



European Monitoring Centre for  
Drugs and Drug Addiction



National Anti-drug Agency



**2013 NATIONAL REPORT (2012 data)  
TO THE EMCDDA by the Reitox National Focal Point**

# **ROMANIA**

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

**REITOX**

**The National Anti-Drug Agency thanks all its partners and collaborators for their contribution to this report.**

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The National Report on Drugs 2013 analyzes data regarding the drug demand and supply in Romania in 2012, national policies and legislation in this field, as well as trends and developments recorded throughout the last years.

The first chapter – **National context and policies in the field** – presents the changes that took place in the reference year in terms of anti-drug policy in Romania. Even if 2012 meant a year with a great deal of political events and changes, from the anti-drug policies point of view, this year represented the moment to draw the line and also the moment to define future lines of actions in this field. Reconfirming the National Anti-Drug Agency as a national coordinator of anti-drug policies meant a reversal to the right approach of the drug-related phenomenon in Romania, and a recovery of normality. This allowed a proper framework for the evaluation of the National Anti-Drug Strategy 2005-2012, as well as for drafting the new strategy, through consultation of all social stakeholders (institutions with responsibilities in this field of action, and also representatives of the civil society) and by ensuring a certain continuity in terms of a unitary understanding of the manner to design anti-drug policies in Romania.

The next eight chapters include data and information related to drug usage and to the response and measures taken in this field. Thus, the second chapter – **Drug use in the general population and among targeted groups** – presents the results regarding drug abuse and use behaviour resulted from the first research dedicated to assessment of risk/social exclusion degree performed in 2012 among non institutionalized drug users. According to such data, more than half of the individuals included in this research are using cannabis, approximately one fifth are using heroin, while over one tenth are users of new psychoactive substances (NPS). Almost half of the respondents included in this survey are practicing use of multiple drugs, as this use pattern is the strongest one among users who stated that the main drug used are ecstasy, cocaine or NPS. Also the results of this research indicate the fact that the most frequent solution for administering these drugs is by smoking/inhaling, and the second most used solution is by injecting them.

The third chapter – **Prevention** – is dedicated to programmes aimed at preventing drug usage. In 2012, the biggest challenge for the activities preventing drug usage was to accompany and provide support to adolescents and young people in managing their behaviour and in coping with multiple influences, as social rules, interacting with peers, living conditions and own personality traits. In this respect, the interventions centered on decreasing risky behaviours related to substance use were intensified, as the fact that young people are influenced by a complex set of environment conditions is well known, like what is considered to be normal and desirable within the communities that they live in, legislation and publicity that they are exposed at, availability of alcohol, tobacco and illegal drugs etc. In exchange, due to the weak matching of sectorial social policies and implicitly of cohesion (structural) funds, some relevant target groups from the point of view of the psycho-social risk are still left “untouched” – parents with mental disorders, children and young people without a shelter, families with a low economic status, population in rural areas, children at risk of school drop-out, women who are victims of domestic violence etc. This is why the need to step up selective interventions in the school-based and family-based environment is obvious, especially for those interventions performed in situations of psychological and/or family crises, with the purpose of identifying some comprehensive solutions for effective and efficient preventive interventions.

The fourth chapter – **Problem drug use** – presents indirect estimates for the prevalence of problematic drug usage (the number of problematic drug users in Bucharest) by using the multipliers method. One can notice a significant decrease in terms of the estimated number of problem drug users in Bucharest in 2012 compared to the previous years. Due to the methodological limitations of the estimates made based on the multiplier method, there is a need for confirming a potential decreasing trend in the number of problematic users. It is possible for the multiplier that was used, extracted from the BSS 2012 survey, to have been affected by the fact that the seeds used in the RDS-type sampling (respondent driven sampling) were collected to a larger extent compared to previous years from among individuals who have benefited from treatment services for drug addiction. The key limitation in

providing a national level estimate is still represented by the level of availability of services/programmes in the rest of the country.

Chapter five – **Admission to treatment consequent to drug use**, another key epidemiological indicator, includes information on the treatment system (institutional and procedural framework, assistance services for drug users, service centres authorisation methodology and criteria, support levels and therapeutical system, etc.) and on the evolution of this indicator during time. Thus, 3788 persons benefited from support consequent to psychoactive substance use in 2012. As compared to the previous year, we note an increase by 5.6% of the number of persons supported, due to an increase in the number of incidental cases (by 7.5% in illicit drug and NPS users and by 9.4% in alcohol and tobacco users). According to the type of support, for illicit drug and NPS use we registered a decrease in the outpatient support and an increase in the number of persons receiving support while imprisoned, as well as in the number of inpatient incidental cases. The main type of substances for which support was requested are heroin, NPS, hypnotics and sedatives and cannabis, and approximately one third of the beneficiaries reported multiple drug use and/or use of a secondary drug (NPSs being most common in multiple drug use/secondary drugs). In 2012 the situation returns to the level of 2010, and opiates rank first as the main drug with highest rate among admissions to treatment, while NPSs rank second in the total number of cases. The increasing trend for hypnotics and sedatives and for cannabis and decreasing trend for admission to treatment consequent to stimulants and hallucinogens use were maintained. There are significant changes in the territorial distribution: the most expanded is the use of cannabis, the most problematic (in number of cases/number of counties) continues to be NPS. On the other hand, Bucharest-Ilfov area registers the highest volume of opiates and NPS use, while most requests for hypnotics and sedatives continue to come from Iasi and Cluj. Moreover, the number of counties with multiple drug use related treatment continues to increase, while the areas with the highest risk continue to be the large university centres or border areas. There are no significant changes in the profile of beneficiaries requesting care consequent to heroin and cannabis use. Nevertheless, for those using NPS, we notice an increase in the period of use prior to requesting treatment, while for those using hypnotics and sedatives there is a decrease in the “gap” period between use onset and request for care.

The sixth chapter – **Health correlates and consequences** – includes information on the other two key epidemiological indicators: drug related infectious diseases and deaths consequent to drug use, as well as data on other drug related health correlates and consequences: medical emergency cases consequent to drug use and drug related psychiatric pathology.

With regards to **drug related infectious diseases**, in 2012, the HBV, HCV and HIV prevalence among IDUs registered significantly increasing trends, partly due to the changes in the use patterns. Another explanation for the trend changes reported in the three types of infections may be the substantial decrease of interventions aiming to reduce the drug related infectious disease risks, caused by a lack of funding, especially for projects implemented by specialised non-governmental organisations. Data available for HIV infection indicate that its prevalence more than doubled, which confirms an alarming trend in HIV spread, with NPS use doubling the infection risk. However, we note a lower HIV prevalence among young people at the onset of injecting use, which can be explained either by a tendency to isolate the infection among IDUs with longer injecting use experience and history, or by the high number of tests and by an intensification of HIV monitoring activities following the identification of the HIV outburst among IDUs in Bucharest. The outcomes of the third *Behavioural Surveillance Survey-BSS* among injecting drug users from Bucharest, conducted in 2012, support some of these conclusions related to the increase in HIV prevalence, as the prevalence they report is almost double: more than ½ of the subjects interviewed are HIV positive.

indicator On the other hand, they indicate a link between the high injecting frequency, characteristic to NPS use, as risk factor, and the increase of HIV prevalence among IDUs.

With regards to **medical emergencies caused by drug use**, although this is not a key epidemiological, it provides a more real-time reflection of the changes in the use pattern at national level. The detailed conclusions presented by this sub-chapter indicate that while the number of medical emergencies caused by illicit drug use is maintained at the level of the previous year, in 2012 we notice a territorial “segregation” of “territorial problem nuclei”, where the number of medical emergency cases caused by illicit drug use is higher. The number of emergency cases caused by NPS use (exclusive or multiple drug use) was maintained at the same level in 2012, but we noted significant increases of the

number of emergency cases caused by exclusive cannabis, opiate, generic drug and volatile solvent use. We note the upward trend in the number of emergency cases caused by multiple drug use whose number doubled in 2012 as compared to the previous year. The incidence of NPS use in a significant number of medical emergency cases where the emergency diagnosis indicated HIV or HCV infection or autolytic attempt by self-mutilation or hanging or even death in the emergency health care unit, indicate additional risks posed by this use pattern.

**The drug related psychiatric pathology** (personality disorders, depression, anxiety disorders, affective disorders, etc.) reflects an increase by almost 6 times of the number of cases diagnosed with various psychiatric disorders, which does not reflect implicitly only the increase in the total number of cases admitted to treatment for illicit drug use registered in comparison with the previous year.

The indicator **drug related deaths** shows that the increasing trend in the total number of drug related deaths, reported during the previous years as well, was maintained. However, the number of deaths directly attributable to drug use returns to values close to the numbers reported in 2007-2010 (years of stabilisation of drug use trend and patterns). Nevertheless, there is a difference with regards to the number of indirect deaths<sup>1</sup>, which, in spite of a slight decrease in comparison with the previous year, still maintains a high level as compared to 2007-2010, leading to the conclusion that only the cause of death changed, but not the number of deaths. Injecting use is still dominant among drug related deaths, and the opiates still predominate among the illegal drugs used in Romania, especially methadone, whose increasing use is alarming. A paradox is presented by the average death age in indirect cases, which is younger than the direct death average age, probably reflecting the accelerated degenerative potential of the new psychoactive substances. We also note the re-occurrence in the drug related direct deaths of substances reported in the past years (fortral, ketamine), as well as the increase of medicine incidence in the casuistry – possible reflection of the increasingly lenient control of medicine distribution.

The seventh chapter **Responses on the consequences of drug-use on health** describes the actions taken in this field. In terms of institutional responses to the sharp rise in the number of cases of HIV infection in 2011, resulted from the rapid proliferation of the phenomenon of new psychoactive substances and significant change in the injection *patterns* followed by IDUs, in 2012 the National Anti-Drug Agency acted within the boundaries of its resources and legal remit in order to cover for the major gap in the provision of harm-reduction services recorded after the main international funding bodies for such interventions pulled off from Romania. To this one may add: a sensible decrease of availability for community services for preventing infectious diseases among IDUs (only two specialized NGOs continued to work in 2012 in the field of community programmes for decreasing the level of risks associated to drug abuse). In this context, the coverage rate for such services decreased significantly compared to previous years (around 23% in 2012 compared to 50% in 2009 and 2010), while the number of syringes available within the distribution/exchange programmes for injection equipment was successfully maintained or even slightly increased. Also, one can also notice a decrease in the average number of syringes/beneficiary/year provided within the syringe exchange programmes throughout the last years, compared to the peak value recorded in 2009, or even with the 2008 value, which directly encouraged an increase of the infection risk for IDUs.

The eighth chapter **Social correlates and social reintegration** tackles aspects regarding the legal context and policies in this field and also social exclusion among drug users. In the year of reference, the civil society (with a serious representation at the level of civil society, as well as that of private providers), as well as state institutions have provided social integration/reintegration services for drug users. The small number of social insertion projects for drug users implemented in the year of reference is generated by the small ratio of active providers who are providing drug users with social rehabilitation services, matched by the insufficient development of services for preliminary levels of assistance (respectively 1<sup>st</sup> level and 2<sup>nd</sup> level assistance). In terms of the social exclusion that the drug users are exposed to, both the results collected during the regular monitoring of two indicators – Admission to treatment as a result of drug abuse and Medical emergencies resulted from drug abuse, as well as those resulted from the first survey performed by the National Anti-Drug Agency for the evaluation of social exclusion among drug users who were not included in assistance services, indicate

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<sup>1</sup> Deaths caused by drug related mental and behavioural disorders, and/or drug related diseases contracted as a result of sharing injecting equipment or of somatic complications caused by psychoactive substance use.

a high degree of social exclusion risk among drug users, especially among opioids and NPS users. Thus, the social profile of beneficiaries admitted to treatment for drug abuse in 2012 matches that of individuals who used emergency services: unemployed persons with secondary education (as a maximum). Moreover one can state that most of the beneficiaries of treatment services resulted from drug abuse have a stable home and over half of these are living with parents or families of origin. According to the survey performed by NAA, the drug users in Bucharest who had not been included in specific assistance services (provided in a public or private system) are mostly unemployed or staying at home and only a small percentage (6%) feel that they are excluded due to the lack of proper schooling or professional training.

The ninth chapter – ***Drug-related crime, prevention of drug related crime and prisons*** – addresses indicators regarding the number of crimes and investigated/convicted individuals, analysed according to the three stages of the criminal trial, and also presents information on the drug usage in prisons and interventions applied within the judicial system. The values recorded for 2012 under the main indicators monitoring the drug supply comply with the development trends recorded over the past years: the number of cases solved through indictment decreases, while the number of indicted individuals has increased compared to the previous years. This fact may emphasize a more intense involvement and increased efficiency of the activities undertaken by the law enforcement agencies in terms of collecting and present evidence within the criminal trial, but it can also act as an indicator in terms of cooperation among a larger number of individuals in order to commit drug-related crimes or associated offences. A significant increase in the number of drivers caught red-handed driving under the influence of substances/drugs may also be noticed. In terms of punishments applied for possession of drugs for one's use, there is a growing trend among judges to apply easier terms of punishment compared to previous years.

In terms of ***drug usage in prisons***, a slight decrease in the number of individuals self-declared as drug users at the beginning of detention may be noticed in relationship to the overall prison population, as registered by the end of 2012. In terms of the assistance provided to incarcerated drug users, one can notice that the decreasing trend for heroin-based admissions (2012- 43.1%) has been maintained, at the same time with the decrease of admissions for use of amphetamines and hallucinogenic drugs. Also, proportional increases are registered for: NPS and cannabis (each of them by 10 percentage points), cocaine, volatile inhalants and methadone.

Data regarding the drug supply (availability of drugs, trafficking routes and drug capturing, market price of drugs) are presented in the tenth chapter – ***Drug markets***. Romania retains its position as an important place of transit for the Balkan route of drug trafficking, as an alternate/secondary route for bringing cocaine to Europe, through the Constanța harbour, especially for the cocaine originated in Bolivia. Also, our country becomes more obviously a destination country also for most types of drugs: heroin, cannabis, cocaine, cannabis resin and synthetic drugs, a fact that is also confirmed by the significant catch recorded throughout 2011 and 2012 compared to the number of captures involved, quantities seized, types of the seized drugs and also their distribution on the Romanian soil. Thus, in 2012, one can notice a significant increase of approximately 60% of the total quantity of seized drugs, with increased levels compared to the previous year for heroin (3 times more) and for the illicit cannabis plants and plantations (3 times more), while the reference year stands out with the largest quantity of opium seized at national level throughout 2001-2012, and also with a significant development/expansion of cannabis plantations in open, as well as in closed locations.

## PART A. NEW DEVELOPMENTS AND TRENDS

### Chapter 1 – National context and policies in the field

2012 stands out as a year scarred by social and political events that generated debates at various levels, others than that included in the National Anti-Drug Agency remit

Due to this context, drug use and trafficking problems did not raise the interest of the political factors as in previous years, and this was reflected in the decreased number of interpellations and parliamentary requests on this topic.

On the other hand, 2012 followed the re-validation of the National Anti-Drug Agency as a legal entity commissioned to ensure the coordination, at national level, of the development and implementation of policies in response to the drug phenomenon, and focused on continuing the institutional reconstruction of the National Anti-Drug Agency and on strengthening its role as national coordinator of the anti-drug fight, maintaining a balanced and multi-sectoral approach on the drugs phenomenon, with a view to reducing both drug demand and drug supply.

At the same time, aware of the stabilisation of phenomena generated by the appearance and use of new psychoactive substances, the Agency continued its efforts to develop adequate legislation that would allow for the effective control of such phenomena, by drafting new legal initiatives aiming to amend and complete existing anti-drug legislation or to promote new legal provisions.

#### 1.1 LEGAL FRAMEWORK

##### 1.1.1 LAWS, REGULATIONS, DIRECTIVES OR GUIDELINES IN THE FIELD OF DRUG ISSUES (DRUG DEMAND AND SUPPLY)

In 2012, the National Anti-Drug Agency assumed its role as a coordinator and integrator of legal provisions and it provided specialised expertise for the development and approval of the following acts:

- **Order no 103 of 26 April 2012 approving the Procedure for the authorization of operations with products susceptible of having psychoactive effects, others than the ones provided by the documents in force, and of the authorisation and evaluation fees, issued by the Minister of Health, the Minister of Administration and Interior, and the President of the National Authority for Sanitary Veterinary Care and Food Safety.**
- **Order of the Minister of Administration and Interior and of the Minister of Health no 97 of 17.04.2012 and 252 of 16.03.2012, respectively, appointing the members of the evaluation commission provided by art. 7 paragraph (1) of Law no 194/2011 on countering the operations with products susceptible of having psychoactive effects, other than the ones provided by the documents in force.**
- **Law no 187/2012 on the enforcement of Law no 286/2009 on the Criminal Code**, published in the Official Gazette, Part I, no 757, of 12 November 2012, whose main objective is to ensure coherence of the existing criminal law with the provisions of the Criminal Code, and to establish rules on solving conflicting legal provisions generated by the coming into force of the new Criminal Code. In order to draft this law, all provisions included in the special laws were analysed, with special focus on aspects such as:
  - Repealing certain texts on incrimination from the special legislation, either because they were included in the Special part of the new Criminal Code or in order to avoid unnecessary overlapping of texts protecting the same social values;
  - Adaptation of sanctions for crimes which are maintained in the special legislation, according to the sanctioning approach of the new Criminal Code;
  - Updating the references to the rules of the Special Part of the Criminal Code, included in the special legislation;
  - Exculpation of certain deeds provided by the special legislation, including them among the minor offences, where applicable.



Law 187/2012 is expected to enter into force on February 1, 2014, together with Law no 286/2009 on the Criminal Code.

Among the legal provisions amended by the new law, with impact on the National Anti-Drug Agency field of competence, we mention:

- I. Law 143/2000 on preventing and countering the illicit drug use and trafficking, published in the Romanian Official Gazette, 1st Part, no. 362 of 3 August 2000, further amended and supplemented (art. 81 of Law no 182/2012);
- II. Government Emergency Ordinance no. 121/2006 on the legal regime of drug precursors, published in the Romanian Official Gazette, 1st Part, no. 1.039 of December 28, 2006, approved with amendments through Law no. 186/2007 (art. 194 of the Law no. 182/2012);
- III. Law no. 194/2011 on counteracting operations with products suspected to have psychoactive effects, other than those stipulated by the legislation in force, published in the Romanian Official Gazette, 1st Part, and no. 796 of November 10, 2011 (art. 232 of Law no. 182/2012).
- IV. Joint order of the Minister of Justice and of the Minister of Health no 429/C/125/2012 on ensuring health care to persons deprived of liberty in the custody of the National Administration of Penitentiaries<sup>2</sup>, comprising provisions on the medical, psychological and social assistance provided to drug users deprived of liberty.

**Table no. 1-1: Amendments brought to some regulatory documents from the specific field of activity through Law no. 187 of 24.10.2012 for applying Law no. 286/2009 on the Criminal Code**

The regulatory document subjected to amendments / Initial version of the text	The amended regulatory document / Current version of the text
<b>LAW No. 143 of 26 July 2000 on preventing and countering the illicit drug use and trafficking, further amended and supplemented</b>	<b>Law No. 187 of 24.10.2012 for applying Law no. 286/2009 on the Criminal Code</b>
<p><b>Art. 2</b>            (1) Growing, production, manufacture, experimentation, extraction, preparation, processing, offering, putting up for sale, sale, distribution, delivery either free of charge or for a consideration, dispatching, transportation, procurement, purchase, holding or other operations related to risk drug circulation, without legal right, shall be punishable by imprisonment from 3 to 15 years and the prohibition of certain rights.            (2) If the actions stipulated under paragraph (1) refer to high-risk drugs, the sentence shall be imprisonment from 10 to 20 years and prohibition of certain rights.</p>	<p><b>Art. 2</b>            (1) Growing, production, manufacture, experimentation, extraction, preparation, processing, offering, putting up for sale, sale, distribution, delivery either free of charge or for a consideration, dispatching, transportation, procurement, purchase, holding or other operations related to risk drug circulation, without legal right, shall be punishable by imprisonment from 2 to 7 years and the prohibition of certain rights.            (2) If the actions stipulated under paragraph (1) refer to high-risk drugs, the sentence shall be imprisonment from 5 to 1 years and prohibition of certain rights.</p>
<p><b>Art. 3</b>            (1) Bringing risk drugs into the country or taking them out of the country, as well as their import or export, without legal right, shall be punishable by imprisonment from 10 to 20 years and the prohibition of certain rights.            (2) If the actions stipulated under paragraph (1) refer to high-risk drugs, the sentence shall be imprisonment from 15 to 25 years and the prohibition of certain rights.</p>	<p><b>Art. 3</b>            (1) Bringing risk drugs into the country or taking them out of the country, as well as their import or export, without legal right, shall be punishable by imprisonment from 3 to 10 years and the prohibition of certain rights.            (2) If the actions stipulated under paragraph (1) refer to high-risk drugs, the sentence shall be imprisonment from 7 to 15 years and the prohibition of certain rights.</p>
<p><b>Art. 4</b>            (1) Growing, production, manufacture, experimentation, extraction, preparation, processing, purchase or holding risk drugs for one's own use, without legal right, shall be punishable by imprisonment from 6 months to 2 years or by a fine.            (2) If the actions stipulated under paragraph (1) refer to high-risk drugs, the sentence shall be imprisonment from 2 to 5 years.</p>	<p><b>Art. 4</b>            (1) Growing, production, manufacture, experimentation, extraction, preparation, processing, purchase or holding risk drugs for one's own use, without legal right, shall be punishable by imprisonment from 3 months to 2 years or by a fine.            (2) If the actions stipulated under paragraph (1) refer to high-risk drugs, the sentence shall be imprisonment from 6 months to 3 years.</p>
<p><b>Art. 5</b>            Knowingly making available, either free of charge or for</p>	<p><b>Art. 5</b>            Knowingly making available, either free of charge or for</p>

<sup>2</sup>Joint order of the Minister of Justice and of the Minister of Health no 429/C/125/2012 on ensuring health care to persons deprived of liberty in the custody of the National Administration of Penitentiaries, published in the Official Gazette of Romania no. 124 of 21. 02. 2012

a consideration, a precinct, dwelling or any other arranged place of public access, for illicit drug use, or tolerating illicit drug use in such locations shall be punishable by imprisonment from 3 to 10 years and the prohibition of certain rights.

**Art. 6**

(1) Intentional prescription of high-risk drugs by a physician, without this being required from the medical point of view, shall be punishable by imprisonment from 1 to 5 years.

(2) The same sentence shall also sanction the intentional release or obtaining of high-risk drugs, based on a medical prescription issued under the terms stipulated under paragraph (1) or on a forged medical prescription.

**Art. 8**

Supplying toxic chemical inhalants to a minor, in view of use, shall be punishable by imprisonment from 6 months to 3 years.

**Art. 10**

Organisation, management or funding of the actions stipulated under articles 2-9 shall be punishable by the punishments provided by the law for such actions. The maximum limits of such punishments shall be increased by 3 years.

**Art. 11**

(1) The urge to illicit use of drugs, by any means, if followed by such action, shall be punishable by imprisonment from 6 months to 5 years.

(2) If the urge to consume drugs is not followed by such action, the punishment shall be imprisonment from 6 months to 2 years or a fine.

**Art. 13**

(1) Attempts to commit the crimes stipulated under articles 2-7, 9 and 10 shall be punishable.

(2) Production or procurement of the means or instruments, as well as taking steps aimed at committing the crimes stipulated under paragraph (1) shall also be deemed an attempted crime.

**Art. 15**

No punishment shall be applied to a person who, before the criminal prosecution starts, denounces to the competent authorities his/her participation in an association or in an agreement aimed at committing one of the crimes stipulated under articles 2-10, thus allowing the competent authorities to identify and hold the other participants criminally accountable.

**Art. 19<sup>1</sup>\***

(1) In case the crimes stipulated under art. 4 are committed the prosecutor shall order an evaluation of the drugs user by the Centre for anti-drug prevention, evaluation and counselling within 24 hours since the inception of criminal prosecution, in order for him/her to be included in the integrated network for assisting drugs users.

(2) After receiving the evaluation report, drafted by the Centre for anti-drug prevention, evaluation and counselling, based on the judicial-medical report, the prosecutor shall decide, with the consent of the

a consideration, a precinct, dwelling or any other arranged place of public access, for illicit drug use, or tolerating illicit drug use in such locations shall be punishable by imprisonment from 2 to 7 years and the prohibition of certain rights.

**Art. 6**

(1) Intentional prescription of high-risk drugs by a physician, without this being required from the medical point of view, shall be punishable by imprisonment from 1 to 5 years and the prohibition of certain rights.

(2) The sentence stipulated under paragraph (1) shall also sanction the intentional release of high-risk drugs, based on a medical prescription issued under the terms stipulated under paragraph (1) or on a forged medical prescription.

(3) Obtaining high-risk drugs by using a medical prescription issued under the terms stipulated under paragraph (1) or a forged medical prescription shall be punishable by imprisonment from one to 3 years.

**Art. 8**

Supplying toxic chemical inhalants to a minor, in view of use, shall be punishable by imprisonment from 6 months to 2 years.

**Art. 10**

Funding of the actions stipulated under art. 2 shall be punishable by the punishments provided by the law for such actions. The special limits of these punishments shall be increased by one third.

**Art. 11**

The urge to illicit use of high-risk drugs, by any means shall be punishable by imprisonment from 6 months to 3 years.

**Art. 13**

(1) Attempts to commit the crimes stipulated under art. 2, art. 3, art. 4 para. (2), art. 6 para. (2)-(3), art. 7 and art. 10 shall be punishable.

**Art. 15**

No punishment shall be applied to a person who commits one of the crimes stipulated under art. 2-8 and art.10 and who, before the criminal prosecution starts, denounces to the authorities his/her participation to committing the crime, thus contributing to the identification of and holding the author or the other participants criminally accountable.

**Art. 19<sup>1</sup>\***) (1) In case the crimes stipulated under art. 4 are committed the prosecutor shall order an evaluation of the drugs user by the Centre for anti-drug prevention, evaluation and counselling within 24 hours since the inception of criminal prosecution, in order for him/her to be included in the integrated network for assisting drugs users.

(2) Depending on the conclusions of the evaluation report drafted by the Centre for anti-drug prevention, reception, evaluation and counselling, within 5 days since its reception, the prosecutor decides, with the drugs user's consent, to include him/her in the

suspect or of the accused, on his/her inclusion in the integrated assistance programme for drugs users, within 5 days.

(3) If the measure of detention under remand was taken against the suspect or the accused, it may be revoked or replaced by other preventive measure.

(4) In all cases, criminal prosecution is continued according to the provisions of the Criminal Proceedings Code.

#CIN

\*) According to art. 2 of Law no. 522/2004 (#M3), the provisions of art. 19<sup>1</sup> shall enter into force on the date of the new Criminal Code entering into force.

#### **Art. 19<sup>2</sup>\***

(1) If, up to the moment when a court decision is reached, the defendant follows the protocol of the integrated assistance programme for drugs users, the court may refrain from applying any punishment to him/her or may postpone the application of such punishment.

(2) In case it postpones the application of a punishment, the court shall set down within the contents of the court decision the date when it is due to issue a decision on such punishment; such deadline may not exceed 2 years, matching the length of the integrated assistance programme for drugs users.

(3) The time interval between the moment when a court decision is issued and the date set out by the court according to para. (2) shall be considered as a trial period for the accused.

(4) The suspect or the accused who refuses to be included in an integrated assistance programme for drugs users shall be subjected to the provisions of the Criminal Code and of the Criminal Proceedings Code.

(5) If, during the trial period, the defendant has complied with the integrated assistance programme for drugs users, the court may refrain from applying any punishment.

(6) If the defendant fails to comply with the integrated assistance programme for drugs users, the court may decide to postpone one more time the punishment, for the same time period and to reinsert him/her in the integrated assistance programme for drugs users or may decide to apply the punishment stipulated by the law.

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\*) According to art. 2 of Law no. 522/2004 (#M3), the provisions of art. 19<sup>2</sup> shall enter into force on the date of the new Criminal Code entering into force.

#### **Art. 2**

The current law enters into force within 3 months since the date when it has been published, except for art. 19<sup>1</sup> and 19<sup>2</sup> of the Law no. 143/2000, which enters into force on the date of the new Criminal Code entering into force.

**The regulatory document subjected to amendments / Initial version of the text**

**Government Emergency Ordinance no. 121/2006 on the legal regime of drug precursors, published in the Romanian Official Gazette, 1st Part, no. 1.039 of December 28, 2006, approved with amendments through Law no. 186/2007 (art. 194 of the Law no. 182/2012)**

integrated assistance programme for drugs users.

#### **Art. 19<sup>2</sup>\***

(1) If, up to the moment when a court decision is reached, the defendant mentioned under art. 191 follows the protocol of the integrated assistance programme for drugs users, the court may decide to renounce to the application of the punishment or to the postponement of the punishment, even if not all conditions stipulated under art. 80, respectively art. 83 of the Criminal Code are fulfilled.

(2) Failure to comply with the terms of the integrated assistance programme for drugs users during the trial period correspondingly results in the enforcement of the provisions art. 88 para. (1) of the Criminal Code.

#### **Art. 158**

The final provision of article II of Law no. 522/2004 for amending and supplementing Law no. 143/2000 on preventing and countering the illicit drug use and trafficking, published in the Romanian Official Gazette, 1st Part, no. 1.155 of December 7, further amended and supplemented, is eliminated.

**The amended regulatory document / Current version of the text**

**Law no. 187 of 24.10.2012 for enforcement of Law no. 286/2009 on the Criminal Code  
DOCUMENT ISSUED BY: Romanian Parliament  
DOCUMENT PUBLISHED BY THE ROMANIAN OFFICIAL GAZETTE No. 757 of November 12, 2012**

<p><b>Art. 22</b>  (1) Making available on the market, import, export, production, manufacture, offering, provision, sale, transportation, delivery under any consideration, dispatching, market placement, procurement, buying, synthesis, extraction, experimentation, intermediary activities, as defined by art. 2 letter e) of Regulation 111/2005, procurement or possession of classified substances, equipment, or materials without legal right shall be deemed a crime and it is punishable by imprisonment from 1 year to 5 years.  (2) Trading classified substances to companies or to natural persons who are not authorized or registered for working with such substances shall also be deemed a crime, in accordance with art. 6-8 of Regulation 111/2005 and it is punishable with the punishment stipulated under para. (1).  (3) Committing the actions stipulated under para. (1) and (2) with the purpose of using them for illicit growing, producing or manufacturing of drugs is punishable by imprisonment from 3 years to 10 years and the prohibition of certain rights.</p>	<p><b>Art. 22</b>  (1) Making available on the market classified substances, their import, export and intermediary activities related to those, and also possession of classified substances without the authorization stipulated by art. 5 para. (1), respectively without the registration stipulated under art. 7 para. (1) and (4) shall be deemed as crimes and are punishable by imprisonment from 6 months to 5 years or by fine.  (2) Trading classified substances to companies or to natural persons who are not authorized according to art. 5 para. (1) or, if applicable, who are not registered according to art. 7 para. (1) and (4) for working with such substances shall be deemed a crime and it is punishable by imprisonment from 3 months to 3 years or by a fine.</p>
<p><b>Art. 23</b>  Crossing classified substances over the border, without the accompanying documents stipulated by this Emergency Ordinance shall be deemed an aggravated smuggling offence, covered and punished by art. 271 of Law no. 86/2006 on the Romanian Customs Code.</p>	<p>Repealed</p>
<p><b>Art. 24</b>  (1) The seizure of classified substances is to be decided in accordance with the law for those crimes stipulated under art. 22 and 23.  (2) If the classified substances that had been the subject of the crimes stipulated under art. 22 are not found, the perpetrator must pay their equivalent money value.</p>	<p>Repealed</p>
<p><b>Art. 25</b>  Criminal prosecution for the crimes stipulated under art. 22 and 23 is performed by prosecutors from the Department for Investigation of Organized Crime and Terrorism within the Prosecutor's Office attached to the High Court of Justice.</p>	<p><b>Art. 25</b>  Criminal prosecution for the crimes stipulated under art. 22 is performed by prosecutors from the Department for Investigation of Organized Crime and Terrorism within the Prosecutor's Office attached to the High Court of Justice.</p>
<p><b>The regulatory document subjected to amendments / Initial version of the text</b>  <b>Law no. 194/2011 on counteracting operations with products suspected to have psychoactive effects, other than those stipulated by the legislation in force, published in the Romanian Official Gazette, 1st Part, no. 796 of November 10, 2011 (art. 232 of Law no. 182/2012)</b></p>	<p><b>The amended regulatory document / Current version of the text</b>  <b>Law No. 187 of 24.10.2012 for enforcement of Law no. 286/2009 on the Criminal Code</b>  <b>DOCUMENT ISSUED BY: Romanian Parliament</b>  <b>DOCUMENT PUBLISHED BY THE OFFICIAL GAZETTE No. 757 of November 12, 2012</b></p>
<p><b>Art. 16</b>  (1) The action taken by a person who performs operations with products that are known to him/her as suspected of having psychoactive effects, without an authorization issued in accordance with this law, shall be deemed a crime and it is punishable by imprisonment from 2 to 8 years and the prohibition of certain rights, unless this action represents a more serious offence.  (2) The action taken by a person who performs operations with products that he/she should or could have foreseen to be suspected of having psychoactive effects, without an authorization issued in accordance</p>	<p><b>Art. 16</b>  (1) The action taken by a person who performs operations with products that are known to him/her as suspected of having psychoactive effects, without an authorization issued in accordance with this law, shall be deemed a crime and it is punishable by imprisonment from 6 months to 3 years or by a fine, unless this action represents a more serious offence.  (2) The action taken by a person who performs operations with products that he/she should or could have foreseen to be suspected of having psychoactive effects, without an authorization issued in accordance with this law, shall be deemed a crime and it is</p>

with this law, shall be deemed a crime and it is punishable by imprisonment from one to 3 years.	punishable by imprisonment from 3 months to 2 years or by a fine.
<p><b>Art. 17</b> The action taken by a person who purportedly performs operations with products that are suspected of having psychoactive effects, by pretending that or disguising them into products authorized in accordance to the law or whose trading is allowed by the law, shall be deemed a crime and it is punishable by imprisonment from 3 to 10 years and the prohibition of certain rights, unless this action represents a more serious offence.</p>	<p><b>Art. 17</b> The action taken by a person who purportedly performs without any legal right operations with products that are suspected of having psychoactive effects, by pretending that or disguising them into products authorized in accordance to the law or whose trading is allowed by the law, shall be deemed a crime and it is punishable by imprisonment from one year to 5 years and the prohibition of certain rights, unless this action represents a more serious offence.</p>
<p><b>Art. 18</b> (1) If the actions covered by art. 16 and 17 have resulted in the injury of one or more persons who require medical care up to a maximum of 60 days, the punishment shall be imprisonment from 6 to 12 years and the prohibition of certain rights, unless this action represents a more serious offence. (2) If the actions covered by art. 16 and 17 have resulted in the injury of one or more persons who require medical care for more than 60 days or in any of the consequences stipulated under art. 182 para. (2) of the Criminal Code, the punishment shall be imprisonment from 7 to 15 years and the prohibition of certain rights, and if action resulted in the death of a person, the punishment shall be imprisonment from 10 to 20 years and the prohibition of certain rights, unless this action represents a more serious offence.</p>	Repealed
<p><b>Art. 19</b> Preventing the control staff within the competent bodies under any circumstances from entering locations and headquarters with the purpose of performing checks, according to the terms of the law, during the regular work schedule, shall be deemed a crime and it is punishable by imprisonment from 6 months to 3 years or by a fine.</p>	<p><b>Art. 19</b> Preventing the control staff within the competent bodies under any circumstances from entering locations and headquarters with the purpose of performing checks, according to the terms of the law, during the regular work schedule, shall be deemed a petty offence and it is sanctioned with a fine ranging from 2,000 RON to 5,000 RON.</p>
<p><b>Art. 20</b> Publicity made to any products by credibly claiming that their use entails psychoactive effects shall be deemed a crime and it is punishable by imprisonment from one to 3 years and the prohibition of certain rights.</p>	<p><b>Art. 20</b> Publicity made to any products by credibly claiming that their use entails psychoactive effects shall be deemed a crime and it is punishable by imprisonment from one month to one year or by a fine.</p>

Source: NAA

On the other hand, the activity related to the development of the legal framework in the field of competence focused on the substantiation of positions on draft legislation regarding the drug field or other related fields.

Thus, in 2012 we submitted proposals and observations on the following: 11 draft laws, 11 draft Government Decisions, 7 draft Ordinances / Emergency Ordinances of the Government, 26 draft Orders of the Minister of Internal Affairs, 16 other legal documents (draft strategies, amendments of administrative regulatory documents of other ministries, standards), 4 drafts of the EU Regulation on EU rules within the area of freedom, security and justice.

The most representative were the following:

- Position on the draft GD on approving the national multi-sectoral strategy on the supervision, control and prevention of HIV/AIDS cases;
- Proposals and observations on the draft amendments to Law 194/ 2011 on counteracting operations with products suspected as having psychoactive effects, other than those stipulated in the regulatory documents in force;
- Proposals and observations on the draft law amending Law 35/ 1997 on the organisation and functioning of the ombudsman;

- Proposals and observations on the draft Regulation on the organisation and functioning of the inter-ministerial committee for defence and citizen safety;
- Proposals and observations on the draft Regulation on the organisation and functioning of the inter-ministerial committee for countering corruption, trans-national organised crime;
- Proposals and observations on the draft GO amending GO no 2/ 2001 on the legal regime of minor offences, further amended and supplemented;
- Proposals and observations on the draft national strategy for social integration of persons deprived of liberty and on the opportunity to amend Law no 290/ 2004 on the criminal record;
- Proposals and observations on the draft Law on social economy.

With regards to the programming documents in the field of drug precursors, 2012 witnessed intense analysis activity at European level. Therefore, the National Anti-Drug Agency indicated its position to the various aspects reviewed, for example COM. proposal 521/ 2012 amending Regulation 111/ 2005 laying down rules for the monitoring of trade between the Community and third countries.

**Table no. 1-2: Bills initiated by members of the Parliament, which targeted drug-related topics, 2012**

1.	PL-x 45/10.04.20 12	Bill of law for the approval of the Government Emergency Ordinance no. 105/2011 for amending art.1 of the Law no.143/2000 on preventing and countering the illicit drug use and trafficking, and also of art.8 from Law no.339/2005 on the legal regime of plants, substances and drugs preparations with narcotic and psychotropic contents The legal possibility is created for amending and supplementing the list including plants, substances and preparations with narcotic and psychotropic contents which are included in the scope of Law no. 143/2000 and of Law no. 339/2005, through a primary regulatory document at the level of an organic law.	Law 23/2013 04.03.2013
2.	PL-x 174/29.05.2 012	Bill of law for supplementing Law no.143/2000 on preventing and countering the illicit drug use and trafficking The draft bill has in its regulatory scope a supplementary position in the 4th Table of the appendix to Law no. 143/2000, including the following substances: "paint thinner, aluminium bronze, silvery bronze or bronze".	Bill rejected 12.03.2013
3.	PI-x 227/29.05.2 012	Bill of law for supplementing art. 3 para.(5) from Law no.349/2002 for preventing and counteracting the effects of tobacco-based product use The draft bill includes in its regulatory scope the amendment of art. 3 para. (5) of Law no. 349/2002, in the sense of making an exception from the prohibition of retail sale of cigarettes for specialized stores and catering companies.	Bill rejected 12.03.2013
4.	PL-x 244/12.06.2 012	Bill of law for amending and supplementing Law no. 339/2005 on the legal regime of plants, substances and preparations with narcotic and psychotropic contents This draft bill includes in its regulatory scope the amendment and supplementation of Law no. 339/2005, with the purpose of establishing the range of competence for the Ministry of Health, Ministry of Agriculture and Rural Development, and also of the National Sanitary Veterinary and Food Safety Agency in applying this law.	Law 179/2012 18.10.2012
5.	PL-x 268/25.06.2 012	Bill of law for amending Law no.194/2011 on counteracting operations with products suspected as having psychoactive effects, other than those stipulated in the regulatory documents in force The draft bill includes in its regulatory scope the amendment and supplementation of Law no. 194/2011 with the purpose of reducing the number of users of substances with psychoactive effects. It is also foreseen to insert in the basic regulatory document a new offence aiming at sanctioning the sale of such substances towards underage persons.	Bill rejected 05.03.2013
6.	PL-x 320/10.09.2 012	Bill of law on quality assurance in the field of social services This bill of law regulates the evaluation, certification, monitoring and control process for quality assurance in the field of social services, as a result of the entering into force of the Social Assistance Law no. 292/2011. The provisions of the law are to be applied to all social services, as well as to public and private social services providers operating in Romania.	Law 197/2012 01.11.2012

Source: NAA

Four interpellations related to the anti-drug issues were issued by Romanian member of the Parliament in 2012, as follows:

- Issuance of methodological rules on the enforcement of Law no 194/2011 on countering the operations with products susceptible of having psychoactive effects, others than the ones provided by the documents in force
- Alignment of Law no 194/2011 on countering the operations with products susceptible of having psychoactive effects, others than the ones provided by the documents in force with Law no 143/2000 on preventing and countering the illicit drug use and trafficking, further amended and supplemented
- Development of a set of measures to prevent illicit production of drugs or other related substances, to be implemented in 2012

6 legal initiatives were drafted<sup>3</sup> aiming to initiate new actions against the trade and use of new psychoactive substances. Although most legal initiatives focused on proposals to amend Law no. 143 of 26 July 2000 on preventing and countering the illicit drug use and trafficking, further amended and supplemented and Law no 339/2005 on the legal regime of plants, substances and preparations with narcotic and psychotropic contents, there were also attempts to develop distinct regulations on the conditions for selling intoxicant, hallucinogen, psychotropic plants, substances and preparations and their derivatives.

### 1.1.2 LAWS IMPLEMENTATION

The implementation of the **Action Plan to counter the trade and use of new psychoactive substances/ products that are health damaging No 5/1194 of 18.2.2011** continued throughout 2012 – in line with its structure focused on three major intervention fields, namely: organisational and legal actions, operational actions and prevention actions.

Without leading explicitly to the implementation of legal regulations in the anti-drug field, the purpose of the controls carried out by the mixed teams<sup>4</sup> was to end the trading of new psychoactive substances by enforcing the existing legal provisions in various fields such as: company law; legislation on documents related to proofs of origin of goods; legislation on compliance with storage, preservation and display requirements provided by manufacturers; legislation on product labelling; legislation in the financial-accounting field and compliance with tax regulations in force; legislation on sanitary requirements and personnel health, etc. The immediate effect of these controls was a significant decrease of the number of stores selling new psychoactive substances so that, before the end of December 2012 only one specialised store was still functioning in Romania (the so-called “dream shops” known as “Spice Shop”, “Smart Shop” or “Weed Shop”), as compared to the 158 existing shops identified when the legislation was adopted (March 2011).

The organisational and legal actions aimed both at the analysis of the existing legal framework both in Romania and in other Member States, to identify intervention means and legal possibilities to ban the advertisement, promotion and trade of the new substances by any means, including by internet, and to enforce the legal provisions identified, through the mixed control teams.

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<sup>3</sup> Romanian Senate – Legal Bulletin, September-December session 2011

<sup>4</sup> Joint Order of the Minister of Health no 121 of 16.2.2011, of the Minister of Agriculture and Rural Development no 43 of 16.2.2011, of the Minister of Administration and Interior no 43 of 17.2.2011, of the Minister of Public Finances no 1.647 of 16 February 2011, of the President of the National Authority for Sanitary Veterinary Care and Food Safety no 8 of 16 February and of the President of the National Authority for Users Protection no 1/239 of 16 February 2011 on setting up mixed teams to carry out controls, according to their competencies, in the places and/ or environments where new psychoactive, health damaging substances and/ or products are being produced, traded, consumed or used, other than those regulated (issued by: the Ministry of Health, Ministry of Agriculture and Rural Development, Ministry of Administration and Interior, Ministry of Public Finances, the National Authority for Sanitary Veterinary Care and Food Safety and the National Authority for Consumers Protection, published in the Official Gazette, Part 1, No 123 of 17 February 2011)

The operational actions aimed to identify all locations where new psychoactive substances are sold and used, to organise and carry out control actions at national level, to identify real opportunities to put in place laboratories for physico-chemical testing and, last but not least, to ensure adequate coverage in the media of activities undertaken and outcomes achieved.

Special attention was given to preventive actions aiming at developing specific activities to discourage the use of psychoactive substances, targeting students and young people in general.

The most significant results achieved in 2012 due to the implementation of the above-mentioned actions were as follows:

**Legal level:**

Order no 103 of April 26, 2012 on the approval of the Procedure for authorization of operations with products susceptible of having psychoactive effects, others than the ones provided by the documents in force, and of the authorisation and evaluation fees was approved and published in the Official Gazette Part I, no 330 of May 16, 2012, for the enforcement of Law 194/2011.

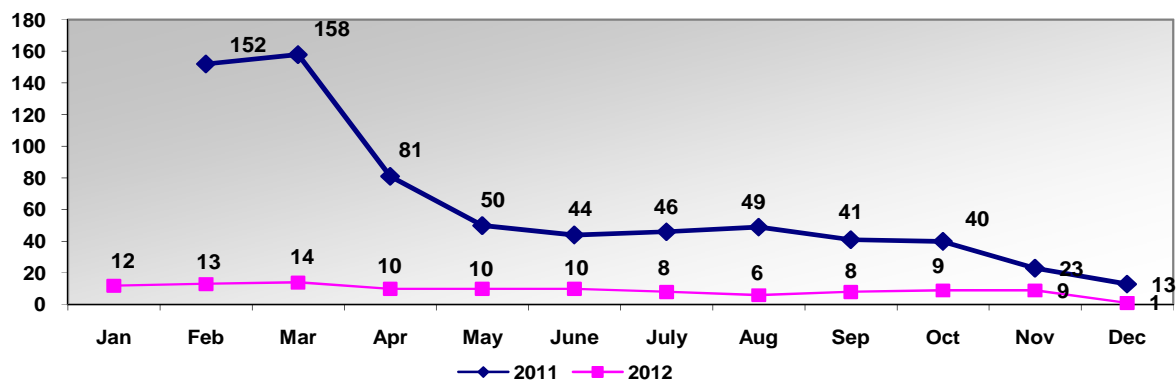
**Operational level:**

Organisation and performance of control activities carried out in compliance with the Joint Order on setting up mixed teams to carry out controls, according to their competencies, in the places and/ or environments where new psychoactive, health damaging substances and/ or products are being produced, traded, consumed or used, other than those regulated.

In January-December 2012:

- 670 control activities carried out.
- 414 civil sanctions and fines in amount of 540243 lei were enforced.
- 38370 envelopes containing NPSs were confiscated.
- The activity of 21 shops was temporary suspended.
- 26 shops were permanently closed.
- 159 criminal case proceedings were filed.
- 228 persons were investigated.
- 48 persons remanded in custody.

**Chart no. 1-1: Dynamics of number of specialised shops identified, data compared 2011-2012**



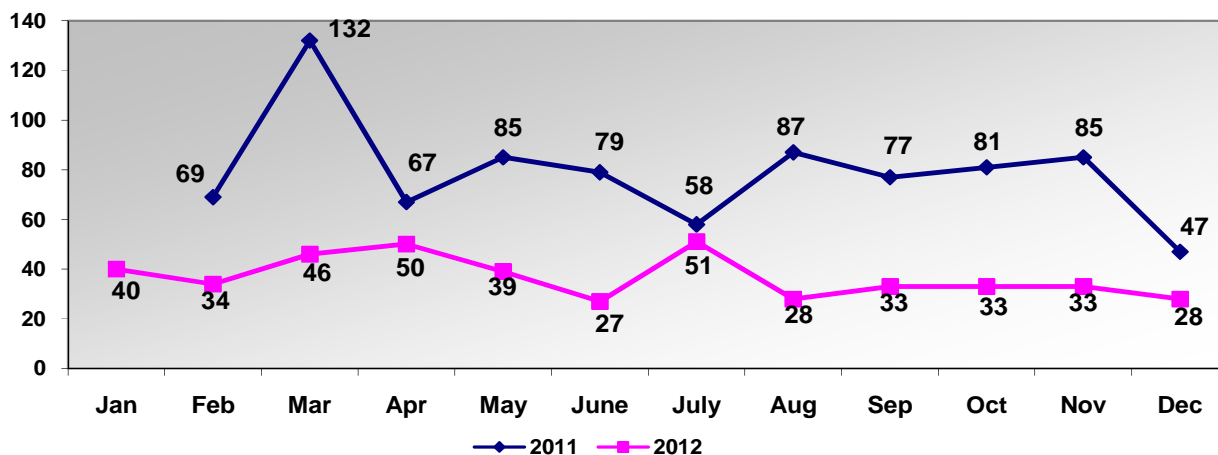
Note: The Joint Order no 121/37/1647/43/8/1/293 of 17.02.2011 was enforced starting with February 2011  
Source: NAA

With regards to the number of shops identified, after the adoption of Law no 194/2011 in November their number decreased significantly, then, starting with December 2011 until June 2012 the number of specialised shops stabilised and remained constant with insignificant variations from one month to another (10,13).



Starting with July until August the decreasing tendency was manifest again, August reporting a minimum of 6 shops identified at national level. Then, due to the appearance of some new shops in Bucharest, there was a slight increase in the number of specialised shops in September-October. In December, after the 8 specialised shops identified in Bucharest were closed, there was only one active shop left, identified in Vâlcea County.

**Chart no 1-2: Dynamics of specialised shops controlled, compared data 2011-2012**



Source: NAA

With regards to the number of shops controlled, starting with December 2011, after the approval of Law no 194/ 2011, the number of controls decreased constantly, following the evolution of the number of shops identified, with two peaks in April and June 2012, when there were wider control activities organised in Călărași County. The preventive monitoring actions were maintained throughout 2012 and will continue in 2013.

The implementation of the national health programmes for 2012<sup>5</sup> was performed in compliance with the technical rules adopted in 2010<sup>6</sup>, maintaining the same reduction of the number of physical indicators identified before.

This, a physical indicator such as number of persons undergoing methadone substitution therapy decreased from 5000 2010 to 4300 in 2011-2012, and the number of patients in post-therapy schemes decreased from 6000 to 5400, while the number of persons undergoing urine drug testing decreased from 4000 to 3400. With regards to efficiency indicators, namely average cost/patient, and to the health care units implementing the drug prevention and treatment sub-programme, the technical rules applicable brought no changes as compared to the values expected for 2010. Consequently, the funds allocated for drug prevention and treatment sub-programme remained lower in 2012, as the number of physical indicators was reduced and the efficiency indicators were maintained.

## **1.2 NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION (ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION)**

During the reference period no other significant changes were noticed at national level with regards to anti-drug public policies, so that the strategic documents adopted<sup>7</sup> during the previous years, due to be finalised in 2012-2013, ensured in 2012 the necessary guidelines at national level for a balanced management of the illicit drug use and trafficking.

<sup>5</sup> Govern Decision no 1388 of 28.12.2010 approving the national health programmes for 2011-2012 (issued by the Romanian Government, published in the Official Gazette, Part 1, no 893 of 30.12.2010)

<sup>6</sup> Joint Order No 1591/1110 of the Minister of Health and of the President of the National House of Health Insurance of 30 December 2010 approving the technical rules for the national health programmes for 2011-2012 (issued by: the Minister of Health and the President of the National House of Health Insurance, published in the Official Gazette, Part 1, No 53, 21.1.2011)

<sup>7</sup> See the National Report – 2011, page 21

## 1.2.1 NATIONAL ACTION PLANS AND STRATEGIES

In 2012, the main strategic document of the national policy on drug demand and drug supply was the National Anti-Drug Strategy<sup>8</sup>, and the setting up of an integrated system of institutions and public services to ensure the decrease of the incidence and prevalence of drug use among the general population, the medical, psychological and social care for drug users and more efficient activities aiming to prevent and counter the illicit drug trafficking and use remained the main strategic option.

At the same time, the Action plan for 2010-2012<sup>9</sup>, focusing on the implementation of the National Anti-Drug Strategy 2005-2012 represented, throughout 2012, the main strategic planning instrument, the activities envisaged, the evaluation and execution deadlines, as well as the relevant institutions responsible aiming to ensure the continuation of the endeavours initiated in 2005, and to achieve the strategic options established by the Romanian Executive.

Building on the experience accumulated and forecasting the trends in the drugs phenomenon, the National Anti-Drug Agency aimed at continuing to ensure in Romania a coherent, integrated and professional policy-making system.

To this purpose, the National Anti-Drug Agency constantly adapted the national policies to the current socio-economic conditions, to the concrete realities and needs and to the existing response possibilities, with the support of decision-makers and social actors at national and local levels, and developed in 2012 the new National Anti-Drug Strategy for 2013-2020 and the Action Plan for 2013-2016 to implement the strategy.

The new National Anti-Drug Strategy and its Action Plan are the response of the Romanian state to the drug threat and they include the overall and specific objectives, as well as concrete actions to be implemented during the reference period by all institutions involved in reducing the impact of the drugs phenomenon at national level.

Following their approval by the Romanian Government on October 9, 2013 the two programming documents were assumed as public policy documents in the field, providing the formal character and the legitimacy of the response to the drugs phenomenon.

The new strategy includes a new approach at the level of national drug-related policies, by placing the focus on evaluation and analysis, in line with the wider context set by the European Union highlighting the importance of research, scientific rigour and cooperation with professionals and academia. The development of the new National Anti-Drug Strategy built upon the National Anti-Drug Strategy 2005-2012 and upon its action plans.

The specific objectives were defined to generate favourable impact on the public health, order and safety. To this purpose, the action plans related to the strategy detail and indicate concrete actions and interventions to reduce drug demand and drug supply, starting from a coherent and efficient approach.

The National Anti-Drug Strategy 2013-2020 aims at the following:

- To reduce the level of drug use and addiction, as well as their consequences on the public health, order and safety;
- To contribute to decreasing the availability of drugs on the market;
- To promote awareness on the drugs phenomenon by systematic evaluation of trends and challenges in the field, in order to substantiate the response of the institutions and of the civil society structures;
- To ensure the necessary framework for dialogue and cooperation between the public institutions involved and the non-governmental sector.

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<sup>8</sup> Government Decision No 73 of 27 January 2005 approving the National Anti-Drug Strategy 2005-2012 (issued by: the Government of Romania, published in the Official Gazette, Part 1, No 112 of 3 February 2005)

<sup>9</sup> Government Decision No 1369 of 23 December 2010 on the approval of the Action plan for the implementation of the National Anti-Drug Strategy 2005 – 2012 (issued by: the Government of Romania, Part 1, published in the Official Gazette, Part 1, No 38 of 17 January 2011)

The documents were designed and developed in line with the European Union Drugs Strategy for 2013-2020, focusing on the five action lines – two vertical action lines: drug demand reduction and drug supply reduction and three cross-cutting action lines, namely coordination, international cooperation and research, evaluation and information, including objectives and actions that cover the vertical objectives.

The National Anti-Drug Strategy 2013-2020 and its Action Plan for 2013-2016 approach the drug problem in a concrete manner, from the perspective of European directives and Romanian realities.

The terminology used by the new Strategy is the terminology used by the policy paper developed by the Pompidou Group of the Council of Europe, and by the other international strategies and documents in the field.

The new strategy intends to bring added value with regards to the response of the Romanian state to the drug problem, by developing the necessary mechanisms for coordination, inter-institutional cooperation, decisional transparency, research and strategic analysis. At the same time, the National Anti-Drug Strategy 2013-2020 strengthens the positive outcomes achieved following the implementation of previous public policy papers and intends to provide solutions to overcome difficulties faced by practitioners and to adopt a humanistic approach to drug use, which is reflected in its very objectives. This document is part of the national regulatory framework and it upholds the fundamental values of the European Union: respect for human dignity, liberty, democracy, equality and the rule of law. The key element of this new strategy is the balance between actions to reduce the drug demand and the drug supply.

Structurally, the National Anti-Drug Strategy takes a balanced and integrated approach on drug demand reduction and drug supply reduction, with a focus on the development of coordination, international cooperation, research, evaluation and information, with the aim to achieve the following overall objectives:

- To reduce the drug demand, by strengthening the national integrated prevention and support system, consistent with scientific findings, to include all prevention programmes, projects and interventions, both general and selective, implemented by the school, family and community, as well as interventions to identify, attract and motivate drug users with the aim to provide specialised support services targeting social integration.
- To reduce the drug supply by identifying and de-structuring the drug trafficking networks, reduced availability of drugs on the market and efficient use of the law enforcement system, together with the development of monitoring and control institutional mechanisms coordinated and adapted to the current needs and to the realities of the drugs phenomenon, able to support in a reliable manner the anti-drug actions.
- To coordinate anti-drug efforts, to ensure a unitary action line in the field of drugs and drug precursors, to monitor ensure efficient use of resources and optimisation of intervention results.
- In the field of international cooperation, to re-iterate Romania's commitment, assumed through the international and bi-lateral agreements signed and to strengthen Romania's position as an active partner in the global efforts to reduce the drug demand, the drug supply and the drug precursors trafficking.
- To improve awareness on the drugs phenomenon at national level starting from scientific findings, through monitoring, research and information.

The specific objectives were defined to generate favourable impact on the public health, order and safety. To this purpose, the action plans related to the strategy detail and indicate concrete actions and interventions to reduce drug demand and drug supply, starting from a coherent and efficient approach. The action plans include concrete actions and the quantitative and qualitative indicators for each action assumed by the relevant institutions.

The implementation of the Strategy will be monitored by regular and systematic collection of data on the current activity, as a basis for evaluation and input for the quality check. Additionally, it will be used as a general and systematic source for future intervention.

In order to collect information on the strategy implementation and on the outcomes at national level achieved by implementing the strategy objectives, the monitoring activities will focus on two directions:

- *Strategy implementation*: provides information on the implementation of the actions described by the action plan. To this purpose, regular monitoring reports will be developed according to the deadlines provided by the action plan. The monitoring reports will be developed by NAA.
- *Achievement of objectives*: the strategy effects will still be in place after the activities envisaged had been implemented. Thus, in order to perform the evaluation of actions proposed we need to undertake a monitoring process which will be conducted both during the strategy implementation and after the strategy has been finalised. During the strategy implementation, some activities deliver results which might lead to changes in the manner they were designed. In such cases, recommendations on the improvement of the activity profile could be provided so that to lead to enhanced performance in reaching the strategy objectives.
- The evaluation will take into consideration the following criteria:
  - Effectiveness and efficiency of measures and actions undertaken to achieve the objectives in terms of performance, results and added value.
  - Relevance of objectives and intervention actions proposed to reach the objectives.
  - Social and economic impact of the results obtained and of the means proposed to achieve them.
  - Long- and medium-term sustainability of results.
  - Added value as novelty element to the previous programming documents.

During the Strategy implementation, the Agency will conduct two evaluations: an interim evaluation at the middle of the implementation period, corresponding to the evaluation of the first action plan, and an ex-post evaluation to include the results of the evaluation of the two action plans.

### **1.2.2. IMPLEMENTATION AND EVALUATION OF NATIONAL ACTION PLAN AND/OR STRATEGY**

In exercising the role of national anti-drug policy coordination, the National Anti-Drug Agency acted towards a balanced approach on the implementation of measures focusing on the reduction of drug demand and drug supply, provided in the Government's Programme, the National Strategy of Public Order and Safety or the National Anti-Drug Strategy.

Thus, throughout 2012, the activities included in the Action Plan for 2010-2012<sup>10</sup> continued to implement the National Anti-Drug Strategy for 2005-2012 ensuring both the continuation of the activities started in 2011, and the necessary framework for the accomplishment of the activities planned for the reference period.

Considering the on-coming deadline for the application of the National Anti-Drug Strategy, respectively the end of 2012, evaluation measures were in place for the strategic document. The results of the evaluation underpinned the substantiation of next the strategic document of the national policy with regards to the decrease of drug demand and drug supply.

At the same time, throughout 2012 the implementation of the National Strategy of Public Order and Safety<sup>11</sup>, as well as of the Strategic Plan of the Ministry of Administration and Interior for 2010-2013<sup>12</sup>, continued, involving both activities envisaged for the reduction of the drug supply and for the reduction of the drug demand, according to the new strategic approach adopted within the two above mentioned documents.

### **Evaluation of the National Anti-Drug Strategy 2005-2012**

The evaluation was undertaken in August-October 2012, it was initiated by the UNICEF Romania (funder), in cooperation with the National Anti-Drug Agency (NAA), and it was performed by an external evaluator, the Romanian Angel Appeal (RAA) Foundation. The purpose of the evaluation was to identify and to measure the effects of the implementation of the National Anti-Drug Strategy at the end of the planning period 2005-2012.

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<sup>10</sup> Government Decision No 1369 of 23 December 2010 on the approval of the Action plan for the implementation of the National Anti-Drug Strategy 2005-2012 (issued by: the Government of Romania, published in the Official Gazette, Part 1, No 38 of 17 January 2011)

<sup>11</sup> See section 16

<sup>12</sup> [www.mai.gov.ro/index15.htm](http://www.mai.gov.ro/index15.htm)

Building upon the data collected, the consultants drafted recommendations which were submitted to NAA to underpin the development of the National Anti-Drug Strategy and of the action plans for the programming period 2013-2020. Whether they aim at short- or long-term, the recommendations propose solutions to enhance the efficiency of the anti-drug actions implemented in 2005-2012, and include references to completely new actions that NAA and other national actors should implement.

The objectives of the evaluation mission were as follows:

1. To evaluate the actions/measures proposed and implemented by the National Anti-Drug Strategy 2005-2012 and by the action plans (2005-2008 and 2010-2012) in all areas: reduction of drug demand, reduction of drug supply, international cooperation, inter-institutional coordination, information, research and evaluation.
2. To identify the outcomes and the lessons learned following the implementation of the National Anti-Drug Strategy 2005-2012.

The evaluation used two data collection approaches:

- **Desk research of data** available from official statistics, activity and research reports (provided by NAA or by other organisations), legal papers, official statements, websites etc. Such data were collected and used to describe the social and legal context of the Strategy implementation, as well as to complete / confirm information collected from various actors (institutions, natural persons) participating in the evaluation process.
- **Qualitative data collection and analysis** by individual interviews (face to face or by e-mail) and by group interviews, based on interview/focus group guides. Thus, **focus groups** were organised with: drug demand reduction service providers (public, and private, both not-for-profit and for-profit organisations), teenagers from the general population, parents, injecting drug users (detained men, women and teenagers from the community). **Individual interviews** were organised with teachers (class masters), representatives of the local and central public institutions responsible for the Strategy implementation (according to the National Action Plans), and representatives of the local non-governmental organisations and of the international organisations and institutions involved in or supporting anti-drug measures.
- The evaluation of the Strategy actions was conducted against the OECD/DAC evaluation criteria - relevance, efficiency, effectiveness, sustainability and impact – as well as against the criteria on human rights and results-based management.

A set of indicative questions was developed for this evaluation against the established criteria:

- **Relevance of National Anti-Drug Strategy 2005-2012 actions**
  - Are the Strategy actions (measures) and their results linked with the overall and specific objectives stated in the Strategy?
- **Effectiveness of National Anti-Drug Strategy 2005-2012 actions**
  - To what extent were the overall/specific objectives of the Strategy achieved?
  - What factors facilitated the achievement/non-achievement of objectives?
- **Efficiency of National Anti-Drug Strategy 2005-2012 actions**
  - Were the Strategy objectives achieved on time?
  - Were the results obtained following the implementation of actions/measures provided by the Strategy proportionate to the allocated resources? (Human resources, financial resources, time etc.)
- **Sustainability of National Anti-Drug Strategy 2005-2012 actions**
  - What factors influenced the sustainability of actions/measures implemented in line with the Strategy objectives?
  - To what extent did the actions/measures funded from international funds prove sustainable?
- **Impact of National Anti-Drug Strategy 2005-2012 actions**
  - What happened following the implementation of the Strategy actions/measures?
- **Compliance with human rights and equity**
  - Did the implemented actions/measures generate violations of human rights and of the equity principle? What kind of violations?
- **Results-based management**
  - Was the principle of results-based management used in the design and implementation of the Strategy actions/measures? How?

The consultants used the **perspective of actors (institutions and organisations)** involved in anti-drug actions and the **perspective of beneficiaries** of drug demand reduction services. In other words, the conclusions on the effects of the Strategy implementation are **objective, quantifiable measurements** of the progress, effectiveness, impact and sustainability of measures implemented in 2005-2012. For example, the perspective on the efficiency of actions undertaken in Romania during the reference period is not a calculation of the cost efficiency parameters, but a subjective answer to the questions “Were the Strategy objectives achieved on time?” and “Were the results obtained following the implementation of actions/measures provided by the Strategy proportionate to the allocated resources? (Human resources, financial resources, time etc.)”. The absence of indicators and measurable targets in the action plans of the National Anti-Drug Strategy made it impossible to measure to what extent the strategy objectives were achieved, the impact of the actions and the cost-effectiveness of the actions.

The evaluation **did not intend to take stock** of the actions to reduce the drug demand and the drug supply undertaken across the country in 2005-2012; most likely that would have resulted in the identification of hundreds of actions implemented by one or several partners, at local or national level, funded by less known sources or by renowned donors. Therefore, the evaluation did not analyse or mention:

- Services provided by organisations which do not have drug demand reduction as main field of activity;
- Low-scale interventions (for example, prevention campaigns at local level, at school level, training activities);
- Information/prevention messages which were not part of an articulated campaign etc.
- Interventions whose results were not documented by public reports.

The evaluation produced a set of recommendations to be followed on short- or long-term. These recommendations include all areas of action tackled by the National Anti-Drug Strategy 2005-2012.

### **Recommendations on drug demand reduction**

- To increase the access of parents, children and members of the community to services aiming to prevent alcohol, tobacco and drug use, by diversification of methods and means to supply information and by training teachers to provide prevention services for students and parents.
- To foster active involvement of young people, parents and members of the community in alcohol, tobacco and drug use prevention actions.
- To adapt the prevention services according to the specificity of beneficiaries: age, gender, type of drug use, level of education, ethnicity etc.
- To evaluate the services provided, by regular surveys among their beneficiaries.
- To inform and raise awareness among the population and the media on compliance with human rights, non-discrimination of drug users, to inform and empower the general population with regards to actions that may be taken to support drug users, existing services etc.
- To develop quantitative and qualitative research, in partnership with non-governmental organisations, to identify the risk groups, the behaviours of injecting drug users and their needs.
- To undertake an estimation of the number of drug users at national level and of the number of injecting drug users among them.
- To create a clear system of referring drug users to counselling and testing services and, if appropriate, to treatment in order to improve the access of injecting drug users to prevention, counselling, treatment and diagnostic services (where applicable, vaccination services as well) for HIV, HBV, HCV, TBC and other drug-related diseases.
- To develop, in partnership with the Ministry of Education, Research, Youth and Sport and with the Ministry of Labour, school and professional reintegration programmes for drug users.
- To include psychological and social assistance services in the syringe exchange and methadone substitution therapy programmes from penitentiaries. To have the NPA personnel trained by NAA personnel in order to prepare them to provide psychological and social services to persons deprived of liberty that benefit from syringe exchange or substitution therapy programmes in the penitentiary.
- To ensure the continuity of substitution therapy for new or former inmates and for those remanded in custody.

- To facilitate the access of young people under 18 to risk reduction services and to substitution therapy; to take action to amend the legal framework providing for parental approval to provide services to underage drug users.
- To adapt the services to the specific vulnerability type of each drug user: female commercial sex workers, men who have sex with men, immigrants, Roma ethnics, women etc. Facilitating women's access to risk reduction services, including by programmes to fight stigma and gender discrimination practices within the community: information and awareness campaigns, services adapted for women.
- To increase the access of pregnant drug users to prenatal services and to social assistance services to prevent child abandonment.
- To explore the possibility of opening safe rooms and syringe vending machines.
- To ensure case management in all institutions providing integrated assistance services to drug users.

### **Recommendations on drug supply reduction**

- To introduce (NAA) in the future action plans some indicators from the drug supply reduction area, together with data collection and reporting methodologies.
- To correlate and adapt its systems for collecting statistical data on the drug supply so that they meet the reporting needs, according to the requirements of the international and European bodies.
- To involve (NAA) the relevant institutional partners in the development of methodologies for collecting and reporting drug supply reduction indicators.
- To strengthen the institutional capacity and its role of national coordinator of drug supply reduction actions.
- To modernize the technical endowment necessary to the institutions responsible with law enforcement in the field, according to international standards.
- To strengthen the legal framework, especially the legislation regulating the regime of new psychoactive substances on the drug market. To extend the working groups TRIDENT and POLVAM to other institutions.

### **Recommendations in inter-institutional coordination, international cooperation, information/ research/ evaluation**

- To strengthen cooperation between the public institutions responsible with the implementation of the National Anti-Drug Strategy, both at central and local levels, and the cooperation between public institutions and organisations of the civil society (including groups of people affected by the drugs phenomenon), academic organisations and providers of drug supply reduction services (for-profit).
- To initiate (National Anti-Drug Agency) its own grant provision system for non-governmental organisations providing assistance and risk reduction services.
- To ensure continuing training of NAA personnel and of the employees of organisations and institutions providing services in the field of drug use prevention, drug demand reduction and drug supply reduction.
- To encourage (or mediate) cooperation (and especially communication) between the national anti-drug actors and similar European and international structures (NAA) – by involving national actors (both public and private) in international projects (involving training, exchange of experience, study visits), by consulting them, including them in working groups or task forces.
- To promote among the relevant local communities (e.g. big cities, border cities, communities providing harm reduction services) the need to initiate/develop cooperation with international local or central institutions or organisations interested in implementing activities in partnership.
- To build NAA's portfolio of projects funded by international donors (such as the European Structural Funds), where NAA is beneficiary (lead partner) or partner, together with other institutions and non-governmental organisations.
- To strengthen the role held by NAA and other relevant institutions as technical assistance providers for third parties interested in the development of policies and interventions aiming at drug demand reduction and drug supply reduction.

- To include in the National Anti-Drug Strategy 2013-2020 actions (such as information, training, evaluation feedback) to enhance the capacity of the actors in the field to implement relevant research and evidence-based interventions.
- To include in the National Anti-Drug Strategy 2013-2020 actions to monitor and evaluate (both internal and external evaluation) the results and outcomes of the public policies and the impact of social policies and of the relevant anti-drug legislation (e.g.: policies in the fields of health care, social protection, tax, environmental protection, development etc.). The monitoring/evaluation reports will provide stakeholders with feedback on the progress made in the implementation of public policies and improvement recommendations.
- To evaluate (NAA) how the drug demand reduction actions interact with and influence the drug supply reduction actions. This recommendation is in line with the EU Drug Strategy which upholds balanced and comparable approach on and financing of drug demand reduction and drug supply reduction actions.
- To plan (through the National Anti-Drug Strategy 2013-2020) surveys to appraise the efficiency and effectiveness of the drug demand reduction public services, both within the community and in penitentiaries.
- To promote and initiate (NAA) research in the following areas: causes and social and economic implications of drug and alcohol abuse (e.g.: poverty, mobility, social inequality, employability etc.); drug abuse, alcohol abuse and mental health. Research in these areas may be the responsibility of NAA or of other relevant organisations (public institutions, academia, NGOs). The National Anti-Drug Strategy may provide for financing such actions and for fostering the research capacity of these organisations, by means of training, consultancy and employment of professionals.
- To attract academic partners and to involve them both in research activities and in the training of NAA personnel responsible for research / evaluation/ information.

### **Evaluation of the National Programme for medical, psychological and social assistance for drug users 2009-2012<sup>13</sup>**

Due to the background presented by the National Reports 2009-2012 the implementation by the National Anti-Drug Agency of the *National Programme for medical, psychological and social assistance for drug users 2009-2012* during the reference period was profoundly limited to the contextual needs, without bringing a significant contribution to the overall objective and the purpose of this programme and, implicitly, to the coherent and unitary implementation of the 9 sub-programmes.

The purpose of the *National Programme for medical, psychological and social assistance for drug users 2009-2012*, in line with the objectives assumed by the policy papers in the field, was *to prevent the drug use by the general population and to attract and maintain drug users and drug addicts in the national integrated system of public assistance services, with a view to their medical, psychological and social rehabilitation.*

*The overall objectives were as follows:*

- To develop universal selective and targeted prevention services with a view to avoid the onset of drug use and turning the occasional use in problem use, as well as to reduce drug abuse consequences;
- To develop a complex integrated system of medical, psychological and social assistance for drug users and drug addicts, focused on the areas with highest drug use prevalence identified following the systematic monitoring of key indicators;
- To ensure initial and continuing training of professionals in the prevention and assistance system, to increase the quality of services provided to the beneficiaries;
- To develop qualitative and quantitative research to inform proposals on the amendment of legislation in the field, to adapt it to the dynamics of the drug phenomenon in Romania.

The sub-programmes which should have been implemented, with a total budget of 15,078 thousand lei, were as follows:

S1 – Prevention of experimental/recreational drug use in school population

<sup>13</sup> Government Decision no 1102/2008 approving the National Programme for medical, psychological and social assistance for drug users 2009 – 2012 (published in the Official Gazette no 672 of 30.09.2008)



- S2 – National/regional media campaigns to prevent drug use
- S3 – Development of strategies to prevent drug use at the workplace, especially for professions identified with high drug use risk
- S4 - ERP (*Enterprise Resources Planning*) software operationalisation – prevention and assistance – included in the twinning convention with Spain
- S5 – Prevention and integrated assistance in prisons and penitentiaries
- S6 – Level 1 assistance services
- S7 - Level 2 assistance services – Integrated Addiction Assistance Centres (CAIA)
- S8 - Level 3 assistance services
- S9 – Continuing training on addictions – National Centre for Training and Research on Addictions.

The physical indicators, both the efficiency and the outcome indicators of sub-programme 1 were fully achieved through the implementation of two projects “*MY ANTI-DRUG MESSAGE*” and “*UNCENSORED*”.

We mention the same situation for sub-programme 2, where the indicators were achieved through the implementation of the following campaigns:

- *The national campaign to prevent drug use with a focus on new psychoactive substances – “THE ABSENT”*
- *The national campaign to prevent drug use in the family environment – “DRUG USE RISKS FOR MOTHER AND CHILD”*
- *The national campaign “TOO REBEL TO BE MANIPULATED!”*

Only one indicator of sub-programme 3 of the National Programme was achieved through the development of the study: “*Social research on the identification of professions at risk of drug use*”.

Sub-programme 4 was not implemented; the above-mentioned software (ERP) was partly included in the twinning convention with Spain, namely the assistance component, and it was operationalised through another project.

Sub-programme 5 - “*Prevention and integrated assistance in prisons and penitentiaries*” – was partly implemented through the campaign “*ADDICTED TO FREEDOM – PRISON IS NOT THE END OF THE ROAD!*”, a campaign aiming to prevent drug use among those deprived of liberty implemented with the purpose to raise awareness on the effects of drug use, targeting mainly the general population in penitentiaries, but also the population of former drug users getting ready to be released from prison, and to inform them on the availability of existing services, both in prison and in the community.

The results of these prevention campaigns and projects are presented in chapter 3 of the National Report on Drug Situation.

Sub-programme 6 “*Level 1 assistance services*” was also implemented only in part, as the indicators were partly reached by procurement of 942,500 syringes and of sanitary materials for injecting drug users registered for assistance services with nongovernmental organisations – “*Romanian Anti-AIDS Association*” and “*CARUSEL*”. The objective of this sub-programme were also achieved through the implementation of the campaign “*NO ADDITIONAL RISKS*”.

The objectives of sub-programme 7 “*Level 2 assistance services 2 - Integrated Addiction Assistance Centres (CAIA)*” were fully achieved by:

- Ensuring methadone and buprenorphine/naloxone substitution therapy for the beneficiaries of these services;
- Ensuring naltrexone abstinence treatment (for opioid and alcohol addicts) for the beneficiaries of these services;
- Ensuring outpatient detox treatment with methadone and buprenorphine/naloxone for beneficiaries included in integrated assistance programmes, based on the results of the medical, psychological and social evaluations performed.
- Testing biological fluids (urine, saliva) for drug presence for beneficiaries included in CAIA integrated assistance programmes.
- Ensuring the health care services, occupational therapy, psychiatric medical assistance, individual, group and family psychotherapy services.

The average annual number of cases that initiated treatment was 926, and the average annual assistance volume was 1,403 beneficiaries.

The objectives of sub-programme 8 “*Level 3 assistance services*” were achieved by the operationalisation and of the day-care “*PERICLE*”. This day-care centre is located in Bucharest, it has a capacity of 10 places and it provided assistance for 13 calendar months December 2011-December 2012. The evaluation of this day-care centre in Bucharest was performed by periodical monitoring

visits, and quarterly and annual reporting. The indicators on assistance provided to beneficiaries in the day-care centre were extracted from the quarterly reports drafted by the centre coordinator.

The therapeutical communities, a second day-care centre and a day-care centre for minors were not operationalised due to the variables indicated in the introductory part of this report.

The objectives of sub-programme 9 “Continuing training on addictions - National Centre for Training and Research on Addictions” were partly reached through the implementation of a training programme for 62 doctors, psychologists and social assistants from the 47 anti-drug prevention, evaluation and counselling centres and integrated addiction assistance centres.

### **1.2.3. COORDINATION ARRANGEMENTS**

As mentioned at the beginning of this chapter, 2012 focused on continuing the institutional reconstruction of the National Anti-Drug Agency, and on strengthening its role of national coordinator of anti-drug fight, role conferred to this institution by the articles of incorporation drafted at the end of 2002<sup>14</sup>. To this purpose, Article 2 of the Government Decision on the organisation and functioning of the National Anti-Drug Agency stipulates that the Agency sets out the conception and coordinates, evaluates, monitors at national level the policies in the field of prevention and countering illicit drug trafficking and use, as well as the integrated assistance for the users, applied by the relevant institutions in the field.

The role of coordinator of the National Anti-Drug Agency represents an essential condition for the provision of an adequate reaction to the social, economic, health and safety issues raised by drugs.

## **1.3 ECONOMIC ANALYSIS - PUBLIC BUDGET AND EXPENDITURES**

Similar to the previous reports, in drafting this subchapter, the proposed methodology could not be used especially with regards to public expenditure, because the state budget does not follow the structure of the European standards referred to in the proposal (COFOG). Moreover, specific expenditure for drug-related activities is not earmarked and cannot be identified separately in the budgets of the institutions that carry out anti-drug activities. The annual expenditure earmarked for anti-drug specific programmes, initiated or implemented by public authorities or in partnership with civil society bodies, is the only “visible” expenditure in the annual budgets or balances of public authorities. Therefore, the data collected and presented in this chapter refer to non-standard public expenditures.

### **1.3.1 LAW ENFORCEMENT, MEDICAL AND SOCIAL ASSISTANCE, RESEARCH, INTERNATIONAL ACTIONS, COORDINATION, NATIONAL STRATEGIES**

At national level, the financial resources allocated to anti-drug policy implementation originated in state budget sources or extra-budgetary sources.

2012 was the last implementation year of the national programme for medical, psychological and social assistance for drug users – 2009-2012<sup>15</sup> implemented by the National Anti-Drug Agency. A total amount of 7,827,955.12 lei was spent during the reference period for the implementation of the 9 sub-programmes, as follows :

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<sup>14</sup> Government Decision No 1489/2002 on the organisation and functioning of the National Anti-Drug Agency further amended and supplemented (issued by: the Government of Romania, published in the Official Gazette, Part 1, No 956 of 27 December 2002).

<sup>15</sup> Government Decision no 1102/2008 approving the National Programme for medical, psychological and social assistance for drug users 2009 – 2012 (published in the Official Gazette no 672 of 30.09.2008)

**Table no. 1-3: Breakdown of expenditure (lei)<sup>16</sup> under the national programme for medical, psychological and social assistance for drug users – 2009-2012**

Sub-programme	2009	2010	2011	2012	Total
Prevention of experimental/recreational drug use in school population	49,882.12	0	72,377.64	22,598.10	144,857.86
National/regional media campaigns to prevent drug use	0	0	44,342.87	328,413.74	372,756.61
Development of strategies to prevent drug use at the workplace, especially for professions identified with high drug use risk	0	0	0	52,328.00	52,328.00
ERP (Enterprise Resources Planning) software operationalisation – prevention and assistance – included in the twinning convention with Spain	0	0	0	0	0
Prevention and integrated assistance in prisons and penitentiaries	0	0	0	107,260.00	107,260.00
Level 1 assistance services	0	0	74,214.00	298,784.25	372,998.25
Level 2 assistance services	1,796,738.24	618,453.28	1,232,616.32	1,089,410.85	4,737,218.69
Level 3 assistance services	932,189.40	1,037,369.82	26,809.17	2,160.95	1,998,529.34
Continuing training on addictions – National Centre for Training and Research on Addictions	0	0	0	42,006.37	42,006.37
<b>Total</b>	<b>2,778,809.76</b>	<b>1,665,823.10</b>	<b>1,450,360.00</b>	<b>1,942,962.26</b>	<b>7,827,955.12</b>

Source: NAA

According to the Activity Report of the Ministry of Health for 2012<sup>17</sup> the National Programmes for non-transmissible diseases, the National Programme for mental health, the Sub-programme for prevention and treatment of toxic addictions, the following activities were undertaken:

- Ensuring opioid substitution therapy (methadone) for people suffering from toxic addictions;
- Testing metabolites of intoxicants in all specialised medical units, both for adults and children;
- Rehabilitation treatment for people suffering from toxic addictions;
- Drafting a curriculum for training professionals in the mental health system on toxic addictions;
- Organisation and provision of training in the field of toxic addictions for professionals in the mental health system,

The indicators achieved are presented in the table below:

<sup>16</sup> Average annual exchange rate in 2012: 1Euro = 4.4560 RON

<sup>17</sup> <http://www.ms.gov.ro/upload/Raport%20activitate%20Ministerul%20Sanatatii%202012.pdf>

**Table no.1-4: Indicators achieved under the Sub-programme for prevention and treatment of toxic addictions**

No	Sub-programme for prevention and treatment of toxic addictions	Physical indicators achieved, cumulated from the beginning of the year	Average cost per physical indicator (lei) <sup>18</sup>
1.	Number of persons tested to identify drugs in urine / number of tests	10304	44,64
2.	Number of patients undergoing substitution therapy	3386	275,01
3.	One curriculum for training professionals in the mental health system on toxic addictions	1	120000,00
4.	Number of professionals trained on toxic addictions	500	80,00
5.	Development and printing IEC materials for population at risk of alcohol and drug use	3	18183,33

Source: Ministry of Health

The budget allocations for the implementation of specific projects and programmes in 2012 in other institutions involved in the implementation of drug demand reduction and drug supply reduction activities were as follows:

- IGPR – 1,123,790.00 lei, goods and services;
- MMFPSPV – 116,171.22 lei, subsidies for three non-governmental organisations implementing drug use prevention activities in three day-care centres;
- ANP – 178,795 lei, of which 116,488 lei were granted for the implementation of the Programme for methadone substitution therapy, while the rest was spent on procurement of goods and services;
- MEC – 2,370,000 lei for implementing the following projects including a component on the prevention of drug use in school population:
  - Inclusive extracurricular educational options for a healthy lifestyle and active citizenship for children from disadvantaged communities, mainly rural and in pre-university education in Romania – 1,200,000 lei
  - Calendar of educational activities – 1,100,000 lei
  - National competition for anti-drug projects “Together” – 70.000 lei

## CONCLUSIONS

1. The approval of Law 187 on the enforcement of the Criminal Code and on the amendment of special laws including criminal provisions<sup>19</sup>, created the pre-requisites for the enforcement of the therapeutic justice concept, for the first time in Romania, and of the legal provisions related to the alternative to imprisonment for drug possession for own use purposes. The amendments to the applicable legislation also include provisions on the amendment of sanctions provided by Law no 143 of 26 July 2000 on preventing and countering the illicit drug use and trafficking, further amended, with the aim to decrease sanctions, in line with the new criminal policy introduced by the enforcement legislation.
2. The evaluation of the National Anti-Drug Strategy 2005-2012 was a transparent process, where the activities undertaken by the governmental institutions were evaluated by a non-governmental organisation, and the funding was provided by an international body I.
3. The legal measures adopted and their enforcement led to decreased trading of such substances through specialised shops (in December 2012 there was only one such shop left in Romania).

<sup>18</sup> Average annual exchange rate: 2009 – 1Euro = 4.24 RON; 2010 – 1Euro = 4.21 RON; 2011 – 1Euro = 4.23 RON; 2012 - 1Euro = 4.4560 RON

<sup>19</sup>[http://www.just.ro/Sections/PrimaPagina\\_MeniuDreapta/LegeAplicareCP/tabid/1438/language/ro-RO/Default.aspx](http://www.just.ro/Sections/PrimaPagina_MeniuDreapta/LegeAplicareCP/tabid/1438/language/ro-RO/Default.aspx)

4. The experience accumulated shows that without unitary coordination, the simple summing up of local and sectoral efforts, even benefiting from funding, cannot allow for the fulfilment of the objectives assumed. Therefore, the re-validation of the National Anti-Drug Agency as national coordinator of anti-drug policies meant a return to the adequate approach on the drug phenomenon in Romania, following a course likely to result in success.

## **Chapter 2 – Drug use in the general population and among targeted groups**

### **2.1. DRUG USE IN THE GENERAL POPULATION**

The latest survey for assessment of knowledge, attitudes, drug use practices among the general population was implemented in 2010 and the results were published in the National Report on Drug Use in Romania, 2011<sup>20</sup>.

The fourth such survey is planned to be applied during this year in order to identify the new trends that developed in the patterns of using various substances with psychoactive effects, in terms of perception of risks and in terms of the attitude towards drug use, drugs and drug users among the general population. Its results shall be published in the National Report on drug use in Romania, 2014.

### **2.2. DRUG USE AMONG TARGETED GROUPS**

In 2012, NAA performed the first specific survey for assessment of risk/degree of social exclusion that the drug users are facing<sup>21</sup>. The results regarding social exclusion are presented in chapter 8 of this report, as here we only specify data regarding drug use and behaviour patterns.

Up to now, the social consequences of drug usage have not been included in the scope of any sociological analysis in Romania, as most of data covering these issues have been collected as a side activity, resulted from implementing activities focused on researching other aspects which are relevant for drug abuse or from the regular monitoring of key epidemiologic indicators.

#### **SURVEY PURPOSE**

The main objective of this research consists from assessing the social exclusion degree among problematic drug users who are not listed as beneficiaries of assistance services provided by the public or private system.

#### **SPECIFIC OBJECTIVES**

- a) Identifying the educational level of problematic drug users who are not listed as beneficiaries of assistance services provided by the public or the private system;
- b) Identifying the employment status of problematic drug users who are not listed as beneficiaries of assistance services provided by the public or the private system;
- c) Identifying the housing conditions for problematic drug users who are not listed as beneficiaries of assistance services provided by the public or the private system;
- d) Identifying the perception of drug users who are not listed as beneficiaries of assistance services provided by the public or the private system regarding the level of access to a workplace;
- e) Identifying the perception of problematic drug users who are not listed as beneficiaries of assistance services provided by the public or the private system regarding their access to education;
- f) Identifying the perception of problematic drug users who are not listed as beneficiaries of assistance services provided by the public or the private system regarding the level of access to medical, psychological or social services.

#### **SURVEY METHODOLOGY**

##### ***Sampling***

The sampling method was represented by the simple random selection; however, when applying it, the simultaneous coverage of all criteria for inclusion in this sample and also the situation where none of the exclusion criteria already established were taken into consideration, according to the following:

- a) Criteria for inclusion in this sample:

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<sup>20</sup> Available at [www.ana.gov.ro](http://www.ana.gov.ro)

<sup>21</sup> <http://www.ana.gov.ro/studii/Raport%20de%20cercetare%20excludere%202013%20final%20OK.pdf>

- Drug user over the past 12 months prior to the reference period
- Age group between 18-49 years old (both limits included)
- Mental and physical ability to understand questions and directions
- Written consent in order to participate to this survey
- To have lived in Bucharest for at least 6 months out of the 12 months prior to the date of the interview (including Ilfov county)

b) Criteria for exclusion from this sample:

- To have been listed as a beneficiary of assistance services provided by the public or the private system
- To have previously answered to the questionnaire in this survey
- Mental or physical inability to cooperate to applying this questionnaire
  - To understand Romanian well enough
  - Not to suffer from a psychic illness that prevents him/her from understanding and taking this interview
  - Not to be under the influence of alcohol or other drugs, in such a situation that prevents the interview from being taken etc

***The data collection instrument***

The questionnaire is made up from 3 sections, out of which 2 were dedicated to collection of data for social-demographic features of the drug users and to the specificity of the usage pattern used, while the third section was allocated for assessing the social exclusion risk. This latter section was structured according to several dimensions, as follows: perception of the social exclusion risk, access to a workplace, access to education/culture, access to health services, housing conditions.

The average period for filling in the questionnaire was of approximately 11 minutes (201 items, 49 questions).

The questionnaire was pre-tested in October, on 30 respondents. The data collection stage took place in November 2013 through the representatives of the CARUSEL Association.

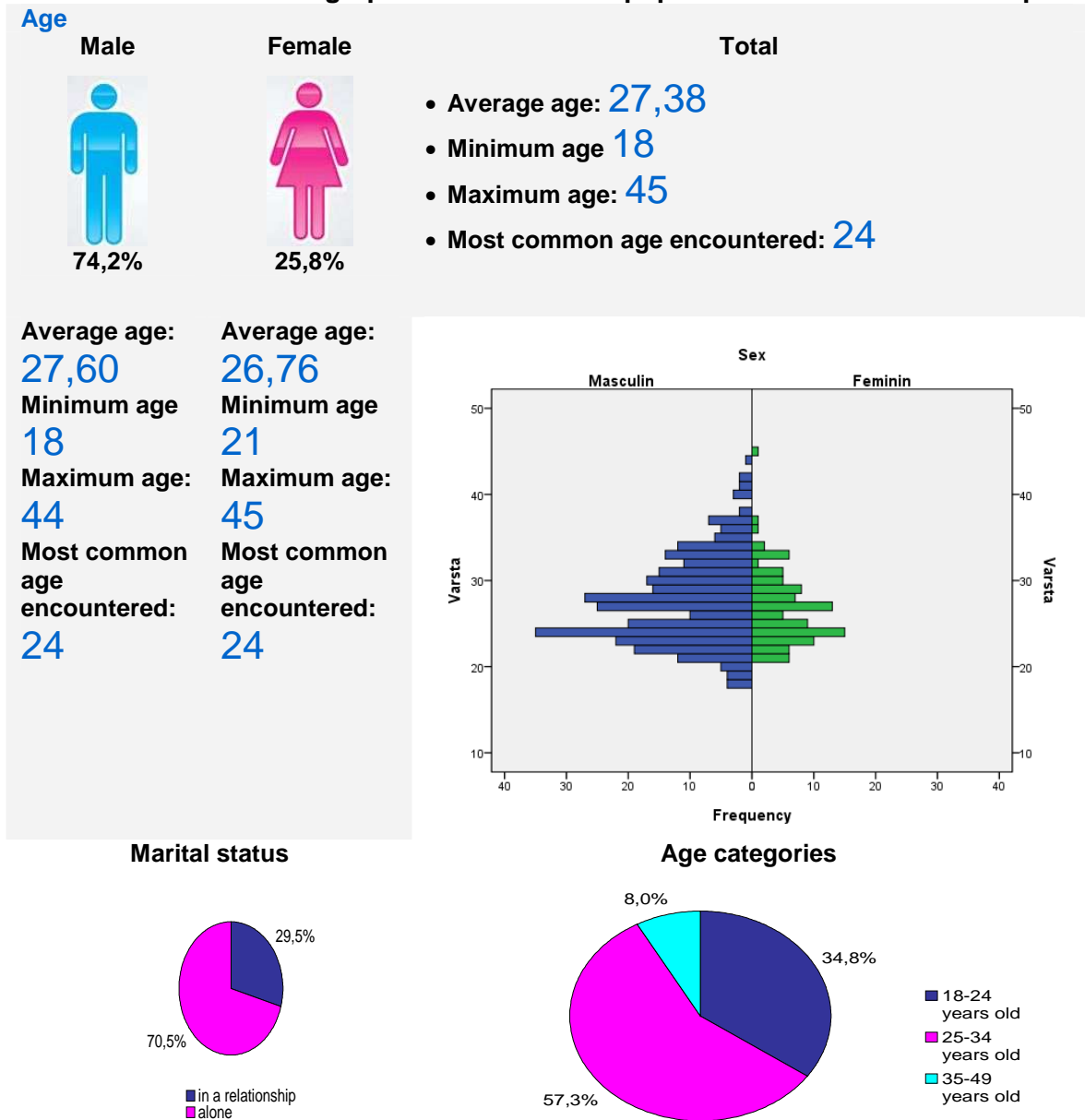
A number of 420 questionnaires were applied, and as a result of the filtering stage, a number of 400 valid questionnaires resulted.

**SAMPLE DESCRIPTION**

Out of the 400 drug users from Bucharest included in this survey, 74.2% are men and 25.8% are women, 95% were born in the urban area, while the rest of 5% were born in the rural area.

In order to perform an analysis, a variable for including respondents in age groups was defined, which resulted in the following data: 34.8% belong to the age group ranging from 18 to 24 years old, 57.2% belong to the age group ranging from 25 to 34 years old and 8% belong to the age group ranging from 35 to 49 years old and another variable was defined in relationship to the marital status, 70.5% declaring that they are alone (widower, not married, divorced/separated from the spouse), while 29.5% declared that they are involved in a relationship (married or with a partner).

Chart no. 2-1: The social-demographic features of the population included in the sample



Source: NAA

84% of the respondents declared that they are Romanians, 14.3% Roma and 1.7% declared that they belong to other ethnic groups: Hungarian, Arabian, Ukrainian, Jewish.

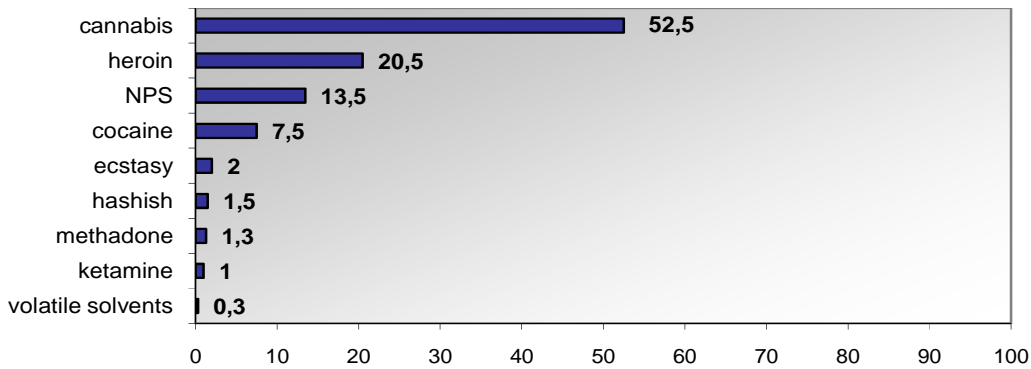
## RESULTS

### Main drug used

According to the main drug used, this is the sample breakdown: 52.5% reported cannabis use, 20.5% are heroin users, 13.5% reported new psychoactive substance (NPS) use, and 7.5% are cocaine users, while 2% reported ecstasy use, 1.5% hashish use, 1.3% methadone use, 1% ketamine use, and 0.3% volatile solvent use.



**Chart 2-2: Respondent distribution by main drug use, %**

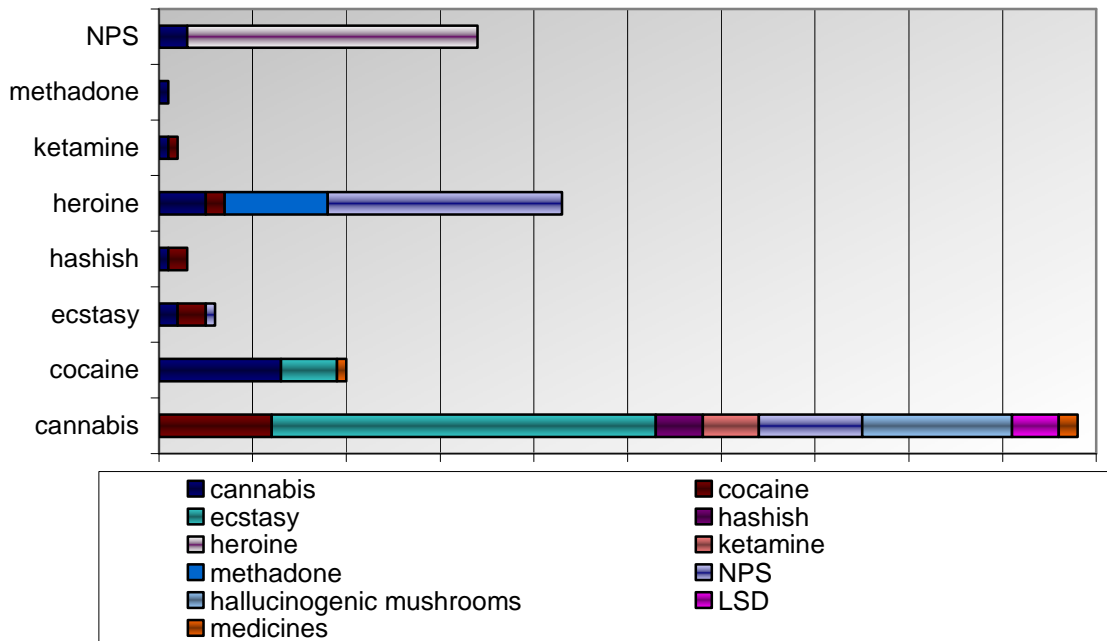


Source: NAA

**Secondary use of other drugs**

Of the 400 drug users included in the survey, 45.5% reported secondary drug use, besides the main drug. Thus, although poorly represented in the sample (only 2%) ecstasy users are those who declared the highest rate of secondary use of other drugs – 75% of them use, besides ecstasy, cannabis, cocaine and NPSs. At the same time, 66.7% of the cocaine users combine cocaine with other secondary drugs such as cannabis, ecstasy and medicines, while 63% of the NPS users reported secondary drug use, mostly heroin (91% of NPS users also use heroin).

**Chart 2-3: Respondent distribution, by main drug and by secondary drug used, %**



Source: NAA

**Frequency of use**

According to the main drug frequency of use, most respondents (57%) are occasional users, of which 30% use the drug 2-3 times a week, and 27% use it less than once a week. On the contrary, those who reported intensive use are distributed as follows: 32% use the drug every day, 11% declared drug use 4-6 times a week.

**Table 2-1: Respondent distribution by the main drug used and by frequency of use (%)**

Main drug	User type		Total
	intensive use	occasional use	
volatile solvents	0	100	100
cannabis	27,1	72,9	100
cocaine	3,3	96,70	100
ecstasy	12,5	87,5	100
hashish	16,7	83,3	100
heroin	76,8	23,2	100
ketamine	25,0	75,0	100
methadone	60,0	40,0	100
NPS	83,3	16,7	100
Total	43,0	57,0	100

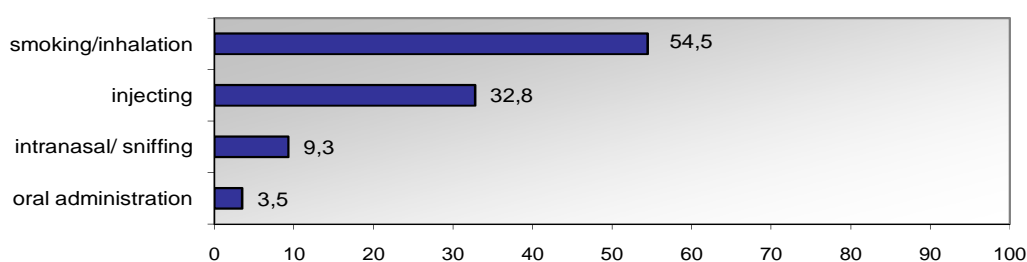
Source: ANA

According to the main drug used, most intensive users (every day or 4-6 a week) were registered among heroin users – 76.8%, NPS users – 83.3% and methadone users – 60%, while occasional use (2-3 times a week or less than once a week) is prevalent among cannabis users – 72.9%, cocaine users – 96.7%, ecstasy users – 87.5%, hashish users – 83.3% and ketamine users – 75%.

**Main drug administration route**

With regards to the main drug administration route, we note that the most frequent route is smoking/inhalation – 54.5%, followed by injecting use – 32.8%. This distribution can be explained by the nature of the sample, according to the main drug used. Thus, if for the most drugs used by this sample there is only one administration route (cannabis, hashish – smoking/inhalation, cocaine, ketamine – intranasal/ sniffing, heroin – injecting, ecstasy - oral), for methadone and NPS there are various administration routes, as follows: methadone – 80% oral and 20% injecting, NPS – 88.9% injecting, 3.7% oral, 5.6% intranasal/ sniffing, 1.9% smoking/ inhalation.

**Chart 2-4: Respondent distribution by main drug administration route, %**

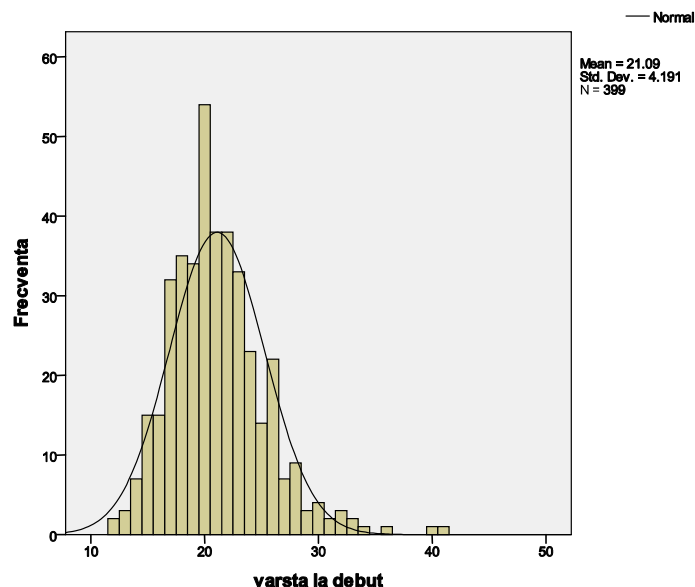


Source: NAA

**Onset age**

With regards to onset age, most respondents started using drugs when they were 20 years old (13.5%). The average onset age is 21 years old, while the youngest onset age reported is 12 years old, and the oldest onset age is 41 years old.

**Chart 2-5: Respondent distribution by onset age**



Source: NAA

According to the first drug used and to the onset age, we note that most users with early onset started with heroin (75% of respondents with onset age under 15), while most of those who started using drugs after 15 but before 34, started with cannabis – 63.1% of respondents with onset age between 15-24, and 52.2% of respondents with onset age between 25-34. Those with onset age after 34 used equally (33.3%) cocaine, heroin and NPS.

**Table 2-2: Respondent distribution by first drug used and onset age, (%)**

Onset age groups	First drug used								Total
	cannabis	cocaine	ecstasy	hashish	heroin	NPS	medicines	heroin/solvents	
under 15	16.7	0	0	8.3	75.0	0	0	0	100
between 15-24	63.1	1.9	1.6	2.5	26.8	3.2	0.6	0.3	100
between 25-34	52.2	1.5	6.0	0	35.8	4.5	0	0	100
between 35-49	0	33.3	0	0	33.3	33.3	0	0	100
<b>Total</b>	59.3	2.0	2.3	2.3	30.0	3.6	0.5	0.3	100

Source: NAA

**Conclusions**

- More than half of the persons included in the survey are cannabis users, about one fifth are heroin users, while more than one tenth are NPS users.
- Almost half of the respondents involved in the survey are multiple drug users, this use pattern being most present among ecstasy, cocaine and NPS users.
- The most frequent administration route is smoking/inhalation, followed by injecting.
- Heroin, NPS and methadone are drugs usually used intensively, while cocaine, ecstasy, cannabis, hashish and ketamine are used mostly occasionally.
- Heroin is the typical drug for onset age under 15; those with onset age between 15-34 usually report cannabis use, while the onset age after 35 typically involved cocaine, NPS and heroin use.

## Chapter 3 – Prevention

### INTRODUCTION

Assumed as a priority within the anti-drug public policy documents in Romania, the drug use prevention aims at achieving the following tangible prevention results, in accordance with the provisions of the European Strategy in the field: *"measurable reduction of the use of drugs, of dependence and of drug-related health and social risks through the development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures within the EU Member States. Drug demand reduction measures must take into account the health-related and social problems caused by the use of illegal psychoactive substances and of poly-drug use in association with legal psychoactive substances such as tobacco and alcohol"*.

In line with similar documents of community member states, the drug use prevention activities carried out during 2011 have been included in the National Anti-drug Strategy 2005-2012 and in the Action Plan for its implementation and were aimed at strengthening the influence of protection factors and reducing the influence of risk factors, by implementing specific awareness raising interventions and measures in the general population, mainly children and young people, and by involving them in universal, selective and indicated drug use prevention programmes, conducted in line with European and national standards.

One of the major problems with the coordination of projects and prevention interventions when there is a large number of stakeholders involved with responsibilities in the field is the information asymmetry in the relations between actors caused by a lack of tradition in terms of public consultation and communication. The information asymmetry between different areas of central and local government consists in the exclusivity of information an institution holds and the non-dissemination of the complete information to other interested partners.

Thus, the trend in measuring the performance of government action in the reference area, reflected in public policy, manifests through the analysis of policies results, but in the current Romanian context, given the difficulties of inter-institutional communication and coordination, each institution tends just to follow the direct result of its own intervention (output) and the way in which it singularly contributes to the achievement of inter-sectoral policy objectives (outcome). In many cases, less efficient communication, structured and practiced by institutions involved in the implementation of national anti-drug strategy makes it difficult to collect information and develop network monitoring and evaluation programs which imply the involvement of several actors. There is a tendency that several programs and projects are coordinated by several institutions that can influence the different results target groups should benefit from. Implicitly, the evaluation of these programs and projects results must take into account the information provided by each institution involved, a separate assessment of these leading to a distortion of information. Even if the outcome of the evaluation is positive, it is impossible to determine which type of policy / intervention determined this result. In addition, most of the times, programs and projects interact between them, making it difficult to separate the effects of a new programme from the long-term effects of the replaced programme.

The questionable quality of monitoring and evaluation reports is due to the difficulties in collecting data and to their accuracy. In many public institutions with responsibilities in the field of drug prevention, the lack of data bases containing information resulting from the monitoring reports is clear. In the cases when these databases exist, the data are scattered between various departments, which do not have a full picture of the impact of prevention programs.

Thus, as a conclusion, the analysis of drug-use prevention programmes, projects and interventions, universal and selective, in school, family and community environments, is mainly centred on *output indicators* - indicators related to the implemented activities, representing the direct "products" thereof, and, to a lesser extent the *result indicators* which should provide information about changes in the behaviour of the direct beneficiaries of preventive programmes, projects and interventions and *impact indicators* relate to public policy consequences beyond the effects on beneficiaries direct.

### **3.1 GENERAL COMMUNITY-BASED PREVENTION (PREVENTION IN THE IMMEDIATE SOCIAL ENVIRONMENT, „ENVIRONMENTAL PREVENTION”)**

Defined as strategies influencing the cultural, social, physical or economic specificities of the proximal environment where people make choices on drug use, such general prevention interventions aim mostly, both at European and national level, at integrated or ad-hoc strategic measures regulating the use of alcohol and tobacco, as well as other types of associated interventions (e.g. preventing drug use in traffic, among drivers).

Despite several regulatory attempts initiated by authorities, there are not yet integrated visions or strategic approaches in Romania to reduce the negative consequences of alcohol and tobacco use and abuse.

However, there are legislative provisions regarding these substances governing contextually the use of alcohol and tobacco from the economic or social point of view or in terms of punitive legal mechanisms.

Thus, when joining the EU, Romania adopted and adapted the European system of taxes and excise duties levied on alcohol and tobacco products regulated<sup>22</sup> in the reference year 2011 by Government Emergency Ordinance No117/2010<sup>23</sup>.

#### **Alcohol**

Romanian law does not prohibit alcohol use but provides penalties for people under 18 who drink alcoholic beverages in public places, as well as for those who sells such beverages to people under 18<sup>24</sup>.

According to applicable regulations, it is forbidden:

- To promote alcoholic beverages in proximity to learning units and health establishments, at a distance less than 200 meters from their premises.
- to sell alcoholic beverages to people under 18.
- To advertise (directly or indirectly) alcoholic beverages in radio or TV programmes from 6:00 a.m. to 10:00 p.m.<sup>25</sup>.
- To broadcast advertising spots to alcohol beverages played by people under 18<sup>26</sup>.
- To sell or expose for sale alcoholic beverages inside of any learning units, hostels and accommodations for pupils and students, in the yards of such buildings, as well as on sidewalks or alleys leading to these units<sup>27</sup>.
- To serve alcoholic beverages to people under 18 in pubs<sup>28</sup>.
- Driving a vehicle on public roads by a person with a blood alcohol concentration over 0.80 g/l or with a breath alcohol concentration over 0.40 mg/l shall be punished with imprisonment from 1 to 5 years<sup>29</sup>.

<sup>22</sup> <http://codfiscal.realitatea.net/anexa-nr-1-la-titulul-vii-accize-si-alte-taxe-speciale>

<sup>23</sup> Emergency Government Ordinance no. 117 of 23 December 2010 for the amendment and supplement of Law no. 571/ 2003 on Fiscal Code and regulation of financial-fiscal measures

<sup>24</sup> Law no. 61/1991 as subsequently amended and supplemented, published in the Official Gazette of Romania no. 387/18.08.2000

<sup>25</sup> Decision of the National Audiovisual Council on the Regulatory Code Regarding Audiovisual Content - Official Gazette of Romania no. 250/02.03.2006

<sup>26</sup> Idem 25

<sup>27</sup> Idem 24

<sup>28</sup> Idem 24

- A driver, or a driving instructor, during the training process, or a examiner designed by the competent authority, during the practical examination for driving license, shall be punished with imprisonment from 2 to 7 years if he/she refuses, resists or avoids to provide biological samples or to allow his/her breath alcohol concentration testing in order to determine the presence of alcohol or narcotic substances or products or drugs with similar effects in his/her blood.<sup>30</sup>

Also, the Romanian Penal Code considers as aggravating circumstance so-called voluntary intoxication as follows: "a crime committed in a state of voluntary intoxication with alcohol or other psychoactive substances induced to commit that crime"<sup>31</sup>.

## **Tobacco**

According to the General Population Survey<sup>32</sup>, conducted by the National Anti-drug Agency in 2010, smoking tobacco products records the second level of drug use prevalence in the population of Romania: more than half of the interviewers (56.9%) smoked at least once in their lifetime.

By Law No 332/2005, Romania ratified the World Health Organization Framework Convention on Tobacco Control<sup>33</sup>.

Some of the most significant provisions of the Romanian laws in this field are as follows<sup>34</sup>:

- smoking in enclosed public places is prohibited.
- smoking is permitted only in specially designated smoking areas under the following mandatory conditions:
  - a) if they are built so as to serve only smoking and to prevent the penetration of polluted air in enclosed public places;
  - b) if they are adequately ventilated so that the level of noxious substances is below the maximum levels permitted.
- excepting bars, restaurants, discotheques and other public places with similar destination, if they meet the conditions mentioned above.
- the above provisions shall not apply to bars, restaurants, discotheques and other public areas with similar destination, whose owner or manager sets and displays the warning: "No smoking here".
- the selling at retail of tobacco products and the marketing of cigarette packs containing fewer than 20 cigarettes are prohibited
- when launched on the market, each pack containing tobacco products must have printed on one side, in Romanian, the quantities of tar, nicotine and carbon monoxide measured in accordance with the legal provisions in force, so that at least 10 % of the corresponding surface is covered
- each pack containing tobacco products, excepting tobacco for oral use and other non-smoking tobacco products, must have printed, in Romanian, a general warning and an additional one (mandatory warnings are: "Smoking kills/Smoking can kill" or "Smoking seriously harms your health and that of others around you")

Although there is no integrated national strategy regulating this field, the **National Anti-Smoking Programme is significant in terms of results achieved**. The national sub-programme for fighting against tobacco use is part of the National Health and Health Education Promotion Programme. A series of activities are carried out under this programme in order to reduce the number of smokers in Romania.

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<sup>29</sup> Art.87, para (1) of Government Emergency Ordinance no.195/ 2002 concerning the road traffic on public roads on - amended and supplemented by GEO. no.63/2006 published in the Official Gazette of Romania, Part I, nr.729/20.09.2006

<sup>30</sup> Art.87, para (5) of Government Emergency Ordinance no.195/ 2002 concerning the road traffic on public roads on - amended and supplemented by GEO. no.63/2006 published in the Official Gazette of Romania, Part I, nr.729/20.09.2006

<sup>31</sup> Art.77, lit.(f) – Penal Code of Romania, Published in the Official Gazette of Romania, Part I no. 510 of 24/07/ 2009, in force starting 24 July 2012

<sup>32</sup> <http://www.ana.gov.ro/studii/GPS%2010.pdf>

<sup>33</sup> published in the Official Gazette of Romania no. 1088 of 2 December 2005

<sup>34</sup> Art.3, para.(1-5) and art.6, para.(1-2)of Law no. 349/2002 on the Prevention and on the Fight Against the Effects of Tobacco products, published in the Official Gazette of Romania no. 435/21.06.2002

Thus, physicians and psychologists properly trained provide smoking cessation therapies (counselling, medication, behavioural therapy) under the "Stop Smoking!" programme. The physicians perform an assessment of the smoker in terms of physical dependence and related diseases, an assessment of smokers' needs, problems and desires, a basic behavioural counselling and a determination of CO exhaled. Finally, if the patient wants it and only in the absence of any contraindications, he/she receives one of the 3 drugs recommended by WHO and professional organisations in the field. Psychologists assess the type and the degree of the psychological dependence and, depending on the smoker's needs establish a treatment plan including behavioural and cognitive elements. The smoker decides whether and how often he/she returns to his/her psychologist to learn how to implement this plan. Both drugs and medical and psychological consultations are free of charge and are provided by the Ministry of Health.

### **Other types of associated interventions – rapid drug testing of drivers**

In order to prevent drug use among drivers NAA, together with Bucharest Road Police and the Brigade for Combating Organized Crime in Bucharest, conducted 162 tests as part of 7 rapid testing initiatives for the identification of the presence of drugs in drivers.

Compared to 2011, a double number of test were performed to identify drugs in body fluids. At national level, anti-drug testing activities for drivers were conducted in Constanta, Iasi, Timisoara.

## **3.2 UNIVERSAL PREVENTION**

Similar to previous years, most universal prevention programmes carried out in 2012 were aimed at providing information, educating and raising awareness of the use of alcohol, tobacco, drug and psychoactive substance, as well as developing attitudes and practices in the general population, by focusing on cultural and artistic activities and sports, as an alternative to drug use.

In 2012, that her greatest challenge of drug-use prevention activities was to accompany and provide support to teenagers and young people in managing behaviour and copings to handle multiple influences such as social norms, interaction with peers, living conditions and their own personality traits. In this respect the interventions focused on reducing risky behaviours related to drug abuse were enhanced, being known that young people are influenced by a complex set of environmental factors such as what is considered normal and desirable in the communities they live in, the laws and advertising they are exposed to, the availability of alcohol, tobacco and illegal drugs, etc..

Considering that adolescence is a risk factor *per se* and that most young people start using drugs at this age, prevention projects and interventions were focused on the school environment, as effective framework for universal prevention. However, in the school age population there are vulnerable groups that required adapted interventions.

Prevention programs have been conducted to provide information about the physiological and psychological effects, building a negative attitude towards drugs, building self-confidence, learning the most effective coping strategies and social life skills, encouraging participation in alternative activities.

Unfortunately, due to insufficient financial resources, information type programs have continued to play a central role in the prevention of drug use, although the latest trend in the field which proved to be effective in the Community Member States, is focused on the reduction of negative consequences of drug use, based on the belief that cognitive skills are more important than behavioural approaches when teaching young people to make decisions and to make informed choices in life.

The year 2012 is also market the stage of **translating and adapting the minimum standards for drug use prevention programmes**, the concrete result of a European project coordinated by the "John Moore" University in Liverpool, supervised by the EMCDDA, project in which Romania has been an active partner. In the next period (2013-2014), the summary version of these standards will take the form of a draft secondary legislation (supplementing and amending GD 860/2005) or a tertiary legislation act.

### **3.2.1 SCHOOL-BASED PREVENTION**

In 2012, drug-use prevention programs / projects in schools were conducted by the NAA's network, consisting of 47 Drug Prevention, Evaluation and Counselling Centres, by decentralized public services

under the Ministry of Education, Research, Youth and Sports, the county school inspectorates, Ministry of Health, through the National Institute of Public Health, or county Public Health Departments, the Ministry of Interior, the county police inspectorates and District Gendarmerie Inspectorate, Ministry of Labour, Family and Social Protection through the Directorates for Social Assistance and Child Protection, Ministry of Justice, through Prison and Probation Department units, respectively the probation services in partnership with civil society.

#### **LOCAL PROJECTS:**

In 2012, CPECA implemented 110 prevention projects in schools, which had the following activities:

- In the preschool environment:
  - o 82 prevention activities
  - o 1559 beneficiaries (1,230 children, 230 parents and 99 teachers).
- In schools (primary and secondary):
  - o 6,287 Prevention activities (4,919 in urban areas and 1,368 in rural areas)
  - o 52,079 direct beneficiaries (students, parents, teachers and police officers)
  - o 24,457 indirect beneficiaries.
- In the university environment:
  - o 38 prevention activities
  - o 4355 direct beneficiaries (4,320 students and 35 teachers)
  - o 13,500 indirect beneficiaries.

As regards the **collaboration at local level with the decentralized public services** subordinated to the Ministry of Labour, Family and Social Protection, General Directorates for Social Assistance and Child Protection (DGASPC) Alba, Arad, Bistrita Nasaud, Buzau, Caras Severin, Cluj, Constanta, Dâmbovița county; Iasi, Mehedinti, Olt, Satu Mare, Suceava, Timis, Vrancea and District 1, District 3 and District 4 of the municipality of Bucharest, in conjunction with the Drug Prevention, Evaluation and Counselling Centres or other non-governmental organizations, it resulted in various information and drug-prevention activities. Also, there were also some initiatives of DGASPCs, put of which we mention the following:

- General Directorate for Social Assistance and Child Protection Cluj which regularly performed activities to prevent drug use in care centres, family type units and the schools in the county. Thus, in 2012, with the participation of 93 students, the institution organized in five schools groups and information sessions on children's right to be protected against illicit drug use, the consequences of drug use and the existing support services network .
- General Directorate for Social Assistance and Child Protection Buzau organized the campaign for the teenagers in Buzau high schools, called: "Ethnobotanicals will not solve your problems," under the motto "It is important you not to let yourself dragged, because one thing entails another, and then you do not know where you get ".

In Calarasi and Ialomita counties, the **probation services** proved to be a partner for Drug Prevention, Evaluation and Counselling Centres, these types of services being involved in activities and projects to prevent drug use among teenagers from the schools and colleges in these counties.

Another organization which involved in drug-use prevention activities in 2012 is **the International Federation of Educative Communities (FICE) - Romania**, which acted with same sense of care and professionalism in peer to peer education activities aimed at preventing drug-use, continuing the projects started 20 years ago, 'First Know, Then decide "- anti-drug project for children, and "Know and Act" – counselling project for parents. The projects were supported by specialists from NAA, Marius Nasta Institute of Pneumology and from the Drug Abuse International Association and were implemented in Bucharest and in Teleorman, Vaslui, Bihor and Iasi counties.

Projects and activities for drug abuse prevention in schools were also implemented by the territorial structures of the Romanian Gendarmerie in Alba, Arad, Arges, Bucharest, Bacau, Bihor, Bistrita Nasaud, Botosani, Braila, Brasov, Buzau, Caras-Severin, Calarasi, Constanta, Cluj, Dâmbovița Dolj, Gorj, Harghita, Hunedoara, Maramures, Mehedinti, Mures, Neamt, Olt, Prahova, Satu Mare, Sibiu, Suceava, Teleorman, Timis, Tulcea, Vaslui, Vâlcea and Vrancea. They involved in the implementation of 51 projects / campaigns focused on the drug-use phenomenon. Out of these, 24 were focused on the drug-se issue while 27 were focused on drug use prevention, such as for example the project implemented by the Gendarmerie County Inspectorate in Teleorman Virginia called "The gendarme-the



friend of those who observe the law! Together for the Safety of your School-Your school without drugs!", the project implemented by Gendarmerie County Inspectorate in Buzau called "Where to start?", the project implemented by the Mobile Gendarmerie Unit "Tomis" in Constanta "Avoid the meeting with drugs " and the project implemented by Gendarmerie County Inspectorate in Brăila called "Drugs - between law and lawlessness."

## **NATIONAL PROJECTS:**

### **THE CONTEST „MY MESSAGE AGAINST DRUGS”, the 9<sup>th</sup> EDITION**

The national contest "My message against drugs", now at its ninth edition, was an appropriate event for pupils and students enrolled in an educational institution to express themselves on this issue, thus contributing, along with other activities of this kind, to the development of healthy living beliefs among young people.

Aiming at developing attitudes and practices in the school population, with the final goal of a healthy lifestyle, without tobacco, alcohol and drugs, the project was implemented in each CPECA, in collaboration with the county school inspectorates, departments for youth and sports, county public health departments, in the period February - June 2012.

According to the rules of the contest, pupils were split in 2 age groups and participated in **10 sessions**: literary essay, web (3 subsections), short film, digital photography, spots, visual arts (3 subsections), sports (8 subjects) - only at county level.

**At national level, over 150,000 pupils** from secondary schools and high schools received information about the contest. **Over 5000 pupils participated** in the competition **with their own works**. The works ranked on the first place at county level participated in the competition at national level.

### **The PROJECT "UNCENSORED"**

"Uncensored" is a drug use prevention project implemented in schools for teenagers aged between 12 and 14, based on the model of social influence.

In 2012, the initiators decided the project team to implement the project at national level, published over **3000 notebooks and sets of cards for pupils, 400 manuals (guidelines) for teachers** and training of trainers sessions were organized at county level.

At the same time, **two specialists were trained in each county/district, one from CPECA and one from the County Resource and Educational Assistance Centre** in each County School Inspectorates / Bucharest School Inspectorate.

An important aspect of the project was its **accreditation** under the training of teachers in secondary education system.

### **THE PROGRAMME "ANOTHER KIND OF SCHOOL "**

According to the partnership between NAA and the Ministry of Education, the two institutions decided to collaborate in the programme "Another kind of school". "

In this programme, Drug Prevention, Evaluation and Counseling Centres organized a number of activities, such as: watching movies with specific themes, presentations from experts on the use of substances and their effects, followed by debates, distribution of information materials etc. Also, press conferences to promote programme activities were organized in most counties and press releases were developed.

## **3.2.2. FAMILY-BASED PREVENTION**

As in most Member States with expertise in preventing drug-use, in 2012 Romania **implemented relatively low number of family-based prevention projects**. This has several causes, as follows:

- macro-social causes - social anomy, economic situation, unemployment etc.
- Individual causes - mechanisms for attracting and motivating at-risk families require funding that could not be provided.

## **LOCAL PROJECTS:**

In 2012, CPECA implemented a total number of **17 family-based prevention projects**, which included:

- **368 prevention activities (216 in urban areas and 152 in rural areas)**

- **3924 beneficiaries (natural parents, foster parents, foster parents and youth in foster care)**

In order to support and promote children's rights, in May-June 2012 **DGASPC Bistrita Nasaud** implemented a campaign dedicated to parents with the aim of strengthening their responsibilities, and raising their awareness on their rights and obligations. The project was implemented in six municipalities in the county. **400 parents** of children in primary and secondary schools, teachers, social workers and police officers took part in the campaign activities. The activities consisted in: video presentations, followed by open discussion on the responsibilities of parents, the phenomenon of human trafficking, violence on the Internet, prevention of abuse, neglect or abandonment, and the problems caused by drug use and trafficking and also their negative consequences. The campaign promoted the child rights provided by Law 272/2004, but also aspects related to rewards and punishments and the importance of communication between parent and child.

## **NATIONAL PROJECTS:**

### **NATIONAL CAMPAIGN "RISKS OF DRUG-USE TO MOTHER AND CHILD"**

On 20 June 2012, at Parliament House, the NAA organized the **National Conference "Risks of drug-use to mother and child"**, event attended by specialists from the Ministry of Interior, Ministry of Health, World Health Organization, Ministry of Labour, Family and Social Protection and UNICEF Romania.

Plenary presentations emphasized the negative effects of drugs to mother and fetus: "Drug-addicted parents", "HIV-positive pregnant women," "Fetal and neonatal consequences of maternal drug abuse during pregnancy", "The implications of illegal substances use on young mothers and their effects on children - a case study", "User Survey **"ethnobotanicals"**", "Risk and protective factors in drug use," "Influence of smoking on lung function in children and mother", "Effects of substance abuse on children and family" "Child protection services ", "NAA care services "etc..

The event marked the start **of the national campaign "Drug-use risks to mother and child"**, the main objective of which was to raise the awareness of future mothers about the risks associated with tobacco, alcohol and drugs on the fetus. The campaign was implemented between **October 5, 2012 - June 26, 2013**.

The campaign aims at:

- organizing debates on the consequences of drug-use in mother and child with the participation of medical, psychological, legal specialists,
- organizing information visit in family planning clinics and distribution of information materials;
- organization of round tables with the participation of all stakeholders involved in medical assistance activities of future mothers in each county

During the campaign debates on the risks of drug-use to mother and child were organized in **8 cities** in the country (Bucharest, Craiova, Brasov, Cluj, Iasi, Constanta, Galati, Ploiesti). The debates included open discussions on the difficult-to-find balance between family life, profession and own wishes, on the rights of mothers, on the life that worth living with dignity and beauty, on the joys and sorrows a mother experiences. At central level and with the help of CPECA, NAA managed to achieve the expected goals for 2012, that is: raising future mothers' awareness on the risks associated with tobacco, alcohol and drugs-use on the fetus and promoting the campaign "Risks of drug-use to the mother and child", through the **information of over 12,938 people**, the main beneficiaries of this campaign and through collaboration with the local authorities, hospital units and civil society.

As part of subprogram 2 of the National Program, **a video material for parents was designed**. The video will be broadcasted on traditional media channels and social networks in 2013.

## **3.2.3 COMMUNITY-BASED PREVENTION**

### **LOCAL PROJECTS:**

In 2012, CPECA implemented a number of **22 community-based prevention projects**, which included:

- **617 prevention activities.**
- **18,832 direct beneficiaries**

- **17,125 indirect beneficiaries (members of local communities, prisoners, volunteers, children and young people in foster care, police and gendarmes).**

## **NATIONAL PROJECTS:**

### **NATIONAL PROJECT FOR MARKING: "World No Tobacco Day -31 May 2012**

The theme promoted in 2012 was "Stop the intervention of tobacco industry".

At national level, CPECA conducted 18 street information activities and information sessions in 86 schools and 2 prisons. 11 seminars / round tables, 4 marches, 2 shows / festivals 10 contests and 10 exhibitions were organized. At the same time 7 sports competitions took place. Press conferences were held in 47 counties, 67 articles were published in newspapers, 18 radio programs and 33 TV shows were broadcasted and 47 press releases were sent at national level.

With these activities **8,299 pupils, 110 students, 234 teachers and 6,540 indirect beneficiaries** were informed about the harmful effects of tobacco use.

Another key public actor involved in these activities for marking the World No Tobacco Day in 2012, was the County Public Health Departments in Ialomita, Calarasi, Dâmbovița Dolj, Hunedoara and Bistrita.

### **NATIONAL PROJECT TO MARK "NATIONAL NO TOBACCO DAY" (November 15, 2012)**

Marking the "No Tobacco Day for Central and Western Europe", the Drug Prevention, Evaluation and Counselling Centres and Public Health Departments (Public Health Departments in Ialomita, Gorj, Calarasi, Dâmbovița Dolj, Hunedoara) together with representatives of civil society conducted information and awareness raising activities about the effects of smoking. On this occasion, at national level, more than **7,000 active and passive smokers received information on the harmful effects of smoking.**

### **NATIONAL PROJECT TO MARK THE INTERNATIONAL DAY AGAINST DRUG ABUSE AND ILLICIT TRAFFICKING - "TOO REBEL TO BE DRIVEN" (26 JUNE 2012)**

To mark this day, the NAA held a press conference to launch a national campaign to prevent drug use, focusing on new psychoactive substances - "Too rebel to be driven" – and the video spot.

Also, at the national level, outdoor activities were organized in 34 counties and districts of Bucharest, information sessions in 12 schools in 12 prisons, 3 county libraries, 5 orphanages, 10 hospitals, 5 sports clubs. At the same time, 15 seminars /round tables, one anti-drug march in Sibiu County, 3 shows / festivals, 4 competitions in 10 parks, 2 swimming centers and 2 school camps were organized. Press conferences were held in 36 counties, 176 articles were published in newspapers, 63 radio shows and 101 TV shows were broadcasted and 25 press releases were sent in the entire country.

At local level, in activities related to the International Day Against Drug Abuse and Illicit Trafficking were organized in partnership with the Public Health Departments in Arges, Buzau, Bistrita; Suceava, Vaslui, Mures, Salaj, Calarasi, Dâmbovița Dolj, Gorj , Vaslui and Vâlcea.

## **PARTNERSHIP WITH CIVIL SOCIETY**

In order to improve the collaboration with civil society in general and with NGOs charged with the drug demand reduction in particular, the methodology for partnerships between the National Anti-drug Agency and NGOs and draft framework protocol with NGOs have been developed to reduce the drug demand at local or national level by carrying out drug use prevention projects or by developing services for drug users.

The Agency aims to create a new national public policy system for fighting against drugs, by aligning with European standards regarding **the role of civil society**, based on its active involvement in the shaping of future national drug strategy 2013-2020.

## **3.3 SELECTIVE PREVENTION IN AT-RISKS GROUPS AND SETTINGS**

### **3.3.1 BASED-SCHOOL SELECTIVE PREVENTION**

Because the vulnerable groups addressed by selective prevention often have significant experience with drugs, both legal and illicit, most selective prevention interventions consist in the provision of customised information, individual therapy and alternatives based on arts or sports. It should however be mentioned that the techniques used in extensive programmes of social influence characteristic for

universal prevention are equally efficient, if not more efficient if applied as selective prevention measures. Normative restructuring (e.g. learning that the majority of the population in the same category disapproves of drug use), training by self assertiveness, motivation and goal setting, as well as demystifying have proved to be highly efficient among vulnerable groups of young people.

### **THE PROJECT „FRED GOES NET – EARLY INTERVENTIONS FOR FIRST TIME DETECTED DRUG USERS”**

In January 2012, the second national edition of the project was launched, aiming at strengthening local partnerships in order to ensure a referral system to CPECA, promote Fred Courses among managers, school counsellors, principals and parents etc and support at least 7 FRED courses at local level, according to the FRED GOES NET Manual.

In 2012, CPECA implemented **103 FRED courses for 987 participants**, compared to 129 FRED courses with 1,045 participants in 2011.

### **3.3.2.COMMUNITY-BASED SELECTIVE PREVENTION**

#### **CAMPAIGN TO REDUCE THE RISK OF DRUG-USE RELATED RISKS "NO FURTHER RISKS!" AUGUST 1-15, 2012, Vama Veche**

The campaign was developed, coordinated and implemented by the NAA in partnership with Carousel Association and had the following **objectives**:

- reducing the drug use related risks among young people spending their holidays at the seaside;
- promoting drug addiction treatment services;
- promoting the concept of drug use related risks reduction, as public health approach and de-stigmatization of drug users.

During the campaign, **4,765 young people have benefited from direct intervention information and advice** from specialists, on the risks of drug use, as public health approach and de-stigmatization of drug users. We estimate about **15,000 people were informed about the activities of the campaign**.

**3,000 leaflets, 500 balloons, 8,640 condoms, 180 syringes, 387 cleansing compresses and 74 distilled water vials** were distributed during the campaign. An important element was related to the recovery of used syringes.

At central and local level, the campaign was promoted by over **50 articles in the newspapers, on the radio and on the Internet**.

**ANP** implemented in 2012, **two prevention programmes for the prisoners in the custody of ANP**, programmes which will continue in 2013:

- **"Information and drug prevention programme"**- 577 prisoners in the custody of ANP benefited from this programme in 2012. The purpose of this program is to inform the prisoners on the types of drugs, and also consequences and risks associated with drug-use.
- **"Psychosocial assistance programme for prisoners with a history of addiction"** - in 2012, 456 prisoners with a history of drug use were included in this program, in order to raise their awareness on the causes that led let to drug-use and prevent the resumption of drug-use.

Another program addressed to another group at risk was conducted in 2012 by **the General Directorate of Social Assistance and Child Protection Sector 4**, in collaboration with the **Romanian Association Against AIDS (ARAS)** - "Information programme for children/ young beneficiaries of day centres and residential services on the risks associated with drug use and unprotected sex."

### **3.4 INDICATED PREVENTION**

Due to limited financial resources in the reference period, no representative prevention projects were implemented.

The only relevant national selective prevention project, which included a component of indicated prevention is **FRED GOES NET - early intervention for drug users identified / detected the first time**, presented at section 3.3.1.

### 3.5 NATIONAL AND LOCAL MEDIA CAMPAIGNS

#### **NATIONAL CAMPAIGN-"TOO REBEL TO BE DRIVEN!"**

The campaign aimed primarily at raising the awareness of the population at-risk, aged 15-24 years and also of the general population on the risks of drug use, as well as the information of the population at risk on the integrated assistance services.

The overall objective of the campaign was the awareness raising on the risks of drug use in general and of new psychoactive substances in particular, and on the effectiveness of complementary strategies of leisure activities, by implementing a national media campaign and promoting the services provided by the integrated national system of prevention and care for drug users.

The implementation period of the campaign was 1 year - 26 June 2012 - 26 June 2013.

In 2012, at national level, the following activities were implemented:

- Prevention activities in schools: **387 activities with a number of 22,231 pupils as direct beneficiaries and 536 teachers, 1,250 parents and 211 specialist as indirect beneficiaries;**
- Public debates: **4 activities with 102 specialists among participants;**
- Prevention activities in universities: **20 specialists and 180 students as direct beneficiaries;**
- Prevention activities in prisons: **14 activities implemented for a total of 443 direct and indirect beneficiaries;**
- Street activities: **50 activities, with an approximate number of 1,500 direct beneficiaries - people informed belonging to the main target group;**
- Round tables: **14 activities organized, 357 specialists among participants;**
- Leisure activities: **7 activities (concerts, thematic camps), 581 direct beneficiaries;**
- Documentary video broadcast: **26 broadcasts; 2366 indirect beneficiaries;**
- TV spot: **98 824 broadcasts, 8,481,748 indirect beneficiaries;**
- Prevention activities in the community: **266 activities implemented for 64,333 indirect beneficiaries.**

Within this campaign, **42 public debates on drug issues** were organized at national level, with the direct involvement of children and adolescents and high school students. Debates were also organized at Parliament House (in Bucharest) and in prefectures (local).

#### **THE CAMPAIGN "NATIONAL MONTH OF INFORMATION ABOUT THE EFFECTS OF ALCOHOL USE" (July)**

The campaign, initiated by the National Institute of Public Health and County Public Health Departments aimed at reducing the harmful effects of alcohol use at the level of the general population and preventing alcohol use in adolescents and young adults and was implemented in July.

The main objectives of the campaign were: direct information of population about the effects of alcohol on their physical and mental health and promotion sports as an alternative for spending spare time. Thus, over **3000 people were informed about the effects of alcohol.**

#### **CONCLUSIONS:**

- Studies and best practice examples in the Community Member States with specialized expertise in the field of drug prevention and care services for drug users indicate the need to intensify the holistic preventive projects and interventions focused both on the general population, but especially on vulnerable groups (at risk). Unfortunately, in Romania, due to poor correlation between sectoral social policies and, therefore, the cohesion (structural) funds, some relevant target groups in terms of psychosocial risks remain "untouched" - parents with mental disorders, homeless children and young people, families with low incomes, rural population, children at risk of school dropout, women victims of domestic violence etc.
- an analysis of the results of national prevention campaigns with a media component, proves their medium and long term and the need to allocate special funds for this purpose. the need to enhance selective interventions in the school and family environment, especially the interventions in cases of psychological and/ or family crisis, in order to identify comprehensive solutions for efficient and effective preventive interventions.

## Chapter 4 - Problem drug use

### 4.1. ESTIMATES OF PREVALENCE AND INCIDENCE OF PROBLEM DRUG USE

The multiplier resulted from the “Behavioural and serologic survey on HIV, hepatitis B and C prevalence among injecting drug users (IDU) in Bucharest – Behavioural Surveillance Survey 2012”, carried out in 2012 by the National Anti-drug Agency, Romanian Angel Appeal and Carusel<sup>35</sup>, was used to provide an estimate of the prevalence of problematic usage of drugs for 2012.

*Benchmark:* beneficiaries of drug-addiction treatment services (substitution + detoxification) registered for 2012.

*Case definition* – use of injecting drugs; age group: 18-49 years old; Bucharest.

The analysis of data from the “Behavioural and serologic survey on HIV, hepatitis B and C prevalence among injecting drug users (IDU) – Behavioural Surveillance Survey 2012” indicated that a percentage of 22.3% (0.2230; 95% CI: 0.2062-0.2398) of the individuals included in this survey were beneficiaries from drug addiction treatment programmes (substitution or detoxification)

Similarly to 2011, the data regarding the treatment beneficiaries originate from comprehensive monitoring, that resulted from the protocol related to the “Admission to treatment as a result of drug use” indicator. The number of individuals under treatment had been reported in previous years only for new cases.

An estimated number of 10583 (10583; 95% CI: 9841 – 11445) problematic users of drugs resulted for Bucharest city, by dividing the number of individuals included in treatment programmes for problematic usage of drugs<sup>36</sup> in 2012 to the above mentioned multiplier.

55% of such problematic users are represented by heroin users, 43.6% by new psychoactive substances (NPS) + amphetamines (most of them NPS) users and 1.3% by cocaine users.

**Table no. 4-1: Estimate (in absolute figures and ratio) of the number of problematic drug users in Bucharest, using the multiplier method, 2007- 2012**

Year	Estimated number of problematic drug users (PDU)	Ratio as per 1000 persons, aged 18 to 49
2007	16 867	17.4
2008	17 387	17.5
2009	17 767	18.0
2010	18 316	19.2
2011	19 265	20.01
2012	10 583	11.05

Source: NAA

A significant decrease can be noticed in terms of the estimated number of problematic drug users in Bucharest in 2012, compared to the previous years. Due to the methodological limitations of the estimates made based on the multiplier method, there is a need for confirming a potential decreasing trend in the number of problematic users.

It is possible for the multiplier that was used, extracted from the BSS 2012 survey, to have been affected by the fact that the seeds used in the RDS-type sampling (respondent driven sampling) were collected to a larger extent compared to previous years from among individuals who have benefited from treatment services for drug addiction.

The key limitation in providing a national level estimate is still represented by the level of availability of services/programmes in the rest of the country.

<sup>35</sup> The main results are presented in chapter 6.1.2

<sup>36</sup> 2360 beneficiaries of treatment services for addiction to opioids, new psychoactive substances, cocaine or amphetamines

#### **4.2. DATA ON PROBLEM DRUG USERS COLLECTED FROM SOURCES OTHER THAN THE TREATMENT ADMISSION INDICATOR FOLLOWING THE DRUG USE**

In 2011-2012, significant developments were registered in the drug usage behaviour of PDU/IDU in the Bucharest metropolitan area.

When the BSS type surveys started to be applied, 97% of IDU respondents stated that heroin was the main drug used (BSS, 2007); however, in 2012 most of IDUs mentioned substances sold as legal drugs or “ethnobotanical drugs”, NPS (49.6%), while heroin was declared as the main drug by 40.5% of the IDUs participating to the survey (BSS, 2012). The NPS usage is associated with a high frequency of injection and with an increased rate of syringe sharing. In 2012, the frequency of the most recent/last date of injection with the main drug was over 4.27 times: over 5 injections per day – 22.8%, 3-5 injections – 35.5%, below 3 injections – 41.7%. 19.3% of the IDUs declared that they used non-sterile syringes for the most recent injection, while 20.1% stated that someone else had used the syringe that they used also.

## Chapter 5 – Drug related treatment

The collection of data necessary to elaborate this chapter is made based on the Standard European Protocol for monitoring the drug related treatment (Standard Protocol 2.0). This is transposed in the national legislation in the Joint Order issued by the Ministry of Public Health and Ministry of Interior and Administrative Reform<sup>37</sup>, thus creating the legal framework for the collection of data brought forward in this chapter. Procedures to harmonize the legislation and data collection instruments (sheets) with the new Protocol (Standard Protocol 3.0) recommended at European level by EODT have currently been initiated.

### 5.1 STRATEGIES/ POLICIES

The institutional and enforcement framework of the drug user care system was not amended in 2012 and it was described in detail in the previous national reports.

### 5.2 NATIONAL TREATMENT SYSTEM

The National Anti-drug Agency provides the illicit drug and alcohol users and their dependents with the facility to access online the database of the institutions with competence in care services for addiction (national coverage)<sup>38</sup>. In addition, the professionals providing care services to drug users can register online quickly and free of charge. The website offers the facility of searching the available services by some filters: according to the location (region or county), type of services (e.g.: rehab, substitute treatment, psychiatric treatment, social care etc.), type of beneficiary (e.g., women, men, minors or drug use vs. alcohol use) and access facilities, every institution having the possibility to view the sheet describing the institution services or competences.

Starting with 2011, in order to implement the new indicator monitoring protocol, the data regarding cases of continued treatment from previous years and those that continued/abandoned/ completed treatment during the reference year started to be collected. These data shall be presented throughout the chapter, but in order to ensure the comparability of the data with the ones collected during previous years, the analysis of the characteristics of the population admitted for treatment consequent to drug use (subchapter 5.3) shall be carried out based on the incidence data (persons requesting care for the first time or who re-entered treatment during the reference year).

During 2006 – 2012, given all the admissions to treatment for psychoactive substance use, we can see that apart from 2009 and 2010, most treatment admissions were for illegal drug use and NPS. Compared to the previous year, 2012 shows a 5.6% increase (from 3587 to 3788) due to an increase in incident cases (7.5% for illegal drugs and NPS and 9.4% for alcohol and tobacco).

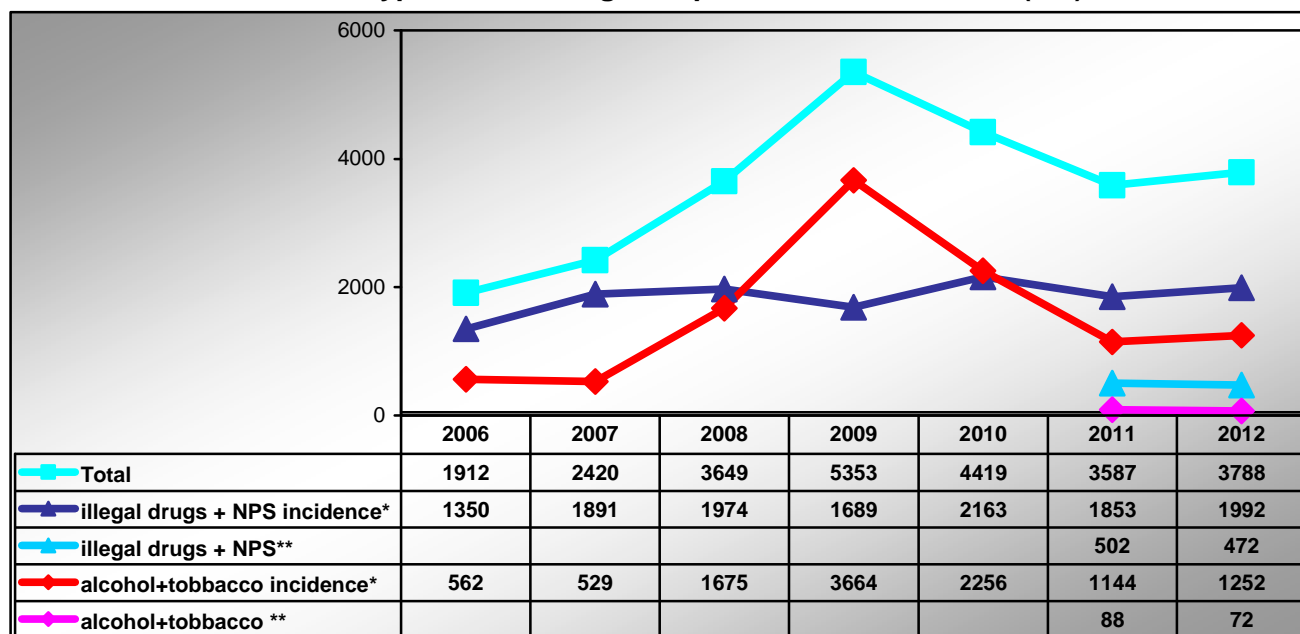
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<sup>37</sup>Joint Order of MH and MIAR no. 770, respectively no. 192/2007 for approving the Methodology to fill in standard records and the transmission of data to be included in the personal emergency medical sheet for drug use, personal drug use treatment admission sheet, the recorded HCV and HBV cases among injecting drug users and the prevalence of HIV, HBV and HCV infections among injecting drug users.

<sup>38</sup> <http://www.ana.gov.ro/asistenta/> (The database was developed in November 2009, under the “Strengthening of the integrated medical, psychological and social care services for drug users in Romania” Project, financed by the European Commission, having aimed the development of the care services and the increase of the accessibility to such services).



**Chart no. 5-1: Evolution of admissions to treatment consequent to psychoactive substances, by the date of admission and type of main drug, compared data 2006 – 2012 (no.)**



Note: \* incidence (persons requesting care for the first time or who re-entered treatment during the reporting year), \*\* - cases of continued treatment from previous years and who continued/abandoned/completed treatment during the reference year

Source: NAA

By the type of care in 2012, compared to the previous year, one can notice the following:

- for illegal drug and NPS use: a decrease in number of out-patients (from 1170 to 1088) and an increase in the number of imprisoned patients (from 187 to 227) and of in-patients;
- for alcohol and tobacco use: a decrease in the number imprisoned patients (from 15 to 5) and an increase in the number of out-patients (from 44 to 99) or of in-patients (moreover, the change is not influenced by therapy communities added to reporting for 2012: from 1091 to 1151 and respectively 1120 – without therapy communities).

**Table no. 5-1: Evolution of admissions to treatment consequent to psychoactive substance use, by the type of admission, type of care and type of main drug, compared data 2011 – 2012 (no.)**

Type of main drug	Data of admission	2011				2012			
		type of care			Total	type of care			Total
		out-patient	in-patient	inmate		out-patient	in-patient (of which TC*)	inmate	
illegal drugs + NPS	incidence**	758	984	111	1853	710	1138 (21)	144	1992
	***prior to the reference year	412	14	76	502	378	11 (3)	83	472
	<b>Total</b>	<b>1170</b>	<b>998</b>	<b>187</b>	<b>2355</b>	<b>1088</b>	<b>1149 (24)</b>	<b>227</b>	<b>2464</b>
alcohol + tobacco	incidence**	44	1091	9	1144	99	1151 (31)	2	1252
	***prior to the reference year	55	27	6	88	47	22 (0)	3	72
	<b>Total</b>	<b>99</b>	<b>1118</b>	<b>15</b>	<b>1232</b>	<b>146</b>	<b>1173 (31)</b>	<b>5</b>	<b>1324</b>

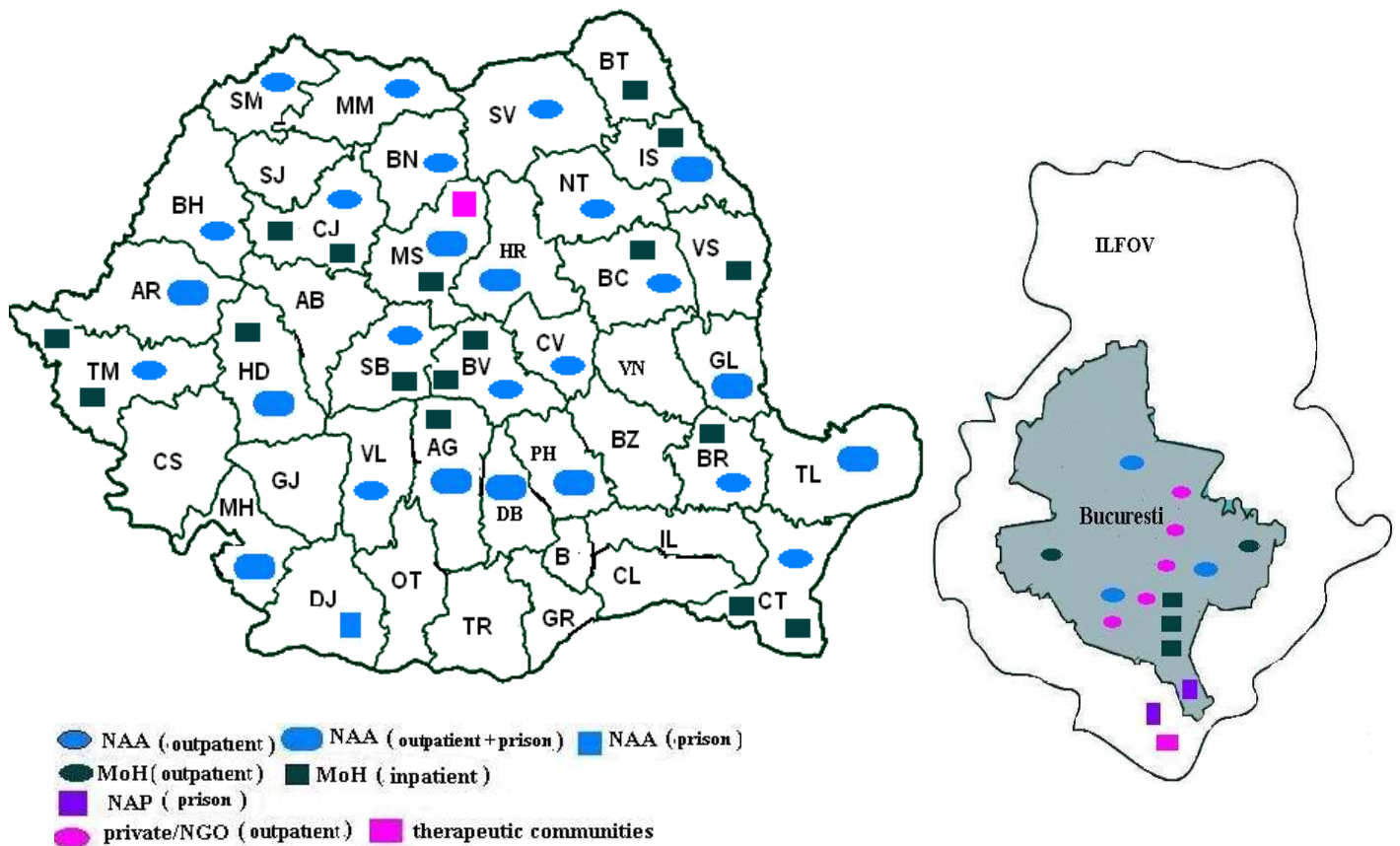
Note: \* TC – therapy communities (in 2011 – no data was reported), \*\* incidence (persons requesting care for the first time or who re-entered treatment), \*\*\* - cases of continued treatment from previous years and who continued/abandoned/completed treatment during the reference year

Source: NAA

In 2012, 62 centres reported granting care to illegal drug and NPS users:

- 22 medical units of the Ministry of Health, out of which, 20 provide rehab services and in-patient medical and psychological care (3 in Bucharest and the rest in: Argea, Bacau, Braila, Botosani, Brasov, Cluj, Constana, Hunedoara, Iasi, Mures, Sibiu, Timis, Vaslui) and 2 (from Bucharest) provide out-patient care – medical, psychological and social care and substitute treatment with methadone/ suboxone/ naltrexone for opiate addiction;
- 31 centres of the National Anti-Drug Agency – granting out-patient medical, psychological and social care, out of which 3 in Bucharest – integrated care for addictions, including substitute treatment with methadone/suboxone/naltrexone for opiate addiction; out of the 31 centres, 13 centres provided care to detainees (arrest/prison);
- 3 centres/ private practices in Bucharest (ANIT – National Association for Drug Addiction Intervention, PSYMOTION and **D&C Medical**)<sup>39</sup> providing integrated care for addictions (including substitute treatment for opiate addiction), for out-patients;
- 2 centres managed by the ARAS nongovernment organization (Arena and Titan) in Bucharest, providing integrated care services for addictions (including substitute treatment for opiate addiction), for out-patients;
- 2 centres of the National Administration of Penitentiaries (Jilava and Rahova Prisons) providing integrated care for addicted inmates (including substitute treatment for opiate addiction);
- 2 centres for post-cure treatment (Bonus Pastor Foundation and Teen Challenge Romania).

**Map no. 5-1: Territorial allocation of centres reporting provision of care to illegal drug and NPS users by the type of care and care provider, 2012**



Source: NAA

<sup>39</sup> <http://www.anit.ro/>, <http://www.psymotion.ro> și <http://www.psihomedcom.ro/contact.html>

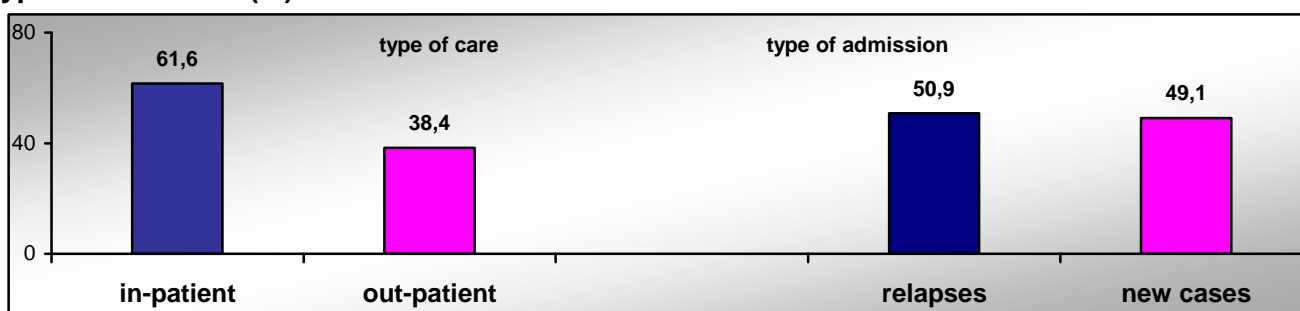
### 5.3 CHARACTERISTICS OF PEOPLE ADMITTED TO TREATMENT FOLLOWING THE DRUG USE(– CHARACTERISTICS OF THE POPULATION ADMITTED TO DRUG RELATED TREATMENT)

In 2012<sup>40</sup>, **1848 individuals** requested care as in- and out-patients<sup>41</sup>, for illegal drug and NPS use, out of which:

- 1138 were in-patients and 710 out-patients;
- 884 individuals had never received care before (new cases), while 916 had been admitted to treatment before (relapse)<sup>42</sup>.

Both the numbers and the percentages show that most admissions were for in-patients (the in-patient/out-patient ratio is 1.6) and relapses (the relapse/new case ratio is 1.04).

**Chart no. 5-2: Percentage allocation of admissions to treatment in 2011 by the type of care and type of admission (%)**



Source: NAA

Heroin (34.6%) and new psychoactive substances – NPS (33.1%) are the **main drugs** for which care was requested in 2012<sup>43</sup>, with the comment that the number of individuals requesting treatment for NPS (36.5%) was almost two times higher, compared to the number of individuals requesting care for heroin (20.6%). Hypnotics and sedatives (13.7%) and cannabis (10.1%) were the next two substances individuals requested care for in 2012:

- new cases: cannabis (16.6%), hypnotics and sedatives (17%);
- relapses: hypnotics and sedatives (10.5%), cannabis (3.7%), other opiates (3.4%) and other substances (2%).

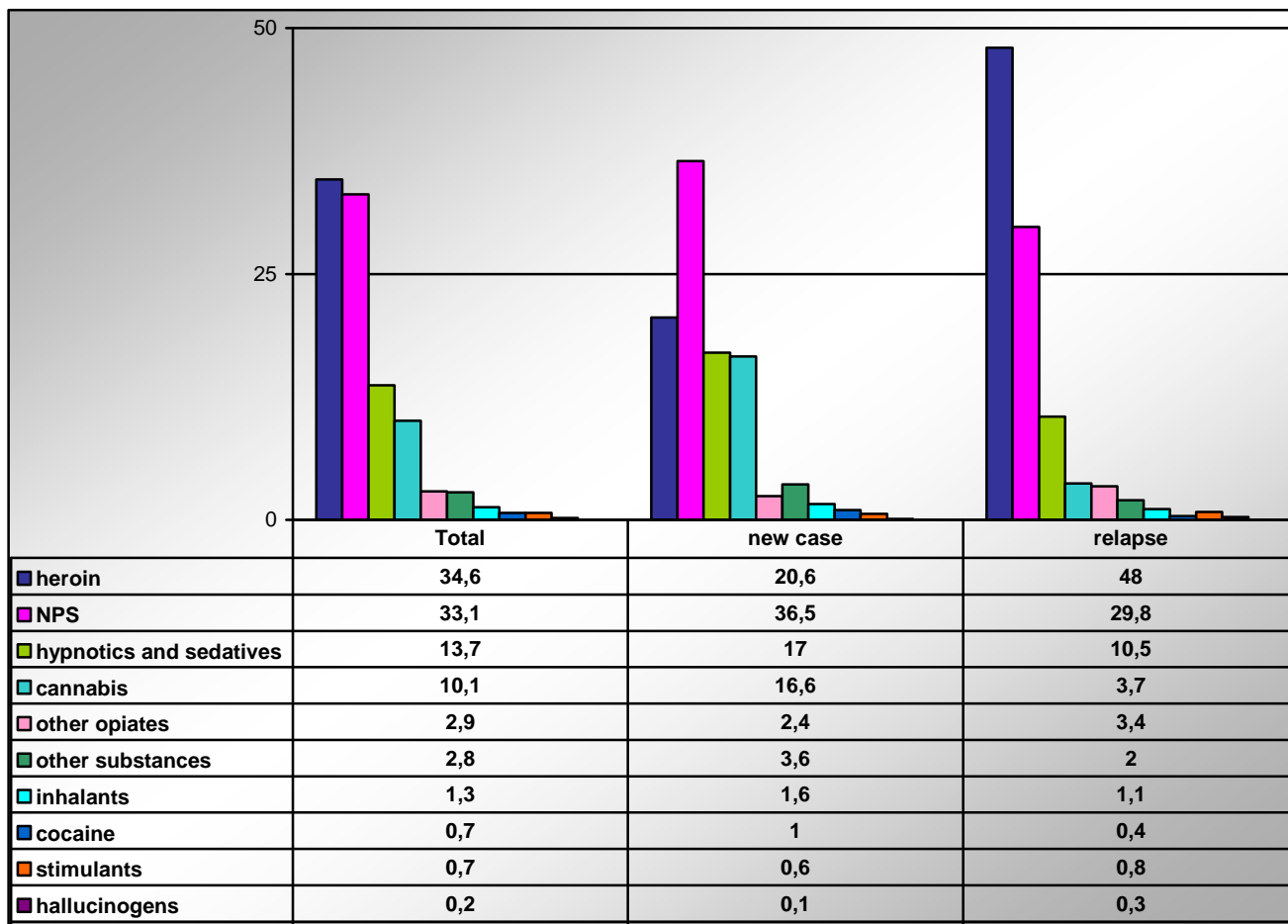
<sup>40</sup> Throughout the analysis, the percentage allocation of cases depends on the total number of cases without non-response (for which the answer value of the variable/item was mentioned). The analyzed data come from the territorial structure of the National Anti-Drug Agency (CAIA and CPECA), the National Center for Statistics and IT for Public Health (within the National Institute for Public Health) and hospitals, ANIT, ARAS, D&C Medical, PSYMOTION, post-cure treatment centres (Bonus Pastor Foundation and Teen Challenge Romania)

<sup>41</sup> the individuals who received care while imprisoned are described under chapter 9

<sup>42</sup> See ST no. 4.1.1

<sup>43</sup> See ST no. 11.1.1

**Chart no. 5-3: Percentage allocation of admissions to treatment in 2012 by the type of main drug and type of admission (%)**



Source: NAA

Out of the 1848 beneficiaries receiving care in 2012, 38.4% (710 individuals) stated only the main drug use, while 30.6% (565 individuals) stated **poly use and/or use of another secondary drug**. 339 beneficiaries (18.3%) stated a **poly use** (538 answers). According to the data presented in the table below, the highest proportions of declared used were for:

- beneficiaries requesting care for **heroin** use (40.1%), **NPS** (33.9%), **cannabis** (9.7%), **benzodiazepines** (4.1%) and **methadone** (2.7%);
- the most frequent in poly use are: **NPS** (24.2%), **cannabis** (16%), **opiates** – 15.9% (methadone – 7.2%, heroin – 4.8% and other opiates 3.9%), **alcohol** (9.5%), **benzodiazepines** (8.6%) and **cocaine** (7.1%).

306 beneficiaries (16.6%) stated to also use other drugs (**secondary drug**)<sup>44</sup> other than the one for which they requested care (between 1-5 secondary drugs, 439 answers). According to the data presented in the table below, the highest numbers of those stating to use one/several secondary drugs:

- requested care for **NPS** (50.3%), **heroin** (29.4%), **cannabis** (11.1%), **methadone** (1.6%) and **cocaine** (1.8%);
- the most used as secondary drugs are: **alcohol** (23.7%), **opiates** - 21.2% (methadone – 10.5%, **heroin** – 6.4% and other opiates 4.3%), **cannabis** (16.4%), **NPS** (12.8%), **benzodiazepines** (7.7%) and **cocaine** (5.2%).

<sup>44</sup> See ST no. 24.1.1

**Table no. 5-2: Distribution of admissions to treatment in 2012 for poly use addicts or addicts also using other drugs (secondary drug) than the one for which they requested care (main drug), by the type of drug (no., %)**

poly drug use	Main drug						Total		
	heroin	NPS	cannabis	benzodiazepines	methadone	other substances	no.	% (538=100%)	
NPS	66	35	15	1	2	11	130	24.2	
cannabis	28	39	8	0	2	9	86	16.0	
alcohol	2	36	6	2	0	5	51	9.5	
benzodiazepines	23	6	2	5	2	8	46	8.6	
methadone	35	2	1	0	0	1	39	7.2	
cocaine	21	9	7	0	1	0	38	7.1	
heroin	0	19	2	0	4	1	26	4.8	
other opiates	9	6	1	1	1	3	21	3.9	
others	17	38	14	10	3	19	101	18.8	
total answers	no.	201	190	56	19	15	57	538	100
	%	37.4	35.3	10.4	3.5	2.8	10.6	100	
total individuals	no.	136	115	33	14	9	32	339	
	%	40.1	33.9	9.7	4.1	2.7	9.4	100	
secondary drug	Main drug						Total		
	NPS	heroin	cannabis	methadone	cocaine	other substances	no.	% (439=100%)	
alcohol	76	6	21	0	0	1	104	23.7	
cannabis	51	12	3	1	3	2	72	16.4	
NPS	12	30	7	1	2	4	56	12.8	
methadone	16	26	1	0	0	3	46	10.5	
benzodiazepines	12	16	1	2	1	2	34	7.7	
heroin	23	0	0	3	1	1	28	6.4	
cocaine	13	7	3	0	0	0	23	5.2	
other opiates	5	13	0	0	0	1	19	4.3	
others	24	9	14	0	1	9	57	13.0	
total answers	no.	232	119	50	7	8	23	439	100%
	%	52.8	27.1	11.4	1.6	1.8	5.2	100	
total individuals	no.	154	90	34	6	5	17	306	
	%	50.3	29.4	11.1	2.0	1.6	5.6	100	

Source: NAA

To conclude, given the **main type of drug, poly drug use and secondary drug**<sup>45</sup> we notice that:

- heroin or NPS are the main drugs of circa  $\frac{3}{4}$  of the beneficiaries with poly drug use (74%) and secondary drug use (79.7%);
- if in case of poly drug use the number of answers is close (heroin – 201, NPS – 190), in case of secondary drugs for NPS users the number of answers is 2 times higher compared to heroin users: 232 vs. 119;
- for heroin – 40.1% of the beneficiaries declared poly use, while 29.4% the use of one or several secondary drugs, the most used being NPS and methadone both as poly drug use and as secondary drug use;
- for NPS – 33.9% declared poly drug use, while 50.3% the use of one or several secondary drugs, the most frequent being cannabis, alcohol, other NPS and heroin as poly drug use and alcohol, cannabis and heroin as secondary drug.

<sup>45</sup> See ST. no. 24.1.1

Out of the 916 beneficiaries receiving care in 2012 and with previous admissions to treatment (relapses), 744 individuals (81.2%) requested treatment for opiate use and NPS (main drug). Given the 2 groups of **main drug and the one for which previous treatment was requested**, we notice the following:

- 705 (94.8%) stated to have requested prior care for opiates and/or NPS<sup>46</sup>: 61.3% for heroin and 34.8% for NPS;
- the most often stated for previous treatment is heroin (56%) and NPS (39.3%);
- out of the 440 beneficiaries requesting treatment in 2012 for heroin: 427 stated to have received prior care for heroin, while 22 for NPS;
- out of the 273 beneficiaries requesting treatment in 2012 for NPS: 200 stated to have received prior care for NPS, while 116 for heroin.

The data indicates that in 2012, relapses have the following characteristics:

- a high number of previous heroin users requested treatment before for NPS use (42.5%);
- switching from NPS to heroin use was less significant (5%);
- those with NPS use present an increasing trend to use several types of NPS (73.3%).

**Table no. 5-3: Allocation of admissions to treatment in 2012 for relapse addicts who also requested care (main drug) for opiates or NPS, by the type of drug for which they received prior care (no., %)**

			Main drug				
			heroin	methadone	other opiates	NPS	Total
total			440	19	12	273	744
Prior treatment for	heroin	no.	427	15	6	116	564
		%	97.0	78.9	50.0	42.5	75.8
	methadone		2	5	1	1	9
	other opiates		0	1	7	0	8
	NPS	no.	22	2	1	200	225
		%	5.0	10.5	8.3	73.3	30.2

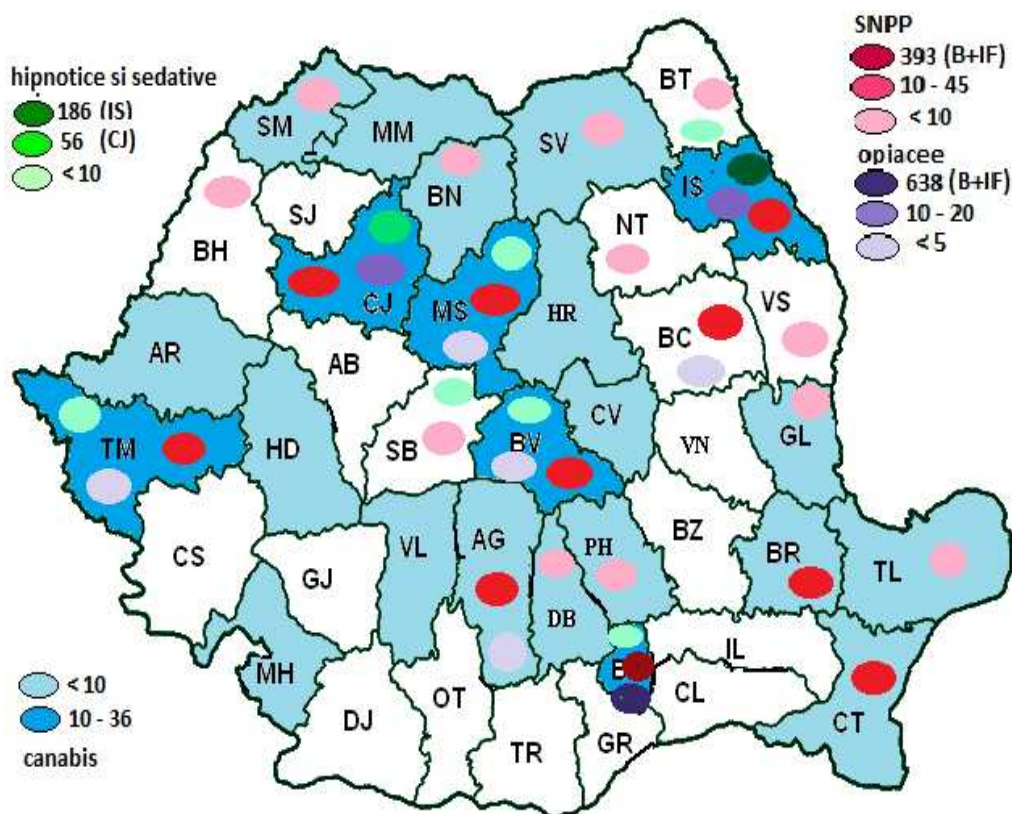
Source: NAA

According to the presented map, **the territorial distribution** of admissions to treatment by the main drug use was the following:

- cannabis – 24 counties, highest values in the counties: Mures (36 individuals), Cluj (28 individuals), Iasi (26 individuals), Bucharest-Ilfov (21 individuals), Brasov (15 individuals) and Timis (10 individuals);
- NPS – 23 counties, most cases being registered in Bucharest-Ilfov (393 individuals) and Cluj (45 individuals);
- opiates – 9 counties, the most being registered in Bucharest-Ilfov (638 individuals);
- hypnotics and sedatives – 8 counties, the highest values being registered in Iasi (186 individuals) and Cluj (56 individuals).

<sup>46</sup> All psychoactive substances for which they received previous treatment (705 beneficiaries and 806 answers) can be mentioned.

**Map no. 5-2: Territorial distribution of admissions to treatment in 2012 by the type of main drug and the county providing care (no.)**



Source: NAA

Moreover, the data analysis shows the following:

- cannabis use has the widest spread, from a demographic point of view (24 counties, but with small values);
- the most problematic continues to be NPS (23 counties, but with far higher values compared to cannabis);
- the Bucharest-Ifov area registers the highest use of opiates and NPS;
- Iasi has the highest number of cases of hypnotic and sedatives and an average number of opiate and NPS use, while Cluj has an average number of hypnotics and sedatives, opiates and NPS; furthermore, although at smaller values, one can state that there is a diverse use also in counties such as Brasov, Mures and Timis where there are admissions to treatment for several types of drugs: hypnotics and sedatives, opiates and NPS;
- the areas with the highest risk (as number of registered cases) is pencilled around large university centres or border counties.

In total, there were 2376 **admissions to treatment** for the 1848 beneficiaries requesting care for illegal drug and NPS use in 2012 (in average, 1.3 admissions per beneficiary). By the main drug, the highest average was registered for hallucinogen users (1.5) and opiates (1.4), while the highest number of treatment sessions describes opiates and NPS users (maximum = 8 and 5 respectively).

**Table no. 5-4: Allocation of admissions to treatment in 2012, by the number of treatment episodes and type of main drug (no., average, maximum)**

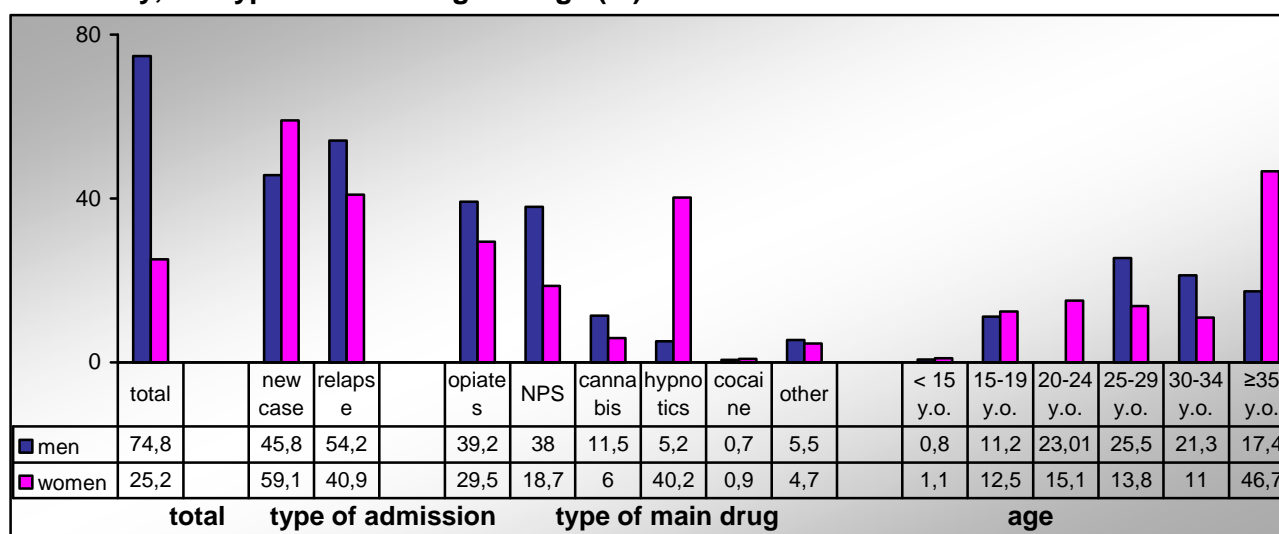
	Valid N	Average	Maximum	total no. of treatment sessions
opiates	679	1.4	8	940
NPS	614	1.3	5	794
hypnotics and sedatives	258	1.2	4	314
cannabis	186	1.1	3	201
volatile inhalants	24	1.2	4	29
cocaine	13	1.1	2	14
stimulants	13	1.3	1	17
hallucinogens	4	1.5	3	6
other	57	1.1	2	61
total	1848	1.3	8	2376

Source: NAA

By the **gender of the respondent**<sup>47</sup>, one can notice the following:

- most beneficiaries are men (M/W ratio of 3);
- for most men beneficiaries, there is a higher relapse rate, admission for opiate care, NPS and cannabis and for ages between 15-34 y (81.8% vs. W – 52.3%);
- for women beneficiaries, there is a higher number of new cases, of care for hypnotics and sedatives and opiates and for ages over 35 (46.7% vs. M – 17.4%).

**Chart no. 5-4: Percentage allocation of admissions to treatment in 2011 by the age of the beneficiary, the type of main drug and age (%)**



Source: NAA

With respect to the age of the beneficiaries, one noticed the following differences, by the gender of the beneficiary, the type of admission and the type of main drug used<sup>48</sup>:

- the smallest age (11 years) was registered for men, the beneficiaries at their first treatment and who requested care for inhalants use;
- the average age of the individuals admitted for treatment varies by the main drug, the lowest values being registered for the inhalants' use (21 y.o.) and the eldest in case of beneficiaries requesting care for the benzodiazepine use (54 y.o.);
- although the average age of women requesting care for drug use was higher than that of men (37.9 y.o. vs. 28.6 y.o.), the most often age for women was smaller than that of men (18 y.o. vs. 23 y.o.);

<sup>47</sup> See ST. no. 4.1.1, 12.1.1 and 13.1.1

<sup>48</sup> See ST. no. 6.1.1, 6.1.2, 12.1.1, 12.1.2, 13.1.1, 13.1.2, 14.1.1 and 14.1.2



- most beneficiaries requesting care for inhalants' use were 14, for cannabis – 22 and NPS – 23, while for opiate users the most often age was 30 and hypnotics and sedatives – 53.

**Table no. 5-5: Age of the beneficiaries (minimum, average and most frequent) by age, type of admission and main drug (years)**

	Total	gender		Type of admission		Main drug				
		men	women	new case	relapse	NPS	opiates	cannabis	hypnotics and sedatives	Inhalants
Minimum	11	11	13	11	14	13	14	14	20	11
Average	30.9	28.6	37.9	29.7	31.7	25	30.3	23.2	54	21
Mode <sup>49</sup>	23	23	18	23	28	23	32	22	53	14
Valid N <sup>50</sup>	1839	1369	465	881	910	611	677	186	257	23

Source: NAA

Regarding the **onset age**<sup>51</sup>, the cases of admission to treatment for illegal drug and NPS use during 2012 present the following characteristics:

- ¾ (74.7%) of the beneficiaries started their use before 24: 39% started using between 15-19 y.o., 25% started using between 20-24 y.o. and 10.7% of the individuals admitted to treatment had an early onset (below 15 y.o.);
- by the age of the patient, women have a higher proportion for early onset, below 15 years (15.2% vs. 9.7%) while over 35 the proportion of men starting to use at this time was a third of women (4.1% vs. 13.2%); in case of men, proportions are higher for the onset between 20 and 34 y.o. (47.5% vs. 31,8%);
- by the type of admission, the differences are rather small: for new cases, there is a higher proportion for the onset between 15 and 24 y.o. (67.1% vs 61.3%), while for relapses for early onset (11.4% vs. 10%) and between 25-34 y.o. (21.5% vs. 17%);
- by the main drug:
  - most opiate users declared an onset age below 25 y.o. (84.6%, out of which 14.2% - early onset),
  - in case of NPS, most individuals started using between 15-29 y.o. (76.6%);
  - most cannabis users requesting care started using in between 15-24 y.o. (84.9%, out of which more than half between 15-19 y.o., typical age for high school).

<sup>49</sup> The most frequent age

<sup>50</sup> Nr. of cases with valid answer

<sup>51</sup> See ST. no. 21.1 – 23.1

**Table no. 5-6: Allocation of admissions to treatment in 2012, by the onset age, gender of the beneficiary and type of main drug (no., %)**

		Onset age per groups (years)						total
		< 15	15 -19	20 -24	25 -29	30 -34	≥ 35	
No.	Total	145	530	340	169	95	81	1360
%		10.7	39	25	12.4	7	6	100
No.	men	106	425	297	146	79	45	1098
	women	39	102	43	23	16	34	257
%	men	9.7	38.7	27	13.3	7.2	4.1	100
	women	15.2	39.7	16.7	8.9	6.2	13.2	100
No.	new case	66	274	169	75	38	39	661
	relapse	78	252	168	93	54	40	685
%	new case	10	41.5	25.6	11.3	5.7	5.9	100
	relapse	11.4	36.8	24.5	13.6	7.9	5.8	100
No.	opiates	81	269	132	50	28	10	570
	NPS	40	158	137	103	57	24	519
	cannabis	10	83	47	10	2	1	153
	hypnotics and sedatives		3	3	3	6	44	59
	other	3	8	10	1		2	24
	volatile inhalants	9	4	1	1			15
	stimulants		3	6	1			10
	cocaine	1	1	4		1		7
	hallucinogens	1	1	1				3
%	opiates	14.2	47.2	23.2	8.8	4.9	1.8	100
	NPS	7.7	30.4	26.4	19.8	11	4.6	100
	cannabis	6.5	54.2	30.7	6.5	1.3	0.7	100

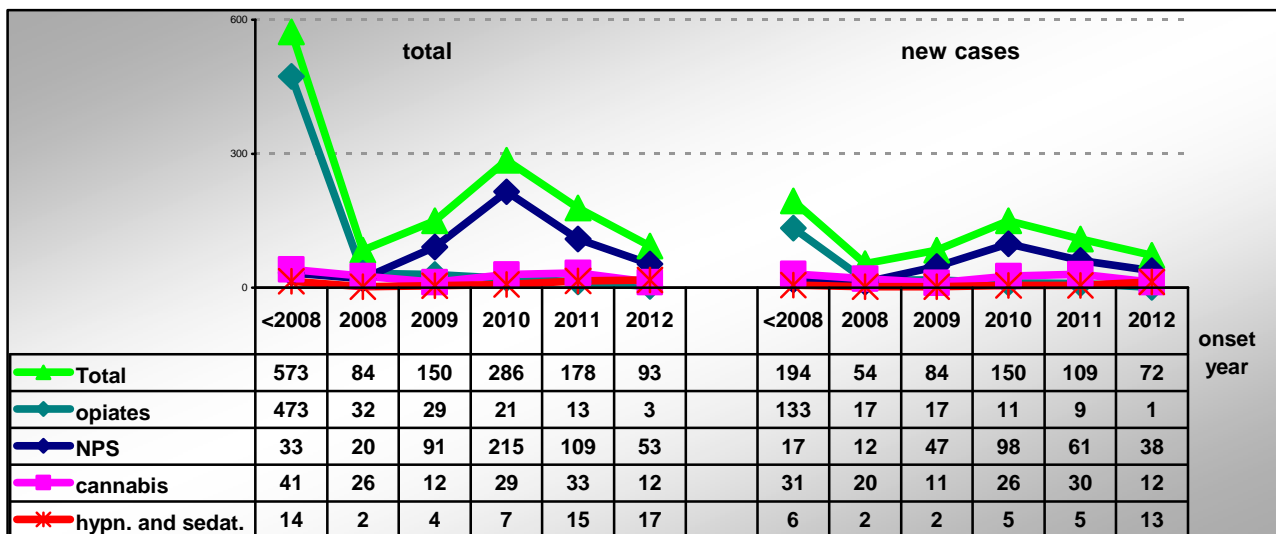
Source:NAA

The total number of cases and new cases, analyzed by the **onset year**<sup>52</sup> and main drug, are described as follows:

- total – after 2009-2010 when there was an increase in the use onset, the past 2 years present a decrease including for new cases;
- opiates – both for the total and for new cases, there is a decreasing trend starting with 2008;
- NPS – the onset in using these substances registered an increasing trend during 2008 – 2010, when it reached the peak, and decreased in 2011;
- cannabis – increase in the number of onset users during 2009-2011, with a decrease in 2012;
- hypnotics and sedatives – for the total number, there is an increasing trend since 2008, while for new cases 2012 presents a higher increase compared to the previous year.

<sup>52</sup> Valid N = 1364 beneficiaries

Chart no. 5-5: Allocation of admissions to treatment in 2012, by the onset age, main drug – total and new cases (no.)

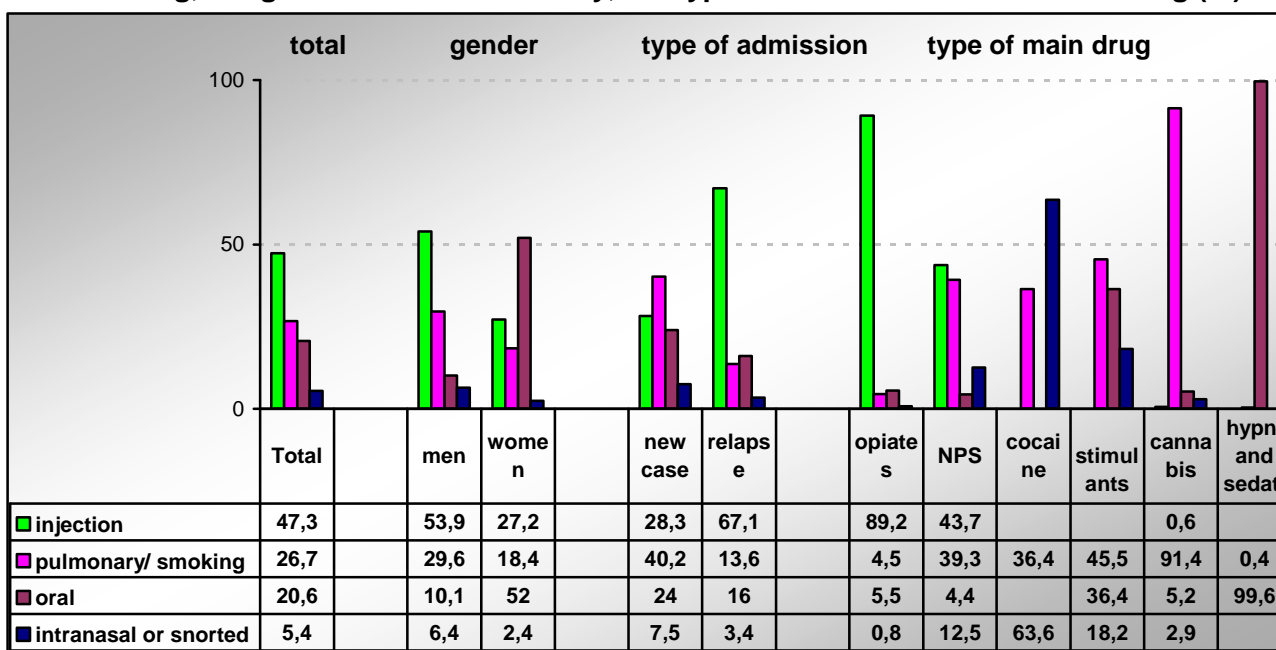


Source: NAA

With respect to the **period of use**, we notice the following:

- NPS – most users requested care after approximately two years of use (total: 377 cases out of 521, new cases: 197 out of 273);
- opiates – treatment is requested after a long period of use;
- cannabis – in approximately 50% of the cases, care is requested after a longer period of use (total numbers for onset use in 2009 or previously: 79 out of the 153 cases, new cases: 62 out of the 130);
- hypnotics and sedatives – a small period of use (maximum one year: total of 32 cases out of 59, new cases: 18 out of 33).

Chart no. 5-6: Percentage allocation of admissions to treatment in 2012, by administration of the main drug, the gender of the beneficiary, the type of admission and the main drug (%)



Source: NAA

Regarding the **administration of the main drug**<sup>53</sup>, the reference year is dominated by the injection use, this being more frequent for men, with relapse, most being opiate users, but also NPS. Comparing the beneficiaries that request care for the first time with those with relapse, new cases present a smaller proportion for injection use, situation also influenced by the type of main drug used: 36.5% - NPS and 20.6% - heroin (compared to 29.8% - NPS and 48% - heroin for relapses, see chart no. 5-3).

Regarding the proportion of beneficiaries that **ever used injection drugs**<sup>54</sup>, be it the drug the user asked care for or another secondary drug, we notice the following:

- 41.2% currently use injection drugs and 43.5% never injected drugs;
- current injection is more frequent among opiate and NPS users, individuals that received prior care for drug use (relapse), men (only circa ¼ - 25.7% of the women used injection drugs), beneficiaries that started using between 25-34 y.o. (and 46.5% of those with an onset before 15 y.o. stated to have used injection drugs in the past 30 days) and those with a longer period of use (for those with over 10 years of use, 58.2% are current injection drug users).

**Table no. 5-7: Allocation of admissions to treatment in 2012, for drug users that previously used injection drugs, by the type of admission, type of main drug, gender, administration, onset age and duration of use (no., %)**

		recent (less than 30 days)	injection than 30	injected, but not recently	never injected	Total
<b>total</b>	<b>No.</b>	580		216	612	1408
	<b>%</b>	41.2		15.3	43.5	100%
type of admission	new case	29.5		5.8	64.6	100%
	relapse	52.8		25.0	22.2	100%
main drug	opiates	61.1		32.9	6.1	100%
	NPS	47.5		5.0	47.5	100%
	hypnotics and sedatives	0.6		1.9	97.5	100%
	stimulants	25.0		12.5	62.5	100%
	cannabis	0.7		2.7	96.6	100%
gender	men	45.3		16.3	38.4	100%
	women	25.7		12.0	62.3	100%
onset age (years)	< 15 years	46.5		14.9	38.6	100%
	15-19 years	37.9		20.0	42.1	100%
	20-24 years	44.1		14.7	41.2	100%
	25-29 years	60.0		10.0	30.0	100%
	30-34 years	71.6		7.4	21.0	100%
	35 years and above	38.2		1.5	60.3	100%
duration of use (years)	< 1 year	54.6		2.1	86.1	100%
	1-5 years	42.0		4.9	53.0	100%
	5-10 years	50.7		22.5	26.8	100%
	> 10 years	58.2		34.2	7.5	100%

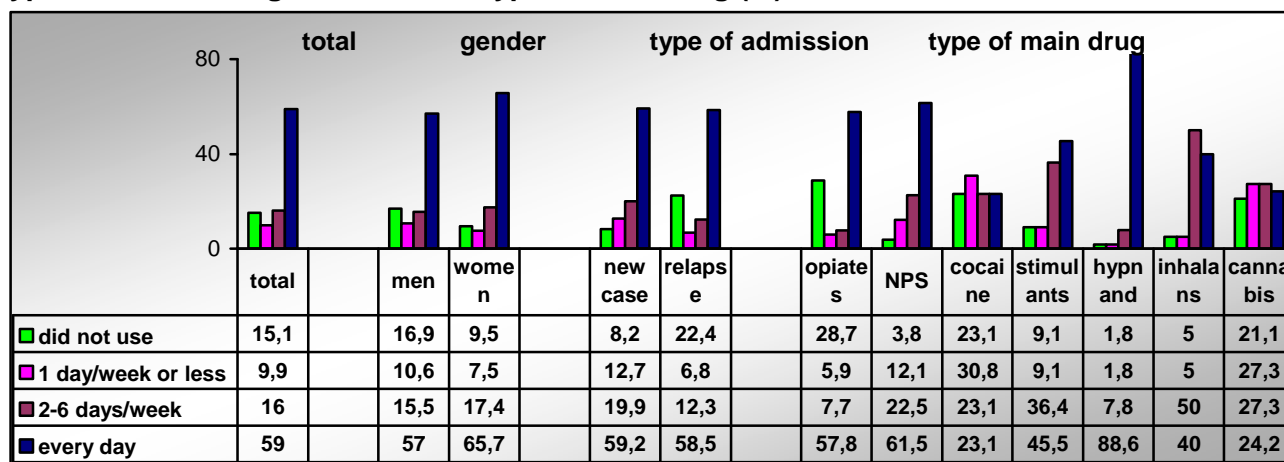
Source: NAA

<sup>53</sup> See ST. no. 15.1.1-17.1.2

<sup>54</sup> See ST. no. 25.1.1, 25.1.2, 26.1.1 and 26.1.2

By the **frequency of use for the main drug**<sup>55</sup>, out of the total of drug users admitted for treatment in 2012, 59% used daily, 16% 2-6 times a week and 9.9% at most once a week. By the gender of the user, one can notice a higher proportion for daily use (total – 57%, male 65.7%). By the type of drug, the most frequent used drugs are hypnotics and sedatives (88.6% of individuals admitted to treatment in 2012 declared a daily use), with high proportions as well for NPS and opiates (61.5% and 57.8% respectively) and even stimulants (45.5%), daily drugs used daily being cannabis (24.2%) and cocaine (23.1%).

**Chart no. 5-7: Percentage allocation of admissions to treatment in 2011 by frequency of use, type of admission, gender and the type of main drug (%)**



Source: NAA

### 5.3.1. SUBSTITUTION TREATMENT<sup>56</sup>

Out of the 2464 individuals receiving care in 2012 for illegal drug and NPS use, 41% were opiate users, out of which 495 patients were already on substitute treatment with methadone or other opiates (buprenorphine, suboxone, naltrexone).

**Table no. 5-8: Admission to treatment for illegal drug use (opiates) in 2011 and the allocation of users already receiving substitute treatment, by the type of treatment centre and date of admission to treatment (no. of people)**

		Type of centre						Total		total
		in-patient		out-patient		penitentiary		2012	prior to 2012	
		date of admission to treatment								
		2012	prior to 2012	2012	prior to 2012	2012	prior to 2012	2012	prior to 2012	
Admission to treatment	<b>Total</b>	1138	11	710	378	144	83	1992	472	2464
	<b>out of which opiates (main drug)</b>	155	2	524	220	66	44	745	266	1011
	out of which heroin	115	2	510	214	62	44	687	260	947
	methadone	17	0	13	5	4	0	34	5	39
	other opiates	23	0	1	1	0	0	24	1	25
Patient/beneficiary already on substitute treatment	<b>Total</b>	79	4	270	128	12	2	361	134	495
	out of which methadone	56	3	204	92	11	2	271	97	368
	other opiates*	12	0	25	24	1	0	37	24	61
	not stated	11	1	41	12	0	0	53	13	66

Note\* - other opiates: Buprenorphine, suboxone, naltrexone

Source: NAA

<sup>55</sup> See ST. no. 18.1.1 - 20.1.1

<sup>56</sup> This subchapter also includes the beneficiaries receiving care while imprisoned

Regarding the type of care provided, out of the total services provided in 2012:

- 1.2% were medicine-based rehab with opiate substitute, as in- or out-patients. 79 individuals benefited from these services (4.3% of the patients);
- 6.1% were treatments to maintain abstinence with opiate agonist/antagonist. 435 individuals benefited from these services (24.1% of the patients);
- other types of services provided are: assessment – 24.8%, psychological care – 21.7%, symptomatic rehabilitation – 13%, treatment of psychiatric co-morbidity - 9,8%, guidance to legal social services for providing care to minors, vocational – 5.5% and non-medicine based rehabilitation – 3.1%.

**Table no. 5-9: Allocation of care services for illegal drug and NPS use granted in 2012 (for all beneficiaries, irrespective of the year of admission), by the type of treatment centre and type of care granted, 2012 (no., %)**

Type of care granted		Type of centre			Total		
		in-patient	out-patient	penitentiary	No.	% services	% patients
assessment		1038	382	146	1566	24.8%	86.7%
medicine-based rehab for in-patients	with opiate substitute	64	0	6	70	1.1%	3,9%
	symptomatic	771	0	1	772	12.2%	42,7%
	not stated	76	0	0	76	1.2%	4,2%
medicine-based rehab for out-patients	with opiate substitute	3	6	0	9	0.1%	0,5%
	symptomatic	43	6	0	49	0.8%	2,7%
	not stated	6	3	0	9	0.1%	0,5%
non-medicine rehab		190	7	1	198	3.1%	11.0%
psychological care		917	355	96	1368	21.7%	75.7%
treatment of psychiatric co-morbidity		612	8	0	620	9.8%	34.3%
guidance to legal social services for caring for minors, vocational		225	121	1	347	5.5%	19.2%
long-term follow-up		191	273	128	592	9.4%	32.8%
treatment for maintaining abstinence	with methadone	55	308	7	370	5.9%	20,5%
	with naltrexone	7	18	1	26	0.4%	1,4%
	with suboxone	17	22	0	39	0.6%	2,2%
	not stated	3	5	0	8	0.1%	0,4%
Other*		33	115	39	187	3.0%	10.4%
Total no. of services provided		4249	1631	426	6306	100%	
Total no. of patients		1108	551	147	1806		

**Note:** \* - **other** – e.g.: counselling for family/friends/employer, inclusion in the Fred Goes Net Group/therapy community, social counselling, urine testing (control) and blood work, counselling for quitting smoking, information, ergotherapy, group therapy, preventing relapses, psychotherapy, sedative treatment etc.

Source: NAA

Out of the 443 individuals using opiates who received treatment for maintaining abstinence in 2012:

- most (87.1%) requested care in the reference year;
- more than half also received prior substitute treatment;
- more than 2/5 requested treatment from their own initiative, and 26.1% were referrals from medical services;
- most are men (this is influenced by the fact that more men use opiates compared to women);
- most (81.2%) are young people with ages between 20-34 years and approximate half started using at ages below 15 years (12.2%) or the “high school” age, 15-19 years (45.9%) and 25.4% between 20-24 years;
- more than half (55.3%) had been using opiates for at least 11 years;
- almost half used opiates daily (47.9%);
- half are unemployed/no occupation (49.9%) and only 29.6% have a job.

**Table no. 5-10: Allocation of individuals using opiates who received treatment to maintain their abstinence, by various characteristics, 2012 (%)**

		%
year of admission to treatment	2012	87.1
	prior to 2012	12.9
prior substitute treatment	yes	61.7
	no	38.3
main reference source	own initiative	44.4
	general practitioner/ primary care	26.1
	spec. services for drug users	3.0
	psychiatry/ emergency services	19.9
	court/ prosecutor's office/probation/arrest/penitentiaries	5.5
	family/ friends	1.1
gender	men	83.9
	women	16.1
age group (years)	15-19 years	1.1
	20-24 years	13.6
	25-29 years	29.7
	30-34 years	37.9
	35-39 years	11.1
	40 years and above	6.6
onset age group (years)	< 15 years	12.2
	15-19 years	45.9
	20-24 years	25.4
	25-29 years	9.5
	30-34 years	5.7
	35-39 years	0.8
	40 years and above	0.5
duration of use (years)	≤ 2 years	12.1
	3-5 years	14.8
	6-10 years	17.8
	≥ 11 years	55.3
frequency of use	every day	47.9
	less than 6 days a week	52.1
occupational status	employee	29.6
	pupil/student	2.8
	retired/stay-at-home/invalid	12.1
	unemployed/ no occupation	49.9
	worker without contract/other cases	5.6

**Note: the rest up to 100% consists in other cases/not stated**

Source:NAA

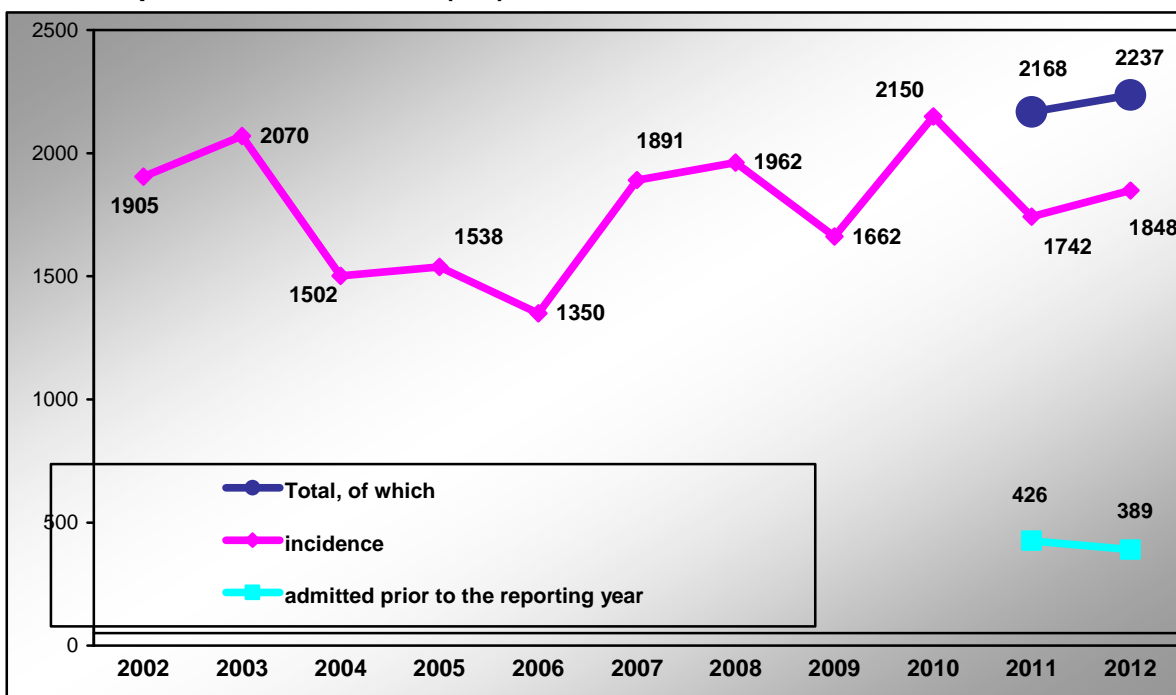
#### **5.4. TRENDS OF CLIENTS IN TREATMENT (TRENDS OF BENEFICIARIES OF TREATMENT SERVICES)**

According to previous statements, starting with 2011, in order to implement the new requirements of monitoring the indicator at a European level, the data regarding cases of continued treatment from previous years and those that continued/abandoned/ completed treatment during the reference year started to be collected.

Compared to the previous year, there is a 3.2% increase in the number of individuals receiving care in 2012 due to the 6.1% increase in the number of incidental cases (from 1742 to 1848). Cases who were admitted prior to the reporting year register an 8.7% decrease compared to 2011.

During 2002-2012, the indicator on admission to drug related treatment varied between 1350 cases in 2006 (first year of implementing the care system as per GD 860/2005<sup>57</sup>) and 2150 cases in 2010 (year prior to the NPS entry on the market). 2012 registered a value almost equal to the one at the beginning of the monitoring period, but the service range was diversified and the data gathering system was reconfigured.

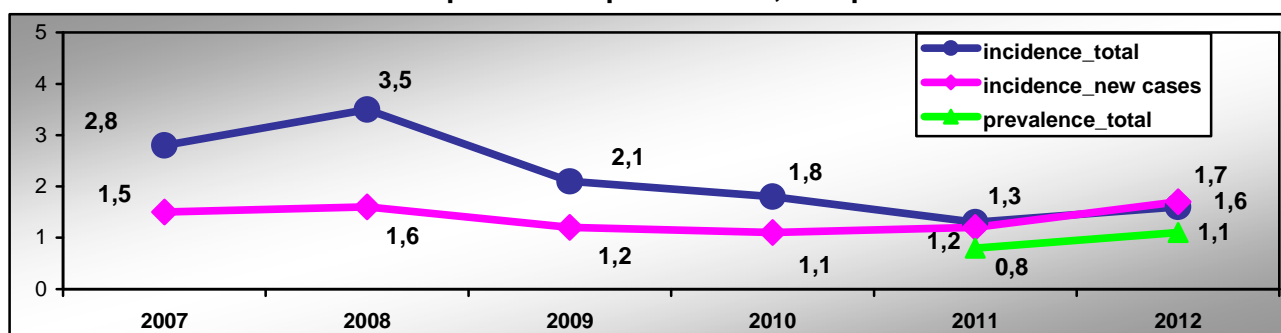
**Chart no. 5-8: Evolution of the number of individuals receiving illegal drug and NPS related treatment, compared data 2002-2012 (no.)**



Source: NAA

Given that the number of single beneficiaries is determined by including only the first admission in the reference year (irrespective if care was provided for in- or out-patients), in order to compare the manner of providing care<sup>58</sup> we relied on the report of new cases which, according to the data below, up to 2010 had a decreasing trend (from 1.6 to 1.1), and increasing in the past 2 years from 1.1 to 1.7. Compared to 2011, there is a increase in the in-patient/out-patient ratio for the total number of incident/prevalent cases.

**Chart no. 5-9: Evolution of the in-patient/out-patient ratio, compared data 2007 - 2012**



Source: NAA

<sup>57</sup> DECISION no. 860 dated 07/28/2005 for approving the Regulation of implementing the provisions for Law no. 143/2000 for preventing and fighting against traffic and illegal drug use, as amended and completed. (Issuer: The Government; Published in: The Official Gazette no. 749 dated the 08/17/2005)

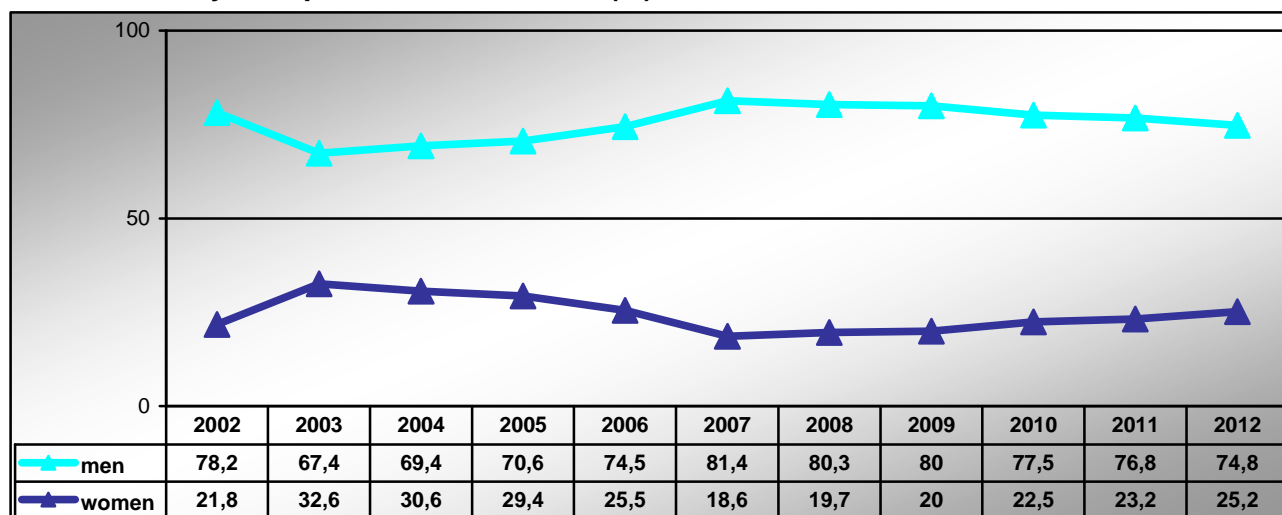
<sup>58</sup> See ST no. 4.1.1



This next analysis shall only be based on incident cases.

Compared to the previous years, we notice that although **men** beneficiaries are dominant, starting with 2007 one can see a slight decreasing trend of accessing treatment and, implicitly, an increase of the proportion of women, from 18.6% to 25.2%. Thus, the M/W ratio continues to be positive, but decreasing, from 4.4 in 2007 to 3 in 2012 (value close to the one for 2002 – 3.6)<sup>59</sup>.

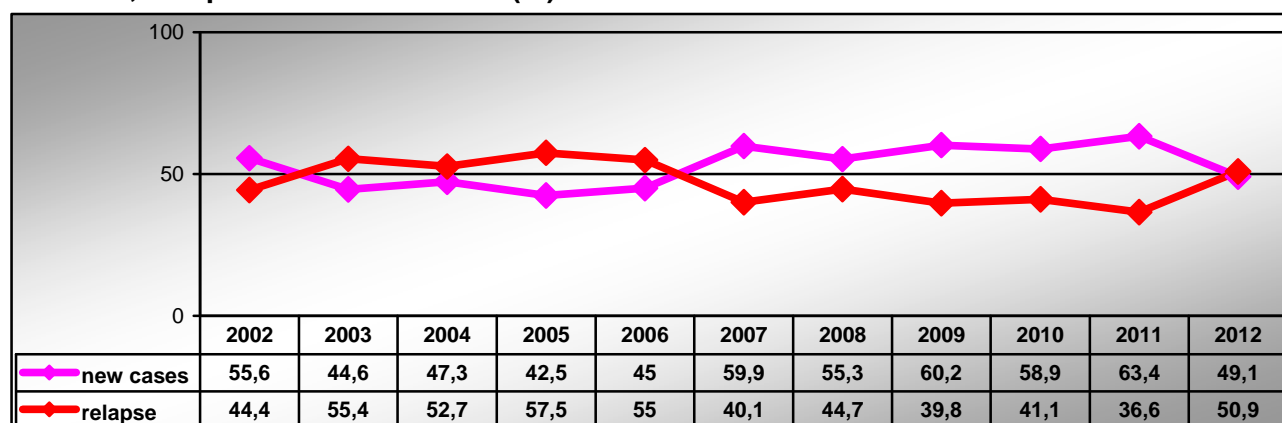
**Chart no. 5-10: Evolution of admissions to illegal drug and NPS related treatment, by the gender of the beneficiary, compared data 2002-2012 (%)**



Source: NAA

Moreover, if in 2002 the proportion of **new cases** was higher than relapses, during 2003-2006 there was a dominance in cases of beneficiaries with previous treatment; in the last period (2007-2011) the new cases of beneficiaries dominated again, while in the last year of the reference year the relapse proportion increased so that the two types of beneficiaries present similar values (49.1% vs. 50.9%) and the new cases/relapse ratio becomes sub-unitary as in 2003-2006.

**Chart no. 5-11: Evolution of admissions to illegal drug and NPS related treatment, by the type of admission, compared data 2002-2012 (%)**

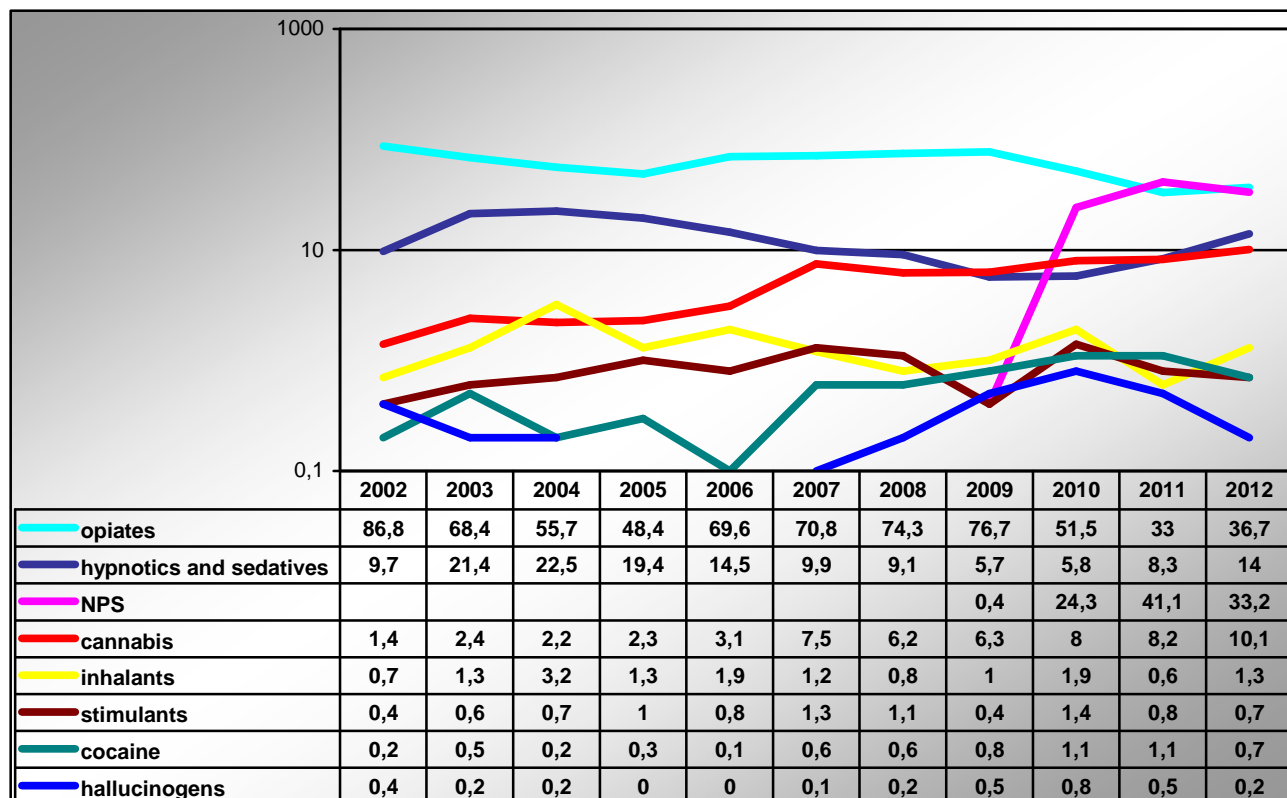


Source: NAA

<sup>59</sup> See ST no. 4.1.1

By the **main drug**<sup>60</sup>, during 2002-2010, with small variations, most drugs used were opiates, hypnotics and sedatives as well as cannabis. In 2012, the situation from 2010 comes back and NPS comes second in the total number of cases, after opiates. Moreover, the trend for hypnotics and sedatives and cannabis is still increasing, while for stimulants and hallucinogens it is decreasing. In case of opiates, compared to the previous year one can see a doubling in the number of beneficiaries requesting care for methadone use (2011 – 13 and in 2012 – 30).

**Chart no. 5-12: Evolution of admissions to illegal drug and NPS related treatment, by the type of main drug, compared data 2002-2012 (%)**



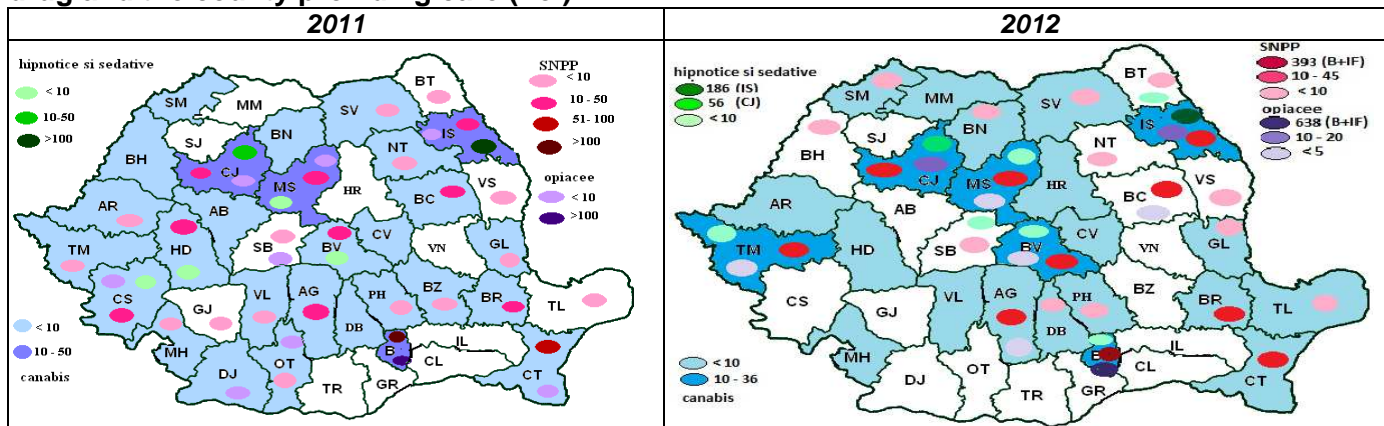
Source: NAA

The analysis of the data for 2011-2012 on **territorial distribution** of admissions to treatment, by the main drug, indicates the following:

- slight decreases for cannabis (from 28 counties to 24) and NPS (from 26 counties to 23); for opiates the number of counties is stable (9), while for hypnotics and sedatives we notice a slight increase in the number of counties (from 6 to 8 counties);
- the most spread is cannabis use, but the most problematic continues to be NPS, with far higher values compared to cannabis;
- the Bucharest-Ilfov area registers the highest use of opiates and NPS,
- the greatest number of requests for hypnotics and sedatives continues to be registered in Iasi and Cluj;
- there is an increase in the number of counties where treatment was requested for a larger number of types of drugs (in 2011 – Iasi, Cluj and Mures, while in 2012 also in Bucharest, Brasov and Timis);
- the areas with the highest risk (as number of registered cases) continues to be around large university centres or border counties.

<sup>60</sup> See ST no. 11.1.

**Map no. 5-3: Territorial distribution of admissions to treatment in 2011-2012 by the type of main drug and the county providing care (no.)**

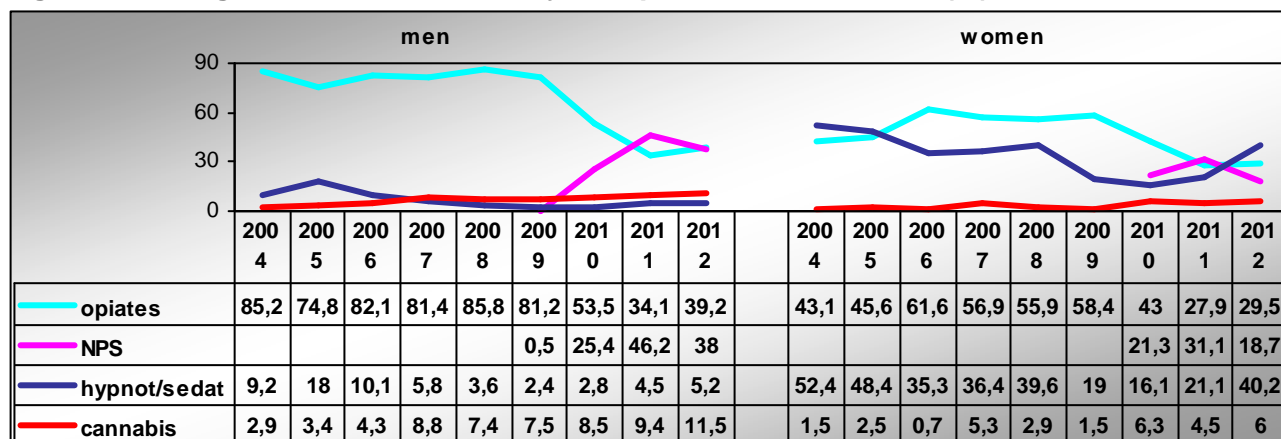


Source: NAA

By the **gender of the beneficiary** and on the **main drug**, we notice the following:

- for men beneficiaries – there is a come-back to the situation in 2010: opiates are first in the ranking, NPS – second, followed by cannabis and hypnotics and sedatives; although slow, there is an increasing trend for cannabis (2004-2.9%, 2012- 11.5%) and hypnotics and sedatives (2009-2.4%, 2012-5.2%);
- for women beneficiaries – the situation is again similar to the one in 2004: hypnotics and sedatives first in the ranking, followed by opiates.

**Chart no. 5-13: Evolution of admissions to illegal drug and NPS related treatment, by the main drug and on the gender of the beneficiary, compared data 2004-2012 (%)**



The rest up to 100% consists in: cocaine, stimulants, hallucinogens, inhalants and other substances

Source: NAA

Given the **age of the beneficiary upon admission to treatment**<sup>61</sup> and **use onset age**<sup>62</sup>, we notice the following for the reference period:

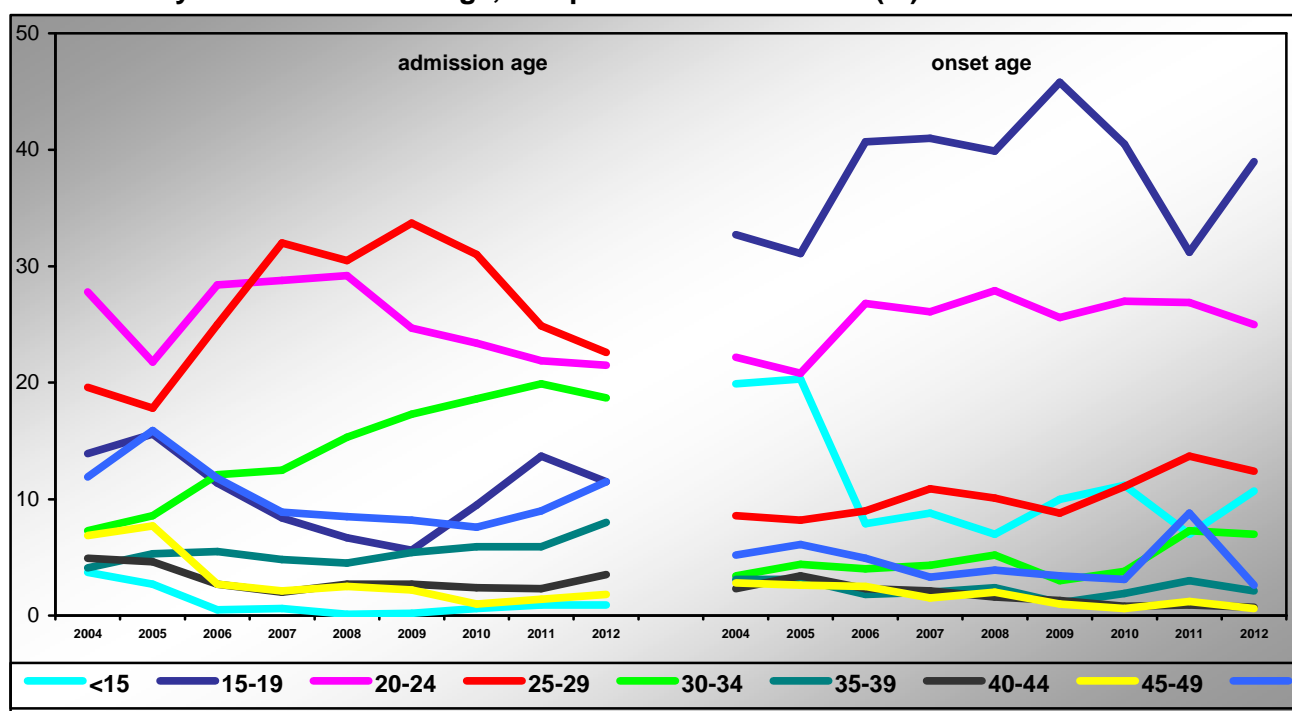
1. most beneficiaries started using in the interval 15-19 years and 20-24 years, while most individuals were 20-24 years old and respectively 25-29 years old upon admission; the situation confirms the hypothesis according to which the use period prior to requesting services (the gap between the use onset and admission to treatment) varies between 5-10 years: most of the users starting between 15-19 years are found later on under treatment between 20-29 years and, furthermore, most of those that starting using between 20-24 years influence later on the high proportion of admissions to treatment at ages between 25-34 years;

<sup>61</sup> See ST no. 14.1.1

<sup>62</sup> See ST no. 23.1.2

2. as a trend, the onset age shows that throughout the entire reference period the age groups with the highest values are 15-19 and 20-24 respectively and a come-back during 2011-2012 to the hierarchy, by age groups, registered in 2006-2008 (40.7% vs. 39% for 15-19 y.o., 26.8% vs. 25% for 20-24 y.o.), but with higher values for early onset (< 15 years) and the one between 25-39 years, suggesting a changing trend of the predominance of onset between 15-24 years, along with an increase in early onset and onset at older ages, respectively 25-39 years;
3. furthermore, as trend for age upon admission to treatment: starting with 2007, the highest value is registered for the 25-29 y. age group, followed by the 20-24 y.; compared to 2004, 2012 presents an increase in the proportion of beneficiaries in the groups of 30-34 y. and 35-39 y. and a decrease of those under 15 years of age.

**Chart no. 5-14: Evolution of admissions to illegal drug and NPS related treatment, by the age of the beneficiary and on the onset age, compared data 2004-2012 (%)**

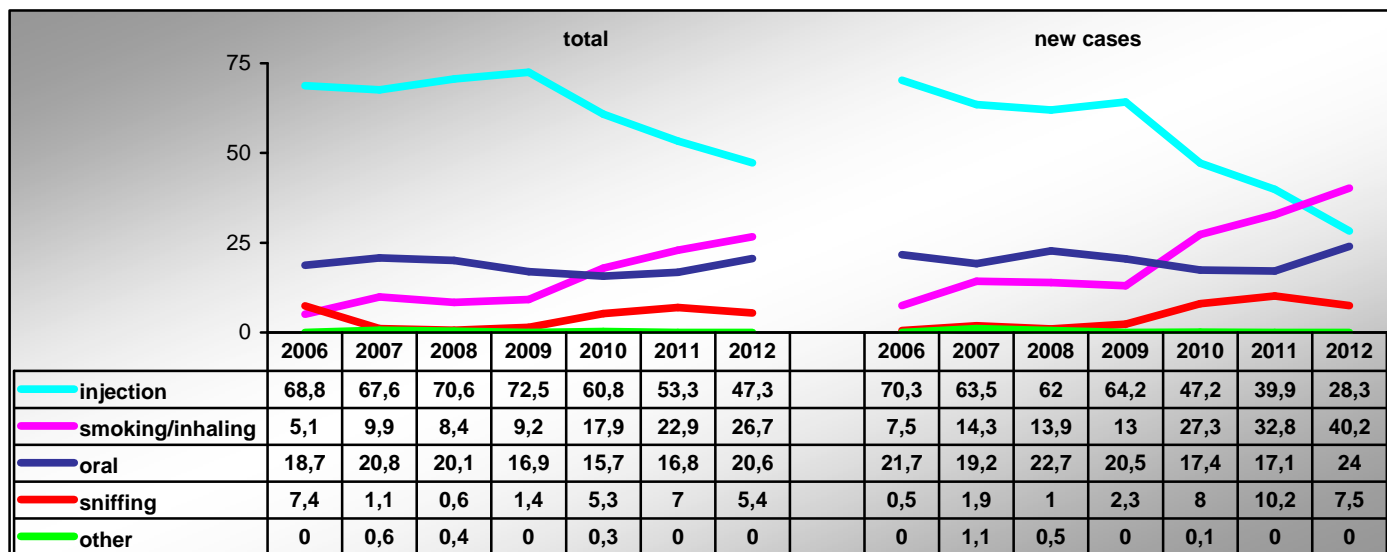


Source: NAA

Regarding the **administration of the main drug**<sup>63</sup>, injection is the most used method of administration, or the entire reference period, in correlation with the main drug used, opiates, and respectively NPS combined with opiates. The predominant administration of NPS is not injection and this is present in trend; in addition, starting with 2010, we notice a decrease in the injection administration and an increase for pulmonary and oral use.

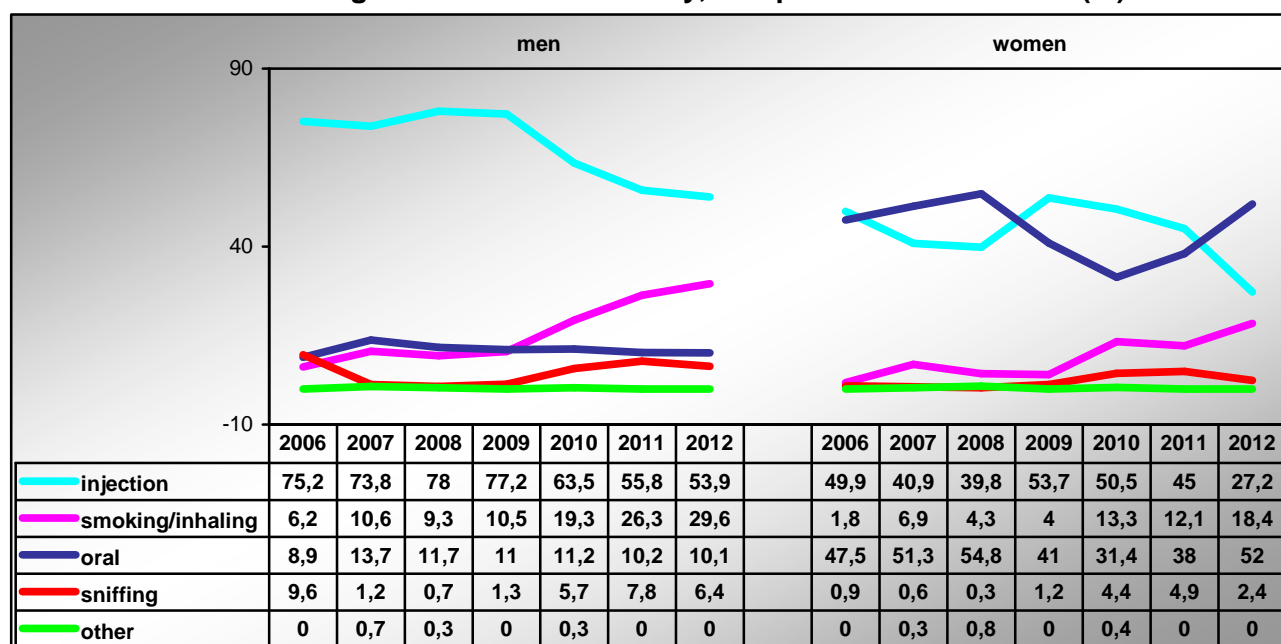
<sup>63</sup> See ST no. 17.1.1 and 17.1.2

**Chart no. 5-15: Evolution of admissions to illegal drug and NPS related treatment, by administration and on the type of admission, compared data 2006-2012 (%)**



Source:NAA

**Chart no. 5-16: Evolution of admissions to illegal drug and NPS related treatment, by administration and on the gender of the beneficiary, compared data 2006-2012 (%)**



Source:NAA

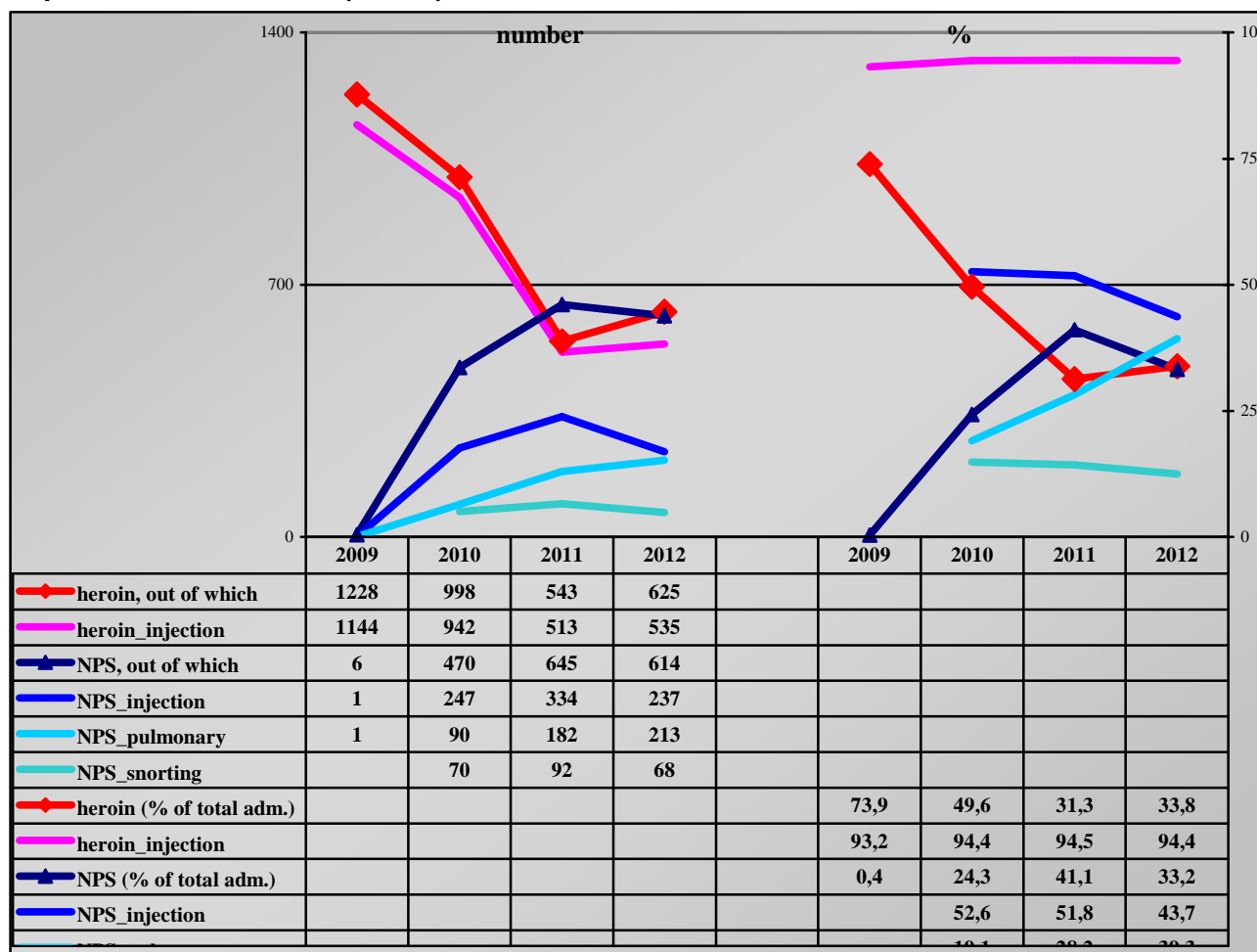
The evolution of admission to treatment by the administration of the main drug and the gender of the user<sup>64</sup> indicate the following:

- different ways of administration determined by use differences, by the type of main drug: more men beneficiaries are admitted to care for opiates, NPS and cannabis, while more women beneficiaries are admitted to care for hypnotics and sedatives and opiates (see chart no. 5.4);
- for men users – although injection is the most frequent way of use declared to care providers, we notice a decreasing trend in the last part of the reference period (from 78% to 53.9%) and an increase in those declaring to use pulmonary or sniffing as main way of using drugs (from 9.3% to 29.6%, from 0.7% to 6.4% respectively);

<sup>64</sup> See ST no. 15.1.1 and 16.1.1

- for women users – the values tend to come back to the trend registered at the beginning of the reference period: a larger proportion for oral administration compared to injection (in 2007: oral 51.3% and injection 40.9%, while in 2012: oral – 52% and injection 27.2%), with the change that the highest difference between the 2 ways of use was caused by the increase in 2009 of the pulmonary use: in 2009 – 4%, while in 2012 – 18.4% (situation caused, in turn, by the increase in cannabis use: 2009 – 1.5% vs. 2012 – 6%, see chart 5.13).

**Chart no. 5-17: Evolution of admissions to heroin and NPS related treatment, by administration, compared data 2009-2012 (no., %)**

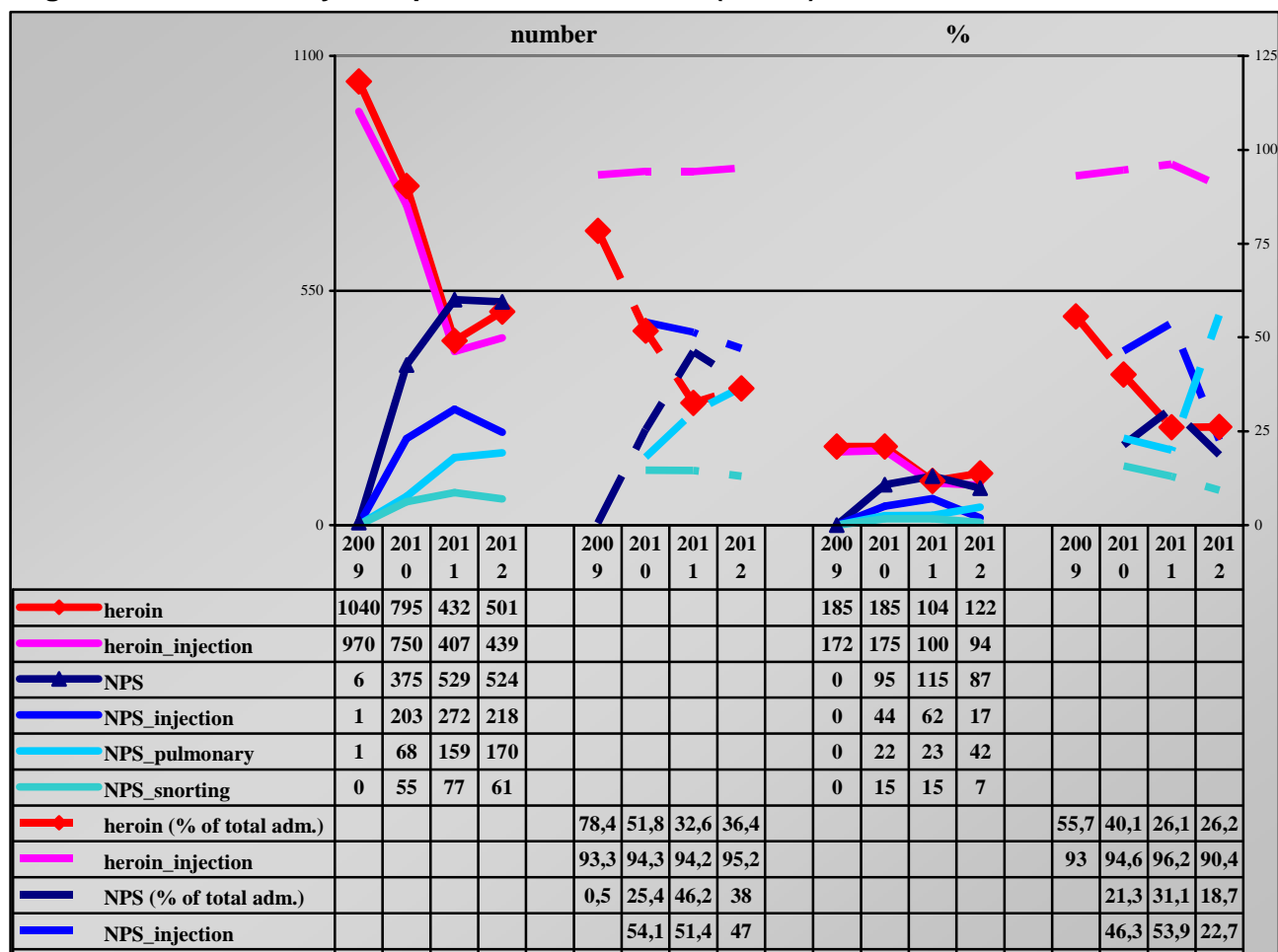


Source: NAA

By analyzing the admissions to treatment for injection heroin and NPS use, by the three specific ways of administration, we notice the following:

- with respect to heroin related treatment both in number and in proportion from the total of admissions, this decreased to less than half during 2009-2011 (from 1228 to 543, respectively from 73.9% to 31.3%), with an increase in the last year (625, respectively 33.8%); those for NPS use have the same mirror trend: very high increase during 2009-2011 (from 6 cases to 645, respectively from 0.4% to 41.1%), and an increase in the last year (614, respectively 33.2%), but with different values: the difference compared to last year for heroin is 82 cases and 2.5%, while for NPS it is 31 cases and 7.9%;
- regarding admission, we notice that while for heroin injection continues to be dominant and at high values (93-94%), for NPS: administration continues to be most often via injection, but the proportion continues to decrease (2010 – 52.6%, 2011 – 51.8% and 2012 – 43.7%), along with a continuous increase in the pulmonary administration (2010 – 19.1%, 2011 – 28.2% and 2012 – 39.3%) and also, although at smaller values, sniffing continues to decrease (2010 – 14.9%, 2011 – 14.3% and 2012 – 12.5%).

**Chart no. 5-18: Evolution of admissions to heroin and NPS related treatment, by administration and gender of beneficiary, compared data 2009-2012 (no., %)**



Source: NAA

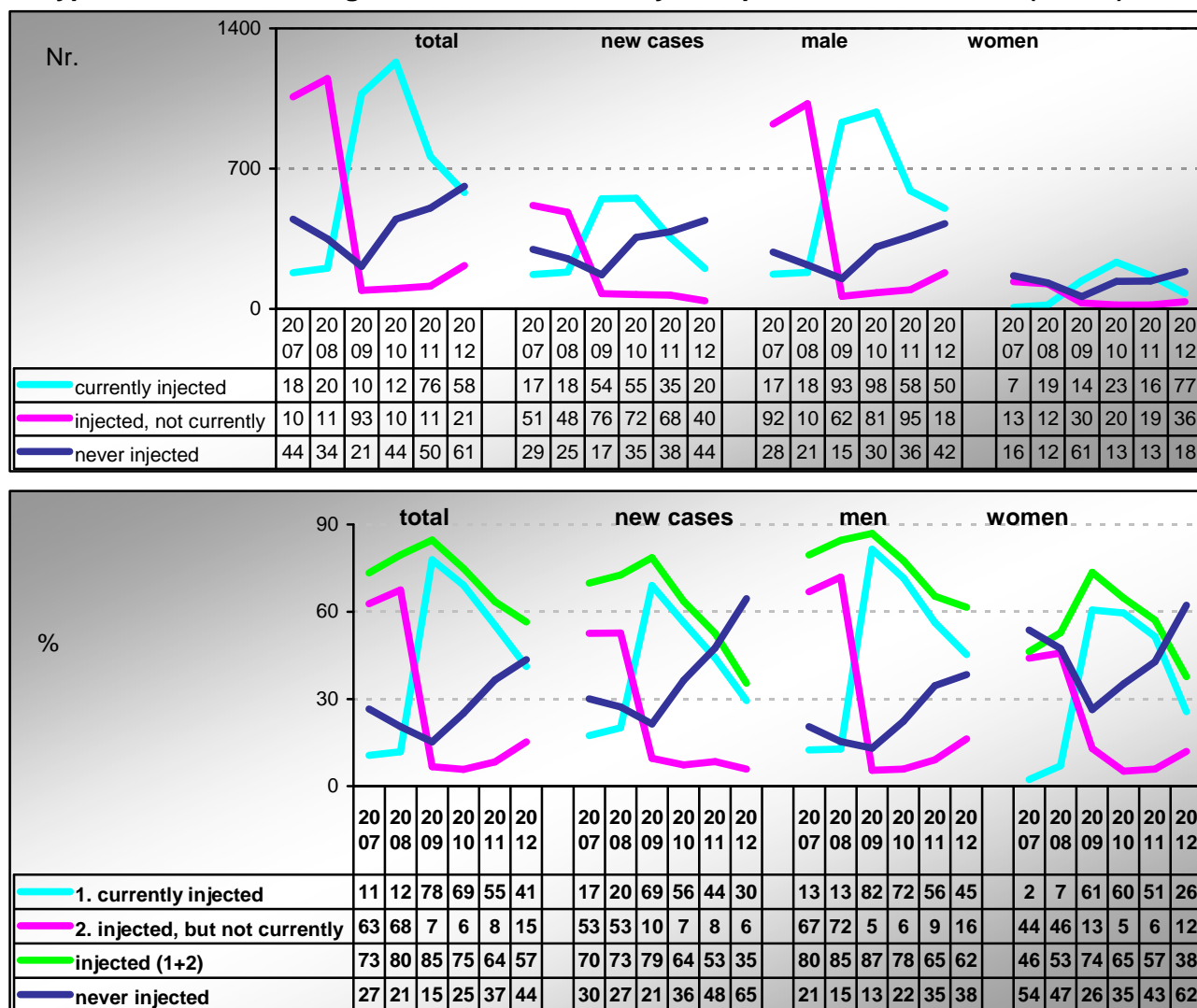
By analyzing the admissions to treatment for injection heroin and NPS use, by the three specific ways of administration but also on the gender of the beneficiary, we notice the following:

- for heroin – both men and women register the same trend (decrease in number and proportion between 2009 and 2011 and increase in 2012, as well as injection administration over 90%), but at lower values for women;
- for NPS – as for heroin, the number and proportion of total admissions present the same pattern, but at lower values for women; regarding the administration for women beneficiaries, compared to men, there are higher decreases for injection use: (from 62 cases to 17 vs. from 272 to 218, respectively from 53.9% to 22.7% vs. from 51.4% to 47%) and lower for sniffing (women – 36% vs. men – 6.5%) and far greater increase in pulmonary use (women – half of the cases and 3.7% vs. men – 16 cases and 1.5%).

Regarding **injection use**<sup>65</sup>, irrespective of the drug used, during 2007 – 2012 this method is more frequent with men and relapses. The graphic representation of the evolution of illegal drug and NPS related treatment, by injection use, type of admission and gender of the beneficiary shows the same pattern for injection use for all types of beneficiaries. In the middle of the period, in 2009, we notice a very high increase in the current injection use, peaking the next year, while starting 2011 the pattern decreases, slower in case of women and faster in case of men and new cases.

<sup>65</sup> See ST. no. 25.1.1 and 25.1.2

**Chart no. 5-19: Evolution of admissions to illegal drug and NPS related treatment, by injection use, type of admission and gender of the beneficiary, compared data 2007-2012 (no., %)**



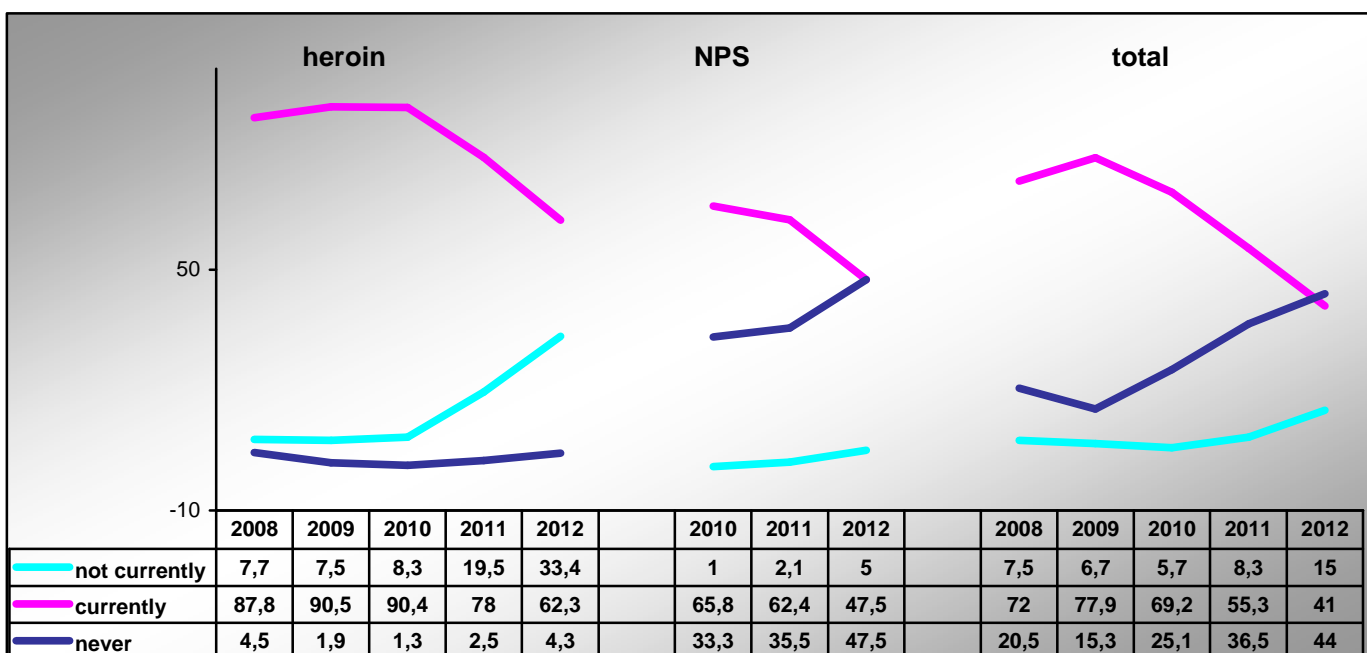
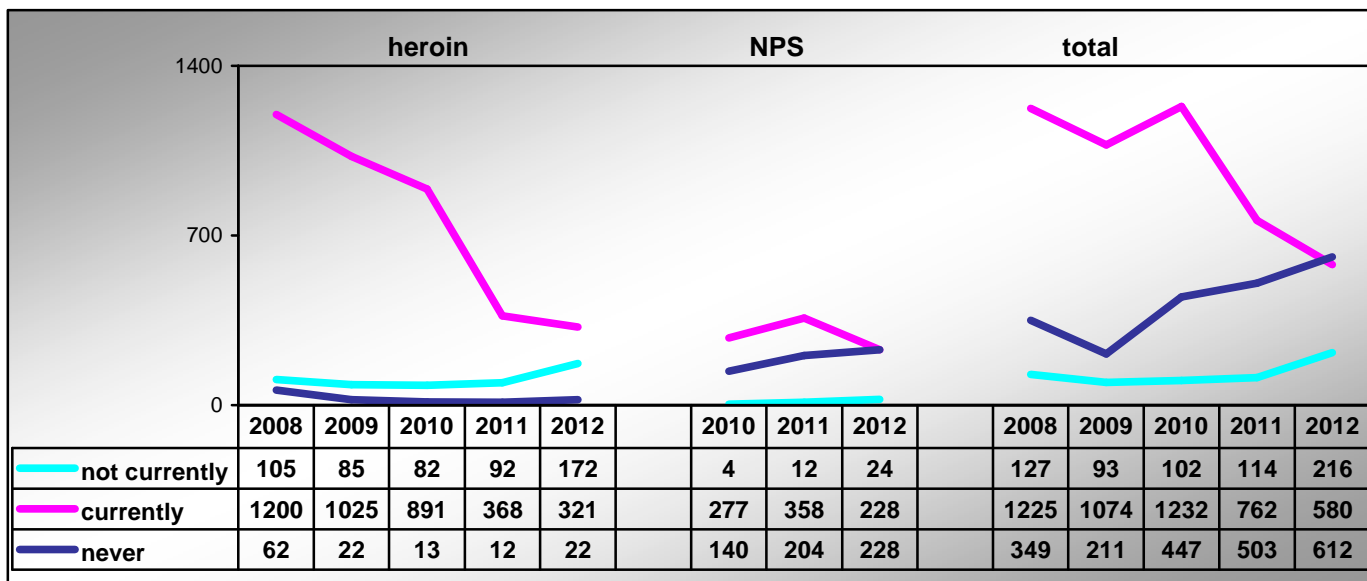
Source: NAA

The analysis of the evolution of admissions to treatment during 2008-2012, for heroin and NPS use<sup>66</sup>, by injection use, indicates an increase in 2011 in the number of beneficiaries stating to have used injection NPS in the last 30 days (from 277 to 358), but a slight decrease in their proportion from individuals requesting care for NPS use (from 65.8% to 62.4%). Drug use in the last 30 days prior to admission to treatment (current) is characteristic for heroin and NPS users for 2009-2011 and over all, both in number and proportion, with a constant trend in NPS users: the most often current injection, but the proportion of those that never used injections is higher than the one of individuals with prior injection use, but not current.

<sup>66</sup> See ST. no. 26.1.1



**Chart no. 5-20: Evolution of admissions to heroin and NPS related treatment, by injection use, compared data 2008-2012 (no., %)**

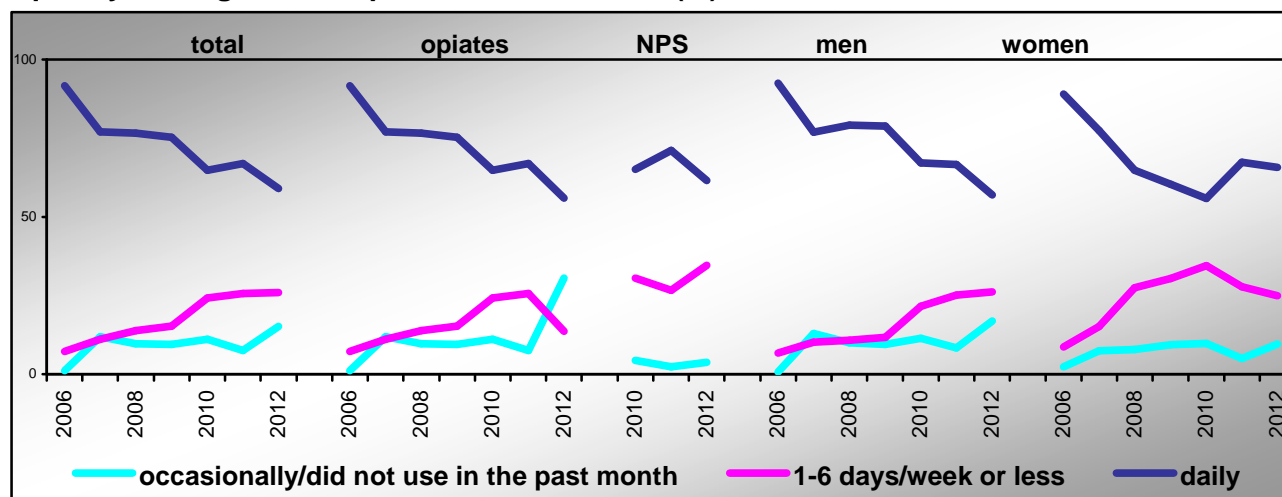


Source: NAA

The evolution of admissions to treatment during 2006-2012, by the frequency of the use<sup>67</sup>, indicates a daily use of drugs, occasional use having the lowest weight. The data on the frequency of use are correlated with the ones presented above on the main drug and pertaining administration: the decrease in the proportion of care requests for injection heroin and the increase in the proportion for NPS smoking (chart no. 5-17). The differences between women and men, during 2006-2011, at values below 8%, indicate that the general tendency is dominated by men's change in drug use. Thus, 2011-2012 shows a 9.6% decrease of women declaring to use drugs 1-6 days/week, while men with the same frequency in use increased by 4.6%.

<sup>67</sup> See ST. no. 20.1.1

**Chart no. 5-21: Evolution of admissions to illegal drug and NPS related treatment, by the frequency of drug use, compared data 2006-2012 (%)**



Source: NAA

**Table no. 5-11: Admissions to illegal drug and NPS related treatment, by the frequency of drug use and on the gender of the beneficiary, compared data 2006-2012 (%)**

		2006	2007	2008	2009	2010	2011	2012
total	occasionally/ did not use in the past month	1.1	11.9	9.6	9.5	11.0	7.5	15.1
	1-6 days/week or less	7.2	11.1	13.8	15.2	24.2	25.6	25.9
	daily	91.7	77.1	76.6	75.3	64.7	66.9	59.0
opiates	occasionally/ did not use in the past month	0.2	10.9	7.3	7.3	8.1	13.6	30.5
	1-6 days/week or less	1.1	5.2	3.5	7.9	15.0	16.2	13.6
	daily	98.7	84.0	89.2	84.8	76.8	70.2	55.9
NPS	occasionally/ did not use in the past month					4.4	2.3	3.8
	1-6 days/week or less					30.5	26.6	34.6
	daily					65.1	71.1	61.5
men	occasionally/ did not use in the past month	0.7	12.9	9.9	9.4	11.4	8.3	16.9
	1-6 days/week or less	6.7	10.2	10.8	11.7	21.5	25.1	26.1
	daily	92.5	77.0	79.2	78.9	67.1	66.6	57.0
woman	occasionally/ did not use in the past month	2.3	7.4	7.8	9.3	9.7	5.0	9.5
	1-6 days/week or less	8.6	15.1	27.4	30.3	34.5	27.7	24.9
	daily	89.0	77.5	64.8	60.3	55.8	67.3	65.7

Source: NAA

During 2009 – 2011, there was a decrease in the number of individuals requesting care for opiate use (from 1302 in 2009 to 648 in 2011), also explaining to a certain extent the decrease in 2011 in the number of previous beneficiaries of substitute treatment. The increase in 2012 of the number of individuals requesting care (in-patients or out-patients) for opiate use also led to an increase in case for individuals receiving prior substitute treatment (including while imprisoned).

**Table no. 5- 12: Evolution of admissions to illegal drug (opiates) related treatment and of the number of users with prior substitute treatment, by the year of granting care and on the type of care, compared analysis 2009 – 2012 (no. of individuals admitted to treatment in the reference year)**

		Type of centre												Total			
		in-patient				out-patient				penitentiary							
Year of admission and of granting care		2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012
Admission to treatment	Total	1126	1389	984	1138	536	761	758	710	27	13	111	144	1689	2163	1853	1992
	out of which opiates (main drug)	825	578	87	155	450	529	487	524	27	11	74	66	1302	1118	648	745
	out of which heroin	784	541	60	115	444	525	485	510	27	11	72	62	1255	1077	617	687
	methadone	25	20	12	17	3	1	1	13	0	0	1	4	28	21	14	34
	other opiates	16	17	15	23	3	3	1	1	0	0	1	0	19	20	17	24
Out of which with prior substitute treatment	Total	80	234	37	79	82	116	221	270	6	9	5	12	168	359	263	361
	out of which methadone	53	177	22	56	53	103	166	204	6	9	4	11	112	289	192	271
	other opiates*	22	17	5	12	9	10	19	25	0	0	0	1	31	27	24	37
	not stated	5	40	10	11	20	3	36	41	0	0	1	0	25	43	47	53

Note: other opiates\* (buprenorphine, suboxone, naltrexone)

Source: NAA

Regarding **provided care**, we notice that the total number of services provided has increased compared to previous years (6306 in 2012 compared to 4756-2009, 6150-2010 and 5988 in 2011). The changes in use mentioned by care service beneficiaries led to changes in the type of services provided:

- assessment services – although their number increased compared to the previous year, there is a decrease in the proportion of beneficiaries (from 89.5% to 86.7%) and a decrease in the proportion from the total of services provided (from 33.8% - 2009 to 24.8% in 2012);
- rehabilitation – throughout the entire reference period, the number and proportion of those receiving medicine-based rehab as out-patients has increased (2009 – 12, respectively 0.7% vs. 67 respectively 3.7%), but there is a decrease in medicine-based rehab for in-patients both as proportion of beneficiaries (from 59.9% to 50.8%), and as services (from 21.3% to 14.5%), as well as a decrease in the number of non-medicine based rehabilitation services (from 678-2009 to 198-2012, as proportion of beneficiaries from 34.1% to 11% and as proportion of services from 11% to 3.1%);
- treatment for maintaining abstinence – decrease both in the number of beneficiaries (from 601-2010 to 443 - 2012), and in proportion of beneficiaries receiving this type of service (28.7 – 2011 to 24.5% in 2012, while for the ones with opiate antagonist from 5.7% in 2009 to 1.4% in 2012) or as proportion from the total services (from 9.7% in 2010 to 6.9% in 2012)
- psychological care, treatment of psychiatric co-morbidity, guidance to social/legal services of minor care/vocational and long-term follow-up – we see increased values for all 3 indicators (number of services, proportion of treated beneficiaries benefiting from the service and the proportion of the respective type of services from the total services).

**Table no. 5- 13: Evolution of admissions to illegal drug related treatment, by the care provided, compared analysis 2009 – 2012 (no. of individuals admitted to treatment in the reference year)**

Type of care granted		No.				% patients				% services			
		Year of admission to treatment											
		2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012
assessment		1607	1893	1561	1566	95.1	87.5	89.5	86.7	33.8	30.8	26.1	24.8
medicine-based rehab for in-patients	with opiate substitute	76	89	80	70	4.5	4.2	4.6	3.9	1.6	1.5	1.3	1,1
	symptomatic	932	1103	812	772	55.2	50.8	46.6	42.7	19.6	17.9	13.6	12,2
	not stated	4	10	5	76	0.2	0.5	0.3	4.2	0.1	0.2	0.1	1,2
medicine-based rehab for out-patients	with opiate substitute	10	5	2	9	0.6	0.2	0.1	0.5	0.2	0.1	0	0,1
	symptomatic	2	10	26	49	0.1	0.6	1.5	2.7	0.0	0.2	0.4	0,8
	not stated	0	11	6	9	0.0	0.5	0.3	0.5	0	0.2	0.1	0,1
non-medicine rehab		0	678	595	198	0.0	31.3	34.1	11.0	0	11.0	9.9	3.1
psychological care		834	949	1258	1368	49.4	43.9	72.1	75.7	17.5	15.4	21.0	21.7
treatment of psychiatric co-morbidity		286	167	214	620	16.9	7.7	12.3	34.3	6.0	2.7	3.6	9.8
guidance to legal social services for caring for minors, vocational		243	432	304	347	14.4	20.0	17.4	19.2	5.1	7.0	5.1	5.5
long-term follow-up		326	172	496	592	19.3	8.0	28.4	32.8	6.9	2.8	8.3	9.4
treatment for maintaining abstinence	with opiate antagonist	323	555	471	409	19.1	25.7	27.0	22.7	6.8	9.0	7.9	6,4
	with opiate antagonist	97	44	29	26	5.7	2.0	1.7	1.4	2.0	0.7	0.5	0,4
	not stated	2	2	0	8	0.1	0.1	0	0.4	0	0	0	0,1
other		14	30	129	187	0.8	1.4	7.4	10.4	0.3	0.5	2.2	3.0
Total no. of services provided		4756	6150	5988	6306					100	100	100	100

Source: NAA

The changes in use presented by beneficiaries of care services led to changes both in the type of services provided and in the social and demographic characteristics of the beneficiaries receiving treatment in 2012 for maintaining abstinence with opiate agonist/antagonist:

- a very high increase in the proportion of beneficiaries with prior substitute treatment (2012 – 61.7% compared to maximum 43.6% during 2009-2011);
- frequency of use: daily use is on a decreasing trend so that, although during 2009-2011 it had the highest value, in 2012 it has the smallest proportion;
- one cannot identify a clear trend, but for the entire reference period the highest proportions are registered for own initiative and medical services (psychiatry/emergency services/other hospital wards or primary care centres);
- for the entire reference period, most beneficiaries are men, with an increasing trend of 30 y.o. beneficiaries and age groups with the highest frequency for onset are 15-19 years and 20-24 years (the latter being the only one with a stable trend throughout the entire period);
- moreover, for the entire period, the highest value is registered for the proportion of unemployed/no occupation, while in 2012 employees come second, followed by the economically inactive (retired/stay-at-home/invalid), the last ranking being pupils/students.

**Table no. 5-14: Evolution of opiate users who received treatment for maintaining the abstinence with opiate agonist/antagonist, by other characteristics, 2009-2012 (compared to the incidence: individuals receiving care during the reference year, including beneficiaries receiving care while imprisoned) - %**

		treatment for maintaining abstinence with opiate agonist/antagonist			
		2009	2010	2011	2012
prior subst. treatment	yes	29.4	43.6	17.4	61.7
	no	68.4	55.1	74.2	38.3
frequency of use	every day	61.9	59.1	52.2	47.9
	less than 6 days a week	27.1	27.2	29	52.1
main reference source	own initiative	44.3	53.1	32.9	44.4
	general practitioner/ primary care	12.6	19.8	11.5	26.1
	spec. services for drug users	7.6	1.3	0.7	3.0
	psychiatry/ emergency services/other hospital wards	5.7	11.8	32.7	19.9
	court/ prosecutor's office/probation/arrest/penitentiaries/legal medicine	5.2	3.8/	10.2	5.5
	family/ friends	4.8	8.7	8.0	1.1
gender	Men	84.5	80.5	71.2	83.9
	Women	15.5	17.0	28.8	16.1
age group (years)	15-24 years	29.8	19.6	34.5	14.7
	25-29 years	40.7	40.3	23.7	29.7
	30 years and above	29	39	41.7	55.6
onset age group (years)	< 15 years	11.0	12.1	8.5	12.2
	15-19 years	45.0	47.9	32.1	45.9
	20-24 years	26.0	26.4	26.1	25.4
	25-29 years	5.2	9.4	17.4	9.5
	30 years and above	2.6	4.1	15.7	7
occupational status	employee	27.4	25.5	12.2	29.6
	pupil/student	3.6	3.8	13.7	2.8
	retired/stay-at-home/invalid	1.2	0.2	28.4	12.1
	unemployed/ no occupation	46.2	61.6	33.9	49.9
	worker without contract/other cases	8.6	7.3	8.4	5.6

Note: the rest up to 100% consists in other cases/not stated

Source: NAA

### Profile of individuals admitted to drug use/addiction related treatment in 2012<sup>68</sup>

**Heroin user profile** – there are no changes in profile for the reference period. It had the following characteristics: male, aged between 30 and 39 years, low education level, requesting care most often from own initiative, most have a stable home and live with their parents or family and in general does not have income (unemployed); he started using between 15-19 years, with a long period of use (at least 6 years) and has requested treatment before for psychoactive substances, used injection heroin most often daily (most injected in the last 30 days prior to admission to treatment) and, most frequent, only uses heroin (no poly drug use or secondary drugs).

**NPS user profile** (new psychoactive substances traded as “ethnobotanicals”): male, under 40 years of age, low level of education, most request care by referral from emergency care, most live with their parents/family, in stable homes, most do not have an income or are pupils/students; approximately one out of three started using before 19, a little over half are new cases, have been using for more than 2 years, use NPS most by injection but also pulmonary (smoking/inhaling) or by

<sup>68</sup> For the other types of drugs the number of cases is too small to create a profile – in 2012: volatile inhalants – 1.3%, stimulants – 0.7%, cocaine – 0.7% and hallucinogens – 0.2%

sniffing, most often daily and more than half either use multiple drugs or other secondary drugs (most often: alcohol, opiates or cannabis)<sup>69</sup>.

**Cannabis user profile** – *there are no changes in profile for the reference period*: male, age between 20 and 24 years, average level of education, most request care by referral from the probation or emergency services or at the request of the family/friends, most have a stable home and live with their family and are either persons without income, or pupils/students. Most are new cases, they started using before 20 years of age and request care after a use period of 2-5 years; the drug is administered pulmonary, most did not use previously injection drugs, do not use multiple drugs and do not use other secondary drugs.

**Hypnotics and sedatives user profile**: female, over 40, most have an average level of education and are economically inactive (stay-at-home or retired) or do not have income, they live with their partner and children or just with their partner in stable homes and enter into care mostly by referral from the general practitioner or psychiatry services, but also due to own initiative; she is at the first admission to treatment for drug use and she started using over 35 years of age; she has been using for maximum 2 years, daily, oral and most never used injection drugs, they do not use multiple drugs and do not use other secondary drugs<sup>70</sup>.

## CONCLUSIONS

1. in 2012, **3788** individuals received care for use of psychoactive substances. Compared to the previous year, there is a 5.6% increase in treated beneficiaries due to **an increase in incident cases** (7.5% for illegal drugs and NPS and 9.4% for alcohol and tobacco). By the type of care, illegal drugs and NPS use register: a decrease in number of out-patients and an increase in the number of imprisoned patients and of incidence in-patients.
2. **1848** in-patients and out-patients requested care for illegal drugs and NP, most admissions being for in-patients and relapses. Compared to the previous year, there is a 3.2% increase in the number of individuals receiving care in 2012 due to the 6.1% increase in the number of incidental cases (the new cases/relapse ratio becomes sub-unitary again, similar to 2003-2006). Cases who were admitted prior to the reporting year register an 8.7% decrease compared to 2011.
3. main types of drugs for which care was requested are **heroin, NPS, hypnotics and sedatives and cannabis**, while circa a third of the beneficiaries also declared poly drug use and/or use of another secondary drug (the most used in poly drug use and/or other secondary drug being **NPS**); if in 2011, for the first time in 10 years, the proportion of cases admitted for opiate related treatment registered the second highest value from the total number of cases, NPS being the main drug for which users requested care, in 2012 the situation returns to the level of 2010 and NPS has the second ranking from the total number of cases, following opiates, but preserving an increasing trend for hypnotics and sedatives and for cannabis and decreasing for stimulants and hallucinogens.
4. as territorial distribution: the most expanded is the use of **cannabis**, the most problematic (in number of cases/number of counties) continues to be **NPS**; the **Bucharest-Ilfov** area registers the highest number of opiates and NPS use, while most requests for hypnotics and sedatives continue to come from **Iasi and Cluj**; the number of counties with **poly drug use** related treatment continues to increase, while the areas with the highest risk continue to the **large university centres or border areas**.
5. although most of the population in care services are **men**, starting with 2007 we notice a slight increasing trend in the women population;

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<sup>69</sup> compared to the profile of beneficiaries receiving care in 2010, we notice an increase in the use period prior to requesting treatment (in 2010 – most declared to have been using maximum for 2 years)

<sup>70</sup> compared to the profile of beneficiaries receiving care in 2010 and 2011, we notice a decrease in the period of use prior to requesting treatment.

6. compared to the age when care was requested and to the onset age, the figures continue to support the hypothesis according to which the gap between the onset use and request of care varies between **5-10 years**; as a trend, for the onset age: age groups with highest values continue to be **15-19 years**, respectively **20-24 years** and there is a changing trend in the predominance of the use onset between 15-24 years, **with an increase in the early onset and older age onset** (25-39 years);
7. although injection has been since 2006 the most used method of administration, starting with 2010 we notice a decrease in injection drug use and an **increase in pulmonary and oral use**;
8. regarding the care provided, we notice changes in use and that the **total number of services provided is increasing** compared to previous years: there is an increase in the number of assessment, the number and proportion of those receiving medicine-based rehabilitation as out-patients, psychological care, treatment of psychiatric co-morbidity, guidance to social/legal services of caring for minors/ vocational and long-term follow-up (decreases are seen for: the proportion of beneficiaries receiving medicine-based rehabilitation as in-patients and in the number of non-medicine based rehabilitation services, as well as in the number of beneficiaries receiving treatment to maintain their abstinence);
9. **there are no significant changes in the profile of beneficiaries** requesting care for heroin and cannabis use; for those using NPS, we notice an increase in the period of use prior to requesting treatment, while for those using hypnotics and sedatives there is a decrease in the “gap” period between use onset and request for care.

## Chapter 6 - Health correlates and consequences

### 6.1 DRUG RELATED INFECTIOUS DISEASES

#### 6.1.1 HIV/AIDS, viral hepatitis, sexually transmitted diseases, tuberculosis, and other types of infectious co-morbidity

##### General background

In 2012, the prevalence of drug related infectious diseases indicates the following trends:

- Significant increase of HBV;
- Significant increase of HCV (exceeding European average);
- Alarming increase of HIV (exceeding European average).

The increases registered as a result of the reduced services aiming to lower the injecting drug use risks following the completion of programmes funded by foreign donors, of the increase in the injecting frequency due to the change in use patterns and to the migration to injecting NPSs (stimulants), as well as of the limited availability of medical and social services.

The data were collected by routine monitoring, based on the agreement on the implementation of Drug Treatment Demand Indicator.

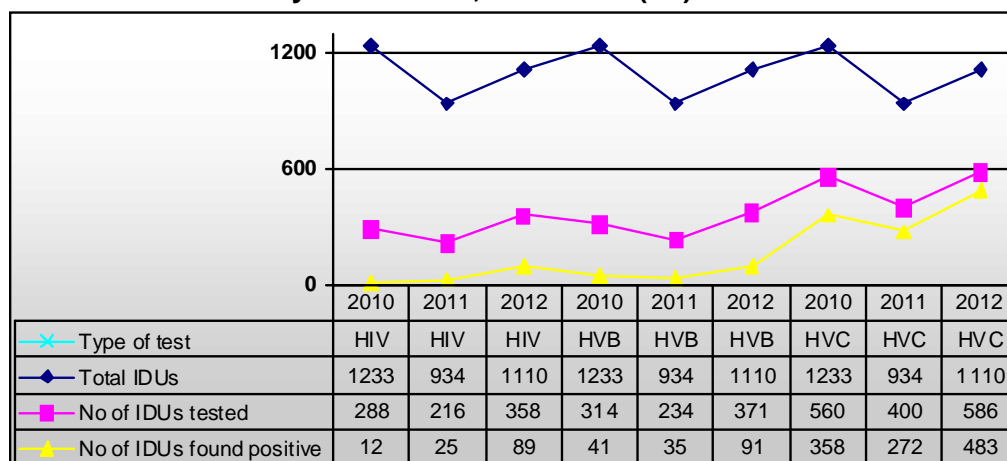
##### Drug related infectious diseases – registered by routine monitoring

In 2012, the above mentioned database registered 1110 cases of injecting drug users (IDUs), as compared to the 934 cases recorded in 2011. The main drug used by IDUs was heroin (823 as compared to 585 in 2011), the rest of cases reporting other substances as main drug, respectively amphetamine-type stimulants called new psychoactive substances (NPSs), traded under the name of "ethnobotanical plants" (247 cases reporting almost completely, PUR), methadone (14 cases), cocaine (1 case) and tramadol (1 case).

With regards to gender distribution, of the total number of cases analysed for 2012, 82.1% were male and 17.6% were female. In comparison with the previous year we note a slight increase of the male ratio in the total population analysed.

Of the 1110 persons registered as injecting drug users, 586 declared they had been tested in the past 12 months for the hepatitis C virus (HCV), 371 for the hepatitis B virus (HBV) and 358 for HIV. No additional data were reported on the confirmation tests. The percentage of persons tested for all types of infections increased as compared to previous years, as highlighted by the following chart:

**Chart 6-1: Distribution of IDUs by test results, 2010-2012 (no)**



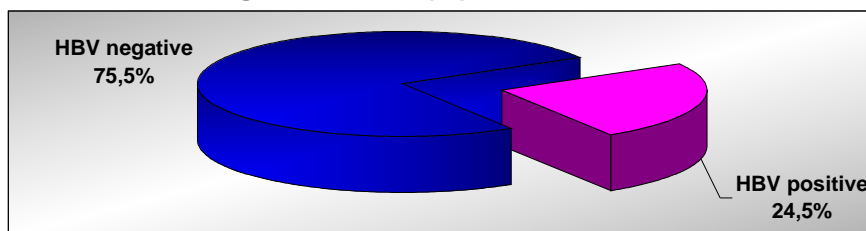
Source: NAA



### a) Infection with hepatitis B virus

In 2012 the prevalence of HBV infection was 24.5% (as compared to 14.9% in 2011) (371 tests, 91 positive results, of which 78 male cases and 12 female cases).

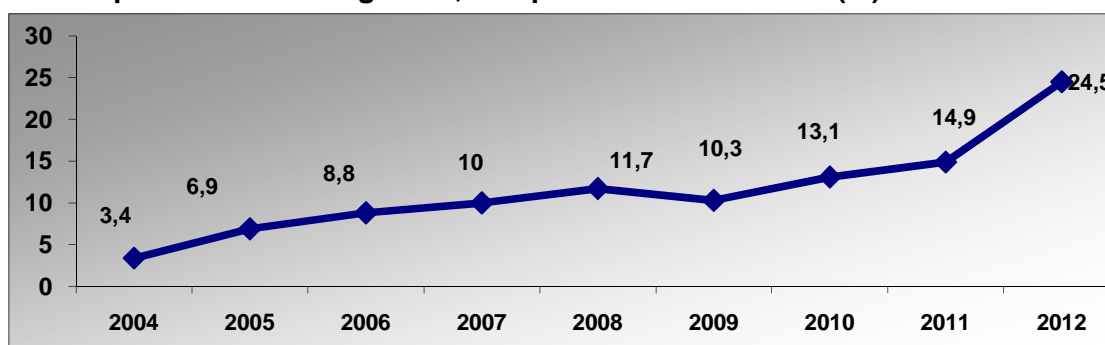
**Chart 6-2: HBV prevalence among IDUs, 2012 (%)**



Source: NAA

The analysis of data for 2004-2012 indicates a constant upward trend in the prevalence of HVB among IDUs (except for 2009).

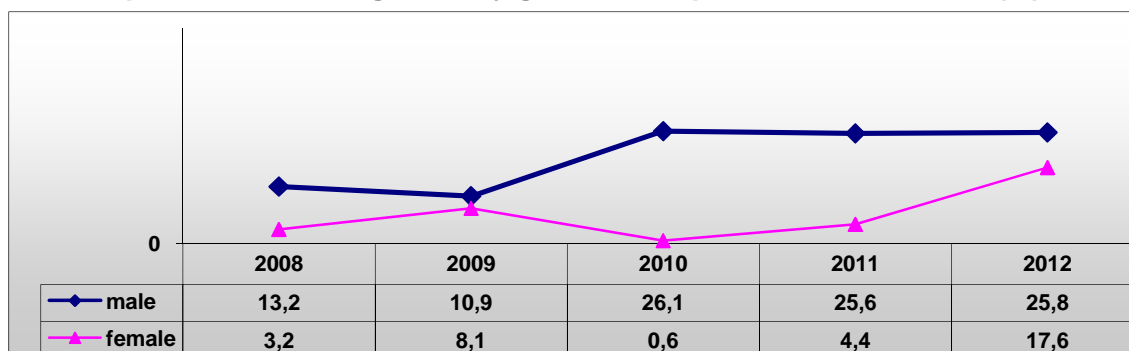
**Chart 6-3: HBV prevalence among IDUs, compared data 2004-2012 (%)**



Source: NAA

As compared to the previous year we note a stabilisation of HBV prevalence among the male population (from 25.6% to 25.8%), and a significant increase of the HBV prevalence among the female population (from 4.4% to 17.6%).

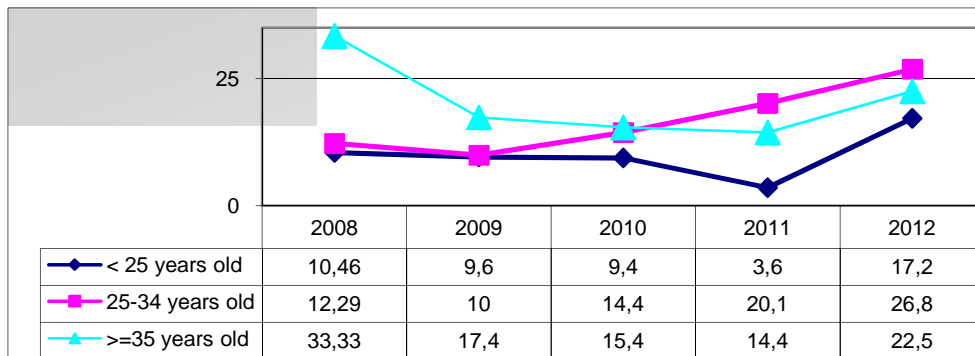
**Chart 6-4: HBV prevalence among IDUs by gender, compared data 2008-2012 (%)**



Source: NAA

According to the age group, the highest HBV prevalence was registered among IDUs aged between 25 and 34 (26.8%).

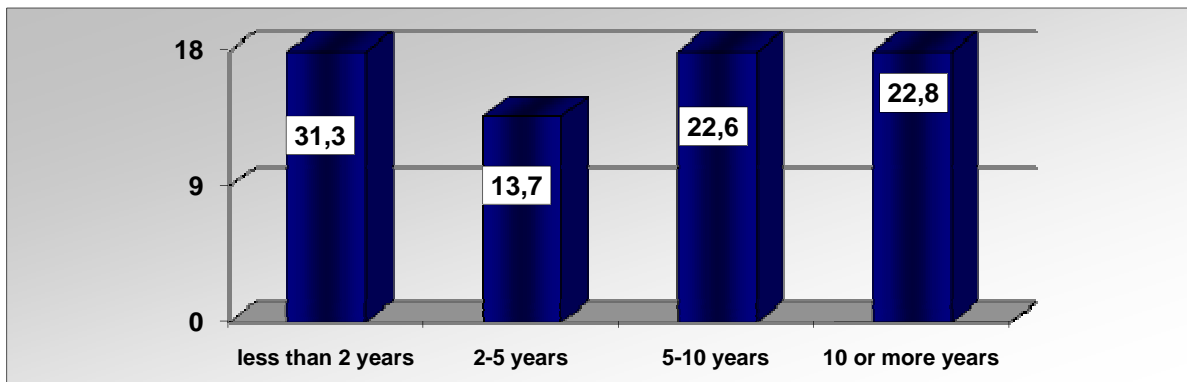
**Chart 6-5: HBV prevalence among IDUs by age group, compared data 2008-2012 (%)**



Source: NAA

As compared to the previous year, we note a high increase of HBV prevalence for most age groups.

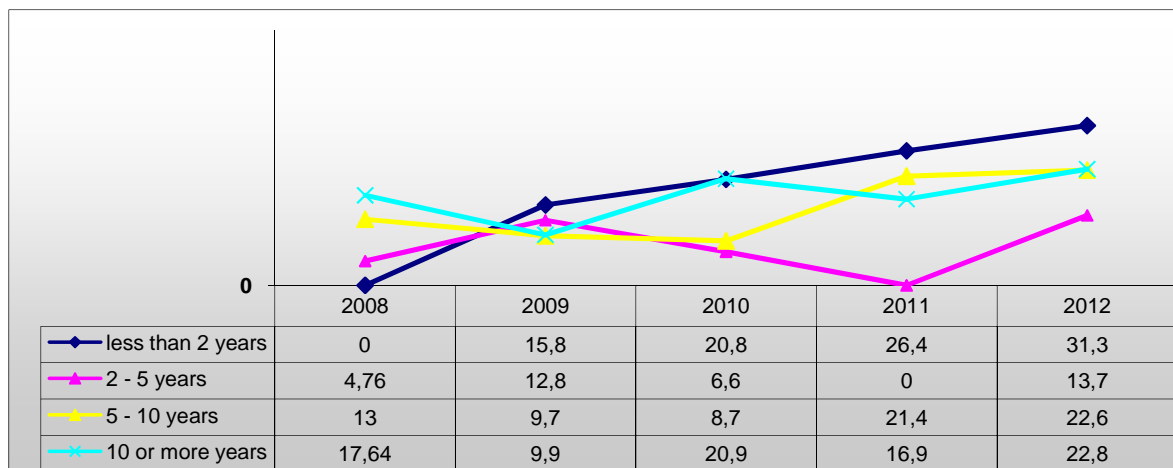
**Chart 6-6: HBV prevalence among IDUs by injecting history, 2012**



Source NAA

The multi-annual analysis shows a high increase of HBV prevalence for most injecting history sub-groups. In case of those with less than 2-year injecting history we notice a constant evolution starting with 2008.

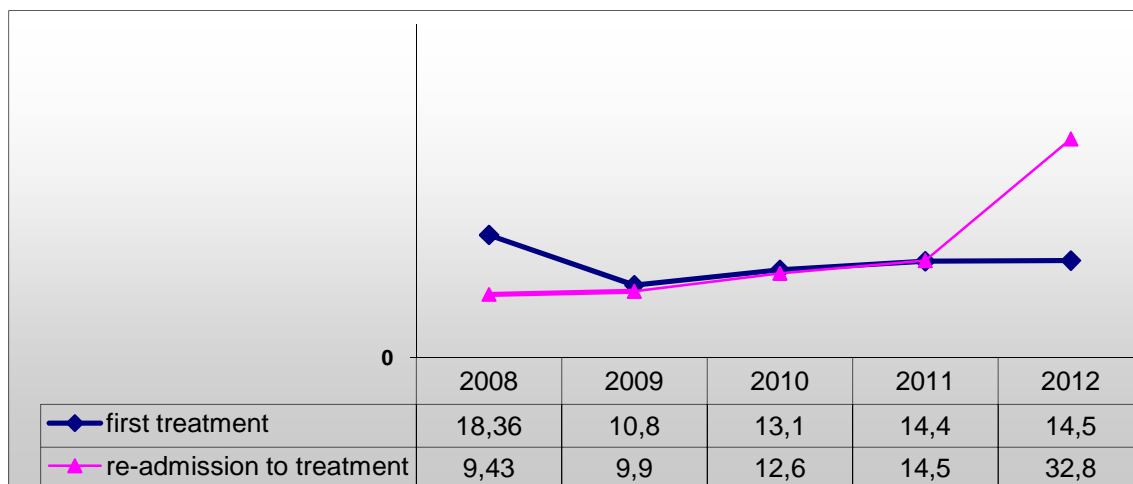
**Chart 6-7: HBV prevalence among IDUs by injecting history, compared data 2008-2012 (%)**



Source NAA

According to the type of admission to treatment (new case or relapse), as compared to the previous year, the HBV prevalence recorded higher values, both in the group of patients admitted to treatment for the first time (14.5%, compared to 14.4% in 2011), and in the case of relapse, where the HBV prevalence doubled, from 14.5% in 2011 to 32.8%.

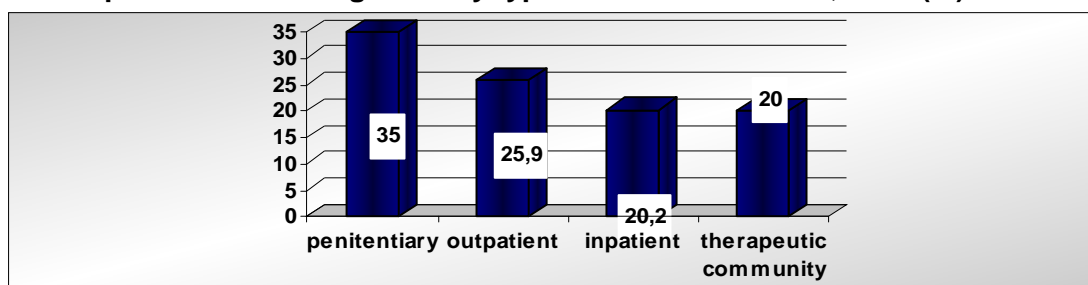
**Chart 6-8: HBV prevalence among IDUs by admission type (new case/ relapse), compared data 2008-2012 (%)**



Source: NAA

Nevertheless, when we analyse HBV prevalence by type of treatment centre (outpatient, inpatient, penitentiary, therapeutic community), we note significant differences between the four types of treatment centres, with the highest HBV prevalence registered, similarly to the previous years, in the group of users located in penitentiary treatment centre (35%). The very high HBV prevalence among drug users in penitentiaries may be explained by the significantly lower number of IDUs tested as compared to other sub-groups analysed (20 IDUs tested in the penitentiary system, of which 7 were HBV positive), but this may also be a warning to authorities managing the problem of detainee drug users.

**Chart 6-9: HBV prevalence among IDUs by type of treatment centre, 2012 (%)**



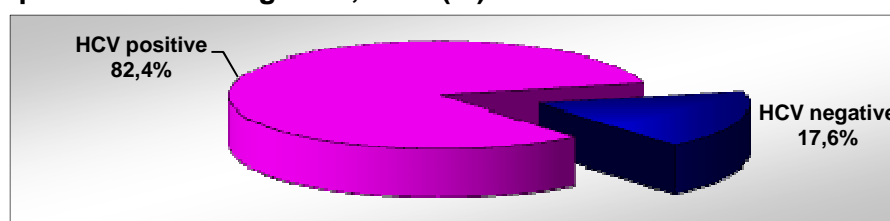
Source: NAA

According to the main drug used, the highest HBV prevalence among the tested IDUs was identified among heroin users (25.3%), while NPS users registered 22.6%.

### b) Infection with hepatitis C virus

The HCV prevalence among the 586 IDUs tested is still very high. The data available for 2012 indicate a HCV prevalence of 82.4% (as compared to 68.5% in 2011), placing Romania among the European countries with highest HCV prevalence.

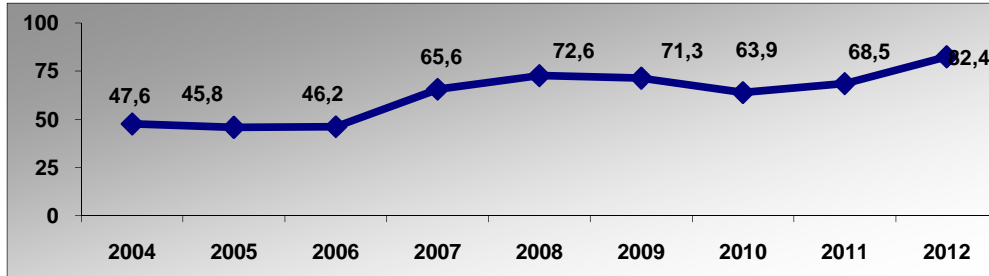
**Chart 6-10: HCV prevalence among IDUs, 2012 (%)**



Source: NAA

The distribution of HCV prevalence in a multi-annual perspective indicates an increase of HCV prevalence among IDUs to more than 80%, after 5 years of variations between 60-70%. The values registered in the past years are very high and the increased HCV prevalence among IDUs may have both direct causes, namely more frequent shared use of injecting tools and unavailability of sterile tools or the lack of information on the injecting drug use risks, and indirect causes, namely increased availability of HCV testing services.

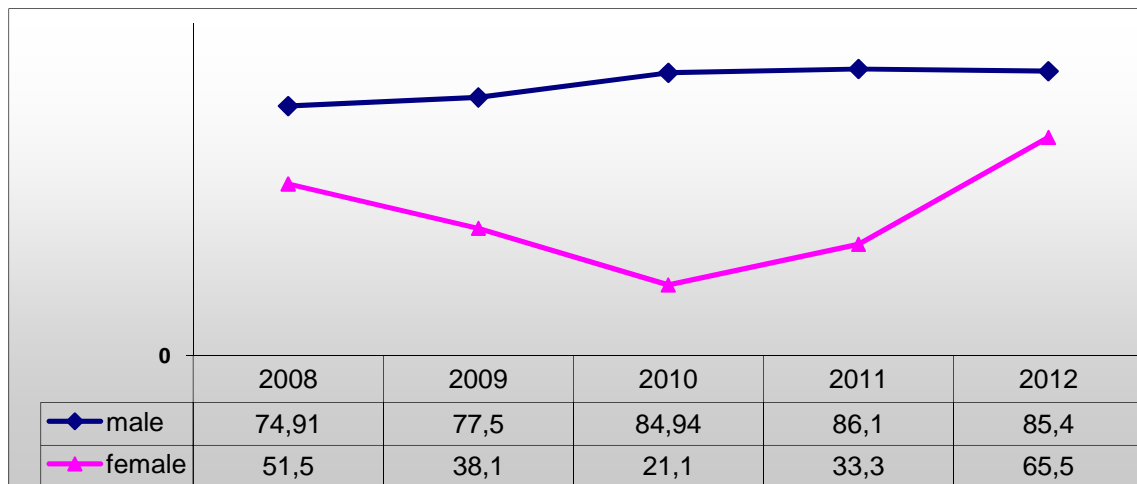
**Chart 6-11: HCV prevalence among IDUs, compared data 2004-2012 (%)**



Source: NAA

The distribution by patient gender shows that HCV prevalence is still significantly higher in the male population – 85.4% as compared to the female population, 65.5%. As compared to previous years, we note an increase of the number of positive HCV female population and a stabilisation of the positive HCV male population.

**Chart 6-12: HCV prevalence among IDUs by gender, compared data 2008-2012 (%)**

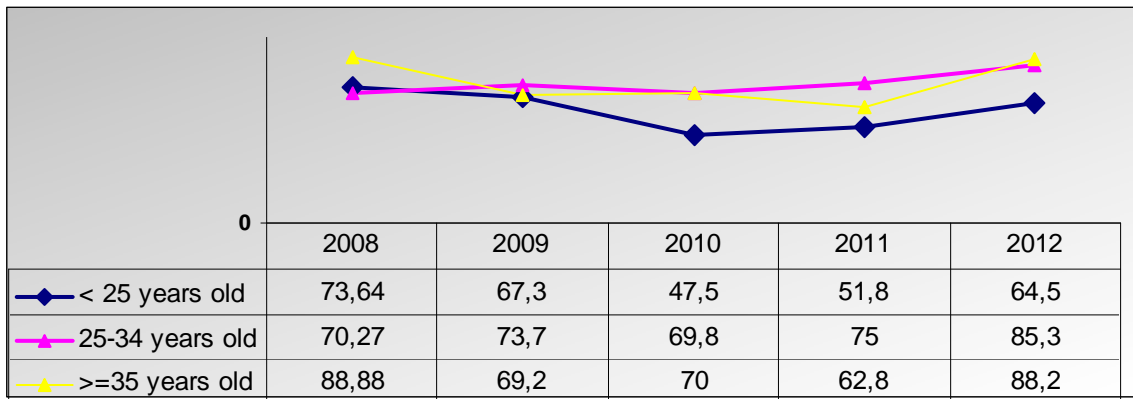


Source: NAA

According to age group, the highest HCV prevalence was recorded for IDUs over (88.2%), followed by IDUs in the age group of 25-34 (85.3).

As compared to the previous period, we note higher HCV prevalence among IDUs of all age groups.

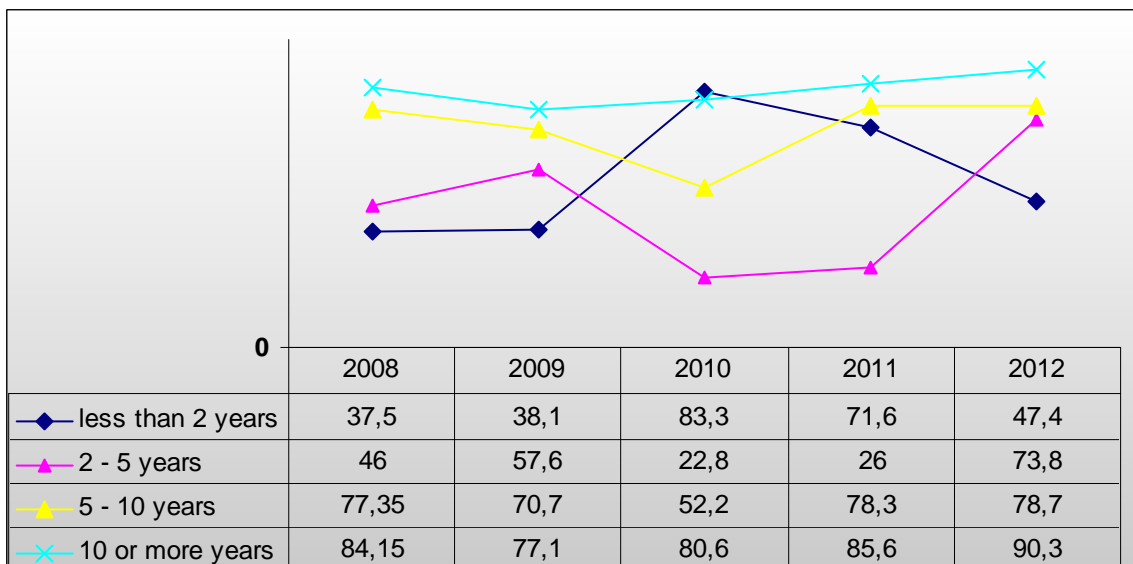
**Chart 6-13: HCV prevalence among IDUs by age group, compared data 2008-2012 (%)**



Source: NAA

The highest rates of HCV prevalence were registered among drug users with long injecting history: more than 10 years (90.3%), and 5-10 years (78.7%).

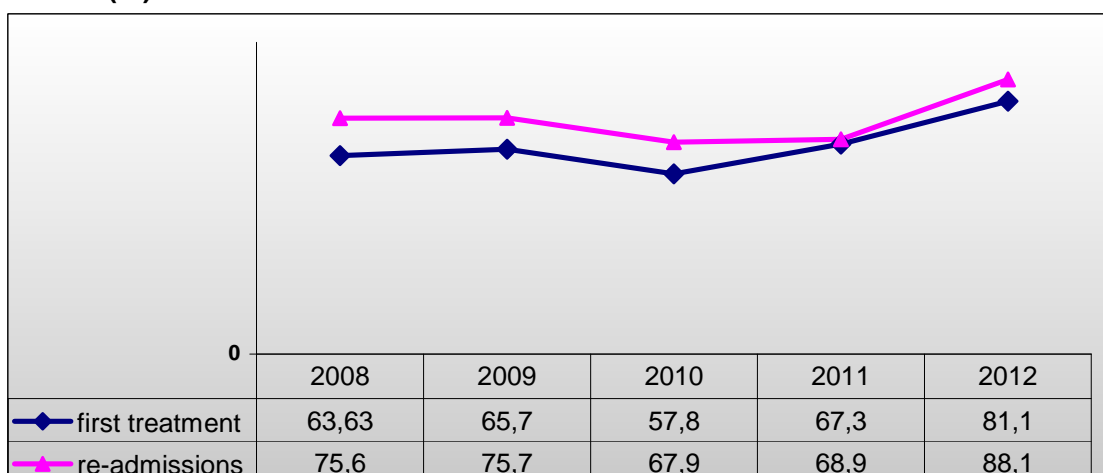
**Chart 6-14: HCV prevalence among IDUs by injecting history, 2008-2012 (%)**



Source: NAA

For all IDUs benefitting from treatment with an injecting history longer than 2 years we registered an increase of the HCV prevalence starting with 2010.

**Chart 6-15: HCV prevalence among IDUs by admission type (new case/ relapse), compared data 2008-2012 (%)**

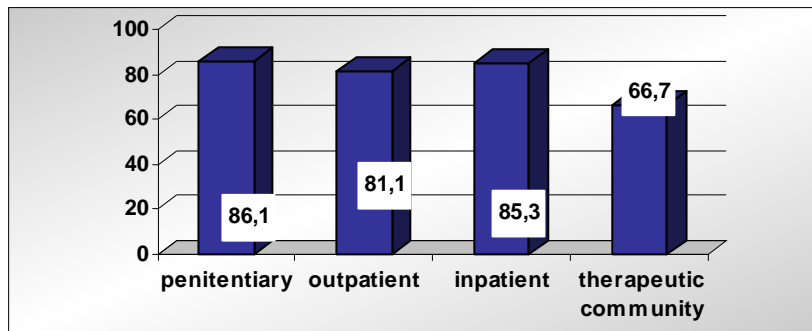


Source: NAA

According to the main drug used, the highest HCV prevalence was identified among injecting NPS users – 84.4%, while HCV prevalence among heroin users was 82.2%.

Similarly to HBV, when we analyse HCV prevalence by type of treatment centre (outpatient, inpatient, penitentiary, therapeutic community), we note a very high HCV prevalence among IDUs tested in the penitentiary system, which might be explained again by the very low number of IDUs tested in the penitentiary system and, consequently, by the reporting of numbers of positive cases identified among them (31 IDUs tested in the penitentiary system, of which 27 positive cases). As opposed to the HBV prevalence, we note a rather high HCV prevalence a inpatient IDUs.

**Chart 6-16: HCV prevalence among IDUs, according to the type of treatment centre, 2012 (%)**

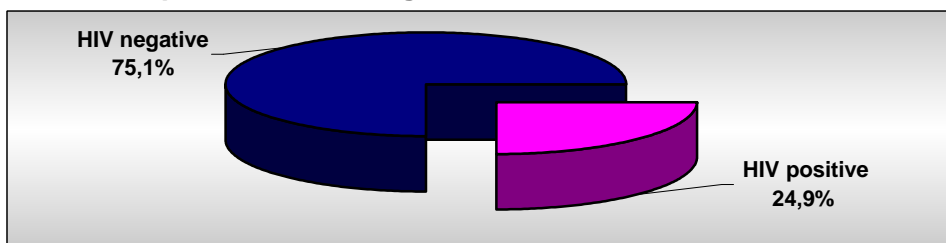


Source: NAA

**c) HIV infection**

In 2012, of the 358 cases of injecting drug users who declared to have been tested for HIV in the specialised medical units in the last 6 months, there were 89 cases (24.9%) of seropositive IDUs, more than double than last years' prevalence.

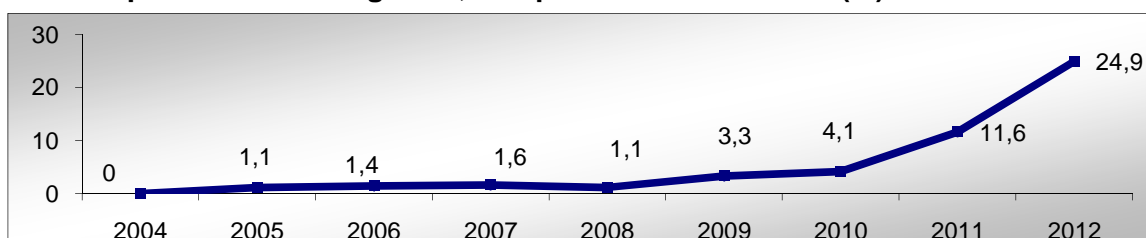
**Chart 6-17: HIV infection prevalence among IDUs, 2012 (%)**



Source: NAA

The trend recorded in 2009-2011 is thus confirmed, and there is an alarming increase of HIV cases among IDUs which calls for fast intervention to limit the spread of this infection, especially among vulnerable groups.

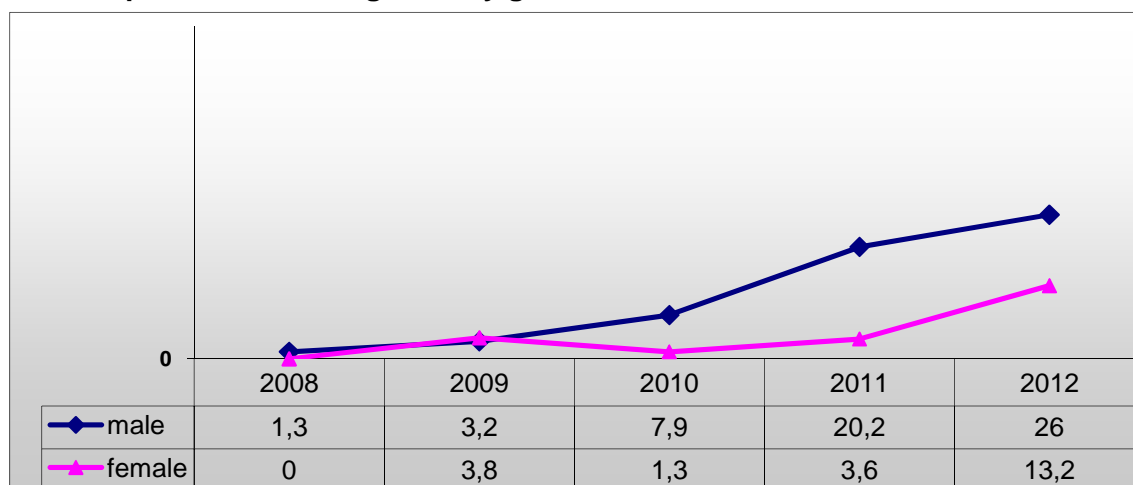
**Chart 6-18: HIV prevalence among IDUs, compared data 2004-2012 (%)**



Source: NAA

The distribution by patient gender shows that the HIV infection prevalence registered higher values among male IDUs (26%), than among female IDUs (13.2%). If during the previous year there was a significant increase among male IDUs, 2012 showed an accelerated upward trend among female IDUs.

**Chart 6-19: HIV prevalence among IDUs by gender, 2008-2012 (%)**

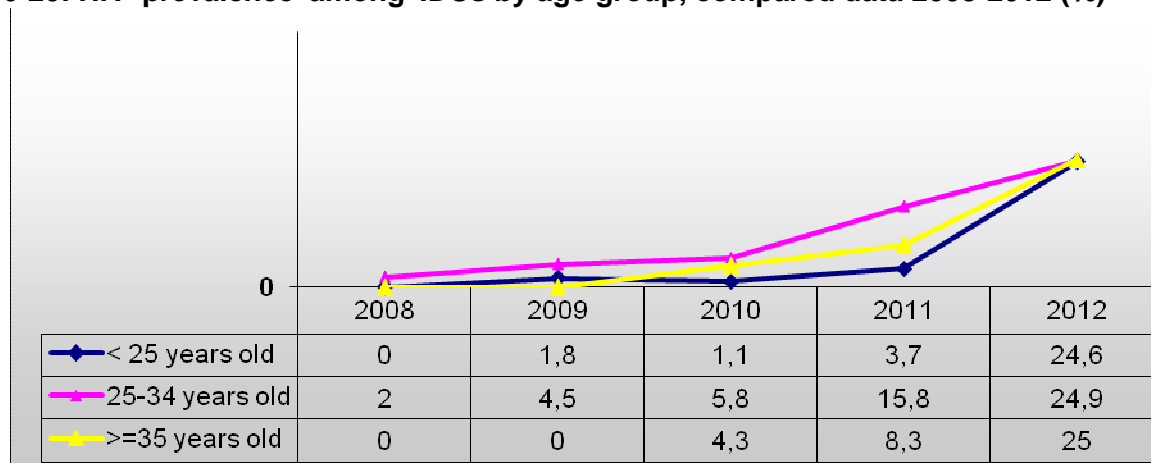


Source: NAA

According to age group, the highest HIV infection prevalence was registered among IDUs over 34 (25%). Second ranked IDUs between 25 and 34 (24.9%).

Similarly to HCV prevalence, starting with 2010 the HIV infection prevalence increased for all age groups. Mention should be made that IDUs under 25 registered the most spectacular increase of HIV infection prevalence, more than 6 times higher than the previous year.

**Chart 6-20: HIV prevalence among IDUs by age group, compared data 2008-2012 (%)**

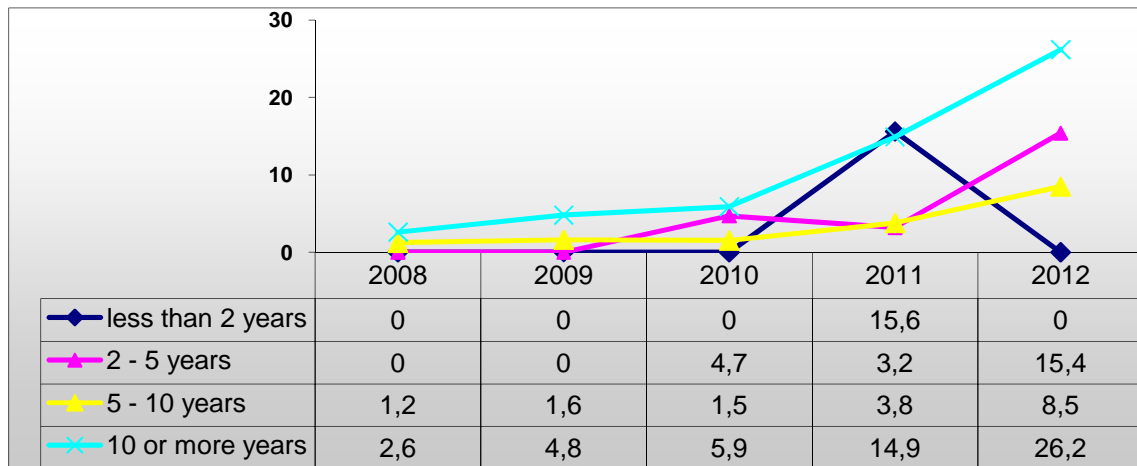


Source: NAA

According to injecting history, IDUs with long injecting history (10 or more years) registered the highest prevalence rate as compared to the previous year when this group ranked second, after recent IDUs (less than 2 years). 2012 witnessed a major change in this sub-group (0% HIV prevalence among IDUs with less than 2 years injecting history).

Except for the sub-group of IDUs with recent injecting history, which registered an important decrease of HIV infection prevalence, all other sub-groups confirmed the increasing trends for HIV prevalence registered during the previous years. We should also mention the spectacular increase of the HIV infection rate among IDUs with injecting history of more than 10 years (from 14.9% to 26.2%).

**Chart 6-21: HIV prevalence among IDUs by injecting history, compared data 2008-2012 (%)**



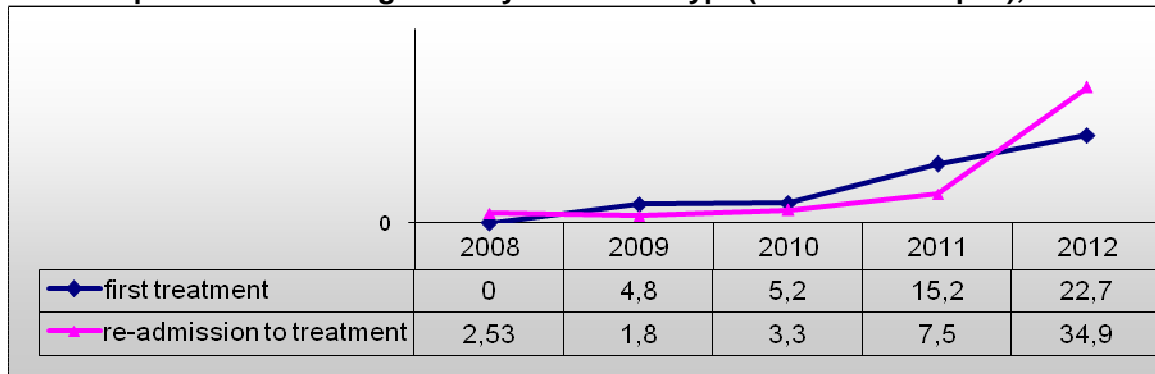
Source: NAA

For IDUs with more than 10 years injecting history, the high HIV prevalence is explained by the longer exposure to risk factors related to this type of drug use.

We also notice that the sub-group of IDUs with 2-5 injecting history registered a similar rate (15.4%) with the one of recent IDUs (<years) reported the previous year. Thus, we might presume a limitation of the HIV outbreak to those with longer injecting history, this indicating their reduced contact with recent IDUs and, basically, an opportunity to limit the HIV transmission among the new users.

When we analyse the HIV infection rate by the type of admission to treatment, we notice that the HIV prevalence was higher among patients re-admitted to treatment following drug use (34.9%), as compared to patients admitted to treatment for the first time (22.7%), the opposite of the trend identified during previous years.

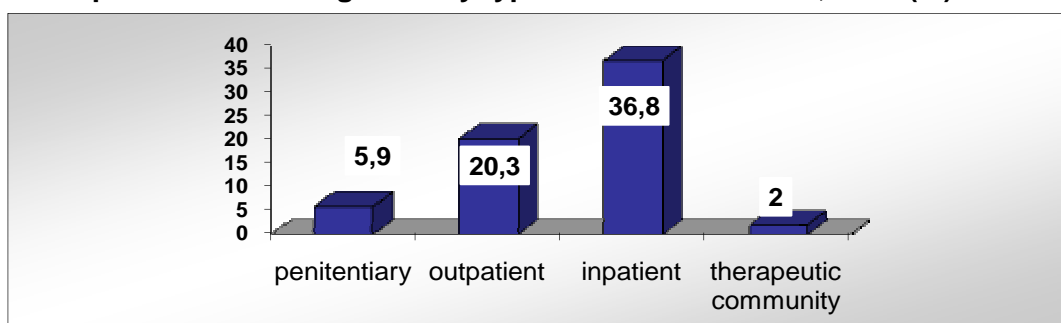
**Chart 6-22: HIV prevalence among IDUs by admission type (new case/ relapse), 2011-2012 (%)**



Source: NAA

When we analyse HIV prevalence by type of treatment centre (outpatient, inpatient, penitentiary, therapeutic community), we notice the highest HIV prevalence among inpatient IDUs.

**Chart 6-23: HIV prevalence among IDUs by type of treatment centre, 2012 (%)**



Source: NAA



According to the main drug used, HIV prevalence among NPS IDUs is 40.2%, and among heroin users, 19.2%. Without saying that heroin users were spared by the HIV infection outburst, we may note that the users who declared NPSs as main injecting drug face double risk of infection.

The differences identified during the in-depth analysis of HIV positive IDUs indicate that most cases were registered among the relapse cases, for the age group 35+ with long history of use (10 or more years).

The changes could be explained either by a limitation of the infection to the IDUs with long history of injecting, or by the fact that HIV testing and monitoring increased for this sub-group, once the HIV infection outburst among IDUs in Bucharest was identified.

In 2012, the HIV/AIDS Monitoring and Evaluation Department of the National Commission for Fight against AIDS within the Ministry of Health reported for Romania 231 new HIV+ cases identified among injecting drug users (31% of the total new HIV cases at national level, for all risk groups). The trend is still upward, highlighting the HIV infection outburst mentioned earlier.

**Table 6-1: Trends in HIV transmission in Romania 2007-2012**

Transmission	31 December 2007	31 December 2008	31 December 2009	31 December 2010	31 December 2011	31 December 2012
<b>Vertical</b>	8 (2%)	7 (1%)	20 (4%)	25 (5%)	21 (3%)	18 (2%)
<b>MSM (men who have sex with men)</b>	14 (3%)	40 (40%)	44 (9%)	60 (11%)	95 (13%)	80 (10%)
<b>IDUs</b>	4 (1%)	3 (1%)	7 (1.4%)	14 (3%)	131 (18%)	231 (31%)
<b>MSM/IDU</b>				1 (<0.5%)	5 (1%)	6 (1%)
<b>Heterosexual</b>	252 (79%)	397 (76%)	383 (77%)	399 (75%)	440 (61%)	382 (51%)
<b>Unknown</b>	67 (15%)	71 (14%)	43 (8.6%)	32 (6%)	28 (4%)	37 (5%)
<b>Total</b>	445	522	497	531	720	754

Source: HIV/AIDS Monitoring and Evaluation Department

As compared to previous years, we noticed increased HIV prevalence in drug users, from 6.12% to 6.93%. We also notice a significant decrease of HIV infection among homosexuals, from 14.08% to 1.72%.

**Table 6-2: HIV testing by risk group, compared data 2010-2012**

Risk group	%	%	%	%
	positive in 2012	positive in 2011	positive in 2010	positive in 2009
on demand	0.97	1.01	0.78	0.75
occasional	2.89	4.23	4.83	3.08
TBC	1.01	1.37	0.95	0.72
pregnant	0.06	0.08	0.11	0.08
HIV contacts	10.25	8.64	7.99	7.7
STD	1.48	0.76	0.67	0.5
motherhood	0.85	5.07	3.25	3.25
drug users	6.93	6.12	1.03	2.12
prenuptial check	0.06	0.10	0.12	0.04
drivers	0	0	4.35	4.35
detainees	0.43	0.42	10.77	1
sailors	0.05	0.04	0.09	0.06
working abroad > 6 months	0.67	0.25	0.85	0.43
holiday abroad > 6 months	0.79	0.75	0	0.68
homosexuals	1.72	14.08	7.84	0
hemodialysis patients	0	0	0	0
transfused	0	0	0	0
commercial sex workers	1.12	6.49	0	0
medical staff	0	0	0	0
<b>Total</b>		<b>0.85</b>	<b>0.66</b>	<b>0.66</b>

Source: HIV/AIDS Monitoring and Evaluation Department in Romania – "Matei Balș" Infectious Disease Institute of Bucharest

### Conclusions:

- HBV, HCV and HIV prevalence among IDUs registered significant upwards trends, partly due to changes in the use pattern (emergence and use of NPSs, conversion of heroin injecting users to NPS injecting users);
- Another explanation of the trend changes recorded for the three types of infections may be the substantial reduction of interventions to decrease the drug related infectious diseases, due to a lack of funding, especially for projects implemented by specialised non-governmental organisations;
- Data available for HIV infection indicate its prevalence is more than double among IDUs and confirm an alarming trend of HIV transmission, and NPS use doubles the infection risk. Nevertheless, we may note a lower HIV prevalence among young IDUs at the onset of injecting use, which may be explained either by a limitation of the infection to IDUs with longer use history or by the higher number of tests and by the intensification of HIV monitoring among IDUs, following the identification of the HIV outbreak in Bucharest. These trends may be confirmed without the analysis of data provided by the **behavioural surveillance survey BSS-2012**.

## 6.1.2 STUDIES ON THE DRUG RELATED INFECTIOUS DISEASE PREVALENCE

### Behavioural surveillance survey among IDUs in Bucharest BSS 2012

**Romanian Angel Appeal, Carusel and ANA** conducted in 2012 (September-October) the third<sup>71</sup> *Behavioural Surveillance Survey (BSS)* among injecting drug users in Bucharest, using UNODC methodology<sup>72</sup>.

The purpose of the survey was to establish a systematic data collection method among injecting drug users in Bucharest, in order to monitor and evaluate the impact of HIV prevention programmes among this population, with the purpose of developing and optimising these services.

**Target population** - BSS targeted IDU population (drug users with injecting history in the past 12 months) over 18, domiciled in Bucharest or the metropolitan area.

**Sample** – the sampling technique was respondent driven sampling; 417 respondents were eventually selected.

The results were calculated for a 95% confidence interval.

**Data collection tool** – the questionnaire included 10 sections with 95 questions related to the drug use history and behaviour, sexual behaviour, knowledge on TBC, HIV/AIDS, hepatitis B and C, infectious disease testing and access to health care services, drug related criminality and imprisonment (including risk behaviour in prison), other vulnerabilities.

#### **Sociodemographic characteristics of the selected sample**

The 417 subjects selected by using the RDS technique are between 18-69 years old, the age being 29.5 and the median 29. Thus, the group of injecting drug users in the Bucharest metropolitan area consists largely of young people in the age group 25-34. 79.1% of the subjects are male and 20.9% female. More than 10% of the respondents have no education, and 20% only graduated primary education. Approximately 35% of the participants work (officially or not), 36% are supported by their families, 6.5% receive social benefits. Most participants in the survey live in households with several members, and 26.4% have no fixed address. An alarming rate (34.1%) declare they have children to support. 52.3% of respondents had been detained at least once. 52.3% of respondents declared they were Romanian and 45.1% declared Roma ethnicity. 76.8% of respondents declare they have no health insurance.

#### **Outcomes**

##### **Substance (tobacco, alcohol, illicit drugs) use**

Most IDUs use substances sold as “legal drugs” or “ethnobotanicals”, NPSs (49.6%), followed by heroin (40.5%) while methadone ranked last, with 5.8%.

The average onset age is 19.3, and the average injecting history is considerable, approximately 10.2. Thus, we may note that they are, generally, users with long history who, most likely, injected heroin before the appearance of NPSs.

##### **Risk behaviours**

Injecting frequency for the last time they used the main drug is higher than 4.27: more than 5 injections/day – 22.8%, 3-5 injections - 35.5%, less than 3 injections – 41.7%.

When we analyse the injecting frequency by the drug used we notice that NPS-using IDUs have the highest rate among those injecting more than 5 times a day, 72.6%. The situation is similar for those who inject 3-5 times/day, of which 55.1% are NPS users.

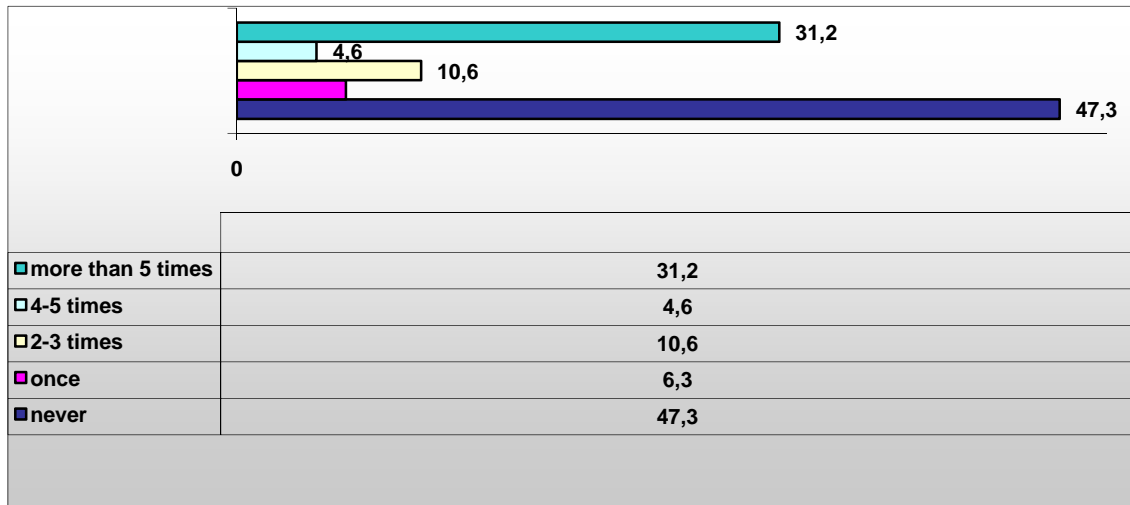
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<sup>71</sup> See RN 2008 and 2010

<sup>72</sup> *Family Health International*, 2000

19.3% of the IDUs declared they used non-sterile syringes when they last injected, and 20.1% declared someone else also used the same syringe they had used. Taking into consideration the other injecting tools, 52.7% of the participants in the survey used non-sterile injecting tools.

**Chart 6-24: How often have you used syringes or phials already used by someone else in the past month?**



Source: BSS 2012

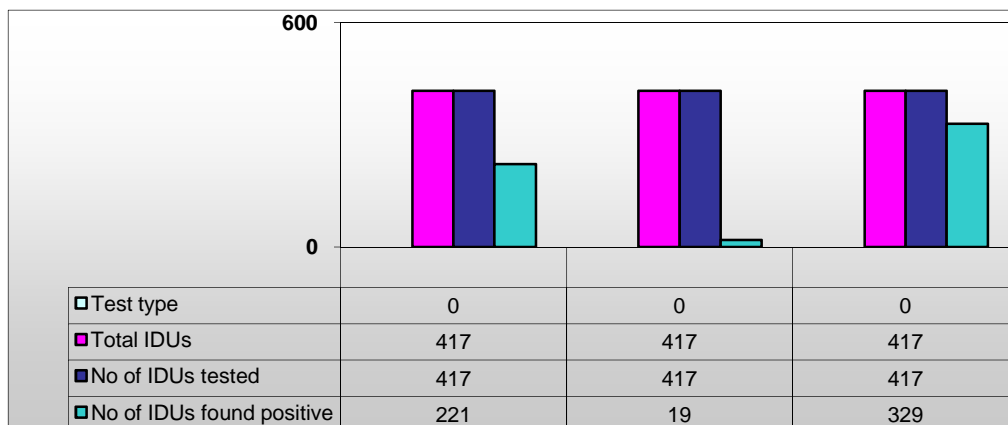
With regards to sexual behaviour, 25.4% of the respondents declared they had used a condom during the last sexual intercourse, either with their main sex partner or with occasional sex partners. Overall, 13.5% of the injecting drug users (11.5% male and 21.2% female) had sex in exchange for money, drugs or other goods.

### Prevalence of transmissible infectious diseases among IDUs participating in BSS

With regards to drug related infectious disease prevalence, the serological testing indicated the following:

- A very high rate of HCV prevalence, 79.3% of the respondents being infected with the virus,
- A relatively low rate of HBV prevalence – 4.7%,
- An alarming rate of HIV prevalence, as 53.3% were found positive.

**Chart 6-25: IDU distribution by test results**



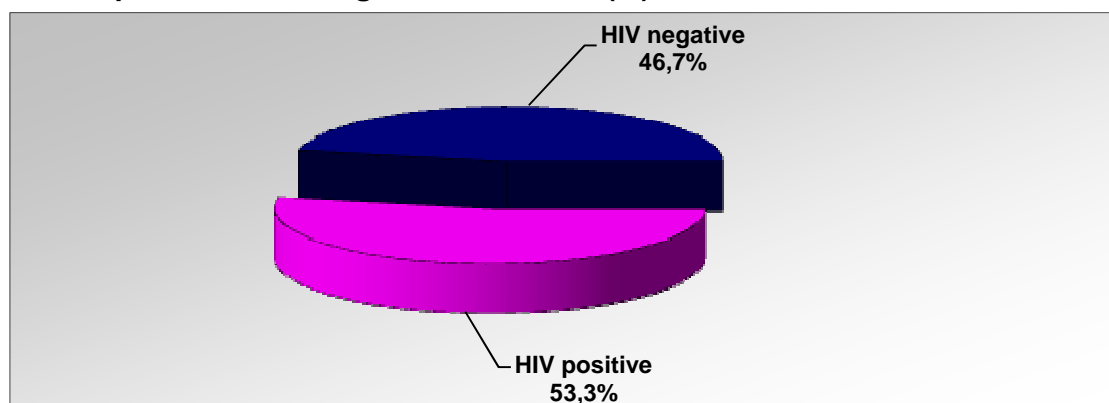
Source: BSS 2012

## A.HIV infection

70.4% of the participants declared they had been tested for HIV and the self-reported HIV prevalence was 5%.

More than half (53.3%) of the 417 subjects tested for HIV under this the survey were found HIV positive. This result confirms the data resulted from the routine monitoring which identified the HIV infection outbreak among IDUs in Bucharest.

**Chart 6-26: HIV prevalence among IDUs, BSS 2012 (%)**



Source: BSS 2012

The distribution by respondent gender indicates higher HIV prevalence among male IDUs (55.2%), as compared to female IDUs (46%). Nevertheless, this difference is not as obvious as indicated by the routine monitoring where HIV prevalence among male IDUs is double than HIV prevalence among female IDUs.

According to age group, the highest HIV prevalence was found among IDUs under 25 (58.5%), followed by IDUs in the age group of 25-34 (54%).

**Table 6-3: HIV prevalence among IDUs, by age group, %**

Age group	HIV prevalence
< 25 years old	58.5
25-34 years old	54
35-44	44.3
45+	40

Source: BSS 2012

According to the injecting history, the highest prevalence was found among IDUs with injecting history of 2-5 years, 59.3%. For IDUs with less than 2 years injecting history the HIV prevalence registered the lowest rate in this category, 42.9%.

**Table 6-4: HIV prevalence among IDUs, by injecting history, %**

Injecting history	HIV prevalence
less than 2 years	42.9
2 – <5 years	59.3
5 - 9 years	55.8
10 or more years	51.6

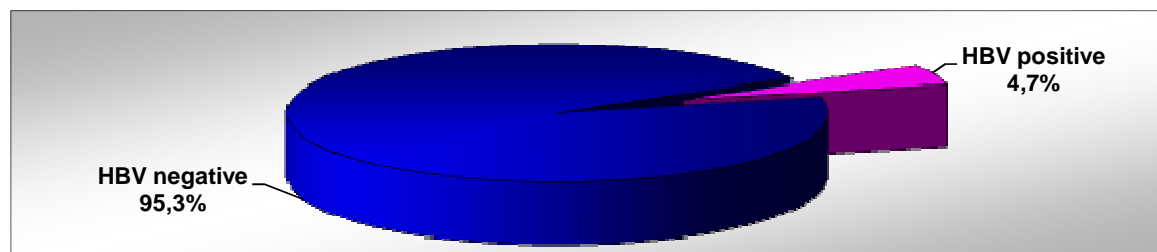
Source: BSS 2012

The highest HIV prevalence was registered among NPS users, 71.4% as compared to 39.3% among heroin users (approximately half of the NPS users).

### b. HBV infection

4.7% of the 417 subjects tested for HBV under this the survey were found HBV positive, indicating a lower HBV prevalence as compared to the information provided by the routine monitoring data in 2012.

**Chart 6-27: HBV prevalence among IDUs, BSS 2012 (%)**



Source: BSS 2012

The distribution by respondent gender indicates double HBV prevalence among male IDUs (5.3%) as compared to female IDUs (2.5 %).

**Table 6-5: HBV prevalence among IDUs by gender, (%)**

Gender	HBV PREVALENCE
male	5.3
female	2.5

Source: BSS 2012

According to age group, the highest HBV prevalence was found among IDUs in the age group of 25-34 (5.7%), followed by IDUs under 25 (4.5%). Thus, the lower the age, the higher the HBV prevalence likelihood.

**Table 6-6: HBV prevalence among IDUs, by age group, %**

Age group	HBV PREVALENCE
< 25 years old	4.5
25-34 years old	5.7
35-44	1.7
45+	0

Source: BSS 2012

According to the injecting history, the highest prevalence was found among IDUs with injecting history of less than 2 years, 7.7%. The following category is IDUs with 5-9 years injecting history, 6.7%; no HBV positive cases were found among IDUs over 45.

**Table 6-7: HCV prevalence among IDUs, by injecting history**

Injecting history	HBV PREVALENCE
less than 2 years	7.7%
2 – 5 years	3.7%
5 - 9 years	6.7%
10 or more years	4%

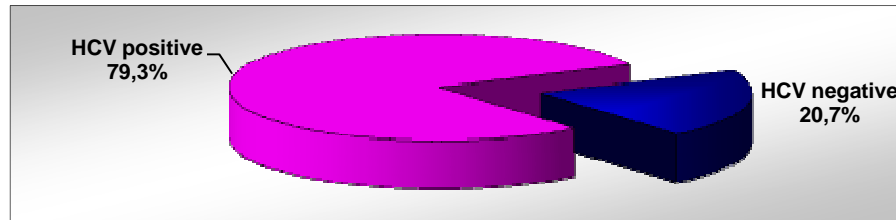
Source: BSS 2012

Similarly to HIV prevalence, the HBV prevalence registered almost double rates among NPS IDUs (7.8%), as compared to the rate of injecting heroin users (3.5%).

### c. HCV infection

The HCV prevalence among the 417 IDUs tested is still very high. Data available for 2012 show HCV prevalence of 79.3%, as compared to BSS surveys from 2007 (82.9%) and 2009 (88.3%)

**Chart 6-28: HCV prevalence among IDUs, 2012 (%)**



Source: BSS 2012

The distribution by patient gender indicated higher HCV prevalence among female IDUs (82.8%), as compared to male IDUs (78.4%). This confirms the trend identified by BSS 2009 when HCV prevalence among the IDUs tested was 87.9% among male as compared to 90% among female IDUs. The BSS survey conducted in 2007 indicated higher HCV prevalence among male IDUs (87.1%), as compared to female IDUs (68%).

**Table 6-8: HBV prevalence among IDUs by gender, (%)**

Gender	HCV prevalence
male	78.4
female	82.8

Source: BSS 2012

According to age group, the highest HCV prevalence was found among IDUs in the age group of 35-44. The age groups between 25 and over 45 have similar prevalence. The lowest HCV prevalence was registered among IDUs under 25, 73.4%.

**Table 6-9: HCV prevalence among IDUs, by age group, %**

Age group	2012
< 25 years old	73,4
25-34 years old	80,9
35-44	81,7
45+	80

Source: BSS

According to the injecting history, we note an increased HCV prevalence among IDUs with long injecting history, with similar values for IDUs having 5-10 years injecting history (83.9%) and IDUs having more than 10 years injecting history (82.9%). HCV prevalence rates are also similar for IDUs with less than 5 years injecting history, and slightly increased for IDUs with less than 2 years injecting history (64.3% as compared to 59.3% for IDUs with 2-5 years injecting history).

**Table 6-10: HCV prevalence among IDUs, by injecting history**

Injecting history	
less than 2 years	64.3
2 – <5 years	59.3
5 - 9 years	83.2
10 or more years	82.9

Source: BSS 2012

Unlike HIV and HBV, the highest HCV prevalence was found among heroin users (80%), while the HCV prevalence among NPS users was 76.2; these rates are pretty similar and they confirm the findings related to the injecting history.

**Table 6-11: Comparative results of the three Behavioural Surveillance Surveys among IDUs**

Variable	2007	2009	2012
<b>Sample</b>	Sample (N=449) built using Respondent driven sampling RDS.	Sample (N=385) built using Respondent driven sampling RDS.	Sample (N=417) built using Respondent driven sampling RDS.
<b>Respondent gender</b>	78% of the total cases were male respondents and 22% were female respondents.	79.2% of the total cases were male respondents and 20.8% were female respondents.	79.1% of the total cases were male respondents and 20.9% were female respondents.
<b>Age</b>	Subject selected are between 18-55 years old. The age group 18-29 included 64% of the IDUs investigated, with an average age of 27.6 and a median of 27.	Subject selected are between 18-55 years old. The age group 18-29 included 59.5% of the IDUs investigated, with an average age of 28 and a median of 27.	Subject selected are between 18-69 years old. The age group 18-29 included 51.5% of the IDUs investigated, with an average age of 29.5 and a median of 29.
<b>Education</b>	72% of IDUs graduated 8 grades at best, and 9% are illiterate.	63.7% of IDUs graduated 8 grades at best, and 19% are illiterate.	30.4% of IDUs graduated 8 grades at best, and 10.3% are illiterate.
<b>Type of drug used and injecting frequency</b>	Most IDUs inject heroin (97%), at least 2-3 times a day (75%).	Most IDUs inject heroin (67.3%), followed by users of substances sold as legal drugs of „ethnobotanicals” (30.6%). The latter are most often substances similar with amphetamine in content and effects. The injecting frequency last time they used the drug was 3 times in 44.9% of the cases, 2-3 times in 41.8% and only 13.2% declare only one injection.	Most IDUs use substances sold as legal drugs of „ethnobotanicals”, NPSs (49.6%) such as “Pure by Magic”, “Special Gold”, “Insomnia” etc. Second ranks heroin, 40.5%. The injecting frequency last time they used the main drug exceeded 4.27 times: more than 5 injections/day (22.8%), 3-5 injections (35.5%), and less than 3 injections (41.7%).
<b>Use practices</b>	15% of the IDUs declared they used syringes previously used by someone else when they last injected.  85% of IDUs declared they bought/received sterile injecting materials from pharmacies or syringe exchange programmes.	15.7% of the IDUs declared they used syringes previously used by someone else when they last injected.  96.8% of IDUs declared they bought/received sterile injecting materials from pharmacies or syringe exchange programmes.	19.3% of the IDUs declared they used non-sterile syringes, and 20.1% declared someone else also used the syringe they had used.



<b>Drug related infectious disease prevalence</b>	82.9% were found positive for viral hepatitis C, 4.7% were infected with viral hepatitis B and 1.1% were found positive for HIV infection.	88.3% were found positive for viral hepatitis C, 3.1% were infected with viral hepatitis B and 1% were found positive for HIV infection.	79.3% of the respondents were found positive for viral hepatitis C, 4.7 were infected with viral hepatitis B and 53.3% were found positive for HIV infection.
<b>HCV prevalence by age group</b>	HCV positive respondents showed higher prevalence among IDUs in the age group of 25-34:87%	HCV positive respondents showed higher prevalence among IDUs in the age group of 25-34: 89.3%	The highest HCV prevalence was registered among IDUs in the age group of 35-44. The age groups between 25 and over 45 show similar prevalence. The lowest HCV prevalence (73.4%) was registered among IDUs under 25.
<b>HCV prevalence by respondent gender</b>	Male IDUs show a slightly higher HCV prevalence. Thus, we registered 87.1% HCV prevalence among male IDUs as compared to 68% among female IDUs.	Female IDUs show a slightly higher HCV prevalence. Thus, we registered 87.9% HCV prevalence among male IDUs as compared to 90%, among female IDUs.	Female IDUs show a slightly higher HCV prevalence (82.8%) as compared to 78.4% HCV prevalence among male IDUs.
<b>HBV prevalence by age group</b>	In case of HBV prevalence by age group we notice an increased prevalence among IDUs over 34: 6.5%	In case of HBV prevalence by age group we notice an increased prevalence among IDUs under 25: 4.2%	The highest HBV prevalence was registered among IDUs between 25-34 (5.7%), followed by IDUs under 25 – 4.5%.
<b>HBV prevalence by respondent gender</b>	Male IDUs show a slightly higher HBV prevalence. Thus, we registered 4.9% HBV prevalence among male IDUs as compared to 4% among female IDUs.	Male IDUs show a slightly higher HBV prevalence. Thus, we registered 4.9% prevalence among male IDUs as compared to 4% among female IDUs.	Male IDUs showed double HBV prevalence, namely 5.3% as compared to 2.5% registered among female IDUs.
<b>HIV prevalence by age group</b>	In case of HIV prevalence by age group we notice an increased prevalence among IDUs between 25-34: 1.8 %	In case of HIV prevalence by age group we notice an increased prevalence among IDUs under 25 and over 34: 1.7%	In case of HIV positive IDUs we notice an increased prevalence among IDUs under 25, 58.5%, and among IDUs between 25-34 (54%).
<b>HIV prevalence by respondent gender</b>	Male respondents show a slightly higher HIV prevalence. Thus, we registered 1.1% HIV prevalence among male IDUs as compared to 1% among female IDUs.	Female respondents show a slightly higher HIV prevalence. Thus, we registered 1% HIV prevalence among male IDUs as compared to 1.2% among female IDUs.	Female respondents show higher HIV prevalence. Thus, we registered 46% HIV prevalence among male IDUs as compared to 54.6% among female IDUs.

Source: *Behavioural Surveillance Surveys among IDUs, 2007, 2009, 2012*

## Conclusions:

- There are no significant differences in terms of gender and age among the injecting drug users included in the three surveys: male users between 18-29 were the dominant category;
- With regards to the educational status of IDUs, we notice a low educational level of the samples of subjects recruited randomly among IDUs, using Respondent driven sampling RDS;
- There is an alarming evolution of the HIV/AIDS prevalence which indicates a real outburst among IDUs from Bucharest. If in 2008 and 2010 the HIV/AIDS prevalence was about 1-1.1%, in 2012 it reached 53.3%, which means than more than half of the recruited IDUs are HIV positive;
- In 2012, heroin is no longer the main injecting drug (from 97% in 2008, to 67.3% in 2010, to 40.5% in the reference year), being replaced by NPSs (from 30.6% in 2010, to 49.6% in 2012);

- The injecting frequency is increasing, with an average of 4.27 times/day in the last survey conducted in 2012, with 72.6% of the NPS users declaring and average injecting frequency of more than 5 injections/day.

### **Conclusions and recommendations**

- If data on HBV prevalence provided by the routine monitoring are not confirmed by the BSS findings, in case of HIV prevalence BSS indicates an even darker picture – almost double prevalence – more than ½ of the interviewed subjects are HIV positive.
- There is a link between the low (or decreased) levels of services provided to prevent injecting drug use risks in Romania and the increase of HIV prevalence among IDUs.
- There is a link between the increased injecting frequency, as a characteristic of NPS use as risk factor and the increase of HIV prevalence among IDUs.
- In order to prevent new HIV cases among IDUs in Romania it is crucial to focus on prevention actions, such as syringe exchange programmes and substitutions treatment.
- A high level of HCV prevalence among IDUs, manifest for several years (about 80%) might have facilitated the HIV infection, but it is also an indicator of infection risks due to improper use practices: shared syringes, unprotected sex, etc. Moreover, hepatitis C treatment is underfunded in Romania and this contributed to the transmission of this infectious disease among IDUs.

## 6.2 OTHER CORRELATIONS AND CONSEQUENCES OF THE DRUG USE UPON HEALTH

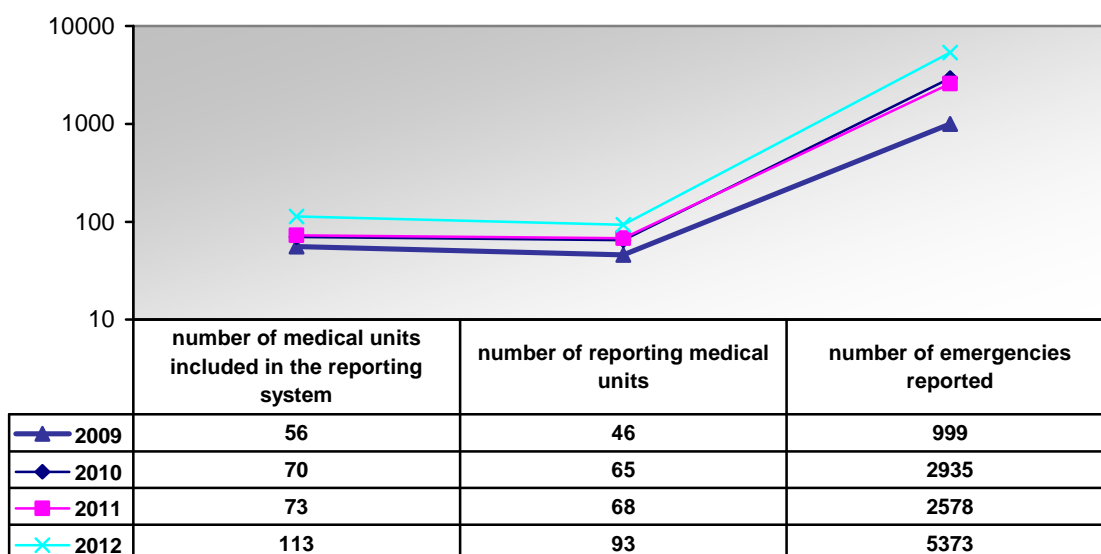
### 6.2.1 NON-FATAL MEDICAL EMERGENCIES CAUSED BY THE DRUG USE

#### A. Medical emergencies caused by psychoactive substance use (alcohol, medicines, illicit drugs, other psychoactive substances)

In 2012, the National Anti-drug Agency further improved the process of collecting data on medical emergencies caused by psychoactive substance use by:

- Updating and disseminating the Methodology for monitoring medical emergencies at national level;
- Involving the NAA territorial structures in collecting data on medical emergencies caused by drug use, by encouraging them to contact directly the data providers, to collect the standard forms and to introduce the data in the data base for medical emergencies caused by drug use;
- Extending the reporting system by including the municipal and city hospitals with emergency units or departments on the list of reporting entities;
- Improving the standard form for registering medical emergencies caused by psychoactive substance use, by introducing new fields, namely: „Educational level” and „Occupational status”.

**Chart no 6-29: Evolution of medical emergency data collection system 2009-2012 (no)**



Source: NAA

Thus, as a result of this increase in the number of reporting medical institutions (113 as compared to 73 in 2011), and of the improved data collection capacity, **5373 medical emergencies** caused by psychoactive substance abuse were reported in 2012. As opposed to the previous years, the database included medical emergency cases caused by alcohol use. This decision was made, on the one hand, due to the results of the recent studies conducted by the National Anti-drug Agency (see GPS 2010, ESPAD 2011, SPS 2011) which found that alcohol use is a risk factor in the onset of illicit drug use, and on the other hand due to the finding derived from the analysis of drug users characteristics, indicating that alcohol is present in almost 20% of the multiple drug use, ranking second, after NPSs, among the most used psychoactive substances in multiple drug use cases.

As opposed to 2011, when 2578 of medical emergency cases caused by psychoactive substance use were reported, in 2012 we notice that their number doubled. This significant difference may be explained both by the improvements in the data collecting system and by including the emergencies caused by alcohol use exclusively, which hold a significant percent in the total number of medical emergency cases reported (43%). Therefore, the analysis of medical emergencies caused by psychoactive substance use will consider the category of substances causing the emergency case and will focus first and foremost on the casuistry generated by illicit drug use, a category that will include the new psychoactive substances (NPS) as well.

With regards to the type of use generating the medical emergency, the emergency cases reported may be grouped as follows: 43.1% were generated exclusively by alcohol use; 27.2% were registered following health problems induced by illicit drug use; 13.3% of the medical emergencies caused by psychoactive substance use were due to the exclusive and excessive use of medicines; 13.2% of the cases were caused by multiple drug use; in 2.2% of the cases the medical emergency was caused by the use of unknown substances, and in 1% of the cases there were requests to harvest biological testing material for toxicological tests.

In comparison with the previous year, we note the following:

- An increase by 48.9% of the number of medical emergency cases caused by multiple drug use;
- An increase by 0.4% of the number of medical emergency cases caused exclusively by illicit drug use;
- An increase by 95.9% of the number of medical emergency cases caused exclusively by medicine used without prescription;
- Almost 4 times increase of the number of people referred to the emergency units to have biological testing material harvested for toxicological tests;
- A decrease by 19.6% of the number of medical emergency cases caused exclusively by the use of unknown substances.

**Table no 6-12: Distribution of medical emergencies caused by psychoactive substance use, by use patterns; comparative data 2011-2012**

Type of use generating the medical emergency	2011	2012
Multiple drug use	476 (18.5%)	709 (13.2%)
Alcohol use exclusively	123 (4.3%)	2316 (43.1%)
Illicit drugs use exclusively	1455 (56.4)	1461(27.2%)
Medicines use exclusively	365 (14.2%)	715 (13.3%)
Unknown substances use exclusively	148 (5.7%)	119 (2.2%)
Harvesting of biological material	11 (0.4%)	53 (1.0%)
Total	<b>2578 (100.0%)</b>	<b>5373 (100.0%)</b>

Source: NAA

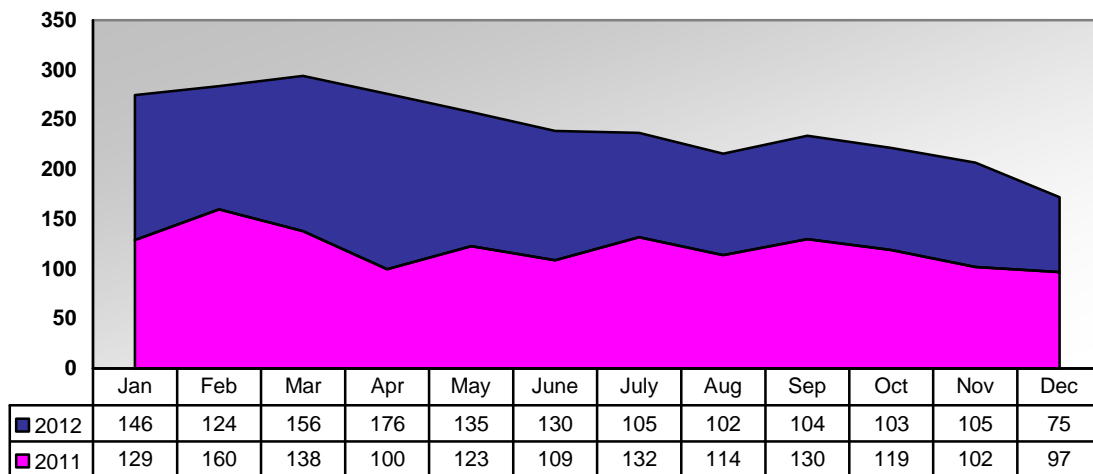
### **B. Medical emergencies caused by illicit drug use (including NPS)**

At national level, the analysis of medical emergency cases caused exclusively by illicit drug use (including NSP), as reported by the health care institutions in 2012, indicates a slight increase by 0.4% of the number of cases registered, as compared to the previous year. The most significant increase was registered in April, when the number of cases registered was almost double as compared to the same month of the previous year. Conversely, there are six months (February, July, August, September, October, and December) when the number of cases registered was lower than during the same months of the previous year.

In order to conduct an analysis of the medical emergencies caused by the use of illicit drugs, according to the category of substances used, we used a classification of such substances, as follows:

- The „cannabis” category includes: cannabis, hashish, THC;
- The „opiate” category includes: heroin, methadone, opium, tramadol, morphine, codeine, naloxone or other substances generally called “opiate” or “opioid”;
- The hallucinogens category includes: ketamine, LSD, PCP, or other substances generally called “hallucinogens”;
- The stimulants category includes: amphetamines, metamphetamines, ecstasy/ MDMA;
- The substances considered “illicit drugs”, “psychotropic substances”, “psychoactive substances”, were included in the “generic drugs” category.

**Chart 6- 30: Evolution of medical emergencies caused exclusively by the use of illicit drugs, by month, data compared 2011-2012 (number of cases)**



*Note: the chart does not include the cases where the medical emergency registration month was not specified*  
*Source: NAA*

### **Sociodemographic characteristics**

The medical emergencies caused by illicit drug use reported in 2012 show an unbalanced gender distribution – 80.9% male, as compared with 19.1% female.

In terms of age and gender, the cases registered in 2012 by the emergency units of reporting hospitals had the following characteristics:

- Most cases (89.5%) are under 34 years old, 10% are aged 35-54, and the others (0.6%) are over 54 (the analysis excluded cases where age was reported);
- The average age is 25.07, slightly older for males (25.26) than for females (24.42);
- Both for male and female, the age group registering most cases is 15-24 (46.5% men, and 57.3% women, respectively).

With regards to the breakdown by age group, we noticed a decrease in the percentage people under 35 reported by medical emergency units: 89.4% in 2012, as compared to 92.2% in 2011. We also noticed an increase in the percentage of men under 34 (90.2%), as compared to women in the same age group (86.5%).

With regards to the breakdown by age group, the men/women ration is obviously dominated by men for people under 39 (reaching a maximum of 6.7:1 for the age group 25-34). Instead, for people over 64, the ratio is 4 women for 1 man.

Although in case of the youngest patients admitted to the emergency units for illicit drug use there were cases of accidental intake, the cases registered are worth mentioning:

- Patient aged 2 – accidental drug intake, the child ingested the father’s methadone (drug addict father), kept in a bottle of *Sprite* and 2 cases of accidental ingestion of diluent;
- Patient aged 4 – accidental opiate intake (no mentioning of substance ingested);
- Patient aged 5 – accidental diluent intake;
- Patient aged 8 – accidental drug intake (no mentioning of substance ingested), but the case history and the psychological test indicate that the mother administered the child drug intravenously.

If we exclude the medical emergency cases mentioned above, as accidental intake of illicit drugs, the overall image of drug use, by gender, among the youngest patients is as follows: the youngest male patient to be admitted to an emergency unit following illicit drug intake had consumed volatile solvents and was 9 years old while the youngest female patient was 8 and requested emergency help for high risk drug use “for a month”, with no mentioning of the type of drugs.

**Table 6-13: Distribution of emergency cases reporting illicit drug use in 2012, by age group and category of substances consumed 2012 (exclusive use as compared to multiple drug use)**

Substance consumed	Youngest age for exclusive use	Youngest age for multiple drug use
<b>NPS</b>	10 years old	10 years old
<b>Opiates</b>	14 years old	11 years old
Heroin	21 years old	15 years old
Methadone	16 years old	16 years old
<b>Cannabis</b>	13 years old	13 years old
<b>Hallucinogens</b>	13 years old	13 years old
PCP	20 years old	15 years old
Ketamine	26 years old	19 years old
LSD	-	20 years old
<b>Stimulants</b>	15 years old	11 years old
Amphetamines/ metamphetamines	15 years old	11 years old
Ecstasy/ MDMA	-	17 years old
<b>Cocaine</b>	15 years old	14 years old
<b>Volatile solvents</b>	9 years old	9 years old
<b>Generic drugs</b>	8 years old	13 years old

Source: NAA

According to the category of substance used, we have the following situation: the youngest patient admitted to an emergency unit following illicit drug use was 8 years old and declared drug use without indicating the substance. The next patient, age-wise, had consumed volatile solvents and was 9 years old. Then we have exclusive NPS use, in 10-year-old patients; cannabis and hallucinogens – for 13-year-old patients and opiates intake for 14-year-old patients; stimulants, amphetamine/methamphetamine and cocaine intake – reported for 15-year-old patients, methadone use – reported for 16-year-old patients, PCP use – 20-year-old patients, heroin use – 21-year-old patients and ketamine use – 26-year-old patients. Mention should be made that in case of multiple drug use involving various psychoactive substances the age of the youngest patients admitted to emergency units is generally smaller than in cases of one-substance use.

In terms of gender, there are significant differences in case of exclusive use of opiates, heroin and methadone respectively, the female patients admitted to emergency medical services being twice as many as the male patients. There are also gender differences in case of:

- Exclusive use of cannabis, with more male users;
- Exclusive use of stimulants, exclusive use of amphetamines/ metamphetamines, and exclusive use of cocaine, with a dominance of female users.

For the other categories of drugs there are no significant differences by user gender.

**Table 6-14: Distribution of emergency cases reporting illicit drug use in 2012, by gender and category of substances consumed (exclusive use)**

Substance consumed	Male	Female	Total
<b>NPS</b>	68.5%	66.3%	68.1%
<b>Opiates</b>	7.6%	11.7%	8.4%
Heroin	4.4%	7.1%	4.9%
Methadone	1.5%	2.5%	1.7%
<b>Cannabis</b>	11.6%	8.2%	10.9%
<b>Hallucinogens</b>	3.0%	2.8%	3.0%
PCP	0.3%	0.0%	0.2%
Ketamine	0.2%	0.0%	0.1%
LSD	0.0%	0.0%	0.0%
<b>Stimulants</b>	0.4%	1.4%	0.6%
Amphetamines/ metamphetamines	0.4%	1.4%	0.6%
Ecstasy/ MDMA	1.4%	1.8%	1.5%
<b>Cocaine</b>	1.0%	1.8%	1.2%
<b>Volatile solvents</b>	2.3%	3.2%	2.5%
<b>Generic drugs</b>	5.5%	4.6%	5.4%

Source: NAA

The distribution of medical emergencies generated by illicit drug use, by age group and substance is as follows:

- **NPS:** 90.6% of the persons admitted to the emergency units due to health problems caused by exclusive NPS use were under 34;
- **Opiates:** most (84.6%) medical emergencies reporting exclusive opiate use involved persons under 34— approximately a quarter (23.9%) were under 24 and 60.7% belonged to the age group 25-34, while 15.4% were between 35 and 54;
- **Heroin:** the vast majority of patients admitted to medical emergency services following exclusive heroin use belonged to the age group 15-34 – 82.4%, while only 17.6% were between 35 and 54;
- **Methadone:** just like with heroin, the vast majority of patients admitted to medical emergency services following exclusive methadone use belonged to the age group 15-34 – 87%, while only 13% were between 35 and 54;
- **Cannabis:** 61.3% of the emergency cases reporting exclusive cannabis use involved persons under 24; 29.7% were between 25 and 34, while 9% belonged to the age group 35-54;
- **Hallucinogens:** more than half (57.9%) of the emergency cases reporting exclusive use of hallucinogens involved persons under 24, and more than one third of the cases (36.8%) involved persons between 25 and 44;
- **Stimulants:** more than three quarters (77%) of the emergency cases reporting exclusive use of stimulants involved persons under 24, and the rest of the cases (22.2%) involved persons between 25 and 34;
- **Cocaine:** more than half (52.9%) of the persons admitted to the emergency units due to health problems caused by exclusive cocaine use were under 24, while approximately one third (35.3%) belonged to the age group 25-34, and 11.8% were between 35 and 44;
- **Volatile solvents:** most medical emergencies reporting exclusive use of volatile solvents involved very young persons (82.4%) under 24, while 14.7% of the cases belonged to the age group 25-44;
- **Generic drugs:** 85.5% of the medical emergencies reporting exclusive use of generic drugs involved persons under 34, while 14.5% of the cases belonged to the age group 35-64.

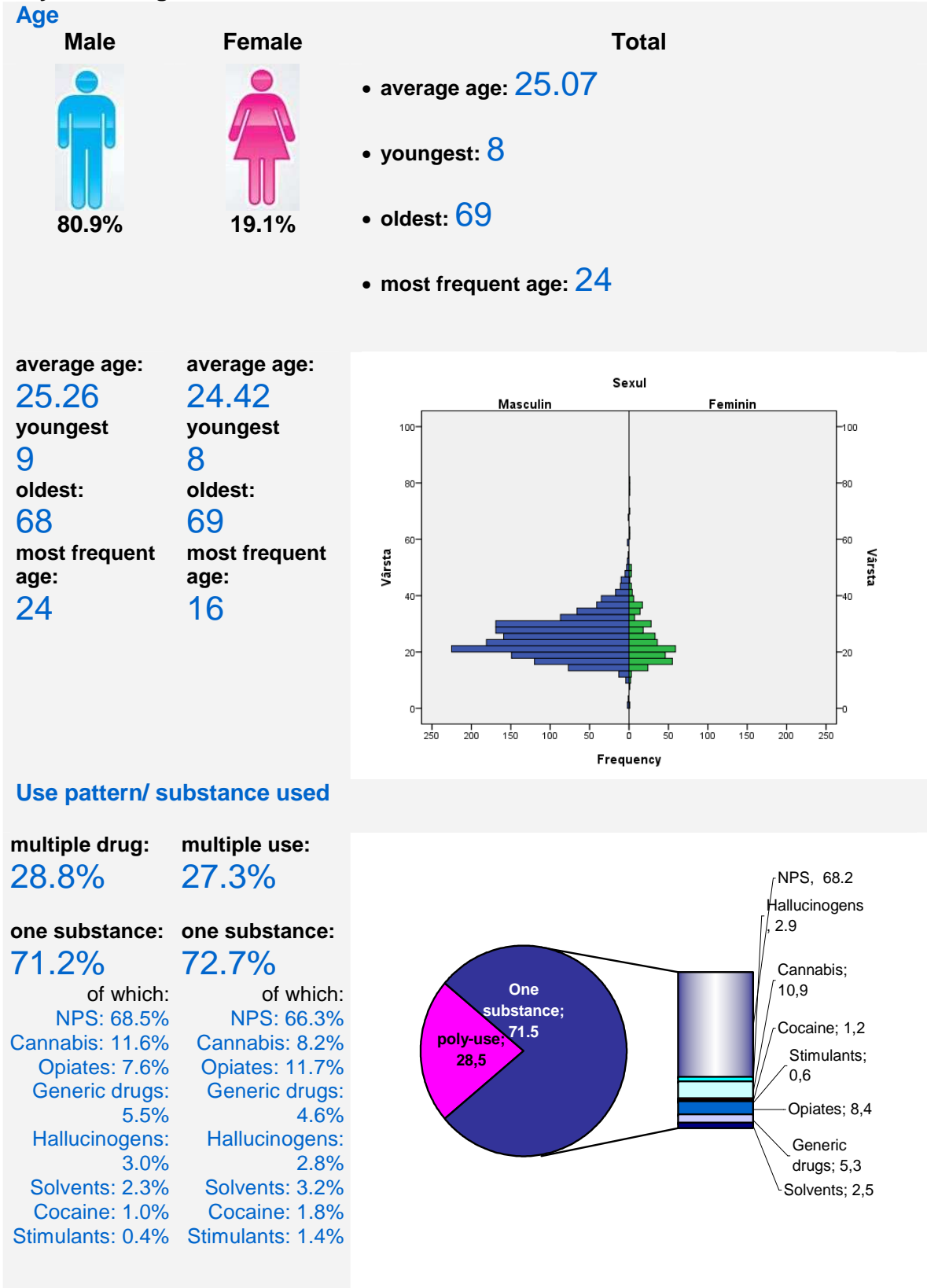
**Table 6-15: Distribution of emergency cases reporting exclusive use of illicit drugs in 2012, by age group and category of substance (%)**

Substance used	Age groups							Total
	under 15	15-24	25-34	35-44	45-54	55-64	over 64	
<b>NPS</b>	4.0	52.0	34.5	8.4	1.1	0.0	0.0	100
<b>Opiates</b>	2.6	21.4	60.7	13.7	1.7	0.0	0.0	100
Heroin	0.0	20.6	61.8	16.2	1.5	0.0	0.0	100
Methadone	4.3	21.7	60.9	13.0	0.0	0.0	0.0	100
<b>Cannabis</b>	1.9	59.4	29.7	7.7	1.3	0.0	0.0	100
<b>Hallucinogens</b>	5.3	52.6	34.2	2.6	2.6	0.0	2.6	100
<b>Stimulants</b>	0.0	77.8	22.2	0.0	0.0	0.0	0.0	100
Cocaine	0.0	52.9	35.3	11.8	0.0	0.0	0.0	100
<b>Volatile solvents</b>	29.4	52.9	11.8	2.9	0.0	0.0	2.9	100
<b>Generic drugs</b>	4.3	43.5	37.7	11.6	1.4	1.4	0.0	100

Source: NAA

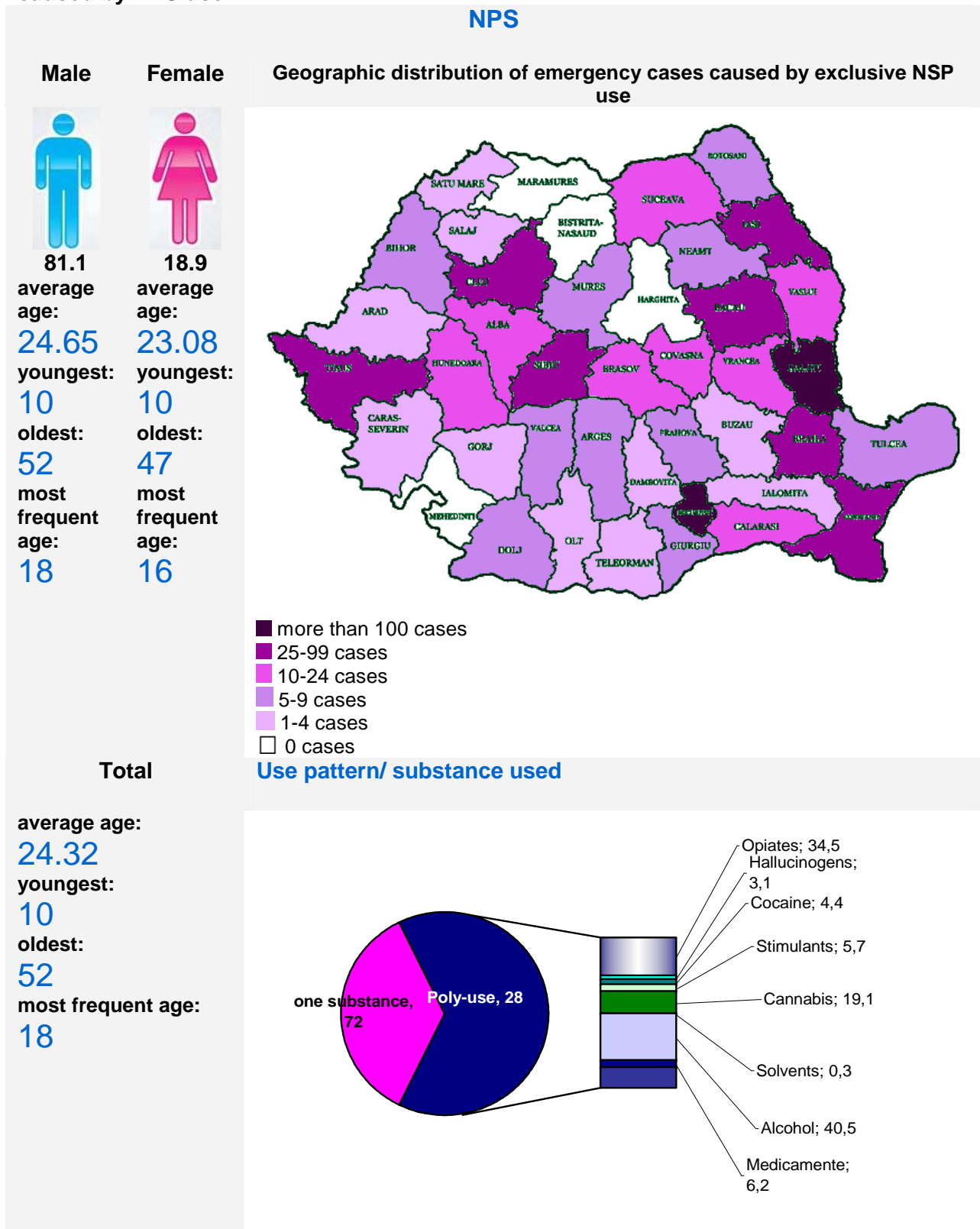


**Chart 6 - 31: Characteristics of persons admitted to emergency units for health problems caused by illicit drug use**



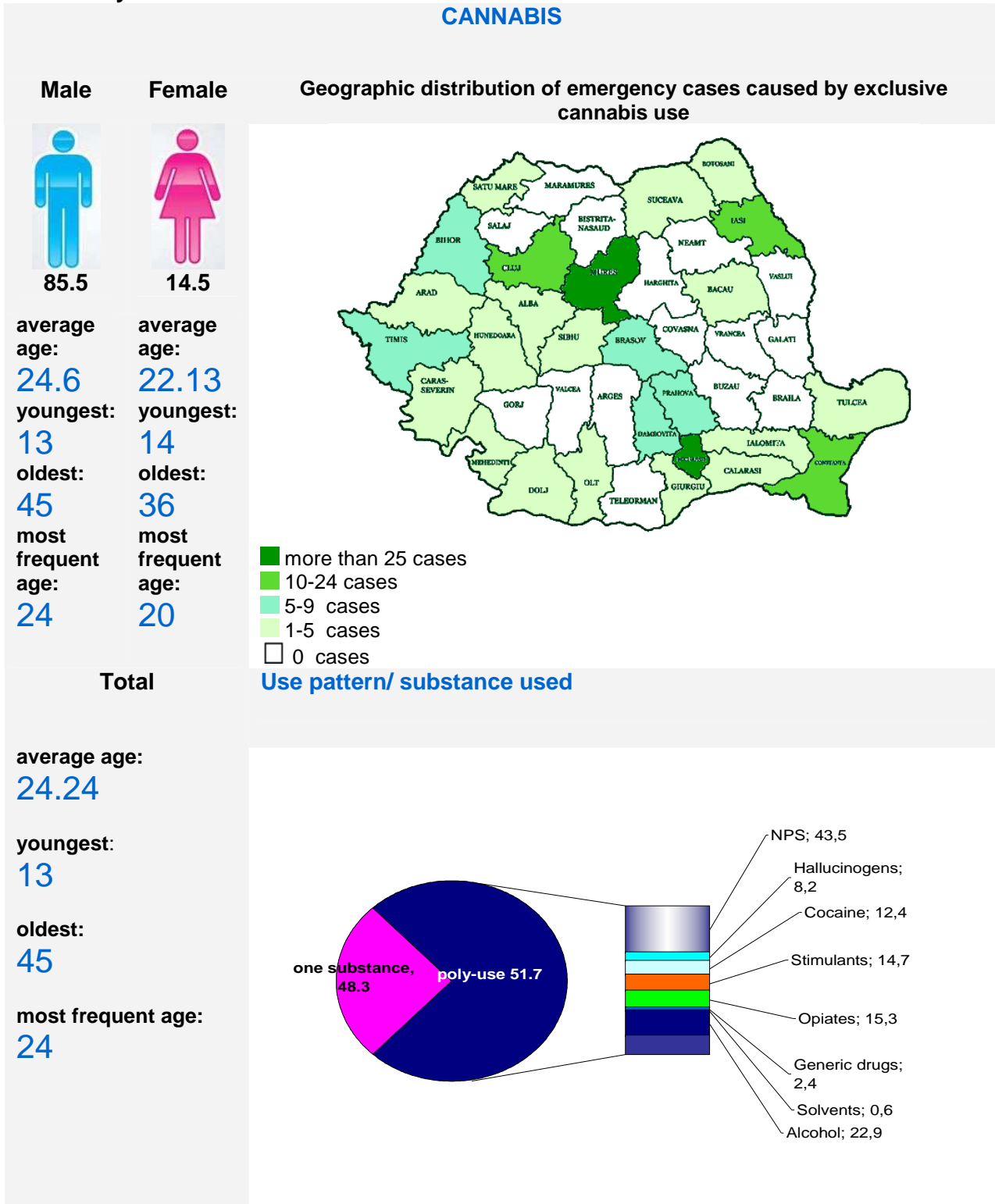
Source: NAA

Chart 6 - 32: Characteristics of persons admitted to emergency units for health problems caused by NPS use



Source: NAA

Chart 6 - 33: Characteristics of persons admitted to emergency units for health problems caused by cannabis use



Sursa: NAA

Chart 6-34: Characteristics of persons admitted to emergency units for health problems caused by opiate use

OPIATES

Male

Female



73

27

average age:

average age:

28.99

28.1

youngest:

youngest:

14

11

oldest:

oldest:

68

63

most frequent age:

most frequent age:

28

25

Total

average age:

28.76

youngest:

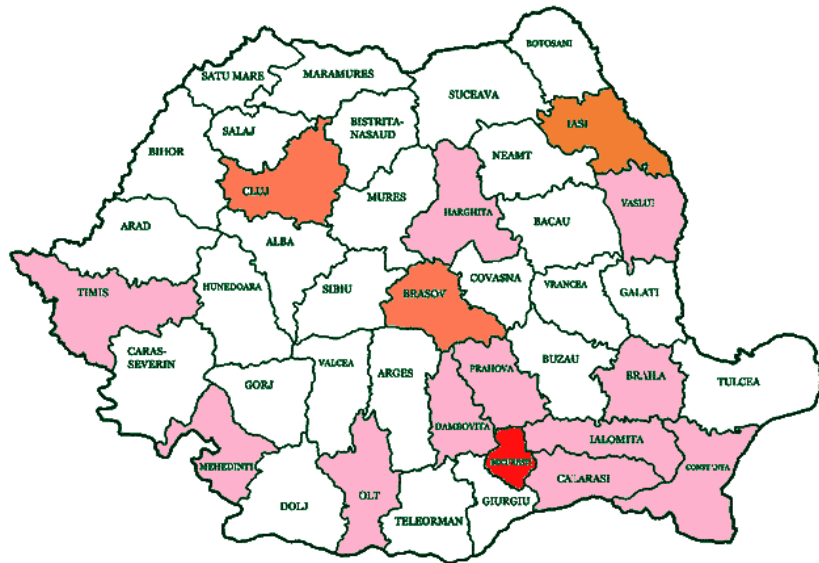
11

oldest:

68

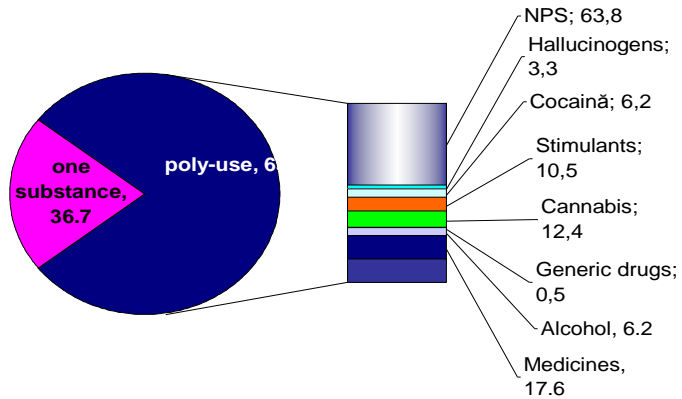
most frequent age: 28

Geographic distribution of emergency cases caused by exclusive opiate use



- more than 10 cases
- 6-9 cases
- 3-5 cases
- 1-2 cases
- 0 cases

Use pattern/ substance used



Source: NAA

## Pattern of use

With regards to the use pattern, more than two thirds of the emergency cases generated by illicit drug use reported exclusive use of one of the various psychoactive substances (71.5%), while 28.5% of the cases reported multiple drug use. There are no significant gender differences with regards to the use pattern adopted: 71.2% of the men admitted to emergency units reported one substance use, while 72.7% had also use only one type of illicit substance.

Of the total number of medical emergencies caused by illicit drug use in 2012, 71.5% of the cases reported exclusive use of one psychoactive substance, while in 28.5% of the cases the medical emergencies were caused by multiple drug use.

Of the total number of cases reporting exclusive use of illicit drugs, 68.2% were caused by the use of new psychoactive substances (“ethnobotanicals”), 10.9% of the cases reported use of cannabis, and 8.4% reported opiate use (heroin, methadone or generic opiates). At the same time, 2.9% of the registered cases reported hallucinogen use; a similar percentage (2.5%) reported use of volatile solvents, 1.2% of the cases reported cocaine use, and 0.6% of the cases reported exclusive use of stimulants. 5.3% reported drug use generally, without mentioning the type of substance.

**Table 6-16: Use pattern reported for medical emergencies caused by illicit drug use, by category of substance, 2012 (%)**

Substance consumed	One substance	Multiple drug use
Cannabis	48.3%	51.7%
Opiates	36.7%	63.3%
Heroin	37%	63%
Methadone	35.8%	64.2%
NPS	72%	28%
Stimulants	12.2%	87.8%
Cocaine	27.4%	72.6%
Hallucinogens	57.3%	42.7%

Source: NAA

Although most medical emergencies caused by illicit drug use reported exclusive NPS use (68.2%), the lowest type of multiple drug use was reported for this type of use (only 28% of the total medical emergencies caused by NPS use). Nevertheless, the level of multiple drug use is much higher for other types of drugs, exceeding 50% in most cases:

- **Cannabis** was reported in 51.7% cases of multiple drug use, the most frequent combinations including NPS – 43.5% of the total multiple drug use cases, and alcohol – 22.9%;
- **Opiates** were mentioned as part of multiple drug use in 63.3% of the emergency cases caused by opiate use; most frequently they were used in combination with NPS – 63.8% of the total multiple drug use cases, and with various medicines – 17.6%;
- **Heroin** was reported as part of multiple drug use in 63% of the cases, the most frequent combinations including NPS – 75.2% of the total multiple drug use cases, and methadone – 14%;
- **Methadone** was reported as part of multiple drug use in 64.2% of the emergency cases caused by methadone use; the most frequent combinations included heroin – 40% of the methadone multiple drug use cases, and NPS – 34.9%;
- **NPS** – although NPSs are present in multiple drug use for many of the substances analysed, the most frequent combinations include alcohol – in 40.5% of NPS multiple drug use, and opiates – 34.5%;
- **Stimulants** – they hold the highest rate in the cases of reported multiple drug use – 87.8% of the total emergency cases reported use of stimulants; the most frequent combinations included cannabis – 38.5% of the total multiple drug use cases, opiates and NPSs – 33.8%;
- **Cocaine** - was reported as part of multiple drug use in 72.6% of the cases, the most frequent combinations including cannabis – 46.7% of the total multiple drug use cases, and NPSs – 37.8%;
- **Hallucinogens** were reported as part of multiple drug use in 42.7% of the emergency cases caused by hallucinogen use; the most frequent combinations included cannabis – 43.8% of the total multiple drug use cases, and NPSs – 37.5%.

**Table 6-17: Distribution of medical emergencies caused by exclusive use of illicit drugs reported in 2012, by substance (%)**

Exclusive use of:	2011	2012	increase/ decrease
NPS	1115	996	-10.7%
Cannabis	96	159	65.6%
Opiates	81	122	50.6%
Generic drugs	54	78	44.4%
Hallucinogens	67	43	-35.8%
Solvents	15	37	146.7%
Cocaine	17	17	0.0%
Stimulants	10	9	-10.0%
Total	1455	1461	0.4%

Source: NAA

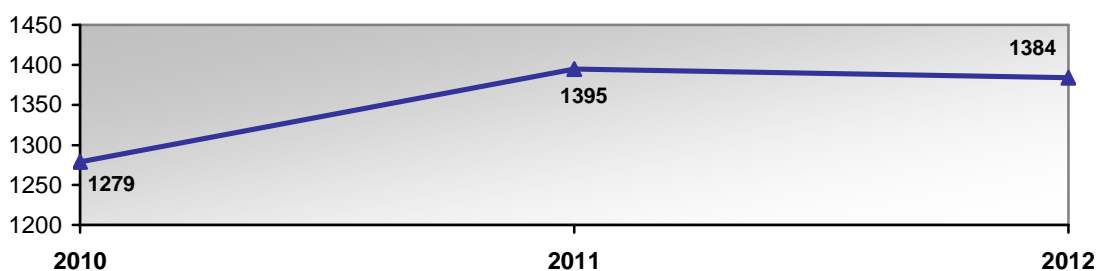
In terms of medical emergencies caused by exclusive use of illicit drugs, as compared to 2011 we may note the following:

- **Increase:**
  - Increase by 65.6% of the number of medical emergency cases caused by exclusive use of cannabis;
  - Increase by 50.6% of the number of medical emergency cases caused by exclusive use of opiates;
  - Increase by 44.4% of the number of medical emergency cases caused by exclusive use of generic drugs;
  - Increase by 146.7% of the number of medical emergency cases caused by exclusive use of volatile solvents.
- **Constant:**
  - Maintained number of medical emergency cases caused by exclusive use of cocaine;
- **Decrease:**
  - Decrease by 10.7% of the number of medical emergency cases caused by exclusive use of NPSs;
  - Decrease by 35.8% of the number of medical emergency cases caused by exclusive use of hallucinogens;
  - Decrease by 10% of the number of medical emergency cases caused by exclusive use of stimulants.

The decrease by 10.7% of the medical emergency cases caused by exclusive use of NPSs, correlated with the same number of medical emergency cases reporting NPS use (either exclusive or multiple drug use) indicates an increase of the number of medical emergency cases caused by multiple drug use involving illicit substances, among which NPSs.

As compared to previous years, the emergency casuistry generated by NPS use (either exclusive or multiple drug use) was maintained to the same level in 2012.

**Chart 6-35: Evolution of medical emergencies caused by NPS use (either exclusive or multiple drug use), by month, data compared 2010-2012 (number of cases)**



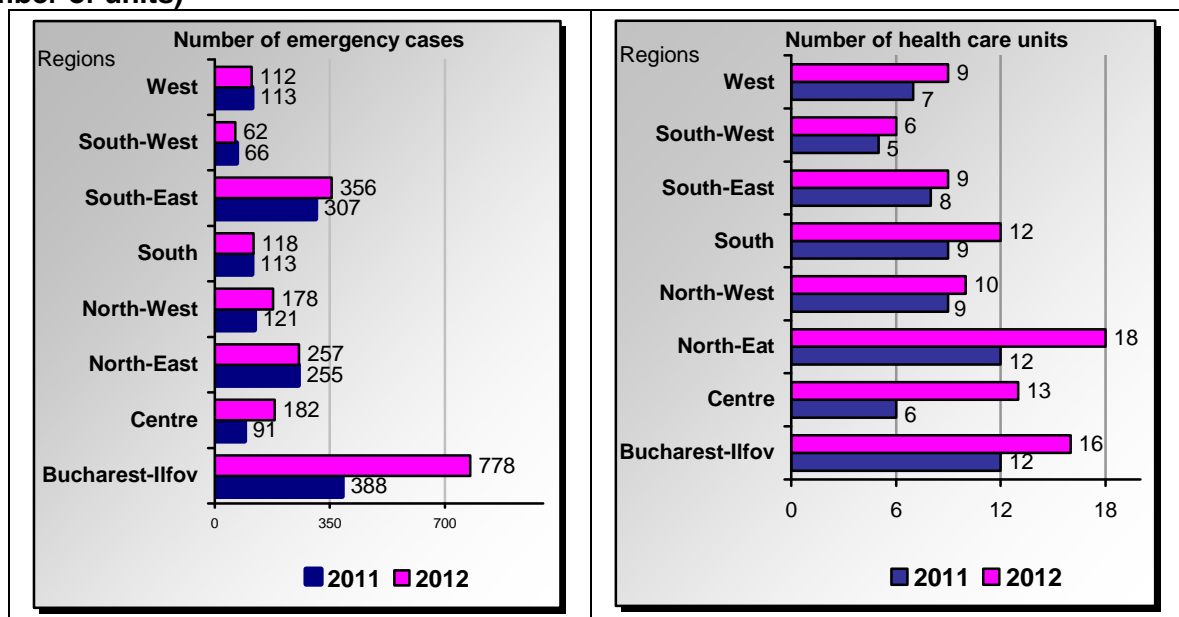
Source: NAA

## Casualty distribution by economic development region

According to the economic development region reporting the medical emergency caused by exclusive use of illicit drugs, the situation in 2012 is as follows:

- North-West (Bihar, Bistrița Năsăud, Cluj, Maramureș, Sălaj, Satu Mare) - 178 cases;
- West (Arad, Caraș Severin, Hunedoara, Timiș) – 112 cases;
- North-East (Botoșani, Suceava, Iași, Neamț, Bacău, Vaslui) – 257 cases;
- South-East (Vrancea, Galați, Buzău, Brăila, Constanța, Tulcea) – 356 cases;
- Centre (Mureș, Harghita, Alba, Sibiu, Brașov, Covasna) – 182 cases;
- South-West (Gorj, Vâlcea, Olt, Mehedinți, Dolj) – 112 cases;
- South (Argeș, Dâmbovița, Prahova, Ialomița, Călărași, Giurgiu, Teleorman) – 118 cases;
- Bucharest-Ilfov (Bucharest Municipality and Ilfov County) – 778 cases.

**Chart 6-36: Distribution of medical emergencies caused by psychoactive substance use and of reporting health care units, in 2011-2012, by economic development region (number of cases/number of units)**



Source: NAA

In comparison with the increase by 37% of the number of reporting health care units in 2012, the casualty of medical emergencies caused by illicit drug use is maintained at the level reported for the previous year, registering just a slight increase by 0.4%. We noted the following evolution of the two indicators analysed (number of cases/number of reporting health care units) by economic development region:

- Bucharest-Ilfov Region:
  - Increase by 1% of the number of cases;
  - Increase by 0.3% of the number of reporting health care units;
- Centre Region:
  - Increase by 1.0% of the number of cases;
  - Increase by 1.2% of the number of reporting health care units;
- North-East Region:
  - Increase by 0.1% of the number of cases;
  - Increase by 0.5% of the number of reporting health care units;
- North-West Region:
  - Increase by 0.5% of the number of cases;
  - Increase by 0.1% of the number of reporting health care units;
- South Region:
  - Increase by 0.04% of the number of cases;
  - Increase by 0.3% of the number of reporting health care units;
- South-East Region:

- Increase by 0.2% of the number of cases;
- Increase by 0.1% of the number of reporting health care units;
- South-West Region:
  - Decrease by 0.1% of the number of cases;
  - Increase by 0.2% of the number of reporting health care units;
- West Region:
  - Decrease by 0.01% of the number of cases;
  - Increase by 0.3% of the number of reporting health care units.

We note that, although there was a significant increase of the number of reporting health care units, this did not lead to significant changes in the emergency casuistry reported for the reference year. Moreover, the emergency casuistry reported by the newly added health care units is not significant.

The analysis of medical emergency distribution in the territorial-administrative units of the country, according to the risk zones identified according to the number of emergency cases reported leads to the following areas:

**Table 6-18: Delimitation of risk areas at county level, according to the number of medical emergency cases caused by illicit drug use, registered in 2012**

County	Area
Bucharest	<b>VERY HIGH RISK AREA</b> (more than 10%)
Cluj, Galați, Iași	<b>HIGH RISK AREA</b> (5% to 9.9%)
Timiș, Mureș, Brăila, Constanța, Bihor, Bacău, Sibiu, Prahova, Botoșani, Brașov, Tulcea, Dolj, Argeș, Alba, Vâlcea	<b>MODERATE RISK AREA</b> (1% to 4.9%)
Hunedoara, Dâmbovița, Neamț, Giurgiu, Ialomița, Călărași, Covasna, Vaslui, Arad, Vrancea, Olt, Buzău, Suceava	<b>LOW RISK AREA</b> (0.5% to 0.9%)
Mehedinți, Satu-Mare, Teleorman, Caraș-Severin, Harghita, Sălaj, Gorj, Maramureș, Bistrița Năsăud, Ilfov	<b>VERY LOW RISK AREA</b> (below 0.5%)

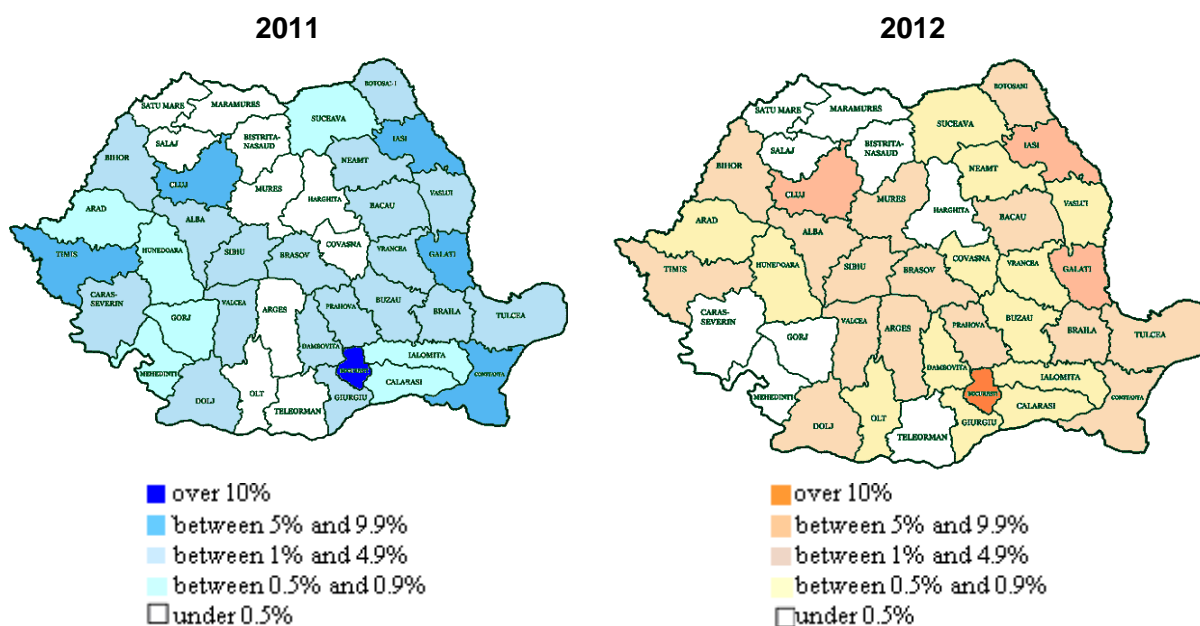
Source: NAA

Mention should be made that only in Bucharest Municipality the percentage of medical emergencies caused by illicit drug use is 38.1%, while only 3 counties (Galați, Cluj, Iași) registered percentages from 5% to 9.9%. Thus, a territorial segment made of only 4 territorial-administrative units accumulated more than half (58.8%) of the total number of medical emergencies caused by illicit drug use.

At the same time, other 15 counties (Timiș, Mureș, Brăila, Constanța, Bihor, Bacău, Sibiu, Prahova, Botoșani, Brașov, Tulcea, Dolj, Argeș, Alba, Vâlcea) grouped in the moderate risk area (1% to 4.9%) cumulate more than a quarter of the total number of cases (31.9%), while the low risk area (0.5% to 0.9%) included 11 counties in 2012 and cumulated only 7.1% of the total number of medical emergencies. On the other hand, the very low risk area consisting of the other 12 counties accounts for only 2.1% of the number of medical emergencies caused by illicit drug use registered in 2012.



**Map 6-1: Geographic distribution of emergency cases caused by illicit drug use, comparative analysis 2011-2012**



Source: NAA

As compared to the previous year, we note the decrease of the number of counties registering rates of 5 to 9.9% of emergency cases caused by illicit drug use (from 4 to 3 counties) and of the number of counties with rates of 1 to 4.9% (from 17 counties to 15 counties), together with an increase of the number of counties with less than 1% emergency cases (from 16 to 22 counties). This change suggests a limitation of the territorial area to 19 counties where the casuistry of medical emergencies caused by illegal drug use is significant, as well as the existence in each economic development region of „problem nuclei” which induce a seemingly uniform use of illicit drugs at country level, while the phenomenon is actually concentrated only in several counties.

### Typology of medical diagnosis

In order to perform an analysis of the casuistry of medical emergencies caused by illegal drug use, according to the emergency diagnosis, we grouped the emergency diagnoses according to the ICD 10 classification recommended by WHO (International Statistical Classification of Diseases and Related Health Problems 10th Revision).

Generally, the emergency diagnoses that may be registered in the medical emergencies caused by use of psychoactive substances belong to the category „Mental and behavioural disorders due to psychoactive substance use” (F10-F19). This category contains a wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed. The identification of the psychoactive substance should be based on as many sources of information as possible. These include self-report data, analysis of blood and other body fluids, characteristic physical and psychological symptoms, clinical signs and behaviour, and other evidence such as a drug being in the patient's possession or reports from informed third parties. Many drug users take more than one type of psychoactive substance. The main diagnosis should be classified, whenever possible, according to the substance or class of substances that has caused or contributed most to the presenting clinical syndrome.

Starting from these considerations, the diagnoses reported by doctors in the standard form for medical emergency caused by psychoactive substance use were classified as follows:

- **Acute intoxication:** A group of diagnoses where the disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. Complications may include trauma, inhalation of

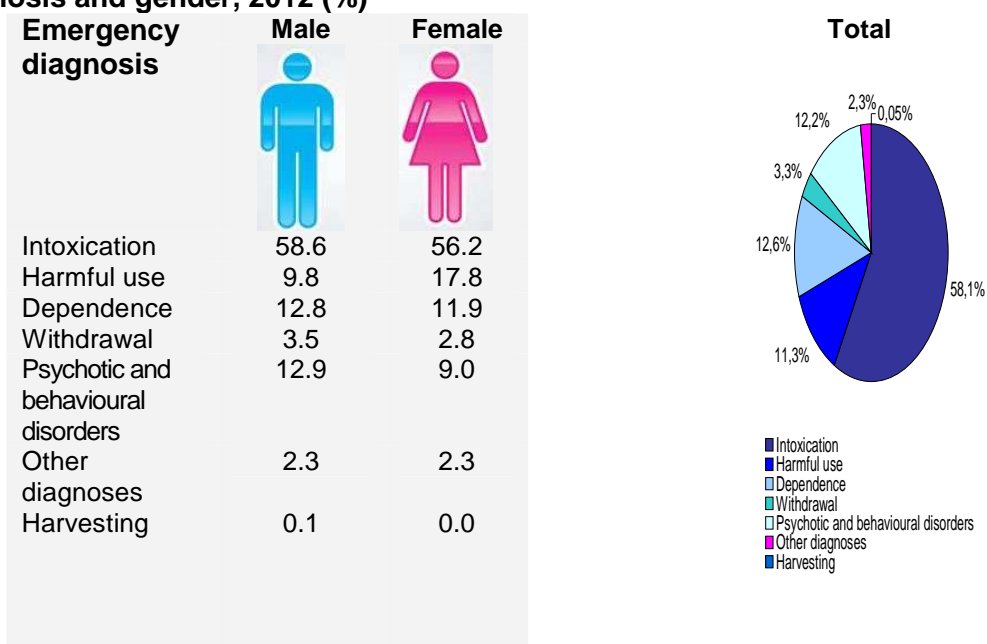
vomitus, delirium, coma, convulsions, and other medical complications. The nature of these complications depends on the pharmacological class of substance and mode of administration.

- **Harmful use:** A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy use of alcohol).
- **Dependence syndrome:** A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances.
- **Withdrawal state:** A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a psychoactive substance, after persistent use of that substance. The onset and course of the withdrawal state are time-limited and are related to the type of psychoactive substance and dose being used immediately before cessation or reduction of use. The withdrawal state may be complicated by convulsions or by withdrawal state with delirium.
- **Psychotic disorder:** A cluster of psychotic phenomena that occur during or following psychoactive substance use but that are not explained on the basis of acute intoxication alone and do not form part of a withdrawal state. The disorder is characterized by hallucinations (typically auditory, but often in more than one sensory modality), perceptual distortions, delusions (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor), and an abnormal affect, which may range from intense fear to ecstasy. Here are included personality or behavioural disorders persisting beyond the effect of the psychoactive substance used.
- **Other diagnoses:** A class of diagnoses induced or determined by psychoactive substance use, such as: self-inflicted wound or trauma, accidents and other external causes.
- **Harvesting of biological material:** cases that come to emergency health care units for harvest of biological testing material for toxicological studies.

With regards to the symptoms of the emergency cases reported we note that of the 2,043 cases, 58.1% were due to acute intoxications with illicit drugs, 11.3% were caused by the harmful use of various illicit substances, 12.6% were registered as dependence syndrome, 3.3% were withdrawal state, 12.2% were psychotic and behavioural disorders, and 2.3% had other diagnoses but were induced or determined by psychoactive substance use (self-inflicted wound or trauma, accidents and other external causes). In 0.05% of the emergency cases reported for illicit drug use there was a request to harvest biological testing material for toxicological studies. Although most of the emergency cases analysed were diagnosed as „intoxication”, which might induce the conclusion of occasional drug use, in 39.1% of the medical emergencies caused by illicit drug use the emergency diagnoses indicated regular illicit drug use, as they involved conditions which become manifest after a longer period of use (e.g.: hepatitis B and C, HIV infection, dependence, withdrawal, psychotic and behavioural disorders).

There are no significant gender differences for most emergency diagnoses, except for the harmful use, where female incidence was almost twice as high as the male incidence.

**Chart 6-37: Distribution of medical emergencies caused by illicit drug use, by emergency diagnosis and gender, 2012 (%)**



Source: NAA

According to the typology of the emergency diagnosis established for the medical emergency caused exclusively by illicit drug use, if we consider an equal distribution of individuals for each use type we note the following:

- Most emergency cases diagnosed as “intoxication” occurred among users who declared exclusive use of cannabis (registered the highest adjusted value among the registered and expected values: 3.3), while the least represented category of users for this type of diagnostic was represented by the opiate users (-9.9);
- “Harmful use” diagnoses were dominant for opiate users (5.7), with a lowest level among cannabis users (-2.6);
- Opiate users were best represented in the “dependence” diagnoses (5.2), while cannabis users were least represented in this category (-3.0);
- Most cases diagnosed as “withdrawal state” involved opiate users (11.2), while the lowest number of such diagnoses was noted for NPS users (-3.7);
- “Mental and behavioural disorders” were diagnosed especially among NPS and stimulant users (1.0), as opposed to opiate users (-1.8);
- Other diagnoses were present especially among cannabis users (2.3), and the lowest number of diagnoses in this category was reported among NPS users (-1.4).

According to the psychoactive substance used, the emergency diagnosis typology has the following characteristics:

- **Cannabis:** the most common diagnostic for emergency cases reporting exclusive cannabis use was “intoxication” (73%). Second come cases diagnosed as “mental and behavioural disorders” (11.3%), followed by “harmful use” cases (5.7%), “other diagnoses” (5%) and “addiction” cases (3.8%);
- **Opiate:** the most common diagnostic for emergency cases reporting exclusive opiate use was “harmful use” (27.9%). Second come cases diagnosed as “dependence” (24.6%), followed by “withdrawal” cases (18.9%) and by “intoxication” (18.9%), by “mental and behavioural disorders” (6.6%) and “other diagnoses” (5%);
- **Heroin:** the most common diagnostic for emergency cases reporting exclusive heroin use was “dependence” (35.2%). Second come cases diagnosed as “harmful use” (22.5%) and “withdrawal” (22.5%), followed by “mental and behavioural disorders” (8.5%), “intoxication” (7%) and, finally, “other diagnoses” (4.2%);
- **Methadone:** the most common diagnostic for emergency cases reporting exclusive methadone use was “harmful use” (58.3%). Second come cases diagnosed as “intoxication” (29.2%), followed by “withdrawal”, “dependence”, and “mental and behavioural disorders” (each 4.2%);

- **NPSS:** the most common diagnostic for emergency cases reporting exclusive NPS use was “intoxication” (62.3%). Second come cases diagnosed as “mental and behavioural disorders” (12%), followed by “harmful use” (11.7%), “dependence” (10.1%), “other diagnoses” (2%) and “withdrawal” (1.7%);
- **Stimulants:** the most common diagnostic for emergency cases reporting exclusive stimulant use was “intoxication” (77.8%), while the rest were considered “mental and behavioural disorders” (22.2%);
- **Cocaine:** the most common diagnostic for emergency cases reporting exclusive cocaine use was “intoxication” (70.6%), while the rest were considered “mental and behavioural disorders” (17.6%) and “dependence” (11.8%);
- **Hallucinogens:** the most common diagnostic for emergency cases reporting exclusive hallucinogen use was “intoxication” (83.7%), while the rest were considered as follows: 7% “mental and behavioural disorders”, 4.7% “dependence”, 2.3% “harmful use”, and 2.3% “other diagnoses”;
- **Solvents:** the most common diagnostic for emergency cases reporting exclusive solvent use was “intoxication” (64.9%), while the rest were considered “mental and behavioural disorders” (16.2%), “harmful use” (13.5%) and “dependence” (5.4%);
- **Generic drugs:** the most common diagnostic for emergency cases reporting exclusive generic drug use was “intoxication” (61.5%), followed by “dependence” (15.4%), “harmful use”, and “mental and behavioural disorders” (10.3%), followed by “other diagnoses” (2.6%);

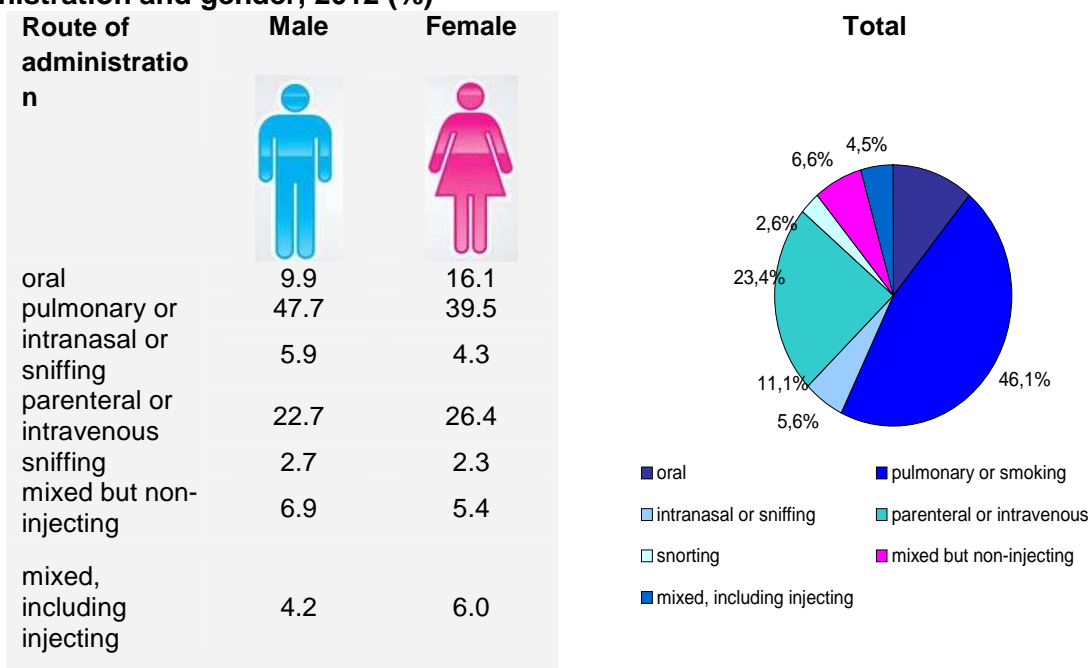
**Table 6-19: Distribution of medical emergencies caused by illicit drug use, by emergency diagnosis typology and by substance used, 2012 (%)**

Emergency diagnosis/ substance used	Intoxication	Harmful use	Dependence	Withdrawal	Mental and behavioural disorders	Other diagnoses	Harvesting
Cannabis	73.0	5.7	3.8	0.6	11.3	5.0	0.6
Opiate	18.9	27.9	24.6	18.9	6.6	3.3	0.0
Heroin	7.0	22.5	35.2	22.5	8.5	4.2	0.0
Methadone	29.2	58.3	4.2	4.2	4.2	0.0	0.0
NPS	62.3	11.7	10.1	1.7	12.0	2.0	0.0
Stimulants	77.8	0.0	0.0	0.0	22.2	0.0	0.0
Cocaine	70.6	0.0	11.8	0.0	17.6	0.0	0.0
Hallucinogens	83.7	2.3	4.7	0.0	7.0	2.3	0.0
Solvents	64.9	13.5	5.4	0.0	16.2	0.0	0.0
Generic drugs	61.5	10.3	15.4	0.0	10.3	2.6	0.0
Multiple drug use	58.5	8.0	15.6	3.9	12.0	2.0	0.0

Source: NAA

In case of multiple psychoactive substance use reporting use of at least one illicit drug, more than half of the emergency cases reporting such a use pattern were diagnosed with “intoxication” (58.5%). Second come cases diagnosed as “dependence” (15.6%), followed by “mental and behavioural disorders” (12%), “harmful use” (8%), and “withdrawal” (3.9%), while 2% of the medical emergencies reporting multiple drug use were diagnosed as “other diagnoses”.

**Chart 6-38: Distribution of medical emergencies caused by illicit drug use, by route of administration and gender, 2012 (%)**



Source: NAA

With regards to the route of administration of illicit drugs causing the medical emergency, we note that the 2012 casuistry was dominated by pulmonary administration or smoking, indicated in 46.1% of the cases, followed by the parenteral or intravenous administration, used by 23.4% of the emergency cases analysed. 5.6% of the cases used the intranasal administration or sniffing, while 2.6% of the patients indicated sniffing as route of administration; 1.2% reported mixed route of administration, including injecting. Only 1% of the cases administered the psychoactive substance using mixed non-injectable routes and 6.6% declared mixed, including injecting use.

**Table 6-20: Distribution of medical emergencies caused by illicit drug use, by route of administration and substance used, 2012 (%)**

Route of administration/ substance used	oral	pulmonary or smoking	intranasal or sniffing	parenteral or intravenous	sniffing	mixed but non- injecting	mixed, including injecting
Cannabis	0.0	97.6	2.4	0.0	0.0	0.0	0.0
Opiate	28.7	0.0	5.7	64.4	0.0	0.0	1.1
Heroin	1.9	0.0	7.7	88.5	0.0	0.0	1.9
Methadone	94.7	0.0	0.0	5.3	0.0	0.0	0.0
NPS	8.4	52.7	7.6	26.8	1.1	2.3	1.3
Stimulants	0.0	25.0	25.0	25.0	25.0	0.0	0.0
Cocaine	15.4	46.2	38.5	0.0	0.0	0.0	0.0
Hallucinogens	32.3	61.3	0.0	6.5	0.0	0.0	0.0
Solvents	0.0	0.0	0.0	0.0	100	0.0	0.0
Generic drugs	7.1	52.4	14.3	19.0	0.0	4.8	2.4

Source: NAA

The route of administration preferred, by psychoactive substance was as follows:

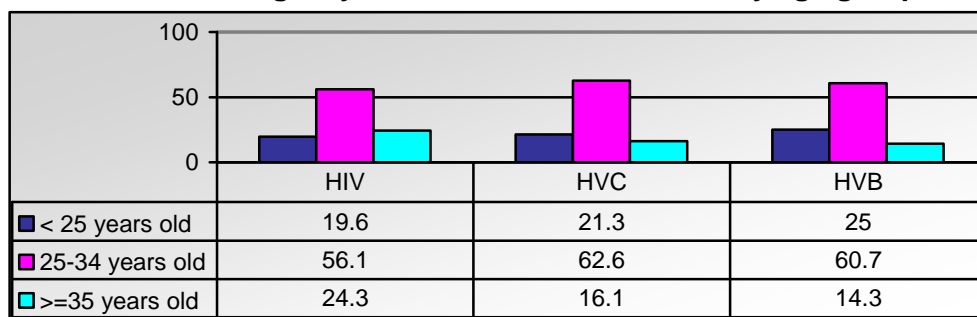
- **Cannabis:** in most emergency cases reporting exclusive cannabis use, the route of administration was pulmonary or smoking (97.6%);
- **Opiate:** in most emergency cases reporting exclusive opiate use, the route of administration was parenteral or intravenous (64.4%);
- **Heroin:** in most emergency cases reporting exclusive heroin use, the route of administration was parenteral or intravenous (88.5%);
- **Methadone:** in most emergency cases reporting exclusive methadone use, the route of administration was oral (94.7%);

- **NPS:** in more than half of the cases reporting exclusive NPS use the route of administration was pulmonary or smoking (52.7%);
- **Stimulants:** emergency cases reporting exclusive stimulants use used equally pulmonary administration or smoking, intranasal administration of sniffing, parenteral or intravenous administration and sniffing (25%);
- **Cocaine:** a significant percentage of emergency cases reporting exclusive cocaine use indicated that the route of administration was pulmonary or smoking (46.2%), while another important percentage indicated that the route of administration was intranasal or sniffing (38.5%);
- **Hallucinogens:** in most emergency cases reporting exclusive hallucinogen use, the route of administration was pulmonary or smoking (61.3%);
- **Solvents:** in most emergency cases reporting exclusive solvent use, the route of administration was only sniffing (100%);
- **Generic drugs:** in more than half of the cases reporting exclusive use of generic drugs, the route of administration was pulmonary or smoking (52.4%).

### C. Drug related infectious disease identified among medical emergencies caused by drug use

With regards to drug use related risks, 2012 witnessed an increase of the infectious disease incidence among people who turn to medical emergency services due to health problems caused by illicit drug use. Thus, medical emergencies caused by illicit drug use reported in 2012 indicated HIV, hepatitis B, C and D or TBC infections in 238 cases, as follows: 63.4% of the cases reported exclusive use of illicit drugs, of which 36.6% reported multiple drug use. Most emergency cases with HIV, HBV or HCV are under 34 years old: 75.7% of the HIV cases, 83.9% of the HCV cases and 85.7% of the HBV cases.

**Chart 6-39: Distribution of emergency cases with HIV, HBV, HCV by age group 2012 (%)**



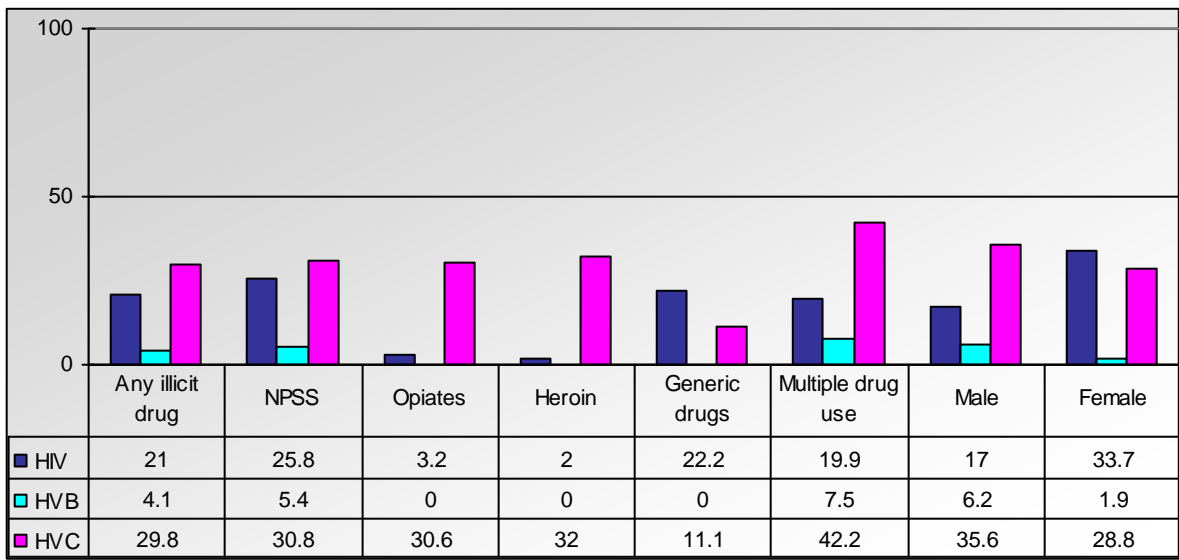
Source: NAA

While mentioning that not all registered emergency cases were tested for HIV, HCV, HBV infections, the HIV, HCV, HBV prevalence among persons who turned to emergency health care units due to illicit drug use and who reported injecting drug use is as follows:

- **HIV infection:** 21% HIV prevalence was reported among illicit drug users who reported injecting drug use of any type of illicit drug. The highest HIV prevalence was registered among users who reported exclusive injecting NPS use (25.8%). The HIV prevalence among users who reported injecting opiate use is 3.2%, including exclusive injecting heroin users for whom the HIV prevalence is 2%. High HIV prevalence was found among users who reported exclusive use of generic drugs (22.2%), and multiple drug use (19.9%). In HIV cases we noted that the prevalence is twice as high among female injecting drug users: 33.7% women as compared to 17% men;
- **HCV infection:** 29.8% HCV prevalence was reported among medical emergencies caused by injecting illicit drug use. The highest HCV prevalence was registered among users who reported multiple illicit drug use (42.2%), and injecting heroin use, respectively (32%). The HCV prevalence among users who reported exclusive injecting opiates use was 30.6%. The HCV prevalence among users reaching emergency health care units due to problems caused by injecting NPS use was 30.8%. The gender differences are insignificant for HCV prevalence: 35.6% male, 28.8% female.
- **HBV infection:** 4.1% HBV prevalence was reported among medical emergencies caused by injecting illicit drug use. The highest HBV prevalence was registered among users who reported injecting multiple illicit drug use HVB (7.5%). The HCV prevalence among users reaching emergency health care units due to problems caused exclusively by injecting NPS use was 5.4%. In terms of

gender differentiation, the HBV prevalence is three times higher among men: 6.2% male patients as compared to 1.9% female patients.

**Chart 6-40: Distribution of emergency cases reporting illicit drug use in 2012, by gender, presence of HIV, HVB, HVC infections and category of substance used 2012 (%)**



Source: NAA

**D. Other drug-related health correlates and consequences, reported among medical emergency cases**

With regards to other correlates and consequences of the psychoactive substance use, the medical emergency cases include 13 suicide attempts and 6 deaths.

Of the 13 tentative suicide attempts (by hanging or self-mutilation), almost half were due to exclusive NPS use (7 cases), 5 were due to multiple psychoactive substance use, and one was due to exclusive generic drug use. Moreover, 3 of the 5 suicide attempts involving multiple drug use reported NPS use, which indicates an additional risk related to this type of use which was involved in a total of 10 of the 13 suicide attempts.

**Table 6-21: Distribution of emergency cases reporting suicide or death, by the type of use generating the medical emergency**

Type of use generating medical emergency	Suicide	Death
Multiple drug use	5	1
Exclusive illicit drug use ex	8	5
of which: NPS	7	4
Generic drugs	1	0
Heroin	0	1
Total	13	6

Source: ANA

Of the 6 deaths reported among medical emergencies caused by illicit drug use, 4 cases reported exclusive NPS use, one reported exclusive heroin use and one reported multiple drug use.

The emergency diagnoses for the 6 drug users who died were: resuscitated cardiac arrest and bilateral pneumothorax, bronchopneumonia (2 cases), sepsis secondary to bronchopneumonia, drug addiction (2 cases). Three of the deceased had HIV and one had HCV. All 6 deceased drug users were in the age group of 25-34.

**Table 6-22: Distribution of emergency cases reporting death, by substance and age group**

Death	Age group			Total	HIV	HCV
	25-34 years old	45-54 years old	over 64			
Multiple drug use	1	0	0	1		
Illicit drugs	5	0	0	5		
NPS	4	0	0	4	3	1
Heroin	1	0	0	1		
Total	6	0	0	6		

Source NAA

### Conclusions:

- We notice that, although the number of reporting health care units increased in 2012, the number of medical emergencies caused by illicit drug use is maintained at the level of the previous year, with only a slight increase by 0.4%;
- After the expansion phenomenon identified at national level in the number of medical emergencies caused by drug use following the appearance of NPSs during previous years, this year we notice a territorial “segregation” of “territorial problem nuclei”, where the number of medical emergency cases caused by illicit drug use is higher (Bucharest, Cluj, Iași and Galați);
- Due to the medical problems caused by exclusive or multiple drug use involving new psychoactive substances, they continue to hold a central role in the medical emergencies caused by illicit drugs reported at national level in 2012;
- More than two thirds (68.2%) of the emergency cases caused by illicit drug use reported exclusive NPS use, while other two thirds (66.7%) of the total emergency cases caused by multiple drug use reported such use in combination with other psychoactive substances;
- As compared to previous years, the number of emergency cases caused by NPS use (exclusive or multiple drug use) was maintained at the same level in 2012;
- We note the upward trend in the number of emergency cases caused by multiple drug use whose number doubled in 2012 as compared to the previous year;
- We note significant increases of the number of emergency cases caused by exclusive cannabis, opiate, generic drug and volatile solvent use;
- As the NPS use is still high and the multiple drug use involving NPSs is increasing, there is an alarming prevalence of drug-related infectious diseases (HIV, HCV, HBV), especially among this group of users, as more than a quarter of the medical emergencies caused by NPS use reported injecting drug use; moreover, these users are exposed to high social exclusion risks (lack of identity documents, low access to primary health services, lack of financial means);
- We noted the first death cases caused or generated by illicit drug use, most of them being attributed to consequences of NPS use; the typology of emergency diagnostics attributed to illicit drug use includes 13 suicide attempts, of which 10 involved NPS use, which indicates an additional risk related to this type of substances;
- We noted that the decrease of emergency cases reporting exclusive use of unknown substances continues, which indicates better diagnosis of emergency cases caused by drug use, as well as increased levels of information;
- Although most of the emergency cases analysed were diagnosed as “intoxication”, which could suggest occasional drug use, in 39.1% of the medical emergencies caused by illicit drug use the emergency diagnostic indicated regular use of illicit drugs, involving medical conditions which occur after a longer period of drug use.

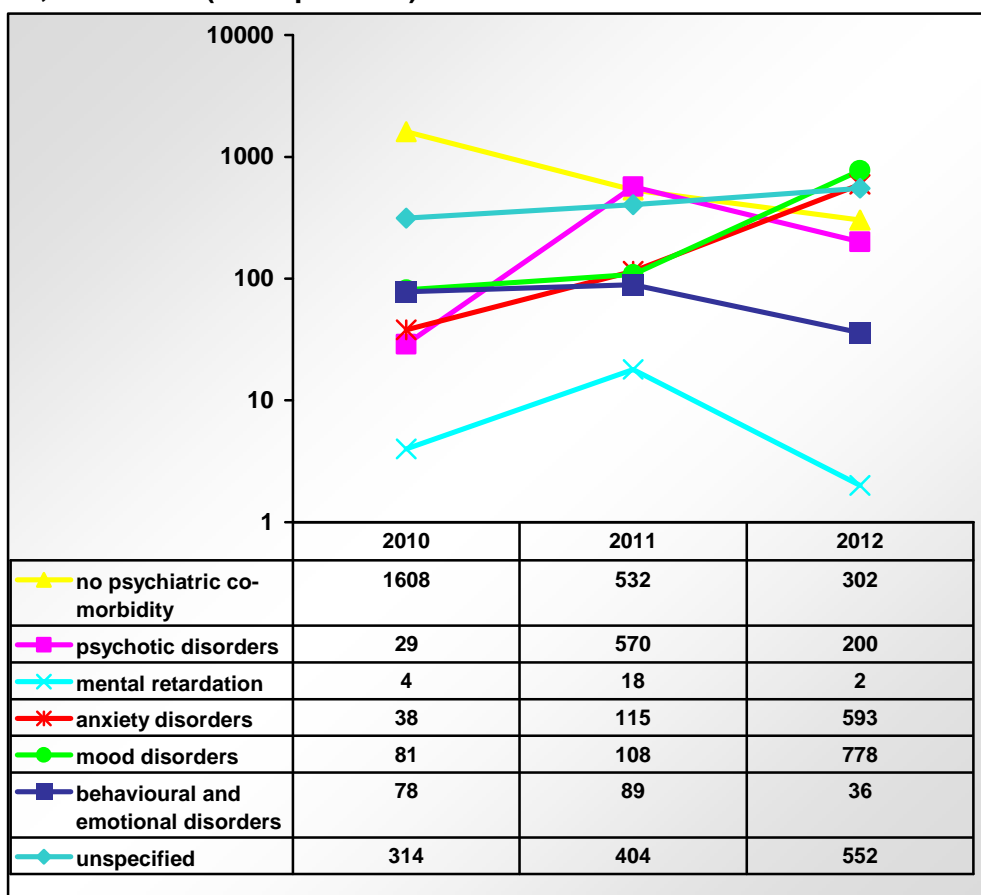


## 6.2.2 Personality disorders, depression, anxiety, emotions disorders etc.

For this sub-chapter 2463 unique cases were analysed and extracted from the database on the Drug Treatment Demand Indicator (excluding alcohol and tobacco addiction cases), as reported by the 31 Anti-drug Prevention, Evaluation and Counselling Centres / Addiction Integrated Care Centres, 24 specialised units within network of the Ministry of Health and of the National Administration of Penitentiaries and 7 outpatient private centres.

The analysis of the data showed that 1609 persons (65.3% of the cases) were diagnosed with various psychiatric disorders. Of these, the most frequent diagnoses were *mood disorders* in 778 cases (31.6%), followed by *anxiety disorders* in 593 cases (24%), *psychotic disorders* in 200 cases (8.1%), and *behavioural and emotional disorders* in 36 cases (1.5%) and *retardation* in 2 cases (0.08%).

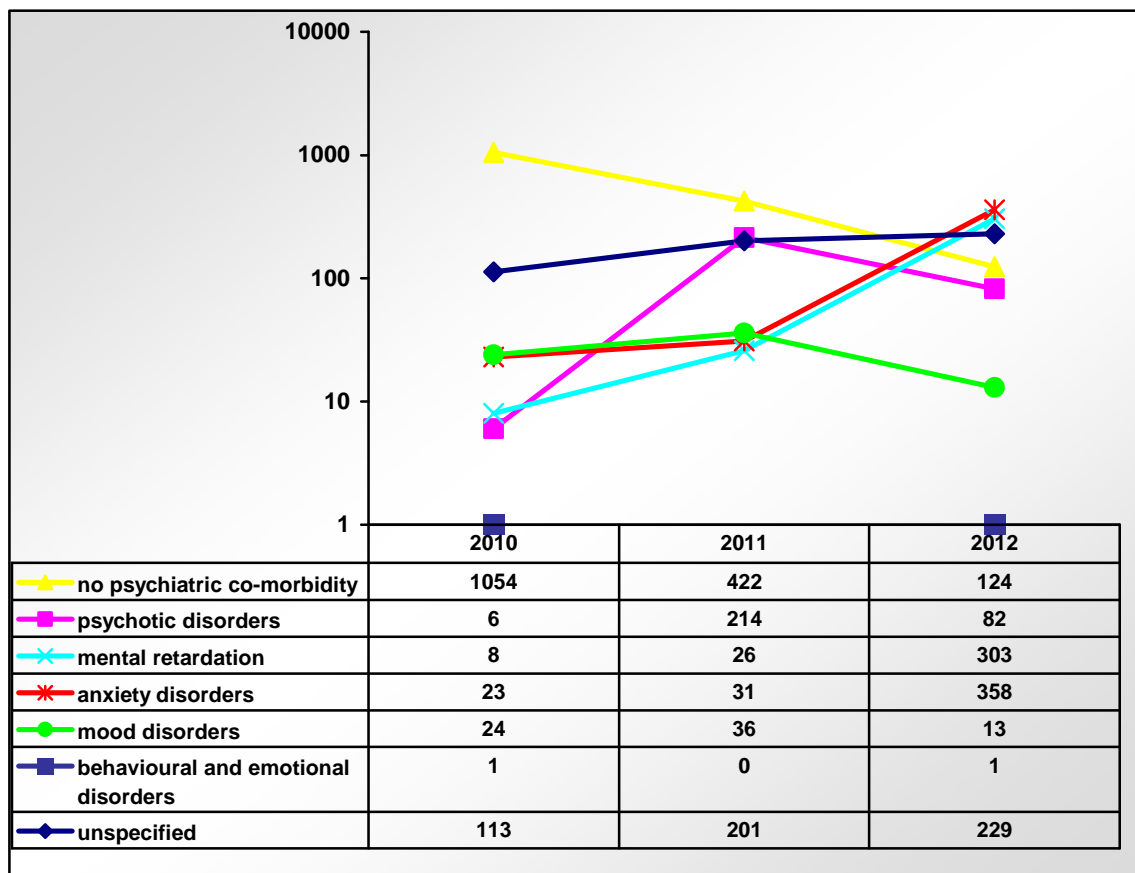
**Chart 6-41: Distribution of the drug users, by psychiatric pathology related to the drug use, compared data, 2010-2012 (no of persons)**



Sursa: NAA

Of the 2463 persons registered, 1110 were injecting drug users (IDUs), and the analysis of these cases according to the related psychiatric pathology indicated a number of 757 persons who had used injected drugs and had been diagnosed with various psychiatric disorders (68.2%). The most frequent diagnoses were *mood disorders* in 358 cases (32.2%), followed by *anxiety disorders* in 303 cases (27.3%), *psychotic disorders* in 82 cases (7.4%), *behavioural and emotional disorders* in 13 cases (1.2%) and *retardation* in 1 case (0.09%).

**Chart 6-42: Distribution of IDU cases, by psychiatric pathology related to the drug use, compared data, 2010-2012**



Source: NAA

As compared to previous years we note:

- An increase by more than 6 times of the number of cases diagnosed with various psychiatric disorders – from 230 persons in 2010 (10.6 % of the cases), 811 persons in 2011 (44.2%) to 1609 persons (65.3% of the cases)
- A decrease of the number of cases that do not include psychiatric co-morbidity related to drug use – from 1608 cases in 2010, 532 in 2011 to 302 in 2012. But there is an increase of the number of cases with unspecified diagnostic – from 314 in 2010, 404 in 2011 to 552 in 2012.
- An increase by almost 10 times of the number of cases diagnosed with mood disorders, from 81 in 2010, 108 in 2011 to 778 in 2012;
- With regards to injecting drug users, we note the same significant increase of the number of cases diagnosed with various psychiatric disorders (from 62 (5%) IDUs in 2010 to 307 in 2011 (33%) and 757 in 2012 (68.2%);
- Similarly to the entire population admitted to treatment for drug use, the IDU sub-group shows the same explosive increase of cases diagnosed with mood disorders (23 cases in 2010, 31 in 2011 as compared to 358 cases in 2012).

## 6.3 DRUG RELATED DEATH AND MORTALITY AMONG DRUG USERS

### 6.3.1. DIRECT OVERDOSE DEATHS AND INDIRECT DRUG RELATED DEATH

Monitoring drugs users' deaths provides a specific picture on the impact of drug use and its consequences. Thus, objectively measuring a number of indicators to evaluate usage trends (consequences of using particular drugs, groups at risk), as well as the type of substances consumed and the dosage allows to promptly identify the problem drug use elements, thus contributing to rapid and adapted reactions in the making of anti-drug policies.

It should be reminded that drug related deaths are of violent cause where a particular role (direct or conditional) is played by a chemical traumatic factor (substances consumed) or the act of its delivery and effects thereof. Direct deaths resulting from the use of psychoactive substances is included in the category of suspect and/or violent deaths and implicitly leads to the initiation of a police investigation. This in turn requires a forensic autopsy<sup>73</sup> to be carried out in order to ascertain the context and conditions of the death.

These clear and unambiguous provisions of the Romanian Laws are now starting to be better known and put into practice by the medical staff in particular, but also by the investigation agencies (mostly by those that carry out the preliminary on-site investigation and decide how to deal with the case), meaning that drug related deaths are referred for judicial and forensic investigation. This is a salutary change that may lead to a reduction in underreporting caused by lack of forensic and judicial investigation of drug use related cases, in particular of "indirect cause" cases.

Drug related mortality covers wider analysis range than the mere name of the indicator may indicate, thus:

- Deaths directly related to the pharmacological action of the drug – commonly known as „overdoses” are covered by the phrase “drug related deaths” (DRD) – meaning “*death occurring shortly after the intake of one or several legal or illegal psychoactive substances and that is directly correlated with the use of narcotics*”.
- Deaths indirectly related to drug use – consequence of specific delivery circumstances (infections, chronic infections – HIV, hepatitis – foreign body embolism etc.), specific lifestyle (including criminality), and accidents occurred during intoxication. This category poses real difficulties in sorting and classifying the cases when the classification criteria and applicable regulations are not known. Identifying in the body certain substances that may be classified as drugs in deaths caused by situations that are defined as being independent from the drug use (infections, accidents, and suicide or in patients under substitution treatment) requires professionalism and experience for sorting the cases appropriately.
- Mortality among drug users – a category that is caused by the progressive accumulation of accelerated and specific pathology, with a much higher incidence than in the overall population, even when including suicide in the absence of intoxication. Monitoring is possible only by cohort studies over time.

The nationwide Special Morality Registry includes data from the National Forensic Medicine “Mina Minovici” of Bucharest, from the regional forensic medicine institutes and from all the County forensic medicine units.

Given that *drug related and induced deaths* are cases that include in the death underlying chain of events a “trauma” component (chemical, mechanical or biological aggression associated with the intake of drugs), as pointed out at the beginning of the section, all such cases require a mandatory forensic autopsy, as required by law. The source of the data is the entire body of forensic cases wherefrom files for this indicator are extracted. The data is centralised based on internal protocols of the national forensics network, using standard reporting templates, and the data is processed at **INML** “Mina Minovici”. By carrying out a judicial review and related provision of evidence, as well as processing the data in corroboration with the results of the toxicological tests – quasi carried out in

<sup>73</sup> Based on Ordinance no. 1/2000 on the organisation and operation of forensic medicine institutes, as subsequently amended.

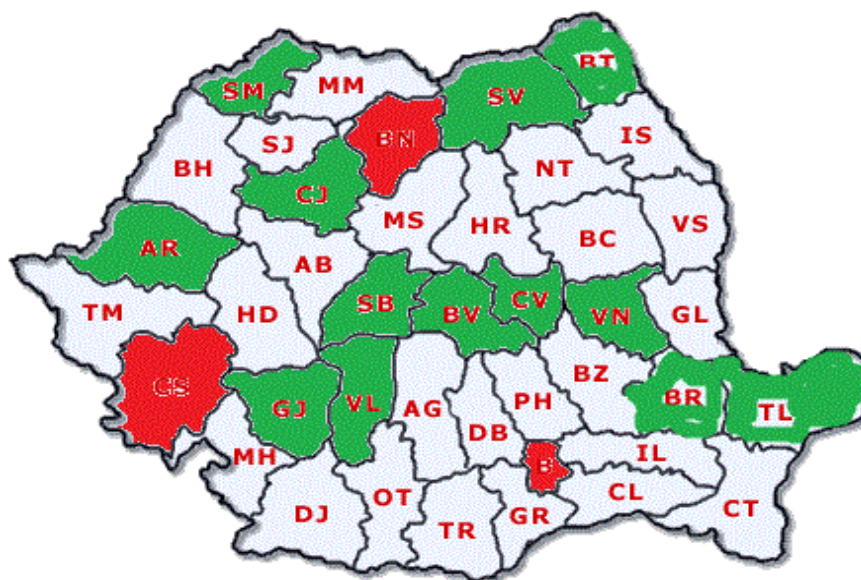
such cases (including as a mandatory requirement the *screening* - immuno-analyser and **GC**, detection and confirmation of **HPLC**, **GC\_MS**, quantitative determination) and with the investigation data (medical, serologic, tanato-chemical and histopathological, including adjusting the final findings after having fully documented the case, the risk is avoided of classifying the case only on the basis of the information immediately available at the time when the death was recorded (data that is sometimes inconclusive and incomplete given the relative lack of specificity of the trauma tables that only support the final rationale for classifying the case if an integrative and corroborative analysis, including exclusion, is carried out).

Under the circumstances of the current shortcomings in the cooperation between various agencies (INS, DSP) and the lack of interconnected IT systems, the advantages of using the Special Mortality Registry become obvious and, moreover, its use is strongly supported by a body of regulations that transforms the forensic cases into a viable and functional source for reporting, in the context whereby exhaustive tests are carried out and a consistent methodology applied by all the forensic entities in the country.

The data presented in this section are taken over from the body of forensics cases, the forensic medicine institutions being the only ones empowered to manage such cases. Once defined as such, for all the forensic cases toxicological investigations are carried out (except carefully selected cases, when the subject has survived the intoxication for a long period of time and when the case is reconstituted based on medical documentation). The forensics autopsy files – some 20,000 cases per annum nationwide – form the selection basis for the Special Mortality Register where drug related deaths are recorded.

For 2012, the current reporting is based on the case history of **INML** “Mina Minovici” Bucharest. Only 17 forensic medicine institutions from around the country have provided information for 2012. Despite the efforts to collect data from the entire forensic medicine network, though diversified and strengthened (efforts that have already become a routine by their annual repetition) the results remain mediocre and it was not possible to obtain information ensuring geographical coverage of the entire territory. The lack of legal regulation requiring mandatory reporting may be one possible explanation.

**Map no. 6-2: Distribution of drug related deaths by administrative division (Counties) for 2010 (no. of cases)**



Source: *INML Bucharest*

Compared to previous years, underreporting for Bucharest is much reduced and the former shortcomings are currently much less manifest. Such shortcomings could be: lack of experience in the management of drug related deaths, lack of forensic medicine and legal knowledge among the medical personnel and of related public services workers, lack of good toxicology laboratories, financial limitations etc. Therefore, the current figures for Bucharest provide an adequate picture of the situation.

The national distribution of cases (with the reserve of sporadic and inconsistent reporting) is totally unsustainable statistically, mainly when compared with other sources of information on the incidence of drug use at the national level. A comparison with other findings of monitoring other drug use indicators across the country (of which emergency treatment given in emergency units is a sound benchmark) supports the above-mentioned discrepancy.

For the 3 million population of Bucharest and its suburbs, 42 indirect deaths are recorded (direct and indirect) and only 3 other deaths for the remaining 18 million inhabitants of the country.

The explanation continues to be rooted in the same causes that have constantly been pointed out since 2006, but that are not yet be fully updateable – amendable, despite sustained efforts to such effect.

Furthermore, the clinical medical staff and even forensic doctors and investigation team members do not quite understand the criteria for determination and the definition of *drug related deaths*, resulting in suspect deaths not being classified in the category of those requiring forensic medicine expertise and, therefore, in underreporting.

The rigidity and conservatism in approaching the presumptive case history of drug related deaths (failure of sorting the cases based on medical history, drug use markers, exclusion of other potential death causes, using only particular relevant *per se* toxicological figures etc.) also lead to involuntary masking the real cause of death. The emergence of “legal drugs” as the main type of drugs used – with all the implicit difficulties in their toxicological identification – has further strengthened this invalid dogma hereby the cause of death is correlated with intoxication only in the undoubtful and toxicologically proven presence of a potentially lethal dose.

Yet another explanation is the lack of personnel that also results in the absence of a forensic doctor from the on-site investigation team thus preventing the selection based on objective forensics criteria of potential cases in the on-site investigation stage, the selection remaining dependant on subjective judgement (a wrongly understood “social convention” type empathy aimed at preventing the *public stigmatisation* of a drug user) and influenced by the lack of understanding of the forensic implications of a possible drug related death.

Although a definite improvement is noticeable in the reporting of hospital deaths (that for a long time have not been reported for forensic examination, particularly in comorbidity cases or with non-toxicological evolutive complications), this remains strictly limited to Bucharest.

A potential source group for selecting cases is eliminated given that toxicological tests are not systematically – most often for financial reasons – required in traumatic deaths (road accidents, suicide, and murder) possibly occurred under intoxication and not even in suspected drug related deaths. Sometimes, this is further supplemented by the investigator’s refusal to issue an order for the forensic necropsy and/or to establish the specific toxicological objectives (that would increase the overall forensic investigation costs).

For these reasons the underreporting at a national level is significant, it being a consequence of the lack of experience of drug related deaths management, forensic and legal knowledge, and existing financial limitations.

The main historic constraint – lack of good toxicology laboratories – has now been overcome, but underreporting seems to remain unchanged at a national level, with the exception of Bucharest.

**In conclusion, taking into account that 25 County forensic institutions did not report at all, 28 directly drug related deaths and 17 indirect ones were reported in 2012 nationwide.**

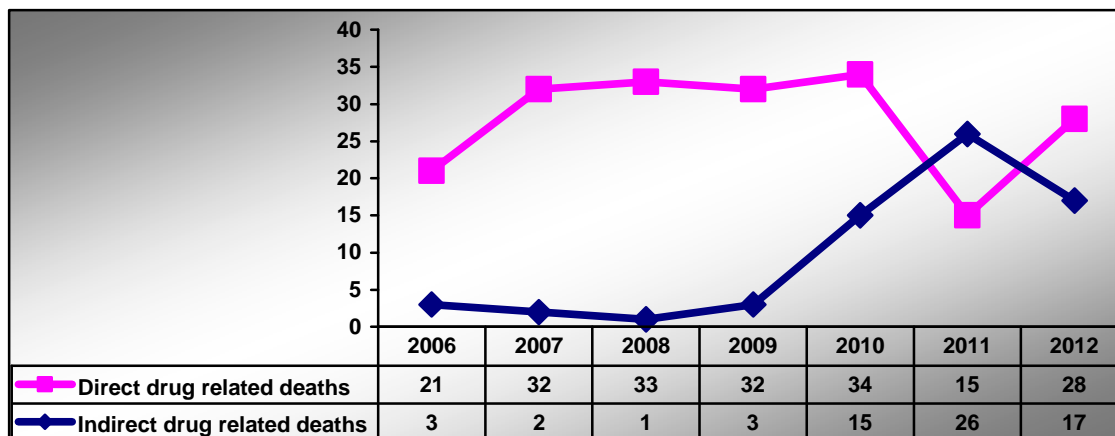
Toxicological tests were performed for all the 28 direct deaths aimed at identifying psychoactive substances. The tests were carried out at the toxicology laboratory of INML Bucharest. (In fact, currently, declaring a direct drug related death is based on viable toxicological test as an objective proof, thus limiting the importance of circumstantial and subjective sorting factors). The improvement is

noticeable of the technical resources of emergency medical units from Bucharest, capable now to perform quality toxicological tests.

Also, a further 17 deaths of known drug users were recorded (with tale tell elements from clinical and necropsy examinations, medical history and investigation data), but whose cause of death was related to pathologies associated or resulting from the chronic use of drugs or to violence. These deaths occurred under the influence of narcotics, not under intoxication (cases with the so called *indirect causality*<sup>74</sup>).

Same as in previous years, the Bucharest cases make up the absolute majority or even the total number of cases of drug related deaths. A significant variation of the figures is noticeable for 2010-2012 compared to the trends in 2006-2009.

**Chart no. 6-43: Distribution of drug related deaths by type of death (direct, indirect), comparative data for 2006-2012**



Source: INML Bucharest

Compared with the previous years, alongside the explosive increase in the number of cases indirectly drug related deaths noticed during the last 3 years, a sine curve of deaths directly associated to drug use is noticeable, after a relative plateau over the previous 4 years. The decrease in the number of direct drug use deaths in 2011 (while the total number of drug related deaths remained similar to that of previous years due to the increase of indirectly associated deaths) proved to be a mere particularity of that year (perhaps in the context of “legal drugs” being accessible at the time, with a lower intrinsic direct death causing potential). In 2012, the figures tend to return to the earlier average, due to the increase in the number of directly drug related deaths, mainly caused by the consume of opiates.

The constantly high number of deaths as a consequence of complications induced by chronic consume – *indirect deaths* – finds a plausible explanation that is also correlated with the numerous data supplied by other indicators of drug use (drug related infectious diseases, medical emergencies caused by drug use, admission to treatment following drug use). Also, such explanation is provided by the radical change in the pattern of abuse substances used lately (and implicitly in the intake practices), with a considerable turn towards the new synthesis drugs, the so-called “ethno-botanical drugs”, on the background of:

- easy availability,
- legality of selling and possession,
- low price,
- being perceived as “low risk drugs”,
- relative legal safety provided by the de toxicological evidence limits for this new class of substances.

However, having in view the relatively limited power of these substances (with a relatively reduced intrinsic risk of immediate and directly lethal overdoses compared to traditional narcotics) and the low

<sup>74</sup>*Indirect deaths* following the use of psychoactive substances – deaths occurred as a result of use-related behaviour and mental disorders and/or contracting diseases following the shared use of injecting equipment and, respectively, the somatic complications caused by the use of psychoactive substances.

half-life, but also the high addictive potential of this type of substances, a change in the consume pattern is identified that is characterised by very frequent intake of the drug – up to 6-8 times a day, in particular by injecting users. Furthermore, moving on from ingestion or smoking to parenteral administration – which is a more potent delivery method – happened much faster.

On the other hand, on the background of a significant cut back of the information campaigns and specific *harm-reduction* services (especially of syringe exchange programmes), the outcomes of drug use were a rapid build up in pathology, in particular infectious, with fulminating or acute evolutions, on the background of *cathinon-like* and synthetic cocaine (dimethocaine) specific immune depression, caused by qualitatively and quantitatively unknown compositions, uncertain excipients, high contamination of street doses, in particular for vegetal products with atypical and rare pathogen flora – fungi and micro-parasites – and the shared use of *paraphernalia*,

An aspect that was empirically, almost colloquially, noticed by the next of kin, yet with arguments that may require future in-depth research, is the rapidly installed and progressively accelerated deterioration of the overall state of health of chronic drug users when the main drug was supplemented or replaced with *NPS* products. Thus, either by the nature of these substances, that sometimes are of vegetal origin that is also a source of bacteria or fungi, or by their *methamphetamine-like* action mechanisms, this type of use contributes to the accelerated consumptive aspect of addiction.

Furthermore, the large number of these *indirect deaths* is most likely also a result of the medical and investigation personnel understanding the need to classify them as forensic cases (given the role played by the drug use in the causality relation determining the death). These were declared to be forensic cases and the pre-existent legal requirements were no longer avoided (avoidance that used to result in morgue autopsy at the best – with its limitations – and implicitly, to cases not being reported), thus increasing the number of cases reported and cases becoming more visible for statistics.

From the perspective of the increase in the number of indirect drug related deaths identified by the forensic medicine network, an inevitable analogy exists with the directly drug related death cases.

Thus, in 2010, in some one third of direct drug related deaths (death as a direct result of psychoactive substances' action) severe pathology elements were identified, similar to those found in indirect cause deaths<sup>75</sup>, but the cause of deaths was unquestionably determined as being the pharmacological action of psychoactive substances. In 2011, significant pathology levels were identified in one fifth of direct drug use death cases, also a result of the limited potency of the new drugs in use that do not have a significant intrinsic thanato-generating capacity, but with the induction of an accelerated and significant pathology that leads to death due to complications, not to *overdose*. At the same time, the pathology identified in these cases is also a result of administration without minimum asepsis/antisepsis and of highly contaminated doses. One comparative example is heating heroin to dissolve it for parenteral delivery (this destroys most of the microbial flora in the street dose), whilst the new abuse drugs are readily soluble at room temperature which leads to direct delivery of bacterial loads in the blood stream.

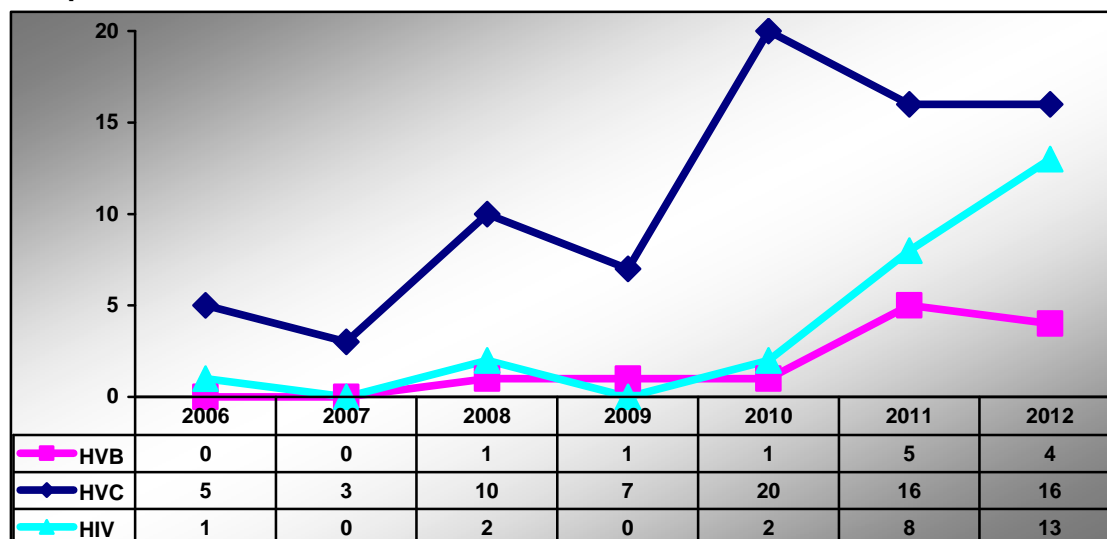
We have reiterated the figures from previous reports in order to further confirm the findings for 2012 when a potentially severe associated pathology was identified in only one case of death directly resulting from the pharmacological action of the drug – an abscess at the place of injection. This situation superposes with the period 2005-2009 when these direct deaths were not associated with acute pathologies (unlike in 2010-2011), as a result of a return to consuming established substances – opiates.

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<sup>75</sup> Most affections are sceptical complications (pneumonia, bronchopneumonia, cellulite at the injection place, boils, meningitis; severe chronic hepatitis), but also complications of the actual drug injection action – thrombophlebitis – or generated by the injected dose (the street dose being a mix of substances with or without psychoactive potential, but with excipients that may cause complications that are independent from the narcotic they *dilute* – lungs granulomatosis, thrombembolia generated by insoluble substances such as talcum). Special attention must be given to the increase in the incidence of infectious endocarditis among Romanian addicts: some 10% of cases in 2010, both directly and indirectly drug use related deaths (the world statistics give percentages ranging between 10% and 25% of the users of injectable drugs).

Of the 45 cases of drug related deaths, infectious endocarditis was found in 10 cases – a cause of death that has “exploded” in percentages starting from 2010 (from 0-1% to about 10% of the cases in 2010, 54% in 2011, and 23.8% in 2012). The acute aspects of some of the above-mentioned pathologies (other than lethal intoxication) support the poor quality of the street doses, *non-safe* injection, non-compliance or lack of knowledge of minimal *harm-reduction* measures.

**Chart no. 6-44: Evolution in the incidence of HVB, HVC and HIV infections in drug related deaths, comparative data for 2006-2012**



Sursa: INML Bucharest

The virology tests carried out (non-standardised, sporadic practice that is not part of the systematic investigation) for drug related deaths were focused on cases where the medical history or the anatomic-pathological examinations were indicative. The results were 18 positive cases for viruses, thus: 16 type C hepatic, 6 HVB infections and 13 HIV infections (the number is equal to that of all cases in the past 6 years!). In 6 of the cases only one of the infections was identified whilst in almost two thirds of the cases they were found in association. Of the latter, all the three viruses were found in 6 cases. In 5 cases the medical cause of death was deemed to be HIV infection in AIDS stage. Alongside this infection, the remaining cases presented associated infectious pathology or were typical drug related deaths, where the intoxication was the cause of death.

Undoubtedly, if all cases would have been tested, the figures would have been even higher (even so they are extremely eloquent in terms of absolute figures, but most of all in trends), but the financial constraints did not allow for this approach to be extended.

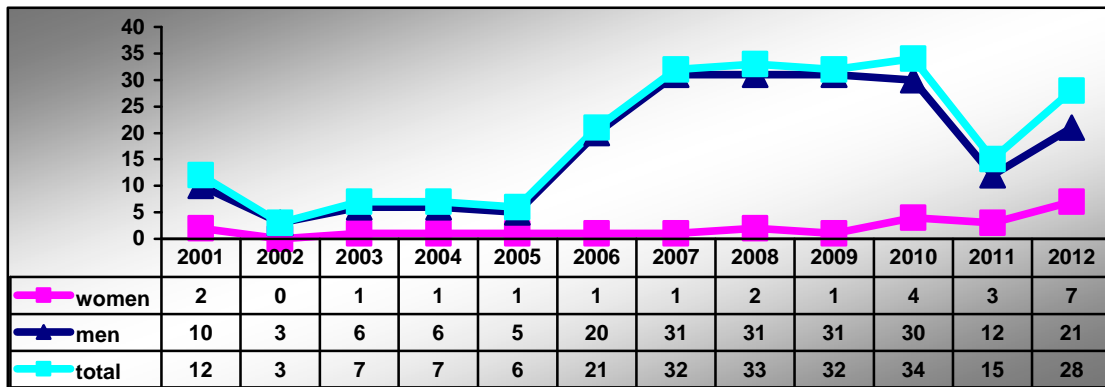
High incidence of HVC infection among drug users in Romania is confirmed, concordant with the data provided by the drug related infectious diseases indicator. The recurrence of HIV infection among directly drug related deaths is an important alarm signal – if 5 cases were identified in the first 5 years of monitoring (2006-2011), 21 cases were identified over the past 2 years. The explanation is similar with the one given above, and is related to the more frequent injection alongside the shared use of *paraphernalia* and the reduction in the syringe provision (caused by the economic crisis), but also very probably caused by the spreading of commercial sex in drug users' communities for procuring a new dose (in the forensics case history, on the occasion of the investigation of prostitution/ traffic of human beings cases, building the person's loyalty to the network by, initially forced, administration of drugs was mentioned). Even in the context of sporadic testing, revealing such an increase in the incidence of HIV (which is probably only the tip of the iceberg) is, perhaps, one of the most important warnings about public health and the need to rapidly take measures.

As seen in previous years, the practice of injecting methadone – originating in dissolving the pills – as well as injecting a wide range of pill or tablet prescription drugs – is an important source of insoluble substances introduced in the body through the veins (the excipients of these medicines constantly



including talcum) and generating accelerated and cumulative granulomatose or micro embolic pathologies that are frequently revealed in the necropsy and histopathologically.

**Chart no. 6-45: Distribution of drug related deaths by gender, comparative data 2001-2012**



Source: INML Bucharest

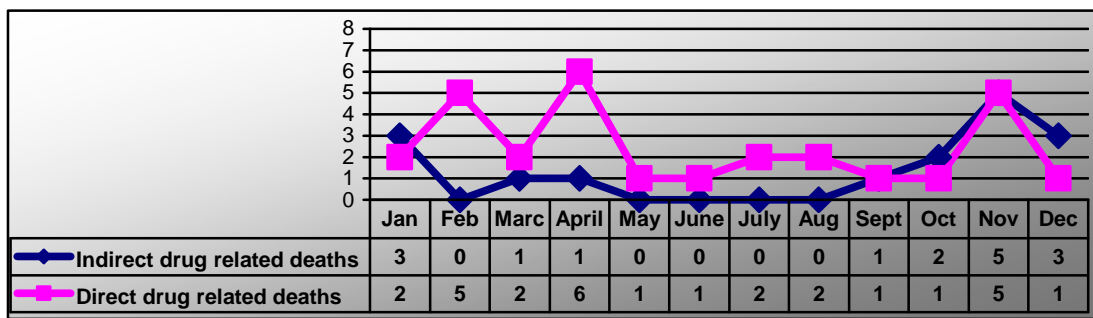
In conclusion, in 2012 were recorded:

- 28 declared direct drug related deaths nationwide, all from Bucharest, all with positive toxicological tests;
- 17 indirect drug related deaths.

By gender, these cases are split thus: 31 males and 14 females. **A major increase in the number of female deaths over the past year is noticeable.** Directly drug related deaths are split by gender thus: 21 among males and 7 among females.

Looking at the monthly distribution of cases, peak incidence is noticed in April with 7 cases, while the overall year distribution is relatively even. However, such incidence peaks should draw the attention of the authorities as to the emergence on the illegal drug market of street doses that are dangerous either by their composition/concentration/associations/excipients (*adulterants*), or by their possible microbial contamination.

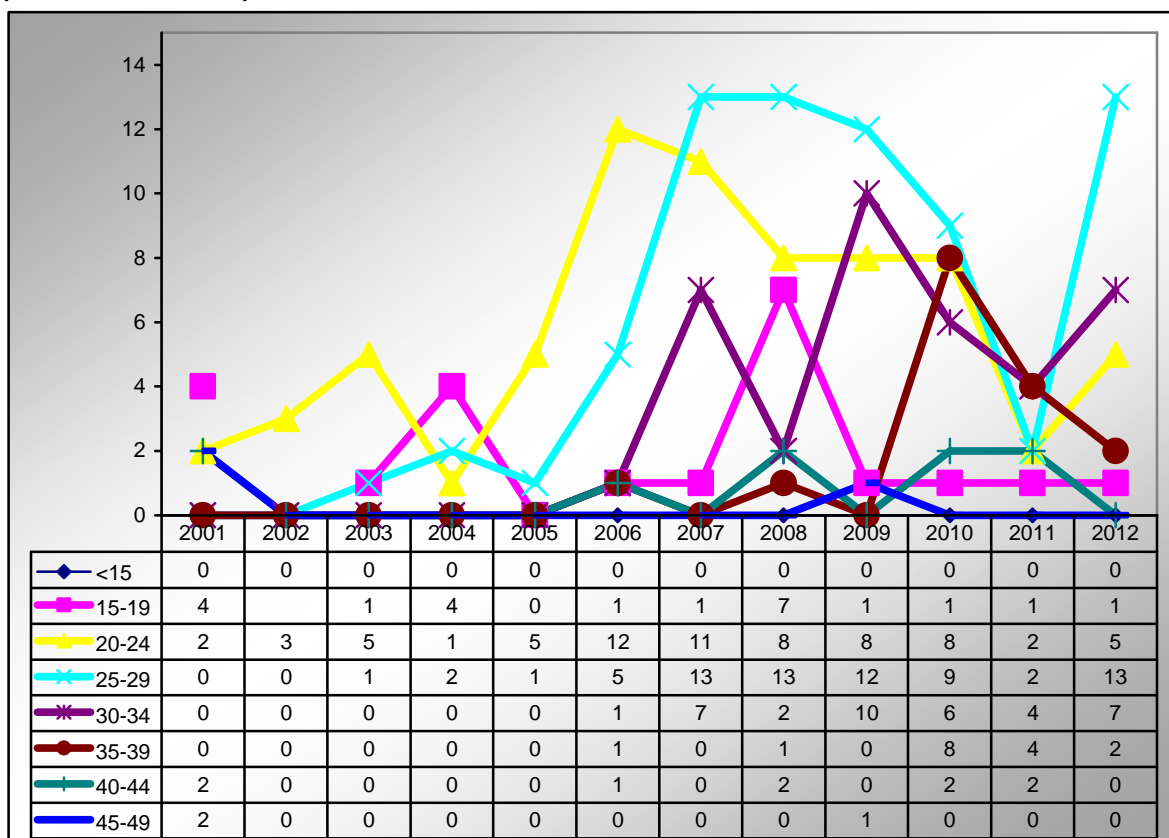
**Chart no. 6-46: Monthly distribution of drug related deaths by type of death (direct, indirect) for 2012 (no. of cases)**



Source: INML Bucharest

Concerning the age of the dead persons, we note that all drug related deaths in 2012 were of persons aged between 15 to 49, most of them in the 20-34 age group (89.2% of the total drug related deaths).

**Chart no. 6-47: Distribution of drug related deaths by age groups, comparative data for 2000 - 2012 (number of cases)**



Source: INML Bucharest

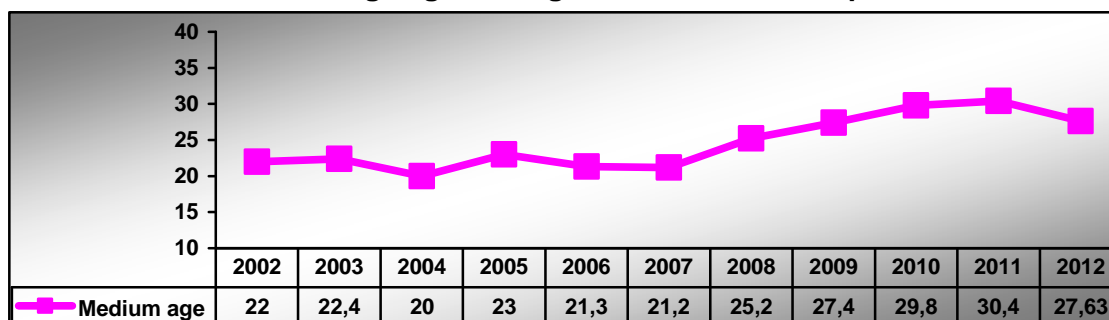
Massive recruitment of drug users from among the very young population is noted in 2008, and in 2009 and more so in 2010 and 2011, a significant increase is observed in the number of direct drug related deaths among the 30-34 and 35-39 age groups – “the old wave” of users. This indicates the “aging” of users, meaning that they have a long term use history, with the progressive accumulation of pathology and risks. It is also possible that experimenting with drugs (typical for young ages) happens latter, as well as it is just as possible that drug use is prolonged on the long term (moving on from the initiation drug to more potent ones happens much later) due to the accessibility of NPS with lower lethal potential and the deaths may continue to occur only among the users of established psychoactive substances, typical for previous generations.

After a continuous increase in the previous years (in 2011 reaching a maximum of 30.4 years), 2012 sees a significant reduction of the average age at the time of death – 27.63 years for direct drug related deaths and 26.4 for the indirect ones. Apparently, comparing the two average death ages seems paradoxical. In general, the indirect cause deaths reflect the progressive-accumulative pathology of the life style, chronic consume, accident risk etc, that are all specific elements of drug addiction, with the subjects’ slow decompensation occurring long time after starting the use, which translates in death at older ages. Surprisingly however, in the drug use case history, the average age of death for indirectly related deaths is lower than that for directly drug related deaths (reflecting “overdoses”).

The most plausible explanation for this apparently illogical discrepancy is given by the significant change in the range of abused substances from established drugs – especially heroin – to low lethal potential drugs *per se* – (NPS). Yet the latter induce consumptive and infectious pathology at an exceptional rate over a short period of time, due mainly to the very high delivery rates – 6-8 injections per day, each intake having significant infectious potential - but also due to the *amphetamine-like* effects of some of these substances, *shunting* the *average life span* of the user until death (10-15 years being the reported time by countries with “traditions” in the use of drugs) for *problem drug users* (PDU), with the progressive accumulation of specific pathology and natural decompensation or changes in the use *patterns*.

A trend is being seen whereby young persons are recruited to use substances with uncertain legal status, with limited overdosing potential, but with an exceptional risk of accelerated psycho-somatic deterioration.

**Chart no. 6-48: Evolution of average age in drug related deaths, comparative data 2002-2012**



Source: INML Bucharest

By the place of death, the figures for 2012 are thus:

- 22 deaths at home,
- 3 in public places (street, lake),
- 2 deaths in other persons' dwellings,
- 1 death in prison,
- 17 deaths in hospitals.

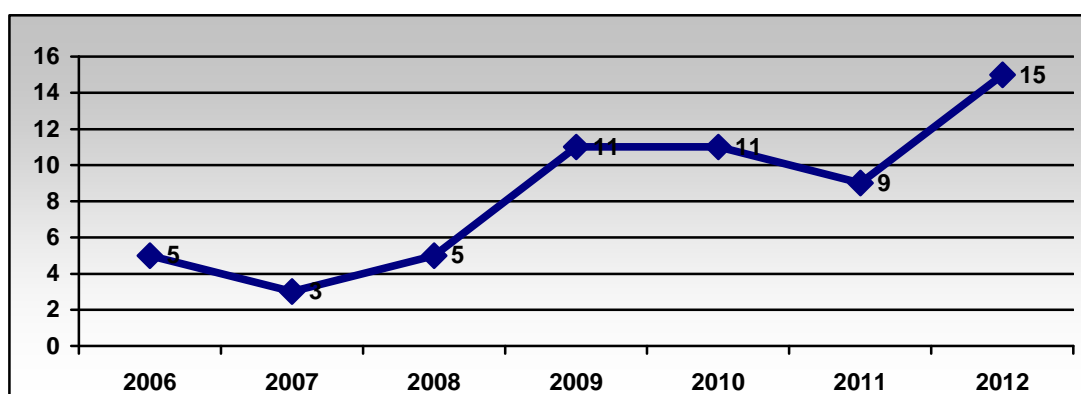
The data is similar to that of previous years, so that it may be said that no major change in the places of use has occurred, the drug user generally preferring the intimacy of his/her dwelling or isolated places. However, an increase is noted in the number of cases referred for medical assistance in terminal phases, the user being frequently brought to hospital by family or friends, possibly as a result of the increased trust in medical services and the reduction of fears of possible legal consequences, and also possibly on the background of medical education measures taken among the populations at risk, these policies thus partially proving their efficiency.

In all the 28 cases of direct drug-use related deaths elements existed indicating chronic drug use. This fact (deaths among chronic users only) supports the possible role of information and prevention campaigns, by the popularisation of *harm-reduction* policies and filling up the consume technique information gap among problem drug users. These actions result in the decrease of first doses death risk (mimetic dose, concentration and frequency of intake influenced by the entourage or possible recruitment by *dealers* who provide high-quality first doses that increase the risk of death at the beginning of use or after periods of abstinence when the previously built up tolerance is lost). Thus, it must be noted that in all such cases elements existed that indicated chronic drug use (elements susceptible of indicating drug use were identified in the necropsy, some of them being *markers*) – superficial peripheral vascular scleroses or post-repetitive injection granuloma, post-infection skin scars on the places of injection or self-mutilation, tattoos or cachexia. This confirms the fact that death does not occur much at the first doses (possibly also due to the low concentration of street doses – 7-9% in Romania for heroin), but mainly among chronic users, with a long use history that associates abuse-generated markers.

IDU's were involved in most direct drug related deaths – mainly by intravenous delivery – while only in four cases the drugs were delivered to bone (stimulating mixture, methadone in giant dose, alcohol and benzodiazepine), associated in three cases with smoking cannabis derivatives. This shows that in drug related deaths the delivery is mainly by injection (85.7% of drug related deaths in 2012, 100% in 2011, 95.1% in 2010, and 87.5% in 2009). This fact also correlates with the increased incidence of associated pathology (generically dubbed "syringe pathology"), mainly of the infectious-chronic type (in particular infection with type C hepatitis and HIV) or acute/sub-acute (endocarditis, sepsis). The increased incidence is noted in the use of amphetamine/ methamphetamine/ MDMA type substances (3 cases).

The number of deaths involving substitute medication (methadone – identified in 15 cases – 53.7% of direct deaths) is on the increase compared with previous years.

**Chart no. 6-49: Evolution of methadone detected in drug related deaths, comparative data 2006-2012**



Source: INML Bucharest

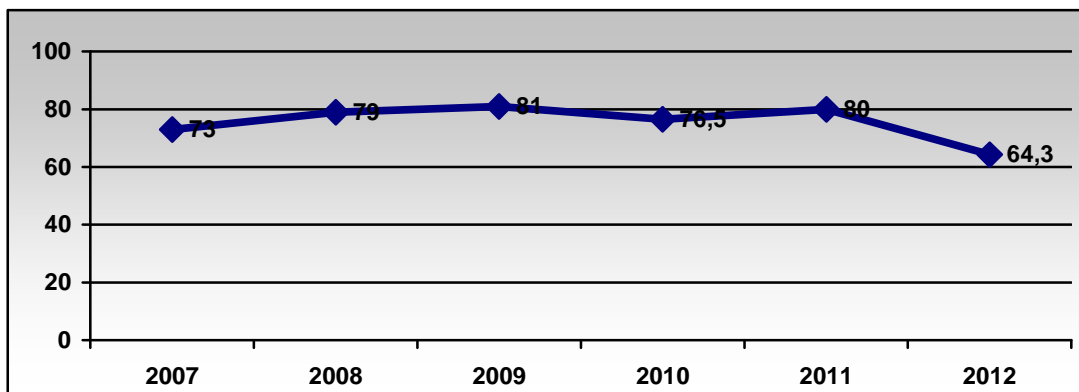
In 13 cases elements of *paraphernalia* were found on site – all including syringes and foil, “street doses”, medicinal drugs blisters, and spoon. This finding suggests either death following the slow decompensation of vital function under intoxication (which leaves the user time to hide the “equipment” needed for delivery), or the fear of the next of kin/witnesses of the potential legal consequences causing them to hide the *paraphernalia*. Not always such material evidence was provided to the forensic doctors. The toxicological test was positive in all cases and in all cases where the *paraphernalia* was also available, the results of toxicological tests carried out on samples taken from the corpse matched those of the equipment. This further strengthens the need for the forensic doctor to be provided with the data provided by the criminal and toxicological investigation of the *paraphernalie*.

The range of substances detected in direct drug related deaths continues to be dominated by opiates (18 cases in total) – mainly methadone (15 out of 28 cases) and a further 5 cases involving heroin. Tramadol (drug included on the list of special release pharmaceutical substances), that had disappeared from statistics last year, has reappeared. Ketamine reappears – 2 cases (one involving a direct death), which had also disappeared from the previous year’s statistics (possibly a result of its being listed as special release substance). Methamphetamine remains present (one case associated with ecstasy and opiates and another with amphetamine and ecstasy). Cocaine continues not to contribute to the causes of direct drug related deaths, as a national specificity, in contrast with European trends. In 3 cases the death was caused by acute intoxication with NPS type substances, their presence being suspected in 2 other cases in association with “classical” drugs<sup>76</sup>.

Intoxications with opiates categorically dominate – 64.3%, which is a significantly reduced percentage compared to previous years, also in the context of the diversification (yet again!) of the range of substances found in various cases. (In 2012, toxicological investigations in direct drug related deaths identified not less than 26 categories of psychoactive substances).

<sup>76</sup> Worldwide, providing toxicological evidence of use is the main obstacle to obtaining objective forensic proof. On the other hand, according to the limited research available to the scientific community, given the infinitesimal doses and the clinical action mechanisms of these substances, it is difficult to prove that death is direct related to them.

**Chart no. 6-50: Evolution of intoxication with opiates in drug related deaths, comparative data 2006-2012 (%)**



Source: INML Bucharest

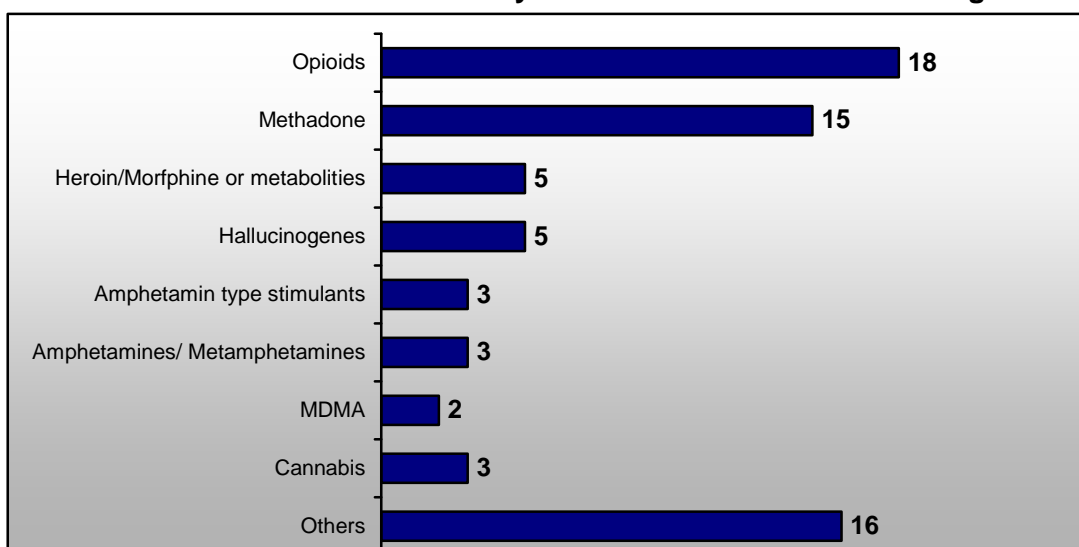
In only 13 cases death involved only one substance. In all others associations of substances were found, either medicines used for augmenting the main doses or as excipients, either for enhancing/nuancing the effects envisaged.

Significant changes exist in the range of substances detected compared with previous years, namely the disappearance of certain substances and the decrease in the incidence of addition medicines (barbiturates - 1 case, benzodiazepine - 7 cases, tetracyclic antidepressants – 1 case, anti-epileptics – 2 cases, anti-psychotics - 2 cases, anti-histamines – 2 cases, all these in various combinations), many a time only used as excipients or enhancers of the main substance in the dose. Also, except for 2 cases, no trend was identified of association with alcohol in the use of opiates.

In 9 cases the cause of death was attributed to intoxication with opiates only and in the others the association use leading to death – opiates with alcohol or other psychoactive medical drug type substances. Medicinal drugs used as narcotics also lead to death in 2 other cases where no illegal drug was identified. One case was found to be the result of intoxication with stimulating substances.

Compared to 2011, but similar to previous years, the incidence of sedative, anxiolytic or anti-psychotic substances has increased (possibly due to the reduced pharmacovigilance and control of sales from pharmacies), whilst diazepam remains relative constant, but their range is diversified.

**Chart no. 6-51: Distribution of death causes by substance detected in toxicological tests, 2012**



Source: INML Bucharest

In 17 cases the toxic substance concentrations were in the toxic-lethal range, which continues to strengthen the non-linear augmentative potential of associations of medical drugs in the other cases, but also the need for flexibility in toxicological thinking when evaluating thanatogenesis. The quantitative toxicological determinations – another important progress made by the Romanian forensic toxicology – allowed nuanced and refined detection and interpretations.

The toxicological examinations evidenced the presence of opiates in 18 cases (15 methadone, 3 heroin, 2 morphine and metabolites), benzodiazepine – 7 detections, anti-epileptics – 2 detections, barbiturates – 1 detection, anti-psychotics/ anxiolytics / sedatives - 2 detections, ketamine 2 cases, ecstasy 2 cases, amphetamines/ methamphetamines 2 cases, cannabinoides 3 cases, tramadol 1 case, anti-histamines 2 cases. These substances were identified in variable combinations. In 4 direct drug related deaths more than 3 classes of narcotics were identified, and in 13 one class only was identified, this confirming the above statements, namely the proliferation of poly-consume by the noticeable re-appearance in the doses of medicinal drugs with potential for abuse.

Alcohol was found in two cases at 1.6 g‰ and 0.4 g‰. No hallucinogenic substances were identified such as LSD, mescaline, phencyclidine.

## CONCLUSIONS:

- The number of drug related deaths has increased compared to last year, the tendency being for the figures to go back to the levels of 2007-2010 (years when the consume trend and patterns were stabilised), fact that clearly demonstrates the end of the changes in the consume patterns seen in 2010-2011 (by the “substitution” of established drugs – mainly heroin – with NPS that have a lower direct thanato-generating potential). The difference in cases is, however, found in indirect deaths (much higher numbers) precisely as a supplementary confirmation of the accelerated traumatic and consumptive potential of these new drugs, leading to an overall direct and indirect mortality similar to that of previous years. **Only the causes of the deaths have changed, not their numbers.**
- Injection remains the rule in the drug related deaths and the opiates continue to dominate the illegal drug picture in România, with the methadone being predominant and on an alarming growing trend.
- The number of “indirect deaths” remains important – possibly as a result of more severe compliance with the legal requirements to classify the deaths that need a forensic investigation approach and, by doing so, to identify the cases for statistical reporting.
- An alarming increase in the drug use associated pathology is noted – acute infectious, sub-acute or chronic, that supports the need to take more efficient *harm-reduction* and medical education measures among the drug users, in particular given the background of the explosion in the use of and move to NPS, with all the risks associated with their specific use *patterns* (very frequent injection, street doses of uncertain quantitative and qualitative composition that are contaminated with microbes).
- It was found that the pathologies consequent to the injection of insoluble substances persist, probably their source being the pills or tablets taken from the pharmacies or treatments.
- The emergence of peaks of incidence in 2 months of 2012 points out to possible fluctuations in the quality of the street doses or to special circumstances that result in the doses’ extensive microbial contamination.
- The average indirect deaths age is paradoxical, it being lower than that found in direct deaths, probably a reflection of the accelerated degenerative potential of the new substances in use (with relatively rapid deterioration/decompensation, once chronic consume is initiated), but also of such substances’ lower lethal potential (that seldom leads to lethal overdoses).
- The opiate category remains the most thanato-generating drug, however frequently associated with medicines.
- In the range of directly drug use associated deaths it is found that substances seen in previous years have reappeared (fortral, ketamine), as well as an increase in the incidence of medical drugs in the cases – possible expression of an ever laxer control of medical drug circuits.

- Cocaine is missing from the cases reported, in opposition with the European trends of the past years. The number of identified amphetamine/ methamphetamine/ ecstasy type substances is on the rise.
- The tendency to decrease the use of NPS found in previous years has ceased. The toxicological identification difficulties, sale and possession legality, the perceived “low” overdose risk, the low price, the sufficient potency have all lead to the extensive use of NPS, thus substituting drugs/medicines widely found in previous years, yet increasing the multi-systemic, quickly installed and rapidly decompensated pathology specific to the injectable drug users and more so the infectious pathology – HVC, HIV.
- The alarming outburst of HIV among the drug users, that has seen a ascending trend during the past two years, requires rapid and energetic intervention.

## RECOMMENDATIONS:

1. Support the forensic medicine network to access Government and European financial support for equipping the toxicology labs all around the country, in order to widen the identification and reporting area.
2. Rapid initiation of equipping and research programmes aimed at developing the means for identification of NPS in biological samples.
3. Accelerating the efforts to implement the legislative proposals in view of unifying the methodology for reporting directly drug related deaths.
4. Unifying the forensics criteria for defining direct drug related deaths.
5. Implementing a computer based data collection system for the direct drug related deaths.
6. National and international dissemination of direct drug related deaths management capabilities of the forensic medicine network. For the purpose of ensuring consistency of toxicological detection all around the country, methodological standards were issued to the County Forensic Services establishing toxicological safety rules and obligations that must be complied with, based on the academic knowledge base acquired from the intensive training programmes, as well as on the recommendations to transfer the samples to good performance labs in selected cases.
7. Facilitate access of forensic doctors to scientific meetings, seminaries, exchanges of experience, in view of ensuring consistency of method in direct drug related death cases.
8. Introducing changes in procedures in view of implementing the measures that proved efficient – data collection and reporting flow.
9. Establishing the custody of material evidence and/or information flow concerning the results of criminal and toxicological investigations etc.
10. Updating the list of psychoactive substances subject to special pharmacy release conditions or that are incompatible with particular activities.
11. Large scale toxicological testing of traumatic deaths.
12. Popularisation among medical and investigation/examination staff of the legal provisions concerning the requirement to apply a forensic approach in drug related deaths.
13. Implementing more efficient *harm-reduction* and medical education measures.
14. Maintaining and strengthening the legal provisions on the sale/use of NPS and amending them with strict definitions of substances and their classes, as well as incrimination of sales methods.
15. Introducing early therapy interventions for HIV infected problem drug users, in view of preventing the spread of the epidemics.
16. Strict regulation – perhaps by adopting national reference guides – of the criteria for including persons in the substitutive methadone treatment and, above all, development and firm compliance with treatment prescription and release rules.

## Chapter 7 - Responses to health correlates and consequences

### RESPONSES ON THE PREVENTION OF CONSEQUENCES OF DRUG-USE ON HEALTH

In terms of risk reduction, the year 2012 was marked by worrying trends revealed by the statistics back since 2010, on the transmission of HIV in Romania.

"Drug users are not criminals. In order to protect ourselves and others we need correct information, education, hospitals, needle exchange programmes, understanding and tolerance. Many have been through extreme experiences, but are willing to come back and rebuild their liver. Give us this chance.", says Alexandru, former drug user<sup>77</sup>, at the **Press conference „Don't ignore! Protect yourself, do the test!"**, organized by the **National Institute for Infectious Diseases "Prof. dr. Matei Balș"**, on the occasion of the **World HIV/ AIDS day** (December 1st 2012).

#### 7.1 PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

The major social actors with a significant presence in this issue in Romania, which carried out specialized interventions for the prevention and treatment of infectious disease of IDUs were in 2012: National Anti-Drug Agency, Ministry of Health (especially the *National Institute for Infectious Diseases „Prof. Dr. Matei Balș"*) and National Administration of Penitentiaries.

This year, only two NGOs were more active in this area –Romanian anti-AIDS Association and the CARUSEL Association, the others remaining without resources and being obliged to limit their activities and stop providing services for injection drug users, as the main donors, Global Fund programme and UNODC withdrawn from Romania.

As the first public authority responsible for anti-drug policies at national level, the National Anti-drug Agency acted according to its resources and within its legal powers to compensate for the major shortage of *harm-reduction* services recorded after the withdrawal of main international donors of such interventions from Romania. Thus:

- Concerned with continuing services for injection drug users and with controlling any HIV epidemic among them, in consultation with civil society representatives, the National Anti-drug Agency decided to procure, within the *Sub-programme 6 of the National programme of medical, psychological and social care of drug users – 2009-2012*<sup>78</sup> 142,500 syringes amounting to 74 214 RON<sup>79</sup>, to be distributed to partner NGOs (ARAS și CARUSEL) in order to reduce the injecting drug use-related negative consequences as a public health approach. Also, at the end of 2012, NAA has also purchased another 800,000 syringes and other medical supplies which will be used during 2013 to control infections caused by injection drugs use.

Pursuant to its role of *national coordinator* of drug policies in Romania, in 2012 NAA made efforts to configure an *institutional framework for consultations and joint interventions*, organizing meetings and joint activities with the NGOs that provide risk reduction services in order to develop needle exchange programmes in the community, to reduce risks and negative consequences of drug use among vulnerable groups.

Also in 2012, NAA signed **5 protocols framework for collaboration with NGOs** working in the field of risk reduction: ARAS, CARUSEL, RAA, ALIAT and SAMUSOCIAL.

<sup>77</sup> <http://www.sanatateatv.ro/stiri-medicale/11399-de-romani-sunt-infectati-cu-hiv/sida/>

<sup>78</sup> GD no. 1102/2008 for the approval of the National Programme of medical, psychological and social assistance of drug users 2009-2012.

<sup>79</sup> Average annual exchange rate in 2012: 1Euro = 4.4560RON



**The Ministry of Health**, as institutional actor, with significant presence and responsibilities in the prevention and treatment of infectious disease among IDUs, acts under **Order no. 1591/ 1110/ of 30 December 2010 for the approval of technical rules for the national health programmes for 2011 and 2012<sup>80</sup> as subsequently amended and supplemented**. Under Chapter I – National programmes on infectious disease, this order provides the implementation of a National programme for infectious disease surveillance and control (priority infectious diseases, HIV infection, tuberculosis, sexually transmitted infections), with four sub-programmes (from 2.1 to 2.4). Sub-programme 2.2. for the surveillance and control of HIV infection is under the technical coordination of the National Institute of Public Health and the National Institute for Infectious Diseases 'Prof. Dr. Matei Bals' in Bucharest, having as main goals: „*maintaining HIV incidence in adults at the level of the year 2008*”, and “*reducing the vertical transmission of HIV*”. One of the physical outcome indicators provides a “*number of HIV tests conducted for risk groups of: 100,000*”.

Also, the Section B of the above-mentioned Order – “Evaluation, preventive and curative national health programmes, funded by the National Unique Health Insurance Fund” provides for, under the National programme for communicable diseases, the implementation of a Sub-programme for the treatment of HIV/AIDS-infected people and post-exposure prophylaxis. The main activity provided thereof is “*providing inpatient and outpatient antiretroviral drugs and drugs for associated infections required for the treatment of HIV/AIDS-infected patients and for the (occupational and vertical) post-exposure treatment*”. The sub-programme provides resources for the treatment of 8,000 HIV/AIDS-infected people (with an average cost/patient/year of 24,965 lei<sup>81</sup>) and for the post-exposure treatment of 350 people (with an average cost/patient/year of 800 lei<sup>82</sup>).

Another institutional actor in the field of public authorities which carried out activities for the prevention and treatment of infectious diseases of IDUs in prison environment is the **National Administration of Penitentiaries**. In 2012 we notice a significant restriction of coverage and impact of the injecting supplies distribution programmes, which were implemented in only two prison units in Bucharest – Rahova and Jilava.

Although fewer than in the previous years, due to the lack of support from international donors and limited governmental resources, the activities carried out by **non-governmental organizations with anti-drug expertise**, especially in the area of syringe exchange community services (*outreach* or *drop in* centres) were promoted and partially supported by authorities (within available resources), being recognized as viable and efficient interventions to prevent and treat infectious diseases among IDUs.

Thus, the most important project implemented by an NGO for the reduction of risks and consequences of drug use in 2012 was the “**SECOND CHANCE**” project, co-financed by the European Social Fund through the Sectoral Operational Programme Human Resource Development 2007 – 2013, “Invest in people”, implemented by ARAS, in partnership with the *Integration* and *Sens Pozitiv* Associations and the *National Institute for Infectious Disease „Prof. Dr. Matei Balș”* between 1 July 2010 and 1 June 2013. The project provided *harm reduction* services and substitution treatment, but its ultimate goal was to facilitate the employment of 3,500 beneficiaries with a total funding of 20,812,555 RON.

In 2012, an important component of this project was the sterile syringe distribution and used syringe recovery and provision of methadone substitution treatment:

- The **Risk reduction centres for drug users** provide free and confidential services of: syringe exchange, HIV/HBV/HCV voluntary counselling and testing, HAV and HBV vaccination, support, information and education, risk reduction counselling, referrals to other types of services.
- **Outreach services** consist of: informing and educating beneficiaries on HIV/AIDS/other STDs, testing procedures, meaning of HIV test, universal safety and hygiene rules, information and counselling on the risk related to injection drugs use, condom distribution, syringe exchange and distribution of other sterile injection supplied; referrals to HIV voluntary counselling and testing centres, referrals to specialised medical rehab, substitution or post-treatment facilities, distribution of information materials

<sup>80</sup> Published in the Official Gazette of Romania, part I, No. 53 bis/ 21.01.2011

<sup>81</sup> Average annual exchange rate 2012: 1 Euro= 4.4560lei

<sup>82</sup> Idem 31

**Table no. 7-1. Number and type of functional syringe exchange programmes within the project**

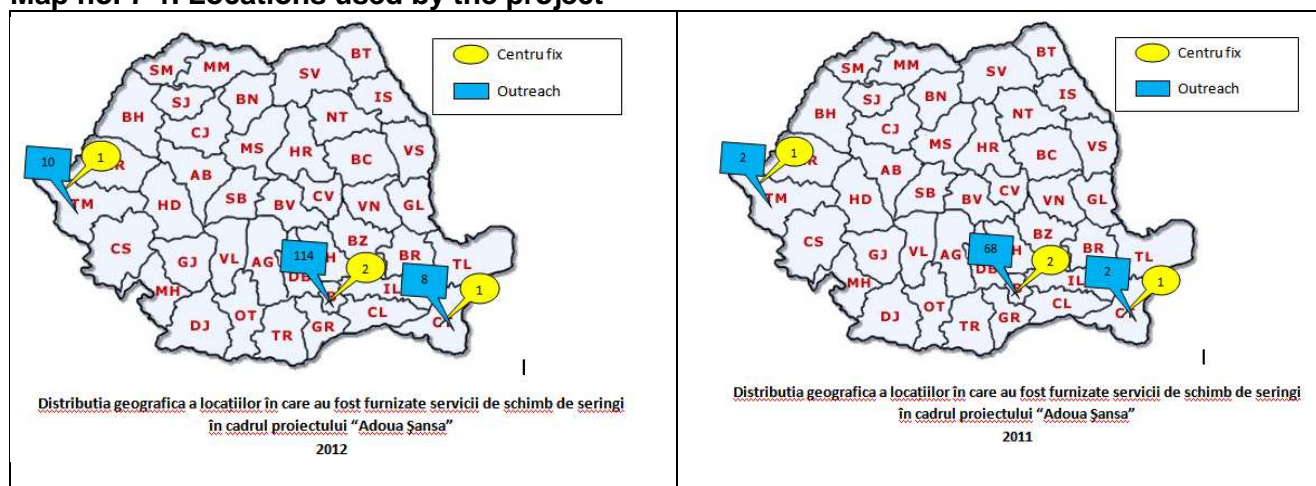
Type of syringe exchange programme	No.	Location/-City
Fixed Centres	4	Constanța Timișoara Bucharest (ARENA Centre) Bucharest (TITAN Centr)
Mobile units – outreach teams	4	Constanța Timișoara Bucharest (ARENA Centre) Bucharest (TITAN Centr)

Source: ARAS

In 2012, the project was implemented in 4 fixed centres in Timișoara and Bucharest (ARENA and TITAN Centres) and in 114 locations of the 4 outreach teams in Timișoara, Constanța and Bucharest.

Similarly to 2011, community syringe distribution/exchange programmes were mainly implemented in Bucharest, although this project also developed services in the two big cities located in the Eastern and Western extremities of the country – Constanța and Timișoara. The situation is similar to that from 2003-2004, when pilot services were implemented in Bucharest, Constanța, Timișoara and Iași<sup>83</sup>, the services in the country being closed because of the lack of resources or beneficiaries' addressability.

**Map no. 7-1. Locations used by the project<sup>84</sup>**



Source: ARAS

Compared to previous years when ARAS covered, through 2 outreach programmes, 10 areas in Bucharest (2006), the data for 2012 indicate the maintenance of an upward trend in the number of locations served by mobile outreach units (114 in 2012 compared to 68 in 2011), which suggests a significant dispersion of users at the level of the three cities where the services were provided.

**Table no. 7-2. Direct project beneficiaries**

Interventions in:	No. of beneficiaries		No. of new beneficiaries	
	2011	2012	2011	2012
Fixed centres	3,135	2,157	2,119	1,101
Mobile –outreach centres	2,040	2,326	1,255	1,359
General total	4,832	4,012	3,030	2,054

Source: ARAS

The number of unique beneficiaries served by the project has significantly decreased in 2012 (about 800 less than in 2011), being equally distributed between the two types of services, with a slight preponderance of mobile outreach services. Even if the project and the partner organisations in the

<sup>83</sup> See National Report of drug use in Romania, 2004

<sup>84</sup> See ST no.10

implementation consortium have not explicitly developed interventions for direct beneficiaries as secondary distributors of sterile injection equipment, we estimated about 25-25% of secondary distributors for fixed centers and 20- 30% for mobile units customers.

The presented project continues, historically, the specialized interventions of ARAS at community level for the distribution / exchange of injection equipment for drug users. Thus, during 2004-2012, the programs of this organization have been accessed by 19,700 beneficiaries, many of whom were assisted both in specialized fixed centers and by the mobile outreach units (2,391 clients). By 2012, the fixed centres for needle exchange, operational since 2007, assisted in total a number of 8,457 customers.

**Table no. 7-3. Supplies distributed in the project**

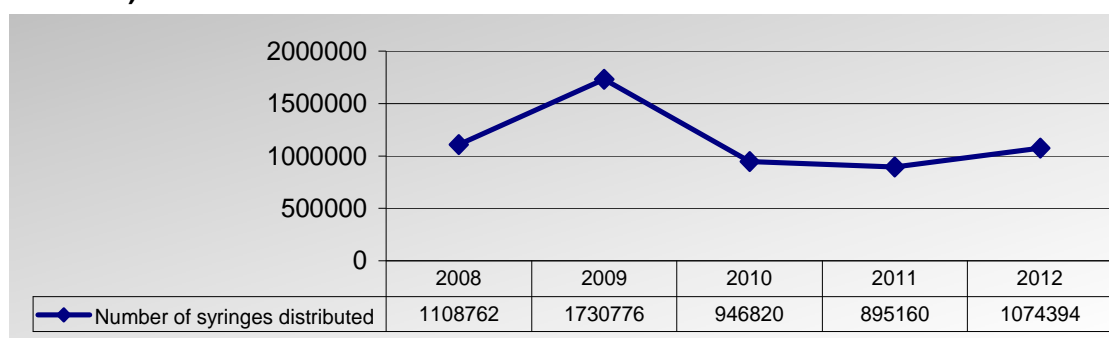
	No.	
	2011	2012
syringes distributed	895,110	1,015,834 <sup>85</sup>
syringes recovered	316,033	340,643
condoms distributed	204,099	189,657

Source: ARAS

Regarding the return of used syringes, in 2012 we registered a rate of 33.5%, slightly lower compared to 2011 (35.3%). Taking into account the return rates reported in the programs funded by the Global Fund to Fight HIV / AIDS, Tuberculosis and Malaria (36.8% in 2010), the indicator remained constant throughout the period of the service implementation.

Analising several data sources available for consultation in the reports developed in this area (*UNGASS Report, Romania, 2010 Country Progress Report on AIDS, January 2010 - December 2011* NAA National Report on drugs, 2011), the specialists of the Romanian Harm Reduction Network (RHRN) achieved, in a report published in 2012<sup>86</sup>, the estimated values of key indicators specific for distribution / syringe exchange programmes developed in Romania between 2008-2011. Continuing the exercise initiated by RHRN by introducing the data reported to NAA by the two providers of such services in 2012, an increase in the number of syringes distributed compared to the last two years and a return to the situation recorded in 2008 is noticed.

**Chart no. 7-1. Evolution of the number of syringes distributed to IDUs in Romania during 2008-2012 (estimation)**



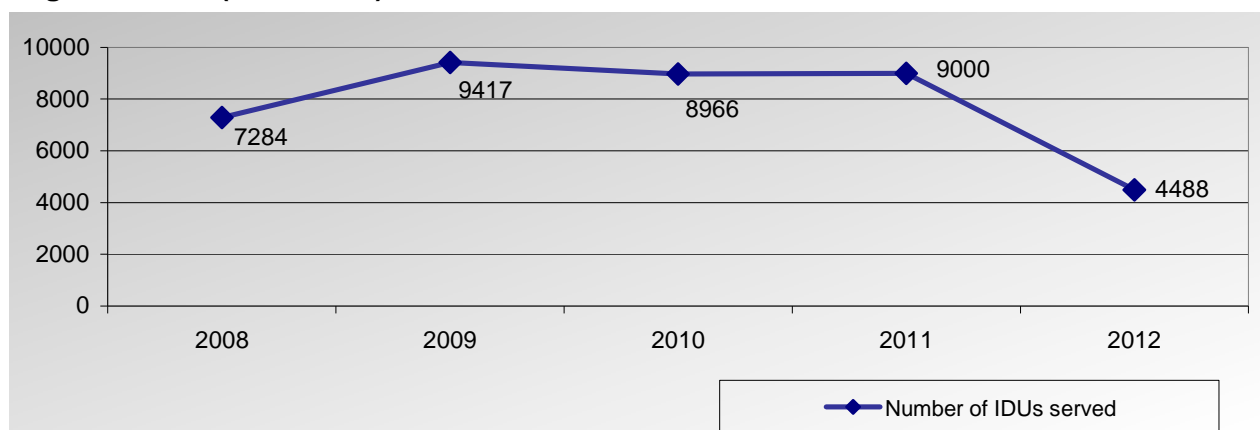
Source: RHRN & NAA

If in 2008 needle exchange programmes were exclusively funded from external funds (the programme "Towards universal access to prevention, HIV / AIDS Treatment and Care and Social Assistance for Vulnerable and disadvantaged groups" funded within the framework of the 6<sup>th</sup> round of EU grant awarded by the Global Fund to Fight HIV / AIDS, Tuberculosis and Malaria) in 2012 the funding was ensured through interventions of public authorities, NAA and MH (the state budget), which added new financial resources from Structural Funds (SOP HRD).

<sup>85</sup> A number of 100,000 syringes were distributed within the project of collaboration between ARAS and NAA during September – December 2012.

<sup>86</sup> <http://rhrn.ro/public/uploads/file/214/costurile-politicilor-antidrog.pdf>

**Chart no. 7- 2. Evolution of the number of IDUs served by the syringe exchange programmes during 2008-2012 (estimation)**



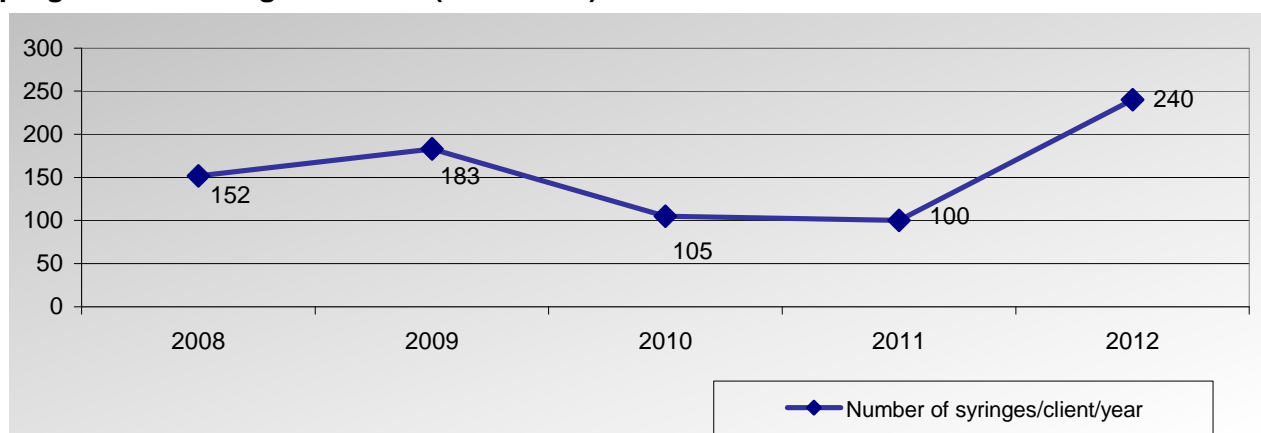
Source: RHRN & NAA

As regards the number of IDUs served in needle exchange programmes, if in 2009 (when most such services were functional) such interventions registered a peak, in 2012 the lowest number of beneficiaries who were distributed sterile injection is registered.

Considering the trend registered in 2012 in the key epidemiological indicator Admission to treatment for drug abuse, of significant decline in the number of users who administer drugs through injections, we can estimate that data provided by the needle exchange programmes follow the same trend.

The next indicator - average number of syringes / user / year is directly correlated with the number of IDUs who benefited from the needle exchange programmes the next indicator -

**Chart no. 7-3. Evolution of average number of syringes /client/ year within the syringe exchange programmes during 2008-2012 (estimation)**



Source: RHRN & NAA

The decrease in the average number of syringes/client/year provided in the syringe exchange programmes in recent years compared to the "peak" recorded in 2009 or even to the value recorded in 2008 directly influences the increase of IDUs infection risk. Community services had a low capacity, providing only a limited number of syringes, the user being forced to use for several times the same injection equipment.

In 2012, the average annual number of syringes / IDU is bigger than the estimated figures for the most "prolific" years in this regard. This may be explained as follows:

- the coverage of such services<sup>87</sup> decreased significantly compared to previous years (about 23% in 2012 compared to 50% in 2009 and 2010), while the number of syringes available in the distribution / exchange programmes was maintained or even slightly increased

<sup>87</sup> Calculated as % of the total of 19,265 IDUs previously estimated by the PDU indicator.

- turning heroin injection users into NPS injection users and the change of *patterns* injection (between 3-5 injections / day<sup>88</sup>) implicitly assumed a greater need for syringes.
- Increased concern of authorities and specialists for the threat of HIV among IDU population resulted in a larger number of syringes offered to each beneficiary.

### RESULTS of the ANA-ARAS-CARUSEL PARTNERSHIP IN 2012

As mentioned previously, the NAA provided, with public funding, the distribution, of 142,500 syringes to injecting drug users in Bucharest, through its non-governmental partners - ARAS Association (Harm Reduction Centres - Grozovici and Titan ) and the Carousel Association (CARACUDA Harm Reduction Centre).

**These syringes have covered only a small part of the actual need relative to the number of injecting drug users (19,265 problematic drug users in Bucharest, according to the National Report on drugs 2012 - Romania) and the number of injections per day administered by them.**

This joint project also provided the opportunity to achieve a pilot system for collecting and analyzing data on syringe exchange services implemented in the municipality of Bucharest. The results of this pilot system, conducted between May and December 2012, are presented below.

**Table no. 7-4: Distribution of the number of visits to services and the number of beneficiaries of each service provider**

Provider	Number of beneficiaries	Number of visits
ARAS	850	2339
CARUSEL	476	1595
Total	1326	3934

Source: NAA

As shown, ARAS has provided drug-related risk reduction services for about 60% of the 1,326 registered beneficiaries, while CARUSEL serviced the remaining 40%.

**Table no. 7-5: Distribution of the number of accessions to services and the number of beneficiaries, by types of services**

Type of service	Number of beneficiaries	Number of accessions and percentages
Fixed centre	1069	3437
		87.4%
Outreach	257	497
		12.6%
Total	1326	3934
		100.0%

Source: NAA

By the type of service accessed, the 1,326 beneficiaries registered 3,934 hits – 87.4% in the fixed centres and only 12.6% were contacted in the field by the *outreach* teams. This suggests on the one hand, a stabilization of the IDUs behaviour in relation to the service provider (confidence in the services provided by fixed centres) and on the other hand the limitations in terms of available resources to achieve systematic and sustained *outreach* activities. Priority access to services like *drop-in* centre represents a significant opportunity, both in terms of opportunities for referral of such beneficiaries to specialized services and in terms of initiation and subsequent development of in depth social research approaches, using qualitative methods and techniques.

Another important aspect worth mentioning is **the average number of hits of any supplier / service type, of 2.96** at the level of recorded population.

Regarding the socio-demographic characteristics of the registered population of beneficiaries we notice the following:

<sup>88</sup> See the results of BSS 2012 in Chap. 4.2. of this report.

**Table no. 7-6: Distribution of direct beneficiaries by age groups and gender**

Gender		Age group							Total
		under 15	15-24	25-34	35-44	45-54	55-64	over 65	
male	Nr.	4	164	590	230	41	5	2	1036
	%	0.3%	12.4%	44.6%	17.4%	3.1%	0.4%	0.2%	78.2%
female	Nr.	0	78	148	54	8	0	0	288
	%	0.0%	5.9%	11.2%	4.1%	0.6%	0.0%	0.0%	21.8%
Total	Nr.	4	242	738	284	49	5	2	1324
	%	0.3%	18.3%	55.7%	21.5%	3.7%	0.4%	0.2%	100%

Source: NAA

As shown in the table above, most beneficiaries are male (78%), only 228 females being registered in the total of 1324 registered beneficiaries (valid cases). Regarding the distribution of beneficiaries by age it is evident their significant concentration within the 25-34 age group, which indicates the correct focus of services on the main group at risk (as shown in most of the studies and surveys conducted by NAA on the IDUs population in Bucharest).

**Table 7-7: Categories of beneficiaries**

Type of beneficiary	IDUs	Sexual workers	Homeless	Street children	Roma people
No.	1326	45	208	8	619
%	100	3.4	15.7	0.6	46.7

Source: NAA

All 1326 registered beneficiaries admitted they were drug users, 3.4% said they were sex workers, 15.7% homeless, and nearly half (47%) are Roma citizens.

**Table no. 7-8: Distribution of beneficiaries by age group, by the main drug used**

Main drug used over the last 30 days		Age group							Total
		under 15	15-24	25-34	35-44	45-54	55-64	over 65	
unspecified	Nr.	0	1	0	1	0	0	0	2
	%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.2%
heroin	Nr.	1	105	319	126	26	1	0	578
	%	0.1%	7.9%	24.1%	9.5%	2.0%	0.1%	0.0%	43.7%
NPS	Nr.	2	124	382	144	20	4	2	678
	%	0.2%	9.4%	28.9%	10.9%	1.5%	0.3%	0.2%	51.2%
polydrug	Nr.	1	13	36	13	3	0	0	66
	%	0.1%	1.0%	2.7%	1.0%	0.2%	0.0%	0.0%	5.0%
Total	Nr.	4	243	737	284	49	5	2	1324
	%	0.3%	18.4%	55.7%	21.5%	3.7%	0.4%	0.2%	100.0%

Source: NAA

By the main type of drug used, we note that in the period when the data were registered the use of new psychoactive substances prevailed (51%), followed by heroin (44%) and two drugs use 5%. Considering the age groups we also note a concentration of both heroin and NPS use in the 25-34 age group.

**Table no. 7-9: Statistical indicators of the central tendency in the number of distributed syringes (medium/ median/ mode)**

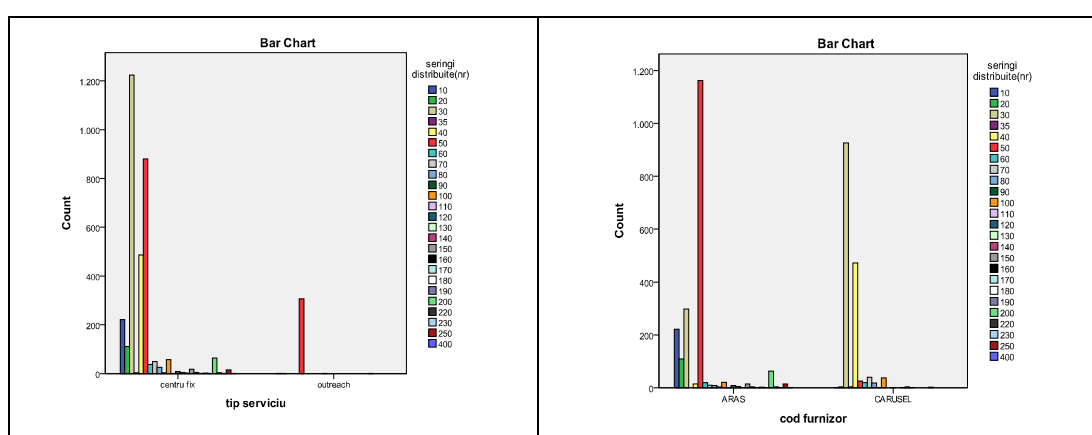
Medium	44.77
Median	40.00
Mode	30
Total	158560

Source: NAA

If we compare the number of syringes distributed, we can see that out of **158560 units distributed** by the two service providers, the most frequent number of distributed syringes / access was 30, in the 3542 hits of *harm-reduction* services mentioned, and on average 40 syringes at each visit.

**Chart no. 7-4: Comparative analysis of the number of syringes distributed, by type of service and type of provider**

**No. of syringes distributed/ type of service      No. of syringes distributed/ provider**



Source: NAA

The comparative analysis of the two graphs above in what concerns the types of services, shows that fixed centres distributed most frequently 30 syringes/visit (mode), while outreach services mainly distributed 50 syringes / access. There are also differences between the two service providers, ARAD distributing mostly 50 syringes / access while CARUSEL 30-40 syringes / access.

**Table no. 7-10: Statistical indicators of the central tendency in the number of collected syringes (medium/ median/ mode)**

Medium	94.50
Median	60.00
Mode	10
Total	37139

Source: NAA

Relative to the number of syringes collected, there is a recoverability rate of only **23.42%** (37139 syringes recovered), **most often about 10 syringes being recovered at each visit to the service provider.**

As noted in the following table, out of the total of 1326 customers served during the mentioned period, almost 60% received information services, only 5% counselling services, 4.2% needed medical care, 0.9 % (12 cases) were tested for infectious diseases and received post-test counselling, one case received accompaniment **and no case has been referred to an upper level service.**

Basically, the monitored services operate mainly autonomously, a strengthening of cooperation with other public or private services available in the reference area being necessary, in order to initiate an integrated and consistent case management of direct beneficiaries identified.

**Table no. 7-11: Number of services/ types of services provided to beneficiaries**

Type of service	information	counselling	Medical care	Infectious disease, HVB, HVC, HIV testing	Infectious disease post-testing counselling	Referrals to other services	accompaniment
Nr.	792	75	57	12	12	0	1
%	59,7	5,6	4,2	0,9	0,9	0	0,07

Spurce: NAA

## Conclusions

In terms of institutional responses to the sharp rise in the number of cases of HIV infection in 2011 that continued in the following year as a result of the rapid proliferation of the phenomenon of new psychoactive substances and significant change in the injection *patterns* followed by IDUs, 2012 is characterized by:

- The cooperation of NAA with all institutional actors involved in activities for reducing the risks related to drug-use in the development and implementation of common measures and interventions to counter balance the growing dynamics of HIV cases among injecting drug users, especially those who have moved from the use of opiates to that of new psychoactive substances
- Sensible reduction in the availability of community services to prevent infectious diseases among IDUs (only two specialized NGOs have worked in 2012 in Community programs to reduce the risks associated with drug use - ARAS and CARUSEL).
- Continuing the efforts to identify alternative funding sources for community programmes to reduce the risks associated with drug use.
- In the new framework of cooperation with NGOs working in the field of reducing the risks associated with drug use (which included the purchase and distribution to partners in civil society a number of 142,500 syringes in 2011 and continued this work in 2012, with the acquisition of other 800,000 syringes), NAA launched in the second half of 2012 a pilot system for collecting and analyzing data on syringe exchange services implemented in the municipality of Bucharest.



## Chapter 8 - Social correlates and social reintegration

### 8.1 SOCIAL EXCLUSION AND DRUG USE(DRUG USE AND SOCIAL EXCLUSION)

#### 8.1.1 SOCIAL EXCLUSION AMONG DRUG USERS

In the national reports from previous years, the data on social issues represented by social correlations of drug use were mainly collected through routine monitoring of the indicator *Admission to treatment as a result of drug use – Treatment admission indicator* - or taken out from other research studies on relevant aspects of drug use.

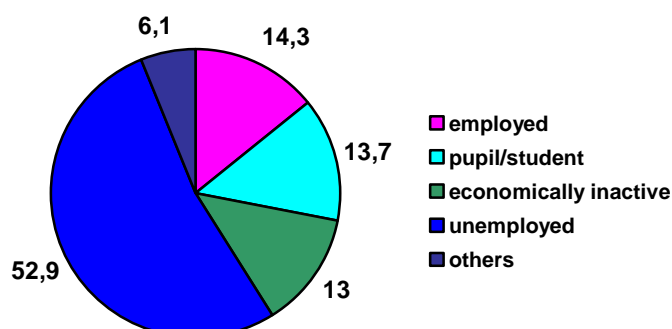
In this report, beside the data collected through the *Treatment admission indicator*, some other data resulted from the following are presented:

- Monitoring the medical emergencies as a result of drug use indicator<sup>89</sup>;
- The first specific study conducted by the National Anti-drug Agency for the assessment of social exclusion risk faced by drug users.

##### 8.1.1.1 Treatment admission indicator data<sup>90</sup>

**Occupational status** – most people (52.9%) who were referred to treatment services in 2012 are not employed on labour market, compared to 14.3%, who were economically active (employed); a similar ratio can be seen also for pupils and students (13.7%) and for those who are economically inactive<sup>91</sup> (13%).

**Chart no. 8- 1: Occupational status of people admitted for treatment in 2012, following drug use (%)**



Source: NAA

Comparatively, by gender, the occupational status of people admitted to treatment in 2012, following drug use, is as follows:

- male beneficiaries are found mainly as belonging to the following categories: „employed” (16.2% versus 8.5%) and „unemployed”<sup>92</sup> (57.5 % versus 39.3%);
- instead, female beneficiaries are mainly found in the „economically inactive” category (32.7% versus 6.3%).

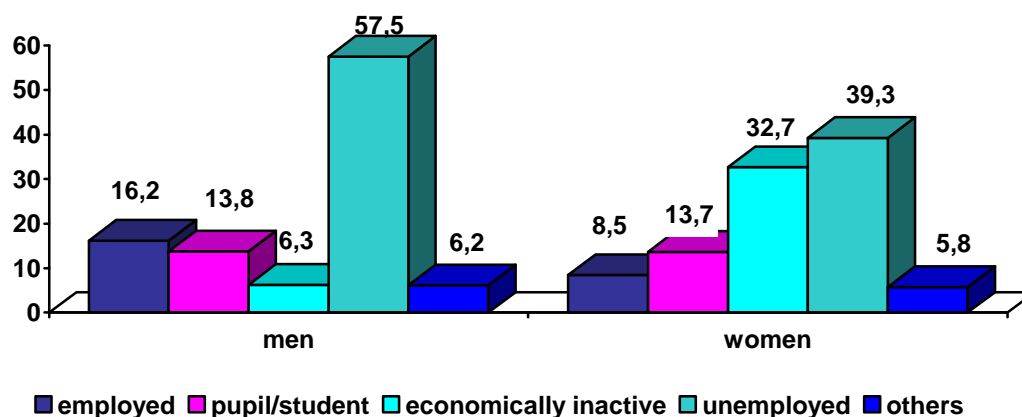
<sup>89</sup> Note: the cases for which the variables: gender, occupational status, educational level were not presented were excluded from the analysis

<sup>90</sup> Note: the cases for which the variables: gender, occupational status, educational level, type of housing, housing conditions were not presented were excluded from the analysis

<sup>91</sup> retired/homeworker/ medically retired

<sup>92</sup> worker without labour contract/ unemployed/ without occupation

**Chart no. 8- 2: Distribution of treatment admissions in 2012, by the occupational status and gender (%)**



Source: NAA

By the types of drugs used before being admitted to treatment, drug users have the following characteristics in terms of occupational status:

- opiate (62.6%), NPS (60,9%), and hallucinogens (60%) users are, mainly, people who are not employed on the labour market, whereas pupils/students represent 41.7% of the stimulant users;
- cocaine users are found in equal proportions in the employed and unemployed categories (21.7%);
- the same situation can be seen for people admitted to treatment for cannabis use, where similar figures are registered for the categories pupil/ student or unemployed (33.8% and 35.7% respectively).

**Table no. 8- 1: Distribution of treatment admissions in 2012, by occupational status and types of drugs used (%)**

Occupational status	Types of drugs								Total
	opioids	cocaine	stimulants	hallucinogens	Solvents and inhalants	cannabis	other substances	Psychoactive substances	
employed	20.9	21.7	25	20	0	18.8	9.4	8.5	15.5
pupil/ student	1.5	13	41.7	0	29.6	33.8	18.9	24.9	15.6
economically inactive	7.8	4.3	0	0	7.4	0.9	20.8	1.3	4.9
unemployed	62.6	21.7	33.3	60	48.1	35.7	50.9	60.9	57.1
others	7.1	39.1	0	20	14.8	10.8	0	4.3	6.9
Total	100	100	100	100	100	100	100	100	100

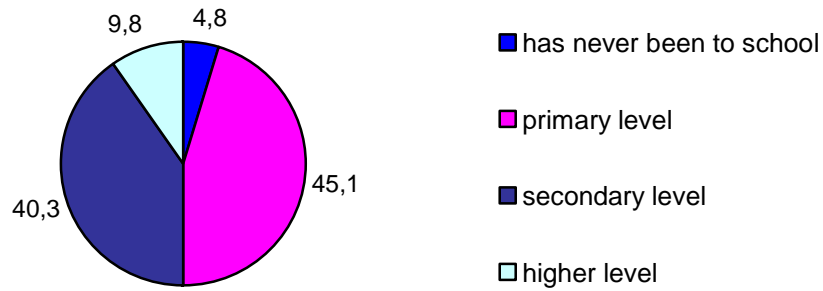
Source: NAA

### Educational level

The educational level of people who addressed to treatment services in 2012 has the following particularities:

- most beneficiaries of assistance services have at most a secondary level of education: primary (45.1%) and secondary (40.3%);
- those with a higher level of education are about twice as many compared to those beneficiaries who have never been to school or who have not completed a primary level of education (9.8% versus 4.8%).

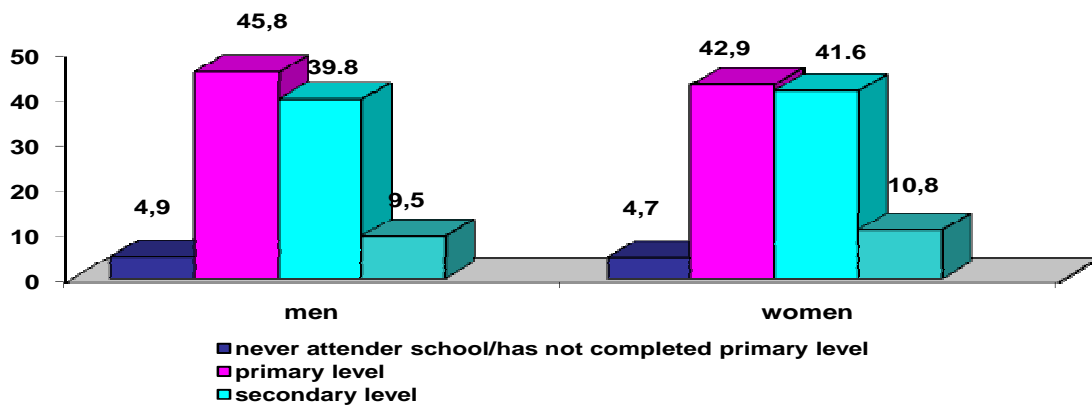
**Chart no. 8- 3: Educational level of people admitted for treatment for drug use in 2012 (%)**



Source: NAA

There are no significant differences by gender, in terms of educational level of people admitted to treatment as a result of drug use in 2012.

**Chart no. 8- 4: Distribution of treatment admissions in 2012, by educational level and gender (%)**



Source: NAA

By the types of drugs used, the research highlights the following:

- beneficiaries with primary education are found mainly among those users who use: hallucinogens - 75%; solvents and inhalants – 66.7%; psychoactive substances - 56%; opioids – 45.2%.
- stimulants and cannabis users are mostly beneficiaries with a secondary level of education (61.5%, and 53% respectively);
- most cocaine users category (90%) is made by relatively equal groups of people with primary and secondary level of education (45.5%).

**Table no. 8-2: Distribution of treatment admissions in 2012, by educational level and type of drug used (%)**

Educational level	Types of drugs								Total
	opioids	cocaine	stimulants	hallucinogens	solvents and nhalants	cannabis	Other substances	Psychoactive substances	
Has never attended school/ has not completed primary education	7.8	0	0	0	22.2	0.9	0	3.7	5.2
Primary level	45.2	45.5	23.1	75	66.7	35.6	38.5	56	47.9
Secondary level	36.2	45.5	61.5	25	11.1	53	53.8	32.7	37.7
Higher level	10.8	9.1	15.4	0	0	10.5	7.7	7.5	9.3
Total	100	100	100	100	100	100	100	100	100

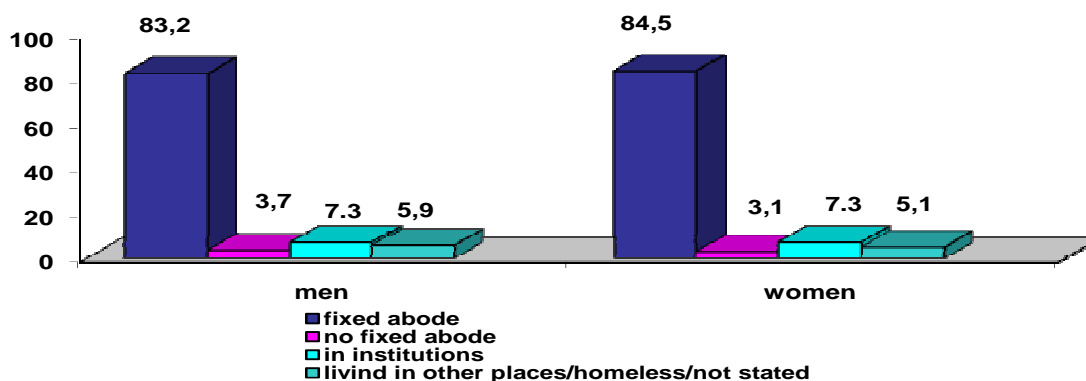
Source NAA

**Living conditions: type of housing and housing condition**

As regards the **type of housing** in which the people admitted to treatment for drug use live in, the following can be seen:

- most people admitted to treatment have a fixed abode (83.5%);
- the number of those living in institutions (7.3%) is twice the number of those with temporary housing (3.5%);
- the difference up to 100%, respectively 5.7%, is represented by the category of people "living in other places / homeless / not stated"

**Chart no. 8- 5: Distribution of treatment admissions in 2012, by type of housing and by gender (%)**



Source NAA

Similarly to the distribution by educational level, as regards the accommodation conditions of people admitted to treatment for drug use in 2012, no significant differences between men and women.

**Table no. 8- 3: Distribution of treatments admissions in 2012, by type of housing and type of drug used (%)**

Type of housing	Types of drugs								Total
	opioids	cocaine	stimulants	hallucinogens	solvents and inhalants	cannabis	Other substances	Psychoactive substances	
Fixed abode	85.9	47.8	78.6	40	67.9	76.1	87.7	81.4	82.1
Temporary accommodation	3	4.3	14.3	20	0	5	3.5	4.1	3.7
in institutions	7.7	39.1	0	20	14.3	16.2	1.8	5.6	8.3
Living in other places/homeless/not stated	3.5	8.7	7.1	20	17.9	2.7	7	8.9	5.9
<b>Total</b>	100	100	100	100	100	100	100	100	100

Source NAA

By the types of drugs used by people that referred to treatment services in 2012, we found the following:

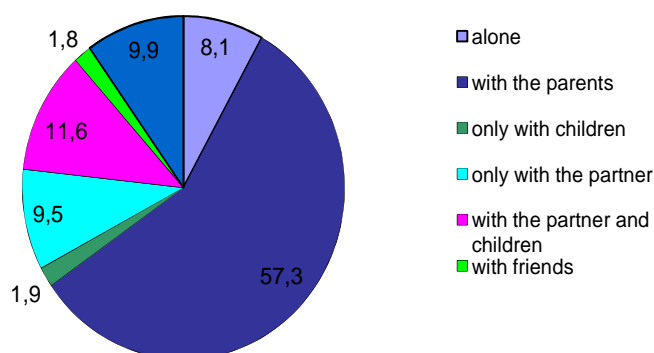
- almost all opioid or psychoactive substances users have a fixed abode (85.9% and 81.4%);
- among those living in institutions we found most cocaine users - 39,1%, 20% of hallucinogens user, 16.2% of cannabis (16.2%) and 14.3% of solvents and inhalants users;
- beneficiaries with temporary accommodation are mostly hallucinogens users (20%) and stimulants users – 14.3%; 5% of those belonging to the other categories have temporary accommodation;
- 20% of hallucinogens users and 17% of solvents and inhalants users live in other places/are homeless /have not stated their living condition; 9% of those using other types of drugs are found belonging to this category 9%.

### Housing situation

As regards the **housing situation** of people admitted to treatment for drug use, we found the following:

- more than a half of those admitted to treatment live with their parents or with their families (57.3%),
- 1,9 of those admitted to treatment live only with their children, while 1.8% live with their friends.

**Chart no. 8-6: Housing condition of people admitted to treatment in 2012 as a result of drug use (%)**



Source NAA

By gender, the housing conditions of drug users is as follows:

- about 2/3 (64.8%) of men and about 1/3 (34.9%) of the women live with their parents or their families;
- similar percentages are registered for men living alone (8%) or with their partner and children (8.5%), while 19.1% of the women live with their partner and 20.8% with their partner and children.

**Table no. 8- 4: Distribution of treatment admissions in 2012, by housing condition and gender (%)**

Housing condition	Men	Women	Total
Alone	8	8.1	8.1
With the parents or with the family	64.8	34.9	57.3
Only with children	0.8	5.2	1.9
Only with the partner	6.2	19.1	9.5
With the partner and children	8.5	20.8	11.6
With friends	1.9	1.5	1.8
Other cases	9.8	10.4	9.9
Total	100	100	100

Source NAA

By the types of drugs used, the beneficiaries of healthcare services have the following distribution:

- ¾ of the psychoactive drugs users and 2/3 of the stimulants users (69.2%) live with their parents or family (75.2%);
- more than 10% of the opioids users and less than 10% of the cocaine users live with their partner and children;
- in turn, about a quarter of hallucinogens users (25%) and of stimulants users (23.1%) live alone.

**Table no. 8- 5: Distribution of treatment admissions in 2012, by housing condition and type of drug used (%)**

Housing condition	Types of drugs								Total
	opioids	cocaine	stimu-lants	halluci-nogens	solvents and inhalants	cannabis	Other substan ces	Psychoa ctive substan ces	
Alone	6.7	13.6	23.1	25	14.8	6.9	16.4	7.7	7.8
With the parents or with the family	58.3	22.7	69.2	50	55.6	62.4	56.4	75.2	64.4
Only with children	1.1	0	0	0	3.7	0	1.8	0.7	0.8
Only with the partner	9.8	9.1	0	0	3.7	6.0	5.5	2.6	6.4
With the partner and children	14	9.1	0	0	0	4.1	12.7	1.6	7.7
With friends	1.4	4.5	7.7	0	3.7	2.8	1.8	2.5	2.1
Other cases	8.8	40.9	0	25.0	18.5	17.9	5.5	9.7	10.7
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Source: NAA

#### **8.1.1.2 Data from the indicator on medical emergencies as a result of psychoactive substances use**

Due to the fact that in 2012 the National Anti-Drug Agency introduced in the data collection protocol for medical emergencies new fields relating to „educational level” and „occupational status”, we present below the results of this analysis.

Thus, by the **occupational status** of the examined persons, the analysis of medical emergencies caused by illicit drug use in 2012 shows the following distribution:

- more than half of the beneficiaries are unemployed (56.3%);
- about a quarter are pupils / students (26.9%);
- 12.7% are employed
- in contrast, 1.3% are economically inactive.

The distribution by gender shows differences in what regards the occupational categories of those who referred to medical emergencies services in 2012 as a result of illicit drug use is the following:

- the category „pupil/student”, is more strongly represented among women compared to men (38.3% versus 23.9%);
- in turn, the number of men who referred to emergency units with problems caused by illicit drug use is three times higher than those of women (14.6% compared to 5.7%).

**Table no. 8- 6: Distribution of people who referred to emergency services in 2012 as a result of psychoactive substances use, by gender and occupational status (%)**

Occupational status	Gender		Total
	Men	Women	
Employee	14.6	5.7	12.7
pupil/ student	23.9	38.3	26.9
Economically inactive	1.2	1.9	1.3
Unemployed	57.3	52.3	56.3
Other categories	3	1.9	2.8
Total	100	100	100

Source: NAA

By the substance consumed and occupational status, the situation of people who referred to medical emergencies services is as follows:

- most cannabis users are unemployed (40.9%) while 34.5% are pupils/ students;
- in equal proportions, 33.3% of cannabis users are unemployed and pupils/ students;
- most psychoactive substances users are unemployed (57.5%), while 30.1% are pupils/students;
- equal proportions of hallucinogens users are employees and pupils/students (29.4%);
- opioids users category is mainly represented by unemployed people (75.6%),
- stimulants users category is made of pupils/students (60%) and unemployed (40%);
- generic drug users category is made of unemployed people (54.5%) and pupils/ students (36.4%);
- volatile solvents users category is made of pupils/ students (18.5%), unemployed (59.3%) and other cases (22.2%).

On the other hand, if within each occupational category we consider an equal distribution of persons by the type of drug consumed, we have the following situation:

- the unemployed are mostly cannabis users (the highest value between observed and expected values: 3.2), a very low number of them being psychoactive substances users (lowest value between observed and expected values:-3.2);
- within the pupils/students category, psychoactive substances users are most strongly represented (highest value between observed and expected values: 2,1), while opioids users are less represented (lowest value between observed and expected values: -5.8);
- most economically inactive people are cocaine users (highest value between observed and expected values:2.8), while a very low number of psychoactive substances users are economically inactive (lowest value between observed and expected values -1.9);
- within the unemployed category, cannabis users is the category with the lowest representation (lowest value between observed and expected values -3.4), while opioids users have the strongest representation (highest value between observed and expected values:3.8).



**Table no. 8- 7: Distribution of people who referred to medical emergency services in 2012 as a result of psychoactive substances use, by occupational status and type of drugs used (%)**

Occupational status	Type of drugs								Total
	cannabis	cocaine	NPS	hallucinogens	opioids	stimulants	Generic drugs	Volatile solvents	
Employee	20.9	22.2	9.4	29.4	19.8	0	3	0	11.8
pupil /student	34.5	33.3	30.1	29.4	1.2	60	36.4	18.5	27.9
Economically Inactive	1.8	11.1	0.7	5.9	1.2	0	3	0	1.1
Unemployed	40.9	33.3	57.5	23.5	75.6	40	54.5	59.3	56.1
Other cases	1.8	0	2.4	11.8	2.3	0	3	22.2	3.1
Total	100	100	100	100	100	100	100	100	100

Source: NAA

By the **educational level**, the distribution of people who referred to medical emergency services as a result of illicit drug use in 2012 is as follows:

- most of the patients of medical emergencies services have a very low level of education: 5.4% have never attended school or have not completed primary education, 45.1% have completed primary school and 40.3% have completed secondary school;
- less than 10% are higher education graduates (9.3%).

**Table no. 8- 8: Distribution of people who referred to medical emergency services in 2012 as a result of psychoactive substances use, by gender and educational level (%)**

Educational level	Men	Women	Total
Have never attended school/ have not completed primary education	4.4	8.8	5.4
Primary education	42.2	56	45.1
Secondary education	43.5	28.2	40.3
Higher education	9.9	6.9	9.3
Total	100	100	100

Source: NAA

In terms of differences between men and women in what regards the educational level, we note that more men have a secondary level of education (43.5% compared to 28.2% of the women). In turn, more women have a primary level of education 56%.

**Table no. 8- 9: Distribution of people who referred to medical emergency services in 2012 as a result of psychoactive substances use, by educational level and type of drugs used (%)**

Educational level	Type of drugs								Total
	cannabis	cocaine	NPS	hallucinogens	opioids	stimulants	Generic drugs	Volatile solvents	
Have never attended school/ have not completed primary education	1	11.1	6.2	0	1.6	0	3.7	12.5	5
Primary education	33.3	22.2	46.9	38.9	43.5	25	48.1	70.8	45
Secondary education	54.5	55.6	39.3	55.6	46.8	0	40.7	4.2	41.3
Higher education	11.1	11.1	7.6	5.6	8.1	75	7.4	12.5	8.7
Total	100	100	100	100	100	100	100	100	100

Source: NAA

By the type of substance consumed, the distribution of people who referred to medical emergency services for problems caused by drug use in terms of educational level is as follows:

- most cannabis users are people with secondary (54.5%) and primary education (33.3%);
- most cocaine users are secondary education graduates (55.6%);
- most NPS users are people with primary education (46.9%), followed by secondary education graduates (39.3%);
- most hallucinogens users are secondary (55.6%) or primary (38.9%) education graduates;
- within the opioids users category, we note equal proportions of people with primary school (43.5%) and secondary school (46.8%);
- the stimulants users category is made of people with higher education (75%) and people with primary school (25%);
- most generic drugs users are people with primary (48.1%) and secondary (40.7%) school;
- volatile solvents users are mostly people with primary school (70.8%).

On the other hand, if we analyse each educational level category by the type of drug used, we notice the following:

- within the category of people with the lowest level of education (have never attended school /have not completed primary school), cannabis users have the lowest representation (lowest value between the observed and expected values -2.0), while solvents users are strongly represented (highest value between observed and expected values:1.7);
- people with educational education who referred to medical emergency services as a result of drug use are mostly cannabis users (highest value between observed and expected values:2.9), solvents users having the lowest representation in this category (lowest value between the observed and expected -3.8);
- among people with secondary education, cannabis users register the strongest representation (highest value between observed and expected values:2.9), while solvents users register the lowest representation (lowest value between the observed and expected -3.8);
- stimulant users are strongly represented within the higher education category (highest value between observed and expected values: 4.7), while NPS users register the lowest representation (lowest value between the observed and expected -1.4);

### 8.1.1.3. Survey outcomes.

In 2012, NAA carried out a specific study for the evaluation of risk/ degree of social exclusion faced by drug users<sup>93</sup>.

The main objective of the study was to assess the degree of social exclusion of problematic drug users that are not registered by the public or private support services, while the specific objective were the following:

- finding information on the educational level, occupational status and housing conditions of problematic drug users that are not registered with the private or public support services;
- finding information on the perceptions of problematic drug users that are not registered with the private or public support services on the access to employment, education and medical, psychological or social services.

The sampling method chosen was the simple random selection, which took account of the simultaneous fulfilment of sample inclusion criteria<sup>94</sup> and the unfulfilment of any of the exclusion criteria<sup>95</sup> established. The sample included 400 drug users from Bucharest (74.2% men and 25.8% women; 95% born in urban areas and 5% in rural areas).<sup>96</sup>

### Results

#### • The existence of identity documents

4.5% of respondents do not have identity documents, which causes a high risk of social marginalization, by limiting their access to basic services needed by every citizen – registration with a GP, school enrolment, employment, participation to elections etc.

By the main type of drug consumed: 20% of methadone users; 16.7% of hashish users; 14.8% of NPS users and 9.8% of heroin users do not have identity documents.

#### • Perception on the social exclusion risk

Only 21.4% of respondents believe they are in a difficult situation because of drug use, the most mentioned problems being the lack of money (41.9%) and of family support (23.9%). Lack of education and training is not perceived as a difficulty by those who participated to this survey, only 6% considering this as the reason for which they are excluded from society.

People (92.9%) who think they are in a difficult situation as a result of drug use are heroin (56%) and NPS (36.9%) users. Few cannabis, cocaine and methadone users consider themselves as being in this situation, the percentages being insignificant in the structure of population perceived as socially excluded (2.4%).

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<sup>93</sup><http://www.ana.gov.ro/studii/Raport%20de%20cercetare%20excludere%202013%20final%20OK.pdf>

<sup>94</sup> Sample inclusion criteria: drug user over the last 12 months prior to the interview, aged between 18-49 (not included), mental and physical ability to understand the questions and instructions, written consent to participate in the research, having lived in Bucharest at least for 6 months within the last 12 months prior to the interview (Ilfov county included)

<sup>95</sup> Sample exclusion criteria: registered in the records of the public or private social assistance services, has answered to the questionnaire before, mental or physical inability to cooperate for the application of the questionnaire, understand Romanian language sufficiently well, no mental disorder that prevents understanding and the conduction of the interview, not under the influence of alcohol or other drugs that might impede the interview etc.

<sup>96</sup> the data collection was done through representatives of CARUSEL Association

**Table no. 8- 10: Reasons for social exclusion, by main type of drug used (%)**

Main type of drug used	Reasons for exclusion					Total
	Lack of education/vocational training	Lack of family support	Lack of a proper housing	Lack of money	Lack of friends	
Cannabis	0	1.2	0	1.2	1.2	2.4
Cocaine	0	1.2	1.2	0	0	2.4
Heroin	4.8	19	9.5	33.3	4.8	56
Methadone	1.2	2.4	0	0	0	2.4
NPS	2.4	9.5	7.1	23.8	3.6	36.9
Total	8.3	33.3	17.9	58.3	9.5	100

Note: the difference up to 100 is made up by other cases

Source: NAA

- **Access to employment / income**

In terms of occupational status, drug users in Bucharest are either employed with a labour contract with indefinite duration (33.6%), or unemployed or staying at home (38.5%). About a tenth of them stated they have a labour contract with definite duration (9.4%) or no labour contract (12.8%).

**Table no. 8- 11: Occupational status, by main type of drug used (%)**

Main type of drug used	Occupational status							Total
	Employed with definite duration labor contract	Employed with indefinite duration labor contract	Working without contract	retired/medically retired	Staying at home/having no occupation	Registered unemployed	Unregistered unemployed	
Solvents	0	0	0	0	0	0	0.3	0.3
cannabis	8.5	26.1	5.8	0	9	0.5	0.5	52.3
Cocaine	0.5	4	0.5	0	2.3	0	0	7.5
Ecstasy	0.5	1.3	0	0	0.3	0	0	2
Hashish	0	0.5	0.3	0	0.8	0	0	1.5
Heroin	0	1.5	3.8	0.3	14.8	0	0	20.6
Ketamine	0	0.3	0.8	0	0	0	0	1
Methadone	0	0.3	0	0	1	0	0	1.3
NPS	0	0.3	2	0	11.1	0	0	13.6
Total	9.5	34.2	13.1	0.3	39.2	0.5	0.8	100

Note: the difference up to 100 is made up by other cases

Source: NAA

While most employees with an indefinite duration labour contract are cannabis users (26.1% out of 34.2%), heroin and NPS users are in the opposite situation (14.8% and 11.1% of the 39.2%) having no occupation or staying at home.

In terms of methods for getting money, the respondents indicated both work contracts, parental support as well as provision of occasional work and illegal activities (sexual services or drug selling).

**Table no. 8- 12: Method of obtaining money, by main type of drug used (%)**

Main type of drug used	Method of obtaining money							Total
	Work with contract	Money from partner/parents or other relatives	Social assistance /unemployment/pension/ other social benefits	Scholarship	Occasional work without labour contract	Selling sexual services	Drug selling	
solvents	0	0	0	0	0	0	0	0.3
cannabis	36.4	18.3	0	0.8	9.7	0	1.5	52.4
cocaine	4.6	3.8	0	0	2.3	0	0	7.6
ecstasy	1.5	0.5	0	0	0.3	0	0	2
hashish	0.5	1	0	0	0	0	0	1.5
heroin	1.3	7.9	0.3	0	12.7	0.8	0	20.6
ketamine	0.3	0	0	0	0.8	0	0	1
methadone	0.3	0.8	0	0	0.5	0	0	1.3
NPS	0	5.3	0	0	8.7	2.3	0.5	13.2
Total	44.8	37.7	0.3	0.8	34.9	3.1	2	100

Source: NAA

By the main type of drug used, the activities carried out in order to obtain an income are as follows:

- for cannabis, cocaine, ecstasy users: employed with labour contract, supported by the family, provision of occasional work, but also drug selling (for cannabis users);
- heroin, methadone, NPS users: supported by the family, occasional work, but also provision of sexual services (in the case of heroin and NPS users) and drug selling (in the case of NPS users).

#### • Access to health services

About a third (31%) of those included in the sample stated they are not registered with a family doctor. Out of those who are not registered with a GP, 36.3% are heroin users, 31.5% are NPS users and 21% reported cannabis as being the main type of drug consumed. Also, out of those who do not have a family doctor, two thirds mentioned the injection drug use (64.5%), while 24.5% reported drug smoking / inhalation.

Among the health problems caused by drug used, the most often invoked was the hepatitis C virus infection – 69%, followed by the infection with HIV – 16.7% and abscesses caused by injection – 14.3%. Other health problems mentioned by the respondents were: muscle pain, mental disorders, headaches, excessive sweating, joint pain, vision problems, weight loss, memory loss, fatigue, dizziness etc.

#### • Access to education/ culture

In order to assess the perception of drug users on obtaining a satisfactory educational status, questions related to their own level of education compared to their aspirations were asked. 61.2% of the respondents said their education level is enough for what they wanted to do in life, while 0.5% consider the level of training obtained is too high compared to their professional aspirations.

Heroin (71.2%), methadone (80%) and NPS (75%) users are mostly dissatisfied with their level of education compared to their ambitions.

About a third (38.3%) who consider themselves insufficiently prepared for their personal ambitions mentioned the lack of motivation as being the main reason for stagnation in terms of achieving the desired educational status (17.3%) and second the financial difficulties faced by their families (12%).

Drug use and the negative influence of the entourage are considered the main barriers in achieving a satisfactory training level compared to the ambitions (11% and 10.5%).

### 8.1.2 LEGAL CONTEXT AND POLICY IN THE AREA

As mentioned in the previous reports, the legal context and the policies in the area were represented by:

- **National anti-drug strategy 2005-2012<sup>97</sup> and the Action Plan for 2010-2012<sup>98</sup>;**
- **National Interest Programme for tobacco, alcohol and drug use prevention - 2009- 2012<sup>99</sup>;**
- **Reform Strategy in the field of social assistance 2011 – 2013** approved by Memorandum of the Romanian Government on the 28<sup>th</sup> of February 2011 and the **Action plan for the implementation of the Reform Strategy in the field of social assistance**, adopted by Order no. 1313/2011;
- **Law no. 292/2011 on social assistance<sup>100</sup> .**

We also mention the specific priority axes and intervention areas included in the structural programmes, through which structural funding can be accessed for projects in the area of reintegration and social reinsertion of drug users:

- Regional Operational Programme (ROP) 2007- 2013 seeks, among other things, to create the necessary conditions for the provision of basic services, contributing to the achievement of the European objective of economic and social cohesion, by improving the infrastructure of health, education, social and public safety services. The Programme includes a priority axis on „improving social, health, public safety infrastructure; modernization of education infrastructure”. The areas of intervention of this priority axis are:
  - Rehabilitation, modernisation and equipping of the health services' infrastructure;
  - Rehabilitation, modernization, development and equipping of social services infrastructure;
  - Improving the equipments of the operational units for public safety interventions in emergency situations;
  - Rehabilitation, modernization, development and equipping of pre–university, university education and continuous vocational training infrastructure.
- Operational Programme for Human Resource Development (SOP HRD<sup>101</sup>)- document proposed by Romania and approved by the European Commission which defines a development strategy, the intervention of the European Social Fund supporting the achievement of objectives in the human resource development area.

One of the thematic priority axis is “Promoting social inclusion”, having as main areas of interventions:

- Developing social economy;
- Improving the access and participation of vulnerable groups to the labour market,
- Promoting equal opportunities on the labour market,
- Trans-national initiatives for an inclusive labour market.

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<sup>97</sup> Government Decision no. 73 of 27 January 2005 for the approval of the National anti-drug strategy for 2005 – 2012 (issued by the Romanian Government, published in the Official Gazette, Part 1, no.112 of 3 February 2005)

<sup>98</sup> Government Decision no. 1369 of 23 December 2010 for the approval of the Action plan for the implementation of the National anti-drug strategy 2005 – 2012 (issued by the Romanian Government, published in the Official Gazette, Part 1, no. 38 of 17 January 2011)

<sup>99</sup> Government Decision no.1101/2008 for the approval of the National interest programme for tobacco, alcohol and drug use prevention - 2009- 2012 (issued by the Romanian Government, published in the Official Gazette no. 672 of 30 September 2008), amended and supplemented by GD 939/2009 for the amendment of the annex to GD no. 1102/2008 for the approval of the National Programme of medical, psychological and social assistance of drug users 2009-2012 (Official Gazette of Romania no. 593/27.08.2009)

<sup>100</sup> governs the general framework for the organization, operation and financing of the national social assistance system in Romania”

<sup>101</sup> Sectoral Operational Programme Human Resource Development 2007 – 2013, „Invest in people”

One of the priorities in this area will be to create a network of Social Inclusion Centres, which would, among others, carry out activities like: development of skills which will allow people belonging to vulnerable groups to play social roles, acquisition of vocational skills and vocational training for employment, re-qualification and further training.

## **8.2 SOCIAL REINTEGRATION OF DRUG USERS**

### **SERVICES AND PROJECTS OF THE NATIONAL ANTI-DRUG AGENCY**

The organisation of the assistance system for drug users in Romania represents at a conceptual and legal level, a combination of therapeutic interventions which cover the entire spectrum of services (centres, programmes etc) available continuously to drug users, in accordance to their needs and within a given period of time, but also the services provided subsequently for a particular disorder, as a part of the recovery and social rehabilitation process.

Reported to the support levels, the services provided in 2012 consisted in:

- first level of support – with the financial, logistical and methodological support of the National Anti-drug Agency, 2 non-government agencies (ARAS și CARUSEL) consolidated the services offered in order to reduce the risks related to drug-use;
- second level of support – represented by the 47 Prevention, Assessment and Anti-drug Counselling Centres, which have an insufficient number of professionals (physician, psychologist and social assistant);
- third level of support, which ensures the social reinsertion of drug users: the services at this level were provided by the private sector and partially by the National Anti-drug agency, through the Pericle Daycare Centre with a capacity of 10 places<sup>102</sup>; during January – December 2012, 37 beneficiaries were registered in the records of this centre. Steps have also been taken for the opening and operation of specific centres for this level of support: daycentre in Bucharest with a capacity of 30 places, therapeutic communities in Dejani and Bălan and the day centre for minors in Bucharest; the limited number of specialized staff, correlated with the inability to recruit staff from external sources, lack of adequate premises and legal limitations in terms of procurement of premises, building and construction, have prevented the NAA open this centres in 2012.

#### **PROJECTS:**

##### **1. “CREATION OF AN INTEGRATED NATIONAL SYSTEM FOR THE REHABILITATION OF DRUG USERS WHO HAVE COMMITTED CRIMES”- MATRA MPAP – MAT09/RM/9/1**

The purpose of this project, based on the Recommendation of the European Commission to strengthen the institutional capacity of Romanian legal authorities, was to develop and implement an inter-institutional working system which ensures the access to treatment for drug users who have committed crimes, as an alternative to imprisonment.

In March 2012, the project ended with a conference, on the occasion of which the following materials were distributed: the work procedures manual „Integrated rehabilitation of drug addicts who have committed crimes” (which can be used in order to multiply the initiative of this project but also for organizing the activities of multi-disciplinary teams) and also the movie which promoted the project.

##### **2. „CREATING 3 THERAPEUTIC COMMUNITIES IN RAHOVA, JILAVA AND TÂRGȘOR PENITENTIARIES” - RO-0034**

This project was implemented in the period 2009-2012, having as the overall objective the support of social reintegration after release from prison of former heroin users and a 5 years sustainability period (2012-2017).

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<sup>102</sup> established within the National programme for medical, psychological and social assistance for drug users - 2008- 2012, approved by GD no. 1102/ 2008.

During January- February 2012, the project organized work groups aiming at improving and adapting the **Guide to good practices** in accordance with the legislative framework in the field of drug users assistance in Romania.

In 2012, the 3 therapeutic communities (created in Rahova, Jilava and Târgșor penitentiaries) have continued their activities as follows: in the first quarter, 81 people were assessed in order to be included in this programme, 65 of them having gained access to the therapeutic communities programme, while 12 of them continued the rehabilitation and social reintegration process within CPECA/ CAIA. In November 2012, observance sessions and monitoring visits were organized within these therapeutic communities.

### **Services and projects initiated by civil society**

The „**SECOND CHANCE**” project, co-financed by the European Social Fund through the Sectoral Operational Programme Human Resource Development 2007 – 2013, „Invest in people”, implemented between 1 July 2010 and 1 June 2013, by the Romanian Anti-Aids Association (ARAS), in partnership with the Integration Association, Sens Pozitiv Association and the National Institute for Infectious Disease „Prof. Dr. Matei Balș”. The project provides *harm reduction* services and substitution treatment, but its ultimate goal is to facilitate the employment of 3 500 beneficiaries with a double vulnerability: Roma ethnics, women, persons who were previously imprisoned, victims of human trafficking, who are also injection drugs users from Bucharest, Ilfov, Timișoara and Constanța, by increasing the level of their socio-professional reintegration, strengthening their self-confidence, promoting a healthy life style and raising awareness of public opinion and of the employers to the problems and needs of these people.

Specific objectives:

O1. Improving the economic, social, psychological and medical status by integrated psycho-medical-social and vocational counselling services for beneficiaries by developing fixed and mobile centres that will provide: social assistance services, substitution treatment for injection drug users, psychological counselling, occupational counselling, prevention of blood and sexually transmitted infections, and referral to other services (e.g. training);

O2. Motivating and involving beneficiaries in activities by recruiting and training peer educators from the target group members;

O3. Informing the public and the employers on drug use and drug users through information campaigns;

O4. Capitalizing the experience gained during the project, in order to replicate it in other cities / regions. The main idea of the project was to provide complex services for labour market reintegration. All services were provided by observing the work standards and professional ethics in medicine, psychology and social assistance, human rights and confidentiality, based on the results of the social workers reports, psychological and medical assessment, so that each client have a tailored socio-professional reintegration plan.

Once stabilized, each user shall be constantly accompanied and supported in order to develop a tailored labour market reintegration plan, which will be followed by the social worker responsible for the case.

- The project "**HOLIDAYS ARE FOR EVERYONE**", implemented in December 2012, in Bucharest, by Carusel Association, in partnership with the Faculty of Sociology and Social Assistance, University of Bucharest, National Council for Combating Discrimination, Romanian Harm Reduction Network-RHRN, having a total budget of 8,000 Eur.

The aim of this project was to improve the life quality of people who are socially marginalized or exposed, including drug users, and the general objective was to raise the awareness of public opinion on the marginalized groups, by organizing a cooking-event followed by the distribution of hot meals to 200 people (injection drug users, people involved in commercial sex, homeless adults).

In principle, the activities had a humanitarian character, aiming at raising the awareness of the community towards the difficulties faced by vulnerable and marginalized groups

In terms of results, we notice a remarkable community involvement:

- presence of academic environment, especially students – future social assistance (Faculty of Sociology and Social Assistance, University of Bucharest);



- presence of the National Council for Combating Discrimination, including the president of the institution.
- mobilization of the members and partner organizations from the Romanian Harm Reduction Network (RHRN); participation of business environment.

### **Conclusions:**

1. In 2012, the data on social correlates of drug use continued to be collected through routine monitoring of the indicator *Admission to treatment as a result of drug use – Treatment admission indicator*, the new elements being represented by:
  - improvement of the data collection process on drug-related medical emergencies, by introducing 2 variables: occupational status and educational level;
  - first specific study conducted by the National Anti-Drug Agency for the assessment of social exclusion risk or degree faced by drug users.
2. Taking into account the issues outlined above, as well as the methodological limitations arising there from, we can conclude that:
  - in general, the beneficiaries admitted to treatment for drug use in 2012 are not employed (52.9% ), have at most a secondary level of education (primary – 45.1% and secondary – 40.3%), fixed abode (83.5%) and live with their parentys or family (57.3%);
  - regarding the medical emergencies as a result of illicit drug use in 2012, the patients who referred to the medical emergency services are: unemployed 56,3%, have at most a secondary level of education (primary – 45.1% and secondary- 40.3%);
  - according to the study conducted by NAA, problematic drug users in Bucharest who were not included in specific assistance services (provided by the public or private system), are mainly unemployed or stay at home, although only few of them (6%) consider themselves as socially excluded because of the lack of education or training.
3. The small number of projects for the social reintegration of drug users implemented in the reference year is caused by the small number of active providers of social rehabilitation services for drug users, and also by the insufficient development of services from the first two levels of support (i.e. first and second level of support).

## Chapter 9 –Crime in the drug regime, crime prevention in drug regime and in the prison system

Romania is not a drug manufacturing country, but it continues to be an important transit hub on the Balkan drug traffic route; opium, basic morphine and heroin transit Romania to Central and Western Europe from Afghanistan, Turkey via Bulgaria or Serbia, while the drug precursors take the reverse route mentioned above, toward Turkey and Afghanistan via Bulgaria. Along with the countries bordering the Black Sea, Romania is an alternative/secondary route of bringing cocaine to Europe, through Constanta Harbour, especially cocaine from Bolivia.

Moreover, the decreasing weight of cocaine on the Romanian drug market was also noticed at the international level and confirmed by U.D.O.D.C., presenting decreases by over 25% of coca cultivated areas in Columbia and over 7% in Bolivia, important pillars for cocaine production.

Thus, drug confiscations in Romania in 2012 shape the general evolution of worldwide drug traffic, the reference year being characterized by the **highest quantity of confiscated opium** at national level during 2001-2012 as well as significant **development/expansion of cannabis crops** both in outdoor and indoor areas.

### 9.1 DRUG RELATED CRIMINALITY

#### 9.1.1 DRUG RELATED CRIMES

##### A. NUMBER OF CRIMINAL FILES SOLVED BY THE PROSECUTOR'S OFFICES FOR DRUG AND DRUG PRECURSOR RELATED CRIMES

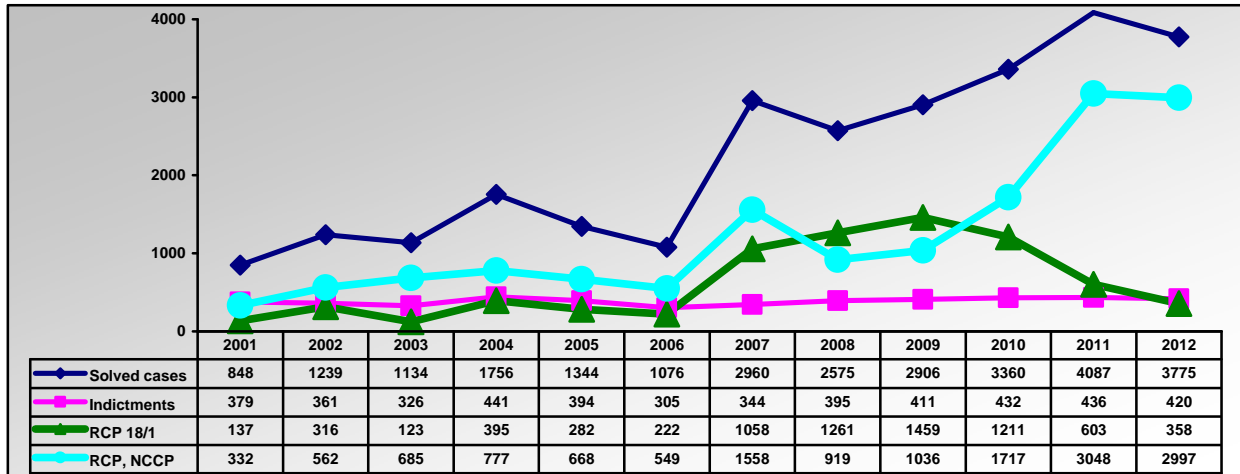
According to the data provided by the Directorate for Investigating Organized Crime and Terrorism (central office and the 15 territorial offices), during 2012 there was a total number of **3,775 cases** solved, which constitutes a **7.63% decrease compared to 2011** when **4,087 cases** were registered.

With respect to resolutions, 2012 did not bring significant changes on the evolution of the monitored indicators or to the percentage allocation of decisions for solved cases.

To this end, **420 cases** (with a **3.67% decrease** compared to 2011) were brought to court during the reference year for criminal proceedings.

Out of the **3,775** criminal cases solved during 2012 by DIICOT, **2,997** cases were solved with the proposal **not to continue with the criminal proceedings** on various grounds, with only **358** cases ending in the decision to **be removed from criminal investigation as per art. 18<sup>1</sup> in the Criminal Code**.

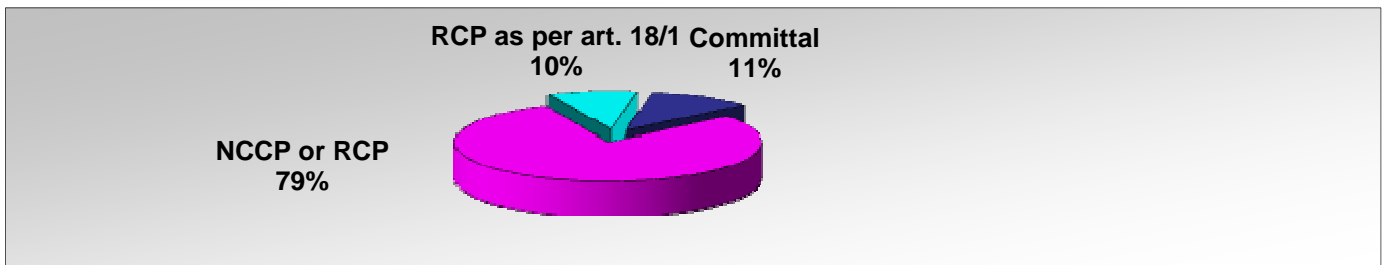
**Chart no. 9-1: Evolution of criminal cases opened by the prosecutor's offices during 2001 – 2012 (no.)**



Source: Prosecutor's Office attached to the High Court of Cassation and Justice, DIICOT

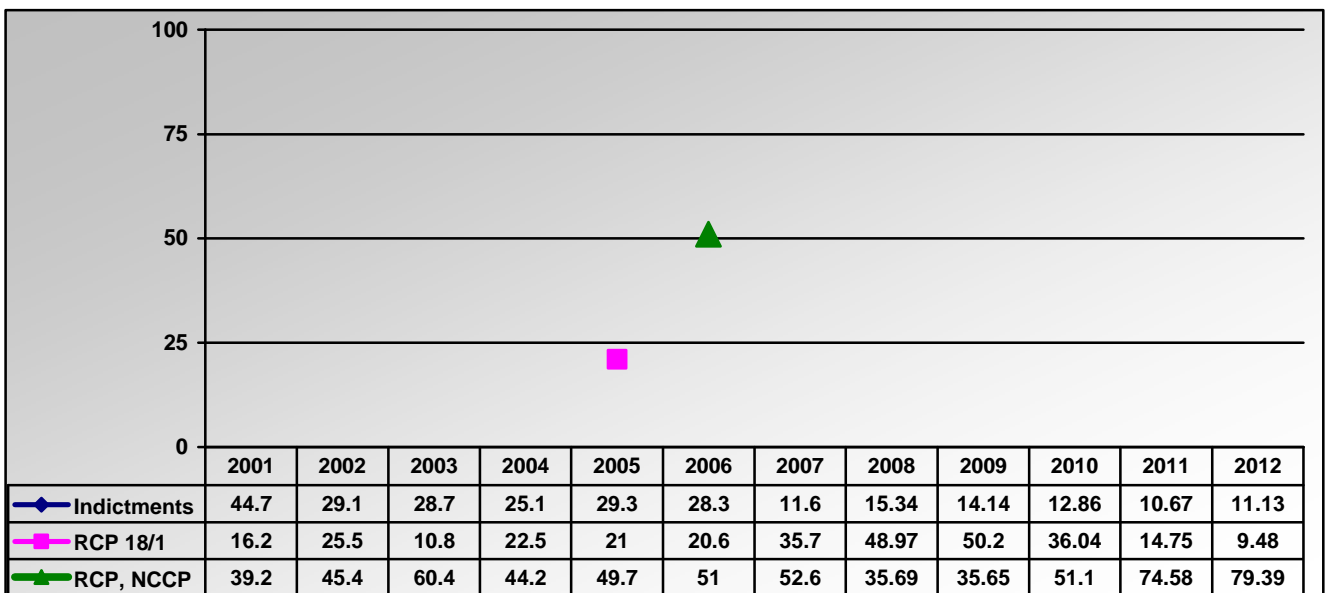
Thus, **2012**, compared to the percentages registered in **2011**, stands out through **increases of the percentage** of committal cases (from **10.67%** to **11.13%**), as well as with the percentage of criminal cases solved by **non-commencement of criminal prosecution or release from criminal prosecution** (from **74.58%** to **79.39%**). In case of criminal cases ending in the **release from criminal prosecution as per art. 18<sup>1</sup>**, one can notice however a decrease in the percentage of total criminal cases solved (from **14.75%** to **9.48%**).

**Chart no. 9-2: Distribution of cases solved in 2012, per type of decision (%)**



Source: Prosecutor's Office attached to the High Court of Cassation and Justice, DIICOT

**Chart no. 9-3: Evolution of the percentage of solved cases by the decision type (committal, RCP as per art. 18<sup>1</sup>, NCCP or RCP), 2012 (%)**



Source: Prosecutor's Office attached to the High Court of Cassation and Justice, DIICOT

The big urban agglomerations as well the cross-border areas have continued to be in 2012 the areas with high potential level of criminality with respect to drug related crimes. This conclusion is supported by the statistical data registered at the level of territorial offices of DIICOT. Thus, **65.96% (2,490 cases)** of the total cases solved at a national level were solved in **Bucharest**, followed by **Constanta** with **4.56% (172 criminal cases)**, **Cluj** with **4.08% (154 criminal cases)** and **Ploiesti** with **3.55% (134 criminal cases)**. One must notice that, compared to 2011, there is a decrease in the number of criminal cases solved by the territorial offices of DIICOT. The offices with **higher rates** are as follows: **Targu Mures** (from 49 in 2011 to 63 in 2012), **Brasov** (from 47 in 2011 to 55 in 2012) and **Oradea** (34 cases in 2011, compared to 41 in 2012).

**Table no. 9-1: Territorial distribution of solved cases by the decision type – compared data 2010-2012**

Territorial Office	Solved cases											
	2010				2011				2012			
	Indictments	RCP18 <sup>1</sup>	RCP/NCCP	Total	Indictments	RCP18 <sup>1</sup>	RCP/NCCP	Total	Indictments	RCP18 <sup>1</sup>	RCP/NCCP	Total
Alba Iulia	15	20	36	<b>71</b>	13	10	48	<b>71</b>	17	16	25	<b>58</b>
Bacau	8	8	29	<b>45</b>	8	8	99	<b>115</b>	12	4	51	<b>67</b>
Brasov	17	7	24	<b>48</b>	13	2	32	<b>47</b>	12	4	39	<b>55</b>
Bucuresti	151	974	1092	<b>2217</b>	120	379	2025	<b>2524</b>	104	204	2182	<b>2490</b>
Cluj	25	31	33	<b>89</b>	47	48	97	<b>192</b>	36	32	86	<b>154</b>
Constanta	23	34	81	<b>138</b>	44	18	124	<b>186</b>	44	15	113	<b>172</b>
Craiova	18	24	68	<b>110</b>	26	16	106	<b>148</b>	23	18	86	<b>127</b>
Galati	24	3	67	<b>94</b>	14	9	63	<b>86</b>	28	5	46	<b>79</b>
Iasi	11	40	45	<b>96</b>	19	47	57	<b>123</b>	8	19	37	<b>64</b>
Oradea	17	9	13	<b>39</b>	17	2	15	<b>34</b>	20	5	16	<b>41</b>
Pitesti	6	9	15	<b>30</b>	12	11	46	<b>69</b>	14	2	34	<b>50</b>
Ploiesti	29	13	86	<b>128</b>	25	9	120	<b>154</b>	26	7	101	<b>134</b>
Suceava	2	1	5	<b>8</b>	13	7	51	<b>71</b>	8	6	27	<b>41</b>
Tg. Mures	10	3	18	<b>31</b>	10	10	29	<b>49</b>	13	11	39	<b>63</b>
Timisoara	30	27	33	<b>90</b>	28	26	57	<b>111</b>	36	10	50	<b>96</b>
Central office	46	8	72	<b>126</b>	27	1	79	<b>107</b>	19	0	65	<b>84</b>

Source: Prosecutor's Office attached to the High Court of Cassation and Justice, DIICOT

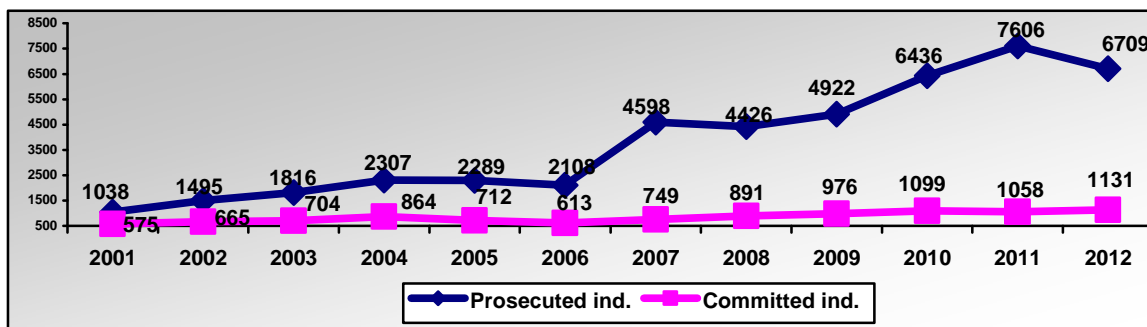
## B. PERSONS PROSECUTED AND COMMITTED FOR TRIAL BY THE PROSECUTOR'S OFFICES

2012 also brings a decrease in the number of individuals prosecuted for drug related crimes. Thus, in the **3,775 criminal cases** solved by the prosecutor's offices, **6,709 individuals** were prosecuted (**11.79%** less than in 2011), out of which **over 40%** - i.e. **2,914 individuals** – were prosecuted by the **Bucharest Territorial Office**.

The value registered during the reference year shows a decrease of this indicator compared to 2012, but it continues to preserve a general increasing trend of this indicator for 2001-2010 with a constant increase in the number of individuals prosecuted for drug related crimes.

The individuals committed for trial during the reference period has increased compared to 2011. Thus, in **2012**, out of a total of **6,709** individuals prosecuted for drug related crimes, **1,131 individuals (16.86%)** were committed for trial as the next phase of the criminal proceedings, while the remaining **5,578** were discharged.

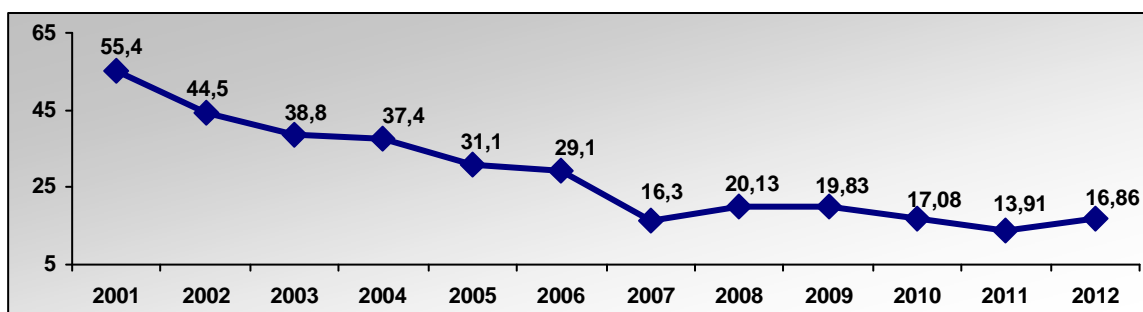
**Chart no. 9-4: Evolution of the number of individuals investigated by the prosecutor's offices and the number of individuals committed for trial for drug and drug precursor related crimes during 2001-2012**



Source: Prosecutor's Office attached to the High Court of Cassation and Justice, DIICOT

By correlating the two indicators, i.e. the number of individuals prosecuted for drug related crimes and the number of individuals committed for trial, one can notice a slightly increasing trend in the weight of individuals committed for trial from the total number (from **13.91%** in 2011 to **16.86%** in 2012), although the total number of prosecuted individuals is decreasing (from 7,606 individuals in 2011 to 6,709 individuals in 2012).

**Chart no. 9-5: Evolution of the percentage of individuals committed for trial from the total number of individuals prosecuted by the prosecutor's office during 2001 – 2012 (%)**



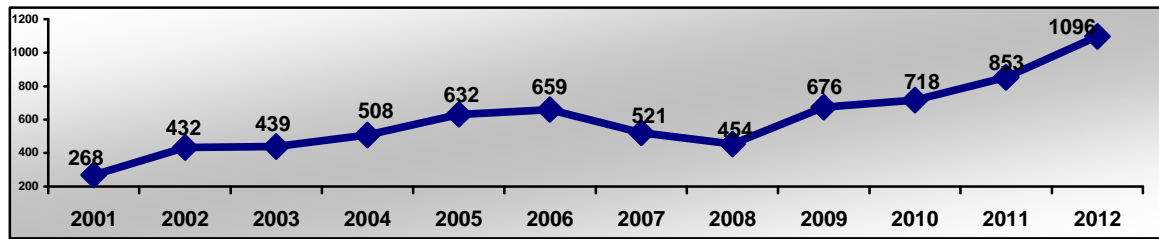
Source: Parchetul de pe lângă Înalta Curte de Casație și Justiție, DIICOT

The **demographic and social-economic indicators concerning the individuals committed for trial in 2012**, the profile shaped during previous years continues to be seen in the reference year regarding breach of legal provisions with respect to drugs. Thus, the individual committed for trial for drug related crimes is, in general, **male (89.83%)**, between **21-54 years of age (90.54%)**, from the **urban area (86.83%)**, with an **average education level (58,8%)** and **unemployed (70.47%)**.

### C. INDIVIDUALS CONVICTED BY COURTS

During **2012**, courts rules that **1,096 individuals** (990 men and 106 women) were guilty for drug related crimes, out of which **1,064 individuals of age** (959 men and 105 women) and **32 minors** (31 male and 1 female). The evolution of this indicator shows a continuously increasing trend from previous years, with a registered value for 2012 **28.49%** higher than the one registered in 2011.

**Chart no. 9-6: Evolution of individuals convicted for drug related crimes during 2001-2012**



Source: The Superior Council of Magistracy

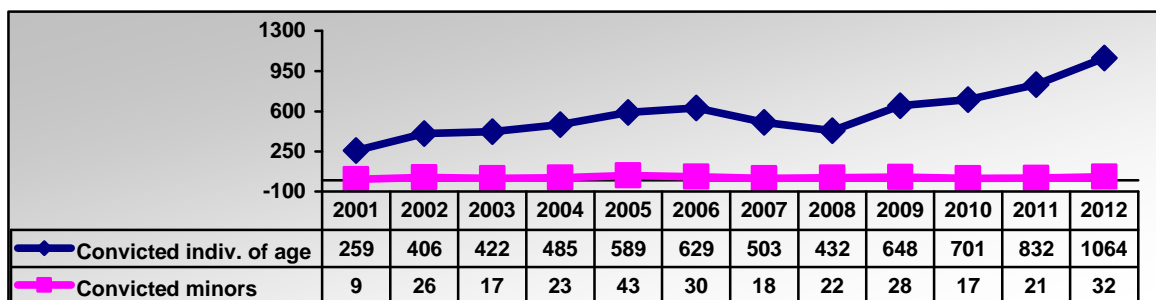
The reference year shows a **decrease in the weight of second offenders** (11.59% in 2012 compared to 14.07% in 2011), as well as of **individuals with criminal records** (5.66% in 2012 compared to 7.27% in 2011) from the total of convicted individuals.

Moreover, the largest part (**74.82%**) of the total of individuals convicted for drug related crimes continued to consist of **individuals convicted for drug traffic**, so that **820** individuals were convicted based on **art. 2 in Law no. 143/2000** for preventing and fighting against traffic and illegal drug use, as amended and completed. Moreover, the **number of individuals convicted by courts for drug possession with intention to use decreased to 5.57% of the total number of convicted individuals** (61 individuals convicted based on **art. 4 in Law no. 143/2000**).

2012 also shows that, out of the total of convicted individuals, **188 (17.15%)** were convicted for bringing to or taking out drugs of the country, as well as for importing or exporting risk drugs, illegally, based on **art. 3 in Law no. 143/2000** for preventing and fighting against traffic and illegal drug use, as amended and completed.

The **minors'** level of involvement in drug related crimes continues to be low, **below 3%**, most convictions being for drug traffic.

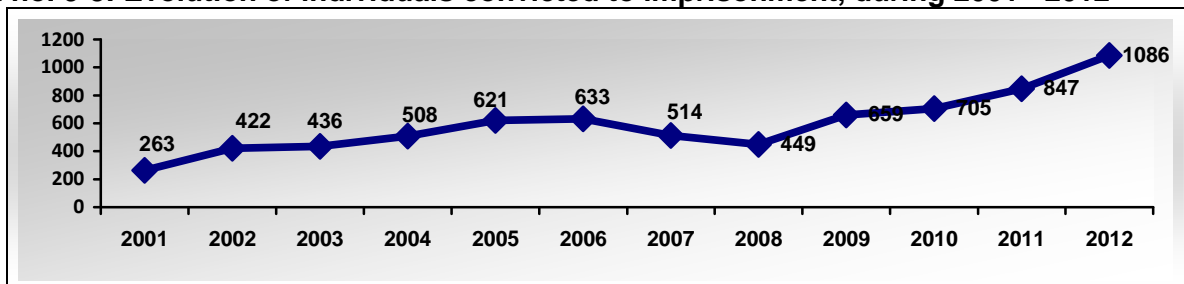
**Chart no. 9-7: Evolution of individuals convicted for drug related crimes during, by the age, during 2001-2012**



Source: The Superior Council of Magistracy

**As far as punishment time is concerned**, during 2012 just as in previous years, courts ruled mostly on imprisonment. Out of the total **1,096** individuals convicted in **2012** for drug related crimes, **1,086** individuals were sentenced to imprisonment, while **10** individuals received a **criminal fine**.

**Chart no. 9-8: Evolution of individuals convicted to imprisonment, during 2001 - 2012**



Source: The Superior Council of Magistracy

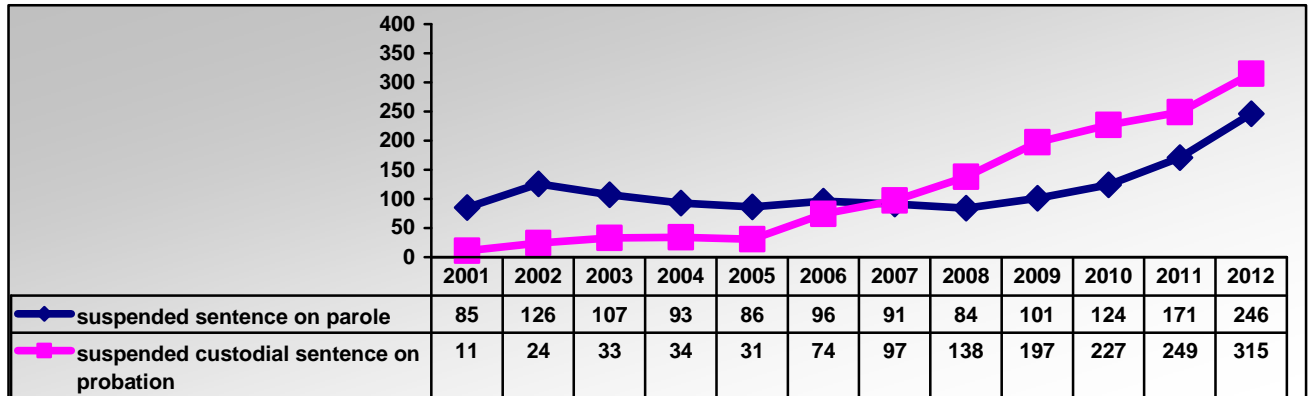
Moreover, from the total **1,086** individuals convicted to imprisonment, **520 (47.88%)** individuals were convicted to **carry out their punishment in prison**, **315** individuals (**29%**) received a **suspended**

**custodial sentence on probation, 246 (22.66%) individuals received a suspended sentence on parole and 5 (0.46%) individuals were sentenced to serve their punishment on the job.**

We notice that the total number of individuals convicted to imprisonment continues to increase, while also keeping the parity between sentences served in prison (47.88%) and suspended sentences (51.66%).

Out of a total of 520 individuals of age convicted to serving the sentence in prison, 55.58% (289 individuals) were convicted to imprisonment from 1 to 5 years. Moreover, for 26.35% (137 individuals) of the adults convicted to imprisonment, the duration of the sentence varied between 5 and 10 years.

**Chart no. 9-9: The compared analysis of the number of individuals convicted with a suspended sentence on parole and those with a suspended custodial sentence on probation, during 2001-2012**

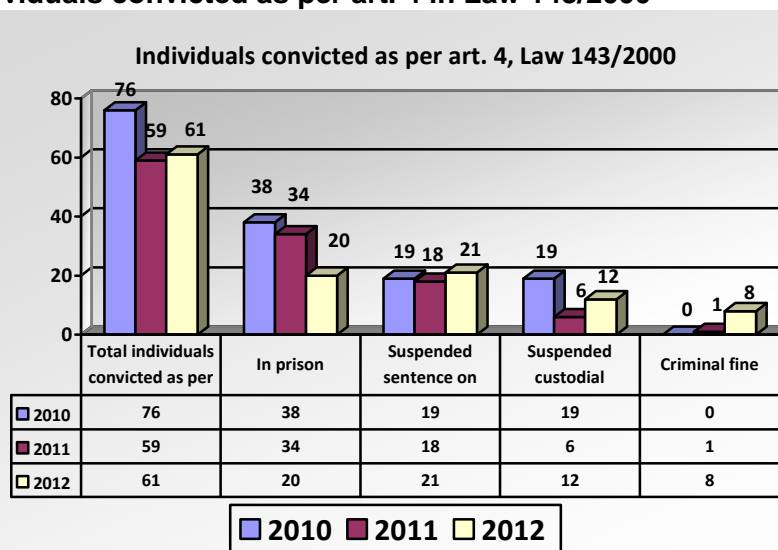


Source: The Superior Council of Magistracy

From the data provided by the Superior Council of Magistracy, one can notice that for 20 of the 61 individuals convicted for drug possession with intention to use (art. 4 Law 143/2000), the courts passed the sentence of imprisonment, which is a decrease compared to the previous year when 34 such cases were registered out of a total of 59 individuals. 33 individuals received suspended sentences as follows: 21 received a suspended sentence on parole and 12 received a suspended custodial sentence on probation.

Moreover, for this category of individuals, we also notice an increase in the number of applied criminal fines, from 1 fine in 2011 to 8 in the reference year.

**Chart no. 9-10: Individuals convicted as per art. 4 in Law 143/2000**



Source: The Superior Council of Magistracy

The most **individuals convicted based on the provisions of art. 4 in Law 143/2000** were registered in Braila (9 individuals, out of which 3 minors), Bucharest and Constanta (8 individuals in each city) as well as in Galati, Giurgiu and Arges (7 individuals in each city).

With respect to **convictions for drug traffic (art. 2)**, the highest number of cases in 2012 was registered in Bucharest (381 individuals, out of which 6 minors), Hunedoara – 89 individuals, Bihor and Cluj (47 individuals in each city) and 44 individuals in Constanta, unlike 2011 when numbers showed Bucharest (206), Cluj (51), Brşşov (37), Bihor (34). As noticed, Bucharest continues to be the city with the highest weight of convictions for drug traffic (40% in 2011 and 47% in 2012).

#### **D. INDIVIDUALS IN PENITENTIARIES**

In the detention units of the **National Administration of Penitentiaries**, on 12/31/2012 there were **1,178 individuals** with final convictions for crimes mentioned in Law no. 143/2000 for preventing and fighting against illegal drug traffic and use, as amended and completed. Compared to 2011 (**1,189 individuals**), the number of detainees as at 12/31/2012 **continues to be stable**.

Throughout 2012, **422 individuals were released on parole** serving sentences for crimes perpetrated under Law no. 143/2000, **10.18% (383 individuals) more** compared to the previous year. Moreover, **7 arrested individuals** were released, after serving a full sentence, from crimes perpetrated under Law no. 143/2000, similar to 2011.

#### **E. INDIVIDUALS REGISTERED IN PROBATION SERVICES**

The data provided by the Probation Directorate within the Ministry of Justice through probation services that elaborated assessment reports highlight the following for 2012:

- Under **drug traffic** (art. 2 in Law no. 143/2000), **the criminal prosecution bodies** requested assessment reports for **3 individuals** compared to 10 individuals registered in the previous year, while **courts** requested reports for **194 individuals** compared to 190 in 2011;
- Under **possession with intent to use**, crime stipulated in art. 4 in Law 143/2000, **the criminal prosecution bodies** requested assessment reports for **3 individuals** (compared to 6 individuals in 2011), while **courts** requested reports for 76 individuals compared to 118 in 2011.

One finds that although the number of assessment reports decreased compared to the previous years, they continue to be a practice especially among courts.

#### **F. INDIVIDUALS HANDED OVER/TRANSFERRED FOR DRUG RELATED CRIMES**

The analysis of the data provided by the International Police Cooperation Centre within the General Inspectorate of the Romanian Police (IGPR) shows that in 2012, as per the assistance requests that Romania received from other states, **133 Romanian citizens** were involved in drug related crimes stipulated in Law no. 143/2000 **on fighting against illegal drug traffic and use** as follows: **122 individuals** involved in illegal activities under art. 2 and art. 4 (drug traffic and use), **8 individuals** were prosecuted for **possession of drugs with the intent to use (art. 4)** and **3 individuals** for other type of crimes under Law no. 143/2000. The highest number of Romanian citizens involved in drug traffic and use was registered in Italy (34 individuals) and Spain (17 individuals).

Moreover, in 2012, **37 individuals were handed over to Romania** for drug related crimes, **42.3% more** compared to 2011, when 26 individuals were handed over to the authorities for the same reason. **Romania** handed over **14 individuals** for drug related crimes. Compared to 2011, the number of individuals handed over by Romania continues to be rather stable (13 individuals in 2011).

With respect to **individuals transferred to Romania** for serving their prison sentence, in 2012 8 individuals were transferred from Spain, Norway, Germany, Portugal and Sweden. **Romania transferred** 6 individuals to serve their sentence in prison throughout 2012 (3 individuals to The Netherlands and 3 individuals to Turkey).

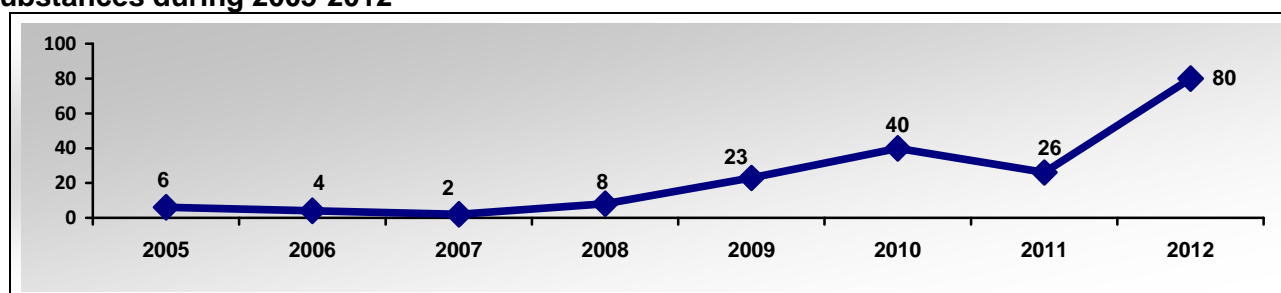


## 9.2 OTHER DRUG USE RELATED CRIMES

### 9.2.1. ROAD TRAFFIC RELATED CRIMES

Throughout 2012, the traffic police found **80 individuals driving vehicles** on public roads under the influence of drugs or drug products<sup>103</sup>, **3 times higher than the one registered in 2011**. From the 80 drivers, **15 drivers** in each city were found in traffic in the county radius of **Constanta and Timis counties**, **2 drivers** in each city in the radius of counties **Alba, Arad, Dambovita, Ialomita, Maramures and Vaslui**, **10 drivers** in the radius of **Bucharest**, **9 drivers** in the radius of **Arges county**, **5 drivers** in the radius of **Bacau county**, **4 drivers** in the radius of **Neamt county**, **3 drivers** in the radius of **Caras-Severin county** and **one driver** in each of the radiuses of counties **Covasna, Dolj, Mures, Olt, Prahova, Teleorman and Valcea**.

**Chart no. 9-11: Evolution of drivers found in traffic under the influence of drugs or psychotropic substances during 2005-2012**



Source: Traffic Police, General Inspectorate of the Romanian Police

### 9.2.2. OTHER DRUG USE RELATED CRIMES

**Crimes against property** continue to be in 2012 as well on the first place among crimes perpetrated by individuals under the influence of drugs and psychoactive substances. Thus, from the **463 individuals** perpetrating crimes under the influence of drugs and psychotropic substances, (**425 men, 38 women arrested**, from the 12 detention centres of the Independent Detention and Arrest Service within the General Police Directorate in Bucharest, **circa half perpetrated crimes against property** (160 thefts and 66 robberies).

From the **463** individuals arrested for crimes under the influence of drugs, there is **one minor, male**.

**Table no. 9-2: Individuals arrested by the perpetrated crime, during 2006 - 2012**

Type of crime	Legal classification	Number of individuals						
		2006	2007	2008	2009	2010	2011	2012
Theft and aggravated theft	Art. 208,209 CC62	278	323	378	221	414	319	160
Drug traffic	Law 143/2000	224	217	183	264	303	103	85
Robbery	Art. 211 CC	47	112	125	100	119	102	66
Murder	Art. 174–178 CP	6	2	1	0	0	0	2
Injury	Art. 181 CC	1	0	3	0	0	0	n/a.
Procuring	Art. 329 CC	2	2	2	30	0	0	n/a.
Destruction of property	Art. 217 CC	1	0	4	0	0	0	n/a.
Fraud	Art. 215 CC	1	3	13	42	0	0	n/a.
Illegal restraint	Art. 189 CC	1	0	3	0	0	0	n/a.
Other crimes		n/a.	n/a.	n/a.	n/a.	n/a.	n/a.	150

Source: Detention and Arrest Service, General Police Directorate in Bucharest

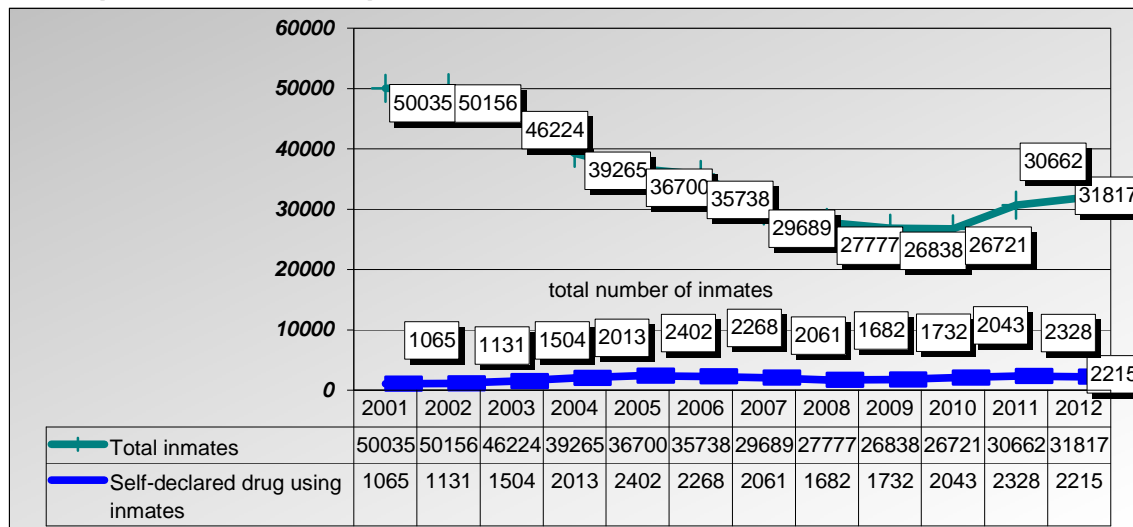
## 9.3 DRUG USE AND PROBLEM DRUG USE IN PRISONS

As per the data provided by the National Administration of Penitentiaries (NAP), in 2012, out of a number of 31,817 inmates, 2,215 persons declared, when imprisoned, to be drug users. Compared to the previous year, a decrease by 0.5% of the number of self-declared drug user inmates when

<sup>103</sup> The data come from unannounced traffic checks carried out by Traffic Police, without performing anti-drug tests in cases of road crashes.

imprisoned can be noticed in correlation with the general population in prisons, registered at the end of 2012.

**Chart no. 9-12: Evolution of the number of self-declared drug users by comparison with the population in penitentiaries, compared data 2001-2012**



Source: ANP

Concerning the demographic characteristics of the self-declared drug user inmates, when imprisoned in the penitentiary, 2012 does not bring significant changes compared to the previous periods, keeping a male predominance of 80.5% (81.7% in 2011) and 19.5% female inmates.

With regard to the age group distribution of the self-declared drug user inmates in 2012, the age group of 15-19 y.o. has the lowest value in the analyzed period (2007-2012), being 0.5% of the reference population.

The greatest decrease is seen among self-declared drug user inmates over 30 in 2012 (from 40.2 in 2011 to 35.5% in 2012).

**Table no. 9-3: Distribution of self-declared drug users, on the basis of gender and age group, compared date 2007 – 2012 (%)**

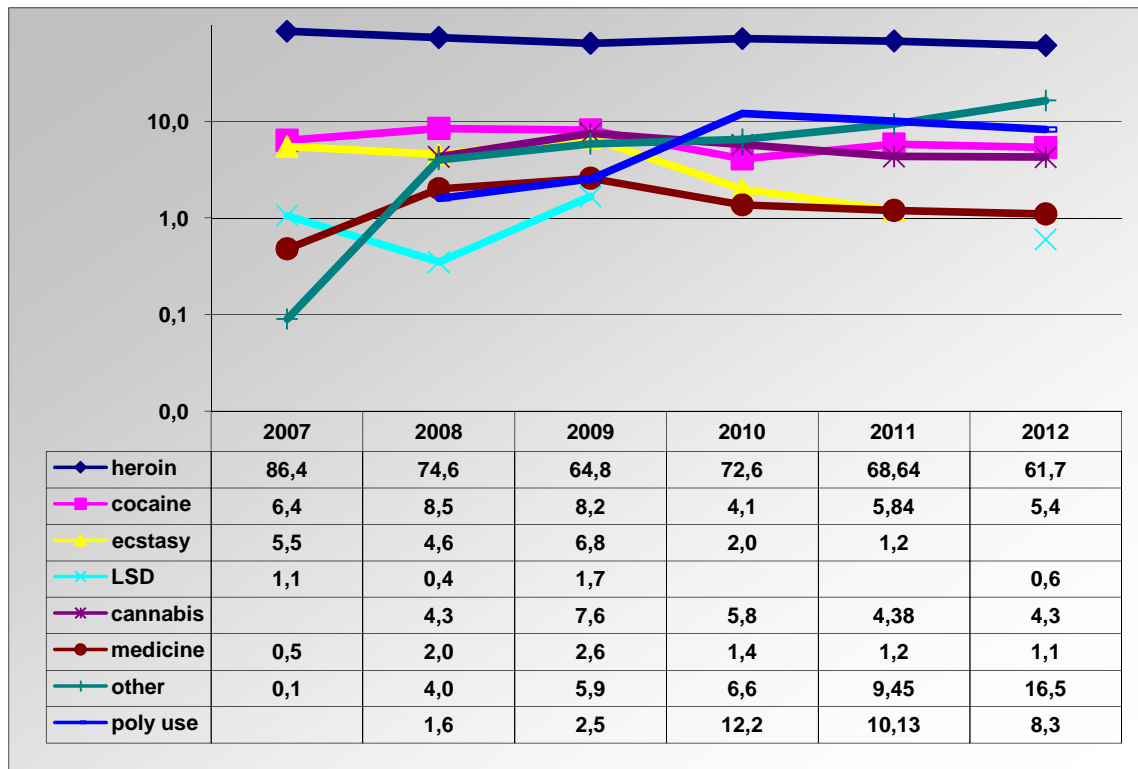
		2007	2008	2009	2010	2011	2012
Gender	Men	88	78.3	84.9	82.9	81.7	80.5
	Women	12	21.7	15.1	17.03	18.2	19.5
Age group	15-19	6.11	4.39	4.27	3.27	3.9	0.49
	20-24	27.46	24.67	32.9	29.22	25.12	28.39
	25-29	40.61	36.26	39.26	33.43	31.96	31.15
	>= 30	25.81	34.66	23.55	34.16	40.16	35.30

Source: ANP

By the self-declared substance as being used before imprisonment, it is observed that, similar to the period 2007-2010, with a registered proportion of 61.7% in 2012 heroin continues to occupy the first place in consuming preferences. While the next ranked drugs, cocaine (5.4%) and cannabis (4.3%), present the same values as the previous year, poly-use is decreasing for a third year in a row (8.3% in 2012 compared to 12.2% in 2010 – the peak of the analyzed period) and one can also notice LSD use (0.6%) after an "absence" period of two years.

One can also see a very obvious increase, compared to last year, in the percentage of users using "other drugs" (16.5 in 2012 compared to 9.4% in 2011), category also including the new psychoactive substances.

**Chart no. 9-13: Distribution of self-declared users by the drugs used, compared data 2007-2012 (%)**



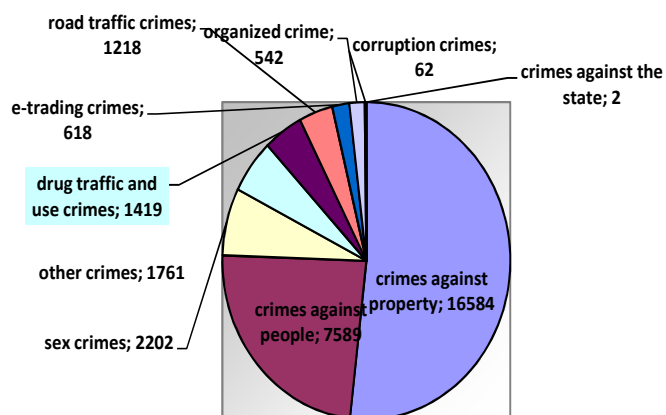
Source: ANP

Regarding the substance used upon imprisonment, most mentioned injections as the most frequent method of administering the main drug. One can still notice a slight decrease as well in the percentage of users injecting their drugs (61.9% in 2012 compared to 71% in 2011).

### 9.3.1. DRUG MARKET IN PRISONS

Out of the total 31.817 detainees in the penitentiary system in Romania as at 12/31/2012, circa 4.5% were convicted for drug related crimes (1,419 people).

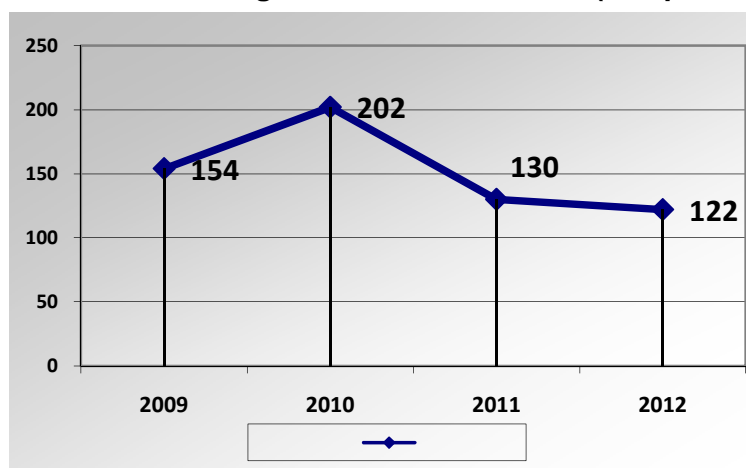
**Chart no. 9-14: Structure of inmate numbers according to crimes**



Source: ANP

As per the ANP data, in the most recent annual assessment report<sup>104</sup> 2012 continues to have a decreasing number of cases in which forbidden substances were identified, registering the lowest value from the entire analyzed period. From the 122 identified cases, in 87 cases powder substances were confiscated, solid substances in 30 cases and liquid substances in 5 cases.

**Chart no. 9-15: Instances of discovering forbidden substances (compared data, 2009-2012)**



Source: ANP

One must mention that in 2012 ANP has implemented new work tools consisting in canine units for detecting drugs and cell phones in 8 penitentiaries (Iasi, Poarta Alba, Margineni, Bucharest Rahova, Gherla, Craiova, Timisoara, Aiud). Drugs were taken from IGPR and distributed to the 8 abovementioned units in order to prepare the canine units.

### 9.3.2. ASSISTANCE OFFERED TO DRUG USERS IN PENITENTIARIES

The common order of the Minister of justice and of the Minister of health no. 429/C/125/2012<sup>105</sup> on providing medical care to detainees in the custody of the National Administration of Penitentiaries is the new norm that sets up that inmates have their health insurance paid by the state budget through special use amounts, through the budget of the National Administration of Penitentiaries, guaranteeing their right to medical care.

According to the law, the detainees benefit from free medical care and medicines, these being provided from the Single National Health Insurance Fund, from the funds of the units in the penitentiary administration, approved to be used in this respect and from other sources.

In 2012, the Drug Addiction Ward of the Penitentiary Hospital Bucharest Rahova treated 165 patients both for withdrawal caused by various drugs and new psychoactive substances and for suicide attempts through voluntary intoxication with several medicines.

2012 was also the year for the project **“Creating Three Therapy Communities in Jilava, Rahova and Targor Prisons”** implemented by the National Administration of Penitentiaries, in partnership with the Probation Directorate within the Ministry of Justice, the National Anti-Drug Agency with all its territorial offices, i.e. Anti-Drug Prevention, Assessment and Counselling Centres; the Phoenix Haga Foundation and the Ministry of Justice – Norway. Among the significant results of this project, we mention:

- planning and providing 3 functional therapy communities for former drug using inmates;
- training 30 specialists within ANP, ANA and the Probation Directorate ensuring the continuous implementation of the services provided within the 3 therapy communities.
- elaborating a methodology draft on therapy communities in penitentiaries.

<sup>104</sup> <http://www.anp.gov.ro/documents/10180/18750/Annual+report+2012.pdf/09f536d9-21d5-4a26-9eae-2a0863df22a7>

<sup>105</sup> See ch. I in this Report.

Operationally speaking, until the end of 2012, 284 inmates were assessed in view of being included in the program in question, as follows: Bucharest Jilava Prison – 133, Bucharest Prahova Prison – 55 and Targsor Prison – 96. Out of these, **117 people completed** the *community therapy* program in the reference year (Bucharest Jilava Prison – 39, Bucharest Rahova Prison – 32, Targsor Prison – 46 inmates)

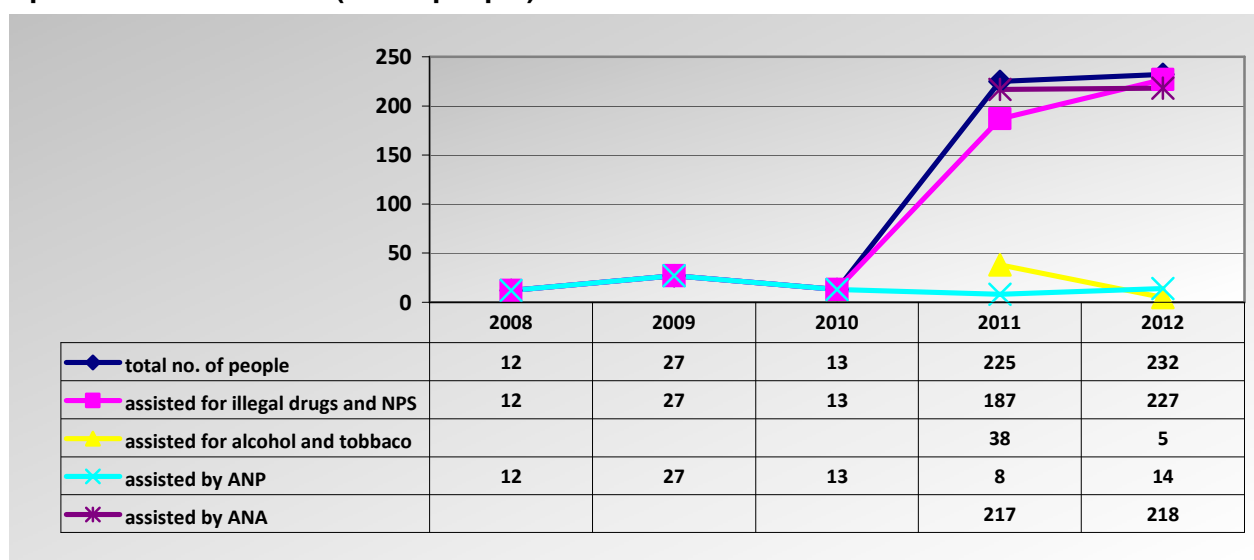
Furthermore, 41 specialized consults (detox) were provided in the specialized ambulatory section for patients benefiting from this substitute treatment.

According to the data registered for monitoring the indicator “Accession to Treatment”, 232 beneficiaries were assisted while in imprisonment in 2012:

- 227 for illegal drug and NPS use and 5 for tobacco and alcohol use;
- 14 beneficiaries by the ANP specialists within substitution programs and 218 beneficiaries – by the specialists in the Anti-Drug Prevention, Assessment and Counselling Centres – the territorial network of the National Anti-Drug Agency.

Compared to the previous year, we notice an increase in the number of assisted inmates for the use of illegal drugs and NPS.

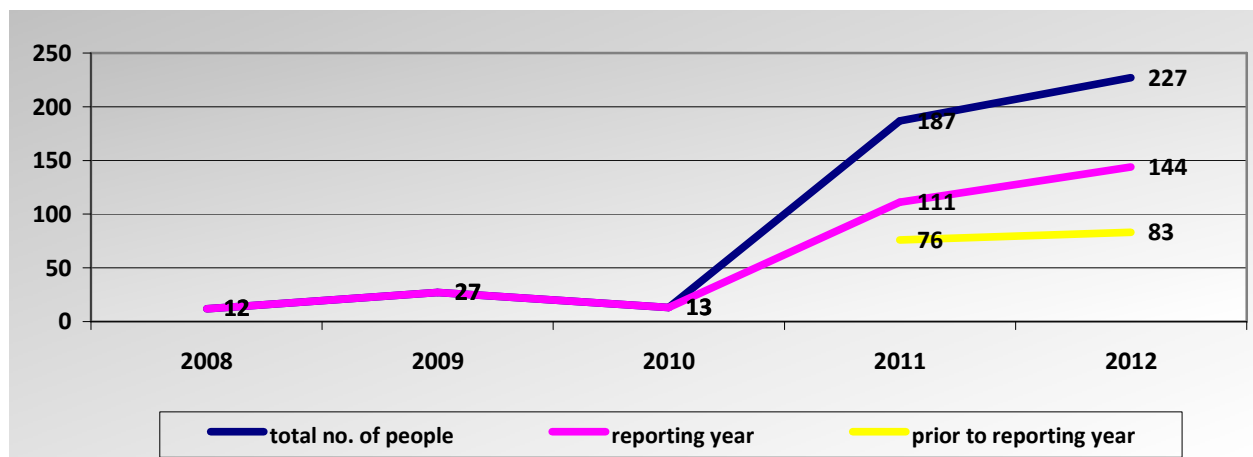
**Chart no. 9-16: Distribution of inmates’ accession to treatment, for psychoactive substance use, compared data 2008-2012 (no. of people)**



Source: ANP and NAA

Regarding the inmates’ accession to treatment for illegal drug use and NPS, compared to the previous year, one can notice an increase in cases by 29.7% and an increase of 7 cases for those already in treatment at the beginning of the reporting year.

**Chart no. 9-17: Distribution of inmates' accession to treatment, for illegal drug and NPS use, by the year of accession, compared data 2008-2012 (no. of people)**

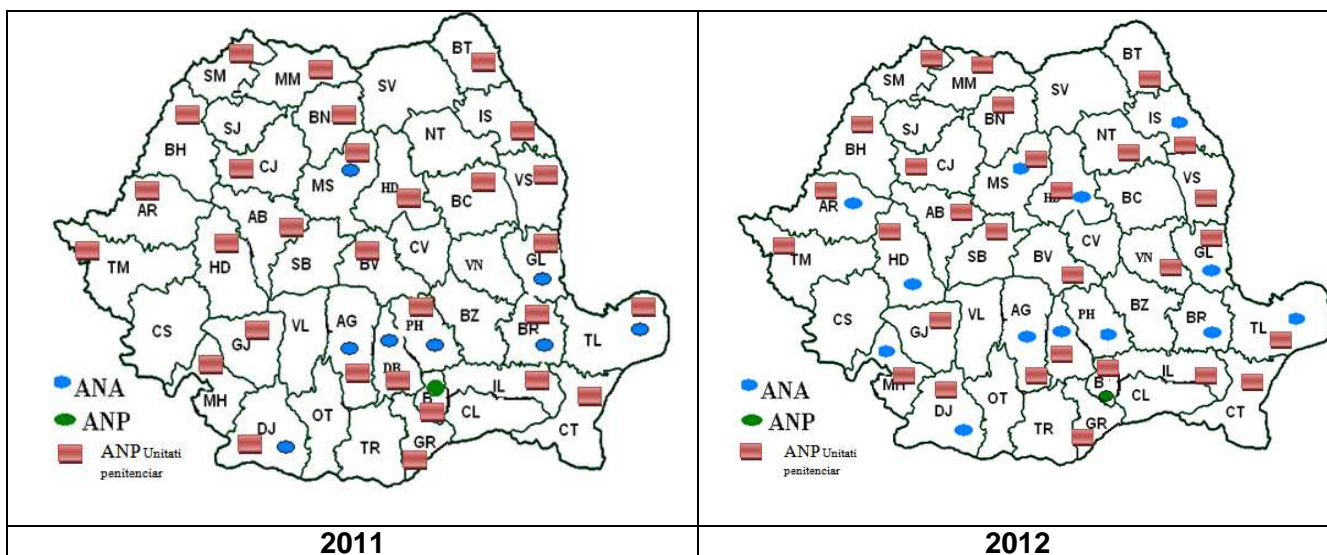


Source: ANP and NAA

**Accessions to treatment for illegal drug and NPS use during the reporting year (incidence)**

Compared to the previous year, with respect to the territorial distribution, one can notice an increase in the number of prisons offering care for illegal drug and NPS use (14 counties in 2012 compared to 9 counties in 2011). In all locations on the chart, ANA provides case management services and psycho-social care, with the support of ANP specialists. Furthermore, medical care is provided independently by ANP specialists in all penitentiaries plus other general psychological and social care services (information, counselling, professional training etc.).

**Map no. 9-1: Distribution of accession to treatment in the reference year for inmates for illegal drug and NPS use by the territorial allocation of locations where care was provided, compared data 2011-2012**



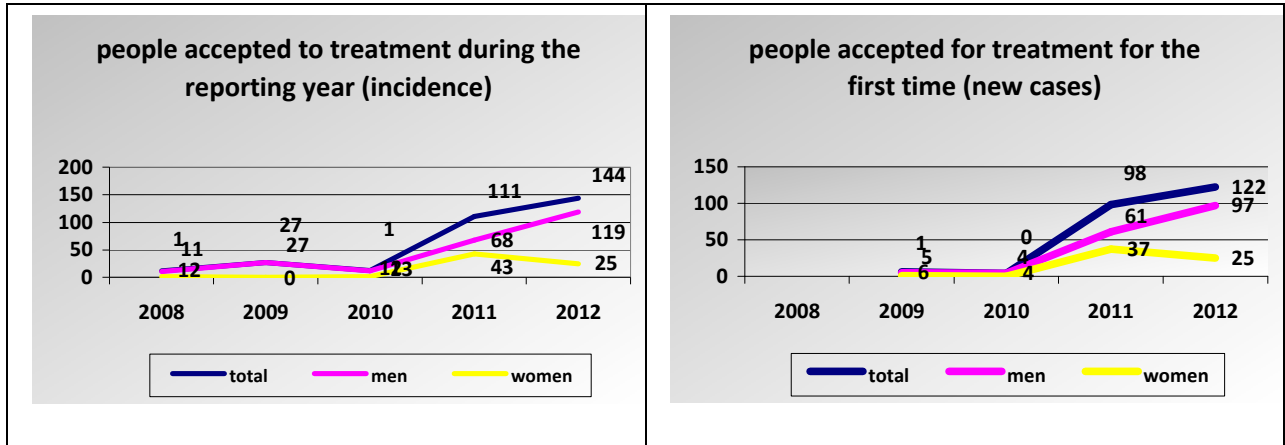
Source: ANP and NAA

After analyzing the incidence of accession to treatment, we notice the following:

- By the **type of accession**, 80% of the cases were inmates accepted to treatment for the first time (slightly decreasing compared to 2011, from 88.3% to 84.7% in 2012). As in the case of the population of users in the community, most persons accepted to treatment in the reference year are men, 82.6%, with a 4.8 M/W ratio, both values presenting increases compared to the previous year (61.3%, 1.6% respectively).

- If we were to take into account the **gender of the beneficiary**, we notice that 82.6% are men in the reference year, with a 4.8 M/W ratio (increasing compared to 2011: 61.3% men and 1.6% M/W ratio)<sup>106</sup>.

**Chart no. 9-18: Distribution of inmates' accession to treatment, for illegal drug and NPS use, by the type of accession and gender, compared data 2008-2012 (no. of people)**



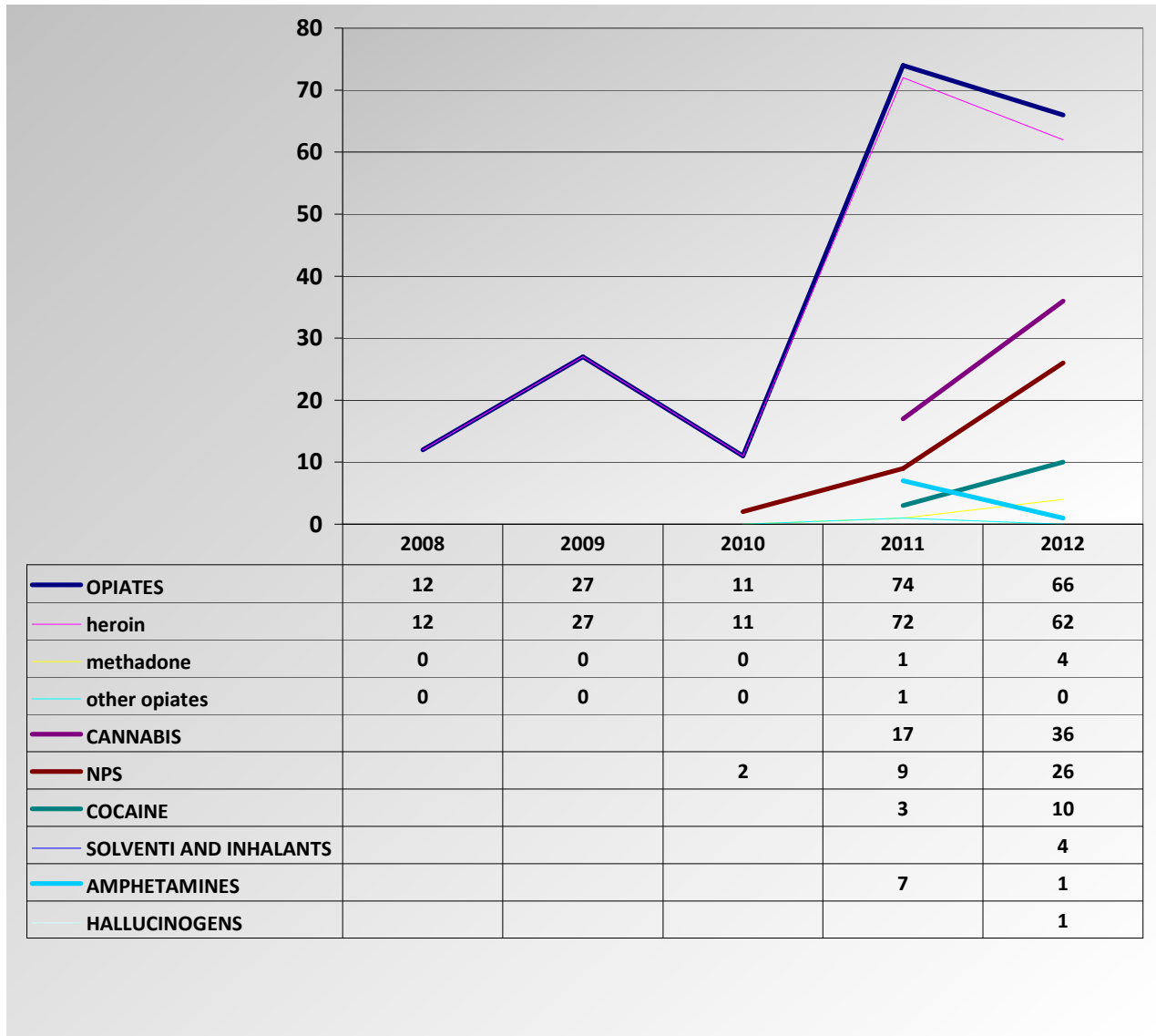
Source: ANP and NAA

By the **main drug**<sup>107</sup>, if most accessions were for heroin in the past years, significant changes can be noticed in the reference year: there continues to be a decreasing trend of accessions for heroin (2012 – 43.1%) along with a decrease in accessions for amphetamines and hallucinogens. One can notice proportional increases for: NPS and cannabis (each with a 10 percent increase), cocaine, inhalants and methadone.

<sup>106</sup> See ST. 4.1.1

<sup>107</sup> See ST. 11.1.1

**Chart no. 9-19: Distribution of inmates' entering to treatment in the reference year, for illegal drug and NPS use, by the main drug, compared data 2008-2012 (no. of people)**



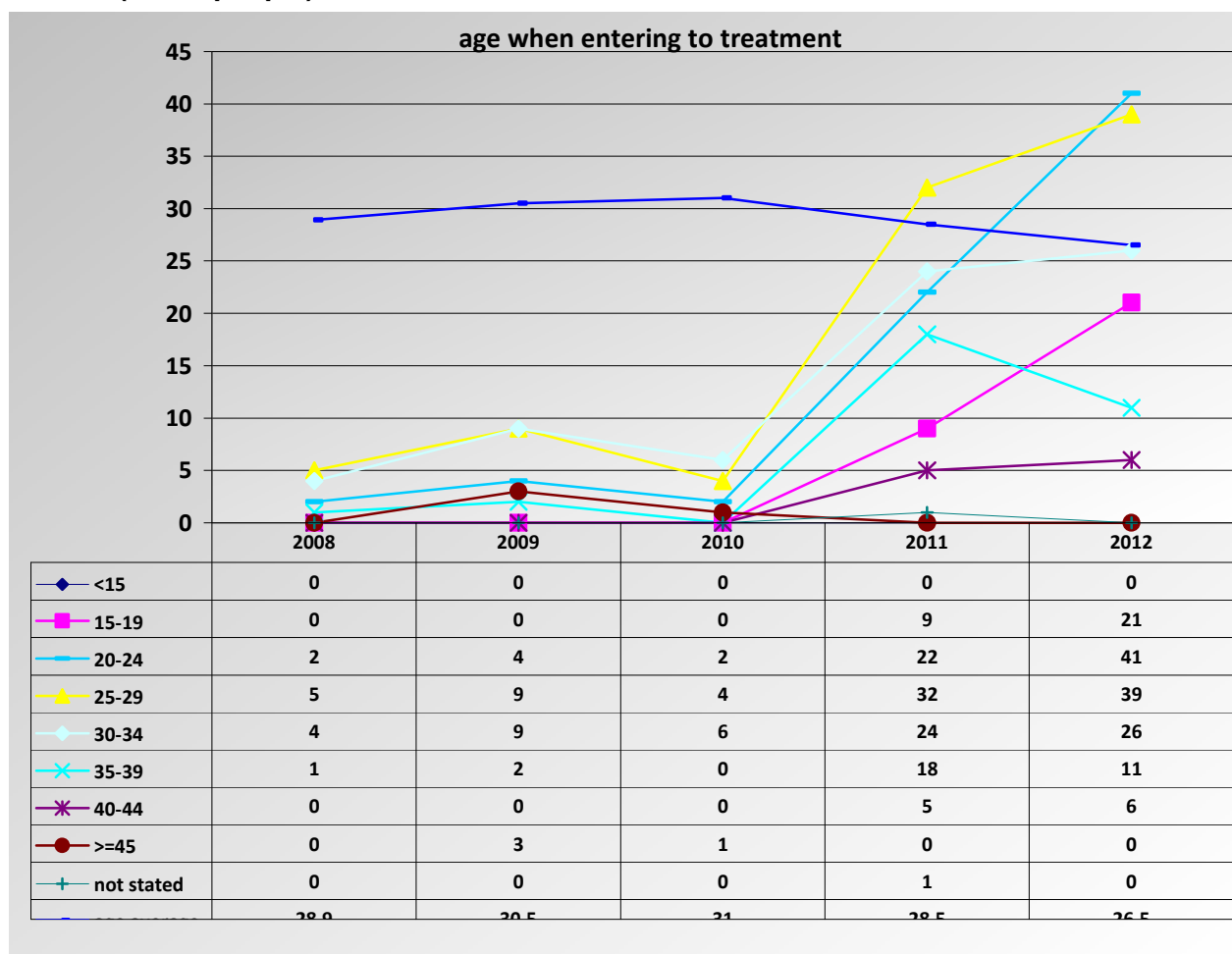
Source: ANP and NAA

Analyzed by the **age group**<sup>108</sup>, most accessions to treatment in 2012 were for people between 20 and 34 y.o., just like previous years. Moreover, there is a decreasing trend of the age group at the date of accession to treatment (from 31y in 2009/2010 to 26.5 y in 2012).

<sup>108</sup> See ST 6.11



**Chart no. 9-20: Distribution of inmates' entering to treatment by age group, compared data 2008-2012 (no. of people)**



Source: ANP and NAA

With respect to the **onset age**<sup>109</sup>, there is an increase compared to previous years for the following;

- early use onset (< 15 y.): from 0 in 2010, to 12.6% in 2011 and 18.1% in 2012),
- onset over 30 (in 2008-2010 one case per year, 5 in 2011 and 9 cases in 2012).

From the point of view of **administration**, one can notice a significant decrease of those injecting heroin (only 41% of the persons in treatment declared to use injections) compared to 2008-2011, when the great majority of persons in treatment used injectable heroin<sup>110</sup> (2008 - 11 people, 2009 - 25 people, 2010 - 11 people, 2011 - 72 people).

58 cases of **poly drug use**<sup>111</sup> were registered in the reference year, the most used as secondary drugs being alcohol (27 cases), NPS (26 cases) and cocaine (20 cases)<sup>112</sup>. Basically there are no significant changes compared to the previous year when there 56 cases of poly drug use, NPS being the most used secondary drug (21 cases).

<sup>109</sup> See ST. 23.1.1

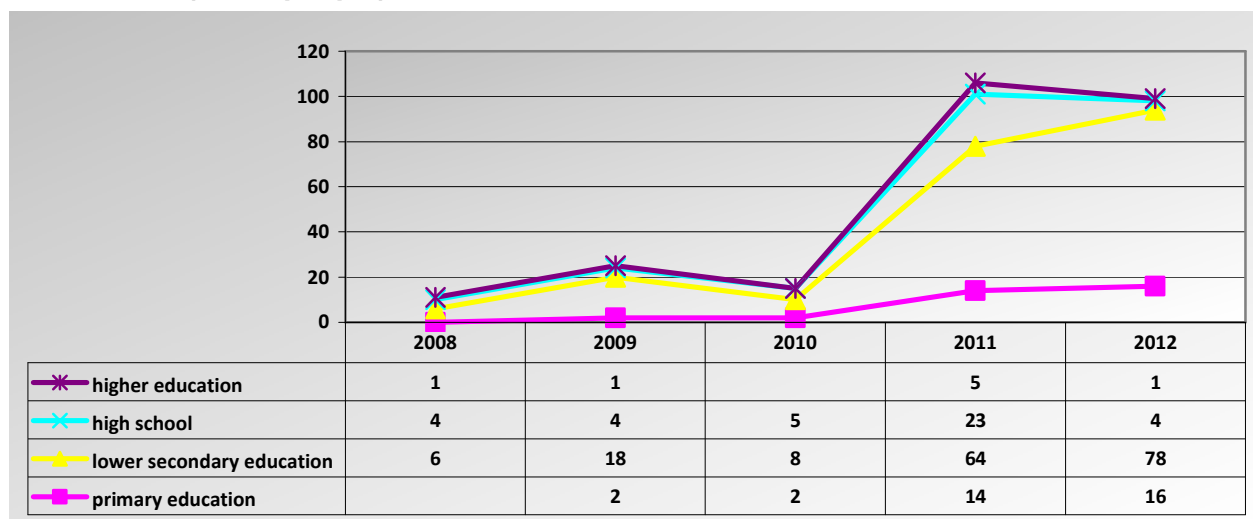
<sup>110</sup> See ST 17.1.1

<sup>111</sup> See ST. 24.1.1

<sup>112</sup> Secondary drug choices are also stimulants (11 cases), cannabis (8 cases), opiates (7 cases), hallucinogens (5 case), benzodiazepines and volatile inhalants.

By the **level of education**<sup>113</sup>, the situation in 2012 is almost similar to the previous years. Out of the total 144 admissions to treatment, most had a low level of education (16 people never attended school/did not graduate primary education and 78 people attended the first level of secondary education), 45 people finished high school and 1 person graduated higher education courses.

**Chart no. 9-21: Distribution of inmates' accession to treatment by level of education, compared data 2008-2012 (no. of people)**



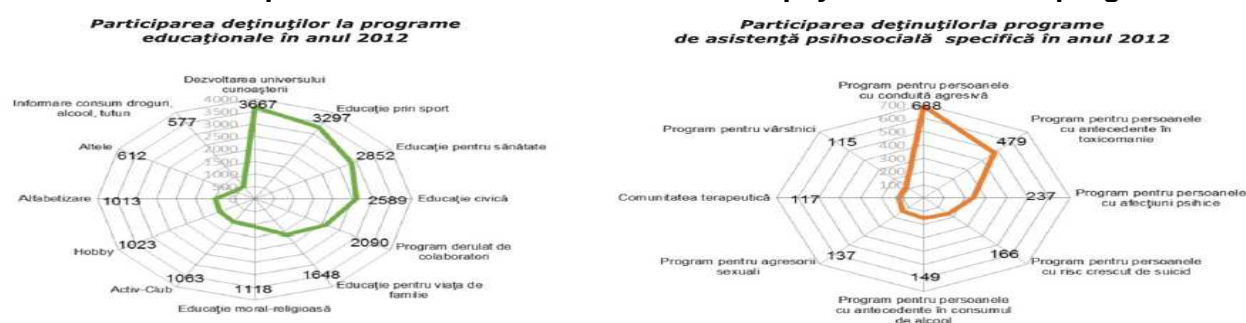
Source: ANP and NAA

### 9.3.3 PREVENTION AND REDUCTION OF DRUG USE RISKS

The implementation of the **Specific Psycho-Social Care Program for Drug User or Former User Inmates continued in 2012** (the program relies on a multidisciplinary approach – teacher, psychologist, social worker and physician), registering 479 inmates as beneficiaries.

Moreover, the **Drug Use Information and Prevention Program** carried throughout 2012 had 577 inmates as beneficiaries.

**Chart no. 9-22: Participation of inmates to educational and psycho-social care programs**



Source: ANP

In 2012, ANP continued to implement the projects regarding “HIV Prevention and Treatment of Injectable Drug Users in Romanian Penitentiaries”. To this end, the **Plan for Developing HIV Prevention Services** was developed for inmates and entailed interventions such as methadone substitution and syringe exchange.

## 9.4. REINTEGRATING DRUG USERS UPON RELEASE FROM IMPRISONMENT

When released from imprisonment, the inmates included in the *Methadone Substitution Program* have the possibility to continue treatment voluntarily within Addict Integrated Care Centres of the National Anti-Drug Agency.

<sup>113</sup> See ST 10.1.1

In 2012, the work groups initiated by the National Administration of Penitentiaries continued their activity with the purpose to elaborate and promote the final version of the **National Strategy for Social Reintegration of Inmates**. The project is posted for public consultation on the official website of NAA<sup>114</sup>.

Starting with February 2012, along with the start of training and qualification sessions for inmates from targeted prisons, a specialized e-learning platform was rendered operational for the beneficiaries of the project "*Strengthening the Functional Capacity on Integrated Services for Addicts and Former Drug Addicts for the Purpose of Integration on the Labour Market through Innovating Tools and Work Methods and Training Programs*", co-financed from the European Social Fund through the Sectoral Operational Programme for Human Resources Development 2007-2013 "Invest in People!". The project, implemented by the Bucharest University in partnership with the Association for Promoting the Right to Health, Siveco Romania and Go Business Solutions, has the objectives of providing medical and psycho-social counselling for drug addicts but also counselling for integrating former drug addicts on the labour market.

## CONCLUSIONS

- Although in 2012 the number of cases ending in committal to trial is decreasing, **the number of committals is increasing compared to the previous year**. This can highlight a greater involvement and efficiency of activities carried out by the law enforcement authorities on gathering and handling evidence during criminal proceedings, but it can also be an indicator on the association of several individuals in committing drug related crimes or associated crimes.
- This can also be confirmed by the increase in number of eliminated crime groups (86 in 2012 and 82 in 2011) as well as by the number of individuals involved in these groups (378 in 2012 and 272 in 2011). We notice a **significant increase in the number of drivers found in traffic under the influence of drugs/drug products** (counties Constanta, Timis, Arges and Bucharest);
- With respect to the **punishments applied for drug possession with the intention to use**, we notice a trend in courts to apply lighter sentences compared to previous years. Thus, from the total number of individuals convicted in 2012, in 67% of the cases the sanctions did not include imprisonment compared to 50% in 2010 and 57% in 2011;
- The **assessment reports** continue to be a practice used by courts (98% of the cases);
- The number of **criminal fines** increased, these being applied entirely for the crime under art. 4 in Law 143/2000;
- Compared to 2011, there were **cases of minors convicted to imprisonment** (3 minors in Braila).

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<sup>114</sup> [http://www.ana.gov.ro/doc\\_strategice/proiecte/strategie%20reintegrare%20ANP.pdf](http://www.ana.gov.ro/doc_strategice/proiecte/strategie%20reintegrare%20ANP.pdf)

## Chapter 10 – Drug Markets

### 10.1 AVAILABILITY AND SUPPLY

#### 10.1.1. DRUGS ORIGIN

As regards the heroin trafficking routes used by organized crime networks, the situation did not change in 2012. Heroin traffic continues to occur on the route Afghanistan – Pakistan – Iran – Turkey – Greece – former Yugoslav states and Western Europe states, which is the traditional Balkan route, with destinations in Romania, England and Netherlands. Romania is part of the northern segment of the Balkan route, alongside Bulgaria and Hungary. **Cocaine** comes from Columbia, Bolivia, Peru and Venezuela and follows, in general, the route Spain – France – Austria – Hungary to Romania or South America – West and Central Africa – Romania – toward Central and Western Europe. This type of drug is found mostly in large cities – Bucharest, Timisoara, Constanta – being a luxury drug, expensive for the economic level of most users in Romania.

**Cannabis** comes from Spain, Greece, Bulgaria, the Netherlands or Albany, transits Serbia and Bulgaria, by the followed route, and enters Romania through Hungary. The significant increase of **local cannabis crops** highlights a reorientation of the traffickers' activity, with the purpose of avoiding risks stemming from possible international transports.

**Synthetic drugs** have known great increase on the Romanian market in the past two years also taking into account that apart from classic substances there are also derivatives known as “designer drugs”. These new substances with psychoactive properties were called improperly ethno-botanical or legal.

The presence of these drugs on the Romanian market was also determined by the free circulation of persons and goods, but also by the price differences for synthetic drugs sold on the Western Europe market and those sold on the Romanian market (in Romania, these drugs cost more than in Western Europe). Moreover, there were also attempts to finance laboratories in Romania for the production of these substances.

**Synthetic drugs** (amphetamines, methamphetamines, ecstasy) continue to come from the states in Western Europe, especially from the Netherlands, transported through packages, sent either by plane or by road, the latter being used by personal vehicles of Romanian citizens returning from the West.

### 10.2 SEIZURES

#### 10.2.1 Quantities of drugs seized and number of seizures

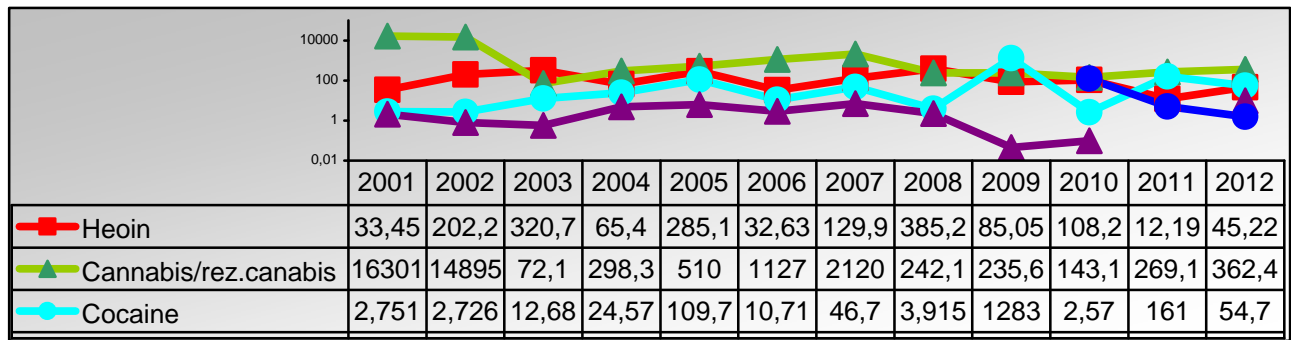
##### A. ILLICIT DRUGS

In 2012, the law enforcement bodies have discovered and seized **794.328 kg, 16,528 tablets, 3.726 litres and 104 doses of drugs**, out of which:

- **high risk drugs:** 115.117 kg, 14,471 tablets, 2.643 litres and 104 doses and
- **risk drugs** 679.211 kg, 2,057 tablets, 1.083 litres.

Compared to 2011, we noticed a **significant increase of circa 60%** in **2012** of the total quantity of seized drugs. **Weed cannabis** (marijuana) continues to be the most seized type of drug at national level, with a weight of **42.18% (335.085 kg)** of the total quantity of seized drugs, followed by **plant cannabis** amounting to **37.78% (300.080 kg)** of the total seizures.

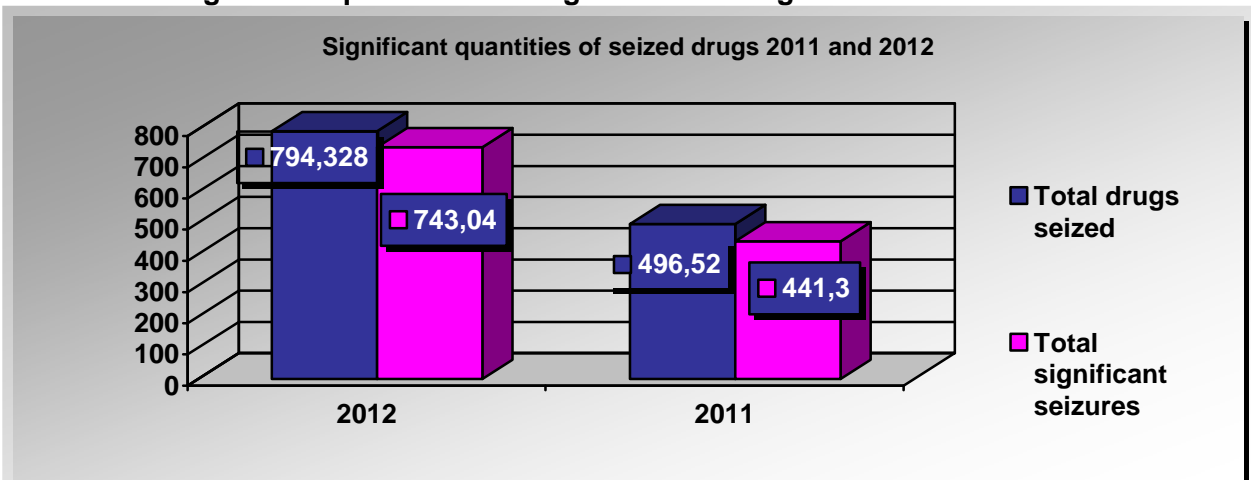
**Chart no. 10-1: Dynamics of drugs seized during 2001-2012 (kg)<sup>115</sup>**



Source: Central Laboratory for Drug Analysis and Profile – IGPR

One must also mention that from the total mentioned above, **743.04 kg and 11301 tablets are significant seizures<sup>116</sup>**. In comparison, seizures in 2011 amounted to 496.52 kg and 17652 tablets.

**Chart no. 10-2: Significant quantities of drugs seized during 2001-2012**



Source: Central Laboratory for Drug Analysis and Profile – IGPR - DCCO

With respect to the **number of drug seizures**, according to the data taken from the registries of the Central Laboratory for Drug Analysis and Profile, most seizures in 2012 consisted in cannabis (**1,492**), cannabis resin – hashish (**262**), followed by heroin (**215**) and MDMA (**112**).

<sup>115</sup> NPS includes seizures of: synthetic cannabis products, 2C, cathinones, piperazines, benzodiazepines, barbiturates, pyrovalerones, tryptamines, dimetocaine and meprobamate which occurred in 2012.

<sup>116</sup> According to the instructions of the United Nations Office for Drugs and Criminality, significant seizure refers to the following:

- opium, weed cannabis, cannabis res. (hashish), plant cannabis etc. **1 kg** and over
- heroin, morphine, cocaine, oil cannabis, coca leaf etc. **100 g** and over
- ecstasy, lorazepam, amphetamines, diazepam etc. **250 tablets**
- psychotropic substances **100 g** and over
- post office traffic seizures **all quantities**

**Table no. 10-1: Number of seizures and seized quantity per types of drugs**

Drugs	2007		2008		2009		2010		2011		2012	
	Seiz.	Quant.	Seiz.	Quant.	Seiz.	Quant.	Seiz.	Quant.	Seiz.	Quant.	Seiz.	Quant.
(kg)	984	129.9	1.055	385.23	1.038	85.046	962	108.19	314	12.191	215	45.217
Cocaine	62	46.695	91	3.91	103	1,282.99	72	2.57	73	161.039	85	54.703
Marijuana	412	6.31	596	208.66	777	198.59	986	80.82	1,365	252.527	1,492	335.086
Hashish	338	2,114.72	506	33.42	594	37.01	321	62.278	328	17.572	262	27.263
Synthetic drugs (tablets)	168	29,280	225	55,455	58	12.73	80	3,709	156	14,916	131 <sup>117</sup>	12,903
LSD (doses)	3	9	n/a.	71	18	308	3	19	12	65	2	104
LSD (ml)									1	6.4		

Source: The Central Laboratory for Drug Analysis and Profile – IGPR

With respect to total seizures, compared to significant seizures, during 2011-2012, we notice a **considerable increase in heroin, cannabis and cannabis resin** seized quantities, along with a decrease in the number of seizures, which could be a clue to the existence/larger presence of this type of drugs on the illegal market.

**Table no. 10-2: Comparative situation of seizures from during 2001-2012**

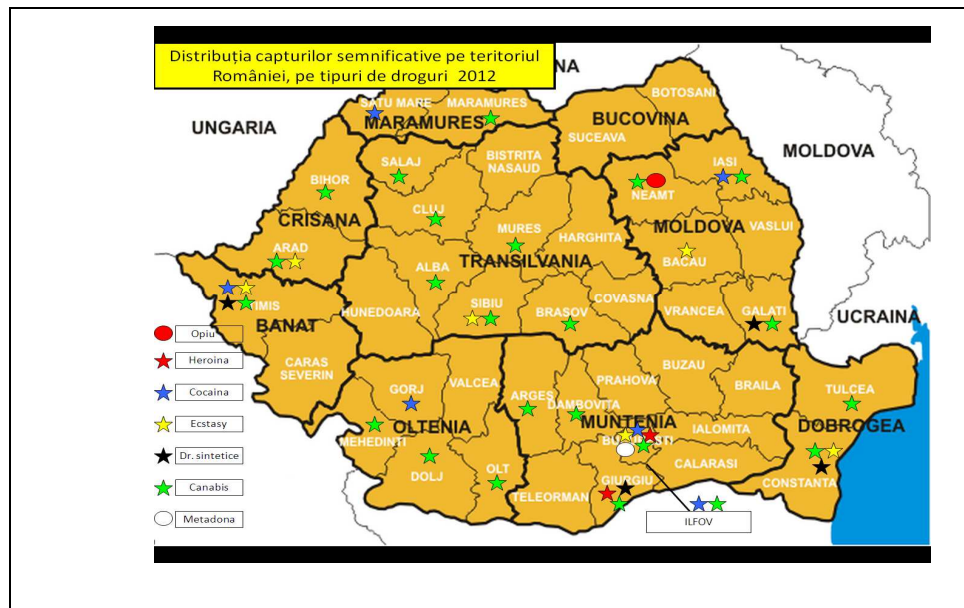
Drugs	2011				2012					
	Total seizures		Significant seizure		Total seizures			Significant seizure		
	No.	Quant.	No.	Quant.	No.	Quant.	Trend	No.	Quant.	Trend
Heroin	314	12.191	17	11.490	215	45.217	↗	3	44.800	↗
Cannabis, cannabis resin	1693	270.09	46	241.97	1754	678.09	↗	43	629.59	↗
Cocaine	73	161.03	10	160.630	85	54.703	↘	12	53.880	↘
Synthetic drugs (tablets)	156	14916	7	14040	131	12903	↘	7	9372	↘

Source: The Central Laboratory for Drug Analysis and Profile – IGPR

At national level, we can notice a uniform distribution of significant seizures of cannabis, as well as grouping of the main types of drugs seized around large urban agglomerations – *in direct relation with the economic and financial potential of the area*: Bucharest, Timisoara, Constanta as well as main entry and exit areas in Romania: Giurgiu, Galati and Iasi – *indicator of the statute of transit territory for drugs for Romania*.

<sup>117</sup> The number of synthetic drug seizures also includes the quantities taken for seizure as powders, not just as tablets.

**Map no. 10-1: Distribution of significant seizures on the Romanian territory, per type of drug**

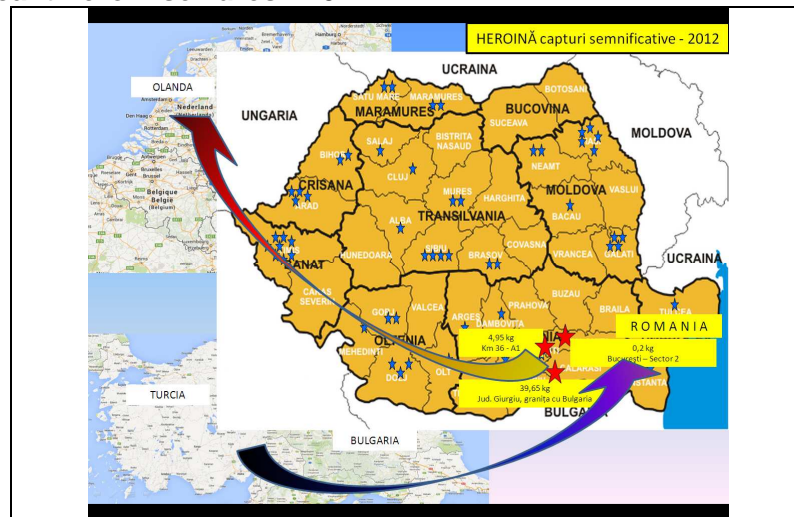


Source: NAA

By the **type of seized drug**, 2012 has the following characteristics:

- Heroin:** **45.217 kg** of heroin were seized from **215 seizures** (206 analyzed by the Central Laboratory in Bucharest, 8 by the Regional Laboratory in Timisoara, 1 by the Regional Laboratory in Iasi), out of which 3 were considered significant seizures with a total of 44.80 kg. Compared to 2011, the reference year registered a 3.7 times increase of the quantity of seized heroin. There is a significant increase of the quantity of seized heroin (more than 3 times) compared to 2011 (45.22 kg in 2012 compared to 12.19 kg in 2011), but still below the level of years 2007 (129.9 kg), 2008 (385.23 kg), 2009 (85.04 kg) which confirms the conclusions of the reports drafted by U.N.O.D.C. regarding the successive increases in 2011 and 2012 of areas cultivated with opium poppy in Afghanistan. This can anticipate the existence of high quantities of heroin on the drug market at international level, including Romania. One must mention that **88%** (39.65 kg) of the quantity seized consequent to the registered significant seizures and 87% out of the total of heroin seizures **were directed toward the Netherlands**. The remaining **0.417 kg** was the object of **212 seizures** at the national level.

## Map no. 10-2: Significant heroin seizures - 2012

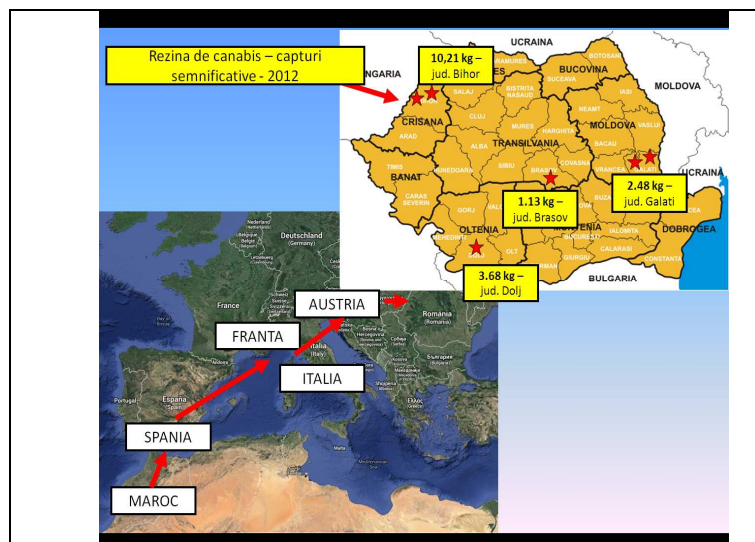


Source: NAA

- Cannabis/cannabis resin: 678.096 kg** were seized, out of which **651.697 kg cannabis** and **27.263 kg of cannabis resin** (hashish), coming from **1,754 seizures** (791 analyzed by the Central Laboratory in Bucharest, 452 by the Regional Laboratory in Cluj, 181 by the Regional Laboratory in Constanta, 181 by the Regional Laboratory in Timisoara, 149 by the Regional Laboratory in Iasi), out of which 43 were significant seizures with a total of 629.59 kg. More than half (65%) out of the seized quantity of cannabis (444.39 kg) originated from Romania.

Moreover, one can notice a considerable increase in the number of identified plants and crops of cannabis. Thus, in the reference year **48 illegal cannabis crops** were discovered in Romania and **3,125 cannabis plants** were seized, both the number of plants and of crops being 3 times more compared to 2011 when 15 illegal crops were identified, amounting to 897 cannabis plants. Out of the 48 illegal crops of cannabis, 12 were discovered outdoor, while the remaining 36 were found indoor. Out of the total quantity of cannabis seized, 406 kg (91.36%) is the green harvested mass (cannabis plants), which can be a clue of an increasing number in cannabis crops (a possibly developing local production).

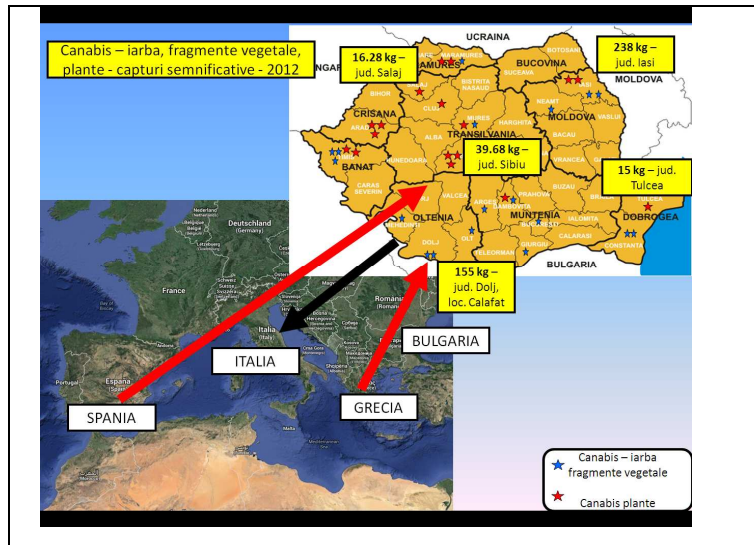
## Map no. 10-3: Cannabis resin – significant seizures 2012



Source: NAA



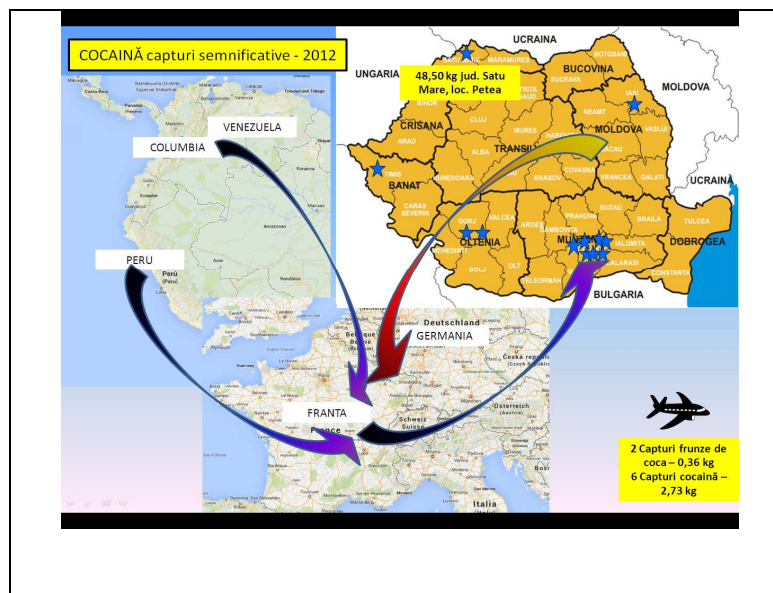
**Map no. 10-4: Cannabis – significant seizures 2012**



Source: NAA

- Cocaine:** 54.703 kg of cocaine were seized stemming from **85 seizures** (45 analyzed by the Central Laboratory in Bucharest, 5 by the Regional Laboratory in Cluj, 18 by the Regional Laboratory in Constanta, 10 by the Regional Laboratory in Timisoara, 7 by the Regional Laboratory in Iasi), compared to 73 in 2011 (16.44% higher). During the reference year, the quantity of cocaine seized by the competent authorities is circa **3 times smaller** compared to 2011. Out of a total of 85 seizures, 12 were significant seizures of cocaine and coca leaves, amounting to 53.88 kg. One must mention that 97% of the total quantity of seized cocaine (53.56 kg) was directed toward Romania, which can be a clue for an increasing demand on the local market for illegal drugs.

**Map no. 10-5: Cocaine – significant seizures 2012**



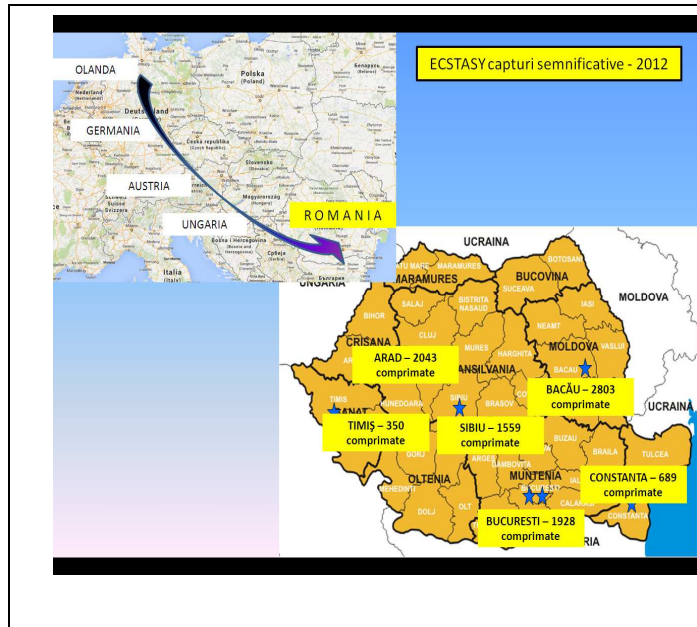
Source: NAA

- **Synthetic drugs**<sup>118</sup>: there is a **decrease of 13.5%** of the quantity of synthetic drugs seized by the authorities, from **14,916 tablets in 2011** to **12,903 tablets in 2012**. Moreover, in 2012 **104 LSD doses** were seized, compared to 65 doses seized in 2011. During the **reference year**, 3.267 kg of methamphetamine were also seized, unlike 2011 when 24.348 kg of methamphetamine were seized (**circa 7.5 times less** compared to 2011).

The quantities of synthetic drugs seized in 2012 come from **133 seizures** (49 analyzed by the Central Laboratory in Bucharest, 11 by the Regional Laboratory in Cluj, 33 by the Regional Laboratory in Constanta, 14 by the Regional Laboratory in Iasi and 26 by the Regional Laboratory in Timisoara), out of which 16 are significant seizures amounting to 11,301 tablets, 4.42 kg and 0.27 litres.

In December 2012, the following quantities of drugs were destroyed in Romania, as per the legal provisions: 168.307 kg of cocaine, 153.322 kg cannabis, 27.436 kg cannabis resin, 82.16 kg heroin, 15.3 kg new psychoactive substances, 10.5 kg medicine, 5.244 kg MDMA, 1.3 kg opium and other combinations 0.3 kg.

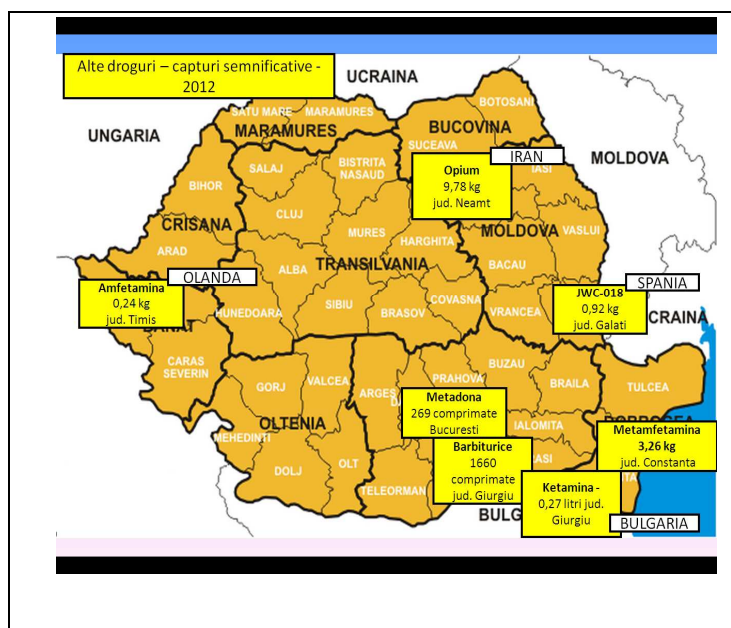
**Map no. 10-6: Ecstasy – significant seizures 2012**



Source: NAA

<sup>118</sup> the following categories of substances were taken into account when computing the number of seizures of synthetic drugs: amphetamine, methamphetamine, amphetamine derivatives, MDMA and LSD.

## Map no. 10-7: Other drugs – significant seizures



Source: NAA

## B. NEW PSYCHOACTIVE SUBSTANCES

During 2012, there was a **significant decrease** of quantities of NPS seized (**1.5 kg**), compared to the ones in 2010 (**125.14 kg**) and 2011 (**4.96 kg**). These results are due both to the continuation of the Measure *Program for Fighting the Sale and Use of New Psychoactive Substances/Products, harmful to health no. 5/1194 dated 02/18/2011*, and to the implementation of *Law no. 194/2011 on fighting operations with products susceptible of having psychoactive effects, other than those stipulated in the laws in force*.

Table no. 10-3: Seizures of new psychoactive substances (kg) during 2010 - 2012

NPS	Seized quantity						Number of seizures		
	Kilograms			tablets			2010	2011	2012
	2010	2011	2012	2010	2011	2012			
Synthetic cannabinoids	57.024	2.865	1.079	0	0	0	379	115	21
Cathinones	50.091	1.863	0.19	324	4	577	480	235	44
Piperazines	6.506	0.023	0.0001	15,094	1,050	89	74	19	19
Pyrovalerones	1.800	0.0048	0.03	6	0	2	54	6	10
Tryptamines	8.932	0.015	0.078	0	0	0	2	1	73
Mitragin	0.139	0.192	0	0	0	0	4	1	0
Salvinorin	0.648	0.0033	0	0	0	0	15	1	0
Dimetocaine	0	0	0.131	0	0	0	0	0	7

Source: The Central Laboratory for Drug Analysis and Profile, IGPR

## 10.2.2. PRECURSORS AND ESSENTIAL CHEMICAL SUBSTANCES

According to the data from the Central Laboratory for Drug Analysis and Profile, there were no seizures of drug precursors or essential chemical substances in 2012 either.

## 10.2.4. ILLEGAL LABORATORIES

During 2012, **two illegal laboratories** were discovered on the Romanian territory for preparing new psychoactive substances<sup>119</sup>, out of which one in the **Bucharest** area and the other in the **Buzau** area. The anti-drug officers discovered the two locations during the activities carried out. Within these laboratories, members of Romanian trafficker networks produced mixtures of vegetal fragments with new psychoactive substances which were later on packed and sized for selling (designer drugs). Among the chemical substances found and seized on site, we mention the following: 4-MEC, UR-144, 4-FA, JWH-203, JWH-122, JWH-081, JWH-210, AM 2201, MAM 2201, NEB, 4-MMA, RCS 4, XLR, acetone, isopropyl alcohol and vegetal fragment used as substrate. These substances enter in the category of cathinones, synthetic cannabinoids or amphetamine derivatives. Apart from these substances, trays, a blender and 2 scales used to prepare the substances were also seized.

## 10.3. DRUG PRICE

### 10.3.1. Drug price on the streets

Compared to 2011, during 2012, part of the drug selling prices remained constant and part decreased. The differences presented in the tables below (a slight increase in the prices of all retail drugs sold and the wholesale price paid for ecstasy) come from the average rate of the Euro<sup>120</sup>, determined by the N.B.R. during 2012, which is slightly higher compared to 2011.

With respect to the wholesale drug prices, these are similar to 2011 and vary by the trend of the demand present on the illegal market, as follows:

- hashish (cannabis resin) – both wholesale and retail prices were almost constant during 2010, 2011 and 2012, similar to the values registered in 2009;
- weed cannabis (marijuana) – the price for this drug did not change for wholesale or retail; values are similar to the ones registered during 2009-2011;
- heroin – the wholesale price continues to decrease slightly, the minimum amount being 15% smaller, while the maximum amount 18.52% smaller compared to the value registered in the previous year;
- cocaine – the wholesale price decreased in 2012 compared to 2011, in a range between 11.1% and 22.2% lower respectively;
- ecstasy (MDMA) – both the wholesale and the retail price increased slightly, due to the average price for 1 Euro during 2012;
- LSD – the retail price was rather stable during 2004-2012.

Moreover, one must mention that the price of wholesale heroin was also influenced by the total traded quantity or by the quality of the merchandise, while the price of retail cannabis also varied by its local or foreign origin.

<sup>119</sup> These substances fall under the incidence of **Law no. 194/2011 on fighting operations with products susceptible of having psychoactive effects, other than those stipulated in the laws in force**

<sup>120</sup> According to the data in the National Bank of Romania, the average rate registered for Euro during 2011 was 4.2379 RON, while in 2012 it was 4.4559;

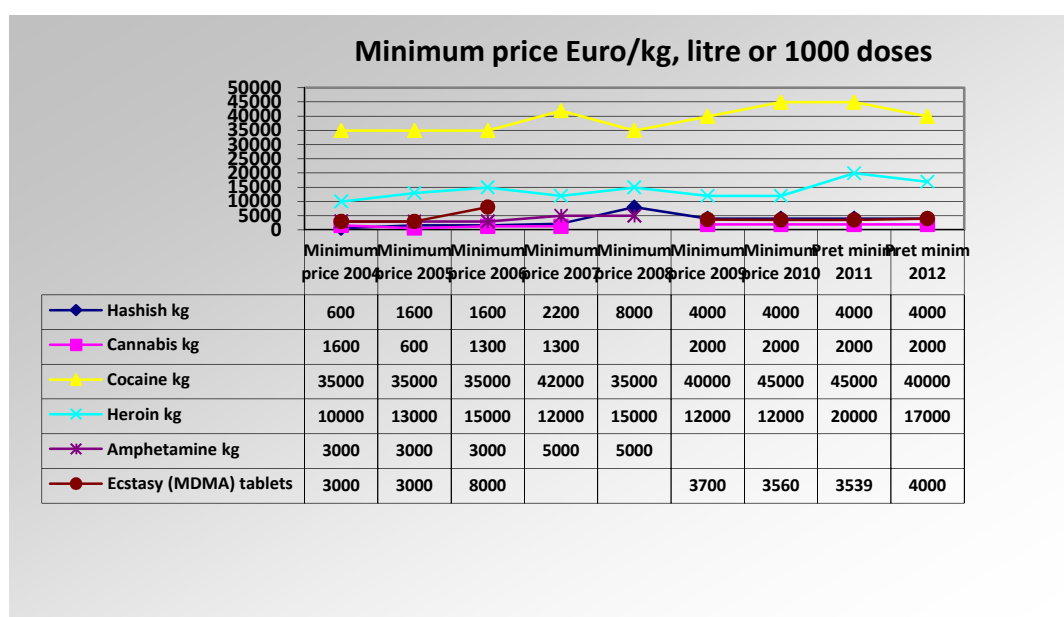
**Table no. 10-4: Minimum and maximum values of prices of drugs sold most often on the illegal market in Romania, during 2004 – 2012**

**A. Wholesale price (Euro/kg, litre or 1000 doses)**

Type of drug	2004	2005	2006	2007	2008	2009	2010	2011	2012
Hashish (cannabis resin)	600-800	1600-2500	1600-2500	2200 – 2400	8000 – 10000	4000 – 7000	4000 – 7000	4000 – 7000	4000 – 7000
Weed cannabis (marijuana)	1600-2500	600-800	1300 - 1500	1300 - 1500	-	2000 – 5000	2000 – 5000	2000 – 5000	2000 – 5000
Cocaine	35000-50000	35000-50000	35000-50000	42000 – 44000	35000 – 55000	40000 – 60000	45000 – 90000	45000 – 90000	40000 – 70000
Heroin	10000-15000	13000-17000	15000-20000	12000 – 15000	15000 – 16000	12000 – 20000	12000 – 20000	20000 – 27000	17000 – 22000
Amphetamine	3000-4000	3000-4000	3000-5000	5000	5000	-	-	-	-
Ecstasy (MDMA)	3000-4000	3000-4000	8000-10000	-	-	3700 – 7500	3560 – 7130	3539 – 7078	4000 – 7000

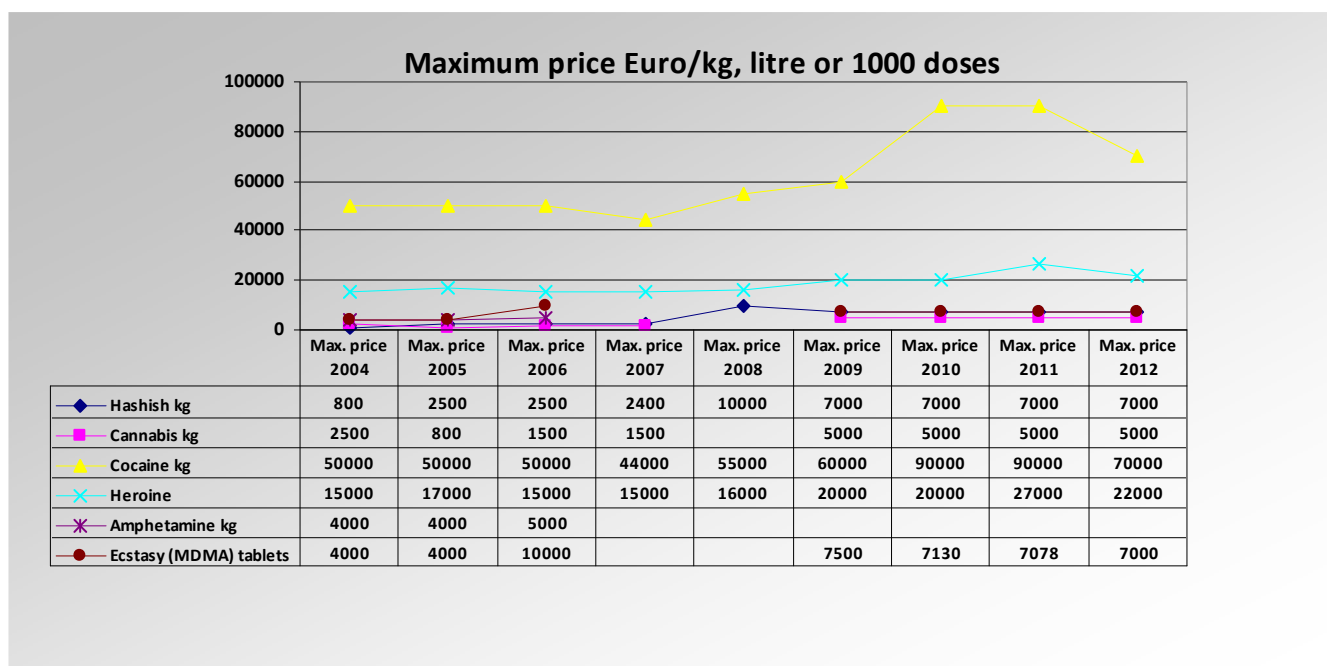
Source: Anti-Drug Service, General Inspectorate of the Romanian Police

**Chart no. 10- 3: Evolution of the minimum price of wholesale drugs, during 2004-2012**



Source: Anti-Drug Service, IGPR

Chart no. 10- 4: Evolution of the maximum price of wholesale drugs, during 2004-2012



Source: Anti-Drug Service, IGPR

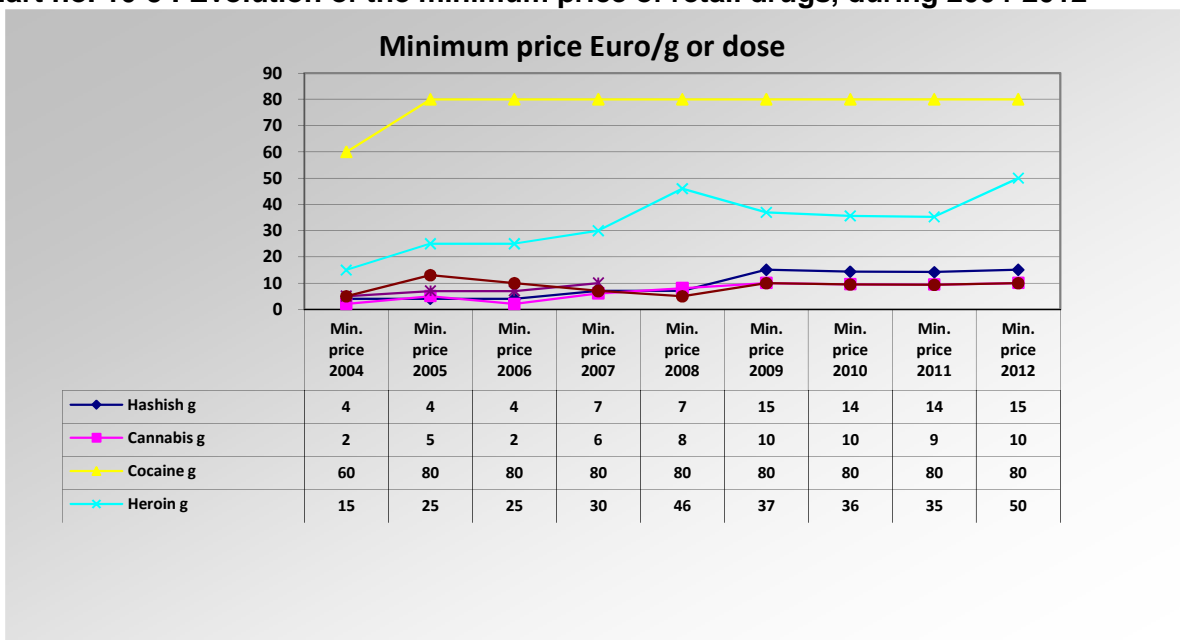
Both minimum and maximum wholesale prices continue to be stable, with slight variations, for most types of drugs. **Cocaine** continues to have the highest price on the drug market, 70,000 Euros showing a decrease compared to 2010 and 2011 (90,000 Euros), but keeping an increasing trend for the period 2004-2012. The same is applicable for the price of **heroin**, 22,000 Euros, decreasing compared to 2011, but keeping an increasing trend compared to the analyzed period.

#### B. Retail prices (in Euros/g or per dose)

Type of drug	2004	2005	2006	2007	2008	2009	2010	2011	2012
Hashish (cannabis resin)	4-6	4-6	4-6	7-9	7-9	15 - 20	14.25 - 19	14.1 - 18.8	15 - 20
Weed cannabis (marijuana)	2-4	5-7	2-4	6-7	8-14	10 - 20	9.5 - 19	9.4 - 18.8	10 - 20
Cocaine	60-120	80-120	80-150	80-120	80-120	80 - 120	80 - 120	80 - 120	80 - 120
Heroin	15-25	25-40	25-60	30-35	46-55	37 - 49	35.63 - 47.51	35.3 - 47.1	50
Amphetamine	5-10	7-13	7-13	10	-	-	-	-	-
Ecstasy (MDMA)	5-10	13-15	10-15	7-12	5-8	10 - 20	9.5 - 19	9.4 - 18.8	10 - 20
LSD (blotter)	20-30	20-30	30-35	33	33	20 - 37	19 - 35.63	18.8 - 35.3	20 - 40

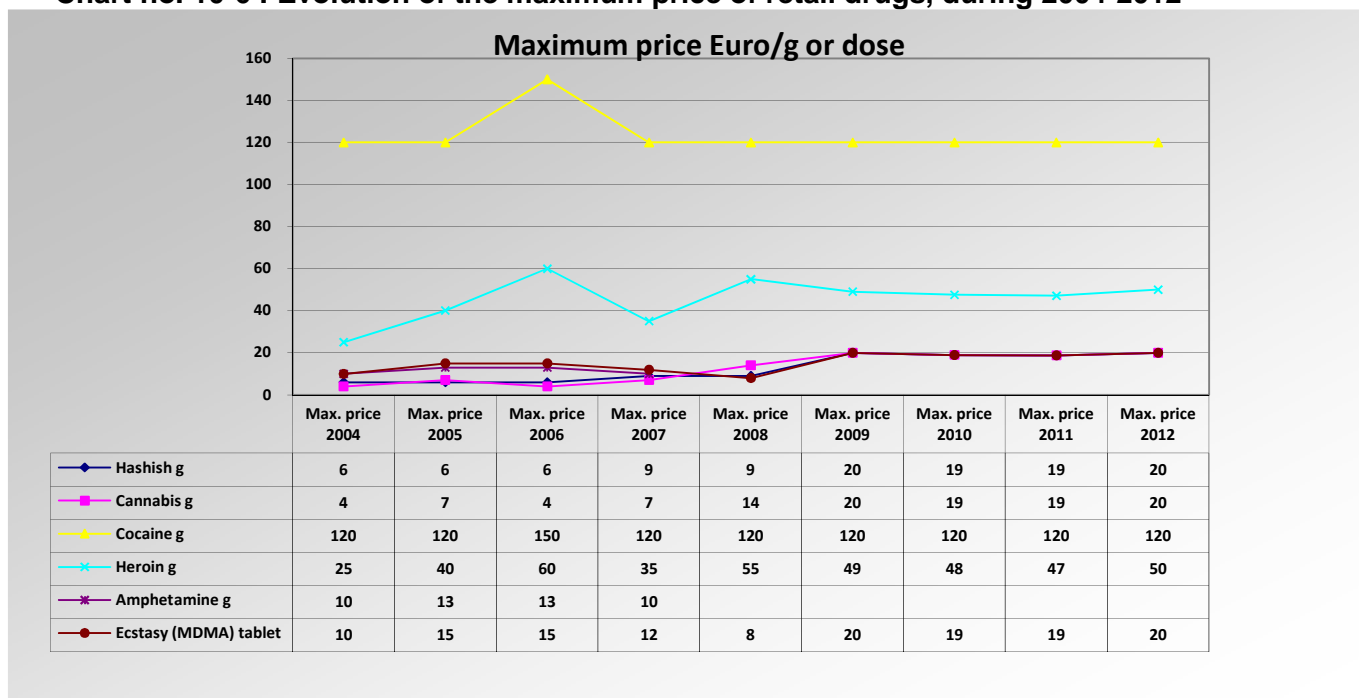
Source: Anti-Drug Service, IGPR

**Chart no. 10-5 : Evolution of the minimum price of retail drugs, during 2004-2012**



Source: Anti-Drug Service, IGPR

**Chart no. 10-6 : Evolution of the maximum price of retail drugs, during 2004-2012**



Source: Anti-Drug Service, IGPR

With respect to prices, after 2004-2008 which presented high fluctuations in amounts, especially of the minimum amounts, starting with 2009 one can notice a rather stable level of the prices for all categories of drugs, the only exception being the minimum price for heroin, which also increased to 50 euro/gram compared to the values compared to the values registered during 2009-2011 (37 Euros/gram, 36 Euros/gram and 35 Euros/gram respectively) and exceeded the maximum of 46 Euros/gram reached in 2008. Cannabis, the most used type of drug, continues to have constant values of the price per gram, between 10 – 20 Euros (minimum and maximum) since 2009. Cocaine continues to be the most expensive type of used drug, the minimum – maximum price being between 80 – 120, ever since 2007, preserved up the present.

### 10.3.2. Drug purity

The concentration of **heroin** sold on the streets varied between 0.22% and 46%. In case of large quantities seized by the agents, laboratory analyses showed a concentration between 34 and 50.36%. The average purity of the heroin samples (retail sale) analyzed during 2012 was 19.62%. The dilution agents and adjuvants/adulterants used most often in heroin samples are: caffeine, paracetamol, dextrometophan and griseofulvin.

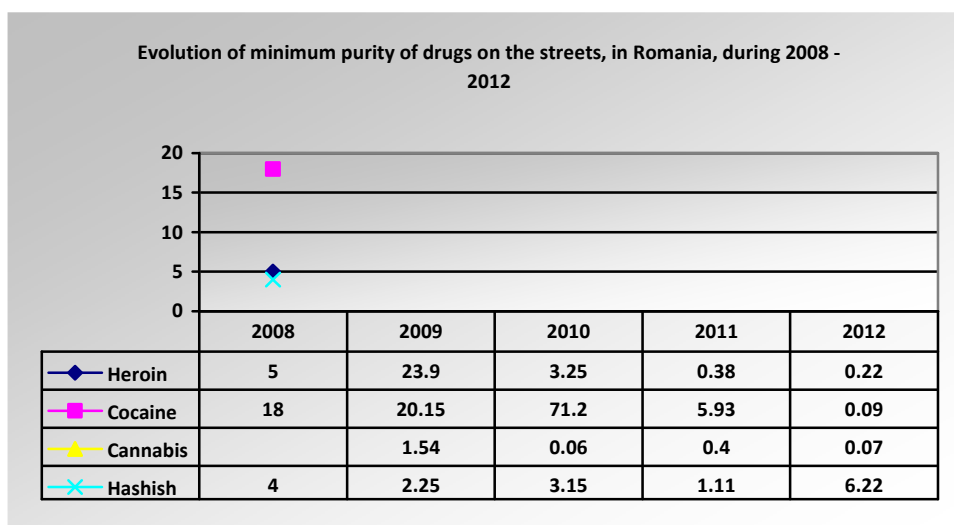
During 2012, the 7 samples of **MDMA** (sold on the street) analyzed had a concentration between 7.99% and 64.4%. MDMA samples showed the presence of caffeine used as adjuvant/adulterant.

The **cocaine** concentration in large seizures, analyzed by the specialists of analysis laboratories, varied between 0.022% and 97.34%, while for the cocaine sold on the streets the concentration varied between 0.09% and 82.65%. During 2012, the average purity of the analyzed cocaine samples (retail sale) was of 36.07%. The substances identified in cocaine samples analyzed during 2012 were as follows: phenacetin, lidocaine, tetracaine, levamisole, caffeine, procaine and tetramisol.

The THC concentration of **weed cannabis (marijuana)** sold on the streets was between 0.074% and 14.78%, while for wholesale the concentration was between 0.43% and 14.63%. The average concentration for the samples of weed cannabis/ marijuana (sold on the streets) analyzed at national level in 2012 was 6.34%.

With respect to **cannabis resin** sold on the streets, the laboratory analyses highlighted a concentration in THC between 6.22% and 7.77%. The average concentration for the cannabis resin samples (sold on the streets) analyzed at national level in 2012 was 7.12%.

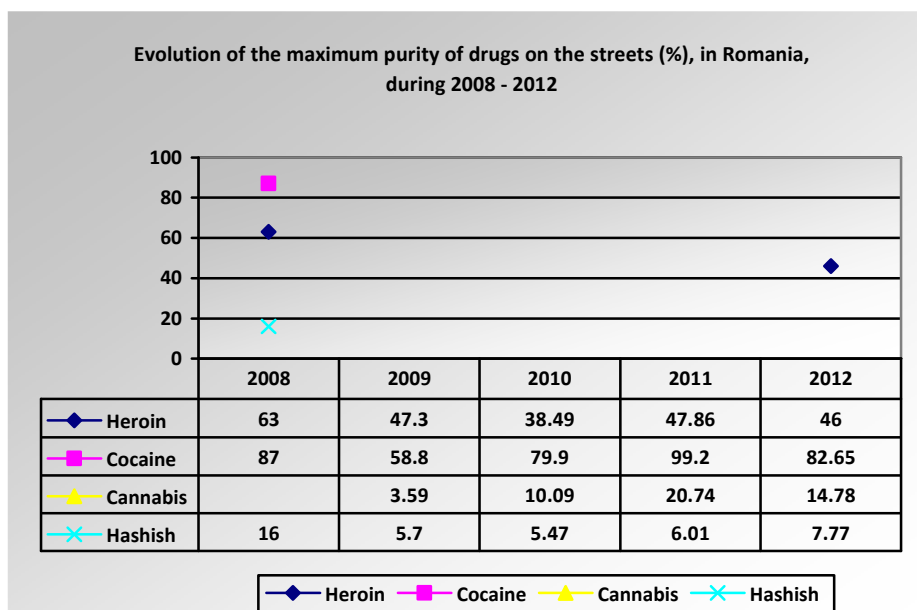
**Chart no. 10-7: Evolution of minimum purity of drugs on the streets (%) in Romania, during 2008 - 2012**



Source: Central Laboratory for Drug Analysis and Profile, IGPR



**Chart no. 10-8: Evolution of maximum purity of drugs on the streets (%) in Romania, during 2008 - 2012**



Source: Central Laboratory for Drug Analysis and Profile, IGPR

#### 10.4 ANNUAL REPORT TO THE EUROPEAN EARLY WARNING SYSTEM

22 new psychoactive substances controlled at national level were identified in 2012, the largest quantity being from JWH-018.

**Table no. 10-5: New psychoactive substances controlled at national level, identified in 2012**

No	Substance	Physical description	Number of cases	Weight
1	Amfepramone	Tablets	1	4
2	para-methoxyamphetamine (PMA)	Tablets	1	3
3	para-methoxymethamphetamine (PMMA)	Tablets	1	1
4	JWH-018	Plants - mix	18	1009.16
5	JWH-250	Plants - mix	1	59.19
6	JWH-073	Plants - mix	1	3.6
7	CP 47, 497-C8	Plants - mix	1	7.82
8	Mephedrone (MMC)	Powder	31	172.28
9	Mephedrone (MMC)	Tablets	4	577
10	Methylone (beta-keto-MDMA)	Powder	1	3.84
11	Fluoromethcathinone/Flephedrone	Powder	2	8.9
12	Ethcathinone	Powder	6	5.04
13	BZP + TFMPP	Tablets	1	52
14	CPP	Tablets	11	22
15	CPP	Powder	1	0.1
16	Amphetamine + CPP	Tablets	4	9
17	MBZP	Tablets	1	6
18	5 MeO-Dalt	Powder	72	78.2
19	DMT	Powder	1	0.13
20	2C-X	Powder	1	5.07
21	Pyrovalerone (MDPV)	Powder	8	30.52
22	Pyrovalerone (MDPV)	Tablets	1	2

Source: Central Laboratory for Drug Analysis and Profile, IGPR

Moreover, during 2012, 27 new psychoactive substances were identified which were not controlled at national level, grouped in 3 categories: synthetic cannabinoids, cathinones and amphetamines, as follows:

**Table no. 10-6: New psychoactive substances not controlled at national level, identified in 2012**

<b>Synthetic cannabinoids</b>	<b>Cathinones</b>	<b>Amphetamines</b>
JWH-019	$\alpha$ -PVP	3-FA
JWH-022	4-MEC	4-FA
JWH-081	4-EMC	4-MMA
JWH-122	NEB	4-FMA
JWH-203	Pentedrone	
JWH-210	Pentylone	
AM-2201	bk-MDEA	
MAM-2201	MDPBP	
MAM-1220	3,4-DMMC	
CB-13		
UR-144		
XLR-11		
STS-135		
AKB-48		

Source: Central Laboratory for Drug Analysis and Profile, IGPR

### Word groups for improving the activity of the network

Work groups were organized in 2012 on the NPS issues.

Similar to previous years, the conclusions of the work groups organized in 2012 highlighted the following:

- the difficulty in finding these new compounds in the biological samples and problems with respect to the technical endowment of profile laboratories, respectively the training of specialized personnel due to the novelty of the phenomenon and of the very dynamic rhythm with which these new substances occurred and developed;
- the lack of endowments in toxicological laboratories in emergency wards;
- lack of a structured approach on treating disorders caused by NPS.

In the last *snapshot* online study carried out by ANA in the beginning of 2013, 7 online shops were identified, with single *url* which, although did not have a *web* domain for Romania “.ro”, stated to deliver NPS on demand in Romania or had a menu in Romanian. Among the traded substances, we mention:

**Table no. 10-7: New psychoactive substances, traded under different names:**

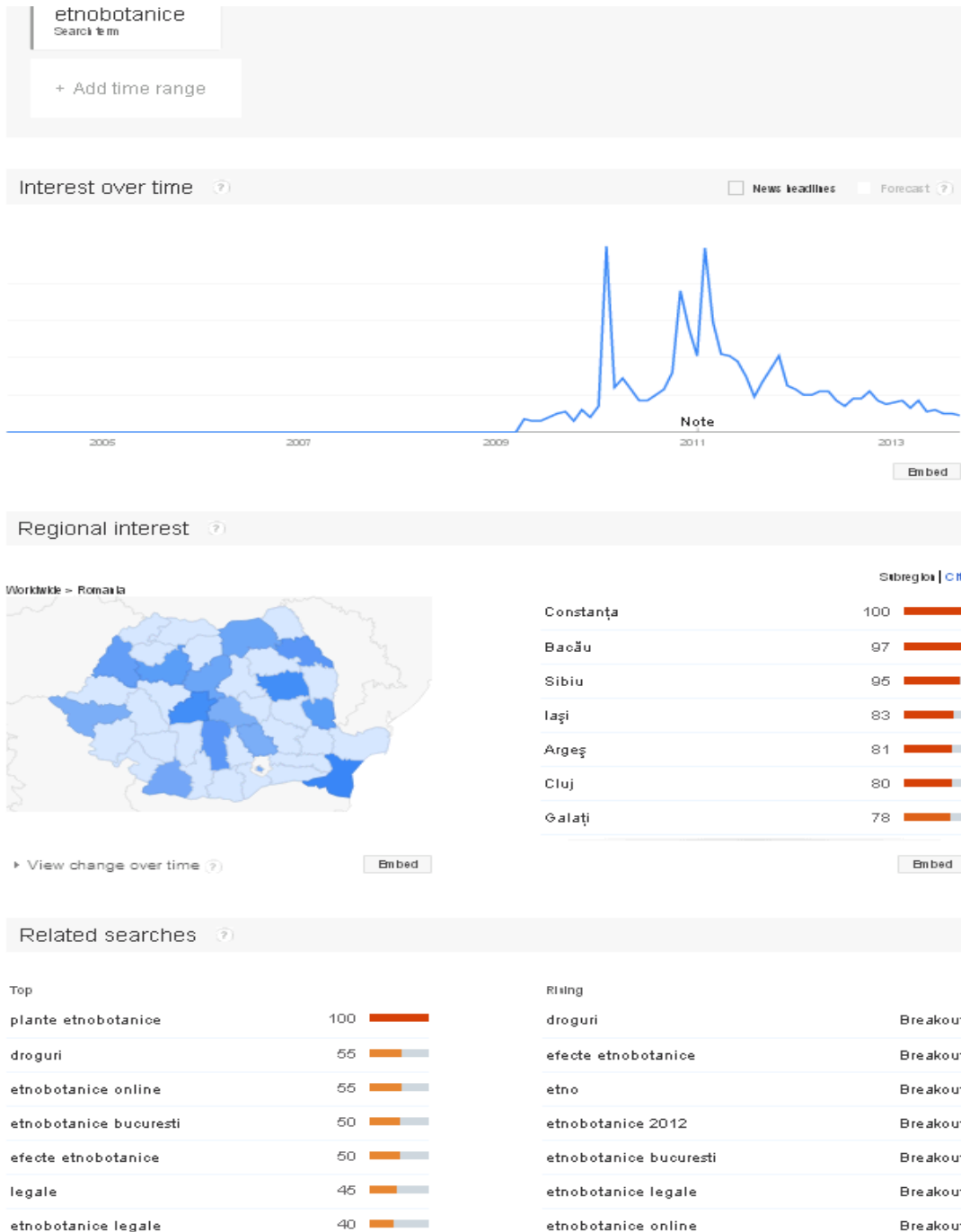
<b>Substance trade name</b>	<b>Grams</b>	<b>Price in lei</b>
Boom Powder	1g	140
Boom Powder	0.5 g	75
Boom Pills	4 p.	150
Boom Pills	2 p	80
Monster Energy Powder	1 g	140
Monster Energy Pills	4 p	150
Monster Energy Pills	2 p	80

Source: NAA

## Online interest for “ethnobotanicals”

As noticed in the chart below, the online interest for the NPS phenomenon is decreasing after enacting the legislation requiring a previous permit for selling such products (Law no. **194/2011**<sup>121</sup>).

**Chart no. 10- 9: Online interest for “ethnobotanicals”**



Source: NAA

<sup>121</sup> Law 194/2011 on fighting operations with products susceptible of psychoactive effects, other than those mentioned in the laws in force.

## CONCLUSIONS:

- Romania is not a drug manufacturing country, but preserves its quality of important transit hub on the Balkan route of drug traffic; Romania, alongside states bordering the Black Sea, is an alternative/secondary route for bringing cocaine in Europe, through Constanta Harbour, especially cocaine from Bulgaria;
- Romania becomes more and more a destination country for most types of drugs: heroin, cannabis, cocaine, cannabis resin and synthetic drugs, matter confirmed also by the significant seizures in 2011 and 2012 by compared to the number of seizures, seized quantities, types of seized drugs, as well as their allocation on the Romanian territory.
- In **2012**, one can notice a **significant increase of circa 60% in the total quantity of seized drugs**, with an increase compared to the previous year in the heroin seizures (3 times more) and of illegal plants and crops of cannabis (3 times more);
- The quantity of drugs coming from significant seizures in 2012 is 79% of the total of seized drugs, as follows:
  - Total quantities of seized drugs: **794.328 kg** and 16,528 tables;
  - Total quantities of drugs from significant seizures: **743.04 kg** and 11,301 tables.
- 2012 registered **the highest quantity of opium seized so far** (9.79 kg);
- In the context in which opium poppy crops in Afghanistan increased significantly<sup>122</sup> both in 2011 (61%) and in 2012 (18% compared to 2011) Romania must be prepared for a possibly increasing trend of heroin quantities that will transit the national territory in the near future. Thus, one estimates that the heroin yielded by the crops of 2011 and 2012 will be available on the international drug market in the period 2013 – 2015;
- There is an **increase in the presence/availability of cannabis and cannabis resin** on the drug market in Romania (2010 – 143.1 kg, 2011 – 269.1 kg, 2012 – 678.1 kg);
- Present in the entire country, cannabis is the most used drug, with more and more information on the decreased import of this drug from other countries and the onset of a local manufacturing phenomenon, which would decrease sale costs and would facilitate the *business* of Romanian traffickers;
- More than half (65%) out of the seized quantity of cannabis (444.39 kg) originated from Romania. Moreover, 406 kg of this quantity (91.36%) is the green harvested mass (cannabis plants), which can be a clue of an increasing number in cannabis crops (a possibly developing local production).
- The quantity of seized heroin registers a significant increase, matter confirmed also by the U.N.O.D.C. reports regarding the successive increases in 2011 and 2012 of the areas of opium poppy crops in Afghanistan. In this respect, one estimates an increasing trend for 2013 and 2014 also;
- Cocaine has a decreasing presence on the drug market in Romania compared to 2011, situation also registered at international level and confirmed and corroborated with U.N.O.D.C. reports which signal decreasing coca crop areas in Columbia and Bolivia, important cocaine producers. Nevertheless, the seized quantity continues to be at a rather high level (over 50 kg);
- By the **country of origin of the drugs** the following was found:
  - Cocaine comes from Columbia and Venezuela;
  - Heroin comes from Turkey;
  - Opium comes from Iran;
  - Cannabis comes from Greece, Bulgaria and Spain;
  - Cannabis resin comes from Morocco;
  - Synthetic drugs come from the Netherlands, Spain, Romania and Bulgaria.
- The following drugs transiting Romania had as **destination** the countries below:
  - Cocaine – destination Italy;
  - Heroin – destination Netherlands;
  - Cannabis – destination Italy, Netherlands and Poland;
  - Opium – destination Germany.
- Almost 98% of the *dream* shops were shut down and one could notice a **significant decrease of NPS seizures (1.5 kg)** compared to 125.14 in 2010 and 4.96 kg in 2011;

<sup>122</sup> Afghanistan Opium Survey 2012, Afganistan Opium Survey 2011 – [www.unodc.org](http://www.unodc.org).

- During 2012, **two illegal laboratories** were discovered on the Romanian territory **for preparing** new psychoactive substances<sup>123</sup>, out of which one in the **Bucharest** area and the other in the **Buzau** area;
- The prices of the main types of drugs are at a rather constant level compared to previous years, the only changes in this indicator being present at wholesale heroin and cocaine quantities (decreasing values – prices have decreased between 11-20%) as well as of ecstasy tablets (*with a slight increase due to the changes in the exchange rate for 2012*).

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<sup>123</sup> These substances fall under the incidence of **Law no. 194/2011 on fighting operations with products susceptible of having psychoactive effects, other than those stipulated in the laws in force.**

## PART B. BIBLIOGRAPHY and ANNEXES

### BIBLIOGRAPHY

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- |    |   |
|----|---|
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**LIST OF ABBREVIATIONS USED IN THE TEXT**

<b>ALIAT</b>	Association for the Fight against Alcohol and Drugs
<b>ANP</b>	National Administration of Penitentiaries
<b>ANIT</b>	Drug Addition Intervention National Association
<b>ARAS</b>	Romanian Association against AIDS
<b>BSS</b>	Behavioral Surveillance Survey
<b>CAIA</b>	Centrul de Asistență Integrată în Adicții
<b>COFOG</b>	Classification of The Functions of Government
<b>CC</b>	Criminal Code
<b>CPECA</b>	Centrul de Prevenire, Evaluare și Consiliere Antidrog
<b>CPI</b>	County Police Inspectorate
<b>DIICOT</b>	Directorate for Investigation of Organized Crime and Terrorism
<b>DGASPC</b>	Direcția Generală de Asistență Socială și Protecția Copilului (General Directorate of Social Assistance and Child Protection)
<b>DGPMB</b>	Directorate General of Police of the Municipality of Bucharest
<b>DRD</b>	Drug-related deaths
<b>DSM</b>	Diagnostic and Statistical Manual of Mental Disorders
<b>DPPDC</b>	Directorate for Child Care and Protection
<b>EESC</b>	European Economic and Social Committee
<b>ELDD</b>	European Legal Database on Drugs
<b>ENDIPP</b>	European Network on Drugs and Infections Prevention in Prison
<b>EGO</b>	Emergency Governmental Ordinance
<b>ERP</b>	Enterprise Resources Planning
<b>FICE</b>	Federația Internațională a Comunităților Educative
<b>GPS</b>	General Population Survey
<b>GRADO</b>	Romanian Group for Human Rights Protection
<b>HIV</b>	Human Immune deficiency Virus
<b>HBV</b>	Hepatitis B virus
<b>HCV</b>	Hepatitis C virus
<b>ICD</b>	International Classification of Diseases
<b>IDU</b>	Injecting Drug Users
<b>IGRP</b>	Inspectorate General of the Romanian Police
<b>INML (LMNI)</b>	Legal-medicine National Institute
<b>IPC</b>	Individualised plan of care
<b>LSD</b>	Lysergic acid diethylamide
<b>MECTS</b>	Ministry of Education, Research, Youth and Sports
<b>MDMA</b>	Methylenedioxymethamphetamine
<b>MDPV</b>	Metilendioxipirovalerona
<b>MAI</b>	Ministry of Administration and Interior
<b>MMFPS</b>	Ministry of Labour, Family and Social Protection
<b>MS</b>	Ministry Health
<b>MSM</b>	Men who have sex with men
<b>NAA</b>	National Anti-drug Agency
<b>NIDA</b>	National Institute on Drug Abuse
<b>NAP</b>	National Administration of Penitentiaries
<b>NGO</b>	Non-governmental Organization
<b>NPS</b>	New Psychoactive Substances Traded as "ethno-botanical plants"
<b>NUP</b>	Prosecution not pursued
<b>OG</b>	Official Gazette
<b>OEDT/EMCDDA</b>	European Monitoring Centre for Drugs and Addiction
<b>OSI</b>	Open Society Institute
<b>OST</b>	Opiate substitution treatment

<b>RDS</b>	Respondent Driven Sampling
<b>PHEA</b>	Public Health Executive Agency
<b>RAA</b>	Romanian Angel Appeal
<b>REITOX</b>	European Information Network on Drugs and Drug Addiction
<b>RHRN</b>	Romanian Harm Reduction Network
<b>RMCDDA</b>	Romanian Monitoring Centre for Drugs and Drug Addiction
<b>SATG</b>	Safe Area Trip Guidance
<b>SEP</b>	Syringes Exchange Program
<b>SOP HRD</b>	Sectoral Operational Programme Human Resources Development
<b>SNA (NAS)</b>	National Anti-drug Agency
<b>NPS</b>	new psychoactive substances (sold as “ethno-botanical plants”)
<b>SSF</b>	Sociology and Social Work Faculty
<b>STD</b>	Sexual Transmitted Diseases
<b>SUP</b>	Suspended prosecution
<b>SW/CMS</b>	Sex workers/commercial sex workers
<b>SJML</b>	legal medicine county services
<b>TDI</b>	Treatment Demand Indicator
<b>THC</b>	Tetrahydrocannabinol
<b>TIP</b>	Treatment integrated programme
<b>UNAIDS</b>	United Nations Joint Programme on HIV/AIDS
<b>UNICEF</b>	United Nations Children’s Fund
<b>UNODC</b>	United Nations Office on Drugs and Crime

## STANDARD TABLES AND STRUCTURED QUESTIONNAIRES

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34		<b>TDI data</b>
	Standard Table	<b>Public expenditure</b>
25	Structured Questionnaire Mustap	<b>Universal Prevention</b>
26	Structured Questionnaire	<b>Selective and indicated prevention</b>

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