2014 NATIONAL REPORT (2013 Data)
TO THE EMCDDA
By the Reitox National Focal Point

MALTA
New Developments and Trends

REITOX
Malta National Focal Point
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Chapter 1 – National Policies and Context

**Legal framework**

As has been reported in previous national reports to date, the principal components of legislation that specifically address substance abuse in Malta are the Medical and Kindred Professions Ordinance (Cap.31) that concerns psychotropic drugs, and the Dangerous Drugs Ordinance (Cap.101) that concerns narcotic drugs.

**New Developments**

Legal Notices 363 and 365 of 2013 amend the Medical and Kindred Professions Ordinance and regulates the following substances respectively, 4-MA4-methylamphetamine and 5-IT5-(2-aminopropyl)indole.

Legal Notice 405 of 2013 amends the Medical and Kindred Professions Ordinance and substitutes the following substance, TETRAHYDROCANNABINOLS, various ISOMERS.

Chapter 2 – Drug Use in the Population

A General Population Survey was conducted in 2013. Seven in every ten respondents (70.6% or 194,000) indicated that they have consumed alcohol in the last 12 months which shows a slight increase of 1.3% or some 4,000 over data reported in 2001 (69.3%). 45% (equivalent to 124,000) of the respondents indicated that they have at least smoked tobacco once in their lifetime. This marks a significant decrease from the 52.3% of respondents who reported ever smoking in the 2001 Survey. Some 4.4% (equivalent to 12,000 of the population) of the respondents reported to have taken cannabis at least once in their lifetime. Ecstasy was the most used among the respondents with 0.7% (1,900) of them having indicated that they have tried the drug at least once in their lifetime. This was followed by 0.5% (1,400) of the respondents who have tried cocaine at least once.

This chapter also outlines the results from the ESPAD study conducted in 2011, with results published in 2012. ESPAD 2011 indicated that alcohol is still widely used among students aged 15 to 16 years with 90% reporting having used the substance. Life time tobacco use on at least one occasion was reported by 38% of 15-16 year old students in Schools. Tobacco use in the last 30 days was reported by 22% of the students, which is 4% less than the previous survey conducted in 2007 which had reported 26% of such use. Life-time use of
inhalants was registered by 14% of the students while those reporting use of cannabis amounted to 10%. These figures show that there has been little or no change in lifetime prevalence of alcohol and inhalants, a slight decrease by 2% in each, and a 1% decrease in cannabis, from the last study carried out in 2007.

Chapter 3 – Prevention

Environmental Prevention
Legal Notice 493 of 2011 (Tobacco Smoking Control Act) came into effect prohibiting smoking in playing fields. Sports activities are no longer permitted to use cigarette companies as sponsors. Cigarette packets also currently graphically depict the effects of smoking together with strong messages with regards to smoking and its consequences.

Other Initiatives
The Leap Project has been launched, which is a nationwide project to combat social exclusion and poverty through training and mobility processes as its mission statement. The project aims to combat social exclusion and poverty through a number of interventions which include the development of a cluster based network system at both regional and local levels which will help foster social cohesion and mobility in various vulnerable localities.

Chapter 4 – Problem Drug Use

Prevalence and Incidence Estimates of Problem Drug Use
The year 2013 again shows an increase on estimates with figures on the higher side, with 1,997 daily opiate users (95% confidence interval 1,861 to 2,201). Though the figures are higher to the ones for the year 2012 but lower than those for the year 2011, it is still felt that the figures are on the high side, and that the lower end of the estimates should be considered. It is also thought that a much higher percentage of daily opiate users had actually attended treatment services in 2013 than estimates suggest.
Treatment Data

All Treated Clients 2013

Treated clients in Malta during 2013 amounted to 1834. During 2013, 82% (1498 out of 1834) of the client base was male. This is consistent with other reporting years. The year 2013 saw another reduction in the number of all clients aged under 35 years (59% as opposed to 64% in 2012). The most significant changes in age cohort are those between the years of 35 to 39, with an increase of 3% (21%) over the preceding year (18%).

First Treated Clients 2013

The total number of first time treated clients during 2013 amounted to 220 individuals. During the last three years (2011-2013) the majority of first time treated clients arose from the Northern Harbour region (29% and 39% and 32% respectively), though 2013 has shown a decrease from the preceding year. The Southern Harbour region has seen an increase of 2% from 2012 (25% in 2013 as opposed to 23% in 2012). The South East region has seen another increase from the preceding year (from 12% in 2012 to 16% in 2013). This shows a higher percentage from the Northern region, which has remained a constant with 15%, the same percentage as in 2012.

Chapter 5 - Drug-Related Treatment

Treatment Systems

The main drug treatment providers are Sedqa, the national agency against drugs and alcohol abuse, SATU (Substance Abuse Therapeutic Unit) which is prison-based and falls under the responsibility of the Ministry of Justice and Home Affairs; and the DDU (Dual Diagnosis Unit) within Mount Carmel Psychiatric Hospital and falls under the responsibility of the Ministry of Health, the Elderly and Community Care, Caritas and Oasi, non-governmental organizations, which receive partial financial support from the Government.

Pharmacologically Assisted Treatment

Methadone, which is distributed in Malta through SMOPU, is still the most commonly prescribed form of medically assisted treatment for drug users in Malta. Of a total of 1139 individuals making use of SMOPU services in 2013, 1078 persons (95%) received substitution treatment. The majority of individuals who received substitution treatment (90%) received only methadone.
Chapter 6 – Health Correlates and Consequences

**Drug-related Deaths and Mortality of Drug Users**
During 2013, 3 drug related deaths were reported by the Police Special Registry, which is the lowest ever amount recorded since 2007. This amount puts 2013 below the average of between 5 to 8 reports yearly.

**Drug-related Infectious Diseases**
A total number of 202 tests were carried out for HCV in 2013, resulting in a total of 12 new cases. The percentage for Hepatitis C infections has decreased when compared to 2012 (46), as well as one new case for Hepatitis B. Of particular concern are the 4 new cases of individuals testing positive for HIV especially when compared with no new cases in the preceding years. All four individuals are injecting drug users and one individual is deceased due to an accident. Two are being followed by SMOPU and the third is being monitored by the Disease Surveillance Unit (DSU).

**Non-Fatal overdoses (NFODs)**
Non-fatal overdoses related to the abuse of illicit drugs in 2013 saw a continued decrease over the preceding three years, with a total of 20 reported cases (20%) of all reported cases (102 cases).

**Psychiatric co-morbidity (dual diagnosis)**
There were 44 individuals who made use of the Dual Diagnosis Unit in 2013. The average age of clients at DDU was that of 32 years, a decrease in average age when compared to the year 2012 with the average age of 35 years.

Chapter 7 – Responses to Health Correlates and Consequences

**Interventions Related to Drug Related Infectious Diseases**

**HIV**
Blood screening and pre and post test counselling is provided by SMOPU, CCF, the GU clinic and the XEFAQ service offered by Caritas.
Needle and Syringe Availability

Though the year 2013 has seen a decrease of 5% in syringe distribution with 357,691 syringes, it is still the second year with the highest amount. The year 2012 has seen the highest syringe distribution ever since 1994 with a total amount of 376,104 syringes distributed.

Interventions Concerning Pregnancies and Children Born to Drug Users.

During the year 2013, 19 substance misusing women attending the Substance Misuse Outpatient Unit (SMOPU) were pregnant. One of the mothers had a miscarriage. Another expecting mother did not use the service. Among the new born children, 10 infants had withdrawal symptoms and were given oral morphine as a substitute. The remaining 9 babies did not require opioid substitution treatment.

Chapter 8 – Social Correlates and Consequences

Arrest Data

In 2013, 499 arrests were made related to drug law offences. Of these arrests, a total of 136 individuals were arraigned for possession and 44 were arraigned for trafficking, totalling to 180 individuals. Data for 2013 shows fluctuations in percentages of charges for trafficking, with the main changes being a relative decrease of 10% for trafficking of cannabis and the percentage increase of 3% in other drugs. Both heroin and cocaine have seen increases, with a slight upward trend of 1% in cocaine and 6% for heroin from 28% in 2012 to 34% in 2013, keeping the upward trend from the previous years.

Probation and Parole Services Data

The Department of Probation and Parole had 351 clients with a known drug problem for 2013, an increase of 20% when compared to 2012 (291 clients). Clients reported as having problems related to heroin use totalled to 173 (49%) showing a decrease in the trend in that in 2012 54% were related to heroin and in 2011 59% were reported. Cannabis was the second drug of choice reported with probation clients totalling to 114 (33%) individuals, showing a continuous increase in persons using this drug when compared to 2012 (27%) and 24% in 2011. Cocaine users amounted to 59 (17%) individuals, a slight decrease when compared to 2012 (18%) but still higher than 2011 (15%).
Court Judgments
In 2013, cases for drug possession brought before the courts totalled 364 cases against the 355 in 2012. This increased trend reflected over the last years with 136 new cases being brought before the courts in 2011 against the 49 new cases reported in 2010. The great majority of individuals charged with possession were males (85%). Possession of cannabis remains the drug by which most individuals were charged in 2013 with 141 cases, an increase when compared to 2012 (125 cases). There has also been a change in the number of persons being charged for possession of cocaine against those for possession of heroin, with 99 individuals for the former and 74 for the latter.

Chapter 9 – Responses to Social Correlates and Consequences
This chapter looks at ways in which drug users are re integrated back into society by training, education, housing, social assistance and employment.

Training and Employment
The year 2013 saw 10 ex-prison inmates, 4 ex-substance abusers and 4 social cases attend a mainstream training course offered by the Employment and Training Corporation and 23 persons have benefited from a work exposure opportunity through the Bridging the Gap scheme during the past twelve months. Moreover, 63 vulnerable jobseekers (ex-prison inmates, ex-substance abusers and social cases) were placed on the Community Work Scheme.

Chapter 10 – Drug Markets
Availability and Supply
Heroin continues to be the most widely used illicit drug among the client population. Most people in treatment for drug related problems seem to continue to be mainly users of heroin as their primary drug. However, there has been an increase in the number of clients receiving treatment for cocaine and cannabis.
Seizures
The total number of drug seizures in 2013 amounted to 458, another increase of 20% over the year 2012 (383 seizures). This shows a constant increase in the last four years with nearly double the amount since 2009 (240 seizures).

Drug Purity
During 2013, the purity levels for Cannabis resin showed another percentage decrease to 6.5% over 2012 (7.5%) and cannabis herb is reported at 6.0% a decrease over the preceding year (7.5%) equalling to 2011. Cocaine purity levels have seen another minimal decrease over 2012 where a marked decrease was noted in that year with 15.5% of purity levels as against the 34.0% in 2011. Heroin showed a percentage increase (21%) when compared to the preceding year where the year 2012 showed a marked decrease in purity with 20.0% when compared to 2011 (30%).

Drug Price
Cocaine has seen the lowest prices in 2013 with an average price of Eur.50 when compared with the mean price of Eur.79 in 2012 and to Eur.63.78 in 2011. Heroin has also been subject to a price reduction with Eur.58 for 2013 when compared to Eur.66 in 2012 but still higher than the Eur.55.50 in 2011.
PART A

NEW DEVELOPMENTS AND TRENDS
CHAPTER 1

NATIONAL POLICIES AND CONTEXT

1.1 Legal framework

The **Medical and Kindred Professions Ordinance (Cap.31)** and the **Dangerous Drugs Ordinance (Cap.101)** are the two main bodies of legislation that regulate substance abuse in Malta.

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

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

These ordinances have been amended over the years in order to bring Maltese legislation in line with the changing international perspective as well as the emergence of new drugs on the market.

**New Developments**

Legal Notice 363 of 2013 amends the Medical and Kindred Professions Ordinance and regulates the following substance:

4-MA4-methylamphetamine
Legal Notice 365 of 2013 amends the Medical and Kindred Professions Ordinance and regulates the following substance:

5-IT5-(2-aminopropyl)indole

Legal Notice 405 of 2013 amends the Medical and Kindred Professions Ordinance and substitutes the following substance:

TETRAHYDROCANNABINOLS, various ISOMERS

With

TETRAHYDROCANNABINOL, following isomers and their stereochemical variants, including all the variants below:

7, 8, 9, 10 - tetrahydro-6,6,9-trimethyl-thepentyl-6H-dibenzo[b,d]pyran-1-ol", (9R,10aR)-8,9,10,10a-tetrahydro-6,6,9-trimethyl-3-pentyl-6H-ibenzo[b,d]pyran-1-ol(6aR,9R,10aR)-6a,9,10,10a-tetrahydro-6, 6,9-trimethyl-3pentyl-6H-dibenzo[b,d]pyran-1-ol(6aR,10aR)-6a,7,10,10a-tetrahydro-6, 6,9-trimethyl-3pentyl-6H-dibenzo[b,d]pyran-1-ol(6aR,10aR)-6a,6a,7,8,9,10,10a-hexahydro-6, 6,9,10a-hexahydro-6, 6,9,10a-hexahydro-6, 6,9,10a-hexahydro-6

In the year 2012 the Restorative Justice Act was set up as a Law. Following this Act, the Department of Probation and Parole (DPP) was set up including two new units within the department that are the Parole Unit and the Victim Support Unit. In June 2013 the Restorative Justice Act was implemented and the DPP started to compile Parole Reports and Victim Reports by the Parole Unit and Victim Support Unit respectively.

1.2 Institutional framework, strategies and policies

The first National Drugs Policy was launched in February 2008 and is directed in the main to lowering the use of drugs as well as providing the necessary services to help those with problems related to drug consumption:

(a) To provide for a more co-ordinated mechanism through which the supply and demand for drugs are appropriately reduced as much as possible in the best interest of society.

(b) To improve the quality and, where necessary, increase the provision of drug related services.
The National Drugs Policy consists of 48 policy actions which are distributed over 9 different sections. The sections are as follows:

**Introduction**

This section of the document provides an overview of the overall purpose of the National Drugs Policy. It also provides a brief description of the Drug Situation in Malta at the time of publication.

The section concludes with the listing of the primary objectives of the Policy:

(a) Ensuring a high level of security,

(b) Achieving a high level of health protection, well being and social cohesion.

**Coordination of the National Drugs Policy**

This section consists of the first three actions within the policy which are concerned with the setting up of the entities that will be responsible for the Implementation of the actions listed in the document.

A National Coordinating Unit for Drugs and Alcohol was set up in November 2010 within the Ministry of Education, Employment and the Family, now re-named to Ministry for the Family and Social Solidarity, that brings together all stakeholders, including service providers working with drug-related settings so as to facilitate the implementation of the National Drugs Policy. This measure is in fact listed as Action 1 within the Policy document. This office includes the National Focal Point and coordinates with all national experts and service providers in the drugs field. The Early Warning System is also monitored through the Focal Point office.

**Legal & Judicial Framework**

This section comprises of actions 4 to 7 and is concerned with the legal aspect of the policy. It is meant to assure that the actions within the policy are in line with national legislation. It is also responsible for the proposal of any amendments that may need to be made within current legislation so as to better reflect the current drugs situation. To better enhance the function of those involved within the judicial framework, talks are underway to consider the setting up of a Drug Court as formulated in the National Drugs Policy.
Supply Reduction
This section deals with actions 8 through to 13 which are concerned with reducing availability of drugs through enforcement of illegal substances and adequate regulation in the provision of prescription drugs. It is also envisaged that a Law Enforcement Body should emerge that will provide a forum for all actors involved.

Demand Reduction
This section of the document is the most extensive and deals with all measures of prevention, treatment, harm reduction and social integration which are to be pursued or taken up on a national scale to reduce the demand for drugs within the Maltese population. The section covers actions 14 to 37 in this document. In the meantime some new services have come into being, namely the Female Harm Reduction Shelter and support services within the community for those who are abstinent and need further aid.

Monitoring, Evaluation, Research, Information and Training
This section of the document covers actions 38 to 45 and deals with the need for constant monitoring of the policy. It also deals with the necessity for the collection of reliable data as well as constant training.

Two studies undertaken that will have an impact on policy are related to in the first instance, “Treatment Outcomes” and secondly the impact of prevention programmes in schools on drug use prevalence.

The International Perspective
This section deals with the last three actions in this document and is concerned with assuring that Maltese Authorities continue to honour our international obligations as well as propose any measures to strengthen cooperation.

In relation to our EU responsibilities, we sit on the Horizontal Drug Group, which is the main EU body that deals with drug policy such as the EU Drug Strategy 2005-2012 and now the 2013-2020 EU Drug Strategy. In relation to monitoring, the EMCDDA is the EU monitoring agency for drugs and drug addiction, and Malta’s responsibilities are to forward national data to the agency through the National Focal Point for Drugs and Drug Addiction, so that it may be collated with the data from other member countries that culminates in the EU report on the drug situation in the EU and the responses to such.
In the broader perspective, Malta holds the Vice Presidency of the Pompidou Group, Council of Europe and also currently holds the Chair of the Mediterranean Network that was launched here in Malta in 1999.

With regards to the UNODC, the drug situation in Malta is reported yearly by completing the ARQ's, and also attending the yearly meetings held in Vienna in March.

**Funding**
The Document also has a section dedicated to the importance of acknowledging the necessity of adequate funds that are needed in the implementation of the Actions within the National Drugs Policy. The section also highlights that Government, through the Ministry of Finance, shall endeavour to allocate more funds to drug related programmes by supplementing current provisions with monies derived from assets confiscated through The Prevention of Money Laundering Act in relation to drug related offenses.

**Conclusion**
Through this section government acknowledges that due to any new trends and circumstances, amendments or additions to the Policy Document may be required and this shall be the responsibility of the Ministry for Social Policy (Currently the Ministry for the Family and Social Solidarity). It also refers to the responsibility of the National Coordinating Unit for Drugs and Alcohol to oversee the implementation of this policy.

**Updates on the National Drugs Policy**
In April of 2011, the National Commission on the Abuse of Drugs, Alcohol and other Dependencies (NCADAD), together with the National Coordinating Unit for Drugs and Alcohol (NCUDA) were involved in an exercise to review the policy actions of the National Drugs Policy 2008 through the preparation of a paper on the current status and strategies and plans of action for the implementation of the policy actions. Further to this paper, The NCADAD and NCUDA have been involved in overseeing the implementation of the National Drugs Policy Strategy. This strategy is being scrutinised by policy makers.
Performance Audit

The Auditor General, under the National Audit Office undertook a performance audit published as ‘Tackling Problem Drug Use’ in 2012. The NAO saw to the performance audit to evaluate how problem drug use is being tackled in Malta on a national level. The audit sought to carry out the following:

- Determine what is being done by the Government to mitigate the problem of drug abuse;
- Reference to all service providers was also made throughout the course of the study;
- An assessment of Government services in place to support service providers within the sector;
- The identification of gaps in the overall system and the establishment of the level of coordination between Government, service providers, as well as other stakeholders;
- Determining whether the sector is appropriately regulated and monitored.

After the auditing process, a number of conclusions and recommendations were proposed for the bettering of service provision and more coherence between stakeholders, mainly:

- Further development and refinement of efforts with respect to the employment component of social reintegration;
- The combined efforts of all stakeholders as the key to an eventual creation of services for minors;
- An increase in collaboration between all stakeholders, with the NCADAD and the NCUDA as the ideal fora and platforms for such collaboration;
- Further development of information management structures to help in decision-making and policy design.

Draft National Standards for Residential Facilities

During the last part of 2012, the Department for Social Welfare Standards issued the Draft National Standards for Residential Facilities which provide accommodation to people with Drug, Alcohol and Gambling-Related issues. This was implemented through a working group including professionals from various sectors of the drugs related services and received feedback from various service users, their families and other ancillary services and
departments. These standards are currently being prepared as guidelines for the said residential treatment centres.

**Arrest Referral Scheme and Extra-Judicial Body**

During 2011, work started on the proposal for the setting up of a new Arrest Referral scheme and Extra-Judicial Body. The Arrest referral scheme is intended to be a measure which will target first time offenders for possession of drugs for personal use. The current proposal combines an Arrest Referral Scheme (ARS) with a diversionary form of proceedings to an Extra Judicial Body (EJB) for the hearing of cases of first time offenders (possession for personal use of a dangerous or psychotropic substance held in breach of Chapter 31 and Chapter 101 of the Laws of Malta). For the purpose of the project a ‘first time offender’ is held to be an EU citizen who is permanent resident in Malta and who has no previous convictions of crimes of a voluntary nature. Arrestees investigated by the Malta Police for possession for personal use will be approached at the place of arrest by an Arrest Referral Officer (ARO) who will advise the arrestee on the workings of the scheme. Consequently, the arrestee has the option of joining the ARS, or alternatively following the regular route of arraignment in court. Taking the EJB route will necessitate an admission to the facts of the case. The fact that the accused chooses to take the EJB route does not preclude that he may still plead not guilty in court later on if he is charged formally through the normal route of the Criminal Justice System. If the individual fulfils the criteria for diversion to the EJB, the police shall not proceed with prosecution.

This proposal was subsequently submitted for the consideration of the Government and was approved and issued for Public Consultation by the Ministry of Justice, Dialogue and the Family in July 2012.

The year 2013 saw a change in government and various ministries have had a change in their remits. Entities and government bodies which used to fall under the Ministry of Justice, Dialogue and the Family became part of the Ministry for the Family and Social Solidarity.

In July 2014 the Ministry for Justice, Culture and Local Government launched a Drug Reform White Paper based on the following three main aspects:

- The government believes that in essence any illegal drug is unhealthy physically, psychologically, emotionally and socially and puts at risk the person who becomes an addict, one’s relatives and close family and also society at large;
The government believes that one must not stop looking at personal use solely as a crime but also the use of drugs as something leading to addiction. In this way the problem should be considered as a health issue. People dependent on drugs should stop being punished for their drug use and instead it should be ascertained that they have access to evidence-based treatment;

Legislation should reflect the seriousness of the crime and the impact the punishment might have on the illegal drugs market. There should be a distinction between casual use and dependency on illegal drugs. Also there should be a distinction between social users, street dealers and organized trafficking. The law should distinguish between these circumstances with regards to punishment and hence make sure the right tools are offered to investigators, professionals in the field, prosecutors and judges.

This new reform makes the distinction between simple possession and aggravated possession (the court of magistrates or the criminal court) with the focus of criminal intent according to each case.

In the case of simple possession, there is reference to the cultivation and use of cannabis, specifically meaning that a person should not be arraigned for such possession but either given a written warning from the Commissioner of Justice or referred to the Justice board where a social inquiry report is done on behalf of the individual and recommendations proposed. It the individual does not follow the proposal the case is taken to the court of magistrates.

The public consultation process closed on the 15th September 2014 and the ministry involved is to put forward the amended white paper for discussion in parliament.
## Entities and Organisations Involved in Responses to Drug Use in Malta

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Table 1.1

Source: National Drugs Policy – end of September 2014
Amended according to amalgamation of Ministries
1.3 Economic Analysis

During the year 2013 the budgets remained basically more or less the same as in the previous year and so the figures have remained the same as those shown in the 2011 Annual Report. Updated figures will be available in the 2014 report.

The following are the estimates of expenditure which have been actualized during the years 2005, 2011 and 2012 as reported previously.
<table>
<thead>
<tr>
<th>Ministry</th>
<th>Department</th>
<th>2005</th>
<th>2011</th>
<th>2012</th>
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<td>Corradino Correctional Facility/SATU</td>
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<td>300,000</td>
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<td></td>
<td>Probation Services</td>
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<tr>
<td></td>
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<td>Customs Division</td>
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<td>307,176</td>
<td>310,138</td>
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<td>2,340,058</td>
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<td>Caritas</td>
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<td></td>
<td>OASI</td>
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<td>205,500</td>
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<td></td>
<td>Commission for Drugs and Alcohol …</td>
<td>--------</td>
<td>60,000</td>
<td>60,000</td>
</tr>
<tr>
<td></td>
<td>‘New Hope’ Caritas</td>
<td>116,504</td>
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<td></td>
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<td>510,123</td>
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<tr>
<td>Ministry for Gozo</td>
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<td></td>
<td>Gozo Hospital short stay unit</td>
<td>53,810</td>
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<td></td>
<td>Gozo hospital detox unit</td>
<td>3,261</td>
<td>16,733</td>
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<td></td>
<td>Methadone dispensing</td>
<td>1,549</td>
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<td>Total Expenditure</td>
<td>(Eur)</td>
<td>4,850,076</td>
<td>5,224,170</td>
<td>5,492,208</td>
</tr>
</tbody>
</table>

Table 1.2
Source: Budget requests from all entities
CHAPTER 2

DRUG USE IN THE POPULATION

2.1 Drug Use in the General Population

Prevalence of drug use in the population is normally estimated using surveys in which the target population is required to complete a questionnaire in which questions related to the use of substances are addressed. A census of population and housing was conducted in 2011, with preliminary results issued in 2012. A General Population Survey was conducted in 2013.

General Population Survey - Introduction

At the time of the survey that is 2013, the population of Malta stood at 425,384. Of this population, 274,780 were between the ages of 18 and 65 (NSO, 2011). From this age group a random sample of 3,000 individuals was drawn up from the most recent electoral register which represented 1.1% of the population. The 1,869 respondents in this study ensured a statistical significant representation at a 95% confidence level at a margin of error of +/- 2.26%.

Alcohol and Tobacco: Number of Users and Frequency of Use

Alcohol

Just over three quarters (75.9%) of the respondents, equivalent to some 209,000 individuals indicated that they have consumed alcohol at least once in their lifetime; this corresponds to the findings of the 2001 General Population Surveys which had also reported lifetime use of 75.6%. Seven in every ten respondents (70.6% or 194,000) indicated that they had consumed alcohol in the last 12 months which shows a slight increase of 1.3% or some 4,000 over data reported in 2001 (69.3%).

Almost three in every five respondents (58.8% or 162,000) reported to have drunk alcohol in the last 30 days. When compared to the figures registered in 2001 (56.2%) the percentage of persons having consumed alcohol in the last 30 days shows the greatest increase of 2.6% or some 7,000. Of the respondents who have drunk alcohol in the last month, 12% indicated that they do so daily or almost daily. This shows a decrease of 1.1% over 2001 which had
reported such consumption at 13.1%. This means that 6.8% or some 19,000 of the total population of 274,820 consume alcohol on a daily/ almost daily basis.

Figure 2.1
Alcohol Prevalence in 2001

Ever, last year and last month consumption of alcohol is the highest among respondents aged between 18 and 24 years of age and this decreases with increasing age brackets. Last month consumption of alcohol amongst the 18 and 24 year old cohort stood at 76% (some 30,000 of the 40,000 age cohort) while that of 60 to 65 year olds stood at 51% (some 18,000 of the 36,000 that makes up this age cohort), meaning a difference of 25%.

Figure 2.2
Alcohol Prevalence in 2013

Tobacco
45% (equivalent to 124,000) of the respondents indicated that they have at least smoked tobacco once in their lifetime. This marks a significant decrease from the 52.3% of respondents who reported ever smoking in the 2001 Survey. A decrease since 2001 (33.5%) was also registered for use of tobacco in the last 12 months with a little less than one third (28.7% or 79,000) of the respondents stated that they had smoked tobacco within
the last 12 months. Some 27.4% (75,000) indicated that they are current smokers of tobacco which is a small decrease as compared to the 31.9% reported in 2001.

Prevalence of tobacco smoking in a lifetime is higher among males than females. While the majority (55%) of the male respondents indicated that they had smoked at least once in their lifetime, 35.5% of the female cohort stated having done so. When comparing these figures to 2001 it can be seen that the prevalence of tobacco smoking use was higher in male respondents than their female counterparts. However, the trend in tobacco use is downwards in that both show a decrease in lifetime use when compared to that reported in 2001 when it was 65.9% in males and the 38.5% in females. Current prevalence of smoking is also higher among males than females. From the aggregate male participants, 33% are current smokers while current smoking of tobacco among women stands at 21%. The highest incidence of tobacco smoking is within the Southern Harbour region of Malta followed by the Northern Harbour region. The lowest incidence can be found within the Western and Northern areas of Malta.

The average age at which tobacco is used for the first time is 16.7 years. This age has remained similar to the age reported in 2001, which stood at 16.8 years. The majority (55%) of ever users of tobacco indicated that they smoked for the very first time when they were between 14 and 17 years of age.
Cannabis Use: Number of Users and Frequency of Use

Some 4.4% (equivalent to 12,000 of the population) of the respondents reported to have taken cannabis at least once in their lifetime. In 2001 the prevalence of lifetime use of cannabis stood at 3.5%, which implies that there was an increase of almost 1% over a 12 year period. About 0.9% (2,500) of respondents are recent users of cannabis which is similar to that found in the previous 2001 study which reported such use at 0.8%. Last month prevalence has also remained the same with 0.4% (1,100) reported herein and 0.5% in 2001.
Malta National Report 2013

Ever use of cannabis is almost four times higher among males than females. In fact, while 2% of the female respondents are ever users, this percentage is almost 8% among the male respondents. In the 2001 GPS male prevalence for ever use of cannabis was also much higher within the male population with 5.3% reporting such use compared to a low 1.6% of female respondents. It can be noted that prevalence among male respondents for lifetime use has increased by 2.7% while only a slight increase of 0.4% was registered among female respondents. The highest concentration of ever users of cannabis can be found in the Southern Harbour region followed by the South Eastern region and Gozo. In 2001 the most prevalent areas for ever use of cannabis were within the central region and Gozo.

Findings in the 2007 and 2011 ESPAD survey report lifetime use of cannabis at 13% and 10% respectively. This demonstrates that the use of cannabis among this age cohort, 15-16 year old students, dropped by 3% between the two surveys. The figure reported for life time use of cannabis among 18 and 24 year olds in the current GPS is just over 5% of the interviewed respondents. This is lower than that found in the ESPAD data quoted above. When comparing use of cannabis in the last 30 days, students in the 2007 and 2011 school surveys reported such recent use of cannabis at 5% and 4.5% respectively, showing a consistent prevalence among the two studies. In the 2013 GPS survey continued use of cannabis during the last month increases to 21.4% of those aged between 18 to 24 years. It is of interest that in the age cohorts following the 18-24 age brackets, last month use of cannabis shows a gradual decline as age increases.

Mean age of first use of cannabis is 18.4 years which is also similar to that of 2001 when first use was registered at a mean age of 18.8 years. The vast majority of the ever users took cannabis for the first time between the ages of 16 and 21 years of age in both 2001 and 2013 surveys. Almost all respondents who have ever tried cannabis tried it for the first time in Malta.

Other Substances: Number of Users and Frequency of Use

Questions regarding the use of the following drugs were asked to all respondents: ecstasy, LSD, mephedrone, new psychoactive substances, amphetamines, cocaine and heroin.
Each of the seven drugs was used by less than 1% of the population some 3000. This figure remains unchanged from the situation presented in the 2001 GPS report which had also reported such use at less than 1%. Ecstasy was the most used among the respondents with 0.7% (1,900) of them having indicated that they have tried the drug at least once in their lifetime. This was followed by 0.5% (1,400) of the respondents who have tried cocaine at least once.

Altogether, 1.4% (3,900) of the respondents has tried at least one of the seven drugs once in their lifetime although none of them are recent or current users. Ever use of these drugs is higher among males than females. In fact, while 0.6% of the females are ever users, this percentage goes up to 2% among males. Again this was also the case in 2001.

The low number of ever users does not allow any conclusion on continuation rates or on the geographical distribution over Malta.

### 2.2 Drug Use in the School and Youth Population

Malta has participated in five ESPAD surveys (years: 1995, 1999, 2003, 2007 and 2011), with the most recent having been conducted in 2011 and published in 2012. The next survey is scheduled to take place during January and February of 2015.
Alcohol and Tobacco: Number of Users and Frequency of Use

As also reported in previous years, alcohol continues to be the most used substance among students. ESPAD 2011 reports that 90% of 15-16 year old students in Malta reported having used alcohol in their life time, a slight decrease of 2% compared to the ESPAD 2007. It should also be noted that the previous report (2007) had also shown a decrease of 1.7% over 2003, which had reported 93.7% life time use. A total of 86% reported use of alcohol in the last 12 months, which only showed a slight decrease of 1% over 2007 which had reported 87% of such use. The greatest decrease was shown in reporting on the use of alcohol in the last 30 days, with a total of 68% reporting having used alcohol. This shows a decrease of 5% over 2007 which had reported that 73% of students had used alcohol in the 30 days preceding the survey.

Among the 68% of students who reported having used alcohol in the last 30 days, 8% had reported having indulged in alcohol use on 20 or more occasions. Heavy episodic drinking during the last 30 days (here defined as consuming five glasses of an alcoholic drink), was reported by 56% of students, which remains consistent with the amount reported in 2007 (57%). A total of 20% of students reported having been intoxicated by alcohol use during the last 30 days.

Life time tobacco use on at least one occasion was reported by 38% of 15-16 year old students in Schools. Tobacco use in the last 30 days was reported by 22% of the students, which is 4% less than the previous survey conducted in 2007 which had reported 26% of
such use. This implies that last 30 day prevalence has been on the decrease for a number of years as 2007 had also shown a 4% decrease from the 2003 survey (30%). Among the students, 12% reported smoking less than 1 cigarette daily, while 10% reported smoking 1 cigarette or more daily. A total of 52% who had ever used cigarettes, reported having started smoking at the age of 13 or younger.

![Frequency of cigarette use in lifetime](image)

**Figure 2.14**
Source: ESPAD 2011

*Other Substances: Number of Users and Frequency of Use*

The most widely used substance among students was inhalants, with 14% reporting lifetime use of this substance in 2011. This is followed by cannabis, which is reported to be used by 10% of the students; making it the most widely used illicit substance among this group. Most respondents who reported ever using cannabis reported doing so between 1 and 5 occasions. Use of alcohol together with pills was reported by 8% of students. Mephedrone was reported to have been used by 5% of respondents, while 4% reported life time use of cocaine. Amphetamine, tranquillizers or sedatives without a doctor’s prescription, and ecstasy were reported by 3%, while use of magic mushrooms, LSD, crack cocaine and steroids was reported by 2% of respondents. Heroin use and GHB use were both reported by 1% of students.

Use of any illicit substances was reported by a greater proportion of males with 14% reporting such use, while 10% of females reported lifetime use of illegal drugs.
Figure 2.15

Frequency of substance use in lifetime

Source: ESPAD 2011
**Attitudes to Drugs and Drug Users**

The perception of availability and the attitudes of young people aged 15 to 16 to drug use are shown here. Perception of availability was measured for cannabis, tranquilizers or sedatives, ecstasy and amphetamines and refers to those respondents who answered that the drug was fairly easy or very easy to obtain. Cannabis, tranquilizers or sedatives, ecstasy and amphetamines were perceived as fairly easy or very easy to obtain by 21%, 17%, 14% and 8% respectively. Results also showed that a significantly higher percentage of boys than girls reported that it would be fairly or very easy to obtain drugs, with cannabis (23% vs. 18%), ecstasy (16% vs. 12%) and amphetamines (11% vs. 6%).

![Graph showing percentage of students perceiving various drugs to be "very easy" or "fairly easy" to obtain](image)

**Figure 2.16**
Source: ESPAD 2011

Turning to perceived risk, occasional smoking was perceived as being of high risk by 12% whilst more regular smoking of 20 or more cigarettes daily was thought to be very risky by 51% of respondents. Consumption of one or two drinks almost daily was perceived to be high risk behaviour by 16% of respondents, whilst consuming four to five drinks almost daily was seen as high risk by 51% of respondents. This shows that regular tobacco use and daily use of 4 or 5 drinks of alcohol are equally perceived to be dangerous by 51% of students.
Occasional use of cannabis was perceived as risky behaviour by 47% of respondents, compared to smoking cannabis once or twice which was reported as high risk by 42%. Most students (72%) seemed to widely disapprove of regular use of cannabis.

![Percentage of students perceiving various drug-related behaviours as a "great risk"](image)

*Figure 2.17 Source: ESPAD 2011*

**Alcohol and Drug use among University students:**

As reported elsewhere, the study conducted in 2009 with University undergraduate students, entitled “Healthy Students Healthy Lives” (Cefai C., Camilleri L. 2009), revealed that 17.3% of students had used drugs during the past 12 months while 10.1% had made use of drugs during the last month.
CHAPTER 3
PREVENTION

3.1 Environmental Prevention

*Environmental prevention strategies aim at altering the immediate cultural, social, physical and economic environments in which people make their choices about drug use.*

With regards to smoking, the product price has consistently risen with each budget proposal. There is also a complete ban on smoking in enclosed spaces and Mater Dei Hospital has adopted a zero tolerance policy towards smoking with three smoking areas in the periphery of the hospital grounds. Moreover Legal Notice 493 of 2011 (Tobacco Smoking Control Act) came into effect prohibiting smoking in playing fields. Sports activities are no longer permitted to use cigarette companies as sponsors. Cigarette packets also currently graphically depict the effects of smoking together with strong messages with regards to smoking and its consequences.

To date there is no standard procedure to quantify the extent and effects of such enforcements.

3.2 Universal Prevention

*Universal prevention strategies are concerned with distributing information on the topic of substance abuse on a national level through initiatives conducted in schools and local communities. The scope of such programmes is to prevent, or at least delay the onset of substance use through informative campaigns as well as enhance personal skills that aid individuals in avoiding substance abuse.*

*School-based Prevention*

As described in previous reports there were no major changes in the provision of school prevention programmes described in 2013. Prevention in Maltese schools is provided by Sedqa, Caritas and the Anti-Substance Abuse Unit within the Education Division whilst prevention services in Gozo are conducted by the OASI Foundation.
School based programmes primarily focus on the development of life-skills that involve enhancing self-esteem, preventing peer pressure, decision making, increasing young people’s abilities to express their feelings and encourage problem solving skills.

In order to maintain the existing quality of services and to further improve such services where this is deemed necessary, more support and collaboration among services, educational institutions and the community is of vital importance and this should be supported by policy. It is for this reason that the National Drugs Policy (2008) gives due importance to such measures in a number of actions listed within the document. These actions specify the importance of the development and maintenance of quality preventive services and also put emphasis on the importance of ongoing training and support for professionals working within the prevention field and also for educators.

Emphasis was and is being made on literacy programmes. During the summer of 2013 the Education Division organised the yearly Skolasajf activity where students gather in their schools in an informal atmosphere and through creative activities and games they are assisted in learning and literacy skills. The Skolasajf classes are taken care of by qualified teachers. Literacy programmes are constantly organised by the Paolo Freire Institute located in Zejtun which is run by the local Jesuit order. The primary aim of the Paulo Freire Institute is to respond to the growing problem of illiteracy amongst children and adults alike. However it has developed into a holistic service, providing literacy classes for adults and children, educational and recreational activities for children as well as a social work service in the community. The Institute also works on a number of community-based projects, generally related but not exclusively to literacy and learning.

**Family-based Prevention**

Universal family based prevention programmes are mostly concerned with topics such as parenting skills, leadership, effective communication, child development, and discussions and information sessions related to the use and abuse of drugs and alcohol. If requested by individual schools, talks can be delivered to parents and teachers by professionals on the topics of drugs and alcohol.

Agenzija Appoġġ, within the Foundation for Social Welfare Services, has given priority to positive parenting which involves parenting techniques based on love, encouragement, discipline, care and positive environment; as opposed to continually criticising, using
incorrect forms of discipline, and using non-effective communication methods. This type of parenting programme is an attempt to decrease abuse or violence where it occurs that in turn may lead to children growing up in a secure, disciplined environment with reductions in challenging behaviour and better self esteem. Children’s rights have to be safeguarded; children need to be guided when making decisions and need the necessary support to grow up without unnecessary pressures, whilst developing their personality. Positive child development is paramount in the prevention programmes organised throughout the country.

Following on the community principles, the St. Jeanne Antide Foundation, is a non-governmental voluntary organisation set up by the Malta Province of the Sisters of Charity of St Jeanne Antide Thouret in collaboration with lay persons located in Tarxien. The objectives of the Foundation are mainly to create support and self-empowerment of socially excluded persons, families and minority groups. Through a network of volunteers, various community initiatives are implemented such as accompanying the Social Worker on outreach work, visiting lonely persons, assisting children in their homework and studies, visiting prisoners and providing learning support to unaccompanied minors with a humanitarian protection status.

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

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

Other services which have an indirect bearing on the prevention of substance use are the Access Resource Centres. The aim of these centres is to bring a number of services together thus offering a more comprehensive service to individuals and families. These types of services aim at strengthening community networks such that these too can be useful resources to support persons in need. Working in partnership with families and all other service providers or other local entities, the services aim at improving the quality of life of service users.
The year 2014 has also seen a strengthening of these community resources with the Leap Project, a nationwide project to combat social exclusion and poverty through training and mobility processes as its mission statement.

The project targets the Priority Axis ‘Promoting an equal and inclusive labour market’ as it aims to create occupational opportunities for disadvantaged groups which are or are often at risk of poverty. The target groups include single parents, people with disabilities, ex-offenders, migrants and working poor amongst others which are considered vulnerable or disadvantaged. The project aims to build a structure which would enable such individuals to be identified amongst society through decentralization and posts within NGOs and Public Entities will be created to reinforce efforts of integration within society and serve as opportunities for these groups which benefit from work experience complimented by the necessary guidance and social mentoring support.

The project aims to combat social exclusion and poverty through a number of interventions which include the development of a cluster based network system at both regional and local levels which will help foster social cohesion and mobility in various vulnerable localities; seek and identify European examples of best practices through the involvement of transnational partners; traineeships within NGOs and Government Entities aimed at vulnerable individuals so as to help them integrate within the labour market; and capacity building for social non-governmental organisations and social workers employed by government. Additionally the project will also embark on implementing a national strategy on anti-poverty as well as create a national database for disability. This project is part-financed by the European Social Fund.

**Other Initiatives**

During 2012, a working group which was appointed by the National Commission on the Abuse of Drugs, Alcohol and Other Dependencies (NCADAD), worked on the completion of a report which was started in 2005-2007. The aims of this study were to “evaluate existing school-based drug prevention programmes amongst 13-14 year olds” with particular reference to measuring:

- a) knowledge, attitudes and behaviours towards licit and illicit drug use pre and post programme intervention.
- b) Prevalence (lifetime, last 12 months, and last 30 days) of licit and illicit drug use amongst the target group pre and post programme intervention.
Following the completion of the report, the NCADAD, together with the National Coordinating Unit for Drugs and Alcohol (NCUDA), organized a morning seminar for relevant stakeholders working directly within the area of drug prevention. In this seminar, an overview of the findings was presented and feedback was sought regarding the way forward. The main point emerging from the seminar was that prevention professionals felt the need to consolidate coordination of services, particularly to promote better cooperation and enhanced pooling of resources. To this effect, the NCADAD, through the NCUDA has proposed that a National Coordinating Body for prevention services should be set up and a number of meetings were held with representatives from the Prevention Network to outline the way forward.
CHAPTER 4

PROBLEM DRUG USE

4.1 OVERVIEW

This chapter provides information regarding the characteristics and socio-demographic details of all persons attending drug treatment services within the Maltese Islands during 2013. The agencies concerned with treatment provision in Malta and Gozo are, Sedqa, Caritas Malta, Oasi, the Dual Diagnosis Unit (DDU) within Mount Carmel Psychiatric Hospital, the Substance Abuse Therapeutic Unit (SATU) and the Maltese Prison Services. Treatment of Drug users refers to both medical and non-medical interventions which are provided locally.

By the end of the year 2013 the Maltese Population stood at approximately 425,384, up by 1% when compared to 2012. Due to this relatively small population, and consequently the small number of service providers operating in the drug treatment sector, any changes in the operating procedures of local agencies or changes in the availability of services can have a substantial impact on national data. However, no major changes were reported in the provision of drug related services since the last publication of the National Report on the Drug Situation 2012.

4.2 PREVALENCE ESTIMATES OF PROBLEM DRUG USE

In Malta problem drug use was estimated using the capture-recapture method, mainly the Poisson distribution, based on data from Maltese daily opiate users attending treatment services. Opiate users were included because treatment is predominately provided to heroin users or to persons who are no longer using heroin but are receiving methadone or other heroin substitutes, with heroin being the primary drug of 74% of all clients. In the years 2010 to 2013 a four source capture-recapture methodology was used.

In 2011, estimates indicate a figure of 2159 daily opiate users (95% confidence interval 1987 to 2369), with an estimated 934 (95% confidence interval 765 to 1147) not attending any of these treatment entities, which implies that approximately 57% of daily opiate users attended
treatment services in 2011. In 2012, estimates also show figures on the higher side, with 1,778 daily opiate users (95% confidence interval 1,670 to 1,911).

The year 2013 again shows an increase on estimates with figures on the higher side, with 1,997 daily opiate users (95% confidence interval 1,861 to 2,201). Though the figures are higher to the ones for the year 2012 but lower than those for the year 2011, it is still felt that the figures are on the high side, and that the lower end of the estimates should be considered.

It is felt, however, that the estimates of daily opiate users (which include individuals who receive methadone from treatment centres) are on the high side. It is also thought that a much higher percentage of daily opiate users had actually attended treatment services in 2013 than estimates suggest. There may be a number of factors contributing to the attainment of these high estimates. One possible reason being that at SMOPU, a unit within Sedqa, which is the only unit licensed to dispense methadone, some clients receive methadone for a number of years. The longer a person receives methadone, the less likely she/is to be in contact with other treatment services. Lower overlaps in clients attending different services produce higher PDU estimates. Over time we see less and less overlap because many clients who start receiving services at SMOPU continue to do so over time, and stop contact with other Agencies.

### Estimates for Malta 2011 – 2013

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<th>Daily opiate users not in treatment</th>
<th>Rate per 1000 pop (aged 15 to 64)</th>
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<td>95% Confidence Interval</td>
<td>Central estimate</td>
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</tr>
<tr>
<td>2012</td>
<td>1,778</td>
<td>1,670 to 1,911</td>
<td>581</td>
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<td>2013</td>
<td>1,997</td>
<td>1,861 to 2,201</td>
<td>788</td>
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Table 4.1

Source: EMCDDA ST7
4.3 PROFILE OF CLIENTS IN TREATMENT

In this section data are provided related to the number of individual clients attending any of the treatment services mentioned above. The number of clients includes people who may have already been attending the services in years prior to 2013 but are still making use of the services in the indicated year.

**Number of Clients**

After data merging, the year 2013 saw a reduction in persons using services with a total of 1834 individuals (a 2% decrease from 2012 with a total of 1874 clients). There was also a decrease of 17% in clients using services for the first time (220 new clients as opposed to 266 in 2012).

<table>
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<td><strong>Previously treated clients</strong></td>
<td>1659</td>
<td>89</td>
<td>1608</td>
</tr>
<tr>
<td><strong>First treated clients</strong></td>
<td>203</td>
<td>11</td>
<td>266</td>
</tr>
</tbody>
</table>

**Table 4.2**

Source: Merged Treatment Data Files 2011, 2012 and 2013

**Gender**

During 2013, 82% (1498 out of 1834) of the client base was male. It is relatively similar to the preceding years and the same as 2012. This year has also shown the same percentage in the male population using the service for the first time with 78% but the trend is one of a decrease as it was 78% for the year 2012 compared to 79% in 2011 and 83% in 2010.

**Age**

In 2012, the number of all treated clients aged below 35 years amounted to 64%, a slight decrease of 2% over 2011 (66%). The most predominant age groups during 2010, 2011 and 2012 were the 25 to 29 age bracket (24% for 2010, 25% for 2011 and 22% for 2012, a decrease of 3% from the preceding year) and the 30 to 34 year old cohort (21% for 2010, 20% for 2011 and 22% for 2012, an increase of 2% from 2011).
Conversely the year 2013 saw another reduction in the number of all clients aged under 35 years (59% as opposed to 64% in 2012). It might reflect the fact that fewer younger clients used services for the first time and previously treated clients are remaining in contact with the services. The most significant changes in age cohort are those between the cohort aged 35 to 39, with an increase of 3% (21%) over the preceding year (18%). All other year cohorts are equal or slightly increase or decrease.

Percentage of All Treated Clients by Age

In 2012, there was a total of 82% of first time clients (218 clients) who were under the age of 35 years, which shows a percentage decrease of 6%, though the numbers are higher. There was a further reduction with new clients under the age of 35 marking 72% in 2013, a decrease of 10% from the previous year. The most significant aspect for the 2013 reporting year is that percentage of persons who started using services in 2013 over the age of 35% increased by 3%. The most significant decrease was in the age cohort of 15 to 19 with a decrease of 6%.
When calculating the rates of treated clients aged 15 to 64 per 10,000 population, once again the southern harbour region shows the highest rate of incidence with 122 per 10,000 residents showing another slight decrease when compared to 2012 (126 per 10,000 residents). It is followed by the Northern Harbour region (70 per 10,000 residents), a minimal decrease on 2011 (71 per 10,000 population). In 2013, the share of clients hailing from the South Eastern region stood at 55 individuals per 10,000 population, the most significant increase in the last three years, that is another increase from the year 2012 (52 individuals per 10,000 population) and the year 2011 (50 per 10,000 population).

The highest rates of first treated clients are those from the Southern Harbour (10 per 10,000) followed by the Northern Harbour (9 per 10,000 population), the South Eastern region (8 per 10,000 population), Gozo (5 per 10,000) and the Western region (4 per 10,000).

These rates have been calculated on the preliminary report of the Census of Population and Housing, which census has been carried out in 2011.
Rate of Persons in Treatment per 10,000 Population Aged 15-64 Years in 2012

<table>
<thead>
<tr>
<th></th>
<th>Southern Harbour</th>
<th>Northern Harbour</th>
<th>Northern</th>
<th>South Eastern</th>
<th>Western</th>
<th>Gozo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population aged 15-64*</td>
<td>53071</td>
<td>82007</td>
<td>44953</td>
<td>45410</td>
<td>40376</td>
<td>20892</td>
<td>286709</td>
</tr>
<tr>
<td>All treated clients</td>
<td>646</td>
<td>572</td>
<td>195</td>
<td>250</td>
<td>139</td>
<td>26</td>
<td>1830</td>
</tr>
<tr>
<td>Rate of persons in treatment per 10,000 of the regional pop. aged 15-64</td>
<td>122</td>
<td>70</td>
<td>43</td>
<td>55</td>
<td>34</td>
<td>12</td>
<td>64</td>
</tr>
<tr>
<td>First treated clients</td>
<td>55</td>
<td>70</td>
<td>33</td>
<td>36</td>
<td>15</td>
<td>11</td>
<td>219</td>
</tr>
<tr>
<td>Rate of persons in treatment per 10,000 of the regional pop. aged 15-64</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 4.3
Source: Merged Treatment Data Files 2013
*based on 2011 National Census results

In 2013, client distribution by region seems to have remained consistent with previous reporting years in that the majority of all treated clients came from the Southern Harbour region followed by the Northern Harbour region. During 2012, most clients attending treatment came from the Southern Harbour region (35%), followed by the Northern Harbour region (31%), the South Eastern Region (13%), the Northern region (10%), the Western region (7%) and Gozo (1%). Percentages remain a constant as for 2012 with only slight or no changes.

During the last three years (2011-2013) the majority of first time treated clients arose from the Northern Harbour region (29% and 39% and 32% respectively), though 2013 has shown a decrease from the preceding year. The Southern Harbour region has seen an increase of 2% from 2012 (25% in 2013 as opposed to 23% in 2012). The South East region has seen another increase from the preceding year (from 12% in 2012 to 16% in 2013). This shows a higher percentage from the Northern region, which has remained a constant with 15%, the same percentage as in 2012.
All Clients Treated by Region 2011, 2012 and 2013

Figure 4.3
Source: Merged Treatment Data Files 2011, 2012 and 2013

First Time Treated Clients by Region 2011, 2012 and 2013

Figure 4.4
Source: Merged Treatment Data Files 2011, 2012 and 2013
Locality

Figure 4.5 displays towns with the highest percentage share of clients in 2011, 2012 and their correlated data for the year 2013. Amongst all treated clients a higher percentage of clients still reside in Valletta, Cospicua and Żabbar. The trend with Valletta is a decrease over the last three years.

Among the first treated clients, the year 2011 saw an increased percentage of clients from Cospicua with the result that this locality recorded the highest percentage of first time treated clients. It was followed by Valletta, Birkirkara and Qormi sharing the same percentage. The year 2012 saw the emergence of new localities with the highest percentages, those of Ħamrun and Mosta with Qormi coming in third in line with the highest percentages. Valletta, Cospicua and Gzira are the towns which have a shared percentage of new clients with figures of 4.1% for all three localities. Birkirkara and Żabbar follow with 3.6% and 3.2% respectively.
The majority of all treated clients were Maltese Nationals during 2013 (97%), the same as that for 2011 and 2012. The number of Maltese first treated clients was reported at 94%, the same percentage as in 2012 and a slight decrease of 3% from 2011 (97%). Treated clients coming from other EU countries in 2013 remained stable at 2% of the entire service using population as in 2011 and 2012.

**Occupation**

The total amount of people in treatment who were gainfully employed in 2013 stood at 40%, the same percentage as in 2012 and a slight increase compared to 2011 (39%). The percentage of unemployment in 2013 stood at 49% once again the same percentage as in 2012. The remaining 11% were classified as ‘other’ (this group includes students and homemakers). These percentages seem to have remained similar over previous reporting years.
All Treatments by Labour Status and Gender

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>regular employment</td>
<td>645</td>
<td>93</td>
<td>738</td>
</tr>
<tr>
<td>pupil / student</td>
<td>46</td>
<td>13</td>
<td>59</td>
</tr>
<tr>
<td>economically inactive (pensioners / housewives, -men / invalids)</td>
<td>34</td>
<td>21</td>
<td>55</td>
</tr>
<tr>
<td>unemployed</td>
<td>702</td>
<td>195</td>
<td>897</td>
</tr>
<tr>
<td>occasionally employed</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>other</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>not known/missing</td>
<td>66</td>
<td>11</td>
<td>77</td>
</tr>
<tr>
<td>Total</td>
<td>1498</td>
<td>336</td>
<td>1834</td>
</tr>
</tbody>
</table>

Table 4.4
Source: Merged Treatment Data Files 2013

First Treatments by Labour Status and Gender

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>regular employment</td>
<td>76</td>
<td>18</td>
<td>94</td>
</tr>
<tr>
<td>pupil / student</td>
<td>14</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>economically inactive (pensioners / housewives, -men / invalids)</td>
<td>11</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>unemployed</td>
<td>41</td>
<td>21</td>
<td>62</td>
</tr>
<tr>
<td>not known/missing</td>
<td>29</td>
<td>5</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>171</td>
<td>49</td>
<td>220</td>
</tr>
</tbody>
</table>

Table 4.5
Source: Merged Treatment Data Files 2013

**Primary Drug of Use**

A primary drug is considered as the drug which creates the greatest degree of health, legal or social problems to the individual. In 2013, as in previous reporting years, heroin continues to be the most popular primary drug amongst all treated clients and stands at 74% of the total treatment using population. However, 2013 shows once again a decrease of 1% over 2012 (75%) and 3% over 2011 (77%). This shows a new trend in the decrease of heroin as primary drug. The second most popular drug was cocaine with 14%, showing an increase of 1% over 2012 (13%) and another percentage increase from 2011 (12%). This is the fifth consecutive year in which cocaine use as a primary drug increased by a percentage point.
Cannabis remained the third most used primary drug with a constant of 8% of clients reporting such use for 2012 and 2013.

**Percentage of All Treated Clients by Primary Drug**

![Percentage of All Treated Clients by Primary Drug](image)

Source: Merged Treatment Data Files 2011, 2012 and 2013

Whilst heroin continues to be the most popular drug among first time treated clients, 2013 registered yet another decrease in percentage when compared to previous years, with 34% when compared to 35% in 2012 and 41% in 2011. Cocaine was the primary drug for 32% of first time treated clients in 2013, an increase of 4% over 2012 (28%). Cannabis has seen a reduction when compared to 2012 with 25% against the 29% of new clients reporting it as primary drug in 2012. Ecstasy is seeing an upward trend with an increase in percentage in the last three years (2% for 2011, 3% for 2012 and 4% for 2013)

**Percentage of First Treated Clients by Primary Drug**

![Percentage of First Treated Clients by Primary Drug](image)
Current Injecting Status
Injecting drug behaviour in 2013 stood at 50%, another increase over 2012 when it stood at 49% of all clients in treatment, and an increase of 11% over the year 2011 (39%). The increase was already notable in the previous year when in 2010 the reported percentage of injecting drug users was 35%.

First time treated clients in 2013 have shown a percentage of 24% of injecting drug behaviour, a 2% increase when compared to 2012 (22%) and equal to 2011 (24%).

Frequency of Use of Primary Drug
There was a drop in percentage of clients making daily use of their primary drug with 38% as opposed to 55% shown in 2012 and 53% in 2011. This difference is marked with an increase of individuals using their primary drug twice weekly or more with 26% as opposed to the 12% in 2012, that is more than twice the percentage, and 15% in 2011.
Profile of Cases by Primary Drug

2013

Female clients using cocaine as their primary drug in 2013 have seen another rise to 20% when compared to 16% in 2012 and 11% in 2011. Heroin use remained equal to 2012 with 19% in the female population. Cannabis use also saw a marginal decrease among female clients in treatment reporting 13% as opposed to 14% in 2012, once again a consistent percentage of 13% for both 2010 and 2011.

Percentage Share and Gender of All Treated Clients 2013 by Primary Drug

<table>
<thead>
<tr>
<th></th>
<th>share%</th>
<th>female%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>74</td>
<td>19</td>
</tr>
<tr>
<td>Cocaine</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Cannabis</td>
<td>8</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 4.6
Source: Merged Treatment Data Files 2013

Among first treated clients, female clients using heroin as their primary drug continued to be on the increase with 33% in 2013 as opposed to 28% in 2012 and 24% in 2011. The percentage of female clients using cocaine as their primary drug increased to 20% in 2013 another significant percentage increase when compared to the 16% in 2012 and 12% in 2011. Cannabis use among the female cohort has seen a decrease from 24% in 2011, 20% in 2012 and a meaningful 10% in 2013.

First Treated Female Clients by Primary Drug

![Graph showing the percentage of first treated female clients by primary drug for 2011, 2012, and 2013.](source)

0 5 10 15 20 25 30 35

Heroin  Cocaine  Cannabis

<table>
<thead>
<tr>
<th></th>
<th>2011%</th>
<th>2012%</th>
<th>2013%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>24</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td>Cocaine</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Cannabis</td>
<td>24</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

Figure 4.10
Source: Merged Treatment Data Files 2011, 2012 and 2013
Unemployment among first treated clients stood at 39%, with figures equalling those in 2012. Injecting behaviour among first treated clients stood at 22%, remaining a constant percentage when compared to 2012 (22%), whilst sniffing saw an increase to 27% when compared to the 18% of 2012. Smoking/inhaling saw a marginal decrease to 45% when opposed to the 47% reported in 2012.

Profile of First Treated Clients 2012 by Primary Drug

<table>
<thead>
<tr>
<th></th>
<th>2012 share</th>
<th>female</th>
<th>unemployed</th>
<th>route of administration</th>
<th>frequency of use</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>Inject %</td>
<td>smoke/ inhal%</td>
<td>sniff %</td>
<td>Daily %</td>
<td>2-6 days per week %</td>
<td>&gt; once a week %</td>
<td>not used/ occasional %</td>
</tr>
<tr>
<td>heroin</td>
<td>35</td>
<td>28</td>
<td>41</td>
<td>52</td>
<td>41</td>
<td>2</td>
<td>77</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>cocaine</td>
<td>28</td>
<td>16</td>
<td>43</td>
<td>14</td>
<td>24</td>
<td>51</td>
<td>35</td>
<td>18</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>cannabis</td>
<td>29</td>
<td>20</td>
<td>36</td>
<td>0</td>
<td>88</td>
<td>1</td>
<td>42</td>
<td>10</td>
<td>5</td>
<td>21</td>
</tr>
</tbody>
</table>

Table 4.7
Source: Merged Treatment Data Files 2012

Profile of First Treated Clients 2013 by Primary Drug

<table>
<thead>
<tr>
<th></th>
<th>2013 share</th>
<th>female</th>
<th>unemployed</th>
<th>route of administration</th>
<th>frequency of use</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>Inject %</td>
<td>smoke/ inhal%</td>
<td>sniff %</td>
<td>Daily %</td>
<td>2-6 days per week %</td>
<td>&gt; once a week %</td>
<td>not used/ occasional %</td>
</tr>
<tr>
<td>heroin</td>
<td>31</td>
<td>33</td>
<td>41</td>
<td>48</td>
<td>36</td>
<td>5</td>
<td>54</td>
<td>15</td>
<td>2</td>
<td>27</td>
</tr>
<tr>
<td>cocaine</td>
<td>29</td>
<td>20</td>
<td>43</td>
<td>11</td>
<td>19</td>
<td>64</td>
<td>27</td>
<td>38</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>cannabis</td>
<td>23</td>
<td>10</td>
<td>36</td>
<td>0</td>
<td>94</td>
<td>0</td>
<td>52</td>
<td>28</td>
<td>12</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 4.8
Source: Merged Treatment Data Files 2013
CHAPTER 5

DRUG-RELATED TREATMENT

5.1 OVERVIEW

The current National Drugs Policy from the demand domain combines education, prevention and treatment in a holistic approach focussing on synergy between service providers and other professions and institutions as well as those involved in the supply side of the equation. In Malta there are five main drug treatment providers. Three of these services are provided and funded by the government: Sedqa, the national agency against drugs and alcohol abuse which forms part of the Ministry for the Family and Social Solidarity; the prison services based during the time of reporting falling under the responsibility of the Ministry for Home Affairs and National Security; and the DDU (Dual Diagnosis Unit) within Mount Carmel Hospital which falls under the responsibility of the Ministry of Health and Energy. Caritas and Oasi are voluntary treatment providers which receive partial financial support from the Government. When looking at the trends one cannot but note a very significant increase in clients between 2006 and 2009. This is important because during this period – apart from the fact that between 2007 and 2008 the focal point was not fully functional – a lot of work was done on the first national drugs policy (2008). During the year 2014 Mount Carmel Hospital opened its first Dual Diagnosis Unit for female patients. This unit is catering for 6 beds and it will be strengthening the DDU to cater for both genders.

5.2 POLICIES AND COORDINATION

The current National Drugs Policy combines education, prevention and treatment in a holistic approach focussing on synergy between service providers and other professions and institutions. Following is an extract from the Drugs Policy referring to this coordination.

5.2.1 Co-ordination between Service Providers, Professionals and Educators

Education, prevention, supply and demand reduction are the key components that can help minimise use of illicit drugs and misuse/abuse of prescription and non-prescription drugs with a view to potentially reduce drug use and its repercussions. The wide range of initiatives involved in effectively addressing drug misuse requires the input of people coming from
different professional backgrounds and who are deployed in various state, voluntary and non-voluntary entities.

In order to make the best use of available resources, reduce duplication of services, enhance interdisciplinary and multidisciplinary collaboration and promote both inter- as well as intra-agency networking, Government shall reinforce the necessary policies that ensure the essential co-ordination of the roles of all field players and that various client groups are adequately covered. In this regard Government shall:

- ensure that appropriate prevention programmes become an integral part of the national curriculum from an early schooling stage and that such programmes continue to cater for persons in all levels of education, as well as in occupational settings;

- enhance the organisation of primary and secondary prevention initiatives with a view to ensuring that all target groups are effectively reached, including by encouraging alternative forms of leisure, especially sports;

- promote a culture that discourages the use of illicit drugs and misuse/abuse of prescription and non-prescription drugs;

- facilitate further collaboration with Local Councils and parishes with a view to promote prevention initiatives at locality level;

- facilitate collaboration with voluntary and non-voluntary organisations involved in the formulation, implementation, monitoring and evaluation of drug prevention programmes;

- ensure that treatment strategies, the availability and accessibility of treatment services and their relative outcome are monitored;

- facilitate the collaboration with voluntary and non-voluntary organisations running programmes for persons using illicit drugs and misusing prescription and non-prescription drugs; and

- seek to develop and maintain a uniform method of compilation of national data to be regularly supplied and utilised by the key field players. Such data will facilitate the monitoring of illicit drugs use and the misuse/abuse of prescription and non-prescription drugs as well as assist with the undertaking of comparative studies analysis.
5.2.2 Co-ordinating Drug Treatment and Implementation

The National Drugs Policy makes clear reference to the coordination of drug treatment and implementation of the policy. The National Co-ordinating Unit for Drugs and Alcohol within the Ministry is also responsible, apart from the focal point, to draw up recommendations for the consideration of the relevant Ministries, as and when necessary, regarding legal issues for the enhancement of this policy and also draw up recommendations, as and when necessary, related to issues that impinge on strategies and service delivery, for the consideration of the relevant Ministries.

The following section identifies the relevant institutions and outlines the roles and responsibilities of these different bodies that among them make up the institutional framework that determines or otherwise the realisation of this policy.

- **The National Commission on the Abuse of Drugs, Alcohol and other Dependencies**, which is appointed and hosted by the Ministry responsible for social solidarity, shall continue to act as Government’s advisory, co-ordinating and initiating body. The Commission shall, through the Director responsible for policy development within the Ministry for social solidarity, submit policy proposals for the consideration of the social solidarity Minister. As and where necessary, these submissions will eventually be forwarded for the consideration of the Cabinet Committee for Social Affairs prior to their being discussed by Cabinet with a view to being adopted as national policy.

- The Government shall implement and monitor the provisions of the National Drugs Policy through the National Commission on the Abuse of Drugs, Alcohol and other Dependencies. This Commission shall:
  
  (a) promote co-ordination and ensure effective co-operation among stakeholders, namely relevant Ministries and Departments, voluntary and non-voluntary organisations and the President’s Forum with a view to achieve and enhance the realisation of the National Drugs Policy.
  
  (b) manage the National Focal Point for Drugs and Drug Addiction which is responsible for:
      
      (i) collecting, analysing and distributing data on drug use,
      
      (ii) evaluating the impact of drug use, and
      
      (iii) ensuring that drug policy measures are realised at all levels.
The National Co-ordinating Unit for Drugs and Alcohol within the Ministry is also responsible for the policy implementations of the above. It is also responsible to draw up recommendations for the consideration of the relevant Ministries, as and when necessary, regarding legal issues for the enhancement of this policy and also draw up recommendations, as and when necessary, related to issues that impinge on strategies and service delivery, for the consideration of the relevant Ministries.

- **The Parliamentary Committee for Social Affairs** may, at any time, decide to discuss any drug related issues that may require amendments to existing legislation.

- **The Foundation for Social Welfare Services**, together with the **Foundation for Medical Services** which are Government’s service providers in the social welfare, medical and health areas, shall be responsible for implementing, in collaboration with voluntary organisations, the relative interventions that are necessary to achieve the goals of this policy.

- The Council for the Voluntary Sector shall facilitate the co-ordination between voluntary organisations working in the area of drug related prevention and rehabilitation services in line with the provisions of this policy.

### 5.2.3 Organisation and Provision of Drug Treatment

For the purpose of this exercise, the first part is based on the five service providers in Malta, with three providing both in-patient and out-patient services.

In Malta there are five main drug treatment providers. Three of these services are provided and funded by the government: Sedqa, the national agency against drugs and alcohol abuse which forms part of the Ministry for the Family and Social Solidarity; the prison services based during the time of reporting falling under the responsibility of the Ministry for Home Affairs and National Security; and the DDU (Dual Diagnosis Unit) within Mount Carmel Hospital which falls under the responsibility of the Ministry of Health and Energy. Caritas and Oasi are voluntary treatment providers which receive partial financial support from the Government.
Specialised drug treatment in Malta started in the first half of the 1980’s when Caritas Malta asked the Coolemine Lodge Therapeutic Community of Ireland to assist them in the setting up of a Rehabilitation Centre in Malta. In March 1985, after Maltese qualified staff returned from specialised training abroad, the very first Rehabilitation Day-Programme was launched. Following an increased demand for treatment a meeting was held in September 1988 between Caritas and a group of professionals and business people who offered their voluntary help in the administration of a Residential Rehabilitation Centre. In June 1989 Caritas started the first long-term rehabilitation centre (San Blas).

Methadone treatment dates back to before 1985, when initially methadone was given on a weekly basis from the psychiatric unit, to a small number of drug users to take home. In 1987, the detox unit was set up at St. Luke’s Hospital, now known as the Substance Misuse Outpatient Unit (SMOPU), where methadone was dispensed both for detoxification and substitution treatment. An inpatient detoxification clinic also existed within the unit. In 1994, the inpatient clinic moved to a building close by and became known as Dar L-Impenn. Initially, detoxification was conducted using methadone and catapress, and in June 1996 naltrexone was also introduced. Drug treatment on the island of Gozo was initiated by Oasi in 1992 as an outpatient service and later extended to residential treatment.

5.2.4 Outpatient Network

The information gathered for the purpose of this exercise comes after data merging for treatment demand. For this reason the individual clients are reported to avoid double counting for the purpose of accurate data collection. The figures shown in the following tables are a reflection of data merging rather than individual services.

The Substance Misuse Outpatient Unit (SMOPU) is the sole national service provider for substitution treatment. It is a centralised methadone treatment unit in Malta falling under the national treatment agency Sedqa.

There are three main service providers, mainly Caritas, Sedqa and OASI which offer low-threshold services. Sedqa is the national agency against drugs and alcohol abuse. Caritas and the OASI Foundation (situated on the island of Gozo), which are voluntary treatment providers partly subsidised by the government, offer among other services, day programmes.
Caritas, which is a voluntary treatment provider partly subsidised by the government, offers among other services the prison inmate programme (PIP) which helps the inmates with social reintegration.

Caritas and OASI, which are voluntary treatment providers partly subsidised by the government, offer among other services motivation and assessment, and motivation and support within their services.

<table>
<thead>
<tr>
<th>Total number of units</th>
<th>National Definition (Types of centre included within your country)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised drug treatment centres</td>
<td>1</td>
</tr>
<tr>
<td>Low-threshold agencies</td>
<td>3</td>
</tr>
<tr>
<td>General/Mental health care</td>
<td></td>
</tr>
<tr>
<td>Prisons</td>
<td>1</td>
</tr>
<tr>
<td>Other outpatient units</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 5.1
Source: Standard table 24
Total Outpatient Treatment Provision (number of clients)

<table>
<thead>
<tr>
<th>National Definition (Characteristics)</th>
<th>Total number of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised drug treatment centres</td>
<td>931 SMOPU is the sole national service provider for substitution treatment. It is a centralised methadone treatment unit in Malta, the Substance Misuse Outpatient Unit (SMOPU).</td>
</tr>
<tr>
<td>Low-threshold agencies</td>
<td>820 Low-threshold services are offered by three main service providers, mainly Caritas, Sedqa and OASI. Sedqa is the national agency against drugs and alcohol abuse. Caritas and the OASI Foundation (situated on the island of Gozo), which are voluntary treatment providers partly subsidised by the government, offer among other services, day programmes.</td>
</tr>
<tr>
<td>General/Mental health care</td>
<td></td>
</tr>
<tr>
<td>Prisons</td>
<td>7 Caritas, which is a voluntary treatment provider partly subsidised by the government, offers among other services the prison inmate programme (PIP) which helps the inmates in social reintegration.</td>
</tr>
<tr>
<td>Other outpatient units</td>
<td>35 Caritas and OASI, which are voluntary treatment providers partly subsidised by the government, offer among other services motivation and assessment, and motivation and support within their services.</td>
</tr>
</tbody>
</table>

Table 5.2
Source: Standard table 24

5.2.5 Inpatient Network

The Dual Diagnosis Unit (DDU) is a residential setting within Mount Carmel Hospital dealing with drug users who have mental health issues. The DDU has seen 63 individual patients in their services.

The three main therapeutic communities in Malta, the Caritas San Blas, the Komunita’ Santa Marija of Sedqa and a short-term therapeutic community offered by OASI in Gozo have reported 39 individuals using these services after data merging.

The Corradino Correctional Facility (CCF) offers methadone to inmates who are under substitution treatment. The figure of 128 individuals making use of this service shows inmates who were admitted to CCF during 2013.
Network of Inpatient Treatment Facilities (total number of units)

<table>
<thead>
<tr>
<th>Total number of units</th>
<th>National Definition (Characteristics/Types of centre included within your country)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-based residential drug treatment</td>
<td>1</td>
</tr>
<tr>
<td>Residential drug treatment (non-hospital based)</td>
<td>2</td>
</tr>
<tr>
<td>Therapeutic communities</td>
<td>3</td>
</tr>
<tr>
<td>Prisons</td>
<td>1</td>
</tr>
</tbody>
</table>

Other inpatient units

Other inpatient units

Table 5.3
Source: Standard table 24
<table>
<thead>
<tr>
<th>Inpatient Unit</th>
<th>Total number of clients</th>
<th>National Definition (Characteristics)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-based residential drug treatment</td>
<td>63</td>
<td>The Dual Diagnosis Unit (DDU) is a residential setting within Mount Carmel Hospital dealing with drug users who have mental health issues.</td>
</tr>
<tr>
<td>Residential drug treatment (non-hospital based)</td>
<td>16</td>
<td>Caritas offers the following: High Risk Female Shelter and the High Risk Male Shelter.</td>
</tr>
<tr>
<td>Therapeutic communities</td>
<td>39</td>
<td>There are three main therapeutic communities in Malta, the Caritas San Blas, the Komunita' Santa Marija of Sedqa and a short-term therapeutic community offered by OASI in Gozo.</td>
</tr>
<tr>
<td>Prisons</td>
<td>128</td>
<td>The Corradino Correctional Facility (CCF) offers methadone to inmates who are under substitution treatment. The figure shows inmates who were admitted to CCF during 2013.</td>
</tr>
<tr>
<td>Other inpatient units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other inpatient units</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.4
Source: Standard table 24
5.3 Key Data

In 2013 as in previous reporting years, heroin continues to be the most popular primary drug amongst all treated clients and stands at 74%. It has seen a slight decrease of 1% when compared to 2012 (75%) and 3% when compared to 2011 (77%). This shows a new trend in the decrease of heroin as primary drug. The second most popular drug was cocaine with 14%, with another percentage increase over 2012 (13%), also showing an increase of 2% over 2011 (12%). This is the fifth consecutive year in which cocaine use as a primary drug increased by a percentage point. Cannabis remained the third most used primary drug with 8% of clients reporting such use for 2013, the same as in 2012.

Though the constant trend is the increase of cocaine as a primary drug, this might seem alarming at face value, however it is worth emphasising that heroin is still the most prevalent drug of choice with a value of some 74%, a very high percentage when compared to all other drugs.

The distribution of the primary drug as shown in Figure 5.1 is the national figure that relates to 1834 individuals who attended a service in 2013, thus it is considered as the national figure, and not an estimate of treatment demand.
Summary table - Clients in Treatment

<table>
<thead>
<tr>
<th></th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total clients in treatment</td>
<td>2039</td>
</tr>
<tr>
<td>Total POUs in treatment</td>
<td>1139</td>
</tr>
<tr>
<td>Total OST clients</td>
<td>1078</td>
</tr>
<tr>
<td>Treatment demands</td>
<td>1834</td>
</tr>
</tbody>
</table>

Table 5.5
Source: ST24 and TDI

5.4 Treatment Modalities

5.4.1 Outpatient Services

The policies and guidelines of each respective service provider offering outpatient services guarantees a holistic approach and also collaboration between services for the benefit of their clients. Though the criteria of the services are somewhat different, there is a good relationship between the agencies with a commitment to collaborate with other stakeholders in the same field.
Services Available in the Outpatient Setting

<table>
<thead>
<tr>
<th>Service</th>
<th>Not available</th>
<th>&lt;25% of outpatient facilities provide this service</th>
<th>Between 25% and 50%</th>
<th>&gt;50% and 75%</th>
<th>&gt; 75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial treatment/ counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Screening of mental health disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mental health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Case management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Outreach to clients in the community in need of treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Established referral processes to relevant medical and social services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Table 5.6
Source: Structured Questionnaire 27P1

5.4.2 Inpatient Services

In Malta, there are a total of five residential drug treatment units, four in Malta and one in Gozo which are provided by the three agencies which were mentioned in section 1.2:

- Komunita’ Santa Marija (Sedqa)
- Komunita’ San Blas (Caritas New-Hope)
- Harm Reduction Shelter for male drug users (Caritas New-Hope)
- Harm Reduction Shelter for female drug users (Caritas New-Hope)
- OASI Residential Unit (OASI)

The Santa Marija residential unit does not provide methadone treatment to residents entering the programme but provides detoxification to those who require such services through the in-patient unit which is also run by Sedqa. However, they sometimes have some residents treated with other types of substitution treatment, such as Suboxone or Subatex, although these are kept to the minimum. Also, pregnant residents must retain any dose of methadone or substitution treatment as prescribed by the resident doctor.
In San Blas T.C, residents admitted into the programme are required to be free from substitution treatment. This means that clients attending group sessions at the Community Services Unit need to be weaned off methadone or any other substitution treatment. Alternatively, those clients who are admitted to the Harm Reduction Shelter are permitted a methadone dose which does not exceed that of 40mg daily. In the event that a client is motivated to enter San Blas T.C., that client would need to be weaned off the methadone dose gradually while residing in the harm reduction shelter and prior to admission to San Blas T.C.

In the case of the female shelter, clients would ideally be on a dose of methadone not exceeding 20mgs daily or 2mg of suboxone before being admitted, however, in exceptional cases and/or crisis, this issue may be managed accordingly following a discussion on a case by case basis. Also, pregnant drug users in need of the services can enter the shelter and retain the dose prescribed by the doctor at the Substance Misuse Out-Patient Unit.

In the case of OASI residential services, clients in need of substitution treatment can be admitted whilst receiving Suboxone treatment.

### Services Available in the Inpatient Setting

<table>
<thead>
<tr>
<th>Service</th>
<th>Not available</th>
<th>&lt;25% of inpatient facilities provide this service</th>
<th>Between 25% and 50%</th>
<th>&gt;50% and 75%</th>
<th>&gt; 75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial treatment/counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Screening of mental health disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mental health services</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Case management</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Established referral processes to relevant medical and social services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Table 5.7
Source: Structured questionnaire 27P1
5.4.3 Opioid Substitution Treatment (OST)

A centralised methadone treatment unit in Malta, the Substance Misuse Outpatient Unit (SMOPU), provides substitution treatment. Methadone is the most commonly prescribed form of medically assisted treatment for drug users in Malta. Of a total of 1139 individuals making use of SMOPU services in 2013, 1078 persons (95%) received substitution treatment. The majority of individuals who received substitution treatment (90%) received only methadone. The other 10% received other forms of substitution treatment according to their needs, either one or more types of medication. These were DHC; Methadone and Buprenorphine; Methadone and DHC; Methadone and Subaxone; Methadone, Subaxone and Buprenorphine; Methadone, Subaxone and DHC; Naltrexone; Subaxone and Buprenorphine; and Subaxone.

5.5 Quality Assurance of Drug Treatment Services

Up until the present day there are still no national treatment standards or guidelines to guide services but each and every service provider has its own guidelines and standards to which they adhere to, and are in line with the national drugs policy.

In November 2012 the Department for Social Welfare standards published a draft set of national standards regarding the residential treatment centres. A period of public consultation ensued and these standards are currently being prepared as guidelines for the said residential treatment centres.

5.6 Trends

When looking at the figures below one cannot but note a very significant increase in clients between 2006 and 2009. This is notable because during this period – apart from the fact that between 2007 and 2008 the focal point had limited function – a lot of work was done on the first national drugs policy (2008). From then onwards a lot of effort was put in coordinating and enhancing communication between service providers and thus every effort was done to create data harmonisation of which the result is the new protocol for data collection. This can also be seen between agencies with referral systems between services being conditional on the type of service a client requires.
New Treatment Entrants

The most predominant drug for new entrants was and remains heroin though these last 3 years it has seen a drastic decrease in persons attending treatment for the drug. The peak years have been 2005 (196 individuals) and 2006 (229 individuals) with another rise in 2010 with 177 individuals. The sharp drop reflected in this figure may reflect the period when there was limited activity by the focal point. The year 2013 has seen the least amount of clients throughout this trend. Currently the three main drugs (heroin with 67 clients, cocaine with 64 and cannabis with 50) of choice are accurate enough to and reflect the numbers of individuals who have used the service for the first time in 2013.

Trends in Numbers of First-time Clients Entering Treatment by Primary Drug, 2004-2013

![Graph showing trends in numbers of first-time clients entering treatment by primary drug from 2004 to 2013.](source: TDI)
All Treatment Entrants

As already noted earlier heroin remains the most popular primary drug. Trends show that the peak period of clients making use of such a drug and being in treatment was between the years 2009 and 2011, with 2010 recording the highest number of individuals (1543) throughout the 8 year period shown in Figure 5.3. The following years have seen a steady decline and although minimal when compared to the overall number of clients in the respective years, it reflects the slow decline in individuals asking for treatment. It is worth noting that the majority of individuals with a heroin problem remained constant with the previously treated clients throughout the years which is also reflected in the number of individuals who have been SMOPU clients for years.

The second most popular drug remains cocaine which has seen a stable increase throughout the period of 2004 – 2013. This increase, though not alarming when compared to heroin, has created a new level of discussion as to how such clients can be assisted in the best possible way. This is because much of the service provision is based on models which work best with heroin users and new approaches are constantly discussed as to the way forward in service provision.

Being the third most sought after drug, cannabis has also seen a constant increase by individuals asking for treatment except for 2013 which has seen a minimal decrease. Cannabis has been the centre of debate over these past few years, with lobby movements asking for its legalisation whilst others have focussed on decriminalisation. The fact is that at present the drug laws are being reformed and a new law will be in place by the end of the year 2014. Though this might not influence the outcome of people seeking treatment for heroin and cocaine, but it might change to some extent the current trend for cannabis.
The short-term trend for OST clients shows a steady increase of clients between 2009 (977 clients) and 2011 (1107), with a slight decrease in the following two years. This largely explains the client base of SMOPU where the absolute majority of the clients are those who have been in the service for more than a year. This decrease in the last year is also reflected in the total client base for 2013. When comparing data for 2009 and 2013 (1078 clients) the client fluctuation seems to be between one hundred individuals, keeping clients in opioid substitution treatment relatively stable.
5.7 New Developments

During the year 2014 Mount Carmel Hospital opened its first Dual Diagnosis Unit for female patients. This unit has at present 6 beds and it is hoped that this will strengthen the DDU’s capability to cater for both genders.

In November 2011, a service-evaluation exercise conducted with residents of homes that provide services for people with difficulties related to drug or alcohol use was done by the Research and Standards Development Unit within the Department for Social Welfare Standards (Vassallo. J, 2011). This exercise was initiated in light of the creation and publication of standards for residential services for people with difficulties related to drug or alcohol use with the main aim of improving the quality of life of service-users.

Service providers were all involved in the development of such standards, and consistently present at working group meetings. Comments from ex-service-users on the draft standards were received and included in the working group discussions. Throughout the development
process of these standards, concerns were raised about the fact that the standards
document would be considered too lengthy and largely incomprehensible to a good number
of service users. The service-evaluation survey offered a more comprehensible and indirect
way of gaining knowledge that would inform the development of the standards and direct the
focus of standards implementation on areas in which service-users consider more important
or as having most needs.

One of the highlights of the results of this survey was the rating of the overall service
received with 33% of respondents claiming that the service received is ‘excellent’ and 32%
claiming that it is ‘very good’. 15% stated that the service is ‘not bad’ and 3% classified the
service as ‘bad’, while none of the respondents chose the ‘very bad’ option.
CHAPTER 6

HEALTH CORRELATES AND CONSEQUENCES

It is well established that drug use and abuse can lead to health related consequences that include both cognitive aspects as well as the more known physical symptoms. At the extreme end of the scale both use and abuse may lead to death. As such, this chapter discusses health issues that are often brought about through, or together with the use and abuse of drugs. Among these are fatal and non fatal overdoses, drug related infectious diseases and mental health problems related to the use of drugs.

6.1 Drug-Related Deaths and Mortality of Drug Users

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

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

During 2013, 3 drug related deaths were reported by the Police Special Registry, which is the lowest ever amount recorded since 2007. This amount puts 2013 below the average of between 5 to 8 reports yearly. The highest number of recorded deaths was in 2007, with an exceptional number of 11 fatalities.
Between 1999 and 2013 the mean age of those succumbing to drug overdoses has continued to fluctuate between 26 years and 38 years of age. The mean age for 2013 was slightly below 2012 (32 years) with the mean age being 31.5 years. These variances in mean age are mainly due to the small size of the numbers reported and may not be indicative of any increase or decrease related to age.
6.2 Drug-Related Infectious Diseases (DRIDs)

DRIDs are defined as diseases contracted as a direct or indirect result of using drugs. This section provides data on the level of Hepatitis C (HCV), Hepatitis B (HBV) and HIV amongst drug users. The Substance Misuse Out-Patient Unit (SMOPU) within Sedqa, conducts tests on drug users attending the outpatient service. The results of tests for the years 2011 - 2013 are presented in Figure 6.3. Data reported in Table 6.1 includes all service users at SMOPU and data reported in Figure 6.3 are the results of IDU’s resulting positive for the tests.

A total number of 202 tests were carried out for HCV in 2013, resulting in a total of 12 new cases. The number of tests carried out in the years 2011, 2012 and 2013 are presented in Table 6.1. Figure 6.3 shows that the percentage for Hepatitis C infections has decreased when compared to 2012 (46), as well as one new case for Hepatitis B. Of particular concern are the 4 new cases of individuals testing positive for HIV especially when compared with no new cases in all the preceding years. All four individuals are injecting drug users and one individual is deceased due to an accident. Two are being followed by SMOPU and the third is being monitored by the Disease Surveillance Unit (DSU).
### Number of Tested Service Users in 2011 - 2013

<table>
<thead>
<tr>
<th></th>
<th>Anti HBC</th>
<th>IDUS HCV</th>
<th>HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 Number Tested</td>
<td>137</td>
<td>153</td>
<td>186</td>
</tr>
<tr>
<td>2012 Number Tested</td>
<td>113</td>
<td>131</td>
<td>138</td>
</tr>
<tr>
<td>2013 Number Tested</td>
<td>196</td>
<td>202</td>
<td>210</td>
</tr>
</tbody>
</table>

Table 6.1
Data Source: SMOPU 2011-2013

### Positive Results for HBV, HCV and HIV between 2011 and 2013 in Injecting Drug Users

![Graph showing positive results for HBV, HCV, and HIV]

Source: SMOPU Data Files 2011-2013

### 6.3 Psychiatric co-morbidity (Dual Diagnosis)

There are 3 specialised units for the treatment of clients with dual diagnosis – The Dual Diagnosis Unit (DDU) at Mount Carmel Hospital, the Dual Diagnosis Outpatient Clinic at Sedqa’s Substance Misuse Outpatient Unit (SMOPU) and the prison pre-release programme at the Substance Abuse Therapeutic Unit (SATU).
There were 44 individuals who made use of the Dual Diagnosis Unit in 2013. The individuals were all male and were all daily users of illicit drugs. The average age of clients at DDU was that of 32 years, a decrease in average age when compared to the year 2012 with the average age of 35 years.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Share % 2011</th>
<th>Share % 2012</th>
<th>Share % 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>83</td>
<td>81</td>
<td>80</td>
</tr>
<tr>
<td>Cocaine</td>
<td>12</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Cannabis</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 6.2
Source: Dual Diagnosis 2011-2013

Table 6.2 shows the percentage of individuals according to their drug of primary use for the years 2011 to 2013 (Table 6.2). The majority of the individuals (80%) make use of heroin as their primary drug. This shows a 1% decrease in the substance when compared to the previous year (81%), but is still on the higher side when compared to 2010 (60%). Heroin is followed by cocaine (5%) a further slight decrease when compared to 2012 (7%). There was no reporting of cannabis use as primary drug for the year 2013. The general pattern however is still that heroin is the major drug for the population of individuals attending drug related services.

6.4 Other Drug-Related Health Correlates and Consequences

Non-Fatal Overdoses (NFODs)
NFOD data are obtained on a yearly basis from the Police Drug Squad records.

The short-term trend of non-fatal overdoses continues to see a decrease in registered cases over the last 4 years. The year 2013 marked yet another one of the decreases with 102 registered cases when compared to 2012 (139 cases) and putting this year on a par with 2008 (102 cases).

Non-fatal overdoses related to the abuse of illicit drugs in 2013 saw a continued decrease over the preceding three years, with a total of 20 reported cases (20%) of all reported cases. Figure 6.4 gives a clear picture of the trends in the last 19 years.
Overdoses linked to medicinal products still contribute the greater majority of cases reported (80%). As reported in previous National Reports, prescription drugs are more easily obtained, making it easier for the occurrence of abuse to remain high.
CHAPTER 7

RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

Among the main objectives which are listed in the National Drugs Policy 2008, great importance is given to the protection of public health through the prevention and reduction of drug related harm.

The main measures listed in the document are related to the dissemination of information to the general public as to the dangers and consequences which may be brought about by drug use. These measures are aimed to:

“promote a culture that discourages the use of illicit drugs and misuse/abuse of prescription and non-prescription medication and paraphernalia such as food and drink associated with such use” (Action 30, National Drugs Policy 2008)

Besides offering information to the general public through the various prevention initiatives taken on board on a national level, the policy also aims at ensuring that vulnerable groups receive adequate information regarding the dangers of drugs and services which are made available to those who may find themselves in difficulties related to drug use. The policy states that the Ministry shall be responsible to:

“plan and develop the co-ordination of social integration services with a view to (a) prevent potential users from falling victim of illicit drug use and misuse/abuse of prescription medication, and (b) help rehabilitate users avert relapse” (Action 27, National Drugs Policy 2008)

These measures are involved with services that effectively deal with promoting prevention and diverting drug using behaviour, but also give due importance to the need to ensure that current harm reduction measures, which address the health and social needs of current drug users, are maintained and possibly improved where such improvement is deemed necessary.

“Improve those harm reduction measures which shall be applied in the case of drug users where abstinence from illicit drugs and prescription and non-
In order to achieve targets related to the prevention and reduction of drug related harm the National Drugs Policy also makes reference to the importance of strengthening collaboration by involving all stakeholders which may contribute to the implementation of the various measures listed in the policy document.

“strengthen co-ordination among stake holders, including Youth Organizations, Professional Bodies and Local Councils. To promote a co-ordinated and focused approach in the national commitment to combat illicit drug use and misuse/abuse of licit medication”, (Action 34, National Drugs Policy 2008)

7.1 Prevention of Drug-Related Deaths

There have been no new developments in relation to those preventative measures already in place targeting the reduction of drug-related deaths in the reporting years (see previous National Reports).

7.2. Interventions Related to Drug-Related Infectious Diseases

**Hepatitis C**

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

Treatment for Hepatitis C includes Interferon treatment alone and Interferon/Ribavarin combination treatment. Drug users who have contracted chronic Hepatitis C and who are still
using drugs are not eligible for treatment as the criteria for eligibility for treatment include drug abstinence and termination of methadone treatment for at least one year.

**HIV**

The prevention of HIV amongst drug users is similar to that of Hepatitis C. Blood screening and pre and post test counselling is provided by SMOPU, CCF, the GU clinic and the XEFAQ service offered by Caritas. Unlike Hepatitis C, the prevalence of HIV amongst drug users appears to be low in Malta (no cases of HIV among drug users were notified between 2009 and 2012). By law, since 2004, HIV has become a notifiable disease and the DSU is responsible for receiving these notifications and conducting contact tracing.

**Hepatitis B Vaccine**

Testing and vaccination for Hepatitis B is a free of charge service provided by health centers to the general public. SMOPU provides a free of charge and highly accessible screening and vaccination program to all drug users who are attending the clinic. Prison inmates are screened on admission for Hepatitis B. A vaccination program for inmates was started in 2007. The prevalence of Hepatitis B amongst drug users is low in Malta (about 1.8%).

**Needle and Syringe Availability**

Syringe distribution started in Malta in the 1980’s as a consequence of the HIV threat to drug users and reached national coverage in 1994. Subsequently, the number of syringes distributed yearly has risen steadily (Figure 7.1). The year 2007 saw an increase of 14% from the year 2006. During the year 2008, a decrease of 8% from 2007 was registered in the number of syringes distributed. During 2009 there was an increase of 11% over 2008. This figure shows the return to levels prior to 2008 and thereon the steady increase as seen in previous years. In 2010 a further increase of 4% over 2009 was reported, bringing the total number of syringes distributed to 321,361. In 2011 there was a decrease of 10%, bringing the total number of syringes distributed to 289,940. The year 2012 has seen the highest syringe distribution ever since 1994 with a total amount of 376,104 syringes distributed and a percentage increase of 23% over 2011. Though the year 2013 has seen a decrease of 5% in syringe distribution with 357,991 syringes, it is still the second year with the highest amount.
7.3 Interventions related to Psychiatric Co-Morbidity (Dual Diagnosis)

The Dual Diagnosis Unit (DDU) at Mount Carmel Hospital serves to detoxify, stabilize and provide medication to dual diagnosis clients. Referrals to and from other drug treatment agencies are often made. The nursing staff provides patients with basic problem-solving interventions, however therapeutic input is limited and further supervision and training in the areas of motivational interviewing, group work, individual and family therapy are needed. Some clients typically discharge themselves against medical advice. Such persons are increasingly susceptible to drug overdose due to their concomitant use of illicit drugs and prescription pills.

SMOPU offers a psychiatric service for clients with varying degrees of mental health problems. The aim of this service which commenced in 2004 is stabilisation of drug use through substitution treatment and treatment of the psychiatric condition.
The standardisation of clients’ intake assessments has enabled drug treatment agencies to detect the signs of any co-morbid conditions more easily. This has meant that agencies are now working more closely and in parallel with psychiatrists and psychologists in order to treat clients with psychiatric co-morbidity more effectively. Additionally, whereas in the past, rehabilitation centres did not accept clients on psychotropic medication, in recent years a large number of clients entering rehabilitation are on medication, although rehabilitation centres still do not cater for clients who are psychotic or who are severely depressed.

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

7.4 Interventions Concerning Pregnancies and Children Born to Drug Users

_Pregnant Substance Misusing Mothers_

During the year 2013, 19 substance misusing women attending the Substance Misuse Outpatient Unit (SMOPU) were pregnant. One of the mothers had a miscarriage. Another expecting mother did not use the service. Among the new born children, 10 infants had withdrawal symptoms and were given oral morphine as a substitute. The remaining 9 babies did not require opioid substitution treatment. Table 7.1 shows the trend within these last 7 years.
<table>
<thead>
<tr>
<th>Year</th>
<th>Mothers attending SMOPU On Methadone</th>
<th>Mothers not attending SMOPU</th>
<th>Stillbirths/miscarriages</th>
<th>Healthy babies on opioid replacement therapy</th>
<th>Babies born not requiring opioid replacement therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>18</td>
<td>0</td>
<td>2</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>2008</td>
<td>22</td>
<td>0</td>
<td>1 (cot death)</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>2009</td>
<td>19</td>
<td>5</td>
<td>3</td>
<td>11</td>
<td>10</td>
</tr>
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<td>2010</td>
<td>15</td>
<td>0</td>
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<td>11</td>
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<td>2011</td>
<td>17</td>
<td>7</td>
<td>3</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>2012</td>
<td>19</td>
<td>1</td>
<td>0</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>2013</td>
<td>18</td>
<td>1</td>
<td>1 (miscarriage)</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

**Table 7.1**

Data: SMOPU 2007 -2013

**Child Protection Services**

‘Appoġġ’ is the National Agency which is directly responsible for child protection services within the country. It offers a comprehensive social work service according to the individual needs of children.

Of all the cases investigated in 2013 by ‘Appoġġ’, 33 cases were issued a care order, a small percentage decrease when compared to 2012 (34 care orders). Out of the 33 care orders, only 4 (12%) were issued a care order in relation to drug using parents, showing a decrease when compared to the previous years. The year 2012 saw 18 care orders, a reduction of 3 cases from 2011 but an increase of 12% (53% of care orders) in relation to the total amount of care orders between 2011 and 2012. This figure is still below the 67% of care orders issued due to drug using parents in 2010.

Fostering cases have also seen a decrease related to children whose parent/s are drug misusing clients. Out of the 246 cases in 2013 there were only 5 children placed in mainstream fostering when compared to the 24 fostered children in 2012 (out of 288 children). The contrast with 2011 is much higher as that year saw 89 children with parent/s having drug related problems in foster care, out of 259 children.
CHAPTER 8

SOCIAL CORRELATES AND CONSEQUENCES

8.1 Drug-Related Crime

Police Arrest Data
During the years of 2010 and 2011 there were slight fluctuations in relation to arrests related to possession and trafficking of illicit drugs. Of particular interest is the year 2012 which has seen a dramatic increase in the number of arrests than the preceding years, with the amount of 681, or an increase of 26% of arrests over the year 2011.

The year 2013 saw another reduction (n=499) in arrests similar to the year 2010 even if the amount of seizures was high for this particular year.

Arrest data can be affected by law enforcement strategies, levels of police enforcement and also by the level of substance abuse problems within the country. Because data may be affected by any of these individual factors, and at times by a combination of all three factors, it is very difficult to establish any concrete conclusions regarding any changes registered in the amount of arrests taking place.
In 2012, 681 arrests for drug law offences were executed by the Malta Police Force, as compared to 2011, when 542 arrests were made, and compared to 2010, when 506 arrests were made. Of these arrests, 403 individuals were arraigned. A total of 254 arraignments were related to possession of drugs while 149 were related to drug trafficking offences. Most charges for possession involved cannabis, heroin and cocaine.

In 2013, 499 arrests were made related to drug law offences. Of these arrests, a total of 136 individuals were arraigned for possession and 44 were arraigned for trafficking, totalling to 180 individuals.

In 2012, there was a slight increase in all main drugs for trafficking, mainly cannabis which saw an increase of 2% from the year 2011 and cocaine which saw a percentage increase from 32% in 2011 to 33% in 2012. Perhaps the most significant increase was that of heroin, an increase of 4% from the preceding year with 28% against the 24% from 2011. Other drugs, which include ecstasy, this was halved from 14% in the year 2011 to 7% in 2012.
Data for 2013 shows fluctuations in percentages of charges for trafficking, with the main changes being a relative decrease of 10% for trafficking of cannabis (32% for 2012 against the 22% in 2013) and the percentage increase of 3% in other drugs (7% for 2012 against 10% in 2013). Both heroin and cocaine have seen increases, with a slight upward trend of 1% in cocaine (from 33% in 2012 to 34% in 2013) and 6% for heroin from 28% in 2012 to 34% in 2013, keeping the upward trend from the previous years.

**Charges for Trafficking by Drug Type 2011-2013**

![Figure 8.2](source: Police Arrests File 2011-2013)

**Demographic characteristics of arrestees charged with drug offences**

Following trends from the previous years, males were the predominant gender to be charged for either possession or trafficking in 2013 with 461 individuals, that is 92% of all individuals charged. This shows an increase of 5% over the preceding year, alternatively reflecting the decrease of the female population from 13% in 2012 to 8% in the following year (38 females). In 2012, 87% of all individuals charged for either possession or trafficking were male (350 males) while 53 females were charged (13%). This shows a marginal 1% decrease in the female population arrested over 2011, when of the 388 persons arrested in 2011, 334 (86%) were male while 54 (14%) were female.

As in the previous year, most persons charged with drug possession in 2013 were aged between 15 and 29 years (51%). Perhaps more significant is the percentage of persons...
charged with drug trafficking in the same year who were aged between 20 and 34 years (65%), (Figure 8.4).

Persons Arrested by type of Charge and Gender in 2013

![Bar graph showing persons arrested by type of charge and gender in 2013]

Figure 8.3
Source: Police Arrests Data File 2013

Persons Arrested by Type of Charge and Age Group 2011-2013

![Bar graph showing persons arrested by type of charge and age group from 2011 to 2013]

Figure 8.4
Another increase has been recorded in cases for drug possession being brought before the courts in 2013 when compared with preceding years, with a total of 364 cases against the 355 in 2012. This increasing trend is reflected over the last years with 136 new cases being brought before the courts in 2011 against the 49 new cases reported in 2010.

Once again the great majority of individuals charged with possession were males (85%) an increase of 4% over 2012 (81%) but still slightly lower than 2011 (88%). When comparing data with the female individuals brought before the courts, the implication is that there was another reduction from the previous year with 15% being female as opposed to the 19% in 2012.

Possession of cannabis remains the drug by which most individuals were charged in 2013 with 141 cases, an increase when compared to 2012 (125 cases). There has also been a change in the number of persons being charged for possession of cocaine against those for possession of heroin, with 99 individuals for the former and 74 for the latter. This shows a
change in trend as whereas heroin was the second drug in cases of possession in 2012 with 107 cases as opposed to 79 for cocaine.

Figure 8.6 shows the differences in percentages for possession cases between the years 2011, 2012 and 2013, with the majority of cases are those possession of cannabis (141 cases), followed by cocaine (99 cases) and heroin (74 cases) for 2013.

As with the preceding years, 2013 saw the majority of cases resulted in a conditional discharge with 58% of all cases, equal to the percentage of 58% for 2012. Cases resulting in a probation order have seen another increase from the preceding years with 11% of all cases when compared to 7% in 2012 and 6% in 2011. Prison term has also seen a decrease when compared to preceding years, with 8% in 2013, 12% in 2012 and 10% in 2011. Fines have also been on the decrease from 19% in 2012 to 14% in 2013.
Outcome of Judgment for New Possession Cases in 2010-2012

<table>
<thead>
<tr>
<th>Outcome of Judgement</th>
<th>No. of Cases 2011</th>
<th>No. of Cases 2012</th>
<th>No. of Cases 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conditional Discharge</td>
<td>92</td>
<td>184</td>
<td>215</td>
</tr>
<tr>
<td>Probation</td>
<td>8</td>
<td>22</td>
<td>41</td>
</tr>
<tr>
<td>Suspended Jail Term</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Imprisonment</td>
<td>14</td>
<td>39</td>
<td>31</td>
</tr>
<tr>
<td>Fine</td>
<td>19</td>
<td>62</td>
<td>52</td>
</tr>
<tr>
<td>Acquittal</td>
<td>2</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Sentence Appealed</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 8.1

**Probation and Parole Services Data**

The Department of Probation and Parole had 351 clients with a known drug problem for 2013, an increase of 20% when compared to 2012 (291 clients). The majority of clients were male with 88%, a slight increase when compared to the previous years (86% in 2012 and 87% in 2011).

Clients reported as having problems related to heroin use totalled to 173 (49%) showing a decrease in trend with 2012 reporting 54% and 59% reported in 2011. Cannabis was the second drug of choice reported with probation clients totalling to 114 (33%) individuals, showing a continuous increase in persons using this drug when compared to 2012 (27%) and 24% in 2011. Cocaine users amounted to 59 (17%) individuals, a slight decrease when compared to 2012 (18%) but still higher than 2011 (15%).

Figure 8.7 shows the trend for the choice of drug by clients with a known drug problem under probation. This trend shows a decrease for heroin, though it is still the primary drug of the majority.

The number of Parole Reports compiled in 2013 amounted to 61 whilst the number of Victim Reports compiled amounted to 83. Since June 2013, 12 inmates have been granted Parole Licence and are in the community under the supervision of a Parole Officer.
Prison (CCF) Data

Due to ever changing circumstances within the CCF the National Focal Point was presented with data which are limited to individuals who were admitted in 2013 and were under treatment for illicit drugs. The total number of persons amounted to 128 individuals, an average of 19% of the new population in 2013 (c.680). Figure 8.8 shows which type of drugs the new inmates were under treatment for, with heroin topping the list as is the choice of drug in the community and treatment demand.

As with previous years inmates needing OST are sent to the Forensic Unit at MCH for treatment. OST is not given in prison as a policy.
8.2 Drug Use in Prison

Mandatory random tests for drug use have commenced once again but results were not available when this report was being finalised.
Problem drug use refers to a subset of drug users that as a consequence of their drug use and related problems have become marginalised from society. These problems normally involve health related issues and social problems such as no fixed abode and criminal proceedings. Often, these in turn lead to loss of employment and income compounding the problem even further and thus these provide the ingredients for social exclusion. Consequently, social integration is a necessary part of treatment if the treated user is to get back on his/her feet again and become a valued member of society.

9.1 Social Reintegration

Training and Employment

The Employment and Training Corporation (ETC) together with the drug treatment agencies Sedqa and Caritas, Probation Services and Corradino Correctional Facility (CCF) work in tandem to provide training and employment for ex-drug users.

The Inclusive Employment Services within the Employment and Training Corporation supports and targets disadvantaged groups to enhance their capabilities in order that they may better integrate into the labour market through the Bridging the Gap Scheme. These client groups are assisted by being provided counselling and placement services together with referrals to adequate training programmes.

This ‘Bridging the Gap’ scheme is designed to support the client during the transition period from unemployment to employment. It allows the employer to evaluate the performance of the client in the workplace, prior to proper engagement. The scheme offers the client a period of work exposure with an employer to enable him/her to demonstrate the skills needed for a particular job. The employer and ETC enter into an agreement regarding the work exposure period, whereby a client is placed on the scheme with the prospect of
employment. The client is considered as an unemployed registrant without the obligation to 
turn up for his/her weekly signing-up.

The year 2013 saw 10 ex-prison inmates, 4 ex-substance abusers and 4 social cases attend 
a mainstream training course offered by the Corporation and 23 persons have benefited 
from a work exposure opportunity through the Bridging the Gap scheme during the past 
twelve months. Moreover, 63 vulnerable jobseekers (ex-prison inmates, ex-substance 
abusers and social cases) were placed on the Community Work Scheme.

The ETC also assists in offering training and educational support schemes for people 
serving a prison sentence. Collaboration between the ETC and CCF continued to be 
maintained during the year 2013, and 30 CCF inmates who were nearing the end of their 
prison sentence were profiled and given information about ETC services. These activities 
were carried out at CCF.

Cooperative Agreements with Caritas and Oasi continued to be operative in 2013, with a 
total 153 (128 Caritas, 25 Oasi) jobseekers referred to respective agreements.

The Advisory Drug Misuse Board that comprises of representatives from ETC, Sedqa and 
the Department of Social Security, evaluates and monitors the employment status and 
employment prospects of particular clients and provides them with additional assistance if 
needed. During 2013, 34 clients were called in for an interview by the Advisory Drug Misuse 
Board. The following chart shows registered unemployed in Part 1 and Part 2 unemployment 
schemes.

<table>
<thead>
<tr>
<th>ETC Data</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Unemployed with ETC</td>
<td>6,587</td>
<td>6,811</td>
<td>7,401</td>
</tr>
<tr>
<td>Registered Unemployed known substance abusers</td>
<td>202</td>
<td>184</td>
<td>194</td>
</tr>
<tr>
<td>Registered Ex-prison inmates</td>
<td>153</td>
<td>140</td>
<td>151</td>
</tr>
<tr>
<td>Registry Unemployed 'social cases'</td>
<td>73</td>
<td>62</td>
<td>57</td>
</tr>
</tbody>
</table>

Table 9.1
Source: Employment and Training Corporation
9.2 Prevention of Drug-Related Crime

**Drug Reform White Paper**

As already mentioned elsewhere in the report, in July 2014 the Ministry for Justice, Culture and Local Government launched a Drug Reform White Paper.

This new reform makes the distinction between simple possession and aggravated possession (the court of magistrates or the criminal court) with the focus of criminal intent according to each case.

In the case of simple possession, there is reference to the cultivation and use of cannabis, specifically meaning that a person should not be arraigned for such possession but either given a written warning from the Commissioner of Justice or referred to the Justice board where a social inquiry report is done on behalf of the individual and recommendations proposed. If the individual does not follow the proposal the case is taken to the court of magistrates.
CHAPTER 10

DRUG MARKETS

10.1 Availability and Supply

Heroin continues to be the most widely used illicit drug among the client population. Most people in treatment for drug related problems seem to continue to be mainly users of heroin as their primary drug, as illustrated in Chapter 4 of this report. However, there has been an increase in the number of clients receiving treatment for cocaine and cannabis.

Herbal cannabis in Malta is generally locally grown, while cannabis resin is imported into the country from North African countries, mainly Tunisia and Libya. Heroin is imported primarily through North Africa (Libya, Tunisia), from Brussels or directly from Turkey. Cocaine is mainly smuggled through Schengen countries, particularly Spain. Ecstasy and other amphetamines are smuggled into Malta mainly from European destinations, particularly from Italy or directly from the Netherlands.

New psychoactive drugs are constantly being made available on the European market and authorities in Malta are informed immediately when one or a number of these substances are reported through the Early Warning System.

10.2 Seizures

The total number of drug seizures in 2013 amounted to 458, another increase of 20% over the year 2012 (383 seizures). This shows a constant increase in the last four years with nearly double the amount since 2009 (240 seizures). After the massive seizure of nearly 50kg of cocaine in 2012 in the Malta Freeport the seizures of the said drug have been slightly lower compared to the preceding years, with a 15% decrease in 2013. Heroin has remained stable with 1300grams as opposed to 1331grams in 2012. The most significant increases have been in seizures of cannabis grass (9738.5grams) and ecstasy tablets (30374.5 tablets). Seizures in cannabis grass show an increase of nearly 300% over 2012 (2785) while seizures for ecstasy amounted to 30374.5 tablets as opposed to 1080 in 2012 (Table 10.1). The majority of persons caught trafficking drugs were Maltese Nationals (72%).
Total Amount of Drug Seizures

Source: Police Drug Squad Annual Reports 2000-2013

Quantities of Drugs Seized 2005-2013

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin (grams)</td>
<td>15487.2</td>
<td>1892.1</td>
<td>16427.1</td>
<td>8270.0</td>
<td>8410.0</td>
<td>5090.09</td>
<td>3967.38</td>
<td>1331</td>
<td>1300.89</td>
</tr>
<tr>
<td>Cocaine (grams)</td>
<td>6398.1</td>
<td>4269.0</td>
<td>9518.5</td>
<td>21144.0</td>
<td>16005.0</td>
<td>4234.7</td>
<td>5354.77</td>
<td>142860</td>
<td>3613.4</td>
</tr>
<tr>
<td>Cannabis resin (grams)</td>
<td>19662.8</td>
<td>44987.3</td>
<td>2271.1</td>
<td>23410.0</td>
<td>23420.0</td>
<td>42771.33</td>
<td>89497.21</td>
<td>16460</td>
<td>535.33</td>
</tr>
<tr>
<td>Cannabis grass (grams)</td>
<td>1886.6</td>
<td>2862.9</td>
<td>48.6</td>
<td>160.0</td>
<td>458000.0</td>
<td>755.45</td>
<td>1510.515</td>
<td>2785</td>
<td>9738.9</td>
</tr>
<tr>
<td>Cannabis seeds (num.)</td>
<td>0.0</td>
<td>0.0</td>
<td>183.0</td>
<td>0.0</td>
<td>0.0</td>
<td>160.0</td>
<td>0</td>
<td>73</td>
<td>54</td>
</tr>
<tr>
<td>Cannabis plants (num)</td>
<td>3.0</td>
<td>39.0</td>
<td>79.0</td>
<td>11.0</td>
<td>6.0</td>
<td>27</td>
<td>44</td>
<td>46</td>
<td>27</td>
</tr>
<tr>
<td>LSD (microdots)</td>
<td>3.0</td>
<td>0.0</td>
<td>8.0</td>
<td>0.0</td>
<td>0.0</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Ecstasy (tablets)</td>
<td>17273.0</td>
<td>16479.0</td>
<td>30259.5</td>
<td>13677.0</td>
<td>21682.0</td>
<td>16400</td>
<td>2171</td>
<td>1080</td>
<td>30374.5</td>
</tr>
<tr>
<td>Amphetamines (grams)</td>
<td>1000.0</td>
<td>0</td>
<td>0.4</td>
<td>50.0</td>
<td>10.0</td>
<td>1.6</td>
<td>0.5</td>
<td>20.19</td>
<td>5</td>
</tr>
<tr>
<td>Mcpp (tablets)</td>
<td>0.0</td>
<td>50533.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Khat (grams)</td>
<td>0.0</td>
<td>11812.3</td>
<td>200.0</td>
<td>0.0</td>
<td>0.0</td>
<td>423030</td>
<td>1401000</td>
<td>1197000</td>
<td>1245</td>
</tr>
<tr>
<td>BZP (tablets)</td>
<td>0.0</td>
<td>170.0</td>
<td>62.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BZP (grams)</td>
<td>0.0</td>
<td>9.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 10.1
Source: Police Drug Squad Records 2005 - 2013
### Table 10.2

Source: Police Drug Squad Records 2013

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Cannabis</th>
<th>Heroin</th>
<th>Cocaine</th>
<th>Stimulants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>American</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Czech</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Hungarian</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Italian</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Libyan</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Maltese</td>
<td>19</td>
<td>12</td>
<td>12</td>
<td>15</td>
<td>58</td>
</tr>
<tr>
<td>Nigerian</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Portuguese</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Romanian</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Serbian</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Spanish</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>17</strong></td>
<td><strong>24</strong></td>
<td><strong>15</strong></td>
<td><strong>81</strong></td>
</tr>
</tbody>
</table>

**10.3 Purity and Price**

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

**Purity**

During 2013, the purity levels for Cannabis resin showed another percentage decrease to 6.5% over 2012 (7.5%) and cannabis herb is reported at 6.0% a decrease over the preceding year (7.5%) equalling to 2011. Cocaine purity levels have seen another minimal decrease over 2012 where a marked decrease was noted in that year with 15.5% of purity levels as against the 34.0% in 2011. Heroin showed a percentage increase (21%) when compared to the preceding year where the year 2012 showed a marked decrease in purity with 20.0% when compared to 2011 (30%). Although the mean purity percentages may vary slightly from year to year, it is important to keep in mind that sample sizes also fluctuate from one year to the next, and this factor could influence the mean percentages. Additionally, one
particular sample that has either very high or very low purity could also skew the overall mean of the reporting year.

Table 10.3 shows the mean purity at street level for different drugs for the years 2011, 2012 and 2013.

<table>
<thead>
<tr>
<th>Drug</th>
<th>2011 purity (%)</th>
<th>2012 purity (%)</th>
<th>2013 purity (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis resin</td>
<td>8.0</td>
<td>7.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Cannabis Herb</td>
<td>6.0</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Heroin</td>
<td>30.0</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Cocaine</td>
<td>34.0</td>
<td>15.5</td>
<td>15</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>54.0</td>
<td>54.5</td>
<td>55</td>
</tr>
</tbody>
</table>

Table 10.3
Source: Malta Forensic Science Laboratory Data 2011, 2012 and 2013

**Price**

Table 10.4 shows the mean price at street level for different drugs between 2011 and 2013 as reported by the Malta Police Force. There has been an increase in prices in relation to ecstasy tablets, probably a reflection of the sudden loss of supply due to the amount of seizures which resulted in 2012. Cocaine has seen the lowest prices in 2013 with an average price of Eur.50 when compared with the mean price of Eur.79 in 2012 and to Eur.63.78 in 2011. Heroin has also been subject to a price reduction with Eur.58 for 2013 when compared to Eur.66 in 2012 but still higher than the Eur.55.50 in 2011.

The limitations as regards drug prices are mainly due to the fact that data is limited to one source (reports by police inspectors) and not multiple sources (e.g. reports by persons in treatment, probation officers through their clients,) that can be cross-compared. Additionally, at present, drug prices are collected only once yearly and this method is not extensive or reliable enough to ensure the integrity and reliability of the data. Finally, prices for cannabis, heroin and amphetamine are reported in amounts that are commonly sold at street level and only roughly ‘translated’ into weights per gram.

As an overall note, it is also important to acknowledge that the drug market is sensitive to changes occurring at social and law enforcement levels and that these factors can affect prices, particularly where drug availability is concerned.
### Prices at Street Level for Different Drugs 2011-2013

<table>
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<tr>
<th>Drug</th>
<th>Mean Price (€) 2011</th>
<th>Mean Price (€) 2012</th>
<th>Mean Price (€) 2013</th>
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<tr>
<td>Cannabis resin</td>
<td>17.85</td>
<td>24</td>
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<tr>
<td>Cannabis herb</td>
<td>23.32</td>
<td>25</td>
<td>25</td>
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<tr>
<td>Cocaine</td>
<td>63.78</td>
<td>79</td>
<td>50</td>
</tr>
<tr>
<td>Heroin</td>
<td>55.50</td>
<td>66</td>
<td>58</td>
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<tr>
<td>Ecstasy</td>
<td>6.65</td>
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<td>24</td>
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PART B

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ANNEXES
ABBREVIATIONS

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