UNIVERSITY MENTAL HEALTH RESEARCH INSTITUTE

Report to the EMCDDA by the Reitox National Focal Point of Greece

Drug Situation 2002

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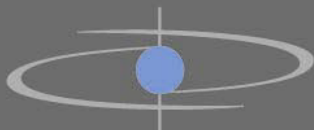

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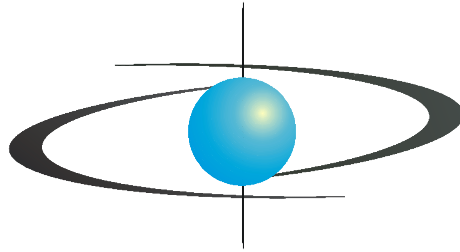

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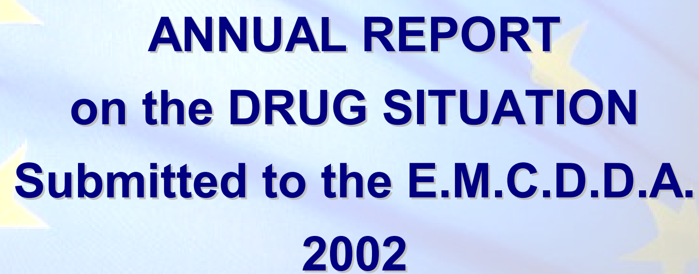

ANNUAL REPORT on the DRUG SITUATION Submitted to the E.M.C.D.D.A. 2002

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SUMMARY

MAIN TRENDS AND DEVELOPMENTS

SUMMARY

Undoubtedly the most important development in 2001 was the launching of the Greek National Action Plan, based on two main axes: reduction of demand and reduction of supply. The Action Plan includes, to a certain extent, provisions for the most important problems and gaps concerning drugs in Greece, as well as for the monitoring of its implementation and its evaluation.

The National Action Plan also promotes integration of demand and supply reduction interventions. A case in point is the establishment of the Local Councils for the Prevention of Crime, where all key agents of the local communities, including the Police, co-operate in a global approach against crime in general and drugs in particular.

The estimated number of problematic users in Greece, in 2001, was 25,430. Approximately a quarter of them (6,500) contacted the different agencies. Of those, around 2,500 were in treatment in the end of the year (December 2001). Taking into account that almost all of the therapeutic centres operate beyond capacity, it is clear that the establishment of new facilities is an urgent need.

The introduction of buprenorphine in OKANA substitution programmes and the recently launched pilot implementation of buprenorphine administration in public hospitals are also new key developments. These measures are expected to relieve a large number of dependent individuals who have been on the waiting lists of substitution programmes for many years.

On the contrary, criminal justice data, particularly prison data, do not leave room for optimism. The number of individuals imprisoned for drug related offences is increasing and demand reduction interventions remain fragmentary, although drug availability, intravenous use and needle sharing are quite prevalent. It should be recognised that health monitoring of prisoners is gradually being systematised and this is expected to at least slow down the spread of infectious diseases. Very recently, in 2002, the inauguration of a Detoxification Correctional Centre for Drug Dependent Prisoners has also been a major development.

Primary prevention is reinforced with new large-scale programmes. The National Network of Health Education established by the Ministry of Education, as well as the new interventions implemented in schools by the Pedagogical Institute, are quite promising for a better co-ordination of primary school prevention actions.

Social exclusion, at present, can mostly be approached theoretically in Greece. The lack of quantitative data on the different socially excluded groups, such as immigrants, repatriated individuals and minorities, makes even the definition of the problem as such difficult. Nevertheless, social exclusion appears to be the resultant of economic, social and educational factors.

A first attempt to track down demand reduction expenditures arrived at a clear identification of the problems in the area. Since the National Action Plan provides for central co-ordination of drug financing, cost assessment is bound to improve in the near future.

PART I

NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORK

1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field

The first official Greek National Action Plan was adopted by Cabinet in December 2001. It has a five-year duration, from 2002 until 2006, and was prepared by the Ministry of Health with the co-operation of 9 relevant Ministries and the Greek Organisation Against Drugs (OKANA) (Ministry of Health and Welfare, 2001).

Action is based on two main pillars:

- Reduction of demand for drugs, i.e. (primary, secondary, tertiary) prevention
- Reduction of supply, i.e. repression

Moreover, action is based on three main principles:

- Complementary and co-ordinated action of all relevant authorities
- Interaction between measures taken by the State and initiatives taken by the civil society.
- Reconfirmation of therapeutic pluralism by the State so as for every treatment need to be appropriately met.

The targets set by the national action plan are:

- Development of infrastructure and prevention programmes so as to cover the total Greek population. Within this framework, a higher degree of vigilance/preparedness, increased public awareness of and information on problems associated to addiction are also pursued.
- Development of infrastructure and all types of treatment programmes so as to secure unimpeded access for all interested users throughout the country
- Reduction of harm caused by the use of addictive substances
- Decrease of drug use prevalence especially among users under 18 years old
- Reversal of the observed upward trend of acute deaths caused by drugs
- Decrease in number of drug related crimes
- Decrease in the available quantities of illicit drugs.

1.1.1 Co-ordination bodies

Ten (10) ministries are involved in policy-making and implementation according to Prime Minister's decision Y 876/22.10.2001. More specifically, the aforementioned decision provides for the establishment of an Interministerial Committee, co-ordinated by the Prime Minister, responsible for co-ordinating and monitoring the implementation of the 5-year national action plan and for determining and allocating the resources needed (see also **1.2 Legal framework**). The Interministerial Committee will eventually be replaced by OKANA as soon as it will start functioning according to a by-law. A draft proposal of OKANA by-law has already been prepared and submitted for

approval to the Ministry of Health since October 2001. Meanwhile, efforts were made by the government to reinforce the autonomy and flexibility of OKANA by virtue of Law 2955/2001. Thus, the decrease in the number of members of OKANA Management Board (now: 7, previously: 15) is considered to be a step that will enhance its flexibility, whereas the envisaged establishment of an Interministerial Co-ordination Committee within OKANA, consisting of the Heads of "drug relevant" sections of the co-competent ministries, is considered to be a further contribution to the autonomy of OKANA. This Committee has not been set up yet, since not all co-competent Ministries have created relevant sections yet.

Ministries involved in drug policy implementation

In regard to drug demand reduction

Ministry of Health and Welfare
Ministry of the Interior
Ministry of Defence
Ministry of Labour and Social Affairs
Ministry of Education and Religious Affairs
Ministry of Culture

In regard to drug supply reduction

Ministry of Justice
Ministry of Public Order
Ministry of Merchant Marine
Ministry of Finance

1.1.2 Priorities and developments at national level

Demand reduction

Priorities set in the NAP	Developments during the last year
Proliferation of OKANA Local Prevention Centres so as to cover every Greek prefecture	Total number of Prevention Centres (October 2002): 62
Financial support to local governments in order for them to subsidise Prevention Centres	A total sum of € 5,459,428 was allocated by the Ministry of the Interior to 49 local governments in 2001. For 2002 the respective sum was € 1,928,200 allocated to 57 local governments in accordance with the 39910/30-09-2002 Decree of the Minister of the Interior.

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Priorities set in the NAP	Developments during the last year
Expansion of the National Network of Health Education to primary education	One person responsible for Health Promotion in primary education was appointed by the Ministry of Education in each Prefecture.
Systematisation of prevention activities in the army	A memorandum of co-operation was signed by the Ministry of Defence and OKANA in June 2002 aiming at the systematisation of prevention activities in all national forces.
Awareness raising of coaches and other sports professionals about drug use risks	In September 2002 the Parliament passed a bill that includes a special chapter on "Combating Doping" in sports activities, whereby the use of specific categories of substances (i.e. stimulants, narcotics, anabolics etc.) is totally prohibited. A joint decree by the Ministers of Culture and Health shall be issued every year to update the list of prohibited substances.
Proliferation of therapeutic programmes and units	Total number: 31 treatment programmes/units throughout Greece.
Provisions for the expansion of substitution therapy in public general hospitals	Two public general hospitals are interested in hosting structures for the administration of substitutes. The relevant health professionals will soon attend a training programme to this effect. Moreover, a recent Decree by the Minister of Health (102480/18-10-2002) provides for the pilot administration of buprenorphine in public general hospitals under OKANA supervision.

Supply reduction

- Emphasis is placed on further strengthening current law enforcement initiatives (Police, Coast Guard, Financial and Economic Crime Office)
- Enhancement of central law enforcement co-ordination –exercised by the Central Anti-Drug Co-ordination Unit- through the elaboration of a joint action plan

Institutional framework

- Integration of Greek legislation on drugs. A Committee within the Ministry of Justice is working in this direction.
- Establishment of directorates or offices responsible exclusively for the implementation of the National Action Plan in every involved Ministry. So far only 4 out of the 10 co-competent Ministries have established such directorates or offices.
- A separate Pay Office for financing drug activities to be enacted during 2002. No further progress as yet.
- An Institute specialised in substance addiction to be established by the end of 2002 and become fully operational in three years' time. No further progress as yet.

1.2 Legal framework

A short description of recently enacted laws and ministerial decrees is presented below.

Prime Minister's decision 876/ 22.10.2001

An Interministerial Committee co-ordinated by the Prime Minister and consisting of the Ministers of 10 relevant Ministries has been established in regard to the National Action Plan. It consists of the Ministers of Health and Welfare (chairing the Committee), Interior, Defence, Labour and Social Affairs, Education and Religious Affairs, Culture, Justice, Public Order, Merchant Marine and Finance. The Committee is mandated to elaborate a five-year National Action Plan, to co-ordinate the authorities involved, to monitor the implementation of the action plan and to determine the resources that need to be allocated for the development of planned activities.

Joint Ministerial Decree by the Ministers of the Interior and of Health and Welfare 22284/28-2-2002.

In order to encourage the professional rehabilitation of former users who voluntarily approached and completed a therapeutic programme, this decree provides that those can be employed in OKANA under a non-fixed-term contract after a 2-year probational employment period.

Decree of the Minister of Labour 30339/10-4-2002

This ministerial decree is issued every year and provides for subsidies to employers who employ former drug addicts for four years, as well as to former drug addicts who plan to establish their own enterprises.

Decree of the Minister of Health and Welfare 100847/ 14-10-2002

This decree provides for the establishment of a common operational framework for OKANA substitution programmes. Moreover, it approves the administration of buprenorphine in OKANA substitution programmes after the successful completion of the pilot phase.

Decree of the Minister of Health and Welfare 102480/ 18-10-2002

This decree authorises OKANA to start the implementation of a pilot programme of buprenorphine administration to opiate-addicted users in public general hospitals. The conditions of administration shall be detailed after the evaluation of the pilot phase.

Decree of the Minister of the Interior, Public Administration and Decentralisation 39910/30-09-2002

This decree provides for the allocation of € 1,928,200 to 57 local governments throughout Greece for the implementation of primary prevention programs by OKANA Prevention Centres.

New substances subject to control in the reporting year

- DRONABINOL (Delta-9-tetrahydrocannabinol) was classified under Table B of Law 1729/1987 according to the 41040/19.11.2001 Ministerial Decree.
- NALBUPHINE (17-cyclobutylmethyl-7,8-dihydro-14-hydroxy-17-normorphine) was reclassified under Table C of Law 1729/1987 instead of Table D according to the 41040/19.11.2001 Ministerial Decree.

1.3 Law implementation

As already mentioned in the previous report, OKANA had set up a Standing Committee in 2001 in order to draft a proposal on the integration of the existing legislation on drugs. The Standing Committee completed its task and, in January 2002, forwarded its final proposal to the relevant joint Committee of the Ministries of Justice and of Health and Welfare. The official classification of drug laws will facilitate a uniform judicial treatment of all drug offences and offenders, which was previously hindered mainly due to overlaps and gaps in the legislation in force.

The current prosecution policy strictly follows the existing legislation, which provides for criminal sanctions to offenders, although it distinguishes between addicted and non-addicted ones. Simple consumption of drugs constitutes an

offence. As a rule, addicted users arrested for possession for personal use went unpunished, since until recently no detoxification units were established in prisons (according to law 1729/1987 offenders are obliged to join such units). However, in September 2002, the first detoxification correctional facility for drug-dependent prisoners was inaugurated in Thiva (Central Greece). For the time being, the treatment programmes implemented there are drug-free and capacity is limited. Thus, the participants are selected among drug addicts who are already imprisoned. Referrals from Courts may also be made in the future, but only for those who chose to attend the program on their own free will.

1.4 Developments in public attitudes and debates

1.4.1 Public perception of drug issues

The most recent findings on attitudes towards drugs (especially cannabis and heroin) and their consumption come from the two nation-wide surveys on the general and the school populations, carried out in 1998 by the University Mental Health Research Institute. Those findings have been already extensively discussed in previous reports. For the reporting year they are considered to be old and non-representative of the current situation. Both surveys will be repeated during 2003 and the findings will be thoroughly presented in future reports.

1.4.2 Public and political debates

The law proposal submitted by 5 Members of Parliament in April 2001 (see also Greek National Report 2001) triggered a wide political debate focused mainly on the distinction between cannabis and other drugs as well as on the decriminalisation of drug use. The vast majority of both politicians and scientists held their reservations about the prospect of a legal distinction between soft and hard drugs, arguing that such a distinction underestimates the psychological dimension of addiction.

Moreover, decriminalisation of drug use -although not included in the aforementioned law proposal- led to confusion as to whether “decriminalisation of drug use” is synonymous to “legalisation of drug use”, a difference that the lay public and the non-jurists seemed to ignore. This was also the reason why the discussion on decriminalisation began, although such provisions were not included in the law proposal. In short, it was argued that sanctions for drug users, and especially addicted drug users, were already too lenient and non-enforceable in the case of first-time or addicted offenders. However, it was repeatedly argued that the lack of provisions for administrative sanctions against drug use constitutes a legal gap in the national correctional system.

Another controversial point included in the above law proposal were the provisions for state controlled administration of drugs to addicted users in special medical centres. The main counter-argument was that such policies were implemented in countries (Switzerland, the Netherlands, and Germany)

with different lifestyles and conditions, where treatment facilities already covered almost 70% of drug addicts. In Greece such a policy seems premature, since it is estimated that only 10% of drug addicts are covered by the existing treatment programmes (Kokkevi, 2002). The law proposal of the 5 MPs was rejected in whole by the Parliament in May 2002.

1.4.3 Media presentation

The most recent known analysis on media presentation of drugs and drug use was carried out in 2000 by the Psychiatric Hospital of Attica in co-operation with the **World Association for Psychosocial Rehabilitation (WAPR),** using both qualitative and quantitative tools in order to record the way in which addiction and addicted users were presented by the press. A total number of 1422 press articles on mental health and drugs published in 1999 were collected and analysed.

The findings –also presented in the previous report- were as follows:

- The media present the problem of drug addiction without any special focus on scientific evidence, mainly due to the fact that they are addressed to the lay public.
- Even experts' opinions reported by journalists are partially presented.
- The concepts of "use", "abuse" and "addiction" are not thoroughly clarified and this quite often results to confusion.
- Statistical data and research findings are also presented in such a way that false generalisations seem at times inevitable.
- Those most often adopting a public stance on the issue through the press are politicians, who often get more media coverage; they tend to focus on the legal and political dimensions of the problem.

1.5 Budgets and funding arrangements

As already repeatedly ascertained in previous years, there are difficulties in separating drugs budgets from the overall funds for law enforcement agencies. Given the fact that the manpower of prosecution authorities –on which data are available- has remained more or less the same and that the lack of other relevant financial data cannot be easily overcome, the Greek Focal Point has confined itself to presenting available data on the 2001 State budget - particularly on the credit lines of the Ministry of Health for agencies working in the demand reduction field. Moreover, the allocation of OKANA funds for the year 2001 is also presented in Table 1.

State Budget for demand reduction agencies for the year 2001[1]

- OKANA: 11,730,000 €

[1] According to the credit lines of the Ministry of Health and Welfare

- KETHEA: 9,332,355 €
- Attica State Psychiatric Hospital – Treatment programme "18 ANO": 512,100
- Thessaloniki State Psychiatric Hospital – Drug Dependence Treatment Unit: 99,800 €

For the reporting year a total amount of € 5,459,428 was distributed by the Ministry of the Interior to 49 local governments for financial support to Prevention Centres.

Allocation of OKANA funds for the year 2001

According to law 2161/1993, OKANA is the central co-ordination interministerial body in the field of drug demand reduction. At the same time, it is also responsible for studying the phenomenon of drugs on a national scale and for implementing drug demand reduction policy at all levels of prevention. The table below presents the allocation of OKANA funds according to its annual financial report. (OKANA, 2002)

Table 1: Allocation of OKANA funds for the year 2001

ACTIVITIES	EXPENSES (€)
Prevention	**3,474,688**
Prevention Centres (54 Centres)	2,468,085
Education & Support	619,222
Salaries for the Primary Prevention & Education Department	199,560
Housing and operational expenses	187,821
Treatment (Secondary Prevention)	**6,462,216**
Substitution Programme (5 Units)	4,751,284
Drug-free therapeutic programme in Patras	387,381
Help Centre	1,323,551
Rehabilitation	**610,418**
Social Rehabilitation Unit	275,862
Vocational Training Centre	334,556
Central Administration	**2,019,971**
TOTAL	**12,567,293**

PART II

EPIDEMIOLOGICAL SITUATION

2. PREVALENCE PATTERNS AND DEVELOPMENTS IN DRUG USE

2.1 Main developments and emerging trends

Since the latest general population survey was conducted in Greece in 1998, there are no recent epidemiological data from direct indicators.

Stability in the drug situation is generally evidenced by indirect indicators.

The shift from intravenous use to safer modes of administration, observed last year, continues. The same holds true for the rate of increase of drug related deaths, which has further slowed down.

The efforts of the Focal Point to improve the quality of data collected have been particularly successful this year. The two major improvements were:

a) enrichment of the TDI network with the addition of the two major therapeutic centres, KETHEA and 18 ANO, which will provide individual data in 2003; the indicator will thus reach around 90% coverage of users seeking treatment, and

b) estimation of the prevalence of problem drug use in the population made possible by the collaboration with these centres.

2.2 Drug use in the population

Findings from the latest nation-wide epidemiological surveys, conducted in 1998, have been presented and discussed in previous Greek National Reports.

A brief summary of these findings is presented in **Chapter 6: Trends per drug.**

Moreover, prevalence among young people, on the basis of data from past and recent small scale surveys is discussed in **Chapter 15: Drug and Alcohol use among young people aged 12-18.**

2.3 Problem drug use

Following the resumption of participation of KETHEA, discussed in the TDI chapter, the FP was able to produce estimates from the present time onwards. The estimates presented here are in fact based entirely on the Treatment Demands database. One would expect to obtain more reliable estimates by combining different sources of data; thus the fact that the police have implemented a new computerised system for their records, which may one day make it possible to obtain good data on arrests for drug offences and drug-related deaths, is an immensely important development. Nevertheless, until this, or an alternative source of data, does actually become available, the quality of our estimates is severely restricted.

Capture-recapture estimates. If n_1 drug users are identified in source 1 (KETHEA only) and n_2 in source 2 (Focal Point TDI data without KETHEA), while m appear in both sources, an estimate of the total population size -including drug users who appear in neither source- is given by the expression n_1n_2 /m. An assumption behind this method is that the two sources are independent. Unfortunately this assumption cannot be tested, therefore two-sample capture-recapture estimates are regarded as unreliable.

Table 2 presents data drawn from capture-recapture calculations on the Focal Point and KETHEA TDI databases for 2001. If KETHEA has a different clientele from other services, with a different geographical distribution, the degree of dependence between the sources may not be very severe, so that the estimate of about 25,500 problem drug users obtained in this way should be closer to the truth. (However, the wide 95% confidence interval –from 20,000 to 30,000– reminds us that the statistical error is large even if the assumptions of the method are satisfied.) Table 2 also presents more detailed estimates, breaking down the population by sex, age and location, as well as by primary substance. Every one of these is subject to the methodological limitation described above.

The overall figure of about 25,500 users represents a rate of 2.33 per thousand population (95% confidence interval from 1.98 to 2.69), or 3.69 per thousand population in the age range 15-64 (95% c.i. 3.05-4.15). The term “user” is to be understood as meaning someone whose drug problem is severe enough to cause him or her to approach a treatment service.

Table 2: Two-sample capture-recapture estimates of numbers of problematic drug users

		Users of all drugs		**Heroin users[1]**	
		Seen	*Estimated total[2]*	*Seen*	*Estimated total*
Total	(15-64)	3673	25430 (21580-29290)	3173	20080 (16990-23180)
Sex	Male	3106	20710 (17380-24050)	2690	16420 (13730-19110)
	Female	567	4990 (2755-7220)	483	3870 (2100-5650)
Age	15-24	1651	9950 (7760-12140)	1389	7420 (5790-9050)
	25-34	1219	6730 (5190-8280)	1089	5990 (4540-7430)
	35-64	803	5440 (3050-7830)	695	4210 (2380-6030)

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		Users of all drugs		Heroin users[1]	
		Seen	*Estimated total*[2]	*Seen*	*Estimated total*
Place	Athens	2305	16170 (13040-19300)	1952	11950 (9640-14260)
	Elsewhere	1368	9190 (6950-11430)	1221	8060 (6000-10120)

[1] Main drug heroin
[2] Includes users seen at the treatment services and the estimated number of unseen users; 95% confidence interval in parentheses

SOURCE: Greek REITOX Focal Point, 2002.

As shown in Table 2, the problematic heroin users in Greece are slightly over 20,000. Most of them are males, living in Athens, aged over 24.

3. Health Consequences

3.1 Drug Treatment Demand

Not only has the inclusion of KETHEA in the TDI network doubled the size of the population, it has also changed its characteristics, as young users and users in drug-free programmes are increasingly represented in the figures. Therefore, the 2001 data are not comparable with those in previous years.

As recorded by the Treatment Demand Indicator, user population seeking treatment in 2001 rose to 3,679 people, including 2,479 (67,4%) from drug-free programmes, 519 (14,1%) from substitution programmes, and 681 (18,5%) from low-threshold centres.

3.1.1 Socio-demographic characteristics of users in 2001

The socio-demographic characteristics of users who sought treatment in 2001 are described in Figure 1:

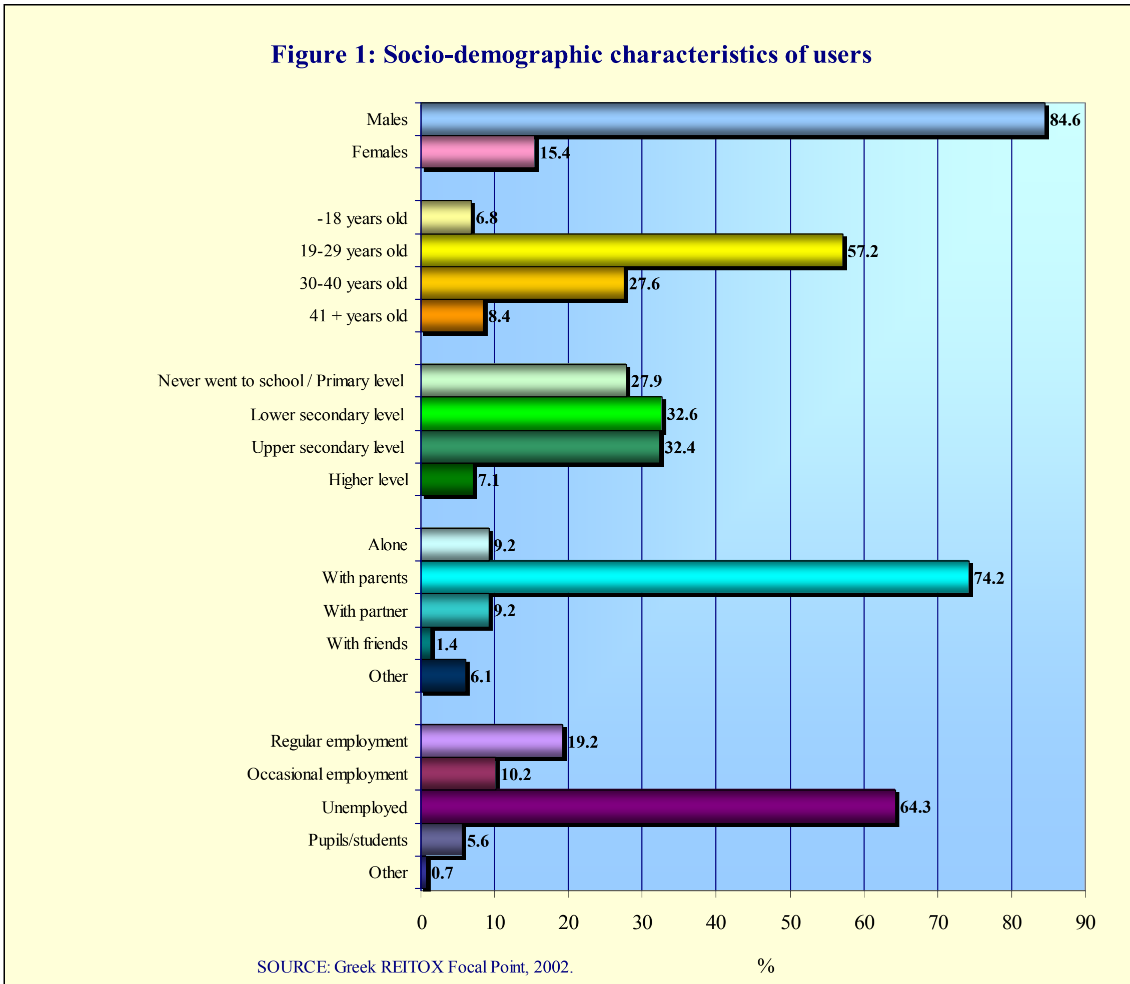


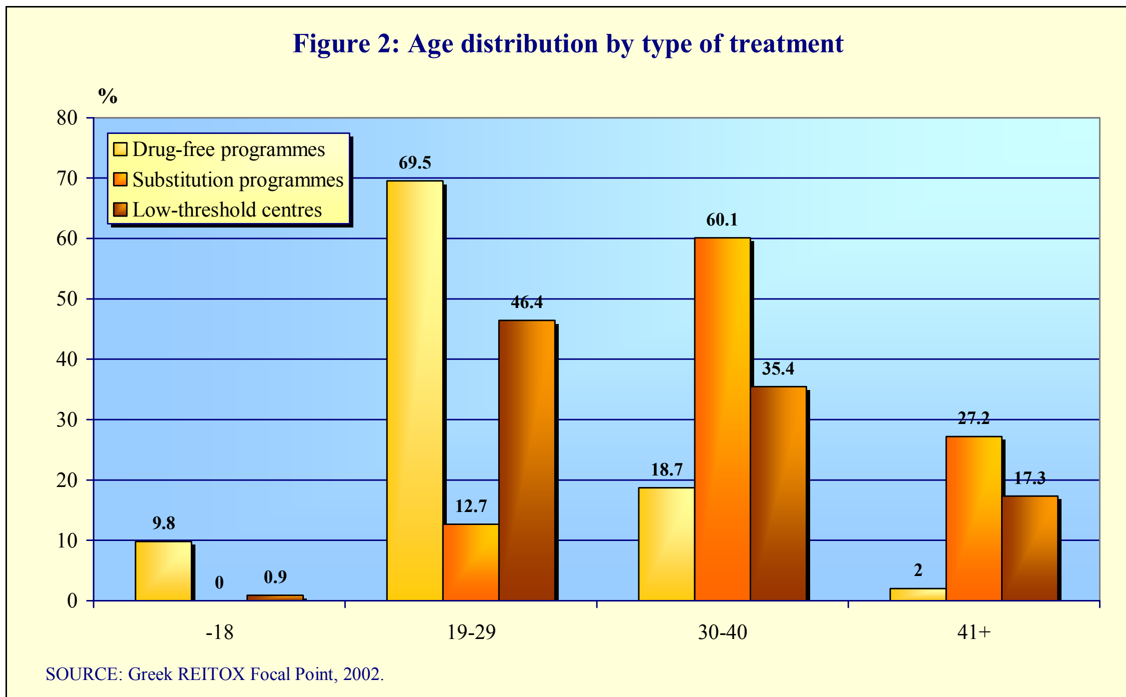
Figure 1: Socio-demographic characteristics of users

SOURCE: Greek REITOX Focal Point, 2002.

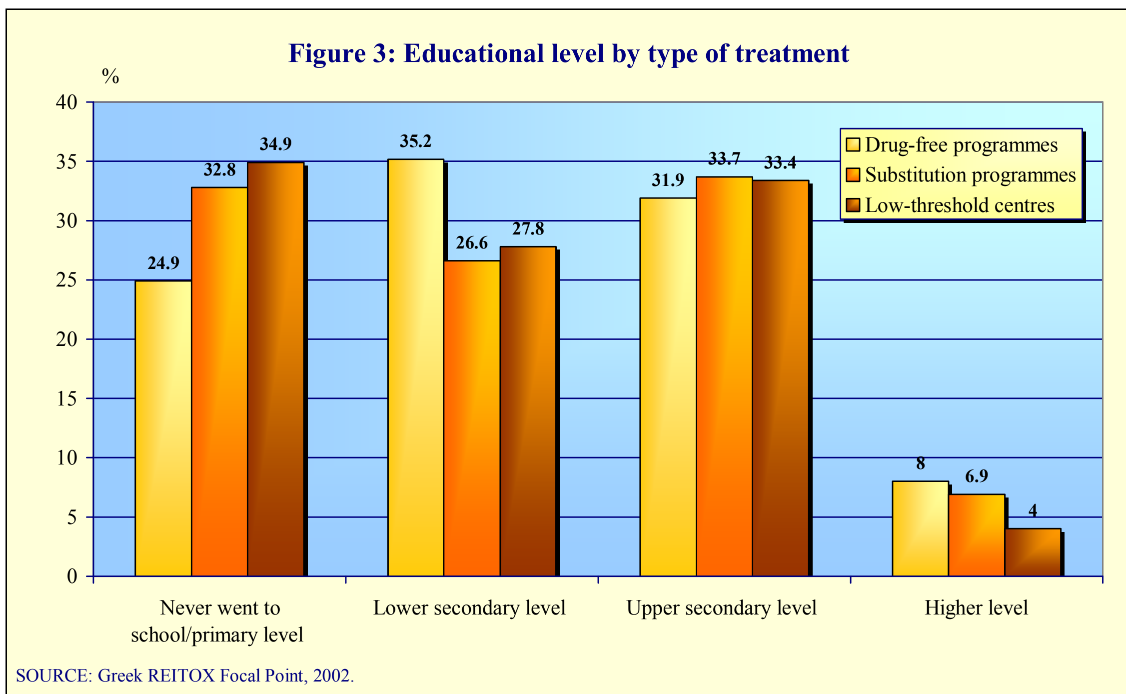
3.1.2 User characteristics by centre type

Socio-demographic characteristics

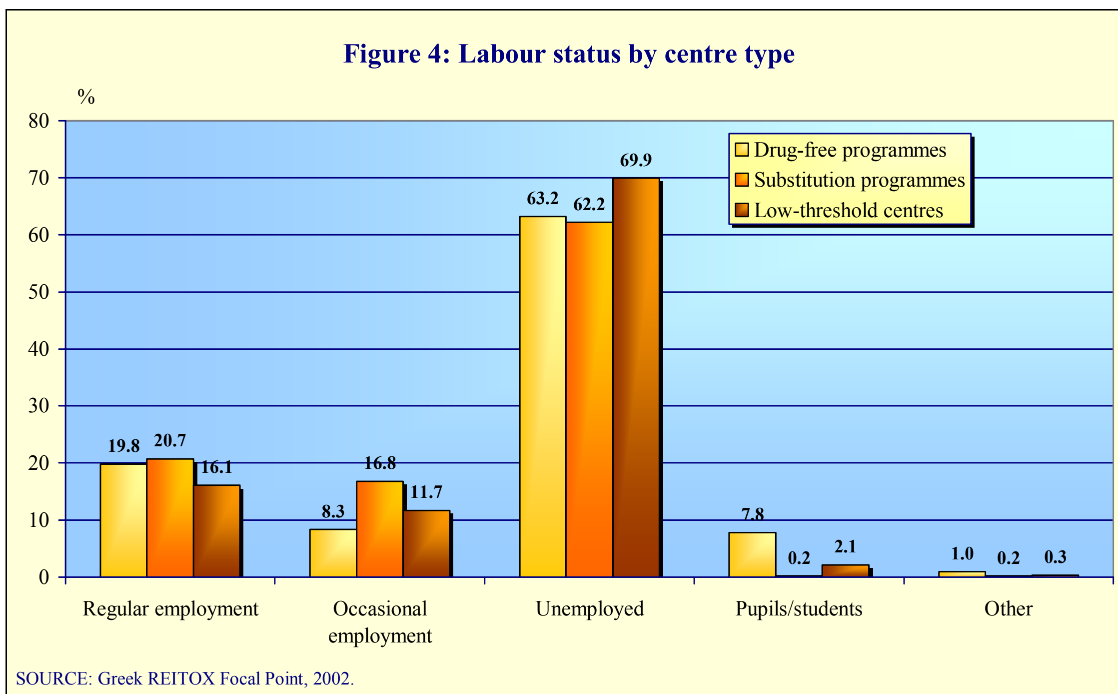
- Drug-free programmes/Other sources (small drug-free units, not officially licensed yet, accounting for 2.7% of the TDI population) account for more men than women (68.4% and 61.7% respectively), and substitution programmes for more women than men (16% and 13.8% respectively). This is also the case with low-threshold centres (22.2% and 17.8% respectively). Selection criteria come into play in substitution programme data on admissions, according to which mothers, pregnant women and user wives are given priority.
- Adolescent users mainly attend drug-free programmes/other sources, including the 'STROFI' treatment programme for adolescents. Young adults mainly attend drug-free programmes/other sources, as well as low-threshold centres. Older people mainly attend substitution programmes, where age is an admission criterion (Figure 2).



- Users who have had no or little schooling tend to address more substitution programmes and low-threshold centres than drug-free programmes/other sources, whereas lower secondary graduates are mainly in drug-free programmes/other sources (Figure 3). About 1/3 of users from all three centre types are upper secondary graduates.



- Most of the users from all centre types are unemployed (Figure 4). However, the largest share of unemployed users is found in low-threshold centres (69.9%); higher education students address drug-free programmes/other sources (7.8%), because they implement special programmes targeted to adolescents and young adults.



Substance use

- Most users report cannabis as the **substance of onset of illicit use** (74.7%), while 8.7% report having started with hypnotics and sedatives, and 6.9% with opiates. The substance of onset of illicit use changes according to centre type (the largest share of cannabis users (78.8%) is found in drug-free programmes; for sedatives-hypnotics (18.1%) and for opiates (13.1%) in substitution centres) and according to age, as shown in Table 3, which includes only those substances for which preference varies considerably among the four age groups.

Table 3: Substance of onset of illegal use by age group

	Age			
Substance of onset of use	*-18* (N=249)	*19-29* (N=2078)	*30-40* (N=1003)	*41+* (N=307)
Heroin/other opiates	2.0%	4.9%	10.1%	14.3%
Inhalants	12.0%	5.2%	1.6%	0%

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	Age			
Substance of onset of use	*-18* (N=249)	*19-29* (N=2078)	*30-40* (N=1003)	*41+* (N=307)
Sedatives and Hypnotics	2.8%	6.3%	13.3%	15.3%
Cannabis	83.1%	79.1%	66.2%	65.5%
Anticholinergic/ Antiparsonic	0%	2.3%	5.9%	3.3%

SOURCE: Greek REITOX Focal Point, 2002.

- The general mean age of onset of illicit substance use is 16 years; 19 for heroin, 16 for cannabis, 15 for hypnotics and sedatives and as early as 13 for inhalants.
- Although most users try cannabis first as an illegal substance, what they seek treatment for is heroin. Out of those who approach drug-free programmes/ other sources, 86.9% seek help for problems related to heroin, 9.7% report cannabis as **their primary drug**, 1.4% hypnotics and sedatives, and only 1.1% report cocaine. In low-threshold centres, 77.7% report using heroin as their primary drug, 14.7% methadone (participating in the substitution programme), 4% cannabis, and 2.2% hypnotics and sedatives.
- The age of onset of use of the primary drug varies according to the drug: 20 years for heroin, 19 for hypnotics and sedatives, and 16 for cannabis. The average age of onset of use of the primary drug is 20 years for men and 19 for women.

The cross-tabulation of main substance of abuse by sex, age, education and labour status shows whether abusers of different substances differ with regard to the above variables. Although sample sizes differ a lot among different substance user groups (3.185 for heroin, 30 for cocaine, 50 for hypnotics and sedatives, 266 for cannabis and 128 for other substances), the main points to note are the following:

- Although for all substances men outnumber women, it seems that this is more the case with cannabis users. However, this gap narrows among cocaine and other drug users, where the largest shares of women abusers are observed.
- Moreover, although most cannabis users (47%) are 19-29 years old, cannabis is abused by adolescents far more than any other substance, whereas older people (30+) abuse “other drugs” more than any other listed substance.
- When comparing the educational level of each different group of users with all the others, results show that cannabis users are more educated than the others, i.e. they are high school graduates. This is in accordance with the

findings presented above: users seeking help for cannabis are mostly young people who seem to prefer drug-free programmes. Furthermore, drug-free programs are attended mostly by high school graduates (Figure 3)

- Finally, the highest unemployment rate is observed among sedatives/hypnotics users. This is also significantly higher for heroin/opiate users than for users of other drugs. Again this finding is supported by previous analyses of user socio-demographic characteristics.

Secondary substance of use

- Men tend to use cannabis as a **secondary substance of use** more than women (56.5% as opposed to 46.8%). With hypnotics and sedatives the opposite trend is observed (50.4% as opposed to 58.1%). There is no gender difference with respect to cocaine.
- Secondary drug use varies according to the age group, as shown in Table 4.

Table 4: Secondary substance of use by age group

	Age			
Secondary substance of use*	*-18* (N=165)	*19-29* (N=1534)	*30-40* (N=759)	*41+* (N=210)
Heroin/other opiates	10.3%	7.4%	6.6%	6.2%
Cocaine	7.3%	18.4%	22.5%	29.0%
Sedatives and hypnotics	57.6%	49.7%	53.5%	54.3%
Cannabis	47.3%	57.8%	52.7%	48.1%
Anticholinergic/ Antiparsonic	22.4%	3.7%	1.3%	1.4%

* Two secondary substances are included

SOURCE: Greek REITOX Focal Point, 2002.

High-risk behaviour

- The overwhelming majority of users who sought treatment in 2001 **had injected** at least once in their lifetime (73.5% in drug-free programmes/other sources, 97.5% in substitution programmes, and 87.4% in low-threshold centres). More than half had done so in the last 30 days (50.1% in drug-free programmes/other sources, 60.3% in substitution programmes, and 53.7% in low-threshold centres). The largest share of intravenous users is found in substitution programmes, since intravenous use is an admission criterion.

- There is a gender difference with regard to intravenous use in the last 30 days: the percentages are 53.8% for men and 44% for women. There is no significant gender difference as to lifetime intravenous use.
- Adults are the main age group injecting in the last 30 days or in their lifetime.
- According to TDI data, users who injected in the last 30 days differ from the rest as to their schooling level (Figure 5). Out of those who injected in the last 30 days, 31.5% have had no / little schooling or are primary school graduates, whereas the respective rate for those who did not inject in the last 30 days is 24%. Similarly, there is a significant difference between intravenous users who are higher education graduates (5.5%), and their non-intravenous peers (9%).

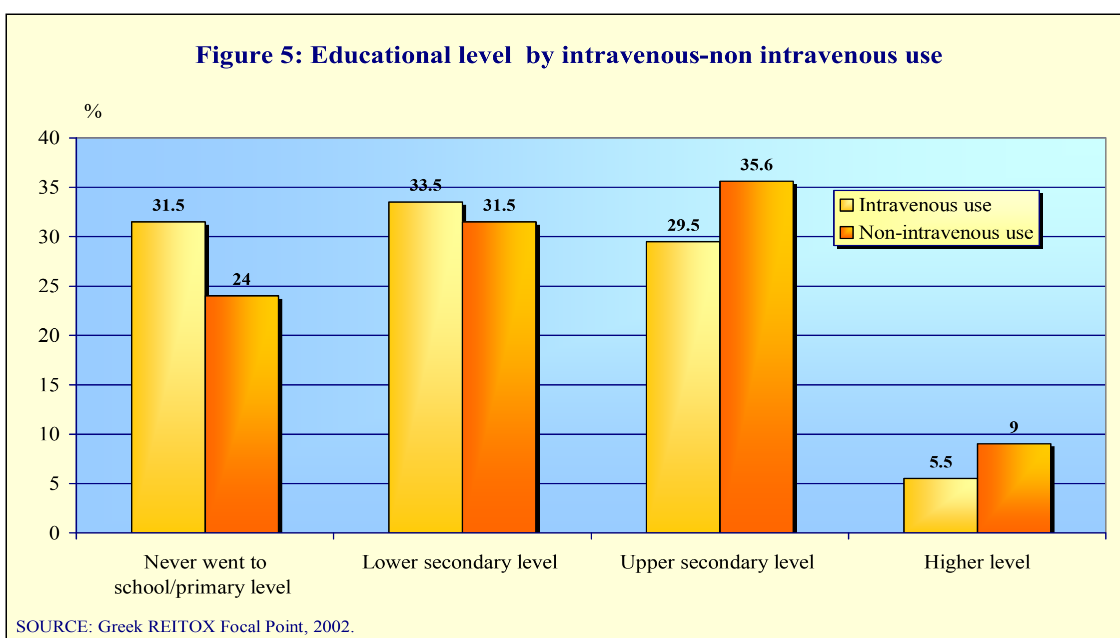


Figure 5: Educational level by intravenous-non intravenous use

SOURCE: Greek REITOX Focal Point, 2002.

- The mean age of the first intravenous use is 21 years.
- More than half of intravenous users (56%) has **shared needles**, and this goes for all centre types. As to needle sharing in the last 30 days prior to their seeking treatment, clients of drug-free programme/other sources come first (33.5%), followed by substitution programme clients (16.3%), and low-threshold centre clients (24.7%).
- More women than men tend to share needles in the last 30 days (37.7% as opposed to 27.7%), and this is also true for lifetime needle sharing (61.1% of women as opposed to 55.1% of men).
- More adolescents and young adults tend to share needles in the last 30 days than older adults. This trend is reversed for lifetime needle sharing with 52.9% of adolescents and 53.8% of young adults, 58.5% of those aged 30-40, and 61.5% of those aged over 41.

3.2 Drug-related mortality

The Greek Focal Point collects data on drug-related deaths from the Third Section of Drugs of the Public Security Directorate of the Hellenic Police. These data are

based on the results of forensic tests and toxicological analyses conducted by the competent authorities (University Forensic and Toxicological Laboratories, and the Forensic Services of the Ministry of Justice) in cases of sudden drug-related deaths.

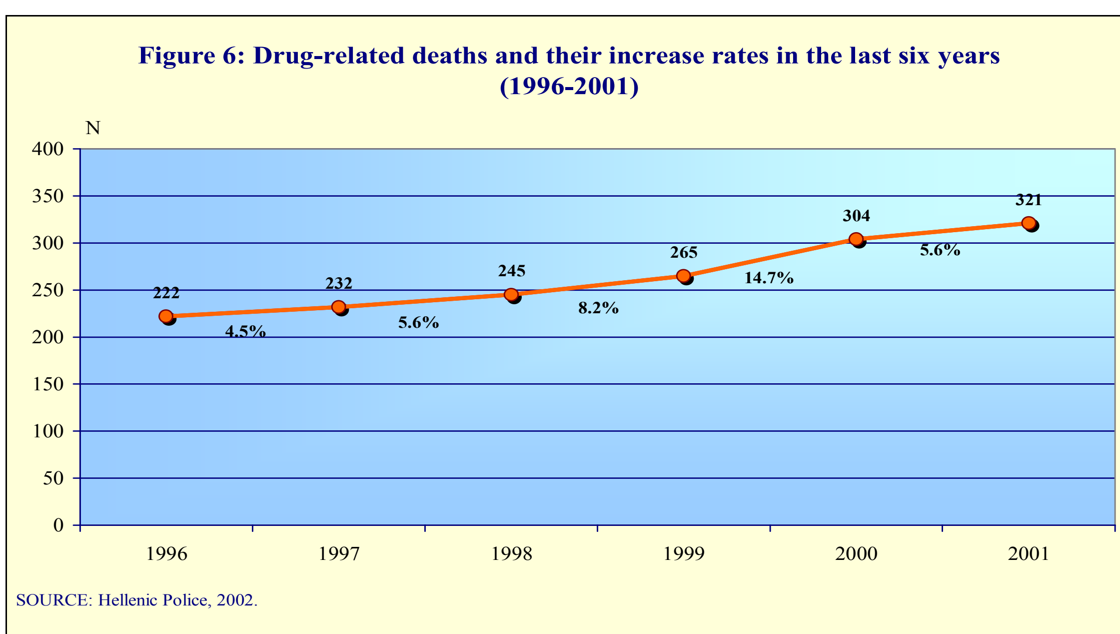
The above do not include deaths indirectly caused by drugs. For instance, they do not include deaths because of infections caused by intravenous use, or violent deaths such as road accidents that happened because the driver was under the influence of drugs. However, even with this set of acute intoxication data, the deaths indicator is a useful clue when it comes to recording the increase rate of the spread of drugs in a given place.

According to these data, in 2001 there were 321 drug-related deaths, of which 318 (99.1%) were related to heroin use and 3 (0.9%) to cocaine use. More specifically:

- Most dead users were men (94%), Greek nationals (96%), single (93%), and unemployed (80%).
- Regarding age, 44% of them were older than 30. The rate of dead users over 30 is steadily increasing as user population "ageing" is both a Greek and a European phenomenon.
- Most deaths occurred in Attica (66%), followed by Thessaloniki (17%).
- As to their educational level, 34% were primary school graduates and 60% high school graduates.

In 2001, drug-related deaths increased by 5.6% compared to 2000. Increase rates for 2000 and 1999 compared to the previous years were 14.7% and 8.2% respectively. Therefore, the increase rate of drug-related deaths dropped considerably in 2001 (Figure 6).

Figure 6: Drug-related deaths and their increase rates in the last six years (1996-2001)



SOURCE: Hellenic Police, 2002.

Table 5 describes the socio-demographic characteristics of drug related death cases from 1990 to 2001.

Table 5: Characteristics of drug related death cases in 1990-2001

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Reported deaths	76	94	86	83	164	190	241	241	255	277	312	334
Confirmed drug related deaths	66	79	79	78	146	176	222	232	245	265	304	321
1. Age												
< 20 years	2	2	1	4	8	7	14	24	33	47	51	46
21-30 years	34	44	47	49	71	90	98	102	112	122	130	158
> 31 years	30	33	31	25	67	79	110	106	100	96	123	117
2. Sex												
Male	59	74	70	70	135	162	202	209	216	245	285	300
Female	7	5	9	8	11	14	20	23	29	20	19	21
3. Nationality												
Greek	63	76	76	74	141	168	212	227	240	251	292	307
Foreigners	3	3	3	4	5	8	10	5	5	14	12	34
4. Area												
Attica	52	61	61	69	105	136	166	166	170	186	200	211
Thessaloniki	9	12	9	4	21	18	25	38	39	30	49	54
The rest of the country	5	6	9	5	20	22	31	28	36	49	55	56
5. Marital Status												
Single	58	67	75	74	129	157	184	96	227	245	289	298
Married	7	11	2	3	13	15	32	8	16	16	12	15
Divorced	1	1	2	1	4	4	6	1	2	4	3	8
6. Education												
Primary level	29	33	27	28	31	73	78	36	87	65	111	108
Secondary level	12	39	27	38	23	30	106	66	143	169	178	194

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	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Higher level	1	3	6	2	1	6	4	2	3	3	4	2
Unknown	23	4	19	10	91	66	34	1	12	28	11	17
Illiterate	1	–	–	–	–	1	–	–	–	–	–	–
7. Profession												
Unemployed	29	51	47	50	81	99	144	73	175	197	232	258
Workers	19	9	15	9	24	29	21	15	31	18	28	11
Private employees	11	10	10	5	16	20	9	6	14	11	15	17
Musicians	2	–	–	–	–	3	2	–	–	–	–	–
Sailors	2	4	4	1	1	4	7	1	–	1	2	–
Others	1	2	1	10	19	16	35	8	21	31	6	33
Prostitutes	2	3	–	1	–	4	1	1	–	1	1	1
Civil servants	–	–	2	2	3	1	–	–	–	–	–	–
Journalists	–	–	–	–	2	–	–	–	–	–	–	–
Scholars	–	–	–	–	–	–	3	1	4	6	20	1
8. Drug Substances												
Heroin	60	74	73	77	134	157	213	222	243	263	300	318
Morphine	6	3	3	–	8	3	1	–	–	–	–	–
Psychotropic substances	–	2	2	1	4	13	7	6	1	1	3	1
Cocaine	–	–	1	–	–	1	–	3	1	1	1	2
Hashish-alcohol	–	–	–	–	–	2	1	1	–	–	–	–

SOURCE: Central Anti-drug Coordinating Unit, 1990-2001.

3.3 Drug-related infectious diseases in intravenous users

In 2001, the national network of the indicator, consisting of two reference centres, one hospital, nine treatment services and one low-threshold programme, provided the FP with individual data using the anonymous code of TDI concerning iological test results for hepatitis B and C.

3.3.1 Hepatitis B and C

Individual data for 2001

The results provided below come from a record of 1,102 individual questionnaires, which were collected and sorted out, leaving double entry cases aside, by the Greek Focal Point.

- Out of 1,102 IDUs, 85.2% were men and 14.8% women. 28.4% were up to 25 years old, 30.6% were between 25 and 34, and 41% were over 34. 1,093 were screened for hepatitis B and 53 (4.8%) tested positive. 1,094 were screened for hepatitis C and 743 (67.9%) tested positive (Figure 7).
- There was no significant gender difference in hepatitis C infection rates in IDUs. On the contrary, men infected with hepatitis B (5.5%) are more than women (1.2%) (Figure 7).
- Also, there were no big differences with regard to age in relation to hepatitis B infection in IDUs, unlike hepatitis C infection rates which increase with age (Figure 7).
- Hepatitis B and C infection rates are higher for 'not recent onset' IDUs (i.e. those who started injecting more than two years ago) than for 'recent' ones (i.e. those who started injecting in the last two years) (Figure 7).

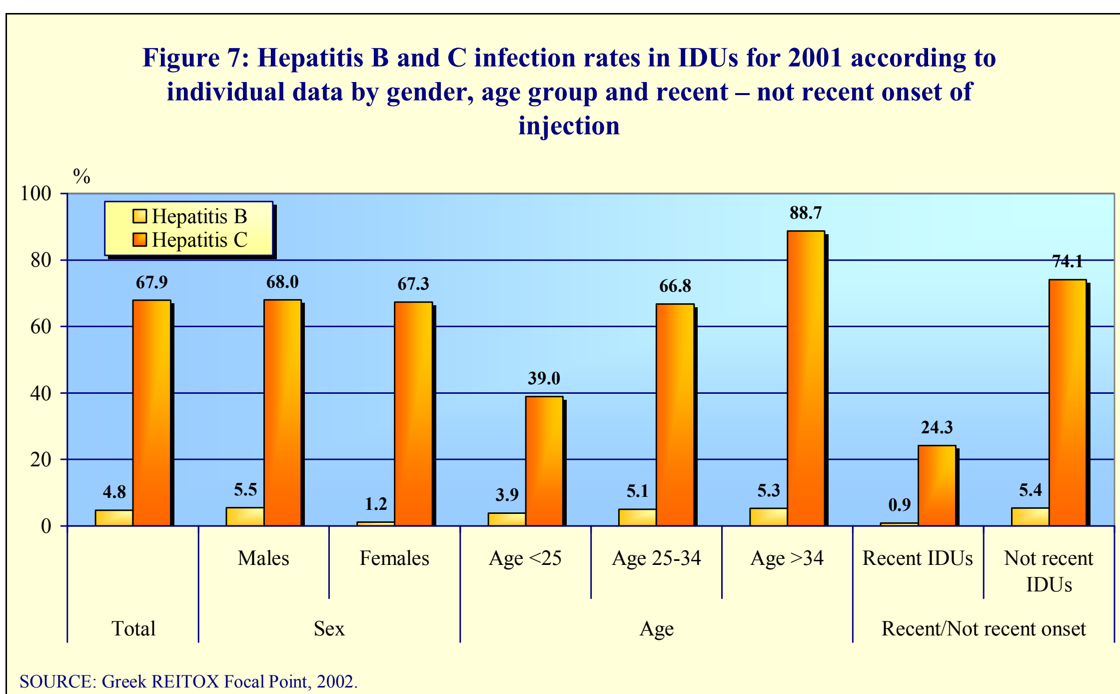


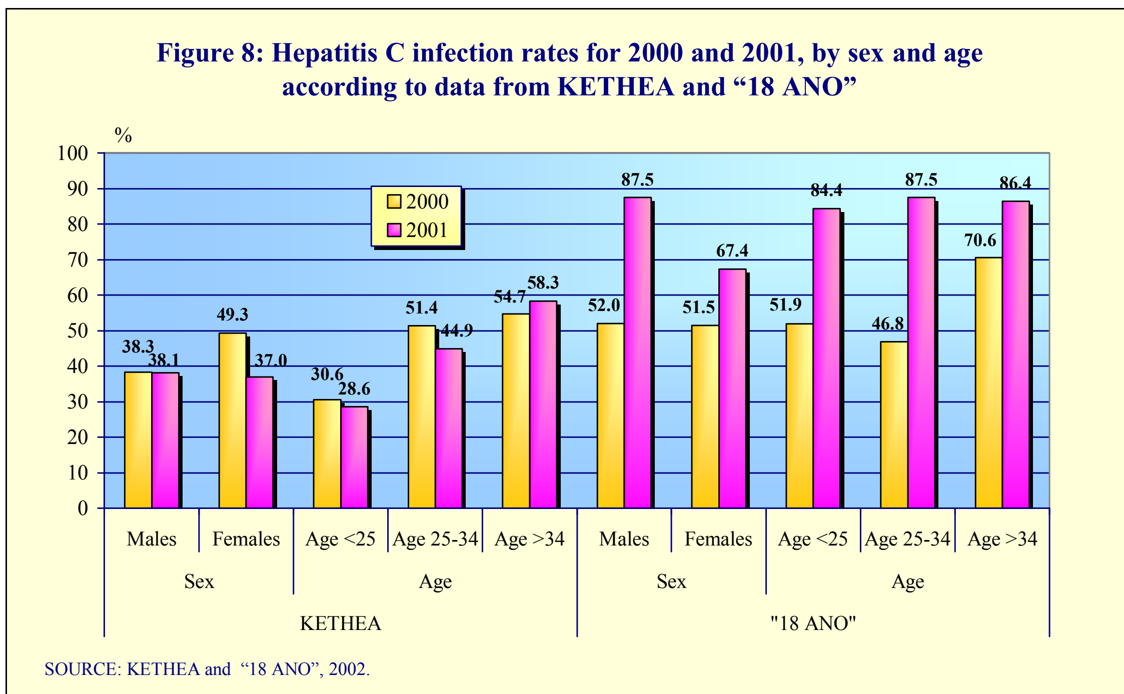
Figure 7: Hepatitis B and C infection rates in IDUs for 2001 according to individual data by gender, age group and recent – not recent onset of injection

Aggregated data for 2001

According to data from '18 ANO' in 2001, 131 intravenous drug users (37 of whom from the addicted women's programme) were screened for hepatitis B and C. 6.1% were infected with hepatitis B and 80.9% with hepatitis C. In 2000, the respective rates were 5.3% for hepatitis B and 51.9% for hepatitis C. More men are infected with hepatitis C than women (Figure 8). On the other hand, 2.3% of men tested positive for hepatitis B compared to 14.0% of women (Figure 9). For 94 out of the 131 users (i.e. excluding the addicted women's programme), hepatitis B and C infection rates do not vary significantly with respect to age (Figures 8 and 9).

According to data from KETHEA in 2001, a total 398 IDUs were tested for hepatitis B and C. 4.8% tested positive for hepatitis B and 37.9% for hepatitis C. The respective rates for 2000 were 3.8% for hepatitis B and 40.1% for hepatitis C. Hepatitis B and C infection rates increase with age (Figures 8 and 9). There is a significant gender difference only with respect to hepatitis B, with a higher infection rate in men than in women (Figure 9).

Figure 8: Hepatitis C infection rates for 2000 and 2001, by sex and age according to data from KETHEA and "18 ANO"



SOURCE: KETHEA and "18 ANO", 2002.

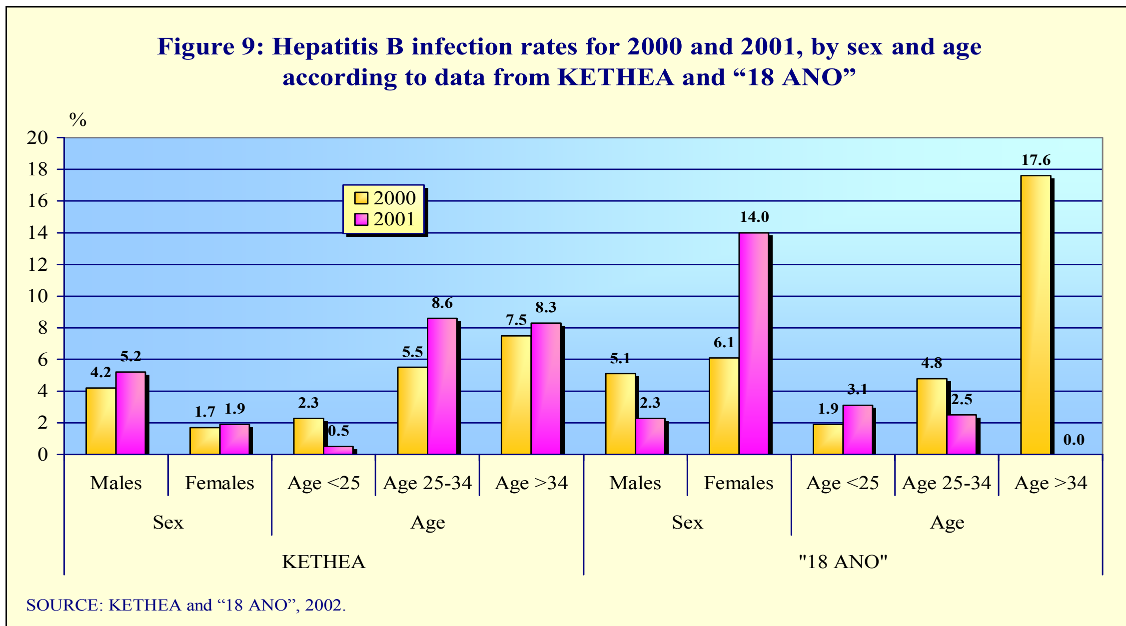


Figure 9: Hepatitis B infection rates for 2000 and 2001, by sex and age according to data from KETHEA and "18 ANO"

SOURCE: KETHEA and "18 ANO", 2002.

3.3.2 HIV/AIDS

Surveillance data on the prevalence and incidence of HIV/AIDS cases in IDUs are provided by the Hellenic Centre for Infectious Diseases Control (KEEL) of the Ministry of Health and Welfare.

In 2001, an additional 427 HIV positive persons were registered (including AIDS cases), 12 of whom (2.8%) were IDUs. The ratio of IDUs to the total number of HIV positive persons registered in Greece to date is 3.4% (201 cases out of a total of 5,859). There were 72 new AIDS cases in 2001, out of which 2 (2.8%) were IDUs. Out of a total 2,254 AIDS cases registered in Greece to date, 85 (3.8%) are registered as IDUs (KEEL, 2002). Figure 10 shows HIV/AIDS cases in IDUs in Greece since 1985.

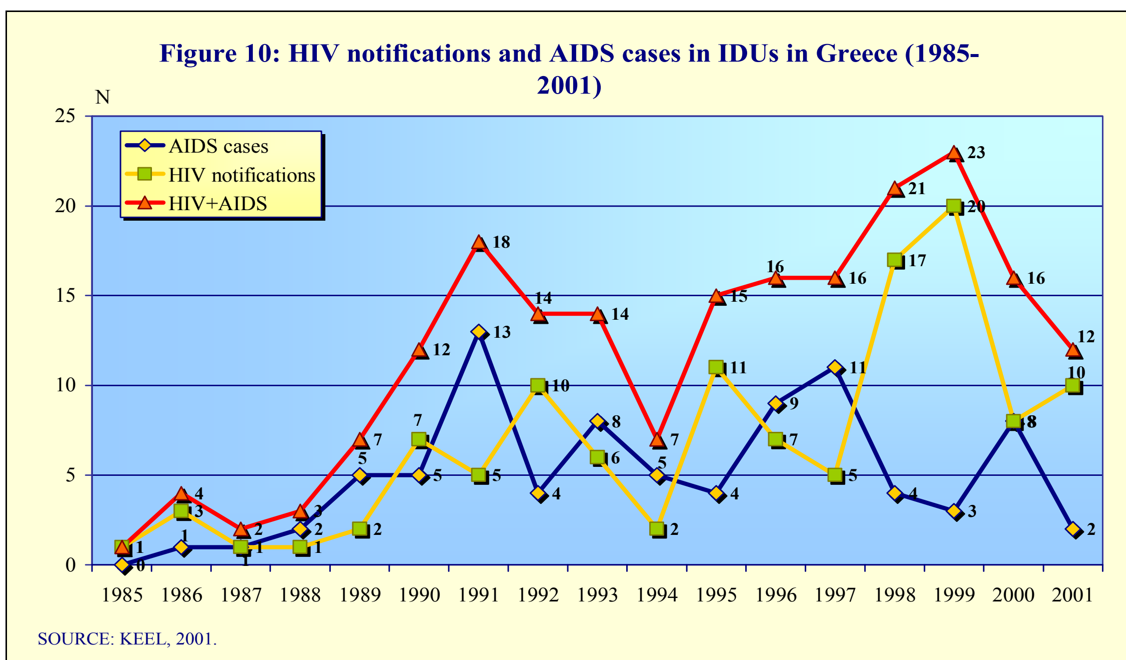


Figure 10: HIV notifications and AIDS cases in IDUs in Greece (1985-2001)

SOURCE: KEEL, 2001.

3.3.3 Conclusions

In summary, data from the Drug-related Infectious Diseases Indicator for IDUs show that:

- Hepatitis B infection rates are lower than those of hepatitis C. Hepatitis B infection rates are about 5%, but hepatitis C infection rates range from 37.9 to 80.9%. These findings are also supported by national research studies (Androulakis et al., 2000; Gonidakis et al., 2000; Kallinikos et al., 1998; Petroulaki et al., 2002).
- Hepatitis B infection rates are generally higher in men than in women, although data from '18 ANO' show the hepatitis B infection rate to be higher in women than men. However, these results should be treated with caution, due to the small sample size of '18 ANO' and the possible bias coming from the inclusion of the Treatment Programme for Dependent Women.
- Hepatitis B and C infection rates increase with age.
- 'Not recent onset' IDUs have higher hepatitis B and C infection rates than 'recent' ones.

The above conclusions are in line with TDI data, although they are based on self-reports rather than test results. Moreover, TDI data show that those sharing needles have higher hepatitis B and C infection rates.

According to KEEL data, HIV/AIDS infection rates in IDUs are still quite low.

3.4 Other drug related morbidity

3.4.1 Non-fatal drug emergencies

No available information on drug emergencies in Greece.

3.4.2 Psychiatric co-morbidity

Studies on psychiatric co-morbidity conducted in Greece have been discussed in previous National Reports. Personality disorders, particularly antisocial personality disorder and suicide ideation were consistently associated with drug dependence.

A recent research on dependent individuals in treatment suggests that female dependent opiate users, compared to males, tend to have a more markedly overstepping behaviour and personality disorders (Douzenis, et al., 2000).

Self-destructive behaviour (suicide attempts, overdose, road accidents) was found to be highly prevalent among dependent individuals in treatment (Liappas, at al., 2000a).

3.4.3 Other important health consequences

Drugs and driving

Most data on this issue come from special surveys.

In the 2001 survey on nightlife recreational drug use conducted by Greek Focal Point on a sample of 204 young people (102 drug users and 102 non-users) frequenting clubs, bars and cafeterias, the results have shown that young users and non-users combine drinking and driving. Moreover, they apparently consent being in a car driven by someone who has consumed a considerable amount of alcohol or a certain illicit drug.

In 2001, the thesis of Papadodima (2001) came to corroborate the aforementioned findings and those of other relevant studies presented in previous years (Athanaselis et al. 1999; Tsoukali et al. 2000)

More specifically, in order to examine the frequency of drug and alcohol detection in victims of traffic accidents, the Laboratory of Forensic Medicine and Toxicology of the University of Athens collected, categorised and presented the results of toxicological analyses conducted in the period 1995-2000 on biological samples taken from drivers and pedestrians in southern Greece.

The sample of the study consisted of 1717 drivers who had been involved in road accidents and 149 pedestrians who died after having suffered injuries in road accidents. The results have shown that:

Drivers

- The vast majority of drivers are men (93%).
- Alcohol is detected in 43.1% of drivers. Although between 1995 and 2000 the number of breath alcohol tests has significantly increased and the legal limit of alcohol concentration in blood has decreased, it should be pointed out that the corresponding analyses have not shown any statistically significant changes in detected alcohol concentration.
- Other psychoactive substances are detected in 11.2% of drivers, the most popular being cannabis, heroin and benzodiazepines.
- Alcohol and other psychoactive substances are detected in more men (40.5% and 9% respectively) than women (26.4% and 5.8%). In addition, the distribution by gender and substance (valid percentages) has shown that men present higher percentages for all psychoactive substances, including alcohol, with the exception of benzodiazepines where women present a higher percentage (13.9%) than men (6%).
- The majority of drivers (30.2%) are 25-34 years old. Alcohol is detected more in those aged 35-44 and 25-34, and other psychoactives in those aged 15-24 and 35-44.

Pedestrians

- The vast majority of pedestrians in the sample are men (61.1%) and aged over 65 (63.1%).
- Alcohol is detected in 31.5% of pedestrians and benzodiazepines (the only detected substance other than alcohol) in 2.7%. No alcohol or drugs were detected in the rest of the sample. Where alcohol is detected, it is done more in men and in those aged below 65, whereas benzodiazepines in those aged over 65.

4. Social and Legal Correlates and Consequences

4.1 Social problems

4.1.1 Social exclusion

See key-issue Chapter 16.

4.1.2 Public nuisance – community problems

As in the previous year, the same phenomena of local communities' strong protests against the establishment of treatment units in their region were observed in 2002. The only difference could be that in the reporting year community reactions were even stronger, with the manifestation of several "acting-out" conducts.

The most severe case of public reaction was recorded when KETHEA, in response to a demand of the Local Authorities of the Prefecture of Evros, decided to launch the Cross-cultural Treatment Programme for drug users and their families in Alexandroupolis (Northern Greece). The programme would be housed in a building made available to KETHEA by the Municipal Council. Despite the decision of the municipal authorities, a group of inhabitants reacted first by threatening the programme's personnel and later by extreme actions, including setting fire to the building and chaining and oxywelding the doors. KETHEA publicised the matter, which got media coverage for several weeks, while the Mayor took legal action. Moreover, the Municipal Council persisted in its unanimous approval of the establishment of the programme in the suggested building and KETHEA organised a wide information campaign for the local community, intended to promote the positive role of drug treatment programmes and dispel the existing myths and stereotypes. As a result of this joint determined action, there was a shift in public opinion in favour of the KETHEA programme, which was also reflected on the local community of Alexandroupolis.

Another case was that of OKANA 2nd Substitution Unit of Thessaloniki, which would be moved to a new building in the city so as to cover a larger number of drug users seeking substitution treatment. Claiming that the unit would further socially degrade the area, where a counselling centre for drug users already exists, and that drug dealing has been observed around the areas where

substitution programmes operate, the local inhabitants have staged a sit-in for more than a month. OKANA has met with local communities' reactions in its effort to find a place for new substitution units in other regions of the country as well. In order to deal with these reactions, OKANA has conducted a survey on public opinion towards drug treatment programmes, and it also plans to implement an awareness-raising programme addressed to local authorities, the police and Members of Parliament on the basis of the results.

For further information on public reaction and attitudes, see Chapter 8.2

4.2 Drug offences and drug-related crime

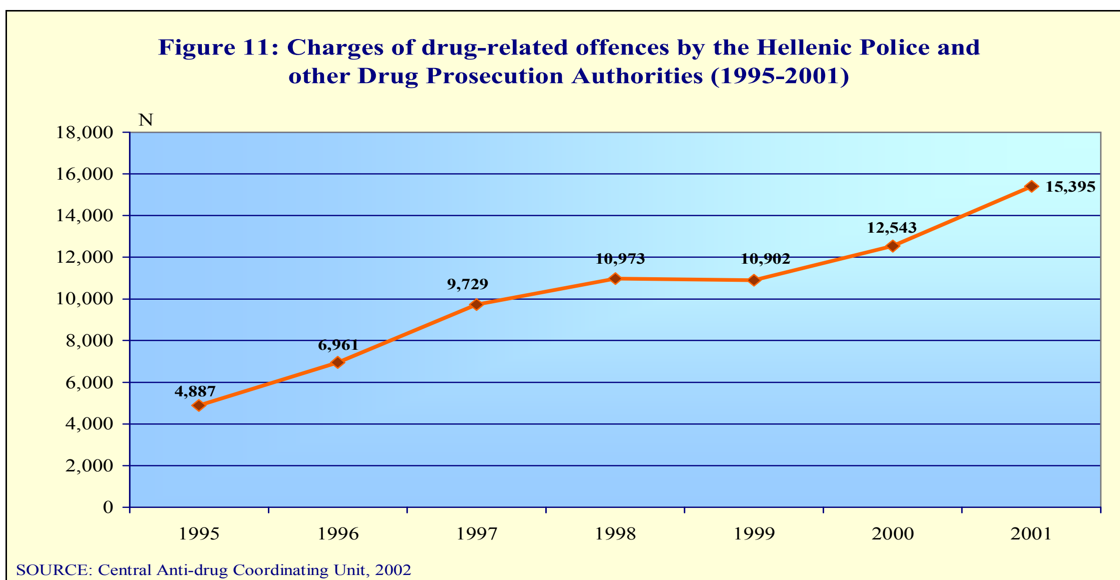
4.2.1 Charges of drug-related offences

Data on charges of drug law offences are collected by the Joint Secretariat of SODN-EMP, which represents the Ministry of Public Order (Hellenic Police), the Ministry of Finance (Customs Service and Greek Financial and Economic Crimes Office – SDOE), and the Ministry of Merchant Marine (Coast Guard).

No data were released by the Hellenic Police on **arrests** in 2000 and 2001.

2001 data available to the Greek Focal Point refer to individuals **charged** by all DPAs. The total number of charges of drug-related offences was 15,395 in 10,066 cases (Figure 11). 97.6% of the charges were brought by the Hellenic Police, 2.1% by the Coast Guard, and the rest by the Customs Service and SDOE.

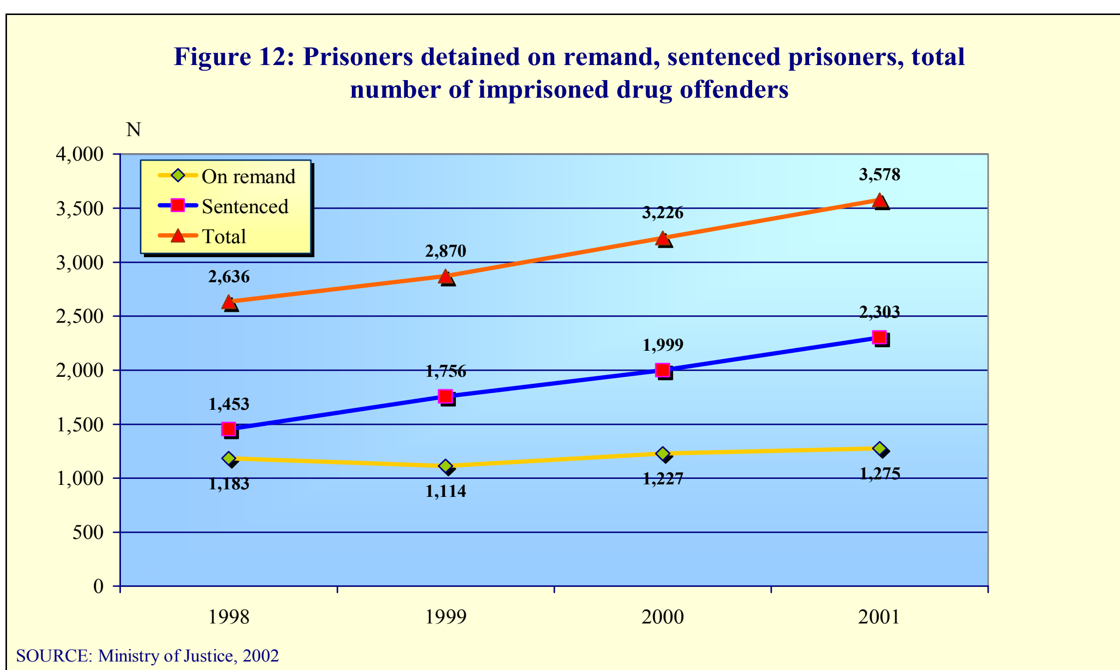
There has been a considerable increase in the total number of charges, since the respective number for the year 2000 (involving all services, namely the Hellenic Police, the Coast Guard, the Customs Service and SDOE) was 12,543. The upward trend observed in the last six years could be explained by a) the increased and rather productive efforts of the Drug Prosecution Authorities (DPAs) to tackle the drug problem and b) the increase in drug abuse prevalence. Large quantity seizures have been reported in recent years (amphetamines in 2000, cocaine in 2001; see Chapter 5, paragraph 5.2). Although the number of charges has significantly increased, given that no similar increase is documented in seized quantities of illicit substances (ibid.), it may be assumed that the charges are more against users or small quantity traffickers (peddlers) and less against drug producers, traffickers and/ or dealers.



4.2.2 Convicted and imprisoned drug offenders

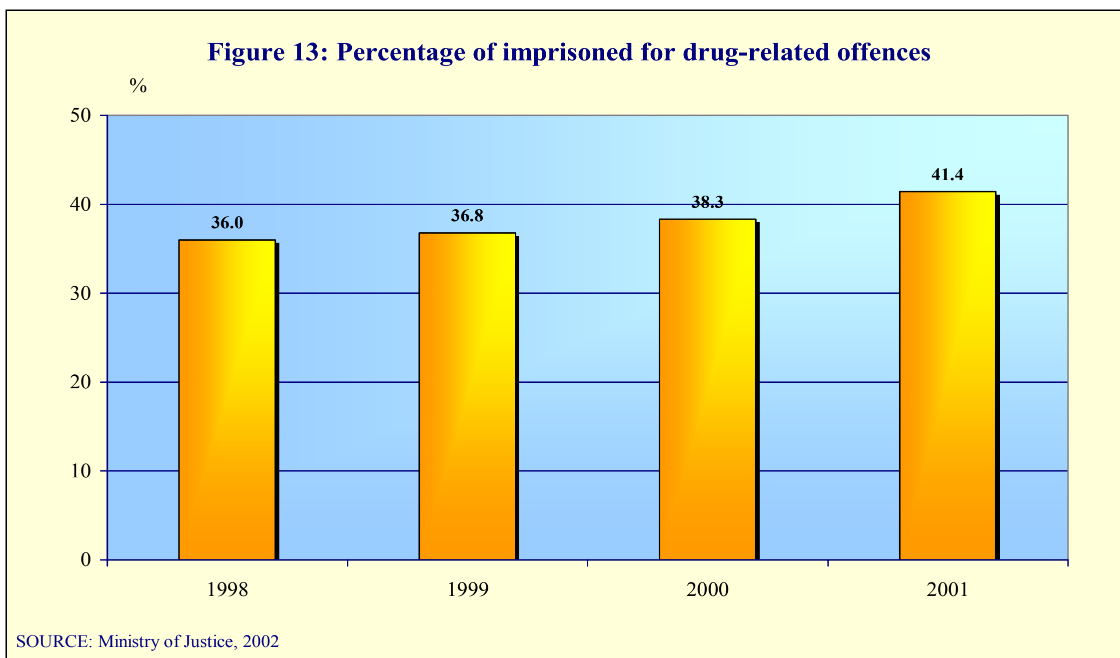
The most recent data about **convicted** drug offenders released by the Ministry of Justice (based on records kept by Greek judicial services and detention centres) date back to 1997. In 1997, 67.7% of the total number of drug offenders were convicted of drug use, 26.5% of drug dealing and/or trafficking, and 5.8% of cultivating drugs.

The data in Figure 12 are drawn from the Prisons Directorate of the Ministry of Justice and show the number of people **imprisoned** for drug offences on December 1st of the reference year from 1998 to 2001. The data presented in this report are not comparable to data from previous years (presented in earlier reports) on individuals sentenced to prison, as data included in this report refer to both sentenced inmates and those on remand.



The overall number of prisoners has been steadily increasing over the last four years. The rate of drug offenders on remand has dropped. On December 1st, 2001, two out of every three imprisoned drug offenders were already sentenced.

The rate of imprisoned for drug-related offences is steadily increasing, as can be seen in Figure 13.



4.2.3 Other drug-related crime

Legal problems of users approaching KETHEA therapeutic centres

It has been reported that 72% of users who approached KETHEA services in 2001 had previously been arrested at least once in their lifetime. Arrests are more frequent among men than women and positively correlated with age. A similar pattern of sex difference is observed with regard to convictions, imprisonments and pending trials as shown in Table 6 (KETHEA, 2002a).

Table 6: Percentage of drug users who approached KETHEA in 2000 and 2001 facing legal problems

	2000		2001	
	Male %	*Female* %	*Male* %	*Female* %
Arrests	76.2	50	76	54.4
Convictions	41.2	22.5	43.9	21.5
Imprisonments	15.9	9	16.6	7.9
Pending trials	50.9	26.6	51	29.3

SOURCE: KETHEA, 2002.

Recent research findings on a sample of dependent users in treatment suggest that around 37% of them had a criminal record, having been arrested mainly for drug and property offences (Liappas, et al. 2000b).

Drug-related crime in adolescents and young adults

Out of 238 adolescents and young adults who approached ‘STROFI’ counselling centre for adolescents and ‘STROFI’ counselling centre in the Juvenile Court in 2001, 176 (73.9%) had been arrested at least once in their lifetime. Of those arrested, 18.7% had been arrested more than 6 times and 45.5% had been arrested for the first time before the age of 15. Of the total number of young people who had previously been arrested at least once, 14.8% had been convicted; of those convicted 21.1% had been imprisoned. Furthermore, 50.8% of those arrested at least once awaited trial. Other drug-related illegal activities are also indirectly suggested by the percentage of adolescents and young adults who reported income from illegal activities (53.8%) (STROFI, 2002).

A preliminary study of the characteristics of 80 adolescents who approached the Counselling Centre of the Thessaloniki Psychiatric Hospital between January 1996 and April 2001, showed that 35% had problems with the law. 47.1% of male adolescents were awaiting trial compared to 11.1% of female adolescents (Zlatanos, 2001).

Drug-related crime in imprisoned adolescents and adolescents at risk

From November 1997 to March 1998, the Aristotle University of Thessaloniki conducted a survey on a sample of 100 juveniles held in the Juvenile Correctional Centres of Kassavetia, Volos and Korridalos, Athens and of 100 juveniles who were classified in the wider category of “juvenile delinquents and adolescents at risk”. The aim was to look into the relation between living standards for juvenile delinquents and their behaviour as such, in order to come up with proposals for a more effective correctional policy for juvenile delinquents, especially with regard to vocational training. Questionnaires provided some interesting answers on the criminal behaviour of both users and non-users.

Among those not imprisoned, 91.7% of drug users had been charged with some crime compared to 57.9% of non-users. Of the drug users who had been charged, 86.4% had been charged with one count as opposed to 13.6% who had been charged with two counts. Half of the users who had been charged were accused of drug-related crimes, one third of property crimes, and only a few were charged with other offences.

Among imprisoned adolescents who used drugs prior to imprisonment, 27.3% were charged with one count, 47.7% with two counts, 15.9% with three counts, and 9% with four counts. The rates for non-users were 69.6%, 28.3%, 2.2% and 0% respectively. Most charges were of property offences (mainly theft), followed

by charges of drug offences. There were fewer cases of bodily injury and traffic offences (Aristotelian University of Thessaloniki, 2000).

Pharmacy burglaries

As already mentioned in previous national reports, the number of pharmacy burglaries provides an indirect indication of drug-related crime. The number of burglaries has been steadily decreasing since 1997 (1997: 56, 1998: 49, 1999:47, 2000: 44, 2001: 35), although the total number of pharmacies has increased (National Statistical Service of Greece, 2001; 2002). According to DPAs, this can be explained by the increasing availability of drugs and by crime prevention measures.

4.3 Social and economic costs of drug consumption

No information available.

5. Drug Markets

5.1 Availability and supply

The geographical position of Greece is such that traffickers of illicit drugs use the country as a transit point between other continents and Europe. Some of Greece's neighbouring countries cultivate, produce, smuggle and store drugs. According to the INCB 2001 report (UN, 2002), Albania continues to provide Europe with cannabis herb and in 2001 an illicit opium poppy laboratory was discovered for the first time. Heroin originating from Southwest Asia is smuggled into Greece through the so-called "Balkan route", while cannabis is imported mainly from Albania and cocaine is shipped in from South America (UN, 2002).

Apart from routine patrols, border and coast surveillance, the Greek DPAs also focus on monitoring illegal drug-related activities taking place in the cyberspace. The Internet is now widely acknowledged in both public and professional discourses as being a central source of intelligence on cultivation, marketing and use of illicit substances (Central Anti-drug Coordinating Unit, 2002 and UN, 2002).

Data made available by the National Intelligence Unit of the Central Anti-Drug Coordinating Unit (SODN-EMP) on drug imports and production for the year 2001 show the following:

- **Cannabis** is imported mainly from Albania (77.6% of cannabis resin and 83.3% of cannabis leaves seizures). It is imported mainly by road (99.3% of cannabis resin and 90.6% of cannabis leaves) and occasionally by sea, and kept in forest hideouts near the border. The vast majority of traffickers are Greeks and Albanians.
  A large proportion of cannabis seized is of unknown origin. Cannabis is also cultivated in Greece in greenhouses and irrigation trenches.

- **Heroin** is imported by road (99.5%) (in TIRs and cars) from Albania (66%), Turkey (31%) and Bulgaria into the northeastern part of the country and hidden in private premises or in coastal areas. According to the 2001 INCB report, the Balkan routes (North Balkan route, two central Balkan routes, the South Balkan route and the Caucasian Balkan route) remain the main distribution routes for heroin originating from Southwest Asia to Europe. Greece is part of the South Balkan route. This route in the past connected Turkey with Italy via Greece but, due to increased inspections on the Greek-Turkish border, since 2001 it has changed and currently also includes parts of Bulgaria, FYROM, and Albania. The majority of heroin traffickers in Greece in 2001 were Albanians (66.3%), but also Czechs (11.3%), Turks (11.2%), Spaniards (8.2%) and Greeks (3%) (Central Anti-drug Coordinating Unit, 2002).
- **Cocaine** is imported by road (16.5%) from Albania, by air (15.5%) from Argentina and Chile, and by sea (68%) from Colombia. Most of the seized cocaine (83%) originates from Latin America, like most cocaine smuggled into Europe (UN, 2002). Packages are hidden in hedges at selected crossings in the prefecture of Attica (greater Athens and Piraeus). Most of the individuals involved in cocaine trafficking are Greeks (74.6%) and Albanians (17.8%).
- **Synthetic drugs** are imported by air or by road and they are hidden in private premises. Most seized pills were trafficked by Greek nationals.

5.2 Seizures

The National Information Unit of the Central Anti-Drug Coordinating Unit (SODN - EMP) releases the total annual seizures data from all DPAs (Hellenic Police, Coast Guard, Customs Service, and SDOE).

The total number of seizures carried out by all law enforcement authorities in 2001 was 10,066. Total quantities seized in 2001 include 330 kg of heroin, 297 kg of cocaine, 12 tons of cannabis and about 59,000 ecstasy pills. Seizures of heroin, cocaine, cannabis by each authority are presented in Table 7.

Table 7: Drug seizures by all Greek DPAs in 2000 and 2001

	Hellenic Police		Customs - SDOE		Coast Guard		Total	
	2000	*2001*	*2000*	*2001*	*2000*	*2001*	*2000*	*2001*
Cannabis (kg)	10292	8408.6	1583.3	3341.5	3090.4	175.2	14966	11925.9
Heroin (kg)	642	231.3	1.54	80.3	15.93	18.2	660	329.7
Cocaine (kg)	19.2	265.2	136.2	32	0.008	0.037	155.5	297.3
Ecstasy (pills)	53548	49114	-	9233	9	498	53557	58845
LSD (doses)	111	286	-	-	-	291	111	577

SOURCE: Central Anti-drug Coordinating Unit, 2002.

In 2001 there was a drop in seizures of **cannabis leaves**, while there was a significant rise in seizures of **cannabis resin** (see Standard Table 6). A rise was also noted in the proportion of total processed cannabis originating from Albania (42.8% in 2000 as opposed to 77.6% in 2001). According to the DPAs, this indicates that Albanians are increasingly involved in processing and that special laboratories may have been created for this purpose. Overall, there is a marginal downward trend in cannabis quantities seized since 1997.

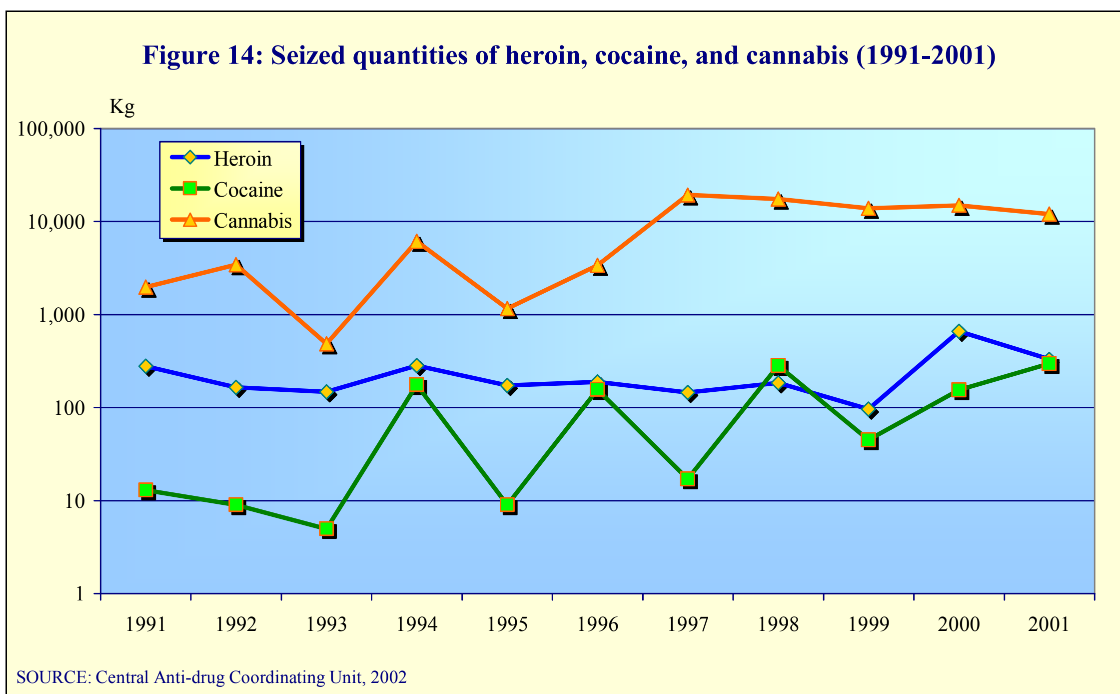
Heroin seizures also dropped compared to 2000. Until 1999 the quantities of seized heroin were on the decline, but this pattern was discontinued owing to a large police operation in December 2000, which resulted in the seizure of 524.6 kg of heroin.

Cocaine seizures have increased since 2000, due to the seizure of one large shipment smuggled from Columbia into Greece in October 2001. Over the past decade, cocaine quantities seized in Greece have been fluctuating to a great extent, but an overall upward trend is observed in Figure 14.

Regarding seizures of **pills**, there was an increase in methadone seizures but a decrease in amphetamine seizures, after a large quantity seizure in a clandestine laboratory in Korinthos in 2000 (Central Anti-drug Coordinating Unit, 2001). Seizures of ecstasy pills have rapidly increased in recent years, while the consumption of LSD is still low as indicated by the number of seizures (see Standard Table 13).

Out of the total quantities seized in 2001, 29% of heroin, 97% of cocaine, 33% of cannabis, and almost all ecstasy pills, were seized in the prefecture of Attica.

Figure 14: Seized quantities of heroin, cocaine, and cannabis (1991-2001)



SOURCE: Central Anti-drug Coordinating Unit, 2002

5.3 Price/purity

The Hellenic Police provide the Focal Point with information on the price and purity of drugs. Updated information can also be found in the report of the Central Anti-Drug Coordinating Unit, which is published annually and contains information on all actions taken by the Greek DPAs against drugs. Purity is assessed by the State Chemical Laboratory, where samples of seized quantities are sent for analysis in accordance with UN methodology (GC/FID, QC/MSD methods) (see Standard Table 14). As of 2002, the Greek Focal Point collects data on the composition of tablets from the 2nd Chemical Service in Thessaloniki, in addition to the existing co-operation with the 3rd Chemical Service in Athens (see Standard Table 15).

Drug **prices** on the illicit market in 2001 are indicated on Table 8 (see also Standard Table 16).

Table 8: Retail and trafficking drug prices in 2001 (€)

Substance	Retail	Trafficking
Cannabis resin	3-6 / gr	900-2350 / kg
Cannabis leaves	1.5-3 / gr	300-880 / kg
Heroin (white)	44-75 / gr	14650-29350 / kg
Cocaine	75-100 / gr	35000-55000 / kg
Amphetamines	3-5 / dose	2.35-3 / dose
LSD	6-9 / dose	3-5 / dose
Ecstasy	10-20 / pill	9-12 / pill

SOURCE: Central Anti-drug Coordinating Unit, 2002.

According to Loukas (2001), the purity of illicit substances largely depends on the number of intermediaries, on admixture with other substances and on the availability of each drug.

In large quantities seized in 2001, **heroin** content rose to 65%-81%. In smaller quantities, purity was lower. At street level (2.1 – 30 gr) it was estimated to range from 14% to 69%. Moreover, a certain number of heroin samples did not actually contain any heroin at all in their chemical composition (adulterated quantities).

Data on **cocaine** are not sufficient, but its purity is considered to be up to approximately 70%. No crack was found in cocaine quantities seized in 2001, a finding that contradicts 2001 TDI data findings (see Standard Table 04), which gave a small number of crack users since 1998.

Cannabis seizures are not analysed for THC content.

With regard to **other substances**, it was reported that there were no available data on the purity of amphetamines. As far as the composition of seized tablets is concerned, data from the State Chemical Laboratory show that the majority of pills analysed (92.3%) were ecstasy pills (MDMA), some were amphetamine or methamphetamine pills (6.25%) and a few samples contained a combination of substances, ketamine or ephedrine (see Standard Table 13). The quantitative analysis of 50 MDMA pills (which varied in colour, weight, logo, size and shape) by the 3rd Chemical Service in Athens demonstrated that the active ingredient MDMA content ranged from 8.7% to 53.5%.

Furthermore, it should be mentioned that a team of experts representing the General Secretariat of the European Council and the European Commission visited Greece in January 2001. The experts evaluated a) the degree and the quality of implementation of legal provisions concerning drug smuggling at the national level, b) the practices used by law enforcement agencies, and c) Greece's role in international co-operation for combating drug smuggling. Greece received positive remarks about the prompt completion of the questionnaire, the overall organisation of the team visits and the provision of intelligence. Greece was also considered to be willing to improve its already high professional standards. The personnel was found to be motivated, qualified and dedicated to their day-to-day tasks (Central Anti-drug Coordinating Unit, 2002).

6. TRENDS PER DRUG

The latest general and student population surveys in Greece were conducted in 1998. Trends for each drug as emerging from those surveys were presented and discussed extensively in previous Greek National Reports.

Trends emerging from the TDI data cannot be estimated this year, as the additional data from the new therapeutic services make comparisons with previous years impossible.

Summary tables showing trends for overall illicit drug use and for specific drugs from the general and student population surveys are presented below.

Among the most important features are:

- the sharp increase in illicit drug use emerging in the mid-90's
- the high prevalence of inhalants, particularly among the student population
- the decrease in licit substance use (tranquillisers/hypnotics) prevalent in the general population

Table 9: Trends in lifetime drug use prevalence in the Greek student population in the 90's

	Total		Gender			
			Boys		*Girls*	
	1993 (10,452) %	1998 (8,515) %	1993 (4,952) %	1998 (4,072) %	1993 (5,498) %	1998 (4,440) %
Any illicit use	6.0	13.7	8.0	17.9	4.2	9.9
Cannabis	4.6	12.6	6.4	16.2	2.9	9.2
Ecstasy		2.1		3.1		1.1
Heroin	0.7	1.1	1.1	1.5	0.3	0.7
Cocaine	1.0	2.0	1.5	3.1	0.5	1.0
Hallucinogens	1.3	2.9	2.0	4.1	0.7	1.9
Inhalants	6.5	13.8	8.9	18.2	4.3	9.7
Tranquillisers	7.1	6.9	6.7	6.7	7.6	7.0
Hypnotics	3.6	4.7	4.2	5.6	3.0	3.8

SOURCE: UMHRI, 1993, 1998.

Table 10: Trends in lifetime drug use prevalence in the general population of Greece by gender

	Total		Gender			
			Males		*Females*	
	1984 (4,289) %	1998 (3,752) %	1984 (1,946) %	1998 (1,809) %	1984 (2,342) %	1998 (1,943) %
Any illicit use	4.0	12.2	7.7	18.8	1.0	6.0
Cannabis	3.9	12.2	7.6	18.8	1.0	6.0
Ecstasy		0.2		0.3		0.2
Heroin	0.2	0.4	0.4	0.7	0	0.2
Cocaine	0.2	1.1	0.5	1.6	0	0.7
Hallucinogens	0.3	0.9	0.6	1.3	0	0.5
Tranquillisers	5.5	4.6	3.8	3.3	6.9	5.7
Hypnotics	0.7	1.3	1.0	1.6	0.5	1.0

SOURCE: UMHRI, 1993, 1998.

Table 11: Trends in lifetime drug use prevalence in the general population of Greece by age

	Age							
	12 – 17		*18 – 24*		*25 – 35*		*36 – 64*	
	1984 (1,322) %	1998 (793) %	1984 (1,120) %	1998 (924) %	1984 (620) %	1998 (710) %	1984 (1,222) %	1998 (1,325) %
Any illicit use	1.0	3.4	7.1	21.6	6.4	22.5	2.6	7.8
Cannabis	0.9	3.4	6.8	21.7	6.4	22.1	2.6	7.8
Ecstasy	-	0.1	-	1.2	-	0.3	-	0
Heroin	0.1	0.4	0.7	0.8	0.3	0.7	0	0.2
Cocaine	0.3	0.3	1.0	2.2	0.3	2.7	0	0.5
Hallucinogens	0.1	0.3	1.1	2.0	0.5	1.7	0	0.5
Tranquillisers	1.5	1.5	6.7	2.9	7.9	5.7	4.7	5.2
Hypnotics	0.5	0.6	1.8	2.2	0.5	1.8	0.7	1.1

SOURCE: UMHRI, 1993, 1998.

7. Discussion

7.1 Consistency between indicators

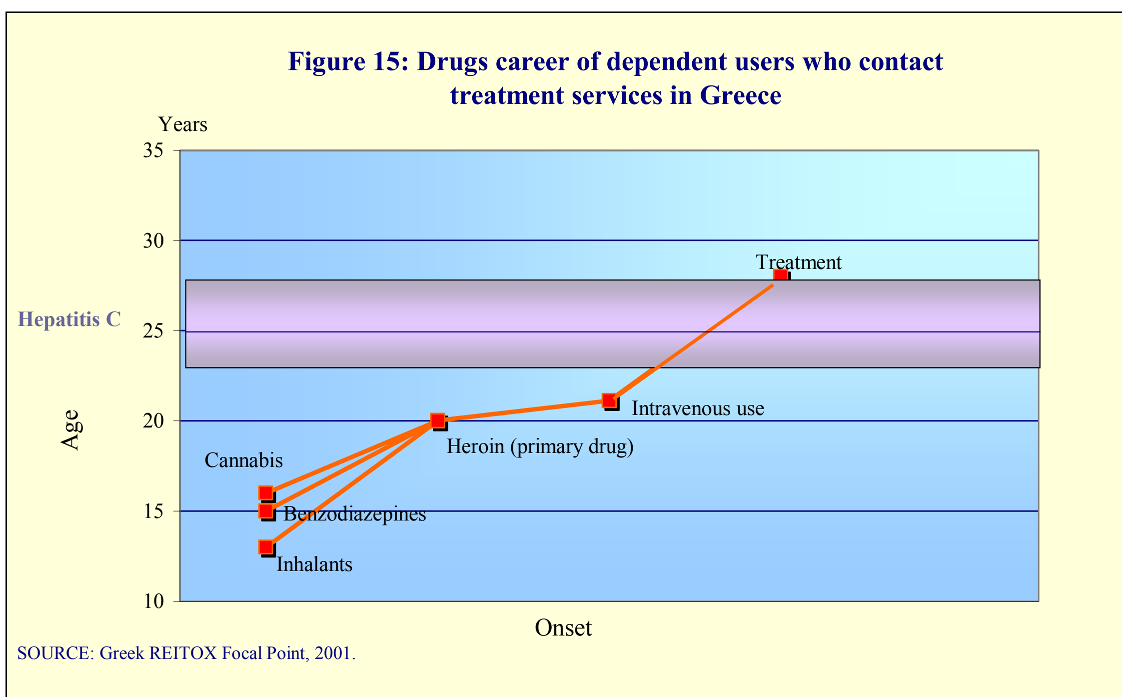
The addition of new treatment services in the TDI data has changed the characteristics of the population under study. The services of the drug-free programme of KETHEA comprised a large number of young people, including adolescents. The extent of change cannot be estimated this year, as the data are not comparable with last year's ones.

The implementation of the problematic prevalence indicator allows, at last, estimation, albeit rough, of heroin users in Greece; these amount to around 20,000 individuals, most of them male, Athenians, aged over 24.

The highly representative TDI data, along with problem use estimates and other indicators, paint a fairly accurate picture of the "drug career" of a user seeking treatment. This career is illustrated in Figure 15.

Most heroin users start use with benzodiazepines or cannabis at the age of 15 or 16 respectively. Young heroin users who seek treatment appear to have started with inhalants at the age of 13. Heroin use, as primary drug, starts around the twentieth year of age, followed by intravenous use one year later. Based on the available data, it is not possible to accurately estimate the age of hepatitis C

infection; it appears to occur about 2-3 years after the onset of intravenous use. The mean age of treatment seeking is 28.



Women dependent users continue to form a sub-group with somewhat different characteristics from those of male users. The issue has been extensively discussed in Greece and in the rest of Europe; still every year there are small indications of this special and different female user profile. An illustrative example is that women appear to engage in needle sharing at higher rates than men, yet there is an equal gender distribution of hepatitis C infection. Women themselves maintain that they share mostly with their permanent sex partners, whom they “know well”.

Social reaction against newly established treatment services is increasing. Although public opinion, as presented by the media, is in favour of the expansion of therapy for dependent individuals, in practice local inhabitants in areas where treatment centres are established tend to react quite aggressively. The simplistic attitude towards such reactions, attributing them to lack of information by the public, has proven insufficient and ineffective. Whenever the local community “feelings” were explored and taken into account, reaction subsided. Social exclusion and social stigma are widely prevalent attitudes in all societies vis-à-vis not only drugs but also social problems other than drugs, such as mental illness. A holistic approach seems to be necessary in order to achieve the desired social reintegration of users.

7.2 Methodological limitations and data quality

The quality of data collected by the Focal Point is improving from one year to the next, owing mainly to enhanced political support and to specific guidelines delivered by the EMCDDA.

The same holds true for the quantity of studies on drugs conducted in Greece by various agencies. In many cases, quality has also improved. Nevertheless, these studies continue to revolve around the same issues and population groups (e.g. students, users in treatment), while other groups, such as minorities or army recruits, do not attract research interest.

As the Greek National Action Plan provides for central co-ordination of research planning and financing, it is hoped that the situation will gradually improve.

PART III

DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

Being the first year of implementation of the National Action Plan Against Drugs (2002-2006), in 2002 both policy-makers and professionals focused their efforts on pursuing the objectives set in the demand reduction field. These efforts were underpinned by the establishment of new programmes, the implementation of new co-operation schemes between different agencies and the launching of innovative interventions, all geared towards extending action against drug demand in various fields and settings and better meeting the existing needs.

Along these lines, the main focus of demand reduction activities for the year 2002 was upon the following:

- Establishment of new Primary Prevention Centres across the country, the ultimate goal being the establishment of at least one Primary Prevention Centre in each Prefecture.
- Extension of prevention activities to cover both specialised settings (i.e. army) and wider environments (i.e. municipalities), promoting an extensive action on the basis of an active collaboration among different actors.
- Further provision of treatment options at regional level, with the establishment of new "drug-free" treatment programmes and the extension of substitution treatment in general hospitals.
- Meeting the treatment needs of special population groups, including adolescents, imprisoned drug users and culturally differentiated groups.

8.2 Approaches and new developments

Primary Prevention Interventions

Since 1996, starting point of the plan of establishing Primary Prevention Centres across the country, a wide network of such Centres created by OKANA in collaboration with the local communities has been developed which at present counts 62 such centres (Annex V - Table I). Among these six were inaugurated in 2001 and eight in 2002 (Figure 16). The existing prevention centres cover the needs of 45 out of the 52 Prefectures in the country (86.5% coverage).

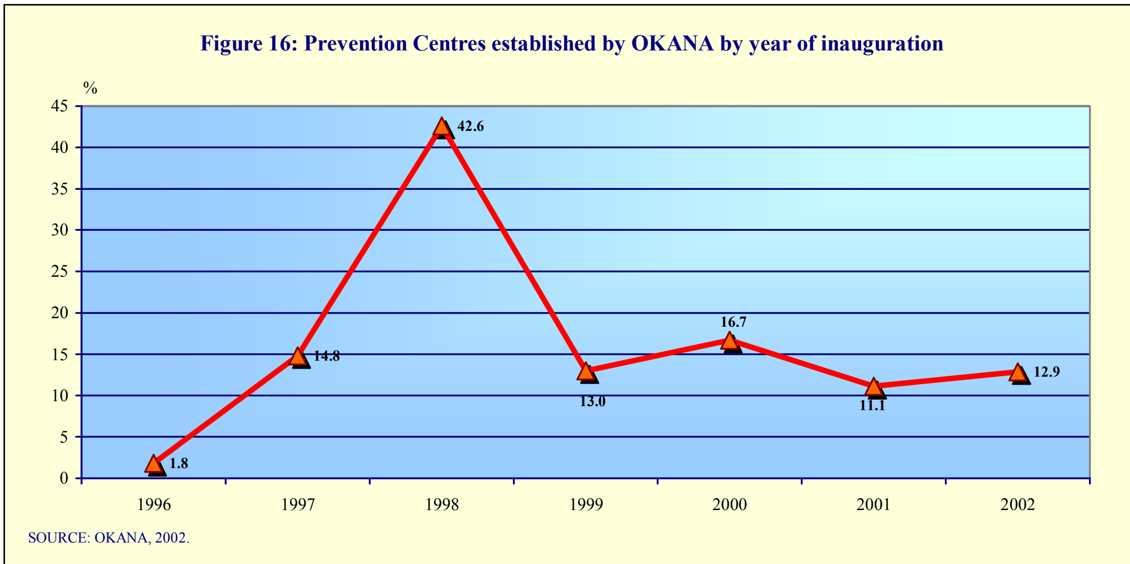


Figure 16: Prevention Centres established by OKANA by year of inauguration

SOURCE: OKANA, 2002.

Primary prevention interventions were consistently developed in local communities in 2001 (Figure 17). According to data collected by the EDDRA and the respective questionnaires of the Standard Tables in 2001, special emphasis was put on prevention interventions in the school community and in the family. Along these lines, there is a clearly growing tendency to approach children and adolescents (either directly or indirectly), given that adolescents are "the group running the most serious risk of messing with drugs, and the group whose age is most propitious for early interventions focused on prevention" (Gossop and Grant, 1994).

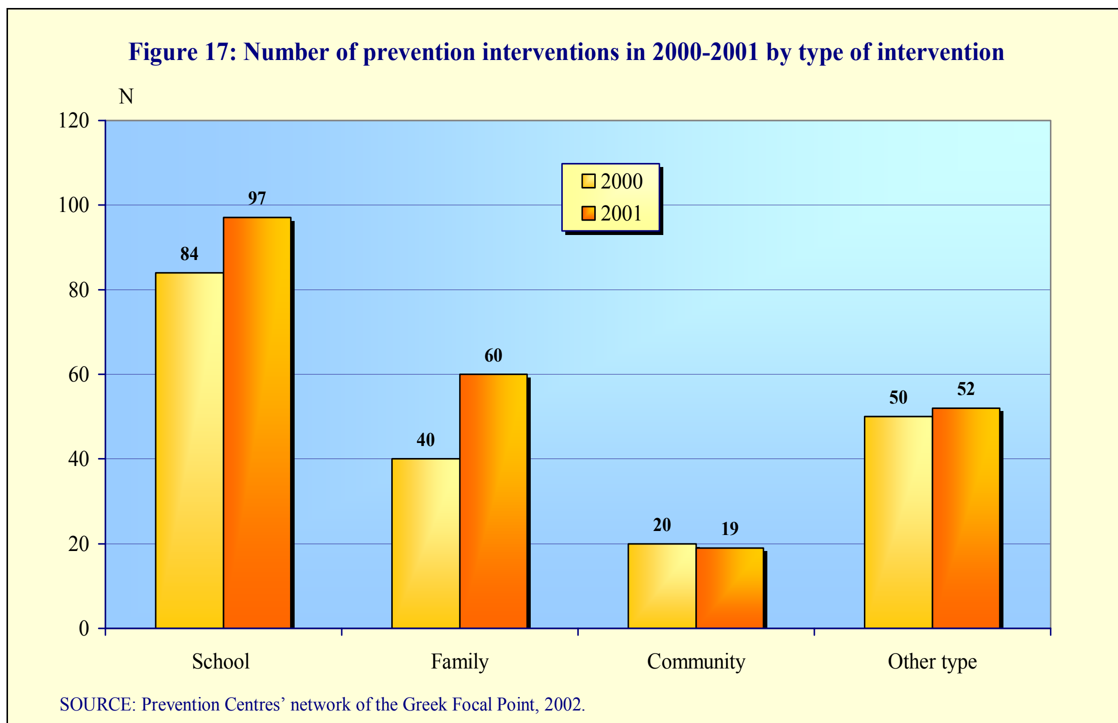


Figure 17: Number of prevention interventions in 2000-2001 by type of intervention

SOURCE: Prevention Centres' network of the Greek Focal Point, 2002.

In addition, the emphasis gradually given on the implementation of prevention programmes in Primary Education is another development that emerged in the last few years. Thus, 29 prevention programmes were implemented in Primary Education in 2001 compared to 9 programmes in 1998. This increase appears to be explained by the fact that prevention agents consider prevention programmes to be more effective when implemented in early childhood.

As a result of the increased inter-agency co-operation, that has been a major priority over the past few years, the Ministry of the Interior subsidised the Primary Prevention Centres twice in 2001-2002. The subsidy funds were granted to local governments in order for them to subsidise prevention centres; this helped the centres overcome the financial difficulties faced by many of them and thus intensify their preventive work.

Another significant outcome of the inter-agency collaboration in the drug demand reduction field in 2002 was the *Memorandum of Co-operation between the Organisation Against Drugs (OKANA) and the Ministry of National Defence*. The main objectives of this collaboration are to reduce drug use in the army and to encourage conscript drug users to undergo treatment. To this effect, the Memorandum provides for the following activities: a. awareness-raising and prevention programmes in the army in co-operation with prevention centres, b. training of the military personnel in organising prevention activities, c. referrals of conscript drug users to treatment programmes, and d. collection of comparable drug-related data. In this vein, the Ministry of National Defence provides for the interruption or the deferral of the military service on condition that the conscript will go under drug treatment.

Primary prevention has also been a major priority on a community level with the initiation of an innovative intervention combining preventive and suppressive measures. Pursuant to Law 2713/99, forty-five municipalities across the country have been in the process of setting up *Local Crime Prevention Councils*, which will consist of social workers and other specialised volunteers, as well as representatives of the Municipal Council, the police and judicial authorities, the social agencies and the local enterprises. Having a two-fold role, Local Crime Prevention Councils are responsible for organising prevention interventions in co-operation with Primary Prevention Centres and for providing the Ministry of Public Order with advice and consultation on the preventive and suppressive measures against crime to be taken in their municipalities.

Treatment interventions

The main trend in the therapeutic field in 2002 was the extension of drug treatment both in terms of types of intervention and geographical coverage, which in any case has remained a major priority over the last few years.

An initiative of great importance in 2002 was the *pilot prescription of buprenorphine* in a selected number of general public hospitals in the

country. It is envisaged that this treatment option, which has already started to be implemented in the General Hospital of Rhodes (capacity: 80 drug addicts), will be extended after the evaluation of the pilot phase. OKANA is responsible for supplying the substance to the participating hospitals and for setting prescription terms for the doctors. In addition, after the tentative prescription of buprenorphine within the existing OKANA substitution programmes in 2001, this particular substance can now officially be prescribed along with methadone.

Apart from the initiation of the General Public Health System's involvement in drug treatment, new specialised therapeutic programmes were established in 2001-2002. More specifically, until the end of 2000 there were only three specialised programmes for adolescent drug users, all of them based in Athens. Since then, KETHEA has established a counselling centre for this target group and its families in Thessaloniki, which in 2001 covered the needs of 39 adolescent drug users and 45 families, and two more *Units for Adolescent Drug Users* started to operate by OKANA in Athens and Thessaloniki in 2002.

All treatment options for drug users in Northern Greece were until recently concentrated in Thessaloniki. Acknowledging the need for decentralised specialised programmes, KETHEA established in 2002 a *Counselling Centre for Adult Drug Users and their Families* in Kavala (capacity: 45 individuals), which will develop into a comprehensive, multi-phase therapeutic programme in the near future. Drug users participating in the counselling programme are currently referred for the main treatment phase to the Therapeutic Community of “ITHAKI” (Thessaloniki). This will also be the case for the *Cross-Cultural Treatment Programme* in Alexandroupolis, which is the first tailor-made programme to meet the needs of different cultural, ethnic and religious groups of drug users.

Socially excluded drug users (i.e. homeless, immigrants and juvenile delinquents) are also the main target group of the innovative *Low-threshold Counselling Unit* of the Therapeutic Programme “NOSTOS”, established in 2001 in Piraeus. The Unit offers a wide range of services aiming at reducing drug-related harm (see also **Chapter 10.1 Description of interventions**).

A pioneering treatment programme started to operate in 2002 in the context of the criminal justice system. The *Drug Dependence Treatment Centre for Drug Addicted Prisoners* in Thebes (Central Greece) is a "drug-free" specialised programme which, although addressed to imprisoned drug users, is based on the perception that this specific population should be considered as "patients" rather than as "prisoners". The therapeutic programme lasts for two years and the capacity is 250 individuals (see also **Chapter 12.1 Assistance to drug users in prisons**). A similar centre is currently under development in Northern Greece, while the Ministry of Justice also foresees the construction of two more treatment centres for imprisoned drug users in Crete and Central Greece.

Socio-cultural developments and developments in the public opinion

In 2002, cases where local communities proceeded with several initiatives with the aim of putting pressure on policy-makers to develop drug services in their regions continued to co-exist with the exact opposite cases where local agents protested against the establishment of drug programmes in their neighbourhood. The initiation of the buprenorphine substitution programme in the General Public Hospital of Rhodes, as well as the impending establishment of new treatment units in Volos (Central Greece) and Chania (Crete), are some of the outcomes illustrating the former case. At the other end, persistent delays in the operation of KETHEA Cross-cultural Treatment Programme in Alexandroupolis and in the functioning of the OKANA's Substitution Unit in Thessaloniki are some of the consequences of local protests against treatment units (*see also* **Chapter 4.1 Social Problems**).

The arguments usually put forward by local people in protest are the following:

- units are located close to schools, sports facilities, and residential areas;
- addicted persons hang about those units (whether they attend the treatment programme or not) and citizens feel that this is a problem (e.g. disturbance of the peace);
- there is petty crime and drug dealing, which is attributed to the existence of the unit;
- real estate value is considered to drop in the surrounding area;
- disadvantaged areas get even more disadvantaged; local inhabitants tend to feel that units open in their community precisely because they have practically no access to decision-makers.

Difficulties arising from the contradictory attitude of local communities towards drug treatment programmes is exceeded by the fact that Local Authorities actively supported in most cases the establishment of treatment units In their region, which would be expected to preventsuch reactions from the inhabitants. However, this inconsistency in the lay public's attitudes appears to reveal that there is a need for further systematic awareness-raising interventions targeted to the general population, aiming at destigmatising addicted persons and changing the aforementioned misconceptions. Moreover, professionals argue that there is also a need for better organisation and custody measures, especially with regard to substitution units, in order to prevent the possible petty crime from appearing near the units.

Permission granted by law to general hospitals to prescribe buprenorphine has aroused great controversy among doctors, who argued that general public hospitals face several organisational problems (i.e. lack of personnel), that the particular substance can meet the needs of a limited number of addicted persons and that there is a danger of creating unrealistic expectations for drug dependence treatment to drug addicts. On these grounds, they alternatively suggested that general public hospitals should rather provide "drug-free" treatment programmes by well-trained personnel. In addition, in 2002 there was an explicit need to establish a common institutional framework for "drug-free"

programmes, which would ensure quality and provide a basis for new programmes to be officially recognised.

New research findings

The overview of studies in the demand reduction field conducted during the reporting year illustrates that there is a growing interest in implementing interventions for younger ages and in determining the aggravating and reinforcing factors in drug treatment.

Recent research has reported that the mean initiation age for drug use tends to decline, indicating that adolescence is considered of critical importance in the developmental process. Within this framework, prevention policy should focus on younger ages (Bardanis, 2001). This perception leads to the implementation of primary prevention programmes in school settings, based on the methodology of instructive and active learning through experiential groups (Evdokimou, 2001). Another study highlights the importance of the active participation of all members of the school community (students, teachers and parents) and emphasises the significance of education as a means to encourage the development of team spirit and initiative (Aggelou, 2001). A further point regarding the involvement of the educational system in intervention areas is raised in a study on the evaluation of teacher training programmes. These programmes give priority to teachers' experiential training by taking advantage of their experiences and concerns (Kiriakidou et al., 2001).

It is further emphasised that counselling should be included in drug prevention practices (Kalliga, 2001). The application of counselling interventions in Secondary Education demonstrated that students had for the first time the opportunity to express the demand for psychological help (Koutras, 2001). In line with the aforementioned principles, another study emphasises the importance of family. Thus, it suggests that parents' needs are of great importance and should be taken into consideration during the planning of drug prevention programmes (Bardanis, 2001). Moreover, a holistic approach to prevention promotes the development of programmes based on the value of three factors: a. voluntary work, b. community training and c. development of a social network. The aim of these programmes is to train volunteer citizens at the regional level in planning and implementing prevention interventions (Zorba and Georgopoulou, 2001).

As regards research findings on drug treatment, a study investigating the correlation between suicidal ideation and the stay and dropouts in substitution programmes, has demonstrated that the admission of drug addicts to a substitution programme is followed by a significant reduction of their suicidal ideation. In addition, it came out that patients with recent suicidal ideation stay in the programme compared to those who did not report suicidal ideation prior to admission (Kouklinos et al., 2000). The findings of another research have shown that the parallel use of opioid drugs and other psychoactive substances is one of the major problems of methadone substitution programmes, due to the harmful effects of synergy. Hence, systematic control and management of

parallel drug use is considered to be of major importance in this setting (Garderi et al., 2001).

Another recent study has pointed out that multiple psychiatric disorders frequently co-exist with drug abuse at a rate estimated to be higher than 50%. Thus, comorbidity appears to be the rule in addicts approaching mental health services. Addicts with comorbidity present particular clinical features and generally have poor compliance and response to treatment. The lack of specialised services for such cases often leads to diagnostic failures and inadequate treatment. Hence, the study suggests better training for professionals, the redefinition of therapeutic attitudes and priorities, as well as the development of relevant services (Liappas et al., 2001).

Finally, some studies have highlighted the importance of combining physical and emotional techniques and have suggested the utilisation of physical/athletic activities or creative arts in drug treatment. These alternative therapeutic methods operate as a means of communication and creativity, offering drug addicts the opportunity to get acquainted with their body and their emotions (Hatzoudi and Haritopoulou, 2001; Karkou, 2001).

Specific events during the reporting year

The following list presents most of the meetings and conferences held in 2002:

1. Conference on “Effectiveness of Drug Abuse Treatment”, Athens, 4 February 2002, organised by KETHEA in co-operation with the Department of Psychiatry of the University of California and the Department of Sociology of the National School of Public Health.
2. 1st Annual European Conference of Telematics and Prevention on “The Use of Telematics for the Prevention of Drug Dependence: Future Perspectives”, Athens, 13 March 2002, organised by the Prevnet Network in co-operation with the University Mental Health Research Institute.
3. Press conference organised by the University Mental Health Research Institute in Athens on 15 March 2002, on the occasion of the presentation of the Greek REITOX Focal Point’s Final Evaluation Report.
4. Meeting on “Vulnerable Populations, Drug Dependent Mothers and their Children”, Athens, 1 April 2002, organised by the Drug and Alcohol Dependence Unit “18 ANO” of the Psychiatric Hospital of Athens.
5. Meeting on “Psychosocial Needs in Family and New Addictions in Adolescence”, Athens, 15 May 2002, organised by the Prevention Centre “ARGO”.
6. Conference on “Training Health Professionals in the Drug Addiction Field”, Athens, 27 May 2002, organised by KETHEA in co-operation with the Department of Psychiatry of the University of California.
7. Meeting on “Drug Dependence and its Treatment in the Health Field”, Samos, 8 June 2002, organised by the Prevention Centre of the Prefecture of Samos.

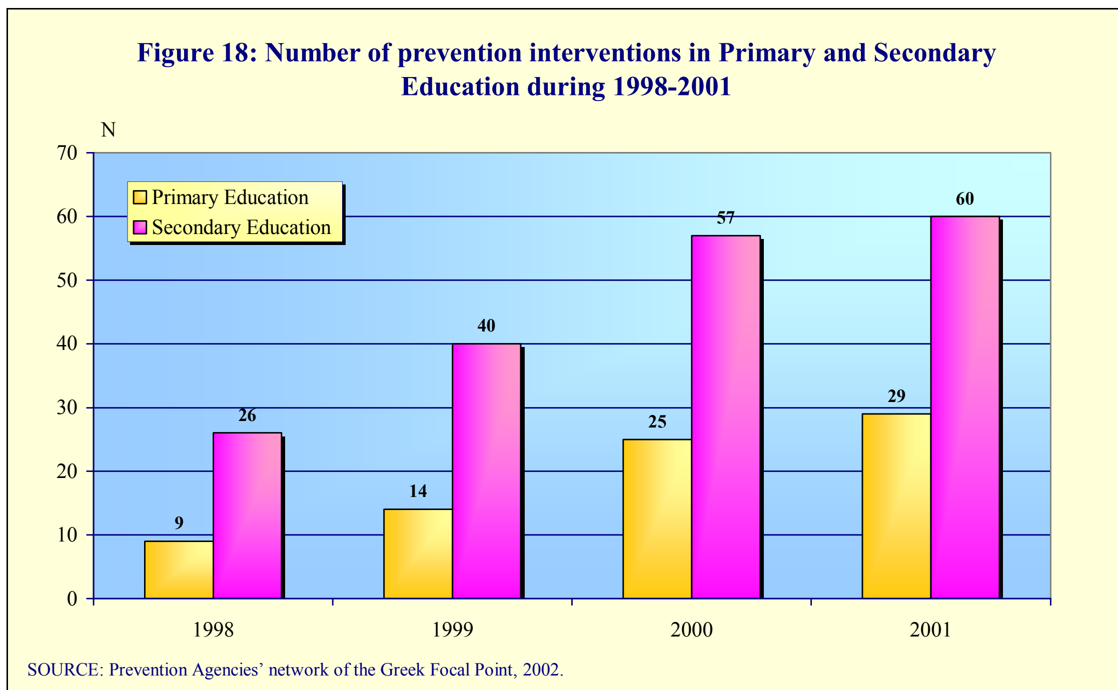
8. Meeting on "Prevention: Act of Life – Responsibility for the Future", Athens, 25 June 2002, organised by OKANA in co-operation with the Union of Professionals Working at the Prevention Centres of OKANA and Local Authorities.
9. Press conference organised by the University Mental Health Research Institute in Athens on 2 July 2002, on the occasion of the presentation of the Greek Annual Report for Drugs and Drug Addiction in Greece.
10. Meeting on "Prevention and Mental Health", Karditsa, 7 September 2002, organised by the Prevention Centre of the Prefecture of Karditsa.
11. Conference on "Stigma and Social Exclusion", Athens, 23 September 2002, organised by KETHEA in co-operation with the Department of Psychiatry of the University of California.
12. Conference on "What is New on Epilepsy?" and "Drugs and their Neurological Complications", Athens, 11 October 2002, organised by the Neurology Department of the General Hospital of Athens in co-operation with the Neurology Department of Columbia University of New York.

9. Prevention

9.1 School programmes

Even though both drug-specific and drug non-specific prevention programmes are still not mandatory at school, interventions in the student population remain the first priority of prevention policy nation-wide.

The Organisation Against Drugs (OKANA) and the Ministry of Education are developing preventive activities at schools through OKANA's Prevention Centres and Health Education Programmes respectively. Prevention Centres, and prevention agents in general, are now increasingly active at school, which is also the field of action of the National Health Education Network set up by the Ministry of Education in order to promote and support health education programmes (see Annual Report 2001). Consequently, primary and secondary education interventions increased in 2001, compared to the two previous years (Figure 18).



Regarding the health promotion interventions developed by the Ministry of Education, in the academic year 2001-2002, 1400 such interventions were implemented in primary education and 900 in secondary education, out of which 220 were interventions on drug prevention.

Moreover, in 2001, the Pedagogical Institute began a pilot implementation of a new school programme starting from nursery and primary schools with a 'flexible zone' of inter-thematic and creative activities, and continuing in junior high school with an 'innovative actions zone'. The main aim of this programme is to reshape the curriculum, so that teachers and pupils are free to model a part of it in a way that would suit their interests, and to develop critical thinking, an attitude of collective effort and initiative. The programme will include thematic modules (i.e. drugs, sports, health education) on the basis of specialised educational material.

In addition, one of the Ministry's of Education actions in order to promote and support health education in the educational institutions is the establishment of the Youth Counselling Centres, as well as the Centres of Diagnosis, Evaluation and Support, in the framework of the National Network of Health Education.

Prevention interventions implemented by prevention professionals in the school community include three stages:

a) Raising the *awareness* of teachers. This includes interventions addressed to teachers, in order to inform them on the work of prevention agencies and raise their awareness about prevention and their own role in it. These are actually experiential seminars in most cases, through which teachers can make their first acquaintance with the concept and processes of prevention, and express their wish to cooperate further in that regard (e.g. to be trained in order to implement a programme).

b) *Teacher training*. This includes seminars either on specific educational packages (e.g. “Skills for primary school children”, “Children’s games” for primary education programmes, “Standing on my own feet” for secondary education programmes) or on prevention issues and modes of intervention in general, in order to enable teachers to implement prevention programmes.

c) *Implementation of programmes* in schools either by teachers (with or without the supervision of prevention professionals) or by prevention professionals.

In addition, prevention professionals consider the involvement of parents to be of importance in the implementation of school prevention programmes, and parents therefore are often included in such programmes (see Unit 3 of this Chapter).

Prevention programmes available in the country

Primary Education. In 2001, 590 teachers and 2,750 schoolchildren were approached. In addition, 185 teachers attended training seminars on primary prevention, while 151 (81.6%) implemented prevention programmes (Table 12).

Table 12: Data on primary prevention interventions in Primary Education in 2001

	Number of interventions/ programmes	Number of participants/ teachers	Mean duration (in months)	Number of participants/ students
Information and awareness-raising interventions addressed to teachers	14	284	2	–
Programmes less than a year long implemented by professionals	3	100	3.5	517
Programmes more than a year long implemented by professionals	1	19	> 12	161
Programmes less than a year long implemented by teachers	4	73 were trained 49 implemented a programme	5	657

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	Number of interventions/ programmes	Number of participants/ teachers	Mean duration (in months)	Number of participants/ students
Programmes more than a year long implemented by teachers	7	112 were trained 102 implemented a programme	> 12	1416

Secondary Education. About 1,280 teachers and 8,600 schoolchildren were approached in 2001. Furthermore, 665 teachers were trained in order to implement a school prevention programme, and 302 (45.4%) did implement such programmes (Table 13).

Table 13: Data on primary prevention interventions in Secondary Education in 2001

	Number of interventions/ programmes	Number of participants/ teachers	Mean duration (in months)	Number of participants/ students
Information and awareness-raising interventions addressed to teachers	14	484	4	–
Information and awareness-raising interventions addressed to students	8	–	4	1265
Programmes less than a year long implemented by professionals	9	92	5.5	2834
Programmes more than a year long implemented by professionals	2	43	> 12	217

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	Number of interventions/ programmes	Number of participants/ teachers	Mean duration (in months)	Number of participants/ students
Programmes less than a year long implemented by teachers	13	200 were trained 131 implemented a programme	8	1967
Programmes more than a year long implemented by teachers	14	465 were trained 171 implemented a programme	> 12	2326

Awareness-raising interventions addressed to both pupils and teachers in primary and secondary education. Some prevention agents run joint awareness raising activities addressed to both primary and secondary education teachers and pupils. In 2001, there were 8 such interventions involving about 250 teachers and 4,225 pupils.

Programmes less than a year long

According to the data provided to the Standard Tables, 29 school prevention programmes were less than a year long, 7 of which in primary and 22 in secondary education. In addition, 17 of them were implemented by teachers and the remaining 12 by prevention professionals (Tables 12 and 13).

These programmes draw on a combination of theoretical models. Life skills, social development and health promotion models are used in all school programmes, while several of them also use the peer approach model.

Regarding the educational material school programmes are built on, 1 primary education programme less than a year long was based on “Skills for primary school children” and the majority of the secondary education programmes (11 out of 13) on “Standing on my own feet”. The rest are not based on specific educational material, but on a variety of theoretical models or on an adaptation of available material according to programme objectives and group needs.

The evaluation of programmes less than a year long is conducted by prevention professionals implementing them, and focuses mostly on the process, on the degree of participants’ satisfaction and on personal estimates about the programme.

Programmes more than a year long

According to the data provided to the Standard Tables, in 2001 there were 24 school prevention programmes more than a year long, 8 of which for primary and 16 for secondary education. Furthermore, 21 of them were implemented by teachers and 3 by prevention professionals (Tables 12 and 13).

The objectives of those programmes are closely related to the psychosocial needs of pupils of that age, as well as to the broader social and cultural demands and to current prevention philosophy, according to which prevention of substance use is mainly a function of developing those personal and social skills which make people more responsible and autonomous when it comes to physical and mental health matters. Other aims include improving communication between pupils and their peers/teachers/families, building resistance mechanisms to peer pressure, changing attitudes towards substance use, and learning how to deal with problems.

To reach these objectives, school programmes use a combination of different theoretical models, such as cognitive, emotional, psychosocial and person-centred/humanistic models, as well as the systems theory.

Moreover, 4 of the primary education programmes more than a year long were based on the educational material “Skills for primary school children” and 1 on “Children’s games”. The majority of the secondary education programmes (12 out of 16) were based on “Standing on my own feet”.

Evaluation studies and results

Most of the 24 school prevention programmes more than a year long (66.6%) indicated that evaluation was still underway, 23.8% that evaluation was ongoing, and 9.6% that evaluation was foreseen in the future. Evaluation is conducted by prevention professionals implementing the programmes.

Below, an indicative reference is made to 2 school programmes in primary and secondary education with specific qualitative and quantitative evaluation data measured in relation to the objectives initially set.

“Let’s play: Skills for primary school children - A theatrical game” (Prevention Centre for Combating Dependent Substances of the Eastern area of the Prefecture of Thessaloniki “ELPIDA”)

In this programme, which has been running since February 1999, 13 teachers from 10 schools were trained, and 11 of them implemented the programme in co-operation with the Prevention Centre staff. Regarding the achievement of the programme’s objectives, according to teachers’ replies, 90% of pupils practised decision making, while the objectives of enhancing their self-image, involving

them in group activities and helping them develop resistance skills to peer pressure were achieved by 80%.

According to qualitative evaluation data, during the programme's implementation, pupils addressed new issues and an atmosphere of confidence developed in class. Some teachers observed that pupils were more interested in their classes and that they tended to participate more actively compared to what was the case before the programme's implementation.

Secondary education teacher training seminar in the educational material entitled "Standing on my own feet" (Prevention centre Against Substance Use of the prefecture of Ilia "Paremvasis")

In the framework of preventive actions in the school community, the Prevention Centre of the Prefecture of Ilia has been running training seminars since 1998 in order to raise the awareness of and train secondary education teachers in prevention programmes.

In October 2000, a training seminar was held for 18 teachers. 35% of the seminar participants went on to implement health education programmes based on the material "Standing on my own feet" and 40% implemented a health education programme without using this material or only using it partly.

Several teachers said that the seminar had helped them get acquainted with active learning methods not just for prevention programmes' implementation but for their own classes, too. Others said that their personal and social skills had been enhanced. Almost all of them agreed that running health education programmes on pupils' psychosocial health was very important, stressing the need to support teachers in their effort to implement such programmes. For more information about the specific programme, see EDDRA Database.

Research projects

- "Investigating trends in substance dependence attitudes among students of the Technological Education Institute of Athens, aged 18-24" (Social Service of the Technological Education Institute (TEI) of Athens, 2001)
- "Ways of aggressiveness, violence and protest in school" (Pedagogical Institute – Education and Initial Vocational Training, 1999)
- "The production and the re-production of violence in school" (National Centre of Social Research (EKKE), Institute of Political Sociology, 2000)
- "Investigating university students' attitudes towards substance use: the need to implement primary prevention programmes in Higher Education" (Section of Primary Prevention and Training – OKANA, Counselling Centre of the University of Piraeus, 2001)

- “Evaluation of the Health Promotion Programme implemented in the 132nd Primary School of Athens” (KETHEA, 2002)

9.2 Youth programmes outside school

Asthe priority of primary prevention policy nationwide focus on actions aimed at preventing drug use and addictive behaviour in young people, interventions addressed to adolescents are not limited on school premises only. Young people cannot be approached only at school, either because school priorities are more academic in nature and there is not much time available for other activities, or because students have sometimes difficulties in participating in school prevention programmes, as experience has shown, or due to the fact that some of them have dropped out of school and, therefore, need to be approached in other settings.

In this framework, youth programmes are based on the principal rationale of school programmes, i.e. to promote health attitudes and to develop personal and social skills. Thus, these programmes include experiential groups for adolescents, as well as information dissemination and awareness raising activities in summer camps, cultural and sports clubs, municipal libraries, etc. In addition, it is important to mention that programmes outside school focus mainly on adolescents outside the school setting, rather than young people at risk or recreational substance users, as this kind of intervention has not yet been fully developed in Greece.

In 2001, 17 youth interventions outside school were developed (groups of adolescents) for 162 adolescents, lasting 16 meetings each, as an average. Also, there were 5 information and awareness raising interventions, during which 316 adolescents were approached. In addition, 2 prevention interventions took place in summer camps with the participation of 50 camp group leaders.

The **Prevention Centre of the prefecture of Aitoloakarnania** has been running since 1998 a self-help group intended for young alcohol and recreational substance users, as well as for high-risk youths. The main aims of this programme include the provision of information and psychosocial support to young recreational alcohol and drug users, as well as their involvement in creative activities alternative to drug use.

For the majority of programmes outside school (47.8%), the aim is to provide reliable information and raise the awareness of young people about prevention, as well as to provide psychosocial support (30.4%). Other aims include peer training (21.7%), offering alternatives to drug use (17.3%), involving young people in community actions, and developing their personal and social skills (13%).

Programmes with the latter objectives involve mainly creative activities, such as participation in community actions, information seminars, painting, clay, games, role playing, screening of films, participation in theatre and photography groups and provision of information through the Internet.

To achieve their objectives, youth programmes outside school apply simultaneously a combination of different theoretical models, including peer approach, the influence-social learning model, the catching-client model (referral or psychosocial support), as well as the life skills model. Furthermore, 5 programmes were based on the educational material entitled "Log Book - Armenistis 1900", which was produced by the Educational Centre for Primary Prevention and Health Promotion for use by prevention professionals running prevention programmes addressed to adolescents outside school. Its aim is to help adolescents down the road to autonomy.

The **Information and Prevention Centre of the Prefecture of Drama** conducted a primary prevention programme for youth outside school, entitled "info-kiosk", in order to provide information about substance use to young people and approach young people of ethnically and culturally different groups. It involves an information centre with PCs, which young people can use in order to search for information on matters like career guidance or prevention of substance use, as well as to create their own websites and communicate with peers by e-mail. In addition, there is a place where young people of ethnically and culturally different groups can meet with local people of their age. Qualitative results indicated that a lot of young people visited the "info-kiosk" and had the opportunity to get more familiar with PCs and the Internet. Furthermore, they received a lot of information about substance use and, as they stated, they transferred this knowledge to their peers. Finally, they had the opportunity to meet other people of their age.

As far as training courses for professionals in this field are concerned, the Educational Centre for the Promotion of Health and the Prevention of Drug Abuse (UMHRI/OKANA) provides special training to prevention professionals in youth interventions outside school, and, more specifically, in the educational material "Log Book - Armenistis 1900".

9.3 Family and childhood

Interventions for pre-school children are still limited in Greece, since preventive agents focus more on students in primary and secondary education rather than children of younger age. Thus, while interventions addressed to children in secondary education greatly outnumber others and prevention programmes for primary school children are continuously expanding, new interventions addressing pre-school children and their families are gradually being organised. However, family is still one of the core target groups of all prevention agents nation-wide. In this context, prevention professionals:

- Implement interventions for parents in order to inform them about prevention and the family's role in it
- Organise interventions in order to raise the awareness of parents whose children participate in school programmes, as prevention professionals support that no intervention in the school community can ever be complete unless parents are involved

- Run programmes for parents (groups of parents) in order to support them in their role, to guide them in their children's upbringing, to help them improve communication in the family, and to give them the possibility to recognise and express their feelings, personal needs and concerns.

In order to achieve these objectives, the systemic model is applied to a large extent. Programmes for parents also apply the cognitive model, the psychosocial approach, the psychodynamic and emotional models, as well as experiential methods and group and active learning techniques. Moreover, 20 family programmes were based on the educational material "Communication in the family" and 2 on "Skills for primary school children".

In the year 2001, 41 family prevention programmes were developed (6 of which were addressed to parents of infants and pre-school children). In addition, 19 information/awareness raising interventions for parents were organised (Table 14).

Table 14: Data on family prevention interventions in 2001

Number of interventions/ programmes	Number of participants – parents	Mean duration (in months)	Average number of meetings	Average frequency of meetings
Information and awareness-raising interventions				
5	1830	2	2	-
Information and awareness-raising interventions in the context of school prevention programmes				
14	420	8.5	-	-
Programmes (parents' groups)				
41	1810	2.5-3.5	12-17	Once a week

Out of the total 41 family programmes, evaluation in almost half of them (53.7%) focused on the scope and acceptability of the programme (process evaluation), and in 46.3% on the extent to which the programme's objectives were achieved (outcome evaluation). Evaluation was conducted by prevention professionals implementing the programme.

Below, there is an indicative presentation of a family programme with quantitative and qualitative evaluation data measured against the objectives initially set.

Prevention interventions for parents – Prevention Centre of the Municipality of Glifada

Ever since it was established, the Prevention Centre of the Municipality of Glifada has approached parents in order to raise their awareness about

prevention and started working through groups of parents. In a cycle of 13 meetings, information was provided on parents' role in prevention. Parents were very responsive, and their active participation in these groups triggered off a second and a third cycle of meetings, during which experiential workshops were conducted about communication within the family. Programme evaluation was carried out through questionnaires administered to the participants at the end of the programme. Table 15 includes parents' answers.

Table 15: Evaluation of the family prevention programme, based on parents' replies

Parents' replies (N=160)	%
Knowledge gained about relationship and communication matters	65
Better dealing with relationship matters in the family	55
Recognition and communication of feelings	45
Better managing conflicts	45

Parents reported that the programme helped them express their opinion, set limits, and manage their own affairs and their communication with others in a better way.

9.4 Other programmes

Peer-to-peer approaches

Peer-to-peer approach, as primary prevention programmes implemented by peers, is not really widespread in Greek prevention philosophy and practice. Rather, prevention professionals tend to assume that young people who participate in prevention programmes will transfer the knowledge and experience gained to their peers. However, in parallel with the development of interventions addressed to children in primary and secondary education, as well as to pre-school children, implemented by professionals and/or teachers on and off the school premises, programmes based on peer-to-peer approach are gradually being organised.

In this framework, in the **Centre for Creative Occupation** (**"PROTASI" Movement**), young people aged 13-18 are given the opportunity to communicate and express themselves, to plan and participate in creative activities, to obtain skills and experiences and, generally, to improve their personal development. The main body of activities implemented by the CCO is through Groups of Creative Occupation (theatre, puppet theatre, music, photography, painting, handicrafts). An important programme implemented in the C.C.O by the prevention professionals of "PROTASI" is the "Day Programme", aiming at informing and raising the awareness of school students about primary prevention. In addition, since 1996, the CCO has been involved

in intercultural exchanges and meetings in co-operation with other Youth Centres in Europe.

Another activity of the "PROTASI" Movement is the formation of a group called SEVACH (Shinbad) group, which is consisted of young people who participate in every prevention programme organised by PROTASI. In 2001, they were trained in the production of radio and TV spots and they produced some spots with prevention messages for the young people of Patras. The messages were about drugs, communication, relationships, and self-esteem. The radio and TV spots were promoted to the media. In addition, the members of the SEVACH group created postcards, which were distributed to the young people of Patras. This action was supported by the Greek National Youth Service in the framework of the EU Programme "YOUTH".

Telephone help-lines

At present five telephone help-lines operate in Greece, three of which are specialised in drug related issues (Table 16).

Table 16: Telephone Help Lines

Telephone Help-lines	Contact Number
Open Line (Drug Dependence Unit “18 ANO”)	210-3617089
“SOS Line” (Help Centre – OKANA)	1031
Telephone Help Line for Psychological Support (“ITHAKI” – KETHEA)	2310-234552, 234506, 234508
Solidarity Line 1037 (Ministry of Macedonia & Thrace)	1037
Telephone Line “Support” (Greek Naval Forces)	801-1147801, 210-5574121

The **Open Line of the Drug Dependence Unit “18 ANO”** was the first specialised help-line with national coverage. It was founded in 1992 and it is an active member of FESAT (Fondation Européenne des services d' aide téléphonique drogues), which provides systematic training to the personnel of the Open Line. According to data for 2001, the total number of phone calls received was 2,291.

The **“SOS Line”** of the **Help Centre** of **OKANA** reported that, during 2001, the total number of telephone calls received was 3,380; 79.8% of the phone calls were from individuals who were calling for the first time, while 20.2% of callers had also called in the past. The individuals who contacted this help line in 2001 can be broken down as follows: 46.2% were parents, 19.4% drug users, 18.1% relatives, 16.3% others (e.g. professionals). Furthermore, the SOS Line participates in the European project “Elaboration of concepts for secondary prevention of drug use” and in the Network of Addicted Mothers, a programme

initiated by the Drug Dependence Unit 18 ANO, while it is an active member of FESAT.

The **Telephone Help Line for Psychological Support** of the therapeutic programme **"ITHAKI"** of **KETHEA**, which has been operating since November 2000 within the framework of URBAN Community Initiative, received a total number of 1,384 phone calls. In 2001, 27% of the callers were from the Prefecture of Thessaloniki and 73% from the rest of Greece. The requests can be broken down as follows: 80% concerned the provision of support to drug users and/or friends and relatives, and 20% asked for information on drug-related issues and services.

Finally, the **Telephone Line "Support 210 5574121"** of the Greek Naval Forces is the only facility of this kind in the Greek Armed Forces. It is addressed to naval conscripts and officers, and offers referrals and information about treatment options, as well as support.

Community programmes

The basic philosophy of community programmes is that the involvement of local community agents in prevention programmes, together with partnerships and social networking between community members, contribute to promoting social cohesion and to restraining the effects of social causes leading to drug use (e.g. social exclusion, marginalisation, lack of communication).

Primary prevention programmes in the community can be conceived either as holistic, multifaceted interventions whose co-ordinated activities are aimed at the general public of the local community and are, most of the times, addressed to specific community groups (e.g. societies, clubs), or as the development of networks of volunteers (e.g. mental health professionals, parents, teachers, the Church) with the aim to involve them in preventive activities.

In 2001, 19 **community programmes** were implemented (average duration: two years) for parents, sports, cultural, social, etc. clubs, schools, local government organisations, health professionals, young people, journalists, police officers, and community members in general.

The main objectives of most community programmes are to provide information on drug use and prevention philosophy, as well as to stress the importance of the involvement of community members (83.3%), to develop personal and social skills (33.3%), to provide health education (27.7%), and to propose alternatives to drug use (16.6%).

To achieve their objectives, community programmes draw on a combination of different theoretical models (Table 17).

Table 17: Main theoretical approaches of community programmes

Models used in community programmes (N=19)	%*
Health Promotion	33.3
Knowledge on drugs	33.3
Life Skill	27.7
Social Development	16.6
Reasoned action - attitude	16.6
Evolutive	16.6
Influence and imitation	11.1
Triadic influence	5.5

* Added percentages exceeds 100% because of multiple answers

Community programme activities include training seminars for involvement in prevention actions, presentations, events, distribution of information material, publicity campaigns on prevention philosophy and work in the community, and creative activities such as drawing, clay, graffiti, etc.

Prevention professionals also approach **volunteers** who are members of local clubs and associations, in the context of their activities aimed at achieving community networking and winning the confidence and support of community members. In 2001, 4 training workshops were implemented for 140 volunteers. Their mean duration was two months and they included 11 meetings as an average. These programmes included information and training seminars in order to:

- offer basic knowledge on prevention principles, protective and risk factors, and psychosocial causes related to drug use
- train participants in the philosophy, planning, implementation and evaluation of prevention programmes
- enhance their personal and social skills
- achieve the permanent involvement of volunteers in prevention actions

Prevention agencies also implement prevention programmes for **local government authorities** and organisations, because their role has its own impact on social attitudes towards primary prevention. In 2001, 3 programmes were implemented for local government people (average duration: 2 months; average number of meetings: 9; total number of participants: 47). The aim of those programmes was to provide information and raise awareness about prevention, as well as to involve participants in relevant activities.

In 2001, prevention agencies ran training seminars for **police and coast guard officers** in order to help them understand their own role in prevention and to facilitate co-operation between the Police, the Coast Guard and prevention

agencies. In 2001 there were 4 such interventions with 166 participants (average number of meetings: 6; duration: 1-2 months).

In the framework of their networking effort, prevention agencies approached **health professionals** from various fields in order to foster co-operation and exchange of experiences and opinions. In 2001, 3 interventions-meetings were held, during which 62 health professionals were approached.

Mass media campaigns

During the period of 2001-2002, the issue of drugs was a major mass media topic. Various TV and radio broadcasts, as well as press articles, dealt with the different dimensions of the drug phenomenon in Greece.

OKANA launched a social mass media campaign on prevention with the contribution of the Association of Advertisement and Communication Companies (EEDE). The target population of that campaign was young people (age group: 12-18). The specific objectives of the campaign were: a) to change the belief that cannabis use is harmless and b) to change young people's perception of recreational substance use. It included development of messages, TV spots, radio messages, as well as press and magazine clips. One advertisement company out of five was selected to run this prevention campaign and offered to provide its services free-of-charge. Similarly, TV spots, radio messages, as well as press and magazine clips were also promoted free-of-charge, thanks to the contribution of the relevant companies. In addition, posters were put up throughout Greece with the help of Prevention Centres, while the network of the Health Promotion Bureau of the Directorate of Secondary Education Curriculum, the General Secretariat of Sports, the Ministry of National Defence, as well as the Company of Thermal Buses (ETHEL) and the Athens-Piraeus Trolley Buses (ILPAP) were engaged in order promote the posters in schools, sports playfields, army camps, buses and trolley buses, respectively.

Another social mass media campaign was launched by the **Therapeutic Programme for Adolescents "STROFI"**. In this context, two TV spots were developed. The first one was addressed to adolescents with the message "in STROFI we can give you a hand for your way back"; the second spot was addressed to parents and the following message was included: "If you realise that your child uses drugs, talk. Talk about the real problem, talk to us; we won't hear this for the first time". A poster was also created and put up in bus stops in Athens. The message of the poster was "This is not a mirror, but if you can see yourself in it, call 210 8820277".

Furthermore, the press gave special emphasis on the coverage of new demand reduction initiatives. The local press, in particular, systematically reported demand reduction developments and activities implemented on a local level. The local press also published articles written in co-operation with staff of Prevention Centres in order to enhance public awareness about drug use and inform people about drug matters. In addition, significant emphasis was placed

on the coverage of various activities organised on the occasion of the International Day Against Drugs.

Finally, prevention professionals consider their co-operation with journalists to be necessary for the prevention philosophy to get through. In 2001, 4 interventions were implemented, during which 37 journalists were approached. The aim was to raise the awareness of the journalists about drug addiction and to make them realise their own role in prevention, as well as to inform them on the work of Prevention Centres.

Internet

The use of the Internet is gradually increasing in the field of demand reduction. Some of the main existing websites are presented below:

Websites of national governmental and non-governmental organisations:

a) http://www. ypyp.gr

Ministry of Health and Welfare (also available in English)

b) http://www.ypepth.gr

Ministry of Education and Religious Affairs (also available in English)

c) http://www.okana.gr

Organisation Against Drugs

d) http://www.ektepn.gr

Greek Focal Point (also available in English)

e) http://www.kethea.gr

Therapy Centre for Dependent Individuals (also available in English)

f) http://www.ydt.gr/drug.htm

Greek Police Force

g) http:// www.msf.gr

Médecins Sans Frontières / Greek delegation

In addition, **prevention and treatment agencies** offer detailed information on their various programmes through their websites. Some of these websites are listed below:

Websites in the field of prevention:

a) http://www.prolipsi.gr

Prevention Centre Against Drugs of the Prefecture of Florina

b) http://www.karditsa-pkp.gr

Prevention Centre Against Dependence of the Prefecture of Karditsa

c) http://www.paremvasis.net.gr

Prevention Centre Against Substance Use of the Prefecture of Amaliada "PAREMVASIS"

d) http://www.prolipsihiou.gr

Prevention Centre Against Substance Use of the Prefecture of Chios

e) http://www.kpelpida.gr

Prevention Centre for Combating Substances of the Eastern Area of the Prefecture of Thessaloniki "ELPIDA"

g) http://www.edessacity.gr/orama

Prevention Centre Against Substance Use of the Prefecture of Pella

h) http://www.forthnet.gr/protasi

Prevention Centre Against Substance Use of the Prefecture of Achaia

(also available in English)

i) http://www.kentro-prolipsis.gr

Drug Prevention & Health Promotion Centre "ATHENA HEALTH"

(also available in English)

j) http://www.nhreas.gr

Prevention Centre Against Substance Use of the Prefecture of Kilkis "NIREAS"

k) http://www.kifissia.gr/portal/$pronoi.php

Prevention Centre Against Substance Use of the Borough of Kifissia "PRONOI"

Websites in the field of treatment:

a) http://www.strofi.net.gr

Therapeutic Programme for adolescents STROFI

b) http://www.kethea-ithaki.gr

Therapeutic Programme ITHAKI

c) http://www.auth.gr/selfhelp/home.htm

Self-help Promoting Programme of the Aristotle University of Thessaloniki (also available in English)

d) http://www.hellasnet.gr/tendetox

Department for Adolescents and Young Adults of the Drug Dependence Unit "18 ANO" (also available in English)

e) http://www.kpp.gr

Multiple Intervention Centre (also available in English)

10. REDUCTION OF DRUG RELATED HARM

Drug-related harm reduction is one of the major priority areas according to the National Action Plan Against Drugs 2002-2006. Taking into consideration the increased number of drug-related deaths, the serious health problems that drug users face or are in risk of facing, and the unwillingness of many addicts to join a treatment programme, the national policy focuses on developing specialised structures that will effectively address these factors. According to the national strategy, harm reduction is based on a two-fold definition that encompasses:

a. a network of crisis interventions to provide immediate and specialised help to drug addicts with health problems, and

b. services to provide counselling, support and training on safe drug use practices to addicts who do not contact treatment programmes.

The key objective of harm reduction interventions is to ensure the least possible physical and mental harm related to drug use. On these grounds, the national policy placed emphasis on the promotion of a harm reduction approach in the past three years, which is mainly reflected on the increased substitution treatment (*see also* **11.2 Substitution and maintenance programmes**). In addition, along with the existing low-threshold services (i.e. OKANA Help Centre and KETHEA Multiple Intervention Centre), new programmes have been launched, including street-work interventions, telephone help-lines, treatment admission services and innovative low-threshold units (i.e. Low-threshold Counselling Unit "NOSTOS").

Greek drug professionals themselves stress the need for the extension of harm reduction services across the country, mostly in the form of low-threshold and outreach interventions. With regard to substitution treatment as a harm reduction means, however, they seem to argue that drug-free programmes should remain the main trend in drug treatment, expressing their objection to the emphasis placed by policy-makers on the substitution approach over the abstinence-oriented one.

Nowadays, almost all the existing low-threshold and outreach services cover the needs of the greater area of Athens, whereas harm reduction practices in the rest of the country are limited to street-work and prevention of infectious diseases in regions where specialised therapeutic programmes operate. Thus, the range of services needs to be extended both in terms of types of intervention and geographical coverage, as envisaged in the National Action Plan Against Drugs. Along these lines, co-ordination of local harm reduction practices on the basis of the national policy also needs to be reinforced with the further involvement of the national general health system. More specifically, five (5) pilot substitution maintenance programmes, nineteen (19) crisis intervention centres and several mobile units for instant medical aid are to be established by

the end of 2006, in co-operation with general public hospitals at regional and local level.

Networking is pursued among harm reduction professionals working at specialised drug programmes, as well as between those and the medical personnel of general hospitals or non-governmental organisations (i.e. Medecins Du Monde), where drug users have medical tests and vaccination against infectious diseases. An example of co-operation between drug specialised services and the general health system is that between the OKANA's Mobile Unit of Pre-hospital Medicine (KIM) and the National Centre of Instant Medical Aid (EKAB) in Athens, aiming at overdose prevention.

The objectives and target groups of harm reduction practices depend on the type of intervention (i.e. whether it is a low-threshold service, a street work programme or a medical unit) and the rationale of each particular agency. A detailed description of the various programmes and services in the harm reduction field is provided below. Harm reduction services are mainly staffed with medical personnel, psychologists, social workers and ex-drug users. In some programmes, peers and volunteers have a valuable contribution to programme implementation.

10.1 Description of interventions

Outreach work in recreational settings

Outreach work in recreational settings is still rather limited in the country. Specialised programmes are quite fragmented, while there are some street-work programmes which, apart from youth at recreational settings, also address other target groups.

An initiative of major importance was the collaboration of the Greek Focal Point and OKANA in the implementation of an EU project entitled "Principles and development of strategies for prompt intervention in the field of secondary prevention of substance use". In the framework of this project, which took place in 2000-2001, 200 young people aged up to 25 from the electronic music and dance scene were approached and they were provided with information material on the safe use of synthetic drugs and cocaine (*see also* 2001 Annual Report submitted to the EMCDDA and www.drug-prevention.de).

An innovative intervention in this field is another European project called "Summer Campaign", based on the collaboration between Greece, Spain, UK and Germany. This project, implemented in Greece by the Prevention Centre of the Prefecture of Rethimnon (Crete), addresses young tourists aged 18-25 who visit Crete and Costa Brava for summer holidays. The project aims at informing about the risks of drug use, reducing combined use of alcohol and drugs and promoting alternative ways of entertainment. These objectives are achieved through the distribution of leaflets in three different languages (i.e. Greek, English and German) by peers at airports, travel agencies and places where tourists hang about (i.e. bars, discos, beaches) (see also www.summercampaign.org).

Detailed information on street-work programmes that address youth at recreational settings in the country is provided below.

Streetwork programme (Addiction Prevention and Health Promotion Centres of the Municipality of Athens 'ATHINA-IGIA')

Number of persons	770
Condoms distributed	4,000
Target groups	adolescents, youth recreational drug scene, high-risk groups, prostitutes
Approaches	• catching-client (referral or psychosocial support) • work with peers/young people (influence-social learning model)
Objectives	• contacts with hidden user populations in order to look into their situation • providing psychosocial support • information – awareness raising • peer training – assigning responsibilities • promoting safe sex practices

Streetwork programme ('PIGASOS' Mobile Information Unit - KETHEA)

Number of persons	1,405
Target groups	youth recreational drug scene, high-risk groups
Approach	catching-client (referrals or psychosocial support)
Main activity	• counselling • distribution of information material
Objectives	• providing psychosocial support • information and awareness raising

Prevention of infectious diseases

Fairly co-ordinated action is taken for the prevention of infectious diseases in drug users and other high-risk groups at specialised treatment centres, low-threshold and outreach services, general hospitals, prevention programmes and non-governmental organisations, as described below.

Streetwork programme (Help Centre - OKANA)

Number of contacts	1,823
Number of persons	1,237
Condoms distributed	2,300
Target groups	Drug users, high-risk groups, ethnic minorities/migrants
Approaches	• peer work (the ‘snowball model’) • public health model: structured, information dissemination, tests for viruses
Objectives	• distribution of information material on prevention of infectious diseases, and injecting equipment • in-situ weekly seminars on safe use and safe sex practices • motivating users to use the services of the Help Centre and other bodies • community involvement - support for other bodies

In addition, the Help Centre implements a needle exchange programme and it has its own General Health Clinic and a microbiological laboratory where drug users can have diagnostic lab tests for hepatitis and HIV, as well as vaccination against hepatitis A and B.

Streetwork programme (Multiple Intervention Centre - KETHEA)

Number of contacts	1,462
Target groups	Drug users, high-risk groups, prostitutes
Approaches	• self-help model • Diclemente’s and Prochaska’s social change model • Motivation interviewing
Services provided	• Psychosocial support • Information – Awareness raising • Primary care • Promotion of safe sex practices

In 2001, the street-work programme of the **Multiple Intervention Centre** further advanced with the operation of a Mobile Unit, while health promotion seminars for drug users who are approached in the street were initiated in co-operation with the Medecins Du Monde. Seminars on the prevention of infectious diseases and safe drug use are also organised in the Diagnostic Centre (151 participants in 2001) and the “Off Club” of the Multiple Intervention Centre on a monthly basis, as well as in Koridallos prison in Athens on a four-monthly basis.

The latter takes place in co-operation with the specialised unit of “Adreas Syngros” hospital for infectious diseases (KETHEA, 2002b).

In March 2001, the Therapeutic Programme "NOSTOS" (KETHEA) established an innovative **Low-threshold Counselling Unit** in Piraeus. The unit mainly addresses socially excluded drug users and their relatives and provides, among other services, information on safe drug use and infectious diseases as well as referrals to public hospitals for medical tests. The latter is a quite common practice at all specialised treatment programmes across the country.

Quite extensive in the field of infectious disease prevention is the work of the "**Medecins Du Monde**". The main activities in this area include distribution of information material, a syringe exchange programme and blood tests for HIV and hepatitis through the street-work programme "Streets of Athens", as well as training and blood tests in the prisons of Avlona once a month (see also 2001 Annual Report submitted to the EMCDDA).

Along with drug users, the street-work programme of the **Prevention Centre "ATHINA-IGIA"** of the Municipality of Athens (see above) also organises information campaigns for the prevention of infectious diseases in special high-risk groups (i.e. prostitutes and immigrants),as well as in school settings. In the same context, the **Hellenic Centre for Infectious Diseases Control (KEEL)**, through its Mobile Information Unit, distributes information material to the general public, students and mobile populations of local communities across the country. In addition, besides the general and school population, the KEEL's Counselling Unit organises training seminars for the medical personnel of the General Hospital "Evangelismos" and students of the Health Visitors' School in Athens. Training in prevention of infectious diseases is also provided to health professionals and the general public by the **Greek Red Cross**.

Prevention of drug related overdoses

Interventions for overdose prevention are implemented in treatment centres, low-threshold services and in programmes for drug addicted prisoners and released prisoners. In all of these cases, overdose prevention is approached within a more general harm reduction context, including interventions to reduce drug use, training in safe drug use and first aid issues, prevention of infectious diseases, relapse prevention and information on hygiene matters. With regard to treatment programmes, overdose prevention is integrated in the general therapeutic programme and it usually takes place at the first stage of treatment (i.e. counselling centres) and/or at the last one (i.e. social rehabilitation centres).

In particular, drug-free treatment programmes organise seminars for overdose prevention on a systematic basis (i.e. weekly, fortnightly or monthly), in most cases in co-operation with general or specialised doctors. In addition, overdose prevention issues are discussed in groups between drug users and the therapeutic personnel. An innovative intervention for overdose prevention is the "Touch screen" programme, which is run in the Off-Club of the Multiple Intervention Centre (KETHEA). Through this electronic programme, drug users

learn about ways of safe drug use and other harm reduction practices by a question-answer game.

Another programme applying electronic methods for overdose prevention is a European one, called "HERO", which is implemented for drug addicted prisoners and released prisoners in Athens by the Multiple Intervention Centre (KETHEA). The aim of this project is to inform addicts about safe drug use issues through the Internet and other electronic sources of information. Apart from this project, seminars on overdose prevention and safe drug use are also organised in the prisons of Athens by the Multiple Intervention Centre and the Drug Dependence Unit "18 ANO" (Psychiatric Hospital of Attica), targeting also released prisoners. These seminars are systematically implemented in co-operation with the non-governmental organisation "Medecins sans Frontieres".

An intervention of major importance with regard to overdose prevention is the **Mobile Unit of Pre-hospital Medicine (KIM)**, run by the OKANA's Help Centre. Its main objectives are prompt handling of overdose cases and provision of paramedics to transfer users who require immediate care to hospitals in Athens. It is staffed with doctors, mainly anaesthesiologists, who have received special training in Emergency Pre-hospital Medicine and with staff from the National Centre of Instant Medical Aid (EKAB). In 2001, KIM did not operate for an extended period of time due to lack of personnel, consequently there was a decrease in the number of calls received in comparison with the last two years. More specifically, in 2001 there were 786 calls from users of dependent substances, mainly heroin and benzodiazepines, while in 2000 and in 1999 the number of phone calls were 2,110 and 1,401, respectively. Out of the total callers in 2001, 186 users (23.6%) received help for overdose, 583 users (74.2%) received help without suffering from overdose and 17 (2.2%) had passed away. The number of drug users who contacted the Help Centre's General Health Clinic in 2001 due to an overdose from drugs came up to 14.

Statistics on overdose incidents from the Therapeutic Programme "EXODUS" (KETHEA) show that in 2002 there was an increase in the number of clients with an overdose experience in their life, as well as in the number of clients having been admitted to hospital for overdose from drugs (Table 18).

Table 18: Clients of the Therapeutic Programme "EXODUS" having suffered from overdose by year of admission

	Year of admission to the programme			
	1999 %	*2000* %	*2001* %	*2002* %
Clients experienced an overdose lifetime	55.7	46	52.9	60.7
Clients in treatment for overdose	24	24.4	27.2	32.8

Users rooms/safe injection rooms

This type of intervention does not exist in the country.

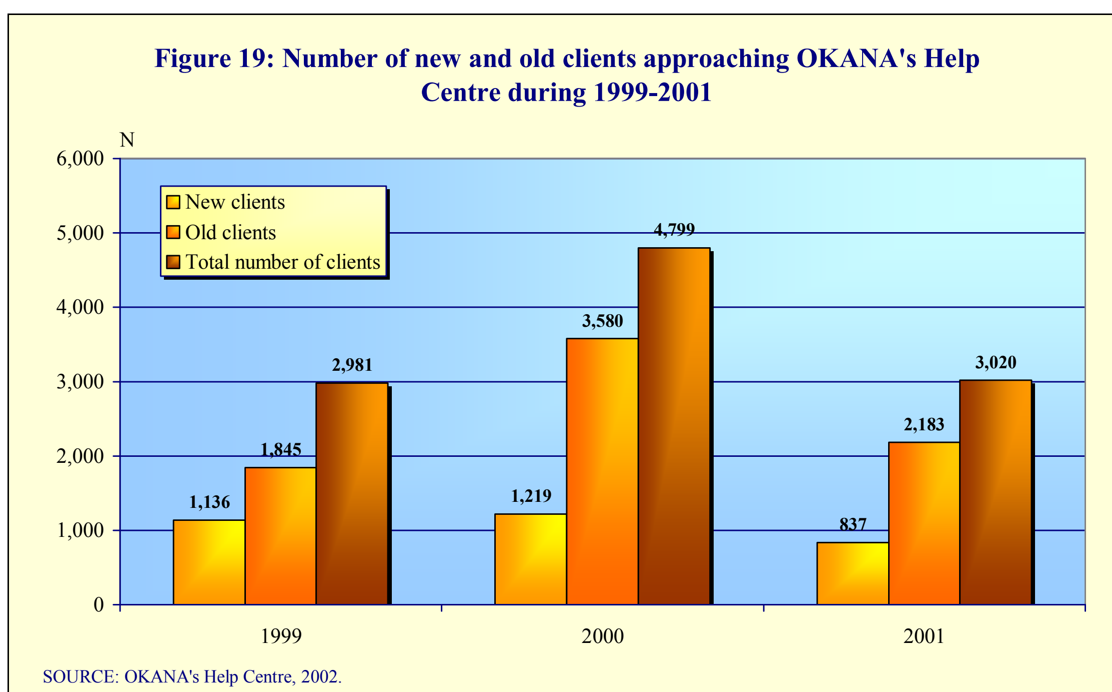
10.2 Standards and evaluations

Although there are no official professional standards for harm reduction professionals, in most cases these are medical personnel or staff with a social science background who have been trained in dealing with the population of drug addicts. Training to harm reduction professionals is provided either in-service or through specialised seminars by national organisations (i.e. Hellenic Centre for Infectious Diseases Control and Medecins Sans Frontieres) and European ones. In this context, the Multiple Intervention Centre organised in 2000 a five-day seminar in Athens, under LEONARDO I, in view of developing a training tool for European street-workers (see also, www.streetworker.org).

Along with the evaluation data already covered under Chapter 10.1, information on evaluation results regarding the services of the Help Centre (OKANA), the Multiple Intervention Centre (KETHEA) and the "Streets of Athens" programme of the Medecins Du Monde is presented below.

The total number of users who contacted the OKANA's Help Centre in 2001 was 3,020. This number dropped by 37.1% compared to the previous year (N=4,799 clients), and remained practically unchanged in 1999 (N=2,981) (Figure 19). As shown in Figure 19, the same increase-decrease trend is observed in new and old clients alike. The decrease in 2001 may be explained by the lack of staff and by the fact that users moved from downtown Athens to other areas. After all, the aim of a low-threshold service is not to keep amassing clients, but to raise their awareness and refer them to treatment.

Figure 19: Number of new and old clients approaching OKANA's Help Centre during 1999-2001



SOURCE: OKANA's Help Centre, 2002.

The number of exchanged syringes in 2001 is practically the same as that in 2000 (N=25,386 and N=25,821 respectively), but it was three and a half times higher in 1999 (N= 86,819). On the other hand, the total number of clients of the microbiological laboratory tripled in 2001 (1,051 compared to 334 in 2000; the laboratory opened in June 2000).

The total number of people who visited the Social Care Service was 296 in 2001, 210 in 2000, and 301 in 1999. Dental patients increased: 749 in 2001, compared to 441 in 2000, and 728 in 1999. Finally, in the framework of the streetwork programme, 1,823 users were approached in 2001, 1,324 in 2000 and 2,218 in 1999 (for more details on Help Centre programmes and services, see 2001 Annual Report submitted to the EMCDDA).

As shown in Table 19, client numbers for most of the KETHEA Multiple Intervention Centre programmes have remained stable or increased slightly.

Table 19: Types of Multiple Intervention Centre's programmes and total number of contacts per year (1999 – 2001) – Possibility of multiple contacts per person

Types of programmes	Total number per year		
	1999	*2000*	*2001*
User Support Centre/«OFF CLUB»	1398	1817	1984
Streetwork programme	1524	1427	1462
Family programme	353	398	476
Awareness-raising centre	364	546	525
Counselling Therapy/Social Rehabilitation Centre	246	127	– *
Prisoners' Support Centre**	1326	1364	1286

* No available data.

** The numbers refer to the two sub-programmes of the Support Centre at Koridallos prison in Athens.

Regarding the streetwork programme of the Medecins Du Monde, from January 2001 to December 2001, the mobile medical unit handled 2.419 cases: 33.6% concerned medical issues (i.e. overdoses, abscesses, other skin diseases), 4.5% psychological support, 56.4% needle exchange, 3.7% information, 1.2% blood tests and 0.6% other issues. In addition, from January 2001 to April 2002, 112 blood tests were performed, of which 1.8% were positive for HIV, 5.4% for hepatitis B, 55.4% for hepatitis C and 6.3% were not defined.

Research on harm reduction issues has been increasing over the past five years, with special emphasis on the study of drug-related health problems. Most of the major research projects in this field have been European ones, therefore they are co-funded by the European Union and national organisations. A list of the major projects during the last years is presented below:

- "Psychosocial factors of risky behaviours related to HIV infection among prisoners in Greek prisons" (National School of Public Health and Stiriln University of U.K., 1995-1998).
- "Euro-excludes - Research project on high-risk behaviours, life-style and information on HIV/AIDS among socially excluded drug users at risk of HIV/AIDS infection" (KETHEA, 1999-2001)
- "The severity of hepatitis infection among opiate addicts in the 1st Substitution Unit of Athens" (OKANA, 2000-2001)
- "Euro-Snowball II: AIDS and Hepatitis peer prevention among drug users" (Help Centre of OKANA, 2000-2002)
- European research project entitled "Elaboration of concepts of secondary prevention of drug abuse" (Greek REITOX Focal Point, Help Centre and 2nd Athens Substitution Unit of OKANA, 2000-2001)
- European IREFREA research study: "Sonar Project - Alternative cultures to drug abuse" (UMHRI, 2001)
- "European research on the health status of drug users - Toxmed project" (KETHEA, 2001-2002).

11. TREATMENT

11.1 "Drug-free" treatment and health care at national level

There are currently 24 drug-free therapeutic units in Greece run under the auspices of governmental and non-governmental organisations. These consist of 8 residential programmes, 16 non-residential programmes (11 for adults and 5 for young people) and one day-care clinic (Annex V - Table II).

Information on treatment programmes in the country regarding objectives, treatment modalities, delivery of services and training, remains the same as that provided in detail in the 2001 Annual Report submitted to the EMCDDA. Thus, the focus of the information presented in this report will be on statistics and comparative data among the different types of drug-free treatment programmes, in view of providing a global overview of the situation of the programmes.

In this vain, a concise description of admissions, waiting lists and completion rates in 2001 is presented below, according to the data provided to the Greek Focal Point by the treatment units' network nationwide. For each type of treatment programme there is the number of new admissions, the total number of admissions (new admissions and readmissions), the number of persons on waiting lists, and programme capacity. For those who left treatment, the cause is mentioned (completion or interruption of treatment), and the reasons for which clients were discharged prematurely. These data only reflect the programmes' main phase of treatment (i.e. therapeutic communities).

According to Table 20, most of the admissions in 2001 took place at the non-residential programmes for adults (721 persons), followed by the residential programmes (426 persons), and the non-residential programmes for

adolescents (354 persons). New admissions show a similar distribution, with a high number of new admissions to non-residential programmes for adults, and a far lower number to non-residential programmes for adolescents. 112 persons were on the waiting list for the main therapeutic phase, while there was no waiting list for the two treatment programmes for adolescents that sent in data for 2001. Drug-free treatment programmes in Greece (according to data from all 20 treatment programmes in the country) have the capacity to accommodate 969 persons, mainly in non-residential units for adults.

The comparison between the capacity of the main treatment programmes and the total number of admissions in 2001 demonstrates that drug-free programmes exceed capacity in order to meet the needs of as many drug users seeking treatment as possible. This is also confirmed by the statistical data provided in 2001 by KETHEA. In particular, the total number of cases at the Counselling Centres of all KETHEA's treatment programmes rose by 7% in 2001 compared to 2000 (4.974 and 4.655 cases, respectively). Moreover, the Therapeutic Communities exceeded capacity (106% full), although capacity had already increased by 30%. This is also the case for the Social Rehabilitation Units of KETHEA, which exceeded capacity (119,4% full) although it had increased by 36%.

Table 20: Admissions, waiting lists and capacity of drug-free programmes in 2001

	Total number of admissions N	New Admissions N	Waiting list N	Capacity N
Residential programmes (N=8)	426	364	53	341
Non-residential programmes for adults (N=8)*	721	672	59	488
Non-residential programmes for adolescents (N=3)**	354	50	0	140
TOTAL	1501	1086	112	969

* Regarding the non-residential programmes for adults, the Greek Focal Point received data for the year 2001 from 8 out of the 9 programmes operating in the country. However, the capacity concerns the total number of programmes.

** Regarding new admissions and waiting lists, the data refer to 2 out of the 3 treatment programmes for adolescent drug users.

SOURCE: Treatment Unit Form (TUF), 2001.

Data estimates on the patients who completed treatment, dropped out, or were discharged prematurely are presented in Table 21. This information comes from all 8 residential drug-free programmes, 5 non-residential programmes for adults,

and 2 programmes for adolescents, which provided the respective data to the Greek Focal Point. Most of those who left the residential programmes had completed treatment, and this goes for adolescents' programmes too. On the other hand, most adults who stopped attending non-residential programmes decided to do so on their own. About one in six adults from residential units, and one in four adults and adolescents from non-residential units were discharged prematurely.

Table 21: Estimated rates of drug users who completed or were discharged from drug-free treatment by type of treatment unit

	8 Residential programmes %	5 Non-residential programmes for adults %	2 Non-residential programmes for adolescents %
Completed treatment	59	17	51
Premature discharge	18	26	23
Drop-outs	24	57	26
TOTAL	100	100	100

SOURCE: Treatment Unit Form (TUF), 2001.

The different types of treatment centres prematurely discharge patients for different reasons. Rates in Table 22 are approximations and reflect certain treatment programmes only, since the Greek Focal Point received the respective data from 5 residential programmes, 3 non-residential programmes for adults, and 2 programmes for adolescents. Consequently, these rates are actually an estimate of true rates.

Table 22: Estimated rates of reasons for premature discharge

	5 Residential programmes %	3 Non-residential programmes for adults %	2 Non-residential programmes for adolescents %
Use of illicit drugs on the premises	5	0	0
Use of illicit drugs outside the premises	5	26	33
Involvement in illegal activities other than using illicit drugs	0	0	0

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	5 Residential programmes %	3 Non-residential programmes for adults %	2 Non-residential programmes for adolescents %
Missing therapy or counselling sessions	0	28	0
Violent behaviour on site	41	4	0
Violation of unit's/programme's rules or regulations	20	17	67
Other reasons*	29	27	0
TOTAL	100	100	100

* Other reasons include adjustment difficulties, alcohol use, sexual relationships on the premises

SOURCE: Treatment Unit Form (TUF), 2001.

According to Table 22, most patients who were discharged prematurely from residential programmes had exhibited violent behaviour within the unit (41%), while violation of unit regulations and "other reasons" were also reported. The situation is different in non-residential drug-free programmes for adults. The three main reasons for premature discharge in this type of programmes were absence from treatment or counselling sessions, illicit drug use outside the unit and "other reasons". The respective rates range from 26% to 28%, but none of the above premature discharge reason takes the lead, contrary to what is the case with residential programmes, and non-residential programmes for adolescents. In most cases of premature discharge in adolescents' programmes the reason was violation of other programme rules (67%), whereas the respective rates for adults were 20% and 17% for residential and non-residential programmes respectively. There have not been any instances of illegal activity other than use in any one of the above types of treatment programmes.

In addition to the results of the follow-up evaluation study, conducted by KETHEA from mid 1999 to June 2001 (KETHEA & NSPH, 2001) (see 2001 Annual Report submitted to the EMCDDA, p. 164-166), the positive outcome of drug-free programmes has been proven by other studies, too. In particular, findings from the evaluation research of the Drug Dependence Treatment Unit of the Thessaloniki Psychiatric Hospital show a significant change and improvement in drug users' way of living. For instance, 100% of the patients on the sample managed to find a steady job and approximately 75% managed to establish a steady sexual relationship (Zlatanos et al., 2001; Zlatanos, 2001).

11.2 Substitution and maintenance programmes

Given the emphasis on substitution treatment over the past few years, there were several developments in the field of substitution programmes in the country in 2002. Along with the new substitution units established in 2000-2001 and the permission granted by law to general hospitals to prescribe buprenorphine to opiate users in 2002, another major development was the officially approved by the Ministry of Health establishment of a common operational framework for the OKANA's substitution programmes, emphasising evidence based best practices.

According to the Ministerial Decree, the Ministry of Health approved the administration of methadone and buprenorphine in OKANA's substitution programmes for opiate addicts within the framework of a therapeutic procedure based on the perception that opioid addiction is a situation of mental, physical and social dysfunction of the individual. Along these lines, the therapeutic procedure should accompany the administration of substitution drugs with the provision of high quality medical and psychosocial services, aiming at:

a) minimisation of drug related risks, not only for drug users but also for the community, and

b) detoxification of drug users from all drugs, including substitution ones.

The specific objectives of the Substitution Units are presented in Table 23.

Table 23: Specific objectives of OKANA's Substitution Units

General aims	Specific objectives
Minimisation of drug related risks	• to retain drug users in the programme by enhancing incentives • to decrease parallel drug use • to decrease antisocial and criminal behaviour • to decrease the probability of being infected by infectious diseases and transmitting them to others • to consolidate a normal way of living, to improve family and social relations, and to increase interest in education/training in order to achieve occupational rehabilitation
Detoxification from drugs	• to abstain from opiate drugs use • to abstain from other drugs use • to abstain from alcohol abuse • to decrease antisocial and criminal behaviour and to promote health • to increase employment perspectives or productive occupation through training and social rehabilitation

The general principles governing the operation of substitution programmes have been set out as follows:

- The Substitution Units follow a non-residential working hour programme adapted to the needs of the individuals in treatment, especially those who work
- The individuals in treatment adhere to the therapeutic plan that they attend
- The admission to a substitution programme takes place on the basis of the serial protocol number of applicants. Exceptional admissions are foreseen in cases such as drug addicts with HIV or other serious physical illnesses, pregnant women, etc.

Admission criteria for OKANA's substitution units have been differentiated and have become more concrete. A major change concerns the age of clients, who should be over 20, as opposed to 22 that used to be up to now. Also, drug users under 35 should have unsuccessfully tried other treatment. All clients should be regular intravenous heroin or other opiate users and having developed physical and psychological dependency. Drug addicts with serious psychiatric commorbidity are excluded from the programme. Patients have to sign at their admission a therapeutic contract. The therapeutic programme of substitution units has become lately more flexible, in order to better meet patients' needs.

Although evaluation results for substitution programmes in the country date back to 2000 (see **2001 Annual Report submitted to the EMCDDA**, p. 117), there are recent statistics regarding the number of admissions to the various units and the treatment completion rates. As shown in Table 24, the total number of admissions to all substitution units in 2001 was 784 with a total capacity of 1,060 persons. 95.9% of the total admissions were new ones. In 2002 the 2nd Short-term Substitution Unit in Athens has been incorporated in the Long-term Substitution Unit, increasing the capacity of this last unit to 800 individuals in total (Annex V - Table II). However, at present only 545 clients follow treatment in the unit due to the insufficient number of personnel.

Table 24: Capacity and admissions to substitution units in the year 2001

Substitution Unit	Capacity	Total number of admissions	New admissions
Short-term Substitution Unit of Piraeus	200	40	40
1st Short-term Substitution Unit of Athens	200	212	209
1st Substitution Unit of Thessaloniki	100	15	7

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2nd Short-term Substitution Unit of Athens	200	292*	271
2nd Substitution Unit of Thessaloniki	150	33	33
Long-term Substitution Unit	210	192	192
TOTAL	1.060	784	752

* Short-term Substitution Units provide an intensive psychosocial support programme along with substitution treatment for a duration of maximum 18 months. Following this period, patients are transferred to the Long-term Substitution Unit to continue their treatment as long as needed.

** The number of readmissions was estimated from 30/4/2001 (total number: 21 readmissions).

SOURCE: Treatment Unit Form (TUF), 2001.

As to the waiting lists, there are currently 550 individuals on the waiting list for substitution units in Thessaloniki and 2,605 individuals for the respective units in Athens, of whom 132 have been reported to have passed away.

Regarding completion of treatment, the majority of patients who left the substitution units were discharged prematurely, especially in the Long-term Substitution Unit (89.2%), with the exception of the 1st Substitution Unit in Thessaloniki, where all those who left had previously completed their treatment (Table 25).

Table 25: Drug users who completed or were discharged from substitution treatment in 2001

Substitution Unit	Completed treatment	Premature Discharge	Drop-outs
	Estimated %	*Estimated %*	*Estimated %*
1st Short-term Substitution Unit of Athens	24	63	13
1st Substitution Unit of Thessaloniki	100	0	0
2nd Short-term Substitution Unit of Athens	15.2	72.2	12.6
2nd Substitution Unit of Thessaloniki	28.6	66.7	4.7
Long-term Substitution Unit	4.6	89.2	6.2

SOURCE: Treatment Unit Form (TUF), 2001.

With regard to other substitution units, 1/4 of those who left the 1st Short-term Substitution Unit in Athens in 2001 had completed their treatment. Out of those who left the 2nd Short-term Substitution Unit in Athens and the 2nd Substitution Unit in Thessaloniki, 1/6 and about 1/4 respectively had completed treatment. Regarding dropouts, one out of eight left the short-term substitution units in Athens on their own volition. There are no data available for the Short-term Substitution Unit of Piraeus, since the unit only operated for one month in 2001.

A research study on the results of the pilot prescription of buprenorphine, conducted by OKANA's 1st Substitution Unit of Athens in 2000-2001, has shown that buprenorphine has several advantages as a substitution drug. In particular, it is a safer drug compared to methadone and drug addicts do not need to have daily dosages. On the other hand, it has been found out that drug users are quite mistrustful of the particular substitution drug, therefore systematic information and awareness raising is needed.

Taking into consideration the emphasis placed on substitution treatment and on general practitioners' role in drug treatment, OKANA translated the EuroMeth "Methadone Guidelines" in 2002 and is also preparing a training manual for professionals dealing with drug addicts in the general hospital setting. Along with the existing training programmes (i.e. EuropASI, specialised seminars, etc.), these materials are expected to contribute to the training of professionals in substitution and drug addiction treatment issues, in general.

11.3 After-care and reintegration

See **Chapter 16.4 Political issues and reintegration programmes**

12. Interventions in the Criminal Justice System

12.1 Assistance to drug users in prisons

Until 2002, no comprehensive assistance plan was implemented in prisons for drug-dependent detainees, despite the fact that the legislation in force allowed for services to be provided to drug users in prisons. More specifically:

- Law 2331/95 was the first piece of legislation to explicitly state that drug dependent prisoners should be treated in a way that respects their special needs. *The 1995 law provided for compulsory treatment for drug dependent prisoners in special facilities outside prison*.
- At the same time, the 1995 law *did not provide for detoxification programmes to run within prisons* (be they substitution, maintenance or drug-free programmes).
- Unlike earlier pieces of legislation (namely laws 1729/87 and 1868/89), the 1995 law did provide a legal base for organisations working in demand reduction within the wider community to develop *in-prison programmes aiming at raising awareness, offering support and motivating drug dependent prisoners for treatment during or after release* (see § Community Links below).

- In addition, the 1995 law gave drug-dependent prisoners on remand incentives to participate in such programmes by way of giving them the prospect of joining a therapeutic community programme outside prison (subject to a Magistrate's Council decision and on condition of their successful participation and completion of the counselling programme in prison). The time spent in the programme would count as time spent in prison. Moreover, those who successfully completed a therapeutic community programme outside prison could have any additional (pending) sentences suspended for a period of 3 to 6 years.

Abstinence oriented treatments

In practice, treatment facilities provided for in the above-mentioned law have hardly been in place. The types of treatment offered in one way or another throughout the different stages of the process (from the initial arrest phase to the release and the post-release phase) have for many years been fragmented (determined on a case by case basis) and directed towards any one of the following three options:

a) medical treatment (often reduced to in-and off-prison provision of first aid),
b) time restricted hospitalisation, and
c) in exceptional circumstances (following a referral and usually a very complicated procedure) time restricted psychiatric monitoring.

What's more, the first and –depending on the circumstances- the only agents available to deal with the day-to-day implications of drug use and misuse in Greek prisons are usually the prison officers. This is the case especially when drug related health emergencies take place outside the office hours of the prison's medical staff. According to expert reports (Koulierakis *et.al*. 2001; MSF 2001), security officers are way far from having the competence to deal effectively with (mis)behaviours and emergencies related to drug misuse. Even now, health psychology, and especially that related to drug misuse, lies outside the main corpus of officers' initial training. At the same time, qualifications that could prove some kind of health knowledge are not part of the job requirements for the posts of prison officers.

Detoxification: In the absence of in-prison mandatory treatment, physicians opt for prescribing analgesics and tranquillisers to addicted prisoners who need to cope with physical detoxification problems in prison. Cases of drug-dependent prisoners requiring emergency treatment are referred to the Psychiatric Unit of Koridallos Judicial Prison Hospital or to other public hospitals.

Drug free units: Until 2002, there were no designated drug free units within prisons. Drug users and detainees for drug related crimes are normally placed in special wings within prisons.

Therapeutic communities in prisons: Although demand reduction communities run programmes within prisons patterned upon those outside

prisons (see below Community links), there is only one integrated therapeutic community organised within prison:

The **Support Centre for Prisoners** of the Multiple Intervention Centre – KETHEA ran in 2001 an integrated programme with the aim to achieve psychological and social rehabilitation of drug dependent inmates in *Koridallos Women's Prison*. The programme started on a pilot basis in 2000 and it is conducted in co-operation with the General Secretariat for Adult Education. Activities run on weekdays (09.00-17.00) and include activities that follow the pattern of a typical therapeutic community (pre-community): counselling and treatment processes, vocational training and cultural events (language courses, jewellery design and crafts workshops, dance, theatre, music), and manual work (cleaning, housekeeping, cooking). In 2001, the programme was attended by 84 female drug dependent prisoners.

Harm reduction measures

All prisons should in principle have a designated medical unit adequately staffed and equipped to deal with *inter alia* the implications of drug use and misuse. Likewise, every prisoner should undergo a medical check performed by the prison medical staff right upon or soon after incarceration.

Expert reports confirm that medical assistance in prisons is problematic. A review of services conducted by the Greek office of the Medecins Sans Frontieres in 2001 in Koridallos Judicial Prison highlights the problem:

- No preventive medical check takes place upon incarceration unless prisoners themselves request so
- The designated medical unit of the prison is understaffed. This makes access to physicians a problematic and lengthy process.
- Physicians employed by prisons to provide services hold weekday office hours during which prisoners may receive medical support. There is no service provision for evening hours and weekends
- Medical examinations take place not in the designated check room but in common spaces, open to passers-by
- Medical checks are commonly reduced to symptom description made by the prisoner and medical advice/support provided by the physician without the use of equipment
- Referrals to public hospitals for more thorough examinations were discouraged in 2001, owing to a couple of escapes of prisoners transferred on medical grounds
- There are problems with the provision of high cost medication (MSF, 2001; 2002)

The above are common to almost all prisons in Greece. The implications for drug dependent prisoners are twofold: first, emergency cases of drug misuse are not necessarily treated by medical staff; second, the much needed special rapport between physician and drug user hardly ever develops.

Blood screening and vaccinations: The problem of short-staffed medical units in Greek prisons has implications in other areas of harm reduction, most notably AIDS and hepatitis prevention. Like all other types of medical checks, systematic blood tests should also be carried out in all prisons (subject to prisoners' consent). According to expert reports (Tsilimigaki, 2000), pilot blood tests for addicted inmates were first introduced in 1991 in co-operation with the Ministry of Health. From 1995 onwards, blood tests are performed in all prisons for all prisoners. All prisoners now have their own 'health cards' that stay with them until their release. By the year 2001, 6,000 prisoners had been tested. Prisoners with hepatitis C are being treated with *interferon* in co-operation with state hospitals. HIV positive prisoners are held in a special wing of Koridallos Prison Hospital.

Provision of disinfectants, condoms and the needle exchange perspective: Arguments in favour of the hygienic use of illegal drugs (e.g. needle exchange) are voiced rather weakly, overshadowed by the popularity the drug-free prison model enjoys within the policy-making community. Thus, unlike the case of blood tests, there are no needle exchange programmes running in Greek prisons. Similarly, condoms, watery lubricants or disinfectants and urine tests for substance use detection are not available.

Community links: Interventions addressing the issues of social rehabilitation and health promotion and aiming at strengthening the personal competencies of drug dependent prisoners are carried out by various organisations working in one way or another in demand reduction. The following organisations developed demand reduction interventions in Greek prisons in 2001: KETHEA, the Addicts Detoxification Unit of the Athens Psychiatric Hospital (18 ANO), Narcotics Anonymous, Médecins Sans Frontières Greece (MSF) and the Médecins Du Monde Greece

Using the "person-centred" approach and "self-help groups", **KETHEA** has been running demand reduction programmes for imprisoned drug users in several prisons since 1987. The programmes aim primarily at improving knowledge and raising user awareness of health risks related to drug use. KETHEA counsellors provide support and prepare drug dependent prisoners to join (of their own accord) a therapeutic community after release.

KETHEA interventions rely a great deal on Law 2331/1995, making it possible for drug-dependent prisoners to commute their prison service to a participation in an off-prison therapeutic community (Art. 20). KETHEA support interventions take place in Greece's biggest prisons. In 2001, KETHEA implemented programmes in 6 prisons: Koridallos Judicial Prison, Athens (since 1987), Koridallos Psychiatric Prison Hospital, Athens (since 1987), Koridallos Women's Prison, Athens (since 1988), Diavata Judicial Prison, Thessaloniki (since 1988), Kassavetia Juvenile Correctional Facility, Volos (since 1998), and Military Prison of Thessaloniki (since 2000). A total of 610 drug-dependent prisoners participated in all programmes in 2001 (530 in 2000) (KETHEA, 2002).

More specifically:

- The Multiple Intervention Centre of **KETHEA** has set up the **Support Centre for Prisoners** to implement demand reduction programmes in the prisons of Athens. 344 prisoners received the services of the Centre in 2001. Following release, 9 of them were eventually referred to therapeutic communities (KETHEA, 2002b).
- KETHEA established, in 1999, in Thessaloniki the **Support Centre for Prisoners and Released Prisoners** for Diavata Judicial Prison and the Military Prison. The Centre, which is in part funded by the EU, targets both prisoners and ex-prisoners who completed in-prison support programmes. For the first category of users, the Centre has organised self-help and preparation groups for them to enter a treatment programme following release. Counselling on legal matters, preventive medicine and health promotion services are also available to prisoners, in co-operation with **MSF,** as well as education and culture programmes. For the second category of users, a social and professional rehabilitation framework has been put in place in order to prevent relapses. In this respect, there is co-operation with MSF and with the local branch of the **Greek Labour Force Employment Organisation** (OAED). Counselling is also provided to the families of addicted ex-prisoners.

Since 1995, the **'18 ANO'** Addicts Detoxification Unit of the Athens Psychiatric Hospital has been running self-help groups for addicted inmates of Koridallos men's and women's prisons, and for Koridallos Psychiatric Hospital. In 2001, 160 inmates joined 6 self-help groups. Moreover, '18 ANO' Counselling Unit runs such groups for ex-prisoners who joined a self-help group while in prison, in order to contribute to their social rehabilitation and prevent relapses. According to Unit data, 25 ex-prisoners were served in 2001.

Since 1994, the Judicial Prison of Koridallos and the Women's Prison of Koridallos have been running one awareness raising, information and support group each for addicted prisoners, co-ordinated by members of **Narcotics Anonymous**. Groups meet once a week and they consist of about 10 men in the men's prison and 6 women in the women's prison.

Upon request by '18 ANO' and with the consent of the Ministry of Justice, in 2000-2001 **MSF** used Koridallos Judicial Prison as their base for health education and awareness raising activities for prisoners and prison staff about health matters (especially infectious diseases and harm reduction for users). MSF provided feedback to the parties involved on the results of their investigation (see MSF, 2001), and then moved on to action implementation in stages, according to programme proposals aimed to strengthen the prison's health infrastructure (especially facilities and equipment). During the same year, two seminars were held, including meetings and presentations on health matters and drug-related harm reduction. In 2001, the target group of those activities rose to 210 staff members and 2,500 inmates.

Médecins Du Monde have also contributed to the demand reduction effort in prisons through blood tests and presentations on infectious diseases and sanitary arrangements in Avlona Juvenile Prison.

12.2 Alternatives to prison for drug dependent offenders

The Drug Dependence Treatment Centres for Drug Addicted Prisoners: A more "holistic" approach to the drug problem in Greek prisons has recently made its way into public policy. First, there seems to be a general consensus that the in-prison health care should be immediately and significantly upgraded. Second, a closer co-operation between the Ministry of Justice and that of Health & Welfare should develop and be sustained for issues of mutual concern.

Issues that were traditionally portrayed as being the responsibility of the Ministry of Justice (e.g. the problem of drug use in prisons) have now also become priorities on the policy agenda of the Ministry of Health & Welfare. The upshot of the changing mood in policy was the creation of the first treatment centre specially designed for drug dependent prisoners.

The **Drug Dependence Treatment Centres for Drug Addicted Prisoners** programme is a forerunner for European standards in this field in that it is one of few European programmes to provide treatment to drug dependent prisoners in institutions that rise above the conventional type of prison. The programme is modelled on that of off-prison therapeutic communities and is to provide screening, counselling and treatment in a drug-free environment on a daily basis, while at the same time effectively holding back drug import and trafficking in the prison.

The first Centre started operating in Eleonas, Thiva on a pilot basis in September 2002. Eleonas Centre can accommodate up to 250 inmates. 160 prisoners from the prisons of Koridallos (Athens), Patras and Avlona applied for admission. At present the Centre has 29 inmates, 7 of whom are aged between 17 and 21. The total staff members are 126, 16 of whom are medical and social scientists with work experience in drug treatment and in promoting social and psychological rehabilitation (physicians, psychologists, sociologists and social workers). Eleonas Centre is built on a 268-hectare piece of land and has a health centre and a culture space. It also offers vocational training in fields such as agronomy and gardening, carpentry, plumbing, electrology and car mechanics. Prisoners can choose the one-month long workshops they wish to attend. Inmates stay in threes and fours in 18 autonomous lodges neighbouring those allocated to staff members.

The Centre's treatment programme and the selection and referral processes are laid down in the joint ministerial decision no. 149020/99. Prisoners have the option to serve their sentence while undergoing treatment. The selection of inmates is made according to a set of strict criteria. In order to qualify for a place in the Centre, prisoners must:

- be drug dependent
- have served one fifth of their sentence
- be sentenced to less than 12 years in prison (prisoners on remand are excluded)

Upon entry prisoners should:

- fully abstain from the use of any type of drugs
- refrain from partaking in violent and/or delinquent behaviour and
- be motivated for rehabilitation

Treatment is based on a 'drug free' programme. The programme has a 22-month timeframe, which is nonetheless adjusted to the sentence imposed on each individual prisoner. Table 26 describes the four phases of the programme:

Table 26: Phases towards rehabilitation of drug dependent prisoners in Eleonas centre

PHASE	DURATION	CONTENT
*Phase A**	2 months	selection period (case suitability) and preparation for the programme
Phase B	**	prison service and detoxification phase
Phase C	8 months	psychological rehabilitation phase along the lines of therapeutic communities, based on a person-centred approach and self-help principles
Phase D	12 months	social rehabilitation phase, during which prisoners are able to move freely for work while being under the protection and control of the Centre, in which they can also reside; depending on their progress in Phase D, prisoners may have their sentence suspended

* at present this phase takes place in the respective prisons of the applicants
** varies according to the sentence

The second Centre of this kind is currently being built in Kassandra, Chalkidiki and is expected to be ready in early 2004. Half of the Kassandra Centre personnel will be security staff, while the other half will consist of medical staff and social scientists. Kassandra Centre will have the capacity to accommodate 400 prisoners, mostly coming from the northern parts of Greece. Finally, two more Centres are planned to be built, one on the island of Crete and another one in mainland Greece.

12.3 Evaluation and training

Evaluation: Evaluation of the services provided is rare and, when it does happen, it is at the initiative of governmental and non-governmental organisations working in demand reduction in Greece.

As part of its overall service evaluation, **KETHEA** remained in 2001 highly concerned about the lack of consistency in the implementation of programmes. With only slight improvements compared to earlier years a) the problems with prison authorities, b) the lack of appropriate facilities and c) the incremental (as opposed to comprehensive) and impromptu manner in which decisions about the everyday life of prisoners are taken by prison management are key problems for the provision of support services to drug-dependent prisoners in Greek prisons (KETHEA, 2002b).

Statistics and research

- In December 2001, about 8,633 prisoners were held in 28 prisons intended for 5,300 people. Overcrowding was the result of the spectacular increase in prisoner numbers (both on remand and convicted) in the last decade.

- Law 2721/99 is lenient with addicted offenders and harsh on dealers. This legislative policy treats users and petty traffickers proportionately to their offence and, on the other hand, helps decongest prisons by categorising trafficking of small amounts and free supply as misdemeanours. Despite this, the ratio of drug offenders to non-drug offenders has remained consistently high in 2001. More than 1/3 (41.4%) of all prisoners (N=3578) were convicted or remanded in custody for drug-related offences. Approximately two out of three were convicted for or charged with use or/and possession of illicit substances, and the remaining 1/3 with offences related to drug production or (mainly) drug dealing. Drug offenders are held practically in every prison, but most of them are in Greece's biggest prisons, i.e. Koridallos Judicial Prison and Larisa, and in the Closed Prison of Patras.

- Médecins Sans Frontières (MSF) conducted a survey in Koridallos Judicial Prison in 2001, in order to examine characteristics and needs pertaining to prisoners' health and living standards. 47.4% of those surveyed (N=136) reported having used addictive substances in the past (alcohol, pills and drugs). Only 0.8% of those who reported being users prior to imprisonment stopped using substances in prison. Most of them reported using illicit drugs (83%), tranquillisers (54%), and alcohol (45.9%). Most of them were polydrug users, too. In general, almost all of the respondents (97.1%) felt that their health was at risk (MSF, 2001).

- Koridallos Psychiatric Hospital provided in 2001 the Greek Focal Point with data on 51 (Greek, male) users, which are presented separately because, in accordance with the Treatment Demand Indicator Protocol, imprisoned users use the health services of Koridallos without actually seeking treatment. Their average age is 34, the substance of onset of use is mainly cannabis (82.4%), and half of them indicate heroin as the primary drug (51%), with cannabis being the main substance for the other half of respondents (49%). Only 1 out of 51 users had been in treatment in the past, and one out of three was either illiterate or had only attended primary school for a few years.

13. Quality Assurance

13.1 Description of new trends and developments

One of the aims of the Greek National Action Plan is to promote quality in the services provided in both prevention and treatment fields on the basis of the following criteria:

- To apply measurable and comparable indicators, based on international and European ones, in order to collect data about the effectiveness of drug policies and programmes
- To conduct ongoing internal and external evaluation, co-ordinated by OKANA
- To provide feedback on evaluation results to the institutions involved, so that they can benefit from evaluation

In order for these objectives to be achieved, the National Action Plan suggests that the following actions should be taken:

- development of a common evaluation policy in order to ensure comparable results
- the application of a common scheme and methodology regarding evaluation should be an important criterion for programme approval, in the fields of both prevention and treatment
- implementation of evaluation by external institutions, as well as networking and collaboration with European agencies for the purposes of external evaluation

With the aim of further promoting quality in the drug field, the Ministry of Health has scheduled the establishment of an Institute for Substances and Drug Addiction, which will set guidelines and priorities in research, education and evaluation in the fields of both prevention and treatment.

13.2 Formal requirements, criteria and instruments applied for quality assurance

As far as the Prevention Centres are concerned, the updated formal requirements and their respective criteria can be classified in the seven major categories presented in Table 27.

Table 27: Criteria in the prevention field according to the formal requirements for quality assurance

Requirements	Criteria
Adequate number and professional background of the Prevention Centres' personnel	• The personnel of each Prevention Centre should include: one scientific responsible, at least three prevention professionals and one secretary • The background of prevention professionals should be in the field of social sciences, with at least one psychologist
Prevention Professionals' qualifications	• All prevention professionals should have a Bachelor's degree in Psychiatry, Psychology, Sociology, Social Work or in the field of Social Sciences • Priority is given to those who have a Master's degree, previous experience in prevention or therapeutic agencies, training in a specific psychotherapeutic method, training in prevention (at least 100 hours) and good knowledge of a foreign language • The scientific responsible should further have a two-year previous experience in prevention or therapeutic programmes or a three-year experience in his/her specialty
Training and Supervision	• Prevention professionals are invited to participate in the three-month training course, which aims at promoting a common philosophy and methodology in the prevention field nation-wide and is organised by the Educational Centre for the Promotion of Health and the Prevention of Drug Abuse • Prevention Professionals are encouraged to continuously participate in training seminars on: a) the implementation of existing and new educational materials, b) planning and development of interventions in specific populations, c) self-evaluation • Provision of continuous supervision to prevention professionals who plan or implement prevention programmes based on educational materials they have been trained in • OKANA is responsible for monitoring and supporting the work of Prevention Centres and the general function of their scientific team (one scientific coordinator for every 8-10 Prevention Centres), as well as for supporting and co-financing external supervision of the scientific team, whenever necessary • OKANA, as the central co-ordinating body on drugs, is responsible for co-ordination and monitoring of seminars by training agencies • Development of new educational materials, so that prevention methods and interventions are enriched
Evaluation	• Prevention Centres are strongly encouraged to implement an internal evaluation of the whole range of their interventions • Prevention Centres should submit a three-year work plan as well as evaluation reports of their activities to OKANA • Training agencies should provide prevention professionals with the necessary scientific material and know-how for evaluation purposes • Training agencies are also evaluated for the quality of their seminars by OKANA • External evaluation of prevention programmes has already been initiated by OKANA
Monitoring of Prevention Centres and Local Authorities	• OKANA should systematically implement a two-way monitoring scheme: monitoring prevention work from planning to outcome, and monitoring local authorities' role in supporting and funding Prevention Centres • Monitoring of and immediate response to the difficulties and needs of Prevention Centres
Co-operation	• Networking of prevention professionals • Prevention professionals should have access to internet, electronic databases, bibliography and educational material • Prevention professionals are encouraged to participate in meetings, seminars and conferences so as to exchange experience • Collaboration with relevant bodies and institutions in order to facilitate and enhance the operation of Prevention Centres
Participation in other projects	• OKANA reinforces Prevention Centres to participate in and implement European projects on primary prevention issues

The following instruments are currently applied for quality assurance in the field of prevention:

- Evaluation questionnaires included in the educational packages used in school and family prevention programmes
- Work-plan form constructed by the Educational Centre for the Promotion of Health and the Prevention of Drug Use (UMHRI) and OKANA, based on the EDDRA questionnaire in order for Prevention Centres to plan their prevention interventions. The completed form is submitted to OKANA for approval
- Evaluation reports submitted to OKANA every 6 months
- Reports drafted by the staff of the OKANA Department of Primary Prevention after their meetings with the scientific teams of Prevention Centres, as well as with their administrative boards
- Reports prepared by the scientific co-ordinator of each Prevention Centre every three years and submitted to OKANA

In addition, for the purposes of monitoring and evaluating prevention programmes, other European questionnaires are systematically applied, namely the EDDRA tool, EMCDDA questionnaires concerning school, family, first childhood and community programmes, as well as questionnaires presented in the Evaluation Instrument Bank.

A single homogeneous scheme for quality assurance in drug treatment has not been implemented yet. This is due to the fact that treatment programmes differ substantially in terms of philosophy, theoretical principles, therapeutic methods and organisational framework. However, although the establishment of common formal requirements for quality assurance in this field appears to be a rather complicated task, there is a need for a formal operation framework for treatment programmes. In this context, in 2002, an official framework of operation was established for substitution programmes (*see* **Chapter 11.2 Substitution and maintenance programmes**), while the respective proposal for drug-free programmes was submitted to the Ministry of Health for official approval. According to this proposal, the major common requirements are the following:

- In terms of philosophy and theoretical framework, each therapeutic programme should involve one or more of the following approaches: medical/psychiatric, individual psychotherapy, counselling/support, group psychotherapy, family therapy, self-help groups, relapse prevention
- To maintain a supportive environment in order to facilitate drug users' physical, mental and emotional development
- To provide adequate accommodation facilities and living conditions (for residential programmes), as well as adequate sanitary arrangements, medical care, legal advice and representation, when needed
- To maintain and provide a comprehensive and clearly defined framework of treatment services
- To provide services to drug users regardless of nationality, sex, country of origin, political beliefs, sexual preferences, family conditions, religion, place

of birth, physical or mental disabilities, criminal record or social welfare situation

- To function under a common framework and ethics which ensure protection of drug users' human and civil rights
- To recognise drug users' right to leave the programme without physical or psychological pressure or harassment

Furthermore, all drug-free therapeutic programmes should be supervised and conduct ongoing internal or external evaluation of their services. In addition, they should be accountable to a specific administrative board, whose members are not involved in the therapeutic process. Each therapeutic programme should submit a financial report to this board for approval.

As far as the treatment field is concerned, the following instruments are used:

- The "Treatment Unit Form" (TUF) questionnaire
- The "Exchange on Drug Demand Reduction Action" (EDDRA) questionnaire
- The "European Addiction Severity Index" (EuropASI) questionnaire
- The "Treatment Demand Indicator" questionnaire
- Self-drawn questionnaires, interviews
- Urine tests to assess the use of illegal drugs and/or alcohol

Along with the requirements and the respective criteria regarding prevention and treatment programmes, OKANA paid special attention to the promotion of quality of training programmes in the demand reduction field.

Regarding training programmes for prevention professionals, OKANA, as the central co-ordinating body, is responsible for co-ordination and monitoring of all training agencies. In this context, OKANA has assigned the training of prevention professionals in various types of interventions and educational materials to three specific training agencies. In addition, in order to provide as holistic and scientifically sound an evaluation as possible, different methodologies and sources of information are used in evaluation programmes. More specifically, the following instruments are currently applied for quality assurance of training agencies:

- Work plan regarding the training programmes
- Summary and final reports
- Participatory observation of the training seminars by the staff of the OKANA Department of Primary Prevention
- Self-drawn questionnaires regarding the work of the training agencies filled out by participants in the training programmes

On the other hand, coupled with the lack of a formal framework and requirements for treatment programmes, as mentioned above, and despite some efforts to promote training seminars for professionals working in the treatment field, there is no formal and uniform framework for the training of treatment professionals. However, all therapeutic agencies actively demonstrate

their interest in continuous improvement of their services through participation in national and international training programmes, conferences and seminars.

13.3 Application of quality assurance and results

Training of professionals remained a major priority, as a result of the emphasis placed by OKANA on the promotion of training as a means of quality assurance in the fields of both prevention and treatment.

The main structures and types of training in the prevention field are as follows:

- In the **Educational Centre for the Promotion of Health and the Prevention of Drug Abuse**, the following training seminars are offered:
  1. a three-month introductory training course in prevention issues, provided to professionals working in Prevention Centres. In 2001, the Educational Centre organised 2 training courses with the participation of 39 professionals working in Prevention Centres
  2. training seminars in the implementation of specific educational materials produced by the Centre and intended for Primary ("Children's games") and Secondary ("Standing on my own feet") Education (three-day training for each educational material), for youth interventions outside school ("Log Book - Armenistis 1900"), and, finally, for parents ("Communication in the family"). In 2001, 9 training seminars were organised and 156 prevention professionals were trained in these educational materials. In addition, the Educational Centre provides support to prevention professionals who plan or implement prevention programmes based on these educational materials.
- **KETHEA** provides an eight-day training course to prevention agents in the implementation of the educational package "Skills for primary school children". In 2001, KETHEA organised 2 such training courses and trained 38 prevention professionals. Moreover, KETHEA organises supervision groups for prevention agents who plan or implement this a prevention programme based on this educational material after having been trained.
- The **Hellenic Centre for Intercultural Psychiatry and Treatment** has been assigned the training of prevention professionals in the implementation of interventions in the army and in ethnically and culturally diverse groups

Moreover, other institutions outside the field of prevention organise seminars related to primary prevention:

- **Athens Institute of Human Research (AKMA)** and the **Human Relations Research Laboratory (EDAS)** provide training in the application of the systemic approach and methodology in the field of primary prevention
- The **Department of Primary Prevention and Information about Substance Use and AIDS** of the **Hellenic Red Cross** organise educational seminars on mental health and primary prevention. In 2001, 2 such seminars took place with 180 participants.

Moreover, regarding evaluation methodology of prevention programmes, a training initiative of great importance was the two-day seminars **“Evaluation of Prevention Programmes: A cohesive procedure”** organised by the Greek Focal Point, in co-operation with the EMCDDA, in October 2002, in Athens and in Thessaloniki. The seminars were addressed to prevention professionals and the initiative was taken in response to the expressed need of Prevention Centres staffs for training in the evaluation of their programmes. The seminars included training in prevention models, the respective intervention components and the existing indicators and tools for evaluation.

According to the participants’ replies in the evaluation questionnaire distributed after the completion of the seminar, the majority reported that the seminar covered many aspects of evaluation (81.3%), and that, through the seminar, their knowledge was expanded (72.7%) and their needs and expectations were mostly fulfilled (62.4%). However, participants stated that the seminar was mainly based on theoretical knowledge (69.1%); it can therefore be concluded that, apart from further training in evaluation methodology, there is a need for training and support in applying evaluation theory to their programmes, because, as they mentioned, there seems to be a lack of experience in implementing evaluation studies.

As far as the treatment field is concerned, along with in-service training, which is the main type of training for professionals working at therapeutic programmes, KETHEA has been organising a two-year vocational training programme on **“Addiction Counselling Competence: Knowledge, Skills and Attitudes of Professional Practice”** since 1998. This programme, organised in collaboration with the University of California, lasts for 2 years and is based on relevant educational material.

Some other training programmes, which KETHEA continued to organise, are as follows: a) “Social Planning and Social Policy”, in collaboration with the Department of Social Policy of Boston College, b) “Introduction to the psycho-sociology of groups”, in collaboration with the Department of Communication and Mass Media of the University of Athens.

In addition, KETHEA is also responsible for providing training in **networking** interventions in local and regional services dealing with drug use problems and other health issues. More specifically, a three-day training seminar is offered on developing networking activities among primary, secondary and tertiary prevention agents at local and regional level. In 2001, KETHEA in collaboration with OKANA organised one such seminar with the participation of 45 professionals who work in the health districts of Macedonia and Thrace.

Moreover, OKANA, in co-operation with the European Addiction Training Institute (EATI), organised a training seminar in motivational interviewing for 52 professionals working in the treatment field.

Research in the demand reduction field is continuously expanding, given the need for evidence-based prevention and treatment interventions. Although more emphasis has been placed on research studies in the treatment field, in 2001, there was a growing interest in conducting research into primary prevention in the school community (see Chapter 9 Prevention).

PART IV

KEY ISSUES

14. Drug Demand Reduction Expenditures in 1999

The Greek Focal Point in its attempt to explore the existing concepts and definitions in the field of drug demand reduction expenditures organised a group discussion among experts in the field of drugs coming from agencies and authorities working in demand reduction.

The discussion highlighted, most of all, the need to strictly define specific categories of activities to which financial resources are allocated, as well as the need to find flexible ways to collect financial data at the national level from all relevant authorities. The difficulties in collecting data on drug expenditures are associated to the fact that the competencies of several agents, such as public hospitals, law enforcement authorities and some Ministries, are not restricted to implementing drug policy alone, therefore separation of financial data on drugs seems impossible. Taking into account the remarks that were made by the group, the Focal Point constructed a comprehensive questionnaire, distributed to all relevant parties in order to collect data on drug expenditures.

14.1 Concepts and definitions

The topics were determined and made known to the participants prior to discussion. The aim, among others, was to explore differences between direct and indirect expenditures and between direct and indirect costs. Drawing on Single and Single et al., the Focal Point considered the concept of "expenditures" as synonymous to that of "external costs" of resources spent on treatment, prevention and research, and understood "cost", whether social or economic, as also including the financial burden of drug use on a society's material and social welfare (production loss, measure for the quality of life years lost) (Single, 1995 ; Single et al. 2001).

The group, however, restricted itself to defining the concepts of "direct" and "indirect expenditures", whereas the concept of "cost" did not seem to representing anything different from "expenditures", i.e. the resources allocated to specific anti-drug activities. The reason for this lack of concepts and definitions is that, generally speaking, no special attention has been paid to calculating the funds spent on combating drugs.

The main categories used by treatment and prevention representatives were as follows:

Direct expenditures: this category includes all funds and resources allocated to drug related activities (prevention, treatment, rehabilitation). There are two national agencies, OKANA and KETHEA, whose missions clearly and solely relate to prevention of use of addictive substances. Moreover, there are treatment programmes within state psychiatric hospitals or rehabilitation programmes run the Ministry of Labour, whose expenditures are also directly related to drugs, but it is too difficult to separate their budgets from the overall budgets of the institutions implementing them.

<u>Indirect expenditures</u>: funds and resources allocated to general health promotion or medical care activities, which either include a part reserved for drugs or relate to combating drugs in a broader sense. This category includes, for instance, health education initiatives implemented in schools, medical care of users treated in general hospitals for health problems caused by drug use, primary prevention initiatives taken by the police, etc.

Based on the above distinction, the group suggested that the study should be limited to the collection of data on direct demand reduction expenditures since, as it was roughly estimated, the expenses reported by OKANA and KETHEA should cover approximately 80% of total expenses in this field. Following the above suggestion, the Focal Point constructed a structured questionnaire, which was distributed to agencies directly related to anti-drug activities (*see also* **14.2 Financial mechanism, responsibilities and accountability**).

Expenses were moreover classified in a) salaries and staff expenses; b) operational expenses; and c) fixed expenses (buildings, equipment, vehicles, etc.). Activities for which expenses were incurred were also classified in the following general categories: prevention; treatment and harm reduction; social rehabilitation; education; research; and central administration.

14.2 Financial mechanism, responsibilities and accountability

14.2.1 Source of funds

Subsidisation of drug demand reduction activities depends on the state budget of the Ministry whose competence individual activities fall in. This means that there is no separate Pay Office, with funds that would cover every anti-drug activity and with a budget that would depend on the drug policy envisaged.

The experts who participated in the group discussion estimated that almost 90% of state funds for demand reduction come from the Ministry of Health; of these funds, as already mentioned, 80% approximately go to OKANA and KETHEA. Thus, in order to carry out the study on 1999 drug expenditures, the Focal Point forwarded the questionnaire on expenses to the following agents: OKANA; KETHEA; Attica State Psychiatric Hospital -Treatment programme “18 ANO”; Thessaloniki State Psychiatric Hospital – Drug Dependence Treatment Unit (all 4 under the Ministry of Health); Drug Dependence Treatment Centre for Drug-addicted Prisoners (Ministry of Justice)[1]; and Greek Labour Force Employment Organisation (Ministry of Labour and Social Affairs).

According to Laws 1729/1987 and 2161/1993 and current practice, funds for demand reduction activities come from:

a) the state budget
b) donations
c) fines and seizures of drug dealers’ properties

[1] The Drug Dependence Treatment Centre for Drug-addicted Prisoners was inaugurated in September 2002. However, provisions for its operation had been laid down in 1999.

d) European Union funds
e) other income (i.e. productive units)

However, it is estimated that the provisions for channelling fines and seizures of drug dealers' properties to combating drugs are not fully implemented.

Most of the above categories of funds (a, c, d) either originate or are usually administered by the State. In the case of European Union funds, every agency –mainly those involved in research- can participate autonomously in specific projects. However, significant amounts of European funds are administered by government authorities, such as the Ministry of Labour. Consequently, most of the above sources are considered to be at the central level and funds are allocated from the central level to individual prevention, treatment or rehabilitation activities. The only case where funds are allocated from and to the local level is with OKANA Prevention Centres. OKANA finances all Prevention Centres by 50% (central level), and the remaining 50% is covered by local authorities and agencies within the territory of the Centre (local level).

14.2.2 Public vs. private

In regard to public or private funds, it should be clarified that, officially, every action aimed at combating drugs is controlled by the state. This means that no new prevention or treatment initiative can be implemented without a license to this effect, granted by the Ministry of Health following the opinion of OKANA (Law 2161/1993). After licensing, supervision is exercised by OKANA. For the time being no private or other initiative has been officially developed or licensed, therefore prevention and treatment delivery is still state-controlled and subsidised.

However, the experts also estimated that unofficially there is also a significant amount of funds from and to the private sector, which is impossible to calculate since such activities –mainly developed in private psychiatric clinics- are not licensed and thus not open to anyone. Moreover, upper-class individuals quite often travel abroad in order to attend detoxification or treatment programmes; such expenditures are also hard to calculate or estimate.

14.3 Expenditures at national level

As already mentioned in the previous section, the Focal Point forwarded the questionnaire on direct expenses for demand reduction to several agencies working in this field. Replies were received by the following: KETHEA, Attica State psychiatric Hospital – Treatment programme 18 ANO and Thessaloniki State Psychiatric Hospital – Drug dependence Treatment Unit. Data on OKANA expenses were drawn from its 3-year report (OKANA, 2002), therefore in certain categories OKANA data are missing. In the table below, consolidated data reflect the situation of 4 agencies, all under the Ministry of Health and Welfare.

For the Drug Dependence Treatment Centre for Drug-addicted Prisoners (Ministry of Justice) no financial data were reported in 1999, since it was inaugurated in 2002; no data were sent in by the Greek Labour Force Employment Organisation under the Ministry of Labour, either.

Table 28: Consolidated data on 1999 drug demand reduction expenses nation-wide

ACTIVITIES	EXPENSES in €
Prevention	2,435,803
– Prevention Centres (39 Centres) (subsidised by OKANA)	2,024,945
– Salaries and staff expenses (staff employed in KETHEA and OKANA)	278,796
– Housing and operational expenses	132,062
Treatment – Secondary Prevention	11,826,466
– Drug-free	6,867,112
– Substitution programme	3,442,406
– Low Threshold	1,516,948
Social rehabilitation	267,058
Research[*]	337,491
Education	792,369
*Central Administration**	541,746
TOTAL	**16,200,933**

All funds included in the above table are centrally administered. The only funds allocated at the local level –not shown in the table- are funds allocated to Prevention Centres by local authorities and agencies. Since financing of OKANA Prevention Centres is covered up to 50% by OKANA and 50% by local authorities and agencies, an estimated additional € 2,024,945 was also allocated to Prevention Centres at the local level in 1999.

Moreover, data on prevention and treatment expenses are considered to be more or less exhaustive. On the other hand, in regard to social rehabilitation, the lack of data from the Greek Labour Force Employment Organisation leaves an information gap, since provisions for subsidies to employers who employ former drug addicts are laid down every year in accordance with the relevant annual Ministerial decrees.

[*] Data of OKANA not included

14.4 Expenditures of specialised drug treatment centres

In 1999 financial data show that almost 73% of known expenditures on demand reduction activities nation-wide, namely € 11,826,466 out of the total € 16,200,933, were for treatment and overall secondary prevention. Data on treatment expenditures are considered to be exhaustive, since they were drawn either from reports published by competent authorities (OKANA) or by questionnaires returned to the Focal Point (KETHEA, 18 ANO, Thessaloniki State Psychiatric Hospital).

A breakdown of 1999 expenditures for treatment according to type of treatment approach is presented in Table 29.

Table 29: 1999 Treatment expenditures according to type of treatment approach

TYPE OF TREATMENT	EXPENSES IN €
Drug-free inpatient	3,929,221
– Salaries and staff expenses	2,575,396
– Housing and operational expenses	1,353,825
Drug-free outpatient for adults	1,687,892
– Salaries and staff expenses	1,037,855
– Housing and operational expenses	650,037
Drug-free outpatient for adolescents	916,018
– Salaries and staff expenses	685,937
– Housing and operational expenses	230,081
Substitution Programme	3,442,406
– Salaries and staff expenses	1,951,577
– Housing and operational expenses	1,490,829
Low Threshold	1,516,949
– Salaries and staff expenses	1,083.199
– Housing and operational expenses	433,750
Family Programmes	333,980
– Salaries and staff expenses	201,918
– Housing and operational expenses	132,062
TOTAL	**11,826,466**

In respect to the data presented in the previous table, the following should be noted:

- In all treatment categories expenditure data on counselling centres were also included.

- Data on salaries and staff expenses were reported by all agencies of all types of treatment programmes where they were incurred.
- Data on housing and operational expenses were fully reported by KETHEA and OKANA. The missions of both agencies, as mentioned above, clearly relate to all levels of drug prevention alone. The treatment programme 18 ANO and the Drug Dependence Treatment Unit, both involved in drug-free treatment, had difficulties in isolating financial data on housing or on operational expenses, since the two programmes operate within the framework of state psychiatric hospitals.
- Overall expenditures for low threshold services were drawn from KETHEA and OKANA. However, the Treatment Programme 18 ANO also reported low threshold initiatives implemented mainly by staff of the Adolescents Unit and of the Counselling Centre for Adults of the same programme. No specific cost, however, could be reported for those initiatives.

14.5 Methodological information

As already highlighted at the very beginning of this chapter, great difficulties arise whenever an effort is made to calculate budgets or expenditures for drugs. In general, those difficulties are associated to shortcomings in separating drug expenses from the overall budgets of the authorities involved.

Two main reasons, both interrelated, can explain those difficulties: a) lack of a single unified drug policy until quite recently and, as a result, b) lack of interest in carrying out studies on funds allocated to combating drugs.

In the previous context, when planning of demand reduction activities was haphazard and uncoordinated, cost assessment was inevitably neglected. Single and Single et al. argue that policy and costs are strongly interrelated, since cost estimates can help to prioritise certain policies in the public policy agenda, to appropriately target specific problems and policies, to identify information gaps and research needs, and to judge the effectiveness of specific policies (Single, 1995 ; Single et al. 2001).

The lack of relevant studies and bibliography also illustrate the aforementioned lack of interest so far. Recently (2001) the government prioritised the idea of single unified policy-making and implementation through the compilation and approval of a 5-year National Action Plan and through a newly-established Interministerial Committee (*see also* **Part I**). As part of the envisaged developments, in 2002 a Pay Office for the Treatment of Addictive Substance Problems was established, whose budget shall be covered by the state budget and by seizures of drug dealers' properties. Funds from the aforementioned pay office shall cover all financial needs of the National Action Plan.

However, a single and separate budget for all drug demand (and supply) reduction activities is yet to be established. As a result, there are still difficulties in calculating budgets or expenses and existing data cannot be considered as 100% exhaustive.

14.6 Conclusions

The problems in collecting financial data on drug-related activities were thoroughly described in previous sections of this chapter. The obstacles may be overcome in the light of a holistic unified drug policy that also takes into account the need for data on individual state budgets allocated solely to drug combating to be included as an indispensable part of the global financial picture. Given the emphasis put by the State on dealing globally with the drug problem, it is expected that this will also entail accurate global cost estimates that can be further broken down.

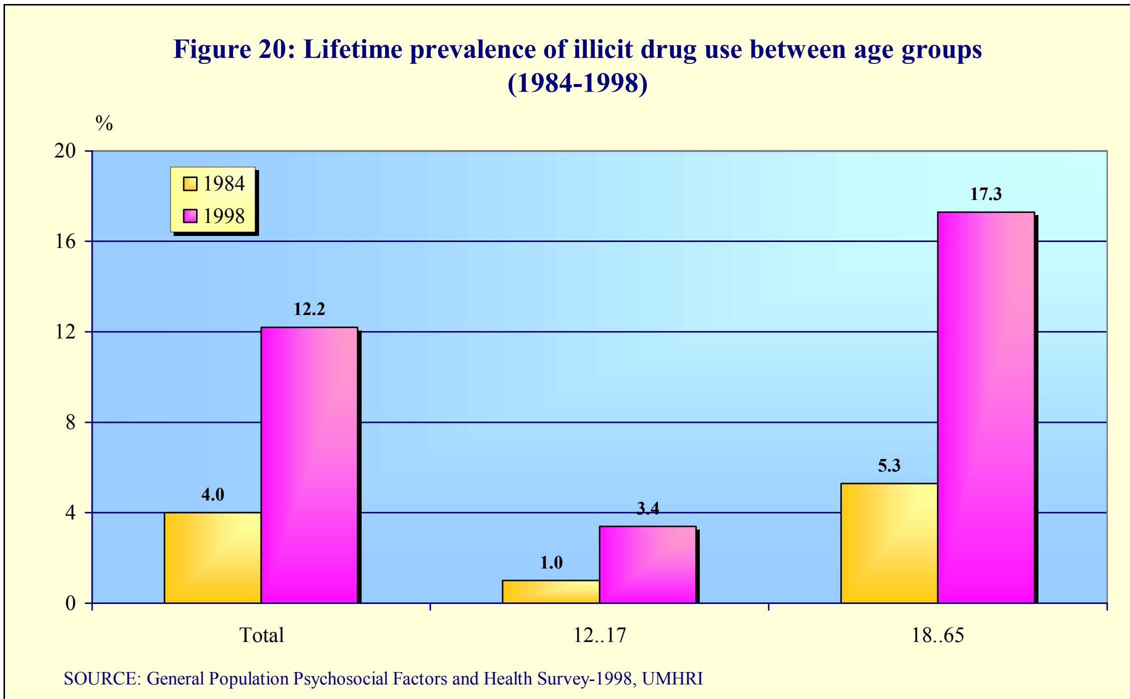
In theory, all unified policies are drawn up on the basis of estimated or evidence-based lists of needs. The necessity to also estimate the amounts of funds required to meet those needs is inherent to the scope of single policy-making. The first step for the application of a drug policy co-ordinated at the interministerial level has already been made in Greece and important provisions that will facilitate such financial tasks have been included in the National Action Plan. Further cost breakdown in economic and social components, although a first priority need, will be possible at a later stage. Hopefully, this will lead to increased research interest, after calculation of the overall funds allocated to drug-related activities has successfully been made.

15. Drug and Alcohol Use Among Young People Aged 12-17

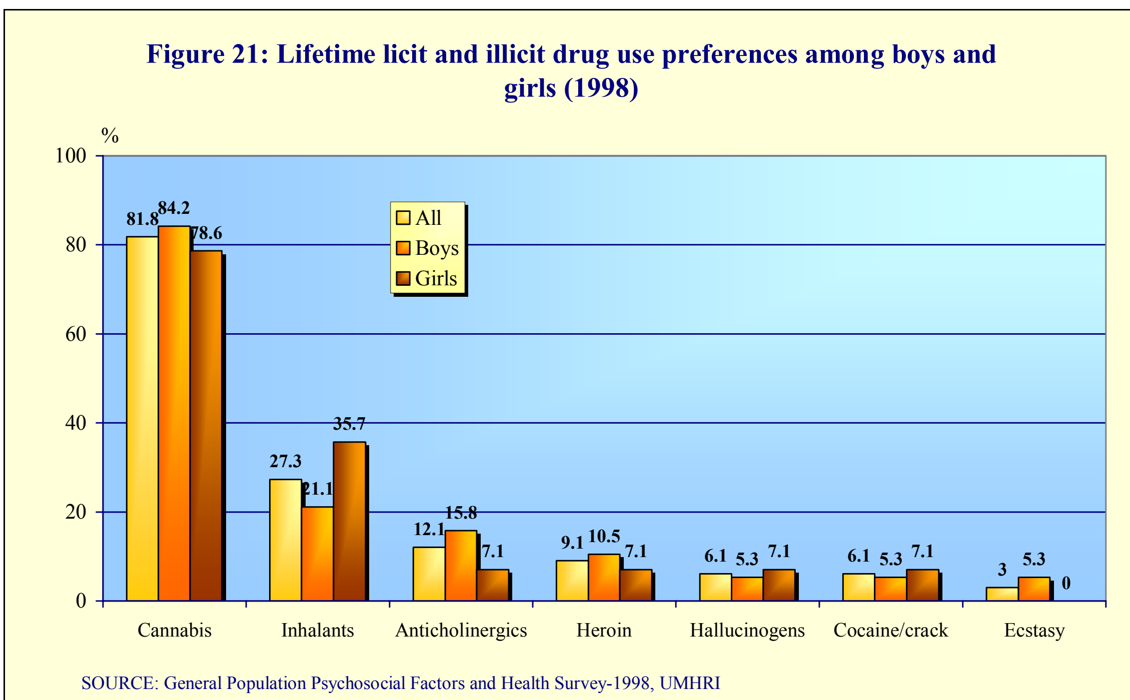
15.1 Prevalence, trends and patterns of use

Prevalence of use among Greek adolescents

General Population Survey: Compared to the age group 18-65, the lifetime prevalence of illicit drug use in adolescents is relatively low. Only three or four out of every hundred (3.4%) adolescents aged between 12 and 17 have a lifetime experience of illicit drug use. Although there was a significant increase in lifetime prevalence between 1984 and 1998 for both age groups, the increase rate for the 12-17 age group is practically the same as that for the 18-65 age group (Figure 20).



Out of the young respondents who reported lifetime use of any licit and illicit drug, 81.8% uses cannabis, followed by inhalants (27.3%), and anticholinergics (12.1%). As to gender, cannabis is slightly more popular among boys (84.2% as opposed to 78.6% for girls), and inhalants among girls (35.7% as opposed to 21.1% for boys) (Figure 21). Both the prevalence of use and the variety of substances used increase with age. Especially with regard to the variety of substances used, whereas the 12-14-year-olds try either cannabis or inhalants, the 15-17-year-olds are reported to have experimented with more substances.



Unlike the general population survey, school population surveys show a higher rate of lifetime illicit drug users.

Adolescents in the School Population Survey (1998): 21% of the 12-17-year-old students surveyed in 1998 reported at least one lifetime experience with some substance. This is almost twice the rate of 1993 (11,8%) (Figure 22).

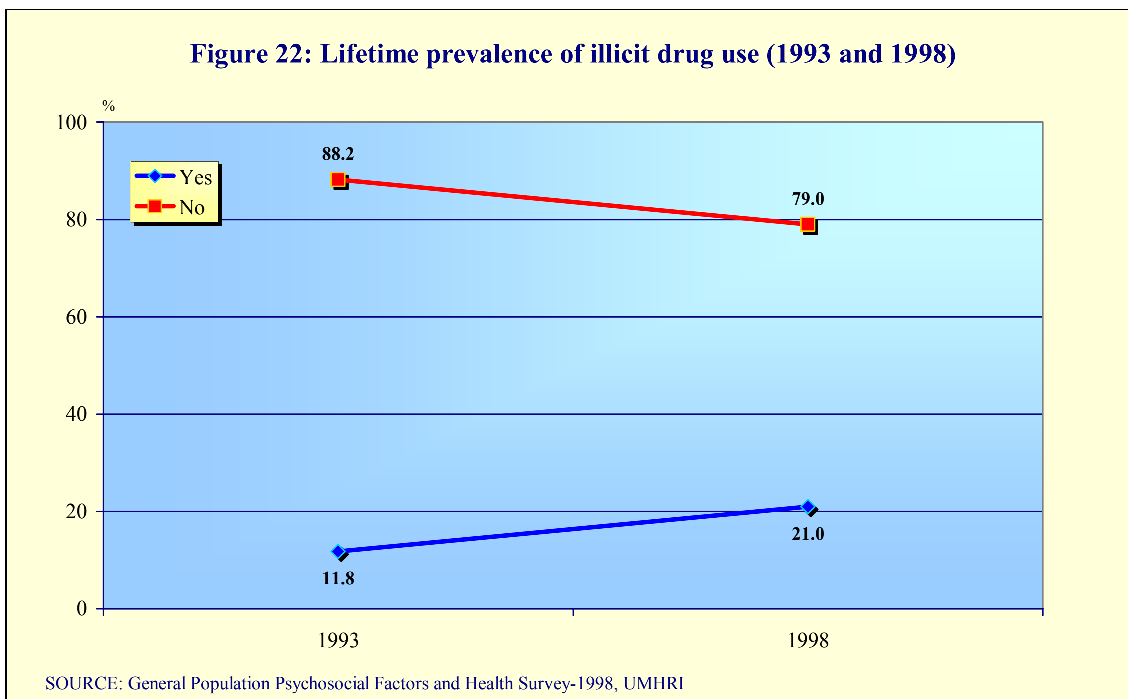
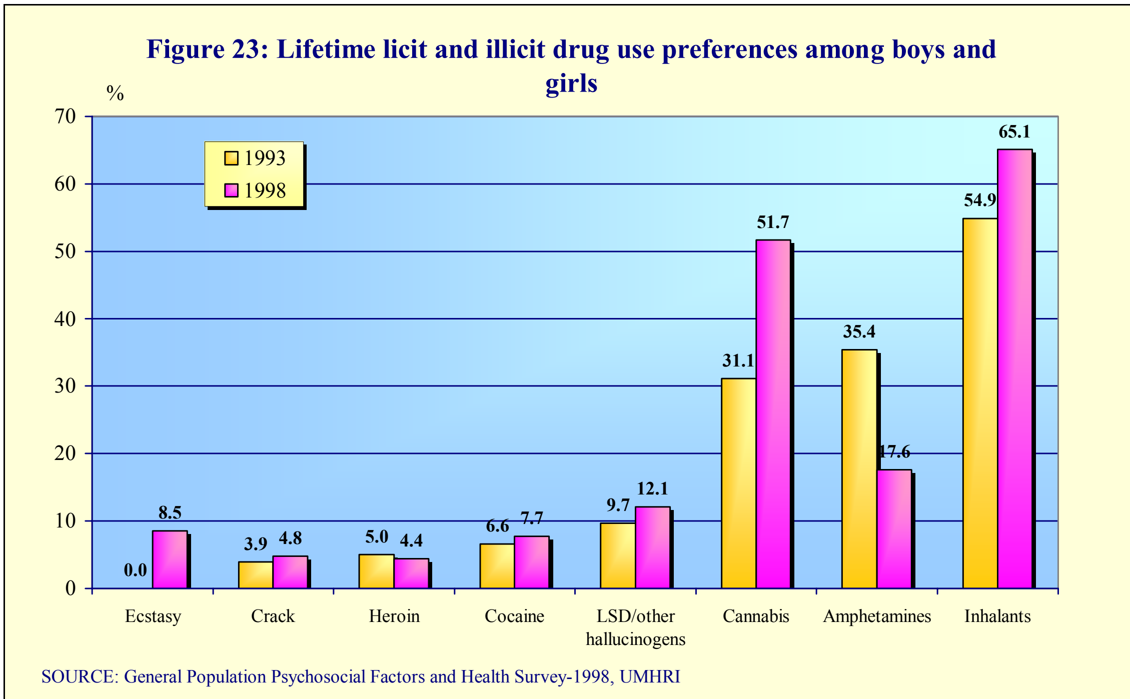


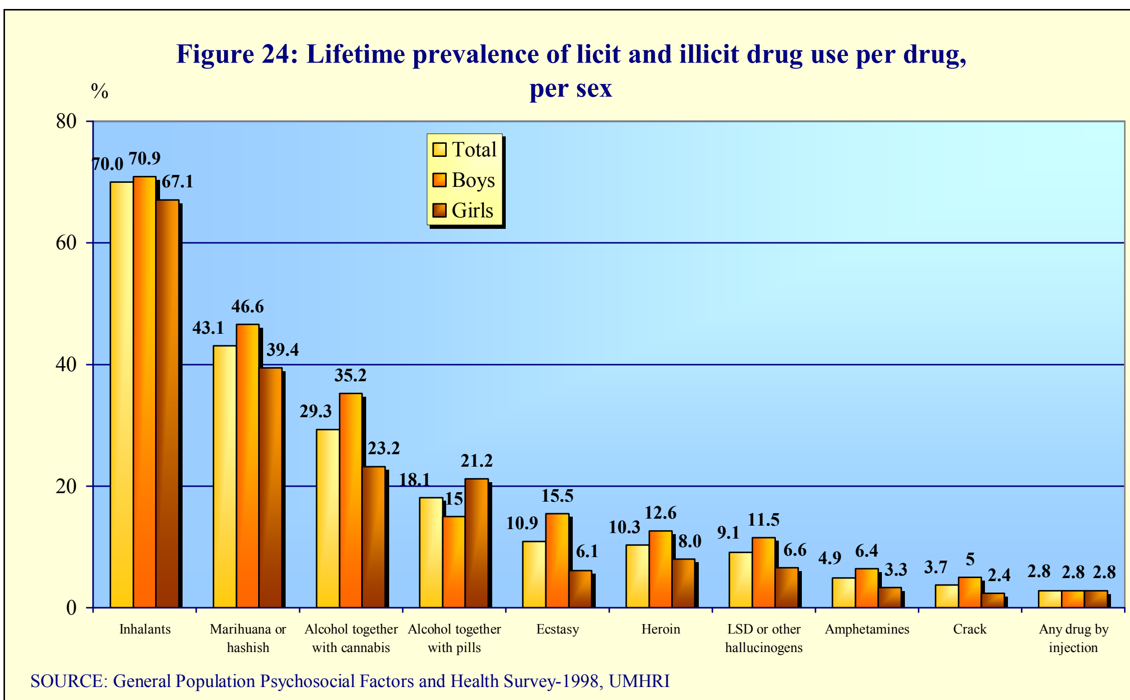
Figure 22: Lifetime prevalence of illicit drug use (1993 and 1998)

SOURCE: General Population Psychosocial Factors and Health Survey-1998, UMHRI

Adolescent pupils with experience in drug use prefer inhalants (65.1%) and cannabis (51.7%), followed by amphetamines (17.6%) (Figure 23). Boys and girls alike prefer or have access to more or less the same substances; this may be related to the cultural characteristics of the youth culture, which legitimises the prevalence of use of specific substances (i.e. inhalants) at the expense of others (i.e. heroin or crack).



E S P A D S t u d y: Similarly to the School survey, the ESPAD Study reported that 19.7% of adolescents had some type of lifetime experience with licit and illicit drugs. Out of those with at least one lifetime experience, 70% have tried inhalants, 43.1% marijuana or cannabis, and 29.3% cannabis with alcohol. There are no significant differences as to the type of substance between boys and girls. Still, boys seem to prefer ecstasy more than girls (15.5% and 6.1% respectively), as well as the simultaneous use of cannabis and alcohol (35.2% and 23.2% respectively) (Figure 24).



Army conscripts

Based on data presented by the Psychiatric Clinic of 251 Air Force General Hospital, 128 out of 265 air force conscripts who were referred to the Psychiatric Clinic for medical checks of all sorts were found to be drug users (243 in 2000). 48 air force conscripts received treatment for, among other things, drug use in 2001 (42 in 2000).

A research conducted in 2000 in the Air Force has shown that 29,3% of conscripts have had a lifetime experience in drug use. The onset age of 46,9% of them was 18-21 and the predominant substance of use at the time of the study was cannabis (12,3%).

Data on patterns of use set and setting, types of combinations and route of administration

Recreational drug use: According to the findings of the survey 'Nightlife of Young People and Drug Use 1998-1999', almost one out of two young adolescents aged 12-17 who are nightlife regulars (at least one or two weekends a month) makes either systematic use of cannabis (43.3%) or has used cannabis once in the past, and then stopped (10%).

In the systematic use category, cannabis is more popular with boys (52.9%) than girls (37.5%). Girls, however, seem to prefer ecstasy for systematic use more than boys (37.5% as opposed to 18.8%), LSD (37.5% as opposed to 12.5% for boys), and cocaine (28.6% as opposed to 18.8% for boys). Generally, cannabis seems to be the most popular drug in the nightlife recreational scene for the majority of adolescents (80.8%), followed by ecstasy (23.1%) and heroin (15.4%). There is, however, a difference between boys and girls as to heroin, LSD and cocaine. Heroin is the third most widely used drug in the recreational scene for boys (16.7%) but, for girls, ecstasy (25%) and crack (25%) come third, too.

Findings in the same study show that almost 20% of adolescents use more than one illicit drug on the same night. This holds true despite of other data that show that, generally speaking, adolescents are ('moderately' or 'very much') aware of the fact that drug use is harmful (73.1% for the frequent use of marijuana, 84% for the use of ecstasy once every weekend, and 69.6% for the use of LSD once a month).

Problem drug use: Data from 27 treatment centres (2001 Treatment Demand Indicator) show that 3,679 demanded treatment in 2001. Out of them, 135 (3.7%) belonged to the age group 12-17. Adolescents seeking help are mainly cannabis and heroin users. One out of every two adolescents wants to abstain from cannabis (54.1%), and four out of ten (39.3%) have problems with heroin. Contrary to boys, who are mainly addicted to cannabis (58.3%), most of the girls who applied for treatment in 2001 (59.3%) had a heroin problem.

More than the half (57%) of the adolescents aged between 12 and 17 reported use of more than one substance (polydrug use). Most users of this group alternate their primary substance with synthetic drugs (74%), followed by cannabis (41,6%).

Based only on KETHEA Treatment Demand Indicator data, the majority of heroin addicts (58,7%) reported injection as the predominant route of administration, followed by smoking (39,1%). Smoking is the ordinary route of administration for cannabis addicts (98,6%).

Perceptions of drug use and drug users

Data from the General Population Survey (1998) show that 43.2% of surveyed adolescents believe cannabis users may have some compelling psychological problems. Opinions differ, however, between those who have and those who have not had some experience in substance use (Table 30).

Table 30: Attitudes towards drug users

People smoking cannabis are:	**ALL**	**YOUNG PEOPLE WITH DRUG USE EXPERIENCE (N=33)**			**YOUNG PEOPLE WITHOUT DRUG USE EXPERIENCE (N=760)**		
	%	*%*	*Boys*	*Girls*	*%*	*Boys*	*Girls*
With psychological problems	43.2	12.1	10.5	14.3	44.5	43.0	46.0
Ordinary	10.9	51.5	63.2	35.7	9.1	9.1	9.4
With family problems	10.0	0	0	0	10.0	9.6	10.4
Misguided	9.0	6.1	5.3	7.1	9.1	9.3	8.8
Socially withdrawn	8.3	9.1	10.5	7.1	8.3	10.6	5.9
Sensitive	2.9	9.1	5.3	14.3	2.6	1.6	3.7
Young and immature	2.9	3.0	0	7.1	2.9	3.1	2.7

SOURCE: General Population Psychosocial Factors and Health Survey – 1998, UMHRI

One out of two (51.5%) adolescents with substance use experience considers cannabis users to be ordinary people with no particular problems. Similarly, only about one in eight (12.1%) adolescents from the same group of respondents believes that cannabis users have psychological problems. Compared to boys, girls of this group agree less with the view that cannabis users are ordinary people (boys 63.2%, girls 35.7%), and believe that it is highly likely for them to be extremely sensitive as personalities (boys 5.3%, girls 14.3%), and suffer from psychological problems (boys 10.5%, girls 14.3%) (Table 30).

On the contrary, adolescents with no substance use experience consider cannabis users to be people with psychological difficulties (44.5%), and, unlike those with substance experience, they believe that cannabis users are likely to have family problems too (10%). Only one in ten (9.1%) from this group of adolescents believes that cannabis users are ordinary people (Table 31).

Respondents in the **School Population Survey (1998)** believe that users are lonely people par excellence, with more psychological problems compared to non-users, and comparatively weaker personalities, which is why they are the easy victims of drug dealers. They come from problematic families, and live in difficult social settings. Similarly, use is not creative, nor does it make one a 'modern' person (Table 31).

Table 31: Perceptions of drug users 1998

Compared to non-users, drug users are …	**Adolescents with drug use experience**			**Adolescents without drug use experience**		
	%	*B*	*G*	*%*	*B*	*G*
With psychological problems	(1)70.2	64.5	79.9	(1)79.3	75.8	82.0
Weaker personalities	(2)58.1	50.4	71.0	(3)66.0	60.6	70.1
Prey to drug dealers	(3)56.8	55.9	58.4	(2)73.2	73.1	73.3
People with family problems	(4)52.3	52.9	51.2	(4)61.1	63.2	59.5
Solitary personalities	(5)40.3	40.0	40.9	(5)44.9	45.4	44.5
Less hardworking	(6)39.4	44.3	31.0	(7)38.2	47.2	31.4
Prey to social problems	(7)38.7	37.6	40.6	(8)37.5	39.3	36.1
Mentally ill	(8)34.4	35.3	33.0	(6)43.8	43.8	43.8
Criminals	(9)28.4	33.9	19.1	(9)36.0	44.2	29.8
Rebels	(10)26.3	25.9	27.1	(12)16.7	18.1	15.7
Sensitive people	(11)24.8	20.2	32.7	(13)15.9	11.9	18.9
Spoiled personalities	(12)23.6	22.9	24.8	(11)17.8	16.6	18.7
Leading immoral lives	(13)15.7	19.2	9.9	(10)18.4	23.7	14.4
Independent persons	(14)15.5	17.5	12.2	(14)7.8	10.2	5.9
Interesting persons	(15)5.5	5.3	5.9	(17)1.0	1.3	0.8
Creative persons	(16)3.8	4.5	2.6	(16)1.1	1.6	0.7
Interested in other people	(16)3.8	4.1	3.3	(16)1.1	0.7	1.4
Modern and progressive persons	(16)3.8	5.3	1.3	(15)1.3	1.3	1.2

SOURCE: Adolescents in the School Population Survey- 1998, UMHRI

There are only a few differences in the views of adolescent pupils with and without use experience. With the exception of the 'rebellious' and the 'more sensitive persons' categories sharing the first ten positions, nine out of ten

strong characteristics from the illicit drug user's profile are common to both categories of adolescents. Given the above, an interesting hypothesis is that adolescent pupils with illicit drug use experience tend to avoid characterising it as an act that might hold something positive for them (e.g. creativity, personal development) or for society in general (e.g. more sociability, participation or awareness of others).

There are some differences between boys and girls of both categories. In the category of adolescents with experience in drug use, girls put greater emphasis on the role of personality (weaker characters, more sensitive people), and the psychological/mental make-up (with psychological problems) as determining factors in a user's profile. On the other hand, boys of both groups of adolescents feel more strongly about the social impact of a user's personality on ethics, diligence and predisposition to criminality.

The **ESPAD study (1999)** shows a generally negative attitude towards the use of any substance (rates vary between 57% and 84.3%). Differences in illicit drug use acceptance/rejection rates relate to the type of substance and the incidence of use. For example, the use of heroin or cocaine is condemned much more than the use of cannabis (79.6%, 76.1% and 57% respectively). Similarly, 57% of all adolescents would be against the use of cannabis and inhalants once or twice, but those against the systematic use of cannabis are as many as 84.3%.

Rates also vary depending on the relation adolescents have with drugs. Among those with drug use experience, the use of inhalants (1-2 times, 29.4%) and cannabis (1-2 times, 33%) is condemned less than the use of heroin (1-2 times, 71.6%). The same category of adolescents seems to know the difference between using cannabis 1-2 times (33%), occasionally (49.9%) or systematically (69.5%). Systematic use is the least acceptable of all.

Table 32: Perceptions of drug use

I do not approve of the use of…	**I agree with the statement**	
	Adolescents with drug use experience	*Adolescents without drug use experience*
Heroin (once or twice)	71.6	81.6
Marijuana or hashish (systematically)	69.5	87.9
Crack (once or twice)	63.4	76.3
Cocaine (once or twice)	61.1	79.8
Ecstasy (once or twice)	55.8	74.5
LSD/hallucinogens (once or twice))	55.0	72.8
Amphetamines (once or twice)	54.2	68.8
Marijuana or hashish (occasionally)	49.9	76.4
Marijuana or hashish (once or twice)	33.0	62.8
Inhalants (once or twice)	29.4	63.7

SOURCE: ESPAD – 1999, UMHRI

The response of adolescents with no drug use experience is quite similar. There is a difference of opinion between the two groups with regard to simply trying or making use of some drugs once or twice. Table 32 shows that adolescents with no drug use experience are much more negative towards use in general, compared to those with use experience who seem to be more tolerant, especially to trying or making use of some drugs once or twice.

Data show that adolescents are, generally, able to distinguish between and semantically rank drugs according to the type of drug and the incidence of use. Drugs such as heroin and cocaine are condemned the most, just like systematic use irrespective of the specific drug abused.

15.2 Health and social consequences

Deaths and overdoses

As indicated in Table 33, 321 cases of acute drug-related deaths were reported in 2001. 30 cases (9,3%) involved young people aged 12-19.

Table 33: Deaths from overdoses in 2001

	Male		Female		Total	
	2000	*2001*	*2000*	*2001*	*2000*	*2001*
All ages	285 100%	300 100%	19 100%	21 100%	304 100%	321 100%
<15	0	1	0	0	0	1
15-19	26	23	6	6	32	29
TOTAL	26 9.1%	24 8%	6 31.6%	6 28.6%	32 10.5%	30 9.3%

SOURCE: Hellenic Police 2001, 2002

Hospital emergencies

There are no data available regarding the hospital emergencies related to drug use involving adolescents. However, members of the medical staff of Athens District General Hospital – Hellenic Red Cross Hospital published in 2001 a study based on data recorded by emergency personnel regarding patients suffering from heroin overdoses. Between 1996 and 2000, the total number of recorded emergency cases of heroin overdose was 477. Data became available for 348 cases. One out of three cases (30,1%) involved young people aged between 15-20 (Dritsas, S. et al. 2001).

Demand for treatment

Out of the 27 treatment centres/institutions providing assistance to users in 2001, 11 responded to the needs of this age group. Most treatment services were provided by KETHEA information centres, 'PLEFSI' (35.6%), 'STROFI' (31.1%), and the Adolescents' Station of the Athens Juvenile Court (24.4%), which specialise in adolescents' and young drug users' treatment. The overwhelming majority of adolescents seeking help are boys (80%) of Greek nationality (95.4%), which is fully understandable considering the general prevalence of use among men. Moreover, the treatment demand rate increases with age. 60.7% of demands for treatment in 2001 was by boys and girls aged 17.

Adolescents decided to seek help from treatment centres when urged to do so by their family (45.9%), by law enforcement and police authorities (32.6%), and by close male/female friends (11.9%). There is a slight difference between girls and boys in that respect, too. Family is just as important for girls and boys alike, but girls tend to be more influenced by their friends when it comes to making their decision, contrary to boys who seem to be forced into deciding to attend this or that form of treatment by the authorities. This is also indicative of a relation between drug use and criminality for boys.

The 2001 data cannot be compared with those from previous years. KETHEA, whose information centres account for the biggest part of information and treatment available for addicted adolescents, only started providing data in 2001. Despite that, and in accordance with data from previous years, there is continuity as to treatment demand characteristics, mainly with regard to age (17 years), gender (mostly boys), and addictive substance (mainly cannabis and, recently, also heroin).

A preliminary study published in 2001 drew data from individuals who approached the Counselling Centre of the Rehabilitation Unit of Thessaloniki Psychiatric Hospital for help. Recorded data show that only 4.5% of the drug users who approached the Centre between 1/1/1996 and 30/4/2001 were adolescents (Table 33). With regard to this age group, one in two boys who left school after the 9th (compulsory) grade (54,7%), is unemployed (49%) or student (26,4%) and has problems with the law (47,1%). As for girls, the majority has reached grades 9-12 of senior high school (66,6%), is mainly unemployed (55,5%) or in school (33,3%), has yet no problems with the law (88,8%).

Table 34: Adolescent clients of the Counselling Centre of the Rehabilitation Unit of Thessaloniki Psychiatric Hospital between 1/1/1996 and 30/4/2001

	TOTAL	Male	Female
All ages	1760	1530 (86,9%)	230 (13%)
<18	80	53 (66,3%)	27 (33,7%)

SOURCE: Zlatanos, 2001

Male adolescents began illicit drug use slightly earlier that female ones. Both have nonetheless had their first experience while in their 14th year of age. Similarly, all adolescents logged an average period of use prior to therapy of about 3 years. Cannabis was the first illicit drug used by all, followed by the combination of cannabis and pills. However, most of them (79%) were heroin addicts at the time of treatment demand. Again most of them (75%) administer heroin through injection.

15.3 Demand and harm reduction responses

Prevention programmes and campaigns targeting young Greeks aged between 12-18 operate mainly at two levels: in-school and off-school (community) level.

Drug prevention programmes run on an annual basis in numerous secondary education establishments. These programmes are not an integral part of school curricula, and therefore they are not mandatory. However, interventions in the student population have proliferated in recent years under the auspices of the Ministry of Health (through the Greek Organisation Against Drugs) and the partnership with the Ministry of Education authorities (see 9.1. School programmes).

Outside school youth programmes operate along the same lines as school programmes. Off-school interventions aim at promoting health attitudes and at developing personal and social skills of adolescents. These programmes comprise a set of actions that may range from straightforward dissemination of information and awareness raising to cultural and sports activities in summer camps. Some programmes also run experiential groups for adolescents (see 9.2. Youth programmes outside school).

There are also programmes based on the peer-to-peer approach targeting Greek adolescents. Adolescents advance their skills in communication and expression, while also developing their creativity through participation in a wide range of activities such as theatre, puppet theatre, music, photography, painting, and handicrafts.

As part of the content of another programme, young people can partake in the development of prevention initiatives organised by prevention centres by way of contributing to the production of radio and TV spots or postcards addressing drug use issues (*see* **9.4 Other programmes**).

Finally, an important prevention policy component is currently running in the mass media targeting especially adolescent Greeks. Non-governmental institutions (OKANA, STROFI – KETHEA) have launched media campaigns aiming at changing attitudes concerning drug use, specific substance use (OKANA campaign) and the demand for treatment (STROFI campaign) (see 9.4. Other programmes).

In terms of harm reduction, therapeutic services specifically addressed to adolescent drug users are provided mostly by KETHEA integrated and multi-

phased therapeutic programmes (STROFI and PLEFSI) and by the Department of Adolescents and Young Adults of the Drug Dependence Unit “18 ANO”:

- STROFI (KETHEA) focuses its programmes on three main areas: a) high-risk adolescent drug users, b) adolescent drug users who also have problems with the law and pendencies (Counselling Centre in the Public Prosecutor’s Office, Athens) and c) adolescent drug users’ families (all programmes offer family therapy aiming at the reform of the family system on new grounds). In addition, STROFI organises educational courses addressed to adolescent drug users who dropped out of school at early stages (Transitional School)
- PLEFSI (KETHEA), originally part of the STROFI programme, is a network responding to the needs of adolescent drug users who, although leading ordinary student or professional lives, are at risk of becoming drug addicts.
- The Department of Adolescents and Young Adults of the Drug Dependence Unit “18 ANO” runs treatment programmes focused explicitly on a psychodynamic approach of each one of the participating adolescents, using supportive, psychodynamically-led psychotherapy. The programmes give emphasis on the personality development of the adolescents.

15.4 Methodological information

Methodological note on surveys

The survey results on which this Chapter is based came up in recent years in an effort to examine as fully as possible the prevalence of use phenomenon among adolescents, as well as their attitudes to drug and alcohol use. Surveys conducted by UMHRI and the Greek Focal Point include:

- the ‘General Population Psychosocial Factors and Health Survey’ (henceforth **General Population Survey**) conducted in 1998
- the ‘School Population Survey’ (henceforth **School Survey**) conducted in 1998 and
- the ‘European School Population Alcohol and Drug Survey’ (henceforth **ESPAD study**) conducted in 1999.

A smaller survey on the ‘Nightlife of Young People and Drug Use 1998-1999’, together with data collected by Greek treatment centres and institutions on demand for treatment by adolescents in 2001, complete the picture.

Data collected in the above-mentioned surveys are not readily comparable. The studies used different questionnaires and sampling frames, and the make-up of the age groups of the target population for each survey was originally different. A considerable number of questions addressed, nonetheless, similar issues (e.g. prevalence, frequency and type of substance used), a fact that allowed for some useful conclusions. Data were processed by sorting based on the answers of adolescents aged 12-17.

16. SOCIAL EXCLUSION AND REINTEGRATION

16.1 Definitions and concepts

Although the term "social exclusion" first emerged in the rest of the EU in the 1970's, in Greece it only appeared during the last decade both as a research subject and a scope of action. In both cases, however, "social exclusion" -which is considered to be a rather vague term- superseded the term "poverty" and replaced all poverty-related concepts prevailing in the respective EU social policy programmes (Tsiganou et al., 2001). In this context, "social exclusion" is not only defined in relation to economic factors -as was the case with the term "poverty"- but also on the basis of more global variables, including social, cultural, family and personal indicators. Thus, although unemployment has been traditionally considered as the key indicator of social exclusion, stigmatisation and social isolation (social factors), different ethnic, religious and cultural background (cultural factors), single-parent or poorly-educated families (family factors) and a person's sex (personal factors) are also taken into consideration as examples of social exclusion indicators (http://locin.jrc.it/en).

The broad nature of the "social exclusion" term leads to encompassing various groups under the same concept, despite their possible differences in terms of special characteristics, problems and needs. However, this all-embracing approach is based on the idea that the various groups considered to be at risk of social exclusion share certain common features that surpass the existing idiosyncrasies. According to the first Greek Report submitted to the European Observatory for Social Exclusion (Karantinos et al., 1990), the primary common characteristic among socially excluded groups is their weak relationship with the main social mechanisms that produce or distribute financial resources, namely the labour market, family or other interpersonal networks, and the State (Kavounidi, 1996).

Common characteristics that transcend any possible differences are also apparent among drug users. The existing “myths” with regard to the substances, the prejudices and the social stigmatisation feed the negative attitudes of society towards drug users and ex-drug users (Matsa, 1994). Moreover, the stigma to drug users has a catalytic effect on their previous relationships with their family and working environment, which impairs their capacity for adjustment and social reintegration (Fakiolas et. al., 1996). In this vein, social exclusion of drug users appears to be a quite complex process and should be seen as a two-fold phenomenon: a. social exclusion as a cause of drug use, and b. social exclusion as an effect of drug use.

It has been argued that exclusion from society is a subsequent choice of drug users, who withdraw from the wider community by means of participating in a sub-group with its own communication codes, drug use being one of them (Matsa, 1996). However, an issue that arises at this point is whether this choice is a free-will one or whether it is imposed by certain social models and by preceding life events that had led to social exclusion anyway. Thus, according to Tsili (1996), drug users' social exclusion appears to be the result of various social processes, which are initially based on simple ideological differences and

end up to stigmatisation and isolation of people with special characteristics, who constitute "stigmatised groups".

Social processes that lead to or are associated with social exclusion are usually conveyed through discursive practices. At the meeting entitled "Stigma and Social Exclusion", organised by KETHEA on 23 September 2002, it was mentioned that the Greek legislation currently employs three different terms to denote drug users, namely “user”, “addict” (i.e. “toxicomaniac”) and “dependent”. Based on an analysis of these terms, it was argued that the use of the word “mania” incited social stigmatisation, whereas the term "user" was limited to the description of the drug use activity. The term "dependent" was, therefore, suggested as the most comprehensive and the least stigmatising one.

The aforementioned two-fold quality of drug users' social exclusion is distinctively demonstrated in the relation between drug use and the penal system. Along these lines, by being an offence, drug use generates further social exclusion through the individual’s involvement in the criminal justice system (secondary deviation: delinquency). At the same time, the application of the suppressive law system exceeds drug users' social exclusion (Matsa, 1996). Institutionalisation, further stigmatisation as a "criminal", long absence from the labour market and lack of vocational training are some of the effects of drug users' involvement in the criminal justice system, which aggravate their unemployment and marginalisation from the rest of society.

Along these lines, professionals and policy-makers stress the need to develop adequate services within the criminal justice system that will effectively deal with drug users and meet their needs at every stage, i.e. from arrest all the way down to specialised interventions within the correctional system and alternatives to prison. Moreover, the issue of drug users' social exclusion was also raised in the context of the debate on decriminalisation of drug use, at least for some "soft" drugs, such as cannabis (*see also* **Chapter 1.4 Developments in public attitudes and debates**). Along with these arguments, it has been pointed out that ex-drug addicts should have equal opportunities for professional rehabilitation in both the public and the private sector (Matsa, 1996), a process that has been recently launched through the Joint Ministerial Decree 22284/28-2-2002 (*see also* **Chapter 1.2 Legal Framework**).

Groups considered to be highly vulnerable to drug use include the following: young school drop-outs, homeless, immigrants, repatriates, culturally different groups in general, prisoners and released prisoners, children of drug users. All of these groups share some common characteristics, which appear with less intensity and frequency in other groups of the general population, if at all, such as low educational level, being unemployed or having a low-level job (i.e. low status and income, no insurance), being deprived of basic social rights, being cut off from the family and/or having dysfunctional family relations. In addition, immigrants and culturally differentiated groups face various psycho-emotional difficulties due to the demands of the acculturation process and language and cultural differences, which quite often isolate them from the mainstream and make their approach by national agencies difficult.

16.2 Drug use patterns and consequences observed in socially excluded populations

Given the lack of a special survey on drug users, data from the 1998 nationwide general population survey in Greece were used.

According to these data, the highest drug use rate is reported by part-time and full-time working students (29.6% and 21.4% respectively), followed by full-time employed (16.6%), unemployed (16.1%), part-time employed (9.1%) and others (6.9%). School dropouts at all educational levels present higher percentages of drug use (i.e. 35.1% of primary school dropouts, 33.6% of high school dropouts, 41% of higher technical school dropouts) compared to students (26.8%).

Data from general population surveys do not refer to special population groups, such as immigrants or repatriates, consequently there are no indications of the specific conditions of such socially excluded groups.

16.3 Relationship between social exclusion and drug use

In investigating the relationship between social exclusion and drug use the TDI data were used, in the absence of special studies on socially excluded groups.

From the TDI population, three groups, who were considered being at risk of social exclusion were isolated and investigated: immigrant users (coming from Africa, Asia and non-EU European countries), unemployed users and homeless users. Table 34 presents these groups in terms of their labour status, educational level, main substance used and route of administration.

Half of the users registered on the TDI monitoring system for 2001 were included in the analysis that segregates the population under study into immigrants and non-immigrants, since nationality has not been reported for users who approached KETHEA counseling services within the year of reference. Only 1.4% of users approaching various therapeutic services in 2001 were immigrants. Regarding labour status, the majority of immigrants are unemployed but this also holds for the entire population under study. However, among those employed, type of employment appears to be correlated with social exclusion, since the percentage of immigrants occupied in part-time jobs is higher than that of non-immigrants (25.9% compared to 13.2%). No large differences are observed in educational level, primary substance used or injecting as the route of administration among immigrants and non-immigrants. Smoking is however more common among immigrants than the rest of the population (22.2% compared to 15%).

Unemployed users comprise 64.3% of all users who approached drug services in 2001 (including KETHEA). Labour status is found to be strongly associated to educational level (the corresponding percentages can be seen on Table 35). Unemployed users are also low-educated individuals. The percentage of unemployed users who have not been confined to compulsory education (36.3%) is not only lower than the corresponding percentage of

employed users (45.3%), but also significantly lower than the corresponding percentage among unemployed individuals in the general population (52.5%-data not shown). Unemployed users use heroin/other opiates as primary drug in larger percentages (90.8%) than employed users (80.3%), while cannabis is used more by non-unemployed users (13.5%). This is expected, since the latter group includes pupils and students. Regarding route of administration, almost 60% of unemployed users inject the main substance, while smoking is preferred among employed users.

In 2001, 4.9% of all users approaching treatment services were homeless users. Living status is found to be strongly associated with labour status, the percentages can be seen on Table 35. The percentage of homeless users (80.6%) who are unemployed is significantly higher than the corresponding percentage for the rest of the users. Also, 13.7% of homeless users are part-time employed, a finding that underlines the complexity of the social exclusion phenomenon. Homeless users are less educated (41.2% have completed primary education) than non-homeless users (26.9%). No large differences between the two groups are observed with regard to substance of use. However, homeless users use injection as route of administration far more often than non-homeless users (72.9% compared to 52.3%).

Summarizing the above findings, it is observed that among the three types of social exclusion, immigrant status is the least related with factors such as labour status and educational level and patterns of use, such as substance of use and route of administration. Nonetheless, an intriguing finding is that in a country, where a large immigration flow has occurred during the last decade, only a very small proportion of users seeking help are immigrants. The socially excluded group of unemployed users, is a group of low-educated users, whose main substance of use is heroin and who inject more than non-unemployed users. Regarding homeless users, their differences from the rest of the population regard labour status, educational level and route of administration.

In conclusion, social exclusion and drug use are two related aspects of social life. Research on socially excluded groups is needed to assess further associations.

Table 35: Socially excluded groups of drug users who contacted the therapeutic services in 2001

	Immigrant (%)	Non-immigrant (%)	Unemployed (%)	Non-unemployed (%)	Homeless (%)	Non-homeless (%)
Labour status						
Unemployed	63	62.4	100	0	80.6	63.3
Full-time	11.1	20.7	0	53.8	4.6	20

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	Immigrant (%)	Non-immigrant (%)	Unemployed (%)	Non-unemployed (%)	Homeless (%)	Non-homeless (%)
Part-time	25.9	13.2	0	28.4	13.7	10
Educational level						
Primary education	37.0	30.1	30.8	22.4	41.2	26.9
Compulsory education	22.2	28.7	32.9	32.3	29.9	32.9
Higher education	40.7	41.2	36.3	45.3	28.8	40.2
Main substance used						
Heroin	92.6	87.6	90.8	80.3	91.6	86.8
Cannabis	0	4.9	3.7	13.5	3.9	7.5
Route of administration						
Injecting	51.9	58.4	59.8	41.8	72.9	52.3
Smoking	22.2	15	17.1	31.8	10.7	23

16.4 Political issues and reintegration programmes

Admittedly, drug users are a socially excluded group. On one hand, society is prejudiced against them, it stigmatises and marginalises them even when they complete their treatment (Matsa, 1995). On the other hand, when drug addicts enter a treatment programme, they have to address, alongside their addiction problem, serious educational and vocational problems making their social reintegration even more difficult (Gitakos and Tsiboukli, 1998). In order to deal with the social exclusion that drug users face, the detoxification process needs to integrate the social dimension of drug use, apart from the physical and the psychological one.

Accordingly, the National Action Plan Against Drugs (2002-2006) focuses on the following three main areas of action that are expected to promote drug users' social reintegration:

a. Development of educational programmes (i.e. "Second Chance Schools", training programmes for the acquisition of basic skills) that will fill the existing educational gaps and increase personal and social skills of drug users

b. Reinforcement of vocational training programmes and increased opportunities for occupational rehabilitation (i.e. EQUAL project, vocational training programmes by specialised treatment agencies, jobs subsidised by the Employment Organisation of Labour Force (OAED), initiatives by local authorities)
c. Active involvement of drug users in treatment in social and cultural events, in co-operation with the Ministry of Culture, so as to broaden their socio-cultural perspectives and minimise social prejudices against them.

In order to achieve the aforementioned objectives, various programmes and activities are developed not only by specialised treatment centres, but also by other governmental and non-governmental agencies, as presented below.

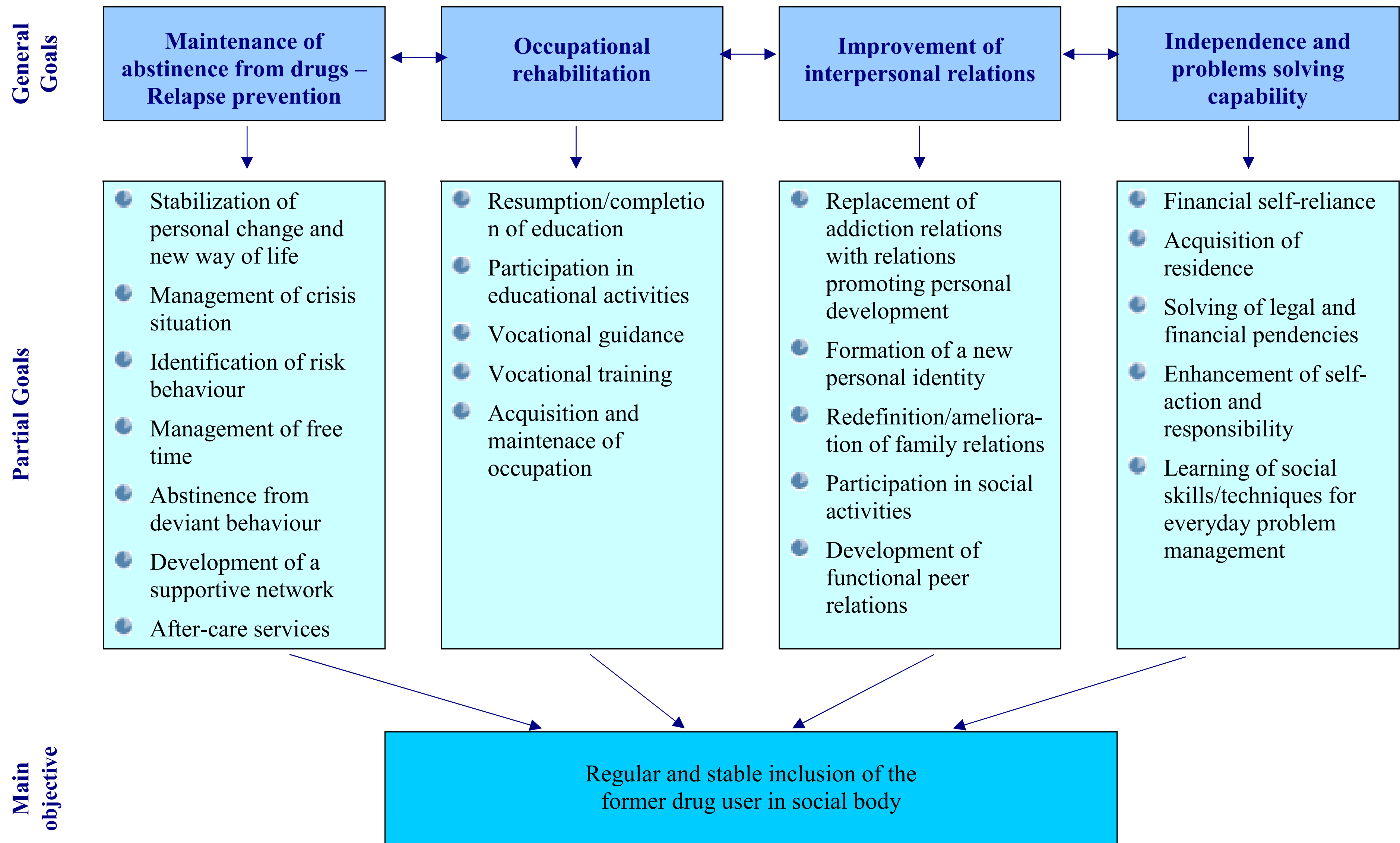
Greek treatment programmes for drug users provide reintegration services either during the last stages of treatment or in specialised social rehabilitation centres, where drug users enter after completing the main phase of treatment. Today there are thirteen (13) Social Rehabilitation Centres, nine (9) of which are run by KETHEA, two (2) by OKANA, one (1) by the Drug Dependence Unit "18 ANO" (Psychiatric Hospital of Attica), and one (1) by the Treatment Programme "ARGO" (Psychiatric Hospital of Thessaloniki).

According to data for the year 2001, social rehabilitation programmes have a great scope of interrelated objectives geared towards the achievement of the general aim (Chart 1).

Education and vocational training

As shown in Chart 1, special emphasis is placed on filling drug users' educational gaps and on vocational training. In this vein, some treatment centres offer specialised education programmes and motivate clients to continue and complete their basic education (e.g. scholarships, studying free of charge in Vocational Training Institutes-IEK).

Chart 1: The objectives of the Social Rehabilitation Services



In addition, there are three (3) specialised educational facilities: the Transitional School for Adolescents of "STROFI" Treatment Programme (KETHEA), the Education Programme of "ARGO" Treatment Programme (Psychiatric Hospital of Thessaloniki), and the School for Adults of "EXODOS" Treatment Programme (KETHEA). Their main aim is to prepare users to sit for senior high school leaving examinations.

Table 36: Data on specific schooling programmes for users in the year 2001

Schooling programmes	Number of participants	Number of individuals who succeeded in exams	Number of teaching hours	Number of professionals
Transitional school for adolescents	88	28	6400*	16
Training programme «ARGO»	5	4	240	2
School for adolescents	15	N.R.**	N.R.	8

* This number refers to the teaching hours in eight different classes run in 2001 (six secondary education classes –junior and senior high school– and two preparatory classes for advancement and high school leaving exams.

** N.R. indicates «Not Reported».

As shown in Table 36, 28 participants in the "STROFI" Transitional School took and passed the exams (100% success) and 5 of them succeeded in entering Higher Education. In addition, 49 adolescents continued their studies in Technological Education Foundations (TEE), private vocational training institutes. The Transitional School also provided training in computers (650 hours) and career guidance to 7 and 69 members, respectively. In 2000-2001, transitional classes for those who had dropped out from school long ago were offered, too (KETHEA, 2001).

Vocational training for drug and ex-drug users is provided either at social rehabilitation centres or at the Specialised Vocational Training Centres. In 1998, KETHEA was certified as a Specialised Training and Support Centre for the regions of Attica, Thessaly and Macedonia, and in 2000 OKANA opened its Specialised Vocational Training Centre (EKEK-OKANA) in Attica. Besides vocational training programmes, these centres also provide a series of supportive services (e.g. career guidance, counselling on labour market issues, and support to jobseekers). Education and vocational training programmes are also provided to imprisoned and released drug addicts (*see* **Chapter 12.1 "Assistance to drug users in prisons"**).

In the framework of concerted action for the vocational rehabilitation of drug users who attend or completed treatment programmes, OKANA started in 2001-2002 to implement a three-year project under the EQUAL initiative, entitled 'National Employability Network for Detoxified Individuals', in co-operation with sixteen other agencies. The main objectives of the project include the following:

- Creating a National Network of Model Specialised Facilities for the social and vocational rehabilitation of ex-addicts having completed treatment or participating in social rehabilitation centres, long-tern substitution clients and HIV positive persons.
- Training of the aforementioned Network staff to work as rehabilitation counsellors by applying the certified training model, as well as training of staff of social services and employment organisations and private labour consultants in matters relating to the rehabilitation of the particular target-groups.

Employment

In 2002, the Ministry of Labour through the Employment Organisation of Labour Force (OAED) implemented three new employers' subsidy programmes and a subsidised programme for young self-employed professionals. In particular, these four-year programmes include the following:

- 400 subsidised full-time posts in the private sector, under non-fixed-term employment contract (250 for ex-addicts having completed treatment or participating in social rehabilitation centres or long-tern substitution clients, and 150 for released prisoners and juvenile delinquents)
- 80 subsidised full-time posts, under fixed-term employment contract (50 for ex-addicts having completed treatment or participating in social rehabilitation centres or long-tern substitution clients, and 30 for released prisoners and juvenile delinquents)
- 50 subsidised part-time posts, under non-fixed-term employment contract, for at least four hours daily, intended for disabled persons, ex-addicts, released prisoners and young offenders
- 250 subsidies for new enterprises (100 for ex-addicts and 150 for released prisoners)

Full-time post subsidy is € 22 daily and part-time post € 12. Subsidies are paid for 36 months, provided that the persons remain employed for one year after the end of the subsidy. For those with no previous experience, the programme provides for a three-month adjustment period with a € 300 subsidy. The main subsidy for new enterprises comes up to a total € 16,000.

According to OAED statistics, the total number of participants in the OAED subsidised programmes in 2001 was 421 individuals, 275 of whom ex-drug addicts (Table 37). Most individuals participated in the programme of subsidised vacancies in the private sector (289 participants), while 132 individuals received a subsidy in order to start up their own business.

Table 37: Number of former drug users, released prisoners and juvenile delinquents participating in OAED programmes in 2001

Ex-addicts: 275 persons				Discharged prisoners: 125 persons				Juvenile delinquents: 21 persons			
Subsidised vacancies: 220 persons		*Subsidised enterprises: 55 persons*		*Subsidised vacancies: 48 persons*		*Subsidised enterprises: 77 persons*		*Subsidised vacancies: 21 persons*		*Subsidised enterprises: 0 persons*	
Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
177	43	46	9	45	3	76	1	13	8	0	0

SOURCE: Employment Organisation of Labour Force (OAED), 2002

For most treatment programmes, vocational rehabilitation of users is the main prerequisite for the completion of the treatment. Treatment programmes actively support participants in their efforts to find employment by keeping them informed on employment opportunities, raising the awareness of employers, and working together with private and public sector bodies. As a result, users completing KETHEA treatment programmes have a stable employment.

Accommodation

Treatment programmes generally provide accommodation help. Social Rehabilitation Centres of KETHEA, the Drug Dependence Unit "18 ANO", and OKANA Treatment Programme "GEFYRA" run hostels of their own, too. These hostels can be of use to users who have to leave their place of residence in order to attend their treatment programme, to clients in the social rehabilitation phase while looking for accommodation and employment, to individuals in treatment whose family members are users or to adolescent users who do not have family support.

Apart from the hostels run by specialised treatment programmes, ex-addicts can also stay in state-funded hostels or in hostels owned by NGOs (e.g. Association for Women's Rights), and volunteer associations (e.g. 'FILIMON'). Local and municipal authorities can also provide accommodation to drug users living in their territory, in co-operation with government agencies.

Evaluation results and difficulties

According to 2001 data, the total number of users who were admitted in Social Rehabilitation Centres in the country was approximately 678 persons (Table 38). Completion rates and relevant quantitative results are indicative of the Social Rehabilitation Centres' important role in the effort of drug users to become socially reintegrated. This is also shown by the qualitative evaluation results, according to which the social rehabilitation phase actually co-shapes a new framework of life for ex-users on a personal, family, vocational and social level, thus safeguarding the positive results of treatment and guaranteeing social rehabilitation.

Difficulties of Social Rehabilitation Centres relate mainly to lack of sufficient and adequately trained staff, lack of awareness on the part of local communities, and lack of co-operation with local authorities in order to respond to accommodation and employment needs of ex-users. It seems that, despite the great importance of the local communities' role, more systematic information and awareness raising are required before social prejudice and stigmatisation is minimised.

Table 38: Data on Social Rehabilitation Centres for the year 2001

Social Rehabilitation Programmes*	**Number of users** (Total: 678 individuals)	**Completion/drop out rates**	**Other quantitative results**
Treatment Programme «ITHAKI»	31	N.R.**	– 99% of those who completed the programme have abstained from drug use for at least 2 years – 50% of the drop outs was due to problems in limiting alcohol use
T.P. «STROFI»	79	31.6% completed treatment 2.5% dropped out	150% capacity
T.P. «PAREMVASI»	109	19% completed treatment	10 individuals initiated longitudinal training
T.P. «DIAVASI»	78	32% completed treatment 12.8% dropped out	N.R.
UNIT «18 ANO»	86	N.R.	N.R.
T.P. «EXODOS»	43	14% dropped out	– legal problems: 75% of the participants in the beginning of treatment, as opposed to 35% during the social rehabilitation phase – only 9% reported family problems
T.P. «NOSTOS»	72	20.8% completed treatment	N.R.
Multiple Intervention Centre	8	N.R.	70% capacity
T.P. «PLEFSI»	42	N.R.	N.R.
T.P. «ARGO»***	11	72.7% completed treatment 27.3% dropped out	N.R.

Continued on next page ➯

Continued from previous page

Social Rehabilitation Programmes*	Number of users (Total: 678 individuals)	Completion/drop outs rates	Other quantitative results
T.P. «ARIADNI»	13	N.R.	– 90% abstinence from drug use and deviant behaviour – 90% management of personal problems – 80% utilisation of the vocational guidance process
T.P. «GEFYRA»	6	N.R.	N.R.
Social Rehabilitation Unit of OKANA	100	8% completed treatment 26% dropped out	N.R.

* The presentation order of the Social Rehabilitation Centres is in accordance with their year of establishment

** N.R. indicates “Not Reported”.

*** The data refer to the period from 1/6/1999 to 31/5/2001.

16.5 Methodological information

Greek research studies on social exclusion in general and drug users' social exclusion in particular are quite limited. This is mainly due to the following factors:

- Social exclusion as a concept has quite recently been introduced in Greece, emerging only in the last decade
- Social exclusion is a multi-dimensional phenomenon, which concerns several different groups, and it is associated with various indicators (in many cases obscure and non-quantifiable ones), which make research a quite complicated task.
- Greece accepted a large number of immigrants and repatriates in a short period of time during the last years. This has resulted in a transitional phase on the one hand, and in the need to respond as quickly and adequately as possible to the urgent practical needs of these groups, on the other. This shifted policy-maker and professional interest from research in this field to the development of services and interventions that would meet these people's psychosocial needs.

All the aforementioned factors have resulted in limited research into social exclusion, with only a few studies beginning in 2001. The main focus of these studies has been on social and work rehabilitation of drug users and ex-addicts. With regard to the main studies carried out in the field of drug users' social exclusion, see above **Chapter 16.3 Relation between social exclusion and drug use**.

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Internet Addresses

- **Canadian Centre on Substance Abuse**
  http://www.ccsa.ca (*see chapter 14.1 Concepts and definitions)*

- **Database on Local Initiatives to combat Social Exclusion**
  http://locin.jrc.it/en (*see chapter 16.1 Definitions and concepts)*

- **Elaboration of Concepts for Secondary Prevention of Drug Abuse**
  http://www.drug-prevention.de (*see chapter 10.1 Description of interventions)*

- **Medecins Sans Frontieres- Press Release regarding the results of the Intervention in the Koridallos judicial system**
  http://www.msf.gr/news/020701.html *(see chapter 12.1 Assistance to drug users in prisons).*

- **The "Streetworker" Project**
  http://www.streetworker.org (*see chapter 10.2 Standards and evaluations)*

- **The "Summer Campaign" Project**
  http://www.summercampaign.org (*see chapter 10.1 Description of interventions)*

ANNEX I

DRUG MONITORING SYSTEMS AND SOURCES OF INFORMATION

1. NEW DEVELOPMENTS IN THE GREEK FOCAL POINT IN 2001

1.1 Introduction

In 2001 the Greek REITOX Focal Point continued to carry out its core tasks, as described in previous annual reports. Only new developments are reported in the following section.

1.2 Epidemiology

- In 2001, the Focal Point achieved the enlargement of the *Treatment Demand Indicator* Network, with the co-operation of the two largest treatment bodies in Greece (KETHEA and '18 ANO') and the inclusion of two new therapeutic services and one low-threshold facility: the Network of therapeutic services of Patras, the new substitution unit of OKANA in Piraeus and the Medecins Du Monde – Greek Delegation. KETHEA provided the Focal Point with individual data, while '18 ANO' initiated the collaboration by sending aggregated data for the last quarter of 2001.

  It is estimated that, as soon as '18 ANO' provides individual data, 90% coverage of users seeking treatment will have been achieved, as well as full geographic coverage. Given that young users and users in drug-free programmes are increasingly represented in the figures of Chapter 3, paragraph 3.1, 2001 TDI data are not comparable with those from previous years.

- The Network of the *Infectious Diseases Indicator* expanded (similarly to the TDI Network) with the affiliation of the Network of therapeutic services of Patras and the new substitution unit of OKANA in Piraeus.

- Following KETHEA participation in the TDI Network, the use of two-sample capture-recapture method to estimate *Problematic Drug Use Prevalence* was possible for the first time.

1.3 Demand Reduction

A. A qualitative and quantitative analysis of similarities and differences among the treatment programmes in the EDDRA Database was presented in the EASAR (European Association of Substance Abuse Research) meeting in Sweden.

B. The EMCDDA publication "Evaluation Guidelines of Outreach Work" was translated and will be soon published.

C. The Focal Point in cooperation with the Prevention Department of OKANA created the methodology and the instruments which will be used in the evaluation of Training Agencies and Prevention Centres.

D. Three EuropASI seminars were organized on OKANA's request as well as two meetings of representatives of treatment agencies and programmes, in order to 'successful treatment' and investigate the situation of evaluation in the therapy field.

1.4 Publications and dissemination

In 2001, the Focal Point published the *Annual report of the Focal Point on the drug situation in Greece 2000 and the Greek Bibliography on Drugs for 2000.*

The following editions have been distributed in 2001:

<u>FOCAL POINT – UMHRI publications</u>

- Annual report of the Focal Point on the drug situation in Greece 2000, Athens 2001 (796 copies, Greek version)
- The Greek bibliography on drugs for 2000, Athens 2001 (655 copies, Greek version)
- Annual report on the drug situation submitted to the EMCDDA 2000 of the Greek REITOX Focal Point, Athens 2001 (66 copies)

<u>EMCDDA publications</u>

- Drug net (184 copies, bi-monthly)
- EMCDDA: Annual report on the state of the drugs problem in the European Union, 2001, Lisbon 2001 (968 copies, Greek version)
- Modelling drug use: methods to quantify and understand hidden processes (EMCDDA Scientific Monograph Series No 6), Lisbon 2001 (8 copies)
- Reviewing current practice in drug-substitution treatment in the European Union (EMCDDA Insights Series 3), Lisbon 2000 (23 copies)
- Injecting drug use, risk behaviour and qualitative research in the time of AIDS (EMCDDA Insights Series 4), Lisbon 2001 (8 copies)
- Greek Press releases on the annual report on the drug situation in the European Union 2001 (185 copies, Greek version)
- Information material for the press conference on the drug situation in the European Union 2001 (185 copies, Greek version)

<u>European Council publications</u>

- The 1999 ESPAD Report, Stockholm 2000 (49 copies)
- Press release ESPAD (170 copies)

IREFREA publications

- Women drug abuse in Europe: gender identity, Venice 2000 (41 copies)
- Risk and control in the recreational drug culture. SONAR Project, Majorca 2001 (35 copies)

2. The Electronic Databases of the Greek Focal Point

The four following electronic databases are accessible though the Focal Point's bilingual website: www.ektepn.gr

Bibliography Database	www.ektepn.gr/Bases/research.html
Early Warning System	www.ektepn.gr/ews/
Research on Drugs in Greece	www.ektepn.gr/research/
Inventory of Drug Prevention and Treatment Services in Greece	www.ektepn.gr/Bases/default.htm

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ANNEX IV

LIST OF ABBREVIATIONS

List of Abbreviations

Abbreviation	*Definition*
AA	Alcoholics Anonymous
ABS	Accion por el Bienestar y la Salud (Association for Health and Welfare)
AKMA	Athens Institute of Human Research
CCO	Centre of Creative Occupation
CeIS	Centro Italiano di Solidarieta di Roma
DPA	Drug Prosecution Authorities
EATI	European Addiction Training Institute
EDAS	Human Relations Research Laboratory
EEDE	Association of Advertisement and Communication Companies
EKAB	National Centre of Instant Medical Aid
EKKE	National Centre of Social Research
ESPAD	European School Survey Project on Alcohol and Other Drugs
EuropASI	European Addiction Severity Index
FESAT	Foundation Européenne des Services d' aide Téléphonique Drogues
IEK	Vocational Training Institutes
ICRC	International Certification and Reciprocity Consortium/ Alcohol and other Drugs
IREFREA	European Research Institute of Risk Factors of Adolescents and Young People
KEK	Specialized Vocational Training Centres
KEEL	Hellenic Centre for Infectious Diseases Control
KETEK	Centre of Technological Training

KETHEA	Therapy Centre for Dependent Individuals
MSF	Medecins Sans Frontieres
NA	Narcotics Anonymous
NAP	National Action Plan
NSPH	National School of Public Health
OAED	Employment Organization of Labour Force
OKANA	Organization Against Drugs
SDOE	Greek Financial and Economic Crimes Office
SODN-EMP	Central Anti-drug Coordinating Unit
TACADE	The Advisory Council on Alcohol and Drug Education
TEE	Technological Education Foundations
TEI	Technological Education Institute
TUF	Treatment Unit Form
VPRC	V-Project Research Consulting
WAPR	World Association for Psychosocial Rehabilitation

ANNEX V

LISTS OF PREVENTION AND TREATMENT CENTRES IN GREECE

Table I. Prevention Centres established by OKANA (1996-2002)
(Total Number: 62 Prevention Centres)

Geographical Region		TITLE	Town/City	Inauguration Year
THRACE	1)	Information & Prevention Centre Against Drugs	Xanthi	1997
	2)	Information & Prevention Centre Against Drugs «ELPIDA»	Alexandroupoli	1998
	3)	Prevention Centre Against Substance Use «ORPHEUS»	Komotini	1999
MACEDONIA	1)	Communication & Prevention Centre Against Psychoactive Substances «KEP PIERIAS»	Katerini	1997
	2)	Prevention Centre for Combating Drugs	Kavala	1998
	3)	Drug Dependence Prevention & Health Promotion Centre «PYXIDA»	Thessaloniki	1998
	4)	Prevention Centre for Combating Substances «ELPIDA»	Thessaloniki	1998
	5)	Prevention Centre Against Drugs	Florina	1998
	6)	Prevention Centre Against Substances «ORIZONTES»	Kozani	1998
	7)	Information & Prevention Centre Against Drugs «DIEXODOS»	Kastoria	1999
	8)	Prevention Centre Against Substance Use «PNOI»	Halkidiki	1999
	9-10)	Information and Prevention Centres «SIRIOS» (2 Centres)	Thessaloniki	2000
	11)	Prevention Centre Against Substances «ORIZONTES»	Grevena	2000
	12)	Information and Prevention Centre of the Western Sector of Thessaloniki «Diktio ALFA»	Thessaloniki	2001
	13)	**Prevention Centre Against Substance Use «OASIS»**	**Serres**	**2002**
	14)	**Prevention Centre Against Substance Use «ORAMA»**	**Edessa**	**2002**
	15)	**Prevention Centre Against Substance Use «NIREAS»**	**Kilkis**	**2002**
	16)	**Prevention Centre Against Substance Use**	**Veria**	**2002**
EPIRUS	1)	Counselling Centre for Combating Drugs	Ioannina	1996
	2)	Prevention Centre «KPN ARTAS»	Arta	1997
	3)	Prevention Centre Against Substance Use «ARIADNE»	Igoumenitsa	1999
	4)	Prevention Centre Against Drugs and Other Substances «KE.PRO.NA.P.»	Preveza	2000
THESSALY/ SPORADES	1)	Social Intervention Centre	Trikala	1997
	2)	Prevention Centre Against Dependence	Karditsa	1997
	3)	Drug Prevention Centre «PROTASI ZOIS»	Volos	1998
	4)	Prevention Centre Against Substances «ORPHEUS»	Larissa	1999
CENTRAL GREECE	1)	Drug Prevention Centre	Halkida	1997
	2)	«Protasi Zois - Drug Use Prevention»	Livadia	1998
	3)	Prevention & Information Centre Against Drugs	Lamia	1998
WESTERN GREECE	1)	Municipal Prevention Unit «ODYSSEUS»	Agrinio	1998
	2)	Drug Prevention Centre	Patra	1998
THE PELOPONNESE	1)	Prevention Centre Against Substance Use «INTERVENTIONS»	Amaliada	1998
	2)	Information - Prevention & Sensitisation Centre Against Psychoactive Substances «KEPEPSO»	Kalamata	1999
	3)	Prevention Centre Against Substance Use «DIOLKOS»	Corinth	2000
	4)	Prevention Centre for Combating Drugs «KPNNA»	Tripoli	2001

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Geographical Region		TITLE	Town/City	Inauguration Year
ATTICA	1-4)	Drug Prevention & Health Promotion Centre «ATHENA HEALTH» (4 Centres)	Athens	1998
	5)	Prevention & Information Centre «ODIPORIKO»	Peristeri	1998
	6)	Social Intervention Centre — Joint Municipal Enterprise of Alimos, Argiroupoli, Elliniko & Glyfada	Alimos/ Argiroupoli/ Elliniko/ Glyfada	1998
	7)	Centre for the Prevention of Substance Use & the Promotion of Health	Zografou	2000
	8)	Dependence Prevention & Mental Health Promotion Centre «ARGO»	Holargos/Aghia Paraskevi	2001
	9)	Prevention Centre Against Dependence «STATHMOS»	Kallithea/Tauros/ Moshato	2001
	10)	**Drug Prevention & Health Promotion Centre**	**Egalaio/ Ag. Varvara/ Haidari**	**2002**
	11)	**Drug Prevention Centre «PRONOI»**	**Kifisia**	**2002**
	12)	**Prevention Centre Against Substance Use «DIEXODOS»**	**Aharnes**	**2002**
	13)	**Prevention Centre Against Substance Use**	**Ilioupoli/ Imittos**	**2002**
IONIAN ISLANDS	1)	Municipal Drug & AIDS Prevention Unit «NIKOS MOROS»	Corfu	1997
	2)	Drug Prevention Centre Against Substances «STORGI»	Zakinthos	1998
	3)	Prevention Centre Against Substance Use	Lefkada	2001
	4)	Prevention Centre Against Substances «APOPLOUS»	Kefalonia (& Ithaca)	2001
NORTH-EASTERN AEGEAN	1)	Prevention Centre Against Substance Use	Hios	1998
	2)	Prevention Centre Against Substance Use «PNOI»	Lesvos	2000
	3)	Drug Prevention and Health Promotion Centre «FAROS»	Samos	2000
CYCLADES	1)	Prevention Centre Against Substances	Paros	1998
	2)	Prevention Centre Against Substances	Siros	1998
THE DODECANESE	1)	Drug Prevention Centre «HIPPOCRATES»	Kos	1999
	2)	Centre for the Prevention of Substance Use and for Health Promotion «DIMIOURGIA»	Rhodes	2000
CRETE	1)	Prevention Centre Against Drugs	Rethimnon	1997
	2)	Prevention Centre Against Substances	Hania	1998

Table II. Treatment units, geographical location & coverage
(Total number: 31 Treatment Units)

UNITS	PARENT INSTITUTION	GEOGRAPHICAL LOCATION & COVERAGE
<u>Residential Treatment</u>		
«PAREMVASI» Alternative Therapeutic Community	KETHEA	Rafina (Prefecture of Attica)
«NOSTOS» Therapeutic Community	KETHEA	Piraeus (Aegean Islands, Crete & Southern Greece in general)
«ITHAKI» Therapeutic Community	KETHEA	Sindos, Thessaloniki (Northern Greece)
«EXODOS» Therapeutic Community	KETHEA	Larissa (Central Greece)
Residential Therapeutic Programme - Drug & Alcohol Dependence Unit «18 ANO»	Attica State Psychiatric Hospital	Haidari (Prefecture of Attica)
Drug Dependence Treatment Unit	Thessaloniki State Psychiatric Hospital	Thessaloniki (Northern Greece)
Programme for Dependent Women – Drug & Alcohol Dependence Unit «18 ANO»	Attica State Psychiatric Hospital	Filothei (Prefecture of Attica)
Specialised Programme for Addicted Mothers	KETHEA	Sindos, Thessaloniki (Northern Greece)
<u>Non-Residential Treatment</u>		
Adults		
«DIAVASSI» Open Therapeutic Community	KETHEA	Athens
«DIAVASSI» Evening Therapeutic Programme	KETHEA	Athens
«IASON»	Mental Health Centre	Athens
Programme for Individuals with Dual Diagnosis – Drug & Alcohol Dependence Unit «18 ANO»	Attica State Psychiatric Hospital	Athens
Therapeutic Programme «ATHENA»	Dept. of Psychiatry, Medical School, University of Athens / OKANA	Athens
Drug-Free Therapeutic Programme «GEFIRA»	OKANA	Patras (the Peloponnese)
Programme of Family Therapy & Counselling – Drug & Alcohol Dependence Unit «18 ANO»	Attica State Psychiatric Hospital	Athens
Alternative Therapeutic Programme «ARGO»	Thessaloniki State Psychiatric Hospital	Thessaloniki (Northern Greece)
Open Therapeutic Programme «ARIADNE»	KETHEA	Heraklion (Crete)
Therapeutic Programme for Adults and Their Families	*KETHEA*	*Kavala (Northern Greece)*
Cross- Cultural Therapeutic Programme	*KETHEA*	*Alexandroupolis (Northern Greece)*
Adolescents		
Department for Adolescents and Young Adults – Drug & Alcohol Dependence Unit «18 ANO»	Attica State Psychiatric Hospital	Athens
«STROFI» Open Therapeutic Community	KETHEA	Athens

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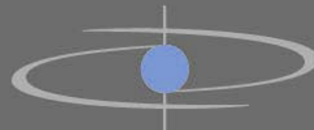
UNITS	PARENT INSTITUTION	GEOGRAPHICAL LOCATION & COVERAGE
«PLEFSI» Early Intervention Community	KETHEA	Athens
Unit for Adolescent Drug Users	*OKANA*	*Athens*
Unit for Adolescent Drug Users	*OKANA*	*Thessaloniki (Northern Greece)*
Substitution Programme, 2nd Unit	OKANA	Thessaloniki
Long-term Substitution Programme	OKANA	Athens
Sorth-term Substitution Programme of Piraeus	OKANA	Piraeus
Low-Threshold Programmes		
Multiple Intervention Centre	KETHEA	Athens
Help Centre	OKANA	Athens



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