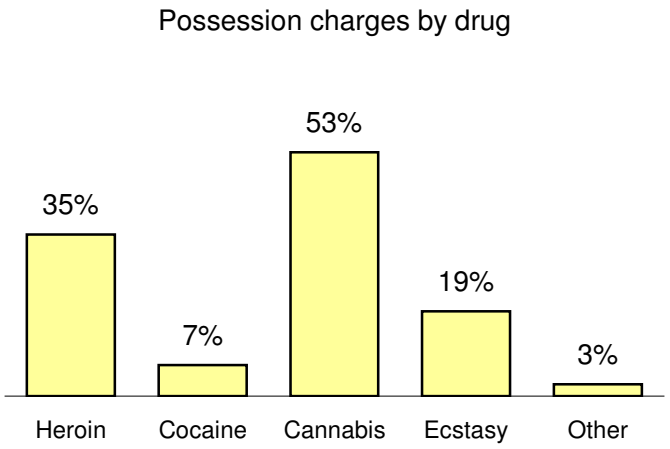

Figure 8.2. Arrested persons in 2003 charged for possession by drug involved
Source: 2003 Police Data File

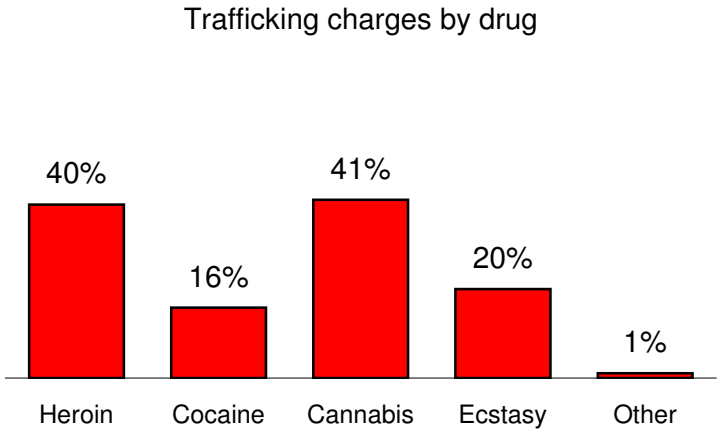

Figure 8.3. Arrested persons in 2003 charged for trafficking by drug involved
Source: 2003 Police Data File

The number of arrests for drug-law offences since 1998 shows peaks in 1999 and 2002 and a drop in 2001 and 2003. (Figure 8.4).

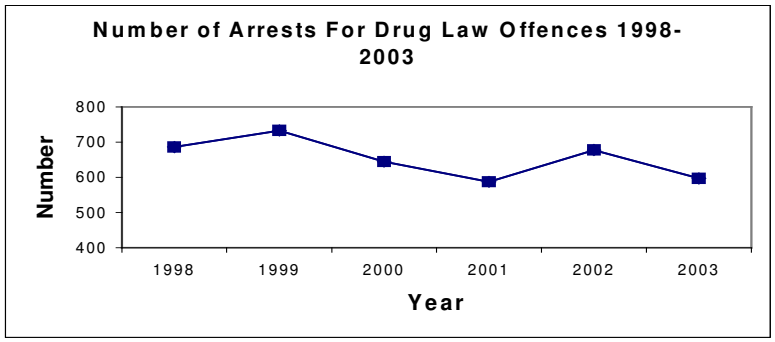

Figure 8.4. Trends for arrests for drug law offences 1998-2003
Source: Police Annual Reports 1998-2003

87% of all persons arrested in 2003 by the Drug Squad were male. Charges related to cannabis and ecstasy regard mostly young adolescents; charges related to heroin and cocaine regard mostly young adults (Figure 8.5, 8.6).

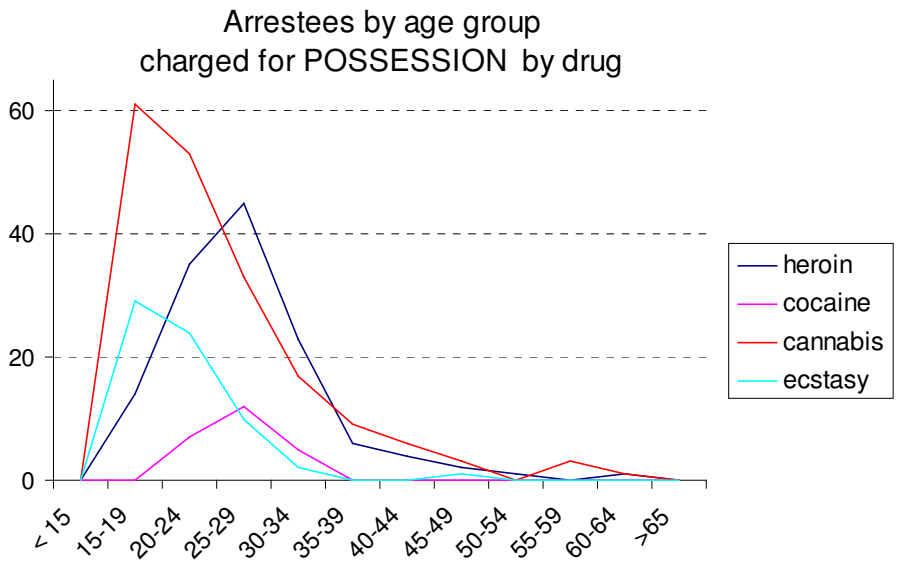

Figure 8.5. Persons charged in 2003 for possession by age group and drug involved
Source: 2003 Police Data File

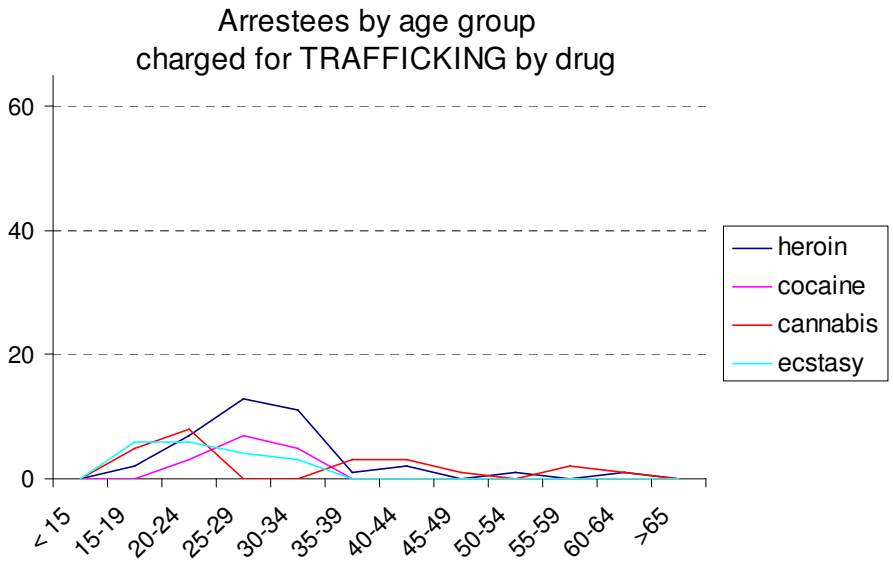

Figure 8.6. Persons charged in 2003 for trafficking by age group and drug involved
Source: 2003 Police Data File

In the public eye a considerable proportion of other crimes committed in Malta, in particular petty theft is attributed to drug users. Although no dedicated studies exist to ground this assumption, CCF and Probation data suggest that many offenders presented to the Maltese Law Courts have a history of drug use.

In 2003, there were 475 persons in prison, either on remand or after being sentenced to imprisonment. 30% of this prison population was charged or sentenced for drug-law offences. According to prison authorities all inmates are tested for drugs upon admission and in 2003, 51% of all inmates and 64% of those imprisoned on drug related charges tested positive for drugs, mainly for heroin and cannabis. (Figure 8.7).

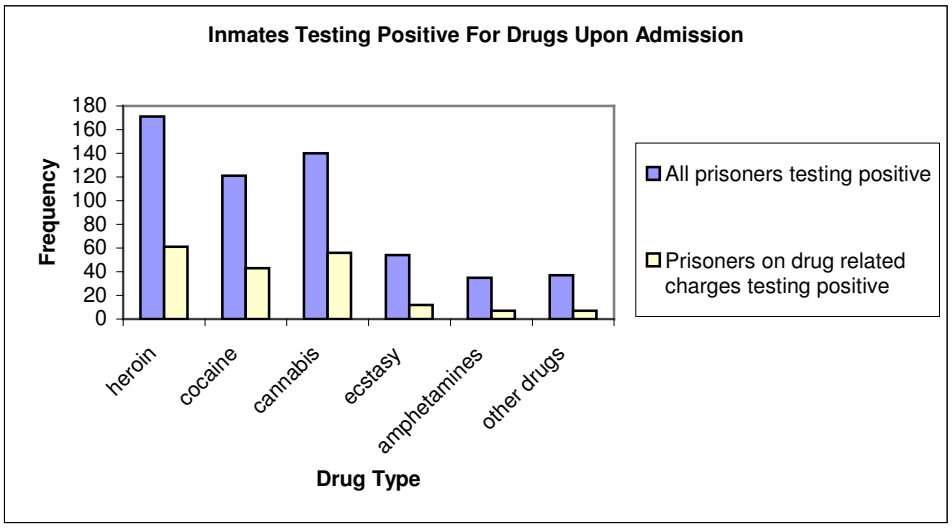

Figure 8.7. Number of inmates testing positive for drugs upon admission to CCF
Source: 2003 CCF Data File

According to the Probation Service over the past ten years almost half of their clients were charged for drug-law offences. In 2003 the Probation Service counted 237 persons with a known drug problem among 632 registered clients (Figure 8.8).

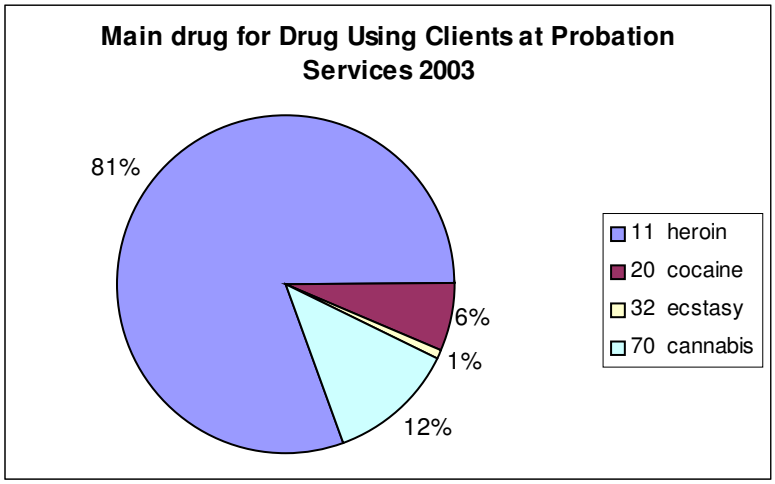

Figure 8.8. Main drug of choice for drug users at Probation Services
Source: 2003 Probation Data File

Obviously there is overlap between Police, Prison (CCF) and Probation data as shown in the pie chart (Figure 8.9). It should be acknowledged however that not all criminal charges by the Police result in prison or probation records. Charges in 2003 might not appear in CCF or Probation records of the same year, whereas CCF and Probation records of 2003 can relate to charges following arrests in previous years.

Also, Police and CCF records may relate to non-resident foreigners, which cannot appear in Probation records.

Overlap between Police (arrested persons), Probation (active clients) and CCF (inmates) data in 2003

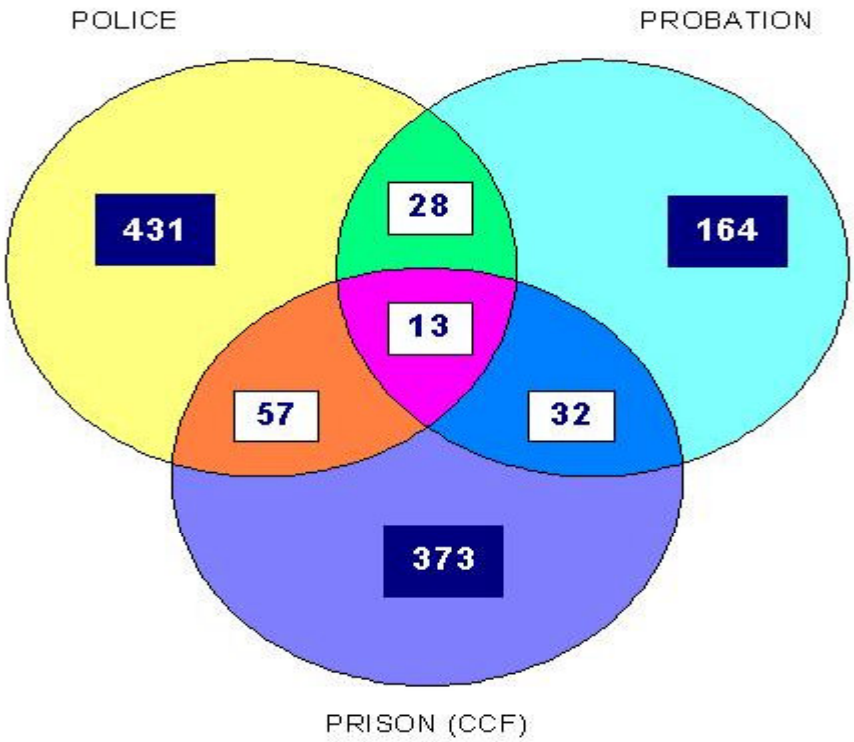

Figure 8.9. Overlap between police, probation and CCF 2003
Source: Merged 2003 Police, CCF and Probation Data Files

8.3 Drug use in prison

In Malta all prison inmates are tested for drug use upon admission (results are presented in chapter 8.2) and on the basis of a monthly random sample. A positive test results in the loss of certain inmate benefits like remission period and reduction of family visits. On suspicion of drug use the director of CCF can also assign individual prisoners for tests outside the monthly random testing schedule. Participation in these tests is in theory only voluntary but refusal is considered in the same vein as a positive test. No data is available on the results of random testing for drug use in prison in 2003.

8.4 Social Costs

Direct costs related to drug activities in the area of Supply and Demand reduction have been stated to be in the region of 1.5 million Maltese Lira or some 3.5 million Euros (see Chapter 1.3). However, no figures are available as yet for indirect costs, namely the costs attributed to medical interventions related to drug use, economic costs that relate to the loss of production which may impact on GDP, as well as indirect social costs related to benefits received by drug users as result of unemployment, child benefits, housing benefits and so on.

Chapter 9. Responses to Social Correlates and Consequences

9.1 Social reintegration

Since data on social exclusion is fragmented, it is not possible to provide an overall global picture on the measures taken to respond to this problem. Some data on social reintegration is presented in the form of activities implemented by long-term rehabilitation centres in this regard.

Long-term rehabilitation programmes in Malta place a considerable amount of emphasis on housing, employment, education and training as part of their reintegration process.

In 2002 the Employment Training Corporation (ETC) signed an agreement with treatment services whereby clients who have completed a drug rehabilitation programme can benefit from different schemes offered by the ETC that would enhance their chances of finding employment. ETC found employment for 20 former drug users in 2002/2003, compared with 24 in 2001/2 and 15 in 2000/01. In addition, it also trained 83 people who had followed Caritas drug rehabilitation programmes (N=101 in 2002 and N=37 in 2000).

Between October 2002 and September 2003, ETC allocated 54 work placements for ex-drug users. According to 2003 ETC data there are currently 204 drug users registering for work.

In 1996 the ETC implemented two additional schemes to assist in training and employment for unemployed persons and vulnerable groups. The Employment Training Placement Scheme assists long-term unemployed persons to re-enter the labour market. The aim of this scheme is to encourage private sector employers to recruit the unemployed by providing them with a financial subsidy. This subsidy comprises 50% of the minimum wage (LM53.13 weekly)[17] for a maximum period of 12 months. Persons employed under this scheme are employed full time and the working conditions are governed by the Conditions of Employment Regulations Act (CERA). Eligibility criteria for this scheme include persons who have been registering for work for over one year and who are 40 years and over. Between October 2002 and September 2003, 2 former drug users benefited from this scheme.

The Bridging the Gap Scheme is designed to support a person's transition period from unemployment to employment. The scheme offers the trainee a period of work exposure in order to gain workplace skills, increased access to employment opportunities and a weekly allowance from ETC of LM35[18] at the expense of renouncing the rights to any Social security benefits throughout the work exposure phase. Between October 2002 and September 2003, 16 former drug users benefited from this scheme.

At present Caritas is planning an in-house education and guidance service targeting drug users in rehabilitation programmes, Maltese employers, and the general Maltese public, aiming to increase the information and awareness on the importance of employment in fostering the social inclusion of ex-drug abusers.

[17] LM53.13=123 euros
[18] LM35 = 85 euros weekly is slightly less than minimum wage

The area of social exclusion is one where there is room for improvement. Clearer definitions on what social exclusion for this target group implies for Malta, enhanced data sources across agencies and other departments are also needed to assess and monitor problems or developments and to improve the implementation of responses in the field of reintegration and social inclusion among drug users.

When looking at this issue from a more global perspective, taking into consideration disadvantage groups at large, Malta has a well-developed welfare system that reduces the risk of poverty. However, according to the National Action Plan on Poverty and Social Exclusion 2004-2006, further work and collaboration between all services is needed in order to enhance the reintegration of disadvantaged groups, which include drug users, in the labour market. Another obstacle faced by authorities is the rise in general of unemployment among Maltese youth and the large number (48.5%) of youth between 18 and 24 who have left school with lower secondary education or less.

One of the key priorities for The National Action Plan on Poverty and Social Exclusion 2004-2006 is “Promoting the access to services faced by disadvantaged groups (persons with mental health problems, single mothers, victims of domestic violence, substance abusers, refugees and illegal immigrants)”. More specific policy measures are “to provide appropriate incentives to take up work for target groups”, “to increase the number of respective students”, “to reinforce the welfare of those who are dependant by setting up additional programs” and to “increase the housing supply and affordability for the most needy and target groups”

9.2 Prevention of drug related crime

Drug laws enforcement interventions - police intelligence, surveillance, arrests, arraignments, court convictions and probation services - have an implicit aim to prevent drug-related crime. Programmes aiming at the prevention of drug use and treatment of drug problems can also contribute to the prevention of drug-related crime.

It is not known to what extent treatment programmes address criminal behaviour of their clients. Treatment agencies do not systematically assess and record the history and follow-up of their clients in the judicial system.

In 1995, Malta started a pre-release programme for prisoners with drug problems to assist their reintegration in society and to prevent relapse into drug use and criminal activities. The Unit was established in October 1995 as a Substance Abuse Assessment Unit and was subsequently upgraded to a Therapeutic Unit in August 1996 (SATU).

In 1996 and 1997 Sedqa and Caritas respectively, began similar pre-release programmes in separate units under the supervision of the Prison Board. All three programmes follow the Therapeutic Community model whereby the residential phase corresponds to the duration of the remaining prison sentence. Inmates can participate in the pre-release programme on a voluntary basis; the main admission criteria are:

- Serving a sentence of not less than 6 months but not more than two years;
- Regular good conduct in prison;
- Not dangerous to society;
- Not detained under Immigration Act;

- Not subject to extradition;
- Not foreign;
- No mental illness or suffering from mental disorders.

Within a common framework the pre-release units of SATU, Sedqa and Caritas differ in regime and intervention approach and eligible prisoners can indicate a preference for a unit of their choice. In recent years SATU has specialised in dual-diagnosis cases and therefore the criterion ' not suffering from any mental illness or mental disorders' does not apply for this programme anymore. In 2003, the majority of SATU clients were dual diagnosis cases.

Following the Treatment Demand Indicator (TDI) protocol the clients of the Maltese pre-release programme are included in the treatment figures presented in Chapter 4. The reach and utilisation of the pre-release programme is not systematically monitored. According to CCF many eligible prisoners do not opt for the pre-release programme and many also do not complete the programme (and consequently return to CCF for the remainder of their sentence). Some information about the programme in 2003 is presented in Table 9.1.

	PRISON INMATE PROGRAMMES 2003		
	CARITAS P.I.P.	SEDQA ST. MARIA	SATU
Number Eligible for Rehab from CCF	47	32	49
Number of Admissions 2003	16	7	16
Total Number of Clients 2003	27	12	17

Table 9.1. Number of persons in prison inmate programmes in 2003 and number eligible for rehabilitation from CCF
Source: CCF, Sedqa, SATU and Caritas Data Files 2003

Currently under debate in Malta is the implementation of a First Offenders Programme, which should give first time drug-law offenders the option to attend a drug rehabilitation programme as an alternative to sentencing by the Law Courts. Additionally, under debate is the proposal to make distinctions between 'sharing drugs', which at present can result in the charge for 'possession with intent to traffic' and in some cases also in a crime for trafficking.

Chapter 10. Drug Markets

10.1 Availability and supply

Cannabis remains the most popular drug of abuse in Malta. The herbal form (grass) can be grown locally. As a result of the climatic conditions on the islands it is very easy to grow cannabis without any artificial assistance. Home growers are not uncommon and commercial operations are discovered from time to time. Cannabis resin (hashish) of North African origin is generally imported through European countries. Heroin is imported from Eastern Mediterranean countries and from North Africa, while cocaine and ecstasy are imported from other European Countries.

Data from the 2001 population survey on "perceived availability for illicit drugs: cannabis, ecstasy, cocaine, heroin and amphetamines" showed that approximately 75% of those who had heard of the drugs, but never tried them believed that it was not easy to get drugs within 24 hours. On the other hand, most of those who ever tried drugs reported that it was easy to get them within 24 hours. There was no significant difference in responses for cannabis and other illicit drugs. This data indicate that perceived availability is mainly linked to experience of having used the substance.

10.2 Seizures

In 2003, the majority of drug seizures were for hashish (37%) followed by heroin (24%). (Figure 10.1). There were 4 airport seizures totalling to 1.7kg of heroin. Large seizures included 1 seizure of 122 cannabis plants and 47,547 seeds, 1 seizure of 2.9kg cocaine, 1 seizure of 7,151 ecstasy tablets and 1 seizure of 29kg of cannabis resin floating at sea. It is uncertain if the latter drugs were destined for Malta.

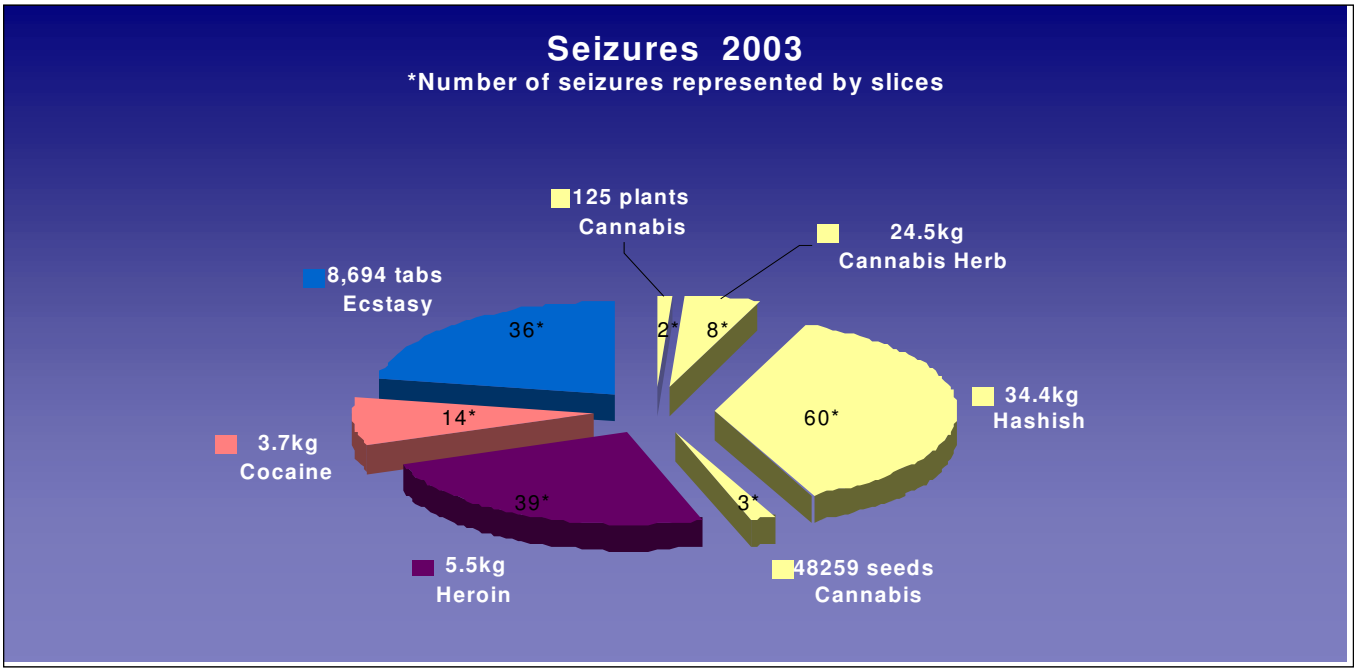

Figure 10.1. Number of drug seizures 2003

Source: Police Annual Report 2003

Recent trends in the number of seizures are not very clear, in particular because seizure data from the year 2000 show a major drop in the total number of seizures for almost all drugs. Only with regard to ecstasy do seizures shows a progressive increase from 2001 (Figure 10.2).

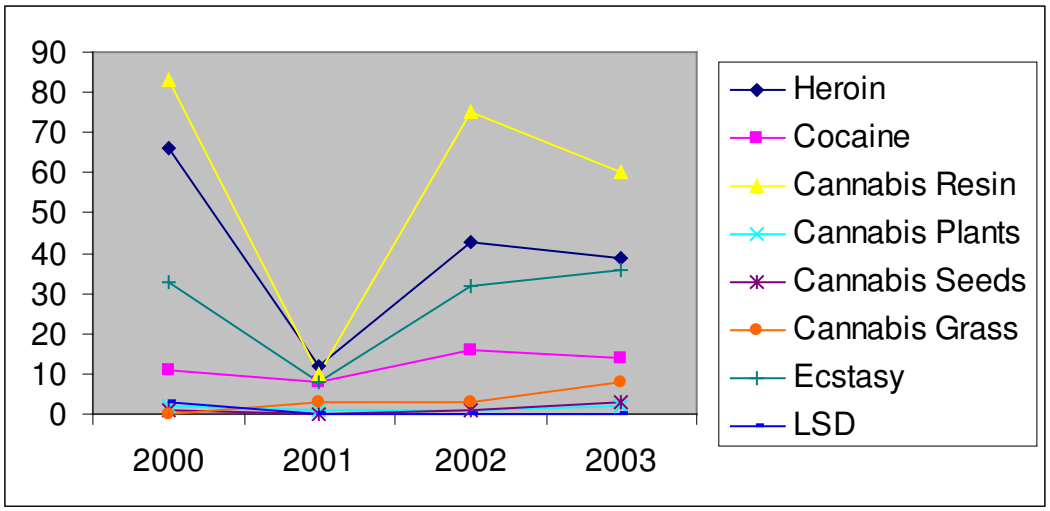

Figure 10.2. Trends in the number of drug seizures, 2000-2003

Source: Police Annual Reports 2000-2003

Quantities of drugs seized across the years are presented in the table (Table 10.1). Similar to the data on numbers of seizures, quantities seized also do not show clear trends over the years, except for ecstasy (Figure 10.3) [19].

Quantities of Drugs Seized between 1995 and 2003

Drug Type	1995	1996	1997	1998	1999	2000	2001	2002	2003
heroin (grams)	2,125	2,658	4,500	498	1,723	5,912	2,848	1,218	5,498
cocaine (grams)	159.3	172.3	301.4	57.6	1,365	28.1	4,549	4,535	3,716
cannabis resin (grams)	954.4	1,670	1,800	25,116	1,606	3,913	3,636	8,801	34,429
cannabis grass (grams)	195.5	721.745.7	163.3	69.1	161	104.9	32.4	846.4	24,533
Drug Type	1995	1996	1997	1998	1999	2000	2001	2002	2003
cannabis (seeds)	129	249	49	72	5	4	3	43	48,259
cannabis (plants)	24	100	153	5	35	22	20	12	125
LSD (microdots)	9	0	19	123	54	462	0	0	0
ecstasy (tablets)	513	686.5	247	153	459	5,191.5	2,458	10,111.5	8,694.5

Table 10.1. Quantities of drugs seized between 1995 and 2003

Source: Police Annual Reports 1995-2003

[19] A large seizure in 1996 of cannabis grass en route through Malta amounting to 721,745.7kg was omitted from graph 1 and a large seizure in 2003 amounting to 48,259 seeds was omitted from graph 2

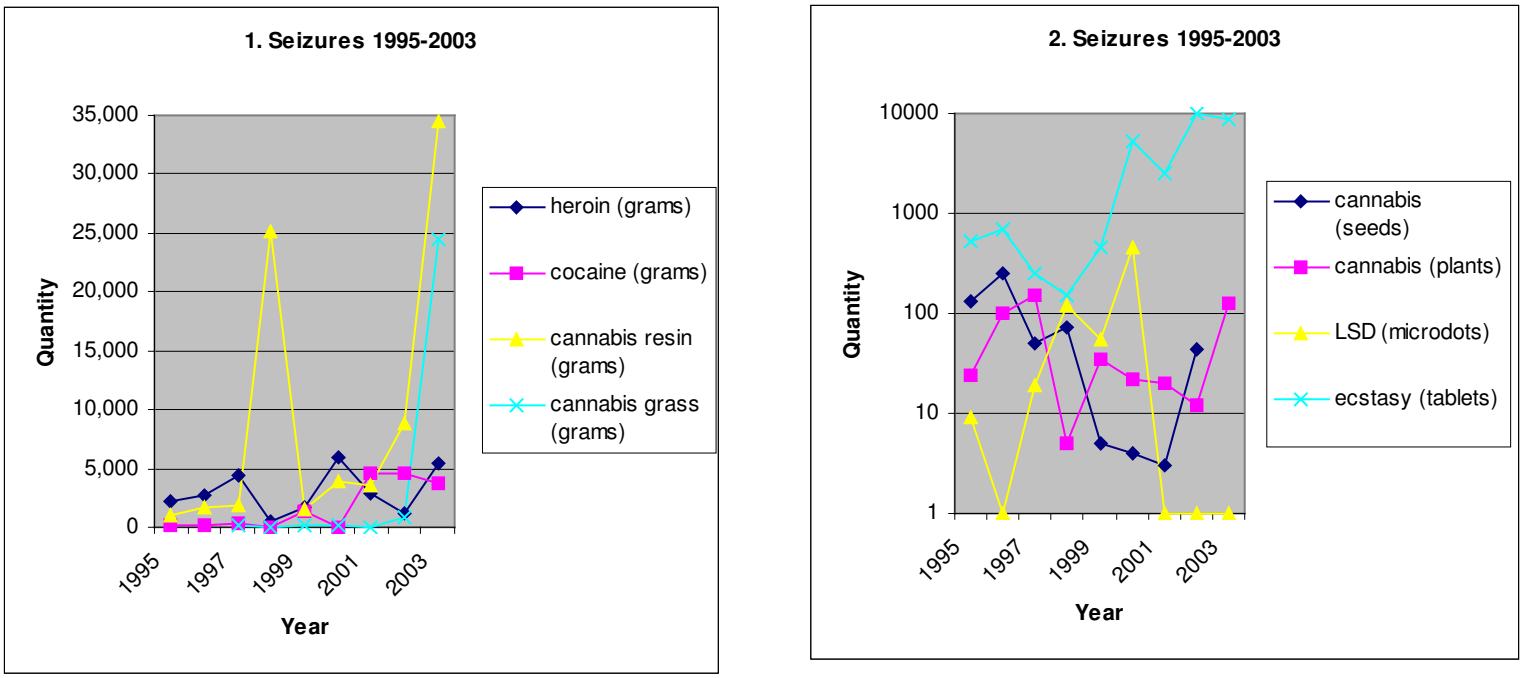

Figure 10.3. Trends in quantities of drugs seized between 1995 and 2003

Source: Police Annual Reports 1995-2003

10.3 Price/Purity

The prices for different narcotic substances are based on information obtained from the Police Drugs Squad. According to their information, street level prices for cannabis herb and resin have remained quite stable since 2001, with cannabis herb costing around LM3[20]per 4 grams and cannabis resin costing around LM10 per 3 grams.

Prices of heroin and cocaine have increased since 2001, from LM20 to LM30 per gram for heroin and LM30 to LM40 per gram for cocaine. Prices for ecstasy have dropped from around LM5-LM6 per tablet in 2001 to around LM4 per tablet in 2003. Being a small country, a large seizure could result in an increase in drug prices and with regards to heroin and cocaine a decrease in purity and a decrease in the weight of powder contained in the sachets.

Information on the average purity of illegal substances is provided by the Forensic Laboratory, which analyzes seizures made by the police and customs. The figure below shows the average percentage of purity at street level between 2001 and 2003 (Figure 10.4). The Annual Report Questionnaire (ARQ) 2003 reports no significant changes in drug purity across all drugs between 2003 and the previous year,

[20] Rate of Exchange: 1 Malta Pound (LM1) = 2.28 Euros

however an increase in heroin purity and a decrease in ecstasy purity can be observed between 2001 and 2002/3.

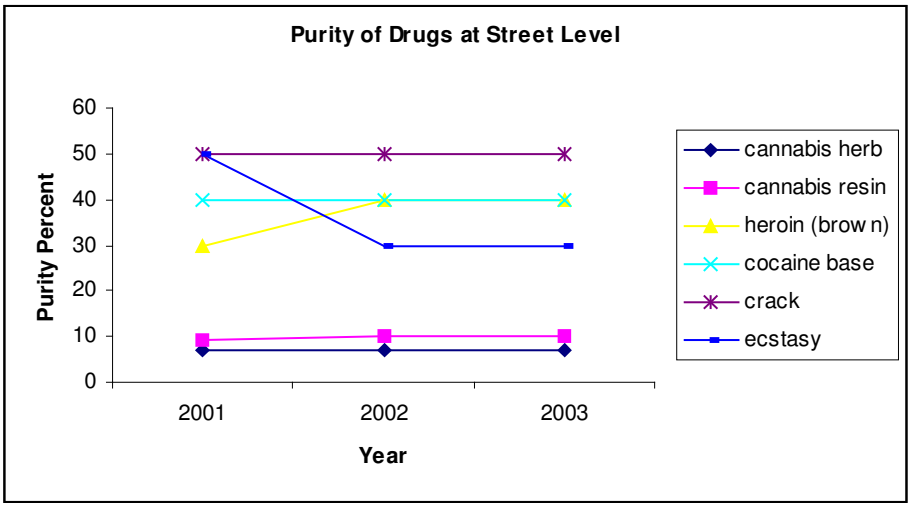

Figure 10.4. Purity % of drugs seized in 2001, 2002 and 2003
Source: Police Annual Reports 2001-2003

Part B

Selected Issues

Chapter 11. Buprenorphine, treatment, misuse and prescription practices

Buprenorphine is not prescribed in Malta and therefore no information is available on this kind of substitution treatment.

Chapter 12. Alternatives to Prison Targeting Drug Use

12.1 Political, organisational and structural information

The Maltese Parliamentary Committee for Social Affairs is made up of representatives from the Government and the Opposition. Discussions on drug policy involve the Ministry for the Family and Social Solidarity, the Ministry for Justice and Home Affairs, the Ministry of Health, the Ministry of Education and the Ministry for Investment.

Currently under debate is one issue related to offering alternative sentences whereby diversionary treatment is considered to be an option.

12.2 Interventions

Conscious of the current situation, the Ministry for Justice and Home Affairs has introduced reasonable reforms relating to the drug problem. It amended the law so that prison leave is granted to prisoners able and willing to undergo a rehabilitation program. It has financed rehabilitation programmes for prisoners with the major agencies allocating Lm80,000[21] yearly for this purpose. The said ministry has also removed mandatory imprisonment for drug users rather than dealers and finally it launched a new probation law guaranteeing more flexibility for the courts of law in attaching the right conditions to any probation order.

The new Probation Act Chapter 446 of the Laws of Malta introduced the Community Service Order, a Combination order (Probation Order with a Community Service Order) and a Provisional Order of Supervision. The latter assesses the needs of the client and refers him or her to other departments for treatment. The sentencing is in the meantime deferred until the Magistrate is clear as to what would be best for the offender. The Probation Officer updates the Court with the progress of the client in a way that the Magistrate can better decide what form of sentence to emit. The desired result would be to hand out an alternative sentence and to avoid sending the offender to prison. This system is very similar to that of the Drug Courts currently being adopted in Ireland. Due to the fact that this system applies to all drug offences, drug abusers may benefit from alternative sentencing.

Malta has a codified legal system and there are times when Magistrates have to imprison offenders even though they may not necessarily deem it as the best corrective or rehabilitative intervention.

The main aim behind the new Probation Act was to decrease the prison population and to increase cost effectiveness. It was also hoped that more clients would be introduced to an agency for rehabilitation purposes and to re-integrate or to integrate the offender for the first time into society. The end result was an increase in the Probation Officers' workload whilst the prison population remained stable.

The current Criminal Justice System has yet to address the need of an adequate system whereby the individual's problems are addressed at the point of arrest. During extensive discussions held at the President's Drug Forum, the Commissioner

[21] Rate of Exchange: 1 Malta Pound (LM1) = 2.28 euros

of Police suggested the introduction of a new system called the Arrest Referral Scheme. The Police Commissioner suggested that this scheme, might initially target those persons under 18 years, who are also first time offenders willing to admit their guilt – possession of illegal substances - with the proviso that he would not be imprisoned later on for the same offence. Such arrestees would be dealt with by a formal authority and not by resorting to a formal trial. (This is also suggested by the U.N. Standard Minimum Rules for the Administration of Juvenile Offenders 1985) Should the offender fulfill these requirements he/she would be referred for a proper assessment which would determine whether the arrestee requires treatment or not, and if affirmative what kind of treatment is required. Suggestions are currently under consideration by the above-mentioned Parliamentary Committee.

The National Commission on the Abuse of Drugs, Alcohol and other Dependencies, under the auspices of the Ministry for the Family and Social Solidarity has offered to conduct an impact study of this scheme.

Pre-Trial Phase

No interventions exist at this phase, however the possibility of introducing an Arrest Referral Scheme is being considered.

Trial Phase

The police prosecute the individual, and the Probation Officer may be asked to carry out a Social Inquiry Report or a Pre-Sentence Report. The accused may during this time be on bail depending naturally on the severity of the crime and the circumstances of the same. Bail is granted in certain circumstances. A provisional supervision order may be issued in all cases – whether bail is granted or not. The Pre-Sentence Report is carried out by a designated Probation Officer and includes recommendations to the Court as to how to proceed with the offender. The recommendations may include any of the following:

- Probation Order
- Community Service Order
- Combination Order
- Suspended Sentence
- Conditional Discharge
- Imprisonment
- Multa (Fine)

Treatment may be a condition in the cases where the offender is given a Probation Order, a Combination Order or a suspended sentence.

Currently this system is being used for cases were drugs are directly related. The person under-going a community service order cannot be under the influence of drugs at the time of the sentence or thereafter. If this were to happen the offender would be reported to the Court who would reconsider the possibility of sending the offender to prison. Victim compensation is also included as a recommendation in a substantial number of these Pre-Sentencing Reports.

Post trial

When a probation order or a Suspended sentence is passed the offender may have already been in contact with the Probation Services through the Pre-Sentencing Report or through the Provisional Order of Supervision. Alternatively he/she would

have been referred for the first time. In any case the Probationer needs an assessment and consequently will be referred for treatment to various agencies or programs available locally.

If a prison sentence is given the sentenced offender may still apply to go for a drug rehabilitation program. There are certain conditions applicable for this to happen. The application can be made only after the person has been in prison for at least 6 months and needs to have a sentence of at least one year but not more than two.

The applicant will then be assessed by the Prison Substance Abuse Assessment Board and if successful he/she will be attend a program for the rest of the prison sentence. Naturally exceptions are considered and the rules are waived when the Board deems it necessary for the good of the person and society. Non-governmental and governmental organisations that offer this service to prisoners are financed by the Ministry for Justice and Home Affairs.

12.3 Quality assurance

There is currently no monitoring body for quality assurance, however the financing body realises the need of introducing such a body due to accountability for funding purposes. The Probation Services have a Supervisory Board that reviews the performance of the Probation Officers and suggests improvements and monitors the administration of discipline.

Agencies do carry out internal evaluations and in 2004, the Malta National Focal Point was set up in order to establish a common way of collecting, inputting and interpreting data that can be used for monitoring and evaluative purposes.

Since the process of analysing our drug problem situation was initiated we have increased our awareness regarding the extent of the problem and also provided better ways to intervene therapeutically. The Police force has shown that they favour therapeutic interventions with minors and will work with the therapeutic organisations and Probation Services so that young people will benefit from alternatives to sentencing and from arrest referrals. For this purpose the Probation Services, since the end of 2003 have started to receive all the cases from the Juvenile Court.

The aspects being considered at the moment are the re-definition of sharing and trafficking so that further improvements may take place in the way the drug problem is handled. These improvements should result in an increased referral of young abusers through the arrest referral scheme and a facilitated system for those persons who bring persons suffering from accidental overdose to medical attention.

Further discussions are required regarding the Drug Court System, whether this needs to be introduced as a new structure or whether the current system may be adapted to form an appropriate arrangement, which would hold a multi-disciplinary team working with the magistrate handling the case.

Chapter 13. Public Nuisance

No information available

Part C

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Annexes

Abbreviations

AA	Alcoholics Anonymous
AIDS	Acquired Immunodeficiency Syndrome
ARQ	Annual Report Questionnaire
EAP	Employee Assistance Programme
EMCDDA	European Monitoring centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
ETC	Employment Training Corporation
CCF	Corradin Correctional Facility
CERA	Conditions of Employment Regulations Act
DDU	Dual Diagnosis Unit
DSU	Disease Surveillance Unit
GMS	General Mortality Registry
HBSC	Health and Behaviour in School Aged Children
HBV	Hepatitis B Virus
KADA	Commission Against Drug and Alcohol Abuse
LSD	Lysergic Dyethylamide Acid
MAT	Medically Assisted Treatment
MCAST	Malta College of Arts science and Technology
MDMA	3,4-Methylenedioxy-n-methylamphetamine
NA	Narcotics Anonymous
NFP	National Focal Point
NGO	Non Governmental Organisation
OD	Over Dose
PE	Physical Education
PIP	Prison Inmates Programme
PSE	Personal and Social Education
PSD	Personal and Social Development
PSR	Police Special Registry
SAFE	Substance Abuse Free Employees
SATU	Substance Abuse Therapy Unit
SMOPU	Substance Misuse Outpatients Unit
TC	Therapeutic Community
TDI	Treatment Demand Indicator
XTC	Ecstasy

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