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OVERDOSE PREVENTION SERVICES UPON RELEASE FROM PRISON

ESTONIA, LITHUANIA, HUNGARY,
POLAND AND ROMANIA

 **Report**



Eurasian Harm Reduction Network

The Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programmes, groups of people who use drugs and their allies from across 29 countries of Central and Eastern Europe and Central Asia (CEECA) who work to advocate for the universal human rights of people who use drugs in order to protect their lives and health. EHRN's mission it is to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and well-being, while protecting human rights at the individual, community and societal level.

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ABBREVIATIONS

EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EHRN	Eurasian Harm Reduction Network
EU	European Union
IEC	Information, Education & Communication
LGBT	Lesbian, Gay, Bisexual & Transgender
MMT	Methadone Maintenance Treatment
NSP	Needle & Syringe Programme
OST	Opioid Substitution Therapy
THN	Take-Home Naloxone
UNODC	United Nations Office on Drugs and Crime
UK	United Kingdom
WHO	World Health Organization

EXECUTIVE SUMMARY

It is widely acknowledged among European Union policymakers that there is a demand to improve the range and quality of health and social care services for prisoner populations and, most notably, for marginalized and at-risk groups vulnerable to drug-related harms. This includes reducing the high rates of overdose among those who use opioids.

People who inject opioid drugs are at particular risk of overdose following release from prison. However, overdose-related deaths are preventable, and continued efforts are needed to improve continuity of care for prisoners, while systematically implementing recommended approaches that are shown to reduce drug-related deaths. This should comprise opioid substitution treatment and overdose prevention programmes which incorporate naloxone distribution as a routine intervention at the point of release from prison for people who inject drugs.

Progress has been made in some European countries, although significant gaps between prison and community-based services still exist, in terms of both coverage and quality of health services available to prisoners. Over the last decade, prison healthcare has increasingly been recognized as part of public healthcare, and changes have been made as to who takes responsibility for this, alongside specific drug and health strategies or regulations for the prison setting. While European Prison Rules specify that prisoners should be offered a medical examination as close as possible to the time of release, this type of routine 'exit' health examination does not seem to be common in Europe.

There is a strong argument to suggest that any successful approach to improving prison health in the future must recognize the importance of including harm reduction and drug treatment services which are integrated with mental healthcare and other relevant services. This requires a significant scale-up of services within prisons, a functioning throughcare mechanism and substantial efforts to improve this liaison and continuity of treatment.

A number of interventions targeting opioid users have been recommended to reduce the risk of a fatal overdose in the period shortly after release from prison. They include pre-release counselling on overdose risks and prevention, along with training in first aid and overdose management – again optimizing referral to maintain solid links between prisons and community-based services.

Naloxone is provided on release from prison across the Scottish prison system but is not widely reported in other European countries, including those studied in this report (Estonia, Hungary, Lithuania, Poland and Romania). There are some examples of good practice, and these successful schemes should be reflected in the development of new overdose prevention and management programmes across Europe. Thus, the distribution of naloxone among opioid users leaving prison should continue to be promoted and lobbied for until there is more widespread access to life-saving measures such as take-home naloxone.

To summarize, it is essential to close the gap between the prisons and community to ensure an equivalence of evidence-based treatment and care which includes comprehensive cover of overdose prevention and management programmes, as well as opioid substitution treatment.

INTRODUCTION AND TERMS OF REFERENCE

In 2013, a two-year project: 'Quality and Continuity of Care for Drug Users in Prisons' (CARE) funded by the European Commission was launched by the Fachhochschule Frankfurt am Main – University of Applied Sciences. As one of the implementing partners, Eurasian Harm Reduction Network (EHRN) was responsible for the implementation of 'Workstream 3' which focuses on continuity of care and overdose prevention for prisoners upon release from prison.

This report concentrates on the mapping of existing overdose prevention and management programmes for released prisoners and has been produced by EHRN as part of the Workstream 3 activities.

This mapping exercise involves the following five European Union (EU) countries: **Estonia, Hungary, Lithuania, Poland and Romania** and includes:

1. identification of existing programmes and services available upon release from prison;
2. availability of naloxone; and
3. opportunities for the introduction of overdose prevention and/or naloxone programmes.

The second activity within Workstream 3 focused on existing best practices in overdose prevention services upon release from prisons in Denmark, Italy, Scotland and Spain. Results are outlined in the fact sheet 'Overdose prevention services upon release from prison: Best practices from Scotland, Denmark, Italy and Spain'.

Methodology

The following set of data collection methods was agreed between the consultant(s) and EHRN:

1. Consultant(s) **reviewed** (in consultation with EHRN) **EHRN methodologies of previous mapping** exercises and determined whether they could be adapted to this work.
2. **Desk review** of literature and documents: the consultant(s) conducted a desk review of existing publications, documents and other materials that relate to the project topics and deliverables, as outlined above.
3. **The consultant(s)**, with support from EHRN, **consulted with partners of the CARE project** as an information resource, and sought advice from them on relevant documents and organizations at the national level.
4. **Interviews** (by telephone and skype) were carried out with key individuals and organizations in the target countries, to gather information about existing programmes and best practices.
5. **Templates and structures** for mapping deliverables were suggested by the consultant(s), then discussed and approved with EHRN.

DATA LIMITATIONS – A NEED FOR COMMON STANDARDS

The European Monitoring Centre for Drugs & Drug Addiction (EMCDDA) Data Sheet and Situation Summary inform much of the content of the country profiles in this report. Up until 2012, the EMCDDA defined ‘problem drug use’ as injecting drug use (IDU) or long duration/regular use of opiates, cocaine and/or amphetamines. Information was also obtained from various other EMCDDA reports – i.e. Drugs and Prisons in Europe (EMCDDA, 2012a); the Annual Report – The State of the Drugs Problem in Europe (EMCDDA, 2012b), and the Preventing Opioid Overdose Report (EMCDDA, 2012c), as well as the Report on the Current State of Play of the 2003 Council Recommendation on the Prevention and Reduction of Health-Related Harm, associated with Drug Dependence in the EU and Candidate Countries (on behalf of the European Commission) (Busch, Grabenhofer-Eggerth et al., 2013).

Data regarding prison populations were obtained from the SPACE I 2011 Report, which is part of the SPACE project (Aebi and Delgrande, 2013). The first part of the project (SPACE I) provides a global overview on the populations detained in penal institutions across Europe. The second part (SPACE II) concentrates on persons serving non-custodial sanctions and measures (Aebi and Marguet, 2013). Both reports have the goal of ensuring as much as possible the collection, analysis and interpretation of reliable data through a common methodology. In particular, the questionnaires used for collection of the data were designed to allow the maximum comparability among Member States of the Council of Europe.

As stated in the Drugs and Prisons in Europe Report (EMCDDA, 2012), the information available on drug use and responses in prison settings has a number of methodological limitations, relating to both the nature of the subject (i.e. drug use and prison) and the lack of standardization in data collection tools within and between countries.

Data collection and research within prison settings are particularly affected by biases associated with self-selection, self-reporting and clustering. There are threats to validity linked to the sensitivity of the topic (illicit drug use) and the setting of the study (prison). In the prison setting, ethical aspects are especially important when collecting data, in particular with regard to confidentiality, anonymity and data protection issues. The use of relevant anonymized data from individual health records would be another option, but clear policies regarding confidentiality and data protection are needed when such data are collated at a central level.

The Drugs and Prisons in Europe Report (EMCDDA, 2012) has demonstrated that prison healthcare delivery varies between countries, and has also documented the progress that has been achieved in some drugs service provision in prisons with regard to the use of evidence-based approaches. However, a number of serious shortcomings remain, and in many cases the monitoring and evaluation of drug-related health services are rare and do not follow the same standards.

At the European level, there is a lack of harmonization of data collection: methodological differences can be found with regard to types of study, sampling methods, target populations and variables studied. These differences make it very difficult to draw comparisons between countries, and thus limit the possibilities for presenting a complete and comprehensive

European picture of problems related to drug use in prison as well as an objective assessment of the need for and provision of drug-related health responses in prisons, including overdose prevention and management interventions.

Assessing trends in the newer EU Member States and candidate countries is more difficult, as the number of reported deaths is small and improvements in reporting capacity may reduce the comparability of data over time. Despite these difficulties, an increase has been observed in the mortality rate linked to drug-induced deaths in **Estonia** and, to a lesser extent, in the Czech Republic, **Lithuania, Hungary**, Croatia and Turkey.

Under the last EU Drugs Action Plan, which ended in 2012, Member States were called on to endorse indicators to monitor drug use, drug-related health problems and drug services in prison on the basis of a methodological framework.

As a complement to the healthcare-related recommendations of the European Prison Rules, an EU monitoring framework of drug-related prison health would address national drug-related prison health policies, data collection and monitoring infrastructures as well as quality standards and guidelines for drug-related services and interventions in prisons. A corresponding set of indicators on service needs (i.e. drug use, risk behaviours, health consequences) and service provision will facilitate the compilation of objective, reliable and comparable data on drug-related prison healthcare in Europe. This acknowledges the need for common standards.

Additional Constraints of the CARE MAPPING Project Methodology

One of the biggest difficulties encountered is related to translations. Most of the documents that had to be reviewed for the mapping report are in the national languages of the focus countries, and in some cases translation of the national literature was required. No budget had been allocated for this, so a combination of Google Translate alongside support and guidance from national contacts was used.

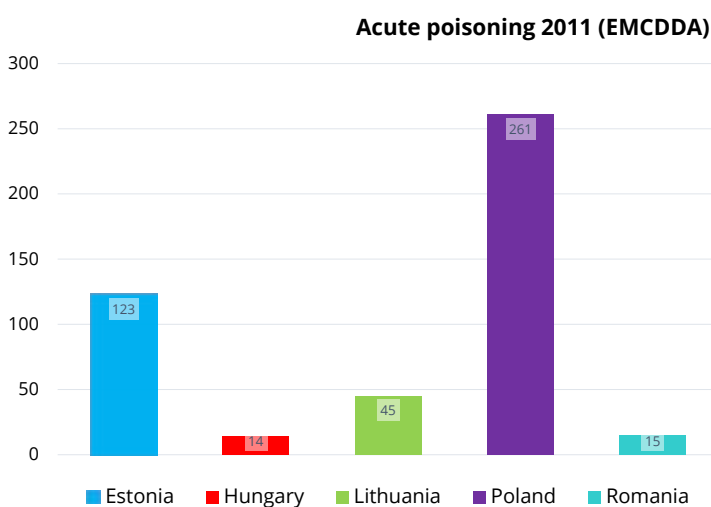
In addition to this, just one person was identified (from each of the countries) to survey and interview. Sometimes, identifying a contact person was an issue and took longer than planned, and arranging interviews in some countries took up to five weeks after initial contact was made. The limited capacity to translate and interpret interviews and resources also compromised data collection – for example, in Poland it almost led to us missing an important harm reduction magazine for harm reduction practitioners and people who use drugs with key articles on overdose prevention.

Some of the information provided by these individuals differs from data obtained elsewhere and other European reports. This has been highlighted within this report where it occurs. Equally, when cross-referencing different reports, there are inconsistencies with or discrepancies between some of the data, which is clearly conflicting.

With available data not being wholly up to date, it is important to acknowledge that the treatment situations may have changed in some countries, and some services may have ceased due to austerity measures; this is the case for both Hungary and Romania.

GENERAL CONTEXT

There are widely acknowledged problems with measuring overdose in a valid and comparable way. A function of the EMCDDA's epidemiological role is to try to reduce these problems by promoting the adoption of current standards in EU Member States. Two main indicators collected by the EMCDDA help reveal the size of the 'overdose' problem: 'acute poisoning' and 'drug-related deaths per million'.



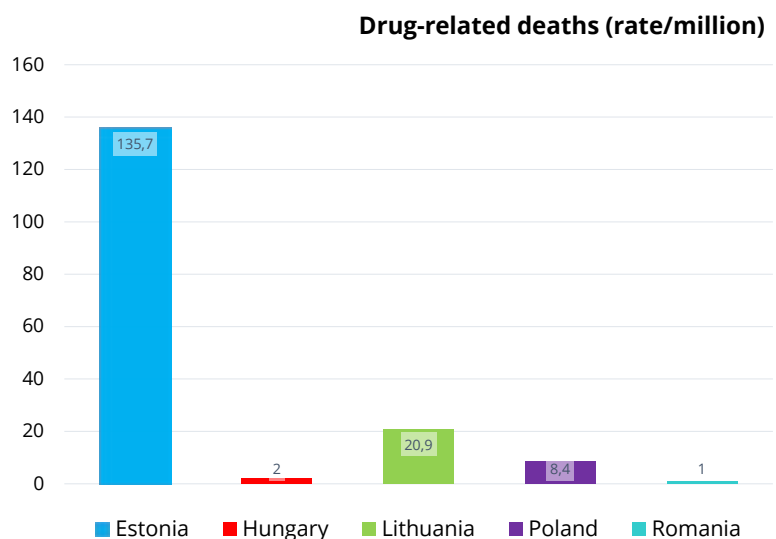
While these should not be regarded as an absolute measure, and some under- or over-reporting may influence the data, the tables compare the absolute number of deaths and the reported rates.

Release from prison is associated with increased mortality from drug overdose. This risk does not appear to have decreased in the last 20 years (WHO, 2010). Upon release, prisoners face a range of physical, practical and psychosocial challenges (Binswanger, Blatchford et al., 2011; Binswanger, Blatchford et al., 2013). For prisoners with a history of opioid use, the

risk of dying from drug overdose greatly increases in the period following release from prison, due to high rates of relapse and lower opioid tolerance (Farrell and Marsden, 2008). This is a critical time for action, when ensuring continuity of care and targeted interventions can both support treatment engagement and save lives.

A review of drug-related deaths occurring within 12 weeks after release (in Europe, Australia and the USA) indicated that 60% of deaths were drug-related (Merrall, Kariminia et al., 2010). The authors concluded that there is an increased risk of drug-related death during the first two weeks after release; that risk remains elevated until, at least, the fourth week.

A study in England and Wales also produced the same results. It reported that, during the first week after release, female prisoners were 69 times more likely to die of drug-related causes, and male prisoners 28 times more likely (Farrell and Marsden, 2008), than the general population of the same age and gender. In addition, an Irish study of people who use drugs who died following release from prison between 1998 and 2005 exposed a significant



risk of death at the time of release. Among the 105 deaths identified, 28% of those occurred within the first week, while a further 18% died during the first month (Lyons, Walsh et al., 2010).

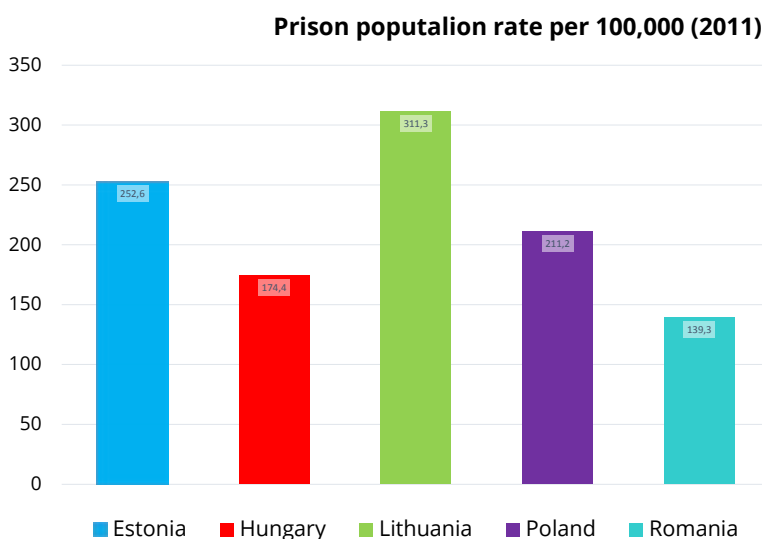
It is, therefore, vital to ensure cooperation between services inside the prison and health/social care services outside, to enable continued support and a seamless transition into community treatment. The term 'throughcare' refers to arrangements for managing the continuity of care before, during and immediately after custody.

In countries where prison and community services operate 'under the same roof', throughcare between the two settings is easier to achieve, as integrated programmes operating inside prison can establish links with the community before the prisoner is released. Within some prisons, pre-release units have been established to facilitate such referrals and allow a smoother transition.

In addition, prison populations are vulnerable in other ways, having complex (often unmet) needs. All evidence points to the fact that, when compared with the general population, prisoners (and particularly people who use drugs) are extremely disadvantaged and marginalized. Many prisoners have limited education and low socio-economic status; poverty, violence and crime are also common features in these people's lives. Similarly, women prisoners (while only accounting for a minority of prisoners) have multifaceted health and social needs. Surveys on prison health cite high levels of physical and mental health problems among prisoners. Indeed, they often suffer from multiple mental health problems and co-morbidities – coupled with chronic, entrenched drug-related problems. Thus, they require comprehensive and specialized services to treat both their drug use and health problems, and liaison with external services is therefore fundamental.

THE EUROPEAN CONTEXT

Over the last decade, Europe has seen an increase in its prison population. On 1 September 2010 there were an estimated 635,000 prisoners in EU Member States (Aebi and Delgrande, 2013; Walmsley, 2013). Most of those in prison are from poor communities and vulnerable social groups (WHO, 2007), with the proportion of prisoners who are immigrants or from minority ethnic backgrounds on the increase (Ronco, Scamdurra et al., 2011). Criminal justice systems and prison policy varies between countries, which affects the number of people in prison who may be at risk of overdose after release. The table below uses 'SPACE I' data to compare rates of imprisonment.



People who use drugs form a large proportion of the overall prison population, with studies showing that a majority of prisoners have used illicit drugs at some point in their life and many have chronic, problematic drug use patterns.

Prisoners differ greatly from the general population in their reported experience of heroin, and experience of illicit drugs, per se, is much more common among prisoners than the general population. Whereas less than 1% of the general population have ever used heroin, lifetime prevalence levels

among European prisoners are much higher. Prisoners sentenced mainly for drug offences constitute approximately 17.5% of the prison population. Similarly, theft constitutes 17.5%, robbery 12.2% and homicide 12.2%. Some of these latter offences may also be drug-related.

In a majority of countries, newly sentenced prisoners are routinely assessed for drug use and drug-related problems. Sixteen countries report procedures other than urine testing to detect illicit substances. The common approach is a clinical assessment undertaken by a medical doctor, psychiatrist or psychologist to diagnose drug dependence and mental health problems. However, in some countries, standardized tests, questionnaires and interviews are used for this purpose.

Prisoners have been recognized as a vulnerable population, and responding to the drug-related healthcare needs of prisoners has been identified as a public health priority by the EU and its Member States. This is evident in the EU Drugs Action Plan 2009–2012, which sets the objective of providing drug users in prison with improved access to healthcare, to prevent and reduce health-related harms associated with drug dependence (European Commission, 2008). Conviction for a drug offence is an important indicator of potential overdose risk that can be used by services to help target interventions to prisoners at highest risk. As the table below shows, the rate of convictions for drug offences varies considerably between countries.

As a general principle, prisoners are entitled to the same level of medical care as people living in the community, and prison health services should be able to provide drug-related treatment and care in conditions comparable to those outside. Pre-release measures are also essential for those who use or have used drugs.

In the majority of European countries, drug treatment in prisons is provided by staff employed by the prison administration. However, it is also common for prison administrations to collaborate with a range of community-based providers, public health services or non-governmental organizations (NGOs) to deliver drug treatment services to those in detention. Collaboration can entail bringing in personnel from public services to work alongside prison staff, or having external providers 'reach in' and work independently inside the prison.

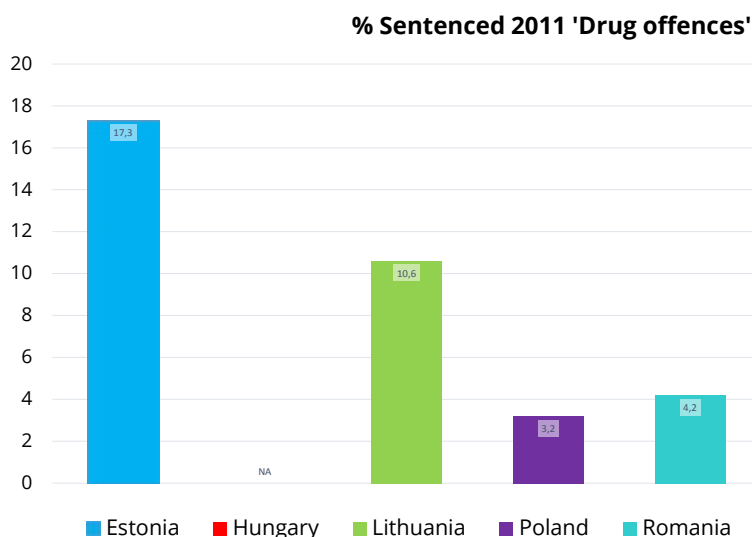
In 2004, in response to concerns about increasing prison populations, the European Parliament adopted a recommendation on the rights of prisoners in the EU which includes the treatment of drug users in prison and the reduction of health-related harm. Growing importance is now being attached to ensuring common minimum prison standards across the EU Member States and the exchange of best practices.

A number of recommendations and resolutions addressing the broader topic of prison health have been adopted by the Council of Europe. Guidance also exists which translates internationally recommended health standards into the prison setting and promotes evidence-based health interventions in prisons, including the WHO Health in Prisons Guide (WHO, 2007) and the United Nations Office on Drugs and Crime's briefing on HIV Prevention, Treatment and Care in Prisons (UNODC, 2012).

A systematic review of the effectiveness of opioid maintenance treatment in prison analysed data from 21 studies, including six experimental studies (Hedrich, Alves et al., 2012). The authors concluded that the benefits of the treatment in prison are similar to benefits in community settings; namely, it presents an opportunity to recruit problem opioid users into treatment, to reduce illicit opioid use and risk behaviours in prison and **potentially minimize overdose risks on release**. Positive outcomes depended on the quality of treatment; the review highlights the importance of establishing effective liaison between prison and community-based programmes, to achieve continuity of treatment (throughcare) and longer-term benefits.

Most procedures, social care and rehabilitation strategies for those leaving prison are directed at the general prisoner population. However, a number of interventions targeting opioid users have been recommended to reduce the risk of a fatal overdose in the period shortly after prison release. They include pre-release counselling on overdose risk and training in first aid and overdose management; optimizing referral to achieve continuity of drug treatment between prison and community; and the distribution of naloxone among opioid users leaving prison. Reliable data about the availability of pre-release measures are scarce. However, naloxone is available on release from prison across Scotland and Wales but is not reported from other countries.

Needle and syringe programmes (NSPs) have existed in prisons in five EU Member States –



Germany, Luxembourg, Portugal, Spain and (previously) **Romania** – although varying levels of provision are reported. Although the introduction of NSPs in prisons is recommended by international organizations (UNODC, 2012), and expert groups in several European countries have considered the measure (e.g. Austria, France, **Hungary**, Norway and the UK), they face strong opposition, since they are perceived as being contradictory to the goal of a drug-free prison. Several countries do provide disinfectants as an alternative, however.

KEY POPULATIONS AND PEOPLE MOST AT RISK OF DRUG-RELATED DEATH

All the populations listed below face secondary stigma and discrimination and, as such, frequently experience difficulties in accessing and engaging with services. In the prison setting, they are all likely to be further marginalized. Thus, they require additional consideration when establishing treatment programmes including take-home naloxone (THN).

Women: Women represent one of the key populations at risk, and on any given day more than 30,000 women are imprisoned in Europe, where they account for about 5% of the prison population. Almost one quarter of them are pre-trial detainees. Between 2000 and 2010, the number of women in prison grew by 27%. Indeed, women prisoners are more likely than their male counterparts to have been incarcerated for drug offences (Borrill, Maden et al., 2003) and to have serious drug-related health problems (Fazel and Baillargeon, 2011). Female prisoners have specific treatment needs that are interlinked with their drug use history and drug-related lifestyles: many have experienced trauma related to (childhood) physical abuse, sexual abuse and domestic/other violence, while also having to deal with mental health comorbidities (WHO, 2009). In addition, the risk of drug-related death is particularly acute among newly released women (Farrell and Marsden, 2008).

Young people: While evidence shows that most overdoses occur in older males, in the Member States that have joined the EU since 2004, drug-related deaths are more likely to occur in younger people. Overall, 11% of overdose deaths reported in Europe occurred among those aged under 25 years. Young people can be said to be at risk of overdose due to their lack of experience and lack of specialist services, as well as an increased availability of potent synthetic opioids such as fentanyl.

Migrants/foreigners: On average, 21% of prisoners are foreigners. Yet, there are very big differences between countries. The lower numbers of foreign prisoners are found in Eastern European countries, where they seldom represent more than 2% of the prison population, and the highest in Western European countries, where they usually represent more than 30%. Around a quarter of foreign prisoners are citizens of EU Member States. Migrants may also be unaware of services available within the community and may have difficulties accessing them.

Roma populations: The Roma people are widely discriminated against throughout Europe. Such marginalization makes them less likely to access services and receive treatment, which is a protective factor, and more likely to be imprisoned.

Homeless people: People who are homeless are at particular risk of overdose and drug-related death. Equally, they are less likely to engage with services, becoming further marginalized, and may come into more contact with law enforcement agencies.

People living with HIV and TB: The numbers of people living with HIV and TB within penal institutions is unknown. Some of the focus countries have high rates of HIV and TB among people who use drugs, particularly those in prisons. These populations may have poorer general health, and some illicit drugs can interact with antiretroviral (ARVs) and TB medications; this may make people more susceptible to overdose due to metabolism issues and health status.

Psychiatric co-morbidity/dual diagnosis: This is the presence of both mental health and substance use problems which particularly affects vulnerable groups including people who use drugs and prisoners. Studies have estimated that for several types of mental health disorders, including psychosis, personality disorders, anxiety and depression, there is substantially higher prevalence of co-morbidity among prisoners than in the general population (Fazel and Baillargeon, 2011). A systematic review of 62 surveys covering about 23,000 prisoners from 12 countries worldwide showed that up to 65% of prisoners have a mental health disorder, which may range from personality disorder (42–65%, mostly antisocial disorder) to major depression (10–12%) to psychotic illnesses (4% including schizophrenia, bipolar and delusional disorders). These problems represent a serious risk factor for suicide and 'careless' drug use.

Lesbian, gay, bisexual and transgender (LGBT): Drug use is widespread within these communities. However, due to additional issues around stigma and discrimination, LGBT people may not access services unless specifically targeted. The number of LGBT people held in the prison system is unknown.

9.1 Background: Strategy, Data Collection, Treatment Demand and Treatment Responses

The Estonian National Strategy for the Prevention of Drug Dependency (NSPDD) 2004–2012 came into force in 2005. The strategy was complemented by triennial action plans for its implementation for the periods 2007–2009 and 2010–2012. Taking a comprehensive approach, its six pillars addressed: prevention; treatment and rehabilitation; harm reduction; drug use in prison; drug supply; and monitoring and evaluation. However, since 1 January 2013 all activities have been incorporated into the National Health Plan (which supersedes the NSPDD), with the Ministry of Social Affairs responsible for its implementation. In February 2014 the Estonian government approved a new White Paper on Drug Policy that provides the overall framework for national activities.

An amendment to the Narcotic Drugs and Psychotropic Substances Act was approved in May 2005. This provided the legal basis to establish a drug treatment database. The database was adopted in 2006, and amendments to relevant legal acts were made. Since 1 January 2008 the National Institute for Health Development (NIHD) has collected data on individuals receiving drug treatment (from its Infectious Diseases and Drug Monitoring Department). The drug treatment demand data for Estonia for 2011 were based on 13 outpatient and inpatient centres (including two prisons).

In 2010 a study to estimate the size and prevalence of the population group 'people who inject drugs' between 2005 and 2009 was conducted in cooperation with the NIHD and the Department of Public Health, University of Tartu. The results indicate a decrease in the number of people who inject drugs by almost 56% during that period (from 14,262 in 2004 to 6266 in 2009).

According to the Estonian Drug Treatment Database, the number of clients who have received methadone has increased over the last few years. OST was provided to 1008 people in 2008; to 1012 in 2009; to 1064 in 2010; to 1076 in 2011; and to 1157 in 2012. However, this contradicts EMCDDA data which cite half as many people – i.e. in 2011, a total of 532 clients entered treatment, of which 163 were new treatment clients, and in 2012, 546 clients entered treatment, of which 125 were new treatment clients.

Some 85.6% were opioid users (mainly fentanyl or 3-methylfentanyl). The figures for all individuals entering treatment show the same distribution: 93.4% were opioid users (mainly fentanyl or 3-methylfentanyl). Most drug treatment clients were receiving OST.

In 2012, some 18.1% of all clients entering treatment were under the age of 25. For new clients entering treatment the proportion of younger clients was considerably higher, with 39.2% under the age of 25. With regards to gender distribution among all clients entering treatment, 77.5% were male and 22.5% female. Similar distribution was noted also among new treatment clients, with 72% male and 28% female.

All those organizations providing drug treatment should report to the database, although not all of them do so. Since the database is not personified (but coded) the data cannot be cross-checked. Data on methadone maintenance treatment (MMT) are collected by NIHD separately as part of the funding procedure, and there are discrepancies between the sources, which ultimately led to the decision to restructure the drug treatment database and make it personified. This is underway and will allow comparison and cross-checking of data.

In Estonia the Ministry of Social Affairs is responsible for the overall administration and coordination of treatment, while the NIHD is responsible for the implementation and funding of drug treatment. Activities and interventions are based on the National Health Plan, which has separate objectives for drug prevention and HIV prevention. OST is budgeted under HIV prevention, and other drug treatment modalities under drug prevention. There are seven service providers offering treatment funded by the State, and only one municipality (Tallinn) funds treatment in addition to the State. It is worth noting that, despite the financial difficulties experienced in 2010–2011, the funding allocated for drug treatment services has remained relatively stable, although this level of funding is still inadequate.

Drug treatment in Estonia is provided through (licensed) psychiatric hospitals and clinics, offering both inpatient and outpatient care. In recent years there has been an increased number of larger hospitals providing drug treatment, and the number of smaller clinics working with people who inject drugs has remained the same. There has also been a growth in the number of non-medical institutions/non-healthcare services engaged in the provision of supportive psychosocial services.

The available treatment methods covered by state or local funding include detoxification, MMT and residential rehabilitation programmes. There are also 12-step programmes; these are classed as non-medical and legally fall under the auspices of social services. Special drug treatment programmes for women and children are also available, although these remain limited, although the prevalence of women using drugs seems to be increasing.

Methadone detoxification has been available in Estonia since 1998, but although MMT was officially introduced in 2001, it has only been used on a significant scale since 2003 as a result of a Global Fund programme which was in operation from 2003 to 2007. While there has also been a modest increase in MMT coverage in recent years, treatment capacities still appear to be unable to meet the growing demand for treatment, which is particularly critical given that the primary opioid of use in Estonia is Fentanyl/3-methylfentanyl, and Estonia has one of the highest overdose rates in Europe.

“ Even experienced users report difficulties in managing dosing of Fentanyl, and the strength varies. Fentanyl is imported, but it is not a pharmaceutical product. ”

Aljona Kurbatova

9.2 Overdose Epidemiology

From the data available, it is not possible to estimate the number of opiate/opioid users at risk of overdose, and clearly OST can be a protective factor against overdose. There is no information available regarding the numbers of non-fatal overdoses (either witnessed or self-reported), and, similarly, we have been unable to obtain data about emergency service attendances for overdose.

Data on drug-related deaths are only available for deaths caused by an acute intoxication of drugs. A total of 123 cases of direct drug-related deaths were recorded in 2011, fewer than in 2009 when 133 cases were recorded, but still exceeding the levels in previous years (i.e. 101 in 2010; 67 in 2008; 68 in 2006; 57 in 2005; and 98 in 2004). Nonetheless, Estonia has one of the highest rates of death by overdose in Europe.

Opioids, 3-methylfentanyl in particular, were present in 95.9% of all deaths with known toxicological results, and in many instances other psychoactive substances were also present. With regard to the distribution of drug-related deaths by age and gender, the majority were men (87.8% of cases), and the deceased were on average 30.1 years old. No data are available regarding the ethnicity of people who died from overdose.

CASES OF DRUG-RELATED DEATH						
2011	2010	2009	2008	2006	2005	2004
123	101	133	67	68	57	98
Drug-related deaths/million: 135.7				Gender: majority male = 87.8%		
				Mean age: 30.1 years		

Number of deaths by drug/alcohol intoxication in prison in 2010: There were eight deaths within penal institutions in Estonia during 2010, **although none of these were reported as being a result of drug overdose.** There was one suicide recorded (which was a woman), and the mortality rate is 23.1 per 10,000 prisoners.

9.3 Drugs, Prisons and the Law

In recent years the general trends with regards to drug production and trafficking in Estonia have not changed significantly. Heroin is mainly smuggled through eastern borders – in very small quantities. In 2011 an increase in the seized amounts of cannabis products, ecstasy, methamphetamine, heroin and fentanyl were noted.

A total of 3821 initial reports on drug-law offences were confirmed in 2011, more than in 2010 but still fewer than the number reported between 2001 and 2009. A vast majority of these are offences related to drug use. From 1 September 2002 the new Penal Code removed repeated use of illicit drugs or possession of a small amount of illicit drugs for personal use from the list of criminal offences, and reclassified them as misdemeanours.

Unauthorized consumption of narcotic drugs (or psychotropic substances) without prescription, or illegal manufacture, acquisition or possession of small quantities of any narcotic drugs (or psychotropic substances) are punishable by a fine (usually from the police) or by detention of up to 30 days. However, proceedings for misdemeanours may be suspended for reasons of expediency.

Any act of illegal possession or dealing drugs not aimed at personal use only is considered a criminal offence – regardless of the type and amount of illicit drug. Activities such as illegal manufacture, acquisition, theft or robbery, storage, transport or delivery of narcotic drugs or psychotropic substances with the intent of trafficking is punishable by 3–12 years' imprisonment, depending on the quantities involved and aggravating circumstances.

A 2004 amendment provides for even stricter penalties with respect to drug-related crimes,

particularly with aggravating circumstances. These crimes are punishable by over 10 years' imprisonment, and up to life imprisonment in some cases.

In 2011, Parliament adopted a legal basis for the implementation of treatment for drug dependency as an alternative punishment for people who use drugs. The treatment can only be applied in cases when a person is sentenced to imprisonment for a period of six months to two years and s/he agrees to undergo the treatment course.

9.4 Prison Population

General Population on 1 January 2011	Total Number of Prisoners (including pre-trial detainees)	Number Sentenced for Drug Offences	Prison Population Rate per 100,000 Inhabitants	Total Capacity of Penal Institutions
1,340,194	3385 Sentenced = 2599	449	252.6	3662
Number of Female Prisoners (including pre-trial detainees)	% Female Prisoners in Total Number of Prisoners	Number of Female Foreign Nationals	% Foreign Females in Total Number of Female Prisoners	Number of Females Aged less than 18
182	5.4	73	40.1	5

34 out of 51 European countries experience high prison population rates (of more than 100 prisoners per 100,000 inhabitants). Estonia ranks seventh in terms of highest population, just behind Lithuania. In 2011, the European median was 122.2 per 100,000; the figure given for Estonia is 252.6 per 100,000.

Source: 2013 Council of Europe Annual Prison Comparison SPACE-1 (2011)

9.5 Prison Systems

Treatment for drug dependence is aimed at both improving the health of prisoners and reducing the often high levels of illicit drug use in prisons.

Generally, treatment options for drug users in European prisons cover a range of modalities, which can broadly be categorized into three types:

1. Low-intensity drug treatment, which covers counselling interventions as well as short-term treatment conducted in an outpatient regime within the prison setting;
2. Medium- or high-intensity drug-free treatment, defined as including inpatient wards for the delivery of drug treatment in a residential setting, such as therapeutic communities in prisons; and

3. Medium- or long-term OST – i.e. methadone or buprenorphine substitution programmes.

A lack of capacity for low-intensity treatment – defined as fully matching prisoners’ demand – was identified in five European countries, one of which was Estonia. Pre-release overdose counselling is provided to a limited extent.

Drug-free inpatient treatment or prison therapeutic communities were seen as available to more than a few but not the majority of prisoners in need in Estonia. The objective of this treatment is to reintegrate people who use drugs.

Methadone detoxification and maintenance has been available in prisons since 2008. It increased significantly during 2010 when the Ministry of Interior agreed to provide MMT in major detention centres, in collaboration with the NIHD and Ministry of Justice, to ensure the continuation of treatment.

9.6 Current Overdose Programmes

Estonia is in the process of establishing a (community) naloxone distribution programme based on the Scottish model. It is centrally funded and is a very new scheme which required several years of planning and negotiation. The programme was first made available in Tallinn in September 2013. Since January 2014 the programme has been available in two locations in Tallinn, also in Jõhvi (in one location), Kohtla-Järve (in two locations) and Narva (in one location). These are the areas most affected by injecting drug use and HIV.

Prior to this, specific responses to preventing drug-related deaths were uncommon in Estonia, although information on overdose risk reduction was available through low-threshold centres and outreach work to a limited extent.

There are also information materials available on prevention of acute drug-related deaths and drug-related emergencies for family and friends, and in 2011 a handbook was produced for prison staff on how to work with people who use drugs, although this does not include information on overdose emergencies and drug-related deaths.

With regard to the new naloxone distribution programme, the target for 2013 was to distribute 500 naloxone kits in the community, although only 113 kits were actually dispensed. It is anticipated that this will increase as more organizations have now been included in the programme, and the stock available for 2014 is 1300 kits. Three doctors trained service users (for approximately one hour) and dispensed naloxone to them, with repeat dispensing being readily available.

Owing to a lack of familiarity with naloxone distribution among stakeholders, the current (Scottish) model was adopted to enable confidence in the programme. The intention is to allow nurses and, ultimately, non-medical staff to be involved in the training and distribution. The potential for peer involvement in the programme is limited at present, although some former drug users work in harm reduction services, but generally there is no community representation.

“ The model is largely based on the Scottish experience, although obviously from a much more resource limited setting. It is similar in that it also receives governmental funding. ”

Aljona Kurbatova

Heroin is not readily available in Estonia, and only in very small quantities; there is very little or no use of it. However, fentanyl is used extensively, this synthetic opioid being associated with very high overdose rates because it is 50 times more potent than heroin. While MMT was officially introduced in 2001, treatment capacity is still unable to meet growing demands in recent years. Clearly, the provision of OST assists in alleviating some risks of overdose, although methadone may also be implicated in drug-related deaths.

The Estonian government started funding NSPs in 2000, within the framework of the National HIV/AIDS Prevention Programme, although NSP provision was extremely limited and almost non-existent. In 2003 this was significantly scaled up as a result of Global Fund funding. In 2004, additional EU Phare Programme funding enabled several new low-threshold centres to be established, and harm reduction measures were specifically mentioned in the National Strategy for the Prevention of Drug Dependency 2004–2012.

Consequently, the coverage and quality of NSPs has improved over the years. All of these initiatives were integrated with the national strategy and implemented by NIHD under the Ministry of Social Affairs. Standards of care for funded NSPs stipulate that counselling on overdose prevention has to be included in NSP interventions. Training has been provided to staff, although these interventions are not structured or systematically assessed. Services report these activities, but they are extremely varied, and it is unclear as to what level of intervention is offered.

More than 2.2 million syringes were distributed in 2012 through a total of 37 syringe exchange sites (14 stationary and 23 outreach programmes). Almost all NSPs use peers to reach risk groups within an outreach framework. This provides further opportunities for naloxone distribution in the future.

9.7 Opportunities for Introducing or Developing Prison Overdose Programmes

While comprehensive treatment is not especially available within prisons in Estonia and thus requires significant scaling up, there may still be opportunities for introducing and developing prison overdose programmes. This is particularly since Estonia is in the process of establishing community-based naloxone distribution programmes based on the Scottish model (which also distributes naloxone to prisoners before release).

Given the protracted negotiations which have occurred over a number of years before getting to this point, it is likely that the community THN programmes will have to be evaluated prior to widespread prison distribution being seriously considered. However, a pilot pre-release training and distribution programme is being planned for the end of 2014, with preparations for it scheduled to start in spring.

Since the primary opioid of use among people who use drugs is fentanyl (a very strong opioid), such prisoners are probably even more at risk of overdose than those using heroin in other countries. Indeed, Estonia has one of the highest overdose rates in Europe, and a significant number of those people who die from overdose in the country will be people who use drugs who have been newly released from prison. Therefore, there is an urgent need for this population to be able to access naloxone as soon as possible after release (but ideally before release).

Treatment providers in Estonia are in a prime position to liaise with the prison authorities to establish robust systems for throughcare and, at the very least, signposting to those service

providers which are quickly able to supply naloxone. Some of the staff employed in such services are former drug users, and other innovative approaches to ensuring newly released prisoners obtain naloxone includes peers meeting them at the prison gate.

It would be relatively simple and not particularly resource-intensive to produce leaflets about overdose prevention and management which could also include details about where naloxone can be obtained. Indeed, the involvement of peers in producing such information, education and communication (IEC) materials could be easily facilitated. These materials could be circulated within all the penal institutions, as well as being made available in health and social care agencies and other organizations which newly released prisoners may access.

10.1 Background: Strategy, Data Collection, Treatment Demand and Treatment Responses

The National Programme on Drug Control and Prevention of Drug Addiction (2010–2016) was endorsed by the Lithuanian Parliament on 10 November 2010. The programme's overarching goal is to reduce supply and demand, as well as the spread of drug dependency, by strengthening individual and public education, health and safety. Several priorities are included in the national programme, addressing: drug demand reduction among children and youth in particular; drug supply reduction; drug use monitoring; information; and coordination and international cooperation.

The first national general population survey on drug use in Lithuania was carried out in 2004, the second one in 2008, and the third in 2012. The 2008 and 2012 surveys were carried out in line with EMCDDA guidelines and conducted among people aged 15–64.

Up until 2012 the EMCDDA defined problem drug use as injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines. The EMCDDA Data Sheet and Situation Summary inform much of the information contained in the country profiles in this report; the in-country national data collection system for treatment demand in Lithuania was developed and introduced in 2012.

Lifetime experience of illegal drugs increased significantly during the 1990s, as shown by the European School Survey Project on Alcohol and Other Drugs (ESPAD) studies conducted in 1995 and 1999. Data from the 2011 ESPAD survey showed lifetime prevalence of heroin at 2%.

In 2010 a capture–recapture study (based on data from the Ministry of Health, Ministry of Justice and Ministry of Interior) was instigated to estimate the number of 'problem drug users' between 2005 and 2007. According to the study, in 2007 there were around 5458 problem drug users (more than 90% of them being opiate/opioid users). This represents a rate of 2.4 per 1000 population aged 15–64. More up-to-date data are not available.

Drug treatment in Lithuania is currently provided by 15 (public) mental health centres (of which there are more than 100) and some private medical institutions which have obtained a mental healthcare licence. Outpatient drug treatment is also provided in specialized 'Centres for Addictive Disorders'. There are five regional (public) Centres for Addictive Disorders, located across the country. These centres offer treatment which includes OST, detoxification, counselling and group psychotherapy.

OST (methadone treatment in this context) was implemented in 1995, and treatment commenced in three cities in 1996. Buprenorphine treatment has been available since late 2002, throughout specialized Centres for Addictive Disorders. OST is regulated by Order No. V-653 (passed in 2007). The Ministry of Health restricts the dispensing of methadone and (now) buprenorphine treatment to treatment centres (not pharmacies).

In 1997 the Vilnius and Klaipeda Centres for Addictive Disorders, in collaboration with the Open Society Foundation in Lithuania, were the first to commence low-threshold programmes for people who inject drugs. A special decree on harm reduction services of the Ministry of Health was adopted in 2006; this provided a background for the expansion of the programmes and also sets the minimum criteria for services. In 2011, nine low-threshold units operated in seven cities in Lithuania. These programmes are funded through local budgets and limited national funding. The number of service points dropped from 11 to 9 between 2010 and 2011 due to financial constraints.

Inpatient treatment, such as detoxification and residential treatment, is delivered by the specialized Centres for Addictive Disorders. There are 19 long-term rehabilitation centres operating across the country. Special treatment programmes are available for children dependent on psychoactive substances, including two long-term rehabilitation communities.

Coordination, implementation and provision of drug treatment are conducted at the local level. The main funding bodies for the different treatment services are the national budget, national health insurance and municipal budgets. Four regional specialized treatment centres were funded from the state budget and one from the Vilnius municipality until the end of 2013. From 1 January 2014, all five regional centres belong to the Ministry of Health and are now funded from the state budget.

In 2011 the healthcare institutions reported approximately 5890 individuals with dependence disorders caused by drugs, of which 251 were new treatment clients. Data indicate that around 72.1% of new treatment clients reported opioids as the primary drug. In 2011 about 26% of new treatment clients were over the age of 35, while 24% were under 25. With regard to gender distribution, 80.9% of new treatment clients were male, and 19.1% were female.

As of 1 January 2012 there were 19 healthcare institutions in 13 municipalities providing OST. In 2011, 798 people received methadone, and in 2012 there were 513 people. Methadone maintenance is continued for clients in police custody; however, it is discontinued if a client is transferred to a prison. OST is not available in Lithuanian prisons.

10.2 Overdose Epidemiology

According to the ECMDDA Data Sheet (2011), 72.1% of all clients receiving treatment and 72.1% of all new clients entering treatment were opioid users.

From the data available, it is not possible to estimate the number of opiate users at risk of overdose, and clearly OST can be a protective factor against overdose. In 2011, Lithuanian healthcare institutions recorded 94 cases of non-fatal overdose/poisoning (53 cases involved opium, and 41 cases heroin). These figures are similar to the number of cases in the previous four years; these data are provided by the State Patients' Fund under the Ministry of Health.

Since 2010, data on drug-related deaths have been submitted by the General Mortality Register of the Institute of Hygiene. Cases of drug-related death are defined as those lethal cases where the direct cause of death recorded on the death certificate is the use of narcotic (or psychotropic) substances.

AGE GROUP	2007	2008	2009	2010	2011	CASES OF DRUG-RELATED DEATH
Under 15	0	0	0	1	0	Source: General Mortality Register of the Institute of Hygiene from 2010.
15–19	3	1	0	0	1	Source: Until 2010, Department of Statistics under the Government of the Republic of Lithuania.
20–24	12	10	6	12	6	
25–29	25	22	24	9	14	Toxicological analyses were reported for 97.8% of cases of drug-related death in 2011. Opioids were the primary substances involved in 54.5% of the cases with known toxicology results, while 40.9% of deaths were due to mixed or unknown substances.
30–34	20	6	16	10	10	
35–39	4	11	10	11	6	
39 and over	8	10	12	8	8	
TOTAL	72	60	68	51	45	Gender: majority male = 82.2% Mean age at death: 33.4 years Drug-related deaths per million: 20.9

Number of deaths by drug/alcohol intoxication in prison in 2010: There were 25 deaths within penal institutions in Lithuania during 2010, **although none of these were reported as being a result of drug overdose.** There were eight deaths recorded as suicide (none of which were women,) and the mortality rate is 28.1 per 10,000 prisoners.

The data from the registry are compliant with drug-related deaths standards, a standard protocol for extracting data on drug-related deaths from registers in EU Member States (which includes acute deaths directly related to drug consumption or overdoses).

In 2011 some 45 direct drug-related deaths were recorded, which indicates a decreasing trend since 2007, when 72 drug-related deaths were registered. With regard to distribution by age and gender, the majority were male (82.2%), and the mean age at death was 33.4 years. No data are available regarding the ethnicity of people who died from overdose.

10.3 Drugs, Prisons and the Law

Lithuania is considered a transit country for the trafficking of illicit substances between Eastern and Western Europe, mainly by land. Heroin is smuggled from Central Asia through the Russian Federation and Belarus. The number of offences related to illicit drug trafficking increased from 959 in 2003 – when harsher laws were adopted – to 2258 in 2011. According to the Lithuanian Ministry of the Interior, more than half of all drug-law offences were linked to the possession and/or dealing of illegal substances. In 2011 around 29% of drug-law offences were related to heroin or cannabis, followed by methamphetamine at 21.6%. In 2011 there were 234 heroin seizures, and the amount of heroin seized remained fairly stable at 11 kg.

A new penal code came into force in May 2003, with further changes to tighten custodial sentences introduced in 2010. Possession of even a small amount of illicit drugs with no intent to distribute is a criminal offence, with a sentence of up to two years' imprisonment. This remains an administrative offence and may be judged to be a misdemeanour, but the penal code takes priority.

Drug traffickers may be sentenced for five to eight years, which increases to 10, then 15 years, depending on the quantities involved and aggravating circumstances (e.g. involvement of minors or an organized group). Quantities of all drugs are set out in a Ministry Regulation that defines small, large and very large quantities. In 2009 an administrative penalty was introduced for offences related to the presence of intoxicated workers at workplaces.

10.4 Prison Population

General Population on 1 January 2011	Total Number of Prisoners (including pre-trial detainees)	Number Sentenced for Drug Offences	Prison Population Rate per 100,000 Inhabitants	Total Capacity of Penal Institutions
3,052,588	9504 Sentenced = 7963	846	311.3	9399
Number of Female Prisoners (including pre-trial detainees)	% Female Prisoners in Total Number of Prisoners	Number of Female Foreign Nationals	% Foreign Females in Total Number of Female Prisoners	Number of Females Aged less than 18
405	4.3	1	0.2	4

34 out of 51 European countries experience high prison population rates (of more than 100 prisoners per 100,000 inhabitants). Lithuania ranks sixth in terms of the highest population, just above Estonia. In 2011 the European median was 122.2 per 100,000; the figure given for Lithuania is 311.3 per 100,000.

Source: 2013 Council of Europe Annual Prison Comparison SPACE-1 2011

10.5 Prison Systems

Reports suggest that interventions aimed at disseminating general information on drug prevention and risks are common in European prisons. These are frequently delivered to prisoners in group settings. Data from Lithuania state that 80% of prisoners accessed IEC materials about drug prevention, treatment and rehabilitation in 2010.

In 2012 Lithuania was one of only four EU countries not to allow prison doctors to prescribe long-term OST. Thus, treatment is disrupted and there is no continuity of care after release, which puts people more at risk of overdose. Drug-free inpatient treatment or therapeutic communities in prisons were considered to be available to all or almost all of those who need it in Lithuania. There are no NSPs in Lithuanian prisons, but they do provide disinfectants as an alternative.

10.6 Current Overdose Programmes

The Report on the Current State of Play of the 2003 Council Recommendation on the Prevention and Reduction of Health-Related Harm, associated with Drug Dependence in the

EU and Candidate Countries states that, with regard to the reduction of drug-related deaths in Lithuania, the dissemination of IEC materials is the predominant response strategy. These information materials are mostly distributed in low-threshold agencies and NSPs, and are also common in specialized drug treatment centres and detoxification services. This report also affirms that risk education and overdose response training is available in nearly all relevant cities or towns, with information about overdose available for police, prison staff, family/friends and nightclub staff.

It is necessary to note, however, that the above information contradicts that offered during interview, whereby it was stated that there are no formal overdose prevention programmes and interventions. Indeed, there are no current plans to introduce naloxone distribution in Lithuania, although comprehensive OST programmes do exist and overdose rates are considered to be very low. This may be due to the supervised consumption of methadone, although it is quite likely to reflect under-reporting as well. There are three mobile outreach and NSPs in Lithuania. IEC materials are also available through these means.

“ There are no plans for naloxone distribution, and OD education is not routine within services. We don't see a lot of overdoses – maybe there are more, but perhaps they are not registered as such. Methadone access is good, and it is well supervised. ”

Dr. Emilis Subata

10.7 Opportunities for Introducing/Developing Prison Overdose Programmes

Since there are no plans to enable community-based naloxone distribution in Lithuania, it is unlikely that prison overdose programmes will be officially introduced and developed at the moment. However, given that there are comprehensive OST programmes in the country, it is important to establish proactive links with prisons to enable effective throughcare arrangements so that community services can initiate 're-tox' as soon as possible, where appropriate.

Such community services may also wish to consider 'in-reach' work within the prison setting (if permitted), whereby education can occur regarding: the risks of overdose; signs and symptoms of overdose; myths in response to overdose; and the correct actions to take in the event of overdose.

The production of information leaflets which are circulated within the prison (and community-based services) offers further opportunities for providing overdose prevention interventions – if these are not currently available – and publication of these IEC materials need not cost a lot and could involve production by peers.

11.1 Background Strategy, Data Collection, Treatment Demand and Treatment Responses

The Act on Counteracting Drug Addiction, adopted on 29 July 2005, is a key legal text regarding drugs in Poland. It sets out, *inter alia*, the priorities to be addressed in the National Anti-Drug Strategy and Action Plan. On 22 March 2011 the fourth National Programme for Counteracting Drug Addiction (2011–2016) was adopted.

Since 2006 the National Programmes have had the status of a legal regulation. Primarily concerned with illicit drugs, their general aim is to reduce drug use and drug-related social and health problems. This is achieved through 110 actions assigned to seven ministries, 22 institutions, provincial pharmaceutical inspectorates and provincial and communal governments across the five pillars of the programme, which is constructed around: (i) prevention; (ii) treatment, rehabilitation, harm reduction and social reintegration; (iii) supply reduction; (iv) international cooperation; and (v) research and monitoring.

Alongside defined time-frames for actions, the National Programme establishes aims that should be reflected in anti-drug programmes at the provincial and communal levels, in line with the 2005 Act on Counteracting Drug Addiction. For the years 2011–2016 a greater emphasis has been placed on improving the quality of drug prevention programmes and the quality of life of those undergoing treatment, harm reduction and social reintegration measures.

The National Bureau for Drug Prevention is responsible for evaluating the programme; mid-term and final evaluations are scheduled for 2014 and 2016. Alongside data collection activities on drug demand and supply reduction issues, the Bureau monitors annual implementation of the Action Plan's measures, with which the relevant ministries, institutions, provinces and communes are required to comply. Analysis of the programme's implementation is presented annually to the Minister of Health, the Council of Ministers and the Parliament.

The third general population survey on drug use was conducted in Poland in 2010, among people aged 15–64. Lifetime prevalence of heroin use is one of the lowest of all drugs, at 2% (similar to Lithuania).

In 2009–2010 Poland was one of the few European countries to conduct an estimation of the population of drug users based on a study of sewage water in the city of Poznan.

An estimate of the number of 'problem drug users' (defined as regular – i.e. daily or almost daily – drug use which causes serious problems, with all illicit drugs included) was undertaken based on 2009 treatment data and using the benchmark method within the framework of a 2010 countrywide population survey. The study estimated that there were between 56,000 and 103,000 problem drug users in Poland (representing 2.1–3.8 per 1000 inhabitants aged 15–64), a decline from a previous calculation in 2005 that estimated 100,000–125,000 problem drug users.

In Poland, information on the number of individuals admitted to residential treatment for drug dependency is collected by the Institute of Psychiatry and Neurology. The national focal point, in the framework of the treatment demand indicator (TDI) implementation pilot project, collected data from 26 treatment facilities.

In 2010 the total number of clients admitted for treatment by the Institute of Psychiatry and Neurology was 14,444, including 6439 new treatment clients. Within the framework of the TDI pilot project, data were submitted by 22 treatment units, indicating a total of 1342 clients admitted to treatment; 364 of these people were new clients. According to the pilot TDI project in 2010, 48.2% were admitted to treatment for opioid use.

Among all treatment clients 40% were under the age of 25. Among new treatment clients around 60% were under 25. With regard to gender, 83.7% of all clients were male, and 16.3% were female. Among new treatment clients 81.6% were male and 18.4% were female. These data reflect all the different drugs used in Poland.

NB: Caution must be exercised when interpreting these data, since they do not cover all of the treatment facilities. It is notable that NBDP is actively working to increase the number of TDI reporting facilities.

Poland has the longest tradition in Central and Eastern Europe of therapeutic communities aimed at rehabilitation and prolonged abstinence. The first centre was established in 1978. The role of these communities has superseded the overriding role given to psychiatric institutions in other Central and Eastern European countries.

The implementation of drug treatment falls under the responsibility of communities and provinces, and it is delivered by a range of providers that have signed contracts with the National Health Fund. Funding for drug treatment is primarily covered by health insurance, while uninsured patients can be treated using funding provided by the National Health Fund. There is also an option to receive private treatment for which the person involved pays an additional fee.

Drug treatment is provided through a network of inpatient and outpatient treatment centres, detoxification wards, day-care centres, hospital drug treatment wards, mid-term and long-term drug rehabilitation facilities, prison drug wards and post-rehabilitation programmes. In areas where there is no specialized drug treatment service, help can be obtained from mental health counselling or alcohol rehabilitation clinics. In line with the public health perspective of drug treatment, the treatment system in Poland has two approaches: 'drug-free' treatment and pharmacological treatment (i.e. OST). Of these two, the 'drug-free' model prevails. There are two settings for treatment: outpatient and residential. Outpatient interventions for users of illicit substances are provided through more than 200 'addiction' counselling centres, mental health counselling centres and day-care centres located in large cities.

Residential treatment is dominated by long-term and mid-term residential treatment that usually lasts no more than one year. Detoxification, which is not classified as a treatment in itself but the first step to treatment, is provided in detoxification wards and usually lasts 8 to 14 days. Outpatient and inpatient drug treatment is mainly delivered by NGOs, followed by public services and private providers. Detoxification is mainly provided by public services, as well as by private clinics and physicians. There are also post-rehabilitation programmes, implemented mainly by NGOs. These are subsidized from the state budgets and with resources from local authorities.

OST is available in Poland, and the first MMT programme was introduced in 1993. Since 2005, such treatment has only been carried out by public healthcare units that have been granted

permission by the governor of the region in collaboration with the Ministry of Health. According to the 2005 drug law, NGOs can also establish and carry out OST programmes, and the first programmes provided by non-public health centres and private facilities were established in 2007. In 2011 there were 32 OST programmes (including seven programmes in prisons) providing services to about 2200 clients, of whom the majority received methadone as the substituting substance, although buprenorphine-based medications are also available.

Harm reduction activities have been carried out in Poland since 1989 and consist mainly of NSPs, prevention-related educational programmes (including programmes for recreational users) and OST programmes. Polish decision-makers generally support the idea of harm reduction, which is also reflected in the Drug Act and in the National Programme for Counteracting Drug Addiction 2011–2016.

Programmes are largely operated by NGOs and based in large cities. They include outreach work at places frequented by people who use drugs and sex workers, homeless shelters, and specialized agencies providing NSPs, including one mobile NSP. In 2011 the National Bureau for Drug Prevention co-financed 12 projects in the field, targeting active 'problem' drug users. Local governments also make important contributions to the funding of around 76 additional programmes.

In 2011 about 195,000 syringes were distributed to 2111 people who inject drugs. Overall, the number of operational NSPs in Poland is declining when compared with 2000. This is attributed to a lack of financing; fluctuating political priorities with regard to drug demand reduction; a change in the priorities in harm reduction to targeting recreational users; a difficulty in retaining staff in NSPs; and a possible decline in the number of people who inject drugs in Poland.

11.2 Overdose Epidemiology

According to the ECMDDA Data Sheet (2011), 48.2% of all clients entering treatment and 14.7% of all new clients entering treatment were opioid users. However, it has been acknowledged that Poland needs to develop its monitoring systems to reflect more precise data; steps are now underway to address this.

From the data available, it is not possible to estimate the number of opiate/opioid users at risk of overdose, and clearly OST can be a protective factor against overdose. There is no information available regarding the numbers of non-fatal overdoses (either witnessed or self-reported), and, similarly, we have been unable to obtain data about emergency service attendances for overdose.

The basic source of information concerning drug-related deaths in Poland is data from the Central Statistical Office (GUS), which is collected and based on ICD-10. Data from the general mortality registers indicate that the number of drug-related deaths seems to be relatively stable. In 2010 the total number of drug-related deaths was 261, and the overall trend has been downward since 2002, when 324 drug-related deaths were registered. Most recently the number of reported cases has fluctuated, between 214 cases in 2007 and 261 in 2010. No data are available regarding the gender or ethnicity of people who died from overdose.

CASES OF DRUG-RELATED DEATH

Source: Central Statistical Office

2010	2007	2002
261	214	324

Drug-related deaths per million: 8.4

Historical data regarding people who inject drugs are very unreliable. There have been recent changes in methodology which is attempting to rectify this issue to reflect a more accurate picture. No data are available for 2011.

Gender: not available

Mean age: not available

Number of deaths by drug/alcohol intoxication in prison in 2010: There were 135 deaths within penal institutions in Poland during 2010, **although data were not available regarding the number of drug-related deaths in prison.** There were 34 deaths registered as being a result of suicide (there are no data about the numbers of women in this number), and no data are available about the remaining 101 deaths. The mortality rate is 16.7 per 10,000 prisoners.

Two thirds (64%) of users accessing harm reduction projects are opiate users, although harm reduction programmes are unable to engage with all people who use drugs – many of whom are hard to reach and remain marginalized. OST is readily available via six harm reduction programmes, of which five are public and one private. There are no waiting lists, but there are some regions in Poland, mainly in the south, where access is more problematic; therefore, drug-related deaths may be more prevalent.

11.3 Drugs, Prisons and the Law

Poland is a transit country for drug trafficking from east to west. Heroin, destined for Germany and the UK, reaches Poland through both the Balkan and Silk routes, although the Polish homemade type of heroin, called 'kompot', is also used in the national market. In 2011 some 51 kg of heroin was seized, which is double the amount seized in 2010. However, it is still below the amounts seized between 2006 and 2009 (155 kg in 2006 and 86 kg in 2009).

The Police Headquarters in Warsaw and the Provincial Police Headquarters report data on drug-law offences. Since 1997 the number of offences related to the illegal production of drugs has been stable, as has the number of reports on the cultivation of poppies. Since 2000 there has been a continuous increase in offences related to encouraging others to take drugs. In line with the change in the drug law in 2000, the number of drug offences has been increasing steadily. In 2006 the number of reported drug offences peaked at 70,202 then fell in the two following years to 57,382 offences in 2008. From 2009 the number increased again, and in 2011 the highest number of drug offences was registered (74,535 offences). In that year, only 1.6% of offences were attributed to heroin use.

Drug dependency in Poland is regulated by the Act of Law of 29/07/05 on Counteracting Drug Addiction. The Act generally has a preventive and treatment-oriented character, and the stipulated sanctions should not be used against problem drug users.

Article 62a, which came into force in 2011, gives the prosecutor and the judge an option to discontinue criminal proceedings against individuals caught in possession of small amounts of narcotic drugs (and psychotropic substances) for private use. Nevertheless, according to the drug law, any drug possession should be penalized, even a small amount for personal use.

In minor cases, the offender can be fined or ordered to serve a sentence involving limitation or deprivation of liberty for up to one year. The court may, however, also decide to oblige a sentenced drug user to undergo treatment. The Polish drug law implements the 'treat rather than punish' principle. Article 72a allows proceedings to be suspended while an offender is in treatment, and Article 73a allows for breaks in serving the sentence while an individual is in treatment. Although treatment in Poland is voluntary, the court can oblige teenagers under the age of 18 to undergo treatment.

Trafficking of drugs is penalized by a fine and imprisonment of between six months and eight years. In the case of a minor offence, the perpetrator may be fined, subjected to limitation of liberty or imprisoned for a maximum of one year. In cases where the amount of drugs is substantial, those concerned may be subjected to a fine and imprisoned for up to 10 years.

11.4 Prison Population

General Population on 1 January 2011	Total Number of Prisoners (including pre-trial detainees)	Number Sentenced for Drug Offences	Prison Population Rate per 100,000 Inhabitants	Total Capacity of Penal Institutions
38,529,866	81,382 Sentenced = 72,692	2308	211.2	86,123
Number of Female Prisoners (including pre-trial detainees)	% Female Prisoners in Total Number of Prisoners	Number of Female Foreign Nationals	% Foreign Females in Total Number of Female Prisoners	Number of Females Aged less than 18
2529	3.1	26	1.0	NA

34 out of 51 European countries experience high prison population rates (of more than 100 prisoners per 100,000 inhabitants). Poland ranks 10th in terms of the highest population. In 2011 the European median was 122.2 per 100,000; the figure given for Poland is 211.2 per 100,000.

Source: 2013 Council of Europe Annual Prison Comparison SPACE-1 2011

11.5 Prison Systems

Generally, treatment options for drug users in European prisons cover a range of modalities, which can broadly be categorized into three types (although not all of them are available in each prison, and quality and coverage will vary):

1. Low-intensity drug treatment, which covers counselling interventions as well as short-term treatment conducted in an outpatient regime within the prison setting;
2. Medium or high-intensity drug-free treatment, defined as including inpatient wards for the delivery of drug treatment in a residential setting, such as therapeutic communities

in prison; and

3. Medium or long-term OST – i.e. methadone or buprenorphine substitution programmes.

In 2011 there were seven OST programmes in prisons in Poland. However, OST is only provided to those who had been receiving it in the community – i.e. it cannot be initiated in prison if there is no record of community-based treatment.

11.6 Current Overdose Programmes

Consideration is being given to establishing a pilot programme within harm reduction services for distribution of naloxone to people who inject drugs. However, the law currently forbids THN. The emergency services do use naloxone as an antidote to overdose situations.

Some form of overdose prevention programmes are being offered by harm reduction projects (15 of these are core funded, while three are locally funded nationally). Telephone help lines, websites and a broad range of educational leaflets are available nationwide in Poland. The provision of IEC via a peer involvement approach is a common response strategy (via low-threshold and outreach programmes). Indeed, with regard to the reduction of drug-related deaths, the dissemination of IEC materials is the predominant response strategy: materials are disseminated at specialized drug treatment services, low-threshold agencies, detoxification services, prisons, entertainment venues etc.

Another common response strategy is risk education/response training, which is delivered in some cities. The provision of overdose information materials is apparently extensive (according to the Report on the Current State of Play of the 2003 Council Recommendation on the Prevention and Reduction of Health-Related Harm, associated with Drug Dependence in the EU and Candidate Countries). The report states that specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for prison staff, nightclub staff and sex workers who use drugs. The provision of overdose response and safer-use training is said to be extensive, while at least three projects have targeted people who use drugs, LGBT and sex workers in recent years. However, specific materials on preventing drug-related deaths and emergencies are not available for family and friends.

OST is available in Poland: the first MMT programme was introduced in 1993. In 2011 some 32 OST programmes (including seven in prisons) provided services to about 2200 clients, the majority of whom received methadone, although buprenorphine-based substitution medications are also available. Some harm reduction projects exist within prisons too, but they primarily offer information on safer drug use etc. but not NSPs.

“ The National Bureau for Drug Prevention funds the production and publication of a three-monthly harm reduction magazine which reports on overdose awareness and prevention. This is targeted at harm reduction workers and people who use drugs. It offers a practical approach to getting important advice and information more widely disseminated. ”

<http://magazynmnb.pl/>

As stated previously, 64% of people who use drugs accessing harm reduction projects are

opiate users, although harm reduction programmes are unable to engage with all people who use drugs – many of whom are hard to reach and remain marginalized. Therefore, additional efforts must be made to proactively engage those people with harm reduction and treatment services. Indeed, in the south of Poland access to OST is more problematic, so a range of overdose interventions should be considered, as drug-related deaths may be more prevalent.

11.7 Opportunities for Introducing/Developing Prison Overdose Programmes

The general aim of the National Programmes is to reduce drug use and drug-related social and health problems. As such, a more comprehensive approach to overdose prevention and management programmes have the opportunity to fit well within this objective.

There are no specific regulations regarding naloxone, but the drug is registered – its use is currently limited to medical personnel. Since attention is being paid to establishing a pilot programme within community harm reduction services for naloxone distribution, if this is deemed a success, it is not unreasonable to expect the programme to be rolled out more widely, including within prisons to prisoners before release, given the extensive evidence that people are more likely to die after release. However, since the law currently forbids THN, this legislative barrier will have to be overcome, and further lobbying may be necessary to secure this change.

There are seven OST programmes in prisons; these programmes offer prospects for the provision of education and other OD prevention interventions – subject to the capacity of staff involved. A training needs analysis could be conducted amongst prison employees whom are involved with people who use drugs, and any necessary training could be implemented, preferably using peers to some degree as well.

12.1 Background Strategy, Data Collection, Treatment Demand and Treatment Responses

Hungary's first national drug strategy, covering 2000–2009, was evaluated in 2009, and a new National Strategy for Tackling the Drugs Problem (2010–2018) was adopted in December 2009. A year later, in December 2010, the new strategy was repealed following the March 2010 elections and subsequent change of government. The drafting and adoption of a new national strategic document for tackling drug problems in Hungary is currently underway but is likely to be more restrictive.

The most recent general population survey on drug use in Hungary was conducted in 2007. It found that lifetime prevalence was less than 1% for heroin. In 2003 the first estimate of hidden 'problem drug use' prevalence was conducted. In 2005 the rate for problem drug use was 3.48 per 1000 inhabitants aged 15–64, corresponding to 24,204 problem drug users (in a range between 19,333 and 29,075).

In 2008–2009 the number of people who inject drugs was estimated to be 5699, with a central rate of 0.8 per 1000 inhabitants aged 15–64. This estimation was based on the records of infectious diseases screening programmes. Capture–recapture data suggest that the population size of opiate users in 2007–2008 was between 2780 and 3480, with a central rate of 0.5 per 1000 inhabitants aged 15–64. Some qualitative studies show a significant decrease in the number of heroin users since 2010, alongside a general shift towards injection of new psychoactive substances.

In 2011 the data collection system for treatment demand was provided by 85 treatment centres. A total of 4783 clients entered treatment, of whom 3222 were new treatment clients. Only 6.8% of all treatment clients and only 2.3% of new treatment clients were opioid users. The majority of all treatment clients enter treatment as an alternative to criminal proceedings, and only about one third enter treatment voluntarily.

The State Secretariat for Health Care is responsible for all aspects of healthcare provided for people who use drugs, while the State Secretariat for Social and Family Affairs is in charge of issues related to social care. Both secretariats are located at the Ministry of Human Resources. Most drug treatment services at regional level are provided by public bodies and, to a lesser extent, by NGOs. Drug treatment services are differentiated on the basis of type of services – namely, medical, health or social services.

Some treatment units provide only health or social care services, while others provide mixed services. A clear separation exists between the financing, definition, regulation and inspection of social and healthcare services. Medical types of drug treatment services are financed by the National Health Insurance Fund, with the exception of about 10% of inpatient and outpatient institutions which are financed by the Church or other organizations. The majority of social services for people who use drugs are financed using a fixed financing model that may be

supplemented with additional resources allocated via tendering.

Treatment is offered at various outpatient and inpatient facilities throughout Hungary. Facilities include rehabilitation and therapy centres, psychiatric departments, therapeutic communities and crisis intervention departments. The need to develop outpatient units specializing in treatment for drug-dependent people was identified, with the first services being established in the 1980s.

In 1994 the first MMT programme was launched in Hungary. By 2010 it was available in 10 institutions in eight towns. In 2011 the total number of clients receiving OST was 639, of whom 510 were on methadone (data from nine treatment centres). Buprenorphine/naloxone combination treatment was introduced in 2007 and accounted for 129 clients in 2011.

In 2007 there were 22 specialized outpatient treatment centres in 15 counties. Inpatient care is offered by psychiatric departments, departments of addiction, crisis intervention departments and NGOs running therapeutic communities. Long-term rehabilitation is mainly provided by NGOs. The services they deliver are only partially medical or healthcare-related, being dominated by social and welfare elements – for example, work therapy and social reintegration. Treatment institutes had a contract with the National Health Insurance Fund for 269 beds in 2009.

A harm reduction approach has been promoted in Hungary for many years. The National Office for Rehabilitation and Social Affairs funds low-threshold services for people who inject drugs through a three-year contract with service providers selected through a tendering procedure. To qualify for funding, the service provider should deliver at least two of the following: psychosocial interventions; information and prevention services; street outreach; or drop-in. NSPs are defined as a complementary service eligible for funds. The complementary funding for low-threshold activities may come from local governments and other tendering procedures of ministries.

A number of low-threshold services provide counselling, referral to long-term treatment, social support and legal assistance. Needles and syringes are available across the country through 22 fixed NSPs (five in Budapest and 17 in other cities), two mobile units (one in Budapest and one in another city) and 13 street outreach programmes (six in Budapest and seven in other cities). Sterile needles and syringes were also available from five vending machines (one in Budapest and four in other cities). However, the vending machine in Budapest was discontinued in mid-2011 due to financial constraints. A total of 24 organizations are involved in delivering NSPs in Hungary. More than 648,000 syringes were distributed in 2011 – an increase from the number distributed in 2010.

12.2 Overdose Epidemiology

According to the ECMDDA Data Sheet (2011), 6.8% of all clients entering treatment and 2.3% of all new clients entering treatment were opioid users.

From the data available, it is not possible to estimate the number of opiate users at risk of overdose, and clearly OST can be a protective factor against overdose. There is no information available regarding the numbers of non-fatal overdoses (either witnessed or self-reported), and, similarly, we have been unable to obtain data about emergency service attendances for overdose.

Since 2009 the data on drug-related direct and indirect deaths have been derived from the mortality module of the National Centre for Addiction reporting system, which contains detailed information on each case, including toxicology results.

In 2011 there were 14 reported drug-related deaths, which is the lowest number in the past 15 years. This compares with 17 in 2010; 31 in 2009; 27 in 2008; and 25 in both 2007 and 2006. Opiates were involved in 71.4% of the reported cases of drug-related death. With regards to distribution by age and gender, all but one case were males, and the mean age at the time of death was 32.1 years.

CASES OF DRUG-RELATED DEATH					
2011	2010	2009	2008	2007	2006
14	17	31	27	25	25
Drug-related deaths per million = 2.0			Gender: all but one case were males Mean age: 32.1 years		

Number of deaths by drug/alcohol intoxication in prison in 2010: There were 51 deaths within penal institutions in Hungary during 2010, **although none of these were attributed to drug overdose.** There were seven deaths as a result of suicide (none of which were women), and the mortality rate is 31.0 per 10,000 prisoners.

12.3 Drugs, Prisons and the Law

Hungary has traditionally been a transit country for heroin trafficked across the Middle East via the Balkan route to Western Europe. However, in 2011 no seizures indicating heroin transit were reported. There has been a declining trend in the quantity of heroin seized since 2005, and in 2011 it was reported that the smallest amount ever had been seized (3 kg).

The drug control sections of the Hungarian Criminal Code were considerably amended in 2003. This amendment was based on the principle that both demand and supply must be reduced, and that there is a need to differentiate approaches towards drug consumers, where prevention, treatment and criminal law must all be taken into account. The Criminal Code was reorganized into sections covering possession, trafficking, minors, addicts, exemptions from punishment and drug precursors. The amendment introduced more detailed provisions (lower maximum sentences if the offender is dependent on drugs, detailed and differentiated regulations on drug-related crimes if people under the age of 18 are involved) and made the treatment option available both for users and those who are dependent. It also removed 'consumption' as a specific offence – although in an indirect way consumption remains punishable, as possessing and acquiring drugs remain offences.

In 2011 some 5989 criminal proceedings concerning the misuse of illicit drugs were registered; the figure has substantially increased when compared to the 5789 cases reported in 2010 and 4828 in 2009. Most of the criminal offences involved cannabis (4741 cases) and were use-related offences (5231 cases).

12.4 Prison Population

General Population on 1 January 2011	Total Number of Prisoners (including pre-trial detainees)	Number Sentenced for Drug Offences	Prison Population Rate per 100,000 Inhabitants	Total Capacity of Penal Institutions
9 985 722	17,413 Sentenced = 12,375	Not Available	174.4	12,604
Number of Female Prisoners (including pre-trial detainees)	% Female Prisoners in Total Number of Prisoners	Number of Female Foreign Nationals	% Foreign Females in Total Number of Female Prisoners	Number of Females Aged less than 18
1,227	7.0	45	3.7	NA

34 out of 51 European countries experience high prison population rates (of more than 100 prisoners per 100,000 inhabitants). Hungary ranks 13th in terms of the highest population. In 2011 the European median was 122.2 per 100,000; the figure given for Hungary is 174.4 per 100,000.

Source: 2013 Council of Europe Annual Prison Comparison SPACE-1 2011

12.5 Prison Systems

A lack of capacity for low intensity-treatment (defined as fully matching prisoners' demand) was identified in five European countries, one of which was Hungary. Theoretically, long-term OST has been allowed in prisons in Hungary since 2001, although it has only been implemented in a few isolated cases since 2005, and it has been reported that there have been no cases since 2009.

NSPs are recommended by international organizations (UNODC, 2012), and expert groups in Hungary have considered the measure, but they face strong opposition, being perceived as contradictory to the goal of a drug-free prison. Indeed, injecting equipment is deemed to be contraband and is regulated at the highest level. Recent studies show a low level of injecting drug use among the prisoner population in Hungary, and this is sometimes cited as the reason why NSPs are not prioritized.

12.6 Current Overdose Programmes

Naloxone is a prescription drug; its use is limited to medical personnel, and its wider distribution is illegal. Ambulance workers are trained in the use of naloxone, and it is standard kit in all ambulances. There are no currently supported plans to introduce a naloxone programme.

Heroin use is decreasing in Hungary, as injecting stimulant use becomes more prevalent; therefore, there are fewer overdoses – most of those occur from methadone intoxication.

OST is technically available in prison but not *de facto*. Regulations assert that if OST is supplied

in the community, then it must be continued during incarceration, although this requires transfer to central prisons. Thus, there are logistical, geographical and systemic obstacles to receiving OST in prisons in Hungary.

Prison officials perceive drugs (in prison) to be a security problem as opposed to a healthcare (or education) issue, and prison systems are evaluated by the success of their security measures. The drugs mainly used in prison are benzodiazepines (i.e. Clonazepam/Rivotril), and the prison authorities try to combat their use by all means. There are 9 or 10 emergency responses to overdose per year across 33 prisons where there may be 18,500 prisoners.

12.7 Opportunities for Introducing/Developing Prison Overdose Programmes

Hungary has some prominent activists within the country who have lobbied for THN, and these advocates need to continue to promote the need for naloxone distribution within the drug-using community.

While OST is technically available in prison, there are barriers to receiving it. The provision of OST offers some opportunities to reduce drug-related deaths, as it is generally a protective factor, and uptake in prisons should be improved, along with collaborative systems for throughcare.

Since the outreach programmes also provide counselling, educational materials and referrals to health services, they too have the chance to, at least, promote overdose prevention through education on: the risks of overdose; signs and symptoms of overdose; myths in response to overdose; and the correct actions to take in the event of overdose.

Once again, the creation of information leaflets targeted at prisoners would be appropriate and may go some way to preventing drug overdose. These organizations are in a prime position to liaise with the prison authorities to establish throughcare and, at the very least, signposting to community-based services to ensure early engagement. Peers could be involved in the production of such leaflets.

13.1 Background: Strategy, Data Collection, Treatment Demand and Treatment Responses

The objectives of Romania's second anti-drug strategy (for 2005–2012), and its action plan for implementation (2005–2008), were to develop an integrated system of institutions and public services to ensure the reduction of drug use, as well as adequate medical, psychological and social assistance for people who use drugs, and streamlined activities for preventing and countering the trafficking and production of illicit drugs and precursors.

The short-term aims of the strategy are to maintain a low level of drug use within the general population, to decrease the number of new drug users and to reduce drug-related (organized) crime. The strategy is comprehensive and focuses on both licit and illicit drugs, covering drug demand reduction, drug supply reduction, international cooperation, information and evaluation, inter-agency coordination and providing the necessary resources. The action plan for 2005–2008 comprised a detailed list of activities with deadlines and responsibilities for implementation. This action plan was evaluated in 2009, and the new action plan for 2009–2012 was adopted on 23 December 2010.

There have been three general population surveys conducted in Romania since 2004. The most recent representative study, with a sample of 5100 people aged 15–64, took place in 2010. The first survey (in 2004) revealed low lifetime prevalence of illicit drug use. However, further studies indicate an increase in the lifetime use of all types of illicit drugs from 1.7% in 2007 to 4.3% in 2010 (including new psychoactive substances).

Since the start of the 1990s, heroin has been the illicit drug associated with the highest level of drug-related problems. Most people using heroin in Romania do so by injecting it. In 2008, 2009, 2010 and 2011 a multiplier method was used to estimate the number of problem drug users in Bucharest. In the first three studies data were based on the number of people accessing NSPs, while the 2011 estimate is based on the number of people who use drugs in treatment. In 2008 the results indicated that there were between 11,855 and 32,600 'problem drug users' (central estimate: 17,387); in 2009 between 16,343 and 19,464 (central estimate: 17,767); in 2010 between 16,619 and 20,386 (central estimate: 18,316); and in 2011 between 14,564 and 26,296 (central estimate: 19,265). The rate was only calculated for those aged 18–49 and is, therefore, not comparable with other countries' rates. However, it suggests that prevalence of 'problem drug use' in Bucharest is one of the lowest among European cities. While the majority are estimated to use heroin, the proportion of those who inject new psychoactive substances has increased and may constitute around a third of all 'problem drug users'.

In Romania OST is provided by Ministry of Public Health medical units, and the National Anti-drug Agency offers integrated care services through its 'Drug Prevention, Evaluation and Counselling Centres'. OST is also provided in prison treatment settings and in specialized treatment centres, which include two NGOs: Arena and Titan Centres (ARAS) and ANIT, as well as the PsyMotion and D & C Clinics, both of which are private facilities.

In 2011 some 78 of 94 treatment units provided data on treatment demand. There were 1853 clients entering treatment, of which 1146 were new treatment clients. Opioids were reported as the primary drug by 35% of all treatment clients. Among new treatment clients, 29.6% reported opioids (mainly heroin) as their main drug of use. About a quarter of all treatment clients reported poly-drug use. More than half of all treatment clients reported that they currently injected a primary substance, while the injecting rate of a primary substance among new treatment clients was 41.8%.

In 2011 some 36% of all clients entering treatment and around 46% of new treatment clients were under 25. With regard to gender distribution, among all clients entering treatment 75.9% were male and 24.1% were female. A similar distribution was reported among new treatment clients, with 76.4% male and 23.6% female.

The healthcare of people who use drugs is coordinated and managed by the General Healthcare and Programme Department within the Ministry of Public Health, provided through national health programmes with therapeutic and social reintegration components. Since 2005 the National Anti-drug Agency has coordinated activities regarding drugs at both national and local levels.

As stated previously, drug treatment is predominately delivered in public medical units, which are financed from the public budget and are operated under the coordination of the Ministry of Public Health and, starting in 2007, by the 47 Drug Prevention, Evaluation and Counselling Centres and five Addiction Integrated Care Centres under the coordination of the National Anti-drug Agency.

A number of NGOs also provide drug treatment, including counselling and OST. Drug treatment is generally funded by the national health programmes through the specific sub-programme for drug treatment.

The drug treatment system in Romania has three levels of assistance and care:

1. The main access path to integrated care for people who use drugs is treatment provided at primary medical assistance units and emergency rooms, together with general social services. It is delivered by public, private and non-governmental organizations.
2. Integrated care services are provided at referral centres, operated exclusively by public treatment services, which provide psychiatric units for primary or specialized care or for mental health treatment.
3. Highly specialized care involves inpatient detoxification treatment and residential therapeutic communities.

Aftercare services are poorly developed, with just one day-care centre in the public network (near Bucharest). This is the Teen Challenge Centre, a faith-based organization which provides daily activities and life skills. There are several foundations and NGOs offering assistance in other Romanian cities. Treatment centres are financed through a special budget line in the public authority budget.

Methadone was introduced in 1998, buprenorphine in 2007, and the combination buprenorphine/naloxone in 2008. The legal procedures for entering OST were revised in 2005 to simplify access to treatment. Coverage of OST is estimated to be low, with 742 clients in treatment in 2011.

NSPs are implemented in Bucharest, which is considered to have the most serious problems related to injecting drug use, and also in two other counties, while the demand for such services outside the capital remains low. In 1999 the first outreach service targeting sex workers was founded. This service had contact with people who inject drugs and started providing sterile injecting equipment to them. After this, the first dedicated NSP was established in 2000 by ALIAT within their drop-in centre.

In 2004 the Global Fund Round 4 allowed NGOs to expand NSP provision. In 2007 UNODC added to this funding, although UNODC technical support programmes ended in 2010–2011. To address the pending cessation of such service provision, the National Anti-drug Agency took the lead on supplying sterile injecting equipment through the National Programme of Medical, Psychological and Social Care of Drug Users 2009–2012. In addition, a decision on further project-based support to NGOs involved in harm reduction service provision was taken.

In 2011, resources from the structural funds were also allocated to close the funding gap of the services, although NSPs reached a peak in 2009 and have been scaled back since 2010. Indeed, of the six NGOs providing NSPs in 2010, there are only two remaining (ARAS and Carusel, a new NGO operating a drop-in centre in one of the most deprived areas of Bucharest). In January 2013 the National Anti-drug Agency procured 800,000 needles and syringes, distributing them to ARAS and Carusel as a means of continuing NSPs. ARAS is financed by European Structural Funds, which ended last year, potentially leaving a further gap with grave implications for people who use drugs, many of whom are living with HIV.

In 2011, NGOs provided services to almost 9000 people who use drugs and distributed around 901,000 syringes, the same level as in 2010. The outreach programmes also provide counselling, education materials, hepatitis vaccinations and referrals to health services.

13.2 Overdose Epidemiology

According to the ECMDDA Data Sheet (2011), 35% of all clients entering treatment and 29.6% of all new clients entering treatment were opioid users.

From the data available, it is not possible to estimate the number of opiate users at risk of overdose, and clearly OST can be a protective factor against overdose, although Romania reported nine overdose cases involving methadone in 2011. There is no information available regarding the numbers of non-fatal overdoses (either witnessed or self-reported), and, similarly, we have been unable to obtain data about emergency service attendances for overdose.

In 2011 data on drug-related deaths in Romania were reported by the Forensic Medicine Network, which is comprised of 53 forensic medicine units nationwide, although the majority of cases of drug-related death still originate from the National Legal Medicine Institute in Bucharest. In 2011 there were 15 drug-related deaths reported. There were 34 drug-related deaths in 2010; 32 in 2009; 33 in 2008; 32 in 2007; and 21 in 2006.

The sharp decline in the number of drug-related deaths reported in 2011 is, in part, explained by an increase in the use of new psychoactive substances, with the use of heroin replaced by the use of these substances. However, NGOs dispute these data and the low figures, believing that overdose and drug-related deaths have been under-reported due to bureaucracy in medical settings, with the cause of death attributed to respiratory failure, and no further investigation.

With regard to drug-related deaths by gender and age, the majority of cases (80.0%) were men,

and the mean age at death was 30.4 years.

Around 73.3% of drug-related deaths in 2011 were caused by opiates, and in nine cases the presence of methadone was detected.

CASES OF DRUG-RELATED DEATH – Source: Forensic Medicine Network and National Legal Medicine Institute					
2011	2010	2009	2008	2007	2006
15	34	32	33	32	21
Drug-related deaths per million: 1.0 NB: Under-reporting suspected			Gender: majority male = 80% Mean age at death: 30.4 Years		

Number of deaths by drug/alcohol intoxication in prison in 2010: There were 77 deaths within penal institutions in Romania during 2010, **although none of these were attributed to drug overdose.** Seven deaths were registered as being a result of suicide (none of which were women). The mortality rate is 27.3 per 10,000 prisoners.

13.3 Drugs, Prisons and the Law

Due to its geographical location, Romania is part of the Balkan route for heroin smuggling. Available data indicate that heroin originates in Afghanistan and is trafficked through Romania towards Western Europe, as well as entering the country through Ukraine and the Russian Federation.

In 2011 a dramatic decline was reported in the quantity of heroin seized. It dropped to a record low of 13 kg, compared to the period between 2000 and 2010 when the amount seized fluctuated between 20 kg (in 2002) and 385 kg (in 2008). In 2011 some 853 people were convicted under the national drug legislation (718 in 2010), the majority (66.7%) of which concerned supply-related offences.

In Romania drug consumption per se is not an offence, but drug possession is. Following a change in 2004, penalties for possession are now separated by type of drug – ‘risk’ or ‘high risk’ – and there are new separate concepts of ‘user’ and ‘addict’, which follow concepts of diagnostic standards for mental health disorders.

The jury can impose a sentence of between six months and two years in prison, or a fine in cases of possession for personal use of ‘risk’ drugs, or up to five years’ imprisonment for ‘high-risk’ drugs. When someone is convicted of any of these offences, on being sentenced s/he can choose an integrated assistance programme instead of prison; the person’s consent is a prerequisite for inclusion in such a programme.

The provisions for an alternative to custody (for the possession of drugs for personal use) are stipulated in the new Penal Code, adopted in July 2009. However, they have not yet been applied because the new Criminal Procedure Code has yet to be adopted.

From 2004, assets seized from drug offences were used to finance projects that target prevention or tackle drug use or trafficking.

13.4 Prison Population

General Population on 1 January 2011	Total Number of Prisoners (including pre-trial detainees)	Number Sentenced for Drug Offences	Prison Population Rate per 100,000 Inhabitants	Total Capacity of Penal Institutions
21,413,815	29,823 Sentenced = 26,278	1100	139.3	33,402
Number of Female Prisoners (including pre-trial detainees)	% Female Prisoners in Total Number of Prisoners	Number of Female Foreign Nationals	% Foreign Females in Total Number of Female Prisoners	Number of Females Aged less than 18
1356	4.5	11	0.8	24

34 out of 51 European countries experience high prison population rates (of more than 100 prisoners per 100,000 inhabitants). Romania ranks 23rd in terms of the highest population. In 2011 the European median was 122.2 per 100,000; the figure given for Romania is 139.3 per 100,000.

Source: 2013 Council of Europe Annual Prison Comparison SPACE-1 2011

13.5 Prison Systems

A lack of capacity for low intensity-treatment (defined as fully matching prisoners' demand) was identified in five European countries, one of which was Romania. Drug-free inpatient treatment or therapeutic communities in prison were restricted to just a few prisoners in Romania.

NSPs existed in prisons in five EU Member States – Germany, Luxembourg, Portugal, Spain and (previously) Romania, although varying levels of provision are reported. Access to the programme in Romania is described as very low, with just 83 prisoners participating in the programmes established in 10 prisons, and it is important to note that these prison NSPs were discontinued in 2013 due to a reported lack of demand from prisoners, with expiry of the needles and syringes. Nonetheless, HIV infection continues to rise among the prison population and remains a serious concern.

13.6 Current Overdose Programmes

There is some OST provision in Romania, with capacity to treat 1000 people who use drugs; there are an estimated 19,000– 20,000 people who inject drugs in Romania, but this includes people who inject new psychoactive substance. Data from 2012 indicate a 50% decrease in the number of people who inject drugs. Coverage of OST is estimated to be low, with 742 clients reported to be in treatment in 2011.

People who use drugs are poorly represented nationally (with limited peer involvement activities), while financial pressures reinforce stigma and the acceptability of rationing services to those who are considered 'undeserving' and 'undesirable' communities. Indeed, discrimination prevails within services and between peers, as people living with HIV have requested separate

(segregated) services for people living with HIV who also use drugs.

Following the survey and interviews, it was reported that there are no formal or strategic responses to overdose prevention and management. Indeed, we are unaware of any educational programmes or specific policies in relation to overdose prevention, and it is unclear as to what is occurring around overdose prevention.

However, this conflicts with information obtained from the Current State of Play of the 2003 Council Recommendation on the Prevention and Reduction of Health-Related Harm, associated with Drug Dependence in the EU and Candidate Countries, which states that THN is available, with doses being distributed to people who use drugs, peers and relatives who have completed first aid training and training on overdose management. This is referenced on the EMCDDA website's 'Harm Reduction Overview' section for Romania, which states that availability of overdose information materials, availability of individual overdose risk assessment (provided by trained drugs or healthcare workers) and availability of overdose response training is rare, but, contrary to this, naloxone is available.

“ There is no direct information from services, but I am unaware of any overdose educational programmes or specific policy on overdose prevention. There are very limited development opportunities in services. ”

Valentin Simionov

We have been unable to find any evidence to support this – i.e. THN being distributed, along with the accompanying training. Naloxone is available to medical/ambulance personnel and is used accordingly.

It has been reported that, in the course of outreach work, NSP provision or at drop-in centres, some of the workers can provide overdose education if requested by the client. This suggests a somewhat 'ad hoc' approach to dealing with overdose.

NSPs are available, but these are dwindling despite some steps to ensure continued provision (see the first section: Background: Strategy, Data Collection, Treatment Demand and Treatment Responses).

13.7 Opportunities for Introducing/Developing Prison Overdose Programmes

As stated previously, the provision of OST offers some opportunities to reduce drug-related deaths. Since the outreach programmes also provide counselling, IEC materials and referrals to health services, they too have the chance to, at least, promote overdose prevention through IEC on: the risks of overdose; signs and symptoms of overdose; myths in response to overdose; and the correct (first aid) actions to take in the event of overdose. Peers could be involved in the production of IEC materials.

Prison in-reach, training of prison staff and more effective systems for throughcare could increase the opportunities for developing some interventions in relation to overdose prevention and management. This includes pre-release counselling on overdose risks and prevention, along with training in first aid and overdose management, and a routine medical examination on exit. While European Prison Rules specify that prisoners should be offered a

examination as close as possible to the time of release, such a routine 'exit' health examination does not seem to be common in Europe but should be enforced as a requirement.

The distribution of naloxone among opioid users leaving prison is unlikely at the moment, but it should continue to be promoted and lobbied for as a fundamental measure to reduce drug-related deaths.

ROLES OF STAFF AND RECOMMENDATIONS

Each member of staff, at each level, plays a crucial role and is an intrinsic part of the process of a successful roll-out of comprehensive overdose prevention and management programmes, which should ideally include naloxone distribution.

Reviews have highlighted that integrated services and effective throughcare are essential to preserving prisoner health and well-being. This can be attained by establishing good links (and liaison procedures) between prisons and community-based services, to optimize referral and access. It is important that people who use drugs are quickly re-engaged with local health and social care providers, as required.

A number of interventions targeting opioid users have been recommended to reduce the risk of a fatal overdose in the period shortly following release from prison. They include naloxone distribution and/or pre-release counselling on overdose risks and prevention, along with training in first aid and overdose management.

Drug services should investigate the potential for 'in-reach' work within prisons so that this training can be offered. Peer-to-peer delivery would be the ultimate goal, although there may be challenges to this, and it may not be immediately feasible. Other innovative approaches to naloxone distribution include meeting released prisoners at the prison gate.

If none of this is practicable, at the very least overdose management leaflets and information materials should be made available in prisons. If naloxone is available in the community, such a leaflet should detail where it can be obtained. This is a relatively simple task which does not have to be resource intensive and can be locally focused. A group of peers could be asked to develop and draft an appropriate leaflet. It would just be a matter of printing costs and ensuring circulation of the leaflet. Alternatively, a national leaflet could be produced in each country as part of a broader strategy and in consultation with people who use drugs.

To summarize, it is essential to close the gap between prisons and the community to ensure an equivalence of evidence-based treatment and care and longer-term public health benefits.

- **National stakeholders:** Legislation may have to be changed in some countries, as this currently presents an obstacle. The willingness to work with people at all levels and involve peers – i.e. people who use drugs – in the planning, implementation and evaluation of services is crucial. Advocacy work to ensure that this can occur is also vital.
- **Prison staff:** To play a positive role in the distribution of naloxone, prison employees require education and training. They have to be able to appreciate the needs of people who use drugs, the serious risk of overdose on release and the necessity for widespread distribution of naloxone. It would be better to train those staff who have an active interest in this area and who are able to establish a good rapport with prisoners.
- **Healthcare professionals:** Those in prisons who may, in the first instance, be responsible for naloxone distribution (as per the Scottish model) also require education and training. Again, they should value this role and be highly motivated to make a difference. This will

ensure both consistency of delivery and development of services.

- **Drugs services/workers:** They can improve liaison between community-based services and prisons, taking a proactive approach to improving throughcare by ensuring that newly released prisoners are swiftly linked with external, community-based services which can provide naloxone, if available, and in the absence of a prison naloxone distribution programme.
- **People who use drugs:** The communities who are affected themselves, potentially, have most knowledge and can increase access to vulnerable populations who are otherwise hard to reach. As such, their involvement in planning, implementation and evaluation must actively be sought (as per the Danish model).

Data Request Template

DATA REQUEST

To develop and share good practice, we are gathering reports and information on national and local opioid overdose prevention programmes for people who inject drugs (PWID) and how they are delivered in both community and prisons based settings. This information will be gathered through:

- Relevant reports and documentation, which we will be reviewing as part of the project
- A brief questionnaire to establish base-line information to inform an interview
- An interview to further explore your local and national overdose prevention programmes

The data we are gathering will focus on:

- a) Naloxone distribution programmes
- b) other programmes for preventing or responding to overdose e.g. overdose management training, inter-agency work with emergency services (e.g. police/ ambulance) who are part of responses to overdose.

The main purpose of this email is to identify documents that we will be reviewing as part of the project. Please complete questions 1 and 2 and provide supporting documentation:

- 1. For your country are there any research reports/policy documents/national strategies/local strategies relating to Naloxone programmes that document: how they operate; their effectiveness; the involvement of people who use drugs?**

a) YES NO (*delete as appropriate*)

b) If yes, please list them below and provide references, web-links or, preferably, attach PDF copies to your email reply as fully as you can and for as many as documents as possible:

- i)
- ii)
- iii)
- iv)
- v)
- vi)

Continue at back of document if necessary.

2. For your country are there any research reports/policy documents/national strategies/local strategies relating to other overdose prevention and management programmes that document: how they operate; their effectiveness; the involvement of people who use drugs?

a) YES NO (*delete as appropriate*)

b) If yes, please list them below and provide references, web-links or, preferably, attach PDF copies to your email reply as fully as you can and for as many as documents as possible:

- i)
- ii)
- iii)
- iv)
- v)
- vi)

Continue at back of document if necessary.

YOUR COUNTRY'S NALOXONE PROGRAMMES

The following additional questions (3-15) are designed to provide initial data to help orientate us to the situation in your country and will form the basis for a follow-up telephone interview. One of the project consultants will be contacting you to arrange an interview.

3. Is Naloxone available through community based services in your country?

Use an 'X' to mark the ONE response that best describes your national situation.

- i) Nationally _____
- ii) In most areas _____
- iii) In a few areas _____
- iv) In one city _____
- v) Not at all _____

4. From what type of outlets/channels?

Use an 'X' to mark ALL response that apply for your country.

- i) NSP _____
- ii) Outreach _____
- iii) Injecting peers _____
- iv) Drug treatment agencies _____
- v) Family/carers _____
- vi) Others (please specify) _____

5. What proportion of people who inject drugs (PWID) have been reached by Naloxone programmes and given Naloxone? (Please provide your best *estimate* if accurate figures are unavailable)

_____ %

6. Do Naloxone programmes exist for recently released prisoners?

YES NO (delete as appropriate)

7. Does the law enable Naloxone distribution to PWID in your country?

YES NO (delete as appropriate)

8. Does your medicines control system enable Naloxone distribution to PWID in your country?

YES NO (delete as appropriate)

9. Does public health or other funding support Naloxone distribution to PWID in your country?

YES NO (delete as appropriate)

OTHER OPIOID OVERDOSE PREVENTION & MANAGEMENT PROGRAMMES IN YOUR COUNTRY

10. Are other opioid overdose prevention and management programmes available through community based services in your country?

Use an 'X' to mark the ONE response that best describes your national situation.

- i) Nationally _____
- ii) In most areas _____
- iii) In a few areas _____
- iv) In one city _____
- v) Not at all _____

11. From what type of services/outlets/channels?

Use an 'X' to mark ALL response that apply for your country.

- i) NSP _____
- ii) Outreach _____
- iii) Injecting peers _____
- iv) Drug treatment agencies _____
- v) Family/carers _____
- vi) Others (please specify) _____

12. Nationally, what proportion of people who inject drugs (PWID) have been reached by these programmes? (Please provide your best estimate if accurate figures are unavailable).

_____ %

13. Do other opioid overdose prevention and management programmes exist for recently released prisoners?

YES NO (delete as appropriate)

14. Does the law enable other opioid overdose prevention and management programmes to PWID in your country?

YES NO (delete as appropriate)

15. Does public health or other funding support other opioid overdose prevention and management programmes to PWID in your country?

YES NO (delete as appropriate)

<u>YOUR DETAILS</u>	
Name	
Job title/role	
Organisation	
Address	
Telephone	
Skype	
Email	

Many thanks.

***Please email this questionnaire with any supporting documents from questions 1 & 2 to:
neil@dadden.demon.co.uk***

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Overdose prevention interventions in the countries of the European Union *Data request template*

Dear colleagues,

Eurasian Harm Reduction Network (EHRN, www.harm-reduction.org) has started EC funded projects (CARE and EuroHRN II) aimed at mapping of overdose prevention responses, with the specific focus on overdose prevention for released prisoners and community-based naloxone distribution. The examples of good practices on overdose prevention will be searched for in Scotland, Italy, Spain, France and Denmark. The existing responses will be mapped in Estonia, Lithuania, Poland, Hungary and Romania and recommendations for improvement will be made for these countries based on good practices reviewed.

Based on the data collected the analytical report and fact sheets will be prepared forming a basis for advocacy and capacity building activities within the projects.

EHRN is working collaboratively with consultants *Neil Hunt* and *Danny Morris* to implement the projects. The questionnaire below serves to establish contacts in the project target countries for further data collection by interviews and identification of relevant documents.

I would like to kindly ask you to assist us in data collecting by filling in and sending back the short questionnaire (pages 2-4 of this document) to neil@dadden.demon.co.uk by **17th October**. We would also be grateful for any information on organizations and/or people in your country who could provide information on overdose prevention programs. Let us know if you would be more comfortable talking on the phone or Skype. We are happy to use either.

We will be conducting interviews during the period 7th – 25th October and the consultants will be contacting you to arrange these.

For more information and questions please contact:
Danny Morris, dannymorris@mac.com, +44 7792 949370
Neil Hunt, neil@dadden.demon.co.uk, +44 7780 665830

We would appreciate very much your support in collecting the data!

Marija Subataite
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