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**ABBREVIATIONS**

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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>EFSI</td>
<td>Estonian Forensic Science Institute</td>
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<td>EU</td>
<td>European Union</td>
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<td>EMCDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<td>ESF</td>
<td>European Social Fund</td>
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<td>EEA</td>
<td>European Economic Area</td>
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<td>ESPAD</td>
<td>European School Survey Project on Alcohol and Other Drugs</td>
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<td>MER</td>
<td>Ministry of Education and Research</td>
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<td>MOJ</td>
<td>Ministry of Justice</td>
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<td>LM</td>
<td>local municipalities</td>
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<td>TCB</td>
<td>Tax and Customs Board</td>
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<td>NDPS</td>
<td>National Drug Prevention Strategy until 2012</td>
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<td>NFM</td>
<td>Norwegian Financial Mechanism</td>
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<td>PSUSSA</td>
<td>Basic Schools and Upper Secondary Schools Act</td>
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<td>PBGB</td>
<td>Police and Border Guard Board</td>
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<tr>
<td>SB</td>
<td>state budget</td>
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<tr>
<td>NHP</td>
<td>National Health Plan</td>
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<tr>
<td>RT</td>
<td>Riigi Teataja (State Gazette)</td>
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<tr>
<td>RCT</td>
<td>randomized controlled trial</td>
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<tr>
<td>NC</td>
<td>national curriculum</td>
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<tr>
<td>MOI</td>
<td>Ministry of the Interior</td>
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<tr>
<td>MSA</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>SEIS</td>
<td>syringe exchange information system</td>
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<tr>
<td>NIHD</td>
<td>National Institute for Health Development</td>
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<tr>
<td>SOCTA</td>
<td>Serious and Organized Crime Threat Assessment</td>
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INTRODUCTION

Drug abuse is a negative social phenomenon, bringing disproportionately large social and personal consequences. The consistent use of drugs is accompanied by addiction, injury, leaving one's educational path, passivity in the employment market, added burdens on the health care and welfare systems, and crime, causing major harm to society and creating even more social problems.

Naturally, the most certain means of preventing addiction is simply not to even begin using drugs. However, if drug use has already begun, then in order to avoid negative consequences their use should be sharply curtailed or ceased altogether. To prevent the start of drug use and their spread, and to limit their harm to users, an environment must be created which on one hand models norms and offers education, and on the other hand contributes to the healing of those already affected by drugs.

Estonia's drug prevention policy focuses on three main activities: 1) prevention, 2) treatment, 3) cooperation with the police. To reduce the demand for drugs we deal first with prevention and second with treatment. The key to reducing supply is cooperating with police to limit drug crime and the availability of drugs. This drug prevention policy is in conformity with the principles and goals of the European Union Drugs Strategy 2013-2020. In developing this policy, the deepening problems with drug use of the last twenty years have been taken into account, as well as the estimated shortcomings in effectiveness of previous drug strategies.

The goal of this drug prevention policy, or the "white paper" is to give a clear message of the need for a scientifically-based and uniformly applicable drug policy. The drug prevention policy was prepared under the leadership of the Ministry of the Interior by the order of the Government Committee on Drug Prevention (RT III, 10.04.2012, 11) as the result of cooperation with several experts in the field and other interested parties, and thorough consultations. The white paper summarizes the policy suggestions of the Government Committee on Drug Prevention which should be taken into consideration in the execution of the National Health Plan and other related development plans.

It is our hope that this white paper will become a living document, helping different partners to form cross-connections between vital activities and move forward in a common direction.

Many thanks to everyone who helped in the production of this document.

Ken-Marti Vaher
Minister of the Interior
• **Drug, substance** a naturally occurring or synthetic psychoactive substance, whose use may cause **drug addiction**. Drugs include both legal (alcohol, nicotine) as well as controlled **narcotic and psychotropic substances**.

• **Drug addiction** is a chronic brain illness, which is characterized by the constant use and search for drugs, regardless of negative consequences.

• **Narcotic and psychotropic substances** are compounds and their stereoisomers, esters, ethers and salts which are listed in the established registry based on narcotic and psychotropc substances and their precursors.

• This document deals primarily with the **non-medicinal use of narcotic and psychotropic substances**. Narcotic and psychotropic substances are referred to in this document as **drugs**. However, it is understood that the development of a drug addiction can begin with a person's initial contact with legal drugs, and therefore even the delay of alcohol use is an important goal in the reduction of drug addiction.

A more thorough glossary is in **appendix 1**.
1. BRIEFLY ABOUT THE SITUATION OF DRUG USE IN ESTONIA

The widespread use of illegal drugs in Estonia began to increase after regaining independence in the early ’90s. Over the last two decades, issues stemming from drugs have deepened and produced new challenges, such as the HIV epidemic. The current situation of drug use in Estonia is characterized by:

The high rate of drug use by school students. Among the nations of the European Union (hereafter also EU), Estonia is noticeable for above-average frequency of drug use among 15-16 year-old students. (ESPAD 2011) Though 7% of 15-16 year-old school students in 1997 had tried some illegal substance, by 2007 this number had increased to 30%, and in 2011 to 32% (Fig. 1). Most often, drugs are tried at age 14-15 and mostly the experience is limited to one or two tries. Among youth, the most common drugs are cannabis, inhalants, poppers, ecstasy and amphetamine. (Kobin et al., 2012)

![Figure 1. Illegal drug use among 15-16 year-old school students during their lifetime (%) 1995-2011 (ESPAD 2011)](image)

Large numbers of drug-related deaths: Between 1999 and 2012, 1,118 people in Estonia died from drug overdoses. Compared to other EU member states, Estonia’s overdose mortality rate is exceptionally high, especially among 15-39 year-olds and men (EMCDDA 2013). Over the years, the average age of those dying of an overdose has increased. In 2002, the average age among deaths by overdose was 24, but by 2012, this had risen to age 31 (Fig. 2). 85% of overdose deaths are related to the use of fentanyl and 3-methylfentanyl (EFSI 2013) and it may be assumed that this is an issue of long-term drug addicts. The aging of the injecting drug users is shown by risk-behavior studies. In 2012, the average age of injecting drug users was 30, and the average period of injection was 11 years. Only about 8% had been injecting for less than 3 years. (NIHD 2014)
Figure 2. Average age among drug-related deaths 2002-2012. (Source: Registry of cause of deaths 2012, National Institute for Health Development)

Large proportion of injecting drug users among drug addicts: Estonia has many injecting drug users, of whom approximately half are HIV-positive. The estimated number of injecting drug users has decreased over recent years, but is still at a high level. The number of injecting drug users among 15-44 year-olds fell from 15,675 (2.7% of the given population) in 2005 to 5,362 in 2009 (0.9% of 15-44 year-olds) (Fig. 3) (Uusküla et al., 2013)

Figure 3. Estimated distribution of injecting drug users (%) among 15-44 year-old Estonians (Uusküla et al., 2013)
Currently, the systems for prevention, treatment, rehabilitation, social reintegration and harm reduction of drug abuse are underdeveloped. There are separate services, but many vital services are either lacking altogether or are of less than satisfactory quality or coverage.

The National Institute for Health Development carries out annual studies in the field, which give a more in-depth overview of the current situation in the field of illicit drugs in Estonia (available at www.tai.ee). An overview of the execution of different interventions into the field of illicit drugs can be found in the 2012 collected report on drug prevention strategies (available at www.sm.ee). Appendix 2 gives a more detailed description of base levels in the area of activity in 2013. The strategic goals for the drug prevention policy have been set in consideration of the current drug situation in Estonia.
2. THE WHITE PAPER'S PRIMARY TASK

The white paper of the drug prevention policy is a scientifically-based guide for the annual planning of activities in the field of illicit drugs, and should be observed equally in both the enactment of the NHP's drug prevention measures (measure 5) as well as the execution of development plans from other appropriate fields. The arrangements for bringing the white paper's policy directives to life are explicated in the chapter on the management of the field. This policy document is based on the European Union Drugs Strategy (2013-2020), other nations' drug strategies, academic publications in the field, and thorough consultations with experts and service providers in Estonia. The policy’s preparation time was between September 2012 and June 2013. Bilateral meetings, the Government Committee on Drug Prevention gatherings, seminars and written consultations were all used as work methods in the creation of this policy, and the document reflects decisions made by consensus.

Estonia has heretofore had several strategic documents whose goal it was to find a solution to the widespread drug epidemic in this country through cooperation between different institutions which are all involved with the field of illicit drugs. Since 1997, drug use reduction has been based on some national program or strategy. The last national strategy was based on cooperation between several sectors and coordinated by the Ministry of Social Affairs - the National Drug Prevention Strategy until 2012 (NDPS). The strategy required tight cooperation with other ministries and their sub-institutions that had contact with drug-related problems. As NDPS ended in 2012, its results were evaluated, revealing that although several strategic goals were met, the strategy's primary goal - reducing the supply and demand of drugs and effective treatment and rehabilitation for people who use drugs, leading to decreased harm as a result of drug use - was not accomplished. The reason for unfulfilled goals was a lack of human and financial resources on one hand, and problems with cooperation between the different parties and coordination on the other. Despite the failure to achieve its primary goal, the activities enacted and services developed under NDPS are a significant step in reducing Estonia's problems with drug use.

With the end of NDPS in 2012, the planning of drug use reduction activities as one measure was rolled into the National Health Plan (NHP) 2009-2020 under the leadership of the Ministry of Social Affairs. The NHP's general goal is to lengthen both the lifespan of Estonia's population and their healthy years. Since 2013, drug use reduction has in fact been based on the NHP and its implementation plan for 2013-2016. The implementation plan's fourth sub-goal, "The population's physical activity has increased, nutrition has become more balanced, and risk behaviors have decreased", measure number 5 is the prevention and reduction of drug use and its harm to health and society.

At the end of 2012, coordination of drug combating measures was delegated from the governing area of the Ministry of Social Affairs to the governing area of the Ministry of the Interior. At the initiative of the Minister of the Interior, Ken-Marti Vaher, the Government Committee on Drug Prevention was created in order to direct greater attention at the highest level to the problem of drug addiction. This Committee's tasks are to establish strategic goals and priorities in the field of illicit drugs, conduct consistent monitoring and evaluation of
activities related to combating and preventing drug abuse, make proposals to the Government of the Republic for solutions to problems regarding the combating and prevention of drug abuse, coordinating actions and measures directed to reducing drug use under NHP area 4, "Healthy Lifestyle" and approving its implementation plans, and advising the Government on solving questions about preventing and combating drug addiction. This white paper of the drug use reduction policy was also compiled by the order of the Government Committee.

Executive compilers of the white paper of the drug use reduction policy are Riina Raudne, PhD and Katri Abel-Ollo, MSc from the Ministry of the Interior.

Consultations were attended by Ivi Normet, Katrin Karolin, Ene Augasmägi, Anniki Tikerpuu, Taavi Lai, PhD and Anna-Liisa Pääsukene from the Ministry of Social Affairs; Ken-Marti Vaher, Katri Abel-Ollo, Leif Kalev, PhD, Veiko Kommusaar, Viola Rea-Soiver from the Ministry of the Interior; Andri Ahven, Jako Salla, Maret Miljan from the Ministry of Justice; Anne Kivimäe, Kadi Ilves, Kadri-Ann Salla, Signe Granström from the Ministry of Education and Research; Risto Kasemäe, Marilis Sepp from the Police and Border Guard board; Peep Rausberg from the Estonian Forensic Science Institute; Marek Helm, Ardi Mitt, Marko Ratt from the Tax and Customs Board; Maris Jesse, Helvi Tarien, Aljona Kurbatova, Ave Talu, Tiia Pertel, Margit Kuus, Maris Salekešin, Sigrid Vorobjov from the National Institute for Health Development; Norman Aas from the Public Prosecutor's Office; Eda Lopato, Kristin Raudsepp from the State Agency of Medicines; Anneli Uusküla, PhD, from the University of Tartu; Merike Martinson, Vahur Keldrima from Tallinn City Government; Aivar Haller from the Parents Association; Elmar Nurmela from the Union of Child Welfare; Monika Schmeiman, Märt Loite, Oliver Väärtnõu from the Government Office; Andres Lehtmets from the Estonian Psychiatric Association; Anne Kleinberg from the Psychiatric Clinic of the Tallinn Children’s Hospital; Nelli Kalikova from NGO AIDSi Tugikeskus.

Special thanks to: Ken-Marti Vaher, Aljona Kurbatova, Maris Jesse, Risto Kasemäe, Andri Ahven and Monika Schmeiman.
3. THE WHITE PAPER'S GOAL AND STRUCTURE

The primary goal of the drug prevention policy is to permanently reduce the use of drugs in Estonia and their accompanying harms to society. Toward the accomplishing of this goal, action will be taken along three main pillars and six interdepartmental cooperative systems derived from those pillars, as well as an independent monitoring system (fig.4). The main activities planned for each system are enumerated in appendix 2.

I PILLAR: We reduce the availability of drugs

System 1: The goal of the system for drug supply reduction is combating the drug market and reducing organized crime.

II PILLAR: We pre-empt the onset of drug use

System 2: With the help of a universal prevention system, demand for drugs both in the present as well as in the future will be reduced. The goal of this sub-system is to ensure the necessary level of awareness as well as social norms that discourage drug use - among those, a drug-free environment in which children can grow up.

System 3: The system for early intervention has as its goal to notice as early as possible the risk factors for drug use and to take appropriate steps in intervention to prevent risk developing into addiction.

III PILLAR: We help people who use drugs

System 4: The harm reduction system's goal is to reduce the spread of infectious diseases and the frequency of overdose deaths among injecting drug users. Several non-governmental organizations are offering assistance in the harm reduction system.

System 5: The treatment and rehabilitation system's goal is to offer treatment for people who use drugs who have fallen into addiction, and thereby reduce the demand for drugs. This system encompasses different treatment services, from in-patient detoxification to various types of out-patient counselling.

System 6: The social reintegration services system's goal is to reduce relapses into use following treatment. Within the framework of this system, support is offered to persons exiting rehab or prison to rebuild an independent life through low-threshold education, subsidized work opportunities and support persons.

System 7: The monitoring system tracks the function of all sub-systems and collects data on the effectiveness of various interventions.
Figure 4. Drug use reduction policy vectors and cooperative systems

Vähendame narkootikumide kättesaadavust

Pakkumise vähendamise süsteem

Vähendame narkootikumide tarvitamist

Universaalse ennetuse süsteem
Varase märgamise ja sekkumisele suunamise süsteem

Aitame sõltlastel terveneda

Kahjude vähendamise süsteem
Ravi ja sõltuvusvastase taastusabi süsteem
Taas-ühiskonnastamise teenuste süsteem
Vähendame narkootikumide kätesaatavust - We reduce the availability of drugs
Pakkumise vähendamise süsteem - Supply reduction system
Vähendame narkootikumide tarvitamist - We reduce the use of drugs
Universaalne ennetuse süsteem - Universal prevention system
Varase märkamise ja sekkumisele suunamise süsteem - System for early intervention
Aitame sõltlastel terveneda - We help people who use drugs to heal
Kahjude vähendamise süsteem - Harm reduction system
Raviv ja sõltuvusvastase taastusabi süsteem - Treatment and rehabilitation system
Taasühiskonnastamise süsteem - Social reintegreation system
Seiresüsteem - Monitoring system
4. PERFORMANCE INDICATORS BY 2018

The white paper of the drug prevention policy does not have a specified validity period, since what is at hand is a long-term scientifically-based vision. All national strategies, action plans and implementation plans having to do with drug use reduction should be based on the white paper. Below and in Appendix 3, these performance indicators will be used to evaluate the effectiveness of the policy guidelines of the white paper of the drug prevention policy. These will be monitored within the framework of the annual NHP report and will be detailed more thoroughly in the report on the results of the NHP.

<table>
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<tr>
<th>Main goal performance indicators</th>
<th>Expected result by 2018</th>
<th>Base level</th>
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<tbody>
<tr>
<td>Drug overdose deaths are reduced. (NHP indicator)</td>
<td>Drug overdose deaths do not exceed 80 per year. (NHP) (source: NIHD registry of causes of death)</td>
<td>In 2012 there were 170 deaths due to drug overdose. (NIHD 2013)</td>
</tr>
<tr>
<td>By 2015 the percentage of 15-16-year-olds who have used drugs in their lifetime will be reduced (NHP indicator). Also the use of cannabis during the last 12 months among 15-16 year-olds will be reduced.</td>
<td>24% of 15-16 year-olds have used drugs during their life. (NHP) (ESPAD) In the last 12 months, 10% of 15-16 year-olds have used cannabis.</td>
<td>According to ESPAD in 2011, 32% of 15-16 year-old school students had used drugs in their lifetime. The 2011 ESPAD study found that 17% of Estonian school students had used cannabis in the last 12 months.</td>
</tr>
<tr>
<td>Every year will show a <strong>two percent decrease</strong> in the use of drugs during the last 12 months among the adult population (18-74 year-olds).</td>
<td>Lower than base level</td>
<td>The base level will be established with the 2014 PGBG study of risk behavior awareness in adults.</td>
</tr>
<tr>
<td>Every year will show a <strong>two percent decrease</strong> in the use of drugs in their lifetime among minors (7-17 year-olds).</td>
<td>Percentage of minors (7-17 year-olds) who have used drugs in their lifetime will be lower than base level.</td>
<td>The base level will be established with the 2014 PGBG study of risk behavior awareness in minors.</td>
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Performance indicators for the three pillars are listed in appendix 3.
5. PRINCIPLES OF THE DRUG PREVENTION POLICY (WHITE PAPER)

Throughout the white paper of Estonia's drug prevention policy, the setting of goals and choosing of actions are done in consideration of scientific studies on the nature of drug addiction and principles which are in harmony with the EU drug strategies.

a. Prevention is more effective than reacting to consequences

Addiction is a complicated chronic brain illness whose treatment is time-demanding, expensive, and not always as effective as desired. The best way to reduce addictions among the population is to prevent and reduce drug use in general, identify initial signs of drug abuse as early as possible and to offer assistance in avoiding addiction to those who have already used drugs to some degree. There are different definitions of drug prevention, but in the broadest sense it is reducing the different risks associated with drug use, so that individuals who have not yet begun to use drugs do not start to use them in the future. Prevention must be much broader that just informing people about drug-related topics - it should be thought of rather as a way of organizing social life and its environment in such a way as to restrict access to drugs and create norms which are disapproving of drug use as a behavior, especially among minors. Therefore, prevention is not merely the realm of some single government department, but is rather a considered and intentional cooperative effort. The best prevention happens in people's everyday contexts - at home, at school, in the community. Social norms which are deprecatory of drug use will ideally be passed on by parents, teachers, specialists in youth work or child care, peers, media, and non-governmental organizations.

b. Treating people who are addicted to drugs is more effective than punishing them

In the case of individuals who are already caught in addiction, the best results have been seen in the offering of detoxification treatment, rehabilitation, and services that reduce drug related harms. This work is itself also a form of prevention - it reduces different health risks associated with drug use, such as HIV and hepatitis, which in turn helps prevent even greater harms, like unemployment, homelessness, criminal activity or asociality. Treatment also reduces, in certain cases, the need for making an illegal income and gives an opportunity to look for ways to turn back to labor market.

c. The harms of illegal and legal drugs are connected

Although the effect of various psychotropic substances on the body and brain are different, the mechanisms of addiction are quite similar in the case of both, legal and illegal drugs. The social and cultural differences in attitude toward alcoholism and drug addiction and their spread is more a function of how they are handled legally - alcohol is legal for adults, illegal drugs are not. From a practical standpoint and in the interest of conserving resources, it is
expedient to deal with the prevention and treatment of both legal and illegal drugs in conjunction so as to avoid the construction of separate, partially redundant systems.

d. **We favor evidence-based or knowledge-based approaches**

Addictions and their accompanying risk behaviors are somewhat persistent phenomena which take root in society easily, though whose spread can be significantly stemmed by the state in cooperation with partners through the execution of purposeful interventions. The prevention of drug use and addiction must preempt or relieve known risk factors for addiction (mental health disorders, initial drug use in the early teenage years, unfinished education), reinforce known protective factors and be based on the best evidence available.

In speaking of being evidence-based, it is not merely being stated that the development of this policy reckons with the findings of different scientific studies. Rather it is being specified that the effect and efficiency of evidence-based interventions have been quantified by experimental trials. Very precise and detailed experimental studies, especially randomized controlled trials give stronger evidence of the effect of intervention than a participant’s later feedback on how much they liked the experience. Simple feedback does not give a basis for knowing if people improved their situation due to the intervention itself, or if they changed their behavior due to some other outside factor (i.e. financial pressure). If an intervention or treatment is evidence-based, it has been determined through the help of different studies and in different contexts that the chosen approach is effective in giving a result specifically along those indicators which the interveners hope to influence.

The implementation of evidence-based practices also means that the concomitant monitoring system allows a reckoning with a routine evaluation of the results. In implementing new approaches and interventions, the **base level** of the situation is first measured and the new approach's suitability is weighed in context, and if needed, is changed. After initial piloting, it must be considered how evidence-based practices can be implemented as an integrated part of existing systems (hospitals, schools, police, kindergartens), and how the implementation of those practices can be consistently measured. For example, evidence-based addiction prevention methods must be a part of everyday life, and early intervention along with referral to counselling could be a part of a family doctor's routine activities. Movement towards implementation of evidence-based practices should be applied systemically, not just on a project-by-project basis, where the results are monitored continuously and where the synergy of services makes cost-effectiveness possible.

e. **Treatment services ensure the individual's privacy**

People who have used the services of systems that allow early intervention of drug abuse, harm reduction, treatment and rehabilitation are guaranteed privacy and the services are provided in accordance with the Personal Data Protection Act valid in the Republic of Estonia.

f. **Treatment and harm reduction is voluntary**

In Estonia, treatment and harm reduction are offered only if the individual is choosing it of their own free will, and no drug user is compelled to go to a service provider.
6. PREREQUISITES FOR POLICY'S SUCCESSFUL ENACTMENT

Drug abuse is a complicated social problem which cannot be solved by any one successful service, but rather needs integration and synergy of influence of different sectors, levels of government and interventions. To achieve the goals of this policy, several prerequisites must be met:

a. Cooperation between different areas of government and a unified articulation of the problem

In order to achieve a synergy of influence between various fields of activity under different areas of government, it is necessary for different organizations to be working towards the same goal and tracking the same performance indicators. To that end, innovative and more flexible forms of cooperation may need to be developed.

b. Coordinated management by the Government Committee on Drug Prevention

Ministry-level attention to the drug situation will help to ensure the cooperation needed for social change and allow quicker detection and resolution of heretofore unnoticed problems. The implementation of the Committee's work is assisted by a task force which coordinates different areas of service. The experts in this task force form themed work groups and communicate on an ongoing basis with service providers and target groups.

c. Permanent funding

To ensure the quality and consistency of the help offered by institutions and groups that deal with combating and reducing drug abuse, we must move away from financing on a temporary or project-dependent basis, and toward permanent funding - integrating evidence-based interventions into the routine activities of child care institutions, schools, and the health care system.

d. Training and development of teamwork

Representatives from various fields come into contact with consequences of and solutions to the problems with drug use. Currently, Estonia has too few specialists who have been trained in dealing with drug-related issues. Continuing education is needed for health care and social work professionals as well as for law enforcement and education workers, as well as the personnel of entertainment facilities. In addition to increasing specialists' knowledge in
solving issues related to problems with drug use, cooperation must be developed between different specialists.

e. **Local implementation**

Prevention and social reintegration must take place in environments where people live and work. On the local level, the supply of drugs can be controlled to some extent, at the same time communities create norms in regard to drugs. The availability of different services that help people with drug problems also depends on a local municipalities's effectiveness. Up till now, varying degrees of effectiveness in local municipalities have not allowed equal levels of service to all citizens. It is necessary to support the development of competence within local governments to offer services for prevention, early intervention and harm reduction, while more specific drug addiction treatment remains a service that is provided on the national level.

f. **Monitoring**

There must be an annual overview of the field of illicit drugs in general and the implementation of the policy, through scientific studies, the routine collection of statistics, and reporting. At the same time, monitoring activity gives an evaluation of the policy's effects and a way to further specify the goals and activities of the field.
7. WHAT WE ARE DOING: PILLARS TO REDUCE THE HARMs OF DRUGS

In the following section we will describe each of the pillars of the drug prevention policy and explain in greater detail the functional logic of each cooperative system as well as their primary and sub-goals. We have also highlighted several performance indicators with each system, which will help monitor progress towards its goal. A list of suggested activities and expected results by 2018 can be found in appendix 2.

I PILLAR: We reduce the availability of drugs

Reducing the availability of drugs is one of the three important pillars in the national drug use reduction policy. Availability will be limited through legal means, outlawing or regulating the use and handling of psychotropic substances, and through strong supervision, which must limit the illegal circulation of narcotic and psychotropic substances on the black market.

System 1: Drug supply reduction

The illegal status of drugs may be a delaying factor in the expansion of the drug trade, but at the same time, in free societies, reducing the drug problem per se by limiting availability has very limited outlooks for success. The evidence-based vision is supported by the understanding that in order to achieve decline in drug use and mitigate its harms, the reduction of supply must be but a part of a policy of reducing demand (prevention, shaping of values, and treatment). The most successful strategy in reducing supply, in terms of reach of influence, has been to direct resources toward limiting the availability of seriously harmful hard drugs. (Roberts et al., 2004)

The primary goal of the system for reducing supply is to impede the drug market and to reduce organized crime. The tools for achieving that result are laws which are in accordance with social changes and the presence of legal protection, the efficient application of the penal system, and on a primary level, the effective work of law enforcement institutions. Cooperation between those institutions is an important factor in achieving these goals, and so is teamwork with other partners and local governments, schools, the private sector, parents and the community at large. The main prerequisite in the field of effectively reducing supply is a singular set of established priorities and the availability of human resources and technical instruments.

The cooperation partners in this system are the Police and Border Guard Board (PBGB), the State Agency of Medicines, the Prosecutor’s Office, the Estonian Forensic Science Institute (EFSI), prisons, detention houses, and the Tax and Customs Board (TCB).
Sub-goals of the system for drug supply reduction

1. Combating organized drug crime

Drug trafficking is a serious, hidden crime, bringing harm to society through increasing the spread of addiction. In fighting against organised drug crime, the ability to discover large drug crimes must be increased. To that end, a sufficient number of officials for tracking and prosecuting, consistent training for specialists in the field, and provision of modern and needful tools (instant tests, technical instruments, motor park, etc.) must be ensured. The effective identification of criminal profit and the confiscation of that profit has an important role in the discovery of serious drug crimes.

In combating organized drug crime, the effect of the criminal policy up to this point upon the areas of drug trafficking, public health and maintenance of law and order must be evaluated. In the future, the effect of criminal policy must be evaluated regularly. In addition to the effect of penal policies, there must also be an annual evaluation of the current condition of the fight against drugs (input into the risk assessment) and on the basis of that evaluation there can be input for international overviews (SOCTA).

2. Reducing the availability of drugs among minors

The activities listed above must also make a significant contribution to the reduction of availability of drugs among minors. There must be a significant increase in attention paid to criminal cases which are connected to inducing minors to the illegal consumption of narcotic and psychotropic substances or the delivery of those substances to minors. Minors caught using drugs in the course of a criminal investigation should have their information forwarded to the appropriate officials/institutions in order to continue the case and direct the young person to prevention projects, support groups and workshops with the goal of their rehabilitation. In the case of minors, the penal system must be open to innovations, that is, the offering of different alternatives to traditional punishments in order to avoid long-term legal entanglements at that critical stage of a youth's development.

3. Reducing the spread of drugs which cause deadly overdoses

The drugs which cause the most overdoses fluctuate according to trends in the drug market. Over the last ten years, and today as well, the most problematic drugs in Estonia are fentanyl and 3-methylfentanyl - over 80% of drug-related deaths are connected with an overdose of these substances. Therefore, the discovery and elimination of these substances must significantly increase. This activity assumes far better tracking information. Better tracking data is being obtained through targeted street operations. Also, drug market activity must be constantly monitored with the understanding that these substances may lose their role in the market and be replaced by other drugs that cause fatal overdoses.

4. Combating the spread of new psychoactive substances

Special attention in legislative drafting must be paid to substances that are not yet added to the schedule of narcotic and psychotropic substances which can be used legally as an alternative to illegal drugs. In the last few years, these sorts of substances have been appering with
greater frequency on the market. The process for adding new psychoactive substances onto the schedule of narcotic and psychoactive substances needs to become quicker and more flexible. One important step is the creation of the early-warning system on new psychoactive substances (EWS), which was established to exchange information between divisions about new psychoactive substances in order to evaluate the risks associated with such substances and the application of means to control them. It is also important to change laws, so that the adding of new psychoactive substances to the schedule of narcotic and psychotropic substances can be done by substance groups, not one substance at a time, and so that if needed, a new psychoactive substance can be restricted temporarily. In addition to the afore mentioned, it is also crucial to make young people and their parents aware of the danger of new psychoactive substances.

5. Preventing the fall of legal narcotics and psychotropic substances, medicines which contain them, and precursors into illegal circulation

In justified cases, the use of narcotic and psychotropic substances for scientific purposes is permitted and warranted. Of particular importance are pain and palliative care medicines (morphine, oxycodone, fentanyl, etc.). They are also used in pharmacologically assisted treatment of opioid addiction (methadone, buprenorphine). The chemical and medicine industries also have everyday uses for the precursors to narcotics (acetone, ephedrine, etc.). The handling of these substances are established by directly applicable EU regulations and the movement of these kinds of substances is controlled by international conventions (the monitoring body of which is the International Narcotics Control Board (INCB)) as well as national laws. The goal of this monitoring is to avoid allowing these substances and medicines to fall into illegal circulation. Estonia's supervision of medicine wholesalers and pharmacies is done by the State Agency of Medicines, which also supervises the handlers of registered narcotics and psychotropic substances who have activity licenses. At this point, the effective cooperation of all parties (handlers, the State Agency of Medicines, Tax and Customs Board (TCB), the PBGB (Central criminal police) etc.) is vital in order to notice and react to unusual transactions and orders. Without precursors there are no synthetic drugs. There will also be cooperative inspections with the Health Board in the healthcare organisations providing pharmacologically assisted treatment of opioid addiction (opioid substitution treatment), supervision will be strengthened and the regulations governing opioid substitution treatment will be supplemented if necessary.

6. Combating the availability of drugs in prison

It is important to continue the already functioning systemic limitations of drugs availability in prison. There must continue to be searches and larger operations for the discovery of illegal substances, even to an expanded degree, if needed. Widespread video surveillance and mail checks must continue to be in effect in prisons, along with the presence of body scanners and trained sniffer dogs and their handlers. The use of necessary technologies for the detection of drugs must be increased and updated as needed.
II PILLAR. We pre-empt the onset of drug use

The second PILLAR of the drug prevention policy is to reduce the use of drugs in general and to prevent and delay the beginning of individual use of drugs. Harmful drug addiction cannot develop if people do not start using drugs. Therefore the highest priorities are reducing the number of people addicted to drugs in society, the general reduction and prevention of drug use, and delaying the onset of drug use until adulthood. Also, avoiding the use, or the delay of the use of alcohol and tobacco (legal drugs) into adulthood helps to reduce addiction. (Kristjansson et al., 2010; Rutherford et al., 2010).

System 2: Universal or primary prevention system

The logic of a universal prevention system is derived from the results of scientific work on brain development and neurology throughout the last few decades, which show that during its life, the brain learns new patterns and habits through repeated behaviors (Eyse, 2009). Childhood and the teen years are times of especially rapid development and patterns of behavior formed in those years affect people throughout their whole lives (Crews et al., 2007; Fox et al., 2010). The purpose of universal prevention is to help all children acquire the skills and abilities needed for success in the 21st century as well as possible and to adjust to the expectations of their families and the educational system. Important norms are taught to a child first in his family, then in educational institutions, and finally from friends (Oetting & Donnermeyer, 1998). These groups also help shape behavior and identity. Trusting relationships within the family help in later emotional adaptation in kindergarten and school and in positive attitudes toward learning and coping. However, complicated family relations and being ill-prepared for school can create a situation where it is easier for a child to find his needed affection and attention from his friends, who have the same problems in adjusting at school, especially with the onset of puberty. Young people, who have difficulty adjusting to a school environment, are therefore especially vulnerable and can buckle under peer pressure to experiment with risk behaviors (Oetting & Donnermeyer, 1998).
The primary goal of the universal prevention system is to offer systems of consistent and sufficient prevention services to strengthen the protective factors of the adult population as well as children.

Prevention directed at children and youth (aged 7-26) focuses less directly on narcotics per se, and more on strengthening general social and emotional skills and adjusting to school and extracurricular education. In the framework of the universal prevention system, adults are offered information primarily through campaigns, internet resources and media coverage on the health effects of drugs and laws and regulations that manage their handling. The tools needed for achieving the goal of the universal prevention system include the implementation of new evidence-based interventions in Estonia and the integration of more effective prevention work in organizations who are already working with children and youth. For example, by this logic the entire general education system, music schools, youth centers and sports clubs could all be involved in prevention, in as much as they all offer youth a structured way to spend their free time, acquire skills and socialize with other children, whose risk of drug use is reduced due to involvement in hobbies and activities. The primary prerequisites in the field of drug use prevention is a singular set of established priorities, interdepartmental cooperation, constant exchange of information and the availability of the tools and evidence-based guidance and resources that have been adapted to Estonia's context.

The cooperation partners in the planning and funding of the universal prevention system are the Ministries of the Interior, Social Affairs, Education and Research, and Culture and the National Institute for Health Development along with local municipalities. The activities are carried out by parents, educational and child-care institutions, youth work and hobby organizations in the non-governmental sector as well as local municipalities.

Situations have especially high risk if:

1) a child shows behavioral problems, antisocial tendencies or aggression in kindergarten or elementary school;
2) a child socializes with other children who have behavioral problems;
3) a child's parents are distant, overly strict and inconsistent with discipline, or have not set reasonable boundaries and expectations for mature behavior and do not monitor their children's activities (Baumrind 1991);
4) a child has not adjusted well to school.

Minors who are successfully directed to evidence-based interventions of universal prevention change at least one of these risk factors in order to prevent longer-term risk behavior (Webster-Stratton & Taylor, 2003).
Sub-goals of the universal prevention system

1. Developing parenting skills

Parenting skills influence the development of children and their ability to cope starting already in early childhood and contribute to an increase or decrease in risk of addictions in the teenage years. Long-term studies have shown that parental education that develops a parenting style characterized by the consistent, kind setting of boundaries (authoritative parenting style) helps children to learn how to control their behavior and to adjust to different situations with skill and self-respect (Baumrind, 1991; Hawkins et al., 1985; Sussman, 2013). Parenting skills can be systematically developed through parental education programs of different levels and specifics, coordinated in Estonia by the Child and Family department of the Ministry of Social Affairs. The Ministry of the Interior invests in raising parents' awareness of their role in preventing risk behaviors and crimes through media campaigns and the internet site tarkvanem.ee.

2. Applying evidence-based universal interventions in child-care and educational institutions

Universal prevention must move away from the heretofore used model of project-based funding and become a permanent part of the educational, social and child-care system. Instead of individual short-term prevention projects, the understanding must be instilled that prevention is among the tasks of all institutions and organizations that are involved with children and youth. Prevention that is arranged in this way does not demand significant additional resources beyond the initial investment, but rather is connected with the organisation of work in schools and their curricula. The availability of evidence-based interventions makes the work of teachers, child care workers and social workers easier, giving clear guidance for teaching the adaptive behavior. To achieve this goal, associated groups must be informed of the principles of evidence-based practices, investments must be made in appropriate interventions, continuing education must be ensured for the personnel of organizations, and the principles of prevention must be integrated into the basic training of child care workers, teachers, youth workers, activity coordinators and other professionals. Evidence-based universal prevention interventions should develop into a national structure, which guarantees the availability of the best prevention practices to national, municipal and non-governmental service providers and which supports practitioners dealing with socialization, who offer different services to children and families from infancy to adulthood. There must be anti-bullying systems applied and practiced in preschools and schools. In the long-term, it will be necessary to offer interventions that teach the skills to adapt to school or social and emotional skills, like the Good Behavior Game, or Botvin Life Skills.

3. Ensuring the development of norms and sufficient information for adults

Adults who do not use illegal drugs or use them very infrequently must be informed of the legal status and dangers of psychoactive substances. This information is conveyed to the public and to risk groups through continuing mass media coverage, media campaigns and internet resources. Prevention activities which take place at the local level and in the
workplace are also an investment in universal prevention for adults, as are police checkpoints for driving under the influence of drugs.

**System 3: Early intervention system**

Early intervention means a timely diagnosis and assistance for children with mental health problems or special needs, who have not yet begun to use drugs, but who are at an aggravated risk to do so in the future. Getting help as early as possible helps avoid inability to cope later on, and the accompanying risk of addiction. Secondly, the early intervention system means that employees of the medical, educational, and law-enforcement systems should be able to see the early signs of drug abuse in their respective target groups and direct people to counselling or other services as needed, in order to avoid the development of addiction out of drug use.

The **primary goal** of the system for early intervention is to notice the risk factors for drug use as early as possible and with the help of appropriate interventions, to prevent the use of drugs from developing into an addiction. The **tools** for accomplishing that goal are evidence-based or best-practice-based guidelines which have been modified for Estonia's context and course plans. The **prerequisites** are a singular set of established priorities and the development of a cooperative network.

The **cooperation partners** in the system for early intervention are the Ministries of the Interior, Social Affairs, Education and Research, and Justice, and the activities are carried out by health care workers, police, local child protective services, school support services experts and social workers.

**Sub-goals of the system for early intervention**

1. **Creating a concept for the system for early intervention**

A concept, guidelines and personnel training plans for the system for early intervention must be worked out, as well as the testing and development of the effectiveness of different counselling techniques. It is important to ensure the person-based conceptual cohesion of the cooperation model - to describe how a young drug user who is at risk of addiction moves between the different services, how risks are identified and detected, how to assess the need for help and how to direct to intervention.

2. **Piloting the services of early intervention and applying them in the health care system**

Early intervention and referring to treatment (Madras *et al.*, 2009; Babor *et al.*, 2007) is an evidence-based approach, which takes place in the health care system. Successful early intervention may reduce health care costs by reducing the expenditure of resources and time on issues caused by or exacerbated through the use of drugs (Estee *et al.*, 2006). Asking about
a patient's use of illegal drugs or abuse of prescription drugs can help a doctor in diagnosis, since it aids in the avoidance of unexpected harmful converging effects of substances and gives the doctor a chance to talk about the harmfulness to one's health of illegal drugs. Today there are technologies which allow short intervention and screening using a computer software or even over the Internet.

3. **Piloting the services of early intervention and applying them in educational and child-care institutions, police work and social and support services**

Often, those who have the initial symptoms associated with drug use do not make it to the needed services early enough to avoid addiction. In addition to the health care system, the system for early intervention must involve school health care workers and support service specialists, daycare workers, family doctors, specialists, the police and local social workers and child protective services workers. The success of early intervention is supported by a situation where out-patient counselling, mental health services and rehabilitation for children with behavioral disorders are available and integrated in the network of the general health care system. Out-patient counselling on the topic of reducing drug use must be supported by local support services. Supporting social and mental health services should be available to all families where there is a risk of drug addiction.
III PILLAR: We help people who use drugs

The PILLAR of helping people who use drugs to improve their health and social situation includes three partially overlapping, though still distinct, systems: harm reduction, treatment and rehabilitation, and social reintegration services. The movement through these systems of a person who needs help is individual and based on the needs of the patient.

System 4: Harm reduction system

Reducing harms is an important step which brings people who inject drugs into contact with health services. The goal of reducing harms is the reduction of risk behaviors associated with drug use, the spread of infectious diseases and overdoses and to encourage people who use drugs to get in touch with health care and social services (EMCDDA). Harm reduction is a pragmatic approach, directed at people who use drugs who do not wish or are not able to stop using them, but whose behavior can be made less risky.

The primary goal of the harm reduction system is to reduce the spread of infectious diseases and fatal overdoses among injecting drug users.

With the realization of this primary goal, drug use related infectious diseases and the number of drug related deaths will decrease. The tools for reaching this result are training workers in the field of harm reduction, offering complex counselling services to drug users and initiating programs to provide syringes and needles and other injecting equipment as well as preventing overdose-related deaths. The prerequisite for the harm reduction is a singular set of established priorities and the availability of financial means and motivated human resources.

The cooperation partners for the harm reduction system are the Ministry of Social Affairs, the National Institute for Health Development, local municipalities and different non-governmental organizations and other organisations working in the field.

Sub-goals of the harm reduction system

1. Preventing drug-related overdoses

The most widespread approach for preventing drug-related overdoses in the framework of harm reduction is counselling injecting drug users on safer injection and avoiding other risks associated with drug use. Due to the widespread use of fentanyl in Estonia and the high rate of overdose-related fatalities, the opioid antidote naloxone must be made available to opioid users and those close to them, in addition to counselling about safe injection. The naloxone pilot project was started in Estonia at the end of 2013. Appropriate intervention measures
have been implemented in many countries and so far, assessments have shown their effectiveness (Dettmer et al., 2001; Maxwell et al., 2005; Galea et al., 2006; Tobin et al., 2009; Seal et al., 2005; Strang et al., 2008; Mayet et al., 2011). Estonia's harm reduction services and health care services directed to opioid users must have a naloxone program added, which includes education for drug users and those close to them, and which instructs how to administer naloxone to an person with overdose.

2. Improving the quality of harm reduction services and expanding their regional availability

Harm reduction services are frequently a drug user's first contact with social services and therefore have an important role not only in providing syringes and needles and other prophylactics, but also in various kind of counselling, legal and social aid. The personnel of harm reduction services must know their target group, be able to motivate their clients and ensure a client's continuing contact with the social and heath care services that he needs. To achieve this sub-goal, it is important that harm reduction service workers get continuous training, including supervision and facilitating practical training. Harm reduction services are concentrated in Ida-Virumaa, Harjumaa and Tallinn, but it is important that services are available in other areas as well (Pärnu, Rakvere, etc.). In areas where the number of people who inject drugs is smaller, it is warranted to integrate harm reduction services with other drug use related services. Harm reduction services must also be available to drug users in prisons as well.

3. The development of new,sofar lacking, services

Studies of injecting drug users' risk behaviors have revealed that a part of the target group does use sterile needles and syringes, but other injection equipment is used multiple times and/or is shared (Uusküla et al., 2009; Lõhmus et al., 2010). In the framework of harm reduction services, in addition to needles and syringes, other paraphernalia must be accessible (filter, fluid, heating dish, etc.) and if possible, integrate initial health care services (sepsis treatment). Since most of injecting drug users in Estonia are infected with the hepatitis C virus, the prevention of that illness should accompany HIV prevention work among injecting drug. Also with harm reduction services there should be education on tuberculosis and anyone suspected of having tuberculosis should be referred actively to health care institutions for a screening. For the purpose of reducing the number of deaths associated with drug use, the practice of so-called "safe injecting" rooms in other countries must be analyzed.
System 5: Drug addiction treatment and rehabilitation system

Drug addiction treatment and rehabilitation is one of the three systems belonging under this pillar which offers people who are addicted to drugs a chance to improve their health. In short, drug addiction treatment and rehabilitation is a network of health care and social services intended for different target groups and that includes different elements from motivation for a drug-free life, detoxification treatment and counselling to integrating the person back into society.

Drug addiction treatment and rehabilitation is by its nature very multifaceted: different approaches and methods can be used in the treatment and rehabilitation process and must be chosen based on the individual's health and social status. The treatment and rehabilitation system also includes different counselling services, among which is post-care services - that is, support for the individual after completion of treatment and rehabilitation, tightly connected with social reintegration or continuing services system.

The treatment and rehabilitation of a person is a process with several stages, each tightly connected to the other. It is difficult to distinguish clearly between a certain treatment system and a client's movement between various treatment, rehabilitation, and continuing services. All clients must undergo a thorough, structured assessment and each service must be applied according to their individual needs.

The primary goal of the treatment and rehabilitation system is to reduce the number of injecting drug users and to prevent the addition of new injecting drug users.

Upon realization of this goal, the number of active injecting drug users and new injecting drug users will grow steadily smaller, and therefore the average age of injecting drug users will increase year by year. The tool for accomplishing this result is the existence of an effective treatment and rehabilitation system. This must not be a splintered collection of services, but a unified system, in which a person can easily navigate. In building this treatment system, resources and personnel cannot be concentrated only on illegal drugs, but rather the construction of a broader structure of addiction treatment. The prerequisite for a functioning drug addiction treatment and rehabilitation system is cooperativeness, availability of financial resources and suitable infrastructure, trained personnel and motivated service providers.

The cooperation partners are the Ministry of Social Affairs, the National Institute for Health Development, the hospitals of the hospital network development plan and other health care service providers, different non-governmental organizations and other organisations working in the field.
Sub-goals of the addiction treatment and rehabilitation system

1. Creating a unified standard of quality and legal basis for treatment, rehabilitation and counselling services

The system must be built up on evidence-based methods. Interventions must not be founded on moral convictions or subjective attitudes. All services belonging to the addiction treatment and rehabilitation system must be subject to unified quality standards, in which the principles of performing the service and the mandatory components of the service are expressed. The development of some addiction treatment and rehabilitation services and the raising of their quality may require the elaboration of a legal basis for offering said service. Specifying the definition and classification of rehabilitation is important, where a clear distinction is made between medical and social rehabilitation, for which there are different requirements.

2. Training and motivating personnel

There must be a solution to the problem of personnel that works in addiction treatment. There are not enough psychiatrists in Estonia and there is an especially sharply felt need for psychiatric proficiency in the treatment of addiction. It is important to place greater emphasis on the training of psychiatrists and other treatment personnel in the field of addiction and to ensure that trained specialists stay in the field. The other important course of action is to amend the psychiatric care act in such a way as to allow a doctor who has completed the appropriate specialized education course and who has a certificate from the Health Board to also offer addiction treatment. Nursing services should also be better integrated into the offering of addiction treatment. There should also be systematic continuing education opportunities, including supervision and practical training opportunities for specialists of different specialities, including nurses, doctors, social workers and psychologists.

3. Developing treatment and support services which are lacking

The National Institute for Health Development has mapped the availability of treatment and support services for adults and minors and identified gaps in their availability, scope, and quality. Emphasis must be placed upon the development of currently lacking services in the addiction treatment and rehabilitation system. There needs to be more development of outpatient counselling services and aftercare and support services which take place upon completion of addiction treatment and/or rehabilitation. These services must be ensured for a wider target group than just opioid users. On the basis of different studies, it can be said that based on regional location, 16-71% of injecting drug users in Estonia are consuming amphetamine (Lõhmus et al., 2010). There also needs to be development of in-patient treatment and rehabilitation services for mothers with small children, such that the mother can bring her children with her. In the development of new services, the existence of motivated service providers and trained staff plays an important role.

4. Increasing the capacity of existing addiction treatment and rehabilitation services for both minors and adults
Although there has been much investment in the treatment system, at the moment the capacity of different services is problematic, and quality must be partially increased. In the case of opioid substitution treatment, there must be an increase in both capacity and quality of service. Initiating opioid substitution treatment in Maardu, Pärnu and Rakvere must be given top priority.

Another important service is in-patient detoxification, a form of treatment where patients spend an extended period of time in the treatment center. More facilities are needed for both adult and underage patients. In-patient detoxification departments are needed in Ida-Virumaa, Tallinn and Southern Estonia. In the case of detoxification, ways must be found to offer treatment, if needed, beyond the 2-3 week period currently being offered. At the same time, it is important to ensure that psychosocial and other support services are offered during in-patient detoxification with the goal of giving patients a chance to gain practical skills.

The capacity of treatment and support services for minors must also be increased. Childrens' mental health centers and rehabilitation services for children with behavioral disorders play an important role in solving underage addiction problems. In addition to the children's mental health center being created at the Tallinn Children's Hospital, there should be a similar center established in Tartu.

In increasing the regional opportunities and availability of addiction treatment and rehabilitation, it is important to cooperate with the hospitals of the Hospital Network Development Plan (HNDP). HNDP hospitals must have the obligation to provide important health care services for public health in order to ensure a minimum level of service availability on a national level. The primary prerequisites for the expansion of all the previously mentioned services are the availability of trained personnel and service providers.

5. Increasing the opportunities to continue treatment and rehabilitation in prison and after release from prison

To reduce personal and social harms it is important to continue to ensure that addiction treatment and rehabilitation is provided also in penal institutions based on throughcare principle. It is also important to ensure support person services, continuing harm reduction services, relapse prevention services, and continuing treatment or rehabilitation plans for those released from prison.

6. Ensuring that addiction treatment and rehabilitation services are provided as an alternative to imprisonment

A functioning addiction treatment and rehabilitation system must be ensured for convicts with drug problems, whose imprisonment has been replaced with treatment or rehabilitation. Affording and encouraging an alternative punishment is an important method for reducing the number of prisoners.

System 6: Social reintegration services system

In terms of social reintegration, or continuing services, there are two possible approaches in Europe. One approach offers people with addiction services within the framework of services offered to vulnerable groups in general. In the case of the other approach some countries offer services specifically drug users who have just finished addiction treatment (e.g. France) (EMCDDA 2011).
The **primary goal** of the social reintegration system is to reduce the relapses among people who are trying to stop using drugs.

The **tools** for reaching that result are the availability of a functioning network of support and social aid services to drug users who want to quit using drugs. This must not be a splintered group of social services being offered, but a unified system, in which the individual can easily navigate. In Estonia, most of the social reintegration services needed by people who use drugs need to be made available on the basis of general social welfare services, although a part of them needs a target-group-based approach. The **prerequisite** for a functioning social reintegration system is the presence of a legal basis for providing services, cooperativeness, availability of funding and a suitable infrastructure, trained personnel, and motivated service providers.

The **cooperation partners** are the Ministries of Social Affairs, Justice, Education and Research, the National Institute for Health Development, prisons, various social service providers, religious associations, educational institutions, employers/entrepreneurs, different non-governmental organizations and other organisations in the field.

**Sub-goals of the social reintegration system**

1. Creating a cohesive concept of the social reintegration system and describing standards for the necessary services

For years, social reintegration services have been underfunded. There have been numerous short-term projects undertaken with foreign funding, but as yet there has not been movement towards building a system. There is a need for developing, piloting and implementing opportunities for recovering drug users to re-enter the main areas of education, housing and work, which will help social reintegration and reduce the risk of relapsing into addiction.

**Case management and support person service**

- Since individuals who have problems with addiction need complex assistance, requiring the cooperation of several different specialists in assessing the needs, planning assistance and applying the methods of help, it is important to strengthen case management. A support person's main activities in working with adults are counselling and guidance. All clients of a support person need counselling (motivating, encouraging, focusing on the client's skills and abilities), and many of them also need guidance in undertaking concrete actions (homework, errands, etc) or their planning. A support person's services helps a person maintain, improve or avoid
a loss of their ability to cope, according to the situation. (Ministry of the Interior, 2013)

Educational opportunities

- Basic education - ensuring educational opportunities to former and current drug users. This is not work or vocational training, but getting an education in the wider sense, which can be important for a former or current drug users's ability to cope independently in the future. This should be a supported learning opportunity, where the person with drug addiction is ensured a support person if needed for adjusting to the school system and coping.

- Vocational education - practical learning opportunity, where skills and methods needed for handling a vocation are acquired. This is either a practical training service aimed at a particular target group or a service intended for vulnerable groups in general.

- Continuing training - learning opportunities for expanding and updating existing knowledge and skills.

Housing opportunities

- Social housing - low-rent living spaces available to vulnerable groups. The funding associated with social housing, including the standards and funding for the service provider, must be systematically described in the concept of an integrated social reintegration system.

- Supported living - a separate living space, where psychological and social assistance is also offered by specially trained individuals. People live their lives independently, but they are supported as needed. In other countries, this service is offered by local municipalities and in general this is a welfare service to vulnerable groups.

Opportunities for entering the labor market

- Intermediate labor market - jobs which are a bridge between long-term unemployment and the open job market. These are frequently seasonal jobs, or jobs intended for socially vulnerable groups. The offering of these jobs could happen through Estonian Unemployment Insurance Fund in cooperation with local municipalities. Currently the EUIF in cooperation with local governments facilitates employment and community service work for everyone according to individual need and ability. A person with addiction typically enters the job market after completing drug addiction treatment and continuing services or during them. Thus, employment program services (practical training, individual employment, counselling to reduce barriers to employment (incl. addiction counseling)) which are primarily focused on long-term unemployed persons are very important to the target group of drug users.
• Supported employment - offering support and help to socially vulnerable groups on a national and local level in order to increase their effectiveness in the open job market (EMCDDA 2013). The offering of jobs could occur through cooperation with the Estonian Unemployment Insurance Fund and local governments. Currently, the EUIF offers the opportunity to get a support person in the framework of individual employment placing.

2. Needs analysis of social welfare services

Analyzing the needs of the target group of people with addiction for social welfare services and ensuring availability of social welfare and special care services as needed. To modify legal basis as needed.
System 7: Monitoring system

The monitoring system is the mechanism that tracks the implementation of the entire policy and the reaching of its goals. The monitoring system does not fall under the policy's main pillars. The purpose of monitoring and evaluation is to collect objective, reliable data on the use and spread of drugs, consequences of their use and national response. Its goal is also to observe the quality of services and evaluate whether the provision of the offered services to the chosen extent is taking us closer to the primary goal - to reduce the harms of drug use in society.

The main goal of the monitoring system is to track the implementation of the policy and observe the drug situation through routine data collection and studies in the field.

Upon reaching the main goal there will be an overview of activities in the field of illicit drugs and their effects, the achievement of synergy between different fields, and objective data on the drug situation in Estonia. The tools for achieving these results are a policy monitoring framework and the availability of reliable epidemiological studies and statistics (EMCDDA - developed indicators). The prerequisites of the monitoring system are tight cooperation between the monitoring unit and cooperation partners, continuing the regular funding of studies in the field, developing studies and data sources that are lacking, and making the gathering of statistics more effective.

The cooperation partners are all institutions, scientific bodies and experts and units involved in social studies which are connected with the planning and implementation of the drug prevention policy. The National Institute for Health Development is responsible for the monitoring of the field of illicit drugs.

Sub-goals of monitoring system.

1. Routine gathering of statistics and information in the field of illicit drugs and compiling of annual overviews

The fulfillment of the EMCDDA grant contract continues, as a result of which both national and international annual overviews of the field of illicit drugs will be prepared, and necessary data will be collected and analyzed. The EMCDDA contract gives a framework for the gathering of statistics and information in the field of illicit drugs, giving us an internal national overview of the field of illicit drugs and ensures comparability with other EU nations. The EMCDDA grant contract is renewed every year with the National Institute for Health Development. An overview of EMCDDA's indicator system is given at http://www.emcdda.europa.eu.
2. Keeping and personalizing a database on drug addiction treatment

The goal of a drug addiction treatment database is to give reliable data on persons in treatment and the treatment services being offered. In accordance with § 111 section 5 of the Narcotic Drugs and Psychotropic Substances Act, a database is being kept on drug addiction treatment in a form which does not allow the identification of the individual in the registry. The drug addiction treatment database has been functioning for five years at this point, and it has become clear that an anonymous database does not justify itself, because it does not allow for an accurate registry of incidence data. Due to anonymous registration, the quality of data suffers, which inhibits getting an overview of the treatment and does not allow the assessment of the treatment's productivity or the doing of scientific work. The laws on data security will be observed and privacy will be ensured for all individuals who have received drug addiction treatment, just like any other medical service. Personalized data is the basis for drug monitoring and for the compilation of an overview of the social and health situation of persons who have entered drug addiction treatment.

3. Conducting regular studies to monitor the situation of injecting drug users

With certain regularity, there must be studies on the risk behaviors of injecting drug users and assessments of the spread of HIV and hepatitis C and B in Tallinn, Narva, and Kohtla-Järve (the study should be repeated in each region every three years). In 2013 there was a study among injecting drug users in Tallinn and in 2014 there will be a study conducted in Narva. Every five years the number of injecting drug users and its dynamics over the years will be assessed. The latest survey on the number of injecting drug users is from 2009.

4. Conducting surveys on the spread of drug use

Every four years the European Survey Project on Alcohol and Other Drugs (ESPAD) is carried out among 15-16 year-old school students in Europe. This survey gives an overview of the use of legal and illegal drugs among school students. The next ESPAD study is planned for 2015. Information on school students' use of alcohol and other drugs can also be found in the International Self Report Delinquency (ISRD). The PBGB conducts a study on risk behavior awareness, which includes questions on drug use. The target group of the survey is 7-74 year-olds, and the survey is conducted separately among children and adults. The survey is annual.

5. Updating the Syringe Exchange Information System (SEIS)

The Syringe Exchange Information System will be updated. The updated information system contains a register of the service provided and injecting equipment given to clients of the syringe and needle exchange service. In addition, the new data-gathering form allows an overview of the client's profile and the risks associated with their injecting and sexual risk behaviour. On the basis of the new database, an overview can also be made of the distribution of injecting supplies, client profiles and regular information on the drugs of choice. On top of data gathering, SEIS should be a tool for the employees of the stringe and needle exchange
program in order to simplify work with the clients. Implementation of the SEIS database will improve the quality of service and reporting.

6. Evaluating and mapping interventions in the field of illicit drugs as needed

Studies to evaluate interventions in the field of illicit drugs or mapping the status of services will be conducted as needed. Greater specificity on the topic of the study will become clear as needed.

7. Monitoring and reporting for the execution of the drug prevention policy

A report on the implementation of the policy will be compiled in the frameworks of both the annual report on the drug situation by the NIHD and the regular reporting of the NHP. A more detailed reporting of performance indicators for the period of 2014-2018 will be presented with the NHP implementation plan results report, submitted to the Government Committee on Drug Prevention for discussion. Later the report for the period of 2014-2018 will be submitted to the government to help make ongoing decisions.
8. MANAGEMENT OF THE FIELD AND ENSURING COOPERATION

Managing and coordinating the policy

The drug prevention policy will be managed at the level of the Government Committee on Drug Prevention in order to ensure consistent cooperation between the areas and levels of government (Fig. 5). The Government Committee on Drug Prevention will hold meetings four times a year for heads of organizations involved with drug prevention and reduction of drug availability as well as representatives of other concerned groups. Four Ministries - Interior, Justice, Social Affairs, and Education and Research - will be represented at the highest level. Substantive coordination of drug policy will be undertaken by work groups dedicated to each subsystem, where service providers, representatives of involved Ministries and the drug coordinators of implementing agencies will meet. The work groups will discuss, for example, common priorities for planning the national budget, solving ongoing problems in cooperation, and the feedback from the work groups will be submitted to the ministers as input for making executive decisions. The work groups will be led by specialists from each field and in the case of the two least developed fields - primary prevention and social reintegration services - the suggestion is to hire a coordinator for at least two years to build up the relevant system. A representative of the monitoring system will participate in all work groups and summarize the input, which will be submitted to the Government Committee on Drug Prevention and the ministers for leadership decisions. The monitoring of policy guidelines of the white paper does not require a new monitoring system, but can rather use the already existing and functioning monitoring unit of the NIHD. National monitoring of drug problems will take place during the course of gathering routine statistics and studies. The performance indicators of the white paper's policy guidelines overlap in large part with the current national monitoring needs.

Since a stumbling block in the previous strategy period was insufficient coordination, it is important to ensure sufficient communication per work group, a constant sharing of a common vision, and tracking the same performance indicators. Each work group should have a permanently appointed leader and the leaders of each group will form their own task force. This body will discuss overlapping and cooperation between the systems and will make suggestions to the government committee regarding concrete needs for stewardship and investment.

Vision for the activities of the white paper of the drug prevention policy (appendix 2)

The white paper's appendix 2 has a list of activities which help unpack the content of the cooperative systems described in the policy document and which are necessary for reaching the goal. Each activity has a description of the current situation and goals to move toward by 2018. Most of the activities are already underway in Estonia right now, but appendix 2 categorizes existing activities by capacity and quality:

(A) existing and functioning activities;
(B) existing activities whose quality/capacity are insufficient, and
(C) activities which are lacking or in need of further development.

The compiling of the action plan is based on input from Ministries and experts in different fields which are connected to the drug problem as well as feedback gained from public consultations. In short, the feedback from the public consultations was concerned with the following questions: the need for greater specificity in the terminology of the white paper, scientific work in the field of illicit drugs and emphasizing the importance of awareness, initiating the discussion on legalizing cannabis, and bringing out the role of preventative measure on a local level. General background material on universal drug prevention also came in during the course of the feedback.

The list of activities by system (appendix 2) is an indicative planning tool for other related strategies, which should give a guideline for an integrated handling of the drug problem in the coming years. Although it may not be feasible to fund all of these activities to their full extent immediately, it is necessary to have a shared understanding and vision for how and by what means the use of drugs in Estonia can be reduced.

Appendix 2 along with the textual part of the white paper is a framing document, on the basis of which the Government Committee on Drug Prevention, having received input from the work groups, will make suggestions for the addition of new services to the implementation plans of the national development plan and annual action plans. In short, appendix 2 is a scientifically-based aid created by the Government Committee on Drug Prevention for the planning of implementation and action plans for development plans which have to do with the field of illicit drugs.

**Coordinating drug prevention on a county level**

In addition to the national structure active involvement on the local level has an important role in the reduction of drug use. Just as described in the chapter on the prerequisites for the successful use of the policy, the local level can control the scope of the supply of drugs, create disapproving norms in regard to drugs and work in early intervention and harm reduction services. Cooperation and sharing of information between specialists on different local level is the foundation of effective drug prevention. Coordinated cooperation networks must be ensured at the local level which can deal with the problem of drug use in multifaceted ways. The topic of drug prevention should be integrated into the work of counties' health councils or other networks which ensure the safety and health of the community.

**Harmonizing policy priorities**

One of the tasks of the Government Committee on Drug Prevention is to harmonize the policy priorities. The field of illicit drugs is wide, and the priorities of ministries in regards to drug-limiting legal acts, changing working arrangements and allocating resources can be at variance. Changes which directly affect the goal of the reduction of drug use must be discussed by the
Government Committee on Drug Prevention and the effect of the changes upon the spread of drug abuse and addiction assessed.
Figure 5. Drug prevention policy management structure
Vabariigi valitsus – Government of the Republic
Valitsuskomisjon - Government Committee
Rakkerühm – task force
Kohalikud omavalitsused - Local municipalities
Sotsiaalministeerium - Ministry of Social Affairs
Siseministeerium - Ministry of the Interior
Rahandusministeerium - Ministry of Finance
Justiitsministeerium - Ministry of Justice
Haridus- ja Teadusministeerium - Ministry of Education and Research
Kultuuriministeerium - Ministry of Culture
Pakkumise vähendamise töögrupp - Supply reduction work group
Esmase ennetuse töögrupp - Universal prevention work group
Varase märkamise töögrupp - Early intervention work group
Kahjude vähendamise töögrupp - Harm reduction work group
Ravi ja taastusabi töögrupp - Treatment and rehabilitation work group
Taasühiskonnastamise töögrupp - Social reintegration work group
Seire töögrupp - Monitoring work group
Figure 6. Division of spheres of responsibility among Ministries for drug prevention policy

Ministry of the Interior -
- Managing the strategy through the Government Committee on Drug Prevention
- Reducing the supply of drugs
- Involving the community in supply reduction
- Investing in prevention through social partners

Ministry of Finance -
- Reducing the supply of drugs through the work of the Tax and Customs Board
Ministry of Justice -
- Crime reduction strategy
- Reducing the supply of drugs in prison
- Treatment services in prison
- Social reintegration services in prison
- Penal Code, analysis of the judicial area

Ministry of Education and Research -
- Prevention in schools and among youth
- Drug awareness in national curriculum
- Vocational education services for social reintegration
- Youth work and hobby education

Ministry of Culture
- Investing in universal prevention through sports and cultural activities

Ministry of Social Affairs
- Universal prevention through parental education and awareness
- Early intervention
- Harm reduction, treatment, rehabilitation and social reintegration
- Monitoring through the State Agency of Medicine
- Monitoring and evaluation
APPENDIX 1. TERMS USED IN THE DRUG PREVENTION POLICY

Harm reduction – activities aimed at reducing the infectious diseases associated with drug use and instances of overdoses and encouraging drug addicts to get in touch with providers of health care and social services².

Protective factors – factors which decrease the probability of starting to use drugs and the development of that use into addiction and harmful drug use habits. The goal of drug prevention is to strengthen protective factors³.

Precursors – all the substances listed in the appendix to the Council Regulation (EC) No 111/205, including compounds and natural products which contain those substances, excluding medicines, which are determined by the European Parliament and Council Directive 2001/83/EU (3), medical preparations, mixes, natural products and other preparations containing precursors listed in registries, which are mixed in such a way as to make the previously mentioned substances infeasible or complicated to extract or use.

Narcotic and psychotropic substances – are compounds and their stereoisomers, esters, ethers and salts which are listed in the established registry based on the Act on Narcotic and Psychotropic Substances and Precursors thereof⁴.

Drug addiction treatment - specifically structured pharmacological and/or psychosocial techniques aimed at reducing or ending a patient's use of drugs¹.

Needle and syringe exchange programmes – a harm reduction intervention aimed at guaranteeing sterile needles and syringes and other injecting equipment for injecting drug users¹.

Psychoactive substance – a substance whose use causes a state of altered consciousness.

Serious drug crime - crimes stipulated in the Penal Code § 183-189 and 392 which are connected to the production of narcotic substances (including their precursors) or the arrangement for mass transportation or distribution, also the financing of these activities.

Rehabilitation – a measure for reducing drug use which includes the restoration of functions lost in the course of drug use⁴.

Risk behavior – a particular form of behavior which can be accompanied by a greater predilection toward drug use⁵.

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² EMCDDA online glossary
³ http://www.drugabuse.gov/
⁴ The narcotic and psychotopic substances and their precursors code
⁵ NHP 2009–2020
Risk factor – social, behavioral, economic, environmental or biological factor which causes or encourages the use of drugs. The goal of drug prevention is to decrease risk factors\(^5\).

Monitoring and assessment – routine collecting and documenting of data on the progress of a program, project or activity and comparing the achieved results with the initial plans\(^2\).

Social reintegration – any sort of social intervention which is aimed at the integration of former and current drug users into society. The three main directions of social reintegration are housing, educational opportunities and work placement\(^1\).

Evidence-based – information on the effect of interventions which has been confirmed by the results of experimental study(ies). Using scientific research of the highest available quality ensures a more fruitful, cost-effective result and promotes open policy. Scientific basis is ensured by the systematic analysis of experimental studies, in the course of which the reliability of the given study is verified and the degree to which it is evidence-based is determined\(^2\).

Drug prevention – any kind of activity which is aimed (at least in part) at preventing or reducing drug use and/or its negative consequences. The goals can also be quitting drug use, reducing the frequency and dosage of drug use, limiting the development of dangerous or harmful habits and/or reducing the negative consequences of drug use\(^2\).

Drug addiction – a chronic brain illness, which is characterized by the constant use and search for drugs, regardless of negative consequences. A set of physiological, behavioral and cognitive phenomena, in the case of which a psychoactive substance gains much more importance for a person than other activities which previously offered interest and satisfaction\(^2\).

Drug supply reduction – activities which are aimed at reducing the demand for illegal drugs. These activities are, for example, combating the spread of drug production, trafficking, precursors, and the money laundering associated with those crimes\(^2\).

Overdose – a lethally dangerous state, caused by an excessively large dose of drugs or by using different drugs together\(^1\).

Universal prevention – activities aimed at the entire population, whose goal is to prevent the beginning of drug use. In this case, it is assumed that there is an equal risk among the population to fall into drug addiction\(^1\).

New psychoactive substance – a pure form of or preparation containing a new narcotic or psychotropic substance which is not listed in the Single Convention on Narcotic Drugs of 1961
or the Convention on Psychotropic Substances, 1971, but which may endanger public health to the same degree as the substances listed in the above named conventions⁶.

**Early intervention** – a strategy which encompasses early detection of and reaction to risk factors or drug use³.
### Appendix 3. Performance indicators of the pillars by 2018

<table>
<thead>
<tr>
<th>Supply reduction performance indicators</th>
<th>Expected result by 2018</th>
<th>Base level</th>
</tr>
</thead>
<tbody>
<tr>
<td>The availability of drugs has been reduced by 20% among injecting drug users, adult population, and 15-16 year-old school students</td>
<td>Among 15-16 year-old school students the following drugs are considered to be easily or very easily available: Cannabis - 26%, Amphetamine - 11%, Ecstasy - 9% (ESPAD). The assessment of injecting drug users and the adult population is lower than the base level.</td>
<td>In 2011, according to ESPAD, 15-16 year-old school students considered cannabis (32%), ecstasy (14%) and amphetamine (11%) to be quite easy or very easily available. The answers of injecting drug users about drug availability will be integrated into the syringe exchange information system SEIS. Adults will be targeted by the PBGB risk behavior awareness survey. Base levels will be available in 2014.</td>
</tr>
<tr>
<td>The number of criminal cases discovered and sent to the Prosecutor's Office which are connected with inducing minors to illegally consume narcotic and psychotropic substances or their delivery to minors increases every year by at least 5%</td>
<td>§ 185 and 187 – 44 cases per year</td>
<td>33 cases in 2012 based on §187 and 185.</td>
</tr>
<tr>
<td>Twice as many street operations aimed at eliminating drugs from the streets by 2018</td>
<td>12 targeted police operations per year</td>
<td>In 2012, six targeted police operations were carried out (three in the North Prefecture and three in the East Prefecture).</td>
</tr>
<tr>
<td>Narcotic and psychotropic substances and medicines that contain them and their precursors do not pass from legal circulation</td>
<td>Maintaining a 0 level</td>
<td>As of 2013 there is no information regarding narcotic and psychotropic substances and medicines that contain them and their precursors passing from legal circulation into illegal circulation (State Agency of Medicine)</td>
</tr>
</tbody>
</table>

### Universal prevention performance indicators
85% of the population is aware of the dangers associated with drugs (also shown by ESPAD's block of questions on risk assessment) | 85% | The base level will be established by the PBGB's risk behavior awareness survey among adults.

### Early intervention system performance indicators

| Educational and child care institutions have implemented services for early intervention through social and support services | By 2018, at least two early intervention services will have been tested (MSA Department of Children and Families and MER) | At present the services for early intervention in educational and child care institutions are inadequate or completely unimplemented |

### Harm reduction system performance indicators

<table>
<thead>
<tr>
<th>Rate of HIV incidence among injecting drug users decreases by 10%</th>
<th>The absolute number of newly diagnosed HIV infections per year is less than 260 and less than 35% of those are infected by using a needle</th>
<th>In 2012, 35% of newly diagnosed HIV infection cases where the infection’s transmission route was injecting. In 2013 there were 325 newly diagnosed HIV infections.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A systemic implementation of naloxone program, within whose framework take-home naloxone is ensured for opioid users and those close to them</td>
<td>At least 500 naloxone doses will be distributed annually</td>
<td>A naloxone pilot project was initiated at the end of 2013.</td>
</tr>
<tr>
<td>At syringe exchange sites filter, etc will be distributed in addition to needles and syringes.</td>
<td>Equipment is ensured at all syringe exchange sites</td>
<td>Currently only sterile needles and syringes are available at exchange sites</td>
</tr>
</tbody>
</table>

### Addiction treatment and rehabilitation system performance indicators

<table>
<thead>
<tr>
<th>The number of injecting drug users is decreasing</th>
<th>Through treatment and prevention, there will be fewer than 5362 injecting drug users by 2018</th>
<th>According to evaluation from 2009, there are 5362 injecting drug users in Estonia (95% confidence interval 3906-9837) (Uusküla et al., 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of new injecting drug users among all injecting drug users is decreasing.</td>
<td>6% of injecting drug users have been injecting for less than 3 years (regional risk behavior studies among injecting drug users)</td>
<td>In 2012 8% of drug users in Kohtla-Järve had been injecting for less than three years. A study from 2010 in Narva showed that those injecting for 0-2 years comprised 19% of injecting drug users. The study carried out in Tallinn in 2009 showed 7% had been injecting for 0-2 years. Risk behavior studies</td>
</tr>
</tbody>
</table>
Table 1: Addictions and Drug Use in Estonia

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual/Goal</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>The average age of injecting drug users increases each year</td>
<td>Average age is 33</td>
<td>In 2012, in Kohtla-Järve average age for injecting drug users was 30 (between 18 and 54). In 2010 in Narva it was 29 (between 18 and 60 and in 2009 in Tallinn it as 27 (between 16 and 46) (NIHD 2013)</td>
</tr>
<tr>
<td>Drug addiction treatment as alternative to imprisonment will be increasingly used</td>
<td>By 2018 this will have been applied to up to 90 people</td>
<td>In 2013 treatment replaced imprisonment only in a few cases.</td>
</tr>
<tr>
<td>The needed legal acts and quality standards are in place for addiction treatment and rehabilitation.</td>
<td>By 2018 this will have been developed/ratified</td>
<td>In 2013 the needed legal acts and quality standards were not in place for addiction treatment and rehabilitation.</td>
</tr>
<tr>
<td>Services that have been missing in addiction treatment and rehabilitation system have been created (NIHD and MSA cooperation)</td>
<td>By 2018 there will be at least two services which are currently missing in the treatment and rehabilitation system</td>
<td>As of 2013, out-patient counselling services for adults and minors, continuing care and support services and special services for stimulant users are missing</td>
</tr>
<tr>
<td>The number of opioid substitution treatment slots will increase by 20%</td>
<td>824 opioid substitution treatment patients slots are filled</td>
<td>As of the end of 2012, there were 687 persons receiving opioid substitution treatment in Estonia</td>
</tr>
</tbody>
</table>

Social reintegration system performance indicators

Due to quality and availability of drug addiction treatment, the percentage of relapses will fall by 20% among all those who seek drug addiction treatment.

Monitoring system performance indicators

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual/Goal</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a reliable overview of the drug situation in the form of annual reports.</td>
<td>Annual national drug abuse reporting continues to function.</td>
<td>There are annual national reports on the drug situation. (This is a requirement of the EMCDDA grant contract.)</td>
</tr>
<tr>
<td>Personalised drug treatment database has been established</td>
<td>By 2018 there will be personalised drug treatment database.</td>
<td>As of 2013, the drug treatment database is anonymous.</td>
</tr>
<tr>
<td>Estonia takes regularly part in the ESPAD survey of 15-16 year-old school students.</td>
<td>The next ESPAD survey will take place in 2015</td>
<td>The ESPAD survey of 15-16 year-old students is conducted every four years. Estonia last took part in 2011</td>
</tr>
<tr>
<td>There exists a data source for the assessment of the extent of legal and illegal drug use among adults.</td>
<td>Beginning in 2014, the PBGB will conduct this survey annually.</td>
<td>Public procurement for developing a survey instrument and conducting the survey has been carried out.</td>
</tr>
</tbody>
</table>
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