



European Monitoring Centre  
for Drugs and Drug Addiction

**2005 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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## **Summary**

This is the second National report on the drug situation in Malta, drawn up annually for the Ministry for the Family and Social Solidarity and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). This report gives an overview of current developments regarding the political and legal framework, the epidemiological situation and demand and supply reduction interventions in the reporting period 2004. Specific issues are highlighted each year and in this report gender differences, drug policies extended beyond illicit drugs and drug use within recreational settings have been selected.

### Chapter 1 – National Policies and Context

In Malta a zero tolerance drug policy applies. Anyone in possession of any type or form of illegal substance, or items related to drug use, its cultivation or manufacture is subject to court proceedings. The principal framework of Maltese legislation related to substance use and misuse comprise the Medical and Kindred Professions Ordinance (Cap 31) and the Dangerous Drugs Ordinance (Cap 101).

### Chapter 2 – Drug use in the General Population

The self reported use of illicit drugs amongst adolescents, young adults and older adults in Malta is lower than most other European countries (ESPAD 1995, 1999, 2003, Population Survey 2001, Health Behaviour in School Aged Children Study 2001/2002). The latest 2003 ESPAD survey however reported an increase in cannabis use amongst 15-16 year olds since the last survey conducted in 1999. Alcohol use is clearly the most commonly used substance amongst young people and the general population of Malta, with remarkably high percentages of recent use, compared to other European countries.

### Chapter 3 - Prevention

The key players involved in drug prevention activities are Sedqa the National Drug Agency, Caritas and Oasi the voluntary organisations and the Anti Substance Abuse Unit within the Education Division. Universal prevention activities incorporate school-based, community-based, media-based and work-place based programmes. Selective/indicated prevention activities target mainly vulnerable schools and vulnerable age groups in selected schools. Additional interventions include individual counselling,

either as a follow-up to programme-based (school, community and workplace) activities or 'outreach' contacts. More outreach work is needed however, in order to reach the more vulnerable or 'difficult to reach' target persons, groups or families.

#### Chapter 4 – Problem Drug Use

A number of indirect methods have been developed in order to estimate the prevalence of problem drug users in a country. Indirect methods start with data sets from a number of sources, for example, different treatment centres, and seek by a variety of different techniques to estimate the hidden unknown number and consequently the proportion of the total problematic drug using population represented by this data set. In Malta, the capture-recapture method was adopted (as described in Hay et. al., 1999). Since the vast majority of clients in treatment are heroin users (86%), our definition of problem drug use is 'daily heroin users'. This definition is consistent with the European methodology, and allows for a meaningful comparison to be made both on a national, as well as on an international level. Using the capture-recapture methodology to estimate the prevalence of problem drug users (as per the EMCDDA definition), the collected data concerned 2004 active clients, registered as 'daily heroin users', attending the centralised detoxification/substitution unit (Sedqa) and two outpatient community services (Caritas and Oasi). The central estimate stood at 1597 problem heroin users, (range: 1497-1723), resulting in a rate of 5.8 (range: 5.4 - 6.2) per 1000 persons aged 15-64 years. This estimate seems plausible due to the fact that in Malta the methadone dispensing unit is centralised, and treatment is generally highly accessible with little or no waiting time at all. In 2004 there were approximately 1100 'known' daily heroin users in treatment. The estimate points towards the 'unknown daily heroin using population' standing at around 500-600. These absolute figures may seem moderate, however compared to other European countries Malta's rates, approximately 6 per 1000 of the population, rank on the high side (range 1-10), indicating that heroin use is still a major problem for a small country like Malta.

*Characteristics of Clients in Treatment* - Similar to 2003, in 2004 the client data of all treatment centres in Malta and Gozo were combined, with the exclusion of double counting, to a harmonised file of the 2004 national treatment population. In 2004, the total number of persons in treatment was 1525. This figure shows that the rate of 'all



clients' in treatment in 2004 relative to the general population of Malta aged 15-64 years was 5.5 per 1000. This rate increases to 10.8 per 1000 with the 15-34 year age group.

The majority of clients in treatment in 2004 were male. The mean age of clients was 28 years (median 27 years). 86.3% of clients were registered as heroin users. Injecting drug use, which poses a number of health risks is still prevalent among drug users, with 88.6% of 'all clients' reporting to have 'ever injected' drugs and 46.7% of 'first ever treated' clients registered as 'current injectors', an increase of 16 percentage points from 2003.

#### Chapter 5 – Drug-Related Treatment

Drug treatment in Malta and Gozo can be classified into the following categories: detoxification and substitution, community treatment and drug free residential. Drug treatment targets all drug users, regardless of age, gender or drug preference. Agencies are continually adapting their services to meet the needs of their clients. In 2004, the following new services opened: the low threshold Caritas Harm Reduction/Shelter targeting chronic relapsers and the homeless, the Dual Diagnosis Unit within Mount Carmel Hospital targeting male clients with more severe psychiatric co-morbidity and the Well Woman Clinic at SMOPU (Substance Misuse Outpatients Unit) which attends to the medical and gynaecological needs of female drug users.

Trends in treatment demand can only be provided from SMOPU, the centralised methadone dispensing service. This data, which dates back to 1994, shows that over the last 10 years the number of 'all active clients' has increased three-fold. All told, the SMOPU trends point towards a recycling of clients already in the system, characteristic of long term maintenance objectives. The fact that heroin clients stay in touch with the system is a positive sign in terms of accessibility of the service, however what remains unclear is to what extent clients are assisted in their overall integration back into society – in terms of measurable levels of cessation or improvement in intravenous opioid use and use of other psychoactive drugs, a reduction in risk behaviour associated with heroin use, improved social functioning and psychosocial rehabilitation, reduced levels of criminality, improvement in health status and psychological adjustment, stabilisation and eventual weaning off methadone.

### Chapter 6 - Health Correlates and Consequences

Information on drug related deaths is provided by two main sources, the General Mortality Registry (GMR) collated by the Department of Health Information, which codes deaths according to the ICD10 and the Police Special Registry (PSR). Data on the evolution of acute/direct drug related deaths over a 10-year period shows that these have ranged from 1 (1995) to 9 (1994) yearly deaths by illicit drugs. The cause of death in 95% of cases was opiates, often in combination with other drugs, including alcohol. Between 1994 and 2004 there were 67 deaths in residents of the Maltese Islands due to drugs typical of abuse. The average age of death in the last ten years was around 34.2 years, with most deaths occurring in the 25 to 34 year age groups. Males were more likely to be the victims of fatal overdoses with a male to female ratio of 11:1. In 2004 the GMR reported 6 acute drug related deaths, which would result in a rate of 2.2 per 100,000 of the population of Malta.

Police records show that in 2004 there were a total of 216 reported overdose (OD) cases, with a female to male ratio of 1:1. The rate of OD cases in Malta amounts to 77 per 100,000 of the population. Most ODs in 2004 occurred as a result of medicinals, namely psychotropic medication. Only 14% of all ODs were the result of illicit drugs, namely heroin. Of these, 23 were males and 5 were females. Trend data, which does not exclude double counting, shows that the number of OD cases from pills and medicinals is on the increase. The mean number of overdoses over the last five-year period (2000-2004), increased by 60% as compared to the previous five-year period (1995-1999). On the other hand, the number of overdoses for illicit drugs has declined between 2001 (N=55) and 2003 (N=15), but doubled between 2003 and 2004 (N=30). The figure for 2004 is representative of the 10-year average, 31.

Dual diagnosis is another challenge faced by all drug treatment centres in Malta and Gozo. In recent years drug agencies have become increasingly concerned with the rise in the number of clients coming forward for treatment with drug problems and namely psychiatric personality disorders, anxiety disorders and affective disorders. Most of these clients are taking prescribed psychotropic medication. Their concurrent and haphazard use of illicit drugs and pills raises a number of concerns, especially attributed to the increased risks of overdose. Interviews with staff members from various treatment agencies indicate that although in recent years more attention has been directed

towards addressing the needs of clients with a dual diagnosis problem, national routine data is still lacking.

#### Chapter 7 – Responses to Health and Social Correlates

Typical measures on the part of treatment agencies in Malta to reduce acute/direct drug related deaths include educating clients on the dangers associated with drug use and the ingestion of multiple substances (including alcohol and psychotropic medication), the risks of over dosing following long term abstinence, and the risks involved in injecting and sharing needles. Methadone maintenance programmes, although not a panacea for resolving all of the problems associated with heroin use are justified because the benefits that ensue from treatment outweigh the risks associated with it, both for the client as well as for the community at large. Substitution treatment in Malta has been available since the early 1980s. In 2004 the total number of clients in substitution treatment was 681, 44.7% of all clients in treatment. Methadone dispensing and substitution treatment in Malta is centralised and highly accessible.

The standardisation of clients' intake assessments has enabled drug agencies to detect more easily the signs of any co-morbid conditions. Agencies are now working more closely and in parallel with psychiatrists and psychologists in order to treat clients with psychiatric co-morbidity more effectively. Additionally, whereas in the past rehabilitation centres did not accept clients on psychotropic medication, in recent years a large number of clients entering rehabilitation were on medication, although rehabilitation centres still do not cater for clients who are psychotic or who are severely depressed. In order for the needs of clients with psychiatric co-morbidity to be addressed more effectively, common definitions and tools need to be used across the different specialised drug agencies. Also clear working protocols regarding the initial diagnosis, treatment plan and referral of clients to different services and agencies need to be established. Finally, training of staff members in the management of clients with dual diagnosis is essential if agencies are to be in line with best practice when intervening with this type of client group.

#### Chapter 8 – Social Correlates and Consequences

In 2004, from a total of 859 drug-related arrests made by the Malta Police Force, resulting in 659 charges. The majority of persons arrested were charged with

possession, namely possession of cannabis, heroin and ecstasy. These drugs were also the most common substances for trafficking arrests. Total arrest data shows that since 1998 peaks were recorded for 1999 and 2002, with drops in 2000, 2001 and 2003. 2004 arrests showed an overall increase of 40% compared to 2003.

In 2004, 448 persons were admitted into prison (Corradino Correctional Facility - CCF). 78.6% were Maltese nationals. 16.3% were charged or sentenced for drug law offences. According to prison authorities all inmates are tested for drugs upon admission. In 2004, 32.6% of all inmates and 9.2% of those imprisoned on drug related charges (trafficking) tested positive for drugs upon admission, namely opiates and cannabis.

#### Chapter 9 – Responses to Social Correlates and Consequences

The detoxification and substitution programme in prison is one intervention aimed at targeting drug using inmates. This treatment, which is implemented in liaison with the Substance Misuse Outpatients Unit (SMOPU) and the Forensic Unit within Mount Carmel Psychiatric Hospital is available for inmates who were already receiving substitution treatment before entering prison. Long term substitution maintenance treatment is available for all prisoners and is accompanied by some psychosocial interventions. Inmates with a drug problem are also provided with the option of attending a drug rehabilitation programme. This option is available for those with a minimum 6-month and maximum 2 year sentence.

Certain lacunae that may act as precipitants to further crime within the prison walls need to be addressed namely:

- 1) There is no drug free zone in prison. Inmates who are not drug users or who are abstinent drug users mix with inmates who are using drugs, resulting in the initiation of drug use or relapsing to drugs within the prison walls.
- 2) Intake assessments are conducted in prison. Although these provide the prison administration with information about each inmate upon admission, the lack of follow-up assessments means that no updated information on inmates who have been in prison for some time is available.
- 3) Inmates who are contemplating or are motivated to some extent to participate in residential treatment are not separated from inmates who are not motivated at all for

such treatment. This situation does not increase a person's motivation, on the other hand, it often results in the person losing interest altogether.

#### Chapter 10 – Drug Markets

In 2004, law enforcement officials were responsible for a total of 308 seizures, marking a 47% increase when compared to seizures in 2003. The majority of seizures in 2004 were for cannabis resin, ecstasy tablets and heroin.

Over the years, drug purity levels for cannabis resin and cocaine base have remained stable overall. However, in 2004 the purity levels for cannabis herb decreased from 7% to 4.7 %. On the other hand, the purity of ecstasy increased slightly from 30% to 33%. This level of purity is almost at par with the levels recorded for 2002 and 2003 but 17% lower than the levels recorded for 2001. This decrease in purity is consistent with MDMA levels found across a number of other European countries. Drug prices between 2003 and 2004 have remained relatively stable.

#### Chapter 11 – Gender Issues

Studies on drug consumption in Malta (Population Survey 2001, ESPAD 1995, 1999 and 2003, Health Behaviour in School-aged children (HBSC) study 2001/2002) have all shown that more men consume alcohol and illegal drugs than women.

Crime data 2004 show that 64% of charges for drug law offences were persons aged between 19-30 years. The male:female ratio for arrests in this age group was 10:1.

Treatment data 2004 shows that male clients outnumbered female clients in treatment with a female: male ratio of 1:6 for 'all active clients in 2004' and a female: male ratio of 1:4 for 'First Ever Treated Clients'. With regards to 'all active clients in 2004' the largest female: male ratio was observed in low threshold harm reduction services (1:7), a unit which targets mainly chronic relapsers.

Although drug use is still primarily a male preoccupation, female drug users in treatment exhibit similar levels of severity of dependence as measured by frequency of use and route of administration. Interviews with various staff members from different treatment

centres have highlighted some observed differences between male and female drug users:

- 1) Initial use of heroin by women is highly influenced by a man, especially by a sex partner who is often a daily heroin user. Women tend to be introduced into the drug scene by their partner.
- 2) Chaotic drug use has been noted more in women than men. Women tend to become addicted to heroin for example, within a short time after initial use. Their drug use increases dramatically and they tend to start using drugs intravenously faster than the men.
- 3) Tranquilisers and sedatives are more likely to be abused by women whether or not other illicit drugs are abused.
- 4) Female prostitution is highly related to drug use. Generally, the woman's partner is also her pimp, protector and drug supplier. Female drug users in these situations find it harder than others to break away from this kind of lifestyle.
- 5) Eating Disorders are reported to be more prevalent amongst female drug users than males.

#### Chapter 12 – European Drug Policies Extended Beyond Illicit Drugs?

The National Commission on the Abuse of Drugs, Alcohol and Other Dependencies, within the Ministry for the Family and Social Solidarity is the key body responsible for providing advice on policy issues in this sector as well as providing co-ordination within the field. Consequently, the said committee has met twice per month during 2005 and together with the Policy Development Unit within the Ministry, outlined a Drugs Policy that includes both illicit drugs and medicinals. It is envisaged that by early 2006 a formal Drug Policy will be presented. In addition, it is intended that a separate policy for Alcohol be considered as part of the Commission's deliberations for 2006.

#### Chapter 13 – Developments in Drug Use Within Recreational Settings

Research in Malta on drug use in recreational settings is extremely scant or non-existent. Non-evidence based observations and information suggest that drug use in recreational settings is on the increase, generally in organized rave parties where ecstasy is the main substance used, as well as in main stream night club settings and dance settings where anything from alcohol to ecstasy and cocaine are used. Overall,

reports point towards the opinion that a considerable number of young people in Malta who frequent such events use drugs recreationally, however since no specific studies on the subject matter prevalence estimates for drug use by young people in such settings are not available.

Drug use in recreational settings in Malta can be divided into the following categories:

*Main stream night club and dance settings*, frequented primarily by young people aged between 15 and 34 years old. The most common substance used in these settings is generally alcohol; however, in some clubs, cocaine and ecstasy are also consumed by certain sub groups.

*Organised rave parties*, usually organised over the summer months or over the Christmas and Easter season. These parties are frequented by a wide array of young people. Opinions of persons present at these parties suggest that the majority of young persons who attend such events use illicit drugs, namely ecstasy.

*Illegal parties or 'After Parties'* generally start during the early hours of the morning, after a rave party or night club. Some even take place in the form of 'weekend binges'. These parties occur in unauthorised venues or private residences. People become informed about such events either via word of mouth, emails, websites or text messages.

*Festi* - Malta's 'harvest festival' known as 'Mnarja' which falls on the 29th June, opens the 'Summer Season'. Very typical of such seasonal events are the village feasts or 'festi' in honour of the patron saint of the particular town or village. Held over a period of five days, the feasts are characterised by decorated streets, band marches and fireworks displays. Village feasts have been reported as milieus for binge drinking and also drug use amongst young people.

# Part A

## New Developments and Trends



## Chapter 1. National policies and context

### 1.1. Legal framework

The **Medical and Kindred Professions Ordinance (Cap. 31)** concerning psychotropic drugs, and the **Dangerous Drugs Ordinance (Cap. 101)** concerning narcotic drugs constitute the principal framework of Maltese legislation related to substance use and abuse.

The **Medical and Kindred Professions Ordinance** was enacted in 1901 and was amended several times. This Ordinance deals principally with the regulation of the medical and para-medical professions but 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. The Ordinance deals specifically with *opium, coca leaves, cannabis, cocaine, morphine* and other drugs, regulating:

1. The production, possession, sale and distribution of raw opium and coca leaves.
2. The exportation, manufacturing, selling, dealing, possessing or use of prepared opium. Offences also include being the occupier of any premises that permits the preparation, use or sale of opium, having in possession any pipes or utensils for use in connection with opium and frequenting any place used for the purpose of opium smoking.
3. The importation and exportation of the resin from the plant Cannabis, including possessing, producing, selling, dealing and cultivating the resin obtained from the plant Cannabis or any preparations of which such resin forms the base or any portion of the plant (excluding its medicinal preparations).

4. The manufacture, sale, possession and distribution of any drugs to which this schedule applies.
5. The control of drugs for external trade including importation, exportation, removal licenses, tampering with and diversion of dangerous drugs.
6. Special licenses, permits or authorities to any police officer (not inferior to the rank of sub-inspector) to inspect and seize any drugs or items related to drugs.
7. Offences and penalties of any person who delays, obstructs, conceals information, acts in contravention of, abets or conspires to sell or deal with drugs. This applies to any person who is a citizen or a 'permanent resident'<sup>1</sup> of Malta. Persons who are exempt from any criminal liability are those who not ordinarily residents of Malta or who have come from a place outside Malta, those who at the first opportunity after landing in Malta surrender the said drug to a police officer or to a customs officer and declare that the same drug was for exclusive personal use, and situations where the quantity of the said drug implies that it was destined for the person's personal use.

Violation of the above-mentioned laws can result in imprisonment for a term of not less than six months but not exceeding ten years, or a fine of not less than LM200 (EUR 480) but not exceeding LM5,000<sup>12</sup> (EUR 12,000). For any other offence, sentences can be either a term of not less than three months but not exceeding twelve months or a fine of not less than LM200 (EUR 480) but not exceeding LM1000 (EUR 2,400) or both imprisonment and fine.

Punishments are increased by one degree if the offence takes place within 100 metres of the perimeter of a school, youth club or any place frequented by young people or if the offence consists in the sale, supply, administration or offer to do any act related to drugs to a minor, a woman with child or a person who is following a programme for cure or rehabilitation from drug dependence.

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<sup>1</sup> Permanent resident means a person whose permit of residence has been issued in accordance with the provisions contained in Article 7 of the Immigration Act

<sup>2</sup> Rate of Exchange: 1MTL = EUR2.33068

Sentences of life imprisonment are given in cases of:

1. Cultivation of a drug
2. Selling or dealing in a drug contrary to the provisions of the Ordinance
3. Conspiring to sell or deal in a drug against the provisions of the Ordinance or promoting, constituting or financing the conspiracy.
4. Money laundering<sup>3</sup>
5. Manufacturing, transporting, distributing any equipment or materials knowing that they are to be used in or for the cultivation, production or manufacture of any drug contrary to the provisions of the Ordinance.

Life sentences are subject to:

- The age of the offender
- The previous conduct of the offender
- The quantity of the drug involved in the offence
- The nature and quantity of the equipment or materials involved in the offence
- A unanimous jury verdict

**The Conduct Certificates Ordinance (Cap. 77)** provides remedies for convictions in some cases (included those relating to drug offences), which result in the non-recording of conduct certificates. However, these types of offences are treated with utmost severity and many conditions apply, namely that the offence is not one involving the selling or dealing in drugs contrary to the provisions of the Dangerous Drug Ordinance and the Medical and Kindred Professions Ordinance.

Depending on the type of offence, if the court, after assessing the information provided, is of the opinion that the offender is a drug user, in need of treatment and agrees to treatment, may grant a 'treatment order', which can be revoked to the original sentence if the person does not comply with the stated conditions. In other cases and depending on the severity of the crime, the offender can be placed on probation in accordance with the

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<sup>3</sup> The primary legislation that criminalises money laundering of proceeds of offences is the Prevention of Money Laundering Act (Cap. 373).

provisions of the **Probation Act (Cap.446)**. A 'probation order' can also include a requirement that the offender submits to drug treatment. Probation is not granted in cases of the crimes listed previously (1-5) and in practice, due to a lack of containment facilities, non first time offenders, who perpetrated in minor transgressions prior to being caught, can only be put on probation prior to incarceration (Scicluna, 2003; Damato, 2004).

If a person is under the age of 16 and has not been charged with someone who has attained the age of 16, he or she is referred to the Juvenile Court. The Juvenile Court, which was established by **the Juvenile Court Act (CAP 287)** in 1980, and was amended twice in 1985 and 1990 deals with cases related to children and young persons aged 16 years and under. A study conducted in 2004 titled 'The Treatment of Juvenile Offenders in Malta: A Call for Reform' highlights the point that if a person under the age of 16 years is caught offending with another person/s over 16 years of age, the former is tried at the Magistrate's Court and not the Juvenile Court. This deprives the youngster of certain privileges otherwise obtained under the Juvenile Court Act. (Damato, 2004). In more recent years the situation regarding juveniles has improved and actions have been taken to keep juveniles away from court as much as possible. For example in 2004, only 4 juveniles were tried in the juvenile court, all other cases were given reprimand.

#### Amendments to some laws related to drugs and substance use

**Legal Notice 118 of 1995** concerning Prisons Regulations gives authority to the Director of Prisons to order any inmate to provide a urine or breath sample for analysis to determine whether alcohol or drugs have been ingested. Refusal on the part of the inmate to comply may lead to disciplinary proceedings. The same legislation also provides a list of offences for which inmates can be charged and sentenced while in prison. This list includes the possession, sale, delivery and transfer of any prohibited or unauthorised article, the use and abuse of drugs (defined in article 12 of the Dangerous Drugs Ordinance or any specified or restricted drug under the Medical and Kindred Professions Ordinance) or alcohol, that are unlawfully in the inmates possession. Punishments in this regard usually range from the loss of certain inmate benefits to extended periods of imprisonment. This legislation and the **Prisons Act (Cap 260)** also

regulate the proper conduct of the Director of Prison, the Prison Officers and the Board of Visitors.

**Legal Notice 99 of 1996** concerns Prescribing and Dispensing of Methadone Rules and deals with regulating methadone dispensing. In Malta only designated practitioners (or dental surgeons) authorised to work in a designated clinic<sup>4</sup> can issue prescriptions for methadone, and only in mixture form or as linctus. The subsidiary legislation deals with the registering of persons under treatment, responsibility for stocks, restricted importation, prescription and dispensing of methadone. The legislation also includes the prescription for pethidine.

**Legal Notice 150 of 2004** concerning Substances Used in the Illicit Manufacture of Narcotic Drugs and Psychotropic Substances Rules deals with the regulation and specific requirements of authorised substances for export and unusual orders and transactions involving scheduled substances, which suggest that such substances intended for import, export or transit may be delivered for the illicit manufacture of narcotic drugs or psychotropic substances.

**Legal Notice 13 of 1985** concerning the Registration of Drug Addicts Regulations states that every practitioner must notify the Superintendent of Public Health, who keeps the 'Register of Addicts', of every patient under his care who is suffering from any form of addiction or dependence on any drug, and of any types of drugs or medication prescribed to such patients.

## **1.2. Institutional framework, strategies and policies**

The set up of the Institutional Framework concerning the Ministry for the Family and Social Solidarity and other Ministries involved in dealing with the drug situation is presented in Table 1. There have been no major changes in the political and administrative framework in the reporting period. During 2004 the National Commission on the Abuse of Drugs, Alcohol and other Dependencies in liaison with the Policy Directorate within the Ministry for the Family and Social Solidarity began a series of

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<sup>4</sup> Designated clinic means a clinic in a government hospital or a clinic designated by the Superintendent of Public Health for the treatment of methadone of drug addicts of other persons needing that drug for a period in excess of 2 weeks

preliminary meetings with the objective of drafting up the first National Drug Policy for Malta.

**Ministries and Departments Involved in the Responses to the Drug Situation**

Ministry for the Family and Social Solidarity	Ministry of Health, the Elderly and Community Care	Ministry of Justice and Home Affairs	Ministry of Finance	Ministry for Investment, Industry and Information Technology	Ministry for Education Youth and Employment
National Drug Agency Sedqa  Subsidised NGO's: Caritas and Oasi  National Commission on the Abuse of Drugs, Alcohol and other Dependencies  National Focal Point for Drugs and Drug Addiction	State Hospitals  Dept. Public Health  Dept. Health Information  Toxicology Laboratory	Police Force  Law Courts  State prison (CCF)  Pre-release Programmes including The Substance Abuse Therapeutic Unit (SATU)	Customs Department	Malta National Laboratory including Forensic Laboratory	Employment and Training Corporation  Student Services Department – Safe Schools Programme

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

**1.3. Budget and public expenditure**

No new information.

**1.4. Social and cultural context**

No new information.

## Chapter 2. Drug use in the Population

### 2.1 Drug use in the general population

The primary source of information with regards to drug use in the general population in Malta is the General Population Survey. To date, only one such study has been conducted. This study dates back to 2001 and the main results were presented in the 2004 National Drug Report. While general population surveys offer estimates on prevalence of illicit drug use among the general population, they do not provide useful estimates on problem drug use, as generally, these specific groups are not captured by such surveys.

*“Despite the importance of such information, data on drug misuse is often fragmented, ranging from local studies of problematic drug use, such as heroin injecting, through to national surveys providing information on levels of drug use, particularly by younger people. While such surveys have provided valuable information on the prevalence of certain kinds of drug misuse e.g. cannabis, ecstasy, hallucinogens, they are less suited to estimating prevalence at the more problematic end of the spectrum, particularly at the local level”* (Kraus et. al., 2002). Estimates on more problematic drug use therefore will be tackled separately and are provided in Chapter 4 of this report.

The population survey 2001 was the first study on the use of licit and illicit drugs among the general population of Malta. The ESPAD survey conducted among 15-16 year olds in 1995, 1999 and 2003, the Health Behaviour Survey in School-Aged Children (HBSC)<sup>1</sup> aged 11-15 years in 2001/2002 and the first National Health Interview Survey<sup>1</sup> in adults aged over 16 in 2002 are also other National independent studies that look at drug use patterns among the Maltese school, youth and adult population.

As regards the Population Survey 2001, the target population was the general population of Malta aged between 18 and 65 years old. As a sampling frame the National Electoral Register was used. From this register a random sample of persons stratified by the 68 local councils was drawn – the age group 18-24 years, 6 selected

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<sup>1</sup> The data from these surveys, which is consistent with that obtained from the General Population Survey 2001 was presented in the 2004 National Report on the Drug Situation in Malta

local councils of Malta and all local councils of Gozo were over sampled. The total sample consisted of 2828 persons<sup>2</sup>. Face to face interviewing was used and the total response rate was 65.8%, which is quite high compared to general population surveys in other European countries. Validity was tested by including 'dummy drug questions', and an 'honesty question' with only 2% reporting to have ever heard of the dummy drug 'relewin', 0% reporting to have ever used that drug and 0.2% giving an answer to the honesty question that was inconsistent with their self-reported drug use. Validity was also tested by comparing self-reported age at the time of interview with the officially recorded year of birth and by comparing self-reported age of first drug use with actual age. Only 2% reported an erratic year of birth and less than 1% reported to have used one or more substances for the first time when they were older than their current age.

According to the results of the Population Survey, the self-reported use of illicit drugs in 2001 was much lower than most other European countries. It was estimated that lifetime use of cannabis amongst the Maltese Population aged 18-65 years was 3.5%. This figure is somewhat increased if one takes the age group 18-24 years and 18-34 years where it rises to 5% and 4.8% respectively. First use of cannabis amongst the 18-34 year cohort was around 16 years, which is in accordance with what is found in school surveys. With regards to the use of other illicit substances such as ecstasy, LSD, amphetamines, cocaine and heroin, 1.2% of the population in 2001 said that they had tried these drugs at least once, this figure increased slightly to over 2% in both the 18-24 and 18-34 year cohort.

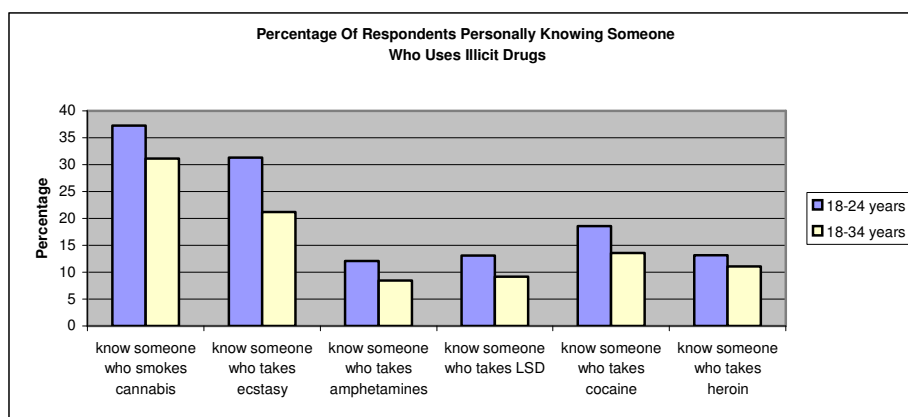
Trends in drug use cannot be presented, as this was the first and only population survey. A problem encountered in the population survey was that the results of the study were most likely an underestimate of 'actual' drug use among the general population of Malta. This stems from the fact that the figures estimated for drug use in the population survey were low when one compares them to the number of clients who were in treatment for drug addiction in Malta in 2001. Secondly, life time use of cannabis in 15-16 year olds as recorded in the 1999 ESPAD survey, was 2 percentage points higher than that of 18-24 year olds recorded in 2001. Moreover, a consistency check revealed that in the Population Survey, around 15% of those who responded that they never used an illicit drug also responded that they were not sure they would have admitted to doing so, even

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<sup>2</sup> Total population of Malta aged 18-64 = 242387 (December 1999 figures)

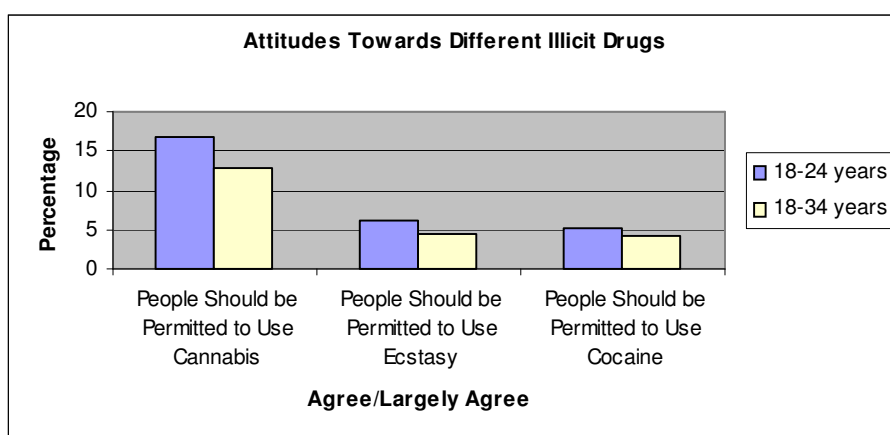


if they did. Also percentages to the question 'do you personally know somebody who uses illicit drugs' were somewhat higher than questions directed to the respondent's own personal use. (Figure 2.1). Malta is a small country, where many people are of the opinion that 'everyone know everyone'. Additionally, the legal and social implications of drug use in societies with restrictive drug laws like Malta, could affect the respondents' willingness to be open about their personal drug use, but less so of others. Taking the most commonly used illicit drug cannabis, further analyses revealed that 17% of those who responded that they did not smoke cannabis, personally knew someone who did.

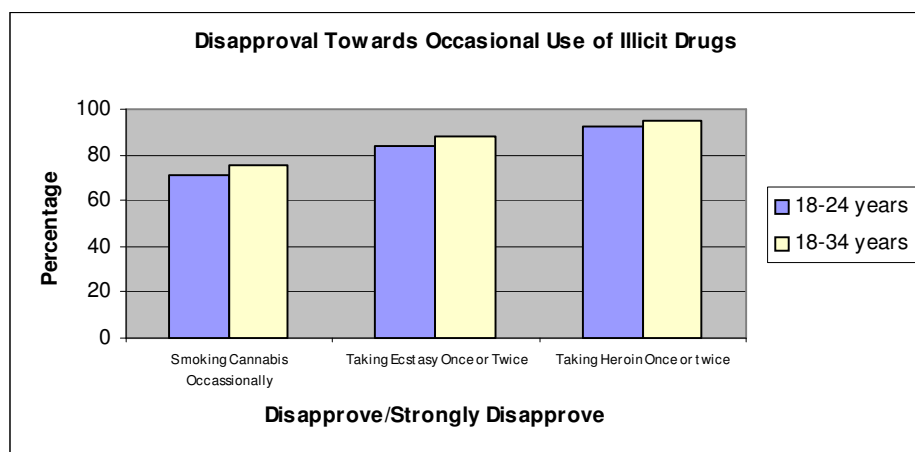


**Figure 2.1. Percentage of Respondents Personally Knowing Someone Who Uses Illicit Drugs**  
Source: Population Survey 2001

Overall attitudes to drug use among 18-24 year olds and 18-34 year olds were nonetheless indicative of a general disapproval towards using illicit drugs, less so in the case of cannabis (Figures 2.2 and 2.3).



**Figure 2.2. Attitudes Towards Different Illicit Drugs**  
Source: Population Survey 2001



**Figure 2.3. Disapproval Towards Occasional Use of Illicit Drugs**  
Source: Population Survey 2001

With regards to alcohol use 75.6% of respondents reported to have drunk alcohol at least once in their lives with 69.3% and 56.2% reporting to be recent and current drinkers respectively. These figures increase when taking the 18-34 year old cohort, with 83% reporting to have ever drunk alcohol, 78% reporting to have drunk in the last year and 65% in the last month. Whereas 47.9% said that they drunk alcohol at least once a week, 24.1% admitted to drinking alcohol several times a week or daily. The high rates of alcohol use amongst the Maltese population are now widely known and studies have shown consistently that this phenomenon is not on the decrease (ESPAD 1995, 1999, 2003, Population Survey 2001, Health Behaviour in School Aged Children Study 2001/2002).

As stated previously, the main public debates on the results of the 2001 Population Survey revolve primarily around low percentages of people admitting to having used illicit drugs. In particular, the media, newspaper columnists, treatment staff and other experts seem to highlight the fact that drug use, in particular cannabis, ecstasy and cocaine use is perceived as being more widely used than depicted by the results of the survey. In fact, the perceived availability of illicit drugs amongst 18-24 year olds and 18-34 year olds is also fairly high when placed in the context of low drug use prevalence obtained from this survey. Figure 2.4 shows the percentage of those who responded that drugs were either easy or very easy to obtain.

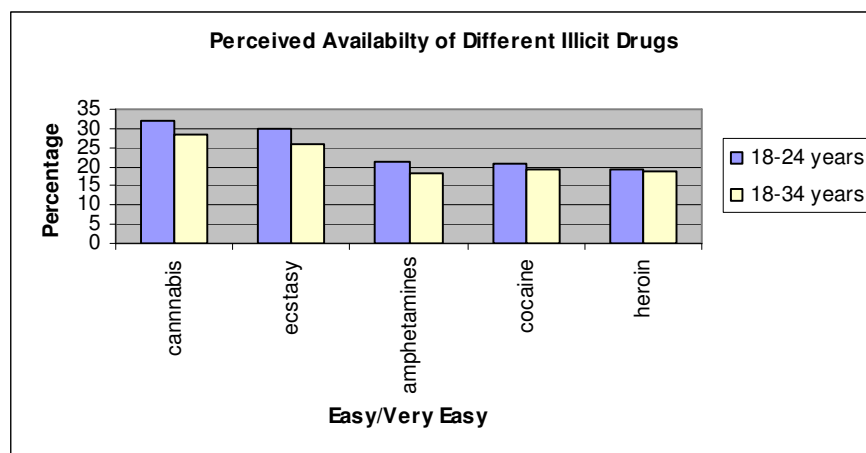


Figure 2.4. Perceived Availability of Different Illicit Drugs  
Source: Population Survey 2001

All told, the results from the Population Survey 2001 can be interpreted in two ways:

1. If the results are to be accepted as reliable estimates of drug use in the general population, this would imply that illicit drug use in Malta is not wide spread throughout the whole population but is limited to certain groups within specific age cohorts and concentrated in a number of areas, venues and social gatherings. The results of other surveys that have been conducted independently over the years all show similar findings, in that illicit drug use in Malta is low compared to other European countries, both in children and adolescents (ESPAD 1995, 1999, 2003; Health Behaviour in School Aged Children Study 2001/2002) and amongst the adult population (National Health Interview Survey 2002; Population Survey 2001).
2. If the results of the survey are somewhat underestimates, due to people's reluctance to respond truthfully about their personal drug use, then illicit drug use in Malta can be assumed to be slightly more widespread.

## 2.2 Drug use in the School/Youth Population

The latest available information for Malta on drug use amongst school age children is the ESPAD 2003 study. The results of this study, as well as the results from the two

previous ESPAD studies (1995 and 1999) were presented in detail in the 2004 National Report on the Drug Situation in Malta. The results of the ESPAD surveys have shown an overall increase in drug use among 15-16 year olds from the first survey conducted in 1995 to the last one conducted in 2003 (Figures 2.5 and 2.6).

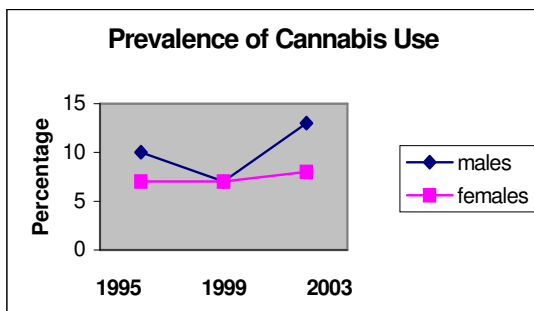


Figure 2.5. Prevalence cannabis use 15-16 yr olds  
Source: ESPAD 1995, 1999, 2003

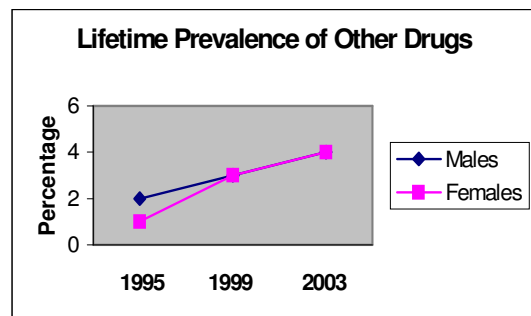
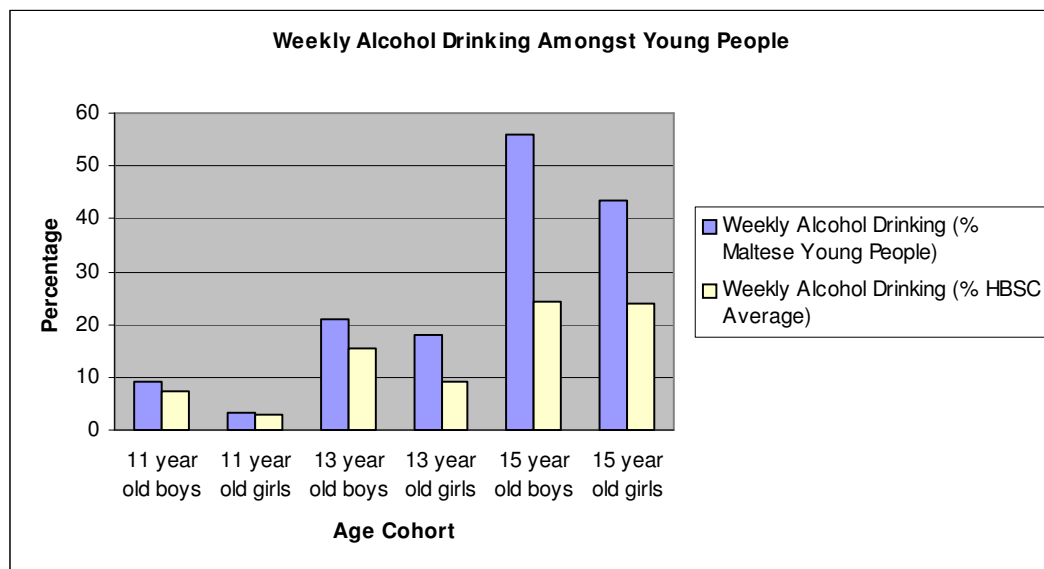


Figure 2.6. Lifetime Prevalence of Other Drugs 15-16 yr olds  
Source: ESPAD 1995, 1999, 2003

Lifetime prevalence or 'experimentation' of cannabis use and other illicit drugs in the ESPAD 1999 survey was 7% and 3% respectively. Last month use or 'more frequent use' of cannabis was 3%, whereas illicit drugs were not used more than twice in a lifetime by those admitting to having used these substances. The 2003 ESPAD data shows a slight increase in illicit drug use amongst this cohort, with lifetime prevalence and last month prevalence of cannabis standing at 10% and 4% respectively. There was no increase in the frequency of last month use of other illicit drugs between the two reporting periods. It appears that although cannabis use amongst 15-16 year olds increased by 3% between the 1999 and 2003 study, Malta still fairs favourably compared to other European countries, which register an average usage of around 10%.

On the other hand, alcohol is clearly the most widely used substance among this cohort, with 94% admitting to have consumed alcohol at least once in their lives. The rate of continuation is also high as revealed by the 75% of those who admitted to having drunk alcohol in the last month and 50% admitting to have drunk five or more drinks in a row during the last month prior to the survey. The overall results of the ESPAD 2003 study point towards the fact that Maltese students drink frequently and also binge-drink to the point of intoxication. The results from the World Health Organisation (WHO) Health Behaviour in School-aged Children study (HBSC) 2001/2002 also revealed remarkably

high percentages of recent alcohol use, especially among 15 year olds in Malta, compared to other European countries (Figure 2.7).



**Figure 2.7. Weekly Alcohol Drinking Amongst Young People**  
Source: Health Behaviour in School-Aged Children Study 2001/2002

Other studies that attempt to understand the patterns of substance use (in particular illicit substances), attitudes and life styles among young people aged over 16 years are certainly needed in Malta. One such study is currently being planned. This study, which will use the European Model Questionnaire as a measure of drug use behaviour, aims to target tertiary education students, and will be the work of a joint effort between Sedqa, the National Agency for Drug Abuse, the National Commission on the Abuse of Drugs Alcohol and Other Dependencies (NCADAD) and the National Focal Point for Drugs (NFP). The data and information obtained from this study will also be used as a basis for future prevention activities targeting this population

#### *Rationale of the Study*

The need has long been felt to acquire a better understanding of the behaviour and attitudes towards legal and illegal substances among young people aged 18-24 years – a cohort where prevalence rates of drug use are highest. While it is difficult to access the whole population of youth, an initial survey targeting a representative sample of youth in secondary and tertiary full time education has been proposed.

### *Aims of the Study*

The main aims of this survey are to obtain reliable and comparable information on:

- Extent and patterns of consumption of different substances among the student population aged 18-24 years.
- Characteristics and behaviours of users and non users among this cohort
- Attitudes of this cohort towards tobacco, alcohol, and drug use.

### *Sample Population*

The target population will be full-time regular students attending post-secondary and tertiary level institutions in Malta and Gozo.

## **2.3. Drug use among specific groups**

No new information available

## **2.4. Attitudes to drugs and drug users**

No new information available

## **Chapter 3. Prevention**

Overall, drug prevention activities in Malta have not changed much from what was reported in the 2004 National Report. The key players in this area remain primarily the National Drug Agency Sedqa, and the voluntary organisations Caritas and Oasi. As stated in the 2004 annual report, Sedqa's universal prevention activities are aimed at targeting children, youth, parents and teachers, mainly through school based initiatives and also youth and parents through community based initiatives, in liaison with some parishes and youth centres. Workplace based programmes also form part of their universal prevention programmes. Similarly, Caritas provide prevention programmes targeting children, youth, parents and teachers in a number of schools and parishes. The Oasi Foundation in Gozo conducts prevention activities targeting schools and the community specifically for the island of Gozo.

Another division that has been involved in prevention work since the year 2000 is the Anti Substance Abuse Unit, which forms part of the Safe Schools Programme, an initiative stemming from the Education Division. This programme shall be discussed in more detail under section 3.1.a.

### **3.1 Universal prevention**

#### **3.1a School-based programmes**

As stated in the National Report 2004, school-based prevention programmes in Malta range from Year 1<sup>1</sup> to Form 6 and aim at targeting students, teachers and parents. A substantial amount of school-based prevention programmes are based on a cross-curricular approach, involving the education system, which assists in the delivery of programmes. Drug, alcohol and tobacco topics are incorporated in the Personal and Social Development (PSD) curriculum in all Maltese schools. This approach results in a substantial amount of material distributed to all schools, however the frequency with which these programmes are implemented as well as the number of schools and students targeted remain unknown.

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<sup>1</sup> Year 1 to Year 6 Primary School = Ages 5-11; Form 1 to Form 5 Secondary School = Ages 11-16; Form 6 = Ages 17 & 18.

One change that occurred in 2004 as a result of this problem was that of increasing the number of 'teachers on loan' who deliver such programmes, as opposed to the delivery of the programme by 'school or subject teachers'. Additionally slightly more emphasis has been given to targeting vulnerable schools. One area that still calls for a more coordinated effort however is that of evaluation. To date, no evaluation of the ongoing prevention programmes have been conducted, and therefore we do not really know the extent of their effectiveness.

In the case of other types of programmes, those delivered directly by the prevention staff (Sedqa, Caritas, Oasi and the Safe Schools Programme which falls under the education division) we do know how many schools and persons are being reached, however as stated previously, most programmes lack clear evaluation indicators and evaluation tools and none of them have any evaluation results. Moreover, although a huge amount of work is being directed at implementing school-based prevention programmes by all the agencies, it remains very difficult to ascertain whether certain groups are being over targeted, under targeted or not targeted at all. In view of these problems, a focus group has been formed, involving the key players in prevention work. The aim of this focus group is to assess the current situation with regards to prevention work in Malta and Gozo, identify objectives and target groups of each programme both within and across agencies, and define specific indicators and common working methodologies in order to be able to effectively monitor and evaluate core programmes.

An overview of the different prevention programmes implemented by the agencies and the Education Division in primary and secondary schools<sup>2</sup> in Malta in 2003/ 2004 is presented in table 3.1

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<sup>2</sup> Primary Schools in Malta: N = 83; Pupils in academic year 2003/4= 31,064 (excludes pre-school level).  
Secondary Schools in Malta N = 48; Pupils in academic year 2003/4 = 29,540 (Source: National Statistics Office)



### Primary and Secondary Schools Prevention Activities 2003 and 2004

PRIMARY SCHOOL PROGRAMS				2003	2004	2003	2004
	Years	Agency	Delivery	Schools	Schools	Pupils Reached	Pupils Reached
TFAL (CHILDRENS PROGRAM)	2 - 6	SEDQA	Teachers & PSD	All	84	24,000 (books)	16,728 (books)
BABES	3	SEDQA	Prevention Staff	61	87	4,100	4,406
SKOLA SAJF (SUMMER SCHOOL)	4,5,6	SEDQA	Prevention Staff	14	19	700	830
VULNERABLE schools		SEDQA	PSD/Teacher on loan	5	4	Not Known	43
FOLLOW UP TO BABES	5	SEDQA	PSD/Teacher on loan	N/A	24	N/A	879
FOCUS	6	CARITAS	Prevention Staff	7	7	630	325
TRUST/ASK SPRINGBOARD	4,5,6	OASI	Prevention Staff	15	15	1631	1610
Other Programmes				2003	2004	2003	2004
	Target Group	Agency	Delivery	Courses	Courses	No. Reached	No. Reached
Parental Skills	Parents	SEDQA	Facilitators	21	27	400	452
Babes Parents Programme	Parents	SEDQA	Prevention Staff	58	87	400	2341
Zazu 'puppet' Visits	Students	SEDQA	Prevention Staff	27 visits	34 visits	Not Known	Not Known
Exhibitions		SEDQA	N/A	35	N/A	Not Known	N/A
Teacher Training	Teachers	SEDQA	Prevention Staff	2	8	30	120
Parents meetings	Parents	SEDQA	Prevention Staff	N/A	35	N/A	828
Parental skills facilitator training	Facilitators	SEDQA	Prevention Staff	3	1	13	12
Parental Skills Courses	Parents	CARITAS	Facilitators	6	10	180	300
Drug Information Talks	Parents	CARITAS	Facilitators	Not Known	10	260	350
SECONDARY SCHOOL PROGRAMS				2003	2004	2003	2004
	Years	Agency	Delivery	Schools	Schools	Pupils Reached	Pupils Reached
JEANS	1,2,4	SEDQA	PSD & Subject Teachers	All	Phased out	10,400 books	N/A
FOCUS	3,4	CARITAS	Prevention Staff	6	3	108	335
STUDIO 4.5	4,5	OASI	Prevention Staff	4	4	1580	1154
Vulnerable Schools	girls&boys schools	SEDQA	PSD/Teacher on loan	4	Not Known	1800	Not Known
Secondary School Programmes	1-3(selected schools)	SEDQA	Prevention Staff	28	125	565	2110
Students seminars	3	education division	Safe schools focal persons	N/A*	14	N/A*	1200 (10 referrals made to drug agencies)
Students seminars	4	education division	Safe schools focal persons	N/A*	10	N/A*	960 (13 referrals made to drug agencies)
Students seminars	5	education division	Safe schools focal persons	N/A*	12	N/A*	1500 (4 referrals made to drug agencies)
Students seminars	2	education division	Safe schools focal persons	N/A*	1	N/A*	100
Students seminars	1	education division	Safe schools focal persons	N/A*	1	N/A*	120
Students seminars	mixed years	education division	Safe schools focal persons	N/A*	1	N/A*	12
Other Programmes				2003	2004	2003	2004
	Target Group	Agency	Delivery	Courses	Courses	No. Reached	No. Reached
Parental Skills	parents	SEDQA	trained facilitators	37	Not Known	572	Not Known
Interpersonal skills	students	SEDQA	prevention staff	4	2	90	33
Prefects course	school prefects	SEDQA	prevention staff	13	12	150	547
Info & awareness seminars	students	SEDQA	prevention staff	28	57	565	1421
Life force international	students	SEDQA	canadian musical grp	30	44	3900	4160
Staff development programmes	teachers	SEDQA	prevention staff	4	6	125	178
Peer leadership course	students	SEDQA	prevention staff	6	Phased out	150	N/A
Students Talks	students	SEDQA	Prevention Staff	N/A	49	N/A	1418
Boys&Girls Secondary Schools course	students	SEDQA	Prevention Staff	105	N/A	1800	N/A
Parental Skills	parents	CARITAS	facilitators	8	4	240	120
Peer leadership course	students	CARITAS	facilitators	14	14	510	520
Drug Information Talks	parents	CARITAS	facilitators	5	8	350	850
Oasi.com@school	students	OASI	bimonthly news letter	N/A	N/A	N/A	1874
Introductory Sessions MCAST	all upper secondary	OASI	Prevention Staff	N/A	7	N/A	700
Parents meetings	parents	education division	SAFE staff	N/A*	26	N/A*	1300
Staff meetings	School staff	education division	SAFE staff	N/A*	12	N/A*	700

\*N/A as data was not collected from this unit in 2003

**Table 3.1 Overview of primary schools and secondary schools prevention programmes**  
**Source: Caritas, Sedqa, Oasi and SAFE prevention division reports 2003 and 2004**

### The Education Division's Anti Substance Abuse Unit

The Anti Substance Abuse Unit falls under the Education Division's Safe School's programme, which also incorporates an Anti Bullying Unit and a Child Safety Service. The unit responsible for tackling substance abuse offers a school-based programme, and technically could also fall under the section selective prevention as it offers assistance to schools whenever cases of alleged substance abuse occur, providing technical advice on matters related to policy and procedures regarding referrals due to substance use. In 2001, The Ministry of Education, Youth and Employment, Sedqa the National Agency for Drugs and the Malta Police Force devised a national policy titled 'Tackling Substance Abuse in Schools' (Ministry of Education Youth and Employment, Education Division, 2001). The policy was drafted and implemented in order that schools identify and formulate relevant procedures should substance abuse occur on their

premises. The provisions of this policy apply to all educational establishments in Malta and Gozo that cater for students up to the age of 18 years, including those providing residential care facilities for minors. This policy forms an integral part of the service provided by the Substance Abuse Policy Team, whose aim is to strike a balance between the needs of the alleged user and the safeguarding of the school. Interventions provided by this team include assisting individuals who are allegedly abusing or are at risk of substance abuse. The process of intervention involves an array of *indirect* and/or *direct* strategies. Indirect intervention may include classroom sessions, fora, seminars, staff development meetings, in-service training and other preventive work. Direct strategies involve sessions with abusers, parents and staff concerned with the individual case and referrals to other agencies if necessary. Participating together with Sedqa and the PSD/Guidance team, the aim of this unit is twofold: to focus on those students mostly at risk and to be pro-active in promoting healthy lifestyles. Activities are directed towards students, parents and teachers.

### 3.1b Community-based Programmes

Community-based initiatives also have not changed much over the last year and consist primarily of projects that target the family and youth in settings such as social environments, religious societies, clubs as well as some local councils (Table 3.2). Some 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 conducted independently by the agencies Sedqa, Caritas and Oasi also liaise with local councils and parishes in organising parental skills courses, peer leadership courses, drug and alcohol information seminars, and also training courses for young people and adults who would like to offer their services within their local community.

Prevention work in this area seems to aim at securing and enhancing healthy lifestyles amongst those people who are already functioning reasonably well in society. These teams are also making themselves accessible to those families and individuals who may need help or who may wish to approach the agency if needed.

**Community-based Activities 2003 and 2004**

Activities	Target Group	Agency	Delivery	2003 No. Activit	2004 No. Activit	2003 No. Reached	2004 No. Reached
Parental Skills	parents	CARITAS	Trained facilitators	10	8	320	240
Parental Skills	parents	OASI	Trained facilitators	Not Known	N/A	299	N/A
Community/Church Activities	youth/adults	SEDQA	Trained facilitators	30	40	Not Known	1255
Drug Awareness Seminars/Talks	General Public	all agencies	Trained facilitators	Not Known		Not Known	
Alcohol Free Parties	teens	CARITAS		2	2	650	650
Exhibitions	youth/parents	SEDQA	Prevention staff	12	Discontinued	Not Known	N/A
OK Club	Pre teens	OASI	Prevention staff	12	14	146	576
Drug Free Marches	General Public	CARITAS		Not Known		Not Applicable	
Grants to comm-based initiatives	General Public	SEDQA		13grants	13grants	Not Applicable	
Live In Week Ends	Teens	OASI	Prevention staff	2	N/A	157	approx 2000
Summer concert 'Riflessi Sajfin'	General Public	OASI	Prevention staff	1	N/A	Gen. Public	N/A
Youth of the Year Award	General Public	OASI	Prevention staff	1	1	Gen. Public	200
Youth Club Activities	ZEST youth group	CARITAS	Trained facilitators	8	10	300	400
Other Events	General Public	OASI	Oasi Staff	N/A	4	N/A	around 2000
Youth Activities	Youth	OASI	Youth	N/A	16	N/A	147

**Table 3.2. Community-based prevention activities 2003 and 2004**  
**Source: Caritas, Sedqa and Oasi Prevention Division Reports 2003 and 2004**

**3.1c Workplace-Based Programmes**

The aim of work-place based prevention programmes is to provide information to managers and employees on 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. Table 3.3 provides a summary of the activities conducted in 2003 and 2004. Most of the programmes delivered to organisations consist of exhibitions, training on how to identify the signs and symptoms of drug use, information on drugs and drug use behaviour, and also meetings with some organisations aimed at developing work place based policies on drug use and abuse.

**Work-Place Based Prevention Activities 2003 and 2004**

Programme	Target Group	Agency	Delivery	2003 No. of Pgm's	2004 No. of Pgm's	2003 No. Reached	2004 No. Reached
SAFE	organisations	SEDQA	Prevention staff	18	20	Not Known	
	managers	SEDQA	Prevention staff	21	9	456	141
	employees	SEDQA	Prevention staff	40	78	945	1531
	organisations	SEDQA	Inhouse publications	N/A	N/A	N/A	N/A
Employees Assistance Program	organisations	CARITAS	Prevention staff	2		120	

**Table 3.3. Work-Place based prevention activities 2003 and 2004**  
**Source: Caritas and Sedqa prevention division reports 2003 and 2004**

**3.1d Media-based programmes**

The Sedqa, Caritas and Oasi Prevention Divisions make extensive use of the media to reinforce health-oriented attitudes. There are a wide range of activities that all three agencies participate in across the span of one year, ranging from information and discussion programmes both on radio and TV to the production of other programmes in collaboration with the national and private radio and TV stations. Other activities include

newspaper articles, the production of posters, leaflets, street billboards and other material conveying prevention messages as well as Webpages<sup>3</sup> providing information on various drug and alcohol related topics and services. The main messages conveyed are those promoting healthy life styles, providing information to the general public about the dangers associated with drug use in general and providing information about problematic drug use and where and how to get help if needed.

### 3.2 Selective/indicated prevention

Selective prevention in Malta is conducted 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 include individual counselling, either as follow-up of programme-based (school, community, work-place) activities or as 'outreach' contacts at locations frequented by youth, where drugs are known to be available. An overview of activities in 2003 and 2004 is presented in table 3.4 and shows that in practice the main target groups seem to be youth in vulnerable schools and as of 2004, also juvenile inmates in prison settings. The Oasi Foundation in Gozo has implemented some individual interventions through their 'immediate intervention service'. These interventions mainly cater for self-referred clients as opposed to clients reached through outreach work.

**Selective/Indicated Prevention Activities 2003 and 2004**

Name of Programme	Type of Intervention	Target group	Agency	Delivery	Number of Schools 2003	Number of Schools 2004	Persons reached 2003
STORM	Tailor made sessions for High Risk Schools	Forms 3 & 4	SEDQA	Prevention Staff	Not known	13	889
STORM	Tailor made sessions for High Risk Schools	Post Secondary Schools	SEDQA	Prevention Staff	Not known	6	1009
STORM	Tailor made sessions for High Risk Schools	Other Institutes	SEDQA	Prevention Staff	N/A	N/A	116
	Individual Interventions	Students	SEDQA	SEDQA	N/A	N/A	271
Immediate Intervention	Individual Interventions	All	OASI	OASI	N/A	N/A	103
	Type of Intervention	Target group	Agency	Delivery	Courses 2003	Courses 2004	Persons reached 2003
YOURS with CCF	Tailor made sessions for young prisoners	Juvenile Prisoners	SEDQA	Prevention Staff	N/A	once a week	all inmates at YOURS
Youth Centres		youth	SEDQA	Prevention Staff	N/A	on request	N/A
Summer Camp		youth	SEDQA	Prevention Staff	N/A	N/A	N/A
Residential Homes	Visits	youth	SEDQA	Prevention Staff	N/A	on request	N/A

**Table 3.4. Secondary prevention activities 2003 and 2004**  
Source: Sedqa and Oasi Secondary Prevention Division reports 2003 and 2004

Although selective prevention does take place in Malta, more outreach work is required in order to reach the more vulnerable or 'difficult to reach' target persons, groups or families. The data on problem drug use in chapter 4 is indicative of a substantial heroin problem in Malta, one that does not seem to be on the decline. More proactive outreach work is needed, possibly incorporating harm reduction approaches in settings and towns

<sup>3</sup> Treatment Centres Web Pages: [www.sedqa.org.mt](http://www.sedqa.org.mt) [www.caritasmalta.org](http://www.caritasmalta.org) [www.oasi.org.mt](http://www.oasi.org.mt)

where problem drug use, crime and poor social conditions are known to be prevalent. Also data from surveys is indicative of the fact that substance use in general is most prevalent between those aged 18-24 years. More dedicated efforts targeting specific recreational settings or open drug scenes targeting this age group are needed; efforts that could address issues such as personal safety, public drug taking, drug-related intoxication, dealing, crime committed under the influence of drugs, as well as intrusive contact from users and their proximity to youngsters or under age youth.

### Future Plans

A new programme in development by the agencies Sedqa and APPOGG (a service that targets many sectors in the community, with particular emphasis on children) aimed at addressing the complex problems of 13-18 year olds and their significant others. This programme, which is due to commence in 2006 is not an exclusive programme for young persons misusing substances, but all-inclusive. It is planned to run three afternoons/evenings weekly so as not to disrupt those who are still of school age. Each participant will be appointed a key worker and will attend weekly sessions for approximately fifteen weeks. Apart from the core programme that will be based on group work (including building on the strengths and addressing vulnerabilities, improving skills, exposure to new activities), there will be ongoing parallel treatment in the form of psychological interventions, medical assessments and family therapy. Each programme will cater for up to eight participants, the progress of the individual participant will be monitored continuously through a tool that will include the views of the parents/caregivers, the key workers/other professionals and those of the participants themselves. The prospective candidates for this programme are expected to be referred from within Sedqa and APPOGG, seeing that both agencies have an existing case load of young persons who require more intense, age appropriate and comprehensive treatment than traditional case work and present resources permit. External referrals will also be welcome but should be channelled through the usual intake procedures of Sedqa/APPOGG, depending on the presenting problem. Funding for the programme has been approved.

### **3.3 Research and Data Analysis**

#### Data Analysis

As stated in the 2004 annual report, research on the impact and effectiveness of prevention activities in Malta has not been conducted. Evaluations by the respective agencies in the form of satisfaction questionnaires following the completion of a specific programme, are administered and evaluated internally. Also, limited evaluation indicators are incorporated in some of the prevention programmes, however, a lack of trained personnel in this area has meant that the evaluative part of these programmes has not taken place. To date, Malta still does not have a global picture on the overall impact and reach of its prevention programmes.

#### Research

One ongoing effort that can be linked to prevention work is the 2003 risk/resiliency longitudinal study that is being conducted by Sedqa and the Youth Studies Programme at the University of Malta with adolescents aged 11-12 years. This study was initiated as a means of investigating the risk and protective factors associated with substance use among Maltese youth with one aim of providing local data to policy makers that will serve as the basis for reviewing and implementing new prevention programmes or studies. Since this study is still ongoing, the data cannot be presented.

## Chapter 4. Problem Drug Use

### 4.1. Overview

Drug abuse has a wide range of definitions, all relating to the use, misuse or overuse of a drug for non-therapeutic effects. Drug addiction has two components: physical and psychological dependency. Physical dependency occurs when a drug has been used habitually and the body has become accustomed to its effects. The person must then continue to use the drug in order to feel normal, or its absence will trigger the symptoms of withdrawal. Psychological dependency occurs when the mind has become emotionally reliant on the drug's effects, either to elicit pleasure or relieve pain, and does not feel capable of functioning without it. Its absence produces intense cravings, which are often brought on or magnified by stress. A dependent person may have either aspects of dependency, but often has both.

Most persons who try drugs, either experimentally or recreationally do not in the main experience serious problems, however, a small but significant minority does. Problem drug users are those persons who are experiencing social, psychological, physical or legal problems related to their regular self-administration of drugs. Any form of injecting drug use is also considered problematic.

Defining problem drug use according to the European Monitoring Centre for Drugs And Drug Addiction (EMCDDA) definition for the purpose of calculating prevalence estimates

Estimating the prevalence of problem drug users in a country leads to numerous discussions as to what exactly constitutes a problem drug user. Work on prevalence estimates of any behaviour in a population, involves both direct and indirect methods. In the case of drug use behaviour, direct methods such as population or household surveys, provide valuable information for monitoring overall drug using behaviours among the general population, and may also shed light on regular use. However, direct methods are not effective enough to measure the prevalence of **more problematic forms of drug use**, for reasons pertaining to the fact that problematic users are often not captured by such surveys. For this reason, indirect methods have been developed to focus specifically on this particular group of users. Indirect methods start with data sets from a number of sources, for example different treatment centres, and seek by a variety

of different techniques to estimate the **hidden unknown number** and consequently the **proportion of the total problematic drug using population** represented by this data set. In Malta the capture-recapture method was adopted (as described in Hay et. al., 1999). Since the vast majority of clients in treatment are heroin users (86%), our definition of problem drug use is 'daily heroin users'. This definition is consistent with the European methodology, and allows for a meaningful comparison to be made both on a national, as well as on an international basis.

#### **4.2 Prevalence estimates of problem drug use (as per EMCDDA definition)**

Using the capture-recapture methodology to estimate the prevalence of problem drug users (as per the EMCDDA definition), the collected data concerned 2004 active clients, registered as 'daily heroin users', attending the centralised detoxification/substitution unit (Sedqa's Substance Misuse Outpatient Unit, SMOPU) and two outpatient community services (Caritas and Oasi). The central estimate stood at 1597 problem heroin users, (range: 1497-1723), resulting in a rate of 5.8 (range: 5.4 - 6.2) per 1000 persons aged 15-64 years<sup>1</sup>. This estimate seems plausible due to the fact that in Malta the methadone dispensing unit is centralised, and treatment is generally highly accessible with little or no waiting time at all. In 2004 there were approximately 1100 'known' daily heroin users in treatment. The estimate points towards the 'unknown daily heroin using population' standing at around 500-600. These absolute figures may seem moderate, however compared to other European countries Malta's rates, 6 per 1000 of the population, rank on the high side (range 1-10 per 1000), indicating that heroin use is still a major problem for a small country like Malta.

Reliable prevalence estimates using capture-recapture are arduous to produce due to the number of methodological problems which arise in relation to its application, therefore the figures obtained are conclusive to a limited extent only and any results are rough approximations which must be interpreted with caution. The main limitation with regards to the 2004 estimate for Malta is due to the lack of independence between data sets, which is a violation of one of the three main assumptions related to capture-recapture method, namely: independence, homogeneity and closed population.

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<sup>1</sup> 2004 Population of Malta aged 15-64 years = 276453 (based on mid-year population 2004)  
Source: Malta National Statistics Office



#### 4.3a Profile of clients in treatment by substance used

This section and the sections that follow in this chapter highlight the characteristics and profiles of all clients in treatment in 2004, first ever treated clients in 2004 and the profiles of clients by centre types. This means that these sections **will not be limited to the EMCDDA ‘Problem Drug Use’ definition** as described in section 4.2, but will cover the whole range of clients in treatment in 2004.

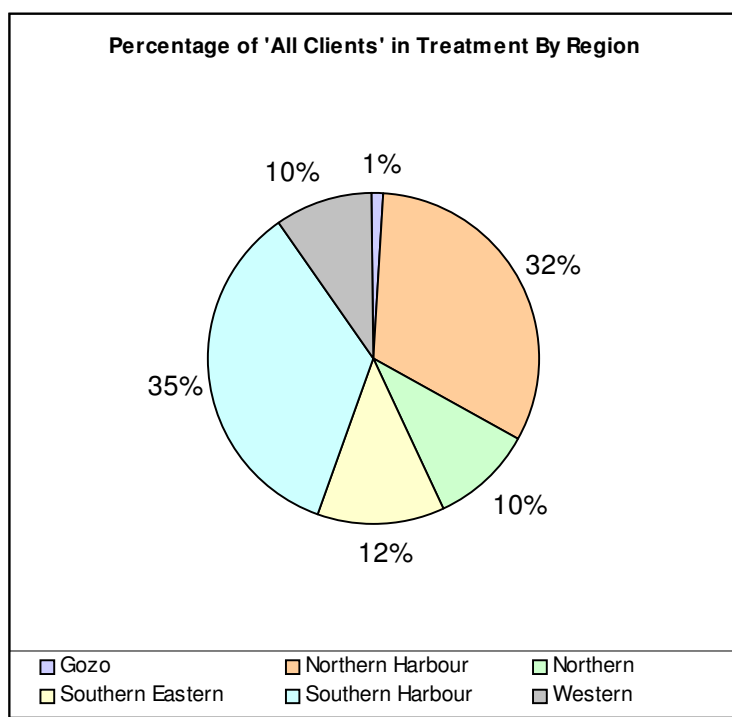
Similar to 2003, in 2004, the client data from all treatment centres (Sedqa, Caritas, Oasi, the Substance Abuse Therapeutic Unit (SATU) and this year also the Dual Diagnosis Unit in Mount Carmel Hospital) were combined, with exclusion of double counting, into a harmonised file of the 2004 national treatment population. ‘All treatment’ is defined in this report as ‘all active clients’ in treatment in 2004. Treatment refers to both medical and non-medical interventions.

Not all the characteristics of clients in treatment can be presented, due to problems encountered in the different data sets pertaining to the proper coding of certain data variables at given times of the year and at different phases of a client’s treatment. For example, it is not clear across all agency data sets whether certain variables like ‘current employment’, ‘current accommodation’ or ‘currently injecting’ refer to the client’s ‘current status in 2004’ or to the client’s ‘status upon admission’, which could have been prior to 2004. For this reason, and in order to present a reliable picture for Malta, only general profiles of **all clients** in 2004 will be presented. In the case of **new clients** that have entered treatment for the first time in 2004, more detailed profiles can be extracted. The same problem was also encountered with last year’s 2003 data sets and this once again highlights the need for consistent inter agency definitions of different client and treatment variables. A number of inter agency meetings have been held over the last year attempting to address this problem and progress has been made, in that some agencies have undertaken the task of amending their databases and other agencies have made plans to do so. Additionally a ‘Treatment Network’ has been formed whereby in 2006 uniform definitions **across all the different client variables** will be established both **within and across all agencies**. Furthermore, the treatment network will draft a short and concise reassessment form, which will be implemented by all agencies in order to be able to systematically update client information at interim periods. This information is

important when mapping a client's progress over time, especially with regards to monitoring health status, treatment outcomes, social exclusion/inclusion and integration back into society.

#### All Active Clients 2004

In 2004, the total number of persons in treatment was 1525. This figure shows that the rate of 'all clients' in treatment in 2004 relative to the general population of Malta aged 15-64 years<sup>2</sup> was 5.5 per 1000 persons. The rate of 'heroin clients' in treatment (N=1316) per 1000 of the population of Malta aged 15-64 was 4.7. If the number of clients in treatment aged 15-34 years (N=1255) and the number of 'heroin clients' aged 15-34 years (N=1078) is taken, then the rates increase respectively to 10.8 per 1000 and 9.3 per 1000 of the population aged 15-34 years<sup>3</sup>. 2004 data shows that the majority of clients in treatment (including services provided in Gozo) were primarily residents from the Southern Harbour (35%) and Northern Harbour (32%) regions. The smallest share of clients in treatment was from Gozo (1%), (Figure 4.1).



<sup>2</sup> End of year 2004 population aged 15-64 years = 278039 (Source: Malta National Statistics Office)

<sup>3</sup> End of year 2004 population aged 15-34 years = 116120 (Source: Malta National Statistics Office)

**Figure 4.1. Percentage of 'All Clients' in Treatment 2004 by Region**  
**Source: Merged Treatment Files 2004**

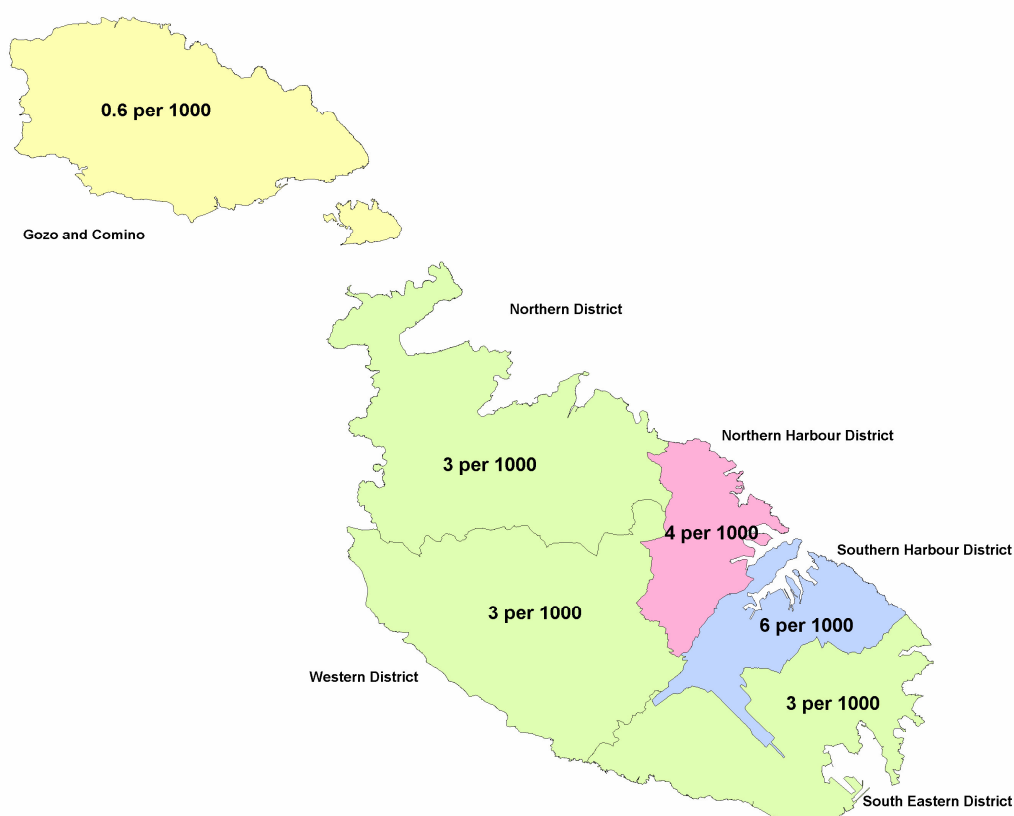
Calculating the rate of clients in treatment relative to the regional population reveals that the highest rates per 1000 of the population are still from Malta's Southern and Northern Harbour Regions and the lowest rate per 1000 of the population remains from Gozo (Table 4.1 and Figure 4.2).

**Rate of 'All Clients' in Treatment Relative to the Number of Inhabitants per Region**

<b>Population</b>	<b>Northern Region</b>	<b>Northern Harbour Region</b>	<b>Southern Harbour Region</b>	<b>Western Region</b>	<b>Southern Eastern Region</b>	<b>Gozo</b>
Total No. of Inhabitants 2004	50,168	123,673	85,749	55,419	55,695	31,964
No. of clients in treatment 2004	148	481	527	145	184	18
Rate of all clients in treatment per 1000 of the regional population	3 per 1000	3.9 per 1000	6.1 per 1000	2.6 per 1000	3.3 per 1000	0.6 per 1000

**Table 4.1. Rate of 'All Clients' in Treatment Relative to the Number of Inhabitants per Region**  
**Source: Merged Treatment Data Files 2004; National Statistics Office End of Year Population 2004**

### **Regional Map of Malta**

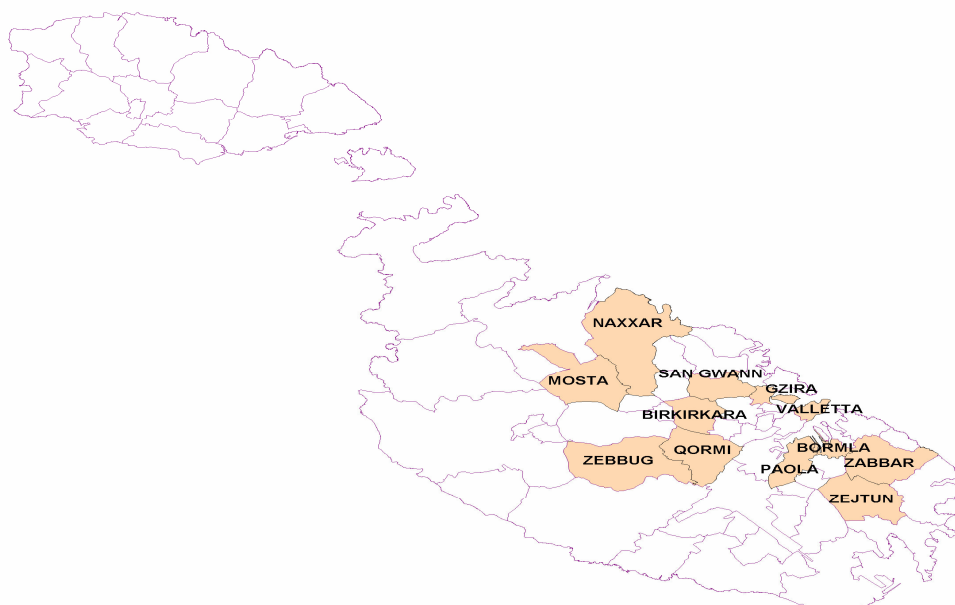


**Figure 4.2. Rate of 'All Clients' in Treatment Relative to the Number of Inhabitants per Region**  
**Source: Merged Treatment Data Files 2004**

The low numbers of Gozitans seen in treatment raises a number of questions. Firstly, can the figures be taken at face value, meaning that the number of Gozitans with drug problems requiring treatment is far less than for Malta? Alternatively, can these figures be placed alongside certain social stigmas that may be felt to a greater extent in a smaller and more closed society? Similar social stigma's may also be extended to other groups, such as the so called 'white collar addicts' for example. It is possible that such groups may prefer to opt for help privately from general practitioners, psychologists or psychiatrists, rather than approaching a drug agency.

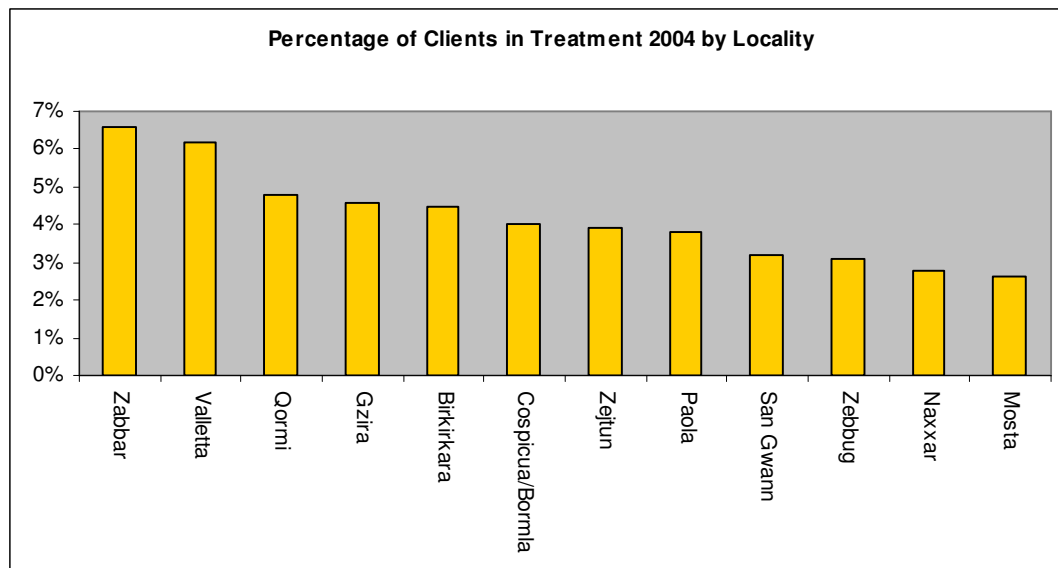
Although Malta is divided into regions, it is important to highlight the fact that each region comprises many towns (N=68). Each town in Malta is practically adjoining another town or a number of other towns, some of which may form part of a different region, despite the proximity. In addition, the problem may be concentrated in particular areas or streets within a locality. For this reason, and in order to underline the areas that may call for specific selective/indicated prevention or outreach work, the share of clients in treatment in 2004 by locality is illustrated below<sup>4</sup> (Figure 4.3.a and Figure 4.3.b).

#### Share of Clients in Treatment 2004 by Locality



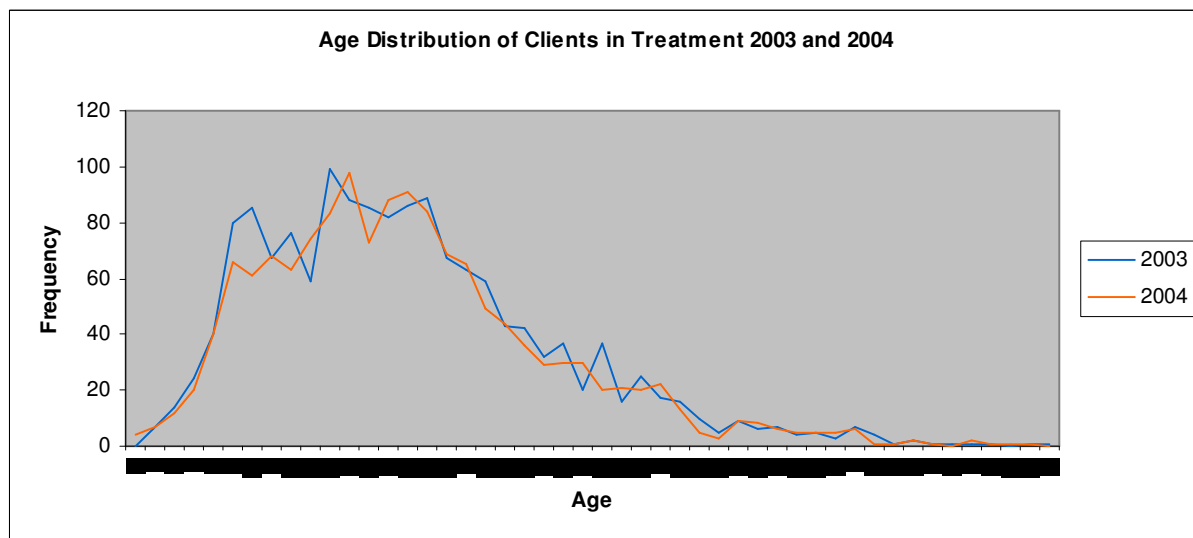
**Figure 4.3.a. Map of Malta Showing the Share of Clients in Treatment 2004 by Locality**  
Source: Merged Treatment Data Files 2004

<sup>4</sup> Only the localities with the highest share of clients are indicated



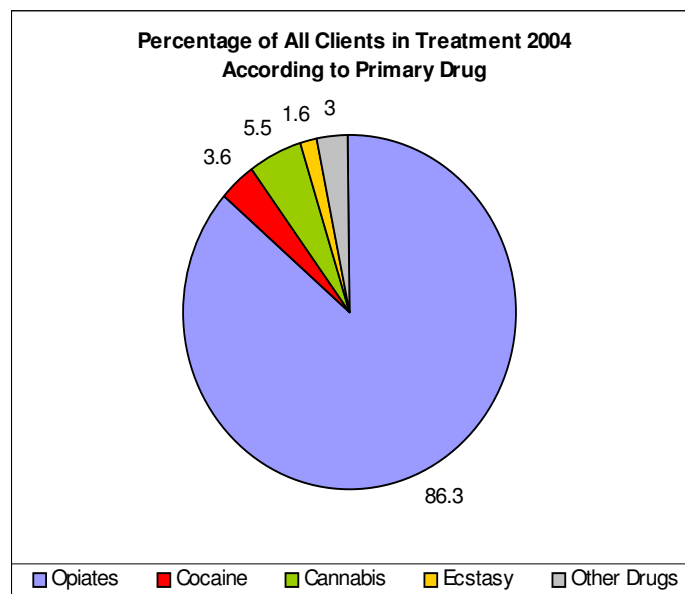
**Figure 4.3.b. Percentage of Clients in Treatment 2004 by Locality**  
Source: Merged Treatment Files 2004

Figure 4.4 shows the age distribution of clients in treatment in 2003 and 2004. The mean age of all clients in treatment at the end of 2003 and 2004 was 28 years. The median age was 27 years indicating that half the clients in treatment in both 2003 and 2004 were 27 years of age and younger.



**Figure 4.4. Age Distribution of Clients in Treatment in 2003 and 2004**  
Source: Merged Treatment Data Files 2003 and 2004

The majority of clients in 2004 (86.3%) were registered as heroin users (Figure 4.5).



**Figure 4.5. Percent of 'All Clients in Treatment 2004' According to Primary Drug**  
Source: Merged Treatment Data Files 2004

Table 4.2 profiles all clients in treatment according to the four main primary drug categories. Most clients in treatment are male. Those clients seeking help for cannabis or ecstasy-related problems represent the youngest age groups. However, the median age of heroin, ecstasy and cannabis clients is 24 years, 23.5 years and 21 years respectively, indicating that a large number of clients in treatment are relatively young.

**Profiles of 'All Clients' in Treatment in 2004 according to Primary Drug**

Primary Drug	Share %	Male %	Female %	Mean	Age Mode	Median
Opiates	86.3	85.6	14.4	28.4 yrs	27 yrs	24 yrs
Cocaine	3.6	85.5	14.5	30.6 yrs	24 yrs	30 yrs
Cannabis	5.5	84.5	15.5	23.9 yrs	20 yrs	21 yrs
Ecstasy	1.6	83.3	16.7	23.4 yrs	27 yrs	23.5 yrs

**Table 4.2. Profiles of 'All Clients' in Treatment in 2004 according to Primary Drug**  
Source: Merged Treatment Data Files 2004

A 'multiple response analysis' for secondary drug<sup>5</sup> revealed that cocaine (32.2%) cannabis (31%) and ecstasy (15.3%) were the most commonly used secondary drugs

<sup>5</sup> Alcohol not included in multiple response analysis as the variable 'alcohol use' is not recorded by all agencies

(Table 4.3). Heroin was only reported as a secondary drug by 3% of persons, indicating that it is recorded mainly as a primary drug. This table represents 67.7% of the total treatment population, as not all treatment services coded data on 'secondary' or 'other drugs' used by clients. Nevertheless the data still provides a reasonable indication of polysubstance use among clients in treatment.

**Multiple Response Table for Secondary Drugs  
All Clients in Treatment 2004**

<b>Secondary Drug Category</b>	<b>%</b>
Cocaine	32.2
Cannabis	31.0
MDMA (ecstasy)	15.3
LSD	7.5
Barbiturates	5.6
Heroin	3.3
Other Substances	3.0
Amphetamines	1.1
Hypnotics/Other Sedatives	0.3
Hallucinogens	0.6
Volatile Inhalants	0.1

**Table 4.3. Multiple Response Table for Secondary Drugs**  
Source: Merged Treatment Data Files 2004

As regards 'Injecting Drug Use', which poses a number of health risks among the drug using population, a total of 88.6% of clients were reported to have at some point in their lives 'ever injected' a drug. 'Current injecting status' for 'all active clients' could not be determined as this variable referred to the client's status upon admission, which could have been prior to 2004 and which could have changed throughout the course of time in treatment. However, if percentages of current injecting status for 'first ever treated clients in 2004' is taken, a figure of 46.7% emerges, and this sheds light on the fact that injecting behaviour is still prevalent among new clients registering for treatment and is in fact higher than that reported for first ever treated clients in 2003 (33.7%). These figures draw attention to the increased need for selective/indicated prevention and harm reduction strategies that amongst other factors should address the health implications of this pattern of drug use.

Another point that arises from the treatment data is the high percentage of heroin users seen across all treatment settings. 86.3% of clients in treatment are heroin users. The data also shows that heroin users also use other drugs concomitantly as seen in the

multiple response tables for secondary drugs. Finally, there are specific localities in Malta that comprise the largest share of clients coming forward for treatment.

The 2003 and 2004 treatment data shows that persons who use cannabis, cocaine and ecstasy as a primary drug are rarely seen in treatment settings. Therefore one questions whether the heroin problem in Malta is somewhat independent from problems associated with other drugs, other types of drug users and other patterns of drug use? This question leads to an array of other questions, which should be considered by policy makers, namely:

- (i) How can Harm Reduction services be better structured and suitably financed to address the needs of chronic heroin users?
- (ii) How can chronic heroin users be better assisted in terms of their integration into society?

As regards non-heroin users:

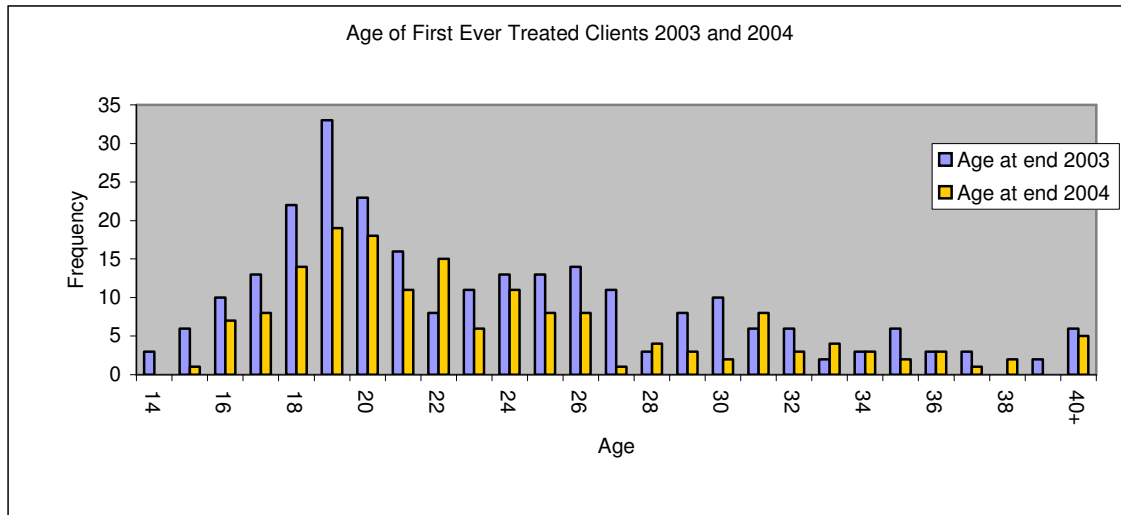
- (i) Is the set up of our currently available treatment settings geared towards targeting these different client groups?
- (ii) Do these types of drug users require different treatment other than that currently available?
- (iii) How can the needs of different client groups who are not approaching treatment services, be targeted more effectively?

#### First Treatment Demand 2004

First treatment demand or 'first ever treated' clients refers to those clients who sought treatment for the very first time in a given year. In 2004 the total number of 'first ever treated' clients was 167. 64.1% (N=107) were registered as daily heroin users. The incidence rates of problematic heroin users in treatment are 0.4 per 1000 of the



population aged 15-64 years<sup>6</sup> and 0.9 per 1000 of the population aged 15-34 years<sup>7</sup>. The mean age of 'first ever treated clients' in 2004 was 24.3 years compared to 23.5 years in 2003. The median age of clients in 2003 and 2004 was 21.5 years and 22 years respectively, indicating that persons seeking treatment for the first time in the last 2 years are mainly in their early twenties (Figure 4.6).



**Figure 4.6. Age Distribution of First Ever Treated Clients 2003 and 2004**  
Source: Merged Treatment Data Files 2003 and 2004

Whereas the bulk of new clients registering for treatment appear to be in their late teens/early twenties, the mean age of 'all active clients in treatment' is late twenties. Figure 4.7 shows the age distribution of 'first ever treated clients' and 'all active clients' and highlights clearly the younger age of 'first ever treated clients' compared to all 'active clients', many of which may have been in and out of treatment for a number of years. These different age groups – adolescents/young adults and adults present different needs in terms of bio-psycho-social and educational development, severity of dependence, lifestyles and the degree of social, criminal and health problems. An 'adolescent programme' which currently does not exist in Malta, would be one way in which the needs of younger clients who are already showing signs of problematic drug use, can be addressed more effectively.

<sup>6</sup> End of year population aged 15-64 years = 278039 (Source: Malta National Statistics Office)

<sup>7</sup> End of year population aged 15-34 years = 116120 (Source: Malta National Statistics Office)

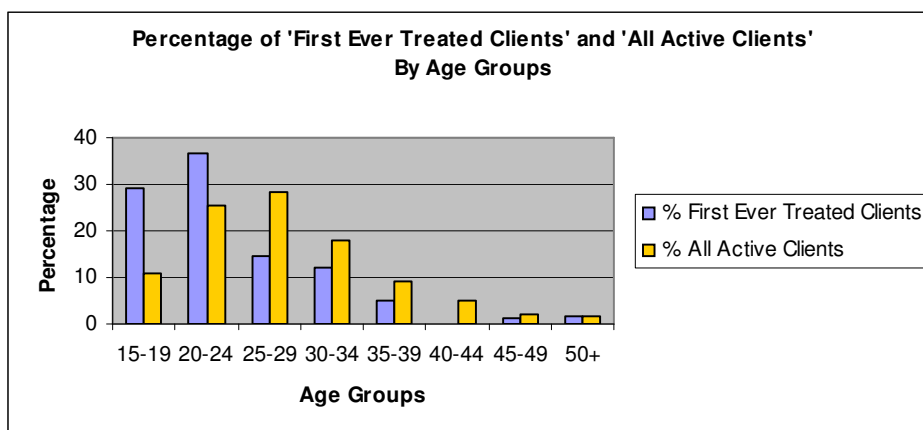


Figure 4.7. Percentage of 'First Ever Treated' and 'All Active' Clients in Treatment by Age Groups  
Source: Merged Treatment Data Files 2003 and 2004

The majority of 'first ever treated' clients in 2004 were male (80.2%), the incidence of females seeking treatment increased from 17.1% in 2003 to 19.8% in 2004. Similar to the situation in 2003, the majority of those seeking treatment for the very first time were heroin users (71.9%). Polysubstance<sup>8</sup> use was recorded for 46.7% of 'first ever-treated clients'. This data is underrepresented as seen in the percentage of missing data (57.3%). Table 4.4 shows the percentages of 'first ever treated' clients who were recorded as having used any drug as a secondary drug. The most commonly used secondary drug among 'first ever treated' clients was cocaine.

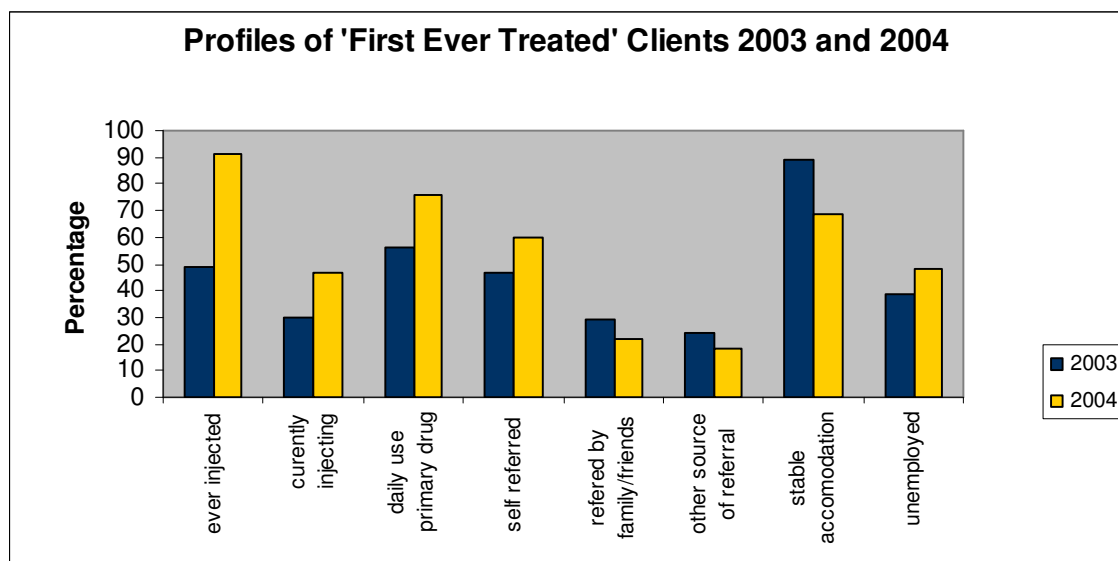
**Multiple Response Table for Secondary Drug  
'First Ever Treated Clients 2004'**

Secondary Drug Category	%
Cocaine	43.4
MDMA (ecstasy)	21.7
Cannabis	17.1
Heroin	7.0
Barbiturates	2.3
Other Substances	2.3
Amphetamines	0.8

Table 4.4. Multiple response table for secondary drug – 'first ever treated clients 2004'  
Source: Merged Treatment Data Files 2004

Some profiles for 'first ever treated' clients in 2003 and 2004 are presented in Figure 4.8.

<sup>8</sup> Alcohol not included



**Figure 4.8. Profiles for 'First Ever Treated' clients 2003 and 2004**  
Source: Merged Treatment Data Files 2003 and 2004

The most pertinent factors with regards to these clients are:

1. The high demand for treatment for heroin problems compared to other drugs.
2. Incidence of injecting behaviour is not on the decrease as seen in the increase in percentages between 2003 and 2004 of first ever treated clients who have 'ever injected' and are 'currently injecting'.
3. The decrease in number of those with a stable accommodation and employment compared to 2003.

#### **4.3b Profile of clients in treatment by centre types**

Based on the manner in which treatment agencies subdivided their services in the annual treatment data file 2004, treatment has been classified in the following categories:

1. Rehabilitation
2. Community (outpatient)
3. Low Threshold Services (harm reduction, shelter and outreach)

4. Prison Inmate Programmes
5. Dual Diagnosis Inpatient Treatment
6. Detoxification and Substitution

Table 4.5 and Figure 4.9(a) (b) and (c) provide a snapshot of some characteristics of 'all clients' in treatment in 2004 according to the definition 'last programme client was frequenting in 2004'. It should be noted that the likelihood of a client frequenting 2 services or agencies simultaneously is also possible, especially in the case of community - detoxification/substitution and low threshold - detoxification/substitution for example. For the clarity of data presentation, the last recorded treatment entry was taken as a cut off point.

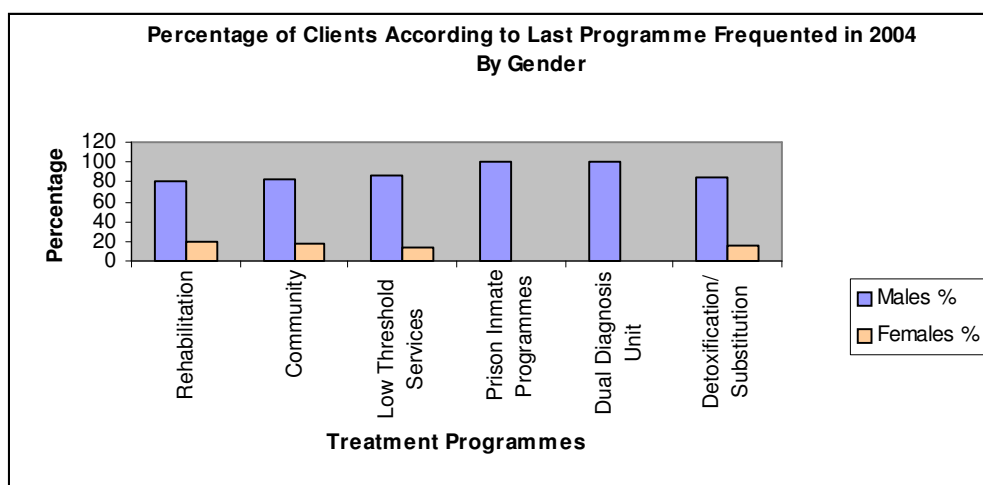
**Distribution of Clients According to Treatment Programme**

Treatment Programme	Client Number	Males %	Females %	Mean age(yrs)	Median Age(yrs)	Heroin %	Cocaine %	Stimulants %	Ever Injected %
Rehabilitation	55	80.0	20.0	24.4	24	83.6	3.6	5.5	85.5
Community	237	82.7	17.3	24.4	23	73.0	5.1	2.1	65.0
Low Threshold Services	177	87.0	13	29.5	29	83.6	4.0	0.6	80.2
Prison Inmate Programmes	35	100	0.0	33.3	33	74.3	20.0	0.0	74.3
Dual Diagnosis Unit	35	100	0.0	31.2	29	97.1	0.0	0.0	97.1
Detoxification/Substitution	807*	85.2	14.8	29.2	28	97.4	0.9	0.2	97.8
Programme Not Identified**	179	87.2	12.8	26.2	24	57.5	11.2	7.3	90.5

\*84.4% are on substitution treatment. Defined as receiving methadone for > 3 months

\*\* Programme not identified = was unclear which programme the client was frequenting

**Table 4.5. Distribution of clients according to treatment modalities in 2004**  
Source: Merged Treatment Data Files 2004



**Figure 4.9(a). Percentage of clients according to last programme frequenting in 2004 by gender**  
Source: Merged Treatment Data Files 2004

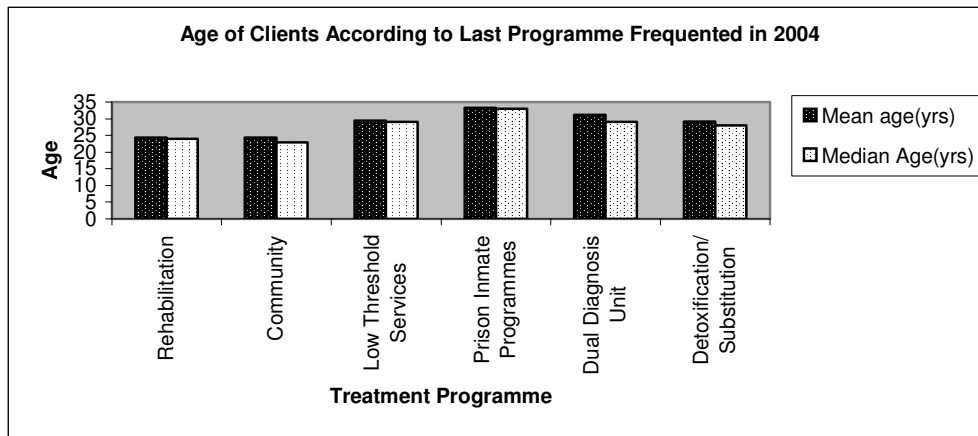


Figure 4.9(b). Age of clients by last programme frequenting in 2004  
Source: Merged Treatment Data Files 2004

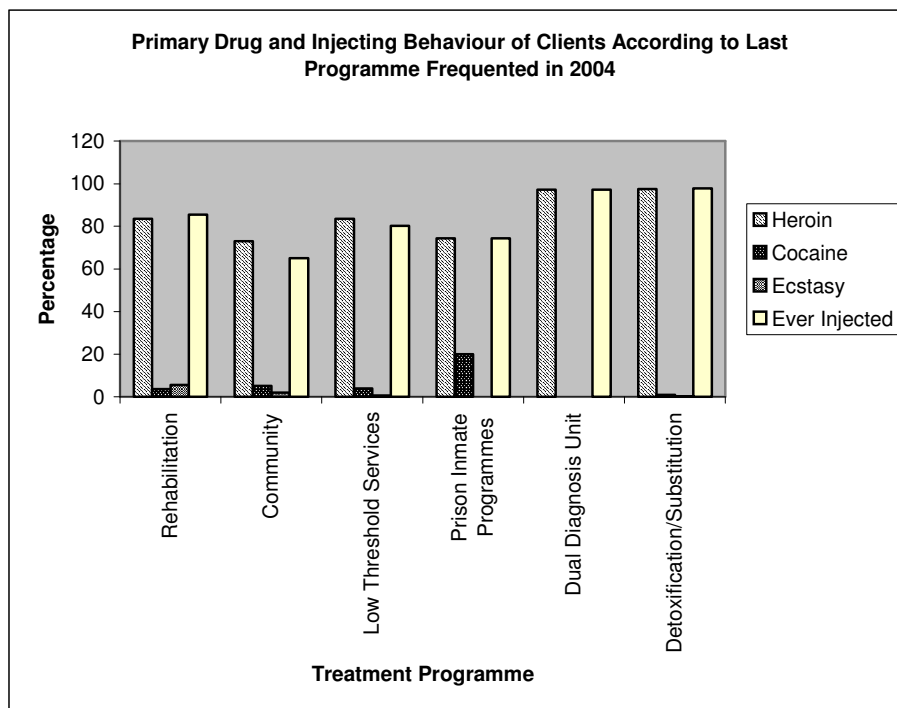


Figure 4.9(c). Drug type and patterns of use of clients according to last programme frequenting in 2004  
Source: Merged Treatment Data Files 2004

Figures 4.9(a) (b) and (c) highlight the following points:

1. The vast majority of clients are male across all treatment settings.
2. The youngest clients are seen in community services or rehabilitation

3. Heroin is the most common drug used amongst clients in treatment.
4. Treatment demand for cannabis, cocaine and ecstasy as 'primary drugs' is low across all treatment settings
5. The percentages of those who have 'ever injected' remains high across all treatment settings, less so in community settings.

#### **4.4 Main characteristics and patterns of use from non-treatment centres**

Malta does not have any national information on characteristics and patterns of use from non-treatment sources.

## Chapter 5. Drug-Related Treatment

### 5.1 Treatment systems

An overview of drug treatment services available in Malta and Gozo in 2004 is presented in table 5.1. Since it is possible for a client to have frequented more than one programme or agency in any given year, the data for this table refers to the *last programme* a client frequented in 2004.

**Types of Services Offered by Maltese Treatment Agencies**

Service Provider	Type of Treatment	Programmes	Model	Drug-free (Y/N)	N clients 2004	Totals
CARITAS	Rehabilitation	San Blas Programme	Bio-Psycho-Social	Y/N*	52	
		Prison Inmates Programme		Y	17	
	Community	Outreach+Short/Long Term Support		N	226	
		Harm Reduction/Shelter		N	149	
		Outreach Prison		N	17	
					461	<b>Total Caritas</b>
OASI	Rehabilitation	Residential**	12-Step & Minnesota	Y	3	
	Community	Outpatient		N	22	
				N		
					25	<b>Total Oasi</b>
SEDQA	Community	Outpatient and Residential***	Bio-Psycho-Social	N	179	
		Detoxification/Substitution		N	807	
				N		
					986	<b>Total Sedqa</b>
SATU	Rehabilitation	Prison Inmates Programme		Y	18	<b>Total SATU</b>
MT. CARMEL HOSPITAL	Rehabilitation	Dual Diagnosis Unit	Psychiatric	N	35	<b>Total DDU</b>
					1525	<b>Total ALL TREATMENT</b>

- 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 Residential Programme opened at the end of 2004
- \*\*\* This figure incorporates clients from Residential AND Community Services

**Table 5.1. Services offered by Maltese treatment agencies**  
Source: Treatment Data Files 2003 and 2004

Treatment systems in Malta and Gozo have been described in detail in the 2004 National Report. As outlined in the aforementioned report, drug treatment can be classified into three main categories:

1. Detoxification and substitution treatment is the setting where the majority of heroin users are treated at one point or another. Medically assisted treatment includes treatment with agonists (methadone, dihydrocodeine) and antagonists

(naltrexone/naloxone and clonidine). The Sedqa detox unit is divided into two: The Substance Misuse Outpatients Unit (SMOPU), which dispenses methadone and provides substitution treatment and the Substance Misuse Inpatient Unit – *Dar L-Impenn*, which offers inpatient detoxification. The waiting time for clients is approximately 10 days for SMOPU and up to 3 weeks for *Dar L-Impenn*. These services are not 'drop in centres' and all clients must be referred to both services through an agency. All clients who receive methadone from Craig Hospital in Gozo are also registered at the Sedqa Detox Unit, and consequently for data purposes, fall under this unit.

2.Community treatment also sees a large number of clients. This setting is generally the point where 'first contact' with the client is made and where the initial assessment usually takes place. Following the assessment, a treatment plan is formulated and the client is either referred to other services within the community setting such as outpatient short/long term support services and counselling services or can begin the induction phase that will lead to admission within a residential therapeutic community. Referrals to and from SMOPU are often made. A newly opened low threshold centre, the Caritas harm reduction / drop in unit, which falls under community services, since it opened its doors in 2004, has succeeded in targeting a population of clients who require a different kind of intervention and support, namely encompassing a harm minimisation approach. Clients who make use of this service are in principal chronic relapsers or those persons who are not able to abstain from illicit drug use.

3.Drug Free Residential treatment generally requires a 4-6 week induction period, usually at community services, in which time drug abstinence must be achieved. Residential treatment targets mainly those people with high motivational levels, good support systems and a desire to abstain from drug use. There are two residential therapeutic communities in Malta (Caritas San Blas Programme and Sedqa Santa Maria Programme) and one in Gozo (Oasi Residential Programme).

Other residential programmes include The Dual Diagnosis Unit within Mount Carmel Psychiatric Hospital, which will be discussed in more detail below and the Prison Inmate Programmes – The Substance Abuse Therapeutic Unit (SATU), the Caritas Prison Inmate Programme (P.I.P) and the Sedqa Prison Inmates Programme within the St.



Maria Therapeutic Community which offer pre-release programmes to inmates who are serving a sentence of not less than six months but not more than two years.

The three drug agencies, Sedqa and Caritas in Malta and Oasi in Gozo all provide community and residential treatment, whereas detoxification and substitution treatment, which is centralised, is entirely in the hands of Sedqa, the National Agency. Supportive methods of intervention accompany the detoxification process, whereas a combination of counselling, cognitive and gestalt therapy, family support and therapy, motivational interviewing and social skills training are the main forms of therapy found in both community and residential settings.

The majority of drug users who approach treatment centres in Malta and Gozo are polysubstance users with a primary heroin problem (please refer to chapter 4 for a more detailed account). As things stand to date, drug treatment in Malta targets all drug users and regardless of age, gender, or drug preference, agencies are continually adapting their services to meet the needs of their clients. For instance in the last year or so, three new services have opened: *the Caritas Harm Reduction Shelter*, *the Dual Diagnosis Unit (DDU) at Mount Carmel Psychiatric Hospital* and *the Woman Clinic at SMOPU*. A description of the Harm Reduction Service and the Dual Diagnosis Unit will be outlined below, whereas the Woman's Clinic at SMOPU will be described in more detail in the Selected Issue on Gender Differences, Chapter 11 of this report.

#### *The Caritas Harm Reduction Shelter*

The concept of a Harm Reduction Shelter which came into operation in October 2004, evolved from long experience with a particular category of clients with drug addiction. Harm Reduction clients have a specific profile: they tend to indulge in polydrug abuse (i.e. using more than one illicit drug concurrently), live an extremely chaotic lifestyle, and typically lack any sort of family support. Very few of these clients have stable housing, and tend to make arrangements for their night's shelter on a day-to-day basis, with friends and acquaintances. Many Harm Reduction clients tend to have an array of psychological and physical difficulties are also prescribed psychiatric medication, and often suffer from malnutrition, untreated injuries and other ailments. Some of these clients do not manage to find shelter and are entirely homeless. At present, existing shelters for the homeless, such as Osanna Pia, Suriel il-Bniedem, and the YMCA, do not

accept persons with a drug addiction problem. Some of these clients have no alternative but to live and sleep in abandoned cars in fields and makeshift shelters. Many of the persons, whose drug-related death reaches the media and national attention, belong to this category of persons with drug addiction.

*Drop-In:* The Caritas Harm Reduction Shelter primarily provides a loosely structured low-threshold programme for persons who are currently abusing drugs and alcohol, and who are not yet in a position to work towards total abstinence. Close contact is sustained with other professionals, such as probation officers, medical doctors, psychiatrists, and the Dual Diagnosis Unit. The Shelter is open for drop-in clients for a number of hours a day. During this time, clients are able to come in, have a meal, and sit in the living area where they are engaged in conversation by the staff, and where they are supervised in their interactions with each other. They may watch television, read newspapers and are encouraged to discuss various news items of interest to them. They are offered therapeutic support, both individually as well as at a group level. Staff members work towards encouraging these clients to regain an interest in the world around them, to relearn a routine of personal hygiene and adequate diet, and to try and resolve family and housing issues.

Clients who are homeless have the opportunity to take up temporary residence at the Shelter until more permanent accommodation can be arranged for them. They participate in a rather more structured day programme, which helps to stabilise their chaotic lifestyle whilst offering them psychotherapeutic support. Clients who manage to reduce their methadone intake to a specified level, and who are motivated to become fully abstinent from drugs, are referred to another service within the agency, with a view to embarking on an inpatient Residential Programme.

In summary, the objectives of the Harm Reduction Shelter are:

1. To perform crisis interventions, and provide support and therapy to clients who are suitable candidates for the Harm Reduction Programme (i.e., not yet suitable for other residential or non-residential programmes).
2. To perform crisis interventions, and provide emergency shelter and support to persons with drug addiction who become suddenly homeless.

3. To work with external professionals (e.g. housing officials, probation officers, social workers, etc.) in order to find more permanent and stable solutions to the clients' various immediate problems.
4. To conduct a thorough and professional assessment of the clients' physical, psychological, spiritual, social, family and legal difficulties, and to devise a holistic therapeutic treatment plan that helps the clients to reduce harmful behaviours gradually.
5. To help the clients find suitable work, thereby helping them to acquire the means to support themselves.
6. To help the clients achieve eventual sobriety and freedom from drug use, regain their dignity and establish themselves as useful and responsible members in society.

The Harm Reduction Shelter presently accommodates up to 10 homeless persons with drug addiction per day and provides a drop-in service to an average of 30 clients a month. It does not only help the clients who attend the programme, but is a concrete means of containing the criminal activity associated with rampant drug use, namely heroin and unstable accommodation.

#### *The Dual Diagnosis Unit*

The Dual Diagnosis Unit (DDU) at Mount Carmel Hospital, which caters for males only, came into operation in June 2004 in an attempt to accommodate persons who suffer both from drug dependence and psychiatric problems. While the unit was being constructed, a committee between the hospital's management and Sedqa, the National Agency for Drugs was set up in order to strengthen the co-operation between these two entities. The DDU now accepts referrals from Sedqa the National Drug Agency, Caritas the voluntary drug agency and also internally from Mount Carmel Hospital.

A designated Substance Misuse Consultant and two psychiatrists manage this six-bedded Unit. The staff compliment is currently 1 psychologist (on call), 1 head nurse, 5 nurses, 4 nursing aids and 3 Consultant Psychiatrists with their own individual firms,

which include a Senior Houseman, a doctor, a social worker and an occupational therapist. The daily medical cover of the Unit is under the responsibility of the doctors of Mount Carmel Hospital in liaison with the Substance Misuse Unit Outpatient Unit (SMOPU) at St. Luke's Hospital.

The DDU targets patients with severe drug abuse problems and psychiatric disorders as defined by the ICD10. Due to the wide array of client motivational, behavioural, psychological and psychiatric conditions, no structural rehabilitative process can be undertaken. The primary focus of the unit is to assess and provide acute management of the psychiatric problem, stabilise the client by means of substitution or detoxification treatment and provide medium or long term treatment plans in liaison with drug treatment agencies.

Currently, treatment is limited to 4 weeks, which may be extended to 6 weeks in the most exceptional circumstances, and only after approval by the Director of Psychiatry. Clients may discharge themselves against medical advice. Readmission takes place if the client returns within one week. If this time period elapses, clients are re-registered. Therapeutic activities take place on a daily basis and are organised either by the head nurse or by the occupational therapist. These take the form of supportive, educational and motivational interventions.

Exclusion criteria for admission to the unit include:

- Those who are under 16
- Those whose only dependence is alcohol
- Those who are drug dependent but do not have co-morbidity
- Those who have been drug free for a period of 8 months prior to admission
- Those with severe physical illness requiring intensive medical
- Those who have social problems but no indications for treatment

## **5.2. Trends in Treatment Demand**

When looking at the evolution of treatment demand across the years, Malta can provide data from the Substance Misuse Outpatient Unit, the centralised methadone distribution service. This is the only data source that has recorded data since 1994. In this section

'all treatment' refers to 'all active clients attending SMOPU in 2004'. This data cannot be compared to the figures presented in section 5.1 or to the data presented in Chapter 4 as data presented here refers to clients who were 'ever registered at SMOPU' and not to the 'last programme recorded across all agencies,' which was the cut off point that was used to calculate and present the data in chapter 4.

The most pertinent point with regards to this data is the increasing workload for the SMOPU unit, seen in the number of 'all active clients', which over the last 10 years has increased three-fold. 'First Treatment Demand' shows dips in 1999 and 2002 and peaks in 1996 and 2000 (Figure 5.1).

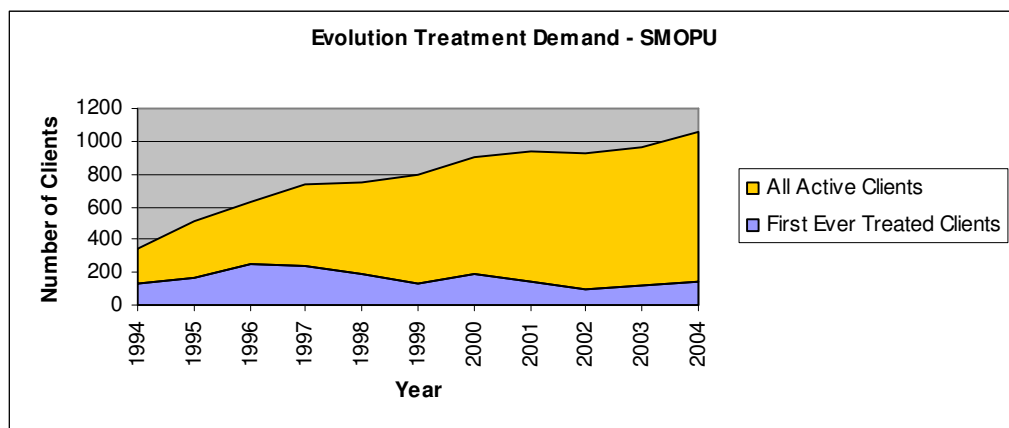


Figure 5.1. Evolution of Treatment Demand – SMOPU 1994-2004  
Source: Sedqa reports 1994-2004

All told the SMOPU figures seem to point towards a situation suggesting 'a recycling of clients already in the system', characteristic of 'long term maintenance objectives'. The fact that heroin clients remain in touch with the system is a positive sign in terms of accessibility of the service. The European guidelines state that countries should try to have sufficient capacity for all persons who need and want methadone treatment (Verster, 2000). However, what remains unclear to what extent clients are assisted in their overall integration back into society – in terms of measurable levels of cessation or improvement in intravenous opioid use and use of other psychoactive drugs, a reduction in risk behaviour associated with heroin use, improved social functioning and psychosocial rehabilitation, reduced levels of criminality, improvement in health status and psychological adjustment, stabilisation and eventual weaning off methadone. These

variables are crucial when measuring the outcomes of substitution treatment, as research shows that methadone substitution can only really be an effective way of treating heroin users if accompanied with the appropriate rehabilitative, follow up, integration back into society and after-care strategies (Verster 2000).

## Chapter 6. Health correlates and Consequences

Drug use behaviour is accompanied by a number of health risks, namely overdose and death, infectious diseases, mental illness and other physical problems. This chapter will focus on acute/direct overdoses - fatal and non-fatal, infectious diseases and mental illness.

### 6.1 Drug related deaths and mortality of drug users

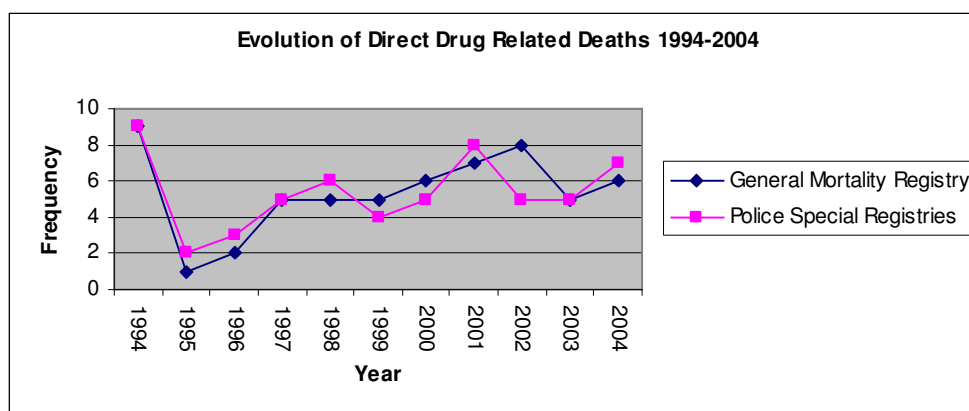
Information on drug related deaths is provided by two main sources, the General Mortality Registry (GMR) collated by the Department of Health Information, which codes deaths according to the ICD10 and the Police Special Registry (PSR). The GMR's records are based on details from death certificates and toxicology reports. The PSR's records are based on reports from inspectors cross-checked with toxicology reports. Cross-checking between the two registries takes place on a yearly basis. The 'National Definition' for reporting to the EMCDDA is based on the GMR.

The EMCDDA definition<sup>1</sup> of acute/direct drug-related deaths refers to deaths that are caused directly by the consumption of drugs of abuse, generally occurring shortly after the consumption of the substance. Data presented in this report refers to the above definition.

Figure 6.1 shows the evolution of acute/direct drug related deaths over a 10-year period. These have ranged from 1 (1995) to 9 (1994) yearly deaths by illicit drugs. The cause of death in 95% of cases was opiates, often in combination with other drugs, including alcohol. Between 1994 and 2004 there were 67 deaths in residents of the Maltese Islands due to drugs typical of abuse. Males were more likely to be the victims of fatal overdoses with a male to female ratio of 11:1.

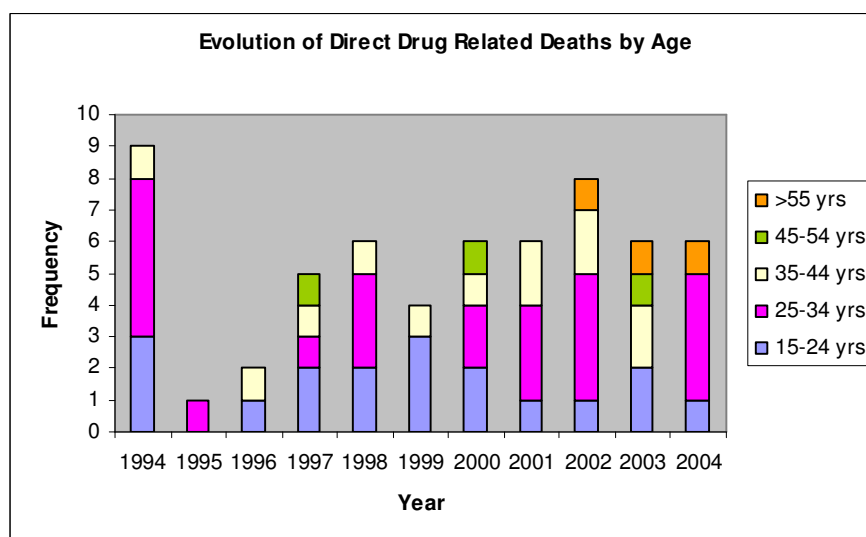
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<sup>1</sup> The EMCDDA's definition of direct drug related deaths include deaths by drug psychosis, drug dependence, non-dependant drug abuse, accidental poisoning, suicide, self-inflicted poisoning and poisoning of undetermined intent. Only deaths due to drugs typical of abuse (opiates, cocaine, amphetamines, cannabis and hallucinogens) are included.



**Figure 6.1. Evolution of Direct Drug Related Deaths 1994-2004**  
Source: Police Special Registry and General Mortality Registry

In 2004 the GMR reported 6 acute drug related deaths, which would result in a rate of 2.2 per 100,000 of the population of Malta<sup>2</sup>. Due to the combination of factors generally associated with drug related deaths, resulting in difficulties in determining the actual cause of death, annual figures may be a slight underestimate. Using the GMR data, the average age of death in the last ten years was around 34.2 years, with most deaths occurring in the 25 to 34 year age groups (Figure 6.2).



**Figure 6.2. Evolution of Direct Drug Related Deaths by Age 1994-2004**  
Source: General Mortality Registry

<sup>2</sup> Rate calculated using 2004 mid-year population of Malta aged 15-64 years for all Maltese and Foreign residents (N=276,449)



Simple Linear Regression analyses revealed a slow rising trend of mean age at death over the years (1991-2004), that has not yet reached statistical significance (Figure 6.3.)

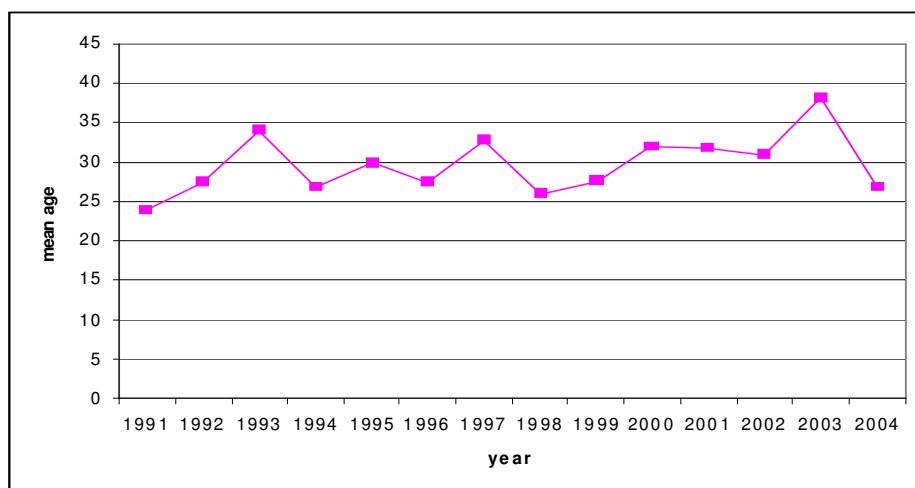


Figure 6.3. Mean age at death of from 1991-2004  
Source: General Mortality Registry 1991-2004

### Main problems encountered in the data on Drug Related Deaths

- ❑ In deaths due to multiple drugs and possibly alcohol, death might be the result of the combination of effects, and the real underlying cause of death difficult to define. Also in drug overdoses the manner of death, for example suicides or accidental poisoning are also difficult to define.
- ❑ Deaths in non-Maltese residents (mainly tourists) are not included in the GMR for Malta but included in PSR (Police).

### 6.2 Drug related infectious diseases

The data presented (Table 6.1) was obtained from the methadone dispensing Substance Misuse Outpatients Unit (SMOPU) and prison (CCF). The base population for SMOPU comprised 'all 2004 active clients' who 'ever injected' (ever IDUs, N=708) and the base population for CCF comprised persons 'admitted to prison in 2004' (N=448). The sample selected for SMOPU was 'ever IDUs who were tested in 2004' whereas the sample selected for CCF was 'prison inmates with a known drug problem who were tested in 2004'.

These specific inclusion criteria were established due to problems regarding the recording of test and re-test results in the data sets from both sources. Thus the SMOPU data excludes those 'who may have been tested in previous years' and those who 'were not active clients in 2004'. The CCF data excludes inmates who 'may have been tested in previous years but were not admitted into CCF in 2004'. Due to these limitations, the percentage of positive cases from both sources is most probably slightly underestimated.

**Estimates of Hepatitis B/C And HIV Among 'IDUs' In a Treatment Setting and 'KNOWN DRUG USERS' in a Prison Setting 2004**

DATA SOURCE	EVER IDUS	EVER IDUS	EVER IDUS
Substance Misuse Outpatients Unit	Anti HBc*	HCV	HIV
Positive (%)	1.4% (2/142)	34.4% (62/180)	1.3% (1/77)
DATA SOURCE	KNOWN DRUG USERS**	KNOWN DRUG USERS**	KNOWN DRUG USERS**
Prison	AntiHBc*	HCV	HIV
Positive (%)	1.7% (1/58)	50% (29/58)	0% (0/58)

\*Percentage relates to persons in whom antibodies of Hepatitis B were found.

\*\*Those tested in prison were known drug users, as per results of drug tests conducted on admission. Injecting Drug Use (IDU) status not known

**Table 6.1. Prevalence of Hepatitis B/C and HIV among IDUs in a Prison and Treatment Setting 2004**  
Source: Sedqa Data File 2004; CCF Data File 2004

### 6.3 Psychiatric co-morbidity (dual diagnosis)

The problem of treating clients with psychiatric co-morbidity is a challenge faced by all drug treatment centres in Malta and Gozo. In recent years drug agencies have become increasingly concerned with the rise in the number of clients coming forward for treatment with drug problems and namely psychiatric personality disorders, anxiety disorders and affective disorders. Most of these clients are taking prescribed psychotropic medication. Their concurrent and haphazard use of illicit drugs and pills raises a number of concerns, especially attributed to the increased risks of overdose. Interviews with staff members from various treatment agencies indicate that although in recent years more attention has been directed towards addressing the needs of clients with a dual diagnosis problem, national routine data is still lacking.

Data from the newly opened male dual diagnosis unit in Mount Carmel Hospital revealed that between June and December 2004, 35 individual persons were treated with a dual diagnosis problem, namely anxiety, major depression and personality disorders. The

majority (approximately 70%) of clients were self-referrals. The mean age of clients was 31.2 years (median 29 years). 97.1% were recorded as having a heroin problem and 91.4% were 'current injectors'. A more detailed description of the unit can be found in Chapter 5.1.

## 6.4 Other drug-related health correlates and consequences

### Non-Fatal Overdoses

Data on 2004 non-fatal overdoses (ODs) was obtained from the Police Drug Squad records. The data has been checked for double counting but has not been crosschecked with other sources, namely St. Luke's Hospital Emergency Department data. Although not 100% accurate, this data nevertheless still gives a reliable picture of the scenario. Data includes overdoses resulting from illicit substances, alcohol and medicinals.

Police records on ODs in 2004 show that the total number of reported OD cases was 216<sup>3</sup> (unique individuals: 205). The female to male ratio was 1:1. In 2004, 7 women and 4 men were admitted into hospital twice for an overdose. Figure 6.4 shows the age distribution of female/male OD victims across all substance categories and shows that the majority of ODs occur in the 20-24 year age group for both males and females.

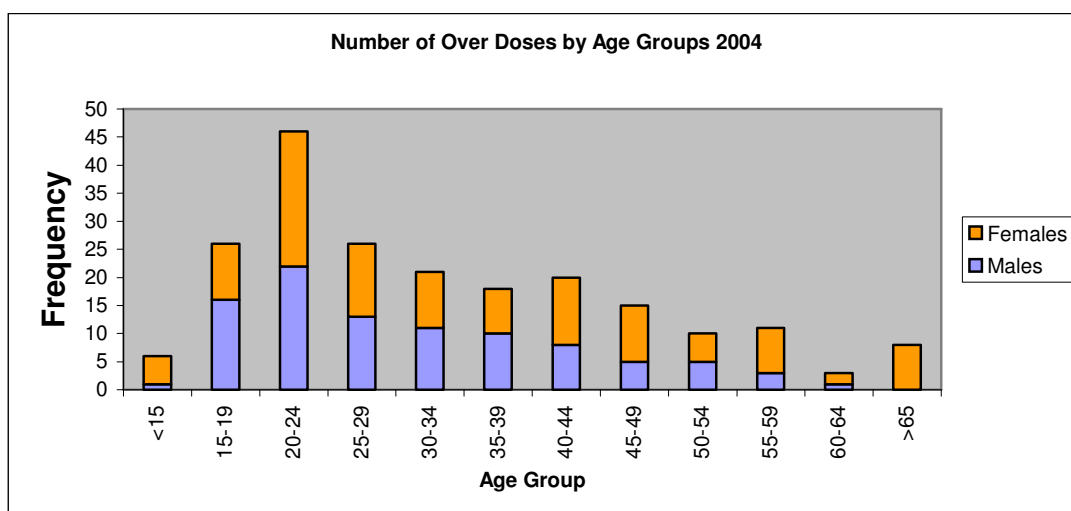
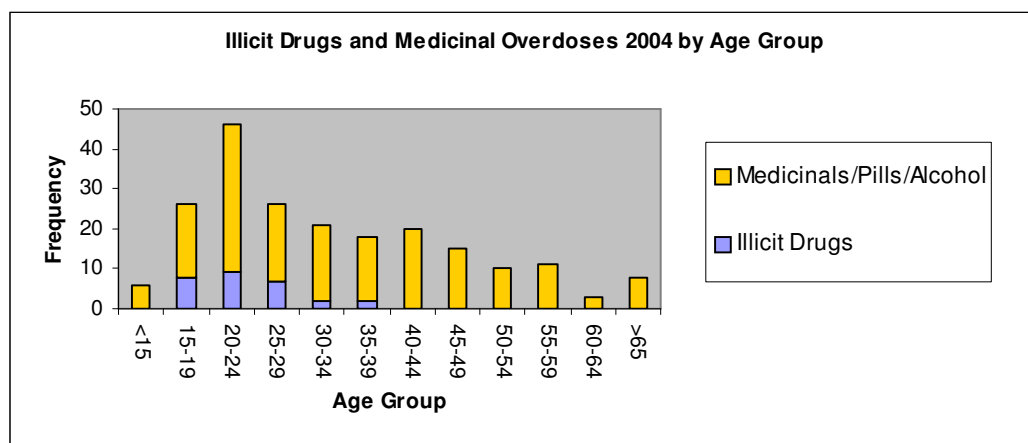


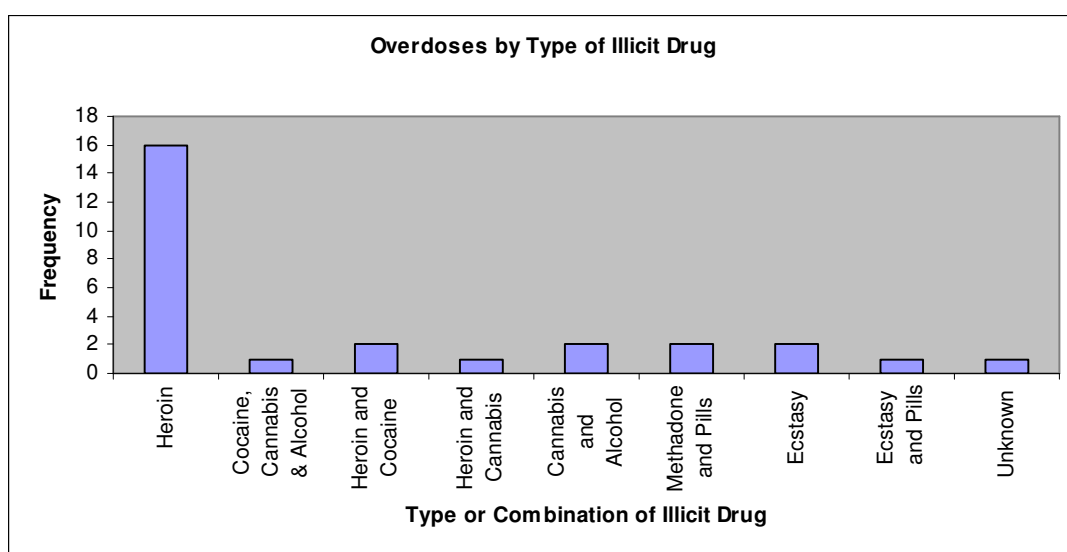
Figure 6.4. Number of overdoses by Age - 2004  
Source: Police Drug Squad Records

<sup>3</sup> Includes non-residents (tourists)

Most ODs in 2004 occurred as a result of medicinals, namely psychotropic medication. Only 14% of all ODs were the result of illicit drugs, namely heroin, as shown in Figures 6.5 and 6.6 respectively. Of these, 23 were males and 5 were females.



**Figure 6.5. Illicit Drugs and Medicinal Overdoses by Age Group**  
Source: Police Drug Squad Records 2004



**Figure 6.6. Overdoses by Type of Illicit Drug**  
Source: Police Drug Squad Records 2004

A study conducted in 2003 that looked at OD data from St. Luke's Government Hospital<sup>4</sup> over an 18-month period (2002-2003) estimated that on average there were

<sup>4</sup> All overdose cases are supposed to be admitted to St Luke's Government Hospital and not to Private Hospitals

approximately 270 OD admissions every year<sup>5</sup> (Gatt, 2004). Women made up an average of 52% of this cohort (these values represent only those treated on an in-patient basis). According to this study, the rate of OD cases in Malta amounts to 77 per 100,000 of the population (Gatt, 2004).

#### Trends in non fatal over doses

Trend data, which does not exclude double counting, shows that the number of OD cases from pills and medicinals is on the increase. The mean number of overdoses over the last five-year period (N=789, 2000-2004), increased by 60% as compared to the previous five-year period (N=494, 1995-1999). On the other hand, the number of overdoses for illicit drugs has declined between 2001 (N=55) and 2003 (N=15), but doubled between 2003 and 2004 (N=30). However, the figure for 2004 is representative of the 10-year average, 31 (Figure 6.7).

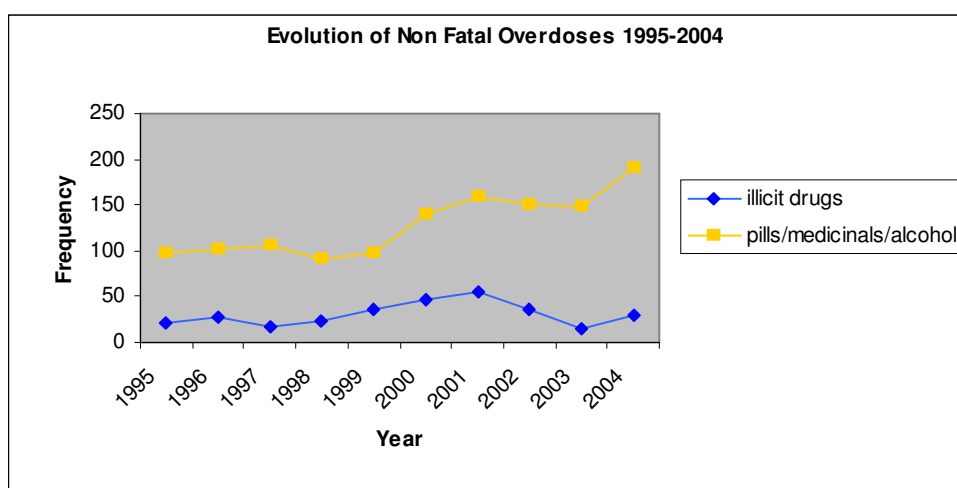


Figure 6.7. Evolution of Non Fatal Overdoses 1995-2004  
Source: Police Drug Squad Records 2004

#### Non fatal overdoses - summary and conclusions

It is becoming increasingly necessary to collect accurate and comprehensive data on drug users who are seen at emergency rooms due to ODs. This data can serve to shed light on:

<sup>5</sup> This figure includes persons who were admitted more than once and excludes data from Gozo

- ❑ Different sub-populations of drug users (e.g. person overdosing from prescribed drugs).
- ❑ Drug use trends and new patterns of drug use
- ❑ Identification and monitoring of health consequences of drug use
- ❑ Indications of the abuse of new substances
- ❑ Indicators for the implementation of appropriate prevention strategies in this area

Over the last year the National Focal Point formed an ‘expert group’ whose aim was to draw up a proposal on how data on non-fatal overdoses can be collected directly from the hospital sources. This proposal is in the process of being forwarded to the relevant authorities for approval. It includes a standard operating procedure of how data should be collected, cross-checked, recorded and passed on to the National Focal Point, complying with Data Protection Regulations. The proposal also includes definitions and inclusion/exclusion criteria, highlighted below.

#### *National Overdose Definitions*

1. A suspected overdose is an episode, which through history, witnesses or circumstances might suggest poisoning with licit or illicit substances.
2. A confirmed overdose is an episode, which is confirmed by clinical and or toxicological tests.

#### *Inclusion and exclusion criteria.*

- Cases must meet one or both of the above definitions.
- Overdoses who are admitted to hospital for inpatient treatment.
- Persons with overdose must be 14 years old and over [all other age groups in Government hospitals are admitted to children’s wards]. No upper age limit is being set.
- Both genders are included.
- Alcoholic intoxications will be excluded unless they are associated with drug overdose. The majority of cases of alcohol abuse are treated in the Accident and

Emergency Department of Saint Luke's Hospital, observed and discharged without requiring inpatient treatment.

- Poisonings that are iatrogenic (e.g. digoxin toxicity), occupational (e.g. chemical poisoning) or environmental (e.g. contamination of water) will not be included.
- All cases of overdoses will be verified before inclusion in the data file. A distinction will be made between (I) tourists and temporary residents and (II) those subjects who have acquired an official identity card from the Electoral Office in accordance with the Identity Card Act as amended in 1993 (CAP 28). The latter will be incorporated with data from Maltese nationals.
- Fatal overdoses are far less common in Malta and will be considered separately.

## **Chapter 7. Responses to Health Correlates and Consequences**

### **7.1. Prevention of Drug Related Deaths**

The number of direct or acute drug related deaths is more easily measurable than those resulting from long-term causes, which may occur decades after drug misuse. It is important however that policies aimed at interventions to reduce drug-related deaths from long-term causes are prioritised alongside those that aim to reduce acute/direct deaths. While the majority of overdose deaths are likely to be accidental, unknown proportions are due to deliberate overdose. Accordingly, the screening for acute mental health problems and co-morbidity of drug misuse and mental health problems is also crucial, as this condition is known to further exacerbate levels of problem drug use and associated harms that can lead to death. Furthermore persons with co-morbidity are more likely to abuse of psychotropic medication together with other drugs and this cocktail of substances can very often prove to be fatal.

#### Prevention of Drug Related Deaths among Problem Drug Users

Typical measures on the part of treatment agencies in Malta to reduce acute/direct drug related deaths include educating clients on the dangers associated with drug use and the ingestion of multiple substances (including alcohol and psychotropic medication), the risks of over dosing following long term abstinence, and the risks involved in injecting and sharing needles.

Methadone maintenance programmes, although not a panacea for resolving all of the problems associated with heroin use are justified because the benefits that ensue from treatment outweigh the risks associated with it, both for the client as well as for the community at large. Research has shown that compared to untreated heroin users, those receiving methadone maintenance have a reduced risk of dying (Ward et. al., 1999; Verster 2000). Substitution treatment in Malta has been available since the early 1980s. In 2004 the total number of clients in substitution treatment<sup>1</sup> was 681, 44.7% of all clients in treatment. Methadone dispensing and substitution treatment in Malta is centralised and highly accessible. In previous years clients who desired this form of treatment were provided with it almost immediately. In more recent years, the waiting

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<sup>1</sup> Substitution treatment is defined as receiving methadone for a period of 3 months or longer



time has increased to approximately 2 weeks, and this is largely due to the increase in the number of clients who make use of this service.

#### Prevention of Drug Related Deaths In Dance/ Rave Venues

As regards the prevention of drug related deaths and overdoses at organised rave parties, paramedics are present at almost all of these venues to ensure that unnecessary risks can be avoided or addressed immediately. No preventative measures exist in mainstream dance venues. Drug agencies use the media to convey drug prevention messages targeting the general public including potential or current experimental or recreational drug users. These messages are primarily geared towards deterring or stopping drug use in the first place as opposed to providing information on how to use drugs safely.

### **7.2. Prevention and Treatment of Drug Related Infectious Diseases**

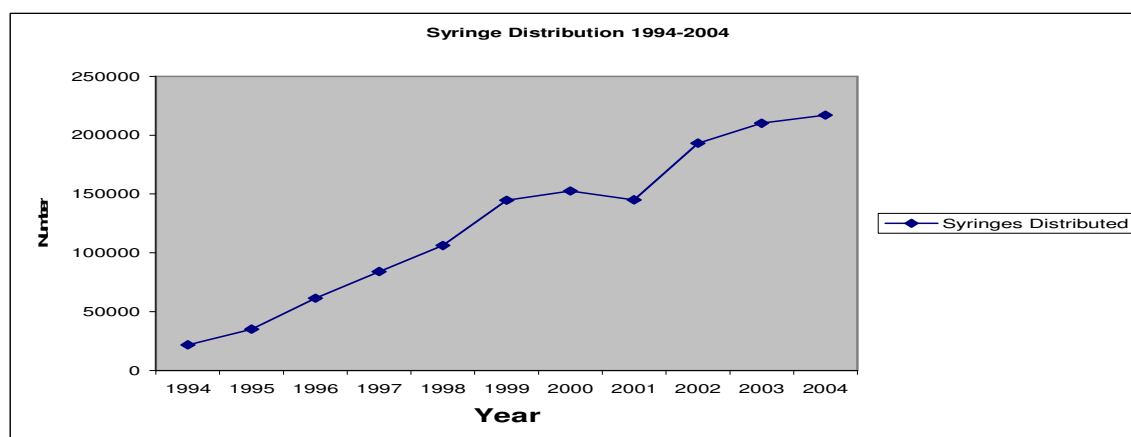
Longer-term causes of drug-related deaths include complications related to prolonged injecting drug misuse, in particular the acquisition of blood-borne viruses (particularly hepatitis C), local and systemic infections, injuries and conditions associated with heavy alcohol misuse concomitant with, or subsequent to, heavy drug use. Drug treatment centres in Malta provide harm minimisation information to clients regarding the health risks involved in taking drugs, using and sharing needles, contracting and passing on infectious diseases, with the aim of creating awareness and reducing the risks of further harm ensuing from substance misuse and associated risk behaviours. The staff working at different treatment centres reported that despite these efforts, a substantial number of injecting drug users, including those infected with Hepatitis C, are still sharing needles and engaging in unprotected sex.

#### Laws in Malta Regulating the Spread of Infectious Diseases

A 2002 amendment to the Criminal Code (CAP9) regulates the spread of infectious diseases by stating that any person who knowingly transmits a disease or condition to another person is liable to imprisonment for a term of four to nine years. In situations where the disease is passed on through imprudence, carelessness or through non-observance of any regulation that person shall on conviction be liable to imprisonment for a term not exceeding six months or to a fine not exceeding LM1000 (EUR 2400) (Criminal Code, CAP9, Section 244A)

### Needle and Syringe Availability

Syringe distribution in Malta began in the 1980s and since 1994 has reached national coverage (Figure 7.1). A progressive increase in the number of syringes distributed yearly can be noted. It is unknown however if this implies 'an increase in safer use', an increase in the 'number of injecting users', or both. Needle exchange programmes do not exist in Malta. An attempt in 2002 by Sedqa the National Drug Agency and the Department of Primary Health Care to initiate a needle-exchange project failed, due to the widespread suspicion on behalf of drug users that they might be prosecuted if found in possession of a safe bin with used syringes. Therefore, drug users' resistance to use the safe bins led to the discontinuation of the project.



**Figure 7.1. Syringe Distribution between 1994 and 2004**  
 Source: Sedqa Epidemiological Report 1994-2002; Sedqa Bimonthly reports 2003 and 2004

### Hepatitis C

Free blood screening as well as pre and post test counselling for Hepatitis C takes place at the Substance Misuse Outpatient Unit (SMOPU). Hepatitis C pre and post test counselling and testing is also offered to clients who are frequenting a drug residential programme. Other settings where testing takes place include prison (CCF), where all inmates are tested upon admission. The Genitourinary (GU) clinic within the department of health also provides a service for free testing of sexually transmitted diseases to the general public. Contact tracing is also effected by this unit. Treatment for Hepatitis C includes Interferon treatment alone and Interferon/Ribavarin combination treatment. Drug users who have contracted chronic Hepatitis C and are still using drugs are not

eligible for treatment as the criteria for eligibility include drug abstinence and termination of methadone treatment for at least one year.

### HIV

The prevention of HIV amongst drug users is similar to that of Hepatitis C. Blood screening and pre and post test counselling is provided by the same sources mentioned above for Hepatitis C. Unlike Hepatitis C, the prevalence of HIV amongst drug users appears to be low in Malta. However, the number of clients who are actually tested is also very small, which implies that the disease could still be prevalent amongst a large number of 'hidden' or unknown' population of drug users. Treatment staff attribute the low numbers of those tested for HIV to the lengthy procedure involved in pre and post test counselling, which often discourages drug users from being tested. A one stop testing procedure could increase the numbers of those who agree to be tested.

### Hepatitis B Vaccine

Testing and vaccine for Hepatitis B is a free service provided by health centres to the general public. SMOPU also provides a free and highly accessible screening and vaccine to all drug users who are attending the clinic. Testing and vaccine for Hepatitis B is also conducted in prison to inmates upon admission.

## **7.3. Intervention Related to Psychiatric Co-Morbidity**

The Substance Misuse Outpatient Unit (SMOPU) offers a psychiatric service for clients with varying degrees of mental problems. The aim of this service which commenced in 2004 is stabilisation of drug use through substitution treatment and treatment of the psychiatric condition. There are three consultant psychiatrists who diagnose clients, using ICD10. Clients are seen by the psychiatrists on an average of once a month.

In terms of inpatient treatment, the Dual Diagnosis Unit at Mount Carmel Hospital offers a service for males with a dual diagnosis problem (This unit has been described in more detail in Chapter 5.1). The unit, which treats clients with more severe co morbid conditions, aims at stabilisation of the client. Psychological or psychotherapeutic interventions and leisure and occupational activities however are lacking. The lack of a resident psychologist with suitable training in dual diagnosis, has led to persons with a

wide array of conditions being admitted to the unit, some for example with a mild psychiatric problem but severe drug addiction. These persons typically discharge themselves against medical advice as they find it difficult to adhere to the conditions of the unit. Such persons are increasingly susceptible to drug overdoses due to their concomitant and often chaotic use of illicit drugs and pills. Also, a working protocol still needs to be established whereby clients, who are not referred to any agency, can be better followed up after discharge.

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

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

## **Chapter 8. Social Correlates and Consequences**

### **8.1. Social Exclusion**

Drug misuse is strongly associated with social exclusion. The socioeconomic factors related to drug use include low educational levels, early school leaving and drop out, unemployment, low paid jobs, low income, debt, unstable accommodation, mortality, drug related infections and social stigma (EMCDDA Annual Report 2003). These factors can act as precursors to drug use, as well as contribute to continued use and social marginalisation.

Some characteristics of social exclusion among problem drug users in Malta are collected by treatment agencies. As things stand to date the variables recorded by treatment agencies are: housing situation, occupational status, highest education attended and highest education attained. It was not possible to determine the 'current status of all clients in treatment' across these different variables as distinctions in the data sets between a client's 'current 2004 status' and 'status upon admission', which could have been prior to 2004, were not made. Additionally the variable 'highest education attained' constituted a large percentage of missing data which consequently affected the reliability of figures obtained; therefore this variable could not be utilised for the analysis. For these reasons, a treatment expert group has been formed to better define characteristics of social exclusion to enable better data collection in the coming years. In this way a client's progress across these different variables can be monitored and used as measurements of treatment outcome and social integration.

Occupation, education and housing situation was produced for 'First Ever Treated Clients' in 2003 and 2004 (Table 8.1). This data provides a snapshot of three factors associated with incidence of treatment demand in 2003 and 2004. Most 'first ever treated' clients in 2003 and 2004 were recorded as having stable accommodation and did indeed attend secondary school education<sup>1</sup>. There was a reported increase in number of persons living in an institution between 2003 and 2004. In both years nearly half of 'first ever treated' clients were unemployed, with an increase in this percentage from 2003 to 2004.

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<sup>1</sup> This does not mean the person completed secondary school education

**Education, Employment and Accommodation – First Ever Treated Clients 2003/2004**

Social Factors	First Ever Treated Clients 2003 (%) *	First Ever Treated Clients 2004 (%) *
Did Not Attend Secondary School	3.3%	4.2%
Unemployed / Inactive	39.3%	49.1%
Unstable Accomodation	0.8%	1.2%
Living in an Institution	4.4%	12%

\*Totals do not sum to 100% as only the values of interest for this section are reported

**Table 8.1. Education, Employment and Accommodation – First ever Treated Clients 2003/2004**  
Source: Merged Treatment data Files 2003 and 2004

Clients aged between 15-19 years and 20-24 years were the ones with the highest share of unemployment. Only 2.4% of clients aged between 15-24 years were registered as students, indicating that the majority of clients in these age groups are unemployed or inactive (Figure 8.1).



**Figure 8.1. Occupation by Age Group for 'First Ever Treated' clients 2003 and 2004**  
Source: Merged Treatment Data Files 2003 and 2004

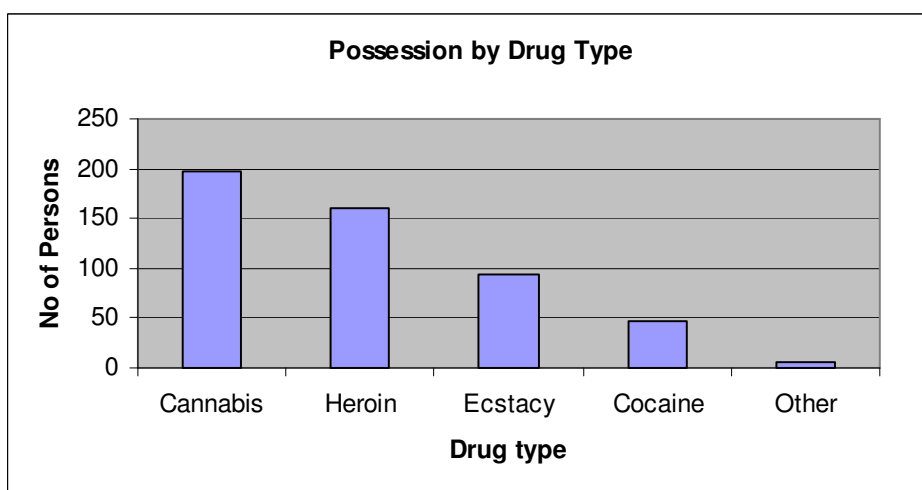
## 8.2. Drug related Crime

In Malta a zero tolerance drug policy applies. This means that anyone caught with any type or form of illegal substance or has items related to drug use, its cultivation or manufacture will be prosecuted. In 2004, from a total of 859 arrests for drug law offences made by the Malta Police Force, 659 individuals were charged (Figure 8.2).



**Figure 8.2. 2004 Arrested persons by Type of Offence**  
Source: Police Arrests File 2004

The majority of persons arrested were charged with possession (N=505; 77%). Of these, 39% were charged for possession of cannabis, 32% for possession of heroin, 19% for possession of ecstasy, 9% for possession of cocaine and the remaining 1% for other drugs including amphetamines and psychoactive medicines (Figure 8.3).



**Figure 8.3. Arrested persons in 2004 charged with possession of drugs by drug type**  
Source: Police Arrests File 2004

From the total number of persons charged with trafficking (N=154; 23%), 34% were charged with trafficking cannabis, 31% with trafficking heroin, 25% with trafficking ecstasy and the remaining 10% with trafficking cocaine (Figure 8.4).

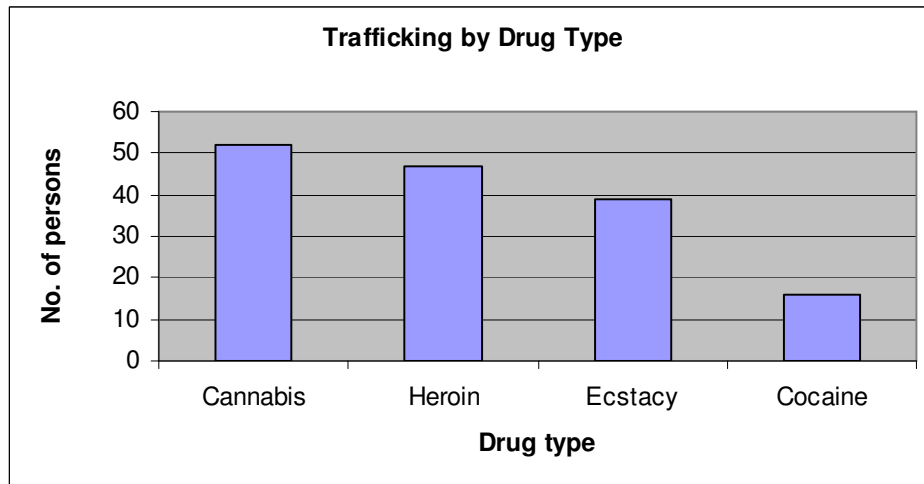


Figure 8.4. Arrested persons in 2004 charged with trafficking in drugs by drug type  
Source: Police Arrests File 2004

Although 200 persons were arrested and not charged, it is a plausible assumption that in order to be arrested by the drug squad these individuals must have at some point been exposed to the drug scene in some way or another.

Total arrest data shows that since 1998 peaks were recorded for 1999 and 2002, with drops in 2000, 2001 and 2003. 2004 arrests showed an overall increase of 40% compared to 2003 (Figure 8.5).

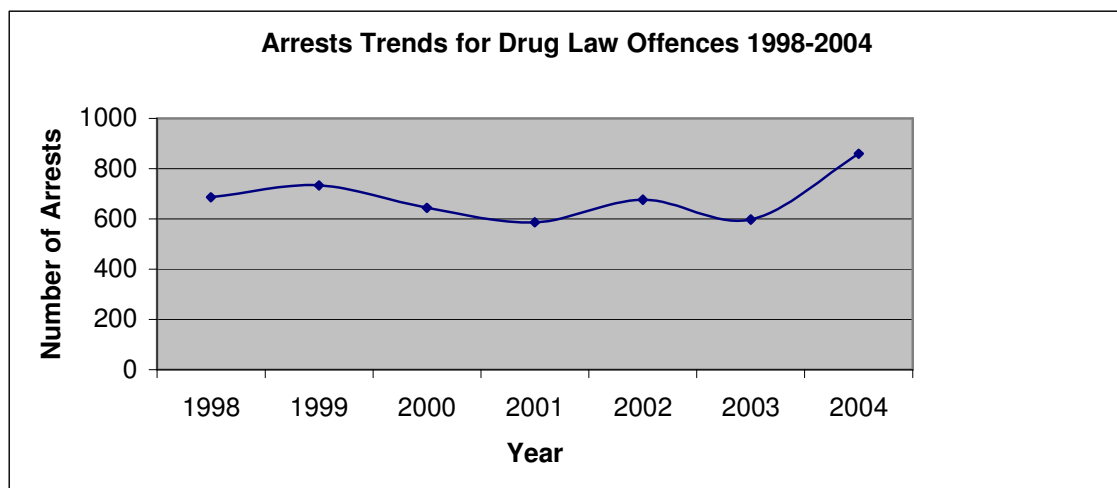
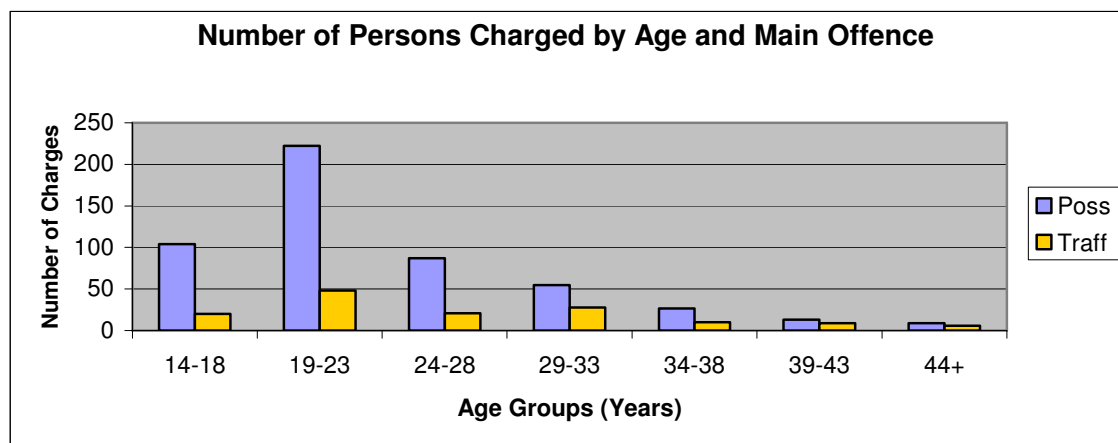


Figure 8.5. Arrest trends for drug law offences 1998-2004  
Source: Police Arrests File 1998-2004

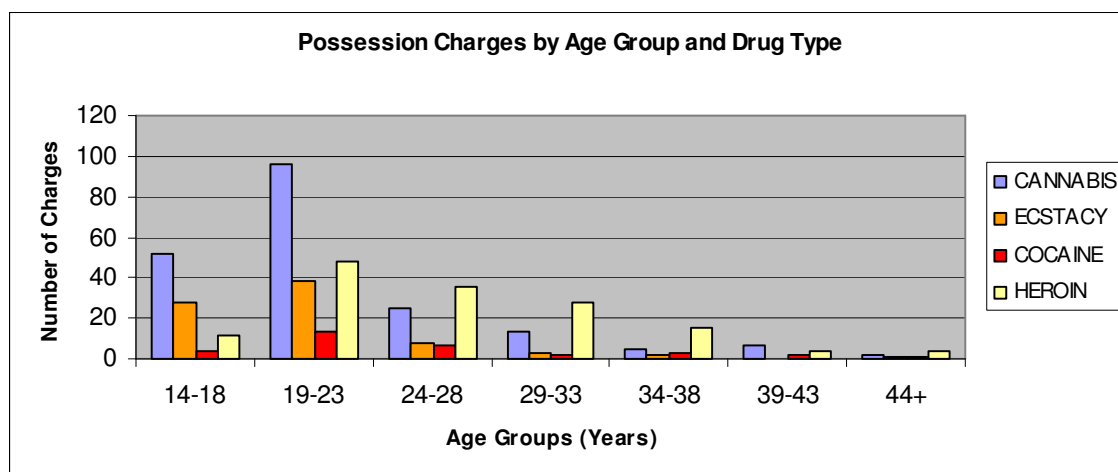


Most arrestees were male (89%). The majority of persons charged for drug law offences were between the ages of 19-30 years (64%). Persons between 14-18 years amounted to 19% of the total number of persons charged (Figure 8.6).



**Figure 8.6. Number of Persons Charged by Age and Main Offence**  
Source: Police Arrests File 1998-2004

The overall observation for drug arrests in 2004 is indicative of the fact that adolescents and young adults (14-18 years to early 20s) are more likely to be arrested for possession of cannabis and ecstasy. Charges for possession of heroin are more common amongst those in their 20s and 30s. Charges for possession of cocaine are low and this sheds light on the fact that comparatively, cocaine users are rarely apprehended by the police (Figure 8.7).



**Figure 8.7. Charges for Possession by Age Group and Drug Type**  
Source: Police Arrests File 2004

In terms of trafficking, younger adults aged between 19-30 years are more likely to be charged for trafficking than older adults over 30 years of age. Most charges for cannabis and ecstasy trafficking occurred amongst those aged 14-23 years, whereas heroin was the most commonly trafficked drug amongst those aged 23-33 years. Charges for cocaine trafficking were comparatively low (Figure 8.8).

In Malta, the sharing of any form of drugs is considered a trafficking offence. Though the law is rigid in this respect, in practice alternatives to prison sentences are usually applicable especially for first time offenders. Nonetheless such a practice is not standard, but functions at the discretion of the court.

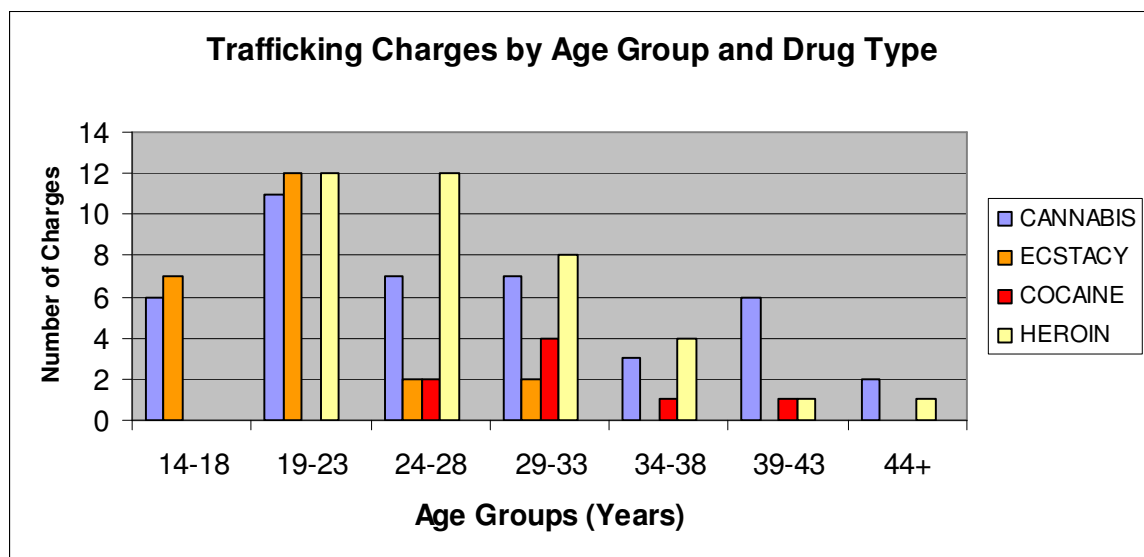
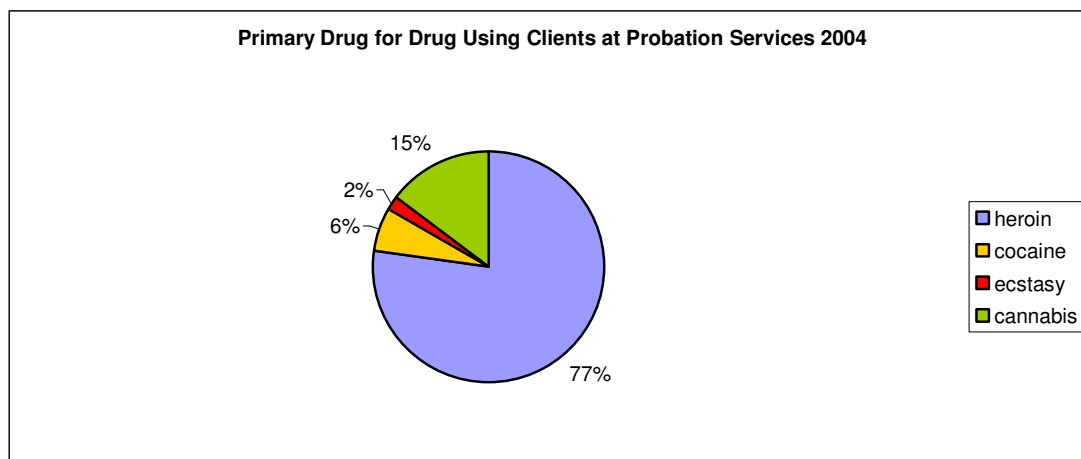


Figure 8.8. Charges for Trafficking by age group and drug type  
Source: Police Arrests File 2004

### Probation Services Data

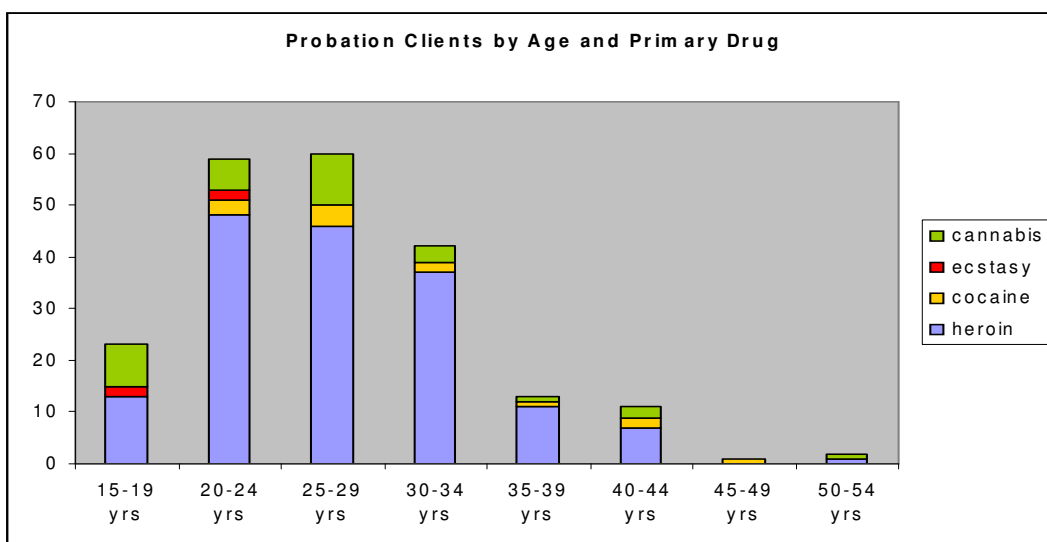
The 2004 Probation Services data show that among all their registered clients (N= 420<sup>1</sup>), 211 (50.2%) were persons with a known drug problem, namely heroin (Figure 8.9).

<sup>1</sup> N=420=Unique Individual Clients



**Figure 8.9. Primary Drug for Drug Using Clients at Probation Services 2004**  
Source: Probation Data File 2004

87.7% of probation clients in 2004 were male. The average age of clients was 27.3 years (median 26 years). Figure 8.10 shows the distribution of clients according to age and primary drug. Most clients are in their 20s and have heroin-related problems.

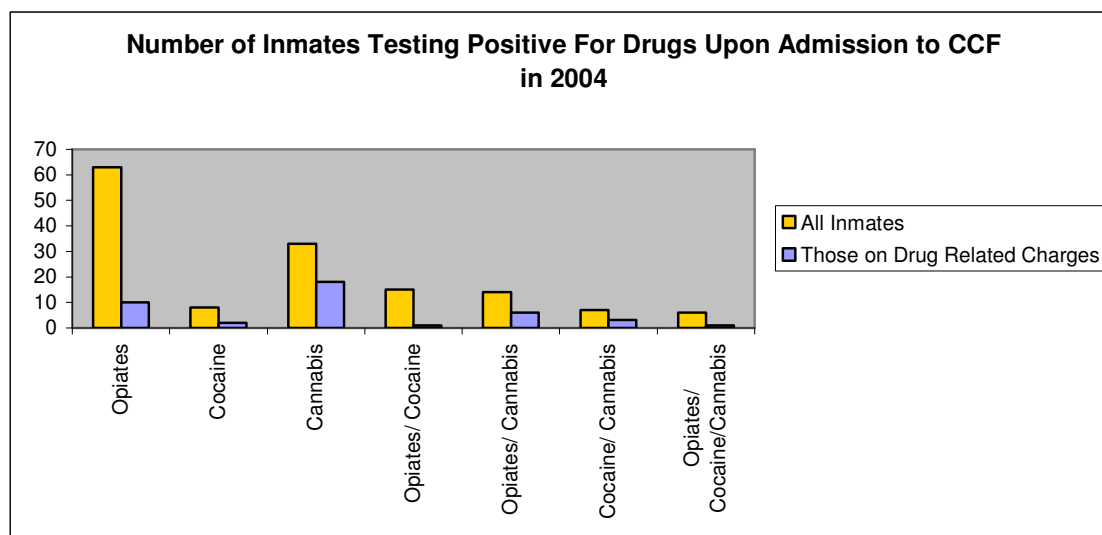


**Figure 8.10 Probation Clients by Age and Primary Drug**  
Source: Probation Data File 2004

### Prison Data

In 2004, 448 persons (92.8% males) were admitted into prison (Corradino Correctional Facility - CCF). 78.6% were Maltese nationals. 16.3% of those admitted in 2004 were charged or sentenced for drug law offences (91.8% males; 8.2% females); 83.6% of those sentenced for drug law offences were Maltese.

According to prison authorities all inmates are tested for drugs upon admission. In 2004, 32.6% of all inmates and 9.2% of those imprisoned on drug related charges (trafficking) tested positive for drugs upon admission, namely opiates and cannabis (Figure 8.11).



\*Data regarding results of ecstasy tests not available

**Figure 8.11. Number of Inmates Testing Positive For Drugs Upon Admission to CCF in 2004**  
Source: Prison Data File 2004

### 8.3. Drug Use in Prison

Prison inmates are also tested for drugs on a monthly basis by means of a random selection of inmates. The director of prison can also assign individual prisoners for tests outside the monthly random testing schedule. In 2004, from a series of 158 random drug tests conducted, 19% resulted positive for drugs, namely for morphine. The CCF data file shows that a number of prisoners were tested more than once and the number of positive results per individual tested on multiple occasions ranged from two to five.

The prison inmates programme SATU (Substance abuse Therapeutic Unit) also conducts random testing for drugs. In 2004, from a total of 69 processed random urine tests, 10% resulted positive for drugs.

### 8.4. Social Costs

No new data available.

## **Chapter 9. Responses to Social Correlates and Consequences**

### **9.1. Social Integration**

Interventions related to the social integration of drug users in Malta cannot be equated with numbers. A description of the different services aimed at tackling this issue can be provided, however the extent to which these measures are proving successful remains largely unknown.

Despite certain limitations regarding data, social integration is being addressed by the drug agencies Sedqa, Caritas and Oasis, and in practice all available resources are used as much as possible in tackling this issue.

#### Housing

The three agencies provide a re entry service following inpatient rehabilitation, whereby clients can be monitored and followed up during their integration phase. After care services, which follow the re entry phase are also available. Interviews with persons who work in this area stressed that one challenge they face with regards to 'housing/accommodation' is the fact that a large number of their clients do have 'accommodation' but in their view it is not always 'stable' or 'healthy'. Staff members attribute a large number of relapse rates to the fact that many of their clients return to an unhealthy or dysfunctional and sometimes unsupportive home environment following rehabilitation. In an attempt to address the issue of homelessness amongst those clients who cannot or do not want to attend a rehabilitation programme, the drug agency Caritas opened a 'drop in / shelter' in 2004. This centre sees an average of around 30 chronic drug users a month, whereas the shelter has a capacity of 12 beds at any one time. A more detailed description of this service can be found in Chapter 4.2.

#### Education and Training

Education is part and parcel of all inpatient rehabilitation programmes in Malta. Drug users frequenting a drug rehabilitation programme or a prison inmates programme are offered a variety of educational courses ranging from literacy to the continuation of general education, preparation for GCSE exams, computer courses and training on employability amongst others. The Employment Training Corporation (ETC) assists in the delivery of such courses, some of which take place within the rehabilitation setting.

Such courses begin with an individual needs assessment and consist of pre-training motivation, consultancy regarding personal skills and talents, motivational interviewing workshops and management skills. Additionally, clients are also encouraged to engage in a variety of sports activities, arts and crafts, social skills training and participation in a number of youth activities.

### Employment

Interviews with staff members from the rehabilitation centres in Malta and Gozo stress that all clients who have frequented rehabilitation programme re-enter the community with employment. Staff members who work in the Re Entry phase of these programmes said that 'employment' is one criterion for entering the Re Entry Phase. Paradoxically, it is the more educated persons who experience greater difficulties in finding employment, due to the fact that the types of jobs these persons are interested in require a 'clean conduct record', which many drug users do not have. Labourers, whose interviews are far less formal, are the ones who experience fewer problems in finding employment. Some of the challenges faced by the ETC with regards to this client group are:

- Their vulnerable work histories and lack of education attainment. Factors which project poor prospects for career development.
- Sporadic commitment in relation to training courses and enhancement of their vocational skills or levels of education.
- Their criminal records and/or pending court cases.
- Methadone clients who are still using illicit drugs and are unfit for work

### Other Social Issues

As things stand to date, the information obtained from all treatment sources, the police, prison and probation services all point towards the fact that with regards to the drug problem in Malta, heroin still remains a major source of concern. The data from Chapter 4 shows that there are certain localities in Malta where this problem is more apparent. Some of these areas were also highlighted in the Malta 1985 and 1995 census data (National Statistics Office 1985, 1995). The aforementioned reports show that certain areas in Malta are more disadvantaged socially and economically than other areas. Rising youth illiteracy levels, high levels of renting as opposing to owning a house, educational attainment, occupational status, incidence of marital breakdown and

criminality were more prevalent in certain localities than in others. The point to be made here is the importance of addressing the socio-economic conditions, which are related to stress in families and also to poverty. These factors can precipitate or maintain a wide array of other related problems, which include drug use and criminality.

There is no national data or documented information regarding the social issues of non problematic drug users or drug users who are not in touch with drug treatment services.

## **9.2. Prevention of Drug Related Crime**

The detoxification and substitution programme in prison is one intervention aimed at targeting the drug using population in prison. This treatment, which is implemented in liaison with the Substance Misuse Outpatients Unit (SMOPU) and the Forensic Unit within Mount Carmel Psychiatric Hospital is available for inmates who were on substitution treatment before entering prison. Long-term substitution maintenance treatment is available for all prisoners and is accompanied by some psychosocial interventions, which are conducted by the prison forensic psychologist and the correctional supervisor.

Inmates with a drug problem are also provided with the option of attending a drug rehabilitation programme. This option is available for those with a minimum 6-month and maximum 2-year sentence. The process entails applying for a drug residential programme to the Prison Substance Abuse Assessment Board (PSAAB) which is constituted of the chairperson, secretary, prison psychiatrist, prison forensic psychologist, clinical psychologist, prison supervisor, a representative from prison and representatives from all the drug agencies. The procedure involves assessments, progress reports and monitoring of the applicants in order to be able to establish whether the person fulfils the criteria for admission. Drug agencies also do outreach work in prison and assess certain clients who may be eligible for drug treatment.

In the case of inmates with mental health problems, the psychiatrist from the Forensic Ward within Mount Carmel Psychiatric Hospital assesses and provides medical treatment to those who may require it. Upon release, some inmates with a less severe dual diagnosis problem may attend drug rehabilitation or counselling in community

settings. Prison outreach work on the part of drug agencies also aims at targeting such individuals. Those with a severe dual diagnosis requiring containment are referred to the Substance Abuse Therapeutic Unit (SATU), the pre release drug rehabilitation programme.

Certain lacunae that may act as precipitants to further crime within the prison walls need further consideration:

1. There is no drug free zone in prison. Inmates who are not drug users or who are abstinent drug users mix with inmates who are using drugs, resulting in the initiation of drug use or relapsing to drugs within the prison walls. The PSAAB have provided a proposal for the implementation of a drug free zone however to date no action has been taken in this regard.
2. Intake assessments are conducted in prison. Although these provide the prison administration and the PSAAB with information about each inmate upon admission, the lack of follow-up assessments means that no updated information on inmates who have been in prison for some time is available.
3. Inmates who are contemplating or are motivated to some extent to opt for drug residential treatment are not separated from those inmates who are not motivated to do so. This situation often results in the person losing interest in treatment altogether. A section of the prison which could be used for motivational interventions may serve to further encourage those who are interested in drug residential treatment.

Responses in relation to the prevention of drug related crime amongst young offenders and alternatives to imprisonment were discussed in the 2004 National Report under the selected issues section 'Alternatives to Prison'. (Malta National Report on the Drug Situation, 2004).



## Chapter 10. Drug Markets

### 10.1 Availability and Supply

Chapter 8 illustrated that as regards arrest data, cannabis and heroin remain the most popular drugs of abuse in Malta. Herbal cannabis is usually locally grown, the climatic conditions of the island provide an ideal environment for growth without artificial instruments or fertilizers. Cannabis resin (Hashish) is generally of North African origin and either imported via the same routes or through European countries. Heroin on the other hand is imported from Eastern Mediterranean countries and North Africa. Cocaine, ecstasy and amphetamines are generally smuggled onto the island from other European countries.

### 10.2 Seizures

In 2004, law enforcement officials were responsible for a total of 308 seizures, marking a 47% increase when compared to seizures in 2003 (Figure 10.1). According to the Police Department Annual Report (2004), the Drug Squad Unit concentrated its efforts to neutralise persons who had been active in drug trafficking in Malta and who managed in the past to avoid detection. The efforts proposed by this intelligence-based policing practice resulted in a 40% increase in arrests for drug related offences between 2003 (N=597) and 2004 (N=859).

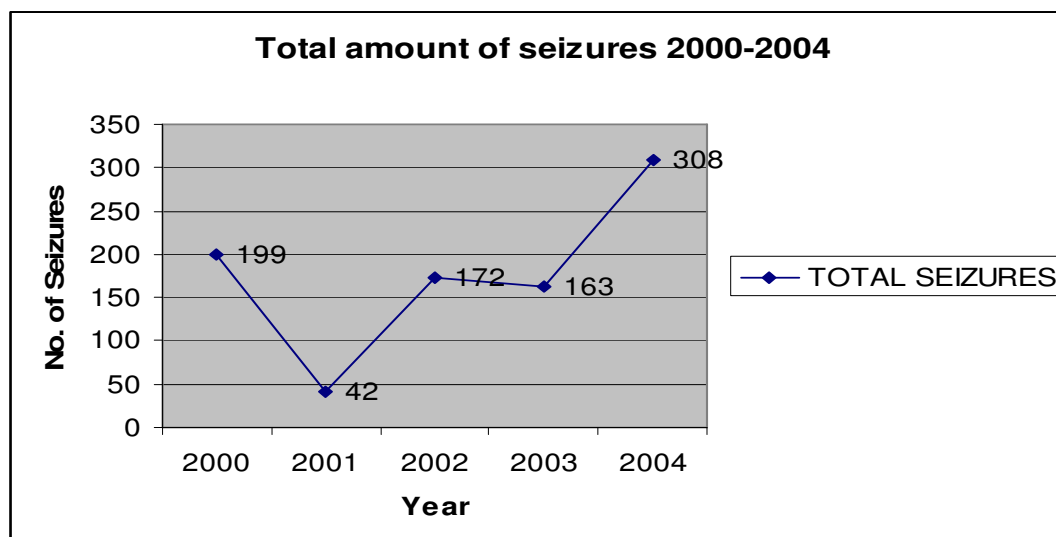


Figure 10.1 Total Amount of Seizures 2000-2004  
Police Drug Squad Annual Reports 2000 -2004

The majority of seizures in 2004 were for cannabis resin (33%, 102 seizures), ecstasy tablets (28%, 87 seizures) and heroin (22%, 68 seizures). Although there was an increase in the total number of seizures in 2004, the amounts of drugs seized were comparatively lower than those for 2003. Law enforcement sources report that this decrease was due to fewer individuals who were caught entering the country by air or by sea carrying large quantities of drugs. Thus most of the seizures made were from the streets.

In terms of trafficking from overseas in 2004, the most significant seizure was that of approximately 10kilos of cannabis resin, which was imported into Malta from Sicily. As for the local scenario:

- Cannabis resin was seized in five separate cases where a total of 14 kilos were seized in various locations around the island, the highest amounting to a total of 8 kilos and the smallest of 1 kilo.
- A cannabis plantation was discovered in the southern region of the island, resulting in a seizure of 290 plants and 2 kilos of cannabis grass.
- Ecstasy was manifest in two separate seizures one of 2000 ecstasy tablets and the other of 400 tablets.

Table 10.1 gives a picture of the total quantities of drug seized between 2000 and 2004.

**Quantities of Drugs Seized 2000-2004**

<b>Drug Type</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
heroin (grams)	5912.0	2848.0	1218.0	5498.0	769.0
cocaine (grams)	28.1	4549.0	4535.0	3716.0	152.0
cannabis resin (grams)	3913.0	3636.0	8801.0	34429.0	33081.0
cannabis grass (grams)	104.9	32.4	846.4	24532.8	2348.0
cannabis seeds	4.0	3.0	43.0	48259.0	2281.0
cannabis plants	22.0	20.0	12.0	125.0	293.0
LSD (microdots)	462.0	0.0	0.0	0.0	0.0
ecstasy (tablets)	5191.5	2458.0	1011.5	8694.5	6071.0
amphetamines (grams)	0.0	0.0	1.0	0.5	69.0

**Table 10.1 Quantities of Drug Seized 2000-2004**  
Police Drug Squad Annual Reports 2000-2004

In 2004 the majority of persons charged with drug trafficking were of Maltese nationality (89%). It appears that most of these persons were generally drug addicts who were dealing and trafficking drugs primarily to support their habit. As regards the number of non-Maltese residents who were caught trafficking drugs, these were more often than not seizures at the point of importation, that is, at the point of entry into the country. In this regard, the Malta Law Enforcement Units (Drugs Squad and/or Customs) apprehended 7 persons at the International Airport, 2 persons were en route from Holland, 1 from Germany, 1 from Turkey and 3 were traveling from Libya. As regards the Seaport, 2 persons were caught with drugs and these were en route from Sicily.

Table 10.2 shows that in 2004, cannabis followed closely by heroin were the most common drugs seized for trafficking.

**Traffickers by Nationality and Seizure Cases**

Nationality	Drug Type					Total
	Cannabis	Heroin	Cocaine	Amphetamines	Ecstasy	
British	3	0	0	1	0	4
French	2	0	0	0	0	2
Italian	3	0	0	0	0	3
Maltese	37	47	16	0	38	138
Libyan	5	0	0	0	1	6
Russian	1	0	0	0	0	1
Serbian	1	0	0	0	0	1
<b>TOTAL</b>	<b>52</b>	<b>47</b>	<b>16</b>	<b>1</b>	<b>39</b>	<b>155</b>

Table 10.2 Traffickers by Nationality and Seizure Cases  
Source: Police Drug Squad Annual Report 2004

### 10.3 Purity and Price

Over the years, drug purity levels for cannabis resin and cocaine base have remained stable overall. However, in 2004 the purity levels for cannabis herb decreased from 7% to 4.7 %. The National Forensic Science Laboratory, which is responsible for analysing seizures made by law enforcement units, stated that such a decrease was due to the plants lacking flowering tops, which in itself decreases the levels of tetrahydrocannabinol (THC).

On the other hand, the purity of ecstasy (MDMA) increased slightly from 30% to 33%. This level of purity is almost at par with the levels recorded for 2002 and 2003 but 17%

lower than the levels recorded for 2001. This decrease in purity is consistent with MDMA levels found across a number of other European countries. Figure 10.2 shows the percentage of drug purity at street level between 2001 and 2004.

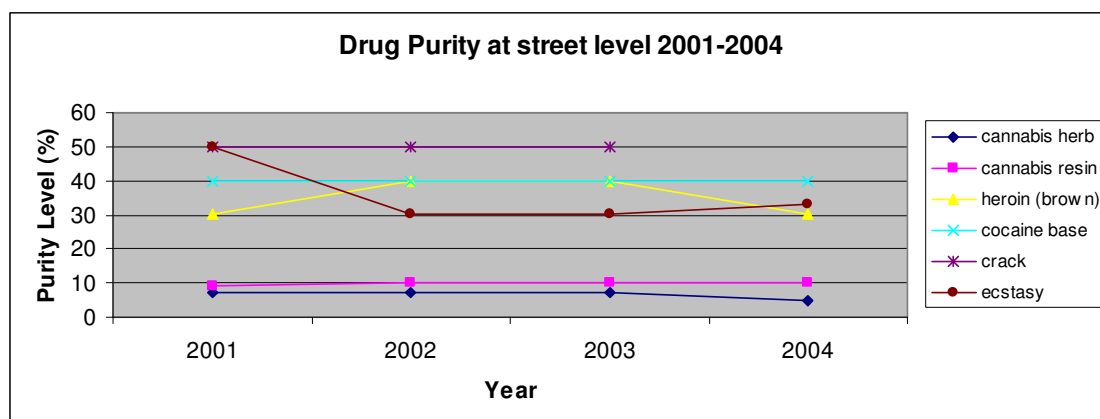


Figure 10.2. Drug Purity at Street Level 2001-2004  
Source: Malta Forensic Laboratory Data 2001-2004

In 2004, the prices for different narcotic substances at street level were collected from the five investigating officers responsible for drug related offences. The information given by the inspectors was obtained during investigations carried during the course of 2004. Drug prices between 2003 and 2004 have remained relatively stable. Table 10.3 shows the minimum price, maximum price and the mode (the most commonly reported price) for each drug. The price of amphetamine powder has remained relatively stable. Although seizures for amphetamine are considerably low (69grams) compared to other drugs, 2004 amphetamine seizures were the highest since 2000, with the drug commonly sold at around LM27 (EUR 64)<sup>1</sup> per gram. This price seems to compare to European retail prices for amphetamine (UNODC World Drug Report, 2005)

Price Range for Drugs at Street Level 2004

Drug Type (Per Gram)	Av. Min. Price (Euros)	Av. Max. Price (Euros)	MODE (Euros)
Cannabis resin	5.05	8.52	6
Cannabis herb	4.65	11.64	11
Heroin brown	49.36	76.82	60
Cocaine powder	76.16	102.43	88
Amphetamines powder	46.55	93.11	64
'Ecstasy' (per tablet)	6.05	19.08	10

Table 10.3 Price Range for Drugs at Street Level 2004  
Police Drug Squad Records 2004

<sup>1</sup>Rate of Exchange: 1EUR=0.429059 MTL

# **Part B**

## **Selected Issues**

## Chapter 11. Gender Issues

### 11.1 Gender-specific consumption amongst adolescents and young persons

Studies on drug consumption in Malta (Population Survey 2001, ESPAD 1995, 1999 and 2003, Health Behaviour in School-aged children (HBSC) study 2001/2002) have all shown that more men consume alcohol and illegal drugs than women. Some gender differences obtained from these studies are presented below.

The HBSC study, which was conducted on children aged 11 years, 13 years and 15 years shows primarily that as regards alcohol use, more boys than girls were reported to consume alcohol weekly, however percentages for Maltese children were higher than the HBSC average across all age groups and across both genders. In terms of cannabis use, more boys than girls reported to have ever used cannabis and to have smoked cannabis in the last year. Percentages in this regard are well below the HBSC average (Table 11.1).

**Tobacco, Alcohol and Cannabis Use Amongst 11, 13 and 15 year olds**

Substance	11 year olds		13-year olds		15-year olds	
	girls	boys	girls	boys	girls	boys
Alcohol (weekly drinking)	3.2%	9.1%	18.1%	21.0%	39.8%	55.8%
HBSC Average	3.0%	7.3%	9.2%	15.3%	23.9%	34.3%
Cannabis (Ever Used)					3.9%	9.2%
HBSC Average					18.9%	25.8%
Cannabis (Last Year Use)					4.4%	7.6%
HBSC Average					16.0%	21.7%

**Table 11.1. Tobacco, Alcohol and Cannabis use amongst 11, 13 and 15 year olds**  
Source: HBSC Study 2002/2002

Regarding alcohol use amongst 15-16 year olds, the last ESPAD study (2003) shows that alcohol use is very high amongst students of this age cohort. Continuation rates remain high as seen in the percentages of those who consumed alcohol in the last month prior to the survey. (Figure 11.1)

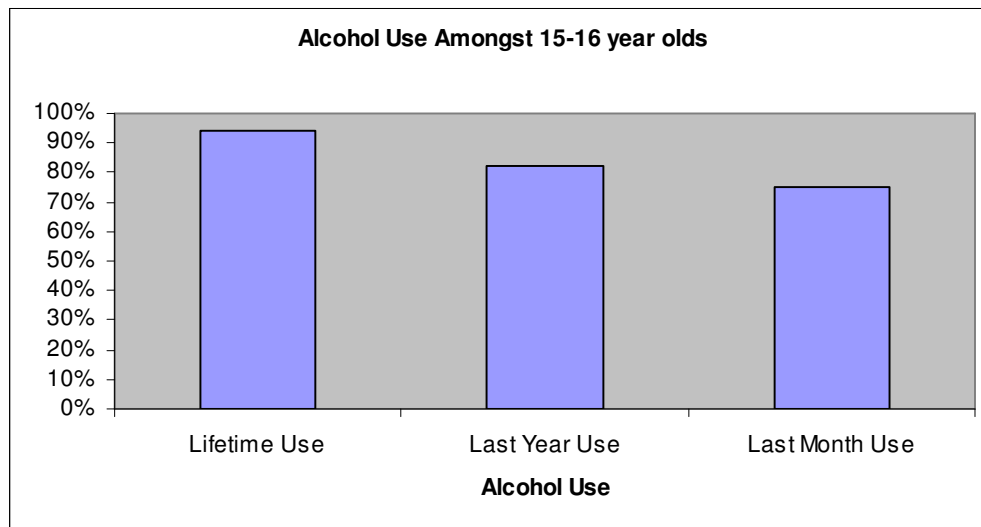


Figure 11.1 Alcohol Use Among 15-16 Year olds  
Source: ESPAD Survey 2003

Gender differences in alcohol consumption patterns exist, with males consuming more alcohol and at a higher frequency than females (Figure 11.2).

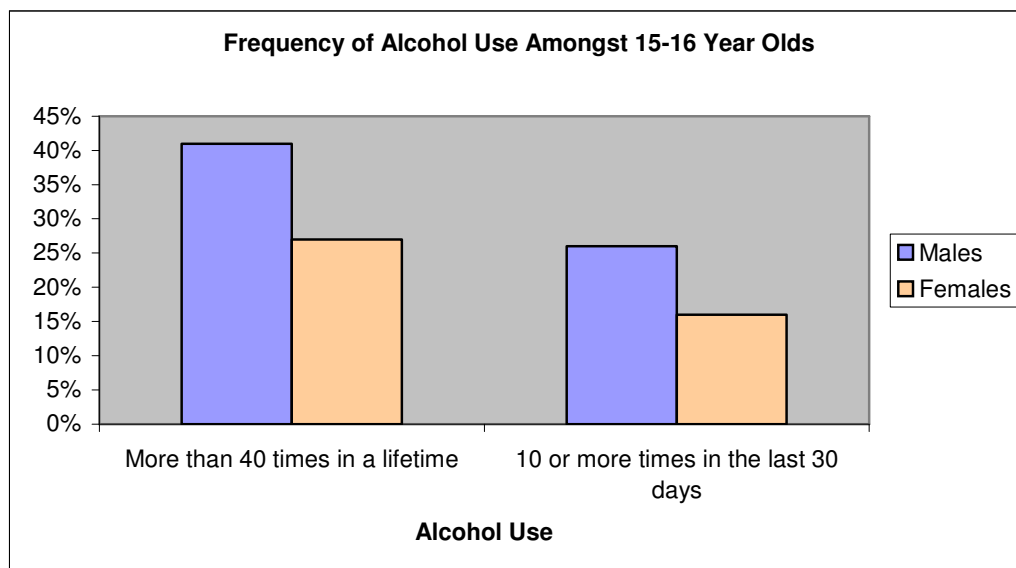


Figure 11.2. Frequency of Use of Alcohol Amongst 15-16 Year Olds  
Source: ESPAD Survey 2003

Alcohol use amongst young adults aged 18-34 years is also higher in males than in females as depicted by the results of the 2001 Population Survey (Figure 11.3)

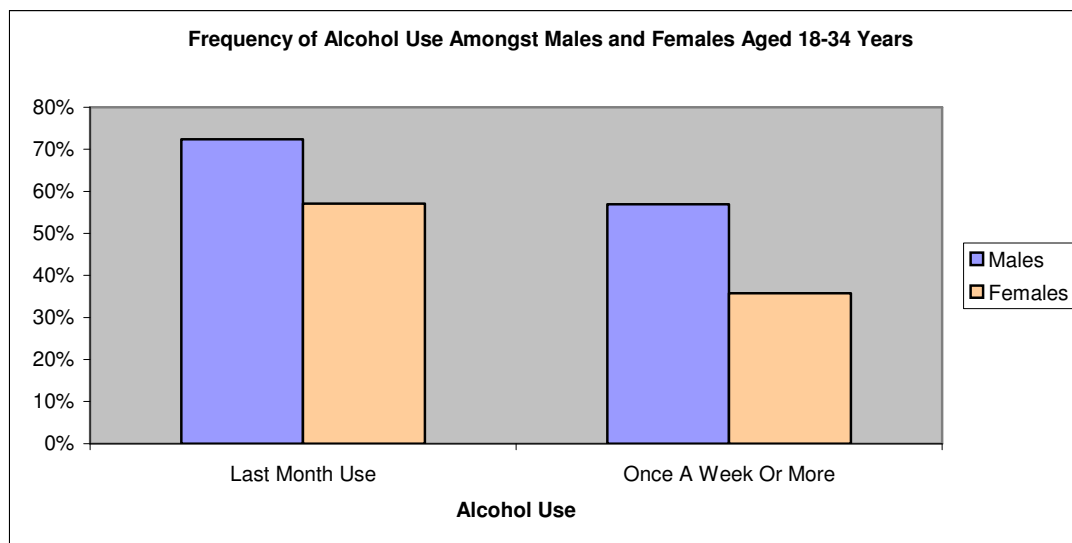


Figure 11.3. Frequency of Alcohol Use – Males and Females Aged 18-34 Years  
Source: Population Survey 2001

Gender differences on illicit drug use from the ESPAD studies (1995, 1999 and 2003) show that although more males use illicit drugs than females, increases in cannabis and other illicit drug use<sup>1</sup> in the reporting years have been observed across both genders (Figure 11.4).

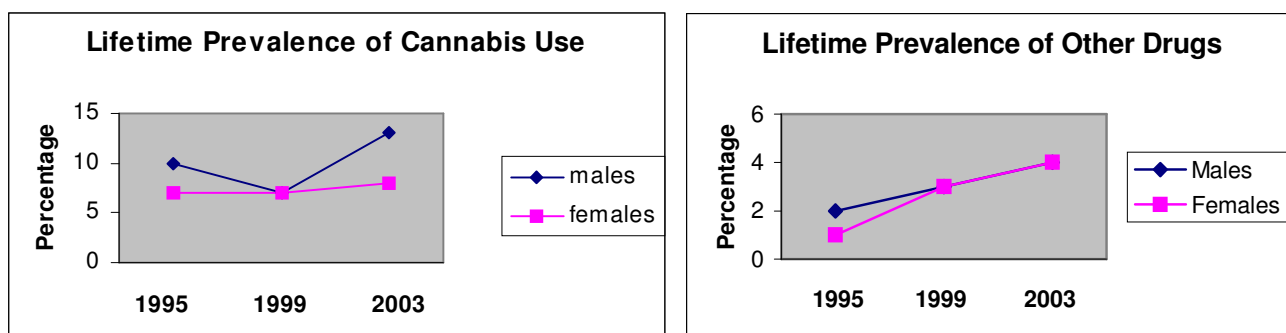


Figure 11.4. Life time Prevalence Cannabis Use and Life Time Prevalence Other Drugs  
Males and Females aged 15-16 years  
Source : ESPAD 1995, 1999, 2003

## 11.2. Other Drug Related Gender Issues

### Gender Issues and Crime

Regarding crime data, the 2004 police arrest data shows that 64% of charges for drug law offences were persons aged between 19-30 years. The female:male ratio for arrests

<sup>1</sup> Other illicit drug use = use of amphetamines, LSD, Crack/Cocaine, Ecstasy, Heroin and Inhalants



in this age group was 1:10. Persons aged between 14-18 years of age amounted to 19 % of the total number of persons charged with drug law offences, the female:male ratio in this age group was 1:7.

Probation data 2004 shows that 87.7% of their clients were male. The average age of males was 27.2 years (median 26 years) whereas the average for females was 27.7 years (median 27.5) years. Overall, there were a larger proportion of younger female clients than males, with the mode for females around 19 years and the mode for males 26 years. Interviews with Probation Officers revealed that Probation Orders given to women ranged primarily from theft to prostitution and even drug trafficking. Probation officers noted that female clients were overall more difficult to work with than male clients and tended to be less compliant than their male counterparts.

CCF (prison) 2004 data showed that incarcerated women were mainly in their 30s or 40s. None were married; most either cohabited or were separated. Female prison sentences ranged from trafficking offences to aggravated theft, prostitution, money laundering, and tax evasion.

#### Gender Issues and Overdoses

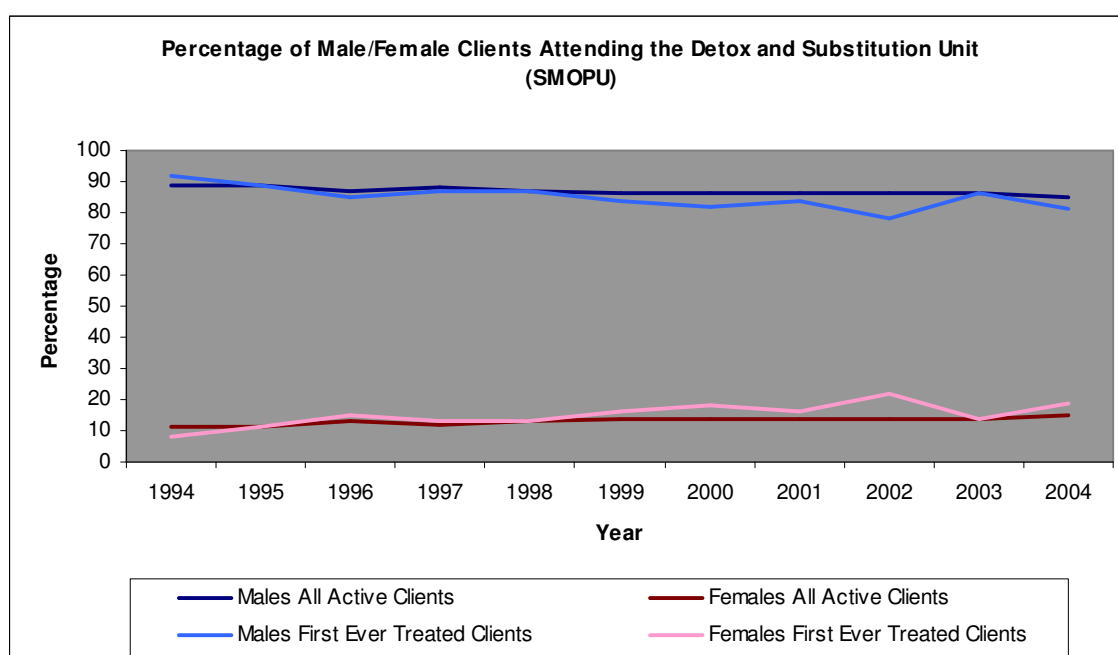
Males are more likely to be the victims of fatal overdoses with a male to female ratio of 11:1. With regards to non-fatal overdoses however, the 2004 data shows that from all the reported overdoses the majority, 54.1% were female. Most overdoses in 2004 occurred as a result of medicinals, namely psychotropic medication. Only 14% of all overdoses were the result of illicit drugs, namely heroin. Of these, 23 were males and 5 were females. This data illustrates that although there were more reports of female overdoses, more males overdose as a result of illicit drugs, whereas more females overdose as a result of medicinals or psychotropic medication.

#### Gender Issues and Treatment Data

The treatment data for 2004 shows that male clients outnumbered female clients in treatment with a female: male ratio of 1:6 for 'all active clients in 2004' and a female: male ratio of 1:4 for 'First Ever Treated Clients'. With regards to 'all active clients in

2004' the largest female: male ratio was observed in low threshold harm reduction services (1:7), a unit which essentially targets chronic relapsers.

Figure 11.5 shows the evolution of Treatment Demand for males and females frequenting the centralized methadone detoxification and substitution unit (SMOPU). Males by far outnumber females however the incidence of women in treatment has increased slightly from an average of 12% between 1994-1998 to 17% between 1999 and 2004.



**Figure 11.5. Evolution of Treatment Demand by Gender**  
 Percentage of male / female clients attending the Detox and Substitution Unit (SMOPU) 1994-2004  
 Source: Sedqa Reports 1994-2004

Overall women tend to seek treatment for the first time at a slightly younger age than men, although the average age of first contact is young across both genders. The average length of time for all clients in treatment in 2004 was approximately 5 years for males and 4 years for females (Table 11.2).

**Gender Differences – Age First Contact by Age in 2004**

2004 Treatment Data Files	Mean Age at First Contact	Median Age at First Contact	Mean Age at end 2004	Median Age at end 2004
All Active Male Clients	23.9 yrs	22 yrs	28.3 yrs	27 yrs
All Active Female Clients	22.3 yrs	21 yrs	26.8 yrs	25 yrs
First Treatment Demand Males	23 yrs	21 yrs		
First Treatment Demand Females	20.8 yrs	20 yrs		

**Table 11.2. Gender Differences – Age First Contact by Age in 2004**  
Source: Merged Treatment Data Files 2004

Patterns of drug use between males and females in treatment seem to be quite similar as seen in Table 11.3.

**Gender Differences - Patterns of Drug Use**

First Ever Treated 2004	No. in Treatment	% in Treatment	Primary Drug Heroin %	Ever Injected %	Currently Injecting %	Daily Use Primary Drug %
Males	134	80.2%	70.9%	91.8%	46.3%	75.4%
Females	33	19.8%	75.8%	90.9%	48.5%	78.8%
ALL Active Clients 2004	No. in Treatment	% in Treatment	Primary Drug Heroin %	Ever Injected %	% in Substitution Treatment	Daily Use Primary Drug %
Males	1299	85.2%	86.7%	89.5%	44.5%	79.4%
Females	225	14.8%	84%	88%	45.3%	80%

**Table 11.3. Patterns of Drug Use by gender**  
Source: Merged Treatment Data Files 2004

The data presented above, shows that although drug use is still primarily a male preoccupation, female drug users in treatment exhibit similar levels of severity of dependence as measured by frequency of use and route of administration. Interviews with various staff members from different treatment centres have highlighted some observed differences between male and female drug users.

- ❑ Initial use of heroin by women is highly influenced by a man, especially by a sex partner who is often a daily heroin user. Women tend to be introduced into the drug scene by their partner.
- ❑ Chaotic drug use has been more noted in women than men. Women tend to become addicted to heroin for example, within a short time after initial use. Their drug use increases dramatically and they tend to start using drugs intravenously faster than the men. Drug addiction is seen as a greater taboo by society for women than for men. It seems, however, that once women overcome the

threshold and start using drugs, they also lose all other forms of control much faster.

- ❑ Tranquilisers and sedatives are more likely to be abused by women whether or not other illicit drugs are abused. Female physiology is different to that of a male – this means that the same drug dose will have a different effect on a woman than it would on a man of the same weight.
- ❑ Female prostitution is highly related to drug use. Generally, the woman's partner is also her pimp, protector and drug supplier. Female drug users in these situations generally find it harder than others to break away from this kind of lifestyle. Sexually transmitted diseases such as Chlamydia, Human Papilloma Virus, which increases the probability of cervical cancer, Gonorrhea and Syphilis, which are highly associated with prostitution and promiscuity, are also major problems faced by women.
- ❑ Eating Disorders are more prevalent amongst female drug users than males. Young female adolescents in treatment are noted to have eating disorders – anorexia, bulimia or traits of both. Weight gain is one of the reasons why women often find it difficult to stop taking drugs.

In spite of the above issues, females in Malta have so far always been treated in settings together with males. None of the agencies have services or programmes that cater only and specifically for females. In other words, the services available for women are really male oriented programmes that might have been modified slightly in order to incorporate some female needs. There is no female Prison Inmates Program, Harm Reduction Shelter or Dual Diagnosis Unit for women, although these are available for males.

To date, the only special service for female drug users is the recently opened Well Woman Clinic at the Sedqa Misuse Outpatient Unit (the detoxification and substitution treatment unit). Women who are referred to the clinic are tested for sexually transmitted diseases and are also provided with basic medical and gynaecological care. Referrals are also made to St. Luke's Hospital Outpatients Gynaecology Unit, if further treatment or follow up is required. Pregnant drug users are also give priority at the clinic and are

closely followed up and monitored during their pregnancy. If they are still using drugs they are encouraged to undertake a methadone maintenance programme and advised to enter an inpatient treatment programme. Although detoxification from opioids prior to delivery is the ideal goal, this is not always possible or recommended. All pregnant drug users are encouraged to attend the antenatal clinic at St. Lukes Government Hospital that liaises constantly with the Well Woman Clinic. After the birth, the Neonatal Abstinence Scoring System is initiated and repeated every three to six hours. Following this, the baby is transferred to the Special Care Baby Unit (SCBU) where methadone is started. After discharge from the nursery, the babies and mothers are followed up and closely monitored by the Well-Baby Clinic, social workers and the respective drug agency.

The overall process of intake adopted with regards to women into the Detox Unit is especially important on the grounds that women in general find it more difficult to admit that they need help with their drug use problem than men. According to the head of the Well Woman Clinic, women do not consider tranquilisers and or benzodiazepines (at times prescribed and very often not) as drugs of addiction. Great care has to be taken, in order to identify those women who, in addition to abusing illicit drugs also abuse psychotropic medication. Women, generally abuse of such medication more than men, and as a result there are more reported overdoses from such drugs by females (refer to Chapter 6, section 6.4). Treatment staff have noted that in general women suffer from more body image problems and overall have a lower self-esteem than men. Additionally, due to hormonal differences, and factors related to the cessation of the menstrual cycle due to long term drug use, mood swings, especially depression, during and following detoxification are also more pronounced in women than in men.

#### Recent improvements in dealing with Gender Issues at Treatment Services

Female residents in a therapeutic setting are offered the opportunity to experiment with different work roles, rather than be restricted to traditional stereotyped roles. Special groups are offered for women, where they are given the space to reflect on what life choices and partner choices they can make. Female residents are more likely to take up with ex-drug users than their male peers possibly due to co-dependency problems. Special care is also given to women with regards to their insecurities and fears about

their physical appearance. Therapeutic communities also offer the possibility and the opportunity for children to visit over the weekend.

Community services also try and accommodate working single mothers by extending their counselling service times and by providing supervision for children during therapy sessions. Women who are eligible to join the therapeutic community but who cannot due to child care responsibilities, are given intensive outpatient support in the form of more frequent individual sessions and long term therapy

Individualised treatment plans are drawn up for pregnant women in a residential setting. Intensive tailor-made psychological and medical support is offered to these clients and their partners and families. There is no waiting list for medical and non-medical treatment for pregnant women. Pregnant heroin users are placed on methadone maintenance as early as possible. Drug using partners of pregnant women in treatment are also given special priority for treatment. Mothers on substitution treatment and their newborns are also given priority importance. In 2004 there were 14 babies born to mothers on methadone. These mothers were offered support and were closely monitored and followed up at intervals by a social worker and a drug agency key worker. Special training sessions are currently being organized to provide nurses and midwives with more knowledge regarding female drug users and their babies.

A study which is currently underway, concerns the possible advantages of using HPV (Human Papilloma Virus) tests instead of regular PAP smears for earlier detection of cellular changes that may result in cervical cancer or other reproductive health problems. If the study confirms that HPV is a better indicator of cellular changes then it may be made available to high-risk female clients.

#### Some general suggestions and the way forward

Although women and their needs have begun to appear more in the foreground, some services are still lacking:

1. In terms of residential treatment, a rehabilitation programme that caters only for women would serve to specifically address the needs of female drug users. Also,

- the dual diagnosis unit at Mount Carmel Psychiatric Hospital, which caters only for men needs to be extended in order to accommodate females with psychiatric co morbidity.
2. In terms of harm reduction, a drop in/shelter needs to be created for women. This service should liaise with the detoxification and methadone unit and the Well Woman Clinic and serve to provide female drug users with basic medical assistance, psychotherapeutic support and temporary accommodation.
  3. With regards to incarcerated women, more can be done in terms of addressing their parenting and relationship skills. Also, there is no provision for specialised monitoring and follow-up on inmates' children and/or their caregivers.
  4. In terms of prevention work, there may be a need for gender-specific prevention projects which focus on gender-typical and gender-sensitive themes.

## **Chapter 12. European Drug Policies Extended Beyond Illicit Drugs?**

### **12.1 Official Endorsement by the National Drug Strategy.**

As stated in the first chapter of this report, at present that is this reporting year 2004, Malta does not have a Drug policy or strategy as such in place. However, as also outlined in the same Chapter 1, the use of illicit drugs and medicinals are strictly regulated by the Dangerous Drugs Ordinance (Cap. 101) and the Medical and Kindred Professions Ordinance (Cap. 31). Both in turn regulate the manufacture, exportation, importation, possession, distribution and sale of such drugs. In addition, the laws covering the production, distribution, sale and purchase of alcohol are several (for example Spirits Ordinance of 1911, Cap. 41 and Alcoholic Beverages Regulations, Legal Notice 115 of 1974). Alas it is poignant to state that in Malta it is illegal to purchase alcohol for anyone under the age of 16 but it is legal to consume alcohol whatever one's age. The Parliamentary sub committee on Social Affairs provides the main forum through which issues pertaining to the area of addictions are discussed and mainly relate to issues of law. Any recommendations resulting thereof are forwarded to Parliament for consideration.

### **12.2 Genesis and Rationale.**

Before outlining current interventions that go beyond illicit drug use, it is relevant to present the information on the use of medicinals and alcohol within the ambit of our current knowledge of the situation. The population survey, the three ESPAD surveys and information on non-fatal overdoses provide a picture that most people in the country drink alcohol and do so for most of their lives. Moreover, the last estimate (Eurocare Alcohol Policy Network, 1998) for average yearly consumption was of the order 5.1 litres of absolute alcohol which is over twice as high as that recommended for the lowest mortality risk level for populations which was established as 2.0 litres of absolute alcohol per person per year (Edwards et al., 1994).

As regards medicinal use for non-medical purposes, both the 2001 population survey and reports of non-fatal overdoses highlight the fact that such substances are being used outside the prescribed regime and thus sometimes also show up at the emergency



department as overdose cases in combination with other substances, normally with alcohol.

In addition to the drug using population per se, there would appear to be an older cohort that resort to such medicines for what ever reason and the last estimate (2001) of current use was of the order of 25,000 or 10% of the population aged between 15-64 years. Increasing use with age however, was a main feature as depicted in figure 12.1. It is also of interest that such continuation rates by comparison are lower than that for alcohol but similar to tobacco.

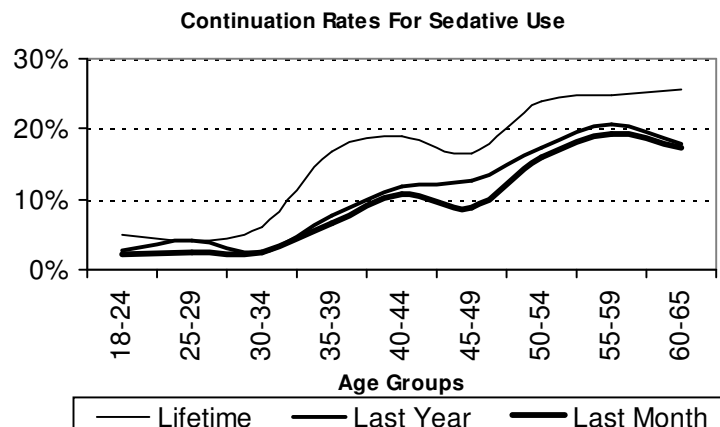


Figure 12.1 Continuation rates for sedative use  
Source: General Population Survey 2001

It is also clear that non-fatal overdose cases are made up two types of cohorts, mainly the younger generation who are admitted due to ODs related to heroin and an older generation punctuated by the presence of females who are admitted following the intake of large quantities of sedatives and/or antidepressants usually in combination with alcohol (Chapter 6). Universal prevention activities in general aim at promoting healthy life styles and thus provide information on all substances including the use of alcohol, tobacco and illicit drugs (Chapter 3).

### 12. 3 Responsibility and Competences (co-ordination).

The National Commission on the Abuse of Drugs, Alcohol and Other Dependencies, within the Ministry for the Family and Social Solidarity is the key body responsible for providing advice on policy issues in this sector as well as providing co-ordination within

the field. Consequently, the said committee has met twice per month during 2005 and together with the Policy Development Unit within the Ministry, outlined a Drugs Policy that includes both illicit drugs and medicinals. It is envisaged that by early 2006 a formal Drug Policy will be presented. In addition, it is intended that a separate policy for Alcohol be considered as part of the Commission's deliberations for 2006.

### **Chapter 13. Developments in drug use within recreational settings**

Research in Malta on drug use in recreational settings is extremely scant or non-existent. The only national data available is that provided by the ESPAD studies (1995, 1999 and 2003) amongst 15-16 year olds and the General Population Survey on licit and illicit drug use conducted in 2001. Whereas these studies provide insight into recreational drug use, and give indications on frequency of use among young people, they do not provide information on drug use in specific recreational settings. Both studies point towards the alarmingly high number of young people in Malta who drink alcohol and binge drink. The results from the ESPAD studies have shown that the majority of 15-16 year olds drink mainly in discos. Both the ESPAD and the Population Survey also report that on the other hand, use of illicit substances amongst 15-16 year olds and 18-34 year olds respectively, is much lower than that found in other European countries. The results of these studies are discussed in Chapter 2 and Chapter 11 of this report.

Non-evidence based observations and information suggest that drug use in recreational settings is on the increase, generally in organized rave parties where ecstasy is the main substance used, as well as in main stream night club settings and dance settings where anything from alcohol to ecstasy and cocaine are used. Observations regarding drug use in dance settings were obtained mainly from young people who frequent these places, outreach workers who at times were present at rave parties in 2003<sup>1</sup> and some paramedics. It is important to highlight that these observations are restricted and refer to young people who frequent rave parties and clubs and therefore exclude young people who are not party-goers or clubbers. Overall, reports point towards the opinion that a considerable number of young people in Malta who frequent such events use drugs recreationally, however since no specific studies on the subject matter exist, prevalence estimates for drug use by young people in such settings are not available.

As regards medical interventions at such venues, reports from paramedics on site confirm that these concern mainly alcohol intoxication and the treatment of wounds. It has been noted that party-goers are generally reluctant to approach the medical assistance on site, for fear of getting in trouble with the law as police are also present at these parties. In terms of safety it appears that in the case of large scale parties, the

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<sup>1</sup> Due to a lack of human and financial resources this outreach activity was terminated in 2004

degree of police attention and safety requirements vary wildly, depending on the organisers of the party.

Drug use in recreational settings in Malta can be divided into the following categories:

*Main stream night club and dance settings* are frequented primarily by young people aged between 15 and 34 years old. The most common substance used in these settings is generally alcohol; however, in certain clubs, cocaine and ecstasy are also consumed by certain sub groups.

*Organised rave parties* are usually organised over the summer months or over the Christmas and Easter season. These parties are frequented by a wide array of young people. Opinions of persons present at these parties are suggestive of the fact that the majority of young persons who attend such events use drugs, namely ecstasy.

*Illegal parties or 'After Parties'* generally start during the early hours of the morning, after a rave party or night club. Some even take place in the form of 'weekend binges'. These parties generally occur in unauthorised venues or private residences. People become informed about such events either via word of mouth, emails, websites or text messages.

*"Festi"* - Malta's 'harvest festival' known as 'Mnarja' which falls on the 29th June, opens the 'Summer Season'. Very typical of such seasonal events are the village feasts or 'festi'<sup>2</sup> in honour of the patron saint of the particular town or village. Held over a period of five days, the feasts are characterised by decorated streets, band marches and fireworks displays. Village feasts have been reported as milieus for binge drinking and also drug use amongst young people.

#### Ecstasy use

The rave/dance party culture in Malta started in the early 90's. During this period, a number of parties were organised by a small group of people who had close ties with the London party scene. Initially these parties targeted a small select crowd, however in 1992 the first rave parties opened to the public (Cassar, C, 1999). A large number of

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<sup>2</sup> One or more feasts are held every weekend during summer

Maltese youth attend such parties, which are commonly associated with alcohol and illicit drug use, namely ecstasy.

A 2001 post graduate thesis titled 'E: For Ecstasy' (Parnis, 2001) looked at the lifestyles and the influence of recreational patterns of substance use on Maltese ecstasy users' daily life. The study used the snowball method to interview seven experienced ecstasy users in depth. The age groups of participants in the study were 16 years to 28 years, which the author describes as representing the average ecstasy using age of Maltese youth. All 7 participants in the study had completed secondary school education, had full time employment and lived with either both or one of their parents. The author of the study states that typical ecstasy users in Malta are most likely to be middle-class, males, and single with no children. Additionally, they are likely to have many other friends who take ecstasy and it is probable that friends introduced them to the drug. The typical ecstasy user will see mainly the positive benefits of taking the drug, will assess this form of substance use as being positive and consequently use of ecstasy will probably become more regular and heavier as time goes by, if consumption persists. The two fundamental elements for taking ecstasy are rave parties and peer usage.

The interviewees in this study said they used ecstasy for the first time between ages 16 and 22 years, mainly out of curiosity. They had also tried a variety of other drugs including alcohol, cannabis, amphetamines, cocaine, LSD and one participant also used heroin. Substances, including alcohol, cocaine and amphetamines are taken as an accompaniment to increase ecstasy's effects and drugs like cannabis for example are used to help with its 'come down'. The average number of pills taken by the respondents in this study was around six per rave party. All respondents claimed to purchase their pills from 'known sources' prior to the rave, as this decreased the risk of buying a 'fake pill' or being caught by police. It emerged from the interviews that sometimes stringent entrance policies at rave venues led to dangerous pill taking behaviour in queues, or hazardous distribution networks inside. Heroin was negatively thought of by six of the respondents who did not want to be treated or regarded in the same way as a drug addict. Three of the respondents had been in touch with a treatment service for drug-related problems.

The author concludes by stressing the importance of harm minimising strategies targeting ecstasy users namely, education in the form of leaflets providing information regarding the short and long term risks of taking ecstasy, what types of chemicals are used in ecstasy pills, the effects of combined use of ecstasy with other psychoactive substances, and what to do to minimise health risks before or after taking ecstasy and in cases of emergency.

Another study titled 'Ecstasy as a recreational alternative' was conducted by an undergraduate student in 2002, with the aim of investigating the motivation, patterns of use and knowledge and attitudes regarding ecstasy use amongst Maltese youth (Galea, C, 2002). Sixteen interviews were conducted among persons aged between 16 and 30 years old. Participants were recruited using the snowball sampling method. None of the users in the study had ever been in touch with a drug agency for drug related problems.

Most respondents took ecstasy for the first time between the ages 16-19 years, however some started under the age of 16 years. Average ecstasy use per person was around 5-6 times yearly. Dependent users claimed to use the drug once a week or more, depending on finances and the types of parties that were taking place that week. The usual dose ranged from 1–7 tablets per time.

Curiosity and conformity with peers emerged as the main factors for trying the drug, whereas pleasurable experiences and 'good feelings' associated with the drug accompanied by availability and the fact that ecstasy is inexpensive, were the most common responses for continued use. Typical responses were:

*"I believe that this is a drug that gives you pleasure and it is a very nice experience and there's nothing to compare to it if you now how to use it well. Personally I think that's what makes it popular, and nowadays it's not expensive and it's easy to get. Plus its demand is escalating and it is also a social drug. If you're the shy kind of person it makes you socialise, and most of the friends I have, I got to know through parties, because with ecstasy you don't think twice before hugging someone whom you've never seen before in your life."*

*“Ecstasy is easy going, because you just pop it, unlike cocaine, heroin or cannabis.....E’s are trendy”*

The majority of respondents said they felt a difference between their initial ecstasy experiences and their present experiences, namely due to acquiring more tact on how to use the drug, more knowledge on how to perceive the drugs effect and augment its effect. The crowd, the music, the setting of the place and the DJ were all factors that ecstasy users consider important. Parties and clubs were the preferred places for using ecstasy amongst the respondents of this study. However, due to societal reactions some respondents stated that they moved to taking ecstasy at private parties or people’s houses in order to safe guard their image within society.

The respondents from this study all used other substances besides ecstasy, namely tobacco, alcohol, cannabis (to come down), and cocaine (either before or after taking ecstasy). LSD, speed and inhalants were also used, but to a lesser extent. Only one person in the study had ever used heroin. Most of the respondents in the study were cautious and aware of the risks involved in taking other drugs or using too much ecstasy and the majority stated that even though they used ecstasy it was not worth all the risks, especially regarding their health. Conversely, they also said that they were willing to use other drugs in order to achieve the desired effect, and in fact most were polysubstance users.

The older age groups said that they were planning to stop using ecstasy namely because they were getting older, bored of the drug, changing their lifestyles and were becoming more health conscious. For the females, the main motivation to stop was starting a family and having children. The respondents in this study did not seem to be aware of all the risks involved with ecstasy use. Most of the knowledge on ecstasy was obtained from the Internet. More experienced users had increased awareness of the risks involved. One respondent said:

*“When you take ecstasy you have to be sure that people around you are ok. If I see someone overdoing it I try to stop him. One problem I see is that there isn’t much education. You see people lying on the floor, their friends just leave them. You have to take care of these people; you can’t just let them be”.*

The general opinion obtained from this study around this theme, was that misinformation on ecstasy use was very common and that more knowledge targeting this group of drug users was needed, especially regarding harm minimisation and safer drug use. The 'say no to drugs' or ecstasy kills you' themes are not digested well by ecstasy users. From an ecstasy user's point of view the following measures and educational information is needed:

1. Leaflets and posters providing information on the general health risks and dangers involved in taking ecstasy and/or other drugs. This information may not be read on the spot, but may be taken home and looked at later.
2. Large posters at venues or additional information on flyers providing harm minimisation messages.
3. Specific information on how to cope in cases of emergencies
4. Outreach workers on site who can try and reach these users (who are not often reached by treatment agencies), disseminate drug education information and raise safety awareness about ecstasy.

If these young people are to be reached in any way it is crucial that secondary prevention measures and outreach work are implemented, strategically outlined and supported with the appropriate resources. As it has repeatedly been shown, young drug users especially those who are affiliated with certain youth scenes can hardly be reached by drug counselling and treatment centres. The internet, in the form of interactive websites providing harm minimisation information on the use of drugs is also another effective medium that can be used to reach this target group.

#### Cannabis, cocaine and other types of drug use

There are no specific studies or data on cannabis, cocaine and other types of drug use in recreational settings. The last Population Survey which sheds some light on recreational drug use among the general population was conducted in 2001. The results of this survey have been presented in Chapter 2 of this report and the 2004 National Report. Further discussions on this survey and future plans regarding a Youth Survey study on licit and illicit drug use can be found in this report, Chapters 2.1 and 2.2 respectively.



# **Part C**

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**Abbreviations**

EMCDDA	European Monitoring centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
ETC	Employment Training Corporation
CCF	Corradino Correctional Facility
DDU	Dual Diagnosis Unit
GCSE	General Certificate of School Exams
GMR	General Mortality Registry
GU	Genitourinary
HBSC	Health and Behaviour in School Aged Children
HBV	Hepatitis B Virus
HIV	Human Immune Deficiency Virus
HPV	Human Papilloma Virus
ICD	International Classification of Diseases
IDU	Injecting Drug User
LSD	Lysergic Dyethylamide Acid
MCAST	Malta College of Arts science and Technology
NCADAD	National Commission on the Abuse of Drugs Alcohol and other Dependencies
NFP	National Focal Point
OD	Over Dose
PIP	Prison Inmates Programme
PSAAB	Prison Substance Abuse Assessment Board
PSD	Personal and Social Development
PSR	Police Special Registry
SAFE	Substance Abuse Free Employees
SATU	Substance Abuse Therapeutic Unit
SCBU	Special Care Baby Unit
SMOPU	Substance Misuse Outpatients Unit
TC	Therapeutic Community
THC	Tetrahydrocannabinol
TDI	Treatment Demand Indicator
WHO	World Health Organisation

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